Core Service Report

General Counseling Services
(Outpatient Mental Health Facilities)

Consumer Category:
Behavioral Health Conditions

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

February 2007

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COMPANION REPORTS

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

ACKNOWLEDGEMENTS

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

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This report reflects the comments from reviewers and United Way Community Investment Committee cluster volunteers.

Suggested Citation: MCS Consulting Service. (2007). Core service report: General counseling services (Outpatient mental health facilities). United Way of Greater Cleveland. Available at http://uws.org

SNAPSHOT

AIRS Code Level I: R – Mental Health Care & Counseling
AIRS Code Level II: RP – Outpatient Mental Health Facilities
Core Service: General Counseling Services RP-450.265 and Outpatient Mental Health Facilities RM-650

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

AIRS Definition (General Counseling): Programs that provide emotional support, information, and guidance to help people resolve whatever personal or interpersonal difficulties they are experiencing. The counselor can address any issue that is troubling the individual, but does not specialize in the treatment of any particular problem area.

AIRS Definition (Outpatient Mental Health Facilities): Programs that provide walk-in, walk-out diagnostic and treatment services for children, adolescents and/or adults with acute or chronic psychiatric disorders but do not need twenty-four hour care; and/or counseling services for individuals, couples, families and extended family groups who may be experiencing difficulty resolving personal or interpersonal conflicts or making personal adjustments to stressful life situations such as separation, divorce, widowhood, loss of a child, poor health, unemployment, family violence, delinquency, or substance abuse.

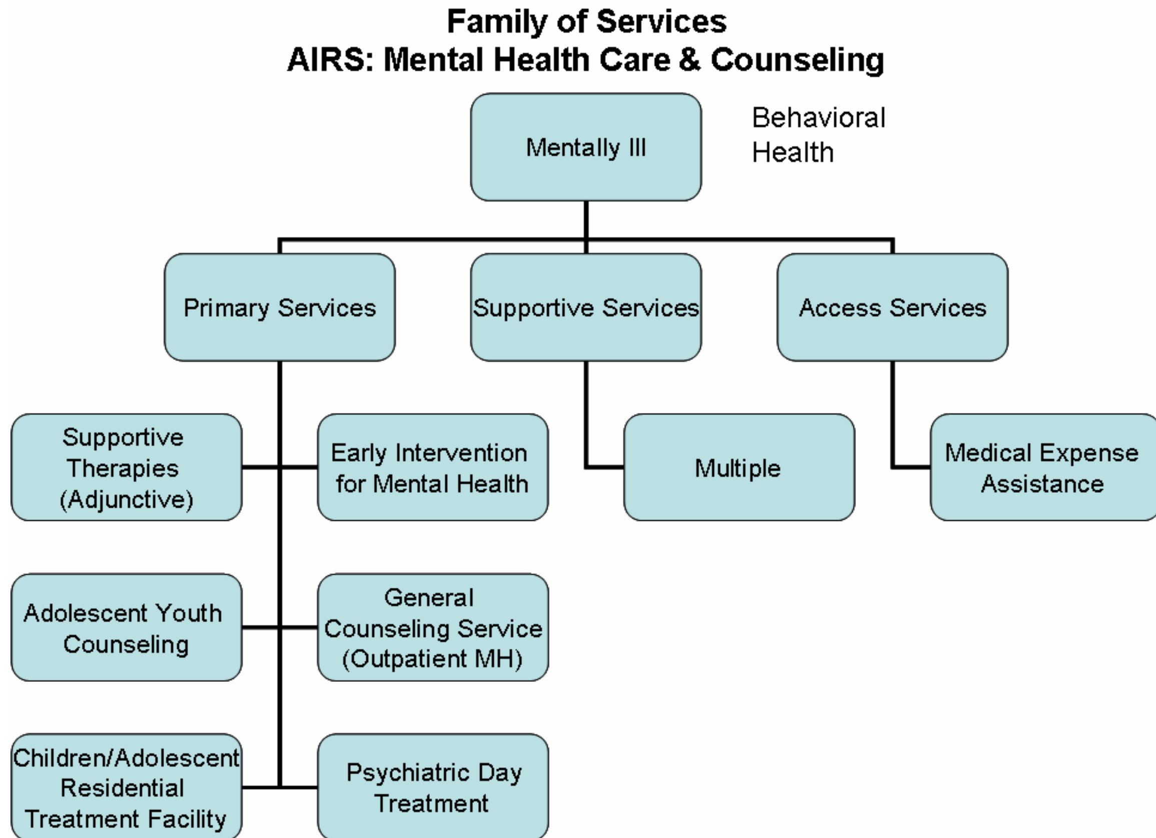
NOTE: Because of the overlap between the general counseling and outpatient mental health facilities core service areas, these two services have been combined into one report.

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

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

General Counseling Services (Outpatient Mental Health Facilities) 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

Counseling is a valuable component of treatment for people with serious mental illnesses, and it is often the mainstay of treatment for common, comparatively mild disturbances. Most counseling occurs in outpatient settings, where service delivery is generally least labor-intensive for providers and least expensive for payers. There are a number of community-based treatments that fit into this middle portion of the spectrum of treatment intensity. During the past two decades, many of the research and development efforts in the mental health field have focused on designing and evaluating community-based interventions that take place in homes, schools, and neighborhoods rather than in office settings.

The Community Mental Health Services Block Grant Program is a major funding policy that affects all persons involved with the publicly supported mental health system. 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 adults ages 18+ years with moderate to severe mental illness who do not need twenty-four hour care.

Mental health problems are common in the general population. According to a recent large-scale study, 51 percent of the American population will experience some type of disturbance at some point in their lives (Kessler et al., 2005). At any given time, approximately 10 percent of American adults experience a diagnosable disorder and, in the course of a year, about 20-25 percent of adults have a disturbance (New Freedom Commission on Mental Health, 2003). About 5 percent of the adult population suffers from a serious mental illness (e.g., schizophrenia, major depression) that substantially impairs their ability to function in basic life areas such as employment, self-care, and interpersonal relationships (U. S. Public Health Service, 2000).

Anxiety disorders comprise the most common category of mental health problems in adults, with a lifetime prevalence rate of 29 percent (Kessler et al., 2005) and incidence rates estimated at 10-13 percent of the population in a given year (National Institute of Mental Health, 2001).

In 2000, approximately 161,402 individuals 18 and older in Cuyahoga County were estimated to be living with mental illness, or 15.4 percent of the 18 and older population. This number is projected to decrease to 156,893 by 2015 because of population shifts.

Core Service Delivery

The definition of the core service for this report is: programs that provide mental health services to adults (18+) in outpatient settings.

General counseling services (outpatient mental health facilities) programs are provided by many different types of providers including community mental health agencies, social service agencies, religious institutions, schools, and private practitioners. Programs also have a multitude of staffing, collaboration, dispatching, and reimbursement/payment structures. Most counseling occurs in outpatient settings where service delivery is generally least labor-intensive for providers and least expensive for payers. Many general counseling services (outpatient mental health facilities)

program providers recognize the need to provide affordable, accessible services that will effectively address the consumers' immediate issues and concerns.

Typical mental health problems addressed by general counseling services include generalized anxiety, phobia, post-traumatic stress, panic and obsessive-compulsive disorders, depression, and impulse-control disorders (e.g., aggression, antisocial behavior, gambling).

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 48 general counseling services (outpatient mental health facilities) program providers operating from 92 different sites, 5 of which are government and 42 are nonprofit. In FY 2004 (July 2003 to June 2004), United Way funded six providers. FCFH call data shows an increase in the number of total requests for general counseling services (outpatient mental health facilities) programs in the county: from 801 in 2000 to 830 in 2004 (4 percent increase). Over the same five-year period, FCFH had 4,624 requests for information about general counseling services (outpatient mental health facilities). Of these requests, they were able to make referrals to 98 percent of callers.

The major sources of government funding for general counseling services (outpatient mental health facilities) are the Community Development Block Grant, the Community Mental Health Services Block Grant Program, the Cuyahoga County Health and Human Services Levies, Medicaid, Medicare, Ryan White Title I, the Social Services Block Grant, the state general revenue fund, and Temporary Assistance to Needy Families

Medicaid has traditionally paid for counseling services for people with low incomes. Recent (and possible future) changes in Medicaid policy may result in reduced reimbursement rates and tightened eligibility requirements, with single adults most likely to be disproportionately affected. Private insurance plans sometimes limit the number of counseling sessions they will pay for, although clear statements from providers that additional services are medically necessary usually produce cooperation from insurance companies. The problem of paying for services is most acute for people with incomes that put them between Medicaid eligibility and private insurance affordability; the working poor frequently lack insurance coverage of any kind.

Between calendar years 2002 and 2004, funding for general counseling (outpatient mental health facilities) decreased in Cuyahoga County: from $6.1 million in 2002 to $4.7 million in 2004. This funding supports persons ages 18 and older.

Medicaid funding for community mental health services increased from $57.6 million in 2002 to $67.8 million in 2004. However, it includes all mental health services, not just those for adults receiving general counseling (outpatient mental health facilities).

As of May 11, 2006, over $8.9 million in revenues for general counseling (outpatient mental health facilities) has been identified countywide. Thirty-one percent of the revenues come from federated fundraising organizations. Six percent of the revenues are from contracts or grants from government organizations. United Way designations and Investment Committee allocations accounted for nearly 54 percent of the total.

On average, general counseling (outpatient mental health facilities) services cost between $90 and $130 per hour. The government typically reimburses anywhere between $0 and $90 for these services. More specifically, Medicaid reimburses initial diagnostic assessment sessions at a $130 rate, and therapy appointments receive $90 of reimbursement. Private health insurance reimburses mental health services at a lower rate, generally in the $60-80 range for therapy sessions.

Psychiatric services have a higher hourly cost, but generally involve fewer hours of service. The generally increasing costs of medication have significantly increased costs for the mental health system.

What Works; What Doesn't

Several general themes have emerged from outcome research on counseling. Overall, counseling seems to be a moderately effective intervention for most mental health problems, producing full resolution of symptoms in approximately one third of clients and substantial improvement in another one third. Follow-up studies indicate that the benefits of counseling usually last for at least several years. Most consumers of these services express a high level of satisfaction with their counseling. The quality of the counselor-client relationship is a strong predictor of treatment outcome.

For adult clients, the outcome literature generally indicates that there is more support for cognitive-behavioral counseling than for any other approach, and this type of therapy has demonstrated positive results with a variety of anxiety, depressive, and behavior disturbances. For adults with serious mental illnesses, research supports interventions based on the recovery model and case management services.

Mental health disturbances involve a high financial cost to individuals and society. Direct expenditures on treatment cost $71 billion per year, and the indirect costs, which consist mostly of lost productivity, are estimated at $79 billion (Coffey et al., 2000, in New Freedom Commission on Mental Health, 2003).

Most non-medical mental health services are provided by members of three professions: psychology, social work, and counseling. Each are licensed by their own profession. In addition, there are small numbers of licensed psychiatrists, marriage and family therapists, registered nurses, music therapists, art therapists, and pastoral counselors who provide psychotherapy to clients.

Gap Analysis

The estimated universe of possible consumers is 60,296, including both realized (12,530) and unrealized (47,766) 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

Most counseling occurs in outpatient settings, where service delivery is generally least labor-intensive for providers and least expensive for payers. However, outpatient therapy frequently cannot adequately meet the needs of people whose mental health problems are of moderate to high severity. Many of these individuals need more intensive services, but they usually do not require interventions as restrictive and expensive as residential placement or inpatient hospitalization. There are a number of community-based treatments that fit into this middle portion of the spectrum of treatment intensity. During the past two decades, many of the research and development efforts in the mental health field have focused on designing and evaluating community-based interventions that take place in homes, schools, and neighborhoods rather than in office settings.

Mental health problems occur in a significant proportion of the U.S. population. At any given time, approximately 10 percent of American adults experience a diagnosable disorder. In the course of a year, about 20-25 percent of adults have a disturbance. Estimates of the proportion of people who experience a disorder in the course of their lifetime range from one third to one half.

While some disturbances involve serious mental illnesses requiring intensive intervention, a substantial majority of mental health problems consist of anxiety, depressive disorders and conduct problems that can usually be treated with some type of counseling and, perhaps, psychotropic medications administered on an outpatient basis. Counseling may be a valuable component of treatment for people with serious mental illnesses, and it is often the mainstay of treatment for common, comparatively mild disturbances.

Weisz (2004) defined psychotherapy as “an array of non-medical interventions designed to relieve psychological distress, reduce maladaptive behavior, or enhance adaptive functioning through counseling, structured or unstructured interactions, training programs, or specific environmental changes.” In essence, counseling strives to help people with mental health problems by talking to them; this special type of talk purports to facilitate the expression of emotions, engender personal insight, change maladaptive attitudes, impart hope, raise self-esteem, and/or teach psychosocial skills.

PUBLIC POLICY ISSUES

NATIONAL

Federal Laws and Regulations

Community Mental Health Services Block Grant Program

The Community Mental Health Services Block Grant Program is a major source of funding for local mental health boards. The program distributes funds to states to move care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED) away from costly, restrictive inpatient hospital care and into the community. Ninety-five percent of the funds allocated to the block grant program are distributed to states through a formula prescribed by the authorizing legislation. States are required to use the funds to carry out the annual plan submitted with the

block grant application. Factors used to calculate the allotments include total personal income; state population data by age groups; total taxable resources; and a cost of services index factor. Funds reached 972 sub-grantees in FY 2002. (Substance Abuse and Mental Health Service Administration, n.d.)

