



2025 Iowa Health and Wellbeing Survey: District Assessment Report

Prepared for
Iowa Department of
Health and Human Services

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The *2025 Iowa Health and Wellbeing Survey Final Report: Methodology and Data Tables*, which includes detailed methodology, data tables, and bivariate analysis for all questions by behavioral health districts, is available upon request.

Disclaimer:

The contents are solely the responsibility of the authors and do not necessarily represent the official views of the Iowa HHS or the University of Northern Iowa.

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Table of Contents

Background and Methodology	1
Methodology	1
Measures	2
Survey Completions	2
Unweighted Respondents' Demographics.....	3
Coding Text Entries.....	3
Weighting and Population estimates	3
Analysis Plan.....	4
SECTION A. Overall Health and Quality of Life.....	5
Overall health	5
Quality of life.....	6
SECTION B1. Awareness of Behavioral Health Services.....	7
Awareness of counseling or treatment services	7
Awareness of Your Life Iowa	8
Awareness of 1-800-BETS-OFF	9
Awareness of Quitline Iowa for tobacco and nicotine cessation	10
Awareness of 988 Suicide and Crisis Lifeline.....	11
Awareness of the State Behavioral Health Service System	12
SECTION B2. Cancer: Perceptions of Risk and Prevention.....	14
Perceptions of risk of developing cancer.....	14
Source of information about risk of cancer	16
Preventive measures to avoid or reduce cancer risk.....	17
Respondents' experience with cancer.....	18
SECTION C. Help seeking and access to care	19
Resources for mental health crisis or emergency.....	19
Resources for substance use crisis or emergency	20
A time that respondents needed to talk or seek help.....	21
Awareness of naloxone and perceptions about substance use treatment services	24
SECTION D. Use of Substance, Mental Health, and Gambling.....	26
Substance use and behaviors	26
Past substance use and recovery	27
Tobacco or nicotine use.....	27
Flavored vape or nicotine product use	28
Quit attempts from tobacco and nicotine products in the past 12 months.....	29
Nicotine replacement.....	30

Indoor/home vaping or use of e-cigarettes	30
Any gambling behavior in the past 12 months.....	31
Mental health	32
Perceived stigma	35
Summary and Conclusions	36

List of Figures

Figure 1. Number of sample addresses by BHD	1
Figure 2. Survey completions by BHD	2
Figure 3. Overall health status in the past 30 days and last preventive care in the past 12 months	5
Figure 4. Average quality of life index (state and by BHD)	6
Figure 5. Awareness of substance use counseling or treatment services (state and by BHD).....	7
Figure 6. Awareness of mental health counseling or treatment services (state and by BHD)	7
Figure 7. Awareness of gambling counseling or treatment services (state and by BHD).....	7
Figure 8. Ever seen or heard of Your Life Iowa (state and by BHD).....	8
Figure 9. Most common sources where they have seen or heard of Your Life Iowa (state).....	8
Figure 10. Seen or heard of 1-800-BETS-OFF (state and by BHD).....	9
Figure 11. Most common sources where they have seen or heard of 1-800-BETS-OFF (state).....	9
Figure 12. Seen or heard of Quitline Iowa (state and by BHD).....	10
Figure 13. Contacted Quitline Iowa (state).....	10
Figure 14. Seen or heard of 988 Suicide and Crisis Lifeline (state and by BHD).....	11
Figure 15. Most common sources where they have seen or heard of 988 Suicide and Crisis Lifeline (state)	11
Figure 16. Ever contacted 988 Suicide and Crisis Lifeline (state).....	12
Figure 17. Seen or heard of Behavioral Health Service System (state and by BHD).....	12
Figure 18. Most common sources where they have seen or heard of Behavioral Health Service System (state)	13
Figure 19. Top exposures and behaviors perceived by respondents as increasing a person’s risk of developing cancer.....	14
Figure 20. Exposures and behaviors with lowest perceived risk (<i>none</i> or <i>low</i>) of increasing a person’s risk of developing cancer	15
Figure 21. Sources of information where respondents may have seen or heard about the behaviors and exposures that increase the risk of developing cancer.....	16
Figure 22. Most common preventive measures respondents indicated as very likely for them to take to avoid or reduce their risk of developing cancer	17
Figure 23. Respondent ever diagnosed with cancer (state and by BHD)	18
Figure 24. Household member ever diagnosed with cancer (state and by BHD).....	18
Figure 25. Resources that respondents feel ‘very comfortable’ contacting for assistance during a mental health crisis or emergency	19
Figure 26. Resources that respondents feel ‘very comfortable’ contacting for assistance during a substance use crisis or emergency.....	20
Figure 27. Alcohol use: needed to talk or seek help (state and by BHD) and received the needed care (state)	21
Figure 28. Tobacco or nicotine use: needed to talk or seek help (state and by BHD) and received the needed care (state).....	21
Figure 29. Legal substance use: needed to talk or seek help (state and by BHD) and received the needed care (state).....	22
Figure 30. Illegal substance use: needed to talk or seek help (state and by BHD) and received the needed care (state).....	22
Figure 31. Mental health: needed to talk or seek help (state and by BHD) and received the needed care (state)	23
Figure 32. Gambling: needed to talk or seek help (state and by BHD) and received the needed care (state)	23
Figure 33. Awareness of naloxone and perceptions of substance use of treatment services of those who somewhat or strongly agree	24

Figure 34. Awareness of naloxone and perceptions of substance use treatment of those who strongly disagree.....	25
Figure 35. Past 30 days substance use or behavior.....	26
Figure 36. Recovery from past substance use or behavior (state and by BHD)	27
Figure 37. Current tobacco and nicotine product use	27
Figure 38. Current (some days or every day) use of any tobacco or nicotine products (state and by BHD).....	28
Figure 39. Ever used flavored vape or nicotine products (state and by BHD).....	28
Figure 40. Use of tobacco or nicotine products and quit attempts among all respondents	29
Figure 41. Use of tobacco or nicotine products and quit attempts among those who had used these products in the past 12 months	29
Figure 42. Use of nicotine replacement therapy (state and by BHD).....	30
Figure 43. Indoor use of vapes or e-cigarettes (state and by BHD).....	30
Figure 44. Any gambling behavior (state and by BHD).....	31
Figure 45. Respondents who felt sad or hopeless (state and by BHD).....	32
Figure 46. Respondents who engaged in any form of non-suicidal self-injury or self-harm such as cutting (state and by BHD).....	32
Figure 47. Respondents who reported suicidal thoughts (state and by BHD).....	33
Figure 48. Made a plan or attempted suicide (state)	33
Figure 49. Respondents who were told by health care professionals that they have a depressive disorder (state and by BHD).....	34
Figure 50. Respondents who consider themselves in recovery from past mental illness (state and by BHD).....	34
Figure 51. Respondents' perceived stigma	35

List of Acronyms

AAPOR	American Association for Public Opinion Research
ARNP	Advanced Registered Nurse Practitioner (ARNP)
ABS	Address based sampling
BHD	Behavioral Health Districts
CBD	Cannabidiol (as primary non-psychoactive component found often in hemp)
CSBR	Center for Social and Behavioral Research
HHS	Iowa Department of Health and Human Services
MICE	Multivariate imputation by chained equations
PA	Physician's assistant
QoL	Quality of Life
RR	Response rate
THC	Tetrahydrocannabinol (as primary psychoactive cannabinoid found in cannabis)
TV	Television
UNI	University of Northern Iowa
YLI	Your Life Iowa

Background and Methodology

The 2025 Iowa Health and Wellbeing Survey was conducted by the Center for Social and Behavioral Research (CSBR) at the University of Northern Iowa (UNI) and funded by the Iowa Department of Health and Human Services (Iowa HHS).

The primary purpose of this survey was to collect data from adult Iowans (age 18 and older) to assess their health and wellbeing, awareness of state programs, substance use and gambling behaviors, cancer risk perceptions, mental health, and risk of suicide. Some of these items were asked for the first time while others were included on previous statewide surveys on gambling and substance use¹.

This is the first statewide survey of Iowa adults that gathered health-related information from the newly established seven Behavioral Health Districts (BHD) in the state. The survey provides baseline data in which to evaluate changes on the various metrics. The findings from this study will be used to plan and implement services across the state to inform policy and support prevention and treatment programs.

METHODOLOGY

The survey used a stratified (by BHD) probability Address Based Sampling (ABS) frame. These addresses were randomly selected from the United States Postal Service delivery sequence file to ensure representativeness of the findings in each BHD. Four thousand addresses were randomly sampled from each of the seven BHD for a total of 28,000 addresses in the statewide sample (see Figure 1). This design allowed for a sufficient number of completed surveys in each BHD to produce both statewide and BHD-level estimates.

Selected households were invited by mail to participate (using up to 3 mailing reminders and questionnaire packets) in a concurrent mixed-mode survey (web and self-administered mail-back questionnaire). To increase response rates, respondents were offered a \$5 gift card contingent upon completion of the questionnaire.

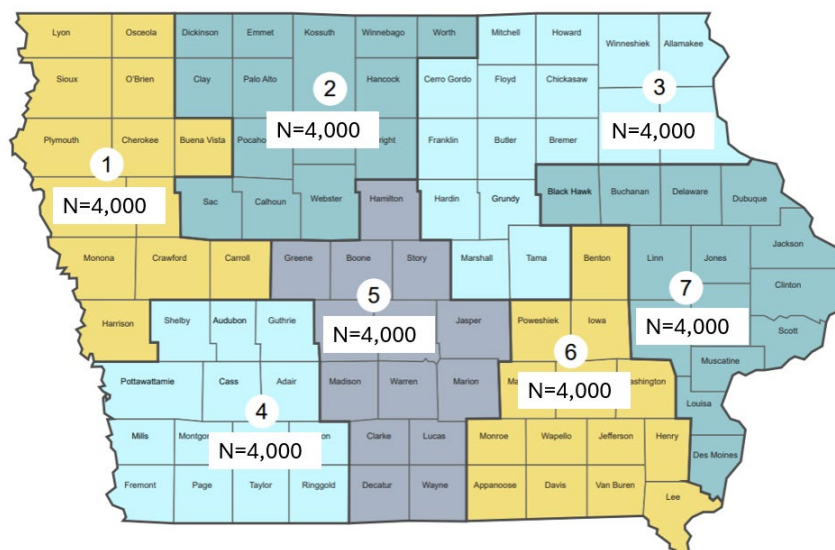


Figure 1. Number of sample addresses by BHD

¹ Park, K., Radunzel, J., Endres, K., & Losch, M.E. (2022). 2021 Iowa Health, Wellbeing, Use of Substances and Gambling Survey. Cedar Falls, IA: Center for Social and Behavioral Research, University of Northern Iowa.

The data collection activities began on October 15, 2025, with the first mailing that contained a paper questionnaire booklet, a letter that provided a unique, address specific, shortened URL and QR code to the online survey, and postage-paid business reply envelope. Two subsequent postal mailings with reminder letters were sent on October 31st and November 13th to those who did not respond to prior mailings. The data collection ended on December 23rd for the web survey. Completed questionnaire booklets were accepted until December 30th to allow mail processing time.

MEASURES

The survey was grouped into six sections and collected information regarding wellbeing and quality of life, awareness of resources and risk perceptions, help seeking and access to care, use of substances and gambling, mental health, and demographic characteristics of the respondents.

SURVEY COMPLETIONS

The survey yielded 3,890 total completions across the state. The completions ranged from 506 in BHD5 to 676 in BHD3 (see Figure 2). There were responses from all 99 counties in Iowa ranging from 1 to 260 responses.

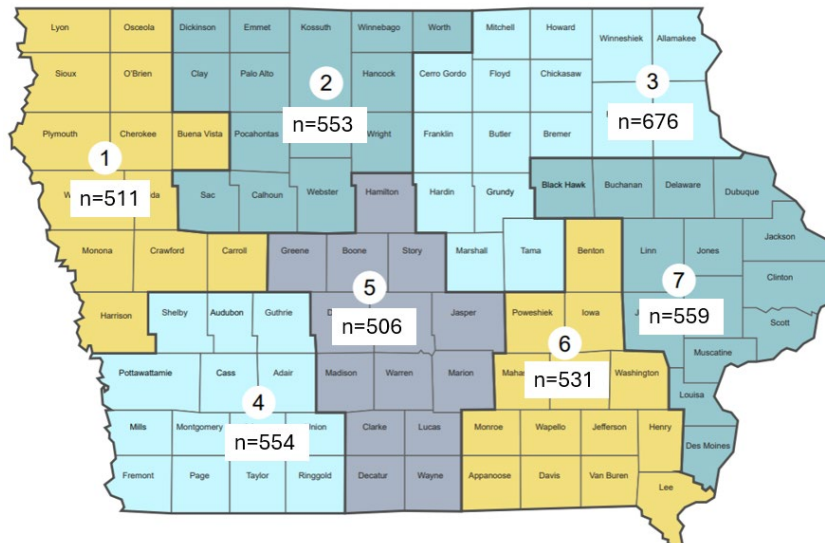


Figure 2. Survey completions by BHD

The paper questionnaires were double entered in digital text formats, compared between the text files, and cleaned where discrepancies existed. This dataset was then combined with the one from the web survey. Duplicates were removed from the combined dataset (paper and web) based on the ID numbers and date of completion. Several cases were also dropped because their responses were empty or incomplete with completion being defined as 50% of all questions being answered. The final number of respondents for the state was 3,890 after duplicate and incomplete cases were removed from the initial 3,993 total records received. The overall response rate (AAPOR RR2) was 14.6% and ranged from 13.3% for BHD5 to 17.7% for BHD3.

UNWEIGHTED RESPONDENTS' DEMOGRAPHICS

The age of respondents was skewed toward older age groups, and there were more female (67%) than male respondents, which is typically the case for general population surveys. Most of the respondents reported that they were white (96%), and two percent of the respondents reported that they were Hispanic/Latino.

CODING TEXT ENTRIES

There were 7 questions with short open-ended responses asking respondents to list the places where they have seen or heard of available resources in Iowa such as Your Life Iowa (YLI) or helplines such as 988. These text responses were reviewed and tallied into common categories, and a second coder verified these assignments. Discrepancies were addressed and a final dataset was created for analysis.

WEIGHTING AND POPULATION ESTIMATES

For analyses, the data were weighted to mirror the Iowa adult population and each of the BHDs on key characteristics including age, sex, race/ethnicity, and education.² These weighted data help adjust for any areas of over- or underrepresentation in the sample and are used to generalize the sample findings to those of the statewide and BHD population of adult Iowans. Descriptive statistics, including frequencies and distributions, are reported for the total sample and across BHDs in figures by topic throughout the report. Frequency tables of survey responses can be made available upon request.

Prior to determining the weights, missing values for variables used in the weighting were imputed based on a multivariate imputation by chained equations (MICE) procedure.³ The post-stratification weights were computed with SUDAAN (see www.rti.org/sudaan; RTI International, 2012). The use of weighted data will help to adjust for the survey design effects and for any areas of over- or underrepresentation in the samples. Response rates were calculated using the American Association for Public Opinion Research (AAPOR) response rate formulas.⁴

Study limitations and data comparability

Survey research, like all research, has limitations. Survey data collection may be subject to coverage error, sampling error, unit-level nonresponse, item-level nonresponse, measurement error, and survey mode effects (see Weisberg 2005, 2018).⁵ In addition, other types of error may be introduced during the analysis and interpretation stages by researchers using the data.

The Iowa Health and Wellbeing Survey (IHWB) and Behavioral Risk Factor Surveillance System (BRFSS) surveys are both population-based surveys utilizing probability samples. The IHWB used randomly selected addresses, while the BRFSS utilizes randomly generated landline and cellphone numbers. Both surveys provide data on attitudes, behaviors, and experiences. Briefly the IHWB is a confidential online and mail-in survey of Iowan adults that was conducted between the months of

² Education was only considered in weighting at the state level.

³ Van Buuren, S., & Groothuis-Oudshoorn, K. (2011). mice: Multivariate Imputation by Chained Equations in R. *Journal of Statistical Software*, 45(3), 1–67. <https://doi.org/10.18637/jss.v045.i03>

⁴ American Association for Public Opinion Research. (2023). *Standard definitions: Final dispositions of case codes and outcome rates for surveys*. <https://aapor.org/wp-content/uploads/2023/05/Standards-Definitions-10th-edition.pdf>

⁵ Weisberg, H. F. (2005). *The Total Survey Error Approach: A Guide to the New Science of Survey Research*. University of Chicago Press.

Weisberg, H. F. (2018). Total survey error. In Atkeson, L.R., and Alvarez, R.M. (Eds.), *The Oxford Handbook of Polling and Survey Methods*, 13-27.

October-December 2025; on the other hand, the BRFSS is a confidential telephone survey of adults administered throughout the whole calendar year.

