LEAGUE OF WOMEN VOTERS OF IOWA

# Report on Comprehensive study of MENTAL HEALTH DELIVERY SYSTEMS IN IOWA Completed February 2009

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# PROPOSED Position on Mental Health
# February 2009 to be presented at LWVIA
# June 2009 State Convention for approval

The League of Women Voters of Iowa supports a centrally coordinated state mental health system that ensures convenient and equitable access to care for all Iowans (children and adults) who need mental health services.

The League of Women Voters of Iowa supports adequate funding of an array of services, especially those that promote early detection and treatment of mental illnesses and co-occurring substance abuse disorders. Appropriate levels of care should be available that meet people's needs in or near their home communities.

The League of Women Voters of Iowa supports a mental health system that individualizes care to meet a person's specific mental health needs and focuses on the person's strengths and ability to recover.

The League of Women Voters of Iowa supports a mental health system that is accountable to its consumers and communities by providing efficient, effective, and evidence-based programs and services.

The League of Women Voters of Iowa supports eradication of the stigma of mental illness and believes persons with mental health needs should be treated with the same respect, and their illnesses treated with the same urgency, as persons with other physical health needs.

## Part I: Background and Context

September 2008

Overall well being is a function of both mental and physical health. Yet the public views mental illness differently than physical illness. "Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning". The stigma attached to mental illness has a long history and continues to be a challenging issue. It is exhibited in bias, distrust, stereotyping, fear, embarrassment, anger and/or avoidance. (1, Ch 1, Sec 1).

The National Institute of Mental Health estimates that in a given year, 26% of Americans of age 18 and older suffer from a diagnosable mental disorder. However, serious mental illness is confined to about 6% of this age group (2).

Several books have been published in recent years that describe the challenges of living with mental illness and trying to access appropriate treatment. A few examples are:

- *Crazy: A Father's Search Through America's Mental Health Madness* by Pete Earley (2006)
- *Crazy in America: The Hidden Tragedy of Our Criminalized Mentally Ill* by Mary Beth Pfeiffer (2007)
- *I Am Not Sick I Don't Need Help* by Xavier Amador (paperback 2007)
- *Street Crazy: America's Mental Health Tragedy* by Stephen B. Seager (2000)
- *The Center Cannot Hold: My Journey Through Madness* by Elyn R. Sachs (2007)

### Awareness of Mental Health Issues at the National Level

The federal government is a major player in determining the direction and attention given to mental health issues. Several major documents have been published in the past decade that identify future directions for mental health delivery and funding in the United States.

**Mental Health: A Report of the Surgeon General** (1999). This report represented the first initiative on mental health by a surgeon general. The complexity of mental health systems, and a good description of the situation in Iowa, is illustrated by this quotation from the document: "Effective functioning of the mental health service system requires connections and coordination among many sectors (public-private, specialty-general health, health-social welfare, housing, criminal justice, and education). Without coordination, it can readily become organizationally fragmented, creating barriers to access. Adding to the system's complexity is its dependence on many funding streams, with their sometimes competing incentives" (1, Ch 6, Sec 1). Eight actions for improving mental health of the population in the new millennium were identified:

- Continue to build the knowledge base.
- Overcome stigma.
- Improve public awareness of effective treatment.
- Ensure the supply of mental health services and providers.
- Ensure delivery of state-of-the-art treatments.
- Tailor treatment to age, gender, race, and culture.
- Facilitate entry into treatment.
- Reduce financial barriers to treatment. (1, Ch 8)

**Children's Mental Health: Developing A National Action Agenda** (2000). A conference focused on children's mental health was initiated by the surgeon general as an outgrowth of the 1999 report. Eight goals and accompanying action steps resulted from this conference (3).

**New Freedom Commission on Mental Health (**2002). President George W. Bush recognized that our country must make a commitment to help individuals with mental health issues so they can be productive members of their communities. In April 2002, he announced the creation of the New Freedom Commission on Mental Health with the mission "to conduct a comprehensive study of the United States mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system." The goal of the Commission was "to recommend improvements to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities" (4, Sec. 3).

This Commission completed its work and submitted a final report, *Achieving the Promise: Transforming Mental Health Care in America*, on July 22, 2003. In the report a fundamental transformation of the Nation's approach to mental health care is recommended. The goal of a transformed mental health system is recovery. The report identified two principles (5, p. 7):

- Services and treatments must be consumer and family centered
- Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience.

Six goals form the foundation for transforming mental health care in the United States and are stated by describing what a transformed mental health system would be like (5, p. 8):

- Americans understand that mental health is essential to overall health.
- Mental health care is consumer and family driven.
- Disparities in mental health services are eliminated.
- Early mental health screening, assessment, and referral to services are common practice.
- Excellent mental health care is delivered and research is accelerated.
- Technology is used to access mental health care and information.

Identifying what is needed is easy compared to delivering the desired action and accomplishing goals.

The need for transformation of mental health systems in this country comes as no surprise to the National Alliance on Mental Illness (NAMI). In 2006 this organization issued a report card for each state based on 39 specific criteria. Category grades for infrastructure, information access, services, and recovery supports as well as an overall grade were reported. This was the first assessment of state programs in 15 years; another assessment is planned for 2009. The top grades were in the B range, and only five states (Connecticut, Maine, Ohio, South Carolina, Wisconsin) were evaluated as being at this level. Eight states received scores of F, including Iowa. The nation as a whole was assessed a grade of D with category grades of D, D, D+, and C- (6*).*

## Awareness of Mental Health Issues in Iowa

The report of the President's Commission on Mental Health has provided an impetus for change in a number of states. Iowa is among those states that are making a concerted effort to improve delivery of mental health services. In 2006, the legislature reestablished the Division of Mental Health and Disability Services within the Department of Human Services (HF 2780). A separate division had been abolished earlier during a time of fiscal crisis in the state. At the direction of the 2007 Iowa legislature (HF 909), the Division of Mental Health and Disability Services established six workgroups with broad-based representation to discuss and make recommendations for improving delivery of mental health services in Iowa. Each workgroup focused on a specific aspect:

- Alternative distribution formula
- Community mental health center plan
- Core mental health services
- Evidence-based practices
- Co-occurring disorders
- Accreditation

The recommendations and priorities resulting from this activity were reported to the legislature and governor in January 2008 (*7,* Recommendations and Comments*).* A 3-phase plan was outlined and details are to be submitted on or before January 15, 2009. Two legislative proposals were presented during the 2008 legislative session:

- Establish a code on Emergency Mental Health Crisis Services (LSB 5362) and budget funds to establish 24/7 emergency/crisis response services to be provided by community mental health centers regionally throughout Iowa
- Establish a code on Children's Mental Health Services (LSB 5355) and budget funds to assist in the development of an infrastructure and local projects for children's mental health services (7, Appendix J).

The code changes were enacted and these budget requests were partially funded. However, no new money was provided for these initiatives.

In the meantime, the College of Public Health at the University of Iowa has been sponsoring a forum series titled *Rebalancing Health Care in the Heartland*. The series has brought together health policy makers and key decision makers in an effort to identify priorities that address health care issues in Iowa. Health care has included both physical and mental health in this series. The first forum, held in November 2006, focused on health care programs in Iowa. The second forum, held in June 2007, focused on state-based health care reforms with particular attention to reforms initiated in Oregon, Tennessee, and Massachusetts. The last forum is scheduled for December 2008 and will zero in on HF 2539 Roadmap. This refers to 2008 Health Care Reform Legislation passed by the legislature (8)

## Financing of Mental Health Services

Funding for mental health services comes from private sources in addition to public funds. Public money is appropriated at federal, state, and county levels.

**Private insurance.** Efforts have been made to include payment for mental health services in private health insurance plans that are comparable to other health services. This refers to mental health parity or equivalent coverage for mental health treatment and clinical visits as for regular medical and surgical benefits within an insurance plan. The federal Mental Health Parity Act of 1996 took effect on January 1, 1998, had a sunset provision of September 30, 2001, but has been extended each year since. The act applies to employers with 51 or more employees that include some form of mental health coverage in their health insurance plans. It does not mandate mental health coverage, and benefits for substance abuse and chemical dependency are excluded. Employers may opt out if mental health coverage would increase their costs by at least 1%. Some variances relating to mental health coverage are permissible under the law:

- Limit on number of patient days covered per member per year
- Limit on number of office visits per member per year
- Limit on amount of benefit cost per member per year for inpatient mental health coverage
- Greater member cost-sharing (9).

Most states have passed some form of mental health parity legislation. Much variation exists among the states, but only two states (Idaho and Wyoming) have no parity or mandate laws (10). In 2005, Iowa passed a limited mental health parity law requiring compliance beginning in January 2006. The law applies only to state-regulated health insurance plans. Employers with 50 or fewer full-time equivalent employees are exempt. The Iowa law covers biologically-based mental health treatment (diseases such as schizophrenia, bipolar disorders, major depressive, obsessive-compulsive disorders, schizo-affective disorders, pervasive developmental disorders, and autism) and requires minimum coverage of 30 days of inpatient care and 52 outpatient visits annually (11).

**Other private funding.** Payment for mental health services may come from out-of-pocket payments by those receiving services, if their incomes are sufficient to cover the costs. Nonprofit providers of services rely heavily on charitable donations to provide services to those who are unable to pay or need a partial

subsidy and to cover shortfalls in reimbursements. Low reimbursement rates in Iowa and dependence on donations or funding from such agencies as United Way provide a precarious foundation for community mental health centers in the state.