Insurance Parity

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

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

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

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

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

STATE

Ohio Regulations

Insurance Parity

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

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

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

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

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

Medicaid

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

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

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

$140 million to $60 million. These changes will have serious impact on Medicaid beneficiaries. (Hayes, 2005)

Medicaid and Family Opportunity Act

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

- can create a new *optional* Medicaid eligibility group for children with disabilities under age 19:
  a) who meet the severity of disability required under SSI without regard to any asset or eligibility requirements under SSI for children, and
  b) whose family income does not exceed 300 percent of the federal poverty level (approximately $58,500 for a family of four).

- can require cost-sharing (premiums and co-pays) on a sliding scale based on income, but cannot exceed five percent of family income up to 200 percent of the federal poverty level, and 7.5 percent of family income from 200-300 percent of federal poverty. The state may waive payment of a premium in any case where the state determines that requiring a payment would create an undue hardship. (Ohio Legal Rights Services, 2006)

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

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

Mental Health Act of 1988

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

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

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

- In FY 1988, the number of admissions and discharges to state hospitals were virtually the same as in FY 1960.

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

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

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

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

Mental Health Transformation State Incentive Grant

According to the Ohio Department of Mental Health (n.d.), the system for delivering services to Ohioans with mental illnesses and emotional disorders will be transformed. Ohio has been awarded $12 million by the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance system transformation planning. The Mental Health Transformation State Incentive Grant is part of the federal response to the president’s New Freedom Commission on Mental Health that President Bush charged to make recommendations for improving mental health care and overcoming the fragmentation of health and mental health care. The commission’s report, “Achieving the Promise: Transforming Mental Health Care in America,” was released in July 2003. As one of seven states receiving funding, Ohio will serve as a platform for learning which strategies and activities hold the most promise for transforming mental health and related systems.

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

mental illness and emotional disorders live in all communities and are in many human services settings, this focus on behavioral health issues and collaboration across settings is essential, both to improve outcomes of these systems and to better meet the needs of mentally ill people wherever they are.

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

The target population addressed in this core service report is adults ages 18+ years with moderate to severe mental illness who do not need twenty-four hour care.

DEMOGRAPHIC CHARACTERISTICS

National and International

Mental health problems are common in the general population. According to a recent large-scale study, 51 percent of the American population will experience some type of disturbance at some point in their lives (Kessler, Berglund, Deemler, Jin, Merikangas & Walters, 2005). At any given time, approximately 10 percent of American adults experience a diagnosable disorder and, in the course of a year, about 20-25 percent of adults have a disturbance (New Freedom Commission on Mental Health, 2003). About 5 percent of the adult population suffers from a serious mental illness (e.g., schizophrenia, major depression) that substantially impairs their ability to function in basic life areas such as employment, self-care, and interpersonal relationships (U. S. Public Health Service, 2000).

Anxiety disorders comprise the most common category of mental health problems in adults, with a lifetime prevalence rate of 29 percent (Kessler et al., 2005) and incidence rates estimated at 10-13 percent of the population in a given year (National Institute of Mental Health, 2001). This category includes generalized anxiety, phobia, post-traumatic stress, and panic and obsessive-compulsive disorders. Depressive disorders, including major depression and dysthymic disorder, are only slightly less common, with a lifetime prevalence rate of 21 percent (Kessler et al., 2005) and with about 10 percent of the population exhibiting this disturbance each year. Kessler et al. also estimated that, at some point in their lives, 15 percent of the population will experience a substance use disorder, and 25 percent will experience an impulse-control disorder, a category that includes problems related to aggression, antisocial behavior, gambling, and so forth.

In North America and Western Europe, mental illnesses cause more disability than any other category of disease (World Health Organization, 2001). Mental disorders represent a serious public health challenge that is often under-recognized. Mental illness can cause death; in fact, suicide causes more deaths per year than either homicide or war (World Health Organization, 2002).

Cuyahoga County

A report by the Federation for Community Planning (now Center for Community Solutions) and the Cuyahoga Country Community Mental Health Board (2003) provided estimates of the numbers of adults with mental disorders in Cuyahoga County based on national prevalence data and county population figures. This calculation produced estimates of 116,657 adults 18-54 years old, and 44,745 older adults 55+ with mental health problems. Assuming that national prevalence rates apply locally, it is estimated that there are approximately 161,402 adults with mental illness in Cuyahoga County.

Table 1 below summarizes by type of disorder the estimated number of persons in Cuyahoga County in need of mental health services. Approximately 16 percent of adults 18-54 and 13 percent of adults 55 and older have mental health issues. The vast majority of these issues are related to anxiety and mood disorders. This is an average of 15.4 percent of the population 18 years and older.

Table 1: National Prevalence Rates and Estimated Number of Persons 18+ in Need in Cuyahoga County, 2003

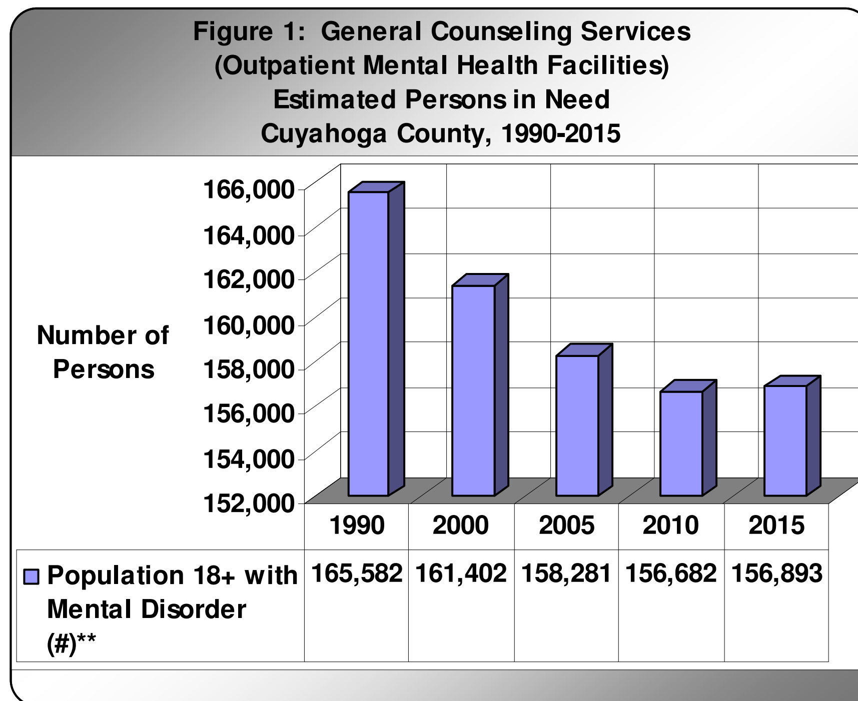
Population by Age	Total Population	Estimated Total with Disorder	% of Total
Total Population 18-54 years	**708,037**		
Any Disorder		**116,657**	**16.5%**
Anxiety Disorders		94,032	
Mood Disorders		40,300	
Schizophrenia		8,484	
Antisocial Personality Disorder		15,140	
Cognitive Impairment		1,414	
Total Population 55+ years	**338,562**		
Any Disorder		**44,745**	**13.2%**
Anxiety Disorders		35,932	
Mood Disorders		11,525	
Schizophrenia		1,356	
Antisocial Personality Disorder		-	
Cognitive Impairment		6,780	
Total Population 18+ years	**1,046,599**		
Any Disorder		**161,402**	**15.4%**
Anxiety Disorders		129,964	
Mood Disorders		51,825	
Schizophrenia		9,840	
Antisocial Personality Disorder		15,140	
Cognitive Impairment		8,194	

Source: Cuyahoga County Mental Health Assessment, December 2003

In relation to mental health, the majority of the participants in the United Way (UW) of Greater Cleveland's core service planning focus groups and key informant interviews reported an impression that their respective client groups have become more disturbed in recent years (2005). They speculated that this change may be partly due to increasingly stringent criteria for inpatient hospital admission, which necessarily results in more disturbed individuals requiring treatment on an outpatient basis. However, the respondents also seemed to believe that, in addition to this change in institutional operation, there has been some intensification of mental health problems among people in Cuyahoga County. For example, they reported increases in dual diagnosis clients (with both mental health and substance abuse problems), co-morbid mental health diagnoses, and people with problems related to educational deficits and unemployment problems.

Estimated Persons in Need

Based on the study discussed above, in 2000, approximately 161,402 individuals 18 and older in Cuyahoga County were estimated to be living with mental illness, or 15.4 percent of the 18 and older population. This number is projected to decrease to 156,893 by 2015 because of population shifts. (See Figure 1.)



Sources:
* U.S. Census 1990, STF 1 (P11); 2000, SF3 (P8); 2005-2015, Ohio Department of Development, (July, 2003).
** "Cuyahoga County Mental Health Assessment," Center for Community Services, December 2003. Rate of persons with mental health disorders 18-54, 16.5 percent, 55+, 13.2 percent. Overall: 15.4 percent which was applied to other periods.

This estimate of persons in need of general counseling (outpatient mental health facilities) is a number that begins to offer some clarity about the extent of need in Cuyahoga County.

REALIZED ACCESS TO SERVICE

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

In FY 2004, United Way funded approximately 9,901 consumers for general counseling (outpatient mental health facilities) programs. The Western Reserve Area Agency on Aging (WRAAA) identified 119 actual annual consumers, and Ryan White Title I, 51. The Cuyahoga County Community Mental Health Board reported serving 12,530 for general counseling/outpatient mental health services in 2004. (See Attachment 3.)

Consumers funded by United Way were primarily females (67 percent) as were those served by WRAAA (59 percent). Ryan White consumers served were predominately male (72.5 percent).

Consumers funded by United Way were 36 percent Caucasian, 35 percent African American, and 5 percent Asian. Ninety-four percent of WRAAA consumers were Caucasians, 5 percent African Americans, and 1 percent Asians. Thirty-seven percent of Ryan White consumers wither Caucasian and 49 percent African American.

Four percent of United Way funded consumers were Hispanics, Ryan White, 12 percent, and WRAAA less than 1 percent.

Thirty-one percent of those funded by United Way reported annual household income below $10,000 and another 9 percent reported household income between $10-14,999. Approximately 48 percent of the household incomes of those served were unknown.

Only services funded by United Way included zip code data. Forty-seven percent resided in Cleveland and 48 percent in the suburbs. The rest were unknown. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of the core service for this report is: programs that provide mental health services to adults (18+) in outpatient settings.

BACKGROUND ON CORE SERVICE

General counseling services (outpatient mental health facilities) are provided by many different types of providers including community mental health agencies, social service agencies, religious institutions, schools, and private practitioners. Programs also have a multitude of staffing, collaboration, dispatching, and reimbursement/payment structures. Most counseling occurs in outpatient settings where service delivery is generally least labor-intensive for providers and least expensive for payers. Current research and development efforts in the mental health field have focused on designing and evaluating community-based interventions that take place in homes, schools, and neighborhoods rather than in office settings.

Many general counseling (outpatient mental health facilities) providers recognize the need to provide affordable, accessible services that will effectively address the consumers' immediate issues and concerns. Typical mental health problems addressed by general counseling services include generalized anxiety, phobia, post-traumatic stress, panic and obsessive-compulsive disorders, depression, and impulse-control disorders (e.g., aggression, antisocial behavior, gambling).

Funding is sometimes restricted by the type of disorder and the limitations Medicaid puts on reimbursement. For example, some providers are only reimbursed for assessments and a certain number of sessions and may not receive reimbursement for adjunctive therapies or for clients needing longer interventions.

A survey was conducted with attendees at Ohio's NAMI (National Alliance on Mental Illness) conference and a pre-NAMI conference day to obtain the perspectives of consumers and family members in the needs assessment and resource inventory for Ohio's Transformation State Incentive Grant (TSIG). The following are the results taken directly from the executive summary of the survey report (Ohio Department of Mental Health, 2006).

Goal 1: Americans understand that mental health is essential to overall health.

- Consumers and family members indicated a need for public education about mental illness in order to overcome stigma. Approximately three-quarters of consumers (71.0 percent) and family members (75.9 percent) indicated that they had experienced stigma related to mental illness.
- Consumers and family members indicated a lack of integration between services for their physical health and mental health and that treatment needs to shift from a medical model toward a more holistic approach.
- Close to 60 percent (59.8 percent) of consumers agreed that their family doctor asked about their mental health.

Goal 2: Mental health care is consumer and family driven.

- Respect for consumers is paramount for increasing consumer involvement. Sixty-five percent of consumers indicated that they had been treated with dignity and respect at the mental health agency.
- Consumers indicated a need for more choices, more coordination of services and more service providers. Specifically, they indicated more family and consumer input in planning, more peer-run services, better coordination of related services such as vocational and housing assistance, more case managers, and decreased waiting time to see psychiatrists.
- Fifty percent of consumers agreed that their needs had driven treatment planning.
- Forty-seven percent of consumers agreed that their input was used in treatment planning.
- Twenty-six percent of consumers agreed that agency staff spoke with them about their responses on the outcomes survey.
- Consumers and family members indicated a need for a recovery focus in the mental health system and that current providers need training in recovery.
- Sixty-six percent of consumers and 52.5 percent of family members believe that staff at the mental health agency believes in consumer recovery.

Goal 3: Disparities in mental health services are eliminated.

