MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND EDUCATION

Seventy-fifth Session
March 28, 2009

The Senate Committee on Health and Education was called to order by Chair Valerie Wiener at 9:08 a.m. on Saturday, March 28, 2009, in Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was videoconferenced to Room 2149 in the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Valerie Wiener, Chair
Senator Joyce Woodhouse, Vice Chair
Senator Steven A. Horsford
Senator Shirley A. Breeden
Senator Maurice E. Washington
Senator Barbara K. Cegavske
Senator Dennis Nolan

STAFF MEMBERS PRESENT:

Marsheilah D. Lyons, Committee Policy Analyst
Mindy Martini, Committee Policy Analyst
Sara Partida, Committee Counsel
Betty Ihfe, Committee Secretary

OTHERS PRESENT:

Donna Coleman
Norton A. Roitman, M.D., FAPA, Clinical Professor, University of Nevada School of Medicine, Las Vegas
Tom Waite, President and Chief Executive Officer, Boys Town Nevada
P. Kevin Schiller, L.S.W., Director, Department of Social Services, Washoe County
Thomas D. Morton, Director, Clark County Department of Family Services
Romaine E. Gilliland, Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services

Michael J. Willden, Director, Department of Health and Human Services
Gard Jamison, Chair, Children's Advocacy Alliance; Chair, Children's Advocacy Center
Julianna I. Ormsby, MSW, Nevada Women's Lobby
Tracey Woods, Nevada Youth Care Providers

CHAIR WIENER:
After we hear Senate Bill (S.B.) 293, we will consider four related bills on the placement of children in the foster-care system. Those bills are S.B. 341, S.B. 342, S.B. 343 and S.B. 344.

I open the hearing on S.B. 293.

SENATE BILL 293: Requires a court order for certain prescriptions of medication for children in the custody of certain agencies. (BDR 38-701)

SENATOR BARBARA K. CEGAVSKE (Clark County Senatorial District No. 8):
After conversations with numerous people, we have incorporated their concerns into S.B. 293. Unfortunately, foster children especially see so many different doctors that no one knows exactly how many prescription drugs they have. What we are intending to accomplish with this bill is to make sure that everyone involved with their care understands how the different medications work or do not work together.

I present my prepared testimony for the record (Exhibit C). According to the Child Welfare League of America, children in foster care are at a higher risk for physical- and mental-health issues, stemming either from the maltreatment that led to their placement, or from preexisting health conditions and long-term service needs. Thoroughly screening children involved with the child-welfare and foster-care systems to identify their mental-health needs, and providing appropriate treatment is essential. There is a growing concern about the use of psychotropic medications with children, partly because very few of these medications have been approved by the U. S. Food and Drug Administration for treating mental-health disorders in children. This measure seeks to greatly improve the monitoring of this practice in Nevada.

DONNA COLEMAN:
I am testifying as an advocate for children, and I have some prepared remarks (Exhibit D). I ask you to vote for S.B. 293 with the changes we will be outlining

in the proposed revised bill (Exhibit E). As Legislators, you hear issues and consider bills because the status quo is not working. For 20 years, I have been advocating for abused and neglected children in Nevada, and I have been hearing about overmedicating foster children for as long as I have been an advocate.

I have been told the number one problem lawyers deal with at the Clark County Legal Services is overmedication. You will hear from critics that this bill does not belong in the courtroom. Ideally, it does not. One thing that everyone I have spoken to about this agrees it is a huge problem. However, for years we have let the caseworkers manage this problem; we have allowed doctors to keep prescribing; we have allowed foster parents to administer this medication without understanding the consequences. I say we must step in now and be the guardians of these children. It is not working the other way.

The best situation might be to have the caseworkers trained, and possibly have a doctor on staff, to oversee every child's medication, but until funds become available to do this, we cannot sit back and do nothing. The revision of this bill suggests beginning with a small group of children less than five years of age and with any child taking more than five psychotropic medications. We can visit this issue again in two years, but in the meantime these children need more oversight than they are presently getting.

NORTON A. ROITMAN, M.D., FAPA (Clinical Professor, University of Nevada School of Medicine, Las Vegas):
I have over 30 years of practical experience treating people of all ages in a variety of psychiatric settings and forensic venues. I am an in-depth psychotherapist and a psychopharmacologist. In my prepared remarks today, my intent is to impress you with the need, even urgency, for the passage of S.B. 293 (Exhibit F).

As a practitioner, medical director and health-care administrator, I have come to the conclusion that child psychotropic prescribing is moving in the wrong direction. Too many prescriptions are being written for our foster children. The drugs are being used to control them rather than to treat illness. There is too little time to assess them, and there are not enough therapeutic services to meet their needs. Psychiatrists are being asked to prescribe miracles.

According to public-record response from the Division of Health Care Financing and Policy dated January 14, 2009, about one-quarter of foster children—1,596 of 7,074—in State custody are medicated, and half of them—735—are on more than one drug (Exhibit G). There are 84 children under age 5 receiving 221 medications for a variety of psychiatric diagnoses—an average of more than two and a half medications per child. There are 4,458 Clark County Medicaid children receiving psychotropics. These statistics are similar to findings in more than five other states. Each of these states has enacted legislation to deal with the issue of increasing amounts and frequencies of diagnoses, medications and polypharmacy—multiple medications per child.

The clinical "state-of-the-art" regulation comes from the American Academy of Child and Adolescent Psychiatry (Academy). The Academy "supports judicious use of combined medications, keeping such use to clearly justifiable circumstances. Medication management requires the informed consent of the parents or legal guardians and must address benefits versus risks, side effects and the potential for drug interactions."

The draft revision of S.B. 293 reverts to the standard procedure of using the legal guardian as regulator just like any other practice of medicine. In addition, with minimal cost, the draft revision provides an alternative pathway for informed consent through the court. No one who is legally responsible for the child is present in the courtroom to consider the best interests of the child. Without informed consent, the doctor is exposed to malpractice, and the case manager is absent for the most important decisions of the child's life. Prescribing has become way too casual, and it is time to correct this trend.

DR. ROITMAN:
This legislation is aimed to deal with the increasing medication problem by directing a small number of outlying cases to the court for the informed-consent procedure if the legal guardian does not give consent. Children less than six years of age and any foster child who is being prescribed six or more psychotropic medications must be reviewed by a guardian before a prescription can be filled. The foster-care provider must discuss the prescription with the case manager who can call the doctor to talk it over. The guardian needs to take parental—not medical—responsibility to act on behalf of the child—to act as though the child is their own.

