How Gaps in Iowa's Behavioral Health and Disability Systems Lead to Crisis, Hospitalization, and Incarceration

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Executive Summary

Iowans with serious mental illness and other disabilities often need treatment, housing, crisis assistance, personal support, and help navigating public systems. When those services are available at the right time and intensity, people can remain connected to their homes, families, work, and communities.

When the services are unavailable, the need moves. Emergency departments hold people while searching for placements. Hospitals retain people who are ready for discharge because no appropriate setting will accept them. Jails may provide medication, meals, shelter, and structure that were not reliably available in the community. Families take on intensive responsibilities while waiting for formal help.

This report examines why those outcomes recur across Iowa's behavioral health and disability service continuum. It draws on interviews with 16 stakeholders across healthcare, social services, and legal systems; analysis of 20 individual stories; 746 excerpts; nearly 3,000 applied qualitative codes; Iowa administrative and policy materials; and national research.

Key Finding	What it means
Community services exist, but many people cannot reach them.	Programs may be listed as available while long waits, geographic limits, staffing shortages, restrictive criteria, or inadequate payment make them inaccessible in practice.
People are left to navigate disconnected systems.	Hospitals, Medicaid, managed care organizations, crisis teams, disability services, housing agencies, courts, law enforcement, and counties may all be involved without one entity responsible for the full course of care.
Iowa lacks enough care between outpatient treatment and hospitalization.	People may need more structure than routine outpatient care but less restriction than an emergency department, hospital, or jail. The system often lacks a workable middle tier.
Staffing and payment policies limit real access.	Staff turnover can make an authorized service unreliable, while reimbursement and managed-care decisions can limit provider participation or continuity with established clinicians.
Help often arrives only after a crisis.	The greatest concentration of public resources may appear after deterioration, while preventive and continuity-focused supports remain delayed, limited, or unavailable.
Hospitals, jails, and families fill the gaps.	Institutions and informal caregivers absorb functions that community services should provide, including supervision, medication continuity, housing, routine, and support.

The relevant question is not simply whether Iowa has programs, licensed beds, waiver categories, or crisis services. It is whether a person can obtain an appropriate service at the time, intensity, and location needed to remain safely in the community.

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Introduction

This report concerns Iowans with serious mental illness and other disabilities who require behavioral health, disability, housing, crisis, or related community-based supports to remain safely integrated in their communities. The evidence assembled for this report shows that people with complex and co-occurring needs are especially vulnerable when services exist nominally but cannot be accessed because of staffing shortages, restrictive eligibility rules, insufficient reimbursement, long waitlists, lack of appropriate placements, or fragmented responsibility across systems.

Across the record, the same pattern appears in different settings. Insufficient capacity to meet the demand for community-based care and missing intermediate levels of care contribute to repeated emergency department use and prolonged boarding; psychiatric beds that exist on paper are not always functionally available; people remain hospitalized because appropriate discharge placements cannot be found; county jails provide structure, medication, shelter, and supervision that individuals may not receive in the community; and Home and Community-Based Services (hereinafter "HCBS") and housing supports are delayed or inaccessible when they are needed. These are not separate problems. They are downstream outcomes of a behavioral health and disability continuum that too often responds after crisis rather than preventing crisis.

We evaluated these patterns under Title II of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Medicaid requirements, and other federal protections discussed in the Legal Appendix, including relevant case law concerning unnecessary institutionalization and community-based services. The central concern is that Iowa administers behavioral health and disability services in ways that unnecessarily segregate people with disabilities, contribute to avoidable institutionalization, and deny meaningful access to services that could support safe community living.

The qualitative investigation included interviews with 16 stakeholders across healthcare, social services, and legal systems and analysis of 20 individual stories. The project produced 746 excerpts and nearly 3,000 applied qualitative codes. Across these materials, six structural findings recur: 1) insufficient community-based capacity, 2) fragmentation across systems, 3) missing intermediate levels of care, 4) workforce and reimbursement barriers, 5) a crisis-driven rather than preventive service model, and 6) reliance on institutional settings as substitutes for unavailable community supports. Iowa-specific reports and national literature independently reinforce many of these concerns.

