[LR34]

The Department of Correctional Services Special Investigative Committee met at 9:00 a.m. Wednesday, October 12, 2016, in Room 1113 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR34. Senators present: Les Seiler, Chairperson; Kate Bolz; Ernie Chambers; Colby Coash; Laura Ebke; Bob Krist; Heath Mello; Adam Morfeld; Patty Pansing Brooks; Paul Schumacher; and Matt Williams. Senators absent: None.

SENATOR PANSING BROOKS: I think we'll go ahead and get started. Good morning and welcome to the LR34 Department of Correctional Services Special Investigative Committee. My name is Patty Pansing Brooks and I am the senator representing Legislative District 28, which is right here in the heart of Lincoln. And we will start off having members of the committee and committee staff do self-introductions, starting on my right with Senator Coash.

SENATOR COASH: Senator Coash, District 27 right here in Lincoln.

SENATOR MORFELD: Senator Adam Morfeld, District 46 in northeast Lincoln.

SENATOR CHAMBERS: Ernie Chambers, District 11 in Omaha.

STEVE LATHROP: Steve Lathrop, counsel for the committee.

OLIVER VANDERVOORT: Oliver Vandervoort. I'm the committee clerk.

SENATOR SCHUMACHER: Paul Schumacher, District 22.

SENATOR EBKE: Laura Ebke, District 32.

SENATOR WILLIAMS: Matt Williams, District 36.

SENATOR PANSING BROOKS: Wonderful. Thank you for all being here. It's my understanding that Senator Krist is coming soon and I'm not sure about a couple of the others

yet. But anyway, today we'll be hearing...oh, and also I want to thank our page, Brenda Gallardo, who is here helping us as well. Today we will be hearing testimony as it relates to restrictive housing and behavioral health. We will begin today with Jerall Moreland from the Ombudsman's Office; and then we'll hear from Director Frakes; and then after, Dr. Alice Mitwaruciu, who's the behavioral health administrator at the Department of Corrections; and Dr. Randy Kohl, who just retired as director of health services for the department. Following that, their testimony, in the afternoon we will hear from Kasey Moyer and Amie Jackson from the Mental Health Association. We had also invited Dr. Martin Wetzel, who's the chief psychiatrist at the department, but he was unable to make it today. So after some discussions with Doctor...or Director Frakes, he is able to make it at the beginning of our next hearing. Dr. Wetzel will come at the beginning of the next hearing, which is important because it's also his last day. So we want to hear from him before he completely retires. And Director Frakes has agreed, yeah, that he's going to testify then. We would ask if you have any handouts among those of you here, to please bring at least 12 copies and give them to our page or the clerk. And if you need to make additional copies, we will help you make some more or they can help you make some more. So each testifier is invited to give an opening statement and we'll go into questions and answers then. We ask all the testifiers to begin by giving us your first name and last, spelling your name for the record. And I want to remind everybody to please turn off your cell phones and put them...or...and put them on vibrate. And with that, we will begin today's LR34 hearing and I'd like to welcome Jerall Moreland from the Ombudsman's Office to begin. Thank you. [LR34]

STEVE LATHROP: If it's okay with the Chair, before we begin I'd like to make a comment just about some of the feedback that I've heard through this process from the folks that work in the Department of Corrections and reiterate maybe a point that you made at the beginning of the last hearing. Today we're going to talk about restrictive housing and mental health and behavioral health and what's happening at the Department of Corrections with respect to both of these two topics. And I'm reminded by the Inspector General, who I've had some conversations with, that there's an awful lot of people at the Department of Corrections that are working very, very hard at their jobs doing what we've asked them to do or what the administration has asked them to do, doing what the Director has asked them to do. And the purpose of these hearings is not to be critical of those people who are at the Department of Corrections, those people who are in mental health and behavioral health, and we'll be talking about them a lot today, but to get an

assessment of what needs to be done or what the needs are at the department with respect to both of these topics. The questions are not intended to be a judgment of the people who are working there, the work that they're doing. And just as an overarching theme, many of them appear to be overworked. Many of them appear to...these areas of Corrections appear to be understaffed, and we recognize that as a committee I think. And what we're trying to do is figure out what we need to do as a Legislature, these folks here, to bring the resources to the Department of Corrections, so that your working conditions are safer, so that you're not working mandatory overtime, so that you're able to do your job in a way that is professionally gratifying. So that's the purpose. It's not a judgment or a criticism of the people that are there at this point in time. [LR34]

SENATOR PANSING BROOKS: And I would just like to reiterate that that is so and that we did mention that last time and I'm really grateful that you mentioned it again. I know that each of us, as sitting senators on the committee, feel grateful for the work of the staff and appreciate the risks that they encounter every day. And we are working to try to make the situation better, to see how we can help to strengthen our correctional system and, thereby, make our public much more safe as these inmates integrate into our communities. Okay. [LR34]

SENATOR CHAMBERS: Madam Chair. [LR34]

SENATOR PANSING BROOKS: Yes, Senator Chambers. [LR34]

SENATOR CHAMBERS: Since we're making semi-opening statements, everybody who works at Corrections is there by choice, is receiving a salary, is an adult, and they need not be handled with kid gloves or apologetically by the committee. Each one of us is different, each of us on the committee. We each have our methodology of trying to elicit the information we need to get from the people who we feel have it. That information will serve as a basis for additional legislation, if necessary, or whatever else the Legislature must do by way of oversight. So one person's critical questioning may be another person's searching questioning. So I don't want anybody to get the impression that my intent, based on what I'm saying here, is to embarrass anybody for the sake of embarrassing somebody, being judgmental for the sake of being judgmental. But I have a responsibility, as an elected official, to do my job and I cannot be expected to do my job in the way that somebody else will do his or hers. But in general, I am in

accord with what the Chairperson, what our legal counsel, what each of them has stated. But that in no way indicates that I'm just going to be a shrinking violet or a potted plant and a "Mr. Personality" contestant. To sum it up, I'd say this. Since I am 79 years old and a good hard sneeze would make me 80, think of me as a kindly, saintly, understanding, grandfatherly gentleman who will be as courteous and polite, and sometimes even courtly, as the circumstances will allow. Thank you. [LR34]

SENATOR PANSING BROOKS: Okay. Thank you, Senator Chambers. And now I'd like to just mention that we have Steve Lathrop here, former senator. And again, Mr. Lathrop has been hired and requested by our committee to address the questioning because of his expertise in that area of the law. So that's why he's here today. So thank you. Mr. Lathrop. [LR34]

STEVE LATHROP: Good morning. [LR34]

JERALL MORELAND: Good morning. [LR34]

STEVE LATHROP: Thanks for being here today. Can you start by giving us your name for the record? [LR34]

JERALL MORELAND: My name is Jerall Moreland, J-e-r-a-l-l, Moreland, M-o-r-e-l-a-n-d. [LR34]

STEVE LATHROP: And you are with the Ombudsman's Office? [LR34]

JERALL MORELAND: That is correct, yes. [LR34]

STEVE LATHROP: How long have you been with the Ombudsman's Office? [LR34]

JERALL MORELAND: Approximately eight to nine years. [LR34]

STEVE LATHROP: And do you have a particular assignment or a responsibility in the Ombudsman's Office? [LR34]

JERALL MORELAND: My capacity in the Ombudsman's Office right now is deputy ombudsman for institutions. [LR34]

STEVE LATHROP: Okay. So you're familiar with the Department of Corrections and you work in that environment in your capacity with the Ombudsman's Office. [LR34]

JERALL MORELAND: That is correct, yes. [LR34]

STEVE LATHROP: Okay. You brought with you an opening statement? [LR34]

JERALL MORELAND: That is correct, yes. [LR34]

STEVE LATHROP: Why don't we let you start there. [LR34]

JERALL MORELAND: (Exhibit ___) Okay. Well, good morning, members of the LR34 Committee. Senator Pansing Brooks, I want to thank the committee for inviting us to offer our views on the department's mental health and segregation systems. Legislation passed last year required the Department of Corrections to implement a needs assessment regarding behavioral and mental health treatment and staffing. It also required the department to issue a report concerning the assessment of January...by January 1, 2016. To meet these requirements the department sought the services of Dr. Bruce Gage, the chief of psychiatry for the Washington Department of Corrections, to assess the Nebraska system's behavioral health services and make recommendations on the system. The Ombudsman's Office has reviewed the assessment presented to the Legislature. We believe the document to provide a fairly comprehensive look at the DCS behavioral health system that addresses many of the concerns of our office. We have seen many initiatives implemented since this report under the leadership of Director Frakes and staff. The report identifies strategies for the department to become more robust in the services offered to its inmate population, including strategies that would ultimately improve for public safety. However, we do want to caution that, in our opinion, there are points where we see that more work needs to be done to assure that division set forth for behavioral health in Nebraska's system can be truly measured and realized. In other words, whereas we do see reform efforts being built within the system, we also believe there to be crucial roadblocks that need to be

addressed and expanded on. For example, overcrowding and staffing vacancy issues are serious deficiencies that we are...that we see impacting the ability of the department to execute those strategies and initiatives set in the Gage report. Also, we still see problems with how an inmate taps into the department's mental health system. And if they do get in, we question how robust the system is to ensure that there will be continuity or continuation of care during their incarceration time. In his report, Dr. Gage appropriately discussed the prevalence of major mental illness in the Corrections system. He indicated that most prevalent studies show rates of psychotic disorders alone in state prisons of 4 to 15 percent, and depression on the order of 10 percent. He goes on to estimate that the prevalence of major mental illness in the system is conservatively closer to 3 to 6 percent with a psychotic or schizophrenic spectrum disorder, and about 10 percent with significant depression or bipolar disorder. We tend to always discuss the system's male population on this issue, but we must not forget the female population. For example, recent reported statistics indicate that as of this August there were 430 female inmates incarcerated within NDCS. Of these women, 344, or 80 percent, were identified to have behavioral health needs. Also, 208, or 48.4 percent, have a co-occurring mental health and substance abuse diagnosis...excuse me, use diagnosis. Of interest in this area is the difference of reported major mental illness within the system. As of August 5, the department reports 47, or 10.9 percent, of its female population is identified to have a major mental illness. However, based on national figures, as represented in the Gage report, it is likely that at least 15 percent of the female population has a major mental illness. There were many recommendations made in the Gage report. We would suggest that since the recommendations were made July of 2015, a follow-up assessment of the department's mental health system be started July of 2017, with the report due to the Legislature in January of 2018. We support the department's continuing efforts to explore options to best meet the needs of its mentally ill inmate population through strategies such as mission-based housing, which would target special treatment approaches for the varied mental health diagnosis of its inmates. I would also like to make a few comments about the department's segregation system, which is another area that LR34 asked the committee to study. Revised Statute Section 83-173.03 requires that the department adopt and promulgate rules and regulations pursuant to the Administrative Procedure Act establishing such levels of restrictive housing as may be necessary to administer the correctional system. Those rules and regulations were to address behavior, conditions, and mental health status under which an inmate may be placed in each confinement level, as well as providing for procedures for making such

determinations. These rules and regulations were also to provide for individualized transition plans for inmates on each confinement level to facilitate transition back to the general population or to society. These individualized transition plans were supposed to be developed with the active participation of the committed offender. As you may already know, the Department of Correctional Services recently promulgated their rules and regulations on restrictive housing. During this process, the Ombudsman's Office provided several comments concerning regulatory standards and principles that we believe needed to be added to the restrictive housing rules and regulations. We would acknowledge that the department did make progress on many of the matters of concern to this office and we feel that these changes could result in good outcomes once the policies are fully implemented. However, considering the overcrowding and staff level challenges currently plaguing the department, there is some concern that the full effect of the changes may not be recognized until the program is thoroughly implemented. On October 7 of this year, Marshall Lux, the Nebraska State Ombudsman, provided each LR34 Committee member a memo detailing our remaining concerns regarding the department's segregated housing regulations. As mentioned in Mr. Lux's memo, there remains two outstanding issues needing to be addressed by the DCS, by the new DCS restrictive housing regulations; namely, how an inmate is selected to be placed on segregation and, second, what due process protections are provided relating to that placement. In addition, I am submitting to the committee a document entitled "Details on the Behavioral Health and Segregation System Within the Nebraska Department of Correctional Services." This document discusses a number of mental health and segregation related issues in further depth. I want to thank the committee for the opportunity to share our perspectives regarding the subjects of mental health and segregation. I can take any questions that you have. [LR34]

STEVE LATHROP: All right. Let's... [LR34]

SENATOR PANSING BROOKS: Thank you. [LR34]

STEVE LATHROP: Thank you for that opening statement and your work in this area. For the committee members, the attachment that you discussed is found at page 118 through 124 in the materials that were provided for today. You have or you're prepared today to talk about mental health and restrictive housing, and I'd like to take up restrictive housing first. LB598 required

some promulgation of regulations, some policymaking by the Legislature as it relates to...pardon me. That was on restrictive housing, LB598 was. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: The Legislature's policy was to bring in somebody to do some kind of a study on behavioral health, and that was done by Dr. Gage. [LR34]

JERALL MORELAND: That is correct, yes. [LR34]

STEVE LATHROP: Okay. You've reviewed that report? [LR34]

JERALL MORELAND: Yes, we have. [LR34]

STEVE LATHROP: And Dr. Gage, in his report which is found in the materials as well, goes through an assessment of the various institutions within the Department of Corrections and makes certain recommendations and judgments. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Would you agree with that? And this was done a year ago,... [LR34]

JERALL MORELAND: That's correct. [LR34]

STEVE LATHROP: ...right? And your testimony or your opening statement suggests that the Ombudsman's Office believes that a lot of the recommendations, generally, you embrace what he's proposed in his report. [LR34]

JERALL MORELAND: We believe that the report is pretty comprehensive and we agree with several of the initiatives in that report. And so, in general, I would say that if we can move forward with implementing those initiatives then we would support it. [LR34]

STEVE LATHROP: So let me talk about Gage's report just generally with you, if you don't mind, Mr. Moreland. And specifically it begins by saying that the department needs some vision with respect to what they're going to do with folks that have behavioral and mental health needs. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Do you see or do you...are you aware of any overarching vision from the department with respect to the care and treatment of people, inmates with mental and behavioral health needs? Did something change after this report? [LR34]

JERALL MORELAND: I believe several reform efforts have been put in place. I think one of the first things they changed is Director Frakes hired two leadership staff members, Dr. Jones and Dr. Wetzel, to carry out the new initiatives as identified in the Dr. Gage report. One of the things that we've looked at is still how is that...how does that vision shape the services that the department is providing? And that's an area where we believe there needs to be some improvement in. We believe where there are reformed efforts in several areas within the mental health system, we haven't really looked at what are the actual needs of the inmate population and what do we need to do to make sure as a system we can accommodate or meet those needs of the population. [LR34]

STEVE LATHROP: Gage actually, in his recommendations, starts with a vision, with the department needs to come up with a vision and the vision needs to address what do you want to do with these people,... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...right? And that is at one end you can give them just enough medication to keep them from acting out or to keep their mental illness from becoming a problem in the population, to the other end of the spectrum--actually providing care and treatment, programming so that when they get out they are more likely to be successful and not return to the prison system. So his suggestion that the department needs a vision is how much care and how

much services do you want to provide while these folks are inmates at the Department of Corrections. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Are you aware of such a vision having been...like, have they made a decision, to your knowledge, about what they want to do with the mentally ill and those who have behavioral health needs while they're inmates? Has something changed since the Gage report? [LR34]

JERALL MORELAND: To my knowledge, they are still moving forward with the vision they had prior. And let me explain. I believe the most...one of the critical questions we have to ask is, how are we going to service that population? And we see it very similar. So prior to the Gage report we had a mental health unit, we had a secure mental health unit, we had restrictive housing, we had a skilled facility. We still see the inmates moving through those facilities or units very similar. We still see that some inmates cannot tap into the mental health system, to the mental health unit, if they are not seriously mentally ill, as described by the department. We still see that county safe keepers are not able to tap into the full array of services, mental health services, that the department provides. And so where we again see some reform efforts, the overall or holistic view is we still have gaps or deficiencies in how we effectively provide those mental health services to the inmate population. [LR34]

STEVE LATHROP: And so maybe I can talk to some of the other witnesses about whether they formulated a vision, whether they've developed a principle as the department what they...as to what they want to do with the mentally ill and those people with behavioral health needs. Do they just want to have these people behave themselves and be medicated, or are they going to get care and treatment and improve and be more successful when they're discharged? I want to ask you, though, since the Gage report, and that was a year ago, that was done at the request of Director Frakes. It was shared with the public and so forth. Tell me what things have happened since the Gage report that you think are positive. [LR34]

JERALL MORELAND: Since the Gage, the Gage report looked at how services would be provided to the inmate population. We are seeing increased reviews of many of those individuals as diagnosed with major mental illness. However, I would also say that we do believe those that are being diagnosed with major mental illness do not match the national numbers as far as most correctional jails throughout the country. And so, example, we've mentioned that in the Gage report, the Gage report mentioned that on a very conservative number that a disorder such as dementia is 10 percent and now the question becomes, how does the department identify dementia? Is it identified as a seriously mentally ill or is it identified as a major illness or a behavior disorder? And so what we run into is that, in our opinion, that there needs to be some kind of assessment done on the population, the inmate population, within Correctional Services to determine the actual needs of that inmate population. [LR34]

STEVE LATHROP: And you're making reference to, in the Gage report he addresses how many of the people at the Department of Corrections or within the...the inmates in the Department of Corrections, what percent have a major mental illness, what percent have a mental illness or some substance abuse needs, but he also identifies some other populations. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: You talked about dementia. His report addresses brain injuries, people with developmental disabilities, and... [LR34]

JERALL MORELAND: Schizophrenic disorder. He talks about the order percentage on that. He also talks about your intellectual...your intellectual disability population. [LR34]

STEVE LATHROP: But...right. And the point of bringing that up is that he thought they needed to be treated differently than those who suffer from a mental illness. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: In other words, if somebody has a brain injury, now they could have a mental illness on top of that, but they need to be off somewhere in a special unit. That's his

recommendation, in a special unit for people with special needs like dementia, brain injuries, and developmental disabilities, and not lumped in with the mentally ill. [LR34]

JERALL MORELAND: Yeah. His point in that is that each diagnosis carries a different need. And so, example, your personality disorders are going to carry a different need than your seriously mentally ill as described by the department, let alone can they mix well together in a treatment setting. And so his suggestion is that there be mission housing to effectively accommodate those specific needs. And so don't create mission housing based on your bed capacity or based on what capacity you have to present that service or provide the service. Instead, take a very thorough look at what are the different diagnosis that your department has as far as their inmate population and create those housing units to meet those populations. [LR34]

STEVE LATHROP: Have we see any change in mission housing or any progress in mission housing where we evaluate, segregate, and treat the brain injury folks or the dementia folks or the developmentally disabled different than we did before the Gage report? [LR34]

JERALL MORELAND: I have not see any reform efforts based on what you've described. I will mention that we have seen, I believe, a veterans' unit. We have seen maybe even an aging population unit. Again, we believe they need to go further and really meet the needs of some...a majority of their population. [LR34]

STEVE LATHROP: So my first question about the Gage report was what improvements have you see since the Gage report, and we ended up talking about the mission-specific housing, which is fine. But are there other things that you've seen that you would call progress since the Gage report as it relates to the mental health system in the department? [LR34]

JERALL MORELAND: So one of the things the Gage report would like to see is a robust system on data: how do we collect data; how do we know the diagnosis of individuals; who's reporting; what they're reporting. And so in that area, we have not seen whatever improvements they may have made. Another area that we are seeing is, as an example, were more reviews when a person is in crisis maybe or if a person has received a misconduct report. Misconduct report is a document where a staff member identifies or believes a inmate has violated a code of offense

within the department. What we have seen is that the department is trying to touch those kind of cases; they're trying to get mental health involved sooner in an intervention possibly. However, again, there's some barriers here. We do know that on certain type of populations they are able to possibly get mental health involved and present or transfer those individuals to the mental health system or to the secure mental health unit or the mental health unit. I mentioned barriers. One of the barriers is the county safe keepers again. County safe keepers, essentially what we see is... [LR34]

STEVE LATHROP: Tell us what the county safe keepers are before you tell us what's happening with them, if you wouldn't mind. [LR34]

JERALL MORELAND: Okay. Sure. County safe keepers are essentially those individuals from county jails that may still be going through adjudication. And what we find is they're very...they tend to be very difficult for the jails to manage. They tend to stress the jail system. And so the recourse is to send the individuals to the state system. [LR34]

STEVE LATHROP: Nikko would be an example of this. [LR34]

JERALL MORELAND: Nikko Jenkins would be an example. Nikko Jenkins I believe has been on restrictive housing, in a restrictive environment for three years, since he's been a county safe keeper. I bring that up because we also see others, county safe keepers, handled in the same manner. Now I will...I should mention that we do...where we do see county safe keepers coming in, typically they do have some kind of mental health issue. So we are seeing that they're...if they are placed in restrictive housing within the department, mental health is getting involved based on the operations of restrictive housing. Mental health is seeing them once every 30 days, I believe. The other situation is, I would think, I believe that they are also probably getting additional mental health outside of what those inmates that have been already adjudicated and sentenced to Corrections are getting. But that's the extent. We have not seen them go to the mental health unit. We are not seeing them go to the secure mental health unit. And so essentially they, in many cases, they are spending well over 30-60-90 days in restrictive housing until two things happen: until, one, they go back to the court to finish out their adjudication; or,

two, the courts commit them to the Lincoln Regional Center for some kind of restoration or possibly competency. [LR34]

STEVE LATHROP: So in answer to my question you've identified a positive thing, which is that behavior health or mental health professionals at the department seem to be trying to touch the patients or the inmates more frequently who have been diagnosed with a mental health problem,... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...which is a positive,... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...right? They're getting to them instead of letting them go for long stretches, months and months without seeing a mental health professional. They have shortened that time frame, which is a good thing. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: On the other hand there is a challenge with safe keepers, who are almost by definition people that the local county jails can't control. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: And they're more likely to have a mental health issue or even a major major health...major mental illness. And they come to the department and end up, through their conduct or otherwise, in restrictive housing where they might have some access to mental health folks. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: That access is a positive because the access in restrict...or the access to mental health professionals has improved in restrictive housing, is that true, in the last year, or no? [LR34]

JERALL MORELAND: Access to mental health in restrictive housing is still a problem,... [LR34]

STEVE LATHROP: Tell us about that then. [LR34]

JERALL MORELAND: ...real effective access. We believe that there is still a population that needs access to secure mental health unit and mission housing. And so when we talk about the access mechanisms that they put in place at restrictive housing, we believe that still is not sufficient to meet the needs of those that are diagnosed with certain disorders, those that do not meet the definition of seriously mentally ill as described by the department. [LR34]

STEVE LATHROP: I want to come back to...I want to come back to restrictive housing because I know you're prepared to talk about that. And the care that they receive and how they get there and how much time they spend is important, I think, to the committee and to the purpose in having you here. Are there other concerns that you have or shortcomings that you can identify for us with respect to the provision of mental health services since the Gage report or in the last year? [LR34]

JERALL MORELAND: We have a...we continue to have a serious problem with mental illness in Corrections. Example, recently I was at the Lincoln Correction Center control unit. We still are seeing inmates designated as SMI, serious mentally ill, by the department in the control unit. The control unit environment is a environment where there you lack the sunlight. It really impacts your sensory. It is an area where usually you hear a lot of screaming from individuals, a lot of individuals banging on the doors. We do not believe it's appropriate or conducive to have serious mentally ill in restrictive housing not only for a short time but they shouldn't be in restrictive housing. So that's an area of deficiency there. At York, I mentioned that we need to spend more time looking at the female population. We just received a call in our office this morning. We know we have a serious mentally ill in restrictive housing in the NCCW, the

women's facility in York. We know that some of the behaviors displayed are very bizarre behaviors. We know they have diagnosis of schizophrenic spectrum or across the board, but we still...the department still does not have the ability to, in our opinion, treat those individuals effectively, effectively defined as in a residential unit. And we believe many...we believe there are several, a part or segment of the population that needs hospital care, that needs inpatient care that the department has attempted to treat or stabilize and they are having problems doing that. And so... [LR34]

STEVE LATHROP: You'd be referring to a certain number of people that are inmates. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: And what...I intend to talk to some other people about the statistics and the percentages of the seriously mentally ill that are inmates, but you're talking about a certain subset of the mentally ill that need to be in a hospital;... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...that they don't...they're just not equipped because they're not a licensed mental health facility, they're not equipped to treat those people the way they need it and with the level of intensity and in a hospital environment. And that would necessarily point towards the Lincoln Regional Center as an option. [LR34]

JERALL MORELAND: That would be correct, yes. [LR34]

STEVE LATHROP: What historically has been the relationship between the department or the ability to take this group of individuals that need care at a licensed facility and get them into the regional center? [LR34]

JERALL MORELAND: Well,... [LR34]

STEVE LATHROP: Is that happening at all or more or less than it was a year ago? Can you give us some take on that? [LR34]

JERALL MORELAND: Historically, there was a mechanism for the department to transfer those, the inmates that need that kind of care, to the regional center. Historically, that has declined to a point where we are not seeing those inmates that are sentenced to the department going to the regional center. We are seeing an increase in those county safe keepers, that where the courts have committed the individual (inaudible) being held at the department to the regional center. We are seeing, based on the requirement for the department to put together a discharge team, we are seeing the department identify those individuals and meet on a regular basis, I think every 30 days with the regional center. They try to identify those, that population that may have to be committed to the regional center. But those inmates that are not going to be released from the department, those inmates that will remain in the department for a period of time that broadcast serious mental illness, we are not seeing them transferred to the department. [LR34]

STEVE LATHROP: Is that a reluctance on, if you know, is that a reluctant on the part of the department to refer them to the regional center or an unwillingness of the regional center to accept it? Or is that a capacity issue over at the regional center, if you know? [LR34]

JERALL MORELAND: So, and in my opinion, if...we had broached that subject with the regional center. The response, one has been capacity; a second response is physical layout. In other words, that the safety risk factor and I believe they don't have a facility to effectively meet or provide security for other individuals within the regional center. Now we have recently...the office has met I think two or three times with the Department of Correctional Services mental health staff and the regional center mental health staff. And what we observed is that the department would take those difficult cases to this group that meets on a regular basis and they would discuss possible recommendations for treatment options. But those treatment options are still based on that individual staying within the Correctional Services facility. We have had conversations with the department on those individuals that we believe, at Department of Corrections, on those individuals that we believe need further treatment or a higher level of care than what they have been able to provide, based on the need of 24-hour care, based on the need of a different environment to help with treatment. We believe there are several cases within the

department that meet that definition that should go to the regional center. We believe with the replacement, Dr. Mitwaruciu, we've had conversation with her about an individual that, in our...it is our understanding they are going to meet with the regional center and make a request for transfer. So we will see how that goes. [LR34]

STEVE LATHROP: We'll see how that goes. But maybe this topic illustrates the multifaceted aspect to mental health. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: And as we look at the institutions of state government to be engaged in the care and treatment of the seriously and significantly and major mental health or major mental illness folks, we have some of them in the population, a significant number of major and seriously mentally ill folks, at the Department of Corrections. A certain number should be in the regional center because they require a licensed care facility. [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR LATHROP: And what we're running into is...and maybe beyond the scope of this committee to evaluate, but we can't get them into the regional center because they don't have the capacity or the facility to keep the public safe from them if they're dangerous. [LR34]

JERALL MORELAND: So I guess I'd make two points. One is when we talk about capacity at the regional center, we are aware that they are increasing beds, I believe by 10 or 14, at the facility. We also believe that they have the ability to increase that capacity by excess of 40 or 50 beds. How do they increase their capacity? We know that they maintain a sex offender treatment program at the Norfolk Regional Center and we know that part of that program is at the regional center campus here in Lincoln. We have had conversation about exploring the opportunity of moving the sex offender treatment center here in Lincoln, that portion, to the Norfolk Regional Center. We believe they have the capacity to accept additional beds at the Norfolk Regional Center. We have not seen a struggle with behavioral health providers for that area. We do believe, however, they will need to increase staffing to accommodate making that move. [LR34]

STEVE LATHROP: You're suggesting there's a solution. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: And you've suggested this to the folks at the regional center, which is if you took the sex offenders out of Lincoln and put them in Norfolk, where you have room,... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...maybe you'd need to staff up, you would have more capacity at the regional center to take those people from the Department of Corrections whose needs require a licensed care facility. [LR34]

JERALL MORELAND: Yes. And I would mention not only meet the needs of Department of Corrections but we know in the community there are discussions that many of the regions believe there needs to be more beds available for mental illness. [LR34]

STEVE LATHROP: Yeah, that gets into a whole nother thing which is when somebody gets brought in on a protective custody, they don't have a place to put them if Immanuel is full or some of those other facilities... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...that are prepared to take somebody who's dangerous to themselves or somebody else, right? [LR34]

JERALL MORELAND: Yes. We also know that the waiting list for court appointments at last time was at 14. I believe with the increase in the new beds they're going to bring on, that may impact that. But we do know there's a waiting list to go into the regional center. [LR34]

STEVE LATHROP: So part of the problem, and it seems to be a theme, part of the problem is having the resources committed to take care of the problem. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: We need to staff up, and the regional center in Norfolk take some of the sex offenders out of Lincoln and move them there. We'd have more capacity but we'd still have to staff up at the regional center and that might alleviate having these people who need that level of care and take them out of the Department of Corrections at least till they're stabilized over... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...at the regional center. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: You are also here today to visit about restrictive housing. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: And the Legislature passed LB598 with the idea that we would reduce the use of restrictive housing, that the department would develop some regulations with respect to the use of restrictive housing, and make some positive changes over there so that we are using it or that the inmates are housed in the least restrictive environment. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Is that right? That's your understanding of LB598? [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Did I properly characterize that? [LR34]

JERALL MORELAND: I believe so, yes. [LR34]

STEVE LATHROP: Okay. So let me ask you what positive changes you have seen within the department since LB598 was passed by this Legislature. [LR34]

JERALL MORELAND: Okay. So in the opening I had mentioned that we do believe that some of the reform efforts by the department are good, some of those reforms being that an individual placed on restrictive housing, there should be a criteria before they're placed on that kind of status. There were discussions between our office and the Department of Correctional Services in regards to those criteria that will be put in place. We would support the criteria that they've put in place because they're ABA standards and principles, and the department adopted those standards and principles. However, there was one provision in there that was added which allowed the department to possibly catch those individuals that didn't fall within the four to five criteria as set by...as set in the promulgation of rules. That's a big one because that allows the department to place anybody on restrictive housing if they believe there's a need. And we believe that subjectivity needs to be managed and reviewed. So in our opinion, we supported that fifth provision that allowed the department to do it as long as the director reviewed every case on an immediate basis. Well, when it went through the promulgation process, apparently it wasn't...that provision was not supported. So the provision of allowing the department to place an individual on restrictive housing, that didn't really fit within the first four point provisions that remained. But the language that requires the department director to review it they struck out. And so it's our opinion that that needs to be looked at and the language that the department has to...that the director needs to review each case, that falls outside of the criteria as supported and adopted by the department, needs to be back in that language. That's one piece. [LR34]

STEVE LATHROP: Okay. Let me talk about that briefly. And for the members of the committee, you're basically referring to the subject matter discussed in Marshall Lux's letter... [LR34]

JERALL MORELAND: That's correct. [LR34]

STEVE LATHROP: ...to the committee members. That's found on pages 126 through 130... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...of the material that we have in front of us today. And basically what happens is the director or the Legislature required that the department promulgate regulations with respect to the use of restrictive housing. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Is that right? And that's an Administrative Procedure Act type of a process. [LR34]

JERALL MORELAND: Correct. [LR34]

STEVE LATHROP: They have hearings and then they promulgate these rules, they get input. And you're saying that the Ombudsman's Office had some input, or at least tried to, with respect to these. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: And the result was a set of criteria for the use of restrictive housing that mirrored the American Bar Association standards, five of them,... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...for the use of restrictive housing, but that the department added a sixth. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: And the first five from the American Bar Association that were adopted and are found in our regulations are objective standards. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Somebody has to be involved in beating up somebody. They have to be involved in one of these gang activities. They have to be trying to incite some kind of violence within the prison. And these are things that are subject to facts. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: You can have a hearing and find out if somebody actually punched a guard or somebody is part of a strategic gang. Is that the term? [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Strategic gang activity or has threatened somebody. So those are facts that you can have a hearing on and elicit testimony. And somebody who is detached and neutral can listen to the facts and say, yep, you did it, so you're going into restrictive housing. But the category that was added by the department when they promulgated the regulations is a subjective category, right? [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: And notwithstanding the fact that they do not want to use restrictive housing to punish, this sixth category that's not found in the APA standards and is now found in our regulations basically says if we think you're a threat to the institution we can use restrictive housing. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Okay. And that's where the Ombudsman's Office is having the heartburn. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: And they're using it. [LR34]

JERALL MORELAND: Correct. [LR34]

STEVE LATHROP: They're using it as a means to put people in restrictive housing. And the difficulty with it is, if I understand Marshall Lux and the Ombudsman's Office concern, is that you can put somebody in that category and use restrictive housing to punish. [LR34]

JERALL MORELAND: That is correct, yes. [LR34]

STEVE LATHROP: Basically, whatever you think, and you can't have a hearing on it. There's no process for a hearing. But even if you did, it's something that's going on in somebody's mind, some judgment they're making, completely subjective, about whether a particular person is a threat to the institution. And if they are, into the restrictive housing they go. [LR34]

JERALL MORELAND: It's a classification action that does not allow due process, which hits the second point in Marshall's. [LR34]

STEVE LATHROP: And you're right and you got a little bit ahead of me. The second concern expressed in that memo and what you've indicated today is that the Ombudsman's Office advocated, during the regulatory process,... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...the Administrative Procedure Act process, to have some due process. So that if somebody is going in long term, it's not the guy that's there for a few days right after he's been involved in an assault but long term, that they have some due process. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Right? And I know we have statistics. We're going to talk about those from the report on the LB598. There's some people spending an awful lot of time in there. [LR34]

JERALL MORELAND: Still. Yes. [LR34]

STEVE LATHROP: Still. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Like that list looks like it has people that have been in there years, right? [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: And they can remain in there if we put them into that sixth category, which would be tempting if they hit a guard to do, right? [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: I'm not suggesting that they have but it's the difficulty with a subjective standard. And you can't apply due process or have a hearing and elicit facts when it is a judgment call by somebody, might be a warden or somebody, that says put him in restrictive housing. And if they were to have a hearing, and we don't have a process for that, all I'd have to say is, well, I think he's a threat to the institution so let's leave him there. [LR34]

JERALL MORELAND: Yes. If I can just describe,... [LR34]

STEVE LATHROP: Go ahead. [LR34]

JERALL MORELAND: ...so the model prior to the promulgation and prior to Director Frakes coming to Nebraska was the department used what they called disciplinary segregation. That disciplinary segregation allowed the department to separate the inmate from general population and placed them in a restrictive kind of environment. However, that disciplinary process was also a process that afforded due process that there had to be a hearing. There had to be a notice of why you were being placed. There had to be a collection of evidence, fact to support why you're placing them. It also allowed the inmate to appeal that move. Well, so recently we discontinued the use of disciplinary segregation, which means we discontinued that due process, and we

replaced it with a model that is called restrictive housing, which is a classification action which allows the department to make very similar decisions but not have to go through that due process piece on why they placed an individual in that restrictive environment. And so that's one of the rubs we have here, is where we support not utilizing disciplinary segregation, we did not bring that up. That is a decision made by the department. We also believe the DS allowed an appeal process all the way up to district court. We don't have that with this element in restrictive housing now and we think we need to look at that piece. [LR34]

STEVE LATHROP: Just as a matter of background in the idea of due process, within the Department of Corrections, they have a lot of due process hearings, right? [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: That's not a stranger to or that wouldn't be a new addition to the Department of Corrections. [LR34]

JERALL MORELAND: Correct. [LR34]

STEVE LATHROP: They have different things that they do to which someone has a right to due process and they have mechanisms there to do that. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: So it's not like we got to reinvent the wheel in how do we do due process. They just didn't put it in here. [LR34]

JERALL MORELAND: Uh-huh. [LR34]

STEVE LATHROP: Are we...in view of the changes or the Legislature's expression of will and apparently the department's intent, and I mean that. I think the director honestly is trying to reduce the use of restrictive housing. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: But the practical effect, have we reduced it? Do we have the same number of people going in every year in restrictive housing that we did before these measures were enacted? [LR34]

JERALL MORELAND: I believe the last numbers I looked at, either we have the same numbers or it has increased. Now I must add that there was a repurpose plan created by the department that had some reform ideas to help reduce those numbers. Eventually, as any breathing document, it changed. And so we believe that that repurposing plan needs to be looked at again to how the department is going to reduce restrictive housing and that repurposing plan should be provided to this committee to review again. In other words,... [LR34]

STEVE LATHROP: Yeah, Mr. Moreland, what do you mean by repurposing? Like are we taking some cells that we once put people in restrictive housing--you're going to be there 24 hours, 23 hours a day, that's where you're going to live--and now we say, well, since we're going to have less-restrictive housing, we're going to make that a different unit and it's going to have a different purpose and it's going to house, I don't know, the veterans or the dementia people or general population? [LR34]

JERALL MORELAND: That's exactly what we're seeing. In other words, what we're looking at, a space that we use one way we're going to use it a different way. [LR34]

STEVE LATHROP: So that leads me to this question. To what extent is the failure to see a reduction in the use of restrictive housing a space issue? In other words, if you're at 160 percent of capacity, you have people sleeping on cots over at D&E, right? You have people sleeping in cots. You're up to your eyeballs in inmates and now you got some space over in restrictive housing. Are we...is the temptation there or are we seeing people in restrictive housing because there's a bed there? And if we didn't have as many beds in restrictive housing and they were repurposed for something else, that we would have fewer people there? [LR34]

JERALL MORELAND: That's a complex answer. I think, yes, to your point, that is correct. I think part of what we're dealing with is we're trying to put a plan in place, restrict housing, which requires staffing, which we don't have staffing, which requires space, which we have limited space and not the best layout in certain facilities. So you add all that stuff in the pot, I think it goes back to what we had mentioned as the two biggest deficiencies and why we believe we're really not sure how to measure what we have yet until we fix those areas is because of that point. There was an attempt to create a central area where you put protective custody individuals at. Protective custody status individuals are those individuals that the department needs to keep safe from either themselves or harm from others. And so the attempt was to move them to a different area, from different facilities. And then there was an attempt to use the restrictive housing or the segregation unit at Tecumseh as mission housing. Well, based on layout and based on staffing and based on other issues that impact it, they had to scrap that. They basically threw that plan away and now they're working on a different plan. And so that's why I go back, how critical it is that the department revisit that repurpose plan on looking at the space they have and bring to this committee another report, a different report that shows us how they are going to accommodate reducing the use of restrictive housing or segregation. [LR34]

