Final Report of the
State Mental Health Institutions Study Committee

Senate Concurrent Resolution 51 of the Sixty-second General Assembly directed that the Legislative Research Committee establish a study committee to conduct "a study to evaluate present and future program, staff, and facility needs of existing board of control institutions serving the mentally ill and mentally retarded." Accordingly, the State Mental Health Institutions Study Committee was established, and Representative Charles P. Miller of Burlington was designated Chairman. Senator J. Henry Lucken of Le Mars was elected Vice Chairman at the Study Committee's organizational meeting. Other legislators named to serve on the Study Committee were Senators John M. Ely, Jr., of Cedar Rapids, Donald S. McGill of Melrose, George E. O'Malley of Des Moines, and Richard L. Stephens of Crawfordsville, and Representatives Floyd P. Edgington of Sheffield, Harry R. Gittins of Council Bluffs, D. Vincent Mayberry of Fort Dodge, and Floyd H. Millen of Farmington.

Shortly after the Study Committee was formed, Representative Gittins resigned from the Legislature to accept appointment to the Pottawattamie County Board of Supervisors. He was succeeded on the Study Committee by Representative Joan Lipsky of Cedar Rapids. In view of Mr. Gittins' interest and background in the field of mental health, particularly as related to county government, he was subsequently appointed an advisory member of the Study Committee and has participated actively in the Mental Health Institutions Study. No other advisory members were appointed to the Study Committee.

The State Mental Health Institutions Study Committee held a total of 17 meetings in the period from August 30, 1967 to November 18, 1968. In the course of these meetings, the Study Committee visited each of Iowa's four hospitals for the mentally ill, both state hospital-schools for the mentally retarded, and the facilities of Black Hawk Developmental Center and of Goodwill Industries, at Cedar Falls and Waterloo, respectively, to observe community programs for the mentally retarded in progress. In addition, the Study Committee has met with officials of the Iowa Mental Health Authority, the state administrative officials responsible for the programs for the mentally ill and mentally retarded formerly under the jurisdiction of the Board of Control and now under the Department of Social Services, and with representatives of the Iowa Association for Mental Health, the Iowa Association for Retarded Children, Progressive Action for the Retarded, the Iowa Comprehensive Alcoholism Program, and the Community Mental Health Center Association of Iowa. Representatives of a number of these agencies and groups have been present at nearly every meeting of the Study Committee.

SCOPE OF THE STUDY

The preamble to Senate Concurrent Resolution 51 in effect posed four broad questions, which might be phrased as follows:

1. In view of the sharp reduction in the average daily patient populations of the state mental health institutes over the past decade, should all four of the institutes continue to be operated exclusively as hospitals for the mentally ill?
2. Could the steady increase in the per-patient-per-day cost of care at the state mental health institutes be arrested or slowed by using staff personnel for care and treatment of patients afflicted with disabilities other than mental illness?
3. Are staff and facilities at the state hospital-schools at Glenwood and Woodward adequate to provide proper care and treatment for the mentally retarded persons at these institutions?
4. What is to be the future role of the state and its facilities in meeting the needs of

Iowa's mentally ill and mentally retarded citizens for adequate care and treatment?

In order to try to answer the latter question, it was also necessary to consider at some length what should be the future role of local governments and community facilities in Iowa in providing needed care and treatment for the mentally ill and mentally retarded.

The Study Committee has been cognizant of the objectives of Senate Concurrent Resolution 51 and has studied them in detail during its deliberations. While consideration has been given to the most effective utilization of existing physical facilities, the paramount concern of the members of the Study Committee has at all times been the welfare of Iowa's mentally ill and mentally retarded citizens.

Explanation of Terms

Two similar terms which have somewhat different meanings are used in this report. The terms are "mental health institutions" and "mental health institutes". The term "mental health institutes" is derived from chapter 226, *Code of Iowa* (1966), which specifically assigns that designation to each of Iowa's four hospitals for the mentally ill, located at Cherokee, Clarinda, Independence, and Mount Pleasant. Where reference is made to a particular mental health institute, the term is capitalized (e.g., the Clarinda Mental Health Institute, or the Clarinda Institute) but collective references to the four institutes are not capitalized. The term "mental health institutions" has been used by the Study Committee to refer jointly to the four mental health institutes and to the hospital-schools for the mentally retarded, located at Glenwood and Woodward.

A PERIOD OF RAPID CHANGE

The State Mental Health Institutions Study Committee's quest for answers to the questions posed by Senate Concurrent Resolution 51 has been conducted during a period of unusually rapid and far-reaching changes affecting not only the state mental health institutions, but also other agencies, programs, and facilities which help to meet the needs of the mentally retarded and the mentally ill in Iowa. Most of these changes result from establishment of the Department of Social Services, in which are combined the functions of the former Board of Control, Board of Social Welfare and Board of Parole, by chapter 209, *Acts of the Sixty-second General Assembly* (1967). In other actions which have been significant in the fields of mental illness and mental retardation, the 1967 Iowa Legislature:

—Increased the annual appropriation for operation of the Woodward State Hospital-School by more than fifty percent, and that of the Glenwood Hospital-School by more than forty-four percent. (Chapter 2, section 1, subsections 5, 6, *Acts of the Sixty-second General Assembly*. The Glenwood appropriation having previously been higher, the differential increases actually make appropriations for the two hospital-schools more nearly even.)

—Required state mental health institutions to bill counties, for care and treatment of mentally ill or mentally retarded patients having legal settlement in the respective counties, at eighty percent of the actual per-patient-per-day cost computed according to statutory formulas rather than at full cost as had previously been required. (Chapter 2, sections 5, 6, *Acts of the Sixty-second General Assembly*.)

—Empowered county commissioners of hospitalization to commit mentally ill persons for treatment in local hospital facilities rather than state mental health institutes, and allowed use of the county's state institution fund to pay the expenses of such treatment in a local hospital. (Chapter 202, *Acts of the Sixty-second General Assembly*.)

—Authorized counties of over 100,000 population to purchase, lease or construct, and operate county health centers in which to "provide those health, welfare and social services which such a county is presently or hereafter authorized or required by law to provide". (Chapter 299, *Acts of the Sixty-second General Assembly*.)

Department of Social Services Established

When the State Mental Health Institutions Study Committee was organized, the six state mental health institutions were under the juris-

diction of the Board of Control of State Institutions, composed of three members appointed for overlapping six-year terms. These institutions were administered through the Board of Control's Division of Mental Health, headed by State Director of Mental Health Dr. James O. Cromwell. Dr. Conrad R. Wurtz held the title Associate State Director of Mental Health for Mental Retardation.

During the time the Study Committee was functioning, the Board of Control—together with the State Board of Social Welfare—was succeeded by a part-time Council of Social Services, consisting of five members appointed for overlapping six-year terms, and a single full-time Commissioner of Social Services holding office at the pleasure of the Governor. Commissioner Maurice A. Harmon assumed this office February 15, 1968. The state departments and agencies formerly headed by the Board of Control, the Board of Social Welfare, and the Board of Parole were merged to form the Department of Social Services.

Subsequently, the former Board of Control Division of Mental Health was reorganized to form two of the five service bureaus established within the Department of Social Services. The Bureau of Mental Health Services is headed by Dr. Cromwell, to whom the superintendents of the four mental health institutes are responsible. The Bureau of Mental Retardation Services is headed by Dr. Wurtz, to whom the superintendents of the two hospital-schools are responsible.

It is to be expected that changes of such magnitude in state administrative structure have had and will continue to have significant effects on services to the mentally retarded and mentally ill in Iowa. However, it is not the Study Committee's responsibility to ascertain or evaluate such changes.

Therefore, while the Study Committee has made a number of specific legislative recommendations, its findings are perhaps less conclusive than would have been the case under other circumstances. Members of the Committee do not believe it desirable to propose further major changes in the mental health and mental retardation programs and facilities under the jurisdiction of the Department of Social Services until the Commissioner has had an opportunity to fully evaluate these programs and services, and the statutes under which they operate.

Reference was made, in the opening paragraph of this division of the report, to some of the other changes made by the 1967 Iowa Legislature which relate to mental health and mental retardation programs. These changes will be discussed in connection with specific findings and recommendations of the Study Committee.

EXPLANATION OF CONCLUSIONS AND RECOMMENDATIONS

The State Mental Health Institutions Study Committee's conclusions and recommendations, and some of the information on which they are based, are presented in the form of comments on and responses to the questions posed by Senate Concurrent Resolution 51. As stated earlier, the questions are paraphrased rather than quoted from the Resolution.

1. **In view of the sharp reduction in the average daily patient populations of the state mental health institutes over the past decade, should all four of the institutes continue to be operated exclusively as hospitals for the mentally ill?**

Iowa has experienced a dramatic and, perhaps most important, a steady decrease in the average daily patient populations of its four state mental health institutes during the past decade. Actually, the peak point in resident patient population at the institutes was in 1945-1946, when the four institutes had a total population of over 6600. This figure dropped to 4951 on June 30, 1956, and then more rapidly to 1559 on June 30, 1967, when the individual patient populations of the four institutes were:

Cherokee	—365
Clarinda	—446
Independence	—353
Mount Pleasant	—395

The decline in average daily patient population at the institutes has been accompanied by the following developments:

—A rapid rise in the total number of patients admitted to and released from the institutes each year, and a significant reduction in the length of time the average patient remains at a state mental health institute.

—A steady increase in the per-patient-per-day cost of care and treatment at the mental health institutes.

—Increased utilization of county homes, privately operated nursing and custodial homes, and similar facilities for long-term care of persons who do not respond to treatment at mental health institutes sufficiently to permit them to return to their homes.

—Inception of out-patient services by the institutes, and development of such services into major portions of each institute's overall mental health effort.

