

Core Service Report

Adolescent / Youth Counseling

Consumer Category:
Behavioral Health Conditions

Primary Consumer Group:
**Persons With or At Risk of
Mental Illness**



February 2007

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COMPANION REPORTS

In addition to the information included in this report, a report of the other core services (80 in total), community leader key informant interviews, United Way - First Call for Help staff focus groups, consumer snapshots, and e-survey of United Way funded executive directors, board presidents, and United Way Community Investment staff are available at <http://www.uws.org>.

ACKNOWLEDGEMENTS

We are grateful to the multiple public and private funders, provider agencies, experts in the various fields of interest, external reviewers, United Way Community Investment Committee clusters, and staff of United Way for their assistance, support, information, and insight. We would like to acknowledge the substantial contributions of the Cuyahoga County Community Mental Health Board.

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SNAPSHOT

AIRS Code Level I: R – Mental Health Care & Counseling
AIRS Code Level II: RP – Outpatient Mental Health Care
Core Service: Adolescent/Youth Counseling RP-450.050

Investment Committee: Strong Families = Successful Children
Cluster: Mental Health/Counseling

AIRS Definition: Programs that specialize in the treatment of adolescents, usually age 12 or 13 through 17, who have adjustment problems, behavior problems, emotional disturbance, a personality disorder or incipient mental illness.

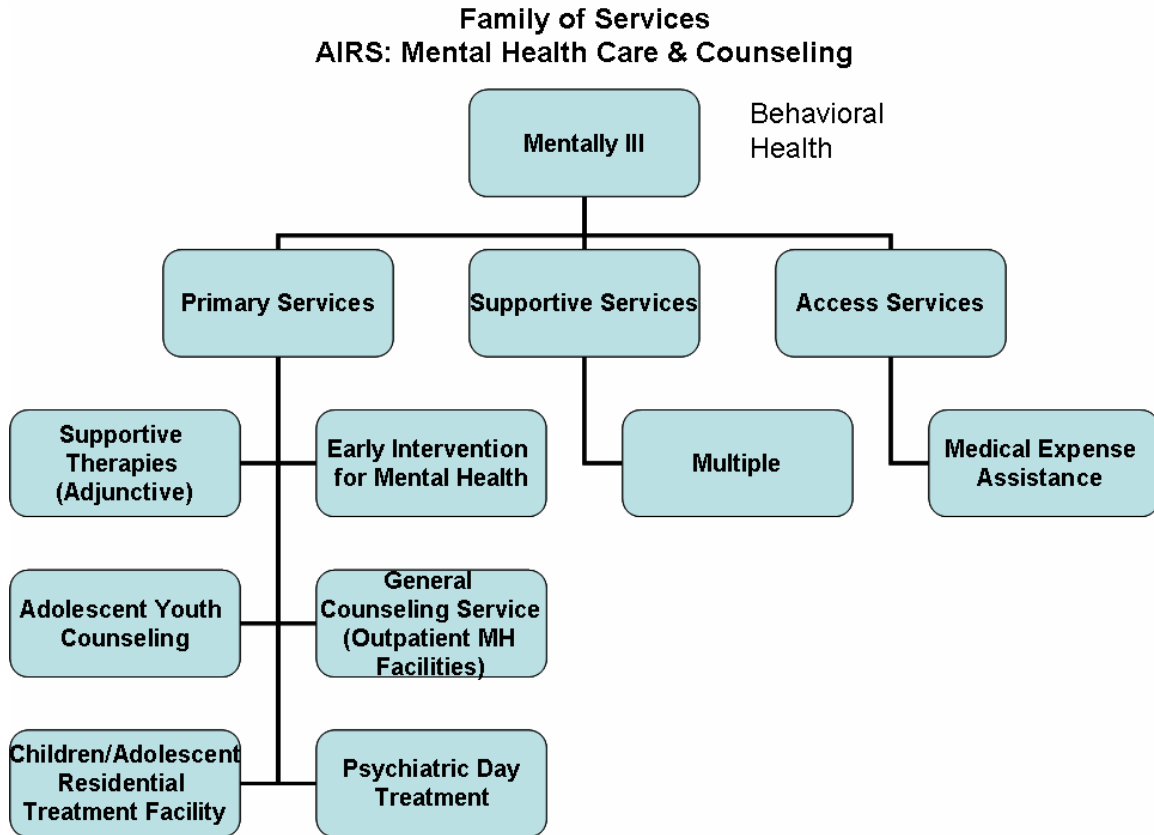
Special Note: There are six core services related to persons with or at risk of mental illness. In order to avoid as much duplication as possible across reports, the core services were organized as a continuum across the mental health services. The table below distinguishes the services by age, severity and service description. Certain sections of the reports are necessarily common across each report, such as the public policy and accreditation sections. Other sections such as the core service environment, service delivery, and what works sections are customized to that population. Some sections will be mixed because of the way funding is reported. For instance, it is not always possible to break out mental health funding by age, as opposed to a core service area such as general counseling. Where possible, every effort was made to make each of the mental health core service reports unique to its population.

Core Service	Consumers		Service Description
	Age	Severity	
Early Intervention for Mental Illness	Children 0-5 years	Have or are at risk for psychiatric disorders.	Programs that conduct general screening efforts for early identification of children 0-3 who have incipient problems to ensure the best possible prognosis; and programs that provide treatment for individuals ages 0-5 whose personal condition and social experiences could potentially produce mental, emotional, or social dysfunctions, with the objective of preventing their development.
Adolescent Youth Counseling	Children and youth 5-17 years	Any mental disorder or serious emotional disturbance	Programs that specialize in the treatment of adolescents through services that are provided in traditional settings (offices and clinics) as well as in the client's natural environment (home, school, or community)
Children's/Adolescent Residential Treatment	Children and youth 5-17 years	Serious emotional disturbances (SED)	Programs that provide a therapeutic living environment in a community-based facility
General Counseling Service (Outpatient Mental Health Facilities)	Adults ages 18+ years	Moderate to severe mental illness who do not need twenty-four hour care	Programs that provide mental health services in outpatient settings
Psychiatric Day	Children,	Any severe mental	Programs that provide therapeutic

Core Service	Consumers		Service Description
	Age	Severity	
Treatment	youth and adults ages 5+ years	disorder that does not require full-time hospital care, but can benefit from a structured environment for some portion of the day or week	services in a structured outpatient setting for several hours of each day and multiple times per week
Supportive Therapies	Children, youth and adults ages 5+ years ¹	A mental disorder	Programs that utilize guided expressive or recreational activities or other specialized interventions as auxiliary forms of treatment to improve the adjustment of individuals with mental, emotional, or social problems; and to facilitate other forms of therapy. Supportive therapies may be used for diagnostic purposes and are, on occasion, utilized as primary treatment modalities.

¹ Supportive therapies are utilized for individuals of all ages, including children under 5. However, most of the important sources utilized in this report (specifically the Cuyahoga County Mental Health Assessment report of 2003 produced by the Center for Community Solutions and the Cuyahoga County Community Mental Health Board) did not provide information for individuals younger than 5. The report on Early Intervention for Children with Mental Illness focuses on this population.

The Adolescent or Youth Counseling Program is part of a family of services for persons with or at risk of mental illness. It is one of six services targeting this consumer group. Medical expense assistance is also a service that helps those who are uninsured or under-insured access mental health services. (See figure below.)



Core Service Environment

Youth with mental health disturbances have elevated rates of substance abuse problems, which may reflect a generally defiant stance toward societal norms and/or an attempt to self-medicate emotional pain. These youth need services that address both their mental health and substance abuse problems. Only about one fifth of these young people receive specialty mental health services. About twice that number receive some type of service from the education, medical, child welfare, or juvenile justice systems, but these services probably do not address clients' mental health problems as directly and effectively as specialized mental health treatments. Research indicates that, with behavioral symptoms held constant, Caucasian youth are more likely to become involved in the mental health system while African American adolescents are more likely to become involved in the juvenile justice system; this discriminatory pattern results in a failure to meet the mental health needs of many African American youth.

A major funding policy that affects all children and adults involved with the publicly supported mental health system is the Community Mental Health Services Block Grant Program. It distributes funds to states through a formula based upon specified economic and demographic factors. The program's overall goal is to move care for adults with SMI (serious mental illness)

and children with SED (serious emotional disturbance) away from costly and restrictive inpatient hospital care and into the community.

Insurance parity, or equal treatment for mental health and addiction treatment, is one of Ohio's major public policy issues affecting private funding for mental health related services through insurance. Coverage for the "diagnosis, care and treatment of biologically based mental illnesses" was written into the new state law SB 116. This law was signed on December 29, 2006 and will take in March 2007.

Greenfield (2005) found that there are two major barriers to policies and full implementation of parity policies: 1) fear of an unmanageable rise in health care costs; and 2) societal stigmas in respect to psychiatric and substance abuse disorders.

Medicaid seems to be the single public policy with the greatest impact on mental health services, including eligibility criteria, covered services, and reimbursement rates. In 2005, Ohio passed a Medicaid budget that significantly limited the projected increase in Medicaid spending mainly by reducing benefits, eligibility, and reimbursements. The Ohio Department of Job and Family Services (ODJFS) estimates that 27,000 patients will lose coverage through this policy action.

According to the Ohio Department of Mental Health (n.d.), the system for delivering services to Ohioans with mental illnesses and emotional disorders will be transformed. Ohio has been awarded \$12 million by the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance system transformation planning.

Core Service Consumers

The target population addressed in this core service report is any person aged 5-17 years with "any mental disorder" or "serious emotional disturbance."

Mental health problems are even more common in children than adults. At any given time approximately 20 percent of American children have an emotional or behavioral disturbance (U.S. Public Health Service, 2000). About 7 percent of young people have a serious emotional disturbance that substantially impairs their functioning and development (U.S. Department of Health and Human Services, 1999).

More than half of the youth treated in community mental health centers are referred because of some type of disruptive behavior problem, with common (and frequently co-occurring) diagnoses including oppositional-defiant disorder, attention deficit hyperactivity disorder, and conduct disorder (Mash & Wolfe, 2005). Most other referred youth have anxiety or depressive diagnoses. Disruptive behavior disorders are more common in boys, and diagnoses based on emotional distress are more common in girls.

According to the Cuyahoga County Mental Health Assessment (2003), approximately 53,712 children ages 5-17 (20.94 percent of the total population 5 to 17 years) have a mental disorder and 17,990 have a serious emotional disturbance (SED) (7 percent of the 5 to 17 age cohort).

In 2000, 53,712 individuals 5-17 in Cuyahoga County were estimated to have a mental disorder and possibly in need of adolescent youth counseling. The number of individuals 5-17 with a mental disorder is projected to decrease to 46,328 by 2015 because of shifts in the population.

Core Service Delivery

The definition of the core service for this report is: programs that specialize in the treatment of adolescents with mental health issues provided in traditional settings (offices and clinics) as well as in the client's natural environment (home, school or community).

For youth in Cuyahoga County, most counseling takes place in outpatient clinic settings and in schools. There is an under-supply of empirically supported, intensive, in-home interventions such as multi-systemic therapy for youth with SED. Despite the positive outcomes of this intervention, and lower costs than residential treatment, multi-systemic therapy is currently offered only by Cuyahoga County Juvenile Court and Berea Children's Home and Family Services. On the positive side, Tapestry, a major new federally-funded initiative administered by the Cuyahoga County Community Mental Health Board, brings together a number of organizations to improve coordination of interventions, provide wraparound services, and increase use of evidence-based practices for SED clients.

There is no data available from United Way - First Call for Help Call for this core service. Callers are referred by type of counseling needed (i.e. drugs, family, abuse, etc.) rather than by age.

The majority of funding for adolescent/youth counseling comes from Medicaid and the Children's Health Insurance Program (CHIP). This funding comes from the federal government and is passed through the state to local agencies that provide mental health services for youth. For Cuyahoga County, this is the Cuyahoga County Community Mental Health Board (CCCMHB). CCCMHB itself does not provide services, but it does fund providers.

Between 2002 and 2004, funding for adolescent/youth counseling programs decreased by 13 percent in Cuyahoga County: from \$2.3 million in 2002 to \$2 million in 2004.

Medicaid funding for community mental health services increased from \$57.6 million in 2002 to \$67.8 million in 2004. However, it includes all mental health services, not just adolescent/youth counseling.

As of May 11, 2006, nearly \$2.2 million in revenues for adolescent/youth counseling programs has been identified countywide, excluding Medicaid dollars. Over ninety-three percent of the revenues identified are from contracts or grants from government organizations. In FY 2004, United Way did not fund the adolescent/youth counseling core service.

The average cost of adolescent/youth counseling services is between \$90 and \$130 per hour. The government typically reimburses anywhere between \$0 and \$90 for these services.

What Works; What Doesn't

The most significant finding in outcome research is that therapy provided in community settings is not as effective as that provided in research-controlled settings.

Outcome research with adolescents exhibiting conduct disorders generally provides stronger support for family therapy than individual treatment. There is little research support for psychodynamic, solution-focused, and narrative interventions for youth, although these strategies are often utilized by therapists.

