

Community Support Services for Persons with Serious Mental Illness in Iowa: Case Manager Survey Results

Introduction

Case managers who work in rural states such as Iowa have a vitally important responsibility, since it falls on them to develop community based treatment plans for a relatively small number of persons with extensive service needs in the context of limited financial and organizational resources.

The purpose of this study is to: 1) describe statewide characteristics of case management and case managers in Iowa; and 2) describe case managers' perceptions of need, availability, and adequacy of community services within their counties. In subsequent studies the perceptions of need, availability, and adequacy by family members and clients will also be assessed.

Background

In 1977, the National Institute of Mental Health developed the concept of a community support system (CSS) as the basis for planning and organizing comprehensive, community based, services for persons with serious mental illness. The NIMH model of community support has ten essential service components defined as necessary in order to provide a continuous, comprehensive system of care for persons with serious mental illness. Community support services are intended to be coordinated by case management, variably defined as a single person, team, or agency. In addition, case management was intended to monitor the adequacy and appropriateness of services.

The ten components of community support that were specified by the NIMH include:

1. Crisis Response Services (crisis telephone services, walk-in crisis services, mobile crisis outreach services, crisis residential service, inpatient services)
2. Mental Health Treatment (diagnostic evaluation, supportive counseling, medication management, substance abuse services)
3. Income Support and Entitlements
4. Protection and Advocacy
5. Physical Health and Dental Services
6. Housing (supportive housing, residential assistance for homeless mentally ill persons)
7. Psychosocial Rehabilitation (social and vocational)
8. Peer Support (self-help, consumer-operated services)
9. Identification and Outreach (client identification, outreach, transportation assistance)
10. Family and Community Support (support and assistance to families, support and education for the community)

In Iowa, case managers for persons with serious mental illness are required to have a bachelor's degree in a human services field and one year experience in the delivery of

services to the population groups they serve or an Iowa license to practice as registered nurses with three years experience in the delivery of services to the population groups they serve. Case managers cannot be direct service providers. All counties provide case management to their counties by one of three methods or by a combination of methods. These include case management by: 1) Department of Human Services (DHS); 2) contract to outside individual or agency (not considered part of the county government system); or 3) the county's own county government organization. Counties who wish to provide their own case management services must meet conditions necessary to be a "provider" as per criteria specified by DHS.

Iowa is a rural state with 99 counties and nine Metropolitan Statistical Areas (MSAs). Systems of mental health service organization in Iowa are county based. Although the state provides accreditation to mental health centers and mental health providers, each county is responsible for the provision of services for persons with serious mental illness who have residence in their county. There are no state mandates for minimum service requirements for persons with serious mental illness. Statewide, there are 37 community support programs (CSPs), all of which are affiliated with a community mental health center (CMHC). Most counties (93/99) have an affiliation with a CMHC and each CMHC center has a catchment area of one to nine counties.

Serious mental illness (SMI) in adults is defined by a: 1) psychiatric treatment more intensive than outpatient care more than once in a lifetime; or 2) single episode of continuous, structured, supportive residential care other than hospitalization. In addition, individuals defined as having a serious mental illness are more likely to be unemployable in a competitive work force, require financial assistance for out of hospital maintenance, have a severe inability to establish or maintain a personal support system, require help in basic living skills or exhibit inappropriate social behavior which results in demand for intervention by the mental health or judicial system.

Methods

The state of Iowa Department of Human Services (DHS) was asked to identify individuals who provided supervision for case management services for persons with mental illness in each of Iowa's 99 counties. Supervisors for all counties were contacted and asked to provide a list of all case managers under their supervision who provided case management services to persons with serious mental illness. Case managers so identified were asked to participate in a survey describing community support services in their county. Two hundred twenty-four case managers who provide case management services in the state of Iowa were identified by this method and were sent a 13 page, 47 item survey to complete and return in a self addressed, stamped envelope between February 1, 1995, and August 15, 1995.

