

NAMI GREATER DES MOINES
Affiliate and Support Group

Issue Booklet

for

Sunday, October 1, 2006

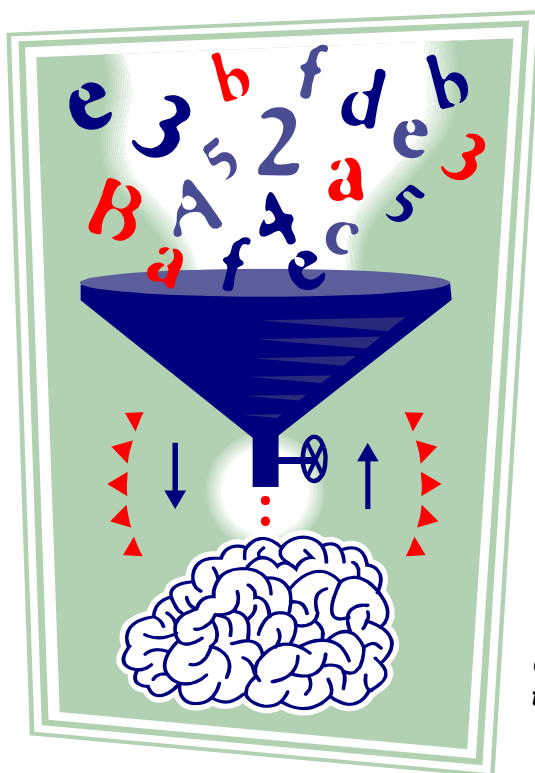
Westminster Presbyterian Church

4114 Allison Avenue, Des Moines 50310

2:00 P.M. to 4:00 P.M. in the gymnasium

“Ask the Legislators”

Legislative Issues for Persons Affected by Brain Disorders, their Families, Friends and Concerned Citizens in Polk County



1 – Introduction

2 – Federal Candidates and Federal Legislative Issues

3 – Polk County State Candidates and State Legislative Issues

“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it’s the only thing that ever has.” – Margaret Mead

Resources

<http://www.infonetiowa.com/> - click on advocate at the bottom of the home page

http://polk.ia.networkofcare.org/mh/legislate/state_index.cfm

<http://www.legis.state.ia.us/>

www.iowademocrats.org/

www.iowagop.org/

October 1-7 is Mental Health Week

We invite everyone who has an interest in mental health issues to our meeting on Sunday, Oct. 1, at Westminster Presbyterian Church, 4114 Allison Avenue - from 2-4:00 P.M. We will have state candidates **to listen to your concerns regarding mental health.** The impetus for this meeting was the "F" Iowa received from NAMI's Grading the States Report and the **countless heartbreaking stories** we hear from people every day for those seeking meaningful help for their loved one who suffers from mental illness.

We are calling on all stakeholders to join us to express their profound concern for the issues that surround mental health. Those stakeholders are:

The ill person
The families and friends of those with mental illness
Law enforcement and crisis units – our first responders
The medical community
Caseworkers, social workers, state agency personnel
Judges, attorneys
The faith community
Community leaders

Please call your legislators and candidates to attend this meeting.

Please ask them to come and discuss these important issues!

For some, you may be deciding between 2 candidates for office.

For some, you will have an opportunity to discuss what needs to occur in the next state legislative session.

Even if you don't utter a word, **your presence will have a profound impact.**

If you choose to share your story, **you will have a profound impact.**

If you choose to speak up about a legislative issue – **you will have a profound impact.**

It's time to stand united and ask for a systemic change for mental health.



Grading the States 2006

NAMI, the National Alliance on Mental Illness, presents this first comprehensive state-by-state analysis of mental health care systems in 15 years. Every U.S. state has been scored on 39 specific criteria resulting in an overall grade and four sub-category grades for each state. The national average grade is D. Five states receive grades in the B range. Eight receive F's. None received A's.

Iowa's overall score was an "F". There were 4 subcategories:

- ✓ Infrastructure – F
- ✓ Information Access – F
- ✓ Services – D
- ✓ Recovery Supports – F

Recent innovations noted were a mental health parity law and the creation of a multi-stakeholder taskforce to implement evidence-based practices (EBP's).

Urgent needs identified were:

- Remove legal settlement rules
- Statewide dissemination of EBP's
- A uniform data collection system
- Rural services
- More options to address acute or emergency treatment needs

Grading the States 2006: Iowa – Narrative

Iowa is a prime example of what President Bush's New Freedom Commission on Mental Health meant when it reported that the nation's mental health care system is "fragmented and in disarray." It must be among the most convoluted mental health systems in the country.

