CHILDREN'S BEHAVIORAL HEALTH TASK FORCE
September 19, 2007

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JIM JENSEN: Well, good morning. Let's begin. Ruth is...there is Ruth. Great, I think everyone is here today, with the exception of Senator Lavon Heidemann, who's beginning his field work, as we're approaching harvesttime, as you all know. And so that's a very important time to those who are in agriculture. Just so thankful that we've got fantastic commodity prices. We've got tremendous yields. And so there is nothing that a farmer can complain about. (Laughter) Welcome everyone. I wasn't here at the last meeting. It went very well. I think Senator Heidemann did a very good job, from what I understand, in conducting the meeting. And so we'll begin. You have an agenda before you. Are there any corrections or additions or changes that should be made to that? If not, we will proceed along those. And the minutes have been sent to you. Hope you had an opportunity to read through those. Are there any additions or corrections to that? Seeing none, they will stand approved as presented. I might mention, I understand from last meeting that we did have that there were individuals in the audience that could not hear the discussion that was going on at the table. And you do have a mike in front of you and it is powered. And so when you do speak, if you would at least get close to that mike, then everyone can hear; not only that, it will be available for the recording. And so with that, that brings us then to Item 4, the development of the task force recommendations. And I'm going to turn this portion over to Jeff to take us from there.

JEFF SANTEMA: (Exhibits 1-6) Thank you, Senator Jensen. And as we lead into that, there were a couple of things from the last meeting they want to just hand around. The working session feedback, you'll recall that we'd asked that the working session leaders put their feedback together. And that was forwarded. And this is the result of that, that's coming around now. Also, since the last meeting, there was some additional information that we wanted to give the task force that Candy and Scot had provided. There are some things related to the Hastings Regional Center. This is some material from Candy on parent focus group input. And then there are three pieces that are coming around from Scot, related to the Hastings Regional Center, Juvenile Chemical Dependency

Program, and some YRTC data. And that's coming around.

JIM JENSEN: Scot, do you need any explanation that you want to make?

JEFF SANTEMA: Yes, please.

SCOT ADAMS: That would be great, thank you. I think there should be a moment of silence for the trees. (Laughter) But a lot of material coming around. And again, as you recall the conversation toward the end of the meeting last time, there were a lot of questions about detail and things. And I may have been a bit exasperated in terms of my response. I apologize, if I was over the line. If I wasn't, that's great and we'll keep going, because I will continue to challenge best as I can. This information is intended to provide fuller background in context to who we serve with regard to Hastings, and also with regard to the YRTC's in Kearney and Geneva, as well. So hopefully, that will help you. This one page is sort of the top ten, sort of moments of pride, if you will, or accomplishments, or major descriptors that I think are a part of the Hastings Regional Center. This document then is a longer document that gives a full description of the program philosophy, also has a variety of charts and graphs with regard to incidence, completion rates, gender, age, those kinds of things, county of admission, a variety of background demographics, as well as program and treatment outcomes and things like that. Then this last document then relates to the YRTC's. And we have county of admission, similar kinds of demographic background for the YRTC operation. So those of you who are insominacs, this is probably a sure-fired cure to help you with that problem. And for those of you not, this hopefully will provide additional background in context for you as you move forward with the deliberations and understanding of the system as it is today.

JEFF SANTEMA: Candy, would you like to comment again, on the material that you provided?

CANDY KENNEDY: Sure. We did...actually the Federation of Families is creating a handbook for family members around the state, kind of to help them navigate the system, and make a successful journey. But I thought it was really interesting. We synthesized some of the comments that we've asked family member and youth. There's two here. And I just thought that it would be nice to share with everyone and hear what family members and youth have...what their concerns are right now.

JEFF SANTEMA: Okay. Thanks very much.

BETH BAXTER: (Exhibit 7) And I don't know if this was one of the handouts that we had sent along. This is just from Group 3, and it goes with the system (inaudible) from Group 3. And so I made copies of just kind of a proposed organizational chart. Pass it, if you would, around. So that way (inaudible). Yes, so this came out in the e-mail. It kind of goes along with our groups work as well.

KATHY MOORE: And, Scot, just in case we didn't kill enough trees, we had gotten an e-mail description of the youth in the Chemical Dependency Program and their previous placements. Is that included...and I think I forgot to bring that. So that's not included in this?

SCOT ADAMS: I don't believe that's in this, no, no.

KATHY MOORE: Okay. I printed it at my office and forgot to bring it. So, okay.

JEFF SANTEMA: Would the task force...members of the task force like that information?

KATHY MOORE: I can (inaudible)...a couple people brought theirs, and I've got it.

JEFF SANTEMA: We have two, Kathy,...

KATHY MOORE: Okay.

JEFF SANTEMA: ...we can make copies of it from downstairs and share it with the commission or the task force, after lunch, if that's okay.

KATHY MOORE: Okay.

JEFF SANTEMA: (Exhibits 8-9) Leading then into a discussion of, again briefly recapping the remaining time before the due date of December 4, the first question I wanted to ask, did all of the task force members, did you bring...happen to bring with you today your SIG grant material that was given to you the last time, that 56-page document, with the various attachments? If you didn't, we have a few extra copies here with us today that you could have, if you find that helpful during the working session activity, a little bit later. Wanted to offer the discussion for a little bit, before you break up into the working session activity, which I think we could possibly get to by 11 o'clock this morning, and so to give some time talking about the final report and the development of dropped recommendation, getting to the meat of the plan. I wanted to hand out a couple of things. The first is just a single sheet, again more trees, I apologize. But this is a single page recap of the requirements from LB542 of that plan. So that you have those elements in front of you again as a reminder. As you recall at the last meeting, we handed out this very broad outline of the final report. And in your working session you made comments about that and added to that and so on. What I'd like to hand out to you now is a more complete outline for you to review and comment on for a while on the recommendations part of the report. The idea here was to get at what things do you want to make recommendations on? How do you organize those recommendations? Are all the elements there that are in the statutory requirements, etcetera, or are there some things that you want to add to that? So that's what's coming around now is a draft outline of recommendations which would be, with your approval and comment, sort of a guideline for putting together that part of the final report. A lot of you have other ideas. If

we could talk about that for a little bit, given the statutory requirements, and there is some commonality between those elements as they were in the statute, your feedback as to how to organize those into some meaningful recommendations. And this outline, just give you a moment to look at that. That was the purpose of this point in the agenda, was to talk about that. In terms of a time line, the idea to ask you about, does this seem reasonable then to consider today and the next meeting, on October 10, focusing on recommendations, distilling some consensus on key elements of those recommendations? Then by October 31 have a, from me, have a first rough draft, although not complete, but a first rough draft for you to look at and to comment on. Then to talk about further refinements of that, more completion of that by the November 14 meeting, and then possibly meeting together on December 4, which is a Tuesday actually, for the sole purpose of approving the final draft of the plan or the report. There could be e-mail, you know, back and forth during those time periods. But that's the other second element to discuss at this point in the agenda is a time line and how we can best come to the point of consensus on some recommendations. And the earliest to get...maybe to use something in a more developed form, an early stage of developed form for you to look at, and then change and alter would be by October 31 as a target. So, Senator Jensen, you could open up discussion now.

JIM JENSEN: Any comments on what Jeff has presented?

SCOT ADAMS: I might have one. As I look at the...and thanks, first of all, for doing this.

JEFF SANTEMA: Sure.

SCOT ADAMS: I think this is a very helpful outline. And I think many...in fact, I wouldn't disagree with any of the topics. I appreciate those. Looking at item 1 on your LB542 Health Plan requirements, it talks about education. Plans for development of a statewide integrated system of care to provide appropriate educational services to children and their families. Do we want to talk to Senator Raikes on this? (Laugh) We

have the opportunity to undo the entire school system, if we want to. More seriously though, that's a piece in here that I don't see necessarily on the outline itself.

JEFF SANTEMA: Right. The interagency coordination, I think, is a key aspect of what we've been talking about. And an integrated system of care is key. I think it may not be on the chart that you have from Group 3 for last time. But it is...in the SIG materials, you'll notice that they included the Department of Education as a partner, interagency cooperation type of effort. Thank you, Scot, for that. It is not specifically on there.

