Mental Health and Disability Services
Significant federal, state and private legal, policy and program developments

Federal/National	Iowa	MHDS Milestones
Mid- 1800's - Dorothy Dix fights for the establishment of hospitals to provide treatment for "the insane," as an alternative to their confinement in prisons and almshouses. President Franklin Pierce's opposition to the federal government becoming "the great almoner" blocks action by Congress, and marks the beginning of a century of federal non-involvement in mental health services. Click here for an interesting power point presentation on the history and politics of community mental health in the US and Iowa. Late 1930's - Standard treatment for people with MI	1842 – Passage of an Iowa "Poor Law" leads to the system of county homes. Counties assumed responsibility for the public costs of services to people with mental illness and mental retardation who could not be or simply were not receiving assistance within the family home. 1861 – Construction of the first Asylum for the Insane in Mt. Pleasant, county funded and supported by farming and livestock operations on campus. The asylum model provides food, shelter, regular routines, and work activities. 1873 – The Independence MHI is opened. 1876 – The Iowa Asylum for Feeble-Minded Children is built in Glenwood. 1888 – Clarinda MHI is opened. 1898 – State Board of Control assumes general oversight all state charitable and correctional institutions, including county homes serving "the insane." Funding for operations becomes an ever greater issue, and attitudes shift about whether mental illness can actually be treated. 1902 – Cherokee MHI is opened.	

(psychotherapy, medications such as bromides and hypnotics, hydrotherapy and psychodrama) were augmented with insulin shock and electroconvulsive therapies for individuals suffering from delusions and hallucinations. Post WWII: Parent advocacy leads to formation of many single disability groups (National Association for Retarded Children, Muscular Dystrophy Assn, United Cerebral Palsy, etc.) 1946 – Growing recognition of the need for mental health professionals. National Mental Health Act provides grants to States to support or build outpatient clinics. 1950's – (1) Frontal lobotomy is introduced as a treatment for people with serious MI. (2) Thorazine is introduced as the "first generation" of antipsychotics, making it possible for MHI residents to improve enough to be discharged. (3) Journalistic exposes of asylums and the psychopharmacologic revolution lead to Mental Health Study Act of 1955, the first call at the national level for care in community settings and fully-staffed clinics and the beginning of federal involvement in mental health. 1963 – In response to the findings of the President's Committee on Mental Retardation, the Community Mental Health Act (PL 88-164 - the "Mental Retardation and Community Mental Health Centers Construction Act of 1963") authorizes multi-year grants to States for community mental health centers (CMHCs), to provide alternatives to institutionalization. The Act also creates university-affiliated facilities (later renamed University Centers for Excellence in Developmental Disabilities) to help build community capacity. 1965 – The Medicaid program is created under Title XIX of the Social Security Act. Institutionally based services for the	1939: Respected UI speech expert tests a theory on the cause of stuttering by exerting psychological pressure on 10 young orphans. 1940's – (1) Iowa's 99 counties develop county homes—an acceptable outplacement opportunity for MHI patients. (2) Growth of psychiatric practices in Iowa. Some psychiatrists begin to treat patients in their offices. (3) The first hospital psychiatric unit opens in 1946. (4) The population of the MHI's begins a 20-year decline of 36.6%. (5) Service needs of returning WWII vets spur growth in the fields of psychology and social work. 1950's – Community mental health centers begin to appear in urban areas—almost entirely funded by counties, unlike the State-funded CMHCs springing up elsewhere in the country. Hospitals are setting up outpatient clinics. Iowa Legislature also begins to provide funding for mental health professionals at the MHIs.	1963: Iowa Mental Health Authority (at the time, the Dept of Psychiatry at the University of Iowa) initiates a federally funded, two year multi-stakeholder planning process to create a vision for mental health services in Iowa.

