CHAPTER 121

DISABILITY SERVICES

S.F. 525

AN ACT relating to reforming state and county responsibilities for adult disability services, making appropriations, and including effective date provisions.

Be It Enacted by the General Assembly of the State of Iowa:

DIVISION I
SERVICE SYSTEM REDESIGN

Section 1. ADULT DISABILITY SERVICES SYSTEM REDESIGN.

1. For the purposes of this section, "disability services" means services and other support available to a person with mental illness or an intellectual disability or other developmental disability.

2. It is the intent of the general assembly to redesign the system for adult disability services to implement all of the following:

a. Shifting the funding responsibility for the nonfederal share of adult disability services paid for by the Medicaid program, including but not limited to all costs for the state resource centers, from the counties to the state.

b. Reorganizing adult disability services not paid for by the Medicaid program into a system administered on a regional basis in a manner that provides multiple local points of access to adult disability services both paid for by the Medicaid program and not paid for by the Medicaid program.

c. Replacing legal settlement as the basis for determining financial responsibility for publicly funded disability services by determining such responsibility based upon residency.

d. Meeting the needs of consumers for disability services in a responsive and cost-effective manner.

3. a. The legislative council is requested to authorize an interim committee on mental health and disability services for the 2011 legislative interim to commence as soon as practicable. The purpose of the interim committee is to closely engage with, monitor, and propose legislation concerning the recommendations and proposals developed by the workgroups and other bodies addressed by this Act, particularly with regard to the identification of core services.

b. (1) It is intended that the interim committee members consist of equal numbers of legislators from both chambers and from both political parties. It is also requested that legislators serving on the interim committee and other interested legislators be authorized to participate in the meetings of the workgroups and subcommittees addressed in this Act.

(2) In addition to addressing workgroup recommendations, it is intended that the interim committee address property tax issues, devise a means of ensuring the state maintains its funding commitments for the redesigned services system, recommend revisions in the requirements for mental health professionals who are engaged in the involuntary commitment and examination processes under chapter 229, recommend revisions to the chapter 230A amendments contained in this Act as necessary to conform with the system redesign proposed by the interim committee, develop proposed legislation for amending Code references to mental retardation to instead refer to intellectual disabilities, and consider issues posed by the July 1, 2013, repeals of county disability services administration and funding provisions in 2011 Iowa Acts, Senate File 209.[1] In addressing the repeal provisions, the interim committee shall consider all funding sources for replacing the county authority to levy for adult disability services.

(3) It is intended that the interim committee shall receive and make recommendations concerning the detailed and final proposals submitted by workgroups during the 2011 legislative interim for consideration by the general assembly in the 2012 legislative session.

[1] Chapter 123 herein

c. (1) The department of human services shall design the workgroup process to facilitate effective decision making while allowing for a broad array of input. The workgroup process shall begin as soon after the effective date of this Act as is practicable. The membership of workgroups and subcommittees involved with the process shall include consumers, service providers, county representatives, and advocates and provide for adequate representation by both rural and urban interests. The department of public health shall be represented on those workgroups and subcommittees with a focus relevant to the department.

(2) The detailed and final proposals developed by the workgroups during the 2011 interim shall be submitted to the interim committee on or before December 9, 2011.

d. At least one workgroup shall address redesign of the adult mental health system and at least one workgroup shall address redesign of the adult intellectual and other developmental disability system. The workgroup process shall engage separate workgroups and subcommittees enumerated in this Act and may involve additional bodies in the process as determined by the department.

e. It is intended that interim committee members be engaged, to the extent possible, in workgroup deliberations and begin formal discussions of preliminary proposals developed by the workgroups beginning in October.

4. The workgroup process implemented by the department of human services pursuant to subsection 3 shall result in the submission of proposals for redesign of adult disability services that include but are not limited to all of the following:

a. Identifying clear definitions and requirements for the following:

(1) Eligibility criteria for the individuals to be served.

(2) The array of core services and other support to be included in regional adult disability services plans and to be delivered by providers based on individual needs and medical necessity and in a manner that promotes cost-effectiveness, uniformity, accessibility, and best practice approaches. The array shall encompass and integrate services and other support paid for by both the Medicaid program and other sources.

(3) Outcome measures that focus on consumer needs, including but not limited to measures addressing individual choice, empowerment, and community.

(4) Quality assurance measures.

(5) Provider accreditation, certification, or licensure requirements to ensure high quality services while avoiding unreasonable expectations and duplicative surveys.

(6) Input in regional service plans and delivery provisions by consumer and provider representatives. The input process shall engage local consumers, providers, and counties in developing the regional provisions.

(7) Provisions for representatives of the regional system and the department to regularly engage in discussions to resolve Medicaid and non-Medicaid issues involving documentation requirements, electronic records, reimbursement methodologies, cost projections, and other measures to improve the services and other support available to consumers.

b. Incorporating strategies to allow individuals to receive services in accordance with the principles established in Olmstead v. L.C., 527 U.S. 581 (1999), in order for services to be provided in the most community-based, least restrictive, and integrated setting appropriate to an individual's needs.

c. Continuing the department's leadership role in the Medicaid program in defining services covered, establishing reimbursement methodologies, providing other administrative functions, and engaging in federal options for program enhancements that are beneficial to consumers and the state such as medical or behavioral health homes.

d. Implementing mental health crisis response services statewide in a manner determined to be most appropriate by each region.

e. Implementing a subacute level of care to provide short-term mental health services in a structured residential setting that supplies a less intensive level of care than is supplied by acute psychiatric services.

f. Reviewing best practices and programs utilized by other states in identifying new approaches for addressing the needs for publicly funded services for persons with brain injury. The proposals regarding these approaches may be submitted after the workgroup submission date set out in subsection 3.

g. Developing a proposal for addressing service provider and other workforce shortages. The development of the proposal shall incorporate an examination of scope of practice limitations and barriers to recruiting providers and maintaining the workforce, including recruitment of minorities and addressing cultural competency considerations for the workforce in general and for accrediting professional level providers, evaluating the impact of inadequate reimbursement, identifying the appropriate state role in providing the resources to ensure an appropriately trained workforce is available, and an examination of the variation in health insurance payment provisions for the services provided by different types of providers.

h. Developing a proposal for service providers addressing co-occurring mental health, intellectual disability, brain injury, and substance abuse disorders. Each workgroup or subcommittee shall address co-occurring disorders as appropriate to the focus of the workgroup or subcommittee. The overall proposal may be developed by a body consisting of members from other workgroups or subcommittees. The proposal shall also provide options, developed in coordination with the judicial branch and department of human services workgroup, for implementation of the provision of advocates to patients with substance-related disorders.

i. Developing a proposal for redesign of publicly funded children's disability services, including but not limited to the needs of children who are placed out-of-state due to the lack of treatment services in this state. The proposal shall be developed by a separate workgroup or subcommittee led by the department of human services, in consultation with the department of public health, and in addition to the other interests and representation required by this section, the membership shall include the department of human services staff involved with child welfare, children's mental health, and Medicaid services, and education system and juvenile court representatives. The preliminary findings and recommendations, and the initial proposal shall be submitted by the October and December 2011 dates required for other workgroups and subcommittees. The initial proposal developed during the 2011 legislative interim shall include an analysis of gaps in the children's system and other planning provisions necessary to complete the final proposal for submission on or before December 10, 2012.

j. Developing a proposal for adult disability services not paid for by the Medicaid program to be administered on a regional basis in a manner that provides multiple local points of access for consumers needing adult disability services, regardless of the funding sources for the services. The proposal shall be integrated with the other proposals under this subsection and shall be developed by a separate workgroup or subcommittee engaging both urban and rural county supervisors and central-point-of-coordination administrators and other experts. The considerations for inclusion in the proposal for forming regional entities shall include but are not limited to all of the following:

(1) Modifying the relevant provisions of chapter 28E for use by counties in forming regional entities and addressing other necessary contracting measures.

