SOUTHWEST IOWA MENTAL HEALTH COURT

Statement of Philosophy

Mental Health Court is designed to provide an alternative to jail or prison time for persons with chronic mental health needs who commit crimes meeting established criteria. Mental Health Court, through intensive individualized services, will help these offenders with chronic mental health needs treat their illness, take their medication as prescribed, meet their basic food and shelter needs, and avoid expensive incarceration or hospitalization. The goals of Mental Health Court seek to impose a sentence that provides maximum opportunity for the rehabilitation of the defendant; the protection of the community from further offenses by the defendant; and consideration of victim's rights and safety.

The SWIMHC (MHC) is an intensely structured program that promotes rehabilitation of the offender by providing intensive supervision; mental health treatment; substance and addiction testing and treatment; and supportive services for housing and other basic needs. The participant is required to attend all assigned treatment activities, comply with supervision, attend status hearings on a regular basis with the presiding judge, abstain from non-prescribed drugs, and refrain from further criminal activity.

The admission into the program requires a plea of guilty to a qualifying offense as negotiated by the offender participant's attorney and the county attorney's office. *If an offender is already on probation, this program may be added as a condition with the consent of the county attorney's office, the defendant, and by the unanimous acceptance of the MHC team.*

PLEASE NOTE: COMPLETE THE APPLICATION TO THE BEST OF YOUR ABILITY.

- If a section does not apply, then please indicate (NA) to show that response
- If you are unsure then indicate that appropriately
- Applications which are incomplete may result in the delay of review for entry and could result in the denial of the application
- Failure to execute the Release of Information form will prevent consideration for admission

THE DEFENDANT'S ATTORNEY SHALL ASSIST THE APPLICANT IN COMPLETING THE APPLICATION.

CASE MANAGEMENT CAN ASSIST WITH THE SWI MHDS REGION APPLICATION

IT IS THE APPLICANT'S/ATTORNEY'S DUTY TO CONTACT CASE MANAGEMENT AND SIGN THE RELEASE FORM. THIS MUST BE COMPLETED AND PROVIDED TO CASE MANAGEMENT TO FACILITATE THEIR ASSISTANCE

ADMISSION CRITERIA:

- Adult offender (18 at time of commission of offense; juvenile waived to adult court or a juvenile offense that allows direct filing of the offense)
- Must reside in the 4th Judicial District
- The charges or probation must originate from the 4th Judicial District
- MH diagnosis within criteria under Eligible Diagnosis
- No persons on parole
- No sex offenses (past or present charges)
- No forcible felonies or offenses where mandatory minimums apply
- Indictable misdemeanors which meet criteria*; Class C and D non violent felonies*
- If currently meets criteria for mental health or substance abuse committal, then not eligible until stabilized enough for participation
- If the applicant has other unresolved charges or warrants then is not eligible (the offender may reinitiate his/her application once those matters are concluded)
- If primary diagnosis is substance abuse then not eligible (may be co-occurring)
- Must be competent as he/she waives rights including entering a guilty plea
- Persons with Intellectual Disability and Traumatic Brain Injury will be considered on a case by case basis
- Must agree to participate and meet all conditions
- The applicant's past criminal history will be considered to determine appropriateness for the program

Eligible Diagnosis:

Schizophrenia Spectrum; Bipolar and Related Disorders; Depressive Disorders and Anxiety Disorders (not solely resulting from substance abuse); Trauma and Related Disorders; Dissociative Disorder (primary diagnosis of substance abuse and addiction disorders; personality disorders or paraphilic disorders are excluded)

Risk Assessment:

In addition to the limitations above, it is the not the intention to admit offenders with high risk of significant violence as this is a community based program. Offenders who possess, use, or display weapons are at high risk for exclusion. Applicants who currently or in the past have caused serious or extensive injury to another will be excluded. Persons who possess, use, or display a firearm will be excluded. Current charges as well as past history will be used to determine violence risk. Past history may include other crimes; history as provided by applicant; applicant's family or treatment provider; number and frequencies of hospitalizations; non-compliance with treatment including aggression toward treatment providers.

