Minutes
Commission on Improving the Status of Children in Indiana
November 18, 2015, 10:00 a.m. – 12:33 p.m.
Indiana Government Center South, Conference Room A

Members Present: Dr. Jerome Adams, Indiana State Health Commissioner, Indiana State Department of Health; Mary Beth Bonaventura, Director, Indiana Department of Child Services; Michael Dempsey, Director, Department of Correction, Division of Youth Services; Representative David Frizzell; Lilia Judson, Executive Director, Division of State Court Administration; Larry Landis, Executive Director, Public Defender Council; Senator Tim Lanane; Danielle McGrath, Deputy Chief of Staff for Legislative Affairs, Office of the Governor; David Powell, Executive Director, Indiana Prosecuting Attorneys Council; Representative Gail Riecken; Glenda Ritz, Superintendent of Public Instruction, Indiana Department of Education; Justice Loretta Rush, Chief Justice of Indiana.

1. Welcome and Opening Remarks. Danielle McGrath opened the meeting. She announced the Governor has established a bi-partisan Task Force on Drug Enforcement, Treatment, and Prevention to evaluate the growing drug problem in Indiana.

   The Task Force has held two meetings so far and have made eight recommendations for immediate action. The Governor has accepted the recommendations and made the following assignments: 1) the Family and Social Services Administration (FSSA) has been directed to examine the feasibility of pursuing the Section 1115 Medicaid waiver to allow Indiana to provide additional treatment services to Medicaid and the HIP populations; 2) agencies have been directed to raise awareness of Erin's Law; 3) the Department of Workforce Development (DWD) has been directed to expand youth assistance programming; 4) the Indiana State Department of Health (ISDH) has been directed to convene a working group to make recommendations on improvements to INSPECT, and to work with appropriate entities to develop acute pain prescribing guidelines; 5) the Professional Licensing Agency (PLA) has been directed to expedite the chronic pain prescribing rules; 6) ISDH has been directed to look at Deloxolone availability compared with overdose demographics; 7) the CISC has been asked to make recommendations on developing age appropriate substance abuse curricula for students; and, 8) the CISC has been asked to make recommendations on finding ways to better connect affected youth with substance abuse services.

2. Approval of Minutes from the August 19, 2015 meeting. The minutes from the August 19, 2015 meeting were approved.

3. Teen Suicide. Senator Breaux stated the topic of teen suicide was brought to her attention by one of her constituents. She requested an interim study committee to study the topic, which was ultimately assigned to the CISC Infant Mortality and Child Health Task Force. She reported suicide is the second leading cause of death among youth ages 15 to 24 in Indiana, and that Indiana has the nation's highest rate of high school students who consider suicide. While Indiana has several very progressive laws and the ISDH has developed an outstanding suicide prevention plan, there still exists fragmentation and silos in our approach to suicide, which ultimately underscore the need to address access to comprehensive mental health services and treatment. The data shows that the problem of teen suicide is complex and multifaceted, yet it is strongly correlated with mental health problems that may be present in a young person's life, such as teenage anxiety brought on by bullying, divorce of the parents, and sexual orientation. Senator Breaux stated she hopes the CISC will provide the direction and leadership that Indiana needs to tackle teen suicide with an effective, comprehensive, and holistic approach.

   Mindi Goodpaster, Director of Public Policy and Advocacy, Marion County Commission on Youth (MCCOY) presented on behalf of the CISC Infant Mortality and Child Health and Substance Abuse and Child Safety Task Forces. Both Task Forces have studied the topic of teen suicide. She reported Indiana has many

youth between the ages of 10 and 24 who are dying from suicide. Youth in our state are more likely than their peers nationally to have been treated by a medical professional because of a suicide attempt in the past year. Indiana has some data collection issues when it comes to understanding how many youth are dying by suicide and the different demographics of people in general who died by suicide. She reported white males in general are more likely to die by suicide than any other group within the state, and we need to know the reason behind it.

