MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Seventh Session
March 4, 2013

The Committee on Health and Human Services was called to order by Chair Marilyn Dondero Loop at 1:33 p.m. on Monday, March 4, 2013, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at nelis.leg.state.nv.us/77th2013. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications. Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Marilyn Dondero Loop, Chair
Assemblywoman Ellen B. Spiegel, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Wesley Duncan
Assemblyman Andy Eisen
Assemblywoman Michele Fiore
Assemblyman John Hambrick
Assemblyman Pat Hickey
Assemblyman Joseph M. Hogan
Assemblyman Andrew Martin
Assemblyman James Oscarson
Assemblywoman Peggy Pierce
Assemblyman Michael Sprinkle

COMMITTEE MEMBERS ABSENT:

Assemblyman Steven Brooks (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kirsten Bugenig, Committee Policy Analyst
Risa Lang, Committee Counsel
Janel Davis, Committee Secretary
Macy Young, Committee Assistant

OTHERS PRESENT:

Valerie Wiener, Chair, Legislative Committee on Child Welfare and Juvenile Justice
Marla McDade Williams, Deputy Administrator, Health Division, Department of Health and Human Services
Janice Wolf, Directing Attorney, Children's Attorney Project, Legal Aid Center of Southern Nevada
Lisa Ruiz Lee, Director, Clark County Department of Family Services
Jon Sasser, representing Legal Aid Center of Southern Nevada and Washoe Legal Services
Buffy Brown, Child Advocacy Attorney, Washoe Legal Services
Joseph R. Haas, Ph.D., Psychologist, Washoe County Department of Juvenile Services
Jill Marano, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services
Jeanette K. Belz, representing Nevada Psychiatric Association
Kathleen M. O'Leary, Chief Deputy Public Defender, Washoe County Public Defender

Chair Dondero Loop:
[Roll was called. Rules and protocol were stated.] I will open the hearing on Assembly Bill 93. I would like to welcome Valerie Wiener.

Assembly Bill 93: Makes various changes concerning investigations relating to child care facilities. (BDR 38-61)

Valerie Wiener, Chair, Legislative Committee on Child Welfare and Juvenile Justice:
The Legislative Committee on Child Welfare and Juvenile Justice submitted ten bills this Legislative Session. Assembly Bill 93 is one of those measures. During the first meeting of our interim work, our Committee reviewed a publication from the Audit Division that referenced the Department of Health and Human Services' (DHHS) oversight of child care facilities. One of the findings of the report indicated that background checks of employees were not being completed in a timely manner.

While *Nevada Revised Statutes* (NRS) 432A.170 requires the Health Division to perform background checks on employees of child care facilities within three days of hire, there is currently no requirement that such a facility notify the Division that a hire has taken place. This puts the Health Division in a very difficult position when they are required to do their part, but there is not a requirement for those providing information. The Health Division recommended that the statute be amended to address the concerns raised in the audit.

In consideration of the testimony we heard, the Committee recommended that this legislation be drafted to require child care facilities to notify the Health Division within 24 hours of: newly hired employees; new residents over the age of 18; or new participants in an outdoor youth program over the age of 18. This recommendation is what you will see in A.B. 93. Marla McDade Williams is here today to answer any other questions.

Marla McDade Williams, Deputy Administrator, Health Division, Department of Health and Human Services:
I want to extend my appreciation to former Senator Wiener and the Legislative Committee on Child Welfare and Juvenile Justice for hearing our concerns and responding to our audit that was conducted by the Legislative Auditor in 2011. That audit made six recommendations. The fifth recommendation was to develop procedures to help ensure employees at child care facilities have timely child abuse and neglect checks. It is one of our responsibilities, which is laid out in NRS 432A.170. This bill amends NRS 432A.175 and requires that notification be given within 24 hours. The information that we need before we can comply with the statute is a complete set of fingerprints and written authorization from the Health Division or its designee to forward the fingerprints to the Central Repository for Nevada Records of Criminal History. We need a written statement detailing any prior criminal convictions and a written authorization for us to obtain information that may be available from the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child as established by NRS 432.100.

As we indicated, NRS 432A.170 requires the Health Division to request information of employees no later than three days after the employee is hired; however, since we are not in the facility on a daily basis assessing their new hiring practices, if they fail to notify us within that time frame, we are the ones who are out of compliance with the statute. We have a couple of methods to verify whether or not a facility notified us. We inspect child care facilities twice a year, so we can identify whether they were late in notifying us. Another option is when they send us information, we can ask when the new employee was hired and verify it then. We are the agency that holds the statutory burden for ensuring the checks are done within three days. We support the premise of

the bill that facilities should have some burden in notifying the Health Division. We will hold them responsible for notifying us in a timely manner so we can do our jobs timely. I will note that this bill does not make any changes to the Health Division's responsibility. If a facility is late notifying us, we will still be out of compliance with the statute.

Chair Dondero Loop:
Thank you. Are there any questions from the Committee?

Assemblyman Sprinkle:
What exactly constitutes notification? What happens if the child care facilities do not notify the Health Division within 24 hours?

