Judicial-DHS Workgroup Minutes

October 11, 2012
10:00 am to 3:00 pm
State Capitol Room 103
Des Moines, Iowa

MINUTES

Attendance

Workgroup Members: Judicial Magistrate Jay Stein, Kathy Stone, District Court Judge Terry Rickers, Neil Fagan, Ron Berg, Diane Brecht, Kathy Butler, Kimberly Wilson, Gretchen Kraemer, Deb Schildroth, John Baldwin, Linda Brundies, Kelly Yeggy, Mary Ann Gibson, Steve Hoffman, Beth Baldwin, Virgil Gooding, Dr. Bhasker Dave, Tom Eachus, Jane Hudson

Co-Chairs: David Boyd and Karalyn Kuhns

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

DHS Staff: Joanna Schroeder

Other Attendees:

Marilyn Austin	Iowa County Community Serve
Marty Ryan	Justice Reform Consortium
Stephanie Kuhn	Judicial Advocate
Melanie Schroeder	1st District Advocate
Nancy M. Fischer	Dubuque Advocate
Jayna Grauerholz	Disability Rights Iowa
Debra Brodersen	Spencer Hospital
Marquetta Hoffman	Judicial Advocate
Rick McVay	Judicial Advocate
Mary Swartz	Judicial Advocate
Karl Schandt	Advocate
Donna Ray	Judicial Advocate
Lisa Swanson	Advocate
Jackie Bailey	Patient Advocate
John Bigelow, Jr. PsyD	Southwest Iowa Mental Health Center
Linda Hinton	Iowa State Association of Counties
Heather Olson	Center fro Alcohol & Drug Services
Kris Bell	Senate Democratic Caucus
Brad Leckrone	County Social Services
Rachele Hjelmaas	LSA - Legal

Other Attendees Continued

Betty Marxen	Taylor Ridge Estates
CJ Schmidt	Advocate
Bill Freeland	House Democrats Caucus
Anna Hyaff-Crozier	House Democrats Caucus
Jackie Dieckman	Advocate
Carrie Kobrinetz	Caucus Staff
Deanna Triplett	Iowa Behavioral Health Association

Beth Baldwin Presentation District Court Administrator, 5th Judicial District
In 2007 and 2008 an advisory council came together as the result of the need to put some kind of boundaries on mental health advocates. This included what an advocate's duties were and what they are not – they are different from the duties of a case manager. The group also discussed what is billable and not billable as a mental health advocate. There were also 35-40 issues small group didn't get to as the work of group was halted in 2009 due to budget cuts.

Advocate Case Oversight Document

- An Advocate is court ordered to a respondent or patient and deals directly with the attorney and court. The court order is involuntary, i.e. not their choice.
- A mental health advocate is advocating for legal issues and his/her role is not about ensuring the best interest (case manger role) but legal interest of the client is ensured.
- The patient advocate works for the client's legal rights and commitment rights, and case management advocates for the best thing for client for services
- In some situations, a mental health advocate might want to appeal the choices made by a case manager but some of the advocate's clients do not have a case manager. If this is the case, then the advocate might serve some of the roles of a case manager.
- Beth Baldwin believes the advocate entity needs to be independent.

Mental Health Advocate Job Description

- 229.19 gives some basic primary duties (1-7). These are high level but it doesn't really encompass what an advocate does. The advisory council added some additional related duties that point out the best-practices that mental health advocates should follow.
- The related duties document has been approved by the Judicial Council, an advisory body to the Iowa Supreme Court.

Guidelines for Appropriate Billable Activities

- Developed because the most common issue a district court administrator asks a mental health advocate or CPC who is responsible for payment. This list appropriates things that are billable.
- At this time the document was created, substance abuse was not paid for but the 2012 Legislation added co-occurring conditions so it is now paid for.
- Also specifies what is billable if the client does not have a case manager.

- There is inconsistent reimbursement. Some advocates are on salary and some are hourly.

The advisory council was moving on to develop a performance-based document but weren't satisfied with it. It is still under construction but this is still an issue that needs to be worked through. The advisory council also talked about some type of auditing for case files.

Status: The job description was supposed to go out to all MH advocates and be abided by but there is no one checking up on it. The billable document has been given out to CPCs and mental health advocates. There is no mental health advocate state director and Beth Baldwin believes there needs to be state management.