- Consumers and family members indicated the need for empathy with, and understanding of, different needs of persons with mental illness across their life-span.
- Cultural competence includes not only a person's ethnic culture, but also disabilities such as sight or hearing impairments.
- Forty percent of consumers indicated that their culture was taken into account in treatment planning
- Fifteen percent of consumers specifically indicated trouble receiving services that fit with their culture
- There is a need for services for persons living in rural areas and a need for funding parity across counties. Rural areas face particular barriers to getting services due to public transportation issues.
- Twenty-four percent of consumers indicated trouble getting services near their home.

Goal 4: Early mental health screening, assessment, and referral to services are common practice.

- Consumers and family members identified needs for appropriate mental health services for children and within schools, screening on trauma-related illness, integrated treatment programs for mental health and substance abuse, and screening for mental health in primary health care settings and across the lifespan.

Goal 5: Excellent mental health care is delivered and research is accelerated.

- There is a need to receive a higher quality of services and a need for quality indicators to drive system improvement.
  - Fifty-nine percent of consumers agreed that they received high quality services; thirty-four percent of family members indicated receiving high quality services at the mental health agency.

- Consumers and family members indicated a need for increased information dissemination and training on available evidence-based practices, and training on trauma-based mental health treatment. They also indicated a need for funding to support implementing evidence-based practices.

Goal 6: Technology is used to access mental health care and information.

- There is a need for integrated information systems that share client information and treatment histories across agencies to ultimately facilitate better care.

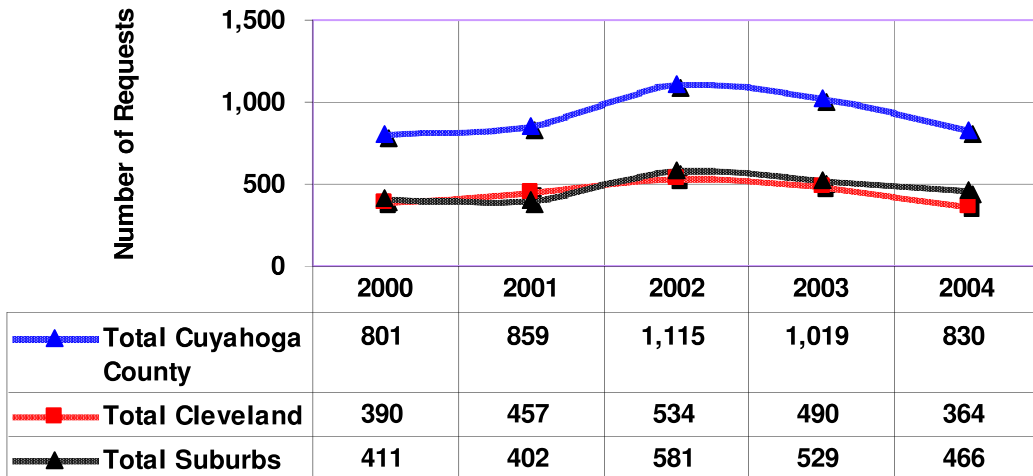
United Way – First Call for Help Call Data

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 48 general counseling (outpatient mental health facilities) program providers operating from 92 different sites, 5 of which are government and 42 are nonprofit. In FY 2004 (July 2003 to June 2004), United Way funded six providers. (See Attachments 5 and 6.) United Way does not specifically track calls for outpatient mental health facilities.

United Way - First Call for Help call data shows an increase in the number of total requests for general counseling (outpatient mental health facilities) in the county: from 801 in 2000 to 830 in 2004 (4 percent increase) with a 7 percent decrease in Cleveland (390 to 364 requests) and a 13 percent increase in the suburbs (411 to 466 requests). On average, the number of calls each year totaled 925 for the entire county, with an almost equal split between the suburbs and the city. (See Figure 2.) Calls came from the majority of Cuyahoga County zip codes with the following experiencing the highest average number of calls from 2000-2004:

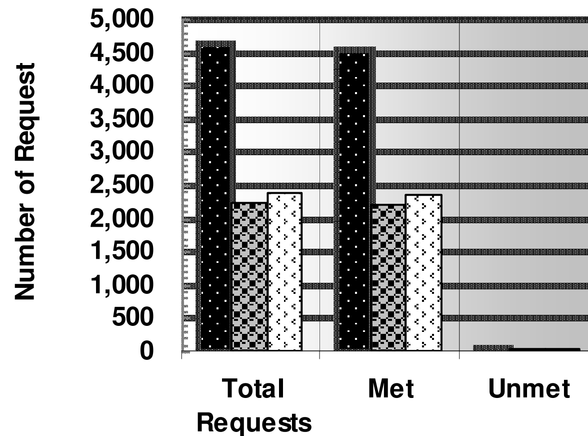
- 44102 (Cleveland/Brooklyn) -69 calls;
- 44109 (Cleveland/Brooklyn Hts) -49 calls;
- 44107 (Lakewood/Cleveland) -45 calls;
- 44120 (Shaker Hts/Cleveland) -43 calls;
- 44108 (Cleveland/Bratenahl) -39 calls;
- 44112 (East Cleveland/Cleveland) -39 calls; and
- 44111 (Cleveland) -35 calls.

No other zip code had greater than an average of 29 calls for the five-year period. (See Attachment 7.)



	2000	2001	2002	2003	2004
Total Cuyahoga County	801	859	1,115	1,019	830
Total Cleveland	390	457	534	490	364
Total Suburbs	411	402	581	529	466

Over the same five-year period, United Way - First Call for Help had 4,624 requests for information about general counseling (outpatient mental health facilities). Of these requests, they were able to make referrals to 98 percent of callers; however, 2 percent of all Cuyahoga County callers (70) had an unmet need, meaning there was no agency to which to refer the caller. Callers from the City of Cleveland had a 1 percent unmet need rate and from the suburbs, 2 percent. The largest unmet needs came from 44107 (Lakewood/Cleveland) with 8 unmet calls and 44109 (Cleveland/Brooklyn Hts) with 7 unmet calls. No other zip code experienced greater than an average of 4 unmet calls for the five-year period. (See Figure 3 and Attachment 8.)



FUNDING OF CORE SERVICES

Major Government Funders

The major sources of government funding for general counseling (outpatient mental health facilities) services are:

- Community Development Block Grant (CDBG) – City of Cleveland:
- Community Mental Health Services Block Grant Program (CMHSBG);
- Medicaid;
- Medicare;
- Ryan White Care Act – Title I;
- Social Services Block Grant (SSBG);
- Temporary Assistance to Needy Families (TANF);
- Ohio General Revenue Fund; and
- Cuyahoga County Health and Human Services Levies.

Below is further explanation of major funders of general counseling (outpatient mental health facilities) services.

NATIONAL

Community Development Block Grant (CDBG) –City of Cleveland

Community Development Block Grant funds are intended to develop viable urban communities by providing decent housing and a suitable living environment, and by expanding economic opportunities, principally for low- and moderate-income persons. The U.S. Department of Housing

and Urban Development (HUD) determines the amount of federal funds that cities and counties are entitled to each year through a formula based upon population, growth lag, poverty level, age of housing, and overcrowding. CDBG provides federal funding for locally initiated neighborhood improvement projects. Cleveland City Council makes funding decisions. City of Cleveland CDBG funding has been trending downward from $31.2 million in 2002 to $24.6 million in 2006. For years 2002 through 2005, $85,650 was allocated annually from the City of Cleveland's CDBG to general counseling (outpatient mental health facilities) programs.

Community Mental Health Services Block Grant (CMHSBG)
The Community Mental Health Services Block Grant (CMHSBG) is authorized by Part B of Title XIX of the Public Health Service Act and is the single largest federal contribution dedicated to improving mental health service systems across the country. The Substance Abuse Mental Health Services Administration's Center for Mental Health Services administers the awards to states, and the Ohio Department of Mental Health (ODMH) administers the grant at the state level. CMHSBG is a formula grant that is based on states' economic and demographic factors. The block grant is intended to provide mental health services to adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) and is a flexible source of funding. The CMHS requires that states develop a comprehensive public mental health system that emphasizes a community-based system of mental health services delivery. States and territories may expend block grant funds only to carry out their annual plan, to evaluate programs and service carried out under the plan, and for planning, administration, and educational activities related to providing services.

ODMH's estimated block grant award for FFY 2007 is $14,278,769, which is a slight decrease from each of the two previous years. The final block grant award for FFY 2006, after two SAMHSA modifications, was $14,333,753, and the award for FFY 2005 was $14,543,753. In a publication outlining their policy for awarding grants from the CMHSBG, ODMH noted that the decrease in funding has not affected direct services for consumer and family organizations.

> As Ohio's Block Grant allocation has dropped slowly and steadily due to population size relative to other states; Ohio addressed these reductions by prioritizing funding for CCOEs, Networks and ending demonstration projects on their planned ending dates. Funding was not reduced for direct services and operating expenses for statewide consumer and family organizations. While most Block Grant funding is for continuing activities, some of the funding is typically used for demonstration and development projects; the expectation is that those projects will evolve into operational entities or have completed their original purpose in keeping with their stated program goals. This funding approach allows continuation funds to be used to begin new innovative projects. With state budget constraints, local systems of care are continuing to find it difficult to self-fund. (Ohio Department of Mental Health, n.d.)

The amount for Cuyahoga County was requested from the Ohio Department of Mental Health, but was not available at the time this report was published.

Medicaid
Mental health services for people with low incomes have traditionally been paid for by Medicaid. Recent changes in Medicaid policy may result in reduced reimbursement rates and tightened eligibility requirements, with single adults most likely to be disproportionately affected.

Medicare
For adults who qualify for Medicare benefits, the Medicare program will finance mental health services as long as the treatment does not consist entirely of activity therapies that are not covered—these activities are typically recreational or diversional.

Ryan White CARE Act – Title I
Authorized under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and administered by the Department of Health and Human Services Health Resources and Services Administration, Ryan White Title I funds provide emergency assistance to eligible metropolitan areas (EMAs) that are most severely affected by the HIV/AIDS epidemic. Formula grants are based on the number of living cases of AIDS, and discretionary grants are available. To be eligible, an area must have reported at least 2,000 AIDS cases during the previous five years and have a population of at least 500,000. Ryan White Title I funds can be used for many different kinds of outpatient and ambulatory health services, including mental health and substance abuse. Local Title I HIV health services planning councils make allocation decisions. In FY 2006 $301 million was allocated nationally from Title I. In 2006, Cleveland received $3.349 million: $1.793 million in formula grants and $1.314 in supplemental funding, with another $214,208 for Minority AIDS Initiative funding.

Social Services Block Grant (SSBG)
Title XX of the Social Security Acts is the Social Services Block Grant (SSBG) program. A formula grant made to states based on state population relative to total U.S. population, SSBG has no matching funds requirement and is an extremely flexible source of funding for a broad range of social services, including psychiatric day treatment. Funded services can be provided through governmental agencies or through grants or contracts with private organizations. Appropriations from the SSBG were $1.7 billion in 2006; they have remained unchanged since FY 2002 but are down significantly from the 1990s, when they were $2.8 billion. The current administration has proposed a $500 million cut to the program. Cuyahoga County received a total of $27 million from SFY 2005-2007 from the SSBG. In Ohio, the Ohio Department of Mental Health is responsible for the administration of a portion of the Title XX resources available, and allocates these funds to county mental health boards. Total SSBG funds for mental health that are available to all counties is $8,675,275. The Cuyahoga County Community Mental Health Board is estimated to receive $1,169,470 for 2006 and 2007.

Temporary Assistance to Needy Families (TANF)
Created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, TANF is administered at the federal level by the Department of Health and Human Services. TANF ended individual federal entitlement to welfare and replaced it with block grants to states. TANF has four purposes:

1. Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives.
2. End needy parents' dependence on government benefits by promoting job preparation, work, and marriage.
3. Reduce the incidence of out-of-wedlock pregnancies and establish annual numeric goals for decreased incidence of these pregnancies.

4. Encourage the formation and maintenance of two parent families.

States have the broad flexibility to decide how TANF funds will be spent to meet these goals. Ohio does use its TANF grant to fund mental health services, defined as "family preservation/reunification services," through its Prevention, Retention, and Contingency program (PRC). PRC is a state-supervised, county-administered program. PRC provides ongoing services and nonrecurring short-term benefits designed to accomplish one of TANF's four purposes by addressing supports needed by working families and by addressing the needs of families with barriers to self-sufficiency. The goal is always to provide the appropriate mix of cash and non-cash services that will enable the family to achieve self-sufficiency. In Cuyahoga County, mental health services can be funded under PRC grants. Individuals served must be below 200 percent of poverty level. There is no cap on services, but services can be provided up to a four month period within a year (Cuyahoga County, 2006). Each year since 1999, the state of Ohio receives $728 million in TANF funds. Ohio spent $19.3 million, or 9.8 percent, of TANF funds on family preservation/support services (ODJFS, 2005). Funding specific to Cuyahoga County for amount spent on outpatient mental health facilities was not available at the time this report was written.