Interagency Release Form

AUTHORIZATION FOR DISCLOSURE AND RELEASE OF MEDICAL, MENTAL HEALTH, SUBSTANCE ABUSE, AND/OR CORRECTIONS INFORMATION

Applicant/Participant_____ **Birthdate**_____

I, the undersigned, authorize each of the agencies initialed below whose purpose is to coordinate the services and treatment of participating clients/patients with involvement in mental health, substance abuse, and corrections conditions:

_____ **Heartland Family Services, 515 E. Broadway, Council Bluffs, IA 51503**
_____ **Jennie Edmundson Hospital, 933 E. Pierce St, Council Bluffs, IA 51503**
_____ **Mercy/Alegent/CHI, 800 Mercy Dr., Council Bluffs, IA 51503**
_____ **Alegent Health Psychiatric Associates, 801 Harmony St, Suite 302, Council Bluffs, IA 51503**
_____ **Pottawattamie County Community Services, 515 5th Ave, Suite 113, Council Bluffs, IA 51503**
_____ **Southwest Iowa MHDS Region, 515 5th Ave, Suite 113, Council Bluffs, IA 51503**
_____ **Pottawattamie County Sheriff's Office, 1400 Big Lake Rd., Council Bluffs, IA 51501**
_____ **Pottawattamie County Jail, 1400 Big Lake Rd, Council Bluffs, IA 51501**
_____ **Council Bluffs Police Dept., 227 S. 6th St, Council Bluffs, IA 51501**
_____ **Department of Corrections, Adult Probation, 801 S. 10th St, Council Bluffs, IA 51501**
_____ **PDO or attorney of record; County Attorney; and other member of MHC team;**
_____ **Mental Health and Substance Abuse Network, 515 5th Ave., Council Bluffs, IA 51503**
_____ **Other:**_____**(family member and/or significant other must include address)**
_____ **Community Mental Health Center, 4102 Woolworth Ave, Omaha NE 68105**
_____ **Lasting Hope Recovery Center, 415 S.25th Omaha NE 68131**

to disclose verbally and/or to release in writing to any and all of the participating agencies initialed above, the following information pertaining to the evaluation and/or treatment of the above-named client/patient:

_____ **Attendance and Compliance**
_____ **Discharge Summary**
_____ **History and Physical**
_____ **Medical/Health**
_____ **Lab, X-Ray, EKG**
_____ **Progress Notes**
_____ **Diagnosis & Assessment (for both mental/substance)**
_____ **Insurance coverage/funding sources**
_____ **Emergency Room Report**
_____ **Pathology Report**
_____ **Consultations**
_____ **Educational records**
_____ **Other information as needed (specify)**
_____
_____ **On-going progress communication**

This information is to be used for the coordination of the applicant/participant's mental health, substance abuse, and corrections conditions. This information is gathered for the purpose of evaluating criteria for admission into Mental Health Court; preparing a case plan for Mental Health Court and to check progress and compliance with the terms of Mental Health Court. I understand that redisclosure of this information by the authorized participating agencies is prohibited, except as permitted by applicable federal and state laws. Once the requested information has been disclosed, the recipient of the information may re-disclose it and the privacy regulations guaranteed with this consent to release information, may not longer protect the information. However, filings with the Clerk of Court will have a level of security to prevent public access.

This authorization will automatically expire in twelve (12) months from the date of my signature, except as hereby specified: _____**(list specific number of days or months). At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time by sending a written notice to the Director of Medical Records of each of the participating agencies whom I have authorized above. I understand that any disclosure or release of information which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my**

rights to confidentiality and that my protected health information may be subject to redisclosure and may no longer be protected by the HIPAA privacy provisions. I further understand that I may inspect the information disclosed by any of the participating agencies by contacting the Director of Medical Records at each such agency. I understand that a medical release is normally 6 months but by my voluntary participation in Mental Health Court-the supervision has a minimum of 12 months. This authorization will automatically expire upon the completion of correctional supervision (institutional or community based).

