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Special Report Issue

League of Women Voters of Iowa Comprehensive Study of Mental Health Delivery Systems in Iowa

PROPOSED Position on Mental Health February 2009

The League of Women Voters of Iowa supports a centrally coordinated state mental health system that ensures convenient and equitable access to care for all Iowans (children and adults) who need mental health services.

The League of Women Voters of Iowa supports adequate funding of an array of services, especially those that promote early detection and treatment of mental illnesses and co-occurring substance abuse disorders. Appropriate levels of care should be available that meet people's needs in or near their home communities.

The League of Women Voters of Iowa supports a mental health system that individualizes care to meet a person's specific mental health needs and focuses on the person's strengths and ability to recover.

The League of Women Voters of Iowa supports a mental health system that is accountable to its consumers and communities by providing efficient, effective, and evidence-based programs and services.

The League of Women Voters of Iowa supports eradication of the stigma of mental illness and believes persons with mental health needs should be treated with the same respect, and their illnesses treated with the same urgency, as persons with other physical health needs.

SUSPENSION OF *THE NATIONAL VOTER*

At its meetings last week, the LWVUS Board of Directors decided to suspend publication of *The National Voter* magazine (paper and digital) until the League's finances are healthier. Publication costs for *The Voter* are prohibitive in a time of budget cutbacks. The Board and the LWVUS staff are committed to finding new ways to deliver information to our members and supporters. We will keep you informed as we move forward. Please read the weekly Leaders' Updates on our Web site. Please also share them with other members and remind them to send us their e-mail addresses. We want you to know that we very much appreciate your willingness to replace the paper Voter with the digital edition, and we regret that we cannot continue. We do welcome your suggestions for ways we can most effectively adapt and communicate material you value in *The Voter*. Questions/comments can be sent to: Board Member Nancy Eitreim at neitreim@speakeasy.net.

Signup for the e-newsletter at <http://www.lwv.org>

Part III: Mental Health Services for Adults February 2009

The mental health system in Iowa for adults 18 years and older is county based. The state legislature defines mandated or core services that must be provided by all counties for those who are mentally ill, chronically mentally ill, mentally retarded, or have developmental disabilities. Each group is considered separately. The county boards of supervisors determine what other services will be funded for those meeting the definition for each of the disabilities and the criteria that indicate need. Services available and the amount of money to pay for services vary from county to county.

Description of Current System

Each county must have a “single point of entry” to access mental health services. This position is known as the Central Point of Coordination (CPC) and is accountable to the county board of supervisors. It is the responsibility of the CPC to manage the system as described in the county management plan for mental health and developmental disability services. This involves funding and service authorizations and collaboration and coordination with consumers, communities, and the multiple institutions that provide services or refer clients (1)

Some of the smaller counties share a CPC. Another aspect of sharing that is being planned on an experimental basis is the pooling of resources among counties sharing a single CPC. This will involve Black Hawk, Cerro Gordo, Floyd, Mitchell, and Butler Counties (K. Pennington, personal communication, December 22, 2008).

Each county must develop a county management plan. The goal of this plan is to “assist the individuals served to be as independent, productive, and integrated into the community as possible” (2, IC 331.439(1b)). This plan has three parts: a policies and procedure manual, a 3-year strategic plan, and an annual report that reviews the management plan and indicates progress made toward accomplishing goals set forth in the strategic plan (3, IAC 441-25.13; 441-25.17; 441-25.18). Included in these plans is a matrix of services that will be paid by the county for eligible persons with mental illness, chronic mental illness, mental retardation, and developmental disabilities. Counties must contract with service providers for the services identified in the matrix, and a list of providers is included in the reports. Many of the provider institutions become access points where persons with disabilities can begin the application process for services. Applications are forwarded to the county CPC for determination of whether the individual qualifies by age, citizenship, legal settlement, medically diagnosed disability, and other requirements for county-paid services.

The Iowa Administrative Code defines basic eligibility standards for financial need. An individual must be eligible, have applied for, and accepted federal or state funded services or supports (such as Medicaid); have income equal to or less than 150% of the federal poverty guidelines; and have resources of \$2,000 or less (\$3,000 or less for a multi-member family unit) (3, IAC 441-25.20(2)).

Upon verification that an applicant meets criteria for county services, the individual is referred to an accredited case management provider. A case manager or service coordinator works with the client to identify needs, develop an individualized goal-oriented service plan, and then refers the client to appropriate services and community resources, accesses and secures the necessary funding, and monitors and coordinates services (2, IAC 441-24). Determination of the need for specific services must be professionally assessed, and the services needed must be included in the county’s management plan. In 2006, 78 of the 99 counties used Iowa Department of Human Services (DHS) targeted case management services for Medicaid clients, whereas the other counties either were accredited by DHS to provide the services or used another accredited service (4)

Because the amount of money a county can spend on mental health and disability services is limited, funds may not be sufficient to provide the services needed by qualified individuals. Under those circumstances, waiting lists for services are established. Emergency services and supports are not wait listed,

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and mandated services are funded. A county states in its policy and procedure manual how services are prioritized, and adjustments are made to make best use of funds (2, IC 331.439(5)).

