



Meeting Record

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

June 21, 2016 | 12:30 p.m. – 4:30 p.m. | Richmond State Hospital | Richmond

Facilitators:

John Hill, Office of the Governor
Dr. John Wernert, Indiana Family Social Services Administration

Task Force Members Present:

Superintendent Doug Carter, Indiana State Police
Judge Roger Duvall, Scott County Circuit Court
Representative Wendy McNamara, Indiana House of Representatives
Commissioner Bruce Lemmon, Indiana Department of Correction
Bernard Carter, Lake County Prosecutor
Senator Jim Merritt, Indiana State Senate
Dr. Jerome Adams, Indiana State Department of Health
Mary Beth Bonaventura, Indiana Department of Child Services
Representative Terry Goodin, Indiana House of Representatives
Dan Miller, Indiana Prosecuting Attorneys Council
Senator Jim Arnold, Indiana State Senate
Dr. Tim Kelly, Community Health
Sheriff John Layton, Marion County Sheriff's Department

Others Present:

Staff Support to the Task Force

Veronica Schilb, Office of the Governor
Adam Baker, Indiana Criminal Justice Institute
Devon McDonald, Indiana Criminal Justice Institute
David Murtaugh, Indiana Criminal Justice Institute
Diane Haver, Indiana Judicial Center

Task Force Members Absent:

Chief Michael Diekhoff, Bloomington Police Department
Dr. Joan Duwve, Indiana State Department of Health
Dr. Joseph Fox, Anthem, Inc.
Tony Gillespie, Indiana Minority Health Coalition
Judge Wendy Davis, Allen County Superior Court
Justice Mark Massa, Indiana Supreme Court
Dr. Charles Miramonti, Indiana University Medicine/Indianapolis EMS
Reverend Rabon Turner, Sr., New Hope Missionary Baptist Church

Meeting Summary:

- The Task Force was informed of the negative impacts that have occurred as a result of the legalization of marijuana in the state of Colorado.
- A native to Union County, Indiana presented to the Task Force on the opiate crisis faced in their small town and the benefits of the Bridge device in efforts to combat opiate addiction.
- A motion passed for the Task force to endorse the recently developed acute pain prescribing guidelines.

Welcome:

John Hill and Dr. Wernert welcomed and thanked the Task Force members in attendance. John Hill directed the attention of the Task Force members to the handouts addressing President Obama's budget proposal relative to the opiate crisis across the nation. Accordingly, Indiana would be eligible for up to 19 million dollars over a two-year period to address the opiate epidemic within our state.

Presentations:

Impact of Marijuana Legalization in Colorado Thomas Gorman, Rocky Mountain HIDTA

Mr. Thomas Gorman began his presentation by touching on the war on drugs and the notion of drug use being a victimless crime. He noted that there are actually four classes of victims correlated with drug use - the user, the family and friends of the user, the taxpayers, and any victim of crimes that occur as a result of addiction. Due to the devastating impact of drug use on people, drug policy aims to reduce the number of people using drugs. Mr. Gorman noted that most users were first introduced to drugs by family.

Mr. Gorman pointed to four primary factors that affect the rate of drug use. First, the affordability of the drug will impact use. For example, opiate addiction will often begin with the use of prescription drugs, but heroin is less costly, thereby increasing use. Second, the availability of the drug impacts use by the amount of time it may take the user to acquire the drug. Third, the perception of risk impacts drug use. An individual who uses drugs may take into consideration how a particular drug will impact him or her physically and mentally. Additionally, the user's choice may be impacted by their family's perception of particular drugs. Finally, public attitudes impact use. Societal tolerance has an influence on individual use.

The impact of the four primary factors was explained through a detailed examples of acceptance and unacceptance. Mr. Gorman reported alcohol as being the worst drug as it creates broken homes and may cause death. When comparing alcohol to the four primary factors that affect the rate of use, the linkages are high. Alcohol is affordable, readily available, the perception of risk is relatively low, and public attitude is relatively positive. Comparatively, efforts in reducing the use of tobacco have been extremely successful. The price has been driven high and availability has been reduced. Public attitudes about smoking have shifted as negative opinions have developed and the risk is known to be dangerous. Government used drug policies and techniques to decrease tobacco use. Mr. Gorman noted that marijuana campaigns should model the anti-tobacco efforts. Relative to the legalization of marijuana in Colorado, people are in the business to make money and young people are the target group. Slide 17 illustrates a brief business profile for the state of Colorado. As noted, 322 Starbucks and 202 McDonalds locations are operating across the state. Comparatively, 424 recreational marijuana shops are currently in operations since the legalization of the drug. Consequently, a Denver homeless shelter has recorded a 500% increase in need while the Salvation Army has recorded a 33% increase in clients between 2013 and 2014. Additionally, citations for consuming marijuana in public have increased from 184 citations in 2013 to 752 citations in 2015. The numbers for impaired driving cases involving marijuana are alarming as well. In 2015 there were 862 impaired driving cases by which 665 of those cases involved marijuana.

Since 2009, the year marijuana was commercialized, traffic fatalities related to marijuana climbed from 47 cases to 94 cases in 2014.

Slide 39 marks the levels of marijuana use among youth in Colorado. While national numbers have indicated a 5% decrease in marijuana use among youth ages 12 to 17, Colorado has seen an increase by 20% among the same population. Colorado is currently ranked number one in the nation for current marijuana use among youth at a 74% higher rate of use when compared nationally. School expulsions have climbed since the commercialization of marijuana. In 2009, 25.6 percent of expulsions were due to drug violations while 3.2% of expulsions were due to alcohol violations. By 2014, that percentage climbed to 41.9% of expulsions as a result of drug violations while only 2.7% of expulsions were due to alcohol violations.

Slide 52 illustrates the increase in emergency department cases that are likely related to marijuana, which increased from 313 cases in 2011 to 554 cases in 2014. The influx of marijuana in other states has become an unintended consequence as a result of the legalization of marijuana in Colorado. Marijuana can be sold in other states for two times the amount of its Colorado retail value. Since 2009, interdiction seizures of marijuana increased from 92 cases to 360 in 2014. Many proponents for the legalization of marijuana would argue that the state may benefit from the collection of taxes. Slide 62 indicates that only .7% of Colorado's total general fund revenue is derived from the marijuana tax revenue. Slide 64 pin-points the results of legalizing marijuana in Colorado:

- Increase in marijuana-related traffic violations
- Increase in marijuana-related traffic deaths
- Increase in youth marijuana use
- Increase in college marijuana use
- Increase in adult marijuana use
- Increase in marijuana-related ED admissions
- Increase in marijuana-related hospitalizations
- Increase in marijuana-related exposures
- Decrease in marijuana-related treatment (and)
- Decrease in THC extraction laboratories

Mr. Gorman noted to the Task Force that Colorado crime has increased, but the causes of the increase have not yet been identified.

Union County Continuum of Care Drug Addiction Program Jeff Mathews, Union County Opiate Treatment Center

Mr. Jeff Mathews presented to the Task Force on steps Union County, Indiana is taking to combat drug addiction. He noted that their community is the second smallest county in Indiana and funds are limited. Their small county jail recently housed a total of 16 inmates, all of whom were booked in on a drug-related offense. Drug use has negatively impacted their small community. The local drug addiction program facility, the Union County Health Clinic, is open four hours a week with the assistance of a retired nurse practitioner volunteer. They have partnered with two treatment facilities, Center Stone and Meridian, to conduct assessments on individuals seeking help.

