

**Joint Informational Hearing of the
SENATE HEALTH AND HUMAN SERVICES COMMITTEE,
BUSINESS AND PROFESSIONS COMMITTEE,
AND THE
SELECT COMMITTEE ON DEVELOPMENTAL DISABILITIES
AND MENTAL HEALTH**

**Chairs
Senator Deborah Ortiz
Senator Liz Figueroa
Senator Wesley Chesbro**

“Children’s Mental Health Care”

**February 13, 2002
State Capitol**

SENATOR DEBORAH ORTIZ: This is a joint informational hearing of the Senate Health and Human Services Committee, the Business and Professions Committee, and the Select Committee on Developmental Disabilities and Mental Health. The topic today, of course, is “Children’s Mental Health Care.”

I would ask that Members who are participating in the joint hearing today to please join us. We do have a rather lengthy agenda, and very important witnesses and participants have joined us today. So, if you’re within earshot, please join us.

[Recording difficulties.]

... A particular concern is their estimate that over one million children in California experience an emotional or behavioral disorder each year, but 600,000 of those children won’t receive adequate treatment.

We clearly need to initiate reforms to do a better job of marshalling both public and private dollars for mental health care for children. Financing children’s mental health, however, comes at a time when we’re dealing with an unprecedented budget deficit. We, at this time, are faced with the challenge of maximizing resources as we see a declining source of revenue to do so.

In Panel 3, I believe, of today's agenda, there will be discussion on ways to make the most of these existing mental health dollars and, also, I hope, present some ideas for bringing more federal funds to California.

Also, as part of this mental healthcare problem, is the shortage of acute care psychiatric beds for children and adolescents. Today, we're going to hear expert witnesses testify on this problem and some potential solutions.

Finally, we have a panel of expert witnesses to address current research and issues and the diagnosis and treatment of Attention Deficit Disorder (ADHD).

As you know, ADHD is one of the most common behavioral disorders among children. One estimate is that approximately 5 out of every 100 children will be affected. Without treatment, these children with ADHD are at an increased risk of physical and behavioral problems, so it is appropriate to address the current research and the treatment protocols for this disorder.

Once again, I'd like to thank you for being here; I know you all have busy schedules. I'm warning everyone that we are going to try to keep to our time schedule. I believe each speaker has been asked to speak for eight to ten minutes, which often turns into ten to fifteen or twenty. I'd ask for participants to please try to adhere to that time schedule. I do have a timer today. I'm not sure that I want to use it, but if I do need to do so – I'd just like everybody to help monitor ourselves.

Let me now allow the other committee chairs who have been looking at this issue as well, who are joining us here today, to offer a few words. Certainly, I want to thank them for working with me to make this committee hearing possible.

Senator Figueroa was here first, so I'm going to extend her the opportunity, and then Senator Chesbro.

SENATOR LIZ FIGUEROA: Thank you, Senator Ortiz.

Again, I also want to thank you for allowing us to participate with this hearing, especially dealing with something that is so important: children's mental health care. As you know, the reason that we are participating is because last year, at the Business and Professions Committee, there was a bill that came to us regarding the prescribing of psychiatric medications to children. Our committee was concerned about the way this bill was handling that issue. We'd like to hear from the people who are the experts in the field about the best way to handle the situation.

As you mentioned, it's a growing situation. In the state of California, we're very concerned about what is happening with medicating our children in schools, what parents know, what the educators know, and what type of medications are out there. We need to have some recommendations from the experts.

I thank all of you for coming and participating in this hearing and, again, Senator Ortiz, for allowing us to participate.

SENATOR ORTIZ: Thank you, Senator Figueroa.

Senator Chesbro.

SENATOR WESLEY CHESBRO: Madam Chair, I want to thank you and your staff for taking the initiative and putting this hearing together and also for all the good work that's gone into getting us here today with this excellent program.

As you know, the Legislature has given special attention to mental health issues over the past year, and we've been able to make some important gains. However, there's still much to do, especially in the area of children's mental health care. Even in the difficult financial times we're faced with, I feel very strongly that we must find new ways to improve access to the quality of services and supports necessary to help guide all of our children successfully to adulthood.

I'm looking forward to this hearing and having the opportunity to hear from our mental health experts today about the nature of the challenges we face, and to discussing the various options and strategies we can employ to better serve children with mental health needs.

Thanks again for putting this hearing together.

SENATOR ORTIZ: Thank you.

Let me now ask our first panel, under Section 2 of the agenda, to come forward. As the agenda indicates, this panel will address the question of system reform and focus primarily on the Little Hoover Commission report, which provided much valuable information and certainly frames the issue on systems reform.

I want to thank them all, and if they could identify themselves. The first speaker that we have listed is Rebecca Hawkins, who is a youth advocate.

Welcome. You may begin, Ms. Hawkins.

MS. REBECCA HAWKINS: As a youth advocate, my role is to use my personal experiences in the children's mental health system to provide support to youth in our community

and to provide a voice for them at all levels of our system. I appreciate the opportunity to share with you today my story and the voice of youth in our community.

Around twelve I was diagnosed with Attention Deficit Disorder. I didn't have the hyperactivity associated with that but just the inability to concentrate. I had a difficult time learning. I was treated by my pediatrician with Ritalin, and after about two-and-a-half to three years of being on this medication, we realized, *It's not working*. So, I was sent to a psychiatrist – my first one – and he prescribed an antidepressant, which is pretty common to treat adolescents with Attention Deficit Disorder.

Shortly after I started taking this antidepressant, I became completely out of control. I would have a thought and I would act. There was no moment between. I jumped out of moving vehicles because I didn't want to be in the car anymore. I would run away and stay gone for several days at a time, not calling to check in, not caring who I was with or where I was. Honestly, I don't really know who I was with or where I was. I was physically violent towards other people, and I was emotionally abusive towards my family. The amount of strength that I had in this mania, I could pick up a couch and throw it. It was almost as if I was on PCP. There were no limits to what I could do.

Awhile after feeling this way and being this out of control, I had my first psychiatric hospitalization after a suicide attempt, and I was fifteen years old. This was my first of eleven psychiatric hospitalizations between fifteen and eighteen.

While I was in the hospital, I spent most of the time in physical restraints because I was so out of control and so angry and so violent. It was the only way to keep me safe and keep the other people around me safe. At one point I spent about four days in physical restraints, getting a shot of Ativan every two hours because it was the only way to keep me calm. After awhile they decided that chemical restraints was the way to treat me. I took, probably, about 14 pills three times a day. Small dosages, but this was handfuls of pills every day to keep me safe. I screamed for days at a time, not able to stop, because I was so frustrated. There was so much anxiety, and the only way I could release it was to throw something or act out or scream. When my body was unable to move because of all the medication, I had no option but to scream.

I was on many different mood stabilizers. None of them really seemed to be effective. Nothing was able to bring me down from this mania. I wasn't able to speak without drooling or without slurring. I appeared to be intoxicated, which I was. I wasn't able to move. It hurt when

I moved because the medication would tighten up my muscles, and the medication that they gave me to counteract those side effects would make it so I couldn't see, or my tongue would swell. I had amazing physical reactions to all the medications, but it was better than the physical reaction of killing myself or killing somebody else.

Something that is really important to me is that, because of all these medications that I took, I don't have a childhood because I don't remember most of my childhood. It affected my memory. I don't remember most of those two or three years. I don't remember my father, who died when I was seven, because of all the medication I had to take to keep me safe. I don't have my childhood.

During these three years, while I was highly medicated and unable to function, I wasn't able to go back to regular high school. I went to several different schools for severely emotionally disturbed kids. Between my freshman year and my junior year, I went to 14 different high schools. I think all but four were SED schools, where I was kicked out of every last one because I was too bad for them.

The teachers wouldn't teach us. They were too busy controlling our every move and making sure that we weren't harming ourselves or somebody else and too concerned with behavior modification to teach us.

We didn't really receive any mental health treatment. When we acted out, we got stuck in a room that they called the "BM Room," for behavior modification. Isn't that lovely?

The curriculum was terrible. My sophomore year in high school, they were teaching us fractions and short division, which is something that I had completed in 4th or 5th grade. For art we watched Bob Ross, and for science we watched *Nova*, and for literature we watched *Reading Rainbow*. These are all kids who were between, I'd say, twelve and twenty-one.

SENATOR ORTIZ: Miss Hawkins, since you've come from such a personal experience, could you give us some insight on the kinds of recommendations you would make to make the system better? Your testimony would be incredibly helpful, I think, to us.

MS. HAWKINS: I think another thing that I really would like to stress about the education is that, while I was there, I was told that "You're not going to be successful," and I begged them, "Please give me a book I can read." That was my life before I couldn't see. "Please give me something that's going to stimulate my mind," and they said, "When you prove to us that you can do this, we'll give you that." So, me being the oppositional child I was, I

never did it. I ended up dropping out of high school my junior year, when I was old enough to leave, without anybody being able to force me to go back.

As the time went on I kept digressing, so finally I had to go into a group home. I went into two groups homes, and the first one I was in I wasn't allowed to have any contact with my family whatsoever. Family has always been a really big part of my life. I wasn't allowed to have phone calls. They'd send letters and they were returned. I wasn't allowed to have any contact at all with my family for the first two weeks, but if I acted out at all then it was longer. So, I ran away and ended up back in the hospital, where I went to another group home where I stayed for almost a year.

Being in a group home – we were on a point system. If we were really good, we could get to a level where we could actually do things. The point system doesn't work for everyone, but everyone had to follow it. The point system did not work for me.

SENATOR ORTIZ: I'm going to encourage everybody to stay within the ten minutes, and I think the really valuable recommendations you may provide for us will help structure our ability to discuss and come back with maybe—

MS. HAWKINS: Why don't I just skip down to that part?

SENATOR ORTIZ: That would be helpful. Thank you.

MS. HAWKINS: The system is a lot different now than it was ten years ago when I was receiving services. We've added so much, but we haven't changed what was already in existence. Children are still treated poorly in the hospital. Children are still not getting an education, and we really need to look at that. Nonpublic schools need to be regulated. Somebody needs to make sure that those kids are learning. All of these kids have so much potential and can do so much if somebody is willing to give them the chance and somebody is willing to teach them and somebody is willing to make sure they're being taught. That is something that's not currently happening.

SENATOR ORTIZ: You were in a nonpublic school.

MS. HAWKINS: Yes, several nonpublic schools – SED schools.

We need to provide training to our line staff, teaching them the value of treating families and youth with respect. It doesn't cost anything to treat people better. That's a point that I really want to emphasize: It doesn't cost a cent to treat somebody with respect, so it's not going to affect the budget.

We need to start earlier in treating families. We have so many kids who come in with really simple things that can be caught early and treated early and fixed early, but because we don't have the money, we're waiting until they're attempting suicide or they're extremely out of control, and we can't do that, obviously. Sometimes we can't fix them once they're too far gone, and these kids will eventually be adults. If we can get them earlier and we can work with them earlier and we can help them get better earlier, we'll save ourselves a lot of money when they become adults.

SENATOR ORTIZ: Absolutely right there.

MS. HAWKINS: I'd also like to encourage you to take a look at family and youth advocacy and what that does for the families and youth we work with. It's a huge part of our system in Sacramento County, and it's been so valuable to the families that we've worked with.

Can I give one quick example?

SENATOR ORTIZ: Please do.

MS. HAWKINS: We got a phone call a few days ago from a mom who said, "I can't take my daughter. I'm going to have to abandon her to the CPS system. We have private insurance and she doesn't meet your target population," because she was diagnosed with conduct disorder. So, we worked with the mom. She had gotten violent with her mother, and she had punched her mother while they were driving forty miles an hour down the road. So, she was in the treatment center. This girl needs treatment. Her mother tried for years; tried to give her to Probation, tried to give her to CPS, and no one would take her. Because we got involved as family advocates, we were able to work with that family in finding other avenues and finding treatment for that girl. Now she's going home with services in place, but that never would have happened had family advocacy not come in and helped that family and supported that family so they were able to do that.

SENATOR ORTIZ: I know that there are going to be questions. I certainly have one, but I want to hold off until all of the panel speaks. I want you to please stay there because I suspect that there'll be questions from Members, unless anyone feels strongly about asking now. We can certainly allow that.

Thank you. I do appreciate it. I know it's difficult. Thank you for being here and providing that important testimony.

I believe the next speaker is Mr. James Mayer, and we're going to start the timer again. If you stay within ten minutes, that gives us the time allotted for the questions to get further clarification.

Welcome.

MR. JAMES P. MAYER: Thank you very much for having us, Senators.

My name is Jim Mayer. I'm the executive director of the Little Hoover Commission, and next to me is Toby Ewing, who is the Commission's project manager on its mental health work and is here to help answer any questions you may have.

As many of you may know, the Commission released a report a year-and-a-half ago on the adult mental health system, and the fundamental conclusion on the adult mental health system that the Commission reached was that we restricted care through the public system to those people who were suffering the greatest, and we were rationing care. That didn't make any sense, for all of the reasons you've heard about from Rebecca.

The Commission then launched a project that focused just on the children's mental health system, and what it found fundamentally in that system was that, while there was more services available and more money in the system, we still had this basic premise that we weren't going to find a way, as a state, to serve all of the people who have a need. As a result, in many ways we were rationing care. Families who engaged this system, because of its complexity – that we'll discuss briefly here – faced an additional hurdle; because once they got in, it didn't mean that they necessarily got the right services, at the right time, by the right people. Those are very general ways to describe these maladies, but that's how the Commission saw it as they looked at it.

The committee asked us some very specific questions, and we've provided what we think are very detailed written responses to those that you can look at and we can discuss, if you'd like. But I want to give you this overview because if what you want to look at is system reform, I think that's what the Commission was advocating from its perspective.

It's important to start this discussion, I think, from the Commission's perspective that it found many very positive things going on in communities, particularly as it relates to children. There were pockets of innovation spawned by state law, supported by state law, or spawned by ambitious, creative, talented people in local communities. You're going to hear from some of them today. Those are hopeful signs and those are signs to the Commission, who are non-

mental-health experts, that we can be doing better. When you see people doing better than the norm, it shows you we need to be setting higher expectations and encouraging people to reach them.

The second was there was some very talented people involved here. These are services that are primarily human services, meaning not just that humans receive them but that they are human offered, human supplied. Again, there was an enormous amount of very talented, dedicated people who are working in this field. The Commission recognizes that as an enormous strength that, as a state and state policymakers, we want to continue to take advantage of.

The third was that there was a growing amount of research; that there are questions about certain modalities. There were places where the research can't guide the layperson, even the informed layperson, to reach a logical decision about how to change policy. But there is a growing amount of research, some of it sponsored by the state, some of it guided by the state's universities that are involved, and that that, too, is a tremendous strength we want to look at.

Funding is always a problem. It will always be a problem in the public sector, but we've put more money into this system. There is an enormous amount of money in serving children and families, and that tells us that there are opportunities if we think creatively about how to use that money better.

Finally, there's significant political capital. This Legislature certainly has demonstrated that, in the last two years, it recognizes the problems that result from unattended mental illness, and they're willing to take on that challenge.

We also saw some fundamental problems that we think you want to address. I will never forget the afternoon that we sat in Patton State Hospital, after the Commission toured the hospital, and we pulled together our first meeting of an advisory committee. These were experts from a variety of places intersecting with the mental health system, and we were probably violating several laws. We were in a room that the fire marshal would probably limit to ten or twelve and we had thirty or forty people in it. It was raining in L.A., and if you want to know what it's like when it's raining in L.A., it's hot and humid. The windows were welded shut in this place because, after all, it's Patton State Hospital.

We asked this group of experts to identify for this Commission what are the biggest challenges that we have to go through. They put them up on the board, and Toby, having been to some fancy facilitative training, figured out how to put these in a priority and to label them in a

way that would make sense to you and I and people who were nonexperts. I have to tell you that the majority of the bullets that they put up on the board were not funding. The majority of the problems were not even within the mental health system. To the people who were trying to improve mental health services to children and young adults like Rebecca, the biggest problem was the intersection between the mental health system and the juvenile justice system, or the mental health system and the educational system.

The reality is we have a very siloed system that you know very much about, but that is a fundamental problem. A siloed system results in funding streams that, while many of them were created to fill a gap, have subsequently created two more, because there's a gap on either side of the criteria eligibility that were created to fund a service. Every time we've tried to patch the system, we've solved a problem that we could identify and define in law or regulation and created some other child whose circumstances didn't meet that criteria. We have this siloed system where the funding follows the silos. It doesn't follow any kind of fundamental policy goal that we're going to sufficiently provide service in the most effective way.

We also have created an organizational structure that supports these disciplines, that support these funding streams. You have education systems, mental health systems, juvenile justice systems, and each of those can work together but just as often cannot. Just as often, people working in these systems, as dedicated as they are, as overworked as they are, as underresourced as they are, set limits, and they set them by their responsibility under the law. At the end of the day you can see that the sum of the legal responsibilities seldom meet the complexity of the kind of situation that was described by Rebecca.

We also added some others. There's a whole list of very specific problems that follow from funding an organizational structure, that follows this system, that we could explore for days. But I want to add a couple of others real quick.

The second is a leadership challenge. We are a place, because of demographics, because of work conditions, because of reasons that we're not sure, facing a tremendous leadership turnover in the counties and in the state. I can give you a couple of numbers. In the last five years, 24 percent of the county mental health directors have retired. In July of last year, 12 percent of all positions were vacant. Another 25 percent of directors are expected to retire in the next five years. Eighteen of those positions have been held by somebody who was in that job for less than twenty-four months.

Let me point out the nexus here between this personnel issue and the problems we've described. If you go back to where we saw innovation, where we saw success, despite these organizational and funding and structural problems, it was because human beings figured out how to make the system work for children like Rebecca.

If you want to figure out how to invest some money, it's to seriously consider the state's role in helping to develop leadership at the state and county level, because skilled public administrators can make more out of the system you have in place. I think they can also develop the trust with the state agencies and the policymakers to tell you how to change the system in ways that don't lead us back to a series of pilot projects that will create more gaps.

The flip side of that is personnel. We had the county mental health director from the county of Los Angeles tell the Commission that if he could choose today between an adequate pool of people to fill the vacant positions or additional funding, he would choose the pool of people. He had money to fill positions he could not fill.

This is not a new problem. It's a problem that's plaguing a variety of human services. It's real. It turns out that the state of California, through the university system, through the Office of Statewide Health Planning and Employment Development Department, has the talent and the structure to focus on that problem. We're spending a lot of money to train people to do something the state of California's policymakers ought to be able to put a focus on what that training is going to do. Clearly, providing adequate personnel is an important way to make sure that the people who are in the system stay in the system and that more people are attracted to it.

Finally, I want to focus on an issue that, systematically, there is no way within the system, or very few ways, where it's a system that learns, where problems are identified and resolved, where policymakers have a clear sense of where this system is failing or not failing. We overrely on anecdotal information, on press clippings, and these others things that I think do a great job of helping us understand the tragedies that occur from a bad system. They even help us to identify specific symptoms of a bad system, but they don't do it in a way that allows either the system at the county, the state level, or even at the policymaker, to constantly be getting better and to capitalize on these strengths that we talked about.