TOM McBRIDE: You know, additionally, with that, there is a legislative task force that's looking at special education and education as it relates to state wards that are in out-of-home placements, as well, I think. We're going to have to consider, you know, as the final, you know, plan is put together.

JIM JENSEN: Also along with that, is Senator Johnson's study on education improvement of those in behavior health: psychiatrists, psychologists, how do we promote that? How do we fund it? That, I think,...did you have a date set on that?

SENATOR JOHNSON: No, not yet.

JIM JENSEN: So that's also a part of that education piece.

KATHY MOORE: Under number 4, System Issues, I'm trying to figure out, and I just have come back from a series of community meetings for the Coalition for Juvenile Justice, in the Panhandle, and one up in Norfolk, on Monday. And the issue of EPC was a top concern for everybody there. And I'm wondering, under System Issues, whether or not that warrants a separate category? Because I think there is clear evidence, and I'm looking at number four in a couple of ways. There's clear evidence that EPC capacity diminished considerably in recent years, as did shelter capacity. Shelter capacity is typically not for the same type of children that need EPC. But I think those are two

pieces. The shelter could fall under...I don't know, maybe under early intervention. But those two may be separate. But I'd like other people's feedback.

LIZ CRNKOVICH: Custody...

KATHY MOORE: Emergency Protective Custody, and it's an issue for adults as well as children. It's that law enforcement, sheriffs, up in Norfolk one sheriff described driving to three different hospital locations before...for him that was about a 300-mile trip, before finding a location. Similarly, there are no...again, it's not the same population, but similarly there have been a number of shelter beds or staff-secure beds closed in the last four years. And so there are just fewer places to take children initially upon pickup.

CANDY KENNEDY: There are...I think it's typical (inaudible). But there can be situations typically where there isn't anything available. So it's not just a rarity, it's typical.

KATHY MOORE: Right. Yeah. And I wouldn't want to get the two categories mixed up, because EPC is clearly for one type of child; shelter staff-secure is typically for another type. But I see those as two needs that might warrant discussion.

BETH BAXTER: I could make a comment there, because both of those...both the shelter care and closing the shelter and (inaudible) and obviously the EPC issue is near and dear to the heart of behavioral health. The shelter and the detention that we've experienced in central Nebraska, in the Region III area, we've probably experienced three shelter staff-secure that have closed. Now, I've got to tell you when you look at community-based services and homelike services, family type services, that's a step forward in our system. Children are...I mean, we've looked at children...taking a child with their belongings in a black trash sack. And taking them to a shelter is not in the best interest of the child. And I know that that places some hardships then on to find an appropriate placement for that child in crisis. But truly, I mean I have to personally say that's a step forward for our system. And that shows a growth within our system. And I

strongly believe, at least in central Nebraska, our work with the Integrated Care Coordination Units, our professional partner work in looking at how do we empower and support families in those types of efforts. That really has allowed our system to evolve and change. And our providers have had to...we work with providers, and how do you figure out how to do something a little bit different. It doesn't alleviate every single issue. But our system has evolved and changes. And that's one of the pieces that we've seen. In the EPC situation, you know, we actually have, for adults we have expanded capacity. And I shared this with Scot before. We have, in the Region III area, we have 56 private hospital beds that we can use, this is on the adult system for EPC and what we call acute inpatient services. And those are the...acute inpatient is what we used to place individuals at Regional Centers for. Last year, our data showed that on any given day the public system, out of those 56 beds, used 8 of them. And so that...and there are times that, yes, when there isn't a bed available. And what happens in on hospital, I mean I don't know why this phenomenon is, but it's just a domino effect. And our struggle is, how do you gear up a system or staff a system for those three, four days a month when that's the phenomenon you experience? And it's just the reality out there. And I know when that happens to law enforcement and it happens to an individual who's in crisis, that's a big deal, I mean it truly is when they can't drive to the local hospital to place that person, it's a huge deal. But it really is...it's not the norm. And that's what we're challenged with, you know, how do we make it right every, single incidence that we experience? But that's really...

CANDY KENNEDY: And to add what Beth says, too, that's been an issue we've discussed, too, is when you do change the system, and it's getting better, I like the idea, instead of building more facilities, more beds, changing how things work so they're not needed. So when we were saying the other day if they build them, they will come, I understand that. And I think that we're on the right road.

BETH BAXTER: But see, I don't know anymore if they will come. I mean I just think, I'm personally convinced that our system is changed enough that they won't. And

(inaudible).

KATHY MOORE: In Region III.

BETH BAXTER: Well, yeah.

KATHY MOORE: I love the fact that you couched it in a very different term, and that's how it should be presented. I think it's important to recognize that much of that, I believe, is because of your collaborative partnering over X number of years, because the information that I got in Norfolk, and in Scottsbluff, and Alliance, and even McCook was completely different. And in fact, the Panhandle partnership, that I thought ten years ago was quite strong, seems to have weakened in recent years. And so unfortunately, whatever we say, I would like to speak to the benefit of collaborative relationship, pooling of funds, whatever we believe are the keys to your success. But we still need to recognize that the change that occurred when these "beds" closed have not universally led to improved services, and that in some instances it's children sitting in a sheriff's car for hours at a time.

CANDY KENNEDY: So, Beth, I guess I wanted to add to what you said. So normally, it's not an issue? And you're saying, though, that those days that it is, you don't think that situation is probably going to change? That's something that we're going to have to deal with and...

BETH BAXTER: Well, on the adult system, yes. I mean, we...and the only way I know how to explain what, I guess, we try to do in the public behavioral health system is just methodically move forward, you know, with whatever resources are available. You just continue to move forward. And as we add additional services and, I mean, we all know the...somewhat of the chaos that change brings for us. And our system is truly a system, you know. We work with law enforcement, the hospitals, providers, families, county attorneys, you know, the courts, and so forth. And so as we continue to add

additional services, and they only come in little bits at a time, you know, we have 12 new beds in a crisis stabilization unit in Grand Island. There are four beds that are what I call medically assisted detox; eight beds are like a crisis stabilization, or respite type. So, yes, I believe that that will have some impact upon the system and provide some relief so that we just move forward with that. But, yes, there are going to be days when, you know, when it doesn't work. And there's never to diminish the...it's difficult for law enforcement, it's terribly (inaudible) for the person that's experiencing (inaudible).

LIZ CRNKOVICH: When you describe the shelter care and the EPC's, through your ICC and the collaborative efforts, I wasn't sure I understood what you were saying. Have they developed kind of immediate, 24-hour, get in there kinds of services? Is that what has helped you lessen the need for shelter care in an emergency situation?

BETH BAXTER: I think it is the process. But, yes, it's involving families as we can. And so it's the thought of not...and I can't articulate this very well, but the thought of not...you know, sometimes our system has to push us to change the behaviors that we, as a system, have created, you know.

LIZ CRNKOVICH: Right.

BETH BAXTER: And so it's (inaudible) that we want to ensure that a child has a family like setting. So if we're going to go in and try to shore up the family, support them in that effort, the safety planning, you know, that every child has. It's not the automatic of what we do is send a child to shelter care.

LIZ CRNKOVICH: Okay. Okay, no, that's helpful, that makes sense. And then competent...making sure that as you're building the services that they are competent that they really fit what the immediate kind of crisis is. But that it didn't happen overnight. It was a...

JIM JENSEN: Todd, and then Candy.

TODD LANDRY: I think it does get to...and I think some of this discussion gets to what I believe is a core philosophy or a core piece of the recommendations that we, as a group, need to come to, which is, do we actually recommend and put forward recommendations that say, we want to build a system that will serve 100 percent of the children and youth, 100 percent of the time, to avoid any situation of, however infrequent they may be, of the sheriff or the police officer having a youth in their car for an unacceptable or large amount of time, or the shelter beds not being available, or hospital beds being available? Or do we say, no, that's not an appropriate use of our resources, and therefore we are going to recommend a system that meets the needs of the children 80 percent of the time, 90 percent of the time, 70 percent of the time, whatever that case may be, recognizing that there are going to be these undesirable situations for some percent of the time that the system is going to have to deal with? It makes a huge difference, in my opinion, in how we actually lay out the complexity, depth, and redundancy that's built into the system.

