Review of Youth Systems, Services and Supports

2025 Review Panel Report

October 1, 2025

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Background

Purpose

Pursuant to 2025 Iowa Acts, SF474, the State of Iowa Department of Health and Human Services (HHS) convened representatives from Iowa HHS, the courts and practitioners involved in civil commitment and juvenile justice proceedings, law enforcement and corrections, hospital systems, service providers, individuals with lived experience and their families, and four members of the Iowa General Assembly (i.e., two senators – one appointed by the majority leader of the senate and one pointed by the minority leader of the senate; two representatives – one appointed by the majority leader of the house of representatives and one appointed by the minority leader of the house of representatives) to review the systems and related services and supports for youth, including but not limited to the civil commitment and treatment provisions under Iowa Code Chapters 125 and 229, and the juvenile delinquency and child in need of assistance (CINA) provisions under Iowa Code Chapter 232. The primary goal of this review was to "facilitate and enhance the interplay of the multidimensional aspects of the systems, services, and supports for youth and the work of the relevant stakeholders to ensure accessible and effectual processes, procedures, protections, and services for affected youth." This review was to be reported to the Governor and General Assembly by October 1, 2025.

Approach

This interdisciplinary review of Iowa's complex and multifaceted system of youth-based services and supports was approached through a civic or system "mapping" exercise using the Sequential Intercept Model (SIM). The SIM illustrates how individuals with behavioral health conditions like mental illness and substance abuse contact and transit through the criminal justice system. By using a diverse group of stakeholders to map available services and supports across the SIM's six intercepts, states and local providers can identify resources and gaps at each intercept and develop strategic action plans to guide improvements.

This review team met on two occasions to complete this mapping exercise. The first was on August 27, 2025, and focused primarily on Iowa Code Chapter 125 and the substance use system, services, and supports for youth. The second was on September 18, 2025, and focused primarily on Iowa Code Chapters 229 (psychiatric civil commitment) and 232 (Child in Need of Assistance, CINA), and finalizing the review.

By mapping Iowa Code Chapters 125, 229, and 232, including related considerations, across each of these six intercepts, this interdisciplinary review was designed to:

1. Develop a comprehensive picture of how youth in Iowa with behavioral health needs flow across the behavioral health and juvenile justice systems to receive needed mental health and substance use services and supports.
2. Identify gaps, opportunities, and needs at each intercept for how youth and families can increase access, quality, and positive outcomes from needed services and supports.
3. Establish priorities for how Iowa can improve their behavioral health system for youth, including those with various legal and system involvement.

Participants

The following representatives participated in this review by attending at least one of the two "mapping" exercises conducted on August 27, 2025, and September 18, 2025.

Representative Body	Participant Name	Participant Title
Iowa Senate	Mike Klimesh	Senator
Iowa Senate	Janet Peterson	Senator
Iowa House of Representatives	Ann Meyer	Representative
Iowa House of Representatives	Josh Turek	Representative
Iowa Senate	Dylan Keller	Senate Republican Caucus Staff
Iowa Senate	Witt Harberts	Senate Democrat Caucus Staff
Iowa House of Representatives	Natalie Ginty	House Republican Caucus Staff
Iowa House of Representatives	Kelsey Thein	House Democrat Caucus Staff
Iowa HHS	Sarah Reisetter, JD	HHS Deputy Director (Mapping Facilitator)
Iowa HHS	Derek Hess JD, PhD	HHS Clinical Director
Iowa HHS	Theresa Clemmons, DO, FAPA	HHS Psychiatry Director
Iowa HHS	Katie Madson, JD	HHS Legal Counsel
Iowa HHS	Patricia Funaro, JD	HHS Legal Counsel