Accompanying and underlying these developments has been an intensive effort to upgrade the quality and quantity of professional services at the institutes. As this report is written, three of the institutes—Cherokee, Independence, and Mount Pleasant—are accredited by the Joint Commission on Accreditation of Hospitals. Psychiatric residency programs have been in operation at Cherokee and Independence for some time, and the Mount Pleasant Institute is prepared to begin such a program as soon as a qualified individual can be employed to head the program. Nursing education and pastoral counseling programs are maintained at all four institutions. The Division of Vocational Rehabilitation of the Department of Public Instruction now assigns at least one rehabilitation counselor to each institute. (The members of the Study Committee concluded, at the time of their visits to the respective mental health institutes in late 1967 and early 1968, that the vocational rehabilitation programs at the institutes should be further strengthened. The Director of the Bureau of Mental Health states that there have been continuing efforts in this direction in 1968.)

The foregoing is an indication of some of the programs and services initiated or greatly expanded by the Iowa mental health institutes as their average daily resident patient populations have declined, although it is not intended to be a complete list of all such programs and services. One question with which the Study Committee has been concerned is to what extent the existing physical facilities of the mental health institutes, which formerly housed a great many more patients than they now do, are needed for the institutes' expanded programs and services. The views of Clarinda Institute Superintendent Dr. John Gambill are representative of those expressed to the members of the Study Committee by administrators and professional staff personnel at the institutes.

Referring to the change in emphasis at the institutes from custodial care to treatment and rehabilitation, Dr. Gambill writes:

> "One of the essential elements in psychiatric treatment and rehabilitation is to treat the patient as an individual person worthy of dignity. This meant giving the patient or according the patient the right to wear his own clothes and to groom himself in a way becoming to his personality. It meant . . . giving the patient the privacy of a room that he may have by himself or share with three or four others rather than share the same sleeping room with twenty to fifty others. This meant space where patients could walk around or for chairs in which they could sit down and talk to each other without having to sit on beds. This meant space for patients to participate in recreational activities, not only on his own ward, but in the hospital gym and other areas of the hospital. This meant that patients were assigned an activity which contributed to the patient regaining his mental health rather than one that is used merely to keep him busy or to serve the hospital as a peon. The hospital had to take steps to preserve the patient's ability to get along outside of the hospital and to retrain the patients who had lost that ability.
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> "How was this done? . . . (In part) by getting more physicians in the hospital and other professionals, such as psychologists, social workers, and activity therapists. They need offices. New drugs were used. Patients responded and there was a need for more personnel to treat the patients who were responding. Nurses, psychologists, social workers, physicians, and attendants used group psychotherapy and remotivation techniques. To get a group together for therapy, it took space for a meeting. In order for a physician or psychologist to lead a treatment team and multiply his insights and therapeutic prescriptions through others, he had to have con-

ferences with the other professionals, and this took space and time. Because we are better staffed, we actually treat more patients with less beds and shorter hospital stays, and fewer days away from work than ever before.

* * *

"The above, I think, will help you understand why we need a good deal of space to treat fewer in-patients today than we did previously." (Letter from Dr. Gambill to Legislative Research Bureau Director Serge H. Garrison, April 23, 1968.)

Allocation of Institutes' Physical Plants

The four Iowa mental health institutes are generally similar in terms of physical plants. Each is housed in a single large central hospital and administration building and a number of other buildings of varying sizes which are presently, or were formerly, used as residential facilities for patients. In addition, there are at each institute a number of employees' apartment buildings or housing units, a fire station, and several garages, sheds, barns, or storage buildings of varying sizes and purposes.

Table I, Part 1, compares in some detail the utilization of the principal buildings at the Cherokee Mental Health Institute in 1945 when its patient population was highest, and at the time the Study Committee visited the Institute in January, 1968. Parts 2 and 3 of Table I make similar, but less detailed, comparisons for the Clarinda and Independence Institutes. The Mount Pleasant Institute has been omitted from the table because only one of the principal buildings which housed patients there in 1946 is still in existance. This is the Infirmary, or 18 Building, which was considered to have a capacity of 78 patients in 1946, but presently has an approved capacity of 42 patients.

Utilization of Extra Space

Members of the State Mental Health Institutions Study Committee noted during their visits to the Iowa mental health institutes, in the late fall and winter of 1967 and 1968, that there was some space in each of the institutes not then being used, directly or indirectly, to serve patients. This was most apparent at the Clarinda and Mount Pleasant Institutes.

One or more wards in the main buildings at Cherokee, Clarinda, and Independence were not in use at the time of the Study Committee's visit. Empty wards on the upper stories of the main buildings at Clarinda and Independence are no longer considered suitable for use as patients' residence areas. The only other empty ward at Independence was reserved as a dormitory for clergymen attending the periodic pastoral counseling courses offered at Independence. Empty wards on the lower floors of the Cherokee and Clarinda Institute main buildings were being remodeled when the Committee visited these institutes.

It should also be pointed out that, apparently, not all of the wards in use as patients' residence areas are fully utilized at all times, in terms of what is presently considered their capacity. For example, part 1 of Table I indicates that the Cherokee Institute had 526 beds available in January, 1968, but its resident patient population was 421 on January 3, 1968 (the date of sample daily patient population statistics given the Study Committee at the time of its visit to the Institute).

Mount Pleasant 20 Building — The Mount Pleasant Institute's 20 Building, a three-story structure erected in 1948, had the highest proportion of unused space of any building in good physical condition which the Study Committee encountered in its visits to the four institutes. The building faces east and consists of a northeast, a southeast, and a west wing, each three stories high and each having an area of 5901 square feet on each floor. The utilization of this building in December, 1967, was:

First Floor—Northeast wing—Special unit for mentally retarded patients (see "Mount Pleasant Pilot Program", page 97.)

—Southeast wing—Occupational therapy, recreation therapy, Institute's standby disaster facility.

—West wing—Physical therapy

TABLE I — USE OF PRINCIPLE BUILDINGS AT STATE MENTAL HEALTH INSTITUTES IN 1945-46 AND IN 1967-68

Part 1. — Cherokee Mental Health Institute

Building	Area	1945*	1968*
Main (south) (constructed 1901)	Ward So. 1	36 patients	out-patient clinic and offices
	Ward So. 2	39 patients	18 beds
	Ward So. 3	45 patients	25 beds
	Ward So. 4	47 patients	temporarily closed (remodeling plumbing)
	Ward So. 5	36 patients	25 beds
	Ward So. 6	43 patients	25 beds
	Ward So. 7	42 patients	temporarily closed (remodeling plumbing)
	Ward So. 8	42 patients	not in use
	Ward So. 9	48 patients	to be remodeled for patients' homemaking classes
Main (north) (constructed 1901)	Ward No. 1	35 patients	professional offices
	Ward No. 2	38 patients	22 beds (male admission ward)
	Ward No. 3	43 patients	29 beds
	Ward No. 4	37 patients	24 beds
	Ward No. 5	33 patients	nursing education study area
	Ward No. 6	45 patients	24 beds
	Ward No. 7	38 patients	employee quarters
	Ward No. 8	43 patients	student nurse quarters
	Ward No. 9	45 patients	ward storage
Infirmary Bldg. (constructed 1911)	Ward NPI-A	34 patients 33 patients	42 beds, in former 2-ward area
	Ward NPI 11	38 patients	20 beds (4 isolation)
	Ward NPI 12	35 patients	24 beds
	Ward NPI 15	33 patients	24 beds (4 isolation)
	Ward NPI 16	32 patients	28 beds
Kinne Bldg. (constructed 1914)	Ward K-1	40 patients	18 beds
	Ward K-2	38 patients	14 beds
	Ward K-3	17 patients	18 beds
	Ward K-4	10 patients	14 beds
Voldeng Bldg. (constructed 1906, now houses children's unit)	Ward V-1 (now 2 areas)	23 patients	showers, game room, lockers, outdoor equipment storage recreation therapy
	Ward V-2 (now 2 areas)	28 patients	8 beds, nursing station, visiting rooms 8 beds
	Ward V-3 (now 2 areas)	42 patients	professional offices, dining area school rooms
	Ward V-4	40 patients	occupational therapy
	Ward V-5	40 patients	8 beds
	Ward V-6	40 patients	therapy rooms, library, study hall

CHEROKEE MENTAL HEALTH INSTITUTE (Continued)

Building	Area	1945*	1968*
Donohoe Bldg. (constructed 1932)	Ward D-1	91 patients	recreation, music, therapy, game room, patient's homemaking
	Ward D-2	99 patients	occupational therapy, woodworking, ceramics
	Ward D-3	82 patients	storage
Wade Bldg. (constructed 1925)	Ward W-A (now 3 areas)	100 patients	dining area, day room, nursing station 28 beds 26 beds
	Ward W-B (now 3 areas)	102 patients	dining area, day room, nursing station 28 beds 26 beds
TOTALS FOR CHEROKEE —		1732 patients*	526 beds*

*NOTE: 1945 figures refer to patients actually in residence;
1968 figures refer to beds available at the Institute.

Part 2. — Clarinda Mental Health Institute

Building	Present Use or Condition
Main (constructed 1889 to 1898)	Central administration, activities, and patients' ward building; top story attic-like areas which housed patients in 1946 not now considered suitable for use as residence areas due to inadequate summer ventilation and winter heat.
Southview Cottage (constructed 1906)	2-story building; was being used as patients' ward building at time Committee visited Institute, but ground floor is being sought by independent Inpatient Stroke Rehabilitation Center which would rent space from Institute.
Northview Cottage (constructed 1908)	Not in use; was offered to but not accepted by Clarinda campus of Area XIII Community College. Now considered deteriorated.
Sunset Cottage (constructed 1918)	Adjacent to Southview, this cottage may also be used by Stroke Rehabilitation Center.
Pines Cottage (constructed 1928)	Now used as a nurses' residence facility.
Hope Hall (constructed 1928)	Relatively large building, serves as Institute Infirmary, houses many of Institute's geriatric patients.