(2) Providing for performance-based contracting between the department of human services and regional entities to ensure the existence of multiple, local points of access for adult disability services eligibility, intake, and authorization, service navigation support, and case coordination or case management, regardless of the funding sources for the services.

(3) Developing a three-year service plan and annual update to meet the needs of consumers.

(4) Providing for the regional entities to implement performance-based contracts, uniform cost reports, and consistent reimbursement practices and payment methodologies with local providers of services not paid for by the Medicaid program.

(5) Providing for the regional entities to determine the Medicaid program targeted case managers to serve the regions.

(6) Providing for the regional entities and the department of human services to regularly coordinate and communicate with one another concerning the adult disability services paid for by the Medicaid program so that services paid for by the program and the regional entities are integrated and coordinated.

(7) Identifying sufficient population size to attain economy of scale, adequate financial resources, and appropriate service delivery.

(8) Addressing full participation in regional entities by counties.

(9) Including dispute resolution provisions for county-to-county relationships, county-to-region relationships, and region-to-state relationships.

(10) Providing for a consumer appeal process that is clear, impartial, and consistent, with consideration of an option that appeals beyond the regional level should be to a state administrative law judge.

(11) Addressing financial management provisions, including appropriate financial reserve levels.

(12) Proposing other criteria for forming regional entities. The other criteria considered shall include but are not limited to all of the following:

(a) Requiring a region to consist of contiguous counties.

(b) Evaluating a proposed region's capacity for providing core services and performing required functions.

(c) Requiring a region to encompass at least one community mental health center or federally qualified health center with providers qualified to provide psychiatric services, either directly or with assistance from psychiatric consultants, that has the capacity to provide outpatient services for the region and has provided evidence of a commitment to provide outpatient services for the region.

(d) Requiring a region to encompass or have reasonably close proximity to a hospital with an inpatient psychiatric unit or to a state mental health institute, that has the capacity to provide inpatient services for the region and has provided evidence of a commitment to provide inpatient services for the region.

(e) Requiring an administrative structure utilized by a region to have clear lines of accountability and to serve as a lead agency with shared county staff or other means of limiting administrative costs to not more than five percent of expenditures.

k. Incorporating into proposals any necessary changes to the chapter 230A amendments contained in this Act.

l. Providing cost estimates for the proposals.

5. The target date for full implementation of the plan and implementation provisions described in subsections 3 and 4 shall be July 1, 2013, provided, however, that any expansion of services is subject to available funding.

Sec. 2. CONTINUATION OF WORKGROUP BY JUDICIAL BRANCH AND DEPARTMENT OF HUMAN SERVICES. The judicial branch and department of human services shall continue the workgroup implemented pursuant to 2010 Iowa Acts, chapter 1192, section 24, subsection 2, to improve the processes for involuntary commitment for chronic substance abuse under chapter 125 and for serious mental illness under chapter 229, and shall coordinate its efforts with the legislative interim committee and other workgroups initiated pursuant to this Act. The recommendations issued by the workgroup shall address options to the current provision of transportation by the county sheriff; to the role, supervision, and funding of mental health patient advocates and substance-related disorder patient advocates, along with options for implementation of the provision of advocates to patients with such disorders; for revising requirements for mental health professionals who are engaged in the involuntary commitment and examination processes under chapter 229; for authorizing the court to order an involuntary hold of a patient under section 229.10 for not more than twenty-three hours who was not initially taken into custody but declined to be examined pursuant to a previous court order; for implementing jail diversion programs, comprehensive training of law enforcement in dealing with individuals who are experiencing a mental health crisis, mental health courts, and other promising reforms involving mental health and the criminal justice system; and for civil commitment prescreening. Preliminary recommendations shall be submitted to the legislative interim committee in October 2011, as specified by the interim committee. Additional stakeholders shall be added as necessary to facilitate the workgroup efforts. The workgroup shall complete deliberations and submit a final report to the legislative interim committee providing findings and recommendations on or before December 9, 2011.

Sec. 3. SERVICE SYSTEM DATA AND STATISTICAL INFORMATION INTEGRATION. In coordination with the legislative interim committee and workgroups initiated pursuant to this Act, representatives of the department of human services, department of public health, and the community services network hosted by the Iowa state association of counties shall develop implementation provisions for an integrated data and statistical information system for mental health, disability services, and substance abuse services. The implementation provisions shall incorporate federal data and statistical information requirements. When completed, the departments and affiliate shall report on the integrated system to the governor, the joint appropriations subcommittee on health and human services, and the legislative services agency, providing their findings and recommendations.

Sec. 4. DEPARTMENT OF HUMAN SERVICES. There is appropriated from the general fund of the state to the department of human services for the fiscal year beginning July 1, 2010, and ending June 30, 2011, the following amount, or so much thereof as is necessary, to be used for the purposes designated:

For the costs of planning and other processes associated with implementation of this Act:
..... $ 250,000

Notwithstanding section 8.47 or any other provision of law to the contrary, the department may utilize a sole source approach to contract to support planning and other processes associated with implementation of this Act. Notwithstanding section 8.33, moneys appropriated in this section that remain unencumbered or unobligated at the close of the fiscal year shall not revert but shall remain available for expenditure for the purposes designated until the close of the succeeding fiscal year.

Sec. 5. EFFECTIVE UPON ENACTMENT. This division of this Act, being deemed of immediate importance, takes effect upon enactment.

DIVISION II
CONFORMING PROVISIONS

Sec. 6. CONFORMING PROVISIONS. The legislative services agency shall prepare a study bill for consideration by the committees on human resources of the senate and house of representatives for the 2012 legislative session, providing any necessary conforming Code changes for implementation of the system redesign provisions contained in this Act.

DIVISION III
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

Sec. 7. Section 135H.3, subsection 1, Code 2011, is amended to read as follows:

1. A psychiatric medical institution for children shall utilize a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of residents in accordance with a medical care plan developed for each resident. The membership of the team of professionals may include but is not limited to an advanced registered nurse practitioner or a physician assistant. Social and rehabilitative services shall be provided under the direction of a qualified mental health professional.

Sec. 8. Section 135H.6, subsection 8, Code 2011, is amended to read as follows:

8. The department of human services may give approval to conversion of beds approved under subsection 6, to beds which are specialized to provide substance abuse treatment. However, the total number of beds approved under subsection 6 and this subsection shall not exceed four hundred thirty. Conversion of beds under this subsection shall not require a revision of the certificate of need issued for the psychiatric institution making the conversion. Beds for children who do not reside in this state and whose service costs are not paid by public funds in this state are not subject to the limitations on the number of beds and certificate of need requirements otherwise applicable under this section.

Sec. 9. PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN AND RELATED SERVICES — TRANSITION COMMITTEE.

1. For the purposes of this section, unless the context otherwise requires:

a. "Iowa plan" means the contract to administer the behavioral health managed care plan under the state's Medicaid program.

b. "PMIC" means a psychiatric medical institution for children.

2. It is the intent of the general assembly to do the following under this section:

a. Improve the reimbursement, expected outcomes, and integration of PMIC services to serve the best interests of children within the context of a redesign of the delivery of publicly funded children's mental health services in this state.

b. Support the development of specialized programs for children with high acuity requirements whose needs are not met by Iowa's current system and must be served in out-of-state placements.

c. Transition PMIC services while providing services in a manner that applies best practices and is cost-effective.

3. The department of human services, in collaboration with PMIC providers, shall develop a plan for transitioning the administration of PMIC services to the Iowa plan. The transition plan shall address specific strategies for appropriately addressing PMIC lengths of stay by increasing the availability of less intensive levels of care, establishing vendor performance standards, identifying levels of PMIC care, providing for performance and quality improvement technical assistance to providers, identifying methods and standards for credentialing providers of specialized programs, using innovative reimbursement incentives to improve access while building the capacity of less intensive levels of care, and providing implementation guidelines.

4. a. The transition plan shall address the development of specialized programs to address the needs of children in need of more intensive treatment who are currently underserved. All of the following criteria shall be used for such programs:

(1) Geographic accessibility.

(2) Expertise needed to assure appropriate and effective treatment.

