Good Morning Participants:

On behalf of the Behavioral Health Provider Coalition of Cape Cod & the Islands (BHPCCCI), we would like to welcome you to our 2nd Annual Behavioral Health Summit. In October of 2013, a small group of dedicated behavioral health providers and consumers representing local agencies organized the first behavioral health summit on Cape Cod to 250 providers in our community including physicians, nurse practitioners, psychologists, social workers, and behavioral health peers. The outcome of our summit was the creation of the Behavioral Health Provider Coalition of Cape Cod & the Islands (BHPCCCI) comprised of 30 organizations on Cape Cod & the Islands whose primary purpose is to facilitate opportunities for networking, communication, and sharing of knowledge between service providers in order to support an integrated and cohesive system of behavioral healthcare for residents in our community.

We are pleased to once again offer a full day Behavioral Health Summit "Building Bridges to Recovery" at the Hyannis Resort and Conference Center. Our objective at this year's summit is simple: to provide an educational opportunity to promote best-practice models in treating patients with co-occurring disorders in a diverse behavioral healthcare system. We are proud to be part of a community promoting awareness and activism that will benefit our most vulnerable patients. As we move forward, we will continue to provide opportunities to promote awareness of behavioral health needs on Cape Cod and the Islands and if you would like to participate and/or become a member of the BHPCCCI, please visit our website at www.bhpccapecod.org.

In addition, we are honored and grateful to have the support and commitment of financial sponsorship in our community as we can continue to promote greater dialogue and behavioral health education. Because of their generosity in making our Behavioral Health Summit a success, we would like to take this opportunity to thank our sponsors:

- Cape Cod Five Cents Savings Bank Charitable Foundation
- Cape Cod Healthcare
- Duffy Health Center
- Gosnold on Cape Cod
- Peter and Elizabeth C. Tower Foundation

If you have any questions, please feel free to contact our Chair/Co-Chair of our BHPCCI for further information and we hope you enjoy our summit program.

Respectfully,

Diane Wolsieffer, APRN, Cape Cod Hospital
Ron Holmes, Executive Director, NAMI Cape Cod & Islands
Chair/Co-Chair, Behavioral Health Provider Coalition of Cape Cod & the Islands

Summit Schedule - Friday, October 3rd

8:00 am to 8:30 am – Registration

8:30 am to 9:00 am – Welcome and Overview of Day

Ron Holmes, Executive Director – Sponsorship Introductions and Overview of the Day
NAMI Cape Cod & Islands

Raymond V. Tamasi, President and CEO – Welcome and Speaker Introductions
Gosnold on Cape Cod

9:00 am to 10:15 am – "Developments in the Integration of Behavioral Health and Primary Care"

Alexander Blount, Ed D
Professor of Family Medicine and Psychiatry, University of Massachusetts Medical School
Director, Center for Integrated Primary Care
Director of Behavioral Science, Department of Family Medicine and Community Health

10:15 am to 10:30 am – Break

10: 30 am to 11:45 am – "Update on Treatment of Co-occurring Substance Use Disorders"

Robert E. Drake, MD, PhD
Andrew Thompson Professor of Psychiatry
Professor of Community and Family Medicine, Dartmouth Medical School
Director, Dartmouth Psychiatric Research Center

11:45 am to 12:00 pm – Review of Break-Out Focus Groups

12:15 pm to 1:15pm – Lunch

1:30 pm to 2:45 pm – Focus Group Break-Out Sessions

1. Facilitator - Emma Barton, LMHC "Why Mindfulness Matters in Substance Abuse Recovery"
2. Facilitator – Raymond V. Tamasi, President and CEO, Gosnold on Cape Cod, "Panel Discussion: Perspectives in Withdrawal and Symptom Management"
3. Facilitator - Vaira Harik, Senior Project Manager, Barnstable County Department of Human Services "Setting Program Priorities in a Data Driven World: A Public Health Approach"

3:00 pm to 4:15 pm – "The Game Has Changed"

Christopher Herren, Founder
The Herren Project

4:15 pm to 4:30 pm - Closing

Diane Wolsieffer, APRN, Cape Cod Hospital
Ron Holmes, Executive Director, NAMI Cape Cod & Islands
Chair/Co-Chair, Behavioral Health Provider Coalition of Cape Cod & the Islands

Focus Group #1 – 1:15pm

"Why Mindfulness Matters in Substance Abuse" – Osterville Conference Room

An interactive demonstration on body-based movement interventions for substance abuse treatment presented by Emma Barton, LMHC

Emma Barton, MA, LMHC, BC-DMT, E-RYT is a board certified dance/movement therapist and a licensed mental health counselor. Prior to completing her Master of Arts in Dance/Movement Therapy and Counseling at Columbia College Chicago, Emma spent eleven years in Asia studying and teaching yoga as a healing modality and professionally practicing yoga therapy for several years. Upon completing her Masters, Emma designed and implemented several effective social service programs incorporating the skills of yoga therapy, dance/movement therapy and the Eastern concept of mindfulness. She has worked extensively in dually diagnosed/substance use disorders, trauma recovery, and severe mental illness and currently has a private practice in Newton, Massachusetts. Emma is an Albert Schweitzer Fellow and the recipient of multiple awards and scholarships, including the Marian Chace Foundation Award for Journalism. Her writing on this topic can be found on www.AddictionHope.com and in the American Journal of Dance Therapy. For more information about Emma's presentation, please watch her video at *http://www.youtube.com/watch?v=b1YryiseVWY*

Focus Group #2 – 1:15pm

"Panel Discussion: Perspectives in Withdrawal & Symptom Management" – Orleans Conference Room

Panel discussion facilitated by Raymond Tamasi, President/CEO, Gosnold on Cape Cod

A panel discussion by community physicians to discuss best practice protocols for evaluating, treating and/or referring addiction/withdrawal and symptom management in an outpatient basis and when to recognize the need for more critical treatment such as, hospitalization. Panel participants include Domenic Ciraulo, MD, Psychiatrist-in-Chief, Boston Medical Center; Margaret Shapiro, BSN, RN, Director of Nursing, Gosnold on Cape Cod; Nathan Rudman, MD, Emergency Physician, Cape Cod Hospital and Jean Talbert, MD, OB/GYN, Cape Cod Healthcare.