For these outlying cases, if informed consent by the guardian is not granted, the legislation directs the court to act in lieu, or to appoint the child's attorney to step in for the court or guardian. Someone other than the foster caregiver and doctor needs to look at these treatment plans. This is not medical oversight. It is just the same procedure required by every hospital before any procedure. Outpatient practices require this before there is any intervention that put the health and safety of the patient at risk.

This proposal bill is an all-win situation. Informed consent is the tried and true method to assure there is a dialogue between doctor and patient about their treatment. There is no justification to bypass this for our foster kids. They need careful attention more than any other group. They are our children. They depend on us. This legislation is an extremely modest step to institute an additional pathway for approval without disturbing the traditional roles of doctor, patient and parent.

CHAIR WIENER:
In the original S.B. 293, it mentioned the prescribing of four psychotropic drugs. We have an amendment that addresses more than five, and in your testimony, you have referred to six. Have you had the opportunity to review the amendment proposed by Donna Coleman?

MS. COLEMAN:
What Dr. Roitman meant is that you would have to go for the sixth drug. It would be up to five drugs.

CHAIR WIENER:
Would the drafting language read "more than five?"

SENATOR CEGAVSKE:
Just to clarify, this amendment was worked out with both Ms. Coleman and Dr. Roitman. Everything he referred to in his notes, Exhibit E and Exhibit F, referred to the amendment. These foster children are pulled and tugged in so many different directions. I do hope we can resolve this, so we can help these children.

SENATOR HORSFORD:
This is an important issue. During the interim study on the Placement of Children in Foster Care, we heard directly from the Nevada Youth Care Providers

about the over-prescription of medication during placement. Why did you select "five" as the number of prescriptions?

DR. ROITMAN:
We consulted with the court. We realized it is important not to put additional burden on the courts. We thought that number would be subject to review and would be manageable under the current budget. The number cannot be too few, because the doctor needs the latitude to individualize the treatment plan and make changes. The idea of six medications was to minimize the burden and to introduce the principle that there is "a limit." Treatments like these need to be justified.

SENATOR HORSFORD:
Can you give us examples of some types of psychotropic medications?

DR. ROITMAN:
A well-known drug is Ritalin, one of the stimulants. A member of another class would be Zoloft, an antidepressant. For antipsychotics, there are Abilify, Risperdal and Seroquel. There are agents for mood control like Depakote or Tegretol which are anticonvulsant medications. There are agents that are used out of class like antihypertensives for attention deficit disorder. Antihistamines are used for behavior control as well, Exhibit G.

SENATOR HORSFORD:
Through their intake-assessment process, children have their past medical history taken. When there are identified medical reasons for the prescriptions, would that fall within this bill? Would it make a difference if they are ultimately placed or could be placed in foster care?

DR. ROITMAN:
In saying medical reasons, do you mean nonpsychiatric reasons?

SENATOR HORSFORD:
Let me review the process. Children come into the welfare system, and they go through an assessment. As part of that risk assessment, the caseworker looks at their past medical history. If they determine there is a medical reason for the child to receive medication, would the provisions of this bill, as amended, affect them receiving the medication, or would they have to go through this process going forward?

DR. ROITMAN:
At the point of assessment, if a child is on six psychotropic medications, there would need to be an informed consent.

SENATOR HORSFORD:
Would that be regardless of whether or not there is a prior medical history that states the child has a medical condition that warrants the medication?

DR. ROITMAN:
That is correct. It is a time to take a look. Traditionally, every transfer to a new facility or a new provider involves a new assessment. This happens because the doctor would want to conduct his or her own treatment plan. If I am going to assume a practice with children on six psychotropic medications and maintain a level of medication or be able to reduce them, I need informed consent.

SENATOR HORSFORD:
In the proposed revised bill on page 1, line 5 of Exhibit E, I do need to understand what "... approval of a LEGAL GUARDIAN, OR IN LIEU, A court of competent jurisdiction ... " means. Because of the stages of the system, who is deemed to be the legal guardian at any particular time? That may be questionable at a certain time when a child needs treatment.

TOM WAITE (President and Chief Executive Officer, Boys Town Nevada):
In 2008 at our emergency shelter and assessment center, we had about 400 kids come through that program. Oftentimes, they were not coming through for the first time. They were passing from one disruptive foster home or where there was a placement issue to another, so they would reside with us temporarily. The medication issue is frequently a problem. On occasion, kids would come in with a plastic bag of medications mixed together with no written prescriptions accompanying them. Before their admission to us, we have to get clarification from their caseworker, their legal guardian or whoever could verify the medications. Even if we know what the prescriptions are, we cannot go by the child saying, "I take the green one in the morning and the pink one in the afternoon. "

There is some inherent problem with a lot of mixed medications. Additionally, there could be medication conflicts as the kids move through different programs and different medications are added and taken away. Either Dr. Roitman, who

works with Boys Town Nevada, or the medical doctor who works with us, identify medication conflicts for us. We do not know about these conflicts until the medical doctor makes it clear to us. Rather than decreasing the child's behavior problems, often the medications contribute to the behavior problems.

Many times the system creates a reliance on medication giving the message that nothing can help the behavior other than the medication. Obviously, this is a false message. We want children to know they can actually get better without developing a dependency upon medications.

We have to focus on the problem, and plan for how we are going to manage and control this issue. There are proven cognitive behavioral and clinical methods that work to help kids deal with behavior problems rather than medicating them to control their behavior. The solution has got to be managed well; it has got to be managed smart, and it has got to be in collaboration with intelligent people who have the right intent for the kids who are in their care. These children really do not have a family. They depend on us to be that for them.

MS. COLEMAN:
What kind of message are we sending to these kids when we medicate them so they can modify their feelings? Later on, if they get on drugs, we wonder how that happened.

CHAIR WIENER:
That is an important question to ponder.

P. KEVIN SCHILLER, L.S.W. (Director, Department of Social Services, Washoe County):
Washoe County clearly recognizes the need for a bill that is going to control the problem of multiple medications for foster children. Creating a practical check and balance system for kids in care would be an important piece of legislation. As a case manager, this does become a difficult issue. I have conferred with our court in Washoe County, and I am willing to work with others on this bill and any proposed amendments to make it workable.

