[LR136]

SENATOR GAY: All right, we'll get started. We're running a little behind. If you could grab a seat. Thank you. We'll get started today. We've got a large crowd, which is great. We're going to open the public hearing on LR136. We have several other senators joining us not on the committee but interested senators in this resolution and they're up here, can ask questions and will ask you questions, listen to your testimony. I have a sheet that we've been talking to interested parties. I have about 12 names on here that I think were kind of agreed upon that proponents, I don't think there's any opponents or proponents whatever but just to get the facts out. Starting with Senator Avery, we'll then hear from the Department of Health and Human Services, go on down, Gary Weiss, Mary Sullivan, Robert Liberman, Richard Hunter, Lisa Taber, Julia Geier, Ed Chase, Tami Burkey, Wendy Andorf, and Dean Settle is who I have on this list. What I'd like to do is I'm going to go down through that list. I know several of those people I mentioned came from long distances to testify and we have some expert witnesses. That way I know we can get to them. They can be heard. They probably have flights to catch and things like that. I would like to limit this a little bit to...I don't want to cut off discussion, but between, you know, between 10 and 15 minutes. I'm going to use my discretion a little bit. But don't exceed that because also you're going to get questions. And once we start asking the questions and now 15 minutes turns into a half an hour real quick. So we'd like to, you know, go today. Several of the senators have other commitments. They will be coming and going and other commitments that they had. So there's never a perfect day for this, so we'll do that. If you have cell phones and if you could mute those, turn them off. Appreciate it. I'm Senator Tim Gay. I represent District 14 which is Papillion-La Vista area, and I'm going to ask the senators to introduce themselves, starting to my right. [LR136]

SENATOR McGILL: I'm Senator Amanda McGill from northeast Lincoln. [LR136]

SENATOR AVERY: I am Senator Bill Avery from right here, District 28, and I'm the

reason you're here. I introduced this resolution. [LR136]

SENATOR GLOOR: I'm Senator Mike Gloor of District 35 which is Grand Island. [LR136]

SENATOR CAMPBELL: I'm Senator Kathy Campbell and I represent the east and northeast part of Lincoln and Lancaster County. [LR136]

SENATOR PANKONIN: I'm Senator Dave Pankonin; I'm from Louisville. I represent District 2 which is the largest part of Cass County, southern Sarpy County, and Nebraska City. [LR136]

SENATOR STUTHMAN: I'm Senator Arnie Stuthman. I represent District 22 which involves Platte County, part of Colfax County, and the Columbus area. [LR136]

SENATOR WALLMAN: Senator Norm Wallman, District 30. Gage and part of Lancaster. [LR136]

SENATOR COASH: Senator Colby Coash, District 27, southwest Lincoln. [LR136]

SENATOR GAY: All right. And then we're also joined by legal counsel Jeff Santema for the Health and Human Services, and the clerk, Erin Mack, will be recording everything. This is also being on the cable channel in the Capitol and also on the Internet, so all these will be recorded, so just so you know that when you come up to speak. So with that, I'm going to get started. Senator Avery, you're the first testifier. [LR136]

SENATOR AVERY: Thank you, Senator Gay. It's good to see all of you back. As I said in my introduction, I'm Bill Avery from District 28. I want to thank the committee for agreeing to take up LR126. The resolution calls for an examination of what I think is a very important issue, and that is the public psychiatric rehabilitation of people in need in

our state. Central to this examination, you probably are already aware, is the Lincoln Regional Center and its program known as the community transition program. This program, for nearly 30 years, delivered top-rate psychiatric rehabilitation to individuals in our state with severe persistent disabling and treatment-resistant psychiatric problems. Throughout the existence of the CTP it functioned as a an exemplary program. It was recognized nationally for rehabilitating some of the most difficult patients and preparing them for integration into less restrictive outpatient settings. The CT program was suddenly and without notice terminated by the regional center in June of this year. According to Nebraska Statute 71-810(3), as authorized in legislation, I believe it was in 2005--LB1083--according to that statute the elimination of this program required those responsible for the closure of the CTP to notify the Governor and the Legislature. And I'll quote just briefly from that pertinent statute. "The division shall notify the Governor and the Legislature of any intended reduction or discontinuation of regional center services under this section. Such notice shall include detailed documentation of the community-based services or other regional center services that are being utilized to replace such services." Well, this did not happen and you probably have heard about that. The regional center, under the authority of the Department of Health and Human Services neither notified the Legislature nor the Governor about plans to close CTP nor did they provide documentation of plans for appropriate replacement services and treatments. A legal opinion was sought from the Attorney General's Office that concluded that the Lincoln Regional Center should have notified, that is they violated the law, but the statute provides no remedy for failure to do so; likewise the statute does not provide any mechanism to undo the actions taken. Maybe we should keep that in mind when we write future laws. I find that these actions by Health and Human Services to be quite simply appalling. There was no advance notice, no credible rationale provided, no explanation of the sudden closure of this successful program, and I think we want and expect to find out why. We must hold the regional center and its director and chief executive officer accountable for unlawfully terminating a program. It is part of the intent of this interim study to investigate why the regional center, without authority, designated this program for closure. But I think we want to go beyond that. It's not just a

matter of finding the answer to why. It is equally important that we know how the regional center plans to provide replacement services as specified in law. We have a right to know that. These are very troubled, difficult people to treat, and in some cases they are even dangerous. And we need to know what is planned for them and what kind of services will be available and whether they're not the people who are administering the treatment services are, in fact, qualified to do so. It is my hope that we discover what the officials at LRC found to be deficient in the CTP program that necessitated closure. I would hope also that we can find some effective treatment for those mentally disabled citizens in the short term. I would hope, too, that to the extent that competing approaches to treatment exists at LRC, that the conflict should be ended or at least not allowed to impede the use of proven treatment protocols. I've talked with a number of people involved in the program in the past, and it appears that there is some conflict of cultures, treatment cultures, at the regional center that may be impeding treatment; may, in fact, have played a role in the closure of the CTP. I would like to see the reinstatement of the CTP program. It was successful. It could either be within the existing structure of the regional center or in the private sector, because the important thing is that rehabilitation once again be a central focus of treatment; not just what I call lock-and-drug. You can drug people and lock them up and they don't bother you. If you drug them enough and keep them locked up enough, they won't bother you, but they won't get better either. And I think what we ought to do is get...make sure the program is in the twenty-first century and not the nineteenth. We have long passed the day when we drug and lock people up. There are better ways to treat people who are mentally disabled. I would also hope that we take steps to reestablish public trust in the accountability of public institutions. We have to ensure that the laws of this state are followed, both in the letter of the law and the intent of the law, and I don't think that this was the case with CTP. We must hold the Department of Health and Human Services accountable for illegally terminating a successful program, and we should make sure that something is done to restore treatment to these people who had a chance under CTP to move into a practical day-to-day functioning life. And now I'd like to know if that is possible under the existing treatment protocols, and if not, why not. And we should

find out what we can do. Today you will hear from the Lincoln Regional Center staff. National experts are here in psychiatric rehabilitation: people with national reputations, people who are well respected around the country. You'll also hear from family members. You'll hear some stories from some very caring parents. In fact, in one case, the child of this parent is no longer in the regional center. Tragically died after being successfully released into the community from an accident unrelated to his illness. This parent is still involved. This parent cares about other patients because he saw how well his son progressed in the CTP program. They will share with you their experiences and you will see that we did have a state-of-the-art psychiatric rehabilitation care program that I am uncertain that we still have. So I'm asking you and I'm sure you will do this, you will listen carefully. You will ask tough questions because we need to uncover the truth about this troubling issue. With that, I will end, and I do thank you for giving me the opportunity and the privilege to sit with you. I told several of my colleagues who came in from out of town that I'm not a member of the committee so I didn't expect to be up there with you, and thereby not able to ask questions. And I promise you, I'll be nice to...I (laughter). [LR136]

SENATOR GAY: Appreciate that. [LR136]

SENATOR AVERY: But I do thank you for that privilege. [LR136]

SENATOR GAY: All right. Thank you, Senator Avery. We're going to be nice to you, too, and not ask you any questions, but you did a... [LR136]

SENATOR AVERY: Good. That's good. A good way to start. [LR136]

SENATOR GAY: But you did a great job of setting up the day and to join us. My protocol is going to be...and I'm a little rusty because this is the first hearing we've had in awhile, but when you do come up I'm going to announce your name. When you do come up, state your name because we are...for the record, and spell it out if you could,

because it will help out clerk. And then what I was thinking while you were talking is out of respect for the committee members, I'm going to let our committee members ask the first questions, and then if they hadn't asked a question maybe to that testifier, well then I'll open it up if that's fair enough. [LR136]

SENATOR McGILL: Okay, wonderful. [LR136]

SENATOR GAY: And you can do the same to us when we're joining you, so. And with that, Senator Gwen Howard has joined us, a member of the Health and Human Services Committee. So that's what we'll do. I see Dr. Adams is going to come up and testify. How many...just yourself for the department? You've got three people. About five minutes each? Or what do you want to do, because we're going to have questions. [LR136]

SCOT ADAMS: It might go...one would be less than that and one would be about that and I'll be a little longer. [LR136]

SENATOR GAY: Okay. And yeah, explain it. Okay. [LR136]

SCOT ADAMS: Okay. Thank you. [LR136]

SENATOR GAY: Scot, who is going to be testifying for you guys? [LR136]

SCOT ADAMS: Dr. Blaine Shaffer and Carol Coussons de Reyes. [LR136]

SENATOR GAY: Okay. [LR136]

SCOT ADAMS: Ready? [LR136]

SENATOR GAY: Yes. Go ahead. [LR136]

SCOT ADAMS: (Exhibit 1) Okay, thank you. Thank you very much. Good afternoon, Senator Gay and members of the Health and Human Services Committee. My name is Scot Adams, S-c-o-t A-d-a-m-s. I serve as the director of the Division of Behavioral Health for the state of Nebraska in the Department of Health and Human Services. And before taking this position two and a half years ago, I worked for 31 years in the community-based service provider; some of that time was as a therapist and some of that time in management. And I was executive director of Catholic Charities during the LB1083 debate several years ago, and part of that discussion and its energy. I appreciate the opportunity to appear today in front of the committee to provide information on LR136. As part of our testimony today, I plan to have Dr. Blaine Shaffer, the chief clinical officer for the state of Nebraska, follow my testimony, and after that, then Carol Coussons de Reyes, who is the administrator for the Office of Consumer Affairs also to speak, and then I would like to accept questions on behalf of the division after that. I will address the topics of the legislative resolution in a general way and the move to more detailed content after that. But let me begin with a brief overview of behavioral health services in the state of Nebraska to give context to the particular questions at hand. Efforts at reforming mental health services in the state of Nebraska to one degree or another have been occurring since the first state hospital began in 1869. Behavioral health services will continue to be updated as new treatments and medications evolve. In recent times, notable reform state efforts have included the 1974 legislation that created the regional system of care that we have, and the search initiative in 1994. The most significant reform in recent times was passed into law as LB1083 in 2004. In short, this legislation required a fundamental change in the way the state approached mental health services by directing that people be treated in their home communities whenever possible. The routine utilization of state hospitals and regional hospitals for the long-term treatment of mental health and substance abuse treatment disorders ended with LB1083. This legislation paralleled similar reform efforts all across the country, resulting in the fundamentally different role for the state hospital. At a recent National Association of State Mental Health Program Directors conference,

there was significant discussion of the changing role of the state hospital from one of that involved with general psychiatry to that involved in sex offender, forensic populations, and those that cannot be safely served in the community. Some states have ended their participation in general psychiatry entirely--entirely--treating all general psychiatric patients in community-based settings. Nebraska has not come that far yet, although the Lincoln Regional Center does indeed have a strong treatment focus on forensics and offender populations. While it has a strong focus on forensic and sex offender populations, it also accepts people who have been deemed too violent for local community resources to manage. I have provided organizational charts for the Division of Behavioral Health and the Lincoln Regional Center in your packets to give you a perspective on our operations so you can sort of see the lay of the land. Please see Attachments A and B. Since LB1083 became law, the Division of Behavioral Health has worked consistently to expand services to consumers in the most feasibly integrated setting as mandated by the United States Supreme Court in the Olmstead v. L.C. decision in 1999. The principles underlying the Olmstead decision are to provide ever-increasing community-based integrated services in settings that allow individuals with mental illness the maximum opportunity to live with those who do not have mental illnesses; in other words, the rest of us. The operant word here in the decision is integration; that is, persons with mental health disabilities must be integrated in community-based settings wherever possible. In this regard, certain hospital-based or institutional treatment modalities are increasingly inconsistent with Olmstead mandates and the spirit of Nebraska's behavioral health reform. We are all challenged to find the most integrated treatment and living setting for persons with behavioral health illnesses--settings that allow us to understand that the face of mental illness is a human face and not a research laboratory. The consolidation of the community transition program treatment modality was a logical and necessary consequence of the Olmstead decision, the Americans with Disabilities Act, and the Nebraska behavioral health reform. The community transition program consolidation has resulted in no loss of services to individuals with mental illnesses. In fact, more people will be able to be served. There is no reduction of regional center staff, no loss of bed capacity, and

community-based services have assumed the vision of CTP. Therapeutic goals of the patient population once served by CTP are no longer best served in hospital-based settings, let alone a state-run hospital. The Division of Behavioral Health, in cooperation with the regions, has generated a range of community-based options for services in the most feasible integrated settings available in Nebraska, and we continue to work on this. The list of services, Attachment C in the handouts--that's an important attachment--documents the services by contract year that have developed as new services in the community and in Nebraska. In short, since 1996, many new services are now in the community. Since '04, 32 of these are new services in the community, and at least nine are within the definition of psychosocial rehabilitation. This document attests to one of the particular questions of what are the services that are available. Nine of those are within the definition of psychosocial rehab. That's an important component because our main point is a fine program--I don't argue with it--belongs in the community. The recovery based philosophy exists in the community-based setting. Happily, we see the success stories of patients discharged to the most integrated settings where they can received services close to their support systems, their family, and their faith. It is fundamentally important to understand that behavioral health reform within the context, not only of LB1083, but of these broader federal law and regulations and the evolution of science and the potential for recovery that has flowered in recent years all across our country. To the specific points identified in the resolution, Item 1: Examination of existing IPRR services in the wake of closing. The decision to consolidate the CTP program treatment modality with other treatment modality with other treatment modalities at the Lincoln Regional Center was the result of increasing demand for forensic services; sex offender services--Phases 2 and 3; services for those who cannot be served safely in the community; and the increasing capacity of the community to provide supportive treatment and recovery services in the community. This furthers the principles of LB1083 by consolidating CTP treatment modality with other treatment modalities and programs at the Lincoln Regional Center. Again, no regional staff were reduced in this decision; no beds reduced; no services stopped or reduced. There was a reduction in one contract with the University of Nebraska for

psychology services by $150,000 due to the change in the treatment modality for general psychiatric patients. Another part-time psychiatrist's contract was not renewed. To give some context of the CTP treatment modality within the larger Lincoln Regional Center, there are five additional charts. One chart is a graph of the average length of stay between all LRC services and the CTP treatment modality. CTP took, on average, two to three years for a person to get out of the hospital. The second is a chart showing the CTP discharges versus all Lincoln Regional Center discharges and readmissions between the years 1988 and 2009. That would be Attachments E, F, and G. The third chart shows readmission rates to the Lincoln Regional Center and CTP overall. This chart shows a CTP readmission rate of 39 percent over the course of 20 years. The national average currently is 20.9 percent readmission rate. And the total Lincoln Regional Center readmission rate on average for the last three years, including CTP, has been 11 percent, inclusive of the CTP admissions again. A final statistic I would offer to you is the context of the program. Over the last 20 years, Lincoln Regional Center has had more than 8,800 discharges, of which 466 or 5 percent have been to the CTP program. We're talking about a treatment modality. Point 2: The impact of closing the CTP on the quality of inpatient services for individuals. We believe there has been no significant or lasting impact on the quality of inpatient services for individuals previously served by that treatment modality, nor will there be an unusual impact on community-based programs. CTP was a 17-bed program, and on April 1, when you received notice about the closure and the transition of this program, it had 15 people in those beds. On May 1, when the transition was completed, four people had already completed treatment in that time frame and moved to the community, and 11 were moved to other treatment modalities and services at the Lincoln Regional Center. Since that time, three other persons have completed treatment and moved to the community, thus nine persons remain in treatment services at the Lincoln Regional Center today. Notably, four of these persons hold the designation of NRRI or not responsible by reason of insanity for a crime they have been found to have committed. Their treatment plans are current and have been reviewed by the courts...reviewed and approved by the courts within the last couple of months. A court has yet to decide if they are safe to

return to the community. Two are waiting placement within the DD system but otherwise are likely ready to move to the community in that system. The remaining three are in treatment in buildings 3 and 10. Point 3: Therapeutic goals for this highly defined population. Each patient admitted to LRC has an individual treatment plan with a defined set of therapeutic goals based on his or her strengths and particular needs. This is true across all programming at the Lincoln Regional Center, as well as community-based treatment programs. It's important to note here that all patients have been admitted first to the Lincoln Regional Center to general psych services and admissions; none go directly to CTP. Further, some believe that CTP accepted all referrals that were made to the program. This is not true. It was a selected population that fit the criteria for the CTP program, thus they were no different than other community-based programs who do not accept every referral that comes along. Point 4: A determination of the nature and capacity of community-based services. I was sorry to see that the interim study focused in its description solely on recovery-based population versus stabilization. There are more ways to look at this than those two. Best practices, as defined in the legislation resolution, is one of four different kids of evidence-based practices. SAMHSA, the Substance Abuse and Mental Health Services Administration, has identified best practices on its Web site and encourages their utilization. CTP is not among those. Indeed, at a recent National Association of State Mental Health Program Directors Conference, I asked my peer state commissioners of mental health services, as well as the NASMHPD Research Institute, if they had ever heard of CTP. None had. There is a letter in your packet supporting that statement. At this point I want to take a specific moment in time to say I have no particular disagreement with the CTP treatment modality and will not argue its pros and cons against the other kinds of services in this forum at this point. The only point that I think is relevant to this inquiry is that a program of psychiatric residential rehabilitation, whether it is CTP or some other kind of psychiatric rehabilitation, should be done in the community, not at a state hospital. Point 5: An evaluation of current service definitions, standards, and regs. You have in your packet a stack of the current service definitions, standards, and regulations for the Department of Health and Human Services that relate to behavioral health.