I understand that if the person or entity listed above is a physician; surgeon; physician's assistant; advanced registered nurse practitioner or mental health professional this authorization also permits _____ to consult with the provider about my medical history and condition relating to my diagnosis; evaluation; treatment; progress notes; attendance and compliance (with medication as well as other therapeutic treatment);and any other information relied upon which bears upon conditions of eligibility; conditions of care plan; or progress/compliance for the Southwest Iowa Mental Health Court.

_____ _____

Signature of Mental Health Court applicant/participant **Date**

_____ _____

Attorney for Applicant/participant **Date**

Specific Authorization For Release Of Information

Protected by State Or Federal Law, 42 CFR Part 2

I specifically authorize the release of information relating to:

(Applicant/participant must initial appropriate line(s))

____ Substance Abuse (alcohol/drug abuse)
____ Mental Health (including psychological testing)
____ Acquired Immune Deficiency Syndrome (AIDS) including Human Immunodeficiency Virus (HIV) test results

_____

Signature/Date

In Order For The Above Information To Be Released, You Must Sign Here <u>And</u> In the Next Column.

_____

Signature of applicant/participant or Authorized Representative

_____

Relationship, if not the applicant/participant

_____

Address

_____

Date

Copy given to applicant/participant on _____(date)

by _____

Information released on _____(date)

by _____

to _____

_____

IN THE IOWA DISTRICT COURT IN AND FOR _____ COUNTY

STATE OF IOWA,

Plaintiff, Case No.:_____

Vs.

APPLICATION FOR SWIMHC

Defendant.

COMES NOW, the Defendant in the above-entitled cause, and informs the Court the following:

1. That he/she was charged by Trial Information with :

   _____

   _____

   And the following simple misdemeanors:

   _____

2. That he/she is a person diagnosed with a mental illness
3. That he/she further desires to plead guilty in this case.
4. That his/her attorney is _____.
5. That he/she has reviewed the proposed Mental Health Court Plea Agreement, and wishes to enter a plea of guilty under the conditions set forth in the MHC Plea Agreement. Defendant understands that the State and/or MHC has no obligation to accept this Defendant into the Court until the proper screening process has been completed.

6. The defendant has signed a **SWIMHC Release of Information form** which is attached.

7. That he/she completed the **SWI MHDS REGION APPLICATION**, which is attached.

8. That he/she has agreed to various assessments including the Gains Screener; PHQ9 Screener; Co-Occurring Disorder Screener; and the SASSI-3 with the therapist.

   **If applicable will provide testing for cognitive functioning if ID or TBI or agrees to complete new testing with the therapist.*

9. That he/she has also completed the **MHC plea agreement** in accordance with the guilty plea necessary for his/her participation in the program..

10. I have minor children _____ yes _____no

    In the below space I will list his/her name and age and whether they reside with me or have another placement (other parent/family member/foster care/etc)

    _____

    _____

    _____

    The defendant currently has a child protection case with DHS-or any involvement with DHS to include the following: (juvenile court case; safety services with DHS; voluntary services with DHS; or otherwise involved with DHS for: abuse assessment; family assessment; or CINA assessment) **LIST BELOW

    _____

11. The defendant is currently on probation or parole **LIST BELOW**

_____

12. The defendant is currently convicted of a sex offense or is on the sex offender registry or is currently facing a sex offense charge or charge that would subject him or her to the sex offender registry. **LIST BELOW**

_____

WHEREFORE, the Defendant prays that the MHC takes jurisdiction of this cause and set a time and place for hearing to accept the Defendant's plea under the MHC Plea Agreement.

Date:_____ Defendant:_____

Date:_____ _____
Attorney for Defendant

IN THE IOWA DISTRICT COURT IN AND FOR _____ COUNTY

STATE OF IOWA,)

Plaintiff,) Case No.:_____

VS.) ***MENTAL HEALTH PLEA AGREEMENT***

Defendant.)

