Integration of Substance Use Services in Mental Health Settings

ADAI ALCOHOL & DRUG ABUSE INSTITUTE

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To understand dilemmas revealed by a transformative integration of substance use services into mental health settings, we must first look back at some precipitating circumstances.

Why was integration thought to be necessary?

Buck[1] outlines a state of affairs preceding legislative efforts to integrate substance use services in other health settings. In 2009, 1 in 10 U.S. citizens over age 12 used illicit drugs and nearly 1 in 4 engaged in binge drinking in the prior month[2]. Substance misuse had been identified as causes or contributing factors to health conditions including diseases of the heart, liver, or infection like HIV/AIDS or Hepatitis C. Historically, substance use services were segregated to a specialty care context, with mainly abstinence-based counseling offered in nonprofit stand-alone or government-operated facilities. Availability of empirically-supported addiction medications and behavior therapies was the exception rather than rule, with service delivery by lesser educated, trained, and supervised personnel in settings lacking the infrastructure and clinical information systems commonly found elsewhere[3-5]. Compounding these structural challenges was an absence of contracts with managed care plans or other patient insurance options, which prompted greater reliance on public funding from state and local governments[6].

What were the legislative solutions?

Buck[1] describes federal legislation since passed to address this state of affairs. First, a Medicare Improvements for Patients and Providers Act of 2008 phased out required patient co-pays for outpatient substance use services. Second, a Mental Health Parity and Addiction Equity Act of 2008 established parity so health plan benefits for substance use were no more restrictive than for medical illness. Third, a Children's Health Insurance Program Reauthorization Act of 2009 extended these provisions to state-level child health plans. Finally, the Patient Protection and Affordable Care Act of 2010 or ACA, for which Table 1 lists core elements[7], promoted integration of substance use services in primary care. Implications noted by Croft and Parish[8] were that patient access to substance use services was to increase, financing/reimbursement for services was to be restructured, and the health system infrastructure was to be greatly enhanced.

Table 1. ACA Core Elements[7]

1	Requirement that all U.S. citizens purchase health insurance, central to the goal of increasing reach of healthcare benefits.
2	State-level opportunity to expand Medicare/Medicaid for medically underserved populations, which occurred in WA.
3	Financial incentives for primary prevention, eliminating co-pays and state-matching requirement for Medicare/Medicaid.
4	Team-based care for chronic illness, reliant on electronic health records, patient registries, and outcome monitoring.
5	Insurance coverage of services for 10 "essential health benefits," which included those for substance use disorders.
6	Outlawing prior insurance company practice to withdraw or deny coverage for persons with or acquiring a chronic illness.
7	Assurance of health insurance portability so plans are maintained when moving or changing employment.
8	Family capability to maintain insurance coverage on all children through college, up to the age of 26.

What impacts did this have for provision of substance use services?

McLellan and Woodworth[7] note several relevant consequences of the ACA:

Of 25 million adults meeting criteria for a substance use disorder, expanded Medicaid benefits was estimated to extend coverage to 12% more of this population, and to a much higher proportion of those who engage in subthreshold yet still medically harmful substance use.

Specialty care settings faced new market forces, with some effectively adapting to assimilate modern information/billing systems, adopt evidence-based therapeutic practices, and embrace a chronic care perspective. Many of those failing to adapt have since closed their doors.

An influx of persons newly-eligible for services exceeded capacity of the specialty care system, prompting efforts to implement screening and brief intervention procedures in primary care. These efforts, not without logistical and philosophical challenges, are continuing.

Owing to increased recognition of substance use disorders as chronic illnesses, evidence-based strategies for disease management and outcomes monitoring were extended to substance use services. This, too, is an evolving effort for health systems and their personnel.

Mainstreaming of substance use services sought to reduce stigmatization and marginalization. These processes will need to persist to counteract future legislative efforts that may seek to undermine progress in how those seeking substance use services are treated.

Has integrating substance use services in mental health settings improved patient outcomes?

Systematic reviews suggest that those who receive integrated mental health and substance use services do show clinical improvement[9,10] and report treatment satisfaction[11]. Some note a greater degree of clinical utility in the integration of mental health services than for substance use services, with the strongest empirical support among the latter suggested for screening and brief intervention for alcohol misuse and tobacco cessation interventions[12,13]. As noted by Croft and Parrish[8], the integrated care initiatives undertaken since passage of the ACA have not forged evidence of robust clinical effectiveness that might otherwise prompt larger systemic shifts toward comprehensive care integration. Thus, many questions of the relative utility of integrated care services among special patient populations remain unanswered.

