

Core Service Report

Supportive Therapies

Consumer Category:
Behavioral Health Conditions

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



February 2007

TABLE OF CONTENTS

Companion Reports	ii
Acknowledgements	ii
Snapshot	iii
I. Foreword	1
Introduction	1
Methodology	1
II. The Core Service Environment	3
Core Service Environment.....	3
Public Policy Issues	4
III. The Core Service Consumers	9
Definition Of Target Population.....	9
Demographic Characteristics.....	9
Realized Access To Service	12
IV. Core Service Delivery	14
Core Service Definition	14
Background On Core Service	14
Funding Of Core Services.....	19
Identified Revenues	20
Reimbursement/Cost	21
V. What Works; What Doesn't	23
Impact On Individuals/Families	23
Impact On Community	25
Accreditations/Standards/Certifications	25
VI. Gap Analysis	27
VII. Summary	28
References	29
Attachments	32
Attachment 1: Researcher List	32
Attachment 2: Technical Notes.....	33
Attachment 3: Actual Consumer Demographics.....	41
Attachment 4: Actual Consumer Zip Codes.....	43
Attachment 5: Profile Of Core Service Providers – 2005	45
Attachment 6: Providers And Functions – 2005	47
Attachment 7: United Way - First Call For Help Requests – 2000-2004	48
Attachment 8: United Way - First Call For Help Requests – 2000-2004: Unmet Need.....	49

COMPANION REPORTS

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

ACKNOWLEDGEMENTS

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

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

Suggested Citation: MCS Consulting Service. (2007). Core service report: Supportive therapies. United Way of Greater Cleveland. Available at <http://uws.org>

SNAPSHOT

AIRS Code Level I: R – Mental Health Care & Counseling

AIRS Code Level II: RM RB – Supportive Therapies

Core Service: Supportive Therapies RB

Investment Committee: Strong Families = Successful Children

Cluster: Mental Health/Counseling

AIRS Definition: Programs that utilize guided expressive or recreational activities, dietary management, hypnosis, or other specialized interventions as auxiliary forms of treatment to improve the adjustment of individuals who have 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.

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

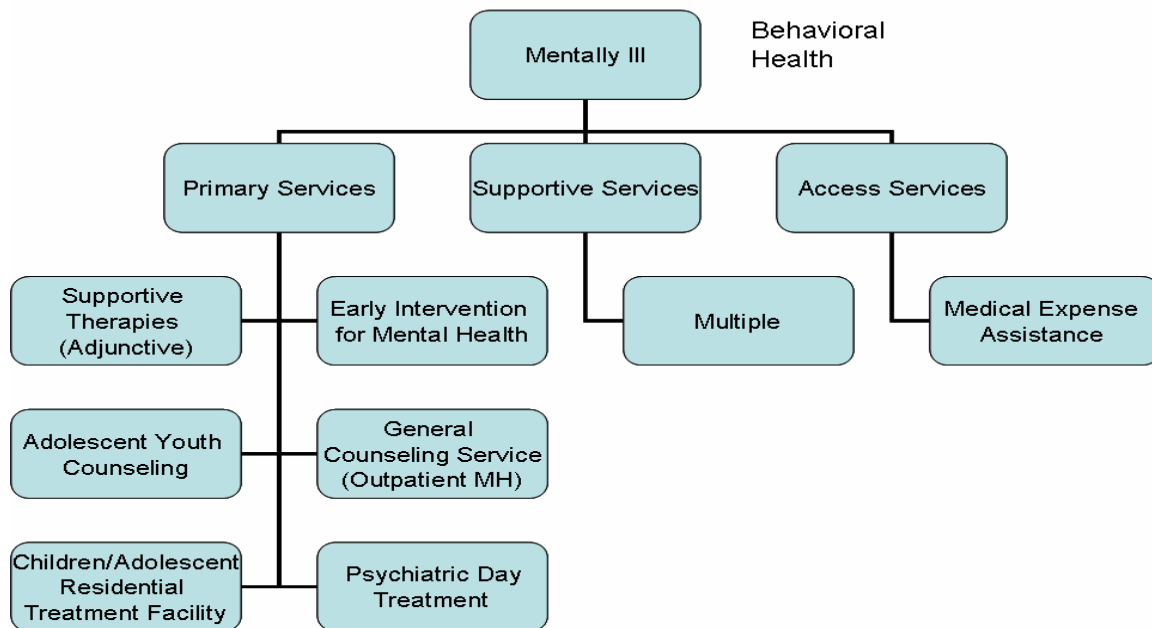
Core Service	Consumers		Service Description
	Age	Severity	
Early Intervention for Mental Illness	Children 0-5 years	Have or are at risk for psychiatric disorders.	Programs that conduct general screening efforts for early identification of children 0-3 who have incipient problems to ensure the best possible prognosis; and programs that provide treatment for individuals ages 0-5 whose personal condition and social experiences could potentially produce mental, emotional, or social dysfunctions, with the objective of preventing their development.
Adolescent Youth Counseling	Children and youth 5-17 years	Any mental disorder or serious emotional disturbance	Programs that specialize in the treatment of adolescents through services that are provided in traditional settings (offices and clinics) as well as in the client's natural environment (home, school, or community)
Children's/Adolescent Residential Treatment	Children and youth 5-17 years	Serious emotional disturbances (SED)	Programs that provide a therapeutic living environment in a community-based facility

Core Service	Consumers		Service Description
	Age	Severity	
General Counseling Service (Outpatient Mental Health Facilities)	Adults ages 18+ years	Moderate to severe mental illness who do not need twenty-four hour care	Programs that provide mental health services in outpatient settings
Psychiatric Day Treatment	Children, youth and adults ages 5+ years	Any severe mental disorder that does not require full-time hospital care, but can benefit from a structured environment for some portion of the day or week	Programs that provide therapeutic services in a structured outpatient setting for several hours of each day and multiple times per week
Supportive Therapies	Children, youth and adults ages 5+ years ¹	A mental disorder	Programs that utilize guided expressive or recreational activities or other specialized interventions as auxiliary forms of treatment to improve the adjustment of individuals with mental, emotional, or social problems; and to facilitate other forms of therapy. Supportive therapies may be used for diagnostic purposes and are, on occasion, utilized as primary treatment modalities.

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

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.

**Family of Services
AIRS: Mental Health Care & Counseling**



Core Service Environment

The largest single subset of supportive therapies involves the therapeutic use of some type of artistic activity. Objectives include reduction of mental health symptoms, better adjustment to physical symptoms or disabilities in medical patients, working through stressful experiences in victims of trauma and, across populations, the enhancement of self-awareness, self-esteem, emotional self-expression, and general well-being. Recreation or activity therapy makes use of enjoyable activities to facilitate general adjustment. As indicated by the term “supportive,” when these therapies are provided to mental health clients their role is usually an ancillary one, and there is typically another type of intervention comprising the core of 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.

Medicaid seems to be the single public policy with the greatest impact on mental health services, including eligibility criteria, covered services, and reimbursement rates. In focus groups and key informant interviews conducted as part of United Way’s core service planning (2005), participants spoke with anxious concern about the impact of Medicaid cuts. With respect to supportive services, there are issues about what is and is not covered under Medicaid. This is also true of Medicare.

Core Service Consumers

The target population addressed in this core service report is persons aged 5+ years with a mental disorder.

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

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

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

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

It is estimated that in 2000, 215,114 (or 16.5 percent) of individuals 5 and older in Cuyahoga County had some form of mental disorder. This number is projected to decrease to 203,371 in 2015 as a result of population shifts.

Core Service Delivery

The definition of the core service for this report is: 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.

Supportive therapies consist of a range of therapeutic interventions that utilize the arts, for example, art therapy and music therapy.