The Union County Health Clinic has begun using the Bridge device almost two months ago with great success. Created by Innovative Health Solutions, the Bridge is installed behind the ear and will send electrode signals to the brain, which help taper the withdraw effects of opiates. The device may be used for up to five days to assist the client in pulling through the withdrawal period. The device minimizes fever, body aches, convulsions, and other violent responses due to opiate withdraw. It is a non-narcotic

pain reliever. Mr. Mathews noted that the Bridge is a tool, not a cure for addiction. Its purpose is to assist the client through the withdrawal period so that he or she may begin recovery with Naltrexone or Vivitrol in conjunction with a full assessment and treatment. Mr. Mathews noted that addiction specialists may see better results with recovery if their patients are provided the bridge to minimize withdraw symptoms in order to advance into treatment. The cost of one unit is \$495 and is usable one time for a period of five days. Because the product is new, the unit is not covered under any insurance programs, but Mr. Mathews feels strongly that it should be covered.

Dr. Jerome Adams, Indiana State Department of Health

Dr. Jerome Adams reminded the Task Force that the State Department of Health has been working with stakeholders to come up with acute pain prescribing rules. They will continue with the efforts. Dr. Adams noted that Brian Tabor with the Indiana Hospital Association and his team developed a series of guidelines for acute pain prescribing rules. There is strong consensus supporting the guidelines. Mr. Tabor explained that this is only one phase in response to the recommendation of the Task Force. They will develop informative webinars for greater enhancement and understanding of the guidelines and also draft handouts to provide to physicians and hospitals. The guidelines are a robust effort towards safe prescribing practices.

Motion by Dr. Adams, seconded by Senator Merritt for the Task Force to endorse the established guidelines on acute pain prescribing practices. Motion passed.



Meeting Agenda

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

June 21, 2016 | 12:30 p.m. – 4:30 p.m. | Richmond State Hospital | Richmond

- 12:30 p.m. – 12:35 p.m. Welcome**
John Hill & Dr. John Wernert, Co-Chairs, Governor's Task Force on Drug Enforcement, Treatment, and Prevention

- 12:35 p.m. – 1:35 p.m. Tour of Richmond State Hospital**

- 1:35 p.m. – 3:05 p.m. Impact of Marijuana Legalization in Colorado**
Thomas Gorman, Rocky Mountain HIDTA

- 3:05 p.m. – 3:45 p.m. Union County Continuum of Care Drug Addiction Program**
Jeff Mathews, Union County Opiate Treatment Center

- 3:45 p.m. – 4:30 p.m. Task Force Discussion**



Speaker Bios

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

► Thomas J. Gorman, Rocky Mountain High Intensity Drug Trafficking Area Director

In 1968 Director Gorman graduated from San Jose State University and joined the California Bureau of Narcotic Enforcement. He served ten years as an undercover agent. He made 1,000 undercover purchases and received two Purple Hearts from being shot and later stabbed.

He was promoted in 1990 to deputy chief in charge of statewide drug enforcement operations. In 1997 he retired to become the director of the Rocky Mountain HIDTA.

Director Gorman is a graduate of the FBI National Academy and is past president of the California Narcotic Officers Association and the National Alliance of State Drug Enforcement Agencies. He is currently president of the National HIDTA Directors Association. He authored *The Myths of Drug Legalization* and *Marijuana Legalization: The Issues*. He authored a recently published book titled *To Believe or not Believe, That is the Question - An Undercover Agent's Quest for the Truth*.

► Jeff Mathews, Union County Opiate Treatment Center

Jeff Mathews is a retired U.S. Navy Officer. He served on the USS Thomas Jefferson SSBN-618/SSN-618, USS Sea Devil SSN-664 and USS Grayling SSN-646. He retired in 1998 as Command Master Chief Submarine Squadron Support Unit Groton. Mr. Mathews started a technology business, which he sold and retired from in 2011. He is currently the Area Plan Director in Union County. He coached wrestling for 15 years and currently is the varsity baseball coach at Union County High School.

INDIANA

Drug Poisoning Death Rate per 100,000, by County, 2010-2014



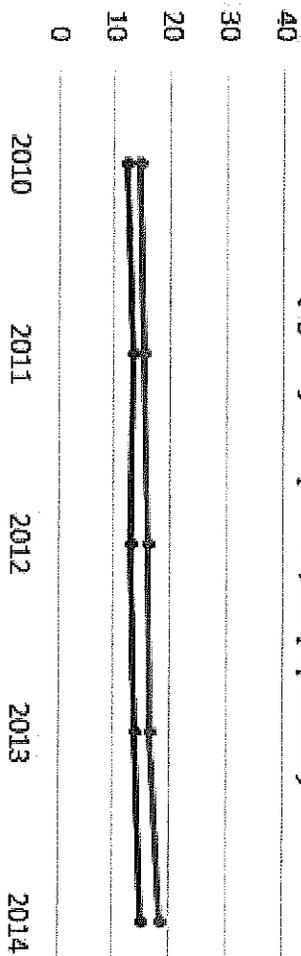
Annual Avg. Drug Poisoning Death Rate per 100,000 population

- ||||| suppressed
- ||||| unref-able
- 50 or less
- >50.0 to 60.0
- >60.0 - 15.0
- >15.0

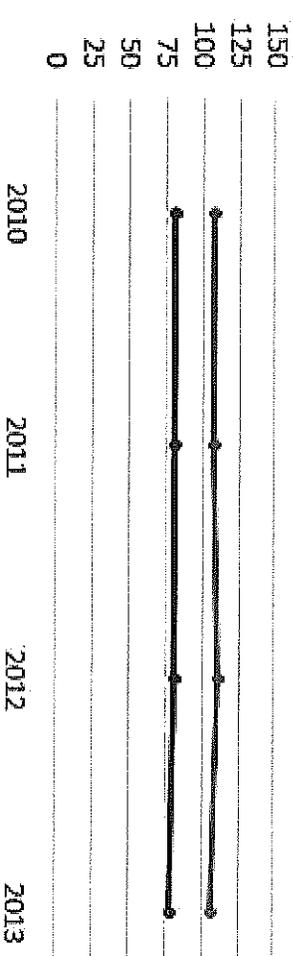
Source: CDC NIVSS Multiple Cause of Death File, 2010-2014

Age-Adjusted Drug Poisoning Death Rate (2014): 18.2 per 100K population
 (Avg. National Rate: 14.7)
 National Rank in Drug Poisoning Death Rate (2014): 15th (tied with AZ, MO)

Drug Poisoning Death Rate by State and National
 (age-adjusted per 100,000 population)



Annual rate of opioid pain reliever prescriptions dispensed by retail pharmacies (per 100 population)

