Core Service Report

Psychiatric Day Treatment

Consumer Category:
Behavioral Health Conditions

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

February 2007

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COMPANION REPORTS

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

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SNAPSHOT

AIRS Code Level I: Mental Health Care & Counseling
AIRS Code Level II: Outpatient Mental Health Care
Name of Core Service: Psychiatric Day Treatment RP-655

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

AIRS Definition: Individuals who have acute or chronic mental or emotional disturbances, who do not require full-time hospital care, but who can benefit from a structured environment for some portion of the day or week.

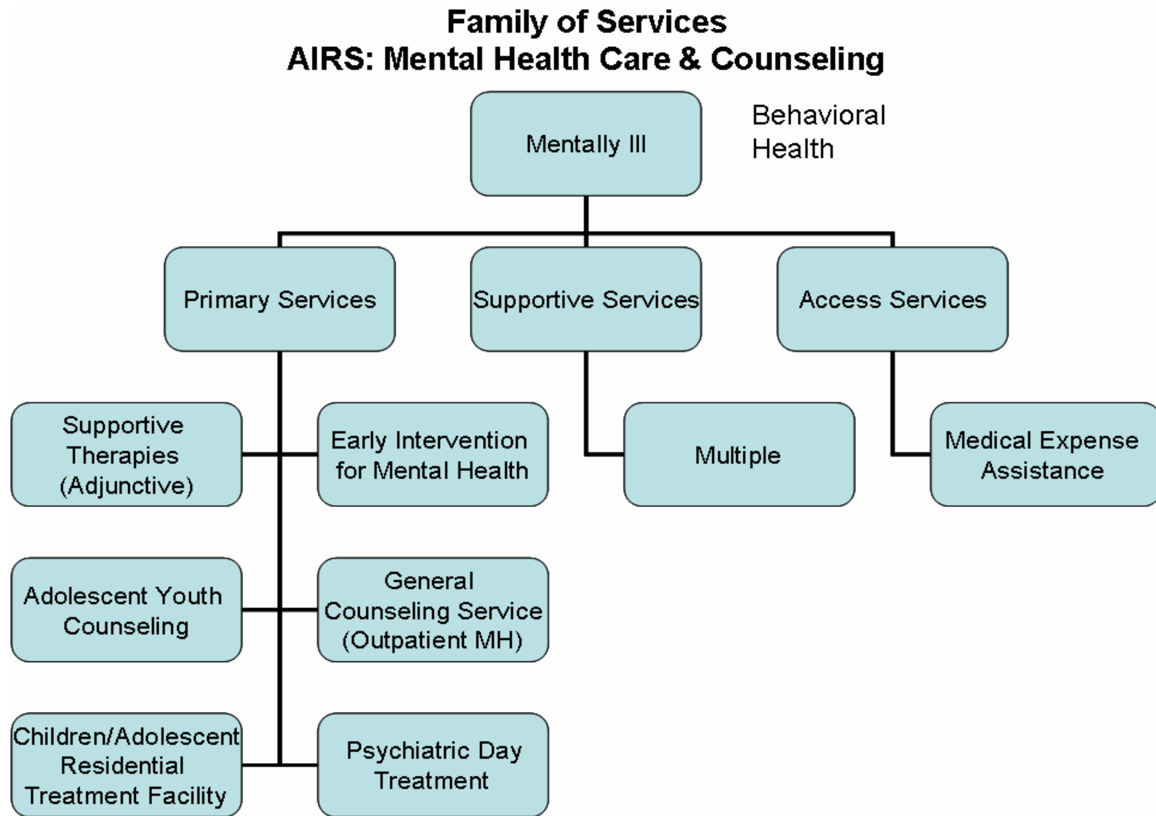
Special Note: There are six core services related to persons with or at risk of mental illness. In order to avoid as much duplication as possible across reports, the core services were organized as a continuum across the mental health services. The table below distinguishes the services by age, severity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

Core Service	Consumers		Service Description
	Age	Severity	
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.

Psychiatric Day Treatment is part of a family of services for persons who are mentally ill. 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
Psychiatric day treatment is an intensive form of intervention that is not needed by the large number of people who have comparatively mild difficulties, but it is appropriate for the smaller number of people with serious disturbances.

Acute day hospitals are among the earliest forms of psychiatric community care, but they are definitely no longer in fashion. Under managed care, psychiatric day treatment programs have been in steady decline since the 1980s, primarily because the preferred alternative to hospital admission is acute home-based care.

Medicaid seems to be the single public policy with the greatest impact on mental health services, including eligibility criteria, covered services, and reimbursement rates. Medicaid generally pays for the traditional mainstream mental health interventions such as individual and group therapy. However, both Medicaid and private insurance sometimes resist paying for components of day treatment.

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 un-manageable rise in health care costs; and 2) societal stigmas in respect to psychiatric and substance abuse disorders.

Core Service Consumers
The target population addressed in this core service report is individuals 5+ with any severe mental disorder who do not require full-time hospital care, but can benefit from a structured environment for some portion of the day or week.

Approximately 16 percent of adults 18-54 and 13 percent of adults 55 and older have mental health issues. The majority of these issues are related to anxiety and mood disorders. The primary disorders for consumers of psychiatric day treatment (partial hospitalization) are schizophrenia and personality disorders, followed by mood and anxiety disorders.

According to the Cuyahoga County Mental Health Assessment (Federation for Community Planning, 2003), approximately 5 percent of the total population of mental health consumers served (25,633) utilized partial hospitalization services. This represents approximately 1,288 individuals utilizing partial hospitalization in Cuyahoga County. These individuals received the second highest number of units of service per consumer (84.3). According to this same report males received more units than females; the highest number of units per consumer was utilized by 5-14 year olds and the second highest by 15-17 year-olds; and the majority of consumers of psychiatric day treatment in Cuyahoga County were children ages 0-17.

In 2000, an estimated 114,277 persons with either SMI or SED represented 8.8 percent of the county's 5+ population. This number is expected to decrease to 108,037 by 2015 because of population shifts.

Core Service Delivery
The definition of the core service for this report is: programs that provide therapeutic services in a structured outpatient setting for several hours of each day and multiple times per week.

Day treatment—sometimes called partial hospitalization—occupies a middle position in the continuum of care as defined by intensity of intervention, restrictiveness, quantity of time devoted to treatment, and financial expense. Day treatment stands between low-intensity interventions such as outpatient therapy and high-intensity treatment such as inpatient hospitalization. This level of intervention takes between 3 to 6 hours per day, 4 or 5 days per week. Day treatment generally involves a package of therapeutic and help-oriented activities including individual, family, and group therapy, special education, psycho-education and social skills training, vocational training and coaching, arts-related therapies, and recreational therapy. Day treatment often involves an integrated curriculum that combines education, counseling, and family intervention. The setting may be a hospital, school, or clinic. In Cuyahoga County, the Positive Education Program utilizes school settings to provide day treatment services to large numbers of youth.

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 19 psychiatric day treatment service providers at 22 locations in the Cuyahoga County area. In FY 2004 (July 2003 to June 2004), United Way funded one of the providers. Over a five-year period, from 2000 to 2004, the number of United Way - First Call for Help inquiries about psychiatric day treatment services ranged between 22 calls in FY 2000 and 40 calls in FY 2002. FCFH had 153 requests for information

about psychiatric day treatment over the five-year period. Of these requests, they were able to make referrals to 97 percent of callers.

The major sources of government funding for psychiatric day treatment are the Cuyahoga County Health and Human Services levies, the Community Mental Health Block Grant, Medicaid, Social Security Block Grant, state general revenue fund, and Temporary Assistance to Needy Families. Medicaid and private health insurance are the two largest funders of psychiatric day treatment.

Medicaid funding for all 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 psychiatric day treatment.

Government funding for psychiatric day treatment, which includes the Cuyahoga County Community Mental Health Board (CCCMHB) and the Cuyahoga County Department of Children and Family Services (DCFS), decreased in Cuyahoga County from $2.6 million in 2002 to $1.5 million in 2004.

As of May 11, 2006, over $1.7 million in revenues for psychiatric day treatment services has been identified countywide. Government funders account for 87 percent of the revenue. The United Black Fund and United Way of Greater Cleveland provide the balance of the funding.

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.

What Works; What Doesn't

It was observed that a day treatment group exhibited reduced behavior problems and improved family functioning after six months of treatment. Studies have found that family participation during and after day treatment is important for achieving and maintaining results.

It has been found that day treatment often produces better results than conventional outpatient services for people with personality disorders, perhaps because these individuals need more intensive intervention. Preliminary evidence suggests that day treatment might lead to a reduction in future health care expenses for this population.

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.

The Ohio Department of Mental Health requires organizations that provide partial hospitalization to receive appropriate behavioral health accreditation from either the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the Joint Commission on Accreditation of Healthcare Organization (JCAHO).

Gap Analysis

Multiple criteria are used to determine whether a client could benefit from psychiatric day treatment, including dangerousness of the condition, psychiatric symptoms, functioning, and treatment history. All of these variables make it difficult to estimate the universe of possible consumers for this service.

