Mental Health Systems Improvement in Iowa:

A Report to the Legislature and Governor

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January 31, 2008

Memorandum

To: Attached Distribution List
From: Allen Parks, EdD, MPH, Administrator/Director, Division of Mental Health and Disability Services, Iowa Department of Human Services
Date: January 28, 2008
Subject: Division Recommendations and Comments on Mental Health Systems Improvement Workgroups Report
Copy: Kevin W. Concannon, Director – Iowa Department of Human Services

Per last year's Appropriation Bill (S909), the Legislature directed the Department of Human Services, Mental Health and Disability Services to convene workgroups, prepare a report of the workgroups, request review by the MHMRDDBI Commission of the report of the workgroups and comment to the Legislature and the Governor on or before January 31, 2008 on major findings and recommendations.

Attached to this email please find the *Mental Health and Disability Services Recommendations and Comments on the Report of the Workgroups on Mental Health Systems Improvement* (MHDS Report). Also attached are the following APPENDICES:

A: Overview and Statement of Need for MHDS Information Systems
B: Framework for a State Mental Health Authority position paper
C: Draft Amendments to Ch. 230A – Community Mental Health Centers
D: Draft Emergency Mental Health Crisis Response Services Code
E: Draft Emergency Mental Health Crisis Response Services Request for Proposals
F: Draft Community Mental Health Centers Act
G: Co-Occurring Disorders Policy Academy Charter
H: Behavioral Health Workforce Vision
I: Behavioral Health Workforce Data
J: MHDS Legislative Proposals
K: Evidence-Based Practices
L: Workforce Development Proposal
M: A View of the Data
N: Community Mental Health Center and Central Point of Coordination Survey Data
O: Recommendations from the Workgroups and Steering Committee on Mental Health Systems Improvement

We would be pleased to discuss further with you the Division's Comments and Recommendations as well as the Appendices and specifically legislative proposals contained herein.

This past year the MHDS requested, and obtained approval of the two legislative proposals contained in APPENDIX J, from the Human Services Council. These two proposals are currently in development with legislative staff in LSB 5362 DP Emergency Mental Health Crisis Services and LSB DP 5355 Children's Mental Health Services. The MHDS is also seeking funding of a Mental Health and Disability Services

Training Institute (APPENDIX L) through reallocation of a portion of what is currently referred to as "psych papers" funds.

I would like to once again express my appreciation to the consumers, family members, advocates, providers, Human Services Council, all of the workgroups, steering committee members, Co-occurring Disorders Policy Academy, Acute Mental Health Task Force, Children's Oversight Committee, Mental Health Planning Council, members of the MHMRDDBI Commission, our partnership agencies and various technical advisors for their patience and ongoing assistance. This report is a culmination of hundreds of people over nearly a year and scores of workgroup, steering committee, task force, and other stakeholder meetings. It has been a pleasure to work with all of the individuals involved who have the shared vision of building and improving, step by step, the Iowa mental health system. Thanks to one and all.

Sincerely,

Allen W. Parks, EdD, MPH
Administrator/Director
Division of Mental Health and Disability Services
Iowa Department of Human Services

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Recommendations and Comments from the Department of Human Services, Division of Mental Health and Disability Services on the *Report of Workgroups on Mental Health Systems Improvement*

Establishment of Workgroups:

As directed by the Iowa Legislature's 2007 HF909, and in order to build upon the partnership between the state and counties in providing mental health and disability services in the state, the Iowa Department of Human Services (DHS) Division of Mental Health and Disability Services (MHDS) established six workgroups for planning and recommendation purposes and engaged equal proportions representing the Department, counties, and service providers. Statewide associations representing counties and community providers appointed county and provider representatives to the workgroups. In addition, each workgroup included a representative of the MHMRDDBI Commission, the Mental Health Planning Council, consumers, and a statewide advocacy organization. Per HF909, workgroups were established for discussion and recommendations in each of the following areas:

- Alternative Distribution Formula,
- Community Mental Health Center Plan,
- Core Mental Health Services,
- Evidence-based Practices,
- Co-occurring Disorders, and
- Accreditation

Formulation of recommendations was to lead to comprehensive plan items. The workgroups met during the summer and fall of 2007. In order to draft a report of the workgroups, MHDS requested that each of the workgroups elect two members from each work group to participate in a steering committee to meet after the workgroups had met and in order to prepare a report for the Commission, the DHS Director, the Legislature and the Governor.

Explanation of the Documents:

Following over fifty meetings that involved over 100 stakeholders, the workgroup-elected steering committee members, MHDS and DHS staff, and technical advisor expert consultants prepared the *Report on the Workgroups on Mental Health Systems Improvements. The Report on The Workgroups* was distributed to the MHRMRDDBI Commission in the months of September through December 2007.In several Commission meetings, workgroup representatives and Steering Committee representatives verbally presented summary findings to the Commission. A written draft report was submitted to the Commission in December 2007. The comments and distribution of documents were reflected in the minutes of the Commission's meetings. Although not required in FH909, the Commission held a public hearing on the *Report of the Workgroups*. On December 13, 7007, the Commission's hearing was held, and verbal and written testimony was offered at a number of locations around the state.

This document, along with the *Report of the Workgroups and Steering Committee on Mental Health Systems Improvements*, and a number of additional documents prepared by MHDS are included with this submission to the Legislature and Governor's office. This document summarizes key recommendations from the *Report of the Workgroups*, prioritizes them, and additional information is provided by the MHDS to begin to design a comprehensive plan. The MHDS is offering this compendium based on a belief in the need for the integration of the key

recommendations of the workgroups since standing alone, no one set of recommendations from any individual workgroup would provide sufficient information to develop a comprehensive plan.

Each section in the following describes the purpose and scope of the Workgroup and the key recommendations from MHDS. Where indicated, explanations are also listed and APPENDICES containing supporting documents are referenced.