A review by Priester and colleagues[14] further highlights issues of health disparity. One salient dimension is residential geography, as those living in rural or under-resourced areas have lesser access to integrated care programs[15]. That disparity is compounded by findings that geographic proximity and absence of transportation to reach services remain pervasive barriers to care[16,17]. A 2nd dimension is culture, as absence of cultural competence in a given care setting contributes to under-representation of ethnic/racial and sexual minority groups among those accessing its available mental health and substance use services[18]. Though clinical services often are tailored to patients' gender and stage-of-life, there is a dearth of comparative study examining these as moderating influences of the utility of integrated mental health and substance use services.

In what settings can integrated mental health and substance use services occur?

Given an estimated 7.9 million adults in the U.S. with co-occurring mental health and substance use disorders[20] and ongoing health system transformation, persons in need of integrated care may present for services at an ever-increasing range of health providers. In addition to primary care settings[1,7], these are likely to include: community health centers, inpatient service providers, hospitals, specialty care centers, independent practitioners in private practice, jails and prisons, mutual/peer support organizations, schools, and telehealth or home-based service providers.

Integrated care—principally involving individual and group counseling, medication-assisted treatments, and support services—hold potential to offer tangible clinical benefit in the form reductions in substance use, psychiatric symptomatology, acute care needs, and criminal justice involvement as well as increases in overall functioning, housing stability, and quality-of-life. Figure 1 illustrates an adapted classification scheme for persons with co-occurring disorders[19], as well as indication of health settings where particular patient groups may be most likely to present for integrated care services. While intended as a heuristic, this may offer a helpful guide as settings move toward redesign in order to provide integrated care.

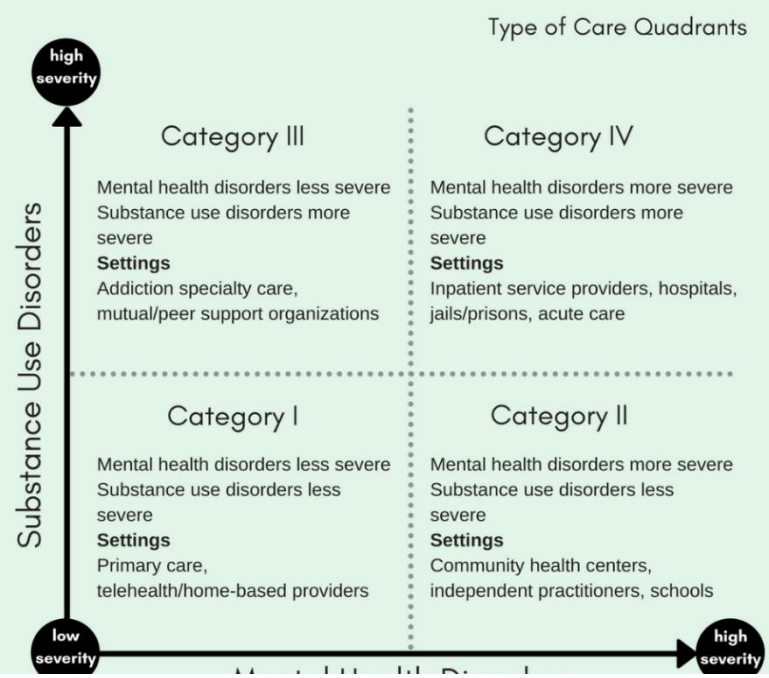

Figure 1. *Adapted classification scheme for co-occuring disorders[19].*

Irrespective of the specific health setting in question, a common set of guiding principles for integrated care[21] are outlined in Table 2. The principles are intended as a guide to provision of integrated care for patients varying in age, gender, race/ethnicity, or socioeconomic circumstance. Integrated care is thought to provide consistent, useful messaging to all patients about treatment and recovery.

Table 2. Principles of Integrated Care for Co-Occurring Disorders[21]	
1	Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders.
2	Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.
3	Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages.
4	Motivational interventions are used to treat consumers in all stages, but especially at initial points.
5	Substance abuse counseling, using a cognitive-behavioral approach, is used both prospectively and in relapse prevention.
6	Multiple formats for services are available, including individual, group, self-help, and family.
7	Medication monitoring is coordinated with behavioral services.