In an attempt to quickly stay within the time frame, I want to touch on just a couple of other real quick things.

SENATOR ORTIZ: You're okay. You've got about three minutes or so.

MR. MAYER: Thank you.

I want to give you some examples of some of the things that the committee asked about. The committee did ask about gaps and asked us to explain what we meant by “gaps.” Clearly, we saw gaps in services where somebody was eligible for a service and the servant was available, again because of personnel or something else. There are gaps in the service that arise because someone isn’t eligible under the law. Gaps arise based on what door you come into this system. If you come into the system and get labeled as a victim of child abuse and end up in the foster care system, your eligibility to services is different than if the first time we find out about you is when you start acting out, having been a victim of child abuse, and then translate that action into ways that we identify you as a criminal and you enter the juvenile justice system. So, there’s a variety of ways that gaps get created. Almost inevitably, many of them are created because we haven’t taken a systematic approach to fixing the system.

We were asked to comment on integrated services. I want to say that this has been a problem that people have long recognized. This isn’t a Little Hoover Commission idea. People have been talking in this building for thirty or more years, recognizing the challenges here. We’ve created the System of Care pilot project. We’ve created wraparound services. We’ve tried to do this, but the reality is that when you look at the bulk of the children who are in this system, they are not receiving well-coordinated, integrated services that are comprehensive and tailored to their needs. So, the Commission has made some recommendations to you about how you could approach that much more systematically. That can be a very expensive proposition, but it doesn’t necessarily have to be an expensive proposition.

We were asked specifically to talk about federal waivers. In the report the Commission identified that there may be opportunities for the state to pursue federal waivers, for instance, and be able to draw down federal dollars to provide mental health services to children in the juvenile justice system. Clearly, I think that’s an important thing for the state to look at.

I also want to impress on you that the Commission advocated that we take a systematic approach to understanding this problem. One of its fundamental recommendations is it believes that if you really want to understand where the gaps are and why services aren’t improving, we need to begin with a community level and county level assessment of what services are available, because the gaps are different in every county. The gaps are different from community to community within a county. The gaps can be different from child to child. You can’t, in the

state of California, be the ones to identify those, but if, at the local level, we were systematically identifying and presenting that information in a uniform way, the state could do a much better job of being the leaders that they're prepared to be, either in the department or in the Legislature.

I would also suggest that out of that you may identify that, yes, we need more money; yes, we can't use federal money here; or maybe we discover we can use federal money to serve one of these gaps. We just didn't previously make the connection.

Federal waivers, I think, are an important part of this process, but it's going to be a better and more effective solution if it's an attempt to build this comprehensive system rather than one more way to finance, on the cheap, a patch that may not ultimately result in comprehensive tailored services.

Clearly at the heart of this is funding reform, because not only do we have a system that restricts how much money we have, but what the Commission found is that we have added incrementally. We have added patch on patch. We've had pilot projects. We should recognize the maladies that are associated with this. The quality and the quantity of care in this state depends often on what your zip code is or what you're labeled under the law. This is clearly a product of attempting to do incremental reform when we don't have the money to do incremental reform, and a good idea gets scaled back to being a pilot project that really isn't a pilot project but a long-term program that only operates in three of the fifty-eight counties.

This is an enormous problem. It's one that took thirty years to evolve. We can't solve it overnight. We can't write one piece of legislation that's going to reengineer the funding here. But we can commit ourselves to a funding stream that provides more discretion to local communities in exchange for real, measurable outcomes so we can all understand how they're getting better. We can dedicate ourselves not to creating new pilot projects and categorical grants but, rather, focus communities on identifying gaps, using available resources in partnerships with other public agencies to fill those gaps and, where necessary, provide additional discretionary money to the counties in exchange for a commitment that they're going to demonstrate how they're meeting that gap.

So, what I really want to suggest to you that the Commission said on funding is that it recognizes how complex this is. The Commission isn't in a position to write a bill that's going to undo thirty years of well-intended, oftentimes very well-crafted, incremental policy that, as a

whole, doesn't meet our needs. Rather, we have to take a long-term approach towards resolving that problem, which by itself can be a very difficult thing.

With that, I want to say that the Commission saw that there was some very important state responsibilities and they were to set expectations so we knew what we wanted to accomplish with this system and make that very clear. Over the long-term we need to and must provide appropriate funding not only adequate but in an appropriate way so that it can be spent by knowledgeable people in the communities to meet their needs. The state needs to offer technical assistance because sometimes the gaps are created by people in one county knowing how to do the job and in one county not knowing how to do the job. It does need to be able to be in a position to disseminate proven and promising practices and to promote accountability.

The local responsibilities, in turn, are to assess their needs, to identify the gaps and do what they can to solve them; when they can't solve them, to aggregate their interest and impress that on the state. They need to integrate and coordinate services wherever they can within the law and clearly identify for the state where they need regulatory or statutory relief to get the job done. They need to, within their own systems, establish clear points of responsibility so that within their systems they know who's responsible for meeting the needs of the children.

Everyone has an obligation to innovate, to evaluate, and to share what they think is the best practice – that's the beauty of having such a large state – and within, just as at the state, to promote accountability towards the outcomes that they're trying to achieve. Ultimately, not only will that improve the system, but it will guide for the policymakers in California how much and how to invest more money; clearly, we think, with the support of _____ Californians.

Thank you very much for the opportunity to testify.

SENATOR ORTIZ: Thank you for your very concise testimony. I know it's raised a number of questions I would like to discuss at the end of the panel.

Let me take a moment to welcome Senator Kuehl who has joined us. We are actually going to have the first panel complete and then maybe go into questions.

Our next speaker, I understand, is Ms. Burne. Welcome.

MS. KATHLEEN BURNE: Thank you. I'm Kathleen Burne, and I'm the mental health director in El Dorado County, and I'm here today to represent the California Mental Health Directors Association (CMHDA), as the Children's System of Care chair for that association, and respond to the Little Hoover Commission report.

We did a written response that I hope you have copies of.

SENATOR ORTIZ: I believe it's in your packets, Members. Thank you for that reminder.

MS. BURNE: And I hope that you will find an opportunity to read that response. We went through each of the findings and recommendations and made a response from the association. I'd like to highlight that response. Given the shortness of time, I can't go through each recommendation and finding, so I'd like to talk to you about some of the highlights.

California's counties have made tremendous strides in increasing care to children and families. Much of this increase is attributable to the Children's System of Care model which was implemented in California fifteen years ago as a pilot program and which has, over time, expanded to nearly all counties. Children's System of Care was designed to promote a holistic approach and bolster the service, administrative, collaborative, and evaluation capabilities of counties.

CMHDA does agree with the Little Hoover Commission that eligibility criteria limits those who can get services in the public system. Many children and families do not qualify for those services. Public mental health is largely driven by a legislated target population and categorical funding. County mental health departments have a mandate to serve children and families with the greatest and most expensive needs. Children's System of Care funding and Medi-Cal's Early, Periodic Screening, Diagnosis and Treatment have increased counties' abilities to provide services. CMHDA does not agree that "care is denied as needs arise." In fact, quite the opposite is true. Legislation and regulations, especially those governing the Medi-Cal program, require significant administrative access and due process procedures. Because of the mission of public services, those with the most need not only get services first but usually the largest amount of services.

We agree that providing high quality services is fundamentally an issue of resources. CMHDA supports the recommendation to develop a strategy to identify additional private and public resources to respond to unmet needs.

We also agree that prevention opportunities are lost. Mandates on county agencies to serve the most high-risk and expensive clients leave little opportunity for public mental health to provide early intervention and prevention. Many prevention activities are happening in counties through other agencies and initiatives, with county mental health usually as one of the

collaborating partners. Additionally, many private agencies see prevention and early intervention as their domain and dedicate their programs to this goal.

One of the opportunities we currently have in counties is the Proposition 10 Children and Families Commission to provide prevention and early intervention to young children. That varies throughout the state significantly in what is being provided in the mental health arena.

CMHDA strongly supports the recommendation that the Governor and Legislature establish a commitment that all children with mental health needs shall be eligible for and receive high-quality, efficient mental health and related services. The public and policymakers must have a shared commitment to care for children and families.

CMHDA agrees with the importance of utilizing proven and promising practices in service delivery. These are included as core elements in the Children's System of Care framework. The California Institute of Mental Health and its Cathie Wright Technical Assistance Center should be further supported in the work that they are already doing with state and county agencies in researching and disseminating information on promising and proven practices.

CMHDA also agrees with the Little Hoover Commission recommendation to require each county to establish a Child and Family Services Board. We do believe, however, that in each county there are up to fifteen different boards, depending on the funding stream, that we are required to sit on. Through the Children's System of Care funding, we have a policy council board which we believe could function and assume the duties recommended by the Little Hoover Commission report.

CMHDA also agrees that a plan for private-public universal coverage should be instituted. We had hoped that the new parity legislation would provide access to care for many individuals who had been denied services. However, many who have coverage find there are no willing providers in their area. This is, in part, due to the extreme shortage of mental health providers but also based on the low reimbursement rates and the tremendous paperwork required for that reimbursement.

Finding No. 2 of the Little Hoover Commission was mental health funding fails to promote quality efficient care. Again, CMHDA agrees that services tend to follow eligibility criteria and that establishing that criteria can be complicated. Mental health care for children is provided through multiple agencies and services such as schools, child welfare, regional centers,

probation, and child care providers. Categorical funding is a way of life for mental health programs, both adults and children. These programs are very complex, with separate administrative requirements and different outcome measures. Eligibility criteria are major components of state and federal oversight protocols. Accountability to different funding streams requires considerable amounts of time and paperwork to maintain the integrity of the funding, particularly Medicaid. This can take time and resources away from direct service and leave children and families without services because they do not meet eligibility criteria.

This is very evident in the juvenile justice system. One of the largest barriers to providing services to this very needy population is the lack of funding dedicated to that population. So many of the juvenile justice population do not meet Medi-Cal criteria, they're not Medi-Cal eligible and, therefore, do not receive funding for that service. Those treatment dollars have to come out of the few discretionary dollars that counties may have.

CMHDA agrees that the complexity of rules and regulations frustrates families. Counties do attempt to address this issue through programs such as the Children's System of Care and the SB 163 wraparound, which are both family-centered, strength-based approaches. Parents and youth are used as employees and volunteers to educate and assist other families in navigating the system and providing advocacy for family needs. These approaches should be supported and expanded. As Rebecca pointed out, she's one of those teens in Sacramento County. Those counties that have set parents and youth as advocates are showing tremendous success, and this should be an area to be expanded. It is also another area that there is very little funding to provide, and counties have to find that out of other treatment dollars. But it is very, very successful.

CMHDA also agrees that there is an inequity of funding among counties for mental health programs. We have significant concerns over the data in the report which shows county revenues as much as 30 percent higher than those counties report the revenues to be. Despite this, there is still a substantial difference between counties and funding available. The reasons for this inequity are numerous. Some counties are more aggressive than others at obtaining funding. Some have more discretionary general fund dollars and the commitment of local government and county board of supervisors to provide additional funds for mental health programs. Even in wealthier counties, these funds become vulnerable during poor economic times. Some counties lose mental health realignment funds and transfers to health and social

services programs. Some counties have significantly higher numbers of Medi-Cal beneficiaries than other counties. Even Medi-Cal distributions through counties are not at the same level county to county.

There are substantial grant and pilot programs available which are usually competitive and short-term. Counties with more resources available are usually those that are also able to apply for those and pursue those grant funds. Many counties, particularly small counties, lack the infrastructure to apply for those grants or to provide the administrative functions usually required if you receive the grants. In many counties, pilot or demonstration grants are discouraged because frequently a program is built, services provided, and funding disappears in two or three years.

In California many exciting and effective programs have been developed out of pilot and demonstration grants. They are seldom, however, taken to scale across the state and sustained in all counties. It took fifteen years to get limited System of Care funding to all counties, and before the last counties could implement the programs, the funding was reduced. The Governor's budget proposes an additional reduction in this program.

CMHDA strongly agrees that California should ensure that public or private funding is available to provide efficient, effective mental health care. Approximately 33 percent of California's children receive mental health care through the private sector. Children and families needing mental health services should receive them in the most appropriate time-conscious way. Prevention and early intervention should be planned and structured.

CMHDA also agrees with the recommendation for long-term funding reform. We agree that the state should study the current funding structure and promote stable, flexible funding. Where feasible, and in the best interest of serving children and families, categorical funding should be decreased. Programs should have reduced administrative mandates and provide the discretion to design services to meet individual child and family needs. However, a major source of funding for children's mental health services is Medi-Cal based, with mandated federal guidelines and regulations. Requesting additional waivers may be a way to increase those revenues and provide more flexibility.

CMHDA also agrees with the concept of providing incentives that promote efficiency and effectiveness and the adoption of proven and evidence-based practices. However, we caution that care should be taken in developing the three funding levels suggested; that they do

not replace previous categorical funding with new categorical funding that has additional administrative mandates and outcomes.

We agree that there is not sufficient personnel in the state of California. Vacancy rates exceed 30 percent in California counties for mental health professionals. This shortage is equally pronounced in other areas such as public health and child welfare. Counties have provided some innovative approaches to addressing staff issues such as the hiring of clients and family members.

The SB 1748 (Statute of 2000) Task Force has done a survey of counties and private providers to determine barriers to acquiring additional mental health professionals and solutions to obtaining more professionals. One of these would be the ability for licensed individuals from other states to more easily be licensed in California.

SENATOR ORTIZ: Ms. Burne, if I could ask you to try to go through your recommendations fairly quickly, so we can adhere to time.

MS. BURNE: Okay, thank you.

We strongly support the recommendation that the Governor and Legislature direct the Health and Human Services Agency to address the crisis of the human services needs of mental health and child welfare and public health.

Another recommendation is on the integration services. Counties have very strong policy councils, some at higher levels than others, working on integration. Those counties who have been System of Care counties for longer periods of time are doing a tremendous amount of integration and blended funding. The newer System of Care counties, in many ways, are struggling to develop those relationships and to do that funding, blending, and integration of services. They should be supported to continue that process.

We also support the recommendation that there be a Secretary of Children's Services at the state level, and we very much support a multi-agency committee or a policy council at the state level, as we already have at the county levels.

Thank you very much for the opportunity. We really appreciate the report and feel that it's a very useful document for us.

SENATOR ORTIZ: Thank you for your testimony. There will be questions after our last speaker on this panel.

Welcome, Mr. Mayberg. If you could introduce yourself to us all once again.

DR. STEPHEN MAYBERG: Thank you.

I'm Steve Mayberg, and I'm the director of the California Department of Mental Health. I have the fortune of going last, and I will be able to make my remarks be brief, I hope.

I had a series of questions that this committee's asked, and I have copies of my response to that. I'll just try and summarize those, starting out with our first presentation. We have to remember this is about people. We tend to talk about it in systems and whatnot, but this is all about individuals and about persons with serious emotional disturbance. Whether it's through resourcefulness or whether it's through resilience, we see that individuals do get better, sometimes because of the system and sometimes in spite of the system, and we need to figure out how to make sure that our system, whatever it is, facilitates people getting better.

I think, from my point of view, the report from the Little Hoover Commission is an excellent document for us to look at. I welcome their honest and objective view of why our system is succeeding and why it's failing. I see them as tremendous advocates for us for system change and system reform, and much like they recommend many things for the state, using that whole process for counties and for individual systems is really important; listening to all of the people who are stakeholders, being objective about it, and looking outside the box.

I think the critical point that Jim talked about is that when we talk about mental health issues, oftentimes the people who should be in the room aren't in the room. Mental health does a good job at what they do, but we are in a silo. We have to be responsible for the silo that we're in, but we have to look at how we engage people to sit at the table with us and work with us.

So, what I'd like to talk about briefly is the things that everybody's talked about: gaps in our system, who our target population is, who we serve, and the problems with who we serve and where we serve them, where prevention plays a role in what we do, what kind of standards and expectations we have – do we set the bar too low or do we set the bar too high? – what happens when we do categorical funding, and then where do we go from here?

In a very brief way, we do have gaps in the system, and we do have silos. There's absolutely no doubt about that. As much as we support Children's System of Care values, as much as we support collaborative planning, as much as the administration is a firm believer in cross-program coordination, we have a thirty-year history of people not cooperating and not collaborating the way they do. Sometimes it's because of federal regulations, sometimes it's because of state rule, sometimes it's because of funding streams, and sometimes it's because of a

bureaucracy that's mired in doing the same old thing the way that we always do it. We need to break out of that and begin to view children and families in a much broader sense rather than just belonging to one entity or the other. That's something that I think is a high priority of the Health and Human Services Agency and of the administration.

Part of that, though, is we do the same thing in looking at children. All of the mental health legislation talks about services to seriously, emotionally disturbed children and children at risk about home placement. We have silos too. We don't look at kids until they get way down the road. As Ms. Hawkins talked about, it's way too late when someone's in the hospital for weeks on end and they're overmedicated to begin doing family interventions. We need to start much earlier than that. Yet, we do this very careful dance of balancing limited finances, and usually prevention does not come out as well as it should on that.

When I look at the programs we have, we do have two models that we should look at. We have Early Mental Health Initiative, where we're intervening with kids in grades K through 3. We have great results for very little money, and those results tend to last. This year we're using some Prop. 10 monies to do an infant mental health program, so we're starting zero to three. That looks promising too. So, it's changing our mindset to who we serve and how we serve those people, and being able to be in it for the long haul. The cost avoidance isn't going to show up this year, it's going to show up in ten years. That's part of the problem with leadership is that people look at what happens on your watch, not on someone else's. I think we're all committed to making California a better place. Whoever's watch it is, as long as it happens, that's really important.

I do take seriously that we need to have standards to be able to show that there has been change and that we have committed money to look at some of those best practices and evidence-based practices. That's a very high priority of the department. Yesterday, we presented for the first time something we call the "Caring for California Initiative." We looked at three different diagnoses. We looked at Attention Deficit Disorder with hyperactivity, major depression, and conduct disorder, and looked at how do we recognize those kids, how do we get them into treatment, and what is the best treatment that we should actually be providing them? We came up with 114 criteria. Now we're looking at all of our systems to see is there a difference between counties? Is there a difference between rural and urban? Is there a difference in terms of by color? If you are of color, are you going to get a different kind of service than if you're not?

So, we're starting to get some really interesting data out of that that will help us set those expectations to say this is best practice, this is what we expect for quality, and this is how we're going to develop standards.

We have our own set of standards that come with our funding streams. If you have Medi-Cal, you live by Medi-Cal standards. If you have Title XIX, you live by Title XIX standards. If you have Healthy Families funding, you live by those standards. If you have private insurance, you have a different standard. We need to look at how we make those more coherent.

Our funding streams are probably akin to the categorical kind of funding we have. People have chosen categorical funding because they want to target a difficult population. As much as realignment envisioned having a block-grant approach, I think unless you target populations in some way, you're not going to get the services you want. We tend to deal with the easier problems, not the harder problems.