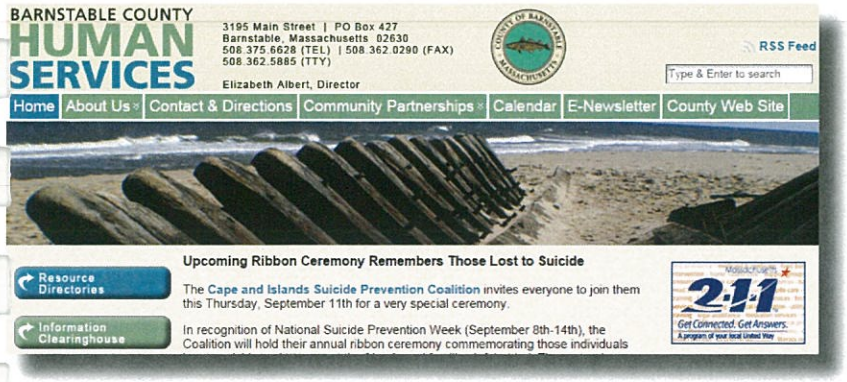
Focus Group #3 – 1:15pm

"Setting Program Priorities in a Data Driven World: A Public Health Approach" – Centerville Conference Room

Presented by Vaira Harik, Senior Project Manager, Barnstable County Human Services

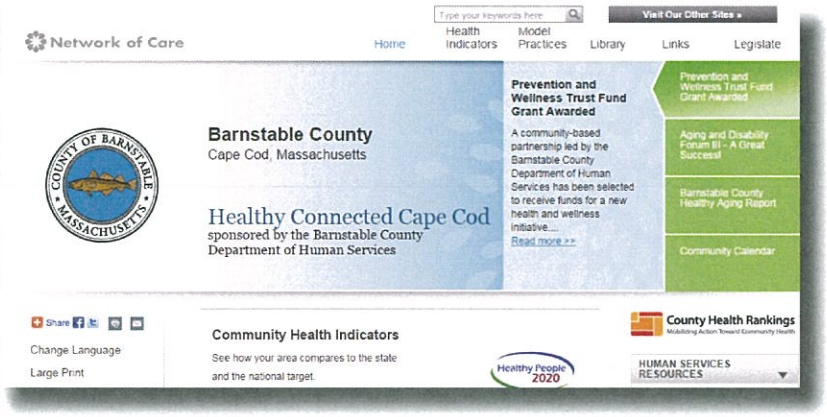
Join the staff of the Barnstable County Department of Human Services as they examine a preliminary report to the community developed by the Barnstable County Regional Substance Abuse Council. This interactive workshop, complete with group work and priority assessment activities, will explore a coordinated and comprehensive approach to substance abuse across the continuum of prevention, treatment, criminal justice, and recovery. Using Cape-related data and highlighting the new Behavioral Health website portal, we will discuss potential advocacy and policy alternatives for our region.

The Barnstable County Department of Human Services is proud to present three websites to serve Cape Cod because a connected community is a healthy community



BCHumanServices.net

The Department's flagship website features up-to-date announcements, information from our community partners, and the Department's bimonthly e-newsletter highlighting upcoming community events



Barnstable.MA.NetworkOfCare.org/ph

The first of its kind in Massachusetts, the Department's Public Health portal provides an overview of our region's health via an array of Health Indicators at the local, state, and national levels

Barnstable.MA.NetworkOfCare.org/mh

The newest member of the Department's online family, the Behavioral Health portal features comprehensive information about behavioral health services in our region, including state and federal legislation updates, tailored self-help information, and a robust Service Directory

For more information, please contact:

Beth Albert, Director
Barnstable County Human Services
balbert@BarnstableCounty.org
508-375-6626

BARNSTABLE COUNTY
DEPARTMENT OF HUMAN SERVICES
POST OFFICE BOX 427
BARNSTABLE, MASSACHUSETTS 02630

Main Office (508) 375-6628 FAX (508) 362-0290 TDD (508) 362-5885

For more information contact:
Elizabeth Albert, Director
508-375-6626
balbert@barnstablecounty.org

FOR IMMEDIATE RELEASE

Barnstable County Human Services Launches Behavioral Health Website and Service Directory

September 22, 2014 – The Barnstable County Department of Human Services is pleased to announce the launch of a new Behavioral Health Website and Service Directory.

"The Barnstable County Behavioral Health website provides much-needed information about behavioral health services in our region in a centralized and comprehensive way," said Beth Albert, Director of the Barnstable County Department of Human Services.

"According to the Pew Research Internet Project, more than 61% of adults use the internet for health information and health decision making." Albert added, "So we are very pleased to be the first county in Massachusetts to bring this dynamic web-based tool to our region. It not only connects people in need with agencies who provide services and supports, but it also allows community members to stay up-to-date on key behavioral health topics, legislation at the state and federal levels, and offers tailored self-help information."

Key features of the website include:

- Comprehensive Service Directory that enables consumers to easily locate the local programs and services they need most;
- Quick reference to all local emergency and crisis intervention programs in the area;
- Access to more than 30,000 articles, fact sheets, and interactive tools; and
- Up-to-date information on the latest developments in behavioral health via an online learning center, daily nationwide news updates, advocacy tools, and state and federal legislation tracking.

The Department will demonstrate the website for the Barnstable County Commissioners at 10:15 a.m. this Wednesday, September 24th in the Superior Courthouse Rooms 11/12. The website will also be featured at the upcoming second annual Behavioral Health Summit on October 3rd in Hyannis.

Visit the Barnstable County Behavioral Health Website and Service Directory at:
http://barnstable.ma.networkofcare.org/mh

BARNSTABLE COUNTY
DEPARTMENT OF HUMAN SERVICES
POST OFFICE BOX 427
BARNSTABLE, MASSACHUSETTS 02630

Main Office (508) 375-6628 FAX (508) 362-0290 TDD (508) 362-5885

About the Barnstable County Department of Human Services:

The mission of the Barnstable County Department of Human Services is to plan, develop, and implement programs which enhance the overall delivery of human services in Barnstable County, and to promote the health and social well-being of County residents through regional efforts designed to improve coordination of human services and to strengthen the fabric of community care available to all.

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Dr. Alexander Blount

Alexander Blount, Ed.D. is Director of the Center for Integrated Primary Care, Professor of Family Medicine and Community Health and Psychiatry at the University of Massachusetts Medical School in Worcester, MA, and the Director of Behavioral Science. He teaches physicians the psychosocial skills of primary care practice and established the post-doctoral Fellowship in Clinical Health Psychology in Primary Care. He is a member of the National Integration Academy Committee of the National Academy for Integrating Mental Health and Primary Care sponsored by the U.S. Agency for Health Research and Quality. Through the National Academy, he serves on the Integration Quality Measures committee and Chairs the Workforce Committee. His books include *Integrated Primary Care: The Future of Medical and Mental Health Collaboration*, published by W. W. Norton and *Knowledge Acquisition*, written with James Brule', published by McGraw-Hill. He is Past President of the Collaborative Family Healthcare Association, a national multidisciplinary organization promoting the inclusion of mental health services in medical settings and he is Editor of *Families, Systems and Health*, a the Journal of Collaborative Family Healthcare.

Primary Care in Behavioral Health

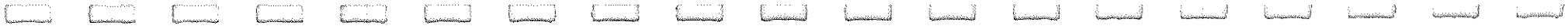
Integrating care is vital to addressing all the healthcare needs of individuals with mental health and substance use problems—regardless of whether primary care services are integrated into behavioral health systems, or vice versa. Many integrated care models illustrate the successful integration of primary care into behavioral healthcare, and can guide behavioral healthcare organizations in integrating primary care into their own service system.

Abstract: People with mental and substance abuse disorders may die decades earlier than the average person

People with mental and substance abuse disorders may die decades earlier than the average person — mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance abuse. Barriers to primary care — coupled with challenges in navigating complex healthcare systems — have been a major obstacle to care.

At the same time, primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general healthcare needs.

The solution lies in integrated care, the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.



