PREVENTING OPIOID ADDICTION

The Role of Integrated Behavioral Health

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Issue Brief 2, March 2018

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)

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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]

LOCAL COALITIONS SUPPORTED BY DRUG FREE COMMUNITY GRANTS HAVE

↓ PRESCRIPTION DRUG MISUSE

in middle school-aged youth

in high school-aged youth

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.

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 adults[19] 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]

chronic pain

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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.

Acknowledgments

The authors would like to gratefully acknowledge Lilian Hoffecker, PhD, MLS, for her guidance in developing the search methodology; Lina Brou, MPH, and Christina Yebuah, BA, for their assistance in reviewing the literature; and Larry Green, MD, Jack Westfall, MD, MPH, and Mark Duncan, MD for their review of the brief.

Suggested Citation

Gold S, Wong SL. *Preventing Opioid Addiction: The Role of Integrated Behavioral Health.* Farley Health Policy Center Issue Brief 2: March 2018. Available at: https://makehealthwhole.org/wp-content/uploads/2018/04/Preventing-Opioid-Addiction-March-2018.pdf

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Support for this initiative was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

TREATING OPIOID ADDICTION

The Role of Integrated Behavioral Health

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make health whole
INTEGRATING CARE. IMPROVING LIVES.

Issue Brief 3, March 2018

Key Messages

Integration of medication-assisted treatment (MAT) in primary care, emergency departments, hospitals, and criminal justice settings expands access

Integrated psychosocial services improve treatment outcomes

- **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)

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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 the treatment of 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 prevention 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.

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]

How is opioid addiction treated?

The bottom line

Similar to other health conditions such as high blood pressure or diabetes, opioid addiction is a chronic disease requiring long-term treatment, and appropriate treatment prevents further health complications.

Policy context

The declaration of the opioid crisis as a public health emergency appropriately frames the epidemic as a health issue. Federal laws, the Drug Addiction and Treatment Act of 2000 and the Comprehensive Addictions and Recovery Act of 2016, allow for treatment of opioid addiction outside of specialty facilities and require specific certification and patient number limits.

The medical term used to diagnose opioid addiction is opioid use disorder. Opioid use disorder is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress, characterized by features such as inability to cut down or control use; spending large amounts of time attempting to obtain the opioid, use it, and recover from its effects; use leading to social problems; and failure in fulfilling obligations at work, school, or home.[8] Approximately 80% of individuals with an opioid use disorder do not receive treatment for their addiction.[9]

There has been a recent shift in recognizing opioid addiction as a chronic disease and as a public health problem rather than exclusively a criminal justice issue.[10] Punitive measures and criminalization of drug use have not been shown to be effective.[11,12] Repressive drug policing in other countries has led to increased risk of HIV infection and created barriers to receiving treatment.[13] This is not unique to other countries; in Tennessee, a law criminalizing drug use in pregnant women was allowed to expire after it was found to cause harm and lead women away from pursuing treatment.[12]

Detoxification or counseling without pharmacologic treatment is not as effective for opioid use disorder as maintenance treatment involving the use of medications, known as medication-assisted treatment (MAT).[14] MAT consists of pharmacologic treatment along with behavioral counseling. MAT decreases overdose deaths, criminal activity, and transmission of infectious diseases like HIV and hepatitis C.[15] MAT for pregnant women decreases neonatal abstinence syndrome,[15] a condition that frequently results when newborns are exposed prenatally to opioids and then experience withdrawal after birth, leading to symptoms such as irritability, hyperactivity, respiratory issues, and impaired sleep and growth.[16]

There are three medications approved for treating opioid use disorder: methadone, buprenorphine (usually prescribed as buprenorphine/naloxone, brand name Suboxone or Zubsolv), and naltrexone (available in oral form or extended-release injectable form, brand name Vivitrol).

