SB 248
SJR 16
AB 179
SB 311
SB 331

SENATE COMMITTEE ON

HEALTH, WELFARE AND STATE INSTITUTIONS

MINUTES OF MEETING # 8

MARCH 5, 1973

The meeting convened at 9:20 a.m.

Senator Walker in the chair.

PRESENT: senator Swobe
Senator Blakemore
Senator Herr
Senator Neal
Senator Drakulich
Senator Young
Senator Raggio

Other interested parties as listed in Exhibit A hereto attached.

S.B. 331: Eliminates requirement that payments for care of mentally ill be made in advance. (BRD 39-1129)
NRS 433.410

Mr. John Crossley spoke as first witness, requesting amending this bill as follows: (Refer to Exhibit B)
Page 1, line 5: Delete the following:
"...and shall be payable monthly in advance..."

Senators Blakemore and Swobe suggested changing "shall" to "may", concluding that would solve the problem.

Senator Walker suggested instead, amending it thus:
Page 1, line 5: after "monthly", insert
", or may be payable in advance."

S.B. 331 received a "Do Pass" as amended by Senator Walker.

* * *

AB 179: Reconciles financial responsibility provisions in public welfare law (BDR 38 - 40)
NRS 422.310

Mr. Tomlinson, Chief, Eligibility and Payment Division, State Welfare Department, and Mr. Springer, District Attorney's office, spoke as witnesses first. Their main concern was that on page 1, line 2, the word "children" be deleted. They felt that since there is no reciprocity between states, one child (a Nevada resident, for example), could be made to bear the

financial burden unfairly, inasmuch as there might exist relatives in another state which could more easily afford such expense.

Other amendments were discussed, as indicated on the bill.

AB 179 received a "Do Pass" as amended, the motion made by Senator Drakulich and seconded by Senator Herr. Senator Swobe opposed.

SJR 16: Memorializes Congress to correct inadequacies in grants of social security and supplemental benefits.

This resolution, after discussion, received a "Do Pass", Senator Swobe making the motion, and Senator Neal seconding.

SB 311: Permits medical services to provide minor women 16 years of age or older with family planning services without parental consent. (BDR 11-1243) (NRS Chapter 129)

Dr. William Edwards, M.D., Chief, Community Health Services, was the first witness. He presented the committee with documented facts and figures pertaining to this matter, a copy of which is hereto attached as Exhibit C. He urged ratification of this bill.

Senator Drakulich stated the age restriction of 16 should be removed, in light Of Dr. Edwards' testimony.

Senator Herr expressed favorable opinion.

Senator Walker asked what percentage of the figures represented married teen-agers.

In answer to this question, Ms. Judy Hamilton took the witness chair representing the Family Planning Clinic of the Clark County Health Department and presented the committee with a study entitled FACTS OF LIFE IN NEVADA compiled in January, 1973. Refer to Exhibit D, hereto attached.

Senator Walker asked if both boys and girls received education and clinical attention who were infected with V.D. Ms. Hamilton replied "yes", that medical examinations and tests were performed on all minors who asked for it, over the legal age limit.

[illegible]

It was noted that the Nevada State Medical Association gave its endorsement to passage of this bill also. The next witnesses were three minor women who testified that had Family Planning Services been available to them, they would have been able to avoid a great deal of family strife, public humiliation and pain. They stated that the majority of parents did not educate teen-agers in matters of sex, but rather only threatened them, should they ever 'get into trouble', warning them not to come home. One girl testified that she ended up in Wittenburg Hall as a consequence of this attitude.

They confirmed the fact that many parents refuse to even discuss sex with their children, let alone aid them in contraceptive prevention of pregnancy.

Mrs. Sharon Richert, a registered nurse and coordinator of the Washoe County Family Planning Program was next witness, whose testimony is hereto attached as Exhibit E. She spoke in favor of this bill, and urged the Committee to pass it without delay.

Mrs. Donna Dixon testified next;a copy of said testimony is hereto attached as Exhibit F. She also spoke in favor of this bill.

The next witness was Mrs. Geneva Beasley, Las Vegas Planned Parenthood Clinic. She, too, spoke in favor of this bill. A copy of her testimony is hereto attached as Exhibit G.

Senator Raggio stated that since the language of this amendment did not preclude abortions, it should be amended to do so. Thus, the following amendment was suggested.

page 1, line 6 and 7:
After the word "treat-ment..." , insert "...of a non-surgical nature...".

The second amendment, as suggested by Senator Drakulich is as follows:

line 7, page 1:
after the word "woman ..." delete "16" and insert "14".

Senator Swobe asked that this bill be tabled until he had a chance to consider it further.

Senator Neal moved for a "Do Pass" as amended, Senator Drakulich seconded the motion, and it was so carried. Senator Swobe and Senator Raggio were opposed.

SB 248 — Due to lack of time, SB 248 was re-scheduled for Monday, March 12, 1973.

The meeting adjourned at 10:50 a.m.

Respectfully submitted,

Jo Ann N. Hughes

Jo Ann N. Hughes, Secretary

APPROVED:

Lee E. Walker, Chairman

Date 5/13 SENATE COMMITTEE ON HEALTH, WELFARE & STATE INSTITUTIONS Meeting #3 5/5/73 EXHIBIT A 2

SB248
SJR: 16
AB: 179
SB: 311

PLEASE PRINT PLAINLY

NAME	DEPARTMENT AND POSITION OR TITLE	CITY	(Check One) (✓) WITNESS	Bill #	(✓) Observ
Cheryl Hegne					
Johan Sims					
Pam Agey					
D.T. Tim Holder	MED ASS.				
Dr Wininow	County Health officer				
SARAH RICHERT	REGISTERED NURSE		✓		
Dr William Edwards	NEVADA STATE HEALTH DEPT		✓		
Judy Hamilton	Clark County Heath Dept		✓		
Geneva Beasley	Planned Parenthood of Nevada		✓		
Wilbur Sprinkle	Dp. A.G - Welfare		yes	179	
D. T. Tomlinson	Chief, Elig + Pymnt. Welfare		"	179	
F. M. YAMASHITA	STATE PLAN COORD.-WELF.				
W. J. LABADIE	STATE WELFARE DEPT. ADM.		✓	179	
Mike Olsen	STATE HEALTH DIV.				
Al Gallus	Chief Pharm. St. Mary's Hos.				
Donald Dixon	Planned Parenthood of Nev. Public Health Assoc.			311	
J.L. Reveley	St Mary's Hosp	Reno	✓	248	
John Crossley	LCB - Fiscal & Auditing	CC	✓	SB 331	
Jim Ehrenburg	R-J newspaper	LV			

Annual Physical Inventory:

We concur with this recommendation. We will take an annual physical count of all property and equipment, however, it cannot be completely reconciled to State Purchasing read-out sheets because many of the purchasing department numbers have been removed in patient areas, also many items have no serial numbers, or were given one number for a group of like items. We shall work to solve this problem.

Bank Checks:

We concur with this recommendation and will comply.

Record Retention Schedule:

We concur with this recommendation. We have requested a record retention schedule as required by the State Administration Manual. We do have a record retention schedule which complies with Accreditation Standards and this will be coordinated with the requirements of the State Administrative Manual. We have had meetings with the State Record Management Agency and we are in the process of establishing schedules of retention.

Non-applicable Statutory Provisions: 433.410

We concur with this recommendation and will comply.

Accounting Procedure Manual:

We concur with this recommendation and will comply.

We would like to comment upon the disposition of recommendations presented in previous audit reports and as you will note, we have not completely complied with six of these recommendations and would therefore like to comment upon them.

Internal Control - Books and Records:

Incoming mail be opened in the presence of two employees and receipt prepared for each remittance. We have attempted to comply with this recommendation but have found it to be very difficult, due to employee attendance. We are watching this very closely, in order to insure that there are two employees present when the receipts are prepared and the mail is opened.

Patient's Subsistence and Care:

Determine collectibility and institute legal procedures where indicated on delinquent accounts:

We have never been able to fully comply with this recommendation, in that our only resource for compliance is the courts. We have requested permission from the Budget Department to be able to utilize collection agencies but as yet have not had a reply. There is but one Deputy Attorney General for the Department of Health, Welfare and Rehabilitation and it is not feasible to utilize his services on a

have partially complied with this recommendation and after the close of this fiscal year, we will have this recommendation fully implemented.

Page 12.15 - imprint on checks "Void after 90 days".

Plans have been made to imprint "Void after 90 days" on our checks as soon as the current supply is depleted. We feel that we have partially complied with this recommendation, which will be fully complied with when the actual imprint is made.

Page 12.16 - develop records retention schedule.

We met with the Records Management Section of the Department of Administration in April of 1972, concerning the Record Retention Schedule. Individuals from the Records Management Services met with our Medical Records Librarian concerning the development of the retention schedule. We do have a records retention schedule which complies with accreditation standards and this will be coordinated with the requirements of the State Administrative Manual. I have recently written a letter to the Records Management Service indicating that we should pursue this further, as there has been a time lag since our last meeting. We feel that we have partially complied with this recommendation but until the actual schedule is in operation, we cannot consider that it is fully complied with.

Page 12.17 - request repeal of portion of NRS 433.410.

We are presently in the process of writing changes to our statutes which will be submitted to the Legislative Counsel Bureau prior to November 1, 1972. We shall recommend that that portion recommended by the Legislative Counsel Bureau be changed as required. We feel that we have partially complied with this recommendation, in that we are in the process concerning this change but cannot fully implement until such time as the Legislature has met and made the change.

Page 12.18 - update and maintain accounting procedural manual.

We have partially complied with this recommendation, in that our manual is updated in pencil but has not yet been typed.

It is our intention to fully implement the recommendations contained in the Legislative Counsel's audit report as soon as possible. We shall notify your office when a recommendation is fully implemented.

Sincerely yours,

T. M. Reynolds

T. M. Reynolds
Acting Superintendent

TMR/ds

cc: Dr. Charles Dickson, Clinic Administrator
Division of Dental Hygiene and Dental Rehabilitation

18

AB 331
Exhibit F

STATUTORY REVISION

NON-APPLICABLE STATUTORY PROVISION

NRS 433.410(1) makes reference to subsistence and care rates being made "...payable monthly in advance..."

We feel that it is extremely difficult to calculate in advance the exact amount of time that a person will be hospitalized.

RECOMMENDATION

We recommend that the Nevada State Hospital request the part of NRS 433.410 which reads "...and shall be payable monthly in advance..." be repealed.

SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Sacramento County Mental Health Plan for 1973-74

The Five Year Plan for Mental Health Services 1971-76 continues to be the basic planning document for mental health services for the citizens of Sacramento County. Prepared in consultation with the County Mental Health Advisory Board, many citizens groups and providors, it called for the development of a series of comprehensive mental health services to be established in the community, available as close as possible to those who needed them, a series of preventive-consultative services as well as direct services focused on the entire family (with children receiving high priority), and which would be oriented towards the avoidance of unnecessary hospitalization or institutionalization. Those services were to be organized and established by interdisciplinary teams of mental health professionals and paraprofessionals, each of which would serve one of the five catchment areas of the County. In this fashion the plan hoped to develop continuity of care and special attention to programs for drug abuse and alcoholism which might be started centrally, but which would eventually be decentralized to neighborhoods. Program evaluation was to be established to determine community needs and how well they were being met. The unique association between the new Medical School at U.C. Davis and the County of Sacramento permitted effective planning, the recruitment of capable professionals, and the establishment of training programs for all mental health professionals in a fashion which was of mutual benefit to the County and University.