Marla McDade Williams:
We have a form that is required to be submitted. On that form, they need to do the self-declaration of whether or not the employee has had any prior criminal convictions. It helps us verify that the fingerprints were submitted to the Central Repository for Nevada Records of Criminal History. There is a release authorizing Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child. If they do not comply, they would be in violation of regulations and it would be on us to go back and hold the facility accountable.

Chair Dondero Loop:
Is there anyone else in support of A.B. 93? Ms. Wiener, do you have any additional comments?

Valerie Wiener:
The Health Division works so diligently to comply with what is required in law in regard to the three-day policy. It is a quick requirement and children are coming and going through these facilities. We should ensure, in every way possible, that the people working with our children every single day are the best people and will not put our children at risk. The law requires that the three-day timeline for the state needs to have this information and we need to hold people accountable. I have confidence that the Health Division will work with the facilities to make it as streamlined as possible so it is not burdensome to contact the Health Division for this information. The bottom line is that we need to have information about who is spending time with our children in these facilities. The sooner we can be more accurate and thorough, the better able we will be to serve those children who cannot serve themselves.

Chair Dondero Loop:
We will now hear opposition to A.B. 93. [There was none.] Is there anyone in a neutral position? [There was no one.] I will close the hearing on A.B. 93. I will open the hearing on Assembly Bill 149.

Assembly Bill 149: Revises provisions concerning persons legally responsible for the psychiatric care of a child who is in the custody of an agency which provides child welfare services. (BDR 38-505)

Janice Wolf, Directing Attorney, Children's Attorney Project, Legal Aid Center of Southern Nevada:
I want to thank the Committee for taking the concerns with both psychotropic medications and the person legally responsible (PLR) situation seriously. We are here to support A.B. 149 and look forward to seeing it implemented.

In February of 2012, the Children's Attorney Project (CAP) wrote a letter to Michael Willden, the Director of the Department of Health and Human Services (DHHS), outlining our concerns with children's mental health in general and psychotropic medications in particular. The letter included, but was not limited to, the overuse and inappropriate use of psychotropic medications; the off-label use of these medications; and multiple psychotropic medications being prescribed to children, some younger than 7 years of age, without true independent oversight of what was being done. The fact that there was no independent voice looking out for these children and asking questions led to the passage of the PLR legislation previously in NRS 432B.4681 through NRS 432B.469. We hope that this legislation would put the necessary safeguards in place to ensure that no child in foster care was put on psychotropic medication without a thorough and detailed inquiry process or without informed consent.

During the interim, that did not happen as we would have liked to see it happen. We raised concerns about PLRs not being appointed timely and having unmanageable caseloads; about PLRs, when appointed, not showing up or not asking any questions and "rubberstamping" the decisions of the psychiatrists. I am speaking from the perspective of the south. The north has PLR issues that are different and will be addressed separately.

Assembly Bill 149 refines the PLR statutes by requiring data gathering and assessment, imposing educational requirements as a prerequisite for appointment, and adoption of regulations for the provision of age-appropriate information concerning any psychotropic medication prescribed to our clients as needed. In talking to other stakeholders, some issues have been raised in regard to some of the language in the bill as it is currently drafted. Some of

those issues center on the requirements being identical for parent PLRs and for professional PLRs. We are very much committed to working with the other stakeholders, as well as with our colleagues up north, to meet the needs of everyone in the state. We feel this is vital and necessary for the needs of our children so that overmedication and misuse of medication can be dealt with safely and appropriately. I want to point out that there is information already available in terms of age-appropriate material for our children. It is a report (Exhibit C) by the DHHS entitled "Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care." I will make this available to the Committee.

Assemblyman Eisen:
Is there a process that ensures people at mental health facilities have a way to access and verify who the PLR is during after-hour times?

Janice Wolf:
That is a good question. I believe Lisa Ruiz Lee can answer that better. To my knowledge, it could usually happen the following day. If the child has a caseworker, the caseworker should know if the child has a PLR. It is necessary information, and if it is not available, then it should be. The technology should be available because the PLRs are appointed by court order.

Assemblyman Eisen:
My concern would be making that available at the time it is needed. If a child happens to come in on a Friday night and has to wait until Monday to find out who is responsible, it is not a practical solution. If Ms. Ruiz Lee has a response to what is going on, that would be helpful.

Janice Wolf:
I know that there are procedures for emergencies. If a child comes into an emergency facility, certain decisions can be made for the child immediately before that issue is sorted out.

Lisa Ruiz Lee, Director, Clark County Department of Family Services:
There are a couple of ways we communicate who the PLR is for these children. When we first appoint a PLR for children, we make sure to reach out to all of the mental service providers and make them aware who that designated person is. We will also provide them with a letter stating who the sole individual is making these decisions for this particular child.

