COMMISSION ON IMPROVING THE STATUS OF CHILDREN IN INDIANA

Final Report

Legislative Council Resolution 17-01

November 15, 2017

Commission on Improving the Status of Children in Indiana

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I. DIRECTIVES

Under Legislative Council Resolution 17-01, the Commission on Improving the Status of Children in Indiana (CISC) is requested to study:

(A) Infant mortality and children born with an addiction. (Source: HB 1080-2017 House Motion #1.)

(B) Licensing requirements as barrier contributing to shortage of child care and child abuse providers. (Source: Personnel Subcommittee of the Legislative Council).

II. SUMMARY OF WORK TO DATE

August 16, 2017. The CISC held its regular quarterly meeting, at which it assigned Study Directive A (infant mortality and children born with addiction) to the CISC Child Safety and Services Task Force, in coordination with the Indiana State Department of Health (ISDH); and Study Directive B (licensing requirements as a barrier) to the CISC Mental Health and Substance Abuse Task Force.

September 28, 2017. Leaders from the CISC Child Safety and Services Task Force and the ISDH confirmed that they were working on a report to the CISC to satisfy Study Directive A. This report will be made to the full CISC at its regular meeting on November 8, 2017.

October 18, 2017. The CISC Mental Health and Substance Abuse Task Force heard a report on Study Directive B (licensing requirements as a barrier) from a Task Force subcommittee. The Task Force voted to present a series of recommendations to the full CISC at its meeting on November 8.

November 8, 2017. As part of its regular quarterly meeting, the CISC heard presentations on both Study Directives from the Task Forces to which they were assigned.

For study assignment A, Martha Allen, MSN, RN, NE-BC, Director of Maternal and Child Health at the Indiana State Department of Health, presented the current status of infant mortality in Indiana, infants born exposed to drugs and alcohol, and the current efforts being undertaken by ISDH and the Indiana Perinatal Quality Improvement Collaborative.

For study assignment B, Cathleen Graham, MSW, LCSW, Executive Director of the Indiana Association of Resources and Child Advocacy, presented on certain challenges in the licensing process as barriers to the timely and efficient licensing of master's level-clinicians in Indiana.

III. FINDINGS AND RECOMMENDATIONS

(A) Infant Mortality and Children Born with Addiction.

Findings:

Regarding infant mortality, ISDH reported that:

- Indiana's infant mortality rate has been higher than the national rate for decades. Indiana's rate for babies born in 2015 was 7.3 per thousand, while the national rate was 5.9.
- 613 Indiana babies born in 2015 died before their first birthday.
- There is a significant racial disparity, with Black babies more than twice as likely as White babies to die before their first birthday.
- Risk factors for infant mortality include maternal obesity, maternal smoking, lack of prenatal care, and unsafe sleep practices.
    - If a woman is obese, she has a 25% chance of delivering a preterm infant. Indiana is the 15th most obese state in the U.S.
    - 14.3% of Indiana mothers smoke while pregnant, twice the national rate
    - Only 69.3% of mothers received any prenatal care in the first trimester
- Breastfeeding helps reduce the risk of infant mortality.
- In Indiana, 80.5% of women are breastfeeding upon hospital discharge. For white mothers, the rate is 82% and for Black mothers it is 68.5%.
- ISDH will be releasing a new pregnancy mobile application at the Labor of Love infant mortality summit on November 15, 2017. The app includes helpful information, Indiana resources, and the ability for pregnant mothers to make goals and track their healthy behavior.
- The Indiana Perinatal Quality Improvement Collaborative (IPQIC) is a statewide group of more than 300 stakeholders who serve as an advisory board to the ISDH and have been working collaboratively to reduce infant mortality since 2010.
- For more information on past efforts and future plans, including IPQIC's annual reports, visit http://www.in.gov/laboroflove/.

Regarding infants born exposed to substances and diagnosed with neonatal abstinence syndrome (NAS), ISDH reported that:

- In 2016, ISDH began a pilot project with four hospitals collecting data on babies born with chemicals in their system.
- In 2017, the pilot project expanded to 26 of the state's 89 delivering hospitals.
- In 2018, ISDH plans to spread the established testing, data collection, and treatment practices statewide.
- In the current pilot, the umbilical cords of infants are tested based on a risk assessment algorithm. NOT ALL infants are tested.
- Exposure to a substance is not the same as a diagnosis of NAS. NAS is a diagnosis based on a cluster of symptoms. Not all infants born with substance exposure exhibit symptoms, and when symptoms are present, the diagnosis is not always applied consistently.
- Approximately 16% of infants born in the pilot hospitals had their cords tested
- Of the cords tested, 19.6% tested positive for cannabinoids (marijuana), and 16% tested positive for opiates. The next most common substances present in positive tests were cocaine and buprenorphine, at 3.5% each.
- Key findings of the NAS pilot study to date include the following:
    - Drug of choice varies depending on location

- Comorbidities can affect the outcomes
- There is a lack of treatment programs for mothers
- Care may be interrupted when a referral is made (because OB/GYNs don't specialize in treating substance abuse, and addictions counselors may not have experience with pregnant women)
- Support services are needed during and after pregnancy
- There is a need to change the culture of providers and pregnant women

(B) <u>Licensing requirements as a barrier contributing to a shortage of child care and child abuse providers.</u>

Findings:

The Substance Abuse and Mental Health Task Force of the Children's Commission clarified the study priority as applying to residential child care and child services providers and professional licensing, conducted a survey of child services providers, consulted with experts in the field and with the Behavioral Health and Human Services board. The Task Force reported:

- The provider survey revealed several factors contributing to delays in clinicians obtaining their licenses, including needs for additional paperwork, need to complete additional internship hours, long hold times with IPLA, and paperwork being lost within IPLA and needing to be resubmitted.
- Current law requires 1000 hours of supervised internship work for a Licensed Mental Health Counselor, while most master's programs, at least 30 other states, and the Council for Accreditation of Counseling and Related Educational Programs require just 700 hours of supervised internship for licensure.
- Applicants seeking clinical licensure may be required to seek supervision outside of their agency or geographic area, if their direct supervisor does not hold the same type of license for which they are applying. The ability to use virtual supervision would help ease this burden, particularly in rural areas.
- Since learning of the long wait times and lost paperwork at IPLA, the Task Force was informed that IPLA had added one full-time staff person and modified its telephone protocol so that calls roll over to another representative if a call is not answered within three minutes.

Recommendations:

The Commission voted to endorse the following recommendations provided by its Mental Health and Substance Abuse Task Force:

- Amend IC 25-23.6-8.5-3(2) regarding LMHC licensure to delete "and one (1) advanced internship of three hundred hours…" and replacing wording of "at least one hundred (100) hours of face to face supervision" with "at least sixty-six (66) hours of face to face supervision."
- This amendment will bring Indiana in line with accrediting requirements for many Master's degree programs and with other states' licensing requirements for LMHCs, with 700 hours of internship and 66 hours of supervision during Master's level graduate study.

- Amend IC 25-23.6-5-3.5 (a) to add a sentence “Virtual supervision by a qualified supervisor may account for up to 50% of the required supervision hours.” Add the same language to IC 25-23.6-8-2.7 (b); IC 25-23.6-8-5-4 (b); and IC 25-23.6-10.5-7 (a).
- This amendment will permit those seeking clinical licensure to more easily obtain post-graduate supervision by a qualified supervisor by removing barriers related to distance for up to one-half of the required hours (requirement is 96 -100 hours).