Can We Provide Necessary Care for Substance Use and Mental Health Disorders in the United States?

Forum on Mental Health and Substance Use Disorder

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Shelly F. Greenfield, MD, MPH

Kristine M. Trustey Endowed Chair of Psychiatry
Chief Academic Officer, McLean Hospital
Professor of Psychiatry, Harvard Medical School
Chief, Division of Women's Mental Health
Director, Clinical and Health Services Research and Education,
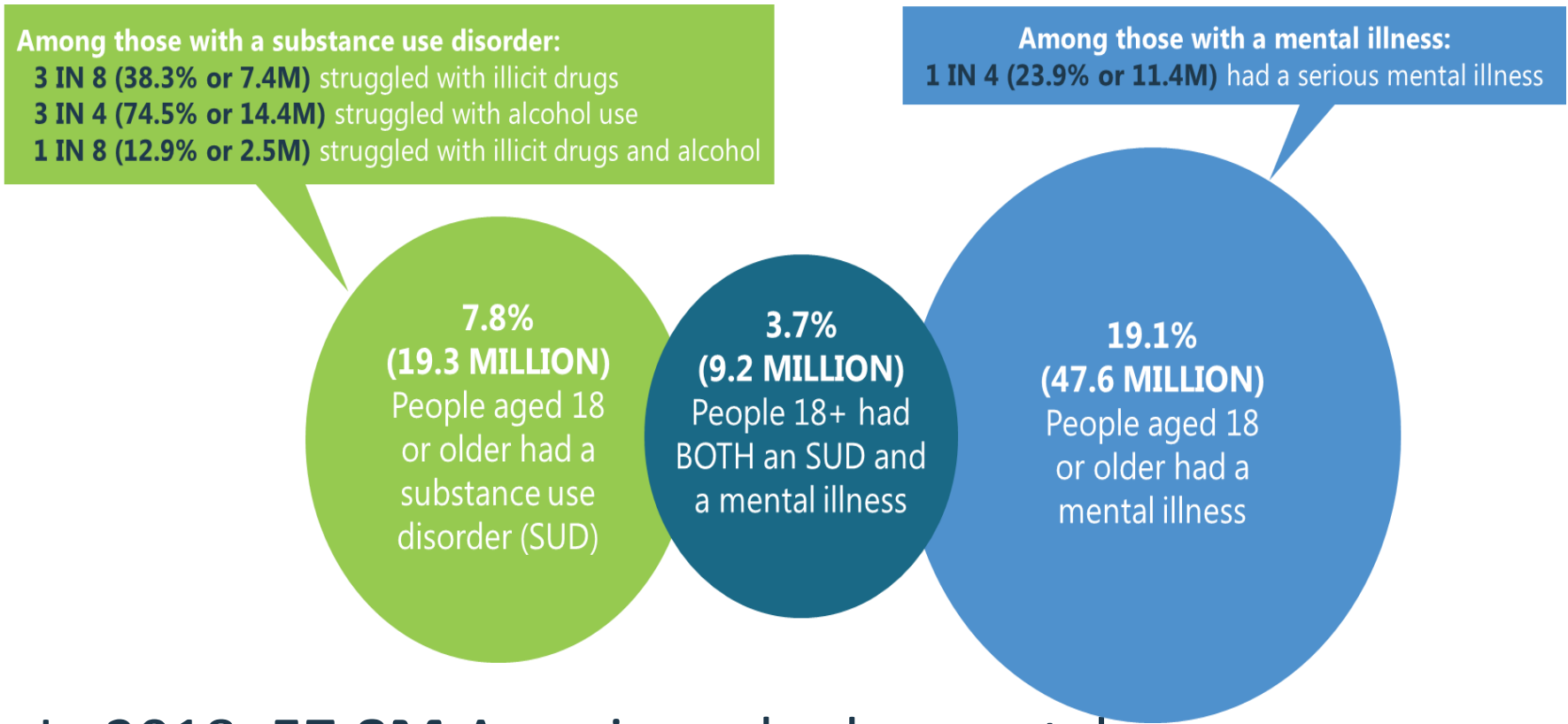Alcohol and Drug Abuse Treatment Program, McLean Hospital

A MEMBER OF **PARTNERS** ®
HEALTHCARE

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE
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Disclosures

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Introduction

- Among the greatest healthcare disparities in the US is access to treatment for mental illness including substance use disorders
- High prevalence of these disorders along with the current dual public health crises of opioid deaths and suicide
- Evidence based treatments
- Chronic lack of a coordinated, integrated treatment infrastructure
- Lack of a trained multidisciplinary treatment workforce
- Long-standing stigma associated with these conditions
- Require a multilevel, linked & integrated health system and a trained workforce
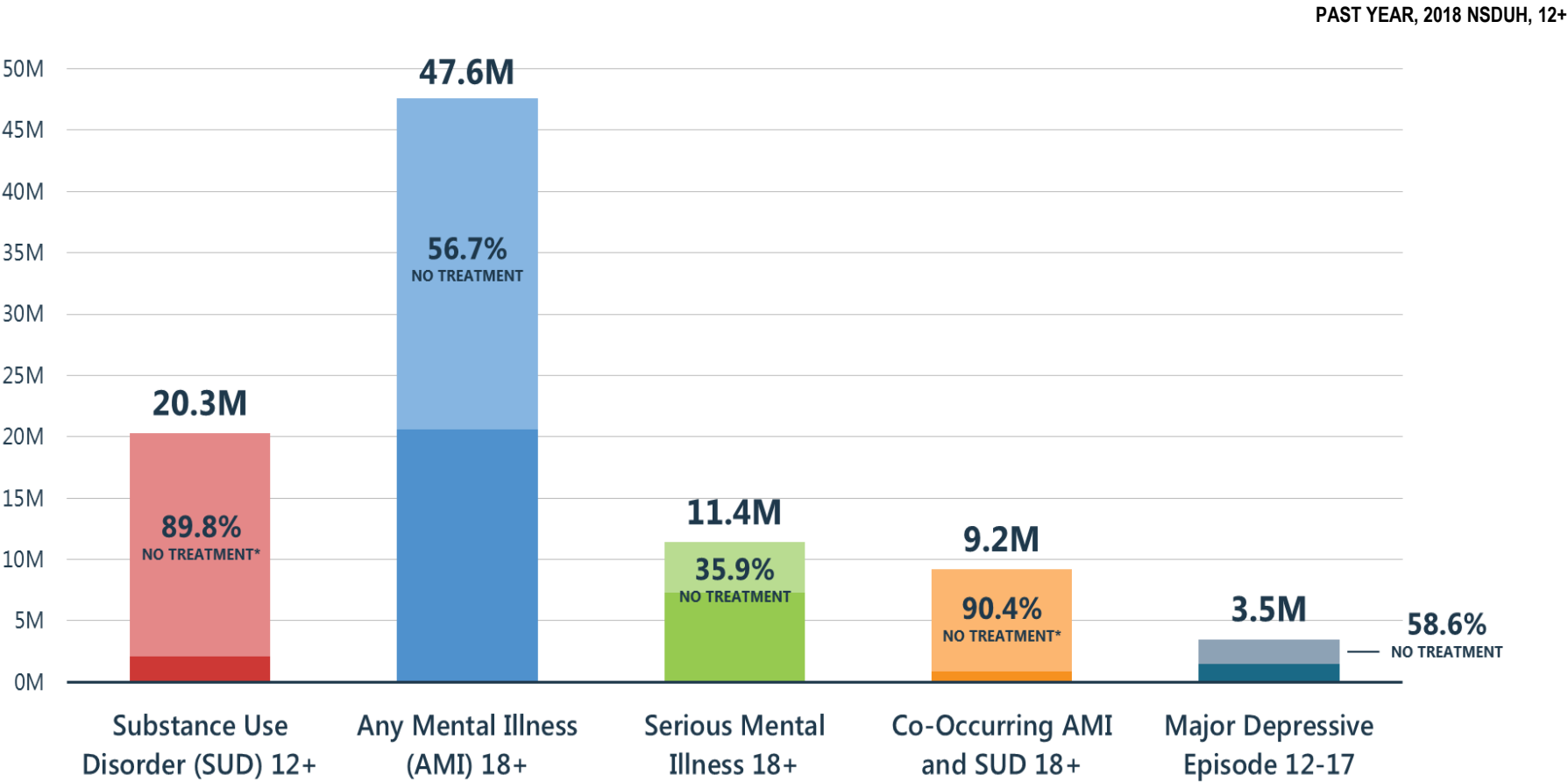- Multiple necessary components of care