STEVE LATHROP: You just brought it back to what seems like a common theme, which is we have overcrowding, we have understaffing, understaffing at the level of guards, understaffing in mental health,... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...and understaffing in programming, all contributing to the fact that as much as we try to legislate this, the senators, as much as they try to legislate policy, you can't make any changes to restrictive housing or appreciable headway until you resolve the other issues. Right? These guys could legislate as they choose to and say, you're not going to use it anymore, but they don't have a choice because they don't have enough people, they don't have enough resources, and they don't have,...they have too many vacancies and too many inmates. [LR34]

JERALL MORELAND: Yes, continuous change. We may be able to see the change made, but is it going to be effective and is it going to continue? That's our concern. [LR34]

STEVE LATHROP: Tell us, if you would, what your take is on the mental health, behavioral health services provided to people in restrictive housing. What's your assessment? [LR34]

JERALL MORELAND: So one of the documents that I passed out is titled "Public Comments to Proposed Regulatory Changes, Title 68," and it talks about how the mental...the designated mental ill inmate has contact with restrictive housing. We believe there's some standards that should be in place when that occurs. And I'll just read this last part. We propose that when a seriously mentally ill inmate is being investigated for a disciplinary offense, the treatment team or treatment leader should make a report as to whether the inmate's current mental illness precludes participation in the disciplinary process, whether the inmate's mental illness contributed significantly to the alleged discipline, whether the inmate's mental status contraindicates any particular form of punishment, and that there be a staff member, if they have to have contact with the discipline process, there be a staff member that attends these kinds of hearings with them. So we believe there needs to be improvement in that area. The current promulgated rules allows the department to place a mentally ill inmate in segregation. It also...or restrictive housing. It also allows the department to retain that inmate during what they call an IS process. During that IS process, that's where they're collecting data to determine what kind of plan to put in place. So after 30 days we start seeing a review. Been on IS for 30 days. Now we see a review by the MDT team, which is at Central Office, which the deputy director has responsibility to review. The director gets involved at 60 days. Well, this whole time, in our opinion, we have a case where, although there is some mental health contact, we also have a case where this individual, who already has a designated mental illness, is deteriorating, can decompensate. And so we do not believe that that is an acceptable solution on how they manage the serious mentally ill. We need to...and one of the...and I'll go back to Dr. Gage's report, to what he talks about, mission housing--how can we, in my opinion, is how can we provide treatment in the right...at the right level of care? And we do not believe the right level of care to provide treatment is in segregated restrictive housing. If I could make one point, we talk about LCC. We talk about mental health unit, and we talk about a secure mental health unit. Mental unit is considered to be a residential unit. It's not a hospital. It's not going to offer the same level

of care as a hospital. The secure mental health unit is supposed to be, by name, mental health unit, but we believe it still has the same elements as restrictive housing. The inmates are still out, at very conservative number, ten, I would say ten hours a week, and we know from the Gage report there are level...nationally they're looking at level of care to increase that out-of-cell time. So I think one of the highest restrictive units nationally that they're looking at is ten hours structured time, ten hours unstructured time. We're not seeing that in the mental...in the secure mental health unit portion. And so, to us, those are still elements of restrictive housing even though it's called serious mentally housing unit. [LR34]

STEVE LATHROP: Okay. The...what I hear you saying, and if we could use a hypothetical inmate, somebody who's in general population, been identified with a serious or a major mental illness, commits some kind of an offense and they can go into restrictive housing, where they have access outside of their cell for one hour a day. [LR34]

JERALL MORELAND: They have approximately two hours a day for five days, for a total of ten hours a week, yes. [LR34]

STEVE LATHROP: Okay. All right, maybe two hours a day. [LR34]

JERALL MORELAND: One being structured, one hour structured, one being one hour unstructured, compared to ten hours and ten. [LR34]

STEVE LATHROP: Okay. And what you're saying is, and I think we learned this a couple years ago, these people decompensate while they're sitting there. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: If they're not getting the care they need, maybe they're getting the medication that they've been prescribed, but if they're not getting some form of therapy, putting them inside of a cell to spend 22 hours a day in there is not good in terms of their mental health. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Any other observations regarding the...tell me about programming. So somebody in restrictive housing--and we have a list in this LB598 report of some people that have spent an awful lot of time in there--are they getting any programming,... [LR34]

JERALL MORELAND: So... [LR34]

STEVE LATHROP: ...so violence reduction, chemical dependency, any of those things that they might need to ultimately be discharged on their parole eligibility date? [LR34]

JERALL MORELAND: Okay. So let's take violence reduction program. Right now we know that there is a shortage in providers within the department to carry out that program. I do believe they have one group going right now and I do know that they are bringing in a group to train individuals to provide that program. So if the question is, are they getting it and how effective is it as far as reaching out to the population, I would say, no, we're not there yet. That goes back to a staffing issue. There are some needier programs, some what we call noncore programs that the individuals do get. [LR34]

STEVE LATHROP: By the way, that means they get a DVD in their cell that they can play... [LR34]

JERALL MORELAND: In some cases. [LR34]

STEVE LATHROP: ...that tells them what they need to do to behave themselves so that they can ultimately get out. [LR34]

JERALL MORELAND: In some cases, or it means they come out as a group and get it as well, yes. [LR34]

STEVE LATHROP: But in terms of them checking the boxes that they need to check in order to ultimately be discharged or eligible for parole, they're not checking any of those boxes, are they? [LR34]

JERALL MORELAND: No. No. [LR34]

STEVE LATHROP: I think that's all the questions... [LR34]

JERALL MORELAND: The...if I can make one point. [LR34]

STEVE LATHROP: Oh, sure. [LR34]

JERALL MORELAND: When we talk about the levels of restrictive housing, we shouldn't just look at restrictive housing or segregation. We have what they call control units. [LR34]

STEVE LATHROP: Why don't you go through those. So when we used "restrictive housing," that's a broad category that includes several subcategories... [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: ...or subsets. [LR34]

JERALL MORELAND: Yes. [LR34]

STEVE LATHROP: Tell us what they are and maybe, if you can, describe what the circumstance is for somebody in each of those particular units. [LR34]

JERALL MORELAND: Okay. So what I'll describe is LCC. At Lincoln Correctional Center, you have mental health unit, secure mental health unit, restrictive housing which is right by the secure mental health unit, then you have what you call a control unit, which is downstairs. That's the area when I mentioned that, in the document, that the department is indicating that they are planning on closing. It's my understanding it should be closed I think October 14, this Friday, or

coming up. But it really is an area that is not humane to put individuals in so we're glad to see the department is going to be closing that. But now that leaves...but we still have that control unit at the penitentiary. It's a very similar kind of environment. Then from the control unit you have what I call converted housing units that they have converted from regular housing units to now restrictive housing. So they're able to see each other probably a little more but it is much larger in area. And from there you have mental health unit, then you have your mission housing. It could be anywhere from, well, your secure mental health, mental health unit, veterans' home...veterans' unit, aging population unit, those kind of things. So it's just when we talk about there's two levels of segregation when we talk about segregation in Corrections. [LR34]

STEVE LATHROP: And which of those categories that you've just described fit into which of the two levels of segregation? [LR34]

JERALL MORELAND: Control unit and segregation. And so... [LR34]

STEVE LATHROP: Okay. Segregation is where we put these guys away or put them because we can't control them because they just beat up a guard, those things where they're going to spend 23 hours a day in a room? [LR34]

JERALL MORELAND: Yes. Yes. [LR34]

STEVE LATHROP: Right? And then there are other units that are less restrictive but restrictive nonetheless. [LR34]

JERALL MORELAND: Yes. And so it's restrictive housing. The department now is referring to segregation as restrictive housing, and they're referring mental health and some of your other places as mission housing. So it's just a difference in terminology that you use. [LR34]

STEVE LATHROP: Okay. I think that's all the questions I have for you. I appreciate your being here today and answering my questions, Mr. Moreland. [LR34]

SENATOR PANSING BROOKS: I just want to follow up on that last one. Thank you very much. So you have some with 23 hours a day in the room. And then the other units, are those the ones that you were saying have ten hours per week out? Is that the difference? [LR34]

JERALL MORELAND: So if we're talking about... [LR34]

SENATOR PANSING BROOKS: We're talking seven versus ten hours. [LR34]

JERALL MORELAND: Yeah. If we're talking about the mental health and secure mental health unit,... [LR34]

SENATOR PANSING BROOKS: Yes. [LR34]

JERALL MORELAND: ...what they're talking about is they would get out one hour a day structured, and they would get out one hour a day unstructured. And that's typically five days a week, so that would be ten hours a week. [LR34]

SENATOR PANSING BROOKS: Okay. [LR34]

JERALL MORELAND: Now in the Gage report, he's suggesting that there's a national effort to offer 10 hours structured and 10 hours unstructured, or around 20. I'm told that the goal by the department is to move from that 10 hour a week to 24 hour a week. We haven't seen that yet but I'm told that's where they'd like to move to. Now if we're talking about restrictive housing, which is a term, and segregation to me, it's still going to be your 1 hour or 23 hours...22 hours a day locked in your cell. [LR34]

SENATOR PANSING BROOKS: Okay. I have other questions, but I'll let the rest of the committee go first. Does somebody have something they...do you? Senator Schumacher, please. [LR34]

SENATOR SCHUMACHER: Thank you, Senator Pansing Brooks. So just to clarify things, a number of years ago we heard different terminologies for different things, but what it boiled

down to was a rather small cell with some basic things: a sink, a toilet, a mattress, maybe a shower if I remember right. [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR SCHUMACHER: And then a screened-in area, I think some people refer to it as a dog run, a small area where they got out for an hour or so a day. That's what we're talking about when we apply these labels? We're still talking about that type of structure? [LR34]

JERALL MORELAND: I think the structure of living is correct, yes. There has been a move to create opportunity for a bigger yard for the individuals to go out to. But as far as their living, yes. [LR34]

SENATOR SCHUMACHER: So the bulk of the time... [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR SCHUMACHER: ...is spent in this. And that's the same case, whether they are suffering from a mental illness or they've just been disruptive sometime. [LR34]

JERALL MORELAND: We are still seeing mental illness in those environments, yes. [LR34]

SENATOR SCHUMACHER: And if I understand you right, the number of people living under those type of restrictions or conditions really hasn't gone down at all, in fact may have gone up slightly during the course of our deliberations over the last three or four years? [LR34]

JERALL MORELAND: It may ebb and flow when they created the first reform plan, but now we're seeing it either the same or increased. [LR34]

SENATOR SCHUMACHER: Okay. And then also in some respects we went backwards, as far as procedurally, because when they used a thing called disciplinary segregation in the past, there was some type of hearing and some type of appeal process? [LR34]

JERALL MORELAND: It was required. The Wolff v. McDonnell case, it was required that there be an appeal process when you apply disciplinary segregation on an inmate. [LR34]

SENATOR SCHUMACHER: And then when we require that there be regulations, there are some standard type regulations that the Bar Association worked out, but then we had a catchall that said if you were a threat to the system, you also were eligible to be placed in that. [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR SCHUMACHER: Okay. And what was in the original drafts was that the director had to personally review those things periodically in order for them to stay there. And that part of director review is taken out. [LR34]

JERALL MORELAND: That is correct. [LR34]

SENATOR SCHUMACHER: So essentially, we have no standards going in and no monitoring of that situation right now. [LR34]

JERALL MORELAND: That appears to be the outcome, yes. [LR34]

SENATOR SCHUMACHER: Is the direct...despite not being required by the regulations to give a review to those cases, is the director doing it anyway? [LR34]

JERALL MORELAND: Not to my knowledge. [LR34]

SENATOR SCHUMACHER: So what is the mechanism for getting out then once you've been put in this situation? [LR34]

JERALL MORELAND: It depends on how long you're in segregation. So there are review steps where the facility, the unit, is allowed to keep the individual in there. I think after 90 days then there has to be an approval and a review by the deputy director. Then the director has a review after a year. After a year, every 30 days from that...every 30 days there has to be a review. And so

once they get to that year mark, we are, one, we're not seeing a director involved until that year mark; and then, two, there's a review every 30 days after that year. So, essentially, there is no deadline on how long the department can keep an individual in segregation. [LR34]

SENATOR SCHUMACHER: And part of the review process then, the guard or the lower rung person that may have been responsible for the inmate going into that restrictive housing in the first place gets input all the way along the line. So if there's an ax to grind, that continues to be ground all along the way? [LR34]

JERALL MORELAND: It could lead to that at a certain level. So your unit custody level, their job is to identify the violation or infraction. From there, there should be a...what it used to be is a separate entity away from housing personnel to say, you know what, we have the facts, we believe this action happened so here's your sanction. When we took away the DS time, we no longer have that. So it appears that there are...there is ability for unit housing to have more of a input in how...not how long they're in there but more of an input on the process. [LR34]

SENATOR SCHUMACHER: One of the things I think we saw on the Nikko Jenkins hearings were...was that when he was in the state system, he was, they call it, in the hole or in one of these situations. But when he was over in Douglas County for a year while he was awaiting trial or some proceeding there, he was manageable, more or less, in the general population. So it gave the inference (inaudible) that this was a rather routine way of handling people in the state system. And in fact, I think we may have seen that in some letters that may have been written or read at the last hearing where that frustration among the system that--the folks in the system and the state system--that there was resistance to just putting people into this type of confinement. [LR34]

JERALL MORELAND: If we're talking about Jenkins, Jenkins, if I recall correctly, was able to function in general population at Douglas County for approximately 17 months. Here, a few days or so he may have separated but was in. When he was returned back to Corrections, yes, the solution was to place him and retain him in segregation. [LR34]

SENATOR SCHUMACHER: One final question: In trying to deal with the frustrations of how do we reduce the level of segregation, we had a bill last year that...kind of a "shot across the bow" bill that if someone was in segregation or these restrictive housing for more than, I think the time was, 90 days--that was a fairly arbitrary number that was put in the bill at that point but for a period of time--they would automatically be eligible for judicial review. Was that an answer or does that just not fit the picture? [LR34]

JERALL MORELAND: I recall that provision there. It did not move forward. [LR34]

SENATOR SCHUMACHER: Right. [LR34]

JERALL MORELAND: We believe where they have taken that due process piece out, something needs to be done in regards to that, and that may be the solution is to allow that direct contact. [LR34]

SENATOR SCHUMACHER: Thank you. [LR34]

SENATOR PANSING BROOKS: Thank you. Anybody else? Senator Bolz. [LR34]

SENATOR BOLZ: Good morning. [LR34]

JERALL MORELAND: Good morning. [LR34]

SENATOR BOLZ: I have a couple of questions related to staffing adequacy. And forgive me, I was at my other job for a few minutes this morning, so if this is repetitive I'll just ask your indulgence. But your report references 30 vacancies in the mental and behavioral health staffing area. I have heard concerns from constituents and staffers in the system about adequate staffing on a 24/7 basis, as is required by the regulation, as well as adequate staffing when there is a crisis to respond to, when there's a suicide attempt or a dramatic scenario in which maybe someone is participating in self-harm or another mental crises. And I was hoping that, from your perspective as the ombudsman, you could talk to me about how the staffing shortfalls impact the cases that

you're seeing and whether or not there have been scenarios in which additional staffing would have been more helpful in terms of meeting people's human rights. [LR34]

JERALL MORELAND: Uh-huh. Okay. So we recently met with the department mental health services, and I believe at that time the number was 38. However, they were in the process of interviewing and they thought they were also bringing on two others. So anywhere between 30 and 38 is the vacancies that we're seeing at...in the behavioral health section. Now some of the impacts from that vacancy is we're seeing nurses triaging the level of care needed. Typically, you don't see that. We...I think in the Gage report he had mentioned, based on the population and the diagnosis, that the department is probably better fitted to have six psychiatrists. And so...at least six psychiatrists. And so we're seeing, as far as psychiatrists, an inability for inmates to actually talk to a psychiatrist on a regular basis. One of the cases I mentioned at York, we have an individual who is supposed to be on what they call the STAR Unit, which is the mental health unit at NCCW. One of the points that Gage made, and we agree with, is it's difficult to operate a mental health unit and share it with a protective custody unit. And so we're not seeing the...to me it goes back to how robust does our system need to be to effectively treat each individual. Another issue we're seeing on the medical side is a waiting list for outpatient services needed, those services needed that the department can't provide. In what they call travel orders, usually an inmate will go out on a travel order, we're seeing that there is a delay in those. When we talk about the mentally ill inmates particularly, we still have an issue with those inmates being placed in restrictive housing. And so, one, we question why are they being placed there; two, we know if they are in secure mental health unit or in a...well, I'd say secure mental health unit, I'm not sure how frequent they would be able to meet appropriate providers as well. [LR34]

SENATOR BOLZ: And just one follow-up question maybe for the record. Your information essentially articulates that the analysis that has been done by the Department of Correctional Services, that between 2 and 4 percent of our population has a severe mental illness, is not in line with national standards, and that if a deeper assessment was done we might find a higher population of the severe mentally ill, which would exacerbate the challenges that you're talking about in terms of staffing adequacy. Have I characterized that correctly? [LR34]

JERALL MORELAND: I think, yes, you have. I would say that one of the things that has to improve is how we collect that data. [LR34]

SENATOR BOLZ: Uh-huh. [LR34]

JERALL MORELAND: But, yes. [LR34]

SENATOR BOLZ: Very good. Well, I appreciate your work. [LR34]

JERALL MORELAND: Sure. [LR34]

SENATOR PANSING BROOKS: Senator Chambers. Thank you, Senator Bolz. [LR34]

SENATOR CHAMBERS: Thank you, Madam Chair. Mr. Moreland, your presentation, taken in conjunction with the written material we have, covers the waterfront very well. But people reading the transcript may not have the benefit of everything we have in terms of what may pass. So the matter of mental illness, solitary confinement may be general terms that can be subdivided into other...to various aspects of the same thing. Let me give an example. If I take an orange and we look at it as an entity, you don't have to break it down into a peel, pulp, seeds, juice, rind, and so forth because you're looking at the entity as one unit. [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR CHAMBERS: But if you're going to evaluate, say, mental illness, you might talk about various manifestations of it, which in and of themselves may be categories requiring a treatment different from other categories, although they all fit under that umbrella. [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR CHAMBERS: If you have a person who may be deemed mentally ill by one health professional, could a different health professional, for whatever reason, say, well, this is not mental illness, it's a behavioral matter? [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR CHAMBERS: Strictly behavioral. [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR CHAMBERS: When you have a situation like we have in the Department of Corrections where there is a tremendous number of vacancies, inadequate staffing maybe throughout the system, there may be a tendency to misdiagnose or mischaracterize in order to fit things within the capabilities of the institution, instead of looking at what the needs are and then saying what the institution should have in order to meet those needs. [LR34]

JERALL MORELAND: That is correct. [LR34]

SENATOR CHAMBERS: Okay. I'm not trying to be confusing because I have some questions and they may overlap. Now this question doesn't go exactly to what I touched on. But if the failure on the part of an inmate to complete or even obtain what would be considered appropriate mental health treatment by the time eligibility for parole would come, could the failure to receive that treatment impact the release date in the same way as maybe the failure to complete an anger management course? Could the failure to receive the mental health treatment have the same impact on delaying a release date? [LR34]

JERALL MORELAND: Yes. So we know there's the core programs--go back to the noncore/core programs--that the Parole Board expects an inmate to complete. We also know that that parole eligibility date, it's very important to complete it by that date or it all plays together. If we can't get the program to the inmate in time by the parole eligibility date, that now impacts our (inaudible) at capacity. If we're talking about a system that is going to bring individuals in, we also talk about a reentry piece of it. And so it's important that that program piece works efficiently so we hopefully can impact and avoid the overcrowding and have individuals sitting in...still incarcerated when they're better off being in the community, so, yes. [LR34]

SENATOR CHAMBERS: In order to make a correct judgment, could it be said that an inmate is denied release on parole due to circumstances beyond his or her control, based on the inability of the institution to provide the programming that may be desirable? [LR34]

JERALL MORELAND: That could be said, yes. [LR34]

SENATOR CHAMBERS: And when that inmate is entitled to parole but for the absence of getting these programs, that could contribute to the overcrowding that would otherwise not have occurred had that person been released. [LR34]

JERALL MORELAND: That is possible, too, yes. [LR34]

SENATOR CHAMBERS: When I was reading through some of the material, I saw where nonclinicians are now performing services or carrying out duties that previously only clinicians handled. Is that correct? [LR34]

JERALL MORELAND: That is correct. [LR34]

SENATOR CHAMBERS: Now are these nonclinicians being utilized because they are as effective in carrying out these functions or to fill up the absence of clinicians? [LR34]

JERALL MORELAND: So we know that CSG, Council of State Governments, came in and looked at the programming offered. [LR34]

SENATOR CHAMBERS: Could you speak just a little louder? [LR34]

JERALL MORELAND: We know that CSG, Council of State Governments, came in and looked at the programming offered by the department. We know that there has been a move by the department to identify those programs that do not necessarily require a clinician to perform them. And so that's part of what we're seeing right now. And so to answer your question, I think in...also Dr. Gage in his report mentioned that there are some program offerings that he believes should be, if I recall, managed by the clinical practitioner versus the nonclinical practitioner. And

so but I think we go back to core program versus noncore programs, supplemental programs versus those core programs. So I can't...I don't know if...I believe what they're trying to do and what I'm noticing in national research is that they have a shortage in behavioral providers. So how do we meet that shortage? And so I know that's one of the areas we're looking at also on overall in the state system. How do we beat that shortage? Are there peer specialists we can use to help provide that programming? Are there...can we...I think the word is "integrate." Can we integrate some of the services? Example: medical versus medical and mental health when you come in. And so those are some of the strategies that I'm seeing as far as research and how do we handle the big issue of not enough behavioral health providers to provide those programs. So I think that's why and one of the reasons why we're seeing the department try to tap into other staff members to provide some programs as long as it's...you know, one of the things we mentioned is we want that to be evidence-based program. And some program offerings have...I do not believe can be done by nonclinical practitioners. [LR34]

SENATOR CHAMBERS: The questions that I ask are not based on an incompleteness of your answer but, rather, in trying to for my sake comprehend whether or not people who are nonclinical, or let me say nonclinicians for the ease of reference, are being assigned duties that clinicians did because of the shortage of clinicians. But to give the impression that these services are still being adequately performed you simply put a label on somebody who will do what he or she is not adequately trained to do in the same way that when--although I wasn't here I read the testimony--the deputy director was pointing out when the escapes occurred, people who did not have training to properly evaluate what the circumstances should be that could prevent somebody who is handling laundry, who maybe shouldn't, the way these bins are handled, the way the vehicles are inspected before they leave the facility, people who were not trained in all of those steps were trying to carry these things out. And because they did not adequately do so, there were openings left for somebody with an intent to escape to escape and in fact the escapes occurred. And based on the testimony that I read of the deputy director, they had taken people who were not qualified by training to do things that should have been done only by those who had the training. So now, by analogy, there might be people who are nonclinicians being described as people who can carry out the work that clinicians had done when they really can't, but it's done for cosmetic purposes, to give the appearance that everything is flowing as it should. Now when you have--and this is going to be a jump--county safekeepers, who establishes the

criteria to determine whether this individual qualifies to fit in that category for the purposes of putting him or her into the correctional system? Would it be the county people who want to get this person off their hands? Or are there objective criteria that Corrections has established for making that determination? [LR34]

JERALL MORELAND: So I'm not aware of any criteria that would keep the...prevent the department from accepting county jails. In fact, I do believe that a request is...the practice is that the request is made by the county jail. I'm not sure if Corrections believes they can refuse that request. I bring that up because I recall this conversation last year in regards to we have an overcrowding issue in the Department of Correctional Services, why do we continue to accept county and federal safekeepers. And if I recall correctly, at the time that Director Houston had mentioned that, they accept county safekeepers; I'm not sure if they can refuse county safekeepers. I have to look into that. And so what we are seeing across the board is that the regions have a tremendous shortage in providing mental health services to those offenders in the county jails. And so we're seeing a request by the counties to transfer those individuals to the department. We do know that many of them come instable, many of them, because they haven't received the mental health treatment they need in the counties; we do know that it's a tremendous hit on the budget of the Department of Corrections to accept these individuals. And one of the biggest things I think we know is that they're not able to...the department is not able to present the array of services to these individuals. [LR34]

SENATOR CHAMBERS: Well, now, if a county has a jail which itself is overcrowded,... [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR CHAMBERS: ...could a person be deemed a safekeeper who might merely be difficult, maybe wants to talk about his or her rights, maybe complains chronically about the conditions and is "difficult" because he or she gets on the nerves of the county jail people or because the county jail is simply overcrowded? [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR CHAMBERS: If those circumstances are really what motivate the county but they label the person in this category, then the department has to accept the county's assessment and receive that person. [LR34]

JERALL MORELAND: That's my understanding, yes, and I think we've seen situations such as that. [LR34]

SENATOR CHAMBERS: If there are inadequate healthcare providers in the department, might there be or could there be an intentional or deliberate misdiagnosis of a person who, in fact, is mentally ill as simply having a behavioral problem and if this person is just misbehaving, you can put them in restrictive housing, solitary or whatever you want to call it, and, therefore, not have to provide the treatment that would be necessary if the person were diagnosed as being mentally ill? Let me ask it this way. Would a person who is considered to have behavioral problems given the same treatment as one diagnosed as mentally ill? [LR34]

JERALL MORELAND: The answer would be no, and I'll explain. When...if you're designated as mentally ill within the Department of Corrections, then there is a method or mechanism they use to bring in mental health intervention. On the behavioral health side, what we have seen is, and it goes back to the mission housing, we do not have targeted treatment approaches for those diagnoses, for example, personality disorder, etcetera. So the treatment is different between the two populations. [LR34]

SENATOR CHAMBERS: Okay, and I'm trying not to linger. [LR34]

JERALL MORELAND: Yep. [LR34]

SENATOR CHAMBERS: If a point is reached where an individual who is mentally ill has reached a jam out date but the department does not seek a civil commitment, that person then would be released into the community, although mentally ill and without having been treated, because that person cannot be held beyond the mandatory release date based on the law. [LR34]

JERALL MORELAND: So in that area, that subject matter, what we are seeing is recently the two...and part of this goes back to the Jenkins case, that there be a review on individuals that present or show signs that they're a danger to the community. And that group is called a discharge team within Corrections, so that discharge team is supposed to review all individuals close to their tentative release date--I believe it's 180 days outside of their tentative release date--supposed to review that individual to see if they meet the criteria for civil commitment, and then that process of identifying the county or notifying the county for that process. [LR34]

SENATOR CHAMBERS: But this has to start with the Department of Corrections. [LR34]

JERALL MORELAND: Yeah, the discharge team is with Corrections. [LR34]

SENATOR CHAMBERS: And if the Department of Corrections decides not to do it,... [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR CHAMBERS: ...then Nikko Jenkins is just released straight into the community, even though Nikko Jenkins had asked that this be done. [LR34]

JERALL MORELAND: Yes. [LR34]

SENATOR CHAMBERS: And there is nothing currently that I'm aware of that would mandate the department do something or anything different from what they had done that would prevent another Nikko Jenkins from being released in the way this literal Nikko Jenkins had been released. And if there is something different in their policies, what is that change and when did it take effect? [LR34]

JERALL MORELAND: If I recall, LB598, there is requirement. Statute requires the department to put together a discharge plan and it requires that they review those cases where there is possible need for civil commitment. That's one of the areas that we have been focusing on as far as the meetings between the Lincoln Regional Center and Corrections. At those points what we have seen is that the department is identifying some individuals that meet the need for a

commitment. We're also seeing that they notify the regional center with those names. Now will they miss some? I'm not sure. But they are required to review all TRDs, or tentative releases, from inmates for that purpose. [LR34]

SENATOR CHAMBERS: And these questions are... [LR34]

JERALL MORELAND: And I'll get that information for you. [LR34]

SENATOR CHAMBERS: I can pursue these matters more with some of the people who come and it may give them an idea of what I'm interested in. I'm going to try to find a final question. This idea of transferring some people to the Norfolk facility, many people talk about the need for a support structure for people who are locked up: family, friends, those who can visit. Norfolk could be considerably farther away than Lincoln or wherever. So would you gain something on the one hand but lose something that's more important on the other in terms of what's best for that person, the inmate? [LR34]

JERALL MORELAND: Okay, so let me clarify the point as far as moving the entire sex offender program from Lincoln to Norfolk. We would not support that. They have two, to me, functions of that program in Lincoln. One function is the treatment, but the other is the reentry piece. And if we're going to reenter back into the community, we feel it needs to be in closer to Lincoln/Omaha area. So right now, on their reentry or transition part of their program, they have about 20, 25. So we would say maintain that transition piece here and move the other 45 or so piece of the program to the Norfolk area. But, no, we do believe it is important that they maintain that transition piece here in Lincoln and open it in Omaha. [LR34]

SENATOR CHAMBERS: Mr. Moreland, although I have numerous questions, those are all that I'll ask you. But we're going to have other testifiers who may can respond. [LR34]

JERALL MORELAND: Okay. [LR34]

SENATOR CHAMBERS: Thank you. [LR34]

SENATOR PANSING BROOKS: Thank you, Senator Chambers. I just have a few I've written out, too, from this morning. On the Gage report, it suggests that there be...that there are separate housing units and you touched on that. How many separate housing units are there, do you know? [LR34]

JERALL MORELAND: Currently you have your mental health unit, your secure mental health unit. [LR34]

SENATOR PANSING BROOKS: And is this at just certain facilities or which facility? [LR34]

JERALL MORELAND: So the two that I just mentioned are only at Lincoln Correctional Center. [LR34]

SENATOR PANSING BROOKS: Okay. [LR34]

JERALL MORELAND: You have an aging population and that's going to be a unit or at least those who meet that aging population are going to be at NSP. You have protective management unit at TSCI. I know there is a...then you have your restrictive housing, they're considered, your mission housing as well, and restrictive housing is going to be at TSCI, Tecumseh State Correctional Institution. Nebraska State Penitentiary, Lincoln Correctional Center, so it...at Diagnostic Center, when...if there is a need for restrictive housing, then they would move over to the Lincoln Correctional Center which, by the way, is what we're seeing happen with county safekeepers. So there's two ways what we're seeing. If we take, if we look at that, the majority of the county safekeepers coming are instable, have some need for mental illness, they're not going to function very well when they get to the Diagnostic and Evaluation Center. So there's two paths they're going. Either they're going to the restrictive housing at...on C Unit at Lincoln Correctional Center, or we're seeing them go to the control center, which is more restrictive, and we're seeing them remain there. [LR34]

SENATOR PANSING BROOKS: Okay, thank you. So then I wanted to ask about the Vera report. It's our...the committee's understanding that Vera was brought in as an outside consultant to review restrictive housing, is that correct? [LR34]

JERALL MORELAND: Yes. That is correct, yes. [LR34]

SENATOR PANSING BROOKS: So do you know, are you familiar with what they were supposed to do and when they were supposed to do it? [LR34]

JERALL MORELAND: Um-hum. Yeah. We highlight that in our report as well, so we think it's critical to analyze some of the...their observations and see what they were able to identify as the possible needs or deficiencies within the department. And so we were expecting that in the summer and I think the last hearing I believe I heard that maybe it was coming in October, end of October, so we would hope it would get here come end of October because I think it could shed some interesting insight for us in regards to restrictive housing within Corrections. [LR34]

SENATOR PANSING BROOKS: Okay, thank you. You touched on the idea of due process in the Department of Corrections. So it's my understanding that due process is used to take away good time. Are there other instances where due process is given? [LR34]

JERALL MORELAND: So there was two ways, through Wolff v. McDonnell, that require due process. [LR34]

SENATOR PANSING BROOKS: Okay. [LR34]

JERALL MORELAND: First would be good time if the department wanted to impact the individual's good time liberty, and the second would be if you were to restrict that individual in disciplinary segregation. And so, yeah, and so now we have one way that they are...have that due process in place. [LR34]

SENATOR PANSING BROOKS: So just the one, okay. When you were talking about the seriously mentally ill being placed in restrictive housing, is that best practices across the country to place the seriously mental ill in restrictive housing? Is that being done across this country in that way? Is that how we best deal with the most mentally ill? [LR34]

JERALL MORELAND: Well, I think we deal with that now. We... [LR34]

SENATOR PANSING BROOKS: I know we're doing it here. I'm wondering what's being done across the country. [LR34]

JERALL MORELAND: Okay, so it is being done across the country; however, the move is to go away from that. We know there are states that will not allow mentally ill in restrictive housing. We know that the federal system has recently went that direction as well. We know that recently, as far as juveniles are concerned, they are not allowed in restrictive housing and we believe this...that's an area that needs to be looked at here as well. We know that there is a move to look at placing pregnant women in restrictive housing, so, yes. [LR34]

SENATOR PANSING BROOKS: Okay, and are the most seriously mentally ill getting some type of programming or are they mostly being left alone in our restrictive housing units? [LR34]

JERALL MORELAND: So essentially the seriously mentally ill are in a program. So what we're looking at is what treatment are they getting while they're in that particular program. And that's where to me sometime the rub is, is how effective and what treatment are they actually getting as far as frequency. And so what I'm seeing, example, at the secured mental health unit is maybe one hour of either therapy, and I think there's some one-on-one accommodations that are built into the guidelines of that program. [LR34]

SENATOR PANSING BROOKS: Okay, so the treatment is the program, is that what you're saying? [LR34]

JERALL MORELAND: I think they are... [LR34]

SENATOR PANSING BROOKS: Because they're not receiving other treatment, you're...or another program, they're receiving treatment and that's their programming. [LR34]

JERALL MORELAND: Yeah, I think it's more...there's other things inclusive about it but, yeah, the treatment is a part. I just...I see them separate even though there's been...that's kind of a shift there, but I see the program they're in and the treatment they're getting as separate. Example: incentive opportunities. So in the program, if you behave correctly or if we're seeing that you're

adhering to rules, regs, well, the program is, okay, in two weeks you get some incentive. Treatment is going to be more on actually hitting their diagnostic needs or that particular area. So they're separate to me as far as the programs, in other words, where they're housed at. So there's several levels in...at...let's take the seriously mentally...the mental health unit. There's several levels and one of those levels...A through F. And so the closer you are to possibly being transferred to general population or to protective custody, in other words, the closer you are to where they believe you can function, that's part of that. You're moving through their program there. Treatment is going to meet their individual plan or their individual needs. I would bring that point, since you brought that up, is that our last visit to Lincoln Correctional Center there was a group, a segment that they referred to as chronic that couldn't be in the mental health unit. They don't want to have them in restrictive housing, so they remain on their secured mental health unit. And one of the things we're looking at is should that chronic group, is that the group that should go for inpatient treatment and then return back to the department instead of staying in a situation where they only have ten hours out a week? [LR34]

SENATOR PANSING BROOKS: Okay. I have a few more but I'm just going to really ask one because I want to know if access to mental health is the same across all levels of the inmates, like from the safekeepers to those on restrictive housing and men versus women. What is the access across? [LR34]

JERALL MORELAND: It's terrible when we look at the access for the women population. You know, we just had a case where, and I'll just share some of the highlights of the case, we have a female individual who is smearing feces and has been in restrictive housing for a week and as of yesterday had not seen a psychiatrist, not talked to them. And so it's those kind of access that I think we need to look at. And some of that is, is there a psychiatrist at the facility at that time? Or does a psychiatrist come on an irregular basis once every three weeks or so? And so, no, there are still deficiencies in the males, the access. And let me go back to a lot of this has to do with they don't have the staff to really meet the entire needs of the population. [LR34]

SENATOR PANSING BROOKS: Is there any kind of waiting list to get into Lincoln Regional Center? [LR34]

JERALL MORELAND: There is a waiting list to get into the Lincoln Regional Center, and the Lincoln Regional Center prioritizes that list. I know I mentioned that the last conversation I had with the center there was 14 on a court-ordered waiting list. And that's why we believe that...and then the regions have designated beds at the center and so that's why we believe there needs to be some consideration, and if we do not look at solutions of moving the sex offender treatment program over, that we look at, at least, identifying designated beds for the department to use. [LR34]

SENATOR PANSING BROOKS: Thank you very much, Mr. Moreland. [LR34]

JERALL MORELAND: All right. [LR34]

SENATOR PANSING BROOKS: Thank you for coming and we appreciate it and we need to get on with the hearing I think. [LR34]

JERALL MORELAND: All right, thank you. [LR34]

SENATOR PANSING BROOKS: Thank you for the time. And now, next, we hope to have Director Frakes come up and speak with us and... [LR34]

SCOTT FRAKES: I'd ask the committee to consider...Dr. Kohl is here. He's here on his own time. He's no longer an employee. [LR34]

SENATOR PANSING BROOKS: Okay. [LR34]

SCOTT FRAKES: If it would be agreeable, could he testify first and I'll keep the rest of the day open? [LR34]

SENATOR PANSING BROOKS: That's fine, yeah. [LR34]

STEVE LATHROP: I'll do whatever you want. [LR34]

SENATOR PANSING BROOKS: Okay, thank you, Director Frakes. Dr. Kohl, if you could come. Come on up, Dr. Kohl. Thank you. Please spell your name for the record. And I don't know if you have an opening statement or something. Wonderful. Thank you for coming. I know that you're coming on your own time and we really appreciate it. [LR34]

RANDY KOHL: It's cold out there today. Good morning, Senator Pansing Brooks and members of the LR34 Committee. My name is Dr. Randy Kohl, K-o-h-l, and I am the former medical director of the Nebraska Department of Correctional Services. I was informed the topic of today's hearing is behavioral health and medical services within the department. Dr. Mitwaruciu is addressing behavioral health and I will briefly address the changes to health services during my time as medical director within the department and then make myself available for any questions. One of the first tasks I took on as medical director was integrating the healthcare disciplines into a cohesive health services department which had not previously existed. In 2004, we reorganized the behavioral health division to better integrate it within health services so that we could ensure a continuum of care that meets both physical and behavioral health needs of the inmate population. We also changed the emphasis from mental health treatment to focus resources on addressing major mental illness and modified admissions criteria for the residential mental health unit. Evidence-based treatment models for sex offender and substance abuse treatment were incorporated at around the same time. More recently, health services has reduced costs and improved access to providers in the community by accessing preferred provider rates through a contractual arrangement rather than the former practice of paying 100 percent of billed charges. Utilizing Medicaid for outside hospital stays when appropriate has also resulted in significant cost savings. A number of changes have also been made in medication delivery. The pharmacy was centralized and a formulary developed. We have also automated the medication packaging and moved to electronic prescribing. Request for an electronic medication administration record system is included in our current budget request and as well as funds to identify what it will cost to move to fully electronic records. The last two items I'd like to mention are the creation of a chief of psychiatry position and the development of the inmate health plan initiated in 2015. Both of these decisions were made in collaboration with Director Frakes and have my full support. The inmate health plan for the first time clearly lays out for inmates and staff services available within NDCS and for the first time defines that community standard of care we are statutorily required to provide. The creation of the chief of psychiatry

position is no less significant as it recognizes the importance of the clinical services for inmates under our care who have significant mental and behavioral needs. In conclusion, I am proud of the progress made within health services during my tenure as medical director. There is no question that challenges remain, but I have full confidence in the quality of the health services staff and the care that they provide to their patients each and every day. We work with a population that has many needs and can be difficult to treat at times. As challenging as the work may be, it is just as rewarding to help them assist those with significant health issues to make changes necessary to return to the community as healthy, productive citizens. I would be happy to answer any questions. [LR34]