The overall pattern of outcome findings suggests that, at least for most clients, therapy may be more effective when it focuses on specific behaviors, thoughts, and family interaction patterns, compared to more non-directive and open-ended therapies. Therapists may be more effective

when they give clients substantive input in the form of skills training, behavioral directives, and the development of more adaptive thoughts, compared to when services are limited to the provision of support, empathy, and a forum for talk—although those elements of therapy are probably necessary for the type of alliance that makes such techniques effective.

Unfortunately, a recent study by Ma and his colleagues suggests that pharmacotherapy is used to substitute, rather than complement, psychotherapy/mental health counseling (Ma et al., 2005).

Feedback from the United Way core service planning process focus groups and key informant interviews (2005) revealed that many who work with youth and adolescents believe that a new approach to meeting client needs is necessary. One respondent described it this way, “...*working with the old way of doing business is outdated*,” by which he meant fragmented services that occur away from the community.

Mental health disturbances create a high financial cost to individuals and society.

Most non-medical mental health services are provided by members of three professions: psychology, social work, and counseling. All three must be licensed in the State of Ohio. In addition, licensed psychiatrists, marriage and family therapists, registered nurses, music therapists, art therapists, and pastoral counselors also provide psychotherapy to clients.

Gap Analysis

Including both realized (13,559) and unrealized access (2,470), the estimated universe of possible consumers for adolescent/youth counseling programs is 16,029 children and youth 5-17.

I. FOREWORD

INTRODUCTION

United Way of Greater Cleveland (UW), in partnership with the Cuyahoga County Board of Commissioners, has initiated a large scale core service planning process to generate data and engage in community-wide dialogue about the community's safety net of core service and consumer needs in the Greater Cleveland area. In addition, UW envisions this process as an opportunity to better understand its role in the community and its long term capacity to improve the lives of Greater Clevelanders.

The primary goal of the Cuyahoga County core service research is to identify consumer needs and assess whether there are service gaps/duplications on a community-wide level. The findings from this research will guide future funding decisions at UW, and they will also be used to stimulate dialogue with other funders and groups in the community. United Way intends to continue to fund a broad array of "safety net" services that are important to the Greater Cleveland area. But it is hoped that the research findings will inform how UW dollars may be dispersed to have the greatest impact on current realities, needs, and priorities in the Greater Cleveland community.

METHODOLOGY

United Way contracted with MCS Consulting Service, LLC, to conduct the core service research, which focuses on both the consumers served and services provided. (See Attachment 1 for list of members of the research team.) The research team has obtained information about each core service from multiple data sources. At the end of the research process there will be substantial information available for some services and less for others, which will provide a clearer picture of what information *is* available and where there are *significant gaps*.

The questions addressed are:

- Including public policies, what are the environmental influences that are impacting both service consumers and the capacity for service delivery?
- Who are the service consumers? What are the factors that lead to a need for services? How many consumers are there? How many have there been in the past several years and what factors influenced the historic trend line? What are the projected numbers for the future? What is their demographic profile? Where do they reside? How many are receiving services funded by government and/or United Way?
- What is the philosophy that drives service delivery? Has it changed? What does the service consist of? Who provides the service?
- What are the funding sources? What are the annual revenues from government sources, federated fund raising organizations, foundations, and United Way of Greater Cleveland? What are the historic government funding trends and what is projected for the future? What is the reimbursement amount?
- What works and what doesn't work in service delivery?
- Are there service gaps, duplication, under-utilization?

The primary information sources used for this report are:

- Results of 20 focus groups with 159 direct service staff of United Way member agencies and non-members, and key informant interviews with 93 experts in the respective service areas (February 2005). Participants were asked about consumer populations that are increasing and those with unmet needs; they provided insight about specific service gaps and duplication, as well as services they perceive to be outdated or under-utilized.
- United Way Program Report data for FY 2004 (July 2003 to June 2004). Each year United Way member agencies submit information to their respective investment committees on each funded core service they provide. Among other things, this information includes a demographic profile of the consumers served, the zip codes where the consumers reside, and all revenue sources that support the service. The research team has aggregated this information for each core service.
- United Way - First Call for Help call data (2000 to 2004) - United Way - First Call for Help provides a 24/7 information and referral service through its 211 telephone line. The research team analyzed data from its large database, which includes the names of service providers for most core services, the activities they provide and the zip codes in which they and those they serve are located, the number of calls received, and whether the need was met or unmet. Unmet needs are those for which there was no resource to reference.
- Literature reviews on service trends and issues as well as best practices (i.e., what works/ what doesn't work in service delivery), including impact on the individual/family and on the community.
- Searches for information on public policies that are currently impacting consumers or service delivery.
- U.S. Census and American Community Survey data for various time periods.
- Data from funders on actual consumer populations and funding levels.

(See Attachment 2 for technical notes on the research methodology as well as limitations of the data.)

II. THE CORE SERVICE ENVIRONMENT

CORE SERVICE ENVIRONMENT

Youth with mental health disturbances have elevated rates of substance abuse problems, which may reflect a generally defiant stance toward societal norms and/or an attempt to self-medicate emotional pain. These youth need services that address both their mental health and substance abuse problems.

Unfortunately, most children with mental disorders do not receive appropriate treatment. Only about one fifth of these young people receive specialty mental health services. About twice that number receive some type of service from the education, medical, child welfare, or juvenile justice systems, but these services probably do not address clients' mental health problems as directly and effectively as specialized mental health treatments. Research indicates that, with behavioral symptoms held constant, Caucasian youth are more likely to become involved in the mental health system while African American adolescents are more likely to become involved in the juvenile justice system; this discriminatory pattern results in a failure to meet the mental health needs of many African American youth.

Most counseling for adolescents and children occurs in outpatient clinic settings, utilized annually by approximately 5 to 10 percent of children and their families in the United States. Outpatient settings include community-based, hospital-based, and private practice clinics. Sometimes, counseling is also delivered as in-home treatment. Compared to outpatient therapy, in-home counseling is offered to a smaller number of youth who need a more intensive level of intervention.

Counseling for youth and adolescents occurs in individual, family, and group treatment modalities. Youth counseling involves a large variety of therapeutic approaches, with most falling into the broad theoretical categories of behavioral, cognitive (often combined as cognitive-behavioral intervention), family systems, psychodynamic, solution-focused, and narrative therapies. Much counseling involves components that are less well-defined theoretically, such as expressive and supportive therapy.

In a study conducted at Stanford, research indicated that the number of adolescents taking antidepressants is up while at the same time fewer depressed teens are being treated with psychotherapy or mental-health counseling (Ma et al., 2005). The number children and adolescents being seen in clinics for depression more than doubled. However, mental-health counseling—including psychotherapy—dropped from 83 to 68 percent, and approximately 42-52 percent of all adolescent patient visits involving medication did *not* incorporate counseling into treatment.

PUBLIC POLICY ISSUES

Although public policy sometimes has significant effects on high-intensity, expensive forms of mental health intervention such as hospitalization and residential treatment, outpatient counseling services generally run a smooth course from year to year, without major changes resulting from shifts in policy. Medicaid and private insurance both pay for these sessions, although providers must sometimes justify long courses of treatment by submitting written treatment plans. Below are some of the major national and state public policy issues that affect adolescent/youth counseling programs.

NATIONAL

Federal Laws and Regulations

Community Mental Health Services Block Grant Program

The Community Mental Health Services Block Grant Program is a major source of funding for local mental health boards. The program distributes funds to states to move care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED) away from costly, restrictive inpatient hospital care and into the community. Ninety-five percent of the funds allocated to the block grant program are distributed to states through a formula prescribed by the authorizing legislation. States are required to use the funds to carry out the annual plan submitted with the block grant application. Factors used to calculate the allotments include total personal income; state population data by age groups; total taxable resources; and a cost of services index factor. Funds reached 972 sub-grantees in FY 2002. (Substance Abuse and Mental Health Service Administration, n.d.)

Insurance Parity

Insurance parity is equal treatment for mental health and addiction treatment. In 1996, Congress enacted a law requiring that if a group health plan offers any mental health benefits, it cannot impose more restrictive annual or lifetime limits on spending for mental illness than on coverage of other health conditions. The federal law, known as the Mental Health Parity Act of 1996, provides limited parity. It does not require an insurer to provide or offer mental health benefits, does not include benefits for chemical dependency treatment, and does not apply to employers with an average of 2 to 50 employees. In addition, the law exempts plans that can show that meeting the law's requirements would increase the plan's cost by one percent or more. The new law took effect January 1, 1998. The original sunset provision (providing that the parity requirements would not apply to benefits for services furnished on or after September 30, 2001) has been extended five times (U.S. Department of Labor, Employee Benefits Security Administration, 2006). The current extension was in effect through December 31, 2006.

In 1999, an administrative directive from President Clinton to the Office of Personnel Management mandated full parity for mental and substance use disorders in coverage for federal employees (Greenfield, 2005).

Several pieces of current federal legislation address the parity issue. The Senate Health, Education, Labor and Pensions (HELP) Committee narrowly defeated a mental health parity amendment to the Health Insurance Marketplace Modernization and Affordability Act (HIMMA, S 1955) (Daly, 2006). A House version of the legislation is also being discussed.

The Help Expand Access to Recovery and Treatment (HEART) Act of 2005 (S 803) legislation was introduced in the Senate and would amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to provide parity with respect to substance abuse prevention and addiction treatment benefits under group health plans and health insurance coverage (Join Together, 2005). HEART would not mandate insurance companies to offer substance abuse prevention and alcohol and drug treatment coverage, but would require that if an insurer does provide such coverage that it be on par with other medical and surgical benefits. The HEART Act is the companion bill to the Time for Recovery and Equal Access to Treatment in America (TREAT America) Act of 2005 which is the House version.

Greenfield (2005) found that there are two major barriers to policies and full implementation of parity policies: 1) fear of an un-manageable rise in health care costs; and 2) societal stigmas in respect to psychiatric and substance abuse disorders.

STATE

Ohio Regulations

Insurance Parity

As it is at a national level, insurance parity is one of Ohio's major public policy issues affecting private funding for mental health related services through insurance. According to the National Mental Health Association (2005):

This would require health insurance to cover mental health and addiction treatment services (behavioral health) the same as other health services. Many insurance plans arbitrarily require higher deductibles, larger co-payments, limited outpatient visits and lower lifetime caps in treating mental illness or substance addiction. Equal treatment focuses on financial equal treatment not benefits equal treatment. Federal law already requires mental health equal treatment for annual and lifetime coverage maximums for businesses of 50 employees and over.

In Ohio, all health plans that cover state employees have implemented full mental health parity, which includes substance use disorders (Greenfield, 2005).

Until December 2006 when coverage for the "diagnosis, care and treatment of biologically based mental illnesses" was written into the new state law SB 116, Ohio was one of 15 states that did not have parity of all mental health and substance abuse disorders under private insurance plans (National Mental Health Association, 2005). The law was signed on December 29, 2006 and will take effect in March 2007.

The bill is somewhat limited in scope, mandating only that companies offer health insurance that includes coverage for seven "biologically based mental illnesses," including schizophrenia, bipolar disorder and obsessive-compulsive disorder. To help gain industry support, advocates also agreed to eliminate a provision in the bill that called for mandates on alcohol and drug addiction coverage. The bill allows insurance companies to opt out of the mental health mandate if they can demonstrate that it causes overall coverage costs to increase by more than 1 percent over a six-month period (The Cleveland Plain Dealer, 2007).

Medicaid

The single public policy with the greatest impact on mental health services seems to be the Medicaid policy, including eligibility criteria, covered services, and reimbursement rates. In focus group and key informant interviews conducted as part of United Way's core service planning (2005), participants expressed concern about the possibility of future Medicaid cuts.

The Cuyahoga County Community Mental Health Board (CCCMHB) experienced a 66 percent increase in the number of Medicaid consumers between 1995 and 2001 (Federation for Community Planning and CCCMHB, 2003). Coupled with prior cuts in Medicaid and new cuts resulting from the Deficit Reduction Act of 2005, this increase seriously threatens the public system's ability to meet the needs of persons with mental disorders. State efforts to cut

Medicaid expenses have tightened eligibility requirements, with single adults targeted for more cuts than families and children.

