Wilder Research

Integration of mental health, substance use, and primary care: Opportunities and challenges

Overview of mental health and substance use disorders

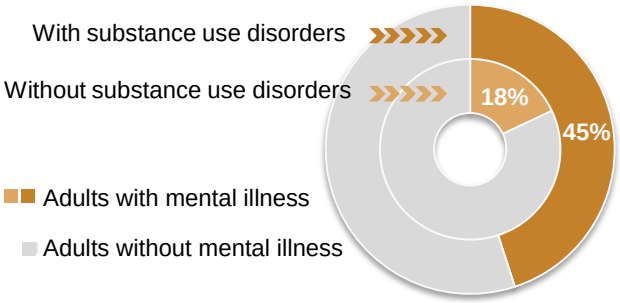
Co-occurring disorders

Individuals with co-occurring disorders have at least one mental health disorder in addition to an alcohol or drug use disorder (DHHS, 2002). These disorders may not interact the same way in all individuals, but each disorder must be diagnosed independently of the other to meet the criteria for a co-occurring disorder. Although research in this area is relatively sparse, it is generally understood that mental health disorders can place a person at greater risk for substance use (for example, depression may trigger alcohol abuse). Conversely, drug abuse intoxication or withdrawal can result in an increase in mental disorder symptoms (for example, cocaine use may exacerbate symptoms of schizophrenia) (DHHS, 2002). Mental health and substance use disorders also share numerous risk factors, most of which are psychological and social stressors, such as the end of a relationship, death of a loved one, economic hardship, racism, trauma, poor physical health, past sexual abuse, and domestic violence (DHHS, 2002).

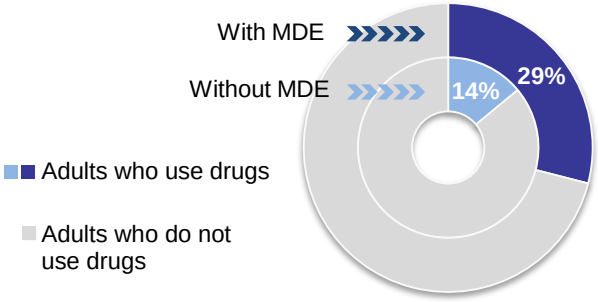
According to the U.S. Department of Health and Human Services (2010), nationally:

- One-quarter of adults with serious mental illness also met criteria for substance abuse/dependence
- 45% of adults with a substance use disorder had co-occurring mental illness, compared to 18% of adults who do not have a substance use disorder
- Adults who had a major depressive episode (MDE) in the past year were more than twice as likely to use illicit drugs as those without MDE (29% versus 14%)

Rate of mental illness in adults with and without substance use disorders



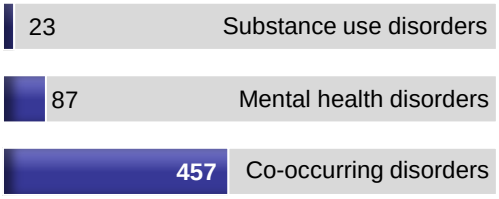
Rate of illicit drug use among adults with and without major depressive episode (MDE)



Long-term effects of mental health and substance use disorders

Health outcomes are poorer and costs are greater for individuals with mental health and substance use disorders. The total costs of serious mental illness (including disability benefits, health care expenditures, and loss of earnings) are over $317 billion annually (Insel, 2008) and the total cost of alcohol and drug abuse is $343 billion annually (including treatment, property damage, and loss of earnings) (DHHS, 2009).

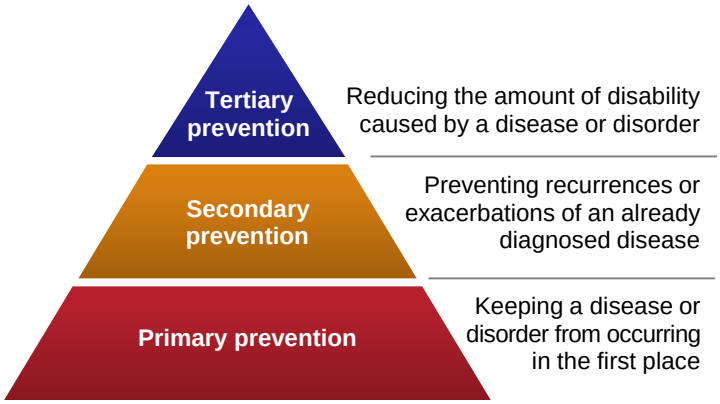
In addition, individuals with co-occurring disorders are much more likely to be hospitalized when compared to patients with a mental health disorder or substance use disorder alone (see figure below) (DHHS, 2009).