(3) Capability to define and provide the appropriate array of services and report on standardized outcome measures.

(4) Best interests of the child.

b. The transition plan shall also address all of the following:

(1) Providing navigation, access, and care coordination for children and families in need of services from the children's mental health system.

(2) Integrating the children's mental health waiver services under the Medicaid program with other services addressed by the transition plan as a means for supporting the transition plan and ensuring availability of choices for community placements.

(3) Identifying admission and continued stay criteria for PMIC providers.

(4) Evaluating changes in licensing standards for PMICs as necessary to ensure that the standards are aligned with overall system goals.

(5) Evaluating alternative reimbursement and service models that are innovative and could support overall system goals. The models may include but are not limited to accountable care organizations, medical or other health homes, and performance-based payment methods.

(6) Evaluating the adequacy of reimbursement at all levels of the children's mental health system.

(7) Developing profiles of the conditions and behaviors that result in a child's involuntary discharge or out-of-state placement. The plan shall incorporate provisions for developing specialized programs that are designed to appropriately meet the needs identified in the profiles.

(8) Evaluating and defining the appropriate array of less intensive services for a child leaving a hospital or PMIC placement.

(9) Evaluating and defining the standards for existing and new PMIC and other treatment levels.

5. a. The department shall establish a transition committee that includes departmental staff representatives for Medicaid, child welfare, field, and mental health services, the director of the Iowa plan, the department of inspections and appeals, a representative of

each licensed PMIC, the executive director of the coalition of family and children's services in Iowa, a person with knowledge and expertise in care coordination and integration of PMIC and community-based services, two persons representing families affected by the children's mental health system, and a representative of juvenile court officers.

b. The transition committee shall develop the plan and manage the transition if the plan is implemented. A preliminary plan shall be provided to the legislative interim committee authorized pursuant to division I of this Act for consideration by the committee in October 2011. The completed plan shall be provided to the interim committee by December 9, 2011, and any revisions to address concerns identified by the interim committee shall be incorporated into a final plan developed by December 31, 2011, which shall be submitted to the general assembly by January 16, 2012. The submitted plan shall include an independent finding by the director of human services, in consultation with the office of the governor and the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, that the plan meets the intent of the general assembly under this section. Unless otherwise directed by enactment of the general assembly the department and the transition committee may proceed with implementation of the submitted plan on or before July 1, 2012.

c. The transition committee shall continue to meet through December 31, 2013, to oversee transition of PMIC services to the Iowa plan.

6. The director of the Medicaid enterprise of the department of human services shall annually report on or before December 15 to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services through December 15, 2016, regarding the implementation of this section. The content of the report shall include but is not limited to information on children served by PMIC providers, the types of locations to which children are discharged following a hospital or PMIC placement and the community-based services available to such children, and the incidence of readmission to a PMIC within 12 months of discharge. The report shall also recommend whether or not to continue administration of PMIC services under the Iowa plan based upon the quality of service delivery, the value of utilizing the Iowa plan administration rather than the previous approach through the Medicaid enterprise, and analysis of the cost and benefits of utilizing the Iowa plan approach.

DIVISION IV
COMMUNITY MENTAL HEALTH CENTERS

COMMUNITY MENTAL HEALTH CENTERS — CATCHMENT AREAS

Sec. 10. IMPLEMENTATION OF DIVISION — LEGISLATIVE INTENT. It is the intent of the general assembly that the statutory amendments contained in this division shall receive further consideration in the disability services system redesign process implemented pursuant to division I of this Act and by the general assembly during the 2012 legislative session. The purpose of the further consideration is to ensure that the statutory amendments are integrated with the system redesign provisions, including but not limited to the provisions involving meeting the needs of consumers, connecting the regional administration of the overall system with the catchment areas for community mental health services, involvement of counties, terminology utilized, matching core services for centers with the core services for the overall system redesign, and matching accreditation standards, financing provisions, and accountability measures.

Sec. 11. NEW SECTION. **230A.101 Services system roles.**

1. The role of the department of human services, through the division of the department designated as the state mental health authority with responsibility for state policy concerning mental health and disability services, is to develop and maintain policies for the mental health and disability services system. The policies shall address the service needs of individuals of all ages with disabilities in this state, regardless of the individuals' places of residence or economic circumstances, and shall be consistent with the requirements of chapter 225C and other applicable law.

2. The role of community mental health centers in the mental health and disability services system is to provide an organized set of services in order to adequately meet the mental health needs of this state's citizens based on organized catchment areas.

Sec. 12. NEW SECTION. **230A.102 Definitions.**

As used in this chapter, unless the context otherwise requires:

1. *"Administrator"*, *"commission"*, *"department"*, *"disability services"*, and *"division"* mean the same as defined in section 225C.2.

2. *"Catchment area"* means a community mental health center catchment area identified in accordance with this chapter.

3. *"Community mental health center"* or *"center"* means a community mental health center designated in accordance with this chapter.

Sec. 13. NEW SECTION. **230A.103 Designation of community mental health centers.**

1. The division, subject to agreement by any community mental health center that would provide services for the catchment area and approval by the commission, shall designate at least one community mental health center under this chapter for addressing the mental health needs of the county or counties comprising the catchment area. The designation process shall provide for the input of potential service providers regarding designation of the initial catchment area or a change in the designation.

2. The division shall utilize objective criteria for designating a community mental health center to serve a catchment area and for withdrawing such designation. The commission shall adopt rules outlining the criteria. The criteria shall include but are not limited to provisions for meeting all of the following requirements:

a. An appropriate means shall be used for determining which prospective designee is best able to serve all ages of the targeted population within the catchment area with minimal or no service denials.

b. An effective means shall be used for determining the relative ability of a prospective designee to appropriately provide mental health services and other support to consumers residing within a catchment area as well as consumers residing outside the catchment area. The criteria shall address the duty for a prospective designee to arrange placements outside the catchment area when such placements best meet consumer needs and to provide services within the catchment area to consumers who reside outside the catchment area when the services are necessary and appropriate.

3. The board of directors for a designated community mental health center shall enter into an agreement with the division. The terms of the agreement shall include but are not limited to all of the following:

a. The period of time the agreement will be in force.

b. The services and other support the center will offer or provide for the residents of the catchment area.

c. The standards to be followed by the center in determining whether and to what extent the persons seeking services from the center shall be considered to be able to pay the costs of the services.

d. The policies regarding availability of the services offered by the center to the residents of the catchment area as well as consumers residing outside the catchment area.

e. The requirements for preparation and submission to the division of annual audits, cost reports, program reports, performance measures, and other financial and service accountability information.

4. This section does not limit the authority of the board or the boards of supervisors of any county or group of counties to continue to expend money to support operation of a center.

Sec. 14. NEW SECTION. **230A.104 Catchment areas.**

1. The division shall collaborate with affected counties in identifying community mental health center catchment areas in accordance with this section.

2. *a.* Unless the division has determined that exceptional circumstances exist, a catchment area shall be served by one community mental health center. The purpose of this general limitation is to clearly designate the center responsible and accountable for providing core

mental health services to the target population in the catchment area and to protect the financial viability of the centers comprising the mental health services system in the state.

b. A formal review process shall be used in determining whether exceptional circumstances exist that justify designating more than one center to serve a catchment area. The criteria for the review process shall include but are not limited to a means of determining whether the catchment area can support more than one center.

c. Criteria shall be provided that would allow the designation of more than one center for all or a portion of a catchment area if designation or approval for more than one center was provided by the division as of October 1, 2010. The criteria shall require a determination that all such centers would be financially viable if designation is provided for all.

Sec. 15. NEW SECTION. **230A.105 Target population — eligibility.**

1. The target population residing in a catchment area to be served by a community mental health center shall include but is not limited to all of the following:

a. Individuals of any age who are experiencing a mental health crisis.

b. Individuals of any age who have a mental health disorder.

c. Adults who have a serious mental illness or chronic mental illness.

d. Children and youth who are experiencing a serious emotional disturbance.

e. Individuals described in paragraph *"a"*, *"b"*, *"c"*, or *"d"* who have a co-occurring disorder, including but not limited to substance abuse, mental retardation, a developmental disability, brain injury, autism spectrum disorder, or another disability or special health care need.