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 the least labor-intensive for providers and the 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 usually do not require interventions as restrictive and expensive as residential placement or inpatient hospitalization. Day treatment—sometimes called partial hospitalization—occupies a middle position in the continuum of care as defined by intensity of intervention, restrictiveness, quantity of time devoted to treatment, and financial expense. Day treatment stands between low-intensity interventions such as outpatient therapy and high-intensity treatment such as inpatient hospitalization. This level of intervention takes between 3 to 6 hours per day, 4 or 5 days per week.

Psychiatric day treatment is an intensive form of intervention that is not needed by the large number of people who have comparatively mild difficulties, but is appropriate for the smaller number of people with serious disturbances. Nationally representative studies indicate that during any given year approximately 5-7 percent of adults experience a serious mental illness such as schizophrenia, bipolar disorder, major depression, borderline personality disorder, and co-occurring mental illness and substance abuse, while about 5-9 percent of children have a serious emotional disturbance that impairs their functioning and development (United States Public Health Service Office of the Surgeon General, 2001).

Acute day hospitals are among the earliest forms of psychiatric community care, but they are definitely no longer in fashion. Under managed care, psychiatric day treatment programs have been in steady decline since the 1980s, primarily because the preferred alternative to hospital admission is acute home-based care. In the 1980s, new radical approaches to community care, such as assertive community treatment and acute home-based care, made day hospitals look old fashioned, stigmatizing, and, worst of all, expensive. According to a recent systematic review, home-based care is considered feasible for about 55 percent of patients who would otherwise be admitted, and it seems to reduce costs and increase satisfaction (Marshall, 2003).

However, benefits of a day hospital include the following: 1) comparatively small numbers of nurses can maintain a high level of input to substantial numbers of patients in a safe environment for one-to-one treatment; 2) doctors can be available as required; and 3) a single healthcare professional can deliver a complex treatment to several patients simultaneously through group therapy (Marshall, 2003).

PUBLIC POLICY ISSUES

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

some of the major national and state public policy issues that affect psychiatric day treatment programs.

NATIONAL

Federal Laws and Regulations

Community Mental Health Services Block Grant Program

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

Insurance Parity

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

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

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

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

The HEART Act is the companion bill to the Time for Recovery and Equal Access to Treatment in America (TREAT America) Act of 2005 which is the House version.

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

STATE

Ohio Regulations

Insurance Parity

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

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

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

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

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

Medicaid

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

The Cuyahoga County Community Mental Health Board (CCCMHB) experienced a 66 percent increase in the number of Medicaid consumers between 1995 and 2001 (Federation for Community

Planning and CCCMHB, 2003). Coupled with prior cuts in Medicaid and new cuts resulting from the Deficit Reduction Act of 2005, this increase seriously threatens the public system's ability to meet the needs of persons with mental disorders. State efforts to cut Medicaid expenses have tightened eligibility requirements, with single adults targeted for more cuts than families and children.

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

Medicaid and Family Opportunity Act

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

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

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

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

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

Mental Health Act of 1988

On March 28, 1988, Amended Substitute Ohio Senate Bill 156, now known as the Mental Health Act of 1988, was signed into law. Recognized as Ohio's most significant mental health legislation in 20

years, the act firmly established the state's commitment to a unified system of community-based services in order to address the mental health needs of Ohioans.

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

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

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

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

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

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

Mental Health Transformation State Incentive Grant

According to the Ohio Department of Mental Health (n.d.), the system for delivering services to Ohioans with mental illnesses and emotional disorders will be transformed. Ohio has been awarded $12 million by the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance system transformation planning. The Mental Health Transformation State Incentive Grant is part of the federal response to the president's New Freedom Commission on Mental Health that President Bush charged to make recommendations for improving mental health care and overcoming the fragmentation of health and mental health care. The commission's report,

"Achieving the Promise: Transforming Mental Health Care in America," was released in July 2003. As one of seven states receiving funding, Ohio will serve as a platform for learning which strategies and activities hold the most promise for transforming mental health and related systems.

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

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

The target population addressed in this core service report is individuals 5+ with any severe mental disorder who do not require full-time hospital care, but can benefit from a structured environment for some portion of the day or week.

DEMOGRAPHIC CHARACTERISTICS

According to "Mental Health: A Report of the Surgeon General" (1999): "Mental health and mental illness are not polar opposites, but may be thought of as points on a continuum." *Mental illness* refers collectively to all diagnosable mental disorders. Mental disorders are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. The surgeon general's report uses the term "mental health problems" for signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder. Almost everyone has experienced mental health problems when the distress one feels matches some of the signs and symptoms of mental disorders. Mental health problems may warrant active efforts in health promotion, prevention, and treatment.

Table 1 summarizes by type of disorder the estimated number of persons in Cuyahoga County in need of mental health services in year 2000 (Center for Community Solutions, 2003). Approximately 16 percent of adults 18-54 and 13 percent of adults 55 and older have mental health issues. The majority of these issues are related to anxiety and mood disorders. The primary disorders for consumers of psychiatric day treatment (partial hospitalization) include schizophrenia and personality disorders, followed by mood and anxiety disorders. There are also an estimated 17,990 children and youth 5 to 17 years with serious emotional disturbances. The term "serious emotional disturbance" is used in a variety of federal statutes in reference to children under the age of 18 with diagnosable mental health problems that severely disrupt their ability to function socially, academically, and emotionally. The term does not signify any particular diagnosis; rather, it is a legal term that triggers a host of mandated services to meet the needs of these children.

Table 1: National Prevalence Rates and Estimated Number of Persons 5+ in Need of Mental Health Services in Cuyahoga County, 2000

Population by Age	Total Population	Estimated Total with Disorder	% of Total
Total Population 5-17 years	**256,467**		
Any Disorder		53,712	20.94%
Anxiety Disorders		33,409	
Mood Disorders		15,934	
Disruptive Disorders		26,470	
Serious Emotional Disturbance		17,990	
Total Population 18-54 years	**708,037**		
Any Disorder		116,657	16.48%
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	13.22%
Anxiety Disorders		35,932	
Mood Disorders		11,525	
Schizophrenia		1,356	
Antisocial Personality Disorder		-	
Cognitive Impairment		6,780	
Total with Any Disorder	**1,303,066**	**215,114**	**16.5%**

Source: Cuyahoga County Mental Health Assessment, December 2003

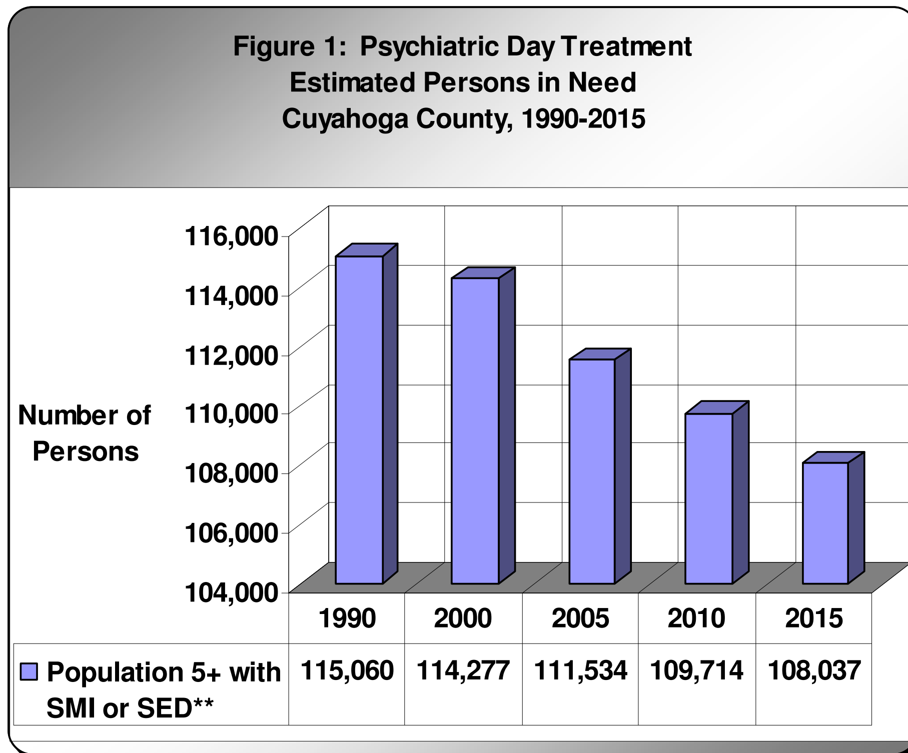
According to the Cuyahoga County Mental Health Assessment (Federation for Community Planning, 2003), approximately 5 percent of the total population of mental health consumers served (25,633) utilized partial hospitalization services. This represents approximately 1,288 individuals utilizing partial hospitalization in Cuyahoga County. These individuals, while a very small percentage of the total population of mental health consumers, received the second highest number of units of service per consumer (84.3). The only other mental health service receiving higher average units per consumer was residential care (99.3 units per consumer). According to this same report:

- Males received more units than females, 88.3 to 76.2 respectively.
- The highest number of units per consumer was utilized by 5-14 year olds (109 units per consumer). The second highest utilization by age group was 15-17 year-olds with an average of 60.6 unites per consumer. The youngest consumers, ages 0-4, averaged 58.2 units per consumer. The lowest number of units per consumer was utilized by 25-44-year-olds (43.7).
- The majority of consumers of psychiatric day treatment in Cuyahoga County were children ages 0-17.
- Approximately 7 percent of the male consumers of mental health services in Cuyahoga County utilized psychiatric day treatment, with only around 3 percent represented by females.