Part 3. — Independence Mental Health Institute

Building	Present Use or Condition
Main (constructed 1872)	Central administration, activities, and patients' ward building; as at Clarinda attic-like upper story areas which formerly housed patients not now considered suitable for such use.
Farmers Lodge (constructed 1885)	Badly deteriorated, Institute is recommending building be demolished.
Grove Hall (constructed 1887)	Now serves as Institute's activities therapy building (music and occupational therapies, recreational and homemaking facilities, and patients' library).
Infirmary (constructed 1910)	Now a 65-bed patients' medical center; housed 177 patients in 1946.

NOTE: A much larger structure, the Witte Building, was constructed adjacent to the Infirmary in 1950, and houses recreation and occupational therapy areas, offices, and wards with a total of 245 beds available, including the Institute's geriatric wards.

Hilltop Cottage (construction date not available)	Now houses Institute's children's unit, with 40 beds available; served as Institute's tuberculosis hospital, with 47 patients in 1946.
Hilltop School (construction date not available)	Children's unit school building.

NOTE: A building called Sunny Villa which housed 240 patients in 1946, has since been demolished.

SOURCE: Data provided by superintendents of the mental health institutes.

Second floor—Northeast wing—Unused, except for some space used by a part-time volunteer program

—Southeast wing—unused

—West wing—Vocational rehabilitation area

Third floor—Northeast wing—Classrooms and laboratory, Area XVI Community College laboratory technician and medical assistant courses

—Southeast wing—unused

—West wing—unused

Committee members were informed that it was proposed to locate on the west wing of the third floor an Area XVI education library, which would serve Des Moines, Henry, and Lee Counties and part of Louisa County with books and other materials purchased by funds obtained by the state under Title II of the Federal Elementary and Secondary Education Act. However, upon learning that Area XVI Community College pays no rent for the space it uses and that it was proposed to extend the same policy to the new education library, some Committee members objected.

Institute Business Manager Monte Welker explained that it is believed the Institute derives certain benefits from the presence of the community college faculty and students, that this would also be true of the education library, and that the Institute incurs no significant cost by allowing them to use space in the 20 Building since the building would have to be maintained in any event. The Committee members who objected expressed the view that if no rent is charged, all of the southeast Iowa counties which are required to support the Institute are in effect subsidizing facilities which serve only Des Moines, Henry, Lee, and Louisa Counties.

It was subsequently reported to the Committee that an agreement had been concluded by the Institute with the joint county school boards of the four counties for use of the third floor, west wing, of the 20 Building as the Area XVI education library site, on a rental basis.

Clarinda Institute Cottages—Four buildings of varying sizes at the Clarinda Institute are identified as "cottages". These are Northview, Southview, Sunset, and Pines Cottages. At the time of the Study Committee's visit to Clarinda in November, 1967, Northview and Sunset Cottages were empty, Southview was being used as a ward for patients admitted or committed for treatment of alcoholism, and Pines Cottage was serving as a nurses residence.

Several months after the Study Committee's visit to Clarinda, the Institute received a proposal, submitted jointly by two doctors in practice in the City of Clarinda and the administrator of the Clarinda Municipal Hospital, to rent the first floor of Southview Cottage and the adjacent Sunset Cottage for use as a privately operated stroke rehabilitation center. The proposal is still pending as this report is written.

Committee members were informed that Northview Cottage had at one time been offered for use by the Clarinda campus of Area XIII Community College, which declined the offer. The building has now been declared surplus, and as this report is written it appears that the Sixty-third General Assembly will be asked to approve its demolition. While the interior of this building is certainly badly deteriorated, its basic structure appeared sound at the time the Study Committee visited the Clarinda Institute. It is the view of Study Committee members that the building should not be razed until careful consideration has been given both to the purposes for which all of the Clarinda Institute's physical facilities are to be utilized in future years and, in this context, to the possibility of renovating Northview Cottage for future use.

Conclusions

One of the questions posed by the Senate Concurrent Resolution 51 was "should all four of the institutes continue to be operated exclusively as hospitals for the mentally ill?" As will be seen from the foregoing paragraphs, not all of the institutes are presently being operated exclusively as hospitals for the mentally ill, so far as utilization of physical facilities is concerned.

For the reasons previously stated, the Study Committee has not made a formal recommendation on the questions whether one or more of the existing institutes could entirely cease to serve as a hospital for the mentally ill without impairing Iowa's present or future mental health programs, and if so, whether it would be wise to do so. State-

ments made to the Study Committee by the Commissioner of Social Services indicate he is aware of the possibility that, now or in the foreseeable future, Iowa may no longer need four state mental health institutes.

On July 19, 1968, Dr. Cromwell informed the State Mental Health Institutions Study Committee by letter of receipt of the formal proposal to rent space in the Mount Pleasant Institute's 20 Building for use as the Area XVI education library, and of the proposal to rent space in two of the Clarinda Institute's cottages for a privately operated stroke rehabilitation center. Dr. Cromwell stated in the letter that he would authorize the superintendents of the two institutes to accept the proposals unless there were objections by members of the Study Committee. The Study Committee had no authority to approve or disapprove any such proposals, but at its July 29 meeting a motion was passed stating the Committee had no objections to either proposal.

With no intent to criticize any person or agency, it is observed that the possibility exists of further changes in use of the physical plant at one or more of the institutes occurring gradually, perhaps without long-range planning, rather than by a more or less simultaneous "conversion" of an entire mental health institute to some other purpose. The Legislature may therefore wish to consider whether guidelines should be established, or a more specific procedure required, when use of a mental health institute's physical facilities by or for the benefit of an agency other than the institute itself is proposed.

2. **Could the steady increase in the per-patient-per-day cost of care at the state mental health institutes be arrested or slowed by using staff personnel for care and treatment of patients afflicted with disabilities other than mental illness?**

As pointed out in the preceding section of this report, the decline in average daily patient population of the state mental health institutes has been accompanied by a steady rise in the per-patient-per-day cost of operating these institutes. It is reasonable to assume that if the patient population of the institutes were again increased, the per-patient-per-day cost would tend to be reduced, however consideration must also be given to what effect such a policy would have on quality of care at the institutes.

Many of the persons who have met with the State Mental Health Institutions Study Committee—representatives of both state agencies and private groups—have urged that needs of people, rather than availability of unused space in buildings at some of the institutes, be the deciding factor in planning new or expanded programs. The point is not that there is no need to be concerned with the cost of maintaining physical facilities which are not being used, or are not being employed to capacity. Rather, the point is that placing additional persons in the available facilities—whether they be mentally ill, mentally retarded, or otherwise afflicted—will not be beneficial to these persons unless competent staff people are available to care for them. The most serious problem confronting the institutes has been recruiting, and keeping, qualified staff personnel. (The superintendent of the Clarinda Institute has indicated he believes the particularly difficult and continuing recruitment problem there is partly due to reports that the Institute may be closed.)

It may be noted that, while per-patient-per-day cost of care at Iowa mental health institutes has risen rapidly in recent years, it still does not —and, in the judgment of members of the Study Committee, never should—approach the daily cost of care in a private general hospital. Also in point is the following comment of an out-of-state doctor.

> "Here in Iowa you are now admitting and treating 5,300 patients a year with only 1,700 patients in residence. This gives you a fantastically higher per diem figure . . . but a total cost of only $11,500,000. In another state, Florida, which has only about 5,000 admissions but 10,000 resident patients, the per diem figure is a low $6.07 but the total cost to the state, because of the large resident patient census, is $22,000,000—just twice what it costs Iowa to more effectively treat more patients."*

*Dr. Harold L. McPheeters, Associate Director, Southern Regional Education Board, speaking at Mt. Pleasant, December 6, 1967. The annual appropriations for the four Iowa mental health institutes for each fiscal year of the 1967-69 biennium actually total $11,809,660.

Mentally Retarded Patients in Mental Health Institutes

One of the matters to which the Study Committee has devoted considerable attention is the question whether some mentally retarded patients should be moved from the hospital-schools for the mentally retarded to mental health institutes, in order to utilize available space and more nearly equalize the patient populations of the institutes and of the hospital-schools. For the reasons stated in the three foregoing paragraphs, it is not at all certain that implementing such a policy would materially reduce per-patient-per-day costs at the mental health institutes, but there are other considerations.

Dr. Cromwell, Director of the Bureau of Mental Health Services, believes that the mental health institutes can and should plan for and provide services to mentally retarded as well as mentally ill patients. Based on their comments to the Study Committee during its visits to the institutes, it appears that two of the present institute superintendents generally share Dr. Cromwell's views, and the other two do not. An additional complicating factor, with respect to possible treatment of mentally retarded patients at mental health institutes, is the establishment in the Department of Social Services of a separate Bureau of Mental Retardation Services, coequal with the Bureau of Mental Health Services. As a result, superintendents of the hospital-schools and of the mental health institutes are no longer directly responsible to the same bureau director, and coordination of programs for mentally retarded patients in mental health institutes may be more difficult.

There are also financial considerations involved in placing mentally retarded patients in mental health institutes. Both the institutes and the hospital-schools bill the individual counties for care of patients who have legal settlement in the respective counties at the rate of 80 percent of per-patient-per-day cost, as computed under present law. Counties in turn are empowered to recover amounts paid for care of any patient from the patient or his legally responsible relatives. (This policy has been commended as tending to maintain the family's interest in and contact with the patient.) However, section 222.78, *Code of Iowa* (1966), limits the liability of parents of a mentally retarded child or youth for the cost of his care at a state hospital-school to "the average minimum cost of care of a normally intelligent, nonhandicapped minor of the same age and sex", and imposes no liability whatever on the parents after the patient reaches age 21.

There is no corresponding section in chapter 230 of the Code, governing support of mentally ill patients, at least partially because it is recognized that the length of stay of patients in a hospital-school is often substantially longer than that of patients in mental health institutes. The Iowa Association for Retarded Children expressed concern to the Study Committee that if mentally retarded individuals should be placed in mental health institutes as patients, their parents would suddenly find themselves faced with a greatly increased financial liability.