Presentation by Rose McVay, Court Mental Health Advocate, 7th District

- Rose presented a pilot project that took place in District 9.
- One of the first steps taken was to combine the outpatient commitment and RCF forms into one. This was done to ensure that enough information is provided to show the client continues to meet all criteria for serious mental illness.
- If the client does not meet the criteria and enters a continuation order then the advocate has the ability to request a review of the order. We rely heavily on the Iowa Supreme Court. (See University of Iowa ruling.)
- Met with hospitals and mental health centers in District 9 to discuss the new form.
- Ninety-three (93) requests have been submitted for a client to be removed from court commitment and it has resulted in 74 cases of clients being removed with only one recommitment. Judges are getting better at reading and understanding the information in the form.
- Since the new form was implemented there has been a 24 percent reduction in commitments in less than one year.
- Recommend these forms become mandatory statewide.
- A civil commitment should not keep a client under the court forever; rather it should be used for just emergencies.
- With the use of these new forms if a client doesn't meet the criteria then they should be taken off a court commitment.
- The majority of the 74 were under outpatient commitment. Most doctors don't think these hurt anything and the only way the patient would continue services.
- Do you know how many of your clients have been involved in the criminal justice system? In Rose McVay's experience, more than half.

Presentation by Mary Swartz, Court Mental Health Advocate for Franklin and Hardin Counties, IA

- Here as representative of Judicial Advocates for Persons with Mental Illness (JAMI), whose overriding goal is to maintain integrity and autonomy of the position to best protect the rights of those we serve.
- Reviewed the recommendations from JAMI.

- First two are the most difficult; 3-7 deals with some of the smaller details of the advocate structure and the last four are essentially the same as the 2010 mental court workgroup recommended.
- JAMI would like advocates involved in discussions relating to jail diversion and the mental health court.
- JAMI believes advocates can't be replaced by a case managers or service coordinators. There are too many significant differences.
- Our duties as advocates are not reimbursable under Medicaid, so if case managers would do what advocates do, they would have to hire additional staff and this would cost more money.
- Performance evaluations are really important in order to look at trends.
- JAMI believes that the systems should be autonomous, accountable and consistent across all judicial districts for all advocates.
- JAMII recommends that advocates continue to be appointed by the chief judge, giving authority to advocates. State oversight would allow for consistent reimbursement across counties.
- Are any advocates part of the electronic medical records system? MH advocate from audience said he likes the system because he can look at patient history. With this system, Court responds faster to reports.
- JAMI would support that all advocates in the state follow the documents presented developed by the advisory council.

Presentation by Heather Olson, VP/CEO for Center for Alcohol and Drug Services in Scott County, IA

- Refer to recommendations and suggestions document.
- Information collected for the substance abuse evaluations does not always include the same objective data. Recommend a standardization of forms.
- Substance-abuse treatment system is overburdened with individuals who are not appropriately placed.
- Inconsistent usage of patient advocates in the state.
- Recommend advocates are more involved in substance abuse commitments. Not just dual diagnosis but for all those with substance abuse.
- Recommend consistent usage of patient advocates in the hearing process, and suggests standardized training, duties and pay.

Presentation by John Bigelow, Jr., Executive Director, Southwest Iowa Mental Health Center & Joseph Cowley Center for Alcohol & Drug Services, Atlantic, IA

- Southwest Iowa Mental Health Center serves about 1,300 patients each year. About 25 under MH commitments and about 10 percent are dually commitment.
- John's experience with MH advocates has been very good. However, he is concerned about individuals court-ordered to his facility that don't have an advocate. He is also concerned about a client who's advocate is released once the client had been released from another entity.
- Found that over the years working with chronically mentally ill individuals, mental capacity can fluctuate every day.

- In some cases John said there is a concern that if the court order is released the client would decide not to keep participating in treatment.
- There is an issue of uniformity. Recommends a statewide system so every county would have to provide MH advocates; advocates can serve as a liaison between the courts and providers and the courts and the client and this is important.
- More education across all domains is needed; the interface between the legal system and the healthcare system needs to be better. Having a patient advocate to help with this relationship would be effective.
- Try to get clients off commitments as quickly as possible if it is in the patient's best interest.
- Recommends the court assign advocates for outpatient commitments as well as inpatient commitments.

Presentation by Rick Bly, consumer from Iowa City, IA

- Rick was committed to a substance abuse facility on December 5, 1998 and this was his 5th treatment facility. In one year he went to three different facilities. This is why he was committed. He did not have a MH advocate.
- Would you have wanted an advocated? No, Rick believes at this point in time he was ready to change, and didn't need a MH advocate. He had a court appointed lawyer, but said it would have been nice to know he had someone on his side such as a substance abuse advocate because he didn't know what was going on. His lawyer made sure his rights were protected but not his well-being.
- Did you ever feel the process was just a revolving door? Absolutely. He got to the point he didn't know if it was ever going to end. After the third time he had been through the process, he thought he would never get out of the process. He knew it wouldn't last forever; he was either going to go to jail or sit before the workgroup now as he did 14 years later.
- Would a longer commitment for substance abuse folks have been helpful for you? During my last stint, he followed through the whole process and was discharged at six months. From the treatment facility, he went to a facility half-way house and then to a half-way house in the community, but his commitment stopped after 45 days.
- The beginning of the commitment was difficult for him and this is when he said he could have used an advocate to assure him that everything was going to be ok and that he was being supported through the initial process. After the committal, the treatment center took care of him well and he was ok after that.
- Should the court continue to consider multiple commitments if the person doesn't have success? Yes. He said he was glad they didn't give up on him.

