F I N A L R E P O R T

NEW STATE MENTAL HEALTH AGENCY STRUCTURE SUBCOMMITTEE OF THE JOINT SENATE AND HOUSE STANDING COMMITTEES ON HUMAN RESOURCES

December, 1978

The New State Mental Health Agency Structure Subcommittee of the Senate and House Standing Committees on Human Resources was created as a response to the passage in 1978 of H.F. 2440, which included provisions setting July 1, 1979 as the target date for the establishment of a unified state mental health agency, and prospectively repealed the statutes which created the Iowa Mental Health Authority and the present Division of Mental Health Resources of the Department of Social Services. Legislators appointed to the Subcommittee were:

Senator Rolf V. Craft
Senator Alvin V. Miller
Senator Charles P. Miller
Senator Elizabeth R. Miller
Senator Tom Slater
Representative B. J. Clark
Representative Gregory D. Cusack
Representative Lyle R. Krewson
Representative Joyce Lonergan
Representative Craig D. Walter

Five meeting days were initially authorized by the Legislative Council.

At its initial meeting August 29, 1978, Senator Slater and Representative Lonergan were elected Co-chairpersons. Formal presentations included: (1) a review of legislative initiatives culminating in H.F. 2440 and House Concurrent Resolution 146 by Phil Burks of the Legislative Service Bureau; (2) an outline by Bill Howard of the Iowa State Association of Counties (ISAC) of the areas of study to be covered in a consultant study which was proposed by a Mental Health Coalition formed pursuant to ISAC's initiative, but which was not in fact undertaken; (3) testimony outlining the problem areas in the delivery of mental health services in Iowa by Norman Pawlewski, Commissioner of Public Health, who recommended that any reorganization of mental health services create a unified mental health agency within the Department of Health; (4) testimony stressing the probable futility of reorganization unless the state is willing to spend more dollars on mental health services and urging that any reorganization create an educationally-related, independent department of mental health, by John Langhorne, Associate Director of the Iowa Mental Health Authority (IMHA); and (5) testimony stressing that the Department of Social Services is interested in carrying out legislative directives rather than controlling mental health services and

cautioning that size per se does not connote unmanageability, by Victor Preisser, Commissioner of Social Services.

Public Hearings

The Subcommittee voted to hold five public hearings on the remaining four authorized meeting days and to utilize the areas of study listed in House Concurrent Resolution 146 as points of departure for public response. A document was prepared by the Subcommittee staff and sent to individuals, groups and agencies interested in the delivery of mental health services in Iowa. The document outlined the background of the Subcommittee's study and suggested the following items as subjects for public comment: (1) pre-admission screening of mental health institute (MHI) patients (which county boards of supervisors may require under H.F. 2440); (2) funding; (3) the concept of consortia arrangements for delivery of mental health services; (4) planning; (5) standards of quality; (6) continuity of care; and (7) structure of a unified state mental health agency.

The five public hearings were held as follows: Storm Lake, September 18; Council Bluffs, morning of September 19; Des Moines, evening of September 19; Waterloo, October 3; and Mt. Pleasant, October 4. The staff prepared a 17-page document summarizing the testimony of approximately 43 hearing participants, to which eighty-five pages of written documents submitted by hearing participants were attached. A number of copies of this summary document remain available in the Legislative Service Bureau office. A synopsis of the most-widely-held concerns follows.

In general, most speakers favored pre-admission screening and felt that reduced admissions to the mental health institutes would result, allowing more people to remain in the community as productive individuals while at the same time proving cost-effective. Certain areas of the state are currently not served by prescreening units. Most support for prescreening was expressly or impliedly conditioned on the availability of adequate alternative care in the community, suggesting that prescreening cannot be fully effective until the entire state is fully served by community mental health centers with adequate prescreening resources. Other significant questions raised were the cost of prescreening, the categories of professional persons authorized to prescreen, the role of the county supervisors, the role of law enforcement officials, and the legal rights of patients to refuse mandated prescreening, to reject the decision of the prescreening professional, and to select the care facility and type of care. Although not directly related, the problem of confidentiality of recipients' names when the county supervisors are asked to pay a portion of a treatment fee has apparently not been completely resolved. One speaker called any solutions differentiating between rich and poor in this matter a bad policy.

