COMMISSION ON MENTAL HEALTH AND ADDICTION

Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

LSA Staff:

Susan Kennell, Attorney for the Commission
Chris Baker, Fiscal Analyst for the Commission

Authority: *IC 12-21-6.5*

MEETING MINUTES[1]

Meeting Date:	**September 17, 2012**
Meeting Time:	**1:00 P.M.**
Meeting Place:	**State House, 200 W. Washington St., House Chamber**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**2**

Members Present: **Rep. Cindy Noe, Chairperson; Rep. Charlie Brown; Sen. Patricia Miller; Sen. Lindel Hume; Kathleen O'Connell; Margie Payne; Ronda Ames; Valerie N. Markley; Bryan Lett; Caroline Doebbling; Kurt Carlson; Rhonda Boyd-Alstott.**

Members Absent: **Chris Taelman; Jane Horn; Dr. Danita Johnson Hughes; Dr. Brenna McDonald.**

I. Call to Order

Representative Cindy Noe, Chairperson, called the meeting to order at 1:05 P.M. and asked the members to introduce themselves. Chairperson Noe informed the members that, as requested at the first meeting, the National Alliance on Mental Health (NAMI) had made booklets entitled "What To Do In Psychiatric Crisis in Indiana" available to the members. Chairperson Noe also explained that many ideas have been discussed during the interim. She asked that members contact her prior to the October 15 meeting if

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[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

they have ideas for legislation. **(For a piece of legislation to be drafted before the October 15 meeting, members will need to contact Representative Noe no later than October 3.)**

II. Children in Need of Services (CHINS)

Representative Noe reiterated that the Commission was given the duty to consider whether prosecuting attorneys should be allowed to file a petition alleging that a child is a child in need of services and to consider the unmet mental health needs of children in the juvenile justice system. Presenters were asked to combine their comments on both topics for their presentations at the meeting. The CHINS discussion revolves around what are known as CHINS 6 issues. That refers to IC 31-34-1-6, which follows:

"Sec. 6. A child is a child in need of services if before the child becomes eighteen (18) years of age:

(1) the child substantially endangers the child's own health or the health of another individual; and

(2) the child needs care, treatment, or rehabilitation that:

(A) the child is not receiving; and

(B) is unlikely to be provided or accepted without the coercive intervention of the court."

(a) Mr. Kevin Moore, Director, Division of Mental Health and Addiction (DMHA), discussed how DMHA provides services to children who are CHINS. (Exhibit 1) According to Mr. Moore, the entire focus of the Family and Social Service Administration is to serve the poorest and neediest. In answer to questions from Representative Brown, Mr. Moore stated that DMHA pays for education only for those children who are in state hospitals. In answer to questions from Chairperson Noe, Mr. Moore stated that, except for adolescent girls waiting for services at Larue Carter, there are no waiting lists for children needing services from the state hospitals. The list of adolescent girls waiting for services from Larue Carter is small. Mr. Moore also said that Evansville Children's Psychiatric Hospital is often underutilized.

(b) Mr. John Ryan, Chief of Staff, and Ms. Lisa Rich, Deputy Director of Program and Services, Department of Child Services (DCS), discussed the plans of DCS for providing services to children with mental health issues. (Exhibit 2) Mr. Ryan provided an overview of the services provided by DCS. There are about 150,000 children served per year due to abuse or neglect. Of those, approximately 80% received services because of neglect and 20% because of abuse. DCS has 1,630 case managers, 240 supervisors, and over 100 attorneys. The entire families of CHINS 6 children are affected and need services. Within the last 90 days, DCS has developed a plan to better address providing services to the CHINS 6 children. DCS is beginning to implement a pilot project for the new plan.

Ms. Rich explained that the DCS has contracts with all of the community mental health centers to provide mental health services to children. DCS will use the centers to provide services to CHINS 6 children in the new plan.

In response to questions from Representative Brown, Ms. Rich explained that the new plan has the two main focuses of relying less on institutional care and maximizing the use of non-state dollars for services as much as possible. In answer to questions from Senator Miller, Mr. Ryan said that they do know there will be some unintended consequences from the changes in providing services, which is why they plan to rely on

the pilot to refine the program. He further indicated that DCS hopes to have the pilot up and running withing 60 days and hopes to begin replicating the pilot by February 1. In answer to questions from Senator Hume, Mr. Moore indicated that the fact that there are available beds at Evansville Children's Psychiatric Hospital does not help with the waiting list at Larue Carter because the ages of the children on the waiting list do not match up with the children served in Evansville. In response to comments from Representative Noe, Ms. Rich said that DCS is meeting every two weeks with the community mental health centers to make sure the centers are ready to provide any new services required by the increased use of the centers to serve CHINS 6 children.

(c) Attorney General Greg Zoeller discussed his plan for providing services to CHINS 6 children. (Exhibit 3) The Attorney General offered his help to the General Assembly to improve the lives of the children served by DCS. The Attorney General indicated that his office has 144 lawyers divided into five divisions. The Attorney General stated that DCS has more than 100 attorneys serving the agency at local court hearings. The DCS attorneys have expanded their work to the appellate level. The Attorney General testified that he believes appearances in appellate courts should be handled by deputy Attorneys General in order to provide consistency in state law. He further stated that in his work with prosecutors on a daily basis there are instances where there is a need for independent review of some CHINS cases.

(d) Suzanne O'Malley, Indiana Prosecuting Attorneys Council, stated that the Council believes that, in addition to DCS, prosecuting attorneys should have the authority to file CHINS 6 petitions in court.(Exhibit 4) The prosecutors would like to have the option of asking courts to find a child in need of services under the CHINS 6.

(e) Mr. Larry Landis, Executive Director, Public Defenders Council, testified that in the case of prosecutors being able to file CHINS 6 petitions, the public defenders, in what Mr. Landis described as a rare situation, are in agreement with the prosecutors that the prosecuting attorneys should have the authority to file the CHINS 6 petitions.

(f) Mr. Matt Brooks, Chief Executive Officer, Indiana Council of Community Mental Health Centers, Inc., testified that the community mental health centers are ready to work with DCS in providing services to CHINS 6 children under the new plan developed by DCS. (Exhibit 5) In response to a question from Representative Noe, Mr. Brooks said that the community mental health centers could be ready to provide the necessary services in much less than two years time.

(g) Ms. Karen Lueck, Wayne County Public Defenders' Office, expressed her opinion on the DCS pilot project for CHINS 6 children. (Exhibit 6)

(h) Ms. Barbara Collins-Layton and Ms. Jill Garner presented letters from several parents detailing the difficulties they had obtaining services for their children. (Exhibits 7, 8 and 9)

(I) Ms. Cathy Graham, Executive Director IARCCA, discussed the need for proper treatment for children and their families. (Exhibit 10)

(j) Dr. Matt Aalsma, child psychologist and member of the Advisory Board for the Indiana Juvenile Mental Health Screening, Assessment ,and Treatment Project, discussed the need for a statewide, evidence-based treatment system to care for youth identified with mental health disorders. (Exhibit 11)

(k) Ms. JauNae Hanger, Indiana Bar Association Civil Rights of Children's Committee, expressed support for the testimony of the Prosecuting Attorneys Council and the Public Defenders Council concerning filing of CHINS 6 petitions. Allowing prosecutors to file CHINS 6 petitions increases the safety net for children and provides an additional tool at the local level for providing services to children.

(l) Mr. Bill Glick, Indiana Juvenile Justice Task Force, Inc., testified that the largest mental health provider for youth in Indiana is the Department of Correction (DOC). He discussed that DOC is changing its model for providing services within the DOC and indicated that there are still missing pieces in service provision. Mr. Glick further discussed the crisis intervention team (CIT) approach for youth and discussed the pilot training program in Marion County.

(m) Ms. Kaarin Lueck, Public Defender, Richmond, stated that in addition to DCS filing CHINS 6 petitions, prosecutors need to have the ability to file CHINS 6 petitions in order to provide as many ways as possible for children to be identified as CHINS so that they can receive the treatment needed.

(n) Ms. Pam McConey, NAMI, provided the Commission with written objectives for providing services to children. (Exhibit 12) Ms. McConey emphasized the importance of involving families in any decision made concerning children with mental illness.

III. Adjournment

Representative Noe adjourned the meeting at 4:20 P.M.

COMH
Meeting 2
9-17-12
Exhibit 1

Family and Social Services Administration

Division of Mental Health and Addiction

Commission on Mental Health and Addiction

September 17, 2012

DMHA Mission

- To ensure that Indiana citizens have access to quality mental health and addiction services that promote individual, family and community resiliency and recovery.

Behavioral health is essential to health

Prevention works

Treatment is effective

People recover

DMHA Priorities

- Mental health promotion and addiction prevention

  To assure that communities in Indiana have sufficient support for provision of services for addiction prevention and mental health promotion

- Integration of primary and behavioral health

  Determine best practice principles for bi-directional integrated primary and behavioral health practices

