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MENTAL HEALTH AND JUVENILE INSTITUTIONS STUDY COMMITTEE

SUBCOMMITTEE ON COMMITMENT LAWS

Report to the Legislative Council
and the Members of the
First Session of the Sixty-sixth General Assembly

State of Iowa
1975

FINAL REPORT

OF THE MENTAL HEALTH AND JUVENILE INSTITUTIONS STUDY COMMITTEE

submitted by its

SUBCOMMITTEE ON COMMITMENT LAWS

This supplementary report consists primarily of the text of Mental Health and Juvenile Institutions Study Committee Draft Bill No. 6, fourth version, "A Bill for An Act relating to hospitalization of the mentally ill," with a number of interspersed explanatory comments. Because this format makes the draft bill somewhat bulky, and because there is interest in this bill on the part of many persons less intensely interested in other bills recommended by the Study Committee, the draft bill and three pertinent appendices are here presented with brief introductory comments separately from the main report of the Study Committee.

The Mental Health and Juvenile Institutions Study Committee's concern about Iowa's commitment laws began in 1971, the year the Study Committee was first established. In 1973, the Study Committee established the Subcommittee on Commitment Laws composed of Senator John Murray, Chairman, Representative Scott Newhard and Mr. Keith Oswald, an advisory member of the Study Committee. The Subcommittee was aware that a Joint Subcommittee of the Iowa Medical Society and the Iowa State Bar Association had been working for some time on possible revisions in the state's mental health commitment statutes. The present members of this interprofessional Joint Subcommittee are Doctors S. M. Korson of Independence, Herbert L. Nelson of Iowa City and Richard E. Preston of Des Moines, and Attorneys Randall Bezanson of Iowa City, Lee Blum of Hampton, J. Eric Heintz of Iowa City and Thomas J. Wilkinson, Jr. of Cedar Rapids.

Dr. Korson and Mr. Wilkinson attended the legislative Subcommittee's first meeting on September 6, 1973, at which time it was agreed that the Joint Subcommittee would make the product of its efforts up to that time available to the legislative Subcommittee as a starting point for the latter group in preparation of a proposed new mental health commitment statute to be reported to the full Study Committee. The legislative Subcommittee has continued to maintain liaison with the Joint Subcommittee, has made a number of changes in the text of the draft bill in response to suggestions by the Joint Subcommittee, and is most appreciative of the assistance and suggestions which have thus been made available. However, it should be understood by all concerned that the legislative Subcommittee has final responsibility for the content of the fourth version of Draft Bill No. 6, which is not necessarily satisfactory in all respects to all members of the Joint Subcommittee.

F I N A L R E P O R T

MENTAL HEALTH AND JUVENILE INSTITUTIONS STUDY COMMITTEE

December, 1974

INTRODUCTION

Major areas of effort for the Mental Health and Juvenile Institutions Study Committee during the 1974 legislative interim have been:

1. Preparation of a proposed new mental health commitment statute for Iowa.

2. The possible removal of all liens imposed for charges resulting from care and treatment at certain institutions or facilities.

3. The Department of Social Services institutional plan and viable alternatives to the recommendations contained therein with particular reference to the future utilization of the Clarinda Mental Health Institute.

4. Plans and arrangements for the conduct of a comprehensive mental health study.

The Study Committee in this report submits to the General Assembly recommendations regarding the first three of the foregoing subjects, and a progress report on the fourth. In addition, a recommendation concerning the manner of allocating state funds used to help pay the costs of mental health services, submitted by the Study Committee in the past, is reaffirmed.

On December 19, 1973, the Legislative Council approved a request by the Mental Health and Juvenile Institutions Study Committee to continue that Study Committee through the 1974 interim. This continuation was requested in order to implement the Study Committee's recommendation regarding the conduct of a comprehensive mental health study pursuant to H.F. 784 (1973) which appropriated $50,000 for that purpose.

Also continued by the Council's action were the Study Committee's mandates in other areas of endeavor in which it was involved. In addition, following adjournment of the 1974 session of the General Assembly, the Council assigned the Study Committee HCR 128, requesting a study of the feasibility of implementing the Department of Social Services' "institutional plan" (a series of reports and recommendations mandated by clauses in the 1973 appropriations measures for the Department).

Representative Edgar H. Holden, Chairman of the Study Committee since its inception in 1971, has continued in that

position during the past year, with Senator Charles P. Miller retaining the position of Vice Chairman. Representatives Joan Lipsky, Jerry Fitzgerald and Scott Newhard and Senators Calvin Hultman and John Murray continued as members. On June 12, 1974, the Legislative Council approved a recommendation from the Studies Committee that two additional legislators be added to the Study Committee. Senator C. Joseph Coleman and Representative Elmer H. Den Herder were subsequently appointed. Advisory members continuing on the Study Committee included Mrs. Sally Frudden of Charles City (Iowa Association for Retarded Citizens), Mrs. Louise Goldman of Davenport (Community Mental Health Centers Association of Iowa), Mr. Nicholas Grunzweig of Des Moines (Director, Division of Mental Health Resources, Department of Social Services), Dr. Herbert Nelson of Iowa City (Director, Iowa Mental Health Authority), and Mr. Keith Oswald of Des Moines (Executive Director, Polk County Mental Health Planning Commission). Dr. Richard C. Preston of Des Moines, who succeeded Dr. Hormoz Rassekh of Council Bluffs as President of the Iowa Psychiatric Society, also replaced Dr. Rassekh as an advisory member of the Study Committee. Mr. Ralph Kauffman, Administrative Assistant to the Senate majority leader, helped staff the Study Committee in addition to Legislative Service Bureau personnel.

I. - Drafting and Review of a Proposed New Mental Health Commitment Law

The Study Committee's Subcommittee on Commitment Laws, formed during the 1973 interim, has during 1974 continued its efforts to develop a new statute governing involuntary hospitalization of the mentally ill in Iowa. The Subcommittee is chaired by Senator Murray, and includes Representative Newhard and Mr. Oswald.

Concern about the adequacy of Iowa's present commitment laws first arose, within the Study Committee, in connection with uncertainty about the legal effect of involuntary hospitalization for reasons of mental illness upon the hospitalized individual's subsequent legal competency, status as a voter, etc. Within the past eighteen months, however, concern has increasingly shifted to the question whether Iowa's current statute would survive a constitutional challenge in the federal courts. Generally similar laws in several other jurisdictions have been found unconstitutional on the ground that they operate to deprive the committed person of liberty without due process of law.

There is much disagreement over how a new Iowa law on involuntary hospitalization for mental illness should be written. Some of the basic questions which have been most troublesome are:

1. What is required as minimum procedural due process in committing a mentally ill person for treatment, and what procedural safeguards, if any, should be incorporated beyond those which are constitutionally required?

2. How can these procedural requirements be balanced with society's interest in seeing that persons who are mentally ill, and who are unable or unwilling to realize their need for treatment, do receive treatment expeditiously and effectively?

3. Under what circumstances, if ever, may a person whose behavior is very distressing to his family or to the community, but who evidences no threat of physical harm to himself or others, be involuntarily hospitalized?

Work on Mental Health and Juvenile Institutions Study Committee Draft Bill No. 6 (the designation of the proposed new involuntary hospitalization law) continued through the early months of the 1974 legislative session, as rapidly as other demands on staff time would permit. A hearing on the second version of the Draft Bill occurred March 14 under the sponsorship of the Senate Human Resources Committee.

In succeeding months, the Subcommittee revised the Draft Bill on the basis of comments received at the March 14 hearing. The legislative Subcommittee has also sought to maintain liaison with a Joint Subcommittee of the Iowa Medical Society and the Iowa State Bar Association which is concerned with this matter, although not all of the members of this interprofessional Joint Subcommittee necessarily support or accept all provisions of the legislative Subcommittee's draft bill.

A third version of Draft Bill No. 6 was completed and distributed in early October, and a public hearing was held on it by the legislative Subcommittee on October 25 in Des Moines. In addition, members of both the legislative Subcommittee and the interprofessional Joint Subcommittee participated in panel discussions of the draft bill at sessions arranged by the Iowa District Court Clerks Association and the Iowa Psychiatric Society, and copies of the third version were distributed widely to a large number of interested parties throughout the state.

The final meetings of the legislative Subcommittee were held December 3 and December 12, to consider comments and suggestions which had been received since release of the third version of Draft Bill No. 6 for public review. Pursuant to actions taken at those two meetings, a fourth version of Draft Bill No. 6 has been prepared, and is reported to the 66th General Assembly by the Study Committee for its consideration. The Draft Bill is designated "fourth version" rather than final version because the necessary conforming amendments have not yet been completed, and because it is recognized that the bill remains controversial and that the standing committees to which the bill will presumably be referred will wish to give further consideration to some of the major policy questions involved. Nevertheless, Draft Bill No. 4 represents the Subcommittee's judgment as to the policies the state should adopt in this area of law, and the full Study Committee on

November 20 authorized the Subcommittee to submit the draft bill to the General Assembly on that basis.

The third version of Draft Bill No. 6 was prepared with a number of explanatory comments interspersed through the text of the bill. These comments, with appropriate modifications, have been retained in the fourth version. Because this format makes the draft bill somewhat bulky, and because there is interest in this particular bill on the part of many persons who are less intensely interested in other recommendations of the Study Committee, Draft Bill No. 4 is not attached to this report, but is separately prepared as a supplementary report. This report includes, in lieu of the text of the draft bill, a comparison of its provisions with those of present Iowa law governing commitment for treatment of mental illness. The comparison, written by Mr. Kauffman, is labeled Appendix I.

Role of the District Court

One of the questions raised by court decisions in other jurisdictions regarding commitment of mentally ill persons for treatment is whether involuntary hospitalization (viewed as a deprivation of liberty) can constitutionally be done by any agency except a court. Concern about this question led the interprofessional Joint Subcommittee, in its early efforts, and subsequently the legislative Subcommittee to draw Draft Bill No. 6 on the basis of direct handling of commitment proceedings by judges of the district court rather than by the three-member hospitalization commissions which now exist in each county.

Initial reaction to this type of procedure, particularly by county district court clerks, was that it is essentially unworkable because in many smaller counties there is insufficient access to a district court judge to allow prompt handling of hospitalization proceedings. Therefore, the subcommittee placed in the third version of Draft Bill No. 6 a section which:

- Authorizes the judges in each judicial district to jointly establish, as an arm of the court, a judicial hospitalization commission to perform most of the functions of the district court in hospitalization matters in any county where the judges consider it advisable to exercise this option.

- Makes the judicial hospitalization commission generally similar in makeup to the existing county commissions of hospitalization, except that the clerk of court would provide staff assistance rather than serving as a member of the commission and the third commission member would be a knowledgeable layman.

- Requires the judicial hospitalization commission to follow all substantive procedures specified in the bill

for the courts, makes the commission's actions subject to appeal to the district courts, and allows only district court judges to issue orders for immediate custody of a respondent pending a hospitalization hearing.

The Joint Subcommittee, on reviewing the third version of Draft Bill No. 6, expressed the view that the use of a judicial hospitalization commission would be unconstitutional. The County Officers Coordinating Committee informed the legislative Subcommittee that, in its view, if the present Iowa commission of hospitalization procedure is unconstitutional then the judicial hospitalization commission would be equally so.*

While the legislative Subcommittee's members do not necessarily agree with the views so expressed, they have decided, after reviewing these objections, to remove the judicial hospitalization commission option from the fourth version of Draft Bill No. 6. However, it appears as an appendix to the supplementary report which includes the text of the draft bill.

II. - Abolition of Liens for Cost of Services at Certain Institutions and Facilities

At the July 18 meeting of the Study Committee, a representative of the Iowa Association for Retarded Citizens voiced concern about the practices followed by county auditors in recording claims for the cost of care of mentally retarded individuals at the state hospital-schools. Although the relevant provisions of Chapter 222 of the Code were changed several years ago so that these claims no longer legally constitute a lien against property, the IARC reported that the claims continue to be listed in such a manner that they are construed by abstractors as liens, and are therefore a barrier to conveying clear title to affected real estate. At Chairman Holden's request, Mr. Kauffman made a study of the matter.

Mr. Kauffman subsequently reported that:

-The problems complained of by the IARC come about because of the practice of county auditors. It appears that at least some auditors list these charges in a book designated as a "Lien Book", although this procedure is not uniform over the state. The practice of abstactors is to show on an abstract of title anything designated as a lien, as a matter of self-protection. They are not expected to sort out what is and is not a valid lien against real estate, but rather to show what is designated by the various officials as liens. The title examiner then determines whether in fact a lien exists and makes whatever requirements he feels necessary to clear the title. Abstractors are confused and as a matter of protection tend to report everything in order to be sure that nothing has been missed, since an

abstractor missing any charges which should have been included might be held personally liable for any damage occurring because of the omission.

-The Code distinguishes between the mentally ill, the mentally retarded, the alcoholic, the care of juveniles, the drug dependent and all indigents served by Psychopathic Hospital in stipulating the type of debt or lien to be used by counties in assessing financial responsibility for services rendered to these persons. (It is generally the responsibility of the county to reimburse the state for the service received, and the county in many cases has authority to collect from the person who received the services, or his or her responsible relatives, if they are able to pay.)

It is the consensus of the Study Committee that all such automatic liens should be removed. Accordingly the Study Committee recommends to the 66th General Assembly the enactment of Study Committee Draft Bill No. 7. The draft bill is designed to accomplish several things:

1. It repeals the lien on property of mentally ill persons or those legally responsible for payment of charges for their care and support.

2. It abolishes existing liens. Recognizing, however, that some liens currently on the books are collectible, counties are given until January 1, 1976 to initiate any action to enforce existing liens.

3. The draft legislation provides that at such time as services or treatment are received, the board of supervisors from the county in which the recipient resides shall enter a determinination of the ability of the recipient, or those persons responsible for his support, to pay any charges for services rendered.

4. An individual or his or her responsible relative become financially liable to the county only for that portion of the cost of services rendered for which they are deemed able to pay. If unpaid, a judgment may be obtained to enforce this liability.

5. Auditors are required to keep accurate records of the accounts of all institutionalized persons in a book designated as an account book or index, and which includes no reference in any place to a lien.

6. A change is made in the classification of claims against the estates of mentally ill persons, which the Code continues to list as second class claims, to correspond with the statutory sixth class claims against the estates of mentally retarded persons.

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6. A change is made in the classification of claims against the estates of mentally ill persons, which the Code continues to list as second class claims, to correspond with the statutory sixth class claims against the estates of mentally retarded persons.

7. Sections of the Code which appear inconsistent with the purpose of the legislation are repealed.

A copy of Draft Bill No. 7 appears as Appendix II to this report.

III. - The Institutional Plan and Future Utilization of the Clarinda Mental Health Institute

The Study Committee's last meeting prior to the 1974 legislative session was devoted to consideration of, and hearing objections to, a recommendation by the Department of Social Services in its "institutional plan" that operations at the Clarinda Mental Health Institute be permanently discontinued. The Study Committee's assessment of this proposal at that time is summarized on pages 8-10 of its Report to the Second Session of the 65th General Assembly.

At the Study Committee's January 3, 1974 meeting, concerned citizens from Clarinda and other southwest Iowa communities urged that the institution remain open, proposing what was referred to as a "two-track" system of services at the Clarinda Institute to meet the unique needs of the relatively sparsely populated southwest section of the state. Under this arrangement, at least two levels of services would be established, divided according to the intensity of the treatment program. This proposal was embodied in a draft bill requested by Representative Horace Daggett and Senator James Briles, however the legislation was prepared too late for introduction during the 1974 session of the General Assembly. Subsequently, the Study Committee examined and discussed this bill (hereafter referred to as the Daggett-Briles proposal) during the 1974 interim.

The Daggett-Briles proposal contemplated establishment of two types of services at the Clarinda facility:

1. An intensive care, inpatient hospitalization unit; and,

2. A secondary care, regional service unit providing, among other things, traveling clinics to those counties which are within reasonable proximity of the facility, and are currently without community mental health centers.