In regard to Senator Horsford's question about consent, here is what happens in our agency. Typically, when a child comes into custody, we get an order for

emergency medical treatment at the protective-custody point. That point would be the hearing after removal. When the child needs surgery or any kind of medical procedure, we seek parental consent. If we are unable to get parental consent, we go to court and ask for an order to give us the authority to move forward with the medical care.

SENATOR HORSFORD:
When a child is first removed from the home and placed in custody, through the assessment process if it is determined from the child's past medical history, or if it is based on current circumstances, that the medications are warranted, how would S.B. 293 and the proposed amendments affect your ability to care for the child in your custody? Does this mean until they are ultimately placed, or is this once they are placed in foster care?

MR. SCHILLER:
When we are on investigation and are looking at whether or not to remove a child from the home, as part of the assessment, we go through a packet which involves several releases. If a parent is available, we collect whatever history the parent is able to provide to us. We ask the parent to sign a consent form for any emergency medical care, and at that point, we would probably include the permission for the medication component.

The way I apply this is by statute. We would not go to a protective-custody hearing for up to 72 hours. If we were unable to get the parental consent at the time of the removal, the issue would be that the child could continue taking that medication before we get to the court and get a removal order.

SENATOR CEGAVSKE:
At our interim study committee meetings, one of the concerns from the judges is that they are not doctors. They expressed that it is difficult for them to say what medications the children should or should not have. How can we help educate the judicial system as to how they can identify when the amount of drugs being given to a child is too much? How can they know when to say the child needs to be medically evaluated again? On page 2 of Exhibit G, there is a list of pharmaceuticals by classification. On page 3, there are the numbers of children taking drugs and which types they are.

DR. ROITMAN:
I am vested in the issue of safe and sane prescribing of medications for children. The information referred to by Senator Cegavske in Exhibit G was compiled by Charles Duarte, Administrator, Division of Health Care Financing and Policy, and I provided it as an attachment to my testimony.

The proposed amendment is not meant to add a layer of medical oversight to prescribing practices. The intent is just to make sure that the same type of diligence performed in the private practice of medicine is performed for our foster children. There is a parent who listens to the justification of treatment from the doctor and can ask questions. The parent says "yes" or "no." The treatment has to make sense to the parent before they agree to fill the prescription and administer it.

There are three parties in these cases. There is the foster-care provider who is not the parent. There is the prescriber who is not the parent. We need someone to act like the parent not like a super doctor. The court could become more and more familiar with these medications, because they have a greater volume to review than the average parent. However, judges do not have a duty to know more than the doctor. That is not the point of this effort.

Dr. Lisa Durette, a Board Certified Child and Adolescent Psychiatrist and Medical Director of the Spring Mountain Treatment Center, asked me to speak for her and submit her written testimony for the record (Exhibit H). The closing paragraph in her letter reads:

> In summary, our group of inpatient and outpatient child and adolescent psychiatrists strongly oppose the legislative mandated restrictions outlined in proposed SB 293. Probable consequences of these restrictions will include delay of necessary treatment to youth, potential harm to the patient and others, and increased financial burden to the state of Nevada, and longer waiting periods in the emergency rooms. Adherence to the standard of care set forth by the Academy of Child and Adolescent Psychiatry ensures that youth are evaluated in the most rigorous manner and are given treatments that are effective and supported in the literature. Departures from these standards of practice can be dealt with by mechanisms already in place, including the State Board of Medical Examiners. Thank you for your time.

THOMAS D. MORTON (Director, Clark County Department of Family Services):
I signed up to testify against S.B. 293 based on its original construction. I respect Senator Cegavske and her intent behind this legislation. It is a problem that I raised with Assemblywoman Barbara Buckley more than a year ago, and I have continued to advocate for the concerns that exist for this population.

I have not had time to review the entire amended language, so I am not prepared to comment on it fully; however, I do have certain concerns. My first concern is that the Governor's proposed budget would strip me of one-sixth of my State-funded staff which is the foster-care staff. Any additional burden placed on the agency has to be considered in the context of our ability to meet the expectation no matter how right or how just it may be.

My second concern is in regard to the proposed amended language, one has to be cautious—and I use the word cautious—about the illusion of protection. I did a review of 600 kids under the age of 6 in my agency to see how many were on psychotropic medications. We found 50 kids. We found no children who were on six medications or more. I have had a child under the age of six come in who was on eight medications at the time of admission to Child Haven. Obviously, this is a concern, and I am not going to argue against protecting "the one," but my question is, "Does this bill actually protect a significant number of children relative to its intent and the concern?"

This bill does address the issue of conflicting medications; it does not address the issue of inappropriate dosage; it does not address the issue of whether or not this medication has been approved and tested for application with children. The bill only provides for a review of children who are on, or who have been recommended to be on, six or more medications. I will say that my agency is moving independently to create an internal policy to strengthen our practice whereby we review all psychotropic medications administered to the children in our custody.

There is language in the amended version of the bill that says the agency that provides child-welfare services on behalf of the child "may" file a petition. It does not say that I have to file a petition, but the reality is that the child-welfare agency is not a party to any proceedings before the court. We have no standing; we do not file petitions. The district attorney files petitions as are needed. I can ask the district attorney to file a petition, but independent of

the district attorney's decision, I have no authority to file a petition on behalf of the child.

I would like to reserve further comments until I have had time to read all of the amendments. After I have done that, I would be glad to submit something in writing to the Committee.

CHAIR WIENER:
Please be thorough and be quick in your responses as we have a requirement to get the policy bills out of the committees by April 10. This Committee will hear them all by April 6.

MR. MORTON:
I will make sure that you have my responses by midweek.

SENATOR CEGAVSKE:
At this time, you certainly could have fewer children on medications than when these concerns were brought to me. However, it has been a serious issue in the past. I do realize that at any given time, the mix of children can change, and I know what we all want is for the kids to be safe. We want to make sure that the medications the children may be bringing in from another state are safe, and we want to make sure if they are coming in from another place in Las Vegas that they are safe. All of this needs to be worked on and analyzed. If it is that one child who is in need, I want to help that one child. Mr. Morton, when you spoke you made it clear that you want to also, so provide us with your response as soon as you can.

SENATOR NOLAN:
Mr. Morton, you identified a number of other situations you thought this type of bill might encompass for those children who are coming to you with multiple prescriptions. My experience has been if you have a child who is on more than three medications, especially psychotropic medications, you have a problem child who may be an overprescribed child. Many children have multiple problems. Their parents take them from physician to physician trying to find answers. In the meantime, the child has one bag of medications from the first doctor and another bag of medications from the next.