Mental Illness and Substance Use Disorders in the United States 2018

McLean HOSPITAL
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Among those with a substance use disorder:
3 IN 8 (38.3% or 7.4M) struggled with illicit drugs
3 IN 4 (74.5% or 14.4M) struggled with alcohol use
1 IN 8 (12.9% or 2.5M) struggled with illicit drugs and alcohol

Among those with a mental illness:
1 IN 4 (23.9% or 11.4M) had a serious mental illness

7.8%
(19.3 MILLION)
People aged 18 or older had a substance use disorder (SUD)

3.7%
(9.2 MILLION)
People 18+ had BOTH an SUD and a mental illness

19.1%
(47.6 MILLION)
People aged 18 or older had a mental illness

In 2018, **57.8M** Americans had a mental health and/or substance use disorder.

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Despite Consequences and Disease Burden, Treatment Gaps Remain Vast

PAST YEAR, 2018 NSDUH, 12+

* No Treatment for SUD is defined as not receiving treatment at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail.

Health Care includes treatment for substance use and other mental health disorders

Need to Correct Longstanding National Health Care Disparity:

Diabetes - 30.3 million Americans, or **9.4%** of the population 2015 (https://www.cdc.gov/media/releases/2017/p0718-diabetes-report.html)

> **76.2%** are diagnosed (23.1 million people)
>
> 23.8% are undiagnosed (7.2 million people)
> 7th leading cause of death

Substance Use Disorder 20.3 million Americans, or **6.2%** of the population in 2018

> **10.2%** received any treatment
> 89.8% received no treatment (National Survey on Drug use and Health 2019)
>
> 70,270 Deaths in 2018 from opioid and other substance poisonings |
> (National Center for Health Statistics, National Vital Statistics System, mortality data (http://www.cdc.gov/nchs/deaths.htm).

Any Mental Illness (age 18 an older) 47.6 million Americans –or **14.7%** of the population in 2018 (NSDUH 2019)

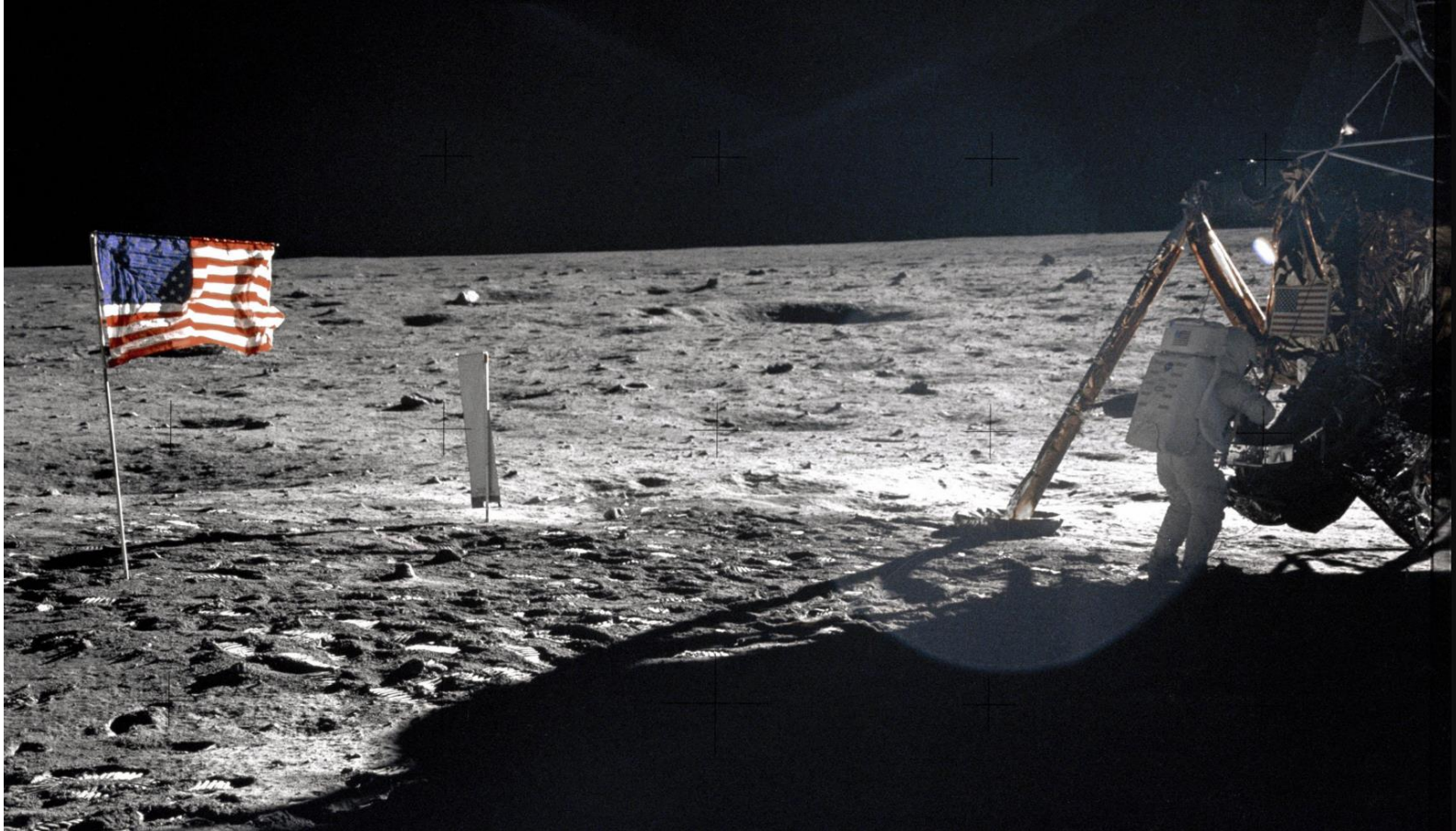> **43.3%** received any treatment
> 56.7% received no treatment
>
> 47,173 Suicide deaths in 2018 – 10th leading cause of death
> (American Foundation for Suicide Prevention https://afsp.org/about-suicide/suicide-statistics/)

