

Members

Rep. Charlie Brown, Chairperson
Rep. Cindy Noe
Sen. Connie Lawson
Sen. Timothy Skinner
Kathleen O'Connell
Stacey Ryan
Margie Payne
Ronda Ames
Valerie N. Markley
Bryan Lett
Caroline Doebbling
Kurt Carlson
Chris Taelman
Jane Horn
Rhonda Boyd-Alstott
Dr. Danita Johnson Hughes



COMMISSION ON MENTAL HEALTH

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Authority: IC 12-21-6.5

MEETING MINUTES¹

Meeting Date: August 19, 2010
Meeting Time: 10:00 A.M.
Meeting Place: State House, 200 W. Washington
St., House Chamber
Meeting City: Indianapolis, Indiana
Meeting Number: 1

Members Present: Rep. Charlie Brown, Chairperson; Rep. Cindy Noe; Sen. Connie Lawson; Sen. Timothy Skinner; Stacey Ryan; Margie Payne; Ronda Ames; Valerie N. Markley; Bryan Lett; Caroline Doebbling; Kurt Carlson; Chris Taelman; Jane Horn; Dr. Danita Johnson Hughes.

Members Absent: Kathleen O'Connell; Rhonda Boyd-Alstott.

I. Call to Order and Introductions

Representative Charlie Brown, Chairperson, called the meeting to order at 10:05 A.M. Representative Brown asked the members to introduce themselves. Representative Brown asked Ms. Susan Kennell to explain the new procedures being used by LSA for meeting notices and the distribution of minutes (Exhibit 1).

II. Presentation from the Youth Law T.E.A.M. of Indiana, Statewide Juvenile Mental Health Screening Assessment and Treatment Pilot Project

Ms. JuaNae Hanger and Dr. Matt Aalsma provided the Commission with an update on the screening project. Ms. Hanger provided the members with a list of the members on the advisory board overseeing the project, (Exhibit 2), and an overview of the project

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.

(Exhibit 3). The pilot project has been expanded from five centers to include 14 of the 22 detention centers in the state. Sixty percent of the youth in detention in the state are being screened under the program. Implementation of the screening program requires overcoming complex legal issues, including protection of juvenile rights against self incrimination and developing procedures to allow for the sharing of information. Outcomes from the screening include the following:

- better identification of youth with mental illness and substance issues;
- intervention and placement in appropriate programs;
- better response by the staff;
- more diversion; and
- more linkages to care at the local level.

The goals of the project include the following:

- expanding the program to the rest of the juvenile centers;
- focusing on systemic barriers to care; and
- issuing a report by the end of 2010 with specific recommendations.

In answer to questions, Dr. Aalsma said that between sixty and seventy percent of the youth screened have mental health issues. Dr. Aalsma also said that some of the centers not involved in the pilot project are doing screening on their own. Dr. Aalsma indicated that lack of insurance coverage for the families is sometimes a barrier for teens receiving mental health services. Dr. Aalsma said the participation costs are estimated to be around \$10,000 and include part of the salary of an individual to coordinate the testing results. Representative Brown asked Ms. Hanger to report back to the Commission on Mental Health (COMH) concerning the costs to a juvenile detention center for participating in the program.

III. Discussion of Issues Relating to Abuse of Incarcerated Youth

A. Department of Correction (DOC). Mr. Tim Brown, Legislative Liaison for the DOC, Mr. Michael Dempsey, Executive Director, Youth Services, and Dr. Andrea Hall, Executive Director of Planning and Technology, provided the Commission with information on DOC policies concerning abuse of teens while incarcerated (Exhibits 4 and 5). The DOC currently has 632 incarcerated juveniles with 565 of those being males and 67 females. The number of incarcerated youth has been reduced over the past several years with the provision of more services in local communities. The DOC has a zero tolerance policy for abuse. The DOC has implemented Prison Rape Elimination Act (PREA) policies. In answer to questions from Senator Skinner, Mr. Dempsey stated that youth between the ages of 12 and 21 are served through the Youth Services Division. Mr. Dempsey also said that youth are incarcerated in separate facilities and not with adult offenders. There are accredited schools at each of the facilities that allow the youth to graduate with degrees. In answer to questions from Representative Brown, the DOC reported that there is PREA training for all employees, and the State Police investigate any reports of abuse at the juvenile facilities.

B. Juvenile Justice Task Force. Mr. Bill Glick, Executive Director, presented testimony on the impact of abuse on the mental health of youth who are incarcerated (Exhibit 6). There is very little specific information on the impact on the mental health of youth who have been abused while incarcerated. Mr. Glick testified that when children are incarcerated, they become the wards of the state, and that the state is then responsible for caring for them.

The Commission broke for lunch and returned at 1:00 P.M.

IV. Discussion of Teen Suicide

(A) Senator Patricia Miller discussed SB 226 from the 2010 Session of the General Assembly that, as introduced, provided for education of teachers in the prevention of teen suicide. Senator Miller indicated that she was grateful to representatives of the Jason Foundation for bringing the issue of the need for education for teachers in prevention of teen suicide to her. When the bill was presented it had broad support. Senator Miller indicated that she believes teen suicide is a health issue and should be treated as such. Senator Miller stated that one person in the United States dies by committing suicide every 16 minutes.

(B) Ms. Bre England, Guidance Counselor at Warren Central High School, discussed the effects of suicide by students and teachers on students. In the fall of 2008, two students and one staff person from Warren Central committed suicide within one month. Ms. England emphasized the importance of educating teachers, administrators, and parents on how to recognize signs that a child is considering suicide and how to help other students if a suicide occurs. Currently in Indiana each school counselor is responsible for 500 students, which makes identifying children with issues and helping them very difficult. While mandatory training will not solve the issue, it can significantly reduce teen suicides according to Ms. England. Representative Brown asked if assessment tools like those discussed in the Youth Law T.E.A.M. presentation could be used to help identify at risk students.

(C) Ms. Nancy Papas, Indiana State Teachers Association (ISTA), expressed support for Senator Miller's bill and testified that 4,500 children each year commit suicide in this country. It is Ms. Papas's hope that the legislature will take steps to combat teen suicide. She discussed the issue of copycat suicides after a student commits suicide. Providing teachers with training to observe signs of potential suicide and to deal with the aftermath of a suicide should also help prevent copycat situations.

(D) Dr. Frank Bush, Indiana School Boards Association, expressed support for Senator Miller's bill. Dr. Bush stated that teen suicide is a serious state and national issue.

(E) Mr. Gerald Mohr, Indiana Association of School Principals, also expressed support for Senator Miller's bill. With education, teachers can be better prepared to support students.

(F) Mr. John Ellis, Indiana Association of Public School Superintendents, expressed support for Senator Miller's bill and shared instances where superintendents have had to deal with suicide. If students can receive the proper counseling, they may be less likely to commit suicide.

(G) Ms. Gina Eckart, Director, Division of Mental Health and Addiction (DMHA), and Dr. Joan Duwve, Medical Director for Public Health and Preparedness, Indiana State Department of Health (ISDH), presented information on a joint DMHA and ISDH suicide prevention survey (Exhibit 7). Representative Brown asked Ms. Eckart to provide more information specifically regarding teens.

(H) Ms. Joni Irwin, the Jason Foundation, expressed the regrets of Mr. Clark Flatt, President and CEO of the Jason Foundation, for his inability to attend the meeting and read Mr. Flatt's letter to the Commission (Exhibit 8). In the letter, Mr. Flatt emphasized the importance of providing education for teachers in recognizing signs that a

teen could be considering suicide.

(I) Mrs. Colleen Carpenter, Director, Indiana Cares Youth Suicide Prevention, IPFW, and Mr. Scott Fritz, Founder, Society for the Prevention of Teen Suicide, provided the Commission with information on the Indiana Cares Youth Suicide Prevention Technical Assistance Center (Exhibit 9). Mr. Fritz shared a video concerning the suicide of his child with the Commission.

V. Discussion of Changes in the Room and Board Assistance (RBA) Program

(A) Ms. Faith Laird, Director, Division of Aging, FSSA, explained that the RBA and Assistance to Residents of County Homes (ARCH) programs have been combined into the Residential Care Assistance Program (RCAP) program. Representative Brown expressed concern that there has been a cap placed on the number of clients who receive funding under the RCAP program who can be admitted into a facility. Ms. Laird reported that the RCAP program is funded with 100% state dollars with the exception of some Medicaid services. The program serves individuals on Medicaid or Supplemental Security Income (SSI) who need less care than they would receive in a nursing home. Individuals on the program receive room, board, and laundry at a cost of \$49.35 per day. Because of budgeting constraints, no new applications for the program were accepted after November 30, 2009. An individual receiving services funded by RCAP can move from one home to another home. But, if an individual leaves a home, a person not previously receiving services cannot enter the home to take the bed of the person who left. Due to the changes, the State has saved \$1.1 million.

Representative Brown expressed concern about where individuals who would have received care under RCAP before the cuts can now receive care. The only alternatives, according to Representative Brown, are more costly than services under RCAP. Ms. Laird indicated that the goal is to reduce the budget by 15%. Other members indicated that the loss of this alternative will put a strain on mental health centers to provide services formerly provided under the RCAP program.

B. Mr. Randall Fearnow, Krieg Devault, discussed the impact of the cuts on the Miller Beach Facility. Mr. Fearnow was accompanied by representatives of Miller Beach. The facility currently has 50 employees. Miller Beach is licensed for 168 beds. When the budget cuts were implemented, Miller Beach served 160 clients. That has been reduced to 125 clients at the present time. The facility is in jeopardy of closing. Mr. Fearnow indicated that he believes the law, IC 12-10-6-1, provides that the funds used for RCAP cannot be reallocated for other programs.

Members expressed concerns about providing services to the population served by RCAP. Emergency room care, for example, is much more costly than the services provided at room and board facilities and county homes. The members wanted more information concerning plans to serve the population currently receiving services funded by RCAP.

VI. Adjournment.

The Commission's second meeting will be held September 7 at 10:00 A.M. in the House Chamber. The third meeting will be held in October. Representative Brown has asked that members have suggestions for a date for the third meeting at the September 7 meeting. Representative Brown adjourned the meeting at 3:30 P.M.

COMH
Meeting 1
August 19, 2010
Exhibit 1

INFORMATION ON 2010 STUDY COMMITTEE MEETINGS

2010 INFORMATION:

The "home page" for the General Assembly is at <http://www.in.gov/legislative/index.htm>

For Legislative Council resolutions concerning study committee topics and procedures, see the links under the "What's New" heading near the bottom of the home page.

For meeting notices, minutes, and other information, go to the "Interim Study Committees" heading on the left side of the home page and click on the "Study Committees" link. This will take you to an alphabetical list of links to web pages for individual study committee pages, where you can view and print these items. In order to reduce copying and mailing expenses, the Legislative Services Agency (LSA) is no longer maintaining study committee mailing lists for the distribution of hard copies of notices or minutes via US mail.

To determine whether a meeting will be webcast, check the meeting notice on the committee's web page. Notices for meetings that are to be webcast will contain a link to the broadcast.

For the upcoming schedule of study committee meetings that are staffed by the LSA, go to the "Interim Study Committees" heading on the left side of the home page and click on the "Calendar" link. You may also pick up a hard copy of the calendar at the Legislative Information Center, in Room 230 of the State House adjacent to the rotunda. The calendar is subject to additions and corrections, including notice of cancellations. Please feel free to call the Legislative Information Center for an update at (317) 232-9856.

NOTE CONCERNING STUDY COMMITTEE EXHIBITS: Beginning with the 2010 interim, any exhibits that were distributed during a study committee meeting will also be attached to the minutes on the committee's web page in a PDF format, eliminating the need to request hard copies through the Legislative Information Center. Please bear in mind that the file for a meeting that had numerous exhibits will be a large document, so it could take a while to open and you may want to consider whether or not to print the entire document.

STUDY COMMITTEE ARCHIVES FROM PRIOR INTERIMS

From the home page of the General Assembly at <http://www.in.gov/legislative/index.htm> , scroll down to the "Archives" heading in the lower left corner, and then select the "Interim" link. This will take you to various links for study committees from 1998 through 2010. Note that exhibits from these meetings are not available online and must be obtained through the Legislative Information Center.

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COMH

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Meeting 1
August 19, 2016
Exhibit 2

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COMH
Meeting 1
August 19, 2010
Exhibit 3

Indiana Juvenile Mental Health Screening, Assessment, and Treatment Pilot Project: Research Findings

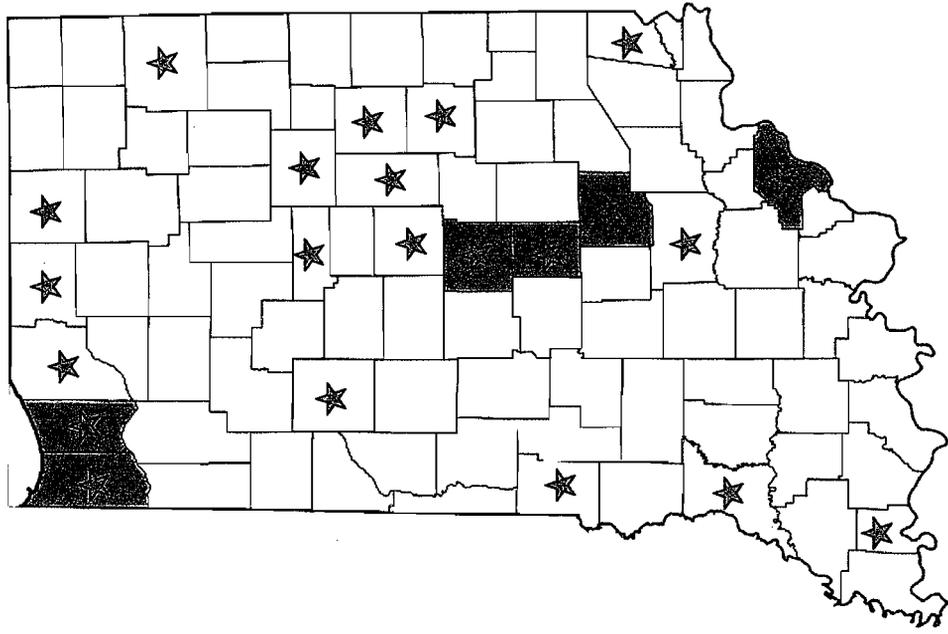
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August, 2010

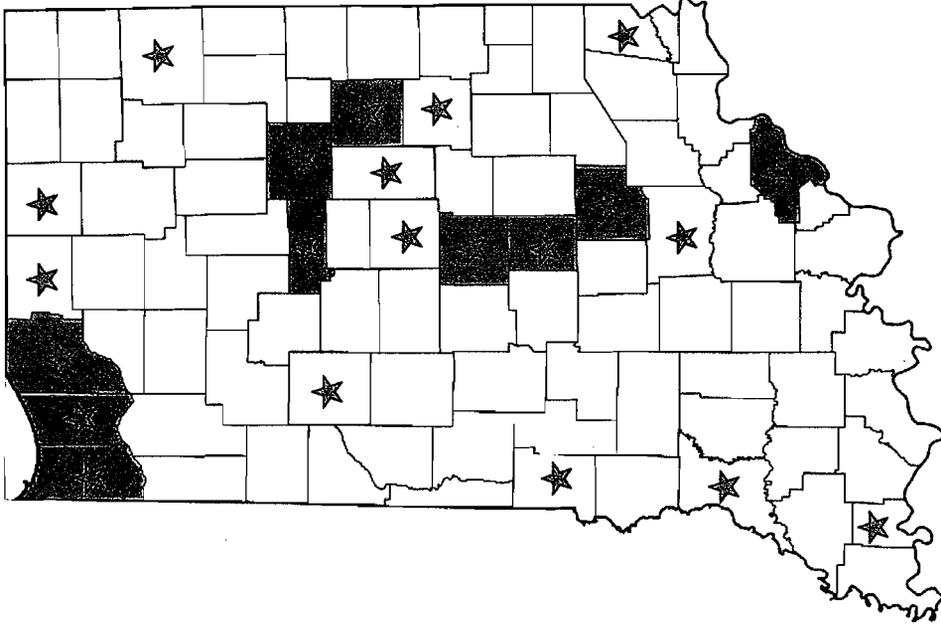
Indiana Juvenile Mental Health Screening and Assessment Pilot Project

