Proposed Minutes
Commission on Improving the Status of Children in Indiana
August 19, 2015, 10:00 a.m. – 1:17 p.m.
Indiana Government Center South, Conference Room C

Members Present: Dr. Jerome Adams, Indiana State Health Commissioner, Indiana State Department of Health; Brian Bailey, Director, State Budget Agency; Indiana Department of Correction; Mary Beth Bonaventura, Director, Indiana Department of Child Services; Michael Dempsey, Director, Department of Correction, Division of Youth Services; Representative David Frizzell; Senator Travis Holdman; Lilia Judson, Executive Director, Division of State Court Administration; Larry Landis, Executive Director, Public Defender Council; Senator Tim Lanane; Susan Lightfoot, Chief Probation Officer, Henry County Probation Department; Danielle McGrath, Deputy Chief of Staff for Legislative Affairs, Office of the Governor; Kevin Moore, Director, Division of Mental Health and Addiction; David Powell, Executive Director, Indiana Prosecuting Attorneys Council; Glenda Ritz, Superintendent of Public Instruction, Indiana Department of Education; Chief Justice Loretta Rush, Chief Justice of Indiana; John Wernert, M.D., Secretary, Indiana Family and Social Services Administration; Greg Zoeller, Indiana Attorney General.

1. Welcome and Introductions. Danielle McGrath opened the meeting. She thanked everyone for attending the meeting and introduced herself as the new chair of the Commission on Improving the Status of Children in Indiana (CISC), replacing Sean Keefer who transitioned out of the Governor's office. The members of the CISC introduced themselves.

2. Approval of Minutes from the May 20, 2015 meeting. The minutes from the May 20, 2015 meeting were approved.

3. Substance Abuse Crisis in Indiana: A Physician's Perspective. Dr. Timothy Kelly (Board Certified in Internal Medicine and Addiction Medicine), Community Health Network. Dr. Kelly started the presentation with a demonstration that established drug addiction is common and treatable. Dr. Kelly pointed out that a quarter of all children in the United States are exposed to alcohol or drug abuse or dependence within their family's immediate environment. The use of alcohol and drugs in the home is linked with poor school performance, delinquency, child neglect, divorce, homelessness, violence, and abuse.

   Up to 80% of incidents of domestic violence are associated with alcohol. Currently, every 25 minutes someone will die from an opiate overdose, and in 2008, opiate overdoses began to exceed motor vehicle accidents as a cause of death in Indiana and in a number of other states. Three years ago, 259 million prescriptions were written for opioids, enough to provide a bottle to every adult in the United States.

   Approximately 80% or more of opioids in the world are consumed in the United States, yet we only have 5% of the world's people. Over 90% of hydrocodone is consumed in the United States, and that is the number one opioid abused on the streets.

Two million people are now addicted to painkillers and over half a million people are addicted to heroin.

One in every twelve high school seniors reported nonmedical use of hydrocodone in the past year and one in twenty reported OxyContin use. As reported in *USA Today*, injection drug abuse has fueled an outbreak of HIV in rural Indiana and has increased the numbers of babies born who must undergo a process to detoxify their bodies from drugs.

There is a nationwide shortage of doctors who are qualified to provide substance abuse treatment. Addiction costs nearly $468 billion a year; however, only two cents of every dollar spent on addiction goes to prevention. The rest goes to hospital care, jail, courts, etc. Studies show that treatment and prevention costs are effective. Every dollar invested saves four to seven dollars in fewer drug related crimes.

Addiction is a primary chronic illness like hypertension, diabetes, asthma, and schizophrenia, with genetic psychological and environmental factors contributing to its development and manifestations. The disease is often progressive and fatal. Drug addiction manifests as a compulsive drive to take a drug despite its adverse consequences. Drug addiction is often viewed as a bad "choice" and a moral failure. Drug abuse is characterized by an intense desire for the drug combined with an impaired ability to control that urge even in the face of adverse, catastrophic consequences (e.g. incarceration, loss of child custody, loss of medical license, etc.) and denial. These symptoms may be continuous or periodic. Adoption studies indicate that DNA, rather than an individual's environment cause 40 to 60% of cases of addiction. Chronic drug use changes the brain. The changes in the brain are long-lasting and persists for years after drug use has been discontinued.

Drugs can be abused for various reasons, including the experience of pleasure, altered mental states, improved performance, to self-medicate a mental disorder, curiosity (novelty seeking), and risk-taking and peer pressure. The repeated use of psychoactive/addictive drugs in vulnerable individuals can result in addiction.