The law passed in 2011 provides parameters for emergency circumstances. If there is a child who is not currently on psychotropic medications, but is hospitalized, the hospital facility has the ability to administer those medications

because of those emergent circumstances that were added to the law. Typically what happens is they will notify the Department of Family Services that the child has been admitted; we will identify if there is a PLR, and communicate that to the facility immediately. If there is not a PLR, we have the ability to nominate immediately. If the child welfare agency has nominated somebody to serve in that capacity, they can make those decisions until it goes to the court for official appointment.

Assemblyman Eisen:
I am looking at page 4, line 28 of the bill, which describes standardized training. Who will determine what the training will be and on what basis will they determine whether or not the training is appropriate?

Lisa Ruiz Lee:
As we present our position and thoughts on this bill, we will tell you that section was particularly concerning to us as well. When we implemented the PLR within Clark County, we did a contract with some local psychiatrists who treat children and adolescents. These psychiatrists had been instrumental in the passage of the original laws. We did four hours of mandatory training for 100 percent of case-carrying staff. We ended with a subsequent eight hours of training for any staff that was designated as PLRs. We have provided them with ongoing support and coaching from the same psychiatrists who were involved with the passage of the law. We continue to provide our staff with robust training on psychotropic medications. From our perspective, while we appreciate the effort to build the training and put it online, we are not 100 percent convinced that the training would actually meet the needs of the folks who are performing that job function. A PowerPoint presentation was utilized by the psychiatrist who presented our trainings. You could take that training, post it on the web, and make it readily available, but the face-to-face dialogue around real cases was the part of the training that was invaluable. I am not certain you would capture that through the Internet.

Assemblyman Eisen:
We need to make sure that we have real evidence-based training for these people so they understand what they are doing. Page 4, line 40 states "the potential impact on future employment." I find that phrase worrisome. I am not sure how that is determined and who makes that determination about what the impact on future employment would be. I also do not know if that is a piece of information that should be part of the consideration about whether or not someone engages in treatment. My hope is that being a recipient of psychotropic medications should never have an influence on future employment. Rather than trying to predict what that might be for a child in foster care, what might the impact be 10 to 20 years from now? I am uncomfortable with that

and I am curious as to why that was included. What specifically was intended to be provided under that provision?

Janice Wolf:
If psychotropic medications were prescribed as necessary, and on a limited basis, we probably would not be here. We would not need PLR legislation. The fact is that psychotropic medications are not always used appropriately; they are misused or overused. The genesis of the particular provision you have an issue with came out of the fact that there are certain career paths limited by psychotropic medications. For example, the military and law enforcement will not let an individual work unless he has been off the medications for over one year. A number of our young people look at the military as a career path, especially teenagers who are graduating. A number of medications that children are being prescribed are not acceptable to the military. Prescribing drugs that may impact a young adult's decision to go into the military was one of the considerations.

Chair Dondero Loop:
Thank you. That was also my question—how would very young children have any idea what could happen later in their careers?

Janice Wolf:
I believe this particular provision came out of the interim hearings where we raised concern for our young adults who are either in or aging out of foster care and are on the brink of making career decisions. Being on these medications may or may not impact their career choices. We feel that they are entitled to know that before making informed decisions for themselves.

Assemblywoman Benitez-Thompson:
I have questions on section 2, subsection 2, paragraph (b) and paragraph (d) of the bill. Is there any current literature or best practices by the foundations that do work in this area around a recommended number? I would hate to see legislation that mandates regulations and then, in the process of developing those regulations, not have a place to go for good information. I was not sure if you were looking to get to something more specific and helpful than just a mandate to regulate.

Janice Wolf:
This was an issue that came up during the interim. We discussed the concern that there were only two or three part-time professional PLRs appointed by the Department to advocate for hundreds of children who required PLRs. The way the statutes were drafted, it required the PLRs to not only go to team treatment meetings at hospitals, but to accompany those children and advocate for them

at individual therapy appointments, which could be once a month when it comes to psychotropic medications.

This is not my field of expertise. I do believe that the DHHS has the ability to determine what a reasonable caseload is and what is reasonable for a professional PLR to be able to meet the needs of the children assigned to that PLR.

Assemblywoman Benitez-Thompson:
I am interested because I serve on the Legislative Commission's Subcommittee to Review Regulations. I think it would be nice to have some type of context so that if you are looking for good public policy to come from regulation, we have some other way of developing that rather than arbitrarily. I think the same would be important for paragraph (d) when we talk about age-appropriate information. You could potentially get into a good conversation about what age a child consents to things. We know they can consent to adoptions at the age of 14 because that is in the NRS, but I would like to know what the national thinking is for age-appropriateness in this area.

Janice Wolf:
I recently read some material—I believe it was from the American Bar Association—that looked at psychotropic medications and decisions by children at various ages. The research was showing that children as young as 8 years of age were coming to the same conclusions as the adult professional making the decision, although not necessarily for the same reasons. I have seen that young children have a pretty good idea, when it is explained to them, what is going on and can at least give their opinions to us, which we should listen to. I do not think that the age of the child necessarily precludes an accurate decision, although the reasoning power to reach that decision may be different.

