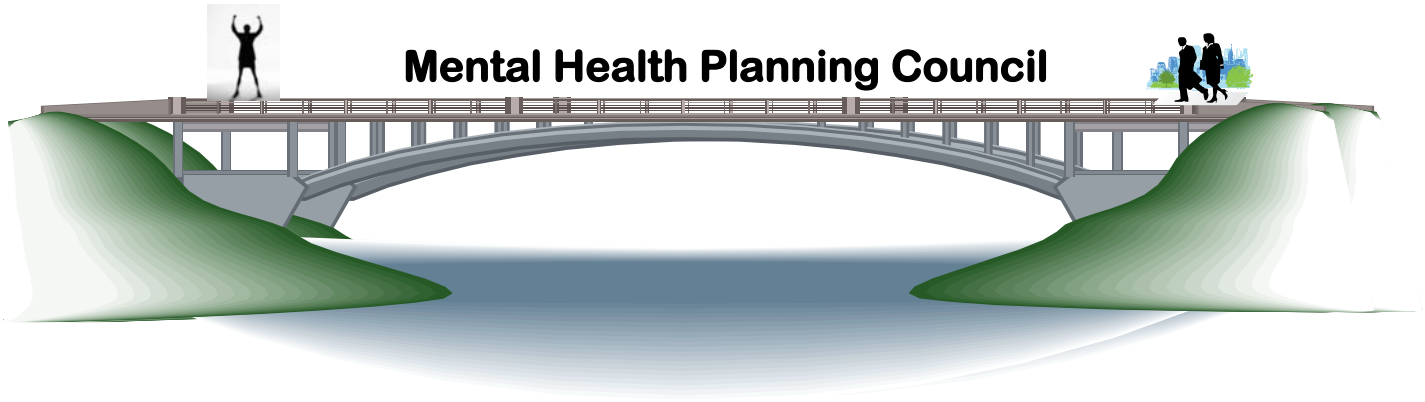

Bridging the Gap for Iowans with Mental Health Issues

Iowa Mental Health Planning Council Comments and Recommendations
RE: 2011 Mental Health and Disability Redesign Preliminary Recommendations Report

The Iowa Mental Health Planning Council respectfully presents for your consideration comments and recommendations on 2011 Mental Health and Disability Redesign Preliminary Recommendations Report.

In our presentation to the Iowa Council on Human Services Annual Public Hearing on August 10 in Des Moines, we prefaced our comments and recommendations with the following introductory statement. We feel it is most appropriate we repeat this statement to you:

It is always important for all of us to never forget why we chose to be on State Councils and Commissions and who we represent. In the case of the Mental Health Planning Council, it is clear what our responsibilities are.

First and foremost, we must speak on behalf of the people the Mental Health System is supposed to serve and we are therefore, obligated to speak truth to power….as an advocate for human rights and to insist on accountability to a very vulnerable population.

We are realists and we all realize the limitations of and the demands placed on our elected officials and the civil servants who work for the County, State and Federal governments. Be that as it may, we must still be forthright and strong in our advocacy. It is morally and ethically wrong for us to ignore the unacceptable conditions which exist.

The service system is inadequate in meeting the needs of adults, children, families and veterans living with mental illness in the State of Iowa. It has been inadequate for an excruciatingly long time and further reductions in services continue to add more insult, more injury and more deaths.

The Iowa Mental Health Planning Council endorses the recommendations of the workgroups subject to the following comments and concerns.

It is our fundamental belief – the proposals are financially possible and politically possible if state legislators, individuals, families, advocates, veterans and other concerned citizens find their voice - and as a result - definite decisions and legislation are passed to fund and implement the redesigned mental health and disability system.