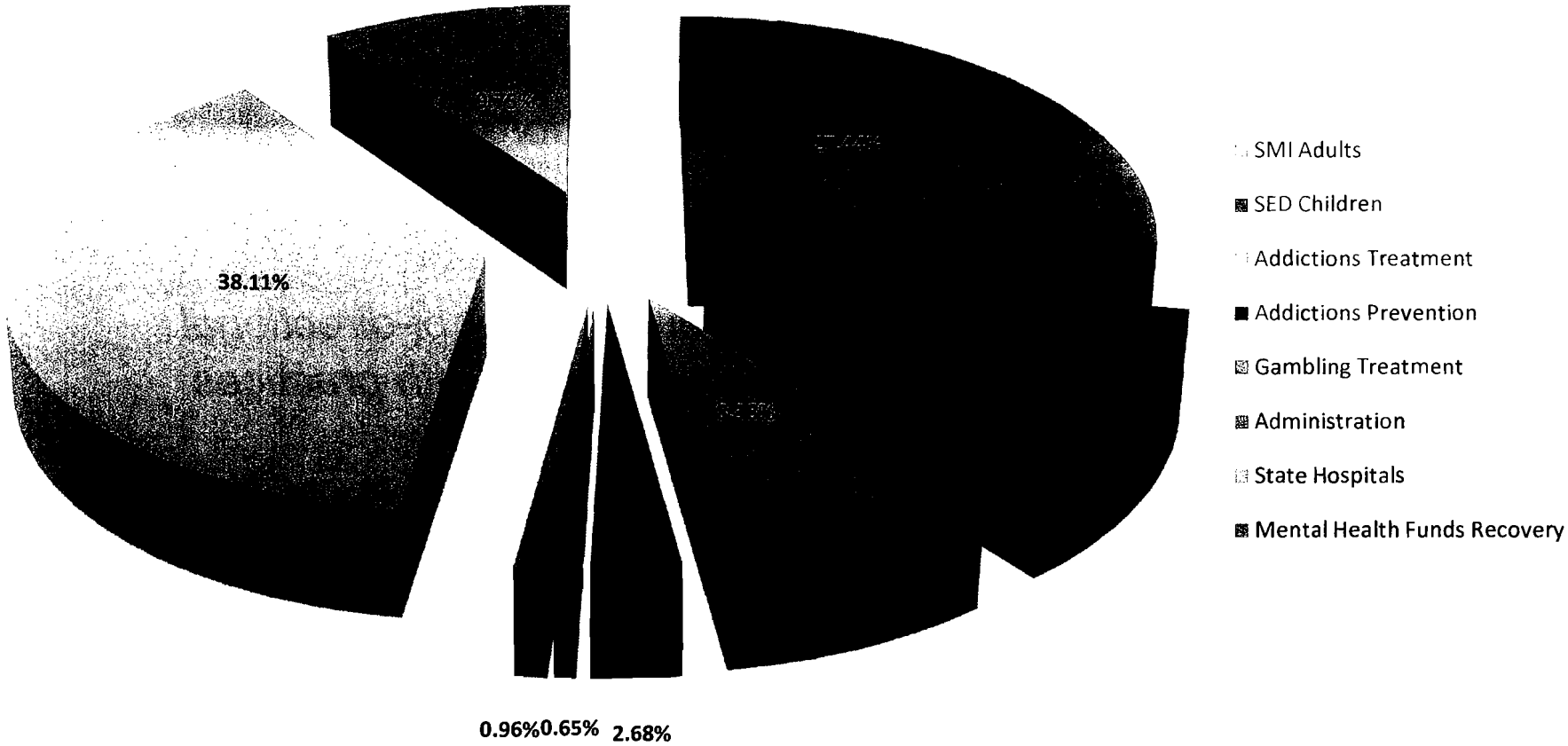
- Safe, affordable housing

  A place in the community for everyone

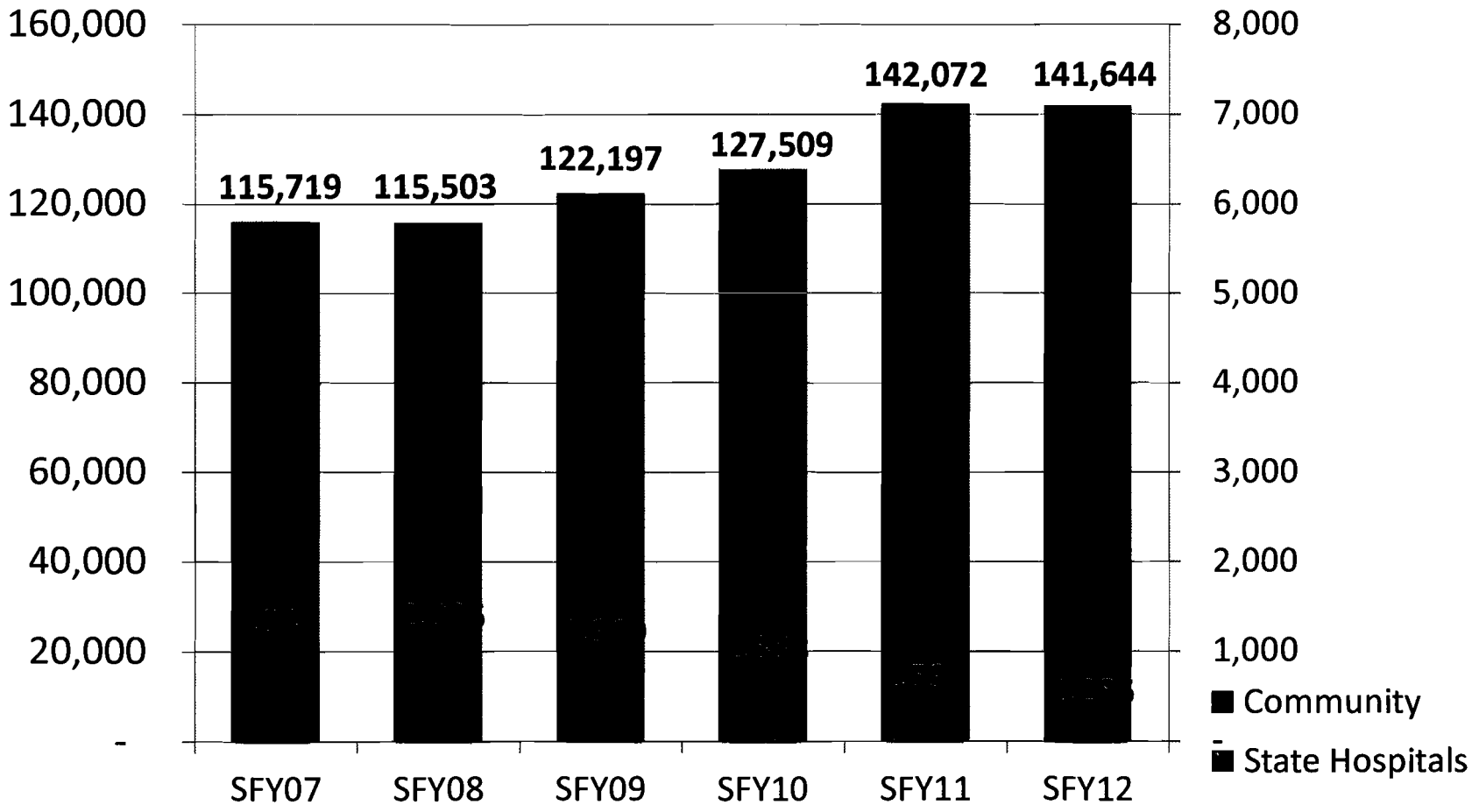
- Recovery supports

  To promote and develop State-wide recovery supports toward the goal of community integration for persons with mental illnesses and addiction