Alternative Distribution Formula

This Workgroup required that the Department submit a final report to the chairpersons and ranking members of the General Assembly's committees on Human Resources and the Joint Appropriations subcommittee on Health and Human Services, and to associated legislative staff, and the Governor's office on or before January 31, 2008.

The legislation requested that the Workgroup identify alternative formulas for distributing mental health, mental retardation, and developmental disabilities allowed growth factor adjustment funding to counties. The alternative formulas were to provide methodologies that, as compared to the current methodologies, more readily understood and better reflect the needs for services, respond to utilization patterns, acknowledge historical county spending, and address disparities in funding and service availability. The formulas should serve to strengthen the partnership between the Department and counties in the state's services system. The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS does not support the majority of the recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee pertaining to Alternative Distribution Formula.

Explanation: During the course of workgroup meetings, several factors became evident:

1. The workgroups lacked adequate county information about the utilization of services to accurately model various funding mechanisms.
2. It was likely that the scope of the workgroup was too narrow and failed to account for major structural changes needed in the overall approach to funding all mental health and disability services and this could not be addressed within the scope of addressing only allowed growth factors.
3. Other issues, such as state and local taxation policy, global concepts of funding health care, and other large-scope issues often were discussed but outside of the scope of the Workgroup.
4. MHDS recommendations to contain the scope to the legislative mandate were resisted by some workgroup and steering committee members during the project process.
5. The development of case rate models (a core recommendation of the workgroup) could not be accurately prepared due to #1 above.
6. As a result of some of these factors, the MHDS has prepared a statement on Information Systems.
7. The global issue of funding the mental health and disability service system continues to be problematic and technical expertise on taxation models needs to study and make recommendations on this in the future.

For further information, see:
APPENDIX A Information Systems

Community Mental Health Centers

The plan shall be submitted to the Governor and General Assembly on or before January 31, 2008. The workgroup should prepare a phased plan for increasing state responsibility for and oversight of mental health services provided by community mental health centers and the providers approved to fill the role of a center. The plan shall provide for an initial implementation date of July 1, 2008. Proposed administrative rules and legislation to amend chapter 230A as necessary to implement the core services beginning July 1, 2008 should be reviewed. The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS supports the following recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee:

1. Develop Emergency Mental Health Crisis Response Services in response to a major systems need.
2. Develop Children's Mental Health Services, as they are non-existent in many counties.
3. Develop School Mental Health Services with the CMHCs throughout the state to offer mental health expertise to families and students.
4. Begin to regionalize CMHCs through funding multi-CMHC projects to serve low-incidence populations (those that are typically high cost programs to individual counties) through collaborative operation of services.
5. Address significant behavioral health workforce issues in all regions of the state.
6. Review the current rate of payment for mental health services to determine if the current rate covers the actual cost of service provision. Included in this also should be a review of the rates for substance abuse and co-occurring mental illness and substance abuse disorders services.
7. Establish the State Mental Health Authority (SMHA) as the statewide policy-making entity for required core safety net services and establish that the CMHCs are primary providers of those services.
8. Establish the SMHA as the statewide oversight entity of other mental health services and service providers (i.e., accrediting body).
9. Determine the role, relationship, and responsibilities of the SMHA and the counties regarding financing and managing the public mental health system:
   a. Endorse that the SMHA is responsible for funding services identified as required core "Safety Net" services (i.e., non-federal portion of Medicaid; Emergency Services, funding for uninsured/underinsured),
   b. Endorse that the SMHA is responsible for the financing of the non-federal portion of all other community level mental health services funded through Medicaid.
   c. Ensure that individual counties are responsible for funding other mental health services based on local need as identified in the *County Management Plan*. This should include responsibility for other local service needs for children.
   d. Delineate in greater detail the contents and requirements for reporting to the SMHA by counties in their County Management Plans.
10. The non-federal portion of community level mental health services remain with one entity and become the responsibility of the SMHA.

    Note: There was considerable discussion in the workgroup about delineation of financial responsibilities for payment for the non-federal portion of mental health services funded through Medicaid being split between the state and the counties. State responsibility for financing the non-federal portion of some Medicaid funded mental health services (i.e., required core Safety Net services) and County responsibility for financing other Medicaid funded mental health services can result in competing interests, influence service provision based on funding responsibilities rather than clinical need, and/or result in other unintended consequences that can negatively impact service access and provision for adults, youth, and their families.

11. Revise *Chapter 230A: Community Mental Health Centers* to enhance the state's role in oversight, funding, and support of CMHCs.

12. Revise *Chapter 24* to:
    a. Establish minimum standards for accreditation of CMHCs as an agency with responsibility for required core safety net services.
    b. Establish standards for accreditation of emergency mental health crisis response services.
    c. Change accreditation of other mental health service providers. Focus on accreditation standards for services rather than providers (i.e., providers would then need to meet standards for a service to provide that service).
13. Revise, amend, or develop other related areas of Iowa Code and/or Administrative Code to be consistent with Mental Health Systems Improvement recommendations.
    a. Involve relevant stakeholders when appropriate (i.e., County Staff, CMHC Reps, Commission, IME, etc.).
    b. Include language clarifying the role of the SMHA.
    c. Assess accreditation process of other MH service providers (i.e., accreditation by individual service or by provider entity). Incorporate necessary changes as it relates to changes, additions of Medicaid services.
    d. Utilize the support and expertise of others such as consultants and legislative staff.
    e. Ensure accreditation standards for mental health service providers and related mental health service standards (i.e., Habilitation Services, Remedial Services, and Psychosocial Rehabilitation, Children's Mental Health Waiver, etc.) are consistent with Mental Health Systems Improvement recommendations.
    f. In collaboration with the Judicial System, include an assessment and recommend revisions to code related to voluntary and involuntary psychiatric commitments (Ch. 229).
14. Convene a workgroup or task force of representative stakeholders to analyze larger funding issues such as the amount of funding needed for safety net services that address the financing for uninsured, underinsured, and uncompensated care.
    a. Assess how current county/state funding is being utilized for uncompensated care (i.e., determine what is being matched to Medicaid, what is not, etc.).
    b. Determine state/county responsibility and role in financing the statewide system (i.e., who is responsible for what segments? Where are responsibilities shared?).
    c. Determine if there is existing funding that can be leveraged for Medicaid services.
    d. Analyze the feasibility of leveraging other federal dollars or other Medicaid options such as: Medicaid administrative funding, the Medicaid TEFRA Option, increasing the utilization of the HCBS Waivers, maximizing the Medicaid buy-in program for people with disabilities.
    e. Assess the pros, cons, and unintended consequences related to funding responsibilities and financing mechanisms.
    f. Utilize a financing model that supports the service needs of consumers and youth, removes cons and other unintended negative consequences, promotes collaboration (and eliminates cost shifting) across responsible parties, and contributes to the successful implementation of Mental Health Systems Improvement.
    g. Coordinate the findings of this group with MHDS and IME regarding related revisions, additions in services in the Medicaid State Plan or new Medicaid Administrative funding.