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1. The Defendant enters a plea of guilty to the offense(s) of

_____

_____

2. The range of sentences possible under this plea in accordance with the above statutes consists of:

_____

_____

_____

_____

3. The following charges are dismissed in consideration of this plea:

_____

_____

_____

_____

4. A sentencing date will be set by the Court, pending the Defendant's enrollment and completion of Mental Health Court. By this agreement, the Defendant agrees to enroll and complete Mental Health Court as specified further herein. Defendant agrees that should he/she fail to complete Mental Health Court, he/she may be sentenced immediately by the Mental Health Court Judge on the charges

pled to herein. The conditions of the Mental Health Court will have the following marked special conditions:

Check if Applicable

_____ (A) The Defendant agrees to enter into the Fourth Judicial District Mental Health Court for a period of (12) months or (24) months and successfully complete the Program. This time period may be extended or lessened by the Mental Health Court Judge.

_____ (B) Report to the Probation Officer in charge of Mental Health Court at once.

_____ (C) Pay the sum of **$300** to the Fourth Judicial District, Department of Correctional Services **(as a supervision fee).**

_____ (D) Undergo a mental health evaluation by the therapist and successfully comply with and complete all recommendations of Court for treatment. If other evaluations are needed for eligibility or for a treatment plan, the defendant will cooperate with those evaluations and also comply with any treatment that is recommended. Undergo substance abuse/addiction evaluation and successfully complete all treatment as determined necessary

_____ (E) Enroll in GED/Vo-Tech Program/college and successfully complete the same as determined appropriate. Maintain steady employment during participation in the Mental Health Court Program.

_____ (F) Make restitution to the victim according to a schedule to be worked out by the Probation Officer and approved by the Court

_____ (G) Remain drug and alcohol free; stay out of bars and away from illicit drugs and substance abusers/users.

_____ (H) Take prescription medication ONLY with the permission of the Treatment Provider, and provide all prescriptions to the therapist and case manager.

5. The Defendant agrees to all Mental Health Court rules and regulations and promises to abide by and obey the orders of the Mental Health Court Judge, and understands that multiple positive drug tests, which indicate the presence of a uniform controlled dangerous substance under Iowa law, or the attempt to falsify a drug test may result in expulsion from the program and the imposition of sentence.

6. The Defendant understands that the application and admission process may require him/her to waive due process rights which he/she may have under the Constitution of the United States and the Constitution of the State of Iowa involved in the administration of Mental Health Court, and in particular the imposition of sanctions by the Mental Health Court Judge, including, but not limited to, the waiver of the ninety (90) day and one (1) year speedy trial requirements by Iowa Rules of Court. These rights will be explained by his/her counsel when a waiver is required.
7. The Defendant agrees to all sanctions imposed by the Mental Health Court Judge, including jail service, community service, frequent court visits and appearances, increased drug testing, AA and NA meetings, individual and group counseling sessions, and any conditions of probation which, in the judgment of the Court, are necessary or beneficial to the Defendant.
8. The Defendant agrees to attend and report to Mental Health Court, his/her Probation Officer and the Treatment Provider as ordered by the Mental Health Court Judge.
9. The Defendant specifically agrees to pay whatever amount his/her Probation Officer/Case Manager recommends and the Mental Health Court approves, to help defray the costs of his/her treatment and participation in the Mental Health Court Program. This is based on both the defendant's ability to pay as well as cooperation in any application process which allows access to benefits or payment for providers.
10. The Defendant expressly waives his/her right to recuse the Mental Health Court Judge, should he/she fail to complete the program, be revoked and sentenced in accordance with this plea agreement.
11. The Defendant understands and expressly waives his/her right to contest his/her extradition under the laws of the State of Iowa, federal law, or any State where he/she may be found should he/she leave the State of Iowa and become subject to extradition back to the State of Iowa.
12. The Defendant and his or her counsel assert that they have disclosed all criminal history and pending charges, whether in the Fourth Judicial District, or elsewhere

as indicated below:

_____

_____

_____

_____

13. The Defendant understands the nature of this plea agreement and the full effect of the agreement, and specifically declares that this agreement contains all of the conditions and agreements of the Defendant, the Court and the State of Iowa.