Representatives of Progressive Action for the Retarded, as well as the Iowa Association for Retarded Children, also expressed their concern about the difficulty of obtaining psychiatric treatment for mentally retarded individuals. While mental retardation and mental illness are not the same thing, some mentally retarded individuals are also mentally ill. The direct admission of such individuals to mental health institutes is prohibited by section 226.8, *Code of Iowa* (1966), although section 222.7 does permit transfer of patients from hospital-schools to institutes and vice versa. In addition, section 226.8 defines a mentally retarded person as one "foolish from birth, supposed to be naturally without mind." This definition is not only out of date, it conflicts in both fact and philosophy with the definition of mental retardation found in section 222.2, a part of the chapter governing the hospital-schools.

Mount Pleasant Pilot Program—In the fall of 1966, a pilot program was initiated involving transfer of 21 severely or profoundly mentally retarded patients from Woodward State Hospital-School to Mount Pleasant Mental Health Institute. (Due to the financial considerations previously discussed, the 21 persons transferred were all state patients, whose care is paid for by the state because they do not have a legal settlement in any county in Iowa.) During its visit to the Mount Pleasant Institute, the Study Committee was informed that the Institute provides a program including recreation, occupational therapy, and considerable individual attention for these patients, who are housed in the northeast wing on the first floor of the "20 Building". Some of the transferred patients were reported to have attained

new skills at Mount Pleasant, and the belief was expressed that all of them had benefitted by the higher staff-to-patient ratio which the Institute was able to provide.

Dr. Cromwell, who as State Director of Mental Health in 1966 had jurisdiction over both the mental health institutes and the hospital-schools, explained the reason for initiating the pilot program:

> ". . . it is to relieve the pressure on Glenwood and Woodward staffs and to upgrade the care of all mentally retarded patients . . . I felt that the four mental health institutes **could** and **should** learn how to program for mental retardation; that as the psychiatrists trained at the mental health institutes entered private practice we at least (since the Psychopathic Hospital does not) should have exposed our resident psychiatrists to training in the care and programming to meet the total needs of mentally retarded patients. I know this idea was violently opposed by **some** of our psychiatrists, . . ." (Letter from Dr. Cromwell to Study Committee, May 27, 1968. Emphasis is Dr. Cromwell's.)

Dr. Cromwell pointed out that the Sixty-second General Assembly had not enacted a requested amendment to section 226.8, to clearly legalize the pilot program. He therefore asked the Study Committee's advice on whether the patients involved in the pilot program should be returned to Woodward. After consideration, the Study Committee on May 3, 1968 adopted the following motion.

> "The State Mental Health Institutions Study Committee endorses continuation of the pilot program, under which mentally retarded patients transferred from the Woodward Hospital-School are receiving care and treatment at the Mt. Pleasant Mental Health Institute, at least until such time as the Committee has completed its deliberations and made its recommendations."

Conclusions and Recommendations

It is the Study Committee's desire to avoid recommending to the Legislature major changes in present laws, which would mandate the reallocation of the state's institutional resources in the field of mental health before the Commissioner of Social Services has had an opportunity to fully evaluate and plan for utilization of these resources. However, it is believed that the way should be open for the Commissioner to continue utilizing space in at least one of the mental health institutes for treatment of mentally retarded patients if he concludes that such a policy is desirable. It is further believed that mental health institutes should be authorized, and strongly encouraged, to provide psychiatric and other services to mentally retarded individuals who are also mentally ill.

Accordingly, the State Mental Health Institutions Study Committee recommends the adoption of the following legislation:

> **House File 5**, relating to establishment of a special mental retardation unit to be located at one of the state mental health institutes, prescribing the functions of the special unit, and providing for the administration and support thereof and the admission of patients.
> **House File 6**, relating to the definition of a mentally retarded person for the purpose of chapter 226 of the Code, and to the admission or transfer of such persons to the state mental health institutes.

House File 5 gives the Commissioner of Social Services permissive, not mandatory, authority to assign space in one of the state mental health institutes for use by a special mental retardation unit. The unit is authorized by the bill to provide psychiatric and related services to mentally retarded persons who are also mentally ill or emotionally disturbed, other services to meet the needs of particular categories of mentally retarded persons designated by the Commissioner to be served by the special unit, and diagnostic evaluation services.

The special unit will be established under chapter 222 of the Code, which presently governs the hospital-schools, rather than under the chapter relating to mental health institutes. Thus parents of mentally retarded minors admitted to the unit as patients will receive the benefit of the limited financial liability for cost of the patient's care, just as if the patient had been admitted to one of the hospital-schools. The special unit will have its own superintendent, becoming in effect "an institution within an institution," although it will utilize existing physical facilities, heat pow-

er, food preparation, and other support services of the mental health institute where the special unit is located.

House File 6 repeals section 226.8, which presently prohibits admission of any mentally retarded person to a mental health institute, and which includes the outmoded definition of mental retardation discussed earlier in this section. The present section 226.8 is replaced with the following language:

> "No person who is mentally retarded, as defined by section two hundred twenty-two point two (222.2) of the Code, shall be admitted, or transferred pursuant to section two hundred twenty-two point seven (222.7) of the Code, to a state mental health institute unless a professional diagnostic evaluation indicates that such person will benefit from psychiatric treatment or from some other specific program available at the mental health institute to which it is proposed to admit or transfer the person. Charges for the care of any mentally retarded person admitted to a state mental health institute shall be made by the institute in the manner provided by chapter two hundred thirty (230) of the Code, but the liability of any other person to any county for the cost of care of such mentally retarded person shall be as prescribed by section two hundred twenty-two point seventy-eight (222.78) of the Code."

The effect of the bill is to permit the admission of mentally retarded individuals to mental health institutes where there is reason to believe that the individuals admitted can be helped by treatment at the institute to which they are admitted. Here again, the limited liability of parents for cost of care of mentally retarded minors admitted to state hospital-schools is applied.

3. **Are staff and facilities at the state hospital-schools at Glenwood and Woodward adequate to provide proper care and treatment for the mentally retarded persons at these institutions?**

The substantial increase in annual operating appropriations for the Glenwood and Woodward State Hospital-Schools during the present biennium was noted earlier in this report. The specific increase for each hospital-school, over the preceding biennium, is as follows:

	1965-67	1967-69
Glenwood	$3,012,800 per yr.	$4,356,595 per yr.
Woodward	$2,907,100 per yr.	$4,891,005 per yr.

This increase in appropriations has permitted both enlargement and improvement in the caliber of staff in all categories below the professional level, by permitting more selective hiring and by making it possible to grant periodic increases, in accordance with established salary scales, to employees who perform satisfactorily. Although professional staff has not been enlarged significantly, Dr. Wurtz, Director of the Bureau of Mental Retardation Services, believes better care by the nonprofessional staff is making the efforts of the professional staff more effective.

The average daily patient populations of the two hospital-schools have been declining in recent years, although the reduction began later and has not yet been so great as that occurring at the state mental health institutes. From a combined total of some 3700 patients in 1953, the patient population had been reduced to 854, at Glenwood, and 830, at Woodward, on June 30, 1968.

The decrease in patient population reflects an effort to make the hospital-schools primarily intensive treatment and training centers for individuals whose return to their home communities within a reasonable time is anticipated, rather than long-term custodial care institutions. Hospital-school patients who are believed unlikely to benefit from further treatment are being removed to county homes, nursing and custodial homes, and other community care facilities, and efforts are being made to limit new admissions sufficiently to permit continued progress toward meeting the standards of the American Association on Mental Deficiency for staffing of residential care institutions for the mentally retarded.

Dr. Wurtz reported in October, 1968, that both hospital-schools are approaching 100 percent of AAMD staffing standards, based on an average daily patient population of 750 at each hospital-school, a figure somewhat lower than the actual patient populations at the time this report is written. Whether the patient population at each hospital-school will be reduced to 750 by the end of the present biennium depends in some degree on availability of adequate community care facilities for patients believed unable to benefit from further treatment at the hospital-schools. (See discussion of community care facilities in the following section of this report.)

The availability of local and regional programs and facilities for the mentally retarded makes it possible for many of these persons to remain in or near their homes, or to return to their home communities after a period of treatment and training at a hospital-school rather than becoming long-term patients there. Thus there is a direct relationship between the programs and facilities for the mentally retarded available at the community level, and the success of the hospital-schools' efforts to further reduce the proportion of their staff time and physical facilities used to provide long-term custodial care.

Special Education for Mentally Retarded—It is therefore significant that growth is apparently continuing in the number of public school classes for the mentally retarded operated by local or county school systems, as evidenced by the following data provided by the Division of Special Education of the Department of Public Instruction.

Growth in Public School Classes for the Mentally Retarded in Iowa

Year	Educable	Trainable	Total
1950-51	93	-----	93
1955-56	158	4	162
1960-61	277	42	319
1965-66	511	101	612
1967-68	627	132	759

The Study Committee visited Cedar Falls and Waterloo to observe a program for trainable (i.e., moderately and severely) retarded children, youth, and young adults being conducted there. This program, operated by Exceptional Persons, Inc. (a voluntary association of 18 public and private community agencies concerned with services to handicapped children in the Area VII educational district, surrounding Waterloo), includes special education, activities, and training in a sheltered workshop situation where it appears such training would be beneficial. The program is financed by a combination of public and private funds, and has permitted some mentally retarded individuals who formerly resided at the Woodward Hospital-School to return home. A building to house the program was built in 1967 with funds received through a bequest and matched by federal funds available under Public Law 88-164, however representatives of Exceptional Persons, Inc. stressed to the Study Committee that the building was built only after the program had been established and operated for several years.

At least two other Iowa communities, each located in one of the state's relatively populous counties, have obtained or made final application for P.L. 88-164 funds, to be used for community mental retardation facilities. In these and a number of other Iowa communities, a variety of programs—usually initiated by local groups of parents or other interested private citizens—are being developed or are in operation, to provide to mentally retarded persons services which the hospital-schools would otherwise be called upon to provide.

