COMPONENTS OF A MENTAL HEALTH CARE PLAN FOR IOWA – THE MUSINGS OF A CONCERNED PARENT

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The recent Mental Health Forum for Iowa Gubernatorial Candidates held at Des Moines University on 12/5/17 marked a much-needed change in how Iowans are addressing mental health care. All of the candidates who attended the forum agreed that Iowa is in a mental health care crisis and that much work needs to be done to resolve it. The first step in solving a problem is recognizing that there is one. As a parent of a person with a serious mental illness, I was pleased to see candidates from various political parties begin to grapple with mental health care. Mental illness knows no political boundaries.

Before Iowa can begin a discussion on how to improve mental health care and ultimately fund these improvements, the Governor and State Legislators must agree in principle on what changes should be implemented to assist Iowa's most vulnerable citizens - those with mental illness. To date, two of the gubernatorial candidates have presented plans for how to address this problem (Andy McGuire [1]; Fred Hubble [2]).

My son's mental illness started about 11 years ago (when he was 15 years old) as a mixture of depression and suicidal ideation, self-medication, and a decline in the normal social activities of a high school student. Since the beginning he has been under close medical and psychiatric supervision. Multiple rehabilitation stints, psychiatric care, and prescriptions yielded little change in behavior. At the age of 20 (while attempting to attend community college) he experienced his first psychotic episode (delusions of grandeur) and the diagnosis of Bipolar Disorder. At age 22 his illness evolved again to include auditory hallucinations and was diagnosed as Schizoaffective Disorder. My son has been a heavy consumer of Iowa's Mental Health Care System over the last 11 years - with over 20 hospital admissions across the state (including the Iowa Mental Health Institute in Independence) and stays at Residential Care Facilities and Group Homes. This disease has shattered my son's life and has stolen more than a decade from our family. Throughout this difficult journey, we've experienced all aspects of Iowa's Mental Health Care System. We've fought diligently to keep our son alive and receiving the best care possible. Many families have not been so lucky. At this point in this unwanted journey, I feel well-qualified to weigh in on how Iowa can improve the delivery of mental health care services.

It's my hope that this commentary (without a discussion of funding) will serve as a potential guide for candidates to consider and to promote discussion across Iowa. This discussion is a list of various topics organized into five general areas -- 1) The Problem, 2) Leadership, 3) Structural Changes, 4) Reducing Barriers to Treatment, and 5) Coordination of Federal and State Funding.

1) The Problem

Should anyone be wondering about the scale of mental health care issues today – here are some statistics for 2016 from the recent ISMICC Report to Congress [3]:

- 4.2% of the adult population (18 and over) are living with a serious mental illness.
- Nearly 1 in 4 adults with a serious mental illness live below the poverty line.
- The suicide rate for those with mood disorders is 25X higher than the general population.

- Approximately 2 million people with a serious mental illness are admitted to US jails each year.
- Approximately 2/3 of the people with mental illnesses in jails or prisons are receiving no treatment.

For a large percentage of Americans, the problem with mental health care is simply not having access to any form of care. The future for these individuals is disturbingly grim. For others who do gain access to care, the care is often not sufficient. The future for undertreated patients is only moderately better than that of the untreated. The life expectancy of people with a serious mental illness is dramatically lower than the general population – due to a variety of issues (homelessness, poor nutrition and general health maintenance, medication side-effects, suicide, smoking, and under-treatment for physical symptoms).

While the toll of human suffering is staggering, the financial cost of treatment (and in many cases under-treatment) of mental illnesses is a significant economic driver ($467 billion in the U.S. in 2012) [4] [5]. The Social Security Administration reports that in 2012, 2.6 and 2.7 million people under age 65 with mental illness-related disability received SSI and SSDI payments, respectively. This represents 43% and 27% of the total number of people receiving such support, respectively [4].