That's Attachment J in the handouts. I should note that there is no standard related to inpatient psychiatric residential rehabilitation so none is included there. There is no service definition. In other words, this was a small treatment modality within a larger hospital system that had never been recognized in the service definitions by the division. I am also handing out a copy of the most recent draft, and I emphasize draft--it is in its fifth iteration--of service definitions for your review. We anticipate that these will be finalized before year's end. That is Attachment K. It doesn't include inpatient psychiatric residential rehabilitation either, because psychiatric residential rehabilitation should be in the community; and inpatient refers to a hospital-based setting. We expect these service definitions to be approved before the end of the year. Additional information can be found on Attachments L, M, N, and O. In summary, the reason the decision was made to consolidate the CTP treatment modality with other services at LRC was to be consistent with federal law and regulations and the state of Nebraska behavioral health intentions. The CTP was a program that provided needed help to some people, but can and should be located in the community. Equivalent services now are available in the community. I would like now to introduce Dr. Blaine Shaffer and I'll be available for questions. [LR136]

SENATOR GAY: Scot, we're going to have you back up after these two, but we're going to reserve the right to ask them questions directly, though. We're going to ask Dr. Shaffer a question if one comes up, and Carol as well, so. [LR136]

SCOT ADAMS: You bet. [LR136]

BLAINE SHAFFER: (Exhibit 2) Good afternoon, Senator Gay and members of the Health and Human Services Committee. My name is Dr. Blaine Shaffer, B-l-a-i-n-e S-h-a-f-f-e-r. I am a psychiatrist and I have the pleasure of serving as the chief clinical officer for the Division of Behavioral Health. I am pleased to be able to offer you my thoughts on the issues described in LR136. In addition to my many academic and organizational affiliations, I am a member of the Coalition of Psychiatrists for Recovery,

a small national group associated with the American Association of Community Psychiatrists. My testimony does not necessarily reflect their views, but is reflective of my longstanding support of the concept of consumer empowerment and recovery. In the document, "Mental Health: A Report of the Surgeon General," psychosocial rehabilitation services are described as a range of multicomponent programs that are distinct from single-component skills training programs. These psychosocial rehabilitation programs combine pharmacological treatment, independent living and social skills training, psychological support to clients and their families, housing, vocational rehabilitation, social support and network enhancement, and access to leisure activities. Recipients of these services experience fewer and shorter hospitalizations than comparison groups in traditional outpatient treatment, and are more likely to be employed. Psychosocial rehabilitation services may include: workplace accommodations, supported employment or education, social firms, assertive community treatment, medication management, housing, employment, family intervention, coping skills and activities of daily living, and socializing. One source describes eight main areas of work: psychiatric, social, vocational/educational, basic living skills, financial, community/legal, health/medical, and housing. Psychosocial rehabilitation is a philosophy or strategy of intervention with a knowledge base, a set of therapeutic tools or modalities, and training; not necessarily a program or a site. It focuses on functional disability and psychosocial risk factors, not chronicity. Thus, CTP is a specific example of psychosocial rehabilitation holds value, but its more appropriate setting is in the community, not a state hospital. Robert Liberman at UCLA speaks of the importance of the natural environment where "the proverbial rehabilitation rubber meets the road to recovery." Natural environments are the community and everyday places where consumers live and work and where treatment effects are best translated into quality of life. It is important that consumers experience recovery in nonstigmatizing, normative living environments. CTP at LRC was a specific treatment modality with specific interventions such as behavioral management. Behavioral management programs--BMPs--or reinforcement therapy is a best practice for working with consumers with refractory severe and persistent mental illness. The rest of LRC, while

not using the manualized BMPs, nevertheless uses individualized treatment plans and other modalities which allow more flexibility depending on the needs of the consumer. "Manualized" means strictly following a written, structured, consistent, planned and scheduled intervention. Effectiveness depends on how faithful the clinician is in following the procedures delineated in the manual. All care at LRC is by an interdisciplinary treatment team, and incorporates modalities that were not used in CTP, such as substance abuse groups, trauma recovery and support groups, and dual disorders--mental health/substance abuse--programming. Various cognitive behavioral modalities are also utilized including dialectical behavioral therapy or DBT. All treatment modalities at LRC are working hard to reduce the use of seclusion and restraint, and other coercive interventions. Consumers are actively involved with those who are at LRC, including Wellness, Recovery, and Action Plan or WRAP, and Consumer Advocacy Team or CAT. There is a major emphasis on trauma awareness and trauma-informed care that allows the consumer to participate more actively. Staff at LRC are well trained and engage in significant continuing education and training to continue to develop skills that enable active involvement with the consumer in the recovery process. There is significant interaction between LRC programs and community providers, as well as the Division of Behavioral Health, including conference calls, team meetings, transition care planning, clinical consultation, etcetera. Community-based--not LRC--psychosocial rehabilitation programs include secure residential rehabilitation in Lincoln and Omaha, acute and subacute care in community hospitals, psychiatric residential rehabilitation, mobile crisis teams, assertive community treatment programs, day rehabilitation programs, community support, supported employment, and supported housing. Other community-based programs which offer support are crisis intervention--CIT--training for law enforcement, case management, medication management, as well as peer specialists, the teaching of Wellness, Recovery, and Action or WRAP by peers, motivational interviewing, cognitive behavioral therapy--CBT, and again dialectical behavioral therapy--DBT. In the pipeline are even more peer support services. As noted from the above discussion, the old dichotomy of a recovery or rehabilitation model and a medical or treatment-as-usual model does not

exist as such in the public behavioral health system as it once did. Care at LRC is consumer-centered, recovery-based, trauma-informed, and striving for as full a life in the community for all consumers as possible. Care for consumers is coordinated by staff at LRC as well as the regions and the division. Comprehensive systems of care have been developed and continue to be developed. As more and more community programs have been developed, the length of stay at the regional center has dropped, and the readmissions rate to LRC and community hospitals remain lower than the national average. The academic support work group, which I chaired as part of LB1083 implementation, gave general recommendations in three areas: work force development, telebehavioral health, and best or evidence-based practices. A newer development is the concept of value-based care as well as evidence-based care. Value-based care involves the consumers' perception of the relevance and utility of the care to themselves. The vast majority of consumers value community treatment care over extended stays in state hospitals. Indeed, those consumers who do not value community-based treatment over hospital-based treatment tend to have spent more than a year at a state hospital. The standard of inpatient services at LRC remains high, as is the interaction with highly rated community programs. The therapeutic goals of the CTP and those of other LRC and community programming were and are the same: a quality of life with opportunity for recovery in the community. Thank you. [LR136]

SENATOR GAY: All right. Thank you. Any questions from the committee? Senator Pankonin. [LR136]

SENATOR PANKONIN: Thank you, Senator Gay. Thank you, Dr. Shaffer, for your testimony. I did have the opportunity to look at the academic support work group best practices that you...as you mentioned, you're one of the authors and contributors on that in January 2005. Based on that and what you've just talked about, where were you on the decision making on the CTP? Are you one of those that advocated that we didn't need this program anymore? [LR136]

BLAINE SHAFFER: I was not part of the decision-making per se. [LR136]

SENATOR PANKONIN: Okay. But you think it was the proper decision based on your past work when you talked about best practices in here? [LR136]

BLAINE SHAFFER: Yes, sir, I do. [LR136]

SENATOR PANKONIN: You think it was the proper decision. [LR136]

BLAINE SHAFFER: I do. [LR136]

SENATOR PANKONIN: Okay. [LR136]

SENATOR GAY: Senator Stuthman. [LR136]

SENATOR STUTHMAN: Thank you, Senator Gay. Dr. Shaffer, in your testimony you stated here that this CTP program holds some value but it's a more appropriate setting in the community and not in the hospital. Can you explain to me how that will be more appropriate in a community-based setting and is there going to be a community-based setting in all of the communities to address these individuals? [LR136]

BLAINE SHAFFER: I guess I'll try to do the first part, first. I think it's more appropriate in the community because most of what occurs in a rehabilitation program is, as mentioned, working with very difficult challenges of people who may not have been successful in other programming that they have been in prior. But people don't like to be in state hospitals. People don't like to be in state hospitals for an extended period of time, and programming that works best is programming where the person is actually out in the community where they have a better opportunity to interact with their family and their friends, have a greater chances of interacting with other community providers. I think there's something to be said for the person to be able to access a variety of

community programming without having all of that programming occur under one roof in four walls. The efficiency of a hospital program doesn't necessarily translate, I believe, into the highest quality of care in terms of rehabilitation that could occur in the community. [LR136]

SENATOR STUTHMAN: Also the state of Nebraska is so different from east to the west. And you made the statement that the individual will do a lot better in his own community setting, his people, his friends, his family, and stuff like that. I will agree with you there. But is there going to be a service in all those areas? [LR136]

BLAINE SHAFFER: Well, I think the issue, there are a whole variety of psychosocial rehabilitation programs that are available throughout the state. Some areas of the state, obviously the most secure of the secure residential rehabilitation programs is in Omaha and Lincoln because those are the kinds of communities that can support that level of care. But some of the other ones that I mentioned, case management, there's an ACT program in Hastings that provides very intensive care for people who otherwise would still be in the state hospital. There are mobile crisis teams throughout the state, law enforcement training that's coming up, and particularly the involvement of, I think, peer specialists and peer...working with peers. Peers are all over the state. Each of the region has a peer specialist attached to their regional administration office and each of those people work with a whole host of consumers in their area, and I think that is where a large portion of this will occur. [LR136]

SENATOR STUTHMAN: Okay. Thank you. [LR136]

SENATOR GAY: Senator Gloor. [LR136]

SENATOR GLOOR: Thank you, Senator Gay. Dr. Shaffer, I might add to a comment you made about people not liking to be in state hospitals, and I'm paraphrasing, but I would add to that, that people don't like being in hospitals, period, for any reason, acute

or behavioral. They want to go home and they want to go home as soon as possible, but common sense dictates and the clinicians also dictate that there are different stages of their ability to get back to the community or back to their home. When I look at the graphs that Mr. Adams provided to us, it looks to me that the number of people that went to CTP were a very small and probably just, by guess and by golly, appropriate percentage of people who made that stairstep from the intense inpatient to the completely back-in-the-community step. And so my concern would be that that jump between inpatient and community-based, for some of those patients seems to be a pretty dramatic one. And I understand the other programs that are there, but they truly are community-based as opposed to having at least a residential institutional component to them. You're telling us that you don't feel that that step for some of those people is too great a step? [LR136]

BLAINE SHAFFER: Well, if it's too great a step then they won't be discharged from the regional center at that point. I think part of the issue is that the population of folks being served at the regional centers now is very different than the population of people even a decade ago. Every person there has severe and persistent mental illness. Every person there has been committed by a board of mental health because they are mentally ill and dangerous in some way. So, in that regard, the people that were served in CTP were not that different from the general population of LRC. And as Dr. Adams has already mentioned, not every one referred to CTP was accepted for their treatment per their protocols. I fully agree with you that there can be a large leap between an inpatient stay and a community placement. That's where programs like ACT, assertive community treatment, who work with people, who would, if those three programs in the state did not exist, those folks probably would not be out of the state hospital. [LR136]

SENATOR GLOOR: But, forgive me, I have a tendency to revert to my acute care background. But your answer of keeping people institutionalized if they're not ready to make that big a leap, to me is the same as somebody who is recovering from a heart attack and being kept in an intensive care unit after they've long since stabilized from

the reason that they're there. We try and move them to less intense forms of care as part of that rehabilitation but we don't send them, after they've had bypass surgery, immediately back home. Most of the time we try not to do that, I believe. There are different steps along the way. [LR136]

BLAINE SHAFFER: Right. [LR136]

SENATOR GLOOR: So my concern is, that leap, maybe it isn't that great a leap, but keeping them institutionalized at that more intensive level of care may also not be appropriate to their rehabilitation. [LR136]

BLAINE SHAFFER: I fully agree, and no one that leave LRC without a treatment plan...every week we have conference calls between the providers at the regional centers and people in the region and providers. Every time a person is deemed ready for discharge, usually the community providers come to the regional center and meet with that person and are part of the treatment to make sure that the transition is more complete. So there is no one that leaves the regional center that has not already been accepted into the community by a treatment provider for the care that they would get. [LR136]

SENATOR GLOOR: Okay. Thank you. [LR136]

SENATOR GAY: Senator Campbell. [LR136]

SENATOR CAMPBELL: Thank you, Senator Gay. Dr. Shaffer, part of the uniqueness of that program was how it was established on, I think, a behavioral reenforcement, but it had a very specialized approach to the clients and patients in there. Is the same type of program now available in another portion of the hospital, or is how the program was run disappeared and the patients are now under a different system of care maybe? [LR136]

BLAINE SHAFFER: Well, as I mentioned, the behavioral management programming was a very unique part of what CTP did, and that was the manualized programming that was very focused on repetition of intervention with patients, particularly those who were less cognitively functioning. That modality, per se, does not exist elsewhere in LRC, but other portions of psychiatric rehabilitation does. And as I mentioned, including programming that did not exist at CTP, particularly trauma recovery, trauma support, recognizing that a significant number of folks that are in the regional centers have been significantly traumatized, both in their history as well as in the past, having been part of the treatment system. [LR136]

SENATOR CAMPBELL: And just as a follow up, Dr. Shaffer, have we, in this short amount of time...and I realize it's a short time since the program has changed, have we seen a person who went into the community and is now back at the hospital? Because part of my concern is, are we tracking the people to see what would happen to them? [LR136]

BLAINE SHAFFER: Tracking folks who had been at CTP. [LR136]

SENATOR CAMPBELL: Right, that might have been released in the community but...I mean, over a long period of time the success of that program was the length that people were in it, it seemed to me and as a layperson, that by the time that period was over with, they were ready to go in the community and they probably didn't come back. But now with the shorter length, or a shorter program, will we see more of a revolving door? That's a critical question for me. [LR136]

BLAINE SHAFFER: Well, actually there was a fairly significant readmission rate for the folks who had been at CTP, and part of that was because there are very challenging issues to deal with. On the other hand, I am not aware, now, because as you may be aware, there has been a short time since the program was consolidated with the rest of LRC, we do keep track of folks who come back. And as I mentioned, the overall

readmission rate is low, certainly compared to the national standards, and if people are readmitted anywhere, they are much more likely to be readmitted for a short period of time in a community hospital, either acute, subacute, and then go back to other kinds of rehabilitation programs in the community, and never even get to the regional center. [LR136]

SENATOR CAMPBELL: Thank you. [LR136]

SENATOR GAY: Senator Howard. [LR136]

SENATOR HOWARD: Thank you, Chairman Gay. I'm going to go just a little bit further with Senator Stuthman's question. One of the concerns that we've heard over and over again, and it's very valid, is the shortage of physicians, the shortage of psychiatrists, the shortage of medical professionals throughout the state. And it's not only in the rural areas. In Omaha, we've really grappled with the problem of the shortage of psychiatrists in Lasting Hope, and it's a very legitimate concern. It's all (inaudible) to talk about having people reintegrated into their communities. But if the appropriate adequate services aren't available to support them in reintegrating into their communities, it's just going to be another bad experience. Continuing along those lines, if we are expecting those people to go into the communities, the professional staff isn't available to them, are we increasing their dependency on pharmaceutical medications to stabilize them out or any attempt to stabilize them out? I hope that...that's kind of a convoluted question but I hope you can address that. [LR136]

BLAINE SHAFFER: Well, I fully support your concerns about the work force. As I mentioned, that was one of the products of the academic support group that I chaired. And I'm very excited that there seems to be some movement now with LB603 to develop a work force initiative at Lasting Hope as a center and to spread to the rest of the state. I actually do not think that we will be making up for any perceived lack of services with overuse of medication. Since I've come to this state and had some

experience interacting with colleagues at the regional center, I have been very impressed with the judicious use of medication at the regional center, certainly nothing like my fantasy was as a person in academic psychiatry never having been involved in this state. So I'm not as concerned with that. I'm actually...if there was ever going to be a concern about too much reliance of medication over services, it would be the fact that the vast majority of psychiatric medications are prescribed by nonpsychiatrists. And I would hope that as part of that work force development, we're not only increasing the number of behavioral health professionals, but we're also increasing the expertise of primary care and other nonbehavioral health folks who are going to be doing a lot of that work. [LR136]

SENATOR HOWARD: Well, I think you hit a nail on the head when you talk about the education of people that could possibly be prescribing these medications and the responsibility of monitoring the medications they prescribe to individuals who are those individuals who overuse or in some cases under use. I think the prescription issue is critical and really we should be well aware of that when we look at the entirety of this picture. [LR136]

BLAINE SHAFFER: I agree. [LR136]

SENATOR GAY: Are there other questions? Don't see any others. Doctor, one thing I forgot to mention, is there a testifier sheet on that table that you would sign? I need to ask everyone else...the clerk got a little grumpy with me. (Laugh) No, here, you need to sign those so she could get your name, as well. So all right, thank you very much. [LR136]

BLAINE SHAFFER: Thank you. [LR136]

SENATOR AVERY: Mr. Chair. [LR136]

SENATOR GAY: Yes, Senator Avery. [LR136]

SENATOR AVERY: When do the nonmembers... [LR136]

SENATOR GAY: You can ask any time. Did you have a question for the doctor? [LR136]

SENATOR AVERY: I did. I was going to wait until everybody else was... [LR136]

SENATOR GAY: When they're done, yeah. Did you have a question for him? [LR136]

SENATOR AVERY: Actually I'd like to ask Mr. Adams. [LR136]

SENATOR GAY: He's coming back. Yeah, what I'm doing, trying to get the committee members, and then when I ask again. Go ahead. [LR136]

CAROLE COUSSONS DE REYES: Hi. Good afternoon, Senator Gay and members of the Health and Human Services Committee. My name is Carole Coussons de Reyes. That's spelled C-o-u-s-s-o-n-s d-e R-e-y-e-s, and I am the administrator for the Office of Consumer Affairs with the Division of Behavioral Health. Before this position I was the director of the office of consumer relations and recovery section with the division of mental health, and that was for the state of Georgia for over two years. I am also a consumer of mental health services and I appreciate the opportunity to be a part of assisting people, travel their road to recovery, and to provide voice for them. Recovery is about relationships. People isolated from their families, friends, and neighbors, in hospitals or institutions, people that are isolated for short stays or especially long stays, interrupt their lifelines. One day, one minute, or one hour is too many for me and many others to be away from their natural supports and community. Recovery is about life in the community. TheOlmstead decision has changed the way our nation views the culture of recovery and its place in the community. TheOlmstead decision was a U.S.

Supreme Court ruling that states individuals must be treated in the least restrictive setting and that not providing care for people in the community was, in fact, discrimination. For consumers that are not a safety risk to others, congregate settings are costly and wasteful spending of taxpayer resources, but are often championed by those that are employed by those settings. Specific information on this can be found in the Bazelon Center for Mental Health Law's publication of "Still Waiting: The Unfulfilled Promise ofOlmstead." Nebraska is moving with the nation. Nebraska has moved with the nation in reducing state hospitals beds and moving resources to the community to support integration and ending the legacy of segregation. This is the intent and vision of LB1083, and Nebraska is continuing to evolve in keeping with the promise of this legislation. Thank you. [LR136]

SENATOR GAY: Thank you. Did you sign that sheet too? We're definitely going to need you to do that. Any questions? I don't see any. All right, thank you. [LR136]

CAROLE COUSSONS DE REYES: Thank you. [LR136]

SENATOR GAY: And then, Scot, you going to answer some questions? [LR136]

SCOT ADAMS: I'd be happy to. I have one last paragraph if I might just before that. I would like to thank you for your attention to this issue, for your attention today. There's a lot of information about this treatment modality and I understand there will be a great deal of emotion regarding this issue. We believe that the decision to consolidate the CTP treatment modality within the larger LRC framework is consistent with theOlmstead decision, Americans with Disabilities Act, LB1083, the national movement that sees persons with mental illness successfully treated, accepted, and living well in their home communities. You have heard that psychiatric rehabilitation is a broad model that has a variety of specific program elements and activities, most of which are not CTP. Again, I'm not knocking CTP; it's just that it's bigger than that. These now exist in the community, when 25-30 years ago when CTP started they did not. I want to

acknowledge that change is seldom easy for individuals or institutions and systems. The history of behavioral health reform these past five years attests to that. I am sorry that there has been disruption for some people as a result of this decision, but the time for change had come. Thank you. [LR136]

SENATOR GAY: Thank you. Questions? Senator Stuthman. [LR136]

SENATOR STUTHMAN: Thank you. The question that I have, and I'm very supportive of a community-based treatment program. [LR136]

SCOT ADAMS: Yes, sir. [LR136]

SENATOR STUTHMAN: The only problem that I have is that there's been a real emphasis on if the individual can get back to the family and stuff like that. But if there is an individual in a community of a population of 25, you know, 80 miles from another town, how in the world can you get services to that individual in his or her community? And we have those situations in Nebraska. There's a lot of communities, ranching communities, where...I mean, they're miles away from any larger community. [LR136]

SCOT ADAMS: Senator, you raise a good point. Let me answer in at least two ways, though. One, first of all, LB1083 defines community-based services as not at a regional center, so it's anything else. But it's very clear that the people wanted services not in a regional center, because that's what they called community-based. Right there in the definition, that's what it is, so that helps us to understand a little bit more, because there's oftentimes misunderstanding about community-based. Is it geography? But in this instance of the law, it means not at a regional center hospital. So that's point one. Point two is each of the regions has their own unique strategies and tactics with which to respond to that particular challenge. Each of the geographies of the regions varies from place to place. Region VI is a much different region than, say, Region I or II. And those more rural and frontier series of counties, the (inaudible) regions, you have more

mobile services. Dr. Shaffer referred to ACT and a mobile system that will go to people's homes and take the service to them. Mobile crisis service will be responsive to the person where they are at the time. We are continuing to develop and to build the network of services. We're not at a done point today. It is a continuing process. We're better than we used to be. [LR136]

SENATOR STUTHMAN: So in other words, your interpretation of the community-based service could be across the street from the regional...the hospital, but still 300 miles away from the community that the person's from. [LR136]

SCOT ADAMS: You know, as a matter of fact, I think the strict legal interpretation of that probably would fit community-based. That's not what we're about, and I think our...but it could be. I mean, I think that is an accurate interpretation and reading of the legislation. Our intention is to develop the networks of services within regions which are closer to those home communities to be able to make them more accessible. And so we have a very specific regionalized system of care, and each region's system of services differs one from the other, so that no one region has it all. [LR136]

SENATOR STUTHMAN: Okay. Thank you. [LR136]

SENATOR GAY: Senator Gloor. [LR136]

SENATOR GLOOR: Thank you, Senator Gay. Mr. Adams, I somewhat hesitate to bring this up, but in this national healthcare debate that's going on right now, with all the hollering and whatnot, there is a common theme that I think makes some sense, and that is outcomes. [LR136]

SCOT ADAMS: Yes. [LR136]

SENATOR GLOOR: The graphs that you have given us really are just number counts.