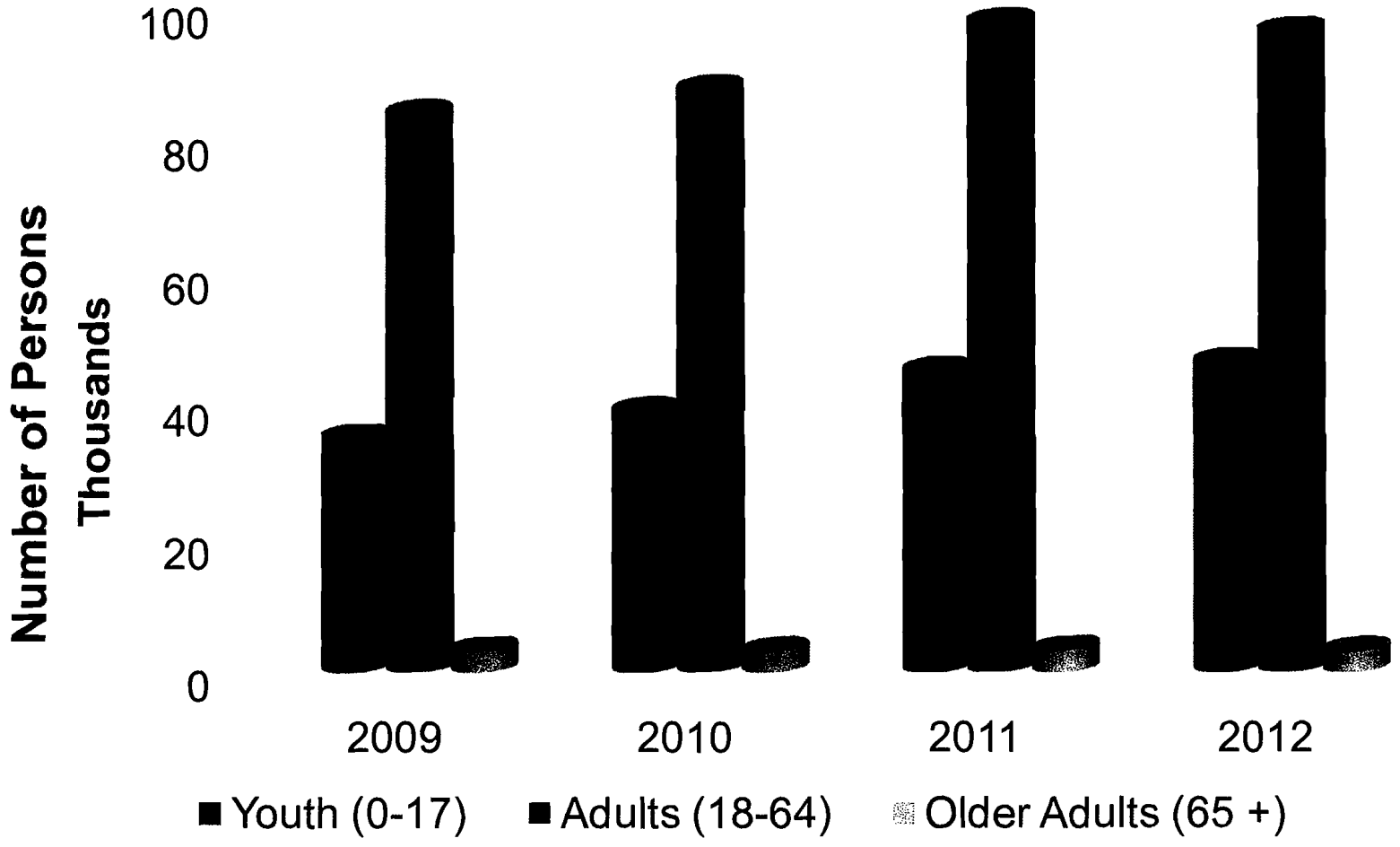
2012 Budget – Federal and State



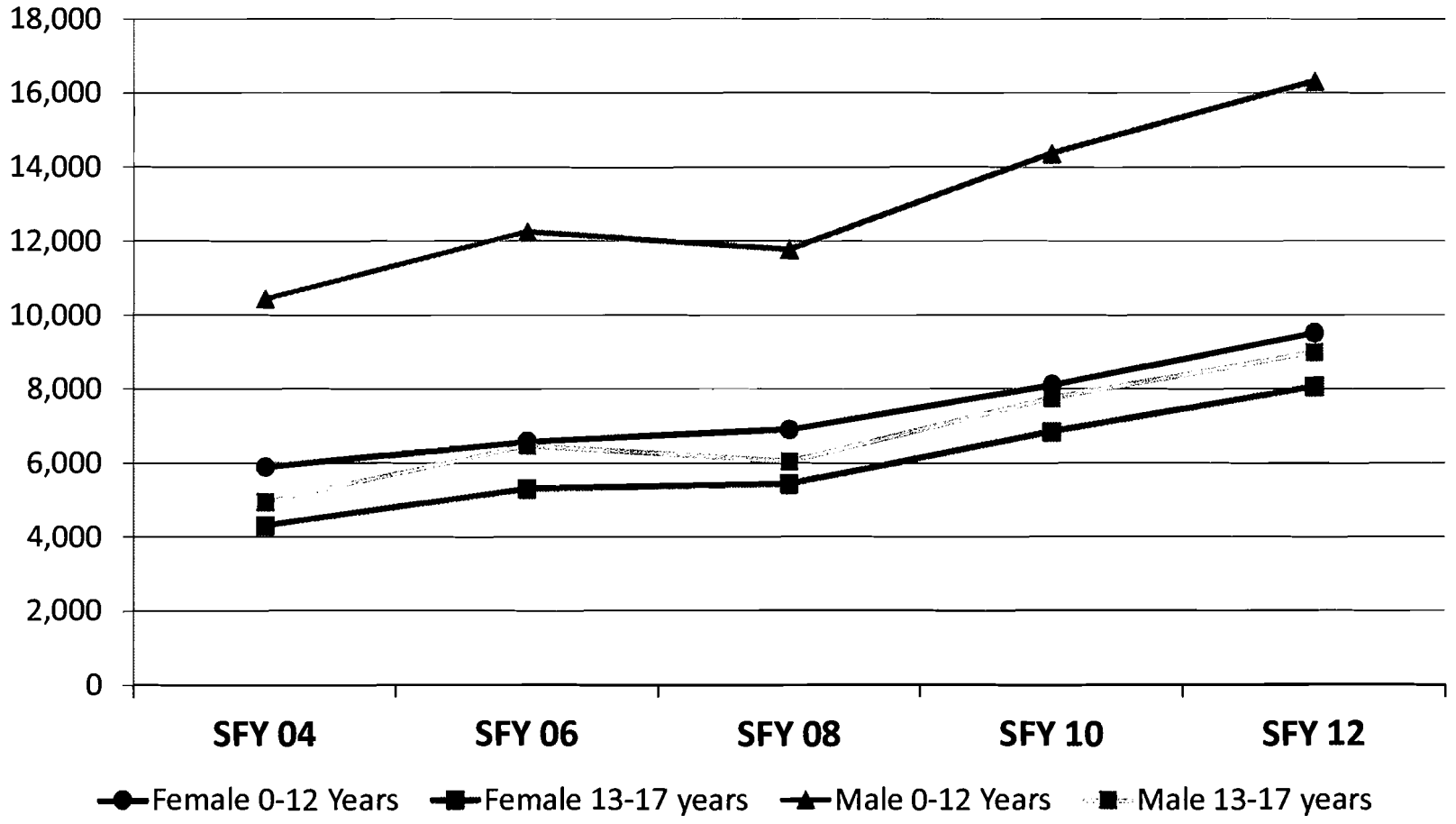
Persons Served



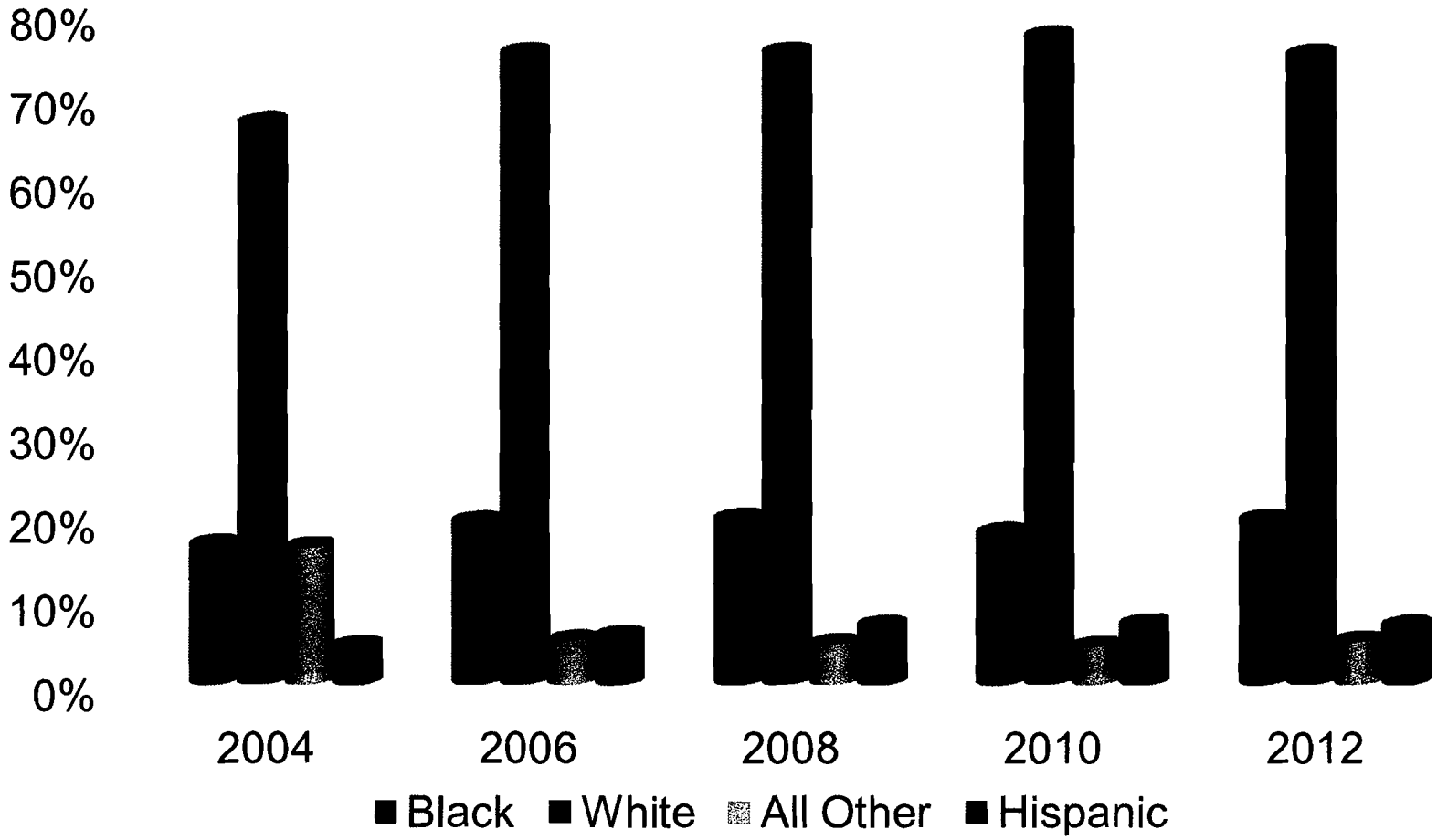
Unduplicated Number of Persons Served by Age



Youth Served by Age Group and Gender



Percentage of Youth by Race and Ethnicity



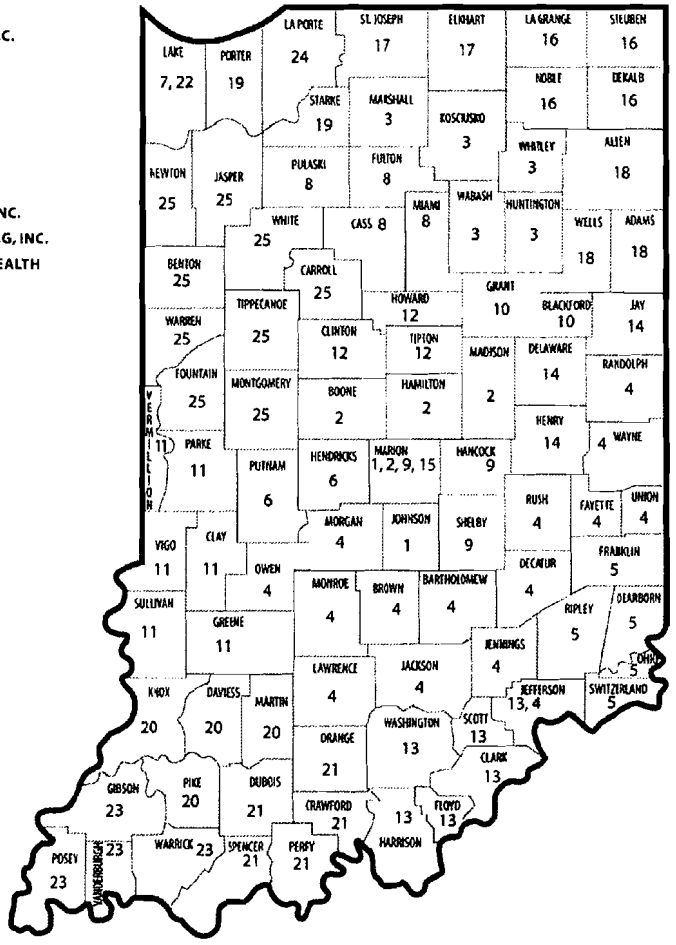
Children's Mental Health

440 IAC 8-2-4 Seriously emotionally disturbed children

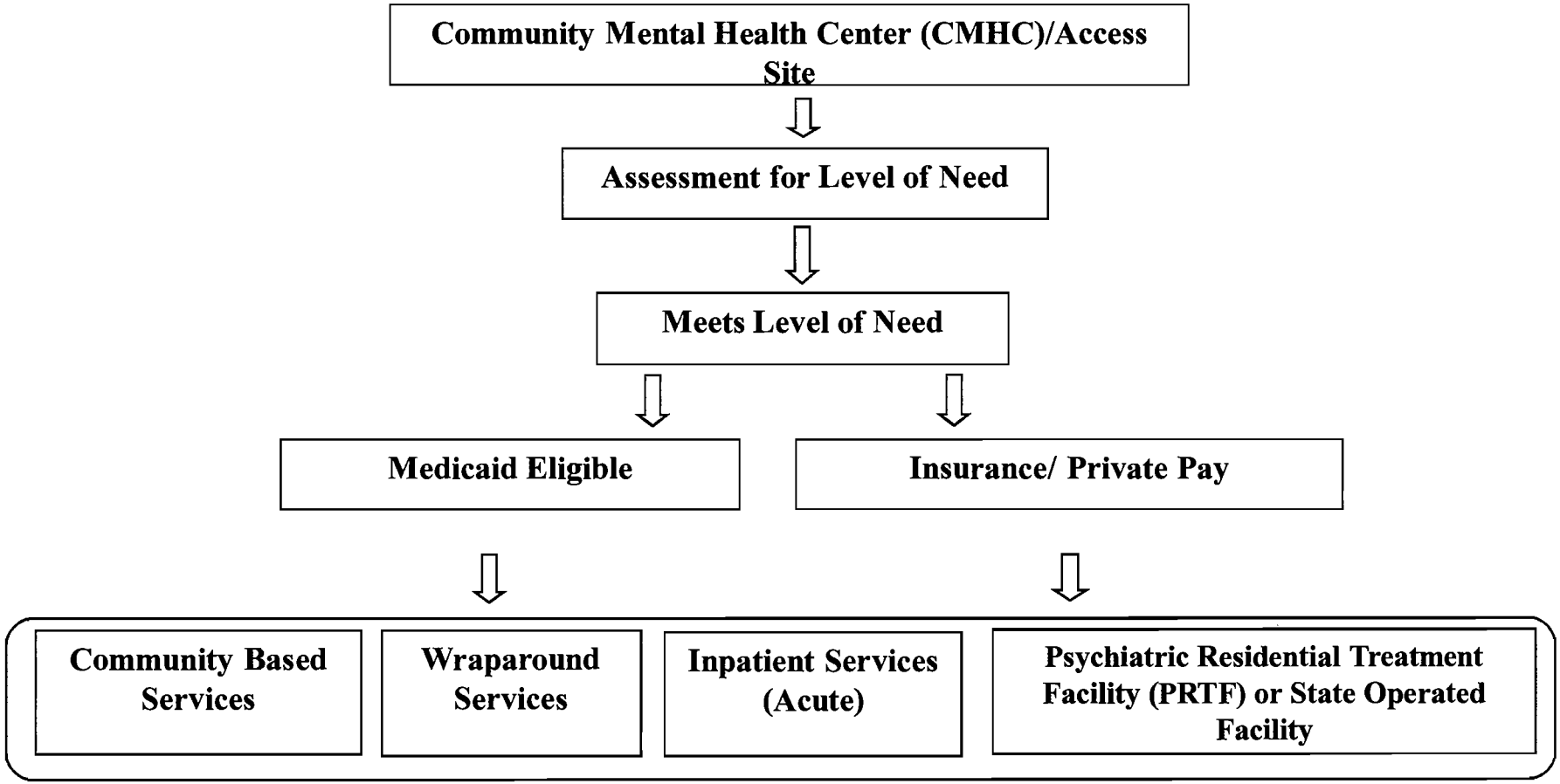
- Sec. 4. An individual who is a seriously emotionally disturbed child is an individual who meets the following requirements:
  - (1) The individual is less than eighteen (18) years of age.
  - (2) The individual has a mental illness diagnosis under Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association (DSM IV).
  - (3) The individual experiences significant functional impairment in at least one (1) of the following areas:
    - (A) Activities of daily living.
    - (B) Interpersonal functioning.
    - (C) Concentration, persistence, and pace.
    - (D) Adaptation to change.
  - (4) The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, individuals who have experienced a situational trauma, and who are receiving services in two (2) or more community agencies, do not have to meet the duration requirement.

