2003-04 SESSION COMMITTEE HEARING RECORDS

Committee Name:

Senate Committee on Health, Children, Families, Aging and Long Term Care

(SC-HCFALTC)

Sample:

Record of Comm. Proceedings … RCP

- 03hrAC-EdR_RCP_pt01a
- 03hrAC-EdR_RCP_pt01b
- 03hrAC-EdR_RCP_pt02

- *Appointments … Appt*
- **

- *Clearinghouse Rules … CRule*
- **

- *Committee Hearings … CH*
- **

- *Committee Reports … CR*
- **

- *Executive Sessions … ES*
- **

- *Hearing Records … HR*
- *03hr_sb0387_pt02*

- *Miscellaneous … Misc*
- **

- *Record of Comm. Proceedings … RCP*
- **

SENATE HEALTH COMMITTEE
SENATE BILL 387
FEBRUARY 12, 2004

SENATE BILL 387 WOULD REMOVE A CURRENT LAW DISTINCTION BETWEEN MINORS UNDER 14 YEARS OF AGE AND MINORS 14 YEARS OF AGE OR OLDER WITH REGARD TO GIVING INFORMED CONSENT FOR MENTAL HEALTH TREATMENT.

THIS CHANGE IS NEEDED BECAUSE CHILDREN ARE SELDOM ABLE TO MAKE WELL-INFORMED DECISIONS REGARDING THEIR MENTAL HEALTH.

CURRENTLY, BEFORE A MINOR 14 YEARS OF AGE OR OLDER CAN RECEIVE THE FOLLOWING TREATMENT, INFORMED CONSENT OF **BOTH** THE MINOR AND THE MINOR'S PARENT OR GUARDIAN IS REQUIRED.

- OUTPATIENT TREATMENT FOR MENTAL ILLNESS OR DEVELOPMENTAL DISABILITY.

- VOLUNTARY ADMISSION TO AND DISCHARGE FROM AN INPATIENT FACILITY FOR TREATMENT OF MENTAL ILLNESS OR DEVELOPMENTAL DISABILITY.

- REEXAMINATION UNDER, OR MODIFICATION OR CANCELLATION OF, AN INVOLUNTARY COMMITMENT

ORDER FOR TREATMENT FOR MENTAL ILLNESS OR DEVELOPMENTAL DISABILITY.

- TRANSFER FROM A JUVENILE SECURED CORRECTIONAL FACILITY TO AN INPATIENT FACILITY FOR TREATMENT FOR MENTAL ILLNESS OR DEVELOPMENTAL DISABILITY.

- INFORMED CONSENT FOR MEDICATION AND TREATMENT.

SENATE BILL 387, ELIMINATES THE REQUIREMENT THAT A MINOR AGE 14 YEARS OR OLDER CONSENT TO THESE ACTIVITIES.

THE CHANGES PROPOSED IN THIS BILL ARE VERY MUCH IN LINE WITH RECENT REVISIONS RELATING TO ALCOHOL AND OTHER DRUG ABUSE TREATMENT. DUE TO CHANGES MADE IN THE BUDGET BILL, A PARENT ALONE CAN NOW PETITION FOR HIS OR HER CHILD AGE 14-18 YEARS OF AGE TO PARTICIPATE IN AODA TREATMENT.

THIS BILL ALSO WOULD LIMIT ACCESS BY A MINOR 14 YEARS OF AGE OR OLDER TO COURT RECORDS AND TREATMENT RECORDS, EXCEPT IN THE PRESENCE OF A PERSON WHOSE PRESENCE IS REQUIRED UNDER CURRENT LAW.

SENATE BILL 387 WOULD PERMIT A MINOR **UNDER** 14 YEARS OF AGE TO PETITION THE JUVENILE COURT FOR APPROVAL OF HIS OR HER ADMISSION TO AN INPATIENT FACILITY IF THE MINOR'S PARENT OR GUARDIAN REFUSES TO EXECUTE THE APPLICATION FOR ADMISSION OR CANNOT BE FOUND. MINORS OVER THE AGE OF 14 CURRENTLY HAVE THIS RIGHT.

THE GOAL IS TO PROTECT THE WELL-BEING OF CHILDREN IN NEED OF TREATMENT FOR MENTAL ILLNESS. THIS BILL, IF PASSED, WILL HELP TO ENSURE THAT MINORS DO NOT MAKE MENTAL HEALTH DECISIONS OUT OF FEAR OR LACK OF UNDERSTANDING ABOUT THEIR SITUATION.

THANK YOU.

JAMES T. DWYER
County Board Chair

DANIEL M. FINLEY
County Executive

Waukesha
COUNTY
COUNTY BOARD OFFICE

February 12, 2004

TO: Senator Carol Roessler, Chair
Members of the Senate Committee on Health

FR: Dave Krahn
Legislative Policy Advisor

RE: **Senate Bill 387 – relating to: eliminating the distinction between a minor under 14 years of age and a minor 14 years of age or older with regard to informed consent for treatment for mental illness**

Eliminating the distinction between a minor under 14 years of age and a minor 14 years of age or over in Chapter 51, results in:

1. The assumption that all children are incompetent regarding treatment and care.
2. Eliminates for all children informed consent to treatment or mental disease and AODA issues.
3. Eliminates confidentiality protection for children as it relates to treatment.
4. Has the potential to allow parents or guardians to force treatment upon a minor over the age of 14 without regard to the child's cooperation, willingness to participate in treatment.
5. Eliminates a portion of a child's due process rights under Chapter 51 as it relates to care and treatment.
6. Requires additional juvenile court activity in the event that a child is placed against his will in an inpatient setting.

The programmatic effects are:

1. This bill compromises the 51.42 Board's authority as it relates to the care and treatment of minors.
2. This bill restricts the confidentiality of the minor and may compromise treatment where parents are seen as counter-productive.
3. This bill compromises alternative treatment options to inpatient and residential care as deemed necessary by the department if in disagreement with the opinions of a parent or guardian.
4. This bill may increase unnecessary inpatient placements as a result of parent choice and lack of due process protection for children over the age of 14.
5. This bill provides for mandatory drug testing without client choice.
6. This bill has the potential of increasing department's court work, placement costs and limiting treatment options.
7. Potential impact on law enforcement due to parental expectations of support.
8. Bill does not define the definition of a minor for legal purposes.

As for fiscal impact:

This bill has the potential of increasing inpatient stays for children, which may be unnecessary. With the increased inpatient activity there may be a residual impact upon residential placements since the authority of the 51.42 Board to control care and treatment is compromised. Medical Assistance dollars will be impacted with increased potential hospitalizations. Additional dollars for drug testing may also increase.

For these reasons, Waukesha County urges you to oppose Senate Bill 387.

Thank you.