We have this many at the Lincoln Regional Center; we have this many in the transitional program. It doesn't in any way measure outcomes with quality of care. Do we have outcomes measures that you can put in front of us that would show us that the care being provided, the traditional inpatient basis compared to the outcomes at the transitional facility, that there is some degree of comparability there or a learning for us or an ability to measure and hold people accountable for the care being provided? [LR136]

SCOT ADAMS: Within your packets, the closet that comes to that is the readmission rate, sir. And the readmission rate, as I mentioned in my testimony, of 39 percent over the last 20 years with CTP, the national average currently being 20.9 percent and the Lincoln Regional Center average readmission rate being 11 percent, this is measured at a 180-day point after discharge from the state hospital. And it's standard reporting across the country in terms of reporting on the data on into the national organizations. That is an indicator, I think, of some level of outcome, though I've got to tell you...you get me started on outcomes and I can go for way too long. [LR136]

SENATOR GLOOR: Me too. [LR136]

SCOT ADAMS: Yeah, but that sounds like a comparison, but it's really...I want to be fair about this. And it's very difficult to compare a population to a population to a population, with a simple statistic. And so while I offer those numbers to you as a measure of outcome, because it is an indication not only of the regional center and CTP performance with a particular group of people and their readmission. It is that. It also takes into account a lot of other factors that can't be controlled, like their experience in the community and their experience of family, the impact of their...oh my, it goes on and on. So I urge great caution with those. [LR136]

SENATOR GLOOR: But 180 days is a long time. A readmission after 30 days sometimes is looked at as a more fair measure of the care provided by a specific

program. As you've said... [LR136]

SCOT ADAMS: I can get you that. [LR136]

SENATOR GLOOR: That would be far more helpful to me. Care provided after 180 days could be...and the readmission could be reflective of the poor care by other programs, some of the same programs we now expect to pick up the slack in this, and that therefore is some of my concern about using 180 days. But, yes, I would appreciate seeing the 30-day readmission rates. [LR136]

SCOT ADAMS: Yeah. I pay attention to the 6-month one because we've got them no matter where they are, and...but I understand what you're saying with this particular issue. We do report that. I don't know that we've broken that out for CTP folks, but I'll give it our best shot and get back to you. [LR136]

SENATOR GLOOR: Thank you. [LR136]

SENATOR GAY: Senator Campbell. [LR136]

SENATOR CAMPBELL: Thank you, Senator Gay. Mr. Adams, I think part of the concern this spring, at least for those of the Lincoln senators that may be sitting up here, was the suddenness, or appearance of it, to families that this program is going away. Is that...do you think that's a fair picture of it, and if so, why not more time to prepare the families in terms of what their loved one's care would be? And going sort of to Senator Gloor's question, do we have the right programs in place for those folks to go into the community? [LR136]

SCOT ADAMS: Yeah. The question of timing is a delicate question of balance. On the one hand, if you go too long with considering this, say months or quarters or perhaps or even the better part of a year, you raise, certainly, anxiety level. Indeed, in Jocelyn

Ritchie's resignation letter from the program, she noted that herself: that is should be implemented rapidly. In our notice, given to Senator Gay and distributed to all members of the Unicameral, our letter was dated on April 1, which was about a week after we had announced that. And in that letter we said, by the end of May. And so we gave 60 days' notice to all folks with regard to this, and practically speaking there was even further notice of about another week or so. It ended up being a closure on May 1 because the principals, the two psychologists involved with the program, resigned from their posts on May 1, and so we had to conclude those operations by May 1 in order to integrate their treatment and keep it going. So we intended...we gave...we gave 60 days' notice in writing to folks in discussions with patients and families. That shortened up considerably. [LR136]

SENATOR GAY: Senator Howard. [LR136]

SENATOR HOWARD: Thank you, Chairman Gay. In looking at the information or listening to the information that you've just provided Senator Stuthman, I can't help but ask you, with the local teams, with the services, with the things that you've described, how are we going to pay for that? And the reason this is such a key question for me is, I spent a lot of time in June in Chicago, and they have a network of social services that really address a lot of worthwhile causes. The problem is, they've run into a huge shortfall now, so they're looking at cutting all of these programs by 50 percent. And when I got back and I was talking to the Governor, and I said I have a whole new appreciation for sustainability. And when I listen to you talk, I think these things sound good and I'd like to see these in place. Number one, how are we going to pay for them? Number two, can we sustain them when the times get tough? And they're not looking like they're getting any better. [LR136]

SCOT ADAMS: Sustainability is, of course, an issue that is all of our concerns and focus. A couple of points about that. First: context. There's a state west of here who received a 30 percent reduction in its mental health services budget in the current year.

Other states have measured double-digit decreases in reductions in services as we go through these difficult times. This year, the state behavioral health system received a point and a half increase in the rate, as you know, and so Nebraska (knock, knock, knock on desk) is faring better than many other states. The question remains valid and let me address it from a different...in a second arena. We have moved $30 million from operations of state regional center hospitals' services and programming to the community over the course of the last five years. Over the course of those five, a total of $30 million that used to be in state hospitals has gone to community-based care. Also in each of the last three years, there have been sort of inflationary increases along with that. Coupled with that strategy to move, operate regional center operational funds to communities, has been the move to include, at a reasonable pace and the appropriate balance, with Medicaid services, and so there has been an increase in the funded proportion of Medicaid services for both mental health and substance abuse services over the course of the last fives years. That's still sort of begs the question: How are we going to maintain that? And I think that question rests with economic vitality overall and the ability of the state to sustain this level or whatever level the Unicameral determines is appropriate. [LR136]

SENATOR HOWARD: Thank you. [LR136]

SENATOR GAY: All right. Any other questions? Senator Avery. [LR136]

SENATOR AVERY: Thank you, Mr. Chair. Mr. Adams, earlier this year you met with me and Senator Coash and some other people, and you...we were asking you to explain to us why you did not inform the Legislature or the Governor about the termination of the program. And you told us that, well, the program hasn't been terminated; it's been moved to the general population of LRC. Now we are hearing that, well, actually CTP didn't work that well; it's not state-of-the-art or best practices anymore, and that these people need to be moved into the community. How do you explain that discrepancy in your position? [LR136]

SCOT ADAMS: Let me, first of all, clarify again: I have not said that it is not state-of-the-art or it didn't work that well. So let me... [LR136]

SENATOR AVERY: But you've provided a letter in here from... [LR136]

SCOT ADAMS: Saying that national experts had not heard of the program. [LR136]

SENATOR AVERY: But that seems to imply that it's probably not a good program or they would have heard of it. [LR136]

SCOT ADAMS: Well, that would be a misreading of that. As it says there, they simply... [LR136]

SENATOR AVERY: What was the purpose of it? [LR136]

SCOT ADAMS: National folks, at my level and in the research institute, have not heard of this particular program. I have heard repeatedly that this is a nationally recognized, nationally renowned program. And I thought, is that right? And so I simply asked my colleagues and others about that, and they said, no, huh-uh. And it's not a reflection of quality. [LR136]

SENATOR AVERY: So they could be badly informed. [LR136]

SCOT ADAMS: They could be badly informed. Fifty other directors of mental health services in the state, and including the SAMHSA, could be badly informed. You're right. To your question though, I think that as we noted here, we have consolidated those services and provided the courtesy notification--we don't believe that the elements of 71-810(3) were triggered in this because it wasn't the particular nature of a service. It is a treatment modality as opposed to a service, and so we didn't give formal notification of

that service to the Unicameral, but we did give courtesy notification with at least the intention level of at least 70 days, 60 days before closure or consolidation of that programming with the rest of the Lincoln Regional Center. So we think we did not need to because it didn't rise to the level of service intended by the Unicameral, and secondly, because it was simply a treatment modality. Community transition program--literally its title, not service; and that no beds were closed, no employees laid off, and no fewer people served. Indeed, more people served. And so by whatever operational definition of service that we could conjure up, we couldn't make it a service and so did not give formal notice. [LR136]

SENATOR AVERY: Don't you think it would have been better if you had a question about whether you ought to inform us or not, that you would err on the side of informing us even though you may not legally be required to do so, and avoid a lot of pain? [LR136]

SCOT ADAMS: And that's part of the reason why on April 1 you all received a letter from us, a courtesy notice about the impending winding down, I believe was the word I used in that letter to you, regarding the community transition program. [LR136]

SENATOR AVERY: May I follow up? [LR136]

SENATOR GAY: Um-hum. [LR136]

SENATOR AVERY: The emphasis on the community and everyday places where people live and work, I understand that and I know that that's where the profession is moving in the treatment of these patients. But isn't it necessary to prepare many of these people for the community-based programs prior to moving them into the community? Because it seems to me I recall that CTP patients were difficult to treat patients, and that makes some of your graphs here totally meaningless because you've got difficult to treat patients being discharged at a much lower rate than people in the

LRC. I expect that. They're harder to treat so they're not going to be discharged at a comparable rate. But isn't it necessary that they be treated before they be put into a community-based program? Isn't that what CTP was doing? [LR136]

SCOT ADAMS: First of all, let me take exception with your statement that the CTP clients were harder than many of the other clients. All of them committed are court ordered. All of them have severe and persistent mental illness. All of them have had a long history of treatment somewhere else; this was not their first stay. These are all very difficult patients with challenging conditions. Secondly, let me also say, CTP did not take every referral given to it. Some were too difficult, challenging, didn't fit the program, but they did not take every patient. That's another really important factor to understand here. So what happened to those folks? Well, they were treated, worked with, brought to greater health so that they could move to the community for their next phases of life and renewal, just like anybody else. [LR136]

SENATOR AVERY: And you have, in the LRC, trained professionals who can provide this same kind of treatment that the CTP was providing. [LR136]

SCOT ADAMS: We have trained professionals, as Dr. Shaffer said. All of the treatment is delivered by a multidisciplinary treatment team composed of psychologists, psychiatrists, recreational therapists, occupational therapists--I'm not sure about occupational, physical therapy. There is dentistry, psychiatry, nurses. Maybe more. Security specialists, treatment technicians. All of those folks come together in a team effort to work with the particular individualized treatment plan that's developed for the person based on his or her individual strengths and needs at the time, as Dr. Shaffer noted. The particular manualized BMPs that went on, don't...aren't there anymore; that's correct. That piece is gone. Psychology still exists. Psychologist testing, psychological input to the treatment planning, the development of the activities and the interventions are all still present. [LR136]

SENATOR AVERY: So they're being treated in the general population the same way other patients are, and CTP modality is not being used anymore. [LR136]

SCOT ADAMS: That's correct. [LR136]

SENATOR AVERY: So the program has been ended. [LR136]

SCOT ADAMS: The program has been consolidated with, sir, within the framework of the Lincoln Regional Center treatment services, larger general psychiatric treatment services. I think, notably, to your question, sir, I explained in my testimony that before the end of April three or four people had completed treatment and moved on, and since May 1 another three people have completed treatment and moved on into the community, and we have two others sort of waiting for placement within the DD system. Treatment continues. Healing continues. People are continuing to get better. They have not languished. Is that true in 100 percent of the cases? I can't say that affirmatively. [LR136]

SENATOR AVERY: Do you have any readmissions of those discharges? [LR136]

SCOT ADAMS: You know, I have heard of one... [LR136]

SENATOR AVERY: Out of three? [LR136]

SCOT ADAMS: ...but I'm not feeling 100 percent confident out of those seven, the four and the three. I'll confirm that. [LR136]

SENATOR AVERY: And that would be within 30 days. [LR136]

SCOT ADAMS: From since all of this began on April 1. I'll confirm that in writing for you. [LR136]

SENATOR AVERY: And the discharges started on April 1? [LR136]

SCOT ADAMS: I'm using April 1 as the... [LR136]

SENATOR AVERY: It really...I think Senator Gloor made a good point about comparing...you really...30-day readmits are far more significant than 180 days. [LR136]

SCOT ADAMS: Yes. I'll confirm that for you. [LR136]

SENATOR AVERY: Okay. [LR136]

SENATOR GAY: Senator McGill. [LR136]

SENATOR McGILL: I just have some clarification questions that are a little bit repetitive and I apologize for that. So to get into the CTP program, only a handful were accepted and they weren't...well, kind of fill me in, remind me of what those standards were. They weren't, like you said...people were rejected for being too ill. Were they rejected then on the other side of things, or was that the main reason folks were rejected? I'm just trying to understand the qualification. [LR136]

SCOT ADAMS: Yes, I want to also clarify something with what you said there, Senator, just so that we're as straight as possible here. The CTP treatment modality was roughly 5 percent of the admissions over the last 20 years, and that's not to say that that was because that was a bad thing or being avoided in any way. That's not the point of that number. It's simply to show context. Of some larger number, and I don't know the total number of people referred to CTP, not everyone was accepted. So that's point two. Point three is, the admission criteria in the manual for the CTP program were the identical admission criteria for the Lincoln Regional Center: serious mental illness, longstanding illness, refractory, difficult to treat, perhaps court-ordered. [LR136]

SENATOR McGILL: What made those stand out, those dozen at a time? [LR136]

SCOT ADAMS: Early on, early on in its beginning, it stood out because it offered the kind of thing that people have talked about here: the kind of step down to going back to community-based living that perhaps allowed them to be more successful in the community. In later years, I'm less clear about that. [LR136]

SENATOR McGILL: And then that's something that piqued my interest in your testimony. It was talking about those that were found by the courts not responsible for a crime for reason of insanity. It says there were four people that were in that program. But how many people, in general, are in the regional center for being found not guilty? [LR136]

SCOT ADAMS: Okay. We have roughly, at the Lincoln Regional Center, not counting the Whitehall campus, there are about 220 beds. Of the 220 beds, there is somewhere I believe around 35 in the forensics program. [LR136]

SENATOR McGILL: Okay. I wanted to see what the comparison was in terms of... [LR136]

_____: Yeah, I think so. I'm not sure how many of them are NRRI . I would...we would have, what? [LR136]

_____: Probably 30. [LR136]

_____: About 30 NRRI people. [LR136]

SENATOR McGILL: So about four of the 30 were in this program and the others were not for whatever reasons. Okay. Thank you. [LR136]

SENATOR GAY: Any other questions? I don't see any. I have one question/comment. I noticed several times that when the department...and you have the right, obviously, to make decisions along, as needed, and then there's informing the legislative sector of the government. But I've noticed several times that when we get informed, as legislators, it's usually after the fact where we can't do anything about it, and I think that kind of rubs people the wrong way. I know in Medicaid we have a rule now that if you're going to cut a program, you have to do it before the Legislature meets, to allow the legislators opportunities to argue the point, submit a bill, do whatever. Anyway, down the road, I just wondered, it's always probably good, and I know things come up and a year is a long time, but again when we're meeting maybe sometimes when these things happen it should be a little more, not midsession or something like that, just...I think timing is everything. And lots of times it may be the right thing to do, maybe the wrong thing, but I think senators from those areas or...if you have an interest in that, you don't hear about it until after the fact. Your hands are tied and you can't...you just feel frustrated. So sometimes I think when we're making decisions, as you know, and out of courtesy you told us because you knew it would be somewhat controversial, and appreciate that, but at some point I've seen where maybe our timing could be better as a state to inform the public and their representatives of what's going to happen so they could take a different course of action. I'm not in favor of having the Legislature run day-to-day operations. But I think timing is everything sometimes, and maybe we could do some of these things...you know, put that in the back of your mind. I hate to require that, legislatively, but I think sometimes common sense would dictate that you put it, this could be tough, by the way here's what we're thinking about doing, because I doubt you came up with this in ten days and decided to do it. So anyway. [LR136]

SCOT ADAMS: I think your point is well taken. Thank you. [LR136]

SENATOR GAY: All right. Thank you very much. I think we've got a good framework from the department's point of view. I've got, on my agenda, Gary Weiss, Mary Sullivan,

Dr. Liberman, and Dr. Hunter. So we'll start off Mr. Weiss. [LR136]

GARY WEISS: (Exhibit 3) Hello, Senators. I'm very thrilled to be here. Thank you for pursuing the issue. My name is Gary Weiss, W-e-i-s-s. Families representing two patients, as well as some staff, approached our office in March, concerned that the community transition program was going to close. We began our process of researching and investigating the situation, and I'm sure you would guess this is a very complex subject to investigate. We found that the most complex part of this is understanding the depth of the seriously persistent mental ill--what Mr. Bill Gibson at the Lincoln Regional Center calls, the hard-to-discharge patients. In this sea of complexities there were two...we had two moments of clarity; two events that I want to share with you right now. After CTP closed, two families requested that our office participate in their loved ones' treatment team meetings. At both meetings, we asked the very basic question: What is the treatment goal for that specific patient? And you've kind of heard this already from the department, that the treatment goal is stabilization. Based on that clarity, we believe there is a legitimate question as to whether the nature of treatment of former CTP patients received while in a program where the treatment goal was recovery was different from the treatment they are currently receiving, and I think that that's actually been answered by Mr. Adams, Dr. Adams, saying that the behavior mod piece is gone, and we would think that is significant. The theme Lincoln Regional Center professionals who told us that the treatment goal was stabilization, said to us, rehabilitation belongs in the community. When we surveyed the community programs available for this subset, for this hard-to-discharge population, we saw...we had that moment of clarity. We saw something obvious. There are people that are ready for recovery and rehabilitation that cannot be discharged. No one will accept them. The two...one of the people that Dr. Adams referred to, that they are dual-diagnosed, has been discharge ready for 700 days. That we understand that there was a CTP patient that was denied admission at the Omaha Telecare Recovery Center because the person, according to the center, lacked insight and that would make them inappropriate for their program. And I do believe that there was one patient who was discharged since the discontinuation of CTP

that was brought back three weeks later. We understand that to have happened. We believe there are gaps and inadequate capacity to support the treatment of this special population, this small, hard-to-discharge population. You'll hear significant testimony from professionals and expert witnesses after me, but the testimony that you will hear from the families who had loved ones in CTP will give you the clarity about the human consequence from gaps and inadequacies and inadequate capacities when that becomes institutionalized. We are also submitting written testimony to the committee and I would be very happy to answer any of your questions. [LR136]