15. DHS establish a multi-agency workgroup with MHDS and IME to revise the Medicaid State Plan and the various Medicaid service options related to mental health so that Medicaid Service Options are consistent with and support the Mental Health System Improvement efforts:
    a. Add/revise services that support the financing of core required Safety Net services (i.e., Emergency Mental Health Crisis Response Services, Intensive Case Management Services, Peer Support and Parent Support).

b. Utilize Medicaid administrative funding to support the financing of core Safety Net services such as assessment, screening and already identified functional assessments related to inpatient psychiatric /residential/ICFMR care (known as Certification, Re-certification, concurrent utilization reviews under federal Medicaid), on call services, community reintegration services, etc.
c. Remove the Clinic Option from CMHC services. Categorize these services under another option (i.e., Other Practitioner Services) so that therapy, psychiatry and other "typical" CMHC services can be provided in any community location.
d. Revise HAWK-I (S-CHIP) to include core required mental health safety net services and to offer a similar mental health benefit package as Medicaid.
e. Revise existing Medicaid services across all mental health service options (i.e., Habilitation Services, Remedial Services, and Psych. Rehab. Services, Children's Mental Health Waiver, etc.) so that they are consistent with Iowa MH Code, Accreditation Standards, core required safety net services, and other changes related to Mental Health Systems Improvement efforts.

16. In relation to Co-Occurring Disorders and in the context of the Co-Occurring Disorders Policy Academy, MHDS, CMHCs, IME, and IDPH should develop a concrete plan to work together to:
    a. Conduct an analysis of and work together to resolve administrative, policy, and funding related to the provision of services to persons with co-occurring disorders.
    b. Resolve inconsistencies/remove barriers between funding streams for mental health and substance abuse services.
    c. Work towards integrated funding for persons with co-occurring disorders.
    d. Institute joint outcomes regarding service provisions for persons with co-occurring disorders.
    e. Develop a data tracking system that can track and identify services provided to persons with co-occurring disorders across services systems (i.e., Mental Health Services, Substance Abuse Services, Inpatient Treatment, etc.). Implement this joint data tracking system within 3 years.
    f. Complete a review of the rates paid for mental health versus substance abuse services to ensure that the rates are comparable to one another based on level of service, qualifications of staff, etc.

For further information, see:

- **APPENDIX B on State Mental Health Authority**
- **APPENDIX C on Ch. 230a Community Mental Health Center Revisions**
- **APPENDIX D Draft Emergency Mental Health Crisis Response Services Code**
- **APPENDIX E Draft Emergency Mental Health Crisis Response Services Request for Proposals**
- **APPENDIX F Draft Iowa CMHC Act**

Core Mental Health Services

The charge to this workgroup was to identify core mental health services to be offered in each area of the state by community mental health centers and core services agency providers. The core services are to be designed to address the needs of target populations identified by the workgroup, and the services may include but are not limited to emergency mental health crisis response services, school-based mental health services, short-term counseling, prescreening for those subject to involuntary treatment orders, and evidence-based practices.

The Report of The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS supports the following:

1. Ensure that Iowans of all ages have access to a comprehensive array of core mental health services and that services can be accessed statewide.

2. Ensure emergency mental health crisis response services can be accessed anytime of the day or night (i.e., 24/7) throughout the state for anyone, any age experiencing a psychiatric crisis.

3. Ensure timely access to all core services (including psychiatry and emergency mental health crisis response services).

4. Standardize the target population definitions used for adults (i.e., Chronic Mental Illness is sometimes used, Serious Mental Illness is sometimes used) to specify who is eligible for what core services. Use the term Serious Mental Illness (SMI) and create a definition that is in keeping with the federal definition for SMI.

5. Create and implement a definition/targeted population of Serious Emotional Disturbance (SED) for youth that is in keeping with the federal definition for SED.

6. Create eligibility criteria for core services which:
    a. Focuses on priority populations and determines service access by clinical eligibility/medical necessity and financial eligibility criteria (i.e., Outpatient and Emergency Services for anyone in need regardless of ability to pay; "Specialized CSS/CBS Services" for individuals experiencing SED/SMI).
    b. Addresses barriers for people that hinder service access related to insurance limitations or having no insurance.
    c. Ensures access to mental health services for people of all ages (i.e., includes children and older adults, is not limited to adults).
    d. Addresses service delivery barriers for providers that results in achieving what is expected with service provision.

7. Ensure that youth experiencing SED and adults experiencing SMI have access to specialized services (i.e., the services that can be provided anywhere in the community) locally, in their own homes and their own communities.

8. Implement Intensive Case Management (ICM) services as a core service for both adults experiencing SMI and youth experiencing SED.

