Left Behind:

An Evaluation of Mental Health Programming in Iowa

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Abstract

The State of Iowa has made momentous changes to programming for individuals with mental health needs. Despite all of the changes to date, there is still significant room for improvement, especially in areas of funding and promoting psychiatrists to come to rural areas. Polk County has implemented jail diversion and crisis programming to reduce the recidivism rate of individuals with chronic mental health needs. A pilot mental health court has been established in Black Hawk County, but lacks support from crisis programming and jail diversion like that offered by Polk County. In order for a county to have successful mental health programming, a combination of crisis programming, jail diversion, mental health court and home based supports must work in tandem. Despite the efforts of State and Federal legislation, no programming can be successful if it is not properly funded through sustainable and expandable sources. Currently providers are not able to receive adequate reimbursement for the services they provide, creating a shortfall of available services. The true costs of the system are currently being shadowed by ineffective services, leading to incarceration and/or hospitalization of clients. Until a true holistic approach is adopted, marrying services and funding, individuals with mental health concerns will continue to be left behind.

Keywords: mental health, mental health court, crisis services, funding, jail diversion, mental health professionals
Since its inception, mental health programing continues to be involved in an ever-changing process, to meet the needs of its clientele while staying within the parameters of available funding. Often persons, with mental health needs are not diagnosed, or do not receive the care that they need in order to integrate to their fullest potential within their communities. Many policy changes have taken place over the years in order to provide funds and create programing for persons with differing diagnoses. However, change in policy has not kept up with need, which causes a plethora of difficulties for individuals attempting to access services, including lack of increased funding or outdated stipulations that directly limit the availability of providers. Individuals with mental health needs also suffer from a lack of support programing related to minimizing the ratio of individuals involved in the correctional system. Although there are several programs specified to work with individuals within the judicial system, they often lack wrap around supports, or are too far widespread to make a difference.

**Funding**

The funding stream for individuals with mental health needs in Iowa is referred to as Habilitation. Habilitation funding falls under HCBS or Home and Community Based Supports and is called The Iowa Plan. Its similar to some of the waivers available in Iowa including: Intellectual Disability (ID), Physical Disability (PD), Children's Mental Illness (CMI), and Elderly, but has stricter standards. Habilitation funding requires that individuals must qualify for Medicaid prior to becoming eligible and receiving services, whereas with one of the State waivers, individuals are able to join, and then qualify for Medicaid as a part of the program. In order to be eligible for Medicaid an individual must not make more than 150% of federal income limitations, with some flexibility recently afforded by the Iowa Medicaid Expansion. The program is listed as a 1915(i) and the waivers are listed as
According to NAMI (National Alliance on Mental Illness), Iowa was the first state to utilize the 1915(i) funding designation through Medicaid (Grading the States, 2009). The largest difference between the requirements of the two classifications is that a 1915(i) under Medicaid code is able to target a specific audience, but not a specific diagnosis. The state is also able to cap the number of individuals served under this program. Habilitation programming works with individuals who have a significant diagnosis in Axis I, or mental health diagnosis. The Intellectual Disability (ID) Waiver requires the diagnosis of an intellectual disability on the Axis II, usually being categorized as Mild, Moderate, Severe or Profound ID, based on findings from a clinical psychologist using Diagnostic & Statistical Manual criteria.

Habilitation programming was initially funded by individual county tax dollars (D. Higdon, personal communication, October, 13, 2014). This posed difficulty in some counties because of declining taxable resources. The introduction of Senate File (SF) 69 in 1996, placed a levy on the amount of money that each county was able to raise for mental health programming (Property Tax Levy, 2009). These fixed rates were expressed as a dollar amount. As such, the funds would not be able to increase with an emerging sector, along with the increase of total taxable values. It would also protect the cap should a county find itself in decline. Maintaining revenue would cause counties to be hard pressed to preserve the levy cap in a decline, as it would mean raising taxes or cutting funding from another program. In swiftly expanding counties wait lists were created, as demand far outpaced the availability of services and the monies allocated for that purpose.

The levy cap for mental health services sat stagnant for nine years before any changes were made. It was not until 2011 that a payment to counties to help reduce the wait list was made, in the amount of $25 Million (Iowa’s Mental Health System, 2014). In addition Senate File (SF) 625 outlined
The process of mental health redesign. Senate File (SF) 2315, was introduced the following year, creating an outline and timeline for the redesign. Included in the new legislation was the creation of a 15-region system; each region made up of several counties that would now share a pool of resources. All of the monies that were once collected for a counties use were now collected by the state and distributed to the regions based on a per-capita system for each of the individual counties. Senate File (SF) 2315 stipulated that the final outcome of funds to be allotted to the regions was $47.28. According to a breakdown of SF 2315 supplied by NAMI, counties that were not raising the per-capita amount would be provided equalization payments for the 2013 and 2014 years (Iowa’s Mental Health System, 2014). No guarantee of any equalization payments were mentioned beyond this time, putting more pressure on counties to come up with the funds, although outlines of balance forecasts include funding for equalization payments and an allowable growth for each year. In order to be eligible for equalization payments, each region was not allowed to have outstanding debt with the State. Some reprieve was allowed for repayments, as any debt incurred prior to July 1, 2011 was forgiven. One downside to the newly created legislation was that levy limits remained in place, causing some difficulty for counties that had experienced increased population, as they had an expanded market without the ability to increase revenue for mental health services.