The IHWB and BRFSS are complementary surveys. These surveys provide comparable, but not identical, results of select measures that overlap both surveys. Differences could be explained by different methodologies and differing questions. Because each survey provides some unique information, monitoring the results of all is necessary to fully understand behaviors and experiences. The BRFSS is used to track state progress for the state health assessment and improvement plan as well as the HHS service systems' state plans strategies and outcomes. The IHWB is used to inform Iowa HHS on overall awareness of behavioral health services, such as 988, Quitline, Your Life Iowa, among others, tracks select risk behaviors complementary to BRFSS, and establishes baseline stigma associated with seeking behavioral healthcare.

ANALYSIS PLAN

Descriptive statistics, including frequencies and distributions, were computed for all key questions for the total state sample and for each BHD sample. IBM SPSS Statistics 31 was used for initial data management and descriptive analyses. SUDAAN v 11.0.3 was used to determine the similarities and differences between state and BHD region estimates. Analyses conducted in SUDAAN have been adjusted for the design effect due to differential probabilities of selection, clustering and weighting. Further explanation of SUDAAN procedures can be found at www.rti.org/sudaan. Chi-square and descriptive procedures were conducted within SUDAAN to determine whether the response percentages differed significantly among the BHDs. The significance level was set at 0.05 (or 5%) for all statistical tests. Margin of sampling error (MOE), considering the design effect, ranged from $\pm 2.5\%$ for state estimates to $\pm 15.5\%$ for estimates using the smallest subgroups in BHDs. Differences in responses across the BHDs are mentioned within the text of the report only when the findings are statistically significant.

Percentages were rounded to the nearest whole number; therefore, percentage totals may not sum to 100% for some of the respondents' characteristics. Unless otherwise noted, percentages reported in all charts and figures and all survey items described in the report are from cued responses (i.e., closed-ended questions). Percentages and *n* counts in the tables are labeled "Valid" to indicate that they are calculated from those who responded to the questions and not from the full sample if those denominators differ. In addition, zero percent was only used when the actual value was 0, and <1% indicates the percentage in that category was below 0.5% and greater than 0%.

SECTION A. Overall Health and Quality of Life

Overall health

Overall health was measured with self-reported physical and mental health status in the past 30 days. In addition, the survey asked about the latest check-up or health physical received by the respondent from a doctor, physician's assistant (PA), or nurse practitioner (ARNP).

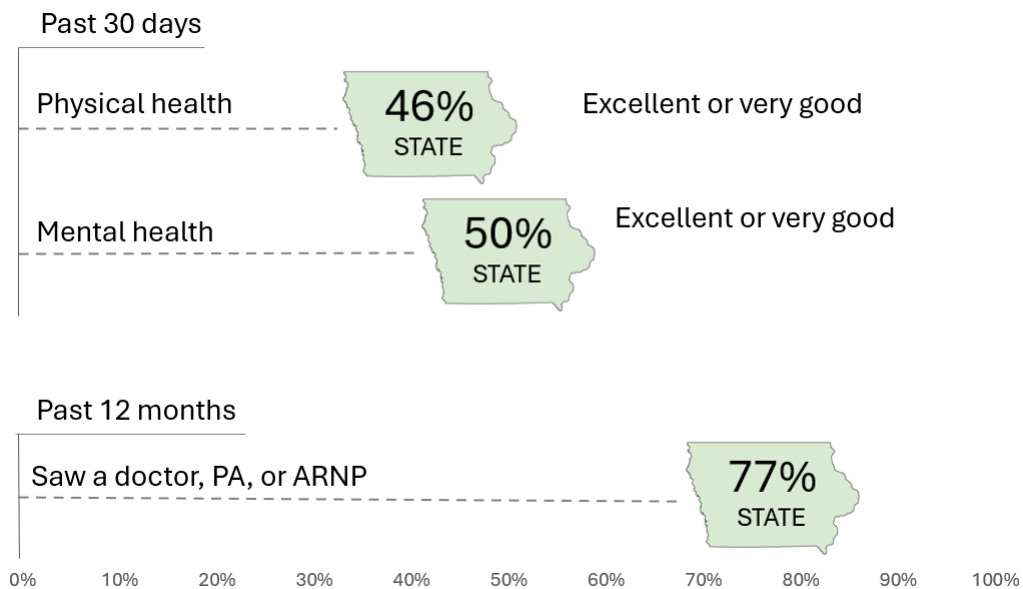


Figure 3. Overall health status in the past 30 days and last preventive care in the past 12 months

About half of adult lowans reported either 'excellent' (12%) or 'very good' (34%) physical health in the past 30 days (see Figure 3).

Similarly, about half of adult lowans indicated either 'excellent' (20%) or 'very good' (30%) mental health in the past 30 days.

About eight in 10 adult lowans (77%) saw a doctor, physician's assistant (PA), or nurse practitioner (ARNP) for a check-up, also called a health physical, within the last 12 months. In addition, about one in 10 adult lowans saw a doctor, PA or ARNP between 12-24 months (12%), or more than 24 months ago or never (12%).

Quality of life

Quality of life (QoL)⁶ was assessed with eight items. The QoL index ranges from one to five with a higher index value indicating better perceived QoL. State average QoL index value was 3.9 (see Figure 4 for BHD estimates).

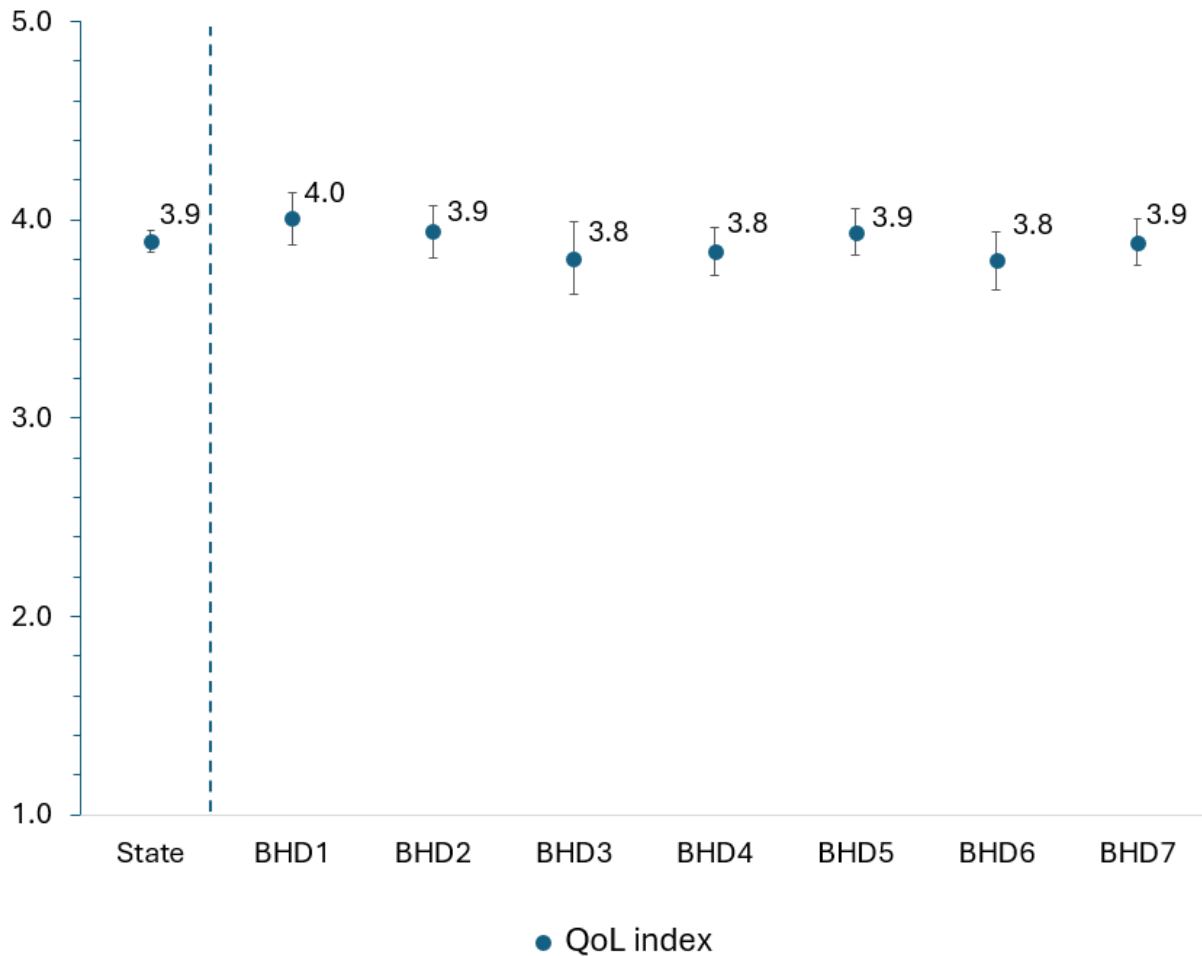


Figure 4. Average quality of life index (state and by BHD)⁷

⁶ Schmidt, S., Mühlhan, H., & Power, M. (2006). The EUROHIS-QOL 8-item index: psychometric results of a cross-cultural field study. *The European Journal of Public Health, 16*(4), 420–428. <https://doi.org/10.1093/eurpub/cki155>

⁷ The error bars in Figure 4 represent the 95% confidence intervals for the mean quality of life index.

SECTION B1. Awareness of Behavioral Health Services

Awareness of counseling or treatment services

The survey gauged awareness of behavioral health services. Specifically, respondents were asked about counseling or treatment services for substance use, mental health, and gambling in their area.

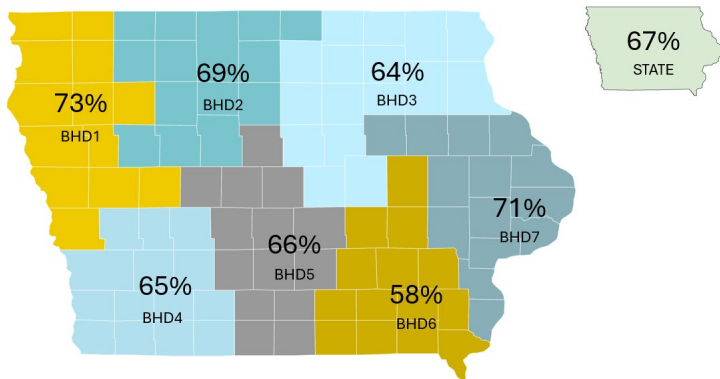


Figure 5. Awareness of substance use counseling or treatment services (state and by BHD)

Two in every three adults in the state (67%) were aware of substance use counseling or treatment services in their area. This level of awareness for each of the BHDs is shown in Figure 5.

About three in four adult lowans (76%) were aware of mental health counseling or treatment services in their area. This level of awareness for each of the BHDs is shown in Figure 6.

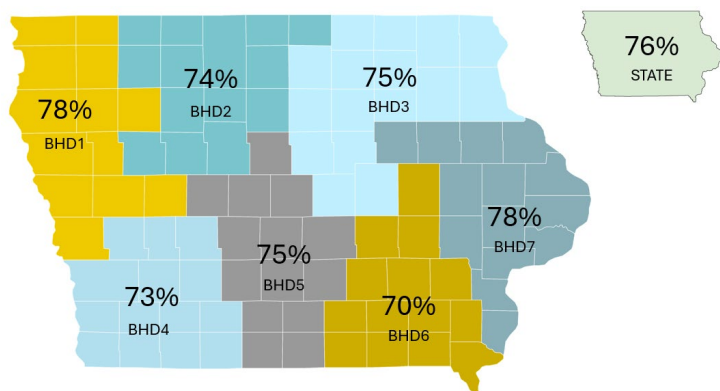


Figure 6. Awareness of mental health counseling or treatment services (state and by BHD)

About six in ten adult lowans (58%) were aware of gambling counseling or treatment services in their area. This level of awareness differed significantly across the BHDs such that the lowest level of awareness was 46% in BHD6 and the highest level of awareness was 63% in BHD7 (see Figure 7; $p \leq 0.05$).

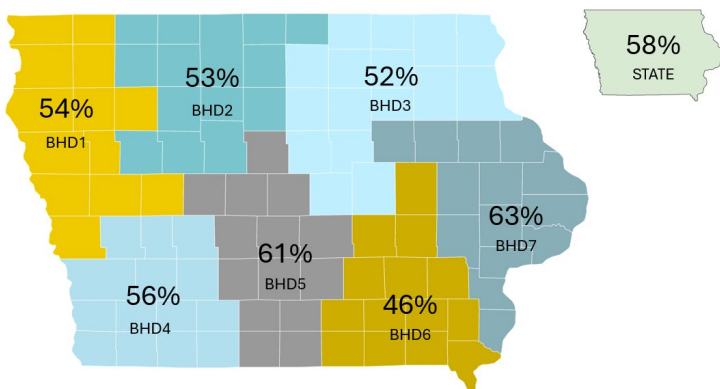


Figure 7. Awareness of gambling counseling or treatment services (state and by BHD)

Awareness of Your Life Iowa

When asked if they have ever ‘seen’ or ‘heard’ of Your Life Iowa (YLI), about one in 10 adult Iowans (9%) indicated that they have seen or heard of it (see Figure 8). While low, this is a 5-percentage point increase from the 2021 survey where 4% of respondents reported they had ever seen or heard of YLI.

A follow-up question asked where⁸ they had seen or heard about YLI; television (TV) and doctor office/family/friends were the most common responses (both at 2%). There were 11 other tallied categories with 1% or less.

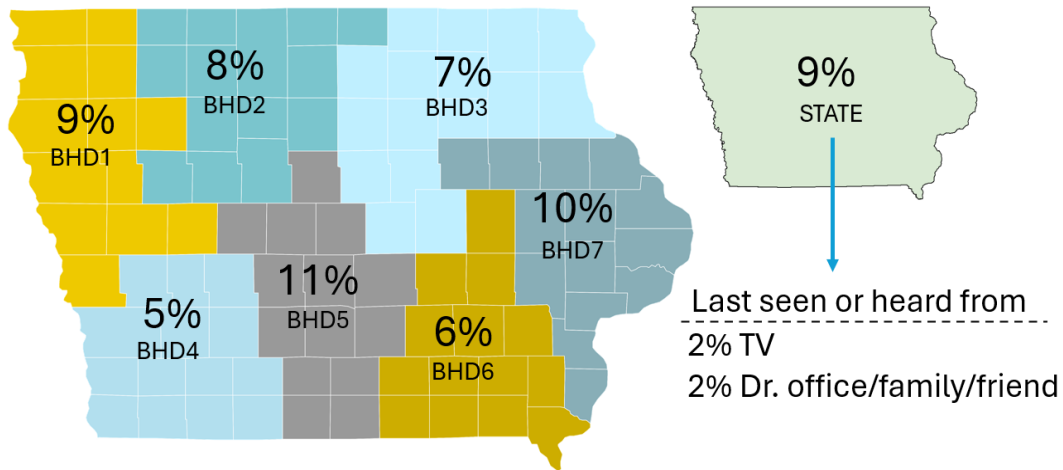


Figure 8. Ever seen or heard of Your Life Iowa (state and by BHD)

Among those who have ever seen or heard of YLI (9%), about one in five (21%) reported that they had last seen or heard of it on TV, followed by doctor’s office or family or friend (17%) and YouTube or other online sources (14%) (see Figure 9).

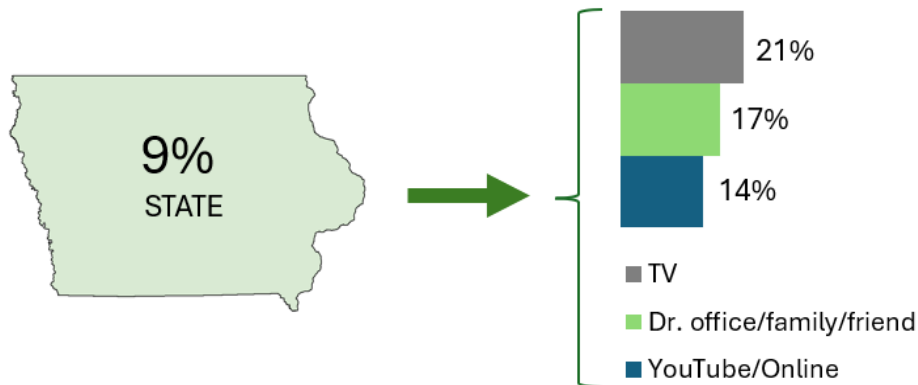


Figure 9. Most common sources where they have seen or heard of Your Life Iowa (state)

⁸ The responses were short open-ended responses which were tallied into 13 categories: Radio or podcast, TV, Billboard, Facebook or Social Media, YouTube or online (not specific), ads or commercials (not specific), a time frame reference only, print and news (not specific), location (e.g. work, school, gas station), family/friend or organization (e.g. clinics), newspaper, other, and don’t remember/don’t know.

