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Rhonda Boyd-Alstott
Dr. Danita Johnson Hughes
Dr. Brenna McDonald



COMMISSION ON MENTAL HEALTH AND ADDICTION

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MEETING MINUTES¹

Meeting Date: October 4, 2011
Meeting Time: 1:00 P.M.
Meeting Place: State House, 200 W. Washington St., Senate Chamber
Meeting City: Indianapolis, Indiana
Meeting Number: 3

Members Present: Sen. Connie Lawson, Chairperson; Rep. Charlie Brown; Kathleen O'Connell; Stacey Cornett; Margie Payne; Ronda Ames; Valerie N. Markley; Bryan Lett; Caroline Doebbling; Jane Horn.

Members Absent: Sen. Vi Simpson; Rep. Cindy Noe; Kurt Carlson; Chris Taelman; Rhonda Boyd-Alstott; Dr. Danita Johnson Hughes; Dr. Brenna McDonald.

I. Call to Order

Senator Connie Lawson, Chairperson, called the meeting to order at 1:05 P.M.

II. Comments from the National Alliance on Mental Health (NAMI)

Ms. Pam McConey discussed issues NAMI sees in the provision of services for individuals with mental illness. (Exhibits 1 and 2)

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.

III. Community Mental Health Center Responses to Medicaid Rehabilitation Option (MRO)

Mr. Thomas Talbot, CEO, and Ms. Julia Rupp, VP, Community Mental Health Center of Lawrenceburg, discussed the impact of changes to MRO on the Lawrenceburg Center. (Exhibits 3 and 4) In answer to a question from Senator Lawson, Ms. Rupp said that the transition to the new MRO guidelines was taking longer than they thought it would. In answer to a question from Representative Brown, Ms. Rupp said the biggest difference in the new system is the use of recovery centers instead of groups as the base for providing services. Representative Brown asked if the Center was pursuing riverboat revenues. Ms. Rupp said that they had not talked with the boats directly, but that they had gone to the City of Lawrenceburg to see if riverboat money was available.

IV. Criminal Justice and Mental Health Issues

A. Ms. Deborah Daniels, Convener of the Criminal Code Evaluation

Commission Staff Workgroup, discussed the joint initiatives of the PEW Center and the Council of State Governments on the public safety justice reinvestment initiative. (Exhibit 5) The report recommended creating a probation improvement fund with savings from reductions in Department of Correction (DOC) commitments.

B. Mr. Steve McCaffrey, President and CEO of Mental America of Indiana, presented proposed legislation for consideration. (Exhibit 6) The proposal is for creating the probation improvement fund recommended in the report presented by Ms. Daniels.

V. Access to Mental Health Drugs - Assure Rx

Mr. James Burns, President and CEO, and Mr. John Bellano, Senior VP, Sales and Commercial Programs, discussed the program Assure Rx is developing and implementing to provide mental health drugs that are tailored to best meet an individual's needs. (Exhibit 7) The program uses the individual's genetic factors to determine exactly how specified drugs will work for the individual. In answer to questions from Senator Lawson, Mr. Burns stated that Assure Rx is processing information for approximately 100 individuals a day. They expect that capacity to triple every two to three months. There is a 36 hour turn around on processing an individual's genetic make up. They hope to get that down to 24 hours. They are adding new elements to the analysis every three to four months. The current cost of the screening is \$3,800. Some insurance plans cover the costs.

VI. Report from Office of Medicaid Policy and Planning (OMPP) Concerning Availability and Use of Mental Health Drugs.

Ms. Sarah Jagger, OMPP, presented the report required by P.L. 143-2011, SECTION 32. (Exhibit 8)

VII. DOC Issues

Mr. Tim Brown, legislative liaison for DOC and **Mr. Craig Hanks**, Director of

Mental Health, discussed mental health issues at DOC. (Exhibit 9) In answer to questions from Senator Lawson, Mr. Hanks indicated that crisis intervention training (CIT) was provided at New Castle and Wabash first and then at Westville and Pendleton.

VIII. Comments from Steve McCaffrey, Mental Health America of Indiana, President and CEO

Mr. McCaffrey stated that he believes the Assure Rx program has great possibilities for enhancing access to the most effective mental health drugs. He further said that OMPP had done what they agreed to do during the last legislative session on the drug study Ms. Jagger reported on. **Mr. McCaffrey** indicated that he thinks there should be more focus on providing appropriate mental health drugs for children. **Mr. McCaffrey** thinks that DOC is becoming more proactive in providing services to individuals with mental illness.

IX. Legislation for October 25 Meeting

Senator Lawson, said that there will be the following three drafts of legislation to be considered at the next meeting:

- (1) The PEW study language discussed by Ms. Daniels and presented by **Mr. McCaffrey**.
- (2) An omnibus bill with three parts:
 - (a) Per diem for lay members of the Commission on Mental Health and Addiction;
 - (b) Consolidation of the Division of Mental Health and Addiction (DMHA) advisory councils; and
 - (c) Three clean up items from DMHA.
- (3) A social host bill dealing with underage drinking.

X. Adjournment

Senator Lawson adjourned the meeting at 4:00 P.M.

COMB
Meeting 3
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Exhibit 1

MENTAL HEALTH & ADDICTIONS COMMISSION

Pam McConey
Executive Director, NAMI Indiana

October 4, 2011

NAMI Indiana

About NAMI Indiana

- NAMI Indiana serves consumers and families affected by mental illness.
- NAMI is the largest grass-roots mental illness organization in the United States
- NAMI Indiana provides over 70 Support Groups a month
- Our Family to Family class is an evidence-based educational program

Community Mental Health Centers

- Lifelines to treatment
- Depend on them for so much
- Cooperate with NAMI Indiana
 - Respond promptly to calls
 - Matt Brooks met with affiliate leaders and board members to explain system changes

DMHA

- Director Eckart
 - Has attended NAMI Indiana Board meetings to explain changes that are occurring
 - Was on a conference call to NAMI Indiana affiliates
 - Gave us permission to have anyone who was having problems accessing treatment to call her

We've Found Problems

- Helpline calls
 - Removal from Medicaid
 - Voc Rehab not effective
 - Fewer therapy sessions available
 - "My son is in jail, and isn't getting his meds"

Evidence Based Programs Deteriorating

- Indiana was leading nation in Evidence Based Programs
- Now very few Assertive Community Treatment (ACT) programs with fidelity
 - Replaced by ACT "light" programs that lack fidelity
 - Concern about their effectiveness
 - ACT is "hospital without walls"
 - Badly need more, not fewer of them
- Supportive Employment programs down
- There is a positive: a new training for people with mental illness to be consumer recovery specialists (CRS).

Children a Major Concern

- Who is going to take responsibility for caring for their mental health?
- Examples of problems
 - CHINS 6 is non-existent
 - The 529 Plan has not been implemented
 - Has never gotten off the ground
 - Potential major benefits not being realized
 - Majority of youth in juvenile detention (65% of males; 75% of females) are there because they have mental illness
- Early intervention will save money and lives
 - Present course is wasting money and lives
 - Inexcusable

Access to Treatment Problematic

- State Hospital beds
 - Now 886
 - 22 for developmentally disabled
 - 225 - 236 for civil commitments
 - The rest for CMHCs
 - Problems getting in to the hospital & problems getting out.
 - Some waiting lists for acute care in the community.

Shining Plus: Crisis Intervention Teams

- Program to train subset of first responders to deal effectively with psychiatric crises
 - Extremely effective pre-arrest diversion into treatment
 - Marked reduction in criminalization of mental illness
- Present in 15 Indiana cities
 - Fort Wayne, Lafayette, Gary, Mishawaka, South Bend, Indianapolis, Warsaw, Elkhart, Porter County, Fishers, Richmond, Bloomington, Evansville, North Vernon, Jeffersonville
 - Kokomo in planning stages
- Funded with existing resources
- Great need to collect data
 - Fort Wayne's data extremely impressive
 - Need others to follow suit

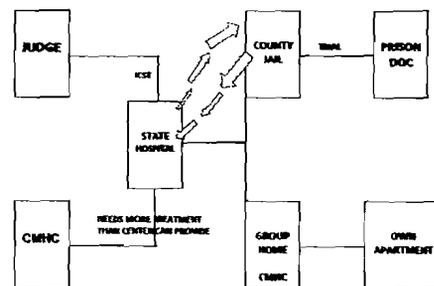
New CIT Possibilities

- CIT for Corrections
 - New 40 hour program for correctional officers
 - Train how to work effectively with offenders with mental illness
 - Based on effective program that NAMI Indiana developed
 - Study by Dr. George Parker
 - Found significant reduction in violent cell extractions and assault with bodily fluids
- CIT for Youth
 - Several cities looking into this
 - Significant potential for decreasing the criminalization of mental illness in youth

Criminalization of Mental Illness

- Mental illness the only illness for which you go to prison for being sick!
 - There are persons with mental illness in criminal justice system for stealing \$16 worth of food
- Horror stories from family members
 - Not receiving medications
 - Medical records bill not being implemented effectively
- Revolving door
 - Person judged incompetent to stand trial
 - Sent to psychiatric hospital to regain competence
 - Competence regained, returned to jail to await trial
 - No medications, loses competence
 - Repeat many times
 - Inhumane on several levels

In Diagram Form





We Still Have a Long Way to Go

Find HELP, Find HOPE, Find NAMI

 **NAMI** Indiana

Impact of a Mental Health Training Course for Correctional Officers on a Special Housing Unit

George F. Parker, M.D.

COMH
Meatins 3
10-4-11
Exhibit 2

Objective: This study determined the impact of a ten-hour mental health training program developed by the Indiana chapter of the National Alliance on Mental Illness (NAMI-Indiana) for correctional officers on a prison special housing (“supermax”) unit. **Methods:** The training was delivered to all of the correctional officers on the unit in five weekly sessions and was repeated 15 months later for new unit staff. The number of incidents reported by unit staff in standard monthly reports, consisting of use of force by the officers and battery by bodily waste on the officers by the offenders, was compared for the nine months before and after both training sessions. **Results:** Attendance at the initial training ranged from 48 to 57 officers per session, and on the basis of Likert ratings, training was well received by the officers. The total number of incidents, the use of force by the officers, and battery by bodily waste all declined significantly after the first mental health training, and the total number of incidents and battery by bodily waste declined significantly after the second training. **Conclusions:** The provision of ten hours of mental health training to correctional officers was associated with a significant decline in use of force and battery by bodily waste. (*Psychiatric Services* 60:640–645, 2009)

In the past two decades the concept of the control unit, or secure housing unit, popularly known as “supermax,” has become popular among U.S. correctional authorities. Although there is some debate as to what constitutes a supermax unit, in 2006 the Urban Institute reported that 95% of prison wardens surveyed agreed that a supermax unit consisted of “a stand-alone unit or part of another facility and is designated for violent or disruptive inmates. It typically involves single-cell confinement for up to 23 hours per day for an indefinite period of time. Inmates in supermax housing have minimal contact with staff and other inmates” (1).

Typically, the stated rationale for such units is the need to house the most difficult and dangerous offenders in an environment that minimizes the risk of trouble for the other inmates and staff. Nearly every state now has at least one special housing unit, and several states and the federal prison system have built entire facilities, called supermax prisons, on this model (2,3). Intended for the most dangerous offenders, special housing units have become “home” to many inmates with mental illness, despite the efforts of mental health and civil rights advocates. A policy paper of the National Institute of Corrections in 1999 stated, “Insofar as possi-

ble, mentally ill inmates should be excluded from extended control facilities . . . much of the regime common to extended control facilities may be unnecessary, and even counter-productive, for this population” (4).

This recommendation was not followed, and the reality of the prevalence of offenders with mental illness in special housing units was evident in a 2004 monograph from the National Institute of Corrections, for it identified mental health as “the major issue emerging in supermax litigation” (5). The author of this report noted that in California, Ohio, and Wisconsin plaintiffs had successfully argued that some offenders should not be placed in a special housing unit because of mental illness and that placement in a special housing unit could cause serious mental illness. The report identified several steps to prevent liability, including screening out inmates with serious mental illness before referral to the special housing unit, ongoing monitoring of the mental status of inmates on the special housing unit, and the provision of adequate mental health care on the unit.

Over the past 20 years the prevalence of mental illness in jails and prisons has been a growing concern for state correctional agencies, state mental health agencies, and advocacy organizations. Systematic examinations of mental illness among inmates have reported a threefold greater prevalence of psychotic and mood disorders in the population behind bars, compared with the adult U.S. population (6). Overall, 10% to 15% of inmates are estimated to have a serious mental illness (7). Although provision of general medical care is a

Dr. Parker is with the Department of Psychiatry, Indiana University School of Medicine, 1111 West 10th St., Indianapolis, IN 46202 (e-mail: geoparke@iupui.edu). A preliminary version of this research was presented in poster format at the annual meeting of the American Academy of Psychiatry and the Law, October 27, 2006, Montreal, Canada.

constitutional duty of correctional authorities (8), inmates with serious mental illness pose more challenges to administrators, compared with inmates with other chronic illnesses; because the symptoms of mental illness, especially psychosis, may cause disruptive behavior. Because maintenance of a secure and stable environment is a primary concern for correctional authorities, disruptive behavior typically results in administrative consequences, up to and including segregation. In state prisons, offenders with mental illness are more likely than those who do not have a mental illness to be written up for breaking institutional rules (58% versus 43%), and they are also more likely to be charged with an assault (24% versus 14%) (9). Offenders with mental illness are thus more likely to be housed in more restrictive settings, including special housing units. Once assigned to a special housing unit, offenders typically do not do well clinically, particularly if they have a mental illness (10), and they also pose significant management challenges to staff of special housing units; they often suffer additional administrative penalties as a consequence.