- Methadone is a full opioid agonist, meaning it fully binds to the opioid receptors in the brain and serves as a replacement therapy for illicit use of opioids.
- Buprenorphine is a partial opioid agonist. Partial agonists function similarly to full agonists, but with a “ceiling effect” that increases their safety and lowers risk of misuse.
- Naltrexone is an opioid antagonist, meaning it blocks the effects of subsequently ingested opioids. Detoxification is required prior to starting naltrexone to avoid precipitating severe withdrawal.[17]

OPIOID USE DISORDER

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Methadone is only available in specialty treatment centers called opioid treatment programs. The Drug Addiction and Treatment Act of 2000 (DATA 2000) allowed primary care physicians, after obtaining a special waiver through the Drug Enforcement Agency, to prescribe other Food and Drug Administration (FDA)-approved opioid agonists for opioid addiction. In 2002, the FDA approved buprenorphine for this purpose, and treatment for opioid use disorder became available in primary care settings. DATA 2000 limited the number of patients that any individual practitioner could treat with buprenorphine at a time to 30.[18] The Comprehensive Addiction and Recovery Act of 2016 allows prescribers to increase this number to 100 after one year,[19] and subsequent regulation increased this number further to 275. As naltrexone is not an opioid agonist, it can be prescribed without any additional certification.

What are the benefits of treating opioid addiction in primary care?

The bottom line

Integration of MAT into primary care expands access to treatment and improves not only substance use outcomes but also leads to better care of other health conditions and lower total healthcare costs.

Policy context

In addition to federal legislation allowing treatment of opioid use disorder in primary care, payer policies supporting integration of behavioral health services and primary care facilitate access and lead to better outcomes in regard to both substance abuse and other health conditions.

Even providing access to medication for treating addiction in primary care represents integration of behavioral health services that have been traditionally separate from physical health care. Until DATA 2000 allowed primary care physicians to prescribe medications for addiction and buprenorphine received FDA approval in 2002, pharmacologic treatment for opioid addiction was only available in specialized treatment centers. Healthcare providers identify that providing substance use disorder screening and treatment in an integrated setting leads to better coordinated care,[20] reduced stigma experienced by patients, and better understanding of whole person health, including not prescribing opioids for pain to patients with addiction issues. Furthermore, the single most important element of integrated services was felt to be the capability to introduce a patient to a behavioral health clinician on the same day as their medical appointment; without this capability, providers report they are less likely to ask about drug abuse.[21] Patients endorse that the ability to receive all of their services at one location facilitates access.[22] Experts recommend using team-based approaches in primary care to address opioid use disorders to allow for better scalability and reflect the need for chronicity of treatment.[23]

Integration of substance abuse treatment, mental health services, and primary care has broader benefits for individuals with opioid use disorder, and for the healthcare system at large, beyond improved substance use outcomes. People with opioid use disorder are more likely to have comorbid chronic physical and mental health conditions.[24] Co-location of MAT and primary care services increases the use of primary care and decreases costly emergency and inpatient services.[25] For patients with HIV, co-located substance abuse treatment helps provide stability to pursue HIV treatment.[26] Integrated, on-site services for mental health comorbidities at substance use treatment facilities leads to greater treatment adherence and reductions in psychiatric distress.[27]

CO-LOCATION OF MAT AND PRIMARY CARE

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Ensuring appropriate treatment of other physical and mental health conditions also improves substance use outcomes. Comorbid mental health conditions, particularly severe mental illness, and other substance use disorders increase the risk of relapse.[28] Expert groups and guidelines recommend a comprehensive mental health and substance abuse assessment prior to starting MAT.[29] For women who were on MAT during pregnancy, integrated services continue to be important after delivery to identify and treat postpartum depression that could lead to relapse.[30] Receiving a psychiatric medication has been associated with treatment retention and negative urine drug screens, suggesting screening for and treating comorbid psychiatric conditions may improve treatment outcomes.[31]

What models should be used to treat opioid addiction?

The bottom line

Models of MAT in primary care should be individualized based on setting to reflect differences in local or regional geography, financing models, and availability of experts and opioid treatment programs. Across these approaches, innovations include the use of a non-physician coordinator, more comprehensive integrated psychosocial services, coordination with centralized centers of excellence, and initiation in other settings with linkage to primary care. In rural settings, use of technology-assisted consultation can support integration. Sources of additional financing at the practice level include use of billing codes for case managers, and at the system-level include Medicaid Health Home waivers, federal grants, and alternative payments available through Accountable Care Organizations.[32]

Policy context

Payer policies can support individualized approaches to MAT in primary care through flexible funding at a practice, regional, or state level. Reimbursement of telehealth is of particular importance in rural areas. States can take advantage of federal funding through available grant and Medicaid waiver opportunities.