Ms. Goodpaster referred to trend data obtained from ISDH between 2006 and 2013. The data shows an upward trend in the number of youth dying by suicide. Many risk factors can lead to suicide, but no one factor is going to say definitively that a person might contemplate and take action. Some of the risk factors for suicide in general are: previous suicide attempts, a history of depression or other mental illness, alcohol or drug abuse, family history of suicide or violence, financial and relationship losses, lack of social support, physical illness, and feeling alone. Risk factors specific to teens and young adults include anxiety and depression, life changes such as parental divorce, moving, bullying, struggling to understand sexual orientation or gender identity, and physical, sexual, or emotional abuse. Protective factors to prevent suicide include problem solving and conflict resolution skills, strong family and community connections, access to effective clinical care for mental, physical, and substance use disorders, and lack of access to lethal suicide attempt methods. Barriers to prevention include stigma, insufficient numbers of qualified professionals, lack of awareness of community suicide prevention methods, lack of awareness of how to help individuals at risk, unwillingness of individuals to seek treatment, and the inability to afford treatment.

Ms. Goodpaster reviewed legislation from the past five years addressing suicide. She said Indiana ranks well among other states in offering suicide prevention training for some school personnel; however, it is not an annual requirement and it does not require training for all teachers. In terms of school district policies and programs on suicide prevention, Indiana does not require any policies or programs for dealing with suicide and suicide prevention in schools, including suicide prevention education for students. Indiana has many suicide prevention resources, including the State Suicide Prevention Advisory Committee, the State Suicide Prevention Regional Councils, the Indiana State Suicide Prevention Plan, and the Indiana Department of Education Resource page for teachers and schools. Additionally, Community Health Network has a Zero Suicide Prevention Initiative funded by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). She recommended this model be studied and considered for statewide implementation.

Ms. Goodpaster reviewed the Teen Suicide Prevention Report and Recommendations jointly prepared by the Infant Mortality and Child Health Task Force and the Substance Abuse and Child Safety Task Force. The recommendations of the Task Forces are as follows:

- Expand SEA-4 Suicide Prevention (2011) to require all teachers be trained in evidence-based suicide prevention and awareness, including a role-playing, skill-based component to demonstrate skill development.
- Incentivize training and education for more youth-serving professionals including child psychiatrists, psychologists, social workers, school counselors, and others and expand the workforce in rural areas.
- Ensure that all schools have a written policy and procedures covering suicide prevention, non-suicidal self-injury, suicide attempts, and suicide postvention (intervention/support after a suicide occurs).
- Build more comprehensive psychiatric response and stabilization services, similar to the recommendation in SB-485 Psychiatric Crisis Intervention (2015).
- Improve access to both inpatient and outpatient behavioral health programs to promote mental health, relevant social services, and prevent substance abuse and suicide.
- Expand the mental health and substance use disorder workforce to address the severe shortage.

- Ensure that all professionals serving children are trained in evidence-based suicide prevention, intervention, and postvention (intervention/support after a suicide occurs).

After discussion, the CISC voted unanimously to support the recommendations with the caveat that this is not an endorsement of the fiscal component and/or the mandate that would be placed on schools.

4. H.E.A. 1016-Newborn Safety Incubators. Representative Cox, author of the legislation, reported the initial version of the bill authorized the voluntary use of newborn safety incubators at hospitals, 24-hour police and fire stations, and certain eligible nonprofit agencies. Eligible entities who installed the newborn safety incubators would be held harmless from any liability from their use, while non-eligible entities that installed the newborn safety incubators could be exposed to liability and subject to fines and other civil penalties.

   Once the bill went to the Senate, a number of questions were raised which resulted in the bill being amended to require the CISC to study some of these questions. The bill also required the Indiana State Department of Health (ISDH) to make recommendations concerning standards and protocols for the installation and operation of newborn safety incubators.

   Existing laws do not specifically prohibit newborn safety incubators, but there are no current polices or standards in place for their use and the potential for liability is currently unknown. The intent of HEA 1016 is to allow these issues to be studied so that the legislature can be in a position to make informed decisions regarding the use of newborn safety incubators in the future.