Mental health disorders alone are associated with negative health outcomes. People with serious mental illness die, on average, 25 years earlier than the general population (Parks, 2008).This is due to the fact that, generally, individuals with mental health disorders are at higher risk for physical health problems such as diabetes and cardiovascular disease. These conditions are often a result of prescription atypical antipsychotic drugs that have an effect on weight gain and glucose metabolism (Newcomer, 2007). In addition, individuals with mental health disorders have higher rates of smoking, less access to preventive healthcare, and many experience poverty and social isolation, all of which contribute to poorer overall health (Parks, 2008; Newcomer, 2007).

Individuals with substance use disorders also suffer from a variety of concurrent medical conditions such as kidney disease, lung disease, and pneumonia (Forum on Integration, 2010). Immediate and long-term health outcomes associated with excessive alcohol use include unintentional injuries, alcohol poisoning, cardiovascular disease, and liver diseases, such as hepatitis and cirrhosis (CDC, 2011). Individuals are also at higher risk for health issues such as HIV and Hepatitis B and C related to intravenous drug use, and cardiovascular health problems and lead poisoning related to the use of methamphetamines (Forum on Integration, 2010).

Prevention of mental health and substance use disorders



A preventive approach to mental health and substance use disorders is crucial to improve health outcomes and reduce costs. Prevention in the mental health and substance use context refers to interventions or activities that occur before the onset of a disorder to keep the disorder from developing. It also refers to interventions that attempt to lessen co-morbidities, relapse, and other consequences (DHHS, 2002; Medina-Mora, 2005).

Prevention strategies are often categorized into three major groupings; primary, secondary, and tertiary prevention. It is important to note that these definitions are not always easily applied to the mental health field because of challenges in diagnosing mental illnesses and shifts in the definitions of mental illnesses over time (DHHS, 1999). However, this can be a useful framework for public health and medical practitioners when deciding how and when to intervene in the lives of individuals with co-occurring disorders.

- **Primary prevention**, as defined by the U.S Department of Health and Human Services (1999) involves keeping a disease or disorder from occurring in the first place. This is the ideal form of prevention, but also the most difficult with respect to mental health and substance use disorders with varied and complex risk factors.

- **Secondary prevention** refers to the prevention of recurrences or exacerbations of an already diagnosed disease. In the case of mental illness and substance use, this would include screening procedures to diagnose disorders (DHHS, 1999). It also may also involve counseling patients with mild alcohol or mental health-related problems that do not yet meet any specific diagnostic criteria (Bradley, 1994).

- Finally, **tertiary prevention** refers to reducing the amount of disability caused by a disease or disorder. In the case of a mental health or substance use disorder, this would include rehabilitation or counseling (DHHS, 1999).

PROMISING APPROACHES:
Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT (Screening, Brief Intervention and Referral to Treatment) is a promising public health model designed to promote secondary prevention of alcohol abuse. A key component of this model is universal screening of all primary care patients (usually taking between 5 and 10 minutes), followed by a brief intervention (another 5 to 10 minutes) for individuals who may have some degree of problem alcohol use (DHHS, 2011). Primary care and behavioral health professionals developed this model with the goal of incorporating it into standard primary care practices (McCance-Katz & Satterfield, 2012). This model may also be an effective approach for depression and drug use prevention; however its use in these particular areas still needs to be explored.

Prevention in primary care

Mental health and substance use disorder prevention can occur in a variety of contexts. The primary care setting, in particular, presents an opportunity for both secondary and tertiary prevention.

Primary care providers act as the front door to health care delivery in the United States. Current estimates suggest that 90% of individuals with mental health and/or substance use disorders are seen in the primary care sector (Kathol et al., 2008). Individuals with co-occurring disorders are often seen in the primary care system because of high rates of other health problems, even if they are not seen in mental health or substance abuse clinics or settings (DHHS, 2002). Additionally, because of the stigma of seeking care for mental health or substance use disorders, or lack of access to those services, many individuals with co-occurring disorders may prefer to see their primary care physician instead of directly seeking out care from a mental health or substance use professional (Feinman et al., 2000). In other cases, patients may not be able to see other medical specialists without a referral from their primary care provider (Hile, 2003).