515 West Moreland Boulevard • Room 170
Waukesha, Wisconsin 53188
Phone: (262) 548-7002 • Fax: (262) 548-7005
www.waukeshacounty.gov

SB387

My name is Hugh Davis and I am the Executive Director of Wisconsin Family Ties. Wisconsin Family Ties is a statewide, family-run, not-for-profit organization serving families that include children with mental, emotional and behavioral disorders. In our most recent fiscal year, we worked with over 1000 families throughout the state.

The families we serve overwhelmingly favor SB 387 over current law. While not perfect, we believe it represents a more rational position than current statutory provisions. It has always seemed incongruous that parents can determine whether their 14-year-old can date, but independently can't make decisions about something much more important.

We believe that there was a time when the provisions in current law were necessary to prevent abuses. However, the landscape has changed dramatically since its adoption. There are few private psychiatric hospitals and the advent of managed care has significantly altered the funding process. Today, major abuses the current law was intended to prevent would require collusion between parents, psychiatrists, hospitals and insurance companies.

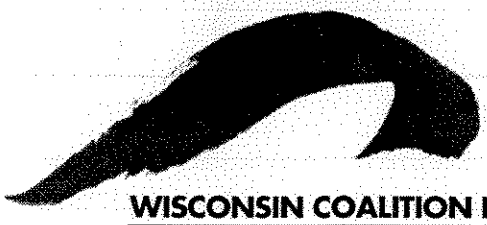
SB 387 is consistent with the rights and protections we afford parents and teens without mental health needs. We don't allow 14-year-olds without mental health needs to decline medical treatment, so why would we give that privilege to those teens who are probably the least able to make sound decisions? We believe we should trust parents to make appropriate decisions for their children and trust the medical profession to provide treatment only if it's medically necessary.

For the most part, we believe SB 387 contains adequate and appropriate protections for minors 14 years of age or above. However, we recognize the unfortunate reality that some children's wellbeing is put at risk by acts or omissions of their parents or caregivers. We believe SB 387 would be stronger and gain wider acceptance if amended to include the following:

- An automatic review of medical necessity in situations where a minor 14 years of age or above is placed in inpatient treatment without his or her consent.
- Preserving the right of minors 14 years of age or above to obtain medically-necessary outpatient treatment and medication without the consent of their parents and without having to petition the juvenile courts.
- Preserving the right of minors 14 years of age or above to continue to receive any medically-necessary treatment when their parents or guardians wish to cease treatment.
- Limiting parental access to treatment records in situations where there is suspicion or evidence of abuse or neglect of the child, or in situations where information in the treatment record could reasonably be assumed to result in the potential for abuse or neglect.

Respectfully submitted on February 12, 2004.

Hugh Davis, Executive Director
Wisconsin Family Ties
16 N. Carroll St., Ste. 640
Madison, WI 53703



WISCONSIN COALITION FOR ADVOCACY

THE PROTECTION AND A

2/12/04 Testimony

February 12, 2004

To: Senate Committee on Health, Children, Families, Aging, and Long Term Care

From: Dianne Greenley, Supervising Attorney
Wisconsin Coalition for Advocacy

Re: 2003 Senate Bill 387

Senate Bill 387 substantially changes the law regarding consent for both inpatient and outpatient mental health treatment of minors aged 14 through 17. It also changes the law regarding consent for release of confidential mental health records and access to those records. The Wisconsin Coalition for Advocacy is opposed to these changes. We urge the Committee to move slowly and thoughtfully in balancing the rights of minors and parents in this extremely complex area of law.

Since the mid 1970's the Wisconsin Statutes have required the consent of both the minor aged 14 and older and his/her parent or guardian for voluntary admission of the minor into an inpatient mental health treatment facility. This requirement was based upon case law in Wisconsin. There is also a provision for court approval of voluntary admissions when the minor wishes to be admitted but the parent or guardian cannot be found, there is no parent with legal custody, or consent is unreasonably withheld. For children admitted into public treatment facilities or when county funding is involved, the juvenile court conducts a paper review of the appropriateness of the admission. This provision does not apply to admissions to private facilities, such as psychiatric units in general hospitals, where insurance or the family is paying for the cost.

The requirement of consent by both minor and parent or guardian has been a major contributing factor in avoiding the abusive psychiatric hospitalization of minors that has taken place in many other parts of the country. I also believe it was a factor in the reduction of for profit psychiatric hospital beds in Wisconsin; if children could not be easily hospitalized a major market for their services was eliminated.

Making inpatient hospitalization of minors easier goes against the grain of several other policy developments in Wisconsin. First, the state has put considerable effort into developing community based services for children and adolescents who need mental health treatment. Increased hospital use could cut into the funding available for these programs. Secondly, there is currently an effort to achieve parity in insurance coverage of mental health services. Opening the door to hospitalization of minors may hinder these efforts as insurance companies fear increased

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Fax 608 267 0368 Toll Free 800 928 8778 (consumers & family members only) www.w-c-a.org

utilization of psychiatric benefits. Thirdly, eliminating a minor's decision making ability in this area sends quite mixed messages to adolescents. In the criminal justice arena they are being held increasingly responsible at younger ages while in the mental health area responsibility is being taken away and given solely to parents. Finally, throughout the mental health system the concept of recovery and consumer empowerment is being implemented. Removing adolescents from a decision making role, means that their opportunities for recovery and empowerment are being reduced.

In making these arguments I do not want to imply bad will on the part of parents who seek inpatient treatment for their adolescents. Frequently a short term admission is needed in a crisis situation or to deal with medication and/or behavioral issues. However, it is a drastic step and should be used sparingly. Engaging the adolescent in making this decision means that the treatment is more likely to be successful. Hospitalization should not be used as a way of handling family conflicts or as a substitute for community treatment approaches.

If the Committee decides to support this change in the law, I urge your consideration of several modifications. As mentioned above the court review of voluntary admissions only applies to those in public facilities or where county funding is involved. This protection should be extended to all minors, including those in the private sector. The court review process also should be strengthened; to date it has been only a paper review. Requiring a guardian ad litem to visit a minor when the admission extends beyond a certain time period, for example fourteen days, to explain his/her rights and review the appropriateness of the admission may provide some greater protections. Finally, there should be some comparability with the juvenile justice code; minors aged 17 should be treated as adults in both systems.

In the outpatient treatment area several other problems occur with the bill. Here the major concerns we hear about involve children who want and need to receive outpatient mental health treatment, but their parents are unavailable or refuse to consent. The bill would give increased control over the receipt of outpatient treatment to parents. What are programs to do who serve abused and/or neglected children and parental consent is not forthcoming?

Under current law there is a provision in Section 51.14 allowing a parent or a minor to petition the juvenile court to obtain outpatient treatment without the consent of the minor or the parent if that consent is unreasonably withheld. A mental health review officer appointed by the court holds a hearing to listen to both sides and make a determination about whether treatment may proceed without consent of the minor or the parent. Unfortunately, this provision has not been well implemented. Instead of changing the law to remove decision making from adolescents, this statute and its implementation should be reviewed and strengthened. In addition, this section needs to be amended to allow an outpatient treatment provider to petition the court, as well as the minor. Also the standard could be revised to include situations when the parent or guardian is unavailable or there is no parent with legal custody.