SENATOR PANSING BROOKS: Thank you, Dr. Kohl. I was going to have Mr. Lathrop go for it, but do you want to start, Senator Chambers? [LR34]

SENATOR CHAMBERS: Oh. Oh, me! [LR34]

SENATOR PANSING BROOKS: Well... [LR34]

SENATOR CHAMBERS: Oh, go ahead. [LR34]

SENATOR PANSING BROOKS: Yeah. [LR34]

STEVE LATHROP: Okay, just a few questions. Dr. Kohl, thanks for being here. Do I understand that you're retired now? [LR34]

RANDY KOHL: I am retired, yes, sir. [LR34]

STEVE LATHROP: And when did you last or when did you leave the department? [LR34]

RANDY KOHL: A week ago. [LR34]

STEVE LATHROP: Freshly retired. [LR34]

RANDY KOHL: Yes. [LR34]

STEVE LATHROP: Okay. [LR34]

RANDY KOHL: And it's really a new experience. I've never done it. [LR34]

STEVE LATHROP: I'll bet it is, I'll bet it is. Dr. Kohl, how long did you work at the department? [LR34]

RANDY KOHL: Fifteen years. [LR34]

STEVE LATHROP: And what did you do before you went to the department? [LR34]

RANDY KOHL: I was head of the emergency services in Beatrice Hospital. [LR34]

STEVE LATHROP: What's your specialty, emergency medicine, or is it general practice? [LR34]

RANDY KOHL: Family medicine. [LR34]

STEVE LATHROP: Family medicine? [LR34]

RANDY KOHL: Yes, sir. [LR34]

STEVE LATHROP: Okay. Fifteen years as a medical director, and in terms of the corporate structure, you're the person on top in terms of providing medical or mental healthcare. [LR34]

RANDY KOHL: Healthcare in general, yes. [LR34]

STEVE LATHROP: To include mental health... [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: ...and behavioral health and if somebody is physically sick or has mental or behavioral problems. [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: So you've retired last week and you are...we, the state, is losing its head of psychiatry, is that right? Dr. Wetzel is leaving? [LR34]

RANDY KOHL: I was not aware of that until several days ago. [LR34]

STEVE LATHROP: Okay. And we have other people at the top in the corporate structure of providing healthcare at the department that are also departing, is that right? [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: Tell us who that's been in the last year. [LR34]

RANDY KOHL: Well, at present time, I have Dr. Gary Hustad serving as the acting medical director. [LR34]

STEVE LATHROP: What's his name again? [LR34]

RANDY KOHL: Dr. Gary Hustad, H-u-s-t-a-d. [LR34]

STEVE LATHROP: Okay. All right. He's taking your place, acting. [LR34]

RANDY KOHL: As acting, yes. [LR34]

STEVE LATHROP: Okay. [LR34]

RANDY KOHL: Essentially many of my daily functions were distributed to other folks where we did not need medical decision making. Otherwise, Dr. Hustad is serving in that capacity, but

at the same time he is also serving as a physician to the three west facilities here in Lincoln. [LR34]

STEVE LATHROP: Yeah, I was going to ask you that. So when you were doing this work, and maybe it's more appropriate to ask about your successor, it's not just an administrative position; you're actually practicing medicine with respect to some of the inmates. [LR34]

RANDY KOHL: I was not actually seeing patients when I left. I was making medical decisions regarding consultations, medication requests, those type of medical decisions. [LR34]

STEVE LATHROP: Okay, so somebody might tell you that an inmate in a particular facility has got a particular complaint and you're going to make a decision whether he's referred out to see a specialist outside the gates, for example? [LR34]

RANDY KOHL: Yes. The request is...was initiated by one of the physicians or one of the midlevel practitioners at the respective facility. Then based on the information provided, then we would make the appropriate referral. [LR34]

STEVE LATHROP: Okay. What has been your role...well, let me just ask you generally. While you were there, right before you left, do you think we were doing an adequate job and meeting the community standard of care with respect to the needs of the patients in the areas of their physical health? [LR34]

RANDY KOHL: I think that the community standard was met. There was some...there are some delays at some of the acquiring some of the imaging and so forth. But again, these are all triaged based on the needs of the patient. [LR34]

STEVE LATHROP: Okay, so you've introduced triage and that always makes me have other questions. You have 5,300 inmates and you're ultimately responsible for their healthcare when you were there as medical director. Would you agree with that? [LR34]

RANDY KOHL: Yes. [LR34]

STEVE LATHROP: And you'd have various needs presented to you by people who are working at the department explaining to you, you know, somebody thinks they have a problem bigger than what the nurse might be able to help them with and they need to be seen by a medical doctor. That would be a common thing that you dealt? [LR34]

RANDY KOHL: Typically that decision making would have been made at the facility. [LR34]

STEVE LATHROP: Okay. Okay, somebody is trying to get him some care and you make decisions about referrals outside the place. [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: When we talk about, and you brought up the statute, it's...we actually have in place a statutory requirement that the care meet the community standard of care. That true? [LR34]

RANDY KOHL: Yes, that was LB154, formerly in 2001. [LR34]

STEVE LATHROP: Okay. And basically for nonproviders or nonpractitioners, that means that you need to provide the kind of care one would expect in that community. So if we're talking about the Lincoln Correctional Center, it's the kind of care one would expect if they were on the outside in the city of Lincoln. [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: Okay. That's the standard we've set statutorily for all care for inmates inside the Department of Corrections statutorily. True? [LR34]

RANDY KOHL: Yes. [LR34]

STEVE LATHROP: Okay. And in terms of the physical taking care of patients, do you feel like you've got...like we are meeting the standard of care? Or are we shorthanded? Do we have some shortcomings there or are we doing an okay job? [LR34]

RANDY KOHL: I think we could do a better job if we had additional staff to see the patients more rapidly. [LR34]

STEVE LATHROP: Okay, talk about that for us. Where do you think that you...are these vacancies or are they positions that you believe should be appropriated for and added to the budget of the Department of Corrections? [LR34]

RANDY KOHL: These are vacancies here. [LR34]

STEVE LATHROP: All right. Tell us about the vacancies, and now I'm not talking about mental health and behavioral health, but just dentistry, optometry, family doctors, nurses, advanced practice nurses. [LR34]

RANDY KOHL: I believe they just hired a physician at the penitentiary which would give a full complement as far as primary care physicians. Midlevel practitioners, at least as of last week, we were still short several. [LR34]

STEVE LATHROP: What's several? [LR34]

RANDY KOHL: I believe--one, two--two short right now here in Lincoln. We do have a doctor filling in part-time for the third one. [LR34]

STEVE LATHROP: And when you say midlevel, are you talking physicians or are you talking nurses? [LR34]

RANDY KOHL: No, midlevel practitioner is a term we use that...to refer to a physician...I mean PAs, physician's assistants, and nurse practitioners, also known as APRNs. [LR34]

STEVE LATHROP: Okay. So you said we were short two systemwide or is that just in Lincoln, sir? [LR34]

RANDY KOHL: Basic here in Lincoln; I don't know what...if they have any shortages at the...at Tecumseh. As you know, the medical staff there are hired by CCS. I understood though the PA was intending to leave, but I'm not sure of the date. [LR34]

STEVE LATHROP: If I can, and I don't want to take so much of your time now that you're newly retired to go through each institution, maybe you could tell me agencywide, so across the Department of Corrections, can you tell me about the vacancies that you think, if filled, would allow the department to meet the community standard of care. [LR34]

RANDY KOHL: I think that if we could fill the midlevel positions that are open, which would be two, potentially three, we would be in good shape in that regard, however, the... [LR34]

STEVE LATHROP: That would be sort of the physicians or what we call the prescribers? [LR34]

RANDY KOHL: Yes. [LR34]

STEVE LATHROP: Okay. [LR34]

RANDY KOHL: However, that does not replace the nurses. [LR34]

STEVE LATHROP: Okay. Tell me about the nurses for the physical needs of the patients and where you think you have vacancies or shortcomings. [LR34]

RANDY KOHL: I believe there was one opening in Omaha. And again, our staffing sort of fluctuates. In other words, we're good in Omaha for awhile, we're good in Lincoln for awhile. [LR34]

STEVE LATHROP: Why don't you just tell me where you were at when you left a week ago. [LR34]

RANDY KOHL: Well, we were short half--50 percent--of the nurses at the penitentiary as an example. [LR34]

STEVE LATHROP: How many would that be? [LR34]

RANDY KOHL: I believe you're talking six. [LR34]

STEVE LATHROP: Six nurses at NSP? [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: Okay. So is that the number we're short or is that the total number there? [LR34]

RANDY KOHL: It's the number short. [LR34]

STEVE LATHROP: Okay. So if we went systemwide and talked about nurses that provide physical care or care of the physical person, how many are we short systemwide? [LR34]

RANDY KOHL: I'd have to give you an estimate on that. I'm thinking... [LR34]

STEVE LATHROP: That’s good enough for today I think. [LR34]

RANDY KOHL: ...eight to ten I believe. But again, I know they were also hiring a couple more when I left. [LR34]

STEVE LATHROP: Okay. So it may be more or less depending upon changes that have happened. [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: What other people are involved in the care besides the midlevel and the nurses? [LR34]

RANDY KOHL: There are dentists. [LR34]

STEVE LATHROP: All right. Are we there on dentists or short or how are we doing? [LR34]

RANDY KOHL: We're short a chief of dentistry and I believe another position in addition. [LR34]

STEVE LATHROP: So two dentists? [LR34]

RANDY KOHL: Yes. [LR34]

STEVE LATHROP: Okay. Any other healthcare providers not involved in behavioral health? [LR34]

RANDY KOHL: I'm trying to think. There was optometry. I think we use a contractor there. [LR34]

STEVE LATHROP: In optometry? [LR34]

RANDY KOHL: Dr. Corn (phonetic), yes. But we had lost another one previously but he's now covering both the west side and the penitentiary here in Lincoln. [LR34]

STEVE LATHROP: Adequately? [LR34]

RANDY KOHL: To my knowledge, yes. [LR34]

STEVE LATHROP: Okay. Any other physical...people involved in the physical health of the inmates? Any additional vacancies we haven't talked about? [LR34]

RANDY KOHL: Other than I have some psychiatric staff that I'm short. [LR34]

STEVE LATHROP: Right. Now we're into behavioral health. [LR34]

RANDY KOHL: Right. [LR34]

STEVE LATHROP: Okay. And before I go there, I just want to...we've covered the physical because we...I asked you earlier about are we meeting the standard of care and you said, well, we're triaging, which means we're figuring out who is worse off, right, and who has the most acute need and that will be addressed first because we're shorthanded? [LR34]

RANDY KOHL: Triaging does refer to addressing those with the greatest need, yes. [LR34]

STEVE LATHROP: Okay. And that's become a part of our...well, you do that anyway in medicine, don't you? [LR34]

RANDY KOHL: We do that all the time, yes. [LR34]

STEVE LATHROP: Yeah, yeah, whether your waiting room is full of people or whether you're trying to figure out which inmate is going to get attention. But when you're shorthanded, it becomes more acute, would you agree with that? [LR34]

RANDY KOHL: Right. And of course this causes people to have to put in more hours and it would...causes a stress on the staff, yes. [LR34]

STEVE LATHROP: All right, so tell us about turnover and now we're talking about these folks that you just listed: the medical doctors, the nurses, the dentists. How is it at the Department of Corrections trying to maintain a state where you're fully staffed? [LR34]

RANDY KOHL: It has been more difficult as of late. [LR34]

STEVE LATHROP: Why? Why is it more difficult? Is it pay? Is it the circumstances of their employment? What is it that's causing the turnover or creating the vacancies in your judgment? [LR34]

RANDY KOHL: I trust you're asking my opinion on this. [LR34]

STEVE LATHROP: I'm asking your opinion. [LR34]

RANDY KOHL: Okay. I think the problem is multifactoral. We did pass legislation some years ago putting the physicians and other psychologists at a nonclassified status which allows some leniency in providing more adequate salaries. The problem is, you know, in my opinion, the state government in a lot of times does not recognize that in healthcare we are competing with the private sector. And the private sector right now has a major shortage, particularly in the areas of psychiatry, in the areas of nursing, nationwide shortage in nursing. One of the local hospitals was looking for 60 nurses. We could not compete with those kind of salaries presently and that creates a problem. Midlevel practitioners are being utilized many times now by specialists to serve their needs at a lower overhead which they get paid much more than we're allowed to pay them under the rules and regs of the state of Nebraska. So that creates a problem. One of the... [LR34]

STEVE LATHROP: So far it's a single factor: salaries. [LR34]

RANDY KOHL: That's one factor, yes. [LR34]

STEVE LATHROP: Okay. [LR34]

RANDY KOHL: But it is a large factor. [LR34]

STEVE LATHROP: I expect it would be. [LR34]

RANDY KOHL: And you would like to think that people don't necessarily move just because of wages, but I have seen a lot of that occurring. [LR34]

STEVE LATHROP: People leaving the department to go work at a different department that pays more? [LR34]

RANDY KOHL: Right, correct. [LR34]

STEVE LATHROP: Okay. [LR34]

RANDY KOHL: Also, I think that the media coverage that we have received, you know, and I've watched this on TV, we've seen it in the newspapers, the people that are going to want to work in Corrections look at that. And I would say there are some concerns then: How safe is it for me or my spouse to work there? [LR34]

STEVE LATHROP: How long you think that's been a consideration? [LR34]

RANDY KOHL: I'm thinking as I look back the last couple of years have been an issue for us. [LR34]

STEVE LATHROP: So do you think your vacancies are higher now than they were a couple years ago? [LR34]

RANDY KOHL: Yes. [LR34]

STEVE LATHROP: All right. By a factor of what? [LR34]

RANDY KOHL: Well, the midlevel practitioner... [LR34]

STEVE LATHROP: Did you have all these spots that you just described filled? [LR34]

RANDY KOHL: Yes. [LR34]

STEVE LATHROP: Okay. [LR34]

RANDY KOHL: And at one time I was completely staffed with nurses. [LR34]

STEVE LATHROP: Okay. And then you had a hospital open with 60...looking for 60 nurses? [LR34]

RANDY KOHL: Well, and not only that, in Omaha of course there's a new facility that has moved there... [LR34]

STEVE LATHROP: Right. [LR34]

RANDY KOHL: ...that is asking for more healthcare staff. But that's a reality. I mean we compete with the private sector. [LR34]

STEVE LATHROP: How short...what percentage of...is there a solution besides raising the pay? [LR34]

RANDY KOHL: I think we do need to do that. I think one of the things that's really important is to have trusted leadership in healthcare. I don't think my leaving has been beneficial in that regard. I feel that my staff did trust me. And I personally recruited Dr. Wetzel, I personally recruited Dr. Hustad, I personally recruited Dr. Ogden, those people that came on board because they knew me and felt that they would like working in that environment. [LR34]

STEVE LATHROP: Okay. [LR34]

RANDY KOHL: So that leadership is important in healthcare. [LR34]

STEVE LATHROP: To this point in time...well, to go back to the question, you talked about salaries, the difficulty with the state competing with the private sector with respect to nurses, doctors, and dentists, I suppose all the healthcare providers,... [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: ...and the fact that there's shortages. And so what...do you have an opinion or a judgment or can you share with the committee what you think we need to do with salaries? Are they half of what they should be? Are they 80 percent of where they should be to get people to entice them to the Department of Corrections and fill these spots? [LR34]

RANDY KOHL: I really can't give you a percentage because it varies by profession. But I think certainly we need to look at each level, each, you know, each profession, and look at what these salaries that are being offered there in Nebraska. If you look at the family physicians across the country, the average salary, 4/20/16, is $225,000 a year. [LR34]

STEVE LATHROP: What do we pay them? [LR34]

RANDY KOHL: Well, we've actually...are starting some at $200,000 or above. So in the physician realm we are actually, or can be, competitive. That becomes the director's decision as far as what the salaries are. But I feel at this point we have been competitive as far as physicians. That's why at this point if indeed they just hired the physician for the penitentiary, we're up to full complement. But that's one of the areas where we have been able to compete. [LR34]

STEVE LATHROP: In preparing for this hearing I looked at a couple administrative regulations. And I'm sure after 15 years you've probably looked at a few state administrative regulations. [LR34]

RANDY KOHL: Every year. [LR34]

STEVE LATHROP: Every year. One of them is administrative regulation 115.23 that requires that each institution ensure that appropriate physical facilities and professional mental staff are available to provide mental health services. That includes a minimum and they lay these out. Do you know, in the 15 years that you were medical director, if that was being done each year? Each of the facilities, so the regulation requires each institution shall ensure that appropriate physical

facilities and professional mental health staff are available to provide mental health services. Was that being done at each institution while you were medical director, Dr. Kohl? [LR34]

RANDY KOHL: As far as staffing was looked at every year, yes. [LR34]

STEVE LATHROP: And physical facilities? Physical facilities: a place to do the things they need to do for the mental health of the patient or the inmate. [LR34]

RANDY KOHL: Yes, and we have difficulty, of course, in some of the facilities as far as space, without a doubt. [LR34]

STEVE LATHROP: Okay. [LR34]

RANDY KOHL: I mean there are issues with that which we've certainly looked at and modified to the best of our ability to have that space to provide the various treatment center needed. [LR34]

STEVE LATHROP: The regulation refers to appropriate to provide the mental healthcare. Do you think the space in the facilities was appropriate? [LR34]

RANDY KOHL: I would say in most of them. [LR34]

STEVE LATHROP: Where do you think you were short on space, because the regulation requires or calls for appropriate space in each of the institutions, where do you think you had problems? [LR34]

RANDY KOHL: I think LCC more space could be available. But again, we have modified that to the best of ability to meet those needs. [LR34]

STEVE LATHROP: Yeah, but the statute, and I don't want to make this like me quarreling with you, I don't want to be argumentative, but it says, "appropriate physical facilities and professional mental health staff are available..." So let me ask you about LCC. Do you think

there's appropriate, and has been, appropriate physical facilities and appropriate professional mental health staff to take care of the people at LCC? [LR34]

RANDY KOHL: I think as far as the mental health staff, yes, and I think as far as the space that we made available by modifying some of the...actually we had to occupy some of the cell space to provide that office space and for meeting with inmates. So I think as far as you use the term appropriate, in other words,... [LR34]

STEVE LATHROP: I was just reading a term out of a regulation. [LR34]

RANDY KOHL: I know. I'm just...I'm saying appropriate is what you can provide then that will indeed provide the adequate care for the inmates. [LR34]

STEVE LATHROP: All right. So another one of the regulations, and this one I may be even more particularly interested in, it's 115.02, and I don't expect you to know that off the top of your head, but it says this is a health personnel management regulation and I'm going to read it to you. It's II, and for the members of the committee it's on page 33. It says, "The facility uses a staffing analysis to determine the essential positions needed to perform the health services mission and provide the defined scope of services. A staffing plan is developed and implemented from this analysis. There is an annual review by the Health Authority to determine if the number and type of staff is adequate." Are you...first of all, are you familiar with that regulation? [LR34]

RANDY KOHL: Yes. [LR34]

STEVE LATHROP: Okay. And are you the...would your position have been the health authority, as that term is used in this regulation? [LR34]

RANDY KOHL: Yes, it is. [LR34]

STEVE LATHROP: Okay. [LR34]

RANDY KOHL: And of course some of those functions are delegated, as an example, to my COO. Typically...you have a question? [LR34]

STEVE LATHROP: Well, I do but I don't want to interrupt you. [LR34]

RANDY KOHL: Okay. Essentially the...each year we would look at all of the facilities and get input from, as an example, the nursing staff. We'd get input from the directors of nursing or the associate directors of nursing on what staffing needs are for the facilities. We would then sit down as the management team for health services to look if we need to make any budgetary requests regarding staffing. [LR34]

STEVE LATHROP: Okay. So when I read this a couple of hearings ago, you may have been aware of this, that the department did a staffing analysis for the front-line corrections guy, right, where they brought...the developed a, or employed, a recognized measure for determining the staffing needs for the front-line corrections officers. And as I read this, as I read this regulation, it would appear to require a similar undertaking by the health authority, you or whoever you delegate this process to. I'm not suggesting there's something wrong with delegating it; I just want to know if it was done. Was somebody...did somebody go through each institution every year as the regulation seems to require and determine how many mental health practitioners do we need, how many psychiatrists do we need, how many psychologists do we need? Was that done formally in response to this requirement that it be done annually? And let's just say the last five years. [LR34]

RANDY KOHL: Essentially, like I said, we would get input, we would request input from the various entities, whether it be behavioral health or whether it be the nursing or whether it be the medical staff. That input would then come to the management team and then we would develop any request for additional staff that was felt to be needed. In other words... [LR34]

STEVE LATHROP: Okay, here's...yeah, here's the challenge then, or maybe I'm going to ask the... [LR34]

RANDY KOHL: I don't have formal records of this. [LR34]

STEVE LATHROP: Pardon me? [LR34]

RANDY KOHL: I do not have formal records of this because these are informal meetings where this would occur. [LR34]

STEVE LATHROP: Okay. That is going...that was going to be one of my next questions, which is, where is the report, because we asked for them and nobody has one. So this is just something informally you'd sit down before budget time and you'd talk to medical staff or mental health staff from around the various institutions and say, how you doing, do you need more people? [LR34]

RANDY KOHL: We would get input from each of the facilities, yes. [LR34]

STEVE LATHROP: Okay. So when we talked about the front-line guys, the corrections officers, and the staffing analysis that was done, we looked at the numbers. And I'm giving you this by way of background because it's leading to a question about your staff. We looked at the numbers and there were like 200 vacancies at any given time. And then the staffing analysis showed they needed another 138. Okay? When you sit down with your people...I have some notes in here that reflect the vacancies. In response to an inquiry by Senator Bolz, we're told that, and this is probably in June, that there were...you know, you were short eight psychologists back then, one psychiatrist, mental health practitioners, eight chemical dependency counselors. Here is my question. If you're short that many people, what's the point in asking for more people? Right? So when you sit down and talk with your people, as this regulation requires, to figure out what's an adequate staff, and you're short that many people, you have that many vacancies in your mental health staff, was anybody asking for more people, or were they just asking to have you get the vacancies filled so that we're staffed up to at least what's been authorized to this point in time? [LR34]

RANDY KOHL: I think for us to have the ability to determine if we need more staff, we need to be fully staffed. [LR34]

STEVE LATHROP: Okay. And that may be exactly the answer I expected, which is when you have that many vacancies and the regulation requires that you do a study to see how many you actually need, it doesn't go anywhere because you can't fill the vacancies that you have and we don't know exactly how many people you ultimately need. [LR34]

RANDY KOHL: I can only speak for health services. [LR34]

STEVE LATHROP: No, I know. I know that. And believe me, I really appreciate your willingness to be here. I'm not trying to be confrontational. So Director Frakes has Dr. Gage come in and do an analysis of behavioral health and that was done about a year ago. [LR34]

RANDY KOHL: Right, and... [LR34]

STEVE LATHROP: Did you...go ahead. I don't mean to... [LR34]

RANDY KOHL: And prior to that we actually had Dr. White come in on two occasions, who is also a national expert, as a psychologist to look at. So we've had like three different individuals provide input. [LR34]

STEVE LATHROP: Okay. Did you assist Dr. Gage in the preparation of the behavioral health report? [LR34]

RANDY KOHL: No. [LR34]

STEVE LATHROP: Did you accommodate him? I mean he comes into town and according to the report, he goes out to various facilities and looks at a lot of statistics on behavioral health and staffing and one thing or another and then authors a report. [LR34]

RANDY KOHL: Well, my staff did a...you know, provided him whatever he was requesting, yes. [LR34]

STEVE LATHROP: Okay. And did somebody share Dr. Gage's report with you? [LR34]

RANDY KOHL: Yes. [LR34]

STEVE LATHROP: Okay. Did you have any meetings with the director or anybody else about the conclusions reached by Dr. Gage? [LR34]

RANDY KOHL: Can't say that we had specific meetings on that. I know that Director Frakes met with the head of my behavioral health staff. [LR34]

STEVE LATHROP: Okay, so I want to make sure I understand. Once that report was done, because one of the first recommendations in the report which I think may be central to what we're kind of driving at here, the first recommendation in the report is behavioral health has to have a vision, right? You read the report? [LR34]

RANDY KOHL: Yes, I did. [LR34]

STEVE LATHROP: Okay. Behavioral health has to have a vision. The vision should define what the scope of the care is going to be for an inmate when it comes to mental and behavioral health. Right? [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: And there was some discussion in his report and basically, if I could paraphrase, he's saying this sets the course for behavioral health and mental healthcare for inmates at the department when you set out what your vision is. Are you going to just try to get people--now I'm paraphrasing, my words, not his--limp them through the system until you can get them discharged into the community? Or are we going to do something more than just medicate him and get him out the door, as in provide him care, get him treatment, maybe get him to a healthy place before their discharge, right? I fairly paraphrased, in my own words, his discussion on establishing a vision. Would you agree with that? [LR34]

RANDY KOHL: Yes. [LR34]

STEVE LATHROP: Okay. So if that was the beginning point in the recommendations of Dr. Gage, were you involved in establishing that vision? Or was there a meeting to sit down and go, you're the head of health in the prison system? Did you participate in implementing that and any other recommendations from Dr. Gage? [LR34]

RANDY KOHL: The recommendations would have been implemented by my behavioral health staff. I also believe that the behavioral health does have a mission and vision. Overall health services has a mission, a vision that was developed some years ago. Matter of fact, it's in the inmate health plan. [LR34]

STEVE LATHROP: Okay. But to the extent Dr. Gage made recommendations, you would have read them and then you believed the head of behavioral health would have implemented those to the extent they've been implemented. [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: In other words, that's something that was delegated. [LR34]

RANDY KOHL: Right. [LR34]

STEVE LATHROP: Nothing wrong with that, I'm not implying that you didn't do something you should have been doing, I'm just trying to figure out who is in charge of it once that report got done. [LR34]

RANDY KOHL: You can't do everything. [LR34]

STEVE LATHROP: No, you can't, and you probably had an awful lot on your hands. So who was the person that would have been delegated to? [LR34]

RANDY KOHL: I believe Dr. Jones at the time. [LR34]

STEVE LATHROP: She's recently departed as well, am I right? [LR34]

RANDY KOHL: Correct. [LR34]

STEVE LATHROP: Okay. So that report was done a year ago. How long was Dr. Jones around to be involved in that? [LR34]

RANDY KOHL: You know, I don't recall. I mean she had been around prior involved in the substance abuse unit at the penitentiary. [LR34]

STEVE LATHROP: Okay. [LR34]

RANDY KOHL: So she's been with us like five years or whatever, but in that position I'm trying to think when we... [LR34]

STEVE LATHROP: A lot of people coming and going. [LR34]

RANDY KOHL: Yes. I'm having some difficulty in recall on some of that. [LR34]

STEVE LATHROP: That's okay. That's okay. So who fills that position now? [LR34]

RANDY KOHL: Dr. Mitwaruciu. [LR34]

STEVE LATHROP: I know she's going to be one of my next witnesses and you got to tell me how to pronounce her name. [LR34]

RANDY KOHL: Mit-wuh-roo-soo (phonetically). [LR34]

STEVE LATHROP: Mit...? [LR34]

RANDY KOHL: Mit-wuh-roo-soo (phonetically). [LR34]

SENATOR PANSING BROOKS: Mit-wuh-roo-shoo (phonetically). [LR34]

RANDY KOHL: And a lot of staff call her "Dr. Alice." [LR34]

STEVE LATHROP: Okay, I may get that informal before we're done, but I won't start out there. When it comes to the particulars of the behavioral health folks, that's going to be something that Dr. Alice will know more about? [LR34]

RANDY KOHL: Yes, absolutely. [LR34]

STEVE LATHROP: Okay. All right. That's all the questions I have. Doctor, thank you for your service and appearing here today notwithstanding your retirement. [LR34]

RANDY KOHL: Thank you. [LR34]

SENATOR PANSING BROOKS: Okay. Thank you, Mr. Lathrop. Senator Chambers. [LR34]

SENATOR CHAMBERS: Thank you. Dr. Kohl, if you don't mind, how old are you, if you don't mind me asking? [LR34]

RANDY KOHL: Since...(laugh) I'm 69. [LR34]

SENATOR CHAMBERS: Well, tell me this, sonny, what right do you have to retire at such an early age compared to me? [LR34]

RANDY KOHL: Well, I thought you would be the holdout so that (laughter)... [LR34]

SENATOR CHAMBERS: (Laugh) Oh, okay. So did you reach mandatory retirement age, though, or you decided that the time had come when you'd like to retire? [LR34]

RANDY KOHL: If you don't mind me sharing, my sons have put much pressure on me to retire because their mother has a life-limiting illness that was diagnosed a year ago. And so there's been pressure for the past year to do this and I kept procrastinating in this process. Matter of fact, I didn't think I was ready to retire. You know, I'm not that old yet. [LR34]

SENATOR CHAMBERS: Right. [LR34]

RANDY KOHL: (Laugh) And... [LR34]

SENATOR SEILER: I agree (laughter). [LR34]

RANDY KOHL: So I did finally succumb to the pressure of my sons and actually I am...it's going to be a good thing for my wife. [LR34]

SENATOR CHAMBERS: And you may find it's a good thing for you too. Once you can reach the point where you can cut that thread from doing what you've always done, you'll find that the sun also rises, there is a morning after, and there is a life after what you'd been doing, and I hope you find it to be the case with you. I just have a very few questions. As counsel pointed out, there is a statutory requirement that the community standard of health be met by the Department of Corrections, and you agreed. [LR34]

RANDY KOHL: Yes. [LR34]

SENATOR CHAMBERS: Since that requirement is in the statute, do you think if we're going to require that standard we would have to have people able to meet that standard, as would be the case in the private sector? In other words, would we have people of the same qualification and capability in Corrections delivering medical treatment? [LR34]

RANDY KOHL: Yes. [LR34]

SENATOR CHAMBERS: Now if those things are true, it would seem logical to me, just dealing with logic, that there should be something in the salary mandating...I meant in the statute mandating that the salary be commensurate with the salary of people providing similar services in the community. That doesn't seem illogical, does it? [LR34]

RANDY KOHL: No. [LR34]

SENATOR CHAMBERS: But there might be political considerations that prevent that from happening, so I'm going to ask this question. Is the salary you receive commensurate with what a doctor performing a similar function in the private sector receive or is it less? [LR34]

RANDY KOHL: In looking at the private sector, a medical director position, as such, I am probably paid less than I would have received working, say, for an insurance company or other businesses, yes. [LR34]

SENATOR CHAMBERS: But if you have a practical person, such as myself, who has been around a long time and wants to see a certain logic pursued, if I would determine that since we mandate the standard of care in the statute, there would be nothing wrong with mandating at least a salary range within the statute for those holding certain positions, meaning not below a certain amount. That would not be illogical, would it? [LR34]

RANDY KOHL: No. Senator, may I say that I didn't work for Corrections to make a lot of money. [LR34]

SENATOR CHAMBERS: I know. I'm not even questioning that. [LR34]

RANDY KOHL: I know. [LR34]

SENATOR CHAMBERS: But do you think I'm in the Legislature and I've given 42 years of my life for $12,000 a year, no insurance, no pension? And for much of that period I was making $4,800 a year. So a lot of us do things for reasons other than money. But if we're going to mandate certain things in statute, and a salary is annexed to the position, and there are certain requirements mandated as to how that position should function, it seems to me that it would not be illogical to have something relative to the salary in the statute. And I'm not saying that because I plan in my twilight years to suddenly go to medical school, get all of the qualifications, and then try to get the position you're in because it would probably still be open based on the way things are going in Corrections. [LR34]

RANDY KOHL: It's never too late. [LR34]

SENATOR CHAMBERS: (Laugh) And that's all that I have. Thank you. [LR34]

SENATOR PANSING BROOKS: Okay. Senator Bolz. [LR34]

SENATOR BOLZ: How do you define what an adequate staffing pattern for mental and behavioral health services is? What are the criteria you might use? [LR34]

RANDY KOHL: I don't think that you have specific criteria. You need input from the individuals on the ground that are providing the services at a certain facility to determine whether or not they have adequate staff to take care of their inmate needs. [LR34]

SENATOR BOLZ: What criteria would the individuals at the facility use to determine whether or not they have adequate staff to meet inmate needs? [LR34]

RANDY KOHL: I would think that you're looking at if they have a backlog of care, that certainly would be an indication, whether or not they can see the patients in a timely manner. And again, we...not we, the department has been auditing for many years on an annual basis each facility looking at the care that's being provided in medical and mental health, substance abuse, dental. They have been doing it. This is an internal audit. It has nothing to do with ACA or anything else. But that allows us to see whether or not those needs are being met. Based on that audit, then there is a response from the facility and then in that response can also be, no, we don't have adequate staff to do the job. We get input again from my medical staff. I met with my medical staff every month; physicians, for the last year or so, I've met with them one on one since they are the major decision makers for medical care and psychiatric care in the facilities. But again, we don't have a criteria set up on so many nurses per so many inmates. In other words, we don't have that set up that way because that varies from facility to facility. Again, it depends upon the number of inmates there but it also depends upon the level of illness that inmates have at that facility. [LR34]

SENATOR BOLZ: Very good. So what I'm hearing you say is that there are data-driven and analysis-driven aspects that would be considered and you're talking about the internal audit, the

waiting lists, the demand for levels of care. There are parameters and benchmarks that you can look at to analyze whether you're adequate or inadequate. [LR34]

RANDY KOHL: Correct. [LR34]

SENATOR BOLZ: And right now what we're hearing in this committee is that there is a question about adequacy because we've heard that they're...you're 50 percent down on nurses at NSP, there's triage happening, we're hearing indicators that the staffing isn't adequate. So I think my...I have two questions here. One is, why wouldn't you develop a formal, clear staffing analysis and plan to set those benchmarks and identify those needs? Why would you do it in an informal process rather than a formal process? [LR34]

RANDY KOHL: I guess I can't answer that. It seemed like the informal process seemed to be functioning well and there didn't seem to be a need that we needed to change that. [LR34]

SENATOR BOLZ: Well, I mean, I think what we've heard today is that there is a challenge here and there is struggle here, so I question those decisions. And that leads me to asking the next question which is, when we requested this information in June, the response that we got back was, and I'll use the words that I received from the department: In reviewing this language and our documentation, we have determined a more in-depth review of our practice is in order. The chief operating officer for health services will be identifying what the best practice should be in developing more specific language and process to meet this standard and make it useful to the agency. So can you tell me about the progress that's being made in developing the best practices? [LR34]

RANDY KOHL: I don't know what that is at this point. Obviously Mr. Wilson is in charge of doing that. So at this point, from my perspective, I don't know what that is. [LR34]

SENATOR BOLZ: So maybe I'll ask Director Frakes for an update on the progress being made in reviewing and updating that practice. [LR34]

RANDY KOHL: But I was aware that Mr. Wilson was going to be working on that, yes. [LR34]

SENATOR BOLZ: Okay, I think that answers my questions for now. Thank you. [LR34]

SENATOR PANSING BROOKS: Thank you, Senator Bolz. Senator Schumacher. [LR34]

SENATOR SCHUMACHER: Thank you, Senator Pansing Brooks. Just maybe asking a little of your perspective and wisdom as to where the process could be made better in deciding where we allocate our resources. We, you know, I think becoming aware that probably Corrections, mental health, some other state functions are short on facilities and short on compensation for the people working the facilities and that's among our problems, and that those two combinations in Corrections over the last decade or so has brought us to some fairly acute problems it's really hard to work our way out of. Somewhere over that same period of time, roughly, we've either with tax cuts or tax breaks reduced the state's income, the state's revenue, on the order of $775 million a year, headed toward $1.1 billion in the year 2024 if we just stay on the present course with what we've mandated ourselves to do. There seems to be a disconnect in the mechanism of the folks at the operative level, like you were, have to do a job, feeling free or being able to communicate or whatever, getting the signal up through the system--look, this is what I need for people, this is what I need for space, this is what I need for money to pay for all that. I assume that you called in your report to somebody with a budget request up the ladder, and that eventually gets to the director. That eventually gets to the Governor's Chief of Staff and the Governor and the Policy Office. That eventually rolls over to our Appropriations Committee and then the green lights light up and we pass a budget on the floor. Well, somewhere there's a lack of communication or at least a lack of smooth communication as to, hey, we really, really, before we do $775 million in tax relief, we really should kind of be minding the shop a little bit more on personnel, space, budget in Corrections or in mental health or in this or that department. Where is the system broke down? How do we end up there if there are needs and if we're seeing growing at the operations level a need for more space, personnel, and money, and that's not getting communicated up the ladder? How can we fix that? [LR34]

RANDY KOHL: (Laugh) If I had the exact answer for that, you know, maybe I could be Governor or something, but anyway, experience in the past has been we have...there have been requests made and this has been in the past years when there were budget issues. I recall many years ago and it certainly...I believe that's when Director Houston was there at that time. But we

had a plan for a substance abuse unit. At the time, I recall, it was $16 million and there was so much time put into that. And I looked at that and I said, this isn't ever going to fly; I says, we put in how many hours of staff time? Well, then a plan B came up which was for $2 million and there were like 16 substance abuse staff. And I can't tell you what year that was. It's been some time back. But over the next several years, because of the budget crunches, we actually had to cut staff. So even though we gained that staff, then we ended up losing that again down the road. That hasn't happened as of late, but at that point certainly we lost staff, which we've never gotten those back, as the need was determined. But I don't know where that happens. At least at some point along the line in the process obviously there has to be prioritization when you take an agency of what is the most important needs. I don't want to use the term "triage" but it's sort of like that, only it's prioritization of those budget items. And then the requests that are put in by the facilities, whether it be by custody or the other entities in Corrections, then we don't get everything that we ask for. And so at some point in time that doesn't happen. [LR34]

SENATOR SCHUMACHER: To what extent would you like to ask for something and then, as you just mentioned, think this will never fly and never relay that need up because of a predetermined "this will never fly"? [LR34]

RANDY KOHL: Well, the decision was made at the time to, in other words, apparently there was discussion much higher than I am regarding that projected plan at the time and it was determined that, by the budget folks, and I can't tell you who those are because I don't know, that it was not going to. And so an alternative plan was submitted which did pass at that point. [LR34]

SENATOR SCHUMACHER: It looks like it's become...the system makes it much too easy for the Legislature to push the button for green, let's cut taxes, and maybe not even realizing that there was a prior discussion saying, you know, we really could use some extra space, personnel, and money. So how do we short-circuit that so that the Appropriations Committee and the Legislature knows that there's real controversy behind the recommendation of "we don't need any money and we should cut taxes"? [LR34]

RANDY KOHL: I don't know how you would circumvent that. [LR34]

SENATOR SCHUMACHER: I don't know, so I'm just asking. [LR34]

RANDY KOHL: No, but I...(laugh) I know I wish I had the answer for that. But again, I'm not sure how that can be done. Certainly, as you are aware, or maybe you're not aware, there's certainly a plan for additional treatment facilities. But again, these have high-ticket items. These are not extra beds in Corrections. These are, you know, they don't count as beds because they're not permanent for folks. [LR34]

