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# *Committee Meeting*

of

## JOINT COMMITTEE ON THE PUBLIC SCHOOLS

*“Invited guests will speak on the topic of mental health in public schools  
and early intervention”*

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**LOCATION:** East Mountain School  
Carrier Clinic  
Belle Mead, New Jersey

**DATE:** September 30, 2015  
10:00 a.m.

**MEMBERS OF COMMITTEE PRESENT:**

Senator Ronald L. Rice  
Assemblyman Benjie E. Wimberly  
Assemblywoman Donna M. Simon

**ALSO PRESENT:**

Rebecca Sapp  
*Executive Assistant*



*Meeting Recorded and Transcribed by*  
The Office of Legislative Services, Public Information Office,  
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

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SENATE

Hon. Ronald L. Rice  
Co-Chair

Hon. Diane B. Allen  
Hon. Christopher "Kip" Bateman  
Hon. James Beach  
Hon. Nilsa Cruz-Perez  
Hon. Linda R. Greenstein  
Hon. Samuel D. Thompson

ASSEMBLY

Hon. Mila M. Jasey  
Co-Chair

Hon. Ralph R. Caputo  
Hon. Betty Lou DeCroce  
Hon. Sheila Y. Oliver  
Hon. Donna M. Simon  
Hon. Benjie E. Wimberly  
Hon. David W. Wolfe



**Joint Committee on the Public Schools**

135 West Hanover Street  
P.O. Box 070  
Trenton, New Jersey, 08625  
Telephone: (609) 847-3365  
Fax: (609) 292-4912

**Amy Tibbetts**  
Executive Director  
[atibbetts@njleg.org](mailto:atibbetts@njleg.org)

**Rebecca Sapp**  
Executive Assistant  
[rsapp@njleg.org](mailto:rsapp@njleg.org)

**MEETING NOTICE**

**TO: Members of the Joint Committee on the Public Schools**

**FROM: Senator Ronald L. Rice, Co-Chair  
Assemblywoman Mila M. Jasey, Co-Chair**

The Joint Committee on the Public Schools will hold a meeting on Wednesday, September 30, 2015 in the Atkinson Amphitheater in the East Mountain School on the Carrier Clinic campus beginning at 10:00 a.m. Invited guests will speak on the topic of mental health in public schools and early intervention.

**The public may address comments and questions to Rebecca Sapp, Executive Assistant, at 609-847-3365, or by email at [Rsapp@njleg.org](mailto:Rsapp@njleg.org)**

Issued September 18, 2015

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**SENATOR RONALD L. RICE (Co-Chair):** Good morning.

**UNIDENTIFIED MEMBERS OF AUDIENCE:** Good morning.

**SENATOR RICE:** Let me, first of all, thank those of you who have taken the time to get up early -- and I'm not certain how the rain is going to treat us -- to be here. I think it's important for us to be here with you and for those of you to be here with us to share information.

My name is Ronald L. Rice, and I am a New Jersey State Senator. I get elected to the 20th Legislative District, and people always say, "Why do you say you get elected to the 20th Legislative District?" Well, that's because I'm a State Senator, so my job is to take care of you throughout the state, whether you like it not. (laughter) You can't vote for me, but when I make decisions-- So I just make it clear to some of my colleagues when I go into their districts -- I know we have some legislators who say, "What are you doing in my district?" I say, "I came here to talk to people." "Well, you should have let me know." "I don't have to let you know, okay? I'm a *State* Senator." (laughter)

And so I am a State Senator. I'm glad to be here.

I am the Co-Chair of the Joint Committee on the Public Schools. The Joint Committee on the Public Schools is charged with the responsibility of, more or less, oversighting and hearing from the public, and having input on education issues affecting the public schools throughout the State of New Jersey -- whether it's school choice, whether it's the urban districts, whether it's school construction. It is our statutory responsibility.

We don't do legislation as a Committee, but we can put together legislation and send it to committees to be heard. I think that the

issues that we're going to be talking about this morning -- that Assemblywoman Simon was kind enough to bring our attention to -- are very, very important. And that's why my members in our subcommittee decided to be here with her today. When she calls, we respond. And so I just wanted to say that to you.

At this point in time, what I'm going to do is let my colleague, Assemblyman Ben Wimberly, introduce himself. He comes from the education system; he can tell you that. And then we're going to turn this meeting over to be chaired by the Assemblywoman.

So thank you very much for being here.

Assemblyman Ben.

ASSEMBLYMAN WIMBERLY: Good morning.

As Senator Rice said, my name is Benjamin Wimberly; I'm the Assemblyman in the 35th District.

This topic is near and dear. I was a Special Education teacher for nine years at Eastside High School in Paterson. And I've been working in this school district now for 26 years, where I am the Joint Recreation Coordinator.

And this is a much-needed topic. Because too often we want to brush things under the rug and act like they are not there, and we're just going to address it through the normal way of going through a Child Study Team, or addressing things. But coaching and teaching for 26 years has really opened my eyes to many of the issues that, not only the school district, but many families want to make go away without addressing them in the right manner.

So it's an honor to be here; and Assemblywoman, this is a great topic and I am glad to be here with you today sharing this experience. And hopefully I can go back and share with not only our district, but anybody who wants to get the real issues at hand on this very, very vital topic.

ASSEMBLYWOMAN SIMON: Thank you.

All right; well, good morning. I'm Donna Simon from Legislative District 16. And I couldn't agree more with Senator Rice -- on that we are hyper-focused on our districts, but we are legislative members of the entire State. So whatever we can do to help is the most important thing to do.

I want to thank Senator Rice for granting this focus, as Chair -- as Chair of our Committee; along with Assemblyman Wimberly. And, unfortunately, Senator Thompson could not be here today. And I know that Senator Greenstein is supposed to be here, so she might show up in a little bit.

And I also want to thank the Carrier Clinic -- Don Parker -- for graciously opening your facility and hosting our off-site meeting here. And I am looking forward to the key speakers and the guests.

So the impetus for me asking for Senator Rice's support for the Joint Committee to address mental illness in schools is because, as legislators, we have an important opportunity to hear from so many constituents who are in need. And as Assemblyman Wimberly -- he has the direct interaction on a school level, so he appreciates this very much too.

And many of our constituents, many of our schools, our teachers, our admin, the Superintendents, Principals -- they really-- Some of them either don't know who to turn to, or they don't have the resources

that they need. Personally, I've been in meetings -- which I find shocking -- with some directors of Special Ed a while back and they have reported an alarming fact: that 5-year-olds are being diagnosed with depression. Think about it -- 5 years of age. These little munchkins are playing, and are supposed to be happy and well-adjusted; they have the rest of their lives ahead of them. And they're being diagnosed with depression. We have a real societal and community issue that we need to address.

I also had conversations with families that are faced with a child or a young adult who can be aggressive. They suffer from -- they're challenged with comorbidity, whether it's autism and mental illness; whether it's Oppositional Defiant Disorder, Conduct Disorder, behavioral maladjustment, social maladjustment -- whatever it is, these are not singular diagnoses. And combined with other diagnoses -- whether it's a medical treatment or psychiatric treatment -- these kids are in crisis. And there's a lack of places for them to go. Very often -- especially for the nonverbal population -- they're placed in residential or hospital environments where they're put into a pool with other violent offenders. And because they're nonviolent, the parents are horrified and worried to death that they'll be abused when they're in there because they really can't speak or communicate.

In our District also -- and I'm sure that there are many legislators who have experienced this -- but we had a tragedy happen in Hillsborough where a beautiful, highly intelligent young woman, who could not cope with the stresses and the stress factors in her life, went missing. And the police and the FBI were looking for her. And unfortunately, she

was found at the bottom of the George Washington Bridge. She had committed suicide.

So we hear stories about this. Now, where does it start? The home has issues; it starts -- the schools see issues. Sometimes the signs and the symptoms that are associated with mental illness are so subtle. Sometimes we misinterpret it as, "Oh, they're just teenagers," or, "It's a stage that they're going through," without really recognizing that there's a serious issue.

And for me, we're not pointing any fingers. So there's no, "It's the parents responsibility, it's the school's--" We are not doing that whatsoever. But what I am saying, and what we are all saying, is it's a partnership. And if we don't handle this together, we're heading down a vortex of a situation where the stats are just going to heighten and we're going to have more and more issues in our school systems.

So this is basically an open and honest discussion about mental illness. We hear about children and adults who cut, right; who are drug and alcohol dependent even in middle school, you know? It's frightening. Children and young adults who suffer from anorexia, bulimia; they abuse bath salts, sniff aerosol cans. Even those who are, unfortunately, sad pawns in the middle of a very turbulent divorce and suffer from parent alienation syndrome and the stress factors that go along with that. We hear about children who have reactive personalities like I had mentioned -- the ODD, the Conduct Disorder. We know children who set things on fire and harm animals. And all of this is under the umbrella of mental illness, right?

I think we can all agree that Adam Lanza, when he went into Newton that day and horrified and just devastated a community and

parents with what he did -- I don't think he woke up at 20 years of age with mental illness. I think he had it for a very, very long time. And not to say anybody was neglecting the fact that he did, but I think that we can do better, as a community.

So the question is, why aren't we talking about this more? Why can't we positively affect the stigma of mental illness? There is no shame; there should be no embarrassment. There should be no ridicule regardless of where it is. Whether it's a home, the neighborhood, the community, the schools -- there should be no ridicule and no shame to talking about mental illness and helping each other with this. It has a devastating effect on the child and the family. Everyone should walk in the shoes of somebody -- in their family, or a neighbor who you know. We're all touched by this, on some level or another; that we face with mental illness -- whether it's physical, emotional, psychological, and the social ramifications.

So I'd like to talk about it; have an open and honest discussion. We should be talking about this like we talk about cancer, or diabetes, or anything else -- any other disease process -- cardiovascular disease. So let's have that difficult discussion. Are parents equipped? Do they know who to turn to? You know, not to say that a psychologist isn't well-equipped; many of them are. Some of them are talk therapists. Do they understand about mental illness -- true issues, where they need to be crisis managers? How are the schools affected by this? Do they have enough resources? Schools have Child Study Teams, but the child has to be classified. What happens if the child isn't classified? The school psychologists -- are they equipped for these more severe mental illnesses? So where is the gap in all

of this? How can we help, either administratively or legislatively? And we're not here for a press release; we're not here for a photo op. We're here to really talk about some real solutions.

And I just appreciate everybody being here; I think this is an incredibly vital topic. So we're going to get started.

So for our first guests I'm going to invite up Don Parker, from the Carrier Clinic; and also Stacey Paulis, who is the Principal for the East Mountain School.

**D O N A L D J. P A R K E R:** Good morning.

SENATOR RICE: Good morning.

MR. PARKER: Thank you all for attending.

If you close your eyes for just a minute--

MS. SAPP (Committee Aide): He's not on the microphone, Senator.

MR. PARKER: --you would actually wake up to your high school in 1975. (laughter)

SENATOR RICE: Excuse me. (raps gavel)

MS. SAPP: Mr. Parker.

MR. PARKER: Oh, I have to talk into a microphone.

SENATOR RICE: Yes.

MR. PARKER: That's a good idea. (laughter)

Oh, great; okay.

Let me just stand up for just a second, then I'll take my seat.

So welcome; I thank you for holding this at Carrier. This is going to restrain me a little bit (referring to microphone cord).

I really want to talk to you first, just a minute, about an issue I think that's vitally important to everyone who is sitting in this audience. And you can all participate in this.

So I want to ask each of you who has had a meaningful discussion in your life -- have you had that meaningful discussion, and has it turned around your life in a significant way? Just raise your hand for just a second if you have had a meaningful discussion in your life.

So I want to know how many of those meaningful discussions happened here. (indicates his cell phone) Nobody. So today, over 60 percent of communications between families happens on this (indicates cell phone). And so we're communicating more, ironically; but the value of the communication has descended precipitously. So 65 percent of the communication that happened during that meaningful discussion -- so eye-to-eye contact, a firm voice, a soothing voice, a hand on the shoulder, a presence of a caring being -- is gone, is missing. And so we wonder today why we have 5-year-olds being diagnosed; we wonder today -- every day at Carrier -- why we've had a 52 percent increase in adolescents admitted to Carrier for psychiatric illnesses in the last four years. We wonder why there has been a 56 percent increase across the nation at my fellow psychiatric hospitals for children with psychiatric illnesses; 56 percent. There is no other health issue in the United States that has had that kind of increase in the last five years.

So it is a subject -- thank you, Assemblywoman Simon -- that we need to be talking about. I was hoping that we'd have a filled auditorium today, and so we should keep striving to get a filled auditorium. And when you go home, think about the amount of communication that

you're depending on this (indicates cell phone) to get the communication through. Think about that, and think about what you need to do in order to turn that around. And that's not just in your family; it's also at work, it's wherever you happen to be.

Let me tell you a little bit about Carrier Clinic. As you entered our campus, it's a little disheveled; we have a variety of things going on. Probably it's the biggest construction that has ever been done here at Carrier Clinic. We're 105 years old; we're the state's largest private psychiatric hospital, with 280 beds. We're the largest residential provider in the state. We have over 90 children in residential treatment; we have a couple of group homes on our campus on the side, where we have kids who are aging out of the system -- we help them work their way through the psychiatric challenges so that as they are adults they can be successful.

We're continuing to build all of that, as we go forward, and we've done it in a unique way. And I want to use this, as I explain to you how we've been able to get where we've gotten, as an example of what needs to happen here -- happen here in our school, happen here in the Assembly, happen here in the Senate.

And so we started about five years ago in finding out how we could rebuild Carrier. It is, literally -- some areas are 100 years old. You can see some of the buildings that need to come down still on the campus. And they're what you might have imagined to be asylums -- because they were asylums at one point.

And so we had a campus of over 300 acres. We took 200 of those acres and we sold it to Green Acres. It gave both the community a sense of safeness because there was a big, development-free zone around

them, and it gave us the same protection from housing encroaching on our campus. So nothing could be done with that. And it's essentially still used by Carrier for our hiking, for camping -- for all different kinds of things that we do here on the campus.

It allowed us to generate enough funds, though, to be able to rebuild and help us to get a loan to rebuild our campus -- to refurnish and refurbish all of our facilities, and to rebuild our acute care wing and some of our kids' areas.

And it was a win-win for everybody. And it was a win between a private not-for-profit that makes about a half-a-percent margin on an annual basis. So it's something that we would have never had -- we have never had enough money to do this; and it's a win for government. And it's a win for government because we're going to continue to provide services for the next 105 years here at Carrier.

So I'd like to, as you're thinking about the things that you're asking our legislators to do, have that in mind as you make proposals. And I'm doing the same.

Let me talk to you about an issue I'd like to be able to secure your attention to.

There are mikes everywhere; I feel like I'm in -- I may be at a U.S. Senate hearing, so-- (laughter)

So again, my name is Don Parker; I have had the privilege of serving as the President and CEO of Carrier for the last three years. And we are in the process of building a new, state-of-the-art facility; a 40-bed addiction/detox program. We have, again, explosive growth. I don't have to tell you guys; you have done all kinds of things -- thank you very much

for the things that you have already done in that area. You've changed the face of drug treatment and addiction here in New Jersey with the kinds of services that you are now requiring to be provided throughout the state.

Carrier has, on any given day, 280 people who you don't want in your backyard and ours. And so we're dealing -- we have over 1,000 employees on our campus, and we are dealing with all different kinds of behavioral health issues. We do very innovative things; we are the largest national providers of electroconvulsive therapy -- it's not what you saw with *One Flew Over the Cuckoo's Nest*; it's a very safe procedure. We do that with teenagers. And it is a very good way to address issues without using psychotropic medication. We're beginning the use of a genetic profile, that we establish with our patients at their entrance to Carrier, that allows us to get a good family history. Every doctor in the United States starts you with a clipboard, and you fill out a family history. We don't have that. We're actually emerging from a "don't ask, don't tell" era in behavioral health, and we now have the ability to get accurate family histories from people so we start their treatments appropriately.

We're using new types of treatments; we have a TENS unit for the brain. So all of you are probably familiar with the TENS unit for injury? Well, the TENS unit for the brain allows us to stimulate the hypothalamus, which atrophies during both psychiatric, and drug and alcohol episodes. It stimulates the hypothalamus back into action literally in a week. It's been used in Europe and in Russia for 25 years, and it has not been approved for use in the United States. We're one of the first hospitals in the country to do drug and alcohol treatment use with it. We have a clinical trial that's starting in the next month with the University of

Pennsylvania in testing it. And we have a variety of different approaches that we're using to do that.

We just replaced 3,000 light fixtures throughout Carrier. Light produces health, especially if it's natural, spectrum lighting. We put in LED lighting with the assistance from PSE&G; it has had a measurable impact on both the attitude and behavior of our patients, as well as our staff feeling better as a result of it.

Our campus, by the way -- we've done all kinds of very interesting things with our campus. We have a 17-acre solar farm that produces 65 percent of our power; it allows us to harvest from the nature around us -- new things. We have buildings that are coming down -- you saw them as you came in -- those buildings are being reharvested into new construction here at Carrier. We took 108 windows-- This past Friday, we had a Healing Arts program training for the entire state -- we had 140 attendees; we had 22 artists on the campus. They painted on those windows, and those windows will be displayed throughout Carrier and the places that we go.

So Carrier has both a long history, and we have a very rich recent history of innovation.

We, however, have a significant issue that we believe needs to be considered by your panel. It's been the practice in Carrier to provide education for our children. We have about 100-plus kids on our campus, and in our residential treatment programs, and in our group homes. We have another 40 kids today, by the way -- our adolescent unit holds 40 kids; we have 40 kids in it today. So we will be turning away kids who need care

today. And it is a regular practice for us -- anytime between September to June -- to be completely filled.

I would tell you that in August we had 19 kids in the unit. So since the beginning of the school year, we are packed. It is the earliest that we have been packed in the history of Carrier. So the issues that Assemblywoman Simon is raising have not abated. They continue to increase, and we see the pressure here.

So about two-thirds of our students in our school are from our lodges and our children's programs, and about one-third are from the area school district. So we mix -- we carefully mix, but we mix so that the kids who are in school here are not just exposed to kids who they are with all the time in our residential programs.

The best outcome that we could look for is that our adolescents who are admitted to our lodge are automatically classified, and therefore eligible to attend our school. That does not happen. Now, I'm not going to be foolish enough -- I was a School Board President for a number of years -- to say to you that you need to automatically classify a kid who comes into Carrier Clinic. What I would like to ask you to consider is, that when a child in our children's system is placed in a residential placement, it trigger an IEP review -- an Individual Education Program review -- that allows for the school, the child's family, and the residential provider to develop a plan that is appropriate for that child. It may include staying in their school. But, in our experience, I would tell you that the majority of the kids who are coming to us are alienated from their school. They are either getting teased there; issues that they are embarrassed about get exposed constantly; they're fragile. The case that Donna talked about is one of those examples.

The 40 kids in our unit, by the way, have to meet criteria. They either have to be homicidal or suicidal; a danger to self, or danger to others. So there are 40 kids who have passed through emergency departments and have seen psychiatrists, and have been committed to us. Very few of the children who are in our units are voluntary. And we're not the only provider in the state that provides care for children, obviously.

So what we'd like to do also, by the way, is-- There is a high level of care; it's called IRTC -- it's Intensive Residential Treatment Centers. Those are kids who are the most fragile; those are children who we are most concerned about in terms of providing them with intense therapy. We generally have them six to nine months. The kids stay with us, and they really do need protection. We have half of those kids not classified; we have 12 kids in that program. It's a very intense program; it's funded by the State, by DCF. And those kids -- frankly, we would like to get them classified so that we could provide them with an education program that's here on our campus -- that is safe -- while we're giving them the skills to function in society. It prevents all different kinds of issues, from the exposure to contraband, to drugs, to weapons -- all kinds of things that they can bring back to the campus to hurt themselves or others. So it puts us in a very tenuous position.

Below that, there are three additional levels of care. We just like to be able to talk to the Child Study Team to make sure that we're getting the right plan together for a kid.

So that is what we're interested in. We currently have 23 -- so it's about a quarter of our kids -- going out to other schools. And my suspicion is that probably half of those kids we would have -- if the schools

would do an IEP process with us -- in a safer place for a period of time until we get them ready to go back to school. Almost all of our kids go back to school when they're released from Carrier. So our job is not to keep them here at Carrier, but to give them a good education and get them back to where they need to be.

So as you're going through your deliberations, I think that that would be very helpful for the residential providers -- not just Carrier, but the legion of residential providers that are around the state taking care of the kids who are in a great deal of need.

I'm going to turn the mike over to my colleague, Stacey Paulis, who is the Principal of our school. She will just give you a little idea about the school itself as an educational process.

ASSEMBLYWOMAN SIMON: Before we do that--

MR. PARKER: Yes.

ASSEMBLYWOMAN SIMON: --we have a couple of questions.

So if a child is in crisis, do they automatically go to an emergency room or-- How do you get them? Is it referral from a pediatrician? Is it a referral from law enforcement? How do you receive a patient?

MR. PARKER: Ninety-five percent of our children in our residential program come from emergency rooms -- from other hospitals. And so they're screened by the series of screening centers that the government pays for -- psychiatric screening emergency centers; each county has at least one, some counties more, depending on their volume. Kids are required to go there before they're placed in Carrier under a committed

status. If they're voluntary -- and we only get about 5 percent of our patients who are voluntary, who are coming from a pediatrician or a family member seeking out treatment. We are dealing mostly with kids who are committed.

ASSEMBLYWOMAN SIMON: Now, I wanted to get your opinion on -- because in speaking before about the population that has that comorbidity of autism and mental illness, or has the conduct disorders, or even pica or anything else -- who are socially maladjusted -- where do they turn to? We have, in our state, hundreds, if not thousands, of med-emerges, right? Clinics where somebody at 10 o'clock at night, or who can't wait for their physician, can go to these clinics at anytime of the evening, and go through their history and physical and get the treatment that they need. Are there places like that that would accommodate -- one a county, one every couple of townships -- that would basically be able to handle these so that the emergency rooms -- that very often you hear the stories that they're in bays for two and three days.

MR. PARKER: Right.

ASSEMBLYWOMAN SIMON: I have constituents call, like I said before, where their child or young adult cannot be served except for at Trinitas, which is in Elizabeth. And they have 18 beds, short-term, inpatient child and adolescents; an intermediate psych unit with 22 beds. That's for the whole state that handles that nonverbal population.

MR. PARKER: Right.

ASSEMBLYWOMAN SIMON: Not to say that other hospitals cannot, but they're kind of pulled in the same department or unit that -- there are violent offenders, and they're very vulnerable. Are there enough

resources in our state, and would constituent, and would children and adults with mental illness be served well by having a type of med-emerge just for behavioral health?