Art therapy is a type of psychotherapy using art-making and creativity to increase emotional well-being. Art therapy combines traditional psychotherapeutic theories and techniques with specialized knowledge about the psychological aspects of the creative process, especially the affective properties of different art materials. (Wikipedia.com, n.d.a)

Music therapy is the use of music by a trained professional to achieve therapeutic goals. Goal areas may include, but are not limited to, motor skills, social/interpersonal development, cognitive development, self-awareness, and spiritual enhancement. (Wikipedia.com, n.d.b)

Supportive therapy programs are offered by many different types of providers including community mental health agencies, social service agencies, schools, and private practitioners. Programs also have a multitude of staffing, collaboration, and reimbursement/payment structures. Most supportive therapy occurs in outpatient settings, where service delivery is generally least labor-intensive for providers and least expensive for payers.

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 19 supportive therapy services providers at 22 locations in the Cuyahoga County area although a local expert noted that there are several more. The majority of these providers (17) are nonprofit agencies. 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 regarding supportive therapy services increased from 16 calls in FY 2000 to 21 calls in FY 2004. . FCFH had 120 requests for supportive therapy services over the five-year period. Of these requests, they were able to make referrals to 97 percent of callers.

Medicaid reimbursement of supportive therapy programs varies from state-to-state. Some private practice music therapists have successfully applied for Medicaid provider numbers in their states (American Music Therapy Association, 2006). Many providers have offered supportive therapy as a supplemental intervention under existing treatment categories such as community support, rehabilitation, or habilitation.

Additional sources for reimbursement and financing of music and art therapy services include many state departments of mental health, state departments of mental retardation/developmental disabilities, state adoption subsidy programs, private auto insurance, employee worker's compensation, county boards of mental retardation/developmental disabilities, IDEA Part B related services funds, foundations, grants, and private pay (American Music Therapy Association, 2006b).

In Ohio, the cost of supportive therapies is primarily shouldered by consumers. While the effectiveness of many supportive therapies is beginning to receive support in the research literature, insurance and government funders are still lagging in their financial support. Medicaid generally does not pay for music, art, and recreational therapies because they view them as less central to mental health treatment. In addition, private insurance generally does not pay for supportive therapy services as they are seen as tangential or optional treatments.

As of May 11, 2006, over \$104,000 in revenues for supportive therapies programs has been identified countywide. This includes information from foundations, which represent 36 percent of the revenue. There is no reported financial support from government federated fundraising organizations or regional, county and municipal governments. United Way of Greater Cleveland provides over 64 percent of the financial support for these activities.

What Works; What Doesn't

There is a good deal of research that supports music therapy. Music therapy has proved successful with people experiencing a wide variety of problems. In addition to youth with emotional and behavioral problems, and children and adults with autism-spectrum disorders, music therapy has produced positive outcomes with adult psychiatric patients, individuals who abuse substances, adult felons, and people exhibiting combinations of mental illness, addiction, and felony histories (Cassity & Cassity, 1994; Gallagher & Steele, 2002; Treder-Wolff, 1990).

There is very little outcome research on art therapy. This approach is based on a wealth of theoretical formulations ranging from psychoanalysis to cognitive research (Junge & Asawa, 1994). Because of the focus on outcomes in this core service report, these studies are not reviewed here. Until such research is performed, there is little basis for confidence in art therapy as a treatment for mental health disturbances.

Recreation therapy includes such a heterogeneous array of interventions—with activities ranging from sports to crafts to pets to horseback riding—that it is not possible to make generalizations about the effectiveness of this category of intervention.

Art, music, dance, and recreation therapists receive training in their medium and also in therapeutic principles and techniques. These disciplines have professional associations that offer certificates documenting the completion of courses and the accumulation of sufficient work experience to practice in accordance with contemporary standards.

Gap Analysis

Because of the diversity of this service, it is not possible to find the necessary data to estimate the universe of possible consumers.

I. FOREWORD

INTRODUCTION

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

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

METHODOLOGY

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

The questions addressed are:

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

The primary information sources used for this report are:

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

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

II. THE CORE SERVICE ENVIRONMENT

CORE SERVICE ENVIRONMENT

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

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

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

The largest single subset of supportive therapies involves the therapeutic use of some type of artistic activity. Art therapy, music therapy, and dance or movement therapy are all based on the idea that participation in the arts, especially in the process of creating art oneself, has potential therapeutic value. These therapies do not consist of artistic activity by itself but also involve techniques to guide artistic processes toward some type of therapeutic end. These objectives include reduction of mental health symptoms, better adjustment to physical symptoms or disabilities in medical patients, working through stressful experiences in victims of trauma and, across populations, the enhancement of self-awareness, self-esteem, emotional self-expression, and general well-being.

Recreation or activity therapy makes use of enjoyable activities to facilitate general adjustment. This type of intervention is based on the idea that leisure activities have potential value beyond their immediate pleasures; when utilized in a strategic fashion, these activities also can produce beneficial effects on participants' sense of competency, self-esteem, energy level and mood. As implied by the term "supportive," when these therapies are provided to mental health clients their role is usually an ancillary one, and there is typically another type of intervention comprising the core of treatment.

PUBLIC POLICY ISSUES

NATIONAL

Federal Laws and Regulations

Insurance Parity

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

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

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

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

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

STATE

Ohio Laws and Regulations

Insurance Parity

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

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

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

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

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

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 populations addressed in this core service report are persons aged 5+ years who have a mental disorder.²

DEMOGRAPHIC CHARACTERISTICS

While consumers of supportive services can experience a variety of conditions such as Alzheimer's Disease and other dementia, mental retardation, those with co-occurring conditions, the focus of this report is on mental health issues. Mental health problems are common in the general population. According to a recent large-scale study, 51 percent of the American population will experience some type of disturbance at some point in their life (Kessler et al., 2005). At any given time, approximately 10 percent of American adults experience a diagnosable disorder and, in the course of a year, about 20-25 percent of adults have a disturbance (New Freedom Commission on Mental Health, 2003). About 5 percent of the adult population suffers from a serious mental illness (e.g., schizophrenia, major depression) that substantially impairs their ability to function in basic life areas such as employment, self-care, and interpersonal relationships (U. S. Public Health Service, 2000).

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

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

² 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.

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

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

Supportive therapies use the arts to work with clients who exhibit many of the mental health disorders described above. In addition, therapists can work with children, adolescents, and adults of all ages. Some of the specific conditions that have been addressed through supportive therapies include persons who are in prison or hospice programs, have neurological issues, HIV/AIDS, addictions, challenging behaviors, autism, communication disorders, emotional and behavioral difficulties, epilepsy, stress, eating disorders, or are victims of sexual abuse. Some of these therapies are increasingly being sought by people who may not have specific difficulties but would like to gain insight into themselves and their ways of relating to others.

Estimated Persons in Need

The target population for supportive therapies is difficult to define because it is so broad. Supportive therapies are used to help mental health clients, medical patients, elderly patients with dementia, and high risk youth. With so many populations potentially appropriate for these services, it is not easy to make general statements about how many people receive supportive therapies or whether these numbers are increasing or decreasing.

However, if the specific focus is on the need for supportive therapies for persons with mental disorders, an estimate with a certain degree of underlying rationality can be made. A report by the Center for Community Solutions (formerly the Federation for Community Planning) and the Cuyahoga County Community Mental Health Board (2003) provided estimates of the numbers of children and adults with mental disorders in Cuyahoga County based on national prevalence data and county population figures. This calculation produced estimates of 53,712 children and adolescents (aged 5-17 years old), 116,657 adults (18-54 years old), and 44,745 older adults (55+) with mental health problems. Assuming that national prevalence rates apply locally, the estimate is that there are approximately 215,114 persons 5 years and older with some type of mental disorder in Cuyahoga County. (See Table 1.)

The public mental health system focuses its resources on the relatively small number of people with severe mental illnesses. As Table 1 above indicates, anxiety disorders are the most prevalent form of mental disability for each age group. By contrast, schizophrenia or other more severe mental disabilities are less common. However, the report of the Center for Community Solutions and the Cuyahoga County Community Mental Health Board estimated that the public system serves only 2 percent of Cuyahoga residents with anxiety disturbances, and 54 percent of people with schizophrenia. The Cuyahoga County Community Mental Health Board also states that, because of limited funding, it primarily serves persons with severe mental disturbances.