Can we provide necessary care for MH/SUD in the United States in 2019?

1969: Apollo 11 Moon Landing – overcoming technology challenges has been easier than harnessing political will to build needed infrastructure & capacity

Innovation and Change in Public Health & Health Care

How do we prioritize our policies to act on our knowledge base?

Do we have the political will to get this done?

Social Strategy

Political will

Knowledge Base

Richmond JB, Kotelchuck M. In: Oxford textbook of public health. Oxford (UK): Oxford Medical Publications; 1991. p. 441-54
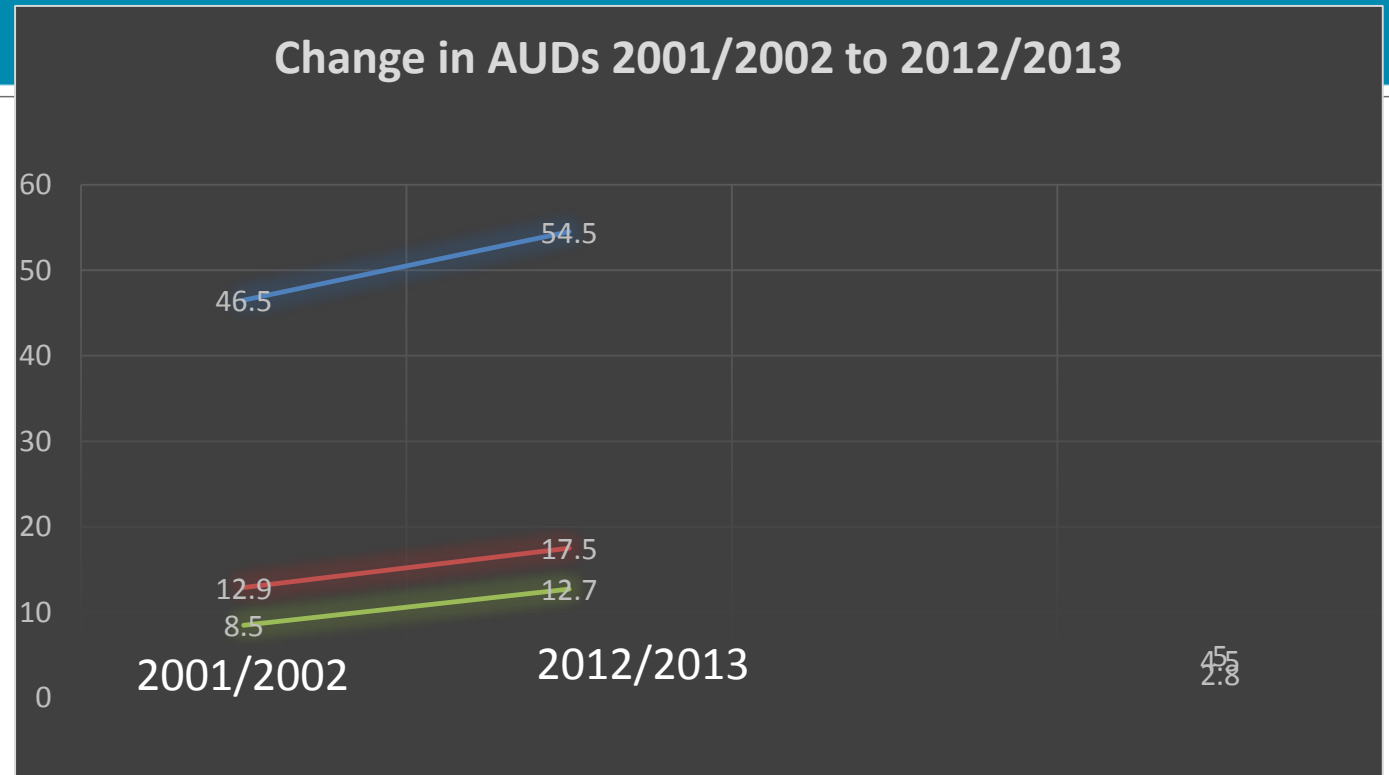
Is there an evidence base? Do we have effective treatments?

Alcohol Use Disorders (AUDs)

IOM Report (1990):

Broadening the Base of Tx for Alcohol Problems:

- Comprehensive continuum of treatment
- In community & specialized treatment

Change in AUDs 2001/2002 to 2012/2013

	2001/2002	2012/2013
	46.5	54.5
	12.9	17.5
	8.5	12.7

Increasing Prevalence & Negative Consequences of AUD in the U.S.