   Dr. Jennifer Walthall, co-chair of the Infant Mortality and Child Health Task Force, presented the report and recommendations of the Task Force. The Task Force reviewed Safe Haven laws, medical literature, and outcome information on the use of newborn safety incubator type devices in the United States and other countries. All 50 states have a Safe Haven law, which provides a mechanism for legal amnesty for persons who are unable to care for newborn infants. Each state's law is different, and Indiana has a thoughtful and generous version of the law. Indiana's Safe Haven law has been in effect since 2001 and allows a person to leave an infant to the care of a designated Safe Haven location, which is a hospital emergency department, fire station, or law enforcement agency with 24/7 staffing until the infant is or appears to be 30 days old and has no signs of intentional abuse. Despite the provisions of Indiana's Safe Haven law, there have been tragic cases of infants who have been abandoned outside of these designated locations.

   In the European countries as of 2012, there are "baby boxes" in 10 of the 27 countries with a movement to decrease their use. In contrast, the anonymous birth policy implemented in Austria demonstrated a significant decrease in neonaticide post-policy implementation as compared to baby box deposits of infants, which was minimal in that country. Germany is currently exploring the feasibility of an anonymous birth policy at health care facilities based on the findings of their 10-year review.

   The United Nations Committee on the Rights of the Child has called for a ban on baby boxes across Europe due to emerging evidence that the expansion of supportive programs for pregnant mothers and new mothers that addresses social determinants of health is far more effective for proactive placement of infants or continued parenting if desired. In fact, the single study on the features of mothers who surrender infants suggests underlying mental health barriers that preclude problem solving.

   Through the Task Force's study, several logistical issues were raised concerning widespread use of baby boxes. The first is the impact on existing Safe Haven law. Indiana currently has a robust Safe Haven law that provides a 30-day window following birth. Many other states only allow a 24- to 48- hour window. The second issue was cost and liability. When a baby box is installed at a facility, there are short-term and long-term costs that must be taken into account.

Specifically, the Task Force noted several concerns: the risk of extreme weather causing power outages; the cost of 24/7 monitoring; reliability associated with a worker calling off; and the effectiveness of devices in urban versus rural settings.

The next issue raised was education. Is the public aware of Indiana's Safe Haven law? Do individuals know where to locate a Safe Haven facility? Are the Safe Haven locations discoverable online or at the local level? Do those staffing a hospital emergency room, fire station, or police station know how to properly respond to an infant being abandoned? Is additional education necessary to ensure consistency at each facility? Finally, the Task Force addressed the target audience. Identifying individuals who would be more inclined to use a baby box as opposed to dropping off an infant to an approved facility is extremely difficult, if not impossible, and the Task Force would like to have more research around how we identify these high-risk families.

Following the Task Force's review of Safe Haven Laws and the history and medical effectiveness of baby box installation in other countries, the data suggest that baby boxes are not effective and that countries who have led that charge are now moving to phase them out. Additionally, multiple concerns were raised about implementation and whether the cost associated with that installation was the most effective use of those dollars. The international literature suggests that policy and programming for pregnant women and their support systems are more effective at a lower cost. Consequently, the Task Force on Infant Mortality and Child Health recommended that Indiana focus additional resources on improving awareness of the existing Safe Haven law through intergovernmental cooperation and marketing efforts. Additional training and education should also be available to those staffing a hospital emergency room, fire station, or police station to ensure consistency if, and when, an infant is abandoned at a facility. Uniform signage at Safe Haven facilities is also strongly encouraged. The public would also be well served with an easily accessible online resource directory that lists all Safe Haven locations in their area.

The Task Force noted there is already an ongoing effort between multiple public and private organizations regarding how to launch a Safe Haven education campaign, and how to do ongoing training at the local level for those who are receiving infants.

After discussion, the CISC unanimously voted 1) not to endorse HEA 1016; 2) to support the promotion of the existing Safe Haven Law, and to continue dialogue on how to reduce infant mortality; and, 3) to ask the Infant Mortality and Child Health Task Force to consider studying liability issues and immunity associated with the Safe Haven law in general.