According to the Iowa Department of Human Services, the payment made to the newly formed regions was equal to $29.8 million in 2013 (Mental Health & Disability Redesign, 2014). Furthermore 54 counties received support, as they were not raising funds equal to the per-capita rate. In 2013 Polk County received the highest equalization payment at $6.2 million and Keokuk County received the smallest payment of $597.00 (Anderson, 2014). Counties are restricted to fifteen percent or less of their funds by current legislation, from year to year. There was discussion of the possible hardships for regions utilizing 15% as an allowable balance to carry into the following year, but none of the
Many of the changes seen in 2012 legislation were used to further align with the US Supreme Court Olmstead decision of 1999, which stated that persons should receive support services in the most integrated setting consistent with their needs (The Plan to Transform, 2012). The State also may have been approaching many concerns raised from a report card for mental health services issued by the National Alliance on Mental Illness (NAMI) in 2006 where the state received a failing grade and a slight upgrade to a “D” in 2009 (NAMI, 2006). On a detailed report card, NAMI provided areas of urgent need, concerning addressing the workforce, streamlining the data collection system for the state, and the implementation of crisis response and stabilization.

Community-based mental health services remain highly decentralized in this rural state, with services largely controlled by 99 county governments. The system is a patchwork quilt, with services varying considerably throughout the state (NAMI, 2006).

Many of the families in Iowa would be better served if they could now find services within the several counties that make up their region, instead of being confined to a single county (with the exception of Polk County, which serves as a stand alone region). Although counties were now combined into regions, many counties still lack individuals who are licensed to provide diagnoses needed for services. The State also mandated that the newly formed regions adhere to several standards, providing “core services,” defined as:

- Treatment designed to ameliorate a person's condition such as outpatient therapy or
inpatient treatment, and medication management

- Basic crisis response provisions including 24-hour access to crisis services
- Support for community living, such as home health aides and home and vehicle modifications, as well as respite services
- Support for employment including prevocational services, job development and day habilitation
- Recovery services including peer and family support
- Service coordination including coordinating physical health and primary care (Palmer, 2014).

In addition, a committee was also created in order to determine ways to cut state financial interests in regional plans and to improve current level of service at the same time.

In 2013, outcomes from SF 2315 took effect; new eligibility rules were applied, five counties implemented Integrated Health Homes, with plans to implement the Health Home process for the remaining regions later, as well as numerous other pieces of legislation related to the delivery of mental health services across the State began to take place. 1995 marked the introduction of Magellan Healthcare for case management of persons with mental health needs. According to Iowa Legislation Iowa Code section 17A.4(1) “b.” on July 1, 2013 Magellan Healthcare would now be overseeing all services received by persons with mental health needs who were being enrolled into the Iowa Health Home program. Prior to this action Magellan was overseeing habilitation funding, but clients were able to keep their case managers for other HCBS funded programs. Initial projections from Iowa Department of Human Services showed that over 14,254 adults would utilize the new program from which 4,642 would be receiving case management services at the time of the change over (Frequently Asked Questions, 2013). In the IHH plan, a six-month time period is allowed for all services to be
picked up and then managed by Magellan, completely rewriting the former case manager out of the process. Clients were provided a “choice of providers” with their new IHH initiative, however, even in one of Iowa’s largest counties (Polk), only two options; Broadlawns, a public Hospital, and Eyerly Ball, a not-for profit entity specializing in mental health services were provided as options. This leaves one to wonder about the general lack of provider services in much smaller counties and what the defined “options” really looked like, especially since clients were no longer permitted to work with their current team members, many of whom had developed a working relationship of several years.

Part of the process of Magellan taking over was a new payment model, in which providers were paid a per member per month (PMPM) payment of $128 a month. Anyone who was enrolled in the HBCS system had services traditionally billed for time spent on the individual, allowing for a fluctuation based on the members need. The PMPM system set payments at a fixed rate which would be paid to providers on a monthly basis, whereas with the HCBS waivers, case managers would bill based on the amount of time spent working directly with the client, or members of their team. The fixed rate did allow for one exception; an additional rate of $200 per month is to be paid to the IHH provider working with a client determined to have needs described as “Intensive,” which according to the level intensity chart from Magellan of Iowa, is any client who requires nine or more hours of services a day (Recovery System, 2014). The lead ideology of the IHH was that individuals would now be working with “a team of professionals working together to provide whole-person, patient-centered, coordinated care for all situations in life and transitions of care to adults with SMI (serious mental illness) (Brussell, 2013).” It is difficult to imagine that there is a lot of collaboration going on with a team of individuals who is supposed to include the client’s psychologist and or psychiatrist, when the main provider is only reimbursed at a rate the would typically cover a “check-in” session with a psychiatrist. Lead IHH organizations, although mainly composed of not for profit entities, still have to pay their staff an hourly
Assuming a theoretical team composed of three members, who all are being reimbursed for their work at $15/hr by their employer. We must assume a rate of all staff members plus operating costs and monies taken for benefits and other costs of operating a business; we will call this a straight $50 per month to provide a conservative measurable amount. Provided this theoretical equation, it would only allow for 2.17 hours per month of collaboration, planning, and execution of a plan before sending the provider into the red or negative monies. ($148-$50)=98/$45(3x15)=2.17 hours provided a three member team. Anything more and the agency will be losing cash and as such, forced to reduce the quality of care or withdraw from the system.