Iowa HHS	Cory Turner	Director, State-Operated Specialty Care; Superintendent of Cherokee MHI
Iowa HHS	Marissa Eyanson	Director, Behavioral Health
Iowa HHS	Janee Harvey	Director, Family Well-Being and Protection
Iowa HHS	Jennifer Robertson-Hill, LMHC	Bureau Chief, Division of Behavioral Health
Iowa HHS	Cade Iverson	Superintendent of Independence MHI
Iowa HHS	Michael Kauffman, LMHC	Behavioral Health Professional, Independence MHI
Courts and Practitioners in Civil Commitment and Juvenile Justice Proceedings	Chad Jensen	Director, Juvenile Court Services
Courts and Practitioners in Civil Commitment and Juvenile Justice Proceedings	Kathy Thompson	Director, Children's Justice, Iowa Judicial Branch
Courts and Practitioners in Civil Commitment and Juvenile Justice Proceedings	Richelle Mahaffey	District Associate Judge – District 8A
Courts and Practitioners in Civil Commitment and Juvenile Justice Proceedings	Jeff Wright, JD	State Public Defender
Courts and Practitioners in Civil Commitment and Juvenile Justice Proceedings	Rachel Antonuccio	Waterloo Juvenile Public Defender
Law Enforcement and Corrections	Tom Peterson	Dallas County Deputy Sheriff
Service Provider	Jennifer Pullen	Executive Director, UnityPoint Health (Berryhill Center)
Service Provider	Tami Soper	Youth Care Policy Advocate, Boys Town
Persons/Family with Lived Experience	Leslie Carpenter	Parent with Lived Experience at Iowa Mental Health Advocacy

Iowa Code Chapter 125: Substance Use Disorders

Intercept 1: Community/Prevention

This stage focuses on the role of schools and community-based services in identifying youth at risk for substance use issues before they encounter the treatment or justice systems.

Current Process

Youth often first exhibit warning signs at school or within family settings. Ideally, this is the stage where screening, prevention programming, and connection to supportive services should occur.

Gaps Identified

- Dual diagnosis screening is inconsistent and hampered by licensure/certification barriers, which means youth with co-occurring mental health and substance use needs are not identified early.
- Evidence-based prevention programs are scarce, and few are tailored specifically for youth with Substance Use Disorders (SUD).
- Lack of integrated practices between SUD and mental health providers leaves families without cohesive support.
- System-wide coordination with community resources is inconsistent, making navigation difficult for families.

Intercept 2: Initial Contact/Crisis Response

This stage involves the point at which youth come to the attention of law enforcement, Emergency Departments (EDs), or other crisis response systems due to substance use–related issues.

Current Process

Families frequently bring youth in crisis to emergency departments, where staff may be reluctant to diagnose SUD due to reimbursement issues. Law enforcement may also become involved, especially when substance use contributes to criminal behavior or acute psychiatric symptoms.

Gaps Identified

- No dedicated youth-specific crisis response for SUD exists, leaving EDs and Juvenile Court Services (JCS) to fill the void with inconsistent approaches.

- Payment structures discourage EDs from diagnosing SUD, resulting in under-identification.
- Prescribers rarely follow up to ensure that post-ED treatment needs are met, leaving families unsupported.

Intercept 3: Initial Court Involvement

This stage covers the start of the Chapter 125 process including referral to the juvenile justice system and pre-application review for SUD treatment under Chapter 125.

Current Process

Law enforcement or juvenile court services may initiate referrals. The pre-application review process under section 125.75 is designed to assess the appropriateness of formal proceedings.

Gaps Identified

- Evaluations typically involve only the youth, with little or no input from collateral contacts such as schools, law enforcement, or families.
- Legislative models in other states require broader collateral input; Iowa lacks this safeguard.
- Information sharing is inconsistent for all involved, creating incomplete assessments.
- Bed shortages and system bottlenecks result in recommendations being altered to fit available resources rather than clinical need.
- Pre-application review is underutilized, meaning opportunities to divert youth early in the process are missed.

Intercept 4: Court and Commitment Hearings

At this stage, the court adjudicates whether youth meet the criteria for SUD commitment and determines the level of care.

Current Process

Youth may be held pre-adjudication for evaluations, often initiated by petitions from law enforcement, family members, or emergency department physicians. Judges rely on evaluations sometimes conducted via telehealth in rural areas to make determinations about inpatient vs. outpatient treatment.

Gaps Identified

- Telehealth evaluators often do not appear at hearings, reducing the quality of judicial decision-making.

- Physicians (MDs/DOs) conduct evaluations instead of SUD specialists, which can skew recommendations toward psychiatric care rather than SUD treatment.
- Comprehensive, evidence-based assessments are often not performed due to time and resource constraints.
- Bed shortages cause clinicians to alter recommendations, undermining fidelity to clinical standards.
- During this part of the discussion Rep. Meyer highlighted HF313 from the 91st General Assembly.

Intercept 5: Placement and Treatment

This stage encompasses residential SUD treatment, state hospital placements, and community-based treatment settings.

Current Process

Following a court order, facilities provide progress reports to the judge every 15–30 days. Youth may request hearings to review their treatment status.