But saying that, I also think we need to learn how to braid funding, or how to blur the lines between funding, so we can use education, social service, and juvenile justice funding to work in a coherent fashion.

So, having said all of that, I think our system has come a long way, but we have a long way to go. It's not just about money. It's about people. It's about getting people to get into our field. It's working collaboratively. It's raising the bar and taking those best practices and those pockets of excellence that have been identified and making those not be the exception but to be the rule in our state, so that every child has an opportunity, regardless of their zip code, of having access to treatment that's appropriate and timely and not as reactive as it is but more proactive. It shouldn't matter whether you come in the juvenile justice system, mental health system, the educational system, or the foster care system; you're the same child. It's just the symptom that showed first, and we need to make sure that all of those doors lead to the same co-part treatment.

Thank you.

SENATOR ORTIZ: Thank you. I want to thank all the members for staying fairly well within the time limits that were requested and let Members know that we have allotted roughly fifteen minutes for questions, which is now our opportunity. I know I have a number of questions, but I'd like to ask my colleagues first whether they have questions of any of the speakers or comments or require further clarification.

Senator Chesbro?

SENATOR CHESBRO: First, I'd like to ask Ms. Hawkins a question and then Mr. Mayberg. Before I ask the question of Ms. Hawkins, I want to say that I wish we could structure all of our hearings where we get the real-life story first before we get into all the government mumbo-jumbo about why we can't do things. And I'm not pointing fingers. We're all caught in the system. But I think it brings the reality to the discussion that is so helpful. It's great that you're here and it's great that you have the courage to tell your story.

My question is – and I know we don't have time for, probably, the complete answer of this – but you talked about what went wrong in the system for you. You're sitting here, and clearly something went right too, so as briefly as you can, if you could give us some idea, in addition to whatever personal resources you may have been able to find to help address this, what may have happened in the system that assisted you in being able to get to the point where you're able to sit here and have this conversation with us so eloquently.

MS. HAWKINS: I think Dr. Mayberg said it right: Some people get better because of the system and some people get better in spite of it. I got better in spite of it. I made a decision that I wasn't going to let them win, so I won. I also had a very supportive family. There were some people that made a huge impact in my life and told me that "They're wrong. You can do this," and that gave me a lot of strength that I needed to get better. It was the people.

SENATOR CHESBRO: Thank you very much, again, for being here.

Dr. Mayberg, as you know, the Governor has proposed in his budget to reduce children's services, and I wanted to know, from your standpoint, what you think the impacts of those that might be, and I'm asking this in the context of understanding we have a huge budget problem – I'm not casting nasturtiums here, so to speak – but how you think we might be able to, if we were to adopt the Governor's proposed budget, at least not go backwards but hold our position and hopefully continue to move forward in terms of improving the systems.

DR. MAYBERG: I think that's a fair question to say how can you cut money and expect a program to still be vibrant and to succeed? I think it goes to the heart of the question. We've been doing Children's System of Care for over fifteen years, and it's taken us a long time to get to full funding. The reality is, when we started doing Children's System of Care, there was no EPSDT; there was no rehabilitation option; there was no commitment to work collaboratively in interagency ways.

On the one hand, I don't feel particularly defensive about eliminating \$4 million from Children's System of Care when we have a \$500 million increase in our EPSDT budget in a four-year period. I think it's how we use the money and where we use the money and what kind of incentives we have to cooperate and to collaborate. Part of the reason that some of that money disappeared is that none of the criteria that were necessary to get the money from the counties who hadn't applied for it were being met. We couldn't get them to sign a memorandum of understanding to work together.

That, to me, is a tragedy. It's a travesty, not a tragedy. If you're a county and you have half a million dollars available, if you'll just agree to work together, and you choose not to, there's something wrong with our system that allows people to walk away from that.

SENATOR CHESBRO: It's obviously a tragedy for the system and for all of us. What kind of response or what kind of tools do you think can help us fix that?

DR. MAYBERG: I think that it is an issue of expectations, and I think it is an issue of the state taking a role that's both technical assistance and training and moving people forward; but also, I think, sometimes being a little bit more assertive and sometimes confrontational in terms of pushing people to take some of the risk that we need to take to work together. Sort of the carrot and the stick approach, in that most counties do very, very well with the carrot; some don't.

SENATOR CHESBRO: I don't suppose that the representative of the directors would want to talk—

DR. MAYBERG: I think that Kathleen can speak for the directors, but my sense is that most mental health directors want the system to be better and don't want to be judged by the nonperformers, and they don't want the whole system dragged down; and that they have supported standards, and they have supported quality, and they have supported taking action to move people forward in that context.

MS. BURNE: I agree with what Steve is saying. I really can't respond to the counties or for the counties that he believes are not meeting standards, because I'm not really in a place to do that. If I thought there were counties not meeting standards and not signing agreements, which is probably the biggest part of System of Care is the requirement that you do integration with your partner agencies, and children get into services whatever door they come into. You can't fund a

county with System of Care dollars who can't even say they're going to work together. So, I definitely agree with that piece.

I also think that if there are counties actually doing that and that made up the \$6 million, then it's okay. I have a feeling the \$6 million is maybe not just the counties that aren't making that first step. So, that's a concern.

SENATOR ORTIZ: Thank you.

Senator Figueroa.

SENATOR FIGUEROA: Ms. Hawkins, thank you again for your presentation. I agree with Senator Chesbro and Senator Ortiz that having the human story really assists in making the decisions that we have to make and putting a face to the problem.

What scared me in your testimony was to hear that when you were in a hospital environment, it kept sounding to me like you were in a prison. My question to you is: Do you think things have changed, or do you still feel that children in that hospital environment continue to feel like they're in a prison? Obviously, you did.

MS. HAWKINS: I think what I'm noticing with the kids that I work with now, the only thing that's changed about our local psychiatric hospitals is that they don't keep us as long, so we're not "in prison" as long. But it certainly does feel that way. When I was there it was sixty days during one visit. Now it's three, if you're lucky.

SENATOR FIGUEROA: What could we do? You started the conversation by saying, Treat us with respect and that doesn't cost anything. And thank you for reminding us of that. Is there other things that you could share with us that would make a difference? I just hate the thought of thinking that our children feel like they're prisoners rather than in a facility that's there to assist them.

MS. HAWKINS: I think that by the time we get there, we're pretty far gone. By the time I got to that hospital, I was pretty far gone. Had I been able to go earlier, I might have been able to get more benefit from that treatment. Had I been able to go there before I tried to kill myself, before I wanted to die, I might have been able to get more and to be less combative. I don't choose my battles very well and a lot of the staff didn't choose their battles well. I think had I been able to go before I was in crisis.

SENATOR FIGUEROA: That's an interesting remark that you make, an observation, that many of the staff didn't choose their battles well, because I would expect the staff to have that knowledge, and they should.

MS. HAWKINS: They should.

SENATOR FIGUEROA: It sounds to me that there's a lot of education that needs to continue.

Thank you very much.

SENATOR ORTIZ: Senator Kuehl, do you have questions or comments?

I have one for each of the speakers, and I want to get through them very quickly so we can get to the next panel.

I think you outlined some points incredibly clearly in terms of early intervention, which has been echoed elsewhere, which we say here about a lot of prevention-intervention programs, whether it's in education or juvenile justice or mental health or health. I thank you for that.

I had just a couple of observations that – oh, actually, one question that I think is really important. Thank you for being a part of a program now that is addressing the issues of other people caught into the system. Let me ask you sort of on point: How is the youth and family advocacy program funded here in Sacramento County? Is it a passthrough of some state funding? Is it totally county money?

MS. HAWKINS: I believe it is funded through the System of Care allocation dollars.

SENATOR ORTIZ: Which is—?

MS. HAWKINS: Sixteen sixty-seven.

SENATOR ORTIZ: That's helpful to know.

I'd like to pose a question for Mr. Mayberg, because I think what I heard, when Mr. Mayer went through recommendations after he highlighted the points in the Hoover Commission report, one of the things that was a recurrent theme was integration, more coordination among the programs, a need for a study to look at and provide that valuable information and cull out the gaps and maybe determine some means of better integrating and working collaboratively across silo lines. It sounds like the kind of thing that should occur; if not solely, at least in partnership with the state. I mean, I know this whole notion of building capacity and understanding infrastructure is always a wonderful project for an endowment or foundation funding, but I need to ask whether the state is taking steps toward that very recommendation.

Secondly, one of the other recommendations really went to the question of not having the entry into the program determine the scope of services or the limitation or the rationing of services, and to the degree we can at a state level remove many of those barriers, what is the state doing, if at all, to, in fact, break down some of those programmatic barriers?

And then a question for Ms. Burne, after Mr. Mayberg's presentation, because I want you to think about this. You had mentioned local Prop. 10 Commission funding some of these programs. I have seen some wonderful programs funded from local Prop. 10 commissions – school readiness, child care, etc. – but I haven't quite seen the innovation, and we're talking mental health, zero to three. I don't know whether we've quite seen some of the diagnostic intervention, early-on programmatic – at least in the Prop. 10 local commissions I've seen. This is the first I've heard about the State Prop. 10 Commission actually funding something, so maybe you could address that as well. Maybe, Ms. Burne, after Mr. Mayberg's presentation, you can give us some insight as to what is occurring in El Dorado County, for example.

DR. MAYBERG: Quickly to respond to your questions, I think it is absolutely true, if we are going to expect counties to do an assessment of gaps, we need to do that too. That really becomes something that is occurring at Health and Human Services Agency in finite ways but not in a global sense. I think we tend to look at that in specifics rather than global. So, what kind interagency collaboration is there about this particular population? We haven't moved much from that, and I think the only thing that's promising in that area is looking at the issue of data integration. It's certainly one of the things that the Little Hoover Commission has been critical of this state and of the department, and that's not being able to give concrete data about prevalence or incidence or use. That's something that we're looking at, how we are able to make educated and informed decisions without having good data, and we don't always have good data. Part of what's helped that, actually, believe it or not, has been working together on HIP implementation. We have to start collecting data in a uniform way. It's not something that we've modeled well, and I think that gets ramped up when you get to the county level and it gets exacerbated.

SENATOR ORTIZ: So, at this point the state is not embarking upon the kind of understanding and survey of the programs to determine where integration could better occur, nor is there technical assistance available by counties—

DR. MAYBERG: Technical assistance is only available in the mental health arena, and we invest in that through the Cathie Wright Technical Assistance Center. But that doesn't get to social service, juvenile justice, or education the way it should. How do we bring our other partners to the table, I don't know.

SENATOR ORTIZ: Ms. Burne, maybe you can elaborate on the Prop. 10 model that might be helpful for other counties to begin looking at.

MS. BURNE: I will as much as I am knowledgeable. The next panel has both Placer County and Sacramento County talking about innovative programs, and I think they have a lot of Prop. 10 programs in their counties that they might be able to give you some information.

I am on the local Prop. 10 Commission in El Dorado, so I'm lucky in that respect to have some influence in our county to move more towards some prevention activities for mental health. It does vary statewide what has happened in the Prop. 10 arena. There are some counties, I know, putting quite a bit of money into some early mental health prevention and treatment, and then there are other counties who are not looking at mental health at all. So, there is a real variety of what is going on.

I think that the home visitation programs are happening in quite a few counties, and I think that that's probably going to increase – at least we are hoping that it will be increasing. I think that's been a very successful program. There are private nonprofits who specialize in early mental health care who are applying for funds to local Prop. 10 commissions and receiving funding.

There is real promise for use of those funds, but it is going to vary from county to county on what they see as priorities.

SENATOR ORTIZ: Thank you.

Senator Kuehl.

SENATOR KUEHL: Thank you, Madam Chair. I wanted to focus for a minute, if I might, on the issue of the shortage of qualified mental health professionals that was reported on by the Commission and in your response. Very specifically, in terms of people from other states who might be qualified to serve in California, you indicated in your response that it can take years for people to make that transition. We hear this in every panel that testifies about every kind of shortage, whether it's nurses or doctors or specialists or whatever.

Can you say a little more about the barriers in terms of the time that it takes for people to be accepted as licensed mental health professionals?

MS. BURNE: To get that license?

SENATOR KUEHL: Yes.

MS. BURNE: It varies by discipline. If you're a psychiatrist, you have one process that you go through. We interviewed a child psychiatrist a month or so ago. She lives in Connecticut. It took her nine months to get licensed in the state of California, and she did that while she was in Connecticut. Wanting to move here, she was going to be sure that she would be able to work here. It took her nine months. A social worker can take a couple of years, depending on the cycle of testing, because they have to go through the California testing. So, the cycle of testing, if it's twice a year, and they miss registration or they don't pass the test the first time around, which is not unusual. For psychologists, Dr. Mayberg could probably talk about that, but it can be years for them to become licensed in this state, and they're not always willing to move here with the risk that maybe they wouldn't become licensed.

SENATOR KUEHL: When you said to include colleges and universities, you meant in addition in terms of preparing new licensees, not in relation to people who come from other places?

MS. BURNE: My comments about including colleges and universities is we have been doing a lot of work on trying to deal with the human resource shortage. The California Mental Health Planning Council held a summit recently and they surveyed counties, and they're working on looking at some solutions. The recommendation by the Little Hoover Commission was to do a summit. Building on what's already been done would be a wise thing to do.

I truly believe that developing those resources requires a lot of work with the colleges and universities to prepare people to work in the public system. Not all of them do that, but many of them prepare them to work in the private therapist world. We are really trying to encourage, when this human resource work goes forward, that the colleges and universities are brought on board as really critical to us in developing the manpower, both masters, bachelors, and even at the community college level training classes and curriculum, to work in our systems.

SENATOR KUEHL: The other question I had related to this issue of the multiple needs of families and how often the services that you get in one system can almost cancel out, or you have to choose, or who's going to fund what? Can you elucidate a little bit again, say, the two

major problems for the integration of systems or the two major barriers to the integration of systems? Because my sense is that where you find, for instance, a dual diagnosis in adult folks, there's often a choice that you have to make in terms of who's going to serve you in the county and even a conflict about that. So, I'd be interested in any of your assessments about that because that's just about every person that we need to serve will have more than one issue and a bifurcation of services.

Is that either too naïve or too broad a question?

DR. MAYBERG: No, it's probably too specific.

SENATOR KUEHL: Oh, good.

DR. MAYBERG: I think you address an issue that we all are in a world of denial about. The most difficult areas in children are the interface between the juvenile justice system and the mental health system, I think, in terms of both the values of the system and the funding streams of the system, and conduct disorders is a great diagnosis that ends up being in one system rather than the other. That is an example.

I think that what we've learned from that is when we look at innovative programs that are succeeding, one of our great successes of the last few years has been our integrated services for homeless adults, our AB 2034 programs. The philosophy of that program is "do whatever it takes." Provide the services, whether it's substance abuse services or getting a pair of shoes, or whether it's medical services, dental services, or mental health services. And that's worked. We've engaged people. We need to look at how do we translate what we've learned from that "whatever it takes" kind of mentality that's really predicated on outcomes and move that to kids and say this is a system responsibility and everybody's got to participate in this and that we all come to the table with that. That's an example of one that works, and I gave you an example of one that doesn't work.

MR. MAYER: Senator, if I may, I would add that whenever the Commission has been trying to probe that issue, it's gone to a couple of counties, including Placer County, that struggled with that and I think made some headway. They're going to come up after us, so I will look forward to their addressing that issue.

The other thing that I'd like to point out is whether the Commission was looking at foster care or whether it was looking at mental health or juvenile justice, this is the critical point: that

you can make so many changes to a system within the silos, but if you want to break out and really make a change, you have to address this issue squarely.

What we found is that at the community level, they're far ahead of the state. At the state level – again, for a variety of reasons and part because of organizational structure and funding and other things – we have a very hard time with coordination. So, even if you're thinking about things like prevention programs, which the Commission recently looked at, where a lot of the funding is discretionary, a lot of it is state originated, we have fifty programs and thirteen departments that have different forms. And even when those people want to work together, it becomes this institutional barrier to it.

In the Commission's mind, they thought this was a fundamental enough problem that when it got done offering the Governor and the Legislature five chapters worth of recommendations on how to improve the children's mental health system, it added that last chapter that said you can't really respond to children's and families' needs merely by fixing the children's mental health system.

SENATOR KUEHL: Right. We just had a mini-hearing on young women in prison and had one before that on adult women in prison, and one of the facts that was just amazing to me was that two-thirds of the women in prison in California have been in the foster care system. No one ever puts these things together. This continuum of lack of care, if we want to call it that, I think it's something we need to pay a lot of attention to.

Thank you, Madam Chair.

SENATOR ORTIZ: Thank you, members of the first panel. I hope Mr. Mayberg comes away with, I think, some really sound recommendations that fall squarely in the ability of the department to look at some of them. I was particularly impressed with the recommendation to create a Secretary of Children's Services, which could be an umbrella for the whole spectrum of issues that we're tackling here in the Legislature in health care, mental health, certainly education, the juvenile justice system; and maybe in better times or when we use limited dollars better – and hopefully that occurs this year – maybe some of that can be taken care of this year.

Thank you, all, for your participation. Ms. Hawkins, you were incredible. Thank you for your personal story.

At this point I'd like to welcome panel number two, which is "Innovative County Programs." I'm going to ask that my colleague, Senator Chesbro, take the gavel while I take a couple of minutes for a break, and then I'll be outside in the hallway in a moment.

This is panel two. Welcome.

SENATOR CHESBRO: Thank you, all, very much for joining us today. This panel is on "Innovative County Programs—Enhanced Funding Options." The first person I'm going to introduce is David Gray, evaluator for the Placer County Children's System of Care.

Before we go into the discussion, let me restate what the chair stated earlier about the importance of trying to be timely. I've got down here about twenty-five minutes all together, eight minutes each – although, divided four ways, that comes out a little different – and, hopefully, with about ten minutes for questions and answers from committee members.

We'll begin with David Gray.

MR. DAVID GRAY: Thank you, Senator Chesbro, Senator Figueroa, other members of the committee. Thank you for giving us the opportunity to talk about our experience with integrating child and family services in Placer County.

We have a handout for you. It says, "Integrating Child and Family Services in Placer County," to follow along with some of the slide show that we ordinarily use.

I'm David Gray of Placer Institute, the evaluator for the Placer County SMART Children's System of Care. With me is Bud Bautista, director of the Children's System of Care. Mr. Bautista is here to answer any questions you might have.

SMART, which stands for the System Management, Advocacy and Resource Team, oversees all public children's services in Placer County. The SMART partners include the presiding judge of the Juvenile Court, the chief of Probation, the director Health and Human Services, the deputy county superintendent of schools, and the public health officer.

We recognize and honor the fine work of the Little Hoover Commission in developing this comprehensive report on children's mental health. This afternoon we would like to focus on one finding and recommendation from the Commission's report – the fifth – regarding serving children and families.

