

Members

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



COMMISSION ON MENTAL HEALTH AND ADDICTION

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MEETING MINUTES¹

Meeting Date: September 6, 2011
Meeting Time: 1:00 P.M.
Meeting Place: State House, 200 W. Washington St., Senate Chamber
Meeting City: Indianapolis, Indiana
Meeting Number: 2

Members Present: Sen. Connie Lawson, Chairperson; Sen. Vi Simpson; Rep. Cindy Noe; Rep. Charlie Brown; Kathleen O'Connell; Stacey Cornett; Ronda Ames; Valerie N. Markley; Bryan Lett; Kurt Carlson; Chris Taelman; Rhonda Boyd-Alstott; Dr. Danita Johnson Hughes; Dr. Brenna McDonald.

Members Absent: Margie Payne; Caroline Doebbling; Jane Horn.

I. Call to Order

Senator Connie Lawson, Chairperson, called the meeting to order at 1:00 P.M.

II. Final Report from the Indiana Bar Association Statewide Juvenile Mental Health Screening and Assessment Project

Dr. Matthew Aasima, PhD, Associate Processor of Pediatrics, Indiana University School of Medicine, reported on the Indiana Juvenile Mental Health

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.

Screening, Assessment, and Treatment Project. (Exhibits 1, 2, and 3) In answer to questions from Representative Cindy Noe, Dr. Aaslma indicated that the screening tool used is the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) which consists of 52 questions. Dr. Aaslma said that the tool is used when it is clear that the youth will be detained at a detention center. Parents are involved primarily in planning for providing services upon release of the child. In answer to questions from Senator Lawson, Dr. Aaslma said that the program had been funded for five years with a federal grant administered by the Criminal Justice Institute.

Ms. JauaNaë Hanger stated that seventy-three percent of the youth in detention centers in the state are in areas with programs covered by the pilot screening project. Sustainability of the screening program is a concern now that the pilot program has ended. It is hoped that the judiciary will take over the program. It would be possible to continue the program either by law or by rule. Those involved in the pilot are not yet ready to make a recommendation as to how to continue and expand the program so that the screening tool for children in detention is used statewide on a uniform basis. In answer to questions from Rep. Charlie Brown, **Ms. Amy Karozos** said that those who ran the pilot project hope that the detention centers not participating in the pilot project will join to ensure uniform testing throughout the state. Of the six centers not participating, three use the MAYSI-2 test but prefer to use it on their own instead of being part of the pilot.

III. Underage Drinking Issues

Ms. Lisa Hutcheson, Director, IN Coalition to Reduce Underage Drinking, Vice President of Policy and Programs for Mental Health America Indiana, made a presentation on underage drinking in Indiana. (Exhibit 4) Ms. Hutcheson said that studies show that youth are using more hard liquor, instead of beer, than in the past. In answer to questions, Ms. Hutcheson said that data indicate that the universal carding law in Indiana did reduce underage drinking. Ms. Hutcheson will provide the members with information on the dates of the data collected. Ms. Hutcheson recommended increasing the tax on alcohol as a means to fund underage drinking programs and to reduce underage drinking. The tax on alcohol has not been increased since 1981.

IV. Family and Social Services Administration (FSSA) Written Responses to Questions from the August Meeting

Responses from FSSA to questions from the August meeting concerning the Suicide Advisory Committee (Exhibit 5) and the transition plan implemented for state-operated facilities (Exhibit 6) were distributed to members.

V. FSSA Presentation

Ms. Gina Eckart, Director of the Division of Mental Health and Addiction (DMHA), complimented Ms. Hutcheson on her presentation on underage drinking. Ms. Eckart and **Ms. Kristina Moorhead, Deputy Director of the Office of Medicaid Policy and Planning (OMPP)**, discussed the Medicaid Rehabilitation Option (MRO) and answered questions raised about MRO at the August meeting. (Exhibit 7)

VI. Community Mental Health Center Responses to MRO Issues

(A) Mr. Kurt Carlson, President and CEO of the Bowen Center, discussed the challenges the Bowen Center faced with the MRO changes and how the Center overcame the challenges. Mr. Carlson indicated that the changes required intensive staff training.

The first month of the new system was catastrophic. The Center initially experienced an eleven percent decrease in MRO clients. After planning and reorientation, the Center has turned that around to an overall thirteen percent increase in the number of clients served. Sixty-two individuals have been added to the staff. Mr. Carlson recommended that OMPP reconsider the group therapy rates and that OMPP begin planning now for major changes in service delivery that may be coming in 2014.

(B) Mr. Eric Crouse, CEO, Gallahue Mental Health Services, testified that the changes in MRO required the staff to make a lot of adaptations. He believes that reimbursement rates still need attention. For Gallahue, MRO was reduced by eight percent. There were reductions in staff. Issues with staffing and the emphasis on individual rather than group care for the most vulnerable should receive further consideration. In summary, Mr. Crouse said he agrees with the efforts of DMHA. He hopes that when data is considered on the outcomes for patients, there may be changes. He also said the continuum of care definitions need to be revised.

(C) Mr. Galen Goode, CEO, Hamilton Center, began by saying that he is pleased to be working in the mental health area in Indiana. The community system has improved over time. The system is, however, very dependent on Medicaid payments. The Hamilton Center lost \$1.5 million last year and is giving away approximately \$5 million in free services. The emphasis on individual care has been difficult for clients who need a group setting for socialization and clients who enjoyed and thrived in a group setting.

(D) Mr. Robert Krumwied, CEO, Regional Mental Health Center, testified that his center provides services to all of Lake County except for the City of Gary. The changes in MRO mean that his center will receive thirty-nine percent less funding in 2011 than in 2010. They have had to eliminate three programs and 38 positions. Those who need services the most are not receiving them. Mr. Krumwied also discussed the loss of socialization for many clients with the changed emphasis on providing services on an individual basis instead of in a group setting.

VII. Adjournment

Rep. Charlie Brown, acting chairman, delayed the presentation of Mr. Thomas Talbot and Ms. Julia Rupp and the presentation from the National Alliance on Mental Illness until the October 4th meeting. The meeting was adjourned at 3:55 P.M.

The next meeting of the Commission will be Tuesday, October 4, at 1:00 P.M. in the Senate Chamber.

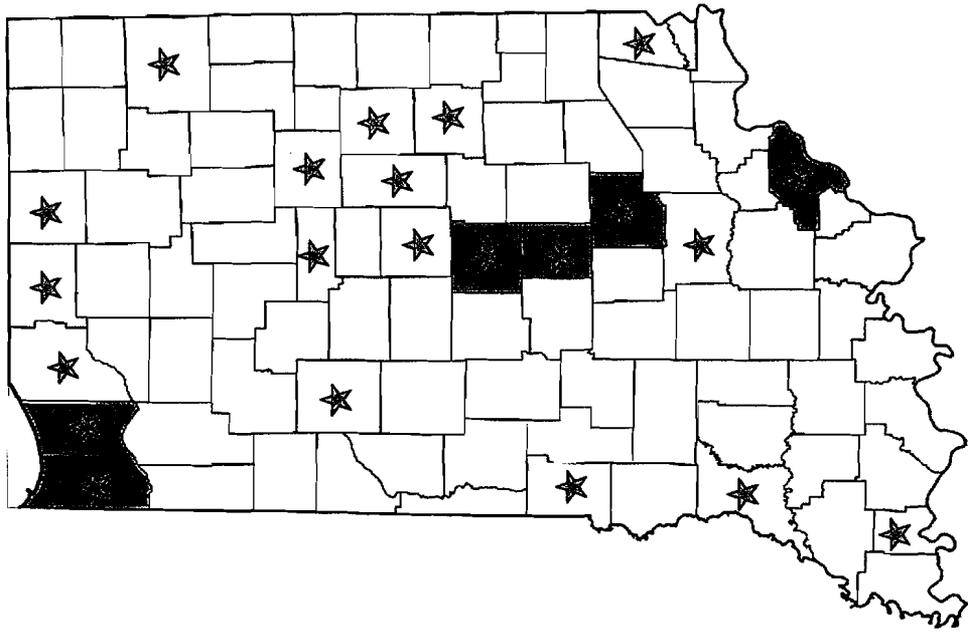
COMH
Meeting 2
9-6-11
Exhibit 1

Indiana Juvenile Mental Health Screening, Assessment, and Treatment Project: 2011 Update

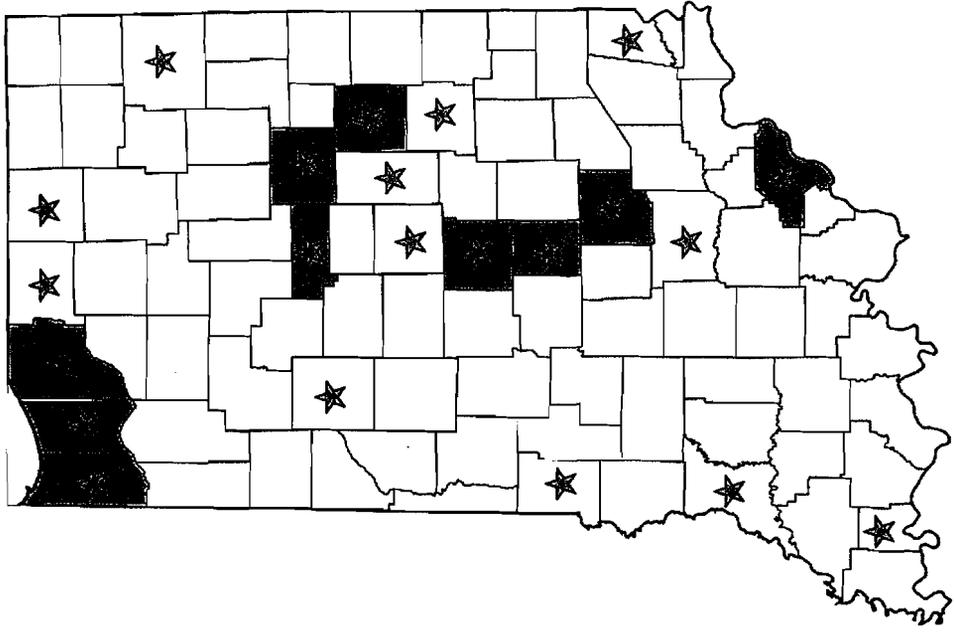
Matthew C. Aalsma, PhD
Associate Professor of Pediatrics
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September, 2011

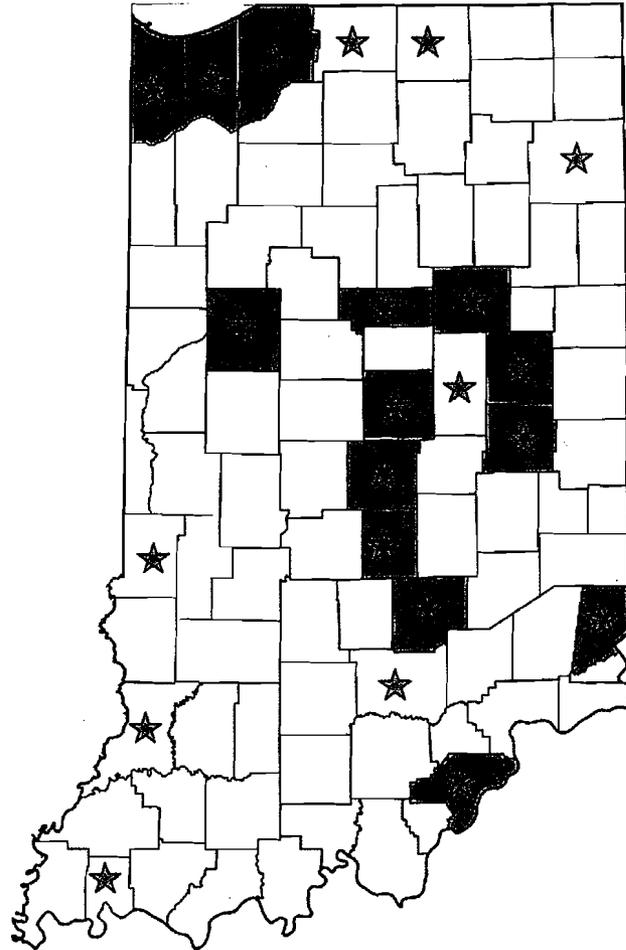
Participating Counties 2008



Participating Counties 2009

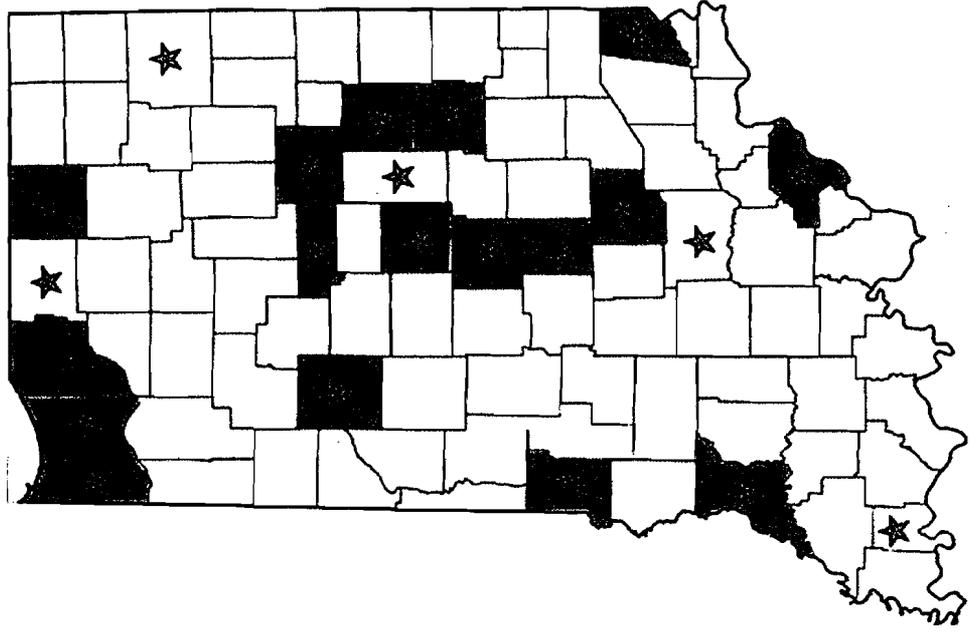


Participating Counties 2010 (through 2/1/10)