SENATOR GAY: Thank you. Any questions? Senator Stuthman. [LR136]

SENATOR STUTHMAN: Thank you, Senator Gay. I just have one question. So, in other words, the goals of the regional center is stabilization. [LR136]

GARY WEISS: That's what we were told, yes. [LR136]

SENATOR STUTHMAN: Stabilization, nothing to do with therapy or recovery or anything like that. [LR136]

GARY WEISS: There is therapy connected to stabilization but the therapy is different than what it would be in a recovery center, as I understand, as I've been told. [LR136]

SENATOR STUTHMAN: So they're only there just to stabilize them. So they don't get worse or better, just stabilize. [LR136]

GARY WEISS: We had two...we participated in two different treatment team meetings and there were psychologists, psychiatrists, social workers, the nursing administration were at these meetings. There were 15 people at these meetings and we asked that clear question: What is the treatment goal? And they said, stabilization. In fact, one...at both meetings there were different people, said clearly rehabilitation belongs in the

community. [LR136]

SENATOR STUTHMAN: Well, I just have some...a real problem with it just being stabilization. You know, that's A, but there should be a B right connected to A, you know, as far as the minute they get stabilized. In other words, if they're stabilized, they should head right to the community-based program? [LR136]

GARY WEISS: That is...I think that that is the spirit. I think that...but there are...there is a population of difficult-to-discharge people, maybe medically resistant is another way that people are talking about or treatment resistant that... [LR136]

SENATOR STUTHMAN: So those that they just keep stabilized all the time. [LR136]

GARY WEISS: ...and they...right, that they're...well, that's what they state as their goal. [LR136]

SENATOR STUTHMAN: Okay. Thank you. [LR136]

SENATOR GAY: Senator Campbell. [LR136]

SENATOR CAMPBELL: Thank you, Senator Gay. I would like to thank Mr. Weiss because through the springtime he'd come down to my office and try to answer some questions as we were looking at this problem, too, and I appreciated that a lot. One of the questions that you and I talked about, and then the session sort of wound to an end and I didn't get to see you again, and that was whether this program could exist within an existing agency or some other private entity rather than in the hospital setting, and you said you were going to take a look at some of the agencies. Did you ever find one that said, we'll step forward and we could do this program? [LR136]

GARY WEISS: Well, there is...there is a recovery rehabilitation program. There are two

16-bed facilities. One is in Omaha, one is in Bellevue. Two of the beds in Bellevue are dedicated to Region 4; otherwise, these are all Region 5. I mean that...part of the region politics, I suppose. The recovery and rehabilitation program there is different, significantly different, than what CTP was. I think it is...one of the documents that helped our research was the best practices document and where the behavior management piece is part of the best practices and where evidence-based practice is part of best practices. I'm not...I'm concerned, we're concerned that those two elements of best practices do not exist. [LR136]

SENATOR CAMPBELL: Okay. Thank you. [LR136]

GARY WEISS: Sure. [LR136]

SENATOR GAY: Senator Avery. [LR136]

SENATOR AVERY: Thank you, Mr. Chair. Mr. Weiss, if the patients in the CTP program were difficult to discharge, doesn't this imply they were difficult to treat, they were resistant to treatment and, therefore, they needed special program? [LR136]

GARY WEISS: That's how I would understand it. [LR136]

SENATOR AVERY: All right. [LR136]

GARY WEISS: I want to emphasize, I don't mean to interrupt but I want to emphasize, I'm not a mental health professional. I mean I don't want to make any...cast any dispersions on any of the staff at the regional centers, the psychiatrists, psychologists, social workers, anybody. This is my observation as an outsider and so... [LR136]

SENATOR AVERY: Okay. [LR136]

GARY WEISS: ...I would assume that difficult-to-discharge people would be very difficult to treat. [LR136]

SENATOR AVERY: And the CTP, by its name, implies that it is a transition program to a community-based environment. If they are difficult to treat, therefore difficult to discharge, it seems to me they need that specialized treatment of rehabilitation, not stabilization but rehabilitation, that they're getting at CTP before they are qualified or eligible to be moved into a community-based environment. It seems to me that the patient is getting lost in this whole thing and treatment is not being provided for some of these most difficult patients. They were getting that treatment under CTP. All the evidence shows they were. All the outcomes indicate that. And some of the charts we have here are very misleading about discharge rates and all that. But what I don't understand is why we're talking about this community-based environment being so important but we don't really have a way to get many of these patients to those community-based programs. Well, what you're doing is condemning some of the former patients in CTP to permanent residence in the general population of LRC. That's my concern. [LR136]

GARY WEISS: Uh-huh. Would you like me to comment? [LR136]

SENATOR AVERY: Yes. [LR136]

GARY WEISS: I think that that (laughter) when the...when we talked about the gaps and inadequate capacity, I think that that's exactly...if the gaps and inadequate capacity, as we understand it, continue, we have a real concern that people will be trapped either in the institution itself or in the institution of the revolving door of mental health. And that's what...I think that the idea of institutionalizing the inadequacy with people, you know, putting into situations that could cause acute behavior, so on, that it becomes an institution unto itself, the revolving door. [LR136]

SENATOR AVERY: We will hear more about the revolving door from Mr. Chase, because his son went through. Thank you. [LR136]

GARY WEISS: Uh-huh. [LR136]

SENATOR GAY: Any other questions? I don't see any. Thanks, Gary. [LR136]

GARY WEISS: Thank you. [LR136]

SENATOR GAY: Can you sign? Did you sign a testifier sheet too? [LR136]

GARY WEISS: Yeah, I... [LR136]

SENATOR GAY: Thanks. All right. Who's on? Mary Sullivan is who I have next. [LR136]

MARY SULLIVAN: I'm Mary Sullivan, M-a-r-y S-u-l-l-i-v-a-n. I was the director of the Community Transition Program from the time that it started. Actually from 1988 to 2009, I was the chair of the program development committee that got it going. Thank you for this opportunity to discuss with you the situation we're in and to answer any other questions that you might have. When CTP was closed, I resigned as a state employee, having served almost 28 1/2 years. And I'm not here to look for a job. I'm just want to reassure people of that. We are here today--families, mental health professionals, advocates--to speak to you about the need for psychiatric rehabilitation in secure settings in Nebraska. This is why we're here. There are people in Nebraska who are seriously and persistently mentally ill who are not currently getting the treatment they need because there now is no effective best practice of rehabilitation anywhere in the state. The cost of failing to effectively serve the group of most seriously, persistently mentally ill individuals are unacceptable in terms of human suffering of the patients and their families, and in terms of the current wasteful use of public funds for people who are either stuck in a hospital or who get stuck in that revolving door that was referred to.

Hopefully, the hearing here will put some human face to this tragedy by hearing from some of the families that have been involved and who are victims themselves of this decision. This is what you're going to hear today from the group that I'm part of. The psychiatrist who's an expert on psychiatric rehabilitation will explain what psychiatric rehabilitation is and why it should be available, must be available in our state. A nationally recognized psychologist who's a consultant on mental health regulations and administration will talk just about that. Family members who have experienced this tragic consequence of not having best practices of psychiatric rehabilitation available for them and for their loved ones will talk about their experience with you. A former Community Transition Program social worker who was a team member and a clinician will briefly describe the quality of services that the CTP provided. Local mental health professionals will tell you about how the CTP affected community services and how the closure of CTP will affect community services. Our testimony today is also backed by the letters that you've received, Senator Gay, from advocates and mental health professionals in the community who are concerned about the closing of the program. I have rewritten my testimony after talking to several of the senators because I realize that the question I'm hearing about more than any other is the question of why did this program close, and here's my answer. The reason CTP was closed is that CTP was run with an amount of accountability and transparency that the rest of LRC could not tolerate. CTP was closed because psychiatric practices today, in general, and psychiatric rehabilitation in particular, bring a degree of accountability and transparency to public institutions that can be threatening and unacceptable to those who want the comfort of traditional treatment as usual. LRC did not simply close the CTP. They dismantled a state-of-the-art computerized clinical data system that precisely tracks staff activity and patient progress. And as a program director, let me tell you this was very important in the running of what was the lowest cost program at the Lincoln Regional Center. CTP raised the bar for accountability and positive outcomes that showed what is possible today in regional centers and this could have been experienced as an embarrassment for other parts of the regional center. At the Community Transition Program, we held staff accountable for what they did, for

providing best practices, and for the outcomes of the practices that they performed or the services they performed within the program. This important point: Dr. Adams referred to CTP being selective of the people that came to CTP. The first question we had to the referral treatment team was, could this individual be discharged to any other program in the community? If the treatment team told us, well, yes, we're talking to CenterPointe or, yes, we're looking at CLS services and possibly living in assisted living, we would say, our response, pursue that before you send them to CTP. Anyone who's in a regional center for longer than 30 days who has not responded to the treatment that's provided to people for that shorter stay is a potential candidate for CTP because it indicates that something else is at work here for this individual. And the people that CTP worked with were people who were not good responders to medications, to the treatment provided as usual. It didn't mean that anything else was wrong with those programs necessarily. It meant that the person, the individual, him or herself, wasn't able to be discharged. CTP worked with individuals who had been hospitalized 15, 20, 25, 30 years and got those individuals back into the community, living lives in the community. CTP worked with the people who are stuck in the revolving door, who had been in and out 8, 10, 15 times. We stopped the door and we helped them learn the skills that they needed to have to live in the community. What that means is helping manage their disorder, working with their care providers in a collaborative way as partners, learning the skills to get up in the morning, do their hygiene grooming. CTP treatment teams learned how to give people the incentive to get going and to get in touch with that hope again that rehabilitation provides to individuals. If CTP were referred to somebody from forensic, let's say, who was actively being very, very aggressive, a level of aggression we knew we couldn't safely handle, you bet we wouldn't accept them then. We ask the team to refer back when they're less aggressive. So, yes, again, we did say no to people, in the one case, because they might get discharged, and if they couldn't they'd come to CTP. Over the years, CTP gained support from both the participants and their families who recognized the difference of CTP and what working with CTP was like for them. CTP set a standard, we in the Community Transition Program set a standard for staff training and commitment that

actually LRC administration and clinical leadership didn't understand or implement. There are a range of possible solutions for us here in Nebraska and they need to be considered very carefully, remembering that the reason CTP got going to begin with, in response to a call years ago to find something, someway to work with these people effectively, the people we couldn't get discharged, was that we were going to find a way to discharge them and we were going to be able to work successfully with them. They are located in the regional center now. The people who have been at LRC for more than 30 days, and I'm not sure of the exact number and that would be an interesting thing to find out, they're potential candidates for rehabilitation. I want to do a couple things right now if I can, just to clarify somethings that Dr. Adams mentioned. For the vast majority of the time that CTP existed, it was a 40-bed program. The reason the numbers went down was because Building 14 out at LRC was getting a new HVAC system, which was great news for all of us who lived and worked in that Building 14. At that time, we went down to 20 beds and it was my understanding, as early as late last year, early this year, that we would go back to...we'd go to 20 with the goal that we might need to go to 30. So that's what I understood, as the program director at the time. The other thing has to do with service definitions, which is something that Dr. Adams brought up and he talked about the state, the services that are paid for have to meet the service definitions. And he's correct, there wasn't one for inpatient psychiatric rehabilitation. Last year I was part of a small group of people who worked on what those definitions would be, and I worked with a person from Behavioral Health, the office downtown, to develop that criteria for inpatient psychiatric rehabilitation. It was presented at an LRC medical...an executive committee of the medical staff. When those service definitions were presented, that was part of the service definitions, so I expected, of course, that it was going to be part of the service definitions and we would gauge our work, again, following those service definitions. And having been somebody who helped develop the service definitions, I had confidence in those definitions. I find it strange that there was no reference made earlier to that. The other thing I want to bring up, and I want to bring it up in due respect, but it really has given me pause about what Dr. Adams said about NASMHPD and the organization he went to. In LRC meeting minutes there's reference to the fact that...and

I'm going to...I don't want to make noise here, that Scot...it quotes: Director Scot Adams attended the commissioners' conference in St. Louis and Fulton State Hospital is using LRC as a model for moving their psychiatric rehabilitation program into the community. This is extremely misleading, and if the senators would like, I have copies of this for you, and if you don't that's fine too. Because our colleagues who work at Fulton State Hospital have never indicated this to us and because Dr. Mandito (phonetic) of Fulton State Hospital wrote a letter to the Legislature in April really concerned that this program had been...the Community Transition Program had been closed, we let him know about this information. He said that was a gross oversimplification and a complete misrepresentation of what they had done. They, too, were looking for ways to get beds, more beds, community...or rehabilitation beds, into the community. When they put out a request, nobody in that specific area of the state came forward to pick up the request. So they had a building and they said, we'll keep it an unlocked building and we'll work with these people until somebody in the community comes forward to take up this program, which is what happened. The Fulton State Hospital runs their 400-plus center, Fulton State Hospital, using psychiatric rehabilitation across all levels of care. They use it in their forensic and they use it in all levels of security because they know the kind of outcomes that occur for people who otherwise don't respond to treatment as usual. So I was concerned and I was not even going to talk about that today unless Dr. Adams brought up NASMHPD and wanted to talk about what he had learned there. So I wanted the committee to know that but, again, I bring it forward in respect. I think there are things we can do. I think studying what we need to do is going to be really important. Because my prediction is, is that if we don't do something to get psychiatric rehabilitation going where the people are then we...our system is going to start backing up and we are going to suffer as a community and as a state because of that fact. So that's my speech. I'm open for all questions, of course. [LR136]

SENATOR GAY: All right. Any questions? Senator Wallman. [LR136]

SENATOR WALLMAN: Thank you, Chairman Gay. I thank you for coming there and

thank you for what you do. And as we heard about, you know, stabilization, your goal was surely more than that, wasn't it? [LR136]

MARY SULLIVAN: Oh, you bet. In the Community Transition Program, we assessed what are people's strengths, what are the problems, what are barriers to getting into the community, what's keeping this individual from being accepted by the community providers. That's where we did our work. Oftentimes when people came to CTP and sometimes even when they left, they weren't so sure they had a mental disorder but they were willing to think that they might and that they'd work with people in the community on this. We taught very practical skills, very much hands-on, out of your chair, practice the skills, make them part of your routine. Many times the first thing we had to do was to try to motivate people to get out of bed in the morning and get in touch with that fact that you, who failed a lot, are going to be a success in this program. [LR136]

SENATOR WALLMAN: So you had guidelines like what you expected from the client, according to his or her ability? [LR136]

MARY SULLIVAN: Right. Right. It's...every plan had to meet what their needs were, building on their strengths and aiming towards a discharge plan that made sense to them. And the focus of discharge was always front and center. That's not unusual in a hospital, that's for sure, but it is very important, especially when people are in rehabilitation. One of the things I wanted to mention is that more than half the people in CTP did get out before 19 months. And that can sound like a long time and I know, but it's not a long time if you've been in the hospital for 10, 20 years. It's not a long time if you've been stuck in a revolving door. And our graduates have gone on to work. Some are very active in the advocacy movement here, day programs. They're successful. [LR136]

SENATOR WALLMAN: Okay. Thank you. [LR136]

SENATOR GAY: Other questions? Senator Pankonin. [LR136]

SENATOR PANKONIN: Ms. Sullivan, obviously, it probably isn't going to happen to put that particular program back together, but I just wanted to follow up with kind of your close. For us as policymakers, looking at the system and hearing the testimony from the department today, what do you think would be the indicators or what do you think as, you know, just kind of general policy for folks here that we should be hoping for happens, you know, with the outcomes, as Senator Gloor has talked about? How do we assess where we're at going forward? [LR136]

MARY SULLIVAN: I would certainly be watching what the length of stay is at the Lincoln Regional Center. The reason that there were back wards and long-term patients there who weren't getting what they needed you could measure in length of stay without people getting discharged. Every year at a 40-bed program we discharged 20 people; 20 new people came in. We discharged 20 people. I mean that was pretty much our rate when we were 40 beds. And it's interesting to me, the money for CTP is in the LRC budget now. I mean the people who could benefit from CTP are in the Lincoln Regional Center now. That's the frustration, I think, that we experience. We learned so much about how to work with this population. We learned so much, and when I say the "we," I mean the staff that worked there, working with the families and the participants. And it is very sad to think that is lost and that is when I hear and think about the word "tragic" for our state. That was a big decision. Again, one that caught me up short because I had understood I would be directing that program into this year and beyond, increasing its numbers of beds, so. [LR136]

SENATOR GAY: I've got a question for you. [LR136]

MARY SULLIVAN: Yes. [LR136]

SENATOR GAY: It leads right into what you said. But how do you go...you said...why would you think, in your mind, the program is growing--you talked about they limited it because of the HVAC thing, makes sense--that it's going to grow and then all of a sudden it's gone? Where was the communication between...how did you not see that coming or why do you think that decision was made then? Because you, in your mind, thought it was growing, you were going to go back to 30, maybe 40 beds, and then all of a sudden... [LR136]

MARY SULLIVAN: I've had a lot of time to reflect on this and it is interesting to me--I tend to be optimistic--and it is interesting to me that I missed it because I think in my discussions with my supervisor, the CEO, and the way he was talking about it and the way that service definition plan showed up with inpatient psychiatric rehabilitation on it in an early this year meeting of the medical staff, things rolling along with that definition, talking to Bill and his saying, well, we know that with the difficult, difficult population that we're getting here at the regional center we're going to need everything we've got. And so we talked about 20 beds and then 30, we'll see how we do with 30, and I was just thinking, well, we're getting set then for more work and it was a very exciting time because it's exciting to have that many people in rehab around you at the same time who are working so hard and working on their plans. I know there were difficulties with the program and, when I talk about accountability and transparency, I was aware that the staff in CTP brought up concerns a lot. But then in CTP, they were...that's the culture of CTP. [LR136]

SENATOR GAY: Because they could see other things happening? [LR136]

MARY SULLIVAN: Yeah, and CTP staff were excellent at, together and individually, saying there's a problem with this, there's a problem with that, we've got to work on this, we've got to work on that, and we did and we solved the problem. I reinforced them for bringing up the problems. And I don't know. I don't know that we made ourselves as popular as I wish we could have. I accept that. Bureaucracies have a different life,

agencies and institutions have different cultures and I understand that. So that's why I wish if I'd even caught on quicker. I don't know if I could have done anything, but it wasn't until the program was closing that I found out it was closing. [LR136]

SENATOR GAY: Thank you. Other questions? Senator Avery. [LR136]

SENATOR AVERY: Thank you, Mr. Chair. Ms. Sullivan, are special skills in rehab needed to treat patients who are difficult to discharge? [LR136]

MARY SULLIVAN: The staff who work in a rehabilitation program have to have an extremely high level of consistency with the work they're doing. They also have to listen very carefully to what the treatment team is directing. So we're not going to have staff out there in the program making a, well, this is what I feel like doing today. The treatment teams in the behavioral management programs were referenced earlier. They must be carried out very specifically and consistently. They're very powerful. Behavior management programs are very powerful. And JCAHO, when they write those accreditation standards, they're very particular about how you run behavior management programs and those standards must be met or there's trouble for the facility. We did really well in CTP but, yes, you had to...one had to have a staff that took its direction from the treatment team, that all your staff could get to the meetings they needed to get to. So you had to have the staff to get to the meetings, learn what the treatment team was thinking about and why they came up with certain plans, and then we had to have, and I mentioned before, the clinical data system, the computerized clinical data system that could get back to the treatment team information about how the person is doing, doing in the milieu--so if you're a psych tech, you're filling out certain information--doing in your groups and classes. All that information comes back to the team. The team then can look at the information and know that whether a decision they made about the treatment plan is working or not, and they get that information back more quickly because of the system we had. Yes, the team at CTP had to have excellent skills. Their interaction skills had to be really...and we hammered on this with

staff, they really had to be respectful and matter of fact. It wasn't a, oh, you poor patient, nothing good will ever come of you. It was very much, you've got a life, you can do it, we know you can, we're here to help you. [LR136]