A review commissioned by AHRQ characterizes models of MAT in primary care by the inclusion of pharmacotherapy with buprenorphine or naltrexone, provider and community educational interventions, coordination and integration of treatment with other medical and psychological needs, and psychosocial services on-site or by referral. Office-based opioid treatment involves a primary care provider waivered to prescribe buprenorphine and a designated clinic staff coordinator, with services funded through reimbursement for billable encounters. In some settings, additional funding may be available for case managers to complete the coordination function, as is done through Medicaid in federally-qualified health centers in Massachusetts. The office-based opioid treatment model has been adapted to HIV primary care in the BHIVES (Buprenorphine HIV Evaluation Support) collaborative model and prenatal care clinics. Alternatively, a primary care provider providing MAT, primary care, and infectious disease services may be integrated into a specialty mental health setting.[33]

Other models have been developed at the regional or state rather than practice level to support primary care provision of buprenorphine. In the hub-and-spoke model in Vermont, “spokes” are primary care clinics providing MAT through the office-based opioid treatment model; “hubs” are opioid treatment programs for higher-needs patients that also provide consultative services to the spokes. Psychosocial services, including social workers, counselors, and community health teams, are integrated in primary care clinics. This model is funded through a Medicaid Health Home waiver, which provides an opportunity for states to obtain flexible financing

BENEFITS OF INTEGRATING CARE

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to integrate services and improve care coordination at a broader level. The Collaborative Opioid Prescribing Model in Maryland involves patient initiation on buprenorphine at an opioid treatment program followed by transfer to primary care for continued treatment. The opioid treatment programs continue to provide ongoing psychosocial services; this requires geographic proximity between care facilities. To support buprenorphine delivery in rural primary care, Project ECHO (Extension for Community Healthcare Outcomes) in New Mexico uses telehealth consultation for primary care providers, financed through a combination of federal grants and Medicaid. Southern Oregon has a network of rural primary care clinics that holds regional stakeholder meetings for additional education and training on MAT. Accountable Care Organizations in the region provide financial support in addition to traditional fee-for-service reimbursement.[33]

What are the barriers to expanding MAT?

The bottom line

Uptake of MAT into primary care clinics has not grown to meet population needs, largely due to gaps in education, financial and regulatory barriers, and lack of behavioral health support.

Policy context

Payer policies can facilitate or create barriers to access to MAT by the inclusion of methadone (through opioid treatment programs), buprenorphine, and naltrexone on formularies; whether prior authorization is required for coverage; and the use of annual or lifetime limits. Policies that promote behavioral health workforce growth and matching distribution to need can lead to better support for addressing addiction in primary care clinics. (Workforce policy is covered in more detail in another brief in this series on system-level needs to address the opioid epidemic.)

In 2012, the estimated gap between treatment capacity and the number of individuals needing treatment was 1.4 million individuals.[35] There is significant geographic variation in treatment availability; as of 2016, about half of United States counties do not have a licensed buprenorphine prescriber. States that have expanded Medicaid, have greater Medicaid funding, and where higher rates of death due to opioids occur have higher numbers of physicians waivered to prescribe buprenorphine.[32]

Access to treatment is particularly low for certain demographic groups, including youth, racial and ethnic minorities, and individuals living in rural areas.[36] Rural communities face additional barriers to preventing and treating opioid use disorder. Travel times to treatment are often lengthier; stigma may be a greater barrier in small communities; and there is less availability of waivered primary care providers, behavioral health providers, opioid treatment programs providing methadone, and residential treatment services.[37,38] Adolescents are unlikely to receive treatment for opioid use disorder unless they are involved in the criminal justice system.[9] It is also less clear what treatment approaches for youth are best; most studies on treatment of opioid use disorder have been conducted in adults.[39] Racial and ethnic minorities are less likely to receive treatment for opioid use disorder than whites, with lower rates of treatment in black and Hispanic Americans and the lowest rates of treatment amongst Native Hawaiians/Pacific Islanders/Asian Americans.[9,40] American Indians/Alaskan Natives are also disproportionately affected by limited access to care for substance use disorders.[41]

Reasons cited by primary care physicians for not prescribing buprenorphine include lack of access to behavioral health services, inadequately trained staff, lack of confidence in ability to prescribe, lack of specialty backup, limited time and office space, lack of institutional support, burdensome regulations including

BRIGHT SPOT

Project ECHO (Extension for Community Health Outcomes)

