By the Numbers:

Developing a Common Understanding for the Future of Behavioral Health Care.

J A N U A R Y 2 0 1 1

Mental Health Advocacy Coalition
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THE CENTER FOR COMMUNITY SOLUTIONS
RESEARCH • PLANNING • ACTION

The Mental Health Advocacy Coalition is comprised of over 80 member organizations, including mental health agencies serving both children and adults, health and human services agencies, the faith-based community, education, government, advocacy organizations, major medical institutions, and the corporate arena. The MHAC's mission is to foster education and awareness of mental health issues while advocating for public policies and strategies that provide an effective, well-funded mental health system that serves those in need, resulting in a stronger community. MHAC funders include: Eva L. and Joseph M. Bruening Foundation; Cleveland Foundation; Community West Foundation; The George Gund Foundation; The Mt. Sinai Health Care Foundation; Saint Luke's Foundation of Cleveland, Ohio; Sisters of Charity Foundation of Cleveland; and Woodruff Foundation.

The Center for Community Solutions provides strategic leadership and organizes community resources to improve health, social, and economic conditions through demographic research, nonpartisan policy analysis and advocacy, and communication. It is a nonpartisan, nonprofit organization focused on policy and system reform. Established in 1913, Community Solutions is nearing its 100th year of helping the people who help people.

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Introduction

The purpose of this report is to consolidate and highlight existing statewide data on behavioral health to better inform policy decisions. In an attempt to show a comprehensive picture of the impact of behavioral health disorders on state government and other relevant programs, this report contains data from the state Departments of Mental Health, Alcohol and Drug Addiction Services, Job and Family Services, Rehabilitation and Correction, Youth Services, Aging, Health, and Education and data from the Ohio Hospital Association, Ohio Association of County Behavioral Health Authorities, The Ohio Council of Behavioral Health and Family Service Providers, and the Ohio Suicide Prevention Foundation. This data demonstrates that behavioral health disorders impact these and other systems. While the data in this report shows the number of people served, service utilization, and costs across systems, it does not reveal whether people are receiving the right services in the right amount at the right time to best address their health needs. The data in this report reflects the most current data available at the time of writing. All data should continue to be reviewed to better illuminate the impact of recent fiscal decisions.

Content

This document is broken into eight sections, including highlights, data analysis, and a summary. The first section covers funding and utilization in the community behavioral health system. This section analyzes the funding sources, including state, federal and one-time funds, available in the community behavioral health system; client demographics; and the services most utilized in the system. The second section looks at Medicaid spending for a subset of the Medicaid population, specifically individuals with a prior community mental health system claim. The analysis compares Medicaid spending across all state Medicaid agencies for this subset to spending for the general Medicaid population. The third section reviews data on individuals with a severe behavioral health disorder and emergency department and inpatient hospital utilization and costs. This section also examines state psychiatric hospital utilization by civil and forensic patients. The fourth section looks at housing and long-term care for individuals with a mental illness. The fifth section explores prevalence of mental illness and cost of mental health services in the adult and juvenile justice systems. This section also examines the length of stay for inmates with a mental illness compared to the general inmate population. The sixth section looks at educational attainment and proficiency of students with an emotional disturbance that impairs their academic performance. The seventh section looks at premature death, including the shorter life expectancy of individuals with a mental illness due to chronic physical health disorders, drug overdoses and suicides, and the societal cost of premature death. Finally, the eighth section lays out recommendations resulting from this report. The recommendations are focused on funding, policy, and other identified data needs and areas for future analysis.

The Landscape

Behavioral health disorders, which include mental illnesses and alcohol and substance abuse disorders, affect everyone. A recent poll found that two out of three Ohioans are impacted by a friend or family member with an addiction and/or mental illness.[1] Over 2.8 million Ohioans have a diagnosable mental illness. Over 550,000 adult Ohioans have a severe mental illness.[2] Over 851,000 Ohioans have a substance dependence or abuse disorder.[3] Roughly 50 percent of individuals with a severe mental illness also are affected by substance abuse.[4] Behavioral health disorders touch individuals from all walks of life and most, if not all, state funded systems. Research shows that with treatment and support an individual with a behavioral health disorder can live independently, maintain a job, care for his or her family, and engage in many other activities that individuals without a behavioral health disorder can do.

Many individuals who need behavioral health treatment receive it; too many others do not. Many individuals receive the care that they need in the community, but others do not because of a lack of services and supports. There are also some individuals who need care outside the community behavioral health system. While care is needed all along the continuum, ideally, treatment and supportive services would be available early enough to prevent the need for more costly interventions in emergency departments, hospitals, nursing homes, the criminal justice system and other expensive systems.

While the community behavioral health system faced significant cuts in state funding in the last biennium, federal stimulus provided $49.9 million in FY 2009 and $56.3 million in FY 2010 through enhanced match for Medicaid services and helped to prevent deeper reductions. This

funding source will end on June 30, 2011 and at the same time state replacement dollars for the Tangible Personal Property Tax will begin to be phased out, impacting local funding for community behavioral health services as well. Not only does the state face a sizable structural deficit, but current state funding levels for community behavioral health will be insufficient to cover the non-federal share of Medicaid in the FY 2012 - 2013 biennium. All of these factors are coming together to create the perfect storm in the FY 2012 – FY 2013 budget. A comprehensive strategy is needed now to integrate physical and behavioral health care and improve coordination between providers and state and local agencies.

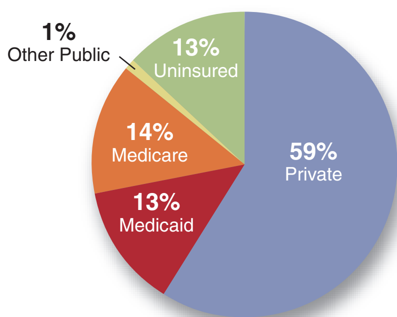
Though Ohio faces a crushing state revenue shortfall, more support is needed now to stabilize community behavioral health services and supports for individuals with behavioral health disorders. This would not only improve the care of individuals with behavioral health disorders but would be prudent fiscal policy as it would stave off the need for future spending in systems that are ill-equipped to provide long-term treatment and stabilization for people with behavioral health disorders.

Ohio's health care delivery system must fundamentally change as a result of federal health care reform. Without system reform the addition of newly eligible low-income adults, coupled with stringent federal Medicaid requirements and inadequate and disparate funding levels across the state, will deepen the cracks that already exist in Ohio's behavioral health system. Ohio cannot continue down its current path. Federal health reform provides the impetus to reform our current delivery systems to improve care for people with behavioral health disorders. Ohio should seize this opportunity by realigning roles and responsibilities between government entities at the state and local levels and various types of providers.

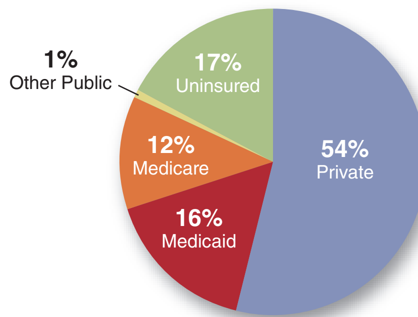
Health Care Coverage

Approximately 1.3 million Ohioans are uninsured. Ohio's uninsured population is proportionately smaller than the United States – 13 percent versus 17 percent. Compared to the nation, Ohio has more individuals covered by private insurance and Medicare. Due to more stringent income requirements for the disabled, Ohio has proportionately fewer individuals covered through Medicaid.

Health Insurance Status - Ohio



Health Insurance Status - US



Source: *Kaiser State Health Facts. Statehealthfacts.org – Ohio: Health Insurance Status*

Medicaid has Closed Some Coverage Gaps; but Many Gaps Remain

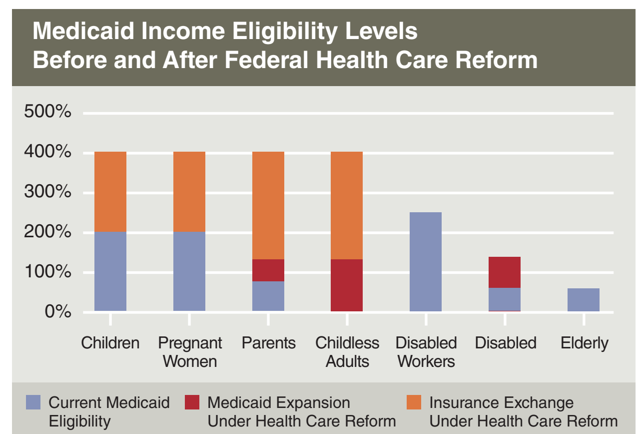
Medicaid is a significant payer of health care services and is the primary payer for mental health services. For alcohol and drug addiction services, Medicaid is significant, but the federal Substance Abuse Block Grant is the largest payer. Medicaid does not cover everyone who needs behavioral health services.

Most individuals eligible for Medicaid are covered through one of two programs: (1) Covered Families with Children, and (2) Aged, Blind, and Disabled. The Covered Families with Children (CFC) category includes low-income children and their parents. The Aged, Blind, and Disabled (ABD) category includes low-income individuals who also meet categorical eligibility due to age or a disabling condition. Medicare pays for many of the acute health care costs for ABD individuals who are dually eligible for Medicaid and Medicare.

While the populations covered by Medicaid have changed dramatically over the past decade with expansions for children, pregnant women, low-income parents, and the working disabled, many low-income and/or disabled individuals are not eligible for Medicaid coverage. Many individuals with behavioral health disorders do not qualify for Medicaid. Sixty-five present of individuals in need of substance abuse services and 40 percent of individuals in need of mental health services are not Medicaid eligible.[5] Among those not generally eligible for Medicaid are low-income childless adults; individuals with a primary diagnosis of substance abuse; individuals who have a illness but have not yet established enough of a medical history to meet the disability definition; and newly poor individuals who still have some assets including houses, cars, and income from retirement and/or severance packages. Lags in Medicaid application processing times and difficulties in the disability determination process place additional stress on safety net services. Some individuals who benefit from CFC lose their eligibility due to age and other restrictions. These individuals must transition to ABD to receive Medicaid coverage. This transition can be time consuming and often individuals go without Medicaid for a period of time.

Coverage Changes under Federal Health Care Reform

Federal health care reform will close health insurance coverage gaps for many. The chart below shows Medicaid eligibility levels now and after implementation of federal health reform. Most uninsured individuals will have access to insurance coverage either through the Medicaid expansions or private insurance through the health insurance exchanges. Ohio expects to add a total of about 554,000 people to the Medicaid program through this expansion[6] and an additional 503,000 through the health care exchanges.[7]



Source: *Greg Moody, Health Policy Institute of Ohio*

Community Behavioral Health System[8]

Highlights

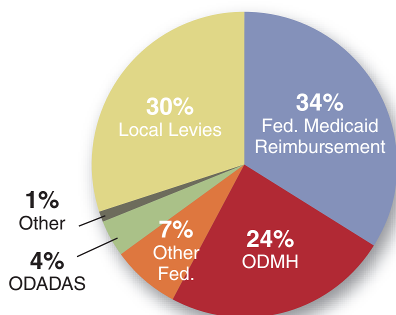
- Medicaid spending on treatment is increasing for Medicaid eligible individuals, but spending is falling for services for individuals who are not enrolled in Medicaid and for supports that are not reimbursable by Medicaid.
- General revenue fund support for behavioral health services has decreased to the point that in FY 2012 – 2013, funding levels will be insufficient to fund the Medicaid program.
- One-time federal funds and local levies have prevented deeper cuts in services in the FY 2010-2011 biennium.
- Between FY 2007 and FY 2010, overall mental health system spending, service utilization, and the number of clients served has increased proportionately; however, there have been significant shifts among services used.
- While overall system spending on alcohol and drug addiction between FY 2007 and FY 2010 has grown by 2 percent, fewer individuals are receiving more services (11 percent increase in service utilization).

The community behavioral health system, comprised of the state departments of mental health and alcohol and drug addiction services, 53 local boards, and more than 400 providers, provides care for both insured and uninsured individuals with behavioral health disorders. As funding has fallen and Medicaid enrollment and service utilization has grown, particularly during the recent recession, many behavioral health care services for non-Medicaid eligible individuals and services not reimbursable by Medicaid have been reduced and/or eliminated.

System Funding

State General Revenue Fund (GRF) subsidies, local levy funds, and federal Medicaid reimbursement are the most significant sources of funding for the community behavioral health system.

Community Behavioral Health System Funding



Source: *Ohio Association of County Behavioral Health Authorities*

- *State Subsidies from Ohio Department of Mental Health (ODMH) and Ohio Department of Alcohol and Drug Addiction Services (ODADAS)* have been declining. Some of the decline during this time period is offset by increasing federal reimbursement for Medicaid.
- *Federal Medicaid Reimbursement* has been growing due to increased caseloads and higher match rates. Federal stimulus has provided Ohio with up to an extra $0.10 in federal funds for every dollar spent on Medicaid services, but the enhanced federal match rate (eFMAP) will drop significantly on January 1, 2011, and will be eliminated on June 30, 2011.
- The amount collected through *Local Levies* for behavioral health has increased from $300.8 million in 2007 to $346.8 million in 2009, an increase of 15 percent that is mainly the result of the passage of 4 new levies since 2007.[9] However, this increase has not been evenly distributed across the state. There are 13 counties that do not have a levy. Many counties have seen their local funds decrease. For example, local funding for mental health in Cuyahoga County dropped by 5 percent during this period.

Board Spending for Behavioral Health Services (all sources)

	2007	2008	2009	2010	% Increase
AOD Medicaid	$66,408,040	$70,543,577	$76,241,431	$80,706,160	22%
AOD Non-Medicaid	$136,664,306	$135,250,658	$136,674,963	$126,658,477	-7%
MH Medicaid	$422,997,042	$447,038,988	$482,873,095	$528,084,968	25%
MH Non-Medicaid	$238,424,426	$246,898,903	$253,510,755	$234,435,985	-2%
Total	**$864,493,814**	**$899,732,125**	**$949,300,245**	**$969,885,590**	**12%**

Source: *Multi-Agency Community Services Information System (MACSIS)*

Overall, total spending in the community behavioral health system increased by 12 percent from 2007 to 2010. System spending on alcohol and drug addiction services – about 21 percent of the total in 2010 – increased by a total of 2 percent between 2007 and 2010. During this period, Medicaid spending for alcohol and drug addiction services grew by 22 percent, while non-Medicaid spending dropped by 7 percent. Between 2007 and 2010, community mental health system spending increased by 12 percent. Spending on Medicaid services increased by 25 percent, while spending on non-Medicaid services declined by 2 percent. Between FY 2007 and FY 2010, Ohio's Medicaid caseload has grown by 16 percent, covering just over 2 million people by the end of FY 2010.