Gaps Identified

Youth are sometimes ordered into treatment without accurate diagnoses, leading to denial of insurance coverage.
Facilities may refuse admissions due to reimbursement concerns or safety issues.
Licensure/certification barriers for dual diagnoses continue to limit treatment availability.
Bed identification is ad hoc, with no centralized database or coordination mechanism.
There is no designated case manager or system navigator to help families coordinate care.

***Commitment ends between Intercepts 5 and 6.**

Intercept 6: Re-entry and Aftercare

This stage focuses on reintegration following treatment or commitment, including return to school, family, probation, or outpatient supports.

Current Process

Youth are discharged back into their communities, ideally with coordinated aftercare services. Civil commitment can extend into outpatient treatment programs, but coordination varies widely.

Gaps Identified

- Outpatient commitment programs require extensive coordination, but responsibilities are often unclear.
- Relapse is frequently treated as treatment failure rather than a recognized part of recovery.
- During this part of the discussion Rep. Meyer highlighted HF385 from the 91st General Assembly.

Iowa Code Chapter 229: Hospitalization of Persons with Mental Illness

Intercept 1: Community/Prevention

This stage focuses on the role of schools and community-based services in identifying youth at risk for mental health issues before they encounter the treatment or justice systems.

Current Process

- Youth often first exhibit warning signs of mental illness or serious emotional disturbance within family and/or school settings.
- Families and supports often seek additional or different community resources to meet their youth's needs without requiring psychiatric hospitalization (e.g., school-based counseling, outpatient psychotherapy, primary care or psychiatric care for medication).

Gaps Identified

- Overall lack of awareness or appreciation for youth development and rates of behavioral health conditions in society at large, including high rates of anxiety and depression among today's youth, which may limit early identification of needs.
- Overall lack of awareness in families and schools for how to access preventative and early intervention resources to avoid psychiatric hospitalization, that psychiatric hospitalization exists, and how to start the psychiatric hospitalization process when needed.
- Logistical and emotional supports for families to access school-based and outpatient services to avoid psychiatric hospitalization.
- Pediatric expertise seems lacking at various levels of behavioral health care like primary care and family medicine, psychiatry, psychology, mental health counseling, social work, and Advance Practice Providers. Limitations are greater for youth with complex or otherwise specialized needs.

- Trauma recognition and appreciation amongst providers seems lacking, particularly in youth with complex presentations and those in the foster care and juvenile justice systems.
- Clear pathways (easy to find and navigate) and system navigation (intervention to help navigate) improvements needed overall like those found within Iowa's new Behavioral Health System.

Intercept 2: Initial Contact/Crisis Response

This stage involves the point at which youth come to the attention of law enforcement, emergency departments (EDs), or other crisis response systems due to acute or otherwise significant mental health needs.

Current Process

- Mental health crises often first occur in the community like in school or at home.
- Mobile crisis exists in all 99 counties in Iowa, but awareness is not consistent across the state.
- Youth in crisis often go to their local emergency department (ED) for an evaluation to determine if they require psychiatric hospitalization.
- The ED recommends psychiatric hospitalization if needed.
- The ED searches for an available psychiatric bed across the state while the youth/family wait in the ED.

Gaps Identified

- There is an awareness gap in how available mobile crisis is across the state. It currently exists in all 99 counties, but families, providers, and/or legal professionals do not have consistent awareness or knowledge of how to access.
- Need more youth crisis centers, beyond mobile crisis, to allow safe places for youth to remain while awaiting a psychiatric hospital bed.
- Eligibility requirements for crisis beds are a barrier for youth.
- The "pre-application" process in Chapter 229 appears ill-timed and under-utilized (similar to Chapter 125). District court is the responsible entity but may not be the best system stakeholder to handle these duties.

Intercept 3: Initial Court Involvement

This stage covers the pre-application review for psychiatric care under Chapter 229 and the referral process into the juvenile justice system.

Current Process

- Psychiatric hospitalizations under Chapter 229 can occur at a state-operated hospital like Mental Health Institute (MHI) or private psychiatric hospital in the community.
- Voluntary admissions of youth under Chapter 229 require a parent/guardian/custodian written application/consent and approval by hospital's clinical director. If the youth or parent objects, juvenile court must order if it's determined in the least restrictive treatment environment. Admission is subject to the capacity and ability of the hospital to serve the patient.
- Involuntary admissions under Chapter 229 occur if the youth has a serious mental impairment which includes being a danger to self or others amongst other considerations.
- Since HHS State-Operated Specialty Care Specialization in 2023 (i.e., FY24 and FY25), Independence MHI has seen significantly more "voluntary" admissions for youth than "involuntary" admissions for youth (272 voluntary admissions vs. 183 involuntary admissions).