17.2% increase in 12 month AUD among high risk drinkers
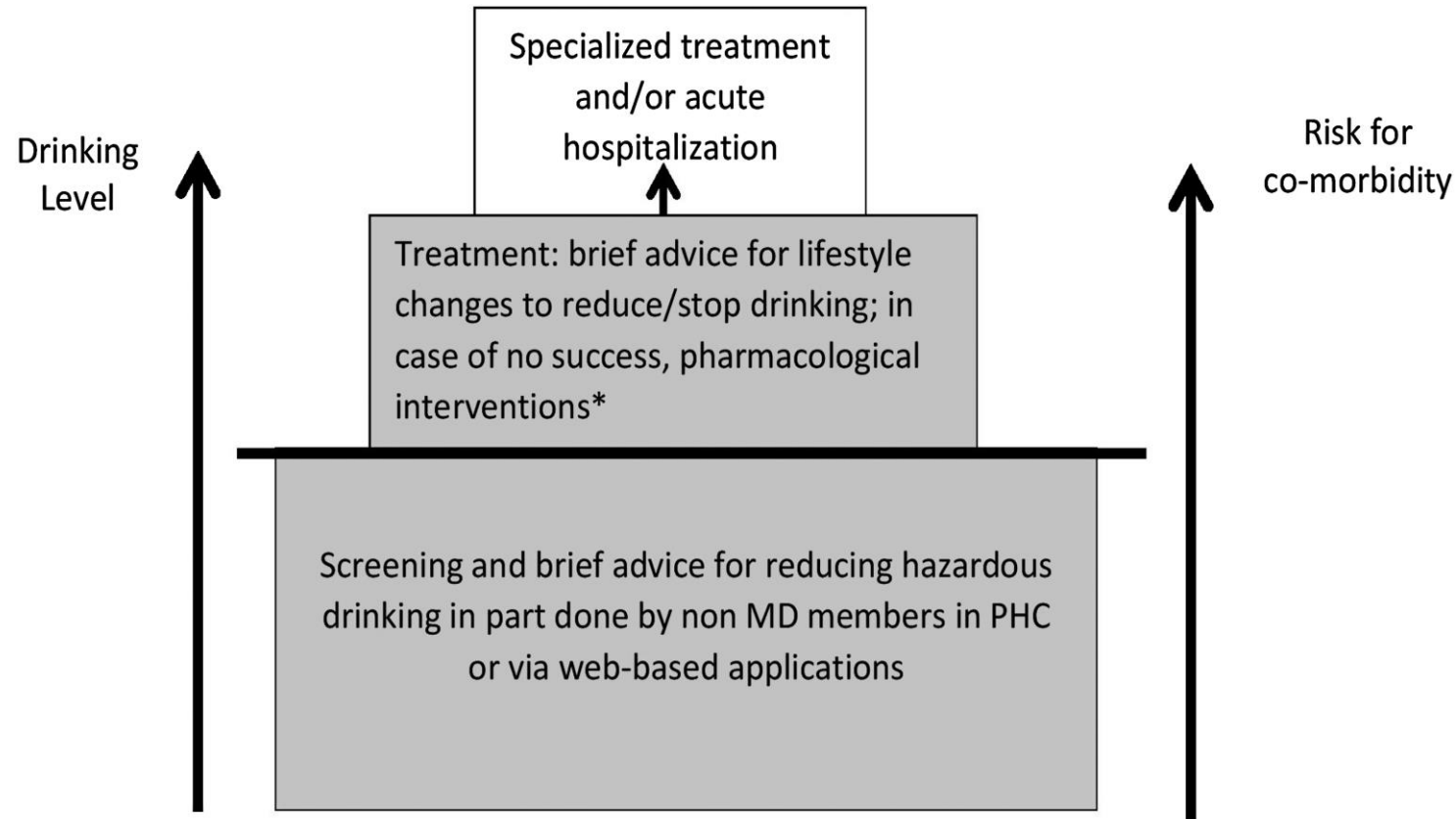
35.7% increase in 12 month AUD among alcohol users

49.4% increase in 12 month AUDs overall

(Grant BF….Hasin DS, 2017)

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Role of Primary Care Physicians in management of alcohol use disorders (AUDs) – one 2015 model

Why doesn't it happen?

At the practitioner level:

- Don't have time
- Don't know what to do/no training
- Can't get paid
- Don't know where to send patient for services/none available
- Are these patients even treatable? Does treatment work?
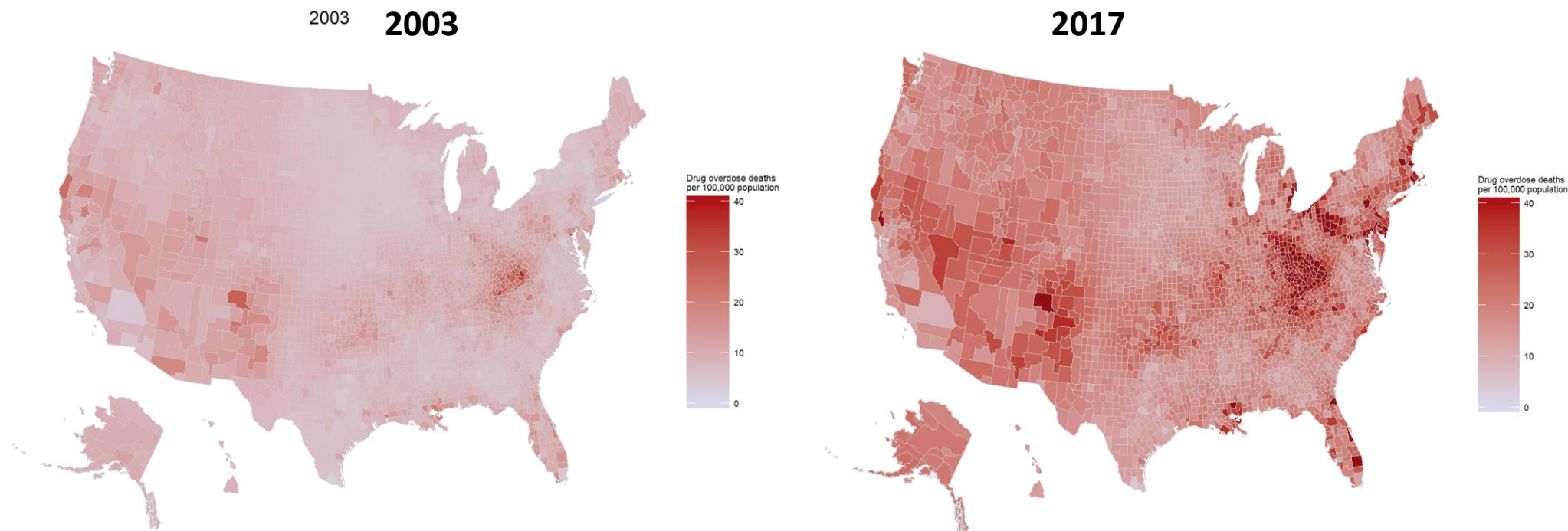
At the systems level:

- Can't get paid
- Too costly to treat
- Don't have services linkage
- Don't have providers for treatment or referral/No capacity
- Stigma

(Babor et al, 2007; Rivera et al 2000; Modesto-Lowe et al, 2000, O'Brien et al, 2019 among others)

National Crisis of Overdose Deaths::
Estimated Age-adjusted Death Rates per 100,000 for Drug Poisoning by County.