MR. PARKER: Well, I have a long history, starting the first urgent care centers for medical purposes in New Jersey over 15 years ago, while I was working for AtlantiCare Health System. I have actually proposed, in many different circumstances here in New Jersey, the creation of psychiatric urgent care centers. I haven't gotten enough interest here in New Jersey, so I'm working now in three other states helping those states to develop such a plan. I'm working in San Francisco with a health system; another health system in the Detroit and Toledo market; and then a third system in Schenectady. The Schenectady program, by the way, is funded by Medicaid, and they are looking at ways to funnel their behavioral health volume out of the emergency department. There is no good experience in an emergency department -- no matter how well equipped the emergency room is -- for behavioral health. When you're in a situation where you have to prove that you're a danger to self or others, there's no pleasantries in that. If you don't prove that for your child, you're leaving that center, generally, without immediate care. You may get it in the next couple of days from the mental health center or from other crisis programs, but you're generally not getting immediate care.

And so the other states that I'm working in are very interested in getting the immediacy behind that and are either financing or promoting the development of urgent care centers.

ASSEMBLYWOMAN SIMON: Okay. So let's rip the Band-aid off of that one. Why do you think that there's no appetite to look into

something like that? Where's the roadblock, where's the obstruction? How can we help?

MR. PARKER: Well, I did-- Actually, I sought initially to get Federal funding for the project. I wrote a grant for part of the Affordable Care Act and Innovation grants. I got a letter back; we made it to the final round of the grant process. I got a letter back from the Department of Human Services saying that they weren't going to fund this because it had never been done before. And so I did question them on their commitment to innovation -- given the fact that, in my book, the definition of *innovation* is that you finance things like that (laughter) to take a look at what the impact may be.

So at the Federal level, I'm pretty much stymied in my ability to do this -- notwithstanding the fact I have been able to get the attention of other legislators in other states about how to do this, and very positive attention. So I don't know that there are roadblocks at this point in time that I can particularly point out. I would say that we would need a concerted effort on the part of a lot of people -- inside State government, outside of State government -- who would be willing to take a look at that issue, and maybe on an experimental basis. Carrier -- we have the capability. It, by the way, is-- Just as a quick example: It is staffed by a nurse practitioner -- a nurse practitioner who has the ability to do a substantial amount of the care that psychiatrists would. We just don't have enough psychiatrists in the United States, let alone in New Jersey, to do this kind of work. And then that nurse practitioner is backed up by telepsychiatry -- with five experts available to them -- child, adolescent, adult, dual, and geropsychiatry available at any time that it's open. It

would be open-- Our proposal was it be open from 5:00 at night until 12:00 at night; it's the times when crises occur. They don't occur during the day. You're going there on the weekends; families don't get out of control and children don't generally get out of control unless they're out in other systems. So it would be available for them at the times when they need it. It would not compete, by the way, with existing providers. It's after-hours; most of the existing providers don't provide care after-hours. That's one of the problems in the behavioral health system.

ASSEMBLYWOMAN SIMON: Okay.

MR. PARKER: And the only place you can get it is at an emergency department.

ASSEMBLYWOMAN SIMON: Right.

MR. PARKER: So I think we have a financial model to make this work. The other states that I'm working in understand that it is a way, by the way, to save money. An emergency room visit is an expensive visit; no matter how much you decide that you're going to charge them to take care, it's an expensive visit; and it can be done much cheaper. That's why there are so many urgent care centers around; that got discovered over the last 15 years in New Jersey -- that they're great alternatives. And if you have ever used them, you know that they are a much better way to get care for most cases than going to the emergency department.

ASSEMBLYWOMAN SIMON: Okay. Well, I think that everybody on our panel would be advocates for that. And I would like to, offline, talk about how we can set up that conversation--

MR. PARKER: Good.

ASSEMBLYWOMAN SIMON: --with the appropriate departments in our State--

MR. PARKER: Great.

ASSEMBLYWOMAN SIMON: --in order to do that.

MR. PARKER: Thank you so much.

ASSEMBLYWOMAN SIMON: Yes, absolutely.

Okay, so you wanted-- Does anybody on the panel have questions?

Senator.

SENATOR RICE: Yes, I have a question.

MR. PARKER: Thank you very much.

SENATOR RICE: Yes, a couple of questions.

Yes, you know, we drill you when we come. (laughter) You know, you don't just get to walk in just at the presentation time.

MR. PARKER: Should I bring my attorney in? (laughter)

SENATOR RICE: You deal with all 21 counties?

MR. PARKER: We deal with all 21 counties and, literally, we also have patients coming in from out-of-state -- from New York and Pennsylvania as well.

SENATOR RICE: Do you have any idea of the diversity of that population of young people?

MR. PARKER: Yes. If you walked in our school-- You're actually not being exposed to our school. Our school is usually right out here today (indicates), but because our noise level is pretty high in our school-- If you imagine 100 kids that, again, you don't want in your backyard and ours -- that creates issues for us. So our kids are in other

parts of Carrier getting their education today. But you would see an incredibly diverse population here at Carrier.

And I would tell you that we, at least, represent the racial breakdown that exists here in New Jersey and across all of the services that we provide.

SENATOR RICE: What about the economic breakdown?

MR. PARKER: You know, the economic breakdown--

SENATOR RICE: In terms of diversity.

MR. PARKER: Yes, behavioral health is an issue that doesn't just exist in poor communities. And, frankly, the dependence on a cell phone doesn't just exist in poor communities. It is even more likely to be an issue in a family's life as the family is busier, making more money, spending more time on other things. So what I found here at Carrier is that socioeconomically, racially, ethnically -- we represent the community.

Now, I ran a detention center in the 1970s; we didn't represent the community in the detention center. We were heavily weighted toward the lower socioeconomic status, toward racial status as well. So I understand the differences between those facilities quite acutely. And I think that this is -- when you see Carrier, you see New Jersey.

SENATOR RICE: The Affordable Health Care Act (*sic*) -- is that impacting you negatively, positively, at all?

MR. PARKER: Well, you know, it's been very interesting. Our business in general -- not just kids -- has gone up 22 percent in the last two years. So we have had a dramatic surge in the use of Carrier. We are full many nights, where we can't take additional patients. And that's one of the reasons we're doing our expansion project.

The Affordable Care Act has had the impact of getting people who would probably be vulnerable in the past and without insurance -- and be totally dependent upon our Department of Mental Health or other types of State-driven services -- they now have insurance. And they want to access a private psychiatric hospital. So we have more and more of them coming. The problem, though, is there is a regulation called IMD -- Institutes for Mental Disease -- and it is a Federal regulation. States, in the past, had the opportunity to get exemption from IMD for a period of time to experiment with it. IMD was promulgated in the 1960s during the Kennedy Administration as a way to satisfy the general public that the new funding for mental health wasn't just going to go to private hospitals. So it exempted private hospitals from taking adults from 21 to 65. We can take kids, so that's good -- especially since most of the kids who are getting care here at Carrier are covered with some type of insurance, and that relieves us.

By the way, the other part of that equation is that Carrier, because we are a psychiatric hospital, we have never been eligible for charity care. So the charity care that we give comes from us. And it really, literally, is charity care for us; there is no other subsidy for it. As we change the charity care regulations looking at psychiatric demand, I think it would be appropriate to think about making some eligibility for psychiatric hospitals to the charity care pool.

Back to the Affordable Care Act: So it's given a lot more demand. The challenge that we're facing is that our uncollectable-- So what we charge patients through their insurance is going up precipitously.

We've had a 32 percent increase in the last year alone on what we charge and what we can't collect.

Patients come to us with mostly Bronze health plans; we admit-- Now, we are covered by EMTALA, so anybody who crosses our doorstep we have to admit. So if you show up at Carrier, we have to admit you no matter what your insurance is. They come with high deductibles -- \$5,000, we have even seen \$7,000 deductibles as part of those health plans. I would tell you that very few people who are coming in for psychiatric care are going to have the wherewithal to have \$7,000 to pay for their care. The first \$5,000 to \$7,000 has to come out of their own pocket, and then we get paid after that. Our lengths of stay are so quick today that generally if you have a heavy psychiatric illness, you may be staying 8 to 10 days with us, maximum. If you are a dual-diagnosis patient -- psychiatric and drug abuse -- you'll stay with us 5 to 7 days, maximum. Children stay with us a maximum, generally, of 8 days. So we have to work hard, work fast. It means your bill, though, is probably in that sweet spot -- under \$5,000 for your care here at Carrier. We don't get paid for that, in many, many more cases than ever. And that's part of the shifting of responsibility to patients that has occurred as part of the Affordable Care Act.

SENATOR RICE: Are you the only type of-- Is this the only-- Are you the only facility of this type in the state?

MR. PARKER: No, there are four other private psychiatric facilities like ours; two of them are run by Universal Health and are for-profit entities. And then general hospitals, by the way -- many of the general hospitals throughout the state have psychiatric beds in them as well; generally, not for children, but they have the beds. Trinitas does for

children, a special program funded by the State; but most of the other psychiatric facilities are adults only. But they do have some beds inside.

We are what is called a *tertiary behavioral health hospital*. So there are three types of hospitals: general hospitals, tertiary, and quaternary. General hospitals are all around us; 90 percent of the hospitals in the state are. Tertiary hospitals are specialized hospitals. They're MD Anderson at Cooper; they're CHOP; they're programs that specialize in areas that need a great deal of expertise. And then the quaternary are hospitals like Robert Wood Johnson and Barnabas where medicine is invented; where new treatment strategies are developed and training occurs. And we're a tertiary; 90-plus percent of the patients we get come from other hospitals, generally meaning that the other hospitals aren't as capable of dealing with the issues as we are.

SENATOR RICE: Do you know whether or not the Affordable Health Care Act is impacting those other units the same way it is impacting you? Because it seems like I hear, coming from you, that the Affordable Health Care Act has a positive side, but then there is this big negative that kind of null and voids the positive things. (laughter)

MR. PARKER: Yes, I think there was a great deal of optimism that charity care would be able to kind of be wound down in the state over a period of time. I just attended a meeting of all the CEOs of all the medical hospitals, as well as psychiatric hospitals, two weeks ago. About a third of our conference for the day was on how we handle these kinds of issues. There is a new source of nonpayment for us that -- hospitals have to face making up that deficit in some way, shape, or form. And it was expected-- Medicaid was more-- By the way, I think you probably know

there was close to double the number of Medicaid patients who were eligible and signed up for the Affordable Care Act in the state, more than you expected. So there are a lot more people with Medicaid, and Medicaid is a lot more difficult for us to conduct our business with.

SENATOR RICE: The final question: Has New Jersey's Congressional delegation had any conversation with you on what you do here, and the need to take a look at the IMD regs and some other kinds of issues with the Affordable Health Care, in terms of impact? Have you had those discussions?

MR. PARKER: I've had multiple discussions with all of our Congressional delegation -- both our two Senators as well as our Representatives. They all understand it; and I've had some meaningful discussions about adjustments to the Affordable Care Act. I believe there will be some changes coming through this year; for instance, the IMD regulations -- there is a bill in the House and the Senate, both supported by our New Jersey delegation, to remove IMD from the regulations. That would allow adults to use Carrier who are Medicaid patients, and it would allow us to service the public more effectively. It would also, by the way -- and they know this, I shared this with them -- it would increase our debt because of the inability to pay. So I think that we're going to have to balance this out, and there needs to be some serious and thoughtful discussion about how the charity pool ratchets down with the increased coverage, but that it just doesn't go away. I think there's always going to be a core of individuals who won't be able to afford their deductibles.

SENATOR RICE: Is that bipartisan support from our delegation -- for the removal of the IMD?

MR. PARKER: I've had bipartisan-- Yes.

SENATOR RICE: So what I would suggest to the Assemblywoman and Committee members is perhaps we need to think about doing a State resolution supporting our delegation in the removal. And what you may want to do, Assemblywoman, is to reach out to the Congressional delegation from this particular District and get their feedback as it relates to the others. So we'll have to call everybody. If that's the case -- bipartisan support -- then maybe we should support them and we can make that recommendation to both Houses of the Legislature.

MR. PARKER: Yes, the two bills that are under consideration are both Murphy bills; I hope they don't end up being Murphy's Law. (laughter) But there is a Senator Murphy from Massachusetts, and the U.S. Representative is Murphy from Pennsylvania. They are companion bills both rolling through Congress right now.

ASSEMBLYWOMAN SIMON: Okay; thank you, Senator.

Assemblyman? Anything? (no response)

MR. PARKER: Thank you very much for the opportunity.

ASSEMBLYWOMAN SIMON: I have one more question for you.

MR. PARKER: Oh, you-- Sure.

ASSEMBLYWOMAN SIMON: So I'm not sure if you are faced with any DSM changes and coding issues for insurance. I know that some of our constituents who have children and young adults with autism -- the DSM change has kicked them out, and insurance companies are denying their claims. Do you face that at all?

MR. PARKER: We haven't had the occasion yet, based on the DSM changes, to have any pushback from the insurance companies. We've met with all the insurance companies about DSM to make sure that the categories that we treat are covered. They are covered; there's an exhaustive increase in the number of DSMs; it's a very complex system. It's going to cost us about \$60,000 in unfunded mandates and software alone, let alone our staff time to train doctors and nurses.

We're, by the way, in the middle of a conversion. Carrier will be one of the first psychiatric hospitals in the country to actually become -- with electronic medical records, based on the fact that part of the Affordable Care Act -- right before it we had a legislation called *Meaningful Use*. And all medical hospitals in the country were given funds to support them getting electronic medical records. Psychiatric hospitals were exempted from that. It's another area we rarely, if ever, get an adequate explanation about why we're not allowed--

ASSEMBLYWOMAN SIMON: Not allowed, yes.

MR. PARKER: If you're talking about disclosure and discussion-- And I think part of the stigma issue allowed us to stay on the sidelines without a lot of support. But that would be another area.

In the two Murphy bills there is Meaningful Use money for psychiatric hospitals. So I think it would be helpful for us.

ASSEMBLYWOMAN SIMON: Unfortunately, the DSM issue -- I wish there was a Federal remedy, but it seems to be an AMA--

MR. PARKER: Yes, it is; it is. So I think that there are many issues around DSM that are going to emerge in the next year that will take us places we've never been before.

ASSEMBLYWOMAN SIMON: Okay. Thank you, Mr. Parker.

MR. PARKER: Thank you.

ASSEMBLYWOMAN SIMON: Thank you for everything that you do for the community.

MR. PARKER: Thank you very much.

Stacey.

ASSEMBLYWOMAN SIMON: Yes, now we have Stacey Paulis, who is the Principal of the East Mountain School.

Thank you very much for being here.

**S T A C E Y P A U L I S, Ed.D.:** Thank you for inviting me. I appreciate that.

ASSEMBLYWOMAN SIMON: Now, do you have a PowerPoint?

DR. PAULIS: I do.

ASSEMBLYWOMAN SIMON: Okay, good.

DR. PAULIS: But I don't want to start it. It's going to be in your eyes.

ASSEMBLYWOMAN SIMON: That's all right.

DR. PAULIS: I so apologize for that.

ASSEMBLYWOMAN SIMON: No, that's all right.

DR. PAULIS: Let me just tell you about myself while it's warming up.

I'm Principal and Director here at East Mountain School. I've been here for going on my third year now. And before that I did public education; I started in Perth Amboy, then moved onto Linden, and went to

Manville School District; and was invited up to Pequannock for my first leadership position. And then I landed, for 10 years, in the Somerset County Education Services Commission -- a public school entity that would do receiving of children who needed services -- usually classified, some were nonclassified; those are students with IEPs. And there would be a need to close the gap between their behaviors interfering with their education.

And I learned, in those 10 years, that it's about being able to build the rapport with schools, with people, with parents, with kids, with teachers. Because the covenant is, is that you want these children to return. They may need intervention for a time, but you don't want it to be chronic and forever. Sometimes, however, as the Assemblywoman was saying, these are chronic behaviors.

When I was kind of selected to come for an interview -- which I was lucky -- Carrier Clinic gave me the interview, and said, "Why do you want to even come here?" And I said, "Because it's the tools that are needed to help the most at-risk population. The kids who no one wants are still joining our society. We have to build tools, and we have to give them a toolkit, and have them be able to go out. Is it always going to work out and be perfect? Absolutely not; but we're going to give it a try."

When I took the job here at Carrier, that's what it was for me. It's that it became the best way and the most -- without saying it in a negative way -- aggressive way to treat kids; to help them build both behaviorally, socially, and educationally their tools that they need to be able to integrate back into society. That may look like going back to their sending districts, that may look like going into a group home. But whatever

it looks like it's about normalization and having them get back to where they were.

When I receive children here and when my staff receives children here, it's because they've reached the most extreme in the system. I work a lot with the Coordinated Care Managers -- the CMOs. And these groups have such a challenge because they're trying to be able to say, "Okay, let's get community, help these children; let's get services in place." Where do you go for psychiatric support? And when they come to us, it's because everything else has now reached this highest level of care. That's where you'll see residential services come in -- which we have here at the East Mountain Youth Lodge. And then you'll see the alternative schools come in. Our school is a continuum of care for the East Mountain Youth Lodge. It also works with the Adolescent Unit that we have here.

So Carrier Clinic became a very unique opportunity, and pretty much put a lot of joy in my heart for a very hard profession -- that we had the tools here to be able to help the kids.

So I've been here; and I'll tell you, it's just been really fantastic being here because it's the tools that we need, with the people who can connect with the kids.

I have prepared a presentation, and it's pretty much a little bit of media to get everybody's attention on why this is important. But the essence and the mission of my presentation was about what we can do in schools, what the action plan could look like, and how we can help.

I'm so sorry to make you turn around. (laughter)

ASSEMBLYWOMAN SIMON: That's okay.

DR. PAULIS: But I appreciate it. Yes, please relocate in my auditorium here.

I am good to go.

My first video is a video from our Senator-- I'm sorry; he was a Senator in Virginia. And his son, Gus, had a long-term mental crisis. And I'm going to let it speak for itself, because it sets the tone for-- When I saw this news story in 2013, it rocked my world; I'm sure it rocked yours, and you'll remember it.

**(video plays)**

**(video stops)**

DR. PAULIS: Senator Deeds goes on to explain that his child had assaulted him -- and those are the scars that you see, of course. And sadly, Gus went into the other side of the house -- the farm -- and he killed himself.

For me and schools, it was too late for Gus. And that's what I feel our covenant is, and what our mission is here at East Mountain School is -- like it or not, we're going to have to address it in schools. Whether we're public or private, these kids are going to need our interventions to help them.

So that kind of drove the mission where I put my brain trust of people here at Carrier together, and we talked about education and how we could help adolescents; and through the compassion and empathy, what that could look like here.

It's about changing our minds; we all have to make that cultural shift. I think every individual sitting in this room has already made that shift -- to take the fear out of talking about mental health. But in public schools and private schools, when we're dealing with PARCC, and we're dealing with the performance tests that the kids have to take, and the high-stakes evaluation models that are there for teachers now -- stuff gets pushed in the back, and it certainly is interfering. I can tell you that here it's our driving primary goal; and that we do want the kids to do well on tests, but we know that they won't until we clear this burden -- or make it manageable for them.

So we had to confront the fear; and the fear is, is that we have to continue talking about it. We have to talk about it as much as we talk about everything else. You know, "Please get your math done; have a seat; let's do the do-now." Well, we have to put this out there, and you can't be shocked by the word *cutting*, and you can't be shocked by the word *bipolar* and what that looks like.

Our recommendations also came down to -- that not only is it a priority, don't wait for the crisis. Have a response team that's always there. A local school district in this area -- right next door, a neighbor; don't want to mention them -- they have a person who is their crisis management person. But this person will see children before it gets to crisis, because they were addressing, locally, the suicide issue. And suicide became something that became their mission to really address.

So the response team changes the whole model of management for kids who have mental illness -- or burgeoning mental illness. We don't know what that looks like. When it's starting, it's smaller. When it's not

addressed, it's bigger. You want to address, of course, the problems when they're smaller.

We have to acknowledge that there is a stigma out there, and we have to work on multiple levels to remove it. And I'll talk more about that. But multiple levels to me are also about redundancy. I might have a school nurse who's an expert in the area; I might have a coach who can work with kids. But you have to find multiple levels and multiple ways to address it with parents, teachers, and kids to be able to try to remove what that stigma is, and just put the conversation out there, or we're not going to remove mental illness from interfering in our schools.

When I gave a call to Rebecca about, "Hey, Rebecca, how do I present this to everyone?" She said, "You know, just kind of tell us where your perspective is." And you know, my perspective comes down to: If I had Adam Lanza, what would we do? And it's about that we don't want an Adam Lanza to fall through the cracks. And the school is going to have to do it. So even with schools locally, I can remember in 1987-- Bridgewater West is where I went -- they brought in a whole group to talk about bullying. You know, that was before the word was even really out there and talking about it. So even having an assembly can get the kids talking, and you're going to need to have parent and staff education throughout this entire process.

If we take the stigma and we're trying to address it, what is that going to look like? Well, with the cultural shift, the strategies could look like the following -- a lot of schools are doing this, and some of you are participating in this: that you are part of the schools, you sit in the schools, and you will provide mental health management for the kids. My team

wanted to caution: Don't pull them out of their lunchroom, because that's a stigma itself. "Come on, come down for lunch. "Oh, you have to miss your gym class." "Hey, that math teacher says, 'Please don't take him out of my math class. I can't have him missing skills.'" There has to be a cultural shift among even all the professionals who say that mental health, and being able to address their cutting issue, their depression issue, the divorce issues that are going on are something that are just as important. Because once you have that barrier being broken down, now the learning can begin, and begin in earnest.

We believe also that it's part of the curriculum programming to have that education in your health classes. You've got to say the word *cutting*; you have to say the word *bipolar*; you have to say the word *suicide* to take the stigma and fear out of it. And our health teachers could do that. But our teachers here -- they deal with this on a daily basis because all these kids put that out there.

I believe, also, in peer leadership. When I was doing the research of this, it seems that the first people who our kids go to are other kids. We have to educate and empower our kids to say, when you have someone who is talking about suicide or a mental health issue comes up, this is what it could sound like. Now go tell somebody. Now go find somebody to help. Because our kids are going to be the ones who are confronted with this.

I've had many kids come to me, "Dr. Paulis, oh my God. It's on the Internet." "I saw it on Snapchat." I had a kid, not two weeks ago, take a picture of Snapchat to bring into us. Now, if you know what Snapchat is -- it goes up as a picture, and it immediately erases -- so they

say. But it does erase. And they took a picture because they were so afraid of what that kid was thinking and saying. And that didn't occur within the walls of my school; it occurred outside, and they brought it here. Why did they bring it to my school? Because we could try to address it. It's too big; the kids are going to bring it here. There's going to be stigma here, but we have to work around that.