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The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence

Alexander Blount
University of Massachusetts Medical School

Michael Schoenbaum
RAND Corporation

Roger Kathol
University of Minnesota Medical School

Bruce L. Rollman
University of Pittsburgh

Marshall Thomas
Colorado Access and University of Colorado Hospital

William O'Donohue
University of Nevada at Reno

C. J. Peek
St. Paul, Minnesota

The health care system in the United States, plagued by spiraling costs, unequal access, and uneven quality, can find its best chance of improving the health of the population through the improvement of behavioral health services. It is in this area that the largest potential payoff in reduction of morbidity and mortality and increased cost-effectiveness of care can be found. A review of the evidence shows that many forms of behavioral health services, particularly when delivered as part of primary medical care, can be central to such an improvement. The evidence supports many but not all behavioral health services when delivered in settings in which people will accept these services under particular administrative and fiscal structures.

Keywords: economics, cost offset, behavioral health, psychology, medical settings

ALEXANDER BLOUNT received his EdD in counseling from the University of Massachusetts at Amherst. He is professor of clinical family medicine at the University of Massachusetts Medical School and director of behavioral science in the Department of Family Medicine and Community Health. He is chair of the Collaborative Family Healthcare Association. His areas of professional interest include the integration of behavioral health services into primary care settings and the training of primary care psychologists and family medicine residents.

MICHAEL SCHOENBAUM received his PhD in economics from the University of Michigan. He is a researcher for the RAND Corporation. His interests include analyses of the Palestinian health system, identification of policy options for improving clinical performance and economic viability in health care, economic analyses for national trials to improve care for depression, and Web-based modeling and decision-support tools to help consumers make health benefits choices.

ROGER KATHOL received his MD from the University of Kansas School of Medicine. He completed an internship in internal medicine at Good Samaritan Hospital in Phoenix, Arizona; residencies in psychiatry and internal medicine at the University of Iowa in Iowa City; and a year of endocrinology fellowship in Wellington, New Zealand. He is adjunct professor of internal medicine and psychiatry at the University of Minnesota Medical School. He has extensive experience in the integration of general medical and behavioral health care. He has international expertise in the development and operation of cross-disciplinary programs and services for clinics and hospitals; health plans; software vendors; case, disease, and disability management organizations; employee assistance programs; and employers.

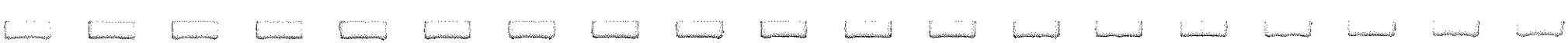
BRUCE L. ROLLMAN received his MD from Jefferson Medical School and his MPH from Johns Hopkins Medical School. He is an associate professor of medicine and psychiatry at the Center for Research on Health Care at the University of Pittsburgh. He is involved with the planning and implementation of clinical trials to improve the quality of treatment for depression and anxiety disorders in primary care settings and for patients with cardiac disease and other comorbid medical conditions. He also leads a team of health services researchers as part of a national Robert Wood Johnson Foundation Program to develop a financially sustainable model for treating depression in primary care.

MARSHALL THOMAS received his MD from Baylor Medical School. He is vice president of medical services and chief medical officer for Colorado Access, Denver, Colorado. He is also vice chairman of psychiatry at the University of Colorado Health Sciences Center Department of Psychiatry and medical director of the University of Colorado Hospital Psychiatric Services. His interests include integrated psychiatric and general medical care, implementation of chronic care models and evidence-based medical practice, mood disorders, and psychopharmacology.

WILLIAM O'DONOHUE received his PhD from the State University of New York at Stony Brook. He is Nicholas Cummings Professor of Organized Behavioral Healthcare Delivery and honorary associate professor of philosophy at the University of Nevada at Reno. He is director of the university's Victims of Crimes Treatment Center and also of its Sexual Assault Prevention and Counseling Services.

C. J. PEEK earned his PhD in clinical psychology at the University of Colorado. He is a consulting psychologist with 25 years of clinical, managerial, and organization development experience in large health care systems, including the integration of biomedical and behavioral health care, patient–clinician communication, and productive conversations across disciplines and organizational areas. He presents regularly on the integration of mental health and medical care and other topics that blend clinical, organizational, and leadership perspectives.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Alexander Blount, Department of Family Medicine and Community Health, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655. E-mail: blounta@ummhc.org



It is in the area of behavioral health that the U.S. health care system could find the largest potential payoff in reduction of morbidity and mortality and the largest increase in the cost-effectiveness of care. (For a discussion of the use of terms such as *behavioral health* and *mental health,* see the Appendix.) The most prominent contributors to premature death are tobacco use, diet and activity patterns, alcohol abuse, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles, and illicit drug use (McGinnis & Foege, 1993). These factors account for about half of all deaths. Of these, individual behavior plays a major role in 86% of these deaths, or 43% of all deaths (McGinnis & Foege, 1993). These factors are commonly, but not always effectively, addressed in primary medical care. Primary care is also the de facto mental health service system for 70% of the population (Regier et al., 1993). It seems to make sense to add behavioral health staff to the primary care team to help physicians meet these identified needs. The crisis in health care costs makes it necessary to show that the introduction of collaborating behavioral health staff at least increases effectiveness of care and may save costs overall. In the past 15 years, randomized controlled trials have been conducted and models developed that allow us to have some confidence in describing how this might be done.

The history of the managed care era is largely a history of attempts to control the supply of health care. The system has controlled the supply of care by denying hospital days, by creating incentives for physicians to use less expensive medications over more expensive ones, by limiting tests, and by controlling access through the use of preferred providers. All of these measures contained costs at first but now have proven to be failures in the marketplace. Costs are rising again. The evidence suggests that if the system meets patients' needs more precisely by addressing the presently unmet behavioral health needs people bring to primary care, the best area for new cost savings may be available. This may provide an alternative to simply asking providers to do more, faster, and for less: a strategy bound to have disastrous effects on the quality of the workforce and care in the long term.

The purpose of this article is to summarize the evidence about the economic value of behavioral health care, especially in primary medical settings; to recount the history of this kind of study; and to describe some of the clinical, administrative, and financial implications of this evidence. Additional articles in the Health Care for the Whole Person series are "Benefits of Comprehensive Health Care for Improving Health Outcomes in Women" (Jarrett, Yee, & Banks, 2007), "Health Care for the Whole Person: Research Update" (Kaslow et al., 2007), and "A Rural Perspective on Health Care for the Whole Person" (Stamm, Lambert, Piland, & Speck, 2007).

People and Institutions Viewed as Established Voices in This Area

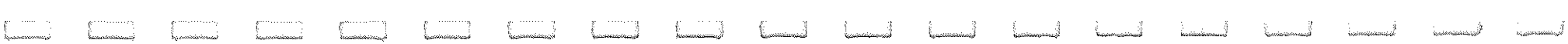
The term *medical cost offset* was coined by Cummings, Dorken, Pallak, and Henke (1990). In the 1980s, they were the first to put forward the idea that mental health treatment could be used programmatically to reduce medical costs in a way that would more than pay for the cost of the mental health treatment. The emergence of systems-based brief therapy in the 1970s in works such as *Problem Solving Therapy*, by Jay Haley (1977), and *Change: Principles of Problem Formation and Problem Resolution*, by Watzlawick, Weakland, and Fisch (1974), provided an opportunity for cost savings that had not seemed possible under the hegemony of the long-term psychoanalytic approaches that were practiced by most psychotherapists.[1] Cummings et al. began targeting people who had chronic medical illnesses for referral to these services even if they had not requested psychotherapy. Initial positive results in California led to the Hawaii Project, in which the entire Medicaid population of Oahu and subscribers to the government health insurance plan on the island became the first large implementation and test of the cost-offset thesis. After randomization, the cost reductions were 38% for Medicaid patients who were not chronically ill, 18% for Medicaid patients who were chronically ill, 35% for "employed" patients (the project's term for patients on group health insurance through an employer) who were not chronically ill, 31% for employed patients who were chronically ill, and 15% for Medicaid patients who had substance abuse diagnoses (Cummings et al., 1990).