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

Participating Counties 2011



Indiana Juvenile Mental Health Screening and Assessment Project

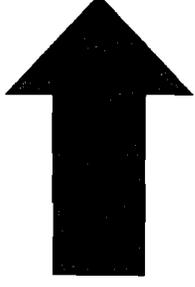
- Data includes:
 - Mental health screening results
 - 6 scales (anger/irritable; suicide ideation; drug/alcohol; depression/anxiety; thought disturbance; somatic complaints; traumatic events)
 - Elevated screen = high on suicide OR high on 2 or more scales
 - Follow-up information during detention
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

Predictors of recidivism

Mental health

Angry-irritable

Drug-alcohol use

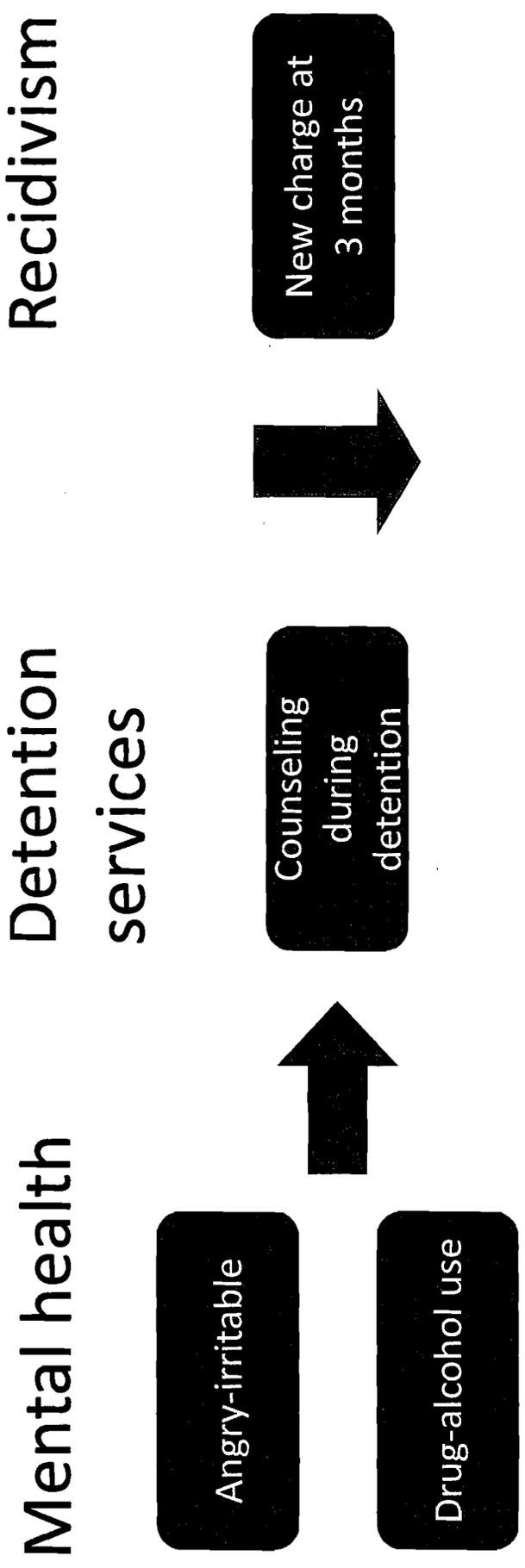


Recidivism

New charge at 3 months

New charge at 6 months

Predictors of recidivism

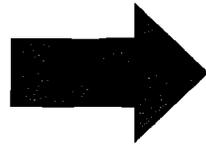


Predictors of recidivism

Mental health

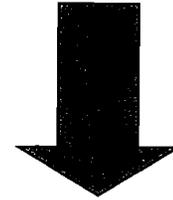
Angry-irritable

Drug-alcohol use



Detention
services

Counseling
during
detention



Recidivism

New charge at
3 months

*counseling during detention effective **only** for less risky youth

Conclusions

- Best practices adopted within Indiana detention centers
- Thousands of Indiana's vulnerable children have screened high for mental health issues
- Suicidal youth have been protected
- Future offenses are lowered with mental health services in detention
- Continued need for systemic coordination
- AND YET . . .

Connection to Mental Health Care

- Data from Marion County
- 2004 – 2008
- Compared 2 years prior and 2 year post-implementation of mental health screening and referral
- Utilized Indiana State Medicaid mental health care billing data

Connection to Mental Health Care

	First Cohort (n=4787)	Second Cohort (n=2451)	OR for Second Cohort Compared to First Cohort (95% CI)	p-value
Mental health visit within 30 days, n(%)	654 (13.7%)	387 (15.8%)	1.08 (0.93-1.24)	0.31
Mental health visit within 60 days, n(%)	833 (17.4%)	474 (19.3%)	1.03 (0.90-1.18)	0.64

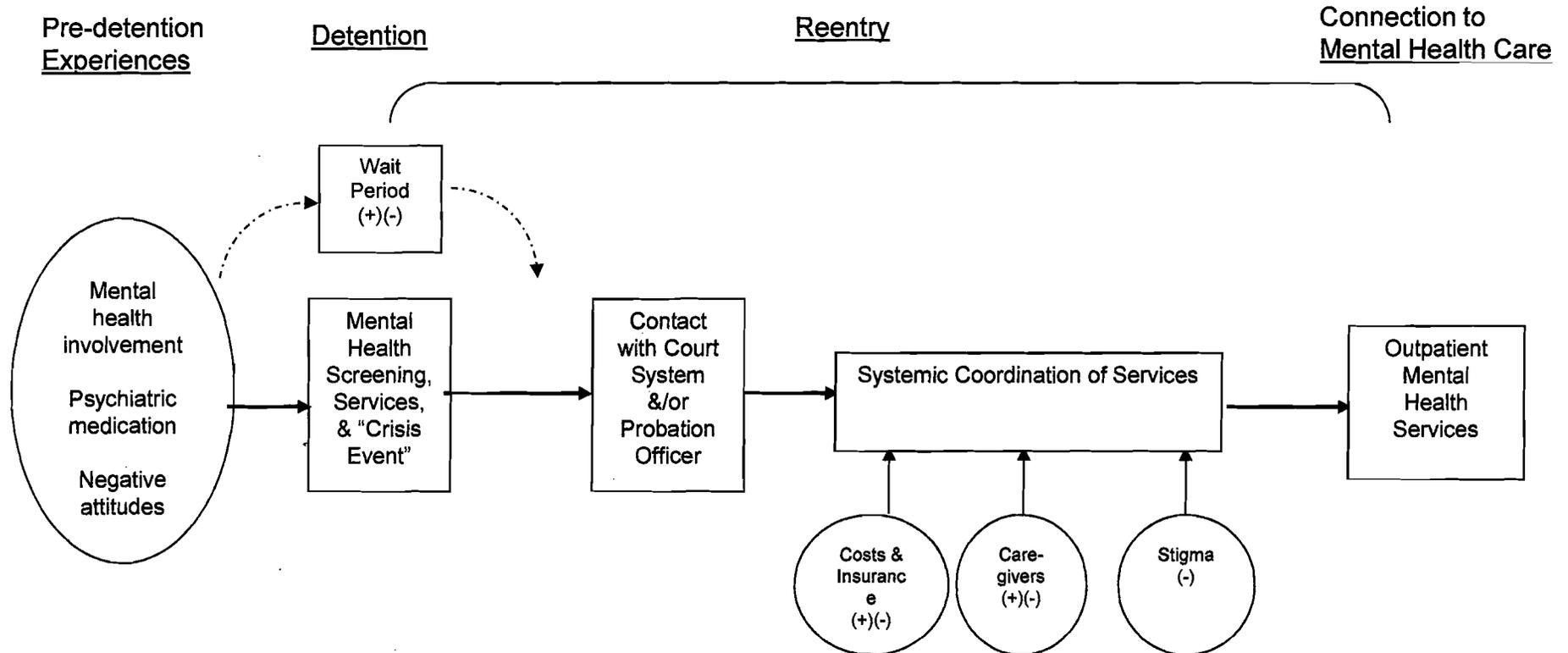
- No significant impact on overall rate of mental health care
- However . . .

Connection to Mental Health Care

	1 st cohort n (%)	2 nd cohort n (%)	Odds ratio for 2 nd vs. 1 st cohort (95%CI)	p-value
Mental health visits within 30 days				
Early Adolescent- 12.0-14.5 years ²	345 (20.4%)	154 (22.1%)	0.85 (0.67-1.06)	0.15
Mid-Adolescent- 14.6-16.5 years ³	194 (12.3%)	154 (17.4%)	1.36 (1.08-1.72)	<0.01
Late Adolescent- 16.6-18.0 years ⁴	115 (7.6%)	79 (9.1%)	1.02 (0.75-1.39)	0.90
Mental health visits within 60 days				
Early Adolescent- 12.0-14.5 years ²	426 (25.2%)	188 (27.0%)	0.84 (0.68-1.04)	0.11
Mid-Adolescent- 14.6-16.5 years ³	251 (15.9%)	188 (21.3%)	1.30 (1.05-1.61)	0.02
Late Adolescent- 16.6-18.0 years ⁴	156 (10.3%)	98 (11.3%)	0.93 (0.70-1.23)	0.62

- An interaction effect of Cohort by Age for Mid-adolescent youth (age 14 ½ - 16 ½)

Juvenile Mental Health Care Re-Entry Model



Community reentry experiences: Release and contact with juvenile justice

14 y/o AA male: *"I was, like, I want to get help all I can and so I was thinking it at the time [detention], but when I got out and I started doing more stuff, I mean, like, I didn't want to go to counseling, wake up all the time and go to counseling."*

Community reentry experiences: Mental health cost

15 y/o AA male: *They're charging way too much for it.*

INT: Can you explain that?

Male youth: *For just basic essentials. Might as well be talking to the mailman to make you feel better. It costs nothing. You go to [C.M.H] or something like that, and they're all like, "Where is your paper work? Where is all this? Where's that? Do you have insurance? Medicaid?" If you don't have all that stuff, you're screwed.*

INT: You don't get in?

Male youth: *You can get in, but you're going to get billed big.*

INT: Has that happened before for you?

Male youth: *I'm lucky enough that my counselor, [C.M.H] has stepped in and paid for most of that.*

Community reentry experiences: Caregiver influence

- 16 y/o Latino male: *“Well originally it was like a negative, I don't care, you're basically forcing me to go there. So I'm not even going to listen to what the dude's saying but then me and that dude had the talk. I then talked to my dad about it and now he usually tries to be more positive when talking about it. He'll usually let me know 20 minutes before I have to go and if he has time he'll usually drive me. He always picks me up now but I guess after I talked to him he was basically, okay I'll see this as a good thing instead of just you're just a bad kid going to your counseling class because that's what it was at first.”*

Community reentry experiences: Systemic coordination

16 y/o White male: *I do it because I have to. My mom thinks I need it. Court thinks I need it. Everybody else thinks I need it, so why not take it then if everybody thinks it going to help?...I've had counseling most of my life. Hadn't really done anything for me, so what was the difference now?*

INT: Is there a difference now?

Youth: *A little bit. It's different in the fact whenever people with different teaching styles, different people come onto you in different ways...When a person comes at you the way that my counselor has, it's really affected me. Really, she's done a good job. I usually didn't take my medicine or anything like that before. She's got me to at least try with my medicine.*

Community reentry and connection to mental health: Systemic coordination

Mother: I was like, she didn't want to go. "I'm not going to any therapist," and I'm like, oh yes you are and she even asked the judge, "Well why do I have to go to therapy" and he said, "Young lady you have some anger issues." So I'm like, yes thank you. If she wants to get off probation it's something she has to do so that's the only reason I think she's doing it but she doesn't give me a hard time. At first she did and I'm so glad for her to hear it from the judge, she takes it more seriously now.

INT: Now that she has been going, is it better?