The Indiana Department of Correction has two special housing units—the first opened in the Westville facility in 1993, and the second, the site of this project, opened in the Carlisle facility in 1995 (11). The Carlisle facility is currently classified as high-medium security by the Indiana Department of Correction, and it has both minimum- and maximum-security units; the Westville facility is classified as medium security and has minimum-, medium-, and maximum-security units (12). The number of offenders with mental illness in the Carlisle special housing unit, which has a capacity of 280, was tracked from 1996 to 2003; the number increased steadily since it opened, from 49 (18% of capacity) in 1996 to 173 (62% of capacity) in 2003 (personal communication, Carlisle Department of Correction superintendent, 2006). Throughout the study, mental health care to offenders housed on the Carlisle special housing unit was provided by a Department of Correction contractor and included psychiatric

and psychology services. However, assessments, monitoring, and programming were limited because of the challenges of communicating through the food slot in the cell door or by the difficult logistics of arranging the movement of an offender from his cell to another location either within or off the special housing unit.

The National Alliance on Mentally Illness (NAMI) is an advocacy organization dedicated to improving the lives of people afflicted by serious and persistent mental illness (13). In 2003 an inmate at the Carlisle special housing unit wrote to the Indiana chapter of NAMI (NAMI-Indiana) to report the difficult conditions faced by offenders with mental illness in the special housing unit. At the invitation of the superintendent, NAMI members subsequently toured the facility. After further discussions, NAMI-Indiana was invited to develop and provide a training program on mental illness for the correctional staff on the special housing unit. This report discusses the effect of this educational intervention on the number of incidents reported by correctional staff on the special housing unit in their monthly reports, both before and after the NAMI training.

Methods

The training program consisted of five two-hour sessions, given over five consecutive weeks. The first session introduced the correctional officers to the major categories of psychiatric disorders (substance abuse disorders, personality disorders, mood disorders, psychotic disorders, and anxiety disorders) by describing the diagnostic criteria for these disorders in clear language, using illustrative examples from clinical practice and popular movies, and encouraging questions and discussion. Session 2 built on the first session by focusing on the biology of mental illness; the speaker used clear diagrams and neuroimaging to outline how brain cells communicate using neurotransmitters and how mental illness affects the chemistry, structure, and metabolism of the brain. Session 3 provided an overview of the treatment of mental illness, with discussions of the major groups of psychiatric medications and how

they affect the neurotransmitter systems, as well as discussion of psychological treatments. The fourth session focused on how to interact effectively with people with mental illness and incorporated a consumer-speaker from NAMI's In Our Own Voice program (14). The curriculum concluded with a session that reviewed and integrated all of the previous sessions and was co-led by a senior supervisor from the Department of Correction. The preparation of the curriculum was coordinated by an administrator from NAMI-Indiana. The curriculum authors were all NAMI-Indiana members and included medical school psychiatry faculty, university basic sciences faculty, a prison administrator, family members, and consumers. The curriculum was designed to be interactive—all of the speakers encouraged questions and discussion—and role-playing exercises for the participants were included. The curriculum was field-tested before the Carlisle training at a meeting of Indiana correctional officials and at a training conference hosted by NAMI-Indiana.

At the invitation of the Carlisle superintendent, NAMI-Indiana provided this training in February and March 2004 to all of the correctional officers assigned to the Carlisle special housing unit. The training was provided at the official training site for the facility, which was located outside the walls of the prison. The special housing unit staff was split in half for the training, and each of the five sessions was provided twice each week. The NAMI members who developed each portion of the curriculum provided the training in person, with the assistance of the NAMI-Indiana coordinator and the Carlisle training supervisor. Attendance was closely monitored by the Department of Correction with sign-in sheets, because the training was deemed mandatory by the prison administration. The correctional officers came in before shift change, stayed after the end of their shift, or came in on days off to attend the training, and they were paid accordingly. Each attendee was asked to complete anonymously a pretest before each session and a posttest and a

Table 1

Evaluation of the first mental health training sessions (February and March 2004) for correctional officers working on a prison special housing unit

Session	Attendance	Content rating ^a		Presenter rating ^a	
		M	SD	M	SD
1	57	3.68	1.13	4.22	1.05
2	54	3.25	1.58	4.18	1.20
3	53	3.46	1.29	4.36	.92
4	55	3.18	1.29	4.13	1.23
5	48	3.50	1.21	4.46	.72
Overall		3.57	1.08	4.15	1.05

^a As measured by a Likert scale. Possible scores range from 1, poor, to 5, excellent.

feedback form at the end of each session. The training was repeated by videoconference in June and July 2005, and all staff who had joined the special housing unit since the initial training attended, along with staff from other units at the Carlisle facility.

The administrators at the Carlisle special housing unit routinely prepared standard monthly quality assurance reports, which included a summary sheet noting the unit census, the total number of incidents for the month, the number of times force was used by unit staff on offenders, and the number of incidents of battery by bodily waste on custody staff. The Carlisle superintendent shared the summary sheets with NAMI-Indiana, beginning nine months before the start of the first training and continuing until the special housing unit underwent a major reorganization nearly two years later. Although the full reports generated by the facility included specific information about the circumstances of each incident and the inmates and correctional officers involved, the research presented here was based only on the summary sheets, because of concerns about confidentiality and informed consent. As a result, it could not be determined whether any given incident involved an inmate with a serious mental illness or a particular correctional officer.

The overall number of incidents and the number of each type of incident, dating from July 2003 to April 2006, were entered into an electronic spreadsheet. The number of total incidents, incidents of use of force, and

incidents of battery by bodily waste were then statistically compared for the nine months before and after each of the two training sessions, using Student's *t* test (15).

This research project was granted exempt status by the Indiana University-Purdue University Indianapolis Institutional Review Board.

Results

Attendance at the first mental health training, which took place in February and March 2004, ranged from 48 to 57 staff per session (Table 1). Attendance was determined by a count of the pre- and posttests turned in for each session; these tests were required for participants to receive training credit from the Department of Correction. Participants were also asked to rate anonymously the content of each session and the presenter, as well as the overall course, using a Likert scale; possible scores ranged from 1, poor, to 5, excellent. The initial training was well received by the correctional officers, with a mean rating of 4.15 for the course presenters and a mean rating of 3.57 for the overall course content. A total of 34 staff from the Carlisle facility attended the second training in June and July 2005. The attendance numbers, evaluations, and test performances of the staff of the special housing unit for this training could not be determined, because the staff of the special housing unit were part of a larger group from the Carlisle facility and the attendance sheets did not note each officer's unit assignment.

In the nine months before the ini-

tial training, the special housing unit was over census for two months, and the mean±SD monthly census was 275.7±5.1 (98.5% of capacity). The special housing unit was over census for eight of the nine months after the initial training, with a mean monthly census of 282.4±2.7 (100.9% of capacity). The monthly census was lower in the nine months before the second training (273.3±6.0, 97.6% of capacity) and declined further in the nine months after the second training (243.6±29.1, 87.0% of capacity). As noted above, the prevalence of mental illness on the special housing unit was 62% in 2003; however, this statistic was not determined in subsequent years, because of a change in supervisory staff (personal communication, Carlisle Department of Correction superintendent, 2008).

In the nine months after the first training, the number of total incidents, number of incidents involving use of force, and incidents of battery by bodily waste on the special housing unit all declined significantly, compared with the nine months before the training (Table 2). In the nine months after the second training, the total number of incidents and the number of incidents of battery by bodily waste declined significantly, compared with the nine months before the training (Table 3). Similar data were sought for the entire Carlisle facility, but only battery by bodily waste was tracked during the study period; all but one battery by bodily waste incident occurred on the special housing unit.

Discussion

Role and training of correctional officers

Correctional officers can play a vital role in ensuring appropriate treatment of offenders with mental illness, but they generally receive little training in mental health issues and have a professional culture that is quite different from that of mental health professionals (16,17). The NAMI-Indiana training program attempted to bridge this cultural gap by educating the correctional officers assigned to a secure housing unit about mental illness. On the basis of the decline in the number of incidents after the

Table 2

Violent incidents before and after the first set of mental health training sessions (February and March 2004) for correctional officers working on a prison special housing unit

Outcome	9 months before training				9 months after training				t	df	p
	Monthly				Monthly						
	N	M	SD	95% CI	N	M	SD	95% CI			
All incidents	162	18.00	7.00	12.75 to 23.25	85	9.44	7.84	4.19 to 14.70	2.44	16	.027
Use of force by officers	148	16.40	6.17	11.48 to 21.41	81	9.00	7.79	4.03 to 13.97	2.25	16	.039
Battery by bodily waste by offenders	14	1.56	1.42	.80 to 2.31	4	.44	.53	-.31 to 1.20	2.20	16	.043

training, the NAMI-Indiana program was successful in reducing both the use of force by the correctional officers, as well as the number of assaults by bodily waste on the officers. The training was also well received by the staff of the special housing unit, despite their initial reluctance to participate in the training.

Little has been written on the role of correctional officers in the management of offenders with mental illness in jails and prisons. Kropp and colleagues (16), in a 1989 article, found that the correctional officers assigned to a maximum-security pre-trial unit felt that working with offenders with mental illness added stress to their jobs, and although they were confident in their abilities to handle the general population in the jail, nearly all of them were interested in further training on how to work with offenders with mental illness.

In recent years, only two articles have been published on the specific topic of mental health training for correctional officers. Appelbaum and

colleagues (17), writing about working in the Massachusetts state prison system, noted the difficult working conditions faced by correctional officers, particularly the threat of violence, and identified the differing professional cultures of security staff and mental health staff as a major issue. They also observed that many correctional officers and many mental health staff work together effectively and share common goals of decent and humane treatment of inmates. They emphasized that correctional officers could and should be recognized as members of the multidisciplinary treatment team for offenders with mental illness, particularly on residential treatment units. Massachusetts offers collaborative training sessions for correctional officers about suicide prevention and mental illness, but this program was not described in detail and no outcomes were described.

Dvoskin and Spiers (18) described the culture of the community inside prison walls and argued that correc-

tional officers could play important roles in the provision of mental health services to offenders, including talking with offenders in a therapeutic manner, talking about the offenders as part of the mental health consultation process, and observing medication effects and side effects. The authors specifically identified special housing programs, including administration segregation units, as places where correctional officers could play a vital role in the identification and management of mental illness; they also emphasized the importance of training to improve the relationship between custody staff and mental health professionals. The authors included descriptions of programs that successfully involved correctional officers in mental health roles, but none of these were accompanied by a reference to a published article that described the program or its outcomes.

Correctional officers play a vital role in maintaining safety and security in prisons, and they are subject to many stresses, including long hours,

Table 3

Violent incidents before and after the second set of mental health training sessions (June and July 2005) for correctional officers working on a prison special housing unit

Outcome	9 months before training				9 months after training				t	df	p
	Monthly				Monthly						
	N	M	SD	95% CI	N	M	SD	95% CI			
All incidents	99	11.00	2.69	8.36 to 13.64	63	7.00	4.56	4.36 to 9.64	2.27	16	.038
Use of force by officers	90	10.00	2.40	7.43 to 12.57	63	7.00	4.56	4.43 to 9.57	1.75	16	.1
Battery by bodily waste by offenders	9	1.00	1.00	.50 to 1.50	0	.00	3.00	-.50 to .50	3.00	16	.008

low pay, and the risk of violence, which is their highest concern (19). In addition, correctional officers have reported high psychological demands on the job, accompanied by low social support, a low sense of control, and feelings of insecurity (20). When one considers the challenges of their work environment, it is perhaps not surprising that correctional officers who work on special housing units have been reported to be physically and psychologically abusive to inmates under their supervision (2,3).

The U.S. Bureau of Labor Statistics notes, "Correctional officers learn most of what they need to know for their work through on-the-job training" (21). Indiana requires only that correctional officers be high school graduates and have three years of work experience; as a result, the recruits generally have little experience with or knowledge about working with people with serious mental illness, even after completing the preservice academy. At the time of the study, Indiana correctional officers received only a very basic orientation to mental health issues in the preservice academy, consisting of 2.5 to 3.0 hours, out of more than three weeks of training, on working with offenders with mental illness, substance abuse, and developmental disabilities (22). The NAMI-Indiana curriculum on mental illness was designed to address this knowledge deficit and was well received by the correctional officers who attended the sessions.

More important, the NAMI training was associated with a significant decline in officers' use of force with offenders and in the number of attacks on the officers by the offenders. Although it is not possible to state with certainty how the training led to these beneficial results, the NAMI team attributed the decline in use of force to improved understanding of the offenders' mental illnesses and to the interacting skills emphasized in the latter part of the training. The reason for the decline in incidents of battery by bodily waste is less obvious, but in discussions between the NAMI team and staff of the Department of Correction, it was felt that the attention giv-

en to skills in interaction with people with mental illness helped in this area as well. Since battery by bodily waste is one of the few forms of retaliation available to offenders on special housing units, it is possible that the officers, by treating offenders with more understanding, may have decreased the frustration and anger that lead to battery by bodily waste.