Project ECHO provides support for primary care providers caring for patients with complex conditions through telehealth specialty consultation and case-based learning. This model was developed to address the need for culturally appropriate and accessible specialty care in rural and underserved areas, and has been applied to treatment of conditions such as hepatitis C in addition to substance use disorders. In the Integrated Addictions and Psychiatry ECHO program in New Mexico, sessions occur weekly for 2 hours, and are facilitated by a team with an addiction specialist, psychiatrist, licensed clinical social worker with addiction expertise, psychiatric nurse, and a community health worker. Participating healthcare providers are able to obtain continuing medical education credit at no cost. Supporting the availability of MAT with buprenorphine has been an area of focus for the program, and waiver trainings are offered. The model has been associated with more rapid growth in numbers of primary care providers waivered to prescribe buprenorphine in the state.[34]

prior authorizations, belief in abstinence-only approaches (despite a lack of evidence), and inadequate reimbursement for necessary services.[32,42,43] To start a buprenorphine program, inclusion of buprenorphine on plan formularies and champions for adoption are key.[44] Requiring training on treatment of opioid use disorder in health professions training programs has been suggested as a mechanism to increase waivered prescribers and access to MAT.[45]

As of 2014, nearly all commercial health plans covered opioid treatment programs for methadone; however, 36.5% (including 53.1% of consumer driven plans) required prior authorization. All commercial health plans covered buprenorphine by 2010; in 2010, 38.9% of plans required prior authorization. Prior authorization was more common in plans that had externally contracted behavioral health services.[46] A 2015 study reports that Medicaid programs in 48 states require prior authorization for buprenorphine, and 11 have lifetime treatment limits of 1-3 years.[45]

MEDICAID PROGRAMS

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What is the role of psychosocial services in MAT?

The bottom line

There is evidence that attending counseling as part of MAT can improve treatment retention and increase abstinence from illicit opioids, particularly for certain groups, and the use of behavioral health-trained case managers is promising. At the same time, in many studies outcomes are similar between groups with more intensive counseling and those with brief counseling as part of medication management; intensive counseling may not be needed for many patients. Further research is needed to determine the most effective level of counseling for different patient groups. Given these findings, efforts should be made to bolster access to behavioral health services, but these services should not be required as part of MAT in a way that creates barriers to receiving pharmacologic treatment.

Policy context

Integrated behavioral health services as part of MAT 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 needs to address the opioid epidemic.) Some payers may require access to behavioral health services as part of reimbursement for MAT.

There have been three systematic reviews conducted on the effects of psychosocial treatment as part of MAT and an additional systematic review on psychosocial treatment as part of medical detoxification.[47,48,49] Psychosocial treatment improves the rate of treatment completion when undergoing medical detoxification.[50] The most recent review on psychosocial treatment as part of

MAT concluded that psychosocial therapy in combination with medication is beneficial; in most studies this improved adherence to treatment and in some studies there were lower rates of opioid use. At the same time, there were studies that did not show a difference between brief counseling by the physician and having additional psychosocial counseling, and some studies suggested the benefits of additional counseling are limited to specific patient groups.[49,51,52] The variation in results may be due to differences in counseling approach, patient groups, study setting, and which medication is used.

A recent study showed improved rates of abstinence from opioids in practices that employed the Collaborative Care Model, an evidence-based approach to integrated care that incorporates population management through use of registries and case managers trained in behavioral health.[53] Other integrated models have also identified case management as a key component or program strength.[22]

Some experts and groups have called for abandoning use of the term "medication-assisted treatment," as it implies the use of medication is secondary rather than primary as the evidence demonstrates.[54] The World Health Organization suggests the term "psychosocially-assisted pharmacotherapy" instead.[45]

In what other settings can MAT be implemented to expand access?

The bottom line

There should be no wrong door for individuals to access treatment for opioid use disorder when they need it; in addition to primary care, this includes other settings such as emergency departments, hospitals, and criminal justice facilities.[45] Other healthcare sites, such as pharmacies, dental offices, and supervised injection facilities, may also present opportunities to identify the need for treatment and refer, though more evidence is needed.

Policy context

Mandates or funding for drug treatment courts and provision of MAT in criminal justice facilities expand access to treatment and, in the case of drug treatment courts, also move towards recognition of drug addiction as a public health rather than criminal justice issue. Payers can employ financial incentives or additional means of reimbursement to support initiation of MAT in emergency departments and hospitals. Policymakers can authorize supervised injection facilities as not only a harm reduction strategy, but also a means to inform individuals about opportunities for treatment and make referrals when appropriate.