We also believe that you're going to need to really identify-- One of the studies that I saw -- in 2nd grade-- When you were talking about the 5-year-olds, I found that so intriguing; because yes, we're seeing kids being diagnosed, and that label can be so stymieing itself. But identifying the students and their risk factors: Do they need to be classified? What family issues do they have? What's coming up for them as far as trauma? A lot of the kids who present here are a trauma that has not been addressed in their younger years. And that's a barrier that we have to work down. I may be a doctor, but I am not that kind of doctor. We have to have professionals in the schools who work at a high clinical level to address the most traumatic issues. And then, yes, connect with the outside services in the community so parents can work in concert. But it's also going to be something the schools have to start. We may not want it, but the burden is there and we're going to have to use it.

We also need to look at-- And when we, kind of, were examining this -- I hesitate to say the words *unfunded mandate*, because that's what happened to us for Tyler Clementi's bullying legislation. And I do applaud Chris Christie for putting that together, because it put the conversation there. But just as common as this conversation is, that's the commonality that we need to have about mental illness. So I would need to

have teachers, educators being exposed to not just the education, but being exposed so that there wouldn't be reprisals against them. If they reported a fear that they had that a kid was going to hurt themselves; or there could be an issue, could you please just check them out? Because we can have parents who say, "Why did you go to my kid? Don't talk to my kid about that; I'll deal with that." If it comes up at the school, we're going to be here to protect the kids.

Clearly, enhancing mental health in schools in comprehensive ways is not an easy task. And, indeed, it's likely to remain an insurmountable task until the school reformers accept that the reality of such activity is essential and does not represent an agenda separate from the school's instructional mission. It is, actually, the mission.

I got this quote, and it really drove my entire presentation, because I'm just trying to put out there -- and with the professionals here at Carrier -- trying to say that, yes, there's a place for PARCC, and there's a place for the Common Core. But embedded within it, not parallel to it -- it has to be part of the conversation and part of the vernacular. Because once you do that, it becomes natural. We take the fear away, and we have students who are part of it.

The last little video clip -- one minute -- is from Patrick Kennedy, who speaks to -- a former Congressman -- speaks to the idea of what stigma looks like, what crisis looks like. And I thought it was really intriguing. Interestingly enough, he's on the Katie Couric show, and it was a promo for *Silver Linings Playbook*. So you're going to see Robert De Niro, and Bradley -- I forgot his last name -- but you'll see him there, so it's a

little star-studded, a little bit. But what he says hit me, and it's about what we need to do in schools.

**(video plays)**

**(video stops)**

DR. PAULIS: What do we need to do? We need to embed it in schools. And how do we avoid the stigma? The stigma is going to be there; we have to acknowledge that and confront it head-on. You have to give teachers a language, and a comfort, and training in that; provide them a safe, nurturing place to be able to have that conversation; and create time for teachers, principals, supervisors -- whoever -- superintendents to be able to have the conversation with clinical professionals who can help understand what the behavior and manifestations look like in a classroom; and how you could be looking at a student with Oppositional Defiant Disorder or, possibly, bipolar. You're not going to have the answers; you just need to be able to go to the right people to help you. And, working together -- it is the community.

So I wanted to end it with that. I thank you. (applause)

ASSEMBLYWOMAN SIMON: Okay. Thank you very, very much.

So the question I have is -- and I'll ask our Hunterdon Central keynote speakers today the same thing -- so what do you do as a parent, or many of us are moms and dads -- what do you do if the parent refuses? What if they refuse their child to be labeled? What if they are in denial? You know, "Not my kid; my kid doesn't have that issue. Oh, he's just a

teenager.” How do you handle that? How do you partner with a parent to help them along with what the necessary steps -- the evaluatory process and the treatment process?

DR. PAULIS: I think that the schools and what we do here need to make the partnership be that, “You may not want to avail yourself to the services at this time, but we’re still walking with you.” Because once we alienate that child and that parent, we’re all done. And once you do, a parent is going to call it -- “You’re labeling my child. You’ve classified my child; they’re forever going to be on meds.” The law has to be that we’re not there to do that now; and if that’s what you don’t want to do as a parent, let’s not do it now. But these are the interventions and the limitations of my interventions based at this level.

And I have had to have that conversation. Let’s just say that behavior is acting out. Well, then, yes, maybe there will be a discipline that comes, and that’s when the conversation can come. You say, “You know, perhaps you would like to look at--” Since this discipline or this suspension came down, or there was this fight, well, “Come on in. Let’s have the meeting for the post-suspension, but let’s talk about whether there are interventions we could provide.” That’s when you bring in somebody clinical just to sit there and be able to give their two cents to be able to say, “I don’t know if you thought about it, but this could be an option.” It can’t be binding, it can’t be accusatory. Parents will mourn, like a death, once their child is not the, I guess, ideal normal that we all expected.

My son probably needed to be classified; my daughter is classified. And I knew at 2 she needed it. And you know something? I’m a Director of Special Services in my old life, and I’m a Director here at a

special school. And, you know what? I swallowed my pride and said, “I don’t know where this is going to take me,” but I handed her over to the schools. And I am not sorry for it.

So sometimes when you open the door it’s -- I believe everything happens for a reason, and that when you open the door, your unexpected wealth that comes is just immeasurable.

So I still don’t know how it’s all going to turn out, but I’m walking it now.

ASSEMBLYWOMAN SIMON: Yes, sometimes they talk about the five stages of death--

DR. PAULIS: It is.

ASSEMBLYWOMAN SIMON: --and what you have to cope with.

DR. PAULIS: It is, absolutely.

ASSEMBLYWOMAN SIMON: But that’s a valid point to handle it; you know, maybe not at that time because some parents think that if you classify my kid tonight, that stigma follows for the rest of their lives. It does not; it does not. As soon as services are no longer needed, that is pulled away and then you transition out of that situation. But when you have that situation in school where there’s a crisis, and consequences, and escape extinction, and impetus--

DR. PAULIS: It’s the impetus for the moment.

ASSEMBLYWOMAN SIMON: Right.

DR. PAULIS: And you have to capitalize on it. And when you have supervisors, and administrators, and clinical personnel who are trained, you use it as the vehicle. And I’ve done it many a time. And you

never know where it's going to go, but every meeting has to have an objective; it's always to help the child.

ASSEMBLYWOMAN SIMON: Yes. And I think it's also valid to talk about how teachers are burdened. And I was speaking out back before about -- that teachers have a lot on their plates. It's no longer like the old days when we were in school--

DR. PAULIS: No.

ASSEMBLYWOMAN SIMON: --where a teacher was a teacher, and they had the authority and the autonomy of a classroom to do their lesson plan. They're inundated with so many more things -- the bullying, and everything else -- that it's quite inundating. And they're already even involved in in-service with social things: bullying, sex abuse, and other social issues. And it gets away from the core curriculum of what you're teaching; and you really need to concentrate on that, but you also need to have that other hat.

And then I'll save the questions for the school district -- of the liability and the responsibility--

DR. PAULIS: Absolutely.

ASSEMBLYWOMAN SIMON: --and the legal side of things, and what should a teacher be responsible for. And if they're not, are they held liable? And should they be held liable?

DR. PAULIS: Right.

ASSEMBLYWOMAN SIMON: It seems grossly unfair for a teacher to be burdened on that level. But I think that's a conversation to be had.

DR. PAULIS: Yes, I think that they could definitely speak to that too.

ASSEMBLYWOMAN SIMON: And then the other question I had is, with such a shortage of psychiatrists, you know, there was some legislation that asked for psychologists to have prescribing powers. And not to say that psychologists are not very gifted and very talented; and this Rx didactic and clinical curriculum that they have, to allow for prescribing, still does not take into account that every person has that medical background, and the clinical and didactic and hands-on experience for internships -- of knowing the body and the medical side of things. There are some people who have two and three pages of medications -- how do they do with the contraindications? So it's a little bit of a heavy lift to expect a psychologist to prescribe; but then we're looking at the shortage of psychiatrists, and what do we do to incentivize that in people, to go into that profession?

DR. PAULIS: I think for-- It's a noble profession, as they would say, because it's so needed. But the education is great and you have to provide -- I would want to provide funding to be able to just have people be able to go into that part of education and want to help juveniles.

It's aggressive, because there is a lot of education that goes with it. So there's a big demand and people say, "Oh, maybe I'll just go a different route to be able to help children, but I'm not necessarily going to go the full medical education route."

They also-- It's an unglamorous job, and you have to get, underneath, that these people came into education to want to help people; and hopefully that's what they want to do if they want to be a child psychiatrist. We definitely need more, but I don't know if-- I can't resolve

that, because I may not be able to speak to something like that. It's about maybe, too, just having more professionals. It's hard to hear. I mean, maybe we don't have more specialists in a high school, but we have more crisis counselors in a high school. And we don't call them a *crisis*-- We just call them *peers*, or we call them friends who can sit with them to talk through issues. Because if the issues are addressed smaller, maybe it won't get into the medical capacities that are needed.

ASSEMBLYWOMAN SIMON: Right. Maybe, like your slide: Instead of saying *Crisis Management*, it's a *Response Team*.

DR. PAULIS: I'm a big believer in that. You can't-- You know, if you're responding, the situation is over. We work in teams here called *pre-crisis* -- that we have to look at antecedents: What happened? And we will actually go back -- whether it's in the residential unit or the school -- we will do a diagnostic, and we will go through all of the things that led to an event so that we can learn from it. And there has to be a comfortability with that. But that's part of our vernacular every day, and it's not necessarily part of the school's. They have so many competing interests.

ASSEMBLYWOMAN SIMON: Proactive versus reactive.

DR. PAULIS: Yes.

ASSEMBLYWOMAN SIMON: Does anybody on the panel have questions?

SENATOR RICE: Yes.

ASSEMBLYWOMAN SIMON: Senator.

SENATOR RICE: The PowerPoint information -- can you share that with the Committee -- your slides?

DR. PAULIS: Which one?

SENATOR RICE: Is that a PowerPoint?

DR. PAULIS: Oh, yes; oh, I'd love to.

SENATOR RICE: Would you share that?

DR. PAULIS: Yes, I would. Thank you; thank you for asking.

SENATOR RICE: I think the Committee could use some of the points that you mentioned -- that was written up in there. And I know that Assemblyman Wimberly, who came out of a district, could use some of that. In fact, I saw him take copious notes.

DR. PAULIS: Yes, I think that it's not for the experts. I'm not an expert, but I'll tell you what: We're just here to, kind of, pull our team together and say, "This is what we're seeing as we get kids here."

ASSEMBLYWOMAN SIMON: Assemblyman.

ASSEMBLYMAN WIMBERLY: I just want to say that it was an excellent presentation.

DR. PAULIS: Thanks.

ASSEMBLYMAN WIMBERLY: I think it really -- I think it speaks to many people. And it's that basic level that people could comprehend. So I think it's excellent.

DR. PAULIS: Thank you. When we sat down to discuss it, I had many contributors to it. And that's exactly what we wanted. We just wanted you to walk away with something that is not a panacea, it's just an idea to address -- providing some strategies.

And I thank you for your time. Thanks for coming to my school today too. It's quite an honor.

ASSEMBLYWOMAN SIMON: Yes, thank you for having us. Thank you very much.

ASSEMBLYWOMAN SIMON: Okay, next up we have, from NAMI New Jersey, Phil Lubitz, and also Lorrie Baumann.

And I have to say my hat's off to you and your organization for being such community leaders in recognizing things that need to be done and confronted. And you do this on a day-to-day basis. We'll talk about your resources and how much -- you have so many great programs I would like to get into. But also, I think the other side of it is, what do you need from us? I'm sure you have a limited amount of resources; you know, we have 590 school districts, 2,500 schools, and every one of them would benefit from the Educate the Educator and other programs that you have. So what we can we do?

So please introduce yourself for the record, and then proceed.

**P H I L L I P L U B I T Z:** Thank you, Assemblywoman Simon, and Senator Rice. Good to see you again, Assemblyman Wimberly

So I'm Phil Lubitz from NAMI New Jersey; I'm Associate Director there. NAMI is the National Alliance on Mental Illness; we're the state's and the nation's largest grassroots advocacy organization advocating for people with a serious mental illness and their families. We were started by family members, I guess nearly 40 years ago. We now include family members, professionals, and people with mental illness.

I'd like to introduce Lorrie Baumann. Lorrie is the parent of a now-adult child with a serious mental illness; also an educator. But Lorrie also directs our NAMI education programs -- programs that were made to expand the knowledge of mental illness in the schools.

I should say in response to your comment, though, Assemblywoman, that neither of these programs receive any State funding at all. So certainly that would be something that would help expand them.

But let me give the mike to Lorrie.

**LORRIE BAUMANN:** I thank you very much for inviting us here today.

As Phil said, I'm a teacher; I taught for almost 30 years in the public schools of New Jersey. I was a middle school teacher in both Franklin Township near New Brunswick, and also in Branchburg Township. I'm a mother of a child who became ill with a mental illness that began in middle school and then high school. As he developed, so did the illness; and the diagnosis changed, the medications changed. And then I turned to NAMI -- because NAMI has a program called Family-to-Family in every county in New Jersey -- for help. Because even though I was a science teacher and I studied the brain, I didn't know very much about mental illness because people in my family didn't talk about it. If there was, no one wanted to talk about it.

And so in the Family-to-Family course that I took, I learned about the illness, I learned how to communicate with my child, and I learned resources.

And then after I retired from teaching, NAMI New Jersey -- you give back and you volunteer your experience. And so, for the last 10 years I've been working as the Director of School Education Programs.

And so I'm going to share with you today some of the programs we have, and some of the recommendations that we have that would help

not just the children who are diagnosed with mental illness, but with the mental health of all children.

So the facts are that 20 percent of U.S. children and adolescents -- or 1 in 5 -- have a diagnosable psychiatric disorder; and half of all lifetime cases begin by the age of 14; and three-quarters by the age of 24. Suicide is the third leading cause of death of our youth between the ages of 15 and 24. And unfortunately, most people -- most children with mental illness are undiagnosed and untreated. It is estimated that only 20 percent of them are receiving some kind of services.

These disorders severely influence their development, their educational attainment, and their potential to live fulfilling and productive lives. So what's the result? The result is undiagnosed and untreated early stage mental illnesses result in school failure. Children with mental illness have the highest dropout rate; substance abuse because they self-medicate with drugs and alcohol; and then they have dual diagnoses, violence. The research clearly shows that untreated ADHD children are constantly being told they're bad, or they shouldn't do this, and they develop very poor self-esteem. And so they go to criminal activity, teenage childbearing, loss of friends and self-esteem, suicide, unstable employment, and a high risk of co-occurring disorders.

So what's the crisis? There are only 8,300 practicing child and adolescent psychiatrists in the United States, and there's a need for 30,000 for the 15 million children who need them. Many families even with insurance wait weeks and months to see a doctor, even though we know that early intervention with these illnesses is so important.

As inclusion and mainstreaming become more prevalent in today's classrooms, both educators and students need to be educated about mental health and mental illness in order to build tolerance, understanding, and destigmatize mental illnesses. They are more common than heart disease, cancer, and diabetes, as Donna said earlier. They are biologically based, and they are of the most treatable of illnesses. And both adults and children need to be aware that there is hope and there is help.

So what's the solution? The World Health Organization says we need to create a healthy system for all. First, we need to ensure that all educators, administrators, people who work in the school system, secretaries, and bus drivers receive in-service professional development on mental illness in children and teens. They need a knowledge base about the symptoms of different mental illnesses and how to react to them in a way that does not escalate the problem; and that helps them to succeed in school. For example, how to react to the impulsivity of a child with ADHD, how to react to the anger of a child with Oppositional Defiant Disorder, or the anxiety in a child with Obsessive Compulsive Disorder.

A child who has bipolar disorder who goes into a rage cannot stop. And punishing a child for that anger is like punishing a child with asthma for wheezing. Teachers must not diagnose, but they must be able to refer these students to the proper health professionals in the school.

And just to emphasize what the Principal said before: Schools need to have adequate staff, adequate personnel, counselors, school psychologists, social workers, and nurses who are knowledgeable about mental illness and can act as resources for parents and teachers. They must coordinate with local agencies so families know when to get help.

In your folder is a flyer about our Educating the Educators professional development program, which we worked with the New Jersey Psychiatric Association and the New Jersey Council on Adolescent and Child Psychiatry to develop a presentation with three speakers. We have volunteer psychiatrists; as busy as they are, they will travel, sometimes over an hour, to present to the educators a knowledge base about these illnesses and the symptoms they're going to see. For example, a child who is depressed does not act sad. A child who is depressed -- the most common symptom is irritability.

And then we have educators who volunteer to teach strategies to the teachers that will help the children to succeed in their classroom. And then we have a parent -- we call that part "A Walk in My Shoes" -- we have volunteer parents who talk about what it's like to have a child with a mental illness; and what are some better ways to communicate with parents, and to destigmatize the mental illness.

To this date, we've professionally developed approximately 8,000 educators; we presented at the NJEA convention seven times, we presented at the Juvenile Justice Commission, at the Child and Family Services School. We travel a lot.

And the second thing, as far as educating educators, is schools of education -- just like when I was becoming a teacher I had to take educational psychology, psychology of learning -- they should-- A course should be required on psychiatric disorders in children, because it is so prevalent today -- approximately 10 percent of a classroom will have ADHD -- and make that as part of a certification; a requirement to learn about psychiatric disorders in children, strategies for working with these children.

And then, lastly, as an educator, we need to educate children about their own mental health from kindergarten all the way up. Your brain is an organ just like your heart. And some health educators maybe don't have enough education in that area that they don't feel comfortable. So we developed a binder called "Every Mind Matters" for health educators, which talks about stress release. There's so much testing and anxiety. Feelings -- feelings are normal. Anger is normal. How do you deal with your anger? There are activities in there about stress relief, about the brain.

And then as we get into the middle school we talk about mental illness and the different mental illnesses, and what are some of the symptoms. And most importantly, there's help; they're treatable.

And in the folder you'll see two information packets -- one on suicide, and one on depression -- from the National Institute of Mental Health. We are the New Jersey partner with the National Institute of Mental Health, and so we can provide flyers and information. There's also a flyer in there called *The Myth of the Bad Parent*. Every family has strengths. And so teachers need to be skilled in learning how to draw on those strengths.

And we also have two family support organizations -- one is called *NAMI Basics*, which is about a five-week evening program for families who have a child with a mental illness. And then there is Family-to-Family -- which is the course that I took -- which is for families who have an older child or an adult with a mental illness. And these are throughout the state, in every county, and they are run by trained volunteers. We are very dependent on our wonderful volunteers.

And lastly, the number of mental health providers must be increased. How can you help? These are some of the recommendations of the American Academy of Child and Adolescent Psychiatry. How can you encourage more medical students to go into child and adolescent psychiatry?

It takes four years of residency to be a psychiatrist, and then two more to be a child psychiatrist -- that's six years of residency. They are going to graduate with huge debt. Provide scholarships and loan repayment programs for all children's health professions. It's a great investment.

Designate child and adolescent psychiatry as a National Health Service core primary care specialty service so that loans would be reduced if child psychiatrists work in underserved areas, as is done with primary care physicians. And create a new model of collaboration between pediatric primary care and mental health professionals. Child psychiatrists could serve as consultants to pediatricians because these medications -- there is so much that they need to know that pediatricians often don't feel comfortable with them. And they are constantly creating new medications, and the child psychiatrists are the best people for diagnosing and treating with these medications -- because many of them do have side effects.

Many states are already implementing this model; they are also using telepsychiatry for areas where children are unable to see a doctor.

And I would recommend that you work with the New Jersey Council on Child and Adolescent Psychiatry to implement some of these incentives.

And so, to finish -- last weekend Pope Francis reflected on Martin Luther King's "I Have a Dream" speech. The Pope said, "It is beautiful to have dreams, and it's also beautiful to fight for them."

As parents, we all have dreams for our children. When a child is diagnosed with early onset psychiatric disorders, we must alter these dreams, but they're still there; hope for all our children to become productive citizens and lead fulfilling lives no matter what their disabilities are. As legislators, you can help these children to have good mental health, and supports, and follow some of the recommendations from the American Academy of Child and Adolescent Psychiatry. Get the educators more education on psychiatric disorders, and get children's mental health as part of every health curriculum from every grade level.

And thank you.

ASSEMBLYWOMAN SIMON: Thank you very much.

So can you expand on the educational programs that you have for teachers and for school systems -- Educating the Educator.

MS. BAUMANN: Sure.

ASSEMBLYWOMAN SIMON: And then, can you speak to -- what are your resources? I know that Phil had indicated that there's no State funding; we can absolutely address that, and look at any kind of Federal granting through Congress, and then also the State.

But the question I have is that -- if you don't have those resources, and if those resources are paid resources; if you have more people to help educate the educators, or are they volunteer?

And then the other thing is, Debbie Bradley and I were talking before about, if you went to the Principals and Supervisors Association in

New Jersey and trained them, maybe they could trickle it down; and the same thing for the Superintendents and Administrators, and same thing for the School Boards Association. If you trained them, and then they trickled it down to their-- You know, we have 590 school districts.

MS. BAUMANN: I know.

ASSEMBLYWOMAN SIMON: And it's not an easy task.

MS. BAUMANN: I know.

ASSEMBLYWOMAN SIMON: So there's so much to do with so little resources. But how are we able to do that?

And I have other questions, but we'll stick to this particular theme right now.

MS. BAUMANN: Okay. So if you look at the flyer, the Educating the Educator's flyer describes the program. And we go to the school districts. I've traveled to every county in New Jersey; I'm getting to know a lot of the roads. And we are very dependent on volunteers, though. And we do charge the districts because we put the people up overnight, and we give them mileage and things like that to help them to provide this.

But in that area, maybe Phil could speak for that. Probably funding in that area would be good and, as you suggested, maybe presenting for the supervisors who could bring that back to the school.

ASSEMBLYWOMAN SIMON: Okay.

MS. BAUMANN: Okay.

ASSEMBLYWOMAN SIMON: So expand on Educating the Educators. Exactly what does that look like? I know--

MS. BAUMANN: Okay.

ASSEMBLYWOMAN SIMON: --at times -- there's a presentation time, two-and-a-half to three hours. But what things do you cover for educators?

MS. BAUMANN: Okay, all right.

We have three speakers; the first speaker is the doctor. The doctor talks about the mental illnesses. He talks about ADHD, depression, bipolar disorder, mood dysregulation disorder, anxiety disorders -- which are some of the most prevalent disorders. And he explains what they are and what symptoms the teachers are going to see.

The second part is the educator.

MR. LUBITZ: One of the things that I think gets stressed in that part is the biological nature of many of these illnesses.