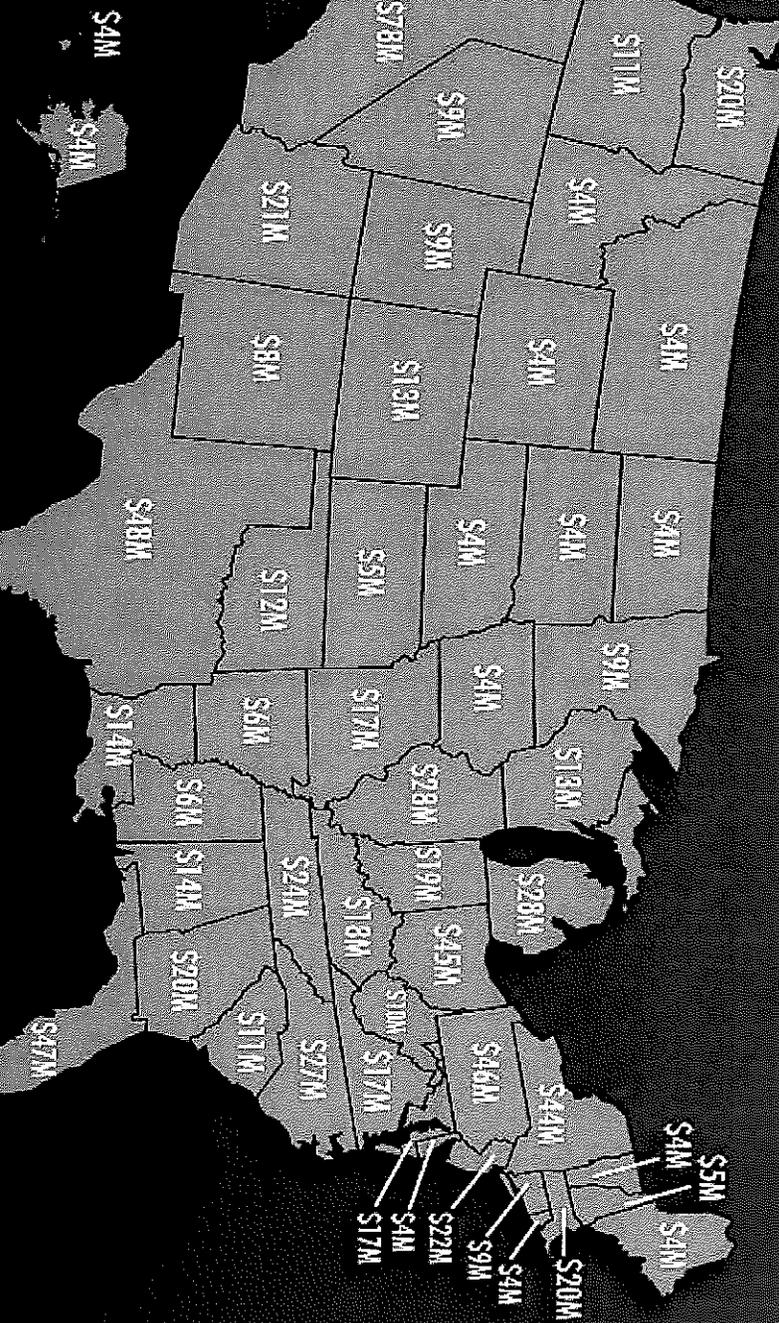


Source: IMS Health

Under the President's budget proposal, Indiana would be eligible for up to \$19 million dollars over 2 years to expand access to treatment for opioid use disorders.

*The final funding amount will depend on Congressional action and the strength of the State's application and plan to combat the epidemic.

PRESIDENT OBAMA'S BUDGET WILL INVEST \$1.1 BILLION TO HELP ADDRESS THE OPIOID EPIDEMIC



*The final funding amount will depend on Congressional action and the strength of the State's application and plan to combat the epidemic

THE WHITE HOUSE

Office of the Press Secretary

EMBARGOED UNTIL 4:00PM ET ON TUESDAY, JUNE 14, 2016

White House Releases Estimated State Opioid Treatment Funding Levels under President's Budget Proposal

Today, as Congress continues to consider legislation related to the prescription opioid and heroin epidemic, the White House released the estimated amount of funding each State could qualify for under the new cooperative agreements proposed in the President's Budget to expand access to opioid treatment, particularly medication-assisted treatment. Under the President's \$1.1 billion proposal to help Americans with opioid use disorders who want treatment get the help they need, States would receive funding based on the severity of the epidemic in their communities and the strength of their strategy to respond to it. The final funding amounts will depend on these factors and Congressional action.

The President has made clear that addressing this epidemic is a priority for his Administration. Without the resources necessary to prevent opioid use disorders and increase access to treatment and recovery services, pending legislation would do little to help the thousands of Americans struggling with addiction get the treatment they urgently need.

The President's Budget builds on current Administration strategies to prevent drug use, pursue targeted drug enforcement activities, improve prescribing practices for pain medication, increase access to treatment, work to reduce overdose deaths, and support the millions of Americans in recovery.

For example:

- The Substance Abuse and Mental Health Services Administration released a proposed rule to expand access to opioid treatment by increasing the number of patients physicians can treat with the opioid use disorder treatment medication buprenorphine.
- The President signed a memorandum requiring Federal Departments to provide training on appropriate opioid prescribing to Federal health care professionals and requiring Departments to develop plans to address barriers to opioid use disorder treatment in Federal programs.
- The Health Resources and Services Administration released \$94 million in new funding to 271 Community Health Centers across the country to increase substance use disorder treatment services, with a specific focus on expanding medication-assisted treatment of opioid use disorders in underserved communities.
- The Centers for Disease Control and Prevention (CDC) released a new Guideline for Prescribing Opioids for Chronic Pain. Following its release, hundreds of medical, nursing and pharmacy schools have committed to prescriber training for their students.
- CDC expanded the Prescription Drug Overdose program to support prevention efforts in 29 States to help end the prescription drug overdose epidemic.

- The Office of National Drug Control Policy expanded its heroin initiative among regional High Intensity Drug Trafficking Areas (HIDTAs) by adding Ohio and Michigan to the effort. These States join the Appalachia, New England, Philadelphia/Camden, New York/New Jersey, and Washington/Baltimore HIDTAs in accelerating local partnerships between law enforcement and their counterparts in public health to combat heroin use and overdose.
- The Drug Enforcement Administration (DEA) held its 11th **National Prescription Drug Take-Back Day** in April, providing a safe, convenient, and responsible way of disposing of unneeded prescription drugs. Millions of pounds of medication have been collected over the last ten Take Back Days. Local communities are also establishing ongoing drug take-back programs.

The State-by-State breakdown of the President's requested funding can be found here:

<https://www.whitehouse.gov/factsheets-prescription-opioid-abuse-and-heroin-use>

• GOVERNOR'S •
TASK FORCE
 on Drug Enforcement,
 Treatment & Prevention



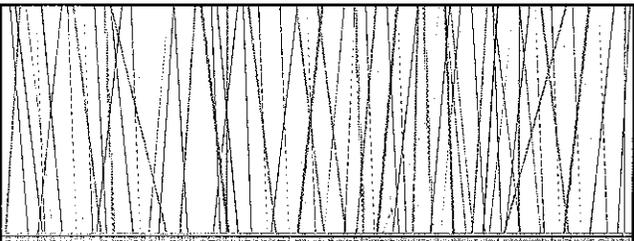

www.rmhidta.org
 click on
 "Reports"

***Drug Policy and
 Legalization of
 Marijuana in
 Colorado***

Thomas J. Gorman, Director
 Rocky Mountain High Intensity Drug Trafficking Area
www.rmhidta.org
 2016



**Has the "War"
 on Drugs Been
 a Failure?**



Drug Policy 101



Questions

- ✓ What is the purpose of drug policy?
- ✓ Isn't drug use a victimless crime?

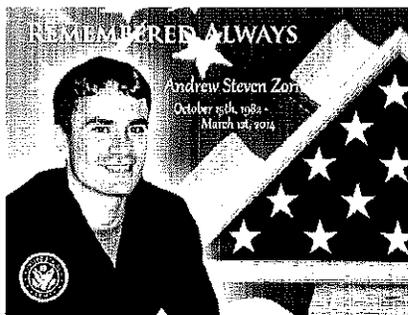
Answers

- Purpose of Drug Policy
 - Limit the number of people using drugs
- Victimless Crime?
 - Four classes of victim:
 1. User
 2. Family/Friends
 3. Victim of Crime
 4. Taxpayers



Answer

- Factors Affecting Rate of Drug Use
 - Four primary factors:
 1. Price
 2. Availability
 3. Perception of Risk
 4. Public Attitude



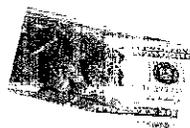
Drug "War" a Failure

Question...

What would it take for you to consider our drug policy successful?

Question

What are the factors that affect the rate of drug use?