Case managers were asked to evaluate the adequacy of each of the 10 components of community support services to persons with mental illness who live in their county. The instrument used was adapted from an earlier, unpublished survey (Friedrich, R.M., 1994) and was reviewed by a multidisciplinary team for content validity. The team consisted of nurses, psychiatrists, and representatives of the Alliance for the Mentally Ill (AMI), DHS, the Community Mental Health Centers Association, and case managers.

Results

Responses were obtained from 91/224 case managers (41%). Of responding case managers, nearly three quarters (66/91) provided case management services for rural counties. About one-third of the respondents indicated that they provided case management services to more than one county, often both urban and rural counties.

Characteristics of Case Management in Iowa

Statewide, there is approximately 1 case manager (0.95) per 10,000 population (269 case managers /2,829,259 state population). The Iowa code allows for case management services to be provided in a number of different ways. Counties are nearly evenly distributed among these options. Case management services in the state are summarized in Table 1.

Table 1: Case Manager Source

	DHS	Contract	County Provider	Combination	Number of counties
all counties	31	30	27	11	99
urban counties	3	2	1	3	9
all rural counties	28	28	26	8	90

Characteristics of Responding Case Managers

Education. The educational degree and discipline of 88/91 respondents is summarized in Table 2. The majority of case managers who responded to the survey (83%) had a BA/BS degree and nearly one-half of all respondents (47%) had a degree in a field other than social work, nursing, or psychology.

Table 2: Educational level and Study Discipline of Case Managers (n=88)

	Social Work	Psychology	Nursing	Other	All (%)
BA/BS	25	16	0	32	73 (83%)
MSW	3	0	0	0	3 (3%)
MAMS	0	0	0	9	9 (10%)
Nursing	0	0	3	0	3 (3%)
all (%)	28 (32%)	16 (18%)	3 (3%)	41 (47%)	88 (100%)

Experience. The average number of years of experience for all case managers (n=91) was 3.6 years with a range of 1 to 16 years reported. Case managers who had primary affiliations in rural counties had less experience than their urban counterparts. Among the 66 respondents from rural counties, the average number of years experience in the county was 3.0 years whereas 24 urban respondents reported an average of 5.4 years experience. Case managers with less than five years experience in their county were 3.2 times more likely to work in a rural as opposed to an urban county ($G^2 = 4.92$; $p = .03$).

Caseload. The average caseload reported by 90 respondents was 29.4 clients with a range of 5 to 45 clients. Caseload in regard to the proportion of SMI clients was also evaluated. The average number of SMI clients per case manager was 13.6 cases with a range of 1 to 43. Overall, case managers reported that 52% of their clients had SMI with a reported range of 6% to 100%.

Perception of Need, Availability, and Adequacy of Services by Case Managers

Estimate of Need Frequency. Case managers were asked to estimate how often services were required, on the average, by a “typical” SMI client during the past year. They were asked to estimate the frequency of use on a four point scale ranging from “weekly” to “never”. Responses of “weekly” and “monthly” were combined and compared to responses of “less than monthly” or “never”.

Perception of Availability. To assess availability, case managers were asked to indicate if specific services were available in their county by answering “yes” or “no”. Results for each of the components are summarized in Tables 4 - 14.