Community Mental Health Centers

1. ADULT & CHILD MENTAL HEALTH CENTER, INC.
2. ASPIRE INDIANA, INC.
3. THE OTIS R BOWEN CENTER
   Bowen Center
4. CENTERSTONE OF INDIANA, INC.
   Centerstone
5. COMMUNITY MENTAL HEALTH CENTER, INC. (LAWRENCEBURG)
6. CUMMINS BEHAVIORAL HEALTH SYSTEMS, INC.
7. EDGEWATER SYSTEMS FOR BALANCED LIVING, INC.
8. FOUR COUNTY COMPREHENSIVE MENTAL HEALTH CENTER, INC.
   Four County Counseling Center
9. COMMUNITY HOSPITALS OF INDIANA
   Gallahue Mental Health Center
10. GRANT BLACKFORD MENTAL HEALTH, INC.
11. HAMILTON CENTER, INC.
12. COMMUNITY HOWARD REGIONAL HEALTH (KOKOMO)
13. LIFESPRING, INC.
14. MERIDIAN SERVICES CORP.
15. HEALTH AND HOSPITAL CORP. OF MARION COUNTY, INDIANA
    Midtown CMHC
16. NORTHEASTERN CENTER, INC.
17. OAKLAWN PSYCHIATRIC CENTER, INC.
18. PARK CENTER, INC.
19. PORTER-STARKE SERVICES, INC.
20. KNOX COUNTY HOSPITAL
    Samaritan Center
21. SOUTHERN HILLS COUNSELING, INC.
22. SOUTHLAKE COMMUNITY MENTAL HEALTH CENTER, INC.
    Regional Mental Health Center
23. SOUTHWESTERN INDIANA MENTAL HEALTH CENTER, INC.
24. LA PORTE COUNTY COMPREHENSIVE MENTAL HEALTH COUNCIL, INC.
    Swanson Center
25. WABASH VALLEY ALLIANCE, INC.



Current Process to Access Services



Standardized Assessment

- Child and Adolescent Needs and Strengths (CANS)
  - Child Behavioral/Emotional Needs
  - Child Risk Behaviors
  - Life Domain Functioning
  - Caregiver Strengths and Needs
- Results identify areas of focus and intensity of treatment interventions

Service access

- Referral to CMHC
- Mental health and CANS assessments
- Determine level of need and types of services available
- Treatment plan created and monitored regularly
- Services may include:
  - Outpatient
  - Wraparound
  - Community based
  - Inpatient

Supplemental programs

- CA-PRTF demonstration grant
- MFP/1915i - proposed
- Block grant funded programs
  - Early childhood mental health
  - Youth MOVE
  - Community mini-grants
  - Trauma focused care
  - System of care support
  - Adolescent dual diagnosis clinic

Inpatient

- State hospitals
  - 42 beds at Larue Carter
    - 11 children
    - 18 adolescent girls
    - 13 adolescent boys
  - Evansville Psychiatric Children's Center
    - 28 children
- Psychiatric Residential Treatment Facility

Mental Health Services for Children

COMH
Meeting 2
9-17-12
Exhibit 2

Presentation to the Commission on Mental Health and Addiction
September 17, 2012

John Ryan, DCS Chief of Staff
Lisa Rich, DCS Deputy Director of Services & Outcomes

INDIANA DEPARTMENT OF CHILD SERVICES

Challenge

- Ensure all children who struggle with significant mental health issues have access to services, regardless of the funding mechanism.

- In an effort to receive services for their children some families:
  - Reach out to many different resources for service, or
  - End up in the child welfare system to access services, even if they have not abused or neglected their child.

INDIANA DEPARTMENT OF CHILD SERVICES

Background

- DCS is statutorily charged with serving children who have been abused or neglected.
  - Indiana law defines Child Abuse or Neglect as those acts or omissions committed by the child's parent, guardian or custodian.
- DCS protects children from abuse or neglect by partnering with families and communities to provide safe, nurturing, and stable homes.
- DCS works with families to try to help resolve situations that make it unsafe for a child to be in the home.

Background

- DCS involvement with a family:
  - Prevention services
  - Informal Adjustment
  - Child In Need of Services (CHINS) proceeding
  - Termination of Parental Rights (TPR)

Background

- Child In Need of Services (CHINS)
  - DCS request authority to file a CHINS petition with court, court must grant request to file for DCS to move forward (I.C. § 31-34-9-1).
  - DCS must prove the following in a CHINS:
    - the child is under the age of 18;
    - The child meets one of eleven sets of circumstances laid out in statute, such as the child's physical or mental condition being seriously impaired or endangered;
    - the "child needs care, treatment, or rehabilitation that the child is not receiving and is unlikely to be provided or accepted without the coercive intervention of the court".
- Removal
  - CHINS petition must be filed within 48 hours of removal.
  - If petition is not approved by the court, child must return home.
  - Termination of Parental Rights filed if a child has been out of home for 15 of the past 22 months.

"CHINS 6"

- A "CHINS 6" is one set of circumstances under which a child can be determined a "Child In Need of Services" (CHINS).

IC 31-34-1-6

Child substantially endangering own or another's health

Sec. 6. A child is a child in need of services if before the child becomes eighteen (18) years of age:

(1) the child substantially endangers the child's own health or the health of another individual; and

(2) the child needs care, treatment, or rehabilitation that:

(A) the child is not receiving; and

(B) is unlikely to be provided or accepted without the coercive intervention of the court.

"CHINS 6"

- Fundamentally different from all other DCS cases:
  - DCS must alleges the child is substantially endangering their own health or the health of another individual.
  - All other CHINS cases DCS alleges the child is not receiving appropriate care by the parent, guardian or custodian.

- CHINS 6 requires:
  - DCS to allege the child is a threat to himself or others.
  - DCS to show the child needs care, treatment, or rehabilitation that the child is not receiving; and is unlikely to be provided or accepted without the court intervention.

"CHINS 6"

- **CHINS 6 is not a family friendly process.**
  - Sets parents up against child in legal battle to prove the other is at fault.
  - Child's attorney has an obligation to represent the child and protect him from being placed in a restrictive treatment facility for an extended period of time.

- Every person is required to be afforded legal due process and proper legal representation.
  - The law only permits the child to admit allegations, the parent(s) cannot admit on the child's behalf. (I.C. § 31-34-10-7).
  - A minor cannot provide his own legal representation, they must be appointed an attorney (I.C. § 31-32-2-1).

INDIANA DEPARTMENT OF CHILD SERVICES

"CHINS 6"

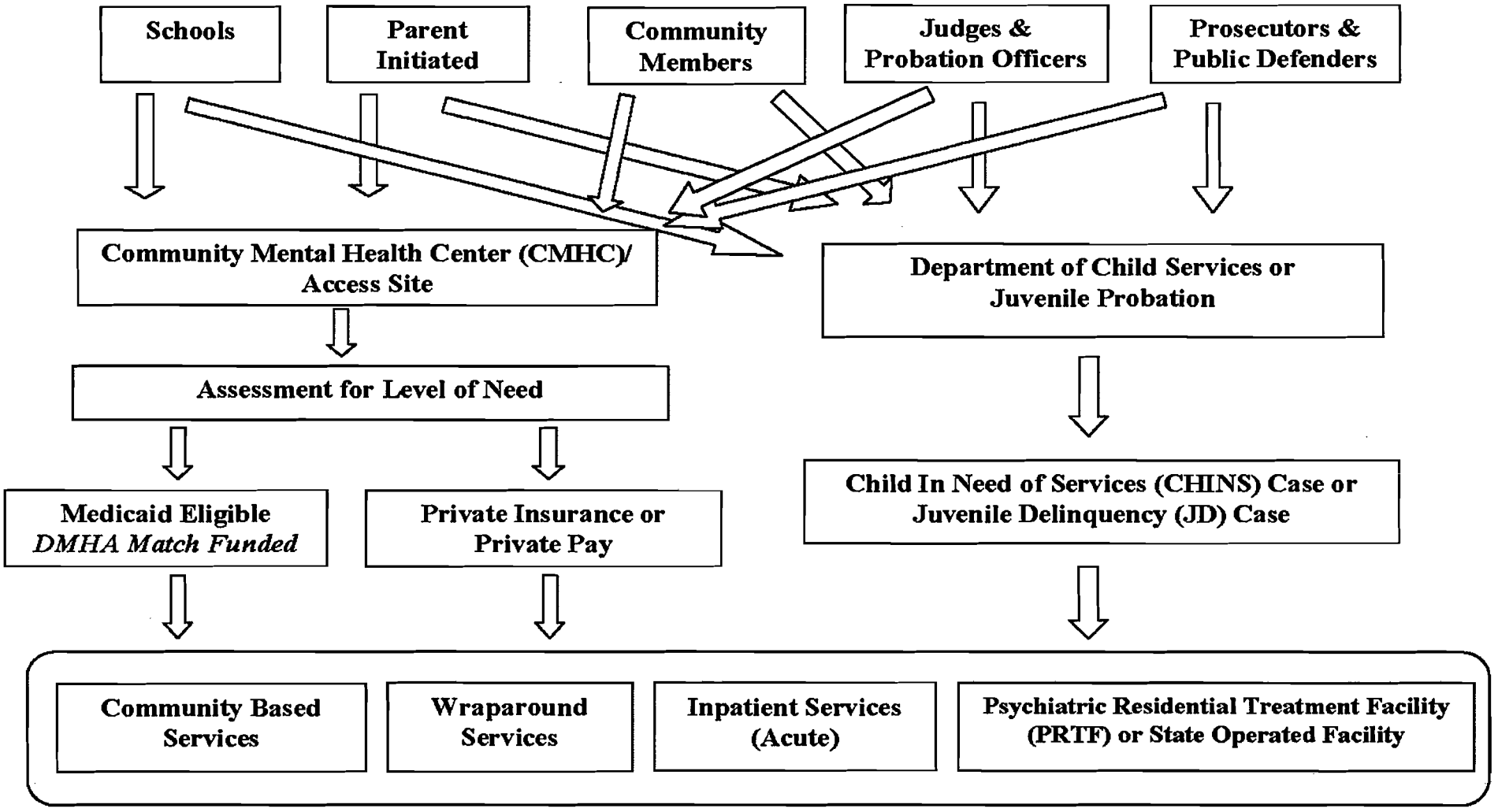
- In the past DCS found that legal due process was not being followed in all CHINS 6 cases, because the child was sometimes not appointed an attorney or advised that they had the right to an attorney.