Mental Health Services Paid by Counties

The Iowa Administrative Code defines mandated services to be paid by the county for persons with mental illness. These include, but are not limited to, the cost of committing a mentally ill individual to a state mental health institute and the cost of inpatient services at the institute. Individuals with chronic mental illness receive additional services. The county is mandated to provide Medicaid-funded partial hospitalization, day treatment, and habilitation services (3, IAC 441-25.61).

The strategic plans for FY 2007-2009 were reviewed for the counties where local Leagues are located. The 12 counties that used the same matrix code to identify services were compared (5). Here are a few examples of what services these counties identified as willing to pay for and whether the service applied to mentally ill (MI) or chronically mentally ill (CMI) clients:

- Prescription medications – two counties covered for CMI only; 10 covered for both MI and CMI
- Outpatient psychotherapy – 11 counties covered for both MI and CMI; one did not cover for either
- Psychiatric rehabilitation – 10 counties covered for CMI only, one covered for both MI and CMI, and one did not cover for either
- Supported community living – three counties covered for CMI only, five covered for both MI and CMI, and four did not cover for either
- Inpatient services/community hospital – nine counties covered for both MI and CMI; three did not cover for either

Mental Health Services for Adults

General categories of services to assist individuals with mental illnesses are emergency services, community-based treatment and services, residential care, and inpatient psychiatric treatment. Many service providers prepare brochures or booklets that identify and describe services available from that provider.

Emergency Services

The need for having an emergency mental health crisis services system in Iowa was recognized in the *Mental Health Systems Improvement in Iowa* report. A survey indicated that less than 20% of counties in Iowa reported having any type of emergency mental health crisis service. One of two legislative proposals introduced in 2008 based on this report was to fund several state block grants to begin development of such a program and to establish standards and procedures for accreditation of service providers in the Iowa Code (6, Appendix J, p. 4). The proposal stated these services “should provide welcoming and empathic, co-occurring-disorder-capable crisis intervention, stabilization, support, counseling, pre-admission screening for persons requiring emergency psychiatric hospitalization, detoxification and follow-up services in all counties and for all people” (6, Appendix J, p. 3). The budget request for \$3 million in FY 2009 was reduced to \$1.5 million and was funded with one-time money for a 6-month period (K. Pennington, personal communication, December 22, 2008).

Twenty-four hour crisis assistance. Many community mental health centers operate a 24-hour crisis hot line providing access to anyone needing immediate crisis intervention services. Sometimes the crisis hot-line service may be provided in conjunction with a local hospital. As an example of usage, Richmond Center Community Mental Health Services received 3,072 after-hour calls to its crisis line and 258 walk-in and phone crises during business hours in 2006 (7). The Richmond Center serves four counties – Boone, Carroll, Greene, and Story.

Mobile crisis response teams. Few locations in Iowa have crisis intervention teams where there is formal collaboration between a local mental health provider and law enforcement to divert mentally ill persons to appropriate treatment rather than incarceration. In these cases, a mental health professional performs an on-site mental health assessment at the request of law enforcement in situations when mental health issues are a primary contributor to committing the offense. The Polk County Sheriff’s Office and the

(Continued on page 4)

(Continued from page 3)

Des Moines Police Department have contracted with Eyerly-Ball Community Mental Health Services since September 2001 to create a mobile crisis response team. The mental health professionals rode with the police officers only during high-incidence shifts (8). During the first 9 months of the program 2% of 445 calls resulted in jail placement, and average length of law enforcement involvement was 50 minutes (9). During FY 2008, the number of calls was 1,930 and 3% of those for whom disposition was reported resulted in jail placement. Law enforcement involvement has been reduced to about 22 minutes per mental health related call. During the time the program has been in place, the most frequent reasons crisis intervention was needed was for suicidal individuals followed by psychotic individuals (45-60% and 18-25% of calls, respectively, where reason was reported). The most frequent dispositions were counseling/referral/stabilization, 45-60%, and voluntary hospitalization, 18-25%, of those whose disposition was reported (K.D. Drane, personal communications, January 27 & 30, 2009).

Black Hawk County developed a similar program, but funding was eliminated before implementation. A needs assessment carried out during calendar year 2007 indicated 321 adult and 45 juvenile mental health commitments were filed, and during the first 6 months of 2008 the numbers were 199 and 16, respectively. The local hospitals in Black Hawk County require law enforcement personnel to remain with a mentally ill person in the hospital emergency room until admission is accomplished, and this ties up hours of law enforcement time (T. Eachus, personal communication, January 14, 2009).

Community-based Treatment and Services

A range of community-based treatment and services for persons with mental illnesses is offered in Iowa, but not in every county. The more common services are outpatient services, some type of day treatment, community drop-in centers, transitional living services, supported community living services, and education and support programs. The Assertive Community Treatment Program is offered in only five cities in the state.

Outpatient services. Community mental health centers and some other non-profit agencies provide basic outpatient services. These would include screening and evaluation, psychological testing, medication management, counseling, and substance abuse treatment referrals.

Day treatment/partial hospitalization. These programs encourage adults with mental illness to live independently in the community and maintain social and family ties while receiving appropriate psychiatric treatment and developing a stable and sufficient support network. For example, Mary Greeley Medical Center in Story County offers an intensive outpatient program that provides follow-up care for adults who have experienced a mental health crisis for which they have been hospitalized. It also provides on-going treatment to help adults manage their conditions for the long term. The program includes meetings three mornings a week with a multi-disciplinary team (10).