Evidence of the effect of bringing behavioral health care into large health systems has tended to arise only when there have been HMO-based health systems that used both physicians and mental health professionals in the same organization. The most productive center for the study of mental health problems in primary care and the development of programs to address them has been collaboration between the University of Washington and Group Health of Puget Sound in Seattle. Wayne Katon is the leader of a team that includes Gregory Simon, Jurgen Unützer, Elizabeth Lin, Michael von Korff, and Patricia Robinson. These researchers have provided 20 years of studies that have formed the foundation of evidence on the clinical effectiveness and cost impact of behavioral health interventions in primary care. Their watershed article documenting the effectiveness of collaborative care for treating depression in primary care was published in 1995 (Katon et al., 1995). An eloquent spokesman for integrating behavioral health into primary care, including articulating the cost savings and the clinical impact, has been Kirk Strosahl. Strosahl worked in both Group Health of Puget Sound and the Kaiser Permanente system in northern California (see Strosahl, 2002).

Core Findings From the Evidence

The majority of visits in primary care are related to behavioral health needs but not to identified mental health disorders. Kroenke and Mangelsdorff (1989) reported that fewer than 20% of patient visits to primary care physicians are for symptoms with discoverable organic causes and that 10% are clearly psychological in nature. That leaves the vast majority of patient visits with no discoverable organic pathology found yet occurring because of physical complaints. The 10 most common presenting symptoms are chest pain, fatigue, dizziness, headache, edema, back pain, dyspnea, insomnia, abdominal pain, and numbness. These complaints account for 40% of all visits, and of patients with these complaints, only 10%–15% were determined, after a year of study, to have an organic diagnosis (Kroenke & Mangelsdorff, 1989).

[1] Using many similar techniques, cognitive–behavioral therapy eventually gained ascendancy over other brief therapies through its attention to developing evidence to support its clinical effectiveness and its adaptability to patient education.



About 75% of patients with depression present physical complaints as the reason they seek health care (Unützer, Schoenbaum, Druss, & Katon, 2006). People who might benefit from behavioral health services to relieve the problems they bring to their physician usually do not think that is what they need when they first come to the doctor. These same people are more likely to come to the doctor's office. The decision by a patient to go to the doctor is usually not related to how sick he or she is (Berkanovic, Telesky, & Reeder, 1981). A person who has a psychological disorder is much more likely to make a visit to a physician for a physical complaint than a similar person without a psychological disorder.

Better identification of behavioral health needs and better targeting of care to those needs, particularly via multidisciplinary collaborative care, lead to lowered overall medical cost in many cases and to more cost-effective treatment when properly designed. People with a diagnosis of depression have about twice the health care costs that people without the diagnosis have (Kathol et al., 2005; Simon, VonKorff, & Barlow, 2003). Randomized controlled trials have shown significant improvement in clinical effectiveness and cost-effectiveness of collaborative models when care managers are used over usual primary care (Lave, Frank, Schulberg, & Kamlet, 1998; Pyne et al., 2003; Schoenbaum et al., 2001; Simon et al., 2001). Some large studies have shown that collaborative care for depression can be cheaper than usual care (Katon et al., 1995). Collaborative protocols in primary care for panic disorder not only are cost-effective but more than offset their cost in savings on other health care (Katon, Roy-Byrne, Russo, & Cowley, 2002). A review of 91 studies found that in the presence of active behavioral health treatment, patients with diagnosed mental health disorders reduced their overall medical costs by 17%, whereas controls who did not get behavioral health care increased costs an average of 12.3%. Behavioral health intervention included crisis intervention, psychiatric consultation, brief psychotherapy, relaxation training, biofeedback, and education about emotions and symptoms (Chiles, Lambert, & Hatch, 1999).

There are a number of ways that behavioral health services can be provided in primary care that would not be considered mental health treatment. These are aimed at many of the behavioral problems brought to primary care that are not identified as mental health problems by patients. Some of these services have come to be called *health behavior coaching*. Reviewing the field in 1995, Friedman, Sobel, Myers, Caudill, and Benson identified seven pathways for better meeting patients' needs in medical settings through behavioral health means. All were found to yield overall cost savings. (Statements below not specifically cited are found in Friedman et al., 1995).

1. Proactive programs that teach patients what level of care they need and how to manage their own illness, both acute (e.g., fever) and chronic (e.g., arthritis), more than pay for themselves in lowered need for services (Kemper, Lorig, & Mettler, 1993).

2. Relaxation response methods taught to patients for conditions affected by stress, such as hypertension, save money by reducing the need for medication and doctor visits (Fahrion, Norris, Green, Green, & Schnar, 1987).

3. A change in unhealthy behavior, such as smoking, drinking, or overeating, works best when it is done through a program rather than through individual encounters with physicians (Black & Bruce, 1989). Highly intensive and expensive programs can pay off by saving a few very expensive procedures. Mutual of Omaha has reimbursed subscribers for expensive heart health programs, given that one bypass operation costs more than 10 times the program's cost. Much less intensive programs pay off by lowering general health care costs. Mailing personalized health risk reports to older patients along with suggestions for lifestyle modifications led to a 10%–20% reduction in health costs (Fries et al., 1993).

4. Targeted social support to patients facing very difficult medical situations, such as recovering from a heart attack or giving birth, can improve outcomes (fewer new heart attacks and fewer caesarian births) and save money (Frasure-Smith, 1991).

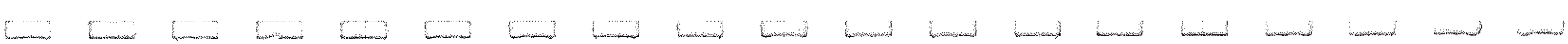
5. Patients with physical symptoms are much more likely to use emergency room services and other medical services when they have co-occurring mental disorders. Screening for mental disorders and providing treatment in populations with as diverse medical problems as chest pain and hip fracture more than pays for the mental health treatment, often by a factor of four or more (Strain et al., 1991).

6. People who experience and express the pain in their life as physical pain are very common. There are many cultural groups and demographic groups (children, older adults, and people with less education) for whom this is the norm. Physicians call them somatizers, although few meet criteria for a diagnosis of somatization disorder. Somatizers rarely accept a referral for mental health treatment, because they do not experience their pain as psychological in origin. Consultation by psychiatrists or other behavioral health practitioners to the primary care doctor and targeted programs for somatizers that are part of a primary care practice have been shown to pay for themselves and reduce overall medical costs (Hellman, Budd, Borysenko, McClelland, & Benson, 1990). These same programs greatly reduce frustration on the part of private care practitioners (PCPs).