By the time these children get to you, I cannot imagine the issues they have plus they are accompanied by a whole bag of different medications. Certainly

children are not qualified to make the determination as to what medications they should or should not be taking. You have dealt with these issues for a long time. What can we do to help the more than just the one child who is coming to you with a lot of problems and medications?

MR. MORTON:
This is a major concern. I do not want to say in any way that S.B. 293 is not important and does not add value, it does. There should be a statewide policy applicable to not only the child in the child-welfare system but also to the child in the juvenile-justice system. The bill addresses a very vulnerable population of children age six and under. What raised my concern about this originally was meeting with a number of our older adolescent youth. In listening to them talk about their medication history, they said they often felt like zombies and at times they felt better when they were taken off the medication.

I am aware of circumstances where medications are prescribed without a DSM-IV diagnosis. For example, a foster parent can take a child to a pediatrician and complain that the child is having sleep disorders, is acting out or is hyperactive. The regular physician prescribes a psychotropic medication. Our policies and procedures have not been adequate in providing medication protection for children. I would urge the Legislature to consider a requirement that the DCFS adopt regulations more broadly around the application of psychotropic medications with the entire population of children who are in the custody of the child-welfare agency.

SENATOR NOLAN:
I would be interested in hearing more before I comment further.

MS. COLEMAN:
I realize that Mr. Morton did not have a chance to see the amended version of S.B. 293 before this hearing. The intent of the amended version is to provide protection for any child less than six years of age who is taking one or more medications and for any child over six years of age who is taking five or more medications.

SENATOR NOLAN:
The recommendation to require a statewide policy makes sense. Senator Cegavske has done a lot more work on this than I have. It sounds as

though we may be suggesting a subcommittee or some approach to get working on this.

SENATOR CEGAVSKE:
I agree to that statewide approach.

MS. COLEMAN:
Mr. Morton pointed out a problem to which I draw your attention. On page 3 of Exhibit E under the heading "Page 2," line 11 says, "The child is under 6 years of age;" and then on "Page 3," lines 14 and 15, it again refers to age and numbers of medications. Our intention is for the protection of any child under the age of six who is taking one or more medications or any child of any age taking five or more medications.

CHAIR WIENER:
Ms. Lyons, did you get that?

MARSHEILAH D. LYONS (Committee Policy Analyst):
Yes, I did.

MR. MORTON:
I will review the proposed amendment in depth.

CHAIR WIENER:
I close the hearing on S.B. 293, and I open the hearing on S.B. 341.

SENATE BILL 341: Revises the list of qualifications for relatives to receive supportive assistance from a program to provide supportive assistance to qualifying relatives of children who provide care for and obtain the legal guardianship of those children. (BDR 38-479)

SENATOR STEVEN A. HORSFORD (Clark County Senatorial District No. 4):
There are four bills before the Committee this morning that are recommendations from interim study committees. I would like to highlight the work of the subcommittee that studied this issue and begin with my testimony on S.B. 341 (Exhibit I).

Senate Bill No. 356 of the 74th Session instructed the Legislative Commission to appoint a subcommittee to study the placement of children in foster care.

They charged the subcommittee to address the following: to study the procedures and standards used in the State for placing children in foster care; to review the procedures and standards used in other states for placing children in foster care; to review and evaluate the standard for determining when to place a child in protective custody pursuant to the *Nevada Revised Statutes* (NRS) chapter 432B; to address the methods of foster-care placements in the State including without limitation the placement of children in group homes, family foster homes, child-welfare facilities and other facilities that house children who have been placed in foster care, and to study any other issues relating to the placement of children in foster care.

The work of the subcommittee resulted in a resolution and the four bills we are hearing this morning. Senate Bill 341 is the result of testimony received from representatives of the Division of Welfare and Supportive Services (Welfare Division) regarding the age requirement of the Kinship Care Program. The program is administered by the Welfare Division and funded with federal Temporary Assistance for Needy Families (TANF) funds. The Kinship Care Program provides maintenance payments for relatives—often grandparents—who become guardians of children removed from their homes by the State and county child-welfare agencies.

SENATOR HORSFORD:
The Kinship Care Program was instituted in 2001 by the Legislature, and has always included a minimum requirement of 62 years of age for participating relatives. Welfare Division representatives testified that the age requirement was an arbitrary standard established when the program was first proposed to the Legislature. The age requirement is eligible to be waived in cases when undue hardship can be demonstrated, including cases involving difficult placements such as sibling groups and children with special needs.

The Welfare Division representatives also testified that relative placements are sometimes initiated through the TANF non-needy caregiver program which provides a lesser benefit payment and then transferred to the Kinship Care Program. This can occur when legal guardians are obtained or hardship waivers are processed. The Casey Family Programs provided great technical assistance to us during the 2007-2008 interim. They also provided testimony on the use of the Kinship Care Program reporting that similar types of subsidized relative-guardianship programs have been considered successfully by other states.

The interim study committee members expressed concern that the age limit of the Kinship Care program could result in the exclusion of relatives who would otherwise be qualified guardians for children. While the use of waivers to the age requirement is a helpful aspect of the program, it could cause a delay in placements while the waiver process is being completed. Senate Bill 341 would remove the age requirement completely, although an income limit and a requirement that relatives become legal guardians would remain in place.

In proposing the expansion of the program, S.B. 341 would result in a fiscal note. Representatives from the Welfare Division are here to speak to the financial portion of the bill.

MR. MORTON:
The age issue is particularly important because the restriction is a barrier to financial-hardship families who would like to take on guardianship. Although there is a hardship provision, it is somewhat limited in its application. Guardianship is a viable alternative; it is a form of permanency. There are a number of circumstances where guardianship is preferable to adoption because it preserves the natural ties between the child and parent while the relative assumes responsibility for caring for the child.

While not specifically addressed in this proposed legislation, I would encourage the Legislature, at some date whether in this Session or in the future, to address the larger issue of NRS 432B – "Protection of Children from Abuse and Neglect." This legislation would fit better under the regular guardianship legislation. In the NRS 159.176, the court is required to review the guardianship annually. In my experience, this is not a meaningful provision as it creates the perception that we are reviewing the guardianships, when in fact, we probably are not.

ROMAINE E. GILLILAND (Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services):
We have looked at the number of cases that would qualify under the Kinship Care and estimate that 2,361 cases would potentially qualify. That would represent approximately $8,047,752 of additional TANF benefits on an annual basis. Due to the depletion of the TANF federal block grant reserve, during the next two years that amount would impact the General Fund.