Estimated Persons in Need

In 2000, approximately 215,114 individuals (or 16.5 percent of the 5+ population) in Cuyahoga County were estimated to be living with a mental disorder. Nationally, according to the 2003 National Survey on Drug Use and Health, an estimated 9.2 percent of adults aged 18 or older had serious mental illness (SMI) in 2003. Rates of SMI were highest for young adults aged 18 to 25 (13.9 percent) and lowest for persons aged 50 or older (5.9 percent). The percentage of females with SMI was higher than the percentage of males (11.5 vs. 6.7 percent).

Applying the 9.2 percent to the 1,046,599 adults 18+ in Cuyahoga County results in an estimated 96,287 adults with SMI. In addition, from Table 1 above, there are approximately 17,990 children and youth with SED. This totals 114,277 persons with either SMI or SED, representing 8.8 percent of the county's 5+ population and the estimate of persons who may be in need of psychiatric day treatment. The number is expected to decrease to 108,037 by 2015 because of population shifts. (See Figure 1.)



Sources:

* US Census: 1990, STF 1 (P11); 2000, SF3 (P8); 2005-2015, Ohio Department of Development, (July, 2003).

** Nationally, according to the 2003 National Survey on Drug Use and Health, there were an estimated 9.2 percent of adults aged 18 or older with serious mental illness (SMI) in 2003. In addition, based on data from the needs assessment for mental health services in Cuyahoga County (Federation for Community Planning, 2003), there are approximately 17,990 children and youth with SED. This totals 114,277 persons 5 plus with either SMI or SED. This represents 8.77 percent of the county's 5+ population and the estimate of persons who may be in need of psychiatric day treatment.

This is likely a conservative estimate of persons in need of psychiatric day treatment programs because persons with severe mental illnesses may be seeking other treatments or are unreported, especially since mental illness is frequently associated with substance abuse. However, it is a number that begins to offer some clarity about the extent of need in Cuyahoga County.

REALIZED ACCESS TO SERVICE

Realized access to service is represented by the 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 (UW) funded 210 persons for psychiatric day treatment programs. The Cuyahoga County Mental Health Board (CCCMHB) funded 1,288 actual annual consumers in CY 2004, and these are assumed to be duplicated with UW funded consumers. (See Attachment 3.)

While 47 percent of the county's total 5+ population is male and 53 percent female, United Way funded consumers were primarily males (68 percent) and 32 percent females. There was no reported information for CCCMHB funded consumers.

An analysis of the racial and ethnic make-up of the service population indicates that 50 percent of the UW consumers were Caucasian, 48 percent were African American and 0 percent Asian. CCCMHB clients were 26 percent Caucasian, 66 percent African American, and 0.1 percent Asian. By way of comparison, 2000 Census data indicates that 68 percent of the county's total 5+ population was Caucasian, 27 percent, African American, and 2 percent Asian.

While 3 percent of the county's 5+ population are Hispanic, 1 percent of United Way funded consumers of 5 percent of CCCMHB were Hispanic.

One hundred percent of those funded by United Way reported annual household income between $0-$9,999. The majority, 69 percent, were in the age range of 35-54 years old.

Geographically, 30 percent of persons 5+ resided in Cleveland and the remaining 70 percent in the suburbs. Thirty-eight percent of United Way funded consumers 5+ resided in Cleveland and 47 percent in the suburbs. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of the core service for this report is: programs that provide therapeutic services in a structured outpatient setting for several hours of each day and multiple times per week.

BACKGROUND ON CORE SERVICE

As alluded to earlier, day treatment, sometimes called partial hospitalization, occupies a middle position in the continuum of care defined by intensity of intervention, restrictiveness, quantity of time devoted to treatment, and financial expense. Day treatment falls between lower-intensity interventions such as outpatient therapy and higher-intensity treatment such as inpatient hospitalization. This level of intervention generally involves consumers spending part of their day (between 3 and 6 hours) at a facility for approximately 4 or 5 days per week. The setting may be a hospital, school, or clinic.

Day treatment generally involves a package of therapeutic and help-oriented activities including individual, family, and group therapy, special education, psycho-education and social skills training, vocational training and coaching, arts-related therapies, and recreational therapy. The term *milieu therapy* is sometimes used to designate packages of activities that involve enough time and variety that the environment itself can be considered a means of treatment.

Partial hospitalization offers individual and group psychotherapy, social and vocational rehabilitation, occupational therapy, assistance with educational needs, and other services to help patients maintain their abilities to function at home, at work, and in social circles. However, because their treatment setting helps them to develop a support network of friends and family who can help monitor their conditions when they are not in the hospital, they can return home at night and on weekends.

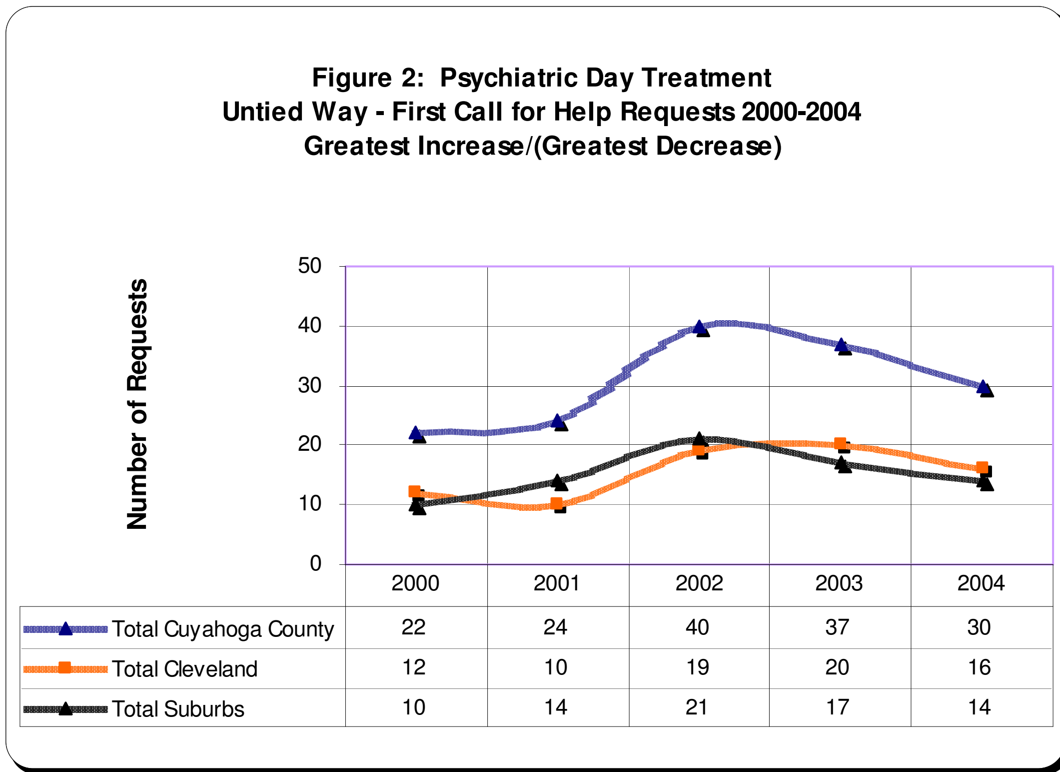
Day treatment is sometimes used as a transitional service (after either psychiatric hospitalization or residential treatment) when the person is at the point of no longer needing constant care, but is not ready to be integrated into the community. It is also used to prevent institutional placement.

United Way – First Call for Help Call Data

There are 19 psychiatric day treatment service providers at 22 locations in the Cuyahoga County area. The majority of these providers (15) are nonprofit organizations; however, there are two for-profit institutions as well as two local governments that provide these services. In FY 2004 (July 2003 to June 2004), United Way funded one of the providers. (See Attachments 5 and 6.) Many of the service providers are local hospitals. Service provision sites, while concentrated in the downtown Cleveland area and the inner-ring suburbs, can also be found in the outer suburbs.