SCOT ADAMS: I think that's a great...a great (inaudible).

KATHY MOORE: It would minimize those things. But it would be unrealistic to consider the elimination of (inaudible).

CANDY KENNEDY: Well, we can hope that maybe some day we can...maybe hope that some day our system would be strong enough and (inaudible).

KATHY MOORE: Well, we have to have an idea of something to which we can (inaudible).

CANDY KENNEDY: Yeah. And I wanted to add one more thing, I'm sorry. But Kathy said that...and Beth, so Beth's explaining what's happening in Region III, how that

works. So, Kathy, with these forms that you've been speaking with, does it seem like it's consistent throughout the state?

KATHY MOORE: I did not...none of the forums drew from Region III. So...and these were simply Panhandle and northeast. So I can't speak to the whole state. Sorry.

BETH BAXTER: But I mean I'm not saying Region III is perfect; absolutely not. You know, that's the only piece in the world I can speak for, you know. And hospital beds for children, yes, that capacity has decreased. We work with Richard Young Hospital. They made a decision that they didn't have the capacity to serve young children any longer, you know that the resources there...so they don't serve younger children, they serve adolescents. And they are system issues that make it very difficult for me on the public behavioral health side to even get access to those beds at times, because we have children there who maybe should go, they've been approved to go to an RTC, but there isn't an RTC bed available, so they are sitting in an acute care facility. When the sheriff in Phelps County has a youth that needs to be placed, and no, we can't get them into that facility because there are children there using beds that they need to be somewhere else. But that's part of the system issues that we experience.

JIM JENSEN: Scot.

SCOT ADAMS: Just a couple of points. I want to just underscore what I...Todd's point, I think, is a very significant point. We have talked about that in terms of the percentage of beds in terms of capacity. What is the number this group is willing to recommend per year for riding around in a cruiser? That might be a concept around which all of the services could be considered. What is an appropriate waiting list? Is it a week? Is it a day? Is it six months? It might be a means, and so I really want to underscore what Todd is saying there. Secondly, the EPC question is a fascinating question as I've come into this. Lot of dynamics, both geographic, if you will, individual in some cases, systemic. For instance, at the same time that you identify in McCook issues, the Region

II system, overall, with regard to EPC data, has been cut by more than half over the course of the last three years. They've made dramatic declines in the number of EPCs. I'm not saying that that's wrong,...

KATHY MOORE: Right, right.

SCOT ADAMS: ...just that both statements are true, and can be a very confusing sort of swirl of dynamics.

JIM JENSEN: Do we have enough information right now that we can establish a benchmark, this is where we are? And I think, you know, if we are going to make improvements there, we need to at least have at least a benchmark, so that we can then see in the future if what we come up with is actually working. Now, there isn't any question about it that we have six behavior health regions, and each one is different. And that's good because then they can address their individual needs. But there is a tremendous amount of difference between those six and how they are working through things, and at different times they have that adjustment, too. I also go along with that. You know, if every church built for Easter and Christmas, (laughter) we would have much larger facilities, I would imagine. And to tell you the truth, if you kind of kind look at your calendar and look at the full moon, I think those are periods that...I don't understand that. But they seem to be those areas where there is more demand during that period than the rest of the time. So I think whatever system we come up with, yeah, maybe that...whether that be the 80 percent that that's the one that you shoot for and try to work around for that really peak period. It is a strange phenomenon, if you talk to people in behavior health, as to not only times of the month, but times of the year where there is a lot of demand as opposed to other periods. And so I think you need to build for the best time that you can. But still there are going to be times where you're going to max out. I think that's just the nature of the beast, if you will. Tom.

TOM McBRIDE: As we talk about the percentages, and I appreciate a great deal what

Todd had said, I guess the eternal optimist in me is we come in and we try to reach 100 percent, you know, situationally. You know, having been an infrantryman, it's a little disconcerting to say we're going to take that hill, and 15 percent casualties are okay. You know, to the leadership you're looking at that saying, well that's okay. To the guy on the ground it's, you know, I don't want to be one of the 15 percent, because you got to write that letter home. Conversely, you know if we set it anything less than 100, recognizing that we're never going to get there, do you say 80 percent, 90 percent, and we're satisfied with that? Or are we saying we're satisfied if we fail 10 percent of the time? It depends on how we look at it. So I think we move forward trying to get as close to the maximum as possible. I don't think we have all of the data to do that yet. I don't think we know how many kids, because there wasn't a bed available, sit in the hospital? How many were in detention as opposed to being able to get approved to access a level of care or whatever service that was necessary for them? You know, the final thing, when there was a lot of shelters that had a lot of...or quite a few shelters had staff-secure beds associated with those local counties, primarily the smaller counties, population wise, had entered into contracts with those shelters for those staff-secure beds, so that if they did have a youngster that needed staff-secure, that they had an affordable route to get to. And they had worked that out in some local contracts that, you know, they were paying $60 a day as opposed to $160 a day. They didn't have as far to drive to hit those detention centers and whatever. I agree that, you know, putting everything in a black bag and taking a kid someplace is not a good idea. But in some cases it's the best idea, as well. And we have to be ready for all those eventualities.

SENATOR JENSEN: I can also...

BETH BAXTER: And just a...I was just going to say just a comment and just from a systems perspective, I guess, that's probably what I do better than anything is look at things systemically. And I've never been an infrantryman, and I probably would turn tail and run, truly. But my experience, and I'm not saying that any failure is ever acceptable. My experience in systems work is that 10 percent makes you work harder to figure out

how to do things differently. When it doesn't work, when it isn't perfect, I mean it's that chaos that makes you have to scratch your head, bring people to the table and figure out, you know, how to do it with the resources that you have at your disposal.

JIM JENSEN: Ruth.

RUTH HENRICHS: I think that...I want to agree with you. I think that one of the questions that we have to do in simplicity and conciseness is, what are all those different levels of care? And let's name them without spending days, and weeks, and months defining the ins and outs of them. But we need to know what those are. And I think from my perspective, I want to say that those services are within reason available to every child in this state. Being a farm girl, I also know the geography of this state. And it isn't going to be equally close in miles for everyone in this state. It can't...it never will be because of geography. I think the ideal goal, Tom, I would agree with you, it's always 100 percent of the kids. But if we staff up whatever this continuum is to always serve kids 100 percent of the time, we will have empty beds and we will be paying for empty beds all over. And I know that's probably not what you're saying. But I want to be clear on that, that I don't think...sometimes if it's the full moon or whatever it is, we're going to transport Omaha kids to Kearney, and we're going to move a Scottsbluff child to Hastings, or Grand Island, or Omaha. I hope that's a rare time. But I think we have to be realistic about that. And maybe that's part of what Todd's question or statement originally was. So I want to encourage us to name the system, without hours of definition, and then to acknowledge that in my opinion how it will be implemented across the state will vary to some degree. Beth's system, in the center of the state, is maybe one unique way of doing it in the state. The Panhandle had it going, and now it's kind of changed. There are almost none of us left in the Panhandle for private providers; we've all left. That doesn't mean we wouldn't go back.

KATHY MOORE: Right, exactly.

RUTH HENRICHS: I'd go back in a heartbeat, if that were possible to go back to the Panhandle. Omaha will never function like the center of the state. I think that's a dream. So I want to encourage us to not get bogged down on the how, other than to acknowledge that we need to do what you've done in whatever creative way across the state, and that is get the kids in at the lowest level possible. We don't need as many of those expensive beds because you've proven that, if you put a child in a lower level and don't send them with a grocery sack somewhere, we can care for them if we wrap services around them. So I want to encourage us to move in that direction. And I think I'm trying to be supportive of what both of you have hinted at (inaudible).

JIM JENSEN: Okay. Kathy, and then Candy.