- Goals of data collection:
 - Prevalence of mental health problems
 - Pennsylvania model
 - Protect youth during detention
 - Suicide prevention and aggressive behavior
 - Initiate mental health care while detained
 - Connect to mental health care upon release
 - Reduce future offenses (recidivism)

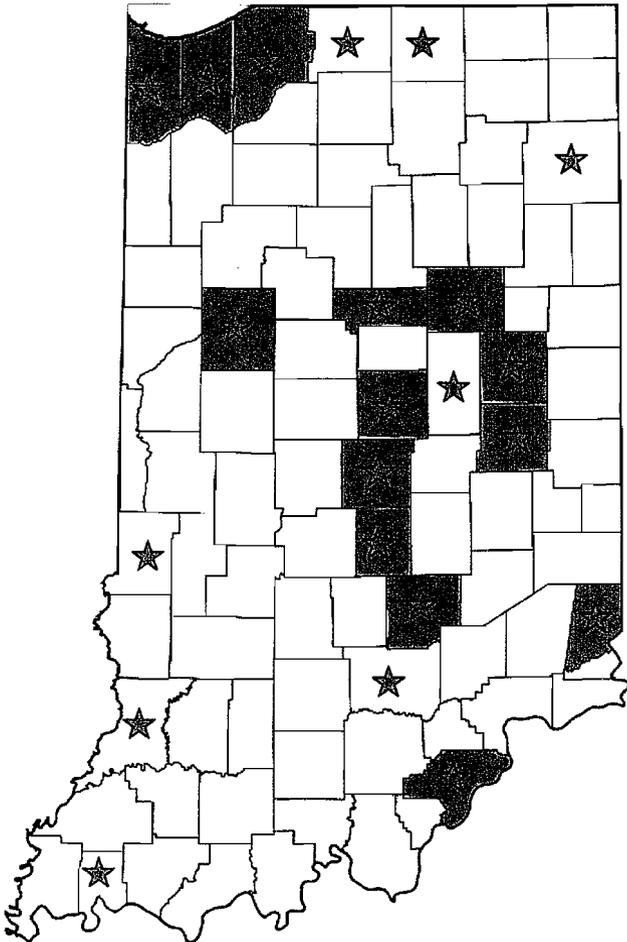
Participating Counties 2008



Participating Counties 2009



Participating Counties 2010 (through 2/1/10)



| Total Admissions | Pilot Site Admissions | % |
|------------------|-----------------------|-----|
| 20,590 | 11,996 | 58% |

Indiana Juvenile Mental Health Screening and Assessment Pilot Project

- Data collected from Jan. 1, 2008 - Feb. 1, 2010 from 9 county sites
- Data includes:
 - Mental health screening results
 - 6 scales (anger/irritable; suicide ideation; drug/alcohol; depression/anxiety; thought disturbance; somatic complaints; traumatic events)
 - Elevated screen = high on suicide OR high on 2 or more scales
 - Follow-up information during detention
 - Offense data post-release
 - Qualitative interviews conducted at 4 pilot sites

State-wide mental health screening



Detention as crisis

INT: How did your experience in juvenile detention affect your receiving counseling services?

17 year old White male: *When I was locked up it kind of scared me and as soon as I got there it was like, "Wow, I can't believe I did all this and stuff. Maybe I do need counseling for all the anger problems I do have."*



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INDIANA DEPARTMENT OF CORRECTION
DIVISION OF YOUTH SERVICES

COMM Meeting 1 August 19 Exhibit 5



Since 2008, the Division of Youth Services for the Indiana Department of Correction has made significant changes; efforts and strategies have been implemented, all in an effort to enhance the services we provide to youth and to reduce incidents of violence or sexual victimization.

Some of the more significant changes include the following:

- Restructured the Division of Youth Services to oversee all programs and services for adjudicated juveniles sentenced to the Indiana Department of Correction;
- Adoption of the Office of Juvenile Justice Delinquency Prevention's (OJJDP) Balanced and Restorative Justice Model to serve as the foundation and core beliefs for providing juvenile justice services to the youth in our care. Moving away from a typical "prison" environment to a more therapeutic environment model approach;
- Participation in the Council of Juvenile Correctional Administrators (CJCA) Performance-based Standards (PbS) program, which is extremely valuable in providing us with tremendous support, data and the ability to track and improve services;
- Focusing on reducing the length of stay for youth in our secure facilities. In 2009 the average stay was 186 days, compared to an average of 256 days in 2007, and 206 days in 2008;
- Focusing efforts on returning juveniles to community-based supervision under the jurisdiction of the sentencing counties/courts for probation supervision when appropriate. Currently, there are only 5 cases of parole violators in our facilities, down from 66 in 2007 and 63 in 2008;
- The population levels at all of our facilities have been reduced from a high of almost 1,100 youth, to under 800 collectively, an all time low for Indiana;
 - For instance, the population level at the Pendleton facility was above 360, today it consistently remains at 270, with a goal to be in the 250 range;
- While we all continue to struggle with budget constraints, these reductions in population size have not affected the authorized staffing levels at any of our facilities. Therefore the authorized staffing ratios at these facilities have increased significantly by reducing the population levels. Despite budgetary challenges, we have been able to fill most vacancies at our Juvenile Correctional Facilities (JCF's);
- All of our youngest juveniles were moved to one facility so that they were no longer serving sentences with older youth.
 - All 12, 13, and 14 year olds (excluding sex offenders) are now housed at a separate facility.
 - Prior to this change, these students were integrated in with older juveniles, including those at the Pendleton facility;
- We have partnered with Liberty Behavioral Health Corporation to oversee the sex offender treatment program at the Pendleton facility;

**Presentation to the Indiana Commission on Mental Health
Indianapolis, Indiana
August 19, 2010**

COMH
Meeting 1
August 19, 2010
Exhibit 6

**Presentation by William N. Glick, Executive Director
Indiana Juvenile Justice Task Force, Inc.**

Good morning, Chairman Brown and members of the Commission:

Thank you for inviting me to present on a very important issue facing youth who are remanded to the custody of the Indiana Department of Correction, Division of Youth Services (IDOC-DYS), that is, the long-term mental health consequences of abuse of adolescents who are incarcerated.

In addressing the issue of the long-term effects of abuse and sexual abuse on incarcerated youth, I have assumed that the genesis of this interest has been the report that was released by the U.S. Bureau of Justice Statistics, based on a survey that was conducted in juvenile facilities nationwide. Unfortunately, as has been reported in the media, the survey results showed an extremely high rate of sexual contact and sexual abuse between students, and between students and staff, in two of Indiana's juvenile facilities. As the survey results pertain to the boys' facility, these startling statistics may have been exaggerated due to a "perfect storm" of conditions that existed in the Pendleton facility for boys at the time; however, the results of the survey should not be minimized and have not been ignored. In fact, the Indiana Juvenile Justice Task Force, Inc. has worked on a pro bono basis with the Division of Youth Services for some months, and recently the Division and the Task Force began a contractual relationship for assessment, training, and technical assistance in regard to these and other issues.

In preparing for this presentation, I have searched the academic and popular literature for studies that would have demonstrated the long-term impact of abuse, sexual contact and sexual abuse on boys and girls who are incarcerated, but this is an area in which surprisingly, little or no work has been done! I have been in contact with colleagues across the country, and have found no body of work that leads us to conclude that anyone has taken sufficient interest in this population to have conducted any long-term studies, nor followed the medical, clinical, emotional, or physical consequences for formerly incarcerated youth who have suffered abuse while incarcerated.

I would like to relay a quote from a research associate at the National Center for Mental Health and Juvenile Justice, which summarizes the fact that the population of boys and girls who are abused while incarcerated has apparently not been deemed worthy of study to this time: "Unfortunately, I am unaware of any recent research surrounding the long-term impact of sexual abuse during incarceration on juvenile offenders." I did find a study that was conducted in Ireland, where the child welfare system is substantially different from ours, and therefore using that as an analogy is not pertinent. Thus, I have drawn my remarks, and fashioned my recommendations, from the body of literature that

deals with youth generally, and interpolated the effects from a variety of sources that have focused on non-incarcerated boys and girls who have been abused during adolescence by their peers, or by adults to whose care they have been entrusted. Most studies of long-term effects have been done on the long-term impact of sexual abuse in young children, or on the impact in adolescence of child sexual abuse. This work may be used as a guide, as many of the students in juvenile correctional facilities have been victims of physical and/or sexual abuse themselves as children.

While there is a wealth of literature on the widely varying effects of abuse and sexual abuse of young children when they reach adolescence, it is not enough to simply lay out the list of mental, emotional and physical symptoms that may occur. Since we are all the nominal parents of the students who are remanded to the custody of the DYS, then we must also focus on what we can do to prevent such abuse, and how we treat the students who may be victimized while in state custody.

First I would like to provide a definitional basis for what I am going to be talking about, so as to make it clear that there are hard-and-fast rules when we talk about youth who are in the care of the State. In this context, there is zero tolerance for student-student or student-staff sexual contact, as all such contact must be considered to be coercive in some respect, e.g., there is always a threat of force; coercion; rewards for participation; threats that may come about as a result of community reentry by one student prior to another; and gang or clique, or group-related coercion. In addition, there is zero tolerance for staff-student sexual behavior by personnel at IDOC-DYS. All such contact is considered to be abuse and there can be no "voluntary" participation, no matter how the staff or student might interpret the activity.

It is no surprise to anyone here that boys and girls who are abused or sexually abused during adolescence may experience long-lasting physical and psychological damage that can lead to a variety of problems in adulthood, especially when that has taken place in an institutional setting, or at the hands of adults who are ostensibly there to guarantee their safety.

Although there exists a myth and misconception that youth who are abused almost invariably become abusers themselves, this is most often not the case. Rather, in adolescents it is more common to find mental health problems such as depression, anxiety, sleep disturbances, hypervigilance, and attention deficits or hyperactivity as consequences of abuse and/or sexual abuse. Non-suicidal self-injurious behaviors, commonly expressed as "cutting," are also frequent consequences for girls, while boys may exhibit high-risk/high danger/high thrill behaviors such as driving too fast, picking fights with larger opponents, or other crime delinquent activities.

Many severe psychological effects of abuse or sexual abuse of adolescents have been cited in the literature, and the exhaustive list includes: low self-esteem, fear, hostility, chronic tension, emotional numbing, flattening of affect, eating disorders, sexual

dysfunction, post-traumatic stress disorder, dissociation, intermittent explosive disorder, and substance abuse.

The higher risk for these disorders is said to result from feelings of powerlessness, guilt, shame, stigmatization, and diminished self-worth. In turn, these feelings cause further damage because coping skills and resiliency may not yet have formed in adolescence, learned helplessness may occur, and there is a reduction in impulse control and a loss of the ability to protect oneself from abuses in other life domains.

In addition, other symptoms that are not necessarily mental health disorders or pathologies may occur as a result of abuse or sexual abuse, and the lack of appropriate recognition or treatment. Hypervigilance and hyperactivity may result in inattention in the classroom, and thus poor grades. Behaviors placing the adolescent's health and safety at risk may lead to medical problems, as could unrevealed physical trauma as the result of abuse or sexual abuse. Thus, not only might emotional and psychological development be damaged, but so can physiological development, cognitive development, and the moral or spiritual development that is necessary for adolescents, especially adolescents who have been incarcerated, to become productive members of their communities.

There are also other, more subtle effects of abuse that may not be manifest until adulthood. For example, there have been many studies conducted of the high-risk sexual behaviors practiced by young adult women who have been victims of sexual assault or abuse in childhood or adolescence. These studies have revealed, among other things, that young adult women who have been abused are at much greater risk to have unprotected sex with injection drug users, which greatly increases their risk of contracting HIV or other serious STD's. Among male victims, sexual aggression and substance abuse are common behaviors that may trace their genesis back to a history of abuse.

Given that there are many emotional and mental disorders and pathological diagnoses among adolescents and young adults that may have their origins in an early history of abuse, it also needs to be stated that not all victims will exhibit psychopathology. Some young people have natural or acquired resilience, or receive appropriate help through counseling or ministering, which minimizes the pain and the negative consequences of the abuse. Thus, it is incumbent upon us to ensure to the best of our ability that youth who suffer abuse in our institutional settings are given the credit and the assistance that they need and deserve.

I will focus then from this point on what is required of us within our institutions in Indiana. The National Prison Rape Elimination Commission has issued guidelines for juvenile facilities, but guidelines are not effective unless we make a concerted effort to bring multi-agency, multi-disciplinary best practices to bear. Some of the recommendations that I will put forth will demand a level of collaboration and cooperation from state agencies that is not typically found. When we make recommendations regarding the safety of youth who are wards of the state, we must do so with the understanding that who pays for treatment or training is immaterial, and debating costs is clearly not in the best interests of the youth.

Thanks to our colleagues at Prevent Child Abuse Indiana for the information that we need to communicate with adolescents in the same manner that we would with younger children. We must consider the basic principles of what we need to do, and what child abuse prevention and intervention training teaches, when we encounter a young person who has been abused in a facility. That is, we must sincerely send the youth two messages: 1) that we believe you when you report abuse; and 2) that we will keep you safe. However, neither of these is easy when we are in any institutional setting. In order to demonstrate to the youth that we believe the report of abuse, we must go back to the first days that a youth enters an institution, and make it clear that abuse is not tolerated; and that includes student-student contact, and staff-student contact. We must then give the youth methods of reporting that are anonymous and non-judgmental. While a grievance reporting procedure exists in our juvenile correctional facilities, we know that the stigma, fear, and intimidation that attaches to sexual abuse is often a nearly insurmountable barrier, and that there needs to be several reporting processes that will help the youth overcome their reluctance to report. Then we must in some manner provide protection for the youth; protection from further abuse, protection from retaliation, and protection from self-harm. We must recognize that trust levels among youth who are abused in facilities may plummet to the point that youth have told us that they trust no one at any time.

The issue of trust is paramount. I had the privilege just yesterday of speaking with an adult survivor of both child and adolescent abuse, and she stated to me that a youth who has been subjected to abuse at the hands of an adult in to whose care she has been entrusted, may never fully trust. This statement has many implications for what we do to prevent abuse from occurring, and what we do after a report of abuse has been confirmed.

Recommendations:

Since DYS by itself is not equipped to fully deal with the impact of institutional abuse, a multi-agency interdisciplinary emergency planning group should be formed to deal with the consequences for the students of any abuse, whether physical or sexual. Such a multi-disciplinary immediate response team would be responsible for treatment planning, and can assist with any investigation conducted by CPS, DOC Internal Affairs, or law enforcement agency.

Since much of the group counseling work done with students in the correctional facilities is done with perpetrators, individual, group, and family work should be directed toward youth who have been victims, and youth who may be at risk of being victimized in the future.

Treatment agencies and providers may find a different set of difficult circumstances to deal with; for example, a boy who had sexual relations with a female staffer, and who then uses that as a badge of distinction, no longer perceiving being sent to DOC-DYS as

a consequence for his crime delinquent activity. This being the case, specialized training should be made available and required for all providers to whom youth are referred.

Since freedom from abuse and sexual abuse in facilities is now recognized as an inalienable human right, students who are victimized within facilities should be assessed for immediate release. If a victimized student is then released, appropriate services should be provided in the community, and barriers to payment for the services should be removed.

Especially considering the contradictory results of previous interviews and surveys when compared to the BJS survey on the incidence of sexual abuse or sexual contact in Indiana facilities, there is a clear need for repeating surveys and interviews on a periodic basis with students and staff.