In addition to low IHH provider rates, individual rates for services were also slashed. Rates for persons, prior to the IHH rollout who were receiving HCBS services had to adhere to the rules of their individual waiver, which would allow exceptions if approved by the Director for a period of up to one year, before requiring an extension and detailed reasoning as to why the increased cost of the services was required. New rates with the IHH home capped all services at $315 a day for all services, which is less than the daily cap for supported living rates for individuals on the ID waiver. For those in the IHH who were enrolled as “High Recovery,” the program would only cover a total of 51 dollars of services per day. In addition, the new legislation creating the IHH no longer allowed for exceptions to policy, as according to Magellan this was written into the new rates. We are now dealing with an issue of reimbursement for direct providers as well, as often the cost of services are more than what is available, in the IHH system. To compare, the current daily cap for supported community living alone is $336.30. This is also determining that the person demonstrates such a need, as they must do with all services.
However, the total sum of all services with the IHH are not permitted to even equal the rate provided for one service provided by the ID waiver, despite potential need of the recipient. Recently, Candeo, a well known and respected service provider, often showing up as one of the top 100 places to work in Iowa, publically announced that they were no longer going to be providing habilitation services, as the reimbursement rates were not high enough for them to maintain quality staff and services. Several other providers have been considering making the same move, but have not yet publicly announced any decisions to withdraw from habilitation services. A few providers have reduced services provided as they are not able to remain viable continuing to provide the services to individuals they serve under the new rates. The changes are summed up nicely by a quote provided by ID action, “Many feel that the 2012 Redesign fell short and will continue to fall short until funding for the system if addressed (Advocates Guide, 2012).”

**Jail Diversion**

One of the most effective and crucial ways to intervene and help those who have mental health needs is to implement a jail diversion program that helps deter individuals from unnecessary incarceration. By offering different assessments and evaluating psychiatric needs through differing forms of evaluation, jail diversion programs strive to assist individuals who are at risk of being taken in by law enforcement. It is first important to clarify some of the facts regarding individuals with mental health needs as public perception and misunderstanding regarding the field of mental health is devastatingly common. A common misconception is that individuals with serious mental illnesses (bipolar disorder, schizophrenia) are more prone to commit violent crimes due to instability and lack of reasoning. However, statistics state that individuals living with a serious mental illness commit approximately 3-5% of violent acts (www.mentalhealth.gov, 2014). Individuals with mental illnesses are reportedly 10 times more likely to be victims of violent crimes than the general population. Inferences can be drawn from this with a majority of individuals that fall victim to these crimes being
the homeless population who are often not being treated and are more vulnerable to being targeted as vagrants or outcasts. These individuals are often self-medicated which intensifies the effects of their illness on a neurobiological level, so it is important for all individuals with mental health needs to have services they can take advantage of them and be assimilated into a functional and understanding society. Another myth is that individuals with mental health needs have a more difficult time than the general population being able to hold a job and contribute to society. If individuals with these needs could be effectively identified and treated it would result in lower total medical costs, increased productivity, lower absenteeism, and decreased disability costs (www.mentalhealth.gov, 2014). A final myth that is important to touch on is the stigma that the general public cannot do anything to help those who suffer from a mental illness or have mental health needs. In fact quite the contrary is true. Unfortunately, only an estimated 38% of adults with diagnosable mental health problems receive the treatment that they need (www.mentalhealth.gov, 2014). If there is a larger awareness and more cohesive community outlook on assisting those with mental health needs, changes can be met to ensure that these individuals are not ostracized and that community-based programs can capitalize on that misunderstanding by educating and making the necessary changes to secure proper treatment.

As of 2001 the statistics stated that approximately 11.4 million people are booked in to U.S. jails with an estimated 7% having current symptoms of serious mental illness (Steadman, Naples, 2005). By enrolling individuals with mental health needs into JD programs, the chance of recidivism as well as time spent in jails drastically decreases (Steadman, Naples, 2005). Community-based treatment serves as an integral piece in helping to rehabilitate and service individuals in a more effective versus the detrimental effects caused by incarceration. Jail diversion activities largely consist of screening and identification of potential divertees, boundary spanning, and linkage of divertees to appropriate and comprehensive services (Case, Steadman, Dupuis, 2009). According to a recent study,
as of 2009 national estimates reported that approximately half of operating post-booking jail diversion programs employ a mental health court model (National GAINS [Gathering information, Assessing what works, Integrating the facts, Networking, Stimulating Change] Center, personal communication, December, 2008). The major conclusions of this study showed that individuals who had been enrolled in post-booking jail diversion programs comparatively spent less time incarcerated and experienced fewer arrests in the year after the study was less than in the preceding year. About half of the individuals were incarcerated with that population being comprised of those that had a longer history of criminal activity. It will later be mentioned in this paper how the State of Iowa may benefit from implementing a mental health court. As it seems at this point in time, it is becoming pertinent to create a mental health system that integrates multiple facets of services. Optimization can be brought to the system if there is a careful balance of making services easily available, enrolling individuals in JD programs, and also offering a mental health specialty court. Through federal and state initiatives, jail diversion programs have been gaining exponential growth as the need for these types of services becomes immensely sought after and necessary.

