S. HRG. 113–690

EXAMINING MENTAL HEALTH: TREATMENT OPTIONS AND TRENDS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING MENTAL HEALTH, FOCUSING ON TREATMENT OPTIONS AND TRENDS

FEBRUARY 25, 2014

Printed for the use of the Committee on Health, Education, Labor, and Pensions

Available via the World Wide Web: http://www.gpo.gov/fdsys/

U.S. GOVERNMENT PUBLISHING OFFICE
86–957 PDF WASHINGTON : 2015

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C O N T E N T S

STATEMENTS

TUESDAY, FEBRUARY 25, 2014

EXAMINING MENTAL HEALTH: TREATMENT OPTIONS AND TRENDS

TUESDAY, FEBRUARY 25, 2014

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:04 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Tom Harkin, chairman of the committee, presiding.

Present: Senators Harkin, Alexander, and Baldwin.

OPENING STATEMENT OF SENATOR HARKIN

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will come to order. Today our committee will examine treatment options and trends for mental health conditions. We held a successful hearing on mental health issues last year, and I'm pleased to have the opportunity to continue the dialog on this important topic with my colleagues and our panel of expert witnesses.

Mental health is an issue that I care deeply about, and I believe we must do everything possible to ensure that individuals with mental illness get the services they need and deserve. I am proud to have championed the Mental Health Parity Act along with Pete Domenici and Paul Wellstone to end the absurd practice of treating mental and physical illness as two different things under health insurance.

We also made a significant step forward in coverage by requiring treatment of mental health and substance abuse disorders as 1 of the 10 essential health benefits under the Affordable Care Act.

Mental health problems often begin at a young age and can last throughout one's life. In fact, half of all mental illnesses manifest by age 14, and three-quarters appear by age 24. This creates a special urgency to make sure that children and adolescents get appropriate treatment for mental health conditions, a challenge that our expert witnesses will address today.

For many children, adolescents, and adults, finding the right mental health treatments can make a profound difference. We know that for some individuals, treatment may entail psychotropic medication, behavioral interventions, community supports, or some combination of all of these. There is, as I am aware, no one-size-fits-all treatment, which is why I have long been an advocate for patient-driven care that is individualized and takes many factors into consideration.

As I noted, there are many individuals who need medication to help manage their symptoms. Yet I am concerned about data pointing to disturbing new trends which we will learn more about today. For example, we are seeing significant increases in the prescribing of psychotropic medications, while the use of behavioral and psychological treatments among children and youth has increased only slightly and has actually decreased among adults.

The use of psychotropic drugs by adult Americans increased 22 percent from 2001 to 2010, with one in five adults now taking at least one psychotropic medication. Another study demonstrates that the use of antipsychotic medications has increased eightfold among children, fivefold among adolescents, and doubled among adults between 1993 and 2009.

This rapid growth of psychotropic drug use has alarmed some mental health professionals. I'd like to better understand why this is happening and what we can do to make sure people are getting the right treatments. I didn't say the right drugs. I said the right treatments.

Today we'll hear from a panel of expert witnesses who will discuss mental health treatment options and best practices from a variety of perspectives. I know there are no easy answers or quick fixes to addressing mental health treatment challenges. So I'm looking forward to learning more from our witnesses today.

I thank you all for being here, and I look forward to your testimony.

With that, I'll turn to Senator Alexander.

OPENING STATEMENT OF SENATOR ALEXANDER

Senator ALEXANDER. Thanks, Mr. Chairman. Thanks for the hearing and thanks for working with us to come up with such a distinguished group of witnesses. We're looking forward to learning from them. I agree with what Senator Harkin said. I'm especially interested in learning all I can about whether children in our country are getting accurate diagnoses and appropriate prescriptions, especially for conditions like ADHD.

I'm sure that older Americans like me read the statistics about the growing number of children who are diagnosed with ADHD with some alarm. We wonder if this is true, that one out of five boys have this diagnosis. Is this true about the doubling of the condition? What are the causes? Are there external factors?

There's much speculation about whether conditions in a school might lead to these diagnoses and prescriptions, whether it's the fact that more money might follow a child if a child is in special education, or whether increased testing forces teachers to put pressure on children who then have more difficulty focusing their attention.

I don't know the answers to those. But in our society, the larger number of children who are diagnosed with attention deficit hyperactivity disorders and who are deemed to have an unusual amount of difficulty focusing their attention—that's something that needs some explanation.

As part of the larger question that Senator Harkin has raised with this hearing about mental health and over-diagnosis, overmedication, and over-involvement, sometimes we hear the alarm on

one side, and then the other side comes from the professionals that say, "Don't get too alarmed. You're overreacting." So maybe you can help us put a proper balance into what we should be doing.

One of the things that the Federal Government does most effectively to enable individuals in this big complex society of ours to look toward the future is research. We're not such good managers. Sometimes we're not even good regulators. But the research that we've funded and encouraged has enabled enormous breakthroughs in the country. So we'd like your advice about research.

And if you have suggestions about the new rule, for example, from the Center for Medicare and Medicaid Services that would limit access to antidepressants, antipsychotics, and immunosuppressants for individuals in the Medicare Part D program, I'd like to know your thoughts about that. The rule, as far as I can tell, has been criticized by nearly everyone who has read it.

But, basically, we're looking forward to some illumination and some discussion about trends in research. I think my goal would be to hope that as a result of this, as a country, we can come closer to the right diagnosis, the right treatment, the right person, and the right setting.

Thank you very much for being here. I look forward to your testimony.

The CHAIRMAN. Thank you very much, Senator Alexander.

Senator ALEXANDER. I'd be happy to introduce Dr. William Cooper. I'm always glad to introduce somebody from Vanderbilt University, such a distinguished university, and the School of Medicine. He is the Cornelius Vanderbilt professor of pediatrics and health policy and associate dean for faculty affairs at the Vanderbilt University School of Medicine. He is a practicing pediatrician, researcher, educator, and administrator. He has focused his research on medication safety for children, as well as prescribing habits.

Dr. Cooper, we're delighted you're here today.

The CHAIRMAN. Our next panelist is Mr. Benjamin Fernandez, a school psychologist with the Loudoun County Public School System in Virginia. Mr. Fernandez has been practicing in the field of school psychology for almost 18 years. He is a recognized leader, was named School Psychologist of the Year in 2010 by the Virginia Academy of School Psychologists, and in 2012 by the National Association of School Psychologists.

Thank you for being here, Mr. Fernandez.

Next is Mr. John Arch, the executive vice president of Health Care and director of Boys Town National Research Hospital and Clinics in Omaha, NE. Boys Town provides a range of treatment for the behavioral, emotional, and physical needs of vulnerable youth. He is here to tell us more about Boys Town's unique model of psychosocial care and careful management of psychotropic drugs among his patients.

We thank you for being here.

Our final witness is Ms. Tiffany Martinez, who is a graduate student at the University of Southern Maine studying to become a family psychiatric nurse practitioner. Ms. Martinez was involved with the Portland Identification and Early Referral program, which provides assessment and treatment for young people who are show-

ing the early signs of mental illness. She is here to share her first-hand experiences with treatment.

Thank you, Ms. Martinez, for being willing to speak to us today about something that is so personal.

We thank you all for being here. I read all of your testimonies last night. They're very compelling. They'll be made a part of the record in their entirety. We'd like to ask, starting with Dr. Cooper, if you could perhaps give us a summary of 5 minutes or so. Then we'll go down the line and afterwards we'll open it for questions.

Dr. Cooper, welcome and please proceed.

STATEMENT OF WILLIAM O. COOPER, M.D., M.P.H., PROFESSOR OF PEDIATRICS, VANDERBILT UNIVERSITY MEDICAL SCHOOL, NASHVILLE, TN

Dr. COOPER. Thank you. Chairman Harkin and Ranking Member Alexander, it's a privilege to be here to speak with you today about mental health disorders in children and ways in which we might ensure that all children are treated in the most appropriate manner.

I'd like to start with a story about a patient that I took care of in the Vanderbilt Pediatric Primary Care Clinic. In late 2002, a 9-year-old boy was referred to our pediatric clinic from a rural community several miles from Nashville for evaluation of rapid weight gain. I noted that he had been placed on a powerful antipsychotic medication, one that is known to cause weight gain.

The child had no history, however, of serious mental illness, but had a long history of disruptive behavior and was at risk for being expelled from school. The family was unable to find transportation to the nearest mental health facility and were told that this medication was his last chance.

Treating mental health disorders can be challenging and requires a careful approach to diagnosis and management. Each child is unique and will respond to medications in their own way. Given the fact that 50 percent to 75 percent of the care for children with mental health disorders occurs in primary care settings, it's critical that consultation and communication between primary care professionals and mental health professionals be optimized.

Guided by our clinical observations in this child and other children like him and a review of existing surveillance data, our research group has performed several studies assessing trends in antipsychotic medication use in children and the potential risk for adverse outcomes from medication used to treat attention deficit hyperactivity disorder, ADHD.

Antipsychotics are a class of medications that have been shown to reduce symptoms of serious mental disorders such as schizophrenia, autism, and severe bipolar disorder. Their efficacy in treating other conditions, however, is just not known. In addition, we don't know whether or not they actually may be harmful to children. So it's important to understand more about this.

In one study in Tennessee Medicaid and another study using a national data set, we identified a fivefold increase in the use of antipsychotics in children. Furthermore, more than half of these children were being placed on these medications for ADHD and

other behavioral disorders for which we don't know whether these medications work.

In October 2013, our group published a study using 43,000 children in Tennessee Medicaid. We compared children who are on antipsychotic medication with children who are on comparable medications in terms of their risk for Type 2 diabetes. We found that children who were using antipsychotics were three times more likely to develop Type 2 diabetes than the similar children placed on other medications. We also found that children that were on higher doses of the antipsychotics and had been on the medications for longer periods of time were at even greater risk for this important complication.

Our research group has also performed several studies assessing the potential risk of medications used to treat ADHD. Stimulant medications have been used to treat ADHD for over 40 years and have had a relatively benign safety profile. However, in 2004, reports of adverse events from Canada and the United States that included cases of sudden cardiac death, heart attacks, and strokes in children taking these medications raised serious concerns about their safety.

We studied the cardiovascular safety of ADHD medications in 1.2 million children and young adults from all regions of the country and found no evidence of a significant increase in risk for serious cardiovascular outcomes in children. A separate study that we conducted in adults also found no increase in risk.

The data on ADHD drug safety highlights the need to educate patients, families, and health care professionals, as well as educators, about the appropriate diagnosis and management of ADHD. While our results about the adverse effects of these stimulant medications were reassuring, ongoing surveillance is needed for these and all other drugs.

What are the challenges we face? As we discussed in introductory comments, are we over-diagnosing these children with mental health disorders? We have excellent tools to make these diagnoses, and we must use these to diagnose individual children. It's critical that health care professionals receive training in the appropriate diagnosis and management, and partnerships between primary care providers and mental health professionals must be utilized to optimize the best diagnosis.

Are we giving children the right medication? Are we giving children too many medications? We need to ensure that children who really need antipsychotics and other medications get them. That's a really critical part of this. But there's little reason to believe that the incidence of these disorders justifies a fivefold or eightfold increase in prescriptions for these drugs that has occurred in recent years.

We need to ensure that children that have a need for mental health services have them available. This is particularly important for vulnerable children and children in States with rural populations where access can present a huge barrier to families. We must work to improve research into the diagnosis and surveillance about drug safety in these children so we can ensure that children are not suffering adverse effects from the treatments intended to help them.

So in reflecting back on that 9-year-old boy and the antipsychotics I've encountered in my 23 years as a pediatrician, several thoughts come to mind. First, medications used to treat these disorders are not magic pills. Children and adolescents with serious mental health disorders may benefit greatly from medications, but it's important to weigh their risks and benefits in the context of a comprehensive treatment plan. Taking time to consider the right diagnosis and treatment is time consuming, but it's essential to ensure that this happens.

In the future, it's possible that there may be other ways to identify individuals who may respond differently to different treatments. But in the meantime, we must address these children one child and one family at a time. We also need to expand our understanding of the best ways to diagnose and treat these children so that the 9-year-old boy who was in my clinic and children just like him can function and reduce the distress and suffering of mental health conditions.

Thank you for the opportunity to speak with you today, and I look forward to the testimony of my fellow panelists and answering your questions.

[The prepared statement of Dr. Cooper follows:]

PREPARED STATEMENT OF WILLIAM COOPER, M.D., M.P.H.

SUMMARY

In late 2002, a 9-year-old boy was referred to our clinic from a rural town several miles from Nashville for evaluation of rapid weight gain. I noted that he had been placed on a powerful antipsychotic medication, one that is known to cause weight gain. The child had no history of serious mental illness, but had a long history of disruptive behavior and was at risk for being expelled from school. The family was unable to find transportation to the nearest mental health facility and were told that this medication was his last chance.

Treating mental health disorders can be challenging and requires a careful approach to diagnosis and management as each child is unique and will respond to treatments in his or her own way. Given the fact that 50–75 percent of the care for children with mental health disorders occurs in primary care settings, it is critical that consultation and communication between primary care professionals and experts in mental health be enhanced.

Guided by our clinical observations and review of existing surveillance data, our research group has performed several studies assessing trends in antipsychotic medication use in children and the potential risk for adverse outcomes from medications used to treat attention deficit hyperactivity disorder, ADHD. In one study in Tennessee Medicaid and another studying children from a national data set, we identified a 5-fold increase in the use of antipsychotics in children. Furthermore, more than half of these children were placed on the antipsychotic for ADHD and behavioral disorders for which these drugs have not been studied. In October 2013, our group published a study drawn from 43,000 children in Tennessee Medicaid in which we compared the risk for type 2 diabetes in children who were recently placed on antipsychotics to comparable children treated with other psychotropic medications. We found that children who were using antipsychotics were three times more likely to develop type 2 diabetes than children on other medications.