Gaps Identified

- There are no youth-based Mental Health Courts in Iowa, only Drug Courts.
- Bed and insurance (reimbursement) limitations and practice habits often lead providers to over-simplify the standard of whether a youth meets psychiatric commitment criteria by focusing solely on their "dangerousness" and often attributing "serious" and "imminent" to that determination despite that language not existing in Chapter 229.
- There appears to be a disconnect between clinicians and judges/magistrates regarding the actual legal understanding of commitment procedures under Chapter 229 criteria, with over-reliance on danger to self or others and not utilizing other pieces of that code section to hospitalize based on harms or "dangerous" things but not necessarily harm to self or others.
- There is a fundamental difference between adult and youth needs under Chapter 229 and that is not considered in current code language.
- During this part of the discussion Rep. Meyer highlighted HF313 from the 91st General Assembly.

Intercept 4: Court and Commitment Hearings

At this stage, the court adjudicates whether youth meet the criteria for psychiatric commitment and determines the level of care needed – inpatient psychiatric hospitalization vs. outpatient psychiatric commitment.

Current Process

- The court orders involuntary treatment to a level of care (not a specific hospital or outpatient provider) and the current provider (e.g., emergency room) locates a provider that can meet the youth's needs.
- The program the youth is committed to (hospital or outpatient provider) provides the court regular updates to monitor their progress. If inpatient, they provide updates every 15 days and 30 days thereafter until discharged. If outpatient, they provide updates every 30 days and every 90 days thereafter until discharged.
- Care and treatment at psychiatric hospitals is typically short-term and acute. State-operated psychiatric hospitals and private community hospitals have the same commitment standards and length of stay considerations. Independence MHI provides the longest potential length of stay as the most "safety net" psychiatric hospital but remains a "short-term" and "acute" hospital.
- In practice, involuntary commitment is largely determined based on the "dangerous" to self or others and does not typically consider the "other" considerations discussed above.

Gaps Identified

- Providers for outpatient commitment often drop commitments and periodic progress reports when youth patients do not show for scheduled appointments, leaving the court without a mechanism to mandate treatment adherence.
- Providers do not always provide periodic reports/updates as required by Code and judges have no way of knowing if these are not submitted given lack of centralized tracking resources and practices.
- Mental health advocate participation varies across counties with wide variability on participation and effectiveness.
- Outpatient Chapter 229 commitments require identified community provider(s) and a coordinated court docket, which may limit its usefulness by some judges/magistrates.

Intercept 5: Placement and Treatment

This stage encompasses inpatient psychiatric treatment at hospitals like Independence Mental Health Institute (MHI) and court-ordered (involuntary) outpatient treatment in community-based settings.

Current Process

- The same commitment criteria and length of stay considerations exist for psychiatric hospitals regardless of whether they are state-operated or private community-based.
- Independence MHI (IMHI) has 36beds for youth across two wards (units). They serve youth ages 7-18 years on section 229.2 (voluntary) and section

229.13/229.14A (involuntary). Since FY24, and through specialization, IMHI has increased the number of youths served by over 300%.
- Courts change their recommended level of care based on availability rather than need when psychiatric hospitalization beds are unavailable to get the youth "something" in terms of care.
- Lack of follow-up or coordination between inpatient psychiatric hospital and outpatient provider(s).

Gaps Identified

- Iowa appears to have enough psychiatric hospital beds for youth but does not have the correct allocation of "specialized" beds that can meet the complex and unique needs of Iowa's youth.
- Psychiatric hospitals are not required to accept youth court-ordered to their level of care as admission is based on bed availability and the hospital's ability to meet their unique needs.
- Insurance coverage is significantly limited by the Institutes of Mental Disease (IMD) Exclusion, which limits psychiatric hospitals with more than 16 beds from being reimbursed federal money for longer term stays.
- Family-based treatment and supports, especially skills for families to manage youth more effectively.
- Bed tracking does not exist for PMICs (only shelter and Qualified Residential Treatment Programs (QRTP)).
- Lack of intensive outpatient programs across the state.
- Whether judges can order youth into crisis stabilization beds is unclear and may vary across jurisdictions.
- Iowa does not have Psychiatric Intensive Care (PIC) for youth (adult only), which may allow psychiatric hospitals to accept more complex or challenging cases given increased reimbursement for services provided.
- No centralized "air traffic control" type entity that can guide youth and families across the continuum of care to access needed services and supports.
- No general "assessment" or centralized intake type of placement to ensure the youth's needs are accurate and they get to the correct level of care at the time needed.
- Long distance between psychiatric hospital and home limits family's engagement with youth during hospitalization.