- DCS began including language in its "CHINS 6" petitions that the child be appointed independent counsel to represent their wishes.
    - This reduced number of CHINS 6 cases that were approved by courts.

History

- Property Tax Reform (2008)
  - State assumed the responsibility for the County Family and Children Fund.
  - Child welfare and juvenile delinquency (JD) responsibilities were divided up.
- Before Property Tax Reform
  - DCS had the legal authority to file CHINS and JD cases.
  - Prosecutors had the legal authority to file CHINS and JD cases.
- After Property Tax Reform
  - After negotiation between the legislature, the prosecutor's and DCS changes were made to statute:
    - DCS only had authority to file CHINS cases.
    - Prosecutor's only had authority to file Juvenile Delinquency (JD) cases.

Current Process: Access to Children's Mental Health Services



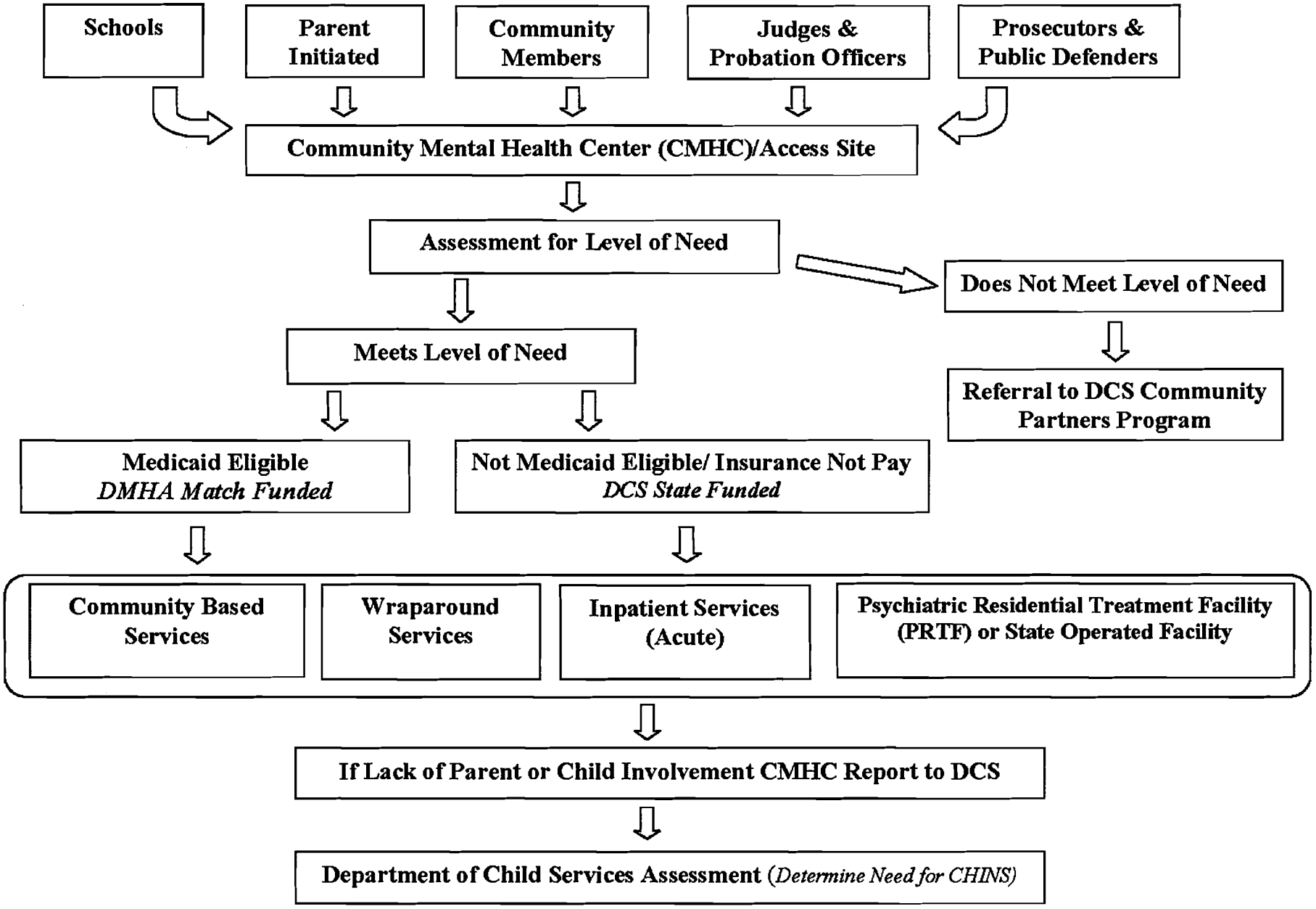
Finding a Solution

- DCS and FSSA began meeting to brainstorm multi-agency solutions for families.
- Indiana has a good service structure in place for Medicaid eligible children, gap exists for those children not covered by Medicaid or private insurance.
- A child should not be deemed a CHINS for the sole purpose of accessing services.
  - Reaffirmed in recent court decisions.

Existing Services

- PRTF transition waiver (CA-PRTF)
- Application for State Plan Amendment for 1915i for children
- Access Sites
- Medicaid Rehab Option (MRO) /Clinic services
- Psychiatric Residential Treatment Facility (PRTF)
- DCS contract with Community Mental Health Centers
- State operated facilities

Proposed Process: Access to Children's Mental Health Services



INDIANA DEPARTMENT OF CHILD SERVICES

Proposed Solution

- Utilize services currently available through the Community Mental Health Center/Access Sites.
- DCS provides funding for families in crisis who cannot afford to access these services.
- DMHA will collaborate with DCS to monitor services.
- Representatives from DCS and FSSA to follow the process and brainstorm solutions when obstacles arise.

INDIANA DEPARTMENT OF CHILD SERVICES

Proposed Solution

- Families referred to Community Mental Health Center/Access Site for:
  - Assessment to determine the level of need.
  - Determination of eligibility for services.
- Who can refer a child to an Community Mental Health Center/Access Site?
  - Anyone
  - Community Members
  - Schools
  - Judges
  - Prosecutors
  - DCS
  - Parent(s)
  - Public Defenders

INDIANA DEPARTMENT OF CHILD SERVICES

Proposed Solution

- Eligibility:
  - Medicaid
  - Not Medicaid Eligible/Insurance will not pay:
    - Families that fall into this category and meet the level of need will receive services funded through DCS.

Proposed Solution

- Target population for DCS funding:
  - Children ages 6 to 17;
  - Experiencing significant emotional and/or functional impairments that impact their level of functioning in home or community;
  - Not being abused or neglected;
  - Not eligible for any Medicaid services; and
  - Meets needs based criteria.

INDIANA DEPARTMENT OF CHILD SERVICES

Proposed Solution

- Needs-Based Criteria
  - Youth/families meeting the Target Group Eligibility criteria also need to meet the following Needs-Based criteria in order to qualify:
    - DSM-IV-TR Diagnosis- Youth meets diagnostic criteria for mental health services.
    - CANS assessment tool- Score of 4, 5, or 6.
    - Dysfunctional Behavior- Youth is demonstrating patterns of behavior that place him/her at risk of institutional placement & unresponsive to traditional outpatient and/or community-based therapy. Specifically maladjustment to trauma, psychosis, debilitating anxiety, conduct problems, sexual aggression, or fire-setting.
    - Family Functioning and Support- Family/caregiver demonstrates significant need in one or more of the following areas: mental health, supervision issues, family stress, or substance abuse.

INDIANA DEPARTMENT OF CHILD SERVICES

Proposed Solution

- Families will be access existing services through a new funding stream:
  - Community based services
  - Wraparound services
  - Inpatient services (acute)
  - Psychiatric Residential Treatment Facility (PRTF)
  - State operated facility

INDIANA DEPARTMENT OF CHILD SERVICES

Proposed Solution

- DCS becomes involved when the parent or child will not cooperate with services.
- DCS will complete an assessment to determine if a court case should be opened, requiring family to engage in services through court intervention, if any of the following are true:
  - Family needs services in order to maintain the safety of the child or other children and family is unwilling to accept offered services.
  - Family insists the child needs to be removed when the assessment indicates child can be maintained at home with services.

Proposed Solution- Pilot

- DCS is piloting the process to:
  - Ensure level of need is appropriate to serve population.
  - Ensure process works for all partners involved.
  - Receive feedback from partners in community (probation officers, prosecutors, juvenile judges, schools, and public defenders and others).
  - Receive feedback from families and children.
  - Ensure appropriate communication is established between all involved.

INDIANA DEPARTMENT OF CHILD SERVICES

Proposed Solution- Pilot

- Two or three pilot sites in communities with strong Community Mental Health Center/Access sites.
  - First pilot at Community Mental Health Center in Lawrenceburg.
    - Serves Dearborn, Franklin, Ohio, Ripley and Switzerland counties.
  - Expected to begin in approximately one month.
- Modify existing DCS master contract to allow service access to families without DCS case.

INDIANA
DEPARTMENT OF
CHILD
SERVICES

Questions?

COMH
Meeting 2
9-17-12
Exhibit 3

Attorney General Greg Zoeller's Remarks to the Commission on Mental Health and Addiction
1:00 p.m., September 17, 2012

Good afternoon, Madame Chair and members, thank you for providing me the opportunity to address the Commission today on this very sensitive, and important issue of child safety and government oversight.

There has been much debate and discussion, both public and private over the past few months on the progress Indiana's Department of Child Services is making in the lives of the children it serves.

As I've followed the discussion, I thought it would be helpful for you to recognize the attorney general's role in some of these issues and offer my assistance in any way that the legislature believes it would be helpful.

As attorney general and in my prior position as chief deputy, I understand and appreciate the relationship between the Office of the Attorney General (OAG) and the Indiana General Assembly.

Indiana is one of only six states where the OAG is created by the legislature and not by the state constitution. Over the years, I've worked to develop a

relationship with the legislature, providing counsel to you as clients and working to support your legal needs while also seeking additional authority that may be necessary to perform the functions of the office. This includes statutes to better protect the most vulnerable among us.

In recent years and working with some of you -- I've sought statutory changes on a variety of issues to provide greater protections for consumers, homeowners and victims of human trafficking.

There is no doubt that some of the most vulnerable among us are our children. The current issues facing DCS are very difficult. Additional efforts to provide greater protection of children are rightly the subject of your attention.

I am careful to seek legislators' ideas and input before offering new proposals. I have spoken to leadership and some of you over the past few months with some specific ideas and have sought more input on these matters.

First, a look at the recent history of legal services may be helpful. I began working in the OAG in 2001 with AG Carter and served during the years of Governors

O'Bannon and Kernan when all services were performed under FSSA.

In 2005 when Governor Daniels created DCS by executive order I worked with John Ryan and others at DCS in restructuring the legal services at the county level. From my own vantage point I can testify as to the remarkable improvements to the system of providing legal services.