Drop-in community centers. Some counties provide a type of drop-in community center or club house for the mentally ill. Promise Center is located in Ottumwa and is a service provided by the Southern Iowa Mental Health Center. It was established in 2001 and provides “a safe, nonjudgmental place to socialize, receive support and be involved in age-appropriate structured and unstructured activities and learning experiences”, regardless of how mental illness is affecting the lives of the members. The center is open weekdays, two evenings a week, and on Saturday. It is staffed by a licensed social worker with a bachelor’s degree. Participants must apply for membership, meet membership criteria, and abide by rules set forth in a membership agreement (11). Attendance averages 21 per day with involvement by approximately 73 different members each month (M. Breon-Drish, personal communication, September 2, 2008).

Transitional living services. These services provide intensive on-site assistance on a short-term basis preparing persons to resume community living after some type of institutional care. It may include assistance in finding independent housing and follow-up services. An example is the Transitional Living Program operated by Mary Greeley Medical Center. There is a 6-bed home-like facility for adults 18 years of age or older who have a mental illness or a co-occurring disorder. The program provides a safe place to

(Continued on page 5)

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“regain perspective and make choices that will enhance their ability to live independently and function on a day-to-day basis” (10).

Supported community living services. These services enable mentally ill individuals to “develop supports and learn skills that will allow them to live, learn, work, and socialize in the community” (3, IAC 441-24.4(12)). Services are designed to meet the particular needs and abilities of the individuals living independently in their own homes, in apartments, or with their families. Sometimes referred to as community based services workers, these personnel may visit the client in the home. Services may include assisting with and teaching basic living skills; providing mental health support, medication management, assistance with medical/psychiatric appointments, and crisis intervention; and promoting development of social skills. Many of the community mental health centers and other agencies offer these services. Some examples include Abbe Center for Community Mental Health (12), Black Hawk-Grundy Mental Health Center (13), Broadlawns Medical Center (14), Community Mental Health Center for Mid-Eastern Iowa (15), Seasons Center for Community Mental Health (16), and Capstone Behavioral Healthcare (17).

Education and support programs. The National Alliance on Mental Illness (NAMI) offers a number of support and education programs that use materials professionally developed either by the national organization or a state affiliate. *NAMI Connection* is a peer self-help support group program that is open only to those who have a mental illness. The program is led by a trained and certified facilitator. *NAMI Peer-to-Peer* is a 9-week, 18-hour series of classes led by three certified facilitators who are themselves coping well with their mental illness. The content focuses on major psychiatric illnesses, emphasizing clinical treatment, and teaching the knowledge and skills to cope effectively with mental illness. Other topics include relapse prevention planning, coping strategies, empowerment, among others. Some NAMI affiliates in Iowa offer *NAMI C.A.R.E.* (Consumers Advocating Recovery Through Empowerment), a self-help support group led by trained facilitators who have a mental illness. *Sharing and Caring*, a combination support and education program open to both family members and those with mental illness, is led by trained family members or persons with mental illness. There are 13 NAMI affiliates in Iowa plus four affiliated campus groups and eight support groups (18).

Assertive Community Treatment (ACT). This team approach with a multi-disciplinary staff provides integrated health care in the community for individuals who are seriously mentally ill. This group includes those with schizophrenia, schizoaffective, bipolar, and severe depressive disorders. Persons with these disorders are the highest users of health care resources. There are five programs in Iowa – Iowa City (1996), Des Moines (1998), Cedar Rapids (1998), Fort Dodge (2004), and Council Bluffs (2006). Approximately 250 individuals were receiving care through these five programs. ACT costs approximately \$14,000 per patient per year but has resulted in 78% reduction in hospital days, 80% reduction in jail days, and 66% reduction in homeless days. Less impressive results were found in reductions in percentage unemployed and percentage abusing drugs. Expansion of ACT in Iowa will require strong “top down” support from the state legislature, a significant contribution of state general funds, and significant use of the Medicaid Habilitative Services and Rehabilitative Services option (19).

Residential Care

When mentally ill individuals require more supervision than is practical in an independent living situation, the next level of services is residential care. Iowa has 14 residential care facilities, located in 13 counties, for mentally ill adults. They provide a total of 331 beds (20, pp. 185-186). The goal of these care facilities is to rehabilitate and maintain individuals with mental illnesses at their highest level of functioning and independence. Typical services include medical supervision, skill building, vocational opportunities, socialization and leisure activities, and environmental supports. Several examples are Westminster House residential care facility operated by Behavioral Health Resources in Polk County (21) and Hillcrest Family Services that has three adult residential homes, two in Dubuque and one in Iowa City (22).

Inpatient Psychiatric Care

Acute psychiatric care may be provided in a community hospital with a separate psychiatric unit or at

(Continued on page 6)

(Continued from page 5)

one of the state mental health institutes.