This report presents an investigation of Iowa's behavioral health and disability service continuum, including community-based treatment capacity, crisis services, psychiatric hospital access and discharge, HCBS and housing access, jail reliance and reentry, workforce and reimbursement policies, and statewide coordination. We examine not only whether programs formally exist, but also whether qualified individuals can actually obtain appropriate services at the time, intensity, and location necessary to avoid preventable institutionalization and support successful community living.

Purpose of the Report

This report documents recurring structural conditions that appear across settings and whether those conditions are consistent with Iowa's obligations under federal disability law. It presents evidence of systemic barriers within Iowa's behavioral health and disability service systems that may prevent people with disabilities from receiving services in the most integrated setting appropriate to their needs. This report synthesizes qualitative interviews and individual case narratives with Iowa-specific administrative and policy materials and relevant national literature.

Methods

The investigation used a mixed-source evidence synthesis. The qualitative component included interviews with 16 stakeholders working across healthcare, social services, and legal systems, together with analysis of 20 individual stories. The team recorded 746 excerpts and applied nearly 3,000 qualitative codes. The team

reviewed these data for recurring patterns involving institutionalization, crisis utilization, service denials, workforce limitations, housing, HCBS access, fragmentation, and transitions between systems. The report also incorporates Iowa reports and administrative materials, policy documents, and peer-reviewed or authoritative national literature relevant to emergency department boarding, psychiatric hospital capacity, jail reliance, community-based services, workforce, and federal disability law, including ADA Title II, Section 504, and *Olmstead*-related case law and policy. Individual stories are used illustratively and do not represent statewide prevalence estimates.

Iowa's Behavioral Health System Findings

The evidence reviewed in this investigation demonstrates that Iowa's behavioral health and disability service systems contain longstanding structural deficiencies that prevent many individuals with disabilities from receiving services in the most integrated setting appropriate to their needs. Interviews with 16 stakeholders across healthcare, social services, and legal systems identified recurring barriers involving community capacity, cross-system coordination, intermediate levels of care, workforce and reimbursement, and access to HCBS and housing. Iowa-specific reports and national literature reinforce many of the same concerns.

The evidence points to a common pattern: when community-based services are unavailable, inaccessible, or unable to meet a person's level of need, responsibility shifts downstream to emergency departments, psychiatric hospitals, jails, families, and other systems that were not designed to provide sustained community support. These findings highlight structural conditions rather than the performance of individual clinicians, agencies, or providers, many of whom described significant efforts to meet needs within impaired systems.

The six findings below explain how gaps in Iowa's behavioral health and disability service continuum contribute to unnecessary institutionalization and to a serious risk of institutionalization.

Finding 1. Iowa's Community-Based Behavioral Health Infrastructure is Insufficient to Meet the Needs of Individuals with Disabilities

Perhaps the most consistent finding from this investigation is that Iowa's community behavioral health infrastructure lacks sufficient capacity to meet the needs of individuals with serious mental illness and other disabilities before crises occur. Across interviews, stakeholders repeatedly described situations in which individuals were clinically appropriate for community-based treatment yet could not access services because programs lacked capacity, staffing, funding, or specialized expertise.

Community providers described programs that were formally available but practically inaccessible. Crisis providers reported that many programs were "*underfunded,*" had "*wait lists,*" and required information that was difficult to obtain within a time-limited crisis placement. Practitioners also described strict admission criteria that excluded people whose needs did not fit neatly within program boundaries. As one provider explained, programs may be intended to help, but "*what happens is people just kind of float around; they can't get in.*"

Although these stakeholders represented different organizations and served different populations, they consistently described individuals who remained untreated because they could not access existing services when needed. Programs frequently operated with lengthy waiting lists, restrictive eligibility requirements, limited geographic coverage, insufficient staffing, or reimbursement structures that prevent providers from accepting additional referrals. Participants repeatedly distinguished between services that technically existed and services that were realistically available.

This distinction between services available on paper and actual access emerged repeatedly across both the interview data and supporting literature. Iowa has many of the components expected in a comprehensive behavioral health system, including outpatient treatment, crisis services, psychiatric hospitals, HCBS waivers, residential treatment, and community support programs. However, stakeholders consistently emphasized that the existence of these programs does not translate into meaningful access for people requiring services. Workforce shortages, reimbursement limits, geographic disparities, insufficient provider capacity, and prolonged waiting periods substantially reduce the practical availability of community-based care.