2. Specific eligibility criteria for members of the target population shall be identified in administrative rules adopted by the commission. The eligibility criteria shall address both clinical and financial eligibility.

Sec. 16. NEW SECTION. **230A.106 Services offered.**

1. A community mental health center designated in accordance with this chapter shall offer core services and support addressing the basic mental health and safety needs of the target population and other residents of the catchment area served by the center and may offer other services and support. The core services shall be identified in administrative rules adopted by the commission for this purpose.

2. The initial core services identified shall include all of the following:

a. Outpatient services. Outpatient services shall consist of evaluation and treatment services provided on an ambulatory basis for the target population. Outpatient services include psychiatric evaluations, medication management, and individual, family, and group therapy. In addition, outpatient services shall include specialized outpatient services directed to the following segments of the target population: children, elderly, individuals who have serious and persistent mental illness, and residents of the service area who have been discharged from inpatient treatment at a mental health facility. Outpatient services shall provide elements of diagnosis, treatment, and appropriate follow-up. The provision of only screening and referral services does not constitute outpatient services.

b. Twenty-four-hour emergency services.
Twenty-four-hour emergency services shall be provided through a system that provides access to a clinician and appropriate disposition with follow-up documentation of the emergency service provided. A patient shall have access to evaluation and stabilization services after normal business hours. The range of emergency services that shall be available to a patient may include but are not limited to direct contact with a clinician, medication evaluation, and hospitalization. The emergency services may be provided directly by the center or in collaboration or affiliation with other appropriately accredited providers.

c. Day treatment, partial hospitalization, or psychosocial rehabilitation services. Such services shall be provided as structured day programs in segments of less than twenty-four hours using a multidisciplinary team approach to develop treatment plans that vary in intensity of services and the frequency and duration of services based on the needs of the patient. These services may be provided directly by the center or in collaboration or affiliation with other appropriately accredited providers.

d. Admission screening for voluntary patients.

Admission screening services shall be available for patients considered for voluntary admission to a state mental health institute to determine the patient's appropriateness for admission.

e. Community support services. Community support services shall consist of support and treatment services focused on enhancing independent functioning and assisting persons in the target population who have a serious and persistent mental illness to live and work in their community setting, by reducing or managing mental illness symptoms and the associated functional disabilities that negatively impact such persons' community integration and stability.

f. Consultation services. Consultation services may include provision of professional assistance and information about mental health and mental illness to individuals, service providers, or groups to increase such persons' effectiveness in carrying out their responsibilities for providing services. Consultations may be case-specific or program-specific.

g. Education services. Education services may include information and referral services regarding available resources and information and training concerning mental health, mental illness, availability of services and other support, the promotion of mental health, and the prevention of mental illness. Education services may be made available to individuals, groups, organizations, and the community in general.

3. A community mental health center shall be responsible for coordinating with associated services provided by other unaffiliated agencies to members of the target population in the catchment area and to integrate services in the community with services provided to the target population in residential or inpatient settings.

Sec. 17. NEW SECTION. **230A.107 Form of organization.**

1. Except as authorized in subsection 2, a community mental health center designated in accordance with this chapter shall be organized and administered as a nonprofit corporation.

2. A for-profit corporation, nonprofit corporation, or county hospital providing mental health services to county residents pursuant to a waiver approved under section 225C.7, subsection 3, Code 2011, as of October 1, 2010, may also be designated as a community mental health center.

Sec. 18. NEW SECTION. **230A.108 Administrative, diagnostic, and demographic information.**

Release of administrative and diagnostic information, as defined in section 228.1, and demographic information necessary for aggregated reporting to meet the data requirements established by the division, relating to an individual who receives services from a community mental health center, may be made a condition of support of that center by the division.

Sec. 19. NEW SECTION. **230A.109 Funding — legislative intent.**

1. It is the intent of the general assembly that public funding for community mental health centers designated in accordance with this chapter shall be provided as a combination of all funding sources.

2. It is the intent of the general assembly that the state funding provided to centers be a sufficient amount for the core services and support addressing the basic mental health and safety needs of the residents of the catchment area served by each center to be provided regardless of individual ability to pay for the services and support.

3. While a community mental health center must comply with the core services requirements and other standards associated with designation, provision of services is subject to the availability of a payment source for the services.

Sec. 20. NEW SECTION. **230A.110 Standards.**

1. The division shall recommend and the commission shall adopt standards for designated community mental health centers and comprehensive community mental health programs, with the overall objective of ensuring that each center and each affiliate providing services under contract with a center furnishes high-quality mental health services within a framework of accountability to the community it serves. The standards adopted shall conform with federal standards applicable to community mental health centers and shall

be in substantial conformity with the applicable behavioral health standards adopted by the joint commission, formerly known as the joint commission on accreditation of health care organizations, and other recognized national standards for evaluation of psychiatric facilities unless in the judgment of the division, with approval of the commission, there are sound reasons for departing from the standards.

2. When recommending standards under this section, the division shall designate an advisory committee representing boards of directors and professional staff of designated community mental health centers to assist in the formulation or revision of standards. The membership of the advisory committee shall include representatives of professional and nonprofessional staff and other appropriate individuals.

3. The standards recommended under this section shall include requirements that each community mental health center designated under this chapter do all of the following:

a. Maintain and make available to the public a written statement of the services the center offers to residents of the catchment area being served. The center shall employ or contract for services with affiliates to employ staff who are appropriately credentialed or meet other qualifications in order to provide services.

b. If organized as a nonprofit corporation, be governed by a board of directors which adequately represents interested professions, consumers of the center's services, socioeconomic, cultural, and age groups, and various geographical areas in the catchment area served by the center. If organized as a for-profit corporation, the corporation's policy structure shall incorporate such representation.

c. Arrange for the financial condition and transactions of the community mental health center to be audited once each year by the auditor of state. However, in lieu of an audit by state accountants, the local governing body of a community mental health center organized under this chapter may contract with or employ certified public accountants to conduct the audit, pursuant to the applicable terms and conditions prescribed by sections 11.6 and 11.19 and audit format prescribed by the auditor of state. Copies of each audit shall be furnished by the accountant to the administrator of the division of mental health and disability services.

d. Comply with the accreditation standards applicable to the center.

Sec. 21. NEW SECTION. **230A.111 Review and evaluation.**

1. The review and evaluation of designated centers shall be performed through a formal accreditation review process as recommended by the division and approved by the commission. The accreditation process shall include all of the following:

a. Specific time intervals for full accreditation reviews based upon levels of accreditation.

b. Use of random or complaint-specific, on-site limited accreditation reviews in the interim between full accreditation reviews, as a quality review approach. The results of such reviews shall be presented to the commission.

c. Use of center accreditation self-assessment tools to gather data regarding quality of care and outcomes, whether used during full or limited reviews or at other times.

2. The accreditation process shall include but is not limited to addressing all of the following:

a. Measures to address centers that do not meet standards, including authority to revoke accreditation.

b. Measures to address noncompliant centers that do not develop a corrective action plan or fail to implement steps included in a corrective action plan accepted by the division.

c. Measures to appropriately recognize centers that successfully complete a corrective action plan.

d. Criteria to determine when a center's accreditation should be denied, revoked, suspended, or made provisional.

Sec. 22. REPEAL. Sections 230A.1 through 230A.18, Code 2011, are repealed.

Sec. 23. IMPLEMENTATION — EFFECTIVE DATE.

1. Community mental health centers operating under the provisions of chapter 230A, Code 2011, and associated standards, rules, and other requirements as of June 30, 2012, may continue to operate under such requirements until the department of human services,

division of mental health and disability services, and the mental health and disability services commission have completed the rules adoption process to implement the amendments to chapter 230A enacted by this Act, identified catchment areas, and completed designations of centers.