SENATOR SCHUMACHER: So what if the Appropriations Committee would say, hey, Doctor, come talk to us about our situation whether or not there are things you think are needed that aren't appearing in this budget request? Would you have felt free to talk to that group of senators and say, look it, this is what I think are needed, this is where we're running into trouble? Or is there an institutional discipline that says, no, no, you go...if you can't get your signal through going up the normal chain of command, you keep your mouth shut? [LR34]

RANDY KOHL: I was never told that, but I was never asked by the Appropriations Committee either, I mean, when I worked in Corrections. I remember with Director Clarke I did appear before the Appropriations Committee when I first started the position, at that time, but I had not been before the Appropriations Committee since then. [LR34]

SENATOR SCHUMACHER: So as we're trying to struggle here to try to...how do we avoid what we...what has become, over the last 15 years or so, a real problem. Should we be reaching out either with the Appropriations Committee or committees like this direct to the front-line people, bypassing the normal chain of command in the budget process through the executive branch, to ask folks like you where are we going wrong, where are we doing right, what money you need, so that we get some balance? Otherwise, it's...for those of us not on Appropriations, for example, it's awful easy just to press the green button on the budget and not know that we may be screwing up. Should we be reaching out then? [LR34]

RANDY KOHL: If that's possible, I think it may be a good idea. [LR34]

SENATOR SCHUMACHER: Thank you. [LR34]

SENATOR PANSING BROOKS: Okay. I'm going to just say... [LR34]

STEVE LATHROP: Can I ask just one, one question, just one follow-up? [LR34]

SENATOR PANSING BROOKS: Sure. [LR34]

STEVE LATHROP: You said that during the budget crunches, I think was the term you used, for the times when we were low on money and we were trying to find savings, that you had positions that were previously in the Department of Corrections under your healthcare that were previously funded and they went away. Are they part of the vacancies that you've described, or are the vacancies positions that are empty after we eliminated a bunch of positions back in the budget crunch? [LR34]

RANDY KOHL: And, no, they are not part of vacancies because we didn't get those positions back. [LR34]

STEVE LATHROP: So, yeah, okay, so when we talk about what do you really need, you actually had a time when you had more people than the vacancies, but we don't count them any longer as vacancies because they were completely eliminated back, oh, five years ago or something like that. Is that true? [LR34]

RANDY KOHL: Yeah, those positions don't exist. [LR34]

STEVE LATHROP: Okay. They weren't fluff back then, however, would you agree with that? In other words, they were people that were doing things, performing functions and providing healthcare either of one kind or another, maybe substance abuse. [LR34]

RANDY KOHL: At that time it was specifically substance abuse, yes, the treatment... [LR34]

STEVE LATHROP: Okay, so when we look at the shortages, and I thought I saw something where we're short eight people in chemical dependency right now, does that sound right? [LR34]

RANDY KOHL: That could be true. [LR34]

STEVE LATHROP: Yeah. That's eight people after we cut how many positions? [LR34]

RANDY KOHL: I think it was six if I recall. [LR34]

STEVE LATHROP: So if we were trying to look for what do we need to do to be fully staffed, it would be the eight vacancies, and would we add the six positions that were eliminated during the last recession? [LR34]

RANDY KOHL: I would say so, if we were going to continue on the plan that we had at that time. [LR34]

STEVE LATHROP: Okay. Thank you. [LR34]

SENATOR PANSING BROOKS: Thank you. And I think we're going to take a break after I ask some...a couple questions too. And then we'll ask Director Frakes to start right at 1:00. And I know some...there's a hearing going on so some of us have to scoot out. But thank you for coming and testifying on all this, Dr. Kohl. Just switching things a little bit, I wanted to ask your opinion on the privatization of medical care at TSCI. I understand that we're privatizing some of that, and what's your thought on that about the state giving up that? [LR34]

RANDY KOHL: I have been involved with the Coalition for Correctional Health Authorities for like ten years now, which is where the...all the health authorities of all the DOCs across the country, including the major jails such as L.A. County, Chicago, Bureau of Prisons also involved. And so that discussion has occurred with some of my colleagues at that level. Some of the states have privatization going on; others have gone to privatization and wish they never had. But to go back is extremely difficult. Essentially, when you put bids out for privatization, they come in with a loss leader and then the dollars go up because the increases over the next few years, and you have no control of that. At Tecumseh, when I came on board, that was already arranged, that contract was in place. Again, Tecumseh opened the same year I started, because I actually took

my wife there on a tour. I made the mistake of doing that on my 30th anniversary, however (laughter). [LR34]

SENATOR PANSING BROOKS: Oh, wow! [LR34]

RANDY KOHL: You're never too old to learn. Anyway, so from a privatization standpoint, I have not been in favor of it because over the years, again prior to CCS, I have found that there were instances where care was not provided and it should not have been. In other words, you would treat one cataract in one eye, but it wasn't...you know, since you had one good eye, you don't need the other one. That's where I had discussions with the national medical director at the time and said this is not the community standard of care. I said the community standard of care in Nebraska is you do both eyes. And so they ended up doing that. The other issue is they were not following our formulary and so essentially we circumvented that by placing all the medication with DCS through a centralized pharmacy so that they can no longer use medications as a cost savings or moneymaking project. I have to admit CCS was far better than the prior company. The difficulty I would have in staffing Tecumseh is its location and being able to get people...I can't pay people well enough to provide care there, particularly in the nursing area. But I have been opposed to privatization for those various reasons. I think the quality of care is not always as good as can be provided by the public sector. You need people on board that actually want to care for the patient and are not concerned of what the cost is. And if you've got somebody that's providing it for cost, the only way you can make money is to cut somewhere. And again, I don't know whether or not that's something the state is looking at for Corrections. I can just say that some of my colleagues have been burned in the process. But again, as we were talking earlier regarding wages, that would come a long ways in helping. But again, you need somebody out there beating the bushes, colleague to colleague, to hire these people on board. That's extremely important. Dr. Hustad, if you didn't know, he was chief of staff of Bryan Medical Center for two years and was chief of staff, so obviously we've got some quality people that we've got on board. But we didn't get those overnight. We didn't have quality back in the early part of the century, so I think it's come a long way getting those people on board. And by the way, we...they also...I interviewed last week a potential person for my position. I don't know the outcome of that but I was recruiting while I was at the CCHA meeting. Dr. Deol in Iowa was actually interviewed here last week. So again, I don't know the outcome on that. [LR34]

SENATOR PANSING BROOKS: That leads to another question but I just want to again say, so with the privatization, do you believe that you lose control in the state, state control of what's...of the medical care of people or what's your thought on that? [LR34]

RANDY KOHL: I think it takes... [LR34]

SENATOR PANSING BROOKS: It seems like it to me but... [LR34]

RANDY KOHL: ...close scrutiny by the medical director and perhaps some delegation there for the contract monitoring, which is in place, but again, how active that is at present time is...I question. [LR34]

SENATOR PANSING BROOKS: Okay, thank you. So then I guess I'll jump to I had...I did have a question regarding your replacement. So somebody was interviewed last week. You were not in that. Are you participating at all in attempting to find your replacement or have we passed the time... [LR34]

RANDY KOHL: Other than I've known this individual for the ten years I've been with the CCHA and I was at a meeting. ACA would not pay for anybody else to go but me, it's by invitation only. [LR34]

SENATOR PANSING BROOKS: Okay. [LR34]

RANDY KOHL: So even though I was leaving shortly, I still went. I brought back much good material that will be actually circulating at Corrections from this meeting. The things that we have issues with, they have issues with all the other DOCs. So we're not alone. Anyway, but while I was there, Dr. Deol and I had breakfast and again chatted. And by the time...before I even left D.C., he had sent me a CV to my telephone. So I had the guy interested at that time. [LR34]

SENATOR PANSING BROOKS: Okay. And have you been asked and/or are you willing to participate in transition with the new medical director? [LR34]

RANDY KOHL: That's one of the things that was very important to him. I told him, if he did indeed get the position, and, matter of fact, I think I've told Director Frakes that, whoever gets the position, I am willing to provide any historical information and will be at their access, telephone, e-mail. I'm willing to do that because I want my staff to have the support they need. I hated leaving my staff. Of everything in Corrections, my staff are the most important thing, so I will do anything I can to provide support. [LR34]

SENATOR PANSING BROOKS: And has that offer been met with a positive reception? People said, great, we'll hope to use you? [LR34]

RANDY KOHL: Yes, yes. [LR34]

SENATOR PANSING BROOKS: Okay, great. [LR34]

RANDY KOHL: Matter of fact, I received that positive feedback from Director Frakes and certainly from Dr. Deol. [LR34]

SENATOR PANSING BROOKS: Great, thank you. And also, just as a final question, how does Dr. Wetzel's leaving affect psychiatric care at the Department of Corrections, in your opinion? [LR34]

RANDY KOHL: I think Dr. Wetzel is a great loss. I was quite surprised when he informed me. I think that certainly as far as the psychiatric care in the unit, we've been in those situations before where we've had to fill in with agency-provided psychiatric care, which is psychiatric care but it's not the commitment that we had from Dr. Wetzel. He will be sorely missed without a doubt. We still have Dr. Baker on board as a public employee. We're using telepsych extensively. [LR34]

SENATOR PANSING BROOKS: With whom? [LR34]

RANDY KOHL: Pardon? [LR34]

SENATOR PANSING BROOKS: With whom? [LR34]

RANDY KOHL: With Premier is...I'm not sure. The only name I know: Premier. Their services have been utilized extensively in many of the facilities. I think that replacing Dr. Wetzel will not be easy because of the shortage nationwide of psychiatry. Psychiatrists are...they've always been down at the bottom of the heap with family physicians, but right now they're the top of the four bottom ones because of the national shortage. And so telepsych is important at this point in time. We also have a number of contracted midlevel practitioners, APRNs, if you will, that are psychiatrically trained that are working with us. Those are also important. [LR34]

SENATOR PANSING BROOKS: Psychiatric nurse practitioners, is that what... [LR34]

RANDY KOHL: Yes, correct. [LR34]

SENATOR PANSING BROOKS: Okay. Well, thank you very much for your time. Thank you for your service to the Department of Corrections and the state of Nebraska. And we're very, very grateful that you were willing to come today. Thank you. [LR34]

RANDY KOHL: Not a problem. [LR34]

SENATOR PANSING BROOKS: And now we will adjourn till 1:00. I'm sorry, Director Frakes, it just...everything ran over, so thank you for being willing to come back. And with that, we'll be in recess. [LR34]

RECESS

SENATOR SEILER: All right, we'll start this session. Senator...the Vice Chair has become ill and so you're stuck with me this afternoon. And, Senator...Director Frakes, you ready to go? Okay. Do you have preliminary comments? [LR34]

SCOTT FRAKES: I do. [LR34]

SENATOR SEILER: Okay. [LR34]

SCOTT FRAKES: (Exhibit __) I have to change them slightly, though, because it was moved from morning to afternoon and a different Chair. So, good afternoon, Senator Seiler, members of the LR34 Committee. My name is Scott Frakes, F-r-a-k-e-s, and I am the director of the Nebraska Department of Correctional Services. My understanding is the topic for today's hearing is behavioral health and restrictive housing. Dr. Kohl and Dr. Mitwaruciu are addressing behavioral health. I will be discussing the restrictive housing reforms we currently have underway, the progress that has been made to date, and the work yet to be completed. I will take a moment to publicly thank Dr. Randy Kohl for his years of service and the excellent leadership he has provided in his role as the NDCS medical director. He is already missed. I provided the committee copies of the long-term plan for the use of restrictive housing which was submitted to the Governor and Legislature on June 30, 2016, and the first NDCS annual restrictive housing report which was filed on September 15, 2016. Together these documents outline the philosophy behind our restrictive housing reform, describe the reforms currently in progress, and provide statistical information on the use of restrictive housing within NDCS and the characteristics of individuals placed in restrictive housing over the last year. Our restrictive philosophy: The reform of restrictive housing within NDCS was something I intended to pursue when arrived in February of 2015, based on my experience in changing the use of restrictive housing in Washington and the benefits I knew it could and would provide. My philosophy surrounding the use of restrictive housing is simple: Restrictive housing should be used to manage risk, not as punishment. People will be housed in the least restrictive environment that is safe for all. Access must be provided to mental health treatment and cognitive interventions to help inmates change their behavior and reduce their risk. Behavior and programming plans must be developed for each inmate to provide clear direction on how to change their behavior and to transition out of restrictive housing. There must be a review process outside of the institution which confirms the initial placement was justified and continued placement is necessary. The best reform of restrictive housing is reducing the need for restrictive housing by improving the quality of life within prisons and reducing inmate idleness. Lastly, there are a small number of seriously mentally ill inmates whose behavior present a high risk to others and who need secure mental health treatment. By allocating a significant amount of treatment resources for these inmates housed in a high-security setting, it is possible to safely transition many to less restrictive

settings. Policy changes implementation to date. The least restrictive environment standard: NDCS adopted a new standard for keeping inmates in restrictive housing as part of Title 72, Chapter 1, rules and regulations which went into effect on July 1, 2016, as required by LB598. The least restrictive environment standard requires an individualized assessment of the risk presented by each inmate in restrictive housing and a determination that there is no less-restrictive environment that the inmate could safely be housed in or could be safely housed in. The inmate's risk is reviewed by the facility warden within 24 hours, again at 15 days, and, if necessary, again at 30 days. Inmates assigned to longer term restrictive housing are reviewed at least every 90 days by the Central Office Multidisciplinary Review Team, the MDRT. As director, I am personally involved in the review of inmates who have been held in longer term restrictive housing for more than one year and I respond to all written appeals of assignment to longer term restrictive housing. As of October 1, 2016, there were 22 inmates in longer term restrictive housing who had been there for more than 365 days, and of those 22 inmates, 14 are currently housed in the secure mental health unit at Lincoln Correctional Center. The Central Office review of restrictive housing placements: The Central Office MDRT has been in place since July 1, 2016, under the leadership of deputy Director Sabatka-Rine. The MDRT makes all assignments to longer term restrictive housing. The MDRT reviews all inmates held in longer term restrictive housing at least every 90 days, and every 30 days for those who have been in restrictive housing for one year of more. From July 1 through the end of August, the MDRT reviewed 254 referrals from the institutions for restrictive housing placements or removals. Of those reviewed, 60.6 percent were placed on longer term restrictive housing, 35.4 percent were removed from restrictive housing and placed in a less-restrictive housing environment, and 3.9 percent were continued on longer term restrictive housing as they continue to pose a threat to the safety of staff, other inmates, or the facility. Creation of protective management and the elimination of protective custody as a housing classification: In the fall of 2015 we began transitioning a living unit at TSCI into a protective management unit which operates similarly to general population in terms of out-of-cell time and access to activities. This allows inmates with protective custody status to participate in congregate activities and programming that are not available to inmates in restrictive housing. There's also a 64-bed protective management unit operated LCC. This change has contributed to significantly reducing the restrictive housing population from 630 inmates in July of 2015 to 324 inmates as of October 6, 2016. And actually yesterday we were down to 315. Mission-specific housing: Protective management is one

example of our efforts to reduce the need for restrictive housing through the creation of mission-specific housing units. The concept is to place inmates who share similar interests or characteristics or needs, such as veterans or inmates with physical limitations, into a single housing unit where they can live together. Mission-specific housing allows us to focus resources for inmates with specific needs more efficiently and also reduces conflict by allowing inmates who may be vulnerable in general population to live together in a safe environment. Protective management, active senior living units, and the veterans' unit, which is currently being developed at the Nebraska State Penitentiary, are examples of mission-specific housing that we have or that we plan to expand in other facilities. The elimination of disciplinary segregation: The fourth major reform to restrictive housing is the elimination of disciplinary segregation. As of July 5, restrictive housing is no longer used as punishment for institutional misconduct. Inmates who pose a risk to others by their actions are placed in restrictive housing. The placement and its duration will be based upon the continued risk posed by the inmate and the progress made in changing his or her behavior. Placement is not an arbitrary length of time for the purpose of punishment. Data collection: As indicated in our annual report, our historical data on restrictive housing is inadequate. We have developed a more robust tracking system as part of the reform process and will be automating these changes as quickly as possible. We've made so many changes to our restrictive housing policy, such as the elimination of disciplinary segregation, that making comparisons to historical data is difficult. With our improved data collection processes, consistent measurements, we are building usable data that will accurately inform our work. The new restrictive housing policies have been in effect for three months. We're making good progress on utilizing the new restrictive housing procedures, including the development of behavior plans and regular review of restrictive housing placements by the Central Office MDRT. They meet every Thursday. We are slowly expanding programming options within restrictive housing where we are currently offering METEOR, the transformation project, GED classes, and a trauma-based, peer support-led class called WRAP, Wellness Recovery Action Plan. And these are not occurring at all restrictive housing locations. We are also...at this point. We are also developing incentives for positive inmate behavior. We will continue to implement and refine the policies established as part of LB598 and codified in the Title 72, Chapter 1 restrictive housing rules and regulations. The long-term restrictive housing work group continues to meet and will be involved in the review of existing rules and suggestions for changes and improvements based upon what we learn in the months ahead. I'm committed to making revisions to the rules and

regulations based upon the data and feedback we gather during this implementation phase. I look forward to coming back before this group to share the successes and challenges after the first year of implementation. Thank you for this opportunity to testify. [LR34]

SENATOR SEILER: Would you like to add any further remarks? [LR34]

SCOTT FRAKES: I'm ready to answer questions. [LR34]

SENATOR SEILER: Okay. Questions? Bob? Or, excuse me, Steve. [LR34]

STEVE LATHROP: Yeah, Steve. Director Frakes, thanks for being here this afternoon. I do want to ask some questions about restrictive housing. And we kind of, by agreement, were going to talk about mental health with the witnesses that follow and direct most of my remarks or questions to you about restrictive housing, right? And so you read some of the reforms that have been undertaken since...some of these were begun before LB598. Would that be right? [LR34]

SCOTT FRAKES: We were thinking about, discussing, beginning to work on, such as the idea of protective management. [LR34]

STEVE LATHROP: Okay, and... [LR34]

SCOTT FRAKES: Not...I wouldn't say before LB598 was passed but before it became effective in August 29 of '15. [LR34]

STEVE LATHROP: Okay. And so when did all these changes take place with respect to restrictive housing in response to LB598? [LR34]

SCOTT FRAKES: Okay. The promulgation and the administrative regulations connected to the promulgation of rules and regulations went into effect July 1, 2016. [LR34]

STEVE LATHROP: So those would be the regulations that we...I don't know. Were you watching Mr. Moreland testify this morning? [LR34]

SCOTT FRAKES: Some of it, yes. [LR34]

STEVE LATHROP: You heard him talking about the regulations? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: The criteria and the due process and that sort of thing? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: Okay. Those were promulgated over the last year and went into effect in July of this year. [LR34]

SCOTT FRAKES: The promulgation process was completed and final signature by the Governor was June 15 and then effective July 1. [LR34]

STEVE LATHROP: Okay. When did you...so restrictive housing used to encompass those people that are in protective housing. Is that true? [LR34]

SCOTT FRAKES: It did. [LR34]

STEVE LATHROP: And it sounds like, from your introductory remarks, that you've split those up, that the protective housing people--and I'm thinking back to two years ago when we talked about protective housing--those people were basically confined like someone who had been put into restrictive housing. [LR34]

SCOTT FRAKES: That is correct. [LR34]

STEVE LATHROP: They had very limited out-of-cell time. [LR34]

SCOTT FRAKES: Correct. [LR34]

STEVE LATHROP: And their purpose in being in protective custody may have something to do with if somebody in general population wants to hurt them or if they have a reason where they want to be segregated from the general population. [LR34]

SCOTT FRAKES: Correct. [LR34]

STEVE LATHROP: Right? And so how many, before you made that separation, how many restrictive housing beds, if you will, or units did you have? I guess beds is the right word. [LR34]

SCOTT FRAKES: More than 630. [LR34]

STEVE LATHROP: And how many did you turn into protective custody? [LR34]

SCOTT FRAKES: We have 430, roughly 438 that are dedicated to protective management. Protective management is the name of the living unit. Protective custody is still a status. An inmate will request protective custody or we'll determine that we believe there's a need for protective custody based on information we have. More often it's the inmate, though, that requests it. [LR34]

STEVE LATHROP: Okay. So in terms of reforms with respect to restrictive housing, that's a significant step forward, right? [LR34]

SCOTT FRAKES: I feel it's very significant. [LR34]

STEVE LATHROP: Right. Treating people who need to be protected from somebody in the population like they were tied up for 24 hours, 23 or 24 hours a day really gave somebody no...a difficult choice to make, right? [LR34]

SCOTT FRAKES: Absolutely did. [LR34]

STEVE LATHROP: I can be protected from people in the yard, but my choice is to go spend 23 hours a day in a cell. [LR34]

SCOTT FRAKES: Sacrifice most of my freedom, yes. [LR34]

STEVE LATHROP: Right. And so a significant portion of that population, almost two-thirds, you turned into a housing unit where these people and live, not exactly like the general population but more so. [LR34]

SCOTT FRAKES: Two living units, but yes. [LR34]

STEVE LATHROP: Two living units. Do they have access to the same programming and mental healthcare that someone in the general population does? [LR34]

SCOTT FRAKES: They all have access to the same level of mental healthcare. They...and in the fact the unit at LCC probably has an advantage because it is located right there with the residential mental health program so there are additional mental health resources in that facility that help with that entire population. They have access to some but not all of the programming that's currently available in population. [LR34]

STEVE LATHROP: So let me stop you there,... [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: ...not to interrupt you but to maybe ask a question. So if somebody elects to go into protective housing and go into this unit, are they going to have access to those core programs that are required for them to become parole eligible or are they at a disadvantage in terms of checking those boxes before they get to the Parole Board? [LR34]

SCOTT FRAKES: Today we have a substance abuse treatment at Tecumseh for protective management and we have sex offender treatment available at LCC. The piece that we have not addressed for protective management is violence. And I couldn't tell you how many of those have a clinical assessment for clinical level violence programming, but that's one piece we don't have addressed yet. [LR34]

STEVE LATHROP: If...do you move these guys around? So if somebody needs the sex offender programming but he's in the wrong protective custody unit, do you move him to the place where they're offering that he can get that programming? [LR34]

SCOTT FRAKES: If it's at all possible, yes. [LR34]

STEVE LATHROP: And of the people that are in protective custody, can you tell us how many of those as a percentage of the population of 630...I assume those are full, right? The 630, those rooms or cells or beds are full in protective custody? [LR34]

SCOTT FRAKES: No, in protective management, today we've got about 430, 440 beds dedicated to protective management. The 630 was... [LR34]

STEVE LATHROP: Oh, I'm sorry. Right. [LR34]

SCOTT FRAKES: Yeah, that's last year's number of who was in restrictive housing. Yes, well, that's a balance. Today they're close to full. They're not...when I checked yesterday I think we had about 50 empty beds between the two locations. So we're always watching that. My preference would be that we only needed 100 beds for the entire system. That would be a good indication of health. So if we dropped down to where we only need 350 beds then we'll look at options. The living unit at Tecumseh is divided into six galleries, or I call them pods. And it gives us all kinds of flexibility. Until a few months ago...it's been more than six months ago, we had the active seniors unit in one section. Prior to that, that section was where we housed the inmates that were sentenced to death. And it's had other purposes. So today we're at a point where we'll be watching closely to see could we, you know, do we need all of those beds dedicated to protective management or is there another part of the population? And then of course you have to make sure you house the appropriate population because of the whole protective management piece. [LR34]

STEVE LATHROP: You don't want the guy they're afraid of in the... [LR34]

SCOTT FRAKES: Correct. [LR34]

STEVE LATHROP: ...same unit. So going back to the to the 438...is it proper to call them beds? [LR34]

SCOTT FRAKES: Um-hum, yes. [LR34]

STEVE LATHROP: Okay, 438 beds that are for protective management, you said that they don't have access to violence reduction programming? [LR34]

SCOTT FRAKES: Not at this time. [LR34]

STEVE LATHROP: And that's a pretty common program for people to be required to have completed before they can be paroled. Am I right? [LR34]

SCOTT FRAKES: I'm trying to remember what the wait list is right now. I want to say the wait is...well, I'm not going to try and guess of the top of my head. In terms of assessed need, I would say it's substance abuse, sex offender treatment, violence reduction. But there is a need and I have no doubt that there's a need within protective management just like there was a need for substance abuse treatment which we finally met at the beginning of this year by establishing the unit, the program at Tecumseh. [LR34]

STEVE LATHROP: In one of the protective units. So what's a person do or what's your plan with respect to allowing or making available the violence reduction program to people in a protective housing unit? [LR34]

SCOTT FRAKES: Well, we've got training scheduled for this month so we'll have additional people that will be trained to facilitate. And that's a clinical program so it requires clinicians to facilitate the program. And then we're going to see where our greatest need is at Tecumseh. We'll look at parole eligibility dates. We'll look at TRDs. We'll look at the wait list and we'll make some decisions about what's our capacity to deliver, where is the greatest need, and move forward. So I'm not going to tell you right now that I know I'm going to fix that problem starting in December. It's on my radar, as is about 250 other things. [LR34]

STEVE LATHROP: I'm getting that sense, that you probably have a lot of things that you're trying to implement at the same time or that there's only so many things you can implement at one time but that, as we discussed previously, the idea that people are parole ready by their parole eligibility dates, kind of a big consideration in terms of ever getting ahead of the overcrowding and alleviating that overcrowding problem that you have. [LR34]

SCOTT FRAKES: It represents about a third of the beds that we expect to ultimately save, reduce, whatever the right term would be, through the JRI work. So one other piece of addressing this need in protective management is our ongoing efforts to reduce the need for protective management. If we can identify and resolve the issues that lead people to seek out protective custody... [LR34]

STEVE LATHROP: Yeah, tell us what you think those are? Why are people...I can only imagine, all I have to do is watch some of that Locked Up on TV and I'd probably be asking for protective management on my first day. But what is it that's driving people to request the protective management? [LR34]

SCOTT FRAKES: It is a host of issues. It is people that have testified against others in court cases. It is people that had issues with others in the community before they came to prison. It is conflict between security threat groups, people that identify with security threat groups. It is people that see it as their mission to decide what the pecking order should be within a prison and, based on your crime, decides whether or not you should have freedom of movement. Sex offenders are often a target. But there's a whole litany of how people value themselves and see themselves in relation to others. [LR34]

STEVE LATHROP: So how much of that are you ever going to have control over? [LR34]

SCOTT FRAKES: I can't... [LR34]

STEVE LATHROP: You said we hope to get to a point where we never need it or we can reduce the number of beds. Is it practical or is there a way for you to do that? [LR34]

SCOTT FRAKES: Mission-specific housing absolutely will help with that process. You provide living areas where people can live together and cooperate with each other and coexist peacefully, you definitely reduce it. If we get the most vulnerable population besides our seriously mentally ill into the mission-specific housing, we will impact that issue. We won't eliminate it. We're not going to eliminate those issues that come from the community and we're not going to eliminate just some of the variety of human behavior. We can certainly reduce. Our protective management population is bigger than it should be for the size of our system. I would easily say we should be at least 100 inmates less in terms of being able to look and say we're headed the right direction. [LR34]

STEVE LATHROP: Okay. I would suspect that as you allow them more out-of-cell time that it gets easier to ask for. The protective...to go into the protective management unit you no longer have to decide between 23 hours a day in your cell. So are you always going to have more people going, yeah, I don't want the...I don't want to deal with this out in the general population? [LR34]

SCOTT FRAKES: That's a potential outcome. At the same time, there's a stigma that's associated. So for many that's a very difficult decision to make. And again, if we provide other alternatives that people view as being just as safe and maybe even healthier and a more pleasant place to live then they're going to opt for those things. So that's where like the active seniors unit that we have, the people that are over 50 years of age, behaving well, get along with each other, we have almost no issues in that unit. I'm one of them so (laugh) we're in there. [LR34]

STEVE LATHROP: Active seniors? [LR34]

SCOTT FRAKES: Yeah, active because that's different... [LR34]

STEVE LATHROP: Over 50? [LR34]

SCOTT FRAKES: That's different than our...well, so for the inmate population, 50 is the new 70... [LR34]

STEVE LATHROP: Wow. [LR34]

SCOTT FRAKES: ...because people in prison, in general, don't take as good of care of themselves. They have a lot more health issues. So somebody 55 and doing time in prison is probably chronologically closer to somebody 65 or older in the community. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: And then we have the living unit at NSP that is for those that are...it's not a geriatrics unit but it's somewhere between. They can still take care of most of their activities of daily living but not all. So we have some healthcare porters that are assigned to help them. And often they have mobility issues are other things. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: And then at some point as we continue to build this system, we will have geriatric space. We're just not there yet. [LR34]

STEVE LATHROP: I want to have a visit about LB598. So the Legislature does its policymaking attempt to make a change to restrictive housing and sort of how you run your railroad over there with respect to restrictive housing. And basically, it was a mandate to have the inmates in the least restrictive environment. [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: Is that right? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: That's certainly been your interpretation, and to enact regulations with respect to the use of restrictive housing, right? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: And we say housing and just so that--people that might be watching this--they're not living off site and then they don't have a house, right? It's restrictive confinement, right, they're in a cell when we're talking about restrictive confinement? [LR34]

SCOTT FRAKES: Okay. Although pretty much everyone is in some level of confinement. [LR34]

STEVE LATHROP: Right. And those regulations were promulgated. I want to go into Marshall Lux's memo and I'm sure you had a chance to read that, his concerns about... [LR34]

SCOTT FRAKES: No. [LR34]

STEVE LATHROP: Okay, well, then I'll share them with you. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: So the department goes through the Administrative Procedure Act to develop regulations with respect to when are we going to use restrictive housing, under what circumstances, okay? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: And the Ombudsman, Marshall Lux, did a memo. I think it's dated October 7 so maybe you haven't had a chance to see it. [LR34]

SCOTT FRAKES: It hasn't come to me yet. [LR34]

STEVE LATHROP: It's in that book. And since we're going to talk about it, it's at page 126. Okay? Let me maybe share with you want his take was, that when the regulations were promulgated that the Ombudsman's Office expressed concern about a couple of things: One was

the standards used to determine who goes into restrictive housing and the second was their concern about due process. And as I read his memo and understood the topic, basically when you enacted these or when you promulgated these regulations and after all the hearings and things that you go through, that the American Bar Association had provided five criteria for the use of restrictive housing. [LR34]

SCOTT FRAKES: Actually there's five and then there's a sixth addition described in this document that was provided to me by Jerall Moreland on March 30 of this year. [LR34]

STEVE LATHROP: A sixth that's in the ABA or that you employed? [LR34]

SCOTT FRAKES: It's in the ABA that we... [LR34]

STEVE LATHROP: Okay. Well, I will share with you that when...in the Ombudsman's addressing this on page 127, in the middle of that page it says the ABA standards on treatment for prisoners addresses the issue by limiting the assignment to administrative segregation to these cases involving...and then it lists them. [LR34]

SCOTT FRAKES: Um-hum. [LR34]

STEVE LATHROP: And if as I understand their concern, it lists five criteria. And you're telling me there's a sixth? [LR34]

SCOTT FRAKES: Yeah. [LR34]

STEVE LATHROP: Okay. Is that a new version of the ABA or an old version? [LR34]

SCOTT FRAKES: I don't know. It was sent to me by Jerall for a conversation when I met with Jerall, James, and Doug Koebernick and we spent about three hours walking through these and came to almost full agreement, almost. [LR34]

STEVE LATHROP: Except for the sixth one. [LR34]

SCOTT FRAKES: Except for the...that I be the one that reviews those that are placed under the sixth criteria. [LR34]

STEVE LATHROP: Right. [LR34]

SCOTT FRAKES: That was the only difference. [LR34]

STEVE LATHROP: I'm going to tell you what this memo suggests and you can tell me if it's wrong, that the ABA has five criteria and that when we went through the regulatory process, this Administrative Procedure Act, that the state, Nebraska, added a sixth criteria which is: those whose presence in the general population would create a significant risk of physical harm to staff, themselves, or other inmates. [LR34]

SCOTT FRAKES: And I will tell you that this document was submitted to me by Jerall Moreland, March 30, 2016. We can provide the e-mail and the document. And it to lists, in addition, inmates whose presence in the general population would create a significant risk of physical harm to staff or other inmates may be assigned a segregated status but only with the personal action and approval of the director. So that was the sixth criteria that's identified. It references...I don't know what...if this document is a revised version of the ABA. It references the ABA standards at the top and a variety of other things. But again, this was provided... [LR34]

STEVE LATHROP: I haven't seen it so I don't know what he submitted to you or where it came from or whether it reflects the American Bar Association Standards. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: The standards that were provided by...on page 129 are the American Bar Association standards. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: Right? And they list the five things that you've talked about. [LR34]

SCOTT FRAKES: That's correct. [LR34]

STEVE LATHROP: And then we have the, when the presence would create a significant risk of physical harm to staff, themselves, or other inmates. [LR34]

SCOTT FRAKES: Um-hum. [LR34]

STEVE LATHROP: Tell us why that was added to the five criteria that basically are mirrored in the ABA standard. [LR34]

SCOTT FRAKES: Okay. We had a workshop meetings. James Davis was a member...is a member of the work group, the external work group. Jerall Moreland, Doug Koebernick, ACLU, members of the community come regularly. I chose to run that work group. It's an open meeting, so it's an Open Meeting Act, but I chose if people wanted to be at the table and be part of the conversation they were welcome to be. So engagement included the committee members as well as others as we were putting together the initial drafts and moving towards what would then be taken forward for promulgation. There was a request for a meeting...or I don't remember if there was a request. I think I actually said why don't we get together and talk. So we scheduled a meeting with Jerall Moreland, James Davis, Doug Koebernick, myself, pardon me, Jeff Beaty, can't remember if there was anyone else in the room. Once again, this document was submitted to us prior to the meeting by Jerall Moreland. It captures the five specific things in the ABA standards. And then again, then it says--this document came from them to me--it says exactly that. In addition, inmates whose presence in the general population who commit a...create a significant risk of physical harm to staff or other inmates may be assigned but only by my approval. And that was the point of discussion. We went back and forth. I was not willing to include the language that said I would be the one that had to approve initial placement in segregation if they used this as their reason for placement because it just wasn't...just doesn't makes sense. There's no way that I could physically go do what should occur, what I expect the wardens to do, to actually review the documents, in some cases meet with the inmate and make an assessment. [LR34]

STEVE LATHROP: So I wasn't at any of these things, right? [LR34]

SCOTT FRAKES: Right. [LR34]

STEVE LATHROP: So when this meeting takes place, was this the first time you had an opportunity to visit with any of the folks from the Ombudsman Office about the criteria? [LR34]

SCOTT FRAKES: I can't remember if we had conversation. I think there was some conversation in a work group meeting about the ABA criteria, but then this meeting was where we really sat down and walk through it and talked about it. [LR34]

STEVE LATHROP: See, what I can't tell...and maybe I'll just put it this way--what I can't tell is whether they said, okay, if you're going to stick in the sixth criteria then we might be okay with it if you're the one that approves people that go into restrictive housing under the sixth. In other words, were they asking for the sixth criteria or were you telling them the sixth criteria is going to be added and they were advocating for your review of those placements? [LR34]

SCOTT FRAKES: Okay. No, initially I was reluctant to put specific criteria. So after conversation I agreed the criteria did make sense. They provided it. I didn't bring this to them; they brought it to me. [LR34]

STEVE LATHROP: Okay. Well, in any case, when they brought it to you, it involved you making a determination that the more subjective standard, which is standard number six, right, the one that differs from the ABA standard, that that would require your approval? [LR34]

SCOTT FRAKES: That's correct. [LR34]

STEVE LATHROP: And when the regulations were ultimately promulgated, the sixth criteria--and by that I mean the five ABA criteria that are, we can agree, pretty much objective criteria. [LR34]

SCOTT FRAKES: Well, pretty objective. [LR34]

STEVE LATHROP: So, history of serious violent behavior in corrections facilities is something that you can get testimony on, have facts on, right? [LR34]

SCOTT FRAKES: Agree, agree. Yep. [LR34]

STEVE LATHROP: And membership in a security threat group, for example. [LR34]

SCOTT FRAKES: That gets a little squishier. Three can get a little bit squishier. But in general, there are more objective criteria here than there would be in that sixth catchall. Yeah. [LR34]

STEVE LATHROP: Right. And you used the term that I wrote down last night when I was looking at this. It's a catchall which really involves the use of a criteria that is subjective: I think he poses a risk, so I'm going to put him in restricted housing. [LR34]

SCOTT FRAKES: Correct. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: Because we have a duty to protect. [LR34]

STEVE LATHROP: No question. No question, a duty to the security staff there and to the other inmates, but we can agree it's a subjective standard. [LR34]

SCOTT FRAKES: More so than the other ones, yes. [LR34]

STEVE LATHROP: Okay. So is there any criteria or any standard for who meets that bill, that sixth criteria? Any process for that? [LR34]

SCOTT FRAKES: In terms of a risk assessment tool, no. In terms of some formalized criteria worksheet, I think...no, I would say that would be wrong. At least we discussed a worksheet but I don't know whether or not we're there with that piece. So... [LR34]

STEVE LATHROP: You don't have any... [LR34]

SCOTT FRAKES: ...it is based on the evidence that's available or sometimes the lack of information because sometimes you have a threat but you don't have credible evidence but to ignore the threat may then lead to a failure to protect. So some of your shift lieutenants are faced with some very difficult decisions around that. [LR34]

STEVE LATHROP: Who's making the call, Director? [LR34]

SCOTT FRAKES: Initially... [LR34]

STEVE LATHROP: If...let's take any one of your institutions. Who's making the call to put people in restrictive housing using the subjective criteria found in your regulation number six? [LR34]

SCOTT FRAKES: So using any of the criteria, it would be a shift commander normally would be the initial approver of a placement. And within 24 hours, the warden of the facility reviews and determines whether or not the person should remain in restrictive housing. If they are under 19, I believe is the age, or if they're pregnant that has to happen within eight hours. [LR34]

STEVE LATHROP: Okay. So how long can somebody stay in there under a criteria number six before somebody makes a judgment that they should be released or kept there? Or is there any review process? [LR34]

SCOTT FRAKES: There is. There's a review at 15 days. There's a review at 30 days. The warden and his classification team are involved in that. At the 30-day mark, if a decision has not been made far as what the next...should the...can the person be housed in a less-restrictive area or should they be recommended for longer term restrictive housing, at 30 days...well, we like the facility to request it more like at 24 days because at 30 days the deputy director must approve a 15-day extension. If at 45 days the issue has not been resolved then they have to come to me. And I've approved, I don't know, less than ten of those so far. [LR34]

STEVE LATHROP: Did you hear Moreland's testimony this morning on this subject? [LR34]

SCOTT FRAKES: On which subject? [LR34]

STEVE LATHROP: This, these criteria and... [LR34]

SCOTT FRAKES: I heard the testimony on the criteria, at least part of it, and I heard the testimony about the belief that there's no longer due process. [LR34]

STEVE LATHROP: Yeah, let's talk about that because that's the next... [LR34]

SCOTT FRAKES: Let's. [LR34]

