Indiana Behavioral Health Commission

Criminal Justice Interface Subgroup Meeting 4.30.21 (1:30 p.m. EDT)

https://www.in.gov/fssa/dmha/indiana-behavioral-health-commission/

Attendees:

Rachel Halleck, Jay Chaudhary, Steve McCaffrey, Sherriff Mike Nielsen, Dr. Christine Negendank, Dr. James Nossett, Katrina Norris, Chase Lyday, Ray Lay

Unable to Attend: Anthony Maze.

Subgroup Charge

This group will analyze the various systems that serve Hoosiers who are impacted by the criminal justice system. When the behavioral health system does not effectively prevent and treat people with mental illness and addiction, people end up in the criminal justice system. This group will examine those linkages and make recommendations. This group should coordinate with the Indiana Justice Reinvestment Advisory Council.

The Following Items Were Discussed:

1. Introductions, areas of expertise and interest
    a. J. Chaudhary advocated the intersection of behavioral health and criminal justice are ripe for change.

2. Review legislation and assessment areas for subgroup
    a. J. Chaudhary emphasized focusing on the cost of untreated mental health needs for this subgroup is a significant area.

3. Goals Discussion – two tracks of focus; 1) Broad areas for final reporting recommendations, 2) Identify specific ideas for early recommendations. What are the "if onlys" in your experience?
    a. C. Negendank – the ability to fund treatment in jails/prisons, focus on a seamless transition when released from detention; more subacute crisis intervention centers.
        i. Lack of communication, lack of funding, lack of maintenance of medication management when in detention.

ii. Use of subacute centers to divert individuals from being sent to detention.

b. M. Nielsen – discussed having 100 hours/week of mental health services on site (Boone County), 40 hours dedicated to institutional mental health needs.
    i. Funding preferred from the State, but had to seek County Council Funding.
        1. Funding is key, local funding also needs to be sought.
c. S. McCaffrey
    i. Recovery Works funding – the state can decide to use this funding while in jails.
        1. Historical reliance on Medicaid for funding, which can't be used in jails.
        2. Ohio example – don't terminate Medicaid while in jail, change policy type for institutional setting, when released, return to community-based policy.
        3. Kentucky – seeking 1115 waiver Medicaid reimbursement while incarcerated.
            a. Advocated for broadening scope of Recovery Works/Medicaid funds.
    ii. Advocated for treatment for misdemeanors as an approach.
d. J. Chaudhary – **Bucket #1**: improving access to behavioral health treatment while incarcerated.
    i. K. Norris – individuals with IDD and TBI, out of facilities due to additional harm/trauma.
    ii. R. Lay shared personal experience, what helped and didn't help through journey; now working as a Peer Recovery Support Specialist and how he approaches this work with others on their journey, emphasis on acceptance.
        1. Lived experience helps with engagement when going in to jails.
            a. J. Chaudhary – while engagement in jails has improved, there is a lot more work to do in this area.
e. J. Chaudhary – Look at Jail Intercept Model, what are areas of focus for Intercept Zero?
    i. C. Negendank – provide best possible care to avoid criminal justice system.
        1. Subacute, crisis intervention settings combined with mobile crisis teams
            a. Challenge – funding, grant based now, impermanent; staffing
            b. Challenge – crises by nature 24/7
            c. Support – use of telehealth
    ii. J. Chaudhary – reminder Crisis Subgroup, emphasis on suicide prevention also working on this area.
f. J. Chaudhary – What areas need to be considered for Intercept One?
    i. M. Nielsen
        1. CIT training for all law enforcement is critical.
        2. First Responders as Communications Officers to support culture change.
    ii. J. Chaudhary – thoughts on multi-disciplined approach to responding to crisis?
        1. M. Nielsen – concerns about having an armed police officer present if using other roles outside of law enforcement, want to avoid putting people in harm's way; once scene is cleared, assistance from someone to support would be helpful.
        2. J. Nossett – daily calls indicated as behavioral in need, rely on law enforcement for ensuring scene is safe to proceed with behavioral health work, focus on de-escalation progress in law enforcement.
            a. Colorado Springs - Community para-medicine/mobile integrated health care – multi-disciplinary mobile unit, grant funded, huge

impacts at diverting from detention, directing to behavioral health response.

3. J. Chaudhary possible pursuit with American Rescue Plan funding; need for radical collaboration = **Bucket #2.**
    a. Need for places to take individuals in addition to the response units.

iii. C. Negendank – emphasis on collaboration, need for top-down approach for culture change, mutual respect/collaboration.