Science (including brain imaging) suggests that addictive individuals suffer from a progressive functional and structural disruption in brain regions that underlie the normal processes of motivation, reward, and inhibitory control. Although initial drug and alcohol experimentation and recreational use is typically voluntary, once addiction develops, behavioral control becomes markedly disrupted.

Normal adolescent behaviors (risk-taking, novelty-seeking, and heightened sensitivity to peer pressure) increase the likelihood of experimenting with legal and illegal drugs and make teens vulnerable to addiction. This in part reflects incomplete development of brain regions that are involved in executive control and motivation. Drug use in adolescence seems to result in brain changes that differ from those occurring during adulthood.

Patients with substance use disorders receive poorer quality care than patients with any other common chronic condition. Most patients do not receive treatment, and medications are particularly under-utilized. Patient-centered care and decision-making are essential for high quality mental health and substance use disorder treatments. There are four effective individual behavioral health treatments, including cognitive behavioral therapy, behavioral couples' therapy, twelve-step facilitation, and motivational enhancement. The disease of addiction is largely treated like an acute disorder, but addiction is not an acute illness, it is a chronic relapsing condition that is highly treatable. Addiction is more like diabetes, hypertension, schizophrenia, that needs long term care, not just punctuated episodes of acute care. Current challenges with addiction treatment include a shortage of trained physicians and nurses, training deficiencies, and high turnover rates.

The Chronic Care Model (CCM) of treating addiction is a long-term, proactive strategy involving multidisciplinary teams. The ultimate goal is to teach the patient and his/her family motivational skills, as well as how to acquire the supports necessary for ongoing self-management of this chronic disease. This is similar to diabetes management. Rather than providing reactive, acute episodes of expensive hospital care following a disease relapse, the CCM is proactive, innovative, and more effective. It is more appreciated by patients and caregivers and does not appear to cost more than traditional care.

Tools for recovery include accountability, medications (for alcohol, opiates, nicotine), mutual support/twelve-step groups, counseling, lifestyle (exercise, eating right, avoiding smoking), service work, spirituality, and positive social support networks. Factors that have led to the current prescription drug abuse epidemic include: a liberalization of opioid therapy for chronic pain; newer, more potent opioid drugs; demand on primary care providers; societal attitudes (drug commercials); parents and health care providers who are often told that addiction is rare, typically less than 1% (actually 30-40%); and, minimal screening/evaluation for addiction.

Red flags that an individual may become addicted include smoking, a family history of addiction, a personal history of substance abuse, active or recent use of illicit drugs, and excessive use of alcohol. Other indicators include: a major psychiatric disorder or personality dysfunction; one who insists on being on multiple classes of controlled substances; a patient who is allergic to, cannot tolerate, or is not interested in non-addictive medications/approaches; a patient who has lots of chaos in his or her life and who never seems to really improve; one whose pain and anxiety are always high; patients who report being or who appear to be intoxicated; patients who require high doses; survivors of preadolescent sexual abuse; poor family support; poor reliability; missed appointments; lost or stolen prescriptions; multi-sourcing; using street names for drugs; a lack of objective findings; and, a vague or unsubstantiated diagnosis.

Doctors should assess each patient for psychiatric illness, addiction, medical co-morbidities, and chronic pain up front when they first start treating a patient who potentially may need pain medication.

Opiates are used to improve function and relieve pain. Studies of functioning and quality of life for patients on strong opioids, lower or weak opioids, and no opioids show that people who take no opioids for chronic pain have the highest functioning and quality of life, while people on strong opioids have the lowest quality of life and functioning. Sedatives and opiates should not be combined, because together they cause cognitive impairment, depression of mood, falls, the worsening of internal pain perception and function capacity.

To improve outcomes, guidelines should be developed and physicians should monitor and screen for alcohol and drug abuse problems. There should be an upper limit established for dosing and written care agreements. Additionally, physicians should keep track of red flags, consider controlled substance medication as a trial (short-term), use statewide prescription monitoring systems (INSPECT), stop chronic opiates in response to red flags, observe universal precautions, avoid simultaneous and chronic use of multiple classes of controlled substances, focus on function, and get the family involved.

Heroin is a trade name of the Bayer Corporation. Heroin is easily accessible and cheap. Over the last four to five years, heroin deaths have increased by 45% and are highest among the poor. In general, overdose death rates have more than tripled since 1990. The Centers for Disease Control (CDC) considers prescription drug addiction an epidemic. Indiana ranks 17th in overdose deaths. One in five Indiana adolescents admits to abusing pills.

