

PREVENTING OPIOID ADDICTION

The Role of Integrated Behavioral Health

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Key Messages



Behavioral health integration

in medical settings supports non-opioid treatment of chronic pain and decreases prescription opioid misuse

Integrated strategies

between social service sectors targeted at youth can prevent future opioid addiction

- ▶ **Opioid addiction is a chronic disease;** the most effective solutions to the opioid epidemic treat it through medical and public health approaches rather than criminalizing drug use
- ▶ The myriad causes and scope of the crisis **require a spectrum of solutions** spanning from prevention to treatment
- ▶ Integrated behavioral health and **policies that promote integration play a role in solutions across this spectrum,** both within the healthcare sector and between sectors (see Table 1)

Overview

The staggering increase in opioid misuse, addiction, and overdose deaths has led the President to declare the opioid crisis a national public health emergency.¹ This issue brief provides an overview of the role of behavioral health integration in addressing this crisis, specific to preventing opioid addiction, and lays out opportunities for action by policymakers, payers, and philanthropy. This is one of a three-part series on behavioral health integration and the opioid epidemic; complementary issue briefs cover the topics of treatment of opioid addiction and opportunities to support integration at the system-level.

Background

Every day, 115 Americans die of an opioid overdose; the opioid epidemic is now a more frequent cause of death than car crashes.² In 2016, approximately 11.5 million Americans misused prescription opioids, 948,000 people used heroin, and 2.1 million had an opioid use disorder, including 1.8 million people with a prescription opioid use disorder and 0.6 million people with a heroin use disorder.³ The far-reaching extent of the epidemic has touched close to half of American lives: 44% of Americans report knowing someone who is addicted to opioids, and 20% report knowing someone who has died of an overdose.⁴ The opioid epidemic cost \$504 billion in 2015, or 2.8% of the gross domestic product.⁵

Many factors led to the opioid crisis facing America today, including:

- inaccurate claims regarding the safety of opioids, fueled in large part by the pharmaceutical industry;
- pressure to fully relieve pain and measure it as the “fifth vital sign,” promoted by the American Pain Society and adopted by the Veterans Administration and the Joint Commission on Accreditation of Healthcare Organizations;
- inclusion of pain control as part of patient satisfaction scores that could affect provider and hospital reimbursement;
- inadequate healthcare professional education on treatment of pain and addiction;
- diversion of prescription opioids by distributors, pharmacies, prescribers, and patients;
- increasing availability of cheap black market heroin and fentanyl; and
- insufficient and isolated treatment services for addiction.¹

Behavioral health integration is a component of many key strategies to address the opioid epidemic. Behavioral health and primary care integration has been defined as patient-centered care that addresses mental health and substance use conditions, health behaviors, life stressors, and stress-related physical symptoms, provided by a team of primary care and behavioral health clinicians.⁶ Addressing whole person health requires applying this concept of integration both within and outside of the traditional healthcare system. Therefore, behavioral health integration pertains to (1) the healthcare sector; and (2) cross sector collaborations between the healthcare sector and social services, employers, schools, and communities.

Ultimately, the underlying principle of behavioral health integration is that physical, behavioral, and social health are inextricably intertwined. Fragmented systems of care create barriers to achieving optimal whole person health. Integration of care is a solution to fragmentation. Understanding the physical, behavioral, and social determinants of health, and their relationship to one another, exposes the root causes of many health disparities. Policies advancing integration support sustainable change to achieve more equitable health outcomes.

Prevention of the opioid epidemic can occur at multiple levels: (1) universal prevention, where the intervention takes place before there is any sign of a problem; (2) selective prevention, where

there are risk factors for a problem; and (3) indicated prevention, where there are early signs of a problem (see Table 1). Having chronic pain and being prescribed opioids for chronic pain are risk factors for developing opioid addiction; thus, the availability of alternative treatment options for pain and having support for appropriate prescribing of opioids are important strategies for selective prevention.