The hospital-schools began working more directly with communities several years ago, when the regional community consultant program was initiated. Dr. Wurtz has stated that as enlargement of the nonprofessional staffs of the hospital-schools reduces pressure upon the professional staffs, professional staff persons are being made available to consult with communities on establishment and improvement of local and regional programs.

Program Uniformity—At the time of the Study Committee's visits to the two hospital-schools, in the fall of 1967, Committee members expressed concern about what appeared to be a difference in some aspects of patient care at Glenwood and Woodward. Specifically, it appeared that care and supervision of some patients—particularly severely retarded adults—at Glenwood was somewhat superior to that at Woodward.

Dr. Cromwell, who was in 1967 the State Director of Mental Health under the Board of Control and had jurisdiction of the hospital-schools, subsequently reported to the Study Committee that:

> "The Director (i.e., Dr. Cromwell) did hold up exactly the same ideal for . . . Glenwood and Woodward to attain. The actual details of administrative implementation were left entirely to each superintendent who literally controls all money and all personnel at each institution, subject to law and to very general policies." (Letter to Study Committee, May 27, 1968.)

Dr. Wurtz has pointed out that the superintendents have faced somewhat different problems in that, historically, Woodward (formerly known

as the State Hospital and School) had a medical orientation and a less active training program than Glenwood (formerly known as the State School). Although both institutions are now designated as hospital-schools, past differences in orientation continue to be reflected in a substantially higher proportion of severly retarded, primarily custodial, patients at Woodward.

At least partially as a result of the Study Committee's observations and informal comments, efforts have been underway in recent months to more nearly equalize all programs common to the two hospital-schools. To this end, teams of professional employees from the hospital-schools have exchanged visits to familiarize themselves with each other's problems and procedures.

Conclusions

Members of the State Mental Health Institutions Study Committee believe that the increased appropriations given the Glenwood and Woodward Hospital-Schools by the 1967 Legislature have resulted in a marked improvement in the quality of care provided the patients at these institutions. There appears to be no reason why improvement should not continue if adequate appropriations are made available.

4. What is to be the future role of the state and its facilities in meeting the needs of Iowa's mentally ill and mentally retarded citizens for adequate care and treatment?

Obviously, the foregoing question could be the topic for a discussion of considerably greater length and detail than is possible in this report. In summary, nearly all of the individuals and groups with whom the Study Committee has met have supported the general proposition that services to the mentally ill and mentally retarded should be provided in the patients' home communities, or as near their home communities as possible. There have been differences of opinion on the implementation of this proposition, but no one has argued that providing services at the community level wherever feasible is undesirable.

There appears to be fairly general agreement that as more of the services needed by the mentally ill and the mentally retarded become available at the community level, the role of the state institutions should become primarily supportive, providing care and treatment in unusual or difficult cases for which it is impractical or impossible to program at the community level. This shift in the role of the state mental health institutions will in all probability be very gradual, and will take place as communities become able to adequately provide services which the mentally ill and mentally retarded must presently receive from the state institutions. It should also be recognized that development of community mental health and mental retardation facilities is occurring, and will continue to occur, quite unevenly in various parts of the state.

Jasper County, for example, utilizes the Jasper-Poweshiek Mental Health Center, facilities of a general hospital in Newton, and the Jasper County Home in such manner that very few patients from Jasper County are admitted to the Mount Pleasant Mental Health Institute. Many areas of the state do not have, and are unlikely to have for some time, either the personnel or the necessary facilities to establish such a program. Therefore, communities should have a high degree of flexibility in determining which of the mental health and mental retardation services needed by their residents are to be obtained from state institutions, and which are to be obtained locally.

The 1967 Iowa Legislature's actions permitting the state's larger counties to acquire and operate county health centers, and authorizing any county to use its state institutions fund to pay for treatment of mental illness in local general hospitals or other suitable local facilities as well as in state mental health institutes, (chapters 299 and 202, respectively, *Acts of the Sixty-second General Assembly*) are steps in the direction of providing more services to the mentally ill and mentally retarded at the community level. At least two counties—Black Hawk and Linn—are proceeding with the acquisition of facilities for and establishment of county health centers.

Dr. Cromwell reports that utilization by counties of local hospitals or other facilities for in-patient treatment of mental illness has not yet had a significant effect on admissions to state mental health institutes. Whether it will do so in the future depends upon the initiative of county officials, and the willingness of local general hospitals, in particular, to accept mentally ill persons as in-patients. Broadlawns-Polk County Hospital has recently undertaken expansion of its facilities for mentally ill patients from twenty-six to forty beds.

Community Mental Health Centers

One of the key resources for providing needed mental health services at the local and regional levels is the community mental health center. There are presently twenty of these centers in Iowa, each serving one or more counties. The twenty centers serve a total of 57 counties which have approximately seventy percent of the state's population. The first Iowa community mental health centers (except the Des Moines Child Guidance Center, which has been in existence since 1936) were established at Burlington, Cedar Rapids, and Davenport in 1949. Two centers, at Atlantic and Fort Dodge, began full-time operation during 1968. Although counted as one of the twenty centers, the Des Moines Child Guidance Center, which serves both Polk and Warren Counties, does not provide services to adults.

The term "mental health center" often implies a facility offering a fairly broad range of services, including in-patient treatment. At present, however, some of the community mental health centers in Iowa operate entirely or primarily on an out-patient basis. In-patient resources are available to most of the community mental health centers in local general hospitals.

Community mental health centers in Iowa have a very high degree of local autonomy. They are loosely linked to the Iowa Mental Health Authority, a state agency located at the Psychopathic Hospital in Iowa City, but presently supported entirely by federal funds.

Section 230.24, *Code of Iowa* (1966), provides that a county or group of counties may establish a community mental health center "in conjunction with the Iowa Mental Health Authority." It is not clear precisely what relationship between the Authority, the community mental health centers, and the counties which help support the centers, was intended by the phrase quoted from section 230.24. Dr. Paul Huston, who until recently was director of the Authority, stated in a letter to the Study Committee that "the Mental Health Authority's role is entirely consultative, not coercive."

The present community mental health centers in Iowa are organized as nonprofit private corporations. The details of administration and arrangements with the supporting county or counties vary from center to center, but characteristically patients are asked to pay that portion of the cost of their treatment which they can afford to pay, and the balance of the cost is paid from county tax funds, or from funds received by the center through community chests, special gifts, or other nontax sources. In response to a survey made for the Study Committee, a few of the centers reported that county tax funds accounted for nearly all of their receipts, and only one center reported receiving less than 60 percent of its total budget for the previous year from sources other than county tax funds.

In past years, most of the federal funds received by the Iowa Mental Health Authority have been expended directly by the Authority, much of it for administrative expense which has included the cost of advising on establishment and operation of community mental health centers. However, Dr. Huston reported in May, 1968, that new federal regulations require that at least 70 percent of the federal funds received by the Authority be distributed directly to community mental health centers.

The Iowa Mental Health Authority reported that the 18 community mental health centers operating in Iowa between July 1, 1966 and June 30, 1967 had a total caseload of 10,827 during that period. This is approximately twice the number of in-patient admissions to the mental health institutes during the same period (although the in-patient admission figures do not reflect the institutes' substantial out-patient caseloads).

Dr. Huston, meeting with the Study Committee, expressed the view that screening by community mental health centers of persons being considered for admission or readmission to mental health institutes could reduce the rate of admissions to the institutes by as much as 50 percent. Some of the institute superintendents expressed vigorous disagreement with Dr. Huston on this point. Independence Institute Superintendent Dr. Selig M. Korson submitted to the Study Committee figures which indicate that the rate of admissions there is higher from counties served by community mental health centers than from those not served by centers. The significance of this data is not entirely clear, but it may indicate more realization of need for in-patient mental health treatment is being brought about through the work of the centers.

Dr. Cromwell states that a patient leaving one of the mental health institutes is referred to

a community mental health center, if one is available to him, but the institutes have no authority to require the patient to contact a community mental health center unless he is a committed patient on convalescent leave. There is no direct statutory or administrative relationship between the mental health institutes and the community mental health centers, a situation in contrast with the relationship between the institutes and county homes which is discussed later in this section of the report. The Iowa Mental Health Authority is not a part of the Department of Social Services. A brief historical explanation of this fact may be helpful.

U.S. Public Law 79-487, passed in 1946, provided allocations of federal funds to each state for mental health research, if the state would designate "a single state agency" as the "mental health authority" through which the funds would be channeled. The Board of Control was not then adequately staffed to handle this responsibility and the University of Iowa College of Medicine, which desired the designation, did not qualify as a single state agency under P.L. 79-487. Since the Psychopathic Hospital did so qualify, the Fifty-second Iowa General Assembly (1947) by resolution designated it as the Iowa Mental Health Authority. In 1965 the Legislature enacted the present chapter 225B, *Code of Iowa* (1966), empowering the Board of Regents to designate the Iowa Mental Health Authority with the advice of the dean of the College of Medicine and of the Mental Hygiene Committee. The Mental Hygiene Committee, a 16-member group intended to be broadly representative of state agencies and private groups concerned with mental health, is a policy-making body for the Iowa Mental Health Authority. The Psychopathic Hospital has continued to be designated the Iowa Mental Health Authority under the 1965 law.

A survey of 30 states which have adopted community mental health services legislation indicates that only three do not assign responsibility for administration of such legislation to the same major state department which administers the state mental health institutions. Iowa was not one of the 30 states included in the survey, since by the standards applied Iowa could not be said to have a community mental health services law (i.e., one involving some degree of state support coupled with minimum state standards).

County Homes as Custodial Care Units

Statistics listing county home residents in Iowa in the first six months of 1967 (the last period for which complete data is presently available from the Department of Social Services) indicate that nearly 75 percent of such residents were mentally ill or mentally retarded. On the basis of a total of nearly 5,000 county home residents, it would appear that there were in 1967, and probably still are, more mentally retarded and mentally ill patients in county homes than in state mental health institutions.