The original bill required that those counties receiving services from traveling clinics, which had not established or affiliated with a community mental health center by July 1, 1978, initiate planning with the Clarinda facility to convert the clinics into community centers. After consultation with representatives from the Department of Social Services (who had expressed interest in the proposal since its inception and had agreed to work with the Clarinda delegation in exploring the possibilities of the

arrangement) the concerned citizens who had helped to develop the proposal agreed to change the July 1, 1978 deadline to July 1, 1977, so that it would fall within the next fiscal biennium. This was intended to assist the Department in formulating its budget request for the Clarinda Institute. However, in the fall of 1974 concern was expressed by at least some of the people who had been parties to the original proposal that the tentative budget request by the Department for the Clarinda Institute did not appear to fully reflect the intent of the proposal.

One of the key features of the Daggett-Briles proposal is the establishment of a citizens advisory board to assist in the planning, development and evaluation of services offered by the Clarinda Institute to communities in its service area. While the institute has had an advisory board functioning in recent years, this board has no standing in law. The assignment of a statutory role to such a body would be an innovation in administration of Department of Social Services Institutions, and would in effect move a step toward the pattern of administration which has prevailed in Iowa's locally-funded community mental health centers.

The idea that mental health services needed in southwestern Iowa could in fact be provided by a multi-county mental health center, established under the provisions of House File 1060 of the 65th General Assembly, 1974 Session, has also been considered briefly by the Study Committee.* H.F. 1060 was enacted (pursuant to a 1973 recommendation by this Study Committee) to provide a more explicit legal framework for establishment of community mental health centers, which in Iowa have traditionally grown out of local initiative and efforts. There appears to be quite general agreement among advisory members of the Study Committee that if counties in southwest Iowa do not desire to provide mental health services within the H.F. 1060 framework, it is not feasible for the state to mandate them to do so. This is not to suggest, however, that it is impossible or undesirable to create incentives and otherwise help to stimulate the desire to establish and support community mental health services on the local level.

The Unique Problems of Providing Mental Health Services in Southwest Iowa

It is the consensus of all parties concerned (at least so far as the Study Committee is aware) that the goal of the state should be to assure availability of high quality mental health services in southwest Iowa in the years ahead. Concerned citizens from Clarinda and elsewhere in southwest Iowa who have appeared before the Study Committee have always stated that this goal is their first priority, and that their efforts to keep the Clarinda Institute open reflect the lack of alternative sources of needed mental health services.

In considering how best to achieve the goal of maintaining quality mental health services for southwest Iowans, the Study Committee has recognized several somewhat unique circumstances affecting this area. These circumstances include:

1. The proportion of counties in the Clarinda Institute's catchment area which have not established or affiliated with a community mental health center is much higher than is the case in the catchment areas of the other three Iowa mental health institutes.

2. The relatively sparse populations of most of the counties not now served by a community mental health center, combined with the requirement of H.F. 1060 that any county or group of counties establishing a community mental health center must have at least 35,000 population, means that several counties must be willing to cooperate if a new center is to be established in southwest Iowa.

3. The economic situations of some of the counties not now served by community mental health centers is likely to compound the difficulty of establishing one or more new community mental health centers in the area, at least unless and until some significant change occurs in the way the state now funds mental health services.

It should be added that the lack of coordination between the Department of Social Services' Division of Mental Health Resources and the Iowa Mental Health Authority (to which community mental health centers relate) also appears to have contributed to difficulty in bringing about establishment of one or more new centers in southwest Iowa. This lack of coordination was referred to briefly in the Study Committee's report to the 1974 session of the General Assembly, and was discussed more fully in its report of a year earlier.

As of November 1, 1974, eleven of the twenty-five counties in the Clarinda Institute's catchment area have not joined in establishment of or affiliated with a community mental health center. These eleven counties range in population from Adams and Ringgold with 6,322 and 6,373 respectively to Page (where Clarinda is located) with 18,507, based on the 1970 census. These eleven counties include several which have per capita income levels among the lowest in the state.

Efforts toward establishment of a community mental health center to serve several of these southwest Iowa counties began some months ago when a task force of representatives from Adams, Clarke, Decatur, Ringgold and Union Counties was formed, and the Iowa Mental Health Authority began working with the task force in planning toward establishment of a center. However, the Study Committee was informed that as the time approached when it would be necessary to ask the respective county boards of supervisors for firm budgetary commitments, support from Decatur and Ringgold

Counties was not forthcoming. This not only crippled funding plans, but reduced the population of the area represented by the task force below the 35,000 minimum necessary for establishment of a community mental health center.

Representatives of the Union County Mental Health Steering Committee who attended the Study Committee's October 22 meeting blamed the lack of support by Decatur and Ringgold Counties on the Clarinda Institute's recent initiation of mental health services to these counties by traveling clinics working out of the Institute. Mental Health Authority personnel contend it is unrealistic to expect the counties in question to commit themselves to support local mental health services so long as services are being provided within these counties by extension from the Clarinda Institute. However, the Union County residents present at that meeting reaffirmed Union County's hope that a community mental health center can eventually be established in the area.

The Clarinda Institute's Social Work Supervisor explained at the October 22 meeting that Decatur County was offered the traveling services on a temporary basis because of the county's large volume of mental health problems demanding immediate attention and the present inability of the county to meet these needs in any other way. He stated that Ringgold County requested the temporary services in order to determine if a need exists there for similar services on a permanent basis. He added that Ringgold County also had expressed doubts concerning the extent of the financial investment which would have been necessary if the county joined in establishing a multi-county community mental health center. (The administrator of the Decatur County Hospital subsequently told the Study Committee that in his opinion that county's board of supervisors would not be willing to consider support for a community mental health center to serve the area if the need for its services were not indicated by response to the Clarinda Institute traveling clinic.)

At the October 22 meeting, the Study Committee decided--by a split vote of the members present--to direct the Legislative Service Bureau to prepare a new draft bill which retains the advisory board concept of the Daggett-Briles proposal, but leaves it largely to the Clarinda Institute superintendent (and the state-level administrators to whom he is responsible) to work out with the advisory board exactly how the Institute is to respond to local mental health service needs. In seeking to meet these needs by providing services directly to individuals at points other than the Institute itself, the Clarinda Institute is required by the bill to do so through arrangements with local mental health centers. This bill, designated Draft Bill No. 8, was considered and revised at the Study Committee's final meeting on November 20 and, as so revised, is recommended for enactment by the 66th General Assembly.

The key features of Draft Bill No. 8 are:

1. Establishment of a one-member-per-county advisory board, appointed by and serving at the pleasure of the respective boards of supervisors of counties in the Clarinda Institute's catchment area.

2. Requirements that the advisory board, in addition to promoting coordination of services between the Clarinda Institute and community mental health centers in its area, review the Institute's biennial budget proposal and that the advisory board submit a report and, if appropriate, recommendations each year to the General Assembly.

3. "Extension services" (those provided to individuals off the Clarinda Institute campus) may not be provided after July 1, 1977 except in counties affiliated with community mental health centers, and then only on the basis of a written agreement with the center; also, the bill requires payment of the full cost of such services by the county in which they are provided.

4. Authorization for the Clarinda Institute, with approval of the advisory board and the state director of the Division of Mental Health Resources (of the Department of Social Services), to lease any specified portion of its physical plant to or contract for purchase of its services by community mental health centers or similar agencies in its service area.

A copy of Draft Bill No. 8 appears as Appendix III to this report.

Mental Health Planning by Metropolitan Centers in Clarinda Catchment Area

A final factor to be considered in any planning for the future utilization of the Clarinda Institute is the impact of any move toward increased provision of services within the two metropolitan centers located in the Clarinda Institute's catchment area. These centers are Des Moines and Council Bluffs.

A high proportion of the Clarinda Institute's present patient load comes from Polk County, which has indicated an interest in providing more intensive services at home. By 1977, Polk County anticipates the availability of a 100-bed inpatient county mental health facility. Some decline in the overall proportion of Polk County patients at Clarinda is already being noted. However, Polk County planners acknowledge that continued access to the Clarinda facility will be necessary to accommodate emergencies and overload, and to provide specialized services which the county does not currently envision offering through its facility.

Out of 729 patients admitted to Clarinda between July 1, 1973 and August 31, 1974, 232 came from Polk County. While there probably will not be a 1-1 ratio between the availablity of beds in the new Polk County facility and the removal of patients from Clarinda, the effects of such developments in Polk County should be considered in any plans for the long-range future of the Clarinda facility.

The Study Committee has no indication of comparable planning in the Council Bluffs-Pottawattamie County area. However, it is understood that physical facilities which could provide a significant inpatient capacity are already available in Council Bluffs, and that what would be required is primarily a decision to staff these facilities for that purpose.

IV. - State Funds for Mental Health Services

In six of the past eight legislative interims, a Study Committee of the General Assembly has scrutinized delivery of mental health services in Iowa. The State Mental Health Institutions Study Committee of 1967-68 included two members (Senator Miller and Representative Lipsky) who have also served continuously on the Mental Health and Juvenile Institutions Study Committee since its establishment in 1971.

One of the recommendations of the 1967-68 Study Committee was that a more specific statutory foundation for establishment and operation of community mental health centers in Iowa be enacted, and that the funds the state provides to pay a portion of the cost of certain mental health services be allocated on a population basis directly to counties, which should be given some flexibility in determining how to use the funds to help obtain needed mental health services. The same recommendation was made by the Mental Health and Juvenile Institutions Study Committee in its first report in December, 1971.

The legislative proposal embodying this recommendation became identified in 1972 as Study Committee Draft Bill No. 1. It was subsequently divided, and Draft Bill No. 1A--the portion dealing with establishment and operation of community mental health centers--ultimately became House File 1060 of the 65th General Assembly and was passed in 1974.

The portion of the original proposal identified as draft Bill No. 1 which deals with state funding of mental health services has been identified by the Study Committee in 1973 and 1974 as Draft Bill No. 1B. Although the bill has not been under active consideration during the 1974 interim, the Study Committee members continue to support the concept, and again recommend its enactment by the General Assembly.

This bill is somewhat complicated and requires some rather detailed explanation. Appropriations made to the state

mental health institutes, and the state hospital-schools for the mentally retarded, in Iowa are not really the same as most appropriations. In most cases, an appropriation is an authorzation to an agency to expend in a given year a stated amount of money; at the end of that year, that amount of money is expected to have been spent and the state must replace that money in the treasury, either through general taxation or from some other source, if it proposes to continue spending at the same rate. In the case of the mental health institutes and hospital-schools, however, while the appropriation is an authorization to expend a certain amount of money, much of this money is expected to be replaced by payments from the several counties to the state treasury. Basically, the institution divides the money expended during each quarter by the total number of patient-days of care it has provided in order to derive an overall per diem figure for the quarter; for each day during which a person who is a legal resident of a particular county was a patient at the institution, the institution bills the county at the established per diem rate and the county must remit the amount so billed to the state treasury.

In past years the state policy was to recover the entire amount of the daily patient charge from the counties in this manner. Thus, at the end of each biennium, the only net outlay from the state treasury for operation of the mental health institutes and hospital-schools was the amount expended for care of "state patients", those persons who do not have a legal place of residence in any county in the state. Since July 1, 1967, however, the state has billed the counties for only 80% of the computed daily patient cost. This policy in effect resulted in a net transfer from the state treasury to the counties of slightly less than $4,900,000 in the fiscal year ending June 30, 1974; that is, the 99 counties together were required to levy nearly $4,900,000 less in property taxes to pay institutional bills than would have been necessary if the 20% discount were not in effect.

In addition, the state has for some years made available to the counties payments of $5 per patient per week to help offset the cost to the counties of keeping chronic mentally ill and mentally retarded individuals in county homes, local nursing homes, etc. These payments are available from the state mental aid fund, to which there is a standing annual appropriation of $1,075,000 under section 227.17 of the Code.

Thus, under present law the state in effect underwrites a portion of the cost of treatment of mentally ill or mentally retarded individuals in state institutions or of chronic care in local residential facilities, but does not provide any money to be used at the local level for the cost of operation of community mental health center programs. What the Mental Health and Juvenile Institutions Study Committee Draft Bill No. 1B proposes to do is to end the present 20% discount on mental health institute and hospital-school billings to counties, abolish the state mental aid fund, and transfer the nearly $6,000,000 now going into these two items to a new state mental health reimbursement fund. This new

fund would be allocated each year among all of the counties on a population basis, and could be used at the discretion of the board of supervisors for any or all of the three following purposes:

1. Support of a community mental health center, except that none of the funds so received may be applied directly to the purchase, leasing or construction of any building to house the center.

2. Payment of charges to the county for care and treatment of patients at any state mental health institute or state hospital-school.

3. Care and treatment of persons who are, in lieu of admission or commitment to, or upon discharge, removal or transfer from, a state mental health institute or state hospital-school, placed in a county hospital, county home, a nursing home or other health care facility as defined by law, or in any other suitable public or private facility which is properly licensed or, if there is no applicable licensing statute, is approved for such placements by the Commissioner of Social Services or his designee.

This change in the manner of allocating among counties the funds which the state is presently using to help counties meet the cost of certain categories of mental health care would, by itself, affect different counties in different ways. A county which has in recent years made very limited use of the state institutions would probably receive more state money under Draft Bill No. 1B than it now receives through the 20% discount on institutional billings and the distribution of the present state mental aid fund. Conversely, a sparsely populated county which has little in the way of community mental health facilities available to it, and has therefore sent proportionately more patients to state institutions than have the more populous counties, would tend to receive less state money under Draft Bill No. 1B. Therefore, a "floor" has been written into the bill providing that initially, no county shall receive an allocation from the proposed new state mental health reimbursement fund which is less than it receives in fiscal 1975 (i.e., the current fiscal year) from the 20% discount on institutional billings and the state mental aid fund which is presently in existence. In order to fund this "floor", approximately $330,000 dollars in additional money will have to be appropriated, over the amount obtained by ending the 20% discount and abolishing the state mental aid fund. (The cost of funding this "floor" provision is based on figures for the most recent complete fiscal year, which ended June 30, 1974.)

In renewing its recommendation of Draft Bill No. 1B, the Study Committee has added a new feature to the bill. This is a requirement that the four state mental health institutes begin cost-related billing for inpatient services. Accounting methods now in use at the institutes make such billing feasible, and the result should be a lessening of the extent to which charges for services to patients receiving less intensive or costly treatment

include a portion of the cost of services provided to patients receiving more expensive treatment.

A copy of Draft Bill No. 1B, as revised for the Study Committee late in 1974, appears as Appendix IV to this report.

V. - Conduct of a Comprehensive Mental Health Study

H.F. 784 passed by the 1973 session of the 65th General Assembly included an appropriation of $50,000 to the Legislative Council to conduct a comprehensive study of all mental health delivery systems in Iowa. The Study Committee was subsequently assigned the responsibility of advising the Council regarding this project. Recommendations relevant to the study, issued following the 1973 interim, can be found on pages 1-4 of the Study Committee's 1973 Report to the Legislative Council. These recommendations were accepted by the Council on December 19, 1973 as noted in the opening paragraphs of this report.

Subsequently, delays in the search for a study consultant occurred because of the lack of time on the part of both staff members and legislators during the 1974 session of the General Assembly. In June, Dr. David Ethridge, Chief of the Bureau of Operational Planning of the Michigan Department of Mental Health and Dr. E. Gordon Yudashkin, Director of the Michigan Department of Mental Health were invited to meet with the Study Committee to discuss the possibility of their serving as consultants.

This meeting took place on June 19. After evaluation of the situation in Iowa, Drs. Yudashkin and Ethridge submitted a report which emphasized the absence of data they considered essential to the study, due to poor data collection systems throughout the state, and expressed concern regarding the lack of coordination among those data systems that are currently being developed. The report suggested that the perceived deficiencies in data collection systems were largely due to lack of state financial support for their development, adding that cooperation of community mental health centers in response to efforts of the Iowa Mental Health Authority exceeds what might reasonably be expected since the state pays no part of the cost of operation of the centers.

The report by Drs. Yudashkin and Ethridge also reflected doubts concerning the feasibility of conducting the study within the $50,000 appropriation. Rather than conduct the follow-up study as proposed, the report recommended that the funds be used instead to develop and refine existing data collection systems "so as to provide a vehicle for the ongoing answering of questions (. . . relative to mental health programs. . .) when they arise".

Meeting on July 18 the Study Committee decided against following these recommendations regarding the conduct of the study. However, the matter of coordinating data systems noted in the con-

sultant's report was subsequently called to the attention of the Interagency Liaison Committee established by Section 28C.1 of the Code.