Today DCS has more than 100 attorneys serving the agency at local court hearings on issues like abuse, neglect, placement and children in need of services. These are difficult cases and I've been told by judges, prosecutors and child advocates that the Department and the process could benefit from the independent, legal counsel the OAG provides.

You might wonder why DCS attorneys are handling these cases at the county level. Some years ago, the OAG consented to DCS utilizing its own lawyers in the hundreds of cases that arise in every Indiana County. The attorney general, DCS and the Governor's Office worked together at the time and determined that DCS was best positioned to represent the interests of children in trial court.

DCS hired its own lawyers rather than using deputy attorneys general who normally serve as state government lawyers. Over time that legal work expanded to include certain types of appellate work, which unless granted authority on a case by case basis –was outside the scope of the earlier consent.

As you know, there was a case in South Bend that made headlines earlier this year where my office had to intervene and withdraw an appeal that DCS had sought, but my observations over the past few months are focused on the big picture, not on one particular case.

Since Appellate courts hear only legal arguments over the law in a case, they don't hear direct testimony or evidence; the facts of the case are instead part of the trial record in the trial court below. The unique requirements faced by attorneys practicing in appellate court are somewhat different from those practicing in trial court. Whenever any other state agency appears in appellate court, Deputy Attorneys General who are the state's appellate lawyers represent that agency.
I've recently been working with DCS to review the appellate work to ensure cases that are appealed will be handled through the OAG. This realignment is closer to what the 2005 limited authorization had intended. This change allows us to harmonize the legal positions of

DCS and other state agencies in appellate court to ensure they are consistent with each other and with our state's legal policy.

You are here today to specifically address CHINS cases – specifically those cases where the child is endangering his/her own health or the health of another person – and to hear from Prosecutors and others on different ideas relating to the initiation of CHINS petitions. As the state's chief legal officer, I am an advocate of the criminal justice system triad – Prosecutors, police officers and the judiciary. My office handles approximately 1600 criminal appeals a year that support the work of the judicial system, keeping criminals behind bars.

We are in communication with prosecutors on a daily basis providing legal support and analysis when needed as well as defending their actions before appellate and supreme court judges.

As I mentioned earlier I often hear from prosecutors about the need for independent review of some CHINS cases when conflict arises between a prosecutor and DCS over the path certain cases involving juveniles should take.

Additionally, we have been in communication with DCS regarding legal representation, case processing procedures, and CHINS 6 matters in an effort to find solutions consistent with our shared commitment to protect children.

The proposals being discussed by DCS should serve to improve the communication and screening functions regarding situations where children suffering from mental health and addiction issues may be in need of mental health services. Furthermore, the Attorney General's Office is uniquely situated to work with and defend both prosecutors and DCS in the normal course of our daily responsibilities.

Our assumption of appellate work will allow us to provide some independent guidance as the CHINS process moves forward. It will allow us to be more engaged with attorneys representing the state at the local level. I wanted to take this opportunity to let you know I am willing and able to have the OAG play any appropriate role you believe would be most helpful.

In addition, the OAG can serve to coordinate other areas of our state's efforts to protect children. This could include working with Indiana's Internet Crimes Against Children (ICAC) task force assisting law

enforcement's efforts to go after on-line child predators – and continued efforts in partnership with the U.S. Attorney in combating human trafficking that preys upon runaway young girls. Finally, I continue to seek greater state support for School Resource Officers who provide both security in our schools while also helping to develop stronger relationships between law enforcement and our youth.

All of this requires working with you and your colleagues, other government agencies and advocates to develop specific roles for the OAG.

The past years of success in performing duties as authorized by the Legislature have developed some credibility among stakeholders and hopefully the public.

As you continue to focus on child safety, I continue to offer my assistance, and to that end, I plan to create a working group within the OAG on "Child Protection Services."

This team will work with all of those involved to draft proposals for legislator's consideration that will offer support and greater coordination for Indiana's effort to serve the most vulnerable among us, our children.

And – last, but not least --I know you heard from a number of experts and advocates during your last meeting about the increasing dangers prescription drugs have created in our State. Many of the individuals who testified on the issue have joined a Task Force that I've created to raise awareness and reduce prescription drug overdoses.

This task force will play an important role over the few months in developing a legislative package intended to strengthen our laws and provide better tools for law enforcement and medical personnel to fight this devastating epidemic.

Thank you for your support and in seeking to learn more about the issue. I look forward to a continued dialogue on this topic as well as on the topic presented today.

Thank you

The question before the Commission, Should Prosecutors be authorized to file CHINS 6 Petitions?

IPAC believes that they should be re-invested with the authority to file CHINS petitions and would support this position.

In 1978 a new Juvenile Code was written, which is the code currently in effect today. Before 1978 delinquency and CHINS cases were treated under the same procedures. The commentary to the code indicates that case law applying to one could be equally applied to the other. Written authority to file a CHINS petition was held by a probation officer, however, courts found that this was only "directory" and that other interested persons could file. Therefore, by case law, a petition filed by a welfare attorney provided the juvenile court with sufficient authority to take action.

The authors of the 1978 code provided more structure to the system. While they treated as delinquent, both criminal acts and status acts, they specified that only prosecutors could file delinquency petitions where the child committed an act that would be a crime if committed by an adult. Both prosecutors and welfare attorneys were provided the authority to file delinquent status offenses. They also specifically provided authority to prosecutors and child welfare attorneys to file all CHINS actions on behalf of the state. This is consistent with the goals of the Juvenile Law as stated in IC 31-6-1-1 two of which are "to insure that children within the juvenile justice system are treated as persons in need of care, treatment, rehabilitation, or protection; " and "to utilize diversionary programs which are consistent with public safety." The goals have since been re-codified under IC 31-10-2-1, and other than some stylistic changes and other additions, are consistent with the 1978 version.

Prosecutors as the sole individuals to charge juvenile delinquents should have the ability to decide that in lieu of charges, treatment for a child through the mental health system is a more consistent public safety approach and in keeping with the policy of ensuring that children are treated as persons in need of care, treatment, rehabilitation, or protection. In short without this ability, the only option for public safety may be in charging a child with a delinquent act which is in opposition to the policy of the Juvenile Code.

Juvenile Judges are the ultimate authority on whether a CHINS petition may be filed and whether a child is considered a Child In Need of Services. This would not change based on the additional authority for prosecutors to file the initial request to file the CHINS petition.

As prosecutors see some children that welfare attorneys presumably may not see, it would make sense to review all cases for alternative means to address public safety and the needs of the child.

Suzanne O'Malley
Indiana Prosecuting
Attorneys Council

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9-17-12
Exhibit 4

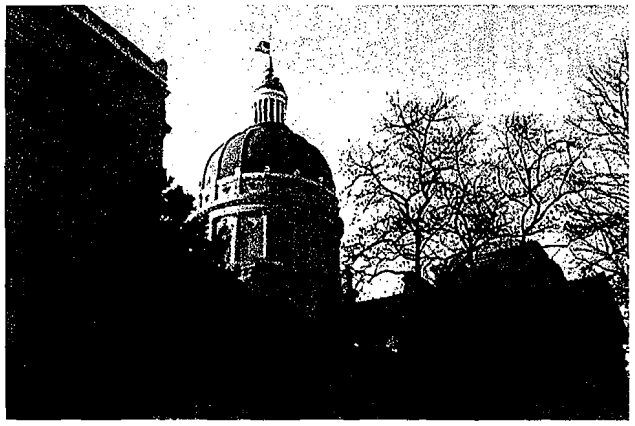

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Exhibit 5

Indiana Commission on Mental Health & Addiction

Community Mental Health Providers and the Indiana Department of Child Services, Working Towards Solutions to the Behavioral Health Issues in Children & Adolescents

Matt Brooks, MA, CEO
Indiana Council of Community Mental Health Centers, Inc.
Indianapolis, IN
September 17, 2012

Background Information on Community Mental Health in Indiana

- By way of background, Indiana has twenty-five (25) certified and accredited community mental health centers (CMHCs) providing statewide behavioral health services for adults, children, and families.

- In FY11, the CMHC industry in Indiana provided over $600 million in behavioral health services and employed almost 8,000 FTEs. Of this total, over 4,300 licensed and trained professionals provide direct behavioral care, services including; psychiatrists, psychologists, nurses, case managers, social workers, and counselors.

- In FY12, CMHCs provided behavioral health services to over 32,200 children and adolescents and utilized over $82 million in Medicaid Rehabilitation Option (MRO) services. By using MRO in lieu of state only funds , the CMHC system is able to leverage approximately $3 in services for every $1 spent.

- Through a partnership with the DCS that began in FY11, the CMHC system has expanded the level of behavioral health services to an additional 7,400 children and adolescents and provided over $15.5 million in additional MRO services.

- This partnership provides new access to intensive case management, family and individual therapy, family education, community and home based services, outpatient services, emergency intervention services, and services directed toward the restoration of the family .

Overview of Challenges and Opportunities

- The CMHC system in Indiana acknowledges the challenges of abused and neglected children and believes that effective behavioral health services focused on evidenced based practices is best suited to treat impacted children and adolescents.

- Many children exhibiting severe behavioral health disorders, that potentially rise to the level of a CHINS 6 determination, have experienced major trauma, which is characterized by the personal experience of interpersonal violence, sexual abuse, physical abuse, severe neglect, loss, and/or exposure to violence.

- The ICCMHC supports a less intrusive process for the treatment of potential CHINS 6 determination cases by getting children assessed and providing the potential for behavioral health services prior to the need for a formal legal action.

- We do believe, however, that the CMHC system is best suited to provide behavioral health services to these children in order to properly assess, treat, and in some cases authorize psychotropic medication for children exhibiting evidence of behavioral health disorders that endangers themselves or others.

Overview of Challenges and Opportunities

- In order to move forward with a plan to address the needs of potential CHINS 6 determination cases, DCS approached the CMHC system to determine if the current MRO program could be utilized to enhance or initiate treatment for such children and adolescents.

- Due to the strong partnership fostered between CMHC providers and DCS over the last two years, the utilization of community mental health services in the behavioral health treatment for these potential CHINS 6 cases became a logical approach to treatment.

- The CMHC systems stands prepared to assist DCS with any child at risk of a CHINS 6 determination through the provision of community based, clinic based child consumer services, and other child-based services directed toward the improvement of the child's behavioral health condition and the restoration of the family .

- The ICCMHC and DCS held a joint statewide meeting in July to begin the process of operationalizing the implementation of this new program in order to address the needs of potential CHINS 6 determination cases.

Overview of Challenges and Opportunities

- Following the joint meeting between CMHC providers and statewide DCS staff, a plan of action was developed that includes the utilization of current Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) access sites already established by the FSSA/Division of Mental Health and Addiction through an existing grant program.

- CA-PRTF services are primarily provided through community mental health centers to provide wrap-around services such as; family training and support, Medicaid covered services, and regular meetings with the child, family, and care givers to determine the well-being and behavioral status of the child.

- By using the existing CA-PRTF access sites, DCS and impacted families are assured that the professional individuals providing services have the appropriate license, training and experience required when addressing a potential CHINS 6 child. This process will allow for an appropriate assessment.

- Thanks to the willingness of DCS to financially support the cost associated with child based treatment, community mental health providers will be positioned to provide assessments, Medicaid Rehabilitation Option (MRO) services , as well as other behavioral health services, to the estimated three hundred (300) children at risk of a CHINS 6 determination.