Finally, the bill changes the law regarding release of confidential records and access to those records. Currently, a minor age 14 or older, a parent, guardian, or person acting in place of a parent (for example, a foster parent) may sign a consent form to release records. This provision

has been helpful when a parent, guardian, or foster parent is not available to sign the release, but the adolescent wants the records released and is able to sign the form. The bill would remove the adolescent from the list of people who could sign the form. Also under current law an adolescent, as well as his/her parent or guardian may have access to treatment records once treatment has been terminated. (During treatment access is at the discretion of the treatment provider.) The bill would restrict access to the adolescent, but still allow parents or guardians to have access. Most of the problems that I have encountered with this law have involved parental access, particularly in cases of abuse or incest, and not access by minors. This change could make this problem even worse.

One rationale for this bill may be the desire to have the provisions relating to mental health treatment for adolescents parallel those for substance abuse treatment. The statutes were changed in 2001 to allow inpatient substance abuse treatment for minors age 14 - 17 based on parental consent. The bill would accomplish this in part. However, Sec. 51.13 (1)(e) requires a special assessment to determine that the admission meets criteria for inpatient substance abuse treatment established by the Department of Health and Family Services. S.B. 387 does not include a parallel safeguard for inpatient mental health admissions.

In the outpatient area minors have long been able to consent to outpatient substance abuse treatment without parental consent in certain circumstances. There is no similar provision for outpatient mental health treatment. Instead the bill would allow outpatient mental health treatment only if the parent consented.

In the area of records federal law requires that both a minor and his/her parent sign a consent for release of substance abuse treatment records. Under S.B. 387 minors would have no say in the release of mental health records, thus making the law different for the two types of treatment. Also, in regard to parental access to records under federal law the minor must consent before parents may have access to substance abuse treatment records. Under S. B.. 387 minors could not prevent their parents from having access to their mental health treatment records.

The entire area of consent for treatment, both inpatient and outpatient, and consent for release of confidential treatment records is extremely complex. Thus, we urge the committee to study the issues addressed in S. B.387 much more thoroughly before taking action. The problems that the bill is designed to address must be clearly identified and solutions developed that are appropriate. As it stands, S. B. 387 has the potential to make a confusing situation even worse while dis-empowering adolescents in the decision making process regarding mental health treatment.

SB 387

Youth age 14-17 were originally given the responsibility for their mental health care at a time when predominately private hospitals (mainly in other states) were admitting and keeping them for inappropriate reasons; an incentive to do this was monetary, as it was a time of nearly unlimited insurance benefits. In the 70's this perhaps made sense. In the year 2003 the standard of care is very different. We now have a different understanding of mental illness. Hospitalization is no longer for the convenience of parents justified by a dubious diagnosis. The standard of care today is for admission to occur if a treatable brain disorder exists such as schizophrenia or more commonly mood disorder and outpatient therapy would not provide adequate safety.i.e. the individual is a danger to him/herself or others. For the 70's scenario to occur it would require collusion between the psychiatrist, parent, hospital staff, JACHO (federally mandated program that reviews hospitals) and the managed care component of the HMO or insurance company (Gone are the days of no benefit oversight). There is a much higher chance of adolescents actually getting needed treatment than this "collusion" to occur nowadays. I am motivated to pursue this issue based upon the frustration, helplessness, and anger expressed by loving parents who want to see the best for their children as well as an attempt to get treatment for those adolescents too impaired to make good decisions. I still remember the rhetorical question of one parent 5 yrs ago who, after being told nothing could be done, said,"why does the state of Wisconsin give the responsibility to make important treatment decisions to the very group of people who are least able to make these decisions because of their acute episode of mental illness." This same parent, as many others before and since, wanted to know why the State trusts parents to make other medical decisions, but not those related to treatment of brain disorders! Supporters of the current situation say a Chapter 51 mental illness commitment is sufficient to deal with this, however, I have had situations in which cases haven't fit the standard, but were immensely debilitating as no treatment could be rendered even though parents were literally begging their brain impaired adolescent to get help.
Parents have told me that seeing their child in such a state has lead to anger, frustration, and helplessness- tipping the power differential to an unhealthy balance.

From a developmental point of view youth in this age group are beginning to individuate; this means that, although by their mid 20's they are statistically more likely to share similar values with their parents, for now there is a developmental need to set themselves apart from the family to prepare for a life of independence. Often, a result of this is the rejection of reasonable requests from the parents. Dress, hair color etc. is of diminished import compared to rejection of treatment for a debilitating brain disorder.

The following are some experiences related to this issue:

JC is a 14 yr old who comes from a very resourceful family he had symptoms of depression and severe cannabis abuse, he was "on the run" not following the rules, and drinking alcohol which is a depressant - the use of which is highly associated with suicide in people who are already depressed. He wouldn't follow an outpatient plan. Safety was an issue; his parents convinced him, after much pleading and promises (which compromised their parenting plan) to sign into the hospital voluntarily, however shortly after he wanted to leave to smoke marijuana. Before he

could do so the parents were forced to pay approximately $25,000 to have two men fly from out of state and escort him out of state where he could get the treatment he needed. Unfortunately most parents don't have these resources and don't want to see their children so far from home.

LB is a 15 yr old boy who up until this fall had many friends, was an honor student and athlete. I received a call from his mother asking what she should do. He had been lying in bed for the past two weeks still eating and drinking to barely get by if food was brought and parents begged him to eat. He was depressed, demoralized, and lacked motivation. He felt hopeless and when his parents asked him to go for an evaluation he refused feeling it "would do no good." Since there was no imminent danger to himself or others "Chapter 51 was not an option."

SG is a 16 yr old girl diagnosed with bipolar disorder. When manic she becomes angry and verbally aggressive as well as physically aggressive. The Police who have been called several times lack understanding of the disorder and refused to act. She knows her "rights" and will stop her medication and refuse to go to appointments on a whim (associated with a mood swing). The mother has felt powerless and feels she is the victim of emotional abuse perpetrated on her by her daughter.

There are legitimate concerns surrounding the adoption of this bill, however I believe we can not withhold treatment for many based upon the possibility of an unlikely scenario affecting a few.