On August 28 the Study Committee reaffirmed its intent regarding the objectives of the follow-up study and instructed the Legislative Service Bureau to contact additional prospective consultants. Pursuant to these contacts, Dr. James V. Lowry of San Diego, retired Director of the California Department of Mental Hygiene met with the Comprehensive Study Subcommittee (Senator Miller, Chairman, Representative Lipsky, Dr. Nelson and Mr. Grunzweig) on September 23 and the Study Committee on September 24. He accepted the Study Committee's objectives as outlined on August 18, and subsequently submitted a proposal outlining a procedure for achieving these objectives.

The specific questions to which answers will be sought are:

1. What kind of aftercare was recommended for each individual by the various mental health inpatient facilities prior to discharge or release?

2. How much and what type of aftercare did patients actually receive upon discharge or release, if any?

3. What were the costs of any aftercare received?

The Study Committee approved these specific objectives, and accepted Dr. Lowry's recommendations regarding administration and methodology of the follow-up study. The field of subjects has been narrowed to include only those patients who have been hospitalized as part of their treatment program. This will necessarily consist of individuals who (1) have been hospitalized in one of Iowa's four mental health institutes, (2) have been hospitalized in Psychopathic Hospital at Iowa City, (3) have been hospitalized as a community mental health center patient or have been served by a community mental health center and referred to a private physician for hospitalization or (4) have been receiving private psychiatric care and were hospitalized during the course of such treatment.

Dr. Lowry's recommendations as accepted by the Study Committee also include the creation of an advisory board consisting of representatives of groups and agencies whose cooperation is important if the project is to succeed. The advisory board consists of the Study Committee's Comprehensive Study Subcommittee and the following persons designated in response to invitations extended on behalf of the Study Committee: Jerold D. Bozarth, Ph.D. (Iowa Mental Health Authority), Rev. William Cotton (Iowa Association for Mental Health), M. D. George, M.D. (Iowa Medical Society and Iowa Psychiatric Society), Verne R. Kelley, A.C.S.W. (Community Mental Health Centers Association of Iowa), Janet Parker (Iowa Association for Retarded Citizens) and Thomas J. Wilkinson (Iowa Bar Association).

The advisory board held its first meeting December 11, and reviewed several applications for the position of project director for the follow-up study. Neither the board nor the consultant, Dr. Lowry, was fully satisfied with the qualifications of the candidates and additional candidates for the position are currently being solicited. It is planned that the project director will be a temporary full-time employee of the Legislative Service Bureau and will be charged with a variety of responsibilities including the preparation of the basic study design and, with Dr. Lowry's advice and assistance, the preparation of the research instrument. It is likely that additional qualified interviewers will later be employed to complete the field work. It is anticipated that the present Legislative Service Bureau staff will assume the clerical responsibilities involved in the project.

Dr. Lowry noted that a study of this nature should require a minimum of six months to complete. Funding for the study extends through June 30, 1975 at which time all unencumbered funds will revert to the general fund unless an extension is provided by the 1975 session of the General Assembly. Study Committee members have discussed the possibility that a request for an extension may be necessary, and that an additional appropriation for the follow-up study might be desirable.

Appendix I

Comparison of Draft Bill No. 6, Fourth Version, and Present Iowa Law

by Ralph M. Kauffman

The following comparison points out similarities and differences between the present Iowa mental illness commitment law and Mental Health and Juvenile Institutions Study Committee Draft Bill No. 6, Third Version. The comparison is organized chronologically with the proposed new law.

Section 1 of the Draft Bill attempts to define the terms which are used in the succeeding sections so that there can be no misunderstanding as to the meaning of such terms. Terms defined include: mental illness, seriously mentally impaired (or serious mental impairment), serious emotional injury, respondent, patient, licensed physician, qualified mental health professional, public hospital, private hospital, hospital, chief medical officer, and clerk.

The present law does little to define terms. Section 229.40 does define "mental illness" in general terms but does not go further in defining such things as "seriously mentally ill" to provide any basis for involuntary commitment. The only other term defined is "director" which is defined by Section 229.44 and does not appear to be necessary under the proposed bill.

Sections 2 through 5 of the Draft Bill are concerned with voluntary admissions to public or private hospitals. Their counterpart is found in Sections 229.41 and 229.42 of the present Code. The proposed bill, however, is more detailed in providing for discharge of voluntary patients, and for certain situations under which they may be retained and proceedings commenced for involuntary commitment. The present statutes deal to some extent with the payment of charges for voluntary patients, but the proposed bill does not deal at this time with the payment of costs. These matters will doubtless be treated somewhat the same way as under present law and will be covered when a complete draft, including all necessary conforming amendments to existing Code sections, is prepared.

Section 6 of the proposed bill sets out the requirements for the application for involuntary hospitalization of the mentally ill. A closely related provision is Section 229.1 of the Code. This provides for the information which commences the involuntary proceedings. The information under present law is much less detailed, does not require supporting statements from a physician or affidavits from other persons. Further, the only requirement seems to be that the affiant believes the individual to be suffering from mental illness rather than that the individual is "seriously mentally impaired" as required by the proposed bill. It would thus appear that a person could be committed under the present statute for any type of mental illness, while under the proposed bill there is the requirement of a showing of danger of

physical or emotional injury. The present section 229.1 also contains the provision for commitment with the consent of the individual by written application signed by his attending physician and one other physician. This provision has been completely removed from the present bill.

Section 7 provides for the service of notice upon the respondent (i.e., the person whose involuntary hospitalization is being sought). This compares with Section 229.2 of the Code, however the present Code appears to contemplate that persons will be taken into custody and held until such time as a hearing is had. Under the proposed bill notice will simply be served upon a respondent unless he is taken into custody as provided by Section 11 of the proposed bill.

Section 8 of the proposed bill sets out the procedure following the issuance of the notice. It provides that counsel must be immediately appointed unless the respondent already has counsel. It further provides that the court must fix a time for the hearing and order an examination by one or more physicians and fix a time for the filing of the report by the physicians.

Section 229.5 of the Code provides for appointment of counsel, however it appears that such appointment is made at the time of hearing and it is questionable whether under such conditions counsel would have opportunity to prepare to represent the respondent in a proper manner.

Section 229.6 provides for the appointment of an examining physician, which physician may be from the membership of the commission or outside the commission. The statute is not clear as to when the appointment is to be made, however it apparently must be done prior to the time of the hearing since a report is submitted at the time of the hearing.

Section 229.7 of the Code sets out a long series of interrogatories for which the physician is required to supply answers based on his examination of the respondent in so far as it is possible for him to do so. This differs from the present bill in that the physician is simply required to make a report and details are left to the designation of the court or the judgment of the physician.

Section 229.8 of the Code provides for such corrections to the answers to these interrogatories as may be necessary by information elicited at the time of the hearing.

Section 9 of the proposed bill provides the information which must be given to the respondent's attorney, and also sets out the duties of respondent's attorney. There is no corresponding section in the current law.

Section 10 of the proposed bill sets out the matters which must be contained in the physician's report and further

provides that the respondent shall have the right to be examined by a physician of his own choice if he so desires and that such examination shall be paid for by the county if the respondent does not have sufficient funds with which to pay such expense. It authorizes any physician conducting an examination under the proposed bill to consult or invite the participation of a "qualified mental health professional" (i.e., a certified psychologist, registered nurse or master's degree social worker qualified by training and experience in the area of mental health). Also, it requires that respondent's attorney must be given copies of all reports and sets the time in which hearing must be had if the physician's report is to the effect that the respondent is "seriously mentally ill". This would appear to correspond to some extent with Section 229.7 of the Code which has been previously discussed.

Section 11 of the proposed bill provides the conditions under which the respondent may be taken into immediate custody. It further provides the places where the respondent may be confined, and under what conditions, as well as the length of time prior to the actual hospitalization hearing. There is no section in the present Code which corresponds with these provisions, at least insofar as detailed instructions are concerned. The only section which bears on this matter is Section 229.2 which is extremely sketchy and appears to give the Commission of Hospitalization a great deal of power without any specifications as to how the powers shall be exercised. It would appear to be entirely discretionary with the Commission as to just what action it would take relative to the confinement of the respondent.

Section 12 of the proposed bill provides for the hearing and sets out in detail the manner in which it shall be conducted. It specifies that the county attorney must appear on behalf of the applicant and also specifies the rights of the respondent.

Sections 229.2, 229.3, and 229.4 are corresponding sections. In general they are much less detailed and would leave the conduct of the hearing largely to the discretion of the commission. There is a provision giving the Commission the right of subpoena which does not appear in the present bill but no such power is needed since the hearing is before the court and the court obviously has the power of subpoena.

Section 13 of the proposed bill provides for the commitment of the respondent for evaluation if the evidence as presented at the hearing justifies such an order. It further sets forth requirements relative to reporting by the chief medical officer of the hospital and prescribes a time in which such reports must be made. This would correspond with Section 229.9 in some respects. However that section provides for an order directing the respondent to be taken to a screening center for evaluation, but the final commitment order is issued under the provision of Section 229.10. Thus, under the present law there may be two separate hearings. At the first the respondent may be sent to the hospital

for evaluation and later, after a second hearing based on the recommendation of the superintendent of the hospital, there can be an order for commitment. These separate proceedings do not appear in the proposed law.

Section 14 of the proposed bill provides for the report to be furnished by the chief medical officer of the hospital and sets out the conclusions which the report may reach. It further makes provision as to what the court shall do upon receipt of the report, and prescribes a time in which such reports are to be made. If the report states that the respondent is seriously mentally ill and in need of care and treatment etc., the court may then order the respondent to be kept in the hospital for whatever treatment may be required, and thus in a sense this is a substitute for the provisions of Section 229.10 discussed above.

Section 15 of the proposed bill provides for periodical reports and the frequency of such reports. It further provides for the action to be taken by the court upon receipt of such report. There is no similar provision in the present law.

Section 16 of the proposed bill provides for the discharge of patients and in substance states that when further care or treatment is no longer beneficial the person in charge of the facility shall so state and the court shall order a discharge and terminate the proceedings. This is similar in many respects to Section 229.30 of the Code.

Section 17 of the proposed bill presents a wholly new concept, namely the appointment in each county of a person known as an advocate. This person is appointed by the judge of the district court and the qualifications are specifically set out. The advocate is to take over the responsibility of protecting each involuntarily hospitalized patient's rights after that patient's own attorney ceases to function, so that there should be someone continually interested in the welfare of all committed patients. The present law has no comparable provision. The nearest thing provided for in the present law is the commission of inquiry which only functions when there is an allegation that a person is improperly detained in a mental health facility. This is provided for in Section 229.31.

Section 18 of the proposed bill provides an emergency procedure for hospitalization of an allegedly mentally ill individual when immediate access to the district court is impossible. It provides that a peace officer may take the individual into custody and take him to a hospital or other appropriate facility. As soon as possible, arrangements must be made to bring to the hospital or facility a magistrate who shall make a determination as to whether there is probable cause for believing that the person is mentally ill and because of the illness presents a physical threat to himself or others. If so, he may be confined in a hospital for a short period of time until there can be further proceedings. There is no similar provision in

the present law, although enactment of a comparable law was proposed to the 65th General Assembly. The section also limits severely the time a person may be held under such emergency procedures.

Section 19 of the proposed bill is a section designed to protect the rights and privileges of a mentally ill person during hospitalization. There is very little in the present law covering this area except sections 226.13, 226.14, and 226.15, which deal primarily with the rights of patients to write and receive letters. Section 229.39 makes it a misdemeanor to fail to furnish any writing materials. The present statute does not provide any penalty for violation of the rights of patients. Section 229.38 provides penalties in case of cruelty or misconduct relative to patients.

Section 20 of the proposed bill states basically that all records in connection with the hospitalization hearing shall be confidential, but does state conditions under which this information may be released. There is no similar provision in the present law.

Section 21 of the proposed bill refers to the confidentiality of the patients' medical records and provides very limited conditions under which this information may be released. There is no similar provision in the present law.

Section 22 of the proposed bill provides that Sections 6 through 15 shall be the only procedure which may be used for involuntary hospitalization of a mentally ill person. There is no section in the present law which specifically so states unless it is a part of some other section and the title of the section does not indicate that this is a part thereof.

Section 23 of the proposed bill provides in effect that hospitalization of a mentally ill person is not to be equated with incompetence, and the fact that a person is so hospitalized does not establish nor create a presumption that he is incompetent. There is also provided a procedure whereby, in connection with the hospitalization proceeding, a determination can be made as to the competence of the respondent. This is an alternative procedure and no one is required to follow it but may use any of the other procedures set forth in the Code. The present commitment law does not contain procedures similar to those set forth in this section.

Mental Health and Juvenile
Institutions Study Committee.
Draft Bill No. 7 - Final Version

December, 1974

Passed Senate, Date_____ Passed House, Date_____

Vote: Ayes_____ Nays_____ Vote: Ayes_____ Nays_____

Approved_____

A BILL FOR

An Act to abolish certain liens and provide procedures for determining liability for payment of charges for care and treatment at certain institutions or facilities.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

S.F. _____ H.F. _____

Section 1. Section one hundred twenty-five point twenty-eight (125.28), Code 1975, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. The board of supervisors shall upon receipt of the list of persons treated at any facility make a determination whether each such person or the persons legally liable for his support are able to pay the charges for the care and treatment at the facility. If the board finds such a person or the persons legally liable for his support are unable to pay for the treatment, they shall direct the auditor not to enter the name of that person in his record.

Sec. 2. Section two hundred twenty-two point thirteen (222.13), Code 1975, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. Upon applying for admission of a person to a hospital-school, or a special unit, the board of supervisors shall make a full investigation into the financial circumstances of that person and those liable for his support under section two hundred twenty-two point seventy-eight (222.78) of the Code, to determine whether or not any of them are able to pay the expenses arising out of the admission of the person to a hospital-school or special treatment unit. If the board finds that the person or those legally responsible for him are unable to pay such expenses, they shall direct that the expenses be paid by the county. If the board finds that the person or those legally responsible for him are able to pay the expenses, they shall direct that the charges be so paid to the extent required by section two hundred twenty-two point seventy-eight (222.78) of the Code, and the county auditor shall be responsible for the collection thereof.

Sec. 3. Section two hundred twenty-two point eighteen (222.18), Code 1975, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. Upon the filing of the petition,

the court shall enter an order directing the county attorney of the county in which the allegedly mentally retarded person resides to make a full investigation regarding the financial condition of that person and of those persons legally liable for his support under section two hundred twenty-two point seventy-eight (222.78) of the Code.

Sec. 4. Section two hundred twenty-two point thirty-one (222.31), Code 1975, is amended by adding the following new subsection:

NEW SUBSECTION. The court shall examine the report of the county attorney filed pursuant to section two hundred twenty-two point thirteen (222.13) of the Code, and if the report shows that neither the person nor those liable for his support under section two hundred twenty-two point seventy-eight (222.78) of the Code are able to pay the charges rising out of his care in the hospital-school, or special treatment unit, he shall enter an order stating that finding and directing that the charges be paid by the person's county of residence. If the report shows that the person, or those liable for his support, are able to pay the charges, the court shall enter an order directing that the charges be so paid to the extent required by section two hundred twenty-two point seventy-eight (222.78) of the Code.

Sec. 5. Section two hundred thirty point twenty-one (230.21), Code 1975, is amended to read as follows:

230.21 DUTY OF COUNTY AUDITOR AND TREASURER. The county auditor, upon receipt of such certificate, shall thereupon enter the same to the credit of the state in his ledger of state accounts, shall furnish to the board of supervisors a list of the names of the persons so certified, and at once issue a notice to his county treasurer, authorizing him to transfer the amount from the county mental health and institutions fund to the general state revenue, which notice shall be filed by the treasurer as his authority for making such transfer, and shall include the amount so transferred

in his next remittance of state taxes to the treasurer of state, designating the fund to which it belongs.