SENATOR RICE: Could you state your name for the record, please?

MR. LUBITZ: Sure; Phil Lubitz.

SENATOR RICE: Okay.

MR. LUBITZ: So a good deal of that is a medical person really stressing the biological nature of many of these illnesses. And that's meant to do a couple of things: one to remove some of the blame that goes towards the kid. I think Lorrie started speaking about the kid who, often, really becomes identified as more of a behavior problem or a bad kid; that's particularly true in minority neighborhoods, where people tend to be underdiagnosed with mental illness, and tend to be considered disruptive and have behavioral problems.

The other thing -- you know, it removes some of the stigma that's involved in having a mental illness as well. So that both helps the

child, but it's also going to help the parent. So earlier there was a question about what can we do to engage parents. And I think Lorrie really put her finger on it. All of us, with our children -- we, for better or worse, we wrap up our hopes and our aspirations on our children. And no one really wants to hear that their child has a mental illness -- especially when the picture that continues to be conveyed is, the individual with mental illness is Adam Lanza. So there's a real stigma to that. Personally, the more I think we talk about Adam Lanza, really, the more difficult we make this whole issue of treating mental illness. I think, in preparing, I've come to learn that only 1 percent of the homicides that involve children occur in school. You know, 1 percent is much too much, but I think we really have to keep this in perspective: 99 percent of the homicides that involve children occur outside of school on the streets. And if we are really concerned about homicide in children, that's where our attention should be.

The other issue with parents, especially -- we really have to be sensitive to cultures. You know, in NAMI New Jersey we have a number of cultural programs -- whether it's Spanish or South Asians or Chinese. And we have come to learn that minority populations feel stigmatized already and are particularly reluctant to open up to people of majority cultures. So it's really important, I think, to have not only cultural sensitivity, but have individuals of the same culture who are there to work with parents and to build trust with parents.

And those are really some of the building blocks, I think, to starting to have a positive relationship with parents.

So I interrupted you.

MS. BAUMANN: No, that's okay.

I agree with Phil. You need to emphasize that Abraham Lincoln, who had severe depression; that Congressman Patrick Kennedy, who has bipolar disorder; Lionel Aldrich, who had schizophrenia; Winston Churchill, who had bipolar disorder; Brooke Shields, who wrote a book about postpartum depression -- the majority of people with mental illness are doing quite well. But we don't talk about it. And I have never given a presentation where I haven't had a teacher come up and thank me and say, "I have a mental illness; people don't realize how hard it is," or about their child -- because, finally, they can talk about it.

And in our educator part, we talk about strategies and we give them a chart of ways to react to Oppositional Defiant Disorder. We have one page which is, "50 Ways to Deal with Anger." We have a page on anti-bullying, because bullying and stigma are so synonymous. How to deal with the impulsivity and the characteristics of a child who has ADHD -- that's a handout that we give them, and in it we have resources. We have all the local mental health and State resources in case the teacher needs to refer or somebody asks her for that.

And then we have books -- we have books for teachers. There is a professor at Harvard, a psychiatrist, who was a teacher before she became a doctor. She taught in Harlem. And she also is the daughter of a mother who committed suicide. And so she wrote a book called, *The Behavior Code*, and she works with the Massachusetts school system. So that's one of the books that we recommend.

We also have books for children -- a page of books about, "What does Sophie do when she's angry -- really, really angry?" -- that a lot of teachers use with children who have autism; or a book on feelings. And

then we have books for children who may have a mental illness in their family, because lots of times they think it's their fault -- and they need to understand that it isn't, and that their mom has a biological illness, or their dad, that is very treatable.

And then the last part, the parent part -- I have a lot of dear friends who volunteer. One of them -- she gives it in Spanish and English, and she talks about her culture and how her father wouldn't speak to her when she got medication for her child. And I have two African American friends who speak about their culture and how people react to mental illness. And they talk about their experiences with their families. And they will travel around the state.

And then the last part of it, we open it up to the teachers and we answer questions that they may have.

ASSEMBLYWOMAN SIMON: Okay. In addition to all the diagnoses that you mentioned, there is also a case of PTSD in--

MS. BAUMANN: Yes.

ASSEMBLYWOMAN SIMON: That's a fairly new phenomenon, faced in abused and neglected children in foster systems too. I was on the board of CASA SHaW -- which is Court-Appointed Special Advocates -- and we dealt with PTSD all the time in those children. It's heartbreaking.

So how do you differentiate; how do you help a teacher or a school system differentiate between-- Because their day is Core Curriculum, and then they have all these other things to handle. How do you help them differentiate a true mental illness, or a flag on the play, for something like that? Or you have your children who have mischievous behaviors, attention

seekers -- “class clowns,” as they say. Some are bored; their parents might say they’re academically bored and need more of a challenge. How do you help the teacher differentiate between a real issue and then something that’s more benign in nature.

MS. BAUMANN: Well, you never tell them to diagnose.

ASSEMBLYWOMAN SIMON: Correct.

MS. BAUMANN: Because they don’t have the expertise.

ASSEMBLYWOMAN SIMON: Yes.

MS. BAUMANN: You tell them to go to the support that they have in the school system -- the psychologist, the counselors, the nurses -- who can help them, and get advice from them, and refer the child to them rather than trying to communicate themselves. As we said before, nobody wants to admit their child has a psychiatric disorder; I know from firsthand experiences. And so they have to be very careful with that, and they also need to open up the lines of communication with parents.

I had gone to Japan to study the Japanese educational system. And I learned that teachers and families have such a close relationship that they go to the home and visit the family. Well, we can’t do that because I had a hundred students. Well, one year I called each one of my homeroom kids -- I were proud if it.

So if they open up a communication with that parent, destigmatize the illness, and develop a positive relationship first, that also can help.

MR. LUBITZ: But if I could add, Assemblywoman, as we’ve learned, there’s little good done for the teacher who becomes sensitized to mental illness in the classroom if she doesn’t have a support system in the

district. And we know that people at the top of the ladder in the district can be terribly insensitive to the mental illness needs of their students, and probably their staff members as well.

So I think there's probably direction that's required through the Department of Education to encourage schools to have district-wide plans on how to meet the mental health needs of all the students in the district -- really, all the way from the top down to the aide in the classroom.

ASSEMBLYWOMAN SIMON: I think another point is -- and I'm not sure, so I'm not speaking from a position of expertise on this -- but when you have a Special Ed teacher, is there a component in their curriculum for mental illness, and would that be helpful? I know that I am working with Secretary of Higher Ed Hendricks on a pilot program for paraprofessional certification for Special Ed. Because very often a paraprofessional, although they need 60 credits of college, could be working at a retail operation, and they come into a Special Ed classroom of classified children who have all types of diagnoses and they're really not equipped to handle that. So there's a need for a paraprofessional -- which New Jersey does not have a certification program -- and possibly helping the special educators, in their majors and minors, maybe focusing something like that on a higher education level.

MS. BAUMANN: Yes.

MR. LUBITZ: Good idea, because that's frequently a person who that one student will make a special relationship with. That could be really the most important person in a student's entire time in school.

ASSEMBLYWOMAN SIMON: Right; okay.

Does anybody have questions?

Senator.

SENATOR RICE: Yes, a couple of things.

First of all, thanks for the presentation. It was very interesting.

I think that the Committee members need to take a look at and have some conversations about some of the suggestions. And perhaps you can work with the Assemblywoman, and she can work with Becky and our staff, to take a look at what legislation should look like, in terms of mandating a course prior to certification, so that we can make sure that our educators are somewhat equipped to identify potential problems without actually diagnosing them themselves.

Also, I think by doing that we'll send a loud and clear message to the Legislature -- but particularly to the Governor, and Governors to come -- that you can't keep cutting these programs in our public school districts. I think that's important.

I think the other issue that needs to be addressed -- and maybe someplace in the country it needs to start; and maybe New Jersey needs to start it -- *mental health*, just the terminology itself, has been around for many, many years. And you do think of people who are chronically -- people used to call them *crazy*, and doing the lip thing. And so it's difficult for generation after generation to really come to grips with this thing of mental health because we think "crazy," not stressed or some other problems.

I know that-- I'm Chairman of the Legislative Black Caucus and we do have these discussions. And I know Speaker Oliver and some of my members are very much concerned with children and young people, in

particular. I don't think people realize that mental health is not all we see on TV -- people who need to be confined.

MS. BAUMANN: Right.

SENATOR RICE: Mental health is just me having some stress today. So it may be momentary mental health, but it's still affecting my mind set in the things I do. I know the Senate President and my colleagues acknowledge that I have a mental health problem, and I'm doing very well, though. So I know that, see? (laughter) So we need to take a look at what we call "these things" as we approach parents to pay attention to them.

And so that's a discussion that we need to have -- is how do we drive that? How do we educate people that we're not talking about someone who technically needs to be confined every time we tell you that in school -- the traditional school -- there's a problem with the youngster that needs to be addressed, okay? It may be something we can take care of in a week's time, you see? But it's creating problems for the kid until we do address it -- and it could get worse. So I just wanted to say that.

The other aspect I question is -- you're traveling throughout the state to the various schools; I heard you say that. Is that correct? You're doing programs. The schools are asking you to come in, etc.?

MS. BAUMANN: Yes.

SENATOR RICE: Okay. Then the question is-- We have this new phenomenon; we need to slow down because we're creating two school systems and eventually eliminating traditional school systems -- which is public -- for this quasi-private that they keep saying is not private. Are the charter schools asking you to come in? Because my experience with the charter schools -- and I can assure you that Assemblyman Wimberly

experienced a little more of the conversation -- is that when it comes to the IEPs and other issues in terms of classification, they can address those issues, and they don't want to address those issues. And even if a traditional public school writes an IEP for the student, and the parent decides to go to the charter school for any type of reason -- that plan follows that student. The charter school tells the parents -- because they can address it -- "You don't really need this," and they disregard the plan. But then eventually the kid may wind up back in a traditional school, and the plan, by law, is supposed to come back with the kid -- and it never comes back.

So these are things we don't want to talk about in Trenton, because charters are making money a lot of different ways. In fact, from my colleagues -- KIPP is going to Puerto Rico; they will have charter schools and taking some of our folks, to help them do that, from the Legislature.

So are charter schools asking you to come to have these conversations with their staff and their teachers, etc.? Or just your traditional public schools you're dealing with right now?

MS. BAUMANN: We have spoken at the charter school convention in Atlantic City to the educators there.

SENATOR RICE: The convention.

MS. BAUMANN: And we did apply for and get a grant from the Rutgers Community Health Foundation, in which we provided Greater Brunswick Charter School -- we brought in our lesson plans for middle school and we taught them about mental health. And then we worked with the mental health professionals from -- I don't know if they're from charter schools or-- But they work in the New Brunswick school system, and we

trained them. And we gave them a series of four presentations. And then also, through the grant, we purchase the books and give them a library.

SENATOR RICE: Okay. For the staff and the Committee, we need to revisit our Committee on School Choice -- this whole issue -- and get the charter schools in -- the other schools too -- in the Committee. But we need to revisit charter schools and find out exactly what they're doing with the mental health issue, if you will.

I know they're not addressing the IEPs and stuff; by law, they have to, and they should. And we need to pin them down, not with the rhetoric and getting around the issue -- exactly what are your schools doing? What is KIPP doing? What is North Star doing? What is this one doing? What is New Brunswick doing? And be specific. If that means, staff, that we have to identify every operating charter school and call each one in, then we need to do that. If we need go hold hearings in their districts, we need to do that, and call them out publicly to force them to say, "Here's what we're doing," or, "We're getting ready to start," or, "Yes, we would like some help." And then we can pull all these connections together to assist them.

And I think that's another reason we need to have a mandatory curriculum in our education -- those who come into New Jersey to teach and to get certified need to have that, because there is no guarantee that that particular graduate student who becomes a teacher is going to wind up in a traditional public school where they can get some relationships. And we know that the NJEA and others are going to eventually push this stuff; they may wind up in a charter school, but our kids are going there sooner or later, okay?

ASSEMBLYWOMAN SIMON: I think that's a very fair point -- where I'm not sure what the capacity of all charter schools-- I'm on that subcommittee of charter schools and alternative schools. I think that's fair for Rebecca to investigate that.

And then, also, I remember going into the Catholic Partnership Schools in Camden -- a superb school system. But they did share that, as far as Special Ed, that wasn't their subject matter expertise. So are the private school systems or the charter schools equipped, generically and holistically, and on a comprehensive level, to handle that? I think that's a very fair question, yes.

Thank you.

Assemblyman -- anything?

ASSEMBLYMAN WIMBERLY: I'm fine.

ASSEMBLYWOMAN SIMON: You're good? Okay.

Thank you very much. We really appreciate you being here. And again, thank you for everything that you do for our communities.

Okay, so next what I'm going to do is switch things up a little, because the next speakers have a time issue; they have to get back to their school. So I'm going to call up Debra Bradley, Suzanne Cooley, Barbara Manfredi, Sharon Rider, Susan Blackwell, Principals and Supervisor Association; and then educators from my school district, Hunterdon Central Regional High School.

Thank you, ladies, for being here.

If each one of you can introduce yourself and let us know where you're from. And for the Hunterdon Central -- my children went to Hunterdon Central; it's an extremely well-run educational system. And we

had a great experience. Thank you for the work that you do as teachers and educators.

So go ahead.

**D E B R A J. B R A D L E Y, Esq.:** Assemblywoman Simon, I'm Debbie Bradley; I'm with the New Jersey Principals and Supervisors Association.

And it is my pleasure to introduce the leadership team here at Hunterdon Central. We have Suzanne Cooley, High School Principal; and Dr. Susan Blackwell-Nehlig, the School Psychologist; and Sharon Rider, an experienced Student Assistant Counselor at Hunterdon Central.

And as an Association, I would just like to say that we're very pleased to be here today to discuss an issue that's of top importance to our members. We represent the principals, assistant principals, and supervisory staff at schools who are not only responsible for the academic side, but also the health and welfare of our students.

I know you've just heard important statistics from NAMI about the prevalence of mental health issues in students and schools, so I won't repeat those statistics. But I would like to just point out the important challenges that this raises to our members working in our schools.

We're focused on trying to meet the educational, social, emotional, and health needs of our students, but we understand that although our core mission is instruction and education of our students -- we understand the critical linkage between health and student learning. And we understand the unique role that we play in all of this. Our members, as well as teachers and all school staff, are involved in not only identifying

early warning signals, but also trying to provide interventions and provide appropriate service or facilitate that.

So I'd like to turn this over to the educators, at this point. And thank you for the opportunity.

ASSEMBLYWOMAN SIMON: Thank you.

**SUZANNE J. COOLEY:** Good afternoon, and thank you. I am Suzanne Cooley; I am the Principal of Hunterdon Central.

And I would like to begin by just painting a picture for those of you in the room who aren't familiar with Hunterdon Central.

We are a very large high school in Hunterdon County. The District is comprised of approximately 152 square miles and serves about 48,000 residents in the County. We serve five municipalities: Delaware Township, East Amwell Township, Flemington Borough, Raritan Township, and Readington Township. We currently have just shy of 3,000 students on campus; and it's grades 9 through 12.

We have what many consider to be very much a college-like campus setting. We have 72 acres that comprise our campus. We have multiple general academic buildings; we have a music communications building; instructional media center -- which, back when we went to school, was the library; a field house; our own radio station; a cable channel that promotes all of our events and publicizes the things that we do there at the high school; a 900-seat auditorium; multiple gymnasiums, athletics stadiums.

The opportunities-- As large as the facilities are, the opportunities are rich as well. We're very proud of an academically rich and rigorous curriculum of 226 general education courses, 46 honors-level

courses, 27 advanced placement courses, and 38 special education courses. We also offer alternative credit pathways for students who do not fit, necessarily, into a traditional high school model, and we give them options as to how to attain that graduation requirement.

In addition to those academics -- and we're very, very proud of the performance of our students; we have very high achieving students at the high school -- that is not the only thing that drives the train for us there. We have a lot of extracurricular opportunities that we provide as well: 33 athletic interscholastic athletic teams, 50 different student clubs and activities, you name it-- It almost feels like, at Hunterdon Central, you name it, we have it. And if we don't, we'll get it if that's what the children want.

So I've been in the District -- I was in the District for 10 years as a Vice Principal, and now I'm in my fourth year as Principal. I am very, very proud to be there; I was a former student of Hunterdon Central as well.

And many would say -- I've heard over time, and I say it as well: We are what one would consider a very resource-rich and a very opportunity-rich District. Unfortunately, that picture I just described to you -- you would think that most students have a wonderful experience when they come to our high school. Unfortunately, not every student does, and that is why I think we're here today to discuss where that breakdown is for every child. And I heard somebody who spoke before mention 1 percent-- It's not a great number, but it's still a number, and it's still somebody's child, and it's still our child when they're under our care as educators.

I want to share a few figures; my team will be much more specific with regard to diagnoses, and treatments, and things of that sort. But we generally conduct surveys across the District. And we are a single-school District, 9 through 12, as I said before. But we did a survey in 2012; it was the Youth Risk Behavior Survey. And it touched on a number of different areas -- mental health issues were not titled *mental health issues*, but they were infused in there under different titles -- risky behavior types of categories.

When our students were asked -- and these are results from Hunterdon Central -- when asked, "During the past 12 months, did you make a plan about how you would attempt suicide?" -- they were asked, all of our students, 9 through 12; and about 2,400 students participated in the survey on that day -- 9.2 percent of our students answered "yes."

ASSEMBLYWOMAN SIMON: Oh, my goodness.

MS. COOLEY: And if you do the math, about 230 students said "yes." Not that they just thought about it at one juncture or another, but they had a-- To me, that "make a plan" piece was a big indicator. They had a plan. Or, at least in their minds, as adolescents, they felt they had a plan.

When asked during the past 12 months, "How many times did you actually attempt suicide?" 2.8 percent said they had at least tried one time; that's 70 students. In a school of 3,000 it doesn't seem like a lot; but if it's more than 1 -- if it's at least 1, then that's a lot to me. And 1.2 percent said they had attempted it two to three times, which is approximately 30 students. When asked, "If you attempted suicide during the past 12 months, did any of those attempts result in an injury,

poisoning, or overdose that had to be treated by a doctor or nurse?” again, it was the 1.2 percent of our students who said that it did. So you’re speaking about 30 students who were so far along in the process beyond the planning, beyond the thinking -- to where they’ve actually engaged in some sort of attempt that required some level of medical attention.

And I present those to you because I think, as many speakers prior to us had said, it knows no boundaries; mental illness happens everywhere. It happens in very resource-rich districts like our own. And we are afraid to talk about it. We don’t-- I think as a society we don’t like to talk about it because that’s not what Hunterdon Central is about, right? I mean, that’s not-- I’m speaking to a former parent in our District -- with Assemblywoman Donna Simon -- and it rings true. It’s not something that-- We hold informational sessions in the evening about some of these topics; perhaps there’s a problem within your own family.

So just to go over just a few ways that we address that at Hunterdon Central. As I said, it’s a very large place, so we try to make a very large school small. And we do that by incorporating what we refer to as the *House System*. There are four Houses, and they’re grade-specific. There’s a 9th grade House, 10th grade, 11th grade, 12th grade. And while it originated as an operational, organizational piece for, probably, administrators and teachers at the time to deal with, it’s evolved into a support system for our students where that team -- and the team is comprised of a Vice Principal, a House Office Secretary, a nurse, a Student Assistance Counselor -- follows that child through their four years. There’s a team of people who all talk about, “How do we identify in a school so large? How do we know?” Well, we have a team of people that gets to

become very familiar with our students and follows them through a four-year period. And hopefully, then, that increases our chances of somebody noticing something, or picking up on some of the cues and the symptoms that the speakers had spoken to previously.

We have a strong counseling support network. Is it enough to address 230 students who are thinking about or having a plan for suicide? I don't think that it is. But it is a strong support system. We have two school psychologists; we have four school social workers; two Student Assistance Counselors. We're fortunate enough to have a partnership with Hunterdon Medical Center, where we get three mental health counselors who are available to our students throughout the year, on a daily basis. We provide regular training to our staff, and while I think it helps, as you've said, with all the competing demands -- is it enough? Those are things that we'll get into.

So for me, before I turn it over, I think there are a lot of things that I would like us all to consider. And I don't just ask it of you; I ask it of everybody in the room -- to consider these things. We are living in an age which is very different than when we grew up. I struggle most with the social media, as a high school Principal, and what that delivers. It's great from a standpoint of connectedness and speaking with people around the world. We use it in the classrooms; you can speak to people in different countries. It's an awesome, awesome thing. But when you speak about student issues and mental health issues, it's devastating our children. They're putting things out there that they can't take back. And it's not just for the few friends who they told at a get-together to see; it's for the world to see, and that's devastating. So that's a big piece for me -- trying to figure

out how to really get a handle on that for young people. It's enough to manage as adults, but for young people it's very, very difficult.

So at this point, I would like to turn our presentation over to Dr. Nehlig, who will go into some of the more specific scenarios.

**S U S A N B L A C K W E L L - N E H L I G, Psy. D.:** Hi. I'm Dr. Susan Blackwell-Nehlig, and I'm the School Psychologist at Hunterdon Central.

So I'd like to thank you very much for your focus on mental health in the schools today. I've been at Hunterdon Central for 14 years, and also served for two years at Phillipsburg High School as a school psychologist.

I'm also a licensed professional counselor, a licensed psychologist, and I have a private practice in the area and I specialize in children and adolescents.

So I think the effect of mental health on school success and achievement is very well documented, with factors such as coping skills, emotional competence, positive peer relationships -- and is very much the core of educational success. Unfortunately, I think many students are not able to avail themselves to learning because of the mental health issues that we see -- you know, emotional, social-emotional; and students spend the majority of their day in school. And I think the mental health services that they receive at Hunterdon Central through us sometimes are the only mental health services that they receive.

And so with that in mind, I know that we have to be very careful in developing interventions and strategies that promote healthy, resilient students.

As a school psychologist, I think I'm uniquely qualified to support the needs of students and the whole child. Mental health, educational -- I interact not only with the students, but also with administrators, families, outside agencies. I do a lot of coordination of services just for the mental health needs that we're not able to provide in the school and we have to coordinate outside.

I do counseling -- individual counseling, mentoring; I promote wellness and resilience through reinforcing communications, social skills, problem solving, anger management. I have seen a tremendous increase in mental health needs in the time that I've been at Hunterdon Central. I would say specifically depression and anxiety. And as you were saying, I think too that students' lives are extremely complicated by peer pressure, social media, all of the things outside; information overload; academic pressures that they have not seen before.

I wanted to share you with a very powerful example of what a senior student with anxiety faces at Hunterdon Central. And I asked him to describe to me what his school day is like with anxiety.

