Core Service Report

Children's / Adolescent Residential Treatment Facility

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.

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SNAPSHOT

AIRS Code Level I: Mental Health Care & Counseling
AIRS Code Level II: Mental Health Facilities
Core Service: Children's/Adolescent Residential Treatment Facilities RM-700.150

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

AIRS Definition: Programs that provide a therapeutic living environment in a community-based facility for emotionally disturbed, severely learning disabled, delinquent, predelinquent, and/or abused children and youth who, because of their problems, are unable to adjust to other placements. Residents often attend on-grounds schools or public special education classes and receive services that are geared to their individual needs and the realization of appropriate future plans such as their eventual return to their own or foster families or emancipation as soon as their personal and social adjustment and development permit.

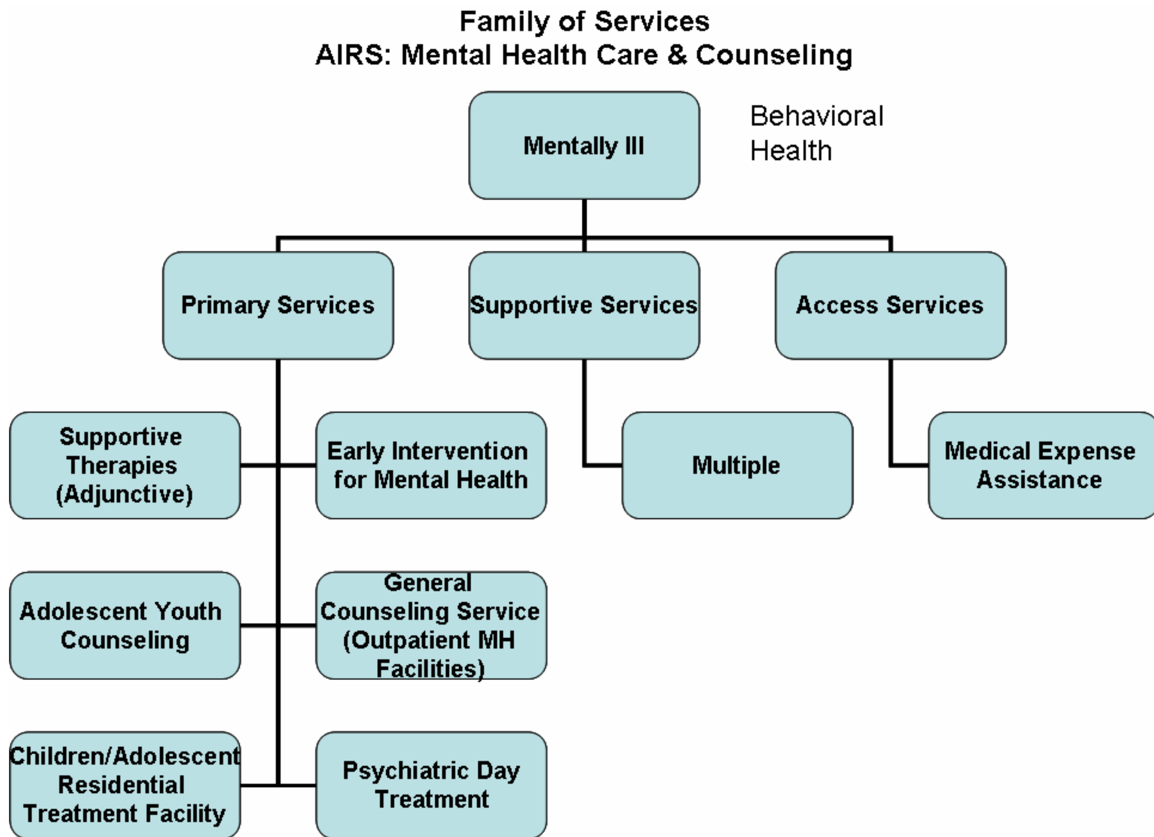
Special Note: There are six core services related to persons with or at risk of mental illness. In order to avoid as much duplication as possible across reports, the core services were organized as a continuum across the mental health services. The table below distinguishes the services by age, severity 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

Core Service	Consumers		Service Description
	Age	Severity	
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 Treatment	Children, youth and adults ages 5+ years	Any severe mental disorder that does not require full-time hospital care, but can benefit from a structured environment for some portion of the day or week	Programs that provide therapeutic 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 Children's/Adolescent Residential Treatment Facilities 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

Approximately 20 percent of American children have a mental disorder. About 7 percent of children ages 9 to 17 are affected by a serious emotional disturbance (SED). An SED designation denotes that treatment beyond outpatient therapy may be necessary. Generally, SED involves a high degree of functional impairment; that is, impairment in the youth's ability to manage one or more developmentally appropriate areas of functioning such as learning in school, forming peer relationships, maintaining safety and self-care, and obeying basic social rules. The purpose of residential treatment centers is to provide services to children with SED who need particularly intensive forms of intervention.

A "Keeping Families Together" Act, currently being considered in the U. S. Senate, could be an important step toward obtaining mental health services for youth whose needs exhaust the resources of their families and health insurance policies.

A major funding policy that affects all persons—children and adults—involved with the publicly supported mental health system is the Community Mental Health Services Block Grant Program. The program's overall goal is to move care for adults with SMI (serious mental illness)

and children with SED (serious emotional disturbance) from costly and restrictive inpatient hospital care 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 children ages 5-17 with serious emotional disturbances (SED).

Approximately 530,000 American children live in out-of-home care (Petit, Curtis, Woodruff, Arnold, Feagans, & Ang, 1999). Of these, 41,000 live in residential group care, 27,000 in community-based group homes, and 23,000 in therapeutic foster care.

A recent study examined the question of how children in group care (institutional care) differ from those in kinship or foster care (Barth, 2002). They found that children in group care are clearly older than other children. However, evidence that their behavior is worse is less clear (NSCAW, 2002 in Barth, 2002).

The NSCAW (2002 in Barth, 2002) report also found that children in group care scored substantially worse on standardized measures than other children in the study. Another difference is that children in group care were 3.5 times more likely to have experienced sexual abuse (27 percent) than children who resided in foster care or kinship care. Many children with a range of social, cognitive, and behavioral problems were also in kinship care and foster care (Barth, 2002).

According to the Cuyahoga County Mental Health Assessment (2003), approximately 53,712 children ages 5-17 (20.94 percent of the total 5 to 17 years population) had a mental disorder and 17,990 had a serious emotional disturbance (SED) (7 percent of the 5 to 17 age cohort). This population is projected to decrease to 15,517 in 2015, due to shifts in the population in general.

Core Service Delivery
The definition of the core service for this report is as follows: programs that provide a therapeutic living environment in a community-based facility for emotionally disturbed, severely learning disabled, delinquent, pre-delinquent, and/or abused children and youth who, because of their problems, are unable to adjust to other placements. Residents often attend on-grounds schools or public special education classes and receive services geared to their individual needs and the realization of appropriate future plans such as their eventual return to their own or foster families, or emancipation as soon as their personal and social adjustment and development permit.

> A residential treatment center (RTC) is a licensed 24-hour facility (although not licensed as a hospital), which offers mental health treatment. The types of treatment vary widely; the major categories are psychoanalytic, psycho-educational, behavioral management, group therapies, medication management, and peer-cultural. Settings range from structured ones, resembling psychiatric hospitals, to those that are more like group homes or halfway houses. While formerly for long-term treatment (e.g., a year or more), RTCs under managed care are now serving more seriously disturbed youth for as briefly as 1 month for intensive evaluation and stabilization. (U.S. Department of Health and Human Services, 1999)

Recent research has tended to be unsupportive of residential treatment because this modality has generally not produced better outcomes than less expensive alternative interventions. Residential treatment has been criticized on the grounds that removing youth from their families and communities, while possibly having the effect of ameliorating an immediate crisis, does not help them develop the skills they need to achieve positive adjustment in the long run. Alternative interventions proven effective for SED youth, particularly intensive in-home treatment and therapeutic foster care, not only produce better outcomes for most youth, but are also significantly less expensive.

Based on United Way - First Call for Help's (FCFH) database (February 2005 there are 6 nonprofit children's/adolescent residential treatment facilities operating from 7 different sites. In FY 2004 (July 2003 to June 2004), 2 providers were funded by United Way. Note that the Cuyahoga County Department of Children and Family Services lists 4 additional providers beyond the First Call for Help list. This includes 6 sites within the county and another 5 out-of-county providers.