9. Utilize CMHCs as the public safety net with the responsibility to ensure the statewide availability of core services and 24/7 access to emergency mental health crisis services. Ensure that the new standard of care focuses on local availability, personal contact, and local coordination of services.

10. Address Behavioral Health Workforce Shortages in the following areas:
    a. Psychiatry, Advanced Practice Nurses, Physician's Assistants.
    b. Other mental health professionals (i.e., doctoral-level Psychologists, Licensed Independent Clinical Social Workers and other licensed practitioners; BA and para-professional level staff).

c. Develop an organized statewide program to recruit and retain mental health specialists.
d. Look at other models to address the gap in psychiatry such as:
    - Telemedicine and consultation support to other prescribers
    - Specialized training in mental health for Primary Care Physicians (PCPs)
    - Utilization of other medical professionals (i.e., ARNPs, PAs, etc.) as "extenders" of psychiatrists.
    - Define an organized statewide program to recruit psychiatrists and other behavioral health workforce professionals where there are shortage areas.

11.Ensure the standard of care for mental health supports an integrated health model (e.g. co-location of related service providers; integration of mental health with primary care physicians).
12.Support the ongoing collaboration of an Acute Mental Health Care Task Force including relevant agencies (i.e., Providers, County Attorneys, Judges, Law Enforcement, Child Welfare, Schools, Hospitals, CPCs, consumers and family members) to review models and approaches in acute mental health services to determine how such services should be carried out in Iowa.
13.Develop training opportunities for all service providers of Co-Occurring Disorders.
14.Create a state level/statewide funding pool specifically for the purchase of medications for people who are uninsured/underinsured. Allow this funding stream to be utilized for lab testing, other services, etc. directly related to medication management. A statewide Medication Assistance Program with oversight and management by MHDS is recommended in order to secure additional resources such as:

a. Resources related to administrative costs of managing Medication Assistance Programs.
b. Prescription assistance programs with pharmaceutical companies (i.e., in kind contributions, reductions in purchasing, etc.).
c. Federal funding or other resources to support the purchasing of medications.

15.Prevent any unfunded mandates. Ensure that adequate resources are dedicated to successfully implement required changes related to the redesign of the Iowa mental health system.
16.Address resource needs related to the uninsured, underinsured that lead to uncompensated care.
17.Identify approaches to deal with increasing levels of uncompensated care.
18.Ensure that any requirements for CMHCs and Inpatient facilities to have a letters of agreement with one another is not misinterpreted to mean CMHCs have financial responsibilities for the cost of inpatient care (and vice versa).
19.Ensure that the shift to community-based service provision is supported through all related processes across agencies.

Accreditation Standards

The Workgroup was to provide recommendations on accreditation changes associated with mental health systems improvement to the Governor and General Assembly on or before January 31, 2008. The charge was to identify standards for accreditation of core services agencies that are not a community mental health center but may serve as a provider approved to fill the role of a center. Such core services agencies could be approved to provide core mental health services for children and adults on a regional basis. The workgroup's recommendations for this section can be found in APPENDIX O.

Recommendations: The MHDS supports the following recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee:

1. Name a CMHC accreditation task force to revise the Ch. 24 standards following the revision of Ch. 230a.

2. Develop new standards that support a fundamental Continuous Quality Improvement process similar to that seen by the Joint Commission on Accreditation of Healthcare Organizations to restore governance, administrative, and services sections and that more completely detail standards specific to CMHCs.
3. Restore community planning, consultation and education services to the definitions of mental health services.
4. Accreditation activities should ensure the following:
    a. CMHCs establish and continuously monitor staff credentials and scope of practice provided to served consumers,
    b. Staff improvement should continue to serve as an important standard establishing the staff development plan, organizational plans and resources, and
    c. Supervision, consultation, and peer review be defined and incorporated within CMHCs continuous quality improvement system.
5. Provide MHDS Accreditation staff with standardized tools and processes, and accreditation standards should reflect and allow for service information to be recorded and accessed electronically.
6. Ensure that Accreditation standards provide for the development of outcome and process indicators on which continuous quality improvement occurs.

Co-Occurring Disorders

The Report of The Workgroups recommendations for this section can be found in APPENDIX O.

The MHDS supports the recommendations from the Co-Occurring Disorders Workgroup:

a. Incorporate a vision statement for a comprehensive, continuous and integrated system of care for individuals with co-occurring disorders.
b. Develop and use a charter document for Co-occurring disorders systems development and expansion.
c. Continue collaboration with IDPH and active participation in a Co-Occurring Disorders Policy Academy.
d. Ensure ongoing future consultation on co-occurring systems development work.
e. Begin development of pilot, co-occurring projects around the states in collaboration with providers and CMHCs.
f. Utilize various management tools developed through the Co-Occurring Policy Academy to facility the implementation of a Comprehensive, Continuous, and Integrated System of Care of Co-Occurring Disorders.

For further information, see:

- **APPENDIX G Co-Occurring Disorders Policy Academy Charter**

Evidence-based Practices

Legislation directed the MHDS to begin phased implementation of evidence-based practices for mental health services over a period of several years in order to provide a reasonable timeline for the implementation of evidence-based practices with mental health and disability services providers. The legislation directed the division to provide for implementation of two adult and two children evidence-based practices per year over a three-year period. The Workgroups recommendations for this section can be found in APPENDIX O.

Recommendations: The Department supports the following recommendations of the Mental Health Systems Improvement Workgroups and Steering Committee:

1. Implement the three-year plan for rolling out EBPs for children and adults (see below for additional details).
2. The Department supports the definition of EBPs put forth by the Institute of Medicine in 2001 (i.e., EBP is the integration of best research evidence with clinical expertise and patient values (Sacket, et al, 2000; Institute of Medicine, 2001).
3. The Department recommends that training in the delineated EBPs be conducted through a newly created Mental Health and Disability Services Training Institute (MHDSTI) in collaboration with the Iowa Mental Health Consortium, the Center for Disabilities Development, and with expert technical assistance from the Annapolis Coalition.