Medication-assisted treatment for opiate addiction is now the standard of care. It is the most effective treatment, but should not be a stand-alone treatment. There are three types of medication-assisted treatment: Methadone, Buprenorphine, and Naltrexone. Medication assisted treatment is supported by the World Health Organization, United Nations, Hazleton, Cleveland Clinic, American Society of Addiction Medicine, and many others.

Detoxification from opioids without pharmacological support afterwards remains the dominant model of treatment, despite decades of experience and evidence to the contrary. The first few weeks following detoxification comprise the most dangerous phase of opioid dependence, with a significant risk of overdose and death. Pharmacologic assistance to prevent overdoses is essential during this period. Experts in the field of addiction medicine estimate that people need one and one-half to two years to establish the behaviors and thinking patterns of recovery necessary to replace the behaviors and thinking patterns of active addiction.

Addiction is a treatable disease and is extremely common. We are in an epidemic and people are dying at an alarming rate (including people in the prime of their lives). Many people want to get better, but lack an effective or realistic strategy and/or access to care. In 2013, 316,000 people tried and failed to get treatment.

Attorney General Zoeller asked Dr. Kelly if there were any studies predicting the outcome later in life of babies born with Neonatal Abstinence Syndrome (NAS). Dr. Kelly responded that since the babies are born to an addict, their risk of developing a drug addiction in later life is four times higher than the general population. Dr. Adams noted

that the Indiana State Department of Health is asked that question as well, and one of the problems with answering it is that there is not a uniform definition of NAS. Medical data suggest that the risk is more related to genetic predisposition and the environment, which is a more important indicator than the fact that a baby was exposed in utero.

Dr. Adams stated there is confusion in the state about coverage for medication-assisted treatment. Dr. Warner added that there is confusion around methadone maintenance because that is a federal program, which requires a federal license. The liquid form of methadone is not covered by Medicaid, but Medicaid does pay for the ten-milligram methadone tablet for pain. The other two classes of drugs used for medication assisted treatment are fully covered. The problem of course, is who is prescribing it, and whether they are prescribing it appropriately, because these particular compounds are very expensive.

Kevin Moore remarked that the Division of Mental Health and Addiction experiences a challenge with finding social workers, psychiatrists, and physicians who are adequately trained in addictions. Dr. Kelly suggested incentivizing addiction training. Attorney General Zoeller noted that the legislature did enact a program to incentivize training, and that some of the monies the state receives from cases against pharmaceutical companies with off-label marketing is used for that program.

David Powell pointed out there are two aspects to this issue, public health and public safety. Dr. Adams observed that the federal government offers grants to states to encourage them to pair the public health community with law enforcement community. Public health and public safety must work in concert, but public safety wins the minds and hearts of the citizens. Dr. Wernert remarked that many people have the philosophy that people who use drugs have a personality flaw or a weakness, rather than a chronic brain disease that needs stable treatment.

Chief Justice Rush asked if there are best practices for physicians in the field of addiction treatment. Dr. Kelly responded affirmatively, but he does not know they involve special training, other than for physicians who become certified buprenorphine prescribers.

Dr. Wernert commented that in addition to the best practices, we need to have intensive outpatient programs, outpatient counseling programs, family support programs, A.A. and twelve-step support programs, medication-assisted therapy, and progressive thinkers all working together. Mental health centers have some capacity, but fill up very quickly. The large health systems need to get involved. We are trying to develop a more comprehensive approach, but it is a slow process; service providers are unable to handle high volume of patients, especially in rural areas.

Larry Landis asked Dr. Kelly if he had a list of recommendations for the Commission concerning policy changes. Dr. Kelly responded that the Commission has touched on a number of them today. One would be to look at funding to improve treatment, and to find ways to train people in primary care to learn more about not only how to treat people with

addictions, but also how to identify them. Dr. Kelly agreed to submit his recommendations in writing to the Commission.