7. Patients with chronic pain are very high utilizers of medical services, even though their encounters with physicians are often frustrating to both parties. Behavioral health services targeted to chronic pain patients reach enough people and make enough difference in reduced utilization of medical services to more than pay for the cost of the behavioral health services (Caudill, Schnable, Zuttermeister, Benson, & Friedman, 1991). Chronic disease self-management programs in the form of seven to eight small-group sessions focusing on building coping skills with common symptoms and emotions can lead to cost savings in medical care of $10 for every $1 spent (Lorig et al., 1999). The services also contribute to patient and provider satisfaction.

It appears that the better targeted the behavioral health intervention is to the needs of patients with specific medical conditions (by means of behavioral medicine, care management, or behavioral health integrated care), the more medical cost savings are realized. The more generic the behavioral health intervention (outpatient psychotherapy) is, the less medical cost savings are realized.

Behavioral medicine in medical settings shows cost offset, but psychotherapy in outpatient mental health settings has not reliably shown the same effect (Chiles et al., 1999; Fraser, 1996; Harvey et al., 1998). Care management by mental health providers (social workers, psychologists, or psychiatrically trained nurses) and consultation to physicians by psychiatrists or psychologists are the methods that currently have the most evidence supporting their effectiveness and cost-effectiveness (Pincus, Pechura, Keyser, Bachman, & Houtsinger, 2006).



The separation of funding streams into two separate worlds of medical and mental health services greatly impedes innovation in the development and implementation of targeted behavioral health programs in medical settings. Patients, providers, and health care economics all suffer when the design of the system (its interlocking clinical, operational, and financial aspects) is mismatched to the basic scientific and clinical realities it confronts daily. In the case of American health care, the design flaw is in the fact that the system operates as if biomedical and psychosocial were separate and parallel domains (Pincus et al., 2006). This problem has been described from within the field of medicine and without. Two of the most notable examples are George Engel's (1977) call for a biopsychosocial model and, more recently, the Institute of Medicine's (2005) *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.*

General medical health plans and government agencies commonly outsource mental health and behavioral care to restricted provider networks that are funded and administered separately from general medical care (behavioral "carve-outs"). Under our current carve-out system, more than 70% of those with mental health or substance abuse problems receive no treatment for those illnesses. Only a fifth of the 30% who are treated (6% of total need) receive what normally would be considered evidence-based care (Kessler et al., 2003; Narrow, Rae, Robins, & Regier, 2002). Independently managed behavioral health business practices prevent general medical and psychiatric service coordination.

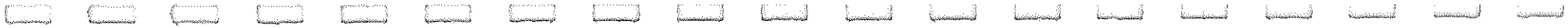
In short, the health care system is providing effective treatment to only a few of the patients who need it. In practice, this causes cost shifting of behavioral health service use from specialty services to general medical providers, who have limited expertise and little time flexibility for addressing behavioral issues. Recognizing these two interlocking problems is only half the battle. Presently, it is very difficult to improve the situation because of competing financial interests between behavioral health and general medical managed care organizations.

Low-income populations have significantly higher levels of behavioral health needs. Forty percent of adults whose low income qualified them for Medicaid in Colorado were identified as having a mental disorder. The presence of any mental health diagnosis increased total health care costs by a factor of 2.24. For members with bipolar and psychotic diagnoses, increased health plan costs were predominately due to increases in pharmacy and specialty mental health costs. In contrast, increased costs for members with depression, anxiety, or substance abuse were the result of increases in general medical services (Thomas, Waxmonsky, McGinnis, & Barry, 2006). Collaborative care appears to be particularly beneficial to people from ethnic minority groups, who tend to be less likely to use specialty mental health care. This makes collaborative care an important approach in reducing disparities in care among groups (Schoenbaum, Miranda, Sherbourne, Duan, & Wells, 2004).

The more broadly we account for the impact of behavioral health services in primary care, the greater the identified savings are, but the more difficult it is to document these savings rigorously. Employers have much to gain from collaborative care in both health premiums' cost savings and reduction of disability days (Broadhead, Blazeer, George, & Tse, 1990), yet usually only the costs of medical care are counted when the cost-effectiveness of care is being studied. Improved occupational functioning is one of the most immediate results of improvement from depression through treatment (Ormel et al., 1993). Depression is associated with an average of 4 to 5 lost work days per month in addition to any days lost to accompanying medical conditions. Underfunctioning ("presenteeism") as a result of depression can equal the same loss in productivity as 2.3 days absent per month (Wang et al., 2004). The monthly cost to an employer of an employee with depression is over $550, significantly greater than the monthly cost of evidence-based collaborative treatment in primary care. In fact, the estimated annual cost in lost productive time to employers is $44 billion (Stewart, Ricci, Chee, Hahn, & Morganstein, 2003). One study showed a marked savings in productive time when employee depression was improved. Patients with severe depression who improved reduced their disability days by 36%, and patients with moderate depression who improved reduced their disability days by 72% (von Korff, Ormel, Katon, & Lin, 1992).

Historically, employers have put the cost of disability and health insurance associated with depression in different categories. Some have developed employee assistance programs to provide in-house counseling for employees' problems with substance abuse, depression, or family problems. Substantial savings have been documented in studies of behavioral health services offered by employers through these kinds of employee assistance programs. A clear example was documented by the McDonnell-Douglas Corporation (1989). An independent company conducted a comprehensive longitudinal analysis over a period of 4 years of approximately 20,000 employees who were identified as having alcohol and drug problems or emotional problems. Employees who used the in-house counseling service lowered their health care and dependent health care costs. The users of counseling services showed 34%–44% decreases in absenteeism and had a 60%–80% lower attrition rate. The McDonnell-Douglas Corporation saved $4 in health costs, absenteeism, and attrition for every $1 spent on the in-house counseling. Yet there were many employees in the same situation who did not use the service. Today, millions of employees in other corporations do not have access to an in-house employee assistance program. Primary care is the venue in which problems such as depression, substance abuse, and family conflict can be first addressed and treated or referred. Primary care needs to be incorporated into an overall approach to dealing with emotional and substance abuse problems in the workplace.

Substance abuse services should always be a part of any plan to bring behavioral health services into medical settings, both because of the level of need presenting in medical settings and because of the overlap of substance abuse problems with medical and mental illnesses. The cost offset in treating substance abuse is a result of heading off the dramatic increase in health care costs that occurs as the illness becomes acute (Holder, 1998). When substance abuse services are integrated into primary care, the cost of treatment is about the same as when the services are provided separately for substance-abusing patients who do not have a substance abuse–related medical illness. For patients with medical illnesses related to substance abuse, the cost of integrated care is less than half the cost of separated care (Parthasarathy, Mertens, Moore, & Weisner, 2003). A significant percentage of people in treatment for alcohol abuse meet criteria for a diagnosis of major depression, and many people have their first major depressive episode after a period of alcohol or drug use (Lennox, Scott-Lennox, & Bohlig, 1993). People with combined alcohol abuse



and depression have significantly higher health care costs than those with only an alcohol abuse diagnosis, but the former are also more likely to seek treatment than the latter.