Our research group has also performed studies assessing potential risks of medications used to treat ADHD. Stimulant medications have been used to treat ADHD for over 40 years and until recently have had a reputation for relative safety. In 2004, reports of adverse events from Canada and the United States that included cases of sudden cardiac death, heart attacks and strokes in children taking medications for ADHD raised serious concerns about their safety. We studied the cardiovascular safety of ADHD drugs in 1.2 million children and young adults from all regions of the country and found no evidence of a significant increase in risk for serious cardiovascular outcomes in children. A separate study that we conducted in adults also found no increase in risk. The data on ADHD drug safety highlight the need to educate patients, families, health care professionals, and teachers about the

appropriate diagnosis and management of ADHD. While our results about the adverse effects of stimulant medication are reassuring, ongoing surveillance is needed for these and all other drugs.

WHAT ARE OUR CHALLENGES?

- Are we over-diagnosing children with mental health disorders? We must use the excellent tools currently available to diagnose the individual child. It is critical that health care professionals receive training in the diagnosis and management of mental health disorders. Partnerships between primary care clinicians and mental health professionals must be utilized to optimize the best diagnosis.
- Are we giving children the right medication? We need to ensure that children who really need antipsychotics get them, but there is little reason to believe that the incidence of these disorders justifies the fivefold increase in prescriptions for these drugs that has occurred in recent years.
- We need to ensure that children with a need for mental health services have them available. This is particularly important in States with rural populations, where access can present a huge barrier.
- We must work to improve the diagnosis and management of these children with thoughtful research and surveillance to ensure that children who are treated go on to live healthy lives without adverse consequences.

Chairman Harkin, Ranking Member Alexander, and members of the committee, my name is William Cooper. I provide general pediatric care for underserved children in the primary care clinic at the Monroe Carell Jr. Children's Hospital at Vanderbilt and direct a research program in epidemiology, conducting population-based studies of medication use in children and assessing adverse effects of certain medications, including many of the medications used to treat mental health disorders. I consider it a tremendous privilege to speak with you today about mental health disorders in children and ways in which we might ensure that all children are treated in the most appropriate manner.

A 9-YEAR-OLD BOY ON ANTIPSYCHOTICS

In late 2002, a 9-year-old boy was referred to our clinic from a rural town several miles from Nashville for evaluation of rapid weight gain. I noted that he had been placed on a powerful antipsychotic medication, one that is known to cause weight gain. The child had no history of serious mental illness, so I spoke with the family to gain a greater understanding of why he was taking this medication and found that he had been placed on the medication by the primary care provider in his rural community. The child had had a long history of disruptive behavior and was at risk for being expelled from school. The family was unable to find transportation to the nearest mental health facility and were told that this medication was his last chance. This story and several like it led our team to pursue a series of studies to further understand how commonly these medications were being prescribed to children and whether or not there were risks to their widespread use in children.

EPIDEMIOLOGY OF MENTAL HEALTH DISORDERS IN CHILDREN

To place our conversation in context, I'd like to share some information with the committee about mental health disorders in children. Nearly 1 in 10 children are affected by a mental health disorder, including attention deficit hyperactivity disorder (ADHD), depression, anxiety, and other mental health disorders.[1] Symptoms of mental health disorders usually begin in childhood, but some do not begin to develop until the teenage years. In my pediatric practice, I have seen firsthand the devastating effects of mental illness on children and their families, particularly for our most vulnerable children, including those who live in poverty and those in the child welfare system.

In recent years, we have seen a tremendous increase in the numbers of children diagnosed with mental health disorders.[1 2] Whether this is a result of increased awareness, improved diagnosis, or other factors is not clearly understood. While we must acknowledge that a part of the increase could be due to over-diagnosis, there is no disputing the fact that a large number of children and their families suffer significantly because of mental illness. Furthermore, given the fact that suicide is the second leading cause of death in 12–17-year-old children,[1] tragic consequences of childhood mental health disorders highlight our sense of urgency in addressing this important problem.

TREATMENT OF MENTAL HEALTH DISORDERS IN CHILDREN

In recent years, there has been a lot of progress in identifying treatment options for children with mental health disorders. Early diagnosis and treatment of children is critical to reduce suffering and the likelihood that the disorder will persist into adulthood.[1] Important advances in the diagnosis and treatment of these children include evidence-based guidelines for appropriate diagnosis and greater understanding of treatments for certain disorders.

Treating mental health disorders can be challenging and requires a careful approach to diagnosis and management. Each child is unique and will respond to treatments in his or her own way. We have come to recognize that 50–75 percent of the care for children with mental health disorders occurs in primary care settings,[2] making it critical that consultation and communication between primary care professionals and experts in mental health be enhanced. In our practice, we routinely engage our mental health colleagues in diagnosis and management of patients in a collaborative model.

Despite guidelines, much of the health care in children occurs in a manner inconsistent with optimal practice, including use of medications for diagnoses for which there is little evidence of benefit, use of multiple medications at the same time (a problem illustrated in particularly vulnerable children such as children in foster care, where a recent study demonstrated multiple psychiatric medications in up to 75 percent of children being treated),[3] and use of medications alone without proven psychotherapies.

These deficiencies likely result from several factors on the system, provider, and family levels. Many clinicians may be unaware of current guidelines and may practice in a way inconsistent with best practice.[4] In some settings, there may be inadequate mental health resources to provide best treatments and few, if any professionals with training in providing mental health care to children. For some families, access to mental health care may be hampered by cost or physical barriers such as long travel distances. Furthermore, stigma associated with mental illness may reduce families' willingness to acknowledge a mental health disorder and seek treatment in the first place.[1]

RESEARCH INTO MEDICATION USE AND SAFETY

Guided by our clinical observations and review of existing surveillance data, our research group has performed several studies assessing trends in antipsychotic medication use in children and the potential risk for adverse outcomes from medications used to treat ADHD.

ANTIPSYCHOTIC MEDICATIONS IN CHILDREN

Antipsychotics are a class of medications that have been shown to reduce symptoms of serious mental disorders such as schizophrenia, severe bipolar disorder, and autism. Their efficacy in treating other conditions in children is not known. In addition, we know very little about whether or not they actually may be harmful to children.

In one study in Tennessee Medicaid[5] and another studying children from a national data set,[6] we identified a fivefold increase in the use of antipsychotics in children. Furthermore, more than half of these children were placed on the antipsychotic for ADHD and behavioral disorders for which these drugs have not been studied.[6] Several studies followed ours and found a similar increased trend in use in children as young as 3 years of age[7] as well as many children receiving multiple antipsychotics at the same time.[8] In high risk populations, such as children in foster care, use of antipsychotics and multiple medications at the same time has been reported to occur in up to 75 percent of children receiving treatments.[3] We know that children are more sensitive to adverse effects of some medications than adults,[9] so it is not possible to extend safety findings from adults to children. Thus, more research was needed to provide sufficient information to guide our considerations of the risks as well as the benefits of therapeutic options.

In October 2013, our group published a study drawn from 43,000 children in Tennessee Medicaid in which we compared the risk for type 2 diabetes in children who were recently placed on antipsychotics to comparable children treated with other psychotropic medications.[10] We found that children who were using antipsychotics were three times more likely to develop type 2 diabetes than similar children on other medications. We also found that children on higher cumulative doses were at even higher risk and that the elevated risk remained for up to a year after the medications were discontinued.

It's important to note that for some children and teens with serious mental health disorders, antipsychotics may be a critical part of their treatment. For many, however, these medications are being used for conditions such as ADHD for which there are safer alternatives. These studies highlight the critical need to ensure that children receive an accurate diagnosis with careful attention to all possible conditions that might be present and that if an antipsychotic medication is needed, children should be monitored for potential safety concerns.

MEDICATIONS USED TO TREAT ADHD

Our research group has also performed studies assessing potential risks of medications used to treat attention deficit hyperactivity disorder, ADHD. ADHD is an important mental health problem and affects up to 8–10 percent of children.[11] The diagnosis of ADHD has increased in recent years, perhaps resulting from greater awareness of the condition on the part of families, teachers, and health care professionals,[12 13] yet many children with ADHD still have serious disruptions in home, school, and social functioning and for many, these symptoms last into adulthood.

There are clear guidelines for the diagnosis and management of ADHD.[4] It is critical to obtain input from multiple sources, including parents, teachers, and others who observe the child's behavior and use validated tools to provide the correct diagnosis. Because up to 40 percent of children with ADHD have other problems including learning disabilities and additional mental health diagnoses,[4] it is also critical to assess children for other issues that may interfere with their ability to function.[13] Guidelines for the care of ADHD include recommendations for behavioral therapies and stimulant medication in selected children, reflecting the 70 percent rate of improvement seen in several studies.[4] I recall one of my patients with ADHD who told me he felt like his brain was like a "motor going too fast" and that the medications allowed him to slow down enough so that the other interventions we were using could work.

Stimulant medications have been used to treat ADHD for over 40 years and until recently have had a reputation for relative safety. Like antipsychotics and any medication, it is critical, however, to observe a child for potential side effects of the medications. In 2004, reports of adverse events from Canada and the United States that included cases of sudden cardiac death, heart attacks and strokes in children taking medications for ADHD raised serious concerns about their safety.[14] Several regulatory and policy decisions resulted from the review of adverse-event reports and led to concern and confusion among health care professionals, patients, and families about the risks of these drugs. In this context, we studied the cardiovascular safety of ADHD drugs in 1.2 million children and young adults from all regions of the country and found no evidence of a significant increase in risk for serious cardiovascular outcomes in children.[11] A separate study that we conducted in adults also found no increase in risk.[15]

The data on ADHD drug safety highlight the need to educate patients, families, health care professionals, and teachers about the appropriate diagnosis and management of ADHD. While our results about the adverse effects of stimulant medication are reassuring, ongoing surveillance is needed for these and all other drugs.

WHAT ARE OUR CHALLENGES?

• Mental health disorders are a common and serious public health problem. Mental health disorders affect 1 in 10 children and in addition to causing tremendous disruptions in their lives, these disorders tragically can end in suicide.

• Are we over-diagnosing children with mental health disorders? We must use the excellent tools currently available to diagnose the individual child. It is critical that health care professionals receive training in the diagnosis and management of mental health disorders. Partnerships between primary care clinicians and mental health professionals must be utilized to optimize the best diagnosis.

• Are we giving children the right medication? We need to ensure that children who really need antipsychotics get them, but there is little reason to believe that the incidence of these disorders justifies the fivefold increase in prescriptions for these drugs that has occurred in recent years.

• We need to ensure that children with a need for mental health services have them available. This is particularly important in States with rural populations, where access can present a huge barrier to families.

• We must work to improve the diagnosis and management of these children with thoughtful research and surveillance to ensure that children who are treated go on to live healthy lives without adverse consequences.

CLOSING THE LOOP: THE 9-YEAR-OLD ON ANTIPSYCHOTICS

In reflecting back on the 9-year-old boy on antipsychotics and many like him I have encountered in my 23 years as a pediatrician, several thoughts come to mind. First, medications used to treat mental health disorders are not magic pills. Children with serious mental health disorders may benefit greatly from medications, but it is important to weigh their risks and benefits in the context of a comprehensive and individualized treatment plan, which typically includes other personalized interventions. Taking time to consider the right diagnosis and the right treatment for each child takes time, but is essential to ensure that children with mental health disorders have the best possible outcomes. In the future, it is possible that other ways to identify individual children who might respond to different treatments might allow us to individualize treatments even further. In the meantime, however, we must address these issues one child and family at a time. Finally, we need to continue to expand our understanding of the best ways to diagnose and treat these children so that that 9-year-old boy and other children just like him can function and reduce the distress and suffering of mental health conditions.

Thank you for the opportunity to testify. I look forward to the testimony of my fellow panelists and I welcome any questions the committee may pose.

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The CHAIRMAN. Thank you very much, Dr. Cooper.

Mr. Fernandez, please proceed.

STATEMENT OF BENJAMIN S. FERNANDEZ, M.S. ED., SCHOOL PSYCHOLOGIST, LOUDOUN COUNTY PUBLIC SCHOOLS, ASHBURN, VA

Mr. FERNANDEZ. Chairman Harkin, Ranking Member Alexander, and members of the committee, thank you for inviting me today to speak about the critical importance of meeting the mental and behavioral health needs of children and youth and the roles schools can play in addressing these issues. My name is Benjamin Fernandez and I work as a lead school psychologist for Loudoun County Public Schools.

I've served Loudoun County Public Schools for the last 12 years, and I've been practicing as a school psychologist for almost 18 years. Loudoun County Public Schools is a school system west of DC in northern Virginia that has experienced a significant amount of student growth in the last 10 years.

In my service to Loudoun County Public Schools, like many school psychologists, I provide a broad range of services to support the successful learning and well-being of our students, create a positive school climate, and ensure ongoing collaboration among schools, families, and community to meet the mental health and behavioral health needs of children and youth. School psychologists provide comprehensive services at both the district and building levels.

Comprehensive school psychological services are defined by the National Association of School Psychologists practice standards. These services include individual student psychological evaluations; consultation with teachers, administrators, and families; social, emotional, and behavioral supports; individual and group counseling; skills building groups; threat assessment; and crisis intervention services.

School psychologists serve on a number of multidisciplinary teams with parents and educators to meet the diverse needs of children and families in our school community. In addition, school psychologists provide critical universal prevention and early intervention services for all students and deliver targeted intervention for those struggling with academic, behavioral, emotional, and mental health concerns.

Mental health is developed early in life, and educators play a significant role in ensuring that students' experiences throughout their school careers contribute to their positive mental health. Mental health issues not only impact students at the individual level, but they also impact school culture and climate, making it imperative that schools adequately address the mental health and behavioral needs of students to ensure the best possible outcomes for the entire school population.

It is estimated that 13 percent to 20 percent of children experience a mental disorder in a given year. However, it's important to note that schools are the largest access point for the majority of these students who require mental health services. Additionally, students are more likely to seek help if they know that school-based services are available to them. That is where school psychologists in collaboration with other school-based mental health professionals and educators come into play.