Since it is incumbent on the state to provide an environment and staff free from the threat of abuse, there is a need for extensive staff screening prior to any person being hired to work in a juvenile facility. This may include in-depth interviews using best practices with all prospective juvenile facility staff, without regard to cost. It is less costly to provide screening to the best of our ability than it would be to prosecute a case, or to pay restitution to a victim. The screening and interview process should be studied to determine whether a potential staff member can be required to undergo polygraph examination with questions paralleling those that are included on the BJS survey instrument, and whether any previously investigated child abuse complaints had been made against the candidate.

It is incumbent on the state to ensure that we are appropriately sending youth to IDOC-DYS facilities. This will require close collaborative efforts between Judges, prosecutors, and defense attorneys in choosing other more appropriate placements in lieu of DYS, for example, for severely cognitively impaired youth, or youth who have an extensive history of prior sexual victimization.

There must be funding set aside for ongoing and periodic staff training not only in behavioral intervention techniques, but also in new findings. For instance, just this past month there has been an influential academic study published purporting to demonstrate that what have been the common notions of characteristics of adolescent sexual offenders may not be the case, based on an analysis of over 50 studies covering thousands of youth.

This is the distillation of dozens of hours of research and interviews that I have engaged in over the past several weeks since having been asked to present to the Commission today. It is my hope that I have informed the Commission about the problems faced now and in the future by youth who are abused while in the custody of the state, and that my recommendations will merit further consideration. Once again, thank you Chairman Brown and members of the Commission for the opportunity to present today, and I will be happy to address any questions you may have to the best of my ability.

COMH
Meeting 1
August 19, 2010
Exhibit 7

DMHA-ISDH Suicide Prevention Survey and Outcome Report

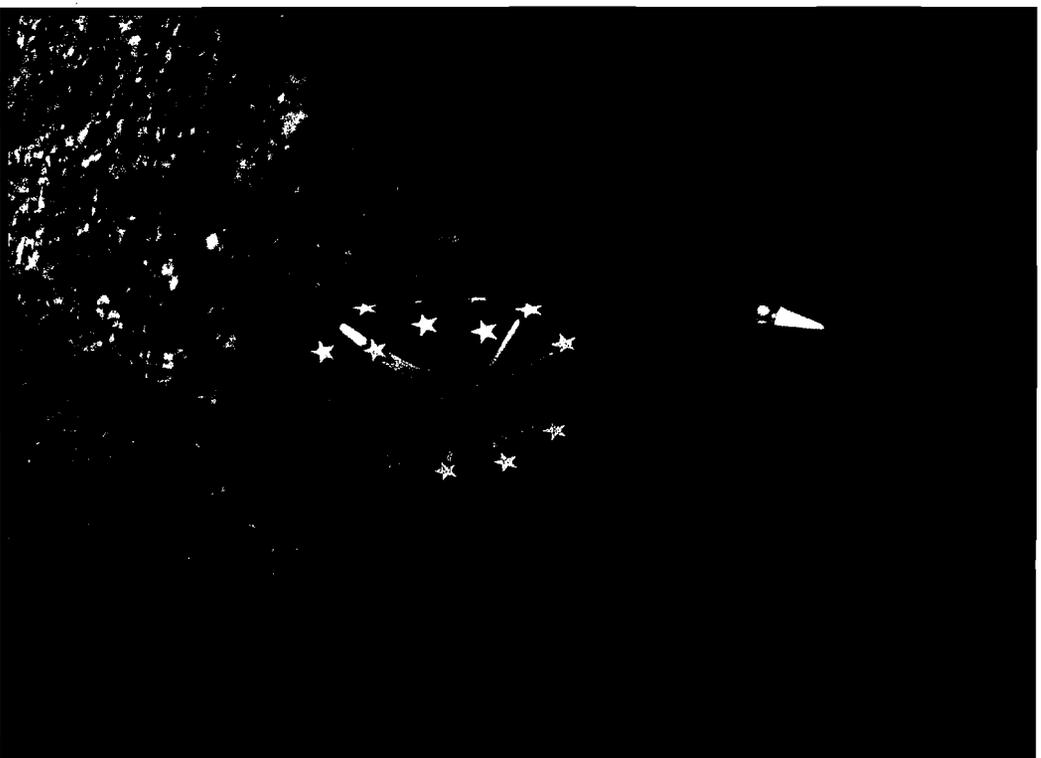
Prepared by Affiliated Service Providers
of Indiana, Inc.

2010

Presentation Overview

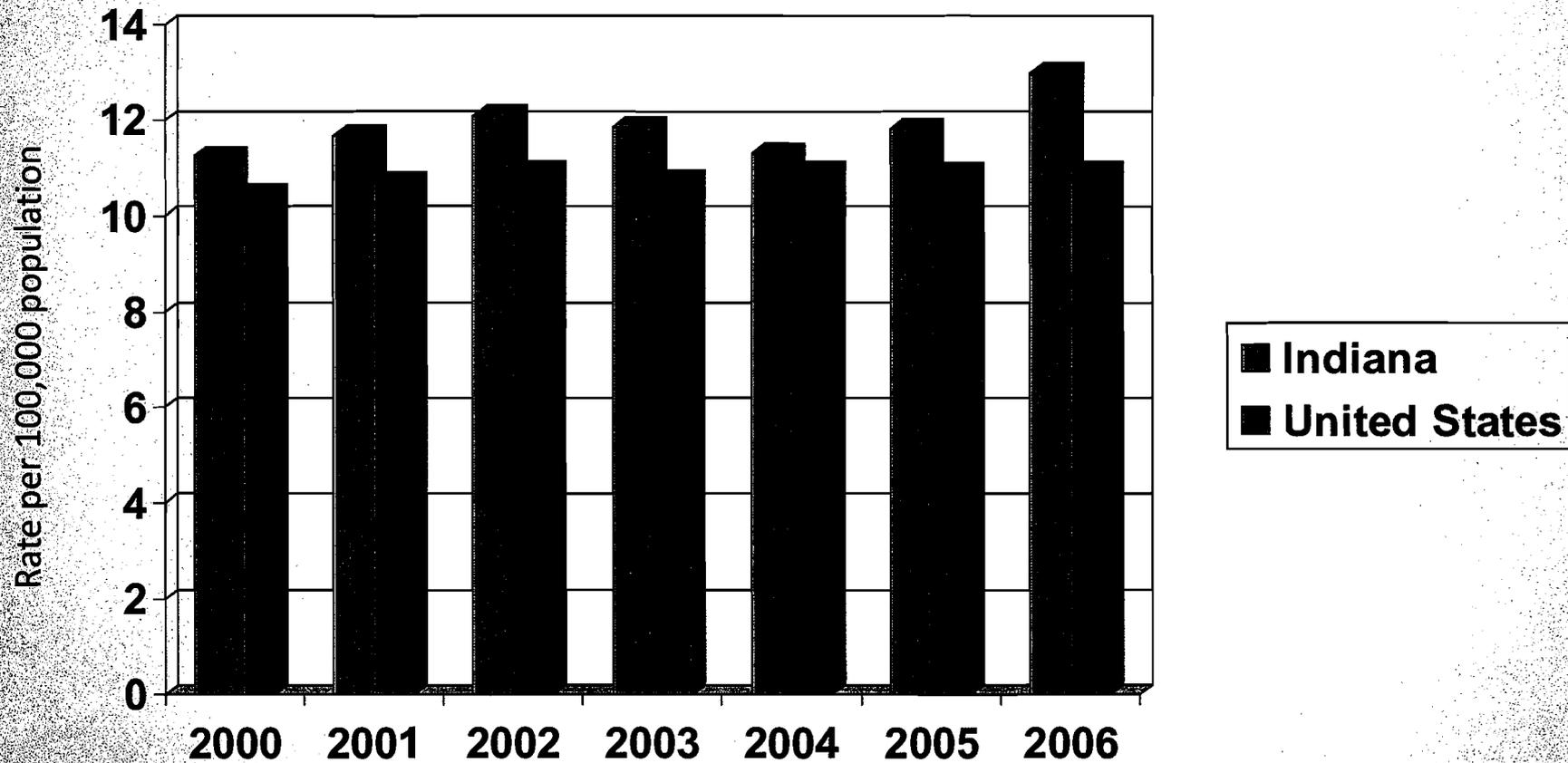
1. State of Suicide in Indiana
2. Current-state of suicide prevention/intervention efforts
3. Gaps and needs
4. Next steps

State of Suicide in Indiana



ASPIN 2010

Age-Adjusted Suicide Rates 2000-2006



Source: CDC, Wisqars

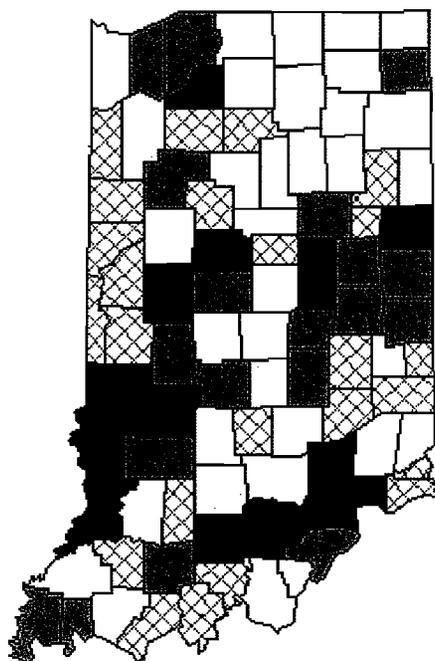
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2000-2006, Indiana

Death Rates per 100,000 Population

All Injury, Suicide, All Races, All Ethnicities, Both Sexes, All Ages

Annualized Crude Rate for Indiana: 11.90



Suppressed/undefined



3.97-10.37



10.38-12.13



12.14-14.89



14.90-26.42

Reports for All Ages include those of unknown age.

* Rates based on 20 or fewer deaths may be unstable. These rates are suppressed for counties (see legend above); such rates in the title have an asterisk.

Produced by: Office of Statistics & Programming, National Center for Injury Prevention & Control, CDC

Data Sources: NCHS National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates.

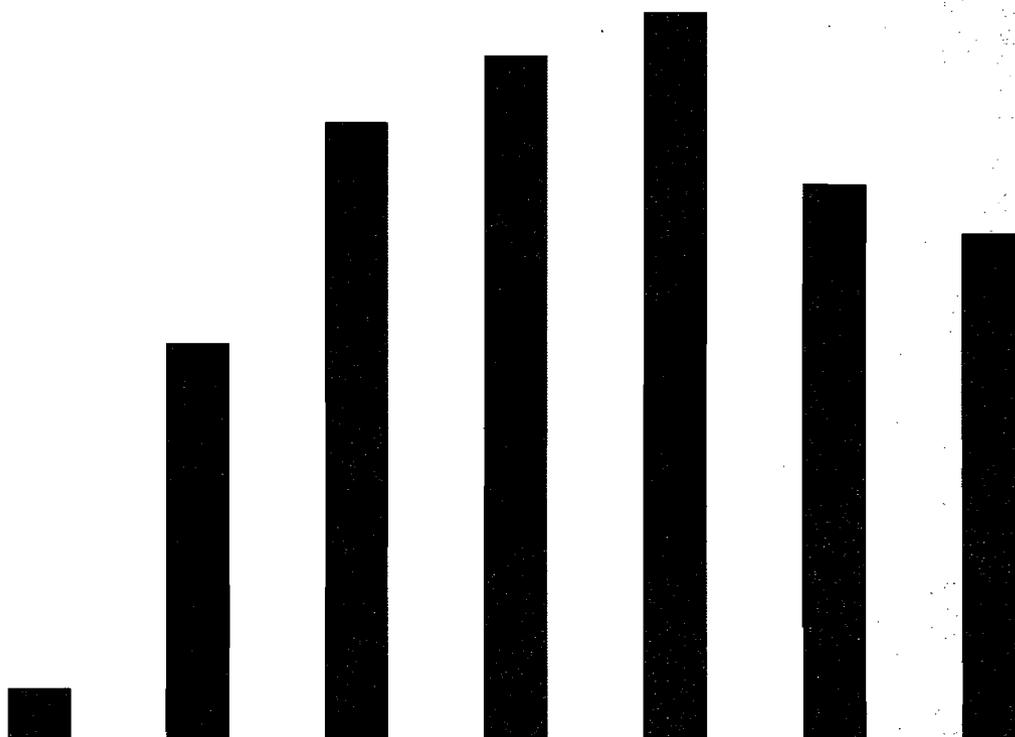
Suicide- A Leading Cause of Death

- From 2002-2006, Suicide in Indiana was:
 - The 4th leading cause of death for 10-14 year olds
 - The 3rd leading cause of death for 15-24 year olds
 - The 2nd leading cause of death for 25-34 year olds
 - The 4th leading cause of death for 35-44 year olds
 - The 4th leading cause of death for 45-54 year olds

