

COUNTY MENTAL HEALTH SERVICES OVERVIEW

Introduction

Counties have historically been responsible for meeting the needs of their elderly, poor, sick and disabled residents. Services provided to meet those needs are known as human services. During the 1960s and 1970s, the federal government assumed responsibility for providing many human services. During those years, the federal government expanded the scope of human services and the class of persons eligible to receive them. This expansion was accomplished through the direct provision and funding of some services and through the allocation of federal dollars to state and county governments for other programs.

During the 1980s, however, the federal government retreated from its activist role in financing human services but maintained requirements that programs be provided (more often known as mandated and/or entitlement programs). During the '80s the federal government eliminated numerous categorical programs and lumped them together, creating "block grants." The Social Services Block Grant and the Alcohol, Drug Abuse, and Mental Health Services Block Grant are examples of grants created in the area of human services. The amount of funds committed to the new block grants was often less than the total dollars allocated to the categorical programs had they not been dissolved. The federal regulatory requirements on the new block grants, to a lesser extent, were reduced and more interpretation of regulations and flexibility in how block grant funds were used was left up to the state.

Some federal funds, such as Medicaid, require state matching funds. As the state of Iowa has expanded the Medicaid program to cover services to persons with disabilities they have frequently required the county to provide the matching dollars for services that were traditionally funded with county property tax dollars. As an example, the state of Iowa requires that the counties in Iowa pay all of the match (non-federal share) for persons living in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) as well as the Home and Community Based Waiver services program for persons with mental retardation.

Services required to be provided by counties are outlined in the Code of Iowa. These requirements are referred to as state mandates. Iowa law also gives counties the option of providing certain services and specifies the manner in which they are to be provided.

County Human Services Responsibilities

Iowa Code chapter 252 governs the provision of general assistance. Iowa Code §252.25 requires the board of supervisors of each county to provide assistance to poor persons in its county who are:

- ineligible for assistance under federal and state programs, or
- who are in immediate need and are awaiting approval and receipt of assistance under federal and state programs, or

- whose needs cannot be fully met by state or federal assistance.

"Poor person" is defined in Iowa Code §252.1 to mean a person who has no property and is unable because of physical or mental disabilities to earn a living by labor. The Iowa Supreme Court has found that people with some property may still fall within the definition of poor person when their property is insufficient to provide support for them. The county must establish guidelines setting eligibility for the assistance. We strongly urge that you establish your general assistance guidelines by ordinance.

The Board of Supervisors determines the form of assistance. For example, it might be food, rent, clothing, utilities or medical care.

Chapter 252 also authorizes counties to grant general assistance to "needy persons." Iowa Code §252.1 is not to be construed as prohibiting "aid to needy persons who have some means, when the board shall be of the opinion that the same will be conducive to their welfare and the best interests of the public."

A general assistance program for "needy persons" is optional on the part of counties, but should be considered when developing your general assistance ordinance. A county's general assistance guidelines could determine who is eligible for such a program, what services will be provided, and how much is to be spent per individual and county-wide.

Iowa Code §252.26 requires the county board of supervisors to appoint a general assistance director for the county. In counties with populations of 100,000 or less, the board may appoint an employee of DHS who is assigned to work in the county as the general assistance director. A person employed by the state DHS who also serves as the county general assistance director is known as an "integrated" assistance director. As a result of the state's reorganization in 1992 the Human Services Area Administrators (HSAAs) became responsible for more counties and as a result fewer of these Administrators are also serving as county integrated general assistance directors.

The general assistance director also administers the allocation of "state papers" that the county receives. The state papers program allows counties to send individuals with serious medical needs to the University of Iowa for care and treatment. The program is funded by the legislature and the funds are given directly to the University of Iowa Hospital.

