

**ACUTE CARE TASK FORCE:  
Recommendations for Creating  
A Statewide Mental Health Acute Care Service System**

**Background:**

In the spring of 2007, the Iowa Legislature passed the *Mental Health Systems Improvement Act* that directed the Department of Human Services, Division of Mental Health and Disability Services (MHDS) to form workgroups, composed of statewide stakeholders representing the MHMRDDBI Commission, Iowa Mental Health Planning Council, consumers, statewide advocacy organizations and counties to make recommendations to the Commission for the improvement of the mental health system.

One of the top priorities that emerged out of several workgroups was the importance of creating a statewide acute mental health care service system, allowing for all Iowans to access critical mental health care for urgent/emergent needs. In the fall of 2008, it was recommended that an Iowa Mental Health Acute Care Task Force be established to design a set of recommendations to MHDS for cross-system planning and implementation of expanded acute care services.

As a result, DHS MHDS invited over 60 statewide stakeholders including representatives from provider organizations, advocacy groups, consumer networks, payer entities, state agencies, legislative staff and other interested groups to join the Mental Health Systems Acute Care Task Force.

Iowa is “transforming” its mental health system to one that is recovery-oriented or based on individual and family needs of the citizens of Iowa, rather than traditional mental health practices and restrictive care. In the area of Acute Care services, this long term plan requires a shift in philosophy from “triage to recovery” and embraces SAMHSA’s National Recovery-oriented Consensus Statement with the following principles: Self-direction (choice), Individualized and person-centered, Strengths based, Responsibility, Respect (self and society), Empowerment (needs, wants, goals), Holistic (community, housing, spirituality, etc.), Non-linear (recovery), Peer support, Hope

**Iowa Partnerships at Work:**

The development and composition of the Iowa Mental Health Systems Acute Care Task Force includes active representation from Iowa department of Human Services, Iowa Department of Public Health (substance abuse), Iowa Hospital Association, University of Iowa department of Psychiatry and Center for Disabilities and Development, Iowa Nurses Association, Alliance for the Mentally Ill of Iowa, Iowa Ombudsman’s Office, consumers, County CPC’s, Magellan Behavioral Health, Iowa Protection and Advocacy, mental health and substance abuse trade associations, Legislative Services staff and many other organizations and individuals that are listed in the table attached.

**Guiding Principles of the Task Force:**

The Acute Care Task Force, through several monthly meetings over the course of a two (2) year period, agreed to use a set of guiding principles for the acute care system that served as the focus of all recommendations made to the MHDS Division.

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The guiding principles for an acute care mental health system are as follows:

- Recovery-oriented, welcoming - Providing the essential and motivating message of a better future – that people can and do overcome the barriers and obstacles that confront them.
- Community-based – Service and supports will be provided within communities, allowing individuals to stay at home, at work, in school
- Least restrictive – An array of services and supports will be available at varying degrees of intensity/restrictiveness to persons receive appropriate mental health care, not just available mental health care
- Client-centered – Pathways to recovery are based on individual’s strengths and resiliencies as well as his/her needs, preferences, experiences, cultural etc.
- Strengths-based – Building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals
- Co-occurring capable – Assumption that co-occurring disorders are an expectation within individuals, not an exception and services and supports should be delivered to appropriately address the whole person
- Enhanced through Training/Education – Education and training are essential to building a system that is recovery-focused
- Evidence based practices – State-of-the-art services should be the hallmark of mental health care for Iowans
- Peer and Family Support Systems, Prevention, Programming and Family education – Mutual support – including the experiential knowledge and skills and social learning – plays an invaluable role in recovery

**By Default, NOT By Design**

The task force spent considerable time reviewing key available data and studying the current “system” for helping people in crisis situations. One of the initial activities was to create a logic map of the acute care system in Iowa, to visually understand the routes through which people enter the system and where they are typically served (see attached).