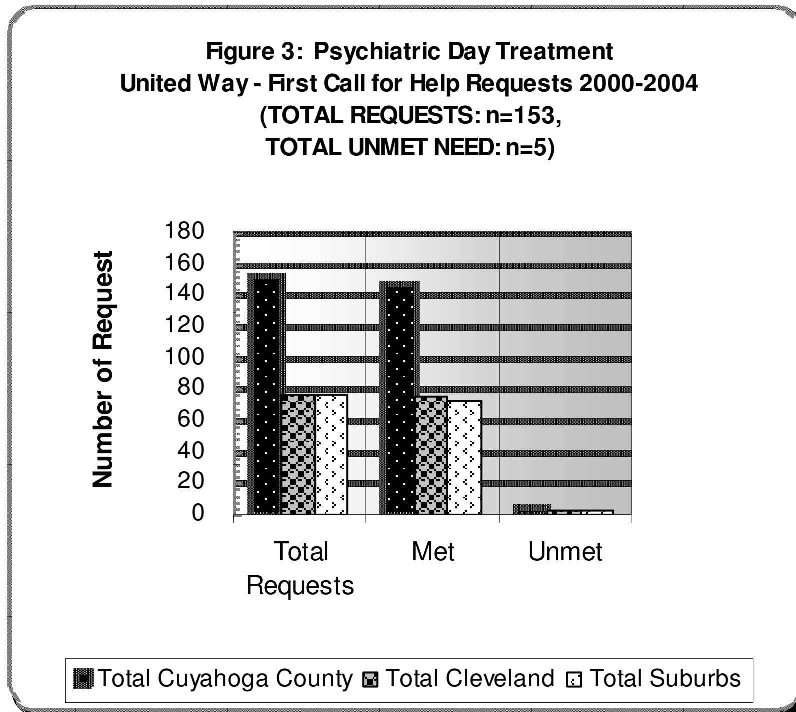
Over a five-year period, from 2000 to 2004, the number of United Way - First Call for Help inquiries about psychiatric day treatment services has ranged between 22 calls in FY2000 and 40 calls in FY 2002. In FY 2004, the last year of available data, there were 30 calls registered from Cuyahoga County. On average, the number of calls each year totaled 31 for the entire county, with an equal split (15 each) between the suburbs and the city. (See Figure 2.)

(See Attachment 7.)



	2000	2001	2002	2003	2004
Total Cuyahoga County	22	24	40	37	30
Total Cleveland	12	10	19	20	16
Total Suburbs	10	14	21	17	14

Over the same five-year period, United Way - First Call for Help had 153 requests for information about psychiatric day treatment. Of these requests, they were able to make referrals to 97 percent of callers; however, 3 percent of all Cuyahoga County callers (5) had an unmet need, meaning there was no agency to which to refer the caller. Two of the callers with unmet need were from Cleveland and 3 from the suburbs. (See Figure 3 and Attachment 8.)



FUNDING OF CORE SERVICES

Major Government Funders

In addition to private insurance, the major sources of government funding that are often blended to provide psychiatric day treatment are:

- Community Mental Health Block Grant
- Medicaid
- Social Security Block Grant
- Temporary Assistance to Needy Families
- Ohio General Revenue Fund
- Cuyahoga County Health and Human Services Levies

Medicaid and private health insurance are the two largest funders of psychiatric day treatment. Medicaid and private insurance sometimes resist paying for components of day treatment that are not traditional mental health interventions (e.g., recreation therapy), but these payers also sometimes support day treatment because of its capability to prevent hospitalizations or residential placements that would otherwise be necessary.

Below is further explanation of major funders of psychiatric day treatment.

NATIONAL

Community Mental Health Services Block Grant

The Community Mental Health Services Block Grant (CMHBG) 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. CMHBG is a formula grant which 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.

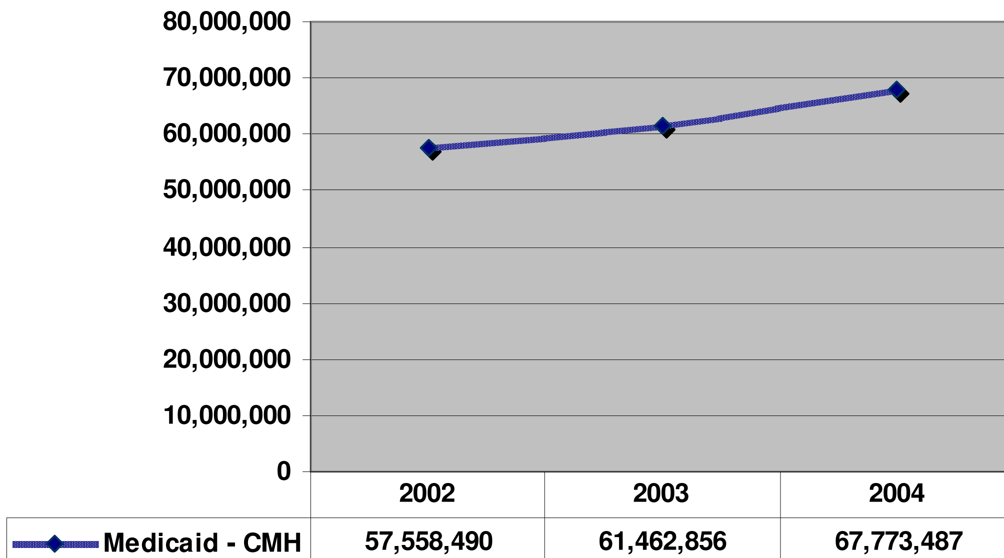
ODMH's estimated block grant award for FFY 2007 is $14,278,769, which is a slight decrease from each of the two previous years. The final block grant award for FFY 2006, after two SAMHSA modifications, was $14,333,753, and the award for FFY 2005 was $14,543,753. In a publication outlining their policy for awarding grants from the CMHBG, 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, 2006)

In 2007, Cuyahoga County received $725,075 in CMHBG funds (Ohio Department of Mental Health, n.d.).

Medicaid

Medicaid funding for all 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 psychiatric day treatment. (See Figure 4.)



* 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.

Mental health services for people with low incomes have traditionally been paid for by Medicaid. Recent (and possible future) cuts in Medicaid funding may result in reduced reimbursement rates and tightened eligibility requirements, with single adults most likely disproportionately affected.

For adults who qualify for Medicare benefits, the Medicare program will finance psychiatric day treatment as long as the treatment does not consist entirely of activity therapies that are not covered—these activities are typically recreational or diversional (DHHS). The Department of Veterans Affairs also provides psychiatric day treatment services for qualified veterans.

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. Per the Cuyahoga County Mental Health Services Title XX Services Plan, all of SSBG funds were allocated for residential treatment services (ODJFS, 2005).

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. It 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 the amount spent on psychiatric day treatment was not available at the time this report was written.

STATE

Ohio General Revenue Fund
The Ohio general revenue fund 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).

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 these levies. 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

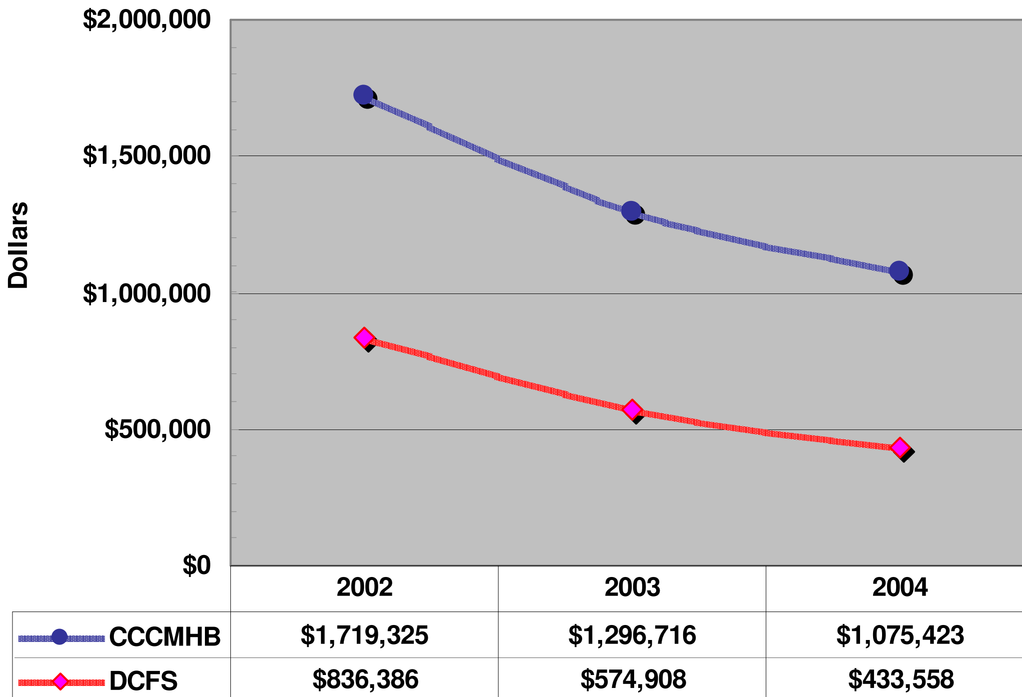
additional $27.3 million annually. The specific amount of HHS levies funds going to psychiatric day treatment programs was not available.