Buprenorphine, initiated in the emergency department with connection to ongoing treatment, is a more effective strategy for engagement in addiction treatment than referral alone or referral with brief intervention.[55] Initiation of buprenorphine for hospitalized patients with connection to outpatient follow up also facilitates engagement in treatment.[56] Given these findings, funding for and requirements of screening, brief intervention, and referral to treatment (SBIRT) programs for opioid use disorder in emergency departments and hospitals could be expanded to include treatment initiation. As other potential points of contact for patients with opioid use disorder, dental clinics and pharmacies could serve as additional settings for screening and referral to treatment; research is needed to determine if this would be effective, and if so, alternative models of reimbursement would be indicated.[57,58,59] Supervised injection facilities also provide a linkage to treatment through referral to primary care and substance use treatment programs.[45]

Behavioral health needs intersect with the criminal justice sector in many ways that are relevant to the opioid epidemic. Individuals with opioid use disorder are more likely to be arrested when they have a comorbid serious mental illness or additional substance use disorder.[60] Among arrestees with opioid use disorder, more than half have never received behavioral health treatment.[40] Opportunities for behavioral health integration in the criminal justice system include crisis intervention teams, pre-booking diversion to treatment services, drug treatment courts, screening and treatment in jails and prisons, and coordinated care on community re-entry to continue or initiate appropriate services.[61] Drug treatment courts offer reduced sentences in exchange for commitment to receiving treatment for addiction and increased supervision.[62] A study from 2012 found that only half of drug courts allowed MAT.[63] The efficacy of drug courts also varies; factors associated with success include providing and encouraging MAT and linkage to wraparound social and economic services.[64] Continuation of MAT for incarcerated individuals reduces risk of overdose on release and leads to higher rates of continued outpatient care. To integrate care between the healthcare and criminal justice sectors for MAT continuation, policies and processes should be agreed upon and standardized between the Department of Corrections and opioid treatment programs.[65] Organizational linkage interventions between correctional agencies and community providers may support coordination of care for individuals on probation or parole, but more research is needed to determine optimal ways to support coordination between systems.[66]

What policy opportunities exist to improve treatment for opioid addiction?

Policy levers to treat 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 prevention 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 treatment of opioid use disorder.

Table 2. Policy levers to treat 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 treatment of opioid addiction and expansion of treatment in criminal justice settings.	Require provision of training on opioid use disorder treatment in health professions schools and training programs, including primary care residency programs. Expand use of drug treatment courts and require that they include MAT. The Department of Justice should establish drug treatment courts in all federal districts, and state and local governments can apply for federal grants for drug court implementation.[1] Require access to MAT in criminal justice facilities and coordination of continued treatment on release.
Payers and Policymakers	Potential policy levers for payers center around removal of regulatory barriers or limitations on treatment, use of billing codes or alternative payment models that support integrated services, and employing financial incentives specific to non-traditional settings and models of care. These levers are relevant to state policymakers as they apply to Medicaid programs.	Remove any coverage limitations or prior authorization requirements for MAT, including both pharmacologic and psychosocial components of treatment. Incentivize use or availability of behavioral health counseling and/or behavioral health-trained case managers for patients receiving MAT; at the same time, remove requirements for receipt of these services to be able to obtain pharmacotherapy. Possible strategies include reimbursement of billing codes for behavioral health case managers and integrated services in primary care, use of alternative payment methodologies such as global payment with earmarked funds for behavioral health services, and pay-for-performance bonuses for access to integrated behavioral health treatment. 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. Provide additional reimbursement or other financial incentives for appropriate initiation of treatment and referral to outpatient services from emergency departments and hospitals.
Philanthropy and Policymakers	Potential levers for philanthropic organizations include directing funding towards answering lingering questions on how best to employ behavioral health integration in treating opioid addiction.	Fund research to answer gaps in the evidence on optimal psychosocial service delivery as part of MAT, including which patient groups are most likely to benefit, and best practices in treating opioid addiction in youth.

At a national level, policies could be strengthened by removing patient number limits for buprenorphine prescribers, or eliminating entirely the requirement for a special waiver to prescribe. The Comprehensive Addiction and Recovery Act of 2016 authorized $181 million annually to strategies that target the opioid epidemic; related to behavioral health integration, this includes grants to localities disproportionately affected by the crisis to expand activities administered by the Department of Health and Human Services, grants for veteran drug treatment court expansion and comprehensive responses to the crisis including expansion of MAT and treatment for youth administered by the Department of Justice, and grants for treating pregnant and postpartum women with substance use disorders.[19] Notably, the President's Commission on Combating Drug Addiction and the Opioid Crisis has recommended that the federal government combine different funding streams into block grants to states to decrease the administrative burden involved.[1] The Bipartisan Budget Act of 2018 allocates an additional $6 billion to combating the opioid epidemic over 2 years.[67] Annual appropriations must continue to support multiple approaches to address the opioid epidemic.