Strengths and limitations

The strengths of this study include the training of the entire staff of a special housing unit and the availability of objective data directly related to safety issues from before and after the training. Weaknesses of the study include the retrospective nature of the study and the lack of a control population. Although the NAMI-Indiana team that created the curriculum was interested in outcomes, the initial focus was on the response of the officers to the training itself; the incident reports did not become available until well after the training had been completed. The Westville special housing unit could have been a good control population for this study, but this facility declined to respond to a request for data on incidents of use of force and battery by bodily waste. The overall Carlisle facility could also have served as a control population, even though it housed both minimum and maximum-security offenders. Unfortunately, the only data available for the entire facility for the study period covered just battery by bodily waste; this report was not particularly useful for control purposes, because over the course of more than two years, only one battery by bodily waste occurred off of the special housing unit—which is clearly evidence of the troubled nature of the offenders on the unit, the disturbing impact of the special housing unit itself, or both.

In addition, as should be expected in a large prison facility, the NAMI training was not the only factor at work over the course of the study. The Indiana special housing unit underwent a number of changes before, during, and after the NAMI training (personal communication,

Carlisle Department of Correction administrative staff, 2006). The administration of the unit changed before the training, as the sergeants were rotated off the unit and a new captain was assigned. In the months immediately after the training (April to June 2004), the Department of Correction gradually transferred selected offenders from the special housing unit to a new program at the prison psychiatric facility, during which time some offenders became more disruptive in an attempt to be placed on the transfer list; as a result, there were high numbers of use of force in two of these three months. However, Carlisle Department of Correction staff noted that the offenders who were transferred were not those who had been involved in the incidents reported in previous months. The transfers were then replaced with new offenders from the waiting list for the special housing unit. Finally, in the fall of 2004, several months after the training, several unit staff received disciplinary action, including arrest, for abusive behavior; this investigation began months before the discipline occurred.

Clearly, each of these factors could have had an impact, for better or for worse, on the culture of the special housing unit. The change in supervisory staff could have set the stage for a positive response to the training; although senior management supported the training, the faculty noted obvious difficulty in engaging the officers in the training, particularly in the early sessions, despite the positive ratings given by attendees. The change in offender population could have removed the offenders who were most involved in reported incidents and thus affected the perceived effectiveness of the training, but a unit administrator noted that the transferred offenders were not those involved in prior incidents. Finally, the investigation and later removal of officers on charges of abuse could have affected the atmosphere on the unit either positively (encouraging for more professional behavior) or negatively (aggravating an already difficult work environment). Although the officers who were re-

moved left the unit more than six months after the initial training, the numbers of incidents declined significantly shortly after the first training ended and rose modestly after their departure, only to decline again after the second training of officers new to the special housing unit. This pattern suggests that the removal of the officers was not the driving force in the decrease in the number of incidents on the special housing unit and that the mental health training played an important role in that decrease.

Conclusions

The NAMI training curriculum, which provided ten hours of education on mental illness to all of the correctional officers who worked on an Indiana special housing, or supermax, unit, was associated with a significant decrease in the use of force by the correctional officers and battery by bodily waste on the officers by offenders. These results suggest that providing mental health training to all of the correctional officers on a prison unit can lead to safer working conditions for the correctional officers and safer living conditions for offenders.

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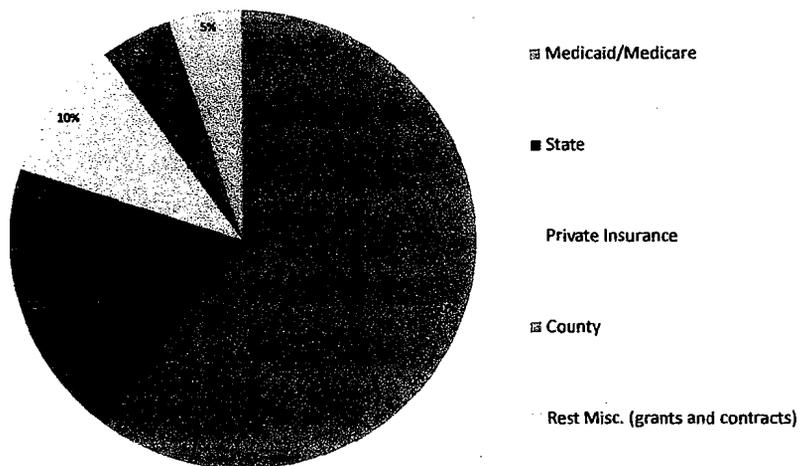
Presentation to: Indiana Commission on Mental Health and Addiction

Tom Talbot Executive Director
Julia Rupp Chief Operations Officer
Community Mental Health Center, Inc.,
October 4, 2011

CMHC, Lawrenceburg Indiana

- 5 rural counties in Southeastern Indiana
- We have an integrated , recovery based, person centered, culturally competent, trauma informed philosophy to delivering services
- We have a full continuum of care from prevention services to a 16 bed acute care hospital
- No FQHC (Federally Qualified Health Center) or Community Health Center 5 county area
- We do have primary health clinic on site for adults with Serious mental illness (LON –Level of Need 3-4-5)
- We have an Electronic Health Record
- We've implemented several Evidenced Based Practices including:

ACT- Assertive Community Treatment
IDDT-Integrated Dual Diagnosis Treatment
IMR-Illness Management and Recovery
Wrap around Care-Coordination for Children
System of Care (Federally Funded)
Dialectical Behavior Therapy (DBT)
Supported Employment
(TIP) Transition to Independence Process
DEAF services
Gambling Services
Wellness Recovery Action Planning
NIATx- (Evidenced based continuous quality
improvement process)



Framework

- Continuum of Care by DMHA is currently under review, we use as our framework the document called Good and Modern Service System, drafted by SAMHSA (handout)
- Document was drafted as a means to get national consensus and common language on what should be included in service array as well as facilitate communication with primary health providers and others

Good and Modern Service Array Proposed April 2011 from SAMHSA

Healthcare Home/Physical Health	Prevention and Wellness Services	Engagement and Services	Outpatient and Medication Services	Community and Recovery Support	Other Habilitation Supports	Intensive Support Services	Out-of- home Residential Services	Acute Intensive Services

Community Mental Health Center Programs Compared with SAMHSA Good and Modern Services

Healthcare Home Physical Health	Prevention and Wellness	Engagement Services	Outpatient and Medication Services	Community and Recovery Support	Other Habilitatio n Supports	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services
**General Out Patient Medical Services (Adults with SMI)	**Screening/Brief Intervention Referral to Treatment	*Assessment	*Individual Evidence Based Therapies	*Peer Supports	**Personal Care	*Substance Abuse Intensive Outpatient Services	**Crisis/ Residential/Stabiliz ation	**Mobile Crisis Services
**Acute Primary Care	**Wellness Programs	**Specialized Evaluations	**Group Therapy	**Recovery Support Services (Clubhouses)	**Homemak er	*Partial Hospital	**Residential Services	**Urgent Care Services
**General Health Screens	**Smoking Cessation	**Service Planning	*Family Therapy	**Family Tracking and support	**Respite	**Assertive Community Treatment	**Supports for children in Foster Care	**24 Hour Crisis
**Care Management	**Health Promotion **Brief Motivation Interviews	**Consumer Family Education **Outreach	*Multi Family Counseling *Medication Management **Pharmacothera py **Laboratory Services **Specialized consultation	**SMI Building **Case Management **Continuing Care **Behavioral Management **Supported employment **Permanent supported housing **Recovery Housing **Therapeutic Mentoring	**Educationa l Services **Transporta tion **Assisted Living Services **Recreation al Services **Other Goods and Services **Trained Behavioral Health Interpreters	**Intensive Home Based Treatment **Multi- systemic Therapy		**Psychiatric Inpatient and Medical Detoxification Services

Other elements of the Good and Modern Document

- Grounded in Public Health model
- Goal is high quality services
- Interventions should reflect evidenced/researched informed practices
- Primary Care should be available within organizations that provide behavioral health services especially for Individuals that view Mental Health Centers as health homes (persons with higher levels of need (MRO population))

Service elements-Good and Modern continued

- Should include activities and services that go beyond traditional interventions such as residential and outpatient
- Coordination with Primary health is essential
- A small percentage of Individuals (Those with High level of need) use the majority of resources
- An array of Services must be designed to incorporate the concepts of community integration and social inclusion

Service Elements-Good and Modern

- Health Promotion
- Prevention
- Screening and Early intervention
- Care Management
- Self Help and Mutual Support
- Continuum of Services

Framework Continued

- CMHC strives to have Programs and Services in the continuum that reflect a philosophy of care that:
 - is integrated (integrated primary care and behavioral health)
 - person centered (client drives the their own treatment)
 - culturally competent
 - trauma informed (good customer service, doesn't re-traumatize persons served)
 - And is recovery based

Recovery Based

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice, while striving to achieve his or her full potential.

Components of Recovery

- Individualized and Person-Centered
- Self-Direction
- Hope
- Responsibility
- Empowerment
- Respect
- Peer Support
- Strengths-Based
- Non-Linear
- Holistic

Recovery is variously called a process, an outlook, a vision, a guiding principle... the overarching message is that hope and restoration of a meaningful life are possible, despite serious mental illness... Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.

Mental Health: A Report of the Surgeon General, Chapter 2, 1999

Operational and financial considerations for CMHC

- Concerned about the availability of MRO match
- No money available for staff training and coaching to sustain Evidenced Based Practices
- Limited Dollars Staff Training
- Limited dollars for safety net services
- Limited dollars for uncompensated care
- No funding available for Technology Costs
- Increased Uncompensated Care Costs

Holding Down Costs- CMHC was able to break even for fiscal year 11 but only because ...

- No staff raises for 3 years
- No replacement of Vehicles
- Falling behind with technology infrastructure
- Putting off building maintenance issues
- Growing DCS business
- Federal grant that helps to pay for EBP
- Foundation Grants

MRO

Impact to Financial Stability

- After July 2010 we were 300,000 in the red.
Cost of retraining staff to new MRO documentation
- Overall MRO income for last fiscal year was down 10%
- Concurrent documentation best practice requires laptops and air cards for all Community based staff (Those that bill MRO)

Continuum of care

Comparison of Indiana Services with CMS Recommended Services

Essential Home Physical Health	Prevention and Wellness	Engagement Services	Outpatient and Medication Services	Community and Recovery Support	Other Habilitation Supports	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services
***General Out Patient Medical Services	***Screening/Brief Intervention Referral to Treatment	***Assessment	*Individual Evidence Based Therapies	**Peer Support	***Personal Care	*Substance Abuse Intensive Outpatient Services	***Crisis Residential/Stabilization	***Mobile Crisis Services
***Acute Primary Care	***Wellness Programs	***Specialized Evaluation	**Group Therapy	***Recovery Support Services	***Homemaker	**Partial Hospital	***Residential Services	***Urgent Care Services
***General Health Screens	***Smoking Cessation	***Service Planning	*Family Therapy	***Family Training and support	***Respite	**Assertive Community Treatment	***Supports for children in Foster Care	***24 Hour Crisis
***Care Management	***Health Promotion ***Brief Medication Interviews	***Consumer Family Education ***Outreach	*Multi Family Counseling *Medication Management	**Skill Building **Care Management	***Educational Services ***Transportation	***Intensive Home Based Treatment ***Multi-systemic Therapy		***Psychiatric Inpatient and Medical Detoxification Services
			***Pharmacotherapy ***Laboratory Services ***Specialized consultation	***Continuing Care ***Behavioral Management ***Supported employment ***Permanent supported Housing ***Recovery Housing ***Therapeutic Monitoring	***Assisted Living Services ***Recreational Services ***Other Goods and Services ***Trained Behavioral Health Interpreters			

Comparison of Indiana Services with SAMHSA Good and Modern Services

Essential Home Physical Health	Prevention and Wellness	Engagement Services	Outpatient and Medication Services	Community and Recovery Support	Other Habilitation Supports	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services
***General Out Patient Medical Services	***Screening/Brief Intervention Referral to Treatment	***Assessment	*Individual Evidence Based Therapies	**Peer Support	***Personal Care	*Substance Abuse Intensive Outpatient Services	***Crisis Residential/Stabilization	***Mobile Crisis Services
***Acute Primary Care	***Wellness Programs	***Specialized Evaluation	**Group Therapy	***Recovery Support Services (Children)	***Homemaker	**Partial Hospital	***Residential Services	***Urgent Care Services
***General Health Screens	***Smoking Cessation	***Service Planning	*Family Therapy	***Family Training and support	***Respite	**Assertive Community Treatment	***Supports for children in Foster Care	***24 Hour Crisis
***Care Management	***Health Promotion ***Brief Medication Interviews	***Consumer Family Education ***Outreach	*Multi Family Counseling *Medication Management	**Skill Building **Care Management	***Educational Services ***Transportation	***Intensive Home Based Treatment ***Multi-systemic Therapy		***Psychiatric Inpatient and Medical Detoxification Services
			***Pharmacotherapy ***Laboratory Services ***Specialized consultation	***Continuing Care ***Behavioral Management ***Supported employment ***Permanent supported Housing ***Recovery Housing ***Therapeutic Monitoring	***Assisted Living Services ***Recreational Services ***Other Goods and Services ***Trained Behavioral Health Interpreters			

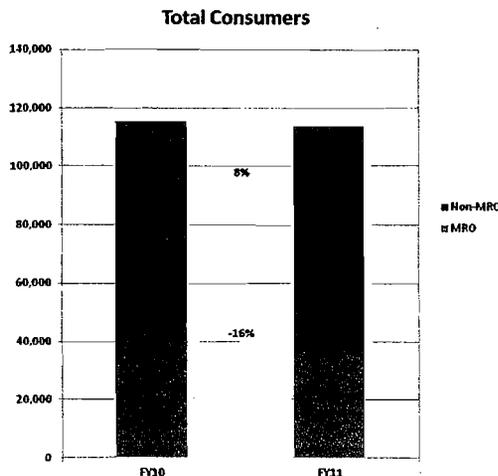
Statewide Medicaid mental health consumers

	MRO Consumer Total	Clinic Option Consumer Total
FY10	73,510	76,333
FY11	60,772	61,498

- From FY10 to FY11, MRO consumers dropped by 12,738 (-17%).
- From FY10 to FY11, Clinic Option consumers dropped by 14,835 (-19%).
- This indicates that we have fewer consumers with Medicaid accessing mental health services.