***Inpatient commitment ends between Intercepts 5 and 6. Outpatient commitment occurs in the community such that coordination and provision of services occur in school, family, probation, and outpatient settings.**

Intercept 6: Re-entry and Aftercare

This stage focuses on reintegration following treatment or commitment, including return to school, family, probation, and/or outpatient supports. This does not include active outpatient commitment even though that occurs in the community.

Current Process

- Court is only involved in changing Chapter 229 commitments from inpatient to outpatient if involuntary orders are required. If not required, the youth is discharged from their inpatient commitment and free to engage in outpatient services without a court-mandate.
- Hospitals are minimally required to notify the court. Overall, transition and discharge-related work is based on individual hospital resources and procedures.

Gaps Identified

- Gaps in time between the psychiatric hospitalization and outpatient appointment in the community can lead to decompensation and cycling in/out of the justice system.
- Community-based services are generally lacking for youth, especially youth with specialized or complex needs, especially in certain jurisdictions.
- Even if outpatient Chapter 229 commitment is ordered, there are significant limitations in its effectiveness like the court does not track these centrally to determine if the provider does not submit timely progress reports or if a new provider is obtained.
- There are payment gaps for targeted care coordination and transfer of care situations, especially from inpatient hospitalization to the community.
- Psychiatric hospitals lack standardization on the discharge and coordination efforts they provide for patients in preparation for and upon discharge.
- Family information and education received upon discharge varies.
- Youth-based recovery and peer-support services are generally lacking.

Iowa Code Chapter 232: Juvenile Justice & Child in Need of Assistance (CINA)

*Iowa Code Chapter 232 covers juvenile court issues like delinquency, as well as child welfare considerations like Child in Need of Assistance (CINA).

Intercept 1: Community/Prevention

This stage focuses on the role of schools and community-based services in identifying youth at risk for abuse or neglect issues before they encounter the treatment or justice systems.

Current Process

- Delinquency is mitigated by school districts and communities having pro-social structured after school, break, and summer.
- Families may pursue the CINA process to access out of home placements and/or specialized services for their child that currently only exist at shelters and QRTPs.

Gaps Identified

- Absence of primary and secondary prevention (early intervention) services leads youth and families to get engaged in the CINA (HHS) system to access needed services given shelter and QRTP providers have a “no eject, no reject” policy that significantly limits their ability to deny referrals.
- Youth with specialized or complex needs (I/DD, PSB, fire setting) are at increased risk of being unable to obtain needed placement or services.
- Direct care and clinical providers appear to lack sufficient trauma informed or trauma responsive expertise that this population experiences at disproportionate rates.

Intercept 2: Initial Contact/Crisis Response

This stage involves the point at which youth come to the attention of law enforcement, emergency departments (EDs), or other crisis response systems due to abuse and neglect issues or parents’ inability to meet their child’s behavioral health needs.

Current Process

- Families seek crisis response services.
- Psychiatric Medical Institutes for Children (PMIC) do not have a “no eject, no reject” policy like shelter and QRTP.

Gaps Identified

- The current system, including lack of accessible and appropriate services for youth with complex presentations and needs, encourages parents to CINA their children in an attempt to access out of home placement or other specialized services for their unique needs. Families think they are accessing services they cannot get elsewhere like those outside the juvenile justice (JCS) or child welfare systems (HHS). The additional services and supports are not necessarily unique and may not meet their child’s needs.

- Treatment access, especially for highly traumatized and other specialized needs doesn't sufficiently exist across the state, particularly in more rural areas.

Intercept 3: Initial Court Involvement

This stage covers the referral process into the HHS child welfare and foster care system.

Current Process

- In non-abuse or neglect situations, CINA petitions are typically pursued after numerous failed attempts at effective treatment interventions, including civil commitment per Chapter 229. For example, inpatient hospitals may say that the youth is too "behavioral" for their setting to admit or continue to treat. They may also be declined admission to other programs like PMIC and QRTP because of this "behavior."
- §232.49 – Juvenile Court Pending Delinquency – court ordered psychological evaluation as part of on-going delinquency case. Commitment for examination must not exceed 30 days, and civil commitment provisions of Chapter 229 do not apply. An examination requires agreement of parent/guardian and youth's attorney if ordered prior to adjudication.
- §232.98 – CINA Petition – A court may order a psychological evaluation as part on CINA case if (1) probable cause exists that child is in need of assistance pursuant to §232.96A, subsection 5 or 6; (2) commitment is necessary to determine whether there is clear and convincing evidence that the youth is in need of assistance; and (3) youth's attorney agrees to the commitment. Commitment must not exceed 15 days if ordered before or during CINA adjudication or 30 days if ordered after CINA adjudication. Provisions of Chapter 229 do not apply.