In Polk county Eyerly Ball is the service provider that has established its Jail Diversion program by working directly with law enforcement in order to train them how to properly deal with individuals who may be picked up with mental health needs. The service they have established is known as the Mobile Crisis Response Team (MCRT, 2014). The MCRT provides short-term crisis management for children, youth, and adults experiencing a mental health crisis. The MCRT is defined as a collaborative effort where registered psychiatric nurses and mental health professionals are dispatched at the request of law enforcement (MCRT, 2014). Polk County health services contracts with Eyerly-Ball in order to provide these services to the public. Eyerly-Ball classifies a mental health crisis as the onset of an emotional disturbance or situational distress involving a sudden breakdown of an
individual’s ability to cope. The protocol is that when a police officer arrives on the scene, they are trained to assess the situation and make the call as to whether the individual may have a mental health need or not. The training is provided by the individuals at Eyerly-Ball who have educated the officers about certain mannerisms and characteristics that allude to an individual possibly having mental health needs. If deemed necessary the officer will call the MCRT at which point a trained mental health professional comes to the scene and assesses the situation and whether there is a real threat present or not. The idea is that the situation can be stabilized and divert an individual from an unnecessary incarceration by using on-site crisis management to diffuse the situation. The MCRT is also able to provide referrals for services if deemed necessary. If the individual poses an immediate threat to themselves or others they will be hospitalized and the necessary measures will be taken. The referral process is used as a means to provide a more appropriate alternative for the individual if it is clear that arresting the individual will cause more harm and the situation can be remedied in a more effective manner. The goals of the MCRT as listed by Eyerly-Ball are to stabilize clients in their home, prevent unnecessary hospitalizations, prevent unnecessary incarcerations, and save valuable police time (MCRT, 2014).

The MCRT operates 20 hours a day 7 days a week and is deemed necessary by both officers and members of the community alike. Senior Police Officer Kelly Drane who heads the MCRT for the Des Moines Police has previously stated “The police officers told me that they would not know what to do without it, because before Mobile Crisis they were limited as to what they could do as police officers” (Mobile Crisis Response Team, 2007). Prior to the MCRT’s inception, police reported spending an average of 3 ½ hours per mental health call, which as of 2007 had reportedly dropped to an average 22 minutes per call, saving about $132,600 dollars a year (Mobile Crisis Response Team, 2007). Through the creation of programs such as these and response teams that are dedicated towards
assisting those with mental health needs in the most appropriate manner, not only are costs cut for the city, but individuals in the community feel more valued and that their needs are being taken into account seriously.

A new service that has opened in Des Moines this year was built off of a program in San Antonio, Texas called Haven for Hope that has been serving as the national model with the types of services they have been providing. The service center in Des Moines is also run by Eyerly-Ball and is named the Crisis Observation Center (COC). The center is located conveniently downtown in the same building that houses Central Iowa Shelter & Services (CISS). The objective of the new COC is to take a more progressive and sustainable approach to broaden services for central Iowans with mental health needs and avoid unnecessary incarceration. The overarching goal aligns with the mission of many mental health service approaches, which is to try and resolve perceived mental health crises in a community based setting. Eyerly-Ball CEO Earl Kelly stated “The Crisis Observation Center will expand crisis services by offering assessments, interventions and referrals by a team of crisis trained mental health professionals including social workers, nurses, discharge planners and nurse practitioners” (Affiliate News, 2014). The program can be utilized by police officers as an additional resource to bring individuals experiencing a mental health crisis in order to avoid an unnecessary hospitalization or incarceration if the perceived threat is benign enough. The ability for the city and community based organizations like this really strengthen the meaning and theme of the word “team” which is very prevalent when looking into the mental health related services provided in central Iowa at this time. It creates a more cohesive atmosphere in which law enforcement and mental health professionals are striving to break down the obstructing communication lines that can lead to a false or unneeded incarceration of an individual that is a possible divertee. The COC also has a great opportunity to reach out and assist the population that is currently being served by CISS, who are
predominantly homeless and may have been previously unable to easily obtain services. Tony Timm, who is the executive director for CISS said “This is a great opportunity for our organization to partner with Eyerly-Ball to have immediate access to mental health services for the people we serve at CISS. In many instances this can be an alternative to jail or a hospital for people in mental health crisis” (Affiliate News, 2014). The program will play a crucial role in serving those with mental health needs because individuals can walk-in and take advantage of services whether they have been brought in by law enforcement or not. It gives individuals who may have thought they have no other options to come in and be able to receive a form of treatment from a trained professional without any type of constraint. The COC stands as another vital effort to attempt to close the gap for individuals in central Iowa being underserved by the current mental health system.

**Providers**

In order for any mental health programs to be effective, potential members of the programs must be accurately identified. Individuals enter mental health programs through a variety of ways. Regardless of how the members enter into a program, entry almost always requires an accurate diagnosis by a mental health care provider. Diagnosis will determine the amount and types of service a member is eligible to receive, which becomes especially important if the member receives Medicaid or other publicly funded payment for services. One way individuals enter treatment is through intervention of the Iowa Court.

Iowa has criteria set for court ordered treatment. This criterion is known in Iowa as "outpatient commitment." For both inpatient and outpatient treatment, a person must meet the following criteria:

- lack sufficient judgment to make responsible decisions concerning treatment and be either:
- a danger to self/others, including that of serious emotional injuries to family members and others
  OR
- unable to satisfy need for nourishment, clothing, essential medical care, or shelter so that it is likely
that the person will suffer physical injury, physical debilitation, or death.