2. The division and the commission shall complete the rules adoption process and other requirements addressed in subsection 1 on or before June 30, 2012.

3. Except for this section, which shall take effect July 1, 2011, this division of this Act takes effect July 1, 2012.

DIVISION V
PERSONS WITH SUBSTANCE-RELATED DISORDERS AND PERSONS WITH MENTAL ILLNESS

Sec. 24. Section 125.1, subsection 1, Code 2011, is amended to read as follows:

1. That ~~substance abusers and persons suffering from chemical dependency~~ persons with substance-related disorders be afforded the opportunity to receive quality treatment and directed into rehabilitation services which will help them resume a socially acceptable and productive role in society.

Sec. 25. Section 125.2, subsection 2, Code 2011, is amended by striking the subsection.

Sec. 26. Section 125.2, subsection 5, Code 2011, is amended by striking the subsection and inserting in lieu thereof the following:

5. *"Substance-related disorder"* means a diagnosable substance abuse disorder of sufficient duration to meet diagnostic criteria specified within the most current diagnostic and statistical manual of mental disorders published by the American psychiatric association that results in a functional impairment.

Sec. 27. Section 125.2, subsection 9, Code 2011, is amended to read as follows:

9. *"Facility"* means an institution, a detoxification center, or an installation providing care, maintenance and treatment for ~~substance abusers~~ persons with substance-related disorders licensed by the department under section 125.13, hospitals licensed under chapter 135B, or the state mental health institutes designated by chapter 226.

Sec. 28. Section 125.2, subsections 13, 17, and 18, Code 2011, are amended by striking the subsections.

Sec. 29. Section 125.9, subsections 2 and 4, Code 2011, are amended to read as follows:

2. Make contracts necessary or incidental to the performance of the duties and the execution of the powers of the director, including contracts with public and private agencies, organizations and individuals to pay them for services rendered or furnished to ~~substance abusers, chronic substance abusers, or intoxicated persons~~ persons with substance-related disorders.

4. Coordinate the activities of the department and cooperate with substance abuse programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local or private agencies in this and other states for the treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders and for the common advancement of substance abuse programs.

Sec. 30. Section 125.10, subsections 2, 3, 4, 5, 7, 8, 9, 11, 13, 15, and 17, Code 2011, are amended to read as follows:

2. Develop, encourage, and foster statewide, regional and local plans and programs for the prevention of substance ~~abuse~~ misuse and the treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders in cooperation with public and private agencies, organizations and individuals, and provide technical assistance and consultation services for these purposes.

3. Coordinate the efforts and enlist the assistance of all public and private agencies, organizations and individuals interested in the prevention of substance abuse and the

treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders.

4. Cooperate with the department of human services and the Iowa department of public health in establishing and conducting programs to provide treatment for ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders.

5. Cooperate with the department of education, boards of education, schools, police departments, courts, and other public and private agencies, organizations, and individuals in establishing programs for the prevention of substance abuse and the treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders, and in preparing relevant curriculum materials for use at all levels of school education.

7. Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders, which program shall include the dissemination of information concerning the nature and effects of ~~chemical~~ substances.

8. Organize and implement, in cooperation with local treatment programs, training programs for all persons engaged in treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders.

9. Sponsor and implement research in cooperation with local treatment programs into the causes and nature of substance ~~abuse~~ misuse and treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders, and serve as a clearing house for information relating to substance abuse.

11. Develop and implement, with the counsel and approval of the board, the comprehensive plan for treatment of ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders in accordance with this chapter.

13. Utilize the support and assistance of interested persons in the community, particularly ~~recovered substance abusers and chronic substance abusers,~~ persons who are recovering from substance-related disorders to encourage ~~substance abusers and chronic substance abusers~~ persons with substance-related disorders to voluntarily undergo treatment.

15. Encourage general hospitals and other appropriate health facilities to admit without discrimination ~~substance abusers, chronic substance abusers, and intoxicated persons~~ persons with substance-related disorders and to provide them with adequate and appropriate treatment. The director may negotiate and implement contracts with hospitals and other appropriate health facilities with adequate detoxification facilities.

17. Review all state health, welfare, education and treatment proposals to be submitted for federal funding under federal legislation, and advise the governor on provisions to be included relating to substance abuse, ~~substance abusers, chronic substance abusers, and intoxicated persons~~ and persons with substance-related disorders.

Sec. 31. Section 125.12, subsections 1 and 3, Code 2011, are amended to read as follows:

1. The board shall review the comprehensive substance abuse program implemented by the department for the treatment of ~~substance abusers, chronic substance abusers, intoxicated persons~~ persons with substance-related disorders~~,~~ and concerned family members. Subject to the review of the board, the director shall divide the state into appropriate regions for the conduct of the program and establish standards for the development of the program on the regional level. In establishing the regions, consideration shall be given to city and county lines, population concentrations, and existing substance abuse treatment services.

3. The director shall provide for adequate and appropriate treatment for ~~substance abusers, chronic substance abusers, intoxicated persons~~ persons with substance-related disorders~~,~~ and concerned family members admitted under sections 125.33 and 125.34, or under section 125.75, 125.81, or 125.91. Treatment shall not be provided at a correctional institution except for inmates.

Sec. 32. Section 125.13, subsection 1, paragraph a, Code 2011, is amended to read as follows:

a. Except as provided in subsection 2, a person shall not maintain or conduct any chemical substitutes or antagonists program, residential program, or nonresidential outpatient program, the primary purpose of which is the treatment and rehabilitation of ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders without having first obtained a written license for the program from the department.

Sec. 33. Section 125.13, subsection 2, paragraphs a and c, Code 2011, are amended to read as follows:

a. A hospital providing care or treatment to ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders licensed under chapter 135B which is accredited by the joint commission on the accreditation of health care organizations, the commission on accreditation of rehabilitation facilities, the American osteopathic association, or another recognized organization approved by the board. All survey reports from the accrediting or licensing body must be sent to the department.

c. Private institutions conducted by and for persons who adhere to the faith of any well recognized church or religious denomination for the purpose of providing care, treatment, counseling, or rehabilitation to ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders and who rely solely on prayer or other spiritual means for healing in the practice of religion of such church or denomination.

Sec. 34. Section 125.15, Code 2011, is amended to read as follows:

125.15 Inspections.

The department may inspect the facilities and review the procedures utilized by any chemical substitutes or antagonists program, residential program, or nonresidential outpatient program that has as a primary purpose the treatment and rehabilitation of ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders, for the purpose of ensuring compliance with this chapter and the rules adopted pursuant to this chapter. The examination and review may include case record audits and interviews with staff and patients, consistent with the confidentiality safeguards of state and federal law.

Sec. 35. Section 125.32, unnumbered paragraph 1, Code 2011, is amended to read as follows:

The department shall adopt and may amend and repeal rules for acceptance of persons into the treatment program, subject to chapter 17A, considering available treatment resources and facilities, for the purpose of early and effective treatment of ~~substance abusers, chronic substance abusers, intoxicated persons,~~ persons with substance-related disorders and concerned family members. In establishing the rules the department shall be guided by the following standards:

Sec. 36. Section 125.33, subsections 1, 3, and 4, Code 2011, are amended to read as follows:

1. A ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder may apply for voluntary treatment or rehabilitation services directly to a facility or to a licensed physician and surgeon or osteopathic physician and surgeon. If the proposed patient is a minor or an incompetent person, a parent, a legal guardian or other legal representative may make the application. The licensed physician and surgeon or osteopathic physician and surgeon or any employee or person acting under the direction or supervision of the physician and surgeon or osteopathic physician and surgeon, or the facility shall not report or disclose the name of the person or the fact that treatment was requested or has been undertaken to any law enforcement officer or law enforcement agency; nor shall such information be admissible as evidence in any court, grand jury, or administrative proceeding unless authorized by the person seeking treatment. If the person seeking such treatment or rehabilitation is a minor who has personally made application for treatment, the fact that the minor sought treatment or rehabilitation or is receiving treatment or rehabilitation services shall not be reported or disclosed to the parents or legal guardian of such minor without

the minor's consent, and the minor may give legal consent to receive such treatment and rehabilitation.