As families strive to assist their children, the topic of medication is raised. Schools do not recommend or prescribe medication. Families are encouraged to work with their physicians to make the decision that is most appropriate for their child.

Research indicates that certain medication can be a highly effective treatment modality for many students with ADHD, depression, and other mental health issues. I have personally seen this with certain students. However, behavioral interventions, counseling, and other supports have also been shown to be effective and is where my focus as a school-based mental health professional is.

In my service to Cool Spring Elementary and Heritage High School in Loudoun County, I've been able to support students in need by providing group counseling, skills groups, individual support and mentoring, and working collaboratively with various teams. Additionally, I work with other educators to deliver supports and prevention initiatives from a multi-tier system of supports for all students.

An example of a student I worked with was at the elementary level. It was a little girl who came to Cool Spring Elementary with a number of issues from behavioral, mental health and emotional, to significant anger issues, as well as academic issues. Through collaborative work with her teachers, her school counselor, her assistant principal, and principal, we were able to deliver a variety of interventions to help address all those needs that she brought to us.

In addition, we built relationships with her grandmother, who was her guardian, her therapist, and other providers that she worked with outside of the school to further address her emotional and behavioral needs in the school as well as in the home. With these combined supports, this student was able to demonstrate academic and behavioral success as she went through elementary school.

Students come to school with more than just a back pack and a lunch box. Some come to school with behavioral, social, emotional, or mental health issues that impede their ability to be successful. For these students, intervention and support is found within a multi-tiered system of supports, as well as through dedicated staff such as school psychologists and other school-based employed mental health professionals.

Addressing the mental health needs of children rarely occurs in isolation. Children access mental health supports within their schools as well as outside a school. Coordinated psychological intervention and medical treatment occur when schools collaborate with medical professionals to address these mental health needs. Providing access to school-based mental health professionals and allowing them to function in the broad role in which they are trained can ensure that the behavioral and mental health needs of students are met.

Thank you.

[The prepared statement of Mr. Fernandez follows:]

PREPARED STATEMENT OF BENJAMIN S. FERNANDEZ, M.S. ED.

SUMMARY

School psychologists provide comprehensive services at both the district and building levels. Comprehensive school psychological services are defined by the National Association of School Psychologists' practice standards, known as the NASP Practice Model (NASP, 2010). School psychologists provide critical universal prevention and early intervention services for all students, and deliver targeted interventions for those struggling with academic, behavioral, emotional, and mental health concerns. A former NASP leader may have said it best, "School psychologists are the educators who know the most about psychology and the psychologists that know the most about education."

Mental health is developed early in life and educators play a significant role in ensuring that students' experiences throughout their school careers contribute to their positive mental health. Access to school-based mental health services and supports directly improves students' physical and psychological safety, social-emotional learning, and academic performance. We can best meet the needs of children if we provide prevention, early identification, and targeted intervention for academic, mental health, and behavioral concerns within a multi-tiered system of supports (MTSS) which encompasses universal prevention for all students, and more targeted interventions for those students in need of additional support. A common vehicle in schools for facilitating the MTSS process and meeting student needs is through the Child Study Team, which is a multi-disciplinary team of professionals who work together to identify causes of academic and behavioral difficulties, develop interventions to address those problems, and monitor their effectiveness.

It is important to note that in the school setting, we do not routinely diagnose disorders, nor are we restricted to a specific diagnosis in order to provide services. Certainly if a student has a diagnosis, we take it into account, just as we assess how the classroom and school environment, social interactions, and family factors might also contribute to behaviors or cause academic learning barriers. Our focus is always on what intervention and supports will help the student best regardless of the cause. If a student is having trouble with outbursts and impulsivity, what matters more in the child study process is which interventions help him or her learn to understand and control their behavior. In terms of medication, schools do not recommend or prescribe medication. In fact many States have laws prohibiting school personnel from even raising it in conversation with families. The decision to use medication rests entirely with the parents and child, in consultation with medical professionals. Research indicates that certain medications can be a part of a highly effective treatment modality for many students with ADHD, depression, and other mental health issues. However, behavioral interventions, counseling, and other supports have also been shown to be effective and this is the focus of school-employed mental health professionals. Ultimately, it is the parents' decision to share information related to their child's medical status; regardless, school psychologists collaborate with other members of the child study team to ensure that the student is receiving the necessary evidence-based supports he/she needs to be successful at school. Students come to school with more than a backpack and a lunchbox. Some come to school with behavioral, social, emotional, or mental health issues that impede their ability to be successful. Providing access to school-employed mental health professionals, and allowing them to function in the broad role in which they are trained, can ensure that the behavioral and mental health needs of all students are met.

My name is Benjamin S. Fernandez, and I am a lead school psychologist for Loudoun County Public Schools (LCPS) in Virginia. I am pleased to have the opportunity to be here today to discuss the critical importance of meeting the mental and behavioral health needs of children and youth and the role schools can play in doing so.

PROFESSIONAL BACKGROUND

I have served LCPS as a school psychologist for 12 years and have been practicing in the field for almost 18 years. In my service to LCPS, like many school psychologists, I provide a broad range of services to support the successful learning and well-being of our students, create a positive school climate, and ensure ongoing collaboration among school, families, and the community to meet the mental and behavioral health needs of children and youth.

What is a School Psychologist?

School psychologists provide comprehensive services at both the district and building levels. Comprehensive school psychological services are defined by the National Association of School Psychologists' practice standards, known as the NASP Practice Model (NASP, 2010). In broad terms, these services include assessment and evaluation, data-based decisionmaking at the student, classroom and building levels, academic, behavioral and mental health supports, case-management and collaboration with community providers, and consultation with teachers, administrators and families. Specific examples include individual student psychological evaluations, classroom behavior management, supports for positive behavior and discipline, individual and group counseling, mental health screening, social skills development, threat assessment, and crisis intervention. School psychologists serve on a number of multidisciplinary teams with parents and educators to meet the diverse needs of the children and families in our school community. In addition, school psychologists provide critical universal prevention and early intervention services for all students, and deliver targeted interventions for those struggling with academic, behavioral, emotional, and mental health concerns. A former NASP leader may have said it best, "School psychologists are the educators who know the most about psychology and the psychologists that knows the most about education."

Comprehensive School Psychological Services Promote Student Success

mental health supports in schools

Mental health is developed early in life and educators play a significant role in ensuring that students' experiences throughout their school careers contribute to their positive mental health. Access to school-based mental health services and supports directly improves students' physical and psychological safety, social-emotional learning, and academic performance. Mental health issues not only impact students on the individual level, but they also impact school culture and climate, making it imperative that schools adequately address the mental and behavioral needs of students to ensure the best possible outcomes for the entire school population. It is estimated that 13–20 percent of children experience a mental disorder in a given year. However, only 16 percent of children who need mental health services receive them, and the majority of students who do, access mental health services in the school setting. Additionally, students are more likely to seek help if they know school based-services are available. Therefore, it is vital that schools provide the appropriate supports for students and have the resources needed to connect students with significant needs with more intensive community supports. We can best meet the needs of children if we provide prevention, early identification, and targeted intervention for academic, mental health, and behavioral concerns within a multi-tiered system of supports (MTSS). Many school districts are moving to an MTSS model which also aligns with and reinforces successful school-wide initiatives such as Positive Behavior Interventions and Supports (PBIS) and Response to Intervention (RtI).

MTSS begins with a universal tier of supports and services provided to all students and that research tells us will meet the academic and behavioral needs of the majority of students. This first tier focuses on prevention, wellness promotion, teaching shared behavioral expectations, and skills building. The second tier focuses on those students who still struggle despite the universal supports and need more targeted interventions. The specific needs of these students are identified through universal screenings; appropriate interventions are delivered and monitored in small groups. An example of such a subset of students might be those who exhibit appropriate behavior most of the time but repeatedly struggle under specific circumstances such as acting out when frustrated, being disruptive during transitions, or having difficulty in social situations. The third tier targets a generally very small population of students who require the most intensive academic, behavioral, or emotional supports. At this level, interventions are often delivered through special education services or other individualized school-based supports. Frequently at this tier, a student is also receiving services from medical and other community providers and ideally school mental health personnel are collaborating closely with them to ensure continuity and efficacy of the interventions. At all levels of service delivery, the school psychologist collaborates with teachers and families to ensure that the proper services are being delivered and that information about the child is being shared with the appropriate people.

CHILD STUDY PROCESS

A common vehicle in schools for facilitating the MTSS process and meet student needs is the Child Study Process. This process is initiated when a teacher, administrator or parent has a concern about a child and it is implemented by the Child Study Team. This is a multi-disciplinary team of professionals who work together to identify causes of academic and behavioral difficulties, develop interventions to address those problems, and monitor their effectiveness. School psychologists play an integral role on this team, and are often the person that provides the targeted interventions, in group and individual settings, for students struggling with behavioral or mental health concerns. To illustrate how this process works and to reiterate the importance of prevention and early intervention, I would like to share some examples from my experience. (All names have been changed.)

PREVENTION AND INTERVENTION IN ELEMENTARY SCHOOL (AMY)

Amy was a young girl being raised along with her brothers by her grandmother. She and her brothers struggled with a variety of behavioral issues, but this girl in particular struggled with defiance, refusal to comply with adult directives, cursing, disrespect, stealing, and aggression. Because of her behavior, she missed a great deal of instruction, peers avoided playing with her, and she was generally unhappy and frustrated with school. There were concerns that Amy was struggling with ADHD and perhaps depression, but she had not been formally diagnosed with either of these.

When the Child Study Team first convened to discuss Amy's difficulties, our collective goal was to help her be more successful at school and to provide advice and supports to her grandmother to help her deal with the challenging behavior at home. Our team included Amy's grandmother, her teacher, the school social worker, the school counselor, and the principal. We created behavior plans, worked with the classroom teachers on how to consistently implement the behavior plan, and how to work with the student. We also determined which type of mental health supports she needed and devised a plan to ensure she received these supports at school while also making sure that she was in the classroom during critical instructional time as much as possible. As she moved through the grade levels, she was placed with teachers who best fit her as a student and would be able to meet her emotional and behavioral needs. Because we were able to identify her needs, and provide Amy with the proper supports, she made continuous academic progress and had a successful transition to middle school. Amy continues to need support but with the supports she was given, she was able to reach her full potential, which included keeping the required GPA to participate on the soccer team.

Schools can provide a number of supports for students to help them cope with behavioral and mental health concerns. Amy received the following supports:

- Small group counseling to address anger management skills with a group of students with similar issues.
- Behavior management plan to help her increase her on-task time in the classroom.
- Individual counseling.
- Connection with supports in the community via the social worker.

In addition to these individualized targeted interventions, there were universal supports that are available to ALL students but also benefited Amy. These include:

- Character education for all students.
- Mentoring program.
- Effective discipline.
- Social emotional learning curriculum in the classroom.

PREVENTION AT THE HIGH SCHOOL LEVEL (THOMAS)

An example of one of the universal prevention initiatives is LCPS's Depression Awareness/Suicide Prevention presentations. Many other school districts also offer this type of prevention programming in their high schools and middle schools. Suicide is one of the leading causes of death in children ages 10–19. This initiative's goal is to teach students the signs and symptoms of depression and the warning signs and risk factors related to suicide. Students are also taught how to seek assistance by telling a trusted adult and that telling a trusted adult is not betraying a friend. These presentations have helped to destigmatize depression and mental health issues allowing for an environment where students feel comfortable approaching staff when they have concerns about a friend or someone else considering harming themselves. This atmosphere has also assisted with students who have concerns for bullying and student threats. In LCPS, these presentations are con-

ducted in all ninth grade health and PE classes. Within the last few years, Heritage High School—along with a number of Loudoun County High Schools—has begun implementing Depression Awareness Booster sessions.

THE CASE OF THOMAS

Another example of how this process works at the high school level, involves a student named Thomas. I first met him when he was a 9th grade student returning to school after his long-term suspension for vandalizing a school bus. Thomas was a student receiving group counseling focusing on social skills, anger management, and coping. Additionally, his mother had health difficulties and there had been a number of deaths within his immediate family that directly impacted him. Overall, he struggled academically, behaviorally, and emotionally. He was frequently late for class, struggled with controlling his temper with peers and adults, and was failing. For Thomas, support and intervention started with staff relationships. This began with his participation in a counseling group that I co-led with a school social worker and with weekly check-ins. Through this process, we were able to identify skill areas he lacked and were able to work with him to manage his anger and appropriately engage with adults in the classroom. In addition to this work, Thomas worked closely with a special education teacher to focus on his academics, which helped foster another positive relationship with an adult in the building. Finally, the multi-disciplinary team, which included myself, the school social worker, teachers assigned to the clinical program, a school counselor, and the assistant principal met twice a month to discuss the progress of not only Thomas, but other students who needed behavioral and mental health support. These problem-solving meetings focused on student successes and challenges with the goal of supporting these students. These supports followed Thomas through his high school career when he ultimately graduated.

As in the example of Amy above, schools cannot only provide a number of supports for students to help them cope with behavioral and mental health concerns, but deliver them at all grade levels. Thomas received the following supports:

- Small group counseling to address social and anger management skills with a group of students with similar issues.
- Behavior management plan to help him increase his on-task time and display of appropriate behaviors in the classroom.
- Individual counseling.
- Direct collaborative and attentive relationships with his teachers and other adults within the school.

In addition to these individualized targeted interventions, there were also universal supports at the high school level that are available to ALL students as well as Thomas. These include:

- Character education for all students.
- Mentoring program.
- Effective discipline.
- Social emotional learning curriculum in the classroom.