As a result, a mismatch emerges between what people need and what the community system can provide. Individuals deteriorate while seeking outpatient treatment, intensive supports, housing-linked services, or appropriate placements. Families assume increasingly intensive caregiving responsibilities. Providers exhaust available community options before a crisis system becomes involved.

State planning materials reinforce the access problem. The Iowa Mental Health and Disability Services Commission (2024) has identified persistent barriers involving service capacity, provider availability, rural access, and the sustainability of community-based services. These deficiencies mean that without access to

appropriate community supports, these resources cannot reliably prevent institutionalization or support timely return to the community.

This finding points to a general capacity problem. The remaining findings identify separate mechanisms that further reduce access, particularly through fragmented responsibility, a missing intermediate level of care, workforce and reimbursement constraints, and a system that concentrates resources after crisis rather than before.

Finding 2. Fragmentation Across Iowa's Behavioral Health System Prevents Individuals from Receiving Coordinated, Community-Based Care

A second structural problem is fragmentation. Individuals with behavioral health disabilities may interact with hospitals, community providers, crisis teams, disability services, Medicaid and managed care organizations, housing agencies, courts, law enforcement, and county systems. Despite this overlap across service providers, no single entity has designated responsibility or authority to coordinate the full course of care.

Practitioners described this problem directly. A psychiatry practitioner said one individual had become "*a hot potato that gets passed around,*" after this patient's service providers were unable to effectively coordinate care. Another provider described people with serious needs engaging "*10 different systems*" while "*those systems don't liaise with one another.*" These accounts describe a problem that is different from simple service scarcity. Services may exist in multiple sectors, but the person still lacks a coordinated pathway through them.

Fragmented authority can also prevent providers from acting even when the need is clear. In one youth case, an agency reported that Iowa and Illinois were "*both… pointing to the other as having responsibility.*" The provider was caring for the youth but could not arrange the next placement because "*only HHS can do that,*" while other shelters would not accept the youth without HHS placement authority. Responsibility was distributed across agencies, but responsibility for ensuring an actual transition was not.

Strict eligibility boundaries compound this problem. Individuals may qualify for one program but not another, face repeated and duplicative assessments, or encounter separate systems for mental health, substance use, disability, housing, and justice involvement. The result is disjointed referrals rather than coordinated care, leaving individuals and families to navigate multiple organizations, rules, and funding streams while needs continue to escalate.

Fragmentation therefore creates risk at the points where continuity matters most, especially during referral, transition, discharge, and transfer of responsibility. It can result in a list of services that provide a series of isolated transactions rather than a functioning continuum of care. This finding is distinct from capacity alone. Even where services exist, poor coordination and gaps in authority can prevent an individual from moving between them in a timely and productive way.

Finding 3. Iowa Lacks Sufficient Intermediate Levels of Care

Stakeholders repeatedly described a gap between traditional outpatient care and more restrictive settings such as emergency departments, inpatient hospitals, jails, or other institutional placements. Many individuals need more structure and higher treatment intensity than outpatient services can provide but do not require permanent institutionalization. Iowa's care continuum rarely offers an appropriate intermediate level of care for this population.

One practitioner called for "*a true subacute program*" for people with combined mental health and substance use needs, where a person could remain in a professional setting long enough to stabilize rather than being limited to brief crisis care. That practitioner also distinguished that recommendation from Iowa's existing framework, stating that although "*the code of Iowa says we have subacute,*" the definition is "*clinically wrong,*" and emphasizing that a 28- or 30-day program is not equivalent to sustained subacute treatment.

The consequences are especially obvious during transitions. After one individual spent three months in a highly restrictive hospital setting and moved to a less structured habilitation home, a provider reported that

"*even just the shock of that transition can make them symptomatic.*" The individual became "*very symptomatic within 48 hours*" and was discharged back to the emergency department. The problem extended beyond the absence of a discharge destination. It was the absence of an intermediate level of care capable of bridging such a stark transition safely.