Conclusion

Opioid addiction is treatable, and behavioral health integration facilitates optimal treatment. Integration of physical health, mental health, and substance use disorder services in both clinical and non-clinical settings expands access to treatment, promotes treatment adherence, decreases illicit opioid use, and improves other health outcomes. Policies should capitalize on the role of behavioral health integration in expanding MAT across settings to reach greater numbers of individuals with opioid addiction and retain them in treatment.

Acknowledgments

The authors would like to gratefully acknowledge Lilian Hoffecker, PhD, MLS, for her guidance in developing the search methodology; Lina Brou, MPH, and Christina Yebuah, BA, for their assistance in reviewing the literature; and Larry Green, MD, Jack Westfall, MD, MPH, and Mark Duncan, MD for their review of the brief.

Suggested Citation

Gold S, Wong SL. *Treating Opioid Addiction: The Role of Integrated Behavioral Health.* Farley Health Policy Center Issue Brief 3: March 2018. Available at: https://makehealthwhole.org/wp-content/uploads/2018/04/Treating-Opioid-Addiction-March-2018.pdf.

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Support for this initiative was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

SUPPORTING PREVENTION AND TREATMENT OF OPIOID ADDICTION

System-level Changes to Enable Integrated Behavioral Health

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Issue Brief 4, March 2018

make health whole
INTEGRATING CARE. IMPROVING LIVES.

Key Messages

System-level changes are needed

to realize the potential of behavioral health integration to address the opioid epidemic:

- Removal of financial and regulatory barriers to integration
- Reinforcement of behavioral health parity legislation
- Integration of data and information sharing across sectors
- Growth and appropriate distribution of the behavioral health workforce
- Reduction of stigma

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 system-level changes that can support behavioral health integration in addressing this crisis, 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 prevention and treatment of opioid addiction at the individual rather than 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

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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.

System-level barriers to behavioral health integration include lack of trained workforce, lack of coordination across sectors, segregated funding streams and reimbursement models that do not support care coordination and psychosocial services, lack of political support, government regulations, inadequate infrastructure for support services, need for bridging across different cultures, and criminalization and stigmatization of drug use.[7,8,9]

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.[10]

62%

of Americans believe reducing stigma around addiction would be an effective strategy to address the opioid epidemic

IF MEDICAID WERE EXPANDED IN ALL STATES, AN ADDITIONAL

1.1 million

individuals would have access to substance use disorder treatment

Stigma

The bottom line

Behavioral health integration helps address stigma by normalizing and facilitating access to treatment for addiction through co-location with other medical or social services. Public education campaigns are an additional mechanism to reduce stigma.

Stigmatization and criminalization of opioid addiction contribute to inaction and use of ineffective strategies to address the epidemic. People of color addicted to opioids are more likely to be viewed as criminal than white individuals addicted to opioids.[11] More than half of Americans (62%) believe reducing stigma around addiction would be an effective strategy to address the opioid epidemic.[4] Integrated services increase access not only by decreasing investment in transportation and time required through receiving treatments at one site, but also by decreasing stigma of receiving behavioral health services through their inclusion in general medical care. Stigma regarding treatment of opioid use disorder has been propelled by the media; news coverage of the opioid epidemic has largely framed opioid use disorder as a criminal justice issue rather than a treatable health condition.[12] Stigma reduction campaigns have been included in some regional and state efforts to address the opioid epidemic, including the State without StigMA campaign in Massachusetts.[13]

Payment

The bottom line

Individuals with opioid addiction need insurance coverage to access appropriate services; Medicaid expansion is an important facilitator in this regard. Payers can support integration by carving in behavioral health services as part of the medical benefit and enhancing payment through the use of additional billing codes to reimburse integrated services, or more optimally, through non-fee-for-service solutions such as global budgets that cover both behavioral and physical healthcare. Better enforcement of parity laws would ensure that behavioral health services are covered equally to physical health services as intended by legislation.