His name is Harry, and he's gifted. He's a gifted student; he takes AP classes. He's also dyslexic and he's dyspraxic. He understands that his anxiety is exacerbated by his learning issues, and he struggles every day.

So I asked him to just write to me what it was like to go through the day, and I would like to read that to you.

"I am Harry, and I am a senior at Hunterdon Central High School. I cope with anxiety each and every day. Anxiety, to me, is being in a state of constant worry -- continually in a state of fear and panic. And the

more you try to deal with the anxiety, the more focused you become on the panic you are experiencing.

“School is even more of a challenge when dealing with this anxiety. People think having anxiety is about completing your work. However, it’s much more. Anxiety feels like the annoying bully that harasses you for every fault you have. There’s no forgiving yourself for not finishing your assignments when you deal with anxiety. While other students can put things aside that are bothering them, a student who suffers from anxiety feels like the biggest problem in the world.

“When I try to deal with my anxiety, I create more angst. One of the biggest challenges for me in coping with the anxiety is dealing with teachers and peers. It’s hard, because when you have anxiety, you want reassurance that everything is going to be okay and appropriate. In a social situation, people never give you the reassurance that everything is going to be okay. And that causes a lot of anxiety for someone to try to cope with it because they are constantly worried about what the other person thinks.

“People with anxiety worry if they are saying the right things and what vibes they are giving off. Students who suffer from anxiety worry or not whether they’re being understood by their teacher in the classroom. People need to be aware that anxiety is more than being a little worried; it can be painful and it can be debilitating.”

So I found that very powerful.

And Harry accesses a variety of services at Hunterdon Central, which includes all levels of interventions that we provide -- which would be primary, secondary, and tertiary. And the purpose of primary prevention at Hunterdon Central is to prevent disease or mental health difficulties before

they occur. So at Hunterdon Central, we do that by educating our students about safe and healthy activities, and fostering resilience -- so that would look like our many clubs, sports activities, things like that; the counseling services, curriculum, the tutorial that we offer, health education classes, etc. In Harry's example, he participates in fencing and he is also in the Robotics Club.

The secondary prevention that Hunterdon Central has is aimed at reducing the impact of the problem or the mental health concern that has already occurred, in order to facilitate resilience. So examples of that at Hunterdon Central would be individual counseling by the school psychologist, school social worker, student assistance counselor; I&RS plans, which are intervention and referral services; 504 plans; special education. Currently, Hunterdon Central has 541 classified students; 41 of those are classified with emotional disturbance. And we also have 81 504 plans.

Harry is classified; he has an IEP, and he also receives individualized counseling.

The purpose of tertiary prevention or intervention at Hunterdon Central is to really lessen the impact of the diagnosis and improve student functioning. Examples at Hunterdon Central, which I'd like to highlight, are our Project Trust program. Other examples would really be participation in outside intensive outpatient programs and/or inpatient settings. But at Hunterdon Central we offer a program that is only offered to classified students; it's called *Project Trust*. And Project Trust is our self-contained, effective-based education program for at-risk students who are classified. One of the mottos that we like to say is,

“building community to strengthen individuals.” So Project Trust is very much like a community: it has two classrooms, 12 students each. And it is designed to provide one-on-one student-teacher conferencing; individualized instruction to meet the needs of the students; the ability to address different learning styles at different levels; formative assessments to help students gauge their understanding and improve their performance; and there’s also a social worker on site who is able to provide counseling as needed and also, as per the IEP, usually on a weekly basis.

Project Trust also utilizes something called *restorative practices*, which is taken from restorative justice. And they do a lot of groups called *circle conferencing*, in which they hold the members of the Project Trust community accountable for their actions. And they ask very specific questions like, “What were you thinking when you did that? What are your thoughts since that happened? How do you think that affected the other individual?” to start generating dialogue and an understanding of what it’s like to be a meaningful citizen and participant of the program -- not just in school, but in general.

Having said all that, I think that the greatest obstacles for the staff -- or at least for me at Hunterdon Central -- in providing mental health services to students is really time and also resources. And I say *time* because we’re providing counseling services, we’re not providing therapy. And so the amount of time that I have to work with a student, I’m very sensitive that I am taking them out of math, English, science. And I think, what was spoken to before, about a shift in culture and how we look at things, and making mental health sort of part of that curriculum so that there’s less stigma of being taken out. And not just be the teachers, but by the students

themselves who are telling me, “I’ve got to get back. I’ve got this test; I’m missing this. I can’t talk to you.” And it’s really just building on the overall stress, I think, that the student is experiencing.

So I think we have to maintain communication with the students at all levels to be able to provide better primary intervention services. And then absolutely know when we need to start providing secondary and tertiary intervention.

ASSEMBLYWOMAN SIMON: So I have a couple of questions.

One, can a student receive 504 -- the adaptive assistance -- without being classified?

DR. BLACKWELL-NEHLIG: Yes.

ASSEMBLYWOMAN SIMON: They can.

DR. BLACKWELL-NEHLIG: The 504 criteria includes the presence of a disability or a diagnosis, and one that would significantly impact their educational progress. But they do not have to be classified.

ASSEMBLYWOMAN SIMON: Okay. And then for your Project Trust -- which is amazing--

DR. BLACKWELL-NEHLIG: It is. It’s often full, and that’s a problem as well.

ASSEMBLYWOMAN SIMON: Yes, you said it’s just for classifieds.

DR. BLACKWELL-NEHLIG: Yes.

ASSEMBLYWOMAN SIMON: Can you -- is there a policy restriction that you can’t open it up to the 504 -- other people who -- other individuals who are needed, or is it just the resource issue?

DR. BLACKWELL-NEHLIG: I think, at this point, it's a resource issue. You know, that being said, it's been full just with the classified students, and we very much do have a need to provide it to students who are not classified.

ASSEMBLYWOMAN SIMON: Okay. And then the -- you had mentioned the counseling services, and again that stigma of being pulled out of math; and their fellow students know what this is about, and all the social ramifications occurring with that. Are there opportunities for afterschool programs or are you now, then, competing also with the extracurricular activities, and sports, and having to get to the bus, and parents are working and they can't-- You have all of this.

DR. BLACKWELL-NEHLIG: Yes, and I think it's the pressure the student, again, is putting on themselves; like, "I have to get to tutorial," which is a service that I noted as a primary prevention to help them. But now they're too stressed out and aren't able to do the counseling because they want to go to tutorial to get their schoolwork done. So I think it's a shift that we also have to make with them -- that it's okay to talk about this, and it's okay to take time out to do it. And it's not only, like, acceptable and tolerated; it's wanted and needed.

ASSEMBLYWOMAN SIMON: Yes.

MS. COOLEY: I think it's important -- and I know Sharon will speak to this a little bit. These issues aren't neat; they don't fit into a nice 10-minute, 15-minute appointment window. And they're messy; they take time, and students oftentimes aren't ready to speak in the 15 minutes, 20 minutes that we have allotted for them. So it is a struggle; you're constantly competing for the time, the opportunity. And when you take

the time -- which our staff always does, because we recognize the value and the importance of it and the immediacy of it, something else falls off the plate. So the time -- we had spoken earlier when we first got here -- there's still only so many hours in the day to address all those needs, yes.

ASSEMBLYWOMAN SIMON: Okay. All right, thank you.

**S H A R O N   R I D E R:** I'm Sharon Rider, Student Assistance Counselor--

SENATOR RICE: Excuse me; a quick question.

I keep hearing the word *resource*. Are we talking financial resources, are we talking human resources, or are we talking a combination of both? And no one is defining or articulating what that resource should look like. Do you have-- What are we talking -- financial? Do you know what kind of -- if it's financial, do you know what kind of dollars we're talking about to fill a void?

DR. BLACKWELL-NEHLIG: I do think it's staff and financial -- and I can have you speak to that -- because obviously if we had more financial resources we could provide more staff to provide the services, to open up another classroom in Project Trust for classified or regular education students.

SENATOR RICE: So maybe, Ms. Rider, when you speak you can maybe address that?

MS. RIDER: A little bit, yes.

SENATOR RICE: Because you know, when we say resource, we can be talking book resource, human resource, as you know -- we need to know exactly what we're talking about.

MS. RIDER: Would you like me to do that now before I present, or (indiscernible).

SENATOR RICE: No, whenever you feel comfortable doing it.

MS. RIDER: All right; let me introduce myself, then.

SENATOR RICE: I'm not going anyplace. (laughter)

MS. RIDER: Okay. I can address that.

I'm Sharon Rider, a Student Assistance Counselor at Hunterdon Central; I've been there for 16 years. And I was hired as the Alcohol and Drug Counselor, as the Student Assistance Counselor. I felt blessed going in there because I also am a Licensed Clinical Social Worker and a Licensed Clinical Alcohol and Drug Counselor. And my background is primarily in the addictions field with adolescents, as well as adult alcohol and drug rehab settings for a couple of years. So I worked with active and end-stage addiction. And then, coming into the high school, I'm working with beginning addiction problems and family issues.

As a SAC counselor, it's very different than a grade level counselor, in that I provide confidential counseling -- under a Federal law -- to be able to talk to students and help educate them about their addiction, and the drugs, and-- I really operate out of trying to educate the client -- educate the student about how addiction is affecting their minds, their bodies, and help them with decision making.

But over my 16 years here -- and I am so happy this meeting is happening -- in 16 years, I really can say that I believe that my job has changed more into crisis counseling because of the mental illness problems that these teenagers are dealing with. In 16 years, it's absolutely amazing to me what's happening.

Our referrals-- There are only two of me: myself and there's Mrs. Heller, the Student Assistance Counselor. Your student referrals come from staff, vice principals, parents can call us and ask us to see the students. It's surprising -- we have a lot of self-referrals. Students will walk in and ask for help themselves. Most of our referrals come from friends who are concerned for their friends. And I attribute that to, we have worked hard to have a good reputation with the students about confidentiality and being respectful to these students. And it's known throughout the school that we're reliable.

The other advantage I have -- and I brought her ID -- is that we have Lucy -- just a little side note. She is the therapy dog at Hunterdon Central, and she has been there for four years. She has her own ID badge. (laughter).

MS. COOLEY: She's official.

MS. RIDER: She's official, and she's probably the only dog that has almost 3,000 teenage fans. The students love her, they readily come to our office -- a lot of times, just for comfort from Lucy. And like I said, she's in her fourth year at Hunterdon Central.

So getting back to what my observations are in the 16 years: the shift of the mental illnesses that we are seeing. We still-- Under mental illness is substance abuse, so that's primary as well. But I don't believe that it's just within our school, and I think you've heard that from earlier speakers -- that I think this is really a cultural, societal, national problem that's happening in our world today. And I could attribute it to a lot of variables that are causing this problem with the young children. But I won't go into detail right now.

I would like to tell you some of the things that we see, mostly which have been mentioned. Depression and anxiety are primary. The ADHD, the Attention Deficit Hyperactivity, is very prevalent; social and emotional problems where the students can't deal with situations or stressful things that come up; PTSD; a lot of cutting with freshman and sophomore girls as a coping mechanism; reported eating disorders. There are family problems that, at times, can take my breath away when I sit and listen to the stories of what some of these children are living with within their family situations -- of absentee parenting, or they're having to care for their younger siblings. And in psychology we call that the *parentified child*. A lot of students are a parentified child; the parent is absent, so the child takes on that role. And it's very psychologically damaging for the teenager.

More recently, parents are in prison -- and that is something new that we didn't experience when I started back in 1999. It is very worrisome for the teenager, as well as abandonment issues. Sexual molestation from parents; bipolar and OCD is prevalent; the drug addiction within the home -- not only for the students themselves, but within their family system there's addiction that causes problems for the teenager. And then there's the autistic spectrum, which is a wide range of issues in itself.

So listing those things and many, many other things-- Can you imagine the student having to carry around that psychological baggage and come to school every day and try and concentrate on their education? It's very heavy; very heavy.

Just a couple-- I'd like to say a couple of cases. One young girl, she came in as a freshman student -- and this is going years back -- she had reported to her mother, at the end of 8th grade, that her father was sexually

molesting her and her younger sister. And to the mother's credit, she took her right to the prosecutor's office. But in her freshman year, she showed up in my office right away for support. That whole freshman year she worked with the prosecutor's office in putting her father in prison. At the end of her freshman year, I went to court with her and her mother to support her -- because I was her safe, go-to person in school -- so that she could testify against her own father, who got six years in prison.

And she functioned; she functioned. She graduated with her class, she was able to concentrate.

Another young lady who came in as a freshman -- she's a sophomore now -- she's the oldest child of eight. Both parents have been in prison; she lives with an aunt. She was sexually molested by her mother's boyfriend at an early age -- and on, and on, and on. The aunt and the uncle do what they can, but imagine: they've taken on eight little children, and she's the oldest of the eight and worries about her younger siblings and trying to take care of them. So again, that psychological damage.

And I could go on and on with a variety of different stories, different cases, that would really shock you.

Given all that, the fortunate thing about being at Central is that we offer -- we can offer individual counseling. Like Dr. Blackwell said, it isn't therapy; but it's individual counseling, one-on-one, in a safe environment. We have 16 grade-level counselors, the two SACs, and then we have the Child Study Team Case Managers. All of our offices are in a quiet, safe environment so that may be the only place that those teenagers can come and talk to somebody who is going to listen to them, put value to

them, in that safe environment. Because when they go home, they may not have that.

The other increase that we see a lot is the suicide thinking -- we call it *suicide ideation*. Huge increase in reporting that in the last three years. It's pretty significant. I would say, on average, we average one or two suicide ideation assessments every other week in school.

And we have come up, at Central, with a serious protocol -- that all the counselors and Child Study Team members are trained in assessing the suicide ideation in the school setting. And then the protocol requires the parents are involved; and we have to have a second assessment done outside of the school, by either the parents, psychiatrist, mental health counselor; generally, they will go the emergency room at the hospital for another assessment. Because we need documentation from the outside clinician or doctor saying that the child is safe to return to school. That's the language we use, and we have a form letter that the outside therapist needs to sign. And then the student cannot come back into school until we have a reentry meeting with all the players, and that form, saying they're safe to return to school.

We offer the parents a referral list of outside agencies because, again, we're not therapists, we're not treatment -- but we refer out to the communities. We have some names of psychiatrists and other agencies that are appropriate, and can give those readily to the parents.

I go into senior health classes to teach about how do people get addicted. Because there are a lot of arguments about gateway drugs and things like that. And I go to the seniors, because they have a maturity level, -- I'm teaching them and offering them information about addictions. And

they're going out into the adult world -- that a heroin addict does not wake up and say, "I think I'll try heroin today." It doesn't happen that way. It is a gateway drug of pot or alcohol -- is the start of it. When I worked in the rehab center, we had heroin addicts in there; and halfway through their treatment -- 30 days to stay -- they would wake up and they'd say, "What am I doing here? What am I doing here? How did I get here? What's this all about?" "You're a heroin addict." And they would say -- because they'd have some clarity of thinking after 10 or 15 days of not using -- we would say, "You were using heroin; you're a heroin addict who we found on the street." "No, I wasn't; I was just smoking pot."

So I'm there teaching our high school seniors that pot and alcohol are definitely gateway drugs. So I do that.

Our four nurses are great. If we have students who have panic attacks or something in our offices, the nurses are right there to help them medically. I have often said our five Vice Principals at school are the ones who keep our school safe. You know, when we have an emergency, they are right there; you know, you just pick up the phone and they are right there.

And then our SAC program runs, on a nice note, a peer mediation program. So we have 60 trained high school students who are good listeners, good negotiators. And when students have problems -- fighting, bullying -- they're referred to do a mediation. We pull in our student mediators who are there to help them, listen to their stories, teach them that they can negotiate their differences and their problems; and the mediators help them resolve their differences. And we ask them to sign a contract so that they can remain respectful for the rest of their high school career.

I had heard earlier -- you were asking if the parent refuses to help their student. That is a little difficult, because there's the expense of medical treatment. But we have FCIU -- we call it *Family Crisis Intervention Unit* -- which is a great asset to have intervene with families and parents. So if a parent refuses treatment, we will either ask the parent to come in here; or we will contact this Family Crisis Intervention Unit, and they will contact the families and go into the homes and work with the parents and help them. So they are accommodating the family system as well.

Resources -- you were asking about resources, what we need. Is that correct?

SENATOR RICE: Right.

MS. RIDER: I'm real clear about this: Hunterdon County, a wealthy county -- we have no inpatient adolescent facilities in Hunterdon County. Every time that we refer for a suicide ideation assessment at our local hospital, they have to be sent out-of-county. There's nothing in it. Alcohol and drug inpatient? We have nothing in Hunterdon County for alcohol or drugs -- for adolescents; this is for adolescents. I think there's a desperate need for inpatient-- Another example: group homes for children who are guardians (*sic*) of the State. We have a boy's group home; we don't have a girl's group home in Hunterdon County. I believe the closest one we have for girls is in Morris County -- that they have to be sent up to, and then transportation has to be arranged for them to be driven back down to Hunterdon Central High School.

ASSEMBLYWOMAN SIMON: Well, that's something that we're going to add to our take-away from today to investigate. We have a

relationship with the Freeholders from Hunterdon County; I think it's a good policy to get a conversation going there.

We're lucky enough, in Hunterdon County -- where other counties are not as fortunate -- where we have Hunterdon Prevention Resources with Karen Widico and Lesley Gabel--

MS. RIDER: Yes.

ASSEMBLYWOMAN SIMON: --and the community that works very close together; even the faith-based One Voice, where, unfortunately, our Rabbi Jaffe has passed away -- but he was part of that group; and just working with the community. So we'll absolutely deal with that. I'm sure that you also see the economic factor, even in Hunterdon County, where I think it was a year-and-a-half or so ago their food stamps were up 512 percent, if I'm not mistaken, is the stat. So in working with the shelters and the homelessness, and Family Promise, and Starfish in Readington, and all of the programs that the families -- and during the holidays in other areas -- that families are in need of this. I'm sure that that also is a dynamic that you find in your schools too -- with the stressors of anxiety and depression.

Do you have any issues with HIPAA, when you have any of these programs? Is there a challenge with--

MS. RIDER: The challenge becomes-- We have the three school-based counselors who come from the high school; they're not school employees, they work through the hospital. They're grant-funded. And they are under the HIPAA law, and they are not able to disclose information under the HIPAA law. But that does not impact us.

ASSEMBLYWOMAN SIMON: Okay. So then, the work with Hunterdon Medical Center and Bob Wise and his team -- it's a great partnership. If you got sign-off from the parent, is that an ability --because they're underage -- does that help you, sort of, with that relationship between the different sources?

MS. RIDER: The parents would have to sign that, yes.

ASSEMBLYWOMAN SIMON: Okay.

MS. RIDER: But again, that doesn't affect the school setting. It's really medical.

ASSEMBLYWOMAN SIMON: It's medical.

MS. RIDER: Yes.

ASSEMBLYWOMAN SIMON: Okay.

When you speak of resources and funding, do you have grant programs? I know sometimes schools have grant writers; that in itself is a separate entity where grants you need -- it's an art form.

MS. RIDER: It is.

DR. BLACKWELL-NEHLIG: It truly is.

ASSEMBLYWOMAN SIMON: You apply for the grant, and if you're lucky enough to get the grant, then you have to have somebody who manages the grant, and it's a whole big thing. But do you -- are there grant systems that you try to apply for, for any help and assistance with funding?

MS. COOLEY: I think we do, but I think they're piecemeal. It's situational; whatever's available at the time. We certainly try to take advantage of that. We've been trained to work within a zero-based budget, and the mantra for years has been to *do more with less*. I think we're-- If you're looking to address issues like mental health, I think that we're

running thin in that regard. I mean, there's only so much you can do with *the less* because everything is mounting. But we take advantage of whatever opportunities, via grants and things that are out there, that we can get our hands on.

ASSEMBLYWOMAN SIMON: Okay.

Let's talk about liability. So what is the responsibility for a teacher if they do notice something and then they go about communicating to the right sources? Is there a liability factor for your schools -- that if they don't recognize it, and then there is an issue-- What are the ramifications around that? Because in this litigious society that we live in, you're trying to do your best in helping students, and it doesn't always work out that way. So from your perch, what are the issues?

MS. RIDER: I could speak with regard to the alcohol and drug issues -- that any staff member who reports a student under suspicion is not liable at all in the eyes of the law. That it is the staff member's duty that if they feel that the student is under the influence of a drug, that they are to immediately report it to the Vice Principal so that the student can get medical attention. That's the whole purpose; again, keeping the student safe. And the law stipulates that there is no consequence for the staff member to have reported that.

MS. COOLEY: I think that said, we tell our staff to -- if there's any doubt, or any concern, to report that to somebody. I think that's the teacher's obligation and responsibility, in them doing their due diligence in that regard.

You know, if you look at the opposite of that scenario -- and this is how we try to educate, particularly some of our newer teachers who

are new to the field -- for something to have happened, and to have to testify that you did see signs and you did see things that you weren't sure of, but hadn't acted -- that's certainly going to go far worse than having a parent conversation that says, "You know, Mrs. Simon, I may be off-base here, but what I'm noticing in your child is *this*, so I referred him or her to one of our counselors. If it's nothing, it's nothing; if it's something, at least we're all aware of it and we can address it."

ASSEMBLYWOMAN SIMON: Right. And you do that with more benign things like dyslexia--

MS. COOLEY: Yes, absolutely.

ASSEMBLYWOMAN SIMON: -- and dyscalculia, and you see a 5 backwards--

MS. COOLEY: You err on the side of caution, and get them treatment if it's needed; absolutely.

ASSEMBLYWOMAN SIMON: You err on the side of caution, right.

MS. RIDER: And I find that-- Oh, I'm sorry.

DR. BLACKWELL-NEHLIG: That's okay.

MS. RIDER: I find that, when dealing with parents, if you can always couch the situation under the child's safety -- that that goes a long way.

ASSEMBLYWOMAN SIMON: Okay.

DR. BLACKWELL-NEHLIG: I think teachers are very concerned about that. And a lot of what I do is consultation with teachers around that. You know, we have a very open dialogue; I'm asked to come into classrooms and observe students. I am constantly checking with

teachers about their concerns for students. So I think a lot of that's taken care of in terms of consultation.

ASSEMBLYWOMAN SIMON: Now, do you agree that there needs to be either more training for Special Ed with that concentration in mental illness; or the paraprofessionals in the classrooms -- who literally can have the 60 credits that are needed to come into the school, but really don't have that training to go into a classroom or maintain it? Is there a need, as I see it, for better training for paraprofessionals, or even a certification program, which nowhere in New Jersey has it?