The mapping showed that hospital emergency rooms (ER) serve as the “hub” of mental health crisis services by default. From ERs, people are commonly referred and/or committed to inpatient psychiatric units for care, including the state-run mental health institutes (MHI). Jails are another entity where people with mental health crisis needs are placed routinely.

Use of community-based services for crisis assistance, such as community mental health centers, substance abuse centers, and other support services are not typically considered as a first stop for an individual or family experiencing a mental health crisis.

The task force determined that Iowa’s acute mental health system has been created BY DEFAULT, NOT BY DESIGN and thus has many gaps and pitfalls through which persons with mental illness fail to get served appropriately, according to the guiding principles desired for a premier service system.

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**Review of Data Tells Us...**

- In last 5 years, mental health and substance abuse applications for commitments in Iowa have increased 10% for adults. Source: Iowa Judicial Branch
- In last 5 years, mental health and substance abuse applications for commitments in Iowa have increased 138% for children. Source: Iowa Judicial Branch
- Iowa has over 800 psychiatric inpatient beds across the state but many of those beds are occupied by people unable to be discharged to a less intense level of service. Source: Iowa Hospital Association and DHS
- There is no standard procedure for locating a bed for court-committed individuals. Many counties ask parents and family members to search for an available psychiatric bed across the state. CPC personnel, Clerks of Court, County auditors, magistrates, sheriff department personnel, CMHC staff and hospital staff are others utilized to locate beds. Source: Iowa Ombudsmans Office CPC Survey
- In the past five years, Magellan paid ~\$32 million dollars for people on psychiatric units that no longer met medical necessity to be on the inpatient unit (over 6,000 patients authorizing more than 46,000 days) Source: Magellan Behavioral Health
- Over 40% of people in Iowa prisons have a mental illness or co-occurring mental illness and substance abuse diagnosis (DOC recognizes this is a low count due to data collection methods) Source: Iowa Dept. of Corrections
- On any given day, there are ~150 kids out of state, the majority of who have serious emotional disabilities. Source: Iowa DHS
- Iowa is 2<sup>nd</sup> highest in the nation of out-of-home placement of kids (2006). Approximately thirty percent (30%) of kids in out-of-home foster care come into custody for mental health service reasons, not safety and protection. Source Annie Casey Foundation
- Suicide is the 3<sup>rd</sup> highest cause of death across the nation for adolescents. In Iowa, suicide is the 2<sup>nd</sup> highest cause of death for adolescents. Source: Iowa Department of Public Health
- The array of crisis services available to Iowans is minimal and is not dispersed equitably across the state. Source: DHS Acute Care Task Force Crisis Services Survey to CPCs, May 2009
- Sheriffs Departments across the state do not have standard assessment tools for assessing the mental health and substance abuse needs of detainees. Many do not assess their detainees at all. Source: Iowa Sheriffs Association Survey from DHS Acute Care Taskforce, 2009

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Mental Health and Disability Services Division**

- Less than 50% of emergency rooms surveyed have access to a behavioral health nurse or social worker to assist with behavioral health patient evaluations and level of care decisions. Source: Iowa Hospital Association, Behavioral Health Affiliate Survey
- When local CMHC assessment services are offered at the Clerk of Court office for persons who have commitment applications filed, over 95% are diverted from psychiatric admission (Eyerly-Ball Mental Health Center, MCRT data, 2008)

**Task Force Recommendations:**

The Acute Care Task Force determined that the following areas are of greatest need for development or enhancement in order to efficiently and effectively serve people in crisis mental health situations. These programmatic/policy areas were chosen as the top priorities from a lengthy list of needs identified in order to have a state-of-the-art acute care mental health system statewide. The choice of the following areas of concentration was made with the thought that these programs and/or policies would provide a greater array of options for people experiencing a mental health crisis while meeting the intentions of the guiding principles of the task force.

A complete Acute Care Task Force Recommendations Outline will be forthcoming from DHS MHDS by December 2009.