What structural barriers exist for integrated mental health and substance use services?

The historical separation of mental health and substance use services contributes to an overall health system that is difficult for persons with co-occurring disorders to navigate. Priester and colleagues[14] also note structural characteristics of treatment programs and systems that pose barriers to integrating mental health and substance use services. One is service access, with the comprehensive screening and assessment procedures that integrated care requires still absent in many community mental health settings[22]. Relatedly, insufficient workforce training to identify both mental health and substance use disorders poses a further barrier to service integration[23,24]. While training of mental health staff is suggested to provide better preparation to identify dual diagnoses[25], interdisciplinary training is proposed as means to increase system capacity to implement comprehensive diagnostic procedures[26]. Other barriers relate to service availability and timing—with use of entry requirements (like substance abstinence) and lengthy

waitlists, bureaucratic 'red tape' during enrollment, inflexible hours during which services are offered, and provider antipathy and selection bias all noted as limiting utilization[27-29].

In addition to structural barriers, interdisciplinary differences in understanding and philosophy about addiction as an illness constitute a significant systemic barrier to the integration of mental health and substance use services. Volkow and McLellan[30] note common myths and misconceptions about opiate addiction that persist as barriers to adoption of substance use services by health professionals. Table 3 provides a selected list of myths and misconceptions.

What is recommended for overcoming these structural and philosophical barriers?

Practical suggestions for overcoming structural barriers among dually-diagnosed patients are co-location and integration of assessment, case management, and treatment services, as well as simplification of care systems to a single-entry point[29,31]. Other suggestions, particularly in rural areas, are for opportunistic use of technology to promote service access and wrap-around services whereby varied needs may be met[32]. As for philosophical barriers, suggestions include increased dual disorder identification via universal screening and diagnostic assessment[25,26], effective treatment referral via frequent interdisciplinary communication and collaboration[22], and mitigation of health disparities by targeting of cultural competence as a workforce aim[18].

Myth	Fact
Addiction is the same as physical dependence and tolerance.	This misconception leads some clinicians to avoid prescribing addiction medications who would benefit from them and many patients to be afraid of taking such medications as prescribed.
Addiction is simply a set of bad choices.	This misconception contributes to the discrimination against patients with addiction and to the willful ignorance by many in the health care system about modern treatment methods. It also promotes mistrust of patients by clinicians and prevents affected patients from seeking help for their addiction.
Only patients with certain characteristics are vulnerable to addiction.	Certain conditions do increase the vulnerability to addiction, including substance use disorder, adolescent developmental stage, and some mental health comorbidities (i.e., attention deficit–hyperactivity disorder, major depressive disorder). Although some patients are more vulnerable than others, no patient is immune to addiction.
Medication-assisted treatments are just substitutes for street drugs.	Use of opioid-agonist medications such as methadone and buprenorphine for opioid addiction has led to the misconception that such drugs are just substitutes for the opioid being abused. Although these medications are opioid agonists, their slower brain pharmacokinetics along with more stable concentrations stabilize physiologic processes otherwise disrupted by intermittent abuse of opioids. Use of these medications also protects against risks associated with opioid abuse during recovery.

Table 3. *Common myths and misconceptions about addiction, adapted from Volkow and McLellan[30].*

Croft and Parrish[8] also strongly advocate that stakeholders from both mental health and addiction settings actively engage in health care reform activities, such that they attain and maintain a voice in persisting debates about health system integration. This will continually position them to effectively advocate for the needs of the dually-diagnosed populations they serve, as issues of care integration begin to intersect more directly with health-involved challenges like affordable housing and employment. It is hoped that, ultimately, settings that overcome existing barriers and effectively integrate mental health and substance use services may then avoid traditional fragmentation and instead provide care for the 'whole person.'

What might integrative models for substance use services look like in mental health settings?

A 2009 review by Armitage and colleagues[34] notes 175 different definitions of care integration, suggesting efforts to integrate substance use services into mental health settings are likely to be uniquely influenced by setting aims, structure, and resources. Nevertheless, classification of such efforts holds heuristic value. Blount[33] distinguishes three types of care integration, with contemporary examples of application of relevant substance use services for dually-diagnosed patients in mental health settings—screening, diagnosis, case management, behavioral and medication-assisted treatment, and referral for complementary services—outlined in Table 4.