Serving kids has been the driving force behind nearly fifteen years of effort to integrate child and family services in Placer County. We know a lot about serving children and families

and, in these few minutes we have today, we would like to share the core of what we have learned.

In order to talk about what Placer has done, I need to lay out very briefly how county agencies are organized. As you well know, every county has an array of specialized agencies that work with children and families. These include child welfare services, mental health, social services, alcohol and drug programs, health services, education, and criminal justice. Each of these county agencies provides a unique set of services through a specialized group of workers to address a significant family and community problem.

As you also well understand, these county agencies are organized categorically to promote specialization and development of high-quality services, to ensure that public dollars get to each intended service, and to prevent different agencies from trying to solve the same problem.

From an organizational perspective, this categorical arrangement makes perfect sense. It is a proven way to account for public spending and ensure the delivery of services.

However, from the perspective of families that use county programs, the categorical service system is a fragmented maze of disconnected services. Families that come into county programs don't have one problem, they have many problems, and these problems are all jumbled together. Under the categorical arrangement, there is no single county agency that can address the full set of their needs, and workers from different categorical agencies cannot work together to help solve the family's problems. Because their full set of needs is not addressed in a categorical service system, most families fail to benefit fully from the services they do receive.

Over the past fifteen years, the State Department of Mental Health and numerous county mental health agencies have worked to soften the boundaries between categorical county agencies and provide comprehensive services to children with emotional disorders. Nonetheless, there remains a fundamental problem within county services, and that problem is this: The categorical arrangement of services that meets organizational and administrative needs prevents families from accessing the full set of services they need.

We see two resource problems at the local county level: service shortages and service fragmentation. There is a shortage of child and family services. You probably hear about the shortage problem every day. But it also is true that services that do exist are fragmented and disconnected and people that need them cannot get to them. This is the fragmentation problem.

Sometimes what looks like a shortage is really fragmentation. The problem is not that a service is missing; the problem is that a family can't get to a service because the agency they are in is not connected to the agency that delivers the service they need.

Placer and many other counties are trying to solve both problems – shortages and fragmentation – by integrating services at the county level. Our intent is to reduce the service shortage problem by making existing services more accessible and, therefore, more effective.

Placer County SMART is an effort to integrate child and family services so that families can get all the services they need. SMART has used four major strategies to address the problem of system fragmentation. First, top administrators have changed the way they govern their respective agencies by sharing authority and decision-making. Second, agencies have developed innovative financing strategies to move and use funds where they are needed. Third, agency service delivery structures have been reorganized, and workers throughout the system have learned how to work together to address the full set of child and family needs. And fourth, SMART has identified a set of comprehensive outcomes that we measure and use to understand and improve the effects our services have on children and families. All these strategies are designed to overcome the categorical barriers and fragmentation problems that are designed under the existing county service structure.

It is the vision of Placer County SMART that all Placer families will be self-sufficient in keeping their children safe, healthy, at home, in school, and out of trouble, regardless of the agency they use to enter the system. We have integrated our services to make these outcomes possible for all children and families in our county.

Placer has developed a learning system that uses evaluation findings to make system changes that improve the outcomes people experience. Our principal evaluation instrument is the Child Outcome Screening Form. You have a yellow copy of this instrument in your packet. Two examples of the evaluation learning system charts derived from the Screening Form are attached at the end of this handout. Perhaps at another time we could show you how we use these charts, and hundreds like them, to understand our evaluation findings.

Placer has gone farther down the path toward comprehensive, system-wide integration than perhaps any other county. It is tempting to see Placer as a county that has overcome categorical agency barriers and constructed an integrated service system. But Placer has not solved the fragmentation problem. Placer has merely constructed a set of structures,

relationships, procedures, and practices over the top of the categorical system that hides the fragmentation problem from children and families.

County-level integration doesn't eliminate fragmentation. It shifts the fragmentation from families to staff, where the double burden of providing comprehensive services to families with one hand, while fighting the categorical system with the other hand, creates huge internal organizational problems. County-level collaboration and interagency agreements are not enough to fix the fragmentation problem. We know this from our experience. Without real relief from state and federal categorical requirements, county integration is a nonsustainable gesture to protect families from system fragmentation at the expense of local county staff.

We are here to make three key points: First, the current categorical arrangement of specialized and fragmented services is a barrier to helping children and families. Placer and other counties need flexibility to integrate county agencies and programs in order to address the needs of the whole child and the whole family and the whole community.

Second, the current system accounts for how counties spend categorical public funds, not the effects public services have on the people we serve. Counties can tell you exactly how they spent every public dollar, but they cannot tell you what the public got for their money. Placer would like to be more accountable for the comprehensive outcomes our children and families achieve and less accountable for how we spend categorical dollars.

Finally, mental health is a place to start, but it is not enough. Every state and federal agency has a part to play in a comprehensive, integrated service system.

The State Department of Mental Health has been a true partner for many years in Placer's integration effort. The state departments of Social Services, Alcohol and Drug Programs, Health Services, and Health and Human Services Agency also have helped at critical points along the way. Nonetheless, Placer's experience working with many state and federal agencies, and the experience of every other county we compare notes with, suggests that the overarching rule at the state and federal levels is this: "Everyone below us has to collaborate, but we can't." When we ask these agencies why they can't work together to help us, they tell us state and federal laws won't allow it.

We need state leadership and laws that bring together state and federal agencies in support of county efforts to integrate child and family services. With your assistance, we believe

we can continue to move forward in our efforts to help keep Placer County kids safe, healthy, at home, in school, and out of trouble.

Thank you very much for giving us this opportunity to speak with you.

SENATOR CHESBRO: Thank you for that very informative presentation. I have a question for you, but I'm going to save it in the interest of getting the panelists through. Then we'll open it up to members of the committee.

In that light, I will introduce Tom Sullivan, who's the director of Sacramento County Mental Health Services.

MR. TOM SULLIVAN: Thank you, Senator Chesbro.

I do want to let folks know that Rebecca's office is just a few feet from mine, and she doesn't scream anymore – particularly at me.

I have been asked to talk about how we put our program together in Sacramento County and expanded our children's services so much and the kinds of things we've been doing.

I guess we start from a place where we've redesigned our entire adult system a few years prior, in 1993-94, and, in so doing, used fifty percent of our planning process with consumers and family. In fact, now in our Adult System of Care, we have over two hundred consumers employed full time.

We started with that model back in 1995 to develop a plan and to put a children's plan together of what we ought to be doing to serve kids in Sacramento County. We put together a forty- to fifty-member task force which included lots of family members, all agencies, public and private, etc., including kids themselves. We were able to put this plan together and it was led by the Mental Health Board. At the end, when we had it done, we ended up with no funding. In fact, the funding we had was sort of taken away from us by the county, so it became difficult.

Then what happened was that the Smith-Belshe lawsuit hit, so we put the task force together again, at least the steering committee of the task force, and said, How can we take what looks like a windfall to us, in terms of Medi-Cal dollars, and how will that fit within our Sacramento County mental health plan that we've put together for children?

We also hired a consultant at that time to look at some of the fiscal pieces, because under the Medicaid piece, you can bill 15 percent to admin but the county has to come up with half of that 15 percent. So, we were looking that we needed to put an infrastructure in and how we'd be able to do that.

We were able to do all of this and we really looked and we have some advantages in Sacramento that are really disadvantages. Number one is we have the fifth largest Medi-Cal population in the state, even though we're the eighth largest county.

SENATOR CHESBRO: Is this in total numbers?

MR. SULLIVAN: In total numbers.

SENATOR CHESBRO: Medi-Cal recipients?

MR. SULLIVAN: Right. One out of every four kids in Sacramento schools is on Medi-Cal. So, we had the large population to deal with of over 200,000.

The way in which we really opened this up is we did design the Access Team – and this was prior to Medi-Cal consolidation – but we put the Access Team together to be able to receive calls, and then we had this very innovative planner on our staff, who's out in the audience today and now works for Steve, but Zoe Todd, who came up with the idea of designing a flyer to put in AFDC checks. People who think that AFDC moms don't read flyers – wrong. We sent that flyer out and we got over 100 calls a day for six months. Our system expanded expedientially from there.

SENATOR CHESBRO: I'd call that a successful outreach program.

MR. SULLIVAN: Yes, successful outreach.

I can tell you that part of what we've done since then is we've trained all of our partners on how to use the Access Team, including CPS workers, probation workers, education, etc. Today, we get between 65 and 90 calls a day to our Access Team. I get a report every week. Last week we averaged 68.9 calls a day to Access. These are all legitimate calls for service of Medi-Cal clients. Some of it is for change, for either more intensive services or less intensive, but more than half of them are new clients every day. We're getting between 30 and 50 clients a day referred.

The program we have is basically a full range of services, including wrap programs. Our wrap programs are really designed around our AB 34 wrap programs. We started off calling them "WIT," which is "whatever it takes," as Dr. Mayberg mentioned. They're very intensive programs. We have a 4E waiver that allows us to expend the residential care monies on these along with the 163 program.

We have focused programs which are much more intense, with our outreach program staff going into the schools; staff going wherever it takes that you need to meet kids and families. Then we have the full range of outpatient services, etc.

We pride ourselves on our family and advocacy program. We require all of our providers to hire at least one family advocate. We actually have thirty-seven full-time family advocates hired in Sacramento County. I have a family advocate who sits on my Executive Management Team, who happens to be Rebecca's mom, and as you can see, she's someone who had a kid who really went through the system, which is what we want for our family advocates. We've hired more youth advocates, like Rebecca, in the system too, so we now have that.

We have the Child and Family Policy Board, that Ms. Burne mentioned, and similar to the SMART board that Placer County has. We actually use their model to look at some of it and how we wrote our ordinance in Sacramento County.

The other thing we do is we have a Children's Subcommittee of the Mental Health Board which meets monthly, and that includes all of our providers. It's about fifty people who meet on a regular basis. Part of it is communication; part of it is planning. Subgroups of that will get involved in task forces, etc.

You're wondering how we pay Rebecca. Mainly, we pay for the family advocacy program through our Children's System of Care grant. We do have a Children's System of Care grant we've had for several years now – after the plan was written, of course – and that pays for family advocates; it pays for training; it pays for other kinds of things.

One of the things it pays for, the folks we were talking about a few minute ago, is we have a community intervention program that we call our 9-12 Program. This is a program in which we take kids, who are young-age kids, who have their first contact with law enforcement. We do a check to see if they've ever had a CPS contact, and if they've had a CPS contact, then they can go into the program. It's a wrap program for kids who have had some kind of CPS contact and their first hit with law enforcement. We actually started this program based on research that showed that the Youth Authority was filled with kids who had young-age first hits and young-age CPS referrals – just as Senator Kuehl was talking about a minute ago.

Where we came from and where we've gone, in 1994-95, we served between 500 and 700 kids and spent a million and a half. Last year we served over 13,000 kids and spent \$50 million. We are, I guess, kind of the leaders in this. How do you export this to other counties?

Well, some counties you can do. Early on I was asked to go to one large county by their children's program and their mental health board and talk to them about how we were doing this, and I did that, and then a few years later I was quoted in the newspaper saying they had a consultant to show them how to do it but they never did it. They have done it now.

I think part of it has to do with risk-taking. There were a whole lot of people at that time, after the lawsuit, that said, "The state is going to cap this; you'll never be able to do it; you're taking too big a risk to do this." My feeling had been I'd spent twenty-five years cutting mental health programs; I could always go back to that if I had to. But if it was out there, then I was going to go get it. I think that's the other thing too. I'm old enough where I can take all these risks with no fear.

Some of the barriers, you've heard Kathleen and Steve and virtually everybody talk about the barriers in terms of human resources. Those really are the huge barriers for us. They're the barriers in terms of finding staff. At any given time I probably have thirty vacancies. My child psychiatry program is through the UC Davis Medical School. They have a free rein to recruit child psychiatrists all over the country at any time. Anybody they can get they can hire, and I'll pay for it with no limits.

SENATOR CHESBRO: I'm going to need to ask you to start winding it towards the end here.

MR. SULLIVAN: The other thing is culturally competent staff. They're trying to find those, train people, and to train people how to do integration with dual diagnosis. We have the ability to treat kids and pay for it out of EPSDT, but we don't have the trained staff to do it.

The whole issue of juvenile justice is difficult because there's no resources. A lot of the probation kids are not Medi-Cal. What we're really talking about is two separate systems here. We have a separate system for non-Medi-Cal uninsured kids – and adults, too, as far as that goes – who we can't pay for, who we have no money to serve, and unless they're really, really down and out and seriously disturbed, they're not going to touch our system. Whereas, Medi-Cal kids, we can hit them for almost anything, and we can serve them for almost anything as long as we have the staff to do that.

Okay, I think I'll close.

SENATOR CHESBRO: Thank you very much, Tom. It is good to hear, in this field that's so rife with gaps – and there's plenty still here, as there are most places – there's some real progress and innovation in trying to figure out how to make it all work.

Next we're going to hear from Sherri Rita, who's a staff attorney with Protection and Advocacy, Inc. As you begin to speak, I'm going to hand the gavel back to the chair.

MS. SHERRI RITA: Thank you, honorable chairs and members.

My name is Sherri Rita. I'm an attorney with Protection and Advocacy here in Sacramento. What I'm here to do is talk about how California can draw down additional federal dollars to provide services in the community to children with serious emotional disturbance.

This comes from a recommendation in the Little Hoover Commission report, which was that California seek a waiver that will permit children in the juvenile justice system to access Medi-Cal mental health services. While the suggestion is laudable, Protection and Advocacy and the Coalition of Californians for Olmstead would like to have California consider an alternate waiver, one that would capture children before they even ever enter into this institutional system.

What this would be would be a home and community-based waiver that would make Medi-Cal mental health services available to children that are otherwise not Medi-Cal eligible because their family incomes are higher than traditional Medicaid guidelines, and would also give California the opportunity to bring in services that are not offered under California's Medicaid plan; services that are geared toward keeping children in their communities, giving them the treatment that they need so that they no longer need treatment.

I'll cut to the chase and give you basically what our recommendation is, in the interest of time.

Given the success of our home and community-based waiver, which we have for people with developmental disabilities, it doesn't seem that it makes sense that we don't use this same type of waiver to provide services to children with serious emotional disturbance. Other states have experimented with this with great success, with great cost savings, and with a reduced rate of institutionalization, and also reduced numbers in the juvenile justice system, foster care systems, etc.

Basically what we're asking is that California consider passing legislation that calls upon the Department of Health Services and the Department of Mental Health to draft a waiver and, in

drafting this waiver, convene a stakeholders group that will consist of county mental health directors, children, parents, providers; all the players that know what children with serious emotional disturbance need in order to thrive in their communities, to define the target population and also define what services ought to be provided under this type of waiver.

Now I'd like to talk about some examples. There are three states that have such a waiver in place right now, the most recent of which is Kansas. It's also known to have the most comprehensive home and community-based program in place for youth with serious emotional disturbance.

Before I do that, I think I ought to provide some basic background into the waiver for people who maybe are not familiar with what this is all about.

The Social Security Act provides for states to apply for a waiver to waive certain traditional Medicaid requirements. One of them is the income eligibility requirement. We know that there are certain children that cannot access Medicaid services because their family incomes are higher than the guidelines. The tragic irony is that these children, once they're institutionalized for thirty days or more, are not considered part of their families for income purposes and thereby qualify for Medicaid. This waiver is meant to remedy that tragedy and capture children before they ever have to enter into an institutional system to qualify.

The other thing that the waiver does is it would allow a state to adopt additional services that are not provided under the state plan, and these services have to be those that would maintain a person in their communities and help them avoid institutionalization. Some of those types of services could include respite, case management, home and personal care, and habilitation. Those are services that are not found in our state plan right now.

In the case of the Kansas waiver, what happens is the traditional deeming rules – what I just described earlier is the parental deeming of income to the child. That's waived, so a child can qualify for Medicaid before they enter into an institution. Kansas' waiver also provides for additional services that include family training and support, wraparound facilitation, and community support, independent living skills, and respite care. These are services that people in the community – providers, parents, children, mental health people – identified as being critical to maintain kids in their communities.

To give you numbers, the average annual cost of serving a child under Kansas' waiver program is \$9,300, and that's a 2000 figure.

Kansas had a developmental disabilities waiver like California and was able to draw upon that experience in drafting that waiver in crafting the SED waiver. Kansas also apparently got a lot of cooperation and encouragement from the local and federal Medicaid offices who helped them in drafting their waiver application so that it could ultimately be approved. I'm told by somebody who was instrumental in crafting Kansas' waiver that the process was not unduly burdensome, the process being the process of defining the target population and deciding what types of services were needed. What was critical in this process of crafting the waiver was convening stakeholders; as I mentioned earlier, parents, children, providers, mental health directors, and other people who are knowledgeable about community services.

There were concerns about cost up front, but they were allayed because the home and community-based services waiver does contain automatic cost-control mechanisms. For instance, each individual waiver needs approval from the local Medicaid office, which means that there's a guarantee that the dollars that are being spent are actually traceable to an individual receiving services. So, it's not this uncontrolled entitlement.

The other thing that keeps things under control is the fact that waivers are meant to target a very specific population so a state can say, "We're going to be serving 'X' number of people under this waiver." Once they reach that cap, arguably, they're not obligated to provide services beyond that. You can also be limited by the amount of the appropriation for the waiver program. That's another way that things are controlled.

Also, in order for a state to receive approval for a waiver program, a state has to prove that the home and community-based care is going to cost less or equal to institutional care.

SENATOR CHESBRO: I know you still have a couple more states that you were going to cover.

MS. RITA: And very briefly.

SENATOR CHESBRO: We're starting to run behind here.

MS. RITA: I understand.

Really, it was Kansas that I was most interested in highlighting. I just wanted to mention that New York also has an SED waiver, and it also waives the income eligibility guidelines, the traditional ones. And then Vermont has had a waiver like this in place since 1982. So, this is not a new idea. It's proven effective. In Vermont we can see that, in order to serve children in the

community, they spend \$18,376 per child as opposed to \$46,306 for a child in an institution. So, there are substantial cost savings that can be realized by adopting this waiver.

Thank you.

SENATOR CHESBRO: Thank you very much for your presentation, and thanks to all the panelists.

I'm going to ask for a, hopefully, very abbreviated question and answer period here so we can try to get back on schedule. Are there questions that any of you wanted to ask?

Incidentally, the traveling gavel did come back to me because I'm doing the next panel. Even though I tried to give it away, it came back to me.

I have one very brief one, if none of the rest of you have any.

Senator Ortiz.

SENATOR ORTIZ: I understand, Ms. Rita, you were looking at a waiver for California as well, to work on a waiver proposal. We have some bill language. Is it the Kansas model that we're looking at? One of them. If you could provide us some direction and assistance on that, we'd greatly appreciate that.

MS. RITA: Absolutely.

SENATOR ORTIZ: Thank you.

SENATOR CHESBRO: I wanted to ask the Placer County representatives – one of our biggest barriers is just getting people to work together. I was in county government for a long time. I understand it at that level. I'm just learning at this level how difficult it is. What strategies did you employ to make this really happen in Placer County? How has that been successful?