In my prepared testimony concerning S.B. 341, the bill removes from statute the ability of the Department of Health and Human Resources (DHHS) to establish a minimum age for qualifying relatives applying for TANF benefits through the Kinship Care Program for children in their care (Exhibit J). As you know, current regulations establish the minimum age for caretakers in this program at 62. The payment is based on 90 percent of the State's foster-care rate in effect June 30, 2007. This rate is currently $534 each month for children through age 12 and $616 each month for children age 13 and older. The payment structure for this TANF group is different from other TANF groups as the payment is based on an individual child amount rather than a payment for the family. A Kinship Care recipient receiving benefits for 2 children over the age of 13 would receive $1,232 each month; the same recipient receiving benefits from the non-needy caretaker program for the same 2 children would receive $476 each month. A needy caretaker with 2 children would receive a TANF benefit of $383 each month.

The Kinship Care Program was primarily developed to assist grandparents who were raising their grandchildren while attempting to live on a fixed income after reaching retirement age. As the statute places no restriction on who may qualify as a Kinship Care caretaker, the lower-age threshold is nearly indeterminable.

Statutorily removing the DHHS's ability through regulation to set a minimum-age requirement removes the ability to control the level of this population. An unintended consequence of adopting this legislation is that the DHHS may not be able to stay within legislatively approved budget amounts, and it would have to explore other means to control the size of the caseload. Currently, the only other option for controlling the population is to impose an even stricter means test such as using a percentage of poverty. For the Kinship Care Program, the household's family income cannot exceed 275 percent of the federal poverty level.

SENATOR HORSFORD:
It would be helpful if we could have a side-by-side comparison chart of the fiscal impact and the potential cost savings. The intent of the interim study committee is to reduce the number of placements. As this Committee knows, financially the counties cover the front end of the services through Child Protective Services. The State provides the payments to the foster families.

Nevada ranks fifth in the nation in the number of children removed and placed in foster care. If we are able to reduce the number of children placed in foster care, there could ultimately be a cost savings. The funds could be shifted to guardian Kinship Care and relieve the State of the tremendous financial burden of the foster-care payment. This should be part of the discussion on the fiscal note. The Welfare Division was part of the technical work group during the interim and had ample time to bring up some of these considerations.

MR. SCHILLER:
I agree this would be a positive step in keeping children out of foster care. That often centers on the front-door-family engagement and the prevention services. This bill would allow us to do the front-door-family engagement and the planning for safe placement with kids without having to assert legal authority. Keeping children in the home and maintaining them there is easier than placing them in the foster-care home.

We recognize the fiscal impact on the TANF side, and this is why we try to build flexible funding. We are ready to do anything we can that will result in a reduction of children being placed in foster care.

SENATOR CEGAVSKE:
Mr. Gilliland, did you attend any of our interim study committee meetings on this issue? I ask because I do not remember these issues being brought before us. Senator Horsford, as chair of that committee, can you refresh my memory about this?

SENATOR HORSFORD:
We had the standing committees of both Houses, the interim study committee and a technical work group which consisted of all the local agencies, private child-care providers and the Casey Family Program people who assisted in the facilitation. The State had several agencies represented, and the Welfare Division was part of several of the meetings and participated in the discussions on the recommendations.

SENATOR CEGAVSKE:
The statements we have heard today from Mr. Gilliland, were those statements brought to us at that time?

SENATOR HORSFORD:
Not to my recollection.

SENATOR CEGAVSKE:
That is what I wanted on the record.

MICHAEL J. WILLDEN (Director, Department of Health and Human Services):
When the Kinship Care Program was established, the purpose was to help with the issue of permanency for children. If a child goes into the child-welfare system, there is going to be a foster-care maintenance payment made on that child's behalf. In addition to that maintenance payment, there is the court time that is spent, the time with the social workers and the time with the family. Every six months or so, there is a court hearing and several reports are made to the court.

The benefit in the Kinship Care Program is that these guardians become permanent legal guardians of the child and this causes savings in two areas. When we established the program, we benchmarked it at 10 percent less than the foster-care maintenance payment. That was the first savings to the system. The second savings came from not having to have the child-welfare system involved with the family and in the child's life. Those are the two savings to which Senator Horsford is referring.

MR. WILLDEN:
I represented the DHHS in the creation of the Kinship Care Program along with a number of Legislators. Many of you may remember the late Jane Horner who headed up the Grandparents as Parents organization in Las Vegas. It was that group that pushed to get this legislation and this program running. It is an excellent program; it simply is a funding-mechanism question to us.

The Welfare Division is telling us that the TANF block grant is "maxed out." We are using General Fund dollars to run the TANF program now. If we expand the Kinship Care Program, either by eliminating the age limit or by lowering it —pick a number 55 or something like that—it would have to be funded 100 percent with General Fund dollars.

The non-needy caretaker program is an option for families. If the families do not want to give permanency to the child through the Kinship Care Program or go through the child-welfare program and get the adoption subsidies, they can go

to the non-needy caretaker program. That program does not have an age limit nor does it have an income limit; however, the payment is much smaller, roughly 50 percent. The subsidy would be provided on the child's behalf to the family.

That is the economics of it. We are absolutely supportive of the Kinship Care Program because it brings a permanency to the children. If we increase the eligibility and if age is not our controlling factor, it will cause us to spend more General Fund dollars. If we exceed the budget, we would have to limit it either by income or in the TANF program there is some flexibility to create "wait lists" or some things like that.

CHAIR WIENER:
I close the hearing on S.B. 341 and open the hearing on S.B. 342.

SENATE BILL 342: Expands the relatives who receive preference when a child is placed in the custody of a person other than the parent of the child by a court, an agency which provides child welfare services or other person. (BDR 38-478)

SENATOR HORSFORD:
In my prepared testimony, I will point out that S.B. 342 is similar to S.B. 341 (Exhibit K). This bill seeks to improve foster care through expanding the use of relatives as placement resources for children who are placed in out-of-home care. Nevada law currently allows child-welfare agencies and judges to place children with relatives who are related within the third degree of consanguinity. Federal law related to Social Security Act Title IV-E which governs child-welfare maintenance payments allows states to expand placements to persons within the fifth degree of consanguinity. The interim study committee heard testimony that indicated that changing Nevada law to include relatives to the fifth degree of consanguinity as placement options would increase the number of children placed with relatives instead of the children remaining in long-term foster care.