This issue brief was developed following a rapid review to summarize evidence, a methodology that streamlines the usual processes for systematic reviews to synthesize relevant evidence in a timely manner for decision-makers in healthcare and policy. [Detailed methods](#) are available in an online appendix.

Table 1. Strategies to address the opioid epidemic, by principal sector involved and level of prevention.

Principal Sector Involved	Primary/Universal Prevention	Secondary (Selective and Indicated) Prevention	Tertiary Prevention/ Treatment
Healthcare	Health care professional education on chronic pain and opioid prescribing*	Coverage of non-pharmacologic treatments for chronic pain* Use of Prescription Drug Monitoring Programs Limits on opioid dosage or duration Coverage of non-opioid medications for chronic pain	Medication-Assisted Treatment in primary care* Health care professional education on treatment of opioid use disorder* Naloxone prescribing Coverage of inpatient and residential treatment programs
Education	School-based youth prevention programs*	School-based youth early intervention programs*	
Community	Public education campaigns Community-based youth prevention programs* Stigma reduction campaigns	Drug “Take Back” Events Community-based youth early intervention programs*	Stigma reduction campaigns Naloxone availability Good Samaritan immunity laws Safe injection facilities Clean needle exchange programs
Criminal Justice	Interventions targeted at drug trafficking	Identification and prosecution of “pill mills”	Drug courts and other diversion programs* Medication-Assisted Treatment in criminal justice settings* Naloxone availability

Strategies integrating behavioral health are denoted with an asterisk. Primary, or universal, prevention refers to interventions that can be applied to the general population, before any evidence of a disease is present. Secondary prevention is targeted at individuals or populations with identifiable risk factors for a condition (selective intervention) or early signs of a problem (indicated intervention). Tertiary prevention, or treatment, seeks to reduce harm and consequences once a disease is already present.⁷

Is there evidence to support universal prevention of opioid addiction?

The bottom line

Evidence-based programs for youth exist that prevent opioid misuse and dependence from ever developing.

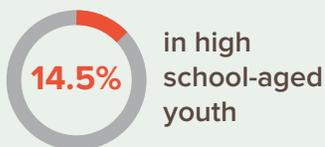
Policy context

While much attention and funding has been directed toward appropriate prescribing of opioids and treatment of opioid addiction, there is limited funding available for more upstream prevention.

The Good Behavior Game, a program for managing classroom behavior in elementary school, decreases the likelihood of heroin use in 8th grade. The Lifeskills Training Program, a middle school substance abuse prevention curriculum, decreases opioid use in 12th grade.⁸ Drug-Free Community grants, which provide matched federal funds for local coalitions working to prevent youth substance misuse, have led to a 21.4% reduction in prescription drug misuse in middle school-aged youth and a 14.5% reduction in high school-aged youth.⁹ These coalitions must include members from the healthcare sector, schools, youth-serving organizations, and law enforcement.¹⁰ Other programs have demonstrated reductions in composite measures of drug use or in risk factors that may lead to later illicit drug use. Key features of effective youth programs in preventing substance misuse include: multi-component programs, which combine efforts in school, family, community, and/or outside social activities; addressing all forms of drugs in combination; strengthening family functioning; developing sustained relationships with caring adults; tailoring to a specific population; building social and emotional competence; and increasing connections between students and schools.¹¹ Despite the evidence, programs at this level of prevention that integrate behavioral health into schools and communities have yet to achieve widespread adoption.

LOCAL COALITIONS
SUPPORTED BY
DRUG FREE COMMUNITY
GRANTS HAVE

↓ PRESCRIPTION DRUG MISUSE



Resources on prevention strategies

Blueprints for Healthy Youth Development

Center for the Study and Prevention of Violence, University of Colorado
Boulder Institute of Behavioral Science
<http://www.blueprintsprograms.com/>

Pain in the Nation: The Drug, Alcohol and Suicide Crises and the Need for a National Resilience Strategy

Trust for America's Health Issue Report
<http://healthyamericans.org/reports/paininthenation/>

Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities

National Research Council and Institute of Medicine Report
<https://www.nap.edu/catalog/12480/preventing-mental-emotional-and-behavioral-disorders-among-young-people-progress>

How can behavioral health integration improve treatment of chronic pain?