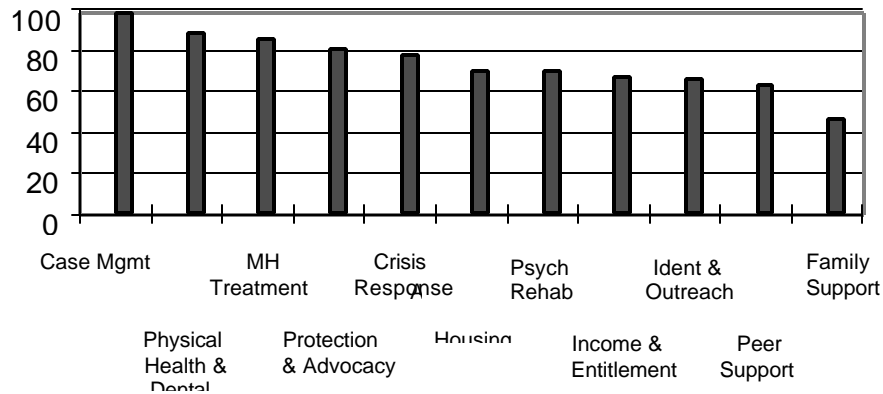
Perception of Adequacy. Adequacy of each of the ten components was assessed by asking case managers how well the services (of each component) met the needs of their SMI clients over the past one year period. They were asked to rate adequacy by using a 4 point scale from 1 (completely) to 4 (not at all). Case managers could also indicate that the service was not needed by any of their clients over the past year. Responses of “adequate” or “complete” were combined and compared to responses of “minimal” or “not at all” to measure case manager perception of service adequacy. Assessment of service adequacy by case managers for each service component is summarized in Table 3.

Most Helpful Resource. Finally, case managers were asked who helped SMI clients the most when they faced a crisis or emergency situation, with choices including family, mental health professional, family doctor, and “other”.

Table 3: Assessment of Service Component Adequacy by Case Managers

Service Component	Assessment of Adequacy		
	number responding	service not needed over past one year	percent indicating adequacy
I. Crisis Response	89	5	77.4% (65/84)
II. Mental Health Treatment	88	1	85.1% (74/87)
III. Income and Entitlement	90	1	67.4% (60/89)
IV. Protection and Advocacy	88	14	79.7% (59/74)
V. Physical Health and Dental	91	0	87.9% (80/91)
VI. Housing	91	3	70.5% (62/88)
VII. Psychosocial Rehabilitation	91	3	70.5% (62/88)
VIII. Peer Support	90	2	62.5% (55/88)
IX. Identification and Outreach	90	3	65.5% (57/87)
X. Family Support	91	10	45.7% (37/81)
XI. Case Management	90	1	97.8% (87/89)

Figure 1: Assessment of Service Component Adequacy by Case Managers (Percent)



**Case Manager Perception of Frequency of Need and Availability
of Service Components**

I. Crisis Response. Overall, crisis response services were rated as “adequate” or “complete” by 65/84 (77%) of the respondents who said that their clients needed crisis services. For most services pertaining to crisis response, over 60% of responding case managers indicated that the service was needed less than once per month. The only exception was that phone contact was perceived as being needed at least weekly or monthly by 71% of the respondents. Services were reported as being available in the county by 75% or more of respondents with the exception of walk-in crisis support services at a community mental health center, mobile crisis unit, short term crisis residential services, and outpatient psychiatric clinic emergency services. Case managers were asked to identify up to four of the most common emergency/crisis situations for which their clients needed assistance. Of the 215 responses given, the most frequent reasons cited were: 1) symptom exacerbation (28%); 2) dangerousness to self and/or others (24%); 3) increased psychosocial stressors (20%); and 4) non-compliance or other medication related problems (16%). A mental health professional was identified by case managers most often as the source of help to clients (52%). Assessment of need and availability for crisis response services is summarized in Table 4.

Table 4: Service Component I. Crisis Response

Service Component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
I. Crisis Response			
24 hour crisis telephone service	33/85 (38.8%)	52/85 (61.2%)	68/83 (81.9%)
walk-in crisis support services at a community mental health center	25/81 (30.9%)	56/81 (69.1%)	55/84 (65.5%)
phone contact with counselor during the week	61/86 (70.9%)	25/86 (29.1%)	74/85 (87.1%)
mobile crisis unit that comes to home	7/81 (8.64%)	74/81 (91.4%)	16/83 (19.3%)
short term crisis residential services	7/85 (8.2%)	78/85 (91.7%)	39/80 (48.8%)
outpatient psychiatric clinic emergency services	18/83 (21.7%)	65/83 (78.3%)	39/75 (52.0%)
hospital emergency room	11/86 (12.8%)	75/86 (87.2%)	74/85 (87.1%)
police department services	6/87 (6.9%)	82/87 (94.3%)	87/88 (98.7%)
emergency visit to family doctor	1/87 (8.1%)	86/87 (98.9%)	84/85 (98.8%)