Assemblywoman Benitez-Thompson:
Having worked in the field on a caseload of children who were around the ages of 3 and 4—this is where we start begging the question of age to consent. We have to ask what a good age is and how do we build that into regulations to get to the well-meaning intention you have in this bill.

Assemblyman Sprinkle:
Is the intent of this legislation to allow these children to make informed decisions about their own treatment? From my understanding, these children are under the age of 18. Why is this legislation in front of me right now? Are these opinions that you, as an agency, are going to take into consideration? There are other places in the statute where it talks about the PLR making decisions for these children. I do not understand the intent of this section.

Janice Wolf:
As it is written now, the statute discusses presenting age-appropriate information to children and young adults. One of the things we are looking to do among the stakeholders is discuss that language and see what tweaks we might want to make. I would leave that question open because I think the stakeholders have a lot of input they would like to make to that provision.

Assemblyman Sprinkle:
Line 43 on page 4 is giving me trouble. In essence it reads, "If, after receiving the information, the child objects to taking the psychotropic medication, the objection must be noted in the child's record with the Nevada Division of Child and Family Services." What is the intent here? I have children and they object, but I still mandate what they are going to do because they are under the age of 18.

Assemblyman Oscarson:
You say object, I say refuse, however you want to put it. Does that trigger some kind of other mechanism within the organization that would refer them back to the prescriber of that medication for an evaluation of efficacy to find out if it is appropriate for that individual?

Why would any of this information be available to a minor? As far as I am concerned, that information should be sealed. When you are talking about career opportunities, it would seem that information is unavailable to the general public, not only because they are juveniles, but because of the Health Insurance Portability and Accountability Act (HIPAA) as well.

Janice Wolf:
I wish you were right. There are certain types of information that we would like to see sealed, should be sealed, but are not sealed. Even juvenile records, to some extent, are discoverable. When a young adult has to fill out an application or questionnaire, that information is discoverable and required to be made available.

Assemblyman Oscarson:
I would appreciate very much if you could provide me with the information that states that is the case.

Chair Dondero Loop:
I would like to revisit Assemblyman Sprinkle's comment about line 43 on page 4 of the bill. If the child is allowed to object, do they still have to take the medications? In other words, we ask them if they object, but it does not mean anything because we still administer the medications.

Janice Wolf:
As a practical matter, with teenage clients, if they say they object, or they are not going to take it, short of prying their jaws open and forcing it down their throats, there is not a lot that any medical provider can do to make them take the medications. Prior to any of this legislation, I have had clients I accompanied to psychiatric appointments, and the psychiatrist has suggested they take a certain medication. The client declines the recommendation, and the doctor says okay. Younger clients are more compliant, but with teenagers, if they do not want to take the medication because they do not like how it makes them feel—and they are not in a locked psychiatric facility where there is more of an element of coercion—there is not a lot anybody can do.

Assemblyman Eisen:
I am concerned about this. There is some expert opinion in health care about how to approach this situation with adolescent patients in particular. I would refer you to a report from the Official Journal of the American Academy of Pediatrics, Committee on Bioethics, entitled "Informed Consent, Parental Permission and Assent in Pediatric Practice." In that practice guideline it states that there is an obligation on the part of the health care provider and one of the elements assent should include is:

> 4. Soliciting an expression of the patient's willingness to accept the proposed care. Regarding this final point, we note that no one should solicit a patient's views without intending to weigh them seriously. In situations in which the patient will have to receive medical care despite his or her objection, the patient should be told that fact and should not be deceived.

I am concerned if what is being proposed here fits in with what I read. I am concerned about what we are encoding into statute and how that meshes with what is considered the standard of care. Fundamentally, if there is a problem with how care is being delivered, particularly psychiatric care to children who are in state custody, the issue is fixing that care, not necessarily changing what the standard of practice is. I do not know if this document would be of some assistance in developing the approach to this. I feel that some of this was written in response to what we are seeing on the ground rather than in response to what things should be. We should not be writing statutes based on things being done other than as they should. If that is the case, we need to fix the practice, not the expectation.

Janice Wolf:
Some of your questions and concerns are addressed in the material I mentioned (Exhibit C). It talks about children having options. This is not something that

was put out by a private agency; it was put out by the United States Department of Health and Human Services. It is quite detailed. I think it would benefit the Committee to look at the material because I believe it addresses your specific concerns. Government has already recognized that children of all ages need to be involved in decision making. I do not think that the U.S. government contemplated cutting children out of the decision-making process.

Assemblyman Oscarson:
I keyed in on a word that you said earlier: coercion. Last time I checked, coercion was not part of standard of care. I mean no disrespect to you by that, but children do have some ability to make decisions, and they have some rights in these instances, especially when it is in regard to types of psychotropic medications.

Janice Wolf:
I think there was no disrespect taken. I see coercion when children are in psychiatric hospitals, are not responding, and are hostile and aggressive. As a matter of course, they use intramuscular injections as a means to controlling behavior in children in that environment.

Chair Dondero Loop:
Thank you. We will hear support on A.B. 149.