Respectfully submitted 2/12/04 by

Kenneth J. Herrmann MD
Board Certified General, Child and Adolescent Psychiatry
608-238-5826

WISCONSIN COALITION FOR ADVOCACY

THE PROTECTION AND ADVOCACY SYSTEM FOR PEOPLE WITH DISABILITIES

February 12, 2004

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Mental Health Association in Milwaukee County
Leading the way for Wisconsin's Mental Health

Position Statement: SB 387

Shel Gross, Director of Public Policy
Mental Health Association in Milwaukee County

Senate Health, Children, Families, Aging and Long-Term Care Committee
February 12, 2004

The Mental Health Association in Milwaukee County (MHA) requests that the Senate Health, Children, Families, Aging and Long-Term Care Committee take no action on SB 387 at this time. This request is consistent with the position of the Wisconsin Council on Mental Health. As the MHA's Director of Public Policy I have participated in a number of discussions with other mental health advocates about this bill. It is clear to me from these discussions that there are many questions about the various provisions in the bill. There has not been adequate time since we first became aware that this bill was scheduled to get answers to all these questions and explore alternative language. The MHA believes this additional time is needed to make sure that the bill, in attempting to address perceived problems in current law, does not create other problems.

The MHA acknowledges that parents of minor children are legally responsible for the care of these children and need to be able to make treatment decisions for them, when necessary. To the degree changes are needed to assist parents who are attempting to act in the child's best interest we support changing the law. However, the law should still balance parental responsibility with due process for youth, recognizing that forcing adolescents into treatment, while sometimes necessary for their protection, can have negative consequences. Indeed, we heard from one of our colleagues that such an experience during his adolescence was so traumatic that it significantly delayed his seeking needed treatment as an adult.

Interestingly, in the discussions to date, we have learned that there are in fact existing procedures that would allow parents to appeal to a mental health review officer should they want to sign their child into treatment and the child is inappropriately withholding consent. However, it is not clear whether people know about this provision or use it. This is one example of an area that requires further exploration.

The MHA would be glad to meet with the Chairperson and other interested individuals to explore these issues further.

Milwaukee Office
734 North 4th Street, Suite 200
Milwaukee, WI 53203-2102
Tel: (414) 276-3122 • Fax: (414) 276-3124
Email: mha@mhamilw.org

Office of Public Policy
133 South Butler Street, Lower Level
Madison, WI 53703
Tel: (608) 250-4368 • Fax: (608) 442-8036
Email: shelgross@tds.net

My name is Hugh Davis and I am the Executive Director of Wisconsin Family Ties. Wisconsin Family Ties is a statewide, family-run, not-for-profit organization serving families that include children with mental, emotional and behavioral disorders. In our most recent fiscal year, we worked with over 1000 families throughout the state.

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We believe that there was a time when the provisions in current law were necessary to prevent abuses. However, the landscape has changed dramatically since its adoption. There are few private psychiatric hospitals and the advent of managed care has significantly altered the funding process. Today, major abuses the current law was intended to prevent would require collusion between parents, psychiatrists, hospitals and insurance companies.

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For the most part, we believe SB 387 contains adequate and appropriate protections for minors 14 years of age or above. However, we recognize the unfortunate reality that some children's wellbeing is put at risk by acts or omissions of their parents or caregivers. We believe SB 387 would be stronger and gain wider acceptance if amended to include the following:

- An automatic review of medical necessity in situations where a minor 14 years of age or above is placed in inpatient treatment without his or her consent.
- Preserving the right of minors 14 years of age or above to obtain medically-necessary outpatient treatment and medication without the consent of their parents and without having to petition the juvenile courts.
- Preserving the right of minors 14 years of age or above to continue to receive any medically-necessary treatment when their parents or guardians wish to cease treatment.
- Limiting parental access to treatment records in situations where there is suspicion or evidence of abuse or neglect of the child, or in situations where information in the treatment record could reasonably be assumed to result in the potential for abuse or neglect.

Respectfully submitted on February 12, 2004.

Hugh Davis, Executive Director
Wisconsin Family Ties
16 N. Carroll St., Ste. 640
Madison, WI 53703

Mental Health Association in Milwaukee County
Leading the way for Wisconsin's Mental Health

Position Statement: SB 387

Shel Gross, Director of Public Policy
Mental Health Association in Milwaukee County

Senate Health, Children, Families, Aging and Long-Term Care Committee
February 12, 2004

The Mental Health Association in Milwaukee County (MHA) requests that the Senate Health, Children, Families, Aging and Long-Term Care Committee take no action on SB 387 at this time. This request is consistent with the position of the Wisconsin Council on Mental Health. As the MHA's Director of Public Policy I have participated in a number of discussions with other mental health advocates about this bill. It is clear to me from these discussions that there are many questions about the various provisions in the bill. There has not been adequate time since we first became aware that this bill was scheduled to get answers to all these questions and explore alternative language. The MHA believes this additional time is needed to make sure that the bill, in attempting to address perceived problems in current law, does not create other problems.

The MHA acknowledges that parents of minor children are legally responsible for the care of these children and need to be able to make treatment decisions for them, when necessary. To the degree changes are needed to assist parents who are attempting to act in the child's best interest we support changing the law. However, the law should still balance parental responsibility with due process for youth, recognizing that forcing adolescents into treatment, while sometimes necessary for their protection, can have negative consequences. Indeed, we heard from one of our colleagues that such an experience during his adolescence was so traumatic that it significantly delayed his seeking needed treatment as an adult.

Interestingly, in the discussions to date, we have learned that there are in fact existing procedures that would allow parents to appeal to a mental health review officer should they want to sign their child into treatment and the child is inappropriately withholding consent. However, it is not clear whether people know about this provision or use it. This is one example of an area that requires further exploration.

The MHA would be glad to meet with the Chairperson and other interested individuals to explore these issues further.

Milwaukee Office
734 North 4th Street, Suite 200
Milwaukee, WI 53203-2102
Tel: (414) 276-3122 • Fax: (414) 276-3124
Email: mha@mhamilw.org

Office of Public Policy
133 South Butler Street, Lower Level
Madison, WI 53703
Tel: (608) 250-4368 • Fax: (608) 442-8036
Email: shelgross@tds.net

My name is Hugh Davis and I am the Executive Director of Wisconsin Family Ties. Wisconsin Family Ties is a statewide, family-run, not-for-profit organization serving families that include children with mental, emotional and behavioral disorders. In our most recent fiscal year, we worked with over 1000 families throughout the state.

The families we serve overwhelmingly favor SB 387 over current law. While not perfect, we believe it represents a more rational position than current statutory provisions. It has always seemed incongruous that parents can determine whether their 14-year-old can date, but independently can't make decisions about something much more important.

We believe that there was a time when the provisions in current law were necessary to prevent abuses. However, the landscape has changed dramatically since its adoption. There are few private psychiatric hospitals and the advent of managed care has significantly altered the funding process. Today, major abuses the current law was intended to prevent would require collusion between parents, psychiatrists, hospitals and insurance companies.

SB 387 is consistent with the rights and protections we afford parents and teens without mental health needs. We don't allow 14-year-olds without mental health needs to decline medical treatment, so why would we give that privilege to those teens who are probably the least able to make sound decisions? We believe we should trust parents to make appropriate decisions for their children and trust the medical profession to provide treatment only if it's medically necessary.