2014 National Survey on Drug Use

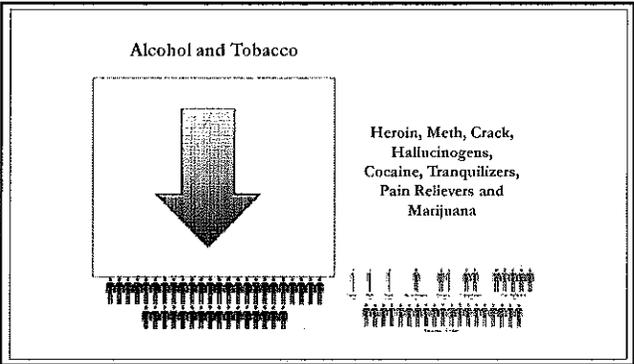
- Americans age 12 and older (past month):
 - ✓ 10% used any illegal drug
 - ✓ 25% used tobacco
 - ✓ 52% used alcohol

**90% of Americans
do NOT use
illegal drugs**

Source: 2014 National Survey on Drug Use

Licensed Marijuana Businesses

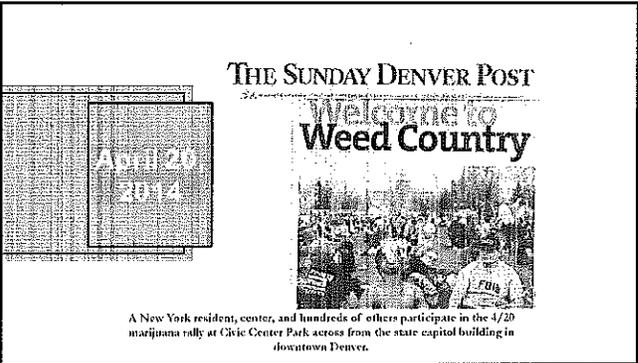
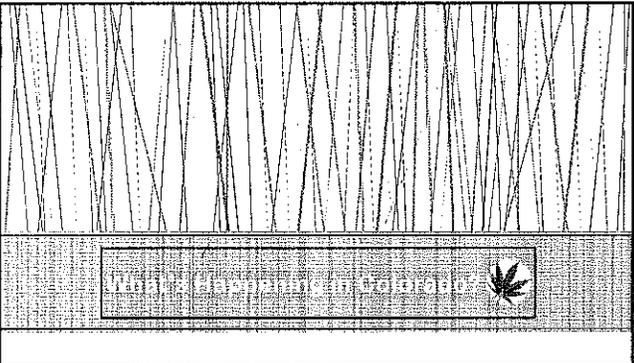
Medical Marijuana (January 2016)	Recreational Marijuana (January 2016)
• 516 licensed centers	• 424 licensed marijuana retail stores
• 751 marijuana cultivation facilities	• 514 licensed marijuana cultivation facilities
• 202 infused products (edibles) businesses	• 168 licenses for infused product (edibles) businesses



Perspective

- Colorado Business Profile, January 2016

	Starbucks	322
	McDonalds	203
	Medical Marijuana Centers	516
	Recreational Marijuana Shops	424



Denver: The Mile HIGH City



210 Licensed Medical Marijuana Centers

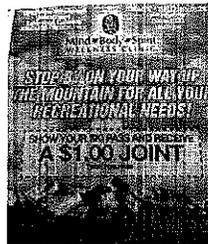
108 Pharmacies



“Legal pot blamed for some of influx of homeless in Denver this summer”

The Denver Post, July 25, 2014

- Urban Peak: 152% increase
- “Majority of new kids here because of weed.”
- St. Francis: 50 more people a day
- “Marijuana only trails looking for work as reason.”



Full-page ads Westword

Marijuana and Public Consumption

“Citations for using pot in public rising”

Denver police say they're not purposely trying to nab users since marijuana was legalized.

*The Denver Post
Sunday, December 28, 2014*

- 2012 = 8 citations
- 2013 = 184 citations
- 2014 = 770 citations
- 2015 = 752 citations

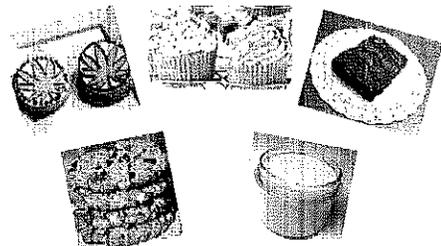
“Legal pot blamed for some of influx of homeless in Denver this summer”

The Denver Post, July 25, 2014

- Haven of Hope: 500% rise over normal in homeless in summer 2014 (50 to 300)
- “They have an attitude”
- Salvation Army: 33% rise since 2014 compared to 2013
- “30% relocated for pot”



Marijuana Edibles



Marijuana Edibles Deaths

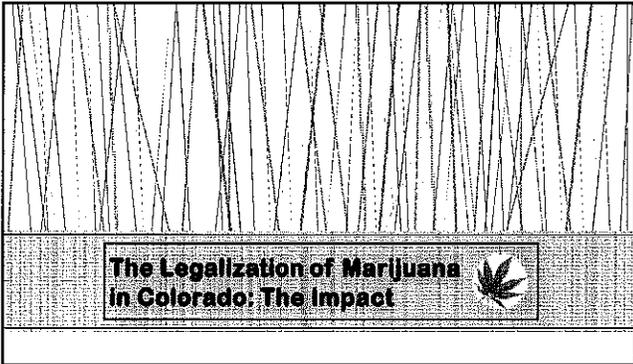


Levy Thamba Pongi and
Kristine Kirk
(Denver, CO)

Luke Goodman
(Keystone, CO)

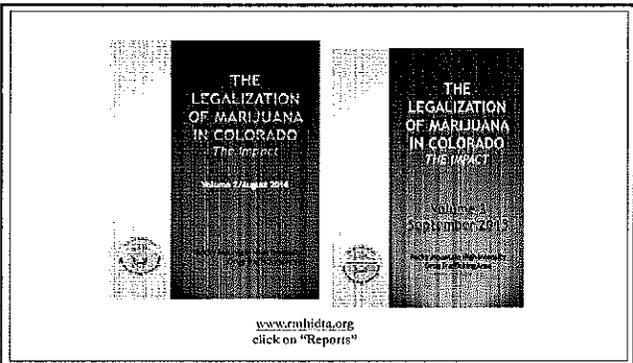
Forecast

- | Support Marijuana
Legalization | Oppose Marijuana
Legalization |
|--|-----------------------------------|
| • Significant Revenue | • Societal Cost Outweighs Revenue |
| • Less DUIs and Fatalities – Safer Drivers | • More DUIs and Fatalities |
| • Little Increase in Use | • Substantial Increase in Use |
| • Lower Access by Youth | • Greater Access and Use by Youth |
| • Lower Alcohol Use | • Little Impact on Alcohol Use |



Forecast

- | Support Marijuana
Legalization | Oppose Marijuana
Legalization |
|-----------------------------------|-----------------------------------|
| • Safe | • Harmful and Increased ER Visits |
| • Stop Drug Cartels | • Little Impact on Drug Cartels |
| • Eliminate Black Market | • Become the Black Market |
| • Free-Up Police Resources | • Increased Policing |