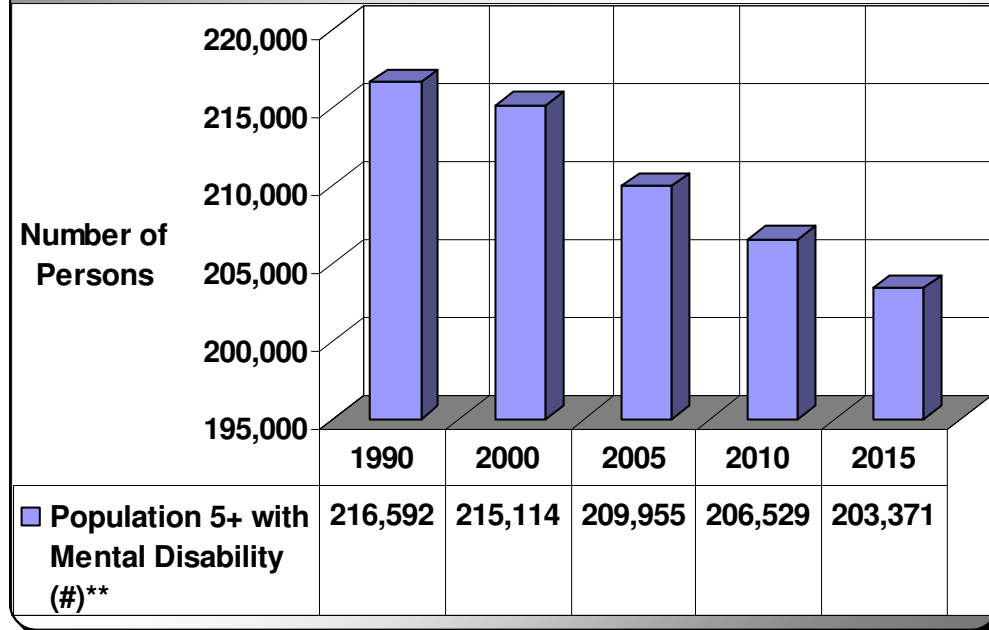
Table 1: National Prevalence Rates and Estimated Number of Persons 5+ with Mental Disorders in Cuyahoga County, 2003

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

Based on this data and applying it to various time periods, it is estimated that in 2000, 215,114 individuals 5 and older in Cuyahoga County had some form of mental disorder, or 16.5 percent of the 5 and older population. This number is projected to decrease to 203,371 in 2015 as a result of population shifts. (See Figure 1.)

**Figure 1: Supportive Therapies
Estimated Persons in Need
Cuyahoga County, 1990-2015**



Sources:
 * US Census: 1990, STF 1 (P11); 2000, SF3 (P8); 2005-2015, Ohio Department of Development, (July, 2003).
 ** "Cuyahoga County Mental Health Assessment," Center for Community Solutions, December 2003. Rate of persons with mental health disorders 5-17, 20.9 percent, 18-54, 16.5 percent, 55+, 13.2 percent. Overall: 16.5 percent. Assumes the same percentage for each period.

This estimate of persons in need of supportive therapies does not capture all in need because persons who do not have mental disorders also use the service for other purposes. However, it is a number that begins to offer some clarity about the extent of need in Cuyahoga County.

REALIZED ACCESS TO SERVICE

Realized access to service is represented by the number of consumers actually served. It includes the actual number of consumers reported by United Way funded agencies 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 138 Cuyahoga County residents 5 years and older for supportive therapies programs. The number of actual annual consumers funded by the Cuyahoga County Department of Mental Health was not available. The Cuyahoga County Board of Mental Retardation and Developmental Disabilities (MRDD) provided supportive services as part of their general services to consumers, but was unable to separate the actual number of

consumers for this core service from other core services provided concurrently. (See Attachment 3.)

While 47 percent of the county's total 5+ population is male and 53 percent female, UW reporting entities primarily served 64 percent males and 36 percent of the females.

In 2000, according to the U.S. Census, racial and ethnic data indicated that 68 percent of the county's total 5+ population was Caucasian, 27 percent was African American and 2 percent Asian. United Way funded programs served a higher percentage of African Americans relative to the total population. Nearly 50 percent of the service population was African American (49 percent), with the remainder mostly Caucasian (47.8 percent).

While 3 percent of the county's 5+ population was Hispanic, only 1 percent of United Way funded consumers were of this ethnic background.

Geographically, 30 percent of estimated persons age 5 and older resided in Cleveland and the remaining 70 percent in the suburbs. United Way funded supportive therapies had a slightly different pattern with close to 20 percent residing in Cleveland and 80 percent living 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 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.

BACKGROUND ON CORE SERVICE

Supportive therapies consist of a range of therapeutic interventions that utilize the arts, for example, art therapy and music therapy.

The term art therapy generally applies to the use of the visual arts in psychotherapy, while creative arts therapy refers to the use of art therapy, dance therapy, drama therapy, music therapy, poetry therapy and psychodrama. Expressive arts therapy is a term that overlaps with creative arts therapy, and generally refers to the use of performing arts for psychotherapeutic purposes. (Wikipedia.com, n.d.a)

Two of these, art therapy and music therapy, are described below as examples of supportive therapies.

Art Therapy

Art therapy is a type of psychotherapy using art-making and creativity to increase emotional well-being. Art therapy combines traditional psychotherapeutic theories and techniques with specialized knowledge about the psychological aspects of the creative process, especially the affective properties of different art materials. As a mental health profession, art therapy is employed in many different clinical settings with many different types of patients. Art therapy is present in non-clinical settings as well, such as in art studios and workshops that focus on creativity development. (Wikipedia.com, n.d.a)

Art therapy is based on the belief that the creative process involved in making art is healing and life-enhancing. Through creating and talking about art with an art therapist, one can increase awareness of self, cope with symptoms, stress, and traumatic experiences, increase cognitive abilities, and enjoy the life-affirming pleasures of artistic creativity. Art therapists are professionals trained in both art and therapy and hold a master's degree in art therapy or a related field. Art therapists work with children, adolescents, and adults and provide services to individuals, couples, families, groups, and communities. (Wikipedia.com, n.d.b)

Music Therapy

Music therapy in its current/modern form has existed in the United States since around 1944, when the first degree program in the world was founded at Michigan State University. It is the use of music by a trained professional to achieve therapeutic goals. Goal areas may include, but are not limited to, motor skills, social/interpersonal development, cognitive development, self-awareness, and spiritual enhancement. Music therapists are found in nearly every area of the helping professions. Some commonly found practices include developmental work (communication, motor skills, etc.) with individuals with special needs, songwriting and listening in reminiscence/orientation work with the elderly, processing and relaxation work, and rhythmic entrainment for physical rehabilitation in stroke victims. The idea of music as a healing modality dates back to the beginnings of history, and some of the earliest notable mentions in Western history are found in the writings of ancient Greek philosophers. (Wikipedia.com, n.d.b)

Music therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. (American Music Therapy Association, n.d.)

Music therapists assess emotional well-being, physical health, social functioning, communication abilities, and cognitive skills through musical responses; design music sessions for individuals and groups based on client needs using music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, music performance, and learning through music; participate in interdisciplinary treatment planning, ongoing evaluation, and follow up. (American Music Therapy Association, n.d.)

Children, adolescents, adults, and the elderly with mental health needs, developmental and learning disabilities, Alzheimer's disease and other aging related conditions, substance abuse problems, brain injuries, physical disabilities, and acute and chronic pain, including mothers in labor can benefit from music therapy. (American Music Therapy Association, n.d.)

The music played covers a wide range of styles in order to complement the individual needs of each client. Much of the music is improvised, thus enhancing the individual nature of each relationship. Through whatever form the therapy takes, the therapist aims to facilitate positive changes in behavior and emotional well-being. He or she also aims to help the client to develop an increased sense of self-awareness, and thereby to enhance his or her quality of life. The process may take place in individual or group music therapy sessions. (Association of Professional Music Therapists, n.d.)