KATHY MOORE: And I don't want to lose two thoughts. One, your point regarding benchmarks. The benchmarks aren't going to be perfect. Tom is correct, we are not going to have completely accurate data on why each of those children sat in detention for X number of months. But we will be able to have data that tells how long they were there. And if we begin to see that shrink in the coming years, we can accurately presume it's for good reasons, I think. I also realize that something that is not on the system issue list, and I was glancing at your focus group data, and thank you, because I think that's great, is some reference to information sharing, to resource, and referral. I see a lengthy discussion of lack of information. And when you are asking, is it universal statewide, etcetera, there were instances in each of those community meetings where someone would complain about the lack of a certain service. And somebody else would say, well, that does exist. There was extensive discussion about whether Richard Young, in Kearney, took any children at all anymore. So there is often confusion or lack of information. And so I would want us, in this system issue portion, to also address information sharing, resource guides, etcetera. And I think what Candy has given us might give us some language to draw from.

JIM JENSEN: We also...what Scot handed out, that first meeting we had, there was a

lot of data in there that I think we need to review. We do know how many out-of-home placements there are. We do know how many people are in foster care.

KATHY MOORE: Exactly.

JIM JENSEN: And so we do have those issues, I think, established. How much more we need on top of that is certainly open for discussion. But that was fairly complete, at that time anyway.

RUTH HENRICHS: And I think we're always pushing to say how much we need below that. I know what you mean, it's additional numbers. But I don't want us to get lost in that. We want less foster care, more wrap, kids going home kinds of stuff. So I think we just need to (inaudible).

SCOT ADAMS: Senator, with your call for benchmarks, might I suggest some. And then I might get us to something maybe. And this may or may not be useful. But here is my suggestion, 90 percent of the time, within 90 minutes of home, assessment occurs within 4 working days, outpatient treatment appointment occurs within 1 week of evaluation, residential placement occurs within 2 weeks of referral. Ninety-five percent of the time three is an EPC bed within 90 minutes of the location, and 95 percent of the time is a mobile crisis response service within 90 minutes of the crisis. Those would be benchmarks for the system. We can argue up or down from there. It takes it out of the ethereal and...

JEFF SANTEMA: Scot, I wonder if we could write those down and copy them for the group?

SCOT ADAMS: Yes, we certainly could. I have them.

JEFF SANTEMA: (Inaudible) maybe over the noon hour (inaudible), please.

SCOT ADAMS: Yeah, that would be great.

JEFF SANTEMA: Or we could begin to do it now, if you'd like.

SCOT ADAMS: Sure, be happy to (inaudible).

TODD LANDRY: You know, there are some federal reviews within the SFSR that have some impact here. But for the sake of this discussion, I think the federal review is going to be much more focused on the absolute number of placements occurred within a period, as well as the total time (inaudible) is a little bit more longitudinal than the near term emergency or short-term needs of the youth. But it plays a role, but I think along what Scot is proposing wouldn't necessarily mean that we would automatically not be able to achieve those outcomes.

TOM McBRIDE: I guess my question was geared towards, if we're coming up for review and we're defining things, why not use, you know, federal benchmarks if they're...

TODD LANDRY: Yeah, the federal benchmarks are much longer-term in nature than what Scot is talking about.

RUTH HENRICHS: Um-hum, and they're for different points on the continuum.

TODD LANDRY: Absolutely.

RUTH HENRICHS: You're really defining entry in crisis, and you're really dealing with placement.

TODD LANDRY: Longitudinal outcome as opposed to the short-term need of the immediate placement.

TOM McBRIDE: We can build that in, too.

TODD LANDRY: But we can't build them both in.

JIM JENSEN: Candy, do you have a comment?

CANDY KENNEDY: Yeah. I just wanted to remind us, back to the question, we're talking about the (inaudible) piece. When you're talking about 10 percent or 20 percent, as a family member, been there, done that, you have to realize that what just one family goes through. It's not just a ride in a cruiser. It's so impactful, it will probably affect, it could possibly affect the whole family for the rest of their lives. This is a huge thing. This is not, you know, sitting somewhere for a couple of hours. This is...so when you say 10 or 20 percent, I'm just picking those numbers, how many people is that? How many families is that in our state? And how often does that happen, if you were talking about the whole year? So how many people have had to deal with that this year? And I know what that feels like, I know. And when you're...again, when you're talking about the...and I understand when we're talking monies, but again when we're talking my son being four hours from me, and to travel back and forth, to be involved in his care, it's huge. I know how many families have...people have given up jobs or anything they possibly can. So it's not just...they're not just a percentage; these are people that it's a very big deal. So when I think about 100 percent of the population, 100 percent of the time, that would be my goal.

KATHY MOORE: But as we look at each of these, I keep thinking, as Beth was describing their ability to overcome closure of shelters and what they've done to supplement and improve upon, it seems as though some of the recommendations need to be plan A, B, and C. So that when plan A is not available, knowing that plan B is a better alternative than plan D, for instance. When I think back to the creation of OJS, there was actually a plan developed that was similar to the benchmarks that Scot was

throwing out that said, generally, there needs to be this service within 50 miles, this services within 100 miles. Now, for an Omaha child to have a service within 100 miles would be very different than a child from Arthur. But the concept was very similar to what he is proposing. So, I guess, I would recommend that we try to not put these forth in an either/or, but in a graduated level. And that we again...that was where I was coming from when I talked about ideal versus secondary, that we can put some statements forward about what we are moving toward. And we do need to always have the human voice in there to say what is occurring in the interim, until we achieve that goal.

RUTH HENRICHS: I want to be clear, too, that I'm not speaking against, at all, what you're saying. But I think I am maybe, for myself, trying to take a...maybe I'm down to just realistic or logical. But I think the flexibility becomes important. And trying to have residential facilities all across this state within 50 miles of every child, in my mind, is not realistic or logical, nor can the state afford it. But I do truly believe that for the family from Arthur who may have to go four hours from that little town, then I'd like to see us have the flexibility to subsidize a parent's for a week, or pay for the hotel, and pay for the transportation. Or I don't know what the answer is. But I think we've got to find the flexibility to deal with the individual cases. It will be far cheaper than building residential treatment every 90 miles across this state so that no child ever has to go farther, or so that the police don't have to drive someone three hours from Pilger. I want to be...I want to keep the compassion there, but I also think...I'm trying to say flexibility is how we're going to serve every child.

_____: Well, and the adults...

JIM JENSEN: Well, let's go to Todd, and then Beth, then back to you, Scot.

TODD LANDRY: Very quickly, whatever we end up deciding, let me just state that I think it's absolutely critical in this report that we establish the appropriate expectation as

a result of those recommendations. I do not want to see us, and hope the others will agree to put forward a plan that serves...that meets what Scot was putting out, with the expectation that it's going to meet 100 percent of the kids, 100 percent of the time. We can easily get ourselves caught on that one. And I want to think...I believe that we owe it to our Legislature and those who commissioned this task force to make sure that we respond with the appropriate expectations that go along with the recommendations that we put forward. Along those...just keeping in mind that you wanted this to...us to be able to move forward at 11 o'clock, I simply have one point of clarification for you, Jeff. On the piece that you passed out, is this just the recommendation section? Or were you intending that this would be entire report?

JEFF SANTEMA: Just the recommendation section.

TODD LANDRY: Okay. Thank you.

JIM JENSEN: Okay, Beth.

BETH BAXTER: Just briefly. I think I know what we're doing here in terms of looking at the service system. But the underlying value, you know, the system of care values, that lays out the values, the principles that we work on. So that when we can't serve everybody, we have a certain set of values that we include families, that we wrap services around them, that we're culturally competent, that we're flexible, that we're willing to do what it takes. So I think that's, when we can't meet every need 100 percent of the time, we have a commitment to serve families and children in a way that may be different than the way we do now. And that has to be underlined through the whole report.

LIZ CRNKOVICH: Right. I frankly, kind of like Kathy's idea of the ideal might be plan A, plan B, plan C. And this isn't meant to be controversial, but to me that gives every caseworker, irrespective of their level of experience and expertise, or that of their

supervisor, some guidance in terms of what might be appropriate at these different levels. Because sometimes in that crisis it's about having the services, it's also about having that depth of insight and immediate understanding. And I think that provides a kind of tool for people to say, oh okay, I don't have A, but B...I can do B or (inaudible). Can I make just a correction on this working session part?