Inpatient hospital psychiatric care. There are 21 general hospitals in Iowa that have separate psychiatric units to treat mentally ill patients. Fifteen provide both inpatient and outpatient psychiatric services and six provide inpatient care only (23). These hospitals have contracts with multiple counties to provide services if beds are available when needed by a client from any of those counties. For example, the Behavioral Health Unit at Mary Greeley Medical Center in Story County has contracts with 14 counties but receives clients from many other hospitals in Iowa who have no psychiatric beds or whose beds are full. There are seven beds for youth and 15 beds for adults in the Behavioral Health Unit, and these beds are for treatment of individuals with mental health and/or substance abuse issues. It is estimated that the adult unit is full on average 2 days a week, with heavier demand in winter and less demand during the summer and holidays (C. Krause, personal communication, January 26, 2009). Consequently, at a specific point in time there might not be an open bed for a client in Story County who needs inpatient psychiatric hospitalization. The executive director of Black Hawk-Grundy Mental Health Center reported that psychiatric inpatient beds in Black Hawk County often are full (T. Eachus, personal communication, January 14, 2009).

Inpatient mental health institute care. Iowa operates four mental health institutes that stabilize and treat the most severely mentally ill patients as psychiatric inpatients. These facilities have a total of 120 adult inpatient psychiatric beds. Periodically these beds have all been full, and a waiting list was maintained. An additional 35 beds at Clarinda provide long-term care for mentally ill geriatric patients exhibiting serious cognitive loss or dementia and significant behavior problems. The numbers of all beds by location are:

- Cherokee – 46 adult (plus 12 child/adolescent beds)
- Independence – 40 adult (plus 25 child/adolescent, 30 PMIC beds)
- Clarinda – 20 adult (plus 35 geriatric beds)

Mt. Pleasant – 14 adult (plus 50 substance abuse, 15 dual diagnosis beds)

During FY 2008, 829 adults received psychiatric treatment services at the institutes, and 74% were admitted on an involuntary basis (24, pp. 123-124).

Public Financing

Various sources of public money provide care to persons with chronic or serious mental illnesses. Federal programs such as Supplemental Security Income and Social Security Disability Insurance provide a basic level of income for those whose conditions preclude their ability to hold a job. The Medicaid program, funded with both federal and state dollars, enables low-income persons with mental illness to receive medical care. The state and counties contribute money to provide services at the local level to qualifying residents who have mental illnesses. Refer to Part I of this series (Background and Context) for additional information.

Federal funding. Supplemental Security Income is a federal program that provides benefits to adults 18 or older who have medically determined physical or mental impairments that result in their inability to be gainfully employed. Very low income and resource limits apply, and these individuals automatically qualify for Medicaid in most states. Maximum monthly benefits are determined annually by Congress (25).

Individuals who have worked in the past and paid Social Security taxes and who are unable to work for a year or more because of their disability may apply for Social Security Disability Insurance. Once approved to receive payments, the medical condition of the recipient is reviewed within 6-18 months, every 3 years, or every 5-7 years depending on whether medical improvement is expected, is possible, or not expected, respectfully (26, pp. 19-20).

Federal and state funding. Medicaid provides health insurance for certain groups of low-income people. Adults who are disabled according to Social Security standards fit into this group. Other qualifications also apply (27).

The IowaCare Medicaid Expansion Program (1115 waiver) expanded Medicaid coverage to adults with income up to 200% of the federal poverty level. Recipients are expected to pay a small monthly premium although the premium is waived in hardship cases. Eligibility is limited to one year when reapplication is necessary (28). The provider network for hospital and physician services is limited to Broadlawns Medical Center in Des Moines, the University of Iowa Hospitals and Clinics in Iowa City, and the four mental health institutes (Cherokee, Clarinda, Independence, Mount Pleasant) in the state. During FY 2007, the mental

(Continued on page 7)

(Continued from page 6)

health institutes provided care to 570 adults, a total of 26,315 days of care giving a mean length of stay of 46 days. Comparable data were not provided for Broadlawns Medical Center and the University of Iowa Hospitals and Clinics (29, attachment).

State and county funding. State funds are appropriated for counties for property tax replacement, allowed growth of mental health and developmental disabilities (MHDD) services, support of MHDD community services, and payment for MHDD services provided to state cases. Because of the state budget crisis, state funds sent to the counties for MHDD services are likely to be cut. Governor Culver has recommended cutting the mental health property tax credit by \$1.4 million in the coming year and \$6.1 million the following year (30).

The amount of money counties can raise for MHDD services from the property tax levy is capped. Data for FY 2008 showed that the mental health services levy that each county can charge its property owners had reached a maximum in 73 of the 99 counties. Two counties (Keokuk and Louisa) were using less than 50% of their allowable levy rates (6, Appendix O, p. 37-39). The highest levy rate was in Jasper County (\$2.80) and the lowest was in Louisa County (\$0.20) (6, Appendix O, pp. 39-41). The fund balances at the end of FY 2008 that counties held in their MHDD accounts averaged 7% of expenditures. However, 24 counties had negative fund balances (31). These data indicate most counties have limited ability to make up any shortfall in state funding for MHDD services.

To Be Continued

What can happen to mentally ill individuals when mental health services are not available to them? Or they have both mental illness and substance abuse issues and are not receiving treatment for either condition? Many are filling our county jails and state prisons. Part IV will look at mental health services for mentally ill adult offenders.