Source: CDC, WISQARS

Suicide Rates by Age Group 2003-2007- Indiana

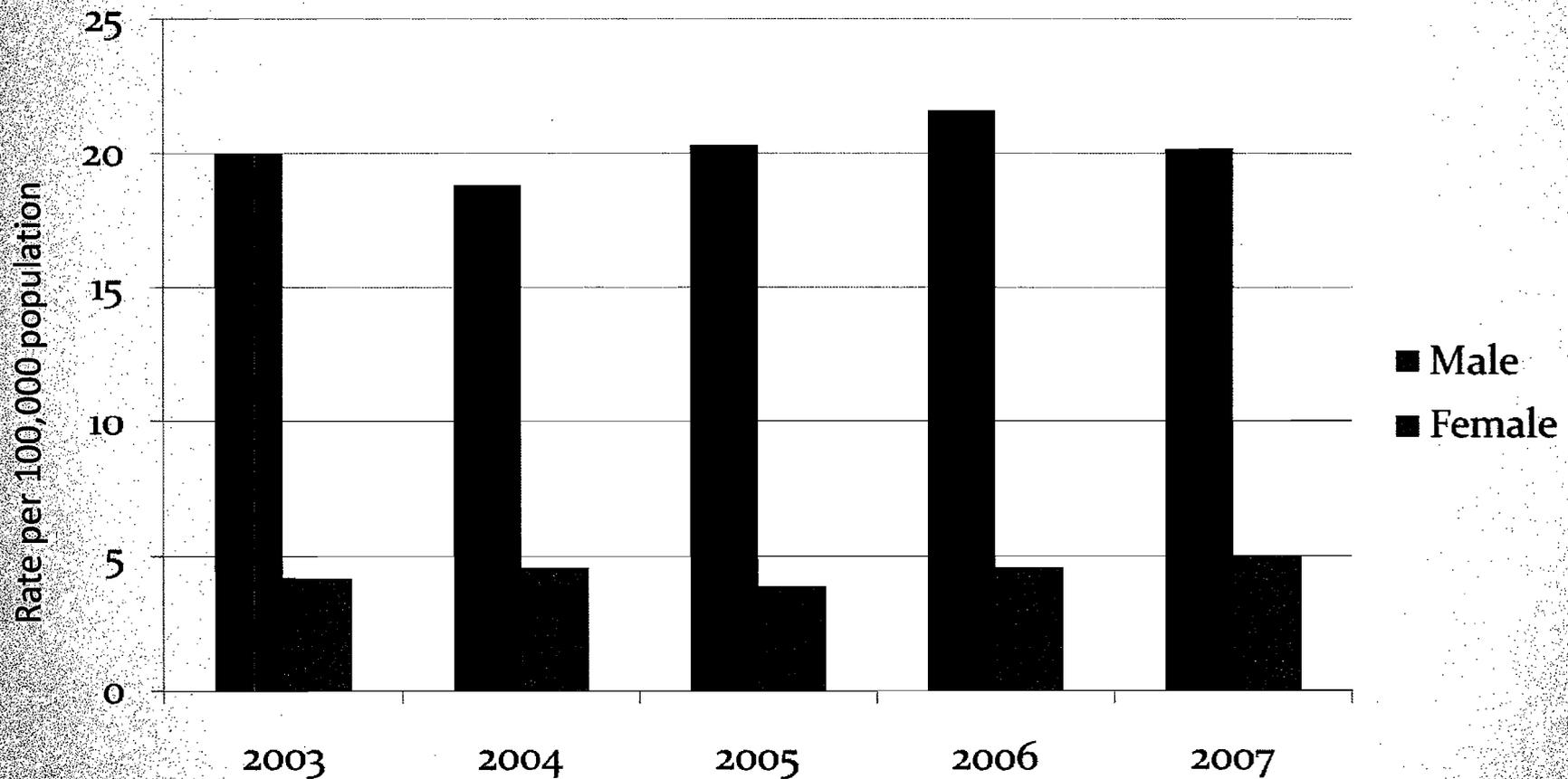
Rate per 100,000 population



Age groups <1, 1-4, & 5-9 have unstable rates due to low numbers

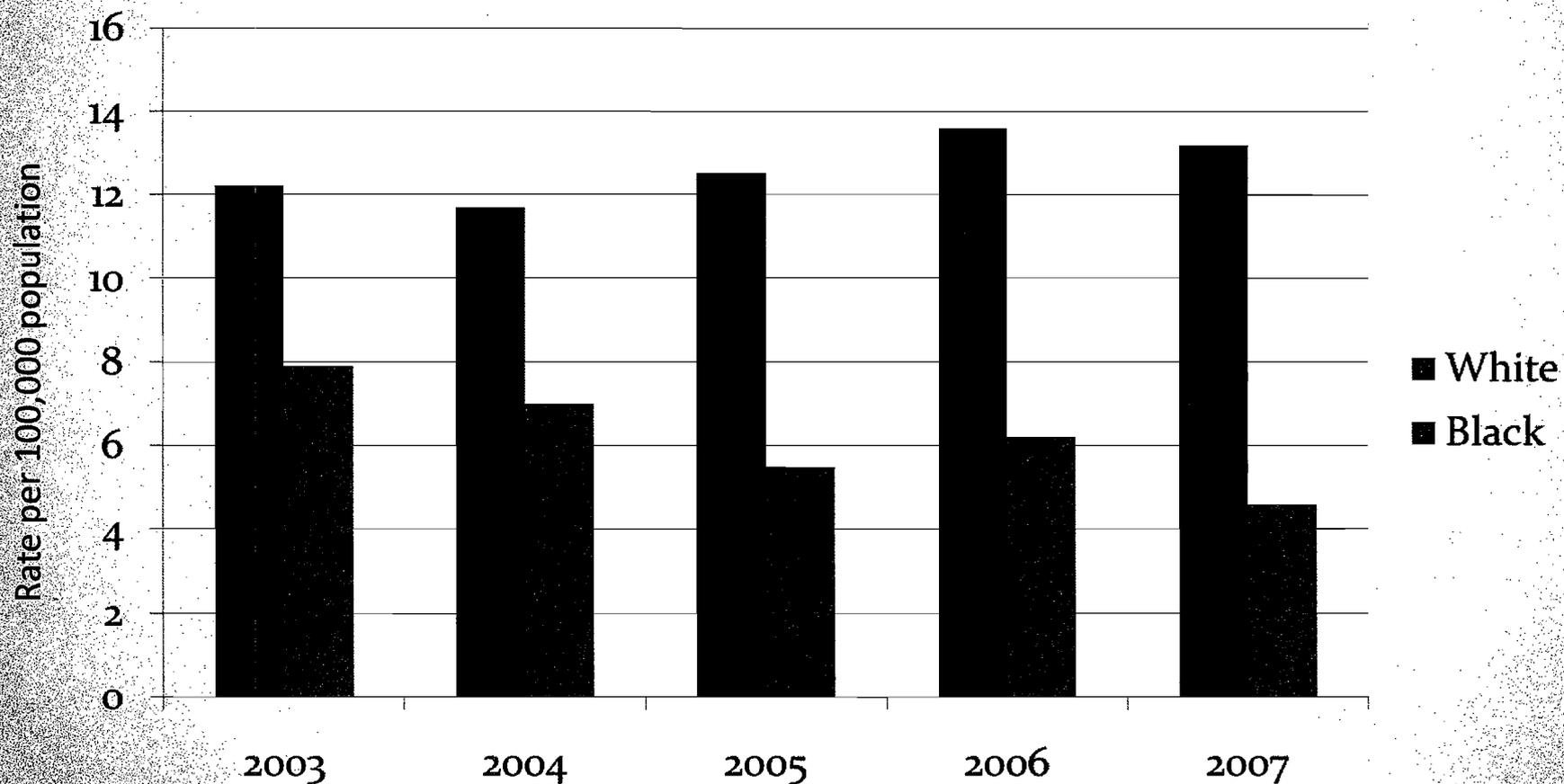
Source: Original Data from Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team. Graph produced by Injury Prevention Program, ISDH

Suicide Rates by Gender-Indiana



Source: Original Data from Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team. Graph produced by Injury Prevention Program, ISDH

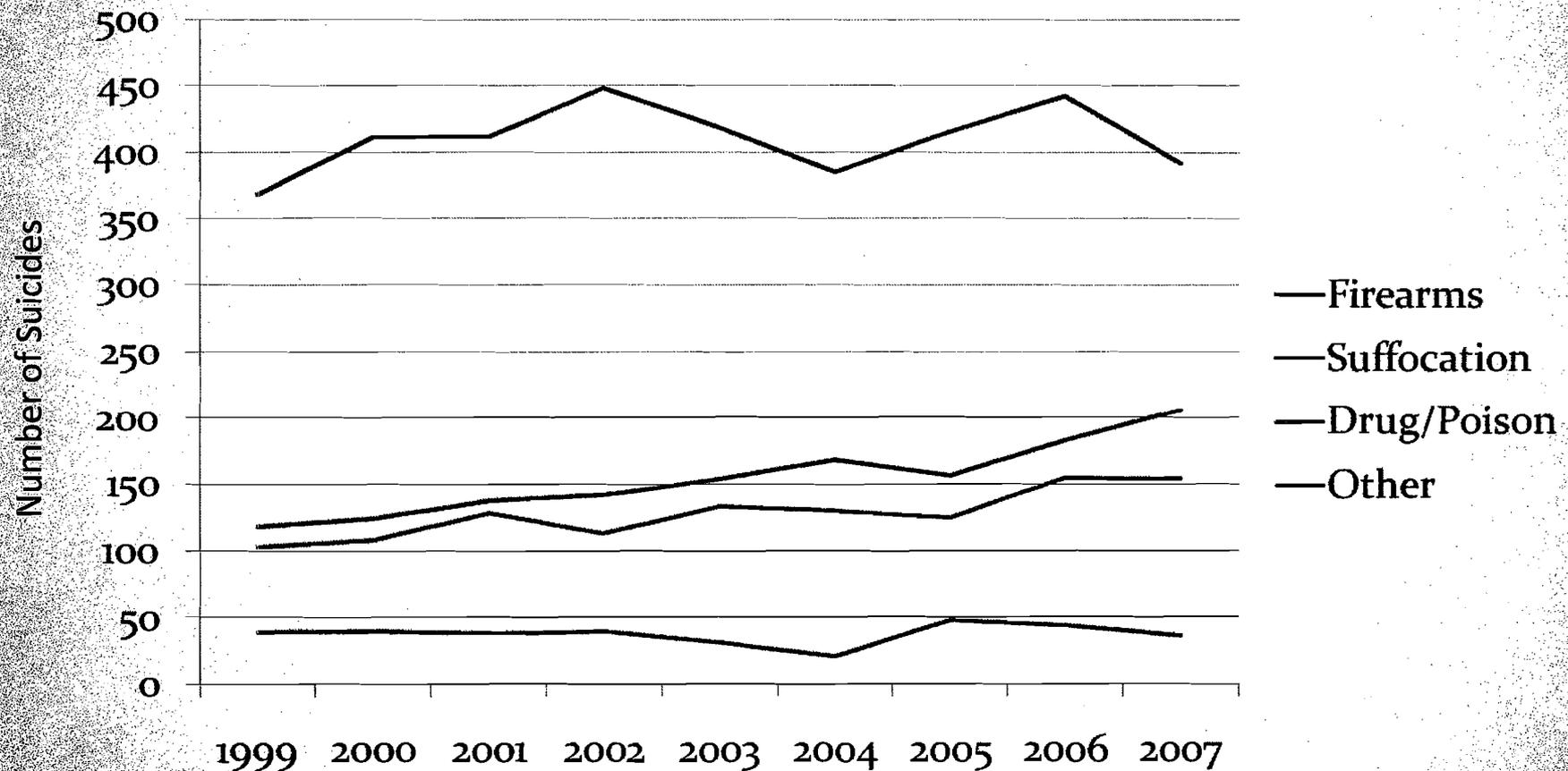
Suicide Rates by Race-Indiana



Source: Original Data from Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team. Graph produced by Injury Prevention Program, ISDH

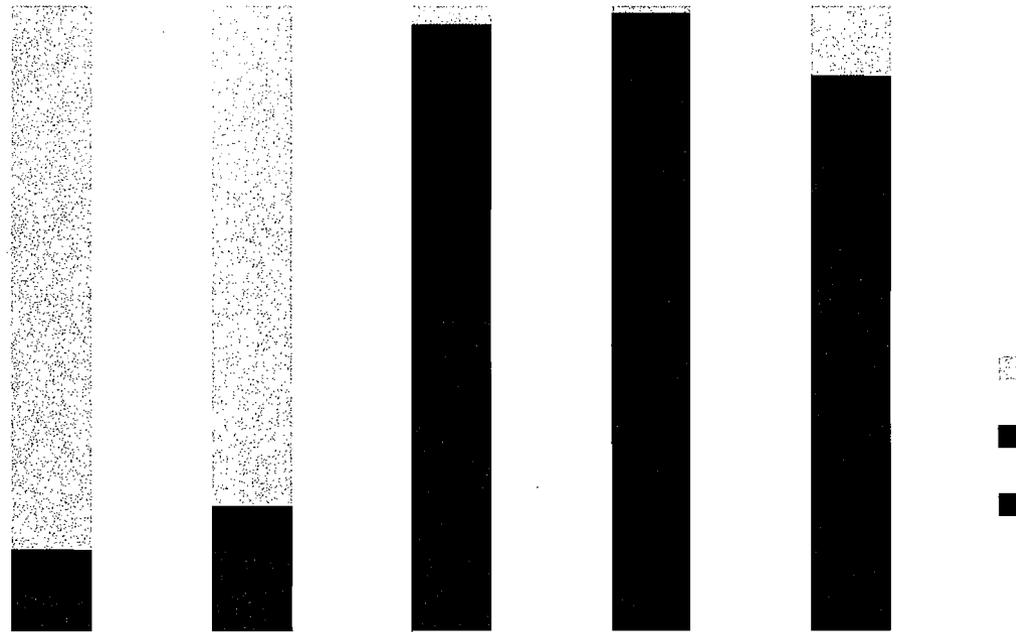
ASPIN 2010

Suicide by Method-Indiana



Source: CDC, WISQARS and ISDH Mortality Data
ASPH 2010

Lethality of Means-Indiana



Source: Original Data from Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team. Graph produced by Injury Prevention Program, ISDH

Youth Risk Behavior Survey (2009)

| | Indiana Students | United States Students | Indiana Students are at ⁽¹⁾ : |
|---|------------------|------------------------|--|
| Seriously considered attempting suicide | 17.2% | 13.8% | More Likely |
| Attempted Suicide | 9.3% | 6.3% | More Likely |

1: Compared to US Students, based on t-test analysis, $p < 0.05$

Source: Indiana Youth Risk Behavior System Report 2009. Available from URL:
http://www.cdc.gov/HealthyYouth/yrbs/pdf/states/yrbs07_indiana_us_comparison.pdf

Indiana Youth Suicide Ideation 2009

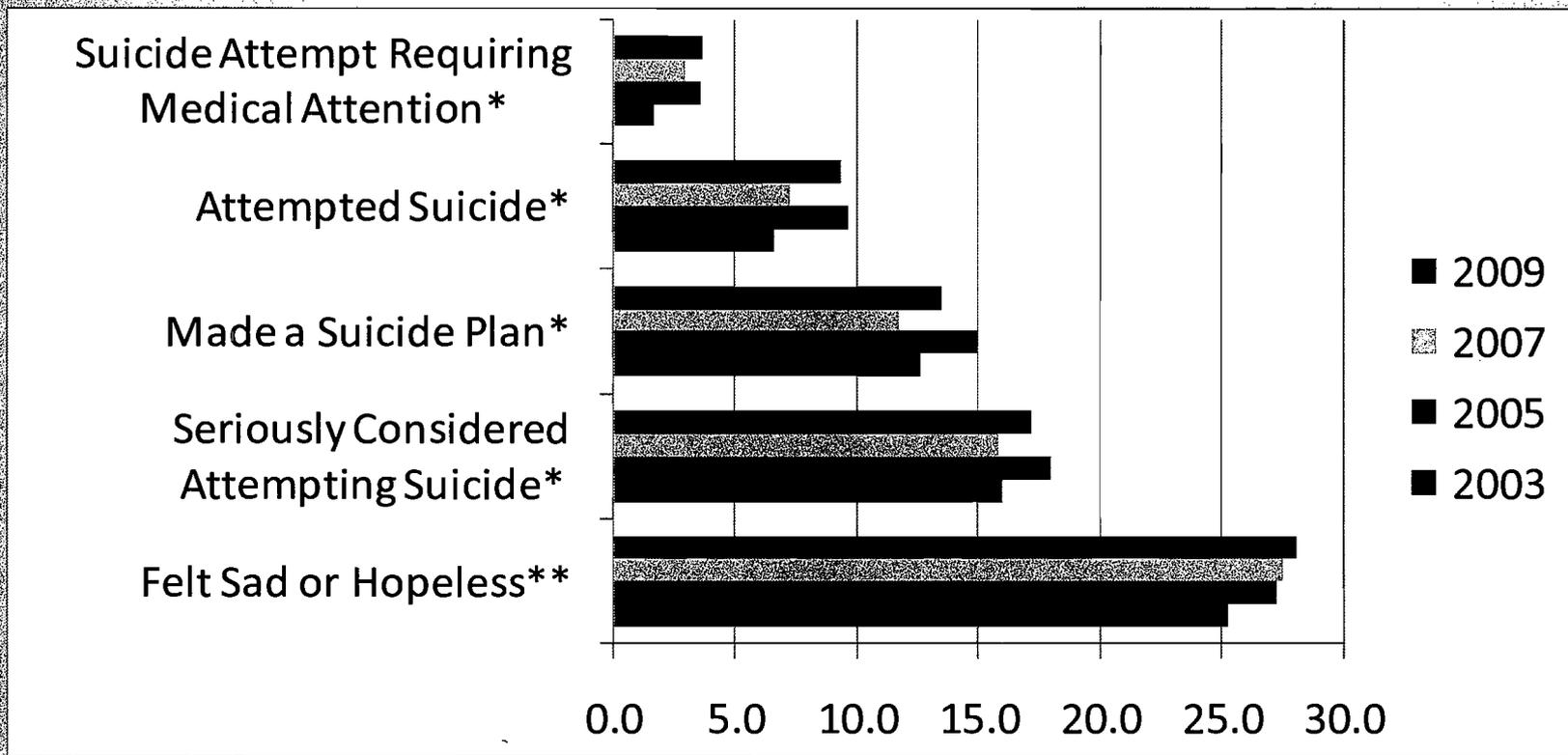
- 28% Indiana youth felt sad or hopeless everyday for two weeks in the past year
- Nearly 1 in 7 made a suicide plan
- More than 1 out of every 6 students seriously considered attempting suicide
- 1 in 11 reported actually attempting suicide
- 55,000 youth in Indiana are thinking of suicide in any two week period

Source: Indiana Youth Risk Behavior System Report 2009. Available from URL:
<http://www.in.gov/isdh/dataandstats/yrbs/index.htm>