ROLE OF DIAGNOSES AND MEDICATION IN SCHOOL SERVICES

It is important to note that in the school setting, we do not routinely diagnose disorders, nor are we restricted to a specific diagnosis in order to provide services. Certainly if a student has a diagnosis, we take it into account, just as we assess how the classroom and school environment, social interactions, and family factors might also contribute to behaviors or cause academic learning barriers. Our focus is always on what intervention and supports will help the student best regardless of the cause. If a student is having trouble with outbursts and impulsivity, what matters more in the child study process is which interventions help him or her learn to understand and control their behavior.

In this vein, we also do not "treat" students in schools; rather we provide interventions and supports to them. This is both a terminology difference and a perspective. Treatment implies a medical model that is usually diagnosis specific and focused on that diagnosis only. Cognitive behavioral therapy provided in school isn't different than cognitive behavioral therapy provided in a clinic but we call it an intervention, not a treatment, and it is almost always just one of a number of strategies being used. Additionally, as noted earlier in the child study process, school-based interventions almost always engage multiple people in the student's life, such as teachers, parents, and other key adults, in order to fully support the student's progress in all relevant settings.

In terms of medication, schools do not recommend or prescribe medication. In fact many States have laws prohibiting school personnel from even raising it in conversation with families. The decision to use medication rests entirely with the parents and child, in consultation with medical professionals. When the student needs to take medication during the school day, the school nurse would be in charge of administering it, with explicit permission from the parents or guardians. Research indicates that certain medications can be a part of a highly effective treatment modality for many students with ADHD, depression, and other mental health issues. I personally have seen this with certain students. However, behavioral interventions, counseling, and other supports have also been shown to be effective and this is where my focus is as a school-based mental health professional.

Sometimes parents raise the issue of medication with us, in which case we can share information, but we do not give advice. We encourage parents and families to work with their doctor to make the decision that is most appropriate for the child. Ultimately, it is the parents' decision to share information related to their child's medical status. In some cases, the school will not know because the parent has decided. In other instances, a parent chooses to share that their child is prescribed medication. In these instances, if the parent gives permission, the school nurse and school psychologist may maintain contact with the doctor to make sure that teachers and other staff are aware of any potential side effects of medication that may impact the student at school. Regardless, school psychologists collaborate with other members of the child study team to ensure that the student is receiving the necessary supports he/she needs to be successful at school.

CONCLUSION

Students come to school with more than a backpack and a lunch box. Some come to school with behavioral, social, emotional, or mental health issues that impede their ability to be successful. Providing access to school employed mental health professionals, and allowing them to function in the broad role in which they are trained, can ensure that the behavioral and mental health needs of all students are met.

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The CHAIRMAN. Thank you, Mr. Fernandez.

Mr. Arch.

STATEMENT OF JOHN K. ARCH, FACHE, EXECUTIVE VICE PRESIDENT OF HEALTH CARE AND DIRECTOR, BOYS TOWN NATIONAL RESEARCH HOSPITAL AND CLINICS, OMAHA, NE

Mr. ARCH. Thank you. Good morning, Chairman Harkin, Senator Alexander, and Senator Baldwin. Thank you very much for inviting me to speak. I am John Arch. I'm the executive vice president of Health Care at Boys Town and director of Boys Town National Research Hospital in Omaha, NE.

First, I'd like to personally thank Senator Harkin for your friendship to Boys Town Hospital over the years, especially your work with our communication disorders kids, deaf and hard of hearing. Thank you very much for your friendship.

The CHAIRMAN. Young kids diagnosed early.

Mr. ARCH. Yes, early diagnosis for the communication disorders. Thank you very much for that friendship.

The CHAIRMAN. You've been very good at that.

Mr. ARCH. I'm honored to represent Boys Town. Founded in 1917, we serve now over 72,000 kids each year across the United States in nine different States with sites. We have a mission that

is very bold. We want to change the way America cares for kids, families, and communities. So that's what brings me here today to talk about the use of psychotropic meds, in particular, one service that I'll mention here in just a second.

Boys Town is divided into two divisions. There's a youth care division and a health care division. The youth care division is probably the better known division, in that that's the Mickey Rooney-Spencer Tracy—the movie, Boys Town—that residential care. While residential care was where Boys Town started, most of their care now is in-home services, trying to keep families intact, trying to keep kids in the home, and those are, again, across nine States.

The Health Care Division that I'm responsible for has the medical services, medically directed services, as well as medical research—I mentioned communication disorders in children—as well as the behavioral health research. Our division, the Health Care Division, serves 45,000 children annually, including the most troubled kids that Boys Town cares for in our Residential Treatment Center. Since opening this center in 1996, we have accepted kids from 38 different States for treatment there. This treatment center is located in Omaha, NE.

Our treatment center provides a secure environment that's designed to offer medically directed care for the most seriously troubled youth. If you can imagine this continuum of care, inpatient care would be most acute care, and that's usually a 3- to 5-day length of stay.

The Residential Treatment Center is a step down from that care. There, we treat children from ages 5 to 18 with an approximate length of stay of about 120 days. These children do not require that acute inpatient care. Their crisis has stabilized, where perhaps they were a danger to themselves or others at that time, and then they maybe step down to our care in the residential treatment. But they include school failures, multiple placements, perhaps a history of self-injury—the truly serious.

Most kids have had some contact with the law by the time they reach the Residential Treatment Center. They've not been successful at lower levels of care. They've experienced multiple placements within the mental health system. So they are admitted to the Residential Treatment Center.

The child psychiatrist is the medical director and the head of the treatment team. The treatment then begins with the assessment of the child and very, very specific—we call it a bio-psychosocial treatment model that includes the medical, the psychological, as well as the social aspects of that child, the behavioral treatment.

The model of care at Boys Town is very behavior-focused. So when the child is admitted to the Residential Treatment Center, certain behaviors are identified that that child needs to work on. During the day, that behavior is taught. All the while, there is a medical management that is going on regarding the use of meds.

When we see kids enter our program, we see kids on multiple psychotropic meds, generally, and we've had kids on up to eight different psychotropic meds admitted to the program. This is a result of them seeing different physicians throughout their life, perhaps a family practice, pediatrician, maybe a child psychiatrist, all attempting to help the family get some self-control and some control

with the child's behavior. So when they come to us, it's because that has not been successful.

Approximately 79 percent of the children that are admitted to our treatment center are being prescribed at that time multiple psychotropic meds. And, like everyone has testified, we're also very concerned about this lack of scientific evidence as to exactly what these antipsychotics can do, both developmentally as well as educationally. When these kids come to our program, they're generally 2 years behind in the educational process and need to catch up.

I have an example. I'll call the child David. He came to us in his early teens. He weighed about 300 pounds, and he was really struggling. He had some extreme temper issues. He was referred to us by a judge to seek some care.

We began to reduce the number of psychotropic meds as well as doses. And successfully, over a period of time, he was tapered off several of those meds as well as reducing the doses. He was able to move down to one of Boys Town's residential homes.

He actually graduated from the high school and went on to an engineering career at the university. So that combination of reducing those psychotropic meds and putting in self-control, those behavior interventions, has worked within our treatment model.

We had a recent study that was conducted at our treatment center, and utilizing this medication management program within that structure of the strong behavioral, we demonstrated a 33-percent reduction in the number of youth on any psychotropic med, a 38-percent reduction in the average number of meds being prescribed at the time of discharge. So we moved from about 75 percent of our kids on meds in the Residential Treatment Center to 50 percent upon discharge.

Then we reduced from about 3.3 average medications per child to about 2.1. In both dose as well as removing completely from psychotropic meds by putting the behavioral model and other interventions into place and teaching to that behavior, we saw that. And, actually, we saw a 63 percent reduction in aggressive behavior at the same time we were moving these kids off of these psychotropic meds. So it obviously was successful in doing that.

But our mission is to change the way America cares for kids. So we are pushing hard into behavioral health research, as we've done in our communication disorders research.

In 2012, we hosted an NIMH-sponsored conference specific to psychotropic meds in kids and gathered experts around the United States to come to Omaha to discuss that and created some task forces. Those task forces, going forward, are going to be taking a look at the forces that drive the current high medication rates, establishing processes for taking children off the medications, and defining effective management of medication use within the context of other treatment. So that work is ongoing after that NIMH-sponsored conference.

But we needed to do more. So we launched a Neurobehavioral Research Center in Omaha. We want to take a look at not only the psychotropic meds, but also alternatives. What we see is not enough evidence of the biological markers. So using FMRI, we want to use that as a primary research modality and take a look at kids.

One of the studies we have is, as they come in on multiple psychotropic meds, having that FMRI done at that time, and as we move the kids off psychotropic meds, continue to examine—are we seeing a normalization of brain activity as we remove these kids and we put other interventions in place, behavioral interventions. We want to take a look at exercise and see what that does.

We want to take a look at some of the alternatives, such as computer games specifically designed to treat depression, and see if some of that can be used—whatever we can do in an attempt to reduce and only use medications when appropriate and when necessary and implement other alternatives.

Thank you very much for allowing me to speak today. I would encourage this committee and the Senators to consider very seriously the ongoing funding for research that's needed, and as those alternatives are developed and intervention strategies, that those alternatives are available in communities, because that's what's driving a lot of this.

Some of the physicians don't have alternatives in those communities to refer to, especially as you get into the rural areas. So they are left with desperate parents that need psychotropic meds, something to control the behavior of their child. So please continue that funding.

Thank you very much.

[The prepared statement of Mr. Arch follows:]

PREPARED STATEMENT OF JOHN ARCH, FACHE

SUMMARY

Boys Town was founded in Omaha, NE in 1917 by Father Edward Flanagan. Today, Boys Town provides care to youth in nine States, directly serving more than 72,000 children annually. The Boys Town mission is "to change the way America cares for children, families and communities" and shapes everything the organization does, including its efforts to address the national concern regarding the appropriate use of psychotropic medications in the treatment of children.

Boys Town's services are organized in two major divisions: youth care and health care. Youth Care offers residential care, family counseling, foster care, and in-home services and many other programs. Health care provides medical care and conducts medical research, including studies relating to childhood communication disorders and behavioral health. The Health Care division offers Boys Town's highest level of behavioral health care at its secure Residential Treatment Center facility. The Center provides medically directed intensive treatment for troubled children ages 5 to 18. Treatment is based on Boys Town's distinctive bio-psychosocial model which coordinates medical, psychological and behavioral treatment.

Approximately 79 percent of the children admitted to the Treatment Center are taking multiple psychotropic medications to control their behavior at the time of admission. Although effective in treating some problems, due to the physical side effects of these medications, more research is needed regarding their safety and appropriate use.

A recent study conducted at the Treatment Center demonstrated the success of Boys Town's treatment model, showing a reduction of 33 percent in the number of children taking any medications and a 38.2 percent reduction in the average number of medications being taken at the time of discharge.

In furthering their mission, Boys Town has undertaken initiatives to study the appropriate use of psychotropic medications in children. For example, in 2012, with a grant from The National Institute of Mental Health (NIMH), Boys Town hosted a diverse group of scientists, physicians, human service providers and child advocates to discuss the issue. Going forward, research teams will examine the forces driving the high medication rates and define effective management of medications. In addition, Boys Town has launched the Center for Neurobehavioral Research in Children located at Boys Town National Research Hospital. Boys Town's long history of providing effective care and the Hospital's successful 40 years of medical re-

search position the Research Center to become a collaborative effort that will offer evidence-based solutions to the larger mental health community. Researchers are currently partnering with NIMH to investigate the effects of these medications on brain functioning using imaging technology.

Good morning Chairman Harkin, Ranking Member Alexander, and members of the committee. Thank you for inviting me to speak with you today on this critical issue. I am John Arch, executive vice president of Health Care at Boys Town, and director of Boys Town National Research Hospital in Omaha, NE.

I would first like to thank Chairman Harkin for his ongoing support of the work of Boys Town National Research Hospital over the years, and his personal interest in continuing to raise awareness of today's issue in Congress and the administration.

I am honored to represent Boys Town, an institution founded in Omaha, NE, in 1917 by Father Edward Flanagan. Boys Town provides care to youth in nine States, directly serving more than 72,000 children each year. While Boys Town cares for a large number of children, our mission is more far-reaching. The Boys Town mission is to "Change the way America cares for children, families, and communities." That mission shapes everything we do, including our efforts to address the national concern regarding the appropriate use of psychotropic medication in the treatment of children.

Boys Town's services are organized in two major divisions: youth care and health care. The youth care division offers residential care, family counseling, foster care, and in-home services among its many programs. The health care division, for which I am responsible, provides medical care and conducts medical research, focusing on communication disorders in children, and behavioral health. The health care division serves 45,000 children annually, including the most troubled children cared for by Boys Town in our Residential Treatment Center. Since opening the Center in 1996, we have treated children from 38 States.

Our Treatment Center provides a secure environment that is designed to offer medically directed care for more seriously troubled youth. These youth require supervision, safety and therapy but do not require inpatient psychiatric care. Each day we care for more than 80 children from ages 5 to 18 with an average length of stay of approximately 120 days.

These children do not require acute inpatient care but need a very structured environment to treat their conditions. Their problems commonly include school failures, aggression, self-injury, property damage and a history of police and court involvement. The majority of the children have not been successful in lower levels of care and have experienced multiple placements within the mental health system. Without intensive treatment, their futures hold little promise.

Our medically directed programs base treatment on Boys Town's distinctive biopsychosocial model. This model of care creates a milieu where medical, psychological and behavioral treatment of children can be coordinated.

Our model of care is very behavior-focused. Children spend each day with specially trained and motivated staff. All staff members actively teach appropriate behavior to replace individual problem behaviors identified when a child enters the program. Children also are taught self-control options to be used in times of stress or in situations where they have historically used inappropriate coping behavior.

Approximately 79 percent of the children who are admitted to our Treatment Center are being prescribed multiple psychotropic medications at the time of admission, with some taking as many as eight to control their behavior. We are very concerned with the lack of scientific evidence regarding the safety and efficacy of these drugs in young patients, especially the potential long-term effects on their development. According to our physicians, these medications, when appropriately prescribed, can successfully combat depression, anxiety, psychosis, ADHD and many other mental health disorders in children. However, children may also experience weight gain, sedation, pre-diabetes and disruptions in hormones while on these medications. These children may also experience developmental problems that affect educational achievement and last into adulthood. Our overall treatment philosophy is to appropriately use psychotropic medication in combination with behavioral and other treatment modalities.