Other Funders

Private Insurance
Workers who are covered by employer health plans typically find that their benefits for mental health (MH) services are much more limited than those for medical or surgical care. In the case of mental health services, inpatient and outpatient treatment are most often covered by health plans. However, there is a continuum of services between inpatient and outpatient care that could effectively treat many mental disorders. These are often more cost-effective than inpatient care. These intermediate services include non-hospital residential services, partial hospitalization services, and intensive outpatient services such as case management, psychiatric day treatment, and psychosocial rehabilitation. Maximum service and dollar benefit limits may also affect access to psychiatric day treatment. Between 60 and 65 percent of service plans (including HMO, PPO, POS, and Indemnity) cover intensive nonresidential types of treatment, which includes psychiatric day treatment (SAMHSA, 2001). The total amount expended for psychiatric day treatment services from private insurance was not available.

Trends of Identified Government Funders in Cuyahoga County
Funding for psychiatric day treatment decreased in Cuyahoga County: from $2.6 million in 2002 to $1.5 million in 2004. (See Figure 5.) Monies are available from the Cuyahoga County Community Mental Health Board (CCCMHB) and the Cuyahoga County Department of Children and Family Services (DCFS).

Figure 5: Identified Government Funding for Psychiatric Day Treatment Cuyahoga County, CY 2002-2004



	2002	2003	2004
CCCMHB	$1,719,325	$1,296,716	$1,075,423
DCFS	$836,386	$574,908	$433,558

Source: Cuyahoga County Community Mental Health Board and Department of Children and Family Services

IDENTIFIED REVENUES

As of May 11, 2006, over $1.7 million in revenues for psychiatric day treatment services has been identified countywide. Cuyahoga County Community Mental Health Board and the Department of Children and Family Services account for nearly 87 percent of the county's revenue. The United Black Fund and United Way of Greater Cleveland provide the balance of the funding. (See Table 2). Because Medicaid services cross over more than one core service, we were unable to provide Medicaid dollars specific to psychiatric day treatment. It is important to note that they account for a significant portion of funding for this core service. (See Figure 4 and Table 2 footnote.)

Table 2: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland Psychiatric Day Treatment Services, 2003/2004.

		A		B	
Funder	Period	Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			**0.00%**	**7,700**	**1.17%**
Other Private Foundations - Not Elsewhere Classified				49,896	
Total - Foundations & Trusts		**0**	**0.00%**	**49,896**	**7.60%**
United Black Fund of Greater Cleveland		18,000			
Total - Federated Fundraising Organizations		**18,000**	**1.03%**	**0**	**0.00%**
Ohio Rehabilitation Services Commission				17,765	
Subtotal State of Ohio			***0.00%***	***17,765***	***2.71%***
Board of Mental Retardation and Developmental Disabilities (169 Board)				13,609	
Cuyahoga County Community Mental Health (648 Board)	2004	1,075,423		319,848	
Department of Children and Family Services	2004	433,558			
Subtotal Cuyahoga County Funding Sources		***1,508,981***	***86.60%***	***333,457***	***50.82%***
Total - Contracts/grants from government organizations		**1,508,981**	**86.60%**	**351,222**	**53.53%**
Total - Membership dues under $150			**0.00%**	**17,000**	**2.59%**
Total - All Other Revenue			**0.00%**	**14,799**	**2.26%**
Subtotal Non - UWGrCle Support		**1,526,981**	**87.63%**	**440,617**	**67.15%**
Total - UWGrCle investment committee allocation		**215,561**	**12.37%**	**215,561**	**32.85%**
Subtotal UWGrCle Support - 4001, 4701 & 4703		**215,561**	**12.37%**	**215,561**	**32.85%**
Total Support/Revenue		**1,742,542**	**100.00%**	**656,178**	**100.00%**

* 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

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.

The costs associated with day treatment vary widely depending on the amount of time involved, the staff to client ratio, and the professional level of service providers (e.g., psychologists vs. recreational therapists). Generally day treatment involves considerably greater costs than outpatient therapy and considerably less than inpatient hospitalization.

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works; What Doesn't
The term *day treatment* does not identify specific therapeutic procedures; instead, it designates a modality or setting in which such procedures can be delivered. Therefore, the effectiveness of day treatment essentially depends on the effectiveness of the therapeutic techniques delivered in this modality. Outcome studies on common individual and family therapy approaches are reviewed in the General Counseling Services (Outpatient Mental Health Facilities) and Adolescent/Youth Counseling core service reports and will not be repeated here. This report focuses on more intensive and specialized forms of intervention for the more severe forms of mental illness that are appropriately treated in day treatment settings.

The research literature suggests significant gains resulting from adolescents' use of day treatment, but most of the studies were uncontrolled. There has been documentation of benefits to academic and behavioral functioning and reduction in, or delay of, hospital and residential placement. About three-fourths of youth are reintegrated into regular school, often with the help of special education or other school- or community-based services. Several uncontrolled studies found that day treatment could prevent youth from entering other costly placements (particularly inpatient and residential treatment centers), which suggests that partial hospitalization may reduce overall costs of treatment. There has been one controlled study of intensive day treatment versus a waiting list control group of 5-12 year old children with disruptive behavior disorders. At six months post-treatment, the day treatment group exhibited reduced behavior problems and improved family functioning. Finally, studies have found that family participation during and after day treatment is important to achieving and maintaining results.

Research reviewed by Levin, Petrila, Hennessy, and Manderscheid (2004) suggests that day treatment produces significant gains for adolescent clients, although the absence of control groups in most of these studies makes it impossible to know how much progress the clients would have made in alternative forms of treatment. With this proviso, research has documented benefits to academic and behavioral functioning and reduction, or at least delay, of hospital and residential placement. About three fourths of youth in day treatment are eventually reintegrated into regular school, often with the help of special education or other school- or community-based services.

Currently, the concept of recovery is a guiding principle in much empirically grounded work with individuals suffering from severe mental illness (Rogers, Farkas, & Anthony, 2005). The concept of recovery has three main components. First there is the idea, which is grounded in research, that the course of severe mental illnesses such as schizophrenia is not inevitably defined by deterioration, and many people with these illnesses rebound and go on to function successfully (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987). Second, recovery is viewed as a fluid, long-term, perhaps never-ending process of striving to overcome illness and improve quality of life, rather than a discrete event corresponding to the notion of cure. Finally, recovery is viewed as a multi-dimensional process that involves more than symptom reduction; even if the illness remains, recovery is still said to occur if the person improves his or her adaptation to the disability, psychosocial functioning, and quality of life. The concept of recovery does not designate one specific intervention, but is a

broad guiding principle that shapes much current, empirically supported work with severe mental illness.

Current psychosocial treatments for severe mental illness are not primarily organized around the goal of cure, or complete cessation of the illness; instead they are oriented toward the goals of maximizing self-control and quality of life while helping the client learn to manage the effects of the illness (Dixon and Goldman, 2004; Drake, Green, Mueser, & Goldman, 2003). Unlike older, psychoanalytic approaches, which have not accumulated empirical support with this population, there is no emphasis on delving into emotional conflicts or past traumatic experiences. Instead, research-based interventions educate the client (and often his or her family) about the nature of mental illness and strategies for coping with it. Often, there is group work with peers. Families are invited to support and collaborate with the client's coping efforts. The substance abuse that frequently co-occurs with mental illness is often an important target of intervention.

The term *psychosocial rehabilitation* refers to programs that help people with serious and persistent mental illness develop the capabilities they need to live successfully in the community. This form of intervention acknowledges the chronic nature of serious mental illnesses, which usually can be controlled but often cannot be cured by current treatments. Psychosocial rehabilitation helps people function more effectively while living with their illness by providing resources and training in psychosocial skills. Specific services include training in independent living, social skills training, psychological support, psychoeducation for family members, housing assistance, vocational training and support, and access to leisure activities. Meta-analyses by Barton (1999) and Dilk and Bond (1996) found that psychosocial rehabilitation produces a range of positive results for individuals with severe mental illness, with demonstrated improvements in psychiatric symptoms, social skills, cognitive functioning, and quality of life. Effect sizes were generally in the medium range. Employment gains have proved more difficult to achieve than the changes listed above. The Clubhouse Model is an empirically supported form of psychosocial rehabilitation that builds networks of both peer and professional supports for clients on a long-term basis (Bond, Drake, Becker, & Mueser, 1999).

Personality disorders comprise a level of mental disturbance that is less severe than psychotic disorders, but is considerably more severe than common anxiety and depressive disorders. A review of outcome research by Ogrodniczuk and Piper (2001) found that day treatment often produces better results than conventional outpatient services for people with personality disorders, perhaps because these individuals need more intensive intervention. Preliminary evidence suggests that day treatment might lead to a reduction in future health-care expenses for this population.

IMPACT ON COMMUNITY

Barton (1999) reviewed evidence that psychosocial rehabilitation produces cost savings, mostly by reducing client psychiatric hospitalizations. His meta-analysis of 14 cost-effectiveness studies found that for every dollar invested in these programs, $1.61 in future savings was achieved.

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.