ASPIN 2010

13

2003-2009 Indiana Youth Risk Behavior Survey 9-12 Graders: Suicide



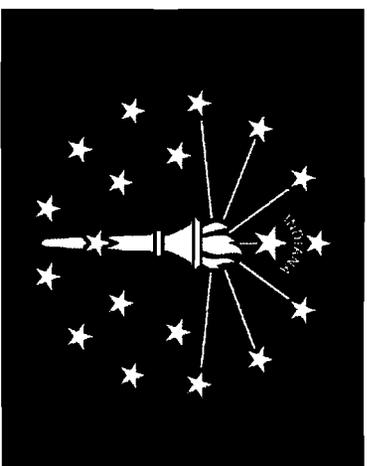
*One or More times during the past 12 months

**Almost everyday for 2 weeks or more

Percentage

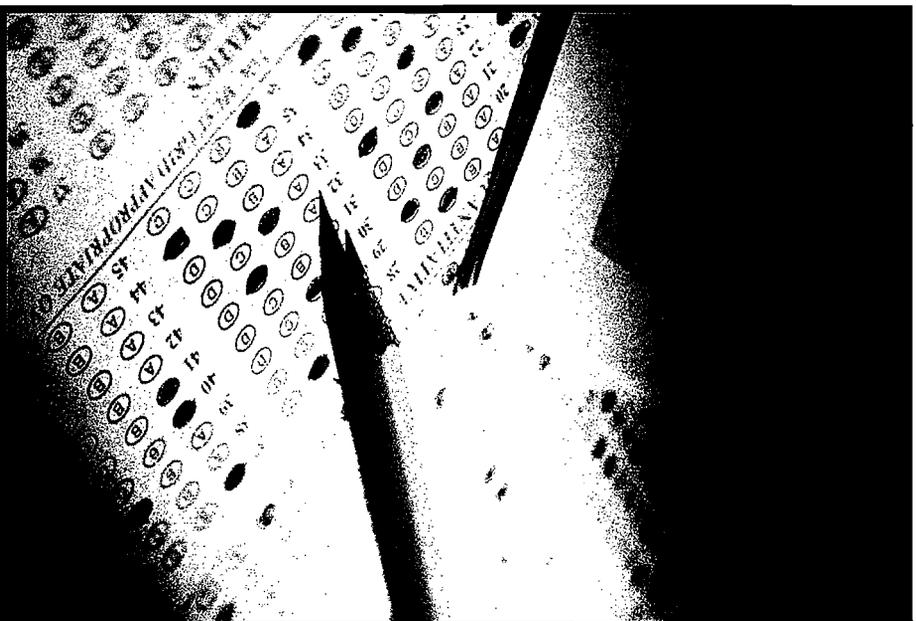
Conclusions

- Suicide is a problem in Indiana.
- All age groups are affected.
- Some areas within the state are more prone to suicidal behavior.



Current-state of Prevention and Intervention Efforts

Prevention/Intervention Statewide Survey



ASPIN 2010

Purpose of the Survey

To develop a State Suicide Prevention Plan

To provide a current snapshot of ongoing suicide prevention and education efforts

To define categories of need for prevention and education efforts

Prevention/Intervention Statewide Electronic Survey

- Lists came from existing sources used with permission including known coalitions, mental health providers, and others.
- Available from February 24 – March 12, 2010
- Could be forwarded
- 15 questions

Survey Questions

1. Name
2. Title
3. Agency/Affiliation
4. Work Status
5. Website/URL
6. County in which headquartered
7. Counties in which services are provided
8. Organizational Focus
9. Funding Source
10. Target Audience for Training/Intervention
11. What training materials do you use?
12. How many people do you serve yearly?
13. Do you refer to a crisis line?
14. If yes, which crisis line?
15. Identify suicide needs in Indiana

Response Summary

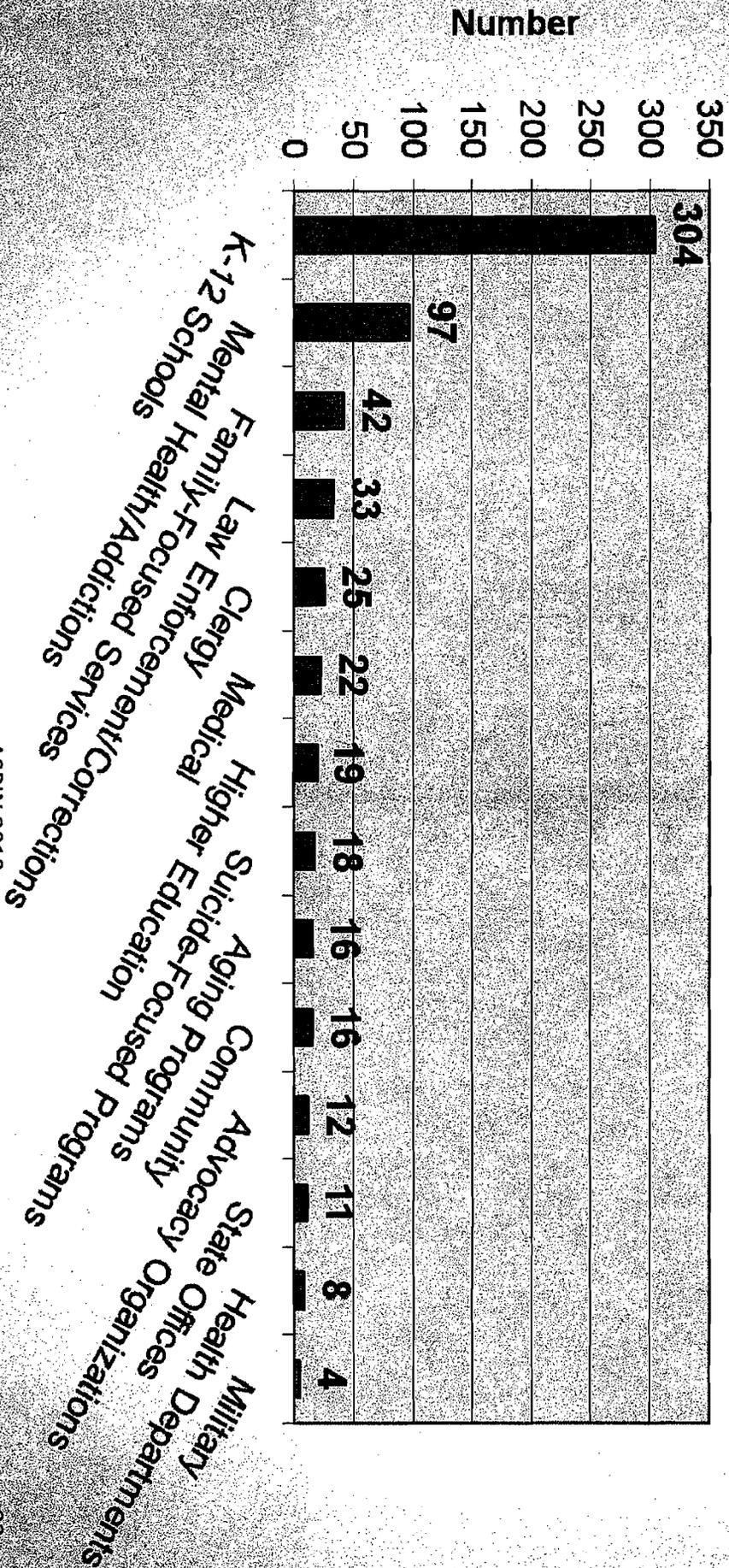
The survey was sent to 1428 persons and forwarded to at least 365 more respondents

- Estimated response rate of 42%
- Full responses: 382
- Incomplete responses: 369
- Total responses: 751

Who Responded

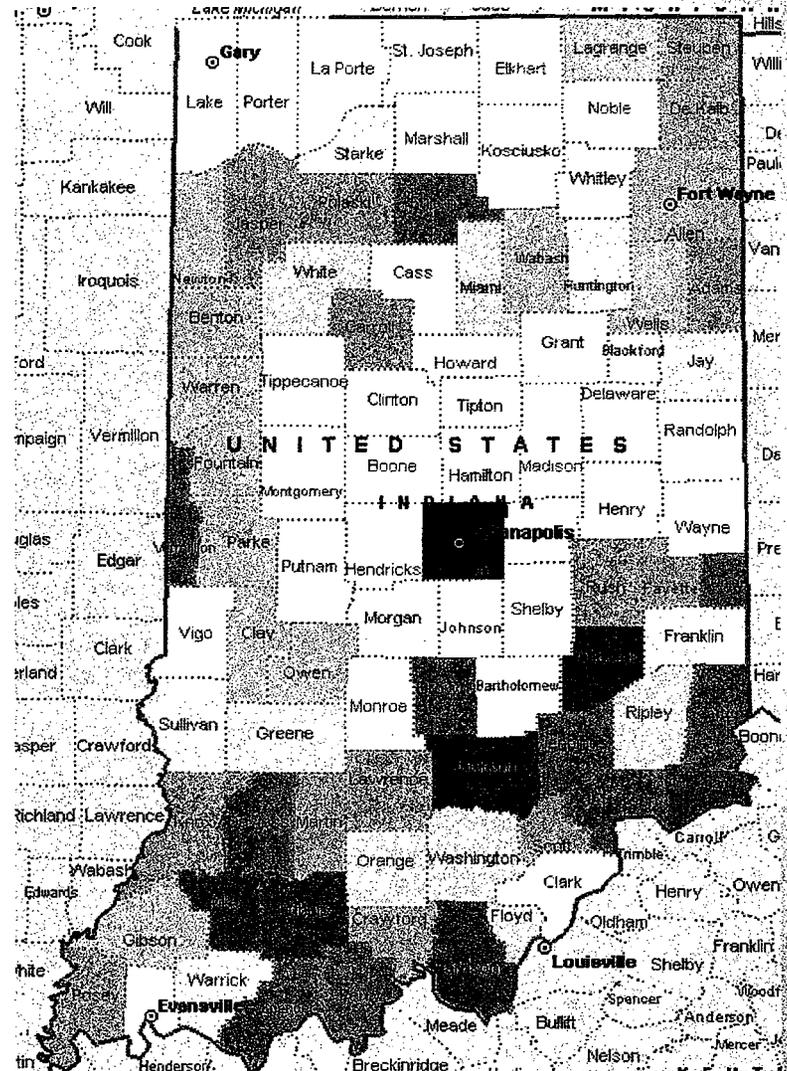
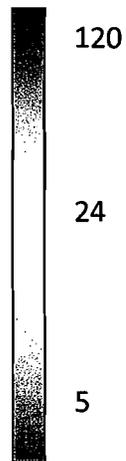
Respondent Affiliations

n=627



Service Coverage by County

Service Locations by County



Question Seven:

Counties in which you provide services:

Top 6 Counties with Highest Coverage in service:

- | | |
|------------------------|--------------------------|
| 1. Marion County (116) | 4. Hamilton County (31) |
| 2. Allen County (58) | 5. Hendricks County (31) |
| 3. Lake County (40) | 6. Johnson County (30) |



Question Seven:

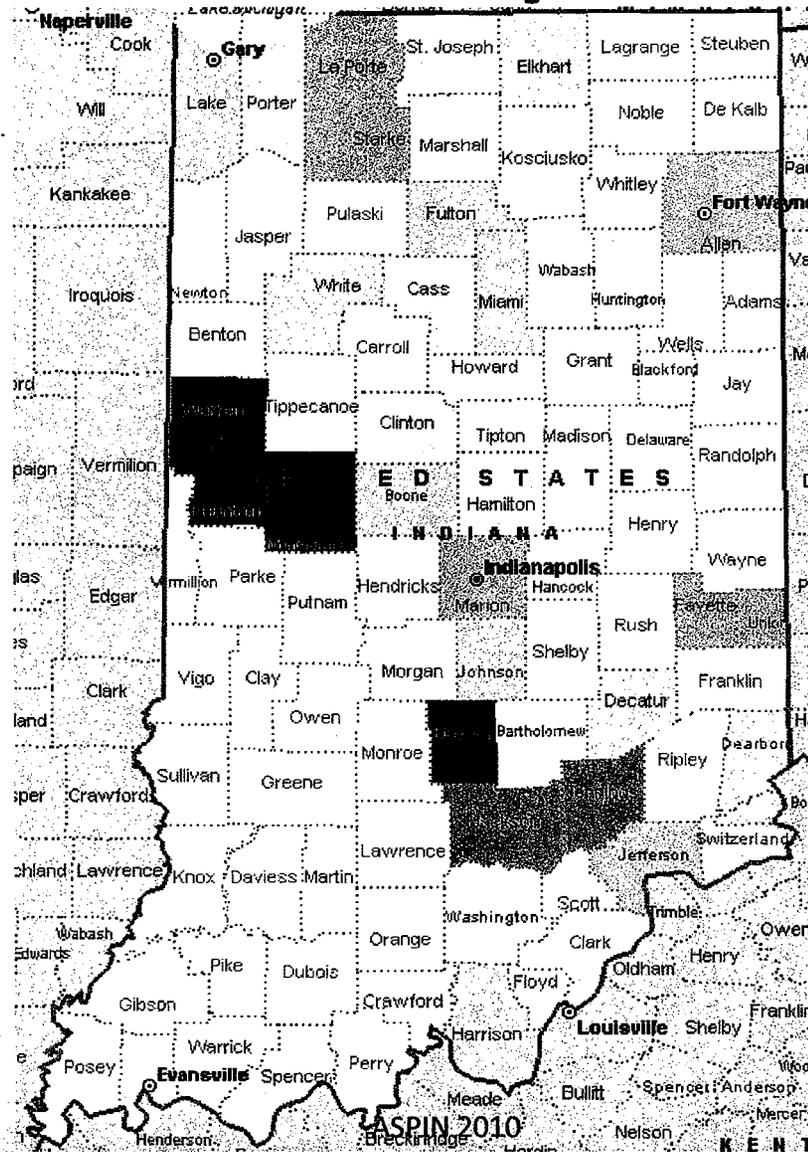
Counties in which you provide services:

Top 6 Counties with Lowest Coverage in service:

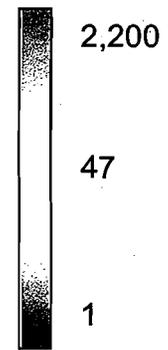
- | | |
|------------------------|---------------------------|
| 1. Decatur County (5) | 4. Jackson County (5) |
| 2. Dubois County (6) | 5. Pike County (6) |
| 3. Harrison County (6) | 6. Switzerland County (6) |



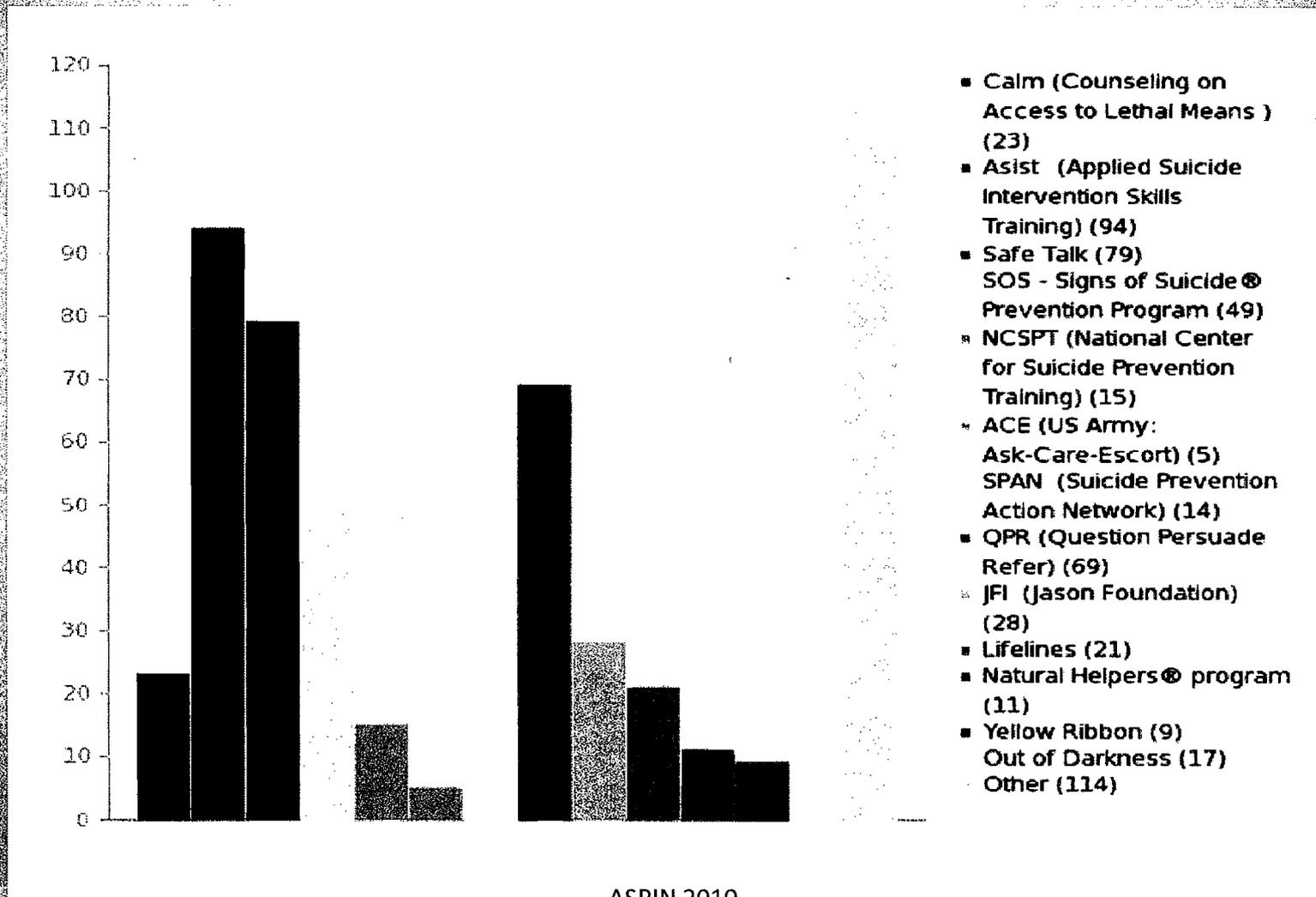
Penetration Map of Training



Number of People Trained by County



Question Eleven: What training materials do you use?