The following page reproduces the Summary Chart of the Five Year Plan for Mental Health Services. It was approved in October, 1970 and submitted to the California Department of Mental Hygiene as the plan for developing mental health programs in the community and of meeting the goals and requirements of the California Mental Health Act (the Lanterman-Petris-Short Program). The items listed under the column "Today" indicated the state of the plan in 1970-71. The goals listed under the column "Five Years Hence" were to have been accomplished by 1976.

As will be seen by the description of the Sacramento County Mental Health Services, most of those goals have already been met. The year 1973-74 will see the further development of the basic plan and will focus on services to children, the serious problems of alcoholism and drug abuse, and will extend the program of decentralization of mental health services (including crisis intervention by a mobile team). The description of the plan for community mental health services will describe the county and its population, the goals and objectives of the program, will outline the organization of the Mental Health Services including its teams and programs and will indicate the specific services and programs already existing, those under development during 1972-73 and those which should be developed during 1973-74.

SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Five Years Ago	Today	Five Years Hence
Inpatient - evaluation only	Generic full services teams (North, South, East) for each of three catchment areas (Child and Adult services)	All mental health services in each catchment area (Child and Adult). Inpatient services in three of the five catchment areas.
Very limited outpatient services	Full service Mental Health Center (Sutter) for Central Sacramento	Full service Mental Health Centers at Sutter and American River Hospitals
No emergency services	24 hour Emergency/Crisis service at Sacramento Medical Center	Crisis intervention services to avoid hospitalization
1/3 to 1/2 of admissions sent to state hospitals - mostly involuntary commitments	Contracts - Mental Health Aide, Suicide Prevention, Family Service Agency, Children's Home, Day Care for Autustic Children	Contracts to utilize and coordinate existing community agency services.
No child services	Drug Abuse Program	Drug Abuse - decentralized services, self-help groups, information-education and coordination services
	Alcoholism Program	Alcoholism - detoxification plus treatment and rehabilitation services
	Program Evaluation underway.	Program Evaluation - sophisticated level
	Training - Medical Students, Psychiatrists, Psychologists, Social Workers, Nurses, Ministers, Psych Technicians	Training - add child specialists plus other appropriate disciplines and volunteer groups
	Developing full service Mental Health Center (American River) for Arden Area	Neighborhood Mental Health Clinic in each catchment area - multi-lingual neighborhood staff
	Pilot Neighborhood Mental Health Clinic at Del Paso	Major attention to children's services - coordinated with public and private health care and schools - preventive, early detection services - all modes of treatment
	Consultation-Preventive Services Jails, Courts, Juvenile Center, Schools, Medical Center, etc.	Full team at Juvenile Center
	Vocational Rehabilitation Program.	Senior Citizens' Program

DESCRIPTION OF THE SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Sacramento County

Sacramento County, which includes the Capital City of California, is located in North-Central California near the head of the Sacramento Valley. The County contains a mixture of urban, surburban and semi-rural areas, and in 1970 had a population of 634,000. The County is growing rapidly and includes two major Air Force Bases as well as other major state and federal government activities. Two major rivers, highway arterial systems, and railroads subidivide the county. Inadequate public transportation, common to metropolitan areas, hinders travel to any central facility. Although the County has relied in the past, on centralized human service facilities, the past five years have seen a major shift to the decentralization of such services.

There is no single central city ghetto within the County. The Sacramento Area Economic Opportunity Council has designated eight depressed areas, all marked by heavy concentrations of minority groups: Oak Park, Southside, Cosumnes, Delta, Glen Elder, Natomas, Washington, and Del Paso Heights. The minority groups include Blacks, Mexican-Americans (Chicanos), and Asian-Americans. Besides a higher degree of unemployment these citizens suffer more physical and mental illness, yet appear to under-utilize present services.

Approximately ten years ago, the California State Mental Health Plan divided Sacramento County into five geographical Catchment Areas (whose population during the 1970 Census was as follows)

# 47	East Sacramento Catchment Area	112,985
# 48	North Sacramento Catchment Area	144,042
# 49	Central Sacramento Catchment Area	104,649
# 50	Arden Catchment Area	127,478
# 51	South Sacramento Catchment Area	145,292
		634,446

The County Mental Health Service has the responsibility for providing comprehensive mental health care to each child and adult resident of the County. In so doing, the Catchment Area concept proved useful - since the Catchment Areas did indeed show reasonable cohesiveness as regards communities and natural boundaries. The County has therefore used the Catchment Area Concept in making each Catchment Area a community for purposes of mental health services. Using existing mental health facilities at Sutter Mental Health Center for the Central Sacramento Catchment Area and at American River Hospital for the Arden Catchment Area, the Mental Health Service developed teams for the other three Catchment Areas.

The five catchment areas are shown in the Map of Sacramento County on the following page.

Objectives of the Sacramento County Mental Health Program

1. To offer direct treatment services to children and adults who require them - making a comprehensive and appropriate range of services available which will meet the needs of all citizens of Sacramento County.

2. To make these services available as close as possible to the population needing them - in effect, decentralizing mental health services to each catchment area, and organizing them in non-institutional settings where possible.

3. To emphasize prevention and early detection as well as direct treatment.

4. To avoid unnecessary hospitalization or institutionalization.

5. To integrate services to children and adults, making services to whole families available as appropriate.

6. To utilize and coordinate existing programs and services including those available in the "private sector" and other community agencies.

7. To involve citizens from the populations served in advisory groups to plan mental health programs, make known the needs of all citizens, and to interpret the available services to the residents of each catchment area.

8. To pay special attention to the needs of minority groups and of ethnic influences on the pattern of mental disorder and the utilization of services.

9. To give high priority to special problems such as alcoholism and drug abuse so as to make services for these problems available within each catchment area as rapidly as feasible.

10. To carry on the programs of a mental health service within the structure of interdisciplinary teams, each having a responsibility to a specific catchment area.

11. To carry on program evaluation studies to determine community needs and how they are being met, the effect of treatment programs on the needs of citizens, to carry on follow-up studies to determine effectiveness of treatment and to determine the benefits of treatment on indices of social disorganization as they can be developed.

12. To carry on training programs in all of the mental health professions and paraprofessional groups as well as to enhance the skills and abilities of existing staffs.

Organization of the Sacramento County Mental Health Services

Mental Health planning is the responsibility of the Sacramento County Director of Mental Health Services who is appointed by the Board of Supervisors and is responsible to them through County administrative organization (in the past through the Hospital Administrator of the Sacramento Medical Center - in the future, through the Administrator of the Health Agency). The Lanterman-Petris-Short Act requires that each county appoint a Mental Health Director who is responsible for preparing and implementing a series of community mental health services under a plan which is reviewed annually. In Sacramento County there is a unique arrangement between the U.C. Davis School of Medicine and the County in which the Chairman of the Medical School Division of Mental Health (and Department of Psychiatry) is also the Sacramento County Mental Health Director.

In addition to the Mental Health Director, there is also a Mental Health Advisory Board appointed by the Board of Supervisors. This is a group of citizens and mental health professionals who advise the Board of Supervisors and the Mental Health Director in the preparation of the Plan for Mental Health Services. The Advisory Board has appointed five catchment area Advisory Committees with each committee consisting of residents of the catchment area plus one member of the County-wide Board.

The Director has organized the mental health program into those provided by staff and employees of the Mental Health Service and those services provided by contracts with existing groups and agencies in the County. Two of the five catchment areas are served by mental health teams based at Sutter Mental Health Center (Catchment Area # 49 - Central Sacramento) and at American River Mental Health Center (Catchment Area # 50 - Arden). The other three catchment areas are served by employees of the Mental Health Services (North, South and East Sacramento Catchment Areas). The County employees who staff the Mental Health Services will become University employees under a contractual arrangement to be developed prior to 1973. This will follow the pattern which was developed when the University of California purchased the Sacramento Medical Center and contracted with the County to purchase certain health care services. The County employees (with a small number of exceptions) will become University staff on July 1, 1973 and the same pattern will be followed for Mental Health Services. In effect, the professional staff of the Mental Health Service have already been part of the University since they were recruited by the Mental Health Director (who is Chairman of Psychiatry in the University) and hold faculty appointments in the University.

The teams serving each catchment area are a group of mental health professionals and paraprofessionals who offer a full range of services, most of them in the catchment area served. Inpatient services and nite-weekend crisis intervention are located at the Sacramento Medical Center. The three generic teams (North, South and East) and the Crisis Team constitute the four basic teams employed by the Mental Health Service.

An administrative group are the staff who serve all three catchment area teams and the crisis intervention team. The administrative group includes the Deputy Director, Discipline Chiefs, Coordinators of Alcoholism and Drug Abuse Programs, and other centralized support functions. The Administrative Group together with the Team Leaders constitute the Executive Committee of the Mental Health Service and meet as the major policy input group of the staff.

The following series of charts describe the organization of the total services.

THE CATCHMENT AREA TEAM

A Catchment Area Team (North, South, or East) consists of:

- 3-4 psychiatrists (at least one child psychiatrist)
- 2-3 clinical psychologists
- 8-10 psychiatric social workers
- 8-10 mental health nurses
- 10-12 psychiatric technicians
- supporting staff and services (including clerical, housekeeping & business).
- neighborhood mental health center with all services except inpatient.
- use of 12 beds at centralized inpatient unit where patients remain team responsibility.
- citizens advisory committee.
- appropriate numbers of students including psychiatric residents, child psychiatry fellows, psychology interns, medical students, nursing students, social work graduate students, and others including pastoral counseling, undergraduate college students and paraprofessionals.

In the Catchment Area Team - there is a team leader who is the professional person responsible to the Director. He administers mental health services for that catchment area in accordance with the policies established by the Mental Health Services. However, within those broad policies, each team has considerable autonomy in program development and each has its own unique characteristics. The team leader and the team work closely with their Catchment Area Advisory Committee and with other citizen and professional groups in the Catchment Area in order to develop services for that part of Sacramento County. Each team has facilities within the catchment area which offer full mental health services except for inpatient services (the most expensive and therefore the most logical services to centralize at the Medical Center). The inpatient services at the Sacramento Medical Center consist of a 37 bed inpatient unit staffed by all three teams. A separate Crisis-Detoxification unit is now being developed and will serve the Crisis Team. Continuity of care on the inpatient unit is insured by giving each catchment area team member responsibility for treating his patients on the inpatient unit when they may require hospitalization. Team members travel between the centralized facility and the neighborhood mental health center located in the catchment area. The Sutter Team has its own inpatient services (approximately 80 beds) and the American River Mental Health Center has its own inpatient service (approximately 45 beds). Sutter has an inpatient unit reserved for children which is available to the entire County.

PHYSICAL FACILITIES of MENTAL HEALTH SERVICE

3 room unit in Sacramento Medical Center Emergency Room (for Crisis Intervention)

Crisis-Detoxification Unit on Ward 11 at SMC (also office space on former Ward 10 which is used for crisis intervention services)

Day Treatment Center on unit formerly called Ward 10

37 bed inpatient services Ward South 6 at SMC

Mental Health Clinic at 4430 V Street (former Juvenile Center) Facilities for outpatient services and administrative office of Mental Health Service

Satellite Center in East Area (Mayhew & Kiefer) and in Del Paso (Grand & Dry Creek) for all services except inpatient.

Expanded mental health clinic at 45th & V Streets (outpatient & day treatment).

SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Summary of Programs

1. Administrative and Coordinating Services	Administrative services including coordination of county-wide programs, recruitment & development of staff, information-education, program evaluation, and training.
2. East Catchment Area Team	Services to children & adults at East Sacramento Mental Health Center and at SMC
3. North Catchment Area Team	Services to children & adults at Del Paso and SMC
4. Central Catchment Area Team (Sutter M.H. Center)	Services to children & adults at Sutter MHC. (Funded in part by Short/Doyle funds and in part by federal staffing grant)
5. Arden Catchment Area Team (American River M.H. Center	Services to adults at American River M.H. Center. (Funded in part by Short/Doyle funds).
6. South Catchment Area Team	Services to children & adults at Sacramento Medical Center (SMC)
7. Crisis Team Services	Crisis intervention services at SMC and with mobile team.
8. Drug Abuse Services	Direct, preventive & coordinating services for drug abuse problems. Gradual decentralization to catchment area teams is planned.
9. Alcoholism Services	Direct, preventive & coordinating services for alcoholism problems. Gradual decentralization to catchment area teams is planned.
10. Contractual Services	Specialized services obtained by contract with existing community agencies. These are in addition to the Sutter & American River contracts.

SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Summary of Administrative Services

EXISTING SERVICES

General administration and coordination of all mental health services.

In cooperation with Mental Health Advisory Board and the Catchment Area Advisory Committees, prepare and submit the annual County Mental Health Plan.

Recruitment and development of staff.

Training programs for mental health professionals & paraprofessionals.

Public information-education.

Program evaluation.

Administration & monitoring of contractual services.

Relationships with other Health Agency Programs.

Extramural consultation including criminal justice system.

Monitoring state hospital services.

UNDER DEVELOPMENT 72-73

Planning for services to senior citizens.

Enhanced public information program for Community Alternatives to State Hospitalization (CASH program).

Development of Community Alternatives to State Hospitalization so as to minimize or eliminate the use of state hospital services.

PLANNED FOR 73-74

Program evaluation expansion including evaluation of specific mental health treatment programs.

Mental health team for Rio Cosumnes Correctional Center (CCCJ Application).

Summary of Mental Health Services for East Sacramento Catchment Area (# 47)

EXISTING SERVICES 72-73

General Mental Health Services

Daytime crisis intervention at East Sacramento Mental Health Center.

Nite-weekend crisis intervention at SMC.

Outpatient services at ESMHC and at SMC.

Day treatment at SMC.

Mental health consultation at SMC.

Inpatient services at SMC.

Aftercare program (in cooperation with ACSU).

Services for Children & Adolescents

Child crisis intervention at ESMHC (daytime) and nite and weekends at SMC.

Child outpatient at SMC.

Child inpatient at SMC.

Pediatric liaison at SMC.

UNDER DEVELOPMENT 72-73

Volunteer services unit in cooperation with Mental Health Assn. (CASH program).

Expanded after-care program (CASH program).

PLANNED FOR 73-74

Day treatment program at ESMHC (federal applic.)

Mental health consultation at ESMHC (federal applic.)

Expanded Juvenile Ctr. consult. Service (Short/Doyle)

Child outpatient at ESMHC (federal applic.)

School staff development program (federal child applic.)

Therapeutic classroom (federal child applic.)

Adolescent day treatment (S/D)

Residential trtmt. for adolescents (CASH program).

Summary of Mental Health Services for North Sacramento Catchment Area (# 48)

EXISTING SERVICES 72-73

General Mental Health Services

Daytime crisis intervention at Del Paso.

Nite-weekend crisis intervention at SMC.

Outpatient services at Del Paso and SMC.

Mental health consultation based at SMC.

Inpatient services at SMC.

Aftercare program (in cooperation with ACSU).

Services to Children & Adolescents

Child & family crisis intervention at Del Paso (days) and SMC (nites & weekends).

Child outpatient at SMC.

Child inpatient at SMC.

Pediatric liaison at SMC.

UNDER DEVELOPMENT 72-73

Day treatment program at Del Paso (federal staffing grant).

Mental health consultation program at Del Paso (federal staffing grant)

Re-socialization-rehabilitation center under contract with ACSU (SRS funds)

Volunteer services unit (in cooperation with Mental Health Assn.) (CASH program).

Community Aides (contract with M.H. Aides). (Federal staffing grant).

Child outpatient at Del Paso (federal staffing grant).

Community Peer Project (314.d award)

PLANNED FOR 73-74

Neighborhood services at North Highlands or Citrus Heights.

Decentralized methadone maintenance program (state drug abuse funds).

School staff development program (federal child applic.).

Therapeutic classroom (federal child applic.).

SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Summary of Mental Health Services for Central Sacramento Catchment Area (#49)

Served by Sutter Mental Health Center - funded in part by Short/Doyle $ Federal Mental Health Grant

EXISTING SERVICES 72-73

General Mental Health Services

Daytime crisis intervention at SMHC

Nite-weekend crisis intervention at SMC.

Outpatient services at SMHC.

Day treatment program at SMHC.

Night hospital program at SMHC.

Inpatient services at SMHC.

Aftercare program (in cooperation with ACSU).

Mental Health consultation at SMHC and in the catchment area.

Mental health consultation and outpatient services at Hacienda Northgate & River Oaks - New Helvetia Housing Projects

Services to Children & Adolescents

Child and family crisis intervention at SMHC (Daytime).

Nite and weekend crisis intervention for children & families at Sacramento Medical Center.

Child outpatient at SMHC.

Child day treatment at SMHC.

Child inpatient at SMHC.

Services to Aged

Decentralized day treatment for elderly patients at Senior Service Center.

UNDER DEVELOPMENT 72-73

Re-socialization, rehabilitation center under contract with ACSU (SRS funds).

Volunteer services unit for community program in cooperation with Mental Health Assn. (CASH program).

Mental health services at Washington Health Center.

Mental health consultation and evaluation for elderly tenants of Sacramento Housing Authority (314 d application).

Services to persons in boarding homes.

Services to persons in nursing homes.

Mental health services to Raza Drug Effort.

Child evening (partial hospitalization) at SMHC

Mental health services in secondary schools.

PLANNED FOR 73-74

Expanded aftercare program (CASH program).

Summary of Mental Health Services for Arden Catchment Area (# 50)
Served by American River Mental Health Center - funded in part by Short/Doyle contract.

EXISTING SERVICES 72-73	UNDER DEVELOPMENT 72-73	PLANNED FOR 73-74
Daytime crisis intervention at ARMHC.	Student mental health services (314.d award).	Children's services program under development.
Nite-weekend crisis intervention at Sacramento Medical Center.	Community volunteer services unit (in cooperation with Mental Health Assn.) (CASH program).	Expanded aftercare services (CASH program).
Outpatient services at ARMHC.		
Day treatment program at ARMHC.		
Inpatient services at ARMHC.		
Mental health consultation at ARMHC.		
Aftercare program (in cooperation with ACSU).		

SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Summary of Mental Health Services for South Sacramento Catchment Area (# 51)

EXISTING SERVICES 72-73	UNDER DEVELOPMENT 72-73	PLANNED FOR 73-74
General Mental Health Services		
24 hr. crisis intervention at SMC.	Resocialization - rehabilitation center under contract with ACSU (SRS funds).	Satellite clinic for South Catchment area - to include all services except inpatient (daytime crisis intervention; outpatient; day treatment; consultation). Probable location in Elk Grove or Galt.
Outpatient services at SMC.	Volunteer services unit (in cooperation with Mental Health Assn.) (CASH program).	Mobile mental health team for services in Delta Area.
Day treatment program at SMC.	Intermediate care facility (under contract - CASH program).	
Mental Health consultation at SMC.		
Aftercare program (in cooperation with ACSU).		
Services to Children & Adolescents		
Child & family crisis intervention (24 hour) at SMC.	Child Aide Program (federal child staffing grant).	
Child outpatient at SMC.	Community Peer program (federal child staffing grant).	
Child inpatient at SMC.	School staff development program (federal child staffing grant).	
Pediatric liaison at SMC.	Therapeutic classroom (federal child staffing grant).	
	Child program evaluation (federal child staffing grant).	

SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Summary of Crisis Intervention Team

EXISTING SERVICES 72-73

24 hr. crisis intervention for children, adults, and families at SMC.

UNDER DEVELOPMENT 72-73

Mobile services for Community Alternatives Program (CASH program).

Crisis unit which includes alcoholism detoxification on Ward 11 at SMC.

PLANNED FOR 73-74

Mobile crisis intervention team (Short/Doyle).

Family drug crisis treatment (federal drug abuse applic.).

SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Summary of Drug Abuse Programs

EXISTING SERVICES 72-73

Drug abuse information-education-coordinating team.

Methadone maintenance treatment for 200 heroin addicts.

Self-help services - contract with Aquarian Effort.

PLANNED FOR 73-74

Decentralization of methdaone maintenance program to North Area (see North Team Summary) (State Drug Abuse Funds).

Outpatient detoxification for drug abuse (State Drug Abuse Funds).

Inpatient detoxification for drug abuse (federal drug applic.)

Family drug crisis treatment (See Crisis Team Summary). (Federal drug abuse applic.)

Abstinence Program (contractual - state drug abuse funds).

SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Summary of Alcoholism Programs

EXISTING SERVICES 72-73

Detoxification services on Crisis Unit (Highes Grant).

Alcohol Traffic Safety Project (State Funded Grant).

Coordination of Existing Services to Alcoholics which includes:

Sacramento Alcoholism Center

Recovery House Programs

Information-Education Programs through Health Dept.

Medical Detoxification at SMC.

Other community programs such as Alcoholics Anonymous.

UNDER DEVELOPMENT 72-73

Pilot project for the public inebriate (SRS funds).

PLANNED FOR 73-74

"Downtown detoxification" program for the public inebriate (Hughes funds for special projects).

Day treatment program for alcoholism (Hughes funds for special projects or Short/Doyle).

SACRAMENTO COUNTY MENTAL HEALTH SERVICES

Summary of Contractual Services

1. Sutter Mental Health Center	To support comprehensive mental health services for Catchment Area # 49 (Central Sacramento).
2. American River Mental Health Center.	To support comprehensive mental health services for Catchment Area # 50 (Arden).
3. Alternate Care Services Unit (formerly Community Services Division of Dept. of Social Welfare).	To purchase mental health services to the previously hospitalized and potentially hospitalizable. Follows many "aftercare" patients both in residential settings and in working closely with each of the five catchment area teams and the crisis team.
4. Aquarian Effort	To support community self-help programs for drug abuse. Works closely with drug abuse program and methadone maintenance program.
5. Child Day Care Center	To provide day treatment for seriously disturbed pre-adolescent children.
6. Mental Health Aides	Services by paraprofessionals (begun by Mental Health Assn.) to poor and minority groups. Aides work closely with mental health teams.
7. Mental Health Assn. New Horizons Club	Aftercare rehabilitation for former state hospital patients.
8. Sacramento Children's Home	Residential treatment of pre-adolescent and adolescents. Includes treatment program at Helen Cowell Center.
9. Suicide Prevention Service	Crisis intervention services with 24 hour telephone call manned by volunteers.
10. Vocational Rehabilitation	Rehabilitation for the formerly mentally ill to make them re-employable.

SACRAMENTO COUNTY MENTAL HEALTH SERVICE

Community Alternatives to State Hospitalization

Objectives

1. To provide Community Alternatives which will diminish the need for patients being sent to state hospitals - or eliminate it altogether.

2. To establish community programs which will provide treatment for the 112 resident inpatients from Sacramento County who are presently at state mental hospitals.

3. To place the responsibility for comprehensive mental health services on the five catchment area teams of Sacramento County. This means that each catchment area will be responsible for providing its own alternatives to state hospitalization and that such services will be readily available to the residents of each catchment area.

4. To gain broad-based community support for new programs of community alternatives and for the principle that community programs would avoid the use of state hospital services away from Sacramento County by providing superior or equivalent services in the community.