The mentally ill and mentally retarded residents of county homes are individuals transferred there because they are incapable of living independently, and are considered unlikely to benefit from further treatment in a state institution. The reasons for making such transfers were discussed earlier in this report. Transfer of a patient from a state institution to a county home does not end the state's responsibility for the patient.

Section 227.2, *Code of Iowa* (1966), as amended, requires the Director of Mental Health to make or have made semi-annual inspections of county homes, and also private nursing and custodial homes and similar institutions, where mentally ill persons reside. In addition the home must be inspected, and each mentally ill resident examined, at least once each year by a staff psychiatrist of the mental health institute serving the county where the home is located.

No systematic survey of county homes in Iowa was undertaken by the Study Committee, however information available to Committee members indicates there is variation not only in size and condition of county home structures, but particularly in the type and variety of activities regularly available to residents. Nearly all of the county homes are operated by a steward and a matron, usually a man and wife, who may or may not have additional help.

The actual cost of operating Iowa's county homes, on a per-patient basis, is most difficult to ascertain. Most of the county homes are located on farms, and many conduct some farming operations. Income from the farming operations, which may fluctuate considerably from year to year, affects the net county expenditure for operation of the home in such a way that the actual operating cost may be quite distorted in the required annual report.

Individuals who otherwise qualify to receive benefits under one of the categorical state-federal welfare programs, such as old age assistance, blind assistance, or aid to the disabled, are not eligible so long as they reside in a county home. Therefore, county home residents who become 65 years of age are usually transferred to a private nursing or custodial home if at all possible, so that old age assistance may be obtained to help pay the cost of such person's care. If mentally ill or mentally retarded residents of county homes become eligible for aid to the disabled or other categorical welfare programs, these persons may be transferred to private facilities, wherever such facilities are available. This possibility appears to raise some questions about the long-range role of county homes as community-level custodial care facilities for the mentally ill and mentally retarded.

Financing of Community Mental Health Services

The following is not intended to be an exhaustive treatment of the problems of financing community level mental health services in Iowa, but rather a discussion of some specific problems which have come to the Study Committee's attention.

The 1967 Legislature, by two separate actions, made a total of more than $4,500,000 available to help ease the burden placed on county property taxpayers by the increasing costs of care and treatment of the mentally ill and mentally retarded. However, the manner in which these state funds are made available does not permit the counties as great a degree of flexibility, in determining where services are to be obtained and how they are to be paid for, as could be provided without further increasing state expenditures.

Chapter 196, *Acts of the Sixty-second General Assembly* (1967), permits the Legislature to specify, when making appropiations for the state mental health institutions, that the institutions shall bill the respective counties for the cost of care of patients having legal settlement therein at a rate less than 100 percent of the average per-patient-per-day cost of care. In the 1967 appropriation act, the institutions' billing rate to counties for the current biennium was set at 80 percent of full cost. At the current level of annual appropriations for operating costs the 20 percent of cost of care and treatment at the institutions which is not being charged to the counties during the current biennium amounts to over $4,000,000 each year.

Counties must pay the cost of care of their legal residents in state mental health institutions from the state institutions fund, which is created by section 444.12, *Code of Iowa* (1966), and supported by property taxation (patients, and their responsible relatives, may in some cases be required to reimburse the county for all or part of such expenditures, if they are able to pay). Thus, the action of the Legislature in reducing the state institutions' billing rate to the counties provides a measure of property tax relief. However, if the $4,000,000-plus which the state is paying for operation of the state mental health institutions during each year of the present biennium, without reimbursement by the counties, had instead been apportioned to the counties on a per capita basis, earmarked for mental health and mental retardation services generally, some counties might have preferred to use a portion of these funds to support a community mental health center or provide more adequate care for mentally retarded and mentally ill patients in their county homes.

The county fund for mental health, created by section 230.24 of the Code, is pertinent to both community mental health centers and county homes. Section 230.24 presently requires that county boards of supervisors levy a tax of one mill or less for the county fund for mental health, which may be used for:

1. The support of mentally ill patients in the county home, "or elsewhere outside of any state hospital for the mentally ill".

2. Construction of additions or improvements to the county home which are needed to permit proper care of mentally ill persons residing in the county home.

Boards of supervisors are also authorized to draw upon the county fund for mental health to pay for "psychiatric examination and treatment of persons in need thereof, or for professional evaluation, treatment, and habilitation of mentally retarded persons," in a community mental health center or other appropriate facility. Any county making such use of the county fund for

mental health is authorized to levy an additional half mill for the fund, or a total of one and one-half mills.

Statements by some county officials and persons working in or with community mental health centers indicate they regard section 230.24 as limiting expenditures from the county fund for mental health, for community mental health center purposes, to the amount which can be raised by a half mill levy. The legislative history of section 230.24 seems consistent with this interpretation, but the actual language of the section does not appear to prohibit use of a part of the basic one mill levy for community mental health center purposes.

When a custodial care patient is transferred from a state mental health institution to a county home, nursing or custodial home, or other community facility, the cost of his care theoretically ceases to be paid from the state institutions fund of the county, and is instead paid from the county fund for mental health. However, if the latter fund is depleted before the end of any year, the cost of the transferred patient's care in any privately operated facility must be paid, during the balance of that year, from the state institution fund, for which there is an unlimited levy, or in the case of the county home, the cost of the patient's care may be paid from the poor fund.

Section 227.16, 227.17, and 227.18, *Code of Iowa* (1966), as amended in 1967, provide a permanent annual appropriation of one million dollars from which is to be paid to each county five dollars per week for each custodial care patient transferred from a state mental health institution and supported by the county in the county home or another community facility. (This standing state appropriation was increased in 1967 from $500,000 per year to $1,000,000 per year, and weekly payments were increased from three to five dollars. Despite this increase, the appropriation apparently will not be sufficient to pay all claims submitted during the present biennium.) However, this state aid may be obtained only on behalf of patients the cost of whose care is paid from the county fund for mental health. When this fund is depleted, and the cost of the patient's care must be paid from another county fund, the county can no longer legally receive the five dollars per patient per week state aid, even though the cost of care is still being paid by the county with funds raised from the same property taxpayers who were taxed for the county fund for mental health.

Conclusions and Recommendations

The State Mental Health Institutions Study Committee, after consideration of the foregoing information, recommends the adoption of the following legislation:

House File 7, relating to establishment of community mental health programs by counties or groups of counties, authorizing state aid for such programs, and providing a permanent appropriation therefor.
House File 8, to combine the present county fund for mental health with the state institution fund, redesignating the latter as the county health and institutions fund, prescribing the purposes for which such fund may be used, and authorizing a levy therefor.
House File 9, relating to county homes.

County Mental Health Programs—The Study Committee believes that community mental health centers are already playing an important role in meeting Iowa's mental health needs, and will do so to an increasing extent in the future. It is further believed that the time has come when the state should encourage the continued development of community mental health services, and assist those communities which have already developed such services, by making some state financial aid available.

Community mental health centers in Iowa presently operate with nearly complete local autonomy. Almost the only references to community mental health centers which have been located in the *Code of Iowa* (1966) are those in section 230.24 permitting a tax levy for support of centers established "in conjunction with the Iowa Mental Health Authority," and authorizing a nonrecurring appropriation of $250 per thousand population in the county from the state institutions fund for establishment of a community mental health center. (There is also a collateral reference in section 444.12, which governs the state institutions fund.) The Iowa Mental Health Authority states that its role is consultative, not coercive. Thus, community mental health centers are operating with no actual state control of methods of organization or administration, the kinds of serv-

TABLE II—COUNTY SUPPORT OF STATE MENTAL HEALTH INSTITUTES AND COMMUNITY MENTAL HEALTH CENTERS IN 1967, AND AMOUNT OF STATE FUNDS COUNTIES COULD RECEIVE UNDER SECTION NINE OF H.F. 7

1	2	3	4	5	6	7
County	Official 1960 Census Population	Mental Health Institute (MHI) Serving County	Total Paid by County for MHI Care 7/1/66 6/30/67	Community Mental Health Center (CMHC) Serving Co. (If Any)	Amount Remitted to CMHC by County in Comparison Period[a]	Amount County would be Allocated if the Procedure Recommended by the State Mental Health Institutions Study Committee Were Followed
Adair	10,893	Clarinda	$ 25,235.86	None		$ 20,164.48
Adams	7,468	Clarinda	$ 17,182.93[b]	None		$ 13,825.48
Allamakee	15,982	Independence	$ 27,275.66	N.E. Iowa M.H.C.	$ 6,432.62[c](FY)	$ 29,584.52
Appanoose	16,015	Mt. Pleasant	$ 57,495.71[b]	None		$ 29,645.40
Audubon	10,919	Clarinda	$ 38,648.08	S.W. Iowa M.H.C.	[d]	$ 20,213.84
Benton	23,422	Independence	$ 74,638.58	None		$ 43,354.92
Black Hawk	122,482	Independence	$354,385.93	Bl. Hawk Co. M.H.C.	$ 75,773.75[e]	$226,704.52
Boone	28,037	Clarinda	$ 71,160.64[b]	Cen. Iowa M.H.C.	$ 7,137.50[f]	$ 51,896.32
Bremer	21,108	Independence	$ 71,317.03	Cedar Vly. M.H.C.	$ 16,730.00	$ 39,071.88
Buchanan	22,293	Independence	$ 37,063.25	None		$ 41,265.48
Buena Vista	21,189	Cherokee	$ 93,415.35	N.W. Iowa M.H.C.	$ 4,669.35	$ 39,222.04
Butler	17,467	Independence	$ 28,207.43	Cedar Vly. M.H.C.	$ 15,100.00	$ 32,333.12
Calhoun	15,923	Cherokee	$ 56,597.92[b]	N. Cen. Iowa M.H.C.	[g]	$ 29,475.28
Carroll	23,431	Clarinda	$ 73,275.88[b]	S.W. Iowa M.H.C.	[d]	$ 43,371.16
Cass	17,919	Clarinda	$ 53,741.12[b]	S.W. Iowa M.H.C.	$ 15,000.00	$ 33,168.84
Cedar	17,791	Mt. Pleasant	$ 25,349.63[b]	None		$ 32,932.76
Cerro Gordo	49,894	Cherokee	$125,008.75[b]	M.H.C. of N. Iowa	$ 40,375.00(FY)	$ 92,351.84
Cherokee	18,598	Cherokee	$105,194.83	None		$ 34,426.28
Chickasaw	15,034	Independence	$ 24,194.19	Cedar Vly. M.H.C.	$ 13,000.00[h]	$ 27,829.24
Clarke	8,222	Clarinda	$ 25,093.96	None		$ 15,220.92
Clay	18,504	Cherokee	$ 65,280.24	N.W. Iowa M.H.C.	$ 16,148.00[i]	$ 34,252.44
Clayton	21,962	Independence	$ 74,532.21	N.E. Iowa M.H.C.	$ 981.00[i](FY)	$ 40,652.32
Clinton	55,060	Mt. Pleasant	$150,580.13[b]	None		$101,912.60
Crawford	18,569	Cherokee	$ 29,115.71	None		$ 34,372.84
Dallas	24,123	Clarinda	$ 65,669.69[b]	W. Cen. M.H.C.	$ 35,000.00[h]	$ 44,652.28
Davis	9,199	Mt. Pleasant	$ 27,519.87	None		$ 17,029.64
Decatur	10,539	Clarinda	$ 27,434.22	None		$ 19,510.04
Delaware	18,483	Independence	$ 69,740.69	None		$ 34,212.88
Des Moines	44,605	Mt. Pleasant	$134,289.95[b]	S.E. Iowa M.H.C.	$ 20,832.65	$ 82,562.80
Dickinson	12,574	Cherokee	$ 43,859.98	N.W. Iowa M.H.C.	$ 7,688.75	$ 23,276.64