Music is essentially a social activity involving communication, listening and sharing. These skills may be developed within the musical relationship with the therapist and, in group therapy, with other members. As a result clients may develop a greater awareness of themselves in relation to others. This can include developing greater confidence in their own ability to make relationships and to find positive ways of making their needs known. It can greatly enhance their self-esteem. (Association of Professional Music Therapists, n.d.)

Music can be a great motivator and can be used to promote developmental work, for example with clients with physical and/or learning disabilities. Involvement in creative music-making can assist physical awareness and develop attention, memory and concentration. Obviously, as each person's needs are different, the various possibilities offered by music therapy will not be so easy to separate. Rather, there will normally be a considerable overlap between the areas described. (Association of Professional Music Therapists, n.d.)

Each therapy program is designed according to the individual client's needs and the therapist's approach. Elements within the therapeutic relationship generally include musical improvisation using instruments and voice. The music made may be verbally reflected upon depending on the approach of the therapist. Music Therapy might be offered in groups or individually which would be decided upon after assessment. (Association of Professional Music Therapists, n.d.)

The benefits gained from music therapy may be as varied as the needs of the clients using the service. For example, music can convey feeling without the use of words. For a person whose difficulties are mainly emotional, music therapy can provide a safe setting where difficult or repressed feelings may be expressed and contained. By offering support and acceptance the therapist can help the client to work towards emotional release and self-acceptance. (Association of Professional Music Therapists, n.d.)

Music therapists work in a variety of settings, such as hospitals, special schools, day centers, the community, the prison service and in private practice... In all work settings, music therapists function as part of a multi-disciplinary team, their observations adding greatly to the understanding of each client's needs, abilities or problems. (Association of Professional Music Therapists, n.d.)

For music therapy to be most effective, certain conditions are essential. They are:

- A music therapy room which is private, where there is little chance of being overheard or disturbed.
- Instruments that are varied in timbre and of good quality. These should preferably include a good piano.

- Time for planning and assessment of each session. Tape and video facilities for recording the work should also be available.
- Clients should meet in the same room (preferably a specific music therapy room) and at the same time each week.
- Whether a group is to be closed or open should be decided beforehand as should the length of time for each session.
- Consistency and commitment of members of staff who attend the sessions are vital. (Association of Professional Music Therapists, n.d.)

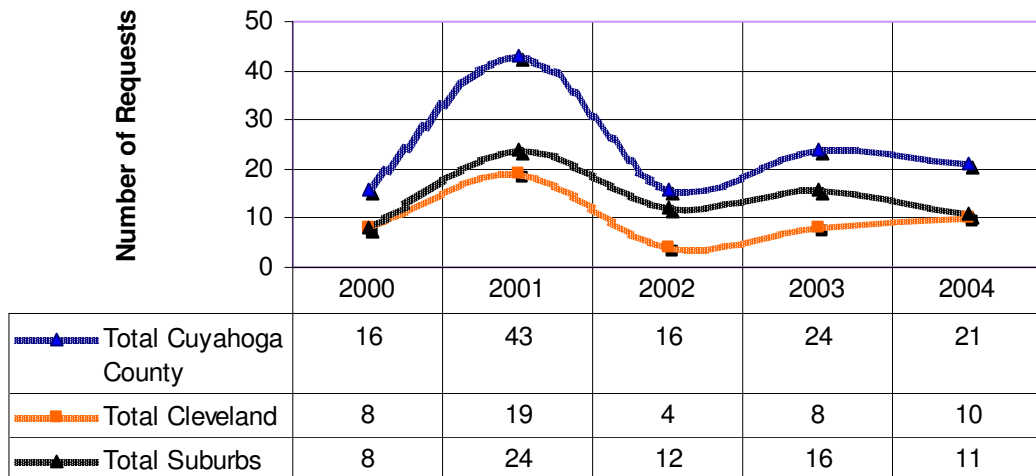
Supportive therapy programs are offered by many different types of providers including community mental health agencies, social service agencies, schools, and private practitioners. Programs also have a multitude of staffing, collaboration, and reimbursement/payment structures. Most supportive therapy occurs in outpatient settings, where service delivery is generally least labor-intensive for providers and least expensive for payers.

United Way – First Call for Help Call Data

There are 19 supportive therapy service providers at 22 locations in the Cuyahoga County area (per First Call for Help); although a local expert noted that there are several more. The majority of these providers (17) are nonprofit organizations. Service provision sites are located throughout the Greater Cleveland area. (See Attachments 5 and 6.)

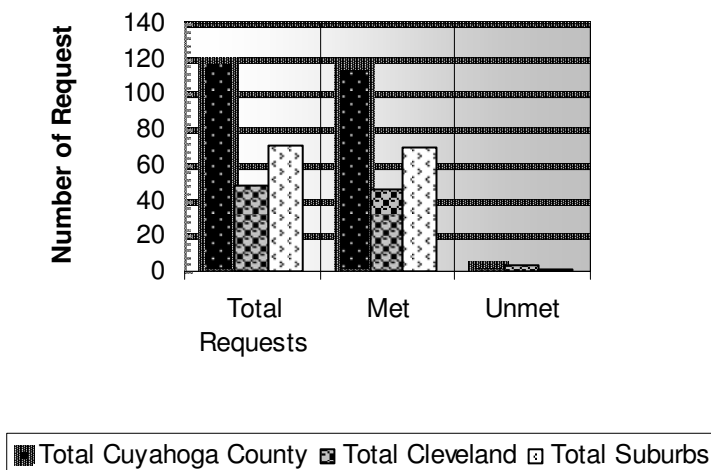
Over a five-year period, from 2000 to 2004, the number of United Way - First Call for Help inquiries about supportive therapy services increased from 16 calls in FY 2000 to 21 calls in 2004 (31 percent) for Cuyahoga County, while calls from Cleveland increased 25 percent and suburbs increased 38 percent. Note that these percentages are inflated because of low numbers. On average, the number of calls each year totaled 24 for the entire county, with an average of 10 calls originating from the city and 12 from the suburbs. (See Figure 2 and Attachment 7.)

**Figure 2: Supportive Therapies
United Way - First Call for Help Requests 2000-2004
Greatest Increase/(Greatest Decrease)**



Aggregate data for Cuyahoga County for the five-year period indicated that 120 calls were received and all but 3 percent United Way - First Call for Help requests for supportive therapy services were successfully referred to service providers. (See Figure 3 and Attachment 8.)

**Figure 3: Supportive Therapies
United Way - First Call for Help Requests
2000-2004 (TOTAL REQUESTS: n=120,
TOTAL UNMET NEED: n=4)**



FUNDING OF CORE SERVICES

Major Government Funders

The major sources of government funding for supportive therapies are:

- Medicare; and
- Medicaid.

Per the American Music Therapy Association, additional sources for reimbursement and financing of music therapy services include many state departments of mental health, state departments of mental retardation/developmental disabilities, state adoption subsidy programs, private auto insurance, employee worker's compensation, county boards of mental retardation/developmental disabilities, IDEA Part B related services funds, foundations, grants, and private pay (American Music Therapy Association, 2006).

In Ohio, the cost of supportive therapies is primarily shouldered by the consumer. While the effectiveness of many supportive therapies is beginning to receive support in research literature, insurance and government funders are still lagging in their financial support. For example, Medicaid generally pays for the traditional mainstream mental health interventions such as individual and group therapy, but generally does not pay for music, art, and recreational therapies because they view them as less central to mental health treatment. In addition, private insurance generally does not pay for supportive therapy services as they are seen as tangential or optional treatments. Many providers are creatively finding ways to supplement these necessary services so clients may still receive the benefits when substantial costs may have dissuaded them from obtaining these services without such assistance. For example, many providers have resorted to providing these services as non-reimbursed supplemental services to traditional mental health interventions that can be billed to insurance companies and Medicaid. The balance of the cost is generally shifted to consumers.

Medicare

Since 1994, music therapy has been identified as a reimbursable service under benefits for partial hospitalization programs (PHP). Falling under the Activity Therapy heading, the interventions cannot be purely recreational or diversionary in nature and must be individualized and based on goals specified in the treatment plan. The current HCPCS Code for PHP is G0176.