Sec. 6. Section two hundred thirty point twenty-five (230.25), Code 1975, is amended by striking the section and inserting in lieu thereof the following:

230.25 FINANCIAL INVESTIGATION BY SUPERVISORS. Upon receipt from the county auditor of the list of names furnished pursuant to section two hundred thirty point twenty-one (230.21) of the Code, the board of supervisors shall make an investigation to determine the ability of each person whose name appears on the list, and also the ability of any person liable under section two hundred thirty point fifteen (230.15) of the Code for the support of that person, to pay the expenses of his hospitalization. However, the board need not make an investigation of any person previously investigated pursuant to this section. If the board finds that neither the hospitalized person nor any person legally liable for his support is able to pay those expenses, they shall direct the county auditor not to make any charges against any of those persons pursuant to section two hundred thirty point twenty-six (230.26) of the Code.

Sec. 7. Section two hundred thirty point twenty-six (230.26), Code 1975, is amended to read as follows:

230.26 AUDITOR TO KEEP RECORD. The auditor of each county shall keep an accurate account of the cost of the maintenance of any patient kept in any institution as provided for in this chapter and keep an index of the names of the persons admitted or committed from such county ~~and the indexing and the record of the account of such patient in the office of the county auditor shall constitute notice of such lien.~~ The name of the husband or the wife of such person designating such party as the spouse of the person admitted or committed shall also be indexed in the same manner as the names of the persons admitted or committed are indexed. The book shall be designated as an account book or index, and shall have

no reference in any place to a lien.

Sec. 8. Section two hundred thirty point thirty (230.30), Code 1975, is amended to read as follows:

230.30 CLAIM AGAINST ESTATE. On the death of a person receiving or who has received assistance under the provisions of this chapter, the total amount paid for their care shall be allowed as a claim of the ~~second~~ sixth class against the estate of such decedent.

Sec. 9. All liens created under section two hundred thirty point twenty-five (230.25), as that section appeared in the Code of 1973 and prior editions of the Code, are abolished effective January 1, 1976, except as otherwise provided by this Act. The board of supervisors of each county shall, as soon as practicable after July 1, 1975, review all liens resulting from the operation of said section two hundred thirty point twenty-five (230.25) and make a determination as to the ability of the person against whom the lien exists to pay the charges represented by the lien, and if they find that the person is able to pay those charges they shall direct the county attorney of that county to take immediate action to enforce the lien. If action is commenced under this section on any lien prior to the effective date of the abolition thereof, that lien shall not be abolished but shall continue until the action is completed.

Sec. 10. Sections two hundred thirty point twenty-eight (230.28), two hundred thirty point twenty-nine (230.29), two hundred fifty-two point ten (252.10), two hundred fifty-two point eleven (252.11), and two hundred fifty-two point twelve (252.12), Code 1975, are repealed.

EXPLANATION

This proposed legislation is designed to do several things. First, it repeals the lien on property of mentally ill persons or those legally responsible for payment of charges for their care and support. Second, it abolishes existing liens. It is almost certain that at least some of the existing liens

are enforceable and an opportunity is given to commence action to enforce any liens which the boards of supervisors of the various counties may consider collectable. The date of January 1, 1976 as a cutoff is admittedly arbitrary and if it is considered that this would be too short a time it could easily be extended to July first or whatever date seems proper. Third, a method is provided at the time persons are admitted or committed to certain institutions or facilities whereby it can be determined whether in fact those persons or persons legally responsible for payment of such charges are able to pay them. If so procedure is provided for collections of such charges, but if not the county is directed to pay them and the auditor's books are not cluttered with uncollectable accounts. As matters now stand there are probably thousands of uncollectable accounts outstanding, and as a result in many cases little or no effort is made to collect any account. While it is recognized that in all probability some accounts will remain uncollected, it is hoped that the number will be reduced and a greater effort will be made to collect those certified as being collectable. Fourth, a change is made in the classification of claims against the estates of mentally ill persons so that they will be in the same class as claims against the estate of mentally retarded persons. Fifth, sections which appear to be inconsistent with the purpose of this legislation are repealed.

Included are repeal of three sections which are in a sense unrelated to the rest of the bill. These three sections are in the chapter on support of the poor. Perhaps this is so unrelated as not to be properly includable however, these sections would appear to be outdated and it is unlikely that they are ever used at the present time. When enacted they were doubtless of value since at that time the township trustees were actively engaged in activities relative to the support of the poor but this is no longer the case. There are presently adequate means for compelling support of children

and it does not seem that these sections serve any useful purpose at this time.

Mental Health and Juvenile Institutions Study Committee
Draft Bill No. 8 - Final Version.

December, 1974

Passed Senate, Date_____ Passed House, Date_____

Vote: Ayes_____ Nays_____ Vote: Ayes_____ Nays_____

Approved_____

A BILL FOR

An Act to establish a Clarinda mental health institute advisory board, to define extension services by the Clarinda mental health institute, and to prescribe the conditions under which extension services, certain other services, and use of portions of the mental health institute physical plant may be made available.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

plant, and to contract for sale of professional services, to community mental health centers in its catchment area.

Mental Health and Juvenile
Institutions Study Committee
Draft Bill No. 1B--Revised
Version. December, 1974

Passed House, Date_____ Passed Senate, Date_____

Vote: Ayes_____ Nays_____ Vote: Ayes_____ Nays_____

Approved_____

A BILL FOR

An Act relating to use of state funds to assist counties in paying a portion of the cost of mental health and mental retardation services, and to charges by state mental health institutes for care of patients thereof.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

S.F. _____ H.F. _____

Section 1. chapter two hundred thirty (230), Code 1975, is amended by adding sections two (2) and three (3) of this Act.

Sec. 2. NEW SECTION. STATE MENTAL HEALTH REIMBURSEMENT FUND--ALLOCATION. There is created in the office of the treasurer of state a state mental health reimbursement fund, to which there is appropriated for the fiscal year beginning July 1, 1975 and each fiscal year thereafter, from any money in the state general fund not otherwise appropriated, the sum of six million three hundred thousand (6,300,000) dollars. Each county shall annually, as soon after July first as reasonably possible, receive an allocation from the fund which shall bear the same proportion to the total amount of the fund as that county's population bears to the total population of the state, based upon the most recent federal decennial census, except that:

1. In no event shall the allocation to any county for the fiscal year beginning July 1, 1975 be less than the total amount realized by that county in the fiscal year ending June 30, 1975 by reason of:

a. The difference between the full cost of care of persons having legal settlement in that county who were patients at any of the state mental health institutes or state hospital-schools during the fiscal year ending June 30, 1975, computed as prescribed by sections two hundred thirty point twenty (230.20) and two hundred twenty-two point seventy-three (222.73), Code 1975, respectively, and the amounts actually charged the county by the state for the care of such patients pursuant to the Acts of the Sixty-fifth General Assembly, 1973 Session, chapter one hundred twelve (112), sections four (4) and five (5).

b. Payments to the county from the state mental aid fund made pursuant to sections two hundred twenty-seven point sixteen (227.16) through two hundred twenty-seven point eighteen (227.18), Code 1975.

2. When a city exercises its authority to have a special census taken as permitted by sections one hundred twenty-three point fifty-three (123.53), subsection three (3), and three hundred

twelve point three (312.3), subsection two (2), of the Code, the population of the county or counties where the city is located shall, for the purpose of this section, be adjusted in accordance with the result of the special census as certified to the secretary of state.

Sec. 3. NEW SECTION. USE OF ALLOCATION BY COUNTY. Upon receipt of each year's allocation to the county from the state mental health reimbursement fund, the county board of supervisors shall immediately place the allocation in the county mental health and institutions fund and may expend from the fund in the same budget year an amount equal to the amount of the allocation for any of the following purposes:

1. Support of a community mental health center established or operated as authorized by section two hundred thirty A point one (230A.1) of the Code, except that none of the funds received may be applied directly to the purchase, leasing or construction of a building to house the center.

2. Payment of charges to the county for care and treatment of patients at any state mental health institute or state hospital-school.

3. Care and treatment of persons who in lieu of admission or commitment to, or upon discharge, removal or transfer from a state mental health institute or state hospital-school are placed in a county hospital, county home, a health care facility as defined in section one hundred thirty-five C point one (135C.1), subsection eight (8), of the Code, or in any other suitable public or private facility which is properly licensed or if there is no applicable licensing statute, is approved for such placements by the commissioner of the department of social services or his designee.

Sec. 4. Section two hundred twenty-two point seventy-three (222.73), Code 1975, is amended to read as follows:

222.73 SUPERINTENDENT TO PREPARE EXPENSE SCHEDULE. The superintendent of each hospital-school and special unit shall certify to the state comptroller on a schedule approved by the

comptroller any amount not previously certified by the superintendent due the state for the expenses of patients in each hospital-school and special unit from the several counties responsible under section 222.60. The comptroller shall thereupon charge the amounts so certified to the proper counties. The amount certified by the superintendent to the comptroller to be charged against each county shall be the per-patient-per-day cost of the hospital-school or special unit, as the case may be, multiplied by the number of days each patient for which such county is liable to the state was carried on the rolls of the hospital-school or special unit as an inpatient, plus the amount due for the treatment of outpatients for which such county is liable to the state during the period for which expenses are being certified. The per-patient-per-day cost shall be determined by listing the number of days each inpatient was actually in the hospital-school or special unit during the period for which expenses are being certified and dividing the total of all such days into one hundred percent of the portion of the appropriation for the hospital-school or special unit expended during such period~~, unless otherwise specified in the biennial appropriations for support of such institutions~~. The amount charged for the treatment of outpatients shall be at a rate to be established by the state director on the basis of the actual cost of such treatment.

Sec. 5. Section two hundred thirty point twenty (230.20), Code 1975, is amended by striking the section and inserting in lieu thereof the following:

230.20 STATEMENT OF CHARGES TO COUNTIES. The superintendent of each state hospital for the mentally ill established by section two hundred twenty-six point one (226.1) of the Code, or his designee, shall on the first day of July, October, January and April of each year, compute the amounts which are due the state from each county for services rendered by the hospital to patients chargeable to those counties. Each hospital's charges for services rendered in a particular quarter shall be

based on that hospital's expenditures during the immediately preceding quarter, and shall be computed as follows:

1. The expenditures of the hospital during the preceding calendar quarter shall be separately computed by program in accordance with generally accepted accounting procedures. In so doing, the superintendent or his designee shall not include any of the following:

a. The costs of food, lodging and other maintenance provided to persons not patients of the hospital.

b. The costs of certain direct medical services, which shall be charged directly against the patient who received the services. The direct medical services to which this paragraph is applicable shall be specifically identified in rules adopted by the department of social services in accordance with chapter seventeen A (17A) of the Code, and may include but need not be limited to x-ray, laboratory and dental services.

c. The cost of outpatient services, which shall be charged directly against the patient who received the services at a rate to be established by the state director on the basis of the actual cost of the services.

2. The total patient days of service provided during the calendar quarter shall be identified and accumulated for each program for which expenditures are separately computed under subsection one (1) of this section.

3. The total expenditure during the calendar quarter computed for each program pursuant to subsection one (1) of this section shall be divided by the total patient days of service provided during the calendar quarter by that program, determined pursuant to subsection two (2) of this section, to derive the average daily patient cost for each program.

4. Each county shall be charged the total of:

a. The charges attributable to each inpatient chargeable to that county, calculated by multiplying the average daily patient cost for each program under which the patient was served by the number of days the patient was so served during the calendar

H.F. _____

Section 1. Chapter two hundred twenty-six (226), Code 1975, is amended by adding sections two (2) through five (5), inclusive, of this Act.

Sec. 2. NEW SECTION. TERMS DEFINED. As used in this Act:

1. "Advisory board" means the Clarinda mental health institute advisory board established by section three (3) of this Act.

2. "Extension services" means any services provided by any employee of a mental health institute at any place other than the mental health institute itself, except:

a. Services provided without reimbursement to the mental health institute and intended only to inform the public about programs and services of the mental health institute.

b. Participation by mental health institute employees, as a part of the duties of their employment, in formal or informal educational activities which are not intended for the therapeutic benefit of any other person participating in these activities.

c. Services provided by professional employees of a mental health institute at the request of and in furtherance of the statutory functions of a court or commission of hospitalization.

d. Services provided by employees of a mental health institute outside the course of such employment, however a county may employ or retain in a professional capacity a person who is a professional employee of a mental health institute only if the county does so through a community mental health center.

3. "Community mental health center" means a community mental health center established or operating as authorized by section two hundred thirty A point one (230A.1) of the Code.

4. "Catchment area" means the area designated pursuant to section two hundred eighteen point nineteen (218.19) of

the Code to be served by a state mental health institute.

Sec. 3. NEW SECTION. ADVISORY BOARD CREATED. There is established a Clarinda mental health institute advisory board to consist of one member from each county in the institute's catchment area. Each member of the advisory board shall be appointed by and shall serve at the pleasure of the board of supervisors of the county that member represents. The appointee to the advisory board shall be a person who has demonstrated by prior activities an informed concern in the area of mental health. Each advisory board member shall be reimbursed for the actual and necessary expenses incurred by service on the advisory board, upon claims filed with the county auditor and approved by the board of supervisors, out of the county mental health and institutions fund established by section four hundred forty-four point twelve (444.12) of the Code.

Sec. 4. NEW SECTION. DUTIES OF ADVISORY BOARD. The advisory board shall meet at least quarterly, shall review the mental health service needs and resources of the area served by the Clarinda mental health institute, shall assist the superintendent of the institute in the planning, development and evalution of mental health services provided by the institute, and shall seek to promote coordination of the mental health services provided by the mental health institute and by community mental health centers so that to the greatest extent practicable they complement each other and are not duplicatory. The superintendent of the Clarinda mental health institute shall consult with the advisory board regarding the proposed budget for the institute for each biennium before the budget estimates required by section eight point twenty-three (8.23) of the Code are completed by the department of social services. Not later than December fifteenth of each year the advisory committee shall submit a report of its activities, including recommendations if the advisory committee so desires, to the department of social

services, the president of the senate and the speaker of the house of representatives. The president and the speaker shall each refer the report to an appropriate committee of the senate and the house of representatives, respectively.

Sec. 5. NEW SECTION. EXTENSION SERVICES LIMITED. The Clarinda mental health institute may provide extension within its catchment area, subject to the following restrictions:

1. Extension services shall be provided only within counties which are affiliated with a community mental health center, and only on the basis of a written agreement with a community mental health center to which the county in which the extension services are provided contributes funds or from which it purchases services, which agreement has been approved by the advisory board.

2. Charges by the mental health institute to the county for extension services shall be itemized and shall include the following:

a. The full cost of all professional staff time utilized in providing the extension services.

b. Travel expenses, including meals and lodging, incurred by the mental health institute staff personnel in providing the extension services.

c. All indirect costs of providing the extension services.

3. The requirements of subsection one (1) of this section, insofar as they prohibit extension services to counties which have not joined in establishing or affiliated with an existing community mental health center, are suspended until July 1, 1977.

Sec. 6. NEW SECTION. AUTHORITY TO MAKE CERTAIN FACILITIES AND SERVICES AVAILABLE. The Clarinda mental health institute may, with approval of the advisory board and the state director:

1. Lease any specified portion of its physical plant to a community mental health center, or to any other community-based agency providing mental health or related services to

residents of the mental health institute's catchment area.

2. Enter into agreements with any community mental health center with which one or more of the counties in the mental health institute's catchment area is affiliated, for the purchase of specified mental health services from the mental health institute by that community mental health center.

Sec. 7. Section four hundred forty-four point twelve (444.12), Code 1975, is amended by inserting after subsection four (4) the following new subsection:

NEW SUBSECTION. Actual and necessary expenses incurred by the county's appointee to the mental health institute advisory board established by section three (3) of this Act, if the county board of supervisors is authorized to appoint a member to that board.

EXPLANATION

This bill establishes a one-member-per-county advisory board drawn from the catchment area of the Clarinda Mental Health Institute, to assist its superintendent in making the programs and services of the Clarinda Institute as responsive as possible to the specific needs for mental health services perceived at the local level. The advisory board is also to assist in coordinating the Clarinda Institute's services with those of community mental health centers. To encourage local support for these centers, the Clarinda Institute is barred from providing extension services (those rendered to individuals at places other than the Institute itself) after July 1, 1977 in counties which have not established a community mental health center. Where extension services are rendered within any county by the Clarinda institute, it must be on the basis of an agreement with a local mental health center serving that county and the county must be charged the actual cost of the services (i.e., the Institute may not subsidize extension services by including any portion of the cost in charges made for in-patient services). The bill also authorizes the Clarinda Institute to lease part of its physical

quarter, and adding the cost of direct medical services received by the patient during the calendar quarter; and

b. The charges attributable to each outpatient chargeable to that county who was served by the hospital during the calendar quarter, calculated at the cost established under subsection one (1), paragraph c of this section.