SENATOR AVERY: Is it your opinion that the LRC now has people on staff with those kinds of skills or that they do not? [LR136]

MARY SULLIVAN: We still have some rehabilitation staff at LRC, there are still. They're not doing rehabilitation. They're working in other programs. As Dr. Adams mentioned, they didn't lose their jobs because they kept the same number of people there, just doing different things with the people there. [LR136]

SENATOR AVERY: Uh-huh. And it is possible for people to retrain if they need to in order to learn these skills. [LR136]

MARY SULLIVAN: Sure. [LR136]

SENATOR AVERY: If you're going to have a rehab program in LRC, it would be possible to do that? [LR136]

MARY SULLIVAN: If the state wanted to, you bet. [LR136]

SENATOR AVERY: If people are in need of retraining in order to provide rehabilitation services, would those training records be public? [LR136]

MARY SULLIVAN: Yes, I would imagine they would. They're state employees. I'm not positive about that though. I do know that the CTP did extensive ongoing training with the staff. This thing you've probably heard about, maybe you've experienced in your life, called drift--everybody is supposed to be doing the same thing and then you turn around and somebody is not quite doing it so you have to retrain staff and make sure

everybody is still on the same page. And that's why rehabilitation is demanding on staff as it is, and it is. People work hard. [LR136]

SENATOR AVERY: So we could request those training records and we would know whether or not training was being conducting in rehabilitation services. [LR136]

MARY SULLIVAN: Right. Right. They're...yes, and again, I don't know levels of confidentiality associated with that, and LRC itself does extensive training when a person first starts working there, you bet, and they have ongoing, you know, training. But the CTP had specialized training for the specialized skills we needed from our staff. [LR136]

SENATOR AVERY: Thank you. [LR136]

MARY SULLIVAN: You're welcome. [LR136]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LR136]

MARY SULLIVAN: Thank you. [LR136]

SENATOR GAY: All right, Dr. Robert Liberman. [LR136]

ROBERT LIBERMAN: (Exhibit 4) Good afternoon, Senators. I spell my name L-i-b-e-r-m-a-n. I'm from California. I've come a long way and really enjoyed looking out the airplane window and seeing the beautiful shades of green and the fact that there are still family-owned farms here in the heartland of America. We don't have that. In California they use airplanes to fertilize and seed the land. At UCLA, I'm distinguished professor of psychiatry and I direct the Psychiatric Rehabilitation Program. I'm pleased to be here this afternoon to provide and offer you a current perspective on psychiatric rehabilitation for the most severely and persistently mentally ill individuals who are

refractory to the usual forms of treatment, including many of the evidence-based and best practices techniques that we've heard about today. One of the key elements in the services that can be helpful in moving these treatment refractory individuals to a more stabilized level and then on, as you're suggesting, to a stable level of functioning and then on to recovery is a social learning program, referred to here...referred here as behavior management. It's not a good description because you're not managing behavior. You're giving positive reinforcement and incentives and acknowledgement and validation to people for very small, tiny improvements in their personal hygiene, in their social communication and conversation, their relationship building, catching the patients every minute, every five minutes, intervals throughout the day--it's a 24-hour, 7-day-a-week, program--catching them doing things that are normal or approximating the normal. People with schizophrenia, with treatment refractory schizophrenia are not psychotic 24 hours a day and there are many opportunities to catch them when they're behaving and communicating in more normal ways. So this afternoon, just in this very brief time I have, I want to try to acquaint you with the reason that there are people who have treatment refractory, severe and persisting mental illness; to describe briefly some of the specialized services that can move them from being refractory, or treatment resistant, on to a more stabilized state, and then getting them ready for treatment in the community, more open and more spontaneous kinds of treatment, less supervised treatment in the community in a stable and recovery orientation; and then also the consequences of not having specialized, highly specialized services here in Nebraska for this category of patients, and a few words about what can be done at this point, where we are right now. Let me first just describe a few of the reasons why I...or how I've developed my speciality in psychiatric rehabilitation. For 40 years my team and myself have developed and designed and developed and then tested and researched, careful research, the kinds of services that are effective in rehabilitation for the most seriously mentally ill. These best...these have been deemed as best practices. Dr. Shaffer has alluded to the documentation of this. They also have been translated into 23 different languages, are used in 50 countries around the world, and have widespread application here in the United States. We've published over 400 articles and 8 books.

The most recent one is called Recovery From Disability: Manual of Psychiatric Rehabilitation, and I was very pleased to hear that Dr. Shaffer did read the first chapter of the book because he almost quoted verbatim some of the points that I made. But he did not...I would like him to read Chapter 8 because Chapter 8 is entitled "Special Services for Special People," and there's a major section there on the kind of unique services that are required to help these treatment refractory patients move on through the dimensions of stabilization, stability, and then recovery. Since starting my professional work in California in 1970, actually I had my training and I was born and raised on the East Coast and I'm sad to say I jumped over the Midwest, although I made up for that partly by marrying my wife, who is from Minnesota. But since coming to California, I've directed a research unit, a Camarillo State Hospital-UCLA collaborative venture, where we took the most refractory, most severely disabled people from all over the state of California. All the other state hospitals, the community mental health programs referred them to us for this, these types of services that were used at the Community Transition Program. I was director of the Clinical Research Center for Psychiatric Rehabilitation and Schizophrenia for 27 years at UCLA. This was funded by the National Institute of Mental Health. I directed a rehabilitation research and training center funded by the National Institute on Disabilities and Rehabilitation. I was chief of rehabilitation at the Los Angeles VA Medical Center, the largest VA hospital in the United States. And I love...my first love is treating patients. I've seen well over 1,000 patients and I have 25 people with serious mental disorders, like schizophrenia, in my practice right now at UCLA. Okay, now let's start with--and we can perhaps take a look at this handout, the first page--who are the most severely, mentally disabled persons and what are their needs? Everywhere you go, doesn't matter what state or what country, approximately 20 percent of people do not respond to medications, the full array of currently available medications, nor to the conventional forms of psychosocial treatment. Dr. Adams mentioned the use of substance abuse groups and trauma-related services. It is not enough for this population to have discussion groups or lectures or 12-step programs. These individuals need much more focused, repetitive, and stepwise programs that involve them in active learning. It is very much...these

individuals, as you can see, they have severe cognitive deficits. They learn very slowly. They're like learning disabled youngsters who need specialized educational programs in our public schools. They have severe and unremitting negative symptoms, meaning a lack of emotional expression, a lack of social interest and social involvement, a lack of initiative, a lack of energy and so on. They have severe and continuing positive symptoms, delusions, hallucinations, incoherence, and they have bizarre behavior, which makes their functioning in the community intolerable to the community. That's why they're referred to a regional center and many of them over the years have been referred to the Community Treatment Program, and especially they have these cognitive deficits, these learning disabilities that require the very systematic attention to the details of their day-to-day improvement and participation in the life of a hospital setting. Okay, let's move on to page 2. Now while the pharmacotherapy and the very best medications, which I'm sure are available at the regional center, can make some dent in their positive and negative symptoms of the illness, medication has never taught anyone, whether they have a mental illness or any other kind of disorder, medication has never taught anyone anything. It reduces symptoms. And so this learning environment has to be created so that all the time that they're living there that it becomes a social learning experience. Treatment in this case is education and clinicians, psychiatrists, psychologists, social workers, nurses and aides, they are teachers, not just clinicians. They have to be teachers. Training in social and independent learning skills need to be based on learning principles. In the modules that we've developed for medication self-management, teaching people to learn how to identify the benefits and the side effects of their medication, how to communicate with a doctor who's very busy, maybe has 15 minutes to have a discussion about medication with the patient, how do you use that 15 minutes fast, how do you specify the nature of the side effects you're having and ask for some assistance with those, how those side effects are interfering with your daily life--medication self-management. Symptom self-management--developing ways of identifying early warning signs of relapse to reduce this revolving door, developing an emergency plan, knowing how to deal and cope with persisting symptoms because even with the very best treatment a lot of these

individuals will continue to have from time to time hallucinations and delusions. They don't necessarily...if they're equipped with self-management ability, they don't have to come back into a hospital. They can cope with...and we have demonstrated that in our research, they can cope with these persisting symptoms, these intermittent symptoms on their own. Substance abuse management module, community reentry module, recreation for leisure module, basic conversation skills module, workplace fundamentals, we have packages of programs that are video-assisted and designed to overcome these very cognitive deficits, these learning disabilities that treatment refractory, severely mentally ill people have. In other words, you've got to create a treatment and an educational program that meets the needs of these individuals, not a broad program that is useful for in general for everybody. Family focused education is extremely important, engaging the family in the treatment. We've now done research for many years, and it's been replicated in many countries, that the family support, the ability of the family to communicate and solve problems with the individuals is 50 percent of the contribution to recovery. It's as powerful as medication. And people are overwhelmed, relatives are overwhelmed. They don't know what's going on with their loved one who has a serious mental disorder and is behaving in a strange and bizarre way, so educating them about that but also teaching them, given these difficulties that arise and the stress that comes up in the home, how do you communicate, how do you respond to that, how can you go ahead and go about solving problems in a joint fashion. And then finally, crafting a program for promoting reentry into the community and that's why they called this program the Community Transition Program. It was oriented from the very start, when the assessment plans were set up, what do you want to have in your life that will make your life better than it is now? This motivates a person to want to follow through with this 24-hour-a-day, 7-days-a-week, arduous step-by-step program. So they identify the needs of the individual to make possible that discharge in the future. And you can see in the graphic on page 2, we're moving programs that are effective in helping people with the refractory forms of schizophrenia and mood disorders, start from disability and then, if they're going to get on that road to recovery, if they're going to emerge with hope and optimism and self-responsibility and move to that level of

recovery, they need best practices of treatment and rehabilitation for this type of disorder. I was on the American Psychiatric Association task force to develop treatment guidelines for schizophrenia. These are the guidelines that are circulated to every psychiatrist in the United States. And one of the important points in this guideline is that there are five types and phases of schizophrenia and the treatment has to be distinctly different for each one. There's the acute phase where people have a relapse or they have a sudden onset of hallucinations and delusions and bizarre behavior, often leading to hospitalization. Then there's the stabilization phase. with proper medication and reasonable treatment, 80 percent of people do make improvements. Their symptoms stabilize, subside. Stable phase: They are able to move into the community and participate in outpatient services. They are acceptable to the outpatient programs and to their families and they can begin to restore their lives there. And then the recovery phase. But then there's the refractory phase, the refractory type of people too. This is a fifth phase and the treatment has to be designed to fit the learning disabilities and the cognitive problems that these individuals have. Okay, page 3, moving ahead, only a little bit left, the question here is, what happens to the severely mentally disabled persons who are refractory to treatment when they fail to receive specialized services and are discharged from state or local psychiatric hospitals? Well, we've heard a lot about the revolving door. We also know that people are trans-institutionalized. They disappear from the state hospital. State hospital census will often decrease. In fact, in California they've closed all the state hospitals. We have no state hospitals now in California for civilly committed patients. All we have are state hospitals now for forensic patients. And as a result of that, the largest psychiatric hospital in the United States is the Los Angeles County Jail--1,500 mentally ill inmates there. And that jail and the state prisons where many of the other individuals are, are currently under the supervision of the Department of Justice, the Civil Rights Division. And I'm sure you haven't read this but the state of California, which is already bankrupt, is on the...they're in a position now where they have to spend $4 billion to bring hospitals...and just think of it, they have to make mental hospitals and general hospitals in the prison walls because there are so many mentally ill and medically ill inmates. So this is one of the consequences. Also,

the patients will move from good quality treatment, like the services that are offered at Lincoln Regional Center, into euphemistically referred to institutions for the mentally disabled. These are warehouses in the community that are locked, that have even more individuals there than state hospitals or regional centers have, where there's no physicians on staff, there's one or two nurses. The doctors come in once a month for a ten-minute meeting with the patient, write something in the order sheet and that's it. They also are sometimes referred to rehabilitation centers, like the ones in the eastern part of the state and near Omaha. These are private, for-profit companies that forage contracts with the state and local agencies and claim that they're going to offer the appropriate, quote, evidence-based treatments for individuals with a serious mental disorder. Well, we have had plenty of experience with private, for-profit companies like Telecare, which I believe is here in Nebraska as well, and they start off with the right words and then they have staffing and so on, and then once they get established and have their contracts they say, well, we want to renew that contract and we won't charge you so much this next year. They begin to cut away the staff. And the losers here, when they basically get back...get down to a custodial approach--safety, supervision, and security only--is that the patients suffer and the families start screaming, and then the Department of Justice comes in. Just takes three letters from family members who are concerned about the well-being of their patients in a facility like that or prison or a state hospital to bring in the Civil Rights Division. Okay, the last page, what can be done then to interrupt the downward spiral of the mentally ill and the failure of the mental health programs throughout the country, not just here in Nebraska, to provide the appropriate specialized services for rehabilitation of these refractory and severely disabled individuals. Well, there are two things, two ways of going about it, and I've already heard retraining. One of you gentlemen or ladies mentioned the possibility of retraining staff. Yes, it is possible to train hospital and community-based staff to use the kind of services and treatment techniques, the best practices that are appropriate and effective with these individuals. And my team at UCLA has actually gone to a number of states that are under the jurisdiction of the Department of Justice and brought those state hospitals out of the monitoring of the Civil Rights Division of the DOJ. Connecticut, we're currently

involved with the sole remaining psychiatric hospital in Connecticut. For the last three years we have spent numerous hours there and we have successfully trained the staff to use social skills training, behavioral family management, social learning techniques, where 24 hours a day, 7 days a week they get this kind of incremental positive feedback for making small gains. And I should say that this is not possible without strong administrative support from the CEO and from the director of mental health for the state. Texas--eight hospitals got out of the supervision of the DOJ--Hawaii, Wyoming, Virginia, New York, and Alaska. So this is possible. It is possible to retrain people. I think it's important that state and local mental health agencies...that we realize that they can shift from treatment as usual to treatment that works. This does not always mean more staff but it means staff doing things differently. And you see here on this map on page 4, one of the best practices that has been alluded to by everyone here today is social skills training, which is this well-organized and designed program to overcome the learning disabilities of people with schizophrenia, and you see some of the states have a considerable amount of this social skills training going on and, unfortunately, there's nil in Nebraska since the Community Transition Program ended. And finally, we see the ten Cs of psychiatric rehabilitation. I think we are all in agreement here about this series of steps, these steppingstones to recovery. Services must be comprehensive. They have to be continuous, coordinated among the various disciplines and agencies working on...with a patient. There needs to be collaboration with the consumer--you had a consumer advocate here. Consumer-oriented services are absolutely essential. If you don't teach a person and help a person identify what their personal goals are and how they would like to have a better quality of life in the future, you're just...you're giving treatment to a passive receptacle. They need to be actively engaged in the learning process. The treatments have to be consistent with the best practices. The staff have to be trained to levels of competence. There needs to be compassion, which I think those...you know, it's taken for granted here. And then there needs to be commitment from--this is probably the single most important factor--there needs to be strong commitment for this from the top management and the middle management of a division, a department, and a hospital. Dr. Drake, who is one of the leaders in

psychiatric rehabilitation, recently published a study. They had several million dollars from the Robert Wood Johnson Foundation and from the Substance Abuse and Mental Health Administration in Washington to disseminate a program called Supported Employment, individual placement and support. I won't go into it but it's a program that's been designed for people who cannot go out and get jobs on their own. And when they go to a state vocational rehabilitation counselor, you know, just forget it. They will sit down and do a test and say, you know, go get a job, this is the kind of job you're suited for. So this is a wraparound program and it's very effective. Fifty percent of people who want to work who have a serious mental disorder get jobs. And what he reports in this paper is that the one reason, the main reason why the services did not take in these various states around the country was lack of administrative support. So with that, I thank you for your attention and be happy to answer any questions. [LR136]

SENATOR GAY: Any questions? Senator Gloor. [LR136]

SENATOR GLOOR: Doctor, let me ask you, if money wasn't an option, if staffing wasn't an option, if we...if the only stipulation was we weren't going to have a unit like we had, how much of the rehab pieces could be established in the existing Lincoln Regional Center or the community-based programs as you understand them here to accomplish some of the rehab? [LR136]

ROBERT LIBERMAN: The programs, both in the hospital, inpatient programs, as well as community-based programs can bring about this continuum of moving through the different phases of the illness if they are properly trained to level of competence and that there is the strong administrative support. We've done it repeatedly around the country. [LR136]

SENATOR GLOOR: So, yeah, it doesn't require a defined unit, I guess is my question. You could take components... [LR136]

ROBERT LIBERMAN: If you have, for example, head-injured individuals... [LR136]

SENATOR GLOOR: Oh. [LR136]

ROBERT LIBERMAN: ...and, you know, the Veterans' Administration, the Veterans' Affairs Department is coping with this, you have to have designated programs. If you have people who are very aggressive, like at Connecticut Valley Hospital, they have a unit. These are forensic patients who are extremely aggressive and you need a specialized unit for that; cannot disperse them around the hospital. But, you know, aside for certain difficult and unique kinds of problems, people can be trained. [LR136]

SENATOR GLOOR: So it's...and my question, I didn't phrase it correctly, is really it's got programmatic aspects that need to be instituted. [LR136]

ROBERT LIBERMAN: Uh-huh. It's a program. [LR136]

SENATOR GLOOR: It's not necessarily an institutional or a defined area within a facility issue. It's programmatic components. [LR136]

ROBERT LIBERMAN: That's right. [LR136]

SENATOR GLOOR: Okay. [LR136]

ROBERT LIBERMAN: It's the quality of the treatment much more important than where the treatment is being held. [LR136]

SENATOR GLOOR: Okay. Thank you. [LR136]

SENATOR GAY: Any other questions? Senator Avery. [LR136]

SENATOR AVERY: Dr. Liberman, is it your opinion that the CTP program can be successfully reestablished within the LRC environment? [LR136]

ROBERT LIBERMAN: Well, I think the answer is that it was functioning at a very high level for 20 years so if...but without administrative support, you know, it's obviously that the top management in the Department of Health and Human Services and the Division of Behavioral Health has decided that, for some reason, that this program isn't needed. So I think without that administrative support the answer would be no; with it, yes. [LR136]

SENATOR AVERY: Yeah, but maybe I need to rephrase the question. [LR136]

ROBERT LIBERMAN: Okay. [LR136]

SENATOR AVERY: We were told that the program was not going to be closed, it was just going to be...it would be moved into a different part of the hospital and that... [LR136]

ROBERT LIBERMAN: How could that be done without training in these specialized methods? [LR136]

SENATOR AVERY: That was my question to Mr. Anderson...or Mr. Adams. [LR136]

ROBERT LIBERMAN: Require intensive training. And these places like Alaska, Texas and Connecticut, it's three...I mean we're not there all the time but we make repeated visits. We do active directive training. We actually work, you have to work with the patients in the local hospital because otherwise you gain no credibility as coachers and as trainers to demonstrate how to do things differently. So it does take external consultation, you know, over a period of years but not necessarily that expensive and that time-consuming. Dr. Hunter will also describe some of the experiences he's had

doing that. [LR136]

SENATOR AVERY: Well, the idea of community-based programs, or natural environments, as you put it in your book, it works. That seems to be... [LR136]