Practitioners also described the need for alternatives that are "*secure and structured and humane*" while still providing quality-of-life and rehabilitative supports. Without options, systems are forced to choose between too little support and overly restrictive care. People may remain in hospitals because no step-down setting can meet their needs, enter emergency departments because outpatient care is insufficient, or end up in jail because the available community structure is inadequate.

Intermediate level care is a missing necessity for many patients. It is not a general shortage of services, as even a system with outpatient programs and hospital beds can fail people whose clinical needs fall somewhere between those two extremes. A functional care continuum requires step-up and step-down options that match intensity to need and support stabilization without unnecessary institutionalization.

Finding 4. Workforce Shortages and Reimbursement Barriers Limit Meaningful Access to Care

Nearly every stakeholder identified workforce shortages as one of the most significant barriers affecting Iowa's behavioral health system. One agency described an individual who required (and was approved for) 24-hour one-on-one support - whose care repeatedly broke down because "*staff were quitting. Left and right.*" The result was intermittent service rather than the continuous support that was needed and authorized. "*He wouldn't have service. He'd have service. He wouldn't have service. It wasn't consistent.*" A separate practitioner's account described an Integrated Health Home (hereinafter "IHH") provider operating at "*50% staffing,"* with three to four caseworkers in one year and no consistent caseworker, which disrupted relationship-building and continuity.

The evidence also identifies insufficient and rigid Medicaid service approval and reimbursement as a separate access mechanism. Practitioners reported that having or using Medicaid narrowed a patient's provider choices because "*most therapists*" were private and did not accept Medicaid, while free appointments were "*always full.*" In another case, Iowa Total Care (a Managed Care Organization that administers Medicaid) denied Intensive Residential Service Home (hereinafter "IRSH") care, refused payment for telehealth with an established psychiatrist, and approved only a distant placement, severing local access to continuity of care.

These accounts show how workforce and reimbursement interact. Low or insufficient payment can limit provider participation and recruitment; staff turnover can make authorized services unreliable, and managed-care decisions can make clinically appropriate care unavailable even when a provider relationship already exists.

State materials reflect the same concern. The Mental Health and Disability Services (hereinafter "MHDS") Commission (2024) has identified recruitment and retention as urgent statewide problems, particularly among Medicaid providers, and has linked inadequate rates to the state's ability to maintain sufficient staffing. These constraints affect both rural and urban areas and extend from licensed clinicians to frontline direct-care positions.

Workforce and reimbursement barriers therefore require separate attention from general service capacity. These findings explain why a program that appears available on paper may have no practical ability to accept, retain, or adequately support the people who need it.

Finding 5. Iowa's Behavioral Health System Responds to Crisis Rather Than Preventing Crisis

The timing of service delivery is an additional structural problem. Practitioners described a system in which the greatest concentration of resources often appears only after a person has deteriorated into a crisis involving

emergency medical services, law enforcement, hospitalization, detoxification, incarceration, or homelessness. Meanwhile, preventive and continuity-focused supports remain limited.

One practitioner's case summary characterized the pattern as "*chronic crisis-driven care,*" involving repeated cycles of ER, jail, detox, and residential treatment. That single case included 96 jailings since 2011, 717 EMS calls since 2011, and 35 emergency department visits since January 2024. While these figures cannot be used to generalize statewide estimates, they do illustrate how extensive downstream system involvement can become when repeated crisis intervention does not produce stabilization.

Other practitioners' observations described the same pattern in similar terms: "*repeated emergency interventions*" with jail or hospital admissions after a crisis. The "*greatest intensity of services post-crisis*" and "*minimal prevention or proactive support.*" Emergency medicine accounts described people being stabilized and discharged after recurrent presentations but with little long-term engagement capable of changing the trajectory.

This pattern matters because it is self-reinforcing. It initiates a cycle in which insufficient preventive treatment and support allow needs to worsen, worsening needs generate acute intervention, acute settings stabilize the immediate crisis, and discharge without sustained support leaves the conditions that produced the crisis largely unchanged. The system then pays again at the next emergency.

In summary, Finding 5 suggests that intensive public system involvement is often easiest to access after deterioration, whereas the services most likely to prevent that deterioration are less reliable, less intensive, or delayed.