The bottom line

Psychosocial therapy, on its own and as part of multimodal approaches, is an effective treatment for chronic pain. Utilization of such services is low, however, due to lack of reimbursement, insufficient education on treatment of chronic pain, and inadequate available workforce.

Policy context

Payer policies can support the use of psychosocial treatment rather than – or in conjunction with – medications for chronic pain through global budgets (which may include specific earmarking for behavioral health) or additional reimbursement mechanisms within fee-for-service (i.e., billing codes for integrated care or behavioral health case managers). Behavioral health carve-outs, where health plans have separate financing systems for physical and behavioral healthcare, create barriers to providing integrated services. (These payment mechanisms are covered in more detail in another brief in this series on system-level change to address the opioid epidemic.)

The most common reason for prescription pain reliever misuse (cited by 62.3% of misusers) is chronic pain.¹² Chronic pain, or pain lasting three months or more or beyond the time of normal tissue healing,¹³ affects millions of Americans. Through high costs of medical care and disability programs as well as lost productivity, chronic pain costs an estimated \$560-\$635 billion annually in the United States.¹⁴ Dramatic increases in the use of opioid medications to treat chronic pain occurred in the setting of under-reporting by pharmaceutical companies of their addictive potential and promotion of measuring pain as the “fifth vital sign.”¹⁵

The most effective treatments for chronic pain incorporate multimodal, interdisciplinary interventions; the evidence is particularly strong for chronic low back pain and fibromyalgia.^{16,17,18} These interventions include a physical component as well as a combination of psychological, social, or work-targeted components. Insurers tend to cover single-modality treatments for pain rather than multimodal interventions or prevention programs.¹⁴

Cognitive-behavioral therapy in particular among psychological therapies has demonstrated improvements in pain and disability. This effect has been observed in both adults¹⁹ and children,²⁰ and through both face-to-face and internet-delivered interventions.²¹ Acceptance and commitment therapy, a form of cognitive-behavioral therapy, leads to similar outcomes.²² Patients with opioid use disorder and chronic pain also benefit from psychological treatments based in cognitive-behavioral therapy to treat pain.^{23,24}

In addition to cognitive-behavioral therapy reducing chronic pain, integrated services can play a role in (1) minimizing the role of medications in pain management; (2) helping increase physical activity; (3) involving family members in improving functional capacity; and (4) discouraging medication seeking behaviors.²⁵ Chronic pain patients experience barriers to accessing psychotherapy, including lack of insurance coverage, lack of available providers, stigma, and lack of existing referral systems.²⁶

A majority of primary care physicians in one survey reported feeling they have been expected to manage chronic pain outside of their scope.²⁷ Expert groups have called for increased education for healthcare professionals on pain management, including non-pharmacologic approaches.¹⁵

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IN THIS BRIEF

the term chronic pain is used to refer to chronic pain not related to cancer or a terminal illness.

How can behavioral health integration prevent prescription opioid misuse?

The bottom line

Assessing for and treating psychiatric and substance use disorders prior to and during use of prescribed opioids, with behavioral health provider support, can improve appropriate opioid prescribing, decrease pain, and prevent opioid misuse.

Policy context

Integrated behavioral health services as part of the treatment approach for patients on chronic opioid therapy can be supported by payer policies that utilize global budgets (which may include specific earmarking for behavioral health) or additional reimbursement mechanisms within fee-for-service (i.e., billing codes for integrated care or behavioral health case managers). Behavioral health carve-outs, where health plans have separate financing systems for physical and behavioral healthcare, create barriers to providing integrated services. (These payment mechanisms are covered in more detail in another brief in this series on system-level change to address the opioid epidemic.)

Opioids have demonstrated effectiveness in treating acute, post-operative, and cancer-related pain; however, there is a lack of evidence showing benefit of the use of opioids for chronic non-cancer pain beyond 12 weeks.¹³ While opioids are not first line medications for chronic pain, there are circumstances in which they may be indicated.