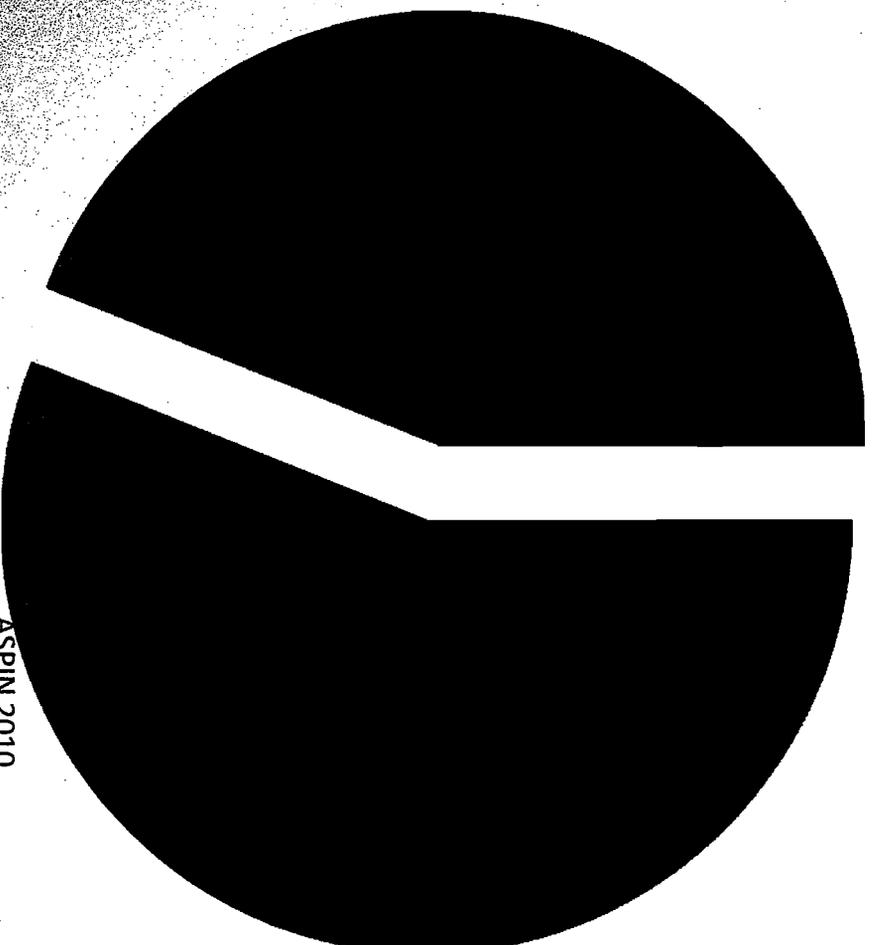
Question Eleven: What training materials do you use?

“Other” responses: sample (114 total)

- VA Suicide Prevention
- Bienvenido
- More than Sad, Truth about Suicide
- NAMI Programs
- Our own we developed
- Various materials
- Course materials self-prepared
- Internet resource
- We train our staff to recognize signs of depression, anxiety, PTSD and other behavior that may lead to suicide.
- No specific program
- Do not use a specific Suicide prevention curricula miscellaneous, use information I gather from variety of sources.

Question Thirteen:

Do you refer to a lifeline or crisis line?



n=364

- Yes
- No

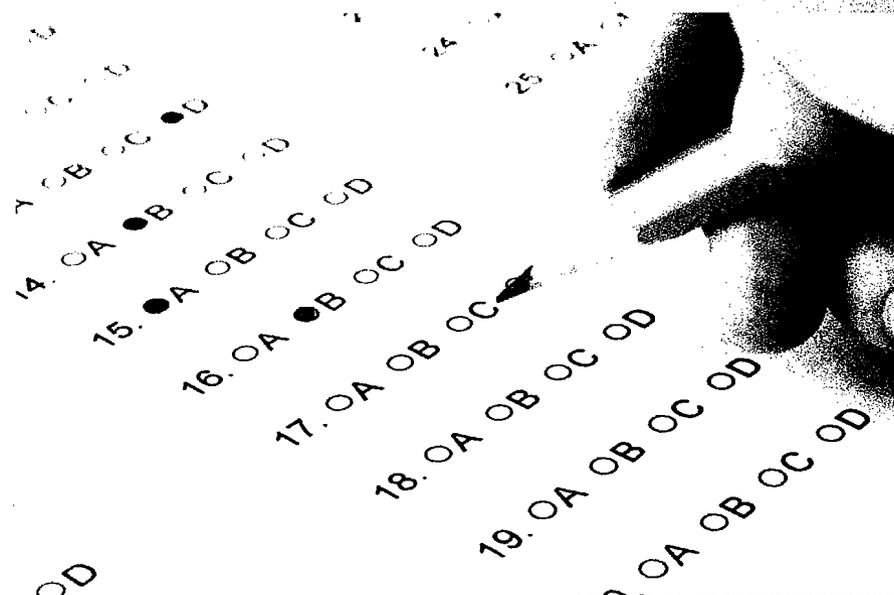
Question Fourteen: If Yes, which crisis line do you refer to? (top answers)

- Local CMHC 36
- 1-800-273-TALK 31
- National Suicide Hotline 18
- Lifeline 10
- 211 9
- 911(police/fire) 4
- Local Hospital 3

Question Fifteen:

**Please identify suicide prevention needs in Indiana.
Consider geographic, population and quality issues.**

- 213 qualitative responses
- 23 similar suggestions
- 5 broad categories



Response Recommendations

School-Age Related

Certified and Non-certified school personnel

Online course for teachers that would count toward certification requirements

Connect to state's "Social Emotional Behavioral Health Plan"

Build suicide prevention into required curriculum

Train to intervene on Facebook and other social site suicidal content

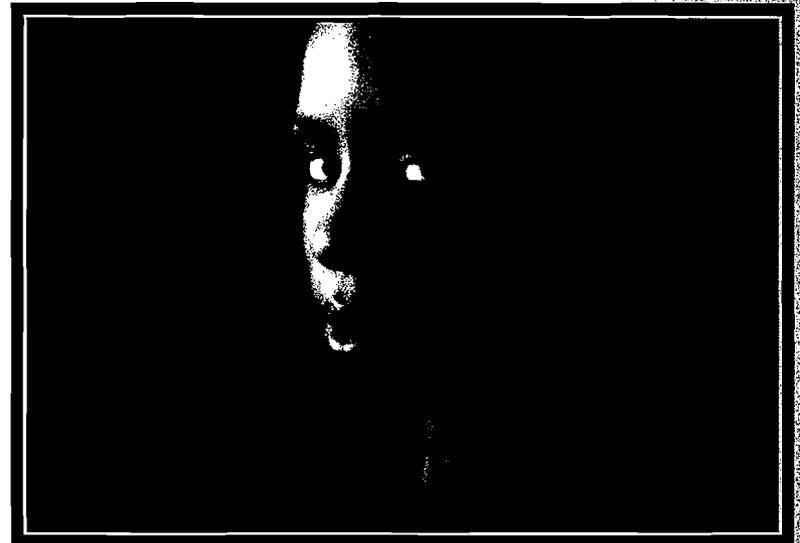
Provide college/university personnel training



Response Recommendations

Special Populations Focus

- African Americans
- Latino
- GLTB
- Elderly
- Medical Community
- Corrections
- Reduce stigma in religious communities



Response Recommendations

Statewide Initiatives

Coordination throughout State

Hotlines in every area code

Emergency-use public phones – no dialing

Statewide community training standards

Low cost training access for all

Assure access to mental health services regardless of ability to pay

Create uniform suicide/suicide attempt reporting system

Ensure telehealth assessment modalities in rural communities



Response Recommendations

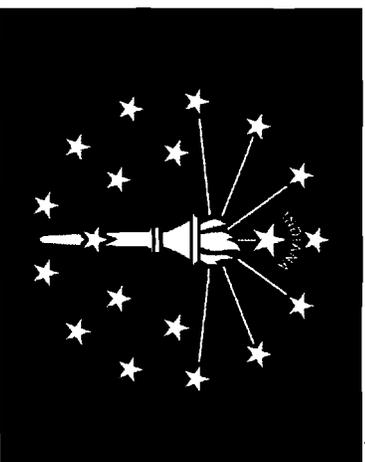
Community-Based

- Create community councils made up of diverse stakeholders to insure community-based supports and training
- Create community resource lists for prevention/intervention/post-vention/grief services



Conclusions from Survey Data

- A good deal of suicide intervention and prevention training is being conducted
- Not all areas of the state receive equal coverage of prevention/intervention efforts
- Trainers do not meet specific qualifications
- Curricula are not uniform or necessarily evidenced based
- The public wants more assistance with the problem



ISDH/DMHA Suicide Prevention Summit

ASPIN 2010

ISDH/DMHA Suicide Prevention Summit

- April 9, 2010 in Indianapolis
- 84 invitees; 39 attendees
- Represented diverse groups
- Information regarding suicide in Indiana, and the survey results were presented
- Two small group work sessions
 1. Share observations and identify gaps
 2. Develop strategies to address areas of concern

GAP Analysis and Observations Summary- Small Group I

Four small groups were asked to identify:

- 1. Observations**
- 2. Prevention Concerns**
- 3. Intervention Concerns**
- 4. Additional data**
- 5. Current Strengths**

Observations

- Better identification needed of at-risk groups
- Silo issues
- Coordination needed
- Many programs in place
- Stigma still strong
- Awareness campaign needed
- School and communities not always receptive
- Concern for elderly
- Rural areas access insufficient

Strengths

- CMHC Crisis Coverage
- A Large Amount of Training is Occurring
- Multiple Active Networks
- High Interest and Passion
- Legislative Study Committee
- Improvements in Cultural Competency
- CIT Program (NAMI)
- State Police Network

Next Steps

- Convene a Suicide Prevention Advisory Group
- Provide a Network for Sharing of Resources and Strategies
- Develop a Pro-active Agenda to Address Identified Needs
- Conduct further Research

**Data and report compiled by
Affiliated Service Providers of Indiana, Inc.
2010**





if The Jason Foundation®

Working to Give Our Youth a Promise for Tomorrow

COMH
Meeting!
August 19, 2010
Exhibit 8

To: Commission On Mental Health

First, let me apologize for not being able to be here with you today to share personally about the value of The Jason Flatt Act. On Tuesday, I had a tragic and sudden death of a family member age 18 and I need to be with family.

Youth suicide is truly a "Silent Epidemic" in our nation today. It only takes a brief look at some of the statistics to confirm its impact on our youth, families and communities. Youth suicide is the 3rd leading cause of death for our youth ages 10-24, the second leading cause of death for our college-age youth and the 4th leading cause for ages 10-14 in our nation today. More teenagers and young adults die each year from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined. According to the Center for Disease Control's 2009- Youth Risk Behavioral Survey: (1) 1 out of every 7 students "seriously consider" suicide in the past twelve months; (2) 1 out of 15 students attempted suicide in the past twelve months.

Of course these are national numbers and many times we believe they don't represent us...it is the "others" in our nation. Let's look briefly at Indiana. I would like to begin with reading a segment and some facts from the Indiana's State Suicide Prevention Plan and the Indiana Suicide Prevention Coalition website:

- ❖ "Suicide is the 2nd leading cause of injury death in Indiana. In fact, the state's rate has been higher than the national average for nearly a decade. The problem of suicide has an incredibly devastating effect on Hoosier families and communities – lost children, lost loved ones, lost employees, and lost resources. These losses are preventable."
- ❖ "Indiana's suicide rate has been higher than the national average since 1999."
- ❖ "In recent years, suicide among Hoosiers ages 15-19 has wavered between the 2nd and 3rd leading causes of death."

This "higher than national average" shows up also in the latest 2009 CDC Youth Risk Behavioral Survey in looking at Indiana's youth. Let's look at all four questions on suicide. I believe this truly gives you a picture of how important it is for Indiana to adopt The Jason Flatt Act for the training of educators.

Educational Programs and Seminars in Awareness and Prevention of Youth Suicide

18 Volunteer Drive • Hendersonville, Tennessee 37075
Phone: 615-264-2323 • Fax: 615-264-0188 Toll-Free: 1-888-881-2323 www.jasonfoundation.com

CDC 2009 Youth Risk Behavioral Survey – Indiana

1. Have you felt sad or hopeless almost every day in a row for a period of greater than two weeks so that it affected your usual activities? (possible beginning of depression)
Indiana 28.1% compared to national 26.1%
** Over 1 out of every 4 of Indiana's students
2. Have you seriously considered suicide in the past twelve months?
Indiana 17.2% compared to national 13.8%
** Almost 1 out of 6 of Indiana's students
3. Have you made a plan to commit suicide? (elevates risk highly)
Indiana 13.5% compared to national 10.9%
** Almost 1 out of 7 of Indiana's students
4. Have you attempted suicide one or more times in the past twelve months?
Indiana 9.3% compared to national 6.3%

As you can see, Indiana's statistics are higher in every account – almost 50% higher than national in attempts.

Let me utilize this report to illustrate what you can expect in Indiana over the next twelve months "IF NOTHING IS DONE DIFFERENTLY" in the state's efforts in youth suicide prevention (assuming current levels are constant and that also remembering you have consistently ranked higher than national over the past decade): ** Based on Indiana's Youth Risk Behavioral Survey and the 2007-08 school population.

1. Question #1: 134,645 students could be considered in the beginning stages of depression. Depression is one of the leading causes of suicide attempts and suicide.
2. 82,416 Indiana youth will "seriously consider suicide" in the next twelve months.
3. 64,687 Indiana youth will "make a plan" to take their life over the next twelve months.
4. 44,562 Indiana youth will "attempt suicide" in the next twelve months. That is an average of 122 young people per day.