5. A statement shall be prepared for each county to which charges are made under this section. Except as otherwise provided or required by sections one hundred twenty-five point twenty-eight (125.28), two hundred twenty-four A point two (224A.2) and two hundred twenty-four A point three (224A.3) of the Code, the statement shall list the name of each patient chargeable to that county who was served by the hospital during the preceding calendar quarter and the amount due on account of each patient, and the county shall be billed for one hundred percent of the stated charge for each patient. The statement prepared for each county shall be certified by the superintendent of the hospital to the state comptroller and a duplicate statement shall be mailed to the auditor of that county.

Sec. 6. Section two hundred thirty point twenty-one (230.21), Code 1975, is amended to read as follows:

230.21 DUTY OF COUNTY AUDITOR AND TREASURER. The county auditor, upon receipt of ~~such certificate~~ the duplicate statement required by section five (5) of this Act, shall ~~thereupon~~ enter the same to the credit of the state in his ledger of state accounts, and at once issue a notice to his county treasurer, authorizing him to transfer the amount billed to the county by the statement from the county mental health and institutions fund to the general state revenue, which notice shall be filed by the treasurer as his authority for making such transfer~~,~~ ~~and~~. The treasurer shall ~~include~~ promptly remit the amount so transferred ~~in his next remittance of state taxes~~ to the treasurer of state, designating the fund to which it belongs.

Sec. 7. Section two hundred thirty point twenty-two (230.22), Code 1975, is amended to read as follows:

230.22 PENALTY. Should any county fail to pay ~~these bills~~ the amount billed by a statement submitted pursuant to section five (5) of this Act within sixty days from the date ~~of certificate from~~ the statement is certified by the superintendent, the state comptroller shall charge the delinquent county the penalty of one percent per month on and after sixty days from the date ~~of certificate~~ the statement is certified until paid. Provided, however, that the penalty shall not be imposed if the county has notified the comptroller of error or questionable items in the billing, in which event, the comptroller may suspend penalty only during the period of negotiation.

Sec. 8. Section two hundred thirty point twenty-three (230.23), Code 1975, is amended to read as follows:

230.23 COST PAID FROM ~~INSTITUTION~~ MENTAL HEALTH AND INSTITUTIONS FUND. All expenses required to be paid by counties for the care, admission, commitment, and transportation of mentally ill patients in state hospitals shall be paid by the board of supervisors from the ~~state institution~~ county mental health and institutions fund.

Sec. 9. Section four hundred forty-four point twelve (444.12), subsection four (4), Code 1975, is amended to read as follows:

4. Any contribution which the board of supervisors may make to the establishment and ~~initial~~ operation of a community mental health center in the manner and subject to the limitations provided by ~~law~~ chapter two hundred thirty A (230A) of the Code.

Sec. 10. Sections two hundred twenty-seven point sixteen (227.16), two hundred twenty-seven point seventeen (227.17), two hundred twenty-seven point eighteen (227.18), and two hundred thirty point twenty-four (230.24), Code 1975, are repealed.

EXPLANATION

The primary purpose of this bill is to change the method of distributing the state funds now used to assist counties in meeting costs of treatment and care of mentally ill or mentally retarded persons, and to broaden to some extent the purposes for

which counties may use these funds. Appropriations to the four state mental health institutes and the two state hospital-schools for the year which began July 1, 1974 are $15,687,066 and $13,012,000, respectively. Under present law, when these institutions provide care and treatment to persons with legal settlement in Iowa, they bill the counties for this care at 80% of actual daily cost (which is determined on the basis of the state appropriations). This statutory 20% discount is, in effect, a transfer of state funds to counties. The respective counties benefit by this transfer in proportion to the extent they make use of the facilities of the state mental health institutions to meet the needs of their residents for mental health services.

Another transfer of state funds to counties occurs through the state mental aid fund, which assists counties with the cost of mental patients living in county homes or other local facilities. The present annual appropriation to this fund is $1,075,000.

Figures compiled by the Legislative Fiscal Director's office indicate that the total amount received by counties from the state through these two transfer mechanisms, in the year ending June 30, 1974, was $5,696,869. However, none of this money was directly available to any county to meet any portion of the cost of mental health services provided through community mental health centers.

This bill abolishes the state mental aid fund, and requires the mental health institutes and hospital-schools to return to the former practice of billing counties at 100% of daily cost as computed on the basis of appropriations. These two steps will make available the bulk of the $6,300,000 which is to be appropriated to the state mental health reimbursement fund established by this bill. This fund is to be allocated annually among all counties on a population basis, but with the provision that no county's allocation shall be less than that county received from the state in fiscal 1975 in the form of discounts on institutional bills and payments from the state mental aid fund.

County supervisors will have greater flexibility to use the money received from the state for mental health needs in what they consider the most effective ways. They may use all or any part of this allocation (1) to help pay state institutional bills, in which case the effect will be much the same as if the present 20% discount had been continued; or (2) to help pay for care of mental patients in county homes and local facilities, as money received through the state mental aid fund is now used. However, they may also use such funds to help pay the cost of operation of a community mental health center, for which no state aid is presently available in any form.

Section five of this bill requires the state mental health institutes to begin billing on a cost-related basis, which is feasible because of improved accounting practices adopted in recent years. Under this method of billing, the charges made for each patient's treatment more nearly reflect the value of the services that patient actually receives. Under the present method of billing at a single daily patient rate, those persons receiving less costly treatment tend to subsidize those receiving the most expensive services.

Concern about the adequacy of Iowa's present commitment laws first arose, within the Study Committee, in connection with uncertainty about the legal effect of involuntary hospitalization for reasons of mental illness upon the hospitalized individual's subsequent legal competency, status as a voter, etc.* Within the past eighteen months, however, concern has increasingly shifted to the question whether Iowa's current statute would survive a constitutional challenge in the federal courts. Generally similar laws in several other jurisdictions have been found unconstitutional on the ground that they operate to deprive the committed person ob liberty without due process of law. A commentary on the relevant constitutional issues written by Mr. Bezanson--a Univerity of Iowa College of Law faculty member--appears as Appendix I to this supplementary report.

Development of Draft Bill No. 6 began in the fall of 1973, and continued during the early months of the 1974 legislative session, as rapidly as other demands on staff time would permit. A hearing on the second version of the Draft Bill occurred March 14 under the sponsorship of the Senate Human Resources Committee.

In succeeding months, the Subcommittee revised the Draft Bill on the basis of comments received at the March 14 hearing. The third version of Draft Bill No. 6 was completed and distributed in early October, and a public hearing was held on it by the legislative Subcommittee on October 25 in Des Moines. In addition, members of both the legislative Subcommittee and the Joint Subcommittee participated in panel discussions of the draft bill at sessions arranged by the Iowa District Court Clerks Association and the Iowa Psychiatric Society, and copies of the third version were distributed widely to a large number of interested parties throughout the state.

The final meetings of the legislative Subcommittee were held December 3 and December 12, to consider the various comments and suggestions which had been received on the third version of Draft Bill No. 6. Pursuant to actions taken at those two meetings, a fourth version of the Draft Bill has been prepared and is by this report submitted to the 66th General Assembly for its consideration. The Draft Bill is designated "fourth version" rather than final version because the necessary conforming amendments have not yet been completed, and because it is recognized that the bill remains controversial and that the standing committees to which the bill will presumably be referred will wish to give further consideration to some of the major policy questions involved. Nevertheless, Draft Bill No. 4 represents the Subcommittee's judgment as to the policies the state should adopt in this area of law, and the full Study Committee on November 20 authorized the Subcommittee to submit the draft bill to the General Assembly on that basis.

Role of the District Court

One of the questions raised by court decisions in other jurisdictions regarding commitment of mentally ill persons for treatment is whether involuntary hospitalization (viewed as a deprivation of liberty) can constitutionally be done by any agency except a court. Concern about this question led the interprofessional Joint Subcommittee, in its early efforts, and subsequently the legislative Subcommittee to draw Draft Bill No. 6 on the basis of direct handling of commitment proceedings by judges of the district court rather than by the three-member hospitalization commissions which now exist in each county.

Initial reaction to this type of procedure, particularly by county district court clerks, was that it is essentially unworkable because in many smaller counties there is insufficient access to a district court judge to allow prompt handling of hospitalization proceedings. Therefore, the Subcommittee placed in the third version of Draft Bill No. 6 a section which:

- Authorizes the judges in each judicial district to jointly establish, as an arm of the court, a judicial hospitalization commission to perform most of the functions of the district court in hospitalization matters in any county where the judges consider it advisable to exercise this option.

- Makes the judicial hospitalization commission generally similar in makeup to the existing county commissions of hospitalization, except that the clerk of court would provide staff assistance rather than serving as a member of the commission and the third commission member would be a knowledgeable layman.

- Requires the judicial hospitalization commission to follow all substantive procedures specified in the bill for the courts, makes the commission's actions subject to appeal to the district courts, and allows only district court judges to issue orders for immediate custody of a respondent pending a hospitalization hearing.

The Joint Subcommittee, on reviewing the third version of Draft Bill No. 6, expressed the view that the use of a judicial hospitalization commission would be unconstitutional. Also, the legislative Subcommittee received a letter from the County Officers Coordinating Committee expressing opposition to Draft Bill No. 6 in its entirety, but also asserting that if the present Iowa commission of hospitalization statute is unconstitutional then the proposed judicial hospitalization commission would be equally so. The letter appears as Appendix II to this supplementary report.

While the legislative Subcommittee's members do not necessarily agree with these views, they decided upon review of the objections that the judicial hospitalization commission option

should be removed from the fourth version of Draft Bill No. 6. There appears to be little reason to retain in the bill such a provision when virtually no support for it has been expressed outside the membership of the legislative Subcommittee. However, for the information of legislators and others who may have occasion to contemplate the mechanics of implementing Draft Bill No. 6 should it be enacted, the judicial hospitalization commission section from the third version of the Draft Bill appears as Appendix III to this supplementary report.

Draft Bill No. 6, Fourth Version--
Text and Explanatory Comments

The text of Draft Bill No. 6, fourth version, and of the explanatory comments interspersed therein, constitute the balance of this supplementary report.

Mental Health and Juvenile Institutions Study Committee, Subcommittee on Commitment Laws
Draft Bill No. 6 - Fourth Version

December, 1974

Passed Senate, Date_____ Passed House, Date_____

Vote: Ayes_____ Nays_____ Vote: Ayes_____ Nays_____

Approved_____

A BILL FOR

An Act relating to hospitalization of the mentally ill.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

S.F. _____ H.F. _____

Section 1. NEW SECTION. DEFINITIONS. As used in this Act, unless the context clearly requires otherwise:

1. "Mental illness" means every type of mental disease or mental disorder, except that it does not refer to mental retardation as defined in section two hundred twenty-two point two (222.2), subsection five (5) of the Code.

2. "Seriously mentally impaired" or "serious mental impairment" describes the condition of a person who is afflicted with mental illness and because of that illness lacks sufficient judgment to make responsible decisions with respect to his or her hospitalization or treatment, and who:

a. Is likely to physically injure himself or herself or others if allowed to remain at liberty without treatment; or

b. Is likely to inflict serious emotional injury on members of his family or others who lack reasonable opportunity to avoid contact with the afflicted person if the afflicted person is allowed to remain at liberty without treatment.

3. "Serious emotional injury" is an injury which does not necessarily exhibit any physical characteristics, but which can be recognized and diagnosed by a medical practitioner and which can be causally connected with the act or omission of a person who is, or is alleged to be, mentally ill.

COMMENT: The three foregoing definitions are crucial to the central issue of who may be involuntarily hospitalized by reason of mental illness.

One of the points often made in court decisions involving commitment statutes of other jurisdictions is that the legal definition of mental illness is overly broad or vague. Yet, mental illness is a term that is quite difficult to define with the precision that is necessary or desirable in describing a condition on the basis of which one may be deprived of liberty by involuntary hospitalization. In this draft bill, an attempt is made

to evade the problem by retaining a broad definition of the concept of mental illness, while defining more narrowly that kind or degree of mental illness which justifies deprivation of liberty.

The definition of mental illness in subsection 1 is basically that now found in section 229.40 of the Code, except that the present definition does not specifically exclude mental retardation. (However, section 226.8 does bar admission of a mentally retarded person to state mental health institutes unless a professional diagnostic evaluation indicates the admission is appropriate for that particular individual.) Involuntary hospitalization may occur under this draft bill if it appears that the prospective patient is "seriously mentally impaired", i.e., so mentally ill that he or she (1) lacks ability to make responsible decisions about hospitalization or treatment, and (2) is also likely to physically injure himself or herself or others, or to inflict serious emotional injury on other persons.

It is recognized that the concept and the definition of "serious emotional injury" is controversial. It represents a search for a middle ground between those who have argued that involuntary hospitalization should occur only when the prospect of physical injury to the prospective patient himself or herself, or to other persons, can be shown (or when this has actually occurred), and the urging of mental health professionals that some situations which do not involve any threat of physical injury are nevertheless so serious that society is justified in compelling the mentally ill person to accept treatment. Some possible examples of "serious emotional injury" might be a disturbed parent who poses no threat of physical injury to anyone, but persists in directing paranoid statements and epithets at spouse and children, or a person who in manic euphoria makes unrealistic expenditures or

financial commitments that threaten to impoverish his or her family.

4. "Respondent" means any person against whom an application has been filed under section six (6) of this Act, but who has not been finally ordered committed for full-time custody, care and treatment in a hospital.

5. "Patient" means a person who has been hospitalized or ordered hospitalized to receive treatment pursuant to section fourteen (14) of this Act.

6. "Licensed physician" means an individual licensed under the provisions of chapter one hundred forty-eight (148) of the Code to practice medicine (, or a medical officer of the government of the United States while in this state in the performance of his official duties).

7. "Qualified mental health professional" means an individual experienced in the study and treatment of mental disorders in the capacity of:

a. A psychologist certified under chapter one hundred fifty-four B (154B) of the Code; or

b. A registered nurse licensed under chapter one hundred fifty-two (152) of the Code; or

c. A social worker who holds a masters degree in social work awarded by an accredited college or university.

COMMENT: The definition of "qualified mental health professional" is included in order to provide a groundwork for utilizing the expertise or information which these persons may be able to contribute to the disposition of some proceedings in which it is alleged that an individual is seriously mentally impaired. It is NOT intended that a "qualified mental health professional" should in any case supplant a licensed physician in the procedure prescribed by this draft bill, but rather that the qualified professional be given standing to serve as an additional

resource. See section 10 of this draft bill.

8. "Public hospital" means:

a. A state mental health institute established by chapter two hundred twenty-six (226) of the Code; or

b. The state psychopathic hospital established by chapter two hundred twenty-five (225) of the Code; or

c. Any other publicly supported hospital or institution, or part thereof, which is equipped and staffed to provide inpatient care to the mentally ill, except that this definition shall not be applicable to the Iowa security medical facility established by chapter two hundred twenty-three (223) of the Code.

9. "Private hospital" means any hospital or institution not directly supported by public funds, or a part thereof, which is equipped and staffed to provide inpatient care to the mentally ill.

10. "Hospital" means either a public hospital or a private hospital.

11. "Chief medical officer" means the medical director in charge of any public hospital, or any private hospital, or that individual's physician-designee. Nothing in this Act shall negate the authority otherwise reposed by law in the respective superintendents of each of the state hospitals for the mentally ill, established by chapter two hundred twenty-six (226) of the Code, to make decisions regarding the appropriateness of admissions or discharges of patients of that hospital, however it is the intent of this Act that if the superintendent is not a licensed physician he shall be guided in these decisions by the chief medical officer of that hospital.

COMMENT: The second sentence of the foregoing definition has been added at the request of the Department of Social Services, which was concerned about the import

of the definition of a "chief medical officer", and the role assigned that individual under this draft bill, where a state mental health institute has a nonphysician superintendent, as permitted by section 226.2.

12. "Clerk" means the clerk of the district court.