Jon Sasser, representing Legal Aid Center of Southern Nevada and Washoe Legal Services:
At the table with me is one of our attorneys, Buffy Brown, who will present the northern perspective on this bill.

Buffy Brown, Child Advocacy Attorney, Washoe Legal Services:
I am here to support the concept of the PLR as a necessary component of our system. When there is a child in foster care, those general standards of practice do not always come to fruition as they should. A lot of times it is because there was not a person who was readily identifiable as the person who would make a big issue out of it. It was unclear, prior to the initial legislation, who ultimately is responsible. We use the terms "legal custody" and "physical custody" of children in foster care, but they do not work as clearly as they do outside of the foster care system.

We fully support the need for PLR. In general, the program is working to address many of the concerns raised from the original legislation. Oftentimes, there are differences between how things are dealt with in the north and in the south. We have different experiences in the north in terms of the number of children on psychotropic medications. There have also been some differences in

how the original legislation has been implemented. With that said, we are in general support of fine-tuning that original legislation. It was a major change in our philosophy. I think it is necessary that we go back and look at those things that did or did not work as intended and fine-tune. We want to work with all of the stakeholders in both the north and the south so we have comprehensive legislation that is going to be used throughout the state.

A couple of the things that we identified have been addressed in terms of training. Among our concerns in the north is the issue of requirements imposed on natural parents, when they are identified as the person legally responsible, or requirements that preclude them from being able to make decisions for their children when they otherwise would make sound decisions. They just physically cannot do all of the tasks required. Data is another issue. It is driving everything. Having some required data is important; but we want to make sure that any data mandated is usable for everybody, so we want to take a look at the data components.

The issue of what happens to a child who opposes the medications has been raised. The intent of requiring informed age-appropriate information be provided to the child is a good one in some respects, but it is very frustrating for a child who does not have a remedy to disagree with what is happening to him. That child then feels even more disenfranchised in terms of the decision making process. We need to be careful about the balance between the two. If children were given age-appropriate information in all of these cases, we probably would not have been here two years ago. I have had quite a few of those experiences where the entire sum of their appointment lasted less than 30 minutes. I think that is improving with the PLRs, but I do not think we have quite dotted all the i's and crossed all the t's in terms of full implementation of what was intended two years ago.

Assemblywoman Benitez-Thompson:
I agree that the intent of this bill is driving something very important. This Committee has had conversations and contemplated getting appropriate medications and diagnoses for children in previous sessions. You mentioned that the north has had a different experience. I am curious to know the number of PLRs in Clark and Washoe Counties and in the Division of Child and Family Services (DCFS). What are the differences between those numbers?

Lisa Ruiz Lee:
The data portion of this is important. I will give you some raw data we have collected. The statewide numbers for foster children who are on psychotropic medications in Nevada are very low compared to the national numbers. The last time we ran them, our statewide numbers were hovering around 11 percent of

children in foster care being on psychotropic medications. In Clark County, about 10 percent of our population, or 355 children, are in foster care and on psychotropic medications.

Through our agency, 208 children have designated professional PLRs. I have four registered nurses who serve as PLRs for these children. They are full-time employees. We have another 147 children, or 47 percent of the total population, who have PLRs who are biological parents, relatives, or foster parents. When I have a vacancy in one of those nursing positions, it becomes very difficult. For example, if I have 208 children who are split among the four registered nurses but one of them resigns, then I go from having four dedicated PLRs to having three until I can fill that position. Filling those positions has been incredibly challenging. We have a lot of staff who initially think this is something that they can do, but when they start to perform these responsibilities, they are no longer interested in them long term. We have incredible turnover in those four positions at times, which causes the number of full-time employees to fluctuate.

Janice Wolf:
When the PLR program first became law, there were part-time positions. Those positions were filled by part-time nurses employed by DCFS. It is a credit to DCFS that they have been able to turn those positions into full-time positions. It is incredibly difficult to keep those positions filled and to keep the appetite for that kind of job up. It is a tough and time-consuming job, but it is necessary to keep the positions filled and full time because otherwise, it is a true nightmare.

Buffy Brown:
Rather than speak for another agency, I believe Dr. Joseph Haas is here from the Washoe County Department of Social Services, and he would be in the best position to answer the question about the numbers in the north.

Joseph R. Haas, Ph.D., Psychologist, Washoe County Department of Juvenile Services:
I am here representing our director, Kevin Schiller. We have 206 youths currently receiving psychiatric care, which is defined as youths both receiving medications and those seeing a psychiatrist but not necessarily on medications. There are 113 youths assigned to two agency PLRs, which is a caseload of 57 children. We devote half of the social service clinical supervisor to that position and a part of the social services specialist who has helped with developing the overarching policies. We put a lot of resources into this project. It is serving our most vulnerable: children on medication. Thirty-three youths are assigned to agency case workers. There are 20 workers serving as PLRs for one or more children; 43 are assigned to caregivers such as foster parents or

therapeutic foster parents; and 16 youths have a parent assigned as their PLR. It averages out to about 26 percent of our total youth being served by PLRs. That fits with national standards in terms of projective rates of serious emotional disturbance, especially among children in foster care.