In 2005, Ohio passed a Medicaid budget that significantly limited the projected increase in Medicaid spending mainly by reducing benefits, eligibility, and reimbursements. The Health Policy Institute of Ohio published a thorough analysis of the bill. Per its findings, among the many provisions the budget calls for to limit spending, the budget eliminates coverage for patients with incomes between 90 and 100 percent of poverty (100 percent of poverty in 2006 was \$20,000 for a family of four). The Ohio Department of Job and Family Services (ODJFS) estimates that 27,000 patients will lose coverage through this policy action. The budget cut spending for the Disability Medical Assistance (DMA) program by \$80 million over the two years of the budget, reducing it from \$140 million to \$60 million. These changes will have serious impact on Medicaid beneficiaries. (Hayes, 2005)

Medicaid and Family Opportunity Act

On February 8, 2006, the Family Opportunity Act (FOA) was enacted as part of the final federal budget law, the Deficit Reduction Act (DRA). Supported by many organizations that advocate for children and adults with disabilities, the purpose of the FOA is to allow middle-income families with children who have severe mental or physical disabilities to purchase health care coverage through the Medicaid. Under the legislation, individual states:

- can create a new *optional* Medicaid eligibility group for children with disabilities under age 19:
 - a) who meet the severity of disability required under SSI without regard to any asset or eligibility requirements under SSI for children, and
 - b) whose family income does not exceed 300 percent of the federal poverty level (approximately \$58,500 for a family of four).
- can require cost-sharing (premiums and co-pays) on a sliding scale based on income, but cannot exceed five percent of family income up to 200 percent of the federal poverty level, and 7.5 percent of family income from 200-300 percent of federal poverty. The state may waive payment of a premium in any case where the state determines that requiring a payment would create an undue hardship. (Ohio Legal Rights Services, 2006)

The provision went into effect on January 1, 2007. The federal law includes a phase-in approach. In the first year, states can offer Medicaid services to families with incomes up to \$60,000 for a family of four if their child is under the age of 6. In the next year, children up to age 12 can participate and in the third year, children under the age of 18 can participate. (Ohio Legal Rights Services, 2006)

States now need to pass legislation to implement the Family Opportunity Act. Ohio currently does not have a Medicaid buy-in program for children with disabilities. The Ohio Disabilities Council is actively advocating for this provision, and it is a component of their 2007 Public Policy Platform (Ohio Developmental Disabilities Council, 2006).

Mental Health Act of 1988

On March 28, 1988, Amended Substitute Ohio Senate Bill 156, now known as the Mental Health Act of 1988, was signed into law. Recognized as Ohio's most significant mental health legislation in 20 years, the act firmly established the state's commitment to a unified system of community-based services in order to address the mental health needs of Ohioans.

The Mental Health Act is largely based upon the twin values of inclusion and shared responsibility for the mental health service delivery system. The implementation of the Mental Health Act is designed to be phased in over a period of several years.

A brief overview of statistics and key events may be useful to understand where the mental health system was and how it arrived at the point of passage of the Mental Health Act of 1988. According to the Ohio Department of Mental Health's Annual Report for FY 1988:

- In FY 1988, the number of admissions and discharges to state hospitals were virtually the same as in FY 1960.
- The caseload of Ohio's community mental health agencies had increased by nearly 1000 percent, from 12,000 in FY 1960 to more than 127,000 in FY1988.
- The average daily cost per patient in Ohio's state psychiatric hospitals had risen from less than \$10 in FY 1960 to more than \$180 in FY 1988.
- In FY 1988, about 15,000 persons were served in about 4,000 beds in the state psychiatric hospital system. In that same year, FY 1988, over 127,000 people were served in the community system.
- Hospital costs for care in FY 1988 were about \$255.2 million for 15,000 persons served, and community costs were about \$302 million for the 127,000 persons served.

There were obvious disparities between utilization and Ohio Department of Mental Health (ODMH) funding for hospitals as compared to communities. Yet the state, not communities, had financial responsibility for the hospital costs. In the view of some, there were no financial incentives for communities to avoid state hospitalization.

ODMH and community mental health boards (CMH) and agencies began working actively to develop and test alternative funding mechanisms. Three CMH boards were chosen to receive grants from the Robert Wood Johnson Foundation. These awards provided significant financial support and sanctions for precisely the type of systems changes at the CMH board level as were needed in the state system as a whole.

The Mental Health Act did not appropriate new funds for the mental health system, but rather shifted funds to be available in the locations where people were being served by the system. Much of the intent of the act revolved around shared responsibility for the mental health delivery system, and the establishment and improvement of mechanisms through which services could become more responsive to individual needs and more available, accessible, appropriate, acceptable, and of higher quality.

Mental Health Transformation State Incentive Grant

According to the Ohio Department of Mental Health (n.d.), the system for delivering services to Ohioans with mental illnesses and emotional disorders will be transformed. Ohio has been awarded \$12 million by the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance system transformation planning. The Mental Health Transformation

State Incentive Grant is part of the federal response to the president's New Freedom Commission on Mental Health that President Bush charged to make recommendations for improving mental health care and overcoming the fragmentation of health and mental health care. The commission's report, "Achieving the Promise: Transforming Mental Health Care in America," was released in July 2003. As one of seven states receiving funding, Ohio will serve as a platform for learning which strategies and activities hold the most promise for transforming mental health and related systems.

The grant funds may be used only for infrastructure changes, such as planning, collaborating, blended funding, or developing service concepts, policies, and procedures that support a transformation agenda. A multi-agency cabinet level group will examine and improve approaches to care across the many areas of government (e.g. health care, criminal justice, education) that touch the lives of persons with mental illness and their families. This model is already being utilized successfully in Ohio. For example, as part of Governor Taft's Access to Better Care (ABC) initiative for children, human service cabinet agencies are collaborating to improve supports to children with behavioral disorders, and their families, across multiple care systems. Similar collaborations are helping adults through mental health diversion and prison re-entry initiatives. Because people with mental illness and emotional disorders live in all communities and are in many human services settings, this focus on behavioral health issues and collaboration across settings is essential, both to improve outcomes of these systems and to better meet the needs of mentally ill people wherever they are.

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

The target population addressed in this core service report is any person aged 5-17 years with “any mental disorder” or “serious emotional disturbance.”

DEMOGRAPHIC CHARACTERISTICS

Mental health problems are even more common in children than adults. At any given time, approximately 20 percent of American children have an emotional or behavioral disturbance (U.S. Public Health Service, 2000). About 7 percent of young people have a serious emotional disturbance that substantially impairs their functioning and development (U.S. Department of Health and Human Services, 1999).

More than half of the youth treated in community mental health centers are referred because of some type of disruptive behavior problem, with common (and frequently co-occurring) diagnoses including oppositional-defiant disorder, attention deficit hyperactivity disorder, and conduct disorder (Mash & Wolfe, 2005). Most other referred youth have anxiety or depressive diagnoses. Disruptive behavior disorders are more common in boys, and diagnoses based on emotional distress are more common in girls.

Achenbach, Dumenci, and Rescorla (2003) reported the results of national survey research on rates of mental health problems in American youth in 1976, 1989, and 1999. Problem frequencies increased from 1976 to 1989, then decreased somewhat in 1999, and remain at a significantly higher level than in 1976.

A report by the Federation for Community Planning (now the Center for Community Solutions) and the Cuyahoga County Community Mental Health Board (2003) estimated the number of children with mental disorders in Cuyahoga County, based on national prevalence data and county population figures. This calculation produced estimates of 53,712 children and adolescents aged 5-17 years old with mental health disorders—approximately 20.9 percent of the 5-17 year population. Assuming that national prevalence rates apply locally, the study estimates that there are 17,990 youth with serious emotional disturbance in Cuyahoga County. (See Table 1.) The majority of these issues are related to anxiety and disruptive disorders.

Table 1: National Prevalence Rates and Estimated Number of Persons in Need in Cuyahoga County Mental Health Assessment, December 2003

Type of Disorder	# of Persons	% of Total
Total Population 5-17 years	256,467	
Any Disorder	53,712	20.94%
Anxiety Disorders	33,409	
Mood Disorders	15,934	
Disruptive Disorders	26,470	
Serious Emotional Disturbance	17,990	

Source Cuyahoga County Mental Health Assessment, December 2003

In Cuyahoga County, estimates of the mental health status of children who have been diagnosed show that 17 percent of youth 5-17 had been informed of a learning disability, 15 percent informed about ADHD (Attention Deficit Hyperactivity Disorder), and nearly 30 percent had taken prescription medication regularly for at least 3 months (Dey & Bloom, 2005).

According to the report referred to in Table 1 above, risk factors for mental health problems (poverty, unemployment, etc.) are higher in Cuyahoga County than in other urban areas and Ohio as a whole. This research estimated that the public mental health system reaches only 32 percent of all residents with mental disorders with an income less than 200 percent of the poverty level. Hispanics and Asian Americans are less likely to receive services than Caucasians and African Americans.

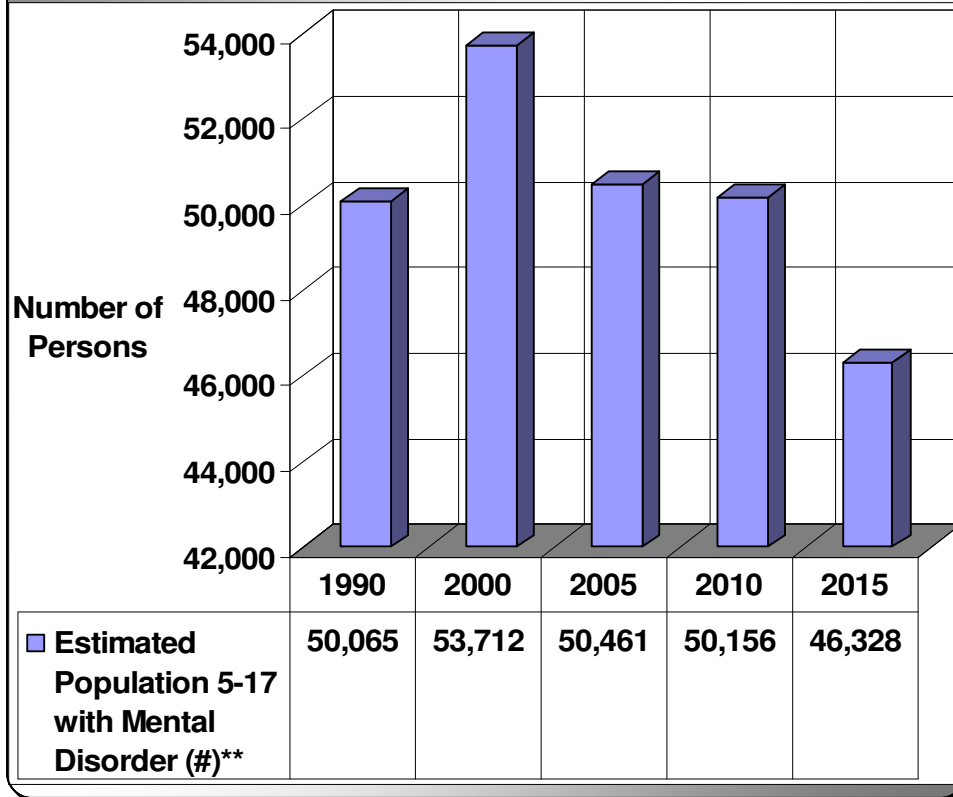
The public mental health system focuses its resources on the relatively small number of people with severe mental illnesses. The Center for Community Solutions/CCCMHB report estimated that the public system serves only 2 percent of Cuyahoga residents with anxiety disturbances, but 54 percent of people with schizophrenia.

Estimated Persons in Need

Two groups are important in determining the need for adolescent/youth counseling programs: those receiving counseling in a traditional office or clinic setting, and those receiving counseling services delivered out of the office and in the client's natural environment (such as at home).

In 2000, 53,712 individuals 5-17 in Cuyahoga County were estimated to have a mental disorder and possibly in need of adolescent youth counseling. This represents 20.9 percent of the 5-17 population. The number of individuals 5-17 with a mental disorder is projected to decrease to 46,328 by 2015 because of shifts in the population of the county. (See Figure 1.)

**Figure 1: Adolescent/Youth Counseling
Estimated Persons in Need
Cuyahoga County, 1990-2015**



Sources:

* U.S. Census 1990, STF 1 (P11); 2000, SF3 (P8); 2004, American Community Survey; 2010, Ohio Department of Development, (July, 2003). Note: Age 5-17 in 2010 was prorated from ages 5-19 using ratios from 2004 age group data.

** "Cuyahoga County Mental Health Assessment," Center for Community Solutions, December 2003; 20.9 percent of population 5-17. Assumes same percentage for each period.

It is recognized that this is a conservative estimate of persons in need of adolescent/youth counseling because persons with low-level anxiety or conduct disorders may never be identified or come into contact with the mental health system. However, it is a number that begins to offer some clarity about the extent of need in Cuyahoga County.

REALIZED ACCESS TO SERVICE

Realized access to service is represented by the number of consumers actually served. It includes the actual number of consumers reported by agencies funded by United Way and by government funders from which it was possible to obtain data. Thus, it is an underestimate of actual numbers of consumers receiving service.

United Way did not fund the adolescent/youth counseling core service in FY 2004. However, estimates can be extrapolated from the UW annual reports for general counseling and outpatient mental health facilities. In FY 2004, United Way funded approximately 1,300 persons 5-17 years for general counseling. The UW report data does not break down the percentage of consumers receiving outpatient mental health services by age, but it did fund a total of 5,787 consumers for this service across all age groups. In FY 2004, the Cuyahoga County Community Mental Health Board identified 13,559 actual annual consumers of adolescent youth counseling services.

In 2000, according to the U.S. Census, 58 percent of the county's total 5-17 population was Caucasian, 36 percent African American, and 2 percent Asian. Youth funded by the Cuyahoga County Community Mental Health Board were 26 percent Caucasian, 65 percent African American, and less than 1 percent other races.

Approximately 7.5 percent of both the county's 5-17 years population and the CCCMHB consumers were Hispanic.