Mental Health/Mental Retardation/Developmental Disabilities Statutory Responsibility

Persons with Mental Retardation: “Persons with mental retardation” means persons who meet the following three conditions: 1. Significantly subaverage intellectual functioning: an intelligence quotient (IQ) of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning) as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association. 2. Concurrent deficits or impairments in present adaptive functioning (i.e., the person’s effectiveness in meeting the standards expected for the person’s age by the person’s cultural group) in at least two of the following areas: communication, self-care, home living, social and interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. 3. The onset is before the age of 18. The county must pay for the “treatment, training, instruction, care habilitation, support, and transportation of persons with mental retardation, as provided for in the county management plan provisions implemented pursuant to section 331.439, subsection 1, in a state hospital school, or in a special unit, or any public or private facility approved by the director of the Department of Human Services.” (Chapter 222.60, Code of Iowa)

Persons with Mental Illness: The county must pay for the cost of hospitalization in a state mental health institute and the “necessary and legal” costs and expenses for “taking into custody, care, investigation, admission, commitment, and support” of mentally ill persons in the mental health institutes (Chapter 220.42 and 230.1, Code of Iowa). The county responsible for the cost of a patient at a mental health institute is required to remove the patient to a county care facility if instructed to do so by the institute and a county without a county care facility may pay for the care in any “convenient and proper” county or private institution (Chapter 227.11 and 227.14, Code of Iowa).

Certain provisions of the Code refer to persons with chronic mental illness.

“Persons with chronic mental illness” means persons 18 and over, with a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. Persons with chronic mental illness typically meet at least one of the following criteria: 1) Have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). 2) Have experienced at least one episode of continuous, structured support residential care other than hospitalization. In addition, these persons typically meet at least two of the following criteria, on a continuing or intermittent basis for at least two years: 1) Are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history. 2) Require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help. 3) Show severe inability to establish or maintain a personal social support system. 4) Require help in basic living skills. 5) Exhibit inappropriate social behavior which results in demand for intervention by the mental health or judicial system. In atypical instances, a person may vary from the above criteria and could still be considered to be a person with chronic mental illness. (IAC 441, Ch. 22)

Persons with Developmental Disabilities: “Persons with a developmental disability” means persons with a severe, chronic disability which: 1) Is attributable to mental or physical impairment or a combination of mental and physical impairments. 2) Is manifested before the person attains the age of 22. 3) Is likely to continue indefinitely. 4) Results in substantial functional limitations in three or more of the following areas of life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. 5) Reflects the person’s need for a combination and sequence of services which are of lifelong or extended duration. There is no requirement for either the state or county to pay for services for persons with developmental disabilities other than mental retardation. Section 331.424 of the Iowa Code, specifies that the Board of Supervisors may pay for services to the extent they deem it advisable to pay for evaluation, treatment, habilitation and care of persons who are mentally retarded autistic, or persons who are afflicted by any other developmental disability, at a suitable public or private facility providing inpatient or outpatient care; may pay for the care and treatment of persons placed in a county hospital, county care facility, health care facility, or any other public or private facility in lieu of admission to a state institution, or upon discharge, removal, or transfer from a state institution.

Persons With Brain Injury: “Persons with a Brain Injury” means persons with clinically evident brain damage or spinal cord injury resulting from trauma or anoxia which temporarily or permanently impairs the individual’s physical or cognitive functions. The county is not required to fund services for persons with a brain-injury. County Management Plan: Beginning in the 1994 legislative session, a number of laws were enacted whose purpose was to significantly increase state funding of MH/MR/DD services and provide the parameters under which the counties must manage the system. The primary purposes of this legislation was to provide property tax relief, and to improve the county’s management of the system through requiring counties to hire qualified staff, develop a system of accountability and control by funders, improve the planning process by increasing stakeholder involvement, and to improve the coordination of services and assure the appropriateness of services that are authorized for public funding. The legislation created a State County Management Committee to further a partnership between the state and the county in the development and management of the system. Counties are required to submit a county management plan for approval by the director of the Department of Human Services, following review by the State County Management Committee. The plans must identify how the county plans to implement the following elements: planning, identifying a provider network and contracting for services, determination of eligibility, funding authorization, service monitoring and coordination, service and cost tracking and evaluation, and quality assurance. Each county is required to establish a central point of coordination (CPC) process (also referred to as the single point of entry process), and employ a qualified CPC administrator.