**A.) Crisis Stabilization Centers for Adults and Child and Adolescent Crisis Stabilization Services**

**General Description:**

Adult - Crisis stabilization centers for adults provide 24-hour access to shelter, food, social support, and comprehensive treatment services for persons experiencing a mental health crisis who are voluntarily seeking assistance and do not need inpatient hospitalization. Services are typically provided in a small, comfortable setting, often preferred by consumers. These centers typically do not serve more than 10 people at a time. Treatment includes intensive discharge planning which links the consumer to natural supports and community resources needed for ongoing recovery. Crisis stabilization centers typically cost a fraction of inpatient hospital care. They are staffed by a multidisciplinary team which includes a psychiatrist, psychiatric nurses, peer support specialists, and social workers &/or mental health counselors. Services often include significant peer provided care and support. Crisis stabilization units are recovery focused and co-occurring capable. Average length of stay is 2 weeks or less. Units should be available statewide.

Youth and Adolescent - Crisis Stabilization Services for Youth and Adolescents provide 24-hour access to a continuum of crisis services that include:

- A) Mobile crisis outreach services that are provided in the home, school, and community to de-escalate interpersonal, community and intra-familial tension that is frequently the antecedent condition that typically underlies high-risk behaviors in children/youth.
- B) Community-based stabilization center is available to provide the children/youth with needed shelter if the situation cannot be de-escalated to a safe level. The family is a critical partner in

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this process and should participate in the crisis stabilization services to the fullest extent possible, including receiving services at the center with their child. The Crisis Stabilization Services Center (CSSC), in addition to providing a safe and welcoming environment that de-escalates interpersonal, family and community tension, allows the child/youth and family to access a professional team that facilitates a multi-faceted mental health assessment that evaluates the therapeutic needs of the child/youth and assists the family in accessing needed services. Discharge planning is also an integral part of this service, with the crisis stabilization worker facilitating smooth transitions back to the home, school, and community.

**What gap is this filling in the current acute mental health care system?**

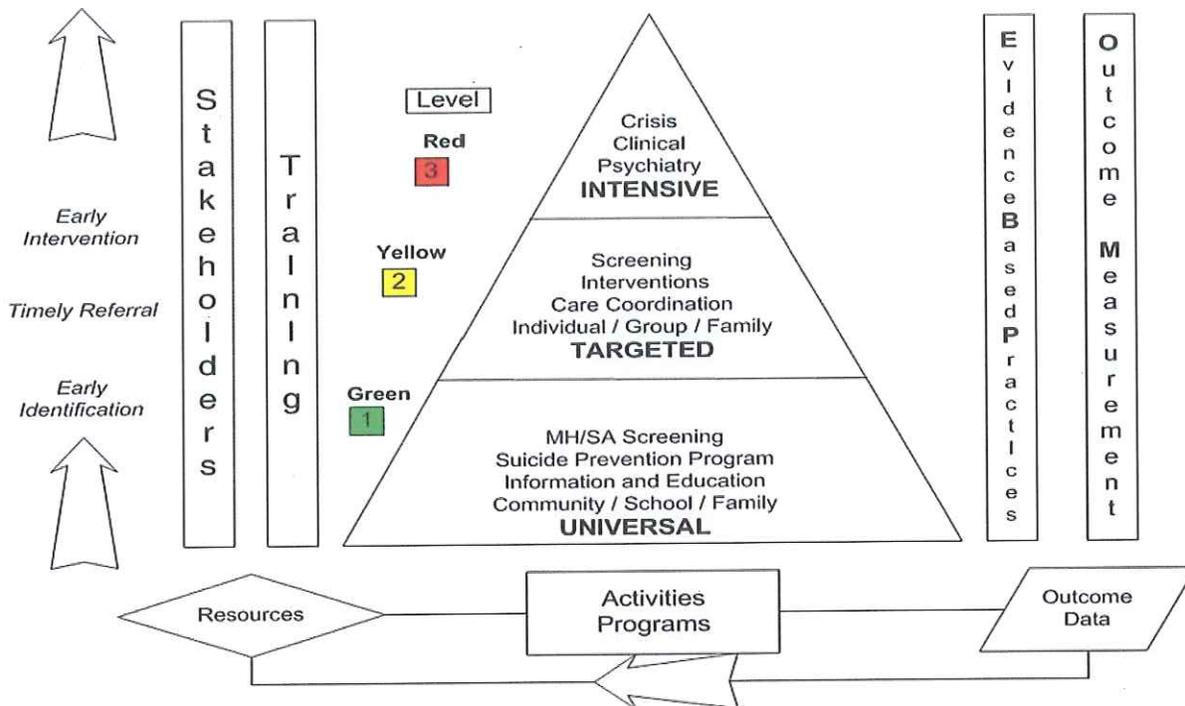
Adult - There is a gap in serving the need of people whose crisis episodes are due to psychosocial stressors/events that can be better resolved through support and linking interventions (care coordination) than by medical interventions generally found on inpatient units. Crisis stabilization centers can provide an alternative to inpatient hospitalization for persons who are voluntarily seeking treatment and support to resolve a mental health crisis and do not need inpatient hospitalization. Small, welcoming home-like settings can provide respite for persons needing intensive support and linking to resources and can assist post-hospitalization for persons needing intensive assistance establishing community supports. This is an appropriate alternative for judges and law enforcement that assists persons with mental health needs to find help.