Over a five-year period, from 2000 to 2004, the number of United Way - First Call for Help inquiries about children's/adolescent residential treatment facilities decreased from 29 in 2000 to 24 in 2004. Over the same five-year period, FCFH had 100 requests for information about children's/adolescent residential treatment facilities. Of these requests, they were able to make referrals to 99 percent of callers.

The majority of government funding for children's/adolescent residential treatment facilities comes from the federal government and is passed through the state to local agencies. For Cuyahoga County, these are the Department of Children and Family Services, the Cuyahoga County Community Mental Health Board, and the Cuyahoga County Juvenile Court. These

funders themselves do not provide services, but they do fund service providers. The balance of funding comes from Medicaid, private insurance, and self-pay fees for services.

Between 2002 and 2004, identified government funding sources decreased allocations for children's residential services. The Cuyahoga County Community Mental Health Board decreased spending from $841,471 in 2002 to $293,724 in 2004, and juvenile court funding decreased from $4.6 million in 2002 to $3.8 million in 2004.

As of May 11, 2006, over $5.9 million in revenues for children's/adolescent residential treatment facilities programs has been identified countywide, excluding Medicaid dollars. Sixty-nine percent of the revenues are from contracts or grants from government organizations. Federated organizations are also significant funders of this service, accounting for approximately 8 percent of total reported funding (with only two reporting). United Way of Greater Cleveland's funds account for 19 percent of the total from Investment Committee allocations and designations.

Residential treatment is expensive, generally costing more than $300 per day plus the costs of specific therapeutic services. Private health insurance policies often limit residential treatment coverage, and few families can afford to pay for this on their own.

What Works; What Doesn't

Outcome studies directly comparing residential treatment and therapeutic foster care have usually favored the latter type of intervention. Some studies of residential treatment have produced encouraging results, although most of these studies had serious methodological limitations—especially the lack of a control group.

A good deal of research indicates that restrictive approaches such as residential treatment, inpatient psychiatric hospitalization, and incarceration—while they temporarily get youth "off the streets"—show little effectiveness at changing behavior and are extremely expensive (Henggeler & Santos, 1997). Often, behavioral improvements achieved while in the residential facility fail to transfer to the natural environment, so clients regress rapidly following discharge (Curry, 1991).

Both research and values-related considerations seem to argue against the use of residential treatment for youth with mental health problems. In the vast majority of cases, less restrictive community-based forms of treatment are probably more capable of restoring youth to a successful adaptation in their natural environment. Nonetheless, there is a small-but-significant sub-population of youth that needs and can benefit from residential treatment.

Gap Analysis

The estimated universe of possible consumers is 1,439 including both realized (167) and unrealized (1,272) access.

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 dare 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

Residential treatment centers, sometimes called therapeutic group homes, provide 24-hour mental health care services for young people. These centers must be licensed. Treatment may include individual, group, and family therapy; special education; recreation therapy; and medical services.

Approximately 20 percent of American children have a mental disorder. About 7 percent of children aged 9 to 17 are affected by a serious emotional disturbance (SED). SED is defined as a combination of diagnoses (with some diagnoses considered "serious" and some not) and the level of intervention required by the youth. For the SED designation, treatment beyond outpatient therapy may be necessary. Generally, SED involves a high degree of functional impairment; that is, impairment in the youth's ability to manage one or more developmentally appropriate areas of functioning such as learning in school, forming peer relationships, maintaining safety and self-care, and obeying basic social rules. The purpose of residential treatment centers is to provide children with SED particularly intensive forms of intervention services.

Untreated SED frequently has serious consequences for children, their families, and the wider society. In addition to causing painful emotional distress, SED may result in school failure, removal from the home, juvenile offending and detention, self-injury, and suicide.

On the continuum of care that ranges from outpatient therapy to inpatient hospitalization, residential treatment occupies a position on the more severe end of the spectrum. Residential treatment is the second most restrictive form of care (next to inpatient hospitalization). Stays in residential settings are generally much longer than hospital stays. Although received by a small percentage of treated children, nearly one-fourth of the national outlay on child mental health is spent on care in these settings (Burns & Hoagwood, 2002).

PUBLIC POLICY ISSUES

NATIONAL

Federal Laws and Regulations

"Keeping Families Together" Act
In the most extreme cases, families are forced to give up custody of their children in order to obtain publicly funded mental health services. This is becoming more common as families lose private health care coverage, and in many cases the situation is worsened by the lack of parity for mental health services under existing health plans.

A "Keeping Families Together" Act, currently being considered in the U. S. Senate, could be an important step toward obtaining mental health services for youth whose needs exhaust the resources of their families and health insurance policies.

The Community Mental Health Services Block Grant Program

The Substance Abuse and Mental Health Service Administration (SAMHSA FY 2005 Budget), the Community Mental Health Services Block Grant Program distributes funds to states to move care for adults with SMI and children with SED from costly, restrictive inpatient hospital care to the community. Applications must include an annual plan for providing comprehensive community mental health services to adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). 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 their 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. In FY 2002, funds reached 972 sub-grantees. (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 Laws and 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).

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 was 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 came to pass 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.

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 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 children ages 5-17 with serious emotional disturbances (SED).

This can include children who are in need of a "therapeutic living environment in a community-based facility for emotionally disturbed, severely learning disabled, delinquent, pre-delinquent and/or abused children and youth who, because of their problems, are unable to adjust to other placements." This also could include youth who repeatedly fail in less restrictive out-of-home care options (e.g., foster homes, kinship care, etc.) and those who are not an immediate threat to the community, but who resist family living, nonetheless (Reviewer comment by Groner, 2006).

DEMOGRAPHIC CHARACTERISTICS

Approximately 530,000 American children live in out-of-home care (Petit, Curtis, Woodruff, Arnold, Feagans, & Ang, 1999). Of these, 41,000 live in residential group care, 27,000 in community-based group homes, and 23,000 in therapeutic foster care.

Because some of the rationale for group care as part of the child welfare service's care continuum is based on the assumption that children in group care are "different" from children in other settings, a recent study examined the question of how children in group care (institutional care) differ from those in kinship or foster care (Barth, 2002). They found that children in group care are clearly older than other children. However, evidence that their behavior is worse is less clear (NSCAW, 2002 in Barth, 2002).

> In the NSCAW sample of children in out of home care for one year, children in group care at the time of the assessment had significantly more behavioral and cognitive scores in the borderline or clinical range. This appears, however, to be so because the group care setting provides care for older children. After controlling for age, children in group care do not appear to have higher clinical scores than children of the same age who experienced the same abuse types and who now reside in kinship or non-kinship care. (Barth, 2002)

The NSCAW (2002 in Barth, 2002) report also found that children in group care scored substantially worse on standardized measures than other children in the study. Another difference is that children in group care were 3.5 times more likely to have experienced sexual abuse (27 percent) than children who resided in foster care or kinship care. Children in group care were somewhat more troubled than other children in out-of-home care, although the overall level of problems shown by children in other out-of-home care settings was also substantial. Many children with a range of social, cognitive, and behavioral problems were also in kinship care and foster care (Barth, 2002).

The NSCAW (2002 in Barth, 2002) data also showed that children in group home care were significantly more likely to receive mental health services than children in kinship care or foster

care (when age, level of problems, and other factors were controlled). Among the children in group home care, 61 percent were receiving some form of specialty mental health services (other than the group care itself), whereas the proportions of children in foster care and kinship care were 28 percent and 13 percent, respectively. (Of particular note, children in group care are significantly more likely [$p<.01$] to have been served in a psychiatric hospital or unit.) A multivariate analysis that controls for age, gender, race, clinical scores, and type of abuse determined that children in group home care are more than 3 times more likely to receive specialty mental health than children in foster care and 7 times more likely than children in kinship care (Barth, 2002).