MR. BUD BAUTISTA: I'll try and answer that. I'm Bud Bautista. I'm the director of Children's System of Care for Placer County and on the executive staff to the SMART Policy Council.

I think it's a question of leadership and, actually, willingness to pursue and succeed in a concept that is not an easy concept. The leadership actually occurred from Judge Richard Cousins back in 1988, so we've been working at this since 1988. His perspective, from the bench, was interesting in that he saw the conflict between mental health systems, probation, and social services. You alluded to the hot potato; the child/adolescent family that's a hot potato:

“They belong to you.” “No, they belong to you.” “No, they belong to you.” He witnessed that from the bench.

It was his leadership that essentially organized the effort to say, We will do this no longer. These children are our children and it is up to you, the departments, to figure out what the best strategy is to handle this case, and then you will come to my courthouse and have a single strategy that you all agree to. So, we really did try to pursue from there the integration of services.

I think the interface that was often alluded to, the problems with the interface, I just want to make a comment on. I took some notes. Every system, really, has a responsibility to promote or provide some level of mental health. Mental health is not a department; it’s not a funding source. It’s something that occurs in many, many different venues and places. As we look at our entire children and adolescent system from education on through, I think there are numerous opportunities to look at how do you promote the ability to support mental health services prevention, whatever you want to call it?

In the juvenile justice system, I just wanted to support that the Crime Prevention Act of 2000 was the very first funding in years – years and years – that came for services in that population, in that program. I think we need to support that on an ongoing basis and expand it if possible.

One more example: education. Education, huge budget, Title 1 funding. Very little of that funding is ever used for social work or the ability to provide personal or family counseling. They do provide academic guidance in many cases, but I think it really depends upon districts to take the next step and say we will be now responsible for providing more than just educational services but supports for our children and families. But that’s a district-by-district discussion.

Part of the organization of this whole initiative, if you want to call it a huge mental health initiative, is what is the responsibility of every part of that system to promote mental health services or the ability to support mental health with their children and families?

SENATOR CHESBRO: Thanks very much. Unless there’s any other questions from Members, I’ll dismiss this panel, and thank you for your contribution today toward our discussion.

I’ll ask the panelists for the “System Capacity/Bed Shortage: California Institute for Mental Health Report” panel to come forward.

I'll ask Patricia Ryan to begin. She is the executive director of the California Mental Health Directors Association.

Welcome.

MS. PATRICIA RYAN: Good afternoon, Madam Chair, and members. Excuse me. Mr. Chair and members.

SENATOR CHESBRO: How about we're all chairs?

MS. RYAN: I am Patricia Ryan, executive director of the California Mental Health Directors Association. I've been asked to talk specifically today about the crisis that county mental health departments are experiencing with the shortage of children's acute hospital beds.

Early in 2001, CMHDA identified an emerging and potentially serious problem of a shortage of acute psychiatric beds available in California. The problem appeared to be most acute for beds available for children and youth. We requested the California Institute for Mental Health to conduct an analysis of the problem and provide some initial recommendations and strategies to address the issues. CIMH then subcontracted with Peter Forster, M.D., of Gateway Psychiatric Systems to conduct a short survey and preliminary data review and provide CIMH with an analysis.

Gateway worked with a committee of CIMH and CMHDA representatives to provide a draft which was then completed by CIMH. The committee suggested that Gateway conduct phone interviews with key informants. Those key informants were both hospital staff and county mental health staff. Of the nineteen people interviewed for this report, all expressed concerns and a belief that there's a shortage of inpatient psychiatric beds in California. Most also felt that this shortage is reaching or has already reached a crisis situation for some parts of the state.

Let me just say, too, hopefully you all have this report, because it's much longer than what I'm summarizing for you here.

On a regional basis, what the report found was that in the Bay Area in Northern California, the inpatient bed shortage is greatest for children. To my knowledge, from the Bay Area north, there are currently only two hospitals in the Bay Area that provide inpatient psychiatric services for children and one hospital in Sacramento. That means that all other Northern California counties must compete with Bay Area and Sacramento health plans and counties to find beds for their kids. In many cases, those beds are full, and they end up searching

sometimes as far south as Los Angeles for an open bed. Even if a bed is available in the Bay Area or Sacramento, it's sometimes hundreds of miles away from the child's home or family.

In the Central Valley, the bed shortage is not as severe for adolescents as for children, but there are still shortages for both.

Some also said that the children being treated are increasingly difficult to manage, and in one instance, a county could not find a bed in all of California for a child because of the safety concerns of the hospitals.

In Southern California, adolescent bed shortages appear to be the most severe, followed by children's beds.

Over the past few days, I've asked several county mental health directors, primarily in Northern California, for some examples of what this difficulty means for them. I think I've given four case studies in the written testimony. I'll summarize one of them for you.

Wednesday evening our on-call staff is contacted regarding an adolescent who has made a suicide attempt and is medically cleared for a mental health assessment. A team reports "continued intent to self-harm." When attempting a 5150, no facility can be located in this state as far south as Stockton. The parents and family have no capacity to care for his safety and refuse to assume responsibility. All local foster-placing agencies will not assume care, even with the offer of a respite worker for 24-hour observation. The teen probably would not cooperate with an outpatient plan even if it could be implemented. The only alternative left is to house the teen in the local juvenile facility that has three locked cells. The parents, mental health, and chief probation officer concur with the plan in spite of the obvious regulatory and rights violations.

I've been with CMHDA for about eight months now, and I have heard story after story of this crisis. This is truly a major crisis in Northern California that they need help with.

The study also looked at what were the causes of the shortage. Issues identified included the fact that Medi-Cal consolidation in 1995 resulted in reimbursement rates for the fee-for-service hospitals that were significantly decreased. The resulting closure of some of the hospital beds was not unexpected, but now that California no longer has an excess capacity of inpatient beds, it's essential for us to switch from a strategy of careful price negotiation with the hospitals to one of collaboration. And that is happening. Probably not in all counties, but it is happening.

Also contributing to the problem is the issue of staffing shortages, which we already heard a lot about, particularly among nurses and child psychiatrists. Inpatient units as well as residential facilities are having difficulties in securing qualified staff. Again, this is particularly true for children's programs.

A third cause was that hospital beds are often filled with people not necessarily in need of acute mental health services, such as people with organic brain diseases, developmental disabilities, and dually diagnosed clients. I've heard, over the past couple of years, over and over again from both hospital and county staff, that this is a major problem, and that when these clients come to the hospital, it's almost impossible to discharge them because nobody will assume responsibility for them once they're in the hospital. So, they end up taking up beds for kids who are truly acute.

The report looked at alternatives to hospitalization and whether or not adequate resources were available. Almost all of the respondents felt that an increase in alternative programs would be a key step in addressing the inpatient psychiatric bed problem for both children and adults. Several studies have suggested, and counties already know, that there are models of care that are quite effective in working with the population of seriously disturbed children, such as the population of children who are being hospitalized.

Other testimony at this hearing obviously talked about some of those different programs. We know what works. We need to do more of that, and obviously, funding is not the only barrier to doing that.

Regardless of counties' efforts, the report also cites general failure by regulatory agencies at the state level to acknowledge the reality of treating California's most seriously disturbed children and youth – for example, those that have risk-taking behavior and acting out – even in the best managed facilities. This appears to have made it almost impossible to find providers who are willing to develop appropriate services. Many of these kids, as we've already heard, are ending up in juvenile justice facilities.

The report recommended some short-term strategies. I'm going to name a couple of them. One is to develop and strengthen partnerships and regional initiatives at multiple levels, to set up discussions with California hospitals through the California Healthcare Association in order to identify steps that could be taken immediately and, in the long run, in order to improve the availability of hospital beds. This recommendation is already in process. There's a work

task force that's been created and pulled together by the State Department of Mental Health. I think we have our fourth meeting coming up in the next month.

SENATOR CHESBRO: Unfortunately, I'm going to need to ask you to try to get to the conclusion here. Thank you.

MS. RYAN: I'll be real quick.

- Conduct a real-time inventory of beds to assess and monitor the acute bed numbers and demand.
- Conduct an assessment of the use of administrative day beds to determine the types of alternatives needed to resolve replacement needs. Again, we are working on some of these things with the task force. Long-term strategies include collaboration with DMH to identify regulatory and legal barriers to developing and implementing alternative programs.
- Create a legislative agenda for change.
- Open alternative placement programs.
- Strengthen the role of regional organizations of mental health plans in meeting the needs of acute psychiatric patients by developing special programs for community-based care.
- Identify ways to reduce the administrative costs of hospitals.
- Conduct more sustained analysis of existing data for better prediction of future needs in the system.

Just to summarize, obviously we have a big problem. I've been hearing about it for at least two or three years. We appreciate the efforts of the State Department of Mental Health and the Healthcare Association in coming together to try to address this. We welcome any ideas that any of you might have for helping us to address this problem. It's going to take a lot of work.

Thanks.

SENATOR CHESBRO: Thank you very much. A very serious problem that we are going to need to have a serious conversation about how to address.

Next I'm going to call on Karenlee Robinson, who is the chief operating officer for Sharp Mesa Vista Hospital in San Diego, representing the California Healthcare Association.

MS. KARENLEE ROBINSON: Good afternoon.

Thank you very much, chairs, and members of the committee, for allowing us this opportunity to present to you. My comments will echo some of Ms. Ryan's concerns, but I represent today over 150 providers of acute psychiatric hospital services in California.

A significant number of psychiatric hospitals have closed, downsized, or consolidated services in the last five years. Many hospitals have experienced great financial pressures due to reduced reimbursements from public and private payers, reduced work force, and increased regulatory pressure. The most significant closures have been in children's services. As Ms. Ryan states, there is a severe crisis not only in Northern California but also in Southern California. In San Diego, we have only three hospitals that are able to accept child and adolescent Medi-Cal patients.

Since the consolidation of inpatient services into mental health managed care in 1995, reimbursement rates for hospitals have significantly decreased. These reductions in acute day rates have been exacerbated by an increase in the number of inpatient beds filled by patients awaiting transfer to a long-term facility. For these waiting patients, hospitals receive an administrative day rate from Medi-Cal which equates to nearly half the reimbursement of an acute day rate. Our Medi-Cal acute rate is \$425 a day, which is below the minimum that we charge for commercial contracts. The administrative day rate, however, is \$289 per day.

The Department of Mental Health data shows that, over the last few years, there's been an increase of 150 percent in the use of administrative days at the lower rate. This data clearly shows an increased difficulty with patient placement after an acute hospital stay. The reality is, in San Diego, the Medi-Cal acute day rate of \$425 is already far below the standard contract rate. It is no longer tenable for hospitals to provide continued acute care to the same patient, in the same bed, at the administrative day rate of \$289.

Changes in the Medi-Cal and private managed care utilization review policies have moved hospitals into becoming acute crisis stabilization providers. Lengths of stay have been reduced to six to eight days at maximum, and many children and adults who require greater supervision and care must be transferred more quickly.

As a consequence, there's been a 26 percent increase in the last five years of individuals who have been readmitted to inpatient hospital services within thirty days of hospital discharge. In Los Angeles County alone, over 8 percent of the county's mental health clients were admitted more than three times in 1998.

In addition, DMH data shows that there's been an 18 percent overall increase in child and adolescent admission rates, with a 100 percent increase in long distance admissions for children to acute psychiatric care. More and more frequently there are times in San Diego County where there are no locked beds available, as Ms. Ryan also stated. This means that a family in crisis has to drive to Orange County or Los Angeles. One evening we had to direct a person to Santa Barbara.

The number of long-term-care beds and community-based services available for Medi-Cal mental health patients has not kept up with demand in the last five years. Medi-Cal patients are increasingly being kept in inpatient acute hospitals longer than is necessary because there are no long-term placements available for them.

Due to the change in the mental health managed care at the county level, patients are required to be removed from inpatient care much more quickly, but the placement options are not available to meet their needs. Thus, the hospital continues to provide the same level of care but is penalized by being paid the admin day rate of \$289, which doesn't come close to covering acute patient care costs.

Acute hospitals are being forced to accommodate these patients awaiting transfer, but we don't have extra beds available to handle an extended patient stay, and these stays can range up to two to three months while patients are awaiting placements. Hospitals end up turning away patients who are truly in need of acute care because the beds are filled, and sometimes for as long as three months. Many hospital systems are no longer choosing to take Medi-Cal patients or are closing their doors entirely to psychiatric care.

As has been mentioned, psychiatric hospitals are suffering greatly from California's workforce shortage. A significant number of hospitals have closed beds because they cannot find a child or adult psychiatrist to staff their units. RN shortages have become so desperate that hospitals in San Diego have joined together to fund professors at the university to train student RNs. The availability of healthcare professionals is even more significant in rural areas. At the Desert Regional Medical Center in Palm Springs, days before the Thanksgiving holiday last year, the Medical Center was preparing to close their entire psychiatric unit because there were no psychiatrists available to work the holiday week. The hospital ended up finding a psychiatrist at the last minute through Locum Tenums, a professional registry, and paid \$1,100 a day for the psychiatric services.

The shortage of child psychiatrists, as has been mentioned, is very significant. There are only 6 child psychiatrists for every 100,000 youth in this country. In California, the number of child psychiatrists is even less.

Hospitals are seeing children and adults in their emergency rooms with increased acuity, multiple diagnoses, and multiple psycho-social issues. It is common to treat adults with dual diagnosis, substance abuse, and mental illness.

The foster care children with their enormous needs has already been discussed. Sometimes children have as many as nine placements by the time they've reached the age of twelve.

So what can we do to resolve the acute mental health bed shortage? First, we must stop the bleeding. First and foremost, the state must work with hospitals and county mental health plans to retain the Medi-Cal mental health beds that are currently being utilized. There are many hospitals right on the brink of closing their psychiatric units or choosing no longer to contract with Medi-Cal. It is imperative that hospitals receive the support they need to stay afloat.

A number of options include:

Increase the rates for acute inpatient mental health services. Again, the issue is we're not only receiving lower acute day rates for psychiatric services, but we're receiving less days at the acute rate. Non-Medi-Cal acutely ill patients are being turned away because acute beds are filled with patients awaiting transfer.

We need to support legislation addressing the administrative day rate. The California Healthcare Association is sponsoring legislation to allow the administrative day rate to be set at the county level and to allow the rate to be paid more broadly where patients are awaiting transfer for all types of community-based services.

We need to reduce the claims denial and administrative challenges. Many hospitals choose to no longer contract with Medi-Cal because they no longer can afford to provide inpatient services and not get paid at all. Medi-Cal claim denials are rampant in many counties. DMH surveyed nine counties in 2001, and of those nine counties, the percentage of acute days disallowed was over 20 percent, and for admin days it was over 90 percent.

Patients are often denied eligibility for hospitalization for arbitrary or technical reasons. County mental health plans need to work with their local hospitals to correct these denials and

inconsistencies to ensure hospitals are able to provide the safety net services the counties themselves cannot provide.

We need to retain the second level appeal at the Department of Mental Health. The Department of Mental Health is proposing through regulation to eliminate the second level of appeal for Medi-Cal claims denials. Currently, claims for payment are first denied at the county, and a first level appeal is offered. In cases where the county upholds the denied claim, the provider has the ability to appeal the denial at the state level. In San Diego County, there have been numerous instances where having the state as a watchdog has been beneficial. If this second level of appeal is eliminated, there'll be no longer assurances that a hospital provider will receive payment for appropriately provided inpatient care.

SENATOR CHESBRO: I'm going to have to ask you to summarize the rest of your recommendations, please.

MS. ROBINSON: I'd like to just say that last year our hospital had \$172,000 of services denied that were overturned at the state level. DMH upheld our payment.

We need to support, as Ms. Ryan said, the bed shortage workgroup efforts. This is a group that is meeting currently and trying to come up with some basic solutions.

We need to implement the recommendations of mental health advocacy groups, such as the California Coalition of Mental Health and the California Mental Health Planning Council. One of their top priorities is to look at ways to increase supportive housing, crisis residential, and community residential care options for mental health clients.

We need to develop comprehensive systems of care. There still exists two systems of care. In the county systems, providers have a larger range of options of services to choose from, including day treatment and case management. Private providers are limited only to inpatient care and to a few outpatient visits per month.

We need to work collaboratively with hospitals to open new beds for children. The lack of children's acute beds must be addressed immediately.

We need to support efforts to increase residential treatment and housing options. Right now there's not a great deal of interest in pursuing the residential and supportive housing options for mentally ill, but there needs to be collaboration among residential providers and the state to identify incentives to develop these needed services.

We need to support Senate Bill 1227 and AB 1008. These will place housing bond measures on the ballot in November which will provide supportive housing for mentally ill in California. Without a continuum of affordable supportive housing options, no matter how good our services and our treatment are, if people don't have a decent place to live, treatment will fail.

In conclusion, the California Healthcare Association's psychiatric hospitals are committed and willing to provide quality acute psychiatric services for Medi-Cal mental health patients. We are unwilling, however, to continue with the challenges of denials of services for appropriately provided care, and we are unwilling to continue with the low reimbursement of the Medi-Cal program. While still supporting the advancement of community alternative programs, it's essential the state not lose sight of the critical need to continue its support of inpatient psychiatric services. California no longer has an excess capacity of inpatient psychiatric beds. It is imperative that the state and the counties switch to a strategy of collaboration and partnership and not be adversarial and exploit the hospitals' commitment to providing quality care to all persons in our communities.

Thank you very much for this opportunity.

SENATOR CHESBRO: Thank you very much, both of you, for your comments. Were there any questions from Senator Ortiz?

SENATOR ORTIZ: No questions.

SENATOR CHESBRO: You've lent us a fairly bone-chilling analysis here. We have the report. Clearly, this is an area that's going to need a great deal of our focus. Thank you very much.

For the next one, I really am going to hand the gavel back over to Senator Ortiz. She's going to take it this time.

SENATOR ORTIZ: Thank you. We were hoping to have three chairs sharing the gavel responsibilities, but Senator Figueroa is unavailable. I know Senator Chesbro has to leave at 4:30. Unfortunately, I had a meeting at 4:15 I will no longer be able to keep. So, I'm going to ask the remaining panelists to try to adhere to time a little more closely than when I was being the gavel holder at the time. I apologize for that.

Let me now welcome the last panel, and then there will be public comment after that. The last panel that is joining us this afternoon is "ADHD Overview." We have Dr. Howard Taras, which I know you were good enough to visit us from across the country, I understand.

Are you Mr. McCracken? Welcome, Mr. McCracken. Is Mr. Lew Mills here? I guess Mr. Mills will not be joining us today.

Welcome, and please try to, if you can, stay within that ten-minute time frame. Otherwise, I'll be actually using this gavel.

DR. HOWARD TARAS: I'll try to paraphrase rather than read.

Thank you for inviting me. I'm actually from San Diego. I just came from the East Coast because of a conference. I'm the chairman of the Committee on School Health for the American Academy, and I practice in San Diego.

