



Mental Health and Disability Services Redesign

Judicial-DHS Workgroup Minutes

September 6, 2012
10:00 am to 3:00 pm
State Capitol Room 103
Des Moines, Iowa

MINUTES

Attendance

Workgroup Members: Beth Baldwin, Dr. Bhasker Dave, Deb Schildroth, Diane Brecht, Gretchen Kraemer, L. Jay Stein, Jesse Hornbeck, John Baldwin, Kathy Butler, Kathy Stone, Kelly Yeggy, Kimberly Wilson, Linda Brundies, Mary Ann Gibson, Neil Fagan, Ron Berg, Steve Hoffman, Terry Rickers, Virgil Gooding

Co-Chairs: David Boyd and Karalyn Kuhns

Facilitator: Donna Richard-Langer, Iowa Department of Human Services

DHS Staff: Karen Hyatt, Joanna Schroeder, Jen Harbison

Other Attendees:

Beth Lenstra	LSA
Cathy Engel	Iowa Senate Democrats
DeAnn Decker	Iowa Department of Public Health
Jeanette Minor	NAMI of Greater Des Moines
Judith Collins	INA
Kris Bell	Iowa Senate Democrats
Paige Thorson	IDA
Rachel Hjelmaas	LSA-Legal
Sandi Hurtado-Peters	Department of Management
Teresa Bomhoff	IMHPC, AMOS, NAMI

FOLLOW-UP ON DATA REQUESTS

Information/data for other states that have combined commitment laws.

- Information recommended for consideration regarding consolidating commitments is posted on the DHS-MHDS website under required reading for the Judicial Workgroup, September 6, 2012 entitled "[State Standards for](#)

[Assisted Treatment: Civil commitment Criteria for Outpatient Psychiatric Treatment](#)

- Although a good resource for the group, the point was made that the document may not be comprehensive for all forms of commitment.

Data on commitment numbers, not just filings.

- There is effort being made to find accurate information on the number of commitments filed in Iowa opposed to multiple filings. It is known there is information available from DHS institutions; however, this does not cover the information outside of the institutions and across the state. In addition, the case management system will be looked at as a source for additional data.

CONTINUED DISCUSSION ON INVOLUNTARY COMMITMENT PROCESS CONSOLIDATION

Identify procedures that could be the same in Chapters 125, 222 and 229.

- It was stated that several states do not have a code specific for commitment and use guardian language instead. There is also a lack of code for intellectual disability commitments in other states.
- There was discussion on the advantages and disadvantages of trying to combine procedures for Chapters 125, 222 and 229 and the benefit of consolidation. Due to the procedures being different in each chapter, there was concern of unintended weakening of the chapter criteria for each.
- If the commitment process was configured in user-friendly and family oriented terms, the information would help people know how to proceed through the commitment process and would be the justification to create one code.
- In contradiction to the above point, others felt the availability or lack of resources is the source for confusion surrounding the commitment process and not the process of commitment itself.
- A frustration on the judicial side is repeated filings on the same individual, leading one to believe the resources available under Chapter 125 do not seem to produce positive results and may be insufficient. Recommendation made that the individual with repeated filings be given the same case number.
- In Chapter 125, commitment is limited to 45 days – 15 days for evaluation followed by 30 days of treatment, which is seen as appropriate for the return to normal physiology. In Chapter 229, the time frame is different and SMI consumers do not generally get well in 30 days. There was discussion on the reporting time frames attached to each chapter and the question was raised if there is a compelling therapeutic reason to define the treatment with timeframes.
- Historically, the code was changed to allow a hearing for a dual diagnosed individual. It was noted that the number of dual diagnosis facilities available are few.
- If the commitment process could be combined for ease of access with a differential placement option for substance abuse, intellectual disability and mental health – there would be support to combine the chapters.