Programs

1. Comprehensive Mental Health Services in each Catchment Area

Each catchment area should accept responsibility for comprehensive mental health care so that alternatives to state hospital care are available. "Aftercare" services should be available within each of the five catchment areas. It should be the philosophy of each mental health team to avoid unnecessary hospitalization through the effective use of pre-care services and to provide continuing care to those who have been previously institutionalized. Day treatment programs should be available in each catchment area, as well as crisis services, outpatient services, mental health consultation services and appropriate inpatient services. The latter should include various levels of inpatient care ranging from acute-intensive (at Sacramento Medical Center, Sutter Memorial or American River Healthcare Center) to intermediate care and/or residential care. Certain specialized services may use facilities outside the catchment area, but within the county (e.g. night and weekend crisis intervention).

2. Crisis Responsiveness

Mental health programs would be able to respond to any family, individual, residential facility, or other agency with crisis intervention services. The crisis services should also be mobile - i.e. have the ability to see patients, families or community agencies in their own settings. The crisis services would be located within each catchment area during regular operating hours, but could be centralized (as at the Sacramento Medical Center) during nights and weekends. The night-weekend crisis services will establish close communications with the crisis services for the five catchment areas and each catchment area's crisis services will establish close working relationships with the other elements of the mental health program in that catchment area.

3. Patient Follow-Up Care System

Patients should not get lost in the system of care, nor should they expect to be patients forever. Each catchment area should maintain records on its own patients, maintaining, of course, the necessary precautions to assure confidentiality of the information. The files will be arranged in such fashion that it would be possible to "track" patients through mental health programs - i.e., to determine what treatment they have had in the past and to effect appropriate exchanges of professional information. Patients discharged from state hospitals should not be released until there has been a community program developed. The catchment area team should participate in the development of that treatment program. Where possible, numbering systems should permit rapid access to information about each patient. Effective referral systems between public resources and private practioners are very important. In order to make an appropriate referral, adequate information must be provided to the private practitioner. Follow-up contact with a private practitioner or public agency will determine that the patient has actually utilized the referral and has found the help needed. Information exchange between agencies and between the public and private funded sectors of the community plan are necessary in order to provide effective mental health services. These must be arranged in such a manner so as to maintain confidentiality and to protect the rights of patients.

4. Rehabilitation Services for the Previously Hospitalized or Potentially Hospitalizable

There should be concerted and comprehensive socialization-resocialization and re-education programs for patients suffering from social breakdown and functional disability. This could include non-institutional centers or series of geographically located centers operating five days a week, which would provide treatment designed to restore socialization, to enhance opportunities for further growth (and employment possibilities) and to serve medical, social, psychological and rehabilitative needs. This should include a mobile arm (station wagons or mini-busses) so as to bring patients to such centers or programs. Other rehabilitation services could be enhanced by sending mental health staff to residential settings where there may be several former state hospital patients. Other approaches would involve expansion of therapeutic ex-patients' clubs such as the New Horizons program. Special settings such as therapeutic residential settings for adolescents and young adults should be part of the program. Likewise, special attention is needed for the senior citizens of this County.

5. Expanded Day Treatment Programs

Not only should there be the non-institutional centers mentioned above, but each catchment area requires a professionally staffed day treatment facility. This could serve as a transition treatment program for the patient who has had intensive inpatient care, or could be an effective alternative to inpatient treatment. In addition to day treatment programs, PM treatment program would also be effective for those who work and go to school during the day and who live in their own homes but who would benefit from a treatment program during the evening hours.

6. Intermediate Care Facilities

Intermediate care facilities which provide 24-hour care, but not necessarily acute intensive hospital treatment, need to be developed - eventually one for each catchment area. These should be available for rapid admission for conservatorship patients and others requiring supervision and treatment not usually available in a residential care setting (sometimes called a Board and Care home).

7. Volunteer Programs

The community alternatives program should include expanded use of volunteers. This could include expanded "Community Friends" programs such as the one established by the Sacramento Area Mental Health Association. There should also be developed new patterns of volunteer services to residential care centers and to intermediate care facilities as well as to the day treatment programs. In addition to the facilities of the Mental Health Association, other patient-help and self-help groups such as "Recovery" should be involved.

8. Information-Education

Expanded information-education programs are an important part of this effort. This will include public information programs for the general population, designed to help all citizens understand that mental illness does not necessarily require hospitalization and that treatment programs in the community are more desirable than treatment away from the community. There should also be information-education programs for private practitioners. Family physicians as well as psychiatrists and other specialists in practice, should be familiarized with the total mental health program, its goals, and with the range of community alternatives. There should be expansion of caretaker training which will make it possible to recruit appropriate operators of residential treatment centers. This requires not only a well structured training effort, but also ongoing consultation which will maintain contact between the mental health programs and such residential settings. Consultation services should be immediately available by telephone to private practitioners, social agencies, and operators of residential settings. For the concept of crisis responsiveness (Program No. 2) has generally been focused on direct services to patients. The same immediate responsiveness must be available to private practitioners and others. Such a telephone consultation service would include data for immediate referral and listings of available services for which referral can be made.

DESCRIPTIONS OF PROPOSED NEW AND EXPANDED PROGRAMS

Sacramento County Mental Health Services

1973-74

Adolescent Day Care Program - East Team

A day care (day hospital - partial hospitalization) program for patients in the adolescent age range. Patients will include all diagnoses. The treatment program will be used both as an alternative to 24 hour care and as a transition program for patients who had been in 24 hour care. Treatment includes teacher staff since patients in this age range require continued education. Program will attend to psycho-educational needs in addition to the usual group, individual, milieu and pharmacotherapies. There is no adolescent day program for adolescents in Sacramento County except for a limited group at Sutter - and that serves predominantly only 16% of the county's population.

Juvenile Center Consultation Team

For evaluation and treatment of juveniles who appear at the Juvenile Center, as well as for their families. This population includes children who have not been admitted for breaking any law - but many admitted because of family problems. They have been deemed "out of control". A diversion pilot project carried on by the UC Davis Law School in cooperation with the Juvenile Center and with the Mental Health Service, has demonstrated that many such cases can be kept out of Juvenile Center by family crisis therapy. Presently the MHS has 1/2 child psychiatrist and 1 PSW doing such consultations. A psychologist, social worker and clerk are needed for full services.

Therapeutic Classroom (one each for North and East Catchment Areas)

Funded by a federal Child Mental Health Services Staffing Grant, there has been established in the South Catchment area, a therapeutic classroom (and a school staff development program as well as a child aide project and a community peer project). The pattern we hope to develop is to establish a therapeutic classroom and a school staff development program in the other catchment areas of Sacramento County. The therapeutic classroom treats children who cannot remain in regular classrooms due to emotional and behavioral problems. Treatment is a psycho-educational approach - i.e., psychologically skilled teachers and teacher aides whose treatment approach will not be exclusively psychotherapy, but rather educationally oriented. Activity therapies round out the program. The classroom is coordinated with the other child treatment activities of the catchment area team.

School Staff Development Program (one each for North and East Catchment Areas)

A school staff development program focuses on preventive services providing consultation to classroom teachers and other school personnel. A child psychiatrist, psychologist and social worker make up a consultation team who work with all the schools in the catchment area. The service provides client centered as well as case centered consultation and teaches the classroom teacher how to recognize and deal with the disturbed child. Help with direct treatment and referral for treatment services are part of the additional functions of the school staff development team.

Down-town Detoxification Services

Presently the alcoholism program admits patients to the detoxification service at the Sacramento Medical Center when patients require medical detoxification for acute medical illness or for alcohol poisoning. We are unable to care for the largest number of alcoholics who are generally "treated" in jail in the "drink tank". A downtown detoxification service would avoid putting such patients in jail and would permit police officers to bring such individuals directly to a detoxification for the public inebriate. This type of detoxification service would send such individuals as require the more expensive medical detoxification to the Medical Center, but would treat directly those who can be detoxified in less elaborate (or expensive) programs. A physician would function as triage officer and would provide medical back-up. A social worker would help establish individual and group treatment programs and arrange for follow-up outpatient or day care treatment. The service would be manned around the clock by psychiatric technicians.

Day Care Program for Alcoholics

A specialized program for alcoholics which would meet the needs of the alcoholic who is completing detoxification and does not require 24 hour care, but who needs more intensive treatment than outpatient treatment. The program would include individual and group therapies, milieu treatment, activitity therapies, and other appropriate approaches. The program would be coordinated with the detoxification and the outpatient treatment programs for alcoholics.

Methadone Maintenance -North Team

Sacramento County presently has 200 heroin addicts in a centralized methadone maintenance program. The program serves less than one fifth of heroin addicts who could benefit. The county proposes to decentralize the program and to begin with a methadone program in the North Catchment Area (which could also serve patients from the Arden and perhaps the East Catchment Areas). As the program requires further expansion or change, there may be need for a methadone maintenance program in the Central Area.

Outpatient Detoxification for Heroin Addicts

Highly motivated drug addicts may be detoxified on an outpatient basis and existing legislation permits it on a research basis. Pending legislation will open the avenues to outpatient detoxification and will make it possible to treat the most highly motivated group without hospitalization. This will be closely coordinated with the methadone maintenace program and with other drug abuse programs.

Abstinence Programs

Some drug abuse programs featuring the goal of abstinence (rather than substitution) and run primarily by self-help or paraprofessional groups, have been successful. We propose to establish such a program on a contractual basis to be run by some community organization such as the Aquarian Effort or a new group similar to Synanon.

Inpatient Detoxification for Adducts and Substance Abusers

We presently do no inpatient detoxification for drug addicts, but limit services to those who "dry themselves out" and become motivated for maintenance therapy or treatment to get them off drug or alcohol. The detoxification services for alcoholics are also limited. This program would establish inpatient detoxification programs for substance abusers who cannot profit from outpatient detoxification.

Family Crisis Services for First Contact Drug Abusers

The Juvenile Center sees many adolescents who appear with family because of a first complaint about drug use. These families are in significant distress, and the problem is new enough so that the family and teen-ager may be motivated for significant help with drug problems. Family crisis therapy would be of significant advantage and would aid in motivating the patient and family to more effective treatment.

Mobile Team for Crisis Intervention

A mobile team for crisis intervention around the clock which would take place in the home setting or the agency where the crisis exists. This team would also function in doing court ordered evaluations and pre-petition screening where that is better done in the home setting.

Satellite Clinic - South Team

The South Team is the only one of the 3 Sacramento County Direct Service Teams which is not decentralized. The catchment area concentrates most of its population near the Medical Center. But the other 30% of the population are deprived of services and those in the Delta Area have real problems of transportation and lack nearby services. A satellite clinic in Elk Grove would provide Day Treatment for the Elk-Grove and Galt Areas and for other residents in the Delta Area. A mobile team would serve the rest of the Delta area providing outpatient mental health servies and consultation to the small towns which constitute the Delta Area.

Program Evaluation

A Chief of Program Evaluation (PhD level) and clerical staff would carry on the data processessing operations necessary to the program evaluation needs of the County Mental Health Service.

FACT SHEET on TEENAGE SEXUALITY
the UNITED STATES

#4
file copy

....During the last decade, numbers of births to those under age 18 have increased by 3,000 each year.