For the most part, we believe SB 387 contains adequate and appropriate protections for minors 14 years of age or above. However, we recognize the unfortunate reality that some children's wellbeing is put at risk by acts or omissions of their parents or caregivers. We believe SB 387 would be stronger and gain wider acceptance if amended to include the following:

- An automatic review of medical necessity in situations where a minor 14 years of age or above is placed in inpatient treatment without his or her consent.
- Preserving the right of minors 14 years of age or above to obtain medically-necessary outpatient treatment and medication without the consent of their parents and without having to petition the juvenile courts.
- Preserving the right of minors 14 years of age or above to continue to receive any medically-necessary treatment when their parents or guardians wish to cease treatment.
- Limiting parental access to treatment records in situations where there is suspicion or evidence of abuse or neglect of the child, or in situations where information in the treatment record could reasonably be assumed to result in the potential for abuse or neglect.

Respectfully submitted on February 12, 2004.

Hugh Davis, Executive Director
Wisconsin Family Ties
16 N. Carroll St., Ste. 640
Madison, WI 53703

Fax Transmission

Point de Vue Public Relations
629 North 8th Street
Suite 203
Sheboygan, WI 53081-4502
Phone: 920-457-4077
Fax: 920-457-4011

JH spoke to Denise on 4-23-04. Told her about potential work group on issue.

NO. PAGES (counting cover page): 12

1-888-233-1667 • www.wcdefa.org

DATE: 2-15-04

TO: Sen. Roessler

FROM: Denise Payzer

RE: I've attached re WI Senate bill 387 mental illness

Thank you.

Point de Vue
PUBLIC RELATIONS, LLC

February 18, 2004

Dear Sen. Roessler:

Enclosed is a statement I prepared last year based on personal experience and at the request of a professor of behavioral biology at Johns Hopkins University School of Medicine. The statement chronicles barriers I encountered to accessing appropriate treatment for my minor child who had clinical depression and was self medicating that depression with cannabis. My son took his life in September 2000; he was 18 and had just began his senior year of high school.

My husband, son and I moved to Wisconsin from Ohio in 1997 – at the start of my son's high school years. Little did I realize that in moving here that state laws would bar us from helping our only child when he was most in need of our assistance – to help curb an addictive disorder that was masking an underlying depressive disorder that in time claimed his life.

I would like to talk with you, Sen. Roessler, about how this statement and my personal experience might be leveraged to support Senate Bill 387 which I understand you are sponsoring. Please contact me at the numbers below.

For clarification, the person at Johns Hopkins who suggested I write this statement was Jack Henningfield, Ph.D., who is also director of the Robert Wood Johnson Foundation Innovators Awards. Dr. Henningfield convened a roundtable discussion last year with former U.S. Surgeon General C. Everett Koop, MD, and other leaders in the field to address "barriers to treatment for addiction in America." My statement was shared by Dr. Henningfied with Dr. Koop and others as part of that roundtable discussion planning.

I'll look forward to hearing back from you, Sen. Roessler, and lending my efforts to support more just laws within Wisconsin to protect the health and well being of our most valuable resource – our children.

Sincerely,

Denise Pazur

Denise Pazur
W7119 County Road N
Plymouth, WI 53073
Office 920-457-4077
Cell 920-207-8747
Home 920-528-7714
denise.pazur@pdvpr.com

2/5/03

Saving the lives of our children

By finding the right balance in laws governing involuntary drug abuse treatment

Helping our children navigate the tumultuous teen years is perhaps more a challenge today than ever before. Parents face a host of barriers to keeping their teens safe and sound as they move toward adulthood.

These barriers are formidable when a child has a depressive disorder or other mental illness. They are nearly insurmountable when that child self-medicates with drugs or alcohol.

And these barriers can be a very real threat to a youngster's life when they prohibit parents from getting their children the help they desperately need.

I'm writing to (appearing before) you today to ask you to consider the perils of laws in certain states that bar parents from mandating involuntary drug or alcohol treatment for their minor children age 14 and over.

Civil rights protection beyond common sense

These laws are certainly grounded in civil rights protection, yet in reality they block parents' ability to help their children to arrest and conquer addictions that, if left to progress unchecked, can become life-threatening.

I speak from experience. My only child was diagnosed at age 11 with clinical depression with suicidal ideation. Psychotherapy and psych meds stabilized him for a time, but on entering high school, he tried cannabis and alcohol and found they could medicate his depression "his way." My son took his life just after his 18th birthday in September 2000.

There were overt signs of drug use in this formerly 4.0 student. Yet my husband and I were powerless to get our son into treatment because Wisconsin state laws bar parents from forcing treatment for any child age 14 and over.

Watching our son spiral downward as he self-medicated his depression, we sensed that this could lead to his death. Then witnessing just that, and knowing we were powerless to prevent it, in part due to Wisconsin state laws, was truly horrific.

These laws are obviously grounded in civil rights protection, yet I suspect that they contribute in a very real sense to the deaths of many youth who simply don't have the skills or life experience to 1) recognize they have addiction issues; 2) admit this to others; and 3) seek help willingly.

This is hard enough for adults to do, but for teens—with their unique rebelliousness and independence-seeking—it is nearly impossible.

- *more* -

Asking too much of our children

As parents we go to great lengths to protect our children, to safeguard their well-being.

Regular visits to the doctor. Buckling their seat belt. Locking the cabinet that contains cleaning products below the sink.

These and more are acts of love that parents adopt to protect their youngsters from harm. And as parents, we expect that when it comes to preserving and defending our children's health, no one—not even the state or federal government—should stand in our way. Unfortunately this is not the case when it comes to treatment for addictive disorders like drug or alcohol abuse.

Consider for a moment the enormity of what these laws—currently in place in Wisconsin and other states—are asking of our children. These laws are presuming:

FIRST, that a child age 14 or older can recognize that their use of drugs or alcohol poses a danger to their well-being. That their use or abuse is affecting their lives in negative ways. That, as the 12 Steps of Alcoholics Anonymous states, "their life has become unmanageable."

Denial is an inherent part of addictive disorders. It is prevalent in adults who have battled alcoholism or drug addiction for decades. So how can we expect that a child who has lived just 14 or 15 years will have the self-knowledge and understanding to recognize the threat that drugs or alcohol pose? If we expect a child to know this, then I believe we expect too much.

SECOND, that a child age 14 or older will believe that there is help and hope for them. That something or someone outside of themselves can offer assistance. And that this assistance can be beneficial and restore balance and happiness in their lives. In other words, that "a power greater than themselves can restore them to sanity," as the 12 Steps say.

With independence-seeking a central theme in the lives of most teens, it seems unlikely that adolescents will willingly tap external treatment programs—especially those whose thinking is marred by depression and drugs. And if parents suggest treatment, then considering the self-reliant mindset of teens—and their inherent distrust of adults—it is all the more unlikely that adolescents will seek treatment on their own.