The recommended EBPs are summarized below:

Children and Adolescents

Key Service Delivery Model:
SYSTEM OF CARE MODEL

Year 1:	1. School-based Mental Health Services 2. Intensive Case Management with Wraparound
Year 2:	1. Parent Support, Education, and Training 2. In-Home and Community Based Services and Supports
Year 3:	1. Functional Family Therapy 2. Integrated Dual Diagnosis Treatment of Co-Occurring Mental Illness and Substance Abuse Disorders

Adults

Key Service Delivery Model:
COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL

Year 1:	1. Integrated treatment for Co-occurring Mental Illness and Substance Use Disorders 2. Peer Support
Year 2:	1. Supported Employment 2. Illness Management and Recovery (including CBT)
Year 3:	1. Assertive Community Treatment 2. Family Psychoeducation

Comprehensive Training Program and MHDS Training Institute

The Legislature directed the MHDS to develop a comprehensive training program concerning practices for community mental health centers, state resource centers and mental health institutes, and other providers, in collaboration with the Iowa Consortium for Mental Health and mental health service providers. The Legislature directed the Division to consult with experts on behavioral health workforce development regarding implementation of the mental health and disability services training and the curriculum and training opportunities offered.

Beginning in the summer of 2007 the MHDS engaged the services of the *Annapolis Coalition*, leading national experts on training and behavioral health workforce development. The MHDS held a series of meetings with the Annapolis Coalition, the Iowa Consortium for Mental Health

and the Iowa Center for Disabilities Development in order to plan the development of a comprehensive training program per legislative direction. MHDS and the Annapolis Coalition held meetings with IDPH, and offered presentations with at MHMRDDBI Commission meetings, the Mental Health Planning Council, and a joint meeting of the Iowa Senate and House Human Resources Committees to discuss behavioral health workforce issues. The MHDS also recently worked with the Annapolis Coalition, the Consortium and Center for Disabilities Development and the Western Interstate Consortium of Higher Education (WICHE) to identify specific behavioral workforce needs with academia, in rural locations, and with primary healthcare providers. Most recently a proposal to develop a Mental Health and Disability Services Training Institute has been developed to address multiple issues of behavioral health workforce needs in Iowa.

THE CHALLENGE. There is a crisis nationally and in Iowa regarding the workforce that delivers mental health and developmental disability services. It is characterized by serious workforce shortages, difficulty recruiting employees into careers and into positions in these fields, high turnover rates, lack of access to relevant and effective training, and the slow pace with which the evidence on effective care informs the practice of the workforce.

Demand for healthcare that is both clinically–effective and cost-effective has led to the proliferation of practice guidelines (such as those promulgated by the American Psychiatric Association) and to increasing demand for evidence-based approaches to behavioral health care (such as the Substance Abuse and Mental Health Services Administration's "Toolkits"). However, the fact that there is still wide variation in clinical practice patterns and failure to deliver care in accordance with established guidelines has generated concerns about the competence of the workforce.

A SOLUTION FOR IOWA. Any effort to address concerns about the quality or quantity of workers in the mental health and disabilities service system must have as its goal *sustainable, practical* approaches. The answers are not to be found solely among existing service providers, in our institutions of higher education, or in state government. What will serve Iowa's citizens best is a structure that brings together the strengths of all of these communities with a heightened focus on real-world solutions to the on-going crisis of having a competent, committed workforce in place to support people with mental illnesses and intellectual and developmental disabilities.

THE NEW VISION. The vision of the proposed Mental Health and Disability Services Training Institute (MHDSTI) is to build a skilled mental health and disability services workforce, including consumers and their families, that will work in local communities, community mental health centers, key state agencies, and service organizations to implement efficient, appropriately applied, and evidence-based services that significantly expand the role of individuals in recovery and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others, and educate the workforce.

THE BUILDING BLOCKS. The implementation of the new vision for Iowa will build upon simple, practical approaches:

The creation of basic infrastructure to manage the process and the creation of a **Workforce Collaborative** to bring together the many skills, voices, and talents needed to implement sustainable change.

A series of tangible work products that address immediate and urgent needs in Iowa's current mental health and disability service system:

- Strengthening the competences of line supervisors—the lynch pin in supporting change and improving quality is the quality of supervision.
- Strengthening the competencies of staff that work with children, adolescents and their families.
- Addressing the needs of our crisis and emergency services statewide.

- Building capacity to serve people with co-occurring conditions, such as mental illnesses and addictive disorders, or mental illnesses and developmental disorders.
- Improving the competencies of front line staff, which spend the most time with people receiving services, yet often receive the least training.
- Supporting consumers of services and their families to become more effective partners and care givers, and to engage them in training the rest of the workforce.
- Providing incentives to recruit and retain highly skilled professionals.

ACHIEVING SUCCESS. Many partners will be required to achieve success, but failure cannot be an option for Iowa. We have recognized the need, and it is within our capacity to move ahead quickly and effectively to make the new vision for our workforce a reality.

For further information, see:

- **APPENDIX H Workforce Vision**
- **APPENDIX I Workforce Data**

Comprehensive Plan

The Legislature directed MHDS to complete a written plan describing the key components of the state's mental health services system, including the services addressed in this subsection and those that are community-based, state institution-based, or regional or state-based.

This document contains a wide range of recommendations that should be considered integral to the phased rollout of an improvement plan. The Legislature directed that the plan should incorporate the community mental health center plan provisions. In addition, the MHDS was directed to complete a written plan for "**the Department to assume leadership and to assign and reassign significant financial responsibility for the components of the mental health services system in this state, including but not limited to the actions needed to implement the provisions of this subsection involving community mental health centers, core mental health services, core services agencies, co-occurring disorders, and evidence-based practices".** We are pleased to present this document in support of that plan.

