MACC

Multiethnic Advocates for Cultural Competence

AN OVERVIEW OF NEEDS IN OHIO

"Learning Your Needs"

Cultural Competence Needs Assessment Project 2006

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The Staff and Board of Directors of the Multiethnic Advocates for Cultural Competence wish to thank all of the individuals, organizations, and systems for their support and participation in the "Learning Your Needs" Cultural Competence Assessment Project. Your work will assist us in more effectively advocating for better access, capacity building, and system changes to ensure quality mental health services for all of Ohio's citizens.

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ABOUT MACC

The Multiethnic Advocates for Cultural Competence (**MACC**) is a statewide network of mental health consumers and family members, service providers and administrators, and advocates dedicated to making Cultural Competence a best practice in Ohio's Behavioral Health Care and other systems of care. MACC was officially formed in 2003. The mission of MACC is *"to enhance the quality of care in Ohio's behavioral health system and to incorporate cultural competence into systems and organizations that provide care to Ohio's most vulnerable and at-risk populations."*

Today, MACC works to achieve its mission in several ways including the sponsorship of educational activities (lectures, forums, workshops), the expansion of the Cultural Competence Resource Library, and by promoting Cultural Competence Assessment as a strategy to improving systems and organizations' ability to better meet consumer outcomes. MACC is located in Columbus, Ohio with members from across the state of Ohio, and is governed by a 20-member board of directors. Seven of MACC's Board members are standing representatives from the following organizations: NAMI; Ohio Council of Behavioral Health Care Providers; Ohio Association of County Behavioral Health Authorities; Ohio Advocates for Mental Health; Ohio Psychological Association; Ohio Psychiatric Association; and the Ohio Federation for Children's Mental Health. Additional board members represent consumers, consumer family members, advocates, providers, and others who care for vulnerable populations and are nominated by the membership of MACC.

WHY A NEEDS ASSESSMENT?

As a relatively new organization, MACC's current priorities can be summarized under three broad points:

- Increase understanding of cultural competence and its role in mental health recovery and resilience;
- Promote best and promising practices in cultural competence; and
- Determine and advocate for necessary system changes

At the heart of addressing these priorities is having a comprehensive and grassroots understanding of the cultural competence needs of the entire Behavioral Health Care system, and knowing which needs are priorities for those within the system. Currently, MACC receives requests for training, presentations, or resource materials that may or may not contribute to systemic changes overall.

Our belief is that by learning the true perspectives of those within our target audience, MACC can create an agenda for itself based on real needs identified by key stakeholders. Understanding cultural competence needs statewide will also assist the Ohio Department of Mental Health to determine how best to support this work through policy development, funding, and advocacy.

THE CHARGE TO RAMA CONSULTING GROUP

RAMA Consulting Group was asked by MACC to undertake a research project to assess and present the needs of a broad range of stakeholders in Ohio's Behavioral Health System. RAMA designed a highly participative process that included facilitating key informant provider and consumer focus groups (Learning Your Needs Forums), collecting and analyzing survey data, conducting cultural specific focus groups, availing opportunities for online feedback from stakeholders, and preparing the report: *"Cultural Competence in Mental Health: An Overview of Needs in Ohio".* These tactics are further discussed in the methodology section of the report. RAMA Consulting Group is a performance management consulting firm based in Columbus, Ohio with expertise in evaluation and assessment, strategic planning, leadership development and cultural competence.

RESEARCH METHODOLOGY

The Learning Your Needs Forums Project was designed to hear real needs from real people. It included a multi-city, multi-perspective process inclusive of key stakeholders in local communities and systems. Due to the enormity of the mental health system of Ohio, a focus was placed on key informant participation in many instances. Ideally, the process would hear from individuals most appropriate to provide insight into the general perspectives of particular communities, systems, or cultural groups.

In short, the needs assessment process sought to address the following seven Learning Questions which constitute the research objectives of the project.

1. What Cultural Competence efforts are currently underway and at what level of intensity?
2. How well do consumers and behavioral health care stakeholders understand the term Cultural Competence and what can be done to increase understanding?
3. What specific types of training and technical assistance are needed for the system to better meet the needs of diverse consumers and experiences?
4. In addition to C-CAT, are there other types of Cultural Competence assessments that would be of value to individuals, organizations, or systems within the state?
5. What statewide policies and systems are needed to assist local systems in providing more culturally competent services?
6. How can the local mental health system be more responsive to the needs of specific cultural groups represented in their communities?
7. What is the role of MACC, ODMH, and other systems in supporting Cultural Competence as a statewide best practice?