Unrealistic expectations

Many people with addictive disorders also are prone to mental ones; they often have a dual diagnosis. This most certainly includes adolescents. It also includes my son.

Steve was a bright and beautiful child who was tested in 1994 for ADD when he was in the 5th grade at Holy Trinity School in Avon, Ohio. Instead of finding an attention deficit disorder, the

school psychologist diagnosed "severe clinical depression with suicidal ideation." Steve was just 11 years old. And as when he had faced other crises in his young life, Steve looked to us, his parents, to help him take charge of this illness and limit its impact on his life.

When Steve entered high school and discovered cannabis, he found that it could offset the debilitating depression he was grappling with. At age 15 and in his freshman year, Steve was forced to face a daunting situation that in time became overwhelming and finally fatal. He faced:

1) A mind marred by depression and terrifying thoughts of suicide as a way to end the pain
2) A mind further clouded by cannabis—a depressant and his way to self-medicate
3) The potential interaction of the cannabis and psychiatric drugs he was willing to take for a brief time

How in the world can we expect a person—especially a youngster—in this debilitated state of mental duress to make sound judgements for themselves, including judgements re their own need for treatment?

The answer, I believe, is that we cannot.

We can't ask more of our children than they are able to give. And I would venture to say that many teens are unable to willingly give themselves over to treatment for addiction.

I believe that children age 14 and over have undeveloped tools to adequately and effectively address their own addictive and mental disorders. They have insufficient life experience, self-knowledge, understanding of drugs and acceptance of their consequences, awareness of their own dependence or addiction, and lack of awareness or understanding of a depressive illness if one is present.

The expectations we have of what these children can handle is well beyond reality for most of them, I suspect, especially for those grappling with life-threatening mental illness that is exacerbated by addiction.

The results of our unrealistic expectations of our children?

1) They are left to solve their own problems related to addiction without the benefit of a parental safety net to buoy them.
2) To cope with this daunting responsibility, they may self-medicate even more to offset their mood and illness that may continue to decline if unchecked.
3) The overall situation deteriorates—at home, in school, with friends and parents, with employers. Relationships—many that can be a source of strength in a crisis—are undermined. Situations continue to decline until they are beyond repair—making suicide appear to be the only way out for many teens.

In summary

Most certainly we agree that drug or alcohol abuse and addiction need to be arrested, and at early stage. The earlier the better.

But willing compliance on the part of a teen—especially to adult directives—is tough. Teens are having too much fun. They believe they "can handle it." They believe that their behaviors aren't addictive. They are mirroring the behaviors of friends their age.

And if teens know that their parents are powerless to force drug treatment, this may only make them more resolute in doing things "their own way."

Kay Redfield Jamison, Ph.D., the noted author of An Unquiet Mind, a book that chronicles her struggles with manic-depressive illness, noted:

"At almost every talk I gave, somebody would come up to me with a photograph of a kid who had committed suicide. The devastation was unbearable, all of that unnecessary pain and suffering. It just broke my heart."

I appeal to you to take Dr. Jamison's words to heart. To recognize that minor children with addictive disorders should not be expected to act on their own behalf to seek treatment. That giving parents in all 50 states the power to mandate involuntary drug and alcohol treatment for their children can indeed save lives. And that without that parental power in place, our children—our future—are left to their own often inadequate and childlike devices to cope with the very adult problems that beset them.

Thank you for your kind consideration.

Sincerely,

Denise Pazur

W7119 County Road N
Plymouth, WI 53073
920-528-7714 home
920-451-9880 work
920-207-8747 cell
bpazur@excel.net
dmp@jacobclark.com

Koop to Lead Discussion of Substance Abuse Issues
U.S. Newswire
10 Feb 10:00

Dr. C. Everett Koop to Lead Provocative Discussion of Nation's Most Pressing Substance Abuse Science and Policy Issues
To: Assignment Desk, Daybooks
Contact: Dennis Tartaglia, Hooshna Amaria or Robyn Finker
212-481-7000

News Advisory:

Former Surgeon General C. Everett Koop, MD, ScD will address shortcomings of the nation's current approaches to substance abuse and addiction during a provocative speech at the National Press Club, Feb. 12, to leading scientists, journalists, policy-makers, advocates, and substance abuse treatment professionals. Substance abuse remains the nation's number one public health problem, responsible for one in four deaths in the U.S. The address will also be webcast and archived at http://www.rwjf.org.

The speech will kick off a roundtable discussion of innovation in substance abuse treatment and prevention featuring some of the field's leaders, such as the scientist whose groundbreaking findings led to restrictions on the availability of alcohol to minors and the psychologist who cocreated a framework for behavior change that enables many more individuals with addictions to be treated more successfully.

The morning program is sponsored by The Robert Wood Johnson Foundation's Innovators Program at The Johns Hopkins School of Medicine. Risa Lavizzo-Mourey, MD, President and CEO, The Robert Wood Johnson Foundation will be on hand to welcome participants, as will J. Raymond DePaulo, Jr., MD, Director, Department of Psychiatry and Behavioral Sciences, The Johns Hopkins University School of Medicine.

"This complex public health problem cannot be solved by simplistic so-called solutions, embodied in catch phrases such as 'legalization' and 'medicalization,'" says Dr. Koop, who is currently Senior Scholar at the Koop Institute at Dartmouth College, New Hampshire. "Our nation's philosophy and policy should be as finely tuned to providing treatment as it is to interdicting drug runners. And we must stop fighting the addicted and start fighting the disease of addiction and its purveyors, be they distributors of cocaine or executives of Big Tobacco."

Prior to Dr. Koop's speech at 9 a.m., participants in the addiction roundtable will have the opportunity to meet some of the field's leaders during "Breakfast with the Innovators" at 8:15 a.m. These include Jack E. Henningfield, PhD, the program's host and newly appointed director of the Innovators program. Dr. Henningfield is Adjunct Professor of Behavioral Biology in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins. His leading edge research and policy innovations helped lay the foundation for recognition of nicotine as an addictive drug.

"We wanted to bring together decision makers in the field with varying viewpoints, representing federal agencies, Congress, academia, and the research and treatment communities, among others," says Dr. Henningfield. "Dr. Koop's discussion of the challenges and opportunities to the field will focus our ensuing panel discussion and the participation of all involved. We hope this will trigger an ongoing dialogue among all concerned on how to best address this public health challenge."

The panel discussion will address such questions as: Did raising the drinking age really make a difference? Shouldn't we tell all children to "just say no?" Why focus on youth smoking in inner cities beset by AIDS and addiction to illegal drugs? Should drug-addicted pregnant women be jailed or treated for their abuse?