Recommendations

Merging funding streams so that all health care plans pay for medical and mental health care from the same pot of money is the long-term goal that would structurally align incentives for collaborative care (Goldberg, 1999; Pincus et al., 2006). This needs to be done in an environment in which people do not change coverage plans frequently. The movement between plans takes away the advantage of savings over the long term that can be realized if programs are better targeted to patient needs. It makes controlling the supply of care the only effective cost-control strategy. As the health insurance market matures, "carving in" behavioral health benefits—that is, reintegrating these benefits with medical benefits—is becoming more common. It is particularly important that Medicaid plans in the various states take the lead in this process.

Several influential leaders in health care, such as the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration (Smith, 2004), the American Academy of Family Physicians (Kahn, 2004), and the Institute of Medicine (2005), have formally recommended the inclusion of behavioral health practitioners (BHPs) on the primary care service team. Unfortunately, when primary care practices attempt to implement an integrated approach, they often run into barriers that can prove insurmountable at the local level. These barriers are related to health insurance carriers' billing and record-keeping regulations. The clinical routines of integrated primary care are substantially different from those of separated primary care and specialty mental health, but most billing and administrative regulations were designed only for the latter.

It is not uncommon for employers who are invested in quality of services and cost control to become interested in the phenomenon of behavioral health in primary care. When negotiating with health plans, they may receive assurances that behavioral health is supported by the plan. These assurances are generally made in good faith. The representatives, to the best of their knowledge, believe their plan supports integrated care. However, most of the health plans have numerous barriers that need to be addressed before behavioral health can become a part of the plan.

A list of fairly minor changes in billing and record-keeping regulations implemented by health plans that can greatly facilitate behavioral health providers working in medical settings can be important if the evidence is to be translated into practice. This brief discussion provides suggestions for employers or health plans that want to make the minimal adjustments in regulations and billing practices that would facilitate the initiation of integrated primary care. For a discussion of ways that the system as a whole can facilitate the introduction of behavioral health into medical settings, see Pincus et al. (2006). For the purpose of this discussion, there is a distinction between integrated care and colocated care (cf. Blount, 2003). Colocated care is behavioral health care provided in the primary care site by a BHP. It is provided on a referral basis. Commonly, patients are encouraged to make the initial appointment with a BHP through their PCP. In many practices, the BHP may be introduced to the patient as part of the referral process, because an introduction increases the likelihood that the referral will result in behavioral health care for the patient. The benefits of colocated care include a quantum leap in information exchange between the BHP and PCP over care in separate locations. Referrals are much more likely to be successful. Patients who would not accept care in a psychiatric facility will see a BHP who is part of their PCP's practice.

Integrated care describes care that has medical and behavioral health components. The patient perceives care as one treatment plan targeted to his or her needs. Because a PCP is directing the plan, most patients experience it as medical. This is necessary for the very high percentage of patients in primary care who have severe behavioral health needs but would not accept care defined as mental health or psychiatric care. Care management programs for depression, special programs targeted at patients with chronic illnesses, and behavioral health consultation or care provided in the flow of patients' visits to their PCPs are all examples of integrated care.

Some Specific Helpful Changes

1. For many patients who need care, the best opportunity for offering care is on the day the needs are identified. Because they experience their problems as medical, patients are not likely to accept a referral to a BHP, although they are willing to meet with a BHP as part of their primary care visit. The PCP feels the need to involve the BHP, but the patient will not make (or keep) an appointment at another time. To the degree that a company has restricted same-day billing between psychological and medical providers, this proscription should be withdrawn.
2. Because it is common for patients to be unwilling to work with a BHP without the active involvement of the PCP, some overlapping time in which both providers are working with the patient needs to be billable. The payer needs to be explicit that this is acceptable, because most conscientious providers will worry about the potential for being charged with fraud in such billing. The practice of the PCP billing for a certain level of office visit and the BHP billing for his or her time under a mental health or behavioral health code should be allowed and affirmed.
3. Because patients are identified as needing service on the day that service should be delivered, to the degree that a company requires preapproval of the first visit in nonemergent situations, this requirement should be waived in primary care practice.
4. Because it is impossible to do a full assessment at an initial contact in primary care, particularly if the patient is not seeking mental health services, it should be explicitly permissible for shorter units of time to be billed before an assessment is done.
5. Because contacts in primary care can be very brief, units of billing as short as 10 min should be allowed.
6. Because contact with the BHP can often be part of the medical care in primary care, the note from the BHP should be able to be part of the medical contact notes, signed by the BHP.
7. Notes that are part of a colocated mental health treatment conducted on a referral basis should be able to be kept in a separate section of the medical chart. This section would enable the extra layer of permission required for release of mental health notes to be obtained. The extra layer of permission is required for notes of treatment because the patient would identify the treatment as mental health treatment, not because it is provided by a mental health professional or because it is paid for by the mental health benefit. Much of the care provided by mental health professionals

in primary care would be identified by the patients as medical and should be part of the medical chart.

8. Consultation to a PCP about a specific patient by a licensed psychologist or qualified psychiatrist should be reimbursed at a rate similar to psychotherapy of the same duration when it is supported by a consultation note from the consultant.

9. Rates should be set and funding authorized for care under the behavioral health codes designating behavioral care given to patients who do not have a psychiatric diagnosis. These would pay for services such as motivational interviewing by a skilled BHP for someone who needs lifestyle changes for cardiac risk factors. These codes were developed by the American Psychiatric Association and have been widely promulgated. A payment rate has been set for these codes by Medicare and some health plans, but many plans have not yet followed suit. When companies begin paying these codes, it is important to promulgate specific instructions regarding how to bill for them and what record keeping is necessary.

10. There are numerous evidence-based protocols that have large or small behavioral components for treating chronic illnesses. There is good evidence for the effectiveness and cost-effectiveness of care management approaches for depression in primary care in addition to behavioral aspects of protocols for diabetes, hypertension, arthritis, irritable bowel syndrome, and asthma as well as problems such as somatization and chronic pain. These protocols are too complex to be mandated through a universal rate for a universal approach to each illness or problem. In this very important area, the insurance company should set up a mechanism for approving and setting a rate for protocols proposed by a practice. To get a protocol approved, a practice would need to cite the evidence in a convincing way; make a case for why its program was described by the evidence; designate the target population; and describe the recruitment strategy, the participating staff, the number of meetings, the meeting activities, and the outcomes that would be tracked.

11. Training for BHPs who can work in primary care is woefully behind demand. Health plans should establish a mechanism to support training in primary care by approving a payment scale for specific services provided by trainees in primary care–based programs approved by the relevant accrediting bodies.

We believe that the way forward requires an iterative process. Existing evidence supports new, more integrated practice that makes new sorts of evidence possible. To achieve wider implementation of new practices, reforms in billing and administrative regulations are necessary. Broader implementation of new practices will transform the assumptions about care of providers and patients, leading to new ideas for improvements in practice. Barring a collapse in funding, the next few years should be a particularly generative time in primary care and behavioral health integration.

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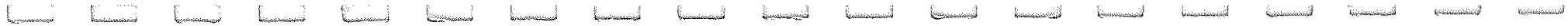

Appendix

Definitions of Terms

1. *Behavioral health services*—an overarching term combining services that are called mental health and substance abuse and services that are called behavioral medicine.