2) Leadership

The current state of mental health care in Iowa is the result of decisions made by former Gov. Branstad and Gov. Reynolds. At the recent Gubernatorial Mental Health Forum, Gov. Reynolds prepared a video where she indicated that Iowa's Mental Health Care System is generally doing well and improving. The Governor's self-assessment is at odds with various metrics used to assess the condition of Iowa's Mental Health Care System.

The Treatment Advocacy Center recommends 50 acute care beds in State Operated Psychiatric Facilities per 100,000 residents. [6] Betsy Johnson (Treatment Advocacy Center), painted a rather depressing picture of mental health care in Iowa in a statement before the State Health Facilities Council in July, 2017. [7] In 2016 (when Iowa's two MHIs had 64 beds for its 3.1 million residents), Iowa was ranked 51st in the United States with ~2 beds per 100,000 residents. [8] A closer examination of this bed count found that 38 of these beds (59.4%) were occupied by forensic patients (those in the criminal justice system). The overall bed count appears to have improved since 2016 as the Iowa DHS indicates that there are approximately 115 State Operated Psychiatric beds. This improvement would adjust the ratio to ~4 beds per 100,000 residents (still well shy of the recommended 50 beds per 100,000).

Another metric is the total number of acute care psychiatric beds in hospitals across Iowa (Fig.1). [9] [10] The most current count finds 615 beds without counting the current capacity of MHIs and 731 beds by including the two MHIs. [9] A bed count of 615 yields 19.6 beds per 100,000 residents and 731 (with MHIs) yields 23.3 beds per 100,000 residents or about half what is recommended by the Treatment Advocacy Center. [6]

According to data found in the "Entities Book" (www.iowa.gov) there are currently 135 RCF/PMI beds available at 10 locations. [11] These beds are listed as being for patients with mental illness. There are 62 Residential Care Facilities in Iowa with 2,014 beds available for a variety of patients. [11]

These beds have 24-hour supervision but they do not require the services of a registered or licensed practical nurse, except for emergencies.

Perhaps the most important measure of Iowa's Mental Health Care System is the opinion of the consumers who navigate this system. One metric would be the admission wait times for patients seeking treatment in acute care settings (e.g., Hospital Emergency Rooms). Also, it would be instructive to examine the daily/monthly call logs at the two remaining MHIs – to track the number of people seeking help for a loved one.

The next Governor of Iowa needs to publicly acknowledge that there's a mental health care crisis in Iowa. Fixing the current situation initially requires an educational campaign to make both the general public and state legislators fully aware of the overall problems with Iowa's Mental Health Care System. This does not require a significant outlay of funds. Speaking publicly about mental health care in Iowa can be done at virtually no cost. A useful byproduct of using the Governor's (and candidates') bully pulpit to speak out about this topic is itself a diminishment of the stigma associated with mental illness. In general, costly ad campaigns aimed at reducing stigma are not cost effective. [12]

Formulating a plan requires a detailed examination of Iowa's entire Mental Health Care System. I propose that the next Governor should appoint a multi-disciplinary committee that is charged with the task of recommending improvements that would make Iowa's Mental Health Care System among the best in the United States. This panel should be comprised of Iowans who have direct knowledge of Iowa's Mental Health Care System. Participants should include representatives from the following areas:

- Director of the Iowa DHS
- Mental Health Care Professionals involved with direct patient care
- Mental Health Care Professionals involved with training of future MHCPs
- County Sheriffs
- Iowa Department of Corrections
- Acute and Residential Care Facilities
- Assisted Outpatient Treatment Programs
- County Administrators
- NAMI Iowa
- Family members who have navigated Iowa's Mental Health Care System.
- Patients with treated mental illnesses who have navigated Iowa's Mental Health Care System.

This committee should not include politicians, those involved with the administration of large hospital systems, insurance companies, or pharmaceutical companies. To provide an unbiased perspective, it would be helpful to have an additional member(s) who is/are a mental health care provider or advocate who is not from the State of Iowa.