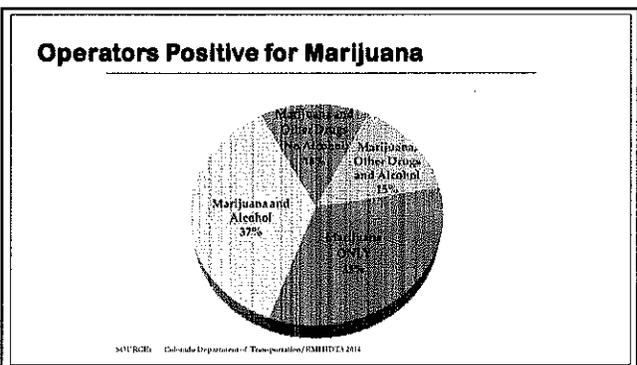
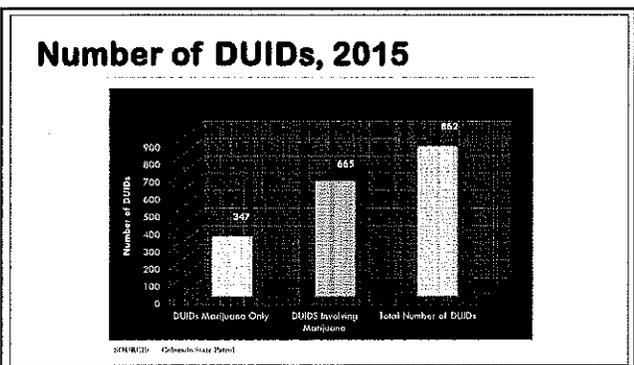
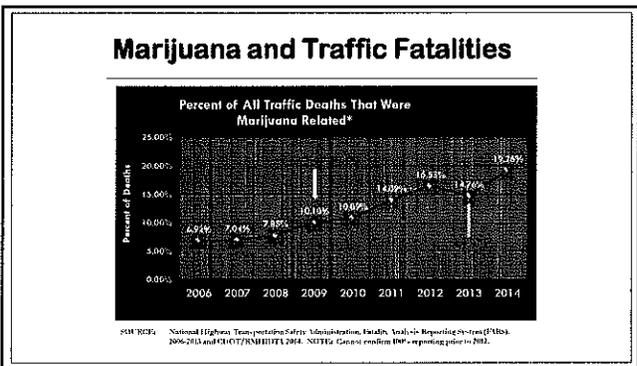
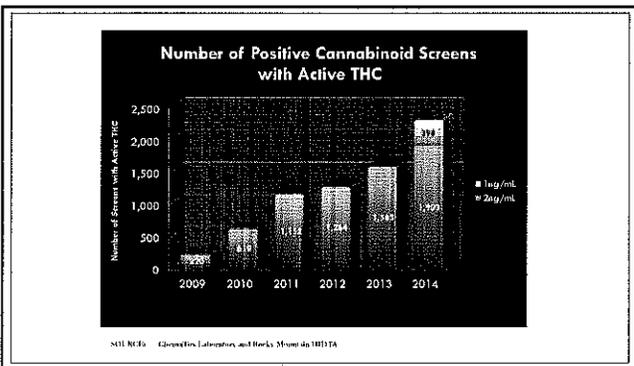
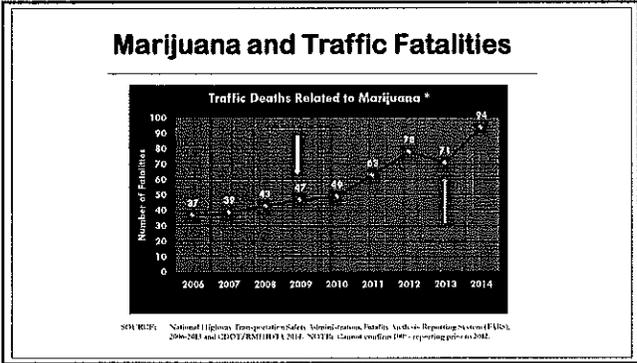
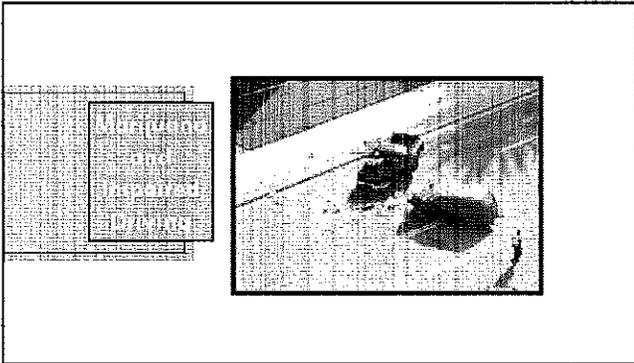


www.emhida.org
click on "Reports"

Forecast

What Does the Data and Trends Show?

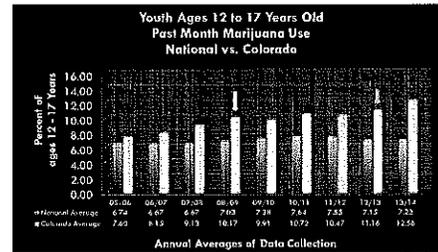




Marijuana Use in Youth



Marijuana Use in Youth

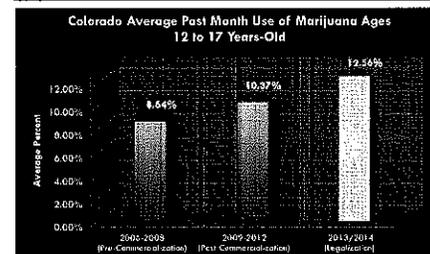


SOURCE: SAMHSA.gov, National Survey on Drug Use and Health 2005 and 2014

Teens and Marijuana



Marijuana Use in Youth



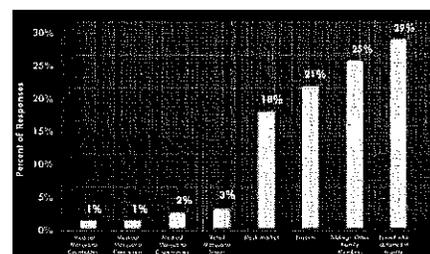
SOURCE: National Survey on Drug Use and Health, 2013 and 2014

Marijuana Use in Youth

Youth (ages 12 to 17 years)
Current Marijuana Use 2013/2014

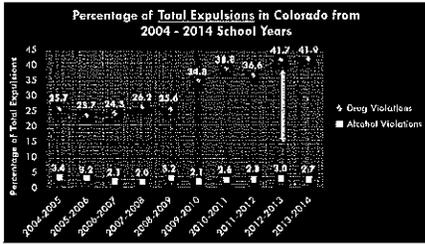
- Colorado ranked 1st in the nation for current marijuana use among youth
 - Ranked 3rd in 2012/2013
 - Ranked 14th in 2006/2007
- Colorado youth use is 74 percent higher than the national average
- 2013/2014 Colorado youth use increased 20 percent compared to pre-legalization years 2011/2012. Nationally a decline of 5 percent.

Student Marijuana Sources



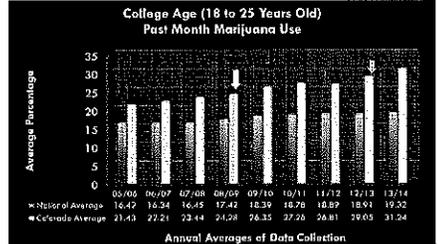
SOURCE: Colorado School Counselor Association (CSA) and Rocky Mountain HHSU, 2015

High School Discipline



NHHSO Colorado Department of Education, 9th Year Total High School Suspensions and Expulsions (includes Home and School)

College-Age Marijuana Use

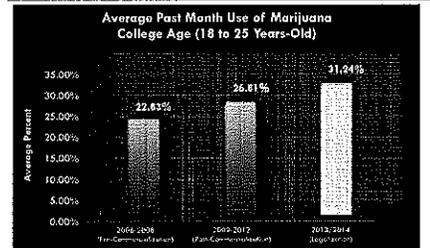


NHHSO SAMHSA.gov, National Survey on Drug Use and Health, 2013 and 2014

College-Age Marijuana Use



College-Age Marijuana Use



NHHSO National Survey on Drug Use and Health, 2005 - 2014

College-Age Marijuana Use

College-Age Adults (ages 18 to 25 years) Current Marijuana Use 2013/2014

- ✓ Colorado ranked 1st in the nation for current marijuana use among college-age adults
- ✓ Ranked 2nd in 2012/2013
- ✓ Ranked 8th in 2006/2007
- ✓ Colorado college-age use is 62 percent higher than the national average
- ✓ 2013/2014 college-age use increased 17 percent compared to pre-legalization years 2011/2012. Nationally a 2 percent increase.