Attention Deficit Disorder is the most common psychiatric diagnosis in childhood. As you know, it's characterized by the inability of a child to attend to a task and difficulty with inhibiting one's own behavior, which is impulsivity, and in some children there's hyperactivity.

Some people say that Attention Deficit Disorder is very much overdiagnosed; that it's an easy diagnosis to slap on a child who's not fitting into a classroom of thirty-four other children, and that the medications are used to kind of make the child quiet and mind-control them.

There's others, of course, who have said that Attention Deficit Disorder is actually underdiagnosed, especially when it's not accompanied by hyperactivity. And then even once it is diagnosed, we have so many parents that are afraid to start treatment, that it's undertreated.

So, which is it? Is Attention Deficit Disorder over- or underdiagnosed? Overmedicated or undermedicated? We believe that the answers are both true. This is happening both ways.

I think there's two ways to deal with this problem, and one way is to say we don't want to have children on so many drugs and let's stop medicating and that would solve the problem for those few children that really need another diagnosis and another management. But there are 3 to 5 percent of children who do have Attention Deficit Disorder, with or without hyperactivity, and we would be doing them a great disservice. They would have certain inability to control their actions, to control every impulse. They would be struggling against all odds, all day, and every day would be left with a sense of failure. It's no wonder that untreated kids with ADD, who do feel that sense of failure every day, that is out of their control, leads to increased substance abuse and leads to early pregnancy and leads to many other maladaptive behaviors.

The way that the American Academy of Pediatrics wants to deal with this is to actually assist in more accurately diagnosing this; have more physicians and psychologists who are using

diagnostic criteria that are appropriate and providing that education to them. Also, when it comes to the treatment choices, to using data that we know in order to define those.

I have copies, and I'll send them up later on, of the actual policy statements by the American Academy of Pediatrics. The first one is on diagnosing and the second one is on treating. These guidelines are not opinion pieces. They're the direct product of systematic review of evidence on ADHD, and for the word "evidence," I mean that they were studies, not just stories of one student or another to display a point, where the design doesn't allow for the experimenter's or researcher's bias to affect the outcome. Treatments where placebos or various different treatments were used. Very often, children's parents, teachers, others, don't know which treatment they're on until the study is over.

The guidelines also were not developed by pediatricians alone, but also by family doctors, psychiatrists, psychologists, developmental specialists, educators, and others that are really involved in this diagnosis.

If you were to look at the guidelines, you would see decision-making trees, sort of algorithms, that help a doctor decide whether someone really has this or not. I'll just highlight some of the things in there.

In a child 6 to 12 years old who presents with inattention, hyperactivity, and impulsivity, primary care clinicians should initiate the evaluation. That's the first diagnostic one. The second, and more important one, is that they use the DSM-IV criteria. DSM is the Diagnostic and Statistical Manual that psychiatrists use to really define what a disorder is. For example, for the attention component of ADD, there are nine sample behaviors, and someone should have six of those nine if they are really to be diagnosed as having the inattention component. Beyond that, they shouldn't just have those six of nine at any one point in time, but it must be consistent for at least six months, and it has to be to a degree that is maladaptive and to a degree that is inconsistent with the child's developmental age. It's much tighter now, what we're encouraging pediatricians to do, than it was ever really before the past couple of years.

The other elements of this diagnosis or treatment are looking for associated coexisting conditions such as learning disabilities, opposition disorders, etc.

The recommendations for treatment are also very important. First of all, we want pediatricians and others to look at this as a chronic condition; meaning, it requires repeated visits. We shouldn't expect the cure to come right at once in all kids, and that we may have to

modify the treatment. Secondly, it should be in collaboration with school personnel. It shouldn't be made just with a doctor's own history when they speak with the parent. School personnel are important. Target outcomes are another manifestation. We should look at what we want the child to be doing – paying attention more, being less impulsive – and basing the treatment on those targeted outcomes. Lastly, they're recommending a lot of system follow-up so that these kids are followed throughout.

I've read some of the things in the back that Senator Figueroa had, and I just want to add some comments to address some of the questions that she put in her document.

Some states have prohibited schools from requiring kids to be on medication. I have no problem with that. I don't think any school should require a child to be on medication. I don't think any doctor requires their patients to be on medication.

SENATOR ORTIZ: Let me ask a question. Is it the teacher that then recommends to a doctor that that child be medicated?

DR. TARAS: Very often it's one teacher that tells the parent, "I really think your child is hyperactive, and I really think he has Attention Deficit Disorder. I want you to go to your doctor and I want him to be put on a medication." You do have teachers saying that.

SENATOR ORTIZ: Is that appropriate though?

DR. TARAS: It's not appropriate, but I don't think legislation against that is maybe the best answer. I think what we have to do is get schools to have more than one teacher make the referral. It should be the student study team or the psych consultation team, whatever they call the multidisciplinary team at different schools.

SENATOR ORTIZ: Or maybe not make a recommendation. Teachers should not diagnose that they are ADHD or that they need medication. They're not qualified to do that.

DR. TARAS: Exactly. As a group, they should be describing the symptoms. Each of them will see different things. The school nurse, the counselor, the Special Ed teacher, and the teacher will see different components, and they should describe that and send it to the doctor.

SENATOR ORTIZ: Is it your opinion you're actually seeing a pattern of teachers across school districts – or how frequent or infrequent is this practice?

DR. TARAS: I'd say most frequently it is a teacher that sends the parent in rather than anything else. Most frequently there isn't a team approach to it at the school level initially when the doctor gets that. Yes, I think it's very common.

Now, it doesn't mean that 60 or 70 percent of the time the teacher isn't right. She or he may be very right. The point is it's still the wrong way to do it, and there's all those times when it should have been more of a team approach and more of a description of what's going on rather than a diagnosis.

SENATOR ORTIZ: But ultimately a doctor goes through the DSM-IV manual to determine whether six of those nine behaviors are present before they make a determination that indeed a child is ADD.

DR. TARAS: That's what should be happening. Had it been happening consistently as the way we would like, the AAP would never have had to put this document out last year. But it is going to be happening increasingly, and I think this document already has had an effect.

SENATOR ORTIZ: But I don't want to come away – or maybe I do want to know whether in fact we have teachers diagnosing a medical condition.

DR. TARAS: I don't believe that doctors listen to what the teachers are saying and for that reason are putting them on it. That's not happening.

SENATOR ORTIZ: But it may in fact cause the parents to say maybe we need to have the child ... (tape turned – portion of text missing)

DR. TARAS: ... Yes, it does put a little bit of a bug in the parent's head; no question.

SENATOR ORTIZ: I'm sorry, I interrupted. Please continue.

DR. TARAS: No, that's okay.

The other thing I think we should remember is, is Ritalin being abused? Are kids getting ahold of Ritalin when they shouldn't? I think that is happening. We do hear of cases where kids are snorting Ritalin, but I don't believe that it's incredibly prevalent in the systems that I have seen. But assume the worst; pretend it was very prevalent. I don't think there'd be any reason to limit our prescriptions that are appropriate for Ritalin when we need to prescribe that.

I think I'm up with my ten minutes. I'll wait for more questions later on.

SENATOR ORTIZ: Thank you for sticking to the ten minutes. I know that I will have questions.

I believe we've been joined by Mr. Mills. Is that correct? Thank you for joining us.

Mr. McCracken is our next speaker. Welcome.

DR. JAMES McCracken: Thank you, Madam Chair, and members of the committee. It's a privilege to join you today to speak to you on this important topic.

I'm a child psychiatrist and professor of Psychiatry at the UCLA Neuropsychiatric Institute, where I direct the Division of Child and Adolescent Psychiatry.

I've organized my remarks today – and will keep to less than the ten minutes – around the five key questions which were posed to me. By way of introduction, though, I'd highly recommend several publicly available documents on the subject of ADHD; the references for which I'll provide in my written testimony. These documents include the NIH "Consensus Statement" on ADHD; the report on ADHD of the Scientific Affairs Council of the American Medical Association; the "Practice Parameters" of the American Academy of Child and Adolescent Psychiatry; and the "Practice Guidelines" of the American Academy of Pediatrics.

The first question is: What is the current research on the diagnosis and treatment of ADHD?

To summarize this field, the diagnosis of ADHD can be made reliably and consistently, using well-researched interview and observational instruments. There is not magic to approaching the assessment of a child with suspected ADHD. However, as is the case for all other psychiatric disorders, at the present time there is no laboratory tests to confirm the diagnosis; so what is required is, in fact, a very extensive history-taking evaluation and collaboration, as has been mentioned, with other observers, professionals, parents, and teachers.

One limitation of some of the diagnostic research on ADHD is that it has largely been focused on the assessment of school-age children with the disorder rather than younger children – perhaps preschoolers – or adolescents and even adults. This is an area in which we have to admit that some of our diagnostic guidelines need possible modification.

In the future, additional approaches to diagnosis may be available. Currently, although brain imaging studies examining differences in the structure and function of the brain in individuals with ADHD represent an area of active research--and, indeed, brain differences can be demonstrated in individuals with ADHD versus nonaffected individuals--currently there is no role for the use of imaging tests in diagnosis.

Major reviews and consensus documents developed by professionals and researchers both in and outside of the field of ADHD research have come to the same solid conclusion; namely, that ADHD is one of the best validated mental disorders in medicine. This includes the reviews and consensus documents that I've referenced earlier.

There is little evidence to suggest that ADHD is the product of toxic or unreasonable influences of modern society. In part, the validity and reliability of the diagnosis is reflected in major community surveys of U.S. communities, Puerto Rico, Germany, England, Canada, New Zealand, Hong Kong, and Finland; all of which show that ADHD is found in many cultures, locales, and situations.

Although the usual prevalence rate observed is between 3 to 5 percent of normal community samples, some differences have been noted that importantly suggest cultural and societal influences on the reporting of and defining of boundaries of illness. Understanding what role cultural influences may have on family members and others reporting symptoms, and seeking treatment, is important and deserves further study. This may be a key in better understanding some of the data, which I'll describe in just a moment, suggesting that many individuals with ADHD go without treatment.

Lastly in this area, it's important to stress that there are many tools available to assist clinicians in the accurate diagnosis of ADHD and office practice, but, actually, it's unknown how commonly employed these tools are in usual care. There's reason to suspect that due to time and reimbursement limitations, they are, unfortunately, not commonly adopted.

The second question is: Are Schedule 2 medications – narcotics or psychostimulants – appropriate treatments for ADHD?

Here, the benefits of psychostimulant medications for the short-term treatment of the core symptoms of ADHD are undisputed. Literally, hundreds of studies observing thousands of children with well-diagnosed ADHD show striking benefits of treatment and excellent safety. Besides dramatic improvement versus controlled treatments – such as placebo – more recent, major comparative studies – such as the MTA study – show that the stimulants are clearly more powerful treatments as compared to even intensive home and school behavioral treatments administered at least over a fourteen-month period.

That being said, however, it is very clear – and consensus documents agree – that added benefits for ADHD are found when medication treatment are combined with other modalities of treatment; that is to say, behavioral and educational approaches. These combined treatments yield greater parent satisfaction, increased academic achievement, and even overall response rates are increased.

It is important to note, however, that psychostimulants are not a cure for ADHD and that not all children with ADHD show improvement or can tolerate the medication. Average rates of good response to these medications range from 55 to 70 percent of school-age children, leaving significant numbers of affected individuals in need of other approaches. The search for alternatives to the stimulants is a major area of current research, and promising treatments are fortunately on the horizon. It will be important in the future to ensure access to, and dissemination of, new information on these new treatments as they emerge.

Psychostimulant prescribing has shown rapid increases during the past decade. There's good data to support that from a variety of perspectives. This raises an important question: Are stimulants being overprescribed?

Here, the data are contradictory, suggesting large variation in practice patterns by region, discipline, and practitioner. However, taking the broadest view, estimated rates of the numbers of children receiving psychostimulant medications has increased to a level close to that of the estimated prevalence of the disorder. Therefore, comparing the rate of prescription against the estimated rate of the disorder would leave one to believe that there is not a significant problem or cause for alarm.

SENATOR ORTIZ: If I might interrupt you on that point, just so I understand this. I think your estimates were 3 to 5 percent – I don't know if that's all persons or all children.

DR. McCRACKEN: All children in normal school populations.

SENATOR ORTIZ: Are diagnosed with ADHD?

DR. McCRACKEN: In surveys received, the diagnosis of ADHD according to strict diagnostic criteria; the DSM-IV criteria that Dr. Taras mentioned.

SENATOR ORTIZ: Of those 3 to 5 percent, does the data show that that's roughly 3 to 5 percent are being medicated? Are we to imply that 100 percent of children who are diagnosed according to the guidelines are that 100 percent are appropriate for medication? Do all ADHD children have to be medicated? I guess is my question.

DR. McCRACKEN: Well, certainly the answer to the latter question is "no." All ADHD children do not necessarily need medication.

In terms of the former question – Are the right children receiving treatment? – I have to say that different studies come to different conclusions. Here, again, there may be prominent regional differences. For example, in one major study of four U.S. communities – Atlanta, New

Haven, San Juan Puerto Rico, and Baltimore – only 13 percent of children diagnosed with strict criteria for ADHD had a history of receiving treatment. That suggests high rates, of course, of undertreatment.

Conversely, there is one study, and it's probably singular in its finding, that in an area of rural western North Carolina, over 70 percent of children diagnosed with ADHD had received stimulants.

So, you can see, without having data more broadly, that there is wide variation. I think what is important to stress, about some of the work that we do have available on ADHD individuals, is that there is the suggestion that many children are going untreated. Again, in the four-community U.S. study, the observation was that the majority of ADHD children were not receiving treatment at all. Interestingly, in that study more children were receiving nonmedical treatment rather than psychostimulants; but again, only about a third of all children diagnosed were receiving treatment, which is consistent with overall institute medicine estimates for the number of children who do not receive treatment for serious emotional disorder.

That being said, I have to also mention that from the North Carolina study, there is a suggestion that some children who do not meet strict criteria are receiving prescriptions for psychostimulants. Here, the situation seems to be that many of these children have symptoms of ADHD but fall short of the diagnosis. In some cases these children may have problems that are often related to ADHD, such as oppositional behavior, aggressiveness, and in some instances psychostimulants may benefit those symptoms. However, it has to be said that that practice is outside of published and recommended guidelines and needs to be looked into further.

Overall, I think in terms of this area, to summarize the current questions, and concerns have to do with whether primary care practitioners have the necessary training and time available to accurately diagnose, to take the time to develop a comprehensive assessment, and to administer treatments for complicated problems like ADHD. Educational efforts directed to primary care should be supported, and future research should help enhance the effectiveness of nonmedical treatments.

The next question had to do with: If ADHD is left untreated, what are the adverse consequences that can result for the teen or child or in adulthood?

Here, the data is very clear: The existence of ADHD is a risk factor for many adverse consequences. These range from increased injury rates in childhood, to increased traffic

accidents, increased traffic violations in young adulthood, reduced school achievement, high rates of school failure, early initiation of smoking, lower vocational attainment, higher rates of delinquency and criminal behavior, and higher rates of substance abuse. Indeed, serious public health consequences.

Other adversities relating to ADHD include high rates of depression in parents of children with ADHD and family strain, both economic and emotional. There are data to demonstrate, fortunately, that successful treatment can reduce many of these negative outcomes. If you're interested, I can cite specific studies, but in particular there is one study that provides data suggesting that psychostimulant treatment actually reduces risk for adolescent drug abuse, contrary to lay and public concern.

So, from a public health view, ADHD is a serious disorder with numerous adverse consequences to individuals and society. The cost to society is difficult to estimate but is considerable. Facilitating access to treatment, reducing barriers, and ensuring the provision of high quality intervention for ADHD should be a public health priority.

The next to last question is: Are appropriate healthcare personnel providing medications for ADHD?

Despite some perceptions to the contrary, the vast majority of medical treatment provided to children with ADHD is from primary care practitioners, not specialists. Although surveys vary in these estimates, it's observed that between 66 to 85 percent of medication for ADHD treatment is provided by family physicians, pediatricians, or internists.

SENATOR ORTIZ: Let me interrupt you there, if I may. I think that's really important. It's unfortunate that Senators Figueroa and Haynes aren't here. I know it was an issue that they had been tackling under the jurisdiction of Senator Figueroa's committee and was of particular interest to both Senator Haynes as well as Senator Figueroa. So, I would ask if there's a way, certainly, to have the studies, the scientific evidence, at least forwarded to my office so I can provide the studies and maybe highlights, and maybe some questions will be answered or maybe new questions will be raised. But I do appreciate that because if I, in fact, were convinced that we have teachers diagnosing and treating children with ADHD and medication, then I would be incredibly alarmed and I would ask why isn't the pediatric and neuroscientific as well as psychiatric community really stepping in? So, I appreciate you calming some of our concerns, but I'm going to ask you to put the studies together in a very

organized fashion so that we can forward that to those Members who did have those questions. I know Senator Figueroa's staff is here, so I'm sure he will be the good staff and share that with the Senator as well.

Please continue.

DR. McCRACKEN: There are clear advantages of having primary care physicians providing medical treatment for ADHD. These advantages include easier access, lower out-of-pocket expenses to families, and the advantage of the long-term relationship that the provider has with the child and family.

However, it has to be said that there are definite concerns right now about current practice patterns suggesting some disadvantages for the bulk of ADHD treatment coming from nonspecialists. For example, in the recently completed MTA study of treatment of ADHD, treatment provided by community practitioners was only half as effective as response to medication-treatment-only administered in the research setting, even though the prime treatment was the same; namely, psychostimulants. How could this be? The prevailing view, or explanation, of this difference between community care as usual versus research treatment focuses again on limited time and limited interaction provided by community practitioners.

As an example here, the research treatment involved monthly visits with extensive communication with the child's school in order to monitor treatment and optimize dosage and response. In the usual care group – community care – typically, children were only seen two to three times per year and school interaction was very rare. Therefore, there are serious concerns about what limits practitioners in the community are trying to deal with, created by time and reimbursement limits, and, conversely, reduced access to specialists needs to be examined, as you've heard many times earlier this afternoon.

The final question is: Is there any other aspect of current research on ADHD that you wish to call to the attention of the California State Senate?

Here, the Senate should be aware that ADHD is a major focus of research at many of the state, public, and private research institutions funded by a variety of sources, including federal and private sponsors. Overall, this is a very exciting time for research in this area. Significant progress is being made, understanding the role of genetics in the causation of ADHD and related problems. It is very clear now that genes play at least some role in creating risk for ADHD. A promise of genetic research is the possible development of new treatments which could spring

from a better appreciation of the actual causes of the disorder. Likewise, genetic research may help develop greatly improved possible diagnostic approaches.

Many new treatments are being tested, both improvements on older available treatments and new and novel interventions both medical and nonmedical. Progress here is slow but steady. As examples, at UCLA, current studies include improved treatments for teaching social skills to children with ADHD, testing parent management and parent behavioral approaches for younger children with ADHD, testing the safety of medication for younger children with ADHD, brain imaging studies to clarify the nature of cognitive differences in ADHD; again, studies of genetics of ADHD; studies of learning problems which so often co-occur with ADHD; and studies and surveys on the use of medication for ADHD and related conditions in foster care and other disadvantaged populations.