With this in mind, I would like to ask you a question. Who will most of these students (or their friends in an attempt to help) turn to during these times of battling depression, considering suicide or when a plan is being made. The Jason Foundation feels that a "teacher" is the most turned to for guidance. In a National Survey of over 2,700 students, 80% listed a teacher as the person they would turn to. I do not mean turning to them for "counseling", but for understanding and help in finding assistance within the current school's support system. When they are turned to for help, they need to be trained in order to be able to help.



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According to a National Mental Health Association Report, four out of five teens who attempt suicide have given clear warning signs” ...that means 80% of the time if we know what to look for and how to respond, we have an opportunity to prevent a suicide attempt or tragic suicide death.

Just how will training our teachers help? Let’s look at a few points:

1. Teachers are with our youth a huge amount of their time and many times can see the changes that others miss.
2. As noted above, teachers were the #1 person a student would turn to for help.
3. When teachers are informed and have the tools and resources to help, they feel more comfortable in addressing youth suicide. Again, let me stress that this is NOT intended to place counseling duties on our educators – rather equipping them with the information, tools and resources to help identify and assist an at-risk youth in getting to the proper resource within the school’s health program.

The legislation we ask you to consider, The Jason Flatt Act, works to provide that information, tools and resources to educators through requiring teachers to have two-hours of youth suicide awareness and prevention training. It does not single out any specific program or organization to deliver such materials. In the states that have passed The Jason Flatt Act, we have seen many organizations such as Mental Health Association, Crisis Centers, Dept. of Health / Mental Health and other non-profits like NAMI, SAVE and The Jason Foundation provide this training.

We believe teacher training is the single action that can impact youth suicide statistics the most for a state. Let me use my home state, Tennessee, who was the first to pass The Jason Flatt Act in 2007. In the Year in Review report made in November 2009 by the Tennessee Department of Health, it was reported that the rate of suicide was up in all age groups but one. Youth suicide rates have decreased by 31.1% over the past five years. We believe that it has been the collaborative efforts of many non-profit and state organizations providing specific programs in awareness and prevention for this age group and particularly the teacher training required by The Jason Flatt Act that has made this very significant difference. It should also be noted that many states did not report even a slight decrease in this area. The Tennessee version of The Jason Flatt Act requires that each teacher receive two hours of youth suicide prevention training each and every year in order to be certified to teach. This very positive approach to prevention has been well-received by the education community, has been done at no-cost to the State, and most importantly has proven to save lives.



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I want to end my presentation by summing up some key points and lending some information to questions that were raised in earlier sessions:

- Suicide is a national health problem and a health problem for Indiana
- Indiana statistics have consistently been higher than the national norm for the past decade.
- For Indiana youth, 1 out of 6 “seriously considered suicide” in the previous twelve months.
- For Indiana youth, 1 out of 11 reported “attempting suicide” in the past twelve months.
- The Jason Flatt Act has been passed in Tennessee, Mississippi, Louisiana, California and Illinois.
- The Jason Flatt Act can be passed without a fiscal note – The Jason Foundation will pledge its On-Line Library of training seminars to Indiana upon passing The Jason Flatt Act. This insures that every educator can have access to the training to fulfill the requirement without cost (only need the use of a computer and high speed internet connection). It is to be stress that the offer of the On-Line Library is a “fail-safe” assurance of availability at no-cost and not an endorsement of JFI’s programs over any other program.

I want to comment here on our On-Line Library programs. We do not submit our programs to other non-profit organizations our programs for review or endorse. We have a team of clinical specialist and educational professionals who review and update our programs regularly. The Jason Foundation is one of the leading non-profit suicide awareness and prevention program national and is a member of the National Council for Suicide Prevention. The Jason Foundation teacher trainings have provided the In-Service Training and Certification needs for educators in every state for several years. In the past 19 months, we have trained and certified over 200,000 teachers (without charge) which we believe no other organization can match nationally.

When considering this legislation, the question is often raised that this could add additional liability to teachers. This most definitely does not add additional liability and in-fact protects both the state and its educators in the event a tragedy should occur in their school. In fact, two states versions of The Jason Flatt Act include wording to indicate that this is not intended to add any legal responsibility to teachers. Lawsuits involving teachers, schools and school districts are up ten-fold over the past decade. One of the leading questions by attorneys is “have you as a school / school district provided training in youth suicide prevention”. In the past, these lawsuits have been dismissed rapidly, stating that it is not the legal “duty” of a teacher. But, the trend appears to be changing with the evidence of lawsuits being settled out of court and not dismissed. Additionally, JFI and its legal representation believe that the legal duty could already be interpreted present in most states under the state’s Child Abuse Law. Unfortunately, a good many states have not provided the necessary training that could prevent a possibly liable situation.



Educational Programs and Seminars in Awareness and Prevention of Youth Suicide

18 Volunteer Drive · Hendersonville, Tennessee 37075

Phone: 615-264-2323 · Fax: 615-264-0188 · Toll-Free: 1-888-881-2323 · www.jasonfoundation.com

Under Indiana Child Abuse Law:

Physical Abuse

Citation: Ann. Code § 31-34-1-2

A child is a *child in need of services* if, before the child becomes age 18, the child's physical or mental health is seriously endangered due to injury by the act or omission of the child's parent, guardian, or custodian.

Evidence that the illegal manufacture of a drug or controlled substance is occurring on property where a child resides creates a rebuttable presumption that the child's physical or mental health is seriously endangered.

Emotional Abuse

Citation: Ann. Code § 31-34-1-2

A child is a *child in need of services* if the child's mental health is seriously endangered by the act or omission of the child's parent, guardian, or custodian.

Mandatory Reporters of Child Abuse and Neglect

To better understand this issue and to view it across States, see the *Mandatory Reporters of Child Abuse and Neglect: Summary of State Laws* ([PDF](#) - 633 KB) publication.

Professionals Required to Report

Citation: Ann. Code § 31-33-5-2

Mandatory reporters include any staff member of a medical or other public or private institution, school, facility, or agency.

Failure to Report

Ann. Code § 31-33-22-1

A person who knowingly fails to make a report required by law commits a Class B misdemeanor.

A person who, in his capacity as a staff member of a medical or other institution, school, facility, or agency, is required to make a report to the individual in charge of the institution, school, facility, or agency, or his designated agent, and who knowingly fails to make a report commits a Class B misdemeanor. This penalty is imposed in addition to the penalty imposed above.

We believe that this law already broadly includes the responsibility to report many of the mental health issues that left un-addressed can result in suicides or suicide attempts and that teachers are named as mandatory reporters under law to report these needs for services.



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The only real reason to consider passing The Jason Flatt Act is not "whose program" will be used or even the legal / liability questions, but that it will save lives! There is no doubt or argument that can be made to dismiss that by providing our teachers the information, tools and resources to help identify at-risk youth and assist them in getting help will save lives.

Thank you again for your time and I apologize for not being able to attend personally.

Sincerely,

A handwritten signature in black ink, appearing to read "Clark Flatt", written over a horizontal line.

Clark Flatt
President / CEO



Educational Programs and Seminars in Awareness and Prevention of Youth Suicide

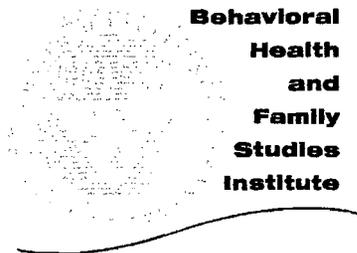
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Preventing Teen Suicide in Indiana



Colleen Carpenter, MA, MPH
Director, Indiana Cares Youth Suicide
Prevention Technical Assistance
Center



**Behavioral
Health
and
Family
Studies
Institute**

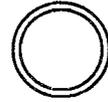
College of Health & Human Services



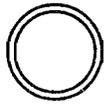
INDIANA SUICIDE PREVENTION COALITION



Overview

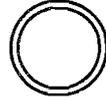


- ❖ Teen Suicide: What We Know
- ❖ Strategies for Preventing Teen Suicide
 - Focus on School Suicide Prevention
- ❖ Efforts to Address Teen Suicide Across Indiana
 - Indiana Suicide Prevention Coalition
 - The Indiana Cares Project Technical Assistance Center
- ❖ Overview of State Policies to Prevent Suicide
- ❖ Recommendations



Teen Suicide: What We Know

Youth Suicide: Recap

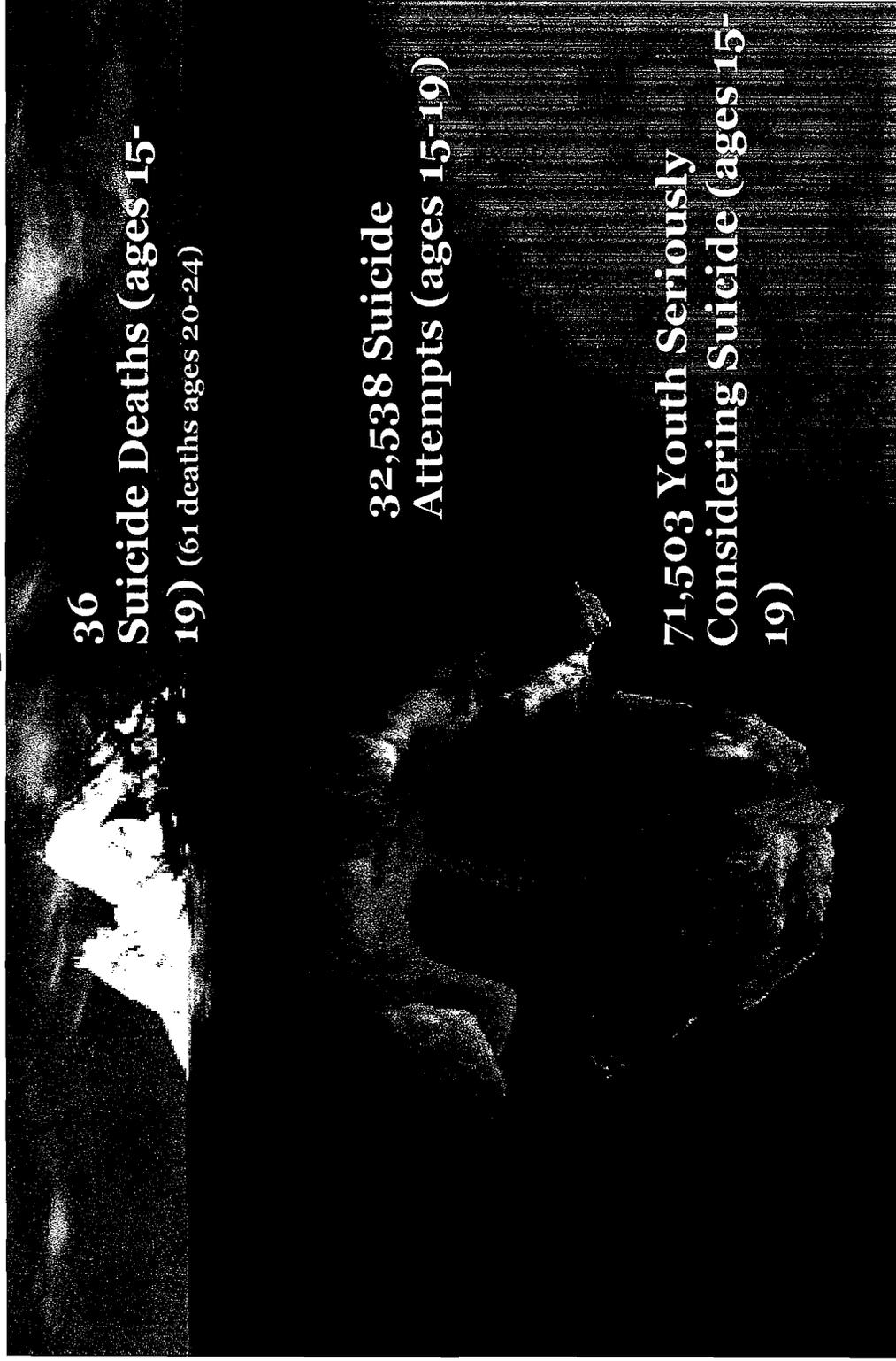


- ❖ A youth dies by suicide approximately every 4½ days in Indiana, but youth are seriously considering and attempting suicide daily.
- ❖ From 2003 to 2007 suicide was the 3rd leading cause of death for:
 - 10-14 year olds
 - 15-19 year olds
- ❖ Data for suicide attempts is sparse
 - People don't report attempts
 - Most hospitals don't "e-code" their data
- ❖ Cost during 2003-2005 for Indiana
 - ED \$16.8 million overall (Youth = \$3.7 million)
 - Inpatient \$58 million overall (Youth = \$5.5 million)

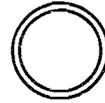
Source: Indiana State Department of Health (ISDH), Mortality Report, 2007;
Centers for Disease Control and Prevention (WISQARS)



Magnitude of the Problem: Indiana High Schoolers (2007)



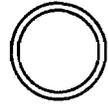
Youth At Risk



- ❖ At-risk youth are everywhere: In a typical classroom, 1 boy and 2 girls have already attempted suicide
- ❖ Higher rates of suicide attempts:
 - Young Latinas
 - LGBT youth
 - Youth living with mental illness, youth facing abuse, and juvenile offenders
 - African American females ages 15-24 were seen more often in inpatient settings for suicide attempts than their white or Latino peers from 2003-2005 in Indiana.
- ❖ 1 in 11 high school teachers and 1 in 3 high school counselors feel confident that they can ID suicidal students

Sources: National Strategy for Suicide Prevention, 2001; AAS Youth Suicide Fact Sheet; Suicide in Indiana, 2001-2005, ISDH Injury Prevention Program, King et al. (2006 & 2009)

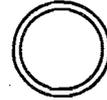




Strategies for Preventing Teen Suicide



School-based Strategies for Teen Suicide Prevention



****Research shows that 9 in 10 youth who are suicidal offer clues or warning signs that can be detected by others****

- ❖ Evidence-based “Gatekeeper training” for those who work with youth (school staff, youth pastors, parents, social workers)
- ❖ Evidence-based curricula for youth (can be used in classrooms, churches, afterschool programs)
- ❖ Appropriate postvention and crisis response can reduce subsequent youth suicide attempts/deaths

Sources: Gould , Greenberg, Velting, and Shaffer, 2003; King, 2006



Other Strategies for Teen Suicide Prevention

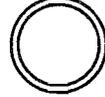
- ❖ ER interventions (“Emergency Room Intervention for Adolescent Females” program)
- ❖ Crisis hotlines (1-800-273-TALK (8255))
- ❖ Reduce access to lethal means
- ❖ Appropriate identification and treatment of youth depression (SSRIs, DBT)
- ❖ Educate pediatricians/family practice doctors to recognize depression and treat it

One study showed that 72% of family physicians and pediatricians had prescribed an antidepressant for a child or adolescent patient, but only 8% had received adequate training in the treatment of childhood depression and only 16% felt comfortable treating children for depression

Sources: Gould et al 2003; King, 2006; Mann et al 2005.