JIM JENSEN: Sure.

LIZ CRNKOVICH: Of course it said juvenile courts, and that sent a red flag to me. But that item 2(e), I've been sitting here, trying to figure out what that meant, since I didn't think I said that. Juvenile courts mark case manager and private probation function separated. And I think what I was referring to was more the concern that the dual role of the OJS worker, as a service case manager, and a parole officer be recognized. And that those are kind of merged functions that require different tasks. I didn't mean to imply that juvenile courts want a case manager and then some probation function separated. I think what's happened...my concern with an OJS is that it's original intent was to be a dual function: parole and case service manager, and that it has become one function: case service manager. Leaving a great many kids without that accountability. So I framed it differently, that the courts want somehow the language that the dual role of the Office of Juvenile Services be recognized with appropriate services to meet that dual role. And the dual role is one of a service provision or case manager and a parole officer that is comparable to a probation officer. Does that make sense? So, I don't know, I just wanted to (inaudible) because I went to law school, so that makes (inaudible). (Laughter) Thank you.

JIM JENSEN: Okay. Are there any other comments, first of all, on the outline of development?

JEFF SANTEMA: What I'm sensing from the task force is that you want to make very clear to establish that we'll meet expectations. So when you talk about

recommendations for system planning, you make the point of the expectation is not perfection, and that you make also system of care values are highlighted as a priority. The values that underlay the system of care and that there is a commitment to those values, although with the realization that you won't be perfectly...and the issue of flexibility was the other important point I heard in stressing, in terms of the system.

JIM JENSEN: Anything else, Jeff?

JEFF SANTEMA: No, that will (inaudible).

JIM JENSEN: Do you want to kind of go into our next step, if we break off into our three groups?

JEFF SANTEMA: Sure. We've kept the groups the same as they were last time. Although we...there is a slight room change. The group two will be with...Ruth's group will be meeting in Senator Heidemann's Office, which is Room 1004, which is right across the hall to the north of Senator Johnson's Office. I see some (inaudible). The intention would be...would give...the first item gives you another chance to talk about again that outline that you've just been discussing. And then there are some other specific things there. If you get started and you say take a break, and you get started by say in 15, 20 minutes or so you kind of get going with your groups, we'll bring lunch around to you around noon or so. And is it realistic to think of being back here, say breakup around 1:15 or so, and be back ready to go by 1:30? It gives you a little extra amount time. An the work you don't get done in the working session, if you could give feedback to Senator Jensen and myself, for example, as to carrying these over then to a working session at your next meeting, and what additional items for a working session would you like to see? To help focus more this discussion about realistic expectations (inaudible) has been extremely helpful to me and taking your guidance on that. So that would be the (inaudible).

SENATOR JENSEN: Okay. Any questions as we move into our groups? Okay, we'll see you back here at 1:30.

JIM JENSEN: Well, let's come back together. Todd wasn't able to come back with us. He had another commitment. But let's go ahead with our reports. And like I said, we'll finish reports, and then go through the rest of the items on the agenda. These reports that each one will give, and we'll go down one, two, three, then will be typed up and submitted to you, so we'll all have that to view. And then at our next meeting we will finish up where we left off today. And I don't know whether it would be best to have one report, go from one to four, or should we do one, three times, two three times?

SCOT ADAMS: With regard to item one, the question with regard to the outline provided by Jeff this morning, we had a number of suggestions. With regard to item...or actually, before item one policy, we suggest adding a core values and guiding principle section. We've had extensive conversation in other meetings about this. And we want to reiterate that. Point two, with regard to Section 1 policy, we suggest three additions. One is to define age of control. That tends of vary by service area and by jurisdiction. Courts to the YRTCs, the age of majority and those kinds of things, and to clarify and specify. Second (inaudible), identify two goals within the policy section where in the overall goal of children's behavioral health is to lessen the need for treatment services, especially high-intensity services. Secondly, as a goal, to develop criteria for successful discharge by level of major service area. Third point under policy then would be that a statement that we hope to serve all, but to use the benchmarks as a measurement system to note system improvement. Moving then to those benchmarks that had been handed out right before we broke, we had a number of suggestions with regard to those. I will read them once through, and try to highlight the change best I can. Ninety percent of the time there will be an initial, that's new, assessment within four working days, and then this is new, four working days of the initial point of entry, utilizing the comprehensive assessment tool. Number two, 90 percent of the time there will be outpatient treatment available, new word, within one week of assessment, new word,

when outpatient is indicated, new phrase. Number three, 90 percent of the time there will be a residential service within two weeks of assessment when residential treatment is indicated; that last phrase is new. Number four, 95 percent of the time there will be an EPC bed identified, new word, within 90 minutes of the crisis. Number five, 95 percent of the time there will be a mobile crisis response initiated, new word, within 90 minutes of the crisis. Going back to the outline, nothing on two, nothing on three. On four, a subpoint under 4(b) comprehensive assessment tool, to include medical, social, and correctional models and dynamics. The content there was that essentially the need and value for a level V facility for some portion of children in the state. 4(c), under single point of entry, five subpoints suggested. One, single hotline and web site for sorting out the systems resources. Two, regionalized resource center. Three, I got centers, three, singular protocol assessment and outcome criteria. Four, singular centralized data system. Five, a singular quality assurance system. Those five points are intended to further define what's meant by a single point of entry. Number five, funding. A, integration, a subpoint, make flex funds available to support families. In the adult system there is a thing called flex funds that can help in a variety of unusual circumstances and allow for those. That's what you were talking about, Ruth. That's all point one.

JIM JENSEN: Okay. Ruth.

TOM McBRIDE: Can I identify something?

JIM JENSEN: Yes.

TOM McBRIDE: I think on number three, we did talk about custody relinquishment.

SCOT ADAMS: You know, I missed that, Tom. What do we have for that?

TOM McBRIDE: We talked about investigating ways where services could be accessed without...

SCOT ADAMS: Oh, yes.

TOM McBRIDE: ...families having to relinquish custody, because of lack of insurance of whatever.

SCOT ADAMS: You know, I do have a series of six points under...and I captured those under question three, rather than...question three of our assignment.

JIM JENSEN: Rather than under one?

SCOT ADAMS: Yeah, rather than question number one. So when we get to question three, if I haven't covered it, make sure we include it. Thank you.

TOM McBRIDE: Okay.

JIM JENSEN: Ruth.

RUTH HENRICHS: I won't repeat what you said. If you would go to number 4(d), which is under the systems issues, the service capacity, we had discussion on that whole systems issue section, wanting us to be very clear to name and identify the continuum of services and also, to some degree, the kind of availability or current capacity. That's been brought up before. But we wanted to make sure that was...that there was some clarity there about that. And a couple of the things you named, we had in other sections, so I'll just skip those.

JIM JENSEN: Okay. And Beth.

BETH BAXTER: Our group...we actually were looking at the draft recommendations. We came up with about three-fourths of a policy statement. We kind of dived right in

there. So basically kind of the gist of it would be that: All Nebraskans understand that behavioral health is essential to overall health, and it is the public policy of Nebraska that all behavioral health services are family-centered, provided in the least restrictive environment based on the individual and unique needs of the child and his or her family. And then we were going to add in a culturally competent manner, outcome-focused and so forth. And then any...let's see. I think number two, let's skip down to number three. I think we wanted to add cultural competency in number three of the draft recommendations. System issues, just maybe a couple of other additions to the system issues. One would be the emergency behavioral health system, that would include EPC-sheltered, detention, staff-secure, and look at the process, and having an appropriate and adequate resources. And then the second one would be the transition from the child system to the adult service system. Funding, I think we just added flexible integration, flexible adequacy and so forth. On the recommendations, and then looking over for the needed piece, number two, that yes we agreed with the SIG report that was on page 16, for the state, regional, and local...oh, I guess we're just on one. Sorry.

JIM JENSEN: Well, as long as you're there, we'll just reverse.