MS. COOLEY: Absolutely. I mean, we add to our annual mandated trainings for our staff every year. And I'm thinking, as I listen to other speakers, we have suicide in there, we have different mandated trainings. But mental health -- you know, that probably needs to be expanded and included on that list as something -- probably more global for those of us who aren't in day-to-day contact, with children in front of us all day long. And then maybe that takes on a different look for the paraprofessionals who are working one-on-one with those students. But absolutely -- trainings.

ASSEMBLYWOMAN SIMON: Yes, okay; good.

MS. RIDER: And I would just like to offer that I think that, as I've seen in the 16 years the progression of mental illness, I think that, futuristically, schools are going to have to be thinking about hiring more crisis counselors -- people who are clinically trained to work with these students.

DR. BLACKWELL-NEHLIG: Yes. And I can speak to that -- when I said about staff resources before. Although I am in a unique

position to provide mental health services to students, I'm also on the Child Study Team. So as a school psychologist, the majority of the work that I'm doing is case management, IEPs -- it's a lot of paperwork. And I feel like I'm not able to provide as much mental health services as I could because I have Federal code to follow regarding IEPs.

ASSEMBLYWOMAN SIMON: And you're spread thin.

DR. BLACKWELL-NEHLIG: Yes.

ASSEMBLYWOMAN SIMON: Because not only are there, you know--

DR. BLACKWELL-NEHLIG: Yes. So I'm in a position to do that, but because of the school psychology Child Study Team, I'm prevented -- my hands are tied, in some ways.

ASSEMBLYWOMAN SIMON: Okay. Any--  
Yes, go ahead.

MS. COOLEY: Oh, I was just going to add to that. In filtering that down to educating -- offering more stress management, anxiety-types of awareness; educational components for younger children. I mean, our children now -- and I tend to look at it beyond the walls of my high school, and look at it as a community -- our children are involved in activities from the time they're very, very young. And it's not just one activity; you're running to soccer, you're running to music lessons, you're running to here. And their day is so filled that, you add schoolwork on top of that -- teaching them to manage those things, or we as the adults in our community taking ownership of lessening some of those expectations for them. We push our kids really, really hard, and then we sit back and look at it, and say, "Why are they so stressed? Where's this anxiety coming from?" Well, we want

them to get into top schools, and we almost expect it in our community in many ways. So from a society -- taking ownership as an adult in our society, as a citizen in our world, looking at that and saying, "Do we need to push our children into doing so many things?" or should we start getting back to focusing on more things--

ASSEMBLYWOMAN SIMON: Back to basics.

MS. COOLEY: I mean, that's where some of it gets lost. So there are some things we can do.

ASSEMBLYWOMAN SIMON: We have a neighbor; he's way out of the college years. But he went to Central, and he applied to Princeton University. He had a 4.0 -- I think 4.5, with AP courses and everything.

MS. COOLEY: Sure.

ASSEMBLYWOMAN SIMON: He had a perfect score on his SATs. And the school turned him down because he didn't have enough extracurricular activities after school. Why is that the basis?

MS. COOLEY: And then you look at that systemically--

ASSEMBLYWOMAN SIMON: Exactly.

MS. COOLEY: --and those expectations changing, so that your kids don't feel compelled to have to be everything to everybody, and do everything. It's too much.

ASSEMBLYWOMAN SIMON: Any comments?

Senator? Yes.

SENATOR RICE: Yes, a couple of quick things -- questions -- and I do this for a reason.

I understand that Hunterdon Central -- this is one of our wealthy districts, is that correct?

MS. COOLEY: Yes.

SENATOR RICE: But I'm hearing problems. And so I want to know -- you have 3,000 students, roughly; what is that ethnic breakdown mix, and gender mix in your school?

MS. COOLEY: Gender--

SENATOR RICE: Just roughly.

MS. COOLEY: Yes, roughly we have -- our minority percentage is probably 14, 15 percent of the entire population.

SENATOR RICE: Okay.

MS. COOLEY: So we're--

SENATOR RICE: And that minority of 14 percent -- African America, Latino, etc., others -- do you have any idea what that looks like?

MS. COOLEY: Not off the top of my head. You know, it's probably pretty balanced between African American, Latino; we have an influx of English Language -- ELL students who have moved into our community.

SENATOR RICE: And the reason I raise it is because, for years-- I've been doing this a long time, that's why I have gray hair. (laughter) And I keep reminding folks that those of us who have come out of the urban districts -- we experience things and we know things that are not necessarily substantial in other communities. But we're smart enough to know that they have not abated or been addressed, and that's been our argument: It's going to spread and get worse. An example is, I'm a former police officer; I've lived in Newark since 1955. I'm a former investigator.

Hearing on the streets of Newark, back in the 1970s, even until today -- 80, 90, 100 percent would argue that, "Something needs to be done."

Now, I've given out free needles; we need programs, treatment, counseling, etc. -- mental health, okay? No one paid attention. Here it is 2015, and I pick the paper up and no one is talking about Newark, or Camden, etc., when it comes to ODs. Now, I don't know if we have gotten immune to the OD stuff or it's not reported, or we (indiscernible) the drugs, but all this OD with heroin stuff -- and the heroin is in the cities -- seems to be in wealthy districts, shore communities, etc. And they have this rapid response statewide to find resources to address the problem. But yet, you need resources at the early stage to prevent us even getting there, and we can identify them.

And so I've been trying to let people know that when we argue from an urban perspective, or more of a blue-collar, working perspective -- diverse communities -- that we're arguing for all of New Jersey, because we know; we've lived it. What elected officials traditionally do, in both parties, who don't represent those areas -- they tend to come into communities like yours and act like these problems don't exist, because they don't want the stigma. Gangs don't exist because they don't want the stigma.

And so I think that, from our perspective -- once again, to staff and to the Committee -- we need to go back and take a look at legislation, and maybe have some more dialogue with this as to how to continue to make education a priority for the Legislature -- because we're doing the opposite. We're cutting funds across the state; we're asking the wealthy districts to go more in their pockets -- whether they can or not, is not the issue; we're taking away afterschool programs -- the kinds of things you're

talking about; we're putting in bills to say, "Well, you know what? Don't give us any money; we'll take it from the lottery side, okay?" We can't get bills moved. So it's almost like we're contradicting ourselves at the State level about where the priorities should be as it relates to education.

The other scenario, for the Committee, is that the labor issues go directly with our Committee. The Workforce Investment Act -- that really came from a lot of other Federal programs over the years -- has just been amended again by President Obama. Interestingly enough, it's that the amendments that have to be addressed by all the states. So I'm going to have to figure out what we're doing, because there are a lot of dollars locked into the amendments. And the amendments are geared toward education. How do we connect K-12 to community colleges, and create alternatives, and bring industry in to identify what it is that industry needs as we set our post-secondary education curricula? We're setting curricula, and then we're graduating kids to find that industry can't use that. That's frustrating in itself, but the reality is that there are dollars there that can really, with some discretion and some flexibility, be directed directly towards some of the needs of these districts.

And the industry piece, and the way that the legislation is driven -- it's clear that industry is not looking for academics on its own anymore. They're looking for skills. So when you look at a district like this, and someone says, "Well, there's a lot of pressure on me, because everybody goes to college." That's what they tell us -- they go to college, they work on Wall Street, you understand? They have to go to Princeton and Stanford, you know? The college down the street isn't good enough, etc. In New Jersey, that's part of that pressure, coming up as a teen. And

what we're saying is that, let's take a look at some of these technical and vocational areas where the skill sets are needed, that are driving where the economy is going in the future.

And so we need to have those kinds of discussions for education. This Committee can't operate in a vacuum as though those other committees -- who are not doing their job, some of them, or not paying attention-- We're going to have to wake them up and say, "Pay attention, because we need you to help us address this whole education piece in New Jersey."

So I just wanted to raise that, and that's why I constantly ask, when I get into districts like this, what's the wealth, what's the ethnic breakdown, what's the gender breakdown? So people can recognize this is not a poor or wealth situation; it's not a black or white, or male/female situation. This is a real serious problem for people in general, particularly the generation coming behind those of us who are a lot older. Because we didn't go through this; we had our own stress, but it was a lot different. We could relieve our stress, okay? What we did is, we had a party on the weekend, or canteen. (laughter) So I think it is important, and we didn't have the social media impacting us -- there were the conversations where we could talk to each other.

And the other thing is that I think we should take a look at some of these programs. And we may not be able to mandate them, but I think we should educate people on peer mediation and things of that magnitude. Because young people do talk to young people; but the young people who are talking to young people-- I'm not so sure, particularly in the urban districts, and I suspects it's in all the other districts too -- Hunterdon

just happens to be unique because of Central, and I see that there is some good leadership here -- is whether or not, if they're talking to someone in Paterson, that the friend would know what to do with it. (laughter) I know what they would probably do -- they would probably say, "Join the gang and get some love" -- you know what I'm saying? And go to jail at the same time. (laughter)

So we really need to look at that, Madam Chair.

ASSEMBLYWOMAN SIMON: Interesting that you said that.

I had a meeting last week with Senator Cunningham in Jersey City, and we spoke about opportunities and kids who are in schools, K-12. And not everybody can afford the four-year college; not everybody has the capacity to go into a four-year college. And we talked about workforce development. And I know that we spoke, and we're going to be dealing with, looking at that specifically. There's a Superintendent in Somerville, Tim Purnell, who does a lot of work with the polytechs and RVCC in helping at-risk kids -- even in Somerville, believe it or not -- to help them incentivize them to stay in school.

So Senator Cunningham -- we're going to get together with our panel and Senator Ruiz, and really talk about workforce development; and how we can partner with Kim Metz, and Polytech, and other things.

And also looking at -- to incentivize kids to feel like they have a future, you know? Not everybody is going to go in for their master's or Ph.D. What's wrong with looking at the labor side of things, where the economic development -- as legislators, in working with not only trying to keep businesses here, but bringing more in -- manufacturing, right?

SENATOR RICE: Yes.

ASSEMBLYWOMAN SIMON: And looking at Hal Wirths at the Department of Labor, the Commissioner; and working with IBEW, the operating engineers, the plumbers, the carpenters. They have apprenticeship programs, you know? And bringing that into the schools so that we can, holistically -- and partner with each other to try to start hitting this from all different avenues.

So thank you.

Assemblyman, do you have any questions?

ASSEMBLYMAN WIMBERLY: Yes. It's great; you guys covered most of it.

But on a high school end, another major issue that I know that we face in Paterson -- a lot of urban areas -- are the lesbian/gay/bisexual/transgender when you talk about depression. I know we have various groups and organizations that address this. And many of the young people are abusing alcohol and drugs because they haven't been able to deal with their families, deal with their identities. How has that impacted your district as far as that is concerned? It's another area that has been taboo; nobody wants to talk about it. But now it's such in the media that I think it has made it easier for some and harder for others to come out, or for their families to accept it, and where do they go from there?

And I know in the urban area, in particular, it has been tough for a lot of young men because they get stereotyped as a not-so-nice name and things of that nature. And then in turn, these are the runaways; these are the ones who end up homeless, these are the ones who are ending up on the street, prostituting or various other areas.

So the mental health issue, with this area, is something that also has to be brought out, has to be talked about. And I think Senator Rice hit it on the head: I don't think it's a situation where it's race, or religion, or anything. I mean, we face many areas with our Muslim community, where kids are depressed because they don't know how to handle these situations. We have a very large Muslim population, and different ethnicities and religions that really, really-- And then, in turn, they turn to drugs, they turn to the streets. They get put out of their houses, in many cases, when they do come out, "This is who I am," or whatever. How is that impacting your district?

MS. COOLEY: I'll start.

I think we were a little bit ahead of the curve before the mandated policy came out for transgender students. We had had experiences prior to that, and had to figure out what to do -- how to best meet the needs and serve the students who were coming to us.

From a policy perspective, getting that then handed down as a mandated policy was comforting and reassuring to districts. But there are many schools out there that are still not there yet. I attended a HIB conference, and the transgender issue came up. And there were many in the audience who were astounded that you allow a male student, who is identifying as a female student, to use a female locker room, or a female lavatory. So that education still needs to -- and that training still needs to take place for educators. I think -- while I think when we do something, that everybody must be doing it, it only takes a few opportunities to see that that's not the case.

So first and foremost, I would say educating the adults around that issue. From a counseling standpoint, I don't know if you--

DR. BLACKWELL-NEHLIG: I would just like to clarify that being gay, lesbian, or transgender is not the mental health issue, but the mental health issues that they suffer--

MS. COOLEY: What manifests--

ASSEMBLYMAN WIMBERLY: Well, my concern is that they deal with it.

DR. BLACKWELL-NEHLIG: --because of the isolation and not being accepted--

MS. COOLEY: And how they deal with it; correct.

DR. BLACKWELL-NEHLIG: --ostracized. It's huge. Sharon and I participated in a suicide assessment on a transgender student two days ago. So it's something that is very much impacting our school. And we are continuing to try to educate the students, not only about a climate of tolerance, but a climate of acceptance, I think; and educating the students as to what's going on. We've also invited students -- transgender students to educate the staff. So they have presented to us, from their perspective, so that we're better able to serve the rest of the students, and really foster and facilitate a climate of acceptance so that they're not feeling isolated, left out, bullied, etc.

ASSEMBLYMAN WIMBERLY: And obviously, with Tyler Clementi, that's an issue, and being outed, and social media. I had an incident recently in our high school where a kid was accused -- and I personally didn't think-- And the kid, he was in denial -- the kid ended up transferring schools over this. And I'm going-- You know, I talked to the

father and-- He's a football player; and now you're a football player with 70 other guys, and somebody makes an accusation about you. And I didn't think the accusation was true after talking to him and his father, but he was so stressed out, he left. He left the district over this.

So you know, the whole outed thing, or social media with the pictures, or whatever it may be. And it may have been photoshopped. But you know, these are situations that I think we have to address. And like I said, here's a situation I just addressed a month ago -- this month, actually -- and the kid left school over this. And it's not easy for kids even being accused -- sometimes it's almost like you're guilty. "No, I'm not," but, you know-- So it's a difficult situation. And like I said, it's not a mental health label, but it can become.

And then the other, like I said, is quite a few of our homeless teens and stuff became alcohol and drug abusers through -- a lot of them were abused. And in turn, from the abuse, they are not really sure what they-- I've sat and talked to people -- kids in different incidents and different program that we've been involved with. And it came from abuse -- be it a parent, or be it an outside person, or be it somebody in authority, in many cases -- that they're just not sure. I mean, it's mental health indirectly, and you deal with it.

ASSEMBLYWOMAN SIMON: That's a very good point. And like I said before, with CASA, and even working with the Covenant House, you get children who are suffering from PTSD because of their home environment; and how to deal with that in the schools.

So thank you very much. We really appreciate you all being here.

ALL: Thank you.

ASSEMBLYWOMAN SIMON: Thank you.

ASSEMBLYMAN WIMBERLY: I will have to excuse myself; I have football practice.

ASSEMBLYWOMAN SIMON: All right, next up we have the School Boards Association -- Michael and Irene.

A hello out to Jonathan Pushman from the School Boards Association.

**JONATHAN PUSHMAN:** (off mike) Thank you.

ASSEMBLYWOMAN SIMON: Thank you, Assemblyman Wimberly; thank you very much for being here.

If you can introduce yourselves, that would be wonderful.

**MICHAEL VRANCIK:** Good afternoon, Chairman, Senator.

I'm Mike Vrancik, the Director of Government Relations for the State School Boards Association. With me is Irene LeFebvre; she is the Chair of our standing Special Ed Committee. We have two working task groups, one on Special Education and one on School Security, that have done some work that is relevant to the discussion today.

I'm going to let Irene start, and then I'll conclude with some comments as well.

ASSEMBLYWOMAN SIMON: Thank you.

Welcome.

**IRENE LeFEBVRE:** Thank you very much for having us here.

My name is Irene LeFebvre; I'm from Boonton, up in Morris County, where I've served on the School Board -- the Board of Education up there for 21 years. As a Board member, I would speak to some of the

issues that you've talked -- that we have been talking about. But also, as a Board member, I've been very active with New Jersey School Boards Association and serve as their Chair of the Special Ed Committee; and was active on the Special Education Task Force. So possibly some of the things that we talked about there have bearing on what we're talking about today.

I'm also the mother of seven; I have seven now-adult children -- we got them there. (laughter) They survived. And they're all products of the public school system. Of my seven children, two had 504 plans when they were in school because of medical issues; and three had special education IEPs, based on specific learning disabilities and exacerbated by some medical issues.

I'm also employed by the Passaic County Ed Services Commission as Director of educational programs, and I work with students throughout Passaic County -- including Paterson -- where, through that program, I run the Alternative Education programs and Special Education programs for some of the more severely disabled children who can't be educated within their own community. So I speak to you from several different perspectives.

And I had a prepared speech, but most of what I would have talked about we've already heard from a lot of people. But let me give you a little bit of some of the things, and then see if I can answer any questions, or whatever.

We're always interested in making sure that all of our children are educated to the perspective that they can become successful adults. It doesn't really matter whether they're in general ed or special ed, whether they're being educated within the district or, if their needs are more severe,

being educated outside of the district. In every single case, we need to make sure that their social and emotional needs are met, as well as their academic needs. And, all too often, we fail to meet that social/emotional side.

No matter how big or small the district is, the reality is that everybody is undermanned in the areas of mental health. We make sure we have enough teachers in our buildings to ensure an appropriate teacher-student ratio; but I don't think anybody has come up with a good, effective counselor-student ratio or even Child Study Team specialists. We might know how many Child Study Teams we need for how many special needs kids, but is the ratio there to provide the support services? We just heard people talk about the fact that so much of our time as a school psychologist is spent doing paperwork, and the skills that she has as a counselor are not always able to be used to that extent.

So one of the things that we did come up with as part of the Special Education Task Force was recommendations for one of those things, -- which is: you can reach out to the local Educational Services Commission -- and there are 10 of them throughout the state -- but you can reach out to the local Educational Services Commission; and the Educational Services Commission can provide extra personnel to the district on a contracted basis to do some of the paperwork -- to do the evaluations, and to do the paperwork. And therefore to free up your counselors to be counselors, your social workers to be social workers, or your learning consultant disabilities people to be in the classroom making sure that IEPs are being implemented appropriately. So that's a service that all 10 Ed Services Commissions throughout the state can provide that might help districts. It's not free, but it helps; it's less expensive than hiring another person.

ASSEMBLYWOMAN SIMON: Now, can I ask you: So the wonderful nonprofit organization, NAMI, has -- they have Educating the Educators. Did the School Board members that you go under--

MS. LeFEBVRE: Yes.

ASSEMBLYWOMAN SIMON: Do you have appropriate training for sensitivity-- And unfortunately there are school board members who are not, I guess, keyed into some of the mental illnesses that the educators have to handle. And is there training for school boards?

MS. LeFEBVRE: Yes. School board members are probably some of the best educated, best trained public servants in the country -- in the state especially, because it's mandated that all school board members receive training -- fairly extensive training in their first year of being a school board member; and then additional training each subsequent year -- the second and third year of their first term, and the first year of each successive term. So I've sat through a lot of trainings over 21 years.

ASSEMBLYWOMAN SIMON: And where do you get your training from?

MS. LeFEBVRE: The New Jersey School Boards Association does new board member training -- which you take during the first year. There are two places -- multiple ways it can be done. The down and dirty is using the online -- there's an online training program, which has been revised and improved, and it is very interactive. There are full-day training programs where board members go to a centralized site, in the north central or southern part of the state, and they receive training in all of the major areas -- law, governance, special education -- those kinds of things -- the mandates.

ASSEMBLYWOMAN SIMON: And is it specifically to mental illness and sensitivity?

MS. LeFEBVRE: No, it's not. No, I would say that that's not. It's to the subject of what your responsibilities as a board member are, to supporting the programs that are recommended to you by your superintendent and by the school personnel, okay? So as a board member, you're not providing a service directly, but you're making sure that the funds are there and that the staff is put in place.

Now, that brings you back to, then -- the question that comes back is your responsibilities as a board member is twofold: provide an excellent education to every child who lives in the community, but to be fiscally responsible and make sure you can operate within the cap of the budget that the community can afford. So you're operating within the fiscal constraints of what the community budget has been, with no more than a 2 percent increase -- by cap -- every year; at the same time that you're balancing absolutely increasing costs in the field of, let's say, insurance premiums, or--

ASSEMBLYWOMAN SIMON: Health care.

MS. LeFEBVRE: --health care. All those kinds of things.

ASSEMBLYWOMAN SIMON: And salaries and benefits are outside that cap--

MS. LeFEBVRE: Outside.

ASSEMBLYWOMAN SIMON: --because that's part of the exemption, right?

MS. LeFEBVRE: No.

ASSEMBLYWOMAN SIMON: And capital expenses for a school?

MS. LeFEBVRE: No.

MR. VRANCIK: Capital expenses, maybe; but not salaries.

ASSEMBLYWOMAN SIMON: But not salaries.

MS. LeFEBVRE: Salaries are part of that. There are very few things that are outside the 2 percent cap; very few.

ASSEMBLYWOMAN SIMON: Okay. For which I understand, I think, for-- There's a stat that, on average, \$19,211 per student; 50 percent of that is salary and benefits. So it's--

MR. VRANCIK: It's actually more than that.

MS. LeFEBVRE: It's more than that.

MR. VRANCIK: It's closer to 80 percent.

MS. LeFEBVRE: Yes. About 80 to 90 percent -- 80 to 85 percent of any district's budget is--

MR. VRANCIK: Salaries.

MS. LeFEBVRE: --taken care of with salaries. It's committed, in terms of contracts, okay? And then with the other 15 to 20 percent, you try to meet the needs for other services, okay? So the financial side is a real constraint.

And your board members come from every walk of life. Board members are doctors, and lawyers, and educators, and custodians, and businessman who are entrepreneurs or who work for corporations. I mean, they come from all over. So they come with a variety of backgrounds in terms of understanding the needs of children in the schools. I have to admit that, 20 years ago, when I first was on the Board, I actually had a

Board member -- a fellow Board member say at a public meeting, "Well, when are you going to fix these special ed kids with you spending all this money on them?" because he had so little understanding of what the needs were.

ASSEMBLYWOMAN SIMON: Sure.

MS. LeFEBVRE: Once that conversation was held -- immediately -- with the Superintendent, and the head of the Child Special Services, and other Board members, he came to understand right away that that was a totally inappropriate remark. And, at the next Board meeting, he apologized to anyone who he had insulted.

But he really didn't understand; he thought you spend the money, you fix it, and you move on.

ASSEMBLYWOMAN SIMON: Unfortunately, even in 2015, we have situations like that.

MS. LeFEBVRE: I'm sure we do. But not in Boonton, okay? (laughter) Because we really fight hard to make sure that all of our Board members do receive training.