2. *Behavioral medicine*—services designed to intervene on physical health using behavioral means. Examples are health behavior change programs; education for better coping with illness; programs to improve adherence to medical regimens; and services that access the relaxation response, such as relaxation training, biofeedback, hypnosis, visualization, and mindfulness.

3. *Collaborative care*—care provided by a team with at least one medical provider and one behavioral health provider. In some protocols, the behavioral health provider is a consulting psychiatrist. In others, he or she is a mental health professional functioning as a care manager.

4. *Mental health services*—therapies and medication treatments to address conditions that meet the definition of mental disorders.

5. *Substance abuse services*—therapies to aid people who overuse, abuse, or are dependent on alcohol, prescription medication, and/or illegal drugs.

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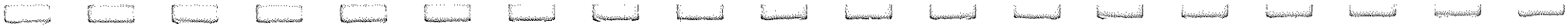

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Addressing the Workforce Crisis in Integrated Primary Care

F. Alexander Blount · Benjamin F. Miller

Abstract Training and education in integrated primary care is limited. We see a need for addressing the looming workforce shortage as behavioral health services in primary care become more widely implemented. Bringing mental health clinicians straight from specialty mental health settings into primary care often results in program failure due to poor skills fit, assumptions about services needed, and routines of practice these clinicians bring from their specialty settings. Health psychology graduate programs tend to prepare graduates for specialty research and practice in medical settings rather than preparing them for the pace, culture and broad spectrum of needs in primary care. Family medicine residency programs provide an underutilized resource for training primary care psychologists and family physicians together. Even if comprehensive graduate training programs in integrated primary care were developed, they could not begin to meet the need for behavioral health clinicians in primary care that the present expansion will require. In response to the demand for mental health providers in primary care, new initiatives have emerged which attempt to provide training for the preexisting mental health workforce to enable their successful integration into primary care settings.

Keywords Primary care · Behavioral health · Integrated care · Psychology · Training · Work force

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F. A. Blount (✉) · B. F. Miller
University of Massachusetts Medical School,
Worcester, MA, USA
e-mail: blounta@ummhc.org

Introduction

Primary care is a critical component of healthcare (Starfield, 2001), and has been touted as the linchpin of the current health care delivery system (Haley et al., 2004). Within the United States, an increase in primary care resources has been associated with better health outcomes and lower health costs (Shi, Starfield, Kennedy, & Kawachi, 1999). The same is true internationally where countries with robust primary care systems have better health outcomes, more equitable distribution of care and lower health care costs than countries with systems more focused on specialty medical services (Starfield, 1998).

The process of integrating mental health services into primary care has been well documented (Blount, 1998; Bray, Frank, McDaniel, & Heldring, 2004; Gatchel & Oordt, 2003). Literature has shown the majority of patients with mental health needs rely solely on their primary care provider (PCP) for treatment (Brody, Khaliq, & Thompson, 1997; Cummings, 1991; Hemmings, 2000). Because the majority of patients using primary care will not seek psychological services outside of their PCPs office (Bridges, Goldberg, Evans, & Sharpe, 1991), primary care has become the de facto mental health system (Reiger et al., 1993).

Besides being able to offer access in primary care for the majority of people with mental health and substance abuse who will not go to specialty settings, there are psychosocial needs that should be addressed in treating chronic illnesses. The skills psychologists use to address mental health needs in primary care, can be used very successfully in the management of chronic disease through behavioral health interventions (e.g., Smith, Kendall, & Keefe, 2002). Complex medical conditions such as cardiovascular disease have several health behaviors linked with their

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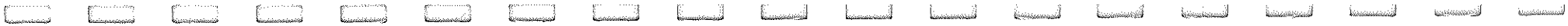

etiology including smoking, limited exercise, and diet/obesity. Behavioral needs are also central to promoting healthy lifestyles. Five of the leading seven causes of death can be attributed in part to unhealthy lifestyle, health behaviors, and stress (Haley et al., 2004). Addressing these behaviors and promoting change is part of the primary care agenda for preventative care.

Background

Central to psychology practice in primary care is the importance of collaboration with physicians and other biomedical providers (McDaniel, 1995; Tovian, 2006). It is important to note that collaboration within medical settings is not simply with physicians, but often non-physicians such as nurses, medical assistants, social workers, and support staff (Belar & Deardorff, 1995). While collaboration may be a central component within interdisciplinary training, it's presence in graduate psychology training and education is rare. If anything, psychology graduate students are likely to be socialized to a competitive stance with physicians, rather than drilled in the routines of collaboration.

If graduate programs offer training in primary care psychology, they typically embed the training into a health psychology track. Some authors have called for primary care psychology to be placed within the generalist model of training in graduate school so all students can benefit (Talen, Fraser, & Cauley, 2002). This approach would be consistent with moving psychology from specialty mental health care to primary health care (Belar, 2006; Bray, 2004; Levant, 2005) and deconstructing the silo mentality that encompasses much of psychology graduate training. Despite a relative increase in programs offering training in health psychology and primary care, some have argued that specialization, which health psychology is considered to be, should occur during internship and postdoctoral fellowships (Olbrisch, Weiss, Stone, & Schwartz, 1985).

There are a variety of internships and postdoctoral fellowships that offer some level of training in primary care settings. A recent online review of the Association of Postdoctoral and Internships Centers online directory (APPIC) reveals 93 APA accredited internship sites that offer a major rotation in primary care and 16 APA accredited postdoctoral programs that have a specialty area in primary care. It should be noted that just because an internship or fellowship identifies itself as offering training in primary care does not mean they offer an integrated primary care training experience. The definition of integrated health care or collaborative care can be different between each training setting.

The goal of this paper is to discuss two training programs offered through the University of Massachusetts Medical School Department of Family Medicine and Community Health, the postdoctoral fellowship in primary care psychology and the Certificate Program in Primary Care Behavioral Health. The former is designed to train psychologists who can be leaders in integrated primary care settings and faculty in medical training settings. The latter is designed to facilitate the transition from specialty mental health settings to primary care for mental health clinicians of many disciplines.

Primary Care Psychology Fellowship

From one perspective, the description of the fellowship is like that of several other such training opportunities. It is a 2-year full time training and service program sponsored by the Department of Family Medicine and Community Health at the University of Massachusetts Medical School. Fellows spend six half-days located in one of the residency Family Medicine practices and four half-days in training experiences. They receive formal training in family therapy, brief therapy, child development, and in behavioral medicine techniques to teach them how to address the behavioral health problems presenting in primary care. Fellows offer lectures on behavioral science topics as asked and can be involved in practice-based research. They provide clinical services to patients in primary care, both as an unscheduled service supporting primary care by physicians and on an appointed basis for follow-ups.

There were several purposes for designing a fellowship as we did. It provides peer experiences of collaborative care for Family Medicine (FM) residents. The fellows are analogous to second year FM residents when they arrive, having completed a doctorate and a year of internship. They train for two more years, just as residents in that position do and are experienced as peers by residents. The fellowship increases behavioral science teaching capacity by bringing more and different behavioral health skills into the residency health centers.