BETH BAXTER: Just reverse, okay.

KATHY MOORE: Beth, before you left the policy, I think there were a couple of other pieces of the policy statement, those bulleted items, culturally competent, outcome-based.

BETH BAXTER: Right, and integrated. Okay, on the policy statement add...we were going to add culturally competent, outcome-focused, and integrated. And we just literally ran out of...we'd still be there if we were working on wordsmithing all of that. Okay. Anything else, did I miss?

KATHY MOORE: Could you repeat the part about...are they family-centered? Should

they be child-centered and family-emphasized? I don't...I can't remember what you said on that part.

BETH BAXTER: Okay. Basically, that all behavioral health services are family-centered, provided in the least restrictive environment based on the...so I think it was using the family-centered practices.

KATHY MOORE: Oh, based on the individual needs of the child and the family is what we...I mean, that's up for debate, I'm sure.

BETH BAXTER: Right, okay. So then for number two, coordinated integrated system of care. Right, the authority...so we talk about the authority and purpose of the children's behavioral health administrator. Because, as Scot announced to us today, there has been an individual appointed to that. And so we looked at kind of shoring up that coordination between that children's behavioral health administrator and the regional youth specialist in each of the six behavioral health regions. Strengthening that coordination, strengthening kind of that contractual relationship between the division and the regions for those coordination responsibilities. And having that contract have some outcomes in it, so that there is...we're looking for specific outcomes in that integration and coordination. And then on the next one is around the SIG developed recommendations. And we agree with the SIG report, recommendations on page 16, that there would be this state, regional, and localized interagency council. Yeah, this one right here, we agreed with that. Let's see, did I miss something? I think that was it for us on two.

JIM JENSEN: On two. Okay. Ruth, you want to go back to...

RUTH HENRICHS: Um-hum. With regard to the SIG, the chart, what we were looking at, there's talk on the SIG grant goals about evidence-based practices and outcomes. And our group, Tom, Candy, and I, really wanted to make sure that we promote

evidence-based and promising innovative best practice. We had quite a lengthy discussion about evidence-based is good, but it's not the end all, be all. And that part of what we talked about this morning is also some promising new and innovative best practice. In the goal, in SIG, about accountability, we talked about agreeing that we need to develop performance and contract outcomes, both, and that we need to put in place quality assurance evaluation that is measurable and objective. And obviously, we believed that that would be something new for the contracts, but felt that it needed to be more exclusive than it was in SIG. The question about the coordinating councils, and should there be state, regional, and local coordinating councils, we were supportive of that as a group. But we also had a caveat that we wanted to recommend with that, and that is that something be eliminated as we create these. We had a fairly significant amount of discussion about the number of coordinating councils and the number of task forces that address the same issue. And Todd's new experience, you know, being new to the state, and there's just so many groups that you have inherited. So we felt we could be supportive, as long as the caveat were heard. But we really ought to try to eliminate some oversight group if we're creating another one. We also wanted to make sure, from the goals, about the service array, the services that SIG talks about developing, that we wanted it clear that the service array...a service array is very important. And that is a goal. But it may be fundamentally different in each service area. It may look different. And we wanted that to be clear. And obviously, we knew about the announcement, and so we were in support of the office of (inaudible) (laughter), since it already happened. So we do support that, and thought that our report should state that we, as a group, support it. I think that was it.

JIM JENSEN: Okay. Scot, you want to go onto two, and then after that go right into three, and we'll work back again.

SCOT ADAMS: Okay, thank you. I want to start with the last (inaudible) about the Office of Children's Behavioral Health, and actually I think it's going to be officially known as the Section of Children's Behavioral Health with an administrator. I tried to spend some

time, within our group, to clarify. And I'd like to do that, if I could, here. The Governor has, initially, developed ten goals for the Department of Health and Human Services to mark its transformation. One of those is the integration of children's behavioral health. Knowing that LB542 was going on, that great content and direction was going to come from this process and subsequent legislative processes, we did not want to sort of preempt or presume the outcome. At the same time, we wanted to anticipate and work with and have the executive branch sort of working in tandem in a coordinated fashion. So while we had an internal conversation within the department about where best could this office be placed, or this section be placed? We considered Medicaid, children and family, protection and safety. In the division we thought that it made best sense about placing it within the division. But want to be very clear here, in I suppose a somewhat formal fashion to encourage the task force, the 542 task force to think apart from that. This is just our first steps. The office could be anywhere. We think it makes sense here. If you want to recommend it in a different direction, that's fine by us. We do not mean to cut off that conversation. Having said that, our group thought it was okay, too. (Laughter)

BETH BAXTER: So just clarify, is that position, is that within the Division of Behavioral Health, or is that what?

SCOT ADAMS: The office is within the Division of Behavioral Health. Vicki Maca, the person who has accepted that position, will be a colleague and a peer to Bill Gibson and Ron Sorensen, all three of whom will report directly to me.

KATHY MOORE: And some of us recalled making that recommendation at a legislative hearing in February. And so we were very much in support of it and (inaudible).

SCOT ADAMS: We may be slow, but we'll get there. (Laughter) Another sort of preamble comment that I want to make is that while I'm reporting sort of highlights from our conversation, not all of the points that I make are necessarily unanimously

endorsed, nor consensually arrived at. Most of the people like most of these. (Laugh) But not necessarily everyone liked every one.

LIZ CRNKOVICH: And I wasn't the rabble rouser. (Laughter)

SCOT ADAMS: Yeah, well, (inaudible).

LIZ CRNKOVICH: (Inaudible) entirely.

SCOT ADAMS: Yeah, you call it what you want.

CANDY KENNEDY: Scot, you sound like the TV station talking about the infomercial. (Laughter)

SCOT ADAMS: That's right, the following paid commercial (inaudible) not necessarily reflect the view of the administration. (Laughter) Okay. A second point then, the first one being endorsement of the children's behavioral within DBH, is some concern expressed for the potential danger of the silo's created in the wake of LB296, the need for interdivisional coordination and communication, the focus there. Point number three, encouragement of small or regionalized services, but not necessarily capital behavioral health regions. Item four, a suggestion to centralize the training given to Foster Care Review Board personnel, guardian ad litems, and court appointed special advocates in the matters of children's behavioral health. So the training for those groups, outside of the system traditionally, would be centralized, standardized, in common, so that we could avoid some of the arguments we get into as to who sees what, how. Eight, encouragement of accreditation as a standard design of assurance of quality across the system. And the potential for managed care within Medicaid as another means by which to provide somebody to help sort through the system. I'd open it up to my colleagues for any other comments. That would be it. Then I get to number three, right?

JIM JENSEN: Yep.

SCOT ADAMS: Number three is a tough one. And, Tom, I think this is one that I need your help with in particular. But we talked about expanding the buy-in programs to Medicaid, those folks who are not initially eligible, but for whom could buy into the Medicaid program. (B) (Inaudible) relinquish in protection and safety instances. (C) This is sort of tongue in cheek, make SIG figure it out. (Laughter) (D) Provide insurance vouchers to parents of some kind, or payment vouchers. (E) Recognizing this as a very large issue of substance. Though we do not think that we are able to provide any prevalence data, especially to the family to whom it impacts. It impacts on a huge level. And finally, following Senator Chambers', we might sue God. (Laughter)

TOM McBRIDE: Not touching the suing God part. (Laughter) You know, on the relinquishment we had...there's been some innovative things around the country, I think, we need to look at as far as people accessing, you know, programs, buy-in programs, supplemental health care, and mental health insurance. The...you know, there's even, as Senator Jensen pointed out, that last night the Wellstone Act was voted out of the Senate, the mental health parity bill which, you know, could have an impact where it brings equal amounts of coverage for mental health issues as it does with your aggregate physical healthcare thing. And as we talked, you know, early on and in various conversations about 7,000 state wards, we don't know exactly how many this would, you know, how many kids are relinquished in order simply to access care. And that there could be a fairly significant number, reduction of wards if we had those programs and keep, you know, families more involved in care and treatment.

LIZ CRNKOVICH: And kind of more invested in that way, too, didn't we (inaudible).