**Public financing.** Public financing supports many of the mental health services that are available. This funding comes from various levels of government but is driven by federal funding. Funding is an ever-changing situation. Uncertainty makes long-term planning problematic.

Federal funding. Federal funding is in the form of major programs such as Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) in addition to federal grants for specific purposes. Each of these programs includes provisions requiring minimum benefits for mental health in addition to general health.

The amount of funding, what services will be funded, and eligibility criteria are subject to change during legislative sessions. For example, during the 2007-2008 legislative session a bill to reauthorize SCHIP with the requirement to provide mental health parity (H.R.976) was passed by Congress but vetoed by President Bush, and the veto override failed (12). SCHIP is operating under a short-term extension that expires in March 2009 (13). Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331) survived a presidential veto. This bill included important provisions for Medicare beneficiaries living with serious mental illness. They related to cost sharing under Part B, coverage of prescription drugs under Part D, and changes in eligibility for low-income subsidies under Part D. It also canceled reductions in Medicare's payment rates for physicians' services (14).

State funding. Both Medicaid and SCHIP (known as *hawk-i*, Healthy and Well Kids in Iowa) require matching money from the states in order to access federal funds. The state funds are appropriated through the legislative process. State funding also may pay for some services not required or eligible for federal funding. For example, some states (including Nebraska, Illinois, and Minnesota) use state funds to provide health care for legal immigrant children who are ineligible to receive services paid with Medicaid or SCHIP money. Otherwise, in Iowa these children must wait 5 years to become eligible. Undocumented children are not covered (15).

Additional state appropriations for mental health and disability services in Iowa are channeled through the Department of Human Services. In addition to requests related to general administration, field services, operation of mental health institutes and resource centers, and other required functions, some funds are requested for competitive state block grants to provide specific services.

Some state funds are appropriated for counties according to a formula established by the legislature. Four appropriations are involved: property tax relief, mental health and developmental disability (MHDD) allowed growth, MHDD community services, and the state payment program (that funds services for Iowa residents who have not established legal settlement in an Iowa county). The legislature has funded an MHDD risk pool to assist in meeting financial obligations for MHDD services when a county is faced with extraordinary circumstances (16, p. 144).

County funding. Additional funds (special revenue funds) are collected through property taxes at the county level in Iowa. The county board of supervisors authorizes the assessment not to exceed a fixed budget amount to provide mental health, mental retardation, and developmental disabilities (MHMRDD) services to those who have legal settlement in the county and meet criteria for financial need. The maximum dollar amount (collected from property taxes and received from the state as property tax relief funds) has been frozen since 1996 at the amount a county spent on these services during FY1996 (17). Core services are mandated for residents with mental retardation. These mandated services used an average of 63% of MHMRDD county resources during FY1999-2006. Chronic mental illness, mental illness, and developmental disabilities represented 24%, 10%, and 3%, respectively of designated county resources during the same period (7, Appendix M, p. 10). Core services are not mandated for those with mental illness. Only the cost of involuntary commitment to a psychiatric unit must be paid by a county for someone with mental illness. Available services that are not mandated, criteria for eligibility, and procedures to follow differ among the 99 counties.

Legal settlement determines which county or whether the state pays for services. It relates to length of time someone has lived in a county (at least one year) and not received publicly-funded treatment during that period of time. It is defined in the Iowa Code (18) and is applicable only to a limited population of citizens 18 years or older (those with mental retardation, developmental disabilities, mental illness, brain injury, substance abuse issues, or blindness). Sometimes a dispute over which county should pay ends up in court, such as a case between Grundy and Tama Counties in 2002 (19). As part of the redesign implementation project, the county of legal settlement basis to determine service funding responsibilities is to be replaced by an approach based on residency (J. Halliburton, personal communication, September 23, 2008).

The County Rate Information System, an entity created by the Iowa State Association of Counties, has established a rate setting methodology to determine appropriate reimbursement rates for service providers based on actual cost of providing services. About two-thirds of the counties use information from this service in negotiations with service providers (20).

The strain on public resources to provide mental health services has been growing. The Medicaid share of total national mental health spending rose from 19% in 1991 to 27% a decade later in 2001. At the same time non-Medicaid state spending for mental health dropped from 27% of total mental health spending to 23% (21, p. xi). Of all health expenditures (physical and mental) in 2006, federal and state governments accounted for about 46% (22).

The number of people who potentially may qualify for public funding of their general and mental health needs continues to grow. Data for 2006 indicate that 14.8% of the U.S. population (36.5 million) had no health insurance. This represented 19.8% of adults (36.5 million) and 9.3% of children (6.8 million) (23). A recent study estimated that 25 million adult Americans are underinsured (24).

## Availability of Psychiatric Beds

The number of public hospital beds for mentally ill persons has declined dramatically over time reflecting the de-institutionalizing of mental health treatment. In 1955 there were 340 public (state and county) psychiatric beds per 100,000 population in the 48 states. By 2005 the number had declined to 17 per 100,000 population in the 50 states, and Iowa ranked fourth from the bottom with 8.1 beds. Less than 12 beds per 100,000 was considered a critical shortage, and a consensus of experts identified 50 beds per 100,000 as the minimum number needed (25).

The loss of psychiatric beds continues in Iowa. In 2007, Trinity Regional Medical Center in Fort Dodge closed its 24-bed inpatient psychiatric unit when its only psychiatrist retired (26). In July 2008, Ottumwa Regional Health Center announced that it would be closing its 23-bed inpatient unit as soon as patients could be discharged or referred elsewhere. The center had lost two of its three psychiatrists and had been unable to recruit replacements (27). These closures put added pressure on the remaining institutions to provide care for a wider geographic area. For a patient it may mean hospitalization at a distant location when the individual is in a vulnerable state.

## Availability of Mental Health Professionals

The number of trained psychiatrists and other mental health professionals in the United States does not meet current needs, and the situation is unlikely to change any time soon. The federal government has been employing mental health professionals at an increasing rate to provide mental health support to military personnel (28). At the end of 2005, Iowa had 220 active psychiatrists practicing in the state. The ratio of psychiatrists per 100,000 population was 7.6 in Iowa compared to 15.8 nationally. The location of psychiatrists in the state is clustered in urban areas. Only 32 of 99 counties have at least one psychiatrist (7, Appendix I, p. 2).

A survey reported 77 full-time (52 adult and 23 child) and 13 part-time (10 adult and 3 child) unfilled budgeted positions for psychiatrists in Iowa. The Critical Demand Index of 0.29 for psychiatrists (calculated by dividing number of open and available positions by current supply) far exceeded the ratio for other primary care specialists in Iowa (7, Appendix I, p. 5). Retention and recruitment of psychiatrists has been a growing problem. Low reimbursement rates in Iowa and lack of health insurance have been cited as contributing factors (29).

Two other categories of licensed mental health professionals are advanced registered nurse practitioners (ARNP) and psychologists. In 2005 there were 1,219 ARNPs living and actively licensed to practice in Iowa. Twenty-three were mental health practitioners, 7 were clinical nurse specialists (CNS) in child/adolescent psychiatry and 37 in adult psychiatry. There were 415 actively licensed psychologists practicing in Iowa, but areas of practice were not known. However, Iowa was ranked 46th in the nation for psychologists per 100,000 population in 2000 (29).

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## Part II: Mental Health Services for Children and Youth

January 2009

The public health approach to mental health emphasizes promoting mental wellness as well as preventing mental health problems and disorders. The majority of lifetime mental illnesses begin in the early years. Half of lifetime cases of diagnosable mental illnesses begin by age 14 and three-fourths by age 24. Early intervention efforts have been effective in contributing to overall well being of children as well as reducing delinquency, substance abuse, risky sexual behaviors, and school failure (1, p. 10).

Early intervention and treatment are particularly important for serious mental illnesses. Research points to the need to forestall brain cell deterioration through early identification and treatment of individuals at risk of schizophrenia. Once the process of brain damage has begun and cognitive defects have been incurred, currently available drugs cannot repair this damage nor can the process be reversed (2, p. 27). It is estimated that 60% of cases of bipolar disorder begin before age 18, and the earlier the onset the more severe the problem. A research study found that it took an average of 8 years from onset of symptoms to arrive at the correct diagnosis, and the subjects had received on average six different courses of medication during that time (3, p. 22).

It is reported that 90% of people who die by suicide have a mental illness (4). In Iowa, suicide is the second leading cause of death for 11-18 year olds. Of the 2,240 deaths by suicide in Iowa from 1999-2005, 150 or 7% were young people of this age (5).

### Description of Current "System"

The mental health care system for children in Iowa is fragmented and lacks coordination. Children in need of mental health services might be identified by their primary care physicians or through the school system (under the Iowa Department of Education), the child welfare and protection system (under the Iowa Department of Human Services), or the juvenile justice system (under Iowa Juvenile Court Services). If substance abuse is a co-occurring disorder then the Iowa Department of Public Health might be involved. Families often are on their own to find appropriate services, availability of services is limited and may not be available in parts of Iowa, and resources to support these services are limited. A recommendation acted upon by the 2008 legislature was to "establish a comprehensive, community based children's mental health system" and to modify Iowa Code 225C to assign responsibility to the Division of Mental Health and Disability Services (6, Appendix J, p. 7).