MRO vs. Non-MRO consumers served

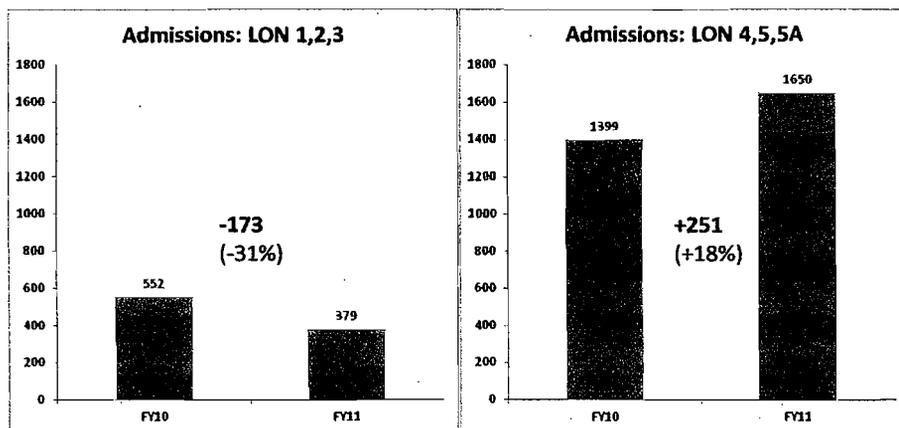
- The figure on the right shows data collected from the ICCMHC membership on the number of MRO vs. non-MRO consumers.
- Consistent with the state figures, there was a 16% drop in MRO consumers (-6,915), but an 8% increase in non-MRO consumers from FY10 to FY11 (+5,384).
- Therefore, we're serving almost the same number of consumers in both years, but many no longer receive MRO services.
- Given that they are not accessing Clinic Option, this most likely represents a rise in uncompensated care in FY11.



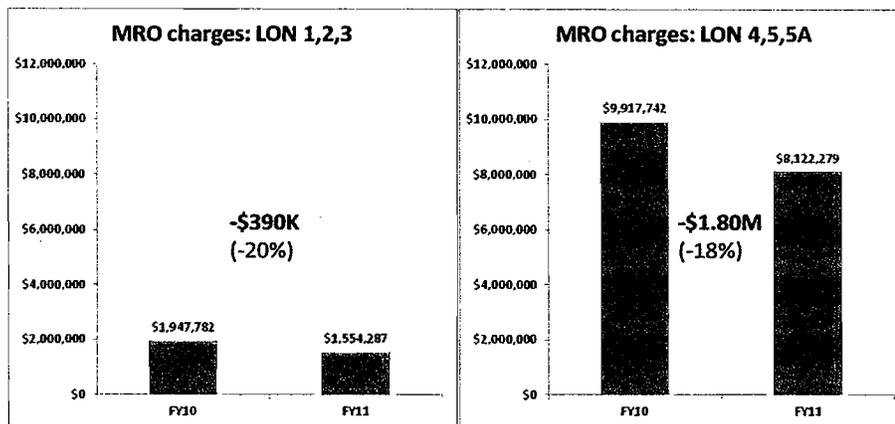
Inpatient study (Indiana Council Survey)

- Purpose was to see if there were changes in inpatient admissions and costs for MRO consumers
- Number of participating CMHCs: 13
- In this sample, roughly the same number of individuals were hospitalized in FY10 and FY11
- Focus on potential differences by level of need (LON):
 - Unduplicated consumers in FY10 = 1,481
 - Unduplicated consumers in FY11 = 1,479
- Hypothesis: Increased hospitalizations would be seen at higher LON (Level of Need).

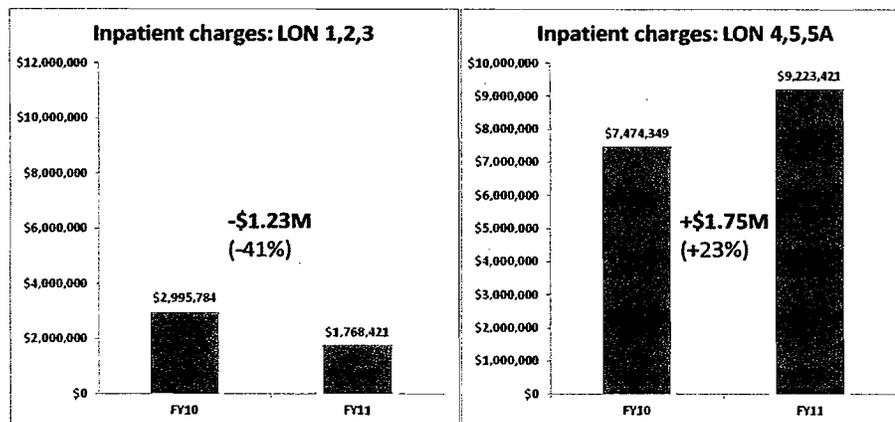
Inpatient study results



Inpatient study results



Inpatient study results



Inpatient study conclusions

- At lower levels of need (LON 1, 2, 3), we are seeing declines in hospitalization and costs for both inpatient and MRO.
- At higher levels of need (LON 4, 5, 5A), there was also decline in MRO costs, but there were increases in hospitalizations and inpatient costs.
 - Note that the savings in MRO are almost entirely offset by the increased costs of hospitalizations.
- We'd like to see the dollars spent on inpatient costs invested back in the community-based, recovery-oriented MRO program.

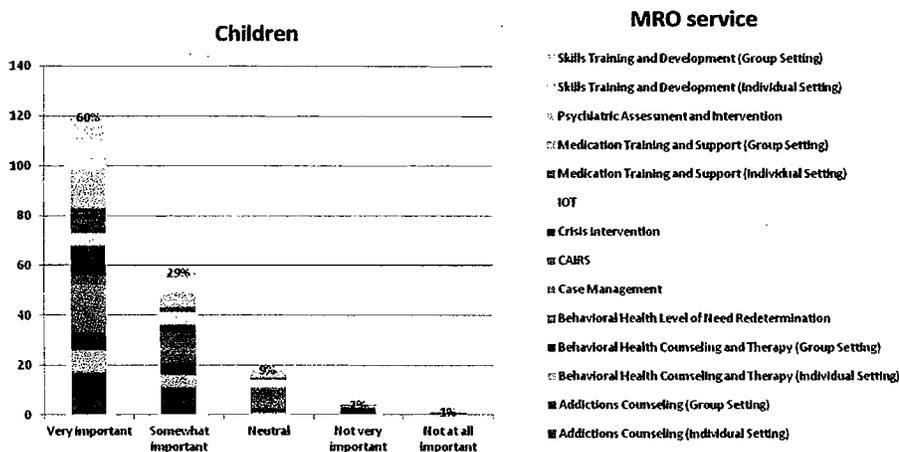
CMHC Inpatient Experience

- Continuum requires inpatient unit, historically we lose 700,000 per year on IPU
- Our Admission rate is up 10% from previous year
- However, July 2011 we almost broke even on IPU due to high census
- Client Impact- Research tells us that every hospitalization results in poorer baseline functioning for persons with serious mental illness

Client Impact

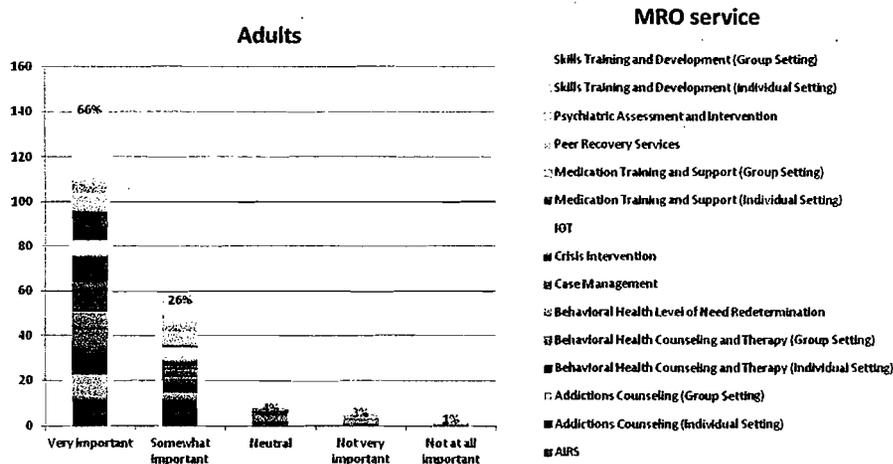
- **Danny-**
 - Level of Need 5, lives in our supportive housing, attends Recovery Center (Clubhouse “like”) prior to MRO change no hospitalization for a year, post change two hospitalizations in one year
- **Bill-**
 - Former ACT client no hospitalization for years while on ACT. Lived independently in the community. Had to move off ACT do to MRO changes. (Reduced geography of ACT team). Currently receiving Intensive CM services. Hospitalized twice psychiatrically and once for diabetes (lost two toes) in winter of 2010

Regardless of reimbursement, how important is the service for a recovery-based continuum of care?



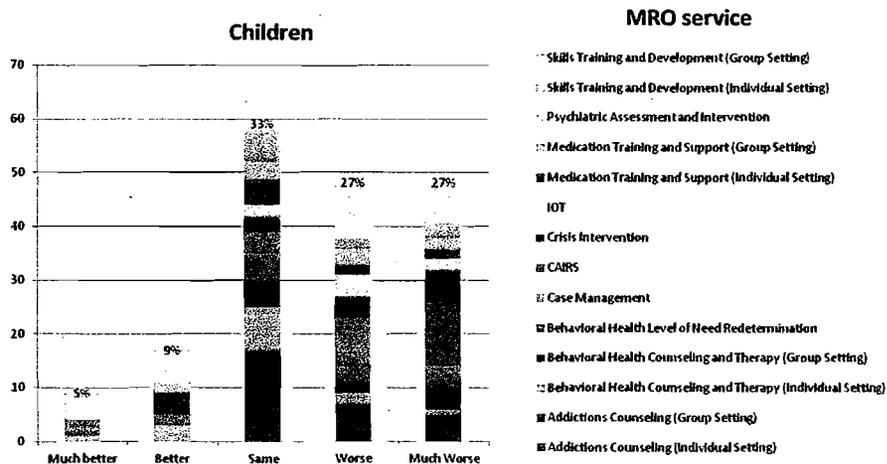
Of all responses, 89% indicated that the MRO services were somewhat or very important; only 3% of responses found them not very or not at all important.

Regardless of reimbursement, how important is the service for a recovery-based continuum of care?



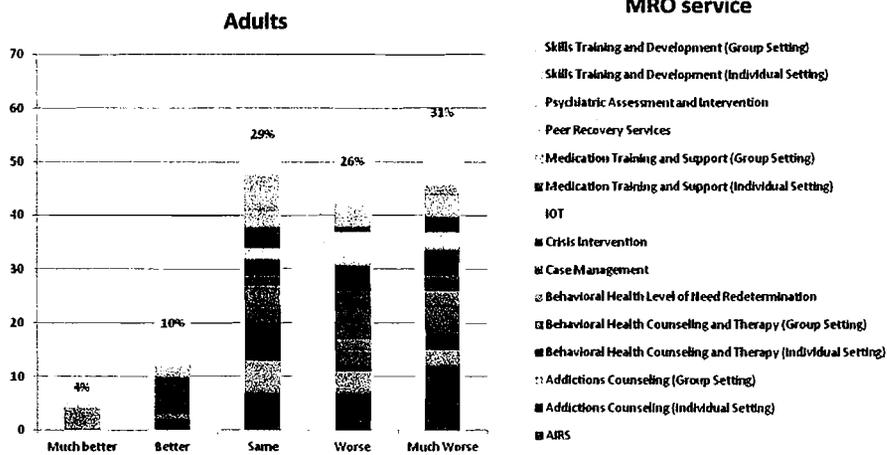
There was a similar picture for adults—92% were somewhat or very important; 4% were not very or not at all important.

How well does the current MRO system serve your consumers vs. the previous MRO system (prior to July 1, 2010)?