No income or geographic data was provided for CCCMHB consumers. (See Attachments 3 and 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of the core service for this report is: programs that specialize in the treatment of adolescents through services that are provided in traditional settings (offices and clinics) as well as in the client's natural environment (home, school, or community).

BACKGROUND ON CORE SERVICE

For youth in Cuyahoga County, most counseling takes place in outpatient clinic settings and in schools. There is an under-supply of empirically supported, intensive, in-home interventions such as multi-systemic therapy for youth with SED. Despite the positive outcomes of this intervention, and lower costs than residential treatment, multi-systemic therapy is currently offered only by Cuyahoga County Juvenile Court and Berea Children's Home and Family Services. On the positive side, Tapestry, a major new federally-funded initiative administered by the Cuyahoga County Community Mental Health Board, brings together a number of organizations to improve coordination of interventions, provide wraparound services, and increase use of evidence-based practices for SED clients.

The status report from the City of Cleveland's poverty summit indicates that the city is developing an early childhood mental health framework that entails both system and child/family outcomes, as well as the preliminary development of an early childhood mental health evaluation.

United Way – First Call for Help Call Data

There is no data available from United Way - First Call for Help Call for this core service. Callers are referred by type of counseling needed (drugs, family, abuse, etc.) rather than by age.

FUNDING OF CORE SERVICES

Major Government Funders

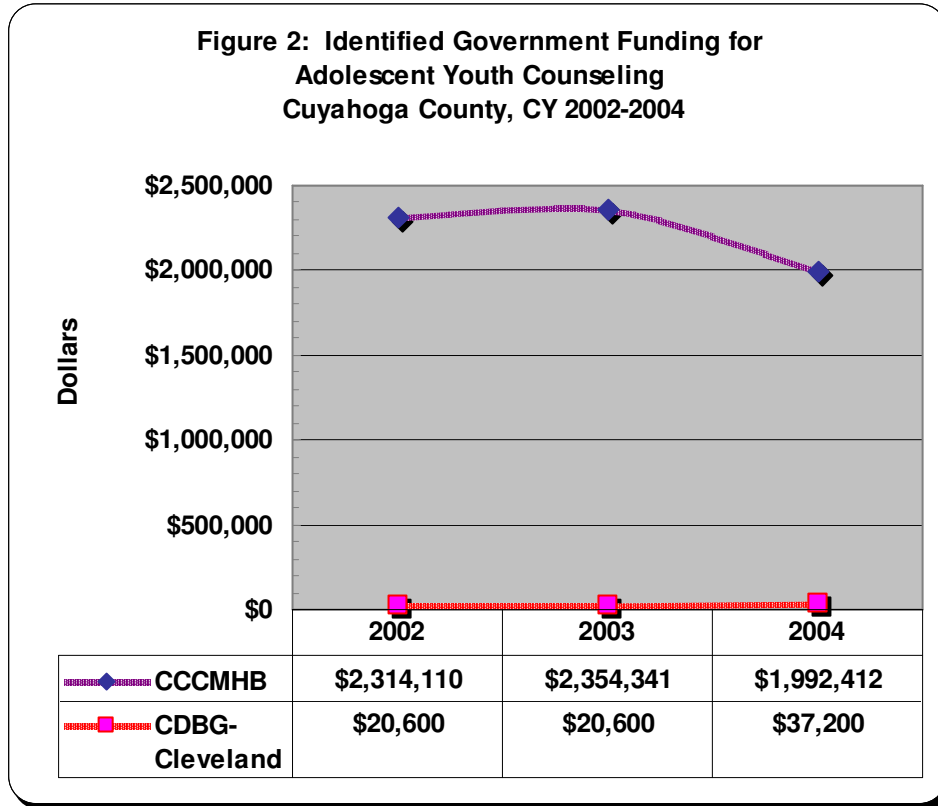
The major sources of government funding of adolescent/youth counseling programs are:

- Community Development Block Grant Program
- Community Mental Health Services Block Grant Program
- Cuyahoga County General Revenue Fund (through the Health and Human Services
- Medicaid (Health Start/SCHIP and Healthy Families)

Most government funding comes from federal sources and is passed through the state to local agencies that provide mental health services for youth. For Cuyahoga County, this is the Cuyahoga County Community Mental Health Board (CCCMHB). CCCMHB itself does not provide services, but it does fund providers.

Trends of Identified Government Funders in Cuyahoga County

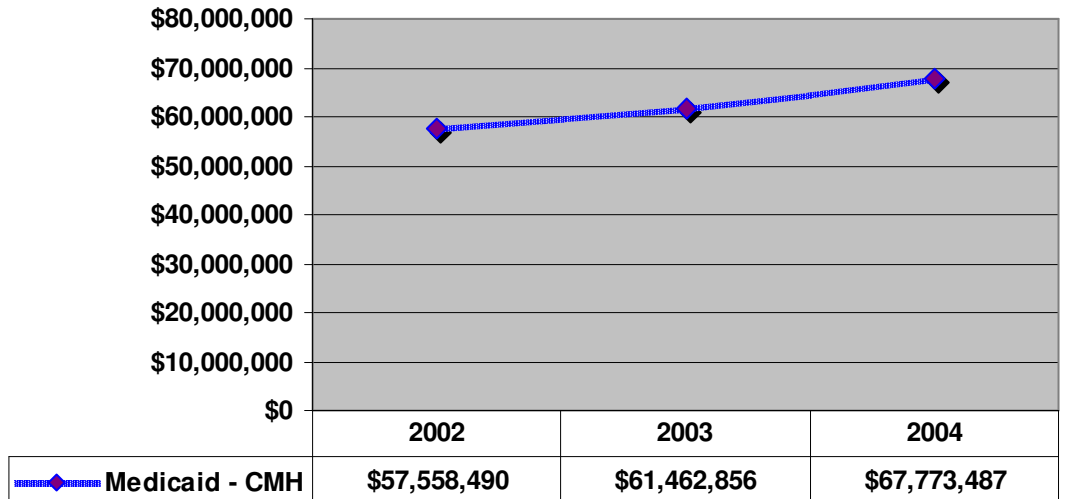
Between 2002 and 2004, funding for adolescent/youth counseling programs decreased by 13 percent in Cuyahoga County: from \$2.3 million in 2002 to \$2 million in 2004. (See Figure 2.)



Source: Respective Funding Sources

Medicaid funding for community mental health services increased from \$57.6 million in 2002 to \$67.8 million in 2004. However, it included all mental health services, not just adolescent/youth counseling. (See Figure 3.)

**Figure 3: Medicaid Funding for CMH *
Cuyahoga County, CY 2002 - 2004**



* Includes the following core services: Adolescent/Youth Counseling, Children's/Adolescent Residential Treatment Facilities, Early Intervention for Mental Illness, General Counseling Services, Outpatient Mental Health Facilities, and Psychiatric Day Treatment.

IDENTIFIED REVENUES

As of May 11, 2006, nearly \$2.2 million in revenues for adolescent/youth counseling programs has been identified countywide, excluding Medicaid dollars. (See Table 2.) This includes information from foundations, federated fundraising organizations, and regional, county and municipal government. Because Medicaid services cross over more than one core service, Medicaid dollars specific to adolescent/youth counseling were not able to be isolated. It is important to note that they account for a significant portion of funding for this core service. (See Figure 3 and Table 2 footnotes.)

Over ninety-three percent of the revenues identified in Table 2 are from contracts or grants from government organizations. The Cuyahoga County Community Mental Health Board (through the county's Health and Human Services levies) and the City of Cleveland (through the Community Development Block Grant) are primary funders of the service. In FY 2004, United Way did not fund the adolescent/youth counseling core service.

Table 2: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland Adolescent/Youth Counseling, 2003/2004.

Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Saint Ann Foundation		25,000			
Woodruff Foundation, The		28,975			
Total - Foundations & Trusts		53,975	2.47%	0	N/A
Jewish Community Federation		90,000			
Total - Federated Fundraising Organizations		90,000	4.12%	0	N/A
Cuyahoga County Community Mental Health (648 Board)	2004	1,992,412			
Subtotal Cuyahoga County Funding Sources		1,992,412	91.11%	0	N/A
Community Development Block Grant	2004	37,200			
Subtotal City of Cleveland Funding Sources		37,200	1.70%	0	N/A
CDBG at Municipality Level	2004	13,200			
Subtotal Other Municipal Funding Sources		13,200	0.60%	0	N/A
Total - Contracts/grants from government organizations		2,042,812	93.42%	0	N/A
Subtotal Non - UWGrCle Support		2,186,787	100%	0	N/A
Total Support/Revenue		2,186,787	100%	0	N/A

* Medicaid dollars have not been entered under countywide total for this core service because not all Medicaid services are a one-to-one match with United Way core services. Medicaid Service - CMH (\$67,773,487 in 2004) - Falls into AIRS 1 Mental Health Care & Counseling and has been entered as an aggregate total for this AIRS Level. CMH includes the following core services: Adolescent/Youth Counseling, Children's/Adolescent Residential Treatment Facilities, Early Intervention for Mental Illness, General Counseling Services, Outpatient Mental Health Facilities, and Psychiatric Day Treatment.

REIMBURSEMENT/COST

The cost of delivering counseling services is generally calculated by the hour. The average cost of adolescent/youth counseling services is between \$90 and \$130 per hour. The government typically reimburses anywhere between \$0 and \$90 for these services.

Counseling services for people with low incomes have traditionally been paid for by Medicaid. Recent cuts in Medicaid funding may result in reduced reimbursement rates and tightened eligibility requirements, with single adults most likely to be targeted. Private insurance plans sometimes limit the number of counseling sessions that will be paid for, although clear statements from providers that additional services are medically necessary usually produce cooperation from insurance companies. The problem of paying for services is most acute for people with incomes that place them between Medicaid eligibility and private insurance affordability; the working poor frequently lack insurance coverage of any kind. Counseling for these clients generally needs to be subsidized by the agency providing the service, and these resources, in turn, are typically provided through sources such as United Way and private donors.

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

With over 300 studies, outpatient counseling is the most extensively studied intervention for children. Reviews of this literature, which often used the statistical technique of meta-analysis to combine results from numerous studies, have identified several broad themes. First, child and adolescent therapy that is carefully defined (usually by a treatment manual) and delivered under carefully controlled research-oriented conditions is usually found to be effective at reducing mental health problems. Typically, effect sizes are of moderate magnitude, with the average treated client showing more improvement than approximately three quarters of youth in control groups. Overall, outcome research has not indicated marked differences in treatment effectiveness as a function of client gender, age, ethnic group, or diagnostic category.

The outcome research literature offers varying amounts of support for different therapeutic approaches. In terms of the number of studies that have produced positive results, behavior therapy is the most well-supported form of intervention, cognitive therapy is second, and there is much support for various combinations of these interventions (called cognitive-behavioral therapy). There is also extensive support for structured forms of family therapy, most of which include prominent cognitive-behavioral elements (e.g., multi-systemic therapy, functional family therapy). Outcome research with adolescents exhibiting conduct disorders generally provides stronger support for family therapy than individual treatment. There is little research support for psychodynamic, solution-focused, and narrative interventions for youth, although these strategies are often utilized by therapists.

Although the interventions examined in research studies have frequently been found effective, the same cannot be said for therapy delivered in community settings. There is very little research on therapy as it occurs on an everyday basis in ordinary clinics that are not participating in a study and, unfortunately, the results that have been obtained are not encouraging. Community therapy does not seem to be as effective as therapy conducted in research settings.

The contrast between outcomes obtained in research and community clinics indicates a need for stronger emphasis on evidence-based practice (i.e., interventions that have received strong support from outcome research). However, depending on the individual needs and strengths of the client, there are probably cases in which the empirically supported strategies found effective for most youth would not be optimal for a specific young person.

In research on child and adolescent treatment, behavioral and cognitive therapies have accumulated much more empirical support than any other type of intervention (Chambless & Ollendick, 2001). Approximately 80 percent of child and adolescent therapy outcome studies have investigated cognitive-behavioral treatment, and the vast majority of these studies produced supportive results. A meta-analysis focusing specifically on these therapies found substantial positive effects across a range of client problems (Durlak, Fuhrman, & Lampman, 1991). Weisz et al.'s (1995) broad meta-analysis directly compared the effect sizes produced by behavioral and non-behavioral interventions and found that behavioral therapies had a larger positive impact on clients.

A meta-analysis of cognitive-behavioral therapy outcome studies found that this type of intervention produces stronger positive effects in youth aged 11 and older, compared to younger children (Durlak et al., 1991). Cognitive and cognitive-behavioral techniques are generally inappropriate for children below 8 years old or so because these strategies require considerable thinking abilities to be beneficial. There are no empirically well-supported therapies for young children whose primary complaint is emotional distress (e.g., anxiety and depression); this sub-population of children represents a gap in the field's repertoire of research-based best practices.