Mother: *Oh yeah, a whole lot better.*

Conclusions

- Some evidence that mental health screening referral may be effective for mid-adolescent age group
- Evidence suggests multiple barriers to mental health care
- Suggestion:
 - Workgroup to Study Access and Utilization of Mental Health and Substance Use for Youth in Juvenile Justice in Indiana

Juvenile Justice Access and Utilization Workgroup

- Overarching goal is to address the gaps and barriers to connecting Indiana youth in juvenile justice with needs for mental health and substance use services
- Goals:
 1. Evidence-based treatment
 2. Funding
 3. Culturally sensitive programming
 4. Accreditation

Conclusions

- **Members:**
 1. State partners – DCS, members of mental health commission, Judiciary, DMHA, Health department, Medicaid, legislators
 2. Family members of youth involved in juvenile justice
 3. County partners - County Court officials, mental health and substance use providers
 4. Legal community – ISBA, prosecutors, public defenders
 5. Academia
 6. Private partners – commercial insurance, business



*A statewide collaboration
to screen and connect youth to mental health care
upon entry into Indiana juvenile detention facilities*

2011 Report and Recommendations

**By Matthew C. Aalsma, Ph.D.,
and the Indiana Juvenile Mental Health
Screening, Assessment & Treatment Project**

**Indiana State Bar Association
Civil Rights of Children Committee
in Cooperation with the Youth Law T.E.A.M. of Indiana**

August 2011

**Indiana Juvenile Mental Health Screening, Assessment
& Treatment Project Sites as of July 2011**

Bartholomew County Juvenile Detention Facility
Clark County Juvenile Detention Center
Dearborn County Juvenile Center
Delaware County Youth Opportunity Center
Elkhart County Juvenile Detention Center
Grant County Youth Services Annex
Hamilton County Youth Center
Henry County Youth Center
Howard County Kinsey Youth Center
Johnson County Juvenile Detention Center
Knox County, Southwest Indiana Regional Youth Village
Lake County Juvenile Detention Center
LaPorte County, Dorothy S. Crowley Juvenile Services Center
Marion County Juvenile Detention Center
Porter County Juvenile Detention Center
Tippecanoe County Juvenile Intake Center
Vigo County Juvenile Center



*A statewide collaboration to screen and connect youth
to mental health care upon entry into Indiana juvenile detention facilities*

2011 Report and Recommendations

By Matthew C. Aalsma, Ph.D., and the Indiana Juvenile Mental Health
Screening, Assessment & Treatment Project

(Released August 2011)

Just a few short years ago, Indiana lacked systematic mental health screening for youth in the juvenile justice system. Our state responded by developing and implementing a unique mental health screening model. As a result of the Juvenile Mental Health Screening, Assessment & Treatment Project, as of Jan. 1, 2011, pilot sites across Indiana had conducted more than 18,500 mental health screens on youth at the critical intervention point of entry into detention. The project has expanded to include pilot sites in 14 counties and continues to grow. Each county participating in the project has demonstrated support and cooperation of the juvenile court judge, probation, county prosecutor, defense bar, detention center and the relevant mental health providers.

While efforts have been made to initiate mental health screening programs at detention centers over the last decade since detained youth evidence significant psychopathology, these efforts have primarily been located in isolated facilities with little focus on connection to mental health care upon community reentry. Indiana undertook a different approach in this collaboration to implement a statewide mental health screening program within detention centers. Unique aspects of this project include a focus on maximizing personal protections and enabling connection to care through legislation.

Project report

Approximately 2 million youth under the age of 18 are arrested annually, and on a given day 100,000 youth are held in a detention or correctional facility (Skowrya & Powell, 2006). Youth placed in juvenile detention centers have high rates of undetected psychopathology (Grisso, Barnum, Fletcher, Cauffman & Peuschold, 2001). A recent review of mental health disorders among adolescents in correctional and detention center facilities found that the majority met criteria for mental health diagnoses (Fazel, Doll & Langstrom, 2008). Substance use disorders among youth in the juvenile justice system are also high. For instance, in one study, approximately one-half of detained youth met the criteria for a substance use disorder (Teplin, Abram, McClelland, Dulcan & Mericle, 2002). The high rates of psychopathology have led to recommendations for universal mental health screening for youth in detention centers. However, institution of mental health screening can be difficult; for example, coordination across systems within juvenile justice (e.g., court, detention, probation) can take significant planning and follow through. Additionally, juvenile justice systems can be slow to adapt to new processes as there are many bureaucratic and logistical matters that complicate such a transition.

For instance, there are legal barriers that take legislative changes, such as juvenile defenders advising their clients to withhold consent to mental health screening due to possible self-incrimination. Moreover, the information gleaned from mental health screening then demands attention by detention center staff, who already have multiple responsibilities. Even so, eliminating these barriers and linking to care youth involved in the juvenile justice system with mental illness are important, since effective mental health treatment is associated with decreased recidivism (Vermeiren, 2003). The Indiana Juvenile Mental Health Screening, Assessment & Treatment Project (Indiana Project) is an initiative that seeks to address the above barriers in order to implement mental health screening and enable connection to mental health care in detention centers across the state.

The concept for the Indiana mental health screening pilot program arose from the Indiana State Bar Association's (ISBA) Children, Mental Health & the Law Summit, held on Aug. 27, 2004. The Summit resulted in a published report with Indiana-specific recommendations for implementation of mental health screening in detention centers. The ISBA then pursued funding through the Indiana Criminal Justice Institute to establish the Indiana Project, which was modeled after a similar statewide effort in Pennsylvania, with a few distinguishing differences. The Pennsylvania Project's goal was to screen all youth entering the juvenile justice system for identification purposes in order to provide improved, targeted services for the duration of the detention stay. The Pennsylvania Project was organized by the Juvenile Detention Centers Association of Pennsylvania and sought to improve services and connection to mental health care within the detention center for those youths identified with a mental health diagnosis. The project utilized the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2), a brief screening tool designed to identify youth who were in need of further evaluation. Fifteen of the 23 juvenile detention centers (JDCs) in Pennsylvania screened 18,607 admissions over a 2-year period (Cauffman, 2004). Through the statewide Pennsylvania Project, it was found that participating detention centers were better able to identify youth with mental health needs and, as a result, improve services. For instance, mental health screening improved staff perceptions of youths and facilitated communication between staff and youths (Williams, Grisso, Valentine & Remsburg, 2008). As staff became aware of the prevalence of mental health issues, they became better able to adjust their responses to behaviors exhibited by youth. Moreover, many Pennsylvania detention centers were able to use

the data from the MAYSI-2 screenings to secure additional funding for better mental health services within the detention center (Williams *et al.*, 2008). However, E. Cauffman, in 2004 in the *Journal of the American Academy of Child & Adolescent Psychiatry*, suggested that identification alone was “not ... sufficient to improve the effectiveness of rehabilitation efforts.” As a result, the Indiana Project made connection to mental health care upon release from detention a central goal. To achieve this goal, the Indiana Project State Advisory Board recognized a need to: 1) maximize protections regarding self-incrimination for detained youth; 2) standardize protocols across county systems; 3) share sensitive mental health information across systems to care for detained youth; and 4) limit barriers to effective mental health care upon community reentry.

Protect against self-incrimination

Items within the mental health screening instrument may reveal behaviors considered to be a crime during adolescence, including substance use and other antisocial behavior. Hence, endorsing specific items may allow for a youth to be charged with additional crime. Furthermore, youth, in the midst of a mental health screening, could mention details of a crime that they may have committed. That information could be used to prosecute the youth for the crime mentioned, instead of being used for obtaining services for that youth. Thus, it is possible the screening process could lead to more charges being filed rather than appropriate care for the underlying mental health issues. This potential for self-incrimination presents another deleterious effect, namely the deterrence of youth from consenting to the screen due to fears of prosecution. If youth refuse the screen, the amount of youth screened decreases, which reduces the overall effectiveness of the universal mental health screening process. As such, a need was noted to protect youth from self-incrimination. A unique feature of the Indiana Project is the partnership with the ISBA. This has resulted in strategic advantages in the planning and implementation process, as well as in addressing barriers, such as self-incrimination.

The State Advisory Board, which is housed at the ISBA, oversees the Indiana Project and meets on a bimonthly basis. The board consists of interdisciplinary individuals representing juvenile justice (for example, judges, lawyers, detention center superintendents), mental health professionals, local and state agencies (Division of Mental Health & Addiction; Department of Child Services), interested professional groups (Indiana Chapter of the American Academy of Pediatrics) and relevant university and community partners. In partnering with the ISBA, the Indiana Project has obtained a strategic advantage in building consensus around reform and eliminating barriers rooted in state public policy, including legislative advocacy.

The ISBA has helped lead collaborative efforts to amend state laws that are pivotal to achieving a continuum of care for youth in detention. For instance, the ISBA enlisted the help of collaborators in the pilot project to obtain passage of legislation that protects screened youth from prosecution as a result of knowledge gained during the screening process. The Indiana General Assembly enacted House Enrolled Act 1339 in February 2007, and it states that information given by the child to an

evaluator during mental health screening, assessment, evaluation or treatment “may not be admitted as evidence against the child on the issues of whether the child committed a delinquent act or a crime.” Hence, protections against self-incrimination due to mental health were established early so that systemic screening contemplated by the Indiana Project could in fact occur. The success the ISBA enjoyed legislatively resulted in large part due to the broad collaboration that the Indiana Project engendered.

Standardized protocols

Clear and consistent protocols for how mental health screening should be conducted allowing for the protection of confidentiality at the county sites were developed by the board, which enabled increased fidelity across county systems. Without predetermined protocols each county would have different operating procedures and would not necessarily implement the screening process with the entire population. Additionally, systematic differences in administration could affect the results of the screening process. Hence, these protocols make it possible to generalize knowledge gained from the screening project, while also specifying the threshold at which mental health services needed to be implemented. Per guidelines from the developers of the MAYSI-2, a youth is considered to have screened high on the MAYSI-2 if the score on the suicide ideation scale is in the caution or warning range, or if two or more subscales are in the warning range (Grisso & Barnum, 2001). However, if the county believes it is necessary, each county site is allowed to use a lower threshold to identify more at-risk youth. If a youth scores above the threshold, per that county’s protocol, a mental health assessment is initiated. This process includes the detention facility contacting the parents/guardians, providing the summary results of the MAYSI-2 to families, and requesting consent for further assessment and evaluation. If consent is not granted, then facility staff has the option to obtain court-ordered treatment on a case-by-case basis in emergency situations.

The process for data collection was also standardized. Non-identified data is collected from each county pilot site on a monthly basis regarding how many youth have been screened, how many of those youth are out-of-county residents, and whether or not a second screening was administered at the detention center. Additionally, information is collected regarding contact with a mental health professional during detention and post-release, referrals for mental health services post-release, and whether or not those services both in detention and post-release were ordered by the court. Furthermore, data is collected for every screened youth exploring whether or not they were re-arrested at three, six and 12 months from the date of their release from detention. Recidivism data for all screened youth informs the project as to the effectiveness of the screening, referral and connection-to-services process.

Lastly, each county has a “steering committee” that reviews protocols, develops county-specific, data-sharing agreements, and adopts screening protocols that allows each county to collaborate with the Indiana Project. Although clear and consistent protocols have been developed for the project as a whole, each county is unique in that it has different resources, restrictions and operating procedures. It is important for the project to be

implemented according to protocol at each site. It is also important for each county site to implement the protocol without causing undue strain. The steering committee reviews the protocols and proposes any possible changes for its county to the State Advisory Board. This process not only tailors the project to each site, it also gives a sense of ownership that improves collaboration between each site and the state project.

Information sharing

In order to connect youth to care upon reentry, information sharing between the juvenile justice and mental health systems is essential. Hence, every effort has been made to ensure confidentiality of information gleaned during the screening process. The Indiana State Bar Association's role in the Indiana Project was crucial in this regard as its legal expertise provided guidance about how best to protect and ensure confidentiality in the implementation of the program. Clear guidelines were developed that governed how screening information was shared between sites and agencies, which ensured compliance with the Health Insurance Portability & Accountability Act (HIPAA) guidelines and the proper application of information gathered from the screening process. This was particularly important since there were multiple discussions and interpretations regarding how HIPAA applies to youth in juvenile justice. Counties were more willing to participate once the role of HIPAA on mental health screening and referral to treatment was delineated.

Limit barriers to mental health care upon community reentry

A second legislative effort resulted in passage of Indiana House Bill 1536, effective July 2009, in an effort to promote connection to care for court-involved juveniles. Federal Medicaid law prohibits participation "with respect to care or services for any individual who is an inmate of a public institution [except as a patient in a medical institution; 42 C.F.R. 441.33 (a)(1), 435.1008(a)(1)]." A. E. Cuellar and colleagues (Cuellar, Kelleher, Rolls & Pajer, 2005) showed that there is substantial confusion about this policy among individuals employed in the juvenile justice system and those employed by state Medicaid programs. Specifically, most states continue to terminate, rather than suspend, Medicaid coverage upon incarceration. Termination of Medicaid coverage is especially problematic for youth who already receive services or for those with relatively acute needs (due to the wait time for re-enrollment of 45 to 90 days) (Koppelman, 2005). Hence, efforts to amend this practice within Indiana were initiated to better enable connection to mental health care upon release from detention and short stays in correctional facilities. The bill states that if a juvenile Medicaid recipient is placed in a juvenile detention facility or a secure facility, his or her Medicaid eligibility shall be suspended for up to six months before it can be terminated. Termination of Medicaid eligibility for incoming inmates was standard procedure before the passage of this bill, thus creating another barrier for juveniles in need of services upon release. Now, if a youth is a Medicaid recipient before entry into a juvenile detention center, his or her Medicaid status is merely suspended during incarceration. When youth are referred for further evaluation

or treatment post-release, they are not denied services due to termination of coverage.