### Primary Health Care System

Primary care practitioners often are the first to identify children with mental health issues. They prescribe the majority of psychotropic drugs and often provide counseling to families about behavior and emotional problems or disorders displayed by children. Referrals from primary care physicians usually are to child psychologists. Accessing treatment can be impeded by such barriers as lack of available specialists, insurance restrictions, and appointment delays (7, panel 1). All of these barriers exist in Iowa. In addition, transportation and distance to providers are issues. Referrals might be made to various types of therapists or counselors.

### Education System

Children with mental health issues may be identified by teachers in the classroom. School counselors may work with these children to help them function effectively, and large school districts may have programs for children with special needs. Area Education Agencies (AEA) employ school psychologists "to provide mental health services that address needs at home and school to help

students succeed academically, emotionally, and socially" (8). These services include developing a plan for each child specific to the particular situation, working with students individually and in groups, and also developing programs to train teachers and parents. Some children with mental health needs may be referred by the school district or AEA to a specialized school that focuses on children with special needs and has low pupil to staff ratios. For example, Tanager Place School in Cedar Rapids provided individual and group instruction to 82 students in FY 2007. The maximum number of students in a classroom was nine. Not all classes were for those experiencing mental illness (9).

School-based mental health programs can help prevent children from developing mental health problems. An example is Potential Achievers – Elementary.This is a comprehensive school-based mental health program in the Ottumwa schools, currently funded by a grant from United Way and administered by the Southern Iowa Mental Health Center. The focus is on children in grades K-2, but the program is available to students in grades 3-6 also. Mental health services are administered by trained professionals who understand child development and recognize child mental health pathology. The program involves not only the children referred for individual therapy, but parents, caregivers, school staff, and other community professionals. Pre and post assessments of the children have indicated improvement on various measures (10).

Another type of program is TeenScreen. This is a voluntary program that assesses youth for mental illness and suicide risk. It was developed by the Child and Adolescent Psychiatry Division of Columbia University. Both the young person and his/her parents sign a consent form before participating. The teen completes a 10-minute, self-administered, computerized questionnaire. This instrument screens for depression, anxiety, and alcohol/substance abuse. A high score on the risk scale leads to an immediate clinical interview by a mental health professional and, if determined to be at risk, the youth is offered a referral for a complete mental health evaluation. Confidentiality is protected. Results are not shared with school staff nor included in school records (11). Screening in Iowa began in 2004, and during 2006 almost 3,000 familes were offered mental health screening through local TeenScreen programs. A listing for June 15, 2007, that has since been removed from the website, identified 13 schools in Iowa as participating in the screenings (5). There are detractors of programs such as TeenScreen (12).

**Community-based Treatment and Services**

Many mental disorders can be effectively treated with one or a combination of therapies such as medication, psychotherapy, group therapy, or specific therapies (13). Community-based interventions for children and youth with mental illness are considered by mental health experts to be preferable to treatment in residential facilities. Such interventions can be cost effective and often have better clinical outcomes and allow the child to remain in the family home (14, p. 11).

A number of the social service agencies that provide mental health services in Iowa offer a wide range of programs and often include substance abuse treatment services, a recognition that co-occurring disorders (mental illness and substance abuse) are a prevalent condition. Programs may involve prevention, treatment, intervention, and aftercare services for children and may include counseling and other programs for parents and family members. Here is a sampling of types of programs available in some communities in Iowa.

Prevention services. Orchard Place in Des Moines runs a Child Guidance Center that offers a number of child-focused and family-centered treatment and prevention services. One of these is Healthy Start, an empowerment case management program for pregnant women and families with newborns and children up to age 4 (15).

Outpatient behavioral health services. Community mental health centers provide assessments and psychotherapy and psychiatric services for all ages in an office setting. Medication management may be among the services available.

Day treatment services. Four Oaks, Inc. of Iowa provides one-half day education and one-half day treatment to mentally-ill children in two communities that allow the children to live at home (16). A similar type of program for adolescents, ages12-17, is provided by Young House Family Services in three communities (17).

Intervention programs. Lutheran Services in Iowa offers a family advocacy program to avoid out-of-home placement of a young person by providing case coordination and support for the youth and family. Another program, CARE (community, advocacy, resources, education), provides intense, collaborative case management to families with seriously emotionally disturbed (SED) children to keep the family together (18). Tanager Place provides several types of family centered in-home services, such as family team meetings and services funded by the children's mental health waiver. These services might include therapy, teaching skills to assist in community and family living, and providing respite care for SED children (9).

Aftercare services. After a mentally-ill youth has been discharged from an institution, a residential care facility, or detention center an aftercare program can provide such services as medication monitoring and outpatient therapy to ease the adjustment back into the family and community. These services are provided by such agencies as Orchard Place, Quakerdale, and Lutheran Services in Iowa (15, 19,18).

Each of these programs meets a specific need, but a child or adolescent may have multiple needs that would require finding more than one program. A system of care with wrap-around services coordinates all the services needed by an individual and is an example of the direction that community-based services may take in the future. This example, Community Circle of Care, is serving as a possible model for the comprehensive, community-based children's mental health system envisioned in the *Mental Health Systems Improvement in Iowa* report (6, Appendix J). Community Circle of Care serves eligible children and youth ages 0 to 21 from 10 counties in northeast Iowa who have serious emotional and behavioral challenges that severely disrupt relationships and daily activities. The program is funded with a 6-year federal grant and represents a collaborative partnership involving the Iowa Department of Human Services, the Center for Disability and Development at the University of Iowa, and the Iowa Child Health Specialty Clinics at the University of Iowa. The Community Circle of Care uses a team approach and a wide range of services to support and service children/youth and their families. The approach focuses on the strengths of the client, family, and community in which they reside to help the client and family function better at home, in school, in the community, and throughout life. The approach is clinically informed; it views childhood emotional/behavioral problems as illness vs. weakness and tries to wrap treatment and services around the child and family in an effort to solve the problems and create positive change and growth.

Education programs. Education and support can help families learn to cope with mental illness of children and youth. National Alliance on Mental Illness (NAMI) offers a number of education and support programs using materials that are professionally developed either by the national organization or a state affiliate and taught by individuals certified for that program. Two programs are focused on helping family members understand and cope with mental illness within the family unit. Both programs focus on major psychiatric illnesses, emphasizing the clinical treatment of these illnesses, and teaching the knowledge and skills family members need to cope more effectively plus additional topics. These programs are *NAMI Family to Family*, a 12-week, 30-hour series of classes

and *Visions for Tomorrow*, an 8-week, 16-hour series of classes. There are 13 NAMI affiliates in Iowa plus four affiliated campus groups and eight support groups (20).

It is helpful to families when they are able to go to a single location to find out what services are available within the community and get connected to those services. Success Street is a youth and family resource center serving individuals ages 0 – 21. The center is owned and operated by the Black Hawk County Health Department and provides access to a variety of services through collaboration with other agencies. Individual mental health counseling is available through Black Hawk-Grundy Mental Health Center and mental health and substance abuse services are provided by Pathways Behavioral Services (21).

**Residential Treatment**

When treatment in less restrictive environments is unsuccessful, residential treatment is the next level of care. There apparently are two levels of residential care. These are residential care facilities for children with serious emotional disturbances (SED) and Psychiatric Medical Institutes for Children (PMIC) that provide sub-acute care. By contrast, hospitals provide in-patient acute care.

In 2007, Iowa had 10 social service organizations operating residential care facilities specifically identified as treating children with SED. These residential facilities were located in nine counties in the state. The same database one year later listed eight organizations in eight counties simply as providing residential care (22). At the same time *The 2007 Iowa Health Fact Book* listed 32 PMIC facilities in 10 counties with a total of 534 beds (23, pp. 191-192). It appears that this list counted the number of housing units even though several units are part of the same campus operated by one organization and that all residential care beds were considered PMIC beds. The Department of Human Services reported that during FY 2008 there were 476 community-based licensed PMIC beds in the state (24, p. 126).

Residential treatment and PMIC facilities provide a structured environment with children living in unit settings with a group of peers. Treatment may include such common therapy components as individual therapy, group therapy, family therapy, and educational services along with supervised recreation. An individual treatment plan is developed for each child by a team that meets on a regular basis, such as weekly, to evaluate progress (15, 16, 18). The most effective residential treatment programs tend to involve the families, begin planning for discharge at time of admission, and include community involvement and services. Maintaining gains made during residential treatment depends on the amount of family involvement in the treatment before discharge, stability of placement following discharge, and the availability of aftercare supports for both the youth and family (14, p. 6).

**Inpatient Hospital Treatment**

There are 21 community hospitals in Iowa, located in 16 counties, that have separate psychiatric units for short-term acute care. Some hospitals, such as Mary Greeley Medical Center in Story County, have behavioral health units specifically for youth (25). The age range of clients that are accepted into these units usually is specified.

Two of the four mental health institutes in Iowa have beds reserved for children and adolescents. In Cherokee there are six beds for children and six beds for adolescents among the 58 total beds. At Independence, there are 15 beds for children, 10 beds for adolescents, plus 30 beds in a Psychiatric Medical Institute for Children (PMIC) among the 95 total beds. These institutes provide acute psychiatric care. Most of the patients (83%) have been admitted involuntarily. Services during FY 2008 were provided to 417 children and adolescents plus 186 youth in the PMIC (24, pp. 123-125)

**Juvenile Justice System**

Studies have shown that 65-70% of youth in the juvenile justice system in the United States have a diagnosable mental health disorder, and that about 25% of all youth in the system have severe mental disorders and are in need of mental health treatment (26, p. 1). Information about mental health status of juveniles in detention in Iowa was not found in the annual reports of detention centers or in the annual reports of Juvenile Court Services.