KATHY MOORE: Um-hum, um-hum.

BETH BAXTER: Our group, what our recommendation would be to examine the data

gathered by SIG to quantify frequency of custody relinquishment in order to access services, knowing that SIG has done that report. And then also a recommendation that we, somebody explore the statutory change to provide services through flexible funding streams that serve status offenders and delinquent youth and their families. And then serve families on a voluntary basis through flexible funding, and that we could move towards prevention and early intervention services using current funding streams. So it's really a flexibility issue as well.

KATHY MOORE: And I would probably add to that, I was on the committee and I didn't add it at the time, but I would say, with follow-up, with monitoring and follow-up.

RUTH HENRICHS: Right, okay.

KATHY MOORE: Because the voluntary cases, I think, are something that can be wonderful, but they also can be of concern when we don't know what's offered versus what's utilized and what the results were.

RUTH HENRICHS: Regarding the custody relinquishments, two of us were actually on the SIG group that requested that data several years ago. And Candy was remembering that it was something, when they actually came back with it, out of all the children...all the state wards, it was something like ten that you could actually document. I mean, it's very, very difficult to document. And we both acknowledged that, that staff in HHS did an incredible job of trying to find that information. But we wanted to acknowledge that we know it happens. But as a small group, we had absolutely no idea how many that actually happens for, and how many...how much of it is anecdotal, but we really don't have documented evidence. Do we just think it happens in three-fourths of the cases or one-third of the cases? So we did talk about that a little bit.

LIZ CRNKOVICH: Yeah, all the 3A cases that are dependencies based on the needs of the kids, are cases where the parents have come in, because they cannot access...I

mean, I got ten at any given time, I got more than ten.

RUTH HENRICHS: Well, I think we were basically just sort of affirming what you said, Beth, that we really don't even have a sense, in order to gather impact or recommendation, we don't even really know how many we're talking about here. But we know how difficult that is for them to be careful. And then we had some conversation that was, I think, Todd was very helpful here in helping us think about we must be careful that we don't end up with unintended consequences out of action that we may take around this. And he was specifically talking about families who do have the ability to pay, since we are setting up a system for all individuals. And he just wanted us, as a group, to be aware of that. And so we did have some conversation about that and the unintended consequences that can come.

JIM JENSEN: Okay. I might mention on three that we didn't actually write anything on, but the recent Foster Care Review Board that was in the paper, I, personally, don't think that's going to go away. It's going to be present, and don't know really what action or anything should ever be done. But I'll just leave it there.

BETH BAXTER: I apologize. I jumped ahead of you, I'm sorry. I thought Tom was (inaudible) too. And I think I was so worried about, oh darn, now we have to start the number four discussion. (Laughter)

JIM JENSEN: Yes, you do. (Laughter)

BETH BAXTER: So I will step up to the plate and do that. (Laughter)

_____: You win.

CANDY KENNEDY: Beth, before you start, before you begin, I wanted to add to what Ruth said, that one of the things that we also discussed was we understand that there

are lots and lots of families out there dealing with that. And one of the issues, too, is to make sure that our families have the knowledge they need to make correct choices, and not choices just on information that other family members have given them. So with a custody relinquishment...

RUTH HENRICHS: Candy had really good examples about parents who have relinquished custody because they've talked to other parents who have said that that was their only route or what they needed to do.

LIZ CRNKOVICH: Or medical personnel at that higher level who immediately say, this is what you must do in order to get the treatment, too.

KATHY MOORE: And I think part of why it's so difficult to document is that if families had the preventive or early intervention services at their fingertip, the child might not become a status offender, the parents might not become neglectful, abusive, whatever. I mean it's so difficult to isolate that as a cause when it's...

CANDY KENNEDY: Well, and sometimes they actually purposely make a trail so that this can happen, create a trail.

LIZ CRNKOVICH: That's interesting.

BETH BAXTER: And we had talked about then the flexibility in the funding streams to be able to do that. Because I could go into the EICC (laugh) (inaudible). You ready?

JIM JENSEN: I'm ready.

KATHY MOORE: Are you ready? (Laughter)

BETH BAXTER: Yes. Number 4, is around the Hastings Regional Center. And we...our

group spent, obviously, a lot of time talking about this. And what seemed to help us move forward a little better is that we looked at it in two separate ways. We looked at the mental health component, and then the substance abuse, the chemical dependency component at HRC. And then just went down the list and tried to answer these questions. So on the mental health side, should HRC continue as a state operated facility, dealing with the mental health services for kids? And our consensus of our group is no, that it shouldn't continue for the mental health services. Should a study be conducted, you know, with the community of Hastings? We said, yes, that that would be an important thing to do. What about the persons with developmental disabilities who are currently at HRC? And our suggestion would be to move them elsewhere, with just...we were trying to understand why they were there. And Kathy reminded us that, I think, Bill Gibson had presented some information to us that...and I do recall the time when...the incident in Lincoln of the adult attacking the five-year-old child, and then, you know, what that triggered in our system to do something about that. HRC, at that point, had...was just closing the adult sex offender program and moving that to the Norfolk Regional Center campus. And so there were 14 beds available, you know, they were there. And so it was a real opportunity for the system to develop that. So we didn't know why...you know, we thought that's why it was there. And maybe there was some other place that it would be appropriate as well. Let's see. And for the chemical dependency side of it, around the program, is it a good program? We thought it was an effective program, yes. We agreed...

KATHY MOORE: But we want more data to document that.

BETH BAXTER: Yeah, we want more data. We agreed that it's not probably the appropriate facility, nor the ideal facility, but knowing that the programming is good. And I guess, that's where we were. And we also wanted to look at some outcome data, follow-up data with the kids and the interaction, kind of the discharge planning, and the follow-up, and the aftercare, and integration for kids back into the community.

KATHY MOORE: And I had suggested also the expertise of staff, based on the fact that so many staff have left the facility. And are we left with the staff who are the most expert in adolescent chemical-dependency? That it should be, in order to be continued as an excellent program, it should have staff who are the best in that area.

JIM JENSEN: Okay. Thank you. Ruth.

RUTH HENRICHS: We started the discussion on Hastings Regional Center by saying to each other and affirming that it was a wonderful facility that has served Nebraska well in its day, and that we shouldn't forget that as we move forward. But then we quickly moved to statements of, shame on us, all of us, and the people of Nebraska for letting that facility deteriorate to the point at which we find that facility today. Because now my group, as Beth's group, said as a group we believe that it is not a facility today at a standard of what we want for our Nebraska children and families. And we spent a fair amount of time talking about the degree of quality and support, and affirming the work that has been done there over the many years by the people that have worked in the Hastings Regional Center and by the community of Hastings itself. And really spent a fair amount of time just sort of shame on all of us for letting that happen and letting it get to that point. But we, too, said that it is a facility that really no longer serves best practice, leading kinds of ways to deliver service in this country in the year 2007 going forward. For the three mental health children who remain in Hastings today, and talking specifically about the mental health portion of those services, it was our recommendation that those three children be RFP'd to the private community, to...their care be RFP'd to private providers in our state, and let private providers propose how those three children could be cared for in creative ways. And that would then close the mental health unit actually at Hastings. We actually talked about RFPing the adult DD beds to private providers, and letting them be creative about how that service would be delivered, and also the substance abuse beds, saying that they ought to be RFP'd, and that we should require that they remain committed to a YRTC in Kearney, but that those beds could be bid and distributed in different numbers across the state so that...and we

didn't have those numbers to share. But we really saw that those could be closer to communities as opposed to where they currently are. We supported, as a group, support given to Hastings and the Regional Center to do an economic feasibility study for the use of the grounds and all of the surrounding property around the facility itself. So we supported that, because we believe that there is a purpose. And also talked about we supported the use of the Hastings property for the construction and/or use in the development of new services. We were not in any way saying in our group that there should not be services there. We were in our group saying that once this continuum...our work as we identify that continuum, that there may well be reason to construct a 2007 facility that would be utilized to children in the state for a piece of that continuum of service. I guess that's it.

JIM JENSEN: Okay. Scot.