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Part IV: Mental Health Services for Mentally Ill Offenders February 2009



Why are there so many mentally ill individuals in prison in the United States? De-institutionalizing of the mentally ill began in the 1960s with the downsizing and ultimate closing of most public mental health hospitals. These actions were in response to availability of effective anti-psychotic medications and increasing litigation surrounding involuntary commitment and release. It was expected that the mentally ill should live in the community as independently as possible with access to adequate community mental health services. Funding for community mental health services has been inadequate, and consequently, prisons have become de-facto mental health institutions (1, background). Although no public mental health hospitals have closed in Iowa, the number of beds has decreased over time.

Description of Mentally Ill Offenders in Iowa

The Iowa Department of Corrections operates nine prisons and 23 community-based corrections facilities. Community-based corrections provide an alternative to incarcerating a person convicted of criminal offenses by placing the individual on pre-trial release, probation, or parole. The individual remains in the community under supervision and participates in treatment programs (2, p. 174).

Mentally Ill Offenders in Prison

Data are available about mentally ill offenders that were collected at three different points in time: June 30, 2005, December 31, 2006, and December 31, 2007. Data collected at the end of 2007 identified that 40.4% (3,582) of all offenders in Iowa prisons had mental illness and 30.4% (2,640) had persistent mental illness (3, p. 69). This represents an increase from comparable data collected in 2005 that indicated 33.8% of the total population of 8,578 offenders was designated as mentally ill, based on psychiatric diagnosis. Although the number of female offenders is small compared to the number of male offenders, females are almost twice as likely to have a mental illness. The percentage of each group had increased from 2005 to 2007, from 31% to 38.9% of male offenders and from 60% to 66.6% of female offenders (4, p. 70; 3, p. 3-8).

Many of the offenders carry more than one psychiatric diagnosis. The two most common categories of diagnosis for the mentally ill population were the same in 2005 and 2006. Depression and major depressive disorders was the most common, afflicting 58.3% of females and 47.9% of males in prison at the end of 2006; data were similar for 2005. Substance use disorders were the next most common; these data reflected increases. In 2005, 29.6% of females and 21.8% of males had this disorder versus 37.7% of females and 35.4% of males in 2006. Personality disorders and anxiety, general anxiety, and panic disorders were the next most common disorders (2, pp. 54-55; 4, pp. 3-8).

In 2005 the mentally ill offenders generally were housed with the general prison population, representing from 19.4% to 56.7% of the population within the institution. The primary exceptions were the Iowa State Penitentiary Clinical Care Unit (89.5%) and the Iowa Medical and Classification Center (IMCC) for the most severe mentally ill female offenders (29.5%). Mentally ill offenders with long-term sentences represented 14.4% of the prison population or 410 inmates. Relatively short-term sentences were given to 37.1% or 1,053 offenders (4, pp. 7-8).

During FY 2005, 2,923 individuals were paroled; 29.9% of those were mentally ill. Reentry of mentally ill offenders into the community by judicial district ranged from 22.5% in the Fourth Judicial District to 36% in the Eighth Judicial District. A slightly higher percentage of mentally ill offenders (37.9%) served out their sentence in prison and were released without supervision compared to those receiving parole or placement in community-based treatment facilities (34.7%) (4, pp. 9-10).

The 3-year recidivism rate for those with chronic mental illness diagnoses was 44.7% for females and 51.6% for males. This compares with 18.9% and 28.1% for females and males, respectively, who did not

(Continued on page 10)

(Continued from page 9)

have mental illness. Recidivism rate was influenced by the number of mental illness diagnoses, with each additional diagnosis increasing the rate. Offenders with four or more diagnoses had a recidivism rate of 84.6%. A one-day review on December 31, 2007 of the most serious type of charge against mentally ill offenders revealed that 41% had been charged for violent offenses (4.8% females; 36.2% males) (3, pp. 71-74)

Mentally Ill Offenders in Community-based Corrections

On October 15, 2007, there were 1,600 offenders in community-based corrections (CBC) residential facilities; 28% had a diagnosed mental illness and an additional 14% had diagnosed co-occurring disorders. Treatment for these disorders was received by 60.9% of those with mental illness and 63.2% of those with co-occurring disorders. On the same day, there were an estimated 22,856 additional offenders under CBC field supervision. In this group, 18% had mental health diagnoses and an additional 9% had co-occurring disorders. Of those with mental illness, 56.5% were receiving treatment as were 64.4% of those with co-occurring disorders (3, pp. 86-88).

Although no data were found describing the mental health status of offender populations in Iowa's county jails, the description of offenders participating in the re-entry program in Eastern Iowa later in this paper gives some idea of the situation.

Issues Within the Prison System

The health, safety, and treatment of individuals in jails and prisons, juvenile correctional facilities, and state or locally run mental health facilities as well as other facilities is a right protected by the Civil Rights of Institutionalized Persons Act (CRIPA) enacted in 1980. The U.S. Department of Justice will investigate situations brought to its attention and bring actions to enforce whatever standards have been established through court decisions (5).