Federal Stimulus

Federal stimulus has provided short-term financial support for the community behavioral health system through the FY 2010-2011 biennium. Through federal stimulus, states received additional federal reimbursement (also known as eFMAP) for Medicaid claims processed between October 1, 2009 and June 30, 2011. Federal stimulus provided $49.9 million in 2009 and $56.3 million in 2010 for the community behavioral health system and has helped to fund the increase in Medicaid clients. The loss of these one-time funds in the FY 2012-2013 biennium will create additional challenges for the community behavioral health system.

Enhanced FMAP Funds in the Community Behavioral Health System

	2009	2010
MH	$42,931,277	$48,944,856
AOD	$ 6,960,261	$ 7,388,287

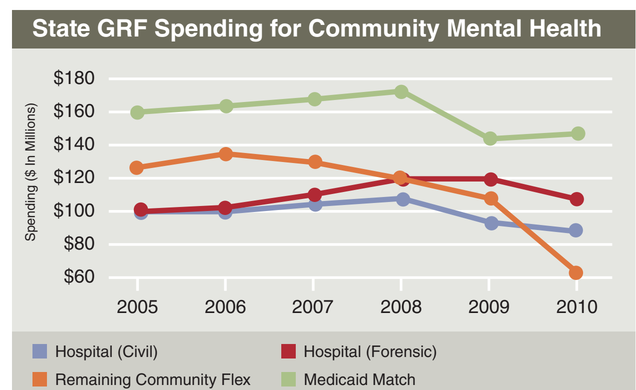
Source: *MACSIS, The Center for Community Solutions*

Community Mental Health System

The community mental health system offers treatment as well as recovery support services for individuals who have a mental illness. Most individuals served in this system either have Medicaid coverage or are uninsured. The increase in both Medicaid enrollment and in Medicaid service utilization has reduced available funding for treatment services for the uninsured and all non-Medicaid reimbursable services.

State GRF allocations to the local alcohol, drug addiction and mental health boards are used to fund the non-federal share of Medicaid expenses, cost of inpatient hospitalization (forensic[10] and civil) in state psychiatric hospitals, treatment services to individuals not eligible for Medicaid, and services that are not eligible for Medicaid reimbursement. The FY 2010-2011 budget made deep cuts in GRF funding for this system. These reductions follow years of stagnant funding levels that have not kept pace with increasing need for services. In fact, in a recent study, 88 percent of county alcohol, drug and mental health services boards report that funding reductions have resulted in longer waits for services for consumers and 65 percent reported that non-Medicaid services have been reduced.[11]

State GRF Spending for Community Mental Health

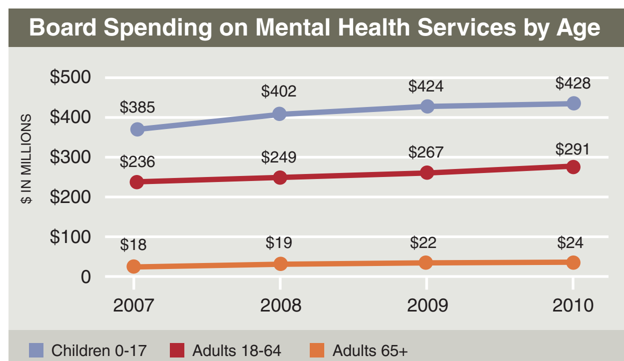


Source: *Ohio Department of Mental Health, MACSIS*

Like many physical health care services, Medicaid mental health and alcohol and drug addiction services are entitlement services on the state's Medicaid plan, yet the non-federal share of Medicaid is the responsibility of the local alcohol, drug addiction and mental health services boards. Increasing numbers of individuals in Ohio's Medicaid program require treatment for mental health and alcohol and/or drug addiction disorders, and increasing numbers of offenders are committed to state psychiatric hospitals for treatment by the court system (forensic patients). For additional information on state hospital utilization, see section titled "Consumers with Severe Behavioral Health Disorders in Hospitals and Emergency Departments."

Current state funding levels are insufficient to fund expected growth in caseload and service utilization of the Medicaid program in the FY 2012-2013 budget. The current system financing structure places tension between Medicaid services and treatment services for non-Medicaid individuals and for support services that are not reimbursed by Medicaid. Continued support for these services is vital to the recovery of individuals with behavioral health disorders. As outlined in the introduction, non-Medicaid funding is critical to ensure that individuals who are not Medicaid eligible receive treatment services and that non-Medicaid support services that are vital to recovery, such as housing and employment services, are available.

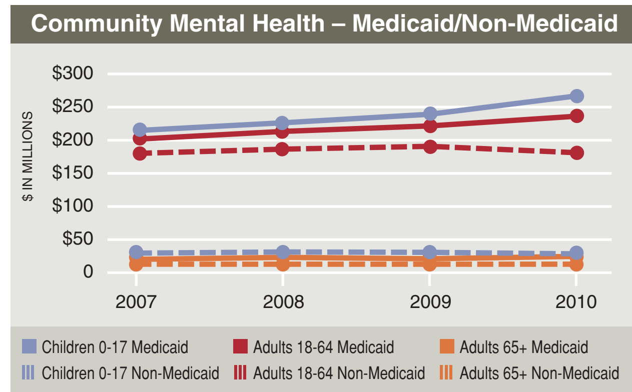
The number of children served in the community mental health system has been growing at a faster rate than other age groups. This is not surprising as the total number of children receiving health care coverage through Medicaid has been increasing. Children now make up about 55 percent of Ohio's Medicaid caseload.



Source: *MACSIS*

Spending across all age groups for community mental health services has risen during this time period. In 2010,

- Adults between the ages of 18 and 64 represented 64 percent of clients served in the community mental health system and accounted for 58 percent of all spending;
- Children under the age of 18 represent 33 percent of clients served in the community mental health system and account for 39 percent of all spending; and
- Adults over 65 represent 3 percent of the system's clients and account for 3 percent of all spending.



Source: *MACSIS*

Between 2007 and 2010, Medicaid spending on community mental health services increased dramatically by 25 percent. During this time Medicaid as a share of total community mental health spending increased from 66 percent in 2007 to 71 percent in 2010. As Medicaid caseloads grew and state subsidies were reduced, spending on non-Medicaid services, particularly for adults between the ages of 18 and 64, dropped significantly between 2009 and 2010.

- Children under the age of 18 represent 43 percent of Medicaid mental health clients and about 50 percent of mental health Medicaid spending.
- Adults, 18 to 64 years of age, represent 51 percent of Medicaid mental health clients and 46 percent of Medicaid mental health spending.
- Adults, 18 to 64 years of age, represent 84 percent of non-Medicaid mental health clients and 85 percent of non-Medicaid mental health spending.

Mental Health Services

The nine services listed below and in chart "Snapshot of Most Commonly Used Community Mental Health Services" in the appendix represent about 90 percent of all system spending. Seven of the services listed are Medicaid-reimbursable for eligible clients. The other two services, residential care and other mental health service (non-health care), are not eligible for Medicaid reimbursement. In FY 2010, the community mental health system served 354,194 clients, an increase of 14 percent since FY 2007. Total spending for these services totaled $762.5 million, and over 25.5 million service units were billed. (All services are billed in one hour increments except CPST and counseling [15 minute increments] and partial hospitalization and residential care [daily rate].) Prices for Medicaid services have been held constant for more than a decade. Between FY 2007 and FY 2010, system spending, service utilization, and the number of clients served have increased proportionately. The number of clients served over this period increased by 14 percent, while system spending and service utilization grew by 15 percent. A closer look at the detail reveals that there are some significant shifts among individual services.

Community Psychiatric Supportive Treatment – Individual – Community psychiatric supportive treatment services (CPST) are rehabilitation services that help individuals remain in the community. CPST services include symptom monitoring, development of personal independence and daily living skills, service coordination, and assistance in crisis management. Since 2007, spending on CPST services for individuals has increased by 16 percent. The number of clients served has grown by 17 percent, while service utilization has increased by 14 percent.

Counseling – Individual – Behavioral health counseling and therapy provides treatment of a person's mental illness or emotional disturbance through individual or group sessions with a clinician in time-limited, structured sessions to achieve mutually defined goals identified in the individual service plan (ISP). Since 2007, spending for individual counseling and therapy has increased by 30 percent. Service utilization has increased by 27 percent, while the number of clients served has only grown by 17 percent.

Pharmacological Management – Pharmacological management provides monitoring and supervision of a patient's prescription medication to minimize symptoms and improve functioning. Since 2007, spending on pharmacological management has increased by 23 percent. The number of clients served has increased by 17 percent, and service utilization has increased by 18 percent.

Partial Hospitalization – Partial hospitalization provides highly structured, clinically intensive mental health interventions to stabilize or increase a patient's level of functioning. Activities may include problem solving, conflict resolution, emotion/behavior management, development of coping skills, and management of symptoms. Services are clinically indicated with clear admission and discharge criteria. Partial hospitalization has grown slowly compared to other mental health services. Since 2007, the number of clients receiving partial hospitalization and service utilization has grown by 6 percent, while spending on this service has grown by 7 percent. In FY 2010, 85 percent of all spending for this service was for children ages six to 17.

Diagnostic Assessment – Non Physician – Diagnostic assessment is a clinical evaluation provided by a qualified clinician either at specified times or in response to treatment, or when significant changes occur to assess client needs and functioning in order to determine appropriate service/treatment based on identification of the presenting problem, evaluation of mental status, and formulation of a diagnostic impression. Since 2007, spending on non-physician diagnostic assessments has increased by 20 percent. At the same time the number of clients served has increased by 15 percent, and service utilization has increased by 17 percent.

Residential care – Residential care includes payment for room and board plus personal care. This service is not eligible for Medicaid reimbursement. Spending on residential care has dropped by 5 percent since 2007 and 733 fewer consumers receive this assistance. The majority of residential care is being provided to adults.

Other Mental Health Services (Non-Health care) – Non Physician – Other mental health services may include representative payeeship, transportation, and other supportive mental health services, and may be offered by a variety of entities, including nonprofit organizations and other governmental entities. This service is not eligible for Medicaid reimbursement. Services offered vary by local board. The number of clients receiving this service has increased by 39 percent since 2007, while service utilization has increased by 3 percent. Overall spending for this service has increased by 30 percent.

Community Psychiatric Supportive Treatment – Group – Community psychiatric supportive treatment services (CPST) are rehabilitation services that help individuals remain in the community. CPST services include symptom monitoring, development of personal independence and daily living skills, service coordination, and assistance in crisis management. CPST services may be delivered to

individuals (noted above) or groups. CPST services for groups have increased at a much faster rate than CPST services for individuals. Total spending on CPST group services has increased by 60 percent since 2007. The number of clients receiving services has increased by 32 percent, while service utilization has increased by 55 percent.

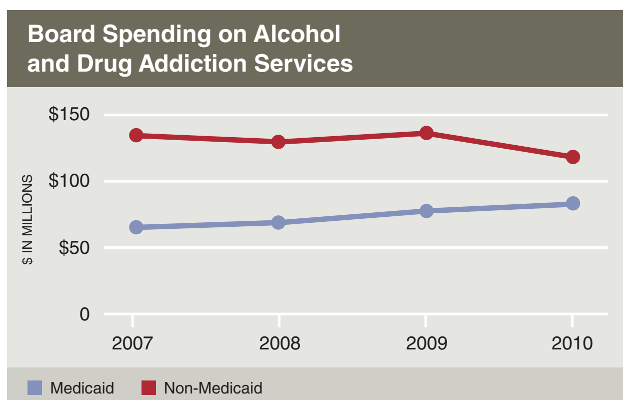
Counseling - Group – Behavioral health counseling and therapy provides treatment of a person's mental illness or emotional disturbance provided in time-limited, structured individual or group sessions to achieve mutually defined goals identified in the individual service plan (ISP). Since 2007, system spending on group counseling and therapy has increased by 14 percent, while the number of clients served has only increased by 3 percent. Service utilization has increased by 10 percent.

Alcohol and Drug Addiction System

Like the community mental health system, the alcohol and drug addiction system offers treatment as well as recovery support services, but unlike the community mental health system, a greater share of system spending is for non-Medicaid services and clients. While Medicaid spending has been increasing, non-Medicaid spending has fallen. Between 2007 and 2010, Medicaid spending has increased by 22 percent. Non-Medicaid spending decreased by 7 percent over the same period.

Federal Substance Abuse and Mental Health Services Administration (SAMSHA) funds provide a significant source of funding for services in this system. Other funding sources include state GRF subsidies and a portion of the revenues from driver's license reinstatements, liquor profits, and liquor permits.

Board Spending on Alcohol and Drug Addiction Services



Source: *MACSIS*

Of total community alcohol and drug addiction services system spending in 2010, the largest share ($59.1 million or 28 percent) was used to treat clients with an opiate addiction. Treatment for addiction to cannabis totaled $36.1 million (17 percent of total spending), while alcohol treatment totaled $17.5 million (8 percent of the total).

Alcohol and Drug Addiction Services

The nine services listed below and in chart "Snapshot of Most Commonly Used Community Alcohol and Drug Addiction Services" in the appendix represent about 75 percent of spending by the community alcohol and drug addiction system. Services listed that are eligible for Medicaid reimbursement include individual and group counseling, case management, methadone administration, assessment, and intensive outpatient services. While the number of clients served had been steadily increasing from FY 2007 through FY 2009, in FY 2010, the number of clients served dropped dramatically. In FY 2010, the alcohol and drug addiction services system served 98,707 clients, 5.5 percent fewer than in FY 2009. Total spending for all services totaled $207.4 million, and over 8.5 million service units were billed. (All services are billed in one hour increments except counseling [15 minutes], methadone administration [per dose], and intensive outpatient services, non-medical community residential treatment: non-acute, and room and board [daily rate].) Between FY 2007 and FY 2010, system spending and service utilization increased while the number of clients served dropped. Except for methadone administration and group counseling, Medicaid utilization is growing quickly while non-Medicaid utilization is dropping.

Counseling – Group – Group counseling includes a face-to-face encounter between two or more clients and a counselor. Counseling helps individuals meet treatment objectives through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions, and decision making. Since 2007, total spending on group counseling has increased by 21 percent. Group counseling spending for Medicaid clients increased by 32 percent, while spending for non-Medicaid clients increased by 8 percent. Service utilization has increased by 14 percent, while the number of clients served has only grown by 5 percent.

Intensive Outpatient Services – Intensive Outpatient Services are structured individual and group alcohol and drug addiction activities and services that are provided at an outpatient program for a minimum of eight hours per week with services provided at least three days per week. Services include assessment, individual and group counseling, and crisis intervention. Since 2007, spending on intensive outpatient services has decreased by 8 percent. The number of clients served has dropped by 10 percent, while service utilization has dropped by 12 percent.

Counseling – Individual – Individual counseling includes a face-to-face encounter between a client and a counselor. Counseling helps individuals meet treatment objectives through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions, and decision making. Since 2007, total spending on individual counseling has increased by 13 percent. At the same time, the number of clients served has increased by 6 percent, and service utilization has increased by 9 percent.