Juvenile Detention Centers. Iowa has 11 secure juvenile detention centers, with at least one in each of the eight judicial districts. Six of these centers serve a region, whereas five are operated by single counties (Woodbury, Polk, Linn, Scott, Dubuque). Counties provide most of the funding for the centers (27, p. 3). The Iowa Code allows state reimbursement at rates ranging from 10% to 50% of the centers' operating budgets. Scott County Juvenile Detention Center reported receiving 22-24% in recent years (28). Detention centers provide educational services through Area Education Agencies, recreational activities, group sessions, structured activity, and chores (28,29). Scott County Juvenile Detention Center provides crisis counseling that may include mental health evaluation (if requested by the Juvenile Court) and various tests and evaluations.

Iowa is participating in a juvenile detention alternatives initiative. This initiative is in cooperation with the Annie E. Casey Foundation and involves a pilot program to change policies, practices, and programs to ensure that only those youth who are at greatest risk to public safety are held in secure detention (30). The central objectives of this program are to:

- Safely eliminate inappropriate or unnecessary use of secure detention
- Minimize re-arrest and failure-to-appear rates pending adjudication
- Ensure appropriate conditions of confinement with secure facilities
- Redirect public finances to sustain successful reforms
- Reduce racial and ethnic disparities found in the juvenile justice system (31, p. 5).

Three counties are participating in this program (Black Hawk, Polk, Woodbury). An initial step was to identify detention alternatives within the county to provide appropriate treatment or services to juveniles who were not a risk to public safety. Among the alternatives, each county identified mental health services, but also indicated that there was a serious gap in mental health services available and that services had decreased over time. This resulted in decisions sometimes being made based on services that were available and funds to pay for those services rather than solely on identified needs or appropriateness. Lack of funding was reported to be a growing concern because lack of services can lead to involvement in other systems (32, p. 4).

State Training Schools and Juvenile Home. Iowa operates the State Training School for Girls and Iowa Juvenile Home in Toledo and the State Training School for Boys in Eldora. The most troubled and delinquent youth aged 12-18 years old are ordered by the court for placement in these facilities. The training schools are for youth adjudicated as delinquent, whereas those adjudicated as Children in Need of Assistance are placed in the juvenile home. One of the many reasons a child could be declared a Child in Need of Assistance is when there is "need of treatment to cure or alleviate serious mental illness or disorder, or emotional damage as evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior toward self or others" and the custodial adult cannot provide the necessary treatment (33, section 6f). These facilities are used when other placements have been tried and found either to be inappropriate or ineffective. At both institutions the adolescents have access to behavioral programming, basic educational and vocational programs, and substance abuse treatment and mental health services. Individualized care plans are developed to guide treatment of each youth (34, 35).

The facility in Toledo has 84 beds. Of the 102 admissions in FY 2008, 54% came as mental health care placements, 27% had five or more separate psychiatric diagnoses, 84% had psychiatric diagnoses that included a diagnosis of a depressive disorder of some type, and 71% required

psychotropic medication. In addition, 34% needed substance abuse treatment. Average length of stay was 8 months for delinquents and 9 months for Children in Need of Assistance. An additional 25 children received 30-day diagnostic evaluations while awaiting placement. The facility in Eldora has 189 beds and had an average daily census of 167 during FY 2008. There were 233 admissions; 34% had five or more psychotropic medications and 69% needed substance abuse treatment. Average length of stay was 8.1 months. In addition, there were 94 30-day diagnostic evaluations (36).

## Public Funding

Public financing of health care for qualifying children includes some mental health services. Funding is provided through the Medicaid and SCHIP programs. Both are federal-state programs requiring the state to provide funding to access the federal money. The federal matching rates for Iowa in FY 2008 were 62% (Medicaid) and 73% (SCHIP). The rates for FY 2009 are 63% and 74%, respectively (37). The counties in Iowa do not have any explicit responsibility to fund services for children. Data for 2006 indicated that services for mentally ill and chronically mentally ill children and youth were provided to 18,963 ages 0-12 years, 11,879 ages 13-17, and 3,715 ages 18-20 (6, Appendix M, p. 2). Other funds for specific types of programs may be available from competitive block grants from the federal or state government.

Medicaid. This program provides health insurance for certain groups of low-income people, including a child under age 21 or a parent living with a child under age 19 (38). Health care providers of services must be enrolled in Iowa Medicaid. In some counties, Medicaid recipients have a free choice among those providers, and the providers are paid by Medicaid on a fee for service basis according to a predetermined fee schedule. In other counties, Medicaid recipients may be required to enroll in managed health care. To access mental health or substance abuse services, prior approval is required.

Prior to the Children's Mental Health Waiver program in 2005, parents of a child under 18 years of age with serious emotional disturbances were required to have the child adjudicated a Child in Need of Assistance or delinquent to access institutional services. Under the waiver program, parents do not have to give up custody of the child and choose to use services and individual supports that allow the child to remain in the family home. An interdisciplinary team of the child, family, providers, targeted case manager, and others is formed to plan interventions, identify services, and guide implementation (39).

SCHIP. The State Children's Health Insurance Program (SCHIP) includes two programs – Medicaid Expansion and Health and Well Kids in Iowa or *hawk-I.* Countable family income that qualifies children for Medicaid Expansion coverage is 185-200% of federal poverty guidelines for infants and 100-133% for children aged 6-18. On June 30, 2008, there were 12,368 children enrolled in the Medicaid Expansion program (number includes those with and without mental illness). The *h*awk-*I* program is for uninsured children under age 19 who are not eligible for Medicaid and with countable family income of 133-200% of federal poverty guidelines. On June 30, 2008 it was estimated that 22,212 children were enrolled in *hawk-I* (number includes those with and without mental illness) (40, p. 49). However, *hawk-I* is not comparable to Medicaid. A recommendation included in the *Mental Health Systems Improvement in Iowa* report is to revise *hawk-I* "to include core required mental health safety net services and to offer a similar mental health benefit package as Medicaid" (6, Appendix O, p. 5).

SCHIP was designed as a commercial health care model. Insurance companies decide whether they wish to provide insurance plans for SCHIP. In Iowa, each county determines which of the insurance plans available will provide *hawk-I* coverage for qualifying children in that county. For enrollment effective March 2008, the choices were Wellmark Classic Blue (indemnity) with Blue

dental, Wellmark Health Plan of Iowa (managed care) with Blue dental, and AmeriChoice with Delta Dental. These plans provide mental health services only from health care providers who are part of a network (Wellmark) or from a provider approved prior to treatment (AmeriChoice). Both companies limit inpatient care to 30 days per calendar year. Wellmark covers 30 outpatient visits per calendar year; AmeriChoice covers 20 outpatient visits per calendar year. The same restrictions apply to substance abuse services. Coverage of medications is an important benefit. Wellmark Blue covers only generic drugs; brand name drugs are not covered unless specifically approved by Wellmark. The same restrictions apply to Wellmark Health except drugs are covered only if a network pharmacy is used and quantity limitations and step therapy may apply for certain drugs. AmeriChoice requires use of a network pharmacy, and drugs must be on a preferred list. Some drugs may require approval to be covered, and a generic equivalent will be provided versus a name drug (41).

Further Expansion of Medicaid and *hawk-I.* The Iowa Legislature in 2008, passed H.F. 2539 stating the intent that all Iowans will have health care coverage, with initial priority being to cover all children eligible for Medicaid or *hawk-I* by January 1, 2011. A *hawk-I* expansion program would cover children under 300% of the federal poverty level by July 1, 2009 if the federal reauthorization of SCHIP provides Iowa with sufficient resources and approves extension of SCHIP coverage to children under 300% of the federal poverty level (42, p.2).

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# Part III: Mental Health Services for Adults
# February 2009

The mental health system in Iowa for adults 18 years and older is county based. The state legislature defines mandated or core services that must be provided by all counties for those who are mentally ill, chronically mentally ill, mentally retarded, or have developmental disabilities. Each group is considered separately. The county boards of supervisors determine what other services will be funded for those meeting the definition for each of the disabilities and the criteria that indicate need. Services available and the amount of money to pay for services vary from county to county.

## Description of Current System

Each county must have a "single point of entry" to access mental health services. This position is known as the Central Point of Coordination (CPC) and is accountable to the county board of supervisors. It is the responsibility of the CPC to manage the system as described in the county management plan for mental health and developmental disability services. This involves funding and service authorizations and collaboration and coordination with consumers, communities, and the multiple institutions that provide services or refer clients (1)

Some of the smaller counties share a CPC. Another aspect of sharing that is being planned on an experimental basis is the pooling of resources among counties sharing a single CPC. This will involve Black Hawk, Cerro Gordo, Floyd, Mitchell, and Butler Counties (K. Pennington, personal communication, December 22, 2008).