> Little effort has been made to compare the perspectives of children about their living arrangements. In the National Survey of Child and Adolescent Well-Being, children 6 and older and in care for about one year were asked for their view about out of home care. Children living for one year in out-of-home care are generally satisfied with their living arrangements and schools, although children residing in group care appear to have different perceptions in several ways. First, they are almost 4 times as likely as those in non-kin foster homes and 10 times as likely as those in kinship care to report that they do not like the people with whom they are living ($p<.05$ and $p<.01$, respectively). They are more likely to report never seeing their biological father or mother (OR = 5.13, $p<.05$; OR = 4.19, $p<.01$). From these analyses it can be inferred that children in group care differ significantly from children both in kinship care arrangements and those in foster care with non-kin. Those in group care are less positive about their experience than children in the other two arrangements. (Barth, 2002)
>
> Children in group care and foster care reported seeing their family members less than children in kinship care. Children in foster care were three times as likely to report seeing their biological mother less than once each month as children in foster care ($p<.01$). Children in group care were four times as likely to report seeing their biological mother less than once each month as children in kinship care ($p<.01$). Children in group care were five times as likely as children in kinship care to report seeing their biological fathers less than once each month ($p<.05$). Finally, children in group care are more likely to report visits being cancelled frequently than are children in non-kin or kinship foster homes (OR = 3.83, $p<.01$). (Barth, 2002)

Estimated Persons in Need

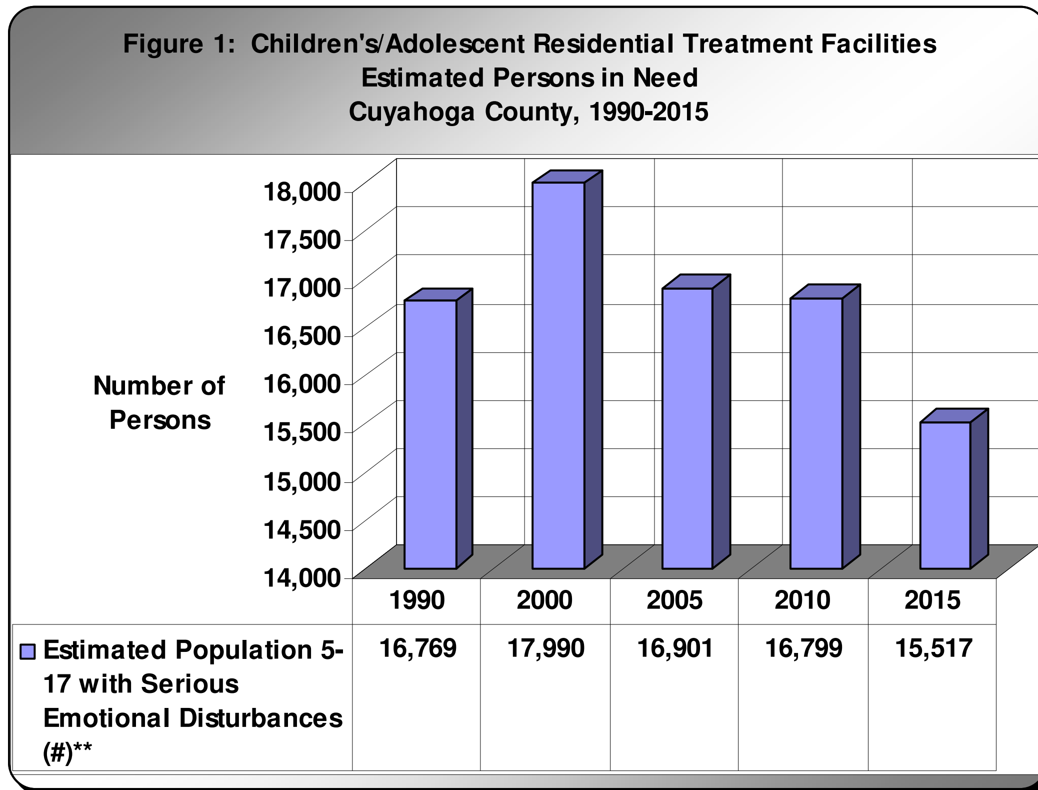
According to the Cuyahoga County Mental Health Assessment (2003), approximately 53,712 children ages 5-17 (20.94 percent of the total 5 to 17 years population) had a mental disorder and 17,990 had a serious emotional disturbance (SED) (7 percent of the 5 to 17 age cohort). (See Table 1.)

Table 1: National Prevalence Rates and Estimated Number of Children and Youth with Mental Disorders in Cuyahoga County, 2003

Type of Disorder	Total Population	Estimated Total with Disorder	% 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***	***7%***

Source: Cuyahoga County Mental Health Assessment, December 2003

Utilizing this estimate, in 2005, 17,990 children ages 5-17 in Cuyahoga County were estimated to be affected by an SED and possibly in need of a residential treatment facility. This population is projected to decrease to 15,517 in 2015, due to shifts in the population in general. (See Figure 1.)



Sources:

* Population 5-17 years, US 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. 7 percent of children 5 to 17 years have a serious emotional disturbance. Assumes same percentage over all periods.

This estimate of persons in need of children's/adolescent residential treatment facilities begins to offer some clarity about the extent of need in Cuyahoga County. Residential treatment will still remain part of the continuum of services for children and youth with serious emotional disturbances (as will be discussed subsequently); however, except for a small but significant sub-population of youth, it is not the preferred treatment modality for this population.

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 United Way funded agencies and by government funders from which it was possible to obtain data. Thus, it is an underestimate of actual number of consumers receiving service.

In FY 2004, United Way funded 542 children and youth for residential treatment. Note that 4 clients are listed as being in the 20-34 age range, leaving a net of 538 ages 5 to 19. However, some of them may not receive the residential treatment service as defined in this report. In CY 2002, the Cuyahoga County Mental Health Board funded 31 actual annual consumers, and the Cuyahoga County Juvenile Court, which reported data for FY 2004, funded 136. (See Attachment 3.)

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. United Way funded 34 percent Caucasian, 63 percent African American, and 0.3 percent Asian children in residential treatment. The Cuyahoga County Community Mental Health Board also funded more African Americans, 74 percent, than Caucasians (19 percent). The juvenile court did not provide demographic data.

Five percent of the county's 5 to 17 year population is Hispanic, while United Way and CCCMHB each funded 3 percent Hispanic consumers.

Fifty-nine percent of those funded by United Way reported annual household income below $10,000. Another 11 percent reported incomes between $10,000 and $30,000. Three percent reported an income of over $30,000. The rest were unreported.

While 34 percent of children and youth 5 to 17 years reside in Cleveland and 66 percent in the suburbs, 7 percent of United Way funded consumers were Cleveland residents and 28 percent lived in suburbs. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of the core service for this report is: programs that provide a therapeutic living environment in a community-based facility for seriously emotionally disturbed children and youth. Residents often attend on-grounds schools or public special education classes and receive services geared to their individual needs and the realization of appropriate future plans such as their eventual return to their own or foster families, or emancipation as soon as their personal and social adjustment and development permit.

BACKGROUND ON CORE SERVICE

> Treatment centers are the second most restrictive form of care (next to inpatient hospitalization) for children with severe mental disorders. Although used by a relatively small percentage (8 percent) of treated children, nearly one-fourth of the national outlay on child mental health is spent on care in these settings (Burns et al., 1998). However, there is only weak evidence for their effectiveness. (U.S. Department of Health and Human Services, 1999)
>
> A residential treatment center (RTC) is a licensed 24-hour facility (although not licensed as a hospital), which offers mental health treatment. The types of treatment vary widely; the major categories are psychoanalytic, psycho-educational, behavioral management, group therapies, medication management, and peer-cultural. Settings range from structured ones, resembling psychiatric hospitals, to those that are more like group homes or halfway houses. While formerly for long-term treatment (e.g., a year or more), RTCs under managed care are now serving more seriously disturbed youth for as briefly as 1 month for intensive evaluation and stabilization. (U.S. Department of Health and Human Services, 1999)

Residential treatment centers (also known as group care facilities) can be in the form of apartments, emergency shelters, and secure settings.

> Concerns about residential care primarily relate to criteria for admission; inconsistency of community-based treatment established in the 1980s; the costliness of such services (Friedman & Street, 1985); the risks of treatment, including failure to learn behavior needed in the community; the possibility of trauma associated with the separation from the family; difficulty reentering the family or even abandonment by the family; victimization by RTC staff; and learning of antisocial or bizarre behavior from intensive exposure to other disturbed children. (Barker, 1998 in U.S. Department of Health and Human Services, 1999)

Recent research has tended to be unsupportive of residential treatment because this modality has generally not produced better outcomes than less expensive alternative interventions.

Residential treatment has been criticized on the grounds that removing youth from their families and communities, while possibly having the effect of ameliorating an immediate crisis, does not help them develop the skills they need to achieve positive adjustment in the long run. Frequently, youth learn how to function successfully in the residential setting but not how to adapt to their natural environment, so that discharge is often followed by a regression in their functioning. An additional problem is that by congregating youth with behavioral disturbances often results in group influence processes that worsen their dysfunction. Alternative interventions proven effective for SED youth, particularly intensive in-home treatment and therapeutic foster care, not only produce better outcomes for most youth, but are also significantly less expensive.