Behavioral parent training has a strong research base as a treatment approach for disruptive behavior disorders in young children. In this treatment modality, the clinician does not provide therapy directly to the child but, instead, trains caregivers in parenting techniques that then provide therapeutically beneficial experiences to children on a day-to-day basis in their natural environment. Caregivers learn how to give effective directives, praise, rewards, and mild negative consequences for misbehavior. Extensive outcome research indicates that this type of therapy reduces disruptive behavior, improves parent-child relationships, and also has positive non-specific effects on children's emotional functioning and self-esteem (Barkley, 1997; McMahon & Forehand, 2003).

There have been four meta-analyses involving comprehensive reviews of the outcome research on child and adolescent therapy (Casey & Berman, 1985; Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995). The results produced by these meta-analyses were quite similar to each other and were consistently encouraging. In most studies reviewed by these meta-analyses, adolescent therapy demonstrated significant positive effects on client symptoms and psychosocial functioning. The effect sizes calculated were in the medium to large range. In the studies summarized by these analyses, the average therapy client achieved more improvement than approximately 75-80 percent of the youngsters in control groups. Most youth who demonstrated improvement continued to show some symptoms of their disturbance at the end of the studies, and only a minority achieved the same level of functioning as average youngsters in non-clinical samples. In the follow-up studies included in these meta-analyses, the positive effects of therapy were usually maintained at least for the 6-month periods typically investigated and sometimes for considerably longer periods of time. In summary, therapy is somewhat helpful for most youngsters, and its beneficial effects usually last for at least six months.

Behavioral and cognitive therapies have accumulated much more empirical support than any other type of intervention (Chambless & Ollendick, 2001). Approximately 80 percent of child and adolescent therapy outcome studies have investigated cognitive-behavioral treatment, and the vast majority of these studies have produced supportive results. A meta-analysis focusing specifically on these therapies found substantial positive effects across a range of client problems (Durlak et al., 1991). Weisz et al.'s (1995) broad meta-analysis directly compared the effect sizes produced by behavioral and non-behavioral interventions and found that behavioral therapies had a larger positive impact on young clients.

Meta-analyses of family systems therapy have produced substantial support for this approach to treatment (Shadish et al., 1993; Stanton & Shadish, 1997). There is particularly strong support for structured forms of family therapy that include cognitive-behavioral elements (e.g., multi-systemic therapy, functional family therapy). Outcome research on treatment for adolescents with disturbances involving overt acting out generally provides stronger support for family therapy than for individual treatment. There is little research support for psychodynamic, solution-focused, and narrative therapies for youth, although these strategies are often utilized by therapists.

Multi-systemic therapy (MST) (Henggeler, 1999; Henggeler & Lee, 2003) is an intensive in-home treatment for young people that utilizes cognitive-behavioral, parent training, and family systems strategies. Multi-systemic therapy utilizes a social-ecological approach that requires therapists to address any aspect of clients' environment that either contributes to their problems or their solutions. These therapists and their backup team are available to clients' families 24 hours a day, 7 days a week for approximately three months of intensive treatment. (There is then a follow-up period with less frequent services.) Multi-systemic therapy takes place in clients' homes and in every other important sector of clients' social environment. Thus, these therapists attend school with clients, go to church with the families, talk to neighbors, meet clients' friends, and so forth. These counselors guide children and parents toward forming positive relationships with pro-social individuals because these relationships will continue to provide help and support long after the counselor has departed. Multi-systemic therapy has received support in a number of studies examining outcomes in youth with severe difficulties such as substance abuse and juvenile delinquency, as well as mental health disturbances. A meta-analysis by Curtis, Ronan, & Borduin (2004) found that the average youth treated with MST showed more gains than 70 percent of the youth in control and comparison groups. The intervention has consistently outperformed conventional juvenile justice services for youth with mental health and delinquency-related problems.

Wraparound services (Grundle, 2002; Van Den Berg, 1993) aim to provide comprehensive, individualized interventions through a combination of case management and flexible funding. Like MST, wraparound services involve an expansive view of mental health treatment that extends beyond traditional professional-client interactions to include virtually any type of relationship or activity with the potential to improve the youth's psychosocial functioning and quality of life. Planned meetings include professional staff and, in addition, other individuals who are important to the youth and who have the potential to provide helpful forms of support and guidance (e.g., neighbors, coaches, relatives). Case managers seek to arrange for whatever activities they think would most benefit their clients and, in addition to funding available for traditional services such as therapy and medication management, might use funds for academic tutoring, music lessons, or participation in organized sports. Outcome research has found that, compared to conventional interventions, youth who receive wraparound services show improved adjustment, reduced behavior problems, and reduced placements outside the community (Grundle, 2002; Hyde, Burchard, & Woodworth, 1996).

This overall pattern of outcome findings suggests that, at least for most clients, therapy may be more effective when it focuses on specific behaviors, thoughts, and family interaction patterns, compared to more non-directive and open-ended therapies. Therapists may be more effective when they give clients substantive input in the form of skills training, behavioral directives, and the development of more adaptive thoughts, compared to when services are limited to the provision of support, empathy, and a forum for talk—although those elements of therapy are probably necessary for the type of alliance that makes such techniques effective.

Use of Evidence-based Practices

In survey research coordinated by the Center for Community Solutions, most community agencies reported extensive use of evidence-based practices. Over 90 percent of child agencies reported using cognitive-behavioral therapy with clients suffering from post-traumatic stress disorder. This type of therapy was also reportedly used extensively with anxiety and depressive disorders. However, this study did not ascertain the degree of fidelity to which the agency therapists implemented their evidence-based practices. It is difficult to know whether

these therapists carefully followed treatment manuals, merely kept certain principles in mind when conducting therapy, or achieved a level of implementation fidelity lying somewhere between these two extremes.

The Center for Community Solutions and Cuyahoga County Community Mental Health Board (2003) recently surveyed all CCCMHB-funded agencies about their use of evidence-based practices. Thirty agencies (18 serving adults and 12 serving children) participated in the study. The researchers defined evidence-based practices as interventions that have been supported by studies with well-designed experimental or quasi-experimental methodologies and adequate sample sizes. They searched the literature through a variety of avenues and identified 13 evidence-based mental health practices for children and 30 such practices for adults. Then they administered a brief telephone interview to survey one senior clinical staff member or administrator at each agency about use of these practices. The researchers acknowledged the potential limitations of this self-report method of data collection; respondents might have over-reported use of evidence-based practices in order to portray their agencies in a favorable light, and no attempt was made to assess the fidelity with which these interventions were implemented. However, the interview utilized probes designed to support the validity of these agency reports of their practices.

The results indicated that Cuyahoga County agencies make extensive use of evidence-based practices. There were a number of specific interventions that 80-90 percent of the agencies reported using. Given that the researchers inquired about 13 interventions for children and 30 for adult clients, their results indicate that virtually all of the agencies use some evidence-based practices, and most apparently use a number of them.

Over 90 percent of the child agencies reported implementing cognitive behavior therapy for posttraumatic stress disorder in children. Eighty-three percent of these organizations said they utilize cognitive behavior therapy for depression. Two thirds of the agencies reported using cognitive problem solving skills for conduct disorder. Significant proportions of the child-serving organizations reported using many of the 10 other empirically supported practices about which the interview inquired.

Although these results may seem to indicate that Cuyahoga County agencies make extensive use of research-based, empirically supported interventions, there are several considerations that make the results of the survey difficult to interpret. First, as the researchers noted themselves, the self-report nature of the data, coupled with many agencies' concern about being viewed positively by CCCMHB, might have resulted in inflated estimates of evidence-based practice utilization, especially because there was no independent check on these agency reports.

Mental health experts participating in focus groups and key informant interviews for the United Way core service planning process (2005) cited a large number of specific, empirically supported interventions as well as broader practices that have general support from research. These best practices include: cognitive-behavioral therapy, the teaching families model, the re-ed model (currently provided by the Positive Education Program), wraparound services, intensive in-home services (as opposed to inpatient or residential treatment), mental health services provided in schools and early childhood mental health services.

The interviewees generally affirmed the importance of collaboration between professionals to improve coordination of care for clients, but noted that limitations of time and resources often make this difficult, especially as neither Medicaid nor private insurance are typically willing to pay for professional time used in this way.

Feedback from the United Way core service planning process focus groups and key informant interviews (2005) revealed that many who work with youth and adolescents feel that a new approach to meeting client needs is necessary. One respondent described it this way, “...working with the old way of doing business is outdated,” by which he meant fragmented services that occur away from the community. Many expressed the importance of having flexible services drawn from a continuum of care. Many consider long-term residential treatment to be an outdated approach to counseling youth and adolescents. Finally, a few respondents feel that sending children out of the county and state for residential treatment is an outdated practice because young people need to learn to adapt to the environments in which they live.

Interviewees in United Way’s key informant and focus group interviews (2005) also suggested several general practices that should be implemented more extensively in the future, such as programs to help youth make the transition to adulthood, school-based mental health services, prevention services, and early intervention

What Doesn’t Work

Unfortunately, a recent study by Ma and his colleagues suggests that pharmacotherapy is used to substitute, rather than complement, psychotherapy/mental health counseling (Ma et al., 2005). From 1995 through 2002, Dr. Ma and his team analyzed data collected from two surveys, the National Ambulatory Medical Care Survey and the Outpatient Department, a component of the National Hospital Ambulatory Medical Care Survey. Over that period, the number of visits in which depression was reported for 7 to 17-year-olds jumped from 1.44 million in 1995-1996 to 3.22 million in 2001-2002. Among these visits, the number of diagnosed major depressive disorders rose only modestly from 392,160 visits in 1995 to 649,969 visits in 2002.

Yet the number of visits with an unspecified depression diagnosis increased by a significant 138 percent, from 693,084 visits in 1995 to 1.64 million visits in 2002. Depression visits were most common among 15-to 17-year-old girls and non-Hispanic Caucasians. The overall increase in adolescent patients is likely due to the growing awareness of depression in children, a problem that’s been historically under-diagnosed. Even though the rate of major depressive disorders only increased slightly, antidepressant use increased remarkably. Selective serotonin reuptake inhibitors (SSRI’s) were the most widely used drugs, accounting for 76 percent of antidepressants prescribed to adolescent patient population in 1995-1996 and 81 percent in 2001-2002. Overall, there was a 2.6 increase in SSRIs use from 1995-2002, the researchers reported (Ma et al., 2005).

Ma and his team (2005) noted that the increasingly prevalent off-label use of SSRIs, as well as possibly inappropriate use of medications in substitution of psychotherapy/mental health counseling as first-line therapy, raises concerns about physicians’ adherence to evidence-based medicine. As drug use increased, counseling decreased. The prevalence of psychotherapy remained above 80 percent from 1995 to 1998, but then it dropped significantly to 54 percent in 1999-2000 before rising to 68 percent at the end of the study period. When looking at physician specialties, the authors found psychologists were three times more likely to prescribe medication alone (odds ratios, 3.42; 99 percent confidence interval: 1.26-9.28). Psychologists were almost six times more likely to prescribe medication in combination with counseling (OR 5.87; 99 percent CI: 1.52-22.59).

Counseling was also twice as common among girls as among boys (OR 2.06; 99 percent CI: 1.03-4.13). It is unclear why more girls received counseling than boys. Clinical guidelines from the American Academy of Child and Adolescent Psychiatry recommend that psychotherapy “be used for all children and adolescents whereas antidepressants, preferably in combination with

psychotherapy/mental health counseling, be prescribed only to those with severe, psychotherapy-resistant symptoms.” The findings come amidst the growing concern over antidepressant use in children and the associated increased risk for suicide. Depression affects up to 8 percent of children and adolescents in the United States and is a major risk factor for suicide, the third-leading cause of death among teens (Ma et al., 2005).

IMPACT ON COMMUNITY

Mental health disturbances create a high financial cost to individuals and society. Direct expenditures on treatment cost \$71 billion per year, and the indirect costs (mostly in lost productivity) are estimated at \$79 billion. Fifty-seven percent of mental health costs are publicly funded, compared to 46 percent of overall health expenditures (Coffey et al., 2000, in New Freedom Commission on Mental Health, 2003).