SCOT ADAMS: We had a number of comments here. Again, it was a good conversation, I think. In no particular order, and again, I would mention that not necessarily was unanimity on all sides.

LIZ CRNKOVICH: We just shared a bunch of ideas, well, we could do this, we could do this.

SCOT ADAMS: Yes. I'm just the reporter. (Laughter)

RUTH HENRICHS: Me, too.

SCOT ADAMS: And I was (inaudible). Okay, here we go. Probably the most direct comment that gained at least more than one voice was, close Hastings Regional Center in lieu of the resources to community-based treatment. Second, fund a highest and best use study for the Hastings Regional Center. Thirdly, assist changed management for the community Behavioral Health Services System, especially providers. This is going

to be a different way of doing things. Some providers will likely go out of business. So some changed management will be necessary with that. Secondly, changed management involvement in participation and support for the city of Hastings. (D)...4, the revolving door issue at the YRTC's in Kearney and Geneva, as noted by the Chinn Study, as the result of lack of sufficient programming there. 5, Revamp Kearney and Geneva with additional programming in some fashion. This is how Hastings got started. 6, Perhaps use Hastings as a Level V facility there. 7, Three kids is too small for a mental health side; close that program. 8, Move McCook's Work Ethic Center to Hastings. We thought there weren't going to be enough cities upset by this (laughter) (inaudible). And to help Hastings realize there could be allies out there, we just (inaudible).

KATHY MOORE: Can we keep the state chamber (inaudible) (laugh).

SCOT ADAMS: Yeah, yeah, that's right. And finally, need to create the vision for the replacement of Hastings. That is to say, if not Hastings, then what? It is not simply an issue of closing down, it is a matter of building what? Because Hastings plays a significant role for a number of people. Cannot just sort of walk away from that. And so alternatives have to be developed; those need to be identified.

JIM JENSEN: Good. Any other questions from anyone? I think that's great work for today, very good. And we'll pick up then at our next meeting from where we left off. And again, all these comments will be circulated. And...

BETH BAXTER: We got to number five.

KATHY MOORE: Yeah, we did, too.

JIM JENSEN: Somebody went to five?

RUTH HENRICHS: Yeah.

JIM JENSEN: Well, we stopped at four, particularly with the information of what happened in the Senate last night. But let's hear your five.

RUTH HENRICHS: Our (inaudible) group supported behavioral health parity, even though it may become a moot point, due to federal legislation and what initially began to happen last night. We felt it was important that we go on record and anything that we produce stating that we support it. Because just because of what happened last night, that's no guarantee that it's going to make it all the way through that federal system. So our group wanted to be on record in support of it, of parity.

JIM JENSEN: Are you suggesting that Washington might not do anything? (Laughter)

RUTH HENRICHS: Those were your words (inaudible). But we would like this group to be on record in support of parity, because of all of the reasons we don't need to name as to why that hurts our system not to have it.

JIM JENSEN: Okay, good.

BETH BAXTER: I want to say, I think we talked about, you know, reintroducing a version of LB647. But Roger reminded us that it hadn't died, it just hadn't come out of committee. So, yes, we're supportive of that.

JEFF SANTEMA: It's still in committee.

JIM JENSEN: I think if we took...

SCOT ADAMS: We lollygagged with three and...

JIM JENSEN: Yeah, I think if we took a census of our group, it would be the same. All right, so we got all the way through five, that's great. We're at the point...any other business that anyone else...from the group...has got? Yes.

RUTH HENRICHS: Could I just share that our group, I don't know or recall just exactly where we had the conversation which question, but we did talk about the acute care and not needing to have licenses for acute care and secure kinds of beds. And just something that came up in our group was the work that is being done by Alegent Immanuel in terms of children's behavioral health. And there was conversation in our group about hospitals across the state, much the way Beth described, you know, finding beds and things in different parts of her region. And so we did have some conversation about that, just don't want to lose it, that we think at some point a conversation with Alegent Immanuel and what they're planning and envisioning. And are they actually even in the process of doing some of the things that we're thinking about? We didn't know, but we felt it would...we don't want to let it become the elephant in the room.

JIM JENSEN: Okay, okay. Anything else?

KATHY MOORE: Well, the only other thing, and Beth, maybe you mentioned it. But we sort of jumped between these two documents, from time to time, and got a little confused. But when we were on this document, number 2, which says, interagency coordination and governance. Beth referenced our discussion in relation to the new Children's Behavioral Health Coordinator. But we did have some conversation there about looking at the role of the regions and the contractual relationship between the regions and Health and Human Services, and just making sure that there are outcomes attached to that, etcetera. And we had some fuzzy discussion. You know, we are not suggesting that we want to try to introduce any legislation that's going to open that regional can of worms again, but that we really do want to look at whether or not it's statute or policy that could be a bit more definitive or specific or whatever. So I just want to make sure that rises.

BETH BAXTER: So how to reinforce the expectations and the outcomes, and kind of...

CANDY KENNEDY: Appropriate ones, yes.

BETH BAXTER: ...through the contractual relationship between the division and the regional governing boards or HHS and the governing boards.

KATHY MOORE: And so we tied that back again when we talked about the children's coordinator, and again addressing their...the youth service...regional youth service person, attaching them, somehow contractually also to the state children's coordinator.

BETH BAXTER: And what I shared is, in our current contracts there is a section in there that there are outcomes required of the regional youth coordination. So it's just making sure that there is teeth and that those expectations are there and there's a process.

KATHY MOORE: Some carrots and some sticks.

BETH BAXTER: Right.

JIM JENSEN: Yes, Scot.

SCOT ADAMS: Just because you got to take a second whack at that topic, I want to come back, too. (Laugh) Because you did report that. There were some strong feelings in our group that there not be a presumptive move to the regions.

KATHY MOORE: That they're not be presumptive moves. Meaning that (inaudible).

TOM McBRIDE: That as you talk about regional care, that that doesn't necessarily mean that that regional care is defined by the mental health region.

SCOT ADAMS: So I just...and I'm not taking a stand, but since you took a second whack at something and then talked about it, I thought that ought to be reraised, because there has been some considerable conversation that, although that is in existence, that may not, in fact, be the best (inaudible).

KATHY MOORE: Got it, okay, okay.

RUTH HENRICHS: Can I ask for a point of clarification? So just because Vicki and the position are in behavioral health, you're saying that that wouldn't necessarily mean that dollars coming to Children's Behavioral Health would flow through the six behavioral health regions?

SCOT ADAMS: That's correct.

RUTH HENRICHS: Thank you.

SCOT ADAMS: State would have authority to contract with regional providers...private providers, and statewide providers, with others not in the game today, with other departments of state government.

KATHY MOORE: Well, then...then...because I hadn't heard that in...yeah. That I'm presuming...I said, I didn't hear that. I would then presume that this task force should try to determine where consensus lied around. Because those are two kind of separate...yeah, I'm glad you raised that. Because it does seem like we should probably have a group discussion at some point then about where our majority opinion lies, yeah.

SCOT ADAMS: That may well be true with each point of our conversations and the three reporting out.

KATHY MOORE: Yeah, good, good. Thanks.

SCOT ADAMS: Again, Jeff gets to be the (inaudible) and we get to argue and (inaudible) the draft.

KATHY MOORE: Yeah, thank you, (inaudible).

RUTH HENRICHS: Jeff, do you want our notes?

JIM JENSEN: Yes, and if all three of you could provide those notes.

BETH BAXTER: I think I better retype mine, and I'll get them right back to you, try to get them back to you (inaudible).

JIM JENSEN: That's okay.

JEFF SANTEMA: If you have them, Ruth, I can give them to (inaudible), or we could try to pick them up (inaudible).

JIM JENSEN: And I'm also...all of you have filled out the sheet for...to be reimbursed for your travel? Okay. Is there any public comment today? Seeing none, I think that's all. Like I said, great meeting. I really think it's been very productive, all the time. And we'll see you at the next one. Oh, Jeff, did you want to explain that?

JEFF SANTEMA: Because the statute, 542, references the section of law, we just wanted you to have that.