In it's legislative proposals, submitted to the Governor in the Fall of 2007, the MHDS included recommendations for funding levels, payment methodologies for new emergency mental health crisis response, children's mental health and school mental health services. Per legislative direction, a more complete plan shall be submitted to the Governor and General Assembly on or before January 15, 2009. The Workgroups recommendations for this section can be found in APPENDIX O.

Presently, the MHDS recommends the following PHASED changes to be updated on or before January 15, 2009 in the following outline:

Phase I:

Develop and Implement

- Data infrastructure and capacity to monitor system utilization.
- CMHCs as lead agencies on the implementation of Emergency Mental Health Crisis Response Services through an RFP process via state "block grants"
- Children's Mental Health Services are designed and developed.
- School Mental Health Services are designed and developed
- Co-Occurring Disorders Programs and Services are piloted through the auspices of the Co-Occurring Disorders Policy Academy and MHDS technical advisors.

- MHDS develops and implements the Mental Health and Disability Services Training Institute through "state psychiatric papers" funds
- Functional Assessment and Outcomes Systems are developed and implement by MHDS in collaboration with CMHCs, MHIs, RCs and Juvenile facilities.
- Create necessary legislative, code, rules, and standards associated with phase changes.

Phase II:

Development and Implement:

- Acute Mental Health Task Force and in collaboration with counties, judicial system, law enforcement, health care systems and other major stakeholders update mental illness commitment procedures
- CMHC and Inpatient Program Information Network with Electronic Linkage with MHIs, RCs, and JJ facilities
- Establish MHDS as provider of Intensive Clinical Management Program
- Contract with a Pilot Regional Mental Health Authority
- Programs and Services for Individuals with Dual MH/MR disorders
- Create necessary legislative, code, rules, and standards associated with phase changes.

Phase III:

Develop and Implement:

- Early Intervention Programs
- Programs and Services for Persons with Autism Spectrum Disorders
- Programs and Services for Older Adults
- Create necessary legislative, code, rules, and standards associated with phase changes.

For further information, see:

- **APPENDIX J Legislative Proposals**
- **APPENDIX K Evidence-based Practices**
- **APPENDIX L Workforce Development Proposal**
- **APPENDIX M A Data View**
- **APPENDIX N CMHC and CPC Survey Responses**
- **APPENDIX O Recommendations from the Workgroups and Steering Committee**

APPENDIX J: MHDS Budget and Legislative Proposals

Attached are 2 proposals for legislative activities for the 2008 Legislative Session from the Department of Human Services, Division of Mental Health and Disability Services. They are:

1. Establishment of Code on Emergency Mental Health Crisis Services (LSB 5362)
2. Establishment of Code on Children's Mental Health Services (LSB 5355)

The attached describes the likely impact of these two initiatives on current and potential legislation, changes in rules, code or regulations.

Also attached are two page summaries describing the Department's rationale for development of the above two areas.

DHS Proposed Legislative Package

2008 Legislative Session

Policy area and code site (if available): Mental Health and Disability Services

MHDS 1: Emergency Mental Health Crisis Services (LSB 5362)

Briefly summarize the proposed change:

"Emergency mental health crisis services" means a coordinated system of mental health crisis services which provides an immediate response to assist a person experiencing a mental health crisis. An "Emergency Mental Health Services Provider" is defined as an organization, such as a community mental health center, that is accredited by the Department of Human Services to provide emergency mental health crisis services.

The proposed change calls for the creation of new code for the establishment, accreditation and operation of emergency mental health crisis services.

(1) The code would be promulgated to establish standards and procedures for certification of emergency mental health crisis service programs. The persons who need those services are persons who are experiencing a mental health crisis or are in a situation likely to turn into a mental health crisis if supportive services are not provided. The Department of Human Services would contract directly with Community Mental Health Centers or Emergency Mental Health Services Providers for the operation of an emergency mental health program certified under this law.

(2) This code would apply to the department, to entities that request accreditation to provide emergency mental health crisis services and to state-contracted agencies that request accreditation to provide emergency mental health services.

(3) This code would relate only to the accreditation of programs providing emergency mental health crisis services. It is not intended to regulate other mental health service programs or other emergency service programs.

Reason for change:

There are no state-wide standards for the establishment, accreditation and operation of emergency mental health crisis services in the state. This is proposed as a result of recommendations from the legislatively-directed mental health systems improvement workgroups.

Budget and/or workload impact:

There is an impact in terms of workload for creating the revisions in Code which can be completed by MHDS and legislative staff; changes to the Code are related to the budget package submitted by DHS/MHDS to the executive and legislative branches this session.

$6,000,000 is being requested to establish 24/7 emergency/crisis response services, provided by CMHC's regionally throughout Iowa.

Impact on the population we serve:

If enacted this would provide a safety net for all Iowans in need of emergency mental health crisis services throughout the state.

____Technical __X_Policy

Explanation on LSB 5362: Emergency Mental Health Crisis Services

Section 1a.

Why is an Emergency Mental Health Crisis Services system important to Iowa?

Currently, all Iowan's do not have access to Emergency Mental Health Crisis Services. In a recent survey, less than 20% of the counties in Iowa report having any type of emergency mental health crisis services.

The goals of emergency mental health crisis services include prevention of escalation of life events to crises, relief of the immediate distress of persons in crisis, prevention of individuals from doing harm to themselves or others, and promotion of independence for those who require ongoing mental health and /or substance abuse services. These goals, if available to all Iowans, are intended to stabilize individuals through community-based crisis services with the ultimate goal of reducing inappropriate hospitalizations or jail placements.