The music therapy must be considered an active treatment by meeting the following criteria:

- Be prescribed by a physician.
- Be reasonable and necessary for the treatment of the individual's illness or injury.
- Be goal directed and based on a documented treatment plan.

The goal of treatment cannot be to merely maintain current level of functioning; the individual must exhibit some level of improvement (American Music Therapy Association, n.d.).

Medicaid

As Medicaid programs vary from state-to-state, so do the Medicaid coverage avenues for music therapy services. Some private practice music therapists have successfully applied for Medicaid provider numbers within their states. Some states offer waiver programs in which music therapy can be covered. In some situations, although music therapy is not specifically listed as a

covered service, due to functional outcomes achieved, music therapy interventions can fall under an existing treatment category such as community support, rehabilitation, or habilitation (American Music Therapy Association, n.d.).

Trends of Identified Government Funders in Cuyahoga County

While the Cuyahoga County Mental Health Board is one of the major government funders of supportive therapies locally, they were unable to specifically identify either consumer numbers or funding amounts for this core service as it is generally billed as a supplement to other treatments. The County Board of Mental Retardation and Developmental Disabilities does financially support music therapy services for its population, but it did not provide funding information specific to this core service. The MRDD Board has music therapists in its early childhood and school-age programs, but there is not a separate funding category for them. They are all music teachers who are Music Therapist-Board Certified (MT-BC), and since they are under the supervision of the school or early childhood building principals, their costs are included in each building's staff budget. Overall, the supportive therapies are more dependent on private sources of funding, including United Way, as compared to the more basic, conventional mental health treatment modalities.

IDENTIFIED REVENUES

As of May 11, 2006, over \$104,000 in revenues for supportive therapies programs has been identified countywide. (See Table 2.) This includes information from foundations, which represent 36 percent of the revenue. There is no reported financial support from government federated fundraising organizations or regional, county and municipal governments. United Way of Greater Cleveland provides over 64 percent of the financial support for these activities.

Table 2: Identified Annual Revenue for Core Services: County-wide and United Way of Greater Cleveland Supportive Therapies Programs, 2003/2004.

Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			0.00%	6,108	1.54%
Woodruff Foundation, The		27,088			
Other Private Foundations - Not Elsewhere Classified		10,000		15,000	
Total - Foundations & Trusts		37,088	35.62%	15,000	3.78%
All Other Funding - Not Elsewhere Classified				308,976	
Subtotal Other Govt Funding Sources		0	0%	308,976	77.80%
Total - Contracts/grants from government organizations		0	0%	308,976	77.80%
Subtotal Non - UWGrCle Support		37,088	35.62%	330,084	83.12%
Total - UWGrCle investment committee allocation		67,043	64.38%	67,043	16.88%
Subtotal UWGrCle Support - 4001, 4701 & 4703		67,043	64.38%	67,043	16.88%
Total Support/Revenue		104,131	100%	397,127	100.00%

REIMBURSEMENT/COST

Reimbursement rates, and even definitions of a unit of service, vary among various types of providers. Music therapy has been identified as a reimbursable service under benefits for partial hospitalization programs (PHP) since 1994.

Medicaid reimbursement of supportive therapy programs varies from state-to-state. Some private practice music therapists have successfully applied for Medicaid provider numbers in their states (American Music Therapy Association, 2006). Many providers have offered supportive therapy as a supplemental intervention under existing treatment categories such as community support, rehabilitation, or habilitation.

The number of success stories involving third party reimbursement for the provision of music therapy services continues to grow. Over the decade, a growing public demand for music therapy services has been accompanied by a demand for third party reimbursement. The American Music Therapy Association now estimates that at least 20 percent of music therapists receive third party reimbursement for the services they provide (American Music Therapy Association, 2006). This number is expected to increase exponentially as music therapy occupies a strong position in the health care industry.

Music therapy is comparable to other health professions such as occupational therapy and physical therapy in that individual assessments are provided for each client, service must be found reasonable and necessary for the individual's illness or injury, and interventions include a goal-directed documented treatment plan. Like other therapies, music therapy is typically pre-approved for coverage or reimbursement, and is found to be reimbursable when deemed medically necessary to reach the treatment goals of the individual patient. Therefore, reimbursement for services is determined on a case-by-case basis and is available in a variety of health care settings for patients with varying diagnoses (American Music Therapy Association, 2006).

Reimbursement has also been a difficult issue for art therapists, mostly because it is not well understood by many practitioners in the field. Also, there are no specific billing codes for art therapy per se, only “psychiatric therapeutic procedures” as listed in the current procedural terminology (CPT) codes. In essence, if an art therapist is eligible to bill an insurance company for services, there is no code to indicate that the session was “art therapy” (Malchiodi, 2005).

Additional sources for reimbursement and financing of music and art therapy services include many state departments of mental health, state departments of mental retardation/developmental disabilities, state adoption subsidy programs, private auto insurance, employee worker’s compensation, county boards of mental retardation/developmental disabilities, IDEA Part B related services funds, foundations, grants, and private pay (American Music Therapy Association, 2006).

No specific reimbursement data for these sources for either Ohio or Cuyahoga County was identified for this report.

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works; What Doesn't Work

Supportive therapies include a broad array of approaches and techniques. Research support for these different types of therapies varies in range from substantial to minimal.

There is a good deal of research support for music therapy. Music therapy has proved successful for people experiencing a wide variety of problems. In addition to youth with emotional and behavioral problems, and children and adults with autism-spectrum disorders, music therapy has produced positive outcomes with adult psychiatric patients, individuals who abuse substances, adult felons, and people exhibiting combinations of mental illness, addiction, and felony histories (Cassity & Cassity, 1994; Gallagher & Steele, 2002; Treder-Wolff, 1990).

Whipple (2004) performed a meta-analysis of 9 studies of music therapy provided to children and adolescents with autism-spectrum disorders. The analysis indicated a mean effect size of 0.77 across the studies, which is in the medium to large range and indicates significant positive treatment effects.

The studies involved a number of different music-based therapeutic techniques, including use of background music during task performance, use of music as a reinforcement, songs designed to facilitate processing of the words in the lyrics, movement, singing, and musical games. The studies examined therapeutic effects on a number of different dependent variables important to the functioning of individuals with autism. Music therapy produced improvement in cognitive processes such as attention, task-focus, academic functioning, and vocabulary acquisition. This type of intervention also resulted in improved social functioning, including increased eye contact, frequency of vocalization, following directions on motor tasks, and decreased self-stimulatory behavior. In analyzing the results from study to study, Whipple noted that music-based techniques produced effects of similar magnitude regardless of the specific techniques implemented and the specific behaviors assessed; music seemed to be helpful to young people with autism-spectrum disorders in a wide variety of ways.

Research on the effects of music therapy has recently been performed locally at the Cleveland Music School Settlement. Kaplan and Steele (2005) analyzed goal attainment in a sample of 40 children and adults with diagnoses on the autism spectrum. Treatment goals included improvement in the areas of language/communication, psychosocial functioning, and cognitive functioning. All 40 clients achieved their initial objectives in these areas within one year of treatment. Seventy-seven percent of the intermediate objectives were attained within this time. All of the parents and caregivers of the clients reported observing some generalization of positive therapeutic effects to the everyday environment. Lesson-based interventions involving music instruction seemed to produce more movement toward intermediate objectives than did less structured musical activities.

Gold, Voracek, and Wigram (2004) performed a meta-analysis of music therapy outcome studies of children and adolescents with emotional and behavioral disorders. The analysis included 11 studies involving 188 subjects. The results indicated a mean effect size of 0.61, which is in the medium to large range. Effect sizes tended to be larger for music therapy

approaches based on psychodynamic, humanistic, and eclectic theories than for behavioral models. This finding is striking because it contrasts with the usual results for psychotherapy outcome research, which typically produces stronger results for behavior therapy than for dynamic and humanistic approaches, especially with child and adolescent clients. However, connecting dynamic and humanistic theory with musical activities seems to represent something of a conceptual stretch, and it is difficult to specify the nature of these connections. The findings for different theoretical approaches also seem difficult to square with the meta-analysis' findings concerning effect sizes for the different dependent variables that were examined; music therapy produced larger changes in developmental and behavioral outcomes than in social skills and self-concept. But despite these interpretive ambiguities, Gold et al.'s meta-analysis makes it clear that music therapy can be an effective intervention for youth with emotional and behavioral disorders.