STEVE LATHROP: So if I understood Mr. Moreland's testimony this morning, he said that before the reforms were undertaken and before you made these changes, that you could use restrictive housing as a form of punishment. You hit a guard so I'm going to give you 90 days or 120 days or whatever was the practice. That was used as a form of punishment. [LR34]

SCOTT FRAKES: That was one of the uses. That's correct. [LR34]

STEVE LATHROP: And one of the things that you eliminated as a proper use of restrictive housing. [LR34]

SCOTT FRAKES: That is correct. [LR34]

STEVE LATHROP: And what we heard this morning was that if a person was put into restrictive housing as a form of punishment, which was something that...a use to which restrictive housing could have been put before your reforms, that they had a right to due process, some kind of a hearing on that. Would you agree with that or do you think that was a misstatement of the inmates' rights if they were being punished with restrictive housing? [LR34]

SCOTT FRAKES: Bear with me and I'll answer your question. [LR34]

STEVE LATHROP: Fine. [LR34]

SCOTT FRAKES: Okay, because there is a misconception. There...the practice prior to July 1 would be an inmate would commit some act, they would be placed in segregation on immediate segregation status. That would be done by the shift commander. If there was a disciplinary issue, a misconduct report would be issued. There might be an investigation tied to that before it's issued so it could be a few days or it could happen within 72 hours. If a misconduct report was issued then a hearing was scheduled. If a finding of guilt was the outcome, the hearing's officer has, still has, a number of options for sanctions. But prior to July 1 one of those options was a sanction of disciplinary segregation time. So they could then be given disciplinary segregation. They were already in segregation. So they didn't get brought from population. They were already there. [LR34]

STEVE LATHROP: Under that IS hold. [LR34]

SCOTT FRAKES: Under immediate segregation status. So they get a seg. They get found guilty of the misconduct. They are given a sanction of disciplinary segregation for 30, 60, sometimes 90 days. The due process component to that piece was tied to the disciplinary hearing and the whole question of liberty interest tied to... [LR34]

STEVE LATHROP: Sure. [LR34]

SCOTT FRAKES: ...specifically to good time, although there are later rulings after Wolff v. McDonnell that talk about segregation as being another piece that can be challenged in certain circumstances, so. So they had a due process right to have a review of the hearing and the outcome, or they could challenge the sanctions as well. I mean there was the...it all falls in that component. But the important piece to understand is that that didn't occur while they were in population. So they had already been placed in segregation, held in segregation, given a sanction that changed their status on paper, limited some of the things that they would have access to while in immediate segregation. But if they in fact challenged it and were found not guilty or they challenged it and the warden or the designee determined that the sanction was too severe, made some adjustment to it, that wouldn't mean that they would automatically be released back

to the population, because then the next component of it was they would complete their disciplinary segregation sanction. Or if it was overturned then it would move...they would then go back to immediate segregation status and there would be a determination at that point of whether or not it was safe to put them back in the living unit they came from, in the facility they were at, was there a justification even without the finding of misconduct to put them in a higher level security facility? So those are all the components and in fact it was possible to be put on administrative confinement independent of any misconduct report. So the misconduct process... [LR34]

STEVE LATHROP: But it's the misconduct report that led to the due process. [LR34]

SCOTT FRAKES: For one specific type of segregation that was utilized... [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: ...while people were in segregation. [LR34]

STEVE LATHROP: And since it's not being used as a tool for punishment, then none of these people have a misconduct landing them in here. [LR34]

SCOTT FRAKES: It may be an outcome. That may be part of but it isn't...they're not put in segregation because of the misconduct report. [LR34]

STEVE LATHROP: As punishment. [LR34]

SCOTT FRAKES: They're put in there because of the risk that they present. [LR34]

STEVE LATHROP: So they're not getting the hearing that they would get if they were put in there for punishment. [LR34]

SCOTT FRAKES: Only specific to one specific type of status. But they also get classification hearings and reviews and those all have appeal rights. So in terms of classification, it

doesn't...you don't have quite the same level of burden of proof as you do in a disciplinary hearing which is still not court of law. [LR34]

STEVE LATHROP: Whose burden of proof, yours? [LR34]

SCOTT FRAKES: The state's, yes. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: Yes. But it's...but that's specific to the misconduct piece. People still have all the same due process rights in terms of disciplinary process and sanctions. We just don't use segregation as a sanction. Placement in segregation is appealable. Continued placement in segregation or restrictive housing is appealable... [LR34]

STEVE LATHROP: As a punishment. [LR34]

SCOTT FRAKES: No. We don't use it as a punishment. [LR34]

STEVE LATHROP: So who are they appealing to? If you put an inmate into let's say category number six, right, somebody thinks that this guy might...I heard through whatever resources, and you have intel people out there, right? [LR34]

SCOTT FRAKES: Right. [LR34]

STEVE LATHROP: I heard through one of my sources that this guy thinks he might punch one of the other inmates. That's enough to get you sent to administrative segregation under this... [LR34]

SCOTT FRAKES: Well, it's enough to start a conversation about it. [LR34]

STEVE LATHROP: Okay. Well, what's he got to do to get himself in there on criteria number six? [LR34]

SCOTT FRAKES: I'd just be guessing. I'm not going to try to guess. [LR34]

STEVE LATHROP: Well, that's part of the problem, I think, or at least what I'm hearing and why we're having a conversation about it because it is subjective. You can have a hearing on all the other five and come up with facts, but when we get to number six... [LR34]

SCOTT FRAKES: But... [LR34]

STEVE LATHROP: Here's maybe the question... [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: ...at least as presented to me. When you have a subjective criteria, that is, he's a threat to the institution, what's stopping corrections from saying this guy just hit another inmate I'm going to throw him in under criteria six because he's a threat to the institution as a form of punishment? [LR34]

SCOTT FRAKES: Because we don't use restrictive housing for punishment, first of all. And more importantly, what you just said was if he hits someone then there would be one of the other five criteria, the more objective criteria to address that. There's a threat that he's going to significantly...going to do some significant violence. So the shift lieutenant does their best assessment, sees what the validity of the intelligence is, looks at the inmate's past history, and makes a decision. You know, I think there could be validity to this and if I leave him out something bad could happen. I'm going to place him in segregation, restrictive housing. Within 24 hours, the warden of the facility reviews that placement and determines whether or not they believe it was appropriate. I realize that there's some sense that because they're the warden of the facility that they won't be objective in their decision making. I don't agree. I think that they are. [LR34]

STEVE LATHROP: Okay. Let's have you turn to page 137. And 137 is part of the report that you provided on administrative segregation. Do you see that table at the top, table five? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: And it says placements on immediate segregation July 1 through August 31, 2016. That's two months' worth of...do you see that? That's two months' worth of data since we've had the new changes or the new criteria. [LR34]

SCOTT FRAKES: Agreed. [LR34]

STEVE LATHROP: Do you see that? [LR34]

SCOTT FRAKES: Right. [LR34]

STEVE LATHROP: And so we have in the rows are the various institutions, right? And in the columns are the six criteria. [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: And as I look at it, at the very bottom it has a percent, right? So it's going to tell us as a percent of all people placed in administrative segregation or restrictive housing, which reason, which one of our six criteria, is used the most or in what percentage, right? [LR34]

SCOTT FRAKES: At this point, the sixth criteria, followed closely by serious acts of violence. [LR34]

STEVE LATHROP: Yeah. So we see the first column is serious acts of violence. That's one of the ABA criteria, right? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: They are until we get to the significant risk of physical harm. That's the number six then. [LR34]

SCOTT FRAKES: Yes, it is. [LR34]

STEVE LATHROP: And just in a two-month period of time, that has accounted for 42.5 percent of all the people that you've placed into restrictive housing,... [LR34]

SCOTT FRAKES: That's correct. [LR34]

STEVE LATHROP: ...if I read that correct. So you can see the subjective standard, which is the sixth criteria in your regulations, is responsible for 42 percent of all the people that have been placed into administrative segregation. [LR34]

SCOTT FRAKES: In a two-month period and something that was brand new to the system. So there's a learning curve that goes with this. [LR34]

STEVE LATHROP: Okay. So do you think it's been overutilized in the first two months? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: Okay, and tell us why. [LR34]

SCOTT FRAKES: Because I think as we've looked at some of them we've seen where there were other...of the...the other five criteria would have been applicable and might have been the better choice. So that's one of the things that we've seen. So it's just educating the people to make these placements and do the data entry, to not just default to the sixth choice just because it's... [LR34]

STEVE LATHROP: The catchall. [LR34]

SCOTT FRAKES: Well, it catches...it's a good descriptive term. It's one that is well known across corrections in America. So that's a part of it. And part of that is getting people to continue to rethink the use of segregation, the use of restrictive housing. It's a big culture change. I want people to use it if there's a risk. I want people...because that's part of what I've been dealing with

as well--a belief by staff that no one goes to segregation. Clearly, you see that's not true. That's that's not been one of our problems since July 1. But I want to make sure that the people that go there, go there for a legitimate need and a legitimate reason. And that's again, where the 24-hour review is helpful. And I don't know that there's data in here specific to how many have been reviewed and released after that 24-hour review. [LR34]

STEVE LATHROP: If we account for the fact that you now have people that would have normally been classified as in restrictive housing but they're now in protected classification, right? [LR34]

SCOTT FRAKES: Right. [LR34]

STEVE LATHROP: So of the remaining beds available in restrictive housing, since these reforms have gone into place or since your new administrative regulations have gone into place, are you using restrictive housing or what's left of it more or less frequently than you did before those reports? Or is it too early to tell? [LR34]

SCOTT FRAKES: Well, it's pretty early to draw a lot of conclusions. The raw...we can go to the straight data. We've reduced by 50 percent--50 percent of that was protective custody; the other 50 percent was people in various forms of...all the other reasons that you end up in restrictive housing. So there was about 315 people on that status in July of 2015, and yesterday there was 315 people in that status. So that's kind of an apples to apples, pretty close. [LR34]

STEVE LATHROP: It sounds like it. [LR34]

SCOTT FRAKES: Yeah. The biggest change that we expect to see in the...and that's...we're measuring it right now, will be length of time spent in restrictive housing. So that's a very important measure. And then I also expect to drive down the number of people that end up in there. But what this process...so I think a very important part of disciplinary...the removal of disciplinary segregation that isn't well understood is the dynamic where, again, nobody in general population went to a hearing, received disciplinary sanction...disciplinary segregation sanction, and was marched off. They were already placed in segregation. Then they had a

hearing, then they got this other sanction. Then when they were done with it, then they went to a different kind of segregation status. And so that's part of our challenge with data, it just goes all over the place. So, important to understand that this was something that happened within segregation. The behaviors that would lead to you being placed in segregation--fighting, assaulting, serious extortion, threatening, occasionally intel, whatever--all the six criteria. Really this sixth criteria captures all the reasons that people went to segregation in June of this year and a year ago as they do today. The behaviors that would take you there, many of those would lead to a misconduct report and you would be found...you know, you might be found guilty and given a sanction of disciplinary segregation. But the other piece that happened way too frequently was once people were in segregation, they would behave in other less desirable ways. They would be threatening to staff, so they yell at them through a door. They would, rather than hand their meal tray through politely, they would shove it out and the officer wouldn't expect it. It would fall on the floor. Those would lead to misconduct reports. Those would lead to findings of guilt. Those would lead to additional disciplinary segregation sanctions. [LR34]

STEVE LATHROP: And we learned this two years ago. All of that's true. Correct. [LR34]

SCOTT FRAKES: Okay. So that's why it's so important to get rid "D-seg." [LR34]

STEVE LATHROP: All of it's true. But the bigger part of that issue then is, I got a number in here, like 90 percent in 2016, 90 percent of the 2,000 inmates that spent time in restrictive housing had at least one behavioral health diagnosis. So they're behaving like you'd expect people to behave who have behavioral health or mental health issues and are confined for 23 hours a day in a cell. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: That's kind of the problem, isn't it? [LR34]

SCOTT FRAKES: Right. [LR34]

STEVE LATHROP: And they're not getting mental healthcare. [LR34]

SCOTT FRAKES: So getting rid of disciplinary segregation was exactly an important component of stopping this cycle. I dealt with people in the last system that I worked in that spent years in restrictive housing because they couldn't go 15 days without doing something (inaudible). [LR34]

STEVE LATHROP: Oh, I think we know of one those guys from the old days. [LR34]

SCOTT FRAKES: We've got our own here. Yes, we do. [LR34]

STEVE LATHROP: Yeah. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: And so what's changed? What's stopping...because and I want to talk about some statistics that you have here that relate to the people with a mental illness. And maybe I'll go through it. This report to the Legislature on LB598 says that in 2016, 2,215 different individuals were in restrictive housing. [LR34]

SCOTT FRAKES: Where are you? [LR34]

STEVE LATHROP: That's on page 134. [LR34]

SCOTT FRAKES: Thank you. [LR34]

STEVE LATHROP: Okay? I'm just going to go through some of the statistics that I read you. That was on page 134, 2,215 different individuals in restrictive housing out of 5,300 inmates. That's 41 percent of your population; 41 percent of your inmates are going through restrictive housing in 2016. Of that, now on page 140, it says 90 percent of the 2,034 inmates in restrictive housing had at least...90 percent of them had at least one behavioral health diagnosis... [LR34]

SCOTT FRAKES: Yep, but you see all the different diagnoses and the spectrum that covers. [LR34]

STEVE LATHROP: Yeah. Well, the next one may be more telling. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: Twenty-eight percent or 698 of them had a serious mental illness. Now we're talking about a major mental illness with like psychotic, schizophrenic, bipolar, those things that show up in the DSM, right? [LR34]

SCOTT FRAKES: Uh-huh, anxiety, major depression. Yeah, it's a spectrum. [LR34]

STEVE LATHROP: But serious...yeah, I've seen it... [LR34]

SCOTT FRAKES: Yeah. [LR34]

STEVE LATHROP: ...defined somewhere and I can find that if you want. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: But it's the things that we...well, we argued about this two years ago when we were talking about Jenkins and whether he was a behavioral or a mental illness. We understand what serious mental illness is, right? Seven hundred people were...seven hundred different people, 28 percent... [LR34]

SCOTT FRAKES: Absolutely. [LR34]

STEVE LATHROP: ...of the people put in restrictive housing. So here's the struggle. Here's the struggle as...and maybe I'm borrowing from two years ago. But here's the problem. We put somebody with a serious mental illness into restrictive housing. They're now in this cell for 23 hours a day, right, with a major mental illness and then when they act up they get more time, right? [LR34]

SCOTT FRAKES: That's...no, that's what we eliminated. [LR34]

STEVE LATHROP: You've eliminated it completely? [LR34]

SCOTT FRAKES: Yes, that's it, have eliminated completely. We've eliminated disciplinary segregation. So that's one option that will significantly change that. Will it still be an issue that has to be sorted out in terms of the restrictive housing staff reporting that the person is not compliant with their programming plan and they're not providing...you know? That's an issue that we'll have to sort through. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: And that's why we do an independent review at Central Office instead of having the facilities make that decision. [LR34]

STEVE LATHROP: Okay. So the person that throws his tray out there under the door or however they get it out of their cell and tries to hit a guard or makes the food splash in the hallway or whatever that is, that person may not be disciplined. But they're not meeting whatever criteria they're supposed to meet in order to get themselves graduated out of restrictive housing? [LR34]

SCOTT FRAKES: Potentially, if it was a willful act. [LR34]

STEVE LATHROP: Okay. Right. I don't disagree with that. They're doing it on purpose. [LR34]

SCOTT FRAKES: Right. [LR34]

STEVE LATHROP: So... [LR34]

SCOTT FRAKES: We're on the same side of this issue. [LR34]

STEVE LATHROP: No, I know we are. I know we are. [LR34]

SCOTT FRAKES: You know, I don't want these people here. [LR34]

STEVE LATHROP: I know we are. I'm just trying to get a sense of where we're at, where we've been, where we're at, and where you intend to go. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: And are we there yet and what's it going to take to get us there? Because next I'd like you to talk about what kind of mental health treatment these people are getting, because many of us who were on the LR424 Committee, which I was on at the time, heard that it wasn't very much, right? Somebody would come by and talk into the door. Maybe people are floating kites out there saying I need some help, I need some help, I need some help, and somebody would come by maybe. [LR34]

SCOTT FRAKES: Yep. [LR34]

STEVE LATHROP: And so tell us for these...and let's talk about the 700 people in 2016 that had a serious mental illness. What kind of care or treatment were they receiving as they sat in this 23 hours of segregated confinement? [LR34]

SCOTT FRAKES: I think what you described may have been pretty close. There's an initial assessment that happens when they're placed in segregation or restrictive housing today. [LR34]

STEVE LATHROP: Tell me how that happens. Is somebody talking through a door? Are we bringing them out in the hall? Are they going into a room? What's that initial assessment look like, Director? [LR34]

SCOTT FRAKES: So do we want to talk about now or the last year? [LR34]

STEVE LATHROP: You can contrast the two if you like. [LR34]

SCOTT FRAKES: Okay, because I'd rather read directly from than try to remember off the top of my head. Okay. So everyone placed in any form of restrictive housing will receive an assessment by health services to identify physical injuries and urgent medical needs. When the

initial screening is conducted by health services staff and they identify any concerns about mental health status and then based on their training as healthcare providers, the inmate will be seen by mental health staff one-on-one, out of cell, within 24 hours. So that's our standard. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: So that's the first piece. [LR34]

STEVE LATHROP: And who's that going to be? Mental health staff, what's that mean? [LR34]

SCOTT FRAKES: A licensed mental health provider, so it could be a licensed mental health provider, that's by job title. It could be a psychologist. Probably rare it would be a psychiatrist, but at LCC it could be. [LR34]

STEVE LATHROP: Okay. So they... [LR34]

SCOTT FRAKES: Yeah, but someone who's qualified. [LR34]

STEVE LATHROP: ...they go through assessment out of cell and what happens next? [LR34]

SCOTT FRAKES: If they determine that there are needs for greater level of care, if they decide that there's a need for residential mental health treatment--so secure mental health, or our next, we have a step down at the LCC--then we'll make arrangements to get them to those beds. If there's a need to... [LR34]

STEVE LATHROP: Director, are they going to have to wait? So if we have somebody, 1 of these 700 with a major mental illness and somebody does the assessment, the licensed mental health professional does an assessment and goes, this guy has some serious, serious problems, he doesn't know where he's at, whatever description of the symptoms are, and you say, well, we need to get him over to the mental health unit or the secure mental health unit. What's the wait look like for that guy? [LR34]

SCOTT FRAKES: If those cells or if those beds are all full, and occasionally they are, then we will use our skilled nursing units as a resource. So if the person is in crisis, serious decompensation, we're going to find an appropriate place to house them. [LR34]

STEVE LATHROP: Right away? [LR34]

SCOTT FRAKES: Right away. [LR34]

STEVE LATHROP: Okay. Sometimes they're waiting though? Or no? [LR34]

SCOTT FRAKES: You know, I'd like to think not but I can't...I'm not in every location and don't assess every case. So I'm not going to say we're flawless yet. [LR34]

STEVE LATHROP: Okay. So they identify him as having problems. The person is 1 of these 700 with a serious mental illness. What kind of...some of them are going to stay there, am I right? [LR34]

SCOTT FRAKES: They are. [LR34]

STEVE LATHROP: They're not all going to get shipped off to the mental health unit. [LR34]

SCOTT FRAKES: Correct, because if they're treatment compliant and they're not decompensating and we have ongoing mental health connection to see if there's any issues, so that's the next part of this, so that we don't just put him in there, look at him and go, oh, you're okay today. [LR34]

STEVE LATHROP: How often is somebody going to check in on him? [LR34]

SCOTT FRAKES: So let's see, the next one is if they stay, they will receive a mental health screening within 14 days. And that's done in a location outside of the inmate's cell. So that's the next piece. [LR34]

STEVE LATHROP: What's the difference between that first evaluation at 24 hours and the screening done at 14 days? [LR34]

SCOTT FRAKES: If, again, if they note at intake or initial placement that there are signs of serious mental illness, decompensation, then they're going to make a 24-hour, they're going to make an assessment within 24 hours. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: If nothing is noted and they stay for 14 days, they will receive a mental health screening. It will be out of cell. So that's the next piece. And I think that is...if we have an inmate with a serious mental illness whose current level of functionality does not require residential treatment, so they're treatment compliant--taking their medication and doing the things they need to, to control their symptoms--they're...our world is full of people that suffer from...not just my world, our world. [LR34]

STEVE LATHROP: Your world certainly is. [LR34]

SCOTT FRAKES: Yeah, but it is. But society, in general, is full of many, many people with mental health issues that successfully work, live, do all those other things. So let me finish. If someone has a serious mental illness diagnosis but they're functionality doesn't require residential treatment, then they will be seen one-on-one, out of cell, every seven days while they are on immediate segregation. So we're going to continue to track them with a mental health provider. [LR34]

STEVE LATHROP: Wait a minute. You said immediate segregation. So how long is immediate segregation for? [LR34]

SCOTT FRAKES: It's 30 days under the warden's control and it can be up to 30 days more under deputy director and then my control. [LR34]

STEVE LATHROP: So these guys are the relatively short-termers? [LR34]

SCOTT FRAKES: They are, yep. [LR34]

STEVE LATHROP: Okay. So they're going to get...they're going to, if they have a serious mental illness and they're taking their meds, we're going to pull them out of their cell and somebody is going to meet with them every seven days? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: Is that like therapy or are we just doing another assessment to see if they are getting worse? [LR34]

SCOTT FRAKES: It could be both. I think part of it is an assessment to see is there some change in behavior, are they having any issues specific to their mental illness. But it's also an opportunity, if there's an ongoing therapy relationship, to address those issues as well. [LR34]

STEVE LATHROP: Okay, I heard you say "could be." We don't know if it is or not. [LR34]

SCOTT FRAKES: It would be based on the mental health provider's assessment. [LR34]

STEVE LATHROP: Okay. And their caseload? [LR34]

SCOTT FRAKES: Nominal with more patient need. If they're out in general population, they have a serious mental illness but they are treatment compliant, managing their symptoms, they might not have contact with mental health, you know, every 90 days or less, which in society is true as well. Just because you have a mental illness doesn't mean you go see a mental health provider every week. [LR34]

STEVE LATHROP: Okay, okay. [LR34]

SCOTT FRAKES: Community standard of care. [LR34]

STEVE LATHROP: So what else are they getting by way...what treatment, besides just somebody bringing their medication by and giving them the medication and seeing them for a check or perhaps even some form of therapy? What else is happening for these folks in administrative segregation? [LR34]

SCOTT FRAKES: I think you captured it. In terms of mental health services, you've captured it. If there's decompensation, if there's a change in functionality, if there's a need for residential care then we'll move them to an appropriate bed. [LR34]

STEVE LATHROP: When we talked about...in a previous hearing we talked about the assaults on guards. [LR34]

SCOTT FRAKES: Officers. [LR34]

STEVE LATHROP: Officers, thanks. [LR34]

SCOTT FRAKES: Thank you. [LR34]

STEVE LATHROP: Assault on officers. And we talked and I had some questions for you about the reasons for that. And if I'm remembering right you said, well, part of these people are just less respectful of the law when they come in. So that piece you don't have control over. [LR34]

SCOTT FRAKES: True. [LR34]

STEVE LATHROP: You also said that the fact that they have...that they don't have programming or things to do during the day also causes or is one of the reasons why you believe that the assaults on officers has increased, is that true? [LR34]

SCOTT FRAKES: I believe it contributes, yes. [LR34]

STEVE LATHROP: So now I'm looking at the numbers--and we talked about them a second ago--90 percent of the people put in, in '16, had a behavioral health diagnosis and 28 percent of

them had a serious mental illness. To what extent are their behavioral health issues and/or their serious mental illness contributing to the reason they're going in? In other words, is somebody having a problem with their mental illness that, for example, is the reason they get in a fight or assault a guard or assault another inmate or break some rule that lands them into administrative segregation? [LR34]

SCOTT FRAKES: It's a little easier to define for those that are housed in secure mental health because those are people that are in high-level, high-security, residential mental health. They are ill and they are in some stage of their illness that could definitely impact their decision making. But for the vast majority of those that are in general population, again, that are treatment compliant, their decision making...I can't...I'm not a doctor so I'm not going to try and give a clinical answer. But in general, what I have had mental health professionals tell me, I've had others that have told me, you cannot take away from people's ability to own their decisions simply because they have a mental illness. So... [LR34]

STEVE LATHROP: Right. No question about it. [LR34]

SCOTT FRAKES: Yeah. Okay. [LR34]

STEVE LATHROP: Let me move this...let me flip the statistic around. Only 10 percent of the people--2,000--that went into restrictive housing didn't have a diagnosed behavioral health issue. [LR34]

SCOTT FRAKES: That's true. But again, that includes... [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: ...substance abuse, sex offender. It's a...you know, anxiety, depression. It's this wide spectrum of things. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: So it is important then. [LR34]

STEVE LATHROP: Well, let's go back to my conversation about assaulting officers because when...and I think we talked about the assault that nine inmates did on four or five of your guards at LCC. [LR34]

SCOTT FRAKES: Officers. [LR34]

STEVE LATHROP: Officers. [LR34]

SCOTT FRAKES: Thank you. [LR34]

STEVE LATHROP: Officers... [LR34]

SCOTT FRAKES: It's really important. I feel it is important. [LR34]

STEVE LATHROP: No, no, that's fine. I don't mind being corrected. [LR34]

SCOTT FRAKES: I don't want to correct you, but it's just...it is really important to my staff. [LR34]

STEVE LATHROP: Sure. The assault on the officers, those guys, many of them had violence reduction programming that they had been called for but didn't have yet. And so here's my question: How much of this is sort of the chicken and the egg? Like they're not getting the programming and they're not getting the mental healthcare and I know you're not the guy I'm going to talk to today about who's getting it and how timely and how well it's being done or how effective it's being done. But how much of these people are going into restrictive housing that might never have gotten there if they were getting timely programming and if they were getting timely mental healthcare? [LR34]

SCOTT FRAKES: I don't have an answer for that. Part of the answer lies in the fact that 80 percent of the population has some kind of behavioral health diagnosis. So the fact that 90

percent of the people that went into segregation had a behavioral health diagnosis isn't as far out of... [LR34]

STEVE LATHROP: It's a little worse than representative of the population. [LR34]

SCOTT FRAKES: Yeah, yes. Okay. But I don't say that to minimize it in any way, because what's really important is 28 percent have serious mental illness. [LR34]

STEVE LATHROP: Exactly. [LR34]

SCOTT FRAKES: So there's a huge issue and we've got to do something with that. As we'll hear, you'll get some more sense of it probably in our conversation from Dr. Mitwaruciu and on the 28th when we really get into programming. There's no question that programming is important both in terms of reducing return to prison and in terms of impacting the health of our prisons. And then you've got the whole tension of, in some cases, when is the best time to deliver it? There's this whole concern if you deliver it too early in the sentence that it's then lost its effectiveness when they released. So we'll...but those are...at this point we've got so far to go that I'm not going to get hung up on that. [LR34]

STEVE LATHROP: Well, let's talk about what the plan is then, because when we talk about the assaults on the officers...and I'll just use them as an example because I think you told me that if they had programming, that programming would, for those that have a violent tendency, include the violence reduction programming. If they were getting all the mental healthcare that they need...and we'll talk to the next witness about whether they're getting the care that is the standard in the community. But if they're getting all those things don't we accomplish several things, including having fewer people do things that get them into restrictive housing? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: I saw in the...I believe it's in the LB598 report that if someone is a long-termer...and in this LB598 report we have some statistics on how long some of these people have been spending there. [LR34]

SCOTT FRAKES: Page? [LR34]

STEVE LATHROP: Specifically on page 142, well, 141 and 142. [LR34]

SCOTT FRAKES: Yeah. Yes. [LR34]

STEVE LATHROP: You were asked to give some statistics to the Legislature on how long are these people...some, you know, how long are some of these spending in restrictive housing. The guy at the top, he's actually in the secured medical unit, am I right? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: He's been there by 5,003 days. [LR34]

SCOTT FRAKES: Yes, he has. [LR34]

STEVE LATHROP: You probably know who he is. I want you to turn the page to page 142 and I want to talk about somebody. And I'm making this a hypothetical more than anything, but I want to use a particular person. One, two, three, four, five, six down, somebody at Tecumseh. [LR34]

SCOTT FRAKES: That's the 11-7-2015 is their 180th day? It's in dark gray? [LR34]

STEVE LATHROP: It's the first guy at Tecumseh,... [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: ...from the top. You see that? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: So let's go through that. He's at Tecumseh. And it says status, LTRH; that's long-term restrictive housing. [LR34]

SCOTT FRAKES: Yeah, longer term. Yes. [LR34]

STEVE LATHROP: It says date assigned. Is that the day he was assigned to restrictive housing? [LR34]

SCOTT FRAKES: That's the date he was placed in, yes. [LR34]

STEVE LATHROP: Then it says, SMI, yes or no. What's that mean? [LR34]

SCOTT FRAKES: That means serious mental illness, no. [LR34]

STEVE LATHROP: So this guy has no serious mental illness. [LR34]

SCOTT FRAKES: Correct. [LR34]

STEVE LATHROP: And here's what he's been doing. Participated in large inmate disturbance, refused housing, continuous threats to kill staff if moved to GP. He's been there 492 days. [LR34]

SCOTT FRAKES: Yes, he has been. [LR34]

STEVE LATHROP: And if this guy stays in there and continues to say, I'm going to hurt somebody if you let me out, right, we're going to leave him in there until 120 days before he is...before his release date, in which case we're going to bring one of your teams in to decide what should happen for a transition. [LR34]

SCOTT FRAKES: Correct. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: A hundred...and I think we're doing it a little farther out than 120 days, but, yes, that's correct. [LR34]

STEVE LATHROP: But I think your regulation or your policy or something says if they're still in there...so this is kind of sort of, if I'm going to call it, the Nikko Jenkins rule. If that guy is still in there for a long, long stretch and we're 120 days from release, we better look at him and come up with a plan, right? [LR34]

SCOTT FRAKES: Well, no. They're already looking at, they're already working on a plan. If that's not working then they're going to change directions and they're going to continue to talk with him and try to find out what's the underlying issue? Is it actually protective custody but he doesn't want that because that brands him as someone then that is less desirable? Is it...what is the factor that's leading to behave this way? And if we can figure that out, can we find some other location? [LR34]

STEVE LATHROP: What if he continues to behave that way? Are you going to leave him there until his discharge date? [LR34]

SCOTT FRAKES: Those are difficult because...especially if he has a demonstrated history of violence. Then it's...then the challenge is do we shove them out into population to have them then assault someone, only then to have people say, well, you knew, he told you so, therefore, you failed your duty to protect? Or do we continue to hold them in segregation, working with them day after day until the day of release and acknowledge that now we've had a direct release. [LR34]

STEVE LATHROP: But how much working with him is happening for a guy that's in that type of confinement? He's there 23 hours a day in his cell, isn't he? [LR34]

SCOTT FRAKES: He is, but it's changing. So again, while we didn't want...we weren't going to play any games so we didn't just start the clock July 1. We could have but that's not right. [LR34]

STEVE LATHROP: No, no. I appreciate that. [LR34]

SCOTT FRAKES: Yeah, okay. [LR34]

STEVE LATHROP: But that allows me to ask this question, which is what I'm driving at. What happens...what's so special at 120 days before his release that you couldn't do 30 days into his confinement? [LR34]

SCOTT FRAKES: And we do. And the question is, what additional resources can we bring to bear because if we reach that point, we failed in all the other efforts to get him to less-restrictive housing. So now we've got to decide two things. Is there any other option that we can try? And what's the risk if we bring him out into the population, acknowledging that if we fail to do that we're going to put him in the community at a bus stop? And how do we...how do I look someone in the face if they then assault the first citizen they come upon? So you have that piece to deal with. You also then...we have resources that are designed around reentry, so our social workers and some of the other resources. We can bring those to bear as well in terms of if we can't get them into...out into population, at least we do the same work that we do with somebody when they're in population getting ready to release. [LR34]

STEVE LATHROP: If this guy had been seriously mentally ill, because I just chose one apparently that wasn't, if he has a serious mental illness are you going to bring some more mental healthcare his way? [LR34]

SCOTT FRAKES: We will. The...we're working so hard to do that. [LR34]

STEVE LATHROP: Okay. That's really maybe...it's the intersection of mental health and restrictive housing maybe that I'm trying to get at. And I used a bad example. If you're going to bring more to bear then are we back to a triage issue, which is, we don't have enough resources on the mental health side to do this earlier but, by gosh, when we get to 120 days before his release we're going to pull out all the stops and we'll find a way? [LR34]

SCOTT FRAKES: No. No, it's not, so. [LR34]

STEVE LATHROP: Okay. Whatever you're going to do at 120 days for the guy with a mental illness, why aren't we doing it sooner? [LR34]

SCOTT FRAKES: Because again, we're going to bring to bear the reentry resources that we use for everyone that's going back to the community, which didn't happen in the past. If you were in restrictive housing, you missed out. So that's an important change. It doesn't matter that you're there. We'll still continue to try to get you into general population because even, in my mind, 15 days is better than 0 days in terms of being out in population and some socialization prior to leaving the facility. So we'll continue that process until the last possible day, but at the same time we're going to bring in the reentry resources to see what else can we do. What kind of community hand-off can we do? Do they need...you know, they've probably already been identified and assessed. If they're not, they need to go before the discharge review team. So that's another component. Are there other community resources that we can bring to bear that would help in transition? But it's very individualized and it isn't like the inmates just tell us everything that we need to know so that we can make the best decisions. If someone is pretending to act violently but really doing that because they're afraid, they just don't want anyone to know they're afraid, then they'll behave that way until the day they walk out the door and then they'll go back home. Now if they have a history of violence, then there's another piece of it. But again, it's just very individualized. Shorter answer is up until the point of where we initiate the reentry services, we're going to do the same things. We'll use our programming. We'll use our mental health staff. We're working to get a dedicated staff in our restrictive housing units. Our first full-time psychologist will come on-line at Tecumseh the end of this month dedicated to restrictive housing. That's his full-time job. And we're working hard to find the same resources for NSP and for LCC. And then really the women's prison has that, in essence, just because of the way that they're structured. So that's another piece of it is getting resources that are dedicated and focused on only that population because they could be asking those questions and looking for opportunities to find out what's the underlying issue? Why won't you leave? And there's a part of the population that ends up in restrictive housing that doesn't want to leave. [LR34]

STEVE LATHROP: Then don't want to leave restrictive housing? [LR34]

SCOTT FRAKES: Right. I've known them for years and I've had them that, back in the old day when we were less thoughtful and educated about it, would leave them with nothing--a blanket and a pillow and the clothes that they wear and a Bible and they would just sit there. [LR34]

STEVE LATHROP: Well, when I look at the statistics on the people coming through the Department of Corrections, in answer to a question that we sent out before this hearing we were told that 1,100 of your 5,300--1,100 of your 5,300--had a serious mental illness. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: Right? And that 25 percent of your men and 50 percent a year women are on psychotropic medications. [LR34]

SCOTT FRAKES: Would you repeat those numbers again? [LR34]

STEVE LATHROP: Twenty-five percent of the men and fifty percent of the women are on psychotropic medications. [LR34]

SCOTT FRAKES: That's sounds correct, again, recognizing that that's a spectrum of medications. So people use that term and people think that we're talking about medications for schizophrenia when it includes low-level antidepressants all the way to very serious high-level medications. So it is a spectrum. [LR34]

STEVE LATHROP: Yeah, but a lot of it is that heavy stuff. [LR34]

SCOTT FRAKES: I was looking at it. It's a good, pretty good spread across the spectrum as I was kind of running through the different things that we prescribe just to take a look and get a sense. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: But we've got a measurable population of people with serious mental illness. [LR34]

STEVE LATHROP: So we talked about how the restrictive housing may have the need reduced if people are getting the proper programming and the proper mental healthcare. And I can't talk

about the restrictive housing without talking to you just for a few minutes about the mental healthcare, because as I look through the report from Gage, who you knew in Washington and asked to come here to do the assessment,... [LR34]

SCOTT FRAKES: I did. [LR34]

STEVE LATHROP: ...right? And so he kind of goes through this, but one of the things he talks about is the vacancies in...and we were given information about the vacancies in, I think, answer to an e-mail question that Senator Bolz had. And that looked like you were down eight psychologists, psychiatrists; nine mental health professionals; eight chemical dependency counselors; two social workers; a nurse practitioner; an RN; a clinical program manager; and three support staff, right? That was in June when they answered Senator Bolz's question. [LR34]

SCOTT FRAKES: (Inaudible) The three support staff kind of made me go, hmm. But, yeah. [LR34]

STEVE LATHROP: But you've also lost your head of... [LR34]

SCOTT FRAKES: Chief psychiatrist is leaving. [LR34]

STEVE LATHROP: Chief psychiatrist is leaving and that leaves you with one psychiatrist--Baker. [LR34]

SCOTT FRAKES: One full time, yes, and then contracted services. [LR34]

STEVE LATHROP: And then Dr. Gage, when he went through and he made several recommendations, right? And I just want to talk about staffing for a moment. But as he went through it, it wasn't a staffing analysis that the regulations call for, right? We agree that the regulations--it's like 115.02 or whichever one it is--calls for the department to do an annual evaluation of staffing needs in behavioral health,... [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: ...right? [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: And in terms of those being done on any kind of a formal basis, they haven't been. [LR34]

SCOTT FRAKES: No. [LR34]

STEVE LATHROP: Is that true? [LR34]

SCOTT FRAKES: That's true I believe. [LR34]

STEVE LATHROP: Okay. So we don't know, unlike your corrections officers where you did a study and you went through to see how many of them you actually needed in addition to the vacancies, all we know about your mental/behavioral health people is what the vacancies are. [LR34]

SCOTT FRAKES: That is true, yes. [LR34]

STEVE LATHROP: But Gage does wade into that a little bit, right? In his report he says you probably actually need six psychiatrists in here, right? [LR34]

SCOTT FRAKES: It's been a long time since I looked at the report, so I'll believe you. [LR34]

STEVE LATHROP: Okay. Well, if you need me to, I can show you where it's at. Six psychiatrists, then he goes into some director positions and that sort of thing. And then it gets a little harder to turn his generalizations into specific numbers. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: Do you intend to do one of those studies the regulations calls for so that the Legislature can get a sense, so that you can get a sense of the needs as opposed to the positions that you have? [LR34]

SCOTT FRAKES: I'm going to follow up on it, based on today's conversation. That's where I'm at today. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: I don't have any definitive plans. [LR34]

STEVE LATHROP: And I don't want to be argumentative, but just so that there's an expectation here, when I'm not around asking questions anymore, that folks on this panel can say, how about letting me take a look at that report, like before the end of the year? [LR34]

SCOTT FRAKES: I don't know that I'm...no, I'm not going to commit to that at this point because there's so many other priorities right now. It's not...if in fact we...first of all, the difference between the custody staffing analysis that we did and these other, as they say, noncustody or healthcare or mental health, there's not a lot of work out there. So that's something that we need to go out and do and go and look and see who out there has done it and done it well. They don't have a...to my knowledge, there's not a course at NIC that you can take to develop a behavioral health staffing model or a healthcare staffing model. So I'm sure there's some work out there that we can find. I have no doubt. [LR34]