Awareness of 1-800-BETS-OFF

About eight in 10 adult lowans (82%) reported that they have ever seen or heard of 1-800-BETS-OFF (see Figure 10). A follow-up question asked where⁹ they had last seen or heard about the problem gambling helpline.

TV (32%) and radio (15%) were the most common responses followed by on a billboard (8%), in ads (unspecified source: 8%) and in casinos (5%). There were ten other tallied categories with 4% or less.

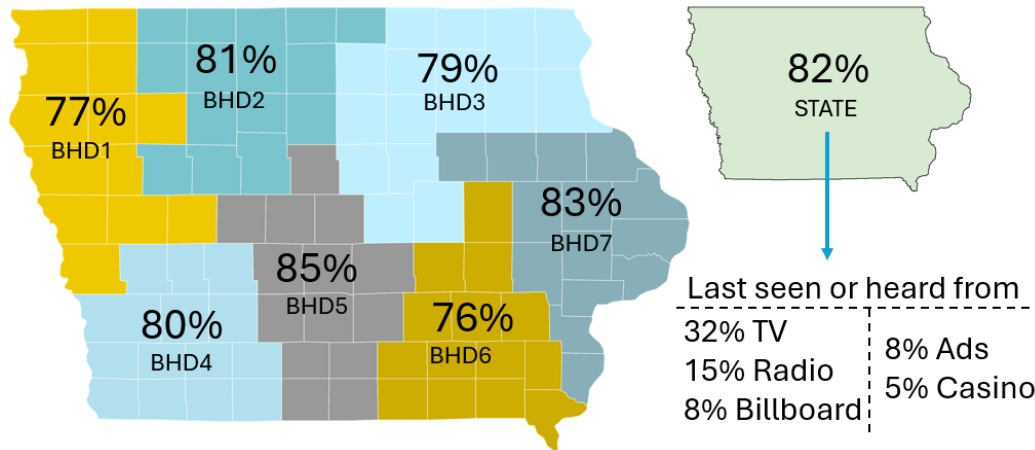


Figure 10. Seen or heard of 1-800-BETS-OFF (state and by BHD)

Among those who have ever seen or heard of 1-800-BETS-OFF (82%), about four in 10 (39%) reported that they had last seen or heard of it on TV, followed by radio (18%), ads, and billboards (10%) (see Figure 11).

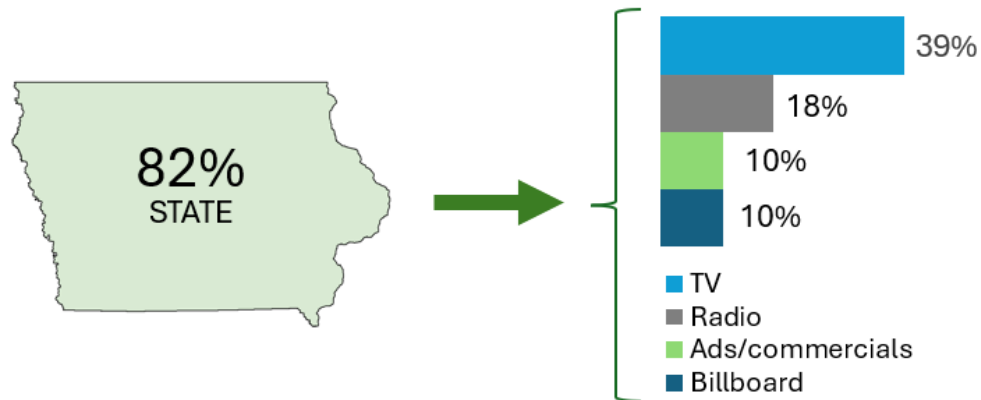


Figure 11. Most common sources where they have seen or heard of 1-800-BETS-OFF (state)

⁹ The responses were short open-ended responses which were tallied into 15 categories: Radio or podcast, TV, Billboard, Facebook or Social Media, YouTube or online (not specific), ads or commercials (not specific), a time frame reference only, print and news (not specific), location (e.g. work, school, gas station), family/friend or organization (e.g. clinics), newspaper, other, gambling apps (e.g. sports wagering apps), in casinos, and don't remember/don't know.

Awareness of Quitline Iowa for tobacco and nicotine cessation

When asked if they have ever 'seen' or 'heard' of Quitline Iowa, about four in 10 adult lowans (38%) reported that they had ever seen or heard of the web or phone coaching program for quitting tobacco and nicotine (see Figure 12).

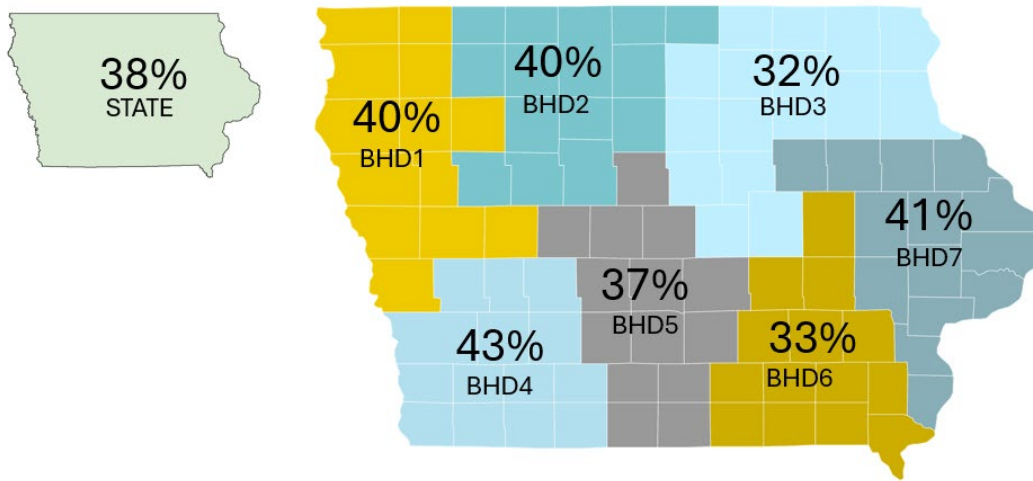


Figure 12. Seen or heard of Quitline Iowa (state and by BHD)

For those respondents who have seen or heard of Quitline Iowa (38%), a follow-up question asked if they or if someone they know had ever contacted (by phone or online) Quitline Iowa. About one in 10 reported that someone they know had contacted Quitline Iowa, and 7% of respondents reported personally contacting Quitline Iowa (see Figure 13).

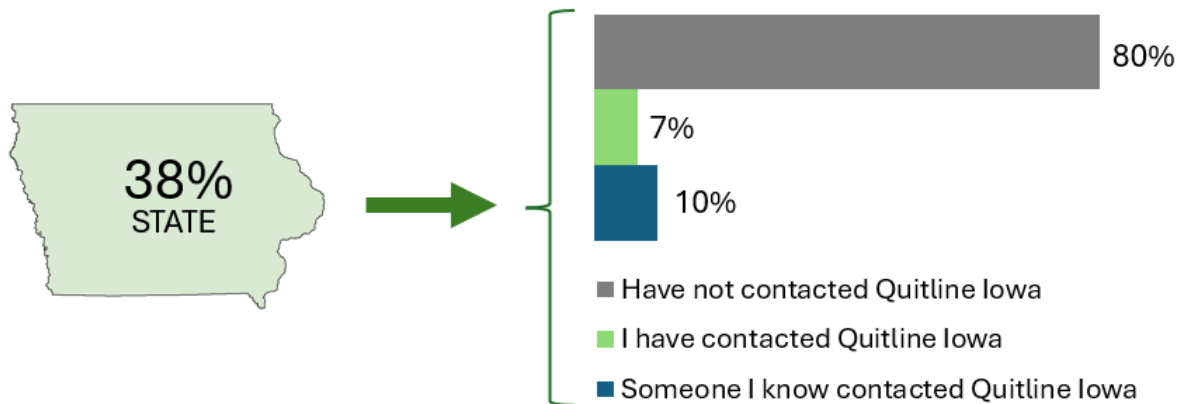


Figure 13. Contacted Quitline Iowa (state)

Awareness of 988 Suicide and Crisis Lifeline

When asked if they have ever 'seen' or 'heard' of 988 Suicide and Crisis Lifeline, about seven in 10 adult lowans (72%) reported that they have seen or heard of it (see Figure 14).

A follow-up question asked where¹⁰ they had last seen or heard about 988. TV (18%), locations throughout the community (8%), family or friends or doctor office (8%) were the most reported sources. Respondents also mentioned YouTube and Radio (both 7%). There were eight other tallied categories with 5% or less.

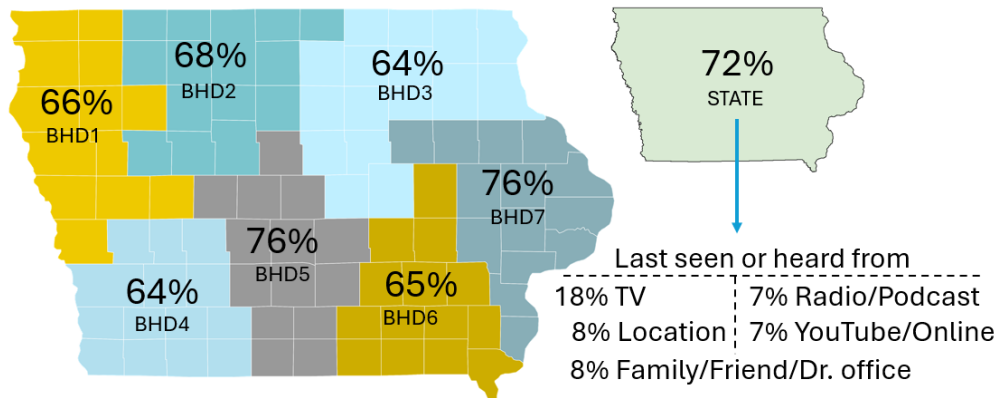


Figure 14. Seen or heard of 988 Suicide and Crisis Lifeline (state and by BHD)

Among those who have ever seen or heard of 988 Suicide and Crisis Lifeline (72%), about one in four (25%) reported that they last saw or heard of it on TV, followed by some locations such as school or work (11%), and from doctor's office, family and friend (11%) (see Figure 15).

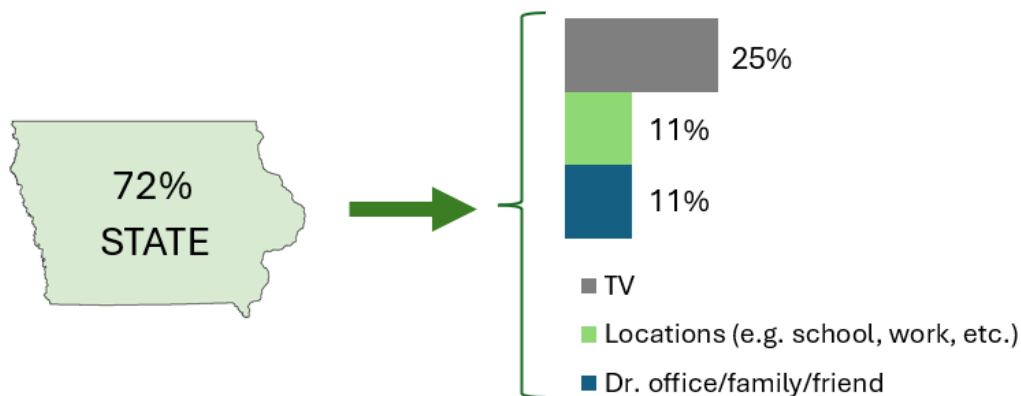


Figure 15. Most common sources where they have seen or heard of 988 Suicide and Crisis Lifeline (state)

¹⁰ The responses were short open-ended responses which were tallied into 13 categories: Radio or podcast, TV, Billboard, Facebook or Social Media, YouTube or online (not specific), ads or commercials (not specific), a time frame reference only, print and news (not specific), locations (e.g. work, school, gas station), family/friend or organization (e.g. clinics), newspaper, other, and don't remember/don't know.

A second follow-up question asked, among those who have ever seen or heard of 988 (72%), if they or someone they knew have ever contacted 988. About one in 20 respondents (4%) reported that they have personally contacted 988 and about one in 10 respondents (9%) reported someone that they know has contacted 988 (see Figure 16).

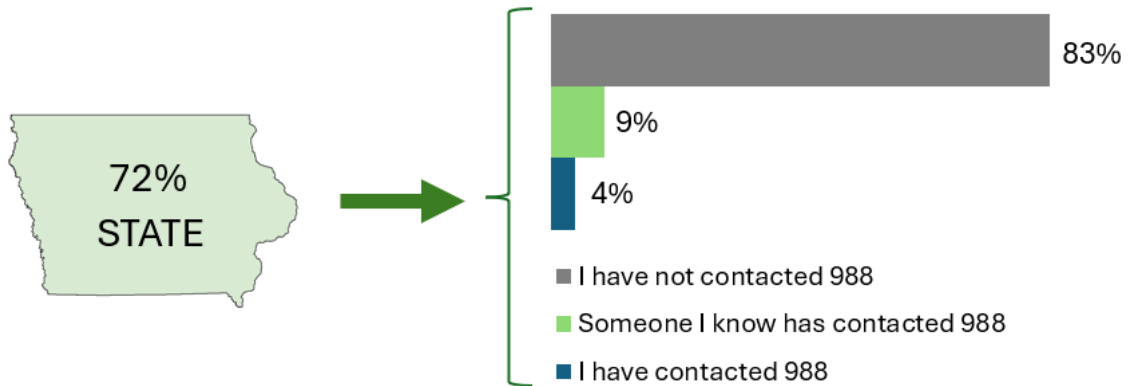


Figure 16. Ever contacted 988 Suicide and Crisis Lifeline (state)

Awareness of the State Behavioral Health Service System

The survey also asked about the awareness of the state Behavioral Health Service (BHS) System. About three in 10 adult lowans (31%) reported that they have seen or heard of it (see Figure 17). A follow-up question asked where¹¹ they had seen or heard about the BHS system, and family or friends or doctor office (9%) and locations throughout the community (5%), were the most reported sources. Respondents also mentioned YouTube/online and TV (both 2%). There were eight other tallied categories with 1% or less.¹²

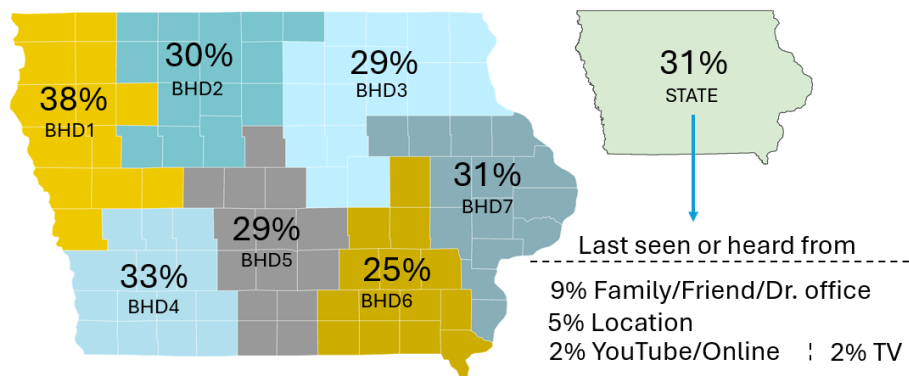


Figure 17. Seen or heard of Behavioral Health Service System (state and by BHD)

Among those who have ever seen or heard of Behavioral Health Service System (31%), about three in 10 (28%) reported that they last saw or heard of it at a doctor’s office, or from family or friends, followed

¹¹ The responses were short open-ended responses which were tallied into 13 categories: Radio or podcast, TV, Billboard, Facebook or Social Media, YouTube or online (not specific), ads or commercials (not specific), a time frame reference only, print and news (not specific), locations (e.g. work, school, building), family/friend or organization (e.g. clinics), newspaper, other, and don’t remember/don’t know.

¹² The **don’t remember/don’t know** category had 4% but is not reported as a valid response.

by some location such as school or work (15%), and TV, YouTube or other online sources (6%) (see Figure 18).