Effects of systematic mental health screening in Indiana

As a result of the Indiana Project, more than 18,500 mental health screens have been conducted on youth entering detention in Indiana since 2008. If the youth is above the cutoff score, the seriousness of his or her symptoms is considered "clinically significant," that is, high enough to require some form of follow-up response. In 2008, pilot sites conducted 5,771 mental health screens; 25.7 percent of youth screened scored above the cutoff requiring a response. Of those screened, 2,472 were African American, 580 were Hispanic, and 128 were "other." In 2009, pilot sites conducted 6,195 mental health screens; 20.4 percent of youth screened scored above the cutoff. Of those screened, 2,618 were African American, 570 were Hispanic, and 150 were "other." From Jan. 1 to April 30, 2010, 2,061 screens were conducted by the pilot sites; 21 percent scored above the cutoff. Of those screened, 855 were African American, 188 were Hispanic, and 41 were "other."

The racial demographic breakdown for youth in the participating pilot sites in the first two years of the project is as follows:

	2008	2009
African American	42.7%	42.2%
Caucasian	44.8%	46.1%
Hispanic	10.0%	9.2%
Other	2.5%	2.4%

Research has shown that minority youth evidence disparity in connection to appropriate mental health care. White youth and females in the justice system are diagnosed with mental illness more frequently, and they are more likely to receive treatment once diagnosed (Herz, 2001; Pope, Lovell & Hsia, 2002; Abram, Paskar, Washburn & Teplin, 2008; Teplin, Abram, McClelland, Washburn & Pikus, 2005; Lopez-Williams, Stoep, Kuo & Stewart, 2006). In one study, race was the only significant predictor of receiving treatment with white youth being more likely to receive treatment than black youth (Shelton, 2005). Even in studies where the level of disturbance is considered, white youths are disproportionately more likely to receive treatment in detention (Glisson, 1996; Thomas & Stubbe, 1996).

Connection to mental health care

A goal of the Juvenile Mental Health Screening, Assessment & Treatment Project has not only been to conduct mental health screening for youth to improve outcomes during the detention stay but also to connect youth to needed mental health care upon community reentry.

Effective treatments exist for mental health problems among youth in the juvenile justice system. For instance, multi-systemic therapy and wraparound services for juvenile justice and other youth with significant emotional difficulties have been shown to reduce recidivism (Anderson *et al.*, 2003; Burns *et al.*, 2000; Henggeler *et al.*, 2003). The state of Vermont, in a study of

recidivism predictors, found that juvenile incarceration rates were negatively related to the utilization of public mental health services (State Department of Developmental & Mental Health Services, Vermont Mental Health Performance Indicator Project). Mental health problems that are untreated tend to be strong predictors of recidivism (Vermeiren, 2003). Although inadequately studied, providing linkages to care during and following detention may substantially lower recidivism (Gupta *et al.*, 2005).

Very little research has been conducted to evaluate the effectiveness of making connections to care after release. Through a separate Juvenile Accountability Block Grant (titled "Connection to Care Project"), which concluded in April 2010, Dr. Matthew C. Aalsma conducted a research study on connection to mental health care for detained youth using four of the original pilot sites in the Juvenile Mental Health Screening, Assessment & Treatment Project. The goal of this study was to explore the perceptions of youth (who scored high on the mental health screening measure) and their parents in accessing mental health care. The most often listed issues described by participants that impacted connection to mental health care included the following: cost of care/insurance; probation officer and family members as facilitators to care; and mental health stigma. Parents who did not have insurance or who had private insurance described paying significant amounts to facilitate mental health care utilization. Parents who did have Medicaid as their youth's insurance, or some variation of federally funded insurance, had the majority of the mental health care covered. The results showed a need for both individual/family as well as juvenile justice system-wide intervention.

The next step to the identified problems in connection to care is the development of a model to effect system-wide intervention, providing assistance and information at crucial points in the reentry process to improve the ability and motivation of youth identified through mental health screening to actually follow up and connect with mental health care.

Conclusion

Currently, 16 out of 22 detention centers and one intake center in the state are participating in the Indiana Project. Our pilot sites are Lake, Marion, Bartholomew, Johnson, Porter, Clark, Grant, Delaware, LaPorte, Howard, Tippecanoe, Hamilton, Henry, Dearborn, Elkhart, Knox and Vigo counties. As a result of the pilot project, by January of 2011, more than 18,500 mental health screens had been conducted on youth entering detention in Indiana.

Plans for the future include continuing to recruit additional pilot sites on a rolling basis and to incorporate these sites into the project. Results of the pilot project will be published as data are received. Published results will continue to inform the State Advisory Board with recommendations for project implementation. In order to ensure the project's permanence, efforts will be made to secure long-term funding sources.

A major, unique feature of the Indiana Project includes partnering with the ISBA, which led to specific legislation, protecting adjudicated youth who participate in the screening process, as well as eliminating a potential obstacle to obtaining

care. The Indiana Project has a diverse group of stakeholders that have worked together during all phases of the project. This diverse, cross-disciplinary approach has been essential to its success. This approach has allowed the project to take into consideration the state's unique political landscape and existing organizational infrastructure as the project was implemented. In particular, when seeking to impact the public health of individuals within the criminal justice system, building cross-system collaborations with nontraditional public health allies, such as bar associations and other professional organizations, will allow for increased cooperation in order to improve public health efforts. Additionally, cross-system and disciplinary partnerships are necessary in order to amend state policies that may impede screening and connection to mental health care. •

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Recommendation 1

The Indiana Juvenile Mental Health Screening, Assessment & Treatment Project should be sustained and supported at the state level.

State-level support in sustaining the pilot project model would provide a means to address both the need to identify youth with mental health needs at an early intervention point and the need to connect those youth with appropriate mental health care. State-level systematization would continue, expand and sustain the routine mental health screening of youth entering detention; institute adherence to protocols that ensure confidentiality and treatment objectives of the screening process; and foster connection to care for youth identified through mental health screening. State governance should encourage the continued involvement of a broad collaborative as the pilot project transitions into a permanently supported service program for children at the point of detention.

- Employ a state-level independent governing board utilizing the diverse, collaborative composition of the pilot project's State Advisory Board as a model.¹

- To help ensure both sustainability and independence of the project, the administrative functions should be assigned to an outside nongovernmental agency, with program oversight and financial support provided through judicial branch administration.

- University analysis of the data is an important aspect of the project from a research perspective to move forward and link data to outcomes. Therefore, the project should continue to utilize university participation for support with data gathering and technical assistance.

- Through the creation and use of incentives, promote the participation of all facilities that securely detain youth in Indiana, so that a uniform screening tool is consistently used, participation in statewide data collection is assured, and protections of project protocols are afforded to youth.

- Pursue legislation or rule change to require the use of a specific mental health screening tool and collection of data at all detention facilities in the state, even for those not participating in the project, so that statewide prevalence data is consistently available.

- Consideration should be given in the long term to expanding the project beyond detention, to youth at intake so that all youth coming in contact with the juvenile justice system are screened for mental health issues.

- There should be state-level coordination and linkage of juvenile justice issues and initiatives in a manner that integrates in and benefits from the continuing work of the mental health pilot project.

Recommendation 2

Electronic database case management systems should be made consistent and compatible throughout the state of Indiana.

An important issue that has arisen through the Indiana Juvenile Mental Health Screening, Assessment & Treatment Project is the lack of uniformity across electronic database management systems in Indiana. Some counties utilize paper and pencil records, others use QUEST, and others use Odyssey. This has resulted in difficulty in measuring recidivism, assessing detention center practices for follow-up of youth who screen positive on the mental health screen, and understanding if youth connect with mental health care upon community reentry. Ensuring that all counties use databases that are consistent and compatible will allow sound data to be collected, as well as uniform follow-up of youth across the state and across systems (juvenile justice, child welfare, corrections).

- Create incentives and funding options for resource-poor detention centers to implement electronic database management systems.

- Assure uniformity in data and in reporting by having already instituted electronic database management systems use consistent definitions of variables.

- Consider the creation of a statewide data repository to ensure data uniformity. This data repository could be utilized not only for the Indiana Juvenile Mental Health Screening, Assessment & Treatment Project but also for other relevant statewide initiatives (e.g., Juvenile Detention Alternatives Initiative; Disproportionate Minority Contact).

Recommendation 3

Gaps and/or barriers to identifying youth with mental health needs and connecting identified youth to appropriate mental health services must be identified and addressed.

In addressing mental health needs of youth in the juvenile justice system, counties face serious obstacles to identifying youth and connecting them to care. Gaps and barriers to identification, assessment and treatment exist at critical points in the juvenile justice system process, including at diversion, detention and release. Once children are identified, there are several barriers to care, including a lack of available community-based mental health services for treatment; a lack of insurance coverage, preventing children from receiving needed care and treatment; difficulties arising from the approval process for the payment of services through government agencies responsible for such payments; lack of training for working with youth with mental health needs on the part of caregivers, law enforcement and detention workers; and the great amount of variation in the availability and types of services, detention practices and probation policies across the state.

- Gaps and barriers should be identified, and state officials and agencies should work in partnership with local communities to invest in addressing these obstacles through development of appropriate resources in all systems of care, so as to create continuous care for all youth.

- Standardization of response systems for youth with mental health needs should be developed through efforts of professional associations and oversight entities.

- Training should be developed based on emerging best practices of those working with and caring for youth with mental health needs.

- Best practices to respond to youth identified with mental health needs across systems should be implemented and extended beyond detention to other areas, such as first response, diversion, arrest, probation, detention, incarceration and reentry.

Recommendation 4

Viable options for funding the ongoing work of the Indiana Juvenile Mental Health Screening, Assessment & Treatment Project should be created through the state's general budget allocation, with a focus on ongoing, long-term financial support for the administrative and oversight functions of the project, and through the development of state and local funding options that support increased access to mental health care for youth in detention.

State-level financial support should be provided in order to sustain the pilot project's continued development over time and underwrite administrative costs of program oversight and data collection. Both state and local funding are needed to support increased access to care through timely access to treatment and case management of youth in local programs (including diverted youth).

- Identify sources for state-level support of the pilot project, including examination of dedicated funds.

- Consider funding programs with awards to counties based on a statewide formula through use of a model such as the GAL/CASA model or LCC model.²

- Develop alternative local funding options and financial incentive programs. •

1. The pilot project is guided and directed by the State Advisory Board, which was created through identifying and assembling key stakeholders of collaborating, cross-disciplinary agencies and organizations. The State Advisory Board includes representatives from the Indiana Judicial Center Juvenile Justice Improvement Committee, Indiana Criminal Justice Institute, Indiana Prosecuting Attorneys Council, Indiana Public Defender Council, Indiana Division of Mental Health & Addiction, Indiana Juvenile Detention Association, Indiana Minority Health Coalition, ISBA Civil Rights of Children Committee, Indiana Chapter of the American Academy of Pediatrics, Indiana University School of Medicine, Probation Officers Professional Association of Indiana, Indiana Department of Child Services, Indiana Department of Correction, Indiana Department of Education, and Indiana Council of Community Mental Health Centers. In addition to these representatives, a representative from each of the pilot site counties and three members of the Indiana General Assembly serve on the State Advisory Board.

2. I.C. §5-2-11. The Governor's Commission for a Drug-Free Indiana works in a collaborative capacity with 92 local coordinating councils (LCCs) representing each of Indiana's counties.

Indiana Juvenile Mental Health Screening, Assessment & Treatment Project Advisory Board

Hon. Mary Harper, Valparaiso, chair; JauNae Hanger, Indianapolis, vice chair; Laurie Elliott, Indianapolis, project director; Amy Karozos, Indianapolis; Matthew Aalsma, Ph.D., Indianapolis; Traci Agner, Lawrenceburg; Ashley Barnett, Indianapolis; Margaret Blythe, M.D., Indianapolis; Hon. Mary Beth Bonaventura, Crown Point; Becky Bowman, Indianapolis; Jason Bowser, Columbus; Bob Bragg, Noblesville; Matthew Brooks, Indianapolis; Rep. Charlie Brown, Indianapolis; Kristi Bruther, Franklin; Hon. Vicki Carmichael, Jeffersonville; Arthur Carter, Indianapolis; Hon. Steve David, Whitestown; David Dickerson, Muncie; Hon. Nancy Gettinger, LaPorte; Jim Higdon, Franklin; Steve Johnson, Indianapolis; Larry Landis, Indianapolis; Sen. Connie Lawson, Indianapolis; Tanya Johnson, Indianapolis; Sue Lummus, Indianapolis; Tracey Malone, Kokomo; Mary McAteer, M.D., Carmel; Kellie Meyer, Indianapolis; Hon. Marilyn Moores, Indianapolis; David Orentlicher, Indianapolis; James Payne, Indianapolis; Mike Small, Marion; Hon. Paulette Stagg, Terre Haute; April Vanlonden, Richmond; Kellie Whitcomb, Indianapolis; Hon. Mary Willis, New Castle; and Jenny Young, Indianapolis.