ROBERT LIBERMAN: Once they're...for the treatment refractory individuals who are severely disabled, like the ones who were referred to the...I mean the reason that the Community Transition Program was established was because there was this need for 24-hour, 7-days-a-week social learning and specialized training. If this type of service was available in the community, it still would not help these treatment refractory individuals. Because when you're out in the community, there's so much social stimulation and there's no way that you can provide this kind of intensive, 7-day-a-week treatment. So how can you move people from a refractory state to a stabilized state? It's not possible. [LR136]

SENATOR AVERY: That was the point I was trying to make earlier. [LR136]

ROBERT LIBERMAN: Not possible. [LR136]

SENATOR AVERY: That's the point I was trying to make earlier, that this is called a transitional program because they are being prepared for movement into a more natural environment. [LR136]

ROBERT LIBERMAN: That's right. Doctor...Senator Gloor, I believe, told us earlier, from his own experience as a hospital CEO and manager, top management, he indicates, you know, you can't just do rehabilitation in the community. You know, you need to start in the hospital. You can...for physical therapy for a person with a stroke, you have to do it four or five times a day for an hour each time; then when they start being able to...when they're able to walk or talk or feed themselves, then you can move them back home and have visits from a therapist to continue on with the rehabilitation. So it's a

phasic process. [LR136]

SENATOR AVERY: But in your professional opinion then, given what we have heard today, what we know about the LRC and the CTP program, do you believe that people who were once in the CTP program and now are in the general population of LRC, do you think they will get the treatment they need so that they might be able to make that transition at some point to the natural environment? [LR136]

ROBERT LIBERMAN: By definition, if they're in the general population, there's no way to provide specialized services for this subgroup of individuals. They're, as we heard today from Dr. Adams, they're with other people. Everyone is getting good, quality treatment the same, exposed to the same services, trauma groups, substance abuse groups. No social skills training of the kind that will really overcome their learning deficits so how...it's a contradiction of terms. If they're in a general population, how can you used these specialized methods unless, you know, you really train staff to do that as well as serve the lesser disabled individuals who don't need such intensive kind of intervention? [LR136]

SENATOR AVERY: Thank you. [LR136]

SENATOR GAY: All right. I'm going to thank you, Doctor. We appreciate it. We're going to take a 10-minute...well, 8-minute break. I'm going to break till 10 after 4:00 and I'll start promptly at 10 after 4:00, so. [LR136]

BREAK []

SENATOR GAY: (Recorder malfunction) Dr. Richard Hunter and we'll get going. Committee members are coming and going. Some have other events, as I mentioned earlier, so we'll see who rejoins us. I've been a little remiss on watching time but we need to be cognizant of time, of course. There's still about another five or six people I

know who would like to speak, and then there's probably others who may even want to share their insight. So we're here for awhile. But let's be cognizant of those others that want to speak so I'm trying to stay in that 10- to 15-minute range. And you can see when questions get going, those quickly change things. So we'll start off, so don't take offense, Dr. Hunter, if I...but we'll start off with Dr. Richard Hunter. Welcome. [LR136]

RICHARD HUNTER: (Exhibit 5) Thank you, Chairman Gay and Senators. My name is Richard Hunter, H-u-n-t-e-r. I'm a clinical psychologist. I'm board certified by the American Board of Professional Psychology. I'm a fellow of the American Academy of Clinical Psychology, a fellow of the American Psychological Association, and for the last 22 years I've held an academic appointment as clinical associate professor in the Department of Psychiatry at Southern Illinois University School of Medicine. I maintain my consulting privileges at McLean Hospital, which is Harvard Medical School's largest freestanding psychiatric hospital. I am chair of the Joint Commission, Behavioral Health Care Professional and Technical Advisory Committee; and president of Clinical Outcomes Group, a consulting firm with national and international clients, primarily specializing in mental health reform programs and improving outcomes for people who are refractory to serious...to treatment programs who are seriously mentally ill. In the past, I've been an instructor at the National Institute of Mental Health Staff College in Washington, D.C. I was a founding member and past chair of the American Psychological Association Task Force on Serious Mental Illness. I spent many years employed in a state hospital. I became clinical director of that hospital and later superintendent. And from there I became an associate deputy director in a state mental health system, overseeing 21 state-operated facilities. I live on a farm in southern Illinois and am familiar with how these issues impact people living in rural and agricultural economies, as well as in urban centers. First, I would like to compliment the Nebraska Unicameral for your persistent and farsighted attention to mental health services. Nebraska's Behavioral Health Care Redesign Act of 1997, requiring psychiatric rehabilitation as the approach of choice for your regional centers, was commendable. Unfortunately, Nebraska is on the verge of making mistakes that many other states

have also made. The mistake is undervaluing the importance of comprehensive, psychosocial rehabilitation and recovery programming in the remaining regional centers. Even with the best possible community services, there is a small but important group of people who need to be in secure settings for extended periods of time. There is no way around this. It's the nature of severe mental illness and how it cycles across episodes of care. If you don't provide comprehensive, cost-effective treatment to those people in all settings, you'll simply perpetuate the problems that led you to mental health reform in the first place. Believing you can stabilize and quickly discharge everybody leads to harm and dysfunction throughout the system, and I'm going to list a few things that I've seen in many other states. I'm not saying I've seen this in Nebraska because I haven't, but it might be your future. This might forecast your future. And I would suggest one of the things this panel might consider in its recommendations is starting to measure or ask for data in the following areas. Many hospitals across the United States have closed comprehensive services as cost-saving measures, thinking it would save money. And here's what they start looking like after a very short period of time. You find they over rely on mediation as the primary and sometimes often only form of treatment left in those hospital settings. They neglect behavioral and psychological treatment as well. Nationally, $100 billion was spent on mental health services in 2003. Of this, $23 billion was spent on drugs. This represented nearly $1 out of every $4 spent on prescription medication compared to only $1 out of every $9 in general medicine. Please look for increased use of chemical and mechanical restraints and seclusion. Hospitals that do not provide comprehensive services and direct treatment of those clients that have co-occurring behavioral disorders as well as their mental illness, they're involved in aggression and so on, when you're not there treating the cause of that aggression and all you're trying to do is just add more medication every time an incident happens, you're going to end up over medicating people, you're going to have more staff hurt, you're going to have more clients hurt, and you're going to have more use of what we call control procedures, which are restraints and seclusion. This dramatically increases harm, not only cost, but it increases harm to patients and you'll put your state at risk of Department of Justice, CMS, and Joint Commission sanctions. You can also measure

what happens when people leave your hospitals, because if your major form of treatment is medication, we know that at least 70 percent of the patients are going to stop that medication when they get out in the community. And even more patients are going to stop if you discharge them with high rates of medication that create intolerable side effects. That's going to lead to more readmissions. As Senator Gloor mentioned awhile ago, one of the measures you're going to see is increased readmission rate, but you're also going to see an increased in readmission rate in 30 days after...within the first 30 days of discharge, which is a pretty clear signal that the hospital treatment program failed. We've seen in many states this happen and all these things seem to be pretty predictable whenever you try to save money by cutting out comprehensive services. Another very harmful effect of that is you will have increased numbers of psychotic episodes for the patients with serious mental illness, and research has demonstrated that the more psychotic breaks a person has across their life the more difficult the recovery journey becomes. You'll have more people with mental illness in nursing homes, jails and prison, and that you can measure as well. You're also going to have more people stuck in the institution because they don't recover enough for community providers to take them. And if you review the history of the CTP program, that's exactly why it was created, because you had a backup in your hospital system and they weren't being treated effectively to move them towards community placement, and that was the exact purpose of the CTP program. So without that and without intensive directed services, you're going to end up probably with an increased population or you're going to have people shuttled off to prisons and jails and nursing homes and other institutions. It sort of sounded like, when I heard Dr. Adams talk this morning, like, oh well, you just do the rehab in the community; we don't need to do it in our hospitals. People who are treatment refractory, who are the subset of people, a small group of people, that are in your state hospital, aren't able to go into community settings. And the states that have tried that, and there has been some states that's been fooled by these private companies that Dr. Liberman talked about, who will come in and they'll sell you this program--oh, we'll take care of your people under contract. They know that states would rather contract and regulate healthcare than provide healthcare

and so they give them this service. They shut down their state hospital beds and they find there's...after a few months, those patients that you had in the hospital are no longer in those community settings. Because of aggression or whatever, they may have been arrested and...or they tried to readmit them or whatever. But the bottom line is, community contractual programs cannot tolerate the risk or take the risk that the state can for these difficult-to-treat, comorbid clients that have serious mental illness and aggression. That's what the state hospital's purpose is. Another problem you have with the community mental health programs, and I'm not against community mental health programs, by the way. I've been...I've spent years training staff in community mental health centers and so on, but it's a different level of care and that's what you got to realize. The other problem is choice. There's only...state agencies are compelled, state hospitals are compelled to take all patients. Local providers have the obligation, and they should refuse to accept high-risk patients they can't safely serve, but they have an obligation to do that as well. It's part of their standards. The Joint Commission standards requires that. So you got to realize that that's a very, very important variable, that the state hospitals are there for a reason and one of the reasons is they have to take the most difficult client because it cannot be efficiently and effectively done in less-restrictive community settings. And then you have an economy of scale and Senator Stuthman was talking about that earlier as well. This population we're talking about, I'm not talking about the entire treatment for people with serious mental illness, we've got about 3.5 million people in the United States that meet the definition of seriously mentally ill. Of this group that are the treatment refractory, they don't respond to medication or they only minimally respond to medication, they account for about between 400,000 and 700,000 people nationally. You'll have your share of them but Nebraska probably would have somewhere between 100 and 200 of them, but you're going to have those and you can't legislate them away. You can lock them on a back ward and forget about them, and you can medicate the heck out of them till they maybe are no longer aggressive or they're under chemical restraints, but you can't legislate that away. That is just where we are in the state of practice today with this population. There is...you're going to have 100 and 200 people probably in this state that you're going to

have that's going to meet this criteria that need intensive psychosocial rehabilitation. Another problem you're going to have in community settings with this type of population is the issue about direct-care staff salaries and wages. Most community programs don't pay the same amount of wages and benefits the state employees have, and as a result of that you have very high staff turnover of direct-care staff. I don't know if you've ever studied that in the nursing home industry. That's another model of a state- or government-funded program in a private sector program. They subsidize a minimum wage labor work force and there are a majority of nursing homes that I've studied over the years, and I haven't really studied them in the last several years, but when I did study it was very common for nursing homes to have over 100 percent staff turnover a year in their direct-care staff. Well, how can you train somebody? Like in a state hospital, those people don't leave. They have good jobs. They have got benefits. They got retirement. So you can train them and you can intensively train them and you can train them to do the kinds of skills-based learning programs that Dr. Liberman and Mary Sullivan just were telling you about. You can't do that with just somebody that's in off the street and then, you know, three months after they're hired they take a job at Taco Bell because it pays $1 an hour more. That is something that affects every community program in every state, compared to private sector versus the public sector. [LR136]

SENATOR GAY: Doctor, I'm going to give you about five more minutes. [LR136]

RICHARD HUNTER: Okay. In the long run, ineffective services cost more, not less. Real reform is possible even with cost savings if resources are devoted to best practices and realignment of programs is based on patient needs. Comprehensive psychosocial rehabilitation and recovery services reduce dependence on medication as the primary and often only intervention provided in hospitals. Between 1993 and 2003, mental health prescription drug expenditures grew by 18.8 percent annually and were responsible for 42 percent of the increase in mental health spending. Be prepared for major budget increases. If you see the programs that Dr. Adams is going to run at LRC increase the use of medications in these patients, be prepared for increased costs.

Regional centers are not the only choice for providing rehabilitation in a secure setting. You don't need to be organized as a hospital. The Joint Commission's behavioral healthcare standards provide for state-of-the-art residential rehabilitation programs in nonhospital settings at a lower cost than a hospital required if you would decide, say, to convert the Lincoln Regional Center into a residential program and be accredited under residential standards as opposed to hospital and hospital standards. For several years, I have referred clients and other clinicians and state mental health program planners to Lincoln Regional Center's Community Transition Program and recommended that they read the program design and evaluation materials produced by staff at CTP. Nebraska had a model program and produced excellent training programs for mental health clinicians. It's a shame that the leadership in this system did not recognize the value of this program to the citizens of Nebraska and the state as a whole. When listening to Mr. Adams' testimony before this panel, I was reminded of something John Stuart Mill said many years ago: Every erroneous inference, though originating in moral causes, involves the intellectual operation of admitting insufficient evidence as sufficient. Mr. Adams may claim high moral grounds and that he understands the consequences of his decision to close the Community Transition Program and the folks out there are still getting the same kind of a treatment, but I can assure this panel that he lacks sufficient information and the understanding of the dire consequences of his actions on the citizens of Nebraska, both now and in the future. I anticipate that when the findings of this pan and the LR136 study is concluded, Mr. Adams will recognize the importance of comprehensive psychosocial rehabilitation and recovery programs across all treatment environments and that he will reestablish these programs in all Nebraska nonacute inpatient units. The essential component of any reform plan begins with realistic assumptions about the nature of serious mental illness; the knowledge of research supporting the provision of comprehensive assessments, case formulation and services; and the importance of sound psychosocial rehabilitation and recovery programs, both in hospital and community settings. Inscribed above the south entrance of this building are the words "Political society exists for the sake of noble living." Please don't deny this opportunity to a subset of Nebraska citizens during times when they are facing their

most serious challenges. Thank you for your interest in improving programs for people with serious mental illness in Nebraska and for allowing me to testify today. [LR136]

SENATOR GAY: Thank you. Senator Stuthman. [LR136]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you, Dr. Hunter, for your presentation. Have you ever studied the fact of rehabilitation when an individual works with...when a patient and the one that is doing the program, the rehabilitation, is consistent and the same individuals through the entire rehabilitation, is the outcome a lot better than changing individuals with the program on the patient? [LR136]

RICHARD HUNTER: Absolutely. Another very important quality is patient...is the relationship the patient has with the therapist and the trust and the hope that can be created when that relationship exists. And so that's true. [LR136]

SENATOR STUTHMAN: It's, in my opinion, it's the same situation as foster care. When they're moved 17 times in five years, the outcomes of that are not very good. [LR136]

RICHARD HUNTER: That's correct. [LR136]

SENATOR STUTHMAN: And I just feel that if this individual that has the problems and needs the help, if they can work with someone through the entire program, stabilization and rehabilitation and therapy, with a program that is consistent staff, outcomes have got to be tremendous, in my opinion. [LR136]

RICHARD HUNTER: It certainly helps. [LR136]

SENATOR STUTHMAN: Yeah. [LR136]

RICHARD HUNTER: It certainly helps, yes. [LR136]

SENATOR STUTHMAN: Okay. Thank you. [LR136]

SENATOR GAY: Senator Gloor. [LR136]

SENATOR GLOOR: Thank you, Senator Gay. Doctor, it's expensive to maintain an acute care license or run a program under the roof of an acute care license. Can a lot of these programmatic aspects for rehab be done under something other than acute care, like a residential care? [LR136]

RICHARD HUNTER: Yes. That was a point I was making. The Joint Commission has a series as standards for residential services. It's called the Behavioral Health Care Standards. And they're not hospital standards so you don't have to have as many nurses and physicians and all of that, although you have to have them. I mean, it's not absent those. But you have to staff your program based on the needs of your client and so these standards will cover anything from a community group home to a foster care program to a substance abuse program to a residential center. It's not commonly done so it would be something that would have to be carefully planned. But you could design the staffing of Lincoln Regional Center around the residential model and you could hire the kinds of staff and train them that you need to run a first-rate psychosocial rehabilitation program, and you could still include the components that Dr. Adams talked about this morning, like substance abuse treatment and trauma-informed care. That's all very relevant and very important. The other thing I'd like to say about that is that, were I running Lincoln Regional Center, even if I was running it under a hospital, I would have psychosocial rehab programming on all my units, on my forensic units, on my sex abuse units, and then on...except my acute care unit. If you have an acute care unit that's two weeks and less length of stay then, no, you don't want those resources there. And you do need an acute care unit but that would be a small unit. And then if patients are there over, say, two, three weeks, a month, then they transfer into these specialized programs and one of them would be the difficult treatment refractory group that you did have with

the CTP program. Another one might be a forensic program. Another one might be the unit of...whatever you had there. I assume, like most states, you're going to end up with three populations. You're going to end up with difficult to discharge and treatment refractory people. You're going to have some acute care in and out, but the acute care actually could even be done by contract with local hospitals with psych units, if you wanted to do it that way, and then use your Lincoln Regional Center as a residential program for psychiatric rehabilitation. And that would improve services to your forensics and your sex abusers and everything else. The programs wouldn't look exactly the same on each unit. There would be different components but they would be based on the needs of the patient. But it would be a much more efficient way to run that hospital and, based on all the research we've ever read and done and Dr. Liberman has ever published, you'll find it will cost you less money, you'll get better outcomes, and your length of hospital stays will go down. [LR136]

SENATOR GLOOR: Thank you, Dr. Hunter. [LR136]

SENATOR GAY: Senator Campbell. [LR136]

SENATOR CAMPBELL: Thanks, Senator Gay. But, Dr. Hunter, you're very clearly saying though that those groups cannot all meld into one; that they do have to be isolated as CTP was, if I'm hearing you correctly. You can do it in residential or hospital, but that grouping has to stay together to be the most effective. [LR136]

RICHARD HUNTER: Senator, I do like specialty units, but I don't know the population of Lincoln Regional Center to know how much difference there is between their forensic unit and the unit, well, in CTP. They may have been very similar; they may not have been. I just don't know that. So what I do, I wouldn't just artificially develop units in a hospital based upon a diagnosis or based on these categories. I'd base it on the treatment needs of the client and how much training they needed and how much...you know, and so I'd do it in like levels of pathology sort of thing, not necessarily whether

they had a court order or not. That doesn't matter. It's what are their actual needs and do they need a more intensive learning program on this one but then maybe over here they might need more vocational or anything, social skills training or something on another unit. That's the way I would divide it. But I would have rehab, psych rehab model, with all these components, on every one of my units, looking different based on the kinds of clients you have there. [LR136]

SENATOR CAMPBELL: Okay. [LR136]

SENATOR GAY: Any other questions? Senator Coash. [LR136]

SENATOR COASH: Thank you, Chairman Gay. Thank you, Doctor, for being here. Your expertise is very helpful. In your testimony, you mentioned that there's a small but important group of people who need to be in secure settings for extended periods of time. Can you expand on that extended periods of time, how you define that? Is an extended period of time four months, ten months? We saw the period of time of folks in the CTP program, average of about 19 months. Is that...is that how you define extended, or is it more or less than? I'm interested in your expertise on that. [LR136]