Non-Medical Community Residential Treatment: Non-Acute – Non-medical community residential treatment provides professionally directed evaluation, care, and treatment for the restoration of functioning for persons with alcohol and other drug problems in a 24-hour rehabilitation facility, without around-the-clock medical care. This service is not eligible for Medicaid reimbursement. Since 2007, spending on non-medical community residential treatment has increased 10 percent. The number of clients served has decreased by 6 percent, while service utilization has increased by 1 percent.

Case Management Services – Case management services include those activities that help individuals gain access to needed medical, social, educational, and other services that are essential to meeting basic human needs. Since 2007, total spending on case management services has decreased by 3 percent. At the same time, the number of clients served has dropped by 3 percent, and service utilization has decreased by 9 percent. Case management services for Medicaid clients have increased by 15 percent, while the same services for non-Medicaid clients dropped by 22 percent.

Assessment Service – Assessment services are used to determine the nature and extent of an individual's abuse, misuse, and/or addiction to alcohol and/or other drugs. Since 2007, total spending on assessment services has decreased by 7 percent. The number of clients served over the same period dropped by 5 percent, and service utilization has decreased by 9 percent.

Education – Prevention education services are provided to reduce the incident of alcohol and substance abuse and addiction by developing or improving decision making, refusal skills, critical analysis, and systematic judgment abilities. This service is not eligible for Medicaid reimbursement. Since 2007, spending on prevention through education has dropped 21 percent. The number of clients served over the same period dropped by 38 percent, and service utilization decreased by 51 percent. The federal substance abuse block grant requires that 20 percent of that funding be spent on education and early intervention activities.

Methadone Administration – Methadone administration is a form of treatment for narcotic addiction. Since 2007, total spending on methadone administration has increased by 44 percent. Spending on methadone administration for Medicaid clients increased by 65 percent and by 24 percent for non-Medicaid clients. The number of clients served has increased by 35 percent, and service utilization has increased by 40 percent.

Room/Rent Subsidies – Room and rent subsidies provide housing assistance to clients enrolled in treatment programs. This service is not eligible for Medicaid reimbursement. Since 2007, spending on these subsidies has increased by 1 percent. At the same time, the number of clients served has decreased by 2 percent, and service utilization has increased by 11 percent.

Summary

State GRF funding has been declining, but one-time funds, specifically federal enhanced Medicaid matching dollars, have prevented further declines in services. The state funding reductions have resulted in a decrease in services not reimbursed by Medicaid or for those individuals not enrolled in Medicaid. Based on current state funding, during the FY 2012 – FY 2013 biennium, GRF funding will be insufficient to meet the expected growth in the community behavioral health Medicaid program. Community based behavioral health services are vital to recovery for an individual with a behavioral health disorder. Ohio needs a comprehensive strategy to ensure the availability of community based behavioral health services, and health care reform can be the impetus for change.

Special Study: Medicaid Spending for Individuals Previously Treated in the Community Mental Health System[12]

Highlights

- Overall, monthly Medicaid per member costs are higher for individuals with mental illness.
- Children between the ages of 6 and 17 account for 11 percent of overall Medicaid spending yet about 50 percent of spending for community mental health services.
- Individuals with a mental illness and co-occurring disorders, particularly developmental disorders, have significant per member costs in the mental health system as well as other Medicaid systems.

Studies in other states have shown that individuals with mental illness have higher overall health care costs due to a higher incidence of chronic disease. To see how Ohio compares, the Ohio Department of Job and Family Services analyzed FY 2010 spending across all agencies[13] for individuals who had at least one claim processed through the community mental health system in FY 2009.

This analysis found that 88 percent of individuals, or just over 244,000, who had a mental health claim in FY 2009, also had Medicaid spending in FY 2010. Total spending for all services across all Medicaid agencies for individuals with a prior community mental health claim was $2.4 billion, or 17 percent of all Medicaid spending.

Fiscal Year 2010 Medicaid Spending (All Agencies)

	Medicaid Members with MH Claim			All Medicaid Members		
	Members	Fiscal Yr. 2010 Cost	Monthly Cost per Member	Members	Fiscal Yr. 2010 Cost	Monthly Cost per Member
CFC	126,373	$556,169,556	$367	1,235,830	$4,565,978,213	$308
ABD	104,135	$1,822,248,489	$1,458	498,554	$9,489,376,473	$1,586
Other	13,788	$34,467,171	$208	85,073	$206,799,899	$203
Total	**244,296**	**$2,412,885,216**	**$823**	**1,819,457**	**$14,262,154,585**	**$653**

Source: *Decision Support System, Ohio Department of Job and Family Services*

Not only is total spending significant, but the monthly cost per member was higher for Medicaid recipients who had previously received mental health treatment services, except for the ABD population.

The per member monthly cost for individuals with mental illness in the Covered Families and Children (CFC) population was 16 percent higher than the average monthly per member Medicaid cost for the overall CFC population.

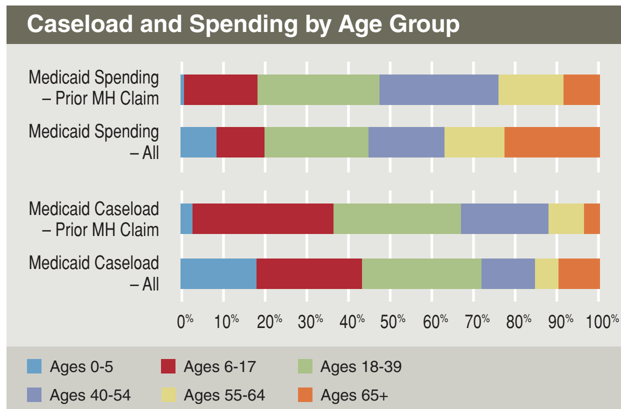
- Even with only five months of data, the mental health subset had significantly higher prescription drug spending.[14]
- Costs may be understated as spending data include the premium payments to managed care and not the encounter cost, or service utilization, data.

The monthly per member cost in the Aged, Blind, and Disabled (ABD) population for the mental health subset is slightly lower compared to the monthly per member cost for the overall ABD population.

- Spending on long-term care services makes up a greater proportion of ABD spending, and these services are more heavily used by elderly and developmentally disabled Medicaid members than individuals with a mental illness.
- While Medicaid spending for this population is significant, Medicaid represents a fraction of total health care spending for many individuals. About 27,000 individuals with mental illness are eligible for both Medicaid and Medicare. For these dually eligible individuals, Medicare pays for inpatient hospitalization and prescription drugs – two areas of significant cost for this population. Other funds, including local mental health levy dollars, are also used to pay for services not eligible for Medicaid or Medicare reimbursement.

The most marked differences between the two datasets are found in three age ranges: children between the ages of 6 and 17, adults ages 40 to 54, and adults over the age of 65.

Caseload and Spending by Age Group



Source: *Decision Support System, Ohio Department of Job and Family Services*

Children Ages of 6 and 17

- *In the Overall Medicaid Population:* Represent 25 percent of the overall Medicaid caseload and 11 percent of the overall spending.
- *With a Prior Mental Health Claim:* Represent 34 percent of the Medicaid caseload with a prior community mental health claim and 18 percent of the spending.
- Spending on community mental health services accounted for 43 percent of all Medicaid spending for children with a previous mental health claim but only 15 percent of the overall Medicaid spending for this age group.

Adults Ages 40 and 54

- *In the Overall Medicaid Population:* Represent 12 percent of the overall Medicaid caseload and 20 percent of the overall spending.
- *With a Prior Mental Health Claim:* Represent 21 percent of the Medicaid caseload with a prior community health mental claim and 29 percent of the spending.
- Spending for services through the Ohio Department of Developmental Disabilities accounted for 30 percent of the Medicaid spending for adults in this age group with a prior mental health claim versus 12 percent of overall Medicaid spending for this group.

Adults Ages 65 and Over

- *In the Overall Medicaid Population:* Represent 9 percent of the overall Medicaid caseload and 23 percent of the overall spending.
- *With a Prior Mental Health Claim:* Represent 3 percent of the Medicaid caseload with a prior community health claim and 8 percent of the spending.
- Spending on long-term care services, including nursing home and home- and community- based services, accounted for 75 percent of overall Medicaid spending for this age group.

Co-Occurring Disorders: Individuals with Mental Illness in Other Medicaid Agencies

Many individuals with a mental illness also have other co-occurring disorders such as developmental disabilities or alcohol and drug addiction disorders. The following chart shows FY 2010 spending on Medicaid recipients who had a mental health claim in FY 2009.

Spending on Individuals with a Mental Illness in Other Medicaid Agencies

	FY2010 Cost Medicaid Members with MH Claim	FY2010 Cost All Medicaid Members	Spending on MH Consumers as % of Total
Aging System	$34,190,565	$454,438,329	8%
Intermediate Care Facilities/MR	$82,767,010	$757,822,713	11%
Developmental Disabilities System	$336,323,479	$1,078,690,590	31%
ODADAS System	$30,025,902	$78,358,059	38%

Source: *Decision Support System, Ohio Department of Job and Family Services*

Medicaid recipients who had been treated previously for a mental illness accounted for 38 percent of Medicaid spending in the alcohol and drug addiction services system (ODADAS). Individuals who had been treated previously for a mental illness accounted for 31 percent of the spending in the developmental disabilities system.

Summary

Medicaid enrollment is increasing in Ohio and the number of Medicaid clients, especially children, utilizing behavioral health services is increasing. Overall, the monthly per member cost for individuals with a prior community mental health claim is higher than the general Medicaid population. Addressing Medicaid costs for all individuals, including those with a mental illness, is essential to containing health care costs in Ohio. Ohio should not eliminate community behavioral health services from its Medicaid program. If these services were eliminated, health care costs will grow at an even faster rate as individuals seek care in more expensive settings.

Consumers with Severe Behavioral Health Disorders in Hospitals and Emergency Departments[15]

Highlights:

- For individuals presenting in Emergency Departments, but not admitted to the hospital:
  - Adults between the ages of 20 to 64 are more likely to be uninsured with 32 percent of all visits billed as self-pay.
  - The average charge for an emergency department visit for an individual with severe mental illness is higher than the average charge for all ED visits.
  - Major depression is the most common severe behavioral health disorder seen in emergency departments.
- Inpatient hospital stays for patients with severe behavioral health disorders paid by Medicaid are increasing, while stays paid by private insurance are decreasing.
- Inpatient hospitalizations for bipolar disorder are increasing, while hospitalizations for major depression are falling.
- Adults between the ages of 20 and 64 comprise the largest group of patients with severe behavioral health disorders in inpatient settings.
- Diabetes mellitus is the most common selected secondary diagnosis for individuals with severe behavioral health disorders in inpatient hospitals.
- Individuals with severe behavioral health disorders admitted to a private hospital have longer stays but lower costs than average. However, an individual with a severe behavioral health disorder and a secondary physical diagnosis has a longer length of stay and higher cost than individuals with a severe behavioral health disorder but no secondary physical diagnosis.
- Since April, 2009, the number of private inpatient hospital beds has been increasing.
- Higher-cost forensic patients make up more than half of the patients treated in state psychiatric hospitals.

Emergency Department Utilization

In 2009, across all payer sources, there were 36,370 visits to Ohio's emergency departments for severe mental illness or substance abuse that did not result in a hospital admission. This number represents less than 1 percent of all emergency department visits that did not result in an inpatient stay. While this percentage may seem small, emergency department visits for severe behavioral health disorders are more likely to be uninsured – 26 percent versus 19 percent. In addition the average charge[16] for an emergency department visit for severe behavioral health disorders was 21 percent higher – $1,593 versus $1,312 – likely an indication that these emergency department visits were more complex. The total charge for emergency department visits for severe behavioral health disorders across all payer sources in 2009 was $57.9 million.

Major depression was the most common diagnosis (59 percent of all cases), followed by bipolar disorder (23 percent) and panic disorder (13 percent). Substance abuse accounted for 4 percent of all cases, and delusional disorder accounted for 1 percent.

Emergency department visits for severe behavioral health disorders for all ages and diagnoses were most frequently paid by Medicaid (28 percent of all visits). Private insurance was a close second paying for 27 percent of all visits, self pay (i.e. uninsured) accounted for 26 percent, while Medicare covered 16 percent.

Emergency Department Visits for Severe Behavioral Health Disorders by Payer

	Total Visits	% of Total	Average Charge	Total Charge
Medicaid	10,186	28%	$1,476	$15,030,990
Medicare	5,779	16%	$1,631	$9,425,953
Other public	802	2%	$1,735	$1,391,439
Private Ins	9,975	27%	$1,576	$15,720,565
Self Pay	9,628	26%	$1,598	$15,380,893
BH-Related Total	**36,370**		**$1,593**	**$57,950,241**
All Visits – Total	**5,366,152**		**$1,312**	**$7,041,035,362**

Source: *Ohio Hospital Association*

Adults between the ages of 20 and 64 account for 77 percent of all cases. Children up to age 19 accounted for 19 percent of all cases, and adults over the age of 65 accounted for 4 percent of all cases.[17]

Children Under 19: Medicaid and private insurance are the primary payers for children. Medicaid paid for 44 percent of all behavioral health ED visits, while private insurance paid for 44 percent.

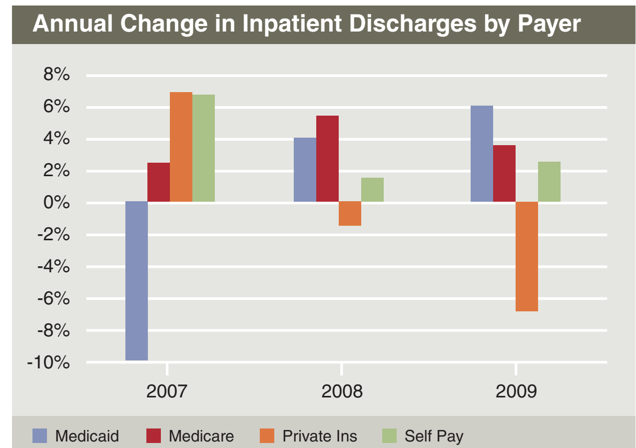
Adults Ages 20 to 64: Medicaid paid for 25 percent of all visits for this age group, while private insurance paid for 24 percent. Medicare paid for 16 percent of the visits for this age group. This age group was more likely to be uninsured with 32 percent of all visits billed as self-pay.

Adults Ages 65 and Over: Medicare was the primary source of payment for adults over the age of 65, paying for 88 percent of all ED visits.

Treatment of Severe Behavioral Health Disorders in Private Inpatient Hospitals

In 2009, there were 55,526 discharges from private inpatient hospitals for individuals with a primary diagnosis of severe behavioral health disorders.[18] These discharges, or hospital stays, represented 3.5 percent of all discharges. The total charge[19] for these stays across all payers was in excess of $740 million.

