Members

Sen. Patricia Miller, Chairperson
Sen. Lindel Hume
Rep. Steve Davisson
Rep. Charlie Brown
Kathleen O'Connell
Margie Payne
Ronda Ames
Valerie N. Markley
Bryan Lett
Caroline Doebbling
Kurt Carlson
Chris Taelman
Jane Horn
Rhonda Boyd-Alstott
Dr. Danita Johnson Hughes
Dr. Brenna McDonald

COMMISSION ON MENTAL HEALTH AND ADDICTION

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

LSA Staff:

Steven R. Wenning, Attorney for the Commission
Chris Baker, Fiscal Analyst for the Commission

Authority: IC 12-21-6.5

MEETING MINUTES[1]

Meeting Date:	**August 7, 2013**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., 431**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**1**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Lindel Hume; Margie Payne; Ronda Ames; Valerie N. Markley; Bryan Lett; Caroline Doebbling; Kurt Carlson; Chris Taelman; Rhonda Boyd-Alstott; Dr. Brenna McDonald; Jane Horn.**

Members Absent: **Rep. Charlie Brown; Rep. Steve Davisson; Kathleen O'Connell; Dr. Danita Johnson Hughes.**

Senator Patricia Miller called the meeting to order at 10:00 a.m.

Crisis Intervention Teams (CITs)

Lt. Tony Maze, Fort Wayne Police Department, provided the following information concerning the establishment of CITs in Ft. Wayne:

- Before CITs were formed a police officer's options for dealing with a mentally ill

[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.

individual were to get a 72 hour commitment or place the individual in jail.
- Ft. Wayne based their CIT on the model used in Memphis, Tennessee.
- There was an initial distrust of police officers by both people in the local community and mental health centers. Mental health center professionals had to learn to trust the police officer's assessment of what the officer observed in the individual's behavior.
- All entities dealing with the mentally ill in the area were brought together as the CITs were being formed. Different mental health centers saw their roles differently.
- The goal of the CITs was to get individuals proper treatment quickly.
- Mental health providers were concerned about receiving payment.
- The number of individuals with a mental illness who are arrested is down considerably.
- More individuals are receiving treatment and jail costs are down.

Lt. Maze stated the following in response to Commission questions:

- Ft. Wayne's CIT program has been working very well. People in other communities need to be made aware that this type of program can be created in their own communities.
- Training for the CIT program should be coordinated by the National Alliance on Mental Illness (NAMI) or the local law enforcement agency. Every agency and entity that is going to be involved in the CIT program needs to be involved in the training.
- The Ft. Wayne Police Department has a policy to not arrest mentally ill individuals who are charged with misdemeanors. Assessments of mentally ill individuals can take place in the field or at the jail.
- Ft. Wayne has a CIT trained officer on each shift. All hostage negotiators are CIT trained. Officers must volunteer to be trained. It takes extra patience and compassion to be an effective CIT officer.

Sgt. Robert Hipple, CIT Coordinator, Indianapolis Metropolitan Police Department, testified concerning the Indianapolis Metropolitan Police Department's (IMPD) experience with the CIT program:

- IMPD offers two CIT classes each year. Anyone who is involved with mentally individuals is invited to attend (e.g. probation officers, public defenders).
- The Indianapolis CIT program has made the community safer.
- The Buddying Program is a pre-crisis program that has allowed CIT trained officers to have frequent meetings with mentally ill individuals. The officer can share knowledge with an individual's therapist to get help if treatment is needed.
- The Buddying program uses fewer resources and the individual gets the help needed.
- The Indiana Law Enforcement Program recognizes NAMI provided CIT training for law enforcement credit.

Sgt. Hipple provided the following responses to Commission questions:

- Indianapolis's CIT training is open to law enforcement officers from other counties.
- There is no extra cost of the CIT program, it is just is a reallocation of existing resources.
- Five minutes of front-end intervention can save hours later.
- CIT officers receive information on incidents that need their attention from many different sources (e.g. Mayor's Action Line, mental health centers, other law

enforcement officers).

Marianne Halbert, National Alliance on Mental Illness (NAMI) of Indiana, described CIT training in Indiana:

- CIT training programs for law enforcement officers take about 40 hours.
- CIT training programs contain a diverse curriculum, including a review of applicable laws, de-escalation techniques, role playing situations, and presentations by health care providers.
- CITs are found mostly in Indiana's larger cities.
- The goal is to reach out to all 400 law enforcement agencies in the state to provide CIT training.
- The Department of Correction uses CIT training for its staff.

In response to questions by the Commission Ms. Halbert provided the following information:

- Some of the additional costs of a CIT program include the cost of pulling law enforcement officers from their shift and printing materials.
- A statewide CIT coordinator is needed, but it is the local community that needs to form the CIT since a team is formed from the resources available to that community.