Finding 6. Institutional Settings Increasingly Function as Substitutes for Community-Based Care

The cumulative effect of the preceding failures is a substitution problem. When treatment, housing, staffing, intermediate care, and coordinated supports are unavailable in the community, institutions and crisis systems assume functions they were not designed to perform. Emergency departments provide supervision while staff seek placement. Psychiatric hospitals may retain people after the acute phase of treatment because they cannot find an appropriate discharge option. Jails may provide medication, shelter, meals, routine, and observation that were unavailable in the community. Families and guardians may provide intensive unpaid support while formal services are delayed or inconsistent.

These settings differ substantially in purpose, yet the underlying theme remains the same. Needed support becomes available only after an individual enters crisis or a more restrictive environment. This does not make those settings appropriate substitutes for community care. It demonstrates that deficiencies throughout the care continuum are being absorbed by systems whose primary functions are emergency medicine, inpatient stabilization, custody, or informal caregiving.

This finding of inadequate preventative services creating spillover into familial, emergency and carceral settings serves as a bridge to the outcome sections that follow. Section III examines how the structural failures described above manifest in four distinct contexts: emergency department boarding, psychiatric hospital capacity, jail reliance, and delayed access to HCBS and housing.

System Outcomes

The structural deficiencies described above have consequences that extend well beyond delayed access to behavioral health treatment. Across interviews, literature, and Iowa-specific reports, the same deficiencies repeatedly resulted in individuals remaining in emergency departments, experiencing prolonged or repeated psychiatric hospitalizations, arrests, court hearings, and jail time and waiting for services necessary to live successfully in the community. These outcomes occur in different settings, but they reflect a common underlying problem, in which inaccessible community-based services result in individuals with disabilities increasingly being served in crisis and institutional settings instead.

Among the interview data coded for this investigation, recurring themes included worsening behavioral health symptoms, unnecessary system cycling, criminal legal exposure, homelessness, economic insecurity, and serious injury or death. The analysis also identified repeated use of hospitals, emergency departments, emergency medical services, and jails as a prominent concern.

Emergency Department Boarding

Emergency department boarding is a clear consequence of the structural deficiencies described in Section II. When outpatient treatment, crisis stabilization, supportive housing, intermediate levels of care, and psychiatric inpatient beds are inaccessible, individuals in behavioral health crises are routed to hospital emergency departments. Once there, they may wait for prolonged periods while medical staff identify an available treatment setting or community placement. Emergency departments are designed to evaluate and stabilize acute medical emergencies, not to function as long-term psychiatric treatment facilities. When individuals cannot be released to another setting after their immediate medical needs have been addressed, the emergency department becomes a holding environment rather than a source of treatment.

National research suggests that people seeking emergency care for mental health symptoms experience longer emergency department stays than people seeking care for physical health conditions. Using nationally weighted emergency department data from 2009 through 2015, Simko et al. (2022) found that 33% of mental health visits lasted longer than 6 hours, and 14% lasted longer than twelve hours. Mental health visits resulting in transfer had a median length of stay of 6.23 hours, with co-occurring psychiatric and substance use conditions associated with the longest stays (Simko et al., 2022).

The burden of particularly long emergency department stays is highly concentrated among people with behavioral health needs. In an analysis of one emergency department, patients with mental health diagnoses represented only 7% of all emergency department patients but 88% of those who stayed longer than twenty-four hours. Factors associated with these extended stays included the need for inpatient admission and transfer to a remote facility. The authors concluded that reducing barriers to psychiatric placement and improving access to appropriate inpatient care may shorten these exceptionally long emergency department stays (Stephens et al., 2014).

Iowa practitioners described the same underlying pattern. Community providers reported that individuals repeatedly returned to emergency departments because no durable community intervention followed stabilization. One provider described a situation in which law enforcement and mobile crisis repeatedly responded, and an individual went to emergency rooms "*dozens of times.*" Emergency medicine practitioners emphasized that the emergency department cannot substitute for sustained behavioral health treatment: "*We're not really there for long-term care.... We see a patient, stabilize them, and kind of send them on their way*."