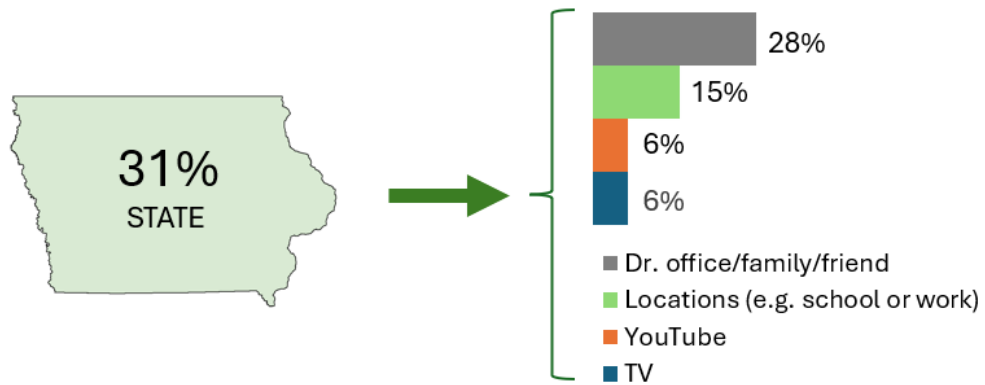


Figure 18. Most common sources where they have seen or heard of Behavioral Health Service System (state)

SECTION B2. Cancer: Perceptions of Risk and Prevention

Perceptions of risk of developing cancer

The survey asked respondents about 14 exposures and behaviors that may increase a person's risk of developing cancer. The following five exposures and behaviors had the greatest percentage of respondents indicating it was associated with a “**high risk increase**” of developing cancer: tobacco product use (75%), exposure to pesticides/herbicides (62%), exposure to occupational chemicals (61%), nicotine product use (61%), and intravenous (IV) drug use (55%) (see Figure 19).

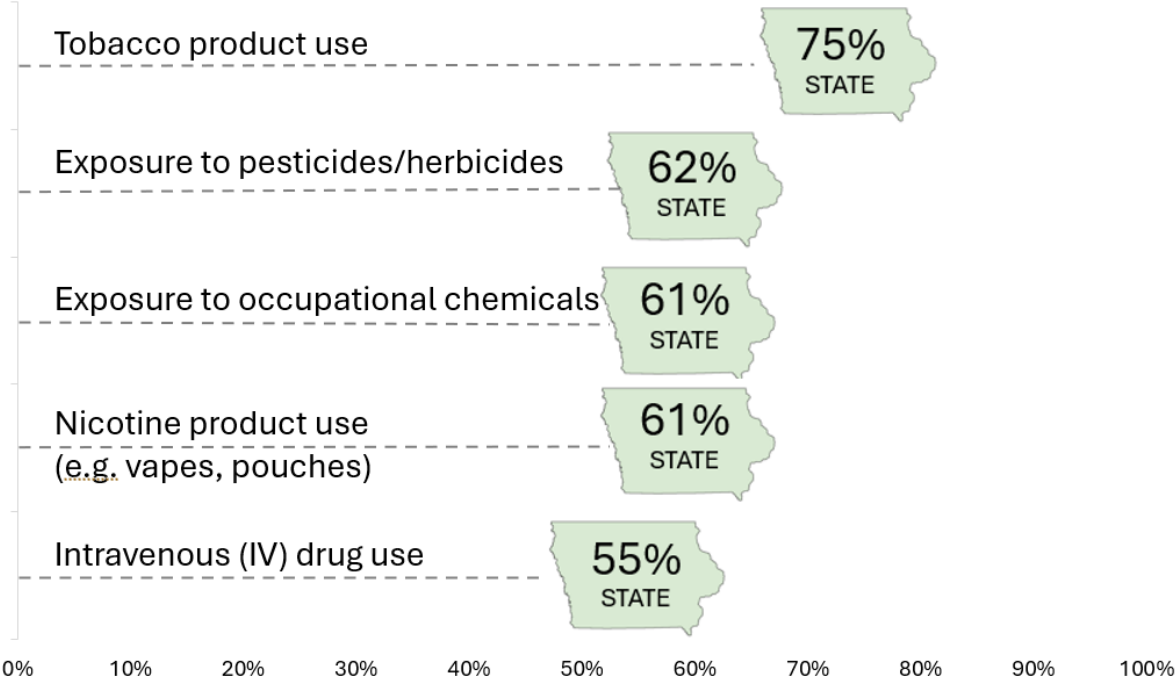


Figure 19. Top exposures and behaviors perceived by respondents as increasing a person’s risk of developing cancer

The exposures and behaviors where between 25% and 50% of respondents indicated it is associated with a “high risk increase” of developing cancer included: human papillomavirus (HPV) infection (48%), exposure to ultraviolet (UV) light (46%), being overweight or obese (38%), exposure to air pollution (38%), drinking water with high nitrate levels (37%), and eating an unhealthy diet (32%). The alcohol consumption behaviors had the lowest “high risk increase” percentages: drinking liquor or spirits (19%), drinking beer (16%), and drinking wine (10%).

Another way of looking at the data is to focus on the combined responses of “none” or a “low risk increase”. Figure 20 shows the five behaviors or exposures that had the highest percentage of respondents indicating they were associated with “none” or a “low risk increase” of developing cancer. These included: drinking wine (57%), drinking beer (42%), drinking liquor (38%), drinking water with high nitrate levels (21%), and eating an unhealthy diet (20%) (see Figure 20).

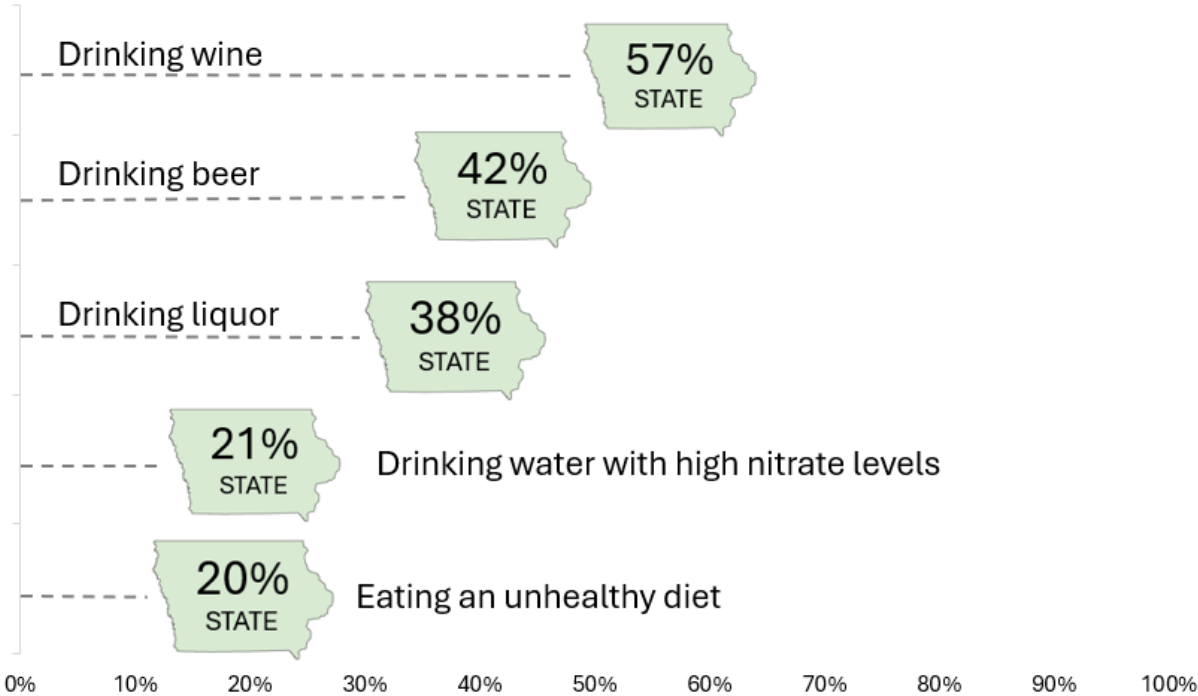


Figure 20. Exposures and behaviors with lowest perceived risk (*none* or *low*) of increasing a person’s risk of developing cancer

Source of information about risk of cancer

The survey asked respondents over the last year, where have they read, seen, or heard about the behaviors and exposures that increase the risk of developing cancer. Respondents were asked to select all that apply. Six out of every 10 respondents selected TV (62%) and social media (56%), followed by 53% selecting the internet (e.g. YouTube, hospital websites, etc.; Figure 21). About one in three indicated my doctor or other health care provider (35%) or the radio (33%) and about one in four identified the newspaper (28%; online or paper) as a source.

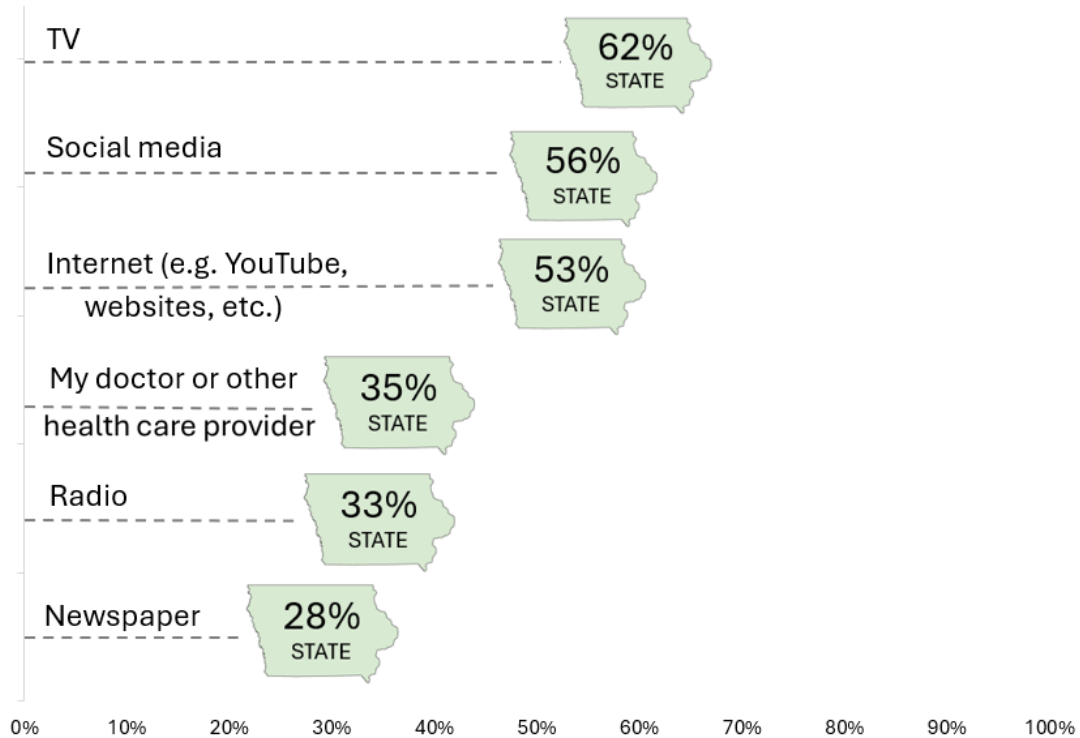


Figure 21. Sources of information where respondents may have seen or heard about the behaviors and exposures that increase the risk of developing cancer

These percentages differed significantly across the BHDs for the following sources: social media ($p \leq .001$), internet (e.g. YouTube, websites, etc.; $p \leq .05$), and newspaper ($p \leq .05$). For example, the percentage of respondents indicating social media as a source for behaviors and exposures associated with an increased risk of cancer ranged from 45% in BHD6 to 61% in BHD5.

Additionally, one in ten adult lowans (10%) indicated that they had not read, seen, or heard anything about the risk of developing cancer in the past year. This percentage differed significantly across the BHDs, ranging from 6% for BHD1 and BHD2 to 14% for BHD6 ($p \leq .05$).

Preventive measures to avoid or reduce cancer risk

For eight behaviors and exposures, respondents were asked how likely or unlikely they are to take preventive measures in those areas to avoid or reduce their risk of developing cancer. At the state level, the four behaviors and exposures that had the highest percentage of “**very likely**” responses were (see Figure 22): 1) Eat a healthy diet (38%), 2) Quit or reduce tobacco product use (24%), 3) Limit exposure to UV light (22%), and 4) Quit or reduce nicotine product use (20%).

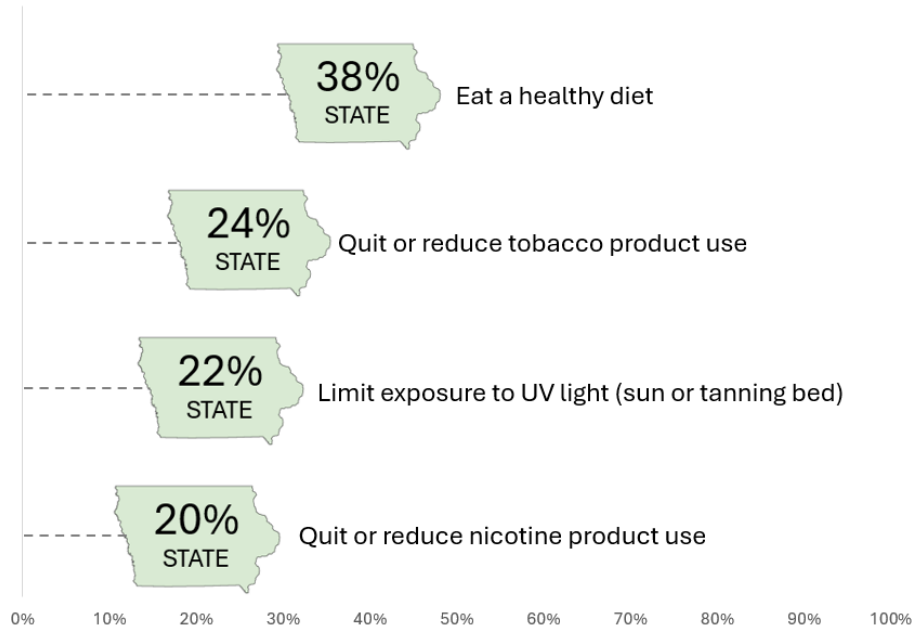


Figure 22. Most common preventive measures respondents indicated as very likely for them to take to avoid or reduce their risk of developing cancer

Respondents' experience with cancer

An additional question asked if the respondent or a member of the respondent's household had been diagnosed with any type of cancer. Just over one in 10 respondents (12%) reported that they have been diagnosed with cancer (see Figure 23). The percentage of respondents diagnosed with cancer differed significantly across BHDs, ranging from 9% for BHD5 to 19% for BHD3 ($p \leq .05$).

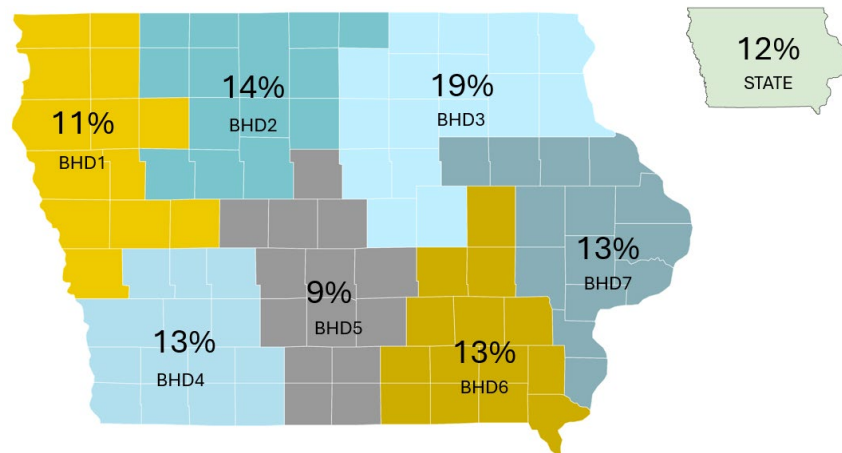


Figure 23. Respondent ever diagnosed with cancer (state and by BHD)

In addition, one in five respondents (20%) reported that someone in their household was diagnosed with cancer (see Figure 24).

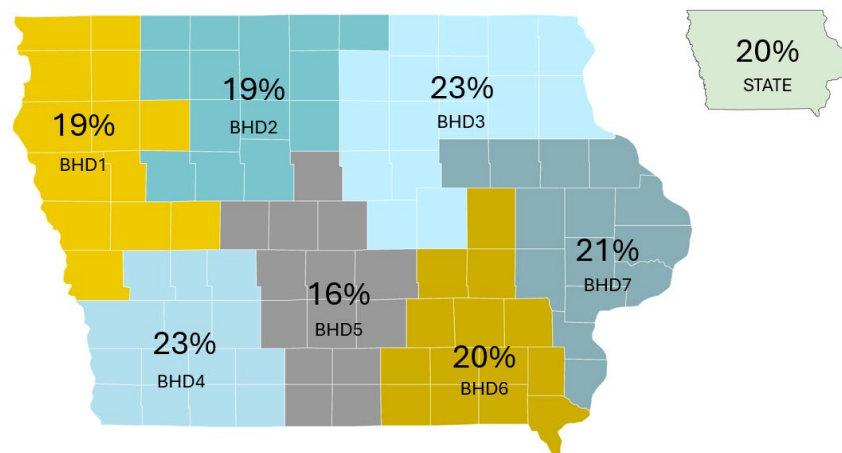


Figure 24. Household member ever diagnosed with cancer (state and by BHD)

SECTION C. Help seeking and access to care

Resources for mental health crisis or emergency

Respondents were asked how comfortable, if at all, they would feel contacting seven respective resources for assistance during a mental health crisis or emergency. At the state level, the four most common resources that respondents feel “**very comfortable**” contacting for assistance (see Figure 25) included: 1) a close friend or family member (53%), 2) a mental health provider (49%), 3) 911 (43%), and 4) 988 Suicide and Crisis Lifeline (38%). These resources were followed by local law enforcement (33%), 1-800-BETS-OFF (30%), and Your Life Iowa (YLI) (25%).