- The workgroup considered whether it was trying to merge incompatible areas within the codes. It was reiterated that the charge for the workgroup is the consolidation of laws. Concern was raised on whether the consolidation helps the consumer.
- The original charge was to combine the chapters to address the need for co-occurring treatment and to expand the definition of co-occurring disorders. The current reality is that individuals have dual commitment filings and care/treatment is not combined.
- It would help the judicial system to have a central registry of treatment options and locations to use as a reference when responding to court filings.
- Funding questions was raised regarding the new regions and how treatment for chapters 125, 22 and 125 would be paid for.
- If one commitment was created (combining chapters 125 and 229), and subsections were created under the filing for different treatment tracks, would this assist the judicial system?
- The judicial perspective was that the court would always know there were two prongs to the case filing and the concern was not from a procedure standpoint but a concern that substance induced disorders would be limited, and this does match the therapeutic concern already stated. People are looking for effective treatment because the current substance abuse treatment is not working. There is limited treatment for dual diagnosis/co-occurring and a lack of resources. Families do not feel the current experience of dual filing is effective.
- The committal laws for substance abuse are important for family members in order to arrange for assistance. A review of the criteria was the person was a danger to self or others. Keeping this in mind, it was felt there should be one code to assist people with co-occurring disorders and language should be written to support this. It was mentioned Iowa does not need to continue with silos of service delivery as this doesn't allow for the opportunity to look at the person as a holistic being. The mission is to improve the experience of those needing help.
- A new code should be built utilizing pieces of the old law to build a new one. The overall current code is seen as pertaining to the institutionalized system and doesn't take into consideration community-based systems that will be developed.
- A presented concern was the commitment forms for chapter 229 do not ask about mental health and substance abuse history. The dual filings are turned over to a clinician for an evaluation to determine where the treatment should be focused.
- In Clay County the commitment filing process is unique in the state:
 - The pre-screen/evaluation is the first starting place.
 - This a front door approach and there is no wrong door – filings are the same process.
 - Determination occurs with a team during the evaluation.
 - Placement is often determined by funding and availability.
 - Paperwork process follows the evaluation.
 - An individual goes to the court house with a documented family concern. The determination is made to send the person to the emergency room for assessment. After the assessment, a decision is made on whether commitment is warranted. If so, the judge orders the filing, utilizing

chapter 229 and/or 125. The determination is then made which filing to dismiss based on the evaluation.

WORKGROUP RECOMMENDATIONS

Motion presented and passed: There is one application for commitment for chapter 125 and chapter 229.

- One application submitted to the clerk of court. That application would state:
 - i) Danger to self or others.
 - ii) Lack of judgmental capacity.
 - iii) Because of serious mental illness and/or substance abuse.
- Provide facts to all three elements. State a presumptive primary problem (SM or SA) if one is identifiable.
- If the applicant seeks immediate custody, the court shall decide whether initial placement is at a psychiatric hospital or a substance abuse facility. The default will be the hospital and the court; at its discretion, can place the person at substance abuse facility if indicated in the facts of the application.
- Hearing will determine danger, lack of judicial custody, based on mental condition. Placement will occur on two tracks: SA (125) and SMI (229) with periodic reporting and discharge provisions governed by the respective chapters.
 - Unresolved issues include where to put the person on immediate custody and being co-occurring capable (do all initial evaluations need to evaluate for both SMI and SA).

Motion presented and passed: Recommend prescreen capability for all respondents before filing for chapters 229, 125 and 222.

- Keep the filing optional / voluntary.
- Utilize the same language as exists in chapter 229.

Motion presented and passed: Abolish involuntary commitment process of chapter 222.

Motion presented and passed: Modified code sections and update the system to include community based service language.

DISCUSSION ON MOTIONS

- Look at each chapter separately.
- Co-occurring problem not stemming from the code but due to lack of resources/not enough treatment facilities.
- Chapter 229 should be community based - would need to keep the institutionalized part of the chapter the same.
- Keep it optional / voluntary.
- Look at the number of current commitment cases.