In Iowa and especially in Polk County, finding and getting an appointment with a mental health care professional has become difficult. US Health Resources and Services Administration (HRSA), Office of Shortage Designation, provides guidelines for determining federally qualified health professional shortage areas (HPSAs) (“HIP-suh”). (42 CFR Chapter 1, PART 5 - DESIGNATION OF HEALTH PROFESSIONAL(S) SHORTAGE AREAS, 10-1-93 edition.) Iowa Shortage designations indicate geographic areas with a shortage of primary care physicians, psychiatrists, or dentists for a given population, according to the HRSA guidelines. A current search provided by HRSA for shortage designations as of 2014 in Polk County ranks well within acceptable number of providers with no shortages. Seemingly a conflict between shortage designations and limited access to mental health care providers would indicate that providers are available, but some other factor is causing difficulty to access them.

Geographic HPSA is rated using a population-to-psychiatrist ratio of greater than 30,000 residents to one psychiatrist. The ratios can change if another high need indicator is present. High need indicators are poverty level, high youth ratio, high elderly level ratio or high substance abuse prevalence. Calculating the provider ratios with the addition of any of the high need indicators changes to 20,000 residents to one psychiatrist. A November 29th, 2014 search of the HRSA find shortage areas search database, reveals ninety-seven of the ninety-nine counties in Iowa are within the ratio of providers.

When trying to assess the figures that state mental health providers are within statistical ranges in Polk County, it further complicates the issue that so many individuals are unable to access these professionals, or are put on extended wait lists, which can extend six months or more to establish care.
Talking with some providers and those involved with payment for services, anecdotally, they give an indication that publicly funded payments for many of these services are not adequate or the claim process makes getting the reimbursement too costly. Some healthcare providers with prescribing privileges are no longer taking Medicaid and Medicare insurance as a result of the reduced payments. As noted earlier, managed payment services and funding streams have reduced payment amounts to many of the private providers previously taking these types of payments. Since the first step to be qualified for mental health services requires an evaluation by a qualified mental health care provider, and with the reduced number of providers willing to take Medicare and Medicaid payments, a person with legitimate needs may not be able to receive a needed diagnosis to receive services.

Although psychologists can make a diagnosis through testing and other diagnostic methods, only health care providers with prescribing privileges can provide medication. Polk County seems to have enough qualified psychologists available, however, the shortage, while not identifiable by HPSA standards, seems to lie with number of medical professional with prescribing privileges whom are willing to take Medicare and Medicaid insurance.

Tony Leys reported in a Des Moines Register newspaper article on May 10, 2014 “Mercy leaders said Friday that they plan to discontinue many of their outpatient mental health care services. The change, which will affect about 8,000 adult patients, is to take effect Aug. 29.”

Mercy sent a letter to patients of the Mercy Franklin clinic explaining they would need to find other therapists or psychiatrists by August 29th as Mercy had decided to discontinue services at this site. Finding a therapist isn’t as difficult as finding a healthcare worker with prescribing privileges to manage medications commonly associated with managing mental health conditions. Before closure of the Mercy clinic, patients would commonly wait 10 to 12 weeks for an initial consultation with a
psychiatrist. In the same May 10 article, Leys quotes Dr. Wael Haidar, chief physician executive for Mercy Clinics as saying:

“it's particularly tough to recruit psychiatrists to Iowa because the public insurance programs Medicare and Medicaid pay lower rates here than almost anywhere else. Psychiatrists tend to see many patients covered by those programs, he said, and they can make significantly more money by working in other states, such as Nebraska or Minnesota.”

The closure of the Mercy Franklin clinic represents the loss of four of the five medical providers who were available prior to the clinics closing. The article mentions that losing this many providers could potentially extend the wait for Des Moines area residents will have for accessing a psychiatrist.

Due to the closure of Mercy’s clinic, Broadlawns and Eyerly Ball end up having the few available psychiatrists health care providers willing to take public funded payments for evaluating new potential members for the Des Moines Metro area. With the reduction of health care professionals with prescribing privileges taking publically funded payments like Medicaid and Medicare, many pre-existing members with this insurance are now having difficulty accessing mental health care providers with prescribing privileges to provide medication therapies. Existing members are being directed to two providers still accepting Medicaid and Medicare, Broadlawns, and Eyerly Ball health care providers for ongoing counseling, medication management and other mental health medical needs. The existing members are finding themselves waiting significant time to establish a new doctor-patient relationship.

While several of the incarceration intervention services in place in Polk County are gaining success in diverting people with mental health from the prison systems, getting newly diverted persons
ongoing care can still be difficult. These same interventions potentially identify a person with mental health issues that can qualify for coordinated mental health services. The next step related to qualifying for services is to obtain a qualifying diagnosis by a qualified psychiatrist or psychologist, which may be delayed due to availability.

Service providers for the entire spectrum of mental health, intellectual disability, elderly care and other publicly funded programs have seen a decline over the last year. According to information pulled from Iowa Medicaid Enterprises Individualized Services Information System, Ninety-nine providers in Polk County were eligible to receive payments for various services in FY 2014. The same report shows in June and September of current FY 2015, the number of providers eligible to accept publically funded payments is reduced to 92 providers in Polk County. Information provided through interviews with providers and data collected from Iowa Medicaid Enterprises seem to correlate with the Mercy Clinic decision to close, as reimbursement rates are too low to sustain qualified provider services.

Mental Health Courts

Statistics show that individuals with mental health disorders have a higher incarceration rate than those without. A study done in 2006 by James and Chase of the Bureau of Justice Statistics shows that 64 percent of inmates in jails, 45 percent of federal prisoners, and 56 percent of state inmates had mental health disorder within the year prior to incarceration. According to that same study, the leading diagnoses of incarcerated individuals included: major depressive disorder, schizophrenia, and bipolar disorder. Those incarcerated were found to be three to four times more likely to have chronic mental health disorders than the general public (AOC Lit Review, 2012). Due to this high rate, there is an immense need to focus on the population within the correctional system. One way this can
be accomplished is through mental health specialty courts.