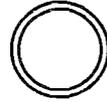


Schools: An Important Avenue for Suicide Prevention



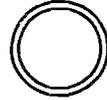
- ❖ Potential to identify youth at risk for suicide and refer them to help is great
 - Reach the highest number of youth
 - Provides contact with adults who want to help
 - Building help-seeking skills is part of building healthy youth

Suicide Prevention is Appropriate



- ❖ Safety for students is a central concern
- ❖ Already have policies and crisis plans for reducing risk and responding to “other directed” violence
- ❖ Growing legal trend to hold schools responsible for failing to take reasonable steps to prevent a crisis or manage a crisis situation

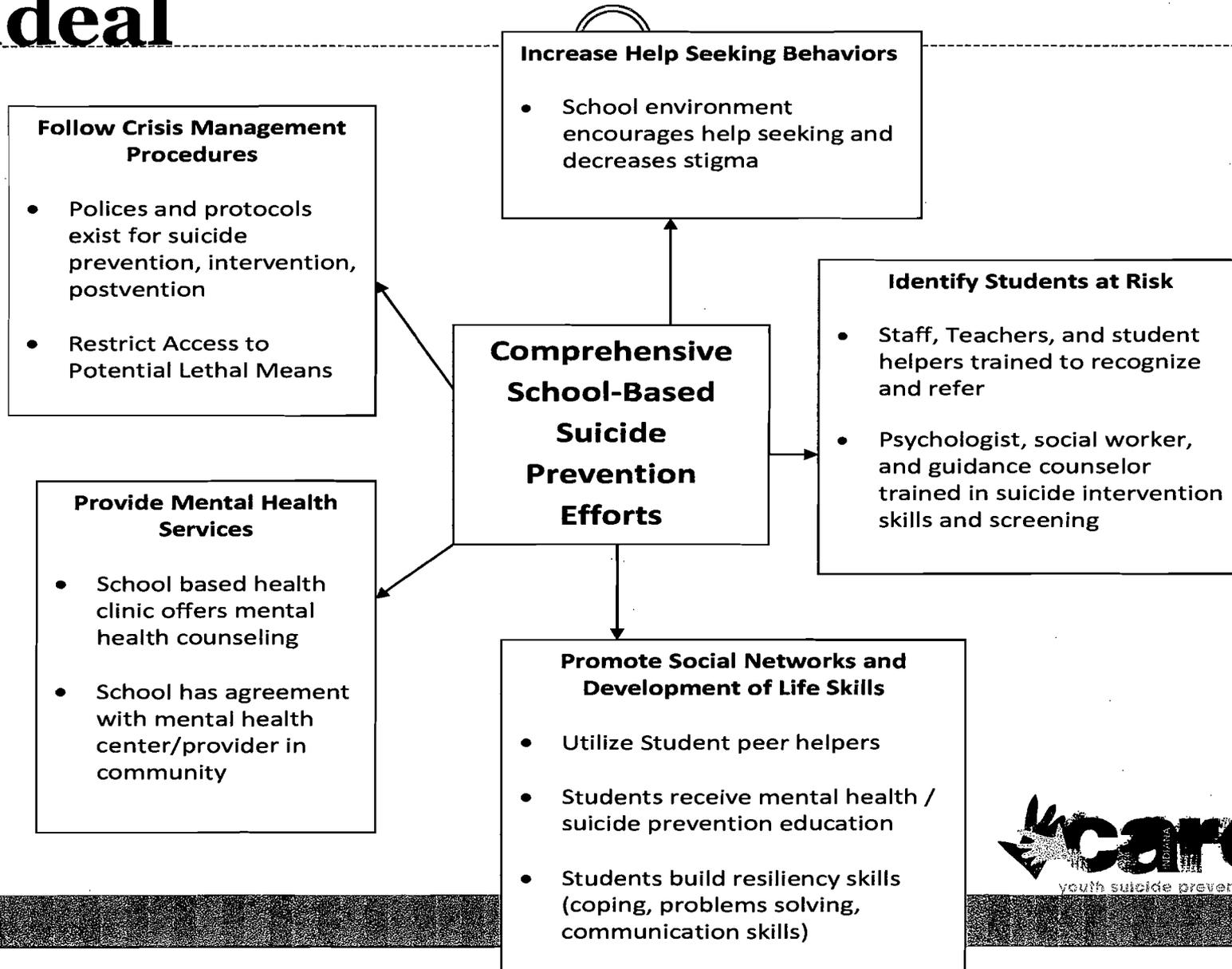
Other Benefits to Schools



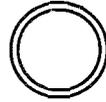
❖ Suicide prevention can...

- Prevent homicides in schools
- Reveal other school problems such as bullying, substance use that can be addressed
- Improve academic achievement
- Reduce the likelihood of “copy cat” suicides

Suicide Prevention in Schools: Ideal

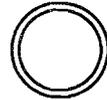


Schools: Recommended Strategy



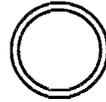
- ❖ Step 1: Assess current policies to make sure they cover pre-, inter- and postvention procedures
- ❖ Step 2: Train student service staff on evidence-based suicide intervention (intervene with suicidal youth)
- ❖ Step 3: Train rest of school staff in evidence-based suicide prevention (recognize risk & refer)
- ❖ Step 4: Educate youth using evidence-based suicide prevention program to recognize risk and turn to a trusted adult
- ❖ Step 5: Implement peer helper program to increase likelihood of identification of at risk youth
- ❖ Step 6: Create climate of help-seeking and destigmatize suicide and mental illness

Schools: Barriers



- ❖ Funding issues for programs, overtime pay and substitutes while staff to attend programs
- ❖ Perception that suicide does not happen at their school
- ❖ Myth that talking about it will “cause suicide to happen”
- ❖ Time/competing demands
- ❖ Lack of knowledge of best programs/guidelines
- ❖ Lack of community mental health services for referral
- ❖ Perceived liability issues

Proceed with Caution...

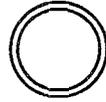


- ❖ Suicide prevention programs might have negative or “iatrogenic” effects unless evidence-based
- ❖ Several studies have found that curriculum approaches may have no effect on students or may be potentially dangerous for certain students. Certain students showed:
 - Less desirable attitudes about suicide after class
 - Were less likely to seek help
 - Were less likely to refer a friend or recommend the class to other students
 - Were more likely after the class to view suicide as a reasonable response to intense stress.

Source: Youth Suicide Prevention School-Based Guide, Florida Mental Health Institute, University of South Florida.



However...



❖ Research has found that when curriculum addresses suicide in a manner consistent with empirical evidence and is taught in a sensitive and educational manner, students:

- Demonstrate improvements in attitudes concerning suicide

- Express more accurate attitudes concerning suicide following curriculum than they did before curriculum.

- Show an increase in knowledge about:

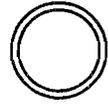
- suicide (warning signs and risk factors)

- where and how to get help for themselves or a peer

❖ If student suicide attempts/deaths are handled well, schools can minimize or eliminate “copy cat” suicide attempts and completions.

Source: Youth Suicide Prevention School-Based Guide, Florida Mental Health Institute, University of South Florida.

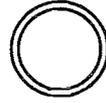




What's Being Done to Address Teen Suicide Across Indiana



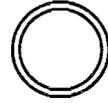
National Support for Suicide Prevention



❖ In 2001, U.S. Surgeon General David Satcher launched the ***National Strategy for Suicide Prevention: Goals and Objectives for Action***

- Identified that suicide is a serious public health problem throughout the United States
- Provided a blueprint for addressing suicide prevention through Awareness, Intervention, and Methodology (AIM)
- Recommended that each state adopt a suicide prevention plan that would incorporate the national recommendations

National Support for Suicide Prevention



❖ In 2004, President Bush signed the ***Garrett Lee Smith Memorial Act (GLSMA)***, the nation's first suicide prevention bill.

Legislation is named for Garret Lee Smith, son of Sen. Gordon Smith, R-Ore., and Sharon Smith, who died by suicide Sept. 8th, 2003

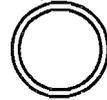
The US Senate Appropriations Committee has approved GLSMA funding each year since 2004

Provides funds for states, tribes, and colleges for youth suicide prevention

✦ Indiana is one of 42 states currently receiving GLSMA funding



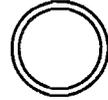
Indiana's Response to National Strategy



- ❖ The Indiana Suicide Prevention Coalition (ISPC) formed in 2001, chaired by Dr. Charlene Graves, pediatrician and Director of Injury Prevention at ISDH (now retired).
 - ❖ Created state plan using National Strategy as a blueprint
 - ❖ The mission of the ISPC is to coordinate, facilitate, advise, and provide resources to Indiana communities for activities that reduce:
 - ❖ Deaths due to suicide
 - ❖ Occurrence of suicidal behaviors
 - ❖ Effects of suicide on Indiana citizens
- ❖ Indiana State Department of Health funded ISPC from 2003-2009 and continues to be supported by Indiana University-Purdue University Fort Wayne (IPFW).



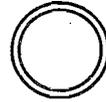
Indiana Suicide Prevention Coalition



- ❖ A diverse group of stakeholders including state agencies, MH providers/advocates, law enforcement, educators, and other interested people, comes together at bi-monthly meetings to:
 - Share resources
 - Coordinate efforts across the state (11 local suicide prevention councils)
 - Develop projects based on Indiana's State Suicide Prevention Plan
 - ❑ National Suicide Prevention Week



Support from National Suicide Prevention Organizations



- ❖ **American Association of Suicidology** www.suicidology.org
 - National suicide prevention conference
 - National journal (Suicide and Life Threatening Behavior)
 - Video review committee

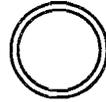
- ❖ **SPRC (Suicide Prevention Resource Center)** www.sprc.org
 - Best Practices Registry
 - On-line library

- ❖ **American Foundation for Suicide Prevention** www.afsp.org
 - Awareness/fundraising efforts such as Out of the Darkness Walks
 - Awareness programs (e.g., “More than Sad”)
 - Survivors
 - Policy (SPAN)

- ❖ **National Suicide Prevention Lifeline**
www.suicidepreventionlifeline.org
 - National suicide hotline: 1-800-273-TALK (8255)
 - Free resources (posters, wallet cards, magnets)



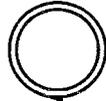
ISPC: Youth Suicide Initiatives



- ❖ Conducted statewide survey of schools to assess suicide prevention programming in place
- ❖ Revised Department of Education manual on suicide prevention, intervention, and postvention guidelines
- ❖ Partnered with Indiana Youth Institute to provide free webinar on Teen Suicide Prevention
- ❖ Established statewide network of suicide intervention (ASIST) trainers
- ❖ Provide tailored consultation with schools to identify most appropriate suicide prevention programs according to their needs
- ❖ Participated in developing Indiana's Coalition to Improve Adolescent Health Strategic Plan
 - ❖ Reducing suicidality is one of the 10 priorities



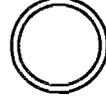
ISPC's School-based Assessment



- ❖ Goal was to survey schools and youth-serving organizations to identify youth suicide prevention, intervention, and postvention programs and services for youth, including
 - Heighten awareness of the issue and available resources
 - Distribute relevant suicide prevention information such as the “Youth Suicide Prevention School-based Guide”
 - Provide relevant data to both regional and county level councils
- ❖ Findings
 - Perception of “minor problem/not a problem” (81%)
 - Of those that have a crisis plan that includes suicide prevention, under half have a policy/procedure to handle a suicide intervention
 - Lack of utilization of evidence-based programming
 - Majority (83%) lack information on “best practices”
 - Majority (69%) lack information on how to implement a suicide prevention plan



Indiana Cares Youth Suicide Prevention Project



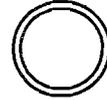
- ❖ A statewide project focused on youth suicide prevention (ages 10-24)
- ❖ Funded by a 3-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA)
 - Indiana is 1 of 42 states that receive or have received youth suicide prevention funds under the Garrett Lee Smith Memorial Act
- ❖ Focus is on building capacity of youth serving systems and communities (training, mini-grants, cultural competency initiatives)
- ❖ Sister project of the Indiana Suicide Prevention Coalition
- ❖ Directed by the IPFW Behavioral Health and Family Studies Institute



Indiana Cares Programs

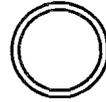
- Evidence-based *training* (emphasis on training for trainers)
- *Mini grants* to communities/organizations to build capacity
- Reduce access to lethal means by providing *CALM* (Counseling on Access to Lethal Means) training for FREE for MH & health care providers
- *Cultural competency* initiatives

Indiana Cares Programs (cont)



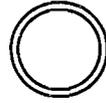
- ❖ *Connect! Project* in Elkhart
- ❖ Work with agencies/systems to *develop policies and protocols* aimed at suicide prevention, intervention and postvention
- ❖ Provide *tailored information and consultation* to youth serving professions, organizations, and communities.
- ❖ User friendly website for youth, parents/caregivers, and organizations/communities

Indiana Cares: Latino Initiative



- ❖ Train Spanish speaking people as QPR Trainers to train Latinos in suicide prevention
 - Help market QPR in Spanish across the state
- ❖ Offer Spanish language suicide prevention materials
- ❖ Integrating suicide prevention into mental health wellness curriculum for teenage Latino immigrants (Bienvenido)

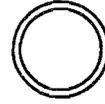
Indiana Cares: African American Initiative



- ❖ Roundtable discussions to raise awareness in two sites: Allen & Lake Counties
- ❖ Working with pastors to discuss and address mental health and suicide prevention in churches
- ❖ Working to build better relationship between African Americans and MH providers and encourage MH treatment
- ❖ Creating a youth steering committee to tailor messages to youth
- ❖ Will make recommendations for other communities across state to engage African Americans in suicide prevention

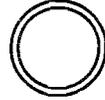


Training

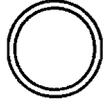


- ❖ Work with schools and other youth serving organizations to obtain training for staff
 - Gatekeeper Training:
 - ❑ Recognizing and responding to suicide risk (e.g., QPR, safeTALK, SPTS on-line training); ideal for anyone
 - ❑ Intervention training (ASIST)
 - Assessment & management of suicide risk (e.g., AMSR) for MH providers, ER staff, EMS
 - Restricting access to lethal means (e.g., CALM Training) for MH providers and health care providers

Technical Assistance



- ❖ Answer requests for information via email, phone, and web
 - Organizations
 - Professionals
 - Suicide prevention coalitions
 - Trainers
 - Family members
- ❖ Provide “Resource Sheets” on special topics and populations
- ❖ Provide one-on-one consultation to organizations and communities to help reduce suicide
- ❖ Resource library offers suicide prevention materials for loan



Overview of State Policies to Prevent Suicide



What Other States Have Done: Teen Suicide Prevention Policy

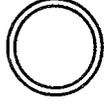
School related policy

- ❖ Mandatory suicide prevention training for teachers, principals, and counselors (IL, NJ, MI, TN, MS, LA)
 - Include suicide prevention in approved in-service topics (CA, CO)
 - Provide information on training (FL, NV, WI)
- ❖ Pilot/implement school programs (FL, HI, LA, MD, WA)
- ❖ Include suicide prevention in curriculum standards (IL, NJ, VT)
- ❖ Educate youth (AL-mandatory, MI-not mandatory)
- ❖ Miscellaneous: Dept of Education to create policy directing the reporting of threats of suicide (AL); Dept of Ed must post SP information on web (KY); Dept of Education must seek youth suicide prevention funding (MD)

What Other States Have Done: Teen Suicide Prevention Policy

Other Policies

- ❖ Improve data collection (ME, NH), review child fatalities/suicide deaths (NH, CO)
- ❖ Appropriate funds for youth suicide prevention (PA, WA, NY (Latinas), AK (all ages))
- ❖ 9 states have state mandated Councils or Initiatives (AK, CT, GA, MA, MD, ME, NY, OR, VA)
 - Must have strategies to address youth suicide (CT)
- ❖ 4 states have suicide prevention “offices” or “departments” (CA, CO, FL, NV)



Recommendations

Supporting Suicide Prevention: What the State Can Do

- ❖ **Mandate evidence-based training for school staff**
 - Prevention training to recognize risk (e.g., teachers, bus drivers, cafeteria workers, office staff, coaches)
 - Intervention training for student service staff (e.g., guidance counselors, social workers, nurses, psychologists, conflict mediators)

Supporting Suicide Prevention: What the State Can Do

❖ Mandate that school “crisis plans” include procedures to address

- Suicide prevention: suicide ideation and threats

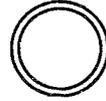
- Suicide intervention: suicide plan/attempt in progress

- Suicide postvention: after a suicide attempt or death has occurred

Supporting Suicide Prevention: What the State Can Do

- ❖ **Mandate that the health curriculum standards include suicide prevention**
- ❖ **Improve data collection by mandating e-coding of injury data in hospitals**
- ❖ **Ensure that a state agency puts resources toward youth suicide prevention**
- ❖ **Urge Congress to reauthorize GLSMA programs under any SAMHSA reauthorization legislation.**





Thank you!

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