Funding
Workforce
Regions
Legal Settlement
Treatment beds
Accountability of the Private Health Insurance Industry
Missing pieces

Funding

- Additional funding for the system to continue this coming fiscal year is critical to prevent system collapse. The proposed additional funding needed is estimated to be $56 million.
- Adequate funding will be central to the success of the redesign effort. We recommend funding continue to be a state-county partnership. Legislation should be introduced to restore the county's ability to levy for mental health and disability services. Instead of a frozen dollar amount that a county can raise, institute a range of acceptable amounts per $1000 of property valuation for counties to choose from (for example: $1.50 to $2.50/1000).
- Any business dependent on one source of income is in an insecure and dangerous financial situation. If services are to be administered regionally and provided locally, counties should be given options to participate financially.
- Adequate provider reimbursement is also a funding mechanism which can either encourage or discourage the development of community services which are the basis of the redesigned system.
- The impact of veteran's demands will continue to grow with veterans with traumatic brain injury and mental illness. If present providers and services are already oversubscribed – where is the capacity to address the needs of veterans and their families? A large part of the solution to reach this additional population resides in sufficient funding.
- Patience will be needed to wait for the cost savings to occur. Initially, more money will be needed to implement the redesigned system – a reality of any system transformation.
- Potential cost savings for maximizing treatment in the community rather than prison and jail is substantial. Study after study shows treatment in the community has better outcomes and has less financial impact on taxpayers than incarceration. One of the quickest ways to find savings is to do more jail and hospital diversion but this will require additional funding.
- Incorporation of practical guidelines for mental illness prevention and mental health promotion in the schools and primary care settings so early intervention is possible and the severity of disability is diminished - is a future cost savings to be realized. More mental health services and education are needed in our schools. More mental health screening is needed in primary care settings.

Workforce

- A taskforce to address workforce issues should be called together immediately. The lack of an adequate workforce will cripple redesign efforts.
- Access to adequate community-based services (viable options outside institutions) are only made possible by an adequate workforce.
- The use of paraprofessionals in rural areas is a critical issue to supplement the workforce. In the absence of available physicians and psychiatrists, nurse practitioners should be allowed to complete an assessment for commitment and direct care.
- The workforce must reflect
    - cultural and ethnic diversity,
    - peer support,
    - be reflective of the needs for all disabilities across the entire life span
    - multi-occurring capable
    - available state-wide, not just in the urban areas
    - and aided by mandates or incentives for advanced degree positions to stay in Iowa.
- Workforce efforts should be aided wherever possible by technology (such as telemedicine), and be integrated with primary care for holistic treatment.
- All State departments dealing with workforce need to work together on this initiative along with DHS, IDPH, consumer and family representation.

Regions

Regions will be the framework for change. Regions will need to be in place for the rest of the system to blossom. It is important for this first step of system transformation be implemented as soon as possible with a flexible vision of how the new redesigned system will reflect its capabilities:

- Continuum of care for the provision of welcoming holistic care
- Multi-occurring capable at all system levels to eliminate the silos and barriers to effective treatment
- Should reflect the rich cultural diversity of our state
- Be inclusive of all disabilities across the entire life span

To assure a table of collaboration is set, representation from law enforcement and primary care should be on the governing body along with the county supervisor representatives of a region, and consumer and family members. We recommend each Region complete a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis of their geographical area and complete a business plan on how they will reach all goals within 5 years.

Legal Settlement

There are two proposals for residency in the preliminary report.

The Adult Mental Health workgroup indicates an eligible person to be a "resident of Iowa".

In the Regional workgroup, the recommendation is the definition as approved by the MHDD Commission:

> *"County of residence" means the county in Iowa, where, at the time an adult applies for or receives services, the adult is living and has established an ongoing presence with the declared, good faith intention of living permanently or for an indefinite period. The "county where a person is living" does not mean the county where a person is present for the purpose of receiving services in a hospital, a correctional facility, a halfway house for community corrections or substance abuse treatment, a nursing facility, an intermediate care facility for persons with mental retardation, or a residential care facility, nor for the purpose of attending a college or university. For an adult who is an Iowa resident but fails within the exclusion for "county where a person is living" as described in this rule, the county where the adult is physically present and receiving services shall be the county of residence. The county of residence of an adult who is a homeless person is the county where the adult usually sleeps.*

The Iowa Mental Health Planning Council recommends the simpler definition of "resident of Iowa" be adopted to rid the system of the wasted time and dollars spent to determine which county pays. We don't want a regional legal settlement issue replacing the county legal settlement issue. Wherever a person presents needing service is where the services are paid for. The primary concern should be access to the services a person needs.