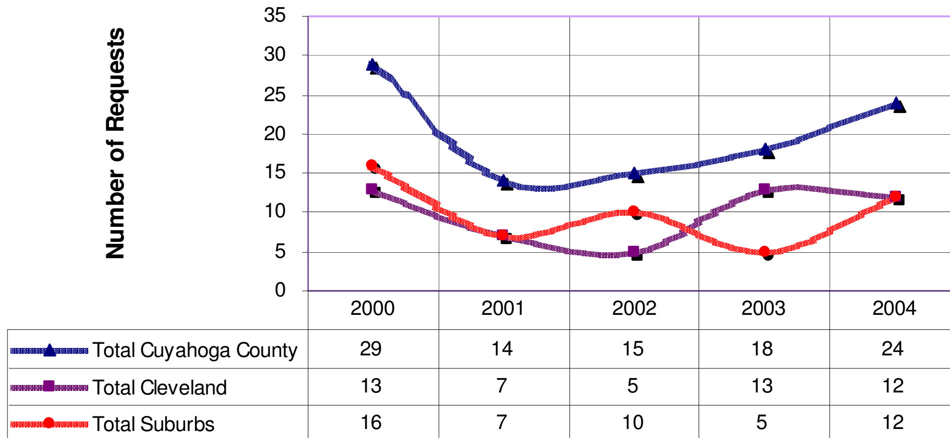
Nonetheless, residential treatment remains an appropriate form of care for a relatively small number of youth with severe problems and needs. Residential care is one means of removing youth from abusive home environments, and many young people in residential care are also in county custody. Also, residential settings protect the community from harmful behaviors, making it an appropriate treatment modality for populations such as juvenile sex offenders.

In keeping with national trends, most local mental health organizations with residential treatment facilities have diversified their services in recent years because many children with SED can be more effectively served by intensive in-home services and therapeutic foster care. Nonetheless, for some youth with particularly severe problems and complex needs, there may be no viable alternative to residential treatment. One notable new and innovative residential treatment program in Cuyahoga County is Bellefaire's Monarch Academy for youth with autism-related developmental disorders.

United Way – First Call for Help Call Data

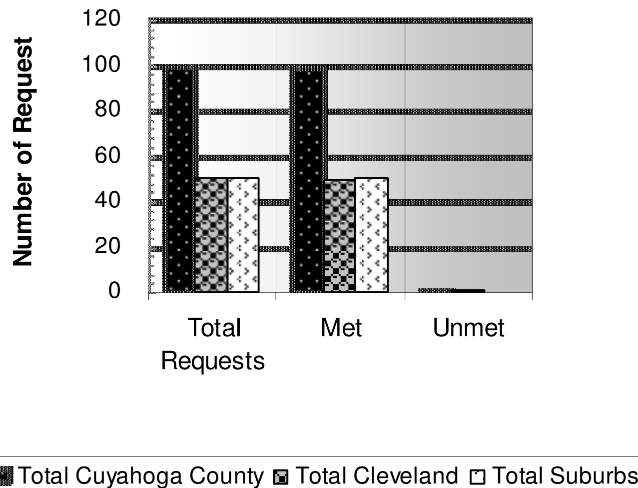
Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 6 nonprofit children's/adolescent residential treatment facilities program providers operating from 7 different sites. In FY 2004 (July 2003 to June 2004), 2 providers were funded by United Way. Note: the Cuyahoga County Department of Children and Family Services lists 4 additional providers beyond the First Call for Help list. This includes 6 sites within the county and another 5 out-of-county providers. (See Attachments 5 and 6.)

FCFH call data shows a decrease in the number of total requests for children's/adolescent residential treatment facilities programs in the county: from 29 in 2000 to 24 in 2004 (17 percent decrease) with an 8 percent decrease in Cleveland (13 to 12 requests) and a 25 percent decrease in the suburbs (16 to 12 requests). Note that this is not necessarily an indication of need. In addition, percentages are inflated because of low numbers. (See Figure 2 and Attachment 7.)



	2000	2001	2002	2003	2004
Total Cuyahoga County	29	14	15	18	24
Total Cleveland	13	7	5	13	12
Total Suburbs	16	7	10	5	12

Over the same five-year period, United Way - First Call for Help had 100 requests for information about children's/adolescent residential treatment facilities. Of these requests, they were able to make referrals to 99 percent of callers; however, 1 percent of all Cuyahoga County callers (1) had an unmet need, meaning there was no agency to which to refer the caller. (See Figure 3 and Attachment 8.)



FUNDING OF CORE SERVICES

Major Government Funders

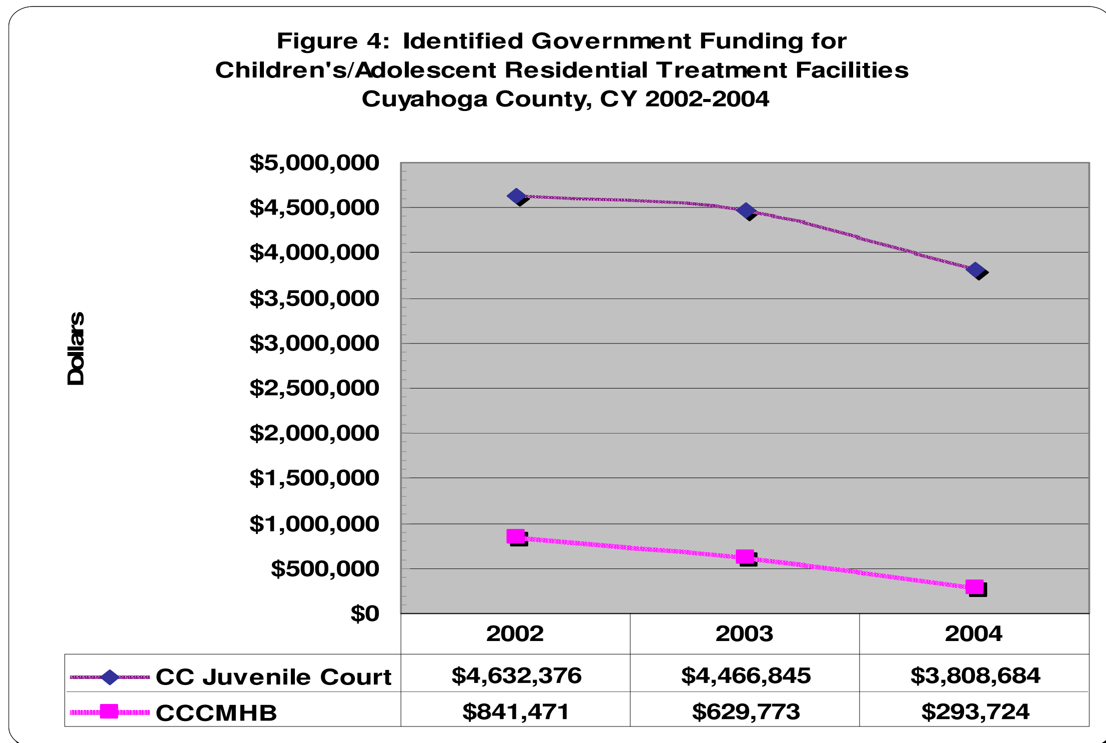
The major sources of government funding for children's residential treatment facilities are:

- Community Mental Health Services Block Grant Program
- Medicaid
- Office of Juvenile Justice and Delinquency Prevention Formula Grants to States
- Title IV-E Foster Care (Kamradt, 2002)

Much of this funding is from federal sources and is passed through the state to local agencies that serve children with mental health needs. For Cuyahoga County, these are is the Department of Children and Family Services for children in the child welfare system, the Cuyahoga County Community Mental Health Board, and the Cuyahoga County Juvenile Court. These funders themselves do not provide services, but they do fund service providers. The balance of funding comes from Medicaid, private insurance, and self-pay fees for services.