Sec. 2. NEW SECTION. APPLICATION FOR VOLUNTARY ADMISSION--AUTHORITY TO RECEIVE VOLUNTARY PATIENTS.

1. An application for the admission of any person who is mentally ill or has symptoms of mental illness to a public or private hospital for observation, diagnosis, care and treatment as a voluntary patient may be made by:

a. The person seeking admission if he is eighteen years of age or older; or

b. The parent or legal guardian of the person whose admission is sought, if the person is under eighteen years of age.

2. Upon receiving an application for admission as a voluntary patient, made pursuant to subsection one (1) of this section:

a. The chief medical officer of a public hospital shall receive and may admit the person whose admission is sought, subject in cases other than medical emergencies to availability of suitable accommodations and to the provisions of section _____ of this Act.

b. The chief medical officer of a private hospital may receive and may admit the person whose admission is sought.

COMMENT: There has been some objection to the inclusion of section 2 in the draft bill, on the ground that there is no need for the law to regulate the furnishing of hospital services to mentally ill persons on a voluntary basis in any different manner than is the case with persons having other kinds of illnesses.

Concern has been expressed that this section as

previously written could give nonresidents access to Iowa's mental health institutes on the same basis as Iowans. The reference to an unspecified section of this Act will be used to tie into this bill present law regarding the financial basis on which admissions are made, and related matters.

Sec. 3. NEW SECTION. DISCHARGE OF VOLUNTARY PATIENTS. Any voluntary patient who has recovered, or whose hospitalization the chief medical officer of the hospital determines is no longer advisable, shall be discharged. Any voluntary patient may be discharged if to do so would in the judgment of the chief medical officer contribute to the most effective use of the hospital in the care and treatment of that patient and of other mentally ill persons.

Sec. 4. NEW SECTION. RIGHT TO RELEASE ON APPLICATION. A voluntary patient who requests his or her release or whose release is requested, in writing, by his legal guardian, parent, spouse or adult next-of-kin shall be released from the hospital forthwith, except that:

1. If the patient was admitted on his own application and the request for release is made by some other person, release may be conditioned upon the agreement of the patient; and

2. If the patient, by reason of his or her age, was admitted on the application of another person pursuant to section two (2), subsection one (1), paragraph b of this Act, his or her release prior to becoming eighteen years of age may be conditioned upon the consent of his or her parent or guardian, or upon the approval of the juvenile court; and

3. If the chief medical officer of the hospital, not later than the end of the next secular day on which the office of the clerk of the district court for the county in which the hospital is located is open and which follows the submission of the written request for release of the patient, files with

that clerk a certification that in the chief medical officer's opinion the patient is seriously mentally impaired, the release may be postponed for the period of time the court determines is necessary to permit commencement of judicial procedure for involuntary hospitalization. That period of time may not exceed five days, exclusive of days on which the clerk's office is not open. Until disposition of the application for involuntary hospitalization of the patient, if one is timely filed, the chief medical officer may detain the patient in the hospital and may provide treatment which is necessary to preserve his or her life, or to appropriately control behavior by the patient which is likely to result in physical injury to himself or herself or to others if allowed to continue, but may not otherwise provide treatment to the patient without the patient's consent.

COMMENT: In an earlier version of this draft bill, section 4 also included a subsection prohibiting commitment procedure against any voluntary patient whose release has not been requested. That subsection was deleted on advice of the Department of Social Services that voluntary patients must occasionally be committed for nonmedical reasons, usually in connection with a transfer to another state or to a facility such as a county home. Some objections to this deletion have been expressed.

Sec. 5. NEW SECTION. DEPARTURE WITHOUT NOTICE. If a voluntary patient departs from the hospital without notice, and in the opinion of the chief medical officer the patient is seriously mentally impaired, the chief medical officer may file an application for involuntary hospitalization of the departed voluntary patient, and request that an order for immediate custody be entered by the court pursuant to section eleven (11) of this Act.

COMMENT: A suggestion has been advanced that section 5 be expanded to include a specific statement that where a voluntary patient departs from the hospital without notice, and that patient is not considered dangerous, the hospital is relieved of any further responsibility for that patient. The Subcommittee felt that such a provision would have implications that should be carefully considered before a decision is made to include it in the bill, and there was no opportunity to adequately consider the question before reporting this Draft Bill to the General Assembly.

Sec. 6. NEW SECTION. APPLICATION FOR ORDER OF INVOLUNTARY HOSPITALIZATION. Proceedings for the involuntary hospitalization of an individual may be commenced by any interested person by filing a verified application with the clerk of the district court of the county where the respondent is presently located. The clerk, or his or her designee, shall assist the applicant in completing the application. The application shall:

1. State the applicant's belief that the respondent is seriously mentally impaired.

2. State any other pertinent facts.

3. Be accompanied by:

a. A written statement of a licensed physician in support of the application; or

b. One or more supporting affidavits otherwise corroborating the application; or

c. Corroborative information obtained and reduced to writing by the clerk or his or her designee, but only when circumstances make it infeasible to comply with, or when the clerk considers it appropriate to supplement the information supplied pursuant to, either paragraph a or paragraph b of this subsection.

COMMENT: Some concern has been expressed about use

of the term "verified application" in the first sentence of section 6. The requirement of a verified application serves to help impress upon the applicant the seriousness of the step being taken, and perhaps to affirm the applicant's good faith, by making it necessary for the applicant to sign under oath a statement that he or she "verily believes" that all statements made in the application are true. The fact that an application is so verified does not create any presumption that the applicant is correct in believing that the respondent is mentally ill.

There has also apparently been some concern that subsection 3 equates the "supporting affidavits" referred to in paragraph b with a physician's statement. However, the intent is to provide for those situations where the perceived need for hospitalization of the respondent is quite pressing, and for some reason a physician's written statement cannot be expeditiously obtained. In evaluating this provision, it must be kept in mind that the emergency hospitalization procedure provided by section 18 is specifically limited to situations where there is no means of immediate access to the district court.

For similar reasons, the Medical Society-Bar Association Joint Subcommittee suggested and the legislative Subcommittee agreed to add to the Draft Bill the provision which appears as paragraph c of subsection 3 of section 6.

Sec. 7. NEW SECTION. SERVICE OF NOTICE UPON RESPONDENT. Upon the filing of an application for involuntary hospitalization, the clerk shall docket the case and immediately notify a district court judge who shall review the application and accompanying documentation. If the application is adequate as to form, the judge shall direct the clerk to send copies of the application and supporting

documentation, together with a notice informing the respondent of the procedures required by this Act, to the sheriff or his or her deputy for immediate service upon the respondent. If the respondent is taken into custody under section eleven (11) of this Act, service of the application, documentation and notice upon the respondent shall be made at the time he or she is taken into custody.

Sec. 8. NEW SECTION. PROCEDURE AFTER APPLICATION IS FILED. As soon as practicable after the filing of an application for involuntary hospitalization, the court shall:

1. Determine whether the respondent has an attorney who is able and willing to represent him or her in the hospitalization proceeding, and if not, whether the respondent is financially able to employ an attorney and capable of meaningfully assisting in selecting one. In accordance with those determinations, the court shall if necessary allow the respondent to select, or shall assign to him or her, an attorney. If the respondent is financially unable to pay an attorney, the attorney shall be compensated in substantially the manner provided by sections seven hundred seventy-five point five (775.5) and seven hundred seventy-five point six (775.6) of the Code, except that if the county has a public defender the court may designate the public defender or an attorney on his or her staff to act as the respondent's attorney.

2. Cause copies of the application and supporting documentation to be sent as soon as practicable to the county attorney or his or her attorney-designate for review.

3. Issue a written order which shall:

a. Set a time and place for a hospitalization hearing, which shall be at the earliest practicable time; and

b. Order an examination of the respondent, prior to the hearing, by one or more licensed physicians who shall submit a written report on the examination to the court as required by section ten (10) of this Act.

COMMENT: The sequence of the provisions within this section is intended to emphasize the requirement that the respondent have the assistance of counsel at the earliest feasible time in the involuntary hospitalization proceeding. Subsection 2 reflects the requirement of section 12 that the county attorney or his designee present the case for the applicant at the hospitalization hearing.

The sequence of sections 7 and 8 were reversed from that of earlier versions of this draft bill because it appeared inappropriate to try to determine whether the respondent has an attorney, or is able to help select one, until notice of the proceeding has been served on the respondent.

Sec. 9. NEW SECTION. DUTIES OF RESPONDENT'S ATTORNEY. The court shall direct the clerk to furnish at once to the respondent's attorney copies of the application for involuntary hospitalization of the respondent and the supporting documentation, and of the court's order issued pursuant to section eight (8), subsection three (3) of this Act. If the respondent is taken into custody under section eleven (11) of this Act, the attorney shall also be advised of that fact. The respondent's attorney shall attend the hospitalization hearing.

Sec. 10. NEW SECTION. PHYSICIANS' EXAMINATION--REPORT.

1. An examination of the respondent shall be conducted by one or more licensed physicians, as required by the court's order, within a reasonable time. If the respondent is taken into custody under section eleven (11) of this Act, the examination shall be conducted within twenty-four hours. If the respondent so desires, he or she shall be entitled to a separate examination by a licensed physician of his or her own choice. The reasonable cost of such separate examination shall, if the respondent lacks sufficient funds to pay

the cost, be paid from county funds upon order of the court.

Any licensed physician conducting an examination pursuant to this section may consult with or request the participation in the examination of any qualified mental health professional, and may include with or attach to the written report of the examination any findings or observations by any qualified mental health professional who has been so consulted or has so participated in the examination.

2. A written report of the examination by the court-designated physician or physicians, and of any examination by a physician chosen by the respondent, shall be filed with the clerk prior to the hearing date. The clerk shall immediately:

a. Cause the report or reports to be shown to the judge who issued the order; and

b. Cause the respondent's attorney to receive a copy of each report filed.

3. If the report of the court-designated physician or physicians is to the effect that the individual is not seriously mentally impaired, the court may without taking further action terminate the proceeding and dismiss the application on its own motion and without notice.

4. If the report of the court-designated physician or physicians is to the effect that the respondent is seriously mentally impaired, the court shall schedule a hearing on the application 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 is requested by the respondent, or as soon thereafter as possible if the court considers that sufficient grounds exist for delaying the hearing.

COMMENT: The provision for participation of qualified mental health professionals in the examination or evaluation of a respondent in an involuntary hospitalization

proceeding, appearing in subsection 1 of section 10, was added by the Subcommittee in response to the suggestion of a clinical psychologist, who felt that such persons (as defined in section 1, subsection 7) might well be able to make a contribution to the procedure.. Participation of qualified mental health professionals is at the option of the physician because representatives of the medical profession expressed concern that the other professionals might otherwise supplant, rather than supplement, the work of the physician, particularly in areas where psychiatrists are not readily accessible.

Sec. 11. NEW SECTION. JUDGE MAY ORDER IMMEDIATE CUSTODY. If the applicant requests that the respondent be taken into immediate custody and the judge, upon reviewing the application and accompanying documentation, finds probable cause to believe that the respondent is seriously mentally impaired and concludes that immediate custody is appropriate, the judge may enter a written order directing that the respondent be taken into immediate custody by the sheriff or his or her deputy and be detained until the hospitalization hearing, which shall be held no more than five days after the date of the order. The judge may order the respondent detained for that period of time, and no longer, as follows:

1. In a suitable hospital the chief medical officer of which may provide treatment which is necessary to preserve the respondent's life, or to appropriately control behavior by the respondent which is likely to result in physical injury to himself or herself or to others if allowed to continue, but may not otherwise provide treatment to the respondent without the respondent's consent; or

2. In a public or private facility in the community which is suitably equipped and staffed for the purpose, provided that detention in a jail or other facility intended for confinement of those accused or convicted of crime may not

be ordered except in cases of actual emergency and then only for a period of not more than twenty-four hours and under close supervision; or

3. In the custody of a relative, friend or other suitable person who is willing to accept responsibility for supervision of the respondent, and the respondent may be placed under such reasonable restrictions as the judge may order including, but not limited to, restrictions on or a prohibition of any expenditure, encumbrance or disposition of the respondent's funds or property.

COMMENT: The second sentence of section 11, and subsections 1, 2, and 3, were drawn in response to various comments received regarding section 11 of an earlier version of this draft, which provided for persons taken into custody and awaiting a hospitalization hearing to be held in "a medical detention facility". The intent at the time was to subsequently define "medical detention facility" in some appropriate manner, but it appears that circumstances in different parts of the state vary so much that any attempt to write a descriptive definition would probably, in fact, become substantive legislation. That being the case, section 11 instead specifies the places and conditions in which detention may be ordered.

Note that the term "hospital", used in subsection 1 of section 11, is defined in section 1, subsection 10 of the bill.

Sec. 12. NEW SECTION. HEARING PROCEDURE. At the hospitalization hearing, evidence in support of the contentions made in the application shall be presented by the county attorney. During the hearing the applicant and the respondent shall be afforded an opportunity to testify and to present and cross-examine witnesses, and the court may receive the testimony of any other interested person. The respondent

has the right to be present at the hearing. All persons not necessary for the conduct of the proceeding shall be excluded, except that the court may admit persons having a legitimate interest in the proceeding. The respondent's welfare shall be paramount and the hearing shall be conducted in as informal a manner as may be consistent with orderly procedure, but consistent therewith the issue shall be tried as a civil matter. Such discovery as is permitted under the Iowa rules of civil procedure shall be available to the respondent. The court shall receive all relevant and material evidence which may be offered and need not be bound by the rules of evidence. There shall be a presumption in favor of the respondent, and the burden of evidence in support of the contentions made in the application shall be upon the applicant. If upon completion of the hearing the court finds that the contention that the respondent is seriously mentally impaired has not been sustained by clear and convincing evidence, it shall deny the application and terminate the proceeding.

Sec. 13. NEW SECTION. HOSPITALIZATION FOR EVALUATION. If upon completion of the hearing the court finds that the contention that the respondent is seriously mentally impaired has been sustained by clear and convincing evidence, it shall order the respondent placed in a hospital as expeditiously as possible for a complete psychiatric evaluation and appropriate treatment. The court shall furnish to the hospital a written finding of fact setting forth the evidence on which the finding is based. The chief medical officer of the hospital shall report to the court no more than fifteen days after the individual is admitted to the hospital, making a recommendation for disposition of the matter. An extension of time may be granted for not to exceed seven days upon a showing of 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. Extension of time

shall be granted upon request unless the request is contested, in which case the court shall make such inquiry as it deems appropriate and may either order the respondent's release from the hospital or grant extension of time for psychiatric evaluation.

COMMENT: It was suggested at the March 14, 1974 public hearing on the second version of this draft bill that, as some people "are skilled at dissembling, either good or bad," a psychiatric evaluation of less than 15 to 30 days is likely to prove insufficient. However, those whose concern about involuntary hospitalization procedures is oriented toward civil and procedural rights tend to view any prolonged period of hospitalization without court review as at least undesirable, if not unconstitutional. Section 13 attempts to reach a compromise between these viewpoints by providing for both an initial fifteen-day period for psychiatric evaluation, and a seven-day extension when the chief medical officer of the hospital so requests. An extension for an additional seven days, beyond the original fifteen-day period, would bring the total period of evaluation well within the range suggested above. The respondent's attorney is notified if an extension is requested, and has the opportunity to oppose the request if he or she considers it unwarranted.

Sec. 14. NEW SECTION. CHIEF MEDICAL OFFICER'S REPORT. The chief medical officer's report to the court on the psychiatric evaluation of the respondent shall be made not later than the expiration of the time specified in section thirteen (13) of this Act. At least two copies of the report shall be filed with the clerk, who shall dispose of them in the manner prescribed by section ten (10), subsection two (2) of this Act. The report shall state one of the four following alternative findings:

1. That the respondent does not, as of the date of the report, require further treatment for serious mental impairment. If the report so states, the court shall order the respondent's immediate release from involuntary hospitalization and terminate the proceedings.

2. That the respondent is seriously mentally ill and in need of full-time custody, care and treatment in a hospital. If the report so states, the court shall order the respondent's continued hospitalization for appropriate treatment.