INTRODUCTION

The needs assessment included a two phase process of gathering data. Phase I consisted of focus groups and surveys aimed at mental health consumers and providers. Phase II was focused on gaining perspectives from specific cultural and demographic groups within the state, whose perspectives are needed to better understand stigma issues, accessibility factors, and other potential barriers to receiving care. Both phases included participation by an experienced and diverse pool of facilitators. The persons who participated in the needs assessment process represent a broad and diverse cross-section of stakeholders and points of view.

Consumer and Provider Focus Groups

The assessment team was cautioned early on that the phrase "needs assessment" may not be received well by the target audience for Phase I of the process. Therefore, in order to capture the spirit of the project, the Phase I focus groups were termed "Learning Your Needs Forums" (LYN). The forum events were held in eight cities (Athens; Cambridge; Columbus; Cincinnati; Dayton; East Liverpool; Massillon; Toledo) throughout Ohio and were designed to be regional in nature. See Appendix for county breakdown of forums.

The LYN Forums were advertised in various ways including several direct mailings to county boards, dissemination by ODMH staff and MACC board members, and direct solicitations to known key informants. RAMA facilitators conducted 12 focus groups with 159 registered attendees. In addition, 28 persons submitted feedback to focus group questions via a web-based questionnaire for a total Phase I involvement of 187 participants. A copy of the focus group questions is included in the Appendix section.

Consumer and Provider Surveys

In order to engage a broader perspective of consumer and providers in the assessment process, the assessment team authored a survey to collect information regarding levels of understanding about cultural competence, current training efforts, as well as, knowledge of MACC and its products and resources. The results of the survey are provided in the Survey Results section of the report and are also highlighted throughout the report in the "Did You Know" and "Interesting Insights" charts.

The survey was completed by 208 respondents. Of these, 82 identified themselves as consumers; 7 as family members of consumers; 76 as mental health providers; and 62 as "other" (respondents could choose multiple categories). Respondents who checked "Other" were mostly county board members and staff, provider agency executives, consumer advocates, and client rights officers. When asked to identify the type of organization they were affiliated with, the 172 respondents who answered the question cited the following: 84 (49%) were Adult Serving organizations; 47 (27.6%) were Youth Serving; 20 (11.7%) were Mental Health Hospital and 21 (12.4%) were Private Providers. 60 respondents also checked the "Other" category (respondents could choose multiple categories), which included majority affiliations with ODMH, county boards, rehabilitation and corrections, and consumer operated services and advocacy groups.

Cultural Specific Focus Groups

In addition to consumers and providers, the other rich perspectives we sought to gain were those minority and cultural groups that are prevalent in regional areas around the state which may not currently be accessing services for a variety of reasons or may have experienced barriers to accessing services. Phase II of the process was to conduct statewide culturally

specific focus groups to unmask barriers, perceptions, and stigma issues. In some cases, these culturally specific groups were held during the evenings and on weekends and efforts were made to conduct the groups in settings familiar to participants. Unlike the forums in Phase I, these focus groups only consisted of the members of that specific culture and the RAMA facilitator in order to provide an atmosphere of trust and openness.

A total of 18 focus groups were conducted around the state among a variety of cultural and underrepresented groups. The following cultural groups participated in the Phase II focus groups: African American, Amish, Appalachian, Asian, College Students, Deaf & Hard/Hearing, GLBT (Gay, Lesbian, Bi-sexual, Transgender), Hispanic/Latino, Muslim, and Native American. The assessment team sought to partner with existing organizations, committees, or leaders within these cultural groups in order to facilitate their immediate participation in the assessment process. Although some participants have chosen not to have their name shared in this report, the cultural specific focus groups consisted of approximately 194 individuals. Feedback from these sessions is presented in the Phase II: Cultural Specific Focus Group section of the report.

Caveats about Accuracy

RAMA Consulting Group has been careful in collecting, aggregating, analyzing and presenting data from a variety of sources to prepare the report: *"Cultural Competence in Mental Health: An Overview of Needs in Ohio"*. Although RAMA has judged its data sources to be reliable, it was not possible to authenticate all data. If readers of the report discover data errors or typographical errors, RAMA (and MACC) welcomes this feedback and will incorporate corrections into future updates of the report.

OVERVIEW OF NEEDS ASSESSMENT FINDINGS

The following 12 findings represent an overview of major themes derived from the needs assessment process. They are not, however, the only conclusions or themes that one might extract from the needs assessment data. It is suggested that the entire report be reviewed in order to gain a broader view of perspectives from the stakeholder groups involved in the process.