- Determine how many guardianship cases are in place then terminate chapter 222 and utilize the probate system. Give current guardianship cases one year to plan for the change (with a specific deadline).
- Look at the Iowa Association of Community Providers for data on the use of chapter 222.
- If a person needs immediate custody, a clinical opinion would be given at the time of the hearing that would determine a substance abuse, mental health or co-occurring diagnosis.
- The basic due process needs information on one set of applications, criteria for danger, how to pick up the order; attend the hearing, and placement criteria.
- Suggestion that the assessment could be conducted on either an outpatient outlet or in an emergency room.
- Chapter 125 requires a medical screening. Not sure how to define no wrong door. At the point of filing the language is not clear.
- Suggestion/comment that the immediate custody default will be the mental health institute.
- Question on whether the mental health institute can implement the 24 hour hold.
- Comment that families should not have to continue to file duplicate commitment filings – support for one filing.
- Judicial comment that the Iowa law states a person has to be intoxicated to receive treatment (involuntary) and if not intoxicated the person cannot be required to stay overnight. Concern regarding the one door policy and how it would work in a substance abuse emergency.
- Question: In current reports, forms for chapter 229, serious mental illness has 125 questions relating to substance use. How does this assessment get translated into the reporting? Answer: North Dakota has the same language and it works.
- Recommend to improve and update chapter 125 (just Division 5) and chapter 229.
- The legislative charge is not broad enough. For a number of years, the judicial branch has been trying to raise the issue with the legislatures to do a review and analysis of chapter 229 and update so it more accurately reflects how the judicial system deals with mental health issues in Iowa. The issues are different in 2012 than when chapter 229 was drafted. Would recommend that the time has come to address chapter 229, update, improve and make it reflective. The current chapter is so geared to institutional outcomes that it leaves out community based options and language.
- There is a need to educate the legislature that unless they are willing to reallocate resources for new problems / issues such as access to dual diagnosis commitment then nothing will change.
- There is a need to strengthen co-occurring resources.

PUBLIC COMMENT

- Comment: SF2315 sets the stage for the state to be more co-occurring capable, to be capable of trauma informed care. DHS has been promoting co-occurring capability utilizing the expertise of Ken Minkoff and Christy Kline and their philosophy is to provide treatment for mental health and substance abuse at the same time and that it is best to treat the person holistically.
- Comment: Despite the lack of resources to refer people to, believes the system should be built right and not based on what is currently lacking. A reminder that DHS applied for the Balancing Incentive Program (BIP) where the whole premise is to treat people holistically with no wrong door. The proposal for commitment fits into this strategy, as is changing the chapter language.
- Comment: There is danger in having only discussion for criteria of commitment. Encourages commitment to treatment and not just commitment to hospitalization.
- Comment: Applauds recommendation about the lack of resources and the commitment needed to enhance these resources.
- Comment: Hears reluctance on the workgroup to review the commitment laws. All the communities recognize it has to be reviewed. Feels it should be reviewed and solutions offered, and would support the changes proposed. Asks the workgroup not to fall into the same trap of deferring the issues on to someone else.
- Comment: Retired psych nurse – rural and urban issues are the same if resources not available. ARNP are the ones who can provide follow up after commitment. Prior to this availability people had to go to family practitioners and specialists. Made the case for nurses to conduct evaluations that are signed off by a physician. ARNP could perform these functions for the court. Would encourage this language be included in the code moving forward.
- Comment: Feels the subgroup, with the inclusion of non-workgroup members, should still meet and jumpstart the process of change. Didn't feel this would be any different than Farm Bureau working on what they would like to see happen and presenting these findings to the legislature. Believes recommendations could be made to the Interim committee

who will be appointed to look at financial concerns, workgroup recommendation, and receive public comment.

Comment:

Appreciates the co-occurring efforts of DHS-MHDS and IDPH. Stated that enhancing efforts through training opportunities has been effective, and believes there needs to be a common will towards the effort between state government, community providers and communities. If the state waits for additional money, the training and common will may not happen – recognizes at some point will need financial infusion.

*Next meeting is October 11, 2012, from 10:00 am to 3:00 pm at the State Capitol, Room 103.

FOR MORE INFORMATION

Handouts and meeting information for each workgroup will be made available at:
<http://www.dhs.state.ia.us/Partners/MHDSRedesign.html>

Website information will be updated regularly and meeting agendas, minutes, and handouts for the Redesign workgroups will be posted there.