STEVE LATHROP: But didn't Dr. Gates talk about that? Like, didn't he say you ought to use a different model in determining what your needs are, and he suggested what that model would look like? [LR34]

SCOTT FRAKES: Again, it has been a long time since I've reviewed the report so if you have a... [LR34]

STEVE LATHROP: He does. I can... [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: I can share that with you if you want. [LR34]

SCOTT FRAKES: All right. But did he identify a specific model or just to look at different models? [LR34]

STEVE LATHROP: No. Well... [LR34]

SCOTT FRAKES: So it's a conversation more than it's go use the Duluth model to determine how you should staff it. It's a need that's important, but it's not a priority today. There are many other priorities. And I go back to filling the positions we have remains the top priority. [LR34]

STEVE LATHROP: Well, yeah, I was going to go to that,... [LR34]

SCOTT FRAKES: Yeah. [LR34]

STEVE LATHROP: ...that you have, what's the number up to now if you take into account...? [LR34]

SCOTT FRAKES: 35. [LR34]

STEVE LATHROP: 35? Does that include the administrators like the head of psychiatry and...? [LR34]

SCOTT FRAKES: It does but I don't know that it includes the three support positions, so. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: I didn't count those as providers. [LR34]

STEVE LATHROP: Yeah, as I look at this topic, behavioral health and restrictive housing, it strikes me that it made an awful lot of sense to look at your staffing needs for the corrections officers. You have a lot of vacancies but you still went ahead and said, well, we need 135 over the vacancies...or 138. [LR34]

SCOTT FRAKES: Yes. [LR34]

STEVE LATHROP: When it comes to behavioral health, and we'll talk about programming in the next hearing, I think the panel, the state senators up here are looking for some idea about what you need to fix the problem. And behavioral health seems to be...since 20 percent of them are coming to you with a major mental illness and I think I saw LCC, probably 90 percent of the people at LCC have some kind of a diagnosed mental health condition. [LR34]

SCOTT FRAKES: Right. [LR34]

STEVE LATHROP: The numbers are pretty staggering. It's like you're running a mental health clinic or a regional center over there, right? [LR34]

SCOTT FRAKES: No question. [LR34]

STEVE LATHROP: A lot of them...you didn't have any control over how they got there, but a lot of them have an awful lot of mental health problems. [LR34]

SCOTT FRAKES: Yeah. [LR34]

STEVE LATHROP: And to make them safe before they get out and preserve the public safety getting them the care they need while they're inside should be the mission, right? [LR34]

SCOTT FRAKES: Agree. [LR34]

STEVE LATHROP: Is Gage the guy to do this? [LR34]

SCOTT FRAKES: To do what? [LR34]

STEVE LATHROP: To do the staffing analysis. [LR34]

SCOTT FRAKES: No, I don't think so. I don't know. No, I don't think so at this point, but I won't rule it out completely. I have total respect for him. But his focus is on psychiatry and on that aspect of it. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: There is a behavioral health administrator in Washington State as well that's (inaudible). [LR34]

STEVE LATHROP: So at some point I think the Legislature, these folks are going to want to know when that will be done. It is in the regulations. It is called for once a year. And another regulation requires that each institution determine whether there are appropriate mental health staff and facilities to provide the care at the community standard. [LR34]

SCOTT FRAKES: Isn't that...isn't that one specific to suicide prevention? Is that the number that you presented? [LR34]

STEVE LATHROP: No, I don't believe so. [LR34]

SCOTT FRAKES: Okay. All right. [LR34]

STEVE LATHROP: So what's the plan? We have...you have 35 vacancies just to get to fully staffed. How are you going to fill them? What's the strategy? You have a budget coming up in the next legislative session. Are you going to request enough resources to get you to 100 percent and fill all the vacancies in health and behavioral health? [LR34]

SCOTT FRAKES: Those positions that are represented are under the bargaining unit, will go through the bargaining process, nurses in particular. I realize it's dipping into the healthcare, but

that's every bit as important. I believe in holistic care. For the discretionary positions, such as a psychiatrist and the, more importantly, the psychologist, I've made adjustments and I've just made another series of adjustments within my own budget to raise those so that we...trying to be more competitive in terms of both getting additional staff and retaining the ones we have. So we're just in the process of figuring...finalizing that. [LR34]

STEVE LATHROP: Okay, two things about your answer. Discretionary doesn't mean that you don't need them around. It means that they're not subject to a collective bargaining agreement. [LR34]

SCOTT FRAKES: Correct, or the rules and regulations. [LR34]

STEVE LATHROP: So if you need to pay a medical doctor $225,000 you can do that if you can get the money from an appropriation. [LR34]

SCOTT FRAKES: Yes, and work it through my budget. Yes. [LR34]

STEVE LATHROP: That would be true of the psychologists? [LR34]

SCOTT FRAKES: Yes, except for one of them I have who has been here long enough that he had the ability to choose and he chose to stay under rules and regulations. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: So he's under a different pay scale and I can't change that. [LR34]

STEVE LATHROP: Okay. So will you be asking for enough? I guess here's the--and I'm about done--here's the question, though. When we say I have to deal with a bargaining unit, and then you say you deal with it and you go, well, if you don't like that, we'll go to the CIR and they're going to give you $16 an hour. And you win, right? You win at the CIR or you tell them it's 16 bucks an hour. And you look at the comparables and that's what the comparables show. But it still doesn't get you fully staffed, right? [LR34]

SCOTT FRAKES: Yeah. [LR34]

STEVE LATHROP: So are we going to put enough money on the table so that we can get you to a place where you're fully staffed with the corrections officers and with the behavioral health people and the medical people that we've been talking about where the vacancies are that is affecting the way the place operates, whether people are ready for parole when their parole eligibility date comes down? [LR34]

SCOTT FRAKES: So again, we're in collective bargaining so I can't discuss that piece of it. Again, the things that I can manage within my budget I'm addressing. And then the pieces that are addressed under rules and regulations, we're having conversations, working with...trying to work with--I shouldn't say trying to--we're working with behavioral health, HHS, having conversations there as a well. So we're trying to figure out what approaches will work for some of the other positions that are not represented under the rules and regulations and under the salary schedules. [LR34]

STEVE LATHROP: The last thing I have for you is on page 144. There is a chart on your LB598 report, table 11 that shows the direct releases to the community from restrictive housing. This would suggest that it's gotten better. But it looks like in 2016 you had 1, 2, 3, 4, 5, 8, 10, 12, 13 people just between July of '15 through May of '16? [LR34]

SCOTT FRAKES: One, two, five, six, seven, eight, nine, ten, what does that...number you came up with? Yeah. I count ten there but it's... [LR34]

STEVE LATHROP: Ten people released directly from administrative segregation to... [LR34]

SCOTT FRAKES: To the community under an old... [LR34]

STEVE LATHROP: ...to the community. In other words, whatever you do at 120 days or whatever you do before these regulations, and you're trying to do something for these people before they leave, 10 or 15 of them, something like that, are being released... [LR34]

SCOTT FRAKES: That's correct. [LR34]

STEVE LATHROP: ...directly from administrative segregation. [LR34]

SCOTT FRAKES: That's correct. And as you look at the chart you can see it's...at least the trend line was moving the right direction. But it's under also a different standard as it's noted. This was...the measurement that we were using and had been using, same measurement I was using in Washington, was those that had been in restrictive housing for 60 days or more. So if someone went into restrictive housing 45, 50 days prior to release, they wouldn't show up in this measurement. [LR34]

STEVE LATHROP: We don't know that they were or they weren't though. [LR34]

SCOTT FRAKES: No. [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: But today, from...since July 1, if you go into segregation a day before, or restrictive housing a day...we've seen old habits are hard to break. If you go under restrictive housing one day before your release date, you'll show up as a statistic. So I expect our numbers are going to go up significantly because we have people that as the...you know, the slang expression is "check in." They get close to their release. They don't want to get in trouble. They don't want to get in a fight. They don't want to get sent on a mission to hurt someone, which is often what comes from typically security threat groups. But let's just...we can use that as the motivation. They have debts that they can't pay, so there's all these reasons. And I don't expect it to be a huge number of inmates, but I do expect this number to show a significant increase because we changed the measurement. And that's good because, again, I wanted it to be 100 percent transparent. [LR34]

STEVE LATHROP: Okay. That's all I've got. Thank you. [LR34]

SCOTT FRAKES: Okay. [LR34]

SENATOR SEILER: Senators, questions? Ernie, you always go last. [LR34]

SENATOR CHAMBERS: Oh, I thought they were (inaudible). [LR34]

SENATOR SEILER: (Laugh) Senator Coash. [LR34]

SENATOR COASH: Thank you, Senator Seiler. Director Frakes, I think in all of that testimony you touched on this, but I just wanted to go back to something with regard to the elimination of disciplinary segregation. We had...last time you were here I had talked to you about some of the concerns that are being brought to my attention from corrections officers with regard to feeling a little bit left out. As the more I learn about this and the more I listen to your testimony I'm wondering, and I think you did talk about this, that elimination of disciplinary segregation, do you see that as one of the reasons that corrections officers may feel like a tool has been taken away from them? [LR34]

SCOTT FRAKES: It contributed. [LR34]

SENATOR COASH: Whether it's fair or not, do you...is that probably...is that maybe where some of those...that anxiety might be coming, or frustration from the officers, because that's no longer an option for them? [LR34]

SCOTT FRAKES: Which it really never was, because they don't...you know, they didn't control the hearing process. Short answer is, yes, I think it has contributed to the perception. The facts don't bear it out based on the number of people placed in restrictive housing over the last three months and the other actions taken, so poor communication on my part in terms of really getting people educated. One of the challenges, and I've said this, if I was able to go back to the spring of 2015, Senator Schumacher, the one conversation I would have--because I supported the bill, correct? you know, and worked with the ACLU to help language in the bill--the one thing I would ask is that we promulgate it in July of '17 rather in July of '16 because what it forced us to do and what it led to us to do was spend from beginning of the work group in September until we promulgated focused on creating the rules and the structure and then we hit the switch and implemented. It would have been we would have had more time to get staff on board,

communicate, help them, maybe get them more involved even in some of the decision making, pilot some different ideas, and then ultimately build the right set of rules. It's still going to work out fine, but that communication breakdown, no doubt, it contributed. People somehow thought that eliminating disciplinary segregation meant nobody was going to segregation. No. As I said last time, I will say it again, the last three months more people went to segregation than I ever expected because of... [LR34]

SENATOR COASH: So back to more people going to segregation, so it's not less people, it's just different reasons than disciplinary? [LR34]

SCOTT FRAKES: It's different reasons in terms of the...their status while they're in there, so it's really semantics more than anything. [LR34]

SENATOR COASH: Okay. [LR34]

SCOTT FRAKES: But it's the same reasons that are leading to people being placed in restrictive housing. [LR34]

SENATOR COASH: Okay. So I just reread. Your opening statement was very helpful in understanding all of the things the department has done over the past several months with regard to restrictive housing, including the elimination of disciplinary segregation, new rules and regs, the least restrictive environment standard, creation of protective management, all of those things. So that was helpful for me. My question is, do you see any correlation between all of these changes that you outlined and the increase in assaults on corrections officers? [LR34]

SCOTT FRAKES: A little bit of anecdotal...I wouldn't call it evidence, anecdotally or at least a belief that some inmates thought that they could behave and they would no longer go to restrictive housing. I think we've pretty much established that's not the case. But whether or not that contributed to some behavior in June and July, it's a question I can't answer. I think some believe that that's true. I haven't had any inmate specifically say, oh, I didn't know I was going to get put in restrictive housing after I hit that staff member. But that is why we follow it up with communication to the population. And now we've got some posters that are about to go out that

describe what happens when you assault staff: that it is a felony, that there is a specific felony for it, that there is a loss of good time if you're found guilty, that there is potential for prosecution and those other pieces. [LR34]

SENATOR COASH: Okay, thank you, Director. [LR34]

SENATOR SEILER: Senators? Any over here? [LR34]

SENATOR PANSING BROOKS: All right. [LR34]

SENATOR SEILER: Senator? I got one and then call on you. [LR34]

SENATOR PANSING BROOKS: Okay, do you have any other questions? [LR34]

SENATOR SEILER: Director, you talked about a Central Office Multidisciplinary Review Team. Who chooses who is going to be on that team? Your appointment? [LR34]

SCOTT FRAKES: Well, the promulgated rules actually spell out the job titles if I can get that real quick. So, you know, we put it in the law that said this is who has to be there and that they must be present for the team to be able to meet and make decisions. [LR34]

SENATOR SEILER: And as I understand it, you're not part of that. Is that... [LR34]

SCOTT FRAKES: I am not because that allows me then to answer the appeals because the inmates have a right to appeal the decision of that committee so I can serve... [LR34]

SENATOR SEILER: Okay, that's what I'm wanted it... [LR34]

SCOTT FRAKES: Yeah. [LR34]

SENATOR SEILER: The notes didn't include an appeal and I was...that's where I was going. [LR34]

SCOTT FRAKES: Yes. [LR34]

SENATOR SEILER: I think you're aware that we're trying to work on emergency protective care. I'd like to visit with you about that. I think we may be able to cut down on your population if we can get that established. [LR34]

SCOTT FRAKES: Okay, great. [LR34]

SENATOR SEILER: So I'll be calling you in a week or so about that. [LR34]

SCOTT FRAKES: Okay. I look forward to that because I agree with you. [LR34]

SENATOR SEILER: Senator Chambers. [LR34]

SCOTT FRAKES: Senator. [LR34]

SENATOR CHAMBERS: Director Frakes, we meet again. [LR34]

SCOTT FRAKES: It's good to see you. [LR34]

SENATOR CHAMBERS: I assure you, I'm not going to have as many questions as I ordinarily have. [LR34]

SCOTT FRAKES: Okay. [LR34]

SENATOR CHAMBERS: When I read what has been presented, it seems that it deals with the male institutions, is that correct? [LR34]

SCOTT FRAKES: Well, it applies across the board, but the female population presents... [LR34]

SENATOR CHAMBERS: So they have rooms, areas, locations at York where all of these things that are applying to Tecumseh and LCC would immediately be applicable there? They have the means to do it and the facility to do it? [LR34]

SCOTT FRAKES: Which is... [LR34]

SENATOR CHAMBERS: This isn't a trick question. [LR34]

SCOTT FRAKES: No, no, and I... [LR34]

SENATOR CHAMBERS: (Inaudible) for information. [LR34]

SCOTT FRAKES: Right. So what you'll see in a small facility, and it's magnified, you know, sixfold in the youth facility, is you have to do some blending because you can't dedicate staff resources for three inmates with this need and four inmates with this need. So where it makes sense and it's safe you may, in fact, have some mixed populations. Now having the protective custody population interacting with the residential mental health population I see as a challenge and I'd like to find a better solution to that. And they also know that the administration of women... [LR34]

SENATOR CHAMBERS: But there would have to be differences between how this philosophy would be administered in these male institutions and administered at York. [LR34]

SCOTT FRAKES: Because of scale. [LR34]

SENATOR CHAMBERS: Okay. [LR34]

SCOTT FRAKES: We still will be able to create some mission-specific housing at the women's prison and they are working on that so. [LR34]

SENATOR CHAMBERS: I may be naive but I accept conclusions arrived at by people who spend a lot of time studying issues, studying the impact on human beings when they are

subjected to various conditions. And as a result of that, I concur with what has been determined by the UN, Amnesty International, and other human rights organizations, even the military, psychiatrists, psychologists who have equated solitary confinement with torture. Do you think that is true? Now I don't mean you put somebody in a time-out room for a day or so but enforced, substantive solitary confinement has been equated with torture. Now you had mentioned in your presentation, and I didn't catch whether you were saying that's the way it used to be or that's the way it is, that a person is in solitary. I know they talk about restrictive housing, control, administrative segregation, all of it, but on the street there is a tendency to reduce things to a common denominator and it goes like this: Dress a monkey as you will, a monkey is a monkey still. So if I'm in my cell 23 hours out of 24 and they say that's restrictive housing, Senator Coash is in his cell 23 hours out of 24 and he's in administrative segregation, and Senator what's-his-name over there, Senator Williams, is in his cell 23.5 days (sic) out of 24 and his is control or something else, and we get together and we talk about it and we say, well, it doesn't make any difference what they call it, it's the same thing, that's the kind of mail I'm getting from prisoners. And the conclusion always, invariably, is they changed the name to restrictive housing but actually there's no difference. They don't apply the term "cosmetic" but I do. In order not to ask a lot of questions, which I said would be my course today, I'm going to read a World-Herald editorial that deals with a specific situation. It was in today's paper. There is at the very top of it, it's an editorial: York Fiasco. Then the headline: Witnesses need prison safety. They're concerned about how what happened at York may impact criminal prosecutions because people may not testify. That's the prosecutorial narrow tunnel vision. I'm looking at it from the standpoint of what happens to human beings when these circumstances arise. "It's disturbing that a prisoner at the Nebraska Correctional Center for Women near York bashed a fellow inmate's face and broke her arm by swinging a lock in a sock. Even more disturbing is that institutional carelessness apparently enabled the assault. Sources told the World-Herald that murderer Erica Jenkins walloped a cousin who had testified against her. The damage inflicted could very well extend beyond what Christine Bordeaux suffered. The Sept. 24 assault, as Douglas County Attorney Don Kleine points out, creates a potential chilling effect on witnesses who agree to testify as part of plea deals in major crimes. 'It's frustrating when you have somebody who did the right thing, came forward,' Kleine told the World-Herald. 'Then they let the bad guy have access to that person.' The (state) prison system, through action or inaction, simply cannot give the accused a chance at revenge. Separating inmates who can't mix is Prison

Management 101." Separating, I repeat--that's not in the editorial like that, I'm repeating this--separating inmates who can't mix is prison management 101. "The Nebraska Department of Correctional Services has declined to comment about the alleged assault, saying state law prohibits the prisons from publicly discussing specific inmate conduct. But given the potential for similar circumstances to endanger future criminal prosecutions, York Warden Denise Skrobecki," S-k-r-o-b-e-c-k-i, "and Corrections Director Scott Frakes," F-r-a-k-e-s, to be equal, "should publicly address how the system will avoid making similar mistakes. Corrections is already facing a full plate of problems that officials need to resolve, including sentence calculation errors, staffing shortages, prison crowding and an increased number of assaults on staff. Here's another black mark on the prison system when it's trying to rebound. Among the questions that need answering: What happened that enabled the accused and her accuser to be in the same space together? Why wasn't there better supervision? How many prisoners systemwide are in similar circumstances and need protection? How are they being protected? And does more need to be done? Jenkins, 26, has a history of assaults during confinement: She has already been convicted of three assaults behind bars. She is serving a life term for the August 2013 shooting death of Curtis Bradford. She and her brother, Nikko, lured Bradford out by saying they would commit a robbery together. Bordeaux, 42, was convicted of criminal conspiracy and attempted robbery from another of Nikko Jenkins' four Omaha murders. She testified against Erica Jenkins, who was convicted of two robberies, and agreed to testify against Nikko. The York prison is Nebraska's only women's prison. If the state can't make sure Erica Jenkins and Bordeaux stay apart, officials might need to transfer one of the two out of state. It is a sensible, basic expectation for the state to keep its inmates safe." But before I ask my question, I want to deal with that comment by the World-Herald because other people make it and some have suggested putting something like this in the law, transferring people convicted of crimes in Nebraska into another state. The constitution means something. I have tried, and I was successful while I was here before being term-limited out, to prevent my colleagues from polluting the constitution by saying hunting, trapping, and fishing should be protected in the constitution. When the cat was away, the mice played. Foolishly they put that on the ballot; stupidly, Nebraskans voted for it. So before any other stupidity, based on what otherwise is a sensible editorial, is contemplated by my colleagues, I want to read from the Nebraska Constitution. Mr. Khan, who made a challenge to Donald Trump, and nobody else can make that challenge to me, namely, that I don't read the constitution. I've read the Nebraska Constitution several times. I'm chagrined at some of the

nonsense that's in it, but I remember things that are in it even though I have to search sometimes to find exactly where they are. So it took me about 15 minutes to find this, because I had need of it in the past. "I-15. Penalties; corruption of blood; transporting out of state prohibited. All penalties shall be proportioned to the nature of the offense, and no conviction shall work corruption of blood or forfeiture of estate; nor shall any person be transported out of the state for any offense committed within the state," not any person. And since juveniles are persons, it should apply to them. But, and people know about by now, I cannot be everywhere doing everything at once which needs to be done. But what we're dealing with here is a very important matter and I want to be sure that all of the good words that are being stated to us are not just words. What I'm concerned about no matter how it is termed: the amount of time people are kept in solitary confinement. As happens with a lot of what some people would consider subtle, but I say exquisite tortures originate with religious people. The term penitentiary comes from being penitent, repenting for your wrong. And some people in New York or somewhere, Auburn, thought that it would be a good idea if somebody committed a crime to put them in a cell and leave them there alone for a long time so they can contemplate the error of their ways, seek God or Christ or whoever they need to find, and change their ways. [LR34]

SCOTT FRAKES: The Quakers. [LR34]

SENATOR CHAMBERS: And errors have a way of persisting when the truth is constantly struggling just for air. I can see you nodding, so you know this is true. [LR34]

SCOTT FRAKES: I do. [LR34]

SENATOR CHAMBERS: I want to see something done concretely that anybody who has studied about penology will agree to, that this idea of locking people up for long periods of time in solitary is the worst thing that can be done. And when you have state doctors who can look at a man's body and it looks like a tapestry of deep cuts, symbols, cut his throat and require 42 sutures to keep him from bleeding out, and those quacks say he's acting out, that this is a ruse, when you can see these deep wounds that would have to be excruciating constantly done and this individual is supplied with razor blades, a badge, keys, and he's acting out and it continues to happen, I cannot sit back and watch that because I'm not a Christian. I cannot sit back and watch

it because I don't believe in any religion that allows that. So because I'm not a Christian, I'm not comfortable in the presence of torture. I'm not comfortable in those whose job it is to enforce the law scoffing at the law. So as a nonreligious man I'm going to make a deal with you. And since you probably are religious in some way, and I'm not going to ask you to identify it, you could call it making a deal with the devil. If you implement a program that substantially cuts into this solitary confinement, as I refer to all of them, stop these guards from tormenting people who are held in solitary, giving them implements for self-mutilation, encouraging them to do it, hounding them, and other guards know it and they all close ranks and lie about it, if you can stop that, you will not have to always hear me say when I see you I think the job has outgrown you, because if you do that, you will have eliminated one of what I consider one of the worst blights in Christian society: the toleration of one of the cruelest forms of torture tolerated by Christian chaplains who go into these prisons, Christian preachers, Christian guards, all of them following Christ. And it takes a devil to say, hey, lighten up. So make that deal with the devil. Think about it. And then we'll talk about it. But I'll tell you why I put it in that context. In literature, whoever writes the story or the version of it, Dr. Faustus selling his soul to the devil, the devil always delivers on his promise. He never reneges. He gives the other party everything that was consented to. And to make sure that there's no mistake, the literary presentation will have the devil calling this individual's attention to how serious this is, tell the person: You have what you call an immortal soul. I don't think there is such a thing. It means nothing to me. But since it means something to you and we're striking a deal where you will lose it, I want you to pay close attention to what you're doing so when time comes for you to pay, you cannot say you didn't know. I want you to draw blood and sign your name to this parchment with your blood. I want you to make every letter carefully so that when your name is read, at any time, there be no mistake about what you're writing. And the person will say, yeah, yeah, yeah, let's do it. And they do it. The person gets everything the devil promised. As a matter of fact, one of the things Dr. Faustus wanted was to be able to go to the Vatican and thump priests on the head because he could be invisible. But he also wanted to be able to discourse with the greatest minds. And the devil did everything he said. Then when time came to pay off, Faustus had become a world-renown scholar. He had students. And when that point came, these students were with Faustus. And he said, I'm going into that room--I'm paraphrasing--I'm going to close that door, I will never emerge, you will never see me again, but whatever you hear don't open that door, don't enter that room. Then he talks about wishing there were some way he could become a drop of water, fall into the ocean,

be absorbed, and disappear. If one drop of Christ's redeeming blood would be made available to him to rescue him from this, if those horses that pulled the chariot of time could be stopped so that midnight would never arrive, but he knew it would arrive and, in fact, the clock told, and when 12:00 was hit, the two ending words: Ah, Mephistopheles! Time had come to pay off. I'm saying this so that you will focus on what I'm presenting to you. Now I'm going to ask you a question or two. No matter how I interpret this, am I understanding correctly that you want to reduce the amount of time that people spend in solitary, or have I misunderstood? [LR34]

SCOTT FRAKES: I want fewer people to go to restrictive housing and I want those that go to spend less time than was...than happened in the past. [LR34]

SENATOR CHAMBERS: Now we're not going to make the deal in front of all these people, but I'm going to have a serious talk with you about that. And if you do that, then you'll find that somebody who you might have thought was an implacable foe can be the best partner that you ever had in your life. I don't have any questions that I'm going to ask, Mr. Chairman, and you can breathe a sigh of relief and thank whoever you believe in. [LR34]

SENATOR SEILER: Senator Krist. [LR34]

SENATOR KRIST: Just a couple--thank you, Chair, and thank you, Director--just one quick question that has to do with...I'm referring to, just for the sake of referring to something, Restrictive Housing Annual Report 2016, September 15, 2016, prepared by NDCS policy and research division, page 6. It lists 1 through 6. [LR34]

SCOTT FRAKES: Is this the September 15 or the June? [LR34]

SENATOR KRIST: The date on the cover is September 15 of 2016. [LR34]

SCOTT FRAKES: Okay. Page 6? [LR34]

SENATOR KRIST: Yes, sir. [LR34]

SCOTT FRAKES: Thank you. [LR34]

SENATOR KRIST: We've talked about those conditions whereby a person would be put into administrative segregation, administrative or some kind of restrictive housing arrangement of some kind, whether it be at their own request or something else. It seems to me that if I read just "1. A serious act of violent behavior (i.e., assaults or attempted assaults) directed at correctional staff and/or at other inmates," and then it goes on from there with a couple of others, threats or actions of violence, a recent escape attempt, etcetera. I asked in a previous hearing of the deputy director to give us some indication of how much good time was actually taken away when these kinds of infractions happened, and the reason I asked the question and the reason I think that we need to look at it is that we legislators are criticized almost consistently for not repealing the good time law because it basically means people get out of prison earlier. Okay. General population, the general public feels that it's part of our inherent problem we're not tough enough on crime, yet when I see some of these things happening I'm not sure if we're using good time and the good time law the way it was intended to be used, and that, as you know in your business, how do you keep people orderly within the system. So what are they afraid of? In some cases what we're afraid of keeps us from our misconduct. Would you agree with that? [LR34]

SCOTT FRAKES: I would. [LR34]

SENATOR KRIST: Okay, so...and I don't want...if you don't want to answer this directly today, factually, I'd really want a factual readout from the department that says, for all of these things, if you are violent towards another person or particularly an officer, what do you inherently lose in terms of good time, and are we using the program as best we can? Is that fair? [LR34]

SCOTT FRAKES: It is, and I actually had hoped that I'd have something today. And we looked at some numbers this morning. I wasn't comfortable that we'd scrubbed them. I don't want to give inaccurate information and it doesn't get down into the kind of details. We looked at security threat groups and then just the broad use of good time. So we will follow up and we will give you a better analysis. What I saw on the overall taking the good time and restoration is we're up. We're taking more good time than we were in the previous years and we're restoring less. So that indicates that we're using it and using it in its intended way. And as I think I talked about last

time, my focus all along has not been trying to impact the use of it as a sanction but to make sure that we have a thoughtful and meaningful restoration process, because when I got here it was just pretty much an automatic. [LR34]

SENATOR KRIST: If I can... [LR34]

SCOTT FRAKES: So we're somewhere in the middle right now and then we have to promulgate the changes, so that will be the other piece. [LR34]

SENATOR KRIST: In an old analogy: What I can give I can take away, and what I can take away I can restore. And that is part of the incentive, the... [LR34]

SCOTT FRAKES: It's the incentive part. [LR34]

SENATOR KRIST: Exactly, and also just a public statement which we need to understand having been part of LR424 and all of this for the last four or five years. It seems to me that good time was not--my opinion--was not administered correctly because there was another incentive: to move people through. And I don't think that that's your intent. I don't think that that's where we are today. [LR34]

SCOTT FRAKES: No. [LR34]

SENATOR KRIST: But I do think that the proper administrative (sic) of good time can restore some order and in restoring order it restores safety. And the safety part of it is always paramount. So there's that balance and I think those numbers will help us see if the tool is being used the way it needs to be in that macro sense. That fair? [LR34]

SCOTT FRAKES: It is, I agree too. Thank you. [LR34]

SENATOR KRIST: Okay. Thank you, Director. [LR34]

SENATOR SEILER: Senator Paul Schumacher. [LR34]

SENATOR SCHUMACHER: (Laugh) Thank you, Senator Les Seiler. Thank you, Director Frakes, for your testimony today. [LR34]

SCOTT FRAKES: Senator. [LR34]

SENATOR SCHUMACHER: To your knowledge, are we on track for the end of this month for the Vera report? [LR34]

SCOTT FRAKES: I have...two weeks ago I thought I was going to have it next week. Then I got an e-mail today saying, can we talk on Friday? So I'll be talking with the leadership on Friday to see if we're there or if there's another hangup. You know, it was...originally should have been delivered around May and then it was July and then it was October and so...and my promise is, when I get it in my hands, I will distribute it. It belongs to everybody. [LR34]

SENATOR SCHUMACHER: Okay. Thank you. On the strategic plan for the department says: Diversity is imperative and integral to our mission. The department is committed to an inclusive environment where differences are accepted, valued, and celebrated for fostering teamwork and safety. Deputy Director Rine was asked about diversity at and staffing at the administrative level and she couldn't put a figure on it. Can you tell us how many deputy directors are from minority populations? [LR34]

SCOTT FRAKES: Deputy directors, well, not knowing what their background is, I really can't answer that question. If you want to talk about in terms of do they look different than I do, so we have a female, but everyone is about the same skin color. [LR34]

SENATOR SCHUMACHER: Okay. How about wardens? [LR34]

SCOTT FRAKES: We have one African-American warden and there again I don't know what the other cultural diversity is of the other wardens. [LR34]

SENATOR SCHUMACHER: Okay. This may be getting in the weeds a little bit. Deputy wardens? [LR34]

SCOTT FRAKES: Hmm. Trying to run through. I'm not pulling up anybody that doesn't appear to be same skin color as I am. [LR34]

SENATOR SCHUMACHER: Majors? [LR34]

SCOTT FRAKES: Hmm. Females but I'm...man, I'm not pulling up a face or a name. [LR34]

SENATOR SCHUMACHER: Associates? [LR34]

SCOTT FRAKES: Hmm. You're going to put me in a position where I hurt somebody's feelings probably because I'm not thinking of every single person. The shorter...let's go to the shorter answer. We know we don't have diversity in our leadership in this department. [LR34]

SENATOR SCHUMACHER: Okay. And that being the case, of the people that are in restrictive housing, solitary, whatever term we put on it, what percentage of those would you estimate are from minority populations? [LR34]

SCOTT FRAKES: I can't remember if we addressed that in one of our reports or not. I don't... [LR34]

STEVE LATHROP: Yeah, you did. [LR34]

SCOTT FRAKES: Did we? [LR34]

STEVE LATHROP: 135. [LR34]

SCOTT FRAKES: One thirty-five, is that specific to us or the national numbers? [LR34]

STEVE LATHROP: You. [LR34]

SCOTT FRAKES: Okay, thank you. [LR34]

SENATOR SCHUMACHER: Would that be 135 out of the 300 or out of... [LR34]

STEVE LATHROP: No, page 135. [LR34]

SCOTT FRAKES: There you go. Sorry. [LR34]

SENATOR SCHUMACHER: Oh, page 135. Well, I guess... [LR34]

SCOTT FRAKES: So, yes, page 135 has the demographics: race, age, distribution across the facilities. [LR34]

SENATOR SCHUMACHER: Okay, so I guess we can plug those numbers into that... [LR34]

SCOTT FRAKES: Yeah. [LR34]

SENATOR SCHUMACHER: ...and answer these questions. So is there anything...first of all, does that imbalance or what appears to be imbalance at all contribute to the demographic of the inmates of the restrictive housing? [LR34]

SCOTT FRAKES: I sometimes wonder about that question. I don't have proof that it does but I do wonder about it just in terms of lack of understanding of how other cultures act, behave, interact with each other. So while I may think that my...you know, the way that I talk to somebody, the volume of my voice, the personal space that's comfortable for me, based on my culture it may be exactly what I think, you know, that's how I should behave. For someone that is from a different culture and doesn't understand that, they could perceive it as threatening behavior or as disrespectful behavior or whatever it might be. So it's a question in my mind and, you know, but the same question starts with the whole criminal justice system and why is there such disparity in terms of who ends up in the criminal justice system, who ends up in our jails, who ends up in our prisons. [LR34]

SENATOR SCHUMACHER: And I think we all recognize that you're having a hard time finding help to work within the department. But is there anything that is being affirmatively done to try to maybe address the situation some? [LR34]

SCOTT FRAKES: Yeah. Right. Well, so we know we don't have any affirmative action. That's been addressed in law. What we do is, and I've said this for years though, the real key to bringing diversity in terms of staff is to make sure that you're looking and advertising for and reaching out to those locations where a more diverse population lives. So we just met a few weeks ago, probably three weeks ago, and talked about are there other more neighborhood-based newspapers or radio stations. We were not advertising on any Spanish-language radio stations, so we are or we're in the process of doing that. You know, what else can we do in terms of recruiting? For the department, our diversity numbers are about 10 percent, so we're not far out of...you know, being consistent with Nebraska's diversity. That's another challenge. We're not an overly diverse state. Then you have Omaha that is a much more diverse urban area. What I haven't looked at, and I'm not sure that our systems even allow us to determine the...well, we probably could get there. What I haven't looked at yet is the ethnicity of our staff employed in our three Omaha facilities to see if there's greater diversity there. Anecdotally I think that's true but I haven't gone out and confirmed that. Then the bigger issue is how do you get to the leadership. So we are looking for ways to provide people with the training, with the skill, with the mentoring. And again, the right way to do that is for all staff to encourage people that may see themselves as marginalized or may think that they don't have an opportunity to have good, meaningful conversations about the fact that that isn't true, that this is a system that anyone can achieve in if they choose to. Does that mean that we have eliminated all of the prejudice and, you know, other issues within our department? No, I don't believe that's true. I don't believe that's true anywhere in America. It's an ongoing battle. But there's no question that we can do a much better job in terms of preparing people to take leadership positions. When one out of ten people represents the diversity of the department, you've already got a narrow pool that we're working with. And because my sense is that there has not been any emphasis around this issue in my department anyway for obviously a long time, that's part of the reason that there isn't greater diversity throughout the ranks. That 10 percent should be represented top to bottom. So it's represented at the warden level, that's one place, but in most cases, I think most of our leadership job classes there is serious lack of diversity. [LR34]

SENATOR SCHUMACHER: Thank you. [LR34]

SCOTT FRAKES: I don't like it either. [LR34]

SENATOR SCHUMACHER: I don't have anything else. [LR34]

SENATOR SEILER: Mr. Lathrop. [LR34]

STEVE LATHROP: I do have one comment and that is, after I stopped asking the questions and some other people were, I had a chance to visit with the Ombudsman Marshall Lux. He explained this criteria number 6, the addition to the ABA standards, has this subjective standard. And as I understand it, they propose that only with the understanding or as part of the criteria that it be only in those circumstances approved by you at the time. [LR34]

SCOTT FRAKES: Okay. [LR34]

STEVE LATHROP: And that was essential to their being at all comfortable with that subjective criteria and that part where you approve each one of these was...did...it was cut on the editing floor, if you will. [LR34]

SCOTT FRAKES: Yes, although we did have, I'd say, extensive conversation, I did, with James, Jerall, and with Doug. [LR34]

STEVE LATHROP: Right, but they insisted the whole time... [LR34]

SCOTT FRAKES: Yeah. [LR34]

STEVE LATHROP: ...that they needed you to be the gatekeeper for that sixth criteria. [LR34]

SCOTT FRAKES: I agree. [LR34]

STEVE LATHROP: And as it turns out, it's 42 percent of the people you're putting in restrictive housing. [LR34]

SCOTT FRAKES: For the first three months, you know. [LR34]

STEVE LATHROP: Right. [LR34]

SCOTT FRAKES: And if that trend continues and if I see that that is an issue that we can resolve and that I feel there's abuse of the system when we go back to revise the rules and regulations and go back for promulgation, I will put my name on that. So you've heard that out loud. I believe that we can get things... [LR34]

STEVE LATHROP: Somebody's listening, too, right? [LR34]

SCOTT FRAKES: I mean it. [LR34]

STEVE LATHROP: Well, we all are but... [LR34]

SCOTT FRAKES: So we've nine more months to make... [LR34]

STEVE LATHROP: Okay. [LR34]

SCOTT FRAKES: ...that and many other pieces of this work the way they need to work. [LR34]

STEVE LATHROP: Yeah, I appreciate the concern that they had, they expressed, which is the first five criteria. The ABA, I mean this is a thoughtful group of people... [LR34]

SCOTT FRAKES: Yeah. [LR34]

STEVE LATHROP: ...who have determined what their model would be, if you will, and they're all objective criteria, and this one has a significant piece of subjectivity to it. [LR34]

SCOTT FRAKES: Yeah. What I didn't want to do was...I appreciated that it was brought forward because it provided a way to deal with those cases which should be the minority of the cases, not 42 percent,... [LR34]

STEVE LATHROP: Forty-two percent, right. [LR34]

SCOTT FRAKES: ...that you either have to force it into one of the five criteria and then justify it, even if it's questionable. Better to have something that people could turn to. [LR34]

STEVE LATHROP: So let me ask this question then. In nine months from now if this group gets together and has another hearing, where should that number be before you start to go, wait a minute, because now you're going to talk to your folks about it better fit in the first five criteria and 6 should be used sparingly because it's a subjective standard. Where are you going to say, wait a minute, that's a criteria that's getting overused and we better take it out or I better be approving it? [LR34]

SCOTT FRAKES: All right. Let's get it below 20 percent by July 1 of 2017. And I don't know that that's the bottom line, but let's start, let's get to that point nine months from now. [LR34]

STEVE LATHROP: Okay. That's all I have. [LR34]

SCOTT FRAKES: And it's a matter of record. [LR34]

SENATOR SEILER: Thank you. Senator Paul. [LR34]

SENATOR SCHUMACHER: Thank you. Just one follow-up to that: If in before nine months from now are up you get a feel that that is being overused or abused or just they should be doing their homework on the first five instead of trying to just get it under the sixth, is there enough leeway in the regulations as they exist now for you to step in and say, wait a minute, folks, we're going to adjust that situation? [LR34]