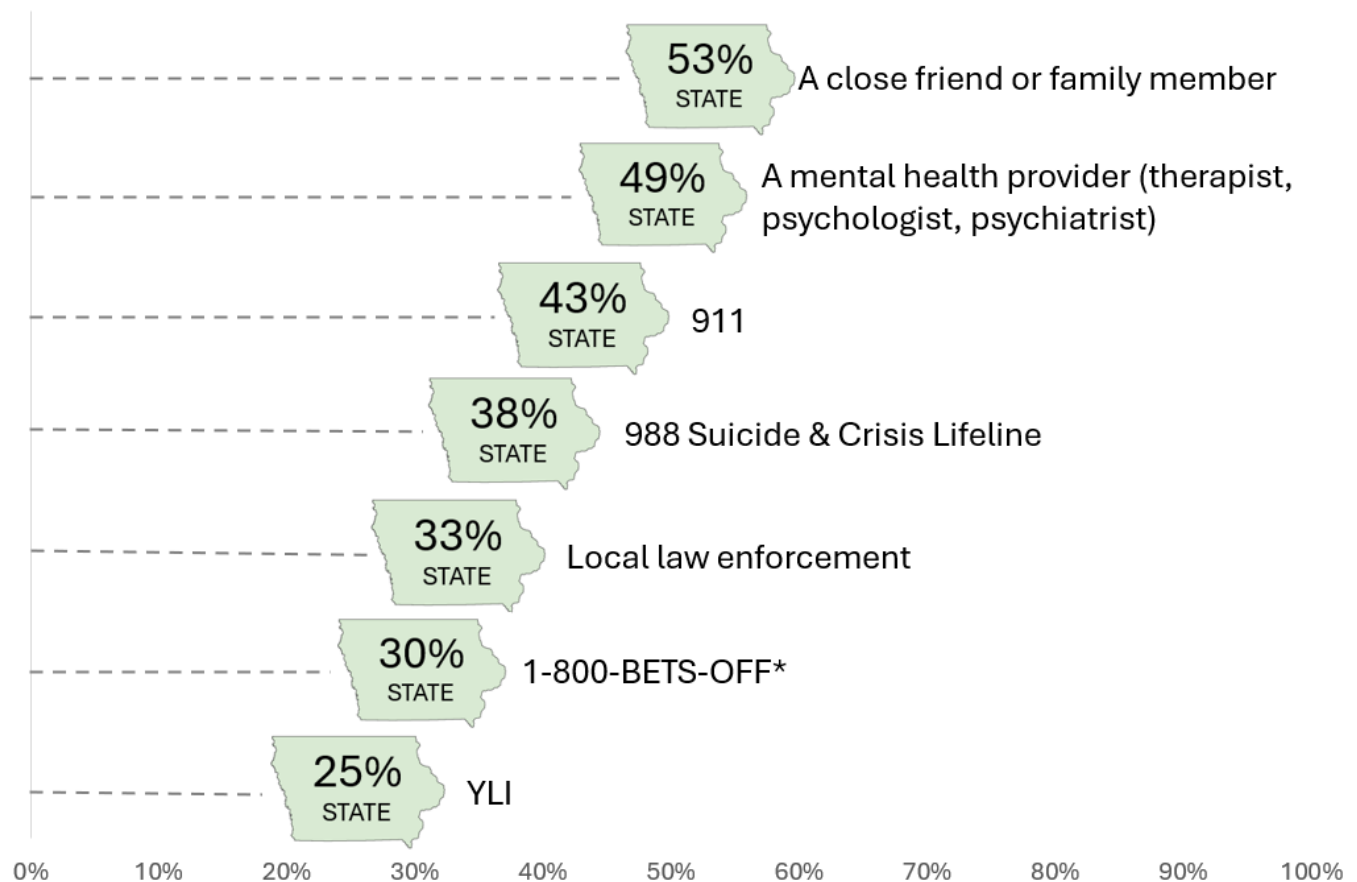


Figure 25. Resources that respondents feel ‘very comfortable’ contacting for assistance during a mental health crisis or emergency

Only one source (1-800-BETS-OFF) differed significantly across BHDs, ranging from 21% for BHD6 to 34% for BHD3 ($p \leq .05$).

Resources for substance use crisis or emergency

Respondents were asked how comfortable, if at all, they would feel contacting five respective resources for assistance during a substance use crisis or emergency. At the state level, the three most common resources that respondents feel “**very comfortable**” contacting (see Figure 26) included: 1) a close friend or family member (52%), 2) a substance use treatment provider (46%), and 3) 911 (44%). Additionally, about three out of every 10 respondents indicated that they felt “very comfortable” contacting local law enforcement (35%) and YLI (29%).

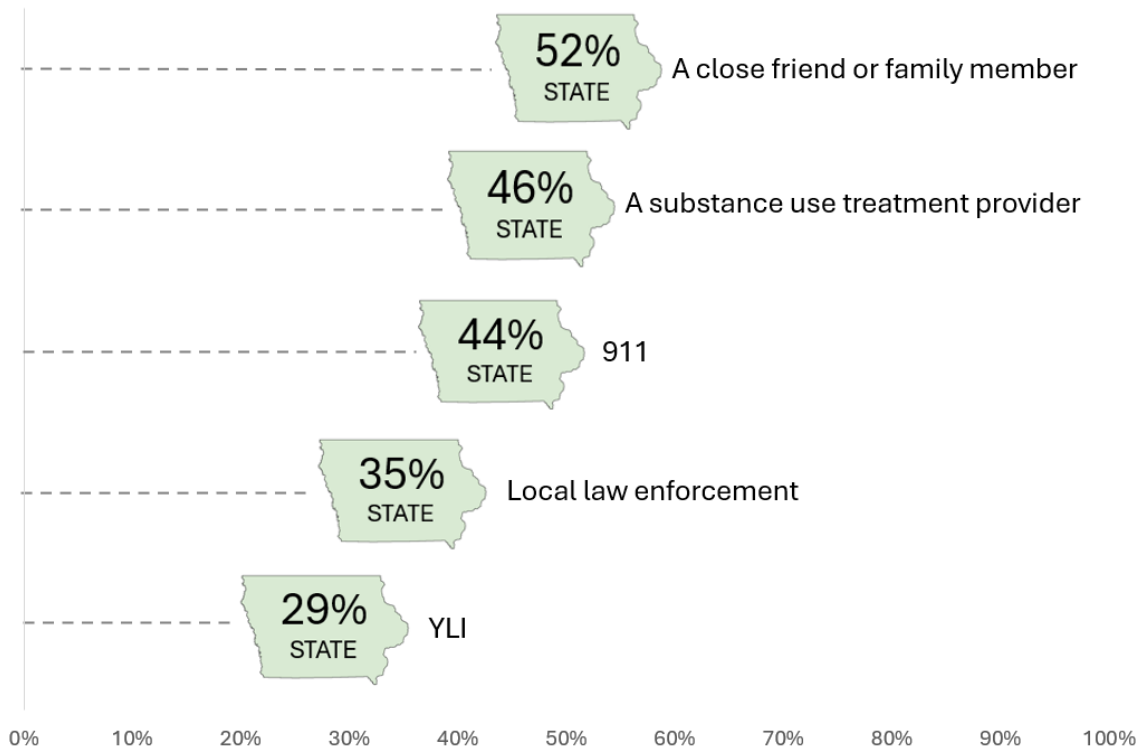


Figure 26. Resources that respondents feel ‘very comfortable’ contacting for assistance during a substance use crisis or emergency

A time that respondents needed to talk or seek help

The survey asked if there was a time when respondents needed to talk to or seek help from a health professional for themselves or for a family member due to substance use, mental health and gambling during the past 12 months.

Alcohol

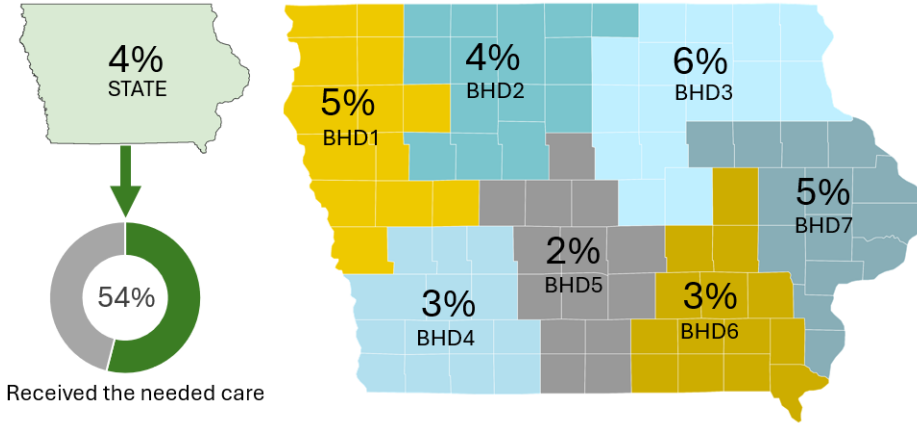


Figure 27. Alcohol use: needed to talk or seek help (state and by BHD) and received the needed care (state)

About one in 20 respondents (4%) reported that they needed to talk to or seek help from a health professional for alcohol use. Among those respondents who needed to talk or seek help, just over half (54%) indicated that they received the care they were seeking (see Figure 27).

Tobacco or nicotine

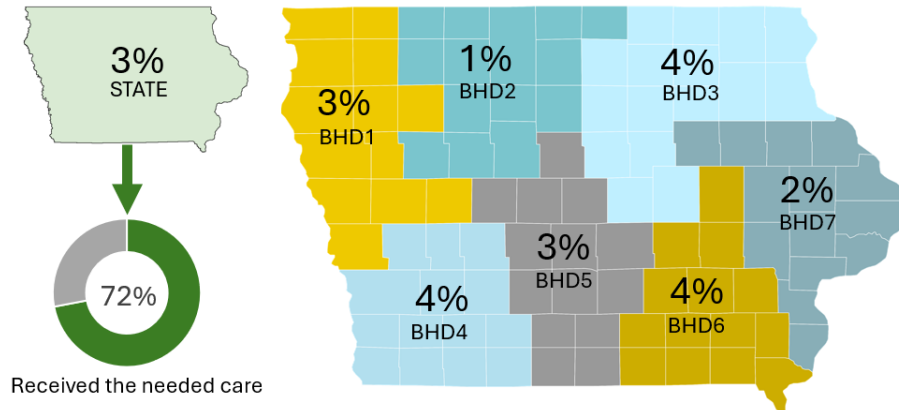


Figure 28. Tobacco or nicotine use: needed to talk or seek help (state and by BHD) and received the needed care (state)

Similarly, 3% of respondents reported that they needed to talk or seek help due to tobacco or nicotine use during the past 12 months. Among those respondents who needed to talk or seek help, about three in four respondents (72%) reported that they received the care they were seeking (see Figure 28).

Legal substance use (e.g. prescription opioids, medical marijuana, etc.)

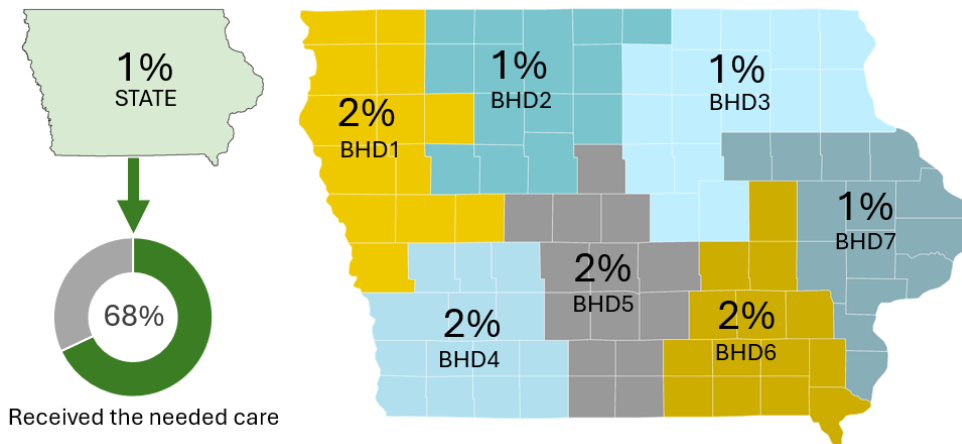


Figure 29. Legal substance use: needed to talk or seek help (state and by BHD) and received the needed care (state)

When asked if they needed to talk or seek help due to legal substance use such as prescription opioids, medical marijuana or medical THC, 1% of respondents reported they needed to talk or seek help during the past 12 months. Among those respondents who needed to talk or seek help, about two-thirds (68%) reported that they received the care they were seeking (see Figure 29).

Illegal substance use (e.g. marijuana, methamphetamine, etc.)

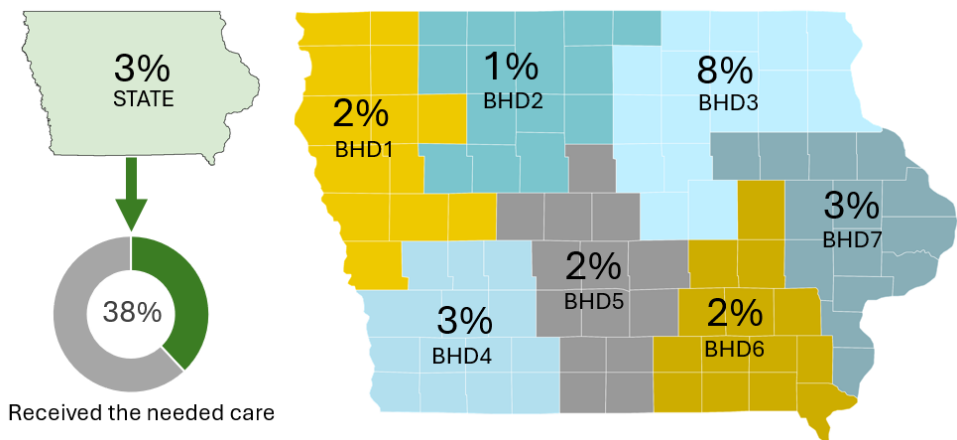


Figure 30. Illegal substance use: needed to talk or seek help (state and by BHD) and received the needed care (state)

For illegal substances, 3% of respondents reported they needed to talk or seek help due to illegal drugs or substances such as marijuana (other than CBD or medical marijuana). Among those respondents who needed to talk or seek help, about two in five respondents (38%) indicated they received the care they were seeking (see Figure 30).

Mental health (e.g. stress, depression, etc.)

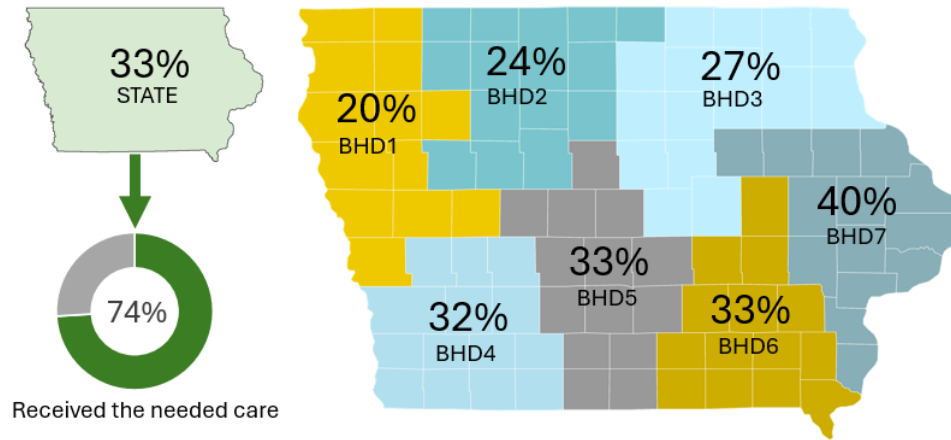


Figure 31. Mental health: needed to talk or seek help (state and by BHD) and received the needed care (state)

Mental health was the most common reason indicated by respondents for needing help from a health professional during the past 12 months. One in three respondents (33%) reported they needed to talk or seek help due to mental health such as stress, depression, problems with emotions, excessive worrying or troubling thoughts.