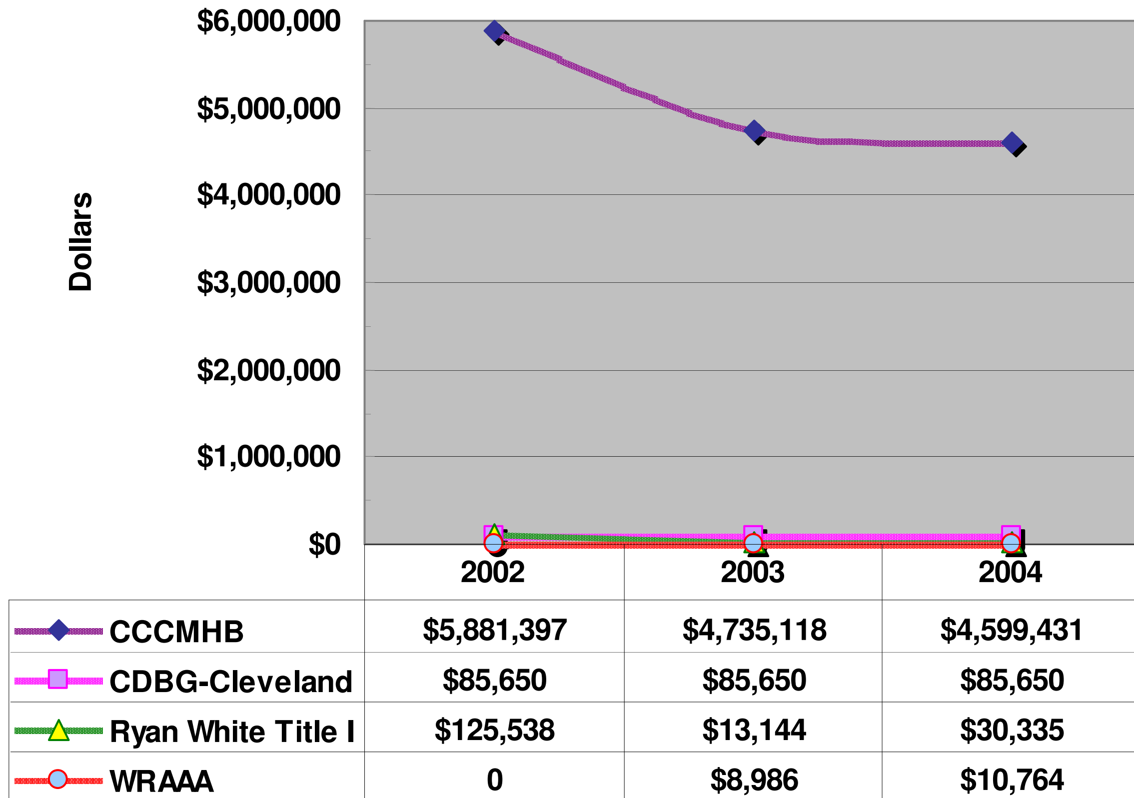
STATE

Ohio General Revenue Fund
The Ohio General Revenue Fund (GRF) is a source of funding to local boards of mental health. There are several different line items in the Ohio Budget for mental health boards. In Cuyahoga County in 2007, the Cuyahoga County Community Mental Health Board received $29.5 million in GRF funds from line item 408 – State and Community Mental Health Services, and $1.4 million from line item 505 Local Mental Health Systems of Care (Ohio Department of Mental Health, 2006). Specific amounts going to general counseling (outpatient mental health facilities) services were from GRF were not available.

LOCAL

Cuyahoga County Health and Human Services Levies
There are currently two Cuyahoga County Health and Human Services (HHS) levies—one at 2.9 mils set to expire in 2011 (as passed in November 2006 as Issue 19), and the other at 4.9 mils set to expire in 2008. The levies provide a flexible source of funds for the county, and the Department of Children and Family Services receives funds from them. The amount of money generated through these levies has been increasing: in 2002 $119.3 million was available; in 2006, $168.4 million is expected to be available. The replacement levy of November 2006 will generate an additional $27.3 million annually. Specific amounts of HHS levies funds going to general counseling (outpatient mental health facilities) services were not available.

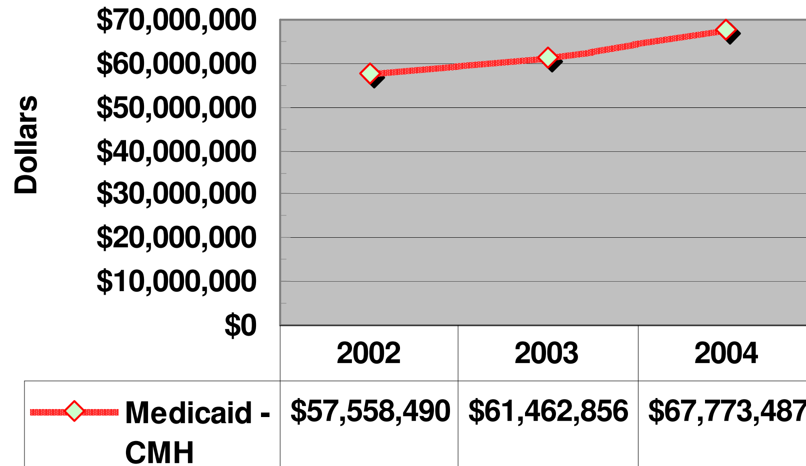
Trends of Identified Government Funders in Cuyahoga County
Between calendar years 2002 and 2004, funding for general counseling (outpatient mental health facilities) decreased in Cuyahoga County: from $6.1 million in 2002 to $4.7 million in 2004. This funding supports persons ages 18 and older. (See Figure 4.)



	2002	2003	2004
CCCMHB	$5,881,397	$4,735,118	$4,599,431
CDBG-Cleveland	$85,650	$85,650	$85,650
Ryan White Title I	$125,538	$13,144	$30,335
WRAAA	0	$8,986	$10,764

Source: Cuyahoga County Community Mental Health Board, City of Cleveland CBDG, Ryan White Title I, and WRAAA

Medicaid funding for community mental health services has also increased from $57.6 million in 2002 to $67.8 million in 2004. However, it includes all mental health services, not just those for adults receiving general counseling (outpatient mental health facilities). (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 many low-income families rely on Medicaid to finance the cost of general counseling (outpatient mental health facilities) services, local area foundation support helps defray the cost of care. Over a three-year period, FY2002 to FY 2004, foundation support totaled over $615,000; however, much of this support came from a 2003 grant totaling over $243,000 from The Cleveland Foundation.

IDENTIFIED REVENUES

General Counseling Services

As of May 11, 2006, over $8.9 million in revenues for general counseling (outpatient mental health facilities) has been identified countywide. (See Table 2.) This includes information from foundations; federated fundraising organizations; regional, county and municipal government; and United Way of Greater Cleveland.

Fifty-three percent of the revenues are from contracts or grants from government organizations. Through designated gifts and Investment Committee allocations, United Way accounted for nearly 37 percent of identified revenues. The rest is from foundations and federated funding organizations.

Because Medicaid services cross over more than one core service, it was not possible to provide Medicaid dollars specific to general counseling (outpatient mental health facilities). It is important to note that Medicaid accounts for a significant portion of funding for this core service. (See Figure 5 and Table 2 footnote.)

Table 2: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland General Counseling Services (Outpatient Mental Health), 2003/2004. (Revenue Tables for General Counseling and Outpatient Mental Health have been merged.)

Funder	Period	A: Total Dollars Countywide		B: Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			**0.00%**	**206,319**	**1.11%**
Bruening Foundation, Eva L. and Joseph M.				37,102	
Cleveland Foundation, The		60,500		156,959	
Deaconess Community Foundation		25,000			
Gund Foundation, The George		15,000			
Mt. Sinai Health Care Foundation, The				19,456	
Reuter Foundation, The		15,000			
Sisters of Charity Foundation of Cleveland		40,000			
Woodruff Foundation, The		64,000		16,723	
Other Private Foundations - Not Elsewhere Classified		28,500		159,010	
Key Foundation		15,000		166,496	
National City Bank Foundation				18,225	
Total - Foundations & Trusts		**263,000**	**2.94%**	**573,971**	**3.08%**
Total - Special Events - Growth			**0.00%**	**465,049**	**2.50%**
Jewish Community Federation	2004	643,000		70,416	
United Black Fund of Greater Cleveland	2004	16,000		9,560	
Total - Federated Fundraising Organizations		**659,000**	**7.38%**	**79,976**	**0.43%**
Other Federal Funders - Not Elsewhere Classified				157,900	
Subtotal Federal Government		***0***	***0.00%***	***157,900***	***0.85%***
Children's Trust Fund				50,000	
Department of Job and Family Services				39,813	
Department of Mental Health				40,000	
Office of Criminal Justice Services				10,717	
PASSPORT				255	
State Department of Education				360,334	
Other State Funders - Not Elsewhere Classified				50,000	
Subtotal State of Ohio		***0***	***0.00%***	***551,119***	***2.96%***
Western Reserve Area Agency on Aging (WRAAA)	2004	10,764			
Subtotal Regional Funding Sources		***10,764***	***0.12%***	***0***	***0.00%***
Board of Mental Retardation and Developmental Disabilities (169 Board)				134,929	
Children Who Witness Violence				1,483	
Community Services Block Grant Program				10,674	
Cuyahoga County Community Mental Health (648 Board)	2004	4,599,431		8,248,763	
Department of Children and Family Services				48,623	
Employment & Family Services				6,700	
HIV Services Planning Council Ryan White Title I	2004	30,335			
Justice Affairs				29,009	
Subtotal Cuyahoga County Funding Sources		***4,629,766***	***51.84%***	***8,480,181***	***45.56%***
Other Lorain County Funders - Not Elsewhere Classified				51,025	
Subtotal Lorain County Funding Sources		***0***	***0.00%***	***51,025***	***0.27%***
Community Development Block Grant	2004	85,650		20,155	
Subtotal City of Cleveland Funding Sources		***85,650***	***0.96%***	***20,155***	***0.11%***
Medicaid *				2,752,252	
Medicare				151,761	
Other Private Insurer				83,054	
Subtotal Third Party Payee/Direct Bill		***0***	***0.00%***	***2,987,067***	***16.05%***
Other Board of Education				1,207,068	
All Other Funding - Not Elsewhere Classified				78,588	
Subtotal Other Govt Funding Sources		***0***	***0.00%***	***1,285,656***	***6.91%***
Total - Contracts/grants from government organizations		**4,726,180**	**52.92%**	**13,533,103**	**72.70%**
Private Pay/Fee for Service				233,521	
Total - Program Service Fees		**0**	**0.00%**	**233,521**	**1.25%**
Total - Investment Income			**0.00%**	**145,338**	**0.78%**
Total - All Other Revenue			**0.00%**	**59,266**	**0.32%**
Total - Prior Period balances/interfund transfers			**0.00%**	**35,828**	**0.19%**
Subtotal Non - UWGrCle Support		**5,648,180**	**63.24%**	**15,332,371**	**82.36%**
Total - UWGrCle designations applied to program		**185,520**	**2.08%**	**185,520**	**1.00%**
Total - UWGrCle investment committee allocation		**3,094,294**	**34.65%**	**3,094,294**	**16.62%**
John K. Mott Youth Fund Distribution Grant		3,000		3,000	
Total - Special UWGrCle grants applied to programs		**3,000**	**0.03%**	**3,000**	**0.02%**
Subtotal UUWGrCle Support - 4001, 4701 & 4703		**3,282,814**	**36.76%**	**3,282,814**	**17.64%**
Total Support/Revenue		**8,930,994**	**100%**	**18,615,185**	**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

The cost of delivering general counseling services (outpatient mental health facilities) is generally calculated by the hour. On average, general counseling services cost between $90 and $130 per hour. The government typically reimburses anywhere between $0 and $90 for these services.

More specifically, Medicaid reimburses initial diagnostic assessment sessions at a $130 rate, and therapy appointments receive $90 of reimbursement. Private health insurance reimburses mental health services at a lower rate, generally in the $60-80 range for therapy sessions. Psychiatric services have a higher hourly cost, but generally involve fewer hours of service. The generally increasing costs of medication have significantly increased costs for the mental health system.

Private insurance plans sometimes limit the number of counseling sessions they will pay for, although clear statements from providers that additional services are medically necessary usually produce cooperation from them. The problem of paying for services is most acute for people with incomes that put them between Medicaid eligibility and private insurance affordability; the working poor frequently lack insurance coverage of any kind. Counseling for these clients generally needs to be subsidized by the agency providing the service, and these resources, in turn, are typically provided by sources such as United Way and private individual donors.

Participants in the United Way of Greater Cleveland's core service planning focus groups and key informant interviews (2005) related to mental health reinforced the importance of government support, especially Medicaid, as a source of payment for mental health services. Private insurance plans received considerably less emphasis. Many participants cited the vital role of support from charitable organizations such as United Way. This type of support was said to be critical to meeting the needs of the working poor, who often have neither Medicaid nor private health insurance. Such donations were also cited as important for supporting the many activities that are beneficial to clients but are not billable because they do not meet the narrow, rigid definitions of medically necessary services.

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

During the past several decades, there has been an increasing emphasis on outcome research as a means of empirically evaluating the effectiveness of different types of counseling. Although the results of this research are complex, several general themes emerged. Overall, counseling seems to be a moderately effective intervention for most mental health problems, producing full resolution of symptoms in approximately one third of clients and substantial improvement in another third. Follow-up studies indicate that the benefits of counseling usually last for at least several years. Most consumers of these services express a high level of satisfaction with their counseling. The quality of the counselor-client relationship is a strong predictor of treatment outcome.

Although direct comparisons of different types of therapy frequently suggest similar levels of effectiveness, the outcome literature does provide varying amounts of support for different types of intervention. Generally, there is more support for cognitive-behavioral counseling than for any other approach, and this type of therapy has demonstrated positive results with a variety of anxiety, depressive, and behavior disturbances.