3. A ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder seeking treatment or rehabilitation and who is either addicted or dependent on a chemical substance may first be examined and evaluated by a licensed physician and surgeon or osteopathic physician and surgeon who may prescribe a proper course of treatment and medication, if needed. The licensed physician and surgeon or osteopathic physician and surgeon may further prescribe a course of treatment or rehabilitation and authorize another licensed physician and surgeon or osteopathic physician and surgeon or facility to provide the prescribed treatment or rehabilitation services. Treatment or rehabilitation services may be provided to a person individually or in a group. A facility providing or engaging in treatment or rehabilitation shall not report or disclose to a law enforcement officer or law enforcement agency the name of any person receiving or engaged in the treatment or rehabilitation; nor shall a person receiving or participating in treatment or rehabilitation report or disclose the name of any other person engaged in or receiving treatment or rehabilitation or that the program is in existence, to a law enforcement officer or law enforcement agency. Such information shall not be admitted in evidence in any court, grand jury, or administrative proceeding. However, a person engaged in or receiving treatment or rehabilitation may authorize the disclosure of the person's name and individual participation.

4. If a patient receiving inpatient or residential care leaves a facility, the patient shall be encouraged to consent to appropriate outpatient or halfway house treatment. If it appears to the administrator in charge of the facility that the patient is a ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder who requires help, the director may arrange for assistance in obtaining supportive services.

Sec. 37. Section 125.34, Code 2011, is amended to read as follows:

125.34 Treatment and services for ~~intoxicated persons and persons incapacitated by alcohol~~ persons with substance-related disorders due to intoxication and substance-induced incapacitation.

1. ~~An intoxicated~~ A person with a substance-related disorder due to intoxication or substance-induced incapacitation may come voluntarily to a facility for emergency treatment. A person who appears to be intoxicated or incapacitated by a ~~chemical~~ substance in a public place and in need of help may be taken to a facility by a peace officer under section 125.91. If the person refuses the proffered help, the person may be arrested and charged with intoxication under section 123.46, if applicable.

2. If no facility is readily available the person may be taken to an emergency medical service customarily used for incapacitated persons. The peace officer in detaining the person and in taking the person to a facility shall make every reasonable effort to protect the person's health and safety. In detaining the person the detaining officer may take reasonable steps for self-protection. Detaining a person under section 125.91 is not an arrest and no entry or other record shall be made to indicate that the person who is detained has been arrested or charged with a crime.

3. A person who arrives at a facility and voluntarily submits to examination shall be examined by a licensed physician as soon as possible after the person arrives at the facility. The person may then be admitted as a patient or referred to another health facility. The referring facility shall arrange for transportation.

4. If a person is voluntarily admitted to a facility, the person's family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, the request shall be respected.

5. A peace officer who acts in compliance with this section is acting in the course of the officer's official duty and is not criminally or civilly liable therefor, unless such acts constitute willful malice or abuse.

6. If the physician in charge of the facility determines it is for the patient's benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

7. A licensed physician and surgeon or osteopathic physician and surgeon, facility administrator, or an employee or a person acting as or on behalf of the facility administrator,

is not criminally or civilly liable for acts in conformity with this chapter, unless the acts constitute willful malice or abuse.

Sec. 38. Section 125.43, Code 2011, is amended to read as follows:

125.43 Funding at mental health institutes.

Chapter 230 governs the determination of the costs and payment for treatment provided to ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders in a mental health institute under the department of human services, except that the charges are not a lien on real estate owned by persons legally liable for support of the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder and the daily per diem shall be billed at twenty-five percent. The superintendent of a state hospital shall total only those expenditures which can be attributed to the cost of providing inpatient treatment to ~~substance abusers or chronic substance abusers~~ persons with substance-related disorders for purposes of determining the daily per diem. Section 125.44 governs the determination of who is legally liable for the cost of care, maintenance, and treatment of a ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder and of the amount for which the person is liable.

Sec. 39. Section 125.43A, Code 2011, is amended to read as follows:

125.43A Prescreening — exception.

Except in cases of medical emergency or court-ordered admissions, a person shall be admitted to a state mental health institute for substance abuse treatment only after a preliminary intake and assessment by a department-licensed treatment facility or a hospital providing care or treatment for ~~substance abusers~~ persons with substance-related disorders licensed under chapter 135B and accredited by the joint commission on the accreditation of health care organizations, the commission on accreditation of rehabilitation facilities, the American osteopathic association, or another recognized organization approved by the board, or by a designee of a department-licensed treatment facility or a hospital other than a state mental health institute, which confirms that the admission is appropriate to the person's substance abuse service needs. A county board of supervisors may seek an admission of a patient to a state mental health institute who has not been confirmed for appropriate admission and the county shall be responsible for one hundred percent of the cost of treatment and services of the patient.

Sec. 40. Section 125.44, Code 2011, is amended to read as follows:

125.44 Agreements with facilities — liability for costs.

The director may, consistent with the comprehensive substance abuse program, enter into written agreements with a facility as defined in section 125.2 to pay for one hundred percent of the cost of the care, maintenance, and treatment of ~~substance abusers and chronic substance abusers~~ persons with substance-related disorders, except when section 125.43A applies. All payments for state patients shall be made in accordance with the limitations of this section. Such contracts shall be for a period of no more than one year.

The contract may be in the form and contain provisions as agreed upon by the parties. The contract shall provide that the facility shall admit and treat ~~substance abusers and chronic substance abusers~~ persons with substance-related disorders regardless of where they have residence. If one payment for care, maintenance, and treatment is not made by the patient or those legally liable for the patient, the payment shall be made by the department directly to the facility. Payments shall be made each month and shall be based upon the rate of payment for services negotiated between the department and the contracting facility. If a facility projects a temporary cash flow deficit, the department may make cash advances at the beginning of each fiscal year to the facility. The repayment schedule for advances shall be part of the contract between the department and the facility. This section does not pertain to patients treated at the mental health institutes.

If the appropriation to the department is insufficient to meet the requirements of this section, the department shall request a transfer of funds and section 8.39 shall apply.

The ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder is legally liable to the facility for the total amount of the cost of providing care,

maintenance, and treatment for the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder while a voluntary or committed patient in a facility. This section does not prohibit any individual from paying any portion of the cost of treatment.

The department is liable for the cost of care, treatment, and maintenance of ~~substance abusers and chronic substance abusers~~ persons with substance-related disorders admitted to the facility voluntarily or pursuant to section 125.75, 125.81, or 125.91 or section 321J.3 or 124.409 only to those facilities that have a contract with the department under this section, only for the amount computed according to and within the limits of liability prescribed by this section, and only when the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder is unable to pay the costs and there is no other person, firm, corporation, or insurance company bound to pay the costs.

The department's maximum liability for the costs of care, treatment, and maintenance of ~~substance abusers and chronic substance abusers~~ persons with substance-related disorders in a contracting facility is limited to the total amount agreed upon by the parties and specified in the contract under this section.

Sec. 41. Section 125.46, Code 2011, is amended to read as follows:

125.46 County of residence determined.

The facility shall, when a ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder is admitted, or as soon thereafter as it receives the proper information, determine and enter upon its records the Iowa county of residence of the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder, or that the person resides in some other state or country, or that the person is unclassified with respect to residence.

Sec. 42. Section 125.75, unnumbered paragraph 1, Code 2011, is amended to read as follows:

Proceedings for the involuntary commitment or treatment of a ~~chronic substance abuser~~ person with a substance-related disorder to a facility may be commenced by the county attorney or an interested person by filing a verified application with the clerk of the district court of the county where the respondent is presently located or which is the respondent's place of residence. The clerk or the clerk's designee shall assist the applicant in completing the application. The application shall:

Sec. 43. Section 125.75, subsection 1, Code 2011, is amended to read as follows:

1. State the applicant's belief that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder.

Sec. 44. Section 125.80, subsections 3 and 4, Code 2011, are amended to read as follows:

3. If the report of a court-designated physician is to the effect that the respondent is not a ~~chronic substance abuser~~ person with a substance-related disorder, the court, without taking further action, may terminate the proceeding and dismiss the application on its own motion and without notice.

