

TREATING OPIOID ADDICTION

The Role of Integrated Behavioral Health

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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)

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

OPIOID USE DISORDER



of individuals
do not receive
treatment for
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MAT decreases

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HIV and hepatitis C

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

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

decreases

costly emergency and inpatient services

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to introduce patients to an on-site behavioral health clinician, primary care providers are less likely to ask about drug abuse

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 waived 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

treatment of other physical
and mental health conditions

**improves substance
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receiving indicated psychiatric medications

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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 waived 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

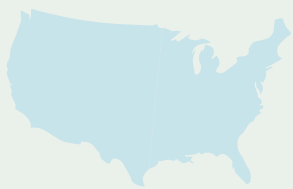
BRIGHT SPOT

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 waived to prescribe buprenorphine in the state.³⁴

treatment are often lengthier; stigma may be a greater barrier in small communities; and there is less availability of waived 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



MEDICAID PROGRAMS

in 48 states

require prior authorization
for buprenorphine

in 11 states

have lifetime treatment
limits of 1-3 years

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 waived 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

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.	<p>Require provision of training on opioid use disorder treatment in health professions schools and training programs, including primary care residency programs.</p> <p>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</p> <p>Require access to MAT in criminal justice facilities and coordination of continued treatment on release.</p>
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.	<p>Remove any coverage limitations or prior authorization requirements for MAT, including both pharmacologic and psychosocial components of treatment.</p> <p>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.</p> <p>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.</p> <p>Provide additional reimbursement or other financial incentives for appropriate initiation of treatment and referral to outpatient services from emergency departments and hospitals.</p>
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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