2003

2017

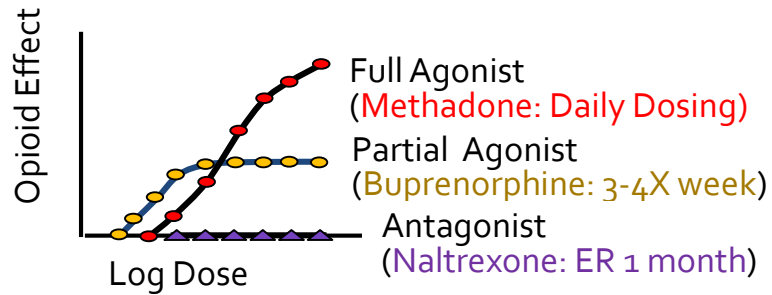Drug overdose deaths per 100,000 population

70,237 Deaths in 2017
47,600 from Opioids (Prescription and Illicit)

SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data (http://www.cdc.gov/nchs/deaths.htm).

Medication for Opioid Use Disorder (MOUD) Treatment

O... ...re"

Opioid Effect (y-axis)

Log Dose (x-axis)

Full Agonist
(Methadone: Daily Dosing)

Partial Agonist
(Buprenorphine: 3-4X week)

Antagonist
(Naltrexone: ER 1 month)

- **DECREASES:**
  - Opioid use
  - Opioid-related overdose deaths
  - Criminal activity
  - Infectious disease transmission

- **INCREASES**
  - Social functioning
  - Retention in treatment

The National Academies of
SCIENCES · ENGINEERING · MEDICINE

CONSENSUS STUDY REPORT

MEDICATIONS FOR OPIOID USE DISORDER SAVE LIVES

Population (M)
2.5
2
1.5
1
0.5

...nt gap
...0% goal

...estimates

Primary prevention
Secondar...

Willi... ...e 2019

**But MOUD treatment is highly underutilized!
Relapse rates are very high!**

Courtesy Wilson Compton MD, National Institute on Drug Abuse, 2019

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What do we lack? What are our strategies?

What do we lack?

- Coordinated, integrated treatment infrastructure with linkages between the necessary components of care
- Trained workforce across all areas of the treatment infrastructure

What are our strategies – Lessons learned:

- WHO Service Organization Pyramid – integration and linkage of necessary components of care
- Evidence from high performing health plans on treatment initiation and engagement for SUD/OUD
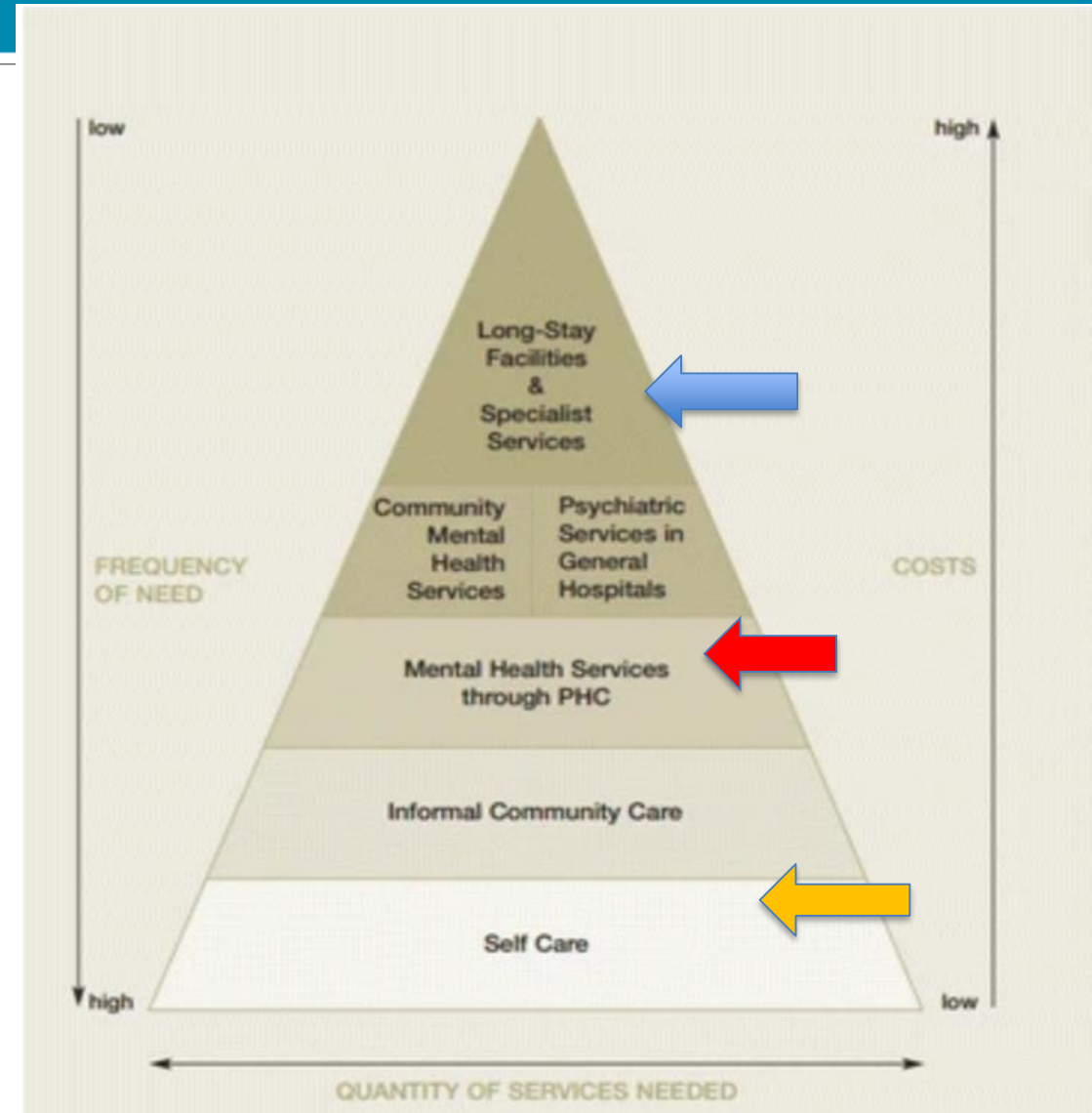- Response to the Opioid Crisis