....In 1972 an estimated 213,000 girls under age 18 gave birth to a child (Consortium on Early Childbearing and Childrearing 1972)

....60% of the young mothers were white and 40% were black or members of other minority groups. (Consortium on Early Childbearing and Childrearing 1972)

....46% of girls under age 20 are sexually active (President's Commission on Population and the American Future)

....The V.D rate in girls aged 15-19 increased 144% between 1960 and 1970 (Center for Disease Control - V.D. Branch)

....The rate of out-of-wedlock births among adolescents has increased 250% from 1940 to 1968. (President's Commission on Population and the American Future)

....Higher infant mortality, prematurity, and parity as well as shorter birth intervals occur with births to teenage mothers than with women in their early twenties. (Family Planning Perspectives, July 1972)

....In a study of unwed girls aged 17 or younger, only 10% of these used a serious form of contraception; 30% used douching, withdrawal or what they thought was rhythm; 54% used no method at all. (Family Planning Perspectives, January 1972)

....The single most important reason for non-use of contraception was the non-availability at the time it was needed. (President's Commission on Population Growth and the American Future)

Clark County District Health Department
Family Planning January 1973

Another example was a recent phone call received at the clinic. This 16 yr. old had asked her mother if she would sign the consent form for the daughter to receive contraception. ---------- th ught she would be sympathetic -------to see if she had a V.D. Or another 16 yr old who had already been to the H.D she planned to continue being sexually active, s

I think one of the most distressing experiences for a family would be that of a pregnant unwed daughter. Given any of the solutions to an unwanted pregnancy-- abortion, giving up a baby for adoption or raising a child without a father, a forced marriage of 2 immature young people--- any of these is bound to cause heartache, driving people farther apart, possibly psychological harm, suicide just to name a few effects.

Rather than continue to neglect or try to ignore the sexuality of our teenagers, we must deal responsibly with this issue by providing appropriate education, fertility control and guidance to teenagers in order to eliminate the incidence of unwanted pregnancy.

Do Pass as amended

S. B. 331

SENATE BILL NO. 331—COMMITTEE ON HEALTH, WELFARE AND STATE INSTITUTIONS

FEBRUARY 28, 1973

Referred to Committee on Health, Welfare and State Institutions

SUMMARY—Eliminates requirement that payments for care of mentally ill be made in advance. Fiscal Note: No. (BDR 39-1129)

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to the care of the mentally ill; eliminating the requirement that subsistence and care payments for committed persons be made in advance.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 433.410 is hereby amended to read as follows:

433.410 1. The daily or monthly rate for the subsistence and care of committed persons shall be determined by the superintendent, if such persons are committed to the hospital, or the chief, if such persons are committed to the mental health center, and shall be payable monthly. [in advance.] The rate shall approximate the actual per diem cost per patient, for the class of patient care provided, for the previous fiscal year.

2. The cost of transportation to the hospital or mental health center shall be payable with the first monthly payment.

3. The assessment of a rate less than the maximum shall not constitute a waiver to a claim for the difference between the actual rate and the maximum rate when the financial ability of responsible relatives or the estate of the committed person warrants the higher rate.

4. Previously determined payments may be decreased or increased by the superintendent or chief if adverse or favorable changes in the financial status of responsible relatives or the estate of the committed person warrant such action.

5. Rates of pay determined by the superintendent or chief may be appealed to and reviewed by the administrator of the division. After review, the administrator may modify the determination of the superintendent or chief.

6. Costs of clothing, personal needs, medical, surgical and related services which have to be purchased outside of the hospital or mental health center shall be additional charges against responsible relatives or the estate of the committed person.

7. The unused portion of *any* advance payments shall be refundable to the source of payment in the event of the committed person's death, parole or discharge from the hospital or mental health center.

Ldo Pass

A. B. 179

ASSEMBLY BILL NO. 179—MESSRS. BENNETT, CRAWFORD AND VERGIELS

JANUARY 31, 1973

Referred to Committee on Health and Welfare

SUMMARY—Reconciles financial responsibility provisions in public welfare law. Fiscal Note: No. (BDR 38-40)

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to the financial responsibility of relatives for assistance received by certain recipients; removing adult children's responsibility; providing uniform enforcement responsibility; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 422.310 is hereby amended to read as follows:

422.310 1. The husband, wife, father, *and* mother [, and children] of an applicant for or recipient of public assistance, if of sufficient financial ability so to do, are liable for the support of such applicant or recipient.

2. The welfare division shall investigate the ability of responsible relatives to contribute to the support of an applicant for or recipient of public assistance and shall determine the amount of such support for which such relative is responsible.

3. In determining the amount of support for which such relative is responsible, his financial circumstances shall be given due consideration.

[4. A married daughter of the applicant shall not be required to make contributions unless she has income constituting her separate property.]

SEC. 2. NRS 422.320 is hereby amended to read as follows:

422.320 Annually the board shall prepare a relatives' contribution scale establishing the amounts to be contributed by relatives responsible for contributing to the support of welfare recipients. Such scale shall be based upon the [cost-of-living index for the state] *National Consumer Price Index* and shall take into consideration the net monthly income of each such relative and the number of persons dependent upon that income. In no case shall a relative be required *by the welfare division* to

make contributions greater than the amount fixed by the [relatives contribution scale.] *relatives' contribution scale, except as may be provided in chapters 62, 123, 425, 426 or 428 of NRS.*

SEC. 3. NRS 422.340 is hereby amended to read as follows:

422.340 The welfare division shall advise the attorney general of the failure of a responsible relative to contribute to the support of a recipient of public assistance as required by law. The attorney general shall cause appropriate legal action to be taken to enforce such support, and in addition may collect a reasonable fee which shall be added to the costs of the action in any [justice's] court of the state, the expense of such fee and costs to be borne by the relative. Any fees collected by the attorney general under the provisions of this section shall be deposited in the general fund in the state treasury.

SEC. 4. NRS 422.350 is hereby amended to read as follows:

422.350 The liability of a relative to contribute to the support of a recipient of public assistance established by this chapter shall not be grounds for denying or discontinuing public assistance to any person; but by accepting such public assistance the recipient thereof shall be deemed to consent to suit in his name by the [county] *welfare division* against such responsible living relative or relatives and to secure an order for his support.

SEC. 5. NRS 425.220 is hereby amended to read as follows:

425.220 1. If, at any time during the continuance of any assistance granted under this chapter, the welfare division finds that any father, mother, adoptive father or adoptive mother of any child receiving assistance is reasonably able to contribute to the necessary care and support of such recipient without undue hardship to himself or his immediate family and such person so able to contribute to the care and support of such recipient fails or refuses to contribute according to his ability to the care and support of such recipient, then, after notice to such person, there shall exist a cause of action against that person for such amount of assistance furnished under this chapter subsequent to such notice, or such part thereof as that person is reasonably able to pay.

2. The action may be ordered by the welfare division and shall be brought in the name of the state by the attorney general for the recovery of such amount of assistance granted after such notice, as hereinbefore provided, together with the costs and disbursements of such action.

3. The liability of a father, mother, adoptive father or adoptive mother to contribute to the support of a recipient of assistance established by this chapter shall not be grounds for denying or discontinuing assistance to any person.

4. The remedy provided in this section is cumulative and may be pursued in addition to any other remedies provided by law to enforce a parent's duty of support.

SEC. 6. NRS 428.310 is hereby amended to read as follows:

428.310 1. No relative of an applicant for or recipient of medical or remedial care may be held liable for contributions for the support of such applicant or recipient except [as provided in chapter 123 of NRS.] *for the duty of support as provided in:*

Ws pass

S. J. R. 16

SENATE JOINT RESOLUTION NO. 16—SENATORS HECHT, ECHOLS, WALKER, LAMB, BRYAN, SWOBE, HERR, NEAL, FOLEY, RAGGIO, POZZI, YOUNG, BROWN, DODGE, WILSON, BLAKEMORE AND DRAKULICH

FEBRUARY 21, 1973

Referred to Committee on Health, Welfare and State Institutions

SUMMARY—Memorializes Congress to correct inadequacies in grants of social security and supplemental benefits. (BDR 993)

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

SENATE JOINT RESOLUTION—Memorializing Congress to correct inadequacies in grants of social security and supplemental benefits.

WHEREAS, The members of the legislature of the State of Nevada have been apprised of the fact that unanticipated hardships have been imposed upon the receipt of social security and supplemental benefits by the sick, the aged and the disabled; and

WHEREAS, The eligibility for many benefits continues so long as the recipient's income does not exceed an established amount; and

WHEREAS, The incomes of many recipients have been increased by the Congress with the belief that the recipients would benefit thereby; and

WHEREAS, For many recipients, the increase in income is more than offset by the disqualification from eligibility for other benefits, and results in a net loss to the recipient; and

WHEREAS, Grave hardships have befallen the very people who have been the object of the laudable social legislation; and

WHEREAS, It is the belief of the members of the legislature of the State of Nevada that the Congress should act with all deliberate speed to correct this oversight and to prevent the dire consequences likely to be inflicted upon the less fortunate; now, therefore, be it

Resolved by the Senate and Assembly of the State of Nevada, jointly, That the legislature of the State of Nevada memorializes Congress to correct the inadequacies in grants of social security and supplemental benefits by raising the ceiling of eligibility for supplemental benefits; and be it further

Resolved, That Congress prevent similar inequities from accompanying future increases in social security benefits by corresponding adjustments of eligibility for supplemental benefits; and be it further

Resolved, That copies of this resolution be prepared and transmitted by the legislative counsel to the President of the Senate, to the Speaker of the House of Representatives and to all members of the Nevada Congressional delegation; and be it further

Resolved, That this resolution shall become effective upon passage and approval.

EXHIBIT C

#9

STATE OF NEVADA
DEPARTMENT OF HEALTH, WELFARE, AND REHABILITATION
DIVISION OF HEALTH
CARSON CITY, NEVADA 89701

OFFSPRING OF TEEN MOTHERS

FACE GREATER HAZARDS

The younger the mother, the more risk to her baby in almost every area.

There is higher incidence of birth defects, and iron deficiency anemia, and they are also more likely to be battered and abused and to suffer serious accidents. Also they suffer from more acute infections during their first year than babies of older mothers.

I feel that Family Planning -- of "Family Spacing" -- like immunizing school children, is another way to guarantee that kids will grow up healthy.

Teen-age pregnancy is primarily in high risk children -- the poor, the disadvantaged, the broken families, and the minority groups.

Nevada State Health Division would prefer to see kids using contraceptives rather than becoming pregnant and having abortions.

William M. Edwards, M.D., Chief
Bureau of Community Health Services
Nevada State Health Division
2/12/73

WME/rg

NUMBER OF BI[redacted] TO YOUNG WOMEN - BY COUNTI[redacted]N NEVADA - 1972

	Under 12	12	13	14	15	16	17	18
[redacted] TOTALS	0	1	6	40	104	217	345	454
CARSON CITY	0	0	0	0	1	9	15	20
CHURCHILL	0	0	0	3	3	1	8	7
CLARK	0	1	6	31	77	147	221	290
DOUGLAS	0	0	0	0	0	0	0	0
ELKO	0	0	0	0	1	7	9	10
ESMERALDA	0	0	0	0	0	0	0	0
EUREKA	0	0	0	0	0	0	0	0
HUMBOLDT	0	0	0	0	2	1	7	4
LA[redacted]ER	0	0	0	0	0	0	2	1
LINCOLN	0	0	0	0	1	0	0	1
LYON	0	0	0	0	0	2	1	9
MINERAL	0	0	0	0	3	7	6	9
N[redacted]	0	0	0	0	0	0	1	0
PERSHING	0	0	0	0	1	1	0	1
STOREY	0	0	0	0	0	0	0	0
WASHOE	0	0	0	5	14	33	71	91
WH[redacted] PINE	0	0	0	1	1	9	4	11

Washoe County Maternity & Infant Program Jan. through Dec. 1972, admitted 349 pregnant women. Of these, 58 were under 18.