Emergency Mental Heath Crisis Services *should provide welcoming and empathic*, co-occurring-disorder-capable crisis intervention, stabilization, support, counseling, pre-admission screening for persons requiring emergency psychiatric hospitalization, detoxification and follow-up services in all counties and for all people. This system currently does not exist for all Iowans.

All Iowans need access to Emergency Mental Health Crisis Services

- Every Iowan – not just the chronically mentally ill may need these services.
- Included are individuals with a diagnosed mental illness or co-occurring mental illness and substance abuse disorder.
- All individuals experience crises.
- All ages and all income levels (those who are insured, under-insured, or uninsured) may be affected.

Section 1b

How Does One Become an Emergency Mental Health Care Crisis Provider?

- Providers shall be accredited or approved by the Department to provide Emergency Mental Health Crisis Services.

Section 2a and b

Features of a crisis include:

- All individuals can experience a mental health crisis
- A person's perceptions determine the importance and significance of a crisis.
- Crises are usually time-limited episodes
- Crises are not necessarily pathological, as they may encourage growth and change,

Section 2c, d and e

Characteristics of Emergency Mental Health Crisis Services include:

- Welcoming, universal participation
- Focuses on individual strengths, not weaknesses
- A hopeful vision of recovery
- Co-occurring capability
- Empowered partnership of stakeholders
- Inclusion of the process of continuous quality improvement of services

Goals of Emergency Mental Health Crisis Services are:

- Symptom reduction,
- Stabilization of the individual
- Restoration of the individual to a previous or enhanced level of functioning.

- Connection to continuing care at the appropriate level of intensity, matched to individual family needs and requests

Section 3a and b

1) The Mental Health and Disability Services Division (MHDS) recommends that Community Mental Health Centers and other community providers apply for competitive state block grants (SBG). It is recommended that the funding of program capacity-developing operational grants is done with the General Fund through the Department of Human Services. These block grants may operate on a quarterly "settle-up" basis to offset uncompensated time to the limit of the grant award. The request is for the annual amount of $6 million for up to ten (10) state block grants of $600,000 each. MHDS has recently added staff to develop and monitor budgets, contracts, and grants as well as develop emergency mental health crisis technical assistance. The Division has experience in the development, issuance, monitoring and oversight of federal mental health block grants that are procured on an annual basis. The Division proposes to develop the Request for Proposal in early spring of 2008 for implementation in January of FY2009.

2) In order to appropriately consider the needs and interests of various stakeholders associated with Emergency Mental Health Crisis Services, to monitor the development of these services and to sustain long-term change, it is recommended that the MHDS Division develop and convene an interagency, coalition/network to monitor these services on a statewide basis. A wide range of stakeholders should be involved in a state-supported collaborative related to service implementation, utilization and future modifications of the acute mental health delivery system. This includes coordination with other mental health, substance abuse and co-occurring mental health and substance abuse services available through the state. The Division is already developing internal capacity to provide state leadership in this initiative through staffing provided through legislative support in FY2007 and FY2008.

Anticipated outcomes include the following:

- Increased utilization for mobile crisis and wraparound services
- Decreased inappropriate admissions to inpatient psychiatric units
- Decreased inappropriate admissions to correctional facilities
- Decreased readmissions to inpatient psychiatric units
- Decreased involvement by law enforcement in the management of community mental health incidents

Additional Future Actions Needed

(1) It is likely that Code needs to be promulgated to establish standards and procedures for accreditation of emergency mental health crisis service providers. There should also be modifications to Ch. 24 for the inclusion of standards related to emergency mental health crisis services. The individuals who need those services are persons who are experiencing a mental health crisis or are in a situation likely to turn into a mental health crisis if supportive services are not provided. The Department of Human Services intends to contract directly with Community Mental Health Centers or emergency mental health services providers for the operation of an emergency mental health crisis services program.

(2) Code should apply to the Department's responsibilities of statewide leadership and oversight of emergency mental health crisis services, to entities that request accreditation to provide emergency mental health crisis services and to state-contracted agencies that request accreditation to provide emergency mental health services.

(3) Code should relate only to the accreditation of programs providing emergency mental health crisis services. It is not intended to regulate other mental health service programs or other emergency medical service programs.

How are Emergency Mental Health Crisis Services different from Emergency Disaster Responses Services?

Disaster services are put into effect following a defined natural or man-made event such as a flood, tornado, hurricane, blizzard or act of terrorism adversely affecting individuals and communities. Disaster mental health counseling is provided immediately after the event, during mitigation and in long-term recovery. In addition, personnel who respond to the event may require Critical Incident Stress Management debriefing to reduce their

risk of acquiring post-traumatic stress and depression. Emergency mental health crisis providers deal with daily acute emergencies. Emergency mental health crisis providers are trained in disaster response and may be part of the statewide effort when a Presidential Declaration has occurred. The Department is working to include the emergency mental health service providers in the plan for disaster mental health response.

DHS Proposed Legislative Package

2008 Legislative Session

Policy area and code site (if available): Mental Health and Disability Services

MHDS 2: Children's Mental Health Services (LSB 5355)

Briefly summarize the proposed change:

There is a lack of code or rule regarding the specific provision of children's mental health services and in certain areas of code children are specifically omitted as an eligible population. The Department of Human Services – Division of Mental Health and Disability Services propose the use and modification of model federal legislation currently being proposed in this area. (See attached).

Reason for change:

As a result of recommendations from the legislatively-directed mental health systems improvement workgroups there exists a need for development of state-supported children's mental health services throughout the state of Iowa.

The Spring 2006 Legislature directed the Department of Human Services (DHS) – Division of Mental Health and Disability Services (MH & DS) to make the changes necessary to "implement a comprehensive, continuous, and integrated state mental health services plan in accordance with the requirements of sections 225C.4 and 225C.6 and other provisions of this chapter, by increasing the department's responsibilities in the development, funding, oversight, and ongoing leadership of mental health services in this state..."