II. Mental Health Treatment. Overall, mental health treatment services were rated as “adequate” or “complete” by 74/87 (85%) of the respondents who said that their clients needed services. Most services pertaining to mental health treatment were needed at least monthly, according to over 50% of case managers responding to the question. Exceptions were group therapy and family therapy which were perceived to be needed at least once per month by only 39% and 11% of respondents, respectively. All mental health treatment services were reported as being available in their county by over 75% of the case managers who gave a response. A mental health professional was identified by case managers most often as the source of most help to clients (62%). Assessment of need and availability for mental health treatment is summarized in Table 5.

Table 5: Service Component II. Mental Health Treatment

Service Component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
II. Mental Health Treatment			
help with medication problems (e.g., side effects)	60/90 (66.7%)	30/90 (33.3%)	79/88 (89.7%)
help with taking medication as directed	69/90 (76.7%)	21/90 (23.3%)	85/91 (93.4%)
individual counseling	63/88 (71.6%)	25/88 (28.4%)	82/90 (91.1%)
group therapy	34/87 (39.1%)	53/87 (60.9%)	65/83 (78.3%)
family therapy	9/85 (10.6%)	76/85 (89.4%)	65/81 (80.3%)
monitor symptoms of mental illness	77/88 (87.5%)	11/88 (12.5%)	78/84 (92.9%)
education in coping skills	63/87 (72.4%)	24/87 (27.6%)	71/83 (85.5%)
education regarding signs of relapse	48/87 (55.2%)	39/87 (44.8%)	66/81 (81.5%)
education concerning mental illness	50/86 (58.1%)	36/86 (41.9%)	67/81 (82.7%)
frequent in-home staff visits	72/87 (82.8%)	15/87 (17.2%)	71/87 (81.6%)
in-home staff visits (e.g., Visiting Nurses Association)	44/84 (52.4%)	40/84 (47.6%)	77/84 (91.7%)

III. Income Support and Entitlements. Overall, income support and entitlement services were rated as “adequate” or “complete” by 60/89 (67%) of the respondents who said that their clients needed services over the past year. All services pertaining to income support and entitlements were needed less than once per month according to 75% of case managers who responded to the question. All services were reported to be available in the county by over 90% of the respondents. Case managers and mental health professionals were equally likely to be identified as the source of most help to clients (25%). Assessment of need and availability for income support and entitlements is summarized in Table 6.

Table 6: Service Component III. Income Support and Entitlements

Service component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
III. Income Support and Entitlements			
assistance with obtaining income supports (e.g., SSI, SSDI)	21/89 (23.6%)	68/89 (76.4%)	81/85 (95.3%)
assistance with obtaining health care financing (e.g., Medicaid, Medicare, private health insurance)	19/89 (21.4%)	70/89 (78.7%)	84/85 (98.8%)
assistance with obtaining welfare benefits (e.g., food stamps, AFDC)	21/89 (23.6%)	68/89 (76.4%)	84/86 (97.7%)
housing assistance	20/88 (22.7%)	68/88 (77.3%)	77/83 (92.8%)

IV. Protection and Advocacy. Overall, protection and advocacy support services were rated as “adequate” or “complete” by 59/74 or 80% of the respondents who said that their clients needed this service, however, 14/88 (16%) of respondents said that none of their clients needed protection and advocacy services over the past year. All services pertaining to protection and advocacy were needed less than once per month according to 75% of case managers who responded to the question. All services were reported to be available in the county by over 85% of the respondents. Case managers and mental health professionals were equally likely to be identified as the source of most help to clients (30%). Assessment of the frequency of need and availability of protection and advocacy services by case managers is summarized in Table 7.