Adult Marijuana Use

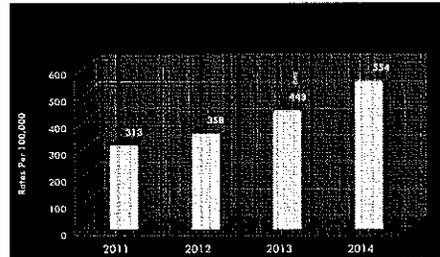


Adult Marijuana Use

Adults (ages 26+ years)
Current Marijuana Use 2013/2014

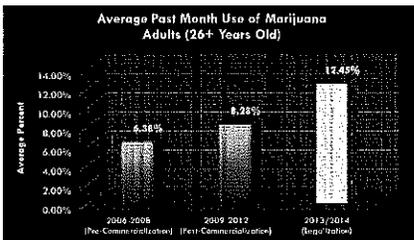
- Colorado ranked 1st in the nation for current marijuana use among adults
 - Ranked 5th in 2012/2013
 - Ranked 8th in 2006/2007
- Colorado adult use is 104 percent higher than the national average
- 2013/2014 adult use increased 63 percent compared to pre-legalization years 2011/2012. Nationally an increase of 21 percent.

Colorado Emergency Department Rates Likely Related to Marijuana



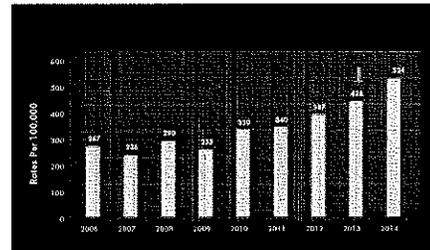
SOURCE: Colorado Department of Public Health and Environment

Adult Marijuana Use



SOURCE: National Survey on Drug Use and Health, 2006-2014

Colorado Hospitalization Rates Likely Related to Marijuana

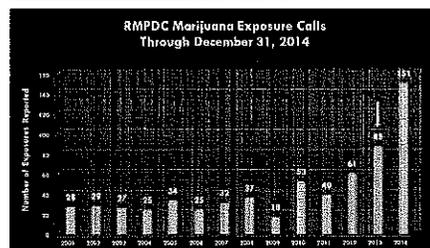


SOURCE: Colorado Department of Public Health and Environment

Emergency Room Visits, Hospitalizations and Marijuana

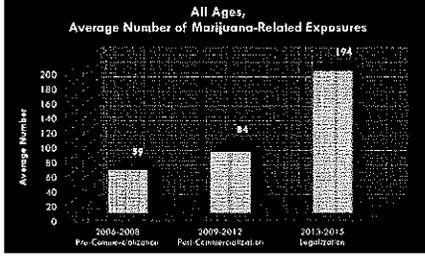


Rocky Mountain Poison Center



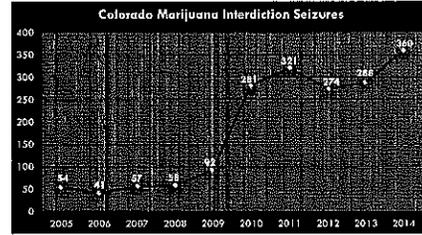
SOURCE: Colorado Department of Public Health and Environment/RMPDC

Rocky Mountain Poison Center



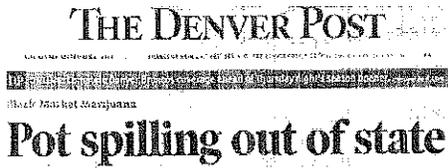
SOURCE: Rocky Mountain Poison and Drug Center

Diversion – By Motor Vehicles

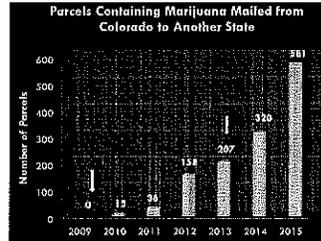


SOURCE: FBI Poison Intelligence Center, National Inference System

Marijuana Diversion

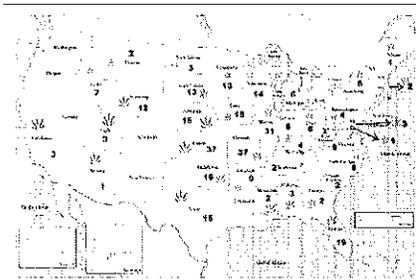


Diversion – By U.S. Postal Service Packages

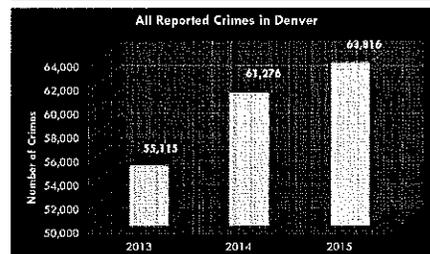


SOURCE: United States Postal Inspection Service – Prohibited Mailing of Narcotics

States to Which Marijuana Was Destined (2014)

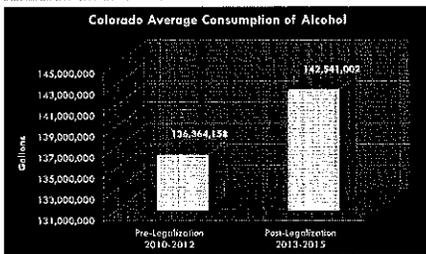


Crime in Denver



SOURCE: City and County of Denver, March 2016

Alcohol Consumption



SOURCE: Colorado Department of Revenue, Colorado Excise Taxes

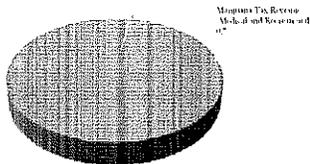
A Snapshot in Colorado

Marijuana-Related DUIs	↑
Marijuana-Related Traffic Deaths	↑
Youth Marijuana Use	↑
College Marijuana Use	↑
Adult Marijuana Use	↑
Marijuana-Related Emergency Room Admissions	↑
Marijuana-Related Hospitalizations	↑
Marijuana-Related Exposures	↑
Marijuana-Related Treatment	↓
Marijuana Diversion	↑
THC Extraction Labs	↓

SOURCE: Rocky Mountain IIRIS

Colorado General Fund

Colorado's Total General Fund Revenue, FY 2015*



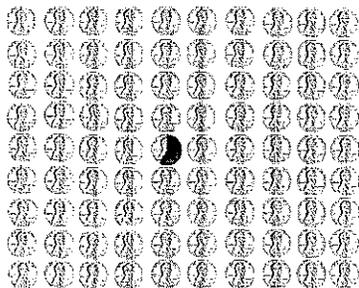
* Preliminary Numbers based on June 2015 Forecast

Local Response to Medical and Recreational Marijuana in Colorado

Of 321 total local jurisdictions:

- ✓ 228 (71 percent) prohibit any medical or recreational marijuana businesses
- ✓ 67 (21 percent) allow any medical and recreational marijuana businesses
- ✓ 26 (8 percent) allow either medical or recreational marijuana businesses, not both

FY 2015 Tax Revenue



Why We Do This

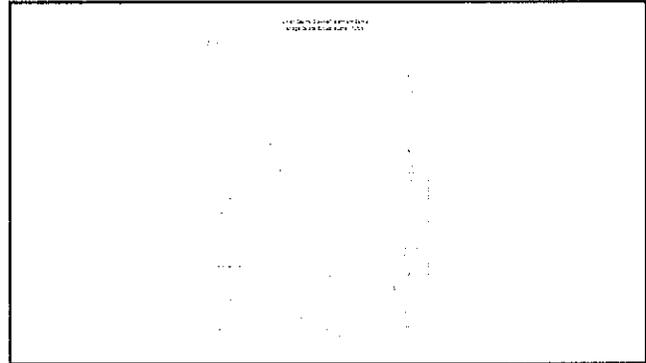
• Important to Remember with Statistics...



Thank you for what you do.