<u>Outcome Research: Cognitive-Behavioral Therapy</u>
Outcome research on psychotherapy for adults provides much more support for cognitive-behavioral therapy than for any other type of treatment. This conclusion is documented in the most recent edition of the *Handbook of Psychotherapy and Behavior Change* (Lambert, 2004) and in the most recent official list of empirically support treatments produced by a task force of the American Psychological Association (Chambless et al., 1998). Research provides a strong basis for confidence in therapies that involve either training in specific psychosocial skills (e.g., relaxation, anger management); application of principles of conditioning and learning (e.g., controlled exposure to anxiety-producing situations); identification, evaluation, and modification of maladaptive thoughts; or the development and everyday use of adaptive self-talk.

However, cognitive-behavioral therapy is not the only type of treatment supported by outcome research. Its predominance is supported by the sheer number of studies whose results have supported it, but this is a function of the number of investigations that have investigated cognitive-behavioral therapy, not a generally higher rate of positive results in the studies that have been performed. In other words, while cognitive-behavioral therapists have long had an affinity for conducting outcome studies, other types of intervention have generally produced similarly positive results in the smaller number of studies in which they have been investigated.

<u>Outcome Research: Adults with Serious Mental Illness</u>
For adults with serious mental illnesses, research supports interventions based on the recovery model and case management services. Several studies have provided support for structured, time-limited forms of psychodynamic therapy, although traditional psychoanalysis has not received empirical support. There is substantial evidence that disturbances involving overt acting out should be treated with directive interventions that emphasize constructive confrontation, the consequences of alternative actions, and training in psychosocial skills. Introspectively oriented therapies emphasizing expression of feelings and development of personal insight may be appropriate for the treatment of emotional distress and low self-esteem, although there is less

evidence on this issue. Research indicates similar levels of effectiveness for counseling delivered in the individual, family, and group modalities.

Outcome Research: Family Systems Therapy

Meta-analyses of family systems therapy have produced substantial support for this approach to treatment (Shadish et al., 1993; Stanton & Shadish, 1997). Family therapy seems to be an especially effective approach when the client's mental health problems are related to difficulties in his or her family relationships. Marital counseling has demonstrated the capability to improve partner relationships and to resolve mental health problems.

Outcome Research: Assertive Community Treatment

Assertive community treatment (Mueser, Bond, Drake, & Resnick, 1998) is an empirically supported model of community care for people with serious and persistent mental illnesses such as schizophrenia. The model provides individualized treatment, rehabilitation, and support services in a community setting. Each client has a multidisciplinary, self-contained team that aims to meet all of the client's mental health needs, with 24/7 availability and services provided in the client's environment. In contrast, case management involves referring clients to various professionals in the community, which seems to result in less coordination of care than that achieved by assertive community treatment. The model is not time-limited, and it continues to serve clients for as long as necessary. Assertive community treatment has been the subject of more than 25 randomized, controlled trials which have generally provided strong support for the model (Boust, Kuhns, & Studer, 2005). The model is particularly effective at reducing psychiatric hospitalizations. It has also been shown to improve housing stability, symptoms of mental illness, and quality of life. The intervention has not demonstrated success at reducing substance abuse and arrests, and it has not improved social adjustment and vocational outcomes. Studies that compared different versions of Assertive Community Treatment demonstrated that the effectiveness of the intervention is directly related to the fidelity with which its principles and practices are implemented; in other words, deviations from the original model seem to result in reduced positive impact on clients (McHugo, Drake, Teague, & Xie, 1999).

Outcome Research: Psychodynamic Therapy

Brief, structured forms of psychodynamic therapy have demonstrated efficacy in outcome research on adult depression (Gallagher-Thompson & Steffen, 1994), and this type of intervention is considered an empirically supported treatment by the American Psychological Association (Chambless et al., 1998). Meta-analyses comparing short-term dynamic therapy to other approaches with adult clients have not found significant differences (Anderson & Lambert, 1995), and a meta-analysis of six studies directly comparing CBT and dynamic therapy for depressed adults found no differences in efficacy (Leichsenring, 2001).

Outcome Research: Insight-Oriented and Symptom-Focused Therapies

Beutler and colleagues (Beutler et al., 2004; Beutler & Harwood, 2000; Beutler, Harwood, Alimohamed, & Malik, 2002) reviewed a number of studies that compared the effectiveness of insight-oriented and symptom-focused therapies. (This dichotomy corresponds roughly to dynamic versus behavioral intervention.) Overall, the results did not indicate that either approach was superior to the other. However, the two approaches varied in their effectiveness with different groups of clients. The distinguishing factor was a personality-related variable called *coping style*. Reflective, introspective, over-controlled clients generally achieved greater therapeutic benefit from insight-oriented counseling, while action-oriented, impulsive, under-controlled clients typically benefited more from symptom-focused interventions. This pattern of results makes sense because it means that clients generally respond best to therapies that match their characteristic preference for

thought versus action. Clients who characteristically cope with problems by thinking about them seem to respond better to dynamic types of therapy, while those who prefer to cope by taking action usually achieve better outcomes with behaviorally oriented interventions.

Use of Evidence-Based Best Practices

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

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

To examine some specific findings, almost 90 percent of the adult agencies reported implementing illness management and recovery for individuals with severe mental illness. Assertive community treatment (or, equivalently, assertive community management) was reportedly used by 67 percent of the mental health organizations, and an identical percentage reported implementing social skills training for schizophrenia. Significant proportions of the adult-serving agencies reported using many of the 27 other evidence-based practices identified in the interview.

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

In addition, quite apart from any desire of respondents to represent their agencies positively, it seems likely that a fundamental ambiguity characterizing the term *evidence-based practice* makes it difficult to determine what these results mean. In its strict sense, this term refers to a precisely specified treatment protocol delineated in a manual that clinicians follow in a step-by-step fashion. This is the type of therapy studied in the clinical trials that, when successful, provide empirical support for interventions. Frequently, however, the term *evidence-based practice* has a much looser, more inclusive meaning that indicates only that therapeutic practice is consistent, in a general way, with the results of research. This ambiguity is apparent within the descriptions of interventions presented in the interview. *Multisystemic therapy* is an example of a specific, manualized intervention. In contrast, the term *cognitive behavior therapy* refers to a broad theoretical orientation and a large array of techniques. Respondents might have reported agency

use of this practice simply because their therapists' work with clients sometimes involves attempts to change maladaptive thoughts and teach behavioral skills, without any specific treatment protocol being used.

Focus Groups and Key Informant Interviews
In the focus groups and key informant interviews conducted as part of United Way's core service planning (2005), it was apparent that most agency staff in the community understands the term *evidence-based practice* in its broad, non-technical sense. While many of these staff members reported the use of best practices by their organizations, they infrequently indicated use of specific, manualized interventions or treatments learned in specialized trainings of the type necessary to replicate the therapies studied in outcome research. To some extent, it seemed as if many staff persons used "best practice" as an expression to affirm the quality of the work done in their agencies without necessarily referring to specific, research-based interventions.

These considerations suggest that the results of the survey conducted by the Center for Community Solutions and CCCMHB could be misunderstood if construed too literally. It does not seem as if most county mental health organizations make extensive use of manualized interventions or even highly specific, research-based techniques, although it seems likely that most of the work done by these organizations is consistent, in a general way, with the results of treatment research. Whether work with clients would be more effective if it were more tightly based on research is a complex question with arguments that can be made on both sides, but it seems probable that some movement in the direction of evidence-based practice, in the strict sense of the term, would enhance the services provided to clients.

What Doesn't Work
Nothing included.

IMPACT ON COMMUNITY

Research on assertive community treatment has given attention to the question of cost-effectiveness. Studies have found that the intervention achieves major reductions in hospitalization costs and that it is cost-effective for clients who, in the absence of effective treatment, would experience extensive hospitalization (Essock, Frisman, & Kontos, 1998). The intervention is less cost-effective for clients who would not otherwise incur substantial hospitalization expenses.

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

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

Most non-medical mental health services are provided by members of three professions: psychology, social work, and counseling. There are 3,765 licensed clinical and school psychologists in the state of Ohio. Based on Cuyahoga County's proportion of Ohio's population and the higher concentrations of mental health professionals in urban and suburban areas, it is estimated that there are approximately 1000 licensed psychologists in our county. Ohio has 14,905 licensed social

workers (LSWs), who practice under supervision, and 6,472 licensed independent social workers (LISWs), who have accumulated sufficient supervised work experience to practice without supervision. Based on these numbers, it is estimated there are approximately 4000 LSWs and 2000 LISWs in Cuyahoga County. Ohio has 3115 licensed professional counselors (LPCs), who practice under supervision, and 3447 licensed professional clinical counselors (LPCCs), who have enough supervised experience to practice independently. It is estimated that there are approximately 900 LPCs and 1000 LPCCs in Cuyahoga County. In addition, there are small numbers of licensed psychiatrists, marriage and family therapists, registered nurses, music therapists, art therapists, and pastoral counselors who provide psychotherapy to clients.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for General Counseling Services (Outpatient Mental Health Facilities):

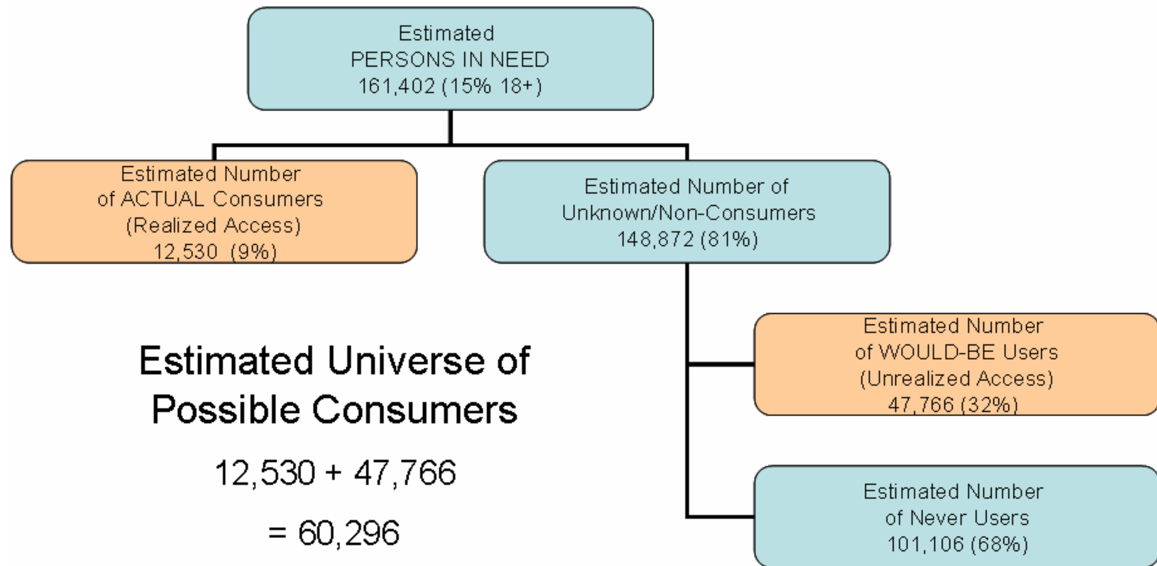
- An estimated 161,402 persons need general counseling programs, which is the estimate of persons 18 and older with mental health disorders in Cuyahoga County.

- Based on available information about actual consumers, approximately 12,530 persons 18+ have realized access to general counseling services. This is the number of persons 18+ estimated to receive funded services from the Cuyahoga County Community Mental Health Board. It is assumed that consumers funded by United Way (9,901), WRAAA (119), and Ryan White Title I (51) are duplicated with the Mental Health Board's. This leaves a net estimate of 148,872 persons 18+. (161,402 – 12,530 = 148,872)[2]

- According to the Cuyahoga County Mental Health Assessment (2003), there were 47,766 adults in need of, but not receiving this service, i.e., would-be consumers. The primary reasons for this lack in services included lack of funding for the working poor and the managed care models used by insurance companies to control utilization (Center for Community Solutions, 2003).

- The estimated universe of possible consumers is 62,960, including both realized (12,530) and unrealized (47,766) access. (12,530 + 47,766 = 60,296). (See Figure 6.)

[2] The Center for Community Solution's Mental Health Needs Assessment estimated the number of persons 18 and older who were served by the public mental health system in Cuyahoga County to be approximately 16,036. This number, however, is not broken down by core service area. Nonetheless, this number provides us with a beginning estimate for how many individuals are accessing the mental health system. In addition, many individuals may be receiving general counseling services from private practitioners but we do not have estimates for this population of consumers.



Service Site Index
Countywide, there are 93 service sites for general counseling (outpatient mental health facilities). This is a ratio of 648 possible consumers (estimated 60,296 total) to one service site countywide. Service providers report to United Way - First Call for Help which zip codes are included in their respective service areas. The Service Site Index in Attachment 9 lists the number of sites per zip code and provides a ratio of consumers to service sites for each zip code. This is a measure of potential service accessibility by possible universe of service consumers per zip code area. Note that this measure does not include the capacity of providers to offer the service, for example, the number of persons receiving counseling on an hourly basis. It is only capturing whether there is a possibility of receiving counseling. The lower the ratio, the greater is the chance of receiving counseling service.

The ratios on the Service Site Index range from a high of 29:1 in zip code 44107 (Lakewood/Cleveland) to a low of 2:1 in zip codes 44040 (Gates Mills/Mayfield Village) and 44114 (Cleveland). In addition to 44107, two other zip codes have ratios greater than 25 consumers to one service site: 44130 (Parma/Cleveland, 28:1) and 44105 (Cleveland/Newburgh Hts/Garfield Hts, 26:1), a high minority area. See Map in Attachment 10.