SCOTT FRAKES: Well, I believe so if I understand how things were...I could be...I can't be less prescriptive than the statute. But if I want to put additional expectations around it, I think that would be within my purview. The first piece is where we're at right now. The deputies met with the wardens today. One of the conversations is, let's look at the data, let's see where things are at, how's it going, what do you do in that 24-hour review, wardens, do you actually...are you actually thinking about it or are you just signing your name to it, so some push back and this question of especially since one facility in particular seemed to be over the top in terms of number of placements for that criteria 6: Tecumseh. So, big facility, large security, large restrictive housing, but there's work to do. What will really help is when we are able to complete the project so that this becomes electronic, and that will also help in terms of data quality, because right now we're still working off of sort of a paper-based system. It's being done through spreadsheets so that... [LR34]

SENATOR SEILER: Senator Chambers. [LR34]

SENATOR CHAMBERS: Mr. President...Mr. Chairman, the people on this committee are hardworking people. You all can parse what I say and understand what I mean. So, lest anybody condemn all of you all for not taking up arms against me for making a reference to Christians, I will specify that I did not say all Christians. Some of my best friends are Christians, as well as some of my worst enemies. I have family members who are Christians. But I'm talking about the people who by their conduct fit into that categorization. And in the same way that Donald Trump says the President will not say "radical Islamist or Islamic" or whatever he says, I don't hear anybody talk about those radical Christians who do the mass killings in this country. I don't see one person talk about those radical Christians who were following the Bundy family out West: Cliven Bundy, who started it, and Ammon Bundy and his brother who are on trial right now for levying war against the United States, which is treason and they were not charged with it. Those are the radical Christians that I'm talking about. And I'm just waiting for Donald Trump to call them what they are. He won't say radical Christian. None of them will say radical Christian. Why won't they say radical Christian? Aren't these people who commit mass murder, serial killers, and they're Christians? Isn't that radical Christianity? That white kid who went in the black church and killed nine black Christians, was he not a radical Christian? But here's what I'm getting at. Not being a Christian, if I had any influence, I would contact the people in the state

where that occurred and say, you're not going to bring back those black people by killing him. And if you talked to the people in that church and their families, they probably would be the ones to say most forcefully don't kill him. That's what brought us to where we are now. People who disagree will feel they have the right to kill. Then those who are outraged and say the killing must stop will kill again. So for those people on KLIN, I think that's the radical Christian station in Lincoln, Fox network, who takes things out of context and spread them all over the country... [LR34]

SENATOR SEILER: You're talking about Colby's radio station. [LR34]

SENATOR CHAMBERS: Oh, well...(laughter) well, if the shoe fits. I hope I've explained what I meant. And the fact that Director Frakes didn't fall over backward out of his chair, I knew he understood. Nobody on the panel...one of my caught seatmates is even yawning. [LR34]

SENATOR BOLZ: I'm caught. [LR34]

SENATOR CHAMBERS: ...was shocked by it. But I've made other statements that I didn't think would shock anybody, but they were taken out of context, so I'm bending over backward to make it clear that people by me are judged by what they do. And I'm talking about the kind of people who are comfortable in the presence of other people's suffering, who can inflict suffering on people yet call themselves Christians. I will call them what they call themselves. That was the context in which I used the term. But I'm going to wait, but I will not wait to exhale until I hear these white people who are running for office, and others, refer to radical Christians, radical Christian terrorists, because that's what they are. With that, I yield the floor. [LR34]

SENATOR SEILER: Thank you, Director, for appearing. [LR34]

SCOTT FRAKES: Thank you. [LR34]

STEVE LATHROP: Thanks. [LR34]

SENATOR SEILER: Dr...I'll call Dr. Mit... [LR34]

STEVE LATHROP: Mit-uh-ray-choo (phonetically). [LR34]

_____: (Inaudible). [LR34]

SCOTT FRAKES: Probably running this way right now. [LR34]

SENATOR BOLZ: Are you sure she might not be running the other way? [LR34]

SCOTT FRAKES: No, she's ready for this and she will do very well. Thank you again for having Dr. Kohl go before me. [LR34]

SENATOR SEILER: No problem. Thank you. [LR34]

SCOTT FRAKES: Good luck. [LR34]

ALICE MITWARUCIU: Thank you. [LR34]

SCOTT FRAKES: Hey, this is the first time for her. [LR34]

SENATOR COASH: She'll be good. She'll be great. [LR34]

SENATOR SEILER: Doctor, will you introduce yourself and spell your last name. [LR34]

ALICE MITWARUCIU: Yes. My name is Dr. Alice Mitwaruciu, M-i-t-w-a-r-u-c-i-u. [LR34]

SENATOR SEILER: Okay. You may proceed. [LR34]

ALICE MITWARUCIU: Okay. Good afternoon, members of the LR34 Special Investigative Committee. My name is Alice Mitwaruciu and I'm the acting behavioral health administrator. It is indeed an honor and privilege to serve at the Nebraska Department of Correctional Services and to be invited by you today to discuss behavioral health services that are provided to over 5,000 inmates. I stepped in the critical role of acting administrator two months ago after the

resignation of the behavioral health administrator. Before that, I was the assistant behavioral health administrator for mental health services and worked very closely with the behavioral administrator. As such, I am familiar with the programs that fall under behavioral health and familiar with the direction the behavioral health division is going and my plan is to keep the programs and services in behavioral health moving in the right direction during this interim time. I will begin by stating that my goal today is twofold: to speak about what behavioral health staff within the Nebraska Department of Correctional Services are doing to meet inmate mental health needs, reduce recidivism and help fulfill our overall mission to keep people safe; and (2) I'll be talking about the successes and challenges that the behavioral health staff face every day while providing these services. Nebraska Department of Correctional Services requested that the Council of State Governments, CSG, Justice Center conduct an in-depth assessment of institutional programs to identify how the department can modify its investment to maximize recidivism reduction. In mid-June of this year, we received the Justice Program Assessment report with several suggestions on how to improve all the clinical programs and services that we provide. After a six-month review, the center for...the Council for Social Government (sic--Council of State Governments) found that Nebraska Department of Justice (sic--Correctional Services) uses several state-of-the-art risk reducing programs. In fact, they ranked our sex offender program as one to the top five in the nation. It is also worthy to note that our violence reduction program was given high ratings as a program that focuses on inmates who were previously not treated specifically for their violent lifestyles with an evidence-based approach. The violence reduction program originated from Canada, is used extensively, and has been found to be successful in reducing the risk to reoffend. The violence reduction program utilizes a three-stage model to deliver effective management of individual risk factors, development of coping skills and intervention strategies, and formulating a relapse prevention plan designed to achieve successful reintegration. After reviewing this report, we recently met with the JPA staff for two days to discuss the implementation phase of the recommendation given to us. This meeting included both clinical and nonclinical staff. We are meeting with JPA consultants again on October 19, which is next week, with a plan to complete the discussion regarding the implementation phase. It is my belief that our treatment programs and clinical services will improve tremendously when we implement the recommendations from this report from JPA. Of course our greatest challenge moving forward is the number of vacancies within behavioral health. As of this week, we have about 35 vacancies in behavioral health. Currently, we have 23

psychologist positions and only 11 of those are filled at this time. Our other behavioral health vacancies include: licensed mental health practitioners, substance abuse counselors, and social workers. The majority of our clinicians who have left accepted employment elsewhere in the community where they are receiving better wages and work under less stressful environments with less difficult clients. We are working to address the issue of wages, and improve working conditions in addition to identifying strengths and preferences of the clinicians, giving them more venues for input and flexibility in their work schedules. We continue to recruit aggressively to fill the vacant positions and retain the clinicians we have. In the last two weeks, we have interviewed at least four candidates that applied through a staffing agency and three candidates who I interviewed that applied through the state process. In September, we hired a psychologist for the restrictive housing unit at Tecumseh. Most applicants are interested the job duties and the experience they gain while working in a forensic setting; however, they are less interested in working in rural locations like Tecumseh. The increased number of inmates who enter our prison system with both criminal and mental health issues is another challenge facing behavioral health. Nebraska Department of Correctional Services is receiving more and more mentally ill individuals due to the declining access to mental health treatment in the community. The Lincoln Regional Center has fewer beds for mentally ill individuals requiring maximum security setting. Many psychiatric beds have been removed from the regional center system including bed spaces lost when the Hastings Regional Center closed in addition to Norfolk and Lincoln Regional Centers reducing their censuses. Another challenge for behavioral health is the lack of consistent leadership. In 2015 we had the behavioral health administrator and the assistant administrator for mental health services resign. Dr. Jones was hired as the behavioral health administrator in the summer of 2015, and resigned in August of 2016. At that time I took over as the acting administrator while at the same time fulfilling the duties of my job as the assistant administrator. I would also like to point that the assistant administrator for sex offender services just resigned this last month, in September. And in addition to that resignation, we had several psychologist supervisors and mental health supervisors also resign, leaving additional leadership positions within behavioral health vacant. The greatest impact is being felt in the delivery of clinical programming services, but it's also challenging to maintain momentum and continuity of care without consistent leadership in behavioral health. We are in the process of requesting a proposal from Correct Care Solutions to provide mental health services at Tecumseh. We have contracted with Maxim, another vendor, to help us fill the positions of psychologists in other institutions.

There are challenges that come with contracting behavioral health services. These include the fact that contract provider's level of commitment is not the same as of those hired by the state, also patients not having access to the same providers, and the wages are significantly higher than those paid to full-time state employees. For these reasons and other reasons I would prefer to fill positions with full-time employees, but at this time, because of the high need, we will continue to utilize contracted services where needed. At this point I would like to highlight some of the work and the programs within behavioral health and I will start by talking about the discharge review team. This is the review team that sits and reviews most of our inmates who are leaving the Department of Corrections and entering the community. And we review risk factors to determine the level of care, whether it is Mental Health Board commitment or law enforcement notifications when they leave our correctional facilities, or whether we need to do a Tarasoff warning if we have identified victims. Over the last year we refined the discharge review team processes to embrace best practice, we developed policy, and are completing the process to promulgate the rules and regulations. We also hired a nationally recognized consultant to ensure our discharge review process achieves our mission to keep people safe. Social work services: We help inmates with identified major mental illness and chronic major medical issues to get ongoing mental health and medical needs in place at the time of discharge. This helps them to be more stable upon discharge. A direct, warm hand-off with community providers helps improve follow-through. We increased the number of social workers between 2010 and 2015 from four total positions to ten total positions. This has helped expand the number of inmates we can work with and provides increased continuity of care. The goal is to have social workers meet with all inmates who have an identified serious mental illness or medical need. Due to current vacancies we are not yet meeting this goal, but our hope is when we fill these positions we can achieve those goals. With substance abuse treatment we have our residential treatment unit at NSP with just about 100 beds, and we have other residential programs at the Women's Correctional Center in York and we also provide substance abuse residential treatment at Tecumseh in the protective management unit. Residential programing has been made more consistent throughout DCS. We have updated treatment materials including treatment manuals, books, and videos. The residential substance abuse program continues to provide residential substance use programming in a timely and humane manner to inmates who have moderate to severe alcohol/drug use issues. In addition, we also provide for the mental health and social work needs of each individual in our program to promote a sustainable recovery lifestyle. We've begun doing more individualization

of programming for repeat offenders and inmates who have prior/multiple treatment episodes. Now going to sex offender programming, we have our Inpatient Healthy Lives Program, which we call IHeLP, which is rooted in the Good Lives Model and dialectical behavioral therapy, DBT. The IHeLP program is a 52-bed inpatient treatment unit that is located at the Lincoln Correctional Center on housing unit E-1. The IHeLP is a 24- to 36-month program, though individual time frames may vary greatly on individual motivation to finish program and amount of risk and needs. Once an inmate has accepted an IHeLP treatment recommendation, they are placed on the IHeLP wait list. And this list is prioritized by their PED or TRD and other clinical factors. I would also like to talk a little bit about the mental health unit and the secure mental health unit. Both are located at the Lincoln Correctional Center, these two inpatient units for those diagnosed with severe mental illness to include schizophrenia, schizoaffective disorder, bipolar disorders, mood disorders, anxiety disorders, cognitive disabilities, traumatic brain injury, and other mental health impairments. In the mental health unit, for this...up to this morning there was about 66 patients that are treated in that unit and we have four medical porters who support those with major mental illness in the unit. And the census for the secure mental health unit was standing at 34 this morning. Services offered in the secure mental health unit and the mental health unit include: individual and group therapy, mental illness awareness, symptom management, social skills, medication management, problem-solving skills, and discharge planning. We also have an adjustment and core group and a personal safety group. Medication management by psychiatry includes involuntary medication orders as well as regular medication management. With improved staffing, the mental health unit will be offering anger management group and we have added two more groups for our chronic population. The secure mental health unit houses inmates with chronic severe mental illnesses in addition to severe behavioral problems including severe self-harming behaviors. The secure mental health unit is currently considered part of our restrictive housing and, therefore, services in this unit are also guided by the new policy that took effect on July 1. Going down, I will discuss the violence reduction program. In the past seven months, there have been 1,484 assessments completed. This is an 83 percent increase. The goal is to assess individuals coming into the Diagnostic and Evaluation Center and the NCCW-D&E within the first 90 days. We now know the overall needs for violent offender programming through the department. Additionally, new individuals entering the system know what is expected of them up-front. We have also added domestic violence programming to the Nebraska Department of Correctional Services which did not exist

previously. This has addressed an ongoing need of our population which they did not have for years. We have trained additional staff and increased the amount of multidisciplinary involvement our clinicians have overall. Our vision is to focus our clinical resources on violence reduction program proven to reduce recidivism and expand VRP to other institutions. As of now, we only run VRP groups at NSP and our hope is to expand that to TSCI when we have enough staffing. At this time I would really like to share my vision in my interim position. I don't know if this is going to...how long I will hold this acting position, but since I'm the...it for now for the department, I would like to share with all of you what I believe is our mission in behavioral health. One of the things we would like to improve is our usage of evidence-based clinical programs that have been found to be efficacious, and also to ensure that inmates are assessed for immediate mental health needs upon admission. And for clinical programming within 90 days of arrival, we need to be doing those screenings so we know what inmates need within 90 days of being admitted at D&E. Also: provide treatment and programming before parole eligibility to maximize potential for success in the community. Another vision is to provide gender-responsive treatment, especially to the women at the NCCW, focusing on trauma issues; also to recruit and retain qualified and experienced behavioral health clinicians so that we can be deliberate in the services we offer and become more effective in our clinical interventions; also provide training to equip the behavioral health staff to address the unique needs of our population. We completed schema-focused training therapy a few weeks ago. We also held our substance abuse training two weeks ago and right now we are scheduled to have the violence reduction training at the end of October and the first week in November. Also my vision for behavioral health is to coordinate services with the parole, probation, reentry and community providers to ensure seamless provision of services once inmates reenter the community, also to build quality assurance treatment fidelity to ensure treatment programs that are delivered to inmates are consistent and are effective. What we need in order to realize the visions I shared with you this afternoon is, first of all, to fill all the vacancies. As I said, we are really hemorrhaging in terms of losing very seasoned, qualified clinicians who are leaving the department and going to work elsewhere. Also, competitive wages has been an issue and the director and his office is addressing those issues, trying to do what we can and also using other stakeholders to be a part of that conversation to increase the wages for the clinicians in behavioral health. Also, in order for us to realize our mission and vision in behavioral health, recognition from the Legislature and the community of the hard work we perform every day in a very stressful and dangerous

environment. Bad press has not been very helpful to the morale of my staff in behavioral health and in the department as a whole and that is hurting our retention and recruiting efforts in a big way. Also, I would request support for leadership. The director and his staff need the respect and support to help us achieve our mission, goals, and achieve our vision which is to keep people safe. I can tell you that in behavioral health the clinicians who are choosing to stay are the most dedicated psychologists, mental health clinicians that I have ever worked with. They walk through the doors of prison not knowing what a day will bring. We don't know what will happen on a given day but they show up every single day. And when they show up and when they put their badge on, they are ready to provide services to the inmates. And I would really like to stress that I would not have stepped into this acting role if I didn't know the quality of staff that are in the behavioral health division. And so for that reason I really would like everybody--you, the community, and everybody else--to support behavioral health so we can continue to provide the services to our inmates that they deserve. Thank you very much. And at this point I'll open it up to you to ask any questions that you may have. Thank you. [LR34]

SENATOR SEILER: Mr. Lathrop. [LR34]

STEVE LATHROP: Okay. Before we start, because you're about the third person or fourth person to come in and talk about how the press is affecting morale, I want to be very, very clear about something, and that is what this committee is trying to do is help the very people you're talking about. [LR34]

ALICE MITWARUCIU: Thank you. [LR34]

STEVE LATHROP: The goal of this committee, as I understand it, is to improve things at the department, to improve safety of the officers, to improve safety for the people that work there, and to provide a better work environment for the very mental health professionals you're telling us are concerned about what they're reading in the paper. So that we are clear,... [LR34]

ALICE MITWARUCIU: I appreciate that. [LR34]

STEVE LATHROP: ...our only purpose here, we are not critical of the people who show up every day and don't know what to expect and what they're going to encounter and who provide those services to the inmates. We appreciate what they're doing and we know many of them could only be incredibly dedicated to stay there when they're being paid less than their contemporaries in private practice. Okay? [LR34]

ALICE MITWARUCIU: Thank you. Appreciate that. [LR34]

STEVE LATHROP: So that we're very clear about that. [LR34]

ALICE MITWARUCIU: Thank you. [LR34]

STEVE LATHROP: I wanted to ask you some questions, and I very much appreciate, Doctor, your being here today so that we can talk about behavioral health. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: And as I was preparing for these hearings I read some statistics. We had requested some information from the department and they advised us that they have 1,100 out of 5,300 inmates that have a serious mental disorder. Right? [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: You have a significant population of 20 percent of the people who are within the Department of Corrections who have serious mental illness. Right? [LR34]

ALICE MITWARUCIU: Yes, that is correct. [LR34]

STEVE LATHROP: And in addition to the 20 percent that have serious mental illness you have, in total, another 60, or a total of 80 percent of people in the Department of Corrections with one or more mental or behavioral diagnoses. Is that true? [LR34]

ALICE MITWARUCIU: Including substance abuse diagnoses. [LR34]

STEVE LATHROP: Including substance abuse. Twenty-five percent of the inmates and 50 percent of the female inmates are on psychotropic medications. Right? [LR34]

ALICE MITWARUCIU: That's correct. [LR34]

STEVE LATHROP: In addition to the mental illness, you also have special needs inmates, those folks that have a developmental disability, a brain injury, or those people with dementia. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: In addition to the individuals that have, or perhaps some of them have codiagnoses, is that true? [LR34]

ALICE MITWARUCIU: Correct. [LR34]

STEVE LATHROP: And you would agree with me that when folks enter the Department of Corrections some 95 percent of them will be returned to the community. [LR34]

ALICE MITWARUCIU: That is correct. [LR34]

STEVE LATHROP: All right. So it is incumbent upon the Department of Corrections when they have the opportunity to provide the highest level of behavioral healthcare... [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: ...and treatment of the mental illnesses so that people improve while incarcerated, and that's part of your vision. [LR34]

ALICE MITWARUCIU: That is correct. [LR34]

STEVE LATHROP: That's the goal. [LR34]

ALICE MITWARUCIU: That is the goal. [LR34]

STEVE LATHROP: In fact, the statutory requirement is that the department provide care equal to the community standard of care. [LR34]

ALICE MITWARUCIU: Correct. [LR34]

STEVE LATHROP: So the fact that they are inside the walls doesn't change what they might expect or what the standard of care should be. [LR34]

ALICE MITWARUCIU: Correct. [LR34]

STEVE LATHROP: It's the same as though they were on the outside. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: The department has issued regulations and I want to ask you questions about these. There's two of them in particular... [LR34]

ALICE MITWARUCIU: Okay. [LR34]

STEVE LATHROP: ...that I wanted to talk about. One regulation requires an annual assessment of each institution to determine whether the facilities and the behavioral staff are sufficient to meet the needs of the inmates at that institution. First of all, are you familiar with that regulation, Doctor? [LR34]

ALICE MITWARUCIU: I'm familiar with the regulation. [LR34]

STEVE LATHROP: Okay. [LR34]

ALICE MITWARUCIU: And we try our best. We have robust review teams that review inmates who have any mental illness concerns, and we use those review teams as our referral. So when inmates are decompensating or their functioning changes, anybody can, whether it's correctional officers, whether it's the caseworkers, whether it's other mental health professionals, if they notice somebody is having mental health issues, they can make referral to our mental illness review committee. And then at that point I may ask a clinical psychologist to complete a psychological assessment to see the level of functioning of that patient to make sure we know the diagnosis; we consult with our psychiatrist who also serves in that mental illness committee. [LR34]

STEVE LATHROP: Okay. [LR34]

ALICE MITWARUCIU: So we have a system in place to make sure that those who have the mental health needs are assessed, a referral is made, and they are placed appropriately to receive mental health services. [LR34]

STEVE LATHROP: Okay, that's a little bit different than the question I asked. [LR34]

ALICE MITWARUCIU: Okay. [LR34]

STEVE LATHROP: The regulation requires that you evaluate by institution annually to determine whether the facilities at the institution and the staffing levels are sufficient to provide the care of the patients or the inmates. [LR34]

ALICE MITWARUCIU: Okay, I see. Okay. [LR34]

STEVE LATHROP: Is that being done,... [LR34]

ALICE MITWARUCIU: At this point... [LR34]

STEVE LATHROP: ...an annual review of the facilities and the mental health staff at each institution? [LR34]

ALICE MITWARUCIU: We are very short staffed and unfortunately I would say we are not following that strictly because of the staffing levels. [LR34]

STEVE LATHROP: I appreciate your candor with that answer. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: I have one more question about regulations. Regulation 115.02 requires that there be an annual staffing analysis to determine whether there are sufficient staff. The director was here and said that's not being done, that we have not done the staffing analysis to determine not just what our vacancies are, but what the need is to provide the level of care law requires,.. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: ...The community-based standard. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: Would you agree those aren't being done? [LR34]

ALICE MITWARUCIU: They are not being done; however, I would like to add that when you have so many vacancies, for example, we are slated for 23 psychologists--just an example, I'll use psychologists, because that's a smaller number I can use--so we have 11...We have only 11 out of those filled, so it would be very difficult even to know, if We were fully staffed, The level of services We could provide. [LR34]

STEVE LATHROP: I can appreciate that. [LR34]

ALICE MITWARUCIU: Yeah. [LR34]

STEVE LATHROP: I can appreciate that and I'm not sure how one goes about doing The staffing analysis of... [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: ...The number of behavioral staff folks that you need, although Dr. Gage made reference to an approach. But what you're suggesting is We have so many vacancies that we're worried about filling The vacancies and not how many more people over and above The vacancies We actually need. Would that be a fair statement? [LR34]

ALICE MITWARUCIU: That's a fair statement because if I was fully staffed in behavioral health and then allocate those people to do The services, I would have an idea of now that We are fully staffed, this is The level of services We can provide. Then I can tell you, in addition to these full positions, this is what I need more to add additional services. [LR34]

STEVE LATHROP: So we've heard and received information I think in response to an inquiry by Senator Bolz about The number of vacancies. And we've heard different numbers today. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: But obviously The medical director is gone and The chief of psychiatry is gone. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: The head of behavioral health is gone. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: And you are now in The acting position. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: And in addition to those three leadership positions We have some 34 other behavioral health staff that are vacant positions. [LR34]

ALICE MITWARUCIU: Vacant, yes, that's correct. [LR34]

STEVE LATHROP: Okay, so given that you are...you must be stretched thin? [LR34]

ALICE MITWARUCIU: Very. [LR34]

STEVE LATHROP: ...Stretched very thin, do you think that you're providing a standard of care equal to The community at this point with all these vacancies? [LR34]

ALICE MITWARUCIU: You know, that is a very interesting question because even with The few staff that We have within Corrections, and this is my belief, We exceed The standard care that is provided in The community, especially when you look at our inpatient programs, The number of individual contact our inmates...I'm using "clients" and The "patients" because I see them as patients as a psychologist. If you look at The number of contacts every month our inmates receive, especially those in inpatient programming and The number of contacts they get with a psychiatrist, you cannot find that level of care in The community. And The reason I say this is because if you take somebody in The community and say, you need mental health inpatient treatment, most people cannot afford 30 days of inpatient... [LR34]

STEVE LATHROP: Did you say fund? [LR34]

ALICE MITWARUCIU: What? [LR34]

STEVE LATHROP: Most people can't fund it? [LR34]

ALICE MITWARUCIU: Cannot afford to pay for more than 30 days' inpatient programming in The community. Now We provide more than 30 days of inpatient care. Most of our programs run

from six months to several years where they are receiving care. So, now, The issue here is We cannot provide that for The 5,000 inmates because they all not need that level of care. But for The acute people with mental illness, even with very few staff, We try our best to put our resources to take care of those people with acute mental illness. [LR34]

STEVE LATHROP: You should understand, and I'm repeating myself, no one is suggesting that you're not doing your best with The resources you have. Okay? [LR34]

ALICE MITWARUCIU: The...yes. [LR34]

STEVE LATHROP: That's not...I'm not concerned that you're not trying hard or that you're not doing The best with The resources you have. The question has to do with whether you have enough resources and you've told me you have all these vacancies. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: And The question is, so where is the...where are We coming up short if We have such a significant number of people who are...make that a significant number of vacancies in behavioral health? [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: Psychologists, mental health workers, eight chemical dependency counselors, how can We not be coming up short in terms of providing timely care and providing it at The community standard of care? [LR34]

ALICE MITWARUCIU: Where We come short is with what We call outpatient services on general population. So my point here is when We are so short staffed, I have to ask in my head where...what group of our inmates need care right now in this moment. So when I do allocation of services, I will direct those services to The inpatient programs because that is where We have severe mental illness. These are people who are psychotic, they have bipolar disorders. They cannot go for weeks without therapy, without groups, without their medication management. So

I allocate The mental health resources to that group of people. So what then that does is other people with just mental illness which does not rise to The level of a major mental illness, We are taking those resources away from them. So our general population and people maybe in protective management are going without that standard care, The community standard of care, because We focus those few resources to The group that has acute mental health illness. [LR34]

STEVE LATHROP: That's triage. [LR34]

ALICE MITWARUCIU: That is triage, exactly, thank you. [LR34]

STEVE LATHROP: Triage: taking care of The most acute problems and The people that are closest to getting out. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: So I want to ask you a question. While you were testifying and giving your opening statement, Doctor, you told us about a number of people that have left. [LR34]

ALICE MITWARUCIU: Correct. [LR34]

STEVE LATHROP: Right? You had a number of departures from The Department of Corrections in The behavioral health. Are you engaged or have you participated in any exit interviews? [LR34]

ALICE MITWARUCIU: Most of...yes, a few others... [LR34]

STEVE LATHROP: Okay, tell us what people are telling you as The reason they are departing The Department of Corrections and going somewhere else. [LR34]

ALICE MITWARUCIU: One of them is wages, so We are competing with The private sector, so We are drawing from The same pool for positions and some of The people are paid higher than We pay within Corrections. So that is number one. Number two, We work with a very criminal

population, which is what We do in Corrections, and that population is very challenging to work with. Some people feel, some even threatened, their licensed is threatened--if you don't give me this, this is what I'm going to say, I'll make sure you get fired. So some people worry about losing their license they spent years working to achieve and to attain. So it's a very difficult population to work with. So when people find a job where they work eight hours under very less stressful conditions, they go for that. Number three, also, is The caseload levels. When you have one psychologist at Tecumseh, a maximum prison with over 1,000 inmates with one psychologist, you can imagine The caseload of that one person or that psychologist. So people look at that and it's...can't be managed. [LR34]

STEVE LATHROP: But is it... [LR34]

ALICE MITWARUCIU: So if they find another position where The caseload is manageable, they are more likely to choose to go to those positions. Also, for The mental health practitioners, We have competition with our sister state agencies like Probation and Parole. So a mental health practitioner working for Corrections can go across The street to The probation and parole services and make $10,000 to $20,000 more than they are making within Corrections. So We are competing with other state agencies and, therefore, that...those are some of The things I hear in The exit interviews. [LR34]

STEVE LATHROP: Dr. Gage came to Nebraska and did an assessment of behavioral health. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: Were you involved in that? [LR34]

ALICE MITWARUCIU: I was. [LR34]

STEVE LATHROP: Tell me what your involvement was, Doctor. [LR34]

ALICE MITWARUCIU: He came and interviewed. At The time, that was 2015. When he came, he toured our mental health unit. And before taking The position of The behavioral health administrator, I was one of The other psychologists in The mental health unit. And so he was reviewing our programming in The mental health unit and The secure mental health unit and he was asking questions about The types of services We provide and how We run that program, so. And I also sat in The exit meeting when he provided us with The feedback after he finished his assessment of our programs. [LR34]

STEVE LATHROP: And he wrote a report. [LR34]

ALICE MITWARUCIU: He wrote a report. [LR34]

STEVE LATHROP: In that book in front of you, if you don't mind opening that,... [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: I don't want this to be a quiz, so I'm going to... [LR34]

ALICE MITWARUCIU: I also brought my report, the Gage report. [LR34]

STEVE LATHROP: Okay, if you want to look at yours, that's fine. [LR34]

ALICE MITWARUCIU: Yeah, that's all right. Okay. [LR34]

STEVE LATHROP: Starting at page 69. [LR34]

ALICE MITWARUCIU: Page 69. All right. [LR34]

STEVE LATHROP: And I tell you where that's at in the book so that if we talk about a page or if you want to review it, so that we can have some conversation about it. But the first thing I'd like to know is, what was your role at the Department of Corrections when this report was issued back in the July? Were you the acting director yet? [LR34]

ALICE MITWARUCIU: July of 2015? [LR34]

STEVE LATHROP: Yes. You would not have been the acting director yet, would you? [LR34]

ALICE MITWARUCIU: I was the acting behavioral health administrator. That's the position that was held by Dr. Weilage. So I was the acting in that position at the time. [LR34]

STEVE LATHROP: Okay, but you were involved in meetings while this was being prepared with Dr. Gage and then sort of a briefing after he'd come to his conclusions. [LR34]

ALICE MITWARUCIU: Not all the meetings, just the questions that involved the mental health unit because that's where I was at the time. [LR34]

STEVE LATHROP: Okay. You've reviewed the report? [LR34]

ALICE MITWARUCIU: I have. [LR34]

STEVE LATHROP: And the report makes a number of observations about the Department of Corrections... [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: ...and its provision of behavioral health services, and then it makes a number of recommendations. Would you agree with that? [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: Can you tell us what was done with this report after it was authored and provided by Dr. Gage? [LR34]

ALICE MITWARUCIU: There is, again, there are a few things that we have done in terms of how often people are seen because he had talked about the number of sessions people are seen,

the number of psychiatric contact the inmates get from psychiatry. And what we have done so far is to add more groups in our mental health unit. There are some other things that he recommended though that we have not achieved yet. And that is like mission-based housing was one of the things he mentioned. And that came out of this observation that we had on what we called the "D Wing" in the mental health unit of individuals who are aging, aging out, and they were mixed with more younger people. And so they needed a slow pace of treatment and he was recommending that we look into finding mission-based housing for patients like those who are aging but also still the chronic mental health illnesses where they could be treated in a unit that was, you know, was serving their needs, especially the...our geriatric population. So that was one of the recommendation I remember him talking about. Also... [LR34]

STEVE LATHROP: He also talked about vision, didn't he? [LR34]

ALICE MITWARUCIU: He also talked about some services being offered by nonclinical people or staff, nonclinical staff, to free time for clinicians to focus on clinical programming. So that was another recommendation. [LR34]

STEVE LATHROP: Are you doing anything with that recommendation? [LR34]

ALICE MITWARUCIU: Yes, we are. We just...because that was also a recommendation from the Justice Program Assessment that we received a few weeks ago and right now, for example, the clinical staff one doing the violence, they...not the violence reduction but the domestic violence groups, which we follow the Duluth Model. And we have trained a few nonclinical staff to run those groups that necessarily don't require a clinician or a licensed mental health practitioner person to run. So we are in the process of streamlining those services to decide which programs fall under nonclinical staff so they can run those groups in the units and then which programs fall under the clinical realm that have to be ran by a licensed mental health practitioner. [LR34]

STEVE LATHROP: That's...you're still undertaking that process? [LR34]

ALICE MITWARUCIU: We are in the process of doing that and implementing those recommendations, yes. [LR34]

STEVE LATHROP: Okay, let me ask a question. One of the very first recommendation he makes is developing vision statement... [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: ...which is, as he's suggested, will provide some focus on how you prioritize your resources, to what degree will mental health participant in the institutional management and control and how is this balanced with patient care. Do you focus on doing a good job treating the sickest or try to expand and stretch our resources to serve as many possible? Is your primary treatment goal symptom reduction or functional improvement? You're familiar. There's a number of things in there. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: And I'm not going to read them all. But have you had any meetings to develop what the vision is for behavioral health and what the scope of the services are going to be for inmates who are within the Department of Corrections? [LR34]

ALICE MITWARUCIU: I'd like to say that the former behavioral health administrator, Dr. Jones, was in the process of working on those things that Dr. Gage recommended. And I've been in this position for just about eight weeks, so that is something I would say I have...I'm not there yet. I was in a crisis mode in terms of making sure the services are going. So that is something I'm assuming that as soon as this position is filled we'll continue to address the mission statement. [LR34]

STEVE LATHROP: Okay. And believe me, once again, this is not a criticism. [LR34]

ALICE MITWARUCIU: Yeah. [LR34]

STEVE LATHROP: I appreciate that you've just come to the position, but before Dr. Jones left--this report is a year old--that had not been done or completed, the vision statement. True? Dr. Jones did not complete the vision statement before her departure? [LR34]

ALICE MITWARUCIU: It would be difficult for me to say yes or no because I'm still going through all these things. She did a lot of good things, I must admit. And so it will take time for me to go through everything that she did and then find out what was not done and determine what needs to be done. So... [LR34]

STEVE LATHROP: Okay. One of the recommendations they make is...has to do with keeping track of information. Right? [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: Some kind of a program that keeps track of where your population is at, who has a mental illness, who is getting care, who's getting treatment,... [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: ...he refers to it as a dashboard, but an ability to look at the statistics for your population. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: Has anything, any progress been made in that respect? [LR34]

ALICE MITWARUCIU: Yes, significant progress. [LR34]

STEVE LATHROP: What is that? [LR34]

ALICE MITWARUCIU: We have our group of people at Central Office. Abbie (phonetic) is...she has a Ph.D. in statistics and we also have Ander Alvarez (phonetic), and she has been

working on those dashboards in the last several months. And we are now able to pull statistics from our NICaMS, which is our reporting system. And this morning, in fact, as I was getting ready for this hearing, I sat down in front of my computer and I was able to pull some statistics from those dashboards. So we are not where we want to be with all the programs, but at this point I feel that we are moving the right direction and there are some statistics that we can pull right now using those dashboards in terms of wait list, who has severe mental illness, and the programming that is provided. So I can confidently say we have some progress in that direction. [LR34]

STEVE LATHROP: I don't want to go through every recommendation or we'll be here until 8:00. But Dr. Gage does wade into, or go into, some staffing recommendations. Would you agree with that? [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: And you're familiar with those recommendations? [LR34]

ALICE MITWARUCIU: Some of them, yes. [LR34]

STEVE LATHROP: Have you compared, Doctor, the recommendations made by Dr. Gage or employed the method that he suggests to determine what your staffing needs are over and above your vacancies? [LR34]

ALICE MITWARUCIU: I would defer that question because again that was before my administrator's role to take care of that and I have to go back again and I can come back at a later time and tell you what has been done. But on the other hand, I have to say that having been with Corrections with several years now, we know what the need is. The question is, do we have the manpower, the womanpower to meet that need? We know how often clients are supposed to be seen if they have a mental illness. We know who needs psychological assessment because we get those referrals every day. And that is piling because I don't have enough psychologists to do that. So in terms of do I know what we need, I know exactly what the need is. We have...I know my expectations of all my psychologists. I expect them to finish diagnostic evaluations. We have

Parole Board evaluations; we have Mental Health Board commitment evaluations. I know what that means. I know exactly the services we are supposed to be providing. The question for me is I do not have enough people to do those job responsibilities. [LR34]

STEVE LATHROP: And that's kind of what I'm driving at. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: And we know what the vacancies are. Dr. Gage has recommended six psychiatrists. [LR34]

ALICE MITWARUCIU: Okay. [LR34]

STEVE LATHROP: Do you agree with that? [LR34]

ALICE MITWARUCIU: Yes, maybe even more. [LR34]

STEVE LATHROP: So in addition to your vacancies, can you tell this committee how many more mental health providers that you need by category? [LR34]

ALICE MITWARUCIU: At this time? [LR34]

STEVE LATHROP: Even if it's a rough estimate. [LR34]

ALICE MITWARUCIU: We have, for example, I can give you an example, we have 23 psychologist positions departmentwide. And even with those 23, the need for psychological services is rising and this is the reason why. We just adopted the policy for restrictive housing. With that policy came recommendations of how often we have to see the inmate in restrictive housing. So if somebody is going to immediate segregation and they...and those in a mental health need, we have to see them within the first 24 hours. Now you have to remember, if they go to IS, which is immediate segregation, on a Friday, they have to be seen on a Saturday to meet that requirement of 24-hour assessment. [LR34]

STEVE LATHROP: Sure. [LR34]

ALICE MITWARUCIU: So that is one. Number two, after the 14 days, regardless of whether they have a mental illness or not, we have to assess them. A mental health practitioner or a psychologist has to assess them within 14 days. So now we go past the immediate segregation or immediate...yes, IS, immediate segregation. When they go into long-term restrictive housing, there is more need for mental health practitioners, behavioral health clinicians to see them, cell front visits every week, okay, out of cell every week. And in addition to being...to those two contact, we have to develop a treatment plan. So to answer your question, I could use another ten psychologists just to take care of restrictive housing requirements. [LR34]

STEVE LATHROP: Over and above the 20? [LR34]

ALICE MITWARUCIU: Over and above, yes. [LR34]

STEVE LATHROP: Over and above the 23? [LR34]

ALICE MITWARUCIU: Yes, because... [LR34]

STEVE LATHROP: So you think you need 33 psychologists. [LR34]

ALICE MITWARUCIU: You know, I don't know the exact number, to be honest with you. I'm just telling you that there is additional need and there is additional request from the policies that are being adopted, requesting more additional services to our inmates with the same staffing levels. So my point is we could use more, yes. [LR34]

STEVE LATHROP: Okay, and that's kind of what we're trying to learn if...and we appreciate your candor. You said there are 23 positions right now. You're short 8 of...from those 23. [LR34]

ALICE MITWARUCIU: Yeah, because we have... [LR34]

STEVE LATHROP: So you could use the eight vacancies filled and another ten psychologists. [LR34]

ALICE MITWARUCIU: We could. [LR34]

STEVE LATHROP: How about the mental health practitioners? [LR34]

ALICE MITWARUCIU: Mental health I would say I'm about the same because they also...they do all those mental health contact as well. Restrictive housing contacts are not just specific to psychologists. I was just giving an example. [LR34]

STEVE LATHROP: Okay. [LR34]