Remember:

**“Do the Right
Thing”**



• GOVERNOR'S •
TASK FORCE
on Drug Enforcement,
Treatment & Prevention

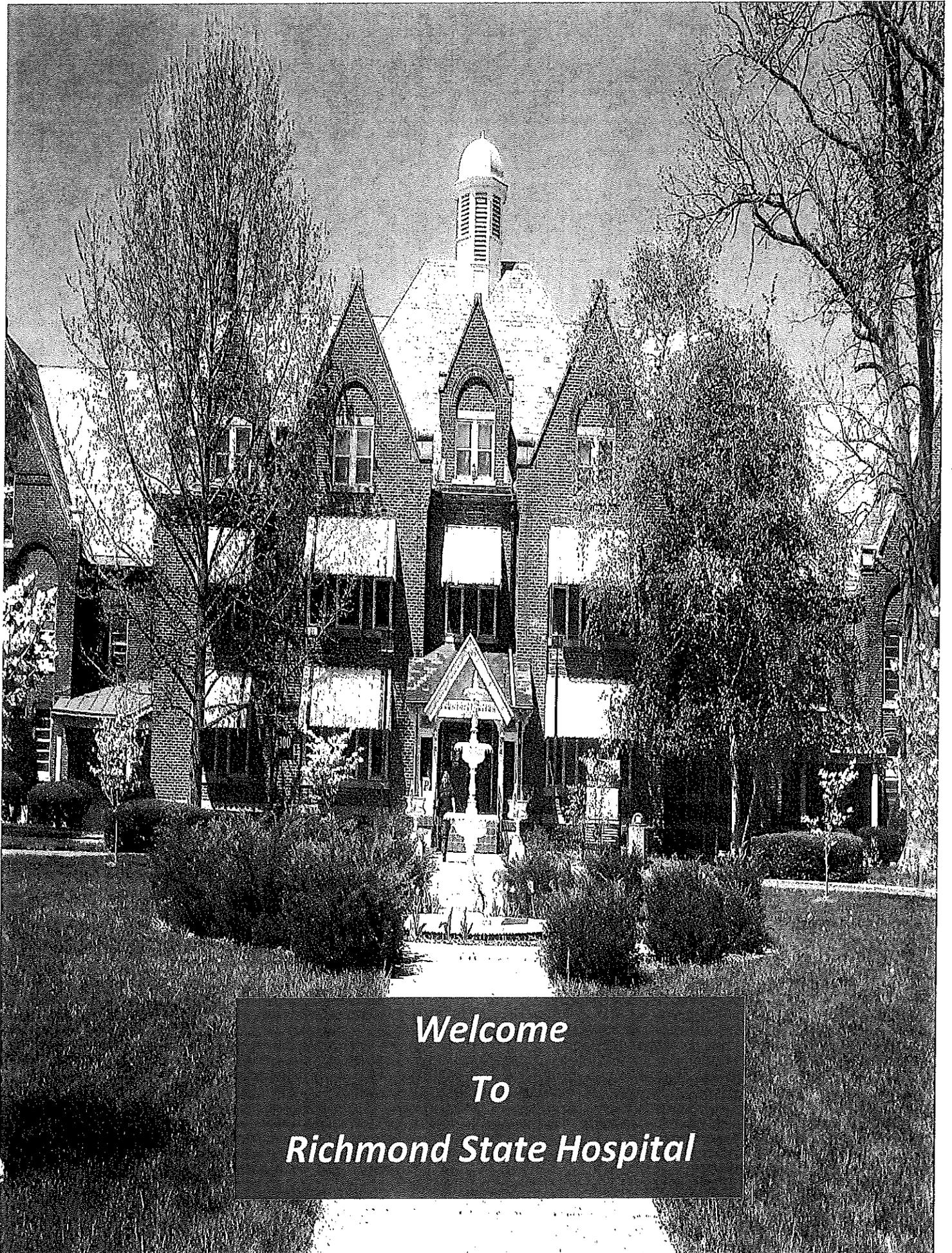


• GOVERNOR'S •
TASK FORCE
on Drug Enforcement,
Treatment & Prevention



Union County Opiate
Treatment Center

Jeff Mathews/Alvin Day



*Welcome
To
Richmond State Hospital*

RICHMOND STATE HOSPITAL
Facility Fact Sheet
SFY 2016

Richmond State Hospital has served persons with mental illness since 1890. Major additions to the campus include the Residential Treatment Center, which opened in 1992 and the Clinical Treatment Center, which opened in August 2002. The Residential Treatment Center, as well as our 417 building, houses the majority of our patient population. The Clinical Treatment Center emphasizes active treatment using the treatment mall approach, which includes multiple classrooms, social area, gymnasium, dental clinic, crafts, training center and pharmacy.

Richmond State Hospital has maintained accreditation from the Joint Commission since 1986. The requirements set forth from the Joint Commission and met by the hospital focus on systems critical to the safety, quality of care, treatment and services provided. The Joint Commission accreditation also has gained the hospital deemed status with federal Medicare and Medicaid programs which allow for federal reimbursement. The hospital continued with their full accreditation status having our last survey in August 2013.

Patient population at Richmond State Hospital is organized into patient care modules with a total bed capacity of 213. We continue to monitor the cost per patient day and the patients who have been in hospital over 18 months. Both measures are well within the range of the performance expectations.

- **420A & B Seriously Mentally Ill:** A 60 bed co-ed care module that admits and provides recovery services for patients with severe and persistent mental illness with the goal of attaining symptom management and skill development for community living. The admission unit's focus is to identify and stabilize the mental health needs and to prepare the patients to return to the community.
- **421A & B Integrated Dual Diagnoses:** A 60 bed co-ed care module that specializes in the care of patients with mental illness and a substance abuse/dependency problem using established best practices as a framework for recovery.
- **422A & B SMI Continuing Care/Medical/Geriatric:** A 60 bed co-ed care module that provides continued services for patients with severe and persistent mental illness. Recovery programming is focused on learning skills such as coping, social, leisure time, emotion regulation, and anger management. These units also have patients with activities of daily living deficits as well as needing mobility assistance. Due to the flooring and window project in the RTC units, 24 of these beds have been located on the 417C unit.
- **417A Seriously Mentally Ill/Developmentally Disabled:** A 23 bed co-ed care module that provides recovery services for individuals with a mental illness and an intellectual disability. The treatment focuses on social skills, self care, behavioral regulation, and symptom management in preparation for community and family living. This unit also includes our fluid management population newly established at the hospital in spring 2011.



State Fiscal Year 2016 up till June 9th

Admissions	85
Discharges	107
Average Daily Population	182

Staffing

Positions on the Staffing table	459
Filled FTE Positions	355

Treatment is individualized through interdisciplinary assessments and may include stabilization of symptoms through psychopharmacology, management of medical problems, individual and group therapy, patient and family education, rehabilitation and recreation therapy, academic and skills training, and vocational training. The interdisciplinary approach utilizes the Treatment Team to oversee the patient's care. Members of the team, based on the patient's needs, may include a psychiatrist/physician, psychologist or behavioral clinician, social service specialist, dietitian, rehabilitation therapist, nurses, behavioral healthcare recovery assistants, recovery specialists and substance abuse counselors.

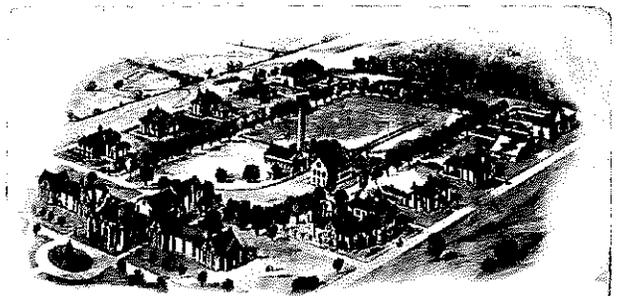
We provide individualized services based on comprehensive and ongoing assessment. We base services on established theory and empirically supported approaches. We provide services in a coordinated manner with active collaboration between the various clinical disciplines. We provide care and treatment in a respectful and humane fashion while focusing on skills, interests, and strengths as well as signs and symptoms of illness. We provide direct instruction to increase skills related to living in the community or transitioning to less restrictive environments. We involve consumers and their families in planning, on a program level, as well as the individual level. We provide services with sensitivity to ethnic, gender, cultural and family characteristics and values.