Essential Mental Health and SUD Treatment Services Pyramid-Transdiagnostic Paradigm- Linked Platforms

☐ *WHO Service Organization Pyramid* for optimal mix of services for mental health (WHO, 2003)

☐ 3 interlinked systems/platforms of care:
- Self-care/Informal Health Care
- Primary Care
- Specialist Health Care

☐ No single service delivery platform can meet all mental health needs

☐ Each platform is an **essential component** of care

World Health Organization service organization pyramid for an optimal mix of mental health services. *Source*: [Organization of Services for Mental Health: Mental Health Policy and Service Guidance Package. Geneva: WHO, 2003.](Shidhaye R, Lund C, Chisholm D et al 2015)

Essential Interlinked Treatment Platforms to Deliver Necessary Components of Care for MH/SUDs

Self Care/Informal Care

- Self: Wellness practices – mindfulness; yoga; exercise; stress relief
- Informal: providers not part of the formal system – peers, traditional healers, family associations, faith based, peer-led education and supports, recovery coaches
- Builds mental health literacy: recognition of signs and symptoms
- Patient self-management

Primary Health Care

- Fundamental component of care
- First level of care within the formal system
- Usually more accessible, affordable, and acceptable for individuals, families and communities
- MH/SUD services more likely integrated with medical issues
- Collaborative/stepped care approach

Psychiatry/Addiction Services

- General hospital psychiatry units – well staffed with trained providers
- Specialty mental health & addiction programs/hospitals
- Community mental health centers, community addiction treatment programs, opioid treatment programs,
- Residential, partial hospital, outpatient for MH/SUDs

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Best Practices and **Barriers** to SUD & OUD Treatment Initiation & Engagement – Study of high performing health plans

What are the models of care & best practices in higher performing health plans for treatment initiation and engagement for SUD/OUD?

- Quantitative analysis of characteristics of health plans that scored high on SUD and OUD treatment initiation & engagement as defined by the NCQA
- 321 SUD health plans with Mean 50,585 beneficiaries and 82 OUD plans with mean of 92,521 beneficiaries
- Qualitative interviews with representatives of 6 plans (1 commercial and 5 Medicaid plans)
- <u>High performing plans were associated with higher rates of outpatient, intensive outpatient and partial hospital visits</u>

(O'Brien P, Crable E, Fullerton C, Hughey L. 2019 2013 and 2014 Truven Health MarketScan Commercial Claims & Encounters Research Database analysis of initiation and engagement rates for SUD and OUD treatment)

Evidence: **Best Practices** and Barriers to SUD/OUD Treatment Initiation & Engagement– Studies of high performing health plans

Plans with higher rates of engagement and initiation –common themes:

- Care models focused on care coordination including physical, mental, behavioral, substance use specific services
- Benefit design – no prior authorization for outpatient treatment and medication for OUD; coverage for at least two MAT options and for naloxone; Medicaid plans had no out of pocket costs for covered services
- Open communications including secure electronic messaging among providers and beneficiaries; outreach teams trained on effective communications

(O'Brien et al, 2019)

Evidence: Best Practices and **Barriers** to SUD/OUD Treatment Initiation & Engagement – Studies of high performing health plans

- Lack of Medicaid reimbursement for residential treatment, peer and recovery support
- Network inadequacy for SUD treatment services
- Lack of buprenorphine prescribers and prescribers taking Medicaid
- Lack of residential beds
- Low reimbursement rates limited plans' abilities to recruit providers and expand network capacity
- Stigma: Barrier to treatment initiation among patients and families and provider stigma to treating patients
- Provider lack of information about what to do
- Members have competing needs including child care, housing, accessing treatment for comorbid physical and other mental health conditions
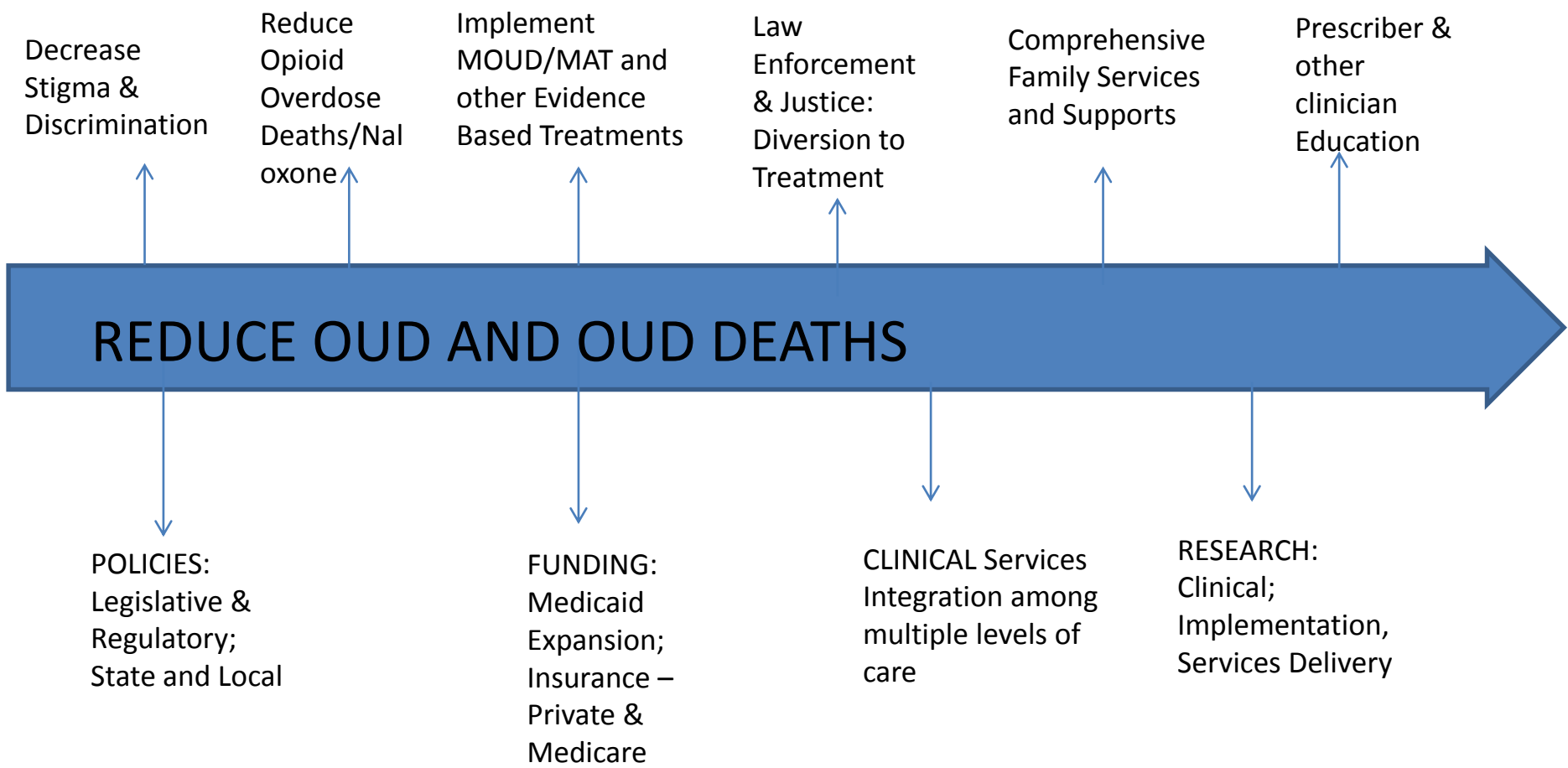
(O'Brien et al, 2019)