Repeated emergency department care use is also not evidence of unrelated crises. National research across 18 acute-care hospitals found that patients with at least one primary psychiatric emergency department visit were 4.6 times more likely to be frequent emergency department users than patients without a psychiatric visit (Brennan et al., 2014). Frequent psychiatric users also frequently had significant medical comorbidities and substance use conditions, demonstrating the complexity of the population that repeatedly relies on emergency care.

Prolonged psychiatric boarding in emergency departments can harm individuals. A qualitative review of 17 North American studies identified recurring concerns involving interpersonal treatment, the emergency department environment, and broader system barriers (Navas et al., 2022). Patients described poor communication, stigmatizing treatment, long waits, inadequate accommodations, and traumatic experiences with restraints. Providers identified inadequate staffing, insufficient mental health training and psychiatric resources, weak discharge planning, and poor connections with community services. The American Psychiatric Association has also noted that emergency departments often lack the specialized psychiatric resources and treatment structure available in dedicated behavioral health settings, and that the overstimulating nature of the ED can worsen symptoms for some psychiatric patients (Nordstrom et al., 2019).

Boarding also affects the broader emergency care system. A boarded psychiatric patient continues to occupy treatment space and often requires nursing observation, physician reassessment, medication management, security or safety monitoring, and other staff resources, while the emergency department continues to respond to new emergencies. One Iowa emergency medicine practitioner emphasized this structural constraint: unlike other hospital services that may cap admissions, the emergency department "*can't say we're not taking*" patients and must continue treating gunshot wounds, heart attacks, and other medical emergencies regardless of existing behavioral health boarding demands.

Importantly, the evidence indicates that boarding cannot be solved solely within emergency departments. The American Psychiatric Association identifies insufficient inpatient capacity and failures throughout the broader behavioral health continuum as contributors to boarding, including inadequate outpatient treatment, crisis services, substance use treatment, supportive housing, and intermediate care (Nordstrom et al., 2019). Until the broader access and continuity issues are resolved, the emergency department services and workforce will continue to be utilized beyond its capacity - since those suffering mental health issues have no suitable alternatives.

Iowa's experience with an alternative psychiatric emergency model also demonstrates that the amount of boarding is not fixed or inevitable. A University of Iowa study examining the implementation of an Emergency Psychiatric Assessment, Treatment, and Healing (hereinafter "EmPATH") unit[1] found that median psychiatric boarding time declined from 212 minutes before implementation to 152 minutes afterward, while median psychiatric emergency department length of stay declined from 351 minutes to 334 minutes (Stamy et al., 2021).

Taken together, the evidence demonstrates that psychiatric boarding is not an emergency department operations problem; it is a downstream consequence of insufficient behavioral health capacity across the continuum. When individuals cannot obtain timely community treatment, crisis stabilization, appropriate inpatient care, or discharge placements, emergency departments become the default setting in which the system's unmet behavioral health needs accumulate.

Psychiatric Hospital Capacity

Limited psychiatric hospital capacity is another outcome of Iowa's broader behavioral health infrastructure deficiencies. Capacity cannot be understood solely by the number of psychiatric beds a facility is licensed to operate. A bed that cannot be staffed is not a bed available to an emergency department seeking placement, nor is it available to an individual requiring inpatient psychiatric treatment.

Iowa-specific information compiled in January 2026 identified 909 licensed inpatient psychiatric beds statewide but only 764 staffed beds, leaving 145 licensed beds that were unstaffed and unavailable (Iowa Inpatient Psychiatric Bed Program Update, January 2026). The entire difference occurred among community hospitals: 817 community hospital beds were licensed, while 672 were staffed. Iowa's two Mental Health Institutes reported 92 licensed and 92 staffed beds (Iowa Inpatient Psychiatric Bed Program Update, January 2026).

The difference between licensed and staffed capacity was substantial at several hospitals. Clive Behavioral Health reported 134 licensed beds and 88 staffed beds. St. Luke's Methodist Hospital reported 72 licensed and

[1] The EmPATH unit transitions patients experiencing acute mental health crisis to a specialized stabilization unit which prevents ER boarding and equips patients with a coordinated discharge plan to sustained supports.