Each county must develop a county management plan. The goal of this plan is to "assist the individuals served to be as independent, productive, and integrated into the community as possible" (2, IC 331.439(1b)). This plan has three parts: a policies and procedure manual, a 3-year strategic plan, and an annual report that reviews the management plan and indicates progress made toward accomplishing goals set forth in the strategic plan (3, IAC 441-25.13; 441-25.17; 441-25.18). Included in these plans is a matrix of services that will be paid by the county for eligible persons with mental illness, chronic mental illness, mental retardation, and developmental disabilities. Counties must contract with service providers for the services identified in the matrix, and a list of providers is included in the reports. Many of the provider institutions become access points where persons with disabilities can begin the application process for services. Applications are forwarded to the county CPC for determination of whether the individual qualifies by age, citizenship, legal settlement, medically diagnosed disability, and other requirements for county-paid services.

The Iowa Administrative Code defines basic eligibility standards for financial need. An individual must be eligible, have applied for, and accepted federal or state funded services or supports (such as Medicaid); have income equal to or less than 150% of the federal poverty guidelines; and have resources of $2,000 or less ($3,000 or less for a multi-member family unit) (3, IAC 441-25.20(2)).

Upon verification that an applicant meets criteria for county services, the individual is referred to an accredited case management provider. A case manager or service coordinator works with the client to identify needs, develop an individualized goal-oriented service plan, and then refers the client to appropriate services and community resources, accesses and secures the necessary funding, and monitors and coordinates services (2, IAC 441-24). Determination of the need for specific services must be professionally assessed, and the services needed must be included in the county's management plan. In 2006, 78 of the 99 counties used Iowa Department of Human Services (DHS) targeted case management services for Medicaid clients, whereas the other

counties either were accredited by DHS to provide the services or used another accredited service (4)

Because the amount of money a county can spend on mental health and disability services is limited, funds may not be sufficient to provide the services needed by qualified individuals. Under those circumstances, waiting lists for services are established. Emergency services and supports are not wait listed, and mandated services are funded. A county states in its policy and procedure manual how services are prioritized, and adjustments are made to make best use of funds (2, IC 331.439(5)).

**Mental Health Services Paid by Counties**

The Iowa Administrative Code defines mandated services to be paid by the county for persons with mental illness. These include, but are not limited to, the cost of committing a mentally ill individual to a state mental health institute and the cost of inpatient services at the institute. Individuals with chronic mental illness receive additional services. The county is mandated to provide Medicaid-funded partial hospitalization, day treatment, and habilitation services (3, IAC 441-25.61).

The strategic plans for FY 2007-2009 were reviewed for the counties where local Leagues are located. The 12 counties that used the same matrix code to identify services were compared (5). Here are a few examples of what services these counties identified as willing to pay for and whether the service applied to mentally ill (MI) or chronically mentally ill (CMI) clients:

- Prescription medications – two counties covered for CMI only; 10 covered for both MI and CMI
- Outpatient psychotherapy – 11 counties covered for both MI and CMI; one did not cover for either
- Psychiatric rehabilitation – 10 counties covered for CMI only, one covered for both MI and CMI, and one did not cover for either
- Supported community living – three counties covered for CMI only, five covered for both MI and CMI, and four did not cover for either
- Inpatient services/community hospital – nine counties covered for both MI and CMI; three did not cover for either

**Mental Health Services for Adults**

General categories of services to assist individuals with mental illnesses are emergency services, community-based treatment and services, residential care, and inpatient psychiatric treatment. Many service providers prepare brochures or booklets that identify and describe services available from that provider.

**Emergency Services**

The need for having an emergency mental health crisis services system in Iowa was recognized in the *Mental Health Systems Improvement in Iowa* report. A survey indicated that less than 20% of counties in Iowa reported having any type of emergency mental health crisis service. One of two legislative proposals introduced in 2008 based on this report was to fund several state block grants to begin development of such a program and to establish standards and procedures for accreditation of service providers in the Iowa Code (6, Appendix J, p. 4). The proposal stated these services "should provide welcoming and empathic, co-occurring-disorder-capable crisis intervention, stabilization, support, counseling, pre-admission screening for persons requiring emergency psychiatric hospitalization, detoxification and follow-up services in all counties and for all people" (6, Appendix J, p. 3). The budget request for $3 million in FY 2009 was reduced to $1.5 million and was

funded with one-time money for a 6-month period (K. Pennington, personal communication, December 22, 2008).

Twenty-four hour crisis assistance. Many community mental health centers operate a 24-hour crisis hot line providing access to anyone needing immediate crisis intervention services. Sometimes the crisis hot-line service may be provided in conjunction with a local hospital. As an example of usage, Richmond Center Community Mental Health Services received 3,072 after-hour calls to its crisis line and 258 walk-in and phone crises during business hours in 2006 (7). The Richmond Center serves four counties – Boone, Carroll, Greene, and Story.

Mobile crisis response teams. Few locations in Iowa have crisis intervention teams where there is formal collaboration between a local mental health provider and law enforcement to divert mentally ill persons to appropriate treatment rather than incarceration. In these cases, a mental health professional performs an on-site mental health assessment at the request of law enforcement in situations when mental health issues are a primary contributor to committing the offense. The Polk County Sheriff's Office and the Des Moines Police Department have contracted with Eyerly-Ball Community Mental Health Services since September 1991 to create a mobile crisis response team. The mental health professionals rode with the police officers only during high-incidence shifts (8). During the first 9 months of the program 2% of 445 calls resulted in jail placement, and average length of law enforcement involvement was 50 minutes (9). During FY 2008, the number of calls was 1,930 and 3% of those for whom disposition was reported resulted in jail placement. Law enforcement involvement has been reduced to about 22 minutes per mental health related call. During the time the program has been in place, the most frequent reasons crisis intervention was needed was for suicidal individuals followed by psychotic individuals (45-60% and 18-25% of calls, respectively, where reason was reported). The most frequent dispositions were counseling/referral/stabilization, 45-60%, and voluntary hospitalization,18-25%, of those whose disposition was reported (K.D. Drane, personal communications, January 27 & 30, 2009).

Black Hawk County developed a similar program, but funding was eliminated before implementation. A needs assessment carried out during calendar year 2007 indicated 321 adult and 45 juvenile mental health commitments were filed, and during the first 6 months of 2008 the numbers were 199 and 16, respectively. The local hospitals in Black Hawk County require law enforcement personnel to remain with a mentally ill person in the hospital emergency room until admission is accomplished, and this ties up hours of law enforcement time (T. Eachus, personal communication, January 14, 2009).

**Community-based Treatment and Services**

A range of community-based treatment and services for persons with mental illnesses is offered in Iowa, but not in every county. The more common services are outpatient services, some type of day treatment, community drop-in centers, transitional living services, supported community living services, and education and support programs. The Assertive Community Treatment Program is offered in only five cities in the state.

Outpatient services. Community mental health centers and some other non-profit agencies provide basic outpatient services. These would include screening and evaluation, psychological testing, medication management, counseling, and substance abuse treatment referrals.

Day treatment/partial hospitalization. These programs encourage adults with mental illness to live independently in the community and maintain social and family ties while receiving appropriate psychiatric treatment and developing a stable and sufficient support network. For example, Mary Greeley Medical Center in Story County offers an intensive outpatient program that provides follow-up care for adults who have experienced a mental health crisis for which they have been hospitalized. It also provides on-going treatment to help adults manage their conditions for the

long term. The program includes meetings three mornings a week with a multi-disciplinary team (10).

Drop-in community centers. Some counties provide a type of drop-in community center or club house for the mentally ill. Promise Center is located in Ottumwa and is a service provided by the Southern Iowa Mental Health Center. It was established in 2001 and provides "a safe, nonjudgmental place to socialize, receive support and be involved in age-appropriate structured and unstructured activities and learning experiences", regardless of how mental illness is affecting the lives of the members. The center is open weekdays, two evenings a week, and on Saturday. It is staffed by a licensed social worker with a bachelor's degree. Participants must apply for membership, meet membership criteria, and abide by rules set forth in a membership agreement (11). Attendance averages 21 per day with involvement by approximately 73 different members each month (M. Breon-Drish, personal communication, September 2, 2008).

Transitional living services. These services provide intensive on-site assistance on a short-term basis preparing persons to resume community living after some type of institutional care. It may include assistance in finding independent housing and follow-up services. An example is the Transitional Living Program operated by Mary Greeley Medical Center. There is a 6-bed home-like facility for adults 18 years of age or older who have a mental illness or a co-occurring disorder. The program provides a safe place to "regain perspective and make choices that will enhance their ability to live independently and function on a day-to-day basis" (10).

Supported community living services. These services enable mentally ill individuals to "develop supports and learn skills that will allow them to live, learn, work, and socialize in the community" (3, IAC 441-24.4(12)). Services are designed to meet the particular needs and abilities of the individuals living independently in their own homes, in apartments, or with their families. Sometimes referred to as community based services workers, these personnel may visit the client in the home. Services may include assisting with and teaching basic living skills; providing mental health support, medication management, assistance with medical/psychiatric appointments, and crisis intervention; and promoting development of social skills. Many of the community mental health centers and other agencies offer these services. Some examples include Abbe Center for Community Mental Health (12), Black Hawk-Grundy Mental Health Center (13), Broadlawns Medical Center (14), Community Mental Health Center for Mid-Eastern Iowa (15), Seasons Center for Community Mental Health (16), and Capstone Behavioral Healthcare (17).