How do we bring drug abuse treatment into communities that have neither the resources nor the tolerance for a treatment center? Shouldn't addicts be forced into treatment, rather than tailoring treatment to their stage of readiness? Moderated by Dr. Henningfield, the panel discussion will include the following participants:

-- Joseph V. Brady, PhD, Professor of Behavioral Biology, Department of Psychiatry and Behavioral Sciences & Professor of Neuroscience, The Johns Hopkins University School of Medicine. Over his four decades of research, Dr. Brady has led innovations in the understanding of how drugs cause abuse and addiction. He recently pioneered a nationally acclaimed mobile drug treatment unit to bring drug addiction treatment and counseling into underserved areas of Baltimore.

-- Carlo C. DiClemente, PhD, Professor and Chair, Department of Psychology, University of Maryland, Baltimore County. Dr. DiClemente is cocreator of the Transtheoretical Model of Change, a model that identifies stages of change and other factors that predict treatment outcomes and allows many more people to enter treatment programs at earlier stages of readiness.

-- Sandra Headen, PhD, Research, Program Implementation and Evaluation Consultant, The Paragon Foundation and North Carolina Tobacco Prevention and Control Branch. Dr. Headen's trailblazing work in research, community advocacy and health promotion in low income communities of color has provided valuable information on how race, gender and other factors influence teens' motivations to smoke or not to smoke.

-- Ralph Hingson, Sc.D, Professor, Department of Social and Behavioral Sciences and Associate Dean for Research, Boston University School of Public Health. Dr. Hingson's landmark research has supported laws that make it illegal for persons under 21 to drive after drinking, lowering the allowable blood alcohol concentration for adult drivers to .08 percent and setting even lower limits for drivers convicted of operating a motor vehicle under the influence. These laws have led to hundreds of lives saved each year.

-- Hendree Jones, PhD, Director, Center for Addiction and Pregnancy, Assistant Professor of Psychiatry, The Johns Hopkins University School of Medicine. Dr. Jones directs the clinical research program at the Johns Hopkins Center for Addiction and Pregnancy, which is among the nation's foremost programs offering intensive comprehensive intervention with wrap-around services for pregnant women with addictions, leading to improved health of the mother and infant and helping to break cross-generational patterns of addiction.

Drs. DiClemente, Headen, Henningfield and Hingson are recipients of the Innovators award.

Immediately following the panel discussion there will be a viewing of the American Visionary Art Museum's (Baltimore) exhibit "High on Life: Transcending Addiction" and conversations with artists Ray Materson and Linda St. John, and museum founder and director, Rebecca Hoffberger.

Innovators Combating Substance Abuse is a national program of The Robert Wood Johnson Foundation that recognizes and rewards those who have made substantial, innovative contributions of national significance in the field of substance abuse and drug addiction. Each award includes a grant of $300,000, which is used to conduct a project over a period of up to three years that advances the field. The program addresses problems related to alcohol, tobacco and illicit drugs through education, advocacy, treatment, and policy research and reform at the national, state, and local levels. Founded in 2000 by the late John Slade, MD at the University of Medicine and Dentistry of New Jersey (UMDNJ)

School of Public Health, the Innovators national program office relocated to The Johns Hopkins University School of Medicine in December 2002. Jack E. Henningfield, PhD, a 2000 Innovator awardee and Adjunct Professor of Behavioral Biology in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins, was appointed national program director.

The Robert Wood Johnson Foundation, based in Princeton, N.J., is the nation's largest philanthropy devoted exclusively to health and health care. It concentrates its grantmaking in four goal areas: to assure that all Americans have access to quality health care at reasonable cost; to improve the quality of care and support for people with chronic health conditions; to promote healthy communities and lifestyles; and to reduce the personal, social and economic harm caused by substance abuse -- tobacco, alcohol and illicit drugs.

Johns Hopkins is one of the world's premier centers for scholarship, research and patient care. The University and The Johns Hopkins Hospital and Health System are separate, but closely allied, institutions. Founded in Baltimore, they now reach across the Baltimore-Washington area, with additional facilities in China, Italy and Singapore and partnerships around the world. The university comprises eight schools, a research and development division called the Applied Physics Laboratory and a number of institutes and centers.

The Johns Hopkins Hospital and Health System comprises three hospitals, as well as other elements of an integrated system, from a community physicians group to home care. Johns Hopkins Medicine, established in 1995 to unite Hopkins' biomedical research, clinical, teaching and business enterprises, brings together The Johns Hopkins University School of Medicine and its faculty with the facilities and programs of The Johns Hopkins Hospital and Health System. The $2.7 billion enterprise is one of the largest employers in Maryland. Its components consistently are named at the top of national rankings for best hospital and best school of medicine, and its faculty consistently win the largest share of NIH research funds. Results of this research continue to advance efforts to diagnose, treat and prevent many diseases.

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News

Feb. 12, 2003

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PR Newswire

Dr. C. Everett Koop Says Nation's Leaders Must Re-Think Public Policy on Substance Abuse

PRINCETON, N.J., and WASHINGTON, Feb. 12 /PRNewswire/ --

PRINCETON, N.J., and WASHINGTON, Feb. 12 /PRNewswire/ -- Former Surgeon General C. Everett Koop, MD, ScD believes the problem of substance abuse "cannot be solved by simplistic solutions" and that "our nation's philosophy should be as finely tuned to getting treatment as the system is for interdicting drug runners," according to an address given at the National Press Club this morning to an audience of leading scientists, journalists, policy-makers, advocates, and substance abuse treatment professionals. The speech was part of a roundtable discussion on innovations in substance abuse treatment and prevention, sponsored by The Robert Wood Johnson Foundation's Innovators Combating Substance Abuse Program at The Johns Hopkins School of Medicine. Substance abuse remains the nation's number one public health problem, responsible for one in four deaths.

Full text and an archived webcast of Dr. Koop's speech can be found at: http://www.rwjf.org/

Dr. Koop, who currently serves as Senior Scholar at the Koop Institute at Dartmouth College, made the following points regarding how public policy toward addiction should be re-evaluated:

* The "Drug Czar" should consider the damage done by tobacco and alcohol, not only illicit drugs, and look at how control of these might be integrated into a fully coordinated strategy of control of abuse and addiction of all psychoactive drugs. * The treatment of addiction should become a comprehensive and coordinated goal of the U.S. Public Health Service in full coordination and on an equal footing with the Drug Enforcement Administration. * Drugs for the treatment of addiction should be fast-tracked by the U.S. Food and Drug Administration (FDA) using the same procedures used to get HIV treatments more rapidly into life-saving use. * Addiction cannot be treated as a public health threat like smallpox; it is more like AIDS/HIV, because the forces that cause the spread of the problem are many and diverse and obstacles to appropriate action are caused more by indifference and prejudice than by the disease process itself. * Enforcement agencies should maintain an appropriate and

flexible attitude toward drugs used in palliative treatment of pain (i.e., opiates) and other disorders, so that critically ill patients do not suffer. Overly restricting medications could unfairly hinder access for people in chronic pain, while drug abusers would continue to find ready supplies of other mood-altering drugs.