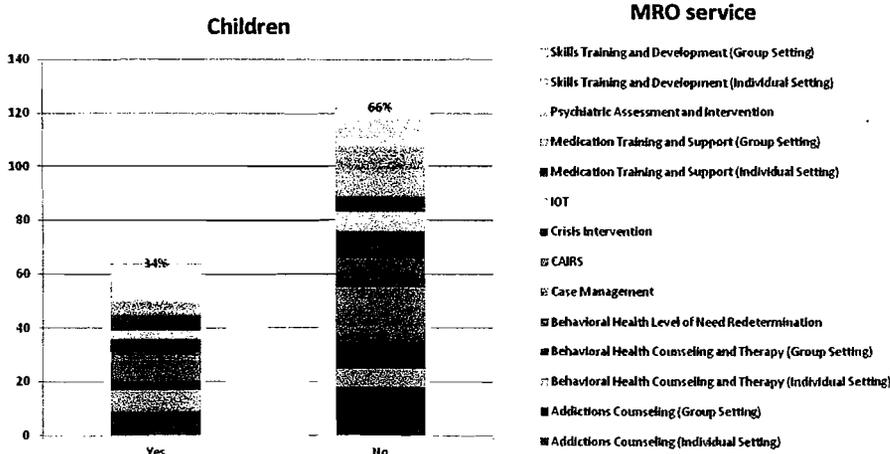
Of all responses, only 14% indicated that the MRO system is better or much better than before; 54% of responses indicated it was worse or much worse.

How well does the current MRO system serve your consumers vs. the previous MRO system (prior to July 1, 2010)?



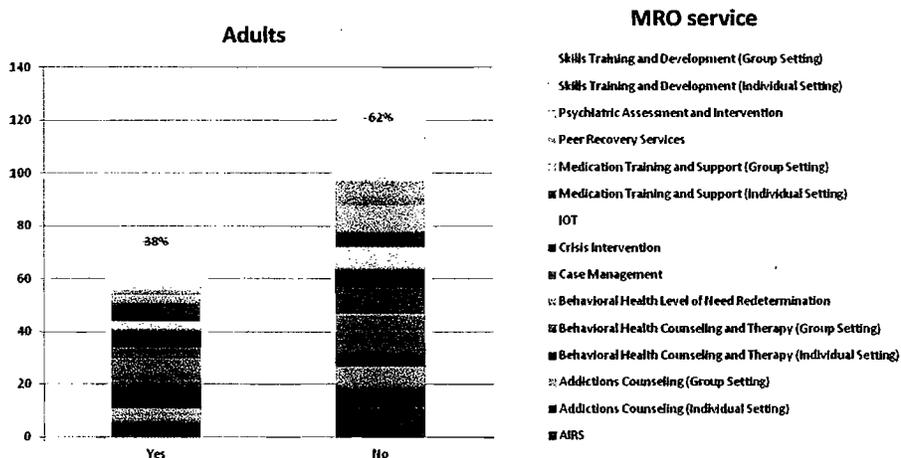
There was a very similar picture for adults—14% were better or much better; 57% thought were worse or much worse.

Does the current MRO service reimbursement cover the cost of the service delivery?



66% of responses indicated that the MRO service reimbursement did not cover the cost of the service for children.

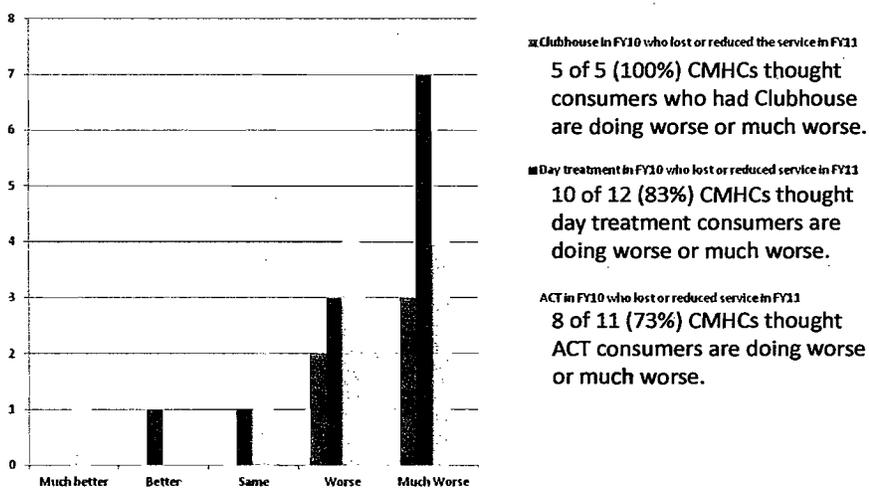
Does the current MRO service reimbursement cover the cost of the service delivery?



There were similar findings in adults. Cost reimbursement is likely a contributing factor to the generally poor perception of MRO changes noted in the previous slides.

How well does the current MRO system serve your consumers vs. the previous MRO system (prior to July 1, 2010)?

Consumer impact based on programmatic changes



CMHC Experience with ACT

- ACT
 - We had to downsize the size of the team from 90 to 55
 - We lost one million due to no ACT per diem
 - We made up 700,000 due to MRO rate changes
 - Net loss on ACT 300,000
 - Psychiatric Assessment and Training- intended for morning meeting but cannot bill do to fidelity issues
 - For clients moved off ACT average days hospitalized went from 1.5 to 4.5 days

Impact on Consumers

- Clients are unhappy at reduction of psycho-social programs (Recovery Centers) and groups. We continue to provide regardless of funding
- Former ACT clients are not doing as well, hospitalization rate higher We had to downsize ACT team (resulting in 9 individuals hospitalized that had not been hospitalized in years)
- We can no longer provide group services to Level of Need 4,5 Children due to poor rate, families see this as a loss
- We do not have as many peer support specialists as we would like (poor rate structure and delay in available training)
- We do have a hand full of clients that have high needs and are no longer eligible due to diagnosis (Traumatic Brain Injury)

Conclusions (cont.)

- Most Centers agree that the MRO changes have not improved services for children and adults at both lower and higher Levels of Need
- Most of the services were identified by the majority of Centers as having rates too low to meet the cost of delivery of that service, constraining the continuum of care able to be provided
- There is considerably more administrative cost due to the management of prior authorization and service packages. For example CMHC,
 - Added administrative positions to manage packages and pre authorization, looking up Medicaid eligibility etc (6)
 - Added supervisors (4)
 - Difficult and time consuming to get additional service packages approved- Average of 2.5 submissions before they are approved
- Evidence/Research Informed Practices such as Clubhouse, Groups and Assertive Community Treatment are no longer supported by current MRO rate

Recommendations

- Rates need to be adjusted to cover costs of programs
 - Engagement, clubhouse (psycho-social programs), ACT, Skills Training group, Peer Recovery Support, Family Peer Support
- Need to have a means to effectively bill Psycho-social Recovery Centers (Clubhouse Programs)
- Need to have training and support dollars for EBP
- Good and Modern System should be funded adequately
- Money saved in State hospital system could be used to support community/Recovery based programs

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Exhibit 4

Description of a Good and Modern Addictions and Mental Health Service System

Description of a Good and Modern Addictions and Mental Health Service System 1

Description of a Modern Addictions and Mental Health Service System..... 3

 Introduction..... 3

 Vision..... 3

 System Results..... 4

 Principles 4

 The Evidence 5

 Service Elements of a Mental Health and Addictions Service System 6

 Core Structures and Competencies for a Modern System 8

 Challenges..... 10

 Conclusion 10

Description of a Modern Addictions and Mental Health Service System

Introduction

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010—together referred to as “The Affordable Care Act (ACA)” recognizes that prevention, early intervention and when necessary, treatment of mental and substance use disorders are an integral part of improving and maintaining overall health. In articulating how these conditions should be addressed in a transformed and integrated system, SAMHSA must describe what services are included in a modern addiction and mental health system in order to clarify the roles and responsibilities associated with its structure, financing and operation.

As outlined in this brief, a modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective. It is a public health asset that improves the lives of Americans and lengthens their lifespan.

This document is designed to describe the basic services required for such a system and foster discussion among the Department of Health and Human Service Operating Divisions and other federal agencies on how best to integrate mental and substance use disorders into the health reform implementation agenda. This document can provide clarity to federal agencies that regulate or purchase services for individuals with mental and substance use disorders; offer guidance to agencies that are presently making decisions about expanding services to these populations; and assist in planning possible changes to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Mental Health Services Block Grant. It will assist SAMHSA to implement its strategic initiatives including supporting military families, prevention, housing and homelessness, and workforce development.

Vision

The vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. The goal of a “good” and “modern” system of care is to provide a full range of high quality services to meet the range of age, gender, cultural and other needs presented. The interventions that are used in a good system should reflect the knowledge and technology that are available as part of modern medicine and include evidenced-informed practice; the system should recognize the critical connection between primary and specialty care and the key role of community supports with linkage to housing, employment, etc. A good system should also promote healthy behaviors and lifestyles, a primary driver of health outcomes.

This vision recognizes that the U.S. health system includes publicly and privately funded organizations and managed care components that must work well together to produce desired outcomes. The integration of primary care, mental health and addiction services must be an integral part of the vision. Mental health and addiction services need to be integrated into health centers and primary care practice settings where most individuals seek health care. In addition, primary care should be available within organizations that provide mental health and addiction services, especially for those individuals with significant behavioral health issues who tend to view these organizations as their health homes. Providing integrated primary care and behavioral health services will allow for cost effective management of co-morbid conditions.

System Results

In order to accomplish the vision, SAMHSA will be committed over time to achieving the following system results:

- People avoid illnesses that can be prevented
- People get well and stay well.
- A continuum of services benefit package, within available funding, that supports recovery and resilience, including prevention and early intervention services, an emphasis on cost-effective, evidence-based and best practice service approaches, with special consideration for service delivery to rural and frontier area and to other traditionally un-served and underserved populations, like populations of color.
- A system that integrates high quality medication management and psychosocial interventions, including supports for community living, so that all are available to consumers as their conditions indicate. Services are available and provided in the appropriate “therapeutic dose”.
- Promoting program standards, including common service definitions, utilization management measurements/criteria, quality requirements, system performance expectations, and consumer/family/youth outcomes.
- Creation and maintenance of an adequate number and distribution of appropriately credentialed and competent primary care and behavioral health care providers.
- Local systems of care in which primary care and behavioral health providers and practitioners care are aligned with one another and with other systems.
- High organizational capacity in all service sectors to access, interpret, and apply performance data and research findings on an ongoing basis to improve care.
Funding strategies that will be sufficiently flexible to promote efficiency; control costs; and pay for performance
- Creation of an adequate number and distribution of appropriately credentialed and competent primary care and behavioral health care providers.

Principles

A good and modern mental health and substance use system should be designed and implemented using a set of principles that emphasizes behavioral health as an essential part of overall health in which prevention works, treatment is effective and people recover. These principles should apply to the provision of mental health and addiction services and cross the lifespan of individuals who need and use these services. At a minimum, these principles should recognize that:

- Preventing and treating mental and substance use disorders is integral to overall health.
- Services shown to be effective must be available to address current health and behavioral health disparities and be relevant to, and respond to, the diverse cultures and languages of individuals and families.
- A wide range of effective services and supports should be available based on a range of acuity, disability, engagement levels and consumer preferences. The consumer's resilience and recovery goals in their individualized service plan should dictate the services provided.
- The system should use information and science to deliver services. Services should be provided in convenient locations in order to reduce barriers, identify needs as early as possible, and engage individuals in care as early and as easily as possible.
- Wherever possible, the health system should support shared decision making with adult consumers, with youth and with families.
- Effective care management that promotes independence and resilience is key to coordinating health and specialty care.
- Service delivery must achieve high quality standards and results as well as outcomes that are measurable and are measured.
- Technology will be an important tool in delivering services. This includes telehealth, web-based applications and personal digital assistants that assist individuals in their recovery. Increased use of technology will expand access to and coordinate care rather than always relying on location-based service delivery.
- Services that are proven effective or show promise of working will be funded and should be brought to scale; ineffective services and treatments that have not shown promise will not be funded.

The Evidence

The system should be guided by principles and evidence that mental illness and substance abuse prevention, treatment, and recovery and resiliency-based services work. Over the past thirty years the body of evidence supporting what systems should provide, and for whom, has evolved significantly. While the list of evidence is voluminous, there are several hallmark programs and research efforts that have shaped effective practice. These programs and efforts include: the Comprehensive Community Mental Health Services Program for Children and Families and the Community Support Program (CSP); the National Quality Forum's Standards of Care for Treatment of Substance Use Disorders. Various Institute of Medicine (IOM) reports, including "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities"; and "Improving the Quality of Health Care for Mental and Substance Use Conditions: the U.S. Preventive Services Task Force (USPSTF); and several Surgeon General Reports, including "Mental Health: A Report of the Surgeon General" and "Mental Health: Culture, Race and Ethnicity". These reports, as well as others, continue to document the effectiveness of treatment for and prevention of mental health and substance use disorders. SAMHSA will issue a companion document detailing research on service effectiveness and its application to the services in the continuum of care.

Service Elements of a Mental Health and Addictions Service System

The system should include activities and services that go beyond traditional interventions such as the current acute care residential or outpatient services. Coordination, communication, and linkage with primary care can no longer be optional given the prevalence of co-morbid health, mental health and substance use disorders.

The good and modern system must incorporate the different functions that are performed within various parts of the mental health and addiction delivery system. General hospitals, state mental health hospitals, community mental health centers, psychiatric/psychosocial rehabilitation center, child guidance centers, private acute inpatient treatment facilities, licensed addiction agencies, opioid treatment providers, individually licensed practitioners, primary care practitioners, recovery and peer organizations all have key roles in delivering mental health and substance use services. Health care reform will push the specialty system to coordinate care among providers of different levels and modalities of care and the mainstream health care delivery system, especially for children and youth, for whom many of the services are provided outside of the specialty mental health and addiction treatment delivery system, requiring linkages with education, child welfare or juvenile justice systems.