Education and support programs. The National Alliance on Mental Illness (NAMI) offers a number of support and education programs that use materials professionally developed either by the national organization or a state affiliate. *NAMI Connection* is a peer self-help support group program that is open only to those who have a mental illness. The program is led by a trained and certified facilitator. *NAMI Peer-to-Peer* is a 9-week, 18-hour series of classes led by three certified facilitators who are themselves coping well with their mental illness. The content focuses on major psychiatric illnesses, emphasizing clinical treatment, and teaching the knowledge and skills to cope effectively with mental illness. Other topics include relapse prevention planning, coping strategies, empowerment, among others. Some NAMI affiliates in Iowa offer *NAMI C.A.R.E.* (Consumers Advocating Recovery Through Empowerment), a self-help support group led by trained facilitators who have a mental illness. *Sharing and Caring*, a combination support and education program open to both family members and those with mental illness, is led by trained family members or persons with mental illness. There are 13 NAMI affiliates in Iowa plus four affiliated campus groups and eight support groups (18).

Assertive Community Treatment (ACT). This team approach with a multi-disciplinary staff provides integrated health care in the community for individuals who are seriously mentally ill. This group includes those with schizophrenia, schizoaffective, bipolar, and severe depressive disorders.

Persons with these disorders are the highest users of health care resources. There are five programs in Iowa – Iowa City (1996), Des Moines (1998), Cedar Rapids (1998), Fort Dodge (2004), and Council Bluffs (2006). Approximately 250 individuals were receiving care through these five programs. ACT costs approximately $14,000 per patient per year but has resulted in 78% reduction in hospital days, 80% reduction in jail days, and 66% reduction in homeless days. Less impressive results were found in reductions in percentage unemployed and percentage abusing drugs. Expansion of ACT in Iowa will require strong "top down" support from the state legislature, a significant contribution of state general funds, and significant use of the Medicaid Habilitative Services and Rehabilitative Services option (19).

**Residential Care**

When mentally ill individuals require more supervision than is practical in an independent living situation, the next level of services is residential care. Iowa has 14 residential care facilities, located in 13 counties, for mentally ill adults. They provide a total of 331 beds (20, pp. 185-186). The goal of these care facilities is to rehabilitate and maintain individuals with mental illnesses at their highest level of functioning and independence. Typical services include medical supervision, skill building, vocational opportunities, socialization and leisure activities, and environmental supports. Several examples are Westminster House residential care facility operated by Behavioral Health Resources in Polk County (21) and Hillcrest Family Services that has three adult residential homes, two in Dubuque and one in Iowa City (22)**.**

**Inpatient Psychiatric Care**

Acute psychiatric care may be provided in a community hospital with a separate psychiatric unit or at one of the state mental health institutes.

Inpatient hospital psychiatric care. There are 21 general hospitals in Iowa that have separate psychiatric units to treat mentally ill patients. Fifteen provide both inpatient and outpatient psychiatric services and six provide inpatient care only (23). These hospitals have contracts with multiple counties to provide services if beds are available when needed by a client from any of those counties. For example, the Behavioral Health Unit at Mary Greeley Medical Center in Story County has contracts with 14 counties but receives clients from many other hospitals in Iowa who have no psychiatric beds or whose beds are full. There are seven beds for youth and 15 beds for adults in the Behavioral Health Unit, and these beds are for treatment of individuals with mental health and/or substance abuse issues. It is estimated that the adult unit is full on average 2 days a week, with heavier demand in winter and less demand during the summer and holidays (C. Krause, personal communication, January 26, 2009). Consequently, at a specific point in time there might not be an open bed for a client in Story County who needs inpatient psychiatric hospitalization. The executive director of Black Hawk-Grundy Mental Health Center reported that psychiatric inpatient beds in Black Hawk County often are full (T. Eachus, personal communication, January 14, 2009).

Inpatient mental health institute care. Iowa operates four mental health institutes that stabilize and treat the most severely mentally ill patients as psychiatric inpatients. These facilities have a total of 120 adult inpatient psychiatric beds. Periodically these beds have all been full, and a waiting list was maintained. An additional 35 beds at Clarinda provide long-term care for mentally ill geriatric patients exhibiting serious cognitive loss or dementia and significant behavior problems. The numbers of all beds by location are:

- Cherokee – 46 adult (plus 12 child/adolescent beds)
- Independence – 40 adult (plus 25 child/adolescent, 30 PMIC beds)
- Clarinda – 20 adult (plus 35 geriatric beds)
- Mt. Pleasant – 14 adult (plus 50 substance abuse, 15 dual diagnosis beds)

During FY 2008, 829 adults received psychiatric treatment services at the institutes, and 74% were admitted on an involuntary basis (24, pp. 123-124).

## Public Financing

Various sources of public money provide care to persons with chronic or serious mental illnesses. Federal programs such as Supplemental Security Income and Social Security Disability Insurance provide a basic level of income for those whose conditions preclude their ability to hold a job. The Medicaid program, funded with both federal and state dollars, enables low-income persons with mental illness to receive medical care. The state and counties contribute money to provide services at the local level to qualifying residents who have mental illnesses. Refer to Part I of this series (Background and Context) for additional information.

Federal funding. Supplemental Security Income is a federal program that provides benefits to adults 18 or older who have medically determined physical or mental impairments that result in their inability to be gainfully employed. Very low income and resource limits apply, and these individuals automatically qualify for Medicaid in most states. Maximum monthly benefits are determined annually by Congress (25).

Individuals who have worked in the past and paid Social Security taxes and who are unable to work for a year or more because of their disability may apply for Social Security Disability Insurance. Once approved to receive payments, the medical condition of the recipient is reviewed within 6-18 months, every 3 years, or every 5-7 years depending on whether medical improvement is expected, is possible, or not expected, respectfully (26, pp. 19-20).

Federal and state funding. Medicaid provides health insurance for certain groups of low-income people. Adults who are disabled according to Social Security standards fit into this group. Other qualifications also apply (27).

The IowaCare Medicaid Expansion Program (1115 waiver) expanded Medicaid coverage to adults with income up to 200% of the federal poverty level. Recipients are expected to pay a small monthly premium although the premium is waived in hardship cases. Eligibility is limited to one year when reapplication is necessary (28)**.** The provider network for hospital and physician services is limited to Broadlawns Medical Center in Des Moines, the University of Iowa Hospitals and Clinics in Iowa City, and the four mental health institutes (Cherokee, Clarinda, Independence, Mount Pleasant) in the state. During FY 2007, the mental health institutes provided care to 570 adults, a total of 26,315 days of care giving a mean length of stay of 46 days. Comparable data were not provided for Broadlawns Medical Center and the University of Iowa Hospitals and Clinics (29, attachment).

State and county funding**.** State funds are appropriated for counties for property tax replacement, allowed growth of mental health and developmental disabilities (MHDD) services, support of MHDD community services, and payment for MHDD services provided to state cases. Because of the state budget crisis, state funds sent to the counties for MHDD services are likely to be cut. Governor Culver has recommended cutting the mental health property tax credit by $1.4 million in the coming year and $6.1 million the following year (30).

The amount of money counties can raise for MHDD services from the property tax levy is capped. Data for FY 2008 showed that the mental health services levy that each county can charge its property owners had reached a maximum in 73 of the 99 counties. Two counties (Keokuk and Louisa) were using less than 50% of their allowable levy rates (6, Appendix O, p. 37-39). The highest levy rate was in Jasper County ($2.80) and the lowest was in Louisa County ($0.20) (6, Appendix O, pp. 39-41). The fund balances at the end of FY 2008 that counties held in their MHDD accounts averaged 7% of expenditures. However, 24 counties had negative fund balances (31). These data indicate most counties have limited ability to make up any shortfall in state funding for MHDD services.

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# Part IV: Mental Health Services for Mentally Ill Offenders
# February 2009

Why are there so many mentally ill individuals in prison in the United States? De-institutionalizing of the mentally ill began in the 1960s with the downsizing and ultimate closing of most public mental health hospitals. These actions were in response to availability of effective anti-psychotic medications and increasing litigation surrounding involuntary commitment and release. It was expected that the mentally ill should live in the community as independently as possible with access to adequate community mental health services. Funding for community mental health services has been inadequate, and consequently, prisons have become de-facto mental health institutions (1, background). Although no public mental health hospitals have closed in Iowa, the number of beds has decreased over time.

## Description of Mentally Ill Offenders in Iowa

The Iowa Department of Corrections operates nine prisons and 23 community-based corrections facilities. Community-based corrections provide an alternative to incarcerating a person convicted of criminal offenses by placing the individual on pre-trial release, probation, or parole. The individual remains in the community under supervision and participates in treatment programs (2, p. 174).

### Mentally Ill Offenders in Prison

Data are available about mentally ill offenders that were collected at three different points in time: June 30, 2005, December 31, 2006, and December 31, 2007. Data collected at the end of 2007 identified that 40.4% (3,582) of all offenders in Iowa prisons had mental illness and 30.4% (2,640) had persistent mental illness (3, p. 69). This represents an increase from comparable data collected in 2005 that indicated 33.8% of the total population of 8,578 offenders was designated as mentally ill, based on psychiatric diagnosis. Although the number of female offenders is small compared to the number of male offenders, females are almost twice as likely to have a mental illness. The percentage of each group had increased from 2005 to 2007, from 31% to 38.9% of male offenders and from 60% to 66.6% of female offenders (4, p. 70; 3, p. 3-8).