Although depression is diagnosed in less than two percent of primary care patients (Feinman et al., 2000), an under-diagnosis compared to the expected prevalence of nearly seven percent (DHHS, 2010), this setting still presents a good opportunity for prevention. Studies have shown that brief screening assessment by primary care providers can increase identification of individuals with mental health or substance use disorders (Hile, 2008). In addition, screening of alcohol use conditions, followed by a brief intervention, is one of the most cost-effective health interventions for adults because it can identify individuals whose alcohol use problems do not meet the criteria for a substance use disorder, and limit the progression of the conditions from misuse to chronic abuse (Forum on Integration, 2010).

Integration

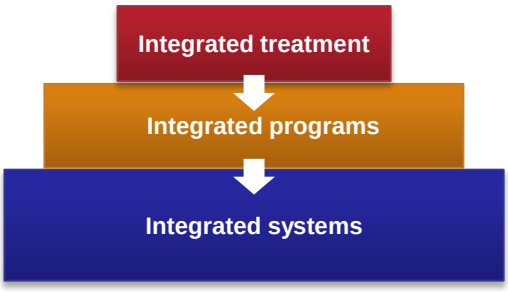
Effective prevention of mental health and substance use disorders does not end at screening. Patients may have a variety of needs that require special knowledge from different providers. Integration of health services or systems ensures that patients with co-occurring disorders have all their needs addressed in a seamless manner.

Distinctions must be made between the various types of care integration:

- **Integrated treatment** – also referred to as service coordination, this describes treatment in which there is regular interaction and communication between mental health and/or substance use clinicians which address the needs of the individual (DHHS, 2002; Forum on Integration, 2010).

- **Integrated programs** – integration of programs represents a slightly more complex organizational structure for providing treatment. In this case, the program is linked with other programs to ensure that a patient's mental health, substance use, and physical health needs are met (DHHS, 2002). An example of an integrated program is the medical or health home. This concept is more commonly seen in pediatrics and can also be applied to the mental health/substance use arena. The services received in an integrated program such as a medical home might involve health screening, preventive health care, acute care, chronic disease management, recovery support, counseling, and medication management (Forum on Integration, 2010).

- **Integrated systems** –finally, entire health care systems can be integrated to form a broad organizational structure for supporting a variety of programs for people with different needs, including individuals with co-occurring substance use and mental health disorders. A system such as this would be responsible for ensuring appropriate funding mechanisms to support the continuum of service needs, addressing credentialing/licensing issues, establishing data collection/reporting systems, assessing needs, planning, and other related functions (DHHS, 2002). Although integration of systems involves more broad focus on reducing barriers to care and overall service coordination and improvement, it is important to note that integrated systems also require integrated services or coordination (DHHS, 2002)



There is strong evidence to suggest that any degree of integration leads to improved clinical outcomes. A 1997 study of 654 patients with substance use disorders found that integrated treatment significantly reduced hospitalization rates and emergency room visits, and significantly reduced total medical costs per patient (Parthasarathy et al., 2003). Additionally, patients who received integrated treatment for substance use disorders had twice the rate of abstinence as patients with traditional care (Forum on Integration, 2010). Patients also reported higher levels of satisfaction in their treatment when they were seen in an integrated model (Parker, 2010).

From a cost-savings perspective, integration is ideal. Actuarial estimates suggest that by integrating medical and behavioral health services, employers could save on health care costs, sick day costs, disability costs, and employee productivity levels. For example, an employer of 31,400 workers could save $3 million/year through integrated health services (Kathol et al., 2008).

Barriers to integration

The current health care system in the United States imposes challenges on the integration of behavioral health and primary care. Many barriers must be addressed before integration can occur. The following list represents several of the most significant barriers.

Approaches to care
Primary care and behavioral health fields may have different philosophies and approaches to care and even within a field, these approaches may differ drastically based on the needs of each particular patient, thus making it hard for providers from different backgrounds to work together to provide seamless care (DHHS, 2002).

Insurance
Insufficient or no health insurance is a barrier to seeking out mental health and substance use services. In 2010, there were 11.1 million adults who reported an unmet need for mental health care. Of these adults, 44 percent reported that a reason for this unmet need was that they "could not afford the cost." Of individuals with substance use disorders who sought treatment but were not able to get it, 38% cited that they had "no health coverage and could not afford the cost" as one of the main reasons they did not receive treatment (DHHS, 2010).

Reimbursement
The current physician reimbursement structure for public insurance does not promote preventive health services that would enhance integration. Primary care physicians are generally not reimbursed for performing preventive behavioral health screenings, making them much less likely to occur during a standard office visit (Mauch et al., 2008). This issue could explain why depression diagnoses in primary care settings are currently low.