Trends of Identified Government Funders in Cuyahoga County

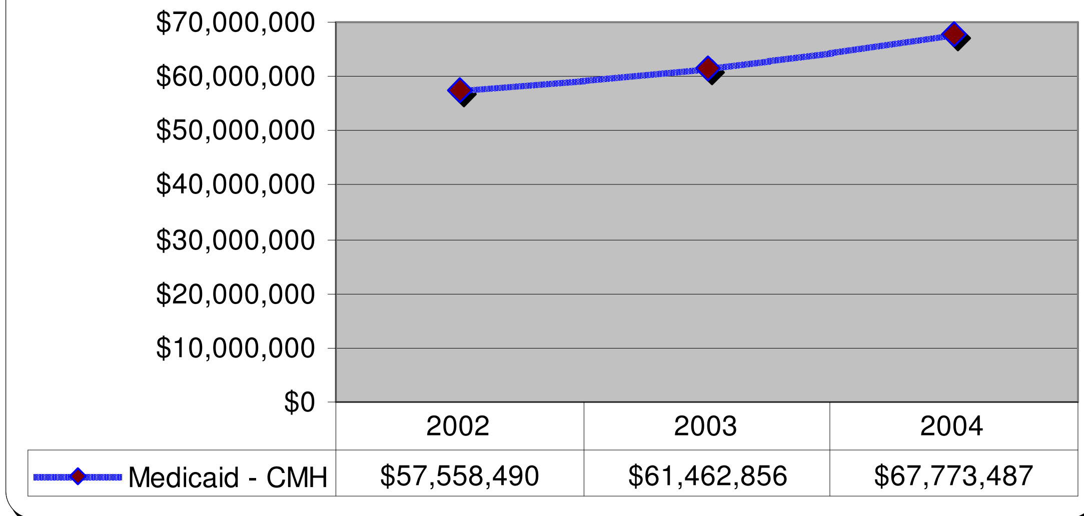
Between 2002 and 2004, identified government funding sources decreased allocations for children's residential services. The Cuyahoga County Community Mental Health Board decreased spending from $841,471 in 2002 to $293,724 in 2004, and juvenile court funding decreased from $4.6 million in 2002 to $3.8 million in 2004. (See Figure 4.)



	2002	2003	2004
CC Juvenile Court	$4,632,376	$4,466,845	$3,808,684
CCCMHB	$841,471	$629,773	$293,724

Sources: Cuyahoga County Community Mental Health Board, Cuyahoga County Juvenile Court

Medicaid funding for community mental health services increased from $57.5 million in 2002 to $67.7 million in 2004. However, this includes all mental health services, not just children's/adolescent residential treatment. (See Figure 5.)



* 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.

While families often rely on insurance for their children's residential treatment, local area foundations also target funding for this activity, which is especially helpful for families lacking insurance coverage. The Margaret Clark Morgan Foundation's 2004 donation of $120,000 makes it the area's largest foundation financier of children's/adolescent residential treatment facilities that was identified in this research. The George Gund, Deaconess, and Wean Foundations each donated $20,000 or more in FY 2004.

IDENTIFIED REVENUES

As of May 11, 2006, over $5.9 million in revenues for children's/adolescent residential treatment facilities programs has been identified countywide, excluding Medicaid dollars. (See Table 2.) This includes information from foundations; federated fundraising organizations; regional, county and municipal government; and United Way of Greater Cleveland.

Sixty-nine percent of the revenues are from contracts or grants from government organizations. The Cuyahoga County Community Mental Health Board is a primary funder of the service, as is Juvenile court. Federated organizations are also significant funders of this service, accounting for approximately eight percent of total reported funding. United Way of Greater Cleveland's funds account for 19 percent of the total from Investment Committee allocations and designations.

Table 2: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland Children's/Adolescent Residential Treatment Facilities, 2003/2004.

		A		B	
Funder	Period	Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			**0.00%**	**86,536**	**0.60%**
Cleveland Foundation, The		8,500			
Deaconess Community Foundation		25,000			
Gund Foundation, The George		30,000			
Wean Foundation, The Raymond John		20,000			
Other Private Foundations - Not Elsewhere Classified		120,000		101,620	
Total - Foundations & Trusts		**203,500**	**3.42%**	**101,620**	**0.70%**
Catholic Charities Service Corporation		485,500		357,000	
United Black Fund of Greater Cleveland		19,000			
Total - Federated Fundraising Organizations		**504,500**	**8.47%**	**357,000**	**2.46%**
Department of Agriculture (USDA)				94,000	
Subtotal Federal Government		***0***	***0.00%***	***94,000***	***0.65%***
Department of Job and Family Services				3,253,031	
State Department of Education				42,112	
Subtotal State of Ohio		***0***	***0.00%***	***3,295,143***	***22.67%***
Cuyahoga County Community Mental Health (648 Board)	CY2004	293,724		196,300	
Employment & Family Services				4,054,300	
Juvenile Court	FY2004	3,808,684		928,051	
Other Cuyahoga County Funders - Not Elsewhere Classified				3,172,800	
Subtotal Cuyahoga County Funding Sources		***4,102,408***	***68.88%***	***8,351,451***	***57.47%***
Medicaid *				1,035,500	
Subtotal Third Party Payee/Direct Bill		***0***	***0.00%***	***1,035,500***	***7.13%***
Total - Contracts/grants from government organizations		**4,102,408**	**68.88%**	**12,776,094**	**87.91%**
Total - Investment Income			**0.00%**	**15,000**	**0.10%**
Total - All Other Revenue			**0.00%**	**51,034**	**0.35%**
Subtotal Non - UWGrCle Support		**4,810,408**	**80.76%**	**13,387,284**	**92.12%**
Total - UWGrCle investment committee allocation		**1,145,735**	**19.24%**	**1,145,735**	**7.88%**
Subtotal UWGrCle Support - 4001, 4701 & 4703		**1,145,735**	**19.24%**	**1,145,735**	**7.88%**
Total Support/Revenue		**5,956,143**	**100%**	**14,533,019**	**100%**

* 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

Residential treatment is expensive, generally costing more than $300 per day plus the costs of specific therapeutic services. Although length of stay has been constrained by managed care, these interventions usually need to last at least several months because of the severity of the disturbances being treated. The expenses that result sometimes exceed the combined resources of families and their health insurance policies.

Private health insurance policies often limit their coverage of residential treatment, and few families can afford to pay for this type of treatment on their own. Therefore, having a child who needs these services may be a financial disaster for his or her family. Families sometimes voluntarily give up custody of their children to state child protection agencies in order to obtain publicly funded services for their children. A "Keeping Families Together" Act, currently being considered in the U. S. Senate, could be an important step toward obtaining needed mental health services for youth with mental health needs that exhaust the resources of their families and health insurance policies.

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works
A good deal of research indicates that restrictive approaches such as residential treatment, inpatient psychiatric hospitalization, and incarceration—while they temporarily get youth "off the streets"—show little effectiveness at changing behavior and are extremely expensive (Henggeler & Santos, 1997). Often, behavioral improvements achieved while in the residential facility fail to transfer to the natural environment, so clients regress rapidly following discharge (Curry, 1991).

Residential places often bring antisocial youth together in groups, and the peer-to-peer processes that occur generally worsen their problems (Dishion, McCord, & Poulin, 1999). In contrast, the main alternatives to residential treatment for youth with SED—in-home, family-based therapy and therapeutic foster care—share the advantages of minimizing contact with antisocial peers and supporting a family-like living situation, whether these settings are with biological or foster families.

Outcome studies directly comparing residential treatment and therapeutic foster care have usually favored the latter type of intervention. In a study of delinquent youths, Chamberlain (1990) found that two years following termination of these two types of treatment, one-half of the youths who had received specialized foster care, compared to 15 of 16 youths who received group care, had been re-incarcerated. In another study of this population, Chamberlain and Reid (1998) found that boys who had received residential group care, as compared to boys who received therapeutic foster care, had fewer runaways, transfers to correctional facilities, and referrals for criminal activity.

Nonetheless, some studies of residential treatment have produced encouraging results, although most of these studies had serious methodological limitations, especially the lack of a control group. Larzelere (2001), in a study of Girls and Boys Town, found significant improvements in emotional and behavioral functioning in youth placed in this facility. In this study, treatment gains were generally maintained at the 10-month follow-up assessment. Frankfort-Howard (2002) followed youth discharged from a residential treatment program into adulthood and found that their rates of antisocial behavior were much lower than would be expected on the basis of their histories.

Additionally, children's residential treatment may be more effective for some sub-populations of youth. Hussey and Guo (2002) found that young age, female gender, and lower IQ were associated with increased levels of psychopathology. This suggest that this population may be an especially treatment-resistant group that would be ill served by community-based options until they have the benefit of residential assistance.