Chair Dondero Loop:
Is there any additional support for A.B. 149?

Lisa Ruiz Lee:
We had a long discussion about what position to take when there is an amendment. In the end, we decided to support the bill with proposed amendments. Last week, the child welfare agencies met to go through A.B. 149 as it was proposed to be able to respond to the Committee with some suggested amendments. The amendments brought forward (Exhibit D) are from Clark County.

Much of the conversation today highlighted a lot of the child welfare agencies' concerns about the proposed legislation. The study of psychotropic medications and children in foster care has been the subject of much debate and contention at the national level for the last several years, and at the state level since 2009. The year 2009 was when we saw the first legislation come forward regarding psychotropic medications and foster children. In 2009, we saw a requirement made to the child welfare agencies to establish policies and procedures and review processes for children who were prescribed psychotropic medications that fell into certain categories. For example, if they were using medications in ways that the U.S. Food and Drug Administration (FDA) had not approved, if the child was less than four years of age, or if there was concurrent use of psychotropic medications either amongst the same class or between classes of drugs.

In 2011, during the Legislative Session, the designation of the PLR for psychiatric care emerged. The bill pertaining to that was successfully passed in 2011. It is important to note that a PLR, as we have defined it in Nevada, is unique. There are no other states using this kind of language or this kind of process or protocol to regulate the use of psychotropic medications for children. Because of that, it would be challenging to establish what an appropriate caseload should be or what appropriate training should be. If you look at the child welfare agencies around the country, you typically see that they have fallen back to focusing on standards of care through the medical professional community as opposed to trying to drive them through the child welfare agencies. They figured out how to build partnerships in order to improve the use of psychotropic medications in children.

In 2011 the psychotropic medications and the PLR was established with the intention that we would designate somebody as a PLR who could love and care for foster children. The 2009 and 2011 legislation has allowed us to analyze the use of psychotropic medications for children who are in foster care. As I indicated earlier, if you look at the statewide usage of such medication in foster children, Nevada sits well below the national average. In this particular case, that is a good thing.

Some of the proposed amendments we sent forward (Exhibit D) address the issue that the PLRs are very diverse in their skill sets. We have professional level PLRs and we also have volunteers, attorneys, foster parents, and relatives who all perform this function because they are dedicated, committed, and they love the child, not necessarily because they are experts in psychiatric care and medication. Given this information, I think it is important that when we look at legislation, the rules we set for some of them, we actually set for all of them. Some of our volunteers and foster parents may not have the capacity to do what we are asking.

In Clark County, most of our PLRs are professional PLRs or registered nurses. Our PLRs spend a significant amount of time attending mental health appointments and visiting with children. In southern Nevada, since January of 2013, our PLRs have attended more than 500 individual visits with children. All of these visits are recorded and documented in the child welfare case record documentation. We also document all of the psychotropic medications the children are taking. We can get reports with that data and information. We have also initiated partnerships with Medicaid in order to share data to have an appropriate Quality Assurance (QA) review process to make sure that we do not have children slipping through the cracks. Clark County has a contract with Mojave Mental Health, an affiliate of the University of Nevada School of Medicine. They are charged with completing reviews for children who are on psychotropic medications. They will maintain a database on those children so we can track long-term side effects.

We do not ask our PLRs to track, which is identified in this bill and deleted in our amendment, the number of medications that PLRs decline. We believe that would be a very challenging fact to track. Many of our PLRs, including parents and foster parents, have developed relationships with psychiatrists, which is what we want them to do. They engage in dialogue about what works best for a child and what is in the child's best interest. I am not sure how we would categorize a decline of a medication, as it is not often as simple as saying "no." It could be conversations about dosages. It is hard to track. I am not sure if tracking that information is helpful or informative. At the end of the day, we want to make sure that whatever data we are tracking is useful. Ultimately, we

want children to receive the best, most appropriate care, and we cannot assume that declining medications is either a good thing or a bad thing. In actuality, that determination would need to be done almost on a case-by-case basis, and not based on some aggregate number.

We do not support the limitation or regulation of the number of children in a PLR, as indicated in the original legislation. We do not set caseload standards for child welfare anywhere in NRS or *Nevada Administrative Code* (NAC). It is because we are often juggling resources to meet service demand. We did some rough calculations across the state of Nevada to determine what would happen from a fiscal impact perspective if we set caseload ratios. We are sitting at about a 1-to-50 caseload ratio now. If we were to go to a 1-to-10 caseload ratio for PLRs, the fiscal impact in southern Nevada alone would be almost $4.5 million. We have limited monies and, ultimately, we could be forced to dedicate a huge percentage of our limited resources to a small population of children. We prefer to have flexibility in how we set that. As I indicated earlier, I cannot control how long people stay in those positions.

In the proposed amendment (Exhibit D), we requested that the training be changed to a "may" from a "shall," simply because we have a variety of people who serve as PLRs and online training may not work, especially for biological or foster parents. We are not opposed to posting training online, but we believe that the training needs to be more robust for professional PLRs than anything you would find on the web.