Service Capacity
According to the report by the Center for Community Solutions and CCCMHB (2003), risk factors for mental health problems (poverty, unemployment, etc.) are higher in Cuyahoga County than in other urban areas and in the state of Ohio as a whole. This research estimated that the public mental health system reaches only 32 percent of all residents with mental disorders with an income less than 200 percent of the poverty level. Hispanics and Asian Americans are less likely to receive services than Caucasians and African Americans.

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

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

The public mental health system focuses its resources on the relatively small number of people with severe mental illnesses. The Federation/CCCMHB report estimated that only 2 percent of Cuyahoga residents with anxiety disturbances are served, while 54 percent of people with schizophrenia are served by the public system.

According to participants of the UW focus groups and key informant interviews (2005), one serious constraint on the effective operation of the mental health system, both private and public, is the chronic shortage of psychiatrists with specialized expertise in psychotropic medications. This shortage is a national problem, but it seems to be more pronounced in the Midwest than on the East and West Coasts. The result of the shortage is long waiting lists for psychiatry services, which sometimes results in the deterioration of mental health conditions before the needed medication is prescribed.

One participant stated that a significant service gap in the community is counseling services for people with severe mental illnesses. The system prioritizes medication-somatic services, housing, employment, and support for this population, and counseling sometimes gets lost in the shuffle. Nonetheless, these individuals often have abuse histories, grief issues, and so forth that warrant counseling just as they do in people with less severe illnesses.

In discussing service gaps, the respondents cited barriers deriving from restrictive Medicaid regulations that, they said, make it difficult or impossible to provide some services that would benefit clients. Because Medicaid generally will not pay for services that do not occur face-to-face with the client, services such as family support groups, social skills training, consultation among professionals sharing responsibility for a client, and outcome evaluation are often difficult to support.

Agencies are providing treatment to more and more people without health insurance and have difficulty paying for services with their own resources. This has resulted in increased use of sliding fee schedules by agencies that are able to offer this, and the fees must slide down to very low payment levels. Furthermore, reduced private sector resources have been accompanied by cuts in government funding for mental health services. Thus, at the same time that needs are intensifying, the resources needed to meet those needs are decreasing.

The interviewees also said that individuals with disturbances of less than extreme severity—in other words, people with mild to moderate degrees of dysfunction—are markedly underserved by the public mental health system. The reason is that the public system's funds are limited, making prioritization necessary, and the policy is to concentrate funds on treatment for the most disturbed

individuals. While there is a clear logic to this policy, one unfortunate ramification is that mild to moderately disturbed individuals' conditions must often deteriorate before they can receive CCCMHB-supported services.

This focus on interventions associated with severe illnesses also has an effect on services for people whose diagnoses do fall within the purview of the community mental health system. While Medicaid funds are frequently available to pay for medication to treat psychotic disorders and severe depression, there is often no way to pay for counseling services that might also be helpful to individuals with these diagnoses.

Some interviewees also said that many private insurance plans provide insufficient coverage for people with major mental health problems. These plans often limit the number of therapy sessions that can be purchased, and they often place especially stringent limitations on forms of treatment more intensive than outpatient therapy.

Some respondents said that, because the needs of mental health clients often extend to general life needs in addition to treatment services per se, these clients require a variety of non-traditional services in order to stabilize both their life situations and their psychiatric conditions. Many clients need help with job skills, finding employment, and obtaining affordable housing. One respondent added that job training is not enough because, even after such programs have been completed, many clients have trouble finding steady employment.

Ex-felons often face a catch-22 in their efforts to obtain employment: they are barred by law from licensure in a number of occupations. Rationales for barring ex-felons from some occupations (e.g., child care) are easy to understand but, for other occupations (e.g., barber), the rationales seem more questionable. As a result of these laws, in combination with the reluctance of many employers to hire anyone with a criminal background, many ex-felons find it difficult or impossible to find work. The presence of a co-occurring mental disorder may make it even more likely that a combination of desperation and distress might lead to the commission of a new offense.

VII. SUMMARY

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

- Counseling is a valuable component of treatment for people with serious mental illnesses, and it is often the mainstay of treatment for common, comparatively mild disturbances.
- During the past two decades, many of the research and development efforts in the mental health field have focused on designing and evaluating community-based interventions that take place in homes, schools, and neighborhoods rather than in office settings.
- The Community Mental Health Services Block Grant Program is a major funding policy that affects all persons involved with the publicly supported mental health system.
- 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 policy seems to be the single public policy with the greatest impact on mental health services, including eligibility criteria, covered services, and reimbursement rates.
- Medicaid funding for community mental health services has increased from $57.6 million in 2002 to $67.8 million in 2004. However, it includes all mental health services, not just those for adults receiving general counseling.
- Between calendar years 2002 and 2004, Cuyahoga County Community Mental Health Board (CCMHB) funding decreased from $5.9 to $4.6 million. Funding went to providers of general counseling services and to outpatient mental health facilities. CCMHB blends funding from several different federal, state, and local sources.
- In Cuyahoga County, identified government funding specifically for general counseling (outpatient mental health facilities), which includes WRAAA, Ryan White Title 1 and CDBG-Cleveland, decreased from $211,188 in 2002 to $126,749 in 2004
- As of May 11, 2006, over $8.9 million in revenues for general counseling (outpatient mental health facilities) has been identified countywide.
- Overall, counseling seems to be a moderately effective intervention for most mental health problems, producing full resolution of symptoms in approximately one third of clients and substantial improvement in another third.
- The quality of the counselor-client relationship is a strong predictor of treatment outcome.
- For adult clients, the outcome literature generally indicates that there is more support for cognitive-behavioral counseling than for any other approach.
- The estimated universe of possible consumers is 60,296, including both realized (12,530) and unrealized (47,766) access.
- Countywide there are 93 service sites for general counseling (outpatient mental health facilities) services programs. This is a ratio of 648 possible consumers (estimated 60,296 total) to one service site countywide.

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ATTACHMENTS

Attachment 1: Researcher List

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Thanks to ***The Center for Community Solutions*** for providing multiple sources of information.

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.

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Attachment 3: Actual Consumer Demographics

Core Service: General Counseling Services RP-450.265 (Outpatient Mental Health Facilities RM-650)									
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****					
	Total Population (%)*	Total Population 18+ (%)**	Population 18+ with Mental Disorder (%)***	UW Program Report Data Cuy Cnty Only 80.9% (%)	WRAAA (%)	CCCMHB (%)	Ryan White Title I (%)	Cleveland - CDBG (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	2004	2004	2004	2004
Age 18-54		708,037	116,657					
Age 55+		338,562	44,745					
TOTAL	1,393,978	1,046,599	161,402	9,901	119	12,530	51	Missing
Percent		75.1%	15.4%					
GENDER								
Male	47.2%	45.9%	N/A	33.2%	41.2%	0.0%	72.5%	0.0%
Female	52.8%	54.1%	N/A	66.8%	58.8%	0.0%	25.5%	0.0%
Unknown Data*****				0.1%	0.0%	0.0%	2.0%	0.0%
Missing Data******				0.0%	0.0%	100.0%	0.0%	100.0%
RACE*****								
White alone	67.1%	70.5%	N/A	35.7%	94.1%	0.0%	37.3%	0.0%
Black or African American alone/combination	27.9%	25.2%	N/A	35.1%	5.0%	0.0%	49.0%	0.0%
Asian alone/combination	2.1%	2.2%	N/A	5.0%	0.8%	0.0%	0.0%	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.7%	N/A	0.2%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.1%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
Some other race alone/combination	2.1%	1.8%	N/A	5.3%	0.0%	0.0%	2.0%	0.0%
Unknown Data*****				18.7%	0.0%	0.0%	11.8%	0.0%
Missing Data******				0.0%	0.0%	100.0%	0.0%	100.0%
HISPANIC*******	3.3%	2.8%	N/A	4.4%	0.8%	0.0%	11.8%	0.0%
AGE								
0-4	6.5%	0.0%	N/A	0.8%	0.0%	0.0%	64.7%	0.0%
5-9	7.3%	0.0%	N/A	4.8%	0.0%	0.0%		0.0%
10-14	7.1%	0.0%	N/A	7.0%	0.0%	0.0%		0.0%
15-19	6.4%	3.2%	N/A	10.9%	0.0%	0.0%		0.0%
20-34	19.1%	25.4%	N/A	17.6%	0.0%	0.0%		0.0%
35-54	29.3%	39.1%	N/A	27.5%	0.0%	0.0%	33.3%	0.0%
55-64	8.7%	11.6%	N/A	5.1%	0.0%	0.0%		0.0%
65-74	7.8%	10.3%	N/A	1.3%	0.0%	0.0%	2.0%	0.0%
75+	7.8%	10.4%	N/A	0.7%	0.0%	0.0%		0.0%
Unknown Data*****				24.3%	0.0%	0.0%	0.0%	0.0%
Missing Data******				0.0%	100.0%	100.0%	0.0%	100.0%
INCOME********								
Average Household Size	**2.4**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
$0-$9,999	11.3%	N/A	N/A	30.7%	0.0%	0.0%	0.0%	0.0%
$10,000-$14,999	6.9%	N/A	N/A	8.7%	0.0%	0.0%	0.0%	0.0%
$15,000-$19,999	6.7%	N/A	N/A	2.8%	0.0%	0.0%	0.0%	0.0%
$20,000-$29,999	13.6%	N/A	N/A	1.9%	0.0%	0.0%	0.0%	0.0%
$30,000 and above	61.5%	N/A	N/A	2.3%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****				53.7%	0.0%	0.0%	0.0%	0.0%
Missing Data******				0.0%	100.0%	100.0%	100.0%	100.0%
Totals	**100.0%**	**N/A**	**N/A**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1); SF4 (PCT144)
** U.S. Census 2000 SF3 (P8); SF4 (PCT3); SF4 (PCT144)
*** "Cuyahoga County Mental Health Assessment," Center for Community Services, December 2003. Rate of persons with mental health disorders 18-54, 16.5 percent, 55+, 13.2 percent. Overall: 15.4 percent for 18+.
****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: General Counseling Services RP-450.265 (Outpatient Mental Health Facilities RM-650)									
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****				
	City/Town (% Cleveland)	Total Population (%)*	Total Population 18+ (%)**	Population 18+ with Mental Disorder (%)***	UW Program Report Data (%)	WRAAA (%)	CCCMHB (%)	Ryan White Title I (%)	Cleveland - CDBG (%)
Period		1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	2004	2004	2004	2004
Age 18-54		-	708,037	116,657					
Age 55+		-	338,562	44,745					
TOTAL		1,393,978	1,046,599	161,402	9,901	119	12,530	51	Missing
Percent			75.1%	15.4%					
44017	Berea	1.4%	1.4%	N/A	0.8%	0.0%	0.0%	0.0%	0.0%
44022	Bentleyville	1.3%	0.8%	N/A	0.4%	0.0%	0.0%	0.0%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	0.2%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%
44070	North Olmsted	2.4%	2.5%	N/A	1.3%	0.0%	0.0%	0.0%	0.0%
44101	Cleveland (100%)	0.0%	0.0%	N/A	0.1%	0.0%	0.0%	0.0%	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	3.5%	N/A	5.9%	0.0%	0.0%	0.0%	0.0%
44103	Cleveland (100%)	1.8%	1.7%	N/A	3.5%	0.0%	0.0%	0.0%	0.0%
44104	Cleveland (100%)	2.1%	1.7%	N/A	2.7%	0.0%	0.0%	0.0%	0.0%
44105	Cleveland/NewburghHts/GarfieldHts	3.9%	3.6%	N/A	4.9%	0.0%	0.0%	0.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	2.4%	N/A	2.4%	0.0%	0.0%	0.0%	0.0%
44107	Lakewood/Cleveland	4.1%	4.3%	N/A	5.8%	0.0%	0.0%	0.0%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	2.4%	N/A	3.4%	0.0%	0.0%	0.0%	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.2%	N/A	3.7%	0.0%	0.0%	0.0%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	1.8%	N/A	2.4%	0.0%	0.0%	0.0%	0.0%
44111	Cleveland (100%)	3.1%	3.1%	N/A	3.9%	0.0%	0.0%	0.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	2.2%	N/A	3.2%	0.0%	0.0%	0.0%	0.0%
44113	Cleveland (100%)	1.4%	1.4%	N/A	1.5%	0.0%	0.0%	0.0%	0.0%
44114	Cleveland (100%)	0.3%	0.3%	N/A	0.4%	0.0%	0.0%	0.0%	0.0%
44115	Cleveland (100%)	0.6%	0.5%	N/A	7.6%	0.0%	0.0%	0.0%	0.0%
44116	Rocky River	1.5%	1.6%	N/A	1.0%	0.0%	0.0%	0.0%	0.0%
44117	Euclid/Cleveland	0.9%	0.9%	N/A	0.6%	0.0%	0.0%	0.0%	0.0%
44118	ClevelandHts/UniversityHts/ShakerH	3.2%	3.3%	N/A	3.6%	0.0%	0.0%	0.0%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	1.0%	N/A	0.6%	0.0%	0.0%	0.0%	0.0%
44120	Shaker Hts/Cleveland	3.4%	3.3%	N/A	4.5%	0.0%	0.0%	0.0%	0.0%
44121	University Hts/South Euclid	2.5%	2.5%	N/A	2.5%	0.0%	0.0%	0.0%	0.0%
44122	Beachwood/Highland	2.5%	2.6%	N/A	1.7%	0.0%	0.0%	0.0%	0.0%
44123	Euclid	1.3%	1.3%	N/A	0.7%	0.0%	0.0%	0.0%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	3.1%	N/A	1.9%	0.0%	0.0%	0.0%	0.0%
44125	Valley View/Garfield Hts	2.1%	2.2%	N/A	0.9%	0.0%	0.0%	0.0%	0.0%
44126	Fairview Park/Cleveland	1.2%	1.3%	N/A	0.7%	0.0%	0.0%	0.0%	0.0%
44127	Cleveland (100%)	0.6%	0.5%	N/A	0.9%	0.0%	0.0%	0.0%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.4%	N/A	2.4%	0.0%	0.0%	0.0%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	2.2%	N/A	1.8%	0.0%	0.0%	0.0%	0.0%
44130	Parma/Cleveland	3.8%	4.1%	N/A	2.6%	0.0%	0.0%	0.0%	0.0%
44131	Independence/Seven	1.5%	1.6%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%
44132	Euclid	1.1%	1.1%	N/A	0.5%	0.0%	0.0%	0.0%	0.0%
44133	North Royalton	2.1%	2.1%	N/A	0.7%	0.0%	0.0%	0.0%	0.0%
44134	Parma/Cleveland	2.9%	3.0%	N/A	1.6%	0.0%	0.0%	0.0%	0.0%
44135	Cleveland/Linndale (90%)	2.0%	2.1%	N/A	2.8%	0.0%	0.0%	0.0%	0.0%
44136	Strongsville	3.1%	3.1%	N/A	0.6%	0.0%	0.0%	0.0%	0.0%
44137	Maple Hts/Cleveland	1.9%	1.9%	N/A	1.0%	0.0%	0.0%	0.0%	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	N/A	0.6%	0.0%	0.0%	0.0%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	1.5%	N/A	0.6%	0.0%	0.0%	0.0%	0.0%
44140	Bay Village	1.2%	1.1%	N/A	0.4%	0.0%	0.0%	0.0%	0.0%
44141	Brecksville	1.0%	1.0%	N/A	0.2%	0.0%	0.0%	0.0%	0.0%
44142	Brookpark/Cleveland	1.5%	1.6%	N/A	1.1%	0.0%	0.0%	0.0%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	1.8%	N/A	0.8%	0.0%	0.0%	0.0%	0.0%
44144	Brooklyn/Cleveland	1.6%	1.7%	N/A	1.4%	0.0%	0.0%	0.0%	0.0%
44145	Westlake	2.3%	2.4%	N/A	0.8%	0.0%	0.0%	0.0%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.4%	N/A	1.1%	0.0%	0.0%	0.0%	0.0%
44147	Broadview Hts	1.1%	1.1%	N/A	0.3%	0.0%	0.0%	0.0%	0.0%
44149	Strongsville	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Cuyahoga County Zip Codes******		0.0%			5.0%	0.0%	0.0%	0.0%	0.0%
Missing*****		0.0%			0.0%	100.0%	100.0%	100.0%	100.0%
Unknown ******		0.0%			23.6%	0.0%	0.0%	0.0%	0.0%
Total Cuyahoga County********		**100.0%**	**100.0%**	**N/A**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total Known Cleveland		**30.5%**	**29.2%**	**N/A**	**46.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total Known Suburbs		**69.5%**	**70.8%**	**N/A**	**48.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Unknown & Missing					**23.6%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S. Census 2000, SF1 (P1)
** U.S. Census 2000 SF3 (P8)
*** "Cuyahoga County Mental Health Assessment," Center for Community Services, December 2003. Rate of persons with mental health disorders 18-54, 16.5 percent, 55+, 13.2 percent. Overall: 15.4 percent 18+.
**** 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	48	6
Number of Providers by Type		
Nonprofit	42	6
For-profit	1	-
Government	5	-
Other	--	-
Total Number of Sites	92	10
Number of Service Sites per Provider		
1	34	4
2 – 5	12	2
6 – 10	1	-
11+	1	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	3	-
44022 – Bentleyville	1	1
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	2	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	5	1
44103 – Cleveland	1	-
44104 – Cleveland	7	-
44105 – Newburgh Hts/Garfield Hts	-	-
44106 – Cleveland Hts/Cleveland	6	-
44107 – Cleveland/Lakewood	2	-
44108 – Cleveland/East Cleveland	2	1
44109 – Cleveland/Brooklyn Hts	4	-
44110 – Cleveland/Bratenahl	1	-
44111 – Cleveland	3	-
44112 – Cleveland/East Cleveland	2	-
44113 – Cleveland	10	1
44114 – Cleveland	1	-
44115 – Cleveland	7	2
44116 – Rocky River	1	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	3	-
44119 – Cleveland/Euclid	-	-
44120 – Cleveland/Shaker Hts	3	1
44121 – University Hts/South Euclid	1	-
44122 – Orange/Warrensville Hts	4	1
44123 – Euclid	-	-
44124 – Pepper Pike/Mayfield Village	3	-
44125 – Valley View/Garfield Hts	4	-
44126 – Cleveland/Fairview Park	-	-
44127 – Cleveland	-	-
44128 – Cleveland/Warrensville Hts	1	-