Youth and Adolescent - When hospitalization criteria are unmet or funding is unavailable, there is an absence of programming designed to provide minors with the opportunity to stabilize their emotional and behavioral situation unless the child/youth is court ordered into shelter or more restrictive services that are intended to consequence negative behaviors. The outpatient system is not designed or equipped to handle children/youth who are frequently in crisis and who may lack adequate support and services to manage their mental and behavioral health issues. Families are left with the option of seeking more restrictive options than may be needed for the situation due to the lack of crisis intervention and stabilization services. Crisis stabilization is a short-term intervention that isolates the youth from provoking stimuli and gives them the opportunity to develop insight and foresight to regain control of their future, while providing families the opportunity to receive support and assistance in improving the situation that led to the crisis.

**B.) School-based Mental Health Services**

**General Description:** The school based mental health model promoted by this task force is based on the public health model of three levels of intervention- primary prevention , secondary (early intervention), and tertiary (intensive) services. School-based mental health services would be available to all students with emotional, substance abuse and mental health needs. Additional consultation and support would be available to families to help them navigate the complex and sometimes frustrating mental health system of care. Educators would be provided with necessary education and support that will help them better understand their students' mental health needs and respond in a more effective manner.

School-Based Mental Health Improvement Proposal Model



**What gap is this filling in the current acute mental health care system?**

Mental health services need to be readily available to children and families in a setting where children spend a significant amount of time, and where many behavioral and emotional issues occur. School based services provide a unique opportunity to address concerns in an environment that is convenient, more comfortable and decreases transportation issues and time away from school for appointments. Increased service provision, improved access to services, and care coordination would be available through schools, using a collaborative team approach to identify children at risk of mental health issues or in need of services, and provide/refer families to appropriate services. Schools and mental health providers would build cooperative relationships that would ensure seamless transition of referrals from schools to outside referral sources, and would maintain communication regarding ongoing needs and issues.

**C.) Jail Diversion Program**

**General Description:**

The term “jail diversion” refers to programs that divert individuals with serious mental illness (and often co-occurring mental health and substance use disorders) away from jail and provide linkages to community-based treatment and support services. Most programs:

- Screen detainees in the criminal justice system for the presence of a mental disorder
- Employ mental health professionals to evaluate detainees and work with the criminal justice system and the courts to develop community-based mental health plans for them

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Mental Health and Disability Services Division**

- Seek a disposition that is an alternative to prosecution; as a condition of reduction in charges; or satisfaction for the charges
- Decide upon a disposition and link the client to the community-based services

**What gap is this filling in the current acute mental health care system?**

Programs divert individuals with serious mental illness and co-occurring substance use disorders from the jail to community-based treatment and support services. This programming allows for avoidance of unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illness/substance illness.