3. That the respondent is seriously mentally ill and in need of full-time custody and care, but is unlikely to benefit from further treatment in a hospital. If the report so states, the chief medical officer shall recommend an alternative placement for the respondent and the court may order the respondent's transfer to the recommended placement. If the court or the respondent's attorney consider the placement inappropriate, an alternative placement may be arranged upon consultation with the chief medical officer and approval of the court.

COMMENT: Included in section 15 of the previous version of this draft bill was a provision representing a major change in the philosophy both of the draft bill and of present Iowa law, i.e. the introduction of the concept that a person may be ordered by the court to receive treatment for mental illness on some basis other than full-time hospitalization. Refusal to receive such treatment as ordered would have resulted in the person involved being placed in full-time hospital care. While this presumably would create some incentive for the person involved to cooperate in the court-ordered treatment program, the provision was not basically intended as a sanction. Rather, it was a recognition that the person involved would have been found seriously mentally impaired, as defined in section 1 of this draft bill, and that the welfare of

society requires his or her treatment for this condition. If the person involved refused to cooperate on any other basis, full-time hospitalization would be the only alternative to allowing him or her to remain untreated.

The provision for court-ordered involuntary treatment was removed from this version of the bill by the legislative Subcommittee, somewhat reluctantly, in response both to apparently unanimous opposition by the medical profession (on grounds that the concept is self-contradictory because out-patient mental treatment can succeed only if it is truly voluntary on the part of the patient), and to some expressions of concern on constitutional grounds by attorneys.

Sec. 15. NEW SECTION. PERIODIC REPORTS REQUIRED.

1. Not more than thirty days after entry of an order for continued hospitalization of a patient under subsection two (2) of section fourteen (14) of this Act, and thereafter at successive intervals of not more than sixty days continuing so long as involuntary hospitalization of the patient continues, the chief medical officer of the hospital shall report to the court which entered the order. The report shall be submitted in the manner required by section fourteen (14) of this Act, shall state whether the patient's condition has improved, remains unchanged, or has deteriorated, and shall indicate if possible the further length of time the patient will be required to remain at the hospital. The chief medical officer may at any time report to the court a finding as stated in subsection three (3) of section fourteen (14) of this Act, and the court shall act thereon as required by that section.

2. When a patient has been placed in a facility other than a hospital pursuant to section fourteen (14), subsection three (3) of this Act, a report on the patient's condition and prognosis shall be made to the court which so placed the

patient, at least once every six months. The report shall be submitted within fifteen days following the inspection, required by section two hundred twenty-seven point two (227.2) of the Code, of the facility in which the patient has been placed.

3. When in the opinion of the chief medical officer the best interest of a patient would be served by transfer to a different hospital for continued full-time custody, care and treatment, the chief medical officer may arrange and complete the transfer but shall promptly report the transfer to the court. Nothing in this section shall be construed to add to or restrict the authority otherwise provided by law for transfer of patients or residents among various state institutions administered by the department of social services.

4. Upon receipt of any report required or authorized by this section the court shall furnish a copy to the patient's attorney, or alternatively to the advocate appointed as required by section seventeen (17) of this Act. The court shall examine the report and take the action thereon which it deems appropriate.

COMMENT: The purpose of section 15 is to insure that the court is advised of and has the opportunity to oversee the treatment of the patient to the extent necessary to insure that the patient's constitutional rights are protected, and thereby meet the procedural requirements indicated by various court decisions in recent months and years. It is recognized that this section will impose duties on courts and judges which could prove burdensome--see section 17 of this draft bill.

The question has been raised whether it would be possible under this draft bill for an involuntary patient who wished to do so to become a voluntary patient. It is believed that the chief medical officer would have latitude to report this fact to the court, which could

take appropriate action. However, there is no specific statement to that effect in the draft bill.

Sec. 16. NEW SECTION. DISCHARGE AND TERMINATION OF PROCEEDING. When in the opinion of the chief medical officer a patient who is hospitalized under subsection two (2) or is in full-time care and custody under subsection three (3) of section fourteen (14) of this Act no longer requires treatment or care for serious mental impairment, the chief medical officer shall immediately report that fact to the court which ordered the patient's hospitalization or care and custody. The court shall thereupon issue an order discharging the patient from the hospital or from care and custody, as the case may be, and shall terminate the proceedings pursuant to which the order was issued.

COMMENT: The provisions of this section are set forth separately from section 15 to emphasize their importance and finality.

Sec. 17. NEW SECTION. ADVOCATE APPOINTED. The district court in each county shall appoint an individual who has demonstrated by prior activities an informed concern for the welfare and rehabilitation of the mentally ill, and who is not an officer or employee of the department of social services nor of any agency or facility providing care or treatment to the mentally ill, to act as advocate representing the interests of all patients involuntarily hospitalized by that court, in any matter relating to the patients' hospitalization or treatment under sections fourteen (14) or fifteen (15) of this Act. The advocate shall, wherever practical, be an attorney. The advocate's responsibility with respect to any patient shall begin at whatever time the attorney employed or appointed to represent that patient as respondent in hospitalization proceedings, conducted under sections six

(6) through thirteen (13) of this Act, reports to the court that his or her services are no longer required and requests the court's approval to withdraw as counsel for that patient. The clerk shall furnish the advocate with a copy of the court's order approving the withdrawal. The advocate's duties shall include reviewing each report submitted pursuant to sections fourteen (14) and fifteen (15) of this Act concerning any patient whose interests, as a patient, the advocate is required to represent under this section, and if the advocate is not an attorney, advising the court at any time it appears that the services of an attorney are required to properly safeguard the patient's interests. The court shall from time to time prescribe reasonable compensation for the services of the advocate. Such compensation shall be based upon reports filed by the advocate at such times and in such forms as the court shall prescribe. The report shall briefly state what the advocate has done with respect to each patient and the amount of time spent. The advocate's compensation shall be paid on order of the court from the county mental health and institutions fund of the county in which the court is located.

COMMENT: The provision for a court-appointed advocate to look after the interests of patients hospitalized or being treated under order of the court is intended to help make the reporting requirements of section 15 meaningful. It is unlikely that all attorneys who represent respondents during the legal proceedings preceding hospitalization will have the time or interest to continue following the case, particularly if the necessary treatment is at all prolonged or the attorney is appointed at public expense.

Sec. 18. NEW SECTION. HOSPITALIZATION--EMERGENCY PROCEDURE.

1. The procedure prescribed by this section shall not be used unless it appears that a person should be immediately

detained due to serious mental impairment, but that person cannot be immediately detained by the procedure prescribed in sections six (6) and eleven (11) of this Act because there is no means of immediate access to the district court.

2. In the circumstances described in subsection one (1) of this section, any peace officer who has reasonable grounds to believe that a person is mentally ill, and because of that illness is likely to physically injure himself or herself or others if not immediately detained, may without a warrant take or cause that person to be taken to the nearest available facility as defined in section eleven (11), subsections one (1) and two (2) of this Act. Immediately upon taking the person into custody, the nearest available magistrate, as defined in section seven hundred forty-eight point one (748.1) of the Code, shall be notified and shall immediately proceed to the facility. The magistrate shall in the manner prescribed by section eight (8), subsection one (1) of this Act insure that the person has or is provided legal counsel, and shall arrange for the counsel to be present, if practicable, before proceeding under this section. The peace officer who took the person into custody shall remain until the magistrate's arrival and shall describe the circumstances of the detention to the magistrate. If the magistrate finds that there is probable cause to believe that the person is seriously mentally ill, and because of that illness is likely to physically injure himself or herself or others if not immediately detained, he or she shall enter a written order for the person to be detained in custody and, if the facility where the person is at that time is not an appropriate hospital, transported to an appropriate hospital. The magistrate's order shall state the circumstances under which the person was taken into custody and the grounds supporting the finding of probable cause to believe that he or she is mentally ill and likely to physically injure himself or herself or others if not immediately detained. A certified copy of the order

shall be delivered to the chief medical officer of the hospital where the person is detained, at the earliest practicable time.

3. The chief medical officer of the hospital shall examine and may detain, care for and treat the person taken into custody under the magistrate's order for a period not to exceed forty-eight hours, excluding Saturdays, Sundays and holidays. The person shall be discharged from the hospital and released from custody not later than the expiration of that period, unless an application for his or her involuntary hospitalization is sooner filed with the clerk pursuant to section six (6) of this Act. The detention of any person by the procedure and not in excess of the period of time prescribed by this section shall not render the peace officer, physician or hospital so detaining that person liable in a criminal or civil action for false arrest or false imprisonment if the peace officer, physician or hospital had reasonable grounds to believe the person so detained was mentally ill and likely to physically injure himself or herself or others if not immediately detained.

4. The cost of hospitalization at a public hospital of a person detained temporarily by the procedure prescribed in this section shall be paid in the same way as if the person had been admitted to the hospital by the procedure prescribed in sections six (6) through thirteen (13) of this Act.

COMMENT: Section 18 is a key part of this draft bill. Iowa presently has no specific statutory procedure for handling those situations which occasionally arise late at night or on a weekend or holiday, in which an apparently mentally ill person is acting in ways which threaten harm to himself or herself, or to others, and the situation must be dealt with at once. The procedure prescribed in this section is similar in many respects to that provided by legislation submitted to the 65th General Assembly

but not acted upon. Major additions during development of this draft bill are the provisions in subsection 2 which require (1) that the magistrate immediately begin efforts to insure that the person whose hospitalization is sought has legal counsel and bring the counsel into the emergency proceeding "if practicable", and (2) that the person detained be taken directly to a hospital or other facility and that the magistrate also come there to handle the required hearing procedure. It has been suggested that the term "reasonable grounds" appearing in the first sentence in subsection 2 and the last sentence of subsection 3 should be changed to "probable cause". The legislative Subcommittee decided against this; i.e., a peace officer may take a person into custody under this section if he believes he has "reasonable grounds" to think that person is seriusly mentally impaired. It is to be noted, however, that the magistrate must release the person from custody unless there is "probable cause" to think he or she is seriously mentally impaired.

Sec. 19. NEW SECTION. RIGHTS AND PRIVILEGES OF HOSPITALIZED PERSONS. Every person who is hospitalized or detained under this Act shall have the right to:

1. Prompt evaluation, emergency psychiatric services, and care and treatment as indicated by sound medical practice.

2. In addition to protection of his constitutional rights, enjoyment of other legal, medical, religious, social, political, personal and working rights and privileges which he would enjoy if he were not so hospitalized or detained, so far as is possible consistent with effective treatment of that person and of the other patients of the hospital. The department of social services shall, in accordance with chapter seventeen A (17A) of the Code establish rules setting forth the specific rights and privileges to which persons so hospitalized or detained are entitled under this section,

and the exceptions provided by section seventeen A point two (17A.2), subsection seven (7), paragraphs a and k, shall not be applicable to the rules so established. The patient shall be advised of these rules and be provided a written copy upon admission to or arrival at the hospital.

COMMENT: Subsection 2 of section 20 has been drafted in accordance with enactment in 1974 of the new Administrative Procedure Act. (The citations in subsection 2 apply to the Code of 1975, not earlier editions.) A number of comments have been received on the provisions of subsection 2, at and after each of the public hearing on the previous versions of this draft bill. These have ranged from objections to the subsection on the ground that calling attention to a list of patients' rights will make treatment of patients in mental hospitals more difficult, to requests that the departmental rule approach be discarded in favor of spelling out all patients' rights in law.

Sec. 20. NEW SECTION. RECORDS OF INVOLUNTARY HOSPITALIZATION PROCEEDING TO BE CONFIDENTIAL.

1. All papers and records pertaining to any involuntary hospitalization or application for involuntary hospitalization of any person under this Act, whether part of the permanent record of the court or of a file in the department of social services, are subject to inspection only upon an order of the court for good cause shown.

2. If authorized in writing by a person who has been the subject of any proceeding or report under sections six (6) through thirteen (13) or section eighteen (18) of this Act, or by the parent or guardian of that person, information regarding that person which is confidential under subsection one (1) of this section may be released to any designated person.

Sec. 21. NEW SECTION. MEDICAL RECORDS TO BE CONFIDENTIAL--EXCEPTIONS. The records maintained by a hospital relating to the examination, custody, care and treatment of any person in that hospital pursuant to this Act shall be confidential, except that the chief medical officer may release appropriate information when:

1. The information is requested by a licensed physician who provides the chief medical officer with a written waiver signed by the person about whom the information is sought; or

2. The information is sought by a court order; or

3. The information is requested for the purpose of research into the causes, incidence, nature and treatment of mental illness. Information provided under this subsection shall not be published in a way that discloses patients' names or other identifying information.

Sec. 22. NEW SECTION. EXCLUSIVE PROCEDURE FOR INVOLUNTARY HOSPITALIZATION. Sections six (6) through (15), inclusive, of this Act shall constitute the exclusive procedure for involuntary hospitalization of persons by reason of serious mental impairment in this state, except that nothing in this Act shall negate the provisions of sections two hundred forty-five point twelve (245.12) and two hundred forty-six point sixteen (246.16) of the Code relative to transfer of mentally ill prisoners to state hospitals for the mentally ill.

COMMENT: As presently worded, section 22 may be too far-reaching. A final decision on the provisions of this section should be made only when the scope of this draft bill has been decided upon. For example, a question has been raised as to whether this section would create a conflict with the criminal sexual psychopath law.

Sec. 23. NEW SECTION. HOSPITALIZATION NOT TO EQUATE WITH INCOMPETENCY--PROCEDURE FOR FINDING INCOMPETENCY DUE TO MENTAL

ILLNESS.

1. Hospitalization of any person under this Act, either voluntarily or involuntarily, shall not be deemed to constitute a finding of or to equate with nor raise a presumption of incompetency, or to cause the person so hospitalized to be deemed a lunatic, a person of unsound mind, or a person under legal disability for any purpose including but not limited to any circumstances to which sections four hundred forty-seven point seven (477.7), four hundred seventy-two point fifteen (472.15), five hundred forty-five point two (545.2), subsection thirteen (13), five hundred forty-five point eleven (545.11), subsection seven (7), five hundred forty-five point thirty-six (545.36), five hundred sixty-seven point seven (567.7), five hundred ninety-five point three (595.3), five hundred ninety-seven point six (597.6), five hundred ninety-eight point twenty-nine (598.29), six hundred fourteen point eight (614.8), six hundred fourteen point nineteen (614.19), six hundred fourteen point twenty-two (614.22), six hundred fourteen point twenty-four (614.24), six hundred fourteen point twenty-seven (614.27), six hundred twenty-two point six (622.6), six hundred thirty-three point two hundred forty-four (633.244), six hundred thirty-three point two hundred sixty-six (633.266), subsection four (4), and six hundred seventy-five point twenty-one (675.21) of the Code are applicable.

2. The applicant may, in initiating a petition for involuntary hospitalization of a person under section six (6) of this Act or at any subsequent time prior to conclusion of the involuntary hospitalization proceeding, also petition the court for a finding that the person is incompetent by reason of mental illness. The test of competence for the purpose of this section shall be whether the person possesses sufficient mind to understand in a reasonable manner the nature and effect of the act in which he or she is engaged; the fact that a person is mentally ill and in need of treatment

for that illness but because of the illness lacks sufficient judgment to make responsible decisions with respect to his or her hospitalization or treatment does not necessarily mean that that person is incapable of transacting business on any subject.

3. A hearing limited to the question of the person's competence and conducted in substantially the manner prescribed in sections six hundred thirty-three point five hundred fifty-two (633.552) through six hundred thirty-three point five hundred fifty-six (633.556) of the Code shall be held when:

a. The court is petitioned or proposes upon its own motion to find incompetent by reason of mental illness a person whose involuntary hospitalization has been ordered under sections thirteen (13) or fourteen (14) of this Act, and who contends that he or she is not incompetent; or

b. A person previously found incompetent by reason of mental illness under subsection two (2) of this section petitions the court for a finding that he or she is no longer incompetent and, after notice to the applicant who initiated the petition for hospitalization of the person and to any other party as directed by the court, an objection is filed with the court. The court may order a hearing on its own motion before acting on a petition filed under this paragraph. A petition by a person for a finding that he or she is no longer incompetent may be filed at any time without regard to whether the person is at that time hospitalized for treatment of mental illness.

4. Nothing in this Act shall preclude use of any other procedure authorized by law for declaring any person legally incompetent for reasons which may include mental illness, without regard to whether that person is or has been hospitalized for treatment of mental illness.