This legislation also states that "the general assembly intends that efforts focus on the goal of making available a comprehensive array of high-quality, evidence-based consumer and family-centered mental health services and other support in the least restrictive, community=based setting appropriate for a consumer..."

Per recommendation from the legislature, the MHDS worked with several stakeholder groups to identify various needs and gaps in the public mental health service system and make recommendations for changes. The mental health systems improvement workgroups and steering committee identified particular service gaps and disparities in mental health services for children and their families and has made recommendations for improvements. As current Iowa Code does not adequately identify mental health service responsibilities or eligibility requirements for children, it is necessary to create code that achieves this.

Budget and/or workload impact:

There is an impact in terms of workload for creating the revisions in Code which can be completed by MHDS and legislative staff; changes to the Code are related to the budget package submitted by DHS/MHDS to the executive and legislative branches this session.

Development of legislation in this area will increase the workload of the MHDS Accreditation staff as there will be a need to development, implement, and monitor standards.

$3,000,000 is being requested to assist in the development of an infrastructure and local projects for children's mental health services.

Impact on the population we serve:

Youth who have mental health service needs will have access to core safety net mental health services in the least restrictive setting possible, preferably at home with their families and the need for more costly, high end care will be reduced.

____Technical __X_Policy

Explanation of LSB 5355 DP – Children's Mental Health Services

NEED: Although children's mental health services exist in Iowa children's mental health services are neither sufficient nor coordinated with other aspects of the children's services network such as child welfare, juvenile justice, primary health care, substance abuse, or education services. Families are often left on their own to find services; service availability is limited, unavailable and varies statewide; and resources to support youth with mental health needs are limited. The juvenile justice and/or child welfare systems often become the systems of "default" which causes unnecessary burden and cost to those systems while also not adequately meeting youth and family needs.

There is a lack of code or rule regarding the specific provision of children's mental health services and in certain areas of code children are specifically omitted as an eligible population. As current Iowa Code does not adequately identify mental health service responsibilities or eligibility requirements for children, it is necessary to create legislation and code that achieves this.

PURPOSE: Per legislation passed in 2006, the Department of Human Services (DHS) – Division of Mental Health and Disability Services (MHDS) was directed to make the changes necessary to "implement a comprehensive, continuous, and integrated state mental health services plan in accordance with the requirements of sections 225C.4 and 225C.6 and other provisions of this chapter, by increasing the department's responsibilities in the development, funding, oversight, and ongoing leadership of mental health services in this state..."

This legislation also states that "the general assembly intends that efforts focus on the goal of making available a comprehensive array of high-quality, evidence-based consumer and family-centered mental health services and other support in the least restrictive, community-based setting appropriate for a consumer..."

The purpose of the proposed legislation is to ensure that youth with mental health disorders have access to mental health treatment, services, and supports in the least restrictive setting so they can live with their families and remain in their community.

INTENT: To meet the mental health needs of youth more appropriately in the community to prevent or reduce utilization of more costly, restrictive care such as institutional care, residential treatment, out of state placements, or other out of home placements; reduce unnecessary involvement of youth who have mental health needs with law enforcement, corrections, and juvenile justice; reduce unnecessary youth involvement with child welfare services; etc.

The Department of Human Services – Division of Mental Health and Disability Services proposes modifications to 225C to establish the state mental health authority's responsibility to develop, implement, oversee, and manage the comprehensive community based children's mental health system in Iowa.

Section 1-Purpose and definition
The purpose of this bill is to establish a comprehensive, community based children's mental health system. Appropriate community level mental health services in Iowa currently do not exist on a consistent statewide basis. Some services and supports exist but are limited by funding, location, and insurance status of the family. As a result youth with serious mental health needs and their families often become unnecessarily involved with the juvenile justice and/or child welfare systems, or other out of home placements because they cannot access more appropriate community based mental health services.

The definition of a child or youth with serious emotional disturbance (SED) is a federal definition, and provides a framework for defining the population in need of comprehensive community based mental health services. As identifying youth with SED is a federal requirement of states, it is necessary that Iowa implement and use criteria to identify and assess youth who have a SED. Additionally, Iowa has received one federal grant and is working on a second federal grant with the Substance Abuse and Mental Health Services Administration to build systems of care for youth with SED which also require the use and implementation of standardized criteria to identify and assess youth with a SED. The language in the bill which addresses the transition age 18-21 population is being included to fulfill requirements in Chapter 225C.6A, directing the department that the "redesign of the children's system shall address issues associated with an individual's transition between the two systems as " they are at risk for many negative outcomes without adequate supports. The language in this bill promotes a more seamless transition from the child to adult mental health system.

Establishing the Mental Health and Disability Services Division as the lead responsible agency of the oversight and management of the children's mental health system also fulfills requirements set forth in 225C and HF909, and is the consistent with federal requirements for states to establish a "state mental health authority". This language simply reinforces existing responsibilities of MHDS to provide leadership, oversight, and funding in order to create a comprehensive, community based mental health service system that reduces inequalities of treatment, minimizes reliance on institutionally-based services, and diverts people with mental illness form unnecessary with the legal system to provide needed services, and promotes strengths-based, community and family driven services and supports.

Section 2-Initial Implementation

The services in the children's mental health system will be provided by local providers using practices that are appropriate for the culture and needs of their community within the parameters of being evidenced based and consistent with system of care principals. The state will contract with these providers to develop services and supports that wrap services around a family, are responsive to individual and family needs, and provide services in the least restrictive setting possible. The competitive bidding process will allow providers to participate at the level that they are able to.

The Department of Human Services – Division of Mental Health and Disability Services proposes modifications to 225C to meet federal requirements and to carry out requirements set forth in HF 2780, HF 909, and 225C to meet the state mental health authority's responsibilities to develop, implement, oversee, and manage a comprehensive community based children's mental health system in Iowa.