Best Practices and Barriers to SUD/OUD Treatment – Studies of high performing health plans: **Potential Solutions**

- Expand treatment options to **cover the care continuum** can help provide access to care when needed and at the level most relevant to patient – remove obstacles to access to all levels of care (prior authorization; waivers for residential care)

- Provide mechanisms to pay for care coordination & management and cross-system integration to ↑ SUD treatment initiation and engagement

- Address needs that interfere with engagement and gender differences (housing, childcare, economic disparities)

- Address workforce shortages – adequacy of reimbursement is one barrier

- Address provider stigma

- Incentivize providers through reimbursement that is reasonable so they can be brought into payer networks (O'Brien et al, 2019)

Lessons from the Opioid Use Disorder Epidemic: Treatment Approaches, Necessary Components of Care & Evidence Based Policy

Decrease Stigma & Discrimination

Reduce Opioid Overdose Deaths/Naloxone

Implement MOUD/MAT and other Evidence Based Treatments

Law Enforcement & Justice: Diversion to Treatment

Comprehensive Family Services and Supports

Prescriber & other clinician Education

REDUCE OUD AND OUD DEATHS

POLICIES: Legislative & Regulatory; State and Local

FUNDING: Medicaid Expansion; Insurance – Private & Medicare

CLINICAL Services Integration among multiple levels of care

RESEARCH: Clinical; Implementation, Services Delivery

Greenfield SF, presented at Responses to the Opioid Epidemic: Innovating Policy to Enhance Treatment and Community Response, Boston, MA, March 2, 2018

Strategies to deliver necessary components of MH/SUD Care – Push All Available Policy Levers at Once

- Incentivize the workforce to see patients in multiple settings for screening, assessment, referral, and treatment
- Build capacity through training
- Provide access to levels of care in all of the necessary delivery platforms
- Acknowledge multiple co-occurring disorders and build in mechanisms and incentives for identification and treatment
- Utilize technology to address wide gaps in care and in training
- Model/assess outcomes across multiple sectors prospectively and longitudinally
- Address the stigma barrier – by society, clinicians, as well as self-stigma
- Restructure payment systems to achieve these goals

Pressing Available Levers – Payment Reforms

- Incentivize physicians and other providers through payments – increase individual provider payments for needed services (e.g., Screening/Diagnosis/Assessments/Smoking Cessation Treatment/Medications for OUD/SBIRT for alcohol/Medications for AUD/Co-occurring disorders assessments, among others)

- Restructure/reform payment system to hospitals and health systems to incentivize achievement of desired outcomes (e.g., ↑addiction trained providers per capita population served within health plan/system; addition of SUD/OUD treatment services integrated vertically through system; establish linkages with community and/or specialty care providers, access to residential care, other services integration necessary to provide linkage for provision of care for mental health inclusive of substance use disorder treatment, etc.)

- Changes in Medicare and Medicaid programs to accomplish these goals

- Stable, reliable and predictable funding base for a coherent system of care

Pressing Available Levers – Training

Require training at all levels of physician education and training:

- Medical student training
- Graduate medical education across all specialties – changes to ACGME requirements
- Post-graduate training perhaps tied to credentialing – state or federal
- Incentivize specialty training through loan repayment programs
- Mentoring for transitioning knowledge to practice
- Use technology assists for training

Require training in all disciplines (nursing, psychology, social work, pharmacy, physician assistants, among others)
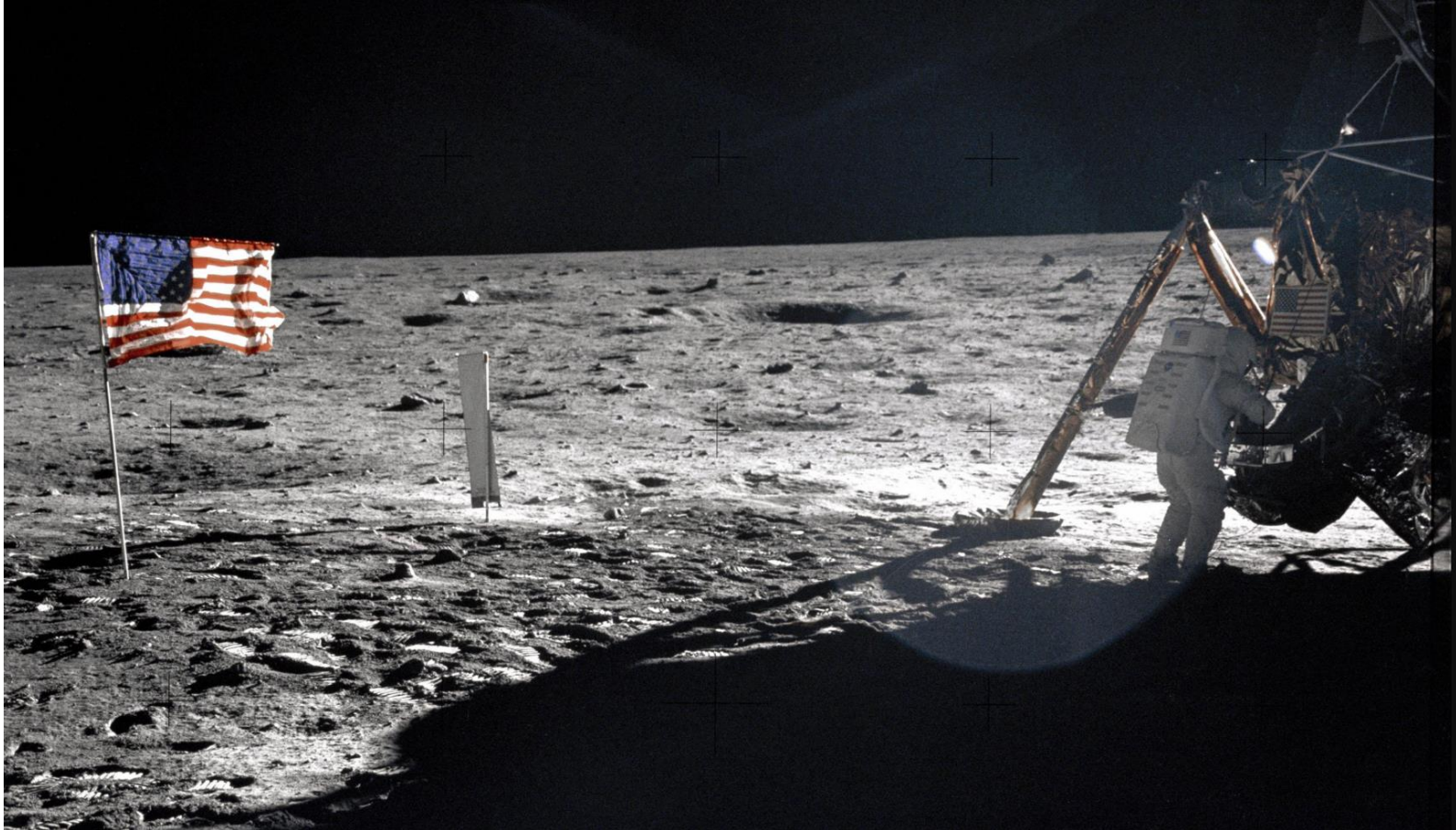
Summary – Closing the Gap