The work product of this panel would be **detailed recommendations for a new Iowa Mental Health Care System – <u>without regard to cost.</u>** If needed, both a majority and a minority report could be generated. Given the urgency of this problem, this panel should have a short window within which to make its recommendations – less than 1 year. After these recommendations are made, the panel

(along with the appropriate non-partisan budget officials) should be tasked with determining the cost of these recommendations. The time allotted for the budgetary aspects of this plan should not exceed 6 months.

While I was well into writing this document, a similar report was delivered to Congress on 12/13/17 by the ISMICC (Interdepartmental Serious Mental Illness Coordinating Committee) entitled: *The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers* [3]. This report provides an excellent roadmap for improving mental health services for adults living with serious mental illness (SMI) and children and youth who experience serious emotional disturbances (SED). Although the ISMICC report focuses on Federal Programs, its basic tenets are applicable to mental health care at any administrative level.

3) Structural Changes

As many Iowans with serious mental illnesses face difficulties with full-time employment and therefore obtaining health insurance, Iowa's Medicaid system becomes a critical consideration in their long-term well-being. Whatever the fate of Iowa's Medicaid system, it ultimately needs to be a stable source of insurance that covers the numerous services needed by the mentally ill.

Iowa is currently divided into 14 MHDS Regions (Mental Health and Disability Services) that cover a wide range of urban and rural areas (Fig.2). [13] It's most unclear why there are such disparate geographic extents and populations between regions (Fig.2, Table 1). [13] In 2016, these regions spent a total of $70,821,579 on a variety of services for 26,748 individuals with Mental Illnesses. [14]

Following a national trend since the 1950s, the number of state-operated acute care psychiatric beds in Iowa has been in decline (Fig. 3). [15] This decline is not due to a lower number of people with a serious mental illness. This trend reflects the transfer of patients to: 1) private hospitals, 2) residential care facilities, 3) county jails, 4) state prisons, and 5) homelessness.

Iowa's population is 3.1 million people. Serious mental illness typically occurs in those above the age of 15 or about 85% of Iowa's population (2.6 million). Using a 4.2% occurrence of serious mental illness [3] in this at-risk population of 2.6 million, there should be approximately 112,000 Iowans who suffer from a serious mental illness. In 2016, the 14 MHDS Regions cared for 26,748 patients [14] with mental illnesses (presumably serious). It's unclear how to account for the other 85,000 Iowans with a serious mental illness.

When Iowa had four functional Mental Health Institutions (MHIs) there was a reasonable geographic coverage for Iowa --- Independence (NE Iowa – Buchanan County) and Cherokee (NW Iowa – Cherokee County), Clarinda (SW Iowa – Page County) and Mt. Pleasant (SE Iowa - Henry County). Closure of the MHIs in Clarinda and Mt. Pleasant has left the residents of southern Iowa (and the prison populations in those towns) underserved. As a result of these closures, family and friends living south of I-80 must drive long distances (2 to 3 hour drives) to participate in the recovery of a patient at the two remaining MHIs. Long travel is costly and logistically difficult for family members who are already stressed. The isolation associated with an involuntary court committal is exacerbated when family and friends are several hours away. As the proximity of treatment facilities to the

patient's support group (family and friends) improves outcomes [16], this should be considered when planning changes to the Iowa's Mental Health Care system.

The most fundamental change to Iowa's Mental Health Care System must be in accessibility to services. This is not as simple as re-opening closed MHI facilities or adding "X number" of acute care beds across Iowa. Acute care beds are the most expensive care option and they may not reflect the level of care that many patients need. For those with a serious mental illness who are in crisis (e.g., in psychosis or having suicidal ideations) – immediate availability of acute care beds is critically important. For patients who are stabilized, yet still require assistance, a range of care options may be needed. [17]

Because those with mental illnesses often require changes in the level of care required, there needs be a continuum of care options available and the ability to move between levels of care as needed (acute care, sub-acute, mid-term, long-term residential care, and assisted outpatient treatment). [17] This system needs to be flexible with respect to moving from one level of care to another - without creating financial and logistical hardships for patients and their families.