We treated a young man I will call David a few years ago who had been in and out of the mental health system several times. He had extreme temper issues and eventually was arrested for assault. The judge referred him to our treatment center.

At the time he was admitted, he weighed more than 300 pounds and was taking multiple psychotropic medications prescribed by different physicians. During his time with us, he was tapered off several of his medications and the level of the other

medications was reduced. With treatment and appropriate medication he improved and was able to step down to one of Boys Town's residential family homes where he went on to graduate from high school near the top of his class and enrolled at a local university to study engineering.

With our approach, we have been able to achieve a significant reduction in medication among the children we treat.

A recent study conducted at our Treatment Center, utilizing a medication management program within the structure of our strong behavioral treatment model, demonstrated a 33 percent reduction in the number of youth on any psychotropic medication and a 38.2 percent reduction in the average number of medications being prescribed at the time of discharge. The study was a part of a nationwide research project conducted by Boys Town in collaboration with other organizations. I have provided the results of that project to the committee.

Children are succeeding with our treatment model, but our Boys Town mission compels us to do more.

In 2012, Boys Town hosted a diverse group of researchers, physicians, human service organizations and other child advocates from across the United States for a 2-day conference funded by the National Institute of Mental Health to discuss the use of psychotropic medications to treat children. Going forward, research teams will examine the forces that drive the current high medication rates, establish processes for taking children off the medications when appropriate, and define effective management of medication use within the context of other treatments.

It was apparent from this conference and other sources that additional research is needed in this field. Therefore, Boys Town launched a new research initiative with its Center for Neurobehavioral Research in Children, located at Boys Town National Research Hospital. Our Research Center is building on recent research to develop alternative intervention methods. Boys Town's long history of providing effective care and the Hospital's successful 40 years of research position our Research Center to become a state-of-the-art collaborative effort that will offer evidence-based solutions for treatment to the larger mental health community.

To better understand whether these medications do have a therapeutic benefit, our Research Center is currently partnering with the National Institute of Mental Health to investigate the effects of these medications on brain functioning using imaging technology.

Chairman Harkin, Ranking Member Alexander, and members of the committee, I want to thank you for inviting me to testify today.

We encourage members of the committee to support research funding to better understand the effects of psychotropic medication in children, to develop effective alternatives to treatment, and to ensure that those alternative treatment programs are available to clinicians and families in communities across the United States.

Thank you again for this opportunity to speak to you today.

The CHAIRMAN. Thank you, Mr. Arch.

And now Ms. Martinez. Welcome.

STATEMENT OF TIFFANY MARTINEZ, STUDENT, UNIVERSITY OF SOUTHERN MAINE, PORTLAND, ME

Ms. MARTINEZ. Good morning, Chairman Harkin, Ranking Member Alexander, and members of the committee. Thank you for having me here today. My name is Tiffany Martinez. I am currently finishing my master's degree in nursing at the University of Southern Maine, studying to become a psychiatric nurse practitioner.

When I meet people today, it's hard for them to believe that I struggled with mental illness. In 2005, at the age of 17, I started to exhibit early signs of psychosis. At first, they were subtle signs, depression, withdrawing from friends, and feeling that something wasn't right.

When I began my freshman year at the University of Southern Maine, the signs intensified. My mind started to play tricks on me. I would see shadows and hear noises. I would believe someone was whispering in my ear when there was no one next to me.

Eventually, the symptoms were interfering with my daily life. I had always been a good student, but I started to struggle academi-

cally and have bizarre thoughts that seemed logical to me. I would fear that the tall trees in the courtyard outside my dorm would fall on me. I had thoughts of hurting myself.

Fortunately, my aunt and friends recognized that something was wrong. They encouraged me to go to the university health center. This was a very hard step. I didn't want to admit I had a problem and needed help. I was scared, confused, and embarrassed.

But the school nurse recognized that I needed immediate help. She had recently attended a seminar conducted by a staff member of PIER. PIER stands for the Portland Identification and Early Referral Program. The nurse was trained to recognize the early signs of psychosis. She referred me to PIER for an evaluation.

Within 1 week of my referral to PIER, I received a more in-depth screening and entered into a comprehensive treatment program. When they told me I was experiencing early signs of psychosis, I became terrified. I have a dad with schizophrenia, so I knew what this could mean. He has a hard time functioning and is homeless. I thought my life was over.

Fortunately, the PIER program was the right option for me. The staff kept me engaged in my care and on the road to recovery, even when things got bumpy. I learned early in treatment about early psychosis symptoms and how to deal with them, as well as coping skills to reduce stress. I met with a counselor and psychiatrist who let me recover at my own pace. The extreme paranoia I experienced made it hard to trust anyone, but I never felt judged by my clinical team. They understood when I was overwhelmed and couldn't do anything on my own.

When I first started treatment and could not leave my dorm room, my counselor picked me up and took me to appointments. I was also prescribed medication that helped control my symptoms and enabled me to function day to day. Initially, I resisted this part of treatment. However, my doctor listened to my concerns and carefully answered my questions.

When I took medication, he would ask me about side effects and how I was feeling. He would regularly check up on me. After consulting with my doctor and evaluating my progress, I ended the use of medication in 2009. I have not needed them since.

One of the key things PIER did to make sure my recovery would be successful was to incorporate my family. They engaged a cousin who lived nearby and helped educate her on how to support me. PIER also worked with the university, which, in turn, made accommodations so I could stay in school and complete my degree.

I also became involved with a multicultural center at the university. I lived on a reservation while growing up, and this allowed me to stay connected to my Native American heritage. Participating in activities that were familiar to me helped me to feel like myself again.

The PIER program not only changed my life. It saved my life. I had access to a program that could intervene early and help me before my condition worsened. As I know too well from my father's experience, not everyone has the opportunity I was given.

A few years after I became involved with PIER, the Robert Wood Johnson Foundation recognized the promise of the program and invested in the Early Detection and Intervention for the Prevention

of Psychosis Program, or EDIPPP. They funded five diverse sites around the country: California, Oregon, New York, New Mexico, and Michigan. The program continues to expand in Oregon and California. Other States have expressed interest in the model.

I urge the committee to consider how these programs can be made available to more people. I am proof that early intervention works. If this was cancer, we wouldn't wait to prevent it if we could. Why treat mental illness any different?

I thank the committee for inviting me here today and for holding this hearing on such an important issue. Thank you.

[The prepared statement of Ms. Martinez follows:]

PREPARED STATEMENT OF TIFFANY MARTINEZ

SUMMARY

Good morning, Chairman Harkin, Ranking Member Alexander and members of the committee.

My name is Tiffany Martinez. I am currently finishing up my master's degree in nursing at the University of Southern Maine. In 2005, at the age of 17, I started to exhibit early signs of psychosis. At first, they were very subtle signs—depression, withdrawing from friends, and feeling that something wasn't right. Eventually, the symptoms intensified and interfered with my daily life. I started to struggle academically and have bizarre thoughts that seemed logical to me. Fortunately, my aunt and friends encouraged me to go to the university health center.

This was a very hard step. I didn't want to admit I had a problem. The school nurse recognized that I needed immediate help and referred me to the Portland Identification and Early Referral (PIER) program. Within just 1 week of my referral to PIER, I received a more in-depth screening and entered into a comprehensive treatment program.

When I was told I was experiencing early signs of psychosis, I became terrified. My father has schizophrenia, so I knew what this could mean. He has a hard time functioning and is homeless. I thought my life was over.

Fortunately, the PIER program was the right option for me. The program is structured to be patient-centered and supportive. I learned early in treatment about early psychosis symptoms and how to deal with them, as well as coping skills to reduce stress.

I was also put on medication that helped control my symptoms. I resisted this part of my treatment, but my doctor listened to my concerns, answered my questions, asked about side effects, and regularly checked-up on me. I ended the use of the medication in 2009 and have not needed them since.

The PIER program not only changed my life, it SAVED my life. I had access to a program that could intervene early and help me before my condition worsened. Not everyone, like my father, has the opportunity I was given.

A few years after I was referred to PIER, the Robert Wood Johnson Foundation recognized the promise of the program and invested in five diverse sites around the country (California, Oregon, New York, New Mexico, and Michigan) to collect solid evidence on the effects of early intervention. The program continues to expand in Oregon and California. Other States have expressed interest in the model.

I urge the committee to consider how early intervention programs can be made available to more people. I am proof that early intervention works. If this was cancer, we wouldn't wait to prevent it. Why treat mental illness any different?

Good morning, Chairman Harkin, Ranking Member Alexander and members of the committee.

Thank you for the opportunity to share my story with you today.

My name is Tiffany Martinez. I am currently finishing up a masters of nursing program at the University of Southern Maine, studying to become a psychiatric nurse practitioner. I also work as a nurse at a local prison and at a program that serves adults with developmental and behavioral challenges.

When I meet people today, they see me as a hard-working young adult with friends and a full life. It's hard for my classmates and colleagues to believe that I struggled with mental illness.

There was a time too, when I would not have imagined that I would be able to sit here today and share my story.

In 2005, at the age of 17, I started to exhibit early signs of psychosis. At first, they were very subtle signs—depression, withdrawing from friends, and feeling that something wasn't right.

When I began my freshman year at the University of Southern Maine, the signs intensified. My mind started playing tricks on me. I would see shadows and hear noises: I would believe someone was whispering in my ear when there was no one next to me.

Eventually, the symptoms interfered with my daily life. I had always been a good student, but I started to struggle academically and have bizarre thoughts that seemed logical to me. I would fear that the tall trees in the courtyard outside my dorm would fall on me. Over time, just leaving my dorm room became difficult. I began having thoughts of hurting myself. Fortunately, my aunt and friends from school recognized that something was wrong. They encouraged me to go to the university health center.

This was a very hard step. I was a young adult. I didn't want to admit I had a problem and needed help. I was scared, confused, and embarrassed. I didn't know how to begin to verbalize all that I was experiencing.

But the school nurse quickly recognized that I needed immediate help. She had recently attended a seminar conducted by a staff member of PIER. PIER stands for the Portland Identification and Early Referral program and it is based at the Maine Medical Center. The nurse was trained to recognize the early signs of psychosis, such as patients seeing or hearing things that are not there; having persistent illogical or irrational thoughts that do not disappear; and being unable to think straight, focus, or speak coherently. After she met with me, she referred me to PIER for an evaluation.

Within just 1 week of my referral to PIER, I received a more in-depth screening and entered into a comprehensive treatment program that included counseling, psychoeducational support, and medication.

When they told me I was experiencing early signs of psychosis, I became terrified. I have a dad with schizophrenia so I knew what that could mean. He has a hard time functioning and is homeless. I thought my life was over.

Fortunately, the PIER program was the right option for me. The program is structured to be patient-centered and supportive. The staff kept me engaged in my care and on the road to recovery, even when things got bumpy.

I learned early in treatment about early psychosis symptoms and how to deal with them, as well as coping skills to reduce stress.

I met with a counselor and psychiatrist who let me recover at my own pace. A nurse also provided care for me early in the program to track vital signs and other physical conditions. The extreme paranoia I experienced made it hard to trust anyone, but I never felt judged by my clinical team. They understood when I was overwhelmed and couldn't do anything on my own. When I first started treatment and could not leave my dorm room, my counselor picked me up and took me to appointments.

The strong support I received helped me form a connection that built trust and kept me on a path to recovery.

I was also prescribed medication that helped control my symptoms and enabled me to function day-to-day. I resisted this part of treatment. But instead of forcing me to take my medication, my doctor acted more like a partner. He listened to my concerns and carefully answered my questions. When I took medication, he asked me about side effects and how I was feeling. He would regularly check up on me to make sure I was keeping to my medication schedule.

And after consulting with my doctor and evaluating my progress, I ended use of the medication in 2009. I have not needed them since.

One of the key things PIER did to make sure my recovery would be successful was incorporate my family. My immediate family lived about 4 hours away from the university, so it was hard for them to participate in my care. The PIER team engaged my cousin, who lived nearby, to play a role in my treatment. PIER educated my family about my condition and taught them how to respond.

PIER also worked with the university to make sure I could stay in school and complete my degree. Thanks to those efforts, the university helped me manage my workload and deadlines so that I could continue going to classes while in treatment.

I also became involved with the multicultural center at the university. This allowed me to stay connected to my Native American heritage. I lived on a reservation from the time I was 6 until I left for college; the Native American culture is a large part of who I am. During my recovery, participating in activities that were familiar helped me begin to feel normal and like myself.

The PIER program not only changed my life, it SAVED my life. I am one of the lucky ones. I had access to a program that could intervene early and help me before

my condition got worse. As I know too well after witnessing my father's experience, not everyone has the opportunity I was given.

I wouldn't be here today if it weren't for a program like PIER. I want you to know that programs like this can make a tremendous difference to people's lives and their futures.

A few years after I became involved with PIER, the Robert Wood Johnson Foundation recognized the promise of a program that focused on treating young people before they experience their first full-blown psychotic episode. Building on the PIER model, the Foundation invested in the Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP). They funded five diverse sites around the country—California, Oregon, New York, New Mexico, and Michigan—to collect solid evidence on the effects of early intervention for mental illness. The program continues to expand in Oregon and California. Other States have shown interest in implementing the program.

I urge the committee to consider how these programs can be made available to more people. Through my own studies to become a nurse practitioner, my colleagues and classmates are interested in programs that help them recognize the early warning signs so they too can prevent people from developing early problems.

Nine years after I was first referred to PIER, I am proof that early intervention works. Mental illness is a disease. With early intervention, it can be managed and treated. If this was cancer, we wouldn't wait to prevent it if we could. Why do we treat a disease like mental illness any different?

I thank the committee for inviting me here today and for holding this hearing on such an important issue.