This percentage differed significantly across BHDs, ranging from 20% for BHD1 to 40% for BHD7 ($p \leq .001$). Among respondents who needed to talk or seek help in this area, about three in four respondents (74%) indicated they received the care they were seeking (see Figure 31).

Gambling

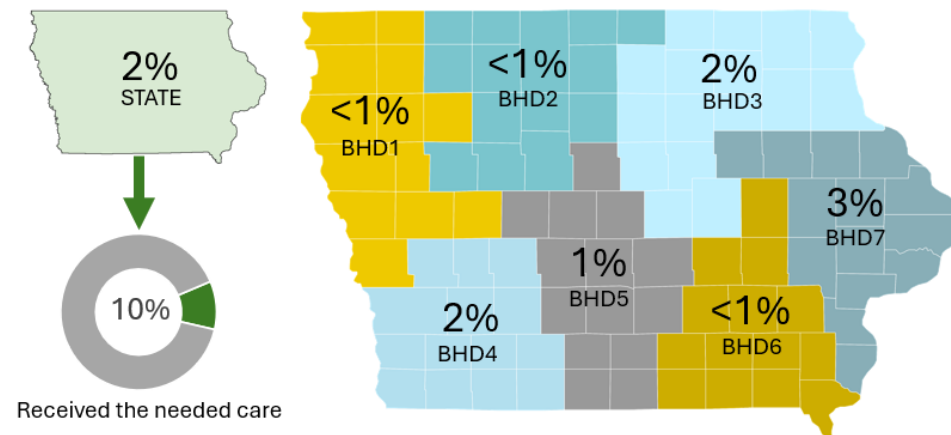


Figure 32. Gambling: needed to talk or seek help (state and by BHD) and received the needed care (state)

Two percent of respondents reported they needed to talk to or seek help from a health professional for gambling such as casino games, lottery games, sports wagering, or fantasy sports. Among those respondents who needed to talk or seek help, about one in 10 (10%) indicated they received the needed care (see Figure 32).

Awareness of naloxone and perceptions about substance use treatment services

Respondents were asked the extent they agree or disagree with four statements about naloxone and treatment services (see Figure 33). About one in five respondents reported that they **somewhat or strongly agree** that they know where to obtain (21%) and how to administer (20%) naloxone. In addition, one in four respondents reported that they **somewhat or strongly agree** how to find quality treatment for an opioid use disorder in Iowa (25%). When asked about the availability of addiction treatment services, about one in five respondents reported that they **somewhat or strongly agree** that Iowa is moving in the right direction (21%).

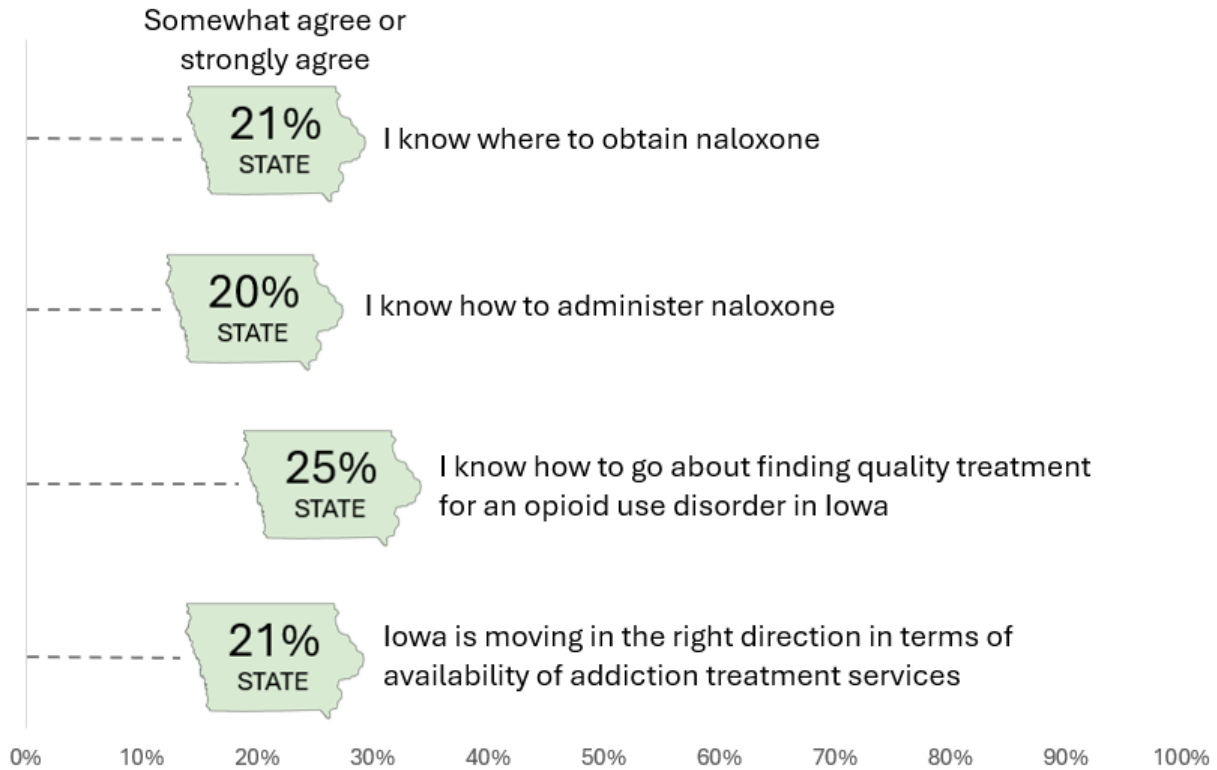


Figure 33. Awareness of naloxone and perceptions of substance use of treatment services of those who somewhat or strongly agree

The biggest difference in awareness of naloxone and perceptions of substance use treatment was in the 'strongly disagree' response option. About two thirds of respondents **strongly disagree** that they know where to obtain naloxone (62%) or how to administer naloxone (64%; Figure 34). Slightly less than half of respondents **strongly disagree** that they know how to find quality treatment for an opioid use disorder in Iowa (43%). When asked about the availability of addiction treatment services, about one in five respondents reported that they **strongly disagree** that Iowa is moving in the right direction (17%).

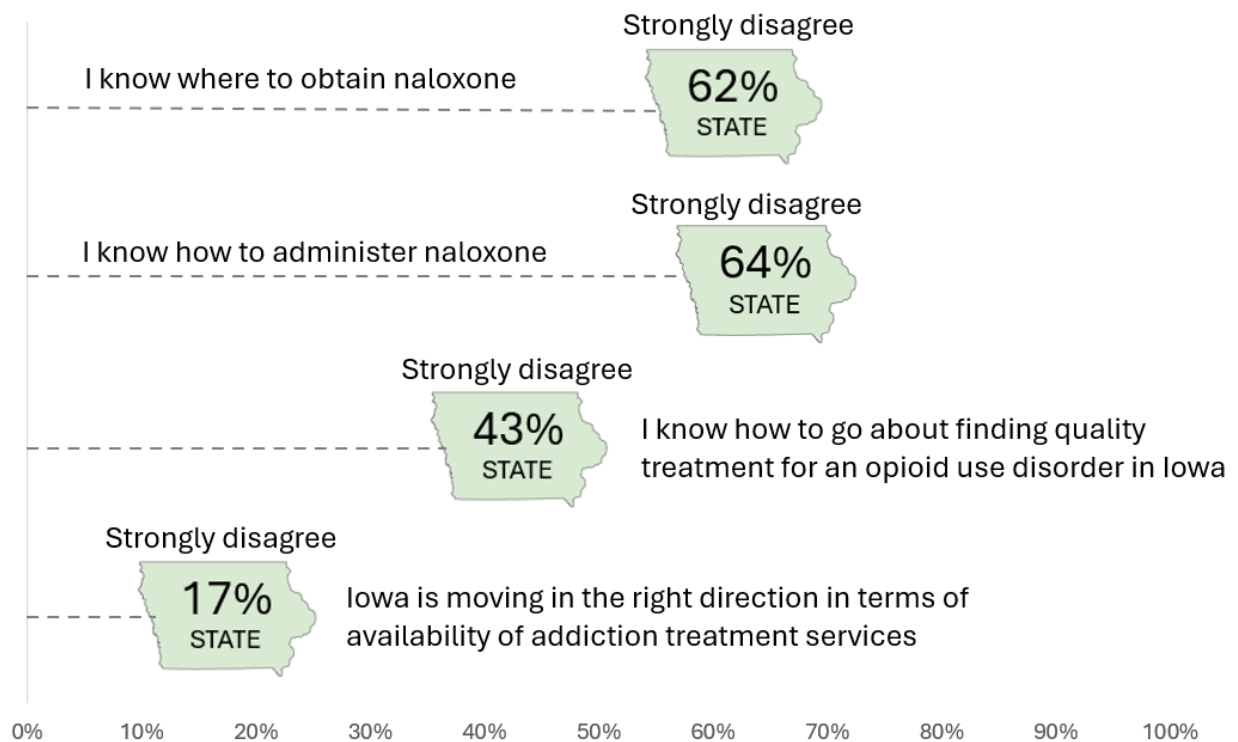


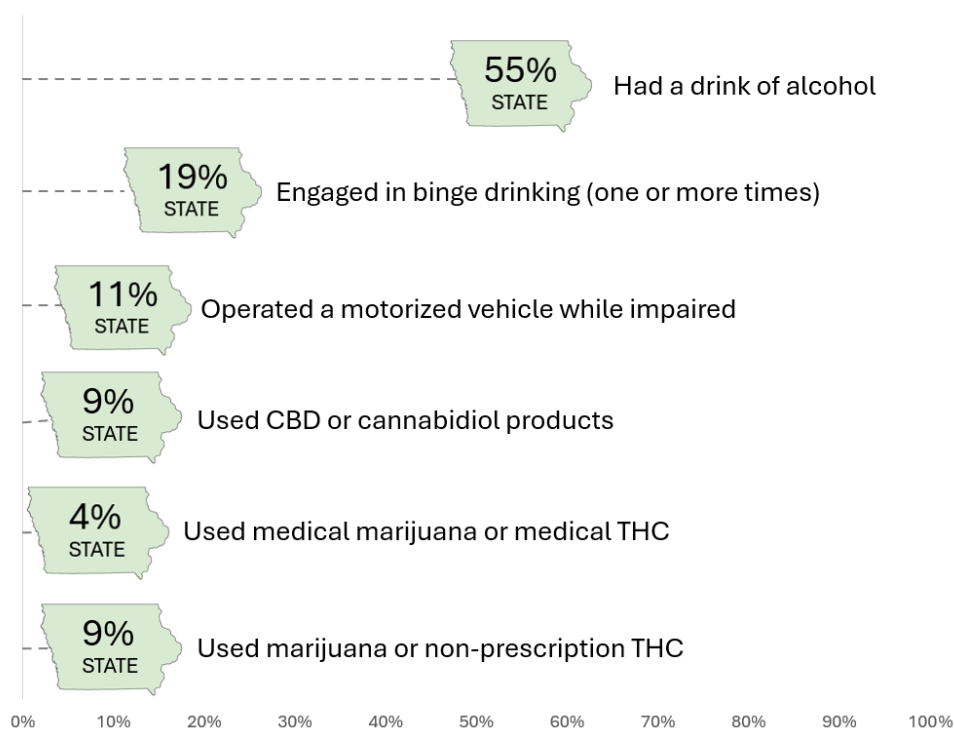
Figure 34. Awareness of naloxone and perceptions of substance use treatment of those who strongly disagree

SECTION D. Use of Substance, Mental Health, and Gambling

The survey asked about respondents' substance use and behaviors. These questions asked for the number of days in the past 30 days that they used or engaged in these behaviors. Results shown below are the percentages of respondents indicating **one or more days** of substance use and/or engaging in the behaviors.

SUBSTANCE USE AND BEHAVIORS

Over half of respondents (55%) had a drink of alcohol (defined as a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor) on one or more days in the past 30 days (see Figure 35). About one in five adult respondents engaged in binge¹³ drinking (19%) in the past 30 days. About one in 10 reported they had operated a motorized vehicle while impaired (11%) during the past 30 days.



About one in 10 respondents used CBD or cannabidiol products (9%) such as CBD drinks, CBD oils, gummies, ointment, etc. The percentage of respondents who used CBD products in the past 30 days differed significantly across BHDs, ranging from 3% for BHD1 to 11% for BHD7 ($p \leq .01$).

The use of medical marijuana or medical THC was about one in 20 adults (4%) in the state.

Figure 35. Past 30 days substance use or behavior

Use of marijuana or non-prescription THC (other than CBD, medical marijuana/THC) was about one in 10 adults (9%) in the state. Percentages for other substances for the state included: 3% for using prescription medications in ways other than directed, 3% for using over-the-counter medications in ways other than directed, 2% for using methamphetamine or meth, and 1% each for using non-prescription opioids, using any other illegal substance, or injecting a non-prescribed substance into their body.

¹³ Binge drinking was defined as if they had 5 or more drinks for males, or 4 or more drinks for females, on any occasion within a two-hour period.

Past substance use and recovery

About one in 10 adult respondents (8%) reported they consider themselves in recovery from past substance use (see Figure 36).

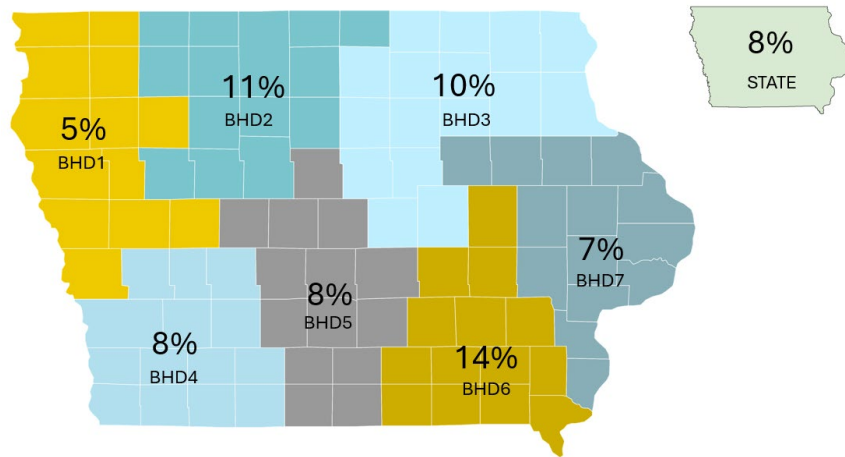
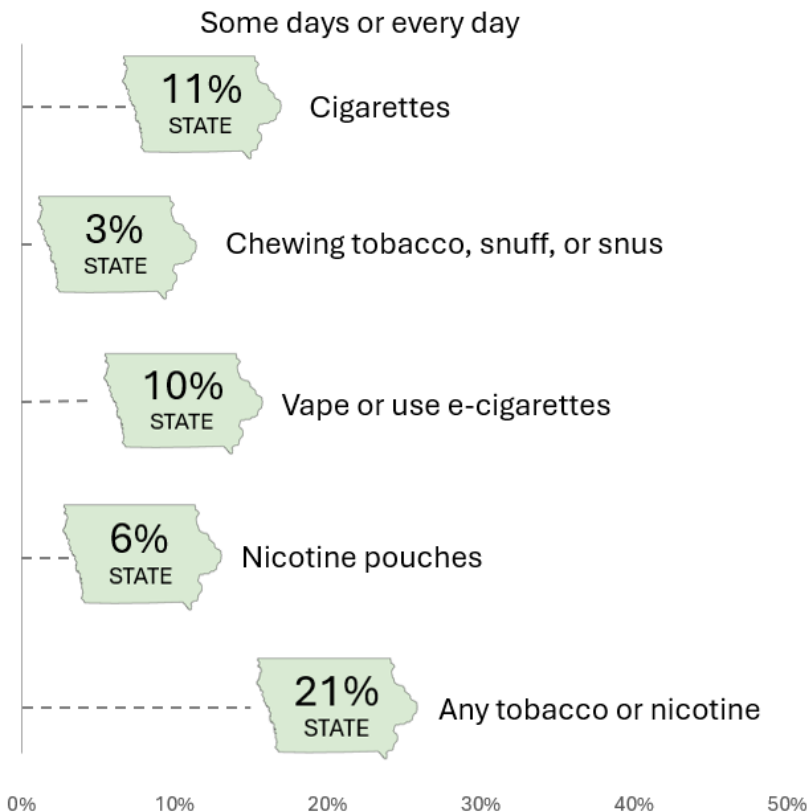


Figure 36. Recovery from past substance use or behavior (state and by BHD)

Tobacco or nicotine use

Tobacco and nicotine product use had its own set of questions as part of the substance use and behavior section. This set of questions asked about the frequency of tobacco and nicotine product use (everyday, some days, or not at all) and whether they had attempted to quit in the past 12 months.