Elderly and Disabled become an entitlement; HCBS do not. Amendments to PL 88 -164 provide grants for staffing at CMHCs. 1970 – The *Wyatt v. Stickney* lawsuit filed against the 5,000-bed Bryce State Hospital in Tuscaloosa resulted in a mandate to the State to set and implement standards to improve services and conditions for residents with MR. The Developmental Disabilities Services and Facilities Construction Act (PL 91-571) is the first "developmental disabilities" legislation. Amended in 1975 as the Developmental Disabilities Assistance and Civil Rights Act and renewed regularly since then under that title, its intent is to encourage States to develop comprehensive plans for the initiation, organization and delivery of an array of DD services on a regional and local basis. 1971 – Title XIX is amended to create the option for States of ICFs/MR to improve the quality of care to people with cognitive disabilities. 1972 – Geraldo Rivera's nationally publicized expose' of Willowbrook State School in New York draws attention to deplorable conditions in a large facility for children with MR. 1973 – Rehabilitation Act (PL 93 - 112) Section 504 prohibits discrimination against people with disabilities by entities receiving federal funds.	1965 - Iowa Board of Social Welfare assumes responsibility for Medicaid. The entitlement to institutionally based services has a profound and lasting impact on Iowa's disability service system. 1968 – SF 739 begins the consolidation of mental health and disability services by creating a single Department of Social Services that also includes the former Board of Social Welfare. 1970's – Large scale deinstitutionalization occurs for Mental Health Institute and State Hospital School residents, leading to significant declines in their populations. In Iowa as elsewhere in the U.S., funds did not follow people to the community, creating a high risk of poverty, homelessness and criminalization.	1965 – *Mental Health Planning in Iowa – 1965* report is released, with a lengthy series of recommendations from the two year planning process. See Summary and Recommendations and/or full report. 1968 – The new Department of Social Services is given responsibility for supervision of "state institutions,"—including the mental health institutes *and* corrections! Within a few years the Department has separate Bureaus for Medical Services (Medicaid), Mental Health, and Mental Retardation. The latter two were later combined into the Division of Mental Health Resources. 1970 – Governor Ray creates the Developmental Disabilities Council in response to the federal Developmental Disabilities Services and Facilities Construction Act (PL 91-571), to plan for the direction, development, implementation and evaluation of a comprehensive system of services for Iowans with DD and to advise him on matters of programs, services and facilities for them. Eventually the Department of Human Services becomes the designated State agency to carry out these functions under federal law.

1975 – Education for All Handicapped Children Act (PL 94 – 142) establishes the right to a free and appropriate education for all students in the least restrictive alternative. Schools conduct assessments to determine "appropriateness." 1977: Shortly after taking office, President Jimmy Carter issues an Executive Order (11973) creating the President's Commission on Mental Health, charged to develop policy recommendations to overcome glaring deficiencies in the mental health system. While the commission's work ultimately leads to formulation of the influential National Plan for the Chronically Mentally Ill (1980), many of the problems that were intended to be addressed remain unresolved, and indeed worsen over the following decade. 1980 - Mental Health Systems Act (PL 96-398) creates the State mental health block grant program. Civil Rights of Institutionalized Persons Act (CRIPA) allows the DOJ to sue the States for alleged violations of the rights of people in mental hospitals and ICFs/MR. 1981 – Omnibus Budget Reconciliation Act repeals Mental Health Systems Act of 1980, withdraws all direct federal support for CMH centers and replaces with state mental health block grants (an idea emerging from Reagan's New Federalism). Ends the federal definition of "community mental health center" and leaves it to States to decide how and to whom services should be provided. *Pennhurst State School and Hospital v. Halderman* – one of many lawsuits brought against large institutions for deplorable conditions but the first with the express purpose of closing the institution. It also leads to the first longitudinal study of deinstitutionalization. 1982 – The Tax Equity and Financial Responsibility Act (TEFRA) amends Title XIX of the Social Security Act to	1977 – Department of Corrections (DOC) eases the overcrowding of the Anamosa State Penitentiary by opening the Mt. Pleasant Correctional Facility on the Mt. Pleasant MH campus.	

allow States to offer an optional State Plan service to children who would otherwise require care in an institution. This "TEFRA Medicaid Option" was created to accommodate Katie Beckett after the Iowa child who was hospitalized with medical needs which could be addressed at home 1984 – The Developmental Disabilities Act of 1984 strengthened provisions for State planning and advocacy for people with DD. 1986 – Amendments to the Mental Health Systems Act express Congressional intent that States incorporate important principles in their State Plans, including informed consent, consumer participation in development of a service plan, the right to services that are the least restrictive of the individual's liberty consistent with his or her needs, privacy, confidentiality, access to advocacy and rights protection services, etc. Late 1980's to mid 1990's – The "second generation " of antipsychotics (Clozapine, Risperdal, Zyprexa, etc.) offers breakthroughs in treatment for many people with MI, further reducing the need for MHI services 1990 - Americans with Disabilities Act prohibits discrimination in employment, public facilities, and government services..	1980 – DOC opens the Clarinda Correctional Facility, a 120 bed medium security prison to serve offenders with chemically dependent and special needs, on the campus of the Clarinda MHI. 1981 – DOC and the Department of Social Services "switch" buildings on the Mt. Pleasant campus, resulting in an expansion of the prison to 550 beds, and the movement of the MHI to its current location. On both the Mt. Pleasant and Clarinda campuses, large numbers of personnel are shared between the mental health and correctional sites on campus.	1982 - The Division of Mental Health and Developmental Disabilities is established by combining the former Division of Mental Health Resources, Mental Health Authority, Developmental Disabilities program staff, and State Mental Health Advisory Council. A 15-member Mental Health and Mental Retardation Commission is established to advise the Division Director. 1983 – The Dept of Social Services becomes the Department of Human Services. Responsibility for correctional institutions transfers to the new DOC. 1984 – Pursuant to the 1984 DD Act, the Developmental Disabilities Council becomes the Governor's Planning Council for Developmental Disabilities

	1984 - Iowa secures approval for its first Section 1915(c) waiver (Ill and Handicapped) which addresses the needs of children like Katie Beckett, but not through the TEFRA option. 1986 – Iowa Protection & Advocacy files suit on behalf of Evert Conner et al. against the State challenging the continuation of institutionally based services at Glenwood and Woodward. A consent decree is ultimately reached in 1994 establishing the right of the plaintiffs to 'seek to choose" where to live "within available resources." The decree has lead to a small annual appropriation for "Conner grants" to help people move to community settings, and to help build community capacity.	1987 – The Mental Health Planning Council is established responding to federal requirements (Mental Health Systems Act) to oversee and advise on the mental health block grant. 1988 – As part of governmental downsizing and reorganization, and partially in recognition of its enhanced advocacy role under amendments to the Developmental Disabilities Act, the Planning Council for Developmental Disabilities becomes a separate entity from the Department, advising the Director.
1991 - Alcohol, Drug Abuse and Mental Health Administration Reorganization Act amends the Public Health Services Act of 1946 (Title XIX Part B) to authorize mental health block grants for States. Title XIX requires: • Establishment of a State Mental Health Planning Council; • Development of a State Plan to reduce institutionalization and improve community services.	1991 – Substance abuse program established at Mt. Pleasant MHI, initially with 92 beds (now 50). 1992 – (1) A legislatively created MI/MR/DD/BI Service Delivery Restructuring Task Force recommends that DHS develop a five year plan to close, or realign to other purposes, two MHIs and one State Hospital School. The plan should ensure that community services are in place prior to any closure, and that until that time the quality of institutional services continues to be a priority. (2) Due to revenue shortfalls, an across-th-board State budget cut of 4.8% is imposed. Among other effects on services, 142 (17.9%)	1992 – "The Mental Health and Developmental Disabilities Commission" is established to advise the administrator of the Division of Mental Health and Developmental Disabilities, the Human Services Council, and the Governor.

	of all operational MHI beds are cut. All geropsychiatric beds are consolidated to Clarinda, and all substance abuse beds at Mt. Pleasant. 1994 - HF 2430 defined state payments to counties for services to mandatory populations (generally, calculated at 50% of the amount by which a county's qualified expenditures during the preceding FY were in excess of a county's base year's expenditures on MR, MH and DD services), established the county CPC system as a single point of entry, created the State/County Management Committee to plan and implement the service system, and required County Management Plans. Iowa requests and is granted a waiver to move to managed behavioral health care for its Medicaid eligible clients, integrating mental health and substance abuse. The contract is initially awarded to Value Behavioral Health. A conflict of interest lawsuit was quickly filed and in 1995 the contract was awarded to Medco (aka Merit Behavioral Health, later aka Magellan Behavioral Health). 1995 - SF 69 creates county MH and DD services funds, caps them at 1993 expenditure levels (later, 1995) less property tax relief received, and deletes supplemental levy authority. Creates Property Tax Relief Fund and establishes a distribution formula. . 1997 – HF 225 defines the "Allowed Growth" formula HF 702 requires people with MR to use the	1994 – Iowa Consortium for Mental Health is established and funded through mental health block grant, with the goal of providing a public-academic liaison, linking DHS with universities. 1997 - A legislatively created Human Services Restructuring Task Force issues its report recommending that the State Hospital Schools be recognized as important providers of