Presentation by Tom Eachus, Community Mental Health Center, Waterloo, IA

- In 1988, The Community Mental Health Center has 325 people on an outpatient commitment. Today there are around 180 due to the work to get people off commitment.
- Black Hawk County has the 4th largest number of commitments of any county in Iowa.

- All the referees and advocates I have worked with at the Community Mental Health Center have been helpful and collaborative in their approach.
- In reviewing duties and responsibilities, the MH advocates the CMHC has worked with have done well.
- Recommend advocates are separate from providers, funders, DHS regions, etc.
- Taking people off commitments who have a documented history of becoming psychotic, posing a danger to themselves and others can lead to homelessness, inappropriate hospitalizations, involvement in the criminal justice system, etc. Tom said he does not believe in letting people decompensate and then ending up in a worse place.

Presentation by Patrick Schmitz, Plains Are Mental Health Center, LeMars, IA

- Patrick has always worked in rural counties and has have been working in this field since 1992.
- He supports the MH advocate program. His first experience with a MH advocates was fantastic. The advocate understood when the time was right to leave someone on a court commitment even though the person was stable.
- Unfortunately in the last two years he has not met his patient advocates. Said none of his therapists know who they are either and there is a need for an active program. Recommends a statewide advocacy program that is consistent across the state.
- The mental health advocate program needs to be completely independent from any authority that has funding or service capacity for that provider, and there needs to be someone who stays abreast of court orders and advocates, know when a person should be taken off a court order.
- Recommends the advocates are held accountable to someone in order for the program to be effective.
- Asked workgroup to keep in mind the need to balance the patient's legal rights with the rights for treatment.

Presentation by Jackie Diekman, parent of consumer from Council Bluffs, IA

- Son diagnosed with paranoid schizophrenia at 18 is now 27.
- Year of turning 18 he started showing signs of severe psychosis and was hospitalized for several months. In the spring of 2005, he was transported to the Mental Health Institute (MHI) in Cherokee, Iowa because the other placement couldn't stabilize him. He was there one month and tried to commit suicide and was placed in seclusion. He told his doctor that the medicine was making situation worse but doctor didn't listen.
- Her son had charges pressed against him for assault and was removed from the acute care unit of the MHI. He was arrested and put in jail in a highly agitated state. Was only given medication by staff, and was only allowed to see him once a week for 30 minutes. During those visits he was highly psychotic and talked about suicide during every visit.
- At this point in time Iowa decided he was competent to stand trial during a competency hearing. She does not know how they found him competent to stand trial. He could face up to 20 years and put in regular prison and as his

guardian, she took a plea because she didn't want her son in prison or felt that he belonged there. He received five (5) years.

- At the time of the assault, he was under a court commitment. She was never contacted by a MH advocate. When he was officially charged, she still wasn't contacted by a MH advocate. She had no idea of his legal rights other than what the court appointed attorney told me.
- After he was sentenced he had a court order to take medicine but this didn't happen. He was in isolation for several months. She got another court order to get him his meds and he began to show improvement. He did have some help through some staff and was paroled in Feb 2007. After 22 months in prison, he was released to a Residential Care Facility (RCF).
- During the first year after his release, he was hospitalized four times and eventually he ended up in Clarinda where he did well.
- Was not at Oakdale the entire time he was in prison. After his first year he was transferred to Ft. Madison.
- She hopes better decisions will be made for those with severe mental illness.
- During all this, she called a lot of people and there was no help for her. There was a mental health advocate but when her son was removed from his placement he lost his advocate.

Presentation from Debra Ann Brodersen, Director of Mental Health Unit, Spencer Hospital, Spencer, IA

- Average daily consensus was around 14-16 and the hospital is a 16 bed acute adult locked unit. Do not have any type of medical unit. Have one doctor and two nurse practitioners who do psych care.
- The patients the hospital was getting were really inappropriate for the facility. Debra visited other facilities and developed an intake process; it's a two-page questionnaire. Now the hospital average is around 8.
- She believes when the state regionalizes this situation won't be any different. When she gets a call for a transfer, her question is will the MH advocate come with the patient? So far this hasn't happened. The hospital has had some patients in the unit for up to three months who don't have an advocate. How are we going to ensure that those from far away have advocates and are getting the help they need?
- Advocates are not following the hearings and not coming to see the patients when the patients request them.
- The patients from the region around the hospital do see their MH advocates. Her biggest concern is that the hospital has so many admissions from other regions and they have no MH advocates support, and they don't have transportation support.
- What is most helpful about an advocate is that the patients get the answer they need about legal issues etc.; 90 percent of the hospital's patients are court committed. The hospital's role is to provide treatment.
- Recommends a standard statewide entity overseeing advocates. Would advocates travel/follow the person or is the process so seamless that they would be able to shift the work back in forth?