Editor's Note: The above list does not yet include representatives from the three newest project sites of Elkhart, Vigo and Knox counties.

Workgroup to Study Access and Utilization of Mental Health and Substance Use for Youth in Juvenile Justice in Indiana

The overarching goal of this subcommittee is to address the gaps and barriers to connecting Indiana youth in juvenile justice with needs for mental health and substance use services

The areas addressed by the committee include the following:

- 1) Evidence-based treatment- Evidence-based treatment for juvenile justice involved youth exist. However, it is estimated that only 5% of youth in juvenile justice benefit from treatment programming that is based on an empirically-based program. Thus, a goal will be to clarify evidence-based practice, evidence-based practices that exist in Indiana and, if a need exists to expand access to evidence-based treatment.
- 2) Funding - Possible barriers to care include funding evidence-based treatment. Therefore, a goal of the subcommittee will be to explore funding options that are feasible in the state of Indiana.
- 3) Culturally sensitive programming -Minority youth are overrepresented at all steps in the juvenile justice process. Thus, a goal will be to identify culturally sensitive programming and treatment options for youth in juvenile justice. Additionally, the workgroup will encourage the implementation of these approaches as necessary models for success in treatment.
- 4) Accreditation - Indiana's current model of accreditation for diagnosis and treatment of adolescent substance use will be explored in light of other state models. Thus, a goal will be to identify availability of and geographic distribution of providers across Indiana. Additionally, mechanisms to improve access will be explored.

As the workgroup convenes, information gathered will be developed in a report which will be disseminated to state and local partners in order to inform care and increase access and utilization in order to limit recidivism.

Members should include representative from the following organizations and interest groups:

- 1) State partners - Judiciary, DCS, DMHA, Health department, Medicaid, legislators, members of Mental Health Commission
- 2) Family members of youth involved in juvenile justice
- 3) County partners - County Court officials, mental health and substance use providers
- 4) Legal community – ISBA, prosecutors, public defenders
- 5) Acadamia
- 6) Private partners – commercial insurance, business

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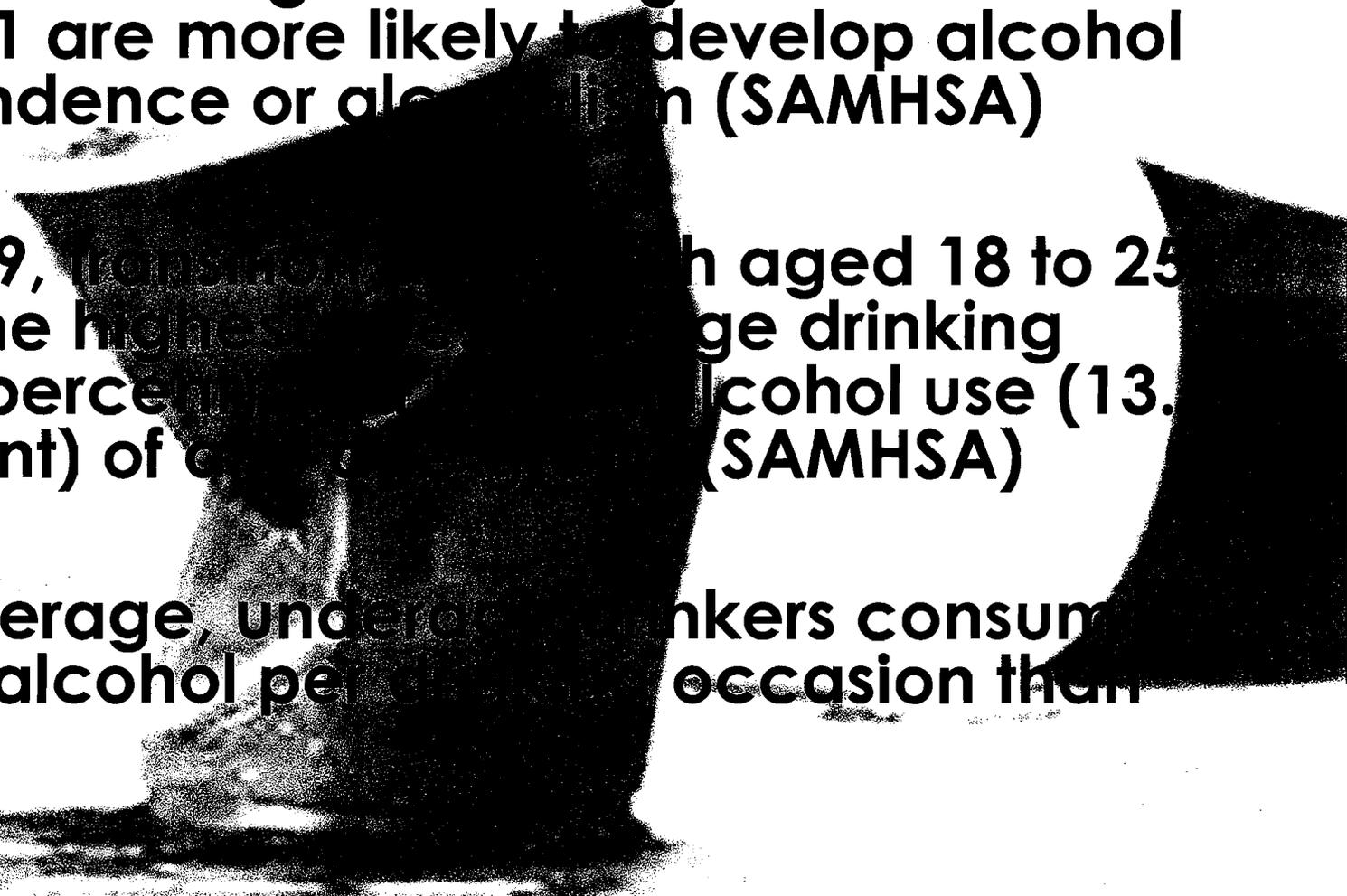
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The National View

- Alcohol is the most widely used drug by adolescents
- People under 21 consume 20% of all of the alcohol in the United States, 40% of the alcohol being consumed by drinking
- Each year, approximately 100,000 youth under the age of 21 are injured or die from drinking (CDC)

- 
- Adults who began drinking alcohol before age 21 are more likely to develop alcohol dependence or alcoholism (SAMHSA)
 - In 2009, young adults aged 18 to 25 had the highest rate of binge drinking (41.7 percent) and alcohol use (13.6 percent) of any age group (SAMHSA)
 - On average, underage drinkers consume more alcohol per drinking occasion than adults

What are they drinking?

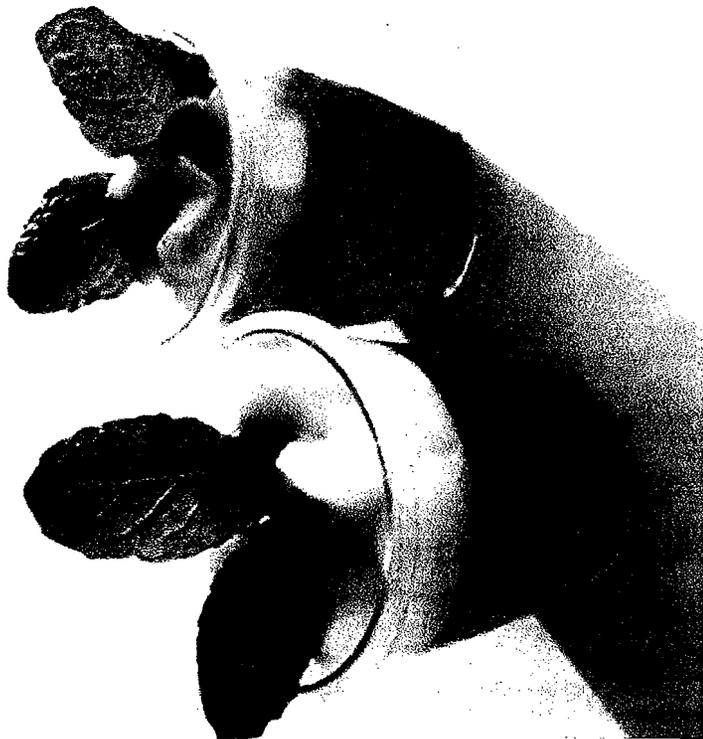
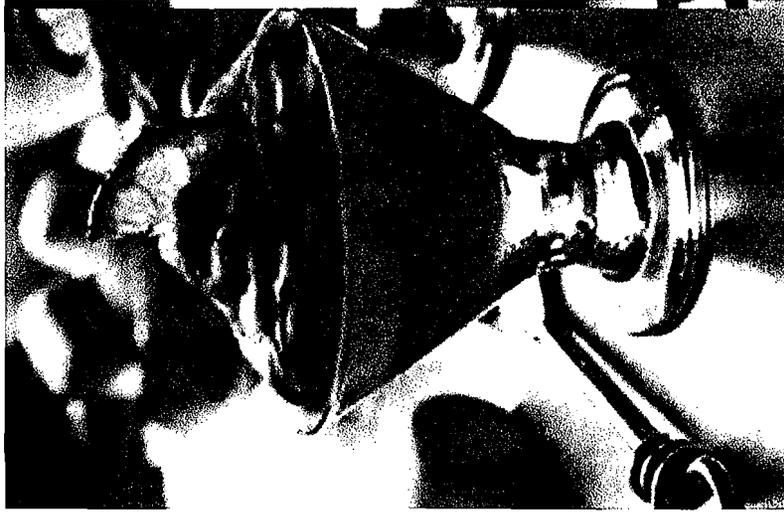
- Beer is quickly being replaced with liquor (28% drank liquor, 24% drank beer)
- Females now drink beverages that are close to male preferences
- Alcopops – sweet tasting, high alcohol content products in large containers with low price

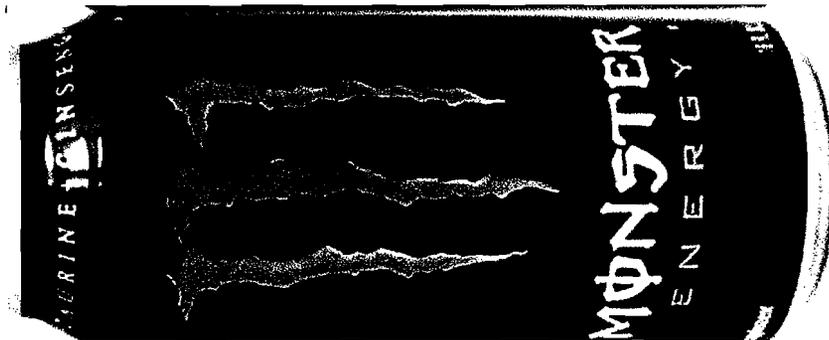
**One of these things
is not like the other...**

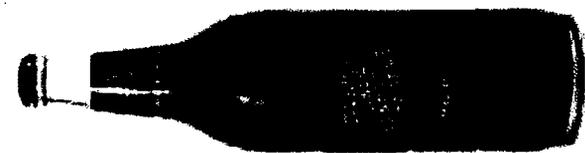
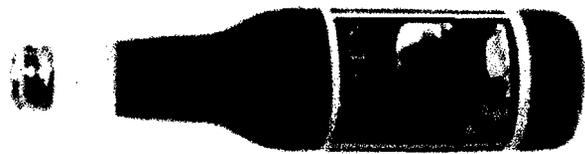
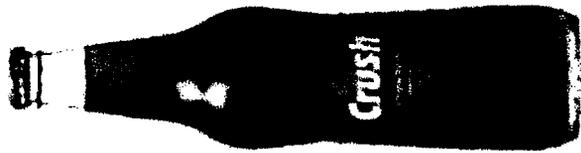
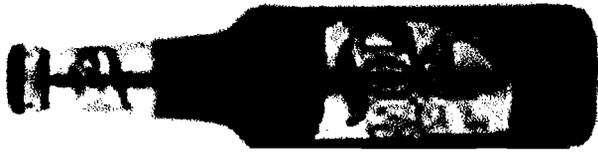
Which of these has alcohol?

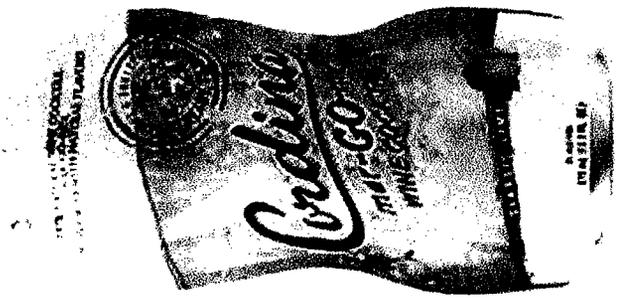
Can you tell which one has alcohol?











What about Indiana?

- The average age of first use for alcohol is 13 (IPRC)
- Adults are the most common source of alcohol for younger adolescents – Older adolescents use family friends and commercial sources

What about Indiana?