Many of the offenders carry more than one psychiatric diagnosis. The two most common categories of diagnosis for the mentally ill population were the same in 2005 and 2006. Depression and major depressive disorders was the most common, afflicting 58.3% of females and 47.9% of males in prison at the end of 2006; data were similar for 2005. Substance use disorders were the next most common; these data reflected increases. In 2005, 29.6% of females and 21.8% of males had this disorder versus 37.7% of females and 35.4% of males in 2006. Personality disorders and anxiety, general anxiety, and panic disorders were the next most common disorders (2, pp. 54-55; 4, pp. 3-8).

In 2005 the mentally ill offenders generally were housed with the general prison population, representing from 19.4% to 56.7% of the population within the institution. The primary exceptions were the Iowa State Penitentiary Clinical Care Unit (89.5%) and the Iowa Medical and Classification Center (IMCC) for the most severe mentally ill female offenders (29.5%). Mentally ill offenders with long–term sentences represented 14.4% of the prison population or 410 inmates. Relatively short-term sentences were given to 37.1% or 1,053 offenders (4, pp. 7-8).

During FY 2005, 2,923 individuals were paroled; 29.9% of those were mentally ill. Reentry of mentally ill offenders into the community by judicial district ranged from 22.5% in the Fourth Judicial District to 36% in the Eighth Judicial District. A slightly higher percentage of mentally ill offenders (37.9%) served out their sentence in prison and were released without supervision

compared to those receiving parole or placement in community-based treatment facilities (34.7%) (4, pp. 9-10).

The 3-year recidivism rate for those with chronic mental illness diagnoses was 44.7% for females and 51.6% for males. This compares with 18.9% and 28.1% for females and males, respectively, who did not have mental illness. Recidivism rate was influenced by the number of mental illness diagnoses, with each additional diagnosis increasing the rate. Offenders with four or more diagnoses had a recidivism rate of 84.6%. A one-day review on December 31, 2007 of the most serious type of charge against mentally ill offenders revealed that 41% had been charged for violent offenses (4.8% females; 36.2% males) (3, pp. 71-74)

### Mentally Ill Offenders in Community-based Corrections

On October 15, 2007, there were 1,600 offenders in community-based corrections (CBC) residential facilities; 28% had a diagnosed mental illness and an additional 14% had diagnosed co-occurring disorders. Treatment for these disorders was received by 60.9% of those with mental illness and 63.2% of those with co-occurring disorders. On the same day, there were an estimated 22,856 additional offenders under CBC field supervision. In this group, 18% had mental health diagnoses and an additional 9% had co-occurring disorders. Of those with mental illness, 56.5% were receiving treatment as were 64.4% of those with co-occurring disorders (3, pp. 86-88).

Although no data were found describing the mental health status of offender populations in Iowa's county jails, the description of offenders participating in the re-entry program in Eastern Iowa later in this paper gives some idea of the situation.

## Issues Within the Prison System

The health, safety, and treatment of individuals in jails and prisons, juvenile correctional facilities, and state or locally run mental health facilities as well as other facilities is a right protected by the Civil Rights of Institutionalized Persons Act (CRIPA) enacted in 1980. The U.S. Department of Justice will investigate situations brought to its attention and bring actions to enforce whatever standards have been established through court decisions (5).

The Iowa Department of Corrections has undergone intensive study in an attempt to create a more streamlined and effective operation. In 2005, improvements in identification and treatment of the mentally ill in prison were being developed to parallel community standards for a graduated mental health program with the following elements:

- Continuity of care
- A continuum of care with criteria for placement based on clinical assessment
- A formalized acute unit as part of the continuum
- Programming appropriate to each level of the continuum (4, p. 11)

By the end of 2006, it was noted that all offenders undergo a complete mental health assessment during the reception process at the Iowa Medical and Classification Center by one psychologist. Very limited access to acute care for offenders in need of hospital level care and limited partial hospitalization beds for females at the Iowa Correctional Facility for Women and for males at the Iowa State Penitentiary continued to be a concern (2, pp. 48-49). The 2008 report indicated that a continuum of mental health treatment and care was under development. This would include acute care, partial/transition care, special needs units, and outpatient care (for the general population). Not all institutions would provide the full continuum of care (3, p. 83).

### Staffing Issues

A recent study of staffing in Iowa's prisons identified some growing concerns related to health care and made recommendations for remediation (6). Medical and mental health acuity of the offenders in the prison system continues to increase. Some of the concerns about meeting these needs, with particular focus on mental health, were:

- Mental health staff were scheduled primarily from 7 am-4:30 pm on weekdays, whereas mental health incidents occurred in the evening, at night, and on weekends (p. 77).
- Most mental health services are provided by psychiatrists and psychologists with only the recent addition of psychiatric social workers (p. 79).
- Health care budgets and subsequent staffing are determined at the institution level; there is no system-wide health care budget or staffing plan (pp. 102-103).
- With the exception of IMCC, the number and type of health care positions did not appear to be consistent with acuity levels of offenders, specialty care needs, size and type of facility, custody classification level, or number of facilities within an institution (p. 104).

Recommendations included focusing specialized levels of care in specific institutions as is being done with mental health special needs units, considering development of a new level of psychologist job classification in addition to bringing consistency to present positions across institutions, and strengthening the position of Mental Health Director. Budget proposals for FY 2010-2012 would increase the number of mental health full-time equivalents (for psychiatrists, psychologists, and social workers) to expand availability during the evening and weekend hours and to meet the increasing mental health workload to manage medications and provide services to offenders in the general population (pp. 203-204).

**Reentry Issues**

Reentry involves the use of programs targeted at promoting the effective reintegration of offenders back to the communities upon release from prison. A three-phase approach is recommended for reentry programs (7). Phase one (protect and prepare) involves programs at the institution level designed to prepare offenders to reenter society. This would include education, mental health and substance abuse treatment, job training, mentoring, and full diagnostic and risk assessment. Phase two (control and restore) involves community-based transition programs that are coordinated with the institution. Services might include education, monitoring, mentoring, life-skills training, assessment, job-skills development, and mental health and substance abuse treatment. Phase three (sustain and support) involves community-based long-term support programs that connect individuals leaving the justice system with a network of social service agencies and community-based organizations to provide ongoing services and mentoring.

An initiative to begin reentry case planning for all offenders upon commitment to an IDOC institution has been adopted. This involves determining the three primary treatment needs for each offender and developing plans that outline the programs and services the offender should complete before release. Plans for offenders with mental health issues require ongoing consultation with mental health staff to determine readiness to participate in reentry programs. Opportunities were limited for this population. Reentry programs varied from prison to prison, and resources were not adequate (2, p. 109).

Long-term recommendations were:

- Develop a detailed plan for additional reentry opportunities/programs for offenders with mental illness and to fund the plan (2, pp. 223-224)
- Expand the number and type of evidence-based reentry programs offered and increase the number of participants (2, p. 226)
- Implement a system-wide tiered step down approach to reentry from each of the prisons (2, p. 227).

**Community-based Corrections Issues**

Currently no CBC residential facilities are prepared specifically to meet the needs of the mentally ill offender. However, the Sixth Judicial District is developing such a facility that will focus on the specialized needs of offenders with serious mental illnesses (3, p. 101). According to a survey of Iowa counties, the availability of county funding for mental health treatment of CBC offenders varied not only by county but also by type of offender. For example, 97% of counties would fund mental health services for mentally ill offenders on probation, 88% of counties would provide for parolees, 55% for residential offenders, but only 33% for those on work release. In 73 counties there was a mental health professional who could prescribe psychiatric medications; however, it would take on average 6 weeks to get an appointment (3, pp. 89-90). This situation can be problematic for parolees who leave the institution with $100 and a 30-day supply of their medications or a prescription for that amount (8, p.1).

A survey of judicial districts indicated that only four districts had probation/parole officers or case managers who worked specifically with offenders who were mentally ill. The need to provide specialized training was recognized by all judicial districts (3, pp. 93, 96). Collaboration among the institutions, judicial districts, and community providers of services to the mentally ill was identified as critical to providing continuity of care for offenders, and recommendations were made to assist in this effort (3, p. 110).

Recommendations were made for improvements in operations of CBCs as well as infrastructure (3). During calendar year 2006, most CBCs were operating at or above their bed capacities, and waiting lists for admission were maintained. A person might be on the waiting list for 2-4 months (2, p. 189). A wide range of programming was available in CBCs but it varied by judicial district and was not available in all counties within a district. Few were specific to assisting those with mental illness (2, pp. 174-176).

## Alternatives to Incarceration

The daily cost for FY 2007 of caring for individuals under the supervision of the Iowa Department of Corrections was (9):

| | |
|---|---|
| Prison | $76.59 |
| Community residential facility | $60.29 (includes no treatment costs) |
| Probation | $ 3.70 |
| Parole | $ 4.21 |

Daily cost for an individual incarcerated in Johnson County was reported as $64.60 if held in the Johnson County jail or $75.60 if held in another county jail during FY 2007 (10). Individuals held in county jails are expected the pay the daily rate, but not everyone has the ability to pay. Inmates in state prisons who earn or receive money are expected to pay certain charges. A formula is applied to those funds to pay such costs as room and board, court costs, restitution, and child support (J. Hammond, personal communication, February 9, 2009).

Not only is it costly to warehouse people in jail or prison, but mentally ill offenders often do not respond well to the coercive environment of a prison, and they are separated from families and other community support systems. If they have been receiving federal benefits such as Supplemental Security Income, Social Security Disability Insurance, and Medicaid, they lose their eligibility to receive benefits and must reapply for benefits after release from incarceration (11). Are there better alternatives?

