

Mental Health Services in Iowa: A Survey of County Boards of Supervisors

Introduction. In Iowa, services to persons with mental retardation and mental illness are county based. Each county is responsible for its own planning, provision, and funding of services for persons in their county who have mental retardation or mental illness. Services for persons with mental retardation are mandated by the state whereas services to persons with mental illness are not mandated. Allocation of county monies for mental health services are determined at the level of the county boards of supervisors.

This report summarizes the response to a telephone survey of county boards of supervisors in 98/99 Iowa counties. Interviews were completed between September, 1995 and November, 1995. The survey was undertaken in an effort to understand the opinions of county boards of supervisors in regard to goals of treatment and funding priorities as they pertain to mental illness and mental retardation.

Methods. The chairperson of each of the county boards of supervisors in all counties of Iowa was identified and asked to respond to a series of questions regarding mental health services in their county or to designate another member of the board of supervisors as the survey respondent. Respondents were then contacted by phone at the pre-arranged time and interviewed via phone. Respondents who did not respond by mail were contacted by phone

to be interviewed or schedule a time when they would be available for interview.

Results. Interviews were completed with a representative of 98/99 Iowa counties. One county declined participation because of concern regarding potential liability. Of the 98 counties who agreed to participate, 97/98 respondents were members of their county board; 1 respondent was the county auditor who was designated as the preferred respondent by the county board members. Two-thirds of respondents (67/98) were board chairpersons. About half of the respondents indicated that they had a family member or family friend with mental retardation or mental illness (52/98). Of those who did, most knew someone with mental retardation (39/52) and a smaller number (27/52) had personal knowledge of someone with mental illness. Almost 1/2 of respondents were members of the board for more than 6 years (48/98); nearly all respondents had lived in their county for more than 6 years (94/98).

Potential for Recovery. A series of questions was asked regarding perceptions about the differences between mental illness and mental retardation. Most respondents (80/98) indicated that they believed that persons with mental illness (as opposed to mental retardation) could fully recover with appropriate treatment. However the remaining responses were relatively equally divided

between the belief that the potential to be “normal” with appropriate services was equal for persons with mental illness and mental retardation (7/98) versus not true for either group (8/98).

Focus of Treatment. When asked about the focus of treatment, the majority of respondents (69/98) indicated that services for both groups should focus on providing basic needs of food, shelter, and safety while allowing residents to live in their own home or apartment. Nearly 20% (18/98) of respondents felt that this focus was more appropriate for persons with mental retardation than mental illness. However, when asked if the best treatment would be for persons to live in a residential facility, *if affordable*, nearly 1/2 of respondents (46/98) indicated that this would be the treatment of choice for persons with mental retardation, but not mental illness; the remainder of the respondents were equally divided between the belief that this was equally appropriate for persons with mental illness and mental retardation (24/98) versus the belief that this was not the best treatment for either group (27/98). When asked whether treatment should focus on helping clients find and keep a job, most respondents (73/98) felt that this was true for

both groups. However, 16/98 respondents felt that this was truer for persons with mental illness as opposed to mental retardation, versus 6/98 respondents who felt that this was truer for persons with mental retardation as opposed to mental illness. When asked about the value of services being focused on keeping persons from disturbing or being dangerous to the community, nearly 1/2 felt that this was more appropriate for persons with mental illness than mental retardation (41/98) although a significant proportion (32/98) felt that it was equally true for persons of both groups. Over 20% (20/98) felt that this should not be a service focus for either group.

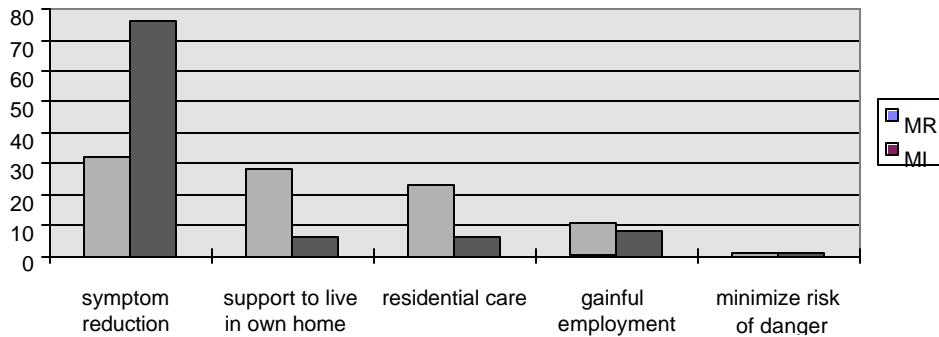
Single Best Treatment. Respondents were asked to indicate what they felt to be the single best treatment goal for services to persons with mental illness and the single best treatment goal for persons with mental retardation. There was more consistent agreement regarding the single best treatment for persons with mental illness (i.e., symptom reduction) as opposed to mental retardation. Opinions regarding the single best treatment for mental retardation showed more variation. These responses are summarized in Table 1 and illustrated in Figure 1.

Table 1. Goal of Treatment

Focus of Service	Mental Retardation (MR)	Mental Illness (MI)
symptom reduction*	32/98	76/98
provide support to live in own home	28/98	6/98
residential care	23/98	6/98
find and secure gainful employment	11/98	8/98
minimize risk of danger or disturbance to community	1/98	1/98

* For this item, symptom reduction for mental retardation was defined as “provide with more training and education”; for mental illness it was defined as “providing treatment that will reduce the symptoms of mental illness”.