42 staffed beds. Iowa Lutheran Hospital reported 68 licensed and 50 staffed beds. University of Iowa Hospitals and Clinics reported 88 licensed and 73 staffed beds. MercyOne Siouxland Medical Center reported 14 licensed beds and six staffed beds (Iowa Inpatient Psychiatric Bed Program Update, January 2026). These data illustrate why licensed-bed totals alone can overstate the psychiatric capacity actually available when emergency departments and other providers seek placement.

National state-level data provides additional context. The National Association of State Mental Health Program Directors Research Institute (2023) reported that, in fiscal year 2022, states averaged 12.3 state psychiatric hospital patients per 100,000 residents on the first day of the fiscal year. Iowa reported 2.1 per 100,000, the lowest rate among the states reported in that analysis. Thirty-seven states reported shortages of inpatient psychiatric beds, which resulted in state hospital admission, non-state hospital admission, emergency department care, and jail-based waits as consequences of those shortages (NRI State Profiles, 2023–2024). Iowa's low rates of psychiatric patients should not be misconstrued as low need for admission, rather, these rates should be interpreted within the context of the system's insufficient capacity to meet demand.

The interviews illustrate what limited placement capacity looks like at the individual level. One provider described an individual who remained hospitalized for eight months "*because nowhere in the state will take him*." The provider emphasized that the problem extends beyond the hospital itself and includes inadequate support for transitioning back into the community.

Limited community-based support capacity also results in repeated, preventable inpatient hospital use when community stabilization is not achieved. A psychiatrist described one individual who was hospitalized "*at least a half a dozen times*" within a year, with early admissions averaging roughly a month. Another mental health agency described a "*revolving door*" in which people are repeatedly treated and discharged without adequate planning or sustained community support.

These accounts demonstrate that psychiatric capacity is affected at both entry and exit. Scarce inpatient resources are consumed when individuals cannot obtain timely treatment before crisis, when people who need admission cannot access an appropriately staffed bed, when discharge-ready patients cannot leave safely, and when unsuccessful transitions lead to readmission. Psychiatric hospital capacity is therefore not simply a question of how many beds Iowa licenses. It depends on whether beds are staffed, clinically appropriate, and supported by a community continuum capable of preventing avoidable admissions and sustaining discharge.

JAIL RELIANCE

The same deficiencies that place pressure on emergency departments and psychiatric hospitals also shift behavioral health needs into the criminal legal system. Interview participants repeatedly described county jails as providing structure, medication access, shelter, supervision, or behavioral stabilization to individuals who lacked comparable supports in the community.

One jail practitioner explained: "*When people [with] mental health issues come to jail. And all of a sudden, now they have structure. They have a roof over their head, 3 meals, showers, medicine, and people to talk to.... You really see people start being successful and striving. And then the second all that's taken away when they get released to the streets, or even a shelter house....*"

A psychiatrist similarly described an individual who characterized incarceration as "*a break*" because he had "*a place to stay for three months*," three meals a day, and people providing daily direction.

These accounts do not suggest that incarceration is an appropriate behavioral health intervention. Instead, they demonstrate that jail is used as a substitute for basic needs that should be available but are realistically unavailable in the community. Practitioners described institutional settings, including jails and hospitals, as temporarily supplying housing, medication, supervision, safety, and structure because supported housing, intensive case management, intermediate residential care, trauma-informed services, and individualized supports were unavailable or inaccessible.

The consequences become especially apparent at reentry. Iowa's Judicial District 6 practitioners described individuals leaving jail or the Iowa Medical Classification Center without adequate aftercare planning or

medication continuity. One practitioner explained that an individual leaves without prescriptions, does not remain on medication, "*ends up back in jail*," and may return to homelessness, including "*living under a bridge*."

Iowa program data also verifies the inverse relationship between community support and criminal legal involvement. The FY2025 Polk County MHDS Integrated Services Outcomes Evaluation identifies reducing jail days as an outcome of providing adequate community supports. It reports that some program participants spent extended periods in jail because of competency-restoration delays or lack of placement options. The report also identifies jail-diversion programs and mobile crisis services as important for reducing justice involvement.

Jail reliance cannot be understood solely as a criminal justice outcome. The interview and program evidence demonstrate circumstances in which incarceration intersects directly with the absence of behavioral health treatment, housing, medication continuity, placement capacity, and structured community support. When those supports disappear at release, the conditions that contribute to crisis and criminal legal involvement can reemerge immediately.

Waitlists and Delayed Access to Community Services

HCBS and stable housing are different from emergency or inpatient services, as their purpose is to make community living possible over time. To access comprehensive services at the appropriate level to accommodate disabilities, Iowans need to apply for and be approved for a disability waiver. When these supports are delayed for months or years, the consequences range from people remaining dependent on family caregivers, losing housing stability, deteriorating while waiting, or remaining in more restrictive settings because the supports required for community living are not available when needed.

Iowa's disability waiver data (2025) illustrate the scale of delays. In 2025, people receiving Brain Injury Waiver services had applied as early as 2017. Reported wait times were approximately eight years and one month for the Brain Injury Waiver, five years and seven months for the Health and Disability Waiver, four years and seven months for the Intellectual Disability Waiver, one year and nine months for the Physical Disability Waiver, and more than one year for the Children's Mental Health Waiver. These timelines demonstrate that formal eligibility for a community-based program does not necessarily translate into timely access to the service itself.

Housing creates a separate but closely related barrier. Provider materials identified a shortage of stable, affordable units that met basic quality standards, were located near transportation, and accepted Section 8 vouchers. Providers also described application barriers including high credit-score requirements, proof of income equal to three times monthly rent, eviction or criminal-history screening, deposits, and application fees. Agencies reported using flexible funding sources to address housing needs but described those resources as limited and sometimes exhausted before demand was met.

The interaction between HCBS and housing is especially important for people with significant behavioral health or disability-related support needs. A waiver service cannot support community integration if the individual lacks a viable place to live. Housing alone may also be insufficient if the person cannot obtain the staffing, case management, behavioral support, transportation, or other services needed to maintain that housing. In practice, access depends on both components being consistently available at the same time.

This section therefore presents a different outcome from the acute-care problems described above. ER boarding, hospitalization, and jail reliance are visible crisis events. HCBS and housing delays are the less visible upstream and downstream conditions that can make those crisis events more likely and make discharge from restrictive settings more difficult. The relevant measure is not whether Iowa has waiver programs or housing resources in the abstract, but whether people can obtain the combination of supports necessary to live safely and stably in the community when they need them.

Cumulative Impact

The significance of these findings lies both in the harm created within any single service system, and in how deficiencies in one part of the continuum transfer need, cost, and responsibility to another. When community treatment, HCBS, housing, or crisis alternatives are unavailable, emergency systems absorb the resulting crisis. When emergency departments cannot identify an appropriate next setting, boarding increases. When hospitals cannot discharge people to adequately supported settings, the already scarce inpatient capacity remains occupied. When treatment, housing, and disability supports remain unavailable in the community, law enforcement and jails increasingly encounter the resulting instability. The built environment of jails and their staff are not equipped in the capacity or training to provide the specialized, long-term treatment the chronic condition of Serious Mental Illness requires; creating conditions conducive to workforce burnout and strained resources.

This process creates a self-reinforcing cycle. Public resources are repeatedly consumed in managing downstream emergencies, while the community services capable of preventing or shortening those emergencies remain insufficient. Hospitals, EMS, law enforcement, jails, families, and individual providers consequently absorb responsibilities that originate elsewhere in the behavioral health and disability service continuum.

For individuals with disabilities, the cumulative harm extends beyond repeated service utilization. Movement through emergency departments, hospitals, jails, shelters, streets, and short-term placements can disrupt housing, medication continuity, treatment relationships, employment, family connections, and participation in community life. Each transition may also make the next community placement more difficult by adding new instability, trauma, legal involvement, or loss of supports.

The record therefore presents a broader concern than any isolated shortage of psychiatric beds, HCBS slots, housing, or crisis programs. Iowa’s continuum can fail at both ends of institutional care. It may not provide sufficient community support to prevent avoidable entry into restrictive settings, and it may not provide the services necessary to facilitate successful return to the community. These combined failures create a foreseeable risk of repeated institutional involvement, even when community-based support could interrupt the cycle.

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