For individuals on Medicaid, Magellan Inc. provides mental health and substance abuse services. For individuals who are not Medicaid eligible, the state's 99 counties provide services, through a combination of state funds and county funds, derived primarily from local taxes.

Iowa's counties also follow a policy known as "legal settlement" which requires that individuals be county residents, and free of the need for mental health services for at least a year before their new county is responsible for paying. These restrictions often lead to inordinate, potentially catastrophic delays in getting services when they are needed.

Grading the States 2006: Iowa – Narrative – continued Although Iowa's counties are required to collect data, there is no statewide system through which this information can be shared. As a result, Iowa is among a minority of states that cannot provide an unduplicated count of whom they actually serve.

The state is working to upgrade its data collection system and hopes to have the capacity to provide unduplicated counts by the end of 2006. That will be an important, fundamental step forward. It is hard to design an effective service-delivery system without first knowing the number of people for whom you are responsible.

Surprisingly, the state mental health authority, called the Division of Mental Health and Developmental Disabilities (DMHDD), does not appear to be actively engaged in strategies to expand access to services for people with serious mental illnesses who live in rural areas of the state.

Among its many attributes, as presidential candidates discover early in party primary campaigns every four years, Iowa is rural - 89 of its 99 counties are classified as such. Any presidential candidate can not be a serious contender without addressing the distinctive needs that flow from this fact.

In some respects, Iowa might be the perfect stage for a well-focused comprehensive debate over mental healthcare policy, as the 2006 and 2008 elections approach.

Iowa also appears to be lagging in its implementation of evidence-based practices (EBPs). To its credit, the DMHD is forthright about the need for better progress and has established a statewide Technical Assistance Center for Evidence-Based Practices to promote their expansion.

DMHD has identified Assertive Community Treatment (ACT) as one of its top priorities. Currently, four programs exist - in Des Moines, Cedar Rapids, Iowa City, and Fort Dodge.

Unfortunately, employment and housing, two critical components of recovery, do not appear to be prominent on DMHD's radar screen. Although the state reports that supported employment services are available to people with serious mental illnesses in 91 of 99 counties, DMHD does not seem to be involved with them through funding or coordination with Iowa Vocational Rehabilitation Services.

DMHD also was unable to provide any information about supportive housing in Iowa, and does not employ, as many states do, a person responsible for coordinating housing services for people with serious mental illnesses.

In his 2006 State of the State address, Iowa Governor Thomas Vilsack took credit for significant accomplishments in the 2005 legislative session that benefited people living with mental illness. He referenced the important milestone of enacting mental health parity legislation, a hard-won victory in a state that was home to some of the most assertive anti-parity lobbying in the country.

Iowa is experiencing significant problems with an overall lack of inpatient psychiatric beds for people with acute treatment needs.

Nationwide, many community hospitals have gotten out of the business of operating psychiatric units - increasing the burden on state hospitals. The few community hospitals that continue to operate inpatient psychiatric units are overwhelmed by demand and do not have enough beds to meet that demand.

For example, in Des Moines there are virtually no hospital beds available for people with acute or long-term care needs.

As acute care beds in community hospitals decrease, the number of state hospital beds decrease as well, worsening the crisis. There are only four state hospitals in Iowa right now that can serve patients with serious mental illnesses, a low number when you consider the geographic size of Iowa.

Iowa's mental health system is in serious trouble. The state needs to move forward with a bold restructuring of its mental health system, which should include removal of legal settlement rules and increased access to mental health services that work for Iowa's residents with serious mental illnesses.

Federal Legislative Issues

www.nami.org/advocacy/

Contact information for members of Congress

Capitol Switchboard 1-202-224-3121

Contact via E-mail can be made directly through their web sites.

<http://grassley.senate.gov/>

<http://harkin.senate.gov/>

<http://www.house.gov/boswell/>

This following is information from the NAMI National Convention on federal legislation. *Contact with your legislator does make a difference.*



Housing

Access to decent, safe, and affordable housing remains a tremendous challenge for adults living with serious mental illnesses. Housing is a cornerstone to recovery. NAMI urges Congress:

- To restore proposed cuts for FY 2007 to the HUD Section 811 program.
- To support the \$209 million increase for the McKinney-Vento Homeless Assistance Act.
- To ensure adequate funding for renewal of all Section 8 rental vouchers for 2007.
- To support HR 5433 to reform the HUD Section 8 rental voucher program and retain key protections for households with extremely low incomes.
- To support HR 5117 to restore eligibility for Section 8 rental vouchers for students with disabilities.