Table 4. Models of Care Integration for Substance Use Disorders in Mental Health[33]

Coordinated care	Addiction care and mental health professionals **practice separately** and often in distinct locations, albeit with an integrated patient records system and common underlying funding sources. Both sets of staff groups diagnose, provide case management and behavior therapies, and oversee medication-assisted treatments in their own areas of expertise, with basic screening and referral as needed for complementary services for substance use and mental health disorders.
Co-located care	Addiction care and mental health professionals **practice together**, with delineation of services according to expertise. Both sets of staff diagnose, provide case management and behavior therapies, and oversee medication-assisted treatments in their own areas of expertise, with basic screening and referral as needed for complementary services for substance use and mental health disorders. Co-location facilitates formal and informal communication that augments cross-linkage for service referrals.
Integrated care	Addiction care and mental health professionals **collaboratively design and implement** unified care plans, with close and continuing cohesion. Both sets of staff are core members of integrated care teams that perform screening, conduct behavioral assessment and diagnosis, provide case management and behavior therapies, and oversee medication-assisted treatments. Integrated care offers benefits in more informed and immediate responses to emergent issues posed by clinical comorbidity.

Can integrated mental health and substance use services also be trauma-informed?

Increasingly, experience of physical and emotional trauma is recognized as prevalent as well as influential on accessing of, participation in, and response to care. This is of elevated concern for women, children, military veterans, persons with disabilities, the elderly, and ethnic/racial and sexual minorities. Trauma-informed care encompasses how treatment systems both understand and respond to persons who have experienced or are at-risk for traumatic events. Table 5 defines four key elements of trauma-informed care[35], for which setting implementation is a transformative process implicating policies and procedures to decrease patients' current reactions to prior traumatic events as well as prevent future experience of additional traumatic events.

Table 5. Key Elements of Trauma-Informed Care[35]

1	Recognition of the pervasive intra- and interpersonal influences of trauma
2	Understanding of how traumatic experience directly and vicariously impacts patients and staff
3	Clinical responses that apply such understanding of trauma-related impacts
4	Clinical responses that seek to prevent future re-experiencing of traumatic events

Integrating mental health and substance use services is a lofty undertaking, given the structural and philosophical barriers for many treatment settings and systems detailed earlier in this report. Ensuring that integrated care is also trauma-informed clearly adds weight to this task. While extant literature does not directly address the comparative utility or effectiveness of integrated care that is vs. is not trauma-informed, integration of trauma-informed perspectives in design and implementation of health services has been strongly recommended among advocates of many patient groups[36-38]. If a treatment setting or system seeks to accomplish this amidst integrating its mental health and substance use services, targeted effort will be needed to minimize potentially traumatic or distressing aspects of care processes. Moreover, the setting or system will need to provide reassurance, hope, and effectively coping supports when patients—and their caregivers and/or family members—do encounter such distress.

What is recommended for health settings to increase capacity to integrate care?

Padwa and colleagues[39] highlight *integrated behavioral care capacity* as a measurable construct comprised of 'inner' and 'outer' context factors. Outer context includes a sociopolitical context (i.e., legislative policy), funding (i.e., continuity), patient advocacy (i.e., partnered consumer agencies), and networking (i.e., linkage to other facilities/professional groups). Inner context includes setting attributes (i.e., size, absorptive capacity), personnel (e.g. values, openness to change), style of leadership (i.e., active), mission (i.e., ideology), and resources (i.e., capacity for staff oversight). Chaple and colleagues[40,41] outline recommendations for increasing integrative behavioral care capacity, based on an empirically-supported technical assistance approach utilized to enhance capacity of a set of federally qualified health centers to support integration of behavioral health services. These procedural recommendations are listed in Table 6.