In conclusion, both research and values-related considerations seem to argue for sparing use of residential treatment for youth with mental health problems. In the vast majority of cases, less restrictive, community-based forms of treatment are probably more capable of restoring youth to a successful adaptation in their natural environment. Nonetheless, there is a small-but-significant subpopulation of youth that needs and can benefit from residential treatment.

What Doesn't Work
Residential treatment has fallen into disfavor during the last 20 years because of concerns about the negative effects of removing youth from their homes and communities and placing them in an environment that, although it has many positive characteristics, differs from their natural environments (Burns & Hoagwood, 2002; Stroul, 1988). Residential facilities remove children from their families, neighborhoods, and communities. Even though there may be serious problems associated with these settings, they do represent the youth's familiar relationships and the environments to which, eventually, they need to adapt. One fundamental difficulty with residential treatment is that the behaviors needed for successful adaptation to these settings are not necessarily the same as the behaviors needed to adapt successfully to the community, so that improved functioning in residential treatment does not necessarily lead to improved functioning in the community.

As a result of these concerns, there has been a national call for community-based mental health treatments (Stroul, 1988). Most recent work on developing and evaluating treatments for seriously emotionally disturbed youth has focused on alternatives to residential treatment. These interventions generally have two complementary goals: maintaining youth in their homes and communities rather than moving them to more restrictive environments, and improving their psychosocial functioning.

Nonetheless, residential treatment remains an appropriate form of care for a relatively small number of youth with severe problems and needs. Residential care is one means of removing youth from abusive home environments, and many young people in residential care are in county custody. Also, residential settings protect the community from harmful behaviors, making it an appropriate treatment modality for populations such as juvenile sex offenders.

IMPACT ON COMMUNITY

Not available.

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

Children's Services Licensing
The goal of children's services licensing is to ensure safe 24-hour substitute care for children in Ohio. In order to be licensed by the Ohio Department of Job and Family Services (ODJFS), foster homes, group homes, and residential settings must meet minimum health and safety standards and training requirements regarding the care of children. These providers and settings are monitored for compliance and, when necessary, ODJFS staff provides technical assistance to improve compliance or take enforcement action.

Ohio Department of Mental Health
The Ohio Department of Mental Health also licenses facilities, which must be licensed in order to receive Medicaid reimbursement. In order to be licensed, the state of Ohio requires that agencies must be accredited by a national accrediting body, such as the Joint Commission on Accreditation of Healthcare Organization (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF), and/or the Council on Accreditation.

Case Planning
The primary care service area (PCSA) worker strives to achieve a placement that is neighborhood-based, culturally-sensitive, and located primarily in the community the child

comes from to preserve relationships and to minimize disruption to the child's life. A case plan for the family is developed to promote permanence for the child and is designed to meet emotional and physical needs in the least restrictive, most family-like setting. For a child to enter substitute care, there is either a voluntary agreement between the PCSA or private child placing agency (PCPA) and the parent; or there is an award of custody by the juvenile court. Intended to be temporary, substitute care consists of services provided to the child, the family, and the substitute care giver.

The number of children placed in group homes and residential centers has decreased, while the number of children placed in kinship care and foster homes has increased. This may be attributed to a conscious statewide effort to develop and use kinship and family foster homes that are located in the neighborhoods where the children lived with their parents. If a court determines it is not in the child's best interest to return home, the PCSA takes steps to find a permanent placement. Good case practice supports concurrent planning for family reunification and an alternative permanent living arrangement (such as adoption or legal guardianship) when family reunification is not in the child's best interest. In order to prevent unnecessary lingering in substitute care, concurrent planning supports engaging the family in the development of an alternative plan during the case planning process.

VI. GAP ANALYSIS

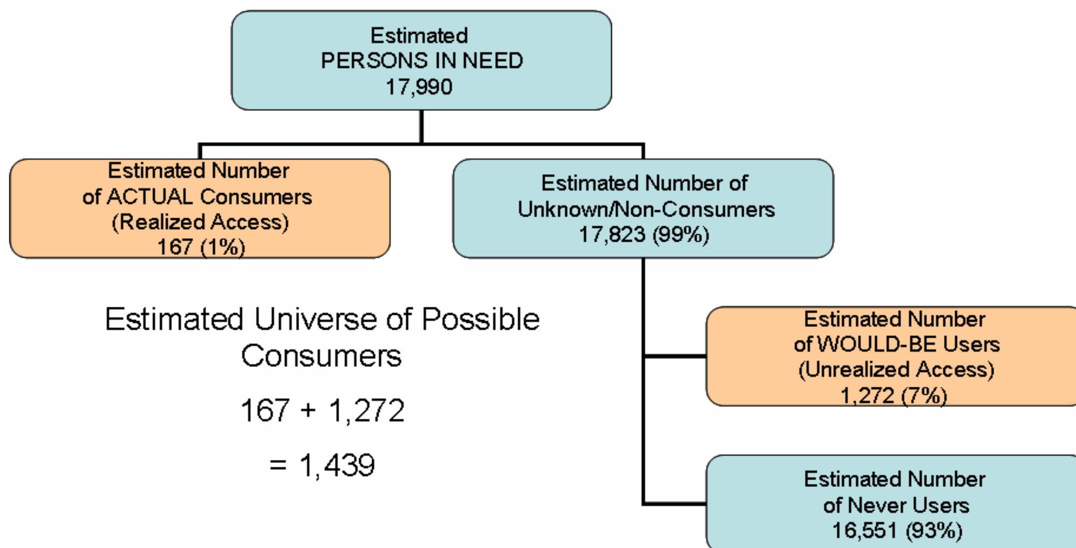
The following is the formula for arriving at the estimated universe of possible consumers for Children's/Adolescent Residential Treatment Facilities:

- A conservative estimate of 17,990 persons need children's/adolescent residential treatment facilities programs, which is the estimate of Cuyahoga County children ages 5-17 with serious emotional disturbances (SED's).

- Based on available information about actual consumers, approximately 167 children aged 5-17 have realized access to children's/adolescent residential treatment facilities programs. This includes those funded by CCCMHB (31) and Juvenile Court (136). (31 + 136 = 167). It assumes that UW funded consumers (538) are duplicated and that the service funded is not necessarily residential treatment as defined in this report.

- This leaves a net estimate of 17,823 children ages 5-17 who are either receiving services from unaccounted-for sources or are not receiving treatment. (17,990 – 167 = 17,823)

- Based on the findings of "Mental Health: A Report of the Surgeon General" (U.S. Department of Health and Human Services, 1999), 8 percent of children and youth with severe mental disturbances are in residential treatment facilities. This amounts to an estimated universe of 1,439 possible consumers, including both realized and unrealized access. (17,990 x 8% = 1,439) (See Figure 6.)



Service Site Index

According to First Call for Help, there are 7 service sites for children's/adolescent residential treatment facilities programs countywide. Note: the Cuyahoga County Department of Children and Family Services lists 4 additional providers beyond the First Call for Help list. This includes 6 sites within the county and another 5 out-of-county providers. Using 11 sites, this is a ratio of 131 possible consumers (estimated 1,439 total) to one available service site. Because of the nature of this service, there is no Service Site Index by zip code.

Service Capacity

Affecting all mental health services is the shortage of psychiatrists, especially child and adolescent psychiatrists.

> 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)

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. Reimbursement is a primary issue (MedIndia, 2006)

VII. SUMMARY

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

- About 7 percent of American children aged 9 to 17 are affected by a serious emotional disturbance (SED). An SED designation denotes that treatment beyond outpatient therapy may be necessary. The purpose of residential treatment centers is to provide services to children with SED who need particularly intensive forms of intervention.
- A "Keeping Families Together" Act, currently being considered in the U. S. Senate, could be an important step toward obtaining mental health services for youth whose needs exhaust the resources of their families and health insurance policies.
- A major funding policy that affects all persons—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.
- Between 2002 and 2004, identified government funding sources for children's/adolescent residential treatment facilities decreased from $5.5 million in 2002 to $4.1 million in 2004.
- Medicaid funding for community mental health services increased from $57.5 million in 2002 to $67.7 million in 2004.
- As of May 11, 2006, over $5.9 million in revenues for children's/adolescent residential treatment facilities programs has been identified countywide, excluding Medicaid dollars.
- Outcome studies directly comparing residential treatment and therapeutic foster care have usually favored the latter type of intervention.
- A good deal of research indicates that restrictive approaches such as residential treatment, inpatient psychiatric hospitalization, and incarceration show little effectiveness at changing behavior and are extremely expensive (Henggeler & Santos, 1997).
- In the vast majority of cases, less restrictive, community-based forms of treatment are probably more capable of restoring youth to a successful adaptation in their natural environment. Nonetheless, there is a small-but-significant subpopulation of youth who need and can benefit from residential treatment.
- The estimated universe of possible consumers is 1,439 including both realized (167) and unrealized (1,272) access.
- Countywide there are 6 children's/adolescent residential treatment facilities, with another 5 out of county. This is a ratio of 131 possible consumers (estimated 1,439 total) to one available service site.