4. If the report of a court-designated physician is to the effect that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder, the court shall schedule a commitment hearing as soon as possible. The hearing shall be held not more than forty-eight hours after the report is filed, excluding Saturdays, Sundays, and holidays, unless an extension for good cause is requested by the respondent, or as soon thereafter as possible if the court considers that sufficient grounds exist for delaying the hearing.

Sec. 45. Section 125.81, subsection 1, Code 2011, is amended to read as follows:

1. If a person filing an application requests that a respondent be taken into immediate custody, and the court upon reviewing the application and accompanying documentation, finds probable cause to believe that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder who is likely to injure the person or other persons if allowed to remain at liberty, the court may enter a written order directing that the respondent be taken into immediate custody by the sheriff, and be detained until the commitment hearing, which shall be held no more than five days after the date of the order, except that if the

fifth day after the date of the order is a Saturday, Sunday, or a holiday, the hearing may be held on the next business day. The court may order the respondent detained for the period of time until the hearing is held, and no longer except as provided in section 125.88, in accordance with subsection 2, paragraph *"a"*, if possible, and if not, then in accordance with subsection 2, paragraph *"b"*, or, only if neither of these alternatives is available in accordance with subsection 2, paragraph *"c"*.

Sec. 46. Section 125.82, subsection 4, Code 2011, is amended to read as follows:

4. The respondent's welfare is paramount, and the hearing shall be tried as a civil matter and conducted in as informal a manner as is consistent with orderly procedure. Discovery as permitted under the Iowa rules of civil procedure is available to the respondent. The court shall receive all relevant and material evidence, but the court is not bound by the rules of evidence. A presumption in favor of the respondent exists, and the burden of evidence and support of the contentions made in the application shall be upon the person who filed the application. If upon completion of the hearing the court finds that the contention that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder has not been sustained by clear and convincing evidence, the court shall deny the application and terminate the proceeding.

Sec. 47. Section 125.83, Code 2011, is amended to read as follows:

125.83 Placement for evaluation.

If upon completion of the commitment hearing, the court finds that the contention that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder has been sustained by clear and convincing evidence, the court shall order the respondent placed at a facility or under the care of a suitable facility on an outpatient basis as expeditiously as possible for a complete evaluation and appropriate treatment. The court shall furnish to the facility at the time of admission or outpatient placement, a written statement of facts setting forth the evidence on which the finding is based. The administrator of the facility shall report to the court no more than fifteen days after the individual is admitted to or placed under the care of the facility, which shall include the chief medical officer's recommendation concerning substance abuse treatment. An extension of time may be granted for a period not to exceed seven days upon a showing of good cause. A copy of the report shall be sent to the respondent's attorney who may contest the need for an extension of time if one is requested. If the request is contested, the court shall make an inquiry as it deems appropriate and may either order the respondent released from the facility or grant extension of time for further evaluation. If the administrator fails to report to the court within fifteen days after the individual is admitted to the facility, and no extension of time has been requested, the administrator is guilty of contempt and shall be punished under chapter 665. The court shall order a rehearing on the application to determine whether the respondent should continue to be held at the facility.

Sec. 48. Section 125.83A, subsection 1, Code 2011, is amended to read as follows:

1. If upon completion of the commitment hearing, the court finds that the contention that the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder has been sustained by clear and convincing evidence, and the court is furnished evidence that the respondent is eligible for care and treatment in a facility operated by the United States department of veterans affairs or another agency of the United States government and that the facility is willing to receive the respondent, the court may so order. The respondent, when so placed in a facility operated by the United States department of veterans affairs or another agency of the United States government within or outside of this state, shall be subject to the rules of the United States department of veterans affairs or other agency, but shall not lose any procedural rights afforded the respondent by this chapter. The chief officer of the facility shall have, with respect to the respondent so placed, the same powers and duties as the chief medical officer of a hospital in this state would have in regard to submission of reports to the court, retention of custody, transfer, convalescent leave, or discharge. Jurisdiction is retained in the court to maintain surveillance of the respondent's treatment and care, and at any time to inquire into the respondent's condition and the need for continued care and custody.

Sec. 49. Section 125.84, subsections 2, 3, and 4, Code 2011, are amended to read as follows:

2. That the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder who is in need of full-time custody, care, and treatment in a facility, and is considered likely to benefit from treatment. If the report so states, the court shall enter an order which may require the respondent's continued placement and commitment to a facility for appropriate treatment.

3. That the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder who is in need of treatment, but does not require full-time placement in a facility. If the report so states, the report shall include the chief medical officer's recommendation for treatment of the respondent on an outpatient or other appropriate basis, and the court shall enter an order which may direct the respondent to submit to the recommended treatment. The order shall provide that if the respondent fails or refuses to submit to treatment, as directed by the court's order, the court may order that the respondent be taken into immediate custody as provided by section 125.81 and, following notice and hearing held in accordance with the procedures of sections 125.77 and 125.82, may order the respondent treated as a patient requiring full-time custody, care, and treatment as provided in subsection 2, and may order the respondent involuntarily committed to a facility.

4. That the respondent is a ~~chronic substance abuser~~ person with a substance-related disorder who is in need of treatment, but in the opinion of the chief medical officer is not responding to the treatment provided. If the report so states, the report shall include the facility administrator's recommendation for alternative placement, and the court shall enter an order which may direct the respondent's transfer to the recommended placement or to another placement after consultation with respondent's attorney and the facility administrator who made the report under this subsection.

Sec. 50. Section 125.91, subsections 1, 2, and 3, Code 2011, are amended to read as follows:

1. The procedure prescribed by this section shall only be used for ~~an intoxicated~~ a person with a substance-related disorder due to intoxication or substance-induced incapacitation who has threatened, attempted, or inflicted physical self-harm or harm on another, and is likely to inflict physical self-harm or harm on another unless immediately detained, or who is incapacitated by a ~~chemical~~ substance, if that person cannot be taken into immediate custody under sections 125.75 and 125.81 because immediate access to the court is not possible.

2. *a.* A peace officer who has reasonable grounds to believe that the circumstances described in subsection 1 are applicable may, without a warrant, take or cause that person to be taken to the nearest available facility referred to in section 125.81, subsection 2, paragraph "*b*" or "*c*". Such ~~an intoxicated or incapacitated~~ a person with a substance-related disorder due to intoxication or substance-induced incapacitation who also demonstrates a significant degree of distress or dysfunction may also be delivered to a facility by someone other than a peace officer upon a showing of reasonable grounds. Upon delivery of the person to a facility under this section, the examining physician may order treatment of the person, but only to the extent necessary to preserve the person's life or to appropriately control the person's behavior if the behavior is likely to result in physical injury to the person or others if allowed to continue. The peace officer or other person who delivered the person to the facility shall describe the circumstances of the matter to the examining physician. If the person is a peace officer, the peace officer may do so either in person or by written report. If the examining physician has reasonable grounds to believe that the circumstances in subsection 1 are applicable, the examining physician shall at once communicate with the nearest available magistrate as defined in section 801.4, subsection 10. The magistrate shall, based upon the circumstances described by the examining physician, give the examining physician oral instructions either directing that the person be released forthwith, or authorizing the person's detention in an appropriate facility. The magistrate may also give oral instructions and order that the detained person be transported to an appropriate facility.

b. If the magistrate orders that the person be detained, the magistrate shall, by the close of business on the next working day, file a written order with the clerk in the county where it is anticipated that an application may be filed under section 125.75. The order may be filed

by facsimile if necessary. The order shall state the circumstances under which the person was taken into custody or otherwise brought to a facility and the grounds supporting the finding of probable cause to believe that the person is a ~~chronic substance abuser~~ person with a substance-related disorder likely to result in physical injury to the person or others if not detained. The order shall confirm the oral order authorizing the person's detention including any order given to transport the person to an appropriate facility. The clerk shall provide a copy of that order to the ~~chief medical officer of the facility~~ attending physician, to which the person was originally taken, any subsequent facility to which the person was transported, and to any law enforcement department or ambulance service that transported the person pursuant to the magistrate's order.