- Opioid crisis is superimposed on longstanding pre-existing failures to provide necessary treatment for substance use and other mental disorders in the U.S.

- Response to opioid crisis demonstrates the need for linked multi-level formal and informal service delivery platforms as well as supports in other services sectors

- WHO integrated, linked services pyramid provides one model

- Evidence-based treatments can be delivered at each level of treatment delivery platforms – but ALL are necessary inter-related, linked components of care

- Solutions require a multilevel, integrated health system <u>and</u> a workforce trained to provide treatment

- Combinations of policies at federal and state levels including payment systems & incentivized clinician training and education will be necessary to provide essential treatment for substance use and other mental disorders and eliminate this vast health care disparity in the U.S.

Providing necessary care for MH/SUD in the United States in 2019

1969: Apollo 11 Moon Landing – Where there is a will, there can be strategies effectively implemented across linked multiple service platforms to close this pressing health care disparity

THANK YOU!

McLean Hospital

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World Health Organization service organization pyramid for an optimal mix of mental health services. *Source*: [Organization of Services for Mental Health: Mental Health Policy and Service Guidance Package. Geneva: WHO, 2003.]

Appendix Slides

Evidence Based Strategies to prevent opioid overdoses

1. Reduce Stigma and Discrimination
2. Decrease opioid poisonings and opioid poisoning deaths
3. Expand of MAT and other Evidence Based Treatments
4. Law Enforcement and Criminal Justice: Diversion to Treatment
5. Comprehensive Family Services and Support
6. Prescriber Education

Greenfield SF, presented at Responses to the Opioid Epidemic: Innovating Policy
to Enhance Treatment and Community Response, Boston, MA, Oct 2, 2018

Evidence Based Strategies to prevent opioid overdoses

1. Reduce Stigma and Discrimination
   - Universal Screening – all health care settings
   - Public Education – Many modalities
   - Workforce Training
2. . Decrease opioid poisonings and opioid poisoning deaths
   - ↑Naloxone availability
   - ↑First responder naloxone training
   - ↑Potency of naloxone for synthetics (e.g., fentanyl)
   - ↑Screening and identification of opioid misuse and earlier intervention (prevention of opioid poisonings)
   - ↑Screening for suicidal ideation + intervention
   - ↑Treatment of co-occurring depression, PTSD, anxiety

Evidence Based Strategies to prevent opioid overdoses

3. Expansion of MAT and other Evidence Based Treatments
- ↓ Implementation Barriers
- Expanded Insurance (Medicaid) and Funding
- ↑ Workforce (Training for physicians, PAs NPs)
- Integration of Care across/within Service Delivery Sites
- Expand access to agonist treatment + comprehensive care for pregnant mothers and their infants and children (stable housing)
- Utilize Evidence Based Approaches (e.g., Hub and Spoke)
- Co-occurring psychiatric disorders/ medical disorders
- Increase care coordination and integration
- Team-based care and case management
- License programs using MAT and other EBTs

(Greenfield SF, presented at Responses to the Opioid Epidemic: Innovating Policy to EnhanceTreatment and Community Response, Boston, MA, Oct 2, 2018)

Evidence Based Strategies to prevent opioid overdoses

4. Law Enforcement and Criminal Justice
   - Diversion to treatment using MAT
   - Increase access across country

5. Comprehensive Family Services and Support
   - Through the spectrum of addiction, treatment and recovery
   - For children, parents, grandparents
   - Involves multiple agencies

6. Prescriber Education
   - Limits on first-time prescribing duration
   - Education of all prescribers
   - Use of PDMPs and PDMPs across state lines

(Greenfield SF, presented at Responses to the Opioid Epidemic: Innovating Policy to Enhance Treatment and Community Response, Boston, MA, Oct 2, 2018)

Evidence-based Strategies: Preventing Opioid Overdose – CDC summary 2018

- Collaboration and open communication
- Enhance access to treatment based on level of readiness to engage
- Wide distribution of naloxone including to patients & family members, and in criminal justice (CJ) & treatment settings
- Increase access to MOUD + ancillary services including in CJ settings
- "Academic Detailing" – market (teach) evidence-based practices to generalist physicians and other practitioners
- Eliminate prior-authorization requirements for MOUD
- Screen for fentanyl in routine toxicology testing
- Extend immunity to bystanders (Good Samaritan) & increase awareness of these laws
- Initiate buprenorphine in Emergency Departments
- Syringe services provide multiple potential intervention opportunities

(Carroll JJ, Green TC, Noonan RK, Evidence-based Strategies for prevention opioid overdose, CDC, 2018)