- Why do minors drink?
 - To have fun with friends
 - To experience life
 - To relieve stress
 - To get sleepy

Monthly Alcohol Use by Grade

- 6% of 6th graders
- 12% of 7th graders
- 19% of 8th graders
- 24% of 9th graders
- 30% of 10th graders
- 32% of 11th graders
- 39% of 12th graders

Binge Drinking by Grade

- 6% of 6th graders
- 8% of 7th graders
- 12% of 8th graders
- 15% of 9th graders
- 18% of 10th graders
- 20% of 11th graders
- 26% of 12th graders

Drinking by College Students

- 57% of college students under 21 drank in the past
- 37% of college students reported binge drinking
- Out of the underage students who purchased alcohol, 40% of purchases were alcohol with no ID, 20% used someone else's ID, and 16% used a fake ID

The Developing Brain

- Our brains aren't fully developed until our mid-20s
- alcohol consumption, especially during adolescence, permanently impairs brain development
- Centers for impulse control, learning, and memory, decision making, and emotional development are impacted

Underage Drinking is a Mental Health Issue

- **Behavioral problems are significantly associated with increased likelihood of underage drinking**
 - Adolescents with behavioral problems are 3 times more likely to drink
 - Oppositional Defiant Disorder (ODD) and Conduct Disorder often co-exist with alcohol abuse

- ***Adolescents with SED (Serious Emotional Disturbance) are even more greatly affected by alcohol***

- Adolescents with SED were 2 times as likely to use alcohol
- Adolescents with SED were 5 times likely to report risk drinking

- ***Alcohol abuse in young people is associated with psychological distress and depression***

- Among 12-16 year olds who drink, 31% exhibited extreme psychological distress and 39% exhibited serious psychological problems
- 12-16 year olds who drink are 4 times likely to suffer depression than non-drinkers

Relationships with Others

- Kids who drink, disengage from family and school activities
- Drinking leads to a breakdown in communication with peers and family
- Drinking and other substance use problems often create stress and family dysfunction in the family
 - Drain on family finances
 - Strain on family relationships – immediate and extended
 - Seen as a “family disgrace”

What Is Needed?

A NATIONAL STRATEGY

- **SAMHSA** has developed a plan of action for 2004-2008
 - #1 priority is to prevent substance abuse and mental illness
 - HHS has established an interagency Coordinating Committee (Dept of Defense, DOE, HHS, DOJ, Labor, DOT, Dept. of Treasury, OMB, etc)

What is Needed?

A STATEWIDE STRATEGY

- Funding, evaluation and evaluating state and local efforts to reduce underage drinking
- Evidence based laws and practices at the community level
- Strong, evidence based laws – social host, increased tax, outlet density, restricted sales

What can you do?

- Support statewide alcohol regulation changes: increase in the alcohol tax, increase in the alcohol density requirement, and place of sales

**“Holding your people solely
responsible for average
drinking water quality in a
responsible way in a
polluted**

Contact

Lisa Hutcheson

Indiana Coalition for Responsible Beverage Drinking

317-633-3123

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SUICIDE ADVISORY COMMITTEE

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Meeting 2
9-6-11

Exhibit 6

Division of Developmental and Rehabilitative Services (DDRS) State Operated Facility Transition Update

- 206 individuals with developmental disabilities were originally identified
- As of July 1, 2011:
 - 103 discharges to the community have occurred,
 - 92 individuals have transitioned to DDRS funded placements,
 - 11 individuals have gone to alternate placements, i.e., nursing facility, family home, etc.
- DDRS has committed to monitoring and reporting on all of the transitions for two (2) years
- The Bureau of Developmental Disability (BDDS) meets weekly for updates on the individuals in services
- BDDS conducts a status survey every 6 months on the status of all individuals who have transitioned
- The Semi-Annual Report (1/1/11 – 6/30/11) shows that based on surveys conducted of the discharged individuals:
 - 97% have had stable health
 - 96% have had success in the same community to which they were discharged
 - 94% have avoided criminal, police (arrest), court involvement
 - 88% have avoided inpatient Psych admission
 - 1% are employed
 - 79% are in day services
 - 99% are receiving ongoing psych services



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Exhibit 7

Medicaid Rehabilitation Option (MRO) Update

Gina Eckart, Director

Division of Mental Health and Addiction

Kristina Moorhead, Deputy Director

Office of Medicaid Policy and Planning





MRO Changes Update

- Implementation on July 1, 2010.
- Mental Health System Transformation framework based on recovery oriented care model.
- Person centered treatment planning and individualized care.



OMPP/DMHA 2010 Activities in Preparation for MRO Changes

- January and February shared process flow for service package assignments and information about required data elements with all CMHCs.
- Provided information to CMHCs regarding issues with Medicaid RID numbers (March - June).
- Invited CMHCs to send staff to DMHA to work on cleaning their data – 8 CMHCs did so.
- All CMHCs received monthly communications and specific data files that indicated potential issues with diagnoses and assessments (April-July).



OMPP/DMHA 2010 Activities in Preparation for MRO Changes

- Tested the HP system process for service package assignment with four selected CMHCs (May-June).
- Amended MRO Rule after extensive collaboration with stakeholders to ensure changes were clinically and operationally sound.
- Developed public website which housed all master documents, presentations, training materials, and FAQs.
- FAQs – 500+ questions collected and answered through transformation@fssa.in.gov.
- Completed 4 “Initial Loads” during July with HP – ensuring as many consumers as possible received packages based on assessments from January through June.
- Developed and published new MRO Manual.



MRO Service Package Assignments by Level of Need, Sep. 10 – Feb. 11

Total Children	Total Adults	TOTAL Packages Assigned
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22,724

27,488

50,212

Service Package	2	3	4	5
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Children

3,596

10,887

5,847

2,394

Service Package	3	4	5	5A
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Adults

8,987

12,846

4,967

688



MRO Service Package Utilization by Level of Need, Sep. 10 – Feb. 11

	MRO Packages Assigned	Number packages of utilized	Percentage of packages utilized
Children	22,724	5,192	22.85%
Adults	27,488	7,817	28.44%
Total	50,212	13,009	25.91%



Utilization of other Behavioral Health Services—Clinic Option*

Number of Medicaid Members

	SFY2009	SFY2010	SFY2011
Children New & Old MRO Services	9,663	13,904	14,457
Children Old MRO Services Only	18,051	26,169	16,406
Adults New & Old MRO Services	12,450	14,191	13,894
Adults Old MRO Services Only	16,969	22,069	16,741

*Partial Hospitalization excluded.



Utilization of other Behavioral Health Services—ER Utilization (Psych Diagnosis)

Number of Medicaid Members

	SFY2009	SFY2010	SFY2011
Children New & Old MRO Services	1,165	1,761	1,982
Children Old MRO Services Only	2,310	3,636	2,947
Adults New & Old MRO Services	5,467	6,411	6,290
Adults Old MRO Services Only	8,320	10,927	8,433



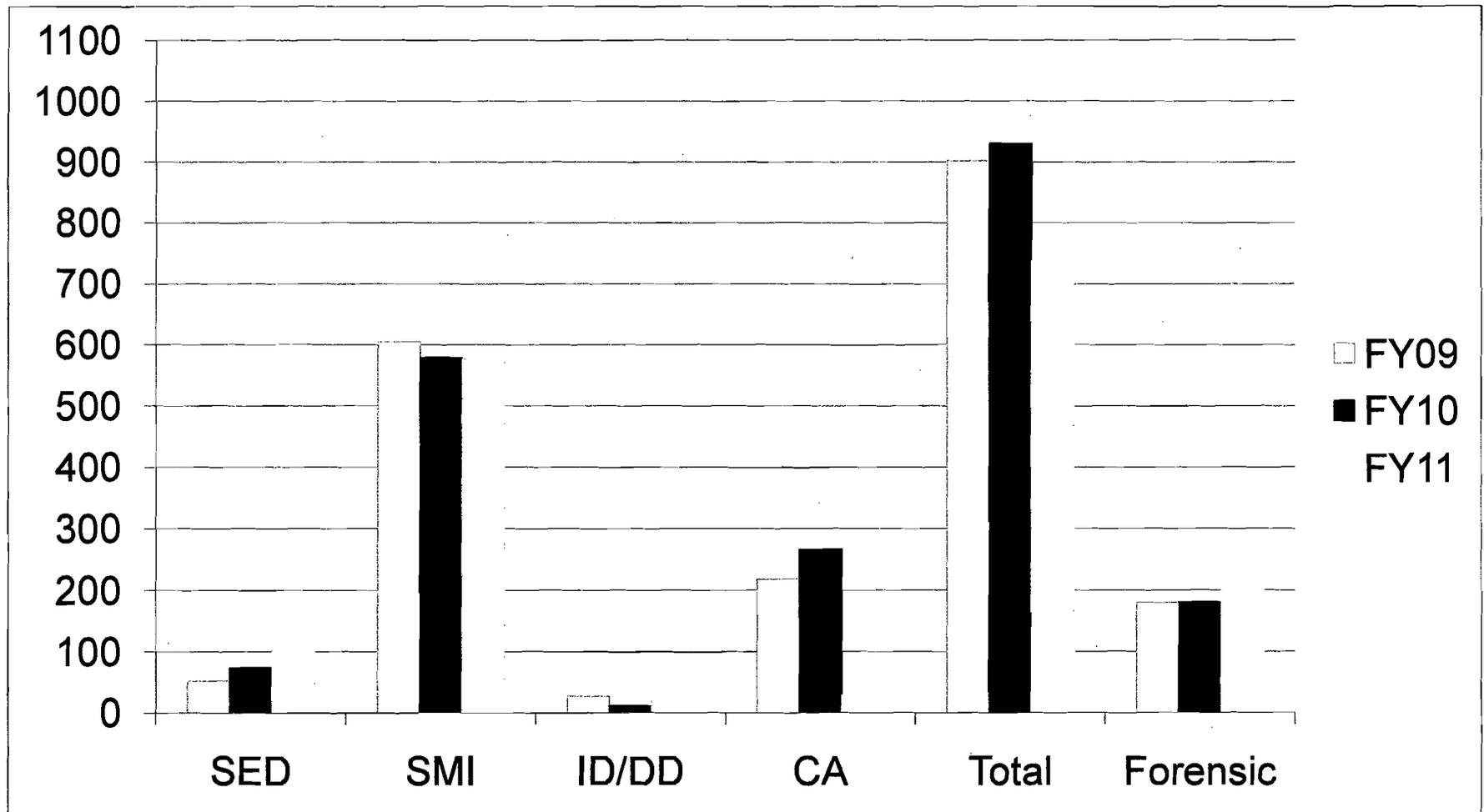
Utilization of other Behavioral Health Services— Inpatient Hospital (Psych Diagnosis)

Number of Medicaid Members

	SFY2009	SFY2010	SFY2011
Children New & Old MRO Services	425	598	543
Children Old MRO Services Only	545	839	378
Adults New & Old MRO Services	567	677	633
Adults Old MRO Services Only	549	965	436

