



Behavioral Health Priorities Survey: A Statewide Survey of System Stakeholder Preferences

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ABSTRACT

This survey identifies behavioral health (both mental health and substance abuse) priorities endorsed by stakeholders in Ohio's behavioral health community for strategic planning purposes. Data were collected during August 2014 on a convenient sample of 571 stakeholders throughout Ohio. Planning priorities identified included affordable outpatient treatment, medication-assisted treatment (MAT), detoxification services, inpatient care, crisis stabilization services, housing and transportation. Of all treatment areas, access to outpatient services (rank 1, $n = 625$), access to inpatient care (rank = 2; $n = 151$), (MAT rank = 3, $n = 107$), access to affordable medication (rank = 4, $n = 96$), and detoxification services (rank = 5; $n = 93$) were considered the top priorities. In terms of support services, housing (rank = 1; $n = 516$), employment (rank = 2; $n = 273$), and transportation (rank = 3; $n = 174$) were considered the most salient issues requiring attention. Results suggest that leadership consider planning from an array of outpatient services in combination with community support services that assist in maintaining long-term tenure in the community.

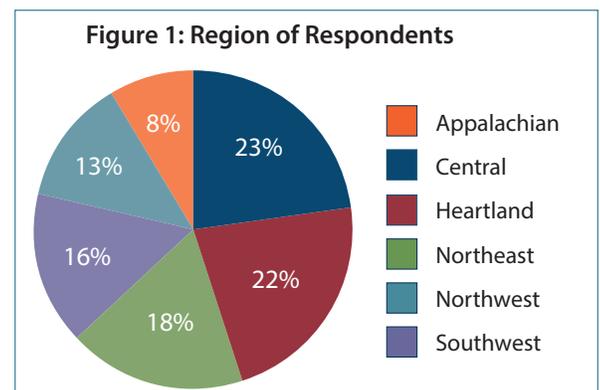
Purpose

A survey was conducted by the Ohio Department of Mental Health and Addiction Services (OhioMHAS), Bureau of Research and Evaluation (BRE) to gather broad stakeholder input from the community about the behavioral health service needs of Ohioans. The goal of the survey was to identify which behavioral health funding priorities are endorsed by survey participants. The data collected by BRE is summarized in this report.

Method

Participants

The survey was completed by 571 individuals representing behavioral health service recipients, behavioral health professionals, family members, advocates, and criminal justice and child welfare workers. The total sample included 245 (43%) behavioral health professionals, 74 (13%) family members of service recipients, 63 (11%) advocates, 53 (9%) court personnel, 40 (7%) concerned citizens, 36 (7%) service recipients, 33 (6%) criminal justice professionals and 27 (4%) child welfare professionals. Figure 1 shows that the regional distribution of the respondents varied: 124 (23%) from the Ohio's Central region, 119 (22%) from the Heartland region, 97 (18%) from the northeast region, 85 (16%) from the southeast region, 69 (13%) from the Northwest region and 45 (8%) from the Appalachian region.



Procedures

Data were collected by questionnaire for three weeks in August 2014. The survey was administered using SurveyMonkey web-based survey technology. To recruit a convenient sample of participants, the link was sent to a list-serv of various behavioral health organizations across Ohio and to all State cabinet-level agencies that work with consumers of behavioral health services. All participants were informed that OhioMHAS was interested in their input for planning and program purposes. Anonymity and confidentiality were emphasized but not promised as a component of the survey. Email addresses were provided by 378 (66%) of the respondents. Questions about the survey were fielded by staff from BRE and the department's Office of Public Affairs.