[redacted]

William M. Edwards M.D., Chief
Bureau of Community Health Services
Nevada State Health Division

RECEIVED
FEB 5 1973
PREVENTIVE MEDICINE

STATE OF NEVADA
DEPARTMENT OF HEALTH, WELFARE, AND REHABILITATION
DIVISION OF HEALTH
CARSON CITY, NEVADA 89701

OEB Family Planning Clinic, Owens Avenue, Las Vegas, in 1972, provided family planning services to the following numbers of women:

17 year old girls	40
16 year old girls	24
15 year old girls	18
14 year old girls	15
13 year old girls	3
12 year old girls	13
11 year old girls	8

William M. Edwards, M.D., Chief
Bureau of Community Health Services
Nevada State Health Division
2/13/73

WME/rg

FAMILY PLANNING STATISTICS

CLARK COUNTY HEALTH DEPARTMENT

	1972	1971	1970
Patients receiving services:			
New	1435	838	539
Old	289	680	884
Total	1725	1518	1423
Patients admitted to Family Planning Services	2327	2828	1684
Patients under age 20 admitted to Family Planning Services	1269	1287	550
Field Visits	2673	1725	1274
Office Visits	8717	6460	4453
SAMI (welfare)	395		

William M. Edwards M.D., Chief
Bureau of Community Health Services
Nevada State Health Division

Edw

ILLEGITIMATE BIRTHS

1972

75% of all illegitimate births occur with mothers between 14-22 years of age. 51% occur with mothers between 15-19 years of age.

40% of all illegitimate births occur with black mothers between 14-21 years of age.

Overall, the rate of black illegitimacy is 36% higher than white illegitimacy (420 illegitimate black births vs. 310 illegitimate white births.) Yet in the 13-17 age category, black illegitimate births run 64% above the white rate. It is important to remember that only 17.9% of all births are black, while they account for approximately 58% of the overall illegitimacy.

Approximately 45% of all black births are illegitimate, while approximately 7% of all white births are illegitimate.

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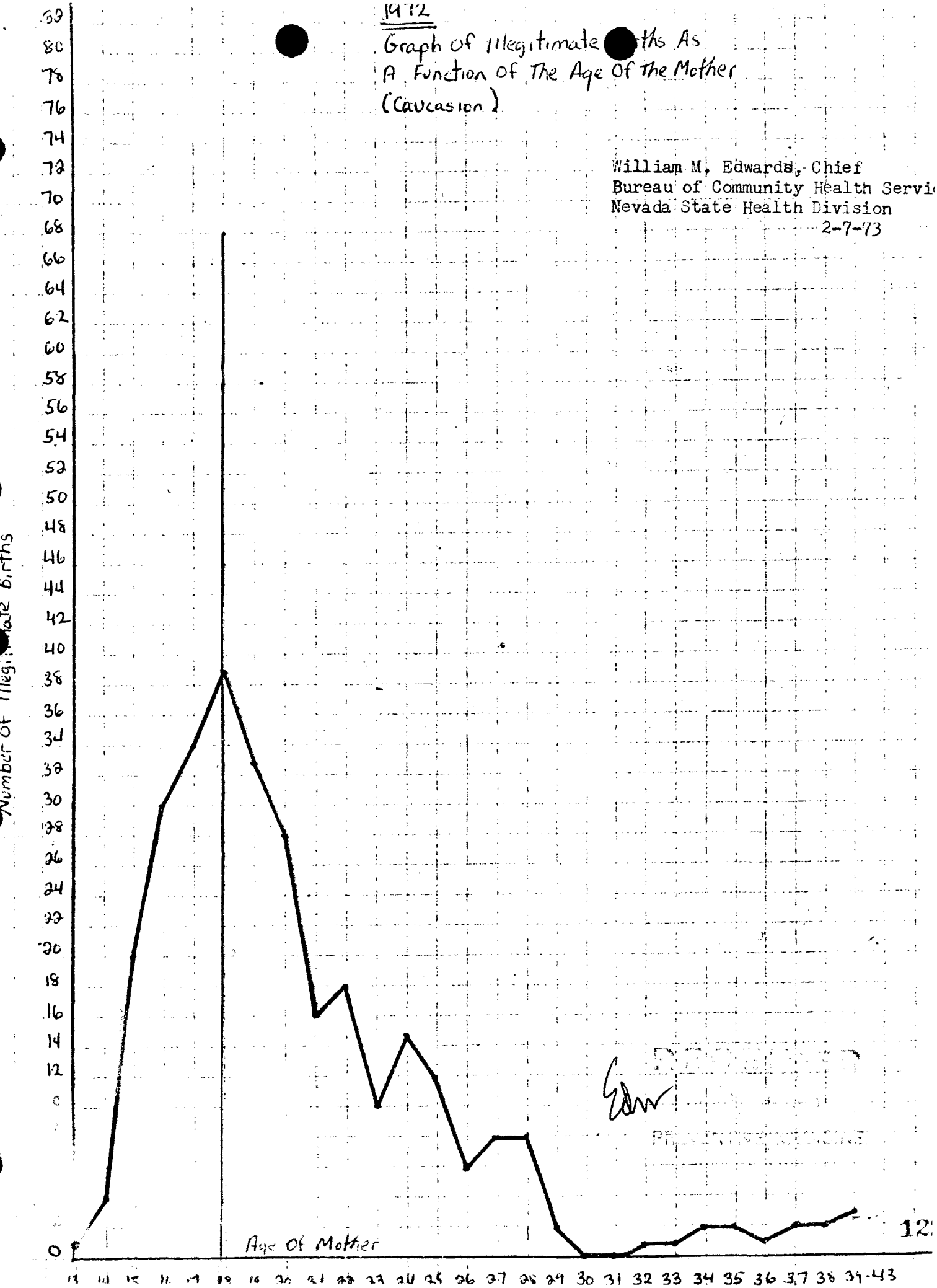
* A compilation by DHD Family Planning

William M. Edwards M.D., Chief
Bureau of Community Health Services
Nevada State Health Division

1972

Graph of Illegitimate Births As
A Function Of The Age Of The Mother
(Caucasion)

William M, Edwards, Chief
Bureau of Community Health Servi
Nevada State Health Division
2-7-73

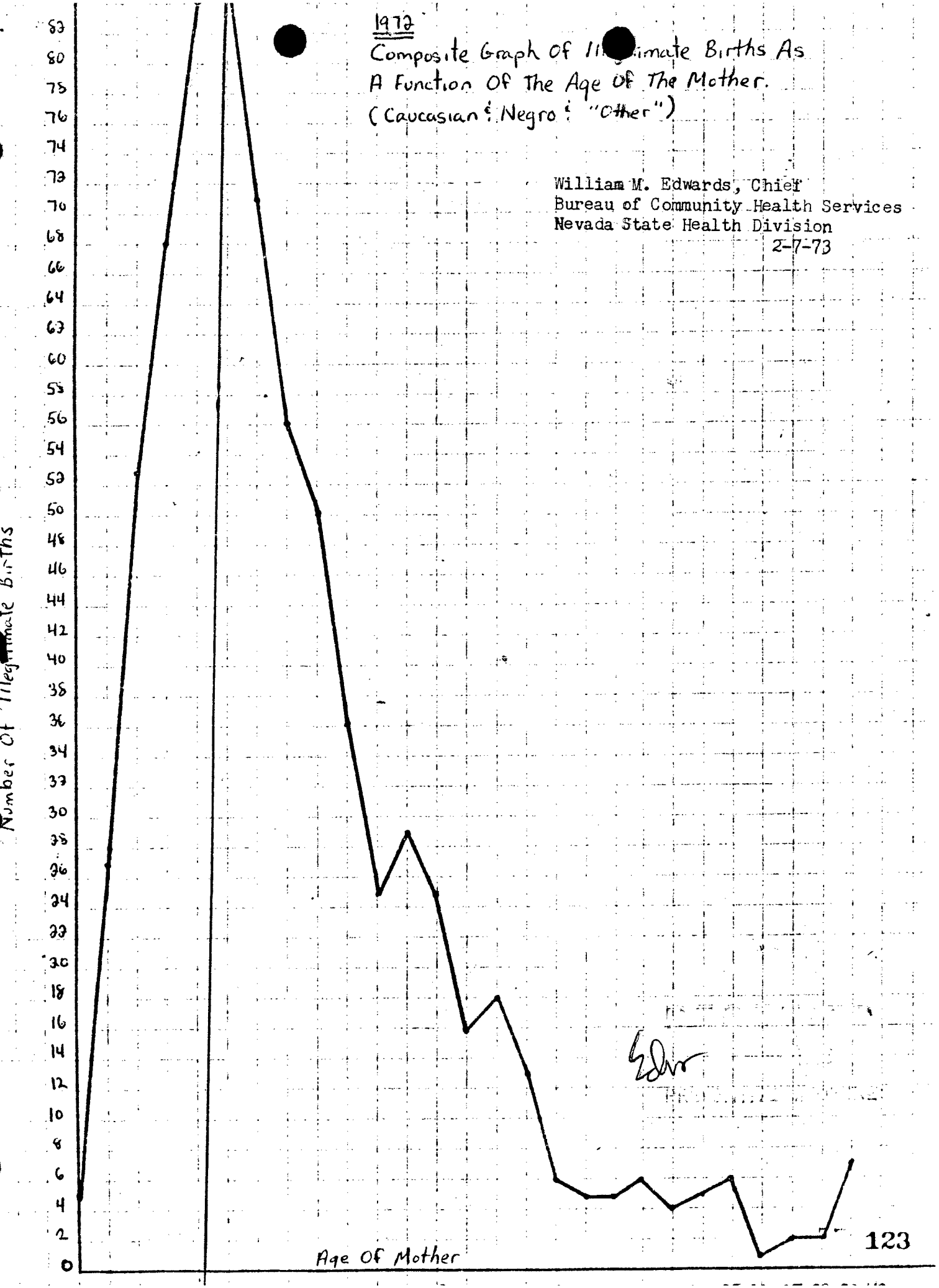


12

1972

Composite Graph of Illegitimate Births As A Function Of The Age of The Mother. (Caucasian & Negro & "Other")

William M. Edwards, Chief
Bureau of Community Health Services
Nevada State Health Division
2-7-73



FACT SHEET on TEENAGE SEXUALITY
in the UNITED STATES

William M. Edwards, M.D., Chief
Bureau of Community Health
Services
Nevada State Health Division

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Reported data indicate that the number of live births out of wedlock in girls under 20 years of age has increased from 42,600 in 1940 to 165,700 in 1968; they represent almost half of all live births out of wedlock in 1968 in the United States, and 2.1% of all out of wedlock pregnancies were in the under 15-year age group. Thus, it was deemed worthy to explore the scope and extent of community efforts to deal with this problem.

William M. Edwards M.D., Chief
Bureau of Community Health Services
Nevada State Health Division

FACTS OF LIFE IN NEVADA

Cost of Welfare in Nevada for one year-1972 (Nevada State Welfare Dept.)

....For mother with one child on ADC. (Assumption: That the mother and the child will have ordinary good health during the year after the child's birth.)

Cash grant	$ 1,500/yr.
Average cost of prenatal care, delivery, and Post-partum care	600
Routine medical check-up for the child	84/yr.
Medical transportation	30/yr.
Total (This figure does not include the cost to taxpayers for housing and food supplements)	$ 2,214

The Cost of Family Planning Services for one year..... $ 50-60

....In 1972 there were 711 illegitimate births in Clark County; 406 were black, 298 were Caucasian, and 7 were Oriental or American Indian.

....The illegitimacy ratio in Clark County rose from 8.5% in 1966 to 13.7% in 1972.

..75% of all illegitimate births occur with mothers between 14-22 years of age; 51% occur with mothers between 15-19 years of age

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....In 1969 the gonorrhea case rate in Nevada for the 15-19 year old age group ranked 5th in the nation.