Medicaid Reform and Access to Mental Health Treatment

Medicaid has increasingly become the dominant source of public funding for treatment and support for both children and adults with serious mental illness. NAMI urges Congress to take action to ensure that these individuals do not lose access to needed treatment and support due to changes authorized under the Deficit Reduction Act (DRA) and Section 1115 Waiver authority. In the Deficit Reduction Act - effective July 1, 2006, anyone applying for or being recertified as Medicaid-eligible will be required to document United States citizenship and identity. Prior to the DRA, states could allow individuals to self-declare citizenship. Now they will be required to show documentation unless they are exempt. These actions should include:

- Exempt certain individuals such as SSI and Medicare recipients from the documentation requirements under the DRA.
- Clarify that states must continue to provide access to all benefits, including mental health treatment, under the Early and Periodic Screening, Diagnosis and Treatment program.
- Require states to provide consumers and families with access and opportunities for meaningful input into state Medicaid reform proposals.
- Protect rehabilitation services under Medicaid.

Children's Legislation

The child mental health care system in nearly every state and community in America is broken. Children are our future and those with mental illnesses want and deserve a health care system that meets their needs. NAMI members should urge Congress to:

- Support S 380 and HR 823 – The Keeping Families Together Act – House and Senate bills designed to end the practice of forcing families to give up custody of their child to access mental health services;
- Support S 537 and HR 1106 – The Healthcare Crisis Relief Act – House and Senate bills designed to help address the critical shortage of child mental health providers. This shortage places a tremendous burden on children with mental illnesses and their families who are often told that they must wait months for services and/or are denied critically necessary mental health services;
- Oppose HR 181 and similar legislative efforts to block federal funding and support for programs that promise to improve the early identification of mental illnesses in children and adolescents. Anti-psychiatry efforts to block voluntary mental health screening, with parental consent, are rooted in stigma and rely on harmful stereotypes.

Decriminalize Mental Illness

Jails and prisons have become de-facto mental health treatment facilities. Public resources should be more effectively utilized for treatment alternatives that would significantly reduce the numbers of people with serious mental illnesses involved with corrections. NAMI recommends:

- Increase funding for the "Mentally Ill Offender Treatment and Crime Reduction Act" to \$10 million in FY 2007.
- Appropriate \$10 million for the SAMHSA jail diversion program.
- Enact the Second Chance Act of 2006 (HR 1704; S 1934)
- Reauthorize federal funding of Mental health Courts (S 289)

Funding for Mental Illness Research and Services

Our nation must maintain and increase its investment in mental illness research and services. To accomplish this, NAMI urges Congress to:

- Appropriate \$1.497 billion for the National Institute of mental Health (NIMH) in FY 2007.
- Support full funding for suicide prevention activities under the Garrett Lee Smith Memorial Act.
- Enact and fully fund the Services for Ending Long-term Homelessness Act (S 798/HR 1471) to help reach the goal of ending chronic homelessness.

Medicare Prescription Drug Benefit

Low income individuals with serious mental illnesses, including those who are dually eligible for Medicaid and Medicare, rely heavily on access to needed medications to maintain stability and achieve recovery. Thus, the Medicare Part D Prescription Drug Plans must be held accountable for maintaining access to needed medications and should not impose barriers including restrictive formularies and cost sharing. NAMI urges support of the following bills:

- S 2409 to waive cost-sharing for certain dual eligibles.
- HR 3151 to allow coverage of benzodiazepines.
- S 2810, to waive the late enrollment penalty for low and moderate income beneficiaries.

Veterans

NAMI places the highest priority on meeting the treatment and community support needs of individuals with severe mental illnesses who have served in the military. The Dept. of Veterans' Affairs is the largest single provider of psychiatric services in the U.S. NAMI urges Congress to:

- Enact HR 1588 to improve programs for the identification and treatment of post-traumatic stress disorder in veterans and members of the Armed Forces.
- Enact S 1180 to reauthorize comprehensive programs serving veterans who are homeless.
- Enact HR 4767 and S 1991 authorizing permanent supported housing for veterans with mental illness and other disabilities.
- Enact HR 3279 to initiate a new homeless Veterans Reintegration program.

Mental Illness Insurance Parity

NAMI strongly asserts that mental illnesses are real, treatment works, and there is no medical or economic justification for health plans to cover treatment for mental illness on different terms and conditions than all other medical disorders. NAMI urges Congress to:

- Co-sponsor and support mental illness insurance parity legislation (Senator Paul Wellstone MH parity bill).
- Oppose federal legislation that would expand the pre-emption of state parity laws or otherwise undermine these laws.