4. Report from the Governor's Adoption Study Committee. Jane Bisbee, Indiana Department of Child Services, and Sharon Pierce, President and CEO, The Villages. Ms. Bisbee and Ms. Pierce reviewed the 2015 Final Report of the Governor's Adoption Study Committee. This Committee was established by the Governor in 2014 pursuant to House Enrolled Act 1222. The Committee met six times between August 2014 and May 2015. The final report and recommendations have been presented to the Governor. First, the Committee recommends an adoption brochure that will help articulate and promote post-adoption services. The brochure would ensure all adoptive families in Indiana know that post-adoption services are available to them. Second, the state should develop a social media campaign and other adoption awareness efforts. The two juvenile judges on the Committee emphasized the effectiveness of adoption fairs and pointed out that several juvenile judges have participated in National Adoption Day activities. Ms. Pierce also pointed out that the Governor and First Lady have established November as Adoption Awareness Month. The third recommendation pertains to fingerprints for adoptive parents. A potential barrier to adoption exists for foster families who wish to adopt children already in their care. These families must pay to be fingerprinted in order to be foster parents, and they must go through the process again when they choose to adopt. This financial burden could discourage families from adopting, and it is the Committee's recommendation that DCS absorbs the cost for the fingerprinting process for families who wish to proceed with an adoption. Fourth, the state should create a more permanent body to continue to study and advocate for adoption. The Committee was intentionally created to be a temporary, targeted effort to identify unnecessary barriers to adoption and offer solutions to make Indiana more adoption friendly. While strides have been made over the past twelve months, the Committee has also discovered several potential barriers to adoption that require more time and resources to address. Therefore, the Committee recommends that efforts continue to identify potential barriers and potential resolutions, and that these efforts be spearheaded by the CISC. Suggested items that the CISC might assess could include, but are not limited to, identifying barriers to adoption; assessing gaps in data; gathering data on best practices; reviewing Indiana's adoption statues and making recommendations for improvements; providing better information on the differences between birth certificates and delayed birth certificates; and, evaluating whether there is a more efficient way to provide adopted children with necessary records of identification needed for other types of government identification. Finally, the Committee recommends that the state continue to provide post-adoption services in order to encourage adoptions and to continue to support those who have helped our most vulnerable children find permanent, safe, and loving homes.

   Dr. Adams asked if the Committee looked at the cost of adoption. Ms. Bisbee responded that it is one of the subjects that the Committee touched on, but they did not delve into individual situations.

   Ms. McGrath thanked the Committee members for their time, effort, and recommendations. She said the recommendations are all actively under consideration not only by the CISC,

but also by the Governor. The Commission took the recommendation to create an adoption study task force under advisement.

5. Underreporting of Crimes of Domestic Violence or Sexual Assault. Representative Christina Hale and Dr. John Parrish-Sprowl, Director, Global Health Communication Center, IUPUI School of Liberal Arts. Representative Hale provided a context for the study: the Centers for Disease Control conducts a biannual study. The 2008 study indicated that Indiana is the second worst in the nation for sexual assaults of children. In fact, nearly one in six Hoosier girls are sexually assaulted by the time they are in high school (and an untold number of boys, because that data had not been tracked). The first step of the study was to gather more information in order to discover the issues. The Criminal Justice Institute awarded a grant that covered part one of the study, which does not include everything that the legislation directed, but which does give some insight into what else we might want to know, and what direction we may want to take in the future.

   Dr. Parrish-Sprowl indicated Indiana has the second-highest rate of forced sexual intercourse among high school females in the nation. Approximately one in five girls will be sexually assaulted by the age of 18. Indiana does not aggregate the data necessary for tracking adolescent sexual assault, making it difficult to formulate policy and programs effectively. Underreporting contributes to the problem. It leads to understating the problem, to de facto protection of (and tacit support for) perpetrators, and to a disconnect between victims and services.

   This study focused on the issue of underreporting. It is well known that feelings of shame, guilt, and fear might be reasons not to report being a victim of sexual assault. If the person somehow finds the courage to report, even while experiencing such devastating feelings, it is important that the process be one that is both encouraging and affirming.

   Should the reporting process prove too difficult, unnecessarily unpleasant, or even re-traumatizing, the victim is less likely to report, leaving him or her to silently suffer with the aftereffects of the assault. This may or may not influence the perpetrator's choice to assault in any given instance, but a dysfunctional reporting process certainly does not contribute to any sense of deterrence. While silence may be the best protection for perpetrators, it can and often does have serious long-term negative consequences for victims.

   The study methodology included a review of the CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) survey, a survey of teachers focusing on their observations and interactions regarding students and sexual assault, focus groups with people who work with adolescents (including teachers, forensic nurses, and staff from afterschool programs), individual interviews with service providers and physicians, and GIS mapping of Indiana Criminal Justice Institute (ICJI) reimbursement for sexual assault service data.

   With respect to the ACE survey, 25.6% of respondents reported that prior to age 18; someone had touched or fondled their body in a sexual manner, with 85% of them saying that it was against their wishes. Only 18.4% of those who indicated that they had been

sexually assaulted reported this to a doctor, nurse, or other healthcare professional. This suggests for every sexual assault reported in the state, there could be as many as four times more that are not reported.