At present, Iowa appears to have a shortage of acute care psychiatric beds. However, the number of patients currently in acute care beds awaiting placement in residential care settings is difficult to estimate. The Director of the Iowa DHS estimates that 4000 bed days per year are associated with this type of placement issue. [18] It's likely that some of the acute care bed shortage could be resolved by transferring current patients to facilities with lower levels of care. Lower levels of care are also less expensive. This begs the question – to where do you transfer these patients?

Sub-acute care facilities are virtually non-existent in Iowa. Residential Care Facilities (RCFs) have 24-hour supervision but with minimal nursing and physician coverage. [11] **The construction of sub-acute care mental health facilities must be a priority for each of Iowa's 14 MHDS regions.** These facilities need elopement and safety precautions, nursing, and physician coverage. Adding these facilities will ease the shortage of acute care beds and provide a transitional setting for patients in the early phases of treatment. Sub-acute care facilities could be used to monitor patients as their medications are adjusted and where additional treatment can be provided (e.g., cognitive behavioral therapy).

Assisted Outpatient Treatment (AOT) [19], the practice of delivering outpatient treatment under court order to adults with serious mental illness who have a history of repeated hospitalizations or arrests, needs to be an option in Iowa. This will require legislation that permits expansion of court-ordered capabilities (similar to Kendra's Law in New York). AOT has been shown to dramatically reduce harmful or violent behavior, arrests and incarcerations, repeat hospitalizations, and homelessness. AOT also reduces care costs by as much as 50%. [19]

Iowa DHS uses CareMatch as their Psychiatric Bed Registry. Although reporting in CareMatch is voluntary, all 29 Iowa Hospitals are reporting (most 5 to 7 days per week). The Iowa DHS website has a link to a presentation by Richard Shults (Division Administrator of Mental Health and Disability Services) that indicates that from Aug. 2015 to May 2016, the average number of available psychiatric beds each day (for both children and adults) was 65.8. [9] In this presentation is a statement that there are 802 Licensed Psychiatric Hospital beds in Iowa – with 731 of these beds being staffed hospital and MHI beds. These are important data. The possibility of having an average of 65 open

psychiatric beds per day seems at odds with numerous accounts by mental health care workers and the families of patients with serious mental illnesses who can't find any available beds. If you subtract the 71 unstaffed psychiatric beds from these calculations (difference between 802 and 731) or if you use 615 beds (all non-MHI beds), the number of available acute care beds falls in line with the anecdotal evidence from around the state of Iowa. If there are truly 65 staffed beds available on average, then either the rationale used to fill beds [9] and/or the CareMatch system are problematic. Ideally, CareMatch would include real time availability of sub-acute and residential care facility beds so that social workers and physicians can place patients being transferred from acute care settings.

The state of Iowa needs to fund an initiative to both train and retain mental health care professionals (Social Workers, Psychologists, Nurse Practitioners, Psychiatrists). Presumably, this will mean enhanced funding for Community Colleges, Colleges, and Universities to provide the necessary curricula and residency programs. Retaining graduates in Iowa will likely require monetary incentives like student loan forgiveness in exchange for time practicing in Iowa. At the same time, Iowa needs to be a place where mental health care professionals would want to work. These improvements would include having modern facilities in which to treat patients, the appropriate community services following initial treatment, and most importantly, mandated reimbursements for services that are on par with other states in the region and/or are above the national average.

At present, the high percentage of inmates with mental illnesses among the jail and prison population is unacceptable (57.3% of the Iowa Prison has some form of mental illness (33.2% Serious Mental Illness; 24.1% Other Chronic Mental Illness). [20] County Jails are often the largest mental healthcare provider in a given county. Jails are not where the mentally ill should be treated. While the existing adult population may be more difficult to modify, teenagers with mental illnesses can avoid incarceration by early intervention by mental health care professionals. Jail Diversion programs, particularly for juvenile offenders, need to be expanded to all counties. Drug use is extremely common in adolescents who have a mental illness. Adolescents with drug-related offenses need to be screened for mental illnesses. True Dual Diagnosis Programs (simultaneous treatment of mental health issues and drug use/addiction) for adolescents and adults are needed at all Iowa Hospitals and longer-term Care Facilities.