Gaps Identified

- Out of home residential placement options for youth that are beyond PMIC, psychiatric hospitalization, and juvenile detention so youth and families are not forced to enter one of these systems to access needed behavioral health care.
- Regulatory reform to improve Iowa HHS's ability to oversee and manage PMIC-type settings.
- Centralized assessment or intake space beyond §232.49 and §232.98 to allow youth and families opportunity to receive comprehensive behavioral health assessments in less restrictive settings and outside of adjudicative systems like child welfare/foster care (HHS) and juvenile justice (JCS).

Intercept 4: Court and Commitment Hearings

At this stage, the court adjudicates whether youth meet the Child in Need of Assistance (CINA) or Delinquency criteria and determines the level of care and placement needs.

Current Process

- This is the stage that formally decides on CINA and Delinquency. Hearings are held, evidence is reviewed, and judicial decisions are made.
- §232.52 – Delinquency Disposition – court ordered psychological evaluation following delinquency disposition. Youth must meet Chapter 229 criteria.

Gaps Identified

- Residential out of home placements and other specialized services that youth and families can access without needing to be adjudicated CINA or delinquent.

Intercept 5: Placement and Treatment

This stage encompasses residential out of home placement or foster care/adoption.

Current Process

- Current out of home placement options accessible through a CINA or Delinquency adjudication include shelter, QRTP, and foster care. Specialized services within these settings include treatment for problematic sexual behavior and neurodevelopmental conditions.
- Shelter or QRTP placement may be pursued as the youth awaits a more appropriate level of care at a PMIC.

Gaps Identified

- Therapeutic foster homes are currently piloted in the Cedar Rapids Service Area only.
- Residential out of home placements and other specialized services that youth and families can access without needing to be adjudicated CINA or delinquent.
- Although these out of home placements provide treatment, they are not treatment settings. The type and quality of treatment and supportive services vary across provider and location in Iowa.

Intercept 6: Re-entry and Aftercare

This stage focuses on reintegration following treatment or commitment, including return to school, family, probation, or outpatient supports.

Current Process

- The permanency plan for youth is often to have them adopted, under guardianship, or in an independent living situation when they turn age 18.

- Adoptive families and public guardianship are both significantly limited for transitional aged youth (transitioning into adulthood).
- Hearings are held to follow-up on placements and needs.

Gaps Identified

- A behavioral health treatment and level of care continuum for youth and families that is accessible without needing to enter the juvenile justice (delinquency) or child welfare (CINA) systems.
- Specialized services and placement options for transitional aged youth like those up to age 26 years when the decision making and emotional functioning parts of their brain are more fully developed.
- Peer support and recovery services for youth and families.

Consensus Findings & Recommendations of the Review Panel

1. The Review Panel identified the need for Iowa to develop a full continuum of behavioral health care, including adequate residential placement, for youth and families that does not require them to enter the CINA (HHS) or Delinquency (JCS) systems to access such care. This process could include changes to Iowa Code Chapters 125, 229, and 232. These laws were not developed with youth and families in mind and are not effective in addressing the complex needs faced today.

2. The Review Panel identified the need for Iowa to improve the competencies of youth and family professionals of various disciplines and levels of expertise and expand access to high-quality behavioral health care, services, and supports. This work includes providers who work with community, delinquency, and child welfare systems. Enhanced competencies are particularly needed for specialized populations like youth with complex trauma, intellectual or developmental disabilities, problematic sexual behavior, violence, and elopement. This work may include value-based contracting and other ways to incentive and reward the use of evidence-based protocols and reinforce successful outcomes.

3. The Review Panel highlighted a need for any legal and systemic reforms to consider not just youth under the age of 18 years, but also those between the ages of 18-26 years. These “transition aged youth” have unique needs that do not fit well within Iowa Code Chapters 125, 229, and 232.

4. Relying on data driven decision making when discussing any future changes to the system is essential. Data points that may help inform future decision making include but are limited to the number of commitment denials by judges and magistrates and the amount of voluntary vs. involuntary commitments within the system.