	single point of entry process to enter Resource Center.	services to individuals requiring institutional care, but that they become "Resource Centers" sharing expertise with community providers, offering respite services, and increasing their Time-Limited Assessment programs. The Task Force also recommended strategies for better utilization of Mental Health Institute facilities and services.
	1998 – Legislator funds establishment of a Psychiatric Medical Institution for Children (PMIC) at Independence MHI to serve young people with serious MI in a less restrictive setting. The PMIC is intended to limit admissions to young people from the Cherokee MHI, the Juvenile Home in Toledo, and the acute care programs at Independence. A multidisciplinary team provides diagnostic and psychiatric services, nursing care, and rehabilitative services. HF 2545e "Per Capita Expenditure Target Pool" and "Incentive and Efficiencies Pool" distribution formulas. The "Risk Pool" is created	1998 – The Mental Health Planning Council commits $200,000 to contract with the Technical Assistance Collaborative, Inc., to do a study of the State's public mental health system. The lengthy report *Quick Fixes or Structural Reform: An Evaluation of Iowa's Public Mental Health System* is published in December 1998 but few if any actions are taken as a result.
1999 – The U.S. Supreme Court, in *Olmstead v. L.C.,* that under the ADA individuals are entitled to receive services in the least restrictive environment consistent with their needs and a state must administer its service system to insure individuals have meaningful choice of living arrangement. The Ticket to Work and Work Incentives Improvement Act of 1999 created the Medicaid Buy-In State Plan option for people with significant disabilities who want to enter or remain in the workforce but who need to retain Medicaid coverage. The Act (TWIIA) also removes other employment	1999 – (1) IME creates the Medicaid for Employed Persons with Disabilities (MEPD) program option in response to the federal Ticket to Work-Work Incentives Improvement Act. HF 664 stipulates that County Management Plans no longer need be revised annually but remain in effect until amended. A Strategic Plan is to be submitted to DHS every 3 years for informational purposes only. An Annual Review is also to be submitted. (2) Cherokee	

barriers related to SSDI and Medicare. David Satcher issues his landmark Mental Health: A Report of the Surgeon General , asserting that mental health is a critical public health issue but that "illnesses of the mind remain shrouded in fear and misunderstanding." 2000 – CMS calls upon States to develop "effectively working plans" to demonstrate compliance with *Olmstead.* 2001 – President Bush announces his New Freedom Initiative, a comprehensive program to promote the full participation of people with disabilities in all areas of society by increasing access to assistive and universally designed technologies, expanding educational and employment opportunities, and promoting increased access into daily community life. The President issues an Executive Order requiring federal agencies to review policies and programs and develop plans to eliminate barriers to community living, leading to the New Freedom Initiative.	MHI starts the Physician Assistant/Advanced Registered Nurse Practitioner post-graduate psychiatry training program with a Federal grant. When the funds were exhausted, Cherokee re-established the program in 2005, out of the MHI's operating budget. The Legislature has appropriated funding since 2007. The one-year residency provides educational and clinical training to Pas and ARNPs to help alleviate the psychiatry shortage in rural Iowa. 2001 – HF 760 provides for aggressive implementation of the rehabilitation State Plan option for people with chronic mental illness. HF 732 reduces Allowed Growth Allocation for FY 02 by $18 million; the community services block grant is included in the allocation formula.	2001 – *Creating a System of Mental Health Services for Children in Iowa* is published by the Children's Mental Health Collaborative (CMHI), a partnership of DHS, IDPH, and DoE. Lt. Governor Sally Pederson calls for a "redesign of the mental health and disabilities system" and requests recommendations on the adult system and children's mental health system respectively over the following two years. The Olmstead Real Choices Consumer Task Force is established and finalizes a Community Development Plan for Iowa calling for policies and programs to support transition from institutions and community living options. Responsibilities for Olmstead implementation are assigned to DHS. Iowa's first Real Choices Systems Change grant is awarded, at a much lower amount than requested. The original objective of supporting institutional transitions is changed