3. The ~~chief medical officer of the facility~~ attending physician shall examine and may detain the person pursuant to the magistrate's order for a period not to exceed forty-eight hours from the time the order is dated, excluding Saturdays, Sundays, and holidays, unless the order is dismissed by a magistrate. The facility may provide treatment which is necessary to preserve the person's life or to appropriately control the person's behavior if the behavior is likely to result in physical injury to the person or others if allowed to continue or is otherwise deemed medically necessary by the ~~chief medical officer~~ attending physician, but shall not otherwise provide treatment to the person without the person's consent. The person shall be discharged from the facility and released from detention no later than the expiration of the forty-eight-hour period, unless an application for involuntary commitment is filed with the clerk pursuant to section 125.75. The detention of a person by the procedure in this section, and not in excess of the period of time prescribed by this section, shall not render the peace officer, attending physician, or facility detaining the person liable in a criminal or civil action for false arrest or false imprisonment if the peace officer, physician, or facility had reasonable grounds to believe that the circumstances described in subsection 1 were applicable.

Sec. 51. Section 226.9C, subsection 2, paragraph c, Code 2011, is amended to read as follows:

c. (1) Prior to an individual's admission for dual diagnosis treatment, the individual shall have been prescreened. The person performing the prescreening shall be either the mental health professional, as defined in section 228.1, who is contracting with the county central-point-of-coordination process to provide the prescreening or a mental health professional with the requisite qualifications. A mental health professional with the requisite qualifications shall meet all of the following qualifications: is a mental health professional as defined in section 228.1, is a certified alcohol and drug counselor certified by the nongovernmental Iowa board of substance abuse certification, and is employed by or providing services for a facility, as defined in section 125.2.

(2) Prior to an individual's admission for dual diagnosis treatment, the individual shall have been screened through a county's central point of coordination process implemented pursuant to section 331.440 to determine the appropriateness of the treatment.

Sec. 52. Section 229.1, subsection 12, Code 2011, is amended to read as follows:

12. *"Psychiatric advanced registered nurse practitioner"* means an individual currently licensed as a registered nurse under chapter 152 or 152E who holds a national certification in psychiatric mental health care and who is registered with the board of nursing as an advanced registered nurse practitioner.

Sec. 53. Section 229.15, subsection 3, paragraph a, Code 2011, is amended to read as follows:

a. A psychiatric advanced registered nurse practitioner treating a patient previously hospitalized under this chapter may complete periodic reports pursuant to this section on the patient if the patient has been recommended for treatment on an outpatient or other appropriate basis pursuant to section 229.14, subsection 1, paragraph "c", ~~and if a psychiatrist licensed pursuant to chapter 148 personally evaluates the patient on at least an annual basis~~.

Sec. 54. Section 229.21, subsection 2, Code 2011, is amended to read as follows:

2. When an application for involuntary hospitalization under this chapter or an application for involuntary commitment or treatment of ~~chronic substance abusers~~ persons with substance-related disorders under sections 125.75 to 125.94 is filed with the clerk of the district court in any county for which a judicial hospitalization referee has been appointed, and no district judge, district associate judge, or magistrate who is admitted to the practice of law in this state is accessible, the clerk shall immediately notify the referee in the manner required by section 229.7 or section 125.77. The referee shall discharge all of the duties imposed upon the court by sections 229.7 to 229.22 or sections 125.75 to 125.94 in the proceeding so initiated. Subject to the provisions of subsection 4, orders issued by a referee, in discharge of duties imposed under this section, shall have the same force and effect as if ordered by a district judge. However, any commitment to a facility regulated and operated under chapter 135C, shall be in accordance with section 135C.23.

Sec. 55. Section 229.21, subsection 3, paragraphs a and b, Code 2011, are amended to read as follows:

a. Any respondent with respect to whom the magistrate or judicial hospitalization referee has found the contention that the respondent is seriously mentally impaired or a ~~chronic substance abuser~~ person with a substance-related disorder sustained by clear and convincing evidence presented at a hearing held under section 229.12 or section 125.82, may appeal from the magistrate's or referee's finding to a judge of the district court by giving the clerk notice in writing, within ten days after the magistrate's or referee's finding is made, that an appeal is taken. The appeal may be signed by the respondent or by the respondent's next friend, guardian, or attorney.

b. An order of a magistrate or judicial hospitalization referee with a finding that the respondent is seriously mentally impaired or a ~~chronic substance abuser~~ person with a substance-related disorder shall include the following notice, located conspicuously on the face of the order:

NOTE: The respondent may appeal from this order to a judge of the district court by giving written notice of the appeal to the clerk of the district court within ten days after the date of this order. The appeal may be signed by the respondent or by the respondent's next friend, guardian, or attorney. For a more complete description of the respondent's appeal rights, consult section 229.21 of the Code of Iowa or an attorney.

Sec. 56. Section 229.21, subsection 4, Code 2011, is amended to read as follows:

4. If the appellant is in custody under the jurisdiction of the district court at the time of service of the notice of appeal, the appellant shall be discharged from custody unless an order that the appellant be taken into immediate custody has previously been issued under section 229.11 or section 125.81, in which case the appellant shall be detained as provided in that section until the hospitalization or commitment hearing before the district judge. If the appellant is in the custody of a hospital or facility at the time of service of the notice of appeal, the appellant shall be discharged from custody pending disposition of the appeal unless the chief medical officer, not later than the end of the next secular day on which the office of the clerk is open and which follows service of the notice of appeal, files with the clerk a certification that in the chief medical officer's opinion the appellant is seriously mentally ill or a ~~substance abuser~~ person with a substance-related disorder. In that case, the appellant shall remain in custody of the hospital or facility until the hospitalization or commitment hearing before the district court.

Sec. 57. Section 230.15, unnumbered paragraph 2, Code 2011, is amended to read as follows:

A ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder is legally liable for the total amount of the cost of providing care, maintenance, and treatment for the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder while a voluntary or committed patient. When a portion of the cost is paid by a county, the ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder is legally liable to the county for the amount paid. The ~~substance abuser or chronic~~

~~substance abuser~~ person with a substance-related disorder shall assign any claim for reimbursement under any contract of indemnity, by insurance or otherwise, providing for the ~~abuser's~~ person's care, maintenance, and treatment in a state hospital to the state. Any payments received by the state from or on behalf of a ~~substance abuser or chronic substance abuser~~ person with a substance-related disorder shall be in part credited to the county in proportion to the share of the costs paid by the county. Nothing in this section shall be construed to prevent a relative or other person from voluntarily paying the full actual cost or any portion of the care and treatment of any person with mental illness~~, substance abuser, or chronic substance abuser~~ or a substance-related disorder as established by the department of human services.

Sec. 58. Section 232.116, subsection 1, paragraph l, subparagraph (2), Code 2011, is amended to read as follows:

(2) The parent has a severe~~, chronic substance abuse problem,~~ substance-related disorder and presents a danger to self or others as evidenced by prior acts.

Sec. 59. Section 600A.8, subsection 8, paragraph a, Code 2011, is amended to read as follows:

a. The parent has been determined to be a ~~chronic substance abuser~~ person with a substance-related disorder as defined in section 125.2 and the parent has committed a second or subsequent domestic abuse assault pursuant to section 708.2A.

Sec. 60. Section 602.4201, subsection 3, paragraph h, Code 2011, is amended to read as follows:

h. Involuntary commitment or treatment of ~~substance abusers~~ persons with a substance-related disorders.

Sec. 61. IMPLEMENTATION OF ACT. Section 25B.2, subsection 3, shall not apply to this division of this Act.

Sec. 62. EFFECTIVE DATE. This division of this Act takes effect July 1, 2012.

Approved July 26, 2011