In the future, consideration should be given for support to assess the adequacy of current ADHD treatment in the public sector, as well as considering mounting demonstration models on approaches to install integrated and empirically supported ADHD treatment guidelines, such as those as have been cited by Dr. Taras and myself, in existing treatment systems. The state of Texas has gone far in this area and could serve as a possible model for what could be considered in California.

SENATOR ORTIZ: Dr. McCracken, could I ask you to please try to conclude your testimony? I've actually given you twice the amount of time, but if you could go through your final points very quickly, I'd appreciate that.

DR. McCRACKEN: Finally, given solid evidence on available treatments and promising new advances on the horizon, there actually is cause for much optimism and better futures for the citizens of California affected with ADHD.

So, thank you, Senator, and the committee.

SENATOR ORTIZ: I do appreciate your thorough presentation. Unfortunately, this part of the presentation is the part that I think many Members had questions about, so I apologize that I'm the only remaining Member. I know Senator Chesbro had to go to a Budget Committee meeting. Unfortunately, those Members who requested this coverage aren't here, but we're videotaping this. Again, your testimony and material is critical, so thank you.

Our last speaker on this panel is Mr. Mills. Welcome. We've had a ten-minute time request and admonition, and I'd ask you to do that because I do know we have a couple of people who want to come forward under public comment.

Welcome.

DR. LEW MILLS: Good afternoon, Madam Chair, and committee members.

I wanted to start with a personal story. When I was in first grade, six years old, my teacher talked to my parents – I wasn't aware of this – and suggested that I be evaluated for ADHD at the Oregon Health Sciences, which was the big research center in Portland at the time. This teacher was more up to date than most. She later ended up becoming a psychologist. But she made this recommendation to my mother, and my mother decided instead to go to the pediatrician that I had been seeing as I was growing up. The pediatrician was not well-educated about ADHD and told my mother that I seemed smart, I didn't seem to be having trouble in school. It lay there for about thirty-five years. I was diagnosed just more recently.

My point for bringing up that story is that I think that most parents, when they're confronted with the possibility that they have a child with ADHD, are reluctant to even accept the diagnosis, much less consider a medication and consider treatment and so on. My concern is that we not create any new barriers to families receiving an accurate science-based diagnosis and treatment.

So, in that context, I'm here today representing CHADD of Northern California and the CHADD national organization. I want to read, just quickly, CHADD's position on ADHD for a minute here. It shouldn't take too long.

As the treatment of ADHD (Attention Deficit/Hyperactivity Disorder) continues to raise discussion across the country, several state legislatures have begun considering legislation designed to restrict the role that physicians and teachers can play in advising families about the use of medication for the treatment of ADHD.

CHADD believes that all families should have access to the best evidence-based science in the diagnosis and treatment of ADHD. We are therefore concerned when legislation is proposed which undermines this critical access. Again, if you think of the anxiety that a parent is going through when they are confronted with the possibility of this diagnosis, it's important to not increase barriers.

Likewise, CHADD is appalled when children are inappropriately prescribed medication that they don't need and is of particular concern when a small subset of children suffer significant side effects from medication. I wanted to underline that the concern is when legislation is proposed which undermines the access to that kind of evaluation.

The Surgeon General of the United States and the National Institute of Mental Health, as well as leading medical societies such as the American Academy of Pediatrics, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, recognize that medication under the prescription of a treating medical professional and when taken as prescribed – along with other nonmedication interventions – provides an effective foundation for the treatment of ADHD. This is called multimodal treatment.

Multimodal treatment is a long-term management plan that combines medication with a variety of other treatment interventions designed to produce the best results. Such interventions include individualized education plans, special education resources when needed, behavior therapy, family training, and counseling. CHADD endorses this multimodal approach in the treatment of ADHD.

CHADD has a specific position on legislative efforts designed to restrict physicians' roles. CHADD believes that legislation must not limit or undermine the ability of a medical professional within the scope of their practice from treating ADHD based on the most widely accepted evidence-based medicine. CHADD encourages all families and physicians to follow best practice assessment and treatment guidelines being uniformly implemented throughout the nation; specifically, the current AAP and AACAP guidelines. Using the force of law and agencies of government, particularly criminal penalties, to monitor and enforce best practice treatment guidelines is an ineffective approach at best and a disastrous approach at worst. Instead, ongoing training and education in the diagnosis and treatment of ADHD should be encouraged among all physicians.

On teacher involvement in recognizing ADHD, the above principles also apply to teachers, given the critical role that they play in assisting children and their families when ADHD is suspected. Teachers are frequently the first to recognize learning, functioning, and behavioral problems in the school setting and therefore should be able to advise parents of such observations. CHADD believes that professionals should act within their professional scope of practice; thus, school personnel should not recommend the use of medication. Medication

assessment and prescription is the role of a physician. However, a teacher should be able to recommend a comprehensive and complete medical assessment by persons licensed to perform such evaluations. Because students spend a significant portion of their day in the classroom, the vital role the teachers play in providing observations to the diagnosing professionals cannot be underestimated. Effective communication among teachers, professionals, and parents is essential and strongly encouraged.

Thank you.

SENATOR ORTIZ: Thank you so much. I think it's really important what your organization's recommendations were. One, that teachers ought not to be precluded or prevented by law from advising parents that their child might have ADHD or that they may want to see a physician or other appropriate medical personnel to determine whether their child in fact has that disorder. But they ought not to be the persons who determine or diagnose a child with the disorder, nor should they be the persons who recommend medication.

I appreciate that because I think there's a lot of debate as to what role teachers should or are playing. Again, I apologize that we don't have Members here to share that, but they'll get that information.

I want to give Senator Figueroa's staff – which we don't normally do – as well as Senator Chesbro's staff an opportunity to ask questions at this time. I want to hold off my questions and give them an opportunity, since their senator is not here, to raise some issues that maybe the panelists can address.

Mr. Gage?

MR. BILL GAGE: Dr. Taras, the one thing you touched upon is the application or the use of these guidelines. I didn't hear from you, though, how consistently these guidelines are being used by the various practitioners, not just pediatricians.

DR. TARAS: I believe that the idea that we have to use DSM-IV criteria to diagnose ADHD is not only in these pediatric guidelines but that family medicine and others, very often behavioral pediatricians and psychologists who don't treat but often diagnose, I believe that increasingly they are using it. If you want to know what percentage each one of those groups is doing it, I don't know if anyone has done a study on that. My guess would be that up to 30 percent of the time they're not using that. It doesn't mean that 30 percent of the time the diagnosis wasn't correct anyhow, because they may have not gone through the six of the nine,

for example, criteria, but they were right anyhow in that they had it. That would be my guesstimate.

MR. GAGE: I heard, at least for some practitioners, there is some variation and some serious inconsistencies in the use of and at least applying these guidelines for purposes of a diagnosis. I'm just wondering, what can we do about that?

DR. TARAS: These guidelines are very new. They came out a few months ago for treatment and just about a year ago for diagnosis. If you look at residency programs and what they're teaching about attention deficit now versus five years ago, versus thirty-five years ago, it's totally different. The idea that you stick to some guidelines like this is far more prevalent than it used to be. So, I think that the education that the professional associations – the American Academy of Pediatrics, the American Academy of Family Physicians, etc. – are doing is having a good effect. I believe it is.

I do feel that very few doctors are putting a child on medication only because a teacher told the parent that that's what they need. I don't believe that has ever really happened that much. I think they may have done it more because they didn't have good criteria in front of them to use and all they needed was a tool. But using a medication because a teacher told them, I think that's a concern but it's unfounded.

MR. GAGE: Well, the one concern we had, Senator, when we were talking about at least what's happening in the schools and teachers' involvement with discussing this with parents, was we have fewer school nurses. We were concerned about what's going on in schools in terms of actually providing these medications on an ongoing basis.

SENATOR ORTIZ: Let me make sure I understand. You're saying that the schools are actually medicating children without a diagnosis?

DR. TARAS: No, no.

SENATOR ORTIZ: You're not. I think I'm hearing Mr. Gage say that.

DR. TARAS: No, I think what he's saying is that there's medication being given in schools or there's referrals from doctors being given in schools where there's no school nurse, and without a school nurse, you're having less of a good history come to the doctor. Is that what you're saying?

MR. GAGE: That's what we're concerned about.

SENATOR ORTIZ: But how are schools giving medication?

DR. TARAS: They're giving the medication; they're not prescribing it.

SENATOR ORTIZ: Why are they giving medication to a child who has not been diagnosed?

DR. TARAS: They're only—

SENATOR ORTIZ: Only those children who have been diagnosed that then have the parent's consent and request for the school to administer it.

DR. TARAS: Right.

SENATOR ORTIZ: Those are the only times that schools are involved in the medication.

DR. TARAS: Right. But I think the question here is: Is the diagnosis based on a really good history from the school? The diagnosis is not a blood test or a CT scan. The diagnosis is history taking, asking really good questions about the child's behavior. You ask that question of the parent, of course, who's sitting in your office, but you also ask that question of the school. If the only person in the school who's giving those answers is the teacher, and there's not a school nurse in the school giving it or a counselor or a resource specialist or Special Ed teacher also observing the child and giving the doctor that information, the doctor may not get as accurate information as they could get. I think that is a concern. The more professionals you can have look at this child in the school the better the doctor is going to be able to use those guidelines.

SENATOR ORTIZ: And when we have a \$12 billion excess or reserve rather than a deficit, there's a lot of things I'd love to see put in place in schools and medical settings. I don't think that we're going to achieve that in this next year when these issues are probably going to come to this committee.

Other questions, Mr. Gage?

MR. GAGE: One other question for Dr. McCracken. There's some concern about the increased prescribing of psychiatric drugs to preschoolers. Are there any current studies that are being done dealing with that in terms of the effects and outcomes for preschoolers?

DR. McCracken: Yes, indeed. The National Institute of Mental Health, in part due to the observations of increasing community prescriptions of psychostimulants and other psychotropics in the preschool population, has launched a major multisite national study which aims to actually look at two treatments for preschoolers with ADHD – both parent management

and parent behavioral therapy – as well as psychostimulants in this age group, with a very big emphasis on assessing safety in that age range.

It is a gap in our knowledge base, but we should have results of that study relatively soon.

MR. GAGE: Thank you.

SENATOR ORTIZ: Questions from Senator Chesbro’s staff?

Let me make sure I understand. There’s a study underway that is being conducted in preschools across the country?

DR. McCracken: There are five sites around the country. At UCLA, we’re participating as well. Other sites include Columbia University, New York University, Johns Hopkins University, Duke University, and University of California, Irvine. We are identifying preschoolers with very severe ADHD that is seen across, at least, the home and school setting and usually in almost all settings or domains of the child’s life. The very first step in this study, besides the careful assessment and evaluation, is parent management; an intensive ten-week course of training these parents in other approaches of positive discipline and behavior management principles. Only for those children who continue to have difficulty following behavior training do we consider introducing medication.

SENATOR ORTIZ: Is it only those children that are in a preschool setting that are a part of the study, or is it preschool age?

DR. McCracken: It’s a good question. As a part of an effort to carefully assess the different effects of these medications and treatments in preschoolers, we are requiring that they be in a day care or preschool setting for at least two days a week in order to be able to have those observations from day care and teachers as well as parents and direct observation.

SENATOR ORTIZ: Are you also looking at Head Start programs? Since we have so few preschools, and it may be skewed socioeconomically in the children that are being observed, are you looking at Head Start programs as well, which are preschool programs?

DR. McCracken: In Los Angeles and at the UC Irvine site, we have made outreach to local Head Start programs and made them aware of the study, as well as made them aware of other programs and services.

It is an interesting observation of some other surveys that rates of psychostimulant and medication treatment for youth do vary significantly by race with rates of psychotropics seen three times greater in Caucasians versus African Americans; at least from one study examining a

Maryland Medicaid database. So, that does suggest possible differences in access to care, differences in diagnostic practice, cultural influences on seeking treatment – complicated factors – but it certainly raised the issue of whether or not we’re making these effective treatments available enough.

SENATOR ORTIZ: I know that our public comment witnesses have been waiting patiently, and I’ve probably spent more time than I should on probing some of these questions, but I really look forward to reading some of the studies you’ve cited because I think we’re just probably beginning to gather the science on this issue. Certainly there is a lot of controversy, but I welcome the data, and maybe we can revisit it in another setting; certainly if, indeed, there are measures that are moving forward through this committee that would attempt to tie the hands of teachers playing a role and at least alerting parents that will come to this committee. So, we may have you come back and testify at a later time.

Thank you, all, for your testimony. I do appreciate it. I think it’s shed much light on this issue.

I want to welcome the public comments. I have two speakers listed under “Public Comment.” I understand we have Ms. Conni Barker as well as Mr. David Quackenbush. Welcome, and thank you for being with us throughout this long afternoon.

MS. CONNI BARKER: Thank you, Senator Ortiz.

Conni Barker. I’m testifying as much as an individual today as I am on behalf of the Psychiatric Association. I think the placement may be pretty good because I’m going to talk about the parent’s viewpoint of what happens in a family’s life when a child is not diagnosed.

The reason I’m doing this is I think what we went through is very common of what families go through. We have some friends who have a daughter about the same age as ours who was just diagnosed with Obsessive Compulsive Disorder, and what they went through with her in high school was almost identical. As a young career woman, she was in such distress they got her to a doctor and finally got OCD diagnosed in her mid-20s, and she’s now in treatment. This happens to a lot of people.

What we find in the system today, I think, is the people that get treatment, as you heard today, are people in the public system or wealthy people. Insured middle-class people don’t get it because the system doesn’t work. It’s not a system. It’s how can you push to get coverage? Or do you give up and write checks? That’s what I’m going to talk about.

Ours is actually a thirteen-year journey from the first symptom to the actual diagnosis. I laughed at the time when my daughter's first grade report card came home and said, "Wiggles a lot and can't sit still in class." I laughed because I thought, *That's my kid*. Same problems as I had as a little kid, so that did not surprise me. However, as things progressed, we found many, many more symptoms, and because she's a girl, I think she was not diagnosed. Girls are almost always missed because they simply don't disturb anything. They're just stressed-out kids who don't perform to their ability. So, there's a gender gap here of a significant proportion.

The key things I've learned is, first of all, ADHD takes the order out of the life of the child and the parents. It stresses the family terribly, as Rebecca's mother could probably tell you, because when you have a child with an undiagnosed mental illness, they simply don't respond to parenting the way other children do. The parents get confused; you start trying different techniques; your parenting gets inconsistent. You're stressed out and it causes real marital stress and stress on the other kids.

Also, ADHD is often comorbid with another mental illness, and I'll talk about that as well. And then there's the genetic factor. It's higher in families with a history of mood disorders. We had depression on my side and bipolar disorder on my husband's side, so it should not be a surprise.

It was also described to me by a wise person: Living with ADHD is kind of like trying to put together a jigsaw puzzle when all the pieces are facedown. Can you imagine how difficult that is for the person who has the disease? It just has to be terrible.

Now let me tell you what we went through. There was the teacher's comment in first grade. Then we're going fine until fourth grade when she started struggling in math. Then in sixth grade, she was getting a bad grade in history. We went to see the teacher, and the teacher said, "She's not doing the homework," and we said, "Yes, she is. She's doing it at the kitchen table." And she said, "I'm not getting it." I had just learned about this disorder, and another mom had shared with me that's how they spotted it in their son. So, that was our first clue.

Then we went on to seventh and eighth grade, and her school performance and behavior started deteriorating. So, we saw a marriage and family therapist and got very little help there. We started getting concerned about whether she had learning disabilities, so we asked the school to do an evaluation for learning disabilities. We were told by the school they didn't have the resources; we needed to try something else. We contacted our insurance carrier and managed to

get an evaluation that way. They found no learning disabilities, but the psychologist did start some counseling, suspected depression, and suggested we get a psychiatric referral to determine if she needed medication.

The defiance continued escalating, and eventually we got one hour for the psychiatrist who didn't find any mental disorders. That was in December of her freshman year in high school. We took a long-planned trip to Europe. We have some relatives in Europe. We went on that and she was getting really horrible in a long exposure.

We got back and about a month later she ended up in the hospital and was diagnosed with Post-Traumatic Stress Disorder, which had come from an incident when she was three-and-a-half, as a toddler, when a creep tried to molest her. We had gotten it treated at the time. The psychiatrist had said she could have a relapse, and she had a relapse. That was treated with psychotherapy. She stabilized, but we were having truancy problems so she went to a continuation high school for a few months and then went to a small private Christian school where she absolutely thrived. We didn't know yet that she had ADHD, but inattention subtype kids like a small environment, lots of personal attention, and a place where they can't get into trouble. She ended up with straight A's. She went back to public school, did really well for the first semester of her senior year, and then started goofing off, but most seniors do.

She got into college and got into real trouble there. She had to take make-up math and flunked it. She took it in summer school and got a D. Because she had so much trouble in college, we decided we're going to try for learning disabilities again or if there's anything else going on. By this time I was working for the Psychiatric Association, so I called up a psychiatrist I trust – who's a constituent of yours – and he told me what to do. We went to an educational psychologist and got a full work-up. Again, he found no learning disabilities and thought that perhaps there was a slight possibility of ADD. But because of the family history, we also went to see a psychiatrist that Dr. Meek recommended. He, for the first time, had my daughter fill out all the forms. I don't think anyone else had ever had her do a lot of the work. She came up with a perfect ten for Attention Deficit Disorder. She went on medication. Wellbutrin didn't work. She couldn't tolerate it. She had side effects, so she went on Effexor and has been on it for two years. She went back to college, aced the dummy math, but then she got overconfident and started goofing off again, because immaturity is also a problem here.

They don't catch up on their maturation when they're undiagnosed. So, she did get in trouble in college a second time, but she went to work, and she's now doing well in the work environment.

It has worked but it has been a terribly difficult journey for our family. I think we're past the tremendous difficulties now, but I think you will find that for family after family after family. We finally got a diagnosis when we decided we'll write checks and figure out if we can get reimbursed later.

SENATOR ORTIZ: Thank you so much for that. It's a story that doesn't get told. You're a resourceful parent, you know the system, and you had challenges moving through the system. Your testimony is the story of, again, a parent who can find ways to at least try to identify a problem, if not the problem. As long as your journey wasn't as difficult as it was and has been and could be, there are families who are probably not even going to begin to get to a place where they have some understanding about their children.

MS. BARKER: No. I do have a few thoughts. One of them, obviously, in this budget year, if all schools could have the resources to do the screening of the kids, it would be helpful. For teachers to learn a little bit more about the girl kind of ADD would be very helpful: the girls who are having trouble in math, starting in, like, fourth grade, because that's a classic symptom; the girls who are not handing in their homework, finding out from the parents if they're doing it. Those kinds of things. If teachers could be alert to that, we might get more referrals, and the girls might be caught earlier. Fortunately, my daughter did not get in the juvenile justice system and did not get pregnant or anything. Thank heaven, but it could happen.