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

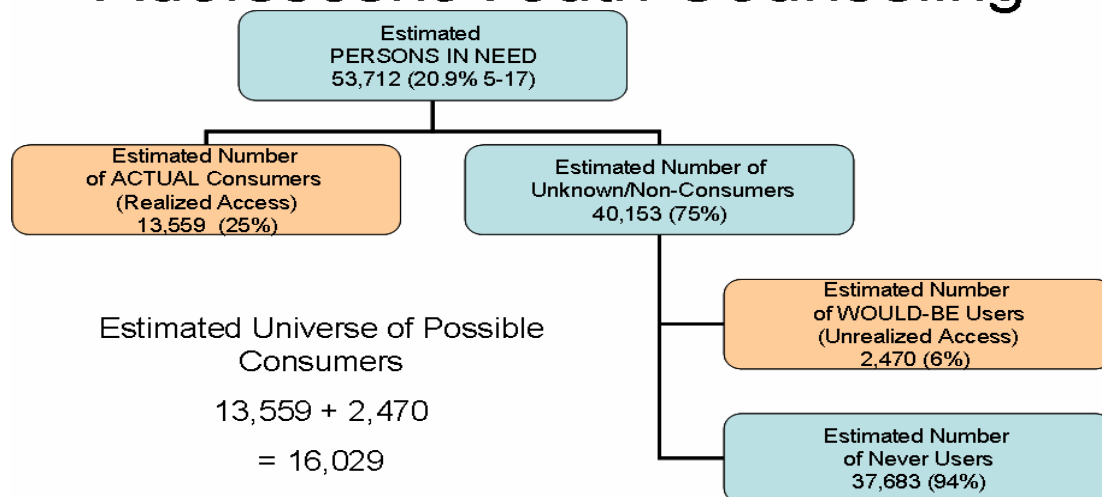
Most non-medical mental health services are provided by members of three professions: psychology, social work, and counseling. There are 3,765 licensed clinical and school psychologists in the state of Ohio. Based on Cuyahoga County’s proportion of Ohio’s population and the higher concentrations of mental health professionals in urban and suburban areas, it is estimated that there are approximately 1000 licensed psychologists in our county. Ohio has 14,905 licensed social workers (LSWs), who practice under supervision, and 6,472 licensed independent social workers (LISWs), who have accumulated sufficient supervised work experience to practice without supervision. Based on these numbers, it is estimated there are approximately 4000 LSWs and 2000 LISWs in Cuyahoga County. Ohio has 3115 licensed professional counselors (LPCs), who practice under supervision, and 3447 licensed professional clinical counselors (LPCCs), who have enough supervised experience to practice independently. It is estimated that there are approximately 900 LPCs and 1000 LPCCs in Cuyahoga County. In addition, there are small numbers of licensed psychiatrists, marriage and family therapists, registered nurses, music therapists, art therapists, and pastoral counselors who provide psychotherapy to clients.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Adolescent Youth Counseling:

- A conservative estimate of 53,712 persons need adolescent/youth counseling programs, which is the estimate of persons ages 5-17 who have or are at risk for mental disorders in Cuyahoga County.
- Based on available information about actual consumers, approximately 13,559 persons 5-17 have realized access to adolescent/youth counseling programs. This is the sum of persons 5-17 estimated to receive counseling funded by CCMHB. This assumes duplication with the 1,300 persons 5 to 17 years funded by UW for general counseling (outpatient mental health facilities).
- This leaves a net estimate of 40,153 persons 5-17 who are either receiving services from unaccounted-for sources or are not receiving counseling. $(53,712 - 13,559 = 40,153)$
- The National Survey of Children with Special Health Care Needs (U.S. Department of Health and Human Services, 2001) found that 25 percent of children needed mental health services, which is slightly higher than the estimate of 20.9 percent in this report. Of those 4.6 percent were not able to obtain the service. The study also found that low-income and uninsured children are least likely to obtain needed services.
- By applying the 4.6 percentage figure to the estimated number of persons in need (53,712), the result is 2,470 children and youth who would use the service if they knew about it, and if it were available and affordable. $(53,712 \times 4.6\% = 2,470)$
- Including both realized and unrealized access, the estimated universe of possible consumers for adolescent/youth counseling programs is 16,029 children and youth 5-17. $(13,559 + 2,470 = 16,029)$ (See Figure 4.)

Figure 4 - Consumer Estimates: Adolescent/Youth Counseling



Service Site Index

Because United Way-First Call for Help does not track requests for this service, there is not sufficient information on number of sites to provide a service site index.

Service Capacity

A shortage of psychiatrists for adults has also been observed nationally, and has been growing in the U.S. for about the past decade. Per the American Medical Association, the supply of U.S. psychiatrists shrank 27 percent between 1990 and 2002. Meanwhile, demand increased by 16 percent over that same time period (MedIndia, 2006).

Most people with mental health problems do not receive the most effective treatments available (Levin, Petrla, Hennessy, & Manderscheid, 2004). Only one third of this population receives a specialized mental health intervention of any kind. Approximately one third of these individuals receive some type of help from someone other than a mental health professional such as a family physician, clergy member, or (for children) school counselor. Uninsured children have a higher rate of unmet needs than children with public or private health insurance.

Even when treatment is initiated, it might not be fully utilized. Premature termination, or dropout, is a serious problem that results in inadequate services for half or more of the people who initiate services (Wierzbicki & Perarik, 1993). Dropout can be the result of ineffective services or the client's mental disorder impairing the personal judgment and organization necessary for consistent utilization.

One constraint on the effective operation of the mental health system, both private and public, is the chronic shortage of psychiatrists with specialized expertise in psychotropic medications. The shortage of child and adolescent psychiatrists is particularly acute. This shortage is a national problem, but it seems to be more pronounced in the Midwest than on the East and West Coasts. The result of the shortage is long waiting lists for psychiatry services, which sometimes results in the deterioration of mental health conditions before the needed medication is prescribed.

Despite the decades-long projection of an increasing utilization of child and adolescent psychiatry services and an undersupply of child and adolescent psychiatrists, the actual growth and supply of child and adolescent psychiatrists have been very slow. Inadequate support in academic institutions, decreasing graduate medical education (GME) funding, decreasing clinical revenues in the managed care environment, and a devalued image of the profession have made academic child and adolescent psychiatry programs struggle for recruitment of both residents and faculty, although child and adolescent psychiatry has made impressive progress in its scientific knowledge base through research, especially in neuroscience and developmental science. While millions of young people suffer from severe mental illnesses, there are only about 6,300 child and adolescent psychiatrists practicing in the United States. There is also a severe mal-distribution of child and adolescent psychiatrists, especially in rural and poor, urban areas where access is significantly reduced. By any method of workforce analysis, it is evident that there will continue to be a shortage of child and adolescent psychiatrists well into the future. (Kim, 2003)

Most counseling for youth in Cuyahoga County takes place in outpatient clinic settings and in schools. There is an under-supply of empirically supported, intensive, in-home interventions such as multi-systemic therapy for youth with SED. Despite the positive outcomes of this intervention, and costs much below those of residential treatment, multi-systemic therapy is currently offered only by Cuyahoga County Juvenile Court and Berea Children's Home and Family Services.

The key informant respondents for United Way's core service planning (2005) noted a number of categories of underserved individuals. All the interviewees emphasized the health insurance factor. They noted that Medicaid provides coverage for many of the county's low-income citizens and that people with good jobs usually have private insurance, but people who are "poor but not poor enough" are often unable to purchase private insurance and also are ineligible for Medicaid, resulting in no coverage at all. One interviewee said that the youngest children (birth-3 years old) and the oldest (16-22 years old) are especially underserved.

Many private insurance plans provide insufficient coverage for comprehensive treatment of children with severe disturbances. Sometimes, the only way these children can receive hospital or residential treatment is for their parents to relinquish custody to the county, which can then purchase these services.

Several participants noted a pronounced increase in late adolescent/young adult individuals needing services. Concerns were expressed about these clients "falling through the cracks" because they are between the child and adult mental health systems.

In regard to ethnic groups, respondents identified Asian and Hispanic children as particularly underserved. There were also individual respondents who said that African American males, children from Appalachian backgrounds, and girls who are withdrawn with unobtrusive problems are underserved.

One respondent noted the inescapable dilemma of whether to devote scarce resources to the prevention of mental health disorders or to treating mental illness when it becomes severe. The prevention approach entails small quantities of services to large numbers of people, and it tends to emphasize services for young children. The opposite approach involves large quantities of intensive services to the small number of people whose disturbances are most severe.

Transportation problems were also cited as a barrier to services. Some interviewees said services should be made available in schools and homes whenever feasible.

Feedback from the United Way core service planning process focus groups and key informant interviews (2005) revealed that many who work with youth and adolescents feel that a new approach to meeting client needs is necessary because target populations have become more disturbed in recent years. They speculated that this change may be partly due to changes in the service mix (particularly decreases in residential facilities) and the elimination of Ohio's public psychiatric hospitals for children, which has resulted in more disturbed youth in outpatient settings as well as youth with more urgent needs concentrated in the few remaining residential facilities. However, the respondents expressed the belief that, in addition to these institutional changes, there seems to be an intensification of mental health problems among young people in Cuyahoga County. A significant proportion of these youth have substance abuse as well as mental health problems.

One respondent noted several specific, serious conditions (bipolar disorder, autism, and Asperger's disorder) that are being diagnosed much more frequently. She noted that it is difficult to separate the effects of changes in the way professionals diagnose children from changes in actual incidence of disorders. All the respondents described a serious worsening of contextual factors that influence risk for mental health disturbance in young people. The interviewees described with concern, and even alarm, an environment of increasing poverty, unemployment, and general social dysfunction in Cuyahoga County. One respondent said he has observed increases in parental drug and alcohol use and parental incarceration that has resulted in a loss of role models, particularly for boys. He added that many children are being raised by their grandparents because many mothers are incarcerated or incapacitated by drugs or other problems.

In discussing service gaps, the respondents repeatedly cited barriers deriving from restrictive Medicaid regulations that, they said, make it difficult or impossible to provide services that would benefit clients. They cited useful services that, as a practical matter, often cannot be provided because they are not billable. Medicaid generally will not pay for services that do not occur face-to-face with the client, such as consultation, conferring between professionals sharing responsibility for a client, therapist input to teachers concerning classroom management of a child, prevention services, and outcome evaluation.

One interviewee said there is a major service gap for youth at the age when they are making the transition to adulthood (approximately 16–24 years old). The respondent noted that youth are no longer eligible for children's services when they reach the arbitrary cutoff point of 18 years old, but they are frequently not mature enough to make good use of adult services.

The interviewees also noted marked increases in the number of uninsured or under-insured families. Furthermore, reduced private sector resources have been accompanied by cuts in government funding for mental health services. Thus, at the same time that needs are intensifying, the resources needed to meet those needs are decreasing.

One participant noted that there are also many adolescents released from the juvenile justice system in this situation, but few agencies are willing to treat them because of their special combination of problems and needs.

VII. SUMMARY

The following are the major findings from the research on this service:

- Youth with mental health disturbances have elevated rates of substance abuse problems, which may reflect a generally defiant stance toward societal norms and/or an attempt to self-medicate emotional pain. These youth need services that address both their mental health and substance abuse problems.
- Research indicates that, with behavioral symptoms held constant, Caucasian youth are more likely to become involved in the mental health system while African American adolescents are more likely to become involved in the juvenile justice system.
- A major funding policy that affects all children and adults involved with the publicly supported mental health system is the Community Mental Health Services Block Grant Program.
- Insurance parity, or equal treatment, for mental health and addiction treatment is one of Ohio's major public policy issues that affects private funding for mental health related services through insurance. Greenfield (2005) found that there are two major barriers to policies and full implementation of parity policies: 1) fear of an unmanageable rise in health care costs; and 2) societal stigmas in respect to psychiatric and substance abuse disorders. In December 2006, Ohio passed a law to facilitate mental health parity.
- Medicaid seems to be the single public policy with the greatest impact on mental health services, including eligibility criteria, covered services, and reimbursement rates.
- Ohio has been awarded \$12 million by the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance system transformation planning.
- Between 2002 and 2004, funding for adolescent/youth counseling programs decreased by 13 percent in Cuyahoga County: from \$2.3 million in 2002 to \$2 million in 2004.
- Medicaid funding for community mental health services increased from \$57.6 million in 2002 to \$67.8 million in 2004.
- As of May 11, 2006, nearly \$2.2 million in revenues for adolescent/youth counseling programs has been identified countywide, excluding Medicaid dollars.
- Outcome research with adolescents exhibiting conduct disorders generally provides stronger support for family therapy than individual treatment.
- The overall pattern of outcome findings suggests that, at least for most clients, therapy may be more effective when it focuses on specific behaviors, thoughts, and family interaction patterns, compared to more non-directive and open-ended therapies.
- Feedback from the United Way core service planning process focus groups and key informant interviews (2005) revealed that many who work with youth and adolescents believe that a new approach to meeting client needs is necessary.
- Including both realized (13,559) and unrealized access (2,470), the estimated universe of possible consumers for adolescent/youth counseling programs is 16,029 children and youth 5-17.

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ATTACHMENTS

Attachment 1: Researcher List

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Attachment 2: Technical Notes

Technical Notes: Methodology, Caveats, Limitations of Data

The following provides descriptions, definitions, methodologies, caveats, or limitations of data for the following components of the core service reports:

- Unit of Analysis
- First Call for Help Data
- Funding Information for Core Services
- Consumer and Financial Data: Caveats
- Gap Analysis Methodology & Limitations
- Service Site Index

Unit of Analysis

The core service is the unit of analysis. United Way of Greater Cleveland either funds or could fund 80 core services. These are the object and subject of the research, specific to Cuyahoga County. A separate report has been developed for each service. It must be noted that the aggregate of any quantifiable data across all of the reports does not comprise a picture of the totality of health and human services in Cuyahoga County because there are many more than 80 services that comprise the community's safety net.

The unit of analysis for estimates of service consumers is the individual, the family, or the household.

United Way - First Call for Help Data

For most core services, United Way First Call for Help (FCFH), the community's resource and referral service data, was used in tables that show the number of service providers and service sites, the geographic location of service providers by zip code, the service area by zip code as reported by providers of the respective services, and to show unmet need and greatest increase/decrease in calls received by FCFH for a particular core service.