Insurance Coverage

Lack of insurance coverage poses a significant barrier to obtaining behavioral health services. Individuals with opioid use disorder are more likely to be uninsured than the general population.[14] Among people with a substance use disorder, those with Medicaid coverage are more than two times as likely to receive treatment as uninsured individuals.[15] Medicaid is the single largest source of coverage for behavioral health services, including substance use disorder treatment. Medicaid expansion in 31 states has provided coverage for an additional 1.2 million people with substance use disorders. Another 1.1 million individuals would be eligible for coverage if Medicaid were expanded in all states.[16] Notably, state restrictions on Medicaid eligibility based on drug tests would bar individuals with opioid use disorder from the primary means of accessing treatment for addiction.[17]

Carve-Outs

Many payers carve out behavioral health services, meaning these services are administered and paid for through a separate contractual arrangement from physical health services. In Medicaid there has been a shift in the past few decades towards more managed care contracts to decrease costs, and many states opted to carve out their behavioral health services under a separate managed care contract or sometimes fee-for-service arrangement. This separation of funding streams can create barriers to reimbursement for treatment of behavioral health diagnoses in primary care.[18] More recently some states are returning to carving in behavioral health services; in 2016, Medicaid programs in 24 states included substance use disorder services in comprehensive managed care contracts that include physical health services.[15] Integrating funding streams rather than employing behavioral health carve-outs is one strategy payers can employ to support integration.

Parity

Parity laws support equal insurance coverage of behavioral health services commensurate with physical health services, but many have cited concerns about enforcement of these regulations. The Behavioral Health Coverage Transparency Act, which was introduced in Congress in 2016 but not enacted, would have required insurers to disclose their analysis of parity determinations and reasons for mental health claims denials. It also would have allowed the Department of Health and Human Services and the Department of Labor to audit health plans regarding their compliance with parity laws.[19]

Federal Parity Legislation

- Mental Health Parity Act (MHPA; 1996) – Prohibits large group plans from imposing lifetime or annual dollar limits for mental health benefits less favorable than physical health benefits (mental health benefits do not include substance use disorders).
- Mental Health Parity and Addiction Equity Act (MHPAEA; 2008) – Requires group market and government plans covering behavioral health services to cover them at least as favorably as physical health benefits, including treatment limits, cost sharing, and in- and out-of-network coverage. Expands the parity requirement from the MHPA to substance use disorders.
- Patient Protection and Affordable Care Act (ACA; 2010) – Increases access to services through expanded insurance coverage (Medicaid expansion, employer and individual mandates). Includes behavioral health services in required Essential Health Benefits for individual and small employer markets. Extends parity requirements of MHPAEA to individual market insurance plans.[20]

Payment Models

In fee-for-service payment models, coverage of services needs to be specified in billable codes. There is often inadequate coverage through fee-for-service codes for integrated behavioral health services in primary care or case management, though codes supporting some integrated services have been created and adopted by some payers.[21,22] Global payment models present an opportunity to allow healthcare providers to more proactively and flexibly use funds to meet patients' needs as they see fit.[23]

separated funding streams create barriers

to reimbursement of integrated care

fee-for-service codes are inadequate

for integrated behavioral health services

Workforce, Education, and Training

The bottom line

More behavioral health providers trained in integrated care are needed, particularly in rural settings. Knowledge gaps should be addressed through enhanced education for all health professionals on pain management and treatment of opioid addiction.

Expert groups and providers themselves have voiced a need for enhanced education regarding chronic pain and opioid use disorder for primary care providers, ancillary clinic staff, and behavioral health providers.[24,25] As integrated care brings together disciplines that have traditionally worked separately with different cultures, training is also needed for healthcare providers to learn how to best work together as a team. Addressing stigma around use of medications for addiction and towards patients with substance use disorders should be included in educational efforts.[24] Similar needs for education apply to other social service sectors as well.

Improvements in education will support current efforts; however, there is also a lack of sufficient workforce of both behavioral health providers and primary care providers prescribing medication-assisted treatment (MAT). Because workforce shortages are particularly an issue in rural areas, strategies for expansion must take geographic distribution into account.