Table 7: Service Component IV. Protection and Advocacy

Service Component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
IV. Protection and Advocacy			
information about legal rights	8/88 (9.1%)	80/88 (90.9%)	73/82 (89.0%)
assistance with commitment process	6/88 (6.8%)	82/88 (93.2%)	77/81 (95.1%)
assistance in contacting agencies about questions or complaints	21/89 (23.6%)	68/89 (76.4%)	82/84 (97.6%)

V. Physical Health and Dental Services. Overall, physical health and dental services were rated as “adequate” or “complete” by 80/91 (88%) of all respondents. Nearly all respondents (86/91) indicated that their SMI clients had medical problems in addition to their psychiatric illness. Most commonly (40%), respondents indicated that 25-49% of their clients had co-occurring medical illness; about 20% each estimated 1-24% or 50-74% had co-occurring medical problems. Ten percent of respondents indicated that 75-100% of their clients had medical illness. All services pertaining to physical health and dental services were needed less than monthly or not at all over a one year period according to two-thirds of case managers who responded to the question. Medical services were reported as being available in their county by over 75% of case managers who responded to the question. The family doctor was identified as the most helpful resource by the greatest number of respondents (31%). Assessment of the frequency of need and availability of physical health and dental services by case managers is summarized in Table 8.

Table 8: Service Component V. Physical Health and Dental Services

Service Component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
V. Physical Health and Dental Services			
assistance obtaining medical (non psychiatric) treatment	28/90 (31.1%)	62/90 (68.9%)	84/89 (94.4%)
assistance obtaining dental services	6/90 (6.7%)	84/90 (93.3%)	81/86 (94.2%)
assistance maintaining physical fitness	24/90 (26.7%)	66/90 (73.3%)	72/86 (83.7%)
assistance with weight control	24/89 (27.0%)	65/89 (73.0%)	70/87 (80.5%)
assistance with alcohol/drug abuse	32/89 (36.0%)	57/89 (64.0%)	76/86 (88.4%)
assistance with pregnancy prevention	5/90 (5.6%)	85/90 (94.4%)	73/82 (89.0%)
assistance controlling smoking	23/89 (25.8%)	66/89 (74.2%)	66/82 (80.5%)
assistance with prevention of sexually transmitted diseases and AIDS	9/88 (10.2%)	79/88 (89.8%)	71/83 (85.5%)

VI. Housing. Overall, housing services were rated as “adequate” or “complete” by 62/88 (70%) of respondents. All services pertaining to housing were needed less than monthly or not at all over a one year period according to 75% of case managers. Housing services were also reported as being available in their county by over 75% of the respondents for each of the services. Case managers were identified most often as the source of most help to clients by case managers (38%). Case manager assessment of the frequency of need and availability of housing services is summarized in Table 9.

Table 9: Service Component VI. Housing

Service Component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
VI. Housing			
help finding housing with on-site support services	17/89 (19.1%)	72/89 (80.9%)	75/86 (87.2%)
help finding long-term, stable housing	15/90 (16.7%)	75/90 (83.3%)	78/85 (91.8%)
help finding affordable housing	19/89 (21.4%)	70/89 (78.7%)	78/85 (91.8%)
help finding emergency housing	10/90 (11.1%)	80/90 (88.9%)	65/83 (78.3%)

VII. Psychosocial Rehabilitation. Overall, psychosocial rehabilitation services were rated as “adequate” or “complete” by 62/88 (70%) of respondents. The estimation of frequency use varied for services pertaining to psychosocial rehabilitation. Over 50% of the case managers who responded to the question indicated that services were needed at least monthly for help with keeping a job, help with tasks of everyday living, supervision or help with money management, and assistance with maintaining personal hygiene. Services which were felt to be needed less than monthly or not at all over a one year period by 50% or more of case managers were help with finding a job, job training, completing education, finding volunteer work, and use of public transportation. Psychosocial rehabilitation services were reported as being available in their county by 74% or more of case managers who responded to the question. “Mental health professional” was identified by case managers most often as the source of most help to clients (48/91 or 53%). Case manager assessment of the frequency of need and availability of psychosocial rehabilitation services is summarized in Table 10.