**D.) Subacute Services**

**General Description:** Subacute services are time-limited services which provide 24 hour comprehensive treatment services for individuals experiencing a mental health crisis who have received acute care in an inpatient setting, yet have not been adequately stabilized such that they can be discharged to their own home or other residency setting. This service is provided as part of a discharge plan to continue care from an inpatient unit. The objective of this service is to provide active treatment, ensure the safety of the person served and the safety of others, to allow time for stabilization, consultation and resource mobilization. Treatment included intensive discharge planning which links the individual to community resources needed for ongoing stabilization and recovery in their own home and community.

**What gap is this filling in the current acute mental health care system?**

In Iowa, some individuals are not stabilized within the timeframe of the acute inpatient stay and cannot be safely discharged to their own home or other permanent residency situation. These individuals stay in the inpatient setting post medical necessity for acute hospitalization resulting in unnecessary costs to the individual/family, the inpatient facility, and any third party insurers (including Medicaid).

**E.) Expanded Role of Designated Community Mental Health Centers**

**General Description:** The community mental health center (CMHC) is viewed as a vital player in the provision of mental health services across the state of Iowa. Still, the CMHC needs to have an enhanced, active and effective role in the delivery of acute mental health services for the communities they serve. The taskforce supports the proposal submitted by a designated advisory committee in spring 2009 to revise Iowa Code 230a, which defines the role of the CMHC. The taskforce recommends that the CMHC should serve as an Access Center for a community, through which a wide array of acute services will be provided on a 24/7 basis. Further, the taskforce recommends fundamental changes in how CMHCs are structured, financed, overseen and accredited statewide in order to allow for the a robust scope of services, including a mandated core safety net of services, to communities regardless of income, diagnosis or age.

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Core safety net services suggested to be mandated include:

- 24/7 crisis emergency response
- 24/7 mobile response
- Screening Services
- Liaison with inpatient/residential when consumer is admitted
- Crisis care coordination

**What gap is this filling in the current acute mental health care system?**

CMHC would serve an active role in the delivery of the mental health safety net service array rather than a passive or selective role. Currently, while CMHCs are required to provide “emergency services”, this often takes the form of an answering service and a referral to a local emergency room, resulting in no meaningful interaction with individual in crisis and the CMHC. This would create a statewide safety net of services with the CMHC serving as the “hub” for these services.

**F.) Psychiatric ER Screening**

**General Description:** The Psychiatric Emergency Room (PER) is the term used to describe appropriate psychiatric assessment and care services are provided within an emergency room setting. In the emergency room, the psychiatric exam should be completed by a behavioral health nurse or another mental health professional, utilizing an acceptable psychiatric assessment tool. Access to a psychiatrist, or mental health-skilled ARNP for level of care determinations and medication consultations should be available either in person, via telephone or via telehealth services at all times. The psychiatric exam should be conducted in a safe environment, i.e. a “safe room”, commonly located apart from the main emergency room bed area.

**What gap is this filling in the current acute mental health care system?**

Because the ER is the first stop for many people in Iowa in need of mental health crisis services, having a designated psychiatric emergency room that is either part of the regular ER or an actual separate emergency department is critical. Currently, most local hospitals, especially in rural areas, do not have trained mental health professional available to provide the appropriate assessment and care services for people with mental health needs. This results in an increase of unnecessary psychiatric admissions, incorrect diagnosis, inappropriate treatment recommendations and medication prescriptions. The final outcome is often delivery of substandard care that is more restrictive than necessary and costly. Having ER staff that is placed in the ER to provide appropriate assessment and intervention will result in better care and higher quality of life outcomes for people.

**G.) Commitment Diversion/Chapter 229 Revisions**

**General Description:** The practices and Iowa Code associated with Iowa’s mental health commitment is recognized to be in need of review and revision. Like other areas of focus, the commitment process looks different in the various communities across the state, largely because the Iowa Code 229 is often interpreted differently by those who are enforcing it. The subgroup working towards recommendations on behalf of the taskforce recommends short and long term goals for redefining commitment procedures in Iowa. Several short term goals have been recommended including statewide training for magistrates, increased utilization of clinical evaluations to determine need for

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hospitalization, identify procedures for release of people from psych units when evaluation does not require hospitalization.