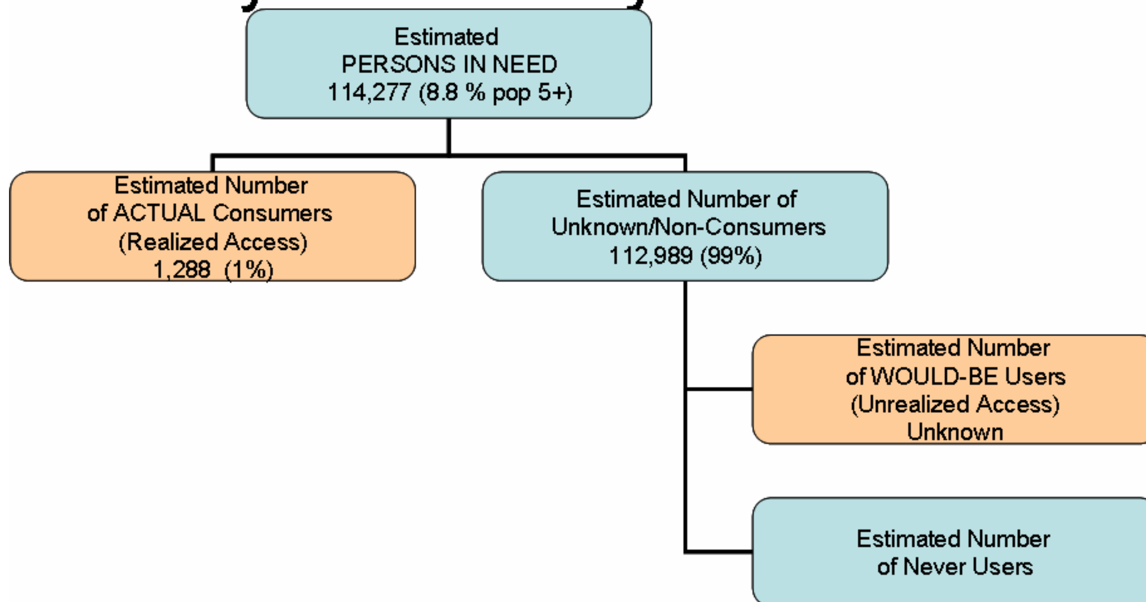
The Ohio Department of Mental Health requires organizations that provide partial hospitalization (the ODMH certified service term for psychiatric day treatment) to receive appropriate behavioral health accreditation from either the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the Joint Commission on Accreditation of Healthcare Organization (JCAHO). ODMH has additional regulations, including standards for minimum duration of sessions.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Psychiatric Day Treatment:

- An estimated 114,277 persons age 5 and older are suffering from severe mental illness and could benefit from psychiatric day treatment. Nationally, according to the 2003 National Survey on Drug Use and Health, an estimated 9.2 percent of adults aged 18 or older had serious mental illness (SMI) in 2003. Applying the 9.2 percent to the 1,046,599 adults 18+ in Cuyahoga County results in an estimated 96,287 adults with SMI. In addition, there are approximately 17,990 children and youth with SED. This totals 114,277 persons with either SMI or SED, and the estimate of persons who may be in need of psychiatric day treatment. (96,287 + 17,990 = 114,277)

- Available data indicates that United Way of Greater Cleveland funded 210 persons, while the Cuyahoga County Community Mental Health Board served 1,288 persons in FY 2004. It is assumed that there is duplication across the two funding sources, with realized access at 1,288. (See Figure 6.)



While the above number is an estimate of the outer boundary of potential consumers of day treatment (i.e., those with SED or SMI), there are other considerations. For example, partial hospitalization or day treatment works best for people whose symptoms are under control. They enter care directly from the community or after being discharged from 24-hour care. It is most

effective for patients who are ready for the therapy and rehabilitation that can move them comfortably back into the community.

The State of North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (n.d.) has a protocol entitled "Adult Levels of Care for Psychiatric Diagnoses" that provides a framework for considering authorization of medically necessary services for adults who are certified for Medicaid and in need of treatment for psychiatric disorders. There is likely a similar protocol for children and youth. For day treatment, partial hospitalization, or psychiatric rehabilitation services, the following criteria are utilized for adults:

- **Dangerousness**
  Due to psychiatric symptoms, there is current suicidal/homicidal ideation or aggression but without intent or a conscious plan to carry out and with the ability to contract for safety.

  OR

  Due to psychiatric symptoms, there is a fluctuating inability for self care to the extent that it moderately compromises the consumer's physical well-being.

OR

- **Psychiatric Symptoms**
  There is evidence of psychosis, a cognitive or affective disorder, but the consumer is able to cooperate with treatment.

OR

- **Functioning**
  A Global Assessment of Functioning (GAF) score of 31-50.

AND

- **Treatment History**
  An adequate trial of active treatment at a less restrictive level has been unsuccessful.

  OR

  The consumer is clearly inappropriate for a trial of less restrictive services.

All of these variables make it difficult to estimate the universe of possible consumers for this service. Much has to do with assessment and factors very unique to a family and its member with a mental illness.

Service Capacity

When looking at adults with severe mental disabilities in general, the following are the findings from a needs assessment of mental health services in Cuyahoga County (Federation for Community Planning, 2003).

> The emphasis for adults is also on those who are the most severely mentally disabled. Schizophrenia is the only diagnostic group for which more than half of those estimated to be in need are being served. There are almost as many consumers with major affective disorders as with schizophrenia that are being served. Because of the higher rate of prevalence for these disorders, however, the percentage of the estimated need being met for those with major affective disorders is about half of that for schizophrenia. Persons with bipolar and major depressive disorders make up most of this diagnostic group.
>
> These two diagnostic groups account for the vast majority of the consumers being served by the public system. The system serves the most severely disabled, almost to the exclusion of others. The small number of persons with a diagnosis of personality disorder is most likely due to the fact that these diagnoses are not generally the ones that are indicated as primary diagnoses. There is most likely a high degree of co-morbidity with both schizophrenia and major affective disorders. Cognitive impairment is primarily found among the elderly population. The elderly are under-represented in these analyses because their services are often paid through Medicare.

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

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

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

VII. SUMMARY

The following are the major findings from the research on psychiatric day treatment:

- Acute day hospitals are among the earliest forms of psychiatric community care, but they have been in steady decline since the 1980s, primarily because the preferred alternative to hospital admission is acute home-based care.
- Medicaid seems to be the single public policy with the greatest impact on mental health services, including eligibility criteria, covered services, and reimbursement rates.
- 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 funding for all community mental health services has increased from $57.6 million in 2002 to $67.8 million in 2004.
- In Cuyahoga County, identified government funding for psychiatric day treatment decreased from $2.6 million in 2002 to $1.5 million in 2004.
- As of May 11, 2006, over $1.7 million in revenues for psychiatric day treatment services has been identified countywide. This excludes Medicaid funding.
- Studies have found that family participation during and after day treatment is important for achieving and maintaining results.
- It has been found that day treatment often produces better results than conventional outpatient services for people with personality disorders.

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ATTACHMENTS

Attachment 1: Researcher List

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Attachment 2: Technical Notes

Technical Notes:
Methodology, Caveats, Limitations of Data

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

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

Unit of Analysis

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

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

United Way - First Call for Help Data

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

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

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

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

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

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

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

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

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

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

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

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

Funding Information for Core Services

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

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

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

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

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

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

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

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

Entered as Aggregate Total Under Appropriate AIRS Level

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

Entered as Aggregate Total Under Third Party Payee/Direct Bill

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

United Way of Greater Cleveland Funding
Financial data for core services funded by United Way of Greater Cleveland was for FY 2004 (July 2003 to June 2004). It included allocations through the community investment committees and donor designations that United Way funded agencies applied to the respective core services. It is important to note that not all United Way funded agencies applied donor designated gifts, which are

unrestricted, to the core service for which they receive United Way funding. It did not include donor designations that non-United Way funded agencies used for any of the 80 core services.

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

Consumer and Financial Data: Caveats

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

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

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

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

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

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

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

Gap Analysis Methodology & Limitations

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

- *Estimate of persons in need of the service*: Unless local research was conducted to determine need for a given service, this estimate was obtained by either using U.S. Census data for Cuyahoga County or applying percentages from national studies and reports to the census data. All references and percentages are footnoted in the respective graphs or tables. In most cases this percentage was also applied to actual 1990 Census figures and population projections 2005 through 2015 that were done by the Ohio Department of Development.
- *Estimate of number of ACTUAL consumers in the public systems (realized access):* Data submitted to United Way by funded agencies was aggregated to determine the number of consumers for each core service. The period was FY 2004, which is July 2003 through July 2004.
  - In some cases data was "unknown," defined as data not collected by agency because no tracking system was available or the type of service delivered made it difficult (i.e., group presentations, telephone information and referral, and drop-ins). This also represents data not completed by consumers either deliberately or inadvertently on intake forms.
  - In other cases, data was missing that, for United Way data, represented computational errors or incorrect completion of online reports. For all other data, "missing" represents data funders/providers were unable to provide.
  - There was no check of the accuracy of data submitted by agencies.
  - Major government funders were asked to provide information about the number of consumers for the respective core services that they funded. In most cases, services were not defined in the same way as the United Way core services which are based on the Alliance for Information and Referral Systems (AIRS) taxonomy. To accommodate these differences, customized crosswalks were developed.
  - We assumed that the numbers of consumers across funding sources were not unduplicated and thus made a judgment about which numbers would be the best estimate of an unduplicated number.
  - The estimate of consumers is not inclusive since it does not include numbers of consumers who use their personal resources to pay for services, nor for other private resources such as insurance or agency fundraising. In addition, it was not always possible to obtain information from some government funders.
- *Estimate of number of "unknown/non-consumers":* This is the difference between the estimated number of actual consumers and the estimate of persons in need.
- *Estimate of number of "would-be users" (unrealized access)*: This is the estimate of persons who would use a service if it were available, typically based on research.
- *Estimate of number of "never users":* This is the difference between the estimated number of unknown/non-consumers and would-be users.