There is very little outcome research on art therapy. This approach is based on a wealth of theoretical formulations ranging from psychoanalysis to cognitive research (Junge & Asawa, 1994). Many art therapists are ambivalent about the use of quantitative, experimental methods for evaluating therapy and, historically, these therapists have used qualitative methods and case studies to assess the effectiveness of this approach (Junge & Linesch, 1993). Of the few studies that have been performed, most have examined process variables that, while possibly informative about the mechanisms of therapy, do not provide reliable information about the effects of art therapy on emotional and behavioral problems. Because of the focus on outcomes in this core service report, these studies are not reviewed here.

Computerized searches for outcome research on art therapy found very few studies, and most of the investigations identified had methodological limitations so serious that there was little basis for drawing conclusions from the results. Saunders and Saunders (2000) attempted to perform a quantitative outcomes-focused study. They performed pre- and post-intervention assessments on 94 children between the ages of 2 and 16 years old. These clients participated in between 2 and 96 therapy sessions. The assessments were based on a symptom checklist developed by the researchers, who stated that the measure had good content validity and internal reliability (although their criterion coefficient alpha of .70 does not indicate strong reliability). There were some significant decreases over the course of therapy in scores on the symptom checklist, which provides support for the effectiveness of art therapy. However, the methodological weaknesses of the study, including the extreme variability in the age range of the client sample and the number of therapy sessions they received, as well as the lack of a standardized outcome measure and the absence of a control group, makes the results equivocal in meaning. The standing of this investigation as one of the strongest outcome studies conducted to date highlights the urgent need for rigorous research on art therapy. Until such research is performed, there is little basis for confidence in art therapy as a treatment for mental health disturbances.

Recreation therapy includes such a heterogeneous array of interventions—with activities ranging from sports to crafts to pets to horseback riding—that it is not possible to make generalizations about the effectiveness of this category of intervention. Also, research on these techniques is complicated by the common practice of combining them with other mental health treatment strategies that usually comprise the primary intervention, making it difficult to separate the effects of the different procedures. However, the American Therapeutic Recreation Association does provide information on research showing improved physical health status, psychosocial status, cognitive status, and improved participation in life, recreation, and community activities (American Therapeutic Recreation Association, n.d.).

IMPACT ON COMMUNITY

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

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

Art, music, dance, and recreation therapists receive training in their medium and also in therapeutic principles and techniques. These disciplines have professional associations that offer certificates documenting the completion of courses and the accumulation of sufficient work experience to practice in accordance with contemporary standards.

Art Therapy

The American Art Therapy Association, Inc. (AATA) regulates educational, professional and ethical standards for art therapists (Art Therapy Credentialing Board, 2006). The Art Therapy Credentialing Board (ATCB) provides the following credentials:

- *Registered art therapist (ATR)*. Upon completion of graduate requirements and 1000 hours of postgraduate, supervised, direct client contact, the ATCB may grant registration as a registered art therapist (ATR).
- *Registered art therapist-board certified (ATCB)*. The ATR who successfully practices art therapy for two years and who passes the written examination administered by the ATCB is granted board certification (ATR-BC), a credential requiring maintenance through 100 hours of continuing education credits over a 5-year period.

Dance Therapy

The American Dance Therapy Association provides the following credentials:

- *Dance therapist registered (DTR)*. Therapists with this title have a masters degree and are fully qualified to work in a professional treatment system.
- *Academy of Dance therapists registered (ADTR)*. Therapists with this title have met additional requirements and are fully qualified to teach, provide supervision, and engage in private practice. 100 hours of continuing education every five years is required to maintain the ADTR.

Drama Therapy

The National Association for Drama Therapy provides the following credentials:

- *Registered drama therapist (RDT)*. Therapists have a master's or doctoral degree in drama therapy, completed a minimum of 300 client hours, and have 500 hours of additional training and work experience.

Music Therapy

The Certification Board for Music Therapists (CBMT) provides the following credentials:

- *Board certified music therapist (MT-BC)*. Therapists have completed an approved academic and clinical training program and passed a CBMT examination.

Poetry Therapy

The National Association for Poetry Therapy accepts members and is open to anyone who shares their mission of “promoting growth and healing through language, symbol, and story.”

Recreation Therapy

The National Council for Therapeutic Recreation Certification provides the following credentials:

- *Certified therapeutic recreation specialist (CTRS)*. Candidates must meet minimum educational and experiential requirements and then pass a computer-based examination.

VI. GAP ANALYSIS

As discussed in Section III of this report, determining the actual number of persons who could benefit from supportive therapy is difficult to estimate because the universe of potential clients is so broad. However, a conservative estimate of 215,114 persons need supportive therapy. This is the estimate of persons 5+ with a mental disability in Cuyahoga County . Children younger than 5 are consumers of supportive therapies; however, data on their numbers is limited and therefore not included, as noted in Section III. Based on available information about actual consumers, 138 persons 5+ have realized access to supportive therapy programs. This is the sum of persons who have received United Way services. Due to the lack of additional data, this greatly undercounts the number of people receiving services. This leaves a net estimate of 214,976 persons 5+ who are either receiving services from unaccounted-for sources or are not receiving supportive therapy services.

Because of the diversity of this service, it is not possible to find the necessary data to estimate the universe of possible consumers.

Service Site Index

A Service Site Index was not developed for this service.

VII. SUMMARY

These are the major findings about supportive therapies from this report:

- The largest single subset of supportive therapies involves the therapeutic use of some type of artistic activity. Objectives include reduction of mental health symptoms, better adjustment to physical symptoms or disabilities in medical patients, working through stressful experiences in victims of trauma and, across populations, the enhancement of self-awareness, self-esteem, emotional self-expression, and general well-being.
- Insurance parity, or equal treatment, for mental health and addiction treatment is one of Ohio's major public policy issues that affects private funding for mental health related services through insurance. Greenfield (2005) found that there are two major barriers to policies and full implementation of parity policies: 1) fear of an unmanageable rise in health care costs; and 2) societal stigmas in respect to psychiatric and substance abuse disorders. In December 2006, Ohio passed a law to facilitate mental health parity.
- Medicaid seems to be single public policy with the greatest impact on mental health services, including eligibility criteria, covered services, and reimbursement rates.
- In Ohio, the cost of supportive therapies is primarily shouldered by the consumer.
- Medicaid generally does not pay for music, art, and recreational therapies because they are viewed as less central to mental health treatment. In addition, private insurance generally does not pay for supportive therapy services as they are seen as tangential or optional treatments.
- While the Cuyahoga County Mental Health Board and the County Board of Mental Retardation and Developmental Disabilities are government funders of supportive therapies locally, they were unable to specifically identify either consumer numbers or funding amounts for this core service.
- As of May 11, 2006, over \$104,000 in revenues for supportive therapies programs has been identified countywide.
- There is a good deal of research that supports music therapy. Music therapy has proved successful with people experiencing a wide variety of problems.
- There is very little outcome research on art therapy. Until such research is performed, there is little basis for confidence in art therapy as a treatment for mental health disturbances.
- Recreation therapy includes such a heterogeneous array of interventions—with activities ranging from sports to crafts to pets to horseback riding—that it is not possible to make generalizations about the effectiveness of this category of intervention.
- Because of the diversity of this service, it is not possible to find the necessary data to estimate the universe of possible consumers.