Integration is also severely limited by Medicaid and Medicare reimbursement restrictions. Medicaid imposes a limitation on same-day billing. Providers cannot bill for activities performed by two different practitioners on the same day (Mauch et al., 2008; Forum on Integration, 2010). In these cases, a practitioner cannot provide a mental health screening during the visit and then bring a mental health provider into the room for a hand-off or consultation. Additionally, Medicaid restrictions in some states do not allow medical and mental health services to be provided on the same day if the same provider is not licensed for both services (Mauch et al., 2008). In general, clinicians are also not reimbursed for any consultation time with other providers, team meetings, etc. (Butler et al., 2008).

Finally Medicaid and Medicare reimbursement for behavioral health services requires a DSM-IV diagnosis, which can be unnecessarily stigmatizing and would not allow a primary care physician to be reimbursed for screening and brief intervention with individuals who may meet some criteria for mental health or substance use disorders, but not all (Forum on Integration, 2010). This restriction alone severely limits the ability of primary care providers to engage in secondary prevention of behavioral health conditions.

PROMISING APPROACHES:
DIAMOND Initiative
Minnesota is currently exploring the feasibility of a unique reimbursement structure in an effort to integrate mental health and primary care. The DIAMOND Initiative (Depression Improvement Across Minnesota, Offering a New Direction), launched in 2007, is an integrative approach to care that is currently offered in more than 90 clinics. Similar to a medical home, it includes a collaborative team of primary care physicians, care managers, and consulting psychiatrists. This model proposes a payment structure that allows Minnesota health plans to reimburse clinics for a bundle of services rather than traditional fee-for-service model available in other clinics (Jaeckels, 2009). Thus, a clinic will be reimbursed for all services provided by the collaborative team which allows for consultations between primary care physicians and mental health practitioners and allows patients to see both practitioners within the same day. Because this model is new, it is still undergoing evaluation.

Other more general insurance barriers to integration include the existence of mental health carve-out networks. These networks are separate, exclusive to mental health, and do not include primary care. Thus, primary care providers who are not practicing in the carve-out network would not be reimbursed for evaluating patients with mental health needs (Mauch et al., 2008; Goldberg, 1999; Kathol et al., 2008).

Funding

In the United States, mental health and substance use services tend to be funded by a variety of disparate federal and state sources, including block grants and other special funds. Therefore, providers who would like to align or integrate their services would have to shoulder the burden for aggregating these funds themselves (DHHS, 2002). This is made more challenging by the fact that there are often restrictions on how categorical mental health and substance use funds and block grants are used, meaning that funds must be kept separate and specific to certain types of health services (DHHS, 2002; Forum on Integration, 2010).

Information barriers

There is a general separation of records, isolated service locations, and lack of communication between clinicians that make it difficult for providers to communicate with one another regarding a patient's needs and progress, thus creating a barrier to integration (Kathol, et al., 2008).

Finally, there is a lack of surveillance and measurement of mental health disorders (Parks, 2008). There is very little information available related to wellness and survival or causes of death of individuals with serious mental illness (Aron et al., 2009). Conversely, there is no evidence at this time to suggest that enhanced surveillance/measurement of substance use disorders is needed.

Recommendations for integrating mental health and substance use prevention in primary care

Full integration of the primary care, mental health, and substance use prevention systems is an ambitious goal and not necessarily feasible for the immediate future. Full integration would likely require a complete restructuring of state and federal health care systems, including funding mechanisms. However, there are steps that Minnesota may take to better align mental health, substance use prevention, and primary care systems to improve health outcomes for patients with co-occurring disorders:

- Build awareness in Minnesota about mental health and substance use prevention, as well as the benefits of system integration.
- Encourage and streamline communication between primary care providers and providers of mental health and substance use services to ensure that patients' mental health and/or substance use needs are identified as early as possible, and to ensure that other physical health needs are not overlooked.
- Consider how primary care providers and clinics could incorporate screening models, such as SBIRT, into regular clinic visits so that all patients receive basic mental health and substance use disorder screening.
- Develop state outcome measures for co-occurring disorders and improve surveillance of mental health disorders to gain a more accurate understanding of how many Minnesotans suffer from mental health and substance use disorders.
- Examine how public and private insurance plans in Minnesota reimburse for behavioral health services and whether or not those policies might encourage or discourage integration.
- Continue to support and evaluate innovative approaches, such as SBIRT and the DIAMOND initiative.

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