- *Estimate of "universe of possible consumers":* This is the total of those actually receiving the service (realized access) and those would-be users (unrealized access).

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

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

Service Site Index

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

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

Specific Service Issues

Senior Services

"Senior Centers" was used as a catch-all category when the funder-defined service covered more than one senior success core service and could not be accurately allocated among the separate core services. Often, funding for transportation and home-delivered meals was not broken out from

senior activities and supportive services at the municipal level, so it was placed under Senior Centers. Because the core services for congregate and home-delivered meals and senior ride were tracked separately, funding for these core services was not included under Senior Centers to avoid duplication of resources, even though senior center activities can and do include congregate meals.

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

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

References

Anderson, Ronald M. (1995, March). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior,* 36(1): 1-10.

Wan, Thomas T. H., Odell, Barbara Gill, & Lewis, David T. (1982). *Promoting the well-being of the elderly: A community diagnosis.* New York: The Halworth Press.

Attachment 3: Actual Consumer Demographics

Core Service: Psychiatric Day Treatment RP-655						
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****		
	Total Population (%)*	Total Population 5+ (%)**	Population 5+ with SED or SMI (%)***	UW Program Report Data Cuy Cnty Only 100% (%)	CCCMHB (%)	DCFS (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	7/1/2003-6/30/2004	7/1/2003-6/30/2004
TOTAL	**1,393,978**	**1,303,066**	**114,277**	**210**	**1,288**	**MISSING**
Percent		**93.5%**	**8.8%**			
GENDER						
Male	47.2%	47.0%	N/A	68.1%	0.0%	0.0%
Female	52.8%	53.0%	N/A	31.9%	0.0%	0.0%
Unknown Data*****				0.0%	0.0%	0.0%
Missing Data******				0.0%	100.0%	100.0%
RACE*****						
White alone	67.1%	67.8%	N/A	50.0%	25.7%	0.0%
Black or African American alone/combination	27.9%	27.4%	N/A	48.1%	66.1%	0.0%
Asian alone/combination	2.1%	2.1%	N/A	1.0%	0.4%	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.7%	N/A	0.0%	0.1%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.1%	N/A	0.0%	0.0%	0.0%
Some other race alone/combination	2.1%	2.0%	N/A	1.0%	0.0%	0.0%
Unknown Data*****				0.0%	2.2%	0.0%
Missing Data******				0.0%	0.0%	100.0%
HISPANIC********	3.3%	3.2%	N/A	1.0%	4.8%	0.0%
AGE						
0-4	6.5%		N/A	0.0%	0.0%	0.0%
5-9	7.3%	7.8%	N/A	0.0%	0.0%	0.0%
10-14	7.1%	7.6%	N/A	0.0%	0.0%	0.0%
15-19	6.4%	6.8%	N/A	0.5%	0.0%	0.0%
20-34	19.1%	20.4%	N/A	13.3%	0.0%	0.0%
35-54	29.3%	31.4%	N/A	69.0%	0.0%	0.0%
55-64	8.7%	9.3%	N/A	16.2%	0.0%	0.0%
65-74	7.8%	8.3%	N/A	1.0%	0.0%	0.0%
75+	7.8%	8.4%	N/A	0.0%	0.0%	0.0%
Unknown Data*****				0.0%	0.0%	0.0%
Missing Data******				0.0%	100.0%	100.0%
INCOME*********						
Average Household Size	**2.4**	**N/A**	**N/A**			
$0-$9,999	11.3%	N/A	N/A	100.0%	0.0%	0.0%
$10,000-$14,999	6.9%	N/A	N/A	0.0%	0.0%	0.0%
$15,000-$19,999	6.7%	N/A	N/A	0.0%	0.0%	0.0%
$20,000-$29,999	13.6%	N/A	N/A	0.0%	0.0%	0.0%
$30,000 and above	61.5%	N/A	N/A	0.0%	0.0%	0.0%
Unknown Data*****				0.0%	0.0%	0.0%
Missing Data******				0.0%	100.0%	100.0%
Totals	**100.0%**	**N/A**	**N/A**	**100.0%**	**100.0%**	**100.0%**

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1); SF4 (PCT 144)
** U.S. Census 2000, SF3 (P8), SF3 (PCT26); SF4 (PCT69)
*** Nationally, according to the 2003 National Survey on Drug Use and Health, there were an estimated 9.2 percent of adults aged 18 or older with serious mental illness (SMI) in 2003. In addition, based on data from the needs assessment for mental health services in Cuyahoga County (Federation for Community Planning, 2003), there are approximately 17,990 children and youth with SED. This totals 114,277 persons 5 plus with either SMI or SED. This represents 8.77 percent of the county's 5+ population and the estimate of persons who may be in need of psychiatric day treatment.
****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: Psychiatric Day Treatment RP-655							
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****		
	City/Town (% Cleveland)	Total Population (%)*	Total Population 5+ (%)**	Population 5+ with SED or SMI (%)***	UW Program Report Data (%)	CCCMHB (%)	DCFS (%)
Period		1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	7/1/2003-6/30/2004	2004
TOTAL		1,393,978	1,303,066	114,277	210	1,288	MISSING
Percent			93.5%	8.8%			
44017	Berea	1.4%	1.4%	N/A	0.0%	0.0%	0.0%
44022	Bentleyville	1.3%	0.8%	N/A	1.9%	0.0%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	0.2%	N/A	0.0%	0.0%	0.0%
44070	North Olmsted	2.4%	2.5%	N/A	0.0%	0.0%	0.0%
44101	Cleveland (100%)	0.0%	0.0%	N/A	0.0%	0.0%	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	3.7%	N/A	5.2%	0.0%	0.0%
44103	Cleveland (100%)	1.8%	1.8%	N/A	3.3%	0.0%	0.0%
44104	Cleveland (100%)	2.1%	2.0%	N/A	0.5%	0.0%	0.0%
44105	Cleveland/NewburghHts/GarfieldHts	3.9%	3.9%	N/A	3.8%	0.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	2.3%	N/A	6.7%	0.0%	0.0%
44107	Lakewood/Cleveland	4.0%	4.1%	N/A	3.8%	0.0%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	2.6%	N/A	2.9%	0.0%	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.2%	N/A	4.8%	0.0%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	1.9%	N/A	2.9%	0.0%	0.0%
44111	Cleveland (100%)	3.1%	3.0%	N/A	2.4%	0.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	2.3%	N/A	5.2%	0.0%	0.0%
44113	Cleveland (100%)	1.4%	1.4%	N/A	1.4%	0.0%	0.0%
44114	Cleveland (100%)	0.3%	0.3%	N/A	0.0%	0.0%	0.0%
44115	Cleveland (100%)	0.6%	0.5%	N/A	0.5%	0.0%	0.0%
44116	Rocky River	1.5%	1.5%	N/A	1.4%	0.0%	0.0%
44117	Euclid/Cleveland	0.9%	0.9%	N/A	0.5%	0.0%	0.0%
44118	ClevelandHts/UniversityHts/ShakerH	3.2%	3.3%	N/A	4.8%	0.0%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	1.0%	N/A	1.9%	0.0%	0.0%
44120	Shaker Hts/Cleveland	3.4%	3.3%	N/A	6.7%	0.0%	0.0%
44121	University Hts/South Euclid	2.5%	2.5%	N/A	4.3%	0.0%	0.0%
44122	Beachwood/Highland	2.5%	2.6%	N/A	1.9%	0.0%	0.0%
44123	Euclid	1.3%	1.3%	N/A	1.4%	0.0%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	3.0%	N/A	0.0%	0.0%	0.0%
44125	Valley View/Garfield Hts	2.1%	2.2%	N/A	1.0%	0.0%	0.0%
44126	Fairview Park/Cleveland	1.2%	1.2%	N/A	0.0%	0.0%	0.0%
44127	Cleveland (100%)	0.6%	0.6%	N/A	0.5%	0.0%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.4%	N/A	3.8%	0.0%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	2.1%	N/A	1.9%	0.0%	0.0%
44130	Parma/Cleveland	3.8%	3.9%	N/A	0.5%	0.0%	0.0%
44131	Independence/Seven	1.5%	1.5%	N/A	0.0%	0.0%	0.0%
44132	Euclid	1.1%	1.1%	N/A	1.4%	0.0%	0.0%
44133	North Royalton	2.0%	2.1%	N/A	0.0%	0.0%	0.0%
44134	Parma/Cleveland	2.9%	2.9%	N/A	0.5%	0.0%	0.0%
44135	Cleveland/Linndale (90%)	2.0%	2.0%	N/A	1.0%	0.0%	0.0%
44136	Strongsville	3.1%	3.2%	N/A	0.5%	0.0%	0.0%
44137	Maple Hts/Cleveland	1.9%	1.9%	N/A	1.0%	0.0%	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	N/A	0.0%	0.0%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	1.6%	N/A	0.5%	0.0%	0.0%
44140	Bay Village	1.1%	1.2%	N/A	0.5%	0.0%	0.0%
44141	Brecksville	1.0%	1.0%	N/A	0.0%	0.0%	0.0%
44142	Brookpark/Cleveland	1.5%	1.5%	N/A	0.0%	0.0%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	1.7%	N/A	1.0%	0.0%	0.0%
44144	Brooklyn/Cleveland	1.6%	1.6%	N/A	0.5%	0.0%	0.0%
44145	Westlake	2.3%	2.3%	N/A	0.5%	0.0%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.3%	N/A	1.0%	0.0%	0.0%
44147	Broadview Hts	1.1%	1.1%	N/A	0.0%	0.0%	0.0%
44149	Strongsville			N/A	0.5%	0.0%	0.0%
Unknown Cuyahoga County Zip Codes******					15.7%	0.0%	0.0%
Missing*****					0.0%	100.0%	100.0%
Unknown ******					0.0%	0.0%	0.0%
Total Cuyahoga County*******		**100.0%**	**100.0%**	**N/A**	**100.0%**	**0.0%**	**0.0%**
Total Known Cleveland		**30.5%**	**30.2%**	**N/A**	**37.6%**	**0.0%**	**0.0%**
Total Known Suburbs		**69.5%**	**69.8%**	**N/A**	**46.7%**	**0.0%**	**0.0%**
Unknown & Missing					**0.0%**	**100.0%**	**100.0%**