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ATTACHMENTS

Attachment 1: Researcher List

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

Attachment 2: Technical Notes

Technical Notes: Methodology, Caveats, Limitations of Data

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

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

Unit of Analysis

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

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

United Way - First Call for Help Data

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

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

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

Because, in many instances, FCFH codes its data with a different level of core services than the 80 core services identified by the United Way Community Investment staff as fundable services, it was necessary to develop a crosswalk. This crosswalk was used for a number of services, however, seven services did not have a match in the FCFH database. The staff of United Way - First Call for Help gave explanations which follow each core service):

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

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

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

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

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

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

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

Funding Information for Core Services

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

Foundation Funding

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

Federated Funding Sources

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

Government Funding

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

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

In other cases, it was not possible to select a specific core service. An example is Medicaid in which Medicaid-defined services crossed over more than four core services in some instances. In cases where Medicaid is a significant source of revenue, the data was entered as an

aggregate total at the appropriate AIRS level. These aggregates are footnoted under the appropriate funding table.

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

Medicaid Funding

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

Entered as Aggregate Total Under Appropriate AIRS Level

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

Entered as Aggregate Total Under Third Party Payee/Direct Bill

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

United Way of Greater Cleveland Funding

Financial data for core services funded by United Way of Greater Cleveland was for FY 2004 (July 2003 to June 2004). It included allocations through the community investment committees

and donor designations that United Way funded agencies applied to the respective core services. It is important to note that not all United Way funded agencies applied donor designated gifts, which are unrestricted, to the core service for which they receive United Way funding. It did not include donor designations that non-United Way funded agencies used for any of the 80 core services.

United Way Agency Revenues

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

Consumer and Financial Data: Caveats

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

All Core Services

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

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

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

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

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

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

Gap Analysis Methodology & Limitations

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

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

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

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

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

Service Site Index

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

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

Specific Service Issues

Senior Services

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

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

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

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: Supportive Therapies RB				
			Estimated Persons in Need	Actual Number/Percent of Consumers
	Total Population (%) [*]	Total Population 5+ (%) ^{**}	Population 5+ with Mental Disability (%) ^{***}	UW Program Report Data Cuy Cnty Only 87.9% (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004
TOTAL	1,393,978	1,303,066	215,114	138
Percent		93.5%	16.51%	87.9%
GENDER				
Male	47.2%	47.0%	NA	63.7%
Female	52.8%	53.0%	NA	36.3%
Unknown Data ^{*****}				0.0%
Missing Data ^{*****}				0.0%
RACE^{*****}				
White alone	67.1%	67.8%	NA	47.8%
Black or African American alone/combination	27.9%	27.4%	NA	49.0%
Asian alone/combination	2.1%	2.1%	NA	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.7%	NA	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.1%	NA	0.0%
Some other race alone/combination	2.1%	2.0%	NA	2.5%
Unknown Data ^{*****}				0.6%
Missing Data ^{*****}				0.0%
HISPANIC^{*****}	3.3%	3.2%	NA	1.3%
AGE				
0-4	6.5%			4.5%
5-9	7.3%	7.8%	NA	14.0%
10-14	7.1%	7.6%	NA	31.2%
15-19	6.4%	6.8%	NA	7.6%
20-34	19.1%	20.4%	NA	10.2%
35-54	29.3%	31.4%	NA	9.6%
55-64	8.7%	9.3%	NA	5.1%
65-74	7.8%	8.3%	NA	1.9%
75+	7.8%	8.4%	NA	8.3%
Unknown Data ^{*****}				7.6%
Missing Data ^{*****}				0.0%
INCOME^{*****}				
Average Household Size	2.4	N/A	N/A	N/A
\$0-\$9,999	11.3%	N/A	N/A	0.0%
\$10,000-\$14,999	6.9%	N/A	N/A	0.0%
\$15,000-\$19,999	6.7%	N/A	N/A	0.0%
\$20,000-\$29,999	13.6%	N/A	N/A	0.0%
\$30,000 and above	61.5%	N/A	N/A	0.0%
Unknown Data ^{*****}				100.0%
Missing Data ^{*****}				0.0%
Totals	100.0%	N/A	N/A	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 (PCT 69)
*** "Cuyahoga County Mental Health Assessment," Center for Community Services, December 2003. Rate of persons with mental health disorders 5 years and older is 16.51 percent of the population 5 years and older.
****Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms.
*****Missing Data - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.
*****The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." Except "White Alone", all racial categories are "... alone or in combination with some other race". This method isolates and minimizes the non-minority population ("White alone").
*****Hispanic - Amount in this field is from data provided by clients on intake forms and may not be accurate as clients may either deliberately or inadvertently provide incomplete data, or data may not be collected by the agency.
*****The U.S. Census reports income by household or family, not individuals. Estimates by income category were derived by applying the ratio of total county population (1,393,978) to total households (571,606) = 2.4. The number of households in each income category was multiplied by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category, which may result in more conservative estimates for children, and the "old old," which may actually have larger proportions of persons in the lower income categories.

Attachment 4: Actual Consumer Zip Codes

Core Service: Supportive Therapies RB					
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****
	City/Town (% Cleveland)	Total Population (%)*	Total Population 5+ (%)**	Population 5+ with Mental Disability (%)***	UW Program Report Data (%)
Period		1/1/2000- 12/31/2000	1/1/2000- 12/31/2000	1/1/2000- 12/31/2000	7/1/2003- 6/30/2004
TOTAL		1,393,978	1,303,066	215,114	138
Percent			93.5%	16.51%	
44017	Berea	1.4%	1.4%	NA	0.0%
44022	Bentleyville	1.3%	0.8%	NA	1.4%
44040	Gates Mills/Mayfield Village	0.2%	0.2%	NA	0.0%
44070	North Olmsted	2.4%	2.5%	NA	0.7%
44101	Cleveland (100%)	0.0%	0.0%	NA	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	3.7%	NA	0.0%
44103	Cleveland (100%)	1.8%	1.8%	NA	13.8%
44104	Cleveland (100%)	2.1%	2.0%	NA	0.0%
44105	Cleveland/NewburghHts/ GarfieldHts	3.9%	3.9%	NA	2.2%
44106	Cleveland/Cleveland Hts (60%)	2.3%	2.3%	NA	1.4%
44107	Lakewood/Cleveland	4.0%	4.1%	NA	0.7%
44108	Cleveland/Bratenahl (90%)	2.6%	2.6%	NA	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.2%	NA	0.7%
44110	Cleveland/East Cleveland (98%)	1.9%	1.9%	NA	0.0%
44111	Cleveland (100%)	3.1%	3.0%	NA	0.0%
44112	East Cleveland/Cleveland	2.4%	2.3%	NA	1.4%
44113	Cleveland (100%)	1.4%	1.4%	NA	0.0%
44114	Cleveland (100%)	0.3%	0.3%	NA	0.0%
44115	Cleveland (100%)	0.6%	0.5%	NA	0.0%
44116	Rocky River	1.5%	1.5%	NA	0.0%
44117	Euclid/Cleveland	0.9%	0.9%	NA	2.9%
44118	ClevelandHts/UniversityHts/	3.2%	3.3%	NA	10.9%
44119	Cleveland/Euclid (50%)	1.0%	1.0%	NA	0.7%
44120	Shaker Hts/Cleveland	3.4%	3.3%	NA	14.5%
44121	University Hts/South Euclid	2.5%	2.5%	NA	10.1%
44122	Beachwood/Highland	2.5%	2.6%	NA	10.9%
44123	Euclid	1.3%	1.3%	NA	7.2%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	3.0%	NA	5.1%
44125	Valley View/Garfield Hts	2.1%	2.2%	NA	0.7%
44126	Fairview Park/Cleveland	1.2%	1.2%	NA	0.0%
44127	Cleveland (100%)	0.6%	0.6%	NA	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.4%	NA	0.7%
44129	Brooklyn/Parma/Cleveland	2.1%	2.1%	NA	0.7%
44130	Parma/Cleveland	3.8%	3.9%	NA	0.7%
44131	Independence/Seven	1.5%	1.5%	NA	0.0%
44132	Euclid	1.1%	1.1%	NA	4.3%
44133	North Royalton	2.0%	2.1%	NA	0.0%
44134	Parma/Cleveland	2.9%	2.9%	NA	0.0%
44135	Cleveland/Linndale (90%)	2.0%	2.0%	NA	0.7%
44136	Strongsville	3.1%	3.2%	NA	0.0%
44137	Maple Hts/Cleveland	1.9%	1.9%	NA	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	NA	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	1.6%	NA	1.4%
44140	Bay Village	1.1%	1.2%	NA	0.0%
44141	Brecksville	1.0%	1.0%	NA	0.0%
44142	Brookpark/Cleveland	1.5%	1.5%	NA	0.0%
44143	Highland Hts/Richmond Heights	1.7%	1.7%	NA	5.1%
44144	Brooklyn/Cleveland	1.6%	1.6%	NA	0.7%
44145	Westlake	2.3%	2.3%	NA	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.3%	NA	0.0%
44147	Broadview Hts	1.1%	1.1%	NA	0.0%
44149	Strongsville	0.0%	-	NA	0.0%
Unknown Cuyahoga County Zip Codes*****					0.0%
Missing*****					0.0%
Unknown *****					13.8%
Total Cuyahoga County*****		100.0%	100.0%	NA	100.0%
Total Known Cleveland		30.5%	30.2%	NA	19.6%
Total Known Suburbs		69.5%	69.8%	NA	80.4%
Unknown & Missing					13.8%