TABLE II (Continued)

1	2	3	4	5	6	7
Dubuque	80,048	Independence	$236,941.42[b]	Dubuque Co. M.H.C.	$ 60,017.47	$148,164.28
Emmet	14,871	Cherokee	$ 34,450.50	None		$ 27,527.56
Fayette	28,581	Independence	$ 59,350.64	Cedar Vly. M.H.C.	$ 6,690.00	$ 52,903.16
Floyd	21,102	Independence	$ 51,923.36[b]	M.H.C. of No. Iowa	$ 12,900.00[i]	$ 39,060.72
Franklin	15,472	Cherokee	$ 47,856.27[b]	M.H.C. of No. Iowa	$ 11,250.00	$ 28,639.92
Fremont	10,282	Clarinda	$ 41,763.45	None		$ 19,033.52
Greene	14,379	Clarinda	$ 50,205.36[b]	None		$ 26,617.44
Grundy	14,132	Independence	$ 26,335.23[b]	Bl. Hawk Co. M.H.C.	$ 4,226.25	$ 26,159.52
Guthrie	13,607	Clarinda	$43,614.58[b]	W. Cen. M.H.C.	$ 15,548.07	$ 25,188.52
Hamilton	20,032	Cherokee	$ 30,983.42[b]	None	($ 5,666.00)[i]	$ 37,080.52
Hancock	14,604	Cherokee	$ 22,744.02[b]	M.H.C. of No. Iowa	$ 9,000.00[i]	$ 27,033.54
Hardin	22,533	Cherokee	$ 63,750.62[b]	Marshall Co. M.H.C.	$ 12,000.00	$ 41,708.88
Harrison	17,600	Clarinda	$ 87,395.72	Pott'mie Co. M.H.C.	$ 10,000.00	$ 32,579.00
Henry	18,187	Mt. Pleasant	$ 48,727.36[b]	None		$ 33,665.32
Howard	12,734	Independence	$ 36,586.49	N.E. Iowa M.H.C.	$ 4,671.58[i](FY)	$ 23,571.24
Humboldt	13,156	Cherokee	$ 60,368.50[b]	N. Cen. Iowa M.H.C.	[g]	$ 24,350.16
Ida	10,269	Cherokee	$ 20,693.28	None		$ 19,008.84
Iowa	16,396	Mt. Pleasant	$ 27,069.33	None		$ 30,349.56
Jackson	20,754	Independence	$ 67,201.89[b]	None		$ 38,465.44
Jasper	35,282	Mt. Pleasant	$ 12,235.81[b]	Jasper-Pow'k. M.H.C.	$ 22,000.00[i]	$ 65,305.52
Jefferson	15,818	Mt. Pleasant	$ 70,738.34	None		$ 29,279.48
Johnson	53,663	Mt. Pleasant	$108,167.74[b]	None		$ 99,326.68
Jones	20,693	Independence	$ 80,893.23	None		$ 38,302.48
Keokuk	15,492	Mt. Pleasant	$ 28,570.91	S. Cen. M.H.C.	$ 8,700.00[i](FY)	$ 28,676.12
Kossuth	25,314	Cherokee	$ 60,318.03[b]	M.H.C. of No. Iowa	$ 8,000.00	$ 46,856.04
Lee	44,207	Mt. Pleasant	$198,856.10[b]	Lee Co. M.H.C.	$ 33,853.09	$ 81,824.52
Linn	136,899	Independence	$394,745.87[b]	Linn Co. M.H.C.	$101,019.00	$253,387.64
Louisa	10,290	Mt. Pleasant	$ 35,834.52	None		$ 19,047.40
Lucas	10,923	Mt. Pleasant	$ 19,581.04	None		$ 20,219.28
Lyon	14,468	Cherokee	$ 38,540.15[b]	None		$ 26,780.48
Madison	12,295	Clarinda	$ 30,681.58	W. Cen. M.H.C.	$ 16,000.00	$ 22,758.20
Mahaska	23,602	Mt. Pleasant	$ 53,670.45	S. Cen. M.H.C.	$ 14,500.00[i](FY)	$ 43,686.72
Marion	25,886	Mt. Pleasant	$ 37,251.04	S. Cen. M.H.C.	$ 10,072.89[i](FY)	$ 47,913.96
Marshall	37,984	Independence	$ 56,384.13[b]	Marshall Co. M.H.C.	$ 25,000.00	$ 70,306.24
Mills	13,050	Clarinda	$ 19,704.02[b]	None		$ 24,156.00
Mitchell	14,043	Independence	$ 43,897.37	M.H.C. of No. Iowa	$ 7,000.00	$ 25,993.48
Monona	13,916	Cherokee	$ 72,901.46[a]	None		$ 25,758.76
Monroe	10,463	Mt. Pleasant	$ 8,862.59[a]	S. Cen. M.H.C.	$ 4,692.00	$ 19,367.68
Montgomery	14,467	Clarinda	$ 29,875.04	None		$ 26,779.12

TABLE II (Continued)

1	2	3	4	5	6	7
Muscatine	33,840	Mt. Pleasant	$114,875.26	None		$ 62,636.40
O'Brien	18,840	Cherokee	$ 48,398.78	N.W. Iowa M.H.C.	$ 4,805.46	$ 34,873.40
Osceola	10,064	Cherokee	$ 34,821.91	N.W. Iowa M.H.C.	$ 2,640.00[l]	$ 18,629.04
Page	21,023	Clarinda	$ 91,088.28	None		$ 38,913.28
Palo Alto	14,736	Cherokee	$ 46,128.80	N.W. Iowa M.H.C.	$ 7,893.81	$ 27,276.96
Plymouth	23,906	Cherokee	$ 58,000.44	None		$ 44,249.16
Pocahontas	14,234	Cherokee	$ 72,520.40[b]	No. Cen. Iowa M.H.C.	[g]	$ 26,347.24
Polk	266,315	Clarinda	$810,901.86[b]	[m]	[m]	$492,924.40
Pottawattamie	83,102	Clarinda	$240,694.23	Pott'mie Co. M.H.C.	$ 43,959.03	$153,815.72
Poweshiek	19,300	Mt. Pleasant	$ 39,242.90[b]	Jasper-Pow'k. M.H.C.	$ 23,000.00[h]	$ 35,724.00
Ringgold	7,910	Clarinda	$ 23,508.91	None		$ 14,642.60
Sac	17,007	Cherokee	$ 44,696.96	None		$ 31,480.52
Scott	119,067	Mt. Pleasant	$241,870.90[b]	Scott Co. M.H.C.	$ 87,633.75	$220,383.12
Shelby	15,825	Clarinda	$ 42,540.74[b]	S.W. Iowa M.H.C.	[d]	$ 29,293.00
Sioux	26,375	Cherokee	$ 66,424.98	None		$ 48,819.00
Story	49,327	Cherokee	$ 71,103.96[b]	Cen. Iowa M.H.C.	$ 28,285.00[i]	$ 91,301.72
Tama	21,413	Independence	$ 41,908.55[b]	Marshall Co. M.H.C.	$ 12,000.00[p]	$ 39,635.68
Taylor	10,288	Clarinda	$ 25,338.89[b]	None		$ 19,044.68
Union	13,712	Clarinda	$ 73,382.20	None		$ 25,381.32
Van Buren	9,778	Mt. Pleasant	$ 19,495.12	None		$ 18,100.08
Wapello	46,126	Mt. Pleasant	$212,065.94[b]	S. Iowa M.H.C.	$ 23,000.00[i]	$ 85,376.36
Warren	20,829	Clarinda	$ 25,820.34	[m]	[m]	$ 38,554.44
Washington	19,406	Mt. Pleasant	$ 65,565.55[b]	None		$ 35,922.16
Wayne	9,800	Clarinda	$ 30,020.11[b]	None		$ 18,141.00
Webster	47,810	Cherokee	$179,400.90[b]	No. Cen. Iowa M.H.C.	[g]	$ 88,493.60
Winnebago	13,099	Cherokee	$ 29,371.30	M.H.C. of No. Iowa	$ 6,000.00	$ 24,246.64
Winneshiek	21,651	Independence	$ 43,958.04	N.E. Iowa M.H.C.	$ 18,776.71	$ 40,055.36
Woodbury	107,849	Cherokee	$340,218.49[b]	None		$199,619.64
Worth	10,259	Cherokee	$ 32,081.71[b]	M.H.C. of No. Iowa	$ 6,000.00	$ 18,990.24
Wright	19,447	Cherokee	$ 52,820.43[b]	M.H.C. of No. Iowa	$ 10,000.00[i]	$ 35,996.92

[a]Figures given in column 6 are those provided by county auditors for the calendar year 1967, unless otherwise noted. Thus comparison in most cases is between payments by county to MHI for period 7/1/66-6/30/67 (column 3), and payments by county to CMHC for period 1/1/67-12/31/67 (column 6). It is assumed that costs are sufficiently constant to permit a valid comparison. Where figures in column 6 are also for period 7/1/66-6/30/67, the letters (FY) appear after the dollar amount in column 6.