So the School Board training is designed to make us aware, as Board members, of all of the various aspects of the responsibility that we've taken on by sitting on the Board. We don't receive training in the details of the Core Curriculum and the details of PARCC, unless we go to additional trainings; and we do that. I mean, I went to one this past week that -- and I'm in the Morris County area -- I went to a training on the PARCC. And tomorrow -- Thursday night I'm going to a training on Common Core that is provided by the State Department of Education personnel -- they're bringing it here.

ASSEMBLYWOMAN SIMON: Sure.

MS. LeFEBVRE: But I'm hearing, after a day here, that this has to be looked at not only from the perspective of the educators in the classroom, but from the people who are providing the financial wherewithal--

ASSEMBLYWOMAN SIMON: And the oversight.

MS. LeFEBVRE: --the oversight; exactly.

ASSEMBLYWOMAN SIMON: Right, right; absolutely.

MS. LeFEBVRE: So this is going to be something -- I've already put down notes about the Educating the Educators and things like that, because certainly the opportunity may very well present itself that we can bring this into the education process of our Board members.

ASSEMBLYWOMAN SIMON: Sure.

MS. LeFEBVRE: And it's something, especially as Chair of the Special Education Committee, that I will bring back to the Special Ed Committee and have them talk about it, too; because it's certainly--

ASSEMBLYWOMAN SIMON: That would be fantastic. And you would assume that anybody who is working with children should be sensitive enough to understand it. But I think it would be important, during the training of school board members, that maybe if they were partnered with--

MS. LeFEBVRE: Right.

MR. VRANCIK: Absolutely. I think, as Irene said, we have-- In statute now there's a mandate that, in the first three years of your initial term you're trained with successive modules that go to more specific details; and then in the first year of each new term. We have an internal group that

looks at our training on an annual basis, and we're in the process of taking a look at that right now. Certainly some of the recommendations from our Special Education Task Force are going to be incorporated into what we do with Board members, in addition to the collaborative things we're doing with the State Department of Education -- where we have additional training that's not mandated, but it's focused on specific kinds of things, like the stuff we're talking about.

ASSEMBLYWOMAN SIMON: Right. And maybe there could be a partnership between the school boards and NAMI.

MR. VRANCIK: Absolutely.

MS. LeFEBVRE: Absolutely.

ASSEMBLYWOMAN SIMON: You know, it doesn't look like-- From where I'm standing, it doesn't look like an exorbitant amount of money; it's ancillary expenses -- that you might have to help them help you, and expand their programs and their resources in order to partner with the School Boards Association. That would be--

MR. VRANCIK: I think--

SENATOR RICE: Excuse me. From the speaker's perspective -- because we're being transcribed -- when you speak, because we're going back-and-forth between the two of you -- just put your name on the record; you know, "This is Michael."

MS. LeFEBVRE: Oh, all right.

MR. VRANCIK: One of the things that we're interested in looking at is how we enhance student achievement, and what do we have to do to create a mindset on the part of board members who, essentially, are overseeing the curriculum that's put in place in local districts.

ASSEMBLYWOMAN SIMON: Exactly.

MR. VRANCIK: How to incorporate these kinds of ideas into the larger curriculum. So, absolutely, it's something that we're going to be taking back.

ASSEMBLYWOMAN SIMON: And it helps with the stigma, right?

MR. VRANCIK: Absolutely.

ASSEMBLYWOMAN SIMON: If we have that open and honest discussion.

I love this quote from Helen Keller: "Alone we can do so little; together we can do so much."

MS. LeFEBVRE: Absolutely.

ASSEMBLYWOMAN SIMON: And it's about partnerships.

MS. LeFEBVRE: Well, one of the things, from a parent perspective and an educator perspective, that I'd like to make sure that is part of the conversation-- And the consideration is, not all mental health issues are wrapped up in children who are classified. There are an awful lot of kids in general education situations who can be pushed over the line by not being given the support that they need early on. Different people have mentioned different examples; but the preschooler or the early elementary school child whose family is in a messy divorce -- given the right support as a very little child, will not necessarily have serious mental issues later on--

ASSEMBLYWOMAN SIMON: No, absolutely.

MS. LeFEBVRE: --but without that support can develop the anxiety issues and things like that.

ASSEMBLYWOMAN SIMON: When one parent denies visitation, there's a custody battle, or parent alienation syndrome -- which are different stages -- that's a big issue.

MS. LeFEBVRE: And sometimes districts make mistakes. Let's lose that expression, okay? I mean, I know of a young lady who, up until 7th grade, was, despite a very severe visual impairment, functioning beautifully in school. She moved into the junior high and became very anxious -- okay? -- not comfortable. But a lot of junior high kids are anxious and uncomfortable. It wasn't the direct result of her visual impairment. But to protect her, the team decided to put her on home instruction. She graduated several years later without ever putting a foot back into the school. So now she sits at home, a graduate with honor grades, but with none of the social skills and none of the mental health skills -- the anxiety and things like that weren't addressed. She was protected into almost like an infancy; into a dependency, instead of being given the support--

ASSEMBLYWOMAN SIMON: Given the support system, yes.

MS. LeFEBVRE: --system to move forward.

Or the youngster who has a chronic illness and ends up with a 504 plan. And then, instead of being supported by the teachers or the counselors, and stuff, is seen to be lazy or to be, maybe, "You're a drug user; you should be tested" -- things like that. And then you end up with a youngster who, instead of getting through the illness and being comfortable in the school, feels themselves on the outside looking in. So, I mean, there are things like that.

We all know that there are the special ed kids who start out with one diagnosis, like autism; then, as time goes on, they become older, deal with hormones, deal with -- and they end up with comorbidities of all kinds of violent issues. And those we've-- Other people with more expertise than myself have talked about that today. But I'm just saying that we need to make sure that when we create a spirit of sensitivity and cooperation, that we look for the opportunity to-- In that Tier 1 intervention that they were talking about before, that we make sure that we reach out to these youngsters who are in our general education classes, sometimes in our honors classes, sometimes in our technical classes; but who are going through issues that need support -- to make sure that the staff is available to them. It's just something that, too often, we don't get there.

The reality is that the recommendation from the Task Force recommends professional development for teams, recommends professional development for the teachers, it recommends professional development for your board members -- so that everybody is on the same page and understands that it's a cooperative process with the family, with the parents to educate children; and that we should not be standing on title when it comes to making sure that everybody gets the services that they need.

And to that end, the Task Force has recommended all of those things. And I think that based on those Task Force recommendations, we do have a much better partnership than we had with the DOE at one point; we have people who are coming out and providing a lot of information and services to the Board members, and that's really a very helpful thing.

ASSEMBLYWOMAN SIMON: And that's where legislators come in. You know, when you have any issues or things that we can help with -- we have that direct line with each department. So that's what we're here for.

MS. LeFEBVRE: Right.

And then the last thing I would say -- and then I will turn it over to Mike -- is you talk about training paras. In Passaic County, at one point, we supplied paras for the City of Passaic; we still supply them for several districts. And we do make sure -- the Ed Services Commission does provide a training program for the paras, and we do make sure that they know-- And we also provide one for our substitute teachers who come through our registry, to make sure that they have an understanding of the types of needs that they may find and the types of behaviors that they may find, so that they have a -- they don't see these as *bad* children who are acting out, or as *immature* children who still need diapering or toileting exercises.

ASSEMBLYWOMAN SIMON: Sure.

MS. LeFEBVRE: So you're right -- it's not mandated, and you're right that it's not -- it hasn't been codified. But it is really something that we do make sure that-- And I don't know for sure, but you may find other ed service commissions that do the same thing, and they may be resources for you in your research.

ASSEMBLYWOMAN SIMON: Okay. Yes, I mean, that's -- it's essential. You're dealing with (indiscernible) issues; you're dealing with transition issues. I mean, it's hard enough to go from a classroom to a lunchroom sometimes.

MS. LeFEBVRE: That's right.

ASSEMBLYWOMAN SIMON: And, you know, there's a lot of things that--

MS. LeFEBVRE: But I'm sure that any ed service commission that's doing it would be pleased to spend time with you. So that would be a ready service.

ASSEMBLYWOMAN SIMON: All right, yes. Thank you very much.

Senator, do you have anything to add?

SENATOR RICE: No.

ASSEMBLYWOMAN SIMON: All right.

MR. VRANCIK: Connected to what Irene said, our School Security Task Force, that was convened after the tragedy in Newtown several years back-- Ironically enough, as they discuss more and more about how to make schools safer-- I spent a fair amount of time with a guy named Maurice Elias who is at Rutgers -- who had something called *The Social and Emotional Character Development Lab (sic)*. We found that school climate is a predictor of incidents and problems. And in the context of recent legislation about the mandatory anti-harassment and bullying, we've obviously included that in our board member training modules.

But we spent a lot of time looking at what we can do in the context of educating our members in terms of looking at how to foster a better student climate. And there is a quote that suggests, "There is also powerful evidence that school climate affects students' self-esteem and self-concept. School climate also colors school-based risk prevention efforts. Effective risk-prevention and health-promotion efforts are correlated with a nurturing

school climate. It also promotes academic achievement. As a result of these findings, fostering socially, emotionally, and physically safer schools has become a primary focus of the U.S. Department of Justice and virtually all state education departments.”

I read that because it’s a quote from the Harvard Educational Review from 2006; this is not new stuff. I think, sadly, some of the tragic events that have occurred have caused us to really focus on this. Dr. Elias and his team have been studying, on an anonymous basis surveying kids. They have been in, I guess, 48 districts across the district-factor groups in New Jersey. And, thus far, they’ve found surprisingly similar responses from kids from, like I said, all different district-factor groups -- all different types of schools: urban, suburban, rural, etc. And clearly what their studies indicate is that focusing on and discussing school climate, and involving students working with other students to generate a climate of respect and concern for other people has not only a beneficial result in reducing the instances of harassment and bullying, but their preliminary studies show that it increases student achievement by as much as 10 percent. So it’s clearly something we want our board members to be focused on.

And our Special Education report, our School Security Task Force report are on our website. I’ll be happy to give you guys the link. There’s a lot of other information on there. But I just thought it was important to suggest that transcending the specific individual student issues -- there’s a global issue here that has to do with improving the school climate, which, hopefully, will address some of these other issues; also will impact student achievement, which I think is paramount to our members.

ASSEMBLYWOMAN SIMON: Okay. Yes, thank you very much.

I really appreciate your relationship with us, Michael and Irene; and also Jonathan who is visiting with us today. You know, it's essential that we keep the open dialogue, and whenever it's an issue that there's open, honest, direct conversations. Because we're all in this together, right? We're all in the same rowboat that we're, I think -- working with each other is essential.

So thank you very much.

MS. LeFEBVRE: It's all about the kids.

ASSEMBLYWOMAN SIMON: It is.

MS. LeFEBVRE: I mean, that's the whole--

ASSEMBLYWOMAN SIMON: That's exactly what it is.

MR. VRANCIK: Thank you.

ASSEMBLYWOMAN SIMON: Thank you very much for being here.

Okay. Oh, boy -- 1:30. Oh, my goodness.

Okay, so we have two more speakers; and I'm pleased to invite Mary Abrams from the New Jersey Association of Mental Health and Addiction Agencies. And then, following that will be Elizabeth Manley, Assistant Commissioner for the Department of Children and Families.

**M A R Y A B R A M S:** Good afternoon.

**ASSEMBLYWOMAN SIMON:** Good afternoon. How are you?

MS. ABRAMS: Very good.

ASSEMBLYWOMAN SIMON: Please introduce yourself.

MS. ABRAMS: Yes. I am Mary Abrams; I am a Senior Health Policy Analyst at the New Jersey Association for Mental Health and Addiction Agencies, often known as NJAMHAA. And I thank you both, Assemblywoman Simon and Chairman Rice, for the opportunity to speak here today on the important issue of mental health in the public schools.

A little bit about NJAMHAA: We represent 160 hospital-based and freestanding nonprofit mental healthcare and substance abuse treatment providers. We treat New Jersey residents of all ages with mental health, substance use, and co-occurring disorders. We actually are in every county and in almost every community, statewide. Nearly 98 percent of the behavioral healthcare market in New Jersey is within our membership, which serves over 500,000 children and adults with mental health and addiction issues annually.

So much of what I was going to say -- and I will still go back to the testimony that you have a copy of -- has been touched on before, today. Some of the most important things I think are the anti-stigma. What was just reported on, about the school climate, what children -- having access to, and families, and taking advantage of anything -- resources -- we do put out there. That stigma is such an important part, so one recommendation right up front is to focus more on those campaigns. There are successful things going on in schools, in regions, and throughout the state. And more resources do need to go to that.

We say there is no health without mental health. And that's another message we've been hearing: That it has to be comprehensive, it has to be a natural part of the curricula, and everybody in the community has to be familiar and comfortable with it.

There are many evidence-based programs out there and a whole list of resources that you can access. And my focus today was going to be on some practical, very low-cost or no-cost approaches that schools can use. I would like to commend Hunterdon; on my list of, like, seven suggestions, they mentioned almost every one; it might be doing the others as well. They have-- The resources they listed -- four social workers, two psychologists, counselors, relationships with the local medical center -- are so-- That's rich compared to so many schools. And still you heard of how little resource that is compared to the need and the size of their student population. So it's critical.

I said in here -- we would recommend, if it was fiscally able, to put at least one social worker in every school. And that social worker would always have a link to a local child psychiatrist -- child and adolescent psychiatrist who they could consult with or refer to. That alone, we know, is beyond the financial ability of so many. I myself worked, many years ago, in a children's agency that used their own grant funding. As we eventually heard from Hunterdon, three of those staff are actually staff of the medical center, and not school staff. The school's resources are just so stretched, as are the resources of the community mental health providers. And we represent-- Of course, we're talking about the nonprofit community.

So that's another thing -- and I'll probably come back to, certainly, the funding; and maybe not come back to what one of the big pushes that NJAMHAA will be having, going forward, from this moment. I just put the finishing touches on a first draft of a paper on reinvestment. This year, in Fiscal Year 2016, the State is saving \$619 million from

Medicaid savings, charity care. For under the ACA -- the various provisions -- populations previously served under special programs, that were partly State funded, now are 100 percent. So that is just -- that's a figure that we got from the Office of Legislative Services. And of that, I know, in the current budget -- I think it was \$72 million; \$72 million, \$74 million -- that the Governor did reinvest; that's in graduate medical education and some in the physicians' rates. We'd like to see a maintenance of effort of much more of that. You heard about the need for inpatient beds, for residence, for the school services; there is just so much need. And for every \$1 spent on prevention, \$7 is saved down the road in those inpatient, or in jails, or in so many other things that are more costly; in not only financial, but in terms of personal stories and whatnot.

So a couple of things. One other comment: A little minor phrase that's in here is that the resources in the schools really have to reach not only those children, but their families. And we know it's very difficult -- and I come from a family of teachers, who I still have my-- My parents were, my sister is, my cousins are -- how much can a teacher do? How much can a school do? But that's why one of the recommendations that I have in here is so important -- to make those community linkages. We don't expect the school-- Like we said, we don't expect the teachers to diagnose; but we want them to know the warning signs. We want everybody -- and not only the teachers, but the secretaries, the custodial staff -- everybody in that school should have those trainings. NAMI spoke of one; I am going to speak briefly about another one -- and I shared a flyer with you on AIR.

But so many of the students are going to have contact with the lunch ladies, you know, the people in the halls, and the people out front watching the buses come in in the morning. So it's really important that everybody, from the school boards on down to the last staff in the school--

So getting to the practical things that I was going to focus on -- one is, just sharing the information for parents. You had asked a question earlier: How do you get this information to the parent, or, if they deny -- if they don't want to take this certain approach? This should go home with the handbooks. People now -- you have to sign off on the school policies at the beginning of the year. In those resources -- if not, within the handbook itself -- should be some basic information on resources, on signs, on what the school is willing to do. Yes, and it should all go -- so at the beginning of the year, during back-to-school night, and at other special events.

One of the flyers -- the first flyer that I shared with you with my testimony is on National Depression Screening Day. It's coming up within the next week-and-a-half or so for this year. This is in its 25th year, and there's a website that's totally devoted -- this organization -- just to screening. And they have a big focus on doing this with the schools, and working there.

And again, these -- I tried to put-- I knew a lot of other people would be saying, "Bring in a lot of resources." And these were things that we feel that the schools -- without the funds, just with a little motivation -- can do.

The next one was about the training, and I mentioned specifically Mental Health First Aid training. It's a national, evidence-based program; it's grant funded. The National Council for Behavioral Health

Services offers this in a lot of states and with a lot of other affiliate organizations. So I don't have the particulars on who's doing it; and perhaps Phil, or Liz, or some others might. But it's widely available, widely known, and certainly proven, for schools and communities, to be successful.

Student assemblies -- that's been mentioned. Specifically I wanted to mention the other brochure -- flyer that I brought: *Attitudes in Reverse*. The Associated Executive Director at NJAMHAA, Shauna Moses, is a Board Member at Attitudes in Reverse, which is called *AIR* for short. And it's a nonprofit dedicated to saving student lives through education about mental health-related disorders and suicide prevention. Both Shauna and the co-founders of AIR have lost family members to suicide. So they share their personal stories; they encourage students to speak up and seek help. They bring their popular exhibit, *In Their Shoes* -- and that's all sets of shoes of youth who have committed suicide -- *completed suicide*, is what they call it -- and their stories. They also bring therapy dogs. So that was very exciting to hear that they have somebody on staff and a therapy dog in Hunterdon because, again, it's proven effective for children and youth.

So that's another resource. And they go out -- and I believe they are free; they're more than happy to-- They've been to schools throughout New Jersey; they've gone to national conferences; they're opening a chapter in California; and they're just so very motivated to help wherever they can.

a, back to where I started. It's such a major barrier -- access to services, the stigma -- and children and adults need to understand that mental health needs are as normal as receiving your vaccines and your flu shots. And from

a marketing approach: repeat, repeat, repeat. You know, you can't have too many assemblies, too many resources.

Building relationships with the local community health providers. Again, whether a source for referral, for consults, to come in when you do have major incidents -- that you're going to need it. And eventually those relationships could mean resources coming into your schools.

Finally, knowing what youth-based services are available to the schools. I did a little bit of research myself, and I came up with the one State program -- the School Based Youth Services -- that is in 67 high schools, 18 middle schools, and 5 elementary schools in all 21 counties. And that's a very comprehensive program of health services, employment, mental health -- everything. I wasn't very familiar with it myself, and I'm sure Liz can speak to it much more extensively. But I could not find out -- and I had been hoping to reach out -- is this a competitive grant funding? You know, how do schools bring that in to them? So again, just making a point of giving the responsibility of getting this information to every school district, every school -- that they know what they can pull on.

To finish, just-- Schools -- it was just said from that report -- children and youth who receive appropriate, timely mental health services do better in school and as adults. There is so much that is needed -- the reinvestment. We touched on child psychiatrists -- the shortage; that certainly needs some attention and resources to bring people into the field. The IMD exclusion -- these are all things that NJAMHAA advocates on. Getting rid of the IMD exclusion for child psychiatrists, for the -- came up on-- The high deductibles under the ACA -- the marketplace plans. Our

providers -- our community providers are running into that just like the hospitals. And these are people who you are setting up -- weekly or biweekly appointments. And people don't even have the co-pays, let alone to meet that high deductible.

So anything that, when you go back and revisit -- these are all pieces of the puzzle that need to be addressed and, hopefully, better serve our children and youth.

ASSEMBLYWOMAN SIMON: Thank you very much.

I agree with you about early detection, early intervention. And it also is a cost-- When you look at the economics of it, with neurodevelopmental diagnoses and early intervention -- we know that if you handle and have a team approach early on it also saves on the economic side later on too, because you're handling it right away.

Do you partner with NAMI, or do you have partnerships with the Association of School Boards and the Supers, and the--

MS. ABRAMS: Not so much directly with the schools, that I'm familiar with. I've only been at NJAMHAA under two years. We really give our attention to every group, from the veterans to the infants. We do represent, again, on the mental health and substance use side -- which was something that I left out -- has been brought up. You had the one substance use counselor here. But 70 percent of those who are using -- substance use -- generally have some kind of mental health indication. And the numbers are high in the reverse.

NAMI -- we're affiliates; we work very closely. There is a group, the Mental Health Coalition. And it's, I think, only about 12

agencies, and NAMI is one, the Mental Health Association is another, and New Jersey Psychologists.

ASSEMBLYWOMAN SIMON: You partner.

MS. ABRAMS: So we do coordinate, and we meet regularly, and we collaborate on many advocacy issues in that way.

ASSEMBLYWOMAN SIMON: When I spoke before about the med-emerges, and how Mr. Parker from the Carrier Clinic had indicated that possibly we can look at doing -- they can initiate a focus, an initiative on a pilot psychiatric, sort of, med-emerge or behavioral health, from that crisis period between 5 o'clock and midnight--

MS. ABRAMS: Absolutely.

ASSEMBLYWOMAN SIMON: Do you happen to know crisis hotlines? You know, how many are reaching out? Does it work? Are they responsive? Is it something that we need to look at?

MS. ABRAMS: There are many hotlines; and, again, they just started the Interim Managing Entity -- so that's a single source for people with substance use, although that has a lot of clarification. Right now -- it just began, so only some of the State-funded programs are going through there. They're only for authorizing assessments. That's going to grow as we move into next year -- more programs and more responsibility for authorization are there.

There are many hotlines; I think-- Well, the Children's System of Care has a single source, and I don't know if that's considered a hotline. But PerformCare is where -- everybody trying to access the Children's System of Care would go through that one line.

But there are others who-- You know, suicide prevention lines. You have some very dedicated-- You have -- the VA has their lines. So there are many-- And others might be able to speak better to that, who have a better history, here; because I'm exposed to all the new ones, and I don't know about the coordination between them.

ASSEMBLYWOMAN SIMON: Sure. And then every vicinage or every district has their own--

MS. ABRAMS: Right.

ASSEMBLYWOMAN SIMON: I happen to think that NAMIs four colors on suicide, and depression, and the signs, and the symptoms-- I mean, we know our kids come home with backpacks. Not only should we know that there's a Halloween party, but some of this information that can be funneled to the parent -- and having them look at that and understand the signs and the symptoms.

MS. ABRAMS: Absolutely.

ASSEMBLYWOMAN SIMON: Because very often, in our busy lives, parents are working. Sometimes it's a two-parent working household. And there's just so much going on between extracurricular activities, and sports, and family issues that it's-- I think it would be a great tool for families to get something -- something informative so that when they get this and read it, that maybe it would set a flag on them of, "Hum, this is very interesting"--

MS. ABRAMS: Yes.

ASSEMBLYWOMAN SIMON: --that Johnny or Susie could possibly be manifesting some of these symptoms.