Two States Enact Laws Intended to Create Near-Universal Health Coverage for Their Residents, Starting Next Year

AARP Bulletin

By Patricia Barry, July-August 2006



Highlights of the Massachusetts law. . . .

- All residents required to have health insurance by 7-1-07.
- All employers required to offer insurance or contribute up to \$295 a year for each uninsured employee.
- Fines for residents and businesses not complying – except individuals unable to find “affordable” policies, or businesses with 10 or fewer employees.
- The Connector links individuals and companies with under 50 employees to a choice of “affordable” private health plans paid for out of pretax dollars.
- Health insurance obtained through the Connector is portable when enrollee changes jobs.
- Subsidized premiums on a sliding scale for enrollees with incomes of up to 300% of the federal poverty level.



Highlights of the Vermont law. . . .

- Catamount Health plan for uninsured starts 10-1-07
 - Businesses with more than 8 employees pay up to \$365 a year for every uninsured employee.
 - Plan offers portable coverage through private insurers and defined benefits and costs, including annual caps on out-of-pocket spending.
 - Subsidized premiums on a sliding scale for enrollees with incomes of up to 300% of the federal poverty level.
- Incentives for enrollees with chronic conditions who participate in a disease management program; payments for doctors who promote preventive care and healthy living.

State Legislation – Click on any of these links to find District maps for locating your legislators!

Here are 4 places on the web to access E-mail to contact your legislators, get mailing addresses, and phone numbers.

<http://www.infonetiowa.com/>

www.nami.org/advocacy/

http://polk.ia.networkofcare.org/mh/legislate/state_index.cfm

<http://www.legis.state.ia.us/>

First, some information about legislative actions during the last session. **Please thank the legislators for these positive steps.**



More Money for MH/MR/DD/BI Services in Iowa in 2007

May 12, 2006 www.infonetiowa.com

As you may remember, ten years ago legislators decided that the state would become equal partners with counties in funding MH/MR/DD/BI services. They passed a law that required the State and counties to evenly split the cost of services, and the state would pick up the growth in the system (what we call “Allowed Growth”).

Back in 2002, the State hit some bad budget years and the economy was bad. The State made all kinds of cuts then, including taking \$18 million out of the MH/MR/DD/BI Allowed Growth funds. They did that because several counties were sitting on very large fund balances (meaning they were taking money and not spending it on services to people).

Legislators created a formula to force these counties to spend down these balances before they are allowed to get state Allowed Growth funding. This formula directed the money to where it was most needed – counties with low fund balances and counties that were already getting as much money as they could from local sources (taxes).

This year, legislators realized their formula worked. Counties spent down their money, so more and more counties were becoming eligible for the Allowed Growth funds. However, as more and more counties became eligible, that meant more money needed to be added back into the pot.

Counties and consumers came to the Capitol this year after word came out that counties would be forced to cut services unless more money was added to Allowed Growth.

Counties were set to get about \$5.3 million in new money this year – but that wasn't enough. It would have led to massive cuts in services in most of the large urban counties and in several smaller counties.

That's where the good news comes in – legislators found another \$5.1 million to add to Allowed Growth this year. That means counties will get **\$10.4 million more** than last year for MH/MR/DD/BI services. **Send your legislators a big thank you!**



MH/MR/DD/BI Redesign – HF 2780

(Mental Health/Mental Retardation/Developmental Disabilities/Brain Injury Redesign)

What it Means to You www.infonetiowa.com 5-12-06

- ✓ **Establishes a new Division of Mental Health & Developmental Disabilities in DHS to give some leadership in the area of mental health and disability policy.** DHS Director Kevin Concannon told legislators that the state has missed out on a lot of opportunities at the federal level, and that re-establishing this Division which was eliminated several years ago would help to make sure we do not miss any other opportunities. This should help elevate disability

issues for legislators, and make them more comfortable in giving additional resources. A new Director of Mental Health services will be hired by Oct. 1.

- ✓ **Begins the transfer of state cases to the counties and begins to remove the barriers to eliminating legal settlement.** People without legal settlement served under the State Payment Program ("state cases") have their services paid for by the state. The state reimburses providers at a lower rate than many counties, and offers fewer services than many counties. In addition, counties and the state spend a lot of time tracking down a person's legal settlement. Getting rid of legal settlement is one of the first goals of redesign – and this bill starts that process three years earlier than recommended by the MH/MR/DD/BI Commission. The bill does not eliminate legal settlement – it simply eliminates some of the barriers to getting rid of legal settlement.

Under the bill, counties will assume responsibility for providing and paying for services to persons with state case status not being served by Medicaid (such as MR Waiver state cases), starting October 1, 2006. Legislators will have to come back next year to move the Medicaid state cases (like MR Waiver state cases) to counties at a later date. The Legislature also added \$1.4 million to state cases funding to help address the increased costs to counties.