Mental Health and Mental Retardation Funding Streams

County Funds: The county property tax has been the major funding source for services to adults with MH/MR/DD. Services to these persons along with other human service expenditures constitute anywhere from 1/4 to 1/2 of county budgets. Beginning with legislation passed in 1994, the state began a process to fund a larger amount from state funds, including 50% of the base and all of the growth in the system. Beginning in FY 1996/97, the county levy for MH/MR/DD services was “fixed” at either the FY 1993/94 or FY 1995/96 level of expenditure, minus the amount of property tax relief dollars the county receives. Beginning in FY 1996/97, the legislature created the county mental health, mental retardation, and developmental disabilities services fund. All revenues from property taxes, state and federal government funds, state payments, property tax relief funds and other sources designated for MH/MR/DD services are to be credited to this fund. All expenditures for MH/MR/DD services must be paid from this fund. Some of the mandated services that must be paid from this fund are reimbursement to the state for 80% of the capped per diem for care provided to adults in state mental health institutes, and all of the non-federal share of the capped per diem for services provided in the Medicaid funded state hospital schools, community facilities licensed as ICF/MR, and the home and community based waiver program for persons with mental retardation.

State Funds:

Mental Health Developmental Disabilities Community Services Fund: The fund is distributed to counties on a two-part formula: 50% based on the proportion of the poverty population and 50% based on the percentage of the total state general population. This fund can be spent on MH/MR/DD/BI services, but no more than 50% can be spent on any one of the population groups. At least 50% of the funds must be spent on “contemporary” services that include: case management, supported employment, community based housing, ICF/MRs of 10 beds or less, individual support services, and day programming. The county must have an approved county management plan in order to receive these funds and spend them in accordance with that plan.

Property Tax Relief Payments: This payment began in FY 1995/96 to reduce the county levies for MH/MR/DD services. The funds are distributed to counties by a three part formula: the county’s share of the population, the county’s share of the state’s total taxable property valuation; and the county’s share of the base year MH/MR/DD expenditures (counties had the option of choosing either FY 1994 or FY 1996 as their base year). The county is required to reduce the MH/MR/DD levy by the amount received in state property tax relief payments.

County MH/MR/DD Allowed Growth Factor Adjustment: The purpose of this fund is to provide state funding to counties to increase the pool of funds available for providing services to persons with disabilities. Counties must have an approved county management plan in order to be eligible to receive these funds. Beginning in FY 2000, the fund is allocated into four separate pools: allowable growth, per capita expenditure target pool, incentive and efficiency pool, and county risk pool. The growth and per capita expenditure funds are allocated to counties using formula methodologies. Counties must earn their allocation from the incentive and efficiency pool by achieving planned outcomes in the areas of equity of access, community based supports, consumer

participation, and administration. Counties can make application to access the risk pool allocation for unexpected expenditures.

Substance Abuse

Iowa Code chapter 125 governs the provision of substance abuse services. Counties are responsible for paying 25 percent of the cost of substance abuse treatment at state mental health institutes. The state pays 100 percent of the cost of substance abuse treatment at community-based facilities. Because detoxification is not considered part of treatment, counties most often pay all detoxification costs.

In cases of substance abuse commitments, counties pay 100 percent of the costs of court-appointed attorneys for indigent persons and the cost of a physician's examination of an indigent person being committed.

Juvenile Services

Juvenile Justice System: The county's responsibilities for juvenile programs are identified in Iowa Code §232.141. Costs charged to the county in which the proceedings are held include fees and mileage of witnesses; expenses of officers serving notices and subpoenas; and compensation for a court-appointed attorney serving as counsel or guardian ad litem.

During the 1992 legislative session action was taken that the counties must pay the difference between the capped rate that the state pays shelter facilities and the actual cost of care at the shelters. Since that time the provision has been modified to limit the county obligation for shelter care costs to the difference between the state capped rate (\$78.14 per day) and the actual and allowable statewide average shelter care rate as determined by DHS (\$104.36 per day). ISAC is seeking legislation to require full state funding of this mandate.