Because initial psychotic episodes associated with Bipolar Disorder and Schizophrenia generally occur between the ages of 13 and 22 (Synaptic Pruning, etc.) [21] college-aged students are an at-risk population that needs special consideration. College and University communities (particularly the three Iowa Regents Universities – with a population of over 80,000 students) need to be equipped to handle the higher than average per capita occurrence of acute mental illness. This is a somewhat predictable influx of patients. Hospitals in these communities should have a higher than normal number of acute care beds, enhanced hospital intake areas, and campus police officers who have received Crisis Intervention Training (CIT).

4) Reducing Barriers to Treatment

There is much discussion about and monies spent on ending the stigma associated with mental illness, the truth is that there are far greater barriers to gaining treatment for a mental illness – like not having access to insurance, psychiatrists, or acute care hospital beds. Discrimination and

prejudice against those with mental illnesses must not be tolerated. To that end, achieving parity between physical and mental illnesses is a necessity. Having elected officials speak openly about mental illnesses to educators, employers, law enforcement, and civic leaders would likely be more helpful than devising costly, anti-stigma campaigns. [12] If asked to prioritize funding, access to patient care (particularly for those with serious mental illnesses) should always come before anti-stigma campaigns. Most family members of those with serious mental illnesses show no reluctance to seeking treatment for their loved ones.

One area where stigmatization is a fundamental barrier to treatment is the process by which patients with serious mental illnesses gain entry to acute care. On this, I speak from first-hand experience. When first responders (typically law enforcement) bring a mentally ill patient to an Emergency Room, this process can often be traumatizing. Psychiatric patients are typically handcuffed and transported in a patrol car. Once they arrive at an Emergency Room (the most typical entry point for Acute Care), the patient remains handcuffed and is escorted by a Police Officer while in a public waiting area. The standard ER intake process can take hours if an Emergency Room is busy. This public humiliation could be avoided if ER facilities had a mental health intake area that was separated from the public – preferably a quiet, safe area. Mandating that each hospital in Iowa (regardless of the number or acute care psychiatric beds are available) has a safe facility available to receive an at risk mentally ill patient would be an excellent first step toward improving this process.

There is a common misconception among some mental health care providers that HIPAA regulations prohibit family members and friends from providing information about a patient with mental illness to MHC Providers. In reality, HIPAA regulations limit information being conveyed from a health care provider to those not specifically designated by the patient. This misconception often hampers communication with family members and is injurious to the patient's care. Would a physician who is treating a person with a serious physical ailment (e.g., a laceration due to a car accident) consult with family members about medications that the patient has or hasn't taken? Now consider a similar scenario where a psychiatrist is covering an Emergency Room where a patient with schizoaffective disorder is brought by local law enforcement officers at the request of family members. Does the psychiatrist seek the same type of information from family members and with the same urgency? Ongoing training of all MHC providers about HIPAA regulations and collecting vital information about patients with mental illnesses is sorely needed.

Laws need to be enacted and/or enforced to put mental illnesses on par with physical illnesses. Insurance companies need to be forced to cover mental health care for periods of time that actually generate positive outcomes. Most medications prescribed to treat serious mental illnesses (anti-psychotics and anti-depressants) require a minimum of 2 to 3 weeks for an initial dose to reach a static, therapeutic level in the patient's blood. Until serum levels of medications stabilize, changes in behavior and potential side-effects (seizures, tardive dyskinesia, over-sedation, etc.) should be monitored as an inpatient. This simply cannot occur during the typical inpatient stays recommended by insurance companies (less than 1 week). Having a mandated inpatient stay for patients starting new medications will reduce recidivism rates and improve outcomes. The general goal should be to use a minimal amount of medication to achieve the desired change in symptoms.