Our clinical model of care emphasizes the combination (FACT) of Acceptance and Commitment Therapy (ACT) and Functional Analytic Psychotherapy (FAP) as a basic stance. Both therapies share a behavior analytic background and research demonstrates the effectiveness and utility of ACT and FAP in treating consumers with a variety of clinical difficulties. All aspects of the Recovery Model; Psychosocial Rehabilitation; Motivational Interviewing techniques; Skills Training; and Dialectical Behavior Therapy techniques such as mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation are incorporated, with FACT serving as the foundation for therapeutic services, staff-consumer interaction, planning, and staff training.

We also have more specific information about the hospital @ www.richmondstatehospital.org.

Executive Team

Dr. Warren Fournier, Interim Superintendent/Medical Director
Josh Nolan, Psy.D. Clinical Director
Judy Cole, RN Point of Contact for Nursing
Kay Stephan, Quality Management Director
Tara Jamison, Community Relations Director
Terresa Bradburn, Human Resources Director
Vacant Assistant Superintendent Administration





125 Year Anniversary Celebration of Richmond State Hospital

1890-2015



July 2015

- **T shirt design contest** – Staff was asked to enter a design for our 125 year shirts. 12 entries were submitted and the patients voted on the one they liked the best. The winner received a free T-shirt and a gift card from our Grass roots Committee.

August 2015

- **T-shirt and hoodie sale** – Grass roots Committee is selling these 125 year items till the end of August.
- **Weekly Trivia Questions** – Starting the first week of August through the last full week of September, a weekly trivia survey of the hospital's history is sent out electronically to our staff. Staff can answer the 8 to 10 multiple choice questions through Survey Monkey. The answers to the questions are revealed at the end of the week.
- **Banners** – Four banners were made and displayed outside key buildings on our campus. The banners state Richmond State Hospital 1890-2015 Celebrating 125 Years.
- **Ice Cream Social** – On Tuesday August 4, 2015, an Ice Cream Social was held for patients and staff on all three shifts. The committee selected this date because on August 4 1890, the first patient was admitted to Richmond State Hospital.

September 2015

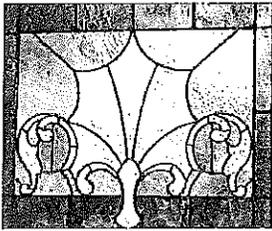
The week of September 21 – 25 we will have a theme each day in which staff will be able to dress based upon the daily theme. The following events will take place also during this week:

- **Monday Sept 21 – Tour of the Museum – (Hat Day)** Our Museum on campus will be open to our staff from 1 to 4 p.m. Staff is welcome to come anytime to wander through our history.
- **Tuesday Sept 22 – Ariel Photo Shoot (125 T-shirt Day)** – Staff will gather for an Ariel Photo picture in which staff will be positioned to spell out "125". The location will be on the north side of the steam plant at 12:30 p.m. Wear your 125 year T-shirt or a Royal Blue or Blue Shirt.
- **Wednesday Sept 23 – Dedication of Two Trees (Tie Day)** – One tree purchased by Aramark will be planted around the food service center. The second tree purchased by the Hospital will be planted on one of our main roads on campus. The ceremonies will be 9 a.m. at the Food Center and the other hospital dedication on the winding road at @ 9:30 a.m.
- **Thursday Sept 24 – Presentation Day (Dress for Success)** – Legislators, FSSA and DMHA personnel throughout the state, local representative from the community, retirees and staff have been invited to a presentation beginning at 1 p.m. in the CTC Training Center.
- **Friday Sept 25 – Employee Appreciation Day – (Decade or 125 T-shirt Day)** Employees will receive a surprise gift on this day to finish off a fun filled week.

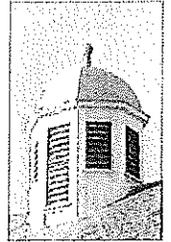
Richmond State Hospital History 1890-2015

The site for the "Eastern Indiana Hospital for the Insane," (now known as Richmond State Hospital), of approximately 307 acres, was purchased in 1878. Construction started in 1884 and was completed in 1890.

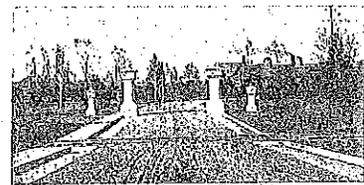
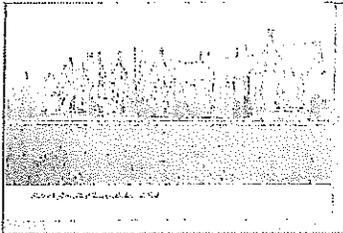
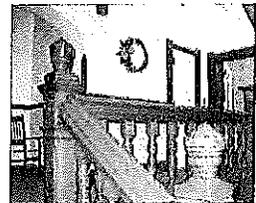
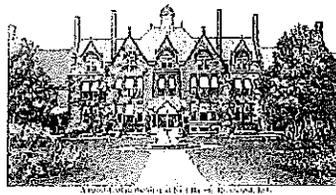
At Richmond, between 1887 and 1890, three of the completed buildings were occupied by "The School for Feeble Minded Youth." In 1890, these patients were transferred to what is now known as the "Fort Wayne Developmental Center." The buildings were refurbished and the hospital formally opened on July 29, 1890, with the first patient admitted on August 4, 1890.



The hospital buildings were constructed on the "cottage plan" in order to prevent any "disastrous conflagration," and provide for immediate evacuation of a small number of persons in case of fire. There are many interesting architectural details in the older buildings, including exterior cupolas, interior detailing such as intricate railings and stained glass.



Although the general layout followed the cottage plan, the main administration building with adjacent buildings extending like wings although it was never an official name, it was long referred to as "East Haven." The post card images below all bear inscriptions which include an "East Haven" designation. Apparently post cards of various "asylums" were once common.



In 1911, the "Colony Act" was passed and additional acreage was purchased to allow patients to work the farmlands. Richmond was selected to be the parent institution for this type of treatment. The five farms acquired were christened "Wayne Farms." Male patients with an agricultural background were placed in the colonies. Their productive efforts were realized in many ways, but specifically through ribbons and prizes received from the exhibits of cattle and farm products at the Wayne County Fair as well as the Indiana State Fair.



On May 16, 1927, the hospital's name was changed from "Eastern Indiana Hospital for the Insane" to "Richmond State Hospital." Located on the grounds is the Klepfer All Faiths Chapel. Financed entirely by donations from the community, the chapel was named in honor of Dr. Jefferson Klepfer, M.D., who served as superintendent from 1953 to 1976. Through the years, many changes have occurred. In 1980, Richmond State Hospital was certified for Medicare/Medicaid patients and, in 1986, the Joint Commission for Accreditation of Healthcare Organizations accredited the hospital.

To better serve the patients who require continued treatment the hospital has programs geared to the needs of individuals with persistent and severe mental disorders and the older person with mental illness. Richmond State Hospital provides services to patients from the Community Mental Health Centers in East Central and Northeast Indiana. Many patients come from larger urban settings, but many of the patients continue to be from small rural communities.

Two of the newer buildings that comprise Richmond State Hospital are the 192-bed Residential Treatment Center and the food Preparation Center. Both were completed in 1991. All of the hospital building are on a 120-acre campus that has been developed into a park-like setting with beautiful trees, shrubs, copious flower beds and a pond.



In 2001 work was completed on the CTC complex. Nestled in front of the existing RTC building, CTC (Continued Treatment Center) brought together our Lab, Pharmacy and Dental Clinic in one centralized state of the art location. In addition CTC houses our social club, gymnasium, crafts area and classrooms dedicated to Recovery and Rehabilitation curriculums. CTC also serves as a regional training site with our spacious training center.

After more than 100 years of providing mental health services, Richmond State Hospital continues the commitment to meet the needs of our changing population. The primary goal of the hospital continues to be to plan for and, in cooperation with other care providers, develop and deliver a comprehensive and integrated system of mental health services of superior quality.

in.gov/fssa/dmha/2614.htm