The Iowa Department of Corrections has undergone intensive study in an attempt to create a more streamlined and effective operation. In 2005, improvements in identification and treatment of the mentally ill in prison were being developed to parallel community standards for a graduated mental health program with the following elements:

- Continuity of care
- A continuum of care with criteria for placement based on clinical assessment
- A formalized acute unit as part of the continuum
- Programming appropriate to each level of the continuum (4, p. 11)

By the end of 2006, it was noted that all offenders undergo a complete mental health assessment during the reception process at the Iowa Medical and Classification Center by one psychologist. Very limited access to acute care for offenders in need of hospital level care and limited partial hospitalization beds for females at the Iowa Correctional Facility for Women and for males at the Iowa State Penitentiary continued to be a concern (2, pp. 48-49). The 2008 report indicated that a continuum of mental health treatment and care was under development. This would include acute care, partial/transition care, special needs units, and outpatient care (for the general population). Not all institutions would provide the full continuum of care (3, p. 83).

Staffing Issues

A recent study of staffing in Iowa's prisons identified some growing concerns related to health care and made recommendations for remediation (6). Medical and mental health acuity of the offenders in the prison system continues to increase. Some of the concerns about meeting these needs, with particular focus on mental health, were:

- Mental health staff were scheduled primarily from 7 am-4:30 pm on weekdays, whereas mental health incidents occurred in the evening, at night, and on weekends (p. 77).
- Most mental health services are provided by psychiatrists and psychologists with only the recent addition of psychiatric social workers (p. 79).

(Continued on page 11)

(Continued from page 10)

- Health care budgets and subsequent staffing are determined at the institution level; there is no system-wide health care budget or staffing plan (pp. 102-103).
- With the exception of IMCC, the number and type of health care positions did not appear to be consistent with acuity levels of offenders, specialty care needs, size and type of facility, custody classification level, or number of facilities within an institution (p. 104).

Recommendations included focusing specialized levels of care in specific institutions as is being done with mental health special needs units, considering development of a new level of psychologist job classification in addition to bringing consistency to present positions across institutions, and strengthening the position of Mental Health Director. Budget proposals for FY 2010-2012 would increase the number of mental health full-time equivalents (for psychiatrists, psychologists, and social workers) to expand availability during the evening and weekend hours and to meet the increasing mental health workload to manage medications and provide services to offenders in the general population (pp. 203-204).

Reentry Issues

Reentry involves the use of programs targeted at promoting the effective reintegration of offenders back to the communities upon release from prison. A three-phase approach is recommended for reentry programs (7). Phase one (protect and prepare) involves programs at the institution level designed to prepare offenders to reenter society. This would include education, mental health and substance abuse treatment, job training, mentoring, and full diagnostic and risk assessment. Phase two (control and restore) involves community-based transition programs that are coordinated with the institution. Services might include education, monitoring, mentoring, life-skills training, assessment, job-skills development, and mental health and substance abuse treatment. Phase three (sustain and support) involves community-based long-term support programs that connect individuals leaving the justice system with a network of social service agencies and community-based organizations to provide ongoing services and mentoring.

An initiative to begin reentry case planning for all offenders upon commitment to an IDOC institution has been adopted. This involves determining the three primary treatment needs for each offender and developing plans that outline the programs and services the offender should complete before release. Plans for offenders with mental health issues require ongoing consultation with mental health staff to determine readiness to participate in reentry programs. Opportunities were limited for this population. Reentry programs varied from prison to prison, and resources were not adequate (2, p. 109).

Long-term recommendations were:

- Develop a detailed plan for additional reentry opportunities/programs for offenders with mental illness and to fund the plan (2, pp. 223-224)
- Expand the number and type of evidence-based reentry programs offered and increase the number of participants (2, p. 226)
- Implement a system-wide tiered step down approach to reentry from each of the prisons (2, p. 227).

Community-based Corrections Issues

Currently no CBC residential facilities are prepared specifically to meet the needs of the mentally ill offender. However, the Sixth Judicial District is developing such a facility that will focus on the specialized needs of offenders with serious mental illnesses (3, p. 101). According to a survey of Iowa counties, the availability of county funding for mental health treatment of CBC offenders varied not only by county but also by type of offender. For example, 97% of counties would fund mental health services for mentally ill offenders on probation, 88% of counties would provide for parolees, 55% for residential offenders, but only 33% for those on work release. In 73 counties there was a mental health professional who could prescribe psychiatric medications; however, it would take on average 6 weeks to get an appointment (3, pp. 89-90). This situation can be problematic for parolees who leave the institution with \$100 and a 30-day supply of their medications or a prescription for that amount (8, p.1).

(Continued on page 12)

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A survey of judicial districts indicated that only four districts had probation/parole officers or case managers who worked specifically with offenders who were mentally ill. The need to provide specialized training was recognized by all judicial districts (3, pp. 93, 96). Collaboration among the institutions, judicial districts, and community providers of services to the mentally ill was identified as critical to providing continuity of care for offenders, and recommendations were made to assist in this effort (3, p. 110).

Recommendations were made for improvements in operations of CBCs as well as infrastructure (3). During calendar year 2006, most CBCs were operating at or above their bed capacities, and waiting lists for admission were maintained. A person might be on the waiting list for 2-4 months (2, p. 189). A wide range of programming was available in CBCs but it varied by judicial district and was not available in all counties within a district. Few were specific to assisting those with mental illness (2, pp. 174-176).