It is important to remember that FCFH receives calls from a variety of sources that include people calling on behalf of a prospective consumer such as social workers, provider agencies, relatives, etc. Not all calls come directly from a prospective consumer, so some of the zip codes are for hospitals and business addresses, although the numbers for these zip codes are relatively small.

Calls also may be from people who are not interested in receiving a service, but wish instead to make a contribution to a program such as clothing, household items, food, books, crafts supplies, etc.

Because, in many instances, FCFH codes its data with a different level of core services than the 80 core services identified by the United Way Community Investment staff as fundable services, it was necessary to develop a crosswalk. This crosswalk was used for a number of services,

however, seven services did not have a match in the FCFH database. The staff of United Way - First Call for Help gave explanations which follow each core service):

- Adolescent/Youth Counseling: A caller asking about help with their troubled teenager would be referred by the type of counseling rather than age. (Example: counseling for drugs, family, sexual abuse, etc.)
- Advocacy: FCFH does not receive calls from people about advocacy.
- Child Care: Calls are directed to Starting Point.
- Condition Specific Rehabilitation Services: FCFH would refer caller back to their primary care physician for a referral.
- Early Intervention for Mental Illness: FCFH does not receive calls for this, but if they did, they would refer to the county's Help Me Grow program.
- Family Support Centers: FCFH defines data by specific service rather than type of agency. Depending on the call, the caller may be referred to General Counseling or Early Intervention for Infants and Toddlers with Disabilities, and so on.
- Preschools: Calls are directed to Starting Point.

A different match was used for other services that had no crosswalk.

- Medical Transportation and Senior Ride: FCFH uses "Paratransit" as they do not differentiate between senior transportation, medical transportation, and transportation for disabled.
- Outpatient Mental Health Facilities: FCFH uses "Mental Health Drop-in Centers."

It must also be noted that, for the most part, the FCFH database does not include for-profit agencies. In the case of home health care providers, we contacted the Long Term Care Ombudsman for a more complete list of provider agencies which includes for-profit organizations.

There were several instances where the FCFH database did not code a United Way-funded agency with the core service for which they were receiving funding. In these instances, the agency was added manually to the Service Provider Table along with their site locations. The core services with the respective United Way of Greater Cleveland agencies that were added are:

- Case/Care Management – Care Alliance, Cystic Fibrosis, Epilepsy Foundation, Golden Age Centers
- Comprehensive Outpatient Substance Abuse Treatment – The Covenant
- Disease/Disability Information – The Muscular Disease Society of Northeastern Ohio
- Early Intervention for Infants and Toddlers with Disabilities – United Cerebral Palsy
- Medical Expense Assistance – North Coast Health Ministry
- Medical Transportation (Paratransit in FCFH) – Kidney Foundation of Ohio
- Senior Centers – Catholic Charities Services Corporation, Jewish Community Center of Cleveland, Jewish Family Service Association of Cleveland, University Settlement House
- Volunteer Development – Neighborhood Leadership Institute

It must also be noted that when numbers are low for trend data reported, the high percentages are slightly exaggerated.

Funding Information for Core Services

We collected financial information for each core service on a countywide level from multiple sources including major government funders, foundations, federated fund raising organizations, and United Way of Greater Cleveland. While we were successful in gathering a substantial amount of data, there is much that has not been collected. It must also be noted that even if we had all major public and private funding gathered, this would not create a total picture of health and human service funding in Cuyahoga County because there are more than 80 core services provided. The following provide highlights of data collected and some of the limitations for each source. It is important to note that funding in each source is changing and represents point in time amounts. The typical period for trend data, when available, is 2002, 2003, and 2004. Note: some services are funded by private insurance or other self-pay arrangements.

Foundation Funding

We attempted to obtain foundation funding amounts for each core service from the latest annual report or 990 PF (foundation tax return to the IRS) of each major foundation that funds social services in Greater Cleveland. Wherever a description of the grant purpose was given, we used our best judgment to match the grant to the appropriate core service. If the grant fell within more than one core service area, it was not listed. When no description was given, the grant was treated like a general operating grant and assigned to a core service only when the mission of the grant recipient fell mainly within one particular core service. In-kind donations, grants for capital and equipment expenses and administrative salaries were not used. When grants were \$10,000 or greater, they were listed by name of the foundation. All others were placed under Other Foundations and not listed. Typically, we did not attempt to provide trend financial data for foundation funding of core services because of the changing nature of funded programs from year to year.

Federated Funding Sources

We approached the major federated funders of core services in Greater Cleveland for funding and consumer information. Some data provided was for a single point in time; others provided three years of trend data. We often had to do a cross walk of United Way of Greater Cleveland funded core services against those funded by federated agencies to agree on the services.

Government Funding

We approached every major government funder for funding amounts for each core service and also did Internet searches for some federal government sources. Due to the constant state of change in government funding, it is important to note that the data provided is a snapshot in time and that many of the programs funded in 2004 have changed definition, are funded through different revenue sources, or no longer exist at all due to a lack of funding. This is particularly true of Community Development Block Grant dollars which have decreased due to shifting federal priorities.

Every effort was made to appropriately match government funding data to the correct core service area; however, this was not always possible as frequently the service definitions were not a one-to-one match. It was necessary, in some instances, to take the closest match or use the sore service which represented a majority of the services being provided.

In other cases, it was not possible to select a specific core service. An example is Medicaid in which Medicaid-defined services crossed over more than four core services in some instances. In cases where Medicaid is a significant source of revenue, the data was entered as an aggregate total at the appropriate AIRS level. These aggregates are footnoted under the appropriate funding table.

Every effort was made to include data from municipalities. However, many did not respond after repeated requests for information. We would like to thank those who took the time to help with this project.

Medicaid Funding

A significant portion of Medicaid funding was NOT entered under the countywide total in the core service reports for two reasons: first, because many of the Medicaid services are not a one-to-one match with United Way core services, and second because some Medicaid services fall into more than one AIRS Level 1 categories. In the first instance, Medicaid funding was entered as an aggregate total at the AIRS 1 level, and in the second instance Medicaid funding was entered as an aggregate total under Third Party Payee/Direct Bill in the combined Master Revenue file of funding across all nine AIRS Levels. They are as follows:

Entered as Aggregate Total Under Appropriate AIRS Level

- Medicaid Service - Home Care (\$17,787,703 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: daily living aids and home health care.
- Medicaid Service - CADAS (\$8,522,183 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: comprehensive outpatient substance abuse treatment, residential substance abuse treatment programs, substance abuse education and prevention.
- Medicaid Service - Therapy (\$2,257,394 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: condition specific rehabilitation, and speech & hearing services.
- Medicaid Service - CMH (\$67,773,487 in 2004) - Falls into AIRS 1 Mental Health Care & Counseling and includes the following core services: supportive therapies, adolescent/youth counseling, children's residential treatment facilities, early intervention for mental illness, general counseling services (outpatient mental health facilities), and psychiatric day treatment.

Entered as Aggregate Total Under Third Party Payee/Direct Bill

- Medicaid Service - Inpatient Hospital (\$188,329,269 in 2004) - Falls into two different AIRS 1 categories: Basic needs and health care. It includes the following core services: condition specific rehabilitation and medical expense assistance.
- Medicaid Service - Waiver (\$128,921,354 in 2004) – This category included all PASSPORT services. Since we reported PASSPORT separately, in order to avoid duplication, we deducted the PASSPORT total of \$52,676,048 from this number and reported the remaining \$76,245,306. This total falls into AIRS 1 Basic Needs, Health Care and Individual & Family Life and includes the following core services: adult day care, home-delivered meals, home health care and in-home assistance.
- Medicaid Service - Habilitation (\$55,550,307 in 2004) - Falls into AIRS 1 Health Care and Individual & Family Life and includes the following core services: condition specific rehabilitation services, early intervention for infants and toddlers with disabilities/delays, and residential living options for people with disabilities.

United Way of Greater Cleveland Funding

Financial data for core services funded by United Way of Greater Cleveland was for FY 2004 (July 2003 to June 2004). It included allocations through the community investment committees and donor designations that United Way funded agencies applied to the respective core services. It is important to note that not all United Way funded agencies applied donor designated gifts, which are unrestricted, to the core service for which they receive United Way funding. It did not include donor designations that non-United Way funded agencies used for any of the 80 core services.

United Way Agency Revenues

Annually United Way-funded agencies submit revenue budgets to United Way for each funded core service. This information for FY 2004 is reported. However, all of the agency data may not be included in the countywide data as agencies may have assigned dollars from unrestricted grants to a specific core service, or allocated a portion of grant monies that fell within two or more core service areas. It was not always possible to match countywide government or foundation funding with that reported by the agencies and that gathered from other funding sources.

Consumer and Financial Data: Caveats

The following applies to revenue sources on tables and graphs and their corresponding consumer data used in the consumer demographics and zip code tables.

All Core Services

Data was self-verified by the funder/provider. Whenever data provided by a funder appeared to be inconsistent or incorrect, an attempt was made to contact the funder. If the funder responded, the data was either adjusted according to their instructions, or the reason for discrepancies footnoted. If they did not respond, or if they said it was correct, the data was left as submitted.

Demographic and zip code data provided by the funder/provider is frequently taken from consumer intake forms which may have missing or incomplete data, or from provider agency databases which contain data entry errors or incomplete consumer intake forms. Whenever possible, the funder was asked for corrected data. In cases where a correction was not possible, the data was counted as either unknown or missing. The usage of these terms is footnoted at the bottom of each table and is explained more fully in the Gap Analysis section of this attachment.

It was not always possible to get information in the format requested as each funder tracks data differently, using different service definitions, terminology and variables. Wherever possible, data was matched to a consistent report format.

When a funder could not provide consumer demographics, but could provide an estimated percentage of consumers by category, we took the total number of consumers and applied the percentages to come up with estimated numbers for the consumer tables. For example, Medicaid tracks individual recipients throughout the year, entering new data if there is a change, each time a claim occurs. Thus, a consumer who has a birthday between claims will appear in the system for that year with two different ages.

To resolve this, the percentage of consumers in each age range was determined for the total number of duplicated consumer ages. Those percentages were then applied to the total number of unduplicated consumers for the year in order to reach a total number of unduplicated consumers for each age range.

The time periods for both revenue and consumers vary by funder/provider. United Way Program Report data is for FY 2004 (July 2003 to June 2004). Other funder/provider data is for either a January to December or July to June fiscal year.

Gap Analysis Methodology & Limitations

Based on Anderson's (1964) seminal needs assessment model, realized access is defined as the number of consumers who receive service while unrealized access is the estimated number of consumers who need and would utilize a service, but are not currently receiving it. This could be considered the service gap. Unrealized consumer access to services drives the need for change in the social service delivery system. Ensuring unrealized consumer access to services requires new models of service delivery related to access, effective use of resources, data management, and funding. There were multiple steps used to conduct a gap analysis:

- *Estimate of persons in need of the service:* Unless local research was conducted to determine need for a given service, this estimate was obtained by either using U.S. Census data for Cuyahoga County or applying percentages from national studies and reports to the census data. All references and percentages are footnoted in the respective graphs or tables. In most cases this percentage was also applied to actual 1990 Census figures and population projections 2005 through 2015 that were done by the Ohio Department of Development.
- *Estimate of number of ACTUAL consumers in the public systems (realized access):* Data submitted to United Way by funded agencies was aggregated to determine the number of consumers for each core service. The period was FY 2004, which is July 2003 through July 2004.
 - In some cases data was “unknown,” defined as data not collected by agency because no tracking system was available or the type of service delivered made it difficult (i.e., group presentations, telephone information and referral, and drop-ins). This also represents data not completed by consumers either deliberately or inadvertently on intake forms.
 - In other cases, data was missing that, for United Way data, represented computational errors or incorrect completion of online reports. For all other data, “missing” represents data funders/providers were unable to provide.
 - There was no check of the accuracy of data submitted by agencies.
 - Major government funders were asked to provide information about the number of consumers for the respective core services that they funded. In most cases, services were not defined in the same way as the United Way core services which are based on the Alliance for Information and Referral Systems (AIRS) taxonomy. To accommodate these differences, customized crosswalks were developed.
 - We determined that the numbers of consumers across funding sources were not unduplicated and thus made a judgment about which numbers would be the best estimate of an unduplicated number.
 - The estimate of consumers is not inclusive since it does not include numbers of consumers who use their personal resources to pay for services, nor for other private resources such as insurance or agency fundraising. In addition, it was not always possible to obtain information from some government funders.
- *Estimate of number of “unknown/non-consumers”:* This is the difference between the estimated number of actual consumers and the estimate of persons in need.

- *Estimate of number of “would-be users” (unrealized access):* This is the estimate of persons who would use a service if it were available, typically based on research.
- *Estimate of number of “never users”:* This is the difference between the estimated number of unknown/non-consumers and would-be users.
- *Estimate of “universe of possible consumers”:* This is the total of those actually receiving the service (realized access) and those would-be users (unrealized access).