QUESTIONS AND ANSWERS

September 17, 2012

Kaarin M. Lueck
Wayne County Public Defenders' Office
301 East Main Street
Richmond, Indiana 47374

Commission on Mental Health and Addiction
Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789

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Exhibit 6

RE: CHINS 6

Dear Rep. Noe and Commission Members:

Thank you for the opportunity to speak today. I am a full-time public defender in Wayne County, Indiana, but I do not represent the views of the Wayne County Government. In my role, I represent most of the juvenile delinquents in our county.

I would like to begin by praising the Department of Child Services ("DCS") for the proposed pilot project. However, the pilot project and CHINS 6 are not either/or propositions. By modifying Ind. Code § 31-34-9-1, the prosecutors would act as a safety net for those children who need immediate access to the juvenile court. There are times when things happen very quickly with juvenile cases. The prosecutors may be forced to act to protect the child or the community by removing the child from the community. Additionally, there are children who need the coercive influence of the court to participate in services. By giving the prosecutors the authority to request a CHINS 6 petition be authorized, the ultimate decision would be left to the juvenile court whether the child is appropriately a CHINS 6, a juvenile delinquent, or not proper for juvenile court involvement at all.

As the DCS pilot project goes forward, it is not enough to have access to services. There must be an adequate supply of services. I would challenge those involved to ensure that there is an adequate supply of services for these mentally ill children.

You heard testimony from Mr. Moore from the Division of Mental Health and Addiction ("DHMA"). He stated that most of the inpatient DMHA beds are for very young children. Juvenile delinquents are generally twelve (12) to seventeen (17) years old, with some exceptions. As DCS and others develop the pilot, there needs to be an adequate number of inpatient beds, whether through DMHA, PRTF, or other residential treatment center beds to meet the needs of these children.

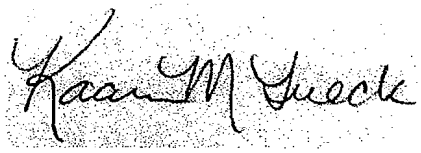
Mr. Brooks from the Community Mental Health Centers stated that every county has access to a Community Mental Health Center. That may be true, but there is an inadequate supply of services. Many of our children get put on waitlists and do not actually receive treatment. It is not unusual for a probationer child to appear at a three (3) or six (6) month review

hearing having never actually received some services. Without the needed services, the child continues to act out -- committing more acts, being drawn back into the delinquency system, and away we go . . . As the DCS pilot project is developed, we need to ensure that there is an adequate supply of community services to meet the needs of these children.

Finally, many have spoken about the consequences of being a juvenile delinquent. The American Bar Association collected information on collateral consequences of juvenile delinquency from around the country. I wrote the Indiana chapter. If you would like more information on how a juvenile adjudication can impact the child's driver's license, access to jobs, access to schooling, etc., you may look at their website at www.beforeyouplea.com.

Thank you again for this opportunity.

Sincerely,



Kaarin M. Lueck, J.D.

Collateral Consequences of Juvenile Adjudications in Indiana

A juvenile adjudication often leads to collateral consequences that children and their parents may not fully understand as they participate in the juvenile justice system. Many state and federal statutes and regulations mandate the disclosure of juvenile adjudication information, which can impact basic needs, such as housing, education, employment, and the ability to get a driver's license. In recognition of this impact on children and their families, the American Bar Association gathered federal and state data – including Indiana's – into an evolving database of these often unanticipated consequences of juvenile adjudications. What follows is a partial summary:

1. Disclosure to the Public – Despite the commonly held belief that juvenile court proceedings are confidential, there are many instances when the child is not shielded from the public gaze and the impact that may follow. For instance, whenever a petition alleges that the child committed an act that would be murder or a felony if committed by an adult, the juvenile court proceeding is open to the public. Ind. Code. 31-32-6-3. If a petition contains allegations of a felony and/or a specified number of misdemeanor offenses, most juvenile court records are open to the public. Ind. Code 31-39-2-8(a). Finally, if a child is placed on the sex offender registry following an adjudication, that information is treated in the same manner as an adult offender. Ind. Code 11-8-8-4.5, -5, -7.

2. Primary or Secondary School Suspension or Expulsion – If the child is adjudicated for a Class A felony, a Class B Felony, a Class C Felony, or two (2) Class D felonies, the juvenile court judge must give written notice of the adjudication to the child's chief administrative officer or school superintendant. Ind. Code 35-50-8-1(a). The school may then suspend or expel the child for any unlawful activity on or off the school grounds if the unlawful activity may: (1) interfere with school purposes or an educational function or (2) the child's removal is necessary to restore order or protect persons on school property, even if the act occurred during weekends, holidays, school breaks, or the summer period. Ind. Code 20-33-8-15.

3. Eviction From Federally-Funding Housing – Public housing authorities may evict a tenant or a household if any household member engaged in drug-related criminal activity, violent criminal activity, or other activity that threatens the health, safety, or right to peaceful enjoyment of the premises. 24 C.F.R 982.553(a)(1)(i); (a)(2)(ii); (b) (2010).

4. Suspension of Driver's License or Permit – Many juvenile adjudications mandate the suspension of the child's driver's license or permit, including for habitual truancy (Ind. Code 20-33-2-11), operating while intoxicated (Ind. Code 31-37-19-17.3), other alcohol-related offenses (Ind. Code 7.1-5-7), controlled substance and prescription drug-related offenses (Ind. Code 31-37-19-13, -14, and -19), criminal mischief with graffiti (Ind. Code 31-37-19-17), and fuel theft (Ind. Code 31-37-19-20).

5. Denial of Military Service Application – In general, all branches of the military mandate that a juvenile adjudication record involving acts that would be crimes must be disclosed during the application process and may prevent an applicant from enlisting unless granted a waiver.

Additional information is available at www.beforeyouplea.com.

Prepared by Kaarin M. Lueck
Wayne County Public Defenders' Office

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Exhibit 7

Good afternoon Madam Chair and commission, Thank you for the opportunity to speak with you today. My name is [redacted] I am the executive director of the National Alliance on Mental Illness in Porter County. I am also the parent of a teenager with serious mental illness. In 2000, it was necessary for my son to be placed in a psychiatric residential treatment facility. At that time, Medicaid did not pay for PRTF. I was advised to have my son declared a child in need of services. I don't know if this was a CHINs 1 or 6. I do know two things. I was not found guilty of abuse or neglect and this was a very positive experience. The judge was very happy to have me play an active role on my child's treatment team. He even allowed us to complete our adoption while my son was a child in need of services. According to Director Payne, DCS does not want to use CHINs 6 because it creates an adversarial position between parents and child. There was nothing adversarial about the entire procedure. What happened? What changed that parents don't have the same avenues for care?

I asked six parents I have been working with to either come to Indianapolis to share their stories or write something so that I could read it to the study committee. This was ludicrous. If these parents had time to make a trip to Indy, or sit down and write a story, they wouldn't need the assistance of the Department of Children's Services.

Our parents are dealing with children who set their house on fire, are unable to communicate because they are nonverbal; therefore they release their anger and frustration by throwing intense tantrums, beating holes in the wall, tearing down light poles, and beating on their parents. When I say tantrums, it's not your normal, everyday child tantrums. These are ten times what a normal child would do. One parent had multiple bruises on her body from her daughter. Another parent lives in fear every day that this will be the day her child commits suicide. A child tells their father that he will slit his throat with a knife. And then we have the

parents who have to call the police because the child is so out of control. One of a parent's worst nightmares is to find their child in the juvenile justice system.

This is the story of just six parents in northwest Indiana. Multiply that by ninety-two. That is 372 children who are in danger of hurting themselves or others.

The statutory definition of CHIN's 6: The child substantially endangers his/her own health or the health of another individual. Why aren't we using this to help our children? Do we wait until they get involved with the juvenile justice system? We can pay now or we can pay later. Or do we wait until they kill themselves because they can't endure the pain they live with on a daily basis. Sometimes it is necessary to put the well-being of our children ahead of the cost. This is one of those times.

I'd like to share some of the stories the parents wrote about these children. The common thread that I got from these parents is that it was heartbreaking to sit down and relive some of the worst moments of their child's life which was caused by serious mental illness.

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Exhibit 8

[redacted] received Medicaid through his adoption which took place in 2004. He has had many diagnoses and health issues throughout his childhood but as he became a teenager, the most significant is that of mental illness and mental retardation. These diagnoses rule his and his family's lives if [redacted] does not have access to the proper behavioral and psychiatric care through his Medicaid. [redacted] is now 16 years old, weighs 260 pounds, and experiencing hormone changes as adolescents go through. He has almost lost his life on several occasions due to the impulsive, uncontrollable behaviors he experiences with this illness. He has seriously injured his family members and school personnel. He has been physically restrained by police, fire personnel, and medical personnel on over twenty different incidents. These have resulted in physical and emotion harm to him and others.

When [redacted] was taken to the hospital(s) in emergency situations, he was placed in ER rooms with a guard and restrained to the bed until a parent (who was often the victim of [redacted] aggression) could sit in the room with him. Social Services would be called to the ER. All this meant for us was that a social worker would be asking the same questions again and would return 2 or 3 hours later to tell us that the hospitals that provide psychiatric care to adolescents on Medicaid would not accept [redacted] for a psychiatric evaluation and treatment. The social worker would then dare to approach the idea of residential placement and say" Have you ever considered residential placement for [redacted]?" This usually came with the impression that his father and I did not understand what was available to help our son and the social worker had a new and fresh idea! When we would explain to the social worker that residential psychiatric facilities either refuse Medicaid patients of if they are one of the few facilities that will accept Medicaid, they require at least two failed hospitalizations from a child psychiatric unit before they can even consider a placement in their program. They generally would not accept this answer and would then disappear for an hour or two to confirm with various facilities what they had been told by us. After confirming with the facilities that this was actually the situation, they would return to the ER room and ask" do you feel safe taking him home?" Of course not "was generally our reply fully knowing that there was no other choice. This cycle of abuse to all of us continued for two years.

Twenty six hospitals in Indiana were contacted to seek the psychiatric placement required to get even a chance for residential help for [redacted]. NOTE: (Only a 72 hour treatment is needed by the hospital to be considered a failed attempt).

In an attempt to resolve the situation with the help of the residential programs, facilities for youth were contacted in all areas of Indiana- All of which either denied Medicaid or would explain that they could not even evaluate our son for treatment until we could supply them with two (sometimes three) failed hospitalizations. Many facilities presented this as one of their first few questions to screen out a caller before an intake or social worker had to take the time

to talk with a family. This cycle seems to be acceptable and common practice. Accepting neglect charges and potentially loosing livelihood (due to the severity of being accused of neglect) and turning one's child over to the court ends up being the only option for many families. DCS will not provide the assistance without the child being turned over to the court and made a Child in Need of Services (CHINS) even in the case of [redacted] being an adopted child (from DCS), This NOT a solution for our son and family but what is? Continuing the cycle of abuse for [redacted] and all of those who love and care for him?

Respectfully,

Lisa Previs/Larry's mom

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Exhibit 9

Madam Chair and Commission, thank you for the opportunity to speak with you today. My name is [redacted]. I am addressing you on behalf of my 12 year old son, [redacted]

[redacted] has been diagnosed with ADHD, Bipolar disorder, Autism and he is mildly mentally handicapped. He has lived with mental illness since he was 2 ½ years old.