The Nevada Commission on Ethics provides a guide on its Website <ethics.nv.gov> for determining the consanguinity of family relationships. Relatives within the third degree of consanguinity include parents as first degree, the second degree is grandparents and brothers and sisters, and the third degree is great grandparents and aunts and uncles. Expanding to the fifth degree of consanguinity would add the fourth degree of first cousins,

great-great grandparents and grand-aunts and grand-uncles, and the fifth degree would add first cousins once-removed and great-grand aunts and great-grand uncles as potential placement options.

This bill goes to the extent that we can place a child with a family member upon determination by local law enforcement or child protective agencies that that may be in the best interests of the child rather than placing the child in a permanent foster-care placement.

VICE CHAIR WOODHOUSE:
We will take testimony on S.B. 342 at this time.

MR. MORTON:
On behalf of the Clark County Department of Family Services, I speak in support of S.B. 342. It is an excellent way to increase relative options. During the interim study committee's work, I mentioned the issue of "fictive kin." It is a common term used throughout the nation. The NRS 432B allows the court to place children with fictive kin at the time of disposition. We recognize fictive kin who have a natural tie to the children. It is also a viable option particularly at the time of taking protective custody. I am not specifically asking you to amend this bill, but urge you to consider the issue of fictive kin and to further clarify the use of fictive kin in regard to the child-welfare program.

MR. SCHILLER:
I agree with Mr. Morton's comments.

CHAIR WIENER:
I close the hearing on S.B. 342 and open the hearing on S.B. 343.

SENATE BILL 343: Requires the Division of Welfare and Supportive Services of the Department of Health and Human Services to expedite the application of a person for treatment or services if the person is involved in the child welfare system. (BDR 38-477)

SENATOR HORSFORD:
Senate Bill 343 addresses a method to help increase the percentage of reunification of families when children have been removed from their homes due to abuse or neglect and to help those unifications occur more quickly. The interim study committee received testimony from the representatives of its

technical work group regarding the need for immediate access to mental health and drug or alcohol treatment services for families involved with the child-welfare system. Work group members testified that in order to meet the federal Adoption and Safe Families Act of 1997, timelines for moving children to permanency and family members needing drug or alcohol treatment must access services immediately when a child is removed. They will not be successful if they are required to wait three to six months for services. This is the length of time we heard about during the interim study committee. It takes that long just to get through the wait list.

Representatives from the Welfare Division testified before the interim study committee that they do not prioritize treatment services for individuals, but rather refer all individuals for services based upon the order in which they are identified by the Welfare Division. Welfare Division representatives also indicated that they were not aware of the wait lists for services among their service providers. The committee members were somewhat skeptical about this assertion based on our experience and the work of another subcommittee dealing with the availability of substance-abuse treatment chaired by Assemblywoman Shelia Leslie. Welfare Division representatives testified that from a fiscal perspective, if treatment services were limited due to available funding, prioritization of services for persons involved with the child-welfare system would be an understandable course of action.

The interim study committee members concurred with testimony about prioritizing drug and alcohol treatment with persons involved with the child-welfare system. They commented that they were aware of a severe shortage of available treatment services. They also chose to include aftercare and outreach services among the types of services to be prioritized.

SENATOR HORSFORD:
Oftentimes, children are removed from their parents because of drug or alcohol abuse by the parent or mental-health issues of the parent. Many children become reunited with their parents within a short time period; however, the availability of services to the parents or legal guardians for the issue that the child was first removed from the home, does not exist. To the extent that funds are available to prioritize those family members who are eligible to receive drug and alcohol treatment, we will be more successful in unifying these families. We would do this in a way that would allow the children not to be placed in foster care.

I recognize there will probably be an issue around the fiscal note because of the Welfare Division's budget now. Their caseload has grown since the interim study committee met. Foster care is a fiscal impact at the end of the system. It would be helpful to this Committee to be reminded of how much we spend each year in the placement of children in foster care.

To remind you, Nevada ranks fifth in the nation for the number of children removed and placed in foster care. The Casey Family Programs have identified a national goal to reduce the number of children in foster care 50 percent across the nation by the year 2020. When you look at the consequences of the children who spend their childhood years in foster care and when you see the results of a higher dropout rate, higher suicide rate, higher cases of depression and other mental-health issues, we have to address this problem as a State. We have to have a strategy, and part of what the interim study committee tried to do was say, "We recognize where our system is today. There are things that we can do now to begin to address this problem, but where do we want it to be in five or ten years from now?" Where we want to be is where all our children are cared for. The practice-model approach says the safety of the child is first and foremost. In cases where there is severe abuse or neglect, the child must be removed, but ultimately, if you burden the system with every child, no one gets cared for adequately. We spend an increasing amount of money on the back end of the system; we are not investing anything on the front end. Senate Bill 343 addresses the front-end needs, particularly in the areas of drug and alcohol abuse and mental-health issues.

CHAIR WIENER:
In addition to the medical costs such as depression, one of the other high costs is the participation of many of these children in the juvenile-justice system. That involvement leads dramatically to their involvement in the criminal-justice system. The impact of that is substantial in dollars and in human cost. This affects not only those who are engaged in the system, but also their families and their communities.

Do we have any statistics on the number of times a child would be removed from the home and then returned to the home?

MR. WILLDEN:
I do not have statistics with me, but we can get that information to you. I do know there is a high percentage of children who are removed and are returned home relatively quickly, within a week to two weeks.

To answer how much money we spend in the child-welfare system for foster-care maintenance payments each year, it is between $50 million and $60 million. The Committee is absolutely correct in getting children and their families engaged in the mental-health and the substance-abuse treatment systems as early as possible. It is essential if we are going to keep them out of the child-care and other systems that we run. It is important to get eligibility established quickly for Medicaid. Medicaid is the big emphasis here. Medicaid is the agency that will pay for these mental-health treatments and for the substance-abuse types of care.

The one issue we have is that our staffs may want to look at this prioritizing applications legislation. It may run in conflict with Title 42 C.F.R., section 431.50, subpart B which is the Medicaid regulation requiring states to have a plan throughout the system that provides for equitable standards for assistance and administration of programs. One of the issues we have to get discussed with the federal government is the prioritizing of one application over another one in an equitable standard. This will have to be balanced.