Alternatives to Incarceration

The daily cost for FY 2007 of caring for individuals under the supervision of the Iowa Department of Corrections was (9):

Prison	\$76.59
Community residential facility	\$60.29 (includes no treatment costs)
Probation	\$ 3.70
Parole	\$ 4.21

Daily cost for an individual incarcerated in Johnson County was reported as \$64.60 if held in the Johnson County jail or \$75.60 if held in another county jail during FY 2007 (10). Individuals held in county jails are expected to pay the daily rate, but not everyone has the ability to pay. Inmates in state prisons who earn or receive money are expected to pay certain charges. A formula is applied to those funds to pay such costs as room and board, court costs, restitution, and child support (J. Hammond, personal communication, February 9, 2009).

Not only is it costly to warehouse people in jail or prison, but mentally ill offenders often do not respond well to the coercive environment of a prison, and they are separated from families and other community support systems. If they have been receiving federal benefits such as Supplemental Security Income, Social Security Disability Insurance, and Medicaid, they lose their eligibility to receive benefits and must reapply for benefits after release from incarceration (11). Are there better alternatives?

Intervention can take place at various points. Examples of some types of interventions are found in Iowa, but generally are not widespread. These include crisis intervention services, jail diversion programs, mental health courts, and reentry programs.

Crisis Intervention Services

This topic was covered in Part III of this series of papers in the discussion of emergency services. In the present context, crisis intervention teams would recognize persons as mentally ill, and police could identify them for diversion to appropriate treatment, thus preventing further deterioration of these individuals' conditions and preventing actions that might result in criminal behaviors. Effective crisis intervention requires training team members and law enforcement personnel about mental illness and how best to work with mentally ill individuals. Only nine of Iowa's 99 counties reported having mobile crisis teams in 2008 (3, p. 92).

Jail Diversion Programs

There are at least two jail diversion programs currently functioning in Iowa. These are in Black Hawk County in the First Judicial District and Story County in the Second Judicial District. Polk County is planning to initiate a 2-year experimental program when the new jail opens (12). These programs divert mentally ill offenders after they have been arrested and booked into jail.

Black Hawk County. The program in Black Hawk County is primarily a re-entry program that also accepts participants on a pre-trial diversion basis. The focus of the jail diversion program is to provide an option for a mentally ill offender to be released and receive services from the mental health re-entry program

(Continued on page 13)

(Continued from page 12)

while the criminal case is proceeding through the court system. The offender may be found guilty, but with support of the re-entry program the situation may be stabilized and the offender can be sentenced to probation rather than serve time in jail (13). The re-entry program is described in a later section.

Story County. The mental health jail diversion program in Story County began in January 2007 and is funded for 30 months with a federal grant from the Department of Justice, Bureau of Justice Assistance. It is a project of the Story County Mental Health and Criminal Justice Task Force that involves 14 community agencies and institutions. Participants must be 18 years or older, have a pre-existing severe and persistent mental health condition, have no felony convictions or violent offenses in the last 5 years, and live in Story County. Participation is voluntary. The program involves intensive interviews to identify appropriate participants, pre-judication approval by the court, development of individual treatment or service plans, intensive case management, and coordination and monitoring for compliance. Services include treatment and other support services such as housing, employment, education, and substance abuse support that may be needed. Minimum length of time in the program is 6 months; some may remain in the program until requirements of the court have been met (14). To date the program has involved 19 persons and an additional two are in progress; eight have been re-incarcerated. Most participants have a co-occurring substance abuse condition. Finding housing for participants is a challenge and is an expensive support service (A. C. Peters, personal communication, December 12, 2008).

Mental Health Courts

Mental health courts represent court-based community justice initiatives. They have been modeled after drug courts. The first four mental health courts were studied on behalf of the Bureau of Justice Assistance. Common attributes shared by these court initiatives were (15, p. viii):

- Participation is voluntary
- Only persons with demonstrable mental illness likely to have contributed to involvement in the criminal justice system are accepted
- The objective is to prevent the jailing of the mentally ill and/or to secure their release from jail to appropriate services and support in the community
- Concern for public safety is a high priority; consequently a predominant focus on misdemeanor and other low-level offenders and careful screening or exclusion of offenders with histories of violence
- Early intervention is expedited through timely identification of candidates
- A dedicated team approach is used
- Emphasis is on creating a new and more effective working relationship with mental health providers and support systems
- There is intensive supervision of participants, with emphasis on accountability and monitoring of participant's performance
- The judge is at the center of the treatment and supervision process.

In addition, each mental health court had unique features.

A number of issues have surfaced as mental health courts have become operational. A few of these are (15, pp. x-xiv):

- Early identification of candidates is difficult when fair, appropriate, and effective screening procedures need to be timely, accurate, and confidential (conflicting goals)
- Participants must be competent to really understand the choices being presented and the consequences of those choices
- There is an inherent conflict between the need of the criminal process to proceed expeditiously to adjudicate criminal charges and the time needed by mental health professionals to diagnose, stabilize, and place the defendant in appropriate supportive services for treatment
- Defining success is difficult because each defendant starts at a different point depending on the variety of symptoms and illnesses exhibited
- Questions are raised about how the coercive power of the courts can be channeled to promote the goals of mental health treatment

(Continued on page 14)

(Continued from page 13)

- Availability of mental health services and resources are often insufficient and have contributed to mentally ill persons becoming part of the criminal justice population.