Currently [redacted] is taking medication for ADHD, an anti-psychotic and a mood stabilizer. Finding the right combination of these drugs is a challenge. They work for a while and then stop. When they are no longer affective, [redacted] suffers from meltdowns.

[redacted] meltdowns have led to behaviors such as flipping desks over, throwing things, and attacking teachers and caregivers. At home he hits and throws things at his little sister. He went after her with a pair of scissors, pushed her down the stairs and then tried to set the house on fire.

When [redacted] is going through a meltdown, he screams, yells profanity and tries to inflict pain upon himself. These meltdowns can last for 30 minutes or longer and many of them require restraining him. [redacted] has talked about killing himself and has to be monitored for sexually acting out.

When [redacted] psychiatrist can no longer find the right combination for his medication, [redacted] must enter a treatment facility for medication management and behavioral therapy.

[redacted] has been in 3 different acute care hospitals. Each visit was from 3-7 days. He has also been admitted to a psychiatric residential treatment facility. He was at Midwest Center for Youth and Families in Kouts 3 times and was placed in Options Behavioral Treatment Center in Indianapolis 3 times. Each of these visits was from 6-9 months.

Medicaid refused to pay for anymore PRTF because they said he was not progressing. I was told to contact the Department of Children's Services. When I contacted DCS I was told they would only help if they found evidence of abuse or neglect. They investigated and found no evidence. I was told to contact the Bureau of Developmental Disabilities. The BDDS office told me they don't cover children anymore.

I was told by Impact that if [redacted] qualifies for a waiver they could place him in an independent living apartment with a 22 year old man. BDDS denied the waiver. They gave him 9 hours of respite care a month and 35 hours of behavioral supports a month. Why would you put a 12 year old boy in an apartment living house?

My family is on an emotional roller coaster. We need help. I don't know where to turn. What does [redacted] have to do; who does he have to hurt before someone takes this seriously?

IARCCA

An Association of Children & Family Services

5519 East 82nd Street, STE A
Indianapolis, IN 46250
Phone 317/849-8497 FAX 317/576-5498
website www.iarcca.org

COMH
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Exhibit 10

Testimony on the unmet mental health needs of children
Commission on Mental Health and Addiction
Prepared by: Cathy Graham, Executive Director
9-17-12

IARCCA is an association of 100 Indiana agencies which provide home-based services, foster care and residential care to abused, neglected, delinquent, and other needy children. IARCCA's membership includes 13 psychiatric residential treatment facilities (known as PRTFs) and seven community mental health centers.

IARCCA believes strongly in the importance of assessing the needs of children and families so that the right services are provided at the right time for the right length of time. It does the child and family no good to put off the response to their needs until the child's behavior escalates to a danger to the child or others, including siblings in the family's home. IARCCA regularly receives calls from parents who are seeking help for their children, and many of these parents have tried multiple interventions for their child. They are not neglectful parents; they are parents in need of the right services for their child. It is important that the right package of services, utilizing the full array of services, be developed to meet the child and family's needs.

IARCCA supports the efforts of the Department of Child Services (DCS) in collaboration with the Division of Mental Health & Addictions (DMHA) to provide services to additional children as presented. IARCCA supports that the following options be available to children and families who need services:

- Services within the child's community that enable the child to remain at home, in school, and out of trouble;
- Voluntary placement under IC 31-34-1-16 that enables the child to receive the care and treatment that the child needs while maintaining the family's custody of the child;
- Use of the CHINS 6 category for those children whose situation warrants the coercive intervention of the court;
- Admission to a PRTF for those children for whom this service is medically necessary;
- Continued efforts to develop community alternatives to PRTF, including support of the federal Children's Mental Health Accessibility Act (S. 3289, authored by Senators Grassley and Kerry).

With the proper treatment, children and their families can have positive outcomes. For 396 children discharged from PRTFs in 2011, IARCCA is pleased to report the following:

- Children's clinical functioning improved from a score of 34 at intake to 48 at discharge on the Global Assessment of Functioning.

- The number of problems that youth experience decreased from 11.6 at intake to 5 at discharge.
- Over 84% of youth experienced a positive educational outcome in attendance, achievement, and behavior in the classroom. Over 90% of those contacted at six months follow-up (119 youth) had positive educational outcomes.
- Also at follow-up, over 83% of youth had no new court involvement due to their behavior.
- Over 56% of youth were discharged to their parent's home; another 9% were discharged to their adoptive home; and 9% were discharged to a relative's home. This means that 74% of youth were able to be returned to the family home. Another 4% were discharged to foster family care, and 3% stepped down to a group home setting.[1]

IARCCA is also part of the national Building Bridges Initiative, which is a national endeavor to promote practice and policy that will create strong partnerships between families, youth, community-and residentially-based treatment and service providers, advocates and policy makers to improve the lives of young people and their families. Information is available at www.buildingbridges4youth.org.

[1]S. Koch, Ph.D. and J. Wall, Ph.D.; The IARCCA Outcome Measures Project Report for Calendar Year 2011; IARCCA . . . An Association of Children & Family Services, Indianapolis, IN; May 15, 2012. Available at www.EvaluateOutcomesNow.org.

COMH Meeting 2 9-17-12 Exhibit 11

Mental Health Needs of Indiana's Children: Options to Bridge the Gaps

Over the past several years, the Advisory Board for the Indiana Juvenile Mental Health Screening, Assessment and Treatment Project has identified significant challenges in connecting the youth with mental health and/or substance use issues to appropriate treatment. A workgroup of the Advisory Board met regularly over the past year to further consider these challenges. The workgroup recognized that the challenges faced by youth who have contact with the juvenile justice system are common challenges for all youth with mental health and/or substance use issues across the state. The following summarizes important options to address the current challenges.

Create a statewide, evidence-based treatment system of care for youth identified with mental health disorders.

- **Access:** Provide youth involved with juvenile justice (detention or probation) with access to care, including universal screening all youth entering the juvenile justice system for mental health and/or substance use issues, and including comprehensive assessments and treatment when necessary. This includes requiring a universal assessment process be used consistently by all systems, across all sectors (i.e., the Child and Adolescent Needs and Strengths tool). Adequately support implementation, and require comprehensive training through state funding.

- **Evidence-based intervention in community:** Ensure early intervention, community-based, best practices. This includes funding mental health front-end diversions for youth, and integrate them into detention reform efforts (e.g., Juvenile Detentions Alternative Initiative). Ensure that all assessments address trauma and educational needs, and require trauma-informed, culturally competent practices to be implemented across public systems. Place school behavior in context and implement interventions and alternatives in schools. Ensure that community based care framework is available to all youth in juvenile justice, including youth committed to correctional facilities. This includes receiving appropriate care for their mental health needs while in confinement, and that appropriate supportive services are provided to youth as they exit from juvenile justice facilities into community based care.

- **Cross-system collaboration:** Support and allow for cross-system collaboration of all child-serving agencies, including information and data sharing, and policy and funding system alignment. Require and fund evidence-based systems of care at sufficient levels in all counties. Services should be developed around home and community based care at multiple levels of intensity that are age appropriate, and should utilize a team approach which is driven by the child and family. Ensure a sufficient number of residential care beds within the state for those who need it. Create programs that allow residential care for stabilization and treatment of children without having to adjudicate the child and without the requirement of failed placements.

Pilot a model of care through a collaborative consortium for purchasing services for all.

- Work with cross-system collaborative, including mental health, addiction, juvenile justice, academic community, child advocates, community mental health, health, education, legal, intellectual/developmental disabilities, families and caregivers, and child welfare, to plan a collaborative consortium for purchasing services for all children.

- Ensure that consortium services are accessible to youth in the juvenile justice system and youth ineligible for Medicaid.

Create a multi-agency fund or funding protocol for treating youth with serious mental illnesses.

- Reform funding and fiscal policies to support a "medically needed" Medicaid funding category so that children with serious mental health needs at all income levels can access care.

- Enable seamless care between systems without children entering the juvenile justice system. Ask DMHA, DOE, DDRS, DCS, DOC and OMPP to develop new funding protocols that blend multi-agency funding to deliver services to children at the earliest possible point. Children's mental health needs should drive programs.

Develop or preserve statutory provisions that act as safety measures

- Prevent youth from entering the juvenile justice system due to mental health crisis or serious, complex mental health needs through statutory provisions that act as safety measures, allowing courts to order appropriate mental health care for children without a delinquency adjudication.

Definitions:

System of Care – a comprehensive spectrum of services and supports which are organized into a coordinated network to meet the multiple and changing needs of children and their families.

Evidence-Based – refers to the existence of a body of research that documents the effectiveness of the process.

Evidence-Based Practices – refers to a defined treatment process that has been shown through objective research to be effective in treating specified conditions.

Best Practices – refers to a defined treatment process that is accepted as being effective in treating specified conditions but does not have the body of objective research to support being classified as evidence-based.

Screening – a process, usually a brief set of questions, which is designed to identify individuals who are at-risk of having mental health/substance use problems or concerns and/or those who would most benefit from more in-depth assessment.

Behavioral Health Assessment – a formal process that is reliable (results are the same regardless of who conducts the assessment) and validated (measures what is intended to be measured) and that results in a thorough depiction of an individual's mental health, social-emotional functioning and/or substance abuse.

NAMI Indiana
National Alliance on Mental Illness

COMH
Meeting 2
9-13-12
Exhibit 12

Children's Mental Health, 2012

Systems of Care Must Be Developed

- Systems of Care that include home and community-based services should be in every county in Indiana.
- Because services for children are dispersed over many agencies, there must be cross-system collaborations. Make sure that each child has a single service plan.
- Systems of care must be FAMILY-DRIVEN, YOUTH GUIDED, COMMUNITY BASED, and CULTURALLY and LINGUISTICALLY COMPETENT.
- Create new services to ensure that all essential child and family needs can be met.
- Establish a range of performance measures and standards that make systems focus on outcomes.

Barriers to Care Should Be Removed

- Do not put "barriers" in front of families seeking care for their children. Families struggle significantly with the stigma of having a child with problems. They often feel disenfranchised and alone when doors are shut.
- Children in juvenile detention who are there because of their illnesses should be released with wrap-around, 24/7 care in the community in which they live. Sick children do not belong in the juvenile justice system.
- A parent should not have to plead to neglect charges to get mental health treatment for his or her child.
- The provisions of CHINS 6 should be fully implemented, so that such pleadings of neglect will not be required.
- Children who are dually diagnosed with mental illnesses and developmental disabilities face unique, significant challenges in our current system. State agencies should collaborate to create new, family-driven pathways for those families to access treatment and support when and how they need it.
- Every county in Indiana needs a "safe place" for children and adolescents to go for treatment.

Increase Access to Financial Resources

- NAMI Indiana believes that ALL children who need mental health treatment should be able to receive it, whether they qualify for Medicaid or not. Private insurance often falls short.
- DMHA should create policies and procedures that encourage providers to serve people and families who do not qualify for Medicaid.
- Make sure that children's needs, rather than funding challenges, drive programs.
- Expand mental health services in schools, and train all school personnel to recognize signs and symptoms of mental illnesses, leading to treatment rather than detention.