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Edw

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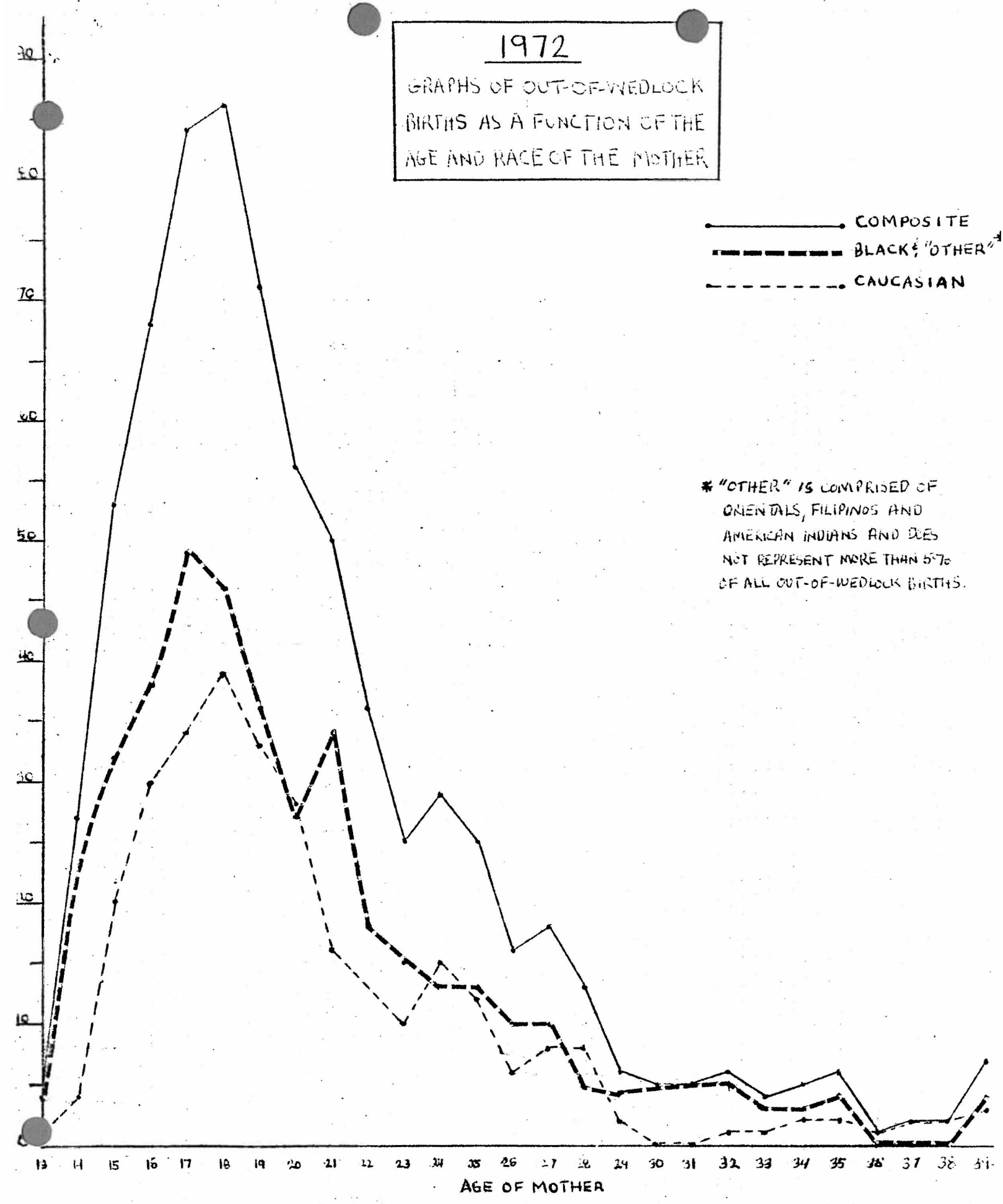
Clark County District Health Department
Family Planning Clinic - January 1973

1972

GRAPHS OF OUT-OF-WEDLOCK BIRTHS AS A FUNCTION OF THE AGE AND RACE OF THE MOTHER



OUT-OF-WEDLOCK
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1972

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* A compilation by Clark County District Health Department Family Planning Clinic - January 1973

YOUNG WOMEN IN CLARK COUNTY SCHOOLS WHO BECAME PREGNANT DURING THE 1971-72 SCHOOL YEAR (IN GRADES 7-12)

AGE	NUMBER OF YOUNG WOMEN
13	4
14	20
15	33
16	45
17	32
18	4
19	1
20	1
TOTAL	140

134 TEENAGERS

INFORMATION SUPPLIED BY CLARK COUNTY SCHOOL DISTRICT

APPROXIMATE OUT-OF-WEDLOCK BIRTHS
FROM A TOTAL OF 5,180 BIRTHS IN CLARK COUNTY, NEVADA

Calendar Year 1972

AGE OF MOTHER	TOTAL	CAUCASIAN	BLACK	OTHER
13	5	1	4	0
14	27	4	23	0
15	53	20	32	1
16	68	30	38	0
17	84	34	49	1
18	86	39	46	1
19	71	33	36	2
20	56	28	27	1
21	50	16	34	0
22	36	18	18	0
23	25	10	15	0
24	29	15	13	1
25	25	12	13	0
26	16	6	10	0
27	18	8	10	0
28	13	8	5	0
29	6	2	4	0
30	5	0	5	0
31	5	0	5	0
32	6	1	5	0
33	4	1	3	0
34	5	2	3	0
35	6	2	4	0
36	1	1	0	0
37	2	2	0	0
38	2	2	0	0
39-43	7	3	4	0
TOTAL	711	298	406	7

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Family Planning Clinic - January 1973

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EXHIBIT E

By Mrs. Sharon Richert, Coordinator
Washoe County Family Planning ..SB 311
Washoe County Health Department

TEENAGE CONTRACEPTION BILL

It is my feeling that the bill on teenage contraception without parental consent is vitally needed.

I can only speak from my own personal experience with those young women who have come to me for counseling and in desperate need of help.

Most of the young women who come to me have already been having sexual relations and are very concerned about the possibility of pregnancy and/or want to know about the methods they can use to prevent pregnancy. They are young adults who have already made the decision to have relations and plan to continue to have them. They are not coming to me for counseling regarding this decision, but how to protect themselves so they will not have an unwanted pregnancy.

These women are well aware of the fact that they are not ready to bring a child into the world at this time and do not feel that abortion should be their only alternative.

Most of them do not have a relationship with their parents which allows them to discuss the fact that they are having sexual relations, and so therefore cannot get their parents to sign the consent form.

Therefore, these women are left with little or no alternative to protect themselves. Most of the young men in these situations do not want to or will not take the responsibility for protection against pregnancy. So what ends up happening is that these young women come back to me for either abortion counseling or to our Maternity Clinic. I have even seen instances where a young women has an unwanted pregnancy , has the child, wants contraception after delivery, and the parents still won't sign the consent.

I know that there are many who feel that if contraception is made available to the teenager this will promote sexual activity. However, to me this is not the question or problem. The problem of increased sexual activity among teenagers already exists, and it seems irrational to me that these young men and women should have to go through the traumatic experience of unwanted pregnancy and/or abortion because contraception is not available to them, or that anyone would want this to happen.

It is obvious from the increased rate of teenage pregnancy just in our clinic alone, that these young women will continue to take the chance in sexual relations, so why should they have to go unprotected? The traumatic experience of unwanted pregnancy and/or abortion is just that and it does not stop them from continuing sexual relations.

It is my feeling that the importance of this bill is to allow these young women an intelligent choice to protect themselves, and to have their pregnancies when they choose to - not by mistake or chance.

Sarah Richert R.N.
Coordinator - Family Planning Program
under supervision of Washoe County Health Dept.

When minors are old enough to become pregnant it seems only reasonable that the ways and means for preventing unwanted pregnancies should be made available to them with or without prental consent. It is a well established fact that minors are very sexually active and it is also common knowledge that many young unmarried girls are becoming pregnant. Look at any magazine stand in Reno & Sparks and you will find numerous articles carefully detailing every sexual act and technique imaginable, but with little mention of methods for avoiding unwanted pregnancies.

Now lets look at some facts:

1. Girls under 17 gave birth to 210,000 babies in 1971. Other large groups, perhaps more than double in number, either had abrotions or married to cover a pregnancey.

2. Both the very young mother and her baby stand in high risk during pregnancy and delivery. The baby of a very young mother is high risk for the first year of life.

3. One of every 10 school-age girls in the U.S. is a mother.

4. 16% of these very young mothers already have two children.

5. Divorce terminates marriage 3 to 4 times as often when couples are wed in their teens as it does couples married in later years.
U.S. Comm. on Population & Amer. Future.

Now lets consider some invalid counter arguments.

1. Making contraception available to minors is said to encourage immorality - what is moral about fostering ignorance that leads to unwanted pregnancies, unwanted children, and unwanted and unnecessary burdens to the mother, her parents and to society at large. When one considers the question of immorality the mature responsible person must also consider its alternatives. (Namely contraceptives to minors)

SB 311
Allow family planning services without parental consent for minor women 16 years or older.

I am speaking ~~to you~~ in favor of this bill as a wife, as a mother of 3 children and as a woman who has worked as a volunteer interviewing patients in family planning clinics for much of the past 5 years--3 different clinics in 2 states. I am currently volunteer coordinator for P.P. of So. Nev.

I have in front of me a full page of statistics about the increase in the number of teens who are sexually active, for instance the Pres. Comm on Population and the Am. future concluded that 46% of girls under 20 years of age are sexually active. And that of 711 illeg. births in C.C. in 1972, 51% of those mothers were 19 or younger. But I know you are familiar with the statistics so I would like to talk to you today as one who has personally talked with some of the girls who are part of those statistics and as one who has observed a definite increase in the number of teens who are sexually active and the resulting number of unwanted pregnancies.

I am convinced the teenage girls who want contraception, who need contraception, are already sexually active, have already made up their minds that this is the way it's going to be regardless of their parents or regardless of whether or not they have birth control.

I was concerned at the reasoning of the Assembly comm. who turned down this same proposal saying it would "break up the family unit." I believe very strongly in preserving the family unit. But I'm also just as concerned with the quality of the life within that family unit. What does the unexpected pregnancy of a 16-year old daughter do to that family? In our L.V. P.P. clinic we see several teenaged girls each week who are there to have the doctor verify their pregnancy. I talked with one 16 yr. old girl this winter who was so frightened I thought she was going to pass out ~~in the office~~ would it help if someone on our staff talked--I'd have to say there is already something amiss in that family. The unwanted pregnancy can only cause further problems.

2. Making contraceptives available to minors without parental consent denies parents of their rightfull responsibility. Nothing could be farther from the truth. Responsibile parents who have sexually active teenagers who are minors will make contraceptives available to them. If the parents are irresponsible then society must fill the gap. So the question of responsibility confuses cause and effect.

In other words, it is only when parents do not live up to their responsibility that society must assume this responsibility for them.

A national Gallup Poll last August showed that 73% of the American people feel voluntary medical, educational and counseling family planning services should be available to sexually active young people.

I urge you to pass SB311 on behalf of the Nevada Public Health Association and Planned Parenthood.

Why the Poor Are Fewer

Long before the word ecology came into its present vogue, an old folk adage summed up the poor man's view of the birth rate: the rich get richer and the poor get children. But last week in Washington, a study of census figures by Planned Parenthood-World Population suggested that the second part of the adage is no longer quite accurate. During the late 1960s, the birth rate in families with less than $5,000 in yearly income declined so sharply that the group produced 1 million fewer children than it would have had it maintained the birth rate of the early 1960s.