As regards funding, most hearing participants were concerned with the historically heavy reliance upon property taxes. Local community mental health personnel viewed this reliance as basic in the development of locally-initiated and virtually autonomous community services. However this reliance has resulted in absolutely no services in a few areas of the state and in a limited scope of services in some existing centers. Many speakers acknowledged the need for additional funding sources but were concerned with the loss of local control and feared increased costs of administration without a concomitant improvement in the quantity or quality of services. Matching federal start-up funds were skeptically viewed by some speakers because of their significant decline after start-up. Proposals include the following: (1) to fund state incentive grants or categorical grants to help counties establish local services where none now exist; (2) to decrease the counties obligation for support of MHI patients from 80% to 60% of total cost; (3) to earmark county mental health funds for local services; (4) to route all available mental health funds to the county supervisors to be used at their discretion; and (5) to totally fund the MHIs through the state while funding community services entirely through the county.

Concerning the creation of locally-controlled, multi-county consortia of mental health providers and consumers, most recommendations were somewhat vague. Supporters of the concept in western Iowa viewed the proper consortia functions as planning, coordination of services, and monitoring. Consortia as a mechanism to comply with federal regulations or to achieve Joint Commission on the Accreditation of Hospitals (JCAH) accreditation was mentioned. Opposition was strongest in eastern Iowa, where consortia were viewed as externally-imposed planning structures simply comprising another level of government which would increase administrative costs and diminish local control. Limited support generally stressed that consortia not disturb local autonomy but rather function to insure grassroots input and integration of services in the statewide planning and coordination of services. Recommendations generally envisioned either a quadrant division of the state, with Polk County as a fifth division, or a seven or eight region division.

Planning was most often referred to as a cooperative function among local providers, consumers, and the public. Many speakers favored local citizen advisory committees. A few speakers, who generally opposed a change in the present system, thought that planning should be a local function with little or no review at the regional or state level. The greatest number of speakers advocated initial local planning with some regional review, possibly limited to scrutiny of significant budget increases. A smaller number of speakers favored planning at all levels to develop a comprehensive state plan eligible for federal funding. Other recommendations included the following: (1)

utilization of the University of Iowa as a center for research, education, and planning; (2) opposition to federal population-based needs-assessment planning while favoring actual market-test assessment planning; (3) approval of all planning programs by the governing unified state agency and the federal Health Systems Agency; and (4) including in the planning process the functions of the county clerks of court and the services of public health nurses; (5) integration in the planning process of substance abuse and job-related services; and (6) the establishment of and integration in the planning process of group homes, half-way houses for schizophrenics, programs for autistic persons, and public education.

The principal concern in the development of standards of mental health care for Iowa was expressed by most hearing participants as a commitment to realistically attainable and flexible standards adopted after an opportunity for local input. Most comments centered on whether the proposed IMHA standards or the JCAH standards would be most appropriate for Iowa's community mental health centers (CMHCs). Center personnel opposed the imposition of JCAH standards due to fear that administrative costs would increase greatly with little if any improvement in services. While some speakers maintained that only local standards are appropriate, others favored minimal statewide uniformity with continued support in the standards for local initiative and setting of priorities. Support for the stricter JCAH standards came from those who believe the IMHA standards are deficient since they are not mandatory, and from those feeling the JCAH standards will be tied in the future to third-party payments and therefore adopted in some form as national standards.

Continuity of care from one provider to another provider was regarded as good by a number of hearing participants who noted that the MHIs and the CMHCs voluntarily refer patients back and forth and that center personnel routinely make consultative visits to the institutes. However, some speakers believe that improvement is needed. Assertions that center personnel work well with other local providers were also heard. A greater variety of negative and positive relationships between the centers and the county care facilities was indicated. Several speakers suggested that some patients will always "fall through the cracks" by simply exercising their rightful option not to receive further treatment. Continuity of care, in terms of the statewide availability of an adequate array of mental health services, is very uneven depending upon location rather than upon need. Southwestern Iowa is reportedly badly underserved, while other areas of the state are well served although gaps and variances exist there also. One speaker indicated that all counties should be served by CMHCs in seven years if the past rate of growth is maintained. Other speakers were skeptical that the remaining, unserved counties--most of which have a limited property tax base--could ever institute even minimal local mental health services unless state or federal funding were

available. Deficiencies were noted in the following service areas: elderly services, mobile treatment units, services for autistic children, half-way houses and group homes, employment opportunities and sheltered workshops, in-home services, visiting nurses, training and rehabilitation, and temporary recommitment procedures.