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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 the 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.
- 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 assumed 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: Children's/Adolescent Residential Treatment Facilities RM-700.150						
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****		
	Total Population (%)*	Total Population 5-17 (%)**	Estimated Population 5-17 with Serious Emotional Disturbance (%)***	UW Program Report Data Cuy Cnty Only 89.6% (%)	CCCMHB (%)	CC Juvenile Court (%)
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	7/1/2003-6/30/2004	7/1/2003-6/30/2004
TOTAL	1,393,978	256,467	17,990	542	31	136
Percent		18.4%	7.0%			
GENDER						
Male	47.2%	51.1%	N/A	47.3%	0.0%	0.0%
Female	52.8%	48.9%	N/A	52.7%	0.0%	0.0%
Unknown Data*****				0.0%	0.0%	0.0%
Missing Data******				0.0%	100.0%	100.0%
RACE*******						
White alone	67.1%	58.0%	N/A	34.0%	19.4%	0.0%
Black or African American alone/combination	27.9%	36.4%	N/A	62.5%	74.2%	0.0%
Asian alone/combination	2.1%	1.9%	N/A	0.3%	0.0%	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.8%	N/A	0.2%	3.2%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.0%	N/A	1.2%	0.0%	0.0%
Some other race alone/combination	2.1%	2.9%	N/A	1.8%	0.0%	0.0%
Unknown Data*****				0.0%	3.2%	0.0%
Missing Data******				0.0%	0.0%	100.0%
HISPANIC********	3.3%	4.7%	N/A	3.0%	3.2%	0.0%
AGE						
0-4	6.5%		N/A	0.0%	100.0%	0.0%
5-9	7.3%	39.7%	N/A	1.0%		0.0%
10-14	7.1%	38.7%	N/A	26.4%		0.0%
15-19	6.4%	21.7%	N/A	71.9%		0.0%
20-34	19.1%		N/A	0.7%	0.0%	0.0%
35-54	29.3%		N/A	0.0%	0.0%	0.0%
55-64	8.7%		N/A	0.0%	0.0%	0.0%
65-74	7.8%		N/A	0.0%	0.0%	0.0%
75+	7.8%		N/A	0.0%	0.0%	0.0%
Unknown Data*****				0.0%	0.0%	0.0%
Missing Data******				0.0%	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	58.8%	0.0%	0.0%
$10,000-$14,999	6.9%	N/A	N/A	4.3%	0.0%	0.0%
$15,000-$19,999	6.7%	N/A	N/A	4.0%	0.0%	0.0%
$20,000-$29,999	13.6%	N/A	N/A	3.0%	0.0%	0.0%
$30,000 and above	61.5%	N/A	N/A	3.1%	0.0%	0.0%
Unknown Data*****				26.8%	0.0%	0.0%
Missing Data******				0.0%	100.0%	100.0%
Totals	100.0%	N/A	N/A	100.0%	100.0%	100.0%

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1); SF4 (PCT 144)
** US Census 2000, SF3 (P8)
*** "Cuyahoga County Mental Health Assessment," Center for Community Solutions, December 2003. 7 percent of children have a serious emotional disturbance.
****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 multipled 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: Children's /Adolescent Residential Treatment Facilities RM-700.150							
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****		
	City/Town (% Cleveland)	Total Population (%)*	Total Population 5-17 (%)**	Estimated Population 5-17 with Serious Emotional Disturbance (%)***	UW Program Report Data (%)	CCCMHB (%)	CC Juvenile Court (%)
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	7/1/2003-6/30/2004	7/1/2003-6/30/2004
TOTAL		1,393,978	256,467	17,990	542	31	136
Percent			18.4%	7.0%			
44017	Berea	1.4%	1.2%	N/A	0.2%	0.0%	0.0%
44022	Bentleyville	1.3%	0.9%	N/A	0.2%	0.0%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	0.2%	N/A	0.0%	0.0%	0.0%
44070	North Olmsted	2.5%	2.4%	N/A	0.6%	0.0%	0.0%
44101	Cleveland (100%)	0.0%	0.0%	N/A	0.0%	0.0%	0.0%
44102	Cleveland/Brooklyn (95%)	3.8%	4.3%	N/A	13.3%	0.0%	0.0%
44103	Cleveland (100%)	1.8%	2.4%	N/A	2.2%	0.0%	0.0%
44104	Cleveland (100%)	2.1%	3.0%	N/A	3.9%	0.0%	0.0%
44105	Cleveland/NewburghHts/GarfieldHts	4.0%	4.8%	N/A	5.9%	0.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	1.8%	N/A	2.8%	0.0%	0.0%
44107	Lakewood/Cleveland	4.1%	3.3%	N/A	2.4%	0.0%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	3.4%	N/A	6.1%	0.0%	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.5%	N/A	3.7%	0.0%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	2.3%	N/A	3.1%	0.0%	0.0%
44111	Cleveland (100%)	3.1%	2.8%	N/A	2.2%	0.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	2.9%	N/A	0.7%	0.0%	0.0%
44113	Cleveland (100%)	1.4%	1.2%	N/A	1.3%	0.0%	0.0%
44114	Cleveland (100%)	0.3%	0.1%	N/A	0.4%	0.0%	0.0%
44115	Cleveland (100%)	0.6%	0.7%	N/A	23.6%	0.0%	0.0%
44116	Rocky River	1.5%	1.3%	N/A	0.2%	0.0%	0.0%
44117	Euclid/Cleveland	0.9%	0.7%	N/A	0.4%	0.0%	0.0%
44118	ClevelandHts/UniversityHts/ShakerH	3.3%	3.1%	N/A	3.1%	0.0%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	0.8%	N/A	0.4%	0.0%	0.0%
44120	Shaker Hts/Cleveland	3.4%	3.7%	N/A	3.3%	0.0%	0.0%
44121	University Hts/South Euclid	2.5%	2.5%	N/A	1.5%	0.0%	0.0%
44122	Beachwood/Highland	2.5%	2.5%	N/A	0.9%	0.0%	0.0%
44123	Euclid	1.3%	1.2%	N/A	0.2%	0.0%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	2.2%	N/A	0.4%	0.0%	0.0%
44125	Valley View/Garfield Hts	2.2%	2.0%	N/A	1.5%	0.0%	0.0%
44126	Fairview Park/Cleveland	1.2%	1.1%	N/A	0.4%	0.0%	0.0%
44127	Cleveland (100%)	0.6%	0.9%	N/A	1.5%	0.0%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.4%	N/A	3.0%	0.0%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	2.0%	N/A	1.7%	0.0%	0.0%
44130	Parma/Cleveland	3.9%	3.0%	N/A	1.3%	0.0%	0.0%
44131	Independence/Seven	1.5%	1.3%	N/A	0.4%	0.0%	0.0%
44132	Euclid	1.1%	1.0%	N/A	0.2%	0.0%	0.0%
44133	North Royalton	2.1%	2.1%	N/A	0.4%	0.0%	0.0%
44134	Parma/Cleveland	2.9%	2.6%	N/A	0.7%	0.0%	0.0%
44135	Cleveland/Linndale (90%)	2.1%	2.0%	N/A	1.3%	0.0%	0.0%
44136	Strongsville	3.2%	3.4%	N/A	1.7%	0.0%	0.0%
44137	Maple Hts/Cleveland	1.9%	2.0%	N/A	1.3%	0.0%	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	N/A	0.0%	0.0%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	2.1%	N/A	0.0%	0.0%	0.0%
44140	Bay Village	1.2%	1.2%	N/A	0.2%	0.0%	0.0%
44141	Brecksville	1.0%	1.0%	N/A	0.0%	0.0%	0.0%
44142	Brookpark/Cleveland	1.5%	1.5%	N/A	0.7%	0.0%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	1.6%	N/A	0.4%	0.0%	0.0%
44144	Brooklyn/Cleveland	1.6%	1.2%	N/A	0.4%	0.0%	0.0%
44145	Westlake	2.3%	2.2%	N/A	0.4%	0.0%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.0%	N/A	0.0%	0.0%	0.0%
44147	Broadview Hts	1.2%	1.2%	N/A	0.0%	0.0%	0.0%
44149	Strongsville	0.0%	-	N/A	0.0%	0.0%	0.0%
Unknown Cuyahoga County Zip Codes******					0.0%	0.0%	0.0%
Missing*****					0.0%	100.0%	100.0%
Unknown ******					11.6%	0.0%	0.0%
Total Cuyahoga County*******		**100.0%**	**100.0%**	**N/A**	**100.0%**	**0.0%**	**0.0%**
Total Known Cleveland		**40.3%**	**34.0%**	**N/A**	**71.6%**	**0.0%**	**0.0%**
Total Known Suburbs		**59.7%**	**66.0%**	**N/A**	**28.4%**	**0.0%**	**0.0%**
Unknown & Missing					**11.6%**	**100.0%**	**100.0%**