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S. Census 2000, SF1 (P1)
** U.S. Census 2000, SF3 (P8)
*** Nationally, according to the 2003 National Survey on Drug Use and Health, there were an estimated 9.2 percent of adults aged 18 or older with serious mental illness (SMI) in 2003. Applying the 9.2 percent to adults 18+ in Cuyahoga County (1,046,599) results in an estimated 96,287 adults with SMI. In addition, based on data from the needs assessment for mental health services in Cuyahoga County (Federation for Community Planning, 2003), there are approximately 17,990 children and youth with SED. This totals 114,277 persons 5 plus with either SMI or SED. This represents 8.77 percent of the county's 5+ population and the estimate of persons who may be in need of psychiatric day treatment.
**** 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	19	1
Number of Providers by Type		
Nonprofit	15	1
For-profit	2	-
Government	2	-
Other	-	-
Total Number of Sites	22	2
Number of Service Sites per Provider		
1	16	-
2 – 5	3	1
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	1	-
44022 – Bentleyville	1	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	-	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	2	1
44103 – Cleveland	-	-
44104 – Cleveland	-	-
44105 – Newburgh Hts/Garfield Hts	-	-
44106 – Cleveland Hts/Cleveland	1	-
44107 – Cleveland/Lakewood	1	-
44108 – Cleveland/East Cleveland	-	-
44109 – Cleveland/Brooklyn Hts	2	1
44110 – Cleveland/Bratenahl	-	-
44111 – Cleveland	1	-
44112 – Cleveland/East Cleveland	-	-
44113 – Cleveland	2	-
44114 – Cleveland	-	-
44115 – Cleveland	2	-
44116 – Rocky River	-	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	1	-
44119 – Cleveland/Euclid	-	-
44120 – Cleveland/Shaker Hts	1	-
44121 – University Hts/South Euclid	-	-
44122 – Orange/Warrensville Hts	1	-
44123 – Euclid	-	-
44124 – Pepper Pike/Mayfield Village	1	-
44125 – Valley View/Garfield Hts	1	-
44126 – Cleveland/Fairview Park	-	-
44127 – Cleveland	-	-

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
44128 – Cleveland/Warrensville Hts	-	-
44129 – Cleveland/Brooklyn/Parma	-	-
44130 – Cleveland/Parma	1	-
44131 – Seven Hills/Brooklyn Hts	-	-
44132 – Euclid	-	-
44133 – North Royalton	-	-
44134 – Parma/Cleveland	1	-
44135 – Cleveland/Linndale	-	-
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	-	-
44144 – Brooklyn/Cleveland	-	-
44145 – Westlake	1	-
44146 – Walton Hills/Oakwood/Bedford	-	-
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	Youth Day Treatment
Beech Brook	School And Activities For Emot. Disturbed Children
Bellefaire Jewish Children's Bureau	After-School Partial Hospitalization Program
Benjamin Rose	Adult Day Care And Partial Hospitalization
Berea Children's Home And Family Services	Partial Hospitalization - Emotionally Disturbed Youth, Psychiatric Treatment - Children
Bridgeway, Inc.	Temporary Psychiatric Crisis Stabilization; Psychiatric case management for young adults
Catholic Charities Services Of Cuyahoga County	Partial Hospitalization - Youth
Cleveland Christian Home	Residential Treatment And Partial Hospitalization Services
Far West Center	Partial Hospitalization
Lakewood Hospital	Mental Health - Psychiatric Services - Outpatient
Laurelwood Hospital	Mental Health - Psychiatric Services
Marymount Hospital	Behavioral Health Center
Metrohealth Medical Center	Partial Hospitalization
Murtis H. Taylor Multi-Service Center	Partial Hospitalization
Positive Education Program	Day Treatment Centers
Recovery Resources	Mental Health - Treatment For Substance Abusers, Mental Health - Treatment And Case Management
Southwest General Health Center	Mental Health - Psychiatric Services
United States Dept. Of Veterans Affairs	Mental Health - Psychological/Psychiatric Treatment
Windsor Hospital	Mental Health - Psychiatric Services

Bold represents agencies funded by United Way for this service.

Attachment 7: United Way - First Call for Help Psychiatric Day Treatment Requests – 2000-2004: Greatest Increase/Greatest Decrease

RP-655 Psychiatric Day Treatment

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**
44146	Walton Hills/Oakwood/Bedford	1	0	0	1	3	200%	1
44102	Cleveland/Brooklyn	1	0	1	3	2	100%	1
44134	Parma/Cleveland	1	0	3	0	2	100%	1
44136	Strongsville	1	1	0	0	2	100%	1
44109	Cleveland/Brooklyn Hts	2	1	1	1	3	50%	2
44111	Cleveland	0	3	4	3	4	N/A	3
44130	Parma/Cleveland	0	2	0	1	4	N/A	1
44127	Cleveland	0	1	1	0	2	N/A	1
44103	Cleveland	0	1	1	2	1	N/A	1
44104	Cleveland	0	0	0	1	1	N/A	N/A
44114	Cleveland	0	0	0	3	1	N/A	1
44070	North Olmsted	0	0	0	2	1	N/A	1
44138	Olmsted Twp/Olmsted Falls	0	0	0	1	1	N/A	N/A
44106	Cleveland/Cleveland Hts	1	0	1	1	0	(100%)	1
44110	Cleveland/East Cleveland	2	2	0	3	0	(100%)	1
44135	Cleveland/Linndale	2	1	2	1	0	(100%)	1
44105	Cleveland/NewburghHts/GarfieldHts	2	0	1	1	0	(100%)	1
44143	Highland Hts/Richmond Heights	1	0	0	0	0	(100%)	N/A
44107	Lakewood/Cleveland	2	0	1	0	0	(100%)	1
44137	Maple Hts/Cleveland	2	0	0	0	0	(100%)	N/A
44121	University Hts/South Euclid	1	0	1	0	0	(100%)	N/A

	2000	2001	2002	2003	2004	%Change	Avg.
****Total Cuyahoga County**	**22**	**24**	**40**	**37**	**30**	**36%**	**31**
****Total Cleveland**	**12**	**10**	**19**	**20**	**16**	**33%**	**15**
****Total Suburbs**	**10**	**14**	**21**	**17**	**14**	**40%**	**15**

* 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 Psychiatric Day Treatment Request - 2000-2004: Unmet Need

RP-655 Psychiatric Day Treatment United Way - First Call for Help Requests 2000-2004 Unmet Need					
Zip Code		TOTALS 00-04			%
		Requests	Met	Unmet	Unmet
44117	Euclid/Cleveland	1	0	1	100%
44137	Maple Hts/Cleveland	2	1	1	50%
44127	Cleveland	4	3	1	25%
44146	Walton Hills/Oakwood/Bedford	5	4	1	20%
44109	Cleveland/Brooklyn Hts	8	7	1	13%

***Total Cuyahoga County**	**153**	**148**	**5**	**3%**
***Total Cleveland**	**77**	**75**	**2**	**3%**
***Total Suburbs**	**76**	**73**	**3**	**4%**

FCFH DATA NOTES

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

Unmet = service request for which there was no referral.

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

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

**United Way of
Greater Cleveland**

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