In one study, about a third of primary care physicians reported they did not feel comfortable managing chronic opioid

therapy.²⁷ Many state and national guidelines regarding the use of opioids for chronic pain have been recently developed, including the Centers for Disease Control and Prevention's "Guideline for Prescribing Opioids for Chronic Pain," released in 2016. In addition to noting that non-pharmacologic or non-opioid medications are preferred treatments for chronic pain, the guideline includes other recommendations for risk reduction.¹³ The use of guidelines can have a modest impact on opioid prescribing but are best combined with other educational interventions and changes in pain management reimbursement.¹⁵

Patients with chronic pain are more likely to be started on chronic opioid therapy, to be prescribed higher doses of opioids, and to remain on opioids longer if they have substance use or mental health disorders.^{28,29,30,31,32} Patients with prior substance abuse or mental health disorders such as depression and post-traumatic stress disorder (PTSD) are also more likely to develop an opioid use disorder.^{33,34} The complex relationship between mental health disorders and chronic pain is further compounded by the fact that depression and PTSD are associated with greater pain severity.^{35,36} Over 60% of patients receiving chronic opioid therapy have depression, and depression often develops after initiating opioids, or between the onset of chronic pain and initiation of opioid therapy. Risk factors for developing depression after onset of chronic pain include lower levels of pain self-efficacy, a potentially modifiable risk factor amenable to psychological therapy.³⁶ Patients receiving opioids for chronic pain also report high rates of interpersonal abuse and suicide attempts.³⁷

Given the association of mental health conditions and prior substance abuse with opioid use disorder, and the fact that treatment of depression and PTSD can improve pain, guidelines and experts recommend a complete psychological assessment prior to initiation of chronic opioid therapy.^{13,35,38} Interdisciplinary evaluation by a behavioral health provider can support physician decision-making and decrease opioid prescriptions to higher risk patients.³⁹ Psychological interventions based in cognitive-behavioral therapy, in

INTERDISCIPLINARY EVALUATION BY A BEHAVIORAL HEALTH PROVIDER CAN SUPPORT PHYSICIAN DECISION-MAKING

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addition to improving pain, may also decrease medication misuse in patients on chronic opioid therapy.⁴⁰ However, rates of collaboration with behavioral health providers and utilization of behavioral health services are low in patients on chronic opioid therapy,⁴¹ including those with a substance use disorder.^{42,43} Particularly in areas where there is not access to a behavioral health provider, telehealth models such as Project ECHO (Extension for Community Healthcare Outcomes) that provide remote access to multidisciplinary consultation can support primary care physicians treating chronic pain. This model has led to greater use of non-pharmacologic treatments and non-opioid medications.⁴⁴

Screening, brief intervention, and referral to treatment (SBIRT) is a model to identify unhealthy or risky substance use behaviors and intervene prior to development of severe substance use disorders. While evidence supports the use of SBIRT for risky alcohol use, the data on opioid misuse is mixed, possibly due to differences in how a brief intervention is defined and what outcomes measures are used.^{45,46} More research is needed before determining what SBIRT program components, if any, are effective at preventing opioid use disorder in patients with risky opioid use.

Efforts to cut down opioid prescribing should be a part of multifaceted efforts. The potential for undertreating pain as an unintended consequence of decreasing opioid prescribing is an important policy consideration. Decreasing supply of prescription opioids without increasing access to treatment for patients with opioid use disorder can also lead to increased black market opioid use, including heroin.¹⁵

BRIGHT SPOT

Partnership HealthPlan of California

Partnership HealthPlan of California, a nonprofit health plan, began a variety of targeted initiatives in 2014 to address the opioid epidemic. The plan made policy changes to limit opioid prescription quantity and dosage and add coverage for chiropractic, acupuncture, podiatry, and osteopathic manipulation services. Support for providers was initiated through educational events, Project ECHO (Extension for Community Healthcare Outcomes) for chronic pain, and incentives for prescribing buprenorphine, leading pain support groups, and conducting appropriate urine toxicology screens. Additional initiatives included expanding naloxone access, toolkit development, creation of pain management registries, and development of a payment plan for implementing and sustaining integrated behavioral health/substance use clinics at primary care sites. From January 2014 to December 2015, they observed a 48% decrease in total opioid prescriptions per 100 members per month, 43% reduction in total opioid users on >120 mg morphine equivalents/day, and 52% reduction in initial opioid fills per 100 members per month.⁴⁷