It is the role of the fellows in the training of Family Medicine residents and vice versa that makes the fellowship currently unique. The Dual Interview requirement in the residency has been the vehicle for this unique interconnection. In the 4 years between the start of the fellowship and the beginning of the Dual Interview program, we got to see how residents interacted with fellows when there was no structure forcing an exchange between them. We found that while all the residents liked having the fellows around, some of them used the fellows actively for consultations while the others used them only as referral destinations. The residents who used the fellows as consultants were enthusiastic about the help they received, but the most common relationship between residents was that

of co-located behavioral health specialist and primary care physician. The Dual Interview program was begun as a way of providing a structure for the development of integrated clinical routines, to give both fellows and residents a regular experience of working in teams in patient care. The program was billed as a longitudinal program for residents that teaches the practical implementation of the skills and concepts taught in the behavioral science curriculum. In fact, it is much more than that.

Dual interviews are meetings between a patient or family, a resident physician and a behavioral health provider. Most of the time that is a fellow in Primary Care Psychology, but it can also be the consulting psychiatrist at the health center or other mental health staff. Residents are required to do 33 dual interviews during the course of 3 years, at a pace that matches the percent of their time they spend in the primary care clinic. In order to meet this challenging total, residents have to learn how to identify patients for whom the addition of a behavioral health clinician's perspective could improve care. Family Medicine residents gradually expand their definition of who could benefit from the most obviously psychiatrically ill patients to the whole array of folks with psychosocial needs in primary care.

Fellows, who commonly have been trained to begin relationships with patients on an appointed basis, learn how to offer brief targeted assistance to a primary care physician, without needing to provide ongoing psychosocial care to every patient. Assessment, problem definition, diagnosis and intervention are all recast when the challenge is to "add value today" in the care of a patient they will probably not work with again. It is a practice that helps the fellows to grow their understanding of how the physician/patient relationship can be psychosocially therapeutic and how they can nurture and support that relationship.

Dual interviews improve care for the complex medical and psychosocial needs of patients who are not likely to accept a referral to behavioral health services. In this way, both residents and fellows get experience in providing more complete care for the difficult situations that present in primary care. It is hard to imagine or promote this sort of care in the future if one has not already seen it in action.

Certificate Program

Background

The movement to bring mental health clinicians into primary care is large and growing. The Bureau of Primary Health Care has mandated that primary care mental health services be part of the core services in every federally qualified health center. Health related foundations in Texas, Kentucky, Colorado, Oregon, California, North Carolina, New Hampshire, Maine, and Rhode Island have funded programs to underwrite the development of integrated primary care.

The current leaders in the movement to integrate behavioral health clinicians into primary care are entities that must address the most socially stressed populations, like the Bureau of Primary Health Care of HRSA or the Veteran's Administration. The "Models that Work" campaign of the Bureau of Primary Health Care of HRSA advocates integrating mental health services into primary care in all Federally Qualified Community Health Centers. The model of the service advocated by the Bureau of Primary Health Care, called the Integrated Primary Care Community Based Health System, can be found at http://aspe.hhs.gov/ezec/issues/primarycare/chart.htm.

The agencies of the Federal government which are responsible for providing healthcare have been working together to move toward integrated care for some time through the Federal Partners Senior Working Group-Mental Health and Primary Care Integration (DoD, HRSA, SAMSHA, OMH, OPHS, AoA, NIMH, AHRQ, ACF, and VA). They produced a report in January of 2008 entitled, "*Compendium of Primary Care and Mental Health Integration Activities across Various Participating Federal Agencies*" which can be found at http://www.samhsa.gov/Matrix/MHST/Compendium_Mental%20Health.pdf.

On July 23, 2008, SAMHSA, HRSA, and CMS released a report proposing strategies to overcome barriers associated with the reimbursement of mental health services provided in primary care settings (http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf). The report expresses the multi-agency commitment to removing barriers to the teaming of non-medical behavioral health clinicians with primary care physicians in providing care in primary care settings.

Integration has been part of the development of many large health systems in which the system was responsible for the whole cost of care, rather than being paid on an encounter basis. This led to large implementations in such HMOs as Kaiser in California, Group Health of Puget Sound in Washington and Health Partners in Minneapolis/St. Paul. The practice of integrated care has continued in all these systems, though they have retreated from the universality of the implementation, as their systems have returned to a financial model that is much more dominated by fee for service.

The advent of 'pay-for-performance (P4P) schemes and advances in the support of integrated care in some states (e.g., NC Medicaid pays for care management and psychiatric PCPs consultation by phone), and the gradual expansion of payment for the Health and Behavior codes for behavioral medicine services in primary care have brought the financial viability of behavioral health clinicians in primary care closer to being a general reality.

We are Headed for a Workforce Crisis

The growing interest in integrated primary care and the sudden increase in foundation and government support to get programs started and to remove barriers to integrating behavioral health clinicians in primary care are not being met by increases in graduates from programs that train psychologists, clinical social workers or other masters level therapist for work in primary care. Fildes and Cooper (2003), after making the case that social workers are the right discipline to provide the services needed in primary care, admit that current training does not prepare them for this role. They see social workers as having good generalist preparation but as needing to be "life long learners" if they are to gain the behavioral medicine and chronic illness management skills needed in primary care. Similarly, McDaniel, Belar, Schroeder, Hargrove, and Freeman (2002), begin their discussion of the training of psychologists for work in primary care by saying, "At this point, there are few organized sequential experiences that enable psychologists to learn the information and gain the skills necessary for working in primary care settings." There needs to be a rigorous orientation to the skills, routines, and assumptions of primary care behavioral health practice for mental health and substance abuse clinicians if we are to begin to meet the growing need for behavioral health clinicians in primary care.

The Department of Family Medicine and Community Health at the University of Massachusetts Medical School has been training mental health professionals to provide services in primary medical care settings for over 15 years. In January of 2007, the department launched a program designed to train mental health professionals to function successfully as behavioral health clinicians in primary care. The program consists of 36 h of didactic and interactive training. It is beamed by videoconference to sites around the US and Canada. The curriculum described next is designed to embody the specific material that a mental health professional would need to add to their graduate training to succeed in primary care. The content has been discussed informally and generally supported by other leaders in the field of integrated primary care, but it is the construction solely of the faculty in the Department of Family Medicine and Community Health. Most of the workshops are co-led by teams consisting of a psychologist and a physician using distance learning technology.

Workshop 1: Primary Care Culture and Needs

Culture and Language of Primary Medical Care (2 h)

- Primary care's role in health system
- Primary care vs. specialty medical care
- Content and sequence of the basic medical interview
- Recommended preventative care expected of primary care physicians (PCPs)
- Role play primary care interview with associated decision-making

Goal: Feel comfortable and oriented in a primary care setting.

Behavioral Health Needs in Primary Care (1 h)

- Mental health and substance abuse rates
- Behavioral health needs
- Chronic illness mental and behavioral health needs
- "Ambiguous" illnesses
- Cultural impact on illness presentations
- A typical morning in practice
- Example of common "complex" cases

Goal: Conceptualizes how a behavioral health professional (BHP) can help in a wide variety of primary care cases.

Consulting with MDs (3 h)

- Common physician perceptions of role of a BHP
- Ways of impacting those perceptions
- How physicians want to be approached
- Determining what input from BHP is useful to the PCP
- Terms for types of collaborative care
- Co-located patterns of care
- Integrated patterns of care
- Practice dual interview
- Practