THE STATE OF IOWA

Iowa Department of Human Services
Division of Mental Health and Disability Services

MENTAL HEALTH INSTITUTE TASK FORCE REPORT AND RECOMMENDATIONS

In accordance with House File 811, Section 22

2009 Session of the Iowa General Assembly

Submitted to: Governor Chester J. Culver
and the Iowa Legislature by
Ro Foege, MHI Task Force Chair
December 14, 2009

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Genesis of the Study

On May 26th, 2009, Governor Chester J. Culver signed into law House File 811, from the 82nd Iowa General Assembly. Section 22 of House File 811 includes language establishing a Mental Health Institute Task Force to conduct a review of the Mental Health Institutes (MHIs) and requires the Department of Human Services (DHS) to submit a proposal for closing one MHI and consolidating the services provided at the remaining MHIs:

> The department shall staff a task force to be appointed by the governor consisting of knowledgeable citizens to perform an in-depth review of the four state mental health institutes, services provided, public benefits of the services provided, economic effects connected to the presence of the institutes that are realized by the communities in the areas served and the families of personnel, and other public costs and benefits associated with the presence and availability of the four institutes. The review shall be coordinated with the proposal to be developed by the department under this section and shall incorporate or address the proposal findings and recommendations. The task force shall submit a report providing findings and recommendations to the governor and general assembly on or before December 15, 2009.
>
> The department shall submit a proposal for closing one state mental health institute and consolidating the services provided at the other state mental health institutes. The proposal shall provide for maintaining the existing levels of beds and services after the consolidation. The proposal shall be developed in coordination with the task force review of the four institutes performed under this section. The department shall incorporate or address the findings and recommendations of the task force in such proposal. The proposal shall be submitted to the persons designated by this division of this Act for submission of reports on or before December 15, 2009.

The MHI Task Force and DHS are required to submit proposals, including findings and recommendations, from their work on or before December 15th, 2009. Governor Culver appointed a 15-member Task Force to conduct the review. The Task Force is chaired by Ro Foege, a former state legislator for 12 years and social worker.

The Task Force held 8 meetings with public hearings across the state to obtain citizen input. More than 1,700 individuals attended the public hearings held at each of the four MHIs with 187 individuals making presentations. Letters were received from over 200 individuals or organizations as well as three petitions signed by 1,046 people.

The Task Force toured and reviewed a wide range of data about each MHI, including the types and demographics of patients served, referral sources, discharge locations, diagnoses addressed, community integration, costs, lengths of service (institutionalization), re-admission rates, outcomes, and employee lengths of service and classification.

A list of the MHI Task Force members may be found in Appendix 1. Dates and locations of Task Force meetings held may be found in Appendix 2.

Recommendations

Recommendations made by the Task Force are grouped into 4 categories: Facility Closure; Forensic Evaluation and Treatment; Continuum of Services; and Resource Utilization. Additional information and discussion regarding the Task Force recommendations may be found in Appendix 3.

Facility Closure

1. No state facilities should be closed, at this time.
2. Decisions that affect the future of the facilities must be made in the context of the whole mental heath service system, the people it serves, public safety, total costs, and best practices.

Forensic Evaluation and Treatment

3. Collaborative efforts and communications should be expanded between the Iowa Departments of Human Services, Public Health, Corrections and Education, the Judicial Branch, and other stakeholders to improve access to treatment and outcomes for those who are at risk of entering or have already entered the criminal or juvenile-justice systems. Suggestions include the following.

a. Uniform screening and assessment instruments to identify persons with mental illness and substance-use disorders should be developed and used statewide.
b. Provision of mental-health services to patients in jails and prison.
c. Cross training for personnel in areas of mental-health, substance-use, and other co-occurring disorders.
d. Expansion of jail-diversion programs and services to route individuals with serious mental illness and co-occurring mental-health and substance-use disorders away from jail.
e. A study of the forensic population in Iowa to quantify the changing need for services as well as current availability of services.

Continuum of Care

4. The recommendations of the DHS Mental Health Acute Care Task Force are supported and adopted as MHI Task Force recommendations, including the following:
    a. Develop regional community-based mental–health and crisis-intervention services as a first-line safety net for children, youth and adults, including Crisis Stabilization Centers, Crisis Resource Centers and Mobile Crisis Stabilization Teams and Services.
    b. Subacute services should be developed to allow for timely transition of patients who no longer need psychiatric inpatient-hospitalization services, to less intensive and less restrictive treatment centers.
    c. Expand capacity in Iowa's local hospital emergency rooms to provide appropriate psychiatric screening.
    d. Expand the role of community mental-health centers to function as Community Access Centers that provide core safety-net services in designated geographic areas on a 24/7 basis.

    The complete recommendations of the DHS Mental Health Acute Care Task Force are included in Appendix 3.

Resource Utilization

5. The purpose and role of the MHIs as acute-care providers, as stated in Iowa Code 226.1, should be reviewed and updated in keeping with changes in technology, treatment approaches, and services now available in Iowa.
6. The MHIs should expand capacity to share professional and clinical expertise with other community-based providers through professional training, case consultation, and other support. Areas of expertise identified include gero-psychiatric care, co-occurring disorder and substance-use treatment, and mental illness.
7. Creative and collaborative opportunities and incentives should be explored with and by all universities, colleges and other public and private-sector providers, and DHS, to include the following.
    a. Physician, Physician Assistant, Advanced Registered Nurse Practitioner, psychology, nursing, counseling, social work and other professional training programs, including potential utilization of medical and dental residents to rotate through all 4 MHIs, in addition to already existing programs.
    b. State-sponsored or other types of scholarships to recruit professionals in the areas of mental illness and co-occurring disorders. Scholarship recipients could repay a scholarship by working in Iowa where professionals are needed.
8. DHS should be encouraged to continue to focus on cost-containment strategies such as joint purchasing and shared staff when feasible, and should implement a coordinated, consistent business management of the MHI facilities, as well as continue current public/private partnerships.
9. Explore opportunities to gain eligibility for Medicaid reimbursement for adult inpatient services at the MHIs which is currently prohibited under a federal policy known as the IMD Exclusion (IMD refers to institution for mental disease).

Economic Impact Analysis

An economic impact analysis of the state's four MHIs was conducted by David Swenson and Liesl Eathington, Department of Economics, Iowa State University. The primary focus was a review of the regional economic and fiscal impacts, demographic outcomes, and

travel and time consequences to patients and their families that might accumulate were one of the state's MHIs to close. As might be expected, the report indicates the economic impact of an MHI on its host community (county) is directly dependent on the number of employees, local purchases and other factors that are made. A large institution has a greater impact on its fiscal and economic impact than a smaller institution. The complete economic impact analysis and methodology used may be found on the DHS Web site at: http://www.dhs.state.ia.us/mhdd/MHI_TaskForce/MHI_TaskForce.html.

Table 1 below shows the combined impact of the 4 MHIs on Iowa's economy. In all, $107.4 million in total public and private output (expenditures), $75.3 million in value added, $63.5 million in labor income, and 1,301 jobs are the direct or indirect result of MHI spending at the four facilities in Iowa.

Table 1

Statewide Economic Value of All MHI Facilities

	Total Industrial Output	Value Added	Labor Income	Jobs
Direct	54,581,808	46,665,766	46,665,766	780
Indirect	6,568,345	4,119,488	2,990,232	60
Induced	46,208,172	24,482,405	13,865,631	462
Total	107,358,325	75,267,659	63,521,630	1,301

Notes:

1. Total Industrial Output is the value of all goods or service production on an annual basis for government and private industry -- in the public sector it is usually the institution's annual budget.
2. Labor Income is made up of the wages, salaries, and employer-supplied benefits to workers.
3. Value-added is composed of all labor incomes plus returns to investors, which take the forms of interest, dividends, or rents, plus indirect tax payments to governments that are part of the production or service delivery process. Value added, especially when measured in total at the regional or state level, is the same as gross domestic product.
4. Jobs - There are more jobs than employed persons in an economy as many people have more than one job. Jobs are counted by the place of work, that is, the actual location of the jobs, which is not necessarily the residence of the workers.

The MHIs directly generate $54.6 million in spending across Iowa. In producing these services to Iowans, the institutions pay $46.7 million in labor to 780 job holders. The institutions combined Iowa-based purchases amount to $6.6 million which creates 60 jobs

in the supplying businesses across the state which generates $2.99 million in salaries for those individuals.

The employees of the MHIs and local business suppliers convert their paychecks into household spending. In so doing they induce (or cause) more local spending as businesses supply goods and services to accommodate their household needs. To do that those businesses buy their goods and services and provide payroll to their workers, which fuels more local buying. The induced spending from the 4 MHIs is $46.2 million which creates 462 jobs and $13.87 million in labor.

Table 2 shows the local expenditures (County-Supplied Inputs), labor and jobs per MHI. As can be seen, Independence MHI generates 277 jobs with a labor cost of $19.2 million and local purchases of $881,624. Cherokee MHI generates 170 jobs with a labor cost of $12.3 million and local purchases of $157,202. Clarinda and Mt. Pleasant MHIs generate 183 and 150 jobs with labor costs of $7.5 million and $7.6 million respectively. Clarinda and Mt. Pleasant have many jobs with shared costs and duties between DHS and the Department of Corrections due to their shared campus.

Table 2

Initial Modeling Input Values

	County-Supplied Inputs	Labor Income	Jobs
Cherokee	157,202	12,315,861	170
Clarinda	149,799	7,514,773	183
Independence	881,624	19,196,023	277
Mount Pleasant	781,767	7,639,109	150
Statewide	$5,455,265	$46,665,766	780

The impact analysis of closure and consolidation of any one of the MHIs as well as impact of patients and families was considered using several different models which can be found on the DHS Web Site at: http://www.dhs.state.ia.us/mhdd/MHI_TaskForce/MHI_TaskForce.html.

Concluding Remarks

The Task Force understands DHS and the Legislature may not be able to implement all of its recommendations immediately. However, in order for the system to meet the needs of consumers, family members, providers, and the community at large, several strategies must be implemented concurrently. The Task Force has endeavored to provide DHS and the Legislature with more than a few short-term recommendations.

A mental-health reinvestment account should be established in state government to receive any proceeds from the sale or lease of an MHI facility or from any reduction in operating costs. This resource will be designated for transitional and ongoing funding for community-based mental-health and other disability services.

The Task Force urges DHS and the Legislature to ensure that the needs of an increasingly aging population with both psychiatric and medical needs are addressed by development of a comprehensive array of community-based services. Furthermore, Iowa must commit to culturally competent treatment of its diverse population.

Finally, the Task Force urges the Legislature to consider the impact of the financial crisis on the mental health of Iowans, when considering recommendations. While we are beginning to see some signs of recovery from the financial crisis, the social, mental–health, and economic impacts will likely increase and continue for many years. “People with mental health problems are among the last to benefit from economic good times and the first to suffer in a downturn.”[1] The Task Force acknowledges that Iowa must improve access to services, the quality and efficiency of services, and funding to support development and provision of community-based resources, at a time when the need and demand for services and supports is increasing.[2]

The MHI Task Force offers this report in the spirit of coordination and cooperation, while recognizing three important facts.

1. Iowa has made some good progress in the past several years:
    a. The State has developed and is operating two Systems of Care projects for children and youth with severe emotional disturbance in the Dubuque and Polk County areas.
    b. A regional service network involving 5 counties was established in which financial and personnel resources were combined to meet client and community needs in a more equitable manner.
    c. In one region, community-based, crisis-services programs were funded for adults and youth.
    d. Mental Health First Aid, an education and training program to create awareness of mental illness and disability issues, was developed and has been brought to several communities and school systems across Iowa;
    e. A behavioral health response network was established and has responded to multiple community-crisis events, such as natural disasters.
    f. DHS partnered with the Iowa Department of Public Health to implement a standardized approach to improve provider competency in treating individuals with co-occurring disorders.
    g. The Iowa Consumer Outcomes Measurement (ICOMS) system that collects data on consumer outcomes from Iowa's community mental-health centers is being implemented.
    h. DHS responded to Iowa's severe weather disasters by developing and implementing a crisis counseling outreach program for thousands of Iowans in 30 counties across the state.

2. Iowa's mental-health system cannot be changed overnight.

3. In these difficult economic times, even though new resources are needed, the cost of improving Iowa's mental-health system must be balanced with other important services and programs needed by the state's citizens.

Regardless of challenges that confront Iowa, services and supports for Iowans with mental illness and disabilities can no longer be treated as optional programs. The needs of these citizens must be elevated to the point that they receive equal consideration with other basic human needs when financial, policy, and program decisions are made.

Iowans care deeply. Hubert Humphrey reminded us that we will be judged by how we treat those in the shadow of life; Iowans believe that. We know that the mentally ill need and deserve the best comprehensive system that Iowa can provide. The MHI Task Force reviewed the MHIs; we listened to staff and clients and communities who care passionately about providing these services.

We conclude that: 1) No MHI should be closed at this time; 2) The MHI mission must be re-defined; 3) MHIs are and should continue to be an important component in the continuum of care; 4) Community-based mental-health and crisis-intervention services must be expanded and strengthened; 5) School-based mental-health services, including early detection and intervention, should be expanded; 6) Subacute care options must be expanded and MHIs may serve in that capacity; 7) Forensic or court-ordered mental-health treatment must be better coordinated by DHS, DOC, the Judicial Branch, and others involved.

Short-term, short-sighted budget reductions such as those experienced in Fiscal Years '02, '09, and already in '10 have been implemented; the mentally ill suffered. A long-term, far-sighted plan and overhaul is a moral imperative.

All data, documents and presentations submitted to the MHI Task Force can be found online at http://www.dhs.state.ia.us/mhdd/MHI_TaskForce/MHI_TaskForce.html.

Respectfully submitted,

Ro Foege, Chair
MHI Task Force

Appendices

1. MHI Task Force Members
2. Dates of Task Force Meetings/Hearings
3. MHI Task Force Recommendation Information and Discussion

Appendix 1

MHI Task Force Members

Name	Address
Neil Broderick	West Des Moines, IA 50266
Preston Daniels	Des Moines, IA 50314
Ro Foege (Chair)	Mount Vernon, IA 52314
Thomas Hanafan	Council Bluffs, IA 51503
Danny Homan	Des Moines, IA 50301
Cindy Kaestner	Newhall, IA 52315
Christine Krause	Alden, IA 50006
Christine Louscher	Algona, IA 50511
Vilas (Sid) Morris	Cedar Falls, IA 50615
Debra Schildroth	Ames, IA 50014
Annette Scieszinski	Albia, IA 52531
Maggie Tinsman	Bettendorf, IA 52722

Appendix 2

Dates of Task Force Meetings/Hearings

Date	Time	Location
September 15, 2009 MHI Site Meeting	10:00 am to 5:00 pm	Cherokee Mental Health Institute 1251 W. Cedar Loop Cherokee, IA
September 28, 2009 MHI Site Meeting	10:00 am to 5:00 pm	Independence Mental Health Institute 2277 Iowa Avenue Independence, IA
October 12, 2009 MHI Site Meeting	10:00 am to 5:00 pm	Clarinda Mental Health Institute 1800 North 16th Street Clarinda, IA
October 26, 2009 MHI Site Meeting	10:00 am to 5:00 pm	Mount Pleasant Mental Health Institute 1200 East Washington Street Mount Pleasant, IA
November 9, 2009 Review of Information and Development of Report	10:00 am to 5:00 pm	Urbandale Public Library Meeting Room B 3520 86th Street Urbandale, IA
November 16, 2009 Task Force Report	10:00 am to 5:00 pm	Urbandale Public Library Meeting Room B 3520 86th Street Urbandale, IA
December 2, 2009	10:00 am to 5:00 pm	Urbandale Public Library Meeting Room B 3520 86th Street Urbandale, IA

Appendix 3

MHI Task Force Recommendation Information and Discussion

Guiding Principles for Decision Making

The agreed upon principles below guided the MHI Task Force's efforts and recommendations, and include:

- Individuals should live and be served in the least restrictive community settings whenever possible. Services and programs should empower and support people with disabilities, elders, and minorities, and be culturally sensitive to allow people to live with dignity and independence in the community by expanding, strengthening, and integrating systems of community-based supports that are person-centered, high in quality and provide optimal choice[3]. This principle is based on the Olmstead Decision, a U.S. Supreme Court decision requiring states to provide services "in the most integrated setting appropriate to the needs of qualified individuals."

- Iowans should have timely access to a comprehensive, integrated, and consistent array of services and supports that are individualized and flexible.

- Innovative thinking, progressive strategies and ongoing measurement of outcomes can help to achieve better results for people.

- Adequately funding services and supports for Iowans with disabilities is critical to achieving outcomes and quality of life.

- Recovery and resiliency should be central tenets for the Department of Human Services, Division of Mental Health and Disability Services in setting policies for mental health and disability services and in the delivery of inpatient and community-based services.

- The public mental health system, as funded by the Department, is the safety net for individuals living with mental illness. The state has a duty to ensure that the safety net remains effective, secure and funded at appropriate levels. The Department must reaffirm its role as the State's Mental Health Authority and be the leader in ensuring that citizens have access to an array of high quality and coordinated mental health services.

- The community-based service system must be strengthened. Change is challenging. The Department must insure that transitions for individuals from Department operated hospitals to community placements are done in accordance with a thoughtful, inclusive planning process that involves all stakeholders and which ultimately presents the best opportunity for each consumer to achieve full recovery. Supports should be provided by a mix of state operated, state contracted and consumer operated services.

MHI Task Force Recommendations and Discussion

The Task Force report includes observations regarding the operation of the mental health institutes and recommendations concerning: facility closure; forensic evaluation and treatment; acute inpatient care; community services; and general policy and administrative matters.

The Task Force is cognizant that the Department cannot implement all recommendations immediately; however, given that in order for the system to meet the needs of consumers, several strategies must be implemented concurrently and strategically.

Facility Closure

1. *No state facilities are recommended for closure by the Task Force, at this time.*

It is potentially "feasible" for the state to close a mental health institute since services could be found for clients in other state facilities as well as in other community-based acute care hospitals. Many negative impacts on client services were documented. It is not advisable to close any state facility until long-term policy is established, clinical and cost goals are articulated, and adequate supports and services are in place in communities to treat individuals with mental illness to prevent crises and ensure lifelong community for everyone.

The system should be designed to respond to the geographical restrictions to care experienced by many Iowans. Special efforts should be made and unique strategies designed to meet the needs of consumers living in rural areas, reduce reliance on state hospital services and decrease the travel burden on consumers, their families and local law enforcement.

2. *Decisions that affect the future of the facilities must be made in the context of the whole service system, the people it serves, total costs, and best practices.*

The state mental health institutes provide the state with the most restrictive and expensive service alternatives for persons with mental illness. Their cost and admission criteria ensure that only small numbers of high need consumers gain access. However, the facilities exist on one end of a complex and slowly growing continuum of care that has expanded in recent years due to advances in evidence based practices[4], new medications, services and supports, but much improvement and more community-based alternatives are needed. The role, cost and demand for institutional services can only be understood in light of the full system of care, the people it serves and its total costs.

Forensic Evaluation and Treatment

The Department of Human Services and the MHIs have a limited role in the provision of evaluation and treatment of individuals involved with the criminal justice system. Forensic admissions are involuntary admissions to a mental health institute that originates from the court or other place of detention. For purposes of this report, the definition of the term “forensic population” applies to that population of adults and children with mental illness who are at risk of entering or have already entered the criminal or juvenile justice system.

Information received by the MHI Task Force from the Department of Corrections indicates that approximately 42% of prisoners within the justice system in Iowa have a mental illness. There is a continued need for the forensic population to receive mental health treatment; which is provided by the Department of Corrections in Iowa.

Pursuant to Iowa Code, 904.201, the Iowa medical and classification center at Oakdale is the forensic psychiatric hospital in Iowa for persons displaying evidence of mental illness or psychosocial disorders and requiring diagnostic services or treatment in a security setting, as a security unit for persons requiring confinement in a security setting, and as a classification unit for the reception, orientation, and classification of inmates before placement in the most appropriate correctional institutions according to necessary security and custody arrangements and the assessed service needs of the inmates. The forensic psychiatric hospital may admit the following persons:

- Residents transferred from an institution under the jurisdiction of the Department of human services or the Iowa Department of corrections.
- Persons committed by the courts as mentally incompetent to stand trial under section 812.4.
- Persons referred by the courts for psychosocial diagnosis and recommendations as part of the pretrial or presentence procedure or determination of mental competency to stand trial.

- Prisoners transferred from county and city jails for diagnosis, evaluation, or treatment for mental illness.
- Other persons may be admitted providing the admissions are not inconsistent with law and are within the capacity of the facilities and staff to accommodate the persons.

3. *Collaborative efforts and communications should be expanded between the Iowa Departments of Human Services, Public Health, Corrections and Education, the Judicial Branch, and other stakeholders to improve access to treatment and outcomes for those who are at risk of entering or have already entered the criminal or juvenile-justice systems. Suggestions include the following.*

   a) Uniform screening and assessment instruments to identify persons with mental illness and substance-use disorders should be developed and used statewide.

   The Task Force recognized the difficulties inherent in development and use of a global screening tool given the variation in correctional and mental health operating procedures.

   b) Provision of mental-health services to patients in jails and prison.

   c) Cross training for personnel in areas of mental-health, substance-use, and other co-occurring disorders.

   Cross training for mental health, substance abuse, and other co-occurring disorders should be developed and provided to criminal and juvenile justice personnel, as well as family members to improve communications and competency in working with the forensic population.

d) Expansion of jail-diversion programs and services to route individuals with serious mental illness and co-occurring mental-health and substance-use disorders away from jail.

Expand existing jail diversion programs and services to divert individuals with serious mental illness (and often co-occurring mental health and substance use disorders) away from jail and provide linkages to community-based treatment and support services.

The jail diversion program would screen individuals entering the criminal justice system for mental illness; use mental health professionals for evaluations and work with the criminal justice system and the courts to develop community-based mental health alternatives for them and link the client to the community-based services.

e) A study of the forensic population in Iowa to quantify the changing need for services as well as current availability of services.

There is no standard for gathering data on inmates with mental illness or the extent of mental health and suicide prevention services being provided across Iowa at this time. Before clear recommendations can be made there is a need to have a better understanding of the issues of the forensic population in Iowa. Data provided by this review would contribute to a cost/benefit analysis that will help shape recommendations for correctional forensic mental health policy initiatives in Iowa.

Continuum of Care

4. *The recommendations of the DHS Mental Health Acute Care Task Force are supported and adopted as MHI Task Force recommendations, including the following.*
    a. *Develop regional community-based mental–health and crisis-intervention services as a first-line safety net for children, youth and adults, including Crisis Stabilization Centers, Crisis Resource Centers and Mobile Crisis Stabilization Teams and Services.*
    b. *Subacute services should be developed to allow for timely transition of patients who no longer need psychiatric inpatient-hospitalization services, to less intensive and less restrictive treatment centers.*
    c. *Expand capacity in Iowa's local hospital emergency rooms to provide appropriate psychiatric screening.*
    d. *Expand the role of community mental-health centers to function as Community Access Centers that provide core safety-net services in designated geographic areas on a 24/7 basis.*

ACUTE CARE TASK FORCE: Recommendations for Creating A Statewide Mental Health Acute Care Service System

Background:

In the spring of 2007, the Iowa Legislature passed the *Mental Health Systems Improvement Act* that directed the Department of Human Services, Division of Mental Health and Disability Services (MHDS) to form workgroups, composed of statewide stakeholders representing the MHMRDDBI Commission, Iowa Mental Health Planning Council, consumers, statewide advocacy organizations and counties to make recommendations to the Commission for the improvement of the mental health system.

One of the top priorities that emerged out of several workgroups was the importance of creating a *statewide* acute mental health care service system, allowing for all Iowans to access critical mental health care for urgent/emergent needs. In the fall of 2008, it was recommended that an Iowa Mental Health Acute Care Task Force be established to design a set of recommendations to MHDS for cross-system planning and implementation of expanded acute care services.

As a result, DHS MHDS invited over 60 statewide stakeholders including representatives from provider organizations, advocacy groups, consumer networks, payer entities, state agencies, legislative staff and other interested groups to join the Mental Health Systems Acute Care Task Force.

Iowa is "transforming" its mental health system to one that is recovery-oriented or based on individual and family needs of the citizens of Iowa, rather than traditional mental health practices and restrictive care. In the area of Acute Care services, this long term plan requires a shift in philosophy from "triage to recovery" and embraces SAMHSA's National Recovery-oriented Consensus Statement with the following principles: Self-direction (choice), Individualized and person-centered, Strengths based,

Responsibility, Respect (self and society), Empowerment (needs, wants, goals), Holistic (community, housing, spirituality, etc.), Non-linear (recovery), Peer support, Hope

Iowa Partnerships At Work:

The development and composition of the Iowa Mental Health Systems Acute Care Task Force includes active representation from Iowa department of Human Services, Iowa Department of Public Health (substance abuse), Iowa Hospital Association, University of Iowa department of Psychiatry and Center for Disabilities and Development, Iowa Nurses Association, Alliance for the Mentally Ill of Iowa, Iowa Ombudsman's Office, consumers, County CPC's, Magellan Behavioral Health, Iowa Protection and Advocacy, mental health and substance abuse trade associations, Legislative Services staff and many other organizations and individuals that are listed in the table attached.

Guiding Principles of the Task Force:

The Acute Care Task Force, through several monthly meetings over the course of a two (2) year period, agreed to use a set of guiding principles for the acute care system that served as the focus of all recommendations made to the MHDS Division.

The guiding principles for an acute care mental health system are as follows:

- Recovery-oriented, welcoming - Providing the essential and motivating message of a better future – that people can and do overcome the barriers and obstacles that confront them.
- Community-based – Service and supports will be provided within communities, allowing individuals to stay at home, at work, in school
- Least restrictive – An array of services and supports will be available at varying degrees of intensity/restrictiveness to persons receive appropriate mental health care, not just available mental health care
- Client-centered – Pathways to recovery are based on individual's strengths and resiliencies as well as his/her needs, preferences, experiences, cultural etc.
- Strengths-based – Building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals
- Co-occurring capable – Assumption that co-occurring disorders are an expectation within individuals, not an exception and services and supports should be delivered to appropriately address the whole person

- Enhanced through Training/Education – Education and training are essential to building a system that is recovery-focused
- Evidence based practices – State-of-the-art services should be the hallmark of mental health care for Iowans
- Peer and Family Support Systems, Prevention, Programming and Family education – Mutual support – including the experiential knowledge and skills and social learning – plays an invaluable role in recovery

By Default, NOT By Design

The task force spent considerable time reviewing key available data and studying the current "system" for helping people in crisis situations. One of the initial activities was to create a logic map of the acute care system in Iowa, to visually understand the routes through which people enter the system and where they are typically served (see attached).

The mapping showed that hospital emergency rooms (ER) serve as the "hub" of mental health crisis services by default. From ERs, people are commonly referred/committed to inpatient psychiatric units for care, including the state-run mental health institutes (MHI). Jails are another entity where people with mental health crisis needs are placed routinely.

Use of community-based services for crisis assistance, such as community mental health centers, substance abuse centers, and other support services are not typically considered as a first stop for an individual or family experiencing a mental health crisis.

The task force determined that Iowa's acute mental health system has been created BY DEFAULT, NOT BY DESIGN and thus has many gaps and pitfalls through which persons with mental illness fail to get served appropriately, according to the guiding principles desired for a premier service system.

Review of Data Tells Us…

- In last 5 years, mental health and substance abuse applications for commitments in Iowa have increased 10% for adults. Source: Iowa Judicial Branch.

- In last 5 years, mental health and substance abuse applications for commitments in Iowa have increased 138% for children. Source: Iowa Judicial Branch.

- Iowa has over 800 psychiatric inpatient beds across the state but many of those beds are occupied by people unable to be discharged to a less intense level of service. Source: Iowa Hospital Association and DHS.

- There is no standard procedure for locating at bed for court-committed individuals. Many counties ask parents and family members to search for an available psychiatric bed across the state. CPC personnel, Clerks of Court, County auditors, magistrates, sheriff department personnel, CMHC staff and hospital staff are others utilized to locate beds. Source: Iowa Ombudsman's Office CPC Survey.

- In the past five years, Magellan paid ~$32 million dollars for people on psychiatric units that no longer met medical necessity to be on the inpatient unit (over 6,000 patients authorizing more than 46,000 days) Source: Magellan Behavioral Health.

- Over 40% of people in Iowa prisons have a mental illness or co-occurring mental illness and substance abuse diagnosis (DOC recognizes this is a low count due to data collection methods) Source: Iowa Dept. of Corrections.

- On any given day, there are ~150 kids out of state, the majority of whom have serious emotional disabilities. Source: Iowa DHS.

- Iowa is 2nd highest in the nation of out-of-home placement of kids (2006). Approximately thirty percent (30%) of kids in out-of-home foster care come into custody for mental health service reasons, not safety and protection. Source Annie Casey Foundation.

- Suicide is the 3rd highest cause of death across the nation for adolescents. In Iowa, suicide is the 2nd highest cause of death for adolescents. Source: Iowa Department of Public Health.

- The array of crisis services available to Iowans is minimal and is not dispersed equitably across the state. Source: DHS Acute Care Task Force Crisis Services Survey to CPCs, May 2009.

- Sheriffs Departments across the state do not have standard assessment tools for assessing the mental health and substance abuse needs of detainees. Many do not assess their detainees at all. Source: Iowa Sheriffs Association Survey from DHS Acute Care Taskforce, 2009.

- Less than 50% of emergency rooms surveyed have access to a behavioral health nurse or social worker to assist with behavioral health patient evaluations and level of care decisions. Source: Iowa Hospital Association, Behavioral Health Affiliate Survey.

- When local CMHC assessment services are offered at the Clerk of Court office for persons who have commitment applications filed, over 95% are diverted from psychiatric admission (Eyerly-Ball Mental Health Center, MCRT data, 2008).

Task Force Recommendations:

The Acute Care Task Force determined that the following areas are of greatest need for development or enhancement in order to efficiently and effectively serve people in crisis mental health situations. These programmatic/policy areas were chosen as the top priorities from a lengthy list of needs identified in order to have a state-of-the-art acute care mental health system statewide. The choice of the following areas of concentration was made with the thought that these programs and/or policies would provide a greater array of options for people experiencing a mental health crisis while meeting the intentions of the guiding principles of the task force.

A complete Acute Care Task Force Recommendations Outline will be forthcoming from DHS MHDS by December 2009.

A.) Crisis Stabilization Centers for Adults and Child and Adolescent Crisis Stabilization Services

General Description:

Adult - Crisis stabilization centers for adults provide 24-hour access to shelter, food, social support, and comprehensive treatment services for persons experiencing a mental health crisis who are voluntarily seeking assistance and do not need inpatient hospitalization. Services are typically provided in a small, comfortable setting, often preferred by consumers. These centers typically do not serve more than 10 people at a time. Treatment includes intensive discharge planning which links the consumer to natural supports and community resources needed for ongoing recovery. Crisis stabilization centers typically cost a fraction of inpatient hospital care. They are staffed by a multidisciplinary team which includes a psychiatrist, psychiatric nurses, peer support specialists, and social workers &/or mental health counselors. Services often include significant peer provided care and support. Crisis stabilization units are recovery focused and co-occurring capable. Average length of stay is 2 weeks or less. Units should be available statewide.

Youth and Adolescent - Crisis Stabilization Services for Youth and Adolescents provide 24-hour access to a continuum of crisis services that include:

Mobile crisis outreach services that are provided in the home, school, and community to de-escalate interpersonal, community and intra-familial tension that is frequently the antecedent condition that typically underlies high-risk behaviors in children/youth.

Community-based stabilization center is available to provide the children/youth with needed shelter if the situation cannot be de-escalated to a safe level. The family is a critical partner in this process and should participate in the crisis stabilization services to the fullest extent possible, including receiving services at the center with their child. The Crisis Stabilization Services Center (CSSC), in addition to providing a safe and welcoming environment that de-escalates interpersonal, family and community tension, allows the child/youth and family to access a professional team that facilitates a multi-faceted mental health assessment that evaluates the therapeutic needs of the child/youth and assists the family in accessing needed services. Discharge planning is also an integral part of this service, with the crisis stabilization worker facilitating smooth transitions back to the home, school, and community.

What gap is this filling in the current acute mental health care system?

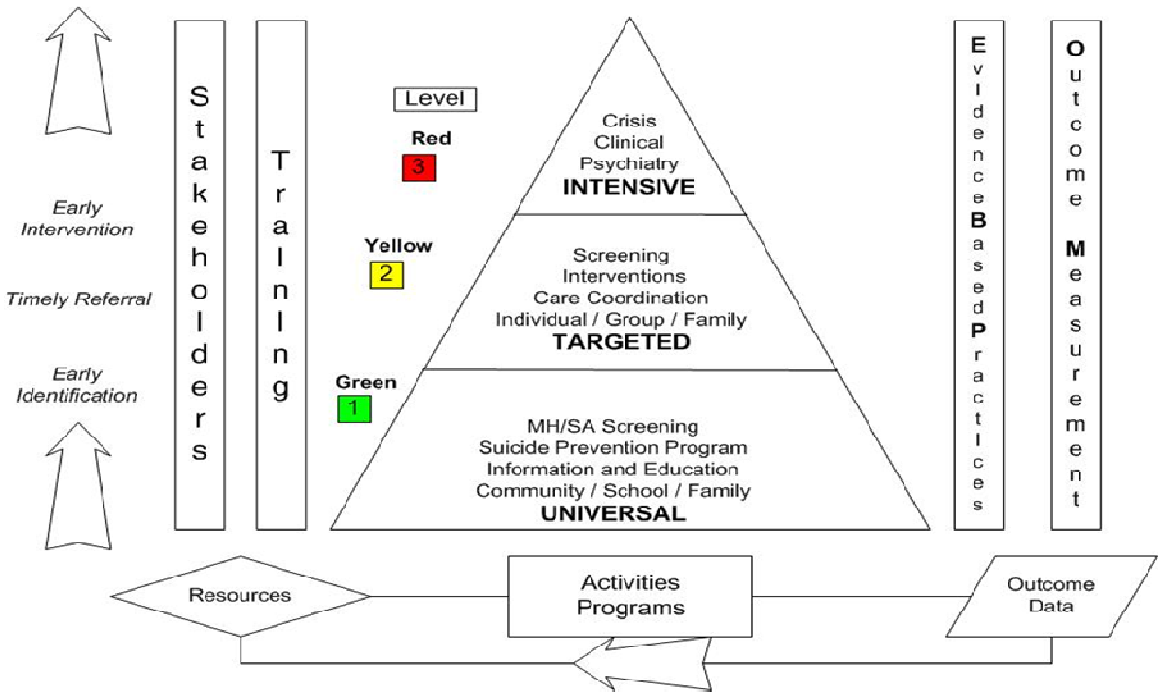
Adult - There is a gap in serving the need of people whose crisis episodes are due to psychosocial stressors/events that can be better resolved through support and linking interventions (care coordination) than by medical interventions generally found on inpatient units. Crisis stabilization centers can provide an alternative to inpatient hospitalization for persons who are voluntarily seeking treatment and support to resolve a mental health crisis and do not need inpatient hospitalization. Small, welcoming home-like settings can provide respite for persons needing intensive support and linking to resources and can assist post-hospitalization for persons needing intensive assistance establishing community supports. This is an appropriate alternative for judges and law enforcement who assist persons with mental health needs to find help.

Youth and Adolescent - When hospitalization criteria are unmet or funding is unavailable, there is an absence of programming designed to provide minors with the opportunity to stabilize their emotional and behavioral situation unless the child/youth is court ordered into shelter or more restrictive services that are intended to consequence negative behaviors. The outpatient system is not designed or equipped to handle children/youth who are frequently in crisis and who may lack adequate support and services to manage their mental and behavioral health issues. Families are left with the option of seeking more restrictive options than may be needed for the situation due to the lack of crisis intervention and stabilization services. Crisis stabilization is a short-term intervention that isolates the youth from provoking stimuli and gives them the opportunity to develop insight and foresight to regain control of their future, while providing families the opportunity to receive support and assistance in improving the situation that led to the crisis.

B.) School-based Mental Health Services

General Description: The school based mental health model promoted by this task force is based on the public health model of three levels of intervention- primary prevention , secondary (early intervention), and tertiary (intensive) services. School-based mental health services would be available to all students with emotional, substance abuse and mental health needs. Additional consultation and support would be available to families to help them navigate the complex and sometimes frustrating mental health system of care. Educators would be provided with necessary education and support that will help them better understand their students' mental health needs and respond in a more effective manner.

School-Based Mental Health Improvement Proposal Model



What gap is this filling in the current acute mental health care system?

Mental health services need to be readily available to children and families in a setting where children spend a significant amount of time, and where many behavioral and emotional issues occur. School based services provide a unique opportunity to address concerns in an environment that is convenient, more comfortable and decreases transportation issues and time away from school for appointments. Increased service provision, improved access to services, and care coordination would be available through schools, using a collaborative team approach to identify children at risk of mental health issues or in need of services, and provide/refer families to appropriate services. Schools and mental health providers would build cooperative relationships that would ensure seamless transition of referrals from schools to outside referral sources, and would maintain communication regarding ongoing needs and issues.

C.) Jail Diversion Program

General Description:

The term "jail diversion" refers to programs that divert individuals with serious mental illness (and often co-occurring mental health and substance use disorders) away from jail and provide linkages to community-based treatment and support services. Most programs:

- Screen detainees in the criminal justice system for the presence of a mental disorder
- Employ mental health professionals to evaluate detainees and work with the criminal justice system and the courts to develop community-based mental health plans for them
- Seek a disposition that is an alternative to prosecution; as a condition of reduction in charges; or satisfaction for the charges
- Decide upon a disposition and link the client to the community-based services

What gap is this filling in the current acute mental health care system?

Programs divert individuals with serious mental illness and co-occurring substance use disorders from the jail to community-based treatment and support services. This programming allows for avoidance of unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illness/substance illness.

D.) Subacute Services

General Description: Subacute services are time-limited services which provide 24 hour comprehensive treatment services for individuals experiencing a mental health crisis who have received acute care in an inpatient setting, yet have not been adequately stabilized such that they can be discharged to their own home or other residency setting. This service is provided as part of a discharge plan to continue care from an inpatient unit. The objective of this service is to provide active treatment, ensure the safety of the person served and the safety of others, to allow time for stabilization, consultation and resource mobilization. Treatment includes intensive discharge planning which links the individual to community resources needed for ongoing stabilization and recovery in their own home and community.

What gap is this filling in the current acute mental health care system?

In Iowa, some individuals are not stabilized within the timeframe of the acute inpatient stay and cannot be safely discharged to their own home of other permanent residency situation. These individuals stay in the inpatient setting post medical necessity for acute hospitalization resulting in unnecessary costs to the individual/family, the inpatient facility, and any third party insurers (including Medicaid).

E.) Expanded Role of Designated Community Mental Health Centers

General Description: The community mental health center (CMHC) is viewed as a vital player in the provision of mental health services across the state of Iowa. Still, the CMHC needs to have an enhanced, active and effective role in the delivery of acute mental health services for the communities they serve. The taskforce supports the proposal submitted by a designated advisory committee in Spring 2009 to revise Iowa Code 230a, which defines the role of the CMHC. The taskforce recommends that the CMHC should serve as an Access Center for a community, through which a wide array of acute services will be provided on a 24/7 basis. Further, the taskforce recommends fundamental changes in how CMHCs are structured, financed, overseen and accredited statewide in order to allow for the a robust scope of services, including a mandated core safety net of services, to communities regardless of income, diagnosis or age.

Core safety net services suggested to be mandated include:

- 24/7 crisis emergency response
- 24/7 mobile response
- Screening Services
- Liaison with inpatient/residential when consumer is admitted
- Crisis care coordination

What gap is this filling in the current acute mental health care system?

CMHC would serve an active role in the delivery of the mental health safety net service array rather than a passive or selective role. Currently, while CMHCs are require to provide "emergency services", this often takes the form of an answering service and a referral to a local emergency room, resulting in no meaningful interaction with individual in crisis and the CMHC. This would created a statewide safety net of services with the CMHC serving as the "hub" for these services.

F.) Psychiatric ER Screening

General Description: The Psychiatric Emergency Room (PER) is the term used to describe appropriate psychiatric assessment and care services are provided within an emergency room setting. In the emergency room, the psychiatric exam should be completed by a behavioral health nurse or another mental health professional, utilizing an acceptable psychiatric assessment tool. Access to a psychiatrist, or mental health-skilled ARNP for level of care determinations and medication consultations should be available either in person, via telephone or via telehealth services at all times.

The psychiatric exam should be conducted in a safe environment, i.e. a "safe room", commonly located apart from the main emergency room bed area.

What gap is this filling in the current acute mental health care system?

Because the ER is the first stop for many people in Iowa in need of mental health crisis services, having a designated psychiatric emergency room that is either part of the regular ER or an actual separate emergency department is critical. Currently, most local hospitals, especially in rural areas, do not have trained mental health professional available to provide the appropriate assessment and care services for people with mental health needs. This results in an increase of unnecessary psychiatric admissions, incorrect diagnosis, inappropriate treatment recommendations and medication prescriptions. The final outcome is often delivery of substandard care that is more restrictive than necessary and costly. Having ER staff that are placed in the ER to provide appropriate assessment and intervention will result in better care and higher quality of life outcomes for people.