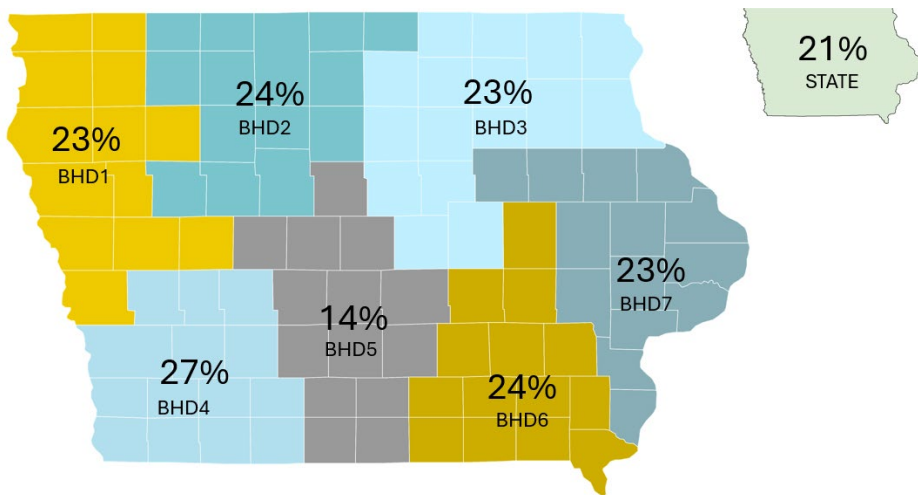


About one in ten adult respondents (11%) reported that they use cigarettes some days or every day. Similarly, one in ten adult respondents (10%) reported that they vape or use e-cigarettes some days or every day. About one in 20 adult respondents reported that they use nicotine pouches (6%) some days or every day.

The least reported tobacco or nicotine products were chewing tobacco, snuff, or snus. Three percent of adult respondents indicated that they use them some days or every day.

Any tobacco or nicotine product use (some days or every day for any of above products) was 21% in the state (see Figure 37).

Figure 37. Current tobacco and nicotine product use

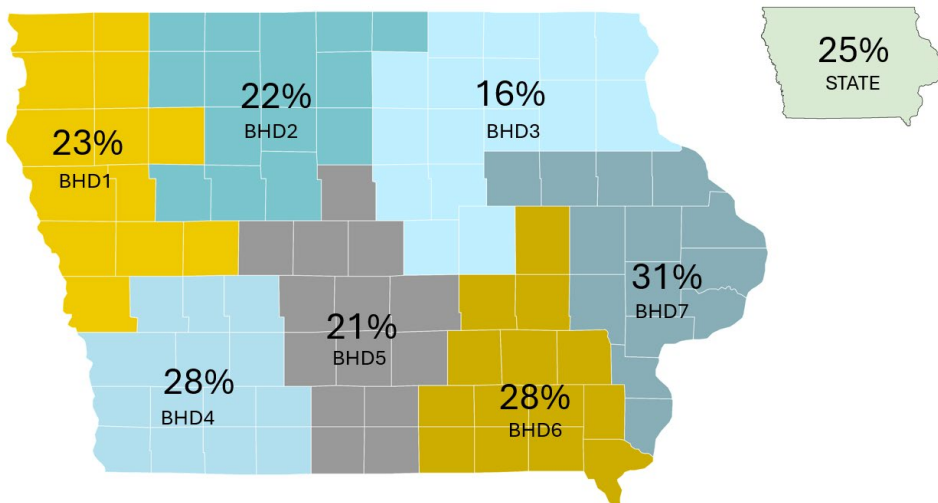


The percentage of respondents who currently use any tobacco or nicotine products did not differ significantly across the BHDs (Figure 38).

Figure 38. Current (some days or every day) use of any tobacco or nicotine products (state and by BHD)

Flavored vape or nicotine product use

One in four adult respondents (25%) reported that they have **ever used** flavored vape or nicotine products (e.g. menthol, mint, fruit, candy, or other).



The percentage of respondents who ever used flavored vape or nicotine products differed significantly across the BHDs, ranging from 16% for BHD3 to 31% for BHD7 (Figure 39; $p \leq .05$).

Figure 39. Ever used flavored vape or nicotine products (state and by BHD)

Quit attempts from tobacco and nicotine products in the past 12 months

About three in four respondents reported that they have not used tobacco or nicotine products (74%) in the past 12 months. Approximately one in 10 adult lowans reported having made a quit attempt of tobacco and/or nicotine products. This includes 4% who quit tobacco but still vape, 1% who quit tobacco but still use nicotine pouches and 5% who quit all tobacco or nicotine product use (see Figure 40).

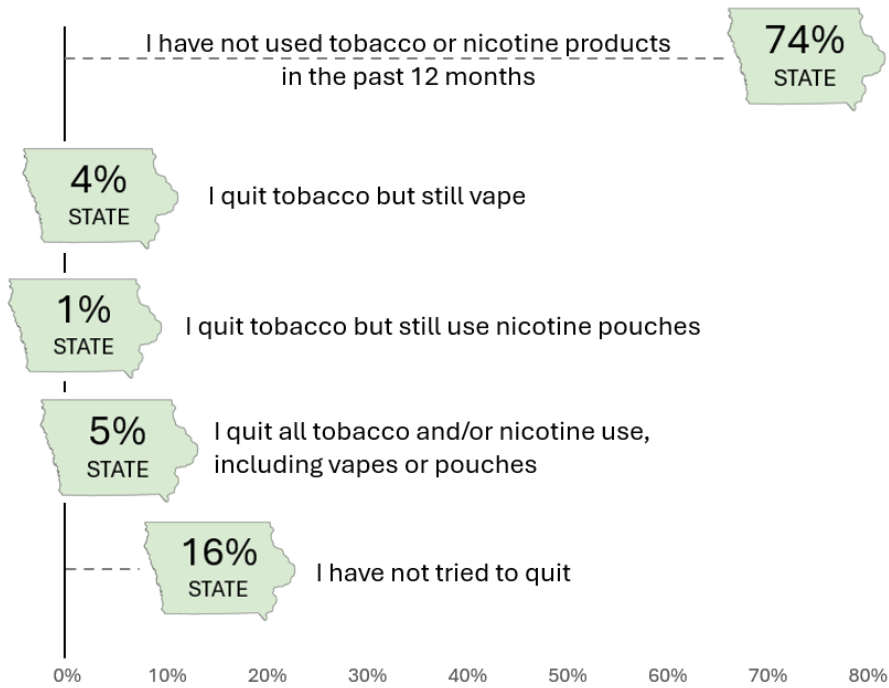


Figure 40. Use of tobacco or nicotine products and quit attempts among all respondents

Another way of looking at the responses is to assess quit attempts only among those who had used tobacco or nicotine products in the past 12 months (26%). For this subset of respondents, 60% have not tried to quit, 14% quit tobacco but still vape, 4% quit tobacco but still use nicotine pouches, and 19% quit all tobacco and nicotine products in the past 12 months (see Figure 41).

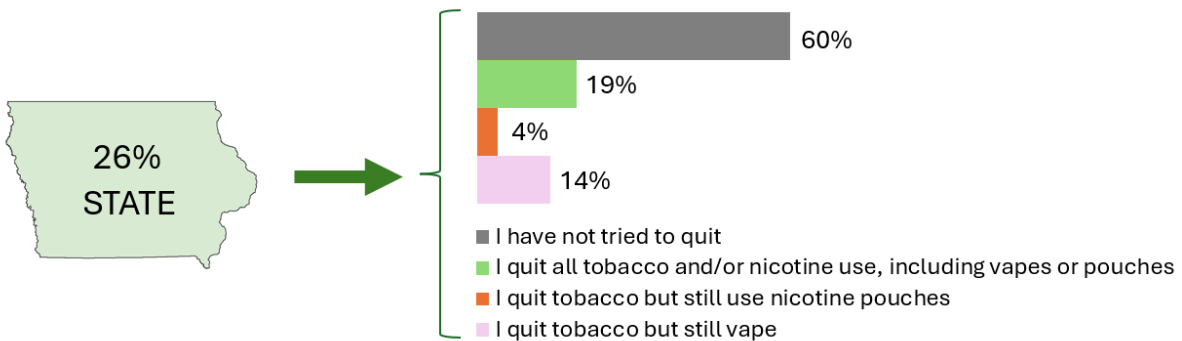


Figure 41. Use of tobacco or nicotine products and quit attempts among those who had used these products in the past 12 months

Nicotine replacement

Respondents were asked if they used nicotine replacement therapy (NRT; e.g., patch, gum, or lozenge) to reduce or quit their tobacco or nicotine use in the past year. Among all respondents, 3% reported having used NRT in the past 12 months (see Figure 42).

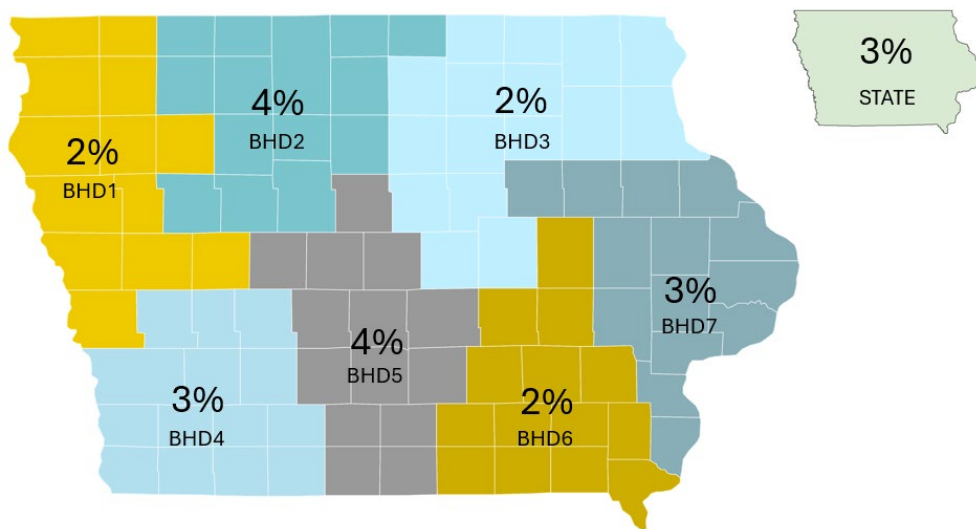


Figure 42. Use of nicotine replacement therapy (state and by BHD)

Indoor/home vaping or use of e-cigarettes

About one in seven respondents (14%) reported that someone in their household vaped or used e-cigarettes inside their home in the past 12 months (see Figure 43).

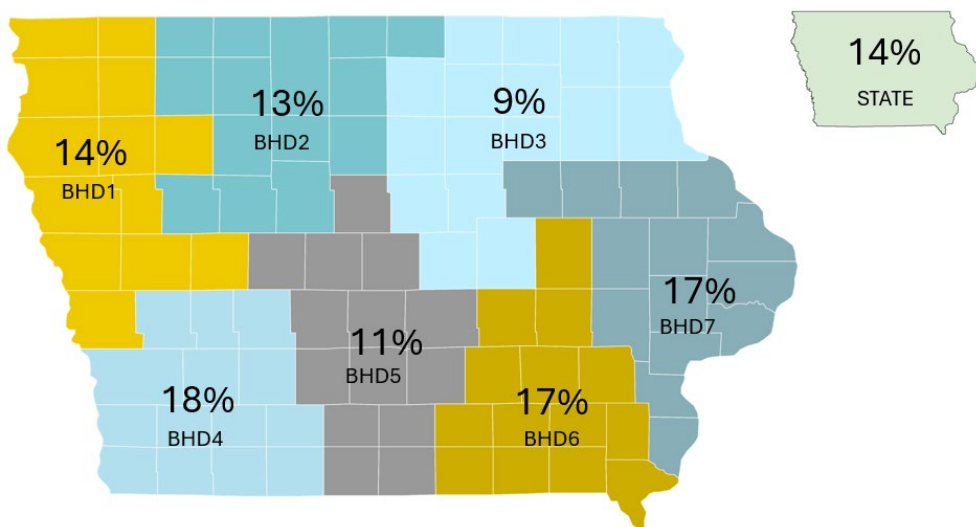


Figure 43. Indoor use of vapes or e-cigarettes (state and by BHD)

Any gambling behavior in the past 12 months

Engagement in gambling behaviors during the past 12 months was asked to all survey respondents. Specifically, respondents were asked about four different gambling types that included: casino games, lottery/number games, sports wagering, and fantasy sports contests. Four out of every 10 respondents (43%) indicated that they had engaged in at least one of the four gambling types in the past 12 months (see Figure 44).

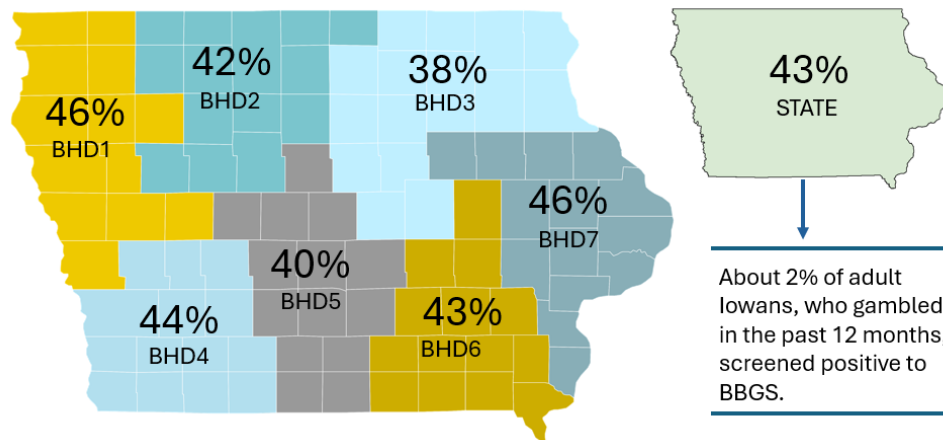


Figure 44. Any gambling behavior (state and by BHD)

For those who had engaged in at least one of the four gambling types in the past 12 months, a set of three questions based on the Brief Biosocial Gambling Screen (BBGS) asked respondents about their adverse experiences with gambling.¹⁴ Two percent of adult respondents screened positive for indicating at least one adverse experience on the BBGS such as becoming restless, irritable or anxious when trying to stop and/or cut down on gambling.

¹⁴ BBGS items include: During the past 12 months, (a) Have you become restless, irritable or anxious when trying to stop or cut down on gambling?, (b) Have you tried to keep your family or friends from knowing how much you gamble?, and (c) Did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends, or welfare?

Mental health

When asked if they ever felt so sad or hopeless that they stopped doing some of their usual activities, one in five respondents reported they felt so sad or hopeless (20%) in the past 30 days. This percentage differed significantly across BHDs, ranging from 13% for BHD1 to 24% for BHD7 ($p \leq .05$; Figure 45).

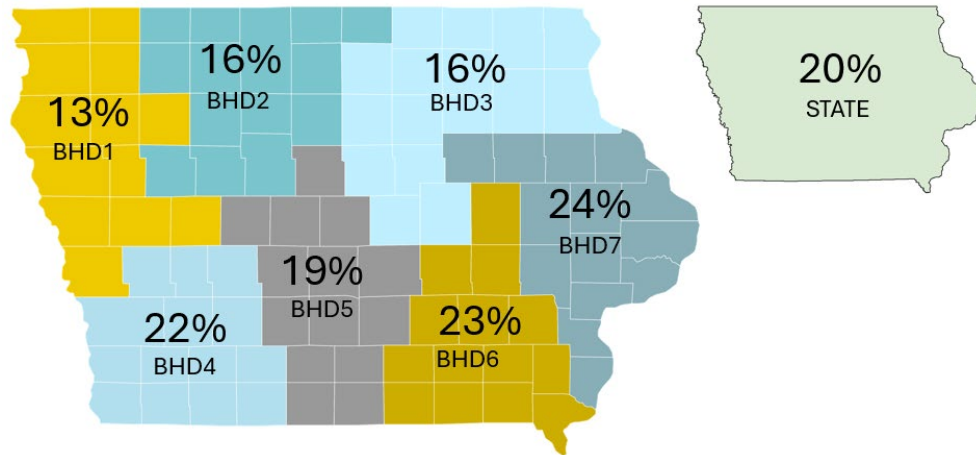


Figure 45. Respondents who felt sad or hopeless (state and by BHD)

The survey also asked a question about respondents engaging in any form of non-suicidal self-injury or self-harm. Two percent of respondents reported self-injury or self-harm during the past 30 days (see Figure 46).