MS. ABRAMS: Yes, absolutely; and that's where I started. By putting those resources-- Right. A lot of families are disconnected from the schools because they are working, there are other children, there might be parents -- so many things.

ASSEMBLYWOMAN SIMON: Sure.

MS. ABRAMS: But if you put it in front of them, at their leisure they can look and they can have-- Or a card with the numbers on it -- just knowing what's available locally. Some of those are more statewide hotlines.

ASSEMBLYWOMAN SIMON: Sure. Knowing there's somebody they can turn to, also--

MS. ABRAMS: Yes.

ASSEMBLYWOMAN SIMON: --in the community, or in their school; and having, again for that stigma, that open and honest discussion.

MS. ABRAMS: Yes, and back to that, like I said, you cannot have enough work done; there cannot be too much work done in the anti-stigma campaign.

ASSEMBLYWOMAN SIMON: Sure, yes.

Thank you very much.

MS. ABRAMS: Thank you.

ASSEMBLYWOMAN SIMON: Senator, do you have anything?

SENATOR RICE: Yes, a quick question.

The School Based Youth Program -- is that a program in this state, or other states?

MS. ABRAMS: That's definitely throughout New Jersey, in all 21 counties. And I think Director Manley can maybe answer more specifics on that, because I think it's within DCF -- under the Department of Children and Families.

And like I said, it's in 67 high schools, 18 middles, and a handful of elementary schools. And it's comprehensive; there was a separate listing I saw for the Newark Youth Health Services Center (*sic*), I think it was called. But these sounded like very comprehensive programs that are offering health services, medical and mental health right in the schools, or close by.

SENATOR RICE: Okay.

Staff, can you have them send us information so we can look at exactly what that program is and be more familiar with it? Because I think you raised the question -- you weren't sure where the funding was coming from or something like that? It was something you weren't certain about.

MS. ABRAMS: Well, it's certainly a State program. Like I said, I found it on their website, but I wasn't sure if was competitive-grant funded.

SENATOR RICE: Okay. So we need to find out, because if it's that great of a program -- a competitive grant -- then that in itself could be problematic. I don't like grants. (laughter) I like permanent money.

MS. ABRAMS: I was a grant writer.

ASSEMBLYWOMAN SIMON: Thank you very much for coming.

And last, but not least, Elizabeth Manley from -- she is the Assistant Commissioner for the Department of Children and Families.

E L I Z A B E T H M A N L E Y: I have some slides in case we need them.

ASSEMBLYWOMAN SIMON: Okay.

MS. MANLEY: Just in case we need some visuals.

ASSEMBLYWOMAN SIMON: Wonderful; thank you.

Thank you for being here.

MS. MANLEY: Absolutely.

ASSEMBLYWOMAN SIMON: Introduce yourself.

MS. MANLEY: Sure. I am Elizabeth Manley; I'm the Assistant Commissioner for the Department of Children and Families, and I oversee the Children's System of Care -- which includes services for youth with behavioral health, substance use, and developmental and intellectual challenges.

ASSEMBLYWOMAN SIMON: Welcome.

MS. MANLEY: Thank you.

You heard a lot today. (laughter)

SENATOR RICE: Yes.

MS. MANLEY: I'm hoping to answer some questions.

So good afternoon, Chairman Rice and Assemblywoman Simon.

SENATOR RICE: Good afternoon.

MS. MANLEY: I'm really, really happy to be here today. I'm pleased to share with you the strides that the New Jersey Department of Children and Families and the Children's System of Care have made, and continue to address the mental health and behavioral health needs of children, youth, and families.

First, I want to thank Governor Christie and the State Legislature for their commitment to the children and families of New Jersey.

And the Children's System of Care is a nationally recognized, public system for serving children with behavioral health needs. We've been asked to deliver presentations to a number of national conferences, and have been held up as the model public children's behavioral health system by leading scholars, and have hosted representatives from states across the country looking to replicate our approach, including Colorado, Delaware, Utah, and Connecticut.

The Children's System of Care is available to all New Jersey residents -- youth, families -- needing behavioral health services. And thanks to the Governor and the State Legislature, we've expanded our model of care to provide children needing services to treat substance use, and for intellectual and developmental disabilities.

The Children's System of Care is built on several core components. The first is a single point of access for children and their families to be able to call 24 hours a day, 7 days a week.

And the second is Mobile Response and Stabilization. New Jersey is the only state in the country to have Mobile Response and Stabilization available 24 hours a day, 7 days a week, from tip to toe in New Jersey. This service provides a trained professional for any family who requests assistance -- whether you would receive Medicaid or have a private insurer.

The third is our Care Management Organizations. We have Care Management Organizations that provide care management across the full State of New Jersey. There are 15 Care Management Organizations;

and Care Management Organizations are designed to bring the individuals, who know the children and their families best, to the table to help solve the complexity of how do we serve this particular youth best.

The fourth is our Family Support Organizations. We believe that the family support voice and the support for families are essential in order for us to be able to address the ongoing needs for youth and families in a sustainable way.

While these core components are structured around the needs of children and parents, there are vital intersections where educational authorities can coordinate with the Children's System of Care to ensure the needs of children are met in school, at home, and in the community. For example, if a child or youth is experiencing a crisis, a parent or guardian may ask to have Mobile Response and Stabilization Services deployed to the school. Even when the immediate crisis response is not at the school, Mobile Response and Stabilization will work with the school and partners to stabilize a planning process and support for the youth in school, at home, and in the community.

We also coordinate through the Children's Interagency Coordinating Councils, which are 21 local planning groups. Those planning groups are generally managed through the counties and supported by the Children's System of Care. DCF supports and works closely with the Children's Interagency Coordinating Councils to enhance services on the county level. Those local partnerships, in planning for behavioral health, substance use disorders, and intellectual and developmental disabilities services, coordinate all that care across the state. At our request, the Coordinating Councils throughout the state have worked to develop

educational partnerships by including county and local education officials in their activities. These efforts provide cross-training opportunities regarding schools and supports, recognizing that children are best served when the educational and social service systems work together. This strategy has been successful in Ocean, Monmouth, and Morris, and we're looking to expand statewide.

And then we also have the Traumatic Loss Coalition, which although it doesn't sit directly in the Children's System of Care, it is a great partner in our work. And the Traumatic Loss Coalition supports children and youth who have experienced a traumatic loss. DCF funds the Traumatic Loss Coalition, and the Coalition responds to schools and communities to provide mental health support services following a traumatic event such as a suicide or a fatality. It is available at the request of any school coping with a traumatic loss.

And the goal for us at the Children's System of Care is to effectively treat and keep children at home, in their schools, and in their own communities by maintaining a robust partnership among our care managers, providers, community partners; and the school is the key.

Chairman Rice and members of the Committee, thank you again for your time and the opportunity to speak with you today.

ASSEMBLYWOMAN SIMON: Thank you very much.

So you had mentioned the single-access to mobile response units, the Care Management Organizations, Traumatic Loss Coalition. How do you connect with the school, or the individual, or the family? Do they reach out to you? Is it the school that reaches out to you? How do you go about that?

MS. MANLEY: Sure. So I think that the Children's System of Care interacts in a couple of different places. And so I think it's important to understand that.

The first is, for the youth and family themselves, the single-point of access is available 24 hours a day, 7 days a week for the parent who is reaching out and requesting help and services.

ASSEMBLYWOMAN SIMON: And how do they-- When they reach out, what does that mean? Do they reach out through their school, their faith-based--

MS. MANLEY: So that means that they actually call.

ASSEMBLYWOMAN SIMON: They call you; okay.

MS. MANLEY: They call -- right; they call our contracted systems administrator. Right now, that's managed through PerformCare. And the phones are answered 24 hours a day by folks who know how to guide and direct families to the right services. That may be mobile response and stabilization, which means that we put a trained professional in the home of any family across the State of New Jersey, 24/7. And that trained professional goes in to really take a look and see what's going on, in terms of what has caused that parent to make that phone call that day. What really drove you to this decision today?

And we develop a crisis plan; there's a 72-hour period in which the Mobile Response and Stabilization staff are available to answer any questions; they can come back in the home multiple times, if that's what's necessary. The goal of that period of time is to stabilize any crisis situation that may have arisen.

After that period of time, our Mobile Response units can stay involved up to eight weeks, at which time they are responsible for coordinating, with the school -- what we call a *bridge plan* -- a plan for whatever is working in the school to actually be engaged at home as well. We believe that's the best way for the right interventions to go into place.

If our Mobile Response units do not believe that they have found a level of stability and a sustainable plan, then they can connect with Care Management, which has a longer-term goal of really being able to develop a sustainable plan for that youth, over time.

ASSEMBLYWOMAN SIMON: Okay. Do you partner with the school districts at all, or do you partner with DOE in disseminating the information to the schools and the parents?

MS. MANLEY: So I'd like to talk about the education partnership, because we think that's the best model. And that is our local CIACCs -- and the CIACC is the Children's Interagency Coordinated Council. They include all of our system partners; they also include our Juvenile Justice partners; they include our Child Protection partners; it includes all of our providers who provide services. It's an open public meeting in which issues directly -- the issues, and concerns, and challenges for our providers around mental health, substance use, intellectual and developmental disabilities -- that's where they talk about that. They talk about gaps, they talk about resources, they talk about communication and collaboration.

So in 2010-2011, the local CIACC started to really think about, how do they engage better with the school districts? Some counties have done a really good job of being able to put together these education

partnerships, in which they have a planning committee that includes local school districts, to talk about what is the cross-training, where is the area of interest across all of these partners.

And so in Morris County, as an example, there are nine cross-trainings that happen every year. And those nine cross-trainings include at least one representative from every school building in Morris County.

ASSEMBLYWOMAN SIMON: And that's at the county level?

MS. MANLEY: Yes.

ASSEMBLYWOMAN SIMON: Huh -- okay.

MS. MANLEY: And so what happens in those education partnerships is, you also have all your system partners -- all the folks who are providing the services on the ground -- and they interact with each other. Which we think is really the best way for a lot of this work to happen, because one of the dilemmas of just handing out information is that folks forget in a crisis situation, "Oh, I need to call that number." This way, when the local principal is struggling because his student is in their office in October, and they were there in September -- and we always tell them, in October, "You should reach out to us. If you're still seeing that same student in October, then we should hear from you."

And so the principal will call, and we'll begin to problem solve -- "How do we engage?" -- in helping that family and that youth engage in services.

ASSEMBLYWOMAN SIMON: Okay. So is it your Department that is reaching out to the counties, and it's just a matter of -- you just have to keep going until you hit all -- the (indiscernible) one?

MS. MANLEY: Yes.

ASSEMBLYWOMAN SIMON: Okay.

MS. MANLEY: And to be honest, there are some challenges, and some of the challenges I think you heard about here today.

ASSEMBLYWOMAN SIMON: Yes.

MS. MANLEY: So some of the challenges are really about the availability of the schools, and how do they really assign staff to this part of the workforce. So that's really where we hit our most -- our biggest challenges. For the communities in which the county superintendent of schools has said this is what we want to do and we want to engage, we have seen great success.

ASSEMBLYWOMAN SIMON: Okay. And there's also great partnership in law enforcement.

MS. MANLEY: Yes.

ASSEMBLYWOMAN SIMON: I know, for Hunterdon, prevention resources that work with the faith-based; they also work with the Prosecutor, Tony Kearns. So bringing in law enforcement because you see the other side of things--

MS. MANLEY: That's right.

ASSEMBLYWOMAN SIMON: --when there's criminal activity, whether it's a misdemeanor or all the way up to some serious offenses and violent offenders.

MS. MANLEY: Absolutely.

ASSEMBLYWOMAN SIMON: You know, it's partnerships with everybody.

So what can-- Is there anything we can do, as a Legislature, that would help your job -- make it easier, or to help disseminate some of

this information to the school boards, or the superintendents, or to get it down to more of the schools to give those tools to the educators, and to school board members, and to parents -- to help in any way?

MS. MANLEY: Sure. So from my perspective, I think that we're looking at targeted interventions. So there are a lot of children who experience anxiety on the first day because they can't open their locker, right? That happens across the full State of New Jersey. The question is, is that youth still experiencing that same anxiety in October? And so really, we want to target the individuals who can really help us find a youth who really needs these interventions early.

And so I do think it's really helpful for us to continue to support our CAICCs, for sure, because we think that they're-- And just to back up for a second. I'll let you know that the CAICCs, over the last two years or so, have really expanded in their membership. And so CAICCs that would have 10 participants now have 30 participants who are coming -- which is really exciting, from our perspective. And so we want to continue that and foster that.

We also want to support our education partners, as they struggle with trying to find the availability of time, to try and get them the information. So any way that we can get them information regarding using mobile response-- Our family support organization is open to every family in New Jersey. It doesn't require a call to PerformCare; it's just a reach-out. So we think that that's really important.

We're also building resource nets -- the resource nets are for local communities, and those are web-based programs. So trying to get that information out to families, I think, will be really helpful, as well, because

that has -- the resource nets tends to have information about: how do you find free activities for families to participate in, and how do you find mental health services for -- how do you find that support group. So it's all in one place for folks to go.

So any way that we can disseminate that type of information, I think would be really helpful.

ASSEMBLYWOMAN SIMON: Okay.

You had mentioned a child having a hard time getting into their locker. We know that neurodevelopmental issues and also mental illness -- you know, they have some central auditory processing disorders, and very much executive functioning issues--

MS. MANLEY: Absolutely

ASSEMBLYWOMAN SIMON: --where they can't get there.

Senator, do you have any questions?

SENATOR RICE: Yes, just one.

First of all, thank you for being patient. (laughter)

The Coordinating Councils and the education partnerships -- you said that that's proven to work very well. And you mentioned three counties -- Ocean, Monmouth, and Morris.

MS. MANLEY: Yes.

SENATOR RICE: Are those the only places they are, or those are the only places you have measured out the impact?

MS. MANLEY: So they are the longest-standing education partnerships in the state -- those three counties. However, there are efforts happening all over the place. So I was just in Bergen County the other day; they've had some educational events, which are very exciting. I'm working

in Essex County; Essex County has some folks who are really interested in getting this off the ground. So where we can find collaboration and where we can find time to put this together is really -- it's been really working very, very well.

The upside about the education partnerships is they really take time, and energy, and persistence to make them happen -- it's not a new infusion of resources to make them happen. It's really about the local community coming together to educate each other around what happens in schools, what happens at home, what happens in the community, what's available. And so, really, wherever we can get these collaborations moving I think we'll find success.

SENATOR RICE: So how long have Ocean, Monmouth-- Are these all new, reasonably new?

MS. MANLEY: No. These three counties started first; Ocean started its first partnership probably in 2010; Morris and Monmouth came up shortly after that. And they've been long-standing. Some other communities have gotten them up and running, and then they've sort of faltered with leadership changes. But in those three counties, they've been able to sustain the ongoing trainings over time. And so we really want to learn the lessons from them.

SENATOR RICE: So what kind of resources are required for them? Just volunteers, or human resources, or appointments -- or is there dollars attached to it?

MS. MANLEY: So there's no real dollars. So the CAICC -- there's a CAICC coordinator who is already paid through the Children's System of Care and our local system partners -- so that includes Care

Management, family support organizations, mobile response and stabilization -- they all come together and say, "We really want to do this." And they begin to outreach to the local educators -- and they really start with the county superintendent, because the county superintendent -- you get them in the county superintendents' roundtable, which is really where that conversation begins. And that's the hardest part for some counties to get to -- is how do we actually get into the superintendents' roundtable and have a conversation about how we partner better together, and how we can talk about some of these resources that don't cost families any money? Any of the resources that we talk about are already paid for; we already have the availability of the resources. So it's really important for us to be able to let our families know that mobile response is available; that Care Management can happen for you if you have complex needs. So we want to really make sure that that gets out to the educators; and to our partners on the medical, as well -- pediatricians, we think, are great partners in this work as well.

SENATOR RICE: Should we mandate that these Coordinated Councils have to be set up by the superintendents?

MS. MANLEY: So the Coordinated Councils already exist; what we're asking you--

SENATOR RICE: Well, should they mandate that they get into the--

MS. MANLEY: So we're really talking about the education partnership component. I don't know that I can-- (laughter) I can tell you--

SENATOR RICE: All right, let me put it this way. Can you send us more information on education partnerships and how it works?

MS. MANLEY: Absolutely.

SENATOR RICE: And we need to think about possibly mandating it. Because what I hear is it's just a matter of folks slowing down and cooperating, and saying, "Come on in, let's talk about this;" rather than folks saying, "I don't have time for it." They may not have time for it; it's not their priority because their priority-- That was the same thing that happened with the Articulation Agreements. No one wanted to deal with it. It was this Committee that forced the conversation, when I was chairing the Committee -- we didn't have Co-Chairs then -- and I made it very clear to the community colleges, "in four years we're going to have articulation. You can help us put it together, or get out of the way because we'll have it." And so they felt it was better to have the discussion and put it together so we wouldn't do it our way.

So my point is, we know more about the education component that we're talking about -- the partnership -- and what that means. And maybe they can send us the models from these three counties--

MS. MANLEY: Sure.

SENATOR RICE: --that piece, and we can say, "Okay, you know what? Here's legislation; we're going to mandate this." And let these superintendents tell us "no." So when they come up again, we can tell them, "We don't need you in our county. We aren't paying for you, okay?" Simple; that's all, right?

ASSEMBLYWOMAN SIMON: I'd love to learn more about CAICC too.

MS. MANLEY: Sure, absolutely.

ASSEMBLYWOMAN SIMON: If you can send us some information, that would be great.

And I wonder -- not to give you more work -- but I wonder if there's sort of a summit that your Department could possibly lead, and bring all those partners in so that we can have that next conversation about how we can get that information down -- sort of similar to what I suggested with NAMI and speaking to the School Boards Association -- and then they can disseminate it.

MS. MANLEY: Sure.

ASSEMBLYWOMAN SIMON: And then, same with the superintendents, and supervisors, and principals. If you meet with them, possibly, they can then be the appendages for that.

A touchy subject -- it's always touchy when we talk about funding.

MS. MANLEY: Sure.

ASSEMBLYWOMAN SIMON: You know, we understand with ACA and all the different other insurances -- that charity care was reduced because of that. And we have federally qualified healthcare centers, and we actually-- People are being served more because of that.

Where the savings are on charity care -- I am wondering if we can look at the funding for organizations like NAMI so that they can do more for less. And rather than have a myriad of organizations -- 30, 40 organizations -- where we can focus on one to give them more resources that would help in the aggregate.

So if you can, I don't know, maybe think about that and partner with us in anything that we can do.

MS. MANLEY: Sure. I do want-- As we touch on funding, I just want to be pretty clear that the Children's System of Care budget is a really interesting budget, in that the majority of services and supports that we provide are really provided through the Medicaid platform.

ASSEMBLYWOMAN SIMON: Oh, okay.

MS. MANLEY: And so it makes our budget look a little bit different than other budgets within the Department of Children and Families. But I would be happy to take that back.

ASSEMBLYWOMAN SIMON: Okay. And, you know, it's-- I know Commissioner O'Dowd is no longer there; we have an Acting, and we might have a new Commissioner of Health. And it might be other departments, you know, also that we can speak to.

MS. MANLEY: Sure. We happen to be pretty creative at the Department of Children and Families.

ASSEMBLYWOMAN SIMON: Yes. (laughter)

All right. Thank you very much. We really appreciate it.

MS. MANLEY: You're welcome.

ASSEMBLYWOMAN SIMON: To wrap up: Thank you to everybody for being here. Thank you to Mr. Parker and Carrier Clinic; thank you to all of our guests; thank you very much, everybody, for partnering in this effort.

I think our take-aways -- and this is just an eagle's view at 30,000-foot view -- is looking at the Carrier Clinic and possibly helping them through the -- and being a conduit to open up the conversation about maybe a pilot program, or even more than that, for medi-emerges in psych and behavioral clinics. That would be helpful.

Looking at State funding; looking at some group homes and inpatient adolescents; training -- more education for the educators; and helping NAMI increase their resources in order to help and disseminate information down to the schools.

Looking at school board training for sensitivity, and also helping them understand how to partner with the educators and with the parents. Because, like I said, we're all in this together.

And then, how we can help parents more by funneling information down to them regarding signs and symptoms; and, as we discussed, it's a very busy world. It's a very busy family life; there are a lot of dynamics happening under a roof in a family. And sometimes just the subtle symptoms and signs of mental illness get missed -- and how to help that and partner with them.

So if you have anything else to wrap things up? I just wanted to say thank you. And thank you again, Senator. To allow this very vital issue of mental illness in public schools -- I appreciate it from the bottom of my heart that you allowed this focus.

Thank you.

SENATOR RICE: Let me just end by saying I thank all of you for your patience, and I thank those who opened up this facility to us. But Assemblywoman Simon is a very dynamic young lady, and she has the Committee really focused on the ancillary components that are very important to this education process that we should be looking at.

And we spend a lot of time talking about school construction, and we know that's frustrating for the students too. And it is directly related to mental health when kids are frustrated and feel that there are no

opportunities. But it's frustrating to the teachers, too, when they have no place to park, and they're in parking lots. So we're not even constructing right.

We know that the whole issue of cutting back on budgets-- And we're getting arguments -- partisan arguments and nonpartisan arguments about where the money is going, etc. The reality is, the money should be going everywhere. And the question is, how much, where, and what the needs are. I always tell people that *fair share* does not mean that if I get \$100,000, you get \$100,000. Fair share means you try to meet your needs. So your need may be -- to accomplish what you need is \$50,000; my need may be \$100,000.

And so we have to go back and, as a Committee, we have to drive these issues by way of educating our colleagues. Because it's too much partisan politics in the State of New Jersey; it's been there for a long time. But it's good to have people like Assemblywoman Simon who can come into our legislature and say, "Oh, you know what? There are other districts out there." And this Committee does move around; that's the good thing about it. We don't have all of our members all the time because I set up, when I was Chairman, subcommittees to address different components of education. For example, there's a School Construction Subcommittee with a Subcommittee Chair. There's a School Choice Innovation Committee, and things of that magnitude. So we're happy to be here; and usually wherever I can be with the members, I'm going to be there.

And so we want to thank you, and let you know that we don't know what the end result is going to be. The transcript is shared with all of our colleagues on the Committee and others who want them, as well as the

Administration. But we're sure going to go back and take a look at some of the things, so don't be surprised if the Assemblywoman and the rest of us recommend legislation based on some your comments. Don't be surprised if we go back and fight for additional financial resources when the budget comes up; and if we don't get them, it doesn't mean we won't fight for them.

And so that's what we do. And that's what we do best.

So thank you very much for having us come in. (applause)

ASSEMBLYWOMAN SIMON: Yes, thank you.

**(MEETING CONCLUDED)**