Specialty courts began first began as specialty drug courts. The first court came into existence in Broward County Florida, and was used to work with persons with long-term substance abuse issues. The Broward County model was then mimicked around the country as it saw success. The first mental health court (MHC) began in 1980 in Indiana. The program did not attract a lot of attention due to its suspension in 1992, but was reintiated in 1996, as a successful jail diversion program. Broward County Florida is often recognized as the home of the first drug, and adult mental health courts in the United States. Similar to specialty drug courts, mental health courts increased in popularity and were copied in counties across the United States. The first Juvenile mental health court opened in 2001 in Santa Clare County, California. The number of mental health courts throughout the United States has grown to over 200 in the last five years.

Mental health courts often differ, composed of unique attributes, specific to the needs of the individuals and overall climate of the communities in which they are based. Despite this unique nature, courts across the country also share many characteristics. For instance, the process of going through the court remains relatively the same in each county. The process begins with a defendant volunteering for the program. One consistent rule found throughout the courts is voluntary participation. Upon entry into the corrections system, a defendant is given a choice to enter the mental health court and leave the conventional judiciary track. There are many instances throughout the process where a defendant can be given this option; the most common of which is during the arrest, or initial hearing phase. Other points where this can occur include, the defendant presenting a guilty plea pretrial through the conventional system, accompanied by approval or recommendation from the presiding judge.
After the first phase, the defendants are screened for possible exclusional material, which can vary depending on the state. General guidelines used most often exclude history of violence, co-occurring disorders with substance abuse, and issues with competency from the possibility of entering the mental health court. Other criteria for participants include specific classifications of offenses accepted by the court. Many of the initial mental health courts allowed only individuals charged with non-violent, petty offenses to participate. The new generation of mental health courts has expanded the target criteria to include felonies and sometimes even violent offenses. The process of a mental health court can take longer than a standard trial but is often preferred, as it will lead to a less blemished record, as well as the ability to connect to community resources.

Mental health courts exist within a family of problem solving court models. They usually consist of a team composed of a variety of individuals working together to create the best solution for the defendant and the general public. Using this multidisciplinary approach, teams are often composed of representatives from the judicial system, mental health providers, and various other support agencies work together to create a treatment plan that focuses upon an individuals plan, focusing on accountability and rehabilitation. Treatment regularly includes therapy sessions, medication evaluation, as well as referrals to various resources such as community-based services.

Persons involved in the mental health court are more widespread than the obvious stakeholders. The defendants are a major stakeholder, benefiting the most from the program while at the same time giving a lot to the program for success. With the addition of each stakeholder, new opinions and roles arise within the MHC. In the traditional court system, judges are often put into a position where they are required to assess a defendant and their mental health status. Without the expertise of a mental
health professional, judges have to discern competency and mental illness without the capacity to understand or identify if the defendant truly has a mental illness, and therefore have to rely on assessments requested by the judge. Specialty courts, on the other hand, employ a team capable of diagnosing the defendant, as well as identifying the best processes to assist an individual based on their needs. Add to that the defense attorneys and prosecutors role of doing what is right for the defendant as well as the public. The main challenge for prosecutors when dealing with defendants who have mental illness is that of public safety. This is a concern throughout the mental health courts and a high priority amongst all the major stakeholders (Denckla, 2001). The main goals of MHC’s is to decrease recidivism of participants as well as increase consistency and treatment for those with mental health disorders, while maintaining safety for the general public.

Mental health Courts have many positives attributes, There are some challenges to initiating a court system that focuses on individual outcomes rather than determining guilt or innocence. According to Derek Denckla and Greg Berman in “Rethinking the Revolving Door: A look at Mental Illness in the Courts” there are 12 major challenges in the mental health Courts; the first of which is defining success (Denckla, 2012). Many mental health courts have similar goals, which often become difficult to measure or define as some individuals may require ongoing assessment or services, which may not have a defined end or point of completion. Due to the difficult nature of defining and measuring outcomes, each court varies in the criteria used to define success.

Another challenge faced by MHC’s is that of proportionality. MHC have more variables in which to determine the conditions of release than a traditional court which heavily weighs the gravity of the offense along with concern for public safety. Mental health courts have to balance the need for
public safety along side the mental health needs of the individual and the gravity of the offense. The needs of the individual may conflict with the concern for public safety as the individual may show promise for treatment, but has a history of repeat offences.

Other challenges mentioned throughout “Rethinking the Revolving Door,” are case targeting, which involves identifying the cases that would work well for the court. Another challenge is the selection criteria used for participants, which varies from court to court, in addition to sanctions for noncompliance. There is also concern for using jail as a sanction for defendants who chose not to comply with requirements set forth by the court, which may include: medication evaluation and treatment, scheduled visits with mental health professionals, or other stipulations related to the treatment of the individual’s symptomatology. Jail as a punishment can cause relapses as well as agitate the jail population as well. Housing is also a concern addressed by the courts as many individuals who have mental health disorders are homeless or lack stable housing.