RICHARD HUNTER: It's not an easy question to answer because, there again, it depends. If you've got a client that's been in the hospital for 30 years and it takes you 2 years to build that person back to enough skills and motivation and capability to move out in the community, that 2 years isn't long if in his life he's already been there 30 years. If you take somebody that has been...I consulted in a hospital several years ago that was just one of these treatment usual hospitals where they came in, medicated them, got them out, and in two weeks, three weeks or whatever back in. And so I was in there in the hospital and I was there to help with another patient and I was sitting with a treatment team. And they were discharging a lady and they took three minutes to write the discharge plan. And I could just tell the way it went, it was real boom, boom, boom. You're going to refer to the mental health center, give her medication script and I don't

know what the other things were, but you know it was real...and I thought, boy, they're not very respectful of this lady. They're not even...you know, they didn't even review her care or discuss strengths and weaknesses and what kind of social support she would need in the community or anything. It was just a discharge plan, boom, boom, boom, and out. So I asked them, I said, excuse me, please may I see the record. You know, I knew something was wrong because that record was about that thick. They showed me the record and so I looked at the discharge plan just before that and then I looked at the one before that and the one before that and they were exactly the same. And then I started saying, well, let me look me look at her treatment plan. And I looked at the treatment plan and it was a general treatment plan, diagnosis, and psychotherapy and socialization group and activity therapy and, you know, something you'd...it wasn't sophisticated at all and the interventions weren't directed to particular problems she was having. It was just like, you know, just threw something at her again. So then I looked at the...that woman, that was her 52nd admission to that hospital. Now if you take these patients that's coming in and out of your door like that and all you're doing is giving them medication, and they have a history, and some of these people have a history of 10, 15, 20 years of taking medications and it doesn't work. Any combination, it doesn't work. And it's toxic. It becomes neurotoxic to people. And so with a patient for whom medication is not going to work for the last 20 times they were in your hospital, you're wasting money as a state if you're paying that hospital to medicate that patient the next time they come in the hospital. You're obligated, you have fiduciary responsibilities to your patient to do something that has reasonable probability of helping that patient and when all your doing is throwing meds at them, you're not helping them. You've proven that for 20 years so why are you guys...I'm not saying you are, but I'm saying if you start looking at your data, you might find this. Why are you investing money to put that person back in the hospital for the 52nd time and give them medication when there's no probability whatsoever that medication is going to do anything but harm that woman. But if you would take those programs and say, wait a minute, we're not going to keep doing that. This revolving door stuff isn't working, we're going to design a psychosocial rehab for those people and we're going to treat them and we're going to find out why,

you know, they do this or do that or give them the skills to work around some of their vulnerabilities, then you're going to have a successful person. And I don't care whether it takes a year or six months. It's to that case, and that family, and you've reduced a lot of suffering in that person's life and their family. So that's what I'm advocating to do is just take a look at what we're doing and let's work smart. Let's not work hard, let's work smart and most hospitals aren't doing that. And I'm not pointing to Nebraska. I'm not saying you're doing it or not. I mean, I don't know. But I go in hospitals all over the country and I see this and I see it time after time after time and I've been in all kinds of states where I hear the state administrators come in because the Governor may want to cut the money to the mental health system and then they come in and justify, got all of these brochures and slick words for you and everything, but if you go back on the unit you really measure what's going on. You're looking for outcomes like you were asking for a while ago and you take a look at the amount of medications that are being prescribed for these people, how much...how these pharmacies are being used. All that slick talking, brochures, is not reality when you cut back programs and you cut back comprehensive services. And all I know right now is you've cut back one of the best model programs in the United States. And I can't understand why for...I've scratched my head trying to figure out why. I think you need leadership in this state that's going to go with what your patients need, not maybe what you try to do to save money. Because you're not going to save money this way. You're really not. You're not going to save money and you're going to increase human suffering. [LR136]

SENATOR GAY: All right. Thank you. Any other questions? [LR136]

SENATOR AVERY: I have one. [LR136]

SENATOR GAY: Make it quick. (Laughter) [LR136]

SENATOR AVERY: When we first started this discussion back in April, I believe it was, we were told that the program wasn't ending, it was just being moved. I'm not convinced

that is the case. Then in June, Mr. Gibson was interviewed by a newspaper reporter and he said, well, really we're doing this because of cost. We have to save money. You've made pretty good argument and I believe Dr. Liberman too, that you don't really save money by shutting down these rehab programs. And today we heard that, well, you know, it's really not that at all. It's that this program ought to be in the community and should not be in the hospital. [LR136]

RICHARD HUNTER: So what do they get in the hospital? Chopped liver or more medication? [LR136]

SENATOR AVERY: Well, I think they get locked up and they get medicated. That's my own opinion. Are we really...I don't think we're getting anywhere near the truth of these three arguments. So is it possible...is it possible there's something out there that can be called a class of cultures at how you want to be treating these patients that we're seeing at the regional center, and one culture lost out and the other one won? [LR136]

RICHARD HUNTER: Absolutely. But I don't...I mean, I don't know that because I'm...you know, I mean, I've heard that alluded to here today but I've been involved with medical staffs and training psychiatrists and working in hospitals for many, many years. And yes, there are...it's called medical politics. And it's a power struggle between people who want to run a medical model kind of a program and there is conflicts. And that's what effective hospital administrators have to resolve. And I'm not saying you shouldn't do the medical model programming because on your acute treatment units that's very important. And medication is very important. I mean, I'm not trying to say medication isn't useful, it is. For most of the people with serious mental illness benefit from medication. But Dr. Liberman and I we differ just a little bit on what proportions are refractory to medication. He says 20 percent. I've got a lot of data saying it's somewhere between 30 and 40 percent don't respond. But even if...you can't if you've got 20 percent or if you've got 30 percent or 40 percent of the people that are refractory to medication and medication doesn't help them, you're not helping that person by putting

them in a medical model acute care unit and giving them medication. You're harming them. Now I can go into a lecture and talk to you about a lot of research that's showing on about ...going on right now about the neurotoxic burden of psychotopic drugs. Nancy Andreesen is doing some wonderful research, MRI studies of brain and showing what's actually happening, especially with clients that don't do well on the meds if they keep taking it, it causes neurodegeneration. But, yeah, there is major conflicts between the medical, vaguely defining as the medical model which means the doctors, you know, the physicians and psychiatrists come in and run and they don't really appreciate what other people can do and they discredit behavioral programming and psychosocial rehabilitation programming. They just don't understand it. And that's okay. They could be good doctors and they could be very good acute treatment unit physicians and psychiatrists but they just don't understand. They haven't been trained in these over things and they don't understand the value. And so they devalue things they don't know. And then you've got people in this state, for instance like Dr. Spaulding who is a national expert in pyschosocial rehab who is coming in and saying, yeah, but, you know, give me a shot because I show you I can, if you let me, you know, design my program which he did at CTP, I can get some good outcomes and that sort of thing. And as a good hospital administrator, what you have to do, you have to resolve those things and you have to say, okay, for your acute care unit, if this psychiatrist or whatever wants to run a program in that way, fine, because it's needed. I mean there are people for whom that is very, very valuable. But the population that ends up in the state hospitals don't have very many people that's really going to need that kind of service. We're dealing with that one to two hundred people in Nebraska probably if you take a look at national statistics that need something a lot more comprehensive than treatment as usual. And I agree very much with what Dr. Liberman said about, you don't just have a social skills program or you don't just have a trauma informed care group and expect people who have a great deal of cognitive impairment to benefit from that. It takes very precise, consistent education and training and behavior modeling and all of that to make those...to give those people an opportunity for success. And so what I think we need to have somebody here in Nebraska do, is, if that medical politics struggle is relevant, they need

to sit down with that and deal with it in a way to where what we're going to think about is the patient's needs and we're going to design a system not based on medical politics. We're going to design a system based on what our patient's need and then just see what your patient's need, and then always measure the outcomes. [LR136]

SENATOR GAY: All right. Thank you. All right. We're going to move on. Thank you, Doctor. [LR136]

RICHARD HUNTER: You're welcome. [LR136]

SENATOR GAY: We're going to move on. We've got six other people who want to talk. I'm going to ask the committee members restrain on questions, quite honestly, because I think the next six people have a story to tell. If you fill out the testifier sheet we can get ahold of you as well if we have other questions, so. But it's quarter to five now and I know some of you members have to be leaving too. I understand that. But we would like to hear from the other six at least that will stay around if others want to talk too. Lisa Taber, Julia Geier, Ed Chase, Tami Burkey, Wendy Andorf, and Dean Settle, is who I have down, so. Lisa, go ahead. [LR136]

LISA TABER: Good afternoon. Thank you for the opportunity to speak before you today. My name is Lisa Taber, T-a-b-e-r. I'm from Lincoln. I live in Bethesda, Maryland, now and I am the guardian for my sister, Madeline Taber, who has schizophrenia, and who was a participant at the psychiatric rehabilitation program, and who is now in Building 3 of the Lincoln Regional Center. I received a call from Madeline's social worker on March 26 of this year telling me that her program was being closed and that she would be moved to the admissions unit, well, what was called the admissions unit at that time in Building 3 within a week. When I asked why the program was being closed, her social worker said they had been told in a meeting just several days prior with the CEO that it was for budget reasons. I was very concerned about what this change would mean for Madeline. You know it said right on the LRC Web site that the admissions programs

goal is to keep individuals, to help individuals rapidly stabilize in transition to a less restrictive environment including back to the community. And it said that the goal of the residential treatment program, the psychiatric treatment program was to help people who could not rapidly be discharged from the hospital directly into the community so that they could recover and avoid this revolving door of repeated psychotic episodes and hospitalizations. And that's a door that my sister had been caught in for many years, so I was very concerned about the closure of the program and her move to admissions and ultimately I was referred to Mr. Scot Adams with my concerns. And when I spoke to Mr. Adams in a phone call on March 31, he was very reassuring. You know, he said, look, your sister is going to continue to receive the same level and range of services that she's receiving now. She will have access to psychiatrists and psychologists and social workers and nurses and groups and everything. So I said, well, then, you know, if she's going to have access to all the same services, why are you closing that program? And he said, emphatically that this was not an economic decision. He said that the psychiatric rehabilitation program was being closed because changes in the law mandated that the LRC shift its focus to sex offenders and forensic patients. And aside from emergency acute psychiatric care, the law said that people should be treated in the community. Well, so, I asked him again then, what would be the differences in Madeline's treatment? And he opened the doors to me to talk to people in Building 3 and to receive some more information about that program and I have to say that I approached this with some serious red flags because like I said, my sister and our family have been through that revolving door they referred to on the Web site many, many times. On the other hand, there's nothing nice about having somebody you love institutionalized and I felt like Mr. Adams was in effect saying to me that the regional center could do a better job; that they could get my sister better and into the community faster and that would be a very good thing if she were able to maintain that level of functioning. So...and you know, he was very convincing and I was ready to listen to what they had to offer. And in fact, I was able to speak to some folks in Building 3 and they gave me these materials, you know, a handbook for family and guardians and this admissions unit handbook for the clients there, as well as this description of the groups

which I read through, and I read through the corresponding materials for the psychiatric rehabilitation program, the class descriptions and the patient handbook and the procedures manual among other documents that tell you a lot about how it works. You know, and obviously here there's a lot more that's documented about the CTP program than about the Building 3 program. But I can't tell you honestly that I really knew exactly what the differences were between these two programs after reading through. I'm not a psychologist or a psychiatrist and I can't say that I fully understood what the differences between the two programs were or what this move would mean for Madeline until she had been in Building 3 for several months. And now I can contrast the two programs from an on the ground perspective. And to describe this contrast it's best to start by talking about how as a participant in the psychiatric rehabilitation program, what everybody still calls the CTP, the team would focus on a really specific set of problems that my sister was having one at a time. In general for this population this might include something like, you know, just not responding when someone speaks to you, or talking very loudly to yourself, or obsessing on a particular delusion and feeling the need to repeatedly call the police, for example. The psych rehab team would work with persistence, would work with my sister to try and understand first, you know, what was driving these behaviors and then help develop a strategy for dealing with them, these very specific problems. And as she made progress in implementing those strategies, she'd earn more privileges and responsibilities like unrestricted access to the phones or an additional trip to the snack machines each day, or permission to walk on the campus, for instance. And in this way, rehabilitation flips on its head, institutionalization, because it lets people assume responsibility and think about themselves as autonomous individuals, and individuals who can make decisions that have an affect over their own lives. And in my sister's case, she had recently been allowed to work at the regional center canteen, which was great because she was beginning to learn a little bit from people's cues and reactions to her when what she was saying was being at least perceived as a delusion. And at the same time, she was earning a bit of real money and working on budgeting it with her living skills teacher and that was very empowering. And so that job was a great opportunity for her to practice a number of the disease

management skills that she was working on with her treatment team. And, you know, it also really challenged her. There was some serious stretch goals involved there and she had regressed a little and was trying to work her way back up to that canteen job when the psych rehab program was closed. It's like what someone at the National Institute of Mental Health explained to me, just down the road from my house, I reached out to them when I was trying to understand what psychiatric rehabilitation was all about, and a doctor there named Bob Hindson, said that the ability to live successfully with severe mental illness requires that skills and strategies for managing the disease must be presented, rehearsed, acquired, and practiced a lot in appropriate settings so that a person can build up those capacities and sustain them. And this process takes time for people with profound psychiatric disorders like my sister. You know, and it makes sense, and it's borne out by her experience. I went back and looked and in the last 15 years Madeline has been hospitalized because of her schizophrenia a total of seven times. One time she was in an institution for 14 months, not in a psychiatric rehabilitation program, but in a decent institution. And she had been out for one month before she had to be rehospitalized. She would be in for four months, out for six. In for seven, out for eight. In fact, in the last 15 years, eight months was her record of living in the community before she finally came to the psychiatric rehabilitation program at the Lincoln Regional Center for the first time. And that time she was there for almost a year and a half and when she was discharged she lived in the community for three years, three years. That might not sound like much but when somebody has schizophrenia and they only have six or eight months or less between these hospitalizations, it means that they're spending time on the brink of another psychotic episode all the time. And I can't tell you what it's like when you know that your sister or your daughter or your son or your mother is out there helpless, not able to take care of themselves, and they may be in danger or dangerous, and you know that, but you can't help them. And you just have to wait until something horrible happens and pray that the worst doesn't happen and sometimes it does. And that's really bad for everyone. Now as much as I would like for Madeline to be able to, you know, achieve results in a shorter period in terms of her stay at the regional center, now that she's been there for four months in Building 3, what's

now called the women's program, I don't see how the Building 3 program could possibly get her better faster for longer than the psych rehab program. And, you know, I think it's very important to say that this is not to disparage the people working in Building 3 or the people working anywhere in the regional center. And I think we have to be very, very careful about characterizing the regional center's general services in terms of, you know, meds and restraints and, you know, kind of vilifying those people because, you know, they're excellent professionals and I appreciate them very much and I know that they're trying to do the best they can. And they're just not set up to manage someone with Madeline's needs and they've said as much off the record. And you know, for instance, they don't do the behavior management programs, they're called, which people have talked a lot about. These are what the psych rehab program team used to narrow in on a particular set of problems that Madeline was having and set her specific goals and monitored her progress every day. Now in Building 3, they have a lot of the same terminology and types of things. You know, they have a treatment plan. They do a strengths and weakness assessment. They do consult with the client. They do have groups and recreation therapy and that sort of thing. But that's not the same as these sorts of behavior modification programs where Madeline knew exactly what was expected of her, and she knew where she stood because of the records they kept. And now in Building 3 she's saying, you know, I'm cooperating, I'm taking my meds, I'm attending my groups, I'm doing my grooming, I'm getting along with people, what more do I have to do to be discharged? And you know, let me be very clear here, no one thinks that Madeline is ready to be discharged into an unsecured facility. And God forbid that that's the result of my testimony here today that she should be suddenly discharged or moved into forensics because those are the only options left at the regional center now. [LR136]

SENATOR GAY: Lisa, I need you to... [LR136]

LISA TABER: Yeah, which brings me to my final point. All the changes they've made at the regional center recently, not just the closing of the psych rehab program, but in

general since about the first of the year, I'd say, there's more of a lock down mentality. For instance, walks on the grounds have virtually been shut down and you hear people say things like, if they can walk on the grounds they can be out into the community. But think about that. Either you're locked down on a ward without so much as the right to wear shoe laces or you're discharged into the community. That's absurd but there is no in-between, not anymore and we need it. Our family members need it. The community needs a program for very disabled people who don't belong in a criminal setting but aren't ready to be fully discharged yet. We had a great program just for these people and I urge you in one form or place or another, I urge you, please bring psychiatric rehabilitation back. Thank you. [LR136]

SENATOR GAY: Thank you. All right. We're going to move on to Julia. And I say here...we've got five senators here. We're losing two more in about fifteen, twenty minutes, I think, because of commitments. We'd like to hear from you and what's going on and I apologize. You know, we've allowed others to kind of run on and we've heard from a lot of experts. Now we're hearing personal stories. I know and they can be quite emotional. But if you shed light of why it worked or didn't work for you or whatever the case may be, otherwise I know this can go a long time. So I would kind of refrain to five minutes, I hope, or, you know, if you got to go further fine, but specifically how it helped or hurt you. Thanks. [LR136]

JULIA GEIER: Well, I can make it short and sweet. I learned something new today. My son is a refractory treatment patient, which is, no meds help him, nothing helps him, nothing ever has. He was diagnosed with schizophrenia when he was 18 years old by Dr. Y. Scott Moore, who just left. And nothing has ever worked. For 20 years he's been in and out of the regional center, he's been in the forensics unit, which for those of you don't know, forensics is the most secure restrictive environment for the most dangerous individuals. For instance, he was on the unit five for five years, ten years, for several years at a time because nothing...I was getting phone calls from the social worker saying, well, we might as well stand on our heads, you know, there's nothing we can do

for him. They would be discharged out into the community and he would either end up in a field having a furry monster wake him up or laying in the middle of an alley nearly being killed over by cars, etcetera, etcetera. This is only the tip of the iceberg. I've been dealing with this for 20 years and so has he. Paranoid schizophrenia is the worst mental illness I believe anyone can get and he has the worst. He's still very delusional, psychotic, and I...the thought of him going out into the community right now terrifies me, terrifies me. He was in CTP the first time from forensics and it didn't work for him because it was too stressful for him. So we had to go back for a few more years in forensics. The second time they put him in CTP they weaned him in. He was attending groups before he stayed there at CTP. And he was successful but he was only there for five months. We had a five day notice that CTP was closing. Before the closing of CTP my son did three things that are monumental for me. He initiated playing a board game. He problem solved with his five-year-old niece. And let's see, the other one is...he didn't want us to leave. He actually talked about his feelings instead of delusions. So those were milestones for me. And in five months he was able to break out of his schizophrenia and actually do something positive. In the five days that we knew that he was going to leave he decompensated to such a degree that he wanted to kill people, he went through a horrible transition back in forensics where he was either going to kill people or he thought people thought he killed people or death and dying and it was horrible. He just now got over that. It's been several months. But I have never in 20 years witnessed the progress that he made when he was in CTP, never before in any other program has he made this kind of progress. Yes, he has been stabilized. This is not testimony against anyone. I don't know what I would have done without the regional center. I still don't know what I would do without the regional center. But I'm here to tell you, I saw progress in CTP that I've never seen in my son before in 20 years. He just celebrated his 38th birthday. So I'm short and sweet, to the point. [LR136]

SENATOR GAY: Thanks, Julia. I appreciate sharing that with us. Moving...Ed Chase. [LR136]

ED CHASE: Thank you very much for enduring this three and a half, four hours, whatever it is. [LR136]

SENATOR AVERY: We're used to it. (Laughter) [LR136]

ED CHASE: (Exhibit 6) You do it well. I don't think I could sit here and I haven't as patiently as you folks do. My name is Ed Chase, C-h-a-s-e, like the bank without the money. (Laughter) [LR136]

SENATOR PANKONIN: They probably don't have any either. (Laughter) [LR136]