As more mental health courts have become a reality, 10 essential elements of mental health courts have been identified to guide development of this alternative to incarceration for adults (16).

Thirty-one states are listed as having at least one mental health court, but the information may not be current (17). Only one is listed for Iowa, in Woodbury County. The *2007 Annual Report of the Third Judicial District Court of Iowa* included data from July 2001-June 2006 for Project Compass Mental Health Court (18, p. 47, Table 21). The project was funded by Woodbury County with assistance of Siouxland Mental Health. Individuals in jail were provided assistance and appropriate mental health services to enable them to succeed and not return to the criminal justice system. During the 5-year period, 175 individuals participated in the mental health court. There were 106 successful completions, 41 unsuccessful completions, with 28 still in the mental health court. Previous number of jail days for the group was 2,796; this was reduced to 83 days. There were 366 previous arrests and that number was reduced to 31 re-arrests.

Three mental health courts were identified in Iowa, in the Fifth and Seventh Judicial Districts in addition to the Third Judicial District (3, p. 101). However, no information was easily accessible about these programs.

Reentry Programs from Jail and Prison

Effective re-entry practices have multiple benefits. They can:

- Enhance public safety through reducing offender's risk to the community upon release
- Demonstrate cost savings through a decrease in incarceration and in a wide array of government programs
- Improve the quality of life of individuals suffering from mental health and substance abuse issues
- Promote safe, orderly, and secure correctional institutions (13, p. 3).

Several reentry programs have been operating successfully in Iowa for several years.

Black Hawk County. The Mental Health Assessment and Jail Diversion Program, as this program is called in Black Hawk County, is supervised by a community treatment coordinator within the Department of Correctional Services. However, the program is a collaborative effort that also involves the sheriff's office, the county attorney's office, the public defender, the local courts system, the mental health center, mental health professionals working within the jails, and other community agencies. Weekly meetings are held to discuss and plan for releases from the Black Hawk County Jail. Referrals of inmates to be screened and provided assistance come from multiple sources, and follow-through is provided by the coordinator.

Programs available include a dually diagnosed program for men and a women's co-occurring disorder program that are carried out in residential facilities. The community is involved in connecting individuals with access to medications, housing options, finances, and employment through a Community Accountability Board that meets monthly. This group is composed of various agencies and individuals who have a vested interest in persons with mental illness (11, p. 9-10).

Data from 34 months of operation as of November 2006 indicated assessment of 415 individuals (68% men and 32% women) with 74% successful transition into the community or diverted from jail and prison, and a re-arrest rate of 26%. Cost savings were estimated at \$54,500 (11, p. 10).

Eastern Iowa. Three transitional mental health re-entry programs have been funded through federal block grants to the state. These programs are operated by the Departments of Community Correctional Services in the First Judicial District (Linn County) and Sixth Judicial District (Black Hawk County) and by the Black Hawk-Grundy Mental Health Center that serves Black Hawk County. Two programs began in Fall 2000 and the third began the following summer. Funding through the Department of Human Services began at \$80,000 per year for each program and had decreased each year to \$10,000 during FY 2007. The programs are designed to provide people with mental illnesses the broad array of support they need to be successful in transitioning back into the community upon release from prison. These supports include assistance such as linking with mental health providers, applying for Medicaid and other programs, finding housing, providing transportation, meeting with Community Accountability Board, enrolling in education or job training

(Continued on page 15)

(Continued from page 14)

programs, and providing emotional support and guidance (8, pp. 2-4).

From inception through June 30, 2007, 361 individuals had been served by the three programs. Although somewhat different populations were served in each program, some combined data describe the overall population. The majority of admissions to the program were on parole; women represented 52% of participants; 67% were Caucasian and 32% African American; average age was 36; the primary diagnosis on admission was depression (44%); 47% had been diagnosed with two or more mental illnesses; 87% had a substance abuse problem; 43% had been incarcerated for less than 1 year as an adult but 38% had been incarcerated from 1 to 3 years; 71% of admissions had already had one or more probation or parole violations; 95% had some high school education; 68% had never worked at a job for more than 1 year (8, pp. 9-15).

Assessments of the 339 individuals who had been discharged from the re-entry program as of June 30, 2007 showed that 70.5% were considered to be successful. Stable housing and access to health care and medications were considered to be essential for successful reentry. To evaluate the program, the re-entry group was compared to a similar group receiving traditional parole services. The reentry group tended to have more barriers to overcome because they had a slightly higher level of criminal risk, were more likely to have a substance abuse problem, and included more women and minorities. However, the reentry group was more successful than the comparison group in successful completion of their program, had greater housing stability, and were less likely to be charged with serious crimes. The comparison group was more likely to be employed (8, pp. 54-55).

And the Bottom Line?

The cost of incarcerating mentally ill individuals is substantial, not only in monetary and societal terms but also in quality of life for the affected individuals and their families. The lack of mental health services often contributes to this situation and not having those services available and accessible at the time of reentry into the community will only contribute to recidivism. And the cycle starts all over again. Doesn't it make more sense to use public funds to assure that mental health services are available to help people cope with their mental illness rather than spending public funds to house them in jails and prisons where they might or might not receive treatment?

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(Continued on page 16)

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(Continued from page 15)

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