A small percentage of adults with serious mental illness and children with serious emotional disturbances consume a majority of resources. An integrated system should develop improved strategies for these individuals who may be underserved or poorly served in the current system. Strategies should be consistent with provisions in the health care reform bill that seek to develop special needs plans, health homes and accountable care organizations.

An array of services must be designed to incorporate the concept of community integration and social inclusion for individuals/families. Community integration ensures that people with behavioral health problems, disabilities and other chronic illnesses have the supports and services they need to live in a home/family/community setting. This includes services to help people live in housing of their choice and support them in school, work, families and other important relationships; both paid and unpaid community supports can help achieve these goals. This will require public purchasers to take a comprehensive look at how its policies impact the way urban, rural and frontier areas develop and how well those places support the people who live there, in all aspects of their lives—education, health, housing, employment, and transportation. This “place-based” approach should be taken to help communities work better for people.

Discussed below are the service elements that should comprise a mental health and substance use system.

Health Promotion. Health promotion is a significant component of a comprehensive prevention and wellness plan, and plays a key role in efforts to prevent substance abuse and mental illness. Since health promotion efforts have been traditionally community- and school-based in the public sector, there is an opportunity to engage the private sector (particularly employers and insurers) in health promotion initiatives.

Prevention. The field of prevention science, well known for advancing the health of people at risk for illnesses such as cancer, diabetes, and heart disease, has also produced effective strategies for the mental health and substance abuse fields. The system must have three levels of prevention practice: Universal, which addresses populations at large; selective, which targets groups or individuals who are

at higher risk of developing a substance abuse problem or mental illness; and indicated , which addresses individuals with early symptoms or behaviors that are precursors for disorder but are not yet diagnosable. Prevention efforts can support safer schools and communities, better health outcomes, and increased productivity. Prevention science tells us that a comprehensive approach to a particular problem or behavior is an effective way to achieve the desired permanent behavioral or normative change. Health reform recognizes that prevention is a critical element in bending the cost curve and in improving the overall health of all Americans. All health-related prevention efforts should recognize and address the interrelated impact of mental health and substance use on overall well-being.

Significantly increased focus should be placed on promoting prevention prepared communities as proposed by the Office of National Drug Control Policy. Prevention programs should be made available to all individuals through appropriate channels including healthcare providers, media, employers, public agencies, communities, and schools. SAMHSA should continue efforts to identify effective prevention services that can be feasibly implemented in community settings, as well as clearly defined, coded and reimbursed.

Screening and Early Intervention. Appropriate screening should be vetted with the USPSTF so that it becomes part of the standard benefit plan and is available without cost to consumers. Screening services must include, at a minimum, services from the A and B list developed by the USPSTF which includes depression screening and Screening, Brief Intervention and Referral to Treatment (SBIRT) for alcohol use. Services should also include mental and substance use screens available through Early and Periodic Screening Diagnosis and Treatment (EPSDT). Screening may also be used to identify warning signs for suicide to enable early intervention and suicide prevention.

Care Management. Effective care management integrates primary care and specialty health services through approaches that coordinate an individual's medical care and provide assistance in navigating other healthcare providers and systems, including behavioral health. Different designs need to be considered that will include components of specific models (such as intensive case management or community support) since it is not likely that a "one size" fits all care management model exists. Regardless of the approach, individuals performing care management must be well trained and appropriately paid and reimbursement systems/strategies must recognize the importance of collateral contacts.

Self Help and Mutual Support. Self/mutual help support groups have been defined as a network of 12-step and abstinence-based groups for persons recovering from various addictions, as well as groups for family members of people with substance use disorders. In recent years support groups specifically for individuals with serious mental illness have grown significantly, as have 'family to family' and 'youth to youth' efforts. These groups provide a social network offering their members: support in managing their lives, role models and the strong belief that they can recover. These voluntary supports will continue be needed in a good and modern system that creates strong relationships with self-help and mutual supports.

Proposed Continuum of Services. A modern mental health and addiction system should have prevention, treatment and recovery support services available both on a stand-alone and integrated basis with primary care and should be provided by appropriate organizations and in other relevant community settings. SAMHSA's proposed continuum comprises of nine domains, including:

- Health Homes
- Prevention and Wellness Services
- Engagement Services
- Outpatient and Medication Assisted Treatment
- Community Supports and Recovery Services
- Intensive Support Services
- Other Living Supports
- Out of Home Residential Services
- Acute Intensive Services

The last page of this document lists the services that should be considered for a modern mental health and addiction system using the vision and principles referenced earlier in this document. These services are not only for individuals with a mental or substance use disorder, but also support their families who are critical to achieving recovery and resiliency.

Core Structures and Competencies for a Modern System

While appropriate, quality services are a critical piece of constructing a modern behavioral health system, there will need to be capacity and infrastructures to ensure that individuals who seek services can access them successfully. Easy and open access to care for all individuals and families, at all points on the continuum of need for care, and through any service sector, will require further development of core structures and competencies, as described below.

Workforce. The modern system must have experienced and competent organizations with staff that can deliver the services described in the previous section. SAMHSA in conjunction with the Health Resources and Services Administration and provider associations will need to develop strategies for creating learning models to ensure the workforce has the information, supervision, technical assistance, and culturally relevant training to effectively implement improved practices. Recruitment and retention efforts will need to be enhanced, especially to increase the available pool of culturally, ethnically and racially diverse practitioners. Providers will need to embrace team-based care and collaboration with other systems as a way of doing business. Licensure requirements need to evolve and certification requirements need to be strengthened for those professions that do not currently require formal licensure. The workforce must also develop an improved ability to use technology to provide, manage and monitor quality care. In addition, SAMHSA and other federal partners must continue to advance the development and use of peer/family specialists and recovery organization staff to address the demand for mental health and addiction services. Four critical efforts loom large: (1) redeployment of the shrinking professional workforce to positions of consultation and oversight; (2) augmentation of the existing workforce to include trained family, youth and peer supports as part of the paid workforce; (3) a more concerted pre-professional training effort to prepare new frontline and professional providers for the modern delivery system that is consumer- and family-driven, youth-guided, recovery/resiliency-oriented and evidence-based; and (4) a robust continuing training effort to develop, enhance, and sustain providers' capacity to access, interpret, and apply performance data and research findings on an ongoing basis to improve care.

Empowered Health Care Consumers. Health care consumers/families will need information and tools to allow them to promote and reinforce their role as the center of the health care system. At a

minimum, this will include a system that supports health literacy, shared decision making, and strategies for individuals and families to direct their own care. Health literacy is the first building block of self-care and wellness. Shared decision making should become the standard of care for all treatment services. Participant direction of services allows individuals and their caregivers (when appropriate) to choose, supervise and in some instances, purchase the effective supports they need rather than relying on professionals to manage these supports. Health care consumers and families will also need access to user-friendly information on the effectiveness of available services in order that they may truly make informed health care decisions.

Information Technology. To achieve optimum individualized care, a modern health system should include a structure in which all holistic outcomes, measures and indicators of health are collected, stored and shared with the individual and all of those providers who are associated with care of the individual. To that end, interoperable, integrated electronic health records will be necessary, as will community-wide indicators of mental health and substance use disorders. This will be challenging given that many behavioral health providers have limited or no modern information technology and need resources to make this transition. Additionally, appropriate security mechanisms and informed consent should drive this system while taking into account protection of individual rights and support to ensure appropriate linkages to services.

Funding and Payment Strategies. In the public sector, individuals/families/youth with complex mental and substance use disorders receive services funded by federal, state, county and local funds. These multiple funding sources often result in a maze of eligibility, program and reporting specifications that create funding silos featuring complicated administrative requirements. If services are to be integrated, then dollars must be also intertwined. In the same way that Medicaid will be required to streamline eligibility and enrollment, the good and modern system must either blend or braid funds in support of comprehensive service provision for consumers, youth and families.

Health care payment reform is intended to align quality and cost and reinforce desired client and system outcomes. The ACA envisions a variety of new purchasing strategies, including episode-based payments, risk-based inpatient/outpatient bundled payments, shared savings, and financial consequences for “never events”. These changes in methodology and requirements will be restructured to support achievement of the outcomes associated with primary care and specialty care integration.

Quality and Performance Management. Quality improvement through the use of outcomes and performance measures is a cornerstone of the Affordable Care Act. It will be critical that SAMHSA clarify the outcome measures that help define a good system of care; use this information to shape programs and practices; and operationalize SAMHSA’s message of “a life in the community for everyone”. A renewed focus on quality will also help payers link performance improvement with payment while moving away from the current incentives to provide more care without evidence of improved outcomes.

Sustainable Practice Improvement . Key to a modern behavioral health system will be an ethic of—and standard operating procedures for—continuous practice improvement to incorporate new evidence and to ensure more accountability, with a focus on “practice-based evidence” as well as evidence-based practice. Standards being developed by national organizations can guide providers (agencies, group practices and individual practitioners) in their efforts to reshape their practice and to sustain changes over time.

Continued Partnerships. While the good and modern system focuses on the need for better integration of primary care and behavioral health, this does not supplant the continued need to work with other systems that serve individuals with mental and substance use disorders. Links between the good and modern system and the child welfare, criminal and juvenile justice, education and aging systems will be more critical than ever.

Challenges

There are many challenges to achieving a good and modern mental health and addiction system. While much progress has been made, stigma still exists regarding mental illness and substance use disorders. Policy makers and payers have limited knowledge and to some degree continued skepticism regarding the efficacy of available prevention strategies, treatments and approaches. Payers will continue to rely on risk based approaches to contain costs. It is imperative to ensure that special protections are in place to address issues regarding adverse selection. The workforce is graying and is struggling to develop adult learning models that can train staff on delivering evidenced based and promising practices. There are still significant boundary issues within and among the mental health, addiction, primary care and other social service systems. More permeable boundaries will need to be created.

Conclusion

The elements described in this document should serve as a starting place for discussion among the various policy-makers and stakeholders concerned about services, reimbursement and infrastructure. There will always be differences of what should be included in a modern mental health and addiction system. However, these differences need to be mediated immediately with an understanding that what is modern in 2011 will change in five, ten or twenty years.

Prevention (including Promotion)	Engagement Services	Outpatient Services	Medication Services	Community Support (Rehabilitative)	Other Supports (Habilitative)	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services
Screening, Brief Intervention and Referral to Treatment Brief Motivational Interviews Screening and Brief Intervention for Tobacco Cessation Parent Training Facilitated Referrals Relapse Prevention/ Wellness Recovery Support Warm line	<ul style="list-style-type: none"> Assessment Specialized Evaluations (psychological, Neurological) Service planning (including crisis planning) Consumer/Family education Outreach 	<ul style="list-style-type: none"> Individual Evidenced Based Therapies * Group therapy Family therapy Multi-family therapy Consultation to Caregivers 	<ul style="list-style-type: none"> Medication management Pharmacotherapy (including MAT) Laboratory services 	<ul style="list-style-type: none"> Parent/Caregiver Support Skill building (social, daily living, cognitive) Case Management Behavioral management Supported employment Permanent Supported housing Recovery housing Therapeutic mentoring Traditional healing services 	<ul style="list-style-type: none"> Personal Care Homemaker Respite Supported Education Transportation Assisted Living Services Recreational Services Interactive Communication Technology Devices Trained behavioral health interpreters 	<ul style="list-style-type: none"> Substance abuse intensive outpatient services Partial hospital Assertive community treatment Intensive home based treatment Multi-systemic therapy Intensive case management 	<ul style="list-style-type: none"> Crisis residential/stabilization Clinically Managed 24-Hour Care Clinically Managed Medium Intensity Care Adult Mental Health Residential Children’s Mental Health Residential Services Youth Substance Abuse Residential Services Therapeutic Foster Care 	<ul style="list-style-type: none"> Mobile crisis services Medically Monitored Intensive Inpatient Peer based crisis services Urgent care services 23 hour crisis stabilization service 24/7 Crisis Hotline Services

vities or services will need to be further defined in the next several months

COMH

Meeting 3

10-4-11

Exhibit 5

**PRESENTATION TO MENTAL HEALTH
COMMISSION**

October 4, 2011

Submitted by Deborah J. Daniels

On behalf of the

Criminal Code Review Research Team

Pew Center on the States/Council of State Governments

Public Safety/Justice Reinvestment Initiative

- **Early 2010:** Invitation from State officials
- **Spring 2010:** Pew/CSG due diligence
- **June 2010:** Creation of Steering Committee
- **July 28, 2010:** First meeting of Steering Committee
- **December 15, 2010:** Findings and recommendations

Findings (Partial List)

- **Significant increase** in people supervised on felony probation
 - 56% increase from 1999 to 2008
- **Significant increase** in probation revocations
 - 1999-2008: revocations increased from 25% to 34% of those sentenced to probation
 - Number of property and drug offenders revoked increased by 53% from 2005-2009

Findings (*continued*)

- **Significant resources invested** in proven substance abuse and mental health disorder treatment (in DOC)
 - Therapeutic Communities Program
 - Proven effective in reducing recidivism
 - 1,700 beds available but only 1,100 complete annually
 - Only 1% of those released in 2009 on Class D felony completed TC
 - Many D felonies are property and drug crimes; offenders often are substance abusers; sometimes co-occurring mental illness

Findings (*continued*)