Intervention can take place at various points. Examples of some types of interventions are found in Iowa, but generally are not widespread. These include crisis intervention services, jail diversion programs, mental health courts, and reentry programs.

**Crisis Intervention Services**

This topic was covered in Part III of this series of papers in the discussion of emergency services. In the present context, crisis intervention teams would recognize persons as mentally ill, and police could identify them for diversion to appropriate treatment, thus preventing further deterioration of these individuals' conditions and preventing actions that might result in criminal behaviors. Effective crisis intervention requires training team members and law enforcement personnel about mental illness and how best to work with mentally ill individuals. Only nine of Iowa's 99 counties reported having mobile crisis teams in 2008 (3, p. 92).

**Jail Diversion Programs**

There are at least two jail diversion programs currently functioning in Iowa. These are in Black Hawk County in the First Judicial District and Story County in the Second Judicial District. Polk County is planning to initiate a 2-year experimental program when the new jail opens (12). These programs divert mentally ill offenders after they have been arrested and booked into jail.

Black Hawk County. The program in Black Hawk County is primarily a re-entry program that also accepts participants on a pre-trial diversion basis. The focus of the jail diversion program is to provide an option for a mentally ill offender to be released and receive services from the mental health re-entry program while the criminal case is proceeding through the court system. The offender may be found guilty, but with support of the re-entry program the situation may be stabilized and the offender can be sentenced to probation rather than serve time in jail (13). The re-entry program is described in a later section.

Story County. The mental health jail diversion program in Story County began in January 2007 and is funded for 30 months with a federal grant from the Department of Justice, Bureau of Justice Assistance. It is a project of the Story County Mental Health and Criminal Justice Task Force that involves 14 community agencies and institutions. Participants must be 18 years or older, have a pre-existing severe and persistent mental health condition, have no felony convictions or violent offenses in the last 5 years, and live in Story County. Participation is voluntary. The program involves intensive interviews to identify appropriate participants, pre-judication approval by the court, development of individual treatment or service plans, intensive case management, and coordination and monitoring for compliance. Services include treatment and other support services such as housing, employment, education, and substance abuse support that may be needed. Minimum length of time in the program is 6 months; some may remain in the program until requirements of the court have been met (14). To date the program has involved 19 persons and an additional two are in progress; eight have been re-incarcerated. Most participants have a co-occurring substance abuse condition. Finding housing for participants is a challenge and is an expensive support service (A. C. Peters, personal communication, December 12, 2008).

**Mental Health Courts**

Mental health courts represent court-based community justice initiatives. They have been modeled after drug courts. The first four mental health courts were studied on behalf of the Bureau of Justice Assistance. Common attributes shared by these court initiatives were (15, p. viii):

- Participation is voluntary
- Only persons with demonstrable mental illness likely to have contributed to involvement in the criminal justice system are accepted
- The objective is to prevent the jailing of the mentally ill and/or to secure their release from jail to appropriate services and support in the community
- Concern for public safety is a high priority; consequently a predominant focus on

misdemeanor and other low-level offenders and careful screening or exclusion of offenders with histories of violence
- Early intervention is expedited through timely identification of candidates
- A dedicated team approach is used
- Emphasis is on creating a new and more effective working relationship with mental health providers and support systems
- There is intensive supervision of participants, with emphasis on accountability and monitoring of participant's performance
- The judge is at the center of the treatment and supervision process.

In addition, each mental health court had unique features.

A number of issues have surfaced as mental health courts have become operational. A few of these are (15, pp. x-xiv):

- Early identification of candidates is difficult when fair, appropriate, and effective screening procedures need to be timely, accurate, and confidential (conflicting goals)
- Participants must be competent to really understand the choices being presented and the consequences of those choices
- There is an inherent conflict between the need of the criminal process to proceed expeditiously to adjudicate criminal charges and the time needed by mental health professionals to diagnose, stabilize, and place the defendant in appropriate supportive services for treatment
- Defining success is difficult because each defendant starts at a different point depending on the variety of symptoms and illnesses exhibited
- Questions are raised about how the coercive power of the courts can be channeled to promote the goals of mental health treatment
- Availability of mental health services and resources are often insufficient and have contributed to mentally ill persons becoming part of the criminal justice population.

As more mental health courts have become a reality, 10 essential elements of mental health courts have been identified to guide development of this alternative to incarceration for adults (16).

Thirty-one states are listed as having at least one mental health court, but the information may not be current (17). Only one is listed for Iowa, in Woodbury County. The *2007 Annual Report of the Third Judicial District Court of Iowa* included data from July 2001-June 2006 for Project Compass Mental Health Court (18, p. 47, Table 21). The project was funded by Woodbury County with assistance of Siouxland Mental Health. Individuals in jail were provided assistance and appropriate mental health services to enable them to succeed and not return to the criminal justice system. During the 5-year period, 175 individuals participated in the mental health court. There were 106 successful completions, 41 unsuccessful completions, with 28 still in the mental health court. Previous number of jail days for the group was 2,796; this was reduced to 83 days. There were 366 previous arrests and that number was reduced to 31 re-arrests.

Three mental health courts were identified in Iowa, in the Fifth and Seventh Judicial Districts in addition to the Third Judicial District (3, p. 101). However, no information was easily accessible about these programs.

**Reentry Programs from Jail and Prison**

- Effective re-entry practices have multiple benefits. They can:
- Enhance public safety through reducing offender's risk to the community upon release
- Demonstrate cost savings through a decrease in incarceration and in a wide array of government programs

- Improve the quality of life of individuals suffering from mental health and substance abuse issues
- Promote safe, orderly, and secure correctional institutions (13, p. 3).

Several reentry programs have been operating successfully in Iowa for several years.

Black Hawk County. The Mental Health Assessment and Jail Diversion Program, as this program is called in Black Hawk County, is supervised by a community treatment coordinator within the Department of Correctional Services. However, the program is a collaborative effort that also involves the sheriff's office, the county attorney's office, the public defender, the local courts system, the mental health center, mental health professionals working within the jails, and other community agencies. Weekly meetings are held to discuss and plan for releases from the Black Hawk County Jail. Referrals of inmates to be screened and provided assistance come from multiple sources, and follow-through is provided by the coordinator.

Programs available include a dually diagnosed program for men and a women's co-occurring disorder program that are carried out in residential facilities. The community is involved in connecting individuals with access to medications, housing options, finances, and employment through a Community Accountability Board that meets monthly. This group is composed of various agencies and individuals who have a vested interest in persons with mental illness (11, p. 9-10).

Data from 34 months of operation as of November 2006 indicated assessment of 415 individuals (68% men and 32% women) with 74% successful transition into the community or diverted from jail and prison, and a re-arrest rate of 26%. Cost savings were estimated at $54,500 (11, p. 10).

Eastern Iowa. Three transitional mental health re-entry programs have been funded through federal block grants to the state. These programs are operated by the Departments of Community Correctional Services in the First Judicial District (Linn County) and Sixth Judicial District (Black Hawk County) and by the Black Hawk-Grundy Mental Health Center that serves Black Hawk County. Two programs began in Fall 2000 and the third began the following summer. Funding through the Department of Human Services began at $80,000 per year for each program and had decreased each year to $10,000 during FY 2007. The programs are designed to provide people with mental illnesses the broad array of support they need to be successful in transitioning back into the community upon release from prison. These supports include assistance such as linking with mental health providers, applying for Medicaid and other programs, finding housing, providing transportation, meeting with Community Accountability Board, enrolling in education or job training programs, and providing emotional support and guidance (8, pp. 2-4).

From inception through June 30, 2007, 361 individuals had been served by the three programs. Although somewhat different populations were served in each program, some combined data describe the overall population. The majority of admissions to the program were on parole; women represented 52% of participants; 67% were Caucasian and 32% African American; average age was 36; the primary diagnosis on admission was depression (44%); 47% had been diagnosed with two or more mental illnesses; 87% had a substance abuse problem; 43% had been incarcerated for less than 1 year as an adult but 38% had been incarcerated from 1 to 3 years; 71% of admissions had already had one or more probation or parole violations; 95% had some high school education; 68% had never worked at a job for more than 1 year (8, pp. 9-15).

Assessments of the 339 individuals who had been discharged from the re-entry program as of June 30, 2007 showed that 70.5% were considered to be successful. Stable housing and access to health care and medications were considered to be essential for successful reentry. To evaluate the program, the re-entry group was compared to a similar group receiving traditional parole services. The reentry group tended to have more barriers to overcome because they had a slightly higher level of criminal risk, were more likely to have a substance abuse problem, and included more

women and minorities. However, the reentry group was more successful than the comparison group in successful completion of their program, had greater housing stability, and were less likely to be charged with serious crimes. The comparison group was more likely to be employed (8, pp. 54-55).

## And the Bottom Line?

The cost of incarcerating mentally ill individuals is substantial, not only in monetary and societal terms but also in quality of life for the affected individuals and their families. The lack of mental health services often contributes to this situation and not having those services available and accessible at the time of reentry into the community will only contribute to recidivism. And the cycle starts all over again. Doesn't it make more sense to use public funds to assure that mental health services are available to help people cope with their mental illness rather than spending public funds to house them in jails and prisons where they might or might not receive treatment?

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