We recognize that this is not a perfect method for assessing either realized or unrealized access to core services. However, we opted to use an imperfect method rather than no method to demonstrate both the complexity and the usefulness of quantifying realized and unrealized access to services as a first step toward a more rigorous methodology. In the business sector this would be a form of market analysis. We also recognize that actual consumer numbers are not unduplicated across funders, or across core services. Thus, there is much work yet to be done to gain realistic estimates of needs.

The numbers we provided are on a countywide level. We recognize that there could be, and often are, differences by demographics and geographical area. In the Actual Consumer Demographics attachment, we have identified the profile of the base consumer group from census, but have little on the estimated persons in need. Occasionally, there is information from other research that describes differences among different racial, ethnic, gender, age, or income groups that is discussed in the narrative. There is also inconsistent information for consumers funded by various governmental bodies. In other words, some funders provided demographic data and others did not. In the Actual Consumer Zip Codes attachment, we have also attempted to identify the geographic profile of the estimated persons in need and actual consumers. However, this information has the same limitations as the demographics.

Service Site Index

For many services a service site index was developed. It provides a ratio of estimated consumers per service site on a countywide level and for each zip code within the county. The ratio is based on the number derived from the gap analysis described in the previous section and on the number of providers who reported to United Way – First Call for Help whether a specific service site includes a given zip code in its service area. A provider site is located in a single zip code, but could serve multiple zip codes. The ratio is a measure of potential service accessibility by estimated universe of service consumers per zip code area. This measure does not include the capacity of providers to offer the service, for example, the number of consumers that can be served on a daily basis. It is only capturing whether there is a possibility of being a consumer. The lower the ratio, the greater is the chance of receiving service. The index also gives an indication of which zip codes have higher ratios which means that consumers have a lower probability of receiving a service as well as any patterns in zip codes that have high percentages of African Americans, Asians, or Hispanics. A map is also attached which provides a graphic picture of the estimated consumers by zip code.

Based on the numbers of providers that report to FCFH whether they serve a given zip code, we had assumed that there would be greater variability across zip codes. In reality, many report that they serve the entire county. Thus the variability across zip codes is often primarily because of differences in the population numbers rather than in service sites that offer service in a given zip code.

Specific Service Issues

Senior Services

“Senior Centers” was used as a catch-all category when the funder-defined service covered more than one senior success core service and could not be accurately allocated among the separate core services. Often, funding for transportation and home-delivered meals was not broken out from senior activities and supportive services at the municipal level, so it was placed under Senior Centers. Because the core services for congregate and home-delivered meals and senior ride were tracked separately, funding for these core services was not included under Senior Centers to avoid duplication of resources, even though senior center activities can and do include congregate meals.

Senior Ride includes disabled individuals of all ages as well as seniors for most funders with the notable exception of Western Reserve Area Agency on Aging (WRAAA) that requires an individual to be 60 years of age or older in order to receive services. If the transportation service was not provided by a senior center, the number of consumers reflects the number of riders using the system and contains duplicates (e.g. paratransit).

Home improvement/accessibility data includes programs for low-income families and people of all ages with disabilities, as well as seniors.

References

- Anderson, Ronald M. (1995, March). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36(1): 1-10.
- Wan, Thomas T. H., Odell, Barbara Gill, & Lewis, David T. (1982). *Promoting the well-being of the elderly: A community diagnosis*. New York: The Halworth Press.

Attachment 3: Actual Consumer Demographics

Core Service: Adolescent/Youth Counseling RP-450.050						
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****		
	Total Population (%)*	Total Population 5-17 (%)**	Estimated Population 5-17 with Mental Disorder (%)****	UW Program Report Data Cuy Cnty Only N/A% (%)	CCCMHB (%)	CDBG (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004		
TOTAL	1,393,978	256,467	53,712	N/A	13,559	MISSING
Percent		18.4%	20.9%			
GENDER						
Male	47.2%	51.1%	N/A	N/A	0.0%	0.0%
Female	52.8%	48.9%	N/A	N/A	0.0%	0.0%
Unknown Data*****				N/A	0.0%	0.0%
Missing Data*****				N/A	100.0%	100.0%
RACE*****						
White alone	67.1%	58.0%	N/A	N/A	25.9%	0.0%
Black or African American alone/combination	27.9%	36.4%	N/A	N/A	64.6%	0.0%
Asian alone/combination	2.1%	1.9%	N/A	N/A	0.2%	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.8%	N/A	N/A	0.2%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.0%	N/A	N/A	0.0%	0.0%
Some other race alone/combination	2.1%	2.9%	N/A	N/A	0.0%	0.0%
Unknown Data*****				N/A	9.1%	0.0%
Missing Data*****				N/A	0.0%	100.0%
HISPANIC*****	3.3%	4.7%	N/A	N/A	7.5%	0.0%
AGE						
0-4	6.5%		N/A	N/A	0.0%	0.0%
5-9	7.3%	39.7%	N/A	N/A		0.0%
10-14	7.1%	38.7%	N/A	N/A	100.0%	0.0%
15-19	6.4%	21.7%	N/A	N/A		0.0%
20-34	19.1%		N/A	N/A	0.0%	0.0%
35-54	29.3%		N/A	N/A	0.0%	0.0%
55-64	8.7%		N/A	N/A	0.0%	0.0%
65-74	7.8%		N/A	N/A	0.0%	0.0%
75+	7.8%		N/A	N/A	0.0%	0.0%
Unknown Data*****				N/A	0.0%	0.0%
Missing Data*****				N/A	0.0%	100.0%
INCOME*****						
Average Household Size	2.4	N/A	N/A	N/A	N/A	N/A
\$0-\$9,999	11.3%	N/A	N/A	N/A	0.0%	0.0%
\$10,000-\$14,999	6.9%	N/A	N/A	N/A	0.0%	0.0%
\$15,000-\$19,999	6.7%	N/A	N/A	N/A	0.0%	0.0%
\$20,000-\$29,999	13.6%	N/A	N/A	N/A	0.0%	0.0%
\$30,000 and above	61.5%	N/A	N/A	N/A	0.0%	0.0%
Unknown Data*****				N/A	0.0%	0.0%
Missing Data*****				N/A	100.0%	100.0%
Totals	100.0%	N/A	N/A	N/A	100.0%	100.0%

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1); SF4 (PCT 144)
** U.S. Census 2000 SF3 (PB)
*** "Cuyahoga County Mental Health Assessment," Center for Community Solutions, December 2003; 20.9 percent of population 5-17
****Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms.
*****Missing Data - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.
*****The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." Except "White Alone", all racial categories are "... alone or in combination with some other race". This method isolates and minimizes the non-minority population ("White alone").
*****Hispanic - Amount in this field is from data provided by clients on intake forms and may not be accurate as clients may either deliberately or inadvertently provide incomplete data, or data may not be collected by the agency.
*****The U.S. Census reports income by household or family, not individuals. Estimates by income category were derived by applying the ratio of total county population (1,393,978) to total households (571,606) = 2.4. The number of households in each income category was multiplied by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category, which may result in more conservative estimates for children, and the "old old," which may actually have larger proportions of persons in the lower income categories.

Attachment 4: Actual Consumer Zip Codes

Core Service: Adolescent/Youth Counseling RP-450.050							
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****		
	City/Town (% Cleveland)	Total Population (%) [*] 1/1/2000-12/31/2000	Total Population 5-17 (%) ^{***} 1/1/2000-12/31/2000	Estimated Population 5-17 with Mental Disorder (%) ^{***} 1/1/2000-12/31/2000	UW Program Report Data (%) 7/1/2003-6/30/2004	CCCMHB (%) 7/1/2003-6/30/2004	CDBG (%) 7/1/2003-6/30/2004
Period							
TOTAL		1,393,978	256,467	53,712	N/A	13,559	MISSING
Percent			18.4%	20.9%			
44017	Berea	1.4%	1.2%	N/A	N/A	0.0%	0.0%
44022	Bentleyville	1.3%	0.9%	N/A	N/A	0.0%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	0.2%	N/A	N/A	0.0%	0.0%
44070	North Olmsted	2.4%	2.4%	N/A	N/A	0.0%	0.0%
44101	Cleveland (100%)	0.0%	0.0%	N/A	N/A	0.0%	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	4.3%	N/A	N/A	0.0%	0.0%
44103	Cleveland (100%)	1.8%	2.4%	N/A	N/A	0.0%	0.0%
44104	Cleveland (100%)	2.1%	3.0%	N/A	N/A	0.0%	0.0%
44105	Cleveland/NewburghHts/GarfieldHts (75%)	3.9%	4.8%	N/A	N/A	0.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	1.8%	N/A	N/A	0.0%	0.0%
44107	Lakewood/Cleveland	4.0%	3.3%	N/A	N/A	0.0%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	3.4%	N/A	N/A	0.0%	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.5%	N/A	N/A	0.0%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	2.3%	N/A	N/A	0.0%	0.0%
44111	Cleveland (100%)	3.1%	2.8%	N/A	N/A	0.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	2.9%	N/A	N/A	0.0%	0.0%
44113	Cleveland (100%)	1.4%	1.2%	N/A	N/A	0.0%	0.0%
44114	Cleveland (100%)	0.3%	0.1%	N/A	N/A	0.0%	0.0%
44115	Cleveland (100%)	0.6%	0.7%	N/A	N/A	0.0%	0.0%
44116	Rocky River	1.5%	1.3%	N/A	N/A	0.0%	0.0%
44117	Euclid/Cleveland	0.9%	0.7%	N/A	N/A	0.0%	0.0%
44118	ClevelandHts/UniversityHts/ShakerHts	3.2%	3.1%	N/A	N/A	0.0%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	0.8%	N/A	N/A	0.0%	0.0%
44120	Shaker Hts/Cleveland	3.4%	3.7%	N/A	N/A	0.0%	0.0%
44121	University Hts/South Euclid	2.5%	2.5%	N/A	N/A	0.0%	0.0%
44122	Beachwood/Highland Hills/ShakerHts	2.5%	2.5%	N/A	N/A	0.0%	0.0%
44123	Euclid	1.3%	1.2%	N/A	N/A	0.0%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	2.2%	N/A	N/A	0.0%	0.0%
44125	Valley View/Garfield Hts	2.1%	2.0%	N/A	N/A	0.0%	0.0%
44126	Fairview Park/Cleveland	1.2%	1.1%	N/A	N/A	0.0%	0.0%
44127	Cleveland (100%)	0.6%	0.9%	N/A	N/A	0.0%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.4%	N/A	N/A	0.0%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	2.0%	N/A	N/A	0.0%	0.0%
44130	Parma/Cleveland	3.8%	3.0%	N/A	N/A	0.0%	0.0%
44131	Independence/Seven Hills/BrooklynHts	1.5%	1.3%	N/A	N/A	0.0%	0.0%
44132	Euclid	1.1%	1.0%	N/A	N/A	0.0%	0.0%
44133	North Royalton	2.0%	2.1%	N/A	N/A	0.0%	0.0%
44134	Parma/Cleveland	2.9%	2.6%	N/A	N/A	0.0%	0.0%
44135	Cleveland/Linddale (90%)	2.0%	2.0%	N/A	N/A	0.0%	0.0%
44136	Strongsville	3.1%	3.4%	N/A	N/A	0.0%	0.0%
44137	Maple Hts/Cleveland	1.9%	2.0%	N/A	N/A	0.0%	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	N/A	N/A	0.0%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	2.1%	N/A	N/A	0.0%	0.0%
44140	Bay Village	1.1%	1.2%	N/A	N/A	0.0%	0.0%
44141	Brecksville	1.0%	1.0%	N/A	N/A	0.0%	0.0%
44142	Brookpark/Cleveland	1.5%	1.5%	N/A	N/A	0.0%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	1.6%	N/A	N/A	0.0%	0.0%
44144	Brooklyn/Cleveland	1.6%	1.2%	N/A	N/A	0.0%	0.0%
44145	Westlake	2.3%	2.2%	N/A	N/A	0.0%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.0%	N/A	N/A	0.0%	0.0%
44147	Broadview Hts	1.1%	1.2%	N/A	N/A	0.0%	0.0%
44149	Strongsville	0.0%	0.0%	N/A	N/A	0.0%	0.0%
	Unknown Cuyahoga County Zip Codes*****				N/A	0.0%	0.0%
	Missing*****				N/A	100.0%	100.0%
	Unknown*****				N/A	0.0%	0.0%
	Total Cuyahoga County*****	100.0%	100.0%	N/A	N/A	0.0%	0.0%
	Total Known Cleveland	30.5%	34.0%	N/A	N/A	0.0%	0.0%
	Total Known Suburbs	69.5%	66.0%	N/A	N/A	0.0%	0.0%
	Unknown & Missing				N/A	100.0%	100.0%

Attachment 4: Actual Consumer Zip Codes (continued)

*U.S. Census 2000, SF1(P1)
** U.S. Census 2000 SF3 (P8)
*** "Cuyahoga County Mental Health Assessment," Center for Community Solutions, December 2003; 20.9 percent of population 5-17
**** Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
*****Missing Data - For United Way - represents computational errors or incorrect completion of online report. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County. For all other data - represents data funder was unable to provide.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County.
***** Totals vary because of rounding. County total population 1,393,978 does not correspond to the total of zip codes because some zip codes include data from adjacent counties



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