Mentally ill patients must also be evaluated and treated for physical issues. Patients with mental illnesses are typically not well-diagnosed for physical ailments. In many cases, real physical symptoms

are dismissed as “conversion disorder” (aka psychosomatic illnesses). Psychiatrists tend to focus on stabilizing those in psychosis without conducting thorough physical evaluations. In Residential Care Facilities, there are typically no full-time physicians or psychiatrists. These facilities generally have a Nurse Practitioner or Physician visit one day per week to meet with patients. Again, physical evaluations may not be the most pressing issues. Priorities and practices need to change.

Mental health care for children is not on par with that of adults. It’s no secret that many pre-adolescents and adolescents use drugs and alcohol. In some cases, drug use is an attempt at self-medication for early symptoms of a mental illness. For adolescents (whose brains are still developing) who are genetically pre-disposed to mental illness, use of marijuana increases the risk of developing schizophrenia and other psychoses. The higher the use, the greater the risk. [22] Having Dual Diagnosis programs for children in all Iowa Hospitals would seem like a reasonable thing to mandate. Early diagnosis and treatment of mental illnesses lead to better long-term outcomes.

Training of K-12 teachers to recognize early signs of mental illness in children is an important component of early intervention. Having at least one trained mental health care worker in each school district would seem like a reasonable approach. When changes in a student’s behavior or performance is identified, evaluations should be performed. Again, early diagnosis and treatment of a mental illness leads to better outcomes. Likewise, training of college and university instructors to recognize mental illness symptoms is equally important as the first psychotic episodes associated with Bipolar Disorder and Schizophrenia typically occur between the ages of 13 and 22. [21]

Training is needed to help first responders recognize behaviors associated with untreated mental illnesses so that these individuals are not harmed or arrested needlessly. It would seem reasonable to mandate that all law enforcement officers receive Crisis Intervention Training (CIT).

Mobile Mental Health Units and Telemedicine are needed for rural/sparsely populated areas of Iowa. Live patient evaluations can be conducted (either in person or via Skype, or other teleconferencing methods) and health care providers can seek the advice of Psychiatrists and other MHC providers in other parts of the State. These services maximize coverage in areas currently understaffed with mental health care professionals and are relatively inexpensive.

Elopement of mentally ill patients from the full range of facilities is far too common. At present, the electronic “pinging” of cell phones by law enforcement is not permitted without a court order as this is in violation of the patient’s 4th Amendment rights of Unlawful Search and Seizure – regardless of potential harm to the patient or others. Modification of this practice is needed for those under court committal. The safety of the patient needs to be the primary concern.

Choosing medications for those with mental illnesses such as Bipolar Disorder or Schizophrenia is not an exact science. When complex psychiatric cases evolve or when medications don’t have the desired effect, it’s often necessary to try different medications. Having all available medications on hospital and insurance formularies provides clinicians the widest range of treatment options. One such medication is the atypical anti-psychotic Asenapine (Saphris). This medication was/is not on the formulary of the hospital treating my son. As a result, doctors were reluctant to prescribe this medication. Instead, Clozapine (Clozaril) was used for nearly a year with severe side effects - debilitating seizures. The transition from Clozapine to Asenapine required a formidable effort (by us as our son’s advocate) to first prove Clozapine was causing seizures (described as conversion disorder)

and then to seek special dispensation to prescribe Asenapine. Discontinuing Clozapine stopped the seizures and the use of Asenapine alleviated the auditory hallucinations. What harm is there in making all medications potentially available?

There is a tendency in acute care settings to primarily dispense medications as a course of treatment. Every effort should be made to begin some form of therapy that involves verbal communication with the patient (psychotherapy, cognitive behavioral therapy, or mindfulness-based therapy). Although medications may stabilize a patient, the underlying reasons for being in an acute care setting may not be addressed. These therapies also initiate a relationship – often something missing in the life of someone with a serious mental illness.