14. The Defendant understands, waives and gives up the following constitutional rights and enters a plea herein:

(a) The right to plead not guilty.

(b) The right to trial by a jury or a judge.

(c) The right to be represented or helped by counsel (a lawyer) of his/her choice, or if he/she cannot afford counsel, his/her right to be represented by court-appointed free counsel.

(d) The right to compel or make witnesses come to trial to testify in his/her behalf.

(e) The right to cross examine witnesses that testify against him/her.

(f) The right to be present when witnesses testify against him/her.

(g) The right to remain silent and not testify.

(h) The right to appeal all matters relating to the trial and sentencing, including the issue of guilt or innocence.

(i) The right to motion in arrest of judgment.

15. The Defendant acknowledges and states that the above-listed rights have been carefully explained to him/her by the Judge in Court, and by his/her attorney, and that he/she fully understands what he/she is doing by pleading guilty to this offense(s). The Defendant further acknowledges that he/she has read the above rights and fully understands his/her above-listed rights and wishes to waive all of them.

16. The Defendant understands the elements of the crime he/she is charged with and entering a plea to, and the maximum and minimum periods of incarceration and fines, as well as any mandatory minimums that apply, with regard to the charges as are indicated on page one (1) of this agreement.

17. The Defendant has reviewed the facts of this case with his/her attorney, and agrees that there are sufficient facts available to the State to justify the plea of guilty that he/she enters to the charges. The Defendant has further reviewed the Trial Information filed by the State in this case, and the Defendant acknowledges and stipulates that if called to testify, these witnesses would testify in accordance with the minutes of testimony, and there is a factual basis for the charge(s).

18. The Defendant expressly declares he/she has not had any drug, alcohol, or medication of any kind in the past twenty-four (24) hours except:_____

_____

And will be asked to assert during the plea proceedings that he/she has not ingested anything that will impair his/her ability to understand the proceedings.

19. The Defendant declares that he/she has entered into this plea agreement freely and voluntarily of his own accord, and with the full understanding of all matters set forth in the information and in this plea agreement.

20. The Defendant declares that he/she is able to read and that he/she has read and understands everything in this plea agreement; or that he/she cannot read, but everything in this plea agreement has been read to him/her; that he/she understands all of it, and that he/she is satisfied with the advice and services given by his/her attorney, and that no one, including his/her attorney, has compelled or induced him/her to enter this plea by any force, duress, threats or pressure. This plea is being entered into freely and voluntarily by the Defendant.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE PLEA AGREEMENT, AND AGREE TO ALL THE TERMS AND CONDITIONS SET OUT HEREIN.

_____ _____

Defendant Date

Attorney for the Defendant _____ Date _____

County Attorney or his/her Assistant _____ Date _____

Judge of the Fourth Judicial District-MHC _____ Date _____

CERTIFICATE OF DEFENDANT'S ATTORNEY

I, Defendant's counsel of record, certify that: I have discussed this case with the Defendant, including the nature of the charges, essential elements of each, the evidence against him/her of which I am aware, the possible defenses he/she has, the maximum penalty for the charges and the facts as set forth in the State's information or on the record. I believe he/she fully understands this plea agreement, the consequences of entering it, and that the Defendant does so of his/her own free will. In my opinion, the Defendant is mentally competent.

Attorney for Defendant _____ Phone # _____ Date _____

CLIENT CONTRACT
MENTAL HEALH COURT TREATMENT PROGRAM

I HAVE CHOSEN TO PARTICIPATE IN THIS PROGRAM. TO ASSURE MY FULL PARTICIPATION IN THIS DRUG AND ALCOHOL FREE PROGRAM, I AGREE TO THE FOLLOWING REGULATIONS:

1. I understand that I must attend all scheduled sessions and appointments made by the staff. If it is necessary to miss any sessions, I will notify the clinic and bring documentation, typed on their letterhead, from my employer or doctor for verification. If I fail to call and bring verification to my next scheduled session, it will be considered an unexcused absence. Each absence, whether excused or not, will be included in the status report sent to the Judge.