Concerning the structure of a new unified state mental health agency, a substantial majority of hearing participants indicated that the concept of a separate state department of mental health is either favored or could be accepted, albeit reluctantly in some cases. Persons reluctantly accepting the separate-department concept had as their first choice the retention of the status quo, at least administratively. This favoring of the status quo, however, should not be interpreted as satisfaction in all cases with the scope of and accessibility to mental health services in all parts of the state. Little support was expressed for placing the new state agency within any existing state department, although the Department of Health was favored over the Department of Social Services if confronted with this limited choice.

The Mental Health Association of Iowa is on record as supporting the creation of a separate department governed by an eleven-member commission appointed by the Governor, as well as the formation of an advisory council and regional boards, numbering seven or eight, to insure grassroots participation in the development of a state mental health plan as well as integration of local programs. The Community Mental Health Centers Association of Iowa is also on record as supporting a separate department, opposing consolidation with any existing agency other than IMHA in its current affiliation with the University of Iowa. The Association's CMHC executive directors group presented a suggested organizational pattern for a new state mental health department. The suggested organizational pattern includes a nine-member commission appointed by the Governor as the policy-making body, an advisory body, and a state director to be appointed by and to serve at the pleasure of the commission. The new department would contain three administrative divisions; community mental health services, coordination and support services, and mental health institutes. (The Social Action Committee of the Mental Health Association subsequently submitted a different proposal, calling for an eleven-member commision, a separate advisory body, and a state director all appointed by the governor, and a department consisting of four divisions; administration, program, standards and evaluation, and consumer representation.)

The county care facilities, whose residents are in many cases there by reason of mental illness, are not included in the above suggested organizational pattern. A degree of responsibility for or control over the county care facilities by the new state agency was advocated, however, by a number of hearing participants although a smaller number opposed the removal of the county care facilities from the responsibility of the county supervisors.

Three prevalent comments voiced during the hearings were that a unified mental health agency might damage local initiative, limit or destroy local autonomy, and impose added administrative costs without improving services. One speaker said that centralization would eventually lead to uniformity and mediocrity while others believe that the necessity of delivering services statewide outweighs the undesirable effects of uniformity on local control, that local initiative is not always the better route, and that state agency responsibility is not always the worst way to assure availability of mental health services at the local level. In response to Subcommittee questions a number of speakers philosophically favored the eventual inclusion of substance abuse programs in a new unified state mental health agency although most agreed that it would not be feasible to initially include the Department of Substance Abuse in the new unified mental health agency.

Later Meetings

In October the Subcommittee requested and received approval for two additional meeting days from the Legislative Council. At its November 15 meeting the Subcommittee heard testimony from Frank T. Harrison, Chairperson of the Commission on Substance Abuse, and from Gary P. Riedmann, Director of the Iowa Department of Substance Abuse (IDSA). They reported that IDSA currently relates to the Division of Mental Health Resources within the Department of Social Services, IMHA, and the CMHCs through:

a. Planning and coordination on the substate level--representatives from IMHA, the CMHCs, and the MHIs participate in district planning for mental health and substance abuse services; potential coordination areas include licensure and accreditation issues, MHI preadmission screening, and referrals for family counseling.

b. Referral agreements between IDSA programs and CMHCs and MHIs--in four cities substance abuse projects are a part of the CMHC administration; the Cherokee MHI houses an IDSA-funded substance abuse treatment program.

c. Training--CMHC and MHI staffs participate in IDSA--sponsored training events.

d. Detoxification--the MHIs provide detoxification and residential services for substance abusers; local substance abuse programs provide aftercare.