Treatment Beds

We have a collapsing system outside of the corrections system. Immediate action should be taken.

- Mental Health Institutes – we speak out against the on-going reduction of beds at our state institutions, both on the adult and the juvenile sides, especially since there are so few. In some areas of the state there are no alternatives for inpatient treatment to individuals who may be dangerous to self and others. Similar to county services and the HCBS waiver system, waiting lists exist at the MHI's and critical cases are being turned away.
- Public hospital beds are being closed and those left are full every day, 365 days a year, turning critical cases away for lack of beds and/or staff.
- The lack of crisis stabilization and sub-acute care beds so persons needing longer term care can recuperate and acute care beds can be available for those meeting acute care criteria.
- The lack of detox beds
- The lack of co-occurring treatment beds
- The new construction of beds is occurring on prison campuses, not in the public or private sector.

Accountability of the private health insurance industry

Iowa will not have a redesigned "mental health and disability system" until the private insurance industry is held accountable. The efforts of the current redesign of the mental health and disability system focus on publicly financed services. A new Mental Health Parity law should be passed which requires private insurance companies:

- To have mental health and disability coverage in every policy they issue in Iowa. The federal Mental Health Parity Act – Domenici-Wellstone – does require mental health parity in services, but only "if" a policy includes mental health coverage.
- Should include coverage for all disabilities through a continuum of care of services which are "recovery based".
- Should have a comparable set of core services which are publicly financed.

Is there something wrong with the picture that private insurance should only be required to cover people who are well? Or to pick and choose which medical conditions are deserving of coverage?

Missing Pieces of the Redesign report which were either not identified for discussion and/or were not fully addressed

1. Medication – There is a "disconnect" between the perceived needs of individuals, families and advocates and the Medicaid program regarding medications for mental illness.

Individuals, families, and advocates know how critical the right medication is in achieving and maintaining recovery. We know "one size does not fit all". To many it appears that generics are "good enough" for this population based on the criteria of price. There has been no evaluation of cost savings or study of adverse human costs since open access was denied for mental health medications.

In further detriment to this vulnerable population, rules were enacted (without the availability for public comment) to reduce the 30 day prescription to a 15 day prescription for new medications. This has increased paperwork and approval burden to providers as well to timely access of medications to consumers. Once again, there has been no evaluation of cost savings or study of adverse human costs since this rule was implemented.

2. Waiting lists – There is no provision for the assessment of "need" for services in the proposal. It is the Council's recommendation that Regions should maintain and report on "waiting lists for services" so the public and the state legislature can assess the adequacy of the mental health and disability system as redesigned and funded.

3. Suicide prevention services are needed for both youth and adults. While there is a draft state suicide prevention plan with goals – what practical steps can individuals, families, and communities take to meet those goals and reduce the number of attempted and completed suicides? There are over 330 suicides every year in Iowa compared to 50 homicides a year. We need to be reacting with urgency to this public health crisis.

Veterans are at particular risk for suicide. Since the VA began their suicide prevention lifeline 2-3 years ago:

462,854 total calls to VA's Crisis Line at 800-273-8255
259,891 calls from veterans
6,030 calls from active duty service members
16,855 "rescues" of veterans and service members
10,000 veterans from all war periods call VA's crisis hotline each mo.
In the last two years more of our service members completed suicide than were killed by the enemy.
An average of 18 veterans from all wars completes suicide every day.

http://www.veteransforcommonsense.org/index.php/veterans-category-articles/2517-vcs *Veterans for Common Sense*

4. Re-write of commitment laws - The Judicial Workgroup needs to address a re-write of the commitment laws to facilitate a change from a singularly focused "crisis based system based on suicide or homicide" to one including the assistance of people to treatment at the appropriate level of care.

The above comments and recommendations are respectfully submitted as approved on November 16, 2011.

Teresa Bomhoff
Iowa Mental Health Planning Council Chairperson