Based upon our proposed amendment (Exhibit D), we deleted a large portion of the section around making sure that children were provided informed consent. We ask you to consider the importance of the appropriate medical professionals and physicians providing informed consent for the use of psychotropic medications. We were concerned that this essentially would put the child welfare agencies in that role. We have spent hundreds of hours incorporating a structured and informed consent process for psychotropic medications for statewide policy. We have consulted with child and adolescent psychiatrists who are instrumental in setting the laws about how best to go about doing that. We believe that process should govern informed consent. We are not opposed to distributing appropriate literature and materials to youth to help them be involved in their own mental health treatment and in whether or not medications are right for them. We are okay with allowing a child to object, and noting that in the child's file. We would like to note that the case record in which it would be noted would be in the agency which provides child welfare services and not strictly DCFS.

To conclude, I believe that this issue was largely driven from the issues that were surrounding, and still are surrounding, a therapeutic foster care system that is not working as effectively as it should be. As we continue to redesign therapeutic foster care and revamp the child welfare system, we are going to see a greater ability to monitor and control the use of medication for children in care, and ensure that the appropriate behavioral intervention strategies, treatment plans, et cetera, are in place for those same children. As we keep our eye toward the future, that will be critical.

We have seen great successes with the preliminary pilot results. In Clark County alone, we have seen a 40 percent reduction in the use of psychotropic medication for those 30 youths involved in the pilot program. I am not saying they are not on any psychotropic medications, but I am saying that we are trying to get them to a dosage that is appropriate and get them off the medication using behavioral intervention and traditional therapeutic approaches, which allow them to address the trauma issues underlying mental health needs.

Chair Dondero Loop:
Thank you. Are there any questions from the Committee? [There were none.] Is there anyone else in support of A.B. 149?

Jill Marano, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services:
As Lisa stated, we were not sure if we should present in support with amendments or if we should present in opposition. I will discuss what we would like changed in the bill. I will start by saying that I echo everything that Lisa Ruiz Lee said. The rural communities currently have 59 youths who are on psychotropic medications, which equals about 12 percent of our population. Like Clark County, we are under the national average.

I would like to highlight the issue on training. Ms. Wolf testified to looking at training for a parent versus professional training. That might be a start down the right path. For the rural communities, it is about training for a medical person versus a nonmedical type of training. Out of those 59 youths, about 53 have PLRs who are parents, relatives, Court Appointed Special Advocates (CASA) volunteers, and different community members who have taken a particular interest in them. The kind of training that they would need to really understand the rules, responsibilities, and data that the child welfare agency needs is very different than that for medical personnel employed by a child welfare agency such as Clark County typically uses. We would need to consider what the most appropriate training might be. We certainly would not want to have something that nonmedical people could not understand.

The only other piece that we would want to add highlights the issues around informed consent and giving informed consent. It often becomes a struggle for nonmedical personnel, because it is not in our scope of understanding or expertise to be able to give the kind of information that a child might need. At the same time, as Dr. Eisen indicated, we have doctors who are doing this. Someone else who is not medically trained could be giving information in conflict with the doctor, which presents a concern to us because we want the youth to be hearing information from the medical person.

Chair Dondero Loop:
Are there questions from the Committee? [There were none.]

Joseph R. Haas, Ph.D., Psychologist, Washoe County Department of Juvenile Services:
We are in complete support of the bill, but propose an amendment (Exhibit E). We propose in section 2, subsection 1, paragraph (a), changing the words "a person professionally qualified in the field of mental health" to "a practitioner of psychiatric care." This is to be absolutely sure that we are not talking about all appointments with all behavioral specialists such as psychologists, counselors, or folks who would not be prescribing medicine. We feel that the proposed change of wording would be broad enough to incorporate other medical professionals who prescribe psychiatric medicines.

As an overall commentary, we wish to refer to written concerns regarding the fiscal impact. The proposed data requirements and potentially restricting the PLR caseloads would result in a large fiscal note due to our need to assign all children to agency employees acting as PLRs to ensure the implementation of the statute. We presented a fiscal note (Exhibit F) that ranges from $550,000 to $950,000 depending on the caseload. We wanted to provide that concern to you. I believe it was provided to you by Mr. Schiller.

Chair Dondero Loop:
Is there anyone in the neutral position?

Jeanette K. Belz, representing Nevada Psychiatric Association:
We are not opposed to this bill, but we signed in as neutral because we have some amendments. A letter from Dr. Lesley Dickson was submitted to the Committee (Exhibit G). I will briefly paraphrase her concerns. In section 2, subsection 2, paragraph (c) regarding the standardized training, Dr. Dickson indicated that the training needs to evidence-based and focused on nonpharmaceutical treatment modalities because drugs do not cure everything. Secondly, there was a concern in section 2, subsection 2, paragraph (d). The Nevada Psychiatric Association would be interested in participating in any

regulatory process regarding age-appropriate information. In section 5, there was a concern that the psychiatrist should be given adequate psychiatric and medical history to ensure that there is a good foundation of information so that the psychiatrist can prescribe safely.