The CHAIRMAN. Thank you, Ms. Martinez. I thank you for being so courageous to talk about your own personal situation like this. I think this gives courage to others to not try to hide it and cover it up but to talk about it openly and to seek the help that they need. So I really thank you for that very, very much.

I thank you all. We'll begin a round of 5-minute questions.

Dr. Cooper, according to the American Academy of Pediatrics, approximately 70 percent of children and adolescents who are in need of mental health treatment do not receive services. Of the remaining 30 percent who do seek treatment, only one in five obtain mental health specialty services, such as those provided by a psychologist or a psychiatrist. Fifty percent to seventy-five percent of the care for children with mental health conditions occurs in primary care settings, family practice, pediatricians, and others.

I was alarmed to find this out. I guess I just never thought about it. But primary care doctors and pediatricians can prescribe psychotropic drugs. I don't know why that never occurred to me. So they read the medical journals. They do a preliminary diagnosis. And perhaps the family or someone has read something or seen an ad, and they say, "I think my kid needs Paxil. That's what it all says, and I think they need that." So the doctor or the pediatrician might say, "Well, OK. I'll prescribe that."

How can we make sure that more pediatricians—I focus especially on pediatricians—have adequate training in assessment, diagnosis, and treatment of various mental health conditions? I'm just really concerned about the over-medication of kids and how much they're giving medication, which we don't even know if it works or not.

So what do we do with this? How do we get more pediatricians to understand that there are other modalities, other than just prescribing a psychotropic drug?

Dr. COOPER. Senator Harkin, I think you highlight a really critical issue here that's echoed by all the panelists today, and that is the notion that we really have to think about the right treatment for the right child. There's a lot of things that probably contribute

to that. One of those things is ensuring that pediatricians and other primary care doctors or professionals have appropriate training and education in what is appropriate to diagnose a child and what the appropriate treatments are, ensuring that there's communication.

One of the challenges is that—as highlighted by some of the cases that were presented today—oftentimes, when the right diagnosis is made and the right plan is put in place, there's a lack of access to resources. So it is absolutely critical that these medications, if they're needed, are used in conjunction with other therapies, behavioral therapies or other psychotherapies.

The CHAIRMAN. Since most of these illnesses manifest themselves in the school setting, that's kind of the first place that it's—teachers say something to the school counselor or something like that. This is the Education Committee. Do we need to be taking a closer look at how many psychologists we have, for example?

I, again, was alarmed to find out that school psychologists—these are people actually trained in psychology, child psychologists. The national average is 1,500 to 1, 1,500 kids to 1. In Iowa, it's 1,294 to 1, not much better. There'll be a shortage of almost 9,000 school psychologists in the United States by 2010—we've already passed that—and an accumulated shortage of almost 15,000 by 2020. Should we be taking a look at that?

Dr. COOPER. I think so. I think Mr. Fernandez is a nice example of sort of how excellence can be achieved there. In our practice, we routinely partner with our education colleagues. So it takes time. You have to call the teacher. You have to call the school psychologist to talk about what's going on with that child and what's going on in their life that helps you to form the best treatment plan for that child. And that's really a critical step.

The CHAIRMAN. Mr. Fernandez, you said here—and I didn't know this—our focus, you say in your testimony, is what intervention and supports will help the student best, regardless of the cause. Then you went on to say that in terms of medication, schools do not recommend or prescribe medication. In fact, many States have laws prohibiting school personnel from even raising it in conversation with families.

Are you suggesting that school personnel be allowed to discuss perhaps different interventions with the family? I don't understand what you meant by that statement. They can't discuss with family interventions, or just medical interventions?

Mr. FERNANDEZ. Mainly the prescribing of medication, because, many times, I'll be in meetings, or I have been in meetings in the past, where the teacher will say, "Well, your child just needs Ritalin" or "Your child needs that." I'm not a physician. I'm not trained in prescribing medication and neither is the teacher. So I think some of those regulations and rules are in place because of that.

The CHAIRMAN. Right.

Mr. FERNANDEZ. We can certainly talk about the variety of interventions and services and initiatives we have in school with a parent, and when those questions come up to us, we encourage them to talk to—sometimes there are clinical psychologists who can link them to a psychiatrist. But we definitely try to encourage them to

talk to a medical professional about the specifics of prescribing medication. So that's what I meant in my testimony.

The CHAIRMAN. I'll come back to that. My time is up. But I'll make a generalized statement here that nonprofessional people sometimes tend to say, "Well, there's a drug that will take care of that. Just take that drug." And that's not a professional way, but a parent might listen to that.

Senator Alexander.

Senator ALEXANDER. Thanks, Mr. Chairman. Let me approach it almost from a layman's point of view, which I am, and I think the way a great many Americans would look at this. This reminds me a little bit of the hearings we've had on food allergies, which, in the experience of most of us when we were young, we didn't ever hear about them, and all of a sudden, here they are, and we wonder where they came from. I know that's an entirely different situation.

But, Dr. Cooper, let me start with you, and let me use this personal example. My mother, for 35 years in Maryville, TN, had 25 3- and 4-year-olds in the morning and 25 5-year-olds in the afternoon in her preschool program. Now, 50 years ago, 40 years ago, how many of those kids would have been considered to have attention deficit disorder? Was that known then? Was that understood then? Do you have any idea how many children in their early childhood ages were diagnosed with ADHD 30 and 40 and 50 years ago? How many of them had medication prescribed?

Today, we're told that 20 percent of boys, by the time they're 17 or 18, are diagnosed with this problem, and 70 percent have medication. So, first, what was going on 30 or 40 or 50 years ago? Was it just not present, or was it just not noticed?

Dr. COOPER. I think that's an important question. In thinking about your mother's classroom and my mother's classroom—she taught second grade and had a similar experience—and I recall back 30 years ago when I was in school—40 years ago, I guess, when I was in first grade. There are children that have had some of these behaviors for years, and they were not necessarily given a diagnosis of ADHD. So whether the increase that we're seeing is because there's an increase in——

Senator ALEXANDER. Excuse me. But, in plain English, we're really talking about a difficulty with highly focused attention in ADHD. Is that a correct way to say that? How would you describe that?

Dr. COOPER. ADHD is sort of a balance of things that—they have an attention—also may have hyperactivity. You would describe these kids as being driven by a motor, and when they show up in my exam room, I can tell what's going on with this child, because they're bouncing from the exam room to the chair. They're knocking the ear specula off the wall. So you can often tell.

But what happens is for a child to have a diagnosis of ADHD, it has to be disruptive. It has to interfere with their functioning. So a child's job is to go to school and grow and be healthy. And when these behaviors or these symptoms interfere with their functioning, that's when we need to put things in place.

Senator ALEXANDER. Has this condition multiplied greatly in the last 20 or 30 or 40 years? Or is it just being noticed more often?

Dr. COOPER. I don't think we know. I think probably it's a combination of several factors. It certainly is being noticed more often, and for some children that may be a good thing. I think if we think about whether or not there's too much diagnosis—and there may be some times where there's other things that can be done to help these children. Behavioral therapies are highly effective. We find that they can really make a difference for these kids.

I had a child a few months ago that we were treating, and we did several behavioral interventions, but they weren't working. We started the medication, and he said, "It's kind of like my mind was being driven by a motor. The medications allowed me to slow down enough for the behavioral therapies to work."

Senator ALEXANDER. I've got about a minute left here. But let me shift a little bit to say you've done a lot of research and studies, as have others who are here. Have you come to any conclusions of your own about why there's so much diagnosis compared to earlier?

Is it something in the environment? Is it the fact that both parents may be working, or the only parent may be working, and there's less time for a child? Is it that schools, as some have suggested, receive more money when a child goes into special education? Is it because high testing is putting pressure on children?

Have you come to any conclusions yourself about the growth and why we have 20 percent of boys by age 17 or 18 with this diagnosis?

Dr. COOPER. It's really perplexing, isn't it? And I don't think we know the answer. I think we need to do more research to understand and figure out if it's an increase, or if it's increased recognition, or some of these other external factors maybe at play.

Senator ALEXANDER. So we just don't know.

Dr. COOPER. We don't know.

Senator ALEXANDER. Little boys bounce around a lot. How do you make the distinction between a disorder and just the familiar characteristic of boys growing up?

Dr. COOPER. I raised one. I can tell you they do. What we find is that if they are able to go to school, if they're able to function, if they're able to function with their peers and have friendships, then some of these symptoms may be managed just by helping the parents with behavioral management. But in times where it interferes with their job—go to school, grow, have friends—that's when we need to think about whether there's something else at play.

Senator ALEXANDER. Thank you.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Alexander.

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman. I want to thank you and the Ranking Member for keeping the focus of this committee on this important topic, mental health, treatment options and trends.

I wanted to spend my question time focusing in on a particular treatment option for particularly vulnerable children and bipartisan legislation that I've recently introduced concerning that treatment option. What is known as either therapeutic foster care or

treatment foster care can be a ray of hope for children who have serious medical, psychological, behavioral, emotional, and social needs.

Under this therapeutic or, as it's sometimes known, treatment foster care model, foster parents are given special, fairly intensive training to address the needs of youths with major mental or physical health challenges. And then children receive intensive in-home services to sustain them in the community. Therapeutic foster care provides critical services to what we estimate to be about 40,000 across the Nation at any given time and about 1,000 in my home State of Wisconsin.

Mr. Arch, I understand that Boys Town has helped pioneer what we now know as therapeutic foster care or treatment foster care, and that you've nurtured this model and have been providing these services to at-risk youth for many years. I'd like you to share for the committee the Boys Town experience with treatment foster care and the ways in which high-quality services of that model can benefit these children.

Mr. ARCH. Yes, we have operated treatment foster care. Boys Town very much believes in a continuum of care. I spoke about the Residential Treatment Center, which is the highest level of that care within Boys Town. The treatment foster care would be a step below that, and it is for those kids. The Residential Treatment Center provides an essential place where a child can step down.

A child may not be ready to make the jump from a Residential Treatment Center, a very highly structured environment, to immediately go home or to another placement at a lower level of care. This is a great transition for that child, where there is still continued structure. The other thing it does is it provides more opportunity to continue to watch the effects of psychotropic meds.

One of the difficulties in managing and reducing psychotropic meds in an outpatient setting, from what the physicians have told me, is that it's difficult because you're not watching that behavior. So you can manage, but the mom comes in and says, "I need help. I'm desperate. We're afraid. The child is really tearing up the home and we need help."

So in a treatment foster care setting, you again have that longer view of behavior in a structured environment where you can step that down. So, yes, we're very much in support. And, of course, the States have a very different definition of that treatment foster care.

Senator BALDWIN. I was going to mention that in followup, that despite the clear benefits of this treatment option for children with significant mental health, behavioral, and sometimes medical needs, current law does not provide any sort of standard definition of treatment or therapeutic foster care under the Medicaid program, in particular. And though these services are provided across the country and are often reimbursed through the Medicaid program and certainly other child welfare funding streams, the lack of a Federal standard definition has, in the evidence that I've gathered, affected both quality and access across the country.

So I wanted to reference the bipartisan legislation that I recently introduced, along with my colleague, Senator Portman of Ohio, that establishes a Federal definition for Medicaid of therapeutic or treatment foster care. And I was pleased to see that Boys Town

was 1 of 265 national organizations that last week sent a letter to House and Senate leadership endorsing the legislation.

Can you speak to how the passage of the Quality Foster Care Services Act would improve care for youth, given the need for high-quality therapeutic foster care services across the country?

Mr. ARCH. I think by standardizing that definition, that goes a long way. And by providing the opportunity for the States to use Medicaid dollars—because it is different in various States. Some do use Medicaid dollars. Others do not. By allowing that, it provides, as I said, that intermediate level of care, and not necessarily long-term care, where the child would stay there for an extended period of time, but as a transition to step down to that lowest level of care that would be appropriate for that child.

Senator BALDWIN. Thank you.

The CHAIRMAN. Thank you, Senator Baldwin.

We're due to have votes at about 11:15, but I want to cover a few other things here. I forget which testimony it was—maybe it was Mr. Fernandez—stating, "Our focus is always on what intervention supports will help the student best, regardless of the cause." That bothers me a little.

Have any of you ever read this book, Manufacturing Depression, by Gary Greenberg?

[No verbal response.]

None of you have read it? Might I suggest that you would read it? I would really appreciate that, and I would appreciate your writing me and getting in touch with me and telling me what you think of it.

One of the things he points out in there is that if we don't look at the cause of certain mental illnesses, then we think it is only a medical problem and, therefore, has a medical solution. Now, in some cases, that might be true—bipolar, schizophrenia, things like that that do require certain medications. But in a lot of other areas, maybe it's due to something else.

So to not look at the cause, the underlying background of what a child may have gone through—I mean, what may be manifested, maybe some years of abuse, abandonment, bereavement, someone has died. Different things can happen to kids in their lives. They have tough lives.

Maybe it's because of things that people have suggested—and I don't know if it's true or not—that society has changed. Kids today, from the earliest time, eat more fat, starches, and sugars and salt—fat, starches, sugar, and salt. Kids from the earliest age are eating a lot more than what we did 50 years ago, or when I was a kid. And kids are not just little adults. They have different metabolism rates and everything else.

And then they don't get as much exercise as what we did, plus they're bombarded from the earliest time with everything. Life is fast, the fast pace. They see all the ads on television, and there's more games. There's more things like this, but not enough exercise. Society has changed greatly in the almost 70 years since I was a kid.

So it seems to me that to say we're not going to look at the cause tends to move you more toward medical, medicine, antidepressants, psychotropic drugs, rather than psychologically—not psychiat-

rically, but psychologically looking at the whole child and thinking, "Well, maybe we need to know more about what's going on there."

I digress a little bit. But we started a program in Des Moines a long time ago. It was called Smoother Sailing. I was able to get some money through Appropriations. We co-partnered, I think, with McDonald's, of all things, to get more trained child psychologists in elementary school, at the earliest possible time.