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	3	-
44130 – Cleveland/Parma	1	-
44131 – Seven Hills/Brooklyn Hts	-	-
44132 – Euclid	-	-
44133 – North Royalton	1	1
44134 – Parma/Cleveland	-	-
44135 – Cleveland/Linndale	3	-
44136 – Strongsville	-	-
44137 – Maple Hts/Cleveland	-	-
44138 – Olmsted Twp/Olmsted Falls	-	-
44139 – Bentleyville/Glenwillow/Solon	-	-
44140 – Bay Village	-	-
44141 – Brecksville	1	-
44142 – Cleveland/Brookpark	-	-
44143 – Highland Hts/South Euclid	1	-
44144 – Brooklyn/Cleveland	-	-
44145 – Westlake	3	1
44146 – Walton Hills/Oakwood/Bedford	2	-
44147 – Broadview Hts	-	-
44149 – Strongsville	-	-

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	**Services**
Applewood Centers	Psychiatry Services For Youth
Bedford Heights City Of -	Social Services - Seniors And Disabled
Beech Brook	Outpatient Mental Health Services
Bellefaire Jewish Children's Bureau	Outpatient Counseling, Neighborhood Family Counseling Program
Benjamin Rose	At Home Care For Elderly (3rd Party Payor / Sliding Scale), Mental Health Services, Social Work Services
Berea Children's Home And Family Services	Counseling - Outpatient
Bridgeway	General Counseling Services
Catholic Charities Health And Human Services - Parish And Community Ministries	Counseling Services
Catholic Charities Services Of Cuyahoga County	Outpatient Counseling Services
Center For Families And Children	Counseling Services - Bilingual/Hispanic, Counseling Services
Cleveland Psychoanalytic Center	Mental Health Treatment
Community Challenge	School - Based Student Assistance & Substance Abuse Programs
Community Re-Entry	Support Services For Women Inmates, Support Services - Women Ex-Offenders
Council For Economic Opportunities In Greater Cleveland	Counseling
Cuyahoga County Dept. Of Justice Affairs	In-Home Family Counseling - Juvenile Offenders
Far West Center	Counseling Services
Free Clinic Of Greater Cleveland	Mental Health/Substance Abuse - Counseling
Friendly Inn Settlement	Counseling
Garfield Heights Community Center	Counseling
Golden Age Centers Of Greater Cleveland	Social Services - Seniors
Hanna Perkins Center For Child Development	Child Therapy
Harvard Community Services Center	Counseling – Youth, Counseling – Seniors, Counseling And Assistance
Jewish Family Service Assn. of Cleveland	Eldercare - Counseling / Case Management, Counseling - Therapy / Group Services
Kaiser Permanente Of Ohio	Mental Health - General And Subject Specific Counseling
Lakewood Hospital	Health Services For Teens

Attachment 6: Providers and Functions – 2005 (continued)

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	**Services**
Laurelwood Hospital	Mental Health - General And Subject Specific Counseling
Lutheran Children's Aid And Family Services	Mental Health Counseling - General/Schools
Marymount Hospital	Behavioral Health Center
May Dugan Center	Counseling Services
MetroHealth Medical Center	Counseling And Outpatient Psychiatric Care
Mt. Sinai Baptist Church	Community Readjustment Program
Murtis H. Taylor Multi-Service Center	Outpatient Services - Diagnostic & Assessment (MDC), Behavioral Health Services
North East Ohio Health Services	Counseling For Deaf And Hard Of Hearing, Psychiatric Case Management – Seniors, Counseling, Children & Adolescent Services
North Olmsted City Of - Dept. Of Human Resources	Services For Youth And Families, Short-Term/Crisis Counseling
Parma Community General Hospital	Outpatient Services / Departments
Parma Health Ministry	Mental Health--Evaluation And General Counseling Services
Positive Education Program	
Prison Fellowship Ministries	Counseling/Support
Recovery Resources	Mental Health - Counseling
River's Edge: A Place Where Relection And Action Meet	Counseling/Spiritual Direction
Salvation Army - The	Social Services/Hot Meal/Home Delivered Meals - Seniors
Southwest Youth Council	Crisis Resolution And Referral For Youth In Crisis
St. John West Shore Hospital	Mental Health - General And Subject Specific Counseling
Tri-City Consortium on Aging	Information/Outreach - Older Adults
United States Dept. Of Veterans Affairs	Mental Health - Psychological/Psychiatric Treatment
Ursuline Sophia Center	Therapies - Counseling/Massage/Nutrition
Visiting Nurse Assn. Healthcare Partners Of Ohio	Older Adult Care
West Side Ecumenical Ministry	Counseling

Bold represents agencies funded by United Way for this service.

Attachment 7: United Way - First Call for Help General Counseling Services Requests – 2000-2004: Greatest Increase/Greatest Decrease

RP-450.265 General Counseling Services (Outpatient Mental Health 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
44142	Brookpark/Cleveland	2	12	14	8	19	850%	11
44114	Cleveland	2	4	4	4	13	550%	5
44124	Pepper Pike/Mayfield Hts./Lyndhurst	4	5	12	11	12	200%	9
44119	Cleveland/Euclid	3	13	10	9	8	167%	9
44136	Strongsville	7	11	11	11	16	129%	11
44139	Bentleyville/Glenwillow/Solon	5	4	5	5	11	120%	6
44123	Euclid	7	8	17	15	14	100%	12
44125	Valley View/Garfield Hts	9	9	18	21	17	89%	15
44146	Walton Hills/Oakwood/Bedford	11	12	20	24	19	73%	17
44113	Cleveland	13	28	28	44	22	69%	27
44129	Brooklyn/Parma/Cleveland	12	9	28	17	20	67%	17
44107	Lakewood/Cleveland	31	48	48	49	51	65%	45
44131	Independence/Seven Hills/BrooklynHts	7	6	5	2	10	43%	6
44111	Cleveland	27	26	41	41	38	41%	35
44103	Cleveland	18	33	31	27	23	28%	26
44145	Westlake	5	8	10	8	6	20%	7
44132	Euclid	10	13	9	12	11	10%	11
44134	Parma/Cleveland	21	10	28	19	23	10%	20
44102	Cleveland/Brooklyn	50	75	95	75	52	4%	69
44149	Strongsville	0	3	9	7	4	N/A	5
44140	Bay Village	0	3	1	0	3	N/A	1
44070	North Olmsted	0	0	1	0	1	N/A	N/A
44143	Highland Hts/Richmond Heights	9	7	5	6	4	(56%)	6
44110	Cleveland/East Cleveland	31	25	33	35	14	(55%)	28
44115	Cleveland	24	18	12	18	11	(54%)	17
44108	Cleveland/Bratenahl	46	36	46	42	27	(41%)	39
44135	Cleveland/Linndale	22	23	24	25	13	(41%)	21
44117	Euclid/Cleveland	16	9	16	15	10	(38%)	13
44126	Fairview Park/Cleveland	8	5	9	8	5	(38%)	7
44130	Parma/Cleveland	29	24	41	20	21	(28%)	27
44017	Berea	9	6	15	9	7	(22%)	9

Attachment 7: United Way - First Call for Help General Counseling Services (Outpatient Mental Health Facilities) Services Requests – 2000-2004: Greatest Increase/Greatest Decrease (continued)

RP-450.265 General Counseling Services (Outpatient Mental Health 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**
44106	Cleveland/Cleveland Hts	36	28	28	23	28	(22%)	29
44137	Maple Hts/Cleveland	18	14	23	28	14	(22%)	19
44128	Warrensville Hts/Cleveland	27	22	35	27	22	(19%)	27
44118	ClevelandHts/UniversityHts/ShakerHts	22	22	29	23	18	(18%)	23
44144	Brooklyn/Cleveland	17	10	16	16	14	(18%)	15
44133	North Royalton	7	7	7	10	6	(14%)	7
44116	Rocky River	8	5	5	14	7	(13%)	8
44121	University Hts/South Euclid	18	11	22	18	16	(11%)	17
44120	Shaker Hts/Cleveland	38	42	46	54	34	(11%)	43
44112	East Cleveland/Cleveland	32	39	51	46	29	(9%)	39
44109	Cleveland/Brooklyn Hts	41	53	59	54	38	(7%)	49
**Total Cuyahoga County		**801**	**859**	**1,115**	**1,019**	**830**	**4%**	**925**
**Total Cleveland		**390**	**457**	**534**	**490**	**364**	**(7%)**	**447**
**Total Suburbs		**411**	**402**	**581**	**529**	**466**	**13%**	**478**