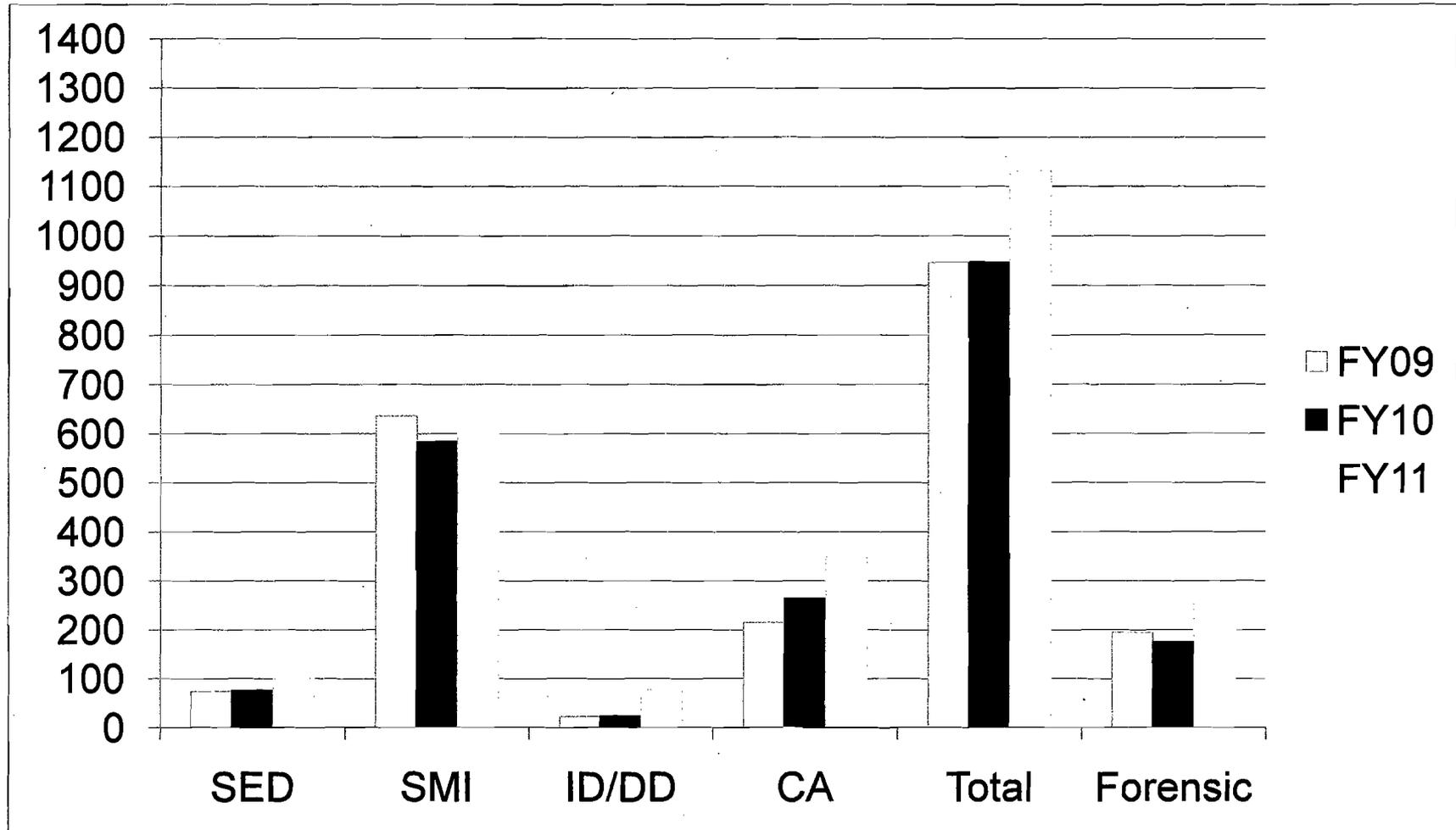


SOF Patient Admissions





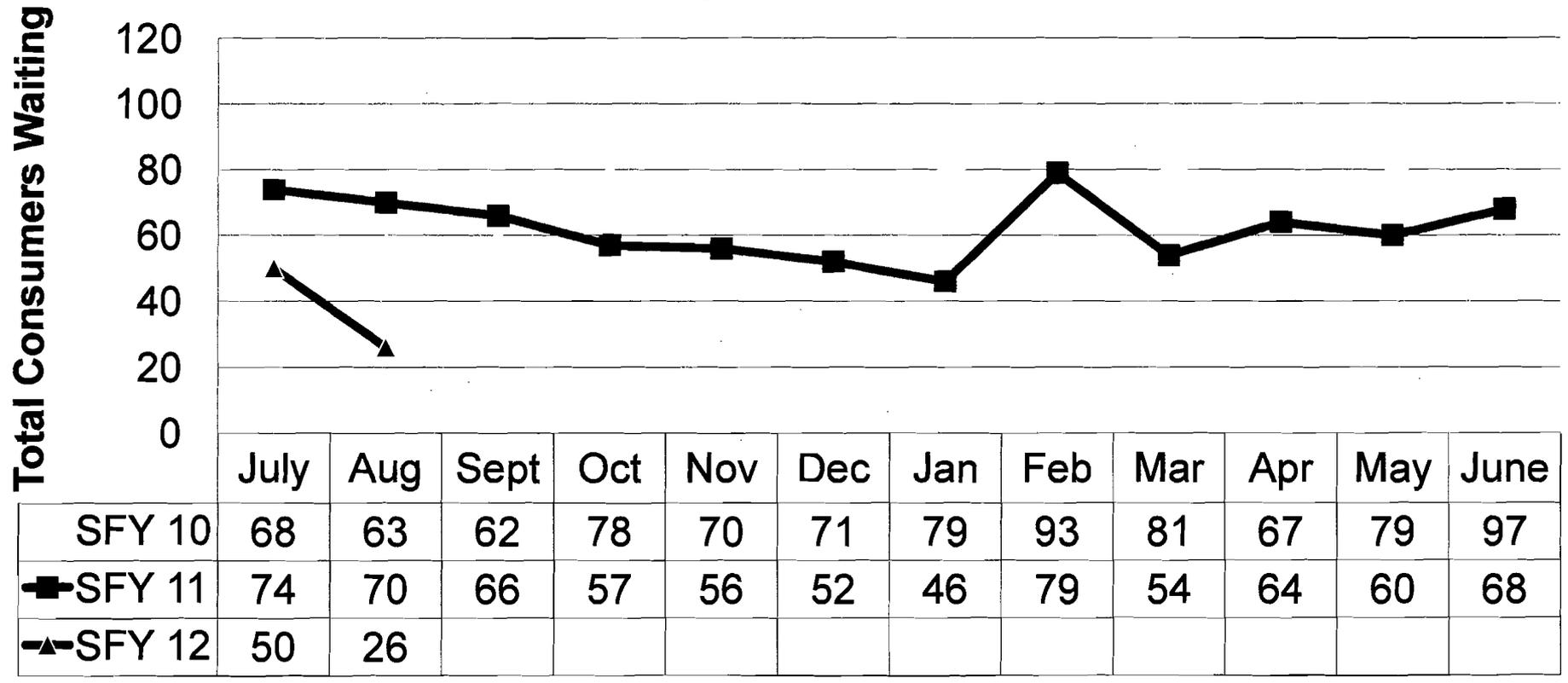
SOF Patient Discharges





SOF Waiting List-Comparing SFY10, SFY11, and SFY12 YTD

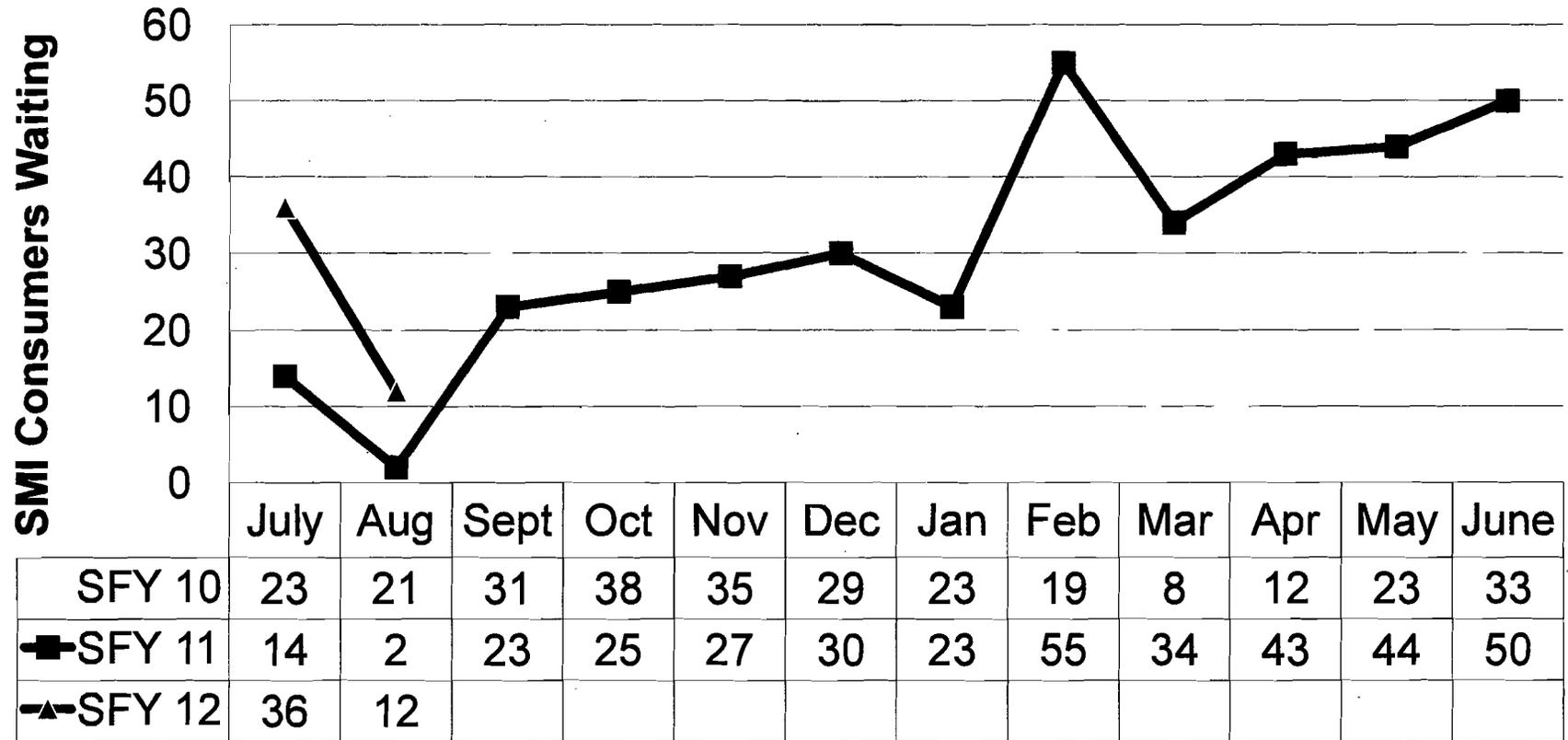
Admissions Wait List SFY Comparison - All Populations





Waiting List-SMI

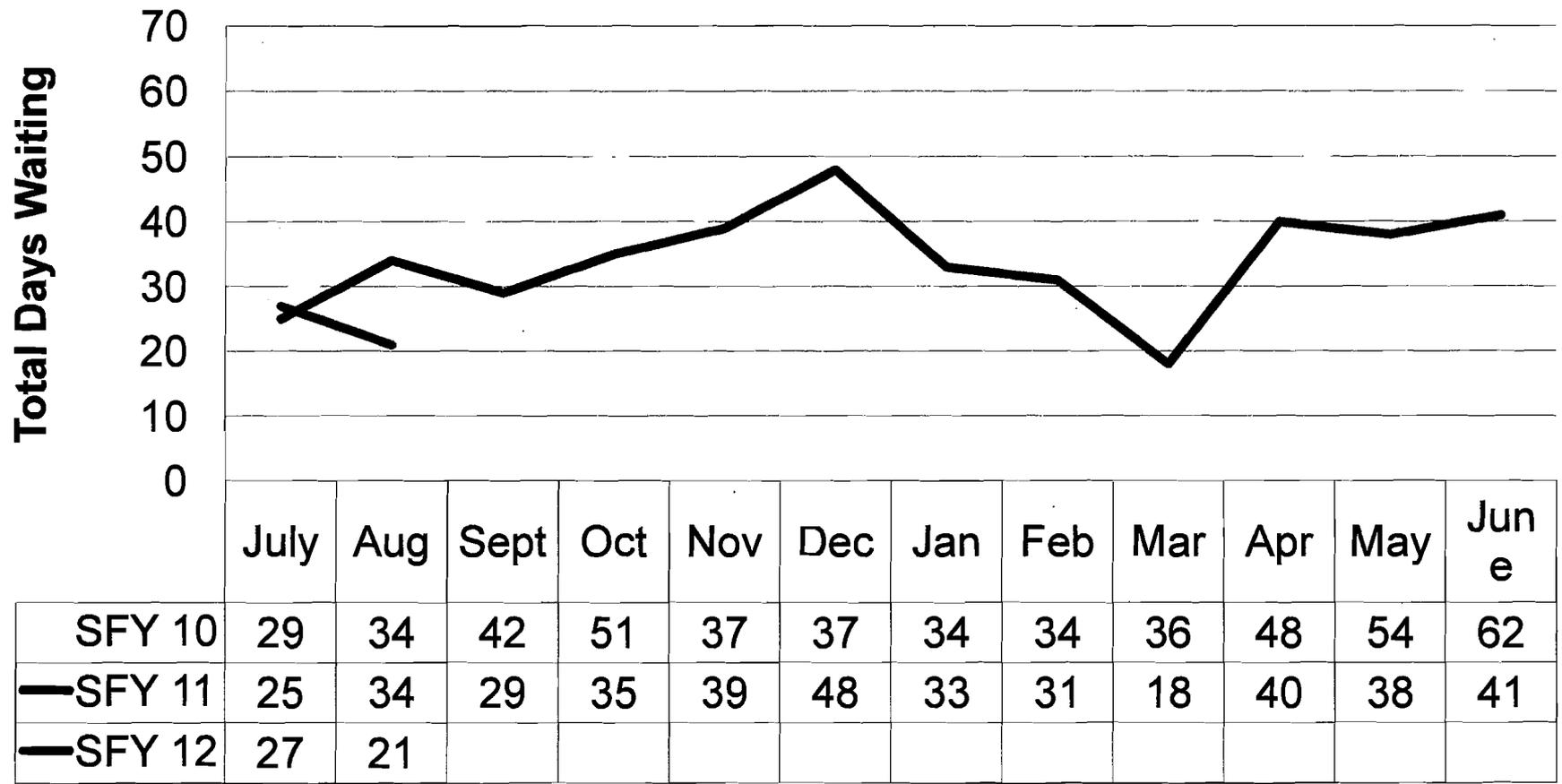
Admissions Wait List SFY Comparison for SMI Population





Time Spent Waiting in Days

Average Length of Wait for SMI (In Days)





Assertive Community Treatment (ACT)

- Originally, ACT implemented under MRO with a daily rate of \$70/client, up to 120 clients/ team.
 - Higher rate to promote utilization of new EBP.
 - In addition, providers billed for discrete MRO services provided throughout the day.
 - DMHA used state dollars to pay \$200,000 to each CMHC participating in ACT (intended to be start-up).
- CMS no longer allows bundled daily rates.
 - New service was created to pay for physician and nurse practitioner time.
 - Other services still accessible under MRO service package.