- **Insufficient substance abuse treatment resources** available in the community
 - TC is most effective with community follow-up
 - 61% of responding probation departments rated service availability in community fair or poor
 - DMHA survey: in FY 2010, 16,686 of 35,027 total referrals originated with criminal justice system
 - Indiana has received \$4m/year for 3 years in federal Access to Recovery funding – but not targeted at likely re-offenders (high risk)

Recommendations Relating to Substance Abuse/MH Treatment

- **Create probation improvement fund** with savings from reductions in DOC commitments
 - **Purposes:**
 - Competitive grants to support **best practices**
 - **Incentive funding** for counties that reduce commitments, incl. probation revocations, to DOC
 - Support **coordination** of multiple probation departments, community corrections within a single county

Recommendations (*continued*)

- **Focus** probation supervision resources **on high-risk offenders**
 - Free up time by moving compliant probationers to non-reporting status
 - Focus more attention on higher risk offenders
- Hold probation violators **accountable** through (local) **swift and certain sanctions**
 - Avoid automatic default to revocation
 - Move more nimbly to enhance accountability
 - Free up space in jail used by those awaiting court hearings

Recommendations (*continued*)

- **Increase access to substance use treatment in the community and cognitive-behavioral therapy (i.e., Therapeutic Communities) in DOC and community**
 - Create **substance abuse grant program**
 - Achieve from portion of DOC savings
 - Focus on high-risk felony probationers w/high need for community-based treatment

Recommendations *(continued)*

- Increase number of inmates completing TC program in DOC
- Increase availability of follow-on cognitive-behavioral therapy in communities

Source/Amount of Funding

(Initial CSG Proposal)

- These and other recommendations would combine to **reduce number of persons serving time in DOC**
 - Remove requirement of nonsuspendability for second-time non-violent Class D felons
 - Use of best practices (BP) by probation staffs
 - Focus on reducing probation revocations through, e.g., swift and certain sanctions as well as BP
 - Increased use of cognitive-behavioral therapy and substance abuse treatment

Source/Amount of Funding

(Initial CSG Proposal, *continued*)

- A **portion of “Marginal savings”** (food, clothing, medical costs) from DOC population reduction would fund:
 - **Incentive fund** to reduce D felony commitments to DOC
 - **Probation improvement fund** (grants to fund collaboration, best practices)
 - Community-based **substance-abuse treatment**

Source/Amount of Funding

(Initial CSG Proposal, *continued*)

- Total amount of marginal savings anticipated based on data for FY 2012, 2013 and beyond
 - 2012: \$3.25 million
 - 2013: \$4.75 million
 - Future years: \$4.75 million per year

Source/Amount of Funding

(Initial CSG Proposal, *continued*)

- **Division of funds by category and FY**

(Based on projected savings due to reduced DOC pop.)

<u>Fund</u>	<u>2012</u>	<u>2013+</u>
<i>Incentive fund (reduced DOC commitments)</i>	\$750K	\$1m
<i>Prob. Improvement</i>	\$500K	\$750K
<i>Comm.-based substance abuse treatment</i>	\$2m	\$3m

Additional Funding Proposed by SB 561, 2011

(As amended in Senate Committee)

- **New fees** to go 100% to counties:
 - New county deferral fee: \$15
 - New pretrial diversion fee: \$30
- **Uses** in order of priority:
 - Jail expense
 - Probation and community corrections programs
 - Problem solving courts and work release programs

Current Status

- **SB 561:** Not called for second reading in Senate (failed)
- **Companion bill** not introduced in House
- **Biennial budget:** No inclusion of proposed cost reallocation (shift) OR new fees
- **No legislative structure** created for achieving reductions in DOC population
 - Population reductions necessary to fund cost shift

- Questions?
- Comments?

Amendment to SB 561

Reference is to proposed amendment to SB 561 #14

Page 21, delete lines 22 through 40

Page 22, delete lines 1 through 29, and insert

SECTION 25. IC 11-13-2.7 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Chapter 2.7. Forensic Addiction Fund

Sec. 1. As used in this chapter, "fund" refers to the forensic addiction fund established by section 2 of this chapter.

Sec. 2. (a) The forensic addiction fund is established.

The fund shall be administered by the department.

(b) Sources of money for the fund consist of the following:

(1) Appropriations from the general assembly.

(2) Donations, gifts, and money received from any other source, including transfers from other funds or accounts.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested. Interest that accrues from these investments shall be deposited in the fund.

(e) Money in the fund at the end of a state fiscal year does not revert to the state general fund.

(f) Money in the fund is appropriated continuously for the purposes stated in section 3 of this chapter.

Sec. 3. (a) The department shall transfer money from the fund to the Division of Mental Health and Addiction to provide substance abuse treatment services for persons under court supervision diagnosed with a substance disorder or co-occurring disorder.

(b) The Division of Mental Health and Addiction shall consult with the Indiana Judicial Center and local probation departments to prioritize the allocation of treatment services.

(c) Mental health and substance abuse counseling provided under subsection (a) must be contracted with a certified mental health or addiction provider as determined by the Division of Mental Health and Addiction.

Sec. 4. The department shall adopt rules under IC 4-22-2 that are necessary to implement this chapter.

COMM

Meeting 3

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Exhibit 6

COMH
Meeting 3
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Exhibit 7




AssureRx Health, Inc.
A Personalized Medicine Company

GeneSightRx

**Commission on Mental Health and Addiction
State of Indiana**

October 4, 2011



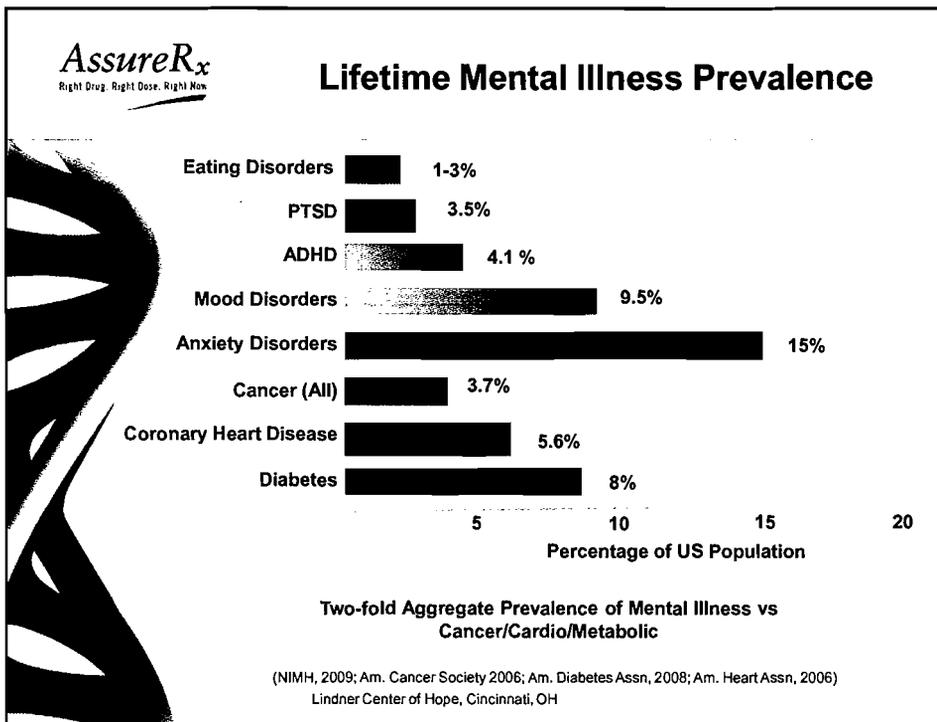

AssureRx Health Mission

Personalized medicine that combines proprietary software algorithms with targeted genetic analyses to help clinicians select the right drug and right dose for individual patients.

We focus on state-of-the-art pharmacogenetic and behavioral health clinical decision support tools to aid in the treatment of patients with neuropsychiatric disorders.

MAYO CLINIC


 **Cincinnati Children's**



Effective Psychiatric Medication Selection A Compelling Medical Need

#1 U.S. public health problem

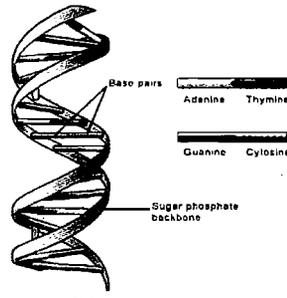
- **Biopsychiatry** 250M scrips/year
- **Prescribing** Empiric – trial & error
- **Toxic Drugs** Black box warnings
- **Polypharmacy** Overlapping Symptoms
- **Genetic variability** High for drug response
- **Non-responders** 50% - 75%
- **Addressable Market** \$2-3 Billion

Ineffective treatment, ADRs, Crushing Costs

AssureRx
Right Drug. Right Dose. Right Now.

Pharmacogenetic Testing

How a person's individual DNA affects their response to medication



Individual genetic variants influence each patient's ability to metabolize and respond to psychiatric medications

AssureRx
Right Drug. Right Dose. Right Now.

Personalized Medicine and Information Technology

Where Information Technology Intersects Medicine

Medical Informatics
+
Pharmacogenetic (PGx) Testing
↓
Individualized Disease Treatment
Focused on Neuropsychiatric Disorders

AssureRx
Right Drug. Right Dose. Right Now.

GeneSightRx® Treatment-Support Solution for Medication Selection

e-Test Ordered



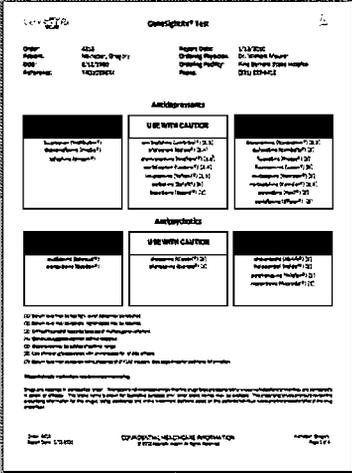
PGx Sample



Proprietary Algorithm



Web-Based Patient Report



AssureRx
Right Drug. Right Dose. Right Now.

GeneSightRx®: 2011-2012

- **6 Genes** (~ 140 peer reviewed publications)
 - CYP2D6
 - CYP2C19
 - CYP1A2
 - CYP2C9
 - HTR2A
 - SLC6A4
- **26-30 Drugs** (95+% of scripts)
 - Antidepressants
 - Antipsychotics
- **Non-genetic factors**
- **Drug-drug interactions**

➔

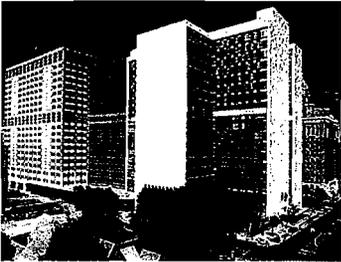
50 Variants

~ 1,300 Composite Phenotypes

~ 40,000 Drug Calls

AssureRx
Right Drug, Right Dose, Right Now

Mayo Clinic and Cincinnati Children's Experience & Technology



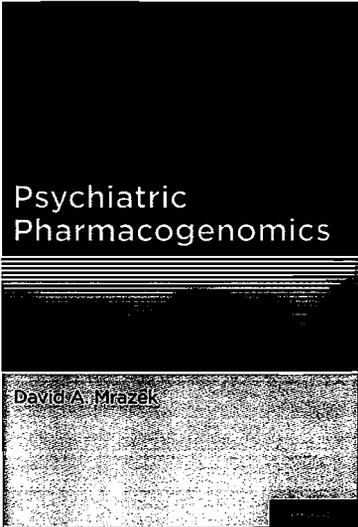
- Patent-pending technology
- >5,000 patients genotyped
- "Gene Team" expertise
- Routine clinical use



- Patent-pending technology
- >7,000 patients genotyped
- Standard-of-care
- Genetic and non-genetic factors
- Drug-drug interactions

AssureRx
Right Drug, Right Dose, Right Now

Clinical Studies & Publications to Build Adoption



Psychiatric Pharmacogenomics
David A. Mrazek

Evidence From Clinical & Economic Studies

- Mrazek Psychiatric PGx Text
- Geriatric Psychiatry Text
- Retrospective Studies
- Prospective Clinical Studies
- Practice Improvement Studies
- Patient Case Studies
- ARx Validation Demographics
- Pharmacoeconomic Analyses

AssureRx
Right Drug. Right Dose. Right Now.

Examples of Responses to GeneSightRx® Profiles

- It was all effortless and very impressive. The results... are completely consistent with the patients clinical history (none of which you were given).
- Mother called crying that her son was on the right medications after 10 years of psychotic episodes.
- “OMG” email from a patient experiencing a dramatic therapeutic response to an antidepressant for the first time after years of treatment.
- A treatment-resistant patient with MDD and OCD lost his job and nearly his marriage – PGx would have prevented years of untreated symptoms, emotional distress, and financial loss.