From 2006 to 2009, the number of inpatient hospital discharges for patients with severe behavioral health disorders grew from 53,649 to 55,526, an increase of 3.5 percent, but the payer of these stays over the same period changed dramatically. Between 2006 and 2007, the number of discharges paid by Medicaid dropped by 10 percent. The addition of prescription drug coverage through Medicare and the tightening of eligibility requirements through the federal Deficit Reduction Act of 2006 led to a reduction in Medicaid caseloads across the nation, perhaps explaining the decrease in Medicaid and increase in self-pay patients. At the same time, Ohio expanded managed care coverage for Medicaid recipients, which may have reduced inpatient hospitalization rates through utilization management. Since 2007, enrollment in Ohio's Medicaid program has risen by 17 percent. The stays paid by private insurance dropped dramatically between 2008 and 2009, likely a result of job loss and the corresponding loss of health insurance due to the recession.



Source: *Ohio Hospital Association*

Medicare was the most frequent payer for adults between the ages of 20 and 64, paying for 31 percent of all cases. Individuals with a severe and persistent mental illness are likely to be dually eligible for both Medicare and Medicaid. Medicare is the primary payer for inpatient stays for the dually eligible. Medicaid paid for 29 percent of all stays, while private insurance paid in 28 percent of all discharges. Self-pay (generally those who are uninsured) accounted for 11 percent of all stays.[20]

By 2009, bipolar disorder surpassed major depression to become the most common primary diagnosis for patients hospitalized for a severe behavioral health disorder. Bipolar disorder accounted for 36 percent of all severe behavioral health disorder inpatient stays in 2009. The number of inpatient stays for patients with bipolar disorder has also grown rapidly – 11 percent from 2006 to 2009. Major depression accounted for 34 percent of all inpatient stays. Schizophrenia accounted for 15 percent of all inpatient discharges, while substance abuse accounted for 14 percent of all discharges.[21]

For most severe behavioral health disorders the average length of stay has been falling, while the average cost has been increasing – a trend seen in inpatient discharges in general. Although the average length of stay for a behavioral health disorder is longer than the average across the system (6.8 days versus 5.26 days in 2009), average charges are about half ($14,694 versus $25,389 in 2009). The charge differential is due to the higher cost of providing surgical care.

In 2009, adults between the ages of 20 and 64 accounted for the majority of cases (77 percent), children between the ages of 0 and 19 accounted for 14 percent, and

adults over the age of 65 accounted for 8 percent. While these shares have been fairly constant, the number of adults over the age of 65 who are hospitalized for behavioral health disorders has dropped compared to 2006. In contrast, the numbers of adults between the ages of 20 and 64 and children up to age 19 have been increasing.[22]

Inpatient Hospital Discharges for Behavioral Health with Selected Secondary Diagnoses

Many individuals with behavioral health disorders have co-occurring chronic physical health conditions. An analysis of inpatient claims for schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), major depression, eating disorders, and substance abuse that included a secondary diagnosis of diabetes mellitus, cardiovascular disease, heart disease, hypertension, and respiratory disease found that 21 percent of inpatient discharges for behavioral health disorders included a secondary diagnosis of one of the physical health conditions.

Diabetes mellitus was the most common secondary diagnosis for hospitalized individuals with primary severe behavioral health diagnosis – occurring in 69 percent of cases with a selected secondary diagnosis.

Behavioral Health Hospital Stays with a Selected Secondary Physical Diagnosis

	Cardiovas. Disease	Diabetes Mellitus	Heart Disease	Hyper-tension	Resp. Disease
Bipolar Disorder	343	2,241	244	253	159
Delusional Disorder	9	49	21	7	4
Eating Disorder	3	1	2	1	0
Major Depression	398	2,714	434	393	187
OCD	0	4	0	1	0
Panic Disorder	14	40	16	16	6
Schizophrenia	195	1,473	183	170	90
Substance Abuse	134	1,642	206	167	79

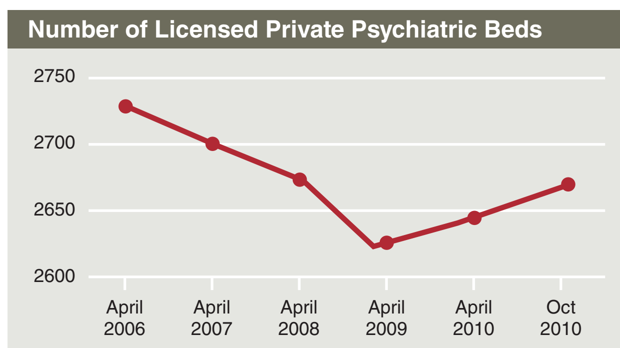
Source: *Ohio Hospital Association*

Severe behavioral health disorder patients with a secondary diagnosis had longer average length of stay and had higher average costs. For a patient with one of the secondary diagnoses listed in the chart above, the average length of stay was 1.24 days longer, and the average charge was $2,788 more.

Licensed Private Inpatient Hospital Beds

Over the past decade, the number of inpatient psychiatric beds in Ohio, particularly in private hospitals, declined; however, this trend may be reversing. Since April, 2009, the number of private psychiatric beds has increased. While a number of beds have been closed in general hospitals – notably Forum Health in Mahoning County, Memorial Hospital in Union County, and Selby Hospital in Washington County – 132 beds have been added in free-standing psychiatric hospitals in Warren, Guernsey, Franklin, and Hamilton Counties.

Number of Licensed Private Psychiatric Beds



Source: *Ohio Department of Mental Health*

In its recent study on acute care for mental health, the Ohio Department of Mental Health expressed concerns about the adequacy of Ohio's acute care system. The number of inpatient beds, both private and public, is well below recommended levels of 50 beds per 100,000 people (about 5,800 beds given Ohio's current population). The department also noted that there are regional differences that affect inpatient hospitalization levels throughout the state. Some of these differences include the availability of local supports, unit occupancy rates and emergency room waiting times, number of homeless individuals with a severe mental illness, and the number of inmates in county jails and prisons who have a serious mental illness that qualify for inpatient level of care.

State Psychiatric Hospitals

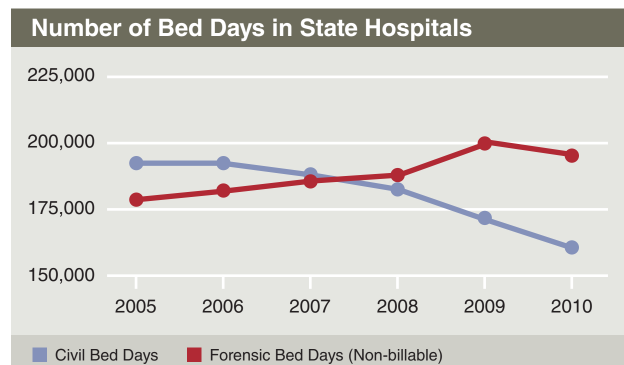
Ohio's state psychiatric hospitals provide care to Ohio's most challenging and complicated psychiatric cases, often those with legal/judicial system involvement. Two state psychiatric hospitals were closed in 2008, which provided one-time system savings. While two hospitals

were closed, additional beds were added at the remaining state hospitals, so there was no net change in the overall bed supply. There are currently 1,133 beds in state psychiatric hospitals.

Each hospital stay is considered to be either civil or forensic, depending on the patient's legal status. The state is responsible for the cost of inpatient care for most of the forensic population. County boards pay for civil stays as well as certain forensic designations.[23] While the current funding system incentivizes county boards to serve people in the lowest cost setting, there is no such incentive for forensic care. The courts decide who will be committed and, with recommendations from the hospital staff, determine when forensic patients may be discharged.

As state funding has fallen, local boards have reduced the number of bed days they purchase for civil patients in state psychatric hospitals – 16 percent since 2005. Over the same period, demand for forensic care grew substantially. The number of bed days for forensic patients has grown by 10 percent since 2005. Forensic patients occupy more than 50 percent of the beds in the state's psychiatric hospitals and have a higher daily cost due to requirements for additional security.[24]

Number of Bed Days in State Hospitals



Source: *Ohio Department of Mental Health*

The average length of stay for a civil patient is currently 13 days. Over the past decade, the length of stay for civil patients has been fairly constant, fluctuating between 12 and 14 days. The average length of stay for forensic patients has fallen from a high of 89 days in FY 2001 to a low of 55 days in FY 2008. The average length of stay for a forensic patient in FY 2010 was 61 days.

State hospitals are funded using a combination of sources, including state GRF funds and Medicare and Medicaid reimbursement for eligible patients.[25] In FY 2010, a total of $220.5 million from all sources was spent on care in state hospitals, down from $231 million in FY 2008. Spending on state hospitals is dropping for both civil and forensic care. Due to reduced state funding, counties have additional incentive to more closely manage admissions to state hospitals. Through the implementation of recommendations from the Forensic Strategies Workgroup,[26] the number of forensic patients, while still substantial, has been reduced. In addition, the closure of two state hospitals reduced overall hospital operating costs.

Summary

Individuals with severe behavioral health disorders utilize emergency departments and hospitals for care for their behavioral health disorder. When treated in the emergency department, individuals with a severe behavioral health disorder are more costly than the general population. Patients in private hospitals being treated for severe behavioral health disorders are less costly than the general population, but when a co-occurring physical condition is being treated, their care becomes more expensive. Medicare is the primary payer for inpatient care in private hospitals for adults under the age of 65 with a severe behavioral health disorder. Improving the availability of and access to community-based behavioral health interventions will decrease the number of inpatient hospital stays and emergency department visits. Co-occurring physical health conditions present a serious health threat to individuals with severe mental illness. Providing better access to integrated primary physical and behavioral health care will lower costs through reduced hospitalizations and improve health outcomes for individuals.

Behavioral Health Consumers in Long-Term Care

Highlights

- Housing is a stabilizing factor in a person's health that helps reduce health crises that can lead to care in more expensive and, often, inappropriate settings, but state and local financial support for housing assistance is dropping.
- In FY 2010, more than 8,100 Medicaid consumers with mental health disorders spent some time in a nursing facility during the year, and 62 percent were under the age of 65.
- Ohio offers few options for individuals under the age of 60 who need long-term care.

Housing is a critical support for individuals with behavioral health disorders. Many individuals with severe behavioral health disorders have extremely low incomes which makes it difficult for them to afford and maintain housing placements without financial assistance. Housing is a stabilizing factor in a person's health that helps reduce health crises that lead to care in more expensive and, often, inappropriate settings.

Housing Assistance

State and local funding for housing assistance in general has been declining. Since 2007, state and local funding for housing for individuals with behavioral health disorders has dropped by 7 percent or $5.1 million. The most significant area of increase has been in temporary housing by community mental health agencies. While funding for temporary housing has almost doubled, the total increase has been relatively small at just over $500,000.

Many individuals with a mental illness require some level of supportive services over the long term in order to manage their health conditions successfully. Without these supports, individuals who, prior to the Mental Health Act of 1988, would have resided in state hospitals for much of their adult life, often can be found living in Ohio's prisons, nursing homes, or on the street. Adult Care Facilities, funded through the Residential State Supplement program in the Ohio Department of Aging, provide a protective level of care, as well as food and shelter to about 1,500 high-need individuals, many of whom have a mental illness. Enrollment in this program has been limited since February, 2003.

State and Local Spending on Housing Subsidies

	2007	2008	2009	2010	% Change
Residential Care-MH	$35,152,352	$33,329,906	$37,603,682	$33,398,992	-5%
Residential State Supplement-AGE	$10,878,000	$11,531,000	$11,385,000	$10,697,000	-2%
Room & Board Subsidy-ODADAS	$7,474,194	$6,572,767	$7,507,571	$7,564,387	1%
Subsidized Housing-MH	$10,564,145	$9,962,437	$8,784,061	$7,472,447	-29%
Community Residence-MH	$8,058,805	$8,488,778	$5,962,433	$7,402,307	-8%
Temporary Housing-MH	$677,610	$833,507	$1,248,403	$1,210,894	79%
Total	**$72,805,106**	**$70,718,395**	**$72,491,150**	**$67,746,027**	**-7%**

Source: *Multi-Agency Community Services Information System (MACSIS), Ohio Department of Aging.*

Nursing Facilities

A number of factors – inadequate inpatient hospital bed supply, limited hospital reimbursements, a lack of appropriate and affordable housing, funding pressures in the community mental health system, and the availability of beds in nursing homes – has led to an increase in the number of individuals with mental illness being admitted to nursing homes. Of particular concern is the number of individuals under the age of 65 who are living in nursing homes.

Ohio has aggressively expanded the use of Medicaid waivers for home- and community-based care to prevent or delay institutionalization for individuals over the age of 60. However, the state has been slow to develop or expand home- and community-based options for individuals under the age of 60 who are in need of long-term care services.

In FY 2010, nursing home spending on Medicaid recipients who had at least one community mental health claim in FY 2009 totaled $248.8 million.[27] With an average Medicaid payment for nursing home care in FY 2010 at $167 per day, this would mean that on any given day more than 4,000 nursing home beds are occupied by individuals with a prior mental health claim. More than 8,100 Medicaid consumers with a prior mental health claim spent some time in a nursing facility during FY 2010, and 62 percent were under the age of 65.[28]

Anecdotally, hospital and nursing home administrators note that the availability of appropriate housing is a significant obstacle to patient discharge. The state's Unified Long Term Care Workgroup has made recommendations to better inform discharge planners on home- and community-based options and to expand housing resources to reduce or avoid unnecessary nursing home placements.[29]

Summary

While behavioral health services are important to an individual's recovery, support services, such as housing, are also critical. Without a stable home, the ability to maintain one's health decreases. Nursing homes are increasingly being used as a means to address the lack of affordable and appropriate housing for individuals with severe mental illness. While a convalescence stay in a nursing home may be an appropriate option for some individuals, the use of nursing homes to address inadequacies in the housing system is inappropriate and expensive.

Adult and Juvenile Justice

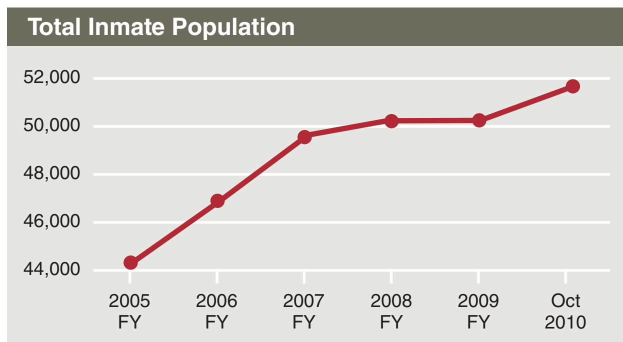
Highlights

- 9 percent of all adult inmates in Ohio Department of Rehabilitation and Correction (ODRC) have a severe mental illness.
- Spending for mental health services at the ODRC totals $70.9 million, or about $8,000 per inmate on the mental health caseload.
- 56 percent of youth in the Department of Youth Services (DYS) facilities are receiving mental health services and this percentage is increasing.
- Juvenile justice diversion programs with community behavioral health treatment have decreased recidivism.
- Individuals receiving mental health services stay longer in corrections facilities than the general population.
  – Adults on the mental health caseload stay in DRC facilities more than 3 times as long as the general population.
  – Youth on the mental health caseload stay in DYS facilities about twice as long.

Adult Criminal Justice[30]

In October, 2010, the Ohio Department of Rehabilitation and Correction (ODRC) had 51,203[31] inmates. Over the last five years, the inmate population has grown substantially by 12.1 percent.

Total Inmate Population



Source: *Ohio Department of Rehabilitation and Corrections*

In October, 2010, 10,464 inmates (20.4 percent of the inmate population) were on the "mental health caseload"[32]. Of those on the mental health caseload, 4,631 had a severe mental illness, comprising 44.3 percent of the mental health caseload and 9 percent of the entire inmate population. While the percent of individuals on the mental health caseload is lower than the percent of the general population with a mental illness (26.2 percent[33]), the percentage with a severe mental illness (9 percent) is higher than the general population (6 percent[34]).

Since the mid-1990s the percentage of inmates on the mental health caseload has remained relatively constant at 18 percent of all inmates. The percent of inmates with a severe mental illness has also remained constant at 9 percent of all inmates. As a result of the increase in prison population, the number of inmates on the mental health caseload and with a severe mental illness has increased.

In 2009, 17,828 inmates (35 percent) received recovery services for substance disorders. Of the total population, 376 inmates utilized both substance abuse treatments and mental health services – less than 1 percent of inmates, and 2 percent of inmates receiving recovery services. Unlike mental health services, substance abuse treatments are voluntary services provided by the ODRC system.

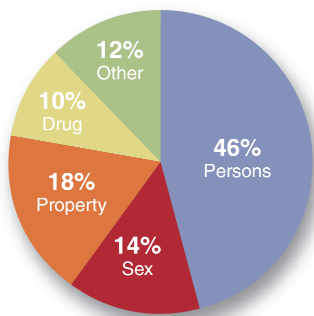
According to the 2009 intake study conducted by ODRC, 67 percent of inmates did not have a history of a mental

illness. Twenty-nine percent received treatment for a mental illness prior to incarceration. Four percent either self-disclosed a mental illness or showed evidence of a mental illness. And less than 1 percent had a diagnosis of a mental illness but had not received treatment prior to incarceration. What is unknown is the length of time between their last treatment and incarceration as this information is not collected during the intake survey.

Over 78 percent of inmates in the same study showed evidence of recent drug abuse, including 1.7 percent who reported having received treatment in the last six months. About 90 percent of inmates had a history of drug abuse, including 33 percent that had received treatment more than six months prior to their arrest. Just under half (49 percent) of inmates have recent alcohol abuse and 70 percent have a history of alcohol abuse.

Based on the 2009 intake study, 42.6 percent of all inmates were not high school graduates or the equivalent.

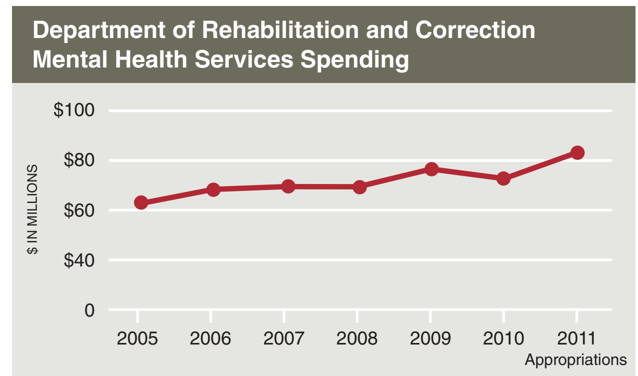
Crime Type for Individuals on the "Mental Health Caseload"



Source: *Ohio Department of Rehabilitation and Correction*

Of those inmates on the mental health caseload in December, 2010, more than half have been convicted for crimes against a person or a sex crime. Less than 12 percent of inmates on the mental health caseload are serving sentences less than 1 year. The average length of stay is much longer for inmates on the mental health caseload, 2,273 days or 6 years 2.5 months versus an average of 2 years for all inmates.

ODRC provides outpatient, prescription drugs, residential care and acute care psychiatric treatment. Every new inmate receives a mental health evaluation at reception, and further evaluations if necessary. These evaluations, services, and some staff are funded through the ODRC mental health line item. From FY 2005 to FY 2010, spending has increased by 10 percent.



Source: *Ohio Department of Rehabilitation and Correction*

The appropriation for the mental health line item for 2011, based on the October, 2010 mental health caseload, equates to about $8,000 per inmate per year. The actual cost per inmate varies based on the patient's needs and the severity of their mental illness, the services received throughout the year, and the cost and amount of prescribed medication. Sixteen percent of inmates are on psychotropic medications, which represents about 78 percent of the mental health caseload. The total cost for psychotropic medications during FY 2010 was $5.3 million – almost half of what was spent in FY 2009. Part of this reduction is due to a change in prescription medication formulary.

During FY 2010, 2,654 individuals with severe mental illnesses were released by ODRC into the community. Twenty percent refused the services of the Community Linkage Program, a partnership between ODRC and ODMH that connects individuals with a severe mental illness with community or inpatient mental health services. Sixty-six percent were released to the supervision of the Adult Parole Authority.[35]

Thirty-six percent of people admitted to prison because of a probation violation have mental health needs.[36] When ODRC studied the recidivism rates of offenders with and without a severe mental illness, it found that recidivism rates were similar for the two populations. Of those offenders who were supervised upon release, inmates with a severe mental illness had a three year return to prison rate of 42 percent (14 percent because of a

violation of the terms of their release and 28 percent because they committed a new crime), while inmates without a severe mental illness had a 41 percent rate (16 percent because of a violation of the terms of their release and 25 percent because they committed a new crime). Of those offenders who were not supervised upon release, inmates with a severe mental illness had a three year return to prison rate of 29 percent, while inmates without a severe mental illness had a 32 percent rate.

Forensic Hospital Population[37]

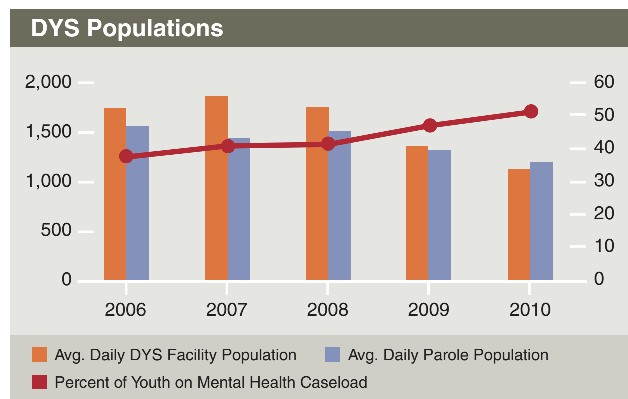
As discussed in the section, "Consumers with Severe Behavioral Health Disorders in Hospitals and Emergency Departments," forensic patients use half of the state psychiatric bed days during the year. Forensic hospital beds are used for individuals with a mental illness involved with the criminal justice system who need to be restored to competency to stand trial; they are classified as "Not Guilty by Reason of Insanity"[38] (NGRI) or "Incompetent to Stand Trial – Unrestorable"[39] (IST-U). NGRI and IST-U individuals are considered "long-term forensic patients." On October 31, 2010, there were 281 individuals in the state psychiatric hospital with a NGRI status and 94 individuals with an IST-U status. During FY 2010, 122 individuals were discharged with these statuses. The average length of stay is 446 days (1 year 2.5 months), which is considerably shorter than the average length of stay of an adult in ODRC on the mental health caseload. The FY 2010 cost at the state psychiatric hospital is $525 a day or $234,150 per average discharge.

Juvenile Justice[40]

The Ohio Department of Youth Services (DYS) is Ohio's juvenile corrections system. DYS is responsible to confine and provide services to youth are have been adjudicated for a felony and committed to one of the DYS facilities. Not all youth who are adjudicated for felonies in Ohio are committed to DYS, some participate in diversion programs. The rate of commitment to DYS in FY 2009 was 17.1 percent. While the rate of commitment over the last several years has remained relatively constant, the number of youth being adjudicated for felonies and committed to DYS has decreased.

The parole population has also decreased from its peak in FY 2005 by 40 percent. During FY 2010, DYS had on a daily average of 1,191 youth on parole. A total of 2,400 youth came through regional offices on parole during FY 2010. Fourteen percent attended mental health services in the community, and 9.6 percent were on prescribed psychotropic medications.

From its peak in FY 2007, the population in DYS facilities has decreased by 62 percent. This population is expected to continue decreasing during the beginning of FY 2011. On December 14, 2010, there were 759 youth in DYS facilities.



Source: *Ohio Department of Youth Services*

In FY 2010, 93.6 percent of youth in DYS facilities were male and ranged in age between 12 and 20 years old. In FY 2010, 79.4 percent of female youth and 83.1 percent of male youth in DYS facilities had previous mental health treatment. A significant number of all female youth in DYS facilities have attempted suicide. Approximately 56 percent of youth admitted to DYS were Medicaid eligible and 54 percent were reinstated to Medicaid upon release. Due to the high number of 17 and 18 year olds in DYS facilities, some youth eligible for Medicaid upon arrival due to their foster care placement are ineligible for Medicaid upon release because they are over 18 years old and not considered in foster care while in a DYS facilities.

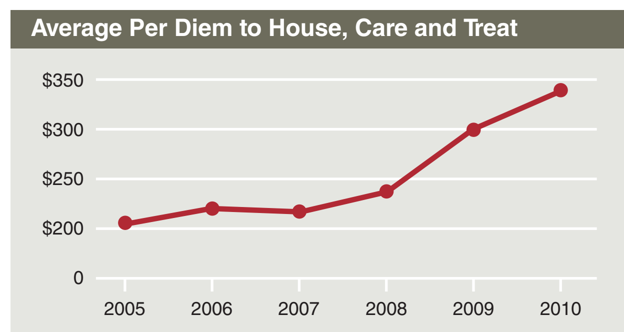
While the overall population in DYS facilities has decreased, the percent of youth needing mental health services has increased. From FY 2006 to FY 2010, DYS experienced a 14.5 percent increase in the percent of youth on the mental health caseload.[41] On December 14, 2010, 49.5 percent of youth in DYS facilities were on the mental health caseload, and 6 percent were on a mental health unit.[42] Of the population on the mental health caseload, 91.4 percent were male, and 8.5 percent were female.

Youth on the mental health caseload have a variety of felony adjudications. Less than 1 percent are in DYS facilities for murder. The majority of youth on the mental health caseload are in DYS facilities for serious felonies. Thirty-seven and a half percent have Felony 1 adjudication, 18.9 percent have Felony 2 adjudication, 19.9 percent have Felony 3 adjudication, 12.8 percent have Felony 4 adjudication, and 10.1 percent have Felony 5 adjudication.

The average length of stay in a DYS facility can fluctuate from year to year, but the average length of stay of youth on the mental health caseload is about twice as long (22 months) as the total population (11.9 months).

Source: *Ohio Department of Youth Services, Annual Reports*

The cost to house, care for, and treat youth in DYS facilities has increased since FY 2005 by 40 percent. The FY 2010 per diem was $338.[43] The average cost per youth on the mental heath caseload for mental health prescription drugs has increased from $1,405 in FY 2006 to $2,699 in FY 2010, a 48 percent increase.[44]



Source: *Ohio Department of Youth Services, Annual Reports*

Juvenile Diversion[45]

Youth Services Grant, RECLAIM Ohio, Targeted RECLAIM Ohio, Behavioral Health/Juvenile Justice Initiative (BHJJ), and Community Corrections Facilities provide juvenile courts with options to make placement and treatment decisions that are in the best interests of the youth and public safety. The BHJJ program diverts youth from detention centers into more comprehensive, community-based behavioral health treatment.[46]

As of June 30, 2009, 709 youth have been terminated from the BHJJ program. Sixty-two percent successfully completed the program. The average length of stay in the program was about 8 months. Youth that have been terminated from the program show significant improvement in functioning level and decreased severity in their disorders while in treatment, as well as decreased drug and alcohol utilization; they were also at less risk for an out of home placement.

All of the youth who have been terminated from the BHJJ program have decreased juvenile court involvement after termination. Youth who successfully completed the program showed lower rates of recidivism than those who do not successfully complete the program. One year prior to BHJJ enrollment, 25 percent of youth had at least one felony charge, while one year after termination 6.5 percent had a new felony charge.

Since FY 2006, ODMH and DYS have invested $4.3 million into the BHJJ program.[47] The average cost per youth is $4,135.

Summary

Investment in community-based behavioral health services can decrease the cost of adult and juvenile corrections. With the increasing numbers of adults and juveniles in correctional facilities needing behavioral health services, the need to improve the availability of and access to behavioral health services is apparent. Access to community-based behavioral health services can prevent crimes and reduce recidivism. The adult and juvenile justice system are costly. Individuals on the mental health caseload stay in correction facilities two to three times longer than the general population, increasing overall costs.

Primary and Secondary Education[48]

Highlights

- Approximately 19,000 children in Ohio's primary and secondary schools have Individualized Education Plans (IEPs) for an emotional disturbance.
- Students with an IEP for an emotional disturbance have higher drop-out rates and lower graduation rates. Only 63 percent of students with an IEP for an emotional disturbance graduated in the 2008-2009 school year.
- Students with emotional disturbances are less likely to test at proficient or higher levels on state proficiency tests.
- 66 percent of students with an IEP for emotional disturbances are also economically disadvantaged.
- Lower levels of academic attainment carry significant personal and societal costs.

Individualized Education Plans

When an evaluation reveals that a student has a disability that impacts the student's educational attainment and requires special education, an individualized education plan (IEP)[49] is developed. The IEP outlines annual educational goals and objectives for a student and the supports and services a student needs to meet the goals. Student disabilities are categorized into 13 categories, including autism, cognitive disability, deaf-blindness, deafness, emotional disturbance, hearing impairment, multiple disabilities, orthopedic impairment, other health impairment (broken out into minor and major), specific learning disabilities, speech or language impairment, traumatic brain injury, and visual impairment.[50]

Estimates show that, nationally, 11 percent of students have an emotional disturbance with significant functional impairment, and 5 percent have extreme functional impairment at home, at school, and with peers.[51] The national average of students (pre-kindergarten through 12th grade) enrolled in schools having an IEP for an emotional disturbance was 0.93 percent in the fall of 2004. At the same time, Ohio had 0.96 percent of students enrolled having an IEP for an emotional disturbance.[52] Since 2004, the percent of students in Ohio with an IEP for an emotional disturbance has increased to 1.1 percent.