Changes in ACT Services

State Fiscal Year	Number of ACT Teams	Number of CMHCs with an ACT Team(s)	Number of Clients Receiving ACT Services <small>(Received at least one service during the year)</small>
2009	32	22 (out of 27)	1,953
2010	30	21 (out of 26)	1,787
2011	14	13 (out of 25)	1,162

Note: Some CMHCs have/had multiple teams



Prior Authorization Status Definitions

- **Approved:** Prior authorization request was approved as submitted.
- **Modified:** Prior authorization request was approved, but required an adjustment to the dates or units requested from the originally submitted request.
- **Suspended:** The prior authorization received did not contain enough information to render a decision, and we need additional information from the provider. Providers will be notified via prior authorization decision letter of specific information needed in order to process request.
 - Additional information must be received within 30 days of suspension or request will automatically be denied.
- **Denied:** This prior authorization request has been denied and cannot be remedied.
 - Specific reason for denial is provided to the member and provider on the prior authorization decision letter.



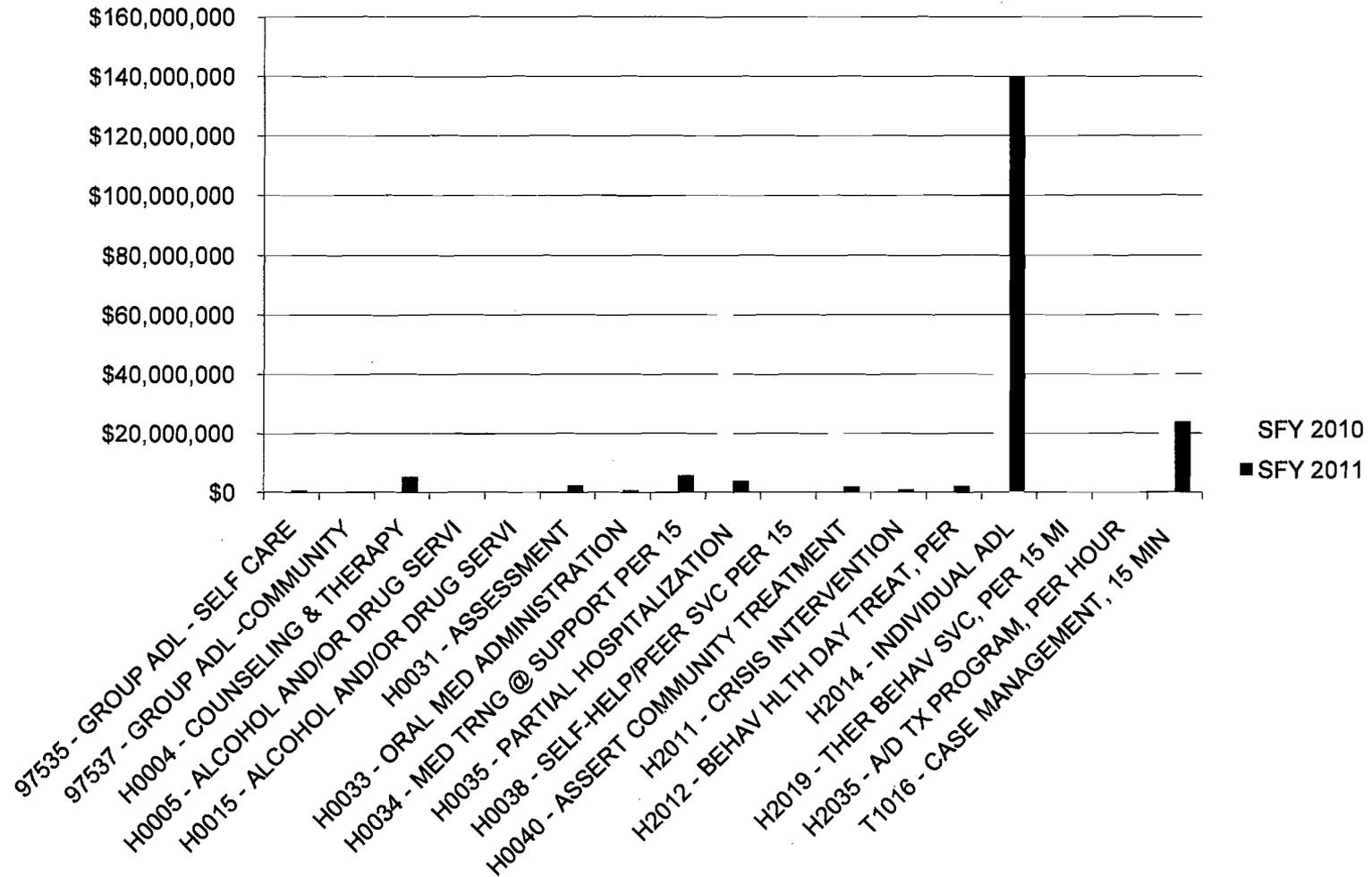
Number of MRO PA Lines by Status

	Approved	Modified	Suspended	Denied	Total
Jul – Dec 2010	7,814	953	0	3,314 (27.4%)	12,081
Jan – Jul 2011	9,228	2,164	45	4,298 (27.2%)	15,752



MRO Expenditures by Service-SFY10 vs. SFY11

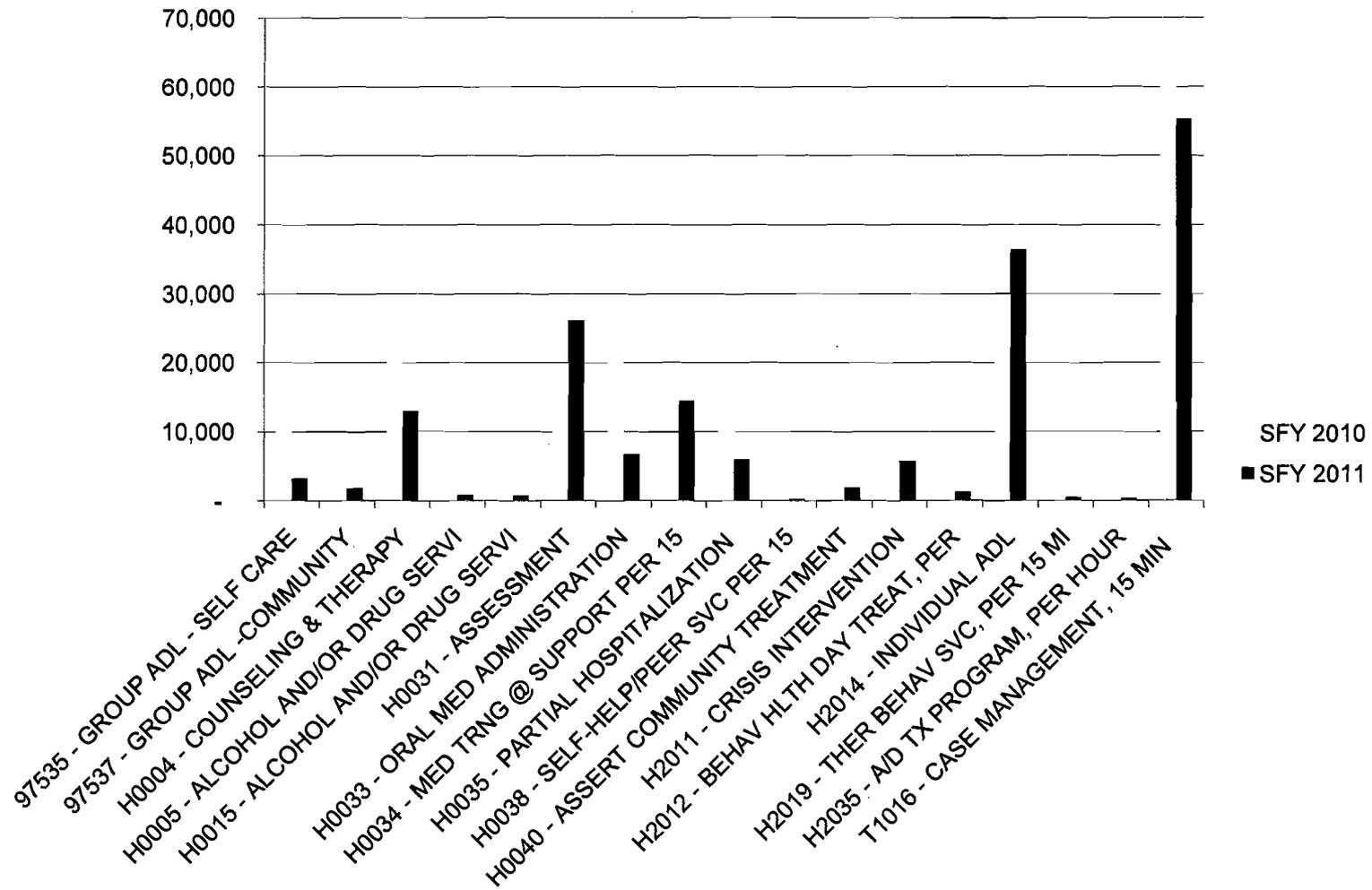
Procedure Code Comparison





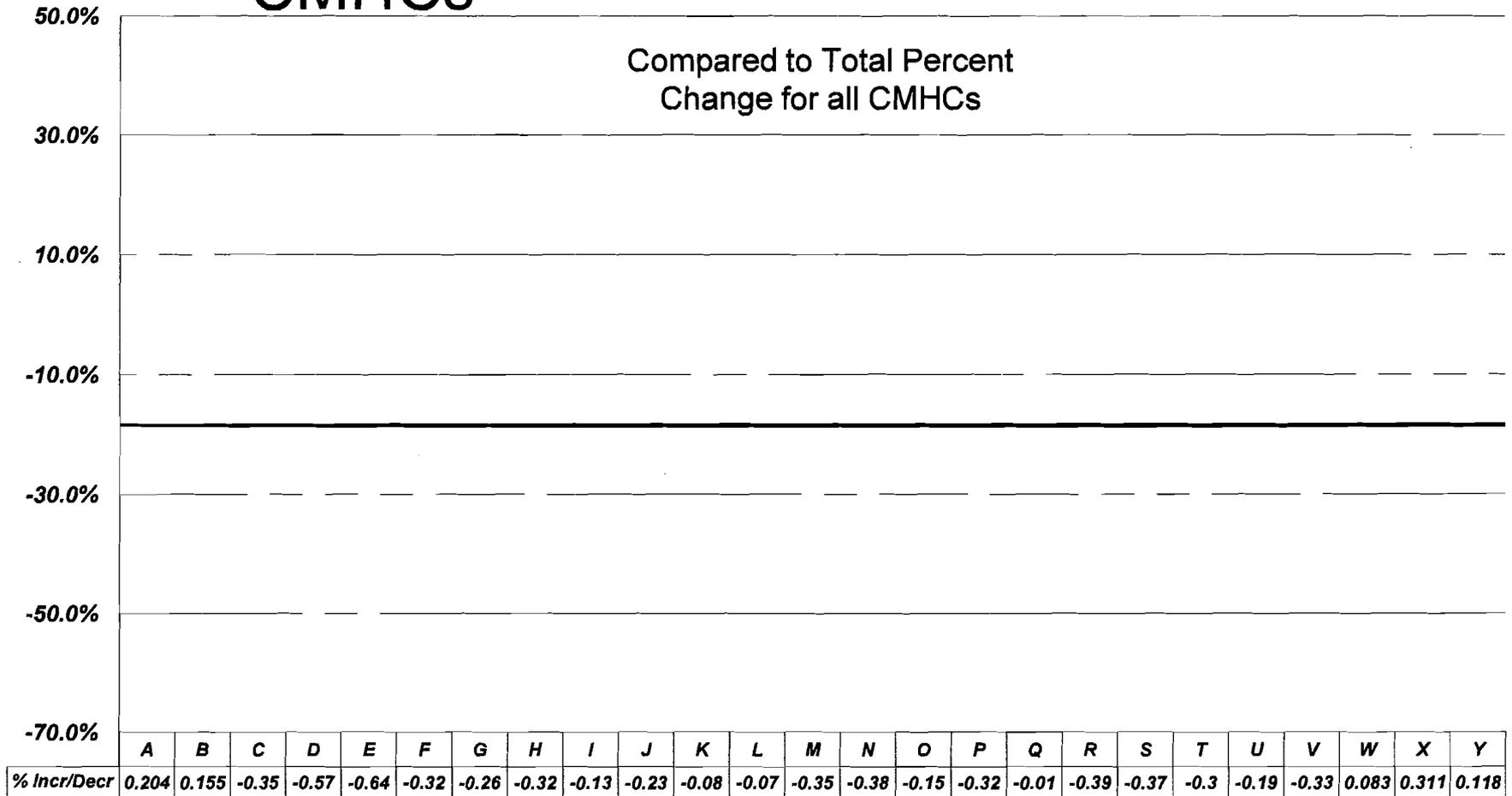
Number of Recipients by MRO Service Code-SFY10 vs. SFY11

Number of Recipients





MRO Expenditures by Provider Compared to Total Percent Change from 2010 for all CMHCs



Axis Title



Percent Change in MRO Expenditures from 2010 by Provider