"Cherry Picking" of psychiatric cases (selecting cases that are more easily treated or where positive outcomes are likely) commonly occurs in Iowa. After treating my son for over a year, a private psychiatric practice abruptly stopped scheduling future visits following a hospital admission. Likewise, it was impossible to schedule an appointment with other local psychiatric practices as they would request his medical records and then provide various excuses for not scheduling. Add Medicaid to this and no private practice will schedule visits. This discrimination relegates those with serious mental illnesses to hospital care. These are the people who need outpatient care (various therapies) and community programs the most and this active discrimination impedes their ability to receive care.

Iowa needs to invest in community organizations that support meeting places that reduce social isolation of those with mental illness. An extraordinary example of this is Fountain House (www.fountainhouse.org) that provides a wide range of support services. NAMI Johnson County is having great success with its newly revamped R Place Peer Center in Iowa City (https://namijc.org/recovery/). With a new location, increased staffing, and expanded hours of operation, R Place is quickly becoming a familiar place where people can build relationships and have a sense of community. At a minimum, these social meeting places provide hope and a sense of purpose through structured activities. Beyond that, these places can provide a range of support services (employment, housing, health care assistance, etc.), that can directly impact the lives of those in need.

5) Coordination of Federal and State Funding:

In addition to issues with Iowa's Medicaid system, many who are disabled by mental illness rely on Social Security and Social Security Disability to provide funding to support their room and board. To receive Medicaid one must first qualify for Social Security Disability. This can often require multiple applications.

For young people disabled prior to earning a salary and paying into social security, the monthly payments from Social Security and Social Security Disability are $755 per month. Although this is federal funding, these payments are tied to the type of care they are receiving (which is typically state-funded). If someone is in an acute care facility (e.g., hospital) for more than 30 days – funds from social security are discontinued until they are discharged. If a patient is in a State facility (e.g., MHI) this funding is discontinued until discharge. If a patient is in a residential care facility, they must pay the RCF all but $100 of their monthly SSI/SSDI income. These funds are required to be paid or discontinued – regardless of what longer-term housing arrangements have been made. Imagine signing a 1-year lease for an apartment and then a month or two after moving in, you're admitted to

a hospital for 35 days – how do you pay rent? These requirements can be the beginning of a downward spiral of homelessness or having to remain in a residential care facility.

To further complicate matters, food assistance is also tied to the patient's residential status. If you're an inpatient, you can't apply for food assistance. These regulations aside – how does a person survive on $755 per month ($9060 per year)? Iowa needs to devise a plan where people with mental illnesses can maintain a residence while receiving acute care. Having a stable place to live improves outcomes. One goal that is often overlooked is returning a person with a serious mental illness back to a productive life. This can't happen when a person has no place to live and is unable to hold a job.

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Figure 1a: Hospital In-Patient Psychiatric Beds – Staffed [9]

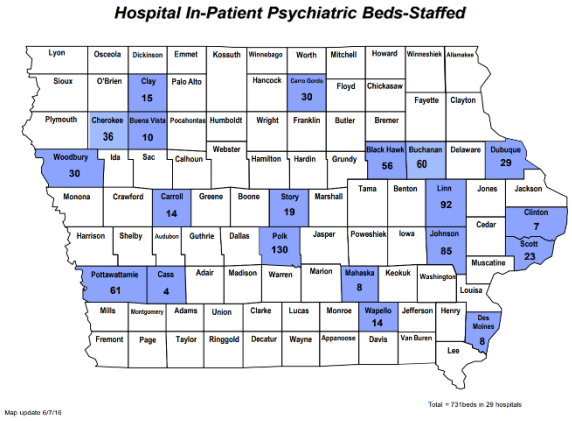


Figure 1b: Array of Core Plus and inpatient mental health services [10]