The long-term recommendation of the taskforce is for the creation of a mental health and judicial task force to build upon the recommendations made by the Iowa Supreme Court's Limited Jurisdiction Task Force and the Acute Care Taskforce to collaborate on recommended changes to Iowa Code Chapter 229 or other related Code and to recommend a plan for achieving systematic consistency across the state between county courts, providers, mental health administrators and policymakers. The recommendations are made so that ultimately a system is developed that provides innovation and consideration of the person in need as the central focus is efficient and does not overuse the powers of courts and Iowa Code to "manage" the mental health needs of Iowans.

**What gap is this filling in the current acute mental health care system?**

There are several gaps due to inconsistent interpretations of Code and subsequent procedural variations across the state related to commitment of people with mental health needs. The trickle down effect is costly to the individual's wellbeing, as well as financially to those entities that cover the costs of commitments and related services (mental health advocate services, sheriff/other transport services, legal costs, facility costs etc). Clear, consistent Code and practices adopted by the involved stakeholders will possibly result in an increase in appropriate care for people, that is often less costly.

Submitted by Kelley Pennington, PhD, MSW  
MHI Task Force  
December 2, 2009

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**Acute Care Task Force Members**

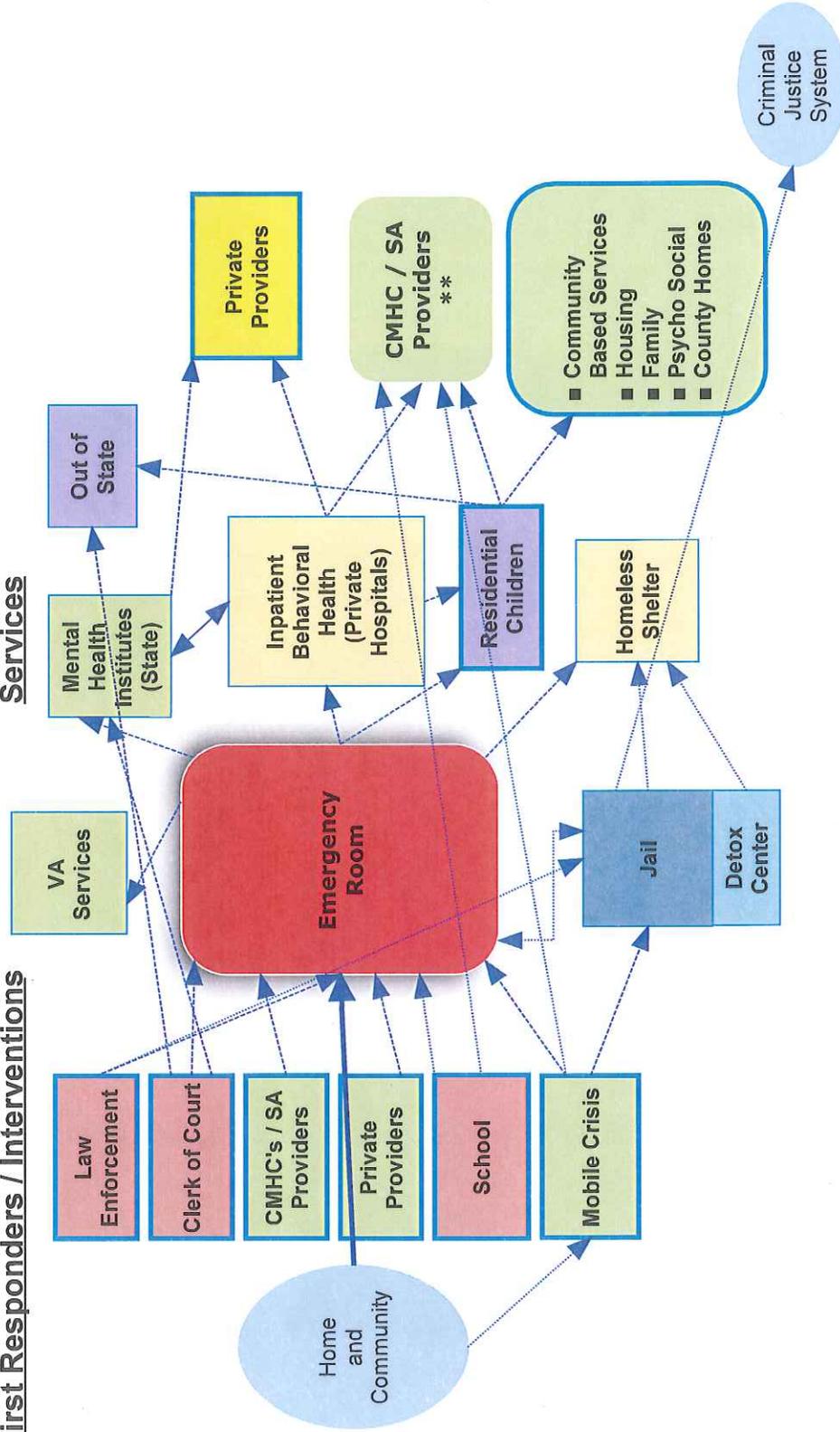
- 1 5th Judicial District
- 2 6th Jud Dist Dept of Correctional Services
- 3 Abbe Center
- 4 Agriwellness
- 5 BerryHill Mental Health Center
- 6 Black Hawk County Sheriff Department
- 7 Black Hawk Grundy Mental Health Center
- 8 Care Initiatives
- 9 Citizen's Aid
- 10 Community Based Corrections
- 11 CPC Representatives from multiple counties
  