Table 6. Recommendation for Increasing Integrative Behavioral Care Capacity[40,41]	
1	Obtain top-down support so setting leadership demonstrates buy-in to positive influence setting culture to embrace and institutionalize substance use services in routine practice.
2	Elicit input from and involve key clinical staff in sculpting new services to enhance the investment and commitment of those staff for those services.
3	Facilitate a change process, with program leadership and clinical staff comprising implementation teams or informal partnerships that guide implementation of new services.
4	Promote peer-to-peer learning about implementing new services so inter-agency collaboration enables sharing and learning among staff from multiple treatment organizations.
5	Employ measurement and feedback processes to enable real-time feedback at iterative points that fosters rapid cycle improvement in the implementation of new services.
6	Build staff readiness and competencies via training and tools for clinical staff including initial workshops and subsequent technical assistance processes to assist navigation of barriers.

Additional Resources

- APA-APM Report: Dissemination of Integrated Care within Adult Primary Care Settings. https://www.psychiatry.org/File Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-APM-Dissemination-Integrated-Care-Report.pdf
- Scattergood Foundation Series on Behavioral Health Policy. http://www.scattergoodfoundation.org/spring-2017-paper-series
- Washington State. DSHS/DBHR. "Why SBIRT." https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/why-sbirt
- Bree Collaborative. Behavioral Health Integration Report and Recommendations. http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf
- Washington State. SBIRT Primary Care Integration. http://www.wasbirt.com/content/sbirt-washington
- Washington State. Research and Data Analysis. RDA Report 4.60.WA.2009.2 https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4.60-WA.2009.2.pdf
- SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). http://www.integration.samhsa.gov/

References

1. Buck JA. The looming expansion and transformation of public substance abuse treatment under the Affordabel Care Act. *Health Affairs.* 2011;30:1402-1410.
2. SAMHSA. *Results from the 2009 National Survey on Drug Use and Health.* Rockville, MD: SAMHSA;2010.
3. McLellan AT, Carise D, Kleber HD. Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment.* 2003;25(2):117-121.
4. McLellan AT, Meyers K. Contemporary addiction treatment: A review of systems problems for adults and adolescents. *Biological Psychiatry.* 2004;56(10):764-770.
5. Roman PM, Ducharme LJ, Knudsen HK. Patterns of organization and management in private and public substance abuse treatment programs. *Journal of Substance Abuse Treatment.* 2006;31(3):235-243.