		to focus on diversion. The Task Force drafts what is to become the Governor's Executive Order 27, mirroring that of President Bush, in anticipation of a similar state agency response. Some funds from the grant are eventually allocated to support identification of a uniform assessment tool for aging, MR/DD and MI populations needing long term supports, to divert them from institutional placement. Interest in the uniform assessment concept grows among both aging and disability advocates, leading to the unsuccessful drive in 2004 to pass the Consumer Choice, Support and Education Act mandating uniform assessment of older Iowans needing long term care.
	2002 – The Legislature, facing a significant fiscal crisis, reduces appropriations for state agencies. The Department of Justice, after a three year investigation of conditions at Woodward and Glenwood, sues the State of Iowa under CRIPA, alleging violations of residents' constitutional rights. A settlement agreement is filed in 2004. HF 2430 provides that the MH/DD Commission assumes the duties of the State/County Management Committee, and provides the Commission with new rule making authority. HF 2304 reduces Allowed Growth by another 2.6%.	2002: Child and Family Policy Center submits a report to the MHDD commission which synthesizes recommendations over the previous few years regarding redesign from many sources. An accompanying chart usefully organizes these recommendations. 2002 – 2007 The State operates without a MHDS Division. The state Mental Health Authority and disability program staff are reduced and placed in other divisions. State resources dedicated to mental health decline.

2003 – The Administration on Aging begins funding State Aging and Disability Resource Center (ADRC) grants, launching a drive promoting virtual and physical single points of entry to long term care. Grants to State aging agencies must address at least one disability population. The Final Report from "President's New Freedom Commission on Mental Health is released. (http://www.mentalhealthcommission.gov/reports/reports.htm	2003 – HF 529 directs the MH/DD Commission to make recommendations for redesigning the MH/DD services system for adults, addressing the issues of clinical and financial eligibility, cores services, legal settlement, coordination of funding streams, and a process by which funding follows the covered individual regardless of categorical funding. Governor issues **E.O. 27**, requiring all state departments to review policies and programs and to develop plans to eliminate barriers to community living for people with disabilities. The Real Choices Systems Change grant provides staff support for state agencies. HF 387 allows RCFs for people with MR to provide HCBS, thus capturing Medicaid funding. 2004 - S.F. 2288 stipulates that 70% of the mental health block grant funds be used to enhance the capacities of community mental health centers to deliver 1) evidence-based mental health practices; and/or 2) emergency services. (DHS has chosen to focus only on the evidence-based practice aspect of this thus far). HF 2537 instructs the MH/DD Commission to address a set of issues related to system redesign, including data collection and analysis, revenue sources for core services, case rates, and a recommendation for a functional assessment tool and process. A Robert Wood Johnson grant funds	2004 – The Mental Health/Mental Retardation Commission becomes the MH/MR/DD/BI Commission. The Commission sends recommendations for redesign of the adult services system, and sets a timeline for the redesign of the children's services system. In response to the Legislature's request, the Commission establishes seven workgroups, composed largely of county CPCs, to make recommendations on legal settlement, cores services, functional assessment, and others.

	development of what is to become the Consumer Choices Option, moving Iowa towards greater consumer control over resources for their services. This "self direction" option is available statewide in by 2007. The Department of Elder Affairs receives an ADRC grant and focuses on development of a virtual No Wrong Door (establishing the LifeLongLink planning portal and linking the I-4A, Iowa COMPASS and 2-1-1 I & R databases).	
2005 - The Deficit Reduction Act of 2005 imposes new restrictions on Medicaid operations but also creates new community living options for people with disabilities, through the Money Follows the Person grant program and through permission for States to include HCBS Waiver-like services in their Medicaid State Plans.	2005 – HF 841 (IowaCare) expresses the Legislature's recognition of Iowa's excessive reliance on institutionally based services and provides for various rebalancing steps. The Iowa General Assembly passes legislation making it possible for families to access certain mental health services without having to relinquish custody of their children. Iowa's second Real Choices grant funds work on I-MERS, a transportation brokerage, MR/DD health assessment, a web based Housing Registry, Iowa COMPASS improvements, and a proposed case mix adjusted reimbursement plan for ICFs/MR. The Iowa Coalition on Mental Health and Aging is established to promote better mental health services for older Iowans.	2005 - The Commission's work groups finalize recommendations; many of them are transmitted to the Legislature. In response, the Legislature appropriates $280,000 to pursue functional assessment.
	2006 – DHS appropriations include renewed funding for the Mental Health and Disability	2006 - As a result of legislation allowing families to access mental health services