As a consumer, this is all good news. This means persons without legal settlement will be treated to the same services, paid at the same rates, as others living in their county. There are still a lot of details that need to be worked out this summer related to how to distribute the state case money to counties, but everyone has a seat at the table for those discussions.
- ✓ **Establishes a review committee to look at how we fund MH/MR/DD/BI services in the state and the formula for distributing it** (recommendations are due by January 1, 2007). Only a handful of people understand the MH/MR/DD/BI formula, and with the Redesign effort moving forward, it's time to take a look at the formula. It's a great time to remind legislators that funding should follow the person – and that the money distributed to counties isn't money for counties – it is money for people. They will not likely have a meeting until September at the earliest.
- ✓ **Requires all counties to have the same eligibility guidelines.** This starts to equalize services across the state by requiring everyone to have the same rules to get services. Persons earning up to 150% of the federal poverty level will be eligible for county-funded MH/MR/DD/BI services. Counties may continue to charge co-pays for some services, but few do and all do it on a voluntary basis.
- ✓ **Requires counties of residence to assume responsibility for managing a person's care (but the county of legal settlement will continue to foot the bill).** Beginning July 1, 2007, counties of residence will manage the services provided to people served in their county but with legal settlement elsewhere. The county of legal settlement will be billed for services, and will have to pay for any services authorized in the county of residence's management plan. That means if you live in Polk County but have legal settlement in Woodbury County, and Polk County authorizes a service not paid for if you lived in Woodbury County, Woodbury County would have to pay for it. This is an important move in getting rid of the disparities in services offered to people, gives counties time to see how eliminating legal settlement will affect their financial bottom line, and makes sure people living in a county are treated the same way, whether state case, resident, or legally settled elsewhere.
- ✓ **Requires Magellan (managed care) to pay community mental health centers at 100% of their actual costs, and reimburse psychiatrists and inpatient psychiatric providers at the same rate Medicaid pays.** Providers serving people with mental illnesses under the Magellan managed care contract have not received the same increases in provider rates that those who serve persons covered under regular Medicaid. These providers are hurting and in some cases the counties make up for the difference, putting further strains on county budgets. This move could free up county resources, eliminate disparities in the system, and help people get the services they need because funding will no longer be a barrier.

2007 Legislative Issues

- ✓ **Legislative priority - appropriating more state dollars for MH/MR/DD or change how the limitation in property taxes is applied.**

Why Does Polk County Have Waiting Lists For MH/MR/DD Services?

Historically, counties in Iowa have been responsible for paying for services for persons with mental illness, mental retardation, or developmental disabilities. Counties can raise money only through property taxes and in the early 1990's many taxpayers keyed in on MH/MR/DD services as the culprit in rising property tax bills.

In some counties, as much as 40% of the property taxes paid to the county were for MH/MR/DD services. (Remember, though, that only about one-fourth of the property taxes you pay in Polk County go to the county--the rest are for schools, cities, and other public functions.)

In 1996, the Iowa Legislature enacted SF 69 to provide property tax relief. That bill froze the amount of money which each county could raise through property taxes at the 1996 level minus the amount given to the county by the state for property tax relief. In addition, all future growth in county spending had to come from the state.

The legislation worked for a few years, but it isn't working now. In Polk County, we have always levied the maximum amount of property taxes allowed by state law for MH/MR/DD services--about \$15 million per year. When adjusted for inflation, that represents a real loss of about \$4.3 million (30%) in FY06. Since the passage of SF 69, taxable value of all real estate in Polk County has grown 60%, but we cannot take advantage of that growing tax base because of the state freeze on county MH/MR/DD property taxes.

When the state ran into budget troubles in 2001, the state cut the amount of money going to counties by \$16 million (60%). The

state said that would be a one-time cut because some counties weren't spending all of their MH/MR/DD money. This situation didn't hurt Polk County because those cuts were targeted at those counties with large reserves. However, the state has not fully restored the cuts. And those counties with large cash balances have spent those balances. That means the state cuts are being spread over more and more counties.

Polk County expects to receive \$3.2 million LESS than we need to maintain current services and to add new consumers we expect will come into the system during the upcoming fiscal year. As a result, Polk County has had to:

- decrease support to individuals with mental illness not considered to be chronic to include only treatment and service coordination services;
- eliminate consultation services between two community mental health centers and other agencies (such as DHS, Juvenile Court, the schools, and senior programs);
- eliminate public education/prevention services targeted at informing the public about people with disabilities and at attacking preventable causes of developmental disabilities;
- and we have had to put new consumers on a waiting list. They cannot receive services until someone else leaves the system.