* 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 General Counseling Services (Outpatient Mental Health Facilities) Services Requests 2000-2004: Unmet Need

RP-450.265 General Counseling Services (Outpatient Mental Health Facilities)					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			**%**
		Requests	**Met**	**Unmet**	**Unmet**
44070	North Olmsted	2	1	1	50%
44145	Westlake	37	34	3	8%
44138	Olmsted Twp/Olmsted Falls	22	21	1	5%
44149	Strongsville	23	22	1	4%
44147	Broadview Hts	25	24	1	4%
44127	Cleveland	50	48	2	4%
44132	Euclid	55	53	2	4%
44107	Lakewood/Cleveland	227	219	8	4%
44139	Bentleyville/Glenwillow/Solon	30	29	1	3%
44131	Independence/Seven Hills/Brooklyn Hts	30	29	1	3%
44117	Euclid/Cleveland	66	64	2	3%
44109	Cleveland/Brooklyn Hts	245	238	7	3%
44144	Brooklyn/Cleveland	73	71	2	3%
44116	Rocky River	39	38	1	3%
44119	Cleveland/Euclid	43	42	1	2%
44124	Pepper Pike/Mayfield Hts./Lyndhurst	44	43	1	2%
44128	Warrensville Hts/Cleveland	133	130	3	2%
44130	Parma/Cleveland	135	132	3	2%
44017	Berea	46	45	1	2%
44122	Beachwood/Highland Hills/Shaker Hts.	50	49	1	2%
44134	Parma/Cleveland	101	99	2	2%
44142	Brookpark/Cleveland	55	54	1	2%
44136	Strongsville	56	55	1	2%
44123	Euclid	61	60	1	2%
44112	East Cleveland/Cleveland	197	194	3	2%
44103	Cleveland	132	130	2	2%
44113	Cleveland	135	133	2	1%
44110	Cleveland/East Cleveland	138	136	2	1%
44105	Cleveland/Newburgh Hts/Garfield Hts	254	251	3	1%
44121	University Hts/South Euclid	85	84	1	1%
44111	Cleveland	173	171	2	1%

Attachment 8: United Way - First Call for Help General Counseling Services (Outpatient Mental Health Facilities) Services Requests 2000-2004: Unmet Need (continued)

RP-450.265 General Counseling Services (Outpatient Mental Health Facilities)					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			**%**
		Requests	**Met**	**Unmet**	**Unmet**
44102	Cleveland/Brooklyn	347	343	4	1%
44120	Shaker Hts/Cleveland	214	212	2	1%
44118	ClevelandHts/UniversityHts/ShakerHts	114	113	1	1%
	*** Total Cuyahoga County**	**4,624**	**4,554**	**70**	**2%**
	*** Total Cleveland**	**2,235**	**2,210**	**25**	**1%**
	*** Total Suburbs**	**2,389**	**2,344**	**45**	**2%**

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.

Attachment 9: Service Site Index

Core Service: General Counseling (Outpatient Mental Health Facilities)
Service Site Index

Zip	Number of Sites*****	City/Town (% Cleveland)	Proportion of Minorities in Geographical Area	Total Population (#)*	Total Population 18+ (#)**	Estimated Persons in Need: Persons 18+ with Mental Disorder (#) ***	Estimated Universe of Possible Consumers per Geographical Area****	Number of Service SITES Serving Geographical Area (Per Agencies Reported Intended Service Area to First Call for	Potential Service ACCESSIBILITY by Service Consumers per Geographical / Ratio of CONSUMERS to Service SITES
Period				1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2004-12/31/2004	1/1/2004-12/31/2004	1/2005	
TOTAL	93			1,393,978	1,046,599	161,402	60,296	93	648:1
Percent					75.1%	15.4%	37.4%		
44117	-	Euclid/Cleveland	African Am 53.1%	12,078	9,662	1,490	557	86	6:1
44105	-	Cleveland/NewburghHts/ GarfieldHts (75%)	African Am 61.9%	54,834	38,080	5,873	2,194	86	26:1
44106	6	Cleveland/Cleveland Hts (60%)	African Am 62.2%	32,417	25,586	3,946	1,474	87	17:1
44110	1	Cleveland/East Cleveland (98%)	African Am 74.7%	26,536	18,517	2,856	1,067	86	12:1
44120	4	Shaker Hts/Cleveland	African Am 76.7%	47,349	34,091	5,257	1,964	86	23:1
44103	1	Cleveland (100%)	African Am 80.2%	25,348	17,372	2,679	1,001	87	12:1
44108	2	Cleveland/Bratenahl (90%)	African Am 94.9%	36,456	24,841	3,831	1,431	86	17:1
44112	2	East Cleveland/Cleveland	African Am 95.2%	33,222	23,087	3,560	1,330	86	15:1
44128	1	Warrensville Hts/Cleveland	African Am 95.8%	33,612	25,177	3,883	1,450	87	17:1
44104	7	Cleveland (100%)	African Am 97.5%	28,904	18,083	2,789	1,042	87	12:1
44115	7	Cleveland (100%)	African Am 98.4%	8,186	5,218	805	301	87	3:1
44114	1	Cleveland (100%)	Asian 20.3%	3,891	3,247	501	187	87	2:1
44109	4	Cleveland/Brooklyn Hts (98%)	Hispanic 20.3%	45,783	32,998	5,089	1,901	87	22:1
44102	5	Cleveland/Brooklyn (95%)	Hispanic 20.4%	52,108	36,707	5,661	2,115	87	24:1
44113	10	Cleveland (100%)	Hispanic 23.5%	19,466	14,922	2,301	860	87	10:1
44017	3	Berea		19,005	15,014	2,315	865	85	10:1
44022	1	Bentleyville		17,720	8,368	1,290	482	84	6:1
44040	-	Gates Mills/Mayfield Village		2,883	2,180	336	126	83	2:1
44070	2	North Olmsted		34,081	26,035	4,015	1,500	86	17:1
44101		Cleveland (100%)		0	0	-	0	25	N/A
44107	-	Lakewood/Cleveland		56,710	44,756	6,902	2,578	88	29:1
44111	2	Cleveland (100%)		42,967	32,373	4,992	1,865	87	21:1
44116	3	Rocky River		21,122	16,649	2,568	959	84	11:1
44118	1	ClevelandHts/UniversityHts/ ShakerHts		45,279	34,387	5,303	1,981	87	23:1
44119	3	Cleveland/Euclid (50%)		13,493	10,787	1,664	621	86	7:1
44121	-	University Hts/South Euclid		35,185	26,506	4,088	1,527	89	17:1
44122	1	Beachwood/Highland Hills/ShakerHts		34,883	27,255	4,203	1,570	89	18:1
44123	4	Euclid		18,363	13,929	2,148	802	84	10:1
44124	-	Pepper Pike/MayfieldHts/Lyndhurst		40,334	32,903	5,074	1,896	87	22:1
44125	3	Valley View/Garfield Hts		29,876	22,875	3,528	1,318	86	15:1
44126	4	Fairview Park/Cleveland		17,196	13,455	2,075	775	88	9:1
44127	-	Cleveland (100%)		8,403	5,537	854	319	87	4:1
44129	-	Brooklyn/Parma/Cleveland		29,658	22,906	3,532	1,320	88	15:1
44130	3	Parma/Cleveland		53,615	43,087	6,645	2,482	89	28:1
44131	1	Independence/Seven Hills/BrooklynHts		20,666	16,579	2,557	955	88	11:1
44132	-	Euclid		15,322	11,616	1,791	669	84	8:1
44133	-	North Royalton		28,685	21,732	3,351	1,252	85	15:1
44134	1	Parma/Cleveland		40,396	31,537	4,864	1,817	88	21:1
44135	-	Cleveland/Linndale (90%)		28,561	21,567	3,326	1,243	87	14:1
44136	3	Strongsville		43,858	32,396	4,996	1,866	84	22:1
44137	-	Maple Hts/Cleveland		26,107	19,380	2,989	1,117	86	13:1
44138	-	Olmsted Twp/Olmsted Falls		18,046	13,612	2,099	784	85	9:1
44139	-	Bentleyville/Glenwillow/Solon		22,231	15,448	2,382	890	84	11:1
44140	-	Bay Village		16,076	11,889	1,833	685	85	8:1
44141	-	Brecksville		13,676	10,242	1,579	590	84	7:1
44142	1	Brookpark/Cleveland		21,132	16,334	2,519	941	88	11:1
44143	-	Highland Hts/Richmond Heights		23,730	18,471	2,849	1,064	87	12:1
44144	1	Brooklyn/Cleveland		21,805	17,462	2,693	1,006	87	12:1
44145	-	Westlake		31,972	24,797	3,824	1,429	85	17:1
44146	3	Walton Hills/Oakwood/Bedford		31,648	24,952	3,848	1,438	85	17:1
44147	2	Broadview Hts		15,954	11,995	1,850	691	84	8:1

* U.S. Census 2000, SF1 (P1)

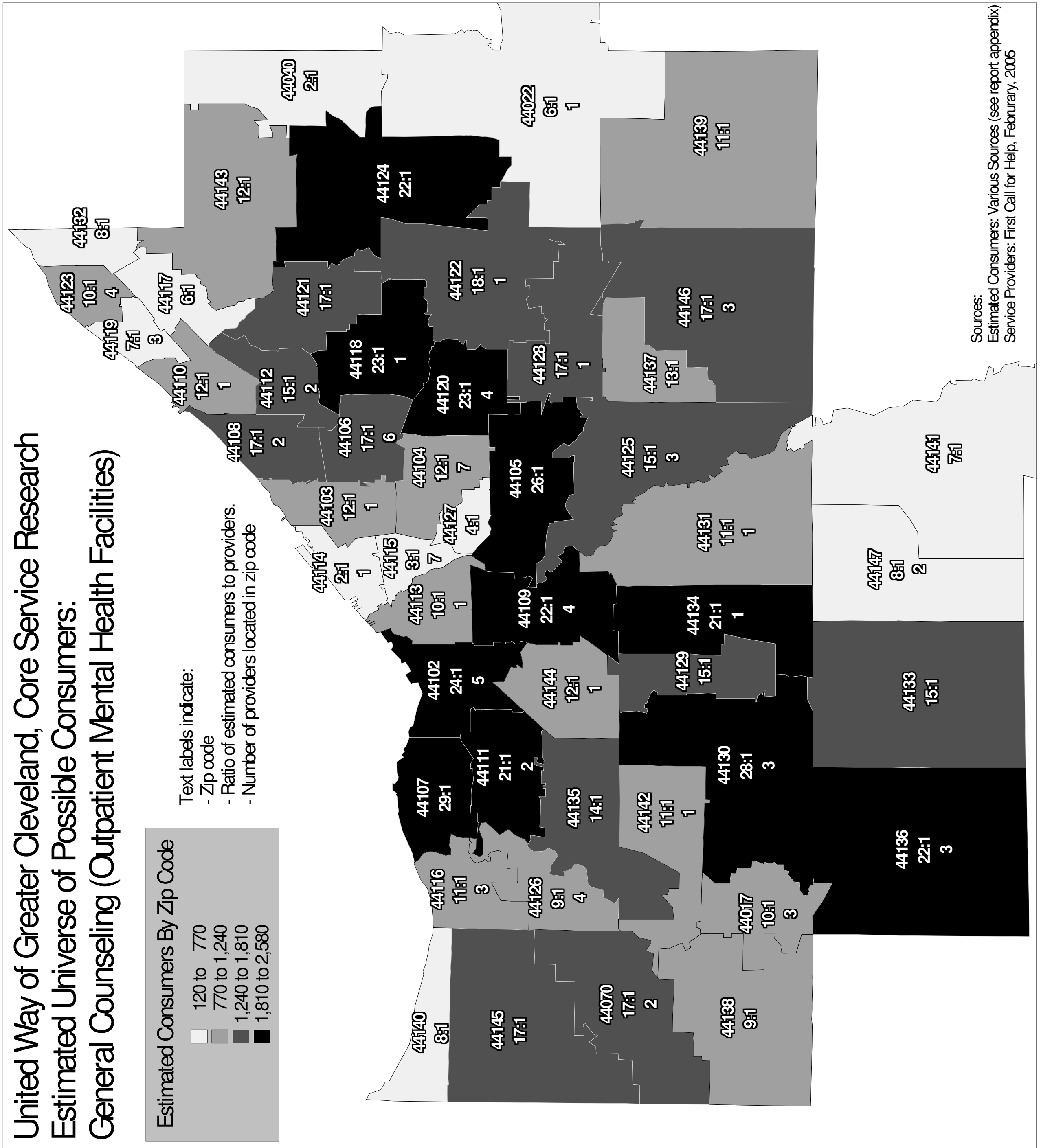
** U.S. Census 2000 SF3 (P8)

*** "Cuyahoga County Mental Health Assessment," Center for Community Services, December 2003. Rate of persons with mental health disorders 18-54, 16.5 percent, 55+, 13.2 percent. Overall: 15.4 percent of 18+ population.

**** According to the Cuyahoga County Mental Health Assessment (2003), there were 47,766 adults in need of, but not receiving this service, i.e. Would-Be Consumers. (Center for Community Solutions, 2003). Including both realized (12,530) and unrealized access (47,766), the estimated universe of possible consumers is 60,296 persons.

***** United Way - First Call for Help, February 2005

Attachment 10: Map



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