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S.Census 2000, SF1 (P1)
** U.S.Census 2000, SF3 (P8)
*** "Cuyahoga County Mental Health Assessment," Center for Community Services, December 2003. Rate of persons with mental health disorders 5 years and older is 16.51 percent of the population 5 years and older.
**** 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		
Non-profit	17	-
For-profit	-	-
Government	1	-
Other	1	-
Total Number of Sites	22	1
Number of Service Sites per Provider		
1	17	1
2 – 5	2	-
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	-	-
44022 – Bentleyville	-	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	-	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	1	-
44103 – Cleveland	3	-
44104 – Cleveland	1	-
44105 – Newburgh Hts/Garfield Hts	-	-
44106 – Cleveland Hts/Cleveland	1	1
44107 – Cleveland/Lakewood	1	-
44108 – Cleveland/East Cleveland	-	-
44109 – Cleveland/Brooklyn Hts	1	-
44110 – Cleveland/Bratenahl	-	-
44111 – Cleveland	-	-
44112 – Cleveland/East Cleveland	-	-
44113 – Cleveland	-	-
44114 – Cleveland	2	-
44115 – Cleveland	1	-
44116 – Rocky River	-	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	1	-
44119 – Cleveland/Euclid	1	-
44120 – Cleveland/Shaker Hts	2	-
44121 – University Hts/South Euclid	-	-
44122 – Orange/Warrensville Hts	3	-
44123 – Euclid	-	-
44124 – Pepper Pike/Mayfield Village	4	-
44125 – Valley View/Garfield Hts	-	-
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	-	-
44131 – Seven Hills/Brooklyn Hts	-	-
44132 – Euclid	-	-
44133 – North Royalton	-	-
44134 – Parma/Cleveland	-	-
44135 – Cleveland/Linndale	-	-
44136 – Strongsville	-	-
44137 – Maple Hts/Cleveland	-	-
44138 – Olmsted Twp/Olmsted Falls	-	-
44139 – Bentleyville/Glenwillow/Solon	-	-
44140 – Bay Village	-	-
44141 – Brecksville	-	-
44142 – Cleveland/Brookpark	-	-
44143 – Highland Hts/South Euclid	-	-
44144 – Brooklyn/Cleveland	-	-
44145 – Westlake	-	-
44146 – Walton Hills/Oakwood/Bedford	-	-
44147 – Broadview Hts	-	-
44149 – Strongsville	-	-

Attachment 6: Providers and Functions – 2005

PROVIDERS AND FUNCTIONS - 2005	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
Beck Center for the Arts	Creative Arts Therapy
Center for Families and Children	Employee Assistance Program/Health and Self-Image Awareness for Youth
Center for Therapy Through the Arts - the Art Studio	Art Therapy for Children/Art Therapy - Contract Services/Art Therapy
Cleveland Clinic Children's Hospital for Rehabilitation	Inpatient, Outpatient & Intensive Treatment (Main Campus)
Cleveland Music School Settlement	Music Therapy
Cuyahoga County Critical Incident Stress Management Team	Critical Stress Debriefing for Professionals
Eliza Bryant Village	Recreation - Older Adults
The Gathering Place	Art Therapy - People Affected By Cancer
Hospice of the Western Reserve	Art Therapy for Bereavement - Adults
Menorah Park Center for Senior Living	Art and Music Therapy
Orange City School District	Senior Center - Art Therapy/Support - Grandparent Caregivers
Professional Flair/Dancing Wheels	Personal Enrichment Classes - Dance/Theater
Psychobiology Clinic of Greater Cleveland	Art Therapy for Mental Health Services for Severely Mentally Ill/Managing Emotions for Severely Mentally Ill
Recovery Resources	Employee Assistance Services
Rock and Roll Hall of Fame and Museum	Music Therapy - Rock Music - Toddlers
Senior Outreach Services	Art and Music Therapy - Health Promotion
Ursuline College	Art Therapy
Ursuline Sophia Center	Therapies - Counseling/Massage/Nutrition
West Side Ecumenical Ministry	Art Therapy - Counseling

Bold represents agencies funded by United Way for this service.

Other providers identified by a local expert in this core service include the following:

- Berea Children's Home
- Cleveland Rape Crisis Center
- Community Dialysis Center
- Cuyahoga County Board of MR/DD
- Fieldstone Therapeutic Riding Center
- Hospice of the Western Reserve
- Lutheran Hospital
- Monarch School for Autism of Bellefaire JCB
- Montefiore
- Music Therapy Enrichment Services
- A New Day Adult Day Care Center
- North Coast Behavioral Health Care
- Royalton Music
- University Hospitals
- VA Hospitals

Attachment 7: United Way - First Call for Help Supportive Therapies Programs Requests – 2000-2004: Greatest Increase/Greatest Decrease

Supportive Therapies RB								
United Way - First Call for Help Requests 2000-2004								
Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change* 00&04	Avg. # Calls 00-04
		2000	2001	2002	2003	2004		
44120	Shaker Hts/Cleveland	1	1	1	1	4	300%	2
44113	Cleveland	0	1	1	0	3	N/A	1
44115	Cleveland	0	0	0	3	3	N/A	1
44102	Cleveland/Brooklyn	0	3	0	1	2	N/A	1
44125	Valley View/Garfield Hts	0	0	0	0	2	N/A	0
44108	Cleveland/Bratenahl	0	1	0	0	1	N/A	0
44110	Cleveland/East Cleveland	0	2	0	0	1	N/A	1
44143	Highland Hts/Richmond Heights	0	0	0	1	1	N/A	0
44129	Brooklyn/Parma/Cleveland	1	1	0	0	0	(100%)	0
44109	Cleveland/Brooklyn Hts	2	3	1	0	0	(100%)	1
44106	Cleveland/Cleveland Hts	3	2	0	0	0	(100%)	1
44105	Cleveland/Newburgh Hts/Garfield Hts	3	0	1	2	0	(100%)	1
44107	Lakewood/Cleveland	3	0	0	3	1	(67%)	1
**Total Cuyahoga County		16	43	16	24	21	31%	24
**Total Cleveland		8	19	4	8	10	25%	10
**Total Suburbs		8	24	12	16	11	38%	14
<p>* Extremely high percentages are due to low numbers.</p> <p>** 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.</p>								

Attachment 8: United Way - First Call for Help Supportive Therapies Programs Requests – 2000-2004: Unmet Need

Supportive Therapies RB					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			%
		Requests	Met	Unmet	Unmet
44123	Euclid	2	1	1	50%
44113	Cleveland	5	4	1	20%
44102	Cleveland/Brooklyn	6	5	1	17%
44109	Cleveland/Brooklyn Hts	6	5	1	17%
* Total Cuyahoga County		120	116	4	3%
* Total Cleveland		49	46	3	6%
* Total Suburbs		71	70	1	1%

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
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