The Board of Supervisors agonized before making these decisions, but their hands are tied--by state law, Polk County cannot put any more property tax money into the system than it is putting in right now.

The only way to change this situation is for the state to make services for persons with disabilities a higher priority and put more money into the system. This can be done either by appropriating more state dollars or by changing how the limitation in property taxes is applied. Consumers, family members, and staff need to tell their state legislators how this funding shortfall is affecting them and ask them to restore the cuts with inflation when the legislature reconvenes in January.

For further information, you can contact:

- David Higdon, Treatment and Prevention Program Planner, at 323-3205;
- Susan Osby, Residential and Support Program Planner, at 243-4560;
- Annie Uetz, Case Management Director, at 883-1597; or
- Maria Walker, Employment Program Planner, at 883-1596.

Please note: The lack of dollars is forcing many programs to put people on waiting lists and can only serve those presently in the system being assisted.

✓ **Legislative priority - Expanding mental health parity.**

- ✓ Eating disorders, panic and anxiety disorders, post traumatic stress disorder and substance abuse should be included.

The present mental health parity law is not guaranteed for every citizen in Iowa because your situation has to fit into the conditions covered by the law. Employers with less than 50 full-time employees are exempt. Self insured plans are exempt. Illnesses covered are limited. Coverage needs to be extended to eating disorders, panic and anxiety disorders, post traumatic stress disorder and substance abuse.

April 2006 - A long awaited study of implementation of parity in the federal employees health benefits program (FEHBP) found that the added use and costs of services were minimal, when compared with the experience of plans with less generous benefits. This study confirms what NAMI has long advocated – that eliminating arbitrary and inflexible limits on coverage for treatment of mental illness is affordable for health plans and employers.

The study, in the New England Journal of Medicine, examined what happened when the FEHBP program (which covers 8.5 million federal employees, retirees and dependents) eliminated inequitable limits such as caps on inpatient days, outpatient visits, higher cost sharing and deductibles, etc. applied on coverage for mental illness and substance abuse.

Over the two years examined in the study, researchers found that the proportion of people using mental health services rose by 1.35% to 2.75%, compared with the two years before the change. However, both spending and use of mental health services did not increase more than a set of similar large employer plans that kept limits on mental health services in place.

However, what did change with plans in the FEHBP program was a significant drop in out-of-pocket costs for those who used mental health services. This new study is important because it demonstrates once again that implementing parity – and eliminating discriminatory limits on coverage – is affordable

✓ **Legislative priority - Address mental health workforce shortages.**

- ✓ A great start was in this year's Health & Human Services Budget (HF 2734) - \$160,000 was appropriated to the University of Iowa for an initiative to address the shortage of mental health professionals throughout the state.

In 2005, the Iowa Dept. of Public Health reported there are over 200 psychiatrists in Iowa, of those 147 are in private practice. Two-thirds of Iowa's counties have no private-practice psychiatrists, state records show.

We are hearing stories from families being turned away from Des Moines area hospitals because psychiatrists are no longer taking additional patients.

Iowa has 6.6 practicing psychiatrists for every 100,000 residents, according to 2001 statistics, the latest available, from the U.S. Department of Health and Human Services. That ratio is worse than in all but three other states: Idaho, Nevada, and Mississippi.

Iowa's numbers fall short of the 10 psychiatrists per 100,000 residents in the Midwest and 14 psychiatrists per 100,000 in the U.S. population. Iowa is 46th in the nation in psychologists and 47th in the nation for number of psychiatrists.

The current demand for psychiatrists (positions which could be filled if a qualified psychiatrist were available):

Full time	Adult	50	Part time	Adult	14
	Child	13		Child	6

Patients are experiencing a 2 month time delay in scheduling first follow-up appointments after release from psychiatric hospitalization.

Based on age, about 50% of the currently practicing psychiatrists will retire within the next 10 years.

The training program at the University of Iowa cannot keep pace with the attrition of psychiatrists so the current work shortage will become increasingly acute.

Talking points with your legislator:

- ✓ There are an insufficient number of mental health professionals to treat Iowa's population.
- ✓ The shortage of mental health professionals hits those without insurance and those on Medicaid particularly hard. Many psychiatrists and therapists have opted out of Medicaid (Magellan) contracts due to poor reimbursement and a sometimes burdensome authorization process; this particularly affects children due to the higher percentage receiving Medicaid.
- ✓ Scholarships, loan forgiveness and other programs need to be targeted toward individuals seeking careers in this field.