- 12 Dallas County Magistrate Judge
- 13 Department of Corrections
- 14 DHS Field Operations
- 15 DHS-MHDS
- 16 Dept. of Inspections and Appeals
- 17 Eyerly-Ball Mental Health Center
- 18 Franklin behavioral Health Center
- 19 IA Behavioral Health Association
- 20 IA Protection & Advocacy
- 21 Iowa Attorney General's Office
- 22 IDHS/Facilities
- 23 IDHS/IME
- 24 IDPH/Behavioral Health Division
- 25 Iowa Assoc. of Community Providers
- 26 Iowa Department of Education
- 27 Iowa Health System
- 28 Iowa Hospital Association
- 29 Iowa Medical Society
- 30 Iowa NAMI
- 31 Iowa NASW
- 32 Iowa Nurses Association
- 33 Iowa Ombudsman Office
- 34 Iowa Protection and Advocacy
- 35 Iowa Psychiatric Society
- 36 Iowa Psychological Association
- 37 Iowa State Sheriff Associations
- 38 ISAC
- 39 Judicial Mental Health Advocates
- 40 Juvenile Court Services
- 41 Legislative Services
- 42 Magellan Behavioral Health

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- 43 Mary Greeley Medical Center
- 44 Mental Health Planning Council
- 45 MHA of Siouxland
- 46 MHMRDDBI Commission
- 47 NASMHPD
- 48 Nurse Practitioners
- 49 Scott County CPC
- 50 Sheriff Association
- 51 SPPG
- 52 St. Luke's Hospital –Cedar Rapids
- 53 State Court Administrator
- 54 Targeted Case Management (multiple counties)
- 55 Trinity Hospital
- 56 U of IA Hospitals and Clinics
- 57 University of Iowa Center for Development and Disabilities
- 58 Wesley Comm. Services

**First Responders / Interventions**

**Services**



**Emergency Acute Care System Flow in Iowa, April 2008**

\*\* Waiting list exists for certain services.  
 CMHC = Community Mental Health Center  
 SA = Substance Abuse Providers  
 VA = Veterans Administration

*Draft of the Acute Care Task Force*