SENATOR ORTIZ: But statistically, that's where most young—

MS. BARKER: Yes. There was a brief substance abuse problem which, after, we got the PTSD treated and it went away. That was, fortunately, very brief.

And the third thing is true insurance parity; not just seriously emotionally disturbed children.

SENATOR ORTIZ: Thank you for those recommendations.

Mr. Quackenbush.

MR. DAVID QUACKENBUSH: David Quackenbush, California Hispanic Healthcare Association.

I wasn't going to touch on ADD/ADHD whatsoever, but with the testimony of the prior witness and also the experts, it's absolutely appalling and pretty ridiculous that someone that has

resources and knows the system has had such trouble getting the appropriate care for a child. From our association's perspective, I would just like to throw on the table, imagine a child that is new to the country or doesn't speak English dealing with the diagnosis such as this.

SENATOR ORTIZ: That one parent who doesn't have health care.

I want to correct you because there, in fact, is that middle – underneath the middle class who have coverage of the uninsured who are working. They're not poor enough to get Medi-Cal. We're talking about 6.8 million people in California who don't have anywhere to go.

MR. QUACKENBUSH: Later in my comments I was going to add: but even the Medi-Cal population. Marriage family therapists and licensed clinical social workers are not reimbursable under the state Medi-Cal plan. They're reimbursed on a county-by-county basis. They're not in the state Medi-Cal plan. That's one of the areas I want to touch on.

But first, thank you for having the hearing, and thank you for being here. I appreciate your commitment to these issues. I'll be very brief. We submitted written testimony that you can refer to later and also others can refer to later who received copies.

We're all well aware of the very large ethnic group population in the state of California. Within this population is a large immigrant population and large pockets of populations in rural healthcare areas. One thing I really wanted to point out was there's 11 million Latinos in the state of California. Eight-and-a-half million of those Latinos are from Mexico. When I was doing research for this, it was very interesting to learn that – and I'll read it – “First generation immigrants have the same rate of psychiatric disorders as residents of Mexico City.” And this is the interesting part: “It is believed that Mexican culture, traditions, and family life protected the first generation, but acculturation into the United States deprived their children of that same protection.”

So, the immigrants that first came were better prepared to deal with the situation, but their children aren't. These are the same children that are the immigrants that are in school, that are the immigrants in rural areas, that aren't receiving appropriate mental health care.

One thing I wanted to make sure that the committee really had a good idea of what I was trying to point out was there's a serious imbalance of prevention and severe mental illness funding and focus within the policy arena, within the professional arena, throughout mental health care. There's various attempts and lots of funding that go into severe mental health,

which is not to say it's not important. We strongly believe that if there's more preventive efforts, there would be less severely mentally ill.

Which brings me back to my original comment earlier, which was MFTs and LCSWs aren't reimbursed under Medi-Cal. If they are reimbursed under Medi-Cal, you automatically – I actually have the numbers that I got from the Board of Behavioral Services. There's 25,000 MFTs and there's 14,000 LCSWs. Obviously, as you go up, I guess, the food chain of mental health practitioners, there's less psychologists and there's less psychiatrists, due to the education and due to the other elements that go into pursuing that profession. LCSWs and MFTs are preventive mental health providers. They're not in the Medi-Cal state plan, and they're also, through the Healthy Families program, are going to start entering into the system.

There's two problems with that: improper reimbursement, and there's also with them and also throughout the system a lack of cultural linguistic competent providers. Where else in health care is language proficiency and cultural understanding more important than in mental healthcare services? Mental healthcare services are dependent on dialogue. If you don't have the ability to dialogue with the patient, the patient's not going to get the appropriate care.

One other quick point is youth violence tends to be treated from a crime prevention perspective and rarely from a mental health perspective. If a lot of these children receive preventive mental health services early on, there would be less violence.

With that, there's three specific recommendations. Assemblywoman Helen Thomson has Assembly Bill 1423 currently in this committee – it will appear before your committee – that will allow for reimbursement of MFTs and LCSWs in the Medi-Cal state plan. It's a very simple idea. There are costs involved, but anything that has benefits, there's going to be costs involved.

Two other quick ones. There's a current task force that Assemblyman Firebaugh created by authoring Assembly Bill 2394, that we sponsored, that has created a task force to address cultural linguistic competency standards and a continuing medical education program that goes with that. Unfortunately, all mental health providers aren't involved in that; aren't going to be talked about through that task force work. That task force or a similar task force should be created to address the issue of cultural linguistic competencies within the mental healthcare services.

The third recommendation is every county is required to create cultural competency plans. Some of these are in depth, some of these aren't too in depth, and typically the issues

around it revolve around the resources available. This is one that would probably cost a significant amount of money but it's important. The counties need to create realistic and tangible plans that can be operationalized in their services; not just left on a shelf, which they tend to be now.

One other thing that I wanted to point out is Assemblywoman Aroner has had a series of hearings on the shortages of social workers, and her committee's work might also help this committee's work.

So, just to conclude briefly is there's a serious lack of cultural linguistic competent mental health providers. Assembly Bill 1423 will directly address the issue. It's really important, and I know Senator Ortiz constantly strives for this, to keep the dialogue comprehensive. If you're going to talk about mental health, you have to talk about prevention. It's very important to concentrate on the entire system.

I appreciate the hearing, and I appreciate the opportunity.

SENATOR ORTIZ: Thank you for your testimony. If you didn't get a chance to look at the Hoover Commission's report, the very discussion about pipeline development of professionals and paraprofessionals going into the field of children's mental health is one of the recommendations. I've said in the past, whether it's nursing in underserved areas, whether it's this whole system of delivery, these are twenty-year blueprints. The disparities in our mental health system based on ethnicity and immigrantcy and poverty are really compelling because we'll be upside down. If we achieve the development of people going into the field, we compensate them appropriately, we avoid burnout, we train them appropriately, then it's going to be a workforce that looks like California. But if we fail to do so with the cultural linguistic demands and needs of our state, we will have failed everybody.

So, thank you for reminding us once again.

I do know that, apparently, there's others under "Public Comment" that have joined us. I would welcome you to quickly come forward and provide concise testimony and add more to this body of knowledge. It's been a long day, and you're going to be the conclusion of this hearing.

Welcome. Do we have four speakers? Three minutes each, if you would, please. I've actually missed two meetings, and I've got a 5:30 that's a half hour drive.

MR. FRANK COONEY: Thank you for your attention in this. My name is Frank Cooney. I'm the executive director of California Citizens for Health Freedom.

I have a long history with Attention Deficit Disorder, being a dropout of high school and struggling for many, many years and then struggling through college at a third grade spelling level, and not having my hidden motor coordination problem identified until I was fifty years old.

I was very active in the California Neurological Handicap Association, which was the precursor to Attention Deficit Disorder. The studies they did in there showed that a majority of these kids going into juvenile hall is done here in Sacramento.

I had hidden motor coordination problems in that area and a son who had motor coordination problems, but he's going through college now. So, I've struggled with this, but I was very active in the Schizophrenic Association. I chaired the Butte County Advisory Committee on Special Education for many years.

I also was the director of a residential treatment center for severely emotionally disturbed children for fifteen years. My home was licensed for having severely emotionally disturbed schizophrenic, homicidal, and severe Attention Deficit Disorder children, but we work with orthomolecular alternative approaches. I want to say that this is something that's being ignored in this area. The alternative approaches to the treatment of children with mental illness, Attention Deficit Disorder, is very successful and should be considered.

The gentleman that was sitting here talked about the Hispanic population. We know that the Hispanic population, about 80 percent of those are allergic to milk. Milk allergies can manifest themselves in mental illnesses, as other allergies can.

But the difficulty we have is those physicians who work on the allergies looking at them – and now I'm referring to the environmental physicians – we had five of them in San Francisco six years ago. The last one is now losing his license because they practice “unconventional” medicine. That needs to be changed. We need to get licensed clinically trained naturopathic physicians who work in the holistic area. We need to have more emphasis on dieticians who really look at the relationship between nutrition and the functioning of children. We need to do the hair analysis and blood analysis. The biochemistry of the brain is an important factor in these children, and it's not being looked at to say what are the biochemical imbalances that exist in there and what nutritional approaches can be used to satisfy them?

It's the most inexpensive system that's been done and showed to be extremely effective. On many of them, you don't have to have the drug approach to go into that whole process. It can be resolved with the Feingold diet. I don't know whether you're familiar with that diet or not, but the Feingold diet, developed by Dr. Feingold in Oakland, is very successful in working with thousands of parents, with no cost essentially. She says there are many children who are allergic to cyclamates, which is in oranges and in some natural foods and into the dyes, and parents who received the information who have their child on a specialized diet for that, their Attention Deficit Disorder, the emotional problems they have, are reduced significantly. And it costs nothing. It costs the state nothing.

What we really need to do is hopefully invent a web site which will show what the parents can choose and look at and move along, because they are the first provider, they are the first therapist for the child, and they need to know what the alternative approaches are.

SENATOR ORTIZ: Mr. Cooney, is there a way that you can forward to the committee staff your list of recommendations?

MR. COONEY: Sure.

SENATOR ORTIZ: I'll make sure that we get this to Members to look at the alternatives.

MR. COONEY: You know, one of them is work on the licensing so that physicians can practice alternative medicine in all areas. This is one specifically. Work on the license of the naturopathic physicians and help the advancement of the nutritionists to advance within California so they can become part of the team to really work in this area.

I have one more comment to make, if I may.

SENATOR ORTIZ: You know what? I have three other speakers. I've asked for three minutes; you're at five, so I really need to get you to wrap up.

MR. COONEY: One real quick one.

SENATOR ORTIZ: Okay.

MR. COONEY: The warning of parents on the dangers of the medication, and I will cite one. The FDA requires the labeling of Ritalin. There's a carcinogenic in it, and there's a 35 percent increase of cancer in children, and it's not in it. A violation of Proposition 65 in California. That's well-documented and well-researched. There's all kinds of dangers when we get into this, and this is one specifically that I would ask you to look at.

Thank you.

SENATOR ORTIZ: I do know that the informed consent is a part of that prescription process, and if you're suggesting that there's something that isn't in the existing informed consent, then we can certainly have that researched and shared.

Thank you.

The other gentleman—? Welcome.

MR. BRIAN BRACKNEY: My name is Brian Brackney.

I got a lot of heavy doses of Ritalin. Under California law back in the early '60s – if I understand correctly – they could keep you out of the public schools for any reason up to the age of eight. That was when the compulsory education began, so I wound up, off and on, going to a couple of private schools. I went to an open classroom school in my junior high years, and then I went through hell in the public high school system and go into a lot of conflicts and so on there.

Ritalin – I'll put it this way: It caused me to get kicked out of a high school chemistry class. The upshot of it was in junior college I had to do makeup lab science, and a lot of that meant meeting the lab science requirements. So, Ritalin was bad for me, and I think a lot of the situation was the school system was regimented. I was cursing at my school counselor. I was in a small classroom situation in high school, but I think a lot of it was simply the institution. A lot of the comments were my own personal interests. I mean, I get distracted. I'm about six months behind on a research project I started last summer because of distractions, but I'm not worried. Because I'm on SSI, I can do my own projects. Sometimes my obsessive-compulsive things mean I get one month or two sidetracked onto another project and I don't get back to it.

But there has to be a situation where workplaces and schools are made to fit people who cannot fit in otherwise. I've seen mental health records. I have some report cards going back to the fifth grade, or actually forever, in my scrapbook at home I picked up way back in the mid-'80s. I finally took my scrapbook which contains things like every other kid's scrapbook: letters from camp, report cards, programs and so on, that my parents kept and later gave over to me.

SENATOR ORTIZ: So, Ritalin did not work.

MR. BRACKNEY: It not only didn't work, it made matters worse. It made me nervous. I'd take it in the morning. I'd feel suddenly not able to stand in place, feeling very uncomfortable. I had a second period high school chemistry class when I was on it and got booted out of it. I wound up taking chemistry. Under the ADA, they probably now could waive

lab science requirements or at least require the labs be accommodating; that you not do the work but somebody else did. It was a kind of de facto thing when I was able to do the math.

But having trouble concentrating was a problem. I have obsessive interests and sometimes I get from one thing to another.

SENATOR ORTIZ: Thank you. We're at four minutes and I appreciate that.

Our next speaker?

MS. CATHLEEN HOLLISTER: My name is Cathy Hollister, and I'm a parent of a child who has Tourette's syndrome and ADHD. He also has a few other issues. He started showing signs in kindergarten. We noticed him ticking, and then the ADHD symptoms really started showing: hyperactivity, impulsivity, and distractibility.

I was really lucky because I have friends who are in the medical profession. I had friends who had children who had Tourette's syndrome and who had ADHD. I also took it upon myself to become very educated about the two disorders and the comorbid disorders that go along with them.

My son went to a pediatrician, and the pediatrician immediately referred him out to a pediatric neurologist, which is very typical for Tourette's syndrome and also ADHD. Pediatric neurologists also treat ADHD. So, my son got a diagnosis right away. It's pretty typical for Tourette's syndrome people to go through about seven different doctors before they actually get a diagnosis.

My son is on medication. His name is Clint; he's in the fifth grade. Medication is only part of the approach for him. He also receives counseling. He goes to social skills classes. My husband and I go to counseling also so that we know how to parent as a team and find out what will work for him. But medication is an important part. If he didn't take medication, he would not be able to be in a classroom because he would be too distracted, he would be very impulsive, and he would "tic" all the time. It would be very difficult for him.

He's a great kid, and he wants to belong. He wants to be with the other kids, and medication has enabled him to be closer to that. He also has an IEP, which is a very important part of his multimodal approach.

Other parents don't have the same resources that I do. They may not be as motivated as I am. They may not have friends who are in the profession that can help them. Teachers really are the first line, quite often, in seeing this. I have a lot of friends who are teachers. My sister is

a teacher. I've always been told the opposite from what I've heard here. They tell me that they cannot tell a parent their child has ADHD. They cannot recommend medication. They've been told by their districts that they cannot do that. So many teachers feel that their hands are tied, and I say, "Well, I can talk to them. I'm a parent. Parent-to-parent. We can do those things." So, it's very counter to what's been talked about. I'm also very involved in the school. It's just not presented.

SENATOR ORTIZ: I appreciate your testimony. I think there are strongly held beliefs on both sides of the debate. I happen to believe that, in fact, we don't have teachers diagnosing, nor should they. I would be incredibly upset if that were the case. But I think the question is: Should teachers be able to at least recommend to parents or advise parents that they think it might be that and they ought to seek professional help?

MS. HOLLISTER: Absolutely, because they're on the first line. They see these behaviors. You know, school is just not about reading, writing, and arithmetic. It's also about social skills. It's about appropriate behavior. It's about managing oneself in the world. Teachers see that and they need to be able to deal with the whole child.

SENATOR ORTIZ: Okay. Thank you. Are you here locally in the schools?

MS. HOLLISTER: Yes.

SENATOR ORTIZ: I would love to find out how you're doing and in which school district, if you feel comfortable sharing with me.

MS. HOLLISTER: I would love to.

SENATOR ORTIZ: You may be within my district or outside, but I think it's valuable testimony and we need to have you come back at another time.

Thank you.

Our final speaker. Thank you, all, for being so patient.

MS. GEORGIA JENKINS: My name is Georgia Jenkins, and I'm here on behalf of my daughter who can't be here because, unlike Rebecca Hawkins' story of success, my daughter was not one of those.

She was found hanging—

SENATOR ORTIZ: Oh my god. I'm sorry.

MS. JENKINS: —in an acute care facility that she had been to twice. She had been in the system for a total of, possibly, six weeks, but we found out when she was sixteen and a half

that at eight years old she had heard voices. Well, actually, just one voice, but she really didn't understand it, and they were bad voices. I guess we were told one in every 100 people hear voices, so this is a very common situation. The psychiatrist that we took her to, which was private, told us that she was not mentally ill, that this was a chemical imbalance and that she could help her. She started her on Effexor. She went to school. She was a 3.75 student, straight A's; very active in the community; cheered. She was in a Bipolar/Schizoaffective Disorder working diagnosis.

We had her in an acute care facility in a 5150 situation because she went into what was like an epileptic seizure. We didn't know what was going on. We took her to emergency, and because she couldn't contract her safety, because she didn't know what had happened, they 5150'd her.

We were faced to go to this acute care facility, which you had made comment to, Senator, that it sounded like a prison.

SENATOR ORTIZ: Oh no, that wasn't me.

MS. JENKINS: I'm sorry.

SENATOR ORTIZ: That was Senator Figueroa.

MS. JENKINS: I'm sorry, Senator. You're right. That listening to Rebecca, that through this she was getting the feeling that it was an environment of being like a prison. Unfortunately, in my daughter's situation, it wasn't prison enough. They still continue to have fatalities there, which I don't understand, that people don't know about. I am trying to go through this system, and I'm doing the best I can with the system and really would like some attention given to why are these places not being looked at and scrutinized more closely. There are tons of red flags walking through this place. You are made to feel, as a parent, to question these things. I had in her record that "the mother hovered." Or that I was "too demanding of knowing, 'What are you doing? What is her prognosis? What are we going to do about this?'" Because she had heard the voices and they continued, we took her back a second time. We had a private psychiatrist, but she could not go to the facility.

SENATOR ORTIZ: She wasn't allowed privileges?

MS. JENKINS: She wasn't allowed privileges to go to the facility. I have great insurance. I paid through the nose to take her wherever I had to. I had a doctor that told me, "Well, if you have \$20,000 a month, you can take her to a private clinic." Again, I'm very

blessed, too, that I have the resources I do. I work for a lobbyist, so I'm in the environment. I had a lot of feelers out there, and I was hands-on the entire six weeks with my daughter.

If it failed for me, I just really have to take a look and say my god, the poor grandmother out there raising their grandchild or the person that doesn't have these resources.

SENATOR ORTIZ: Single parents.

MS. JENKINS: It's huge here, and to be able to have the opportunity to come, hopefully open your hearts and minds to think about what can we do, I'm open to help in whatever way I can.

Unfortunately, like I said, my daughter was not the success story.

SENATOR ORTIZ: I'm so sorry.

MS. JENKINS: But if I don't come here today and tell you that, then no one ever knows that these things have to be changed. And that's what I have to do at this point is hope that I can make a difference through this loss and be here and available.

SENATOR ORTIZ: I thank you, and I know how difficult it is for every one of the parents and every one of the persons directly affected. Your story is an incredibly sad closing to this hearing but thank you for this. You've extended that offer to help, so watch out.

MS. JENKINS: Absolutely.

SENATOR ORTIZ: We're going to take you up on it.

MS. JENKINS: Thank you.

SENATOR ORTIZ: I do appreciate everybody's time and patience sitting through a lot of very technical but, I think, very important, often controversial presentation and information. So thank you, all, for being a part of it.

This meeting is adjourned.

##