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S. Census 2000, SF1 (P1)
** US Census 2000, SF3 (P8)
*** "Cuyahoga County Mental Health Assessment," Center for Community Solutions, December 2003. 7 percent of children have a serious emotional disturbance.
**** 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

Attachment 5: Profile of Core Service Providers – 2005

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	6	2
Number of Providers by Type		
Nonprofit	6	2
For-profit	-	-
Government	-	-
Other	-	-
Total Number of Sites	7	-
Number of Service Sites per Provider		
1	5	1
2 – 5	1	1
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	1	-
44022 – Bentleyville	-	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	-	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	1	1
44103 – Cleveland	-	-
44104 – Cleveland	-	-
44105 – Newburgh Hts/Garfield Hts	-	-
44106 – Cleveland Hts/Cleveland	-	-
44107 – Cleveland/Lakewood	-	-
44108 – Cleveland/East Cleveland	-	-
44109 – Cleveland/Brooklyn Hts	1	1
44110 – Cleveland/Bratenahl	-	-
44111 – Cleveland	1	-
44112 – Cleveland/East Cleveland	-	-
44113 – Cleveland	-	-
44114 – Cleveland	-	-
44115 – Cleveland	-	-
44116 – Rocky River	-	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	1	-
44119 – Cleveland/Euclid	-	-
44120 – Cleveland/Shaker Hts	-	-
44121 – University Hts/South Euclid	-	-
44122 – Orange/Warrensville Hts	-	-
44123 – Euclid	-	-
44124 – Pepper Pike/Mayfield Village	1	-
44125 – Valley View/Garfield Hts	-	-
44126 – Cleveland/Fairview Park	-	-
44127 – Cleveland	-	-
44128 – Cleveland/Warrensville Hts	-	-

Attachment 5: Profile of Core Service Providers – 2005 (continued)

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44129 – Cleveland/Brooklyn/Parma	-	-
44130 – Cleveland/Parma	-	-
44131 – Seven Hills/Brooklyn Hts	-	-
44132 – Euclid	-	-
44133 – North Royalton	-	-
44134 – Parma/Cleveland	1	1
44135 – Cleveland/Linndale	-	-
44136 – Strongsville	-	-
44137 – Maple Hts/Cleveland	-	-
44138 – Olmsted Twp/Olmsted Falls	-	-
44139 – Bentleyville/Glenwillow/Solon	-	-
44140 – Bay Village	-	-
44141 – Brecksville	-	-
44142 – Cleveland/Brookpark	-	-
44143 – Highland Hts/South Euclid	-	-
44144 – Brooklyn/Cleveland	-	-
44145 – Westlake	-	-
44146 – Walton Hills/Oakwood/Bedford	-	-
44147 – Broadview Hts	-	-
44149 – Strongsville	-	-

Note: the Cuyahoga County Department of Children and Family Services lists 4 additional providers beyond the First Call for Help list. This includes 6 sites within the county and another 5 out-of-county providers.

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	**Services**
Applewood Centers	Youth Residential Psychiatric Treatment, Residential Services For Juvenile Offenders
Beech Brook	Residential Treatment
Bellefaire Jewish Children's Bureau	Residential Treatment - Autistic Children, Residential Treatment - Intensive Long Term, Residential Treatment - Crisis
Berea Children's Home And Family Services	Residential Treatment, Residential Treatment - Aggressive Boys
Catholic Charities Services Of Cuyahoga County	Specialized Residential Services For Youth
Cleveland Christian Home	Residential Treatment And Partial Hospitalization Services

Bold represents agencies funded by United Way for this service.

Attachment 7: United Way - First Call for Help Children's/Adolescent Residential Treatment Facilities Requests – 2000-2004: Greatest Increase/Greatest Decrease

RM-700.150 Children's/Adolescent Residential Treatment Facilities United Way - First Call for Help Requests 2000-2004 Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change*	Avg. #
		2000	2001	2002	2003	2004	00&04	Calls 00-04
44107	Lakewood/Cleveland	1	1	1	3	2	100%	2
44134	Parma/Cleveland	1	0	0	1	2	100%	1
44146	Walton Hills/Oakwood/Bedford	1	0	0	0	2	100%	1
44139	Bentleyville/Glenwillow/Solon	0	0	0	0	2	N/A	0
44111	Cleveland	0	0	0	0	2	N/A	0
44110	Cleveland/East Cleveland	0	0	0	1	2	N/A	1
44135	Cleveland/Linndale	0	0	0	1	2	N/A	1
44144	Brooklyn/Cleveland	0	0	0	0	1	N/A	0
44104	Cleveland	0	0	0	1	1	N/A	0
44114	Cleveland	0	0	0	1	1	N/A	0
44130	Parma/Cleveland	0	0	0	0	1	N/A	0
44103	Cleveland	1	1	1	0	0	(100%)	1
44115	Cleveland	2	0	1	0	0	(100%)	1
44109	Cleveland/Brooklyn Hts	2	1	1	3	0	(100%)	1
44105	Cleveland/Newburgh Hts/Garfield Hts	3	1	1	0	0	(100%)	1
44118	ClevelandHts/UniversityHts/ShakerHts	2	0	1	0	0	(100%)	1
44112	East Cleveland/Cleveland	3	0	0	1	0	(100%)	1
44137	Maple Hts/Cleveland	2	0	0	0	0	(100%)	0
44116	Rocky River	2	0	1	0	0	(100%)	1
44136	Strongsville	1	0	0	0	0	(100%)	0
44128	Warrensville Hts/Cleveland	1	0	1	0	0	(100%)	0
44102	Cleveland/Brooklyn	2	0	0	3	1	(50%)	1
	****Total Cuyahoga County**	**29**	**14**	**15**	**18**	**24**	**(17%)**	**20**
	****Total Cleveland**	**13**	**7**	**5**	**13**	**12**	**(8%)**	**10**
	****Total Suburbs**	**16**	**7**	**10**	**5**	**12**	**(25%)**	**10**

* Extremely high percentages are due to low numbers.

** These totals do not reflect the sum of the numbers above which are the zip codes reflecting the greatest increase or decrease. Rather, they are the total of calls from ALL zip codes many of which do not appear on this table.

Attachment 8: United Way - First Call for Help 2000-2004: Unmet Need

RM-700.150 Children's/Adolescent Residential Treatment Facilities Facility					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			**%**
		Requests	**Met**	**Unmet**	**Unmet**
44104	Cleveland	2	1	1	50%
	*** Total Cuyahoga County**	**100**	**99**	**1**	**1%**
	*** Total Cleveland**	**50**	**49**	**1**	**2%**
	*** Total Suburbs**	**50**	**50**	**0**	**0%**

FCFH DATA NOTES

Met = service request resulting in referral to an organization. (Does not mean agency was able to provide the service.)

Unmet = service request for which there was no referral.

Note: Zip Codes shared by Cleveland and surrounding suburbs whose boundaries fall 50% and greater within the city of Cleveland are highlighted and totaled as Cleveland. Others are totaled as Suburbs.

* These totals do not reflect the sum of the numbers above which are the zip codes reflecting unmet need in 2004. Rather, they are the total of calls from ALL zip codes some of which do not appear on this table.

United Way of
Greater Cleveland

1331 Euclid Avenue

Cleveland, Ohio 44115

uws.org/CoreServicesPlanning