Although the data from the Ohio Department of Education for students with an IEP is the best representation of the students with an emotional disturbance that impairs their function in Ohio's primary and secondary educational system, this data does not represent all students who have an emotional disturbance in Ohio's schools. Students whose educational attainment is not negatively affected by their emotional disturbance or other illness do not qualify for an IEP and, therefore, are not included in the following data sets. Throughout this section, students with an emotional disturbance are defined as students with an IEP due to an emotional disturbance.

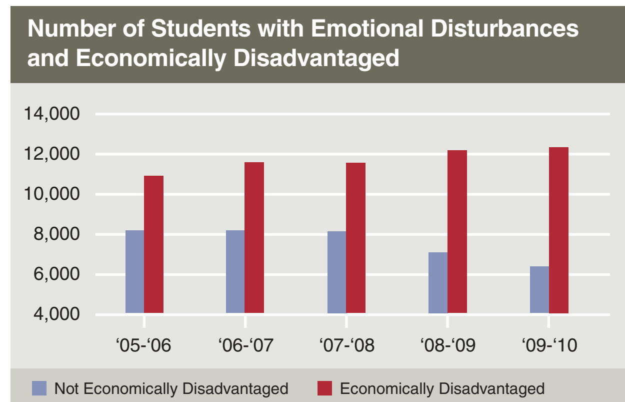
Enrollment

During the 2009–2010 school year, 15 percent (over 261,000) of Ohio's students had an IEP. The top 6 IEP categories are specific learning disabilities (6.2 percent of the student population), speech and language impairments (1.9 percent), cognitive disabilities (1.8 percent), other minor health impairments (1.7 percent), emotional disturbances (1.1 percent, 18,981 students) and autism (0.8 percent). Over the last five school years, the percent of students with an IEP has remained fairly constant; however, the percent of students with a cognitive disability has decreased, while the percent with other minor health impairments and autism has increased. From the 2005–2006 school year to the 2009–2010 school year, the percent of students with an IEP for an emotional disturbance has remained constant.

The need for an IEP is re-evaluated every three years. Headcounts by grade for students with no disabilities, emotional disturbances, cognitive disabilities, specific learning disabilities, and other minor health impairments peak in the 9th grade. For students with speech and language impairments and autism, headcounts decline from the 1st grade on.

Students who are identified as being economically disadvantaged represent 66 percent of the students with an emotional disturbance. Of the total student body in Ohio, 57 percent are identified as being economically disadvantaged. To be identified as economically disadvantaged the student must be eligible for free or reduced-price lunches, live with another student who is eligible for free or reduced-priced lunches, be known to be receiving or whose guardians are receiving public assistance, or meet the income guidelines for Title I.[53]

Number of Students with Emotional Disturbances and Economically Disadvantaged



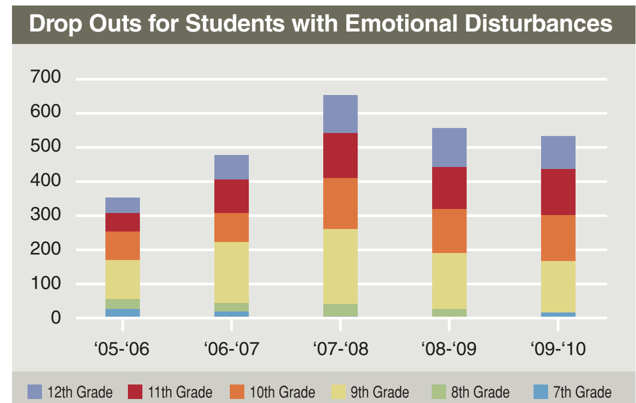
Source: *Ohio Department of Education, online interactive Local Report Card*

Dropout Rates

During the 2009–2010 school year, 1.4 percent of students without disabilities dropped out of school. Students with emotional disturbances had the second most dropouts of the top six disability categories (2.8 percent), only behind students with specific learning disabilities (3.9 percent).

Since 2005, students with emotional disturbances had no dropouts before the 7th grade. During the 2009–2010 school year, the largest number of students with an emotional disturbance dropped out during the 9th grade – 30 percent of dropouts for all students with emotional disturbances. Students with an emotion disturbance also had high dropout numbers during the 10th, 11th, and 12th grades – 23 percent, 25 percent, and 20 percent of dropouts, respectively.

Drop Outs for Students with Emotional Disturbances



Source: *Ohio Department of Education, online interactive Local Report Card*

Proficiency Testing

Ohio has a series of proficiency tests that students take throughout their schooling. Starting in the 3rd grade, students take proficiency tests every year until the eighth grade. Proficiency tests resume in the 10th grade. The 10th grade proficiency test is Ohio's Graduation Test. Students have the ability to take this test as many times as it is offered between the 10th grade and 12th grades to score at the proficient level. For a student to be considered proficient in the subject matter on the test, the student must test at the proficient level or higher (accelerated or advanced).[54]

When looking at 8th, 10th, and 12th grade proficiency test results for the top six disability categories, students with emotional disturbances have the second smallest percentage of students testing at the proficient level or higher. The disability with a smaller percentage is cognitive disabilities. However, for 8th grade math tests, students with an emotional disturbance have the smallest percent of students testing at proficient or higher.

When looking at a specific cohort of students, for example those graduating in school year 2009–2010, the percent of students with emotional disturbances testing at the proficient level or higher increases as they move through the grades. This is partially due to a student's ability to repeat the 10th grade test until he or she passes it. (Once a student scores at the proficient level or higher, he or she does not take the test again.) The percentage of students passing the tests in the 11th and 12th grades is cumulative of the previous years' scores. Another possible reason for some of the increase is students dropping out of school, decreasing the number of students who are

trying to pass the tests. Fewer students with an emotional disturbance are scoring at accelerated or advanced levels than students in other disability categories.

Percent of Students with an Emotional Disturbance Scoring Proficient or Higher

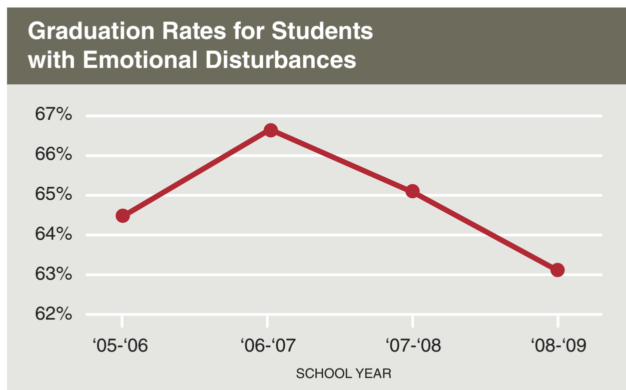
	8th Grade '05-'06 School Yr.	10th Grade '07-'08 School Yr.	11th Grade '08-'09 School Yr.	12th Grade '09-'10 School Yr.
Reading	34.4%	43.0%	60.8%	65.8%
Writing	Not given	35.6%	56.6%	62.3%
Math	20.1%	31.5%	46.7%	53.9%
Social Studies	Not given	38.9%	49.7%	56.1%
Science	Not given	29.2%	44.9%	51.4%

Source: *Ohio Department of Education, online interactive Local Report Card*

Graduation Rates

The number of students with emotional disturbances who are graduating with honors is small (less than 1 percent). Graduation rates for students with emotional disturbances peaked during the 2006 – 2007 school year. Since then, graduation rates have decreased almost 4 percent. When compared to students without disabilities and students with the other top six disabilities, students with emotional disturbances have the lowest graduation rates for the past four years.

Graduation Rates for Students with Emotional Disturbances



Source: *Ohio Department of Education, online interactive Local Report Card*

Costs of Dropping Out of High School

High school dropouts face significant challenges to employment, which in turn negatively affects their ability to support themselves and pay taxes. For an individual who has dropped out of high school, there is a six in 10 chance they are employed if they are between 20 and 24 years of age and a four in 10 chance if they are between 16 and 19 years of age.[55] If an individual is employed without a high school diploma, their income is considerably less than if they had completed high school or pursued a college degree. In the United States during 2009, an individual without a high school diploma made on average $18,432 a year, while a high school graduate made $26,140 a year.[56] These high rates of unemployment and low incomes significantly impact local, state and federal tax revenues. In addition to reducing tax revenues, high school dropouts comprise nearly 50 percent of heads of households who are receiving public assistance.[57]

Summary

Students with IEPs due to an emotional disturbance perform worse on school proficiency tests and have lower graduation rates than students with other or no disabilities. Poor academic outcomes affect these individuals for life. Not graduating from high school decreases employment opportunities and earning potential and increases reliance on public assistance programs. In addition, individuals that do not graduate from high school, even if employed, pay less in taxes. Providing adequate support for students with IEPs due to an emotional disturbance would improve student proficiency and increase graduation rates, improving the quality of Ohio's future workforce.

Premature Death

Highlights

- Many individuals with severe mental illnesses die earlier from preventable illnesses than the average person.
- Unintentional fatal drug overdoses, particularly from prescription drugs, are much higher in Ohio compared to the rest of the nation and are increasing.
- In 2008, there were more than 3 deaths in Ohio each day from suicide, and the number of deaths by suicide are increasing.
- Premature death has a significant societal cost.

Individuals with severe mental illnesses and substance abuse disorders are chronically ill individuals who need continued care and supports. While Ohioans with severe mental illnesses may be receiving mental health services, many also have other chronic health conditions that need attention. Some individuals with mental illnesses and substance abuse disorders die younger than the average Ohioan. Many of these premature deaths, including those from suicide, can be prevented.

Co-Morbidity Leading to Early Death[58]

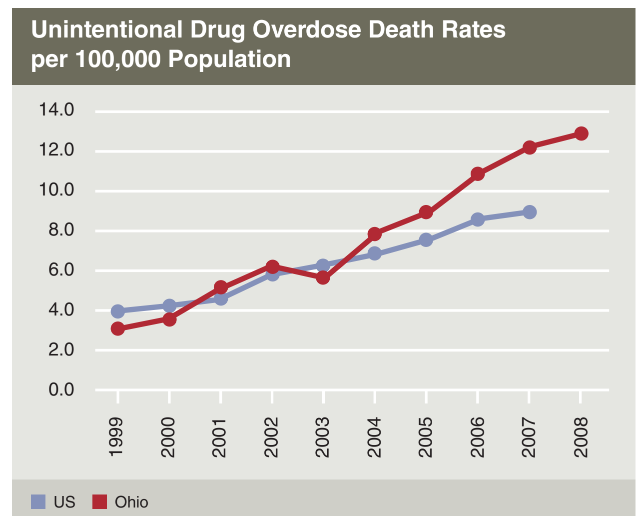
Research done by comparing medical records to death certificates, showed that individuals with a severe mental illness who have at least one hospitalization die on average 32 years younger than Ohio's general public. A similar study found that Ohioans with a severe mental illness who have not been hospitalized but are receiving community mental health services die an average of 14.5 years younger than the general public. Both of these studies show that there are serious health care gaps for individuals with severe mental illnesses in Ohio.

The leading cause of death for both of these groups of people with severe mental illnesses is heart disease, which is also the leading cause of death in the general public.[59] An individual in Ohio who has both a severe mental illness and heart disease will die approximately 27 years younger than an Ohioan who only has heart disease. Heart disease causes three times as many deaths among individuals with severe mental illness as in the general public. Other diseases that result in premature death for individuals with severe mental illnesses are liver disease, cancer, and septicemia. Many individuals with severe mental illnesses do not receive adequate preventative services and treatment for heart disease and other physical illnesses.

Accidents, including unintentional overdoses, and suicides also result in premature deaths among individuals with severe mental illnesses.

Prescription Drug Overdoses[60]

Ohio's Prescription Drug Abuse Task Force recently published their Final Report, showing that the rate of fatal drug overdoses in Ohio has jumped substantially since 1999. In 1999, Ohio's unintentional drug poisoning death rate was 2.9 per 100,000 Ohioans. In 2008, it rose to 13 per 100,000 Ohioans. Since 2004, unintentional drug overdose rates for Ohio have been higher than the U.S. rate.[61] In 2007, the number of deaths in Ohio from unintentional drug overdoses surpassed motor vehicle crash fatalities and suicides. These unintentional drug poisoning deaths are resulting from the increased prescription opioid misuse, abuse, and overdose.



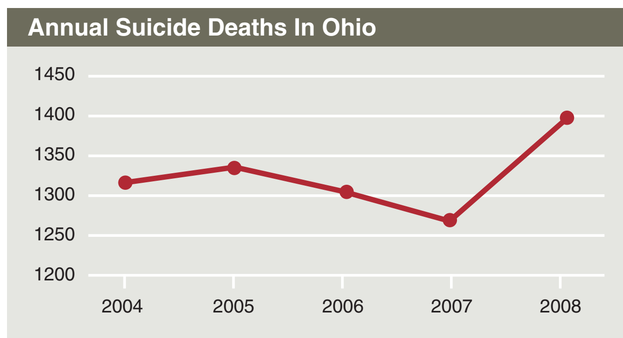
Source: *Ohio Prescription Drug Abuse Taskforce Final Report*

The estimated annual cost nationwide of unintentional fatal drug overdoses is $3.5 billion, including medical costs of $4.9 million, work loss costs of $1.2 billion, and quality of life costs of $2.2 billion.[62]

Suicides[63]

Suicide is another preventable public health problem facing Ohio. Suicide deaths have a significant correlation with mental illness and substance abuse. More than 90 percent of people who die by suicide have a mental illness, a substance abuse disorder, or a combination of both.[64]

In 2008, 1,402 Ohioans completed suicide. This equates to more than three suicides in Ohio every day. From 2005 to 2007, completed suicides were decreasing in Ohio. In 2008, the number of completed suicides jumped significantly, a 10 percent increase.[65] The most recent recession began in December, 2007, which may be a contributing factor to the increase in the number of suicide deaths in Ohio.



Source: *Ohio Department of Health, Office of Vital Statistics, Analysis by Injury Prevention Program. Provided by The Ohio Suicide Prevention Foundation*

Suicide is the tenth leading cause of death in Ohio. The average potential life lost before the age of 65 was over 21 years in 2007.[66] Suicide is most prevalent among working age adults.[67] Based on Ohio's population, a larger percentage of 35 to 44 year olds are completing suicide than any other age group.

Suicide is also a significant public health concern in the younger population. For 10 to 14 year old Ohioans, suicide is the fourth leading cause of death (behind unintentional injury, malignant neoplasms, and homicide). For 15 to 24 year old Ohioans, suicide is the third leading cause of death (behind unintentional injury and homicides). For 25 to 34 year old Ohioans suicide is the second leading cause of death, surpassing homicide for the first time. For 35 to 44 year olds, suicide is the fourth leading cause of death (behind unintentional injury, malignant neoplasms, and heart disease).[68]

More men complete suicide than women – 80 percent of suicides in Ohio are completed by men.[69] Nationally, more women than men attempt suicide.[70]

There is a significant cost to society when an individual completes suicide. The average annual medical costs exceed $3.8 million in Ohio.[71] The average annual work loss costs exceed $921 million in Ohio.[72] This represents not only lost wages for a family, but lost tax revenues as well.

In the United States, 11 attempted suicides occur for every completed suicide.[73] With treatment and supports, an individual can overcome their suicidal ideology. Crisis intervention and community mental health and substance abuse treatment can prevent suicides.

Summary

In Ohio, individuals with a severe mental illness die younger than the general public. Part of this shorter life expectancy is due to the prevalence of co-occurring physical health conditions. Improving care through the integration of physical and behavioral health care may increase the life expectancy for individuals with a severe mental illness. Overdose deaths and suicides are also on the rise in Ohio. These premature deaths have significant personal and societal costs.

Recommendations

Behavioral health disorders impact every Ohioan, either personally or through services they support with their tax dollars. In order to make informed policy decisions, comprehensive data must be collected and analyzed. This report analyzed available data sets, but additional data is needed to more fully understand certain system interactions. This and future research is intended to inform policy decisions. In implementing these and future recommendations, stakeholders from all sectors impacted by behavioral health must work together to ensure appropriate, effective, integrated, fiscally prudent behavioral health services are available to those needing them.

Funding

- Align behavioral health care Medicaid match responsibility with other health care by moving the Medicaid match responsibility to the state's primary Medicaid match line item (Ohio Department of Job and Family Services 525).
- Protect locally supported levies so they can support locally identified needs.
- Fully fund Ohio Department of Mental Health line items 404, 408, 505 and Ohio Department of Alcohol and Drug Addiction Services line item 401 so that cost efficient services can be delivered in Ohio's communities, not in more expensive, less effective settings.
- If state policies are changed to require treatment instead of incarceration, then appropriate and adequate funding for behavioral health services must be allocated to build capacity to ensure services are available to all those in need.
- Ohio should explore funding opportunities in the Patient Protection and Affordable Care Act, including the 1915 (i) waiver (the Medicaid state plan amendment for home and community based services); incentives for enrolling individuals with chronic conditions, including behavioral health disorders, into health care homes; and the Institute of Mental Disease pilot project.

Policy

- Health care reform provides an impetus to address access issues and increase efficiencies. Health care reform efforts must fully encompass and address the needs of behavioral health consumers.
- The integration of behavioral health care and physical health care should be fully supported to increase access to care and improve health outcomes.
- Better maintain the health of individuals in the community by improving the Medicaid-funded behavioral health benefit. Services such as intensive community-based mental health services, including Assertive Community Treatment (ACT), peer support and family counseling should be added as Medicaid-funded services. State regulations governing the provision of these services need to be changed to facilitate their application in Ohio. In addition, Ohio must ensure that Medicaid behavioral health services are provided in adequate amount, duration, and scope to meet their intended purpose in all areas of the state.
- Improve transition of services for individuals, specifically youth, moving from Covered Families and Children to Aged, Blind and Disabled Medicaid eligibility.
- Federal and State rules and regulations around "aging out of foster care" need to be examined to allow for youth who turn 18 in the Ohio Department of Youth Services system to utilize the expansion of Medicaid for foster children.
- Target high cost/high need consumers across systems for additional services to help stabilize their health conditions. A subset of the population with behavioral health disorders will require long term support. Better identify who these individuals are and what services are needed to better stabilize their conditions.

- Analyze system trends, service utilization, and treatment outcomes to improve care for consumers with behavioral health disorders. In order to support consumers in the community, they must have access to a full continuum of behavioral health services, including prevention and early intervention, that provides the right support and services at the right time and in the right amount. Behavioral health consumers also require a continuum of services beyond health care, including housing, employment, and educational supports among others.
- Establish a state level dashboard across systems to track real-time leading indicators (such as all hospital admissions and discharges and track status of Medicaid applications) to better track patient transfers between systems, system capacity, and utilization.
- Continue to build upon work already done by numerous groups of stakeholders including: the Forensic Strategies Workgroup (http://www.mh.state.oh.us/assets/forensic-services/forensic-strategies-workgroup-final-report.pdf); the Unified Long Term Care Budget Workgroup (http://aging.ohio.gov/information/ultcb/); and the Ohio Prescription Drug Abuse Taskforce (http://www.odh.ohio.gov/features/odhfeatures/drugod/drugoverdose.aspx).

Hospitalization

- The future role of state psychiatric hospitals must be analyzed given opportunities for payment restructuring through health care reform and the impact of integrating care.
- Reduce hospital readmissions by adding step down care, which is frequently used in physical health care, to better stabilize patients. Following an inpatient stay, an individual with severe and persistent mental illness is incredibly vulnerable, yet there is and will continue to be strong pressure to discharge these patients from inpatient hospital settings as soon as possible. This would be a first step toward creating a continuum of care that allows for transition between appropriate levels of care.

Housing and Long-term Care

- Successfully deinstitutionalize inappropriately housed individuals by increasing funding for capital and operating support and supportive services in housing. Many individuals with severe and persistent behavioral health disorders will also require some level of support over the long term in order to manage their home and health conditions successfully. Individuals who currently are or are at risk of being institutionalized should receive priority assistance.
- Strong state leadership is needed to unify housing policies to better support vulnerable populations. Additional state investment in capital investment, operating support, and supportive services is needed along with improved coordination of policies between agencies and across the state.
- Apply the principles of the Home First law, for those in the PASSPORT, Assisted Living, and Pace programs, to the Home Care waiver to allow individuals under the age of 60 with long term care needs who are at imminent risk of a nursing home placement to circumvent waiting lists for home and community based services to avoid more costly institutionalization.

Adult and Juvenile Corrections

- Improve connections and access to services for individuals leaving the custody of the adult and juvenile criminal justice system. Individuals with behavioral health disorders leaving state institutions must be connected with and have access to a continuum of adequate and appropriate community based services, including behavioral health services.
- Ohio Department of Rehabilitation and Correction should revisit policies around recovery services to refocus on appropriate and adequate treatment and education for alcohol and other drug abuse.

Primary and Secondary Education

- Improve supports for children with emotional disorders in primary and secondary education settings to increase student proficiency and graduation rates, and decrease dropout rates.

Premature Death

- Increase education and prevention around suicide and unintentional drug overdoses to decrease the incidence of both and reduce societal costs.

Identified Data Needs and Areas for Further Research

Data that should be collected and analyzed includes:

- Historic data, where unavailable to the authors for the areas reviewed, for relevant information including trends.
- Data that was unavailable for this report for 2009 and 2010 and data for all areas analyzed beyond 2010 to determine impact of actions on consumers and the systems that serve them.
- Data from the child welfare system on the number of children in the child welfare system with a behavioral health disorder, the number with a parent with a behavioral health disorder and the number who receive behavioral health care treatment. This information does not exist in electronic form. To gather this information currently, manual chart reviews are required.
- Centralized data on the mental health caseload and spending for individuals incarcerated in jails.
- Medicare data for those dually eligible for Medicaid and Medicare.
- Managed care encounter data for information on service utilization.
- Many individuals receiving care in the community mental health system have a dual diagnosis of a developmental disabilities disorder, additional research on the incidence and service utilization of individuals with this dual diagnosis in the different systems should be undertaken.
- Data on individuals with a mental illness in nursing facilities, including length of stay, admission source, per stay cost, diagnosis and reason for admission.
- Analysis of prescription drug usage by Ohio behavioral health consumers from all payers, including comparison to national data, on types, dosage, treatment costs of side effects, link between use of prescription drugs and other treatment modalities.
- Data on medical costs, length of stay, and diagnosis for patients admitted to a hospital with a primary diagnosis of a physical health problem, and a secondary diagnosis of a severe behavioral health disorder, for patients admitted to the hospital from the emergency department with a primary diagnosis of a severe behavioral health disorder and for patients admitted to the hospital from the emergency department with a primary physical health problem and a secondary severe behavioral health disorder. This data would provide additional information on the chronic physical health conditions of individuals with severe mental illness.
- Further research on why prisoners on the Ohio Department of Rehabilitation and Correction mental health caseload are incarcerated, on average, 3 times longer than those not on the caseload and juveniles on the Ohio Department of Youth Services mental health caseload are incarcerated, on average, 2 times longer than those who are not.

Endnotes

1 Ohio Association of County Behavioral Health Authorities, Poll 2009.

2 Calculated based on Census and National Institutes of Mental Health data.

3 The Ohio Council of Behavioral Health and Family Service Providers.

4 National Alliance on Mental Illness and reports published in the Journal of American Medical Association.

5 Ohio Association of County Behavioral Health Authorities.

6 Presentation by Maureen Corcoran, Assistant Deputy Director, Ohio Department of Jobs and Family Services Office of Ohio Health Plans, before the Medicaid Pharmacy Quality Forum, June 7, 2010.

7 Testimony to the Joint Legislative Budget Planning and Management Commission from Greg Moody, Interim Director, Health Policy Institute of Ohio, July 19, 2010. Health exchange estimates are based on data from the 2008 Ohio Family Health Survey.

8 The state's behavioral health claims processing system, MACSIS, provides the most comprehensive collection of data on mental health and alcohol and drug addiction services provided by agencies contracted by Ohio's local alcohol, drug addiction and mental heath boards. Data shown in this section is based on data currently available through MACSIS, which was extracted on October 2, 2010. Additional claims for services rendered in FY 2010 may have been processed since this date. As MACSIS is a claims processing system, not all board expenses, particularly those for the administration, are included in this database.

9 Ohio Association of County Behavioral Health Authorities.

10 Forensic patients are offenders who have been committed to state hospitals for treatment by the court system.

11 Economic Impact Study, Ohio Association of County Behavioral Health Authorities, July, 2010.

12 The Medicaid data in this section provided by the Ohio Department of Job and Family Services. Data was retrieved from the Medicaid Decision Support System and does not include Medicare premium payments.

13 Data includes Medicaid spending from the Ohio Departments of Job and Family Services, Aging, Mental Health, Alcohol and Drug Addiction Services, and Developmental Disabilities.

14 The prescription drug data only includes claims paid by the state (not by managed care). The state took over management and payment for the prescription drug benefit in February, 2010.

15 The emergency room and inpatient hospital data in this section comes from the Ohio Hospital Association's Statewide Clinical and Financial Database and includes information on hospital discharges in calendar years 2006 through 2009. Primary diagnoses included in this data set were based on a severity index prepared by the Ohio Department of Mental Health. Data does not include spending in freestanding psychiatric hospitals.

16 Data in this section was derived from claims data and shows the amount charged, not the amount paid.

17 **Number of ED Visits by Disorder and Age**

	Children Ages 0-19	Adults Ages 20-64	Adults 65+
Major Depression	4,335	16,276	787
Bipolar Disorder	1,856	6,227	184
Panic Disorder	653	3,959	200
Substance Abuse	34	1,238	41
Delusional Disorder	20	343	80
Obsessive Compulsive Disorder	35	63	2
Eating Disorder	18	19	0
Total	**6,951**	**28,125**	**1,294**

Source: *Ohio Hospital Association*

18 Disorders include bipolar disorder, schizophrenia, major depression, substance abuse and other diagnoses, including obsessive compulsive, delusional, panic, and eating disorders.

19 Data in this section comes from the Ohio Hospital Association's Ohio Hospital Association Statewide Clinical and Financial Database. Charges include amounts billed, not amounts paid.

20 Medicaid was the most frequent payer for inpatient stays for children ages 0 to 19. Medicaid paid for 52 percent of all stays for this age group. Private insurance was next, paying for 44 percent of all stays. For adults over the age of 65, Medicare was by far the most common payer for inpatient stays, covering 91 percent of all stays.

21 Discharges by Disorder

	2006	2007	2008	2009	Change 2006-09
Bipolar Disorder	17,934	18,914	20,279	19,962	11.3%
Major Depression	19,075	18,528	18,356	18,847	-1.2%
Schizophrenia	8,497	8,426	8,643	8,503	0.1%
Substance Abuse	7,380	7,240	7,271	7,540	2.2%
Other	763	701	686	674	-11.7%
Total	**53,649**	**53,809**	**55,235**	**55,526**	**3.5%**

	Average Charge per Discharge				Average Length of Stay			
	2006	2007	2008	2009	2006	2007	2008	2009
Bipolar Disorder	$11,021	$10,605	$12,081	$13,006	7.0	6.5	6.7	6.5
Major Depression	$10,132	$10,063	$10,644	$11,177	6.2	6.2	5.8	5.6
Schizophrenia	$13,259	$12,609	$16,091	$15,531	9.0	7.9	8.8	8.4
Substance Abuse	$15,024	$13,466	$14,918	$17,214	9.6	8.1	8.3	8.9
Delusional Disorder	$11,409	$14,749	$14,522	$14,192	7.4	8.0	7.0	7.2
Eating Disorder	$21,610	$14,243	$28,489	$26,150	7.3	6.6	12.0	8.6
OCD	$ 9,109	$8,619	$9,408	$14,175	5.9	6.0	5.2	6.4
Panic Disorder	$10,044	$7,543	$8,948	$9,074	3.0	2.9	2.7	2.7
BH Discharges	**$12,533**	**$11,395**	**$13,914**	**$14,694**	**7.1**	**6.6**	**7.0**	**6.8**
All Discharges	**–**	**$23,999**	**$25,637**	**$25,389**	**–**	**6.0**	**5.5**	**5.3**

Source: *Ohio Hospital Association*

22 In 2009, bipolar disorder was most common diagnosis (55 percent of total) for children between the ages of 0 and 19. Major depression was the second most common diagnosis at 33 percent of the total. Schizophrenia and substance abuse accounted for 8 percent and 3 percent, respectively. Bipolar disorder was also the most common diagnosis for adults between the ages of 20 and 64, but only accounted for 34 percent of the total. Major depression accounted for 33 percent of the total, while schizophrenia and substance abuse accounted for 17 percent and 16 percent of the total, respectively. Major depression was the most common diagnosis for adults over the age of 65. Major depression accounted for 48 percent of the total for this age group, while bipolar disorder accounted for 24 percent of the total. Schizophrenia and substance abuse accounted for 14 percent and 10 percent, respectively.