Table 10: Service Component VII. Psychosocial Rehabilitation

Service Component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
VII. Psychosocial Rehabilitation			
help finding a job	40/90 (44.4%)	50/90 (55.6%)	82/86 (95.4%)
help keeping a job	48/90 (53.3%)	42/90 (46.7%)	78/86 (90.7%)
help with job training	38/90 (42.2%)	52/90 (57.8%)	75/86 (87.2%)
help with completing education	17/90 (18.9%)	73/90 (81.1%)	74/82 (90.2%)
help with finding volunteer work	11/88 (12.5%)	77/88 (87.5%)	75/86 (87.2%)
help with tasks of every day living (e.g., housekeeping, grocery shopping)	76/89 (85.4%)	13/89 (14.6%)	79/82 (96.3%)
help with the use of public transportation	39/90 (43.3%)	51/90 (56.7%)	61/82 (74.4%)
supervision or help with managing finances	81/90 (90.0%)	9/90 (10.0%)	82/85 (96.5%)
assistance in maintaining personal hygiene	65/90 (72.2%)	25/90 (27.8%)	82/85 (96.5%)

VIII. Peer Support. Overall, peer support services were rated as “adequate” or “complete” by 61% of respondents. All services pertaining to peer support were felt to be needed weekly or monthly by 50% or more of case managers except for help in getting along with family which 62% of respondents felt was required less than once per month or not at all. All peer support services listed were reported as being available in their county by over 75% of the respondents. “Mental health professional” was most frequently cited as the source most helpful to clients (30%). Case manager assessment of the frequency of need and availability of peer support is summarized in Table 11.

Table 11: Service Component VIII. Peer Support

Service Component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
VIII. Peer Support			
help getting along with family	33/88 (37.5%)	55/88 (62.5%)	71/81 (87.7%)
assistance with recreational and leisure activities	63/88 (71.6%)	25/88 (28.4%)	66/82 (80.5%)
help with making friends	56/87 (64.4%)	31/87 (35.6%)	65/83 (78.3%)
help getting along with friends	59/88 (67.1%)	29/88 (33.0%)	66/83 (79.5%)
help with significant other relationship	49/88 (55.7%)	39/88 (44.3%)	73/83 (88.0%)
help with day to day social interactions	60/87 (69.0%)	27/87 (31.0%)	70/83 (84.3%)

IX. Identification and Outreach. Overall, identification and outreach services were rated as “adequate” or “complete” by 57/87 (66%) of respondents. Three services were estimated to be necessary more frequently than monthly by over one-half of respondents: coordination of community services, transportation to services, and home visits for clients who were deteriorating. However, outreach services to individuals who decline a formal treatment program were estimated to be necessary weekly by only 14% of respondents and monthly by 20%. About 50% of respondents indicated that information about service availability, referral to agencies for services, and outreach services to clients who miss appointments or discontinue medication was needed at least monthly and half of the respondents perceived less frequent need. All identification and outreach services were reported as being available in their county by over 75% of the respondents except for outreach services to individuals who decline a formal treatment program (64%). Mental health professionals and case managers were equally likely to be identified as the most helpful source to clients (about 40% each). Case manager assessment of the frequency of need and availability of identification and outreach services is summarized in Table 12.