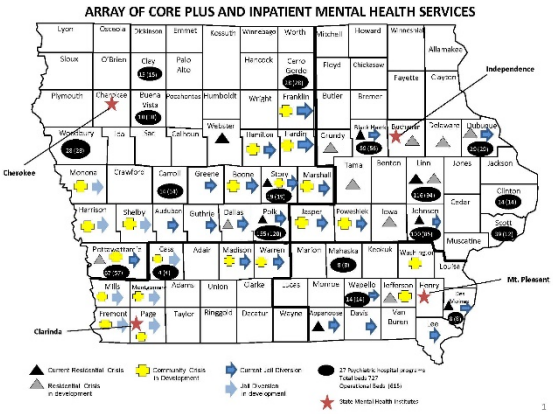


Figure 2: Iowa Mental Health Disability Services Regions [13]

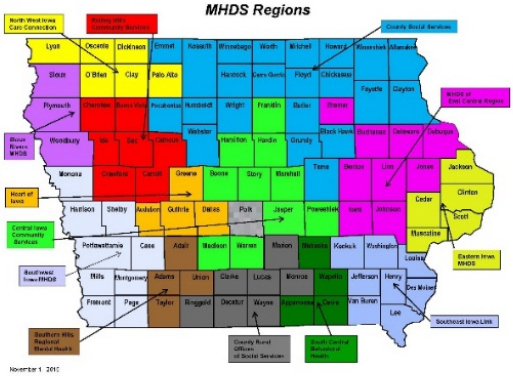
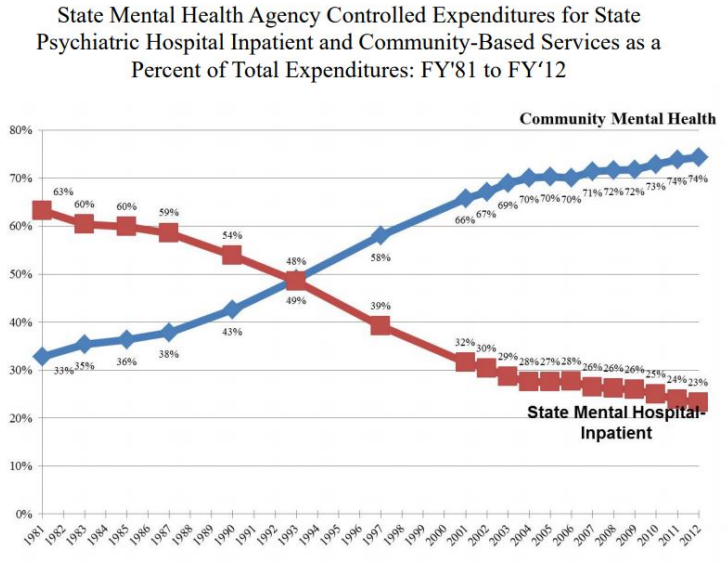


Table 1: 2016 Census Population for each Iowa MHDS Region

Row Labels	Sum of Population
Central Iowa Comm. Services	327,186
County Rural Offices of Social Services	78,676
County Social Services	460,208
Eastern Iowa MHDS	300,649
Heart of Iowa	109,830
MHDS of East Central Region	590,777
North West Iowa Care Connection	74,461
Polk County	474,045
Rolling Hills Community Services	95,924
Sioux Rivers	162,877
South Central Behavioral Health	78,485
Southeast Iowa Link	163,030
Southern Hills Regional Mental Health	29,421
Southwest Iowa MHDS	189,124
Grand Total	3,134,693

Figure 3: State Mental Health Agency Controlled Expenditure for State Psychiatric Hospital Inpatient and Community-Based Services as a percent of Total Expenditures: FY'81 to FY'12. [15]



Source: NRI 2012 State MH Agency Revenues and Expenditures Study

NASMHPD and the NASMHPD Research Institute, Inc., (NRI) have documented a historic shift in the focus of state government expenditures for mental health services. In state fiscal year 1981, almost two thirds of State Mental Health Authority (SMHA) expenditures for mental