5. Casey Family Program Partnership. Barry Salovitz, Senior Director of Strategic Consulting, Casey Family Programs, reviewed the Casey family legacy, and the mission, beliefs, and focus of Casey Family Programs (Casey). Casey works with the White House, the National Governors Association, the National Council of State Legislators, with the executive branches in all of the states, and are increasingly working with state and local judiciary and family and child focused stakeholders and service providers within states.

   Casey has partnered with CISC since its inception. At the request of the CISC Executive Committee, Casey was asked to give input into the organizational structure and governance of the CISC, and to provide program priority issue analysis and depiction. Currently, Casey has an ongoing member on the Data Sharing and Mapping Task Force, and a judicial engagement team working with judicial leaders to implement the dual status youth pilot project. Casey has recently been asked to provide evidence-informed input to the CISC and to provide project management support to the task forces.

   Holly Merz, Casey Family Programs Technical Assistance Unit, reported she will be working with the CISC and the task forces going forward. She reported Casey will be assisting the task forces to help improve

communication, enhance exchange of information, ensure integration of focus areas, and prioritize areas of focus and action items. She will help the task forces develop standardized minutes and report forms and develop a quarterly task force bulletin, which will be a quick snapshot of what each of the task forces are working on. Because many task forces seem to be working on similar priorities and areas of focus, the goal is to help integrate and better inform one another about who they might need to connect with.

Representative Riecken remarked she has noticed over the two years of the CISC is that there has been a lot of success in getting funding for things that have been recognized as important by the CISC. The advocacy effort has been successful and she would like to see funding issues addressed/incorporated into the strategies and recommendations of the task forces.

6. Department of Child Services, Proposed 2016 Legislation. Parvonay Stover, Legislative Director, Department of Child Services (DCS) highlighted the Department's legislative agenda for the coming year. The primary legislative agenda item is to help child victims of human trafficking. She remarked that human and sex trafficking is a serious and significant problem in our state. At the November 2014 CISC meeting, the Attorney General, prosecutors, the State Police, policy experts, and human trafficking survivors spoke about the growing problem and the need for action in the state. Currently though, human trafficking is not referenced in the Children in Need of Services (CHINS) statute, and the only reference to trafficking in Indiana law deals with criminal prosecution of the trafficker. There is nothing that speaks to providing help for trafficking victims. DCS must establish legal sufficiency to file the CHINS petition based on the factors outlined in the statute and the facts of the individual case, and in cases where DCS finds human trafficking and child abuse and neglect by the parent or guardian, DCS can file the CHINS petition. However, when the child's parent or guardian is not the perpetrator or the facilitator of the trafficking, DCS and the courts do not have a good mechanism to intervene and provide services for the child. Often, DCS finds that it is not the parent who is the trafficker; it is often a stranger that is the perpetrator of that trafficking. The DCS proposal is to add a definition of human trafficking victim to Title 31, the statute that deals with child welfare activities, and add human trafficking to the CHINS code so DCS and the courts can intervene in the serious and significant cases. The proposed language also states that a person under 18 is a victim of human trafficking regardless of whether they consented to that act or that conduct. DCS would like the CISC to support the proposal to add human trafficking to the CHINS statute this upcoming legislative session. The CISC voted unanimously to support adding human trafficking to the CHINS statute.

7. Report on National Adoption Awareness Month Activities. Danielle McGrath reported November is National Adoption Awareness Month. There has been a collaborative effort among the judicial, legislative, and executive branches of government to help children find loving permanent homes. The judicial branch has twenty-five trial courts celebrating National Adoption Awareness Month. One hundred-forty children will be adopted during National Adoption Awareness Month activities, and these court hearings will be open to the media. Other activities that have been taking place include the Governor's Annual Adoption Fair on November 16, where more than a dozen adoption agencies and state agencies gathered in the atrium of the Statehouse to promote adoption awareness as a whole. There have also been events at the agency level. DCS has partnered with the Children's Bureau and other adoption agencies to host more than 25 celebrations throughout the state. These are the celebrations that recognize adoptive parents and provide information on how others can adopt. Director Bonaventura reported DCS facilitated over 1,100 adoptions children across the state in 2014. The CISC concluded with a 3-minute video of an adoption day celebration.