Figure 1 Mental Retardation versus Mental Illness Goal of Treatment



Funding. Respondents were asked questions about their opinion regarding funding issues. When asked if the financing of services for persons with mental illness should be a responsibility of county government, most respondents said that it should not (72/98); 14/98 respondents indicated that it should, and 11 respondents were undecided.

When asked about redistribution of county funding for mental retardation versus mental illness, about 1/2 felt that the distribution was appropriate as it presently existed (46/98). Over 20% felt that less should be spent on mental re

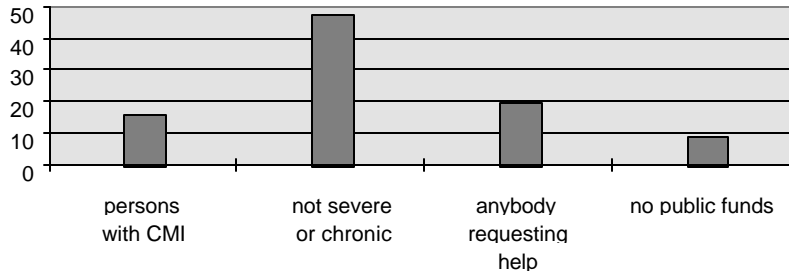
tardation and more on mental illness. The remaining responses were approximately equally distributed between the opinion that more should be spent on mental retardation (as opposed to mental illness) and the opinion that less should be spent on both groups with monies reallocated to a different service area.

Priority Group for County Services. Respondents were asked to identify the population of persons with mental illness on whom county funding should be focused. The results are summarized in Table 2 and illustrated in Figure 2.

Table 2. Priority Group for County Funded Services to Persons with Mental Illness

Priority Group Description	Respondents Indicating Priority
persons with serious and chronic mental illness	16/98
persons who are not severely ill or who are ill for brief periods of time	48/98
anybody requesting help with a personal mental/emotional problem	20/98
public funds should not be spent	9/98

Figure 2 Priority Group for County Funded Services to Persons with Mental Illness



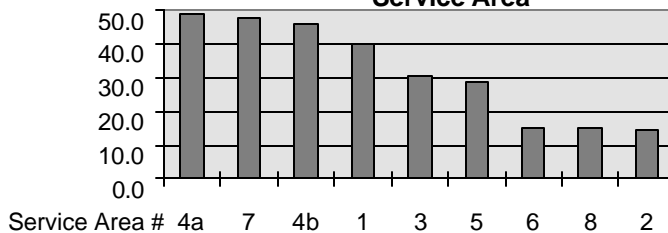
Priority for Funding by Service Areas. Respondents were asked to identify three service areas in which more money should be spent if additional money were available to the county and could be spent on any area. These re-

sponses are summarized in Table 3 and ranked in Figure 3. Although mental retardation and mental illness are both assigned to the same service area, they were divided into separate priority areas for the purpose of this question.

Table 3. Priority for Funding by Service Area if Additional Money were Available to the County

Service Area Number and Description	Rank 1	Rank 2	Rank 3	Respondents Ranking Area as Priority
1. public safety	22	8	10	40/98 (40.8%)
2. court services	2	5	7	14/98 (14.3%)
3. physical health education	13	9	8	30/98 (30.6%)
4a. mental retardation	13	24	11	48/98 (49.0%)
4b. mental illness	12	22	14	46/98 (46.9%)
5. social services	8	7	13	28/98 (28.6%)
6. county environment	2	4	9	15/98 (15.3%)
7. roads and transportation	20	13	14	47/98 (48.0%)
8. state and local government services	4	4	7	15/98 (15.3%)

Figure 3 Priority for Funding by Service Area



Conclusions

- Counties place a high priority on the provision of services to persons with mental illness and mental retardation. Even though services for mental illness are not mandated by the state, counties identify funding for mental illness as their third priority behind funding for mental retardation, and roads and transportation. However, a significant proportion of respondents (73%) do not believe that financing of services for persons with mental illness should be the responsibility of county government.
- Nearly all representatives of county government (over 80%) believe that mental illness is treatable and that persons can become well with appropriate treatment or services.
- Respondents express the belief that the most appropriate treatment for persons with mental illness is the reduction of symptoms of their illness (78%).

Mental Retardation versus Mental Illness.

- 1) *Attitudes regarding residential care.* Respondents are more likely to express the belief that residential care is more appropriate for persons with mental retardation than for persons with mental illness (46% versus 1%) although 70% of respondents felt

that the focus of services for persons of both groups should be services which allow them to live in their own home or apartment. Most respondents (74%) believe that help with finding and keeping a job is equally important for both groups.

- 2) *Perception of dangerousness.* A much larger proportion of respondents felt that services for mentally ill persons should focus on prevention of disturbance or danger to the community (41%) than for persons with mental retardation (4%). However, 33% of respondents felt that this focus was equally important for both groups.
- 3) *Single best treatment.* There was more variation in opinion about the single best treatment for persons with mental retardation as opposed to the single best treatment for persons with mental illness. In the former group, responses were relatively equally divided between providing more training and education, providing support to live in their own home and apartment, and residential care. For mental illness, an overwhelming majority (78%) felt that the single best services were those which provide treatment that will reduce the symptoms of mental illness.