[b]County was billed $500 or more for care provided by one or more MHI's other than that in whose district the county is actually located.

[c]Amount CMHC reported, in audited financial statement, was received from Allamakee County in period 7/1/66-6/30/67. Allamakee County treasurer reported contributions of $7,846.53 to CMHC in period 1/1/67-12/31/67.

[d]Audubon, Carroll, Shelby Counties did not affiliate with S.W. Iowa M.H.C. until late in 1967.

[e]Black Hawk Co. M.H.C. 1967 financial statement shows receipts of $80,000 from "county board of supervisors". This figure is not broken down between Black Hawk and Grundy Counties, and no information was received from Black Hawk County auditor. Figure in column 6 derived by subtracting amount Grundy County auditor reported was contributed in 1967 from the $80,000 total.

[f]Amount county auditor reported was levied and collected for CMHC, but CMHC reported receipts of $8,475 attributed to "Boone County tax".

[g]N. Cen. Iowa M.H.C. did not actually begin operation until 1968.

[h]Amount county auditor reported was levied and collected for CMHC in 1967. In absence of statement to contrary, it is assumed full amount was actually remitted to CMHC.

[i]Amount CMHC reported was received from county in 1967. County auditor's figures on remittances to CMHC for same period not available.

[j]Amount CMHC reported was received from Hamilton County in 1967. County withdrew support from CMHC during 1967.

[k]Amount Lee County auditor reported was paid to CMHC in 1967, but CMHC reported receipts of $40,980.00 from Lee County in 1967. It is not certain both reports were intended to refer to same period of time.

[m]Although Polk and Warren Counties contribute to support of the Des Moines Child Guidance Center they have been treated as counties not served by a CMHC in this table because it is believed that cost figures might not be representative of a CMHC serving both children and adults.

[n]Amount CMHC reported was received from Scott County in period 10/1/66-9/30/67.

[p]Amount Tama County auditor reported was paid to CMHC in 1967, but CMHC reported receipts of only $11,000.00 from Tama County in 1967.

ices to be rendered, or standards of professional competence, services to be rendered, or standards competence, and are subject only to such external control as county supervisors may insist upon as a condition of county financial support.

The foregoing is by no means intended to suggest that community mental health centers in Iowa have abused their autonomy. In fact, because the present pattern of operation of the centers—nonprofit private corporations providing services to counties under financial arrangements agreed upon with the boards of supervisors—has not been unsatisfactory, House File 7 has been carefully drawn to permit this general pattern of operation to continue, while providing for a degree of state control sufficient to assure that state aid will be properly utilized.

House File 7 authorizes counties, individually or jointly with other counties, to establish county mental health programs providing any or all of a number of kinds of mental health services which the board or boards of supervisors believe are needed by the residents of the county or counties served. The list of services which the program may provide is based upon the services which it is required or suggested be provided by a comprehensive community mental health center, as defined by federal regulations issued pursuant to Public Law 88-164, the Community ental Health Centers Act of 1963.

The policy-making body for a county mental health program, under the general authority of the board or boards of supervisors, will be a county mental health board, which may be constituted in any of the three following ways:

1. The members of the board or boards of supervisors may serve, ex officio, as the county mental health board.

2. Where a county mental health program is established by two or more counties, an equal number of members of the board of supervisors of each county may make up the mental health board.

3. The board or boards of supervisors may appoint any number of residents of the county or counties, other than themselves, to serve on the county mental health board, for staggered three-year terms.

The power to decide which specific mental health services are to be provided rests with the board or boards of supervisors of the county or counties supporting a county mental health program. When this determination has been made, the county mental health board may contract for any or all of the services which the board or boards of supervisors believe should be provided, with any of the following:

1. A community mental health center which meets the standards of the Iowa Mental Health Authority, relating to administration, standards of professional competence, fee schedules, and accounting procedures.

2. Individuals, associations, corporations, or hospitals or other health facilities operated by political subdivisions of the state, upon a finding by the Mental Health Authority that the person or persons who will provide the services meet "generally recognized standards of professional competence."

3. Any state hospital or institution in Iowa.

House File 7 intentionally preserves to some extent the present autonomy of community mental health centers in Iowa, and does not directly prescribe the manner in which community mental health centers are to be organized and operated. The Iowa Mental Health Authority is given power to establish some standards for community mental health centers, and any center meeting these standards is eligible to contract to provide services to a county mental health program. Representatives of the Iowa Mental Health Center Association have indicated that most members of the Association do not object to delegating such rule-making power to the Iowa Mental Health Authority, as presently constituted.

State Aid for Mental Health—A key provision of House File 7 is section nine, under which an annual appropriation totaling at least one million dollars, plus whatever additional amount the Legislature sees fit to appropriate, is made to a newly established state mental health reimbursement fund. The entire amount appropriated to this fund for each fiscal year is to be allocated in that year among all of the counties in the state on a per capita basis. Counties may use the funds so allocated, in such proportions as they deem advisable, for any or all of the following purposes:

1. To pay up to 50 percent of the cost of a county mental health program established under House File 7.

2. To pay up to 20 percent of the charges to the county by the state for care and treatment of residents of the county in state mental health institutions.

3. To pay up to 50 percent of the cost of care of mentally ill or mentally retarded persons in the county home or other community facilities.

It is recognized that the Legislature may well be reluctant to approve new state expenditures in 1969. Therefore, it is suggested that the state mental health reimbursement fund be established by shifting state funds presently channeled to counties, directly or indirectly for mental health purposes, in the following manner:

1. Repeal of sections 227.16, 227.17, and 227.18, *Code of Iowa* (1966), under which one million dollars per year is appropriated to the state mental aid fund for distribution to counties (see "Financing of Community Mental Health Services" earlier in this report), and substitution of a one million dollars per year permanent appropriation to the new state mental health reimbursement fund.

2. Direction by the Legislature to state mental health institutions to resume billing counties, for care of their residents who are patients in the institutions, at 100 percent of average per-patient-per-day cost rather than at the present 80 percent rate, and appropriation to the new state mental health reimbursement fund of an amount equal to the amount being expended from the state treasury during the current biennium (1967-69) to pay the 20 percent of the per-patient-per-day cost which is not being charged back to the counties.

The foregoing procedure would neither increase total state spending for mental health nor decrease the amount of state funds expended in lieu of property taxes for support of mental health services, but would give the counties added flexibility in determining where mental health services needed by their residents are to be obtained.

Table II shows amounts expended by counties for care of patients in state mental health institutes and for services obtained from community mental health centers in the period July 1, 1966-June 30, 1967, the last fiscal year during which state mental health institutions were billing counties at full cost. Column 7, Table II, shows the amount which would be allocated to each county from the proposed state mental health reimbursement fund if the procedure outlined in the foregoing paragraph were followed.

House File 7 and House File 8 (see following paragraph) together replace section 230.24 of the Code, which creates the county fund for mental health. Section seven of House File 7 replaces that portion of section 230.24 authorizing a tax levy for support of community mental health centers and a nonrecurring appropriation for expenses of establishing a center.

County Fund for Mental Health Abolished—House File 7 incorporates in section 444.12 of the Code, which creates and prescribes the use of the state institutions fund, the present provisions of section 230.24 other than those specifically relating to community mental health centers. Since both the state institutions fund and the county fund for mental health are raised by property taxation, and the unlimited-levy state institutions fund may be drawn upon for support of mentally ill and mentally retarded patients in local facilities when the one mill levy for the county fund for mental health is depleted, it is believed adoption of House File 8 would simplify county bookkeeping.

Updating of County Home Law—A quick review of chapter 253, *Code of Iowa* (1966), will indicate that county homes in Iowa were not originally conceived of as community mental health facilities, but that is largely what they have become. The Study Committee believes the time is approaching when Iowa should decide either to greatly update many of its county homes, no doubt at considerable expense, or else to abandon county homes, as such, as community custodial facilities for the mentally ill and mentally retarded. However, no recommendation as to which course of action would be preferable should be made until more study has been given to the question than has been permitted by limitations of time and of the priority assigned by the Study Committee to other matters.

House File 9 is intended simply to update chapter 253 to reflect the actual purpose and mode of operation of present-day county homes in Iowa. The bill requires the annual financial statement of each county home to be presented in such manner as to permit easy determination of the actual cost of operating the home, on a per-patient basis. Reference to the county home matron, as well as to the steward, is inserted, and the outdated provisions for education of poor children residing in county homes are repealed. Provisions for admission, commitment, and release of residents of the home are rewritten to be more suitable to the persons actually being cared for in present-day county homes. Authority for the board of supervisors to lease the county home for private operation is updated, and the requirement that all county homes be licensed as nursing or custodial homes which has been in effect for several years is specifically written into chapter 253. The provisions of sections 230.25 through 230.30, inclusive, *Code of Iowa* (1966), which now relate to support of patients in state mental health institutions, are also made applicable to support of residents of county homes.