G.) Commitment Diversion/Chapter 229 Revisions

General Description: The practices and Iowa Code associated with Iowa's mental health commitment is recognized to be in need of review and revision. Like other areas of focus, the commitment process looks different in the various communities across the state, largely because the Iowa Code 229 is often interpreted differently by those who are enforcing it. The subgroup working towards recommendations on behalf of the taskforce recommends short and long term goals for redefining commitment procedures in Iowa. Several short term goals have been recommended including statewide training for magistrates, increased utilization of clinical evaluations to determine need for hospitalization, identify procedures for release of people from psych units when evaluation does no require hospitalization.

The long-term recommendation of the taskforce is for the creation of a mental health and judicial task force to build upon the recommendations made by the Iowa Supreme Court's Limited Jurisdiction Task Force and the Acute Care Taskforce to collaborate on recommended changes to Iowa Code Chapter 229 or other related Code and to recommend a plan for achieving systematic consistency across the state between county courts, providers, mental health administrators and policymakers. The recommendations are made so that ultimately a system is developed that provides innovation and consideration of the person in need as the central focus, is efficient and does not overuse the powers of courts and Iowa Code to "manage" the mental health needs of Iowans.

What gap is this filling in the current acute mental health care system?

There are several gaps due to inconsistent interpretations of Code and subsequent procedural variations across the state related to commitment of people with mental health needs. The trickle down effect is costly to the individual's wellbeing, as well as financially to those entities that cover the costs of commitments and related services (mental health advocate services, sheriff/other transport services, legal costs, facility costs etc). Clear, consistent Code and practices adopted by the involved stakeholders will possibly result in an increase in appropriate care for people, that is often less costly.

Resource Utilization

5. The purpose and role of the MHIs as acute-care providers, as stated in Iowa Code 226.1, should be reviewed and updated in keeping with changes in technology, treatment approaches, and services now available in Iowa.

6. The MHIs should expand capacity to share professional and clinical expertise with other community-based providers through professional training, case consultation, and other support. Areas of expertise identified include gero-psychiatric care, co-occurring disorder and substance-use treatment, and mental illness.

7. Creative and collaborative opportunities and incentives should be explored with and by all universities, colleges and other public and private-sector providers, and DHS, to include the following.
    a. Physician, physician assistant, Advanced Registered Nurse Practitioner, psychology, nursing, counseling, social work and other professional training programs, that work with the MHIs and other mental-health providers, in addition to already existing programs.
    b. State-sponsored or other types of scholarships to recruit professionals in the areas of mental illness and co-occurring disorders. Scholarship recipients could repay a scholarship by working in Iowa where professionals are needed.

8. DHS should be encouraged to continue to focus on cost-containment strategies such as joint purchasing and shared staff when feasible, and should implement a coordinated, consistent business management of the MHI facilities.

9. Explore opportunities to gain eligibility for Medicaid reimbursement for adult inpatient services at the MHIs which is currently prohibited under a federal policy known as the IMD Exclusion (IMD refers to institution for mental disease).

An IMD or institution for mental diseases is a hospital, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.[5] The IMD exclusion prevents a state psychiatric hospital from receiving Federal Medicaid for its patients that are over age 21 and under age 65 who reside in an IMD, whereas the same patients hospitalized in a psychiatric unit of a general hospital or treated in a community setting are eligible for such funds. The Task Force heard testimony from Ted Lutterman from the National Association of State Mental Health Program Directors Research Institute regarding an ongoing effort by states to review and pursue opportunities to make state institutions exempt from the IMD exclusion. For example, the State of Minnesota recently closed two large state mental health institutes in favor of creating 10 sixteen bed institutions located across the state that are exempt from the IMD exclusion.[6] For children age 21 and under, different planning parameters apply - institutions with 16 or more beds are eligible for Medicaid reimbursement.

Reference Documents

(Available on the DHS Web Site but not attached)

http://www.dhs.state.ia.us/mhdd/MHI_TaskForce/MHI_TaskForce.html.

1. Economic Impact Analysis
2. Mental Health Institute Overview – All 4 MHI's
3. Cherokee Mental Health Institute
4. Independence Mental Health Institute
5. Clarinda Mental Health Institute
6. Mt. Pleasant Mental Health Institute

END NOTES

[1] International Roundtable: Impact of the Recession on the Mental Health of Workers and Their Families Summary Report. Mental Health Commission of Canada, August 16 & 17, 2009, Ottawa, Canada.

[2] Smith, R. (1987), Unemployment and Health: A Disaster and a challenge. Recent evidence suggests that the recession may increase risk of heart disease, sleeping disorders, migraine, high blood pressure and smoking. People are forgoing prescriptions, checkups and preventative care. Smith suggests that the recession causes increased unemployment and reduced wages (low pay, job insecurity). These factors increase stress, poverty and health behavior changes (social isolation, tobacco, alcohol, drug abuse, less exercise). These factors combine resulting in sub-nutrition, poor housing, increased physical health problems and increased mental health effects, such as anxiety, depression and suicide.

[3] Olmstead Decision. In 1999, the U.S. Supreme Court rendered a decision in Olmstead v. L.C, a case that challenged the state of Georgia's efforts to keep people with mental disabilities institutionalized. The Court interpreted the Americans with Disabilities Act (ADA) to require states to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Additionally, the Court indicated that each state should develop an Olmstead plan to demonstrate efforts to be consistent with the ruling. A state plan typically addresses six areas: 1.) Helping individuals transition from institutional care; 2.) Expanding access to community-based services and supports; 3.) Improving the capacity and quality of community-based services and supports; 4.) Expanding access to affordable and accessible housing with supports; 5.) Promoting employment of persons with disabilities and elders; and, 6.) Promoting awareness of services and supports.

[4] Evidence-Based Practices are those for which consistent scientific evidence shows that they improve client outcomes. The scientific evidence is comprised of several randomized clinical trials (or quasi-experimental studies with comparison groups) in a variety of typical community mental health settings, conducted by different researchers that show consistently better results for consumers than alternative practices or no intervention.

[5] 42 U.S.C. 1396d (i).

[6] Ted Lutterman presentation during MHI Task Force meeting held on November 9, 2009.