Data Integration

The bottom line

Integration of care delivery and coordination of initiatives across sectors require integration of data sources, real-time data sharing, and consensus on measures of integrated outcomes.

integrated care brings

together disciplines that have traditionally worked separately

a coordinated response

requires real-time data sharing across sectors

Behavioral health providers are not able to access controlled substance prescription data in 30 of 49 states that have a prescription drug monitoring program (PDMP). Furthermore, 42 CFR Part 2 prohibits the inclusion of data from substance use disorder programs in PDMPs; methadone administration from opioid treatment programs is excluded.[26] This regulation applies confidentiality rules to any federally-assisted substance use disorder program and mandates that prior written patient consent is required for each disclosure of information unless it is part of mandatory abuse and neglect reporting or a medical emergency disclosure to another healthcare provider.[27]

Law enforcement has identified lack of real-time data sharing across sectors as a barrier to a coordinated response, particularly with regard to identifying batches of fentanyl-adulterated heroin leading to overdose deaths. One district in Pennsylvania developed a regional clearinghouse to receive reports of heroin overdoses and seizures from first responders, which has led to new leads and enhanced investigation.[28]

The need for standardized measures to better assess the response to the opioid epidemic has been recognized,[17,29] and experts have called for broad outcomes measures to include polysubstance use, physical and psychological health, mortality, criminal activity, self-efficacy, and quality of life.[30] Specific measures have been proposed to assess behavioral health integration in criminal justice settings,[31]

treatment of pain,[32] care by addiction specialists,[33] and to monitor the opioid epidemic at a state level, including overdose data, receipt of treatment, and use of measures from the National Behavioral Health Quality Framework (such as metrics on abstinence, patient satisfaction, and continuity of care).[13] Vermont has developed a statewide dashboard to help policymakers track trends related to addiction prevalence and treatment capacity.[13] At the practice level, electronic health record dashboards with integrated physical and behavioral health data increase adherence to guidelines and behavioral health visits.[34]

Policy Levers

Policy levers to address the opioid epidemic specifically through system-level changes that support 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 for prevention and treatment of opioid addiction are listed in complementary briefs in this series.

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: • enforcement of parity laws, • Medicaid expansion, • support for behavioral health workforce growth, and • addressing regulatory barriers to data sharing	Strengthen enforcement of behavioral health parity laws, such as allowing the Department of Labor to levy penalties and launch investigations for violations.[1] In states that have not already done so, expand Medicaid to enable access to treatment services. Increase behavioral health provider training and recruitment programs, particularly in rural areas, such as through scholarships and loan repayment from the National Health Service Corps. Remove regulatory barriers, including through 42 CFR Part 2, to information exchange for physical and behavioral health providers caring for the same patient.
Payers and Policymakers	Potential policy levers for payers include: • carving in behavioral health services, • use of global budgets, and • additional reimbursement of integrated services	Eliminate carve-outs of behavioral health services. Employ global budgets that include both behavioral and physical health services for comprehensive, whole-person healthcare. Where global budgets are not used, reimburse additional billing codes for integrated services.
Philanthropy and Policymakers	Potential levers for philanthropic organizations include funding support to train providers and practices to integrate care.	Fund training programs for behavioral health providers in integrated settings and practice transformation support for behavioral health integration.

Additional recommendations are relevant to integrating efforts across social service sectors. The President's Commission on Combating Drug Addiction and the Opioid Crisis has called for block granting federal funding to states for all activities related to the opioid epidemic to streamline the process of obtaining funding between agencies and reduce administrative burden and logistic barriers to states.[1] The National Academies of Medicine recommends the development of a systems model for addressing the opioid epidemic, establishment of the data infrastructure needed to support it, and assigning responsibility to a lead agency for developing and implementing a national strategy.[26]

Conclusion

Opioid addiction is both preventable and treatable, and behavioral health integration plays a key role in many effective strategies for prevention and treatment alike. System-level changes to support behavioral health integration, however, are needed to fully realize its potential in addressing the opioid epidemic. The current insufficient availability and isolation of addiction services are driven by inadequate and ill-distributed integrated workforce capacity, lack of insurance coverage, fragmentation of data, and separated funding streams. Policies that integrate underlying system infrastructure will enable integrated healthcare services and efforts across sectors.

Acknowledgments

The authors would like to gratefully acknowledge Lilian Hoffecker, PhD, MLS, for her guidance in developing the search methodology; Lina Brou, MPH, and Christina Yebuah, BA, for their assistance in reviewing the literature; and Larry Green, MD, Jack Westfall, MD, MPH, and Mark Duncan, MD for their review of the brief.

Suggested Citation

Gold S, Wong SL. *Supporting Prevention and Treatment of Opioid Addiction: System-level Changes to Enable Integrated Behavioral Health.* Farley Health Policy Center Issue Brief 4: March 2018. Available at: https://makehealthwhole.org/wp-content/uploads/2018/04/System-level-Changes-to-Address-Opioid-Epidemic-March-2018.pdf.

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Support for this initiative was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.