ALICE MITWARUCIU: Our mental health practitioners do the same...they do the same contacts,the 24-hour assessment, the front cell door assessment, out of cell, pulling these guys out of their cells for assessment and therapy. Also, in addition to that, I would really like to take this opportunity to say we have also our mental health officer of the day duties, which is after-hours crisis calls and during the weekend calls. And if you look at the mapping of our institutions, some...I have psychologists and mental health practitioners who drive to Tecumseh to help them out with mental health crisis calls after hours and during the weekend. And they drive there on the weekend. They don't get any compensation for that in drive time. They don't get any mileage reimbursement, nor do they get a dime of the salary they make when they work a 40-hour week, so... [LR34]

STEVE LATHROP: Dedicated staff. [LR34]

ALICE MITWARUCIU: What? [LR34]

STEVE LATHROP: Dedicated staff. [LR34]

ALICE MITWARUCIU: Dedicated staff, every single day. [LR34]

STEVE LATHROP: If I could go back to the question then, it would appear that you have nine vacancies, if I understand it right, with the mental health practitioners. In addition to filling the nine vacancies, how many more do you think you need to provide the standard of care? [LR34]

ALICE MITWARUCIU: Honestly, I don't want to give you numbers without consulting, you know, like the director and the people who do appropriation of these positions. All I can say is we can use more. [LR34]

STEVE LATHROP: But... [LR34]

ALICE MITWARUCIU: But it would be very...having been in this position for eight weeks, I don't want to be the one saying Dr. Alice asked for ten people. Maybe we needed ten or they can say, oh, maybe we needed five, so... [LR34]

STEVE LATHROP: But this is the problem, if I may. [LR34]

ALICE MITWARUCIU: Okay. [LR34]

STEVE LATHROP: And Senator Schumacher referred to this before. Unless we ask somebody at the ground level, you know, this may come to Appropriations and they go, we don't need any more mental health professionals. [LR34]

ALICE MITWARUCIU: So then my request... [LR34]

STEVE LATHROP: So what we're looking for is just your thoughts on, in addition to the nine vacancies, do you feel like you need more mental health practitioners? [LR34]

ALICE MITWARUCIU: So then can I request that you give me a chance to look at my staffing levels and come back to you with those numbers, please? [LR34]

STEVE LATHROP: Yes. [LR34]

ALICE MITWARUCIU: Well, thank you. [LR34]

STEVE LATHROP: As long as they're your numbers, okay? [LR34]

ALICE MITWARUCIU: Okay, sure. [LR34]

STEVE LATHROP: And I don't mean to imply anything about anybody that you have to report to, but we want the unvarnished number... [LR34]

ALICE MITWARUCIU: Sure. [LR34]

STEVE LATHROP: ...and not the one that gets scrubbed for the budget. [LR34]

ALICE MITWARUCIU: Yeah. I can come back and consult with my other supervisors in behavioral health and I can bring you back a number depending on our need. [LR34]

STEVE LATHROP: Okay. [LR34]

ALICE MITWARUCIU: Thank you. [LR34]

STEVE LATHROP: Same with the chemical dependency counselors? [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: You're short eight there? [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: And you can't tell us how many more you need? [LR34]

ALICE MITWARUCIU: Not at this...not today,... [LR34]

STEVE LATHROP: Okay. [LR34]

ALICE MITWARUCIU: ...at a later time. [LR34]

STEVE LATHROP: What are we doing to recruit? [LR34]

ALICE MITWARUCIU: To recruit? [LR34]

STEVE LATHROP: So if we need six psychiatrists and all these psychologists and mental health practitioners, what are we going to do to put them on and get them hired? [LR34]

ALICE MITWARUCIU: One of the things I think, again, is be competitive when it comes to wages. I think that helps. Sometimes money talks, you know. So I truly believe if we are competitive with the private sector and what people are getting in the community, we can recruit some very well-trained, seasoned people to come and work within Corrections. So that is number one. Number two, I think also our...in general, the department, you know, how safe our institutions are can be a big factor because when we have news press about staff assaults and lockdowns and riots, people are like, is that the position, is that the place I really want to work? So this issue of staffing also, if we can increase more correctional officers and more captains, you know, in that realm, because we work...the reason I do my job and I walk through a facility without thinking twice if I'm going to be hurt or not is because I know I have a correctional officer who is looking out for me. So if they get that support in terms of numbers and our morale increases and our institutions become safer than they are, I can tell you people will be more inclined to work there knowing they can work there with the five fingers on their hands and they'll go to their families with five fingers, not four. So that is like to me it's departmentwide safety issue and that again goes to increasing the salaries of those correctional officers because my behavioral health staff, we are lucky--knock on wood--that nothing has happened to us. But you know why? Because when I have a dangerous inmate for therapy session or for assessment, it's because I have a correctional officer at the door looking out for me. So we are all one family and we look out for each other. So in order for us to fill these positions we have to think this is not just behavioral health, it's a systematic change in terms of salary, in terms of recruiting, in terms of making our system safe. For me that is where I think we lack at this time. We have to be

a place where people are proud to come in to work. And it's a very tough population to work with but people are willing to do that every day, and so that is the support they need. Now at this time though, because I realize we are very short staffed, we have ventured into looking for outside vendors to help us recruit. And so the problem with that, as you know, is they can come for three months and say, sorry, you know, three months was enough, I'm gone. Now I have a patient who has to change a provider because the contract person has gone. So I don't think... [LR34]

STEVE LATHROP: And you pay the fee in the meantime. [LR34]

ALICE MITWARUCIU: What? [LR34]

STEVE LATHROP: And you've paid the fee in the meantime. [LR34]

ALICE MITWARUCIU: Exactly. And you know what, and they also to me when we find somebody from a contract psychologist or a contract mental health practitioner, they get paid so much, you know, to work in that setting. And then my mental health practitioner is like, wow, you know what, I can go work for a contractor and make much more, why am I being paid $17 an hour with a master's degree when a contract person is coming and making maybe $62 an hour? So that to me, in as much as I want to fill those positions with contract providers, sometimes I feel like I'm killing the morale of my state employees because of the discrepancy. [LR34]

STEVE LATHROP: Yeah, and Dr. Gage was not impressed with the contract workers. [LR34]

ALICE MITWARUCIU: No, nor am I. But this time though, because I have...this is the thing I told the director when he called me to his office to request me to be the acting behavioral health administrator. I told him, you are asking me to take on a very huge task. But I said I'll take it for two reasons. And I said, one, regardless of our staffing levels, the inmates don't care; they need the care they deserve. They need to be seen because their need does not go away simply because we have two psychologists. Their need is ever present. They need those services. So I was like, you know what, at this point the needs of our inmates is ever present and they have to be seen, so

that is number one reason. Number two reason I took on this position in the interim, I looked at the clinicians who chose to stay behind and I thought they deserve leadership, they deserve somebody to vouch for them, you know. So we can be short staffed, but they go out of their way. Tecumseh did not have a psychologist for a while and I reached out to all of them and I said let's find a plan, let's pitch in. And I'm telling you, for the last two years, mental health providers from other facilities drive to Tecumseh, two weeks at a time, each institution covers Tecumseh for crisis coverage. So for those two reasons for me is the reason why I keep going: knowing that the needs of inmates need their mental health needs addressed and I have a staff of dedicated people who need the support, they need the leadership, and they need somebody to vouch for them every single day. So that's... [LR34]

STEVE LATHROP: Well, I appreciate that. [LR34]

ALICE MITWARUCIU: Yeah. [LR34]

STEVE LATHROP: And again, we appreciate what you're doing and we also appreciate what your staff is doing, especially the folks that are driving on their own dime to cover the Saturdays and doing all of the things that you've described. I genuinely, and I keep repeating myself about this today, nothing should be interpreted as a criticism of those dedicated people. [LR34]

ALICE MITWARUCIU: Thank you. [LR34]

STEVE LATHROP: The concern is whether we have enough. And your previous answer to the last question illustrates what I came to this conclusion in the last few days which is it's all interconnected, right? [LR34]

ALICE MITWARUCIU: Yes, it is. [LR34]

STEVE LATHROP: The safety and making the environment better is a function of having more programming, better mental healthcare. You have better mental healthcare and more programming, you're going to have less assaults, people are going to be less worried about working there, and it's all a chicken and an egg thing. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

STEVE LATHROP: But it starts out, it seems to me, if I can editorialize in response to your statement, that we have to get the officers fully staffed, the corrections officers fully staffed so the place is safe. We have to have the inmates receiving proper mental healthcare and we have to have them receiving programming with some hope that they'll be discharged at or near their parole eligibility date. And the whole thing turns around. [LR34]

ALICE MITWARUCIU: Thank you. [LR34]

STEVE LATHROP: That's all I have. [LR34]

ALICE MITWARUCIU: Thank you. [LR34]

STEVE LATHROP: Mr. Chairman. [LR34]

SENATOR SEILER: Senators? Paul. [LR34]

SENATOR SCHUMACHER: Thank you, Senator Seiler. Thank you for your testimony. It's been very enlightening. And thank you for coming. Just a few questions: Your report says that between 2010 and 2015 you increased the number of social workers from four to ten. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

SENATOR SCHUMACHER: How many of those ten positions are vacant now? [LR34]

ALICE MITWARUCIU: Right now when I...let me see. I think we have three positions open right now. [LR34]

SENATOR SCHUMACHER: How many? [LR34]

ALICE MITWARUCIU: We had five positions open at the beginning of the month and Kathy Foster, who is our director for social work, was able to hire two. So we, out of those five, now we have three positions open. [LR34]

SENATOR SCHUMACHER: Okay. now one of the problems I would guess that you struggle with is not only do you have to hire people who are skilled in psychology and in mental health but those same people have got to speak the language of the inmate who needs the help. To what extent are you able to hire people in those positions that speak the same language? What are our struggles in that area? [LR34]

ALICE MITWARUCIU: There is that need. We have our interpreters who are hired to help me there, interpretation services. But to your point, it would be beneficial for me to hire maybe Spanish-speaking therapists who don't need any translator. Because, again, mental health services, we are supposed to hold confidential conversations with them. So when you bring an interpreter who is not a mental health person, it's very difficult to maintain that confidentiality. So at this point we don't have many people who speak those languages and...now. And having said that, though, it would really take a lot of hard work because most of our inmates come from different countries, different nationalities, different dialects. You know, I'm from Kenya myself, born and raised in Kenya, educated in the U.S. I can speak Swahili but I can find another inmate who is from Kenya but does not speak Swahili, will speak another dialect. So that is a challenging one but that does not mean we cannot make an effort because there are people who speak other languages like me who have been educated in the U.S. They have degrees in psychology and mental health practitioners. We can work on that. We can improve on that area. [LR34]

SENATOR SCHUMACHER: To the extent that there are language difficulties and some of the services, like the sex offender service or the anger management service,... [LR34]

ALICE MITWARUCIU: Yes. [LR34]

SENATOR SCHUMACHER: ...are not able to be efficiently delivered because of a language barrier, how many people does that keep from checking off that box on the parole eligibility thing so that they can become eligible for parole? [LR34]

ALICE MITWARUCIU: I would say very few, because we also have to remember in the Department of Corrections we offer GED classes and so for those inmates serving, you know, several years of their sentences also can take GED and improve their spoken and written English as well. So I wouldn't say that they are very many people who fail to finish these programs because of language barrier. We also have another group of inmates who's reading level is maybe 3rd grade or 6th grade, and we take time to work with them, especially the violence VRP groups. We have some therapists, too, dedicated to reading the materials out to them. And so we do the best we can to support people with (inaudible) reading, low reading levels to finish those programs. We can do better. We can improve. But we also encourage most of our inmates to take opportunity to take those GED classes because they're free and we have teachers who can work with them to improve their reading skills and their writing skills as well in order for them to finish those assignments and homework that come out of those groups. [LR34]

SENATOR SCHUMACHER: For, let's just say, a master's level entry level position,... [LR34]

ALICE MITWARUCIU: Yes. [LR34]

SENATOR SCHUMACHER: ...how does the hourly rate paid by the department compare to, say, the hourly rate in private industry? [LR34]

ALICE MITWARUCIU: Now different private providers I think pay differently, so it would be difficult for me to give you a figure except I know we are on the low range of that conversation. [LR34]

SENATOR SCHUMACHER: What is the range that the department pays for entry level master's? [LR34]

ALICE MITWARUCIU: I think our master's level with a provisional license make just about $17 an hour. And when they get their license, they are paid about $21 an hour, that's all, with a master's degree and a license in their pocket. [LR34]

SENATOR SCHUMACHER: And do they get then health insurance and everything above that? [LR34]

ALICE MITWARUCIU: They're given benefits, yes. [LR34]

SENATOR SCHUMACHER: Okay. But apparently they don't get mileage if they drive back and forth? [LR34]

ALICE MITWARUCIU: No. They don't, nor do they get compensation for overtime. If they put in weekends, they don't get any compensation for those several hours of crisis intervention. [LR34]

SENATOR SCHUMACHER: As Senator Lathrop pointed out, what we're trying to struggle with is making sure that the political process and the budget process and the appropriation process doesn't end up with a product that is out of sync, as far as the adequacy of money, from what the people who are on the front lines know that we need. In the last ten years, that's been a problem because what we end up appropriating and feeling very good about that we've done our job, we've now learned in the last three, four years has been wholly inadequate. And so we need to get information channels open so that we know for sure that the numbers we are appropriating are really what is needed, not what's been watered down for political purposes. [LR34]

ALICE MITWARUCIU: Thank you. Appreciate that. [LR34]

SENATOR SCHUMACHER: And that's what I think. You know you've been requested to be quite frank with us when you get your numbers. [LR34]

ALICE MITWARUCIU: Yes. Sure. Appreciate that. [LR34]

SENATOR SCHUMACHER: Thank you. [LR34]

SENATOR SEILER: Senator Bolz. [LR34]

SENATOR BOLZ: Thank you. A couple of comments and then a question. The first is that I want to reiterate from someone at the table who's an elected official that we do appreciate the work that the staff in the Environmental Health Services do, and we've dedicated a lot of hours to understanding it and trying to improve it. [LR34]

ALICE MITWARUCIU: Thank you. [LR34]

SENATOR BOLZ: So I want to put that on the record. [LR34]

ALICE MITWARUCIU: Thank you. [LR34]

SENATOR BOLZ: But I also appreciate what you're saying about a safe work environment and that the recruitment challenges you face are connected and related to the recruitment challenges and the security officer positions. I hear that loudly and clearly, and appreciate that perspective. One more comment and then a question: And I have heard from you and from Director Frakes earlier today that you haven't done the formal staffing analysis or plan because you can't fill the vacancies that you have now. And I just...I want to say that I don't...I just don't agree with that premise. I would argue that when you have challenges in a system it's a good time to analyze and plan. The regulation doesn't say that you need an ideal plan. It says you need a plan. If I had a baseball team and I didn't have a winning record because I lacked a pitcher and a catcher, I would assess my bench and come up with a recruiting strategy. [LR34]

ALICE MITWARUCIU: True. [LR34]

SENATOR BOLZ: So I guess I'm pushing the department to consider what a staffing analysis and plan would look like. To get to the point and to get to my question, I heard you say earlier that it's a challenge to meet those acute needs within the Department of Correctional Services. And you've had to make some choices in terms of serving the most acute population versus

surveying what you called outpatient needs or patient needs within the general population. And so here's the question which is, do you think that it would be valuable to have, for the Department of Correctional Services, to have dedicated beds at the Lincoln Regional Center in order to better serve some of those acute needs? [LR34]

ALICE MITWARUCIU: That's a very good question because my understanding before I came to Corrections was the Lincoln Regional Center was...they had warm beds and their census has gone down. And my understanding also is those beds are allocated by the regions. So this region has X amount of beds. Now we fall under Region 5, I believe, and so we are not the only one looking for those beds. Other people in the community are looking for those beds. So we have made some referrals. There is in our AR a provision that if we have a patient who is very ill and we cannot manage them within Corrections, we can make a referral for involuntary commitment. And I have attempted to do that on numerous occasions. And they are very careful in how many people they can take, not because they don't want to serve them; because they also have a bed space situation. So once in a while we have a very...in the last I would say two years or a year we have a relationship with the regional center where we meet once a month and we review cases that I refer to the regional center. Now if they cannot take those patients, they give us some suggestions on how we can manage them. So at the end of the day we go back with our patients, but they give us some recommendations in terms of medication management and a good behavior plan to manage those cases. Usually the cases we refer are those with serious self-harming behaviors where we feel it's between life and death. They need more supervision and the correctional setting is not the best setting to manage those patients with serious self-harming behaviors, which can lead to death. So I cannot discuss individual cases because this is a public hearing, but I had one case where we made a referral to the regional center and they gave is recommendations, and those recommendations was for this inmate to have supervision 24 hours. And you can imagine, with our staffing levels with correctional officers, how much that took away from the rest of the institution because we have to staff that one person 24 hours for several weeks. It went into months. And let me tell you, we felt the pain because we had to have somebody with that person 24 hours, during the day, during the night. So problem is we have a correctional setting where we are being asked to manage very ill people, mentally ill people. And then you have the regional center, which is supposed to be our psychiatric institution, where we are saying, can you take these guys who are from Corrections? So it's a very interesting dynamic

there because the regional center looks at us and says, you guys are correction officers, you have all the security measures that we don't, you know? So it's going to be difficult, especially if the person is volatile and, you know, self-harming or even targeting other people. And then we look at them and say, we are Corrections and we have these mentally ill people, severe mental illness; we can't manage them within the correctional setting; they belong there. So it's a very interesting dynamic and I think if you are to ask me my ultimate suggestion is having maybe a psychiatric, just an entire unit or facility within Corrections, that is just for the mentally ill, because we have an entire unit there within Corrections and some of these cases can be difficult to manage in that environment, so. [LR34]

SENATOR BOLZ: I appreciate the complexities. I do think that it is worth additional conversation when we have a waiting list at the Lincoln Regional Center of 15 and the intense needs that I'm hearing you articulate at Department of Correctional Services. Ensuring that we have the capacity we need within both systems I think is a conversation that we need to have again. [LR34]

ALICE MITWARUCIU: Yes. [LR34]

SENATOR SEILER: Any Senators? Thank you very much for your testimony. [LR34]

ALICE MITWARUCIU: Thank you. [LR34]

STEVE LATHROP: Thank you, Doctor. [LR34]

ALICE MITWARUCIU: Thank you for having me. [LR34]

SENATOR COASH: Thank you. [LR34]

SENATOR SEILER: Kasey Moyer and Amie Jackson. Good afternoon. [LR34]

KASEY MOYER: Good afternoon. [LR34]

AMIE JACKSON: Good afternoon, Senators. [LR34]

SENATOR SEILER: Well, we have six and a half hours before we set a record, so you got plenty of time. [LR34]

KASEY MOYER: No thank you. (Laughter) [LR34]

SENATOR SEILER: Will you introduce yourself and spell your last names. [LR34]

KASEY MOYER: My name is Kasey Moyer. It's K-a-s-e-y, Moyer, M-o-y-e-r. [LR34]

AMIE JACKSON: Amie, A-m-i-e, Jackson, J-a-c-k-s-o-n. [LR34]

SENATOR SEILER: Do you have preliminary remarks? [LR34]

AMIE JACKSON: I do. Am I going first? [LR34]

KASEY MOYER: I can go ahead. [LR34]

SENATOR SEILER: It's up to you two. [LR34]

KASEY MOYER: All Right. [LR34]

AMIE JACKSON: Okay. [LR34]

KASEY MOYER: We'll figure this out. Again, my name is Kasey and I am the executive director of the Mental Health Association of Nebraska. The Mental Health Association is a peer-run organization, which means that all of us who are employed by the Mental Health Association have lived experience with mental health, substance use, poverty, trauma, Corrections. You name it, we kind of cover it all. We started about 12 years ago and have been provided services for 12 years now, and our first...I just wanted to give you a little overview of we do provide services, such as supported employment for people living with severe mental health and substance use

issues. We have two respite homes in town that allow people who are dealing with those issues to take a break before they have to wait for it to become a crisis and end up in your hospital emergency or law enforcement involvement. They check in and then they can check out. And we're really big on helping people become responsible for their own behavior, their own wellness, and knowing when things are breaking down and how to ask for help when they need that. We also have a program with the Lincoln Police Department where if they go out on a call, someone is not breaking the law but is clearly in need of some support, they will call us and we respond to them within 24 hours. We have 300 officers who refer to our program and have received 1,500 referrals in that program. It's very effective. And I'll talk a little bit later, but I would love to be able to see some of the education that we have provided to the Lincoln police to be able to educate some of our correction officers, because we're seeing a lot of issues there. The last program that we have implemented is the reentry program with the Department of Corrections. We've had a contract with them for a year and a half now, and we started out with opening up the Honu Home, which is a transitional house for people coming out. They can stay there for up to three months. And people...then we also provide supported employment and we provide outreach to folks. So if they maybe transition somewhere else to their apartment, to their family wherever they are, we can reach out to them and just kind of walk through some of it as they acclimate back into the community. Most recently we started what's called Wellness Recovery Action Planning. And again, that's kind of like an advanced directive for mental health and it's something that we write for ourselves. It is an evidence-based practice. We do it in the Lincoln Public Schools with youth. And then we just started doing it with the Department of Corrections inside the facilities. Again, this is to help people recognize when...what it is like when they're doing well. If they're dealing with mental health, how do you stay well? What are things that you can do every day? And it's not a treatment plan that's developed by someone else and given to you. You have buy-in in it and you know what works for you and you know what doesn't work for you. And if it doesn't work then you know you better change it so that you can find something else that will help. We are very specific about what triggers are, what triggers you, what the plan is when you are triggered, how do you know when things are breaking down, again how do you stay well. I like it a lot because you do talk more about staying well rather than looking at symptoms and maintaining. It's about being well and growing and moving forward in recovery. This last time we started we have facilitated these groups now in York women's facility, LCC, NSP, and in Tecumseh in the restrictive housing unit. We are on our sixth

week with the guys there in the restrictive housing unit and they have been very awesome group of guys to work with. We have engaged with them. They have opened up. They have talked about how they got there, what happened to them, the mental health stuff that they deal with, what has worked for them, what doesn't work for them. And we really just process with each other how it is for us. Maybe there's some things that we do that they could try. Maybe there's some things that they do that I could try. But we share those things and it's been a really awesome experience. There have been some issues that we have seen that I would like to bring up. And then I'd also like to talk about some of the solutions that we see that could be maybe helpful for people, especially dealing with mental health issues and in restrictive housing. Amie was going to talk a little bit about her personal experience of what that was like for her. [LR34]

AMIE JACKSON: If you don't mind. Thank you. I am a certified peer support and wellness specialist with the Mental Health Association of Nebraska. I have worked with the Department of Corrections since receiving the reentry grant in early 2015. I was a board member of the advisory committee when we first started planning. I am a member of RAN, the Reentry Alliance Nebraska. I facilitate WRAP in the long-term restrictive housing unit at Tecumseh. I speak at the RTC program at NSP every two months and also at the panel, the WRAP panel, at the women's penitentiary in York. I work with the men and women at CCC-L. And I'm the peer outreach specialist for MHA's REAL Program. My personal experience started in 2011 when I became an inmate with a number because of the lifestyle I lived and the choices I made at that time. I was also dealing with severe mental health and addiction issues, both of which led me to prison. Prison was traumatizing. Prison is traumatizing. The people living and working in that community are experiencing trauma on a regular basis. If we want to see harm reduction for both staff and inmates, I believe that implementing trauma-informed care to both Corrections employees and those living behind the walls would be helpful in bringing change in that environment. My personal experience happened in 2013 when I started having visions that contributed to me being in psychosis. I was taken out of my housing unit and first put in a holding cell, stripped of my clothing, locked in a tiny cell and all alone. I want to tell you that I was seeing snakes and guns being pointed at my face. No one knew what I was dealing with and no one asked. I had no one to talk to. I would see an officer walk by my cell and look in that tiny window just to see if I was in there and still alive. Not one person stopped to ask me how I was doing or if I was okay. I was in such severe psychosis and having problems with my medications

that as soon as I closed my eyes to go to sleep, my whole body would shake as if it was being shocked, and that's exactly what it felt like--an electric shock throughout my whole body. I had no choice but to lay there and to deal with it all alone. I was forced to stay in there. I had no one or nowhere to run to or even talk to. I do believe that that stems from some of my post-traumatic stress disorder, not only from that time period in my life but other traumatic events that happened in my life, and people deal with trauma in different ways. They act out. They, you know, they...I heard a lot of testimony today about people shoving the trays through the doors. Well, it's some part of trauma, and I truly believe that the people got there for traumatic events that happened in their past or other things. And I really feel that, you know, getting to the core of a person's trauma really helps work through what they're dealing with at the time. It did for me. And like I said, they deal with it in different ways. I work with people coming out of prison, still traumatized or even more traumatized than when they went in. But it is also possible to work through it. Recovery is possible and hope is powerful. I would not be where I am today had it not been for the peers at MHA. I believe I would still be living the vicious cycle of a very chaotic life had it not been for my peers who were willing to listen, share their lived experience, my peers who inspired me to do the right thing, my peers who gave me hope and showed me that I can be the hope. It is now my passion to provide hope, encouragement, compassion, and understanding for those inside and entering our communities. I truly believe that it would be helpful to have peers working and helping those who are experiencing trauma, psychosis, addictions, anger, helplessness, hopelessness, and that significant change has to come from all different angles. Again, I facilitate WRAP, Wellness Recovery Action Plan, in long-term restrictive housing Tecumseh should you have any questions. Thank you. [LR34]

SENATOR SEILER: All right. Kasey, are you going to close then? [LR34]

KASEY MOYER: Yeah, I think, you know, there are a lot of things that I want to talk about. I can't say enough about how the director, the administrators, the wardens, the reentry specialists, the social workers have made themselves very available to us and have always listened to us and been really willing to hear us out. The issues that I see that exacerbate the problem is correction officers and the front-line folks. I can give you several, several examples where, I don't care if you have a mental health issue or not, when somebody is provoking you or instigating or pushing buttons, eventually you get tired of it and you go off on people. And I think that there is such a

disconnect between DOC staff, some of them, not all of them. I really want to clarify that because there's some good employees there. But when you separate yourself so much from the population that you're trying to serve, it's really hard to help them move forward and gain the skills that they need when you know it's a very us and them mentality. For example, you know, we have the group in restrictive housing. There's five guys in there, none of whom...well, there might be a couple of them getting out, but most of them are going to be there. They kind of have established where they sit, and it's a typical group. You know you get comfortable after week after week; you come back and you sit in the similar spot that you did the week before. That's human nature I think. But this last time one of the correction officers, for no reason, decided that this guy was going to sit in the back of the room. Well, he was typically one that sat right up front, was very engaged, wasn't causing any problems, we didn't have no issues with him. But just to change it up, they decided to put him at the back of the room and he totally disengaged and you could see that he was upset about not being able to sit in closer with the group. But this went on through the whole...it affected the whole meeting all because, to me, it was a power trip of, no, I know you want to sit up there but you're going to sit back here today. And we see that stuff with correction officers quite a bit, more than I ever thought we would see it. To me, if you don't want to get punched maybe, you know, you shouldn't push those buttons. But I really would hope that we could be training officers more on de-escalation, problem solving, conflict resolution, motivational interviewing, all these things. And not seeing the...I don't see them de-escalate problems. I see them escalate things. And then the person ends up in restrictive housing when it clearly, much of the time, could have been possibly prevented. We did have a unit manager who sat in on our work group with us because we do engage with them and we have deep conversations with them. And his comment was that all correction officers should have to sit in this group just so that they could see that these guys are actually human. And so I think if they're not seeing them as human, that it is our job to do something to help solve that problem. WRAP is wonderful. It has really affected our lives and that's why we like to share it with other people who deal with similar things. And we have had people for the first time talk about trauma and relate it to the mental health and substance use issues that have never been discussed before. One of the women out at York had several numbers and it was just like this moment of clarity when she figured out that some of her trauma background had definite impact on where she is now and what has happened to her. So I think we could do a lot more with engaging with inmates positively. Even if somebody is in restrictive housing. We would love to go sit with them

and ask them, you know, what do you need, what triggers you, how do we help you get out of here. It doesn't always have to be a licensed mental health practitioner or a psychiatrist. It has to be someone who cares about where they're going and that wants to help them find the solutions to move forward. I think that's it. [LR34]

SENATOR SEILER: Okay. Steve. [LR34]

STEVE LATHROP: Just a few questions: You're talking to and your group, how many are there? [LR34]

KASEY MOYER: As far...how many... [LR34]

STEVE LATHROP: Yeah, you... [LR34]

KASEY MOYER: ...inmates or...? [LR34]

STEVE LATHROP: ...it sounds like there's a group of you. [LR34]

KASEY MOYER: Well, I have 34 staff. [LR34]

STEVE LATHROP: Oh, okay. And they're all going and doing some contact either inside or... [LR34]

KASEY MOYER: Outside. [LR34]

STEVE LATHROP: ...helping people with reentry. [LR34]

KASEY MOYER: Yes. [LR34]

STEVE LATHROP: Okay. And that's a contract you have with the state, compensated for that. [LR34]

KASEY MOYER: Right. And we have several other contracts too. But for the reentry and for the work inside, it's through the reentry grants. [LR34]

STEVE LATHROP: And my questions, and I'll just have a few, relate to your experience or what you've observed about the people who are confined to restrictive housing and whether they're getting, in addition to what you guys do by going and talking to them and doing the peer to peer. Are they getting what they need? [LR34]

AMIE JACKSON: Can I answer? [LR34]

STEVE LATHROP: Yes. [LR34]

AMIE JACKSON: Just from...I mean I have seen caring staff, don't get me wrong, but they say...the men have said they will send a kite, which is an inmate request form, and it's never returned, never returned with an answer. It's thrown away. So they kind of feel a little bit like they're just being discarded. Like as if the kite was discarded, their wants, needs, and wishes are also being discarded. [LR34]

STEVE LATHROP: Does the kite relate to mental healthcare or can it be I need a... [LR34]

AMIE JACKSON: It could be...it could be... [LR34]

STEVE LATHROP: ...I need a blanket or whatever? [LR34]

AMIE JACKSON: It has been I think connected to mental healthcare. It could be an answer to when I'm getting out, when is my next review, when is my hearing. Or, yeah, can I have my hygiene back? Can, you know, just different questions. And that's exactly what those are for. The inmate request form is for when you have a question, you send it formally to get an answer because most of the time staff walking around doesn't have the answer. So they send a formal...send the question in a formal manner to get an answer back. And a lot of times they're not even getting those back. [LR34]

STEVE LATHROP: So that would understandably make them feel a certain way, like no one... [LR34]

AMIE JACKSON: Yeah, that would probably... [LR34]

STEVE LATHROP: ...no one is listening, no one cares. [LR34]

AMIE JACKSON: Right. [LR34]

STEVE LATHROP: But in terms of the amount of care that they're getting for mental health, can you address that? Do you have an observation about that? [LR34]

AMIE JACKSON: I do not. [LR34]

KASEY MOYER: I don't know if I could...you know, I don't have research or numbers. It's just from having conversations with them. And I know that they feel often that they are not heard. And even sometimes when they do requests, certain things, that it's kind of dismissed as they're manipulating, they're this, they're that. And I think if we did actually sit down and hear them out, again, you're...you would be de-escalating some of those situations. [LR34]

STEVE LATHROP: When Director Frakes, and I know you guys were here all day and thank you for your patience. When Director Frakes was testifying about the folks in mental...or in restrictive housing, the mental healthcare, he went through the number of assessments they have, like they pull them out, do a screening, put them back in there and make sure things aren't getting worse or at least they have an idea how bad it's getting every 30 days or something like that. But do you have a sense whether somebody is actually giving them the therapy, in addition to the medications that they may need, that somebody is actually doing some therapy with them? [LR34]

AMIE JACKSON: From what I'm hearing with the numbers that were provided today, there's not enough staff to do that for everybody. Peer work, I would just like to suggest that, you know, that you have a lot of...there are a lot of staffing issues within the department. There's a lot of budget

issues. There are a lot of people who fear to work with that community, but peer work is an evidenced-based practice and I am a living, breathing document...or I mean I'm...not document but living breathing soul of that, that it does work. And like she said, you know, these men have engaged and, I don't know, I just think we could be doing more from a community level to help all of the department, the Legislature, the community, the inmates, the people. [LR34]

KASEY MOYER: And I do feel like if you are living with some significant mental health issues, to not be seen for 14 days, 30 days, I mean if you're seeing things that are pretty scary, that's a long time to be dealing with some of that. And I think people need support much sooner than those time frames. [LR34]

AMIE JACKSON: The 14 day... [LR34]

STEVE LATHROP: You were actually at York... [LR34]

AMIE JACKSON: Yes. [LR34]

STEVE LATHROP: ...when you experienced this. [LR34]

AMIE JACKSON: Yes. [LR34]

STEVE LATHROP: When did you...and I maybe wasn't paying close enough attention. [LR34]

AMIE JACKSON: Okay. [LR34]

STEVE LATHROP: Did you say that you were in restrictive housing when you had these episodes? [LR34]

AMIE JACKSON: It first started in my housing unit, but I was taken out of my housing unit and put into restrictive housing. And, yes, I was forced to stay in restrictive housing and deal with it. [LR34]

STEVE LATHROP: Can you give us a time frame? When was that stuff all happening? [LR34]

AMIE JACKSON: It was 2013. And I know there's been some changes since, but that happened in 2013. There was something else I wanted to tell you. Oh, of the safety issues and the safety concerns that, you know, they had for when I was seeing my psychiatrist, it was in the medical unit, in a medical room, through a computer with a witness, so there could be some ways... [LR34]

STEVE LATHROP: The telepsychiatry? [LR34]

AMIE JACKSON: Huh? Telepsychiatry, yeah. That there could be some ways... [LR34]

STEVE LATHROP: Does that...tell about that. Does that work? [LR34]

AMIE JACKSON: It did for me. I mean she listened, she gave me the medications I knew that would work and that I needed and she was willing to try new things. So, yeah, it did for me at the time, it worked. [LR34]

STEVE LATHROP: Okay. [LR34]

AMIE JACKSON: You know, for others that may have... [LR34]

STEVE LATHROP: And on your solutions here, and this is the last question I have. On the solutions here you talk about doing some training for the corrections officers on de-escalizing... [LR34]

AMIE JACKSON: De-escalation. [LR34]

STEVE LATHROP: ...de-escalization. And what you're...so is this a...so we've had hearings on the turnover with these guys, right? Thirty percent of them, a third of them, walked out the door every year. So are we having a problem with the young guys? So is this a problem with we're

taking anybody that comes through the door? They're there for less than a year and this is kind of what you get when we're on a hiring rampage? [LR34]

KASEY MOYER: Because some of them have been there a long time and are treating people, you know, I don't know, I think it's just...I don't think it really matters from what I've seen of how long they've been there. I mean some of the newer guys are learning from the older guys and that's where the treatment is coming from. But we've seen things. Just the other day we were doing a WRAP group and we had the guys in there and I hear all this screaming. We just assumed it was an inmate, but come to find out afterwards it was a correction officer that had lost his mind, screaming at somebody. So I just really feel strongly that... [LR34]

STEVE LATHROP: Do you think that should happen before they start, like incorporate this kind of training into the training process? Or is this something we do like when they start to feel the stress of being a corrections officer? [LR34]

KASEY MOYER: I think you need to have, you know, for new staff orientation, I think having people who, with lived experience, talk about what it's like and how they can either help this or they can, you know, escalate the situation. And I think in-services periodically throughout their careers. We do trainings with law enforcement. We do their new recruits. We do their in-service trainings and then we do an annual training with them. And they come out of there going, you know, some of them have said, I will never treat people like I have in the past again. Because if you don't know the background and all you ever see is people on their worst day, you make judgments on that. But when they can see us in recovery and have done well in our working and our contributing and we're not, you know, causing problems, it helps them see what could be. And I think it helps them treat us a little bit better. But I really believe that the training needs to start not just with new recruits right now. It needs to...we need to catch the ones who have been there for a long time on, again, not instigating things and not pushing buttons and those power trips. When an inmate says, don't disrespect me, and the correction officer comes back and says, don't disrespect me, we're not teaching them proper skills in how to deal with some of those things, so. [LR34]

STEVE LATHROP: Very good. That's all the questions I have. [LR34]

SENATOR BOLZ: One. [LR34]

SENATOR SEILER: Senator Bolz. [LR34]

SENATOR BOLZ: Very quick. Thank you for being here. Appreciate your time. [LR34]

KASEY MOYER: Thank you. [LR34]

SENATOR BOLZ: Just very briefly, do you recall, when you were in restrictive housing and you had your psychotic episode, how long did it take for you to see the medical professional that you needed to see? Do you remember? [LR34]

AMIE JACKSON: I believe I went in before the weekend. I had to wait the whole weekend and then somebody came and talked to me. [LR34]

SENATOR BOLZ: Okay. That's helpful. Thank you. [LR34]

AMIE JACKSON: Okay. [LR34]

SENATOR SEILER: Anything else? Thank you very much for your patience. [LR34]

KASEY MOYER: Can I... [LR34]

STEVE LATHROP: That was. That was very helpful too. [LR34]

KASEY MOYER: Thank you. [LR34]

SENATOR SEILER: It was. [LR34]

KASEY MOYER: I just...one more thing because an inmate had asked me to say this. But what he wanted, because we are teaching them to be responsible for their own behavior, right? We're talking about that a lot. And what he wanted was the ability to...he's going to be there for the rest

of his life. And being on the yard can be a little overwhelming, especially when he does hear voices and he does deal with significant mental health issues. And he said that he wished that they would be able to check themselves into, if things are overwhelming, he can feel things escalating, to check himself into a restricted housing, away from general pop., and it be on their own. They know that things are breaking down for them and they want it not, and they need time to regroup. And they...he said I'd like to be able to do that without having to cause problems to get put in restrictive housing. And they can ask to go to restrictive housing, but if they talk about it being a mental health issue then it's not on when they feel they're ready to get back out to the yard. They have to be cleared by mental health and then that can take three, four weeks. [LR34]

AMIE JACKSON: Or months. [LR34]

SENATOR SEILER: He wants the right to check in and check out. [LR34]

AMIE JACKSON: Right. He wants the right to be able to go there on his own time when he feels like he needs to get away, because he's going to be there for the rest of his life. And that don't happen. He goes there and then they assess the situation and the threat, and then they decide when he gets out. And so he has a fear of going in because he doesn't know when he's getting out. [LR34]

KASEY MOYER: But it's hard to teach people to be responsible and do what they need to do if they... [LR34]

STEVE LATHROP: When they feel it coming. [LR34]

KASEY MOYER: Yeah. He even...he referred to it as like, you know, when you take a vacation from your job. (Laughter) But I think just sometimes being able, especially if you deal with significant mental health, to be aware that things are escalating and to be, you know, self-aware of what you need. We want to encourage people to be able to identify those things and have options rather than waiting until it's a crisis and things blow up and then we go, jeez, wish we could have done something about that, so. [LR34]

STEVE LATHROP: Makes sense to me. [LR34]

SENATOR SEILER: Thank you very much. [LR34]

KASEY MOYER: Thank you. [LR34]

AMIE JACKSON: Thank you. [LR34]

STEVE LATHROP: Thanks again, and for your patience. [LR34]

SENATOR SEILER: Thank you, Senators, for lasting this all out. [LR34]