Mike Woody, President, CIT International, provided a national perspective on CIT training, including the following information:

- The first national CIT conference was held in Ohio in 2005. Over 700 individuals from 42 states attended.
- Law enforcement officers lack training in proper techniques in how to defuse a situation with a mentally ill individual (e.g. body language, word choices). New recruits receive about 6 hours of training that covers all special needs populations. About 16 hours is needed. Ten percent of all police calls are mental health related.
- Training officers to be on a CIT is important, but it is the experience that helps CIT officers to become very good.
- Rural counties face a larger burden to send officers away for CIT training. NAMI of Ohio helps off set the cost incurred by rural police departments.
- The state of Virginia is rapidly expanding the use of CIT programs. A review of the essential elements of Virginia CIT programs can be found at: http://vacitcoalition.org.
- The key to the success of a local CIT program is that it is a partnership.

In response to questions by the Commission Mr. Woody stated the following:

- Full community training is required. This means including the mental health community, the police, conservation officers, security personnel at hospitals and universities, etc.
- Ohio spends about $190,000 per year for a state CIT coordinator and three staff positions.

Kurt Carlson, President & CEO, Otis R. Bowen Center for Human Services, distributed information on a rural model for CITs and a letter from the Chief of the Syracuse Police Department (Exhibit #1). His remarks included the following information:

- The Bowen Center has provided CIT training for seven years to over 300 people.
- The Bowen Center serves five primary counties and five secondary counties.
- The Bowen Center has developed a curriculum that trains CIT training for rural communities. A section was recently added concerning issues that face military personnel families.
- A training session may cost $5,000 for the cost of the presenters. There are additional costs faced by the organizations that sent people for training.

Michael Kempf, NAMI of Indiana, spoke about the challenges facing rural counties because of the limited availability of treatment options. If a rural police officer has to transport a mentally ill individual to an urban mental health center, the officer may be taken away from his community for his entire shift.

Joseph Vanable, NAMI of Indiana, stated that mental illness is a treatable condition. It is unlikely that an individual will improve while in jail. Placing the mentally ill in jails creates a 'revolving door' situation. Both incarceration and treatment have costs, but treatment can reduce the overall costs incurred by a community.

Children's Social, Emotional, and Behavioral Health Plan (529 Plan)

Stephen C. McCaffrey, President and Chief Executive Officer, Mental Health America of Indiana, provided background information concerning the 529 Plan and made policy recommendations for improving the plan:

- A traditional approach to treating the mentally ill was the crisis approach that offered treatment and services after a crisis had occurred.
- In 2005, SB 529 passed the Indiana General Assembly requiring the development of a children's social, emotional, and behavioral health plan that would be available from birth to 22 year of age. The goal of the plan was have an integrated interagency plan.
- The plan was developed in 2006 and it created several long term goals.
- An interagency task force, including the Division of Disability and Rehabilitative Services, should reexamine the plan and report back to the Commission on any needed changes.
- Better interagency integration would lead to better use of the money that is available.

Kevin Moore, Director, Division of Mental Health and Addiction (DMHA), presented an overview of the work done at DMHA to meet the goals of the 529 Plan (Exhibit #2):

- No single agency can accomplish all the goals of the 529 Plan by itself.
- DMHA has developed identification and assessment of mental health issue tools through the Child and Adolescent Needs and Strengths (CANS) tool and the creation of a suicide prevention plan.
- Access to treatment has been provided through a balanced service delivery system that includes community mental health centers (several are located in schools), state hospitals, psychiatric residential treatment facilities, and residential care.
- Access to treatment in the juvenile justice setting has remained a challenge.
- DMHA has coordinated provider services and interagency referral networks.
- DMHA and the Indiana State Department of Health are in a partnership with Project LAUNCH to create a safe and supportive environment for children who are entering school.
- DMHA has several programs to try to reduce the stigma associated with mental

illness, including a billboard campaign and the IN Youth MOVE program.

John Barnes, Director of Legislative Affairs, Indiana Department of Education, stated that the Indiana Department of Education (DOE) would encourage a reexamination of the 529 Plan. DOE would like to be part of any task force that looks at the issues in the 529 Plan. There has been a loss of institutional knowledge because many of the DOE employees who participated in the development of the initial plan are no longer working for DOE.

Joshua Sprunger, Executive Director, NAMI-Indiana, Connections to Care Workgroup, presented the following testimony:

- There is a need to create a statewide, evidence-based treatment system of care for youth who are identified with mental health disorders. The system must provide access for youth, be community based, provide for the best practices, and support cross-system collaboration of all child serving agencies.
- Should create a pilot program to plan a collaboration consortium for purchasing services for all children who receive services.
- One specific problem is that the 529 Plan lacks specific recommendations.
- Suicide rates are up in the juvenile justice system

Mark St. John, Indiana Family Network & Indiana Coalition for Human Services, supports efforts to review the 529 Plan and realign children's services.