What was discovered over about a several year period of time was that a lot of these kids brought to school—as someone said in their testimony—more than just their back packs and their school lunches. But they're bringing a lot of problems from home.

And once these school psychologists went home with the child and talked with the family and found out what was going on and was able to work with the family, things changed. Now, barring that, that kid might have been given Ritalin or something, which may have caused other kinds of problems, like diabetes.

Was that you that pointed out the increase in diabetes?

I say all this because I was concerned about that statement, about we don't look at the cause. We just treat the child. Shouldn't we be looking at the cause in these children, thinking about what the background of this—what's all that background noise that's going on that may cause that child to act out?

Am I just misreading what you said?

Mr. FERNANDEZ. Yes. I probably could have worded that a little bit better. I think we do very much look at all the variables and factors that impact a student. But working in the public schools, we have to support every child that walks through the door, regardless of what they bring to us, whether it be emotional, behavioral, or social issues.

So regardless of what comes to the door, we are charged with addressing those needs and supporting those students. But we very much do look at the various causes and reasons that may be impacting a student, because I think it's important that we are providing the right interventions, and that when we collaborate with outside professionals, we are able to provide that information to them as well.

We work very hard to build relationships with families. Schools can't function in a vacuum. The best work, the best support, and the most success for students can be seen with that collaborative relationship with school and family. So I guess my point in that was regardless of who walks through our doors, we have to support them.

The CHAIRMAN. So you're not saying don't go into their backgrounds and what's happening with their families.

Mr. FERNANDEZ. No. That's correct.

The CHAIRMAN. Oh, that's my misreading of it.

Mr. FERNANDEZ. Yes, because there are a lot of things on the surface, and if you just look at symptoms that are presented or behaviors that are presented, you can think, "Oh, that's ADHD." But when you take a step back——

The CHAIRMAN. Yes. My time has run out. But I want to ask Ms. Martinez to think about my next question, because it's going to be: What would you suggest to other young people about how they

overcome their internal fears? But we'll have to wait until my next time.

Senator Alexander.

Senator ALEXANDER. Thank you, Mr. Chairman.

Mr. Arch, let me pursue Senator Harkin's line of questioning and ask you some of the same questions I asked Dr. Cooper. For a lay person who looks at this, the straightforward way to look at it is to say if you have a problem where, suddenly, you read that 20 percent of boys are diagnosed with this attention disorder, the first place you'd go to find out why—the cause—is home. The second place you'd go is the school. The third place you'd go is the environment in which the child lives, watching several hours of screens a day with violent images and all that you see. And the next place you'd go would be the doctor or other medical personnel that the child sees.

My first question is: Has there been a big increase in the actual condition over the last 30 or 40 years? Boys Town is the most celebrated outfit in the country, I guess, in looking at this. And now you look at it in so many States and so many settings. Has there been a big increase in the number of boys, let's say, who have attention deficit disorders? And based on the children you see, do you see lots of examples of—well, why is that? And, three, do you see lots of examples of over-medication to deal with it?

Mr. ARCH. Senator, like you, I am also a lay person. So I'm not a physician and not a clinician. However, I can tell you that for children that are admitted to the Residential Treatment Center below the age of 12, Ritalin is the No. 1 most prescribed medication. Now, that doesn't prove cause-effect, obviously, and I think the struggle that we all have in answering that question is what is the cause. It's not an experimental design that we can study. So it's more observation.

I can also tell you that in discussions with the psychiatrists, they certainly have seen an increase in diagnoses of that. They believe that they are seeing that, but that's anecdotal. So, like Dr. Cooper, I'd say more research is needed.

Senator ALEXANDER. But Boys Town has been around since 1917. Surely, in 1917, 1947, 1957, 20 percent of boys didn't have attention deficit disorder, did they? Or did they?

Mr. ARCH. Maybe that's another question for Dr. Cooper. But I'm not sure when ADHD was actually added to the list of diagnoses. I don't know the answer to that question, Senator. I'm sorry.

Senator ALEXANDER. But over-medication—you see many boys coming into your system. What about over-medication?

Mr. ARCH. We definitely see that, and that's a big concern. I say over-medication—multiple psychotropic meds being prescribed. And as I say, some of that has to do with just the coordination of care. A medical home, the ability to have a kid with special needs that's being overseen by a single physician, would go a long way toward that, more medical home treatment, so that there is a coordination of that, of the prescribing of those psychotropic meds instead of going from physician to physician. And that sometimes happens, especially as these kids move from placement to placement.

Senator ALEXANDER. I know our time is short, Mr. Chairman. I'll give my time to Senator Baldwin.

The CHAIRMAN. Senator Baldwin.

Senator BALDWIN. Thank you.

Dr. Cooper, in your testimony, you spoke about health care providers often being unaware of the best practices, frankly, and guidelines for treating children with behavioral and mental health issues. And, often, that results in inappropriate treatment with medications.

What would be the best way to close this gap and ensure that both providers and families have clear information and various treatment options? And could you comment on the significant holes that I think exist in current research on treatments for children that we ought to be addressing? If you could focus us in on what those key gaps are, that would be great.

Dr. COOPER. Senator Baldwin, I think that's a really critical point, because it turns out that there are excellent tools. There are treatments that are available. But the challenge is education of community-based providers, including that early on in the training course so that as people are going through their medical training or their professional training, they receive appropriate guidance on those things.

One of the things that actually works really well is a model of identifying those behaviors or those providers who are sort of out of line and providing them with information, sort of an academic detailing model by peers. So in Tennessee, for example, the State of Tennessee has foster care centers of excellence.

And one of the critical roles that those centers of excellence play is to identify children in the foster care system who are receiving multiple medications or receiving medications that are not consistent with therapy, helping then to give that information back to the health care provider who's having that practice and saying,

> "For some reason, you appear to be practicing out of the norm with your peers. You're prescribing at this rate, whereas your peers are prescribing at another rate."

There's been a tremendous benefit from that level of detail. That's intensive, but that's been really helpful. I think that's an area where we could think about closing that gap.

Senator BALDWIN. I'll yield. I know you wanted an additional round of questions.

The CHAIRMAN. Thank you. We've got time. We've got plenty of time.

Ms. Martinez, this is all well and good. But it all comes down to the individual who has suffered some form of mental illness, and especially young children. I was intrigued by your testimony and—intrigued—that's the wrong word. I was encouraged by your testimony and what you did as you looked at yourself. You said, "Fortunately, my aunt and friends encouraged me to go to the university health center."

So this started to manifest itself in university. And, at least, from my reading, a lot of these mental health disorders exhibit themselves when kids go away from home for the first time and they go to college. I've had hearings in the past with this committee on eating disorders and was alarmed to find that the single largest cause of young women dropping out of college is an eating

disorder, and that eating disorders then continue to evolve into other forms of mental health problems.

I guess what I'm wondering is in your experience—you obviously did something very courageous. You self-diagnosed. You talked to friends. You took the right course of action. But I'm sure you must know others of your peers that didn't take that course of action.

Is there anything we should be doing in terms of young people, when they—I'm thinking now of college. Before, I've been talking about grade school and elementary school—but when they go to college, that they get some kind of counseling right away so that they can recognize these early symptoms. Should we be thinking along those lines?

Ms. MARTINEZ. In my experience, I was not a stranger to counseling. All my life, I had been in some sort of mental health treatment, but not to this extreme. But when I went away to school, then there were sort of these exacerbations—just not feeling like myself—and people started to notice that around me. So other people were able to speak up and say, "This is how you're presenting. This isn't normal."

I had support around me in that really critical and vulnerable time period, which I'm so thankful for. I went and saw the counselor, who then was smart enough to refer me to the practitioner, who just happened to have had this seminar and this training on this model, the PIER program, and was able to identify my signs and symptoms early.

It does take a lot of courage, I think, especially for people that aren't used to being treated and talking about mental health issues. It's very scary and shameful and embarrassing. So trying to have as much support as possible, especially when you move away to college, is crucial.

The CHAIRMAN. Tell me a little bit more about this PIER program. I'm not familiar with it. You said it saved your life.

Ms. MARTINEZ. Right. It's a model. It's a preventative sort of model. They replicated this model in different areas of the country. But, basically, once you get a referral and you sort of meet criteria for this research program, they start treatment right away. I can just speak about my own experience with it.

But, basically, the treatment was fast and it was early. So the model really stresses prevention, trying to catch it sooner rather than later and not waiting for having a first episode, a psychotic episode, to happen, doing something before that episode. It really—it stops that progression of a major mental illness, and that's what happened in my case. I was treated very early on because of really good assessment and evaluation and treatment.

The CHAIRMAN. Some of which had gone back to your earlier life, right—I mean, younger, when you were much younger.

Ms. MARTINEZ. I had treatment for other things earlier in life, yes, but not in this model, though, not this way.

The CHAIRMAN. Thank you.

Mr. Arch, you said approximately 79 percent of the children admitted to the treatment center are taking multiple psychotropic medications to control their behavior at the time of admission. Although effective in treating some problems, due to the physical side

effects of these medications, more research is needed regarding their safety and appropriate use.

You said that you had reduced by 33 percent the number of kids taking any medications and a 38 percent reduction in medications being taken at the time of discharge. So you do try to get kids off of medication, then.

Mr. ARCH. That's right. We try to reduce—as the psychiatrist has said to me—he says,

> "I'm not sure what I'm looking at when a child is first admitted. I'm not sure if I'm looking at the drugs, the effects of the psychotropic meds, or if I'm looking at the behavior."

But in a structured environment, such as our Residential Treatment Center, we're able to wean the kids down to what the psychiatrist believes is an appropriate level of medication.

The CHAIRMAN. And, obviously, you've found that when they transition—do they stay at that level? I mean, once you've taken them off that, do they stay at that level then?

Mr. ARCH. I don't know the answer to that question. I don't know that our research did that—a 6-month followup on that. I could check on that, but I'm not sure.

The CHAIRMAN. Senator Alexander.

Senator ALEXANDER. I don't have anything else.

Senator Baldwin.

[No verbal response.]

Nothing else. Well, I've got a lot of questions. This is something that interests me greatly. I don't mean to prolong it. But I just want, again, for all of you here—Dr. Cooper, you've published several articles about the off-label use of antipsychotic medications for treatment of conditions such as ADHD and depression in both adults and children.

What does that mean? What does off-label mean?

Dr. COOPER. The labeling requirements for medications require that there be proven efficacy for a medication in a certain condition. So antipsychotics have been proven to work and are approved for use in certain children for schizophrenia, for autism, and, in some settings, severe bipolar disorder. When it's used for another diagnosis or another indication, that's technically off-label.

The prescribing regulations allow a health care professional to make decisions about what might make sense for an individual patient. And while that's important, in these settings, over half of the antipsychotic prescriptions that we studied were for ADHD and other behavioral things. We don't know if they work in these settings. Now we've done some research that shows that they actually can be harmful.

The CHAIRMAN. I mentioned the ratios here for school psychologists. The national average is 1,500 to 1. The recommended ratio is 700 to 1. School counselors—ratio of students is 457 to 1, twice the recommended ratio of 250 to 1.

School social workers—some States have 2,500 to 1. The School Social Workers Association determined that the maximum ratio is 800 to 1. The Department of Education uses a ratio of 800 to 1. The recommended ratio of school social workers is 250 to 1.

I guess the question I would ask is do we need more school psychologists—I mean, someone trained as a child psychologist—and

counselors and school social workers in our elementary schools? What would you think? Do we have enough? I'm just asking. Yes or no?

Dr. COOPER. I don't think we have enough. What I find is that for these children who have these chaotic social situations, lack of access, mental illness, mental illness in their family, all these things, there are so many challenges that they face, and school is the primary point of contact.

When we try to interface with schools as health care providers, it's often challenging to find the right person to help this child get access. We really believe in collaborative partnerships to help ensure that the right child gets the right treatment every time.

The CHAIRMAN. Mr. Fernandez, do you think we need more school psychologists or social workers?

Mr. FERNANDEZ. I do. I agree with what Dr. Cooper was saying. The access point for a lot of students with mental health and behavioral concerns is the school, and there's not enough of us to address all the needs that walk through our doors.

The CHAIRMAN. Mr. Arch, what do you think?

Mr. ARCH. I think research is pretty clear that early intervention is a big key to this, and school is where a lot of this behavior is manifested. So if that will help, yes.

The CHAIRMAN. Ms. Martinez, from your experience?

Ms. MARTINEZ. Yes, definitely. I think access to the resources is a key thing and just doing it, being more collaborative. That's how my care went, and that's what worked.

The CHAIRMAN. Our bells have rung. I just want to ask this. We have all your testimony. You gave your statements here. We've asked questions. Is there anything that any one of you wants to say to us before we gavel this down that maybe we haven't raised or you really think that we should know or consider? Is there something that you think, "I wish they had asked this or looked at this." Is there anything? Maybe we have. I don't know.

Dr. Cooper.

Dr. COOPER. I think the critical thing is that you're having this conversation, and that's what's really important. We have to be aware of these issues. We have to be aware of the challenges that mental health disorders create for children and ensure that we continue to talk about this and identify ways to identify children early, intervene, get these right treatments for the right child, and ensure that we're moving forward in the right way for these kids.

The CHAIRMAN. Mr. Fernandez.

Mr. FERNANDEZ. We've all spoken today about the collaborative work. We can't address student needs in isolation. Working with outside providers, medical professionals, clinical psychologists, school counselors—all these people come together as a much larger team to support the needs of a student. I think that's probably one point I definitely would like to make sure that everyone knows.

The CHAIRMAN. Mr. Arch.

Mr. ARCH. Like you, Senator Harkin, I come from a rural State, and what we see in the rural State is a lack of child-adolescent psychiatrists. That is the reality. I don't think that's going to change. I would encourage Congress to take a look at some possible creative funding mechanisms that can allow a child psychiatrist in an

urban setting to support a rural family practice doctor or a pediatrician as they're wrestling with some of the issues regarding psychotropic meds.