Since 1991, there has been a lawsuit pending in federal court in this State that Barbara Buckley, as a freshman lawyer, brought against me as a welfare administrator. It is called *Hamilton v. Griepentrog*. It is Case #CV-S-91-152-LDG (RJJ) and concerns a specific federal court oversight about how timely we must process certain Medicaid and public-assistance applications. There has to be some balancing against that federal lawsuit.

MR. SCHILLER:
We have done some increased family engagement on the front end. What we are finding is when we engaged with the family through our family-solutions team process and get them into services after children have been removed from the home based on safety, conservatively, we are returning about 15 to 20 percent of those kids in less than 10 days.

MR. MORTON:
The DCFS recently received its data profile in preparation for the federal Child and Family Services Review occurring this year. In Nevada in the period under review, 18.5 percent of children taken into foster care were returned home in 7 days or less.

In regard to the question of how many times a child is removed and returned into care, it depends on how you count that figure. In the year under review, there were about 8.5 percent of kids who were returned home and then came back into care. On the other hand, as point-in-time data, there were about 20 percent of kids who had had 2 or more placement episodes. There were mostly only two placements, but that becomes a larger percentage of kids when you slice it vertically at a point in time.

I want to emphasize that S.B. 343 is important. Arguably, anyone in need of services constitutes an urgent situation and to delay care for anybody in need is a problem. But for families in the child-welfare system, and particularly families with children in foster care, there is an additional issue. In 1997, the passage of the Adoption and Safe Families Act changed the requirements for a final dispositional hearing and moved it from 18 to 15 months. It basically says that for any child who has been in foster care for 14 of the last 22 months, we are obligated to file a petition with the court for termination of parental rights. In Nevada, that statute reads 13 of the last 21 months. The reason for that is time is very important in the lives of children, and we want to prevent kids from remaining in foster care without a permanent situation for years and years and years.

The implication of that timing is if I am a parent and my child enters the foster-care system, the child-welfare agency is required to take some actions. It must make reasonable efforts to unify the family. However, DHHS is required to file for termination of parental rights at about 12 months. Basically, that gives the parent only 12 months to demonstrate adequate progress towards correcting the conditions that caused the removal of the child. To the extent that parent has to wait three to six months for access to mental-health or substance-abuse services, obviously, the clock is ticking. Our parents are among the only parents in the nation who stand to lose their parental rights and the rights of their children if they are delayed in getting timely access to mental-health and substance abuse services.

MR. MORTON:
These two problems constitute the major issues we encounter in families where maltreatment occurs. Currently the waiting list at Bridges Counseling is about three weeks for an initial assessment with treatment not beginning until some time later. This situation is my argument on behalf of giving prioritization to this particular population. Simply put, for no one else does the time clock tick quite the same way as it does for them. The cost of not moving quickly can be the loss of their children. More importantly, through the eyes of a child, the child stands to lose his or her family.

CHAIR WIENER:
Written testimony was submitted by Mr. Gilliland on S.B. 343, and it will be entered in the record (Exhibit L).

I close the hearing on S.B. 343, and I open the hearing on S.B. 344.

SENATE BILL 344: Authorizes the Director of the Department of Health and Human Services to create an interagency committee to evaluate the child welfare system. (BDR 38-475)

SENATOR HORSFORD:
My prepared testimony explains the need for an interagency committee to evaluate the child-welfare system (Exhibit M). Senate Bill 344 is the result of the interim study committee's desire to strengthen and increase collaboration between child-welfare stakeholders. Testimony was received about the need to engage all stakeholders, including those in the judicial and corrections systems, TANF, the education system and the mental-health and substance-abuse treatment systems as well as from the child welfare community. The purpose would be to generate information, energy and solutions from these partners and stakeholders about the child-welfare system. The proposed vehicle to accomplish this would be a voluntary interagency committee, organized by the director of the DHHS. They will meet to evaluate the child-welfare system throughout the State. It is anticipated that the inclusion of all stakeholder groups will increase the likelihood of successful implementation of best practices and help develop a sense of community responsibility for the welfare of our children.

As Mr. Morton just indicated, there are a number of issues that continue to emerge on this subject and we are not able to deal with all of them during this

Legislative Session. We need an interagency group that can take on these challenges. Where there are legislative solutions that need to be proposed, the group can bring them to the Legislature.

The interim study committee included, as a method to ensure accountability of the committee, the requirement of an annual report to be provided to the director of the Legislative Counsel Bureau. The director would distribute the report to the chairs of the Assembly Committee on Health and Human Services, the Senate Committee on Health and Education, and the Assembly and Senate Committees on Judiciary. The legal staff has recommended the report be provided biennially on January 1 of odd years in time to be distributed for the regular Legislative Sessions, and the bill drafts could be considered at that same time.

SENATOR HORSFORD:
The NRS 432B, relating to the protection of children from abuse and neglect, was largely created in the 1980s, and while there have been a number of additions and amendments over the years, there has not been a systematic review of the statute. The interim study committee also incorporated a recommendation from the child-welfare agencies as one of the interagency committee's first duties that they review the language of the statute and related regulations to ensure they are aligned with current child-welfare practice.

The interim study committee did look at this, but without a technical group identifying issues over the years, some of the regulations have become stagnant. Some of the regulations apply to child-welfare agencies, but the law enforcement agencies are not included, and there is little reference to the juvenile-justice system. We have heard consistently that about 30 percent of the kids in the juvenile-justice system are also in the child-welfare system. There is a significant impact on the education system because many of the kids in foster care do not obtain their high school diploma or go on to post-secondary education. This type of interagency, interdisciplinary model attempts to bring all of these parties together.

Senate Bill 344 is intended to enable the formation of this interagency committee but not necessarily mandate it. The interim study committee did not want to create "just another committee." Representatives from the DCFS testified that they participate on 19 different

boards or committee. They noted that the lack of collaboration among all of the various groups can sometimes be detrimental to the children served. Representatives from external stakeholder groups indicated that there are many members of community, faith-based, and nonprofit organizations that meet and serve on boards supporting child welfare, but input from them is not always heard by the Legislature, especially on matters concerning the State budget for child-welfare services. This bill provides for the biennial report of the interagency committee to be submitted directly to the Legislature every session. It also allows the committee to submit one request for a legislative measure directly to the Legislative Counsel Bureau each session if it determines that changes in legislation are necessary.

I would be remiss if I did not acknowledge the Casey Family Programs for providing technical and expert staff to work with our subcommittee at no cost to the State. That cost would have amounted to at least $500,000 of support services. The organization did this because it is dedicated to improving care for all children.