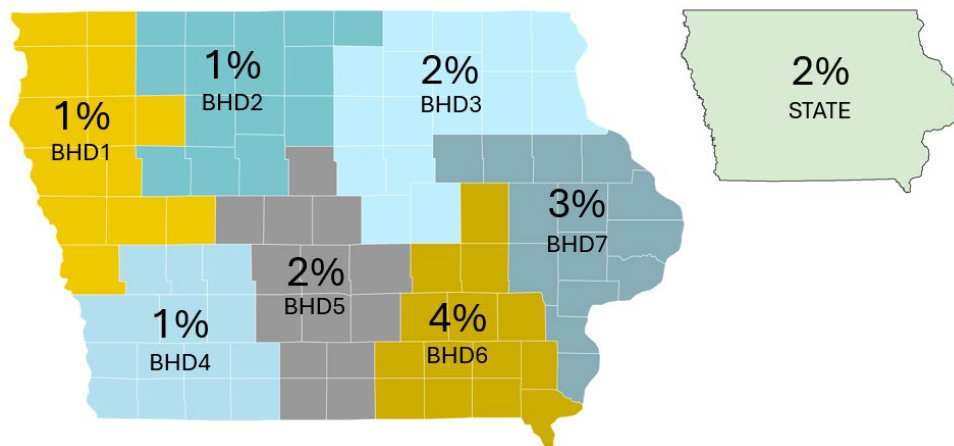


Figure 46. Respondents who engaged in any form of non-suicidal self-injury or self-harm such as cutting (state and by BHD)

When asked if respondents have thought about killing themselves during the past 30 days, 8% of respondents reported that they have had suicidal thoughts in the past 30 days.

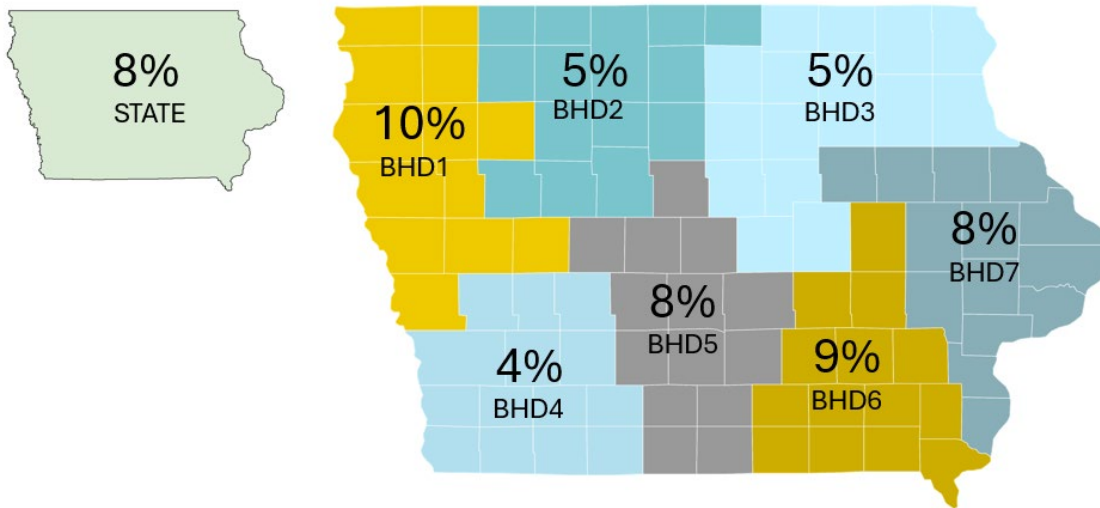


Figure 47. Respondents who reported suicidal thoughts (state and by BHD)

For those who have had suicidal thoughts (8%), a couple of follow-up questions asked if they had made a plan or attempted killing themselves. About one in five (18%) of those who have had thoughts of suicide, made a plan about how to kill themselves. Two percent of those who have had thoughts of suicide, reported they attempted killing themselves in the past 30 days (see Figure 48).

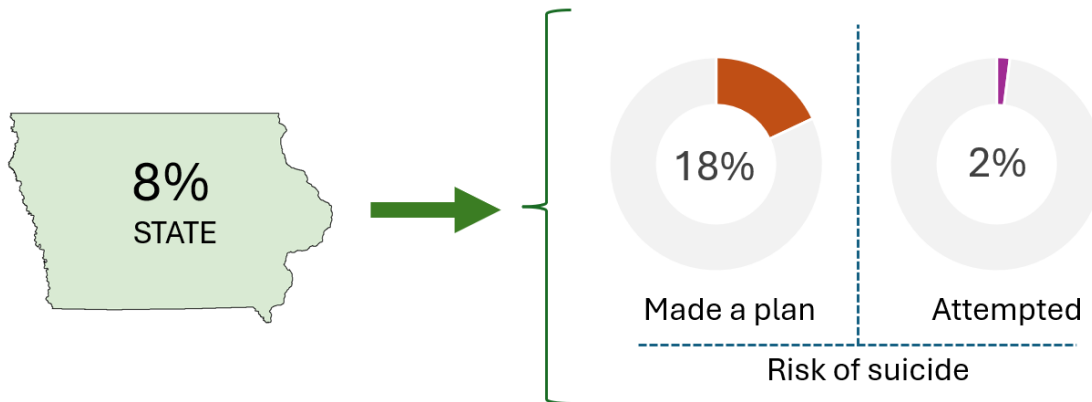


Figure 48. Made a plan or attempted suicide (state)

When asked if a doctor, nurse, or other health professional ever told them that they had a depressive disorder (including depression, major depression, dysthymia, or minor depression), three in 10 reported that they have been diagnosed with a depressive disorder (30%) in the state (see Figure 49).

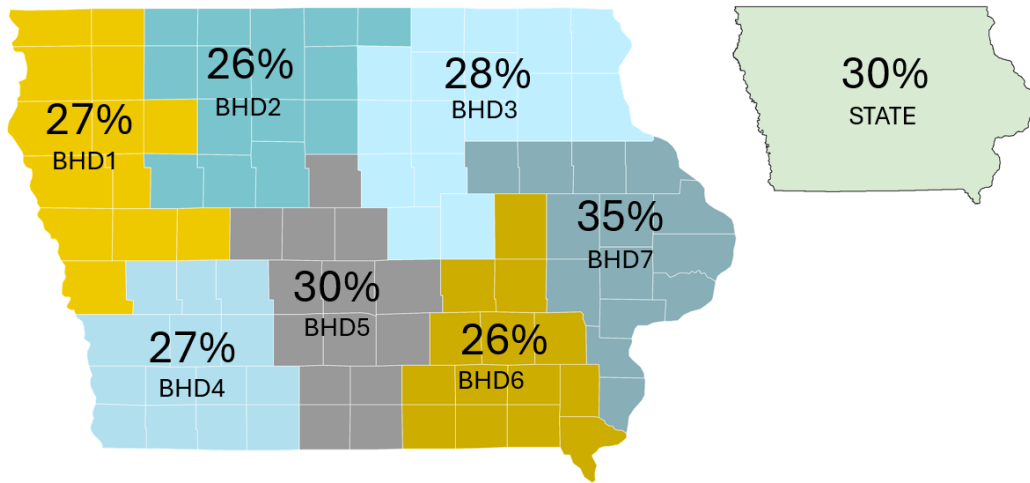


Figure 49. Respondents who were told by health care professionals that they have a depressive disorder (state and by BHD)

One in five respondents in the state considered themselves in recovery from past mental health illness (20%; see Figure 50).

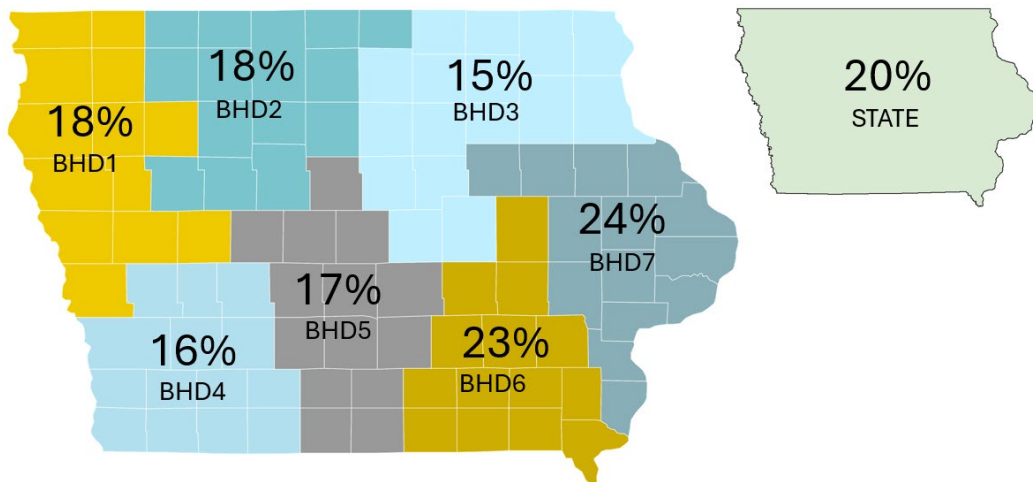


Figure 50. Respondents who consider themselves in recovery from past mental illness (state and by BHD)

Perceived stigma

Four questions assessed respondents' perceived stigma toward receiving substance use, mental health, or gambling treatment. More than half of respondents (55%) indicated that they **agree or strongly agree** that it might harm their chances when applying for jobs. About one in three (30%) reported they agree or strongly agree that they would be embarrassed or ashamed about receiving the treatment. Roughly four in 10 respondents indicated that they agree or strongly agree that they were concerned that people would not take them seriously (36%) or that they were concerned about what people at their work might think, say, or do (40%; see Figure 51).

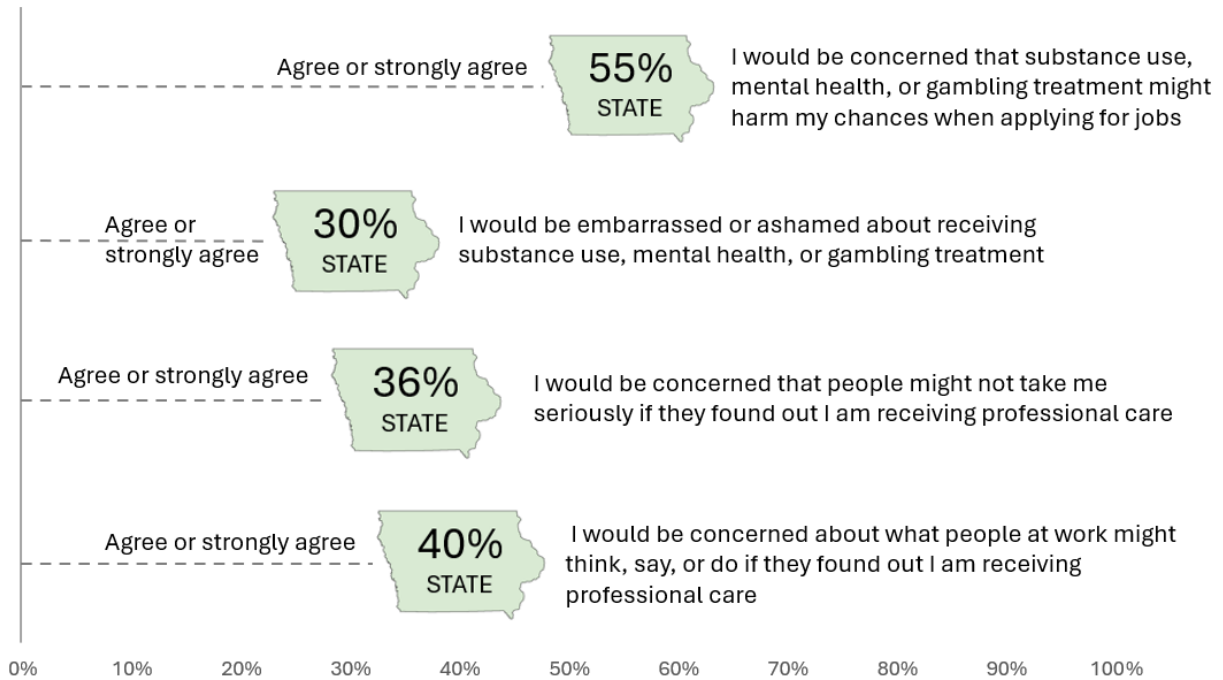


Figure 51. Respondents' perceived stigma

Summary and Conclusions

The 2025 Iowa Health and Wellbeing survey is the first statewide survey of Iowa adults implemented since the Iowa Behavioral Health Districts (BHDs) were established. As in the prior statewide survey in 2021 it asked about Iowa adults' awareness of state resources such as YLI, respondents' health status, substance use, gambling and mental health in a single survey. New topics on the 2025 survey included asking Iowans about their perceptions of cancer risk, stigma, and opioid overdose prevention and treatment. The 2025 questionnaire also included more detailed assessment of tobacco and nicotine product use.

Additionally, this year's survey has some substantial methodological differences noted in the Background and Methodology section of this report. Stratified sampling by BHD and weighting to adjust for any areas of over- or underrepresentation in the statewide and BHD samples allows us to generalize the sample findings both to those of the adult state population and within each of the BHDs. Although limitations exist in all surveys (see those noted in the Methodology section), the study design and weighting of this survey provide a rigorous foundation to ensure that the findings of the study will provide valuable information for planning and implementation of prevention and treatment programs across the state in the coming years.

This report focused on an initial descriptive analysis for the state and by BHD. Interestingly, some of the state-level estimates show marked changes from those reported in the 2021 statewide survey report¹⁵ (e.g. awareness of YLI increased from 4% in 2021 to 9% in 2025). In general, the estimates across the BHDs did not differ significantly for many of the primary topics of interest (e.g. health status, awareness of state resources, or level of perceived stigma). The few areas where significant differences in responses existed across the BHDs included:

- The percentage of respondents who indicated that they were aware of gambling counseling and treatment services in their area differed significantly across the BHDs, ranging from 46% in BHD6 to 63% in BHD7 ($p \leq 0.05$).
- The percentage of respondents who indicated that they feel "very comfortable" contacting 1-800-BETS-OFF differed significantly across BHDs, ranging from 21% for BHD6 to 34% for BHD3 ($p \leq .05$).
- The percentage of respondents who reported that they needed to talk or seek help due to mental health such as stress, depression, problems with emotions, excessive worrying or troubling thoughts differed significantly across BHDs, ranging from 20% for BHD1 to 40% for BHD7 ($p \leq .001$).
- The percentage of respondents who indicated that they felt sad or hopeless in the past 30 days differed significantly across BHDs, ranging from 13% for BHD1 to 24% for BHD7 ($p \leq .05$).
- The percentage of respondents who used CBD products in the past 30 days differed significantly across BHDs, ranging from 3% for BHD1 to 11% for BHD7 ($p \leq .01$).
- The percentage of respondents who ever used flavored vape or nicotine products differed significantly across the BHDs, ranging from 16% for BHD3 to 31% for BHD7 ($p \leq .05$).

¹⁵ Park, K.H., Radunzel, J., Endres, K., & Losch, M. (2022). *2021 Iowa Health, Wellbeing, Use of Substances and Gambling Survey*, Cedar Falls, IA: Center for Social and Behavioral Research, University of Northern Iowa.

- The percentage of respondents who indicated that they had been diagnosed with cancer differed significantly across BHDs, ranging from 9% for BHD5 to 19% for BHD3 ($p \leq .05$).
- The sources selected by respondents about where they get information about behaviors and exposures associated with an increased risk of cancer differed significantly across the BHDs, indicating that there are some regional differences on how adult lowans get health related information. The sources with significant differences across the BHDs included:
 - The percentage of respondents who indicated social media as a source for information about behaviors and exposures associated with an increased risk of cancer ranged from 45% in BHD6 to 61% in BHD5 ($p \leq .001$).
 - The percentage of respondents who indicated internet (e.g. YouTube, websites, etc.) as a source for information about behaviors and exposures associated with an increased risk of cancer ranged from 42% in BHD6 to 58% in BHD1 ($p \leq .05$).
 - The percentage of respondents who indicated newspapers as a source for information about behaviors and exposures associated with an increased risk of cancer ranged from 21% in BHD4 to 34% in BHD2 ($p \leq .05$).
 - The percentage of respondents who indicated that they had not read, seen, or heard anything about the risk of developing cancer in the past year ranged from 6% for BHD1 and BHD2 to 14% for BHD6 ($p \leq .05$).

These descriptive findings provide an important, high-level summary, but they do not provide important detail and nuance to understand differences across groups, experiences, or indicators of important predictors of response. Future analysis and reports could focus on expanded bivariate analyses of responses by their demographic characteristics such as sex, race/ethnicity, income, or education, as well as on specific behaviors (e.g. use of alcohol) and how each behavior relates to multiple factors simultaneously. Other valuable analyses could illuminate how behavioral intentions to reduce cancer risk relate to demographic and other behavioral characteristics (e.g., substance use).