✓ Legislature priority - Address the critical lack of inpatient psychiatric beds and recovery centers

Iowa is experiencing significant problems with an overall lack of inpatient psychiatric beds for people with acute treatment needs. Nationwide, many community hospitals have gotten out of the business of operating psychiatric units - increasing the burden on state hospitals. The few community hospitals that continue to operate inpatient psychiatric units are overwhelmed by demand and do not have enough beds to meet that demand. For example, in Des Moines there are virtually no hospital beds available for people with acute or long-term care needs.

As acute care beds in community hospitals decrease, the number of state hospital beds decrease as well, worsening the crisis. There are only four state hospitals in Iowa right now that can serve patients with serious mental illnesses, a low number when you consider the geographic size of Iowa.

✓ Develop state-wide diversion programs to reduce the number of individuals put in jails and prisons instead of treatment programs. A NAMI 2006 and 2007 legislative priority.

Talking points with your legislator:

- ✓ Too many individuals are being put in jails and prisons instead of in treatment programs.
 - The present capacity of Iowa's prisons is 6990 – yet there are 8700 currently incarcerated. There is projected overcrowding of 29% by mid year 2006.
 - 3700(e) or 40% have a diagnosable mental health condition of which 1619 out of 8700 have an Axis I diagnosis. The prisons have become the new mental hospitals.
- ✓ NAMI supports increased funding for mental health care in our state and local criminal justice system
- ✓ Establish diversion plans so that persons charged with crimes, once qualified, can be diverted from prison to community programs. For example: mental health courts www.consensusproject.org or crisis intervention training for law enforcement.
- ✓ NAMI supports the need for the training of law enforcement personnel through programs such as Crisis Intervention Team and Crisis Teams.
- ✓ Increase funding for the Dept. of Corrections so that mental health and addictive treatment can be properly staffed and resourced in order to move the individuals more quickly to parole and community-based corrections. At the present time, there are only 3 psychiatrists and 27 psychologists for 8700 inmates.
- ✓ Provide sufficient funding for community mental health and substance abuse programs which can be accessed by persons on parole or probation in the community based correction system and continuing on after they are released from parole.
- ✓ NAMI opposes the death penalty for persons with serious mental illness.



Mental Health Courts

Bureau of Justice and Council of State Governments

In 1997 there were 4 known mental health courts in the country. By January 2004, the number of mental health courts had grown to 70 in 29 states. As of March 2006, there were over 120 known courts in 35 states.

Mental health courts are a promising strategy for communities seeking to improve the response to people with mental illness in the justice system.



Law Enforcement/Mental Health Partnership Program

Bureau of Justice and Council of State Governments

The New York City Police Dept. responds to a call dispatched as involving a person with mental illness every 6.5 minutes. The Los Angeles County jail, the Cook County jail (Chicago) and Rikers Island (New York City) each hold more people with mental illness on any given day than any hospital in the United States.

Law enforcement officers across the country are all too familiar with calls for service that repeatedly bring them into contact with people whose mental illness is not adequately addressed.

Officers often find themselves in the difficult position of determining whether to resolve such incidents informally or to take the person into custody, either for arrest or emergency evaluation. Although these incidents are generally resolved safely, on rare –

but highly publicized occasions – they can involve the use of force and the police officer, the person with mental illness, or both are seriously injured or killed. Without adequate training and access to community-based mental health resources, officers face tremendous obstacles in managing these incidents.

The Council of State Governments' (CSG's) Criminal Justice/Mental Health Consensus Project, with guidance from the Police Executive Research Forum (PERF), has launched a program that builds on the successes of individual communities across the country to address police encounters with mental illness.

This Bureau of Justice Assistance-funded program will provide resources for law enforcement leaders and their community partners to develop and enhance initiatives that make it easier for law enforcement to connect people with mental illness to much-needed services and to minimize the likelihood that law enforcement encounters will result in injury or death.

This program will:

- 1) **Provide training resources** – they have a toolkit -
 - *Why Training Matters* – a primer on the critical issues related to police encounters with people with mental illness and the latest thinking on how training can advance agencies' goals and public safety.
 - *Guidelines for Developing a Training Initiative*
 - *Core Training Curriculum*
- 2) **Facilitate peer-to-peer assistance** - They will identify and collect information about existing specialized law enforcement response programs in an on-line database at www.cjmh-infonet.com
- 3) **Promote best practices** - They will identify and describe the ten "essential elements" of successful law enforcement/mental health programs.
- 4) **Assist statewide efforts to coordinate local law enforcement partnerships** - In many states, local police/mental health partnerships operate in relative isolation, CSG and PERF will study and support those states that have made progress promoting and coordinating these specialized police responses statewide.