SENATOR NOLAN:
This is a monumental task, and the bills you have brought forward, if enacted, are going to make a significant difference in the lives of these children. A lot of the time we do things that have a material effect; these things, I am confident will have an even greater effect.

You said the DHHS staff participates in 19 different committees of various factions—probably half of them are legislative committees. In constructing S.B. 344, was any consideration given to doing away with some of those committees?

SENATOR HORSFORD:
Yes, that issue was discussed. Many of the committees on which the stakeholders serve are federally or State-mandated. To the extent this interagency committee can meet the requirements of the State or federal governments, some of those committees could go away. It is something we want the interagency committee to do, although we did not want to set that in the bill itself. The stakeholders believe if they formulate the committee effectively, they should be able to reduce the number of other committees on which they serve. They are looking at streamlining functions and making better decisions.

MR. MORTON:
I express our support for S.B. 344. There is an element of NRS 432B as well as *Nevada Administrative Code* chapter 432B that is somewhat like the refrain to the Johnny Cash song about assembling a Cadillac from car parts from different years. Although these bills are a monumental piece of work, in the near-term there is a need to take a comprehensive look at this legislation which has evolved since the 1950s. There have been numerous amendments, and it is time to make it a cohesive, modern package to benefit the abused and neglected children in Nevada.

GARD JAMISON (Chair, Children's Advocacy Alliance; Chair, Children's Advocacy Center):
I commend the great work of the interim study committee. Earlier, we heard about nonprofit organizations working apart from one another. We have a small subgroup which consists of a number of people who are concerned about child welfare. The thrust of these four bills has been that healthy families lead to healthy communities. I applaud the motivation behind this work. With respect to S.B. 341, your analysis of the cost-benefit was hugely beneficial. Vanderbilt University has done a study called "The Cost of One Child." The study suggested if a child falls through the system, it costs about $2.3 million. We need to recognize that as we move forward. We need to recognize, too, that the best place to keep our children is with the families. The efforts at reunification are greatly appreciated.

I understand there is a bill, S.B. 3, coming up soon that would create a subcommittee on juvenile justice and child welfare. Is this bill intended to displace S.B. 3?

SENATE BILL 3: Creates the Legislative Committee on Child Welfare and Juvenile Justice. (BDR 17-213)

SENATOR HORSFORD:
Senate Bill 3 has been proposed on behalf of the Legislative Committee on Heath Care which is a statutory committee. If that bill is adopted, it would create another statutory committee, the Legislative Committee on Child Welfare and Juvenile Justice. The juvenile-justice subcommittee, which is a subcommittee on the Advisory Commission on the Administration of Justice under the direction of Nevada Supreme court Chief Justice James Hardesty, proposed this to ensure that juvenile-justice issues would continue to be

addressed. They would be considered separately and apart from the adult-correction issues.

Senate Bill 344 is intended to be the "boots on the ground" doing the work in the field. It would be the stakeholders, the nonprofit, community and faith-based organizations plus the State agencies that would provide the technical direction to support one another and streamline efforts.

CHAIR WIENER:
Each function complements the other, but each one is necessary to accomplish the task at hand.

MR. JAMISON:
There was a study by the Howard Institute that suggested in our communities, we have a lot of silos. Silos are people doing things apart from one another. I applaud S.B. 344 because it brings those silos down. To the extent we can have collaboration and cooperation between public and private entities, we are going to solve these problems. The goodwill of this Committee is appreciated.

MR. SCHILLER:
I would point out that this interagency committee is critical in moving us forward for kids in Nevada. There is a lot of momentum occurring right now around how we have to solve this as a state and as communities versus the governmental organizations. If we are going to continue to move forward in spite of funding difficulties, if we are going to continue to improve how we impact kids, the Casey Family Programs is one way. They have provided crucial help both in the north and the south in creating system-wide change. The proposed interagency committee will bring a statewide focus to move us forward. When we talk about silos, we often say we need to address them. With this approach, we would be breaking some of those down. Here in the north, the juvenile services and social services are working collaboratively to serve the foster-care population. The questions are how do the nonprofit organizations get involved, and how do we involve private providers to solve these problems as a group.

I echo and support the remarks made by Mr. Morton and Senator Horsford.

CHAIR WIENER:
I close the hearing on S.B. 344. I entertain a motion on S.B. 341.

SENATOR CEGAVSKE:
On S.B. 341, upon our vote, would the bill be referred to the Senate Committee on Finance?

CHAIR WIENER:
It is my understanding that we can vote on it in this Committee, and it will be picked up by the Senate Committee on Finance on the Senate Floor.

SENATOR CEGAVSKE:
I support this bill. I just want to make sure we have the funding to do it.

CHAIR WIENER:
If we can move this now, it will get to the Senate Committee on Finance that much sooner.

SENATOR CEGAVSKE MOVED TO DO PASS S.B. 341.

SENATOR BREEDEN SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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SENATOR CEGAVSKE MOVED TO DO PASS S.B. 342.

SENATOR NOLAN SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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SENATOR CEGAVSKE MOVED TO DO PASS S.B. 344.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR WIENER:
We have moved three measures forward and have more work to do on S.B. 293 and S.B. 343. Is there anyone wishing to speak under public comment?

JULIANNA I. ORMSBY, MSW (Nevada Women's Lobby):
Child-welfare issues have long been a cornerstone of the Nevada Women's Lobby, and they are always a priority for us. We are supporting all the legislation before you today. We have worked closely with the child-welfare network and the Children's Advocacy Alliance during the interim, and we also followed closely the subcommittee that produced the four measures dealing with the placement of children in foster care. It was a productive committee with input from community stakeholders.

The one point I want to make is that community stakeholders are often at the table on these issues. What was particularly important and resonated with us on the interim study committee was the testimony from current and former youth who are currently or were formerly in foster care. We thought their input contributed a lot to the work being done. Thank you for listening to their voices which are not often heard in the process. We look forward to working with the sponsors on these bills.

TRACEY WOODS (Nevada Youth Care Providers):
I want to comment on S.B. 293. We just need a little time to review the amendments. We do support the intent of the bill and appreciate Senator Cegavske for bringing it forward. We look forward to working with her on the measure.

CHAIR WIENER:
With no further business to come before the Senate Committee on Health and Education, the meeting is adjourned at 11:01 a.m.

RESPECTFULLY SUBMITTED:

Betty Ihfe,
Committee Secretary

APPROVED BY:

Senator Valerie Wiener, Chair

DATE: