STUDY CONCLUSION AND RECOMMENDATIONS

Each chapter in this report includes a conclusion, summarizing key findings. The purpose of this concluding statement is to provide researchers’ recommendations, based on the assessment of data from both primary and secondary sources.

It is important to note that needs assessment is not an exact science. The best assessment of need includes more than one data source or type of data so that data may be triangulated (Mechanic, 2003). This study includes all four types of needs assessment data: epidemiological data, utilization data, and the perceptions of both clients and family members and experts, or providers and administrators.

Following are our recommendations, based on overall findings of both primary and secondary data sources. Readers of this report may identify other recommendations, based on their own assessment of the report’s findings. We do not intend for these recommendations, or our report to be the “final and definitive word” on the need for mental health and substance use services in Cuyahoga. The question is complex, and even we, as researchers, only have this study and our somewhat limited understanding of the behavioral health system of care in Cuyahoga County. It is our sincere hope that the report’s findings and these recommendations provide useful information and “food for thought” for strategically planning the way forward.

In presenting these recommendations, we are aware that some of these approaches or strategies may already exist. Where that is the case, it may be that more of such strategies could be beneficial. For example, if there is only one agency offering a given model or program, would it be helpful to offer the program in another location? It may also be the case that there is a plethora of a type of program mentioned below. If so, providers, clients and potential clients may benefit from being aware of the program. With these caveats in mind, following are our recommendations.

Role of the ADAMHS Board

Our primary recommendation is that the ADAMHS Board consider this as an opportunity to work collaboratively with agencies and community leaders to develop a strategic plan that uses the report findings as well as other data sources to enhance the ability of the County overall to address the needs of residents for substance use and mental health services. As described in this report, findings from participants reported a wide range of roles for the ADAMHS Board, in addition to funding. These roles include leadership, support, advocacy, and training. This seems to be an excellent opportunity for the ADAMHS Board to continue to build on its leadership role, and work with the community to engage in a meaningful strategic planning process.
Tele-health, service delivery, and COVID-19

Continue to support and grow tele-health as a viable option for mental health and substance use service delivery, as appropriate.

Soon after 2020 began, agencies had to adjust to the realities of social distancing and lock down as a result of COVID-19. When thinking about planning for future services, it remains to be seen whether some of the service delivery changes made to adjust to COVID-19 endure. Or, will all agencies and service providers go back to business as usual once COVID-19 is no longer a threat? Currently, 67.6% of Executive Directors and 77% of providers strongly agreed that their agency will be seeking to purchase additional personal protective equipment such as masks and disposable gloves in response to COVID-19. 14.7% of Executive Directors and 22% of providers agreed that they would be purchasing additional PPE. This is at least a short-term impact.

Many agencies began or increased their use of tele-health and are finding for the most part it is working well. For some, it is a challenge in serving clients who do not have access to the internet, or a smart phone. At the same time, telehealth can be a viable strategy to increase access and acceptability of services.

In terms of funding, at least one provider of residential treatment indicated their agency is taking a loss as there are fewer individuals in detox, yet costs are the same. Adjusting to the loss of income may be temporary and short-term. Beyond funding, the community may see a rise in the amount of mental health and substance use concerns as community members continue to cope. Understanding how COVID-19 is impacting agencies and the communities they seek to serve is beyond the scope of this current study. Given this, we recommend that the impact of COVID-19 on service delivery, agency viability, and community needs for mental health and substance use treatment be monitored and/or assessed.

Consider Integrated Behavioral Health Models

Health is multi-dimensional. The population served by agencies funded by the ADAMHS Board is largely one with multiple risk factors for poor behavioral and physical health outcomes. This is illustrated in the demographic data. Additionally, the ACE Pyramid, presented in the chapter on risk factors illustrates how adverse childhood experiences contributes to mental health and substance use concerns in adulthood, leading to an early death. Integrating mental health and substance use treatment to the extent possible, can have many benefits toward reducing health disparities, improving substance use and mental health outcomes, especially among the most underserved
populations, improving outcomes and increasing efficiency. This is especially relevant for individuals with co-occurring disorders and those with multiple and/or chronic concerns. Based on findings in this report, persons with co-occurring disorders, the homeless, immigrants, and persons who have been incarcerated were identified as being underserved. Organized around the extent and complexity of an individual’s mental health and substance use concern, the Four Quadrant Model can be a useful framework and collaborative planning tool to address the needs of underserved populations. (Mauer & Druss, 2010). This model suggests that services may be organized depending on whether mental health or substance use is the primary concern.

In considering opportunities for strengthening integration, the ADAMHS Board, along with providers, may need to take into account its unique operational factors such as: services that are currently available and accessible, client preferences, workforce capacity, agency and providers’ support for collaborative services, and the extent that reimbursement allows for collaborative care.

Culturally-competent and culturally-appropriate evidence-based interventions: Adaptation

While identified in surveys, interviews, and focus groups, the research literature also supports the necessity of implementing interventions that are culturally-competent and culturally-appropriate as well as being evidence-based. Such strategies can enhance service acceptability and improve outcomes. Even interventions that are supported in the research literature often must be adapted for a given community. For example, an intervention that may have been adapted for the African-American community in South Carolina may not directly translate to the African-American community in Cuyahoga County. Similarly, an intervention developed for the LGBTQ population in California may also need to be adapted for the local community.

Client-engagement and client-based practice research

To address the need for culturally-competent services and services that are acceptable to a wide range of populations, engage clients in developing models from the ground up, and keep them involved throughout. Models such as client-based practice research (CBPR) are designed to incorporate clients as research and evaluation partners and can quickly address the growing problem of racial and cultural disparities and the disconnect between clients and the means to recovery (Minkler & Wallerstein, 2003).
Evidence-based interventions

As pointed out by at least one respondent, training for evidence-based interventions can be expensive, and staff turnover can add an additional wrinkle to maintaining a workforce qualified to provide an evidence-based intervention. Consideration may be given to providing more centralized education, training, and resources to agencies and providers to support the implementation of evidence-based interventions. In addition to this suggestion, there may be other strategies to support implementing and sustaining evidence-based interventions county-wide.

Treatment fidelity

Once implemented, evidence-based interventions, such as Motivational Interviewing, have very specific fidelity measures that must be accomplished in order to continue to be considered an evidence-based practice. Treatment fidelity is an ongoing process to assess the extent that an evidence-based intervention has been implemented as designed and that providers adhere to the components of the intervention. Assessing fidelity on an ongoing basis can be time-consuming, and perhaps is not a reimbursable activity. Dissemination of strategies for resource-efficient methods to assess fidelity could support agencies and providers in monitoring fidelity.

Increase access to medication assisted treatment (MAT)

MAT has been shown to be safe, cost-effective, reduce overdose risk, increase treatment retention, reduce transmission of infectious diseases, and reduces criminal activity. While MAT is supported in Cuyahoga County, there is an ongoing need to increase access and reduce barriers to access. This may include increasing provider and community knowledge of the full spectrum of available medications, including buprenorphine-naloxone (Suboxone) and naltrexone (Vivitrol), among others.

Harm reduction

Harm reduction includes a set of strategies aimed at reducing the negative consequences associated with drug use. It is a public health strategy developed initially for adults with substance use problems for whom abstinence was not feasible. Examples include needle exchange programs, managed alcohol programs, shelter first approaches to homelessness, and increased flexibility in treatment to “meet clients where they are,” as opposed to requiring them to adhere to 100% of rules in order to get services. Harm reduction approaches have been effective in reducing morbidity and mortality in adult populations with substance-abusing populations when abstinence
does not work. They have also been shown to lower risky alcohol use and risky behaviors associated with HIV transmission.

**Medical marijuana and substance use treatment**

With the passage of House Bill 523, the state of Ohio made medical marijuana legal in 2016, for a specific list of health and mental health conditions. The law also established the Ohio Medical Marijuana Control Program (Ohio Medical Marijuana Control Program, 2016). With this in mind, substance use treatment providers should continue to assess how the legalization of medical marijuana is impacting treatment and the extent that legalization has changed clients’ and the public’s perceptions of the risks associated with cannabis use. While available medically to treat certain conditions, individuals may still develop cannabis use disorder, and youth and adolescents may especially be at-risk for experiencing negative consequences. Further, extensive cannabis use may be especially harmful for children and youth’s cognitive, emotional, educational, and social development (Lewandowski, in press).

**Prevention and public health strategies**

Several respondents mentioned the value and importance of prevention and we urge that prevention and public health approaches to addressing substance use and mental health be increasingly adopted to address disparities and improve outcomes. Today, there are numerous evidence-based prevention models to address mental health and substance use concerns. These include both community-based prevention models, and models that target identified populations, such as children and youth, and the prevention of risk-behaviors among those with mental health concerns and who may be engaged in substance use.

**Addressing the needs of persons who are homeless**

Persons who are homeless experience higher rates of mental illness and substance use disorders than the general population. They are also less likely to have access to evidence-based interventions for these difficulties (Sauer-Zavala et al., 2019). In addition to adults, youth who are homeless also face myriad challenges (Bassuk et al., 2015). With the fallout from COVID-19, it is anticipated that homelessness will increase, due to higher unemployment rates. Given that persons who are homeless have multiple concerns and face challenges in accessing treatment, we recommend that a range of strategies be examined to identify best and promising practices that may be adapted for Cuyahoga County.
Programs for women with children

As shown in the data, women tend to be under-represented in residential treatment programs, both nationally, and in Cuyahoga County. Having responsibility for children and even other caregiving responsibilities are frequently a barrier for women in accessing treatment. Further, women who have children and who use substances are often reluctant to engage in treatment out of concern that they may lose custody of their children (Sauer-Zavala et al., 2019; Lewandowski & Hill, 2009). There are few services in the County for women who are mothers, especially residential services where they may also bring their children. We recommend considering looking specifically at strategies to increase access and acceptability of programs for women, especially for women who have children and/or who may be pregnant. In addition to increasing services, other strategies include outreach, education, co-location, and tele-health and/or week-end hours.

Wrap-around service delivery models for youth and a system of care

Wrap-around is an empirically supported, family-driven, strengths-based planning approach to services for youth that provides individualized care using an array of formal services and natural supports (Winters & Metz, 2009). It is especially designed to help families with the most challenging children and youth to function more effectively in the community. It is a team-based process and families are full-service partners. Plans are developed based on interagency, community-based collaborative process.

Engaging transition-age youth

The findings suggest that transition-age youth may be underserved and are an at-risk population. It can be difficult for transition-age youth to be engaged in treatment. We recommend continuing and strengthening strategies to enhance a coordinated system of care while emphasizing flexibility in services and across organizations. Strategies and interventions that engage youth and caregivers in planning of services, focusing on educational advancement and employment have shown evidence of positive outcomes. Meeting the mental health and substance use treatment needs of transition age youth requires a multi-level approach, including the system of care overall, organizations, and programs. Evidence-based interventions that are adapted to the unique needs of youth and the community in which they live is the most ideal approach (Sukhera et al., 2015).
Co-location of services

While co-located services may already be provided, consideration may be given to increasing co-located services. In addition to substance use and mental health providers, individuals and families are often receiving services from child welfare agencies, schools, public child welfare offices, domestic violence shelters, and criminal justice systems, including law enforcement, parole and probation offices, and juvenile justice. Individuals and families may have more than one case manager or service provider, to the extent that being a client becomes a full-time job (Lewandowski & Hill, 2008a). A pre-dominant model of co-location models is co-locating substance use counselors in child welfare offices, where multiple traumas and inter-related concerns of addiction, behavioral health, and/or child abuse/neglect may be addressed in a team-based approach.

Study limitations

One of the primary limitations of the study is the small number of providers, administrators, and consumers (clients, advocates, and family members) who participated in the focus groups and responded to the survey. We note that less than half of the agencies funded by the ADAMHS Board participated in the survey. Only a small percentage of providers overall participated, and they represent less than half of agencies as well. The small number of participants, relative to the number of agencies, providers and clients in the county reflects in part, the impact of COVID-19 on the study. Similar to agencies, researchers also had to adjust, from an initial plan of conducting focus groups face to face, to one where focus groups were conducted online, taking away from valuable recruitment time, as well as the potential opportunity to conduct focus groups at pre-planned meetings, and at agencies. Once implemented, participants seemed to be able to participate fairly well in the online environment.

Regarding the assessment of evidence-based interventions, the description of evidence-based interventions does not include in-depth assessment of the extent they have demonstrated efficacy across a broad-ranges of populations. Though it cannot be ascertained, meta-analyses and system reviews are more likely to include studies using different populations in their samples than interventions that, to date, do not have a body of research large enough to merit a meta-analysis or systemic review. Further investigation into the research literature could reveal the demographics of populations in the identified studies.

Two of the major limitations of the NSDUH are the exclusion of the population under 12 years old and the people who are not included at the household level. In particular, the
NSDUH’s exclusion of homeless and institutionalized populations (such as in prisons or mental institutions) is problematic given the high prevalence of substance use and mental illness among these populations.

In terms of the ADAMHS Board client data, it has limitations characteristic of all administrative data. Overall, variables are pre-defined, and the data were collected to serve an administrative rather than a research function. Having said this, the ADAMHS Board data is fairly robust and designed in a way to be able to answer the questions included in the utilization analysis portion of this study.