BRIGHT SPOT

Project Lazarus

Project Lazarus: Chronic Pain Initiative is an integrated care program in North Carolina led by Community Care of North Carolina (CCNC). This program was initially piloted in Wilkes County, which in 2007 had the third highest overdose rate in the nation. Between 2009-2011, the number of overdose deaths decreased 69%, and there were no overdose deaths reported in 2011. Based on the success of the pilot, this program was expanded statewide in 2012.⁴⁸

The program is built on community coalition action, public awareness, and data evaluation. The community coalition includes partners across sectors including healthcare professionals, law enforcement, patients, school officials, and faith community representatives. Specific program interventions consist of community education, provider education, emergency department policies, addiction treatment, diversion control, pain support for patients, and harm reduction.⁴⁹

Community coalitions are supported by Project Lazarus to choose the interventions they feel will work best in their locality. The workforce available to carry out implementation of initiatives chosen by the community coalition consists of the CCNC central office behavioral health team, CCNC network resources (behavioral health coordinators, Chronic Pain Initiative coordinators, psychiatrists, and pharmacists), and care managers.⁴⁸

While provider education and emergency department policies limiting opioid prescribing were found to have the largest individual impacts, the use of a coalition-driven multimodal approach was also felt to play a critical role.⁵⁰

What policy opportunities exist to prevent opioid addiction?

Policy levers to prevent opioid addiction that specifically incorporate behavioral health integration are highlighted in Table 2. The listed opportunities for payers and philanthropy also apply to policymakers as they relate to state Medicaid policy and research funding. Additional policy opportunities addressing treatment of opioid addiction and system-level interventions are listed in complementary briefs in this series; system-level opportunities related to workforce, payment, and data integration are also relevant to prevention of opioid use disorder.

Table 2. Policy levers to prevent opioid addiction that incorporate behavioral health integration.

Decision maker	General Approach to Policy Opportunities	Specific Policy Opportunities
Policymakers	Potential policy levers for policymakers include requirements for healthcare professional training on pain management.	Support collaboration between state medical schools and expert organizations to develop and disseminate a national curriculum on pain management, including a focus on non-pharmacologic management.
Payers and Policymakers	Potential policy levers for payers include coverage of psychosocial treatment for pain. These levers are relevant to state policymakers as they apply to Medicaid programs.	Provide coverage of non-pharmacologic treatments for pain, including psychosocial interventions separately and as part of multimodal treatment approaches. Incentivize use or availability of behavioral health counseling for patients on chronic opioid therapy. Provide means of reimbursement or up-front investment in telehealth to increase access to treatment in rural areas. Remove any regulatory barriers to reimbursement of telehealth.
Philanthropy and Policymakers	Potential levers for philanthropic organizations include directing funding towards upstream prevention programs and answering lingering questions on how best to employ behavioral health integration in preventing opioid addiction.	Fund evidence-based programs for youth in schools and communities that prevent future opioid misuse and addiction. Fund research to answer gaps in the evidence, including on promising non-pharmacologic approaches to treating chronic pain ¹⁵ and the role of and best practices for SBIRT for opioid misuse.

Conclusion

There is a gap between what we know can prevent opioid addiction and what is currently being done, and there are multiple policy opportunities to close this gap through integrated solutions. Policies that support behavioral health integration in clinical settings decrease opioid prescribing and misuse. Policies that support integrated, multi-sector efforts targeted at youth prevent opioid abuse even further upstream. Decision-makers in policy, health plans, and philanthropy all have a role to play in facilitating these solutions.

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