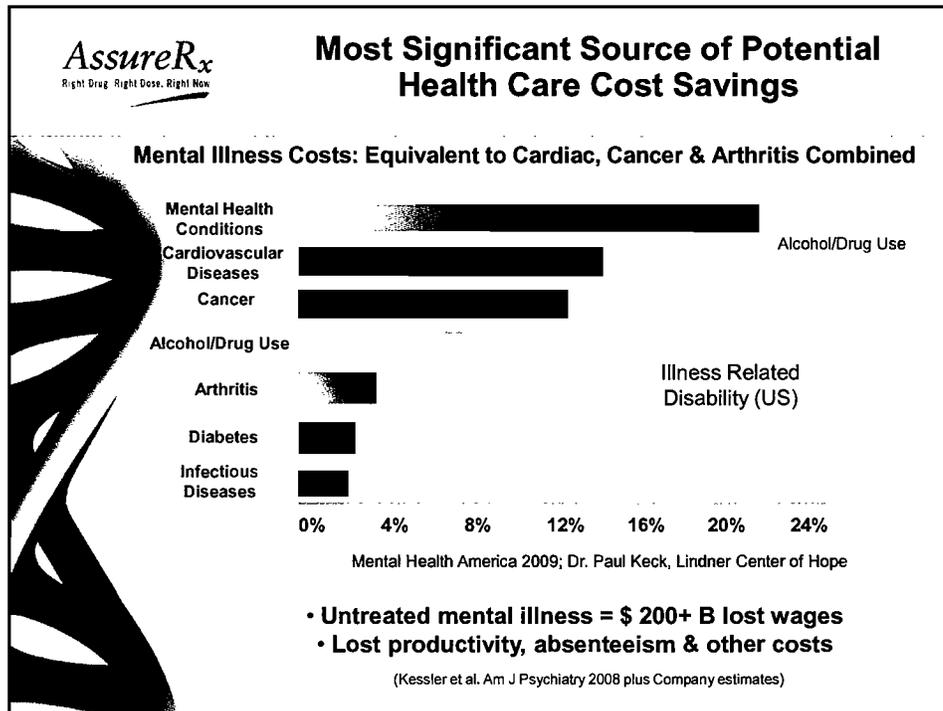
AssureRx
Right Drug. Right Dose. Right Now.

Psychiatric Practice Improvement Outcomes

PGx-Directed Improvement of 44% for “Red Bin” Patients

Percent Change in Symptom Score by Initial Medication Category

Initial Medication Category	Percent Change in Symptom Score
Use as Directed	9.1
Use With Caution	12.3
Use With Caution and More Frequent Monitoring	44.2



-
- ### Compelling Clinical Rationale
- Actionable evidence-based treatment product
 - Clinically significant in reducing ADRs
 - Focused on behavioral health patients
 - Huge market, compelling need, commercialized
 - Medical informatics with genetic content
 - Validated science; extensive clinical experience
 - Cincinnati Children's, Mayo research partners
 - Cost effective and reimbursable

AssureRx
Right Drug. Right Dose. Right Now.



AssureRx Health, Inc.

Right Product.
Right Market.
Right Time.

www.assurerxhealth.com



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Exhibit 8

MEDICAID ACCESS TO MENTAL HEALTH DRUGS

October 4, 2011

Commission on Mental Health & Addiction

Office of Medicaid Policy and Planning





Collaborative Quality Oversight

OMPP and the Mental Health Quality Advisory Committee (MHQAC)

- Appropriate use of antipsychotic medications in children and adolescents
- Prescriber outreach and education
- MHQAC utilization edit changes
- Prior Authorization (PA) statistics
- Implementation of PA requirements for brand medically necessary mental health drug prescriptions



Appropriate use of antipsychotic medications in children and adolescents

Directed Medicaid Medical Advisory Cabinet (MMAC) to update past national study which examined the use of antipsychotics in children and adolescents and to focus research on Indiana Medicaid specific data.

- Initial study published in 2010 by Rutgers in collaboration with the Medicaid Medical Directors Learning Network (2004 – 2007)
- Key findings suggest improving pediatric mental health treatment and outcomes in Medicaid have the potential for considerable public health impact, such as:
 - % of the pediatric FFS population receiving antipsychotic medications
 - Outlier utilization in specific populations (e.g., foster children)
 - Changes in utilization trends in the Medicaid population
 - Utilization patterns in Indiana Medicaid as compared to other State programs.



Appropriate use of antipsychotic medications in children and adolescents

- MMAC will incorporate changes to the Indiana Medicaid program and additional data specific to Indiana:
 - Addition of quality edits (2007)
 - Implementation of utilization edits & quantity limits (2007)
 - Implementation of Smart PA (2009)
 - Consolidation of Medicaid Pharmacy Benefit (2010)
- Intent of study is to:
 - Translate national study results to Indiana specific experience and data.
 - Gain clearer understanding of Indiana Medicaid population to inform future policy.
 - Improved prescribing guidelines
 - Reduction in adverse patient events
 - Reduction in overutilization, waste and Medicaid expenditures
 - Improved health outcomes



Prescriber outreach and education

- Recommended to the Drug Utilization Review (DUR) Board a Retrospective Drug Utilization Review (RetroDUR) focusing on the appropriate use of antipsychotic medication in children and adolescents.
 - RetroDUR is federally required educational intervention to prescribers.
 - The DUR Board directed the adoption of the RetroDUR and execution will occur over the next 18 months.
- The expected outcomes of the RetroDUR are:
 - improved prescribing,
 - appropriate utilization and
 - positive treatment outcomes.



MHQAC utilization edit changes

- Utilization edits are policies to establish appropriate utilization standards.
- Development of utilization edits are part of the duties assigned to the MHQAC.
- Five new utilization edits have been developed by clinical experts to address new drug products.
- Edits will be considered for approval by MHQAC and DUR board in October.



Prior Authorization (PA) statistics

- PA statistics are reviewed in order to:
 - measure the impact and effectiveness of the MHQAC edits.
 - identify potential issues or burdens to providers or members.
- Statistics covering the period of January - June 2011 are being compiled and will be presented to the MHQAC at the October meeting.
- PA statistics are presented every 6 months.

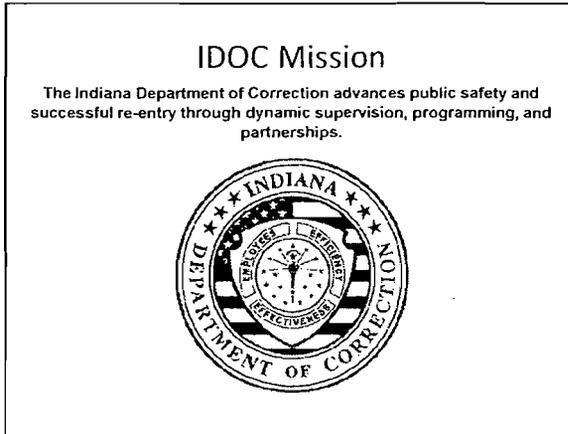


Implementation of PA requirements for brand medically necessary mental health drug prescriptions

- Budget bill (Sec. 145) allowed PA for a prescriber's indication of "brand medically necessary" for A-rated, therapeutically equivalent generic drug products for brand name drug products within the mental health drug classes.
- This change allows mental health drug classes to be treated in the same manner as all other drug classes have been managed since 2001.
- Implemented July 1, 2011 with minimal member or provider complaints for mental health medications. In the first two months following implementation:
 - 150 PA requests were made for brand medically necessary drugs with a mental health indication.
 - The PA denial rate for these requests was 6%.



QUESTIONS?



Overview

- 5.1 Million Adults in Indiana, 2010 census
- IDOC Total Adult Population: 28,082
- 2010 Adult Admission: 15, 429
- 2010 Adult Release: 19,845
- Return for a new charge: 50.7%
- Recidivism rate: 39.3%

Mental Health Numbers

- Adults with a Mental Health Diagnosis
 - Female 439
 - Male 3736
 - Total= 4175
- Adults on Mental Health Medications
 - Female 271
 - Male 2248
 - Total= 2519

MH Increase

- Increase in the number of offenders with Mental Health needs being released from Prison.
- Mentally ill offenders tend to have a higher rate of return than non-mentally ill offenders.
 - Between 3.5% and 6.3% for the 2007-2009 time frame.

Transfer of Medical Records

- Transfer of medical records from county jails to IDOC
- Electronic Medical Records (EMR) has assisted in the successful transfer of records from DOC to community health providers.
- In instances where records have not been sent our medical staff has been able to remedy the situation.

Medicaid for Inmates Leaving DOC

- In 2006, DOC entered into an MOU with FSSA to assist in providing transitional services for offenders soon to be released who qualified for Medicaid.
- Currently working with FSSA to refashion a new MOU which reflects the current electronic system.
- FSSA is providing training for casework managers to assist in processing new cases.

IDOC Mental Health Goals:

- To promote programs that insure a high level of treatment and care in the community. This permits those with mental health needs to remain in the community.
- Through existing partnerships with communities, family, other agencies and advocates promote a teamwork approach to resolving individual offender mental health issues while in the Indiana correctional system.
- Seek partnerships with communities, other agencies and advocates to better ensure that the transition into community for those offenders with mental illness is sound and safe.

House Enrolled Act 1437

Indiana Code 11-8-2-8

House Enrolled Act 1437 passed by the 2004 session of the Indiana General Assembly requires training for law enforcement personnel, jail officers, probation officers, and correctional employees who interact with persons with mental illness, addictive disorders, mental retardation and developmental disabilities.

The Department of Correction (DOC) is required to provide six (6) hours of this training (IC 11-8-2-8) to be taught by persons approved by the Secretary of the Indiana Family and Social Services Administration (FSSA), using teaching methods approved by the Secretary and the DOC Commissioner.

Pre-service Training

All newly hired employees receive the following training during their respective Pre-service Academy (Institutions / Parole). This training is completed prior to supervising any offenders.

- Working with Special Needs Offenders (3.0 hrs)
 - Substance Abuse (3.0hrs)
 - Suicide Prevention Intervention (2.0hrs)
- ❖ These modules are taught in a traditional classroom setting.

Annual Training

Each year (July – June FY) all employees are required to complete the following Annual Inservice training.

- Special Needs Offenders
- Substance Abuse

Additionally, staff may elect to complete the following course:

- Antisocial Personality Disorder
- ❖ These programs are Computer Based Training Modules.

Specialized Training

In 2010, the Indiana Department of Correction collaborated with Correctional Medical Services (Corizon) to develop three (3) specialized training programs for working with mentally ill offenders.

- Affective Interactions with Mentally Ill
- Basics of Mental Illness
- Communicating with the Mentally Ill

Suicide Prevention Intervention

In 2009, the Indiana Department of Correction collaborated with Correctional Medical Services (Corizon) to develop Suicide Prevention Intervention training for all staff.

Additionally, Corizon conducted two (2) Train the Trainer programs to train Corizon and DOC staff to present this program.

Suicide Rate Statistics

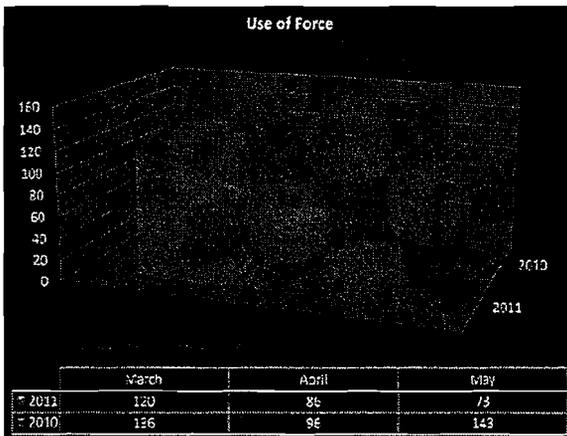
- Indiana male suicide rate 19.81 per 100,000.
- National prison suicide rate is 16 per 100,000.
- Indiana prison suicide rate 10.98 per 100,000.

The Indiana Justice Model Crisis Intervention Team (CIT) Training Curriculum

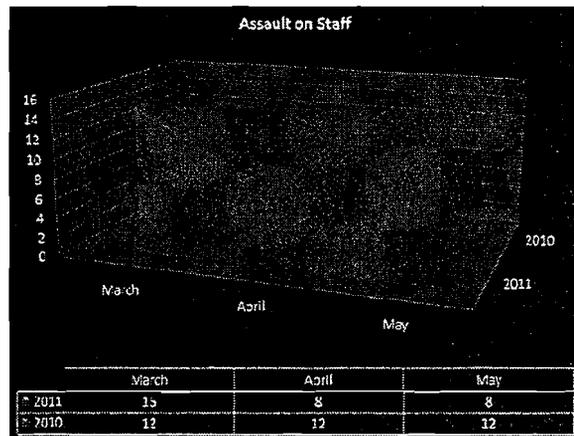
The curriculum consists of:

- Indiana Justice Model 101
 - Calm Down Form*
- Motivational Interviewing*
- Mental Health Training*
- Treatment Planning*
 - Multi-Subject*
 - Basics
- Use of Force Training*
- Indiana Justice Model 102

Use of Force



Assault on Staff





Mental Health Training (CIT)

The focus of this module of training is to increase staff knowledge and awareness of symptoms of mental illness. Further, staff will gain knowledge of medications used to treat mental illness, side effects of medications, crisis and de-escalation techniques effectively used to interact with and communicate with mentally ill offenders.

Use of Force Review Training (CIT)

At the conclusion of this module participants will be able to:

- Critically analyze and review video and incident reports of a "Use of Force".
- Participate in the review of video and incident reports in a Review Team meeting.
- Develop strategies for staff follow up and receive feedback on a "Use of Force" Report.
- Sustain a facility culture that has a focus on minimizing the Use of Force.

Treatment Team Training (CIT)

The Unit/Treatment Team has long been used as the key to developing the required treatment plans and making the essential classification decisions for each offender. A focus on the Unit/Treatment Team can provide much more. With the proper Team make up and development of creative strategies, the Treatment Team can become the focal point for changing offender behavior and impacting the facility culture. This model will examine the selection of Team members and the roles of the Team in managing offenders and the facility.