For more information, visit the Consensus Project web site, <http://consensusproject.org/projects/law-enforcement/>

There are many examples of statewide efforts in Florida, Indiana, Georgia, Ohio, Tennessee, and other states as well as in numerous cities around the country.



The NAMI CIT Technical Assistance Resource Center

<http://www.nami.org/Template.cfm?Section=CIT2>

The mission of the NAMI CIT Technical Assistance Resource Center is to supply consumers, family members, mental health professionals, law enforcement, and policy makers with the latest information about CIT (Crisis Intervention Training) and related jail diversion initiatives and innovations.

The Center serves as a repository of information about CIT programs nationwide. This information includes detailed descriptions of model programs as well as relevant data. The Center provides technical assistance and referrals to experts in the field.

In addition to this clearinghouse function, the Center facilitates ongoing communications between CIT programs and engages in national networking to establish standards and promote the expansion of CIT. The Center advocates for pre and post booking jail diversion strategies and aims to assist advocates to establish CIT programs in their communities.

The NAMI Cit Technical Assistance Resource Center publishes a monthly newsletter – "CIT in Action" – which spotlights community law enforcement and mental health collaborations nationwide. To receive this newsletter electronically, contact Bonnies@nami.org.



What is Crisis Intervention Training (CIT)?

Police officers are frequently first responders to people with mental illness in crisis.

CIT is community collaboration between local law enforcement and mental health care professionals. Ideally, Cit programs should include 3 components: 1) Training 2) The designation of trained officers to respond to people experiencing psychiatric crises, and 3) Coordination between police and mental health agencies to link people with treatment instead of incarceration whenever possible.

CIT training teaches officers about crisis de-escalation techniques and how to best assist consumers to obtain needed services. CIT "changes attitudes" of all involved. It takes huge amounts of planning and scheduling, along with determination and persistence, to form the necessary partnerships to establish CIT. CIT is often the "elephant" in the living room, a metaphor to which those who have promoted CIT in their community can relate.

Studies of CIT programs have demonstrated lower consumer arrest rates, fewer consumer and police office injuries, and quicker linkages of consumers with needed treatment.

- ✓ **Legislative priority - Make ACT a Medicaid reimbursable service in Iowa.**
- ✓ *ACT could be one of the most effective tools counties across the state could use in delivering services to their citizens with mental illness.*

Why Act is Needed - People with severe mental illness have multiple needs and have trouble negotiating complex systems. Many find their symptoms are unresponsive or only partially responsive to medications. Community mental health centers and other agencies may not be equipped to meet the needs of persons with severe mental illness. Families can't bear all the burden of care.

Assertive Community Treatment (ACT) is a way of organizing services for a person with a severe mental illness that fosters integration, teamwork, and continuity of care.

It incorporates proven treatments for integrated treatment for co-occurring disorders, supported employment, social skills training, appropriate use of medications, and education about the illness.

The key features of ACT are: multidisciplinary staff, team approach: daily rounds, integrated care: continuity of care, care is provided in the community, favorable ratio of 7 clients per staff member, assertive outreach to those in need, 24/7 availability for crisis intervention, and time unlimited services.

How well does ACT work? Here are some outcomes:

- ✓ Fewer hospitalization for persons with severe mental illness.
- ✓ Improved housing stability for persons with SMI.
- ✓ Better quality of life for persons with SMI.
- ✓ Better retention in mental health services.
- ✓ High satisfaction (patients and families)
- ✓ Cost effective (cost neutral to cost savings)

PACT of Greater Des Moines serves residents in Polk and Warren County. Office hours are Monday through Friday 8 a.m. to 8 p.m. and 8 p.m. to 4:30 p.m. weekends and holidays. To make a referral or to learn more about the local PACT team, contact the Team Leader, Darla R. Krom, LMSW at 235-8846

✓ **Retain “open access” for mental health drugs.** A 2006 and 2007 legislative priority.

Talking points with your legislator:

- ✓ NAMI supports the “open access” language that is available for all psychiatric medications for those that are on Medicaid
- ✓ Requiring prior authorization for mental health medications will interfere with patients receiving the treatment that their physician/health care provider has determined to be most appropriate.
- ✓ Requiring a person with mental illness to try less effective medicines before receiving the medicine that is right for them will extend that person’s suffering, place them at greater harm, and will in some cases increase hospitalization rates (at higher cost and in a system with inadequate in-patient treatment options).
- ✓ Limiting access to achieve a short term line item cost reduction will carry with it a high risk of higher overall treatment and social service costs.