General

FINDING #1:

There is lack of clarity and consistency regarding the definition of "Cultural Competence" behavioral health care.

Based on the survey results as well as, anecdotal information collected during forum and cultural specific groups, there is neither a common definition for cultural competence nor standards for providing culturally competent care. While MACC did provide a working definition during these events to give participants a starting point, many did not agree with the definition or thought it was either deficient in some way or too verbose and academic. The failure to consistently articulate what cultural competence means within the behavioral health care arena affected the thoughts and comments provided regarding the degree to which the system was culturally competent or how it could improve in this area.

FINDING #2:

Consumers must be involved and considered at every level in addressing organizational and system wide cultural competence.

Consumers should drive the services that are designed to meet their needs and support their recovery. Consumers and providers consistently cited the need to have consumers involved in the delivery and design of training programs and cultural competence experiences. Consumers should also be allowed to serve as trainers and have access to organizational leaders to share directly experiences with those who have an impact on how services will be designed and delivered. Consumers of diverse backgrounds often feel "double stigma" as a cultural minority and as a mental health consumer. These consumers may offer the best perspective regarding how the system can meet the needs of people of similar circumstances.

FINDING #3:

Many cultural groups of smaller size are not being serviced by providers in a manner consistent with their culture and beliefs.

Participants in the culturally based focus groups as well as, diverse consumers who attended the forums believe services are not designed to meet their needs from a cultural perspective. Many believed that providers were dismissing their cultural beliefs, experiences, and norms as "invalid" or describing them as possible triggers of their mental illness. Participants consistently stated that they are less likely to access services when they perceive them to be culturally insensitive.

OVERVIEW OF NEEDS ASSESSMENT FINDINGS

FINDING #4:

Many cultural groups are not familiar or barely familiar with the composition and location of mental health services in their community.

These groups are often close-knit and self-contained which makes penetration by outsiders somewhat difficult. Unless there are trusted mental health professionals in that community many are hesitant to reach out for services which leads to general ignorance by many lay persons about the mental health system and the provided services. Most expressed an interest in having more education on the mental health system if presented in a respectful culturally competent manner.

Training

FINDING #5:

Cultural Competence trainings and coursework must be included in the educational requirements for behavioral health care providers attending educational institutions.

Providers consistently stated that in order to make cultural competence institutional in the system, that education must begin within the academic training programs of practitioners. Many suggested working with the institutions and other licensing bodies to mandate a certain number of hours in diversity/cultural competence for each practitioner prior to entering the behavioral health system. Post graduation, cultural competence should be among the continuing education requirements needed to maintain one's certification in these fields.

FINDING #6:

To meet the needs of local providers, cultural competence training should be offered regionally and should be designed to address geographic concerns.

Participants consistently stated trainings offered locally present a better opportunity for customization and relevancy to local providers and stakeholders. Regional trainings may also lead to better participation since the time away from the worksite would be lessened. Providers and consumers stressed using trainers who are familiar with their region as well as, cultural competence as a whole. Training should also be offered in a number of formats (i.e. web-based, lecture, seminars, etc.) and settings in order to meet the needs of the providers responsible for service delivery.

OVERVIEW OF NEEDS ASSESSMENT FINDINGS

Technical Assistance

FINDING #7:

Providers and other system stakeholders need guidance in choosing cultural competence resources to best meet their needs.

Many providers and stakeholders admitted their own limited knowledge about cultural competence or how to make it integral to how they deliver services. They cited the need for guidance by a team of individuals dedicated to helping organizations and systems assess, interpret, and institutionalize culturally competent practices. In addition to the need for human resources, the participants consistently requested that resource publications be readily available 24/7 and easily accessible throughout the state.

FINDING #8:

Many in the behavioral health community are still largely unaware of the role of MACC and the resources it provides.

According to the consumer and provider survey conducted during the needs assessment process, only 6% of respondents were "very familiar" with MACC's role and the services it provides. After participation in this process many participants cited the need to amplify MACC's agenda and its available resources to all system stakeholders. MACC was also consistently applauded for undertaking the needs assessment process as many participants recalled that they are often not consulted about their needs before changes are made or new initiatives are begun. It was also strongly suggested to develop MACC regional networks to convene local providers to work together on cultural competency initiatives and to share resources. Statewide advocacy and leadership on cultural competence policy issues was also cited as an appropriate role for the Multiethnic Advocates for Cultural Competence (MACC).

Cultural Competence Assessment

FINDING #9:

Many direct care staff and providers are not aware or familiar with the Cultural Competence Assessment Tool (C-CAT).

The C-CAT Tool developed by ODMH and housed at MACC is largely unfamiliar to stakeholders in the system making its utilization very low throughout the state. Many participants could only recite what they have heard about the tool although most had not direct knowledge of it. Feedback in that regard was mixed between "favorable" and "unfavorable" perceptions about the C-CAT. It was noted that often information about tools like C-CAT are targeted to agency and board leadership and may get lost among other important priorities. Suggestions were to use regional networks of "champions" in cultural competence to advocate for use of assessment tools like C-CAT.

OVERVIEW OF NEEDS ASSESSMENT FINDINGS

FINDING #10:

Cultural Competence Assessment processes and tools must be flexible and adaptable to diverse participants and geographical areas.

In discussions regarding the ideal cultural competence assessment, participants consistently cited that assessment should be flexible and implore several methods of gathering data including 1-to-1 interviews, focus groups, and web-based options. It is important that systems and organizations implementing the assessment be able to customize a process ideal for completing the assessment within the culture of the organization and surrounding community. In addition, cultural competence assessments must have appropriate support of system leaders and include appropriate levels of accountability to encourage buy-in from stakeholders.

System and Infrastructure

FINDING #11:

Medicaid based system of reimbursement focuses on productivity rather than providing appropriate culturally competent care.

Although not a new finding for many needs assessment participants, this was consistently cited as a major barrier of allowing clinicians the time to appropriately diagnose the best treatment methodology from the consumer's cultural perspective. Consumers often commented about feeling like a "number" and not a person when receiving care. Some providers who admitted that the pressure to "bill" Medicaid sometimes outweighs the ability to provide more in-depth analysis for a particular client of a diverse background echoing this feeling.

FINDING #12:

Cultural competence should be included into ongoing, mandatory accreditation processes currently required of providers.

Many provider and board leaders stressed that in order to institutionalize cultural competence and make people give it the attention it deserves, it must be included into an existing or its own accreditation process. Since agencies/boards are routinely evaluated on a number of criteria to warrant their worthiness to provide services, many cited the need to have cultural competence as one of these criteria. It was further suggested that MACC could emerge into this accreditation body and over a certification program for systems and agencies employing best and promising practices.

Survey Results

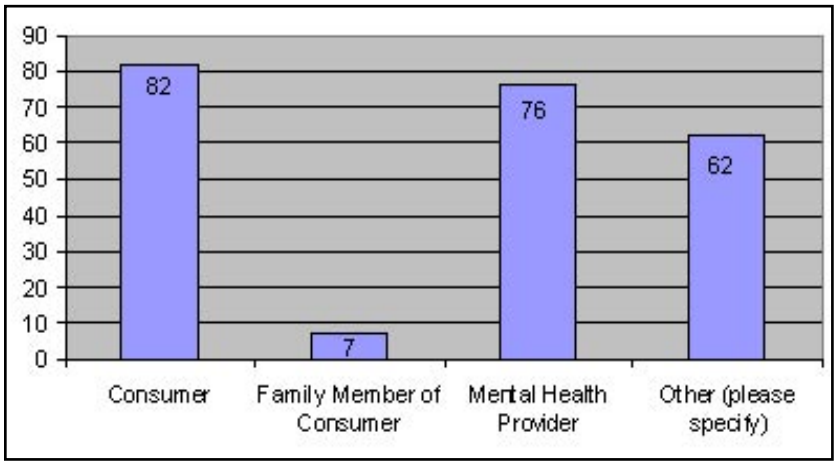
SURVEY RESULTS

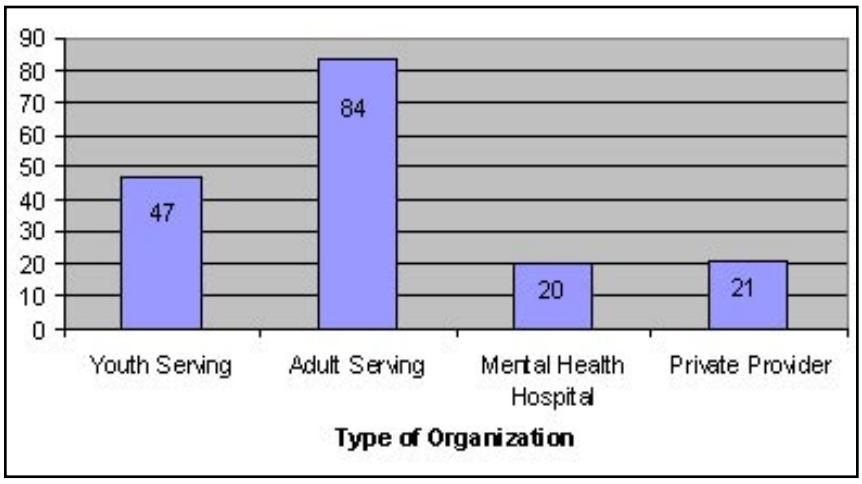
Provider and Consumer Survey Results

In order to gain a broader perspective from providers and consumers in the state behavioral health care system, the Forum participants were augmented with a survey instrument. The survey was offered in both paper and web-based versions and disseminated to MACC members, Forum participants, county board executives, and statewide partner organizations and other stakeholders. The survey was designed to gather information on topics such as the incidence of cultural competence assessment, current training initiatives within organizations, and overall understanding of cultural competence and its connection to recovery. The results of the survey are presented here and offer a snapshot of insights of those on both sides of this issue.

208 respondents completed the survey. Of these, 82 identified themselves as consumers; 7 as family members of consumers; 76 as mental health providers; and 62 as "other" (respondents could choose multiple categories). Respondents who choose "Other" were mostly county board members and staff, provider agency executives, consumer advocates, and client rights officers.

When asked to identify the type of organization they were affiliated with, the 172 respondents who answered the question cited the following: 84 (49%) represented Adult Serving organizations; 47 (27.6%) were Youth Serving; 20 (11.7%) were from Mental Health Hospitals and 21 (12.4%) were Private Providers. 60 respondents also checked the "Other" category (respondents could choose multiple categories), which included the majority of people affiliated with ODMH, county boards, rehabilitation and corrections, and consumer operated services and advocacy groups.



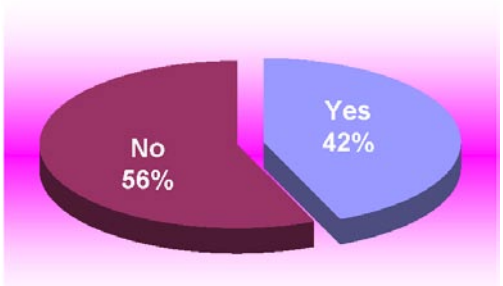


SURVEY RESULTS

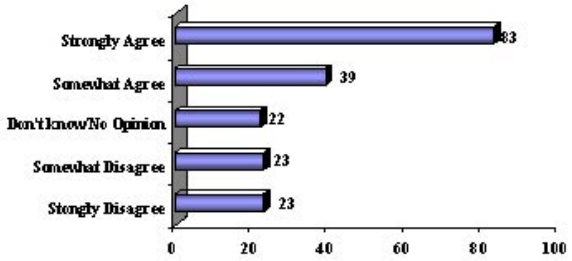
Survey Results at a Glance

The following questions were among those posed in the survey instrument and provide a snapshot of current knowledge of cultural competence and organizational efforts to support culturally competent service delivery.

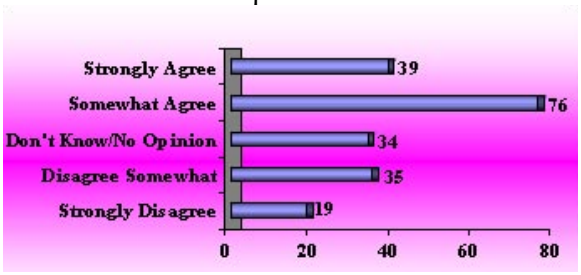
Do you have a particular definition of cultural competence you embrace? **



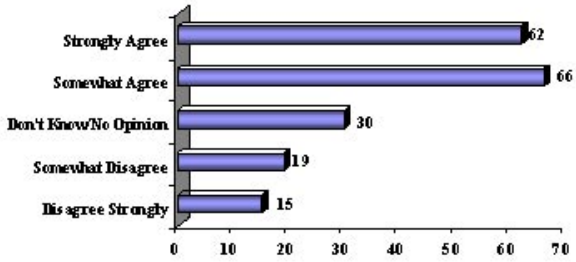
There is a strong relationship between cultural competence and mental health recovery. *



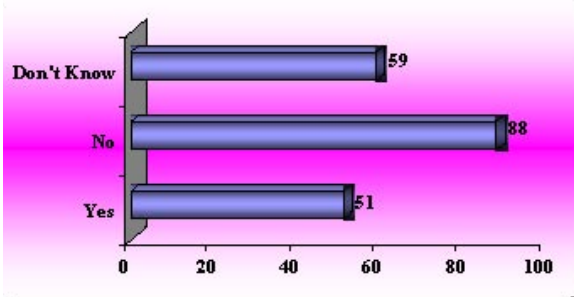
I would rate my organization's overall understanding of cultural competence as excellent. *



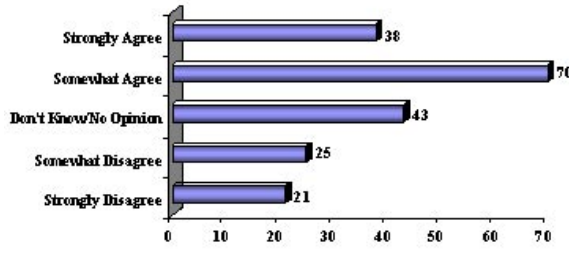
My organization has a strong commitment to ensuring culturally competent practices and service delivery.*



Has your organization or system used any other cultural competence assessment other than C-CAT?



My organization's cultural competence efforts are well planned and thoughtful. *



** Likert Scale used ranging from "Strongly Agree" to "Strongly Disagree"*

*** All respondents did not answer all questions; Percentages are of total respondents (208) not of those answering that question.*

SURVEY RESULTS

Additional Survey Insights

- On average, respondents attend 1-2 cultural competence trainings per year. Most often, the trainings were sponsored by their own organization, the local county board or non-profit organizations in their area.
- 64% of respondents were not or only slightly familiar with the C-CAT toolkit product.
- 47% of respondents were not familiar at all with the mission and purpose of the MACC organization; 6% rated themselves as "very familiar" with MACC
- 70% of respondents desired to be added to the MACC mailing list after their participation in the needs assessment project; 48% signed up to become MACC members

Appendix

FOCUS GROUP QUESTIONS

Multiethnic Advocates for Cultural Competence
Learning Your Needs Forum

Focus Group Questions
Part I:
Training and Technical Assistance

1. Imagine the entire behavioral health care system of Ohio has made cultural competence a cornerstone (integral to how it does business), what kinds of practices would be evident to all people entering the system or accessing services?
    a. Follow-up: What kinds of current behaviors and practices would have been eliminated?

2. As you consider some of the challenges you have encountered in working with diverse populations what specific kinds of training would be hopeful to people in your geographical area?
    a. Follow-up: Ideally, how long should these trainings last and how frequent would they occur?

3. Have you found that trainings are better embraced when they are conducted regionally (close to you) in smaller groups or do you prefer larger training events in more central locations? Why?

4. In addition to providing training on the topics we just identified, what other ways (technical assistance) could MACC and the Ohio Department Mental Health (ODMH) help your system to better embrace Cultural Competence?
    a. Follow-up: Are there particular publications you feel might be helpful in this area?
    b. Are there enhancements to the MACC website that would be helpful or if you have not seen the website what might you hope to see?
    c. What types of additional aides might the Cultural Competence Resource Center at MACC provide?

5. If MACC has the opportunity to hire a person solely dedicated to working statewide on Cultural Competence needs what additional things would you like that person to work on within your local areas?

FOCUS GROUP QUESTIONS

Part II
Facilitator Introduction Talking Points

Facilitators should review and change the talking points below to meet their conversational needs while keeping the intent of the questions in tact. We do need to make sure there is an introduction to this portion of the day since "Assessment" and "Infrastructure and System" needs are not self explanatory for the participants. After the break, facilitator should recap the first half of the session and do an intro into part II.

Suggested Script:

- *We are continuing to get a sense of the needs of the system but let's turn our attention toward two other important aspects we want to learn about: Assessments and System Needs.*

- *One of the things that MACC values is cultural competence Assessment or in other words the process of individuals, organizations, and systems exploring their own levels of cultural competence and how they might improve upon this work. MACC also currently manages the tool developed by the Ohio Department of Mental Health that is used to assess systems and organizations, known at the C-CAT (Cultural Competence Assessment Tool). Some of you may be familiar with the tool already.*

- *We also want to discuss overall system and infrastructure needs for the mental health system. In other words, what are those policies, procedures or requirements that would help all of the folks in the system deliver more culturally competent services. Let's focus on those things that may be out of the reach of your agency or board but might need to occur to support your efforts in this area.*

For more information on MACC/ODMH's C-CAT refer to www.ccattoolkit.org
Multiethnic Advocates for Cultural Competence
Learning Your Needs Forum

Multiethnic Advocates for Cultural Competence
Learning Your Needs Forum focus Group Questions
Part II:
Assessments & System and Infrastructure Needs

1. Other than the C-CAT that I talked about briefly, what other cultural competence assessments or processes have you encountered or used in mental health?
    a. Have you found them to be effective?
    b. What didn't you like about them?

2. Currently, the C-CAT is designed to assess entire organizations or systems. Have you noticed a need to have other levels of assessment (i.e. agency departments, individuals, etc) in your work?

3. For those of you who may not have done any assessment work to date, discuss what kinds of things you would want to learn from a cultural competence assessment?

4. What process would work best to gather the data for an assessment of cultural competence in your geographical area (i.e. Online, focus groups, survey, etc.)?

5. MACC has noticed that sometimes providers are reluctant to perform an assessment because they view this as a "report card" on their progress. Although this is not the intent of cultural competence assessments, what would make a tool or process more embraced by providers and boards?

6. As we switch now to overall system needs, and given your organizations most sincere efforts to improve cultural competence, there still remain things outside of your immediate control. What overall changes within the mental health system need to be addressed to better support this work?

7. As you think about the major barriers to having a more culturally competent mental health system, where would you suggest are the biggest opportunities for change? In other words, which things already identified would have the most significant impact for the system?

8. We have noticed that the mental health community has isolated efforts. Some providers and boards are making cultural competence a priority and doing a lot, while some others have not made it as much of a priority for their system. Why do you think this diversity exists?
    a. What can MACC or ODMH do to duplicate and highlight the effective initiatives happening in some communities?

9. Are there additional needs that MACC needs to know about that may not have been brought out today in regards to building a culturally competent system?

FOCUS GROUP QUESTIONS

Multiethnic Advocates for Cultural Competence
Learning Your Needs Forums
Culturally Specific Focus Groups Questions

MACC Cultural Competence Working Definition: A set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals, and enables this system, agency or those professionals to work effectively in cross-cultural situations (Cross, et. al., 1989).

1. (Referencing the culture competence definition on the wall) What does this definition of cultural competence mean to you?

2. How would friends and colleagues within your culture describe a person who appears to have a mental illness or for those who might be consumers what things have been said about you? What words would they use? How would they treat this person in a public setting?

3. If this same person was a family member or friend of yours, where would you recommend they go to receive help or assistance?

4. Are there any special rituals, practices, or ways some members of your culture might attempt to "cure" the mental illness?
    a. What kinds of remedies would they suggest?
    b. Are there particular people or professions that a person with mental illness might be taken to for services.

5. How familiar are you with the mental health system and how it is designed?
    a. Would you consider yourself more or less educated on the system than the average person from your culture?

6. How would you describe the level of comfort within your community about accessing mental health services?

7. Ideally, where should services be located or co-located to make them more accessible to your community? (i.e. in the Afr. American, Latino, Asian sections of town, on the bus line, in religious institutions etc.)

8. Based on what you know about mental health providers (social workers, psychologists, etc) what specific trainings would you suggest they go through to better understand and meet the needs of your culture?

ASSESSMENT PROCESS PARTICIPANTS

Special Thanks!

The Multiethnic Advocates for Cultural Competence would like to thank all who participated in the needs assessment process by registering for forums events, attending focus groups, sharing online feedback or lending overall project support. Your contributions will help us better understand and meet the needs of all of Ohio's consumers.

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Carla Rosler
Carol Hammonds
Carol Simpson
Charita Gowdy
Cheryl Mchan
Christ Pinkelman
Christy Murphy
Cindy Houston
Clarence Griffin
Comie Greebaugh
Connie Richards
Curtis Williams

D
D. Larry Branham
Dan Huddleston
Daniel Harrel
Darlene Mims
David Weaver
David Wesner
Deb Fonseca
De'Keta Mcallisters
Denise Buchanan
Denise Shrader
Diana Baker
Diana Baker
Don Thacker
Donna Lane-Sherman
Dorothy Boudinot
Douglas F. Conley
Doug Metcalfe

E
Ed Cross
Eddie Allen
Elaine Manning
Ellen Jones
Ellen Ringler
Elena Santos
Ellen Tait-Page
Eloise V. Traina
Eva Moore Sloan

F
Fatima Perkins
Felipe Amunetegui
Foluso Lawal-Solarin

G
Gary Bright
George Weigly
Georgina Valerio
Gerardo Cisneros
Gregory Farmer
Gwen Jones