There have been few extensive studies on the effectiveness of adult mental health courts, and even fewer on juvenile mental health courts. Despite the lack of research, there is evidence of improved outcomes related to the use of mental health courts from across the country. However, there are many challenges to completing an adequate study. The main challenges are as follows:

“Some authors have noted that evaluating collaborative justice courts such as mental health courts have inherent challenges. Wolff and Pogorzelski (2005) identified five such challenges; defining the nature of therapeutic intervention, finding an appropriate control group, selecting a representative sample, ensuring appropriate and consistent dosage of treatment, and measuring effects at appropriate follow-up intervals (Judicial Council of California, 2012).”
Even with these challenges, some information is accessible and leads the reader to the conclusion that there are positive consequences related to the implementation of mental health courts. According to Derek Denckla and Greg Berman in “Rethinking the Revolving Door” Broward Mental Health Court in Florida reported evaluating 1,530 defendants for participation from July 1997 to June 2000. Of those evaluated 652 were found to be eligible. “Fifty-four percent of defendants presented with mental illness only, 16 percent with co-occurring disorders, 2 percent with substance abuse disorders alone, 2 percent with development disabilities and 26 percent with an undetermined diagnosis.” (Denckla, 2012). These statistics, derived from the intake process show how large the need for a separate court process can be. Denckla and Berman also state that King County mental health Courts had a rate of forty one percent of defendants referred, opt for the MHC. Although there isn’t a lot of concrete data that accounts for the various treatments and control groups, King County mental health Court found a steep drop in the recidivism amongst those who participated compared to those who opted for the standard court.

According to the AOC Lit Review researchers have found positive results in three main outcomes One was “Utilization of Treatment Services.” Participants were dramatically more likely to report having attended more than two therapy sessions. Furthermore, those linked through the court to the mental health system and its providers have a higher likelihood of gaining access to housing and other supports than those with mental disorders in a traditional court. Reduced recidivism rates were also found for those who participated in a mental health courts than those who went through standard courts. In addition, individuals who engaged in the mental court process spent considerably less time in jail than their standard court counterparts. Mental health courts are also seen as remarkably cost-
Effective. States with mental health Courts were found to have lower criminal justice costs, although overall treatment costs were greater in the short term, but were overshadowed by savings linked to reduced recidivism, and the need for repeated treatment.

Iowa has a history of being a forerunner in advancing criminal and human rights movements. Therefore, it comes as no real surprise that Iowa has a mental health court in Black Hawk county. However, it does leave one wondering why Iowa’s capital is without such a positive feature. Determining the exact rates of individuals incarcerated with mental disorders in Iowa is difficult, if not impossible. Mental health symptomatology tends to wax and wane, and as such, not all persons are not going to be identifiable in regards to their mental health needs. Iowa has many programs dealing with diversion of persons with mental disorders into community-based services as well as shortened jail terms. As stated earlier, many community-based services are available, and more as appearing each year. This can be attributed to many things, but the two main factors as found throughout the literature, it is the growth of the mental health needs within the state, as well as the growing awareness within the population.

Specialty courts for mental health have appeared around the state of Iowa, the largest and most well-known of which is in Black Hawk County. This court opened in early 2009, following the initiation of a jail diversion program, which was initiated in 2004. Black Hawk counties mental health court results have yet to be measured. Woodbury County has its own specialty court, the first of its kind in the state of Iowa. Why then has Polk County, with a population of over 440,000 citizens, nearly double the population of Woodbury and Black Hawk counties combined, not been selected for their own mental health court?
Many agree that pre-booking services for jail diversion would be beneficial, however, difficulties in finding sustainable funds for these services may be creating a service gap. Funding sources have decreasing steadily over the last few years, leading to a reduction in services (Stageberg, 2012). Programs where jail diversion is used in combination with a mental health court, report a reduction of hospital visits and recidivism, reducing overall costs imposed upon taxpayers by individual offenders.

Many of the mental health courts seem to follow a natural progression from jail diversion programming within counties in the United States, providing more solutions for those who enter the correctional system. Due to lack of continuous resources, many of these programs are finding it difficult to maintain consistency and growth, negatively impacting the overall condition of individuals with mental health needs. Polk County has taken steps that point to greater success for individuals with mental health needs. The County would further benefit from the creation of a mental health court which would tie together existing jail diversion and crisis programs, creating a platform, from which a larger number of individuals can be linked to needed services and supports. The creation of a mental health court in Polk County, would provide an extra step, in which individuals are identified and linked to services within the community, minimizing undesired outcomes, and increasing the rate of success.

Conclusion

The condition of Iowa mental health programming has improved over the last few years. Part of the mental health redesign has opened up access to individuals in rural areas who might not have had access before the implementation of the regional system. In addition, the creation and implementation of jail diversion programs and crisis services are proving to be beneficial, and working well. The funding for overall MH programming, however, appears to be lacking, creating a deficit of services in
many of Iowa’s counties. This has the potential to put further financial burden on budgets elsewhere. Individuals who are not receiving the proper services have an increased likelihood of entering the correctional system or ending up in a hospital, where there stay is paid, in part by Medicaid, but quickly falls to the hospital, who will in turn pass the costs to patrons, through insurance. To under fund the system is not only a disservice to the persons who utilize it directly but to the taxpayers who fund it, as they will be paying a higher price overall for a system that is not working as it should. In the short time that the program has been implemented, providers have already withdrawn from crucial services based on poor reimbursement rates, with no flexibility and little adjustment based on individual need. At this point it is certainly not sustainable. Iowa is also lacking an integral piece to services related to jail diversion. Individuals with MH needs, are still overrepresented in Iowa’s jail system. Iowa has yet to promote a pilot or fully operating program where there is a full array of jail diversion opportunities, including a mental health Court in which individuals would gain access or be referred to needed services, before the threat of incarceration. All three of these programs have been implemented, but not in the same county, and so far no single county has seen overwhelming amounts of success. Polk County is well represented with Crisis services and Jail Diversion for those who have been arrested, but lacks a mental health court. Black Hawk county was selected for a mental health court, but lacks crisis service options.