Cathy Graham, Executive Director, Indiana Association of Residential Child Care Agencies, commended DMHA and the Indiana Department of Child Services for the work they have done together. She also thanked the General assembly for the extra funding that was provided in the budget.

Senator Miller adjourned the meeting at 12:05 p.m.

COMH 8/7/13
Exhibit #1

Commission on Mental Health and Addiction

August 7, 2013

Crisis Intervention Team (CIT)

RURAL MODEL

CIT Schedule
Days One and Two

	Tues. April 9, 2013	Wed. April 10, 2013
8:00-8:15	Welcome	Welcome
8:15-8:50	Big Mental Healthcare Picture Kurt Carlson, Bowen CEO	24 and 72 Hour Detentions Ron Clark, Bowen Center Senior Vice President
9:00-9:50	Overview of Behavioral Illness in America Richard Ruhrold Ph. D., HSPP	NAMI Todd Biller
10:00-10:50	Understanding Fetal Alcohol Syndrome Richard Ruhrold Ph. D., HSPP	Wall of Sound Todd Biller
11:00-11:50	ADHD Richard Ruhrold Ph. D., HSPP	Recovery and Skill Building Christina Bolden MA
12:00-1:00	Lunch Provided	Lunch Provided
1:00-1:50	Depression Richard Ruhrold Ph. D., HSPP	Cultural Diversity and Our Spanish Speaking Community Araceli Grant MSEd, LMHC, LCAC, LMHT
2:00-2:50	Bipolar Disorder Richard Ruhrold Ph. D., HSPP	Autism Spectrum Disorder With a Personal Perspective Bil Easly and Barb Heimbach
3:00-3:50	Schizophrenia Richard Ruhrold Ph. D., HSPP	Anti-Social Behavior Don Starke, MA, LMHC, LCAC
4:00-4:50		Family Violence in America Candace Tate, Psy. D.

CIT Schedule

Days Three and Four

	Thurs. April 11, 2013	Fri. April 12, 2013
8:00-8:15	Welcome	Welcome
8:15-8:50	"We're Here to Help" Tour of Inpatient Unit Huntter	Strategies for Working With Military Personnel and Their Families Jennifer Dyarman, MSW
9:00-9:50	Bowen 24 hr. IPU Huntter 9:30 HIPAA in Mental Health Joanne Mickley	Strategies for Working With Military Personnel and Their Families
10:00- 10:50	Mental Healthcare for the Geriatric Population Dan Carey M.Div., LCSW	Crisis Intervention for the Hospice Patient and Family Robert Jarboe, Mdiv.
11:00-11:50	Mental Healthcare For The Developmentally Disabled Brooke Carey Cardinal Services	Sexual Offenders Kevin Brown, MS, LMHC
12:00-1:00	Lunch at Wilson Castaldi Hosted by Wilson Castaldi and The Harbours	Lunch Provided
1:00-1:50		Drop In A Bucket Janet Shull, MA, LMHC, LCAC
2:00-2:50	Pharmacology of Addictive Substances Vicki Ley MA, MAC, LMHC, ICACII	QPR; Question, Persuade, Referal Suicide Prevention and Awareness Huntter Randall B.S.
3:00-3:50	Pharmacology of Addictive Substances Vicki Ley	Escape From Stress: A Balanced, Reenergizing Approach Siquilla Liebetrau, PsyD, LMHC
4:00-4:50	Self Mutilation Lisa Wooley Psy. D.HSPP	An Officer Speaks Tony Ciriello Syracuse Chief of Police

Rural CIT Model
Individuals Trained by Bowen Center

Police Chiefs
Police Officers
Town Marshalls
Sherriffs
Sherriffs Deputies
County Jail Personnel
College Security Officers
Hospital ER Staff
Other Hospital Staff
EMS Workers
High School Counselors
College Counselors
Probation Officers
MR/DD Facility Personnel
Juvenile Detention Facility Personnel
CASA Volunteers
American Red Cross Staff
Addiction Treatment Facility Staff
Shelter for Abused Women Staff

Rural CIT Model
Indiana Counties Trained by Bowen Center

Bowen Center Primary Counties

Kosciusko

Wabash

Huntington

Marshall

Whitley

Other Counties

St. Joseph

Miami

Jasper

Starke

DeKalb

Fulton

Polaski

Allen

Cass

Noble

Lagrange

SYRACUSE POLICE DEPARTMENT

310 N. HUNTINGTON STREET
SYRACUSE, IN 46567

TELEPHONE (574)457-5333 FAX (574)457-2106
WWW.SYRACUSEIN.ORG

Anthony W. Ciriello, Chief

Commission on Mental Health and Addiction

Chairperson Senator Patricia Miller and Distinct Members,

Please let me take a moment to introduce myself, I am Tony Ciriello and I am the Chief of Police for the Syracuse, Indiana Police Department. I have 32 years of law enforcement experience in a variety of roles to include patrol officer, investigator and administrator. The reason for my letter is to provide to you my views on Crisis Intervention and Training for law enforcement and first responders in general. While I was not able to be present with you during this hearing I authorize Mr. Kurt Carlson to share this letter with the committee for consideration as testimony.