	Services Division, (formerly the Mental Health and Developmental Disabilities Division). HF 2780 establishes new standards for the delivery of disability services, including that they be individualized to assist people in living, learning, working and recreating in their community of choice. HF 2780 provided a 3% rate increase for providers, established new services for Iowans with BI, increased Medicaid reimbursements to CMHCs, psychiatrists and hospital inpatient psych units, and took the first steps towards eliminating legal settlement by transferring State Payment program cases (with some State funding) to the county of residence of those individuals. An Interim Study Committee ponders county funding issues. Children aging out of foster care are ensured access to Medicaid to the age of 21 and are provided with assistance in the transition to work or higher ed. HF 2734 increases growth allocation to counties by $3.1 million. Management of the state payment program is transferred to the counties. State appropriations eliminate waiver waiting lists. 2007 - SF 909 mandates plans to address mental health systems transformation.	without relinquishing custody of their child, DHS (1) gains approval to implement a HCBS Waiver for children with serious emotional disorders, allowing families to receive intensive home and community based services for their child - a critical step to meeting needs of children with mental health disorders in their own home and community; (2) makes changes in access to Psychiatric Medical Institutions for Children (PMIC), allowing children to receive this service without the need for their family to relinquish custody; (3) implements Remedial services through Medicaid, further increasing the array of home and community based services available to Medicaid eligible children with mental health disorders. The MHDS Division is re-established with legislative appropriations, allowing the hiring of additional Division staff, including a Division Director and Adult and Children's Bureau Chiefs. Recommendations from 2004 System Redesign are updated and summarized in a useful manner by new MHDD commission members. Commission recommendations impact the legislative deliberations leading to HF 2780. The report of the Children's SED/MR/DD/BI Oversight Committee is submitted to the MH/MR/DD/BI Commission highlighting system fragmentation and proposing the "lighthouse" approach.

	DHS is awarded a $51 million Money Follows the Person grant to help 528 residents of ICFs/MR move to more independent community settings.	DHS implements the first System of Care for Children, Youth, and Families, an initiative to develop services and supports in the community, for children and youth with serious emotional disorders, that are coordinated with the services of education, child welfare, court services, health care, etc. to provide alternatives to out of placement or treatment options, so children and youth can remain at home with their families, attend their own schools, and a be a part of their own communities, 2007 –MHDS leads the Mental Health Systems Improvement process, engaging a series of stakeholder workgroups to address system improvements in key targeted areas. Recommendations from this work address: Improving the service systems ability to provide services to individuals with co-occurring mental health and substance abuse disorders; enhancing the role of Community Mental Health Centers as part of the public safety net in the community; Alternative Distribution Formula to recommend changes in how funding for adult mental health and disability services is distributed; incorporating Evidenced Based Practices into the community based services system; define Core Mental Health Services to be offered in each area of the state by community mental health centers and other core service providers; Mental Health and Core Service agency standards and accreditation to determine services standards needed for CMHCs and other core services providers. The report can be found at the MHDS reports and

		publications page. Among the issues addressed is improvement in services to individuals with co-occurring mental health and substance abuse issues (COD). MHDS and the Iowa Department of Public Health launch a cooperative effort to promote holistic service planning and treatment by providers, and a welcoming environment for those seeking services. The concept of integrating treatment for individuals with COD is later expanded to encompass those with co-occurring intellectual disabilities and mental illness. The University of South Florida conducts systems of care practice reviews for children's mental health. IME takes advantage of the Deficit Reduction Act to add Habilitation services to the State Plan that are tailored to the needs of people with chronic mental illness.
2008 – Mental Health Parity Act expands parity requirements for insurers who offer coverage for both physical and mental health services.	2008 - SF 2425 provides for creation of an emergency mental health crisis system and a comprehensive community-based mental health services system for children and youth. The Legislature also funds demonstration projects in crisis prevention and children's mental health. The ADRC grant funds two demonstrations of one stops providing options counseling to older Iowans and people with disabilities. The Legislature establishes work groups to explore the Single Point of Entry concept. Report is published in December.	2008 –MHDS moves forward with intentions set forth in legislation to develop Emergency Mental Health Crisis Services for Iowans and community based Systems of Care for Children, Youth, and Families. 2008 – 2009 - Under Project Recovery Iowa,