6. Levit KR, Kassed CA, Coffey RM, et al. *Projections of national expenditures for mental helath services and substance abuse treatment, 2004-2014.* Rockville, MD2008.
7. McLellan AT, Woodworth AM. The affordable care act and treatment for 'substance use disorders': Implications of ending segregated behavioral healthcare. *Journal of Substance Abuse Treatment.* 2014;46:541-545.
8. Croft B, Parish SL. Care integration in the Patient Protection and Affordable Care Act: Implications for behavioral health. *Administration and Policy in Mental Health and Mental Health Services.* 2013;40(4):258-263.
9. Drake RE, O'Neal, E.L., Wallach MA. A systematic review of psychosocial research on psychosocial interventions for people with co-occuring severe mental and substance use disorders. *Journal of Substance Abuse Treatment.* 2008;34:123-128.
10. Donald M, Dower J, Kavanagh D. Integrated versus non-integrated management and care for clients with co-occurring mental health and substance use disorders: A qualitative systematic review of randomised controlled trials. *Social Science & Medicine.* 2005;60:1371-1383.
11. Schulte SJ, Meier PS, Stirling J. Dual diagnosis clients' treatment satisfaction - a systematic review. *BMC Psychiatry.* 2011;11:1.
12. Agency for Healthcare Research and Quality. *Integration of mental health/substance abuse and primary care.* Rockville, MD: Agency for Healthcare Research and Quality;2008.
13. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Systematic Review.* 2012;10:CD006525.
14. Priester MA, Browne T, Iachini A, Clone S, DeHart D, Seay KD. Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *Journal of Substance Abuse Treatment.* 2016;61:47-59.
15. Hester RD. Integrating behavioral health services in rural primary care settings. *Substance Abuse.* 2004;25:63-64.
16. Adler G, Pritchett LR, Kauth MR, Mott J. Staff perceptions of homeless veterans' needs and available services at community-based outpatients clinics. *Journal of Rural Mental Health.* 2015;39(1):46-53.
17. Godley SH, Finch M, Dougan L, McDonnel M, McDermeit M, Carey A. Case management for dually diagnosed individuals involved in the criminal justic system. *Journal of Substance Abuse Treatment.* 2000;18:137-148.
18. Eliason M, Amodia D. A descriptive analysis of treatment outcomes for clients with co-occurring disorders: The role of minority identifications. *Journal of Dual Diagnosis.* 2006;2:89.
19. SAMHSA. *Substance abuse treatment for persons with co-occurring disorders.* Rockville, MD2005.
20. Center for Behavioral Health Statistics and Quality. *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health.* Rockville, MD2015.
21. SAMHSA. *Integrated treatment for co-occurring disorders: Building your program.* Rockville, MD: U.S. Department of Health and Human Services;2009.
22. Sterling S, Weisner C, Hinman A, Parthasarathy S. Access to treatment for adolescents with substanc use and co-occurring disorders: Challenges and opportunities. *Journal of the American Academy of Child and Adolescent Psychiatry.* 2010;49:637-646.
23. Foster S, LeFauve C, Kresky-Wolff M, Rickards L. Services and supports for individuals with co-occurring disorders and long-term homelessness. *The Journal of Behavioral Health Services and Research.* 2010;37:239-251.
24. Green AE, Drake RE, Brunette MF, Noordsy D. Schizophrenia and co-occurring substance use disorder. *American Journal of Psychiatry.* 2007;164:402-408.
25. Kerwin ME, Walker-Smith K, Kirby KC. Comparative analysis of state requirements for the training of substance abuse and mental health counselors. *Journal of Substance Abuse Treatment.* 2006;30:173-181.
26. Hawkins EH. A tale of two systems: Co-occurring mental health and substance abuse disorders treatment for adolescents. *Annual Review of Psychology.* 2009;60:197-227.
27. Grella CE, Gil-Rivas V, Cooper L. Perceptions of mental health and substance abuse program administrators and staff on service delivery to persons with co-occurring substance abuse and mental disorders. *The Journal of Behavioral Health Services and Research.* 2004;31:38-49.
28. Libby AM, Riggs PD. Integrated substance use and mental health treatment for adolescents: Aligning organizational and financial incentives. *Journal of Child & Adolescent Psychopharmacology.* 2005;15:826-834.
29. Drake RE, Morse GG, Brunette MF, Torrey WC. Evolving U.S. service model for patients with sever mental illnesses and co-occurring substanc use disorder. *Acta Neuropsychiatrica.* 2004;16:36-40.
30. Volkow ND, McLellan AT. Opioid abuse in chronic pain - misconceptions and mitigation strategies. *The New England Journal of Medicine.* 2016;374(13):1253-1263.
31. Minkoff K. Best practices: Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services.* 2014;52:597-599.
32. Browne T, Priester MA, Clone S, Iachini A, DeHart D, Hock R. Barriers and facilitators to substance use treatment in the rural south: A qualitative study. *The Journal of Rural Health.* 2016;32(1):92-101.
33. Blount A. Integrated primary care: Organizing the evidence. *Families, Systems, & Health.* 2003;21:121-133.
34. Armitage GD, Suter E, Oelke ND, Adair CE. Health systems integration: State of the evidence. *International Journal of Integrated Care.* 2009;9:2.
35. SAMHSA. *Trauma-informed care in behavioral health services.* Rockville, MD: SAMHSA;2014.
36. Sales JM, Swartzendruber A, Phillips AL. Trauma-informed HIV prevention and treatment. *Current HIV/AIDS Reports.* 2016;13(6):374-382.
37. Marsac ML, Kassam-Adams N, Hildenbrand AK, et al. Implementing a trauma-infromed approach in pediatric health care networks. *JAMA Pediatrics.* 2016;170(1):70-77.
38. Decker MR, Flessa S, Pillai RV, et al. Implementing trauma-informed partner violence assessment in family planning clinics. *Journal of Women's Health.* 2017;in press.
39. Padwa H, Teruya C, Tran E, et al. The implementation of integrated behavioral health protocols in primary care settings in Project Care. *Journal of Substance Abuse Treatment.* 2016;62:74-83.
40. Chaple M, Sacks S, Randell J, Kang B. A technical assistance framework to facilitate the delivery of integrated behavioral health services in federally qualified health centers (FQHCs). *Journal of Substance Abuse Treatment.* 2016;60:62-69.
41. Chaple M, Sacks S. The impact of techical assistance and implementation support on program capacity to deliver integrated services. *Journal of Behavioral Health Services & Research.* 2016;43(1):3-17.

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