The speech launched a roundtable discussion of innovation in substance abuse treatment and prevention featuring some of the field's leaders and sponsored by the Innovators program. Risa Lavizzo-Mourey, MD, MBA, President and CEO, The Robert Wood Johnson Foundation and J. Raymond DePaulo, Jr., MD, Director, Department of Psychiatry and Behavioral Sciences, The Johns Hopkins University School of Medicine kicked off the program. The program was hosted by Jack E. Henningfield, PhD, newly appointed director of the Innovators program. Dr. Henningfield is Adjunct Professor of Behavioral Biology in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins. His leading edge research and policy innovations helped lay the foundation for recognition of nicotine as an addictive drug.

Panelists included: Joseph V. Brady, PhD, Professor of Behavioral Biology, Department of Psychiatry and Behavioral Sciences & Professor of Neuroscience, The Johns Hopkins University School of Medicine; Carlo C. DiClemente, PhD, Professor and Chair, Department of Psychology, University of Maryland, Baltimore County; Sandra Headen, PhD, Research, Program Implementation and Evaluation Consultant, The Paragon Foundation and North Carolina Tobacco Prevention and Control Branch; Ralph Hingson, ScD, Professor, Department of Social and Behavioral Sciences and Associate Dean for Research, Boston University School of Public Health; and Hendree Jones, PhD, Director, Center for Addiction and Pregnancy, Assistant Professor of Psychiatry, The Johns Hopkins University School of Medicine. Drs. DiClemente, Headen, Henningfield and Hingson are recipients of the Innovators award.

Founded in 2000, Innovators Combating Substance Abuse is a national program of The Robert Wood Johnson Foundation that recognizes and rewards those who have made substantial, innovative contributions of national significance in the field of substance abuse and drug addiction. Each award includes a grant of $300,000, which is used to conduct a project over a period of up to three years that advances the field. The program addresses problems related to alcohol, tobacco and illicit drugs through education, advocacy, treatment, and policy research and reform at the national, state, and local levels. The late John Slade, MD at the University of Medicine and Dentistry of New Jersey (UMDNJ) School of Public Health was its first Program Director. In December 2002 the Innovators national program office relocated to The Johns Hopkins University School of Medicine. Jack E. Henningfield, PhD, a 2000 Innovator awardee and Adjunct Professor of Behavioral Biology in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins, was appointed national program director.

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Robert Wood Johnson Foundation

CONTACT: Dennis Tartaglia, or Hooshna Amaria, or Robyn Finke, +1-212-481-7000, cell: +1-732-221-3433, all of M Booth & Associates

Halbur, Jennifer

From: Asbjornson, Karen
Sent: Friday, February 20, 2004 4:48 PM
To: Halbur, Jennifer
Subject: FW: senate bill 387

CR email

Karen Asbjornson
Office of Senator Carol Roessler
(608) 266-5300/1-888-736-8720
Karen.Asbjornson@legis.state.wi.us

SB 387

-----Original Message-----
From: Bev Taylor [mailto:bevtn@yahoo.com]
Sent: Friday, February 20, 2004 2:56 PM
To: sen.roessler@legis.state.wi.us
Cc: Bevtn@yahoo.com
Subject: senate bill 387

Senator Roessler, it was a pleasure talking to you this week. I promised to send you names of people I've dealt with on doing my story concerning the infamous law on mental health treatment and 14 year olds. Here they are:
Psychotherapist Dr. Doug Meske 262-646-3788
Tough Love Support Group- Stacey Slotty 262-542-6203
Tough Love Support Group- Carl Henderson 262-780-9919
Aurora Psychiatric Hospital Medical Dir. 262-691-1574

All of these people are encouraged by your bill.
My story airs Monday in the 9p.m. newscast.

Beverly Taylor
Fox 6 News

Halbur, Jennifer

From: Asbjornson, Karen
Sent: Friday, February 20, 2004 5:05 PM
To: Halbur, Jennifer
Subject: FW: senate bill 387

CR email

Karen Asbjornson
Office of Senator Carol Roessler
(608) 266-5300/1-888-736-8720
Karen.Asbjornson@legis.state.wi.us

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From: Bev Taylor [mailto:bevtn@yahoo.com]
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Subject: senate bill 387

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Aurora Psychiatric Hospital Medical Dir. 262-691-1574

All of these people are encouraged by your bill. My story airs Monday in the 9p.m. newscast.

Beverly Taylor
Fox 6 News

SB387

Halbur, Jennifer

From: Edward Fuenmayor [edynkat@sbcglobal.net]
Sent: Monday, February 23, 2004 9:27 PM
To: Sen.Roessler@legis.state.wi.us
Subject: Senate Bill 387

Please help pass Senate Bill 387

Kathy Fuenmayor
5701 W Warnimont Ave
Milwaukee WI 53220

SB 387

Halbur, Jennifer

From: Ginny Bronesky Stuesser [ginbro@sbcglobal.net]
Sent: Monday, February 23, 2004 9:29 PM
To: sen.roessler@legis.state.wi.us
Subject: Mental health bill (387)

Dear Senator Roessler:

I am the parent of a 17 year old with severe mental illness.

He was hospitalized for the first time at age 11, when he said voices were telling him to kill a child at his school whom he barely knew. He cycled in and out of hospitalizations until I filed a CHIPS at age 14. Right now, he is in a specialized treatment center for deaf children experiencing severe emotional disturbance. It took every bit of legal help and advocacy for me to keep him there. At one time, I testified in front of the board of Waukesha Health and Human Services that he felt compelled to kill his gym class, because voices said "they were ugly."

Senator, my son is schizoaffective and deaf. The voices have never completely left him. He only speaks about 3 subjects or so, has the communication skills of a six year old, and very little judgment. Yet he has the full rights of an 18 year old. I doubt if he knows the name of the president of the United States.

Why must us parents be forced to call the police and testify in court against our children to get their most basic mental health needs met?

As a well educated woman raised to "take care of your own," I resisted drastic action. In the meantime, I dealt with a violent household, a loss of career for me, the breakup of my marriage, and imminent danger for my daughter, who is five years younger. At one time, we were counseled to provide her a personal alarm (at age six) and to "lock our knife drawer."

Please put some teeth back in these laws. Private insurance only will allow a psychotic child who is a threat to others stay in a hospital for 5-7 days. At one point when my son said he needed to "kill his favorite nurse because the voices told him so" he was discharged by our mental health provider the next day.

I love my son. He's a good boy, innocent, but needs 24/7 supervision. Let him get the treatment he needs. It beats the alternative--incarceration or homelessness as he grows.

Help us.

Ginny Bronesky Stuesser
109 Harrogate Drive
Waukesha, WI 53188
p/office: 414.225.0011

p/home: 262.524.2430