WORKGROUP DISCUSSION

I. Recommendations already made by 2011 workgroup and accepted by legislature:
   A. Statewide oversight by an independent entity for mental health advocates.
   B. Advocates be assigned for those with co-occurring conditions.

II. What do we need to do to be responsive to our 2012 charge?
   A. Statewide independent oversight.
   B. To include:
      i. 125 substance abuse
      ii. 222 ID – transition issues
      iii. 229 mental health
      iv. Those found not guilty by reason of insanity
   C. Consistent reimbursement standard

Recommendation on Advocates for Involuntary Committals, Found Not Guilty by Reason of Insanity (NGRI)

- Support NGRI in limited number; could utilize advocate per 129 but not 125.

Discussion about Need for Substance Abuse Advocates

- Workgroup member has concerns about inconsistency in the process and among advocates across the state. Hasn't seen or heard of cases of those with substance abuse committals who haven't had their rights represented.
- If looking at conserving funds, believe those with mental health committals have more long-term and severe issues. Believe substance abuse people have more of an ability to advocate for themselves.
- Let's fix the issues surrounding mental health advocates first and then take a look at substance abuse advocates.
- For someone going through an involuntary substance abuse committal, perhaps an advocate is needed but in a more limited role than a mental health advocate. This might be a good use of peer-support.
- Recommend in the future feasible for advocacy for 125, include possibility of peer support.
- The real problem is the resources. How much time is spent by an advocate trying to find a bed, etc.?
- When you are dealing with substance abuse where agencies can re-commitment them, that is a big deal and there is a need for an advocate.
- Recommendation that the funding comes from the legislature for substance abuse advocates.

Discussion about Statewide Mental Health Advocates System

- We in private practice also deal with advocates. They're extremely important. Some suggestions: it would be helpful that advocates have some clinical experience or knowledge. Also important for them to have some general understanding regarding the functions of the Department of Human Services (DHS). There are often co-occurring issues and a patient is caught up with DHS trying to get their kids back or not lose them. Advocates need to have some

sense of child protective stuff/how child protective services work. There is also a need for consistent supervision of advocates that ensuring that performance evaluations are consistently done.
- Comment about JAMI proposal, not enough money in levies to fund current system. Not a good idea. Be careful about using this type of language. No county funds should be transferred.

Jane Hudson made a motion that the workgroup recommend there be an attached unit of the Department of Inspections and Appeals (DIA) with a director presiding over the unit, to provide oversight for a statewide mental health advocacy program. Kathy Stone seconded. Motion passed.

NEXT MEETING

- Next meeting discuss the proposals from: JAMI, Kelly Yeggy, Linda Brundies and County Social Services.
- There was a request from a workgroup member that the group discuss making a recommendation to make justice involved services a core service.

PUBLIC COMMENT

Comment:	In light of this discussion, I recommend everyone on the workgroup read *Crazy in America* by Mary Beth Pfeiffer.
Comment:	Regarding the discussion about substance abuse advocates, we have outpatient programs in Dubuque for substance abuse. What I'm hearing are complaints that after the person is committed the individual/family still have questions and don't know who to go to for help. When a patient is outpatient this really isn't short-term and there are a lot of problems with patients going back into facilities. Support advocates for substance abuse.
Comment:	We appreciate the task and fiscal responsibility of the workgroup and we are very supportive of the role mental health advocates fill, but we would like to see an effective stateside mental health advocate system in place before expanding the advocates to substance abuse.
Comment	People under guardianship still need a mental health advocate. Regarding substance abuse committals, I believe we need advocates for those with just substance abuse only committals. I keep hearing these are short-term, but where I'm from this is very long-term, and people don't drive so this becomes a huge issue. There are a lot of issues that do come up that a patient really needs an advocate for.

Comment:	One concern I have is the discussion around accountability for patient advocates. It's not necessarily accountability that you need to be concerned about, but consistency on reimbursement and duties.
Comment:	I would like to see some consistency within the advocacy system. People with the same issues have very different experiences.
Comment:	I am an advocate and I'm the only one can connect all the dots between facility, county of residence and the court house. I do this on a daily basis. It's a 24 hour, 7 day a week job. Many times advocates are the only people patients have since oftentimes if a person is committed by a family, they don't want to talk to them.

*Next meeting is November 8, 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.