	The June floods throughout the State disrupt community services and divert the human and financial resources of DHS and other State agencies to disaster recovery. The need for mental health services spikes for adults and children. 2009 – The MR Waiver is renamed the Intellectual Disabilities Waiver. The Legislature authorizes the addition of three new mental health services to the ID Waiver to address the needs of individuals with co-occurring ID and MI. The Legislature authorizes the creation of a transportation brokerage service to coordinate all Medicaid Non Emergency Medical Transportation. The Legislature authorizes establishment of a Mental Health Institute Task Force to consider the economic impact on communities that would result if one of the State's four MHIs were closed. The Legislature calls for the formation of an Adult MH DD work group to consider alternative methods of funding the county-based mental health and disability services system. In the wake of the nationwide recession, the Legislature uses federal stimulus funds to avoid cuts in Medicaid and to try to mitigate cuts in county-funded services. Nevertheless, lower appropriations and a 10% cut for FY	(and funded by the Federal Emergency Management Agency and the Substance Abuse and Mental Health Services Administration), MHDS funds local mental health providers to provide counseling to over 15,000 individuals affected by the 2008 natural disaster in Iowa. 2009 – DHS focuses on workforce issues related to transitioning of individuals with challenging behavior out of ICF/MRs, under the Money Follows the Person program, by making available, free of charge to all MFP providers, the web based curriculum of the College of Direct Support, and offering on-site trainings to support staff statewide. DHS engages in intensive efforts to develop a crisis intervention provider network in the State, exploring possible roles for mental health professional staff at the State Resource Centers, possible program initiatives for Magellan Health Services (Iowa's Medicaid behavioral health managed care organization), etc. MHDS initiates a "Mental Health First Aid" train-the-trainer program to build mental health literacy among first responders to crisis situations. MHDS creates the Disaster Behavioral Health Response Team (DBHRT) program to respond to disaster and crisis situations statewide. Six DBHRT teams are established and over 300 volunteers trained. DBHRT is activated three times in that same year.

	1020 impacts mental health and disability services (e.g., a waiting list for State Payment Program services). In response to the alleged abusive treatment of 21 men with intellectual disabilities by a contractor operating in Atalissa, the Governor appoints a Dependent Adult Task Force to recommend steps to strengthen protections for dependent adults living in unlicensed homes providing board and care.	The Ticket to Hope project, funded by a federal grant, provides free counseling for up to 4,000 Iowans affected by the 2008 natural disasters, and who are uninsured or who have exhausted their coverage for mental health. The Olmstead Consumer Task Force and MHDS collaborate in marking the tenth anniversary of the *Olmstead* decision with statewide celebrations. MHDS launches the second children's mental health system of care in Polk and Warren Counties, with the Child Guidance Center in Des Moines as the lead agency that serves as the access point for services in the community. The Acute Care Task Force established by MHDS prepares its report and recommendations on better utilization of acute care resources for people with mental health crises by expanding community service options and establishing mechanisms to divert individuals in crisis to appropriate services. MHDS launches an initiative to create a five-year unified mental health and disabilities services plan, with stakeholder input, to identify long range goals and establish yearly strategic priorities. MHDS introduces the Iowa Consumer Outcomes Measurement System (ICOMS) to CMHC providers. The ICOMS tool is a data-gathering and analysis system that Iowa providers can use to collect self-report

		outcomes data and obtain consumer progress notes. The Autism Council develops policy recommendations on early identification, seamless support and coordination of care, and funding to address the needs of children and adults with autism. Iowa receives federal funds to establish a Family to Family Health Information Network--a statewide network of parent mentors/educators to serve families of children with special healthcare needs. A second federal grant, Family Support 360, will build a one-stop navigation network fostering a family-driven system of care for children with disabilities. Both grants are overseen by the same family-driven governance group.