In percentage terms, the decline in the birth rate among poor women was 21 per cent; for more affluent families, the decline was 18 per cent. But in absolute figures, the number of births fell almost twice as far in poor families as it did in wealthier ones. Thus births to poor women dropped by 32 per thousand, compared with a drop of 17 fewer per thousand among the rest. For poor black women, the fall was even greater: they produced 49 fewer babies per thousand.

Reasons for the lowered birth rate varied, but the chief cause appears to be the increase in government-sponsored birth-control clinics. A study in one New Orleans hospital, for instance, showed that of 30,000 poor women who came in for birth-control advice between 1967 and 1970, some 75 per cent had been using no contraception at all or cheap devices that often failed. When offered more effective means, such as the Pill or intrauterine devices, however, fully 85 per cent vowed to change their habits.

Newsweek, March 13, 1972

Where the Action Is

The following paragraphs summarize the Commission's four principal goals, and 62 of its major recommendations for policies and programs to achieve those goals. In each instance, we have indicated whether, in our judgment, action to implement the proposals is required by public and private institutions at the national (N), state or regional (S) or local (L) levels.

Goals

- The nation should consciously "welcome and plan for population stabilization," gradually slowing and finally halting population growth by maximizing the opportunities for individuals to make free, rational and responsible choices about their fertility, as well as to realize to the fullest their human potential, without discrimination because of sex or economic or minority status. **(N S L)**
- The government should help guide internal migration and foreign immigration so as to ease the problems brought about by population movement from farms, towns and villages, and from countries abroad, to our large metropolitan areas. **(N S L)**
- The nation should implement "a national policy and voluntary program to reduce unwanted fertility, to improve the outcome of pregnancy, and to improve the health of children." **(N S L)**
- Measures must be taken to conserve resources and halt pollution, quite distinct from action related to population growth or distribution. **(N S L)**

Recommendations

Fertility-Related Health Services

- At an estimated additional social cost of $1 billion a year, public and private health financing mechanisms should pay the full costs of all fertility-related health services, including prenatal, delivery and postpartum services, pediatric care for the first year of life, contraception, voluntary sterilization, safe termination of unwanted pregnancy and medical treatment of infertility. **(N S L)**
- Since these services "could easily be integrated into current publicly administered health financing mechanisms, and made part of a new comprehensive national health insurance system . . . Congress should include this coverage in any health insurance system it adopts." **(N)**
- Programs should be created to train doctors, nurses and paraprofessionals in the provision of all fertility-related health services, develop new patterns for the utilization of such personnel and evaluate improved methods of organizing service delivery. **(N S L)**

Involuntary Childbearing

- Eliminate legal inhibitions and restrictions on access to contraceptive information, procedures and supplies, and adopt statutes affirming the desirability that all persons have ready and practicable access to contraceptive information, procedures and supplies. **(S)**
- Repeal laws which now restrict abortions so that they may, as under New York State's law, ". . . be performed on request by duly licensed physicians under conditions of medical safety." The decision to have or not to have an abortion ". . . should be left to the conscience of the individual concerned . . . with the admonition that abortion not be considered a primary means of fertility control . . . ." **(S)**
- Make government funds available to support abortion services so legalized. **(N S L)**
- Include abortion specifically in all comprehensive public and private health insurance benefits. **(N S L)**
- Extend the current family planning project grant program under Title X of the Public Health Service Act from FY 1973 to FY 1978, and provide additional authorizations to reach a federal funding level of $225 million in FY 1973, $275 million in FY 1974, $325 million in FY 1975 and $400 million thereafter. **(N)**
- Maintain the family planning project grant authority under Title V of the Social Security Act beyond this fiscal year at the current funding level – about $30 million annually. **(N)**
- Continue Office of Economic Opportunity family planning programs at current levels of authorization – about $21.5 million annually. **(N)**
- Increase financial support of family planning services by state and local government and private contributors. **(N S L)**
- Reject "means tests" in determining eligibility for publically funded family planning programs since many nonpoor individuals need such assistance effectively to control their fertility. **(N S L)**
- Remove administrative barriers to access to voluntary sterilization (such as requirements of age, marital status or previous parity) so that the decision for sterilization may be made solely by the patient and the physician. **(N S L)**
- Reject rewards for nonchildbearing or penalties for childbearing, in the form of tax incentives or disincentives, subsidies or withdrawal of subsidies, on the grounds that they discriminate against the poor and penalize children. **(N S L)**

Research

- Establish a new, separate National Institute of Population Sciences within the National Institutes of Health. This would create a stronger base from which to carry on expanded biomedical, social and behavioral research, to command the necessary level of funding and to attract more scientific talent. **(N)**
- Assign the "highest priority" to research in reproductive biology and development of improved methods, for which purpose the full $93 million authorized for FY 1973 under P.L. 91-572 should be appropriated by Congress and should increase to a minimum of $150 million by 1975. **(N)**
- Increase private support for research in this field. **(N S L)**
- Provide at least $100 million annually in federal funds for basic biomedical research in human reproduction. **(N)**
- Provide at least $100 million annually – mostly in federal and partially in private funds – for developmental work on methods of fertility control. **(N S L)**
- Provide $50 million annually in federal funds for behavioral and operational research related to population and family planning. **(N)**
- Increase support for research to identify genetically related disorders, development of better screening techniques and better ways to provide genetic counseling services, and appropriate funds to train necessary personnel. **(N)**
- Exempt programs to train population scientists from the general freeze on training funds. **(N)**
- Supplement the decennial census with a mid-decade census of the population, and provide stronger support to Census Bureau efforts to improve the completeness of the census enumeration. **(N)**
- Provide adequate support for the biennial national Family Growth Survey to be commenced by the National Center for Health Statistics later this year. **(N)**

- Achieve more rapid development by the National Center for Health Statistics of comprehensive statistics on family planning services, and improve the timeliness and quality of the vital statistics it collects. **(N)**

Teenage Services and Sex Education

- Eliminate legal restrictions on young peoples' access to contraceptive and prophylactic services and information "because of the serious social and health consequences involved in teenage pregnancy and the high rates of teenage out-of-wedlock pregnancy and venereal disease." **(N S L)**
- Adopt affirmative laws permitting minors to receive such information and services "in appropriate settings sensitive to their needs and concerns" without requirement of consent of parents or guardians, to move "toward the goals of reducing unwanted pregnancies and childbearing among the young." **(S L)**
- Develop and finance a program to train teachers and school administrators, and to assist states and local communities in integrating information about family planning into school courses. **(N S L)**
- Make high-quality programs in sex education available to all through community organizations, the media and the schools. **(N S L)**
- Make funds available to the National Institute of Mental Health to support the development of model school- and community-based programs in human sexuality. **(N)**
- Give teenagers who do become pregnant the opportunity to continue their education and to get adequate health, nutritional and counseling services. They should not be stigmatized by being removed from society. **(S L)**
- Do not stigmatize children born out-of-wedlock with the label "illegitimate." Revise laws which discriminate against them. **(N S L)**

Population and Other Educational Programs

- Enact a Population Education Act "to assist school systems in establishing well-planned population education programs so that present and future generations will be better prepared to meet the challenges arising from population change." **(N)**
- Appropriate adequate federal funds – at least $25 million in the next three years – for teacher training, curriculum development, materials preparation, research and evaluation and support of 'model programs', and to assist state departments of education in developing competence and leadership in population education." **(N)**
- Include population study in all introductory college social science courses. **(S L)**
- Expand and adequately fund programs of education in parenthood (including accurate information on the costs of raising children), in family life (encompassing a variety of life styles), in genetically related disorders and in nutrition for the general public and for professionals. **(N S L)**

Status of Women

- Modify sex and family roles so that women "may choose attractive roles in place of or supplementary to motherhood [and be] free to develop as individuals rather than being molded to fit some sexual stereotype." **(N S L)**
- "Federal, state and local governments should undertake positive programs to ensure freedom from discrimination based on sex." **(N S L)**
- End discrimination against women in education and employment, and give women equal access to all jobs, so that careers and more attractive work become more available to them. **(N S L)**
- Ratify the Equal Rights Amendment to the Constitution. **(N S L)**
- Modify content of schooling for both girls and boys to remove sex role stereotypes and encourage varied life-choices and life-styles. **(N S L)**

Child Care and Adoption

- Encourage joint efforts of public and private forces "to assure that child-care programs, including health, nutritional and educational components, be available to families who wish to make use of them." This could help to "tap the enormous learning potential of preschool children, and might also work to reduce fertility by offering women who want to work the opportunity to enter or reenter the labor force much sooner than they would be able to otherwise." **(N S L)**
- Subsidize families who wish to and are qualified to adopt children, but are unable to assume the full financial cost of a child's care. **(N S L)**

Immigration

- Maintain the present level of immigration – almost 400,000 a year – because of "the compassionate nature of our immigration policy" and in recognition of "the contribution which immigrants have made and continue to make to our society." However, do not increase these levels. **(N)**
- Halt illegal immigration, which exacerbates many of our economic problems, through an effective enforcement program backed up by tougher federal legislation. **(N S L)**
- Develop comprehensive immigration and emigration statistics by a task force of the Office of Management and Budget to improve registration procedures of noncitizens and provide more information on their distribution and characteristics. **(N)**

Internal Population Distribution

- Develop national population distribution guidelines, including goals, objectives and criteria. **(N)**
- Encourage the growth of selected urban centers in economically depressed regions. **(N S L)**
- "As an alternative to the traditional path to big cities," encourage migration to cities in the 25,000-350,000 population range with "a demonstrated potential for future growth" to 50,000-350,000 people (a growth center strategy). **(N)**
- Increase freedom in choice of residential location by eliminating current patterns of racial and economic segregation, including promotion of bias-free housing in metropolitan areas and assurance by federal and state governments that more housing for lower income groups be built in the suburbs. **(N S L)**
- Provide technical and financial assistance to regional, state and local governmental planning and development agencies. **(N)**
- Develop coordinated programs of education, health, vocational development and job counseling to equip blacks and other deprived minorities for fuller participation in economic life. **(N S L)**
- Reduce the dependence of local jurisdictions on locally collected property taxes to help promote a "more racially and economically integrated society." Instead, taxes should be "raised on the basis of fiscal capacity and distributed on the basis of expenditure needs." **(S L)**
- Establish state or regional development corporations to implement comprehensive development plans. **(N)**
- Anticipate, monitor and evaluate the demographic effects of such governmental activities as defense procurement, housing and transportation programs, zoning and tax laws. **(N)**
- Give more support to the Current Population Survey to improve information on migration and to study ways in which administrative records of federal agencies such as the Internal Revenue Service and the Social Security Administration may be made more useful for developing statistical estimates of internal migration. **(N)**
- Restructure local governments to "reduce overlapping jurisdictions with limited functions and the fragmentation of multi-purpose jurisdictions. . . ." **(S L)**

The Economy and the Environment

- Conserve water resources, restrict pollution emissions, limit fertilizers and pesticides, preserve wilderness areas, protect animal life threatened by man. **(N S L)**
- Develop clean sources of energy production such as nuclear fusion. **(N)**
- Price adequately public facilities and common property resources such as rivers and air, reversing current monetary incentives which work to induce waste and pollution. **(N S L)**

Other Administrative Recommendations

- DHEW's Office of Population Affairs should be strengthened; Congress should establish a Department of Community Development with a population component; an Office of Population Growth and Distribution should be created within the Executive Office of the President; Congress should establish a Council of Social Advisors, one of whose main functions should be the monitoring of demographic variables. **(N)**
- State governments, through existing agencies or creation of new ones, should give greater attention to problems of population growth and distribution. **(S)**