Table 12: Service Component IX. Identification and Outreach

Service Component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
IX. Identification and Outreach			
information about services available	46/89 (51.7%)	43/89 (48.3%)	87/89 (97.8%)
referral to agencies for services	44/89 (49.4%)	45/89 (50.6%)	86/90 (95.6%)
coordination of community services	58/88 (65.9%)	30/88 (34.1%)	83/88 (94.3%)
transportation to services	56/87 (64.4%)	31/87 (35.6%)	68/85 (80.0%)
outreach services to clients who miss appointments or discontinue medication	47/86 (54.7%)	39/86 (45.4%)	69/88 (78.4%)
home visits for clients on a downhill turn	63/87 (72.4%)	24/87 (27.6%)	75/89 (84.3%)
outreach service to individuals who decline a formal treatment program	29/87 (33.3%)	58/87 (66.7%)	56/87 (64.4%)

X. Family Support. Overall, family support services were rated as “adequate” or “complete” by 37/81 (46%) of respondents; 10 respondents indicated that these services were not needed by any of their clients over the past year. All family support services were perceived as being necessary less than once per month or never by 74% or more of case managers who responded with the exception of assistance with handling daily problems related to psychiatric illness (56%). Identification of respite services were indicated as never being needed over the past one year period by over one-half (57%) of respondents. Family support services were reported as being available in their county by over 75% of the respondents for the services of education, assistance with daily problems, and involvement of family in treatment planning. The service least likely to be reported as available was identification of respite services, with over one-half of respondents (43/81) indicating that this service was not available in their county. “Mental health professional” was identified by case managers most often as the source of most help to families (40%). Case manager assessment of the frequency of need and availability of family support services is summarized in Table 13.

Table 13: Service Component X. Family Support

Service Component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
X. Family Support			
identification of temporary caregivers so the family could get away	8/88 (9.1%)	80/88 (90.9%)	38/81 (46.9%)
referral to family support groups (e.g., AMI)	8/88 (9.1%)	80/88 (90.9%)	58/83 (69.8%)
referral to family therapy groups	6/88 (6.8%)	82/88 (93.2%)	52/82 (63.4%)
education about the illness and medications	23/88 (26.1%)	65/88 (73.9%)	67/86 (77.9%)
assistance with handling daily problems related to psychiatric illness	39/88 (44.3%)	49/88 (55.7%)	69/86 (80.2%)
involvement of family in treatment planning	17/88 (19.3%)	71/88 (80.7%)	66/83 (79.5%)

XI. Case Management Overall, case management services were rated as “adequate” or “complete” by 87/89 (98%) of respondents. All case management services were perceived as being necessary at least monthly by 50% or more of case managers except for the development of comprehensive treatment plans (43%). Not unexpectedly, case management services were reported as being available by virtually all responding case managers. Case managers were asked who was the most helpful in facilitating case management services. Social workers (26/90) and community support program staff (20/90) were most frequently indicated. Only 2 respondents indicated that a psychiatrist was the most helpful resource in facilitating case management services. Other sources identified as being helpful included other case managers, public health workers, residential staff, and county general relief coordinators. Case manager assessment of the frequency of need and availability of case management is summarized in Table 14.

Table 14: Service Component XI. Case Management

Service Component	Frequency of Need		Availability
	weekly or monthly	less than once per month or never	service available in county
XI. Case Management			
arrange for individualized services	69/90 (76.7%)	21/90 (23.3%)	84/86 (97.7%)
make referrals to agencies (e.g., VNA)	51/91 (56.0%)	40/91 (44.0%)	86/87 (98.9%)
advocate on behalf of the client to programs and agencies	69/91 (75.8%)	22/91 (24.2%)	86/86 (100.0%)
develop comprehensive treatment care plans	39/91 (42.9%)	52/91 (57.1%)	86/87 (98.9%)
monitor client’s condition (e.g., change in psychiatric symptoms)	86/91 (94.5%)	5/91 (5.5%)	86/87 (98.9%)

Additional Comments by Respondents

Additional comments were provided by 1/3 of respondents. Most frequently, case managers reported problems with transportation, and described conflict in their role of being a manager but not a provider of services. As summarized by one respondent, “Rural areas present increased challenges to staff, case management, and crisis intervention. Frequently the crisis intervention ‘system’ fails in as much as direct staff are not available and case managers are called upon by consumers to provide direct service intervention which is not permitted according to Chapter 24 DHS Code of Iowa. I am contacted by consumers for phone and for face to face intervention monthly - at least.”