1. J. Chaudhary – how can we make a recommendation to the state that encourages the culture of collaboration?
    a. Local JRACs will help
        i. K. Norris
            1. local JRACs (emphasis on rural community needs).
            2. Community education, data-driven, emphasis on cost, prevention.
        ii. J. Chaudhary – CIT for Intercept One, **Bucket #3.**
        iii. R. Lay – emphasis on need for collaboration; advocated for Stepping Up Initiative, Kahoots in Eugene, OR.
        iv. C. Negendank – need to start with being in same room, common understanding approach.

g. J. Chaudhary – Intercept 2/3 – issues with competency to stand trial, impacts on treatment and criminal case.

i. Barriers – access to state hospitals, fundamental system issues.

1. K. Norris – look at specialty court options to get individuals what they need, avoid jamming up the system.
    a. Individuals with organic brain needs, need for a more humanitarian approach.
    b. Community education, collaboration with prosecutors and law enforcement.
2. J. Chaudhary – people who need a civil commitment are impacted negatively.
3. C. Negendank – not everyone needs a state hospital bed, outpatient and jail-based approaches may avoid higher level of care.
    a. Different state approaches – IDD/TBI, released to outpatient care; timeframes for restoration, commitment orders impact on needs/treatment/medication.
        i. J. Chaudhary - DMHA will have a strong proposal on this for the commission to review and hopefully support.

h. J. Chaudhary – what is the perspective on juvenile-based needs/system?

i. C. Lyday

1. Challenge – lack of resources for a behavioral need.
2. Challenge – school-based resources reliant on Medicaid, need for services for others.
    a. Impact – referral for court-based services, requires arrest or do nothing if the arrest is too determinantal.
3. Advocated for a model that brings services to children pre-arrest.

ii. S. McCaffrey provided an example of a legislator experiencing being placed in system to obtain resources.
iii. **J. Chaudhary – advocated this area taking a deeper dive with the Children and Families subgroup; avoiding placing youths in the system to obtain resources**.
iv. C. Lyday advocated for a scalable model for the state to navigate with consistency.

i. J. Chaudhary – what other pressing items need to be discussed?
    i. S. McCaffrey – consider regional treatment centers for people who would otherwise be incarcerated.
        1. A need to address overcrowding in jails, jails are not mental health providers – alternative placement with security would be beneficial.
            a. Who owns? How funded?
            b. How do you provide appropriate mental health treatment for people who are a security risk?
        2. C. Negendank – MI, Center for Forensic Psychiatry, considered maximum security state hospital, treatment oriented.
            a. J. Chaudhary – concern about response of creating more institutional settings, need to consider more, **review 3 models for examples.**
        3. M. Nielsen – concept of regional jails has also been discussed, goes by the wayside; advocates jails not be responsible for mental health care if regional settings are pursued.
            a. New facility in process, focus on rehabilitation.

j. J. Chaudhary – gap in settings between state psych/incarceration and community-based treatment, explore in future meetings.
    i. R. Halleck – advocated for development of way to address attrition in compliance during transitions in levels of care, complex system navigation.
        1. Peer supports as a possible tool to address.
        2. Impact on families, generational lens.
        3. Emphasis on this approach may address need for additional facilities.
            a. J. Chaudhary – advocated a system approach where you feel like you're not going through things alone would be beneficial.
    ii. C. Negendank – other states CMHCs are tasked with providing treatment in jail system, positive impact on seamless transition needs, addresses recidivism needs.

4. Chair Leadership
    a. Opt out via email to Amy, Elaine, Rachel and/or Jay

5. Next Meeting – Friday, June 4, 2021 1:30pm-3pm (EST)

Buckets:

1) Improving access to treatment in jails

a. Peer component in the jails, available for transition in levels of care

2) Multi-disciplinary teamed response

a. Somewhere to take individuals that can respond to their needs
b. Crisis stabilization
c. Top-down approach – need everyone on board, behavioral health providers, law enforcement, cmhc's, collaboration-collaboration-collaboration – culture change
d. Legislation change – local JRAC's, state can help to encourage collaboration by education the community on cost analysis, data, and resources (rural specifically), investing in prevention and intervention is important – Katrina Norris.

3) Increase CIT training and other strategies for Intercept One

After meeting via email:

- R. Lay opted out
- K. Norris offered to co-chair, recommended the Just and Well document be reviewed and get a speaker from IDOC about their re-entry case management