As a municipal law enforcement administrator I feel very strongly about officers and other first responders being trained to recognize and deal with persons that are suffering from addictions and mental health problems. Most of the persons within these categories are often under recognized by first responders and are treated or incarcerated when other forms of assistance is needed or required. It is a known fact that training first responders in Crisis Intervention allows for a better diagnosis of a person in a situation to receive the help and treatment that is needed for their behavior.

In Kosciusko County, through the Bowen Center, we have researched numerous models of CIT, including the Memphis Model to provide training to our first responders. During our evaluation of these models we determined that most of them, especially the Memphis Model are good programs, however they address the issues in a large metropolitan setting and not in the rural setting where the vast majority of first responding law enforcement agencies are the norm. In Indiana the average police department employs 17 officers, some more and some less, having that in mind the ability to have numerous officers on duty at any given time is virtually impossible in order to have a team of officers trained in CIT to respond to a scene and deal with the pending situation. Most of the time only one officer is responding to a call for service within their jurisdiction and therefore must deal with the situation at hand without assistance.

Given this fact, with the assistance and backing of the Bowen Center and the cooperation of our law enforcement agencies we have developed a curriculum for rural CIT that we have been using for several years now to train first responders and others in some type of emergency care. Using the curriculum we have developed and by offering two trainings per year, we have trained law enforcement officers, emergency room personnel, EMS personnel, domestic violence shelter staff, CASA volunteers, corrections officers and as well as others, from at least 9 counties in CIT.

As a member of our CIT planning committee, since its inception I fully understand the importance of providing this type of training and our goals are to provide quality training to meet the needs of our rural locality. Our planning committee sets the curriculum we use, reevaluates our curriculum after each class, use student evaluations to judge the materials and delivery of the materials, utilize local experts in their respective fields as instructors and provide the opportunity for continuing education to those whom have been trained. Our local planning committee is made up of mental health experts, law enforcement and staff of the Bowen Center.

I cannot express in writing the value of and need for CIT in all communities, and I must emphasize that a Rural Model is the best model of CIT for Indiana communities. I would be honored and humbled to be able to speak with you at another time as a committee or individually regarding this topic. I thank you for allowing me to offer my insight into this very valuable discussion.

Anthony W. Ciriello, Chief
Syracuse Police Department

Mental Health Commission
August 7, 2013

Children's Social Emotional Behavioral Health Plan (529 plan)

I want to outline work done at DMHA that relates to the goals of the 529 plan. Some have been planned to fulfill the Plan; others have been done outside of the Plan but relate to it nonetheless.

- **Identification and assessment of mental health issues**
  - Adoption of the Child and Adolescent Needs and Strengths tool (CANS
    - Need for services
    - Intensity of services
    - Baseline for measuring improvement or new issues
    - Modules include assessing for trauma history and includes family/caretaker issues
    - Support for Early Childhood Mental Health Consultation
      - Clinician training
  - Created suicide prevention plan
- **Access to treatment**
  - Services across the continuum are vital to a balanced service delivery system
  - Includes CMHCs (several are in schools), residential, PRTF, and SOF
  - Support SOC development in 80 counties since early 2000's
  - Children's Mental Health Initiative
    - Partnership with DCS
  - DCS utilizing CMHCs as service providers to leverage federal Medicaid funds
  - CA-PRTF/Transition Waiver/MFP/1915I
    - Access sites for services
  - Coordination with BDDS for needed mental health services
  - Juvenile justice access remains a challenge
- **Coordinate provider services and interagency referral networks**
  - Collaboration with DCS
  - Partnership with ISDH with Project LAUNCH
    - Targets access to services for children 0-8 years old
  - Initiated fidelity for Wraparound Service delivery

- **State budget**
  - SED - $15m
  - Child Psychiatric Fund - $17m
  - Funds for state hospitals serving children
  - $6m in federal grants (Block grants, SAT-ED, SOC expansion)
  - Performance based contracts include measure of improvement for children
- **Stigma**
  - Recovery is Possible billboards
  - IN Youth MOVE
  - Re-alignment of prevention resources to address addiction and mental health issues across the life span
  - Certified Recovery Specialist training