Mr. Harrison and Mr. Riedmann oppose the merger of IDSA with a unified state mental health agency at this time, commenting that the past year has been spent cooperatively developing a sense of direction for the newly-combined alcoholism and drug abuse

services and that the next year will see the implementation of the newly-developed program of licensing standards and management information systems, with another year needed to refine and build on these accomplishments. They both felt merger would create confusion when real progress and growth are beginning to show good results.

Dr. Marvin Julius and Ms. Diane Heins from the Iowa Association for Retarded Citizens (IARC) also testified on November 15, explaining the distinction between mental illness and mental retardation, and presenting a chart outlining the complexity of state and federal services for the mentally retarded. The Association opposes moving mental retardation services outside the Department of Social Services, maintaining that the creation of a new agency will not solve the problem of coordinating mental retardation services. Should the Legislature create a unified mental health agency within the Department of Social Services, the Association recommends mental retardation services be given equal administrative status with mental health services.

The Subcommittee on November 15 requested the Legislative Service Bureau staff to begin drafting a proposed committee bill which would establish a unified mental health agency as a separate state department. The initial draft was prepared in two alternative forms, one based on the CMHC executive directors suggestion and the other on the Mental Health Association Social Action Committee proposal, both described earlier. Each of these alternatives included as an option the inclusion of the present Department of Substance Abuse within the new department. The county care facilities and mental retardation services are not to be included in the draft. The request for the draft was not intended to be a final committee proposal but rather a point of departure. The creation in this draft of a separate mental health department was thought to be principally beneficial in grasping the necessary relationships which would have to be legislatively developed between a unified mental health agency and other state departments, whether or not the unified agency is finally created within or outside an existing state department.

Development of Resource Material

Staff services for the Subcommittee have been furnished by the Legislative Service Bureau, Legislative Fiscal Bureau, Senate and House majority and minority caucus staffs, and Mr. Frank Primmer, who until December 1 was employed as a Human Resources Committee staff person under a grant obtained from the federal Department of Health, Education and Welfare. On November 15, a number of resource materials was distributed by the staff.

The Legislative Fiscal Bureau has sought information to provide a better picture of the overall mental health funding

effort in Iowa. On November 15, Dick Davis of the Fiscal Bureau reported via memorandum that this data collection, when completed, should report the proportional contribution to the CMHCs' budget from county, Title XIX, federal and other funds, the combined expenditures by county for the two largest providers of mental health care, i.e., the CMHCs and MHIs, and expenditures at the county care facilities and other facilities other than at the CMHCs or MHIs.

Mr. Primmer informed the Subcommittee on November 15 that his HEW project report should be complete before the final Subcommittee meeting. The report contains four chapters. Chapter I discusses the Iowa mental health provider network and major state and federal legislation relating to each provider. Chapter II studies problems and issues reviewed from 1967 to 1978 in six special legislative interim subcommittees and four outside study reports, including comprehensiveness of services, coordination and quality assurance, information collection and dissemination, planning, and funding. Chapter III reviews alternative mental health service delivery systems in five other states. Chapter IV establishes a decision-making guide to identify priorities and to establish priority roles and levels of participation. Concluding Mr. Primmer's report is a recommendation for legislation establishing priorities among service constituencies, for rank ordering priorities under budgetary constraints, and for establishing allowable, preferred, and required service modalities. At least a limited number of copies of Mr. Primmer's final report, 76 pages in length, should be available when the 68th General Assembly convenes or shortly thereafter.

The Department of Social Services provided a packet of materials outlining departmental services for the mentally retarded at the various state institutions and at the community level. Particularly instructive are the first three tables, which list 22 different types of departmental services provided by 4 different methods to 3,228 mentally retarded persons in 17 different types of living arrangements.

A packet of materials was also distributed from the State Board of Regents containing information on the in-state training and job-placement of professional and para-professional mental health personnel. This material was gathered after a participant in the public hearings, Dr. Joy Menne, suggested that mental health professionals trained in Iowa are leaving the state to find employment elsewhere.

The University of Northern Iowa indicated that 213 persons were trained in 1977-78 for fields related to mental health and that, with few exceptions, these graduates are employed in Iowa.