1. **Lack of Mental Health Professionals**

   Most counties in Iowa, despite being now composed of regions are still lacking psychologist and psychiatrist positions, greatly reducing the efficiency of service, as individuals are subject to extended wait times before being able to obtain diagnosis or develop a relationship with medical staff able to assist with prescriptions. The ratio of available professionals is not currently high enough to meet the needs of the citizens of Iowa. The regional system opens up availability of existing providers,
however, decreases in funding and complexity of paperwork from Medicaid, are causing current providers to no longer accept these funds, reducing the number of professionals in the current pool and deterring new providers from coming to Iowa.

2. **Funding is not sustainable**

Reimbursement rates for IHH programming as it is written, is not sustainable. Polk county, one of Iowa’s largest counties is already noticing providers who are withdrawing from services due to a daily service cap and a tiered system that greatly limits the services any individual may access. The current rates for programing do not allow providers to provide needed services and remain viable. If rates are not increased or re-negotiated, Iowa will continue to see service providers submitting letters of resignation from mental health programming. Furthermore, the Iowa Health Home program does not allow for an exception to policy or directors exception, which could allow for individual exceptions to the daily cap, leaving individuals with only an option to appeal the individual notice of decision, should it fall below the rate caps. The current limits on services refuse to acknowledge individual need, proclaiming that all persons must fit into a pre-designed category of care, to which there is no exception. Until an individual’s needs are allowed to be assessed as such, Iowa will continue to see these needs met in other ways, either through hospitalization or incarceration.

3. **Counties are missing complimentary services**

Despite having several jail diversion programs and crisis’ services across the State, there is not yet one county that has implemented a mental health court in combination with jail diversion and crisis services. It appears that crisis observation supports are gaining recognition and playing a role in ensuring the individuals who are in need of services are receiving them. However, without a mental health Court, a large piece of the puzzle is missing, allowing individuals to be fed through a system that
does not provide respite or treatment of the individual based on their needs. Individuals who are believed to have a mental health concern are currently taken for observation, then released or charged. Without a system to assist individuals in receiving needed services, the hidden costs of mental health services, which have a high potential to remain as such as individuals are picked up by the department of corrections or private hospitals, keeping the true cost of care shrouded by the failure to achieve expected outcomes.

**Solutions:**

1. **Expand tuition forgiveness**

   Expand work with the National Health and Service Corps. According to the U.S department of Health and Human Services, Health Resources and Services Administration, Iowa is currently only receiving $140,000 for student loan repayments. Currently 89 of Iowa’s 99 counties have provider agencies that are short positions and would qualify for loan forgiveness([www.hrsa.gov](http://www.hrsa.gov), 2014). Iowa would benefit from further advertizing and announcing potential loan forgiveness programs and the areas that would qualify for program payments. In addition, the creation of a State Based loan forgiveness program, with an emphasis on students who are attending Iowa schools should be implemented. A portion of funds collected from individual counties and retained from the general fund could be used to create a sustainable account to fund such loan forgiveness, or other incentives to retain qualified professionals to remain in shortage areas. According to the NHSC, in 2012 there were 64 total participants of the loan forgiveness program, consisting of physicians, dentists, advanced nurse practitioners, psychologists and other mental health providers. Out of these 64, only 14% stated that they planned on remaining in their areas of practice for 10 or more years.

2. **Reassess reimbursement rates and tiered system payments**
Reimbursement rates and the tier system must be reassessed. The rates that individuals qualify for are not enough to meet their needs nor allow for long term viability for providers, causing several providers to withdraw from viable services. This puts further strain on an already fragile system, creating an increased bottleneck of individuals attempting to receive services from a reduced pool of providers. A larger portion of funds needs to be distributed to the regions, so they might be able to fund services at current needs. For the FY 2015 an increase for the General Budget request is $22,765,000 over the 2014 FY. According to The Iowa Department of Human Services, potential use of the general funds include: reducing waitlists, ensuring core services, expanding core services, creation of crisis programing and potentially expanding programing to new populations or expanding eligibility should all of the previous areas be met (Mental Health & Disability Services Redesign, 2014). However to date, no monies from the general fund have been redistributed to any of the counties or used for any of the purposes purposed. The levy on funding for services also needs to be increased, with plans to allow for yearly inflation. Counties have been using an outdated levy rate, while the State has implemented a list of services that each region must provide. Furthermore, the retention rate of funds should be increased to 25% from the current 15% allowing programs to adjust to unexpected increases of services without compromising the level of care or creating waiting lists.

3. Create Complimentary MH programs related to the correctional system

In Iowa there is not a single county that has implemented crisis observation, jail diversion and a mental health court in addition to home based services. Black Hawk County has created a pilot mental health court, but lacks support from jail diversion and crisis programing. Polk County, has implemented crisis programing and jail diversion, but does not currently have supports to assist individuals who have entered into the correctional system, providing guidelines and suggestions to promote stability, rather than sending them to a hospital for evaluation, or allowing them to remain incarcerated without proper treatment. The three programs, when applied in the same region, have the
ability to reach individuals who require more assistance and have the greatest chance of falling through
the gaps of the system, only to be left behind.

References