COMMENT: No substantive change has been made in either of the two preceding sections, as compared to the

previous versions of this draft bill. The terminology used in the second sentence of subsection 2, section 24, is based on Notes of Decisions, item 2, following section 229.40, Iowa Code Annotated.

It is recognized that a number of conforming amendments revising or repealing present statutes in accordance with this bill are necessary before the bill is ready for introduction. These amendments will be prepared as soon as possible.

APPENDIX I

Involuntary Hospitalization of the Mentally Ill--

I - Constitutional Issues

by Randall P. Bezanson

A threshold problem is where to start in a memorandum of this sort. Rather than proceeding on an analysis of the particular provisions of Iowa's current legislation or the proposed bill, I will address the issue more generally, defining some of the basic constitutional guarantees bearing on the commitment process. I will proceed, so far as possible, in a generally chronological manner.

At the outset, two points should be made. First, constitutional requirements should most appropriately play only a secondary role in any commitment legislation. The primary goal should be to seek the fairest, most accurate, and most effective process for the treatment and ultimate release of persons suffering from mental disorder. To the extent that such an "ideal" system based on these premises would satisfy constitutional requirements--or even exceed them--those constitutional requirements should play no important role. If for reasons of fairness and policy we provide more protection than the constitution requires, we should not retreat to the constitutional minimum simply because that document would require less. The issue is different, of course, where the constitution would require more, and it is from this perspective that I will address the question.

A second point is that a remarkable thorough analysis of the relevant state statutes and constitutional guarantees may be found in a 200-page article in a recent issue of the Harvard Law Review. Note, Developments in the Law--Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190 (1974).

The balance of this memorandum will be devoted to an enumerated list of selected constitutional issues that are raised by the current Iowa commitment statute and bear on the proposed statute.

1. The Statutory Standard for Commitment. The central constitutional issue raised under this heading concerns whether dangerousness in some form is a prerequisite for commitment to full-time hospitalization of the mentally ill. I think it can be safely stated that the clear and recent trend of decision is to require that a person exhibit dangerous tendencies as a precondition to full-time hospitalization. See, e.g., Cross v. Harris, 418 F. 2d 1095 (D.C. Cir, 1969); People v. Stoddard, 227 Cal. App. 2d 40 (Dist. Ct. App. 1964); Davy v. Sullivan, 354 F. Supp. 1320 (M.D. Ala. 1973); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded on other grounds, 94 S. Ct. 713 (1974); Welsch v. Likins, No. 4-72-Civ. 451, slip op. at 15

(D. Minn., Feb. 15, 1974). The issue, of course, is more difficult than this. It appears from the cases that physical injury to self or others will suffice, as well as a threat of severe emotional injury to others. People v. Stoddard, supra.

Interestingly enough, there is a growing body of authority to the effect that the constitution requires commitment on the least restrictive terms, even in those cases where it is otherwise justified. See Lessard v. Schmidt, supra; Dixon v. Attorney General, 325 F. Supp. 966 (M.D. Pa. 1971); Kesselbrenner v. Anonymous, 33 N.Y. 2d 161 (1973); Welsch v. Likins, supra. This view is quite consistent with well-established constitutional doctrine in many other areas, and accordingly is deserving of substantial weight. Our proposed bill, as most recently amended, satisfies this constitutional requirement, for it permits commitment by the commission or district court for out-patient treatment. This is a position which I have held ever since completion of the commitment study in 1970, and I was very happy to see it incorporated in the recent draft.

Other issues, of course, abound in relation to the statutory standard for commitment: what is the permissible definition of mental illness; is the standard unconstitutionally vague; does the standard incorporate (as ours does) a requirement of "treatability"? Without going into these matters, my off-hand judgment is that the proposed bill satisfies the constitution in all pertinent respects. The old statute, both in its definition of mental illness and its failure to require that the committed patient be a fit subject for treatment in all cases, is deficient.

2. Procedural Rights--Notice. While the Supreme Court has not directly addressed the issue of the extent of due process protection which must be afforded the civilly committed person, its opinions in closely allied areas virtually preclude the view that due process does not apply. E.g., In re Gault, 387 U.S. 1 (1967); Goldberg v. Kelly, 397 U.S. 254 (1970); Richardson v. Perales, 402 U.S. 401 (1971); Jackson v. Indiana, 406 U.S. 715 (1972); Morrissey v. Brewer, 408 U.S. 471 (1972). With this in mind, I will simply offer my opinion as to those procedural protections which due process most likely requires. First, notice to the patient is most assuredly required; where notice would be ineffective or dangerous, emergency commitment and temporary detention under the safeguards prescribed in our bill would suffice. Whether or not notice is served on the prospective patient directly or through counsel if immediately retained may not be of great constitutional moment where custody is not immediate, but our bill provides for notice to both and is thus the best and safest means of providing clear notice.

3. Procedural Rights--Hearing. Detention prior to a hearing for purposes of evidence gathering and evaluation is not absolutely prohibited, but the permissible length of detention is circumscribed. The Lessard court held that a preliminary hearing must be held within 48 hours of custody. While a longer period may

well pass constitutional muster, there seems little reason to test the point, and the proposed bill doesn't, as a 48-hour period is prescribed there as well.

The preliminary hearing further serves to eliminate in large measure the time pressure for a full hearing. Our bill provides that the full hearing must take place within about 15 days of the preliminary hearing, and this is consistent with the opinion in the Lessard case. While a longer period may well pass constitutional scrutiny, any delay in excess of 20 or 25 days would, in my judgment, be pressing the outer limits. Indeed, as the normal period of hospitalization does not exceed 30 days in many cases, permitting a delay of that length would in effect eliminate the hearing altogether. The benchmark must be identified in view of the principle reasons or justifications for delay. Delay cannot at this stage be justified by a need for treatment, for commitment itself has not taken place, and therefore treatment of the patient before the hearing may raise substantial constitutional questions. Rather, the delay can be justified only in order that diagnosis be made and the state and individual have ample time to prepare for the hearing. In view of this a 15-day limitation would seem fully adequate in all but the rarest of cases.

4. Right to Counsel. While Iowa now provides appointed counsel for the prospective patient, mention should at least be made of the constitutional underpinnings of this right. In view of abundant Supreme Court authority in related areas, as well as most if not all recent cases decided in lower courts, there seems little room for argument that counsel need not be provided. And it seems clear as well that the right to counsel attaches immediately after the information has been filed or the patient has been taken into custody. E.g., In re Gault, supra; Heryford v. Parker, 396 F. 2d 393 (10th Cir. 1968); Lessard v. Schmidt, supra.

5. Right to Jury Trial. The right to a jury trial in the civil commitment setting has not attracted much attention in prior decisions, although a few recent cases have held that juries are constitutionally mandated. See Lessard v. Schmidt; Quesnell v. State, 517 P. 2d 568 (Wash. 1973). The weight of authority, however, seems contrary to this position, as the Supreme Court has refused to extend the jury trial right in highly analogous contexts. In re Gault, supra; McKeiver v. Pennsylvania, 403 U.S. 528 (1971). The weight of reason, as well, disfavors the jury trial, at least when not requested by the patient, for the likelihood of prejudice on the jury's part in this context seems accute.

6. Right to Judicial Officer. The reasons supportive of a right to jury trial, however, are that through the device of the jury the nonmedical components of the commitment decision are separated from the medical judgment. Commitment is not strictly a medical decision. Accordingly, while a jury may not be required, there is some force in the argument that a judge or panel composed of nonmedical personnel (subject to immediate and direct review by

a court) must make the ultimate commitment decision. This view is all the more forceful in light of the difficult legal questions which will constantly arise in the commitment setting: procedural rights; standard of proof, and the like. See Lessard v. Schmidt. It is noteworthy, as well, that many states now require judges in the commitment process, and at least five states either require or permit jury trial. Alaska Stat. section 47.30.070(h); Tex. Rev. Civ. Stat. ann. arts 5547-48; Ala. Code tit. 45, section 210; Ark. Stat. Ann. 6 59-101; D.C. Code ann. section 21-545(a). (Alabama and Arkansas make the right discretionary with the judge.)

7. Standard of Proof. It seems well settled that at the very least the prospective patient must be shown to be seriously mentally ill by clear and convincing evidence or by a preponderance of the evidence. The real question lies elsewhere. A number of fairly recent decisions have taken the position that serious mental illness must be established beyond a reasonable doubt. See, e.g., Lessard v. Schmidt, supra; In re Bailey, 482 F. 2d 648 (D.C. Cir. 1973). The reasonable doubt standard has been required in the analogous juvenile setting, In re Winship, 397 U.S. 358 (1970), although the nature of the issues to be determined in the civil commitment setting are arguable more vague than in the juvenile setting, and thus one might conclude that the reasonable doubt standard would simply be unworkable in the instant context. While I believe that there is much truth to this observation, it must be carefully employed. Any admission that mental illness cannot be proved beyond a reasonable doubt raises serious questions about the legitimacy of civil commitment itself. I would hate to tell someone that the standard of proof is less simply because we know we are guessing or speculating about the very condition with which we are so concerned. For present purposes, however, I think a requirement of proof by clear and convincing evidence, coupled with the extensive diagnosis and the periodic review which is required under the proposed bill, is constitutionally sufficient.

8. Miscellaneous Matters. By labelling the following issues as "miscellaneous" I do not intend to depreciate their significance, but rather to indicate that my analysis of them has not been as thorough. First, I think the patient's presence at the hearing is constitutionally required, at least in the absence of substantial disruption or a clear and unequivocal waiver of that right by the individual. A right to appeal is also required, with appointed counsel at this stage, as now provided in the Iowa Code. So also, I think, is a periodic reporting of the patient's status required, although the relevant time intervals are not clear. Finally, a right to treatment has become almost universally recognized, although many of the cases justify it on statutory rather than constitutional grounds. Nonetheless, treatment is the only justification for commitment and involuntary hospitalization, and it would shock one's conscience to say that no right to treatment existed in light of this. An exhaustive list of cases decided on this point can be found in the Harvard Law Review article cited above, at pages 1316-1344.

There are two other issues on which I have done no research, but about which I have some tentative feelings. First, does the prospective patient have a privilege against self-incrimination? If so, the medical examination required under the proposed bill would be substantially undermined. Second, may parents constitutionally "commit" their children against their will on a voluntary basis? While this issue is not clear from a constitutional point of view, I think a case can easily be imagined where a child hospitalized under such conditions could successfully challenge the validity of his or her confinement.

In my judgment the proposed bill satisfies the constitution. The current statutes, however, fail to do so in significant respects.

APPENDIX II

COUNTY OFFICERS COORDINATING COMMITTEE

December 6, 1974

Senator John S. Murray
Chairman, Sub-Committee on Commitment Laws
Mental Health and Juvenile Study Committee
c/o Iowa Legislative Service Bureau
State House
Des Moines, Iowa 50319

Dear Senator Murray:

The County Officers Coordinating Committee at their regular meeting on November 20, 1974, discussed at length the proposed revision of Iowa Law pertaining to civil commitment for the treatment of mental illness.

The Committee, organized in 1955, is comprised of representatives from the County Supervisors Association, County Auditors Association, County Clerks Association, County Home Administrators, and Administrators of the six institutions within the Division of Mental Health Resources, and Central Office personnel.

The new commitment bill authorizes judges to delegate commitment to a Judicial Hospitalization Commission. This, in fact, is practically identical to the present Hospitalization Commission process, except that it would substitute a lay person for the Clerk. If the present law is unconstitutional, this part of the new commitment bill would also be unconstitutional. It would also place an additional burden on the already overloaded courts, greatly increase the duties of the Clerks, and there is an indication the administrative cost to the counties would be considerable.

For the above-stated reasons, the Committee went on record as opposing the enactment of this bill.

Sincerely,

COUNTY OFFICERS COORDINATING COMMITTEE

Wilbur Rust, President
Grundy County Auditor

WR/aw

S.F. _____ H.F. _____

APPENDIX III

Judicial Hospitalization Commission

The following is the proposed judicial hospitalization commission section which appeared in the third version of Mental Health and Juvenile Institutions Study Committee Draft Bill No. 6, but was deleted from the fourth version for the reasons explained in this supplementary report of the Commitment Laws Subcommittee.

Sec. ___. NEW SECTION. JUDICIAL HOSPITALIZATION COMMISSION.

1. As soon as practicable after the adoption of this Act the judges in each judicial district shall meet and shall determine, individually for each county in the district, whether it is practical for the district court in that county to perform the duties prescribed by sections seven (7) through sixteen (16), inclusive, of this Act. In any county in which the judges find it impractical for the district court of that county to so act, the chief judge of the district shall appoint a judicial hospitalization commission. The judges in any district may at any time review their determination, previously made under this subsection with respect to any county in the district, and pursuant to that review may establish a judicial hospitalization commission, or abolish it, in that county.

2. Each judicial hospitalization commission shall consist of three members, all of whom shall be residents of the county in which the commission is established. One member, who shall preside in all proceedings of the commission, shall be an attorney engaged in the practice of law in that county, one member shall be a physician engaged in the practice of medicine in that county, and the third member shall be a person who has demonstrated an informed interest in the field

of mental health. For purposes of this subsection, such interest may be demonstrated by volunteer work in areas related to mental health as well as by professional experience in related fields.

3. When established in any county, the judicial hospitalization commission shall perform all of the duties which would otherwise be performed by the district court of that county pursuant to sections seven (7) through sixteen (16) of this Act, inclusive, except that if a request is made for an order that a respondent be immediately taken into custody under section eleven (11) of this Act, the request must be referred to and such order may be entered only by a judge of the district court.

4. Any respondent with respect to whom the judicial hospitalization commission has found the contention that he or she is seriously mentally ill sustained by clear and convincing evidence presented at a hearing held under section twelve (12) of this Act, or the respondent's next friend, may appeal from that finding to the district court by giving the clerk thereof, within thirty days after the commission's finding has been made, notice in writing that an appeal is taken. The notice may be signed by the appellant or his agent, next friend, guardian or attorney. When so appealed, the matter shall stand for trial de novo. Upon appeal, the court shall schedule a hospitalization hearing at the earliest practicable time. The court may, but shall not be required to, order a new examination of the appellant by one or more licensed physicians.

5. If the appellant is in custody under the jurisdiction of the judicial hospitalization commission at the time of service of the notice of appeal, he shall be discharged from custody unless a judge of the district court enters, or has previously entered, an order that the appellant be taken into immediate custody under section eleven (11) of this Act, in which case the appellant shall be detained

as provided in that section until the hospitalization hearing before the district court. If the appellant is in the custody of a hospital at the time of service of the notice of appeal, he 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. In that case, the appellant shall remain in custody of the hospital until the hospitalization hearing before the district court.

6. The hospitalization hearing before the district court shall be held, and the judge's finding shall be made and an appropriate order entered, as prescribed by sections twelve (12) and thirteen (13) of this Act. If the judge orders the appellant hospitalized for a complete psychiatric evaluation, jurisdiction of the matter shall revert to the judicial hospitalization commission.

7. Each member of the judicial hospitalization commission shall receive forty dollars per diem for each day or portion of a day actually devoted to the duties of the office, and shall be reimbursed for actual and necessary expenses incurred in the course of such service.

8. The clerk of the district court in each county in which a judicial hospitalization commission is established shall provide the clerical services required by the commission in the performance of its official duties.

COMMENT: This section seeks to effect a compromise between the view that only a court may constitutionally involuntarily hospitalize (i.e., deprive of liberty) a person, and the urgent representations to the legislative Subcommittee that in many areas of the state it is simply impossible

for the courts, as presently organized, to assume this additional burden. The proposed "Judicial Hospitalization Commission" would be similar in many respects to the present Commission of Hospitalization, but would be legally an arm of the court. Also, the clerk of court would no longer be a member, but would continue to provide staff services to the Commission.

The Commission would exercise nearly all of the functions of the district court, if the judges of the district conclude that it is not feasible for the district court itself to perform this role in any given county. The sole exception is that only a district judge could issue an order to take into immediate custody a person whose involuntary hospitalization is being sought. The finding of the Commission could be appealed by any person ordered hospitalized for a psychiatric evaluation, but if the finding should be upheld upon trial in the district court, jurisdiction reverts to the Commission to receive the required reports from the hospital, etc.