Right now, there's just not that ability. If a child psychologist doesn't see that patient, there's no way for that child psychiatrist to be reimbursed for their time. But something like that might be a little creative to help some of the family practices and pediatricians.

The CHAIRMAN. Ms. Martinez.

Ms. MARTINEZ. I think what you can take away from my testimony today is really being an ally to supporting these programs like PIER and EDIPPP that use prevention against major mental illness—recovery, if possible, for us. So that's the big take-home.

The CHAIRMAN. Thank you all very much. I would just say this in my closing. I'll ask Senator Alexander if he has any closing remarks. And this is my own view. I only speak for myself, obviously.

But we spend a lot of time here, and we have over the last 30 years that I've been here, looking at elementary and secondary education. We have tests and No Child Left Behind, and now we have this and now we have that. We're looking at all the different ways of measuring kids' achievements.

I don't know that we've spent enough time looking at the other part of the child in school. I think—and, again, I speak for myself. I tend to think of a more bucolic time. When I was younger, we had nuclear families. We lived in small communities. We had church groups. We had all these things we did. We weren't bombarded with television and all these games. We exercised. We ate good food.

I wish we had that, but times have changed. I'm just wondering if maybe we've focused too much on tests and scores and things like that, but not enough on the whole child in terms of our elementary and secondary education. That's just my thoughts.

Senator Alexander, did you want to say anything else?

Senator ALEXANDER. No.

The CHAIRMAN. I request that the record be kept open for 10 days for statements and questions for the record. And, again, I thank you all very much, and please read Manufacturing Depression by Gary Greenberg and let me know what you think.

Thank you all very much for being here. I know some of you came a long distance, and I appreciate it very much.

The committee stands adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

RESPONSE TO QUESTION OF SENATOR HARKIN BY TIFFANY MARTINEZ

Question. Ms. Martinez, thank you for the testimony you provided regarding how the Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP) helped you in your own journey with a mental health condition. Can you tell us more about the EDIPPP program's locations, goals and the research findings generated by the program? How can Federal agencies like SAMHSA and NIMH benefit from knowledge gained through EDIPPP programs? In particular, what are the implications for prevention efforts aimed toward reducing severity of mental illness?

Answer. Thank you for your questions and for inviting me to speak before the committee. If I had not been referred to the Portland Identification and Early Referral (PIER) program, the model for EDIPPP, I would not be getting ready to graduate next month with my master's degree to become a nurse practitioner from the University of Southern Maine. When I first found out I was experiencing the early signs of schizophrenia, I thought my life was over. PIER gave me hope and helped me to live a fulfilling and meaningful life. EDIPPP, a national study funded by the Robert Wood Johnson Foundation from 2006–13 provided this opportunity to thousands of other young people ages 12–25. EDIPPP was designed to replicate PIER in five sites (Sacramento, CA; Salem, OR; Albuquerque, NM; Queens, NY; and Ypsilanti, MI) around the country, each with unique geographic, socio-cultural, and environmental characteristics.

The goal of EDIPPP is to identify and curb the early signs of psychotic illness before they develop into severe mental illness. The program focuses on educating families and those who routinely interact with at-risk youth—teachers, mental health professionals, and doctors—about key signs to look for in young people to identify those with early signs that might lead to psychosis and thus prevent psychosis before it starts. Once a person is identified, the program provides an evaluation of an individual's current mental health status and treatment needs. Those who meet the criteria for the program are engaged in treatment, which includes family engagement. They also learn new skills—to complement professional support—that help them recognize symptoms, manage stress, and decrease the risk of movement to full-blown psychosis. All treatment is based on an individual treatment plan, which includes counseling, supported education or employment services, and, if necessary, medication.

The results of EDIPPP are promising. A recent article published in *Psychiatric Services* suggests that PIER-reduced hospitalizations for initial psychotic episodes by 26–34 percent in a mid-sized city. In addition, a large peer-reviewed study of EDIPPP found:

- The conversion to psychosis was 6.3 percent at 2 years, within a narrow range (4.3 percent–7.7 percent) across six cities.
- 84 percent of the at-risk youth already had a DSM–IV major disorder, alleviating some of the concern about treating those who do not develop a psychotic disorder. Early intervention for psychosis can thus be early intervention for a wider spectrum of psychiatric illness during its early phase.
- 83–84 percent of at-risk youth and those experiencing very early onset psychosis were in school or working at baseline; this remained stable or increased at 2 years with 83–90 percent in school or working.

NIMH and SAMHSA can benefit from the lessons learned by EDIPPP as they develop guidelines for early identification and intervention in serious mental illness under the 5 percent set-aside in the Community Mental Health Services (CMHS) Block Grant. The EDIPPP findings should help to inform the guidelines on how to incorporate evidence-based strategies for early intervention for psychosis at a stage prior to the onset, as well as at a first episode of psychosis. For the majority of people who develop psychotic disorders the onset is gradual and preceded by a host of identifiable risk indicators. These indicators include significant declines in cognitive function, social and role (school and work) functioning, as well as the development of other diagnosable mental health problems such as anxiety and depression. By engaging a person and their family early and providing appropriate support, we can either prevent the illness from becoming acute or reduce how long the illness remains at an acute level. Already, Oregon and California are in the process of expanding the program. In Oregon, through its Early Assessment and Support Alliance (EASA), services similar to EDIPPP have been made available to 81 percent of the population. Once people are in EASA there was a major and immediate drop in hospitalizations and most people remain actively involved in school and work. Other States have shown an interest in EDIPPP implementation.

As you know, psychotic disorders often first appear in the mid-late teens or early 20s, and exact a tremendous cost to individuals, their families, and communities. The findings from EDIPPP and a large growing body of research should help to change the way mental health services are delivered. We have an opportunity to move our mental health system from a costly system that is disability-oriented to one that focuses on easy access, strengths, self-determination and developmental progress. Communities that are willing to commit to making early identification and intervention supports available to teenagers and young adults will increase these individuals' ability to stay in school, maintain employment, and live healthy, productive lives.

Thank you for your questions. I am happy to provide any other information that may be helpful.

RESPONSE TO QUESTIONS OF SENATOR MURRAY BY BENJAMIN FERNANDEZ, M.S., ED.

MENTAL HEALTH

Thank you for attending the HELP Committee hearing and sharing your experience with the committee.

As you are well aware, there is an urgent need to improve mental health care all across the country. Stigma associated with mental illness remains widespread, and often results in individuals feeling isolated and afraid—causing them to forego the treatment or support they need. An estimated one in five Americans will suffer from a mental or neurological disorder at some point in their lives, yet two-thirds of people with a known mental disorder never seek treatment.

Question 1. What can we do to instill in children from a very early age that mental health is just as important as physical health? How can we work to reduce stigma associated with mental health, and educate individuals, families, and schools?

Answer 1. For starters, we need to infuse the importance of mental health into health curricula that discusses the importance of physical health. Currently, we focus on physical health and mental health as two completely separate issues. However, physical health can impact one's mental health, and vice versa, so we need to be more explicit in the inclusion of mental health in health curricula. Additionally, we need to provide education regarding mental health and wellness for all children, beginning when they are toddlers. Adults need to teach our young people that sharing their feelings, seeking help when they need it, and caring for others who need help is just as important as getting fresh air, eating fruits and vegetables, and playing outside. Additionally, as a country we need to intentionally start discussing mental illness openly and honestly. In school, students learn about various physical diseases (e.g., cancer, heart disease) and how to prevent them, but rarely are mental illnesses, such as depression, mentioned. Mental illness is a disease. In some cases it is preventable, in all cases it is treatable. Children who have asthma, or diabetes think nothing of sharing their story, showing their inhaler, or telling a friend they have to go to the school nurse once a day to get a shot. However, students who are receiving treatment for an emotional, behavioral, or mental health issue are often less open about their treatment. Students who need to seek counseling should not have to hide it. We need to do a better job of engaging in an open dialog about mental illness—what causes it, how to prevent it and how to treat it—in the same manner that we discuss physical ailments. With intentional public outreach, we can reduce the stigma associated with mental illness.

There are also a number of ways that schools can assist in reducing the stigma regarding mental illness and instill the importance of mental wellness through a student's academic career. Students can learn about the concepts of mental wellness through lessons such as Mindfulness (a cognitive behavioral process teaching students to self-regulate emotion, behavior, and attention) and key concepts related to resiliency and positive behavior can be incorporated within the school day and environment. In Loudoun County Public Schools, eighth grade middle-school students learn about mental health as part of the general health curriculum via the "Exploring Mental Health" program. "Exploring Mental Health" is conducted by school psychologists, school social workers, and school counselors to educate students about mental health and positive ways to maintain mental wellness. At the high school level, all ninth grade health classes receive Depression Awareness/Suicide Prevention education. School psychologists, in conjunction with the school social worker and school counselor, teach students the signs and symptoms of depression, clarify the facts and myths associated with depression and suicide, and teach students how to identify the warning signs and risk factors associated with suicide. Importantly, this program teaches students how to address a situation where a friend or someone they know may be in danger of harming themselves. Students are taught to seek

out a trusted adult in school and/or at home to share their concerns and ensure that the student receives help. Additional outside resources specific to their community are also provided for students. Delivery of this type of education has helped to create an environment where students feel comfortable going to trusted adults to get help and has helped to reduce the stigma of depression. Additionally, a Depression Awareness Booster session has been conducted in a number of the high schools. This presentation reinforces concepts from the initial Depression Awareness/Suicide Prevention presentation but focuses on how students can seek the help they may need as they transition to college or career.

Question 2. What more needs to be done to educate individuals and families to recognize early signs of behavioral health issues? How can we ensure families understand their options and know where to turn when they need access to mental health services?

Answer 2. Much more needs to be done in terms of education on how to recognize behavioral health issues and where to go for help. For example, parenting books and parenting classes need to include more information regarding typical behavior vs. atypical behavior across the life span. Parents have a wealth of information about where to turn for help when their young child may not be meeting developmental milestones such as walking or talking later than typical. However, information for parents who are concerned about the behavioral or mental health of their child is lacking. Schools can also be more proactive in this effort. Schools frequently send home information on how to help a student struggling to learn, how to deal with homework difficulties, and how to help a child become more organized. However, with help from school-employed mental health professionals (e.g., school psychologists) schools can also provide information to parents on strategies to support mental wellness and how to seek help if they have concerns about their child's mental health. Many school systems wait until a problem has reached a critical point before sharing this type of information with parents. Mental health supports should be viewed as equally important to the academic support services made available for kids.

In Loudoun County, school employed mental health professionals routinely attempt to engage parents. To help parents better understand mental wellness and mental illness, the content and topics covered in "Exploring Mental Health" and "Depression Awareness" education programs are available for parents to review. In many schools, these presentations are given in their entirety for parents. Parents have the right to "opt-out" their child from these education programs if they feel it is necessary. Additionally, schools psychologists are available to discuss these topics with parents and answer any questions related to mental health and supports available. Below are a few examples of how LCPS school psychologists, in conjunction with other school-employed mental health professionals, provide education on mental and behavioral health:

- A preschool psychologist and one of our school psychologists run a series of parenting classes that provide parenting skills as well as addressing developmental issues with children.
- Hosting workshops and parent coffees on topics related to anxiety, eating disorders, and drug abuse.
- Parents as Educational Partners meetings for ELL families after school hours offering workshops on anxiety, depression awareness and suicide prevention, family reunification, dating violence, gang prevention and intervention.

Question 3. Can you share best practices on how government agencies and the community where you practice have worked together to find effective solutions to these issues?

Answer 3. Loudoun County has several partnerships with other local government and community agencies. Below are a few examples:

RESTORATIVE JUSTICE/PRACTICES—DEPARTMENT OF JUVENILE JUSTICE AND LCPS

- Restorative Justice (RJ) emphasizes values of empathy, respect, honesty, acceptance, responsibility, and accountability. It provides ways to address undesirable behaviors, offers alternatives to suspensions and expulsions, incorporates learning, and improves safety by preventing future incidents.
- LCPS staff, Loudoun County Juvenile Court Services, and Fairfax County Public Schools are collaborating to bring training for facilitators in order to fully implement these services.

STUDENT ASSISTANCE PROGRAM (SAP)—LOUDOUN COUNTY MENTAL HEALTH

• A collaborative program between Loudoun County Mental Health and Loudoun County Public SAP provides a Loudoun County Mental Health therapist who will be available to conduct a free assessment at school for students who are having significant difficulties due to behavior problems, emotional problems, family difficulties, peer relationships, or other outside issues. This person sees the student for three sessions and provides the school and the family with recommendations regarding what, if any, further treatment is warranted.

COMMUNITY PROVIDER MEET AND GREET SESSIONS

• Each year LCPS holds a Meet and Greet session with private mental health providers and community agencies. This gives school-employed mental health staff, school psychologists, school social workers, and school counselors) the opportunity to personally meet these outside providers and to learn about services offered.

• A list of providers is then compiled with provider name, expertise, insurance taken, and services provided. This list is made available to the schools for future reference.

Local school/community partnerships are certainly important in addressing the behavioral and mental health needs of students during and after school. However, it is imperative that the Federal Government continue to provide explicit funding to assist these endeavors. There is a shortage of school employed mental health professionals (school psychologists, school social workers, and school counselors). These professionals are specially trained to provide behavioral, social, emotional, and mental health supports within the context of learning and the school system as a whole. These professionals are critical partners with community resources and agencies and can help ensure that students have access to the supports they need in the community, and can provide critical supports during the school day. Currently, the Elementary and Secondary School Counseling Program is the only Federal grant that can be used to implement or expand school counseling programs—including hiring school psychologists, school social workers, and school counselors. These funds can help schools better provide mental and behavioral supports to children, while forming the partnerships with communities needed to meet the comprehensive needs of all students.

Thank you for your dedication to the mental wellness of our students.

[Whereupon, at 11:24 a.m., the hearing was adjourned.]

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