Iowa State University indicated that its social work program graduates 30 to 40 persons a year with about 30% accepting mental health-related positions, probably 75% of which are in-state. The Department of Child Development reported approximately 35 graduates per year who are approved to teach preschool handicapped children, 90% of whom are employed in-state. The Department of Psychology reported graduating 26 persons with advanced degrees in school psychology or counseling psychology in the last three years with approximately 60% employed in-state. The Department of Family Environment reported no statistics but listed student practicum placements and graduate job placements related to mental health services.

The University of Iowa School of Social Work reported 16 practicum sites in which mental health training is a central learning experience, and outlined the use of National Institute of Mental Health grants for the training of 53 students in mental health and aging, psychiatric social work, and community mental health. Of the 53 students, 35 were known to be employed in mental health related settings of whom 70% were employed in-state. The number of social work graduates known to be employed in mental health centers is 118, and 201 are employed in mental health related agencies.

The Department of Psychiatry of the University of Iowa College of Medicine has 7 first-year positions in its residency training program in adult and pediatric psychiatry. The Department of Social Services oversees 9 first-year positions in its psychiatric residency programs in the MHIs at Cherokee and Independence. The University of Iowa has graduated 48 psychiatrists in the last 13 years, 24 of whom have located in Iowa. The number of graduates in the next decade is expected to be approximately 75% greater than in the last 10 years due to the increase in psychiatric residency enrollment. The University of Iowa also reported that 30 family practice residents with an orientation in psychiatry have entered private practice in the past three years. The Department of Psychology reported that 5 to 6 students complete the doctoral training program in clinical psychology each year. Of the 30 most recent graduates 8 accepted positions within the state.

Subcommittee Recommendations

At its final meeting of the 1978 interim, held December 19, the Subcommittee considered the two alternative partial drafts prepared pursuant to its directions at the November 15 meeting. By virtue of decisions arrived at on December 19, the Subcommittee will transmit to the Standing Committees on Human Resources at the Sixty-eighth General Assembly, for further consideration and continued development, a partial draft bill including the following major provisions:

-Creation of a separate new state Department of Mental Health, combining the present functions of the Iowa Mental Health Authority at Iowa City, those of the Division of Mental Health Resources of the Department of Social Services (exclusive of the Division's responsibility for the Hospital-Schools at Glenwood and Woodward, which will remain with the Department of Social Services), and--as of July 1, 1981--the functions of the present Iowa Department of Substance Abuse.

-Establishment of a seven-member State Mental Health Commission, appointed by the Governor for staggered six-year terms, as the policy-making body for the new Department.

-Designation of a Director of Mental Health, appointed by and serving at the pleasure of the Governor, as chief administrative officer of the new Department.

-Internal organization of the new Department into major divisions on a functional basis, rather than in a manner reflecting present jurisdictions of the existing agencies being combined to form the new Department.

-Imposition upon the new Department of responsibility for oversight of the operation of county care facilities, insofar as those facilities serve as residences for chronically mentally ill persons.

-Making the pre-admission screening of mental health institutes admittees, which is optional under House File 2440 of the 1978 Session, mandatory by July 1, 1980.

The Subcommittee is well aware that further, important decisions must be made, both about the content of the draft bill it is transmitting and in the broader field of state policy on the funding and delivery of mental health services in Iowa. The Subcommittee recommends that the standing Committees on Human Resources of the Sixty-eighth General Assembly examine in particular the following areas:

1. Mental health funding alternatives, including such options as per capita payments to counties, increased payments for care of mentally ill persons in county care facilities, bloc program grants, increasing the state's share of the cost of care of patients in the mental health institutes, or some combination of those options.

2. Specifying the number, approximate boundaries, and responsibilities of a number of mental health sub-state areas or regions in Iowa, and the structure and responsibilities of a citizens board in each; also, how to insure efficient utilization through such a regional structure of particular facilities in the state, such as the new Broadlawns mental health facility in Polk County.

3. Changing the composition of the Mental Health Advisory Council, established by House File 2440 of the 1978 Session, to reflect and represent the regions referred to in item 2.

4. Extent of the proposed new Department's authority over licensing or accreditation.

5. Supervision of the patients' advocates, appointed under section 229.19 of the Code, and inclusion of substance abusers in their responsibilities.

6. Inclusion in the mental health statutes of a privacy clause similar to that in the substance abuse law, appearing in Code section 125.16 as amended in 1977.