23 Forensic Designations and Who Pays For Care

Legal Status Code	Legal Status Description	Inpatient Cost Paid by
2945.371 G3	Competency Evaluation	County Board
2945.371 G4	Sanity Evaluation	County Board
2945.371 G3/G4	Competency & Sanity Evaluation	County Board
2945.38 A	Competency Maintenance	County Board
2945.38 B	Competency Restoration	ODMH
2945.38 H4/5122.11	ISTU-Probate Court Jurisdiction/ Judicial Commitment	County Board
2945.38 H4/5122.141	ISTU-Probate Court Jurisdiction/ Probable Cause	County Board
2945.38 H4/5122.15	ISTU-Probate Court Jurisdiction/90-day - 2-year Commitment	County Board
2945.38 H4/5122.02	ISTU-Voluntary	County Board
2945.39 A	ISTU- Criminal Court Jurisdiction (CJ)	ODMH
2945.4	Not Guilty by Reason of Insanity	ODMH
2945.402 A	Not Guilty by Reason of Insanity - Conditional Release	ODMH
2945.402 A1	ISTU- CJ Conditional Release	ODMH

Source: *Ohio Department of Mental Health, Forensic Strategies Workgroup Final Report, January 2010.*

24 Department of Mental Health, Public Records Request, April 20, 2009 meeting, http://www.mh.state.oh.us/partner-resources/fund-408-roundtable-dialogues.shtml.

25 State psychiatric hospitals also receive reimbursements from Medicare for eligible recipients and Medicaid for eligible individuals who are under the age of 21 and over the age of 65. To prevent from refinancing their state psychiatric hospitals through Medicaid, federal regulations prohibit Medicaid reimbursement for services in institutions for mental disease (IMDs) for adults ages 21 to 65.

26 Forensic Strategies Workgroup, Ohio Department of Mental Health, January 2010.

27 Data from the JFS Decision Support System (DSS) provided by the Office of Ohio Health Plans, Ohio Department of Job and Family Services. See section entitled "Special Study: Medicaid Spending for Individuals Previously Treated in the Community Mental Health System" for more information on this dataset.

28 Ibid.

29 "Ohio's Progress Towards a Unified Long Term Care Budget." December 2010. Online at www.aging.ohio.gov/resources/publications/ULTCS_report_2010.pdf

30 Data in this section was provided by the Ohio Department of Rehabilitation and Corrections.

31 During FY 2009, 4 inmates completed suicide and 62 inmates attempted suicide. Over the last five years, the number of suicides has fluctuated but attempted suicides have steadily decreased. Suicide attempts have decreased by 126 percent since FY 2005. The decrease in suicide attempts could be due to The Suicide Prevention and Review Team (SPART) concept that was developed in 2004. The team's responsibilities are to study the propensity for suicide behavior, review all written procedures and review, evaluate and revise prevention efforts.

32 Inmates are assigned to the "mental health caseload" if:

- They are on psychotropic medications prior to entry into the prison system and their evaluation indicates the need to continue medication and/or other treatments
- They are referred based on the initial and detailed screenings at reception
- Referrals from self or staff

Inmates not on the "mental health caseload" can receive crisis services and/or up to 3 clinical contacts. After 3 clinical contacts, if the clinician and inmate decide future services are necessary the individual receives a treatment plan and is placed on the "mental health caseload". Individuals can refuse to be on the "mental health caseload". If they refuse, an assessment is done to determine whether or not they have the cognitive ability to refuse and determine if treatment should be mandated through a due process hearing.

33 National Institutes of Mental Health.

34 Ibid.

35 Data provided by Ohio Department of Mental Health.

36 The Council of State Governments: Justice Center. *Justice Reinvestment in Ohio.*

37 Data in this section was provided by Ohio Department of Mental Health.

38 An individual who is "Not Guilty by Reason of Insanity" is unable to know the wrongfulness of his or her actions at the time of an alleged criminal offense, as a result of a mental disease or defect.

39 An individual who is "Incompetent to Stand Trial – Unrestorable" is unable to understand his or her legal situation or assist his or her attorney due to a mental illness or intellectual disability and is unable to be restored to competency through treatment during a reasonable period of time.

40 Data in this section was provided by the Ohio Department of Youth Services.

41 A youth on the “mental health caseload” is being seen and followed by psychology and has a behavioral health services plan and/or is being seen by psychiatry.

42 Youth placed on a mental health unit are referred by the youth psychology staff and the youth is approved for transfer through the Office of Mental Health Services.

43 Mental health services costs are not broken out from the cost to house, care and treat youth in DYS facilities.

44 Mental health prescription drugs are purchased from the Office of Support Services Center Pharmacy at ODMH at a significantly reduced cost.

45 Information form “An Evaluation of the Behavioral Health/Juvenile Justice Initiative: 2007-2009.”

46 The BHJJ program has projects in Cuyahoga, Fairfield, Franklin, Logan/Champaign, Montgomery, Union, Butler and Hamilton counties. The BHJJ program enrolls juvenile justice-involved youth between the ages of 10 and 18 who meet several of the following criteria:

- A DSM IV Axis I diagnosis;
- Substantial mental status impairment;
- A co-occurring substance use/abuse problem;
- A pattern of violent or criminal behavior; and
- A history of multi-system involvement.

Between FY 2006 and FY 2010, 1,035 youth have been enrolled in the BHJJ program. Over half of the youth were females. The youth involved in the BHJJ had an average of 1.94 Axis I diagnoses per youth. The most common diagnosis for females was Oppositional Defiant Disorder while the most common diagnosis for males was Attention Deficit Hyperactivity Disorder.

47 This amount does not include additional monies spent by the State, including Medicaid reimbursement, nor does it include any additional funds spent by individual BHJJ counties.

48 Data in this section is from the Ohio Department of Education’s online interactive Local Report Card. This data can be obtained at: http://ilrc.ode.state.oh.us/. Data is available for schools at the State, County and District level for most of the data discussed.

49 A parent, teacher or school representative can begin the process for a student to be evaluated for an IEP. IEP’s are reviewed annually to ensure the student is making progress toward the outlined goals and that the services and supports remain appropriate for the student. Every 3 years the student is re-evaluated to determine if special education is still needed and if the services and supports being provided through specials education are appropriate.

A student whose education performance is impacted and has a condition showing one or more of the following characteristics over a “long period of time” qualifies for an IEP due to their emotional disturbance:

- An inability to learn that cannot be explained by intellectual, sensory or health factors:
- An inability to build or maintain satisfactory relationships with peers or teachers;
- Inappropriate types of behavior or feelings under normal circumstances;
- A general pervasive mood of unhappiness or depression; or
- A tendency to develop physical symptoms or fears associated with personal or school problems.

50 Ohio Department of Education. *Whose IDEA Is This? A Parent’s Guide to the Individuals with Disabilities Education Improvement Act of 2004 (IDEA).*

51 Mental Health: A Report from the Surgeon General.

52 U.S. Department of Education. *28th Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2006. Vol. 2.*

53 Ohio Department of Education.

54 Ibid.

55 Educational Testing Service. *One-Third of a Nation: Rising Dropout Rates and Declining Opportunities.*

56 U.S. Census, 2009 American Community Survey.

57 U.S. Department of Education, National Center for Education Statistics, *Condition of Education 1996* (Washington, D.C.: 1996), Indicator 36.

58 Data in section is from:
Miller, Brian, Paschall III, C. Bayard and Svendsen, Dale. Mortality and Medical Comorbidity Among Patients with Serious Mental Illness. *Psychiatric Services*. 2006; 57 : 1482 – 1487.
Piatt, Elizabeth, Munetz, Mark and Ritter, Christian. An Examination of Premature Mortality Among Decedents with Serious Mental Illness and Those in the General Population. *Psychiatric Services*. 2010; 61 : 663-668.

59 WISQARS. Center for Disease Control's Fatal Injury database.

60 Data in this section is from the Ohio Prescription Drug Abuse Taskforce. *Final Report*. October 1, 2010. The report is available at http://www.odh.ohio.gov/features/odhfeatures/drugod/drugoverdose.aspx.

61 WONDER (NCHS Compressed Mortality File, 1999-2007).

62 Children's Safety Network Economics & Data Analysis Resource Center, Pacifica Institute for Research and Evaluation, as cited in the Ohio Prescription Drug Abuse Taskforce's Final Report.

63 The number of completed suicides, suicide rates, medical and work loss costs related to suicide are all available by county as well as for Ohio.

64 Moscicki EK. Epidemiology of completed and attempted suicide: toward a framework for prevention.
Clinical Neuroscience Research. 2001; 1:310-323.

65 Ohio Department of Health, Office of Vital Statistics, Analysis by Injury Prevention Program. Provided by The Ohio Suicide Prevention Foundation.

66 WISQARS. Center for Disease Control's Fatal Injury database.

67 Moscicki EK. Epidemiology of completed and attempted suicide: toward a framework for prevention.
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68 WISQARS. Center for Disease Control's Fatal Injury database.

69 Moscicki EK. Epidemiology of completed and attempted suicide: toward a framework for prevention.
Clinical Neuroscience Research. 2001; 1:310-323.

70 WISQARS. Center for Disease Control's Non-Fatal Injury database.

71 Expenses include medical examiner, medical transport, emergency department, inpatient hospital, and nursing home costs.

72 WISQARS. Center for Disease Control's Fatal Injury database.

73 Ohio Department of Health, Office of Vital Statistics, Analysis by Injury Prevention Program. Provided by The Ohio Suicide Prevention Foundation.

Appendix

Snapshot of Most Commonly Used Community Mental Health Services: Total Cost, Clients Served, Units Administered**

	2007 Board Cost	2008 Board Cost	2009 Board Cost	2010 Board Cost
Community Psychiatric Supportive Treatment-Individual	$203,239,005	$213,331,712	$223,084,901	$235,257,412
Counseling & Therapy-Individual	$108,557,938	$113,600,475	$127,475,833	$141,321,315
Pharmacologic Management	$97,539,279	$104,300,386	$112,738,059	$119,525,382
Partial Hospitalization	$51,291,096	$54,477,652	$57,559,495	$54,787,250
Diagnostic Assessment-Non Physician	$33,264,207	$34,266,486	$37,302,863	$39,978,186
***Residential Care**	$35,152,352	$33,329,906	$37,603,682	$33,398,992
***Other MH Service** (Non-Healthcare)	$15,141,496	$18,890,195	$20,638,431	$19,664,389
Community Psychiatric Supportive Treatment -Group	$12,240,744	$14,943,853	$15,587,404	$19,644,675
Counseling & Therapy-Group	$16,965,742	$17,817,926	$18,436,395	$19,374,775
Total System Spending	**$661,421,468**	**$693,937,891**	**$736,383,851**	**$762,520,953**

	'07 Total Clients	'08 Total Clients	'09 Total Clients	'10 Total Clients	'07 Units of Service**	'08 Units of Service**	'09 Units of Service**	'10 Units of Service**
Community Psychiatric Supportive Treatment-Individual	135,116	144,177	150,981	157,722	9,692,713	10,147,214	10,542,709	11,034,029
Counseling & Therapy-Individual	152,810	156,498	168,132	179,253	5,027,245	5,241,077	5,823,498	6,401,164
Pharmacologic Management	158,183	165,448	177,107	185,675	485,350	527,572	557,396	572,683
Partial Hospitalization	7,611	7,667	8,116	8,105	446,681	476,206	499,425	472,519
Diagnostic Assessment-Non Physician	144,035	148,215	160,751	165,468	273,813	280,753	303,561	319,038
***Residential Care**	4,497	4,186	4,097	3,764	561,137	527,117	473,505	381,513
***Other MH Service** (Non-Healthcare)	12,855	15,985	18,793	17,924	895,783	1,088,932	1,280,730	925,353
Community Psychiatric Supportive Treatment -Group	13,991	15,302	16,557	18,409	1,377,570	1,617,563	1,684,361	2,134,778
Counseling & Therapy-Group	23,027	22,519	23,040	23,750	1,861,712	1,916,178	1,962,562	2,042,900
Total Served: Unduplicated Clients/Units of Service	**311,422**	**323,117**	**340,594**	**354,194**	**22,174,987**	**23,259,862**	**24,581,816**	**25,586,092**

Source: *MACSIS*

** Non-Medicaid Services. ** All services are billed in one hour increments except CPST and counseling (15 minute increments) and partial hospitalization and residential care (daily rate).*

Snapshot of Most Commonly Used Community Alcohol and Drug Addiction Services:
Total Cost, Clients Served, Units Administered**

	2007 Board Cost	2008 Board Cost	2009 Board Cost	2010 Board Cost
Counseling-Group	$34,147,443	$36,876,869	$39,379,387	$41,189,923
Intensive Outpatient Services	$28,847,119	$29,975,069	$28,208,373	$26,512,155
Counseling-Individual	$17,950,456	$18,176,385	$19,908,820	$20,250,225
***Non-Medical Community Residential Treatment:** Non-Acute	$17,405,664	$17,550,000	$17,535,200	$19,231,371
Case Management Services	$13,980,187	$13,983,272	$14,497,620	$13,500,035
Assessment Services	$12,976,886	$12,909,319	$13,489,870	$12,014,824
***Education**	$14,578,040	$13,556,513	$13,077,521	$11,582,333
Methadone Administration	$7,807,205	$9,223,231	$10,831,523	$11,275,060
***Room/Rent Subsidy**	$7,474,194	$6,572,767	$7,507,571	$7,564,387
Total	**$203,072,345**	**$205,794,235**	**$212,916,394**	**$207,364,637**

	'07 Clients	'08 Clients	'09 Clients	'10 Clients	'07 Units of Service**	'08 Units of Service**	'09 Units of Service**	'10 Units of Service**
Counseling-Group	38,121	39,061	41,222	39,905	4,429,140	4,759,682	4,904,295	5,056,389
Intensive Outpatient Services	13,807	13,813	13,478	12,368	269,320	275,490	257,957	236,915
Counseling-Individual	47,214	48,638	50,850	49,840	873,480	875,902	945,874	955,505
***Non-Medical Community Residential Treatment:** Non-Acute	4,033	3,896	3,700	3,789	162,648	166,533	158,574	164,672
Case Management Services	52,224	53,564	54,703	50,817	198,639	205,051	192,500	181,315
Assessment Services	68,964	69,733	72,486	65,322	145,296	144,571	148,307	131,954
***Education**	775	678	568	562	183,467	162,397	145,003	121,531
Methadone Administration	3,312	3,590	4,032	4,464	686,258	786,255	914,621	963,362
***Room/Rent Subsidy**	2,063	1,974	2,035	1,829	108,726	104,010	105,863	98,882
Total	**100,292**	**101,331**	**104,481**	**98,707**	**7,648,223**	**8,050,296**	**8,349,859**	**8,498,943**

Source: *MACSIS*

** Non-Medicaid Services*

*** All services are billed in one hour increments except counseling (15 minute increments), methadone administration (per dose), and intensive outpatient services, non-medical community residential treatment (daily rate).*

Mental Health Advocacy Coalition

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4500 Euclid Ave.
Cleveland, Ohio 44103
216-432-7262
mentalhealthadvocacy.org

1501 Euclid Ave., Ste. 310
Cleveland, OH 44115
216-781-2988

37 W. Broad St., Suite 800
Columbus, Ohio 43215
614-224-1344

communitysolutions.com