ED CHASE: And I don't want you to think that I've got a, you know, a good life here or anything. I'm here to testify on behalf of my son who is a patient at LRC for two years. He had schizophrenia. Prior to LRC he spent eight years in the revolving door of mental health care in four states. The question is why, of course, and the answer is because community-based treatment does not work for the seriously mentally ill. And Scot Adams contention that it does defies reality because if community-based rehab worked for this difficult discharge treatment population, we wouldn't have the revolving door. Before I go on, I'd like to just professionally introduce myself. I spent 25 years in the healthcare business working for Johnson & Johnson managing their country's companies around the country. I know the drugs, the clinical results, and keep people in the mental health industry. I also been an active member and contributor to the National Alliance for Mental Illness, the country's largest advocacy organization. Following retirement I spent ten years in the trenches of mental healthcare struggling to get the treatment for my son, Ed, the care he needed and deserved. I have to say it was like wrestling with a jellyfish. And mental healthcare treatment, as you know, is in the dark ages compared to physical healthcare. With that perspective, here's Ed's story. At 16 he was struck down with schizophrenia. An honor student and Division I recruited college hockey player, his illness swallowed up his life. As a seriously ill, difficult to treat patient, he was forced into the revolving door of mental healthcare. He was continuously

recycled through community-based inpatient/outpatient hospital facilities for eight years. Doctors released him knowing he couldn't survive on his own and he didn't. He ended up homeless and desperate just like other mentally ill patients in this country. As I said, anybody that believes that community-based treatment works for this population has to consider why there are so many people in the revolving door of healthcare. In June, 2006, he as committed to LRC. He was put into the treatment as usual program under Dr. Klaus Hartman. I would describe it as high doses of drugs and TV therapy. I demanded that he be put in CTP after he made no progress in nine months. He was put in CTP and his new psychiatrist who knew psychopharmacology got Ed on the right combination of drugs. He then began the rigorous program of psych rehab. Unfortunately, time does not permit me to explain the program but as it has been said today, it is individualized, systematic program customized to fit the needs and goals. And what you have to understand why this can't be done in the community because people with serious mental illness, you can't even get them out of bed. I would have him at home and I couldn't even get him out of the bed. They need to be in a secure controlled setting where there are incentives to get them out of bed, where there are incentives for him to communicate with people, to come out of themself. It's like a seriously ill stroke patient. We would not take that person and immediately rehab him in the community. Well, once in CTP, I would visit LRC once a month for about a week over this two-year period. After being in the CTP program for six months, I could see my son coming back to life. After a year he was well enough to leave LRC and move to the community and get a job at Wal-Mart full time. In short, he got his life back. He was ecstatic. It was a miracle, or was it? To use an analogy, psych rehab does for mental illness what physical rehab does for physical illnesses like stroke and spinal cord injuries. It gets the patient back mentally to where he was prior to the illness within reason. Fortunately for Nebraska, it had CTP which has saved the lives of hundreds of people over the past 20 years. It has won recognition as one of the best programs in the world and a model for other states to follow. So you might ask, with such ground breaking results, why would anyone want to close CTP? Well, in June, at the Behavorial Health Oversight Committee meeting, Bill Gibson said, "to save $200,000...end of

discussion." His emphasis on "end of discussion" was shocking in it's lack of compassion for patients left twisting in the wind. So what really happened? In my opinion, this wasn't about mental healthcare. CTP was closed because LRC and HHS leadership lacked the competence to manage the well known culture clash that existed between the old institutional model and the state of the art rehab therapy at CTP, which is endorsed by the National Institute of Mental Health. Now you might wonder how I know this. Well, because I lived essentially in the belly of the beast for two years. I was there once a week every month for two years. I know the people from who cleaned the toilets to who ran the place. I became friends with the people that worked there. I knew the heart of the organization. I heard the complaints of the people, the morale of the people. As all of you know, closing CTP was also blatantly illegal. It did not inform you prior to it's closing nor provide comparable services to these patients. And an e-mail from the Attorney General's Office agrees with that assessment. So what do we do now? Well, first, I think we have to realize we've got a train wreck on our hands. We need to investigate what caused this crash and terminate those responsible. In the private sector, these people would have been gone four months ago. Otherwise, we could have another Beatrice on our hands. Second, put in place a management team at LRC and HHS that will focus on wellness management, not power politics, and one committed to successfully rehabilitating the difficult to treat population that CTP has successfully done over the past 20 years. In closing, I'd just like to leave you with this one thought. In life few of us will ever save somebody's life but by reopening CTP you have the opportunity to save hundreds of life. From that perspective there's nothing more noble or important you could do. Thank you very much. [LR136]

SENATOR GAY: Thank you, Mr. Chase. [LR136]

SENATOR PANKONIN: I just have one comment. Mr. Chase, no need to come back up. I think you've been before the HHS committee. I've been on here for three years. I think you've been back three times and I know your son is deceased but I just want to tell you it's also a noble thing what you've done to just keep his memory alive and what

his story is and I just want to tell you I appreciate it. [LR136]

ED CHASE: Well, thank you very much. [LR136]

SENATOR PANKONIN: You've honored him and honored the process by being so diligent in being such an advocate and as a parent, you're honoring him the best way you can. I appreciate that. [LR136]

ED CHASE: Well, thank you very much. I owe a great bit of gratitude to Nebraska and all the people of Nebraska because I'm from Florida and everybody used to say, how did you get into that program from Florida. It was a world-class program and you brought my son back to life even if it was only for a year. And he was robbed but he had a great life and I am very grateful for that. [LR136]

SENATOR GAY: Thanks, Mr. Chase. Tami Burkey. [LR136]

TAMI BURKEY: (Exhibit 7) Hello, Senators of the committee. I really appreciate the opportunity to be here today. I'm going to try to be as brief as I can. My name is Tami Burkey, B-u-r-k-e-y. I'm a social worker and a therapist. I worked in CTP for almost 12 years. I left CTP in October of 2008 and I currently work at the Veterans Administration. I'm here today because I feel I have a very distinct...my circumstances are unique in that I actually worked in two separate programs in facility. And I provided, tried to disseminate some of the services, the groups and classes in the other two remaining psychiatric programs. So I've worked in all four psychiatric programs out there, not full time, only full time in two of them. I want to directly rebunk three of the myths that have been spread by people who are benefiting from the absolute approach to treatment that now is out at LRC. The first myth is that people were in CTP longer than they needed to be. I know this is not true because I'm a social worker and it was my job to get people discharged and into the community. The criteria for discharge is the same all over the regional center. You have to have people go to a safe and stable situation and the main

reason for being hospitalized needs to be resolved, which means whatever brought them in. Whatever dangerousness they have has to be somewhat resolved and be able to be managed in the community. In the CTP we only served the people who couldn't get out anywhere else. My coworkers in the other buildings they were trying, they were calling all the other agencies. As a matter of fact part of the handout would be to say where did you try? What all places have you been denied? It's not the social worker, we're not being lazy or incompetent which has been suggested by psychiatrists and administrators at LRC in the past. It's because community providers could not accept the risk of those people until they achieved a better livable functioning. Our community services have been improving for years. When I first started working there, the average length of stay was a lot longer. (Laugh) It's gotten way down. I've seen people be treated through our program in six months and I've seen them go on to get their master's degree, that same person. So it doesn't necessarily have to take two years. It can be quick, quicker. Not as quick as a week or a month, but it doesn't have to take forever. And those other services that are being created in the community, it's helping. It's working. But you still have a group of people that won't get out of bed, won't do anything or won't stop being aggressive or self-harmful. Okay. The second myth I want to talk about is that families only like CTP because it provided a respite for the stress that they're going through with their family member living out in the community. I think you've kind of heard from families today the change that they saw in their person which is why...that's why I've been there 12 years. When you see somebody come in and they can't hardly speak a clear sentence and they're mumbling and drooling all over themselves, to never drooling, talking clearly, working, it's a huge change and it makes you committed for as long as you can be. So CTP, I think the families when they came to our program, I worked directly with them. I provided some of the behaviorial family therapy that Dr. Liberman talked about. We are the only program at the regional center that provides that service, or I guess, worked the only program. We also work with them, their treatment teams. We've met with them. We've told them, here's exactly what we're working with, here's exactly what we're doing. This is what their behavioral management program does. This is how you could help us. And some of them agreed

and some of them didn't and we still kept on with treatment even if they disagreed and even if they wouldn't help. But that collaboration was there and I think that that's what made people, families so diligent about why they're here. The last myth that I'd like to talk about is the...that there's no difference between rehab, psychiatric rehab and the treatment that's now provided at LRC, which I think highlights my experience that I had over the last two years while I was there. I provided three different groups, advanced social skills, interpersonal problem solving skills, and DBT. I'll just give you an example. We tried to put interpersonal problem solving group into forensics. I went over there, instructed the group. The group started out with seven participants, by the time we were done I think there was only four. It's not the same. They don't come. They don't have any BMP to help entice them to come. They don't do their homework. They don't have an environment where the psych tech says, hey, you look like you have a interpersonal problem with your peer here. Why don't you use some of those problem solving skills? It didn't work. They didn't learn it. I was struggling to get them even to come to group. If you don't have them even come, they're not going to learn, especially with their cognitive difficulties. The second group that I'd like to talk about is, I passed out some information about DBT. And it's...basically what we did, we were disseminating DBT throughout the hospital. We provided it in Building 10 for a while until it turned into an all male unit and then we provided it in Building 3 for a while. And UNL did some...one of the UNL psychologists that was residence was really interested in DBT so she joined up with me and started learning how to do the therapy, learning how to do the group, and she started providing both the group work as well as the therapy. And she did the dissertation and did some research on what happened to the patients that were in both groups. We had a group that was in treatment as usual, DBT, and then we had a group that was in DBT in the psychiatric rehab program. I think you'll see from the data that the people who were in the DBT overall is effective in a psychiatric program. Let me backtrack just for a minute. Dielectrical behavior therapy is a very specialized form of therapy for people who have severe emotional instability. They are commonly, people who are commonly diagnosed with what's called borderline personality disorder. They suck up the majority of our financial resources in the state. Anyway, it's a specialized

form of care for them. There's all sorts of research out there about its effectiveness, its ability to be done in the hospital, its ability to be done in the community. It's widely recognized as an evidence-based practice. Anyway, as you'll see, aggression went down, self-harm went down, and it goes down and stays down when you have somebody in rehab. You can kind of tell it goes down for a while and then it peaks back up for treatment as usual. So I wanted to point out the differences in those treatments. They're not the same. You can't just move a patient to a generalized population and say, okay, we're going to say we have this service. Unfortunately, DBT is currently being provided in one of the units at the LRC, but not in a rehab unit. It's also being provided by less experienced and less trained therapists. Those therapists have spoke to me in the past about the state's unwillingness to send them out of state to get the proper training that they need. The originator of the treatment, she only provides her services. You know, you have to...I think I went to Denver and Kansas for my trainings. Sometimes you have to go to Seattle, all sorts of places. They've refused to allow them to have treatment to go to trainings outside and they are working their hardest to provide those services but it's been apparent to me just based on questions that they had, concerns that they've had, that they're not aware of what they're doing. They're also not providing the therapy. DBT has two components to it, group and therapy. And you need both of them together to call it evidence-based treatment and they're not providing that. So I would really encourage this committee to try to find out a little bit more about that service. They call that their informed trauma care. It is trauma informed care service but I don't think it's meeting the criteria of what DBT is really about. Just to make note, I passed out...I also passed out some statements from former participants. I felt that being here, my reason for being here, my job's done. I don't plan to go back. I enjoy my job at the VA, but I very much felt the need to be here to say that people with severe mental illness need a voice. And that was my reason for coming today, is that they're not often a voice for themselves, their illnesses. These retractory people, they struggle with just day to day things. They're not going to be able to come up here and testify, and so that's why I'm here. And what I did was I only had like three copies so not everybody is going to have one. But when they got discharged from our program, many

times they went to Midtown Center which is a day program that would, you know, teach them job skills. There they could write articles and they wrote...two of them wrote articles about their experience in CTP and I just felt that I would share that with you as well, that it would be helpful. I hope this committee looks beyond the superficial claims and disinformation that's been spread as reasons for closing CTP and do what needs to be done to ensure the mentally ill, severe retractory patients have the services they need. I'm open for any questions if you have anything. [LR136]

SENATOR GAY: All right. Thank you. Any questions? I'm trying to watch the questions. [LR136]

TAMI BURKEY: I know. [LR136]

SENATOR GAY: Okay. Thank you. Thank you very much, Tami. We've got Wendy and Dean coming up and quite honestly, it's 5:30, we're going to listen to them and I'm going to close this hearing out, okay? So we've got Wendy Andorf and Dean Settle and appreciate everyone coming here, but we'll get through that. But I think I do think we need to close it otherwise...you can always add and turn it in to the clerk as well. And we did receive some information, Nebraska Advocacy Services and Nebraska Association of Social Workers. We did receive that too. But if you have anything else to add, this is open and we'll continue to follow this. But go ahead, Wendy, thanks for... [LR136]

WENDY ANDORF: (Exhibit 8) Okay. I'll make this quick. My name is Wendy Andorf. I'm a social worker by training. For the last 30 years I've been employed at the Community Mental Health Center of Lancaster County, here in Lincoln, Nebraska. The last 27 of those years I've been a program manager for Community Living Services which is that arm of services that provides services to the severe and persistent mentally ill adult. I'm here today because I feel we've lost a vital link in the provision of services to adults with severe mental illness. In my tenure at the Mental Health Center we've always striven to

improve our services to be, to fill the gaps, to adhere to best practices, and to pay attention to the needs of those we serve. And for about 80 percent of this population I think we do a really fine job. When consumers are able to engage in their recovery, the tools that we offer are effective and life changing. Try as we might, there has always been a segment of this population that we haven't been able to help and I'm referring to that 20 percent that we we've talked about today. The need for safety and structure cannot be met in community programs as they currently exist. We've struggled with this group of consumers prior to the establishment of the CTP program and sadly, we are returning to that struggle today. This is also a group of individuals who consume the most services. In preparation for today I wasn't exactly sure how to go about this but I started thinking back to the years of being at mental health and the people that we literally stayed awake about, the people that we worried about, the people that we couldn't make sure that they were safe. And I started just making a list of those names that you remember over the years. I took that list and I took the top 12 and I pulled their files at the Mental Health Center. And I wanted to look at two things. I wanted to know how they were doing today because suddenly I realized as I looked at this list, we weren't hearing those names so much anymore. And I wanted to know what and when those changes happened that we weren't hearing about them. And it was really interesting because 11 of those 12 individuals were currently in our service system. They had moved from that 20 percent category over to that 80 percent category of people that we can serve and we can treat, those same 11 people had been through the CTP program. I think that kind of speaks for itself. I don't, and I don't think that's coincidental. I talked to a colleague of mine about that and he said to me, well, maybe Wendy, those are the people who just aged out and because, you know, they're older, they've gotten more stable. So I thought about that too and went and followed up on these same 12 individuals with staff members who had worked with them in the past, community providers who had worked with them in the past. And invariably people were saying to me, when that individual went through the CTP program that's when we saw changes. That's when things started to turn around. The interesting thing too with the ages that I looked at their ages and they're anywhere from 24 to 62 going through that

program. So we weren't aging people out at that point in time. Community Mental Health Center is also a partner in the Psychiatric Res Rehab Program, CTP at The Heather. We provided that program. We started it ten years ago in conjunction with the state of Nebraska and the Lincoln Regional Center. Since that time the regional center has pulled out. We now run that program in conjunction with University of Nebraska and Mary Hepburn-O'Shea. The graph that's part of this illustration shows...for me, it's pretty alarming. In the last five months since the closing of CTP, we've readmitted three individuals. That's really unusual in the ten years. Usually we readmit one, maybe two a year at the most, or actually those are larger quantities than years, they're about 18 months. So consumers from CTP come to us with skills for safe and stable community living. They learn to make better use of our services. They learn to have relationships with their families. They come to us with less stress and better understanding of their illness. And we try, we really do try to get better at providing rehab services but there are some people that we just cannot, we just cannot help. And at this time I'm aware of no other community or institution based program that can speak to the rehab needs of this population. I heard an earlier testimony that those services exist in this community and even act teams cannot be there 24/7 to provide that stability and structure. It's just not there. And so at this point I'm grateful for the opportunity to speak to you and I would just really encourage you to explore whatever alternatives are available to restore the service. Thank you. [LR136]

SENATOR GAY: Thank you, Wendy. Dean Settle. [LR136]

DEAN SETTLE: (Exhibit 9) Good afternoon, Senators. My last name is Settle, S-e-t-t-l-e, that should settle in at this late hour and we'll all go home soon, I hope. I appreciated your time and your interest and your concern about this topic. I, too, would reiterate that the Community Mental Health Center that I am the administrator of here in Lincoln, we serve over 4,500 people a year. We also operate the Region 5 Crisis Center. So we are the administrative entity that actually send people from this region to the Lincoln Regional Center. So we're the front door, if you will, to the regional center,

and then our Heather, CTP Heather program was the exit point, the back door for LRC. So we really have seen people in their most acute day of need and we see people as they have come out of the institution. I wanted to share some, just general observations. First of all, as Wendy mentioned, for the past 11 years we've actually operated The Heather program. It's a 15-bed psych res rehab program here in Lincoln and it's integrated into an apartment house. The staff was trained at CTP at the Lincoln Regional Center for the most part and that training has been absolutely essential in operating The Heather and continuing on with the rehabilitation and social learning and behavorial management programs that are so essential in that effort. I do believe strongly that there is a small number of people, and I think Dr. Hunter was very correct. I don't know what that number is but my belief is in running a community mental health center if we can do it in an unlocked facility then they belong in the community and we have basically the skills to make that happen. If the person needs a secure facility, a locked facility, much more structured, then that's what we rely on the Lincoln Regional Center for. And so that's a very simplistic way of kind of looking at who we serve and why we serve them. I do think though that a lot of the psychiatric rehabilitation services can indeed be taught to staff and the community and what we're doing right now is the result of the closing of CTP at the Lincoln Regional Center is retooling and redirecting the day rehab program at Midtown Center here in Lincoln and we're also beefing up the rehabilitation components that are independent living program, a lot more contact in our community support program, and I see more utilization of our partial hospitalization program. As people begin to decompensate, they can immediately take advantage of that and we prevent a rehospitalization. So as a result of the closing of the CTP program, we already are making programmatic adjustments and we will continue to make programmatic adjustments until we know the resolution of this issue. I think it's absolutely imperative that we continue to figure out the best ways to serve people and I like the social learning concept that Dr. Liberman outlined. It makes imminent sense. We know that the schizophrenic individuals that we serve, the common word that I always think of is chaos. And by reordering their day and reordering their life, then things begin to be possible again. There is a life, there is job opportunity, there is

possibly of going back to school. One of the things that as the administrator of a large community mental health center, when we serve people who come to us NRRI condition, we want to make sure that if something goes wrong we want to have immediate protocols and court orders in place to return the individual to a secure institution as quickly as possible for public safety and to make sure that the person is safe. I believe that it's in the best interest of people who are persons with mental illness to make sure that we stop the revolving door process. Getting the person to the right level of care in a timely manner is an absolute imperative in the field of mental health. We waste time, money, professional resource every time we misplace someone or redirect incorrectly the person to the proper level of care. I think Wendy mentioned earlier, who spoke earlier, that in working with this particular high-need population, in this community, in this size of this community, collaboration is the key. Centerpointe, the Community Mental Health Center, working with co-occurring kinds of situations, working with community colleges, all those kinds of skill sets and professionals can come together to do a really good social learning curriculum and outline for life accommodation. Last, I think the state must adopt best practices, not only for the state institution but for community-based programs as well. We know we can do a better job and we can be more efficient, more effective with tax dollars if we approach what we do with better case management, supported employment, social learning, acting, all of these within the rubric of recovery principles. We can do a much better job but it should be a uniform kind of seamless expectation for not only the Lincoln Regional Center but anyone who receives someone coming out of the Lincoln Regional Center as well. Thank you. You've been very patient today. [LR136]

SENATOR GAY: Thank you. I'd just say I appreciate all of you coming and staying with us all afternoon and into the evening, I should say. But anyway, you know, these interim hearings, this is very good. You'd never have a chance to have a four and a half, four hour hearing on one subject. So I think it's very worthwhile. I know all the senators gained a lot here. Heard it from both sides and got some personal views of things and that's very helpful in deciding public policy. So appreciate all your time as well and my

colleagues for your patience and we'll take this information and hopefully create good public policy one way or another. Thank you very much. [LR136]