Underreporting is high and a significant part of the problem. The ACE survey is designed to look at the long-term consequences of adverse childhood experiences. People who are sexually assaulted have higher incidences of substance abuse, relational problems, professional problems, and other kinds of issues that affect their lives. There are economic, social, and human consequences for the entire state of Indiana.

Of those disclosing assaults in the ACE study, 29.5% reported that a person who lived in their home was involved (20.9% of perpetrators were relatives); 51.4% of assaults involved a family friend or person they knew who did not live in their household; 75% of assaults involved someone they trusted; 62.5% involved verbal persuasion or pressure to get them to participate in sexual experiences; 10.5% involved threats to harm them if they did not participate; 34.2% were physically forced or overpowered to make them participate; 28.9% were given alcohol or drugs; and, the median age of the sexual assault victim was nine to ten years old.

Schools are a logical and likely locus for reporting. Teachers generally understand their duty to report, but for many reasons they are often reluctant to get involved. Teachers are also reluctant to talk about the topic (especially with males). The process of reporting is often not clear to students or teachers. Both students and teachers may be reluctant to report for fear of repercussions. Some teachers see the system as reactive, but think it should be proactive (i.e., we require reporting of the crime but not education regarding it). Teachers are often told not to talk about the topic of assault and abuse. Male teachers are often afraid to have such conversations with female students. Students are often willing to have the hard conversations if given the space to do so. Teachers observe abuse within adolescent couples. Finally, mapping of ICJI data demonstrates that this is a statewide problem, not simply regional, urban, or rural.

Dr. Parrish-Sprowl presented the following recommendations: 1) create a process for reporting and a repository for all data relating to adolescent sexual assault in the state. This effort should be proactive, ongoing, and integrative. It should include data from law enforcement, ICJI, and other relevant sources to provide a comprehensive picture of adolescent sexual assault across the state. 2) Teachers should receive training regarding both the short and long-term consequences of sexual abuse and assault, how to recognize the signs, how to have reporting conversations that encourage adolescents to disclose, and how to get them connected to necessary support services. 3) Students need a multi-year curriculum that focuses on how to develop and maintain healthy relationships, as well as the full range of issues that young people face as they enter into such relationships, including choices about sexual activity, managing conflict, and dating violence. 4) Indiana needs to develop a coherent and comprehensive policy that assists victims of sexual assault when social media are involved. 5) The state should explore a policy that includes restorative justice models as an option in adolescent sexual assault cases. This could encourage reporting and successful mitigation of consequences in many cases. 6) Schools

and afterschool programs need trained adults to facilitate discussions with adolescents related to sexuality and relationships. Students need to learn to have informed and thoughtful discussions around this topic. There are a number of programs around the world and in this country that could be useful to look at, but that requires another study. The recommendations presented do not solve the problem, but they can make inroads.

Representative Frizzell asked if the perpetrators of these crimes have been sexually abused themselves in their lives, and if so, what is the percentage. Representative Hale responded that was not studied.

Attorney General Zoeller commented that at some point, Indiana is going to have to look at whether to continue to have two different organizations, one for domestic violence, and one for sexual assault. He asked if Representative Hale and Dr. Parish-Sprowl could incorporate some review to help with this decision. Representative Hale suggested that since this is such a big topic, and because there's so much that we do not know, there really needs to be one entity taking responsibility for this issue, to think through all these different angles, to determine where our law is inadequate, etc.

6. Report on the "Cross Systems Youth Symposium" held on July 24, 2015. This topic was tabled until the next meeting.

7. Open Discussion. Superintendent Ritz reported at the last CISC meeting that she planned to assemble a committee to talk about surveys that were happening in the schools. She said Senate Enrolled Act 500 calls for the appointment of a committee to streamline data collection and surveys within schools, so this will be a topic for that committee to address.

   Director Bonaventura reported that the Governor authorized the Department of Child Services to hire 113 additional family case managers. All 113 of those positions have been created, and DCS is identifying qualified candidates. The authorization to hire the additional family case managers occurred in response to a 26% increase in CHINS cases across the state. Director Bonaventura expressed her appreciation to the legislature and the Governor for their support. Larry Landis raised the issue that the 26% increase in CHINS cases has caused a crisis in the indigent defense system. The increase in CHINS filings results in an increased need for indigent counsel. Counties are struggling to try to figure out how to provide that representation, because that is an unfunded mandate on county government.