Conclusions

1. Overall, case managers perceive that community support services are adequate in the state of Iowa. Over 75% of case managers in the state of Iowa feel that the service components of crisis response, mental health treatment, protection and advocacy, physical health and dental services, and case management are “complete” or “adequate”. Between 50% and 75% of case managers felt that income and entitlement, housing, psychosocial rehabilitation, peer support, and identification and outreach services are complete or adequate.

The only service for which less than 50% of case managers perceived adequacy was family support (46%). This finding suggests that families in rural areas such as Iowa are assuming a greater burden of care and may be assuming many of the roles that support services and case management care provide in more urban areas. Although 70% of case managers felt that housing services within their counties were adequate, only 39/80 case managers said that short term crisis residential services were available in their county and only 38/81 case managers said that respite services for families were available in their counties.

2. Although case managers fulfill many functions that are traditionally ascribed to the discipline of social work (e.g., identifying and coordinating funding for services, securing housing and vocational opportunities, and advocating for clients) only one third (32%) have formal training in social work. Only 3 case managers in this study had a master's degree in social work. Persons with serious mental illness have many medical and psychiatric problems (e.g., symptom exacerbation, co-occurring substance abuse, and side effects of their medications). However, only 3 case managers in this study had a degree in nursing. Although nearly all respondents in this study felt that case management services in their counties were complete or adequate, it is possible that case managers would feel more confident in their tasks if their skills in social work and in medical and psychiatric assessment were supported and strengthened by on-going training initiatives directed towards these areas.

3. Individual counties, and, in particular rural counties with low populations, are unlikely to have the capacity to provide comprehensive services for each service component. It is likely that counties formally or informally prioritize the service components that they provide based on perceptions of importance, frequency of need, and cost. In this study, the services with the highest perceived frequency of need were mental health treatment and peer support in addition to some aspects of psychosocial rehabilitation (e.g., assistance with tasks of everyday living) and outreach (e.g., transportation to services and home visits). The present study provides information about statewide service perceptions which may be a starting point for counties to choose service priorities for their own county. Similarly, services that are perceived to be important but infrequently needed may be provided more cost effectively if provided cooperatively by several adjoining counties (e.g., services pertaining to crisis response and family support).

4. The restriction that case managers cannot provide direct services to clients is problematic, particularly in rural counties where resources are limited. It is possible that direct support to mentally ill clients by case managers could reduce service redundancy with other agencies that receive funding to provide community support services (e.g., community support programs). Alternatively, persons who are providing direct services

through community support programs are well positioned to provide case management services. Support services that require outreach as opposed to those services that are office or agency based were often reported by case managers to have low availability. For example, emergency psychiatric services were reported to be available by only 39/75 respondents and mobile crisis units were even less likely to be available (16/83). Outreach services to individuals who decline a formal treatment program could be met by case managers if they received support and supervision in direct service provision. Hence, options for case managers to provide direct services under defined conditions may be an appropriate subject for future study.

Limitations of the present study should be considered in its interpretation and application. Case managers who responded to the survey may have been different from non-respondents by a non-random self-selected process. For example, case managers who felt that services were inadequate in their county may have been less likely to respond to the survey than case managers who felt that services were adequate.

Finally, the present study describes the perceptions of service availability and adequacy by case managers and is not an objective measure of service structure or system organization. Self report of service adequacy by case managers may not be a reliable measure of service adequacy. Development of a state wide data base obtained from administrative sources is necessary in order to obtain objective measures of service access and availability in order to make statements regarding the adequacy and quality of services for persons with serious mental illness who live in Iowa.