Juvenile Detention: In 1987, the State of Iowa was ordered by a federal district court judge to submit a plan to reduce the rate of jailing juveniles to bring Iowa in compliance with the federal juvenile detention standards by the end of 1987. The state passed SF 522 in 1987 to comply with the court order and to put severe restrictions on the cases in which a juvenile may be placed in an adult detention facility and the length of time the juvenile may be held there. HF 2278, passed during the 1988 session, made further adjustments to the juvenile detention laws. The jail removal effort put additional pressure on county juvenile detention facilities.

In 1991, SF 471 loosened the juvenile detention laws, providing that if the court has waived its jurisdiction over the child for the alleged commission of a forcible felony, and there is a serious risk that the child may be a harm to others, the child may be held in the county jail. However, "wherever possible" the child shall be held in sight and sound separation from adult offenders.

There are nine juvenile detention facilities currently in operation around the state, including facilities operated in Polk, Woodbury, Linn and Scott counties. The most recent facilities opened in 1992 in Lucas and Lee counties. The ten facilities have a total of 215 beds. Several counties operate some of the facilities. A group of 13 counties joined together to build a 14-bed center in Black Hawk County which opened early in 1989. In 1998, this facility expanded to 30 beds. A group of nine counties in the Council Bluffs area built a detention facility. A 20 bed multi-county facility has also opened on the training school campus in Eldora.

One of ISAC's major legislative objectives has been to get increased state financial assistance for juvenile detention expenses. County and multi-county juvenile detention facilities are entitled to receive financial aid from the state in an amount not to exceed 50 percent of the costs of establishing, improving, operating and maintaining the facilities. The state has never appropriated a significant amount to assist counties with these expenses. In 1997, the legislature recognized the need for additional funding for juvenile detention, but instead of increasing the general fund appropriation for juvenile detention, tied the appropriation amount to the first \$1 million generated from driver license reinstatement fees. Last year, this surcharge generated approximately \$900,000, which allowed the state to reimburse 8.2% of county costs of juvenile detention. It is estimated that it will take approximately \$1.6 million in FY 2000 to reimburse counties for 10% of the costs incurred during FY 1999.

Local Boards of Health and Public Health Nurses

Iowa Code chapter 137 requires the county board of supervisors to establish a local board of health in the county. The board of supervisors appoints members of the local board of health care for a three-year term. The local board of health has jurisdiction over public health matters in the county. Often this includes sanitation, ambulance service, homemaker health aides, and public health nurses. Aside from funds the local board of health receives from the state or federal government for specific programs, funding for the local board of health is a responsibility of the board of supervisors.

A significant program operated by the local board of health is the public health nursing service. The legislature appropriates funds to the Department of Public Health (IDPH) for public health nursing. The IDPH allocates these funds to reach local board of health according to a formula. This appropriation helps the county fund the public health nursing program and helps reduce county and state hospitalization costs.

Homemaker Health Aide and Chore Services are services counties provide to help keep people in their own homes and avoid institutionalization. These services are provided to elderly, disabled, and other persons at risk of institutionalization. The legislature appropriates funds to the IDPH for provision of homemaker health aide/chore services. These funds are then allocated to each county board of supervisors based on a formula. The county board of supervisors decides how the services will be provided in its county. Eligibility and program standards are developed by the IDPH in administrative rules.

County Care Facilities

What we now know as county care facilities in Iowa area a modern version of what were known not too many years ago as "county homes."

County care facilities are residential health care facilities licensed by the IDPH in Iowa Code chapter 135C. The populations of county care facilities are primarily chronically mentally ill persons, substance abusers, mentally retarded or other disabled persons. Since the mid-1970s, a number of counties have chosen to enter into a contractual agreement with private entities for the operation of such facilities. This so-called "privatization" effort has resulted, by late 1994, in only a handful of county care facilities owned and operated by local government. The major reason for the move toward private care facilities is a set of federal regulations that prohibit Medicare or Medicaid funding for resident of state-or county-administered facilities that house more than 15 persons. This federal rule penalizes individuals who are entitled to SSI only because they choose to live in publicly-owned facilities.