I
Isatou Sagnia

J
Jackie Button
James Johnson
James Roberts
Janelle Edwards
Jane Krason
Jan Myers
Jauils Robinson
Jay Choi
Jeff Deckebach
Jennifer Dennis
Jenifer Schwirian
Jermain Pettis
Jessica Horne
Jim Clements
Jimmy Mckeller
Jim Martin
Joe Trolian
Joey Young
John Maiden
Josefina Contreras
Joyce Campian
Joy Gay
Juan Phillips
Judith Dennis
Julia Phillips
Julius Simmons

K
Karen West
Karen Wheatley
Kathleen Chaffee
Kathie Chaffee
Kathy Regal
Kevin Dixon
Kim Jensen
Kim Swango Johnson
Kimberly Meals
Kim Tapie
Kamille James
Kara Stevens

L
Lanna Samaniego
Larry Braman
Laura Everly
Laura Mclaughlin
Lenne Bowlmen
Leroi Birch
Linda Biggs
Linda Cole
Linda Piccolantonio
Linda Shellito
Lisa Countee
Lisa Griffen
Lisa Grubbs
Lisa Gowdy
Lonny Breoster
Lori Hunter
Lynette Loury

M
Margo Rodriguez
Margo R. Wynk
Marian L. Kindel
Miriam Casey
Mark McDaniel
Marisol Colon
Maritza Cruz
Martin Chambers
Maryann Theiss
Mary Chambers
Mary Isa Garayua
Mary Kelly
Mary Powell
Mary Ramey
May Chen
Melissa Giraud
Melissa Wallace
Melissa Winfied
Meiko Smith
Michael Copeland
Mildred Purdin
Melissa Thomas

N
Nancy Belvins
Nancy Stever
Nila Mckinley
Nora Hess

O
Ollie Collier Jones

P
Patrice Lee
Patricia L. Polatka
Pat Hackett
Pat Printke
Paul Lilley
Pam K.
Peggy Pasko
Phil Siebel

R
Rachel Over
Richard Young
Dr. Rick D`Arca
Rima Rafidi-Kern
Robert Santos
Robert Purpin
Roger Samaniego
Roma Barickman
Ronald Browder
Ronald Patton
Ronda K. Seeley
Ron Hill
Ron Monroe
Rosa Valdez
Roselin Runnels
Ruth Addison

S
Sandra Cannon
Sandra Geronimo
Sandra Harstine
Sandra L Walker
Sandy Greer
Sharon Thornton
Shirley Crane
Shirley Holland
Steven Burggraf
Steven Dunkin
Steven Hammer
Steve Hedge
Stephen Pearson
Stephen Willey
Sue Hanson
Susan Mocker
Susan Waddell
Sylvester Lainin

T
Tammy Nicholls
Terrell Stephens
Terri Chase
Terry Swartz
Terry L. Young
Theresa Braddy
Tina Pine
Tom Lianes
Tonni Guagenti
Tracee Black
Tracy Shoemoo
Trina Combs
Twilla Simpson
Tyrone Ruthland

V
Valeria Bledsoe
Valerie Hicks
Venus Mackey
Vicki Hill
Vicki Wartner
Victor Leandry
Vonni Rubin

X
Xiomare Simmons

Y
Ye Fan Glavin
Yvette Vanmeter

FORUM COUNTY BREAKDOWN

Toledo
(June 5th)
Defiance
Erie
Fulton
Hancock
Henry
Huron
Lucas
Ottawa
Putnam
Sandusky
Seneca
Williams
Wood
Wyandot

Massillon
(June 7th)
Ashland
Ashtabula
Cuyahoga
Geauga
Holmes
Lake
Lorian
Medina
Portage
Richland
Stark
Summit
Trumbull
Wayne

Athens
(June 12th)
Adams
Athens
Gallia
Hocking
Jackson
Lawrence
Meigs
Scioto
Vinton
Washington

Dayton
(June 14th)
Allen
Auglaize
Clark
Darke
Greene
Hardin
Madison
Mercer
Miami
Montgomery
Paulding
Preble
Shelby
Van Wert

Columbus
(June 16th)
Champaign
Crawford
Delaware
Fairfield
Franklin
Knox
Licking
Logan
Marion
Morrow
Union

Cincinnati
(August 1st)
Brown
Butler
Clermont
Clinton
Fayette
Hamilton
Highland
Pickaway
Pike
Ross
Warren

East Liverpool &
Cambridge
(August 2nd & 3rd)
Belmont
Carroll
Columbiana
Coshocton
Guernsey
Harrison
Jefferson
Mahoning
Monroe
Morgan
Muskingum
Noble
Perry
Tuscarawas