2. I understand that I may be required to submit to breath tests to verify I am alcohol free. If I am found to be drinking at any time during treatment, I agree to follow through with referral to detox, inpatient or any recommendation by the treatment staff. If sent to detox or inpatient, I agree to return to the clinic immediately upon release from such facility to check in with staff to reassess my level of participation in the program.

3. I understand that I will be required to submit to supervised random urine screens. If I fail to produce a urine specimen, or if it is not of sufficient quantity, it will be considered a stall on my part and it will be treated as if it was positive for drugs/alcohol. If I am found to be using at any time during treatment, I agree to follow through with referral to detox, inpatient or any recommendation by the treatment staff. If sent to detox or inpatient, I agree to return to the clinic to check in with staff to reassess my level of participation in the program. TAMPERING WITH A SAMPLE CAN RESULT IN SANCTIONS INCLUDING TERMINATION FROM THE PROGRAM.

4. I understand I am responsible for informing and providing documentation of all prescription medications I am taking. I am also responsible for notifying staff if there are any changes to the prescriptions. I agree to take medications only as prescribed to me.

5. I understand that I am required to participate in all scheduled sessions. Failure to participate will be noted by my counselor, who will include this in the status report to the Judge.

6. I understand that while I am waiting for admission into an appropriate residence or living arrangement, I may be incarcerated and if not I will continue to maintain scheduled appointments.

7.. I understand I am to cooperate with the treatment staff in formulating my treatment plan. I agree to sign the consent forms for the release of information in order to help the staff communicate with individuals or agencies that can assist me in my recovery.

8.. I understand that sanctions may be imposed by the Judge for my failure to comply with the Mental Health Court Program. I understand that my failure to comply with the program can result in additional conditions and requirements which will be made part of my treatment plan. I agree to comply with the additional requirements in order to continue in the program.

9.. I understand that if I am found to be under the influence of drugs or alcohol when I arrive for a treatment session, I will not be allowed to stay and participate. I agree to surrender my keys to the staff for my safety, as well as others. I will call someone who is not under the influence to drive me home.

10. I understand that if I insist on driving, the staff will be obligated to notify the Sheriff's Department of an impaired driver on the road and a description of the vehicle will be given.

11.. I understand that if I test positive for drugs or alcohol, the Court has the option to have me immediately be taken into custody until a decision is made as to my future part in the Mental Health Court Program.

I HAVE READ AND UNDERSTAND THE CONTRACT. I AGREE TO FOLLOW THESE REGULATIONS.

Client:_____ Date:_____

Staff:_____ Date:_____

Staff:_____ Date:_____

FOURTH JUDICIAL DISTRICT
MENTAL HEALTH COURT
COUNCIL BLUFFS, IOWA

ADMISSION SCREENING

Name:_____ Date:_____

Address:_____ SSN:_____

_____ Sex/Race:_____

Telephone Numbers: Home:_____ Work:_____

Birthday:_____ Age:_____ Work#:_____

E-mail _____

Legal History

Current lawyer _____

Charges pending in what jurisdictions _____

_____

If yes, please list:

	Charged With	Where	Date	Status
1.				
2.				
3.				
4.				
5.				

(**Criminal History**: See attachment-provided by CA)

Are you on Probation or Parole?_____ PO's Name_____

Are they sex offender or currently facing sex based charges (under Chapter 709 of Iowa) or any other jurisdiction? Yes _____ No _____

Additional contacts:

Name	Relationship	Phone Number
1.		
2.		

CASE MANAGEMENT

Housing:_____ Parenting Skills:_____

Life Skills: _____ Physical Health: _____

Education: _____ Employment:_____

Medical Insurance: _____ Disability Application:_____

_____ _____

Case Manager Date

THERAPIST

Diagnosis:_____

_____

Substance Abuse: What is substance of choice?_____

Level of Addiction _____

Co-occurring Personality or Behavior Disorder?_____

_____

Intellectual Disability or TBI?_____

Criminal Thinking: _____

History of Trauma_____

Anger management _____

Other needs for treatment:_____

_____ _____

Treatment Provider Date