Kathleen M. O'Leary, Chief Deputy Public Defender, Washoe County Public Defender:

We represent approximately 300 parents who have children in care. We have been involved with both the Second Judicial District Court and Washoe County Department of Social Services in presenting training on psychotropic medication for children in foster care for some time. The reason we have always been concerned about this area is summarized in a report by Tufts University, which did a multistate study. They found that there has been a 200 to 300 percent increase in the number of children who are on psychotropic medication in the last 10 years. I believe that is, in part, related to children who have Medicaid benefits, and those medications are paid through Medicaid. Nationally, only 4 percent of children are on psychotropic medications. In the foster care population, the number reaches from 13 to 52 percent.

We have been involved in the PLR implementation in the Second Judicial District Court. Dr. Haas testified that there are only 16 PLRs in our jurisdiction. I will tell you that our parents want to be the PLRs. They are the most appropriate people, because they will continue to be the PLRs until their children are emancipated. The unintended consequences of the previous legislation were to require those parents to have administrative and notification responsibilities that indigent people just cannot do.

We mostly support everything in this bill with the addition of a few amendments (Exhibit H). One amendment would be that the child welfare agency assists a parent PLR with the administrative functions and notification procedures required. It requires photocopying and postage; and while this might be minimal to us, it is overwhelming to parents. We support parent PLRs not only for their appropriate participation in the decision-making process of psychotropic medications, but so they can provide a more complete psycho-social history of their child. We frequently find that foster parents or a representative of the child welfare agency will give that psycho-social history to the care provider and they are simply unaware of that child's full history.

We support the continued oversight of the Legislature and the use of psychotropic medications in foster care, and for that reason, we also support data collection. Additional areas of data collection include four areas that, nationwide, are red flags for appropriate practice. I believe Dr. Eisen was concerned about that. They would include collection of aggregate data to show

any deviation from the types of medication or dosages that fall outside of FDA guidelines. In other words, these are uses of psychotropic medication in children where it has not been approved by the FDA and in the nomenclature is referred to as "off label use," or "black box" warnings. We also suggest you collect aggregate data on the number of foster children under 4 years of age who are prescribed psychotropic medication. We would ask that you collect aggregate data on the number of foster children concurrently on three or more psychotropic medications and the number of children on two psychotropic medications within the same classification. Nationally, you will see that those are best practices to make sure that use of psychotropic medications by children in foster care as prescribed by their care providers are appropriate and documented and that there is no indication of misuse or overuse.

Assemblyman Hambrick:
Last session there was also a question raised about overprescribing medications. You could go to the Nevada State Board of Pharmacy, which has an amazing database on psychotropic medications, to compile a list of those being medicated. I am concerned that multiple prescriptions by different doctors are being given to one individual. We need to gather all of this information. I am curious how to do this and what your next recourse is. Do you go back to the department or to the court?

Kathleen O'Leary:
I do not know all of the intricacies of how each of the child welfare agencies keeps their data. I believe you have heard testimony that they keep data on the number of medications. I believe the Medicaid records of reimbursement would also provide that data. We are not indicating that you should collect it at this juncture on each individual child, but as an aggregate amount so that in the future, the Legislature can make judgments as to whether or not the PLR legislation has accomplished its goals.

As Mrs. Benitez-Thompson indicated, maybe this is an area for regulation. We are certainly open to having a work session on this matter. We have been working with the Washoe County Department of Social Services for over two years on this issue.

Chair Dondero Loop:
Would all of you who have amendments make sure that you submit them in writing? Thank you.

Jill Marano:
I wanted to provide some information on the current tracking that the Division of Child and Family Services and the child welfare agencies currently do regarding the use of psychotropic medication.

The four areas that were just mentioned are currently tracked within our statewide database. We have worked extensively with Medicaid on identifying a way where we could cross our systems to be able to track it. Currently we are not able to do that electronically; however, we have an agreement with Medicaid and they send us their information on youth who are being prescribed medication. We then enter that information into our statewide database which will aggregate a report that will show us the number of youths under 5 years of age on psychotropic medications and the youth taking two or more of the same class of medications, any that are off label usage, and all of those national recommendations.

Chair Dondero Loop:
Are there any comments or questions? [There were none.] I will close the hearing on A.B. 149. Is there any public comment? [There was none.] The meeting is adjourned [at 2:56 p.m.].

RESPECTFULLY SUBMITTED:

_____
Janel Davis
Committee Secretary

APPROVED BY:

_____
Assemblywoman Marilyn Dondero Loop, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: March 4, 2013 **Time of Meeting: 1:33 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 93	C	Janice Wolf	Report
A.B.149	D	Lisa Ruiz Lee, Clark County	Amendments
A.B. 149	E	Joseph Haas	Amendments
A.B. 149	F	Joseph Haas/Kevin Schiller	Fiscal Notes
A.B. 149	G	Lesley R. Dickson	Letter
A.B. 149	H	Kathleen O'Leary	Amendment