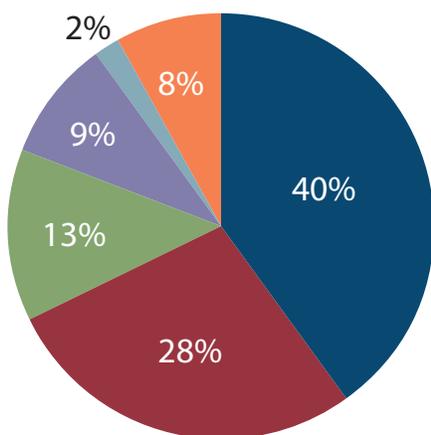
Measurement

The Ohio Behavioral Health Priorities Survey was developed based on the feedback from OhioMHAS leadership. The questionnaire, which follows the report, was designed to provide OhioMHAS leadership with programmatically informative information about how community stakeholders viewed funding priorities for public behavioral health services in Ohio. The elements of the questionnaire included: stakeholder group, county of residence, ranking of mental health and substance abuse priorities, and three open-ended questions about how to address priority issues, who the respondents would need to partner with to address the priority issues, and the impact of addressing the issues. For the rankings, participants were asked to fill in five (5) open-ended comment boxes, with the first open-ended comment box being the most important issue to address/fund and the fifth (5) comment box being the fifth most important priority to address/fund. They were asked to rank mental health and substance abuse priorities separately.

Analysis

Descriptive statistics included percentages, means and standard deviations. Because the questions were mostly qualitative in nature (open-ended, fill in the blank) all questions had to be thematically coded and analyzed. Three reviewers independently read and coded the 571 answers consisting of 6,163 separate comments. Respondents were asked to identify the top five priority areas in AOD and MH services. To code the questions, each reviewer flagged sections of the text that participants frequently mentioned. Repeated observations in the questions were labeled by each reviewer. Similar themes were identified, named and defined. After developing the themes, the reviewers read the answers and coded several questions simultaneously. The reviewers discussed discrepancies in the codes and revised their coding practice to more accurately reflect new interpretations. Problems with codes included redundant codes for the same priority, vague code definitions, a lack of mutual exclusivity between codes, and a lack of shared understanding in the procedures for using specific codes. Based on the 6,163 coded comments, the top ten priorities were tabulated. Reviewers also agreed upon quotes that would be used to represent the themes in this report. Themes were tabulated and are presented below.

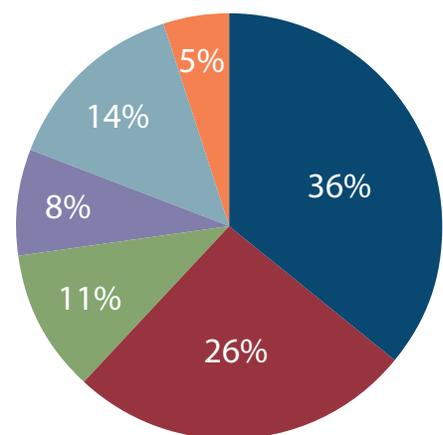
Figure 2: AOD Priority Needs



Categories



Figure 3: MH Priority Needs



Findings

Comments on behavioral health system funding priorities were divided into six categories: Treatment, Treatment Supports, Prevention, Finance, Workforce, and Community Issues. These themes were used to further sort priorities in both AOD and MH system needs. Although all respondents commented on the same categories, their priorities differed. For example, Figures 2 and 3 show that MH respondents had more comments related to workforce issues, and AOD respondents had more comments related to community issues. Because the comments for the Prevention, Workforce, Financing and Community Issues categories overlapped for both groups, priorities were determined by combining the coded comments for AOD and MH.

TREATMENT NEEDS

AOD Treatment Needs

Forty percent (40%) of the comments ($n = 906$ mentions) regarding *AOD System Needs* were related to treatment (See Table 1). Of those comments, 30% ($n = 272$ mentions) suggested that access to outpatient substance abuse treatment was the highest priority for the state of Ohio's AOD system of services. Respondent's suggested that the demand far exceeded the treatment that is currently available in the community. Participants named several other areas that should also be considered priorities, including: Medication-Assisted Treatment ($n = 107$, 12%), Detoxification Services ($n = 96$, 11%), Inpatient Treatment ($n = 96$, 11%), Residential Treatment ($n = 77$, 8%), Recovery-Oriented Systems of Care ($n = 75$, 8%), Integrated Care ($n = 55$, 6%), Dual Disorders Treatment ($n = 44$, 5%), Adolescent/Youth Treatment ($n = 43$, 5%), and treatment provided in a timely manner ($n = 41$, 5%).

Theme	# of Comments	%
Access to Treatment	272	30
Medication-Assisted Treatment	107	12
Detoxification Locations	96	11
Inpatient Treatment	96	11
Residential Treatment	77	8
Recovery-Oriented Systems of Care	75	8
Integrated Care	55	6
Dual Disorders Treatment	44	5
Adolescent/Youth Treatment	43	5
Timely Treatment	41	5

MH Treatment Needs

Thirty-six percent (36%) ($n = 850$ mentions) of the responses were related to *Mental Health (MH) Treatment Needs* (see Table 2). Of the comments on Treatment Needs, the most salient issue mentioned was access to appropriate treatment ($n = 353$, 42% of comments). Other areas related to treatment that respondents felt warranted additional focus included: Access to Affordable Medication ($n = 96$, 11%), Case Management Services ($n = 92$, 11%), Multi-System Coordination ($n = 78$, 9%), Inpatient Treatment ($n = 55$, 6%), Crisis Stabilization Services ($n = 51$, 6%), Integrated Care ($n = 48$, 6%), Dual Disorders Treatment ($n = 31$, 4%), Better Screening and Assessment ($n = 26$, 3%), and increased availability of intensive treatment options such as Assertive Community Treatment and/or Integrated Dual Disorders Treatment ($n = 19$, 2% of responses).

Theme	# of Comments	%
Access to Treatment	353	42
Access to Affordable Medication	96	11
Case Management	92	11
Multi-System Coordination	78	9
Inpatient Treatment	55	6
Crisis Stabilization Services	51	6
Integrated Care	48	6
Dual Disorders Treatment	31	4
Better Screening and Assessment	26	3
More Availability of Intensive Treatment Options (IDDT, ACT, IHBT)	19	2

TREATMENT SUPPORTS

AOD Treatment Support Needs

Twenty-eight percent (28%) of the comments (n=629 mentions) regarding AOD needs were related to *Treatment Supports* (See Table 3). Of those comments, 39% (n=248 mentions) suggested that access to safe and affordable housing was the highest priority for providing support for people with AOD addiction issues. Other AOD treatment support needs mentioned as priorities included employment (n = 175, 28%), transportation (n = 84, 13%), family supports (n = 79, 13%) and peer supports (n = 43, 7%).

MH Treatment Support Needs

Twenty-six percent (26%) of the comments (n = 614 mentions) regarding MH funding priorities were related to MH Treatment Supports (see Table 4). Similar to AOD treatment supports, respondents suggested that housing (n = 268, 44%), employment (n = 98, 16%), transportation (n = 90, 15%), family supports (n = 75, 12%) and peer support (n = 11, 2%) all needed increased funding to support persons with mental illness in their recovery process. However, unlike AOD treatment supports, respondents suggested that programs should also support enhancing community activities (n = 55, 9%), i.e. having something to do, and respite beds (n = 11, 2%).

Table 3. Prioritized AOD Treatment Support Needs based on coded comments. (n = 629 mentions)

Theme	# of Comments	%
Housing	248	39
Employment	175	28
Transportation	84	13
Family Supports	79	13
Peer Support	43	7

Table 4. Prioritized MH Treatment Support Needs based on coded comments. (n = 614 mentions)

Theme	# of Comments	%
Housing	268	44
Employment	98	16
Transportation	90	15
Family Supports	75	12
Community Activities	55	9
Respite Beds	17	3
Peer Support	11	2

PREVENTION

Nine percent (9%) of the comments (n = 411 mentions) regarding overall behavioral health priorities were related to Prevention Services (See Table 5). Of those comments, 48% (n = 146 mentions) suggested that educating the community about mental illness and substance abuse was the highest prevention priority for the state of Ohio's behavioral health system of services. Other prevention areas that respondents suggested be considered for priority funding included: Stigma Reduction Campaigns (n = 129, 66%), Early Identification and Education (n = 126, 4%) and suicide prevention (n = 10, 4%). While comments in all categories were mentioned for both AOD and MH, community education and stigma reduction were predominately MH focused, and early identification and intervention were largely geared toward AOD prevention efforts.

Table 5. Prevention priorities based on coded comments (n = 411 mentions)

Theme	# of Comments	%
Community Education	146	48
Stigma Reduction	129	66
Early Identification and Intervention	126	4
Suicide Prevention	10	4

FINANCING

Twelve percent (12%) of the comments (n = 551 mentions) regarding the needs of Ohio's behavioral health care system were related to Funding (See Table 6). Of those comments, 51% (n = 280 mentions) indicated a need for more funding. These comments suggested current funding levels were not sufficient to meet the growing needs of Ohio's residents with behavioral health issues (AOD and MH combined). Respondents continually mentioned issues with insurance and billing (both private and Medicaid) as significant barriers to providing person-centered care. Some of the comments suggested that there needed to be considerable

reform in the area of Medicaid billing (n = 155, 28%) to keep up with treatment advances and evidence-based care (e.g., bundled rates, or ability to bill for peer support, ACT, IHBT, etc...). Finally, 116 comments (21%) suggested that there needed to be low cost or no cost care provided to those without the means to pay. Respondents indicated that access to care is often denied because the person seeking services does not have the ability to pay.

Table 6. Financing priorities based on coded comments (n= 551 mentions)

Theme	# of Comments	%
More Funding	280	51
Insurance/Medicaid Billing Issues	155	28
Low Cost/No Cost Care	116	21

WORKFORCE

Eight percent (8%) of the comments (n = 380 mentions) regarding overall behavioral health priorities were related to Workforce needs (See Table 5). Of those comments, 59% (n = 226 mentions) indicated a need for more training opportunities for the behavioral health workforce. The remainder of the comments centered on the significant shortages in the number of professionals in the behavioral health care workforce. Twenty percent (20%) (n = 75 mentions) of the comments were related to the lack of psychiatrists, 16% (n = 61) to the lack of mental health professionals, and 5% (n = 18) to the need for more substance abuse professionals. Participants suggested that while demand for services is at an all-time high, the supply of professionals and agencies to provide those services continues to shrink.

Table 7. Workforce priorities based on coded comments (n = 380 mentions)

Theme	# of Comments	%
Training	226	59
Lack of Psychiatrists	75	20
Lack of MH Professionals	61	16
Lack of SA Professionals	18	5

COMMUNITY ISSUES

Finally, an overall theme called “Community Issues” (n = 141 mentions) was developed to categorize comments related to matters that were not necessarily within the behavioral health system, but represented broader public and societal issues that directly affect consumers of behavioral health services. Many of these comments were related to the interaction among the criminal justice, court and behavioral health systems.

Table 8. Community Issues based on coded comments (n = 141 mentions)

Theme	# of Comments	%
Poverty/Crime/Safe Neighborhoods	73	51
Sentence Reform	24	17
Drug Courts	21	15
Decriminalization	12	9
Monitoring Prescribing Behavior	11	8

Fifty-one percent (51%) (n = 73 mentions) of the responses in this category suggested a need to address poverty, crime, and safety of neighborhoods, particularly for persons with addiction issues. Overall, because of the crime and availability of drugs, respondents indicated that these neighborhoods jeopardize a person’s recovery from addiction issues. The next three largest themes in this area were related to the criminal justice system: 17% (n = 24 mentions) of the comments suggested a need for sentence reform related to drug offenses, 15% (n = 21) suggested a need for more drug courts, and 9% (n = 12) wanted drugs decriminalized. Finally, 8% of the comments (n =11 mentions) were related to monitoring prescribing behavior of physicians. These comments directly related to the prescribing of prescription pain killers.

CONCLUSION

The Behavioral Health Priorities Survey was an attempt to identify which areas of behavioral health services are considered priority areas by stakeholders in Ohio's behavioral health community. It extends efforts by OhioMHAS to identify priority areas for policy and programming in a number of different areas using a variety of funding sources. The identification of priority areas endorsed by behavioral health care stakeholders suggests a number of important directions for policy and programming. Because of a wide consensus in the community that access to affordable Outpatient Treatment, Medication Assisted Treatment (MAT), Detoxification Services, Inpatient Care, Crisis Stabilization Services, and Housing are the most salient priority areas, policies and interventions should support these areas. There was also support to fund Community Education and Stigma Reduction Campaigns throughout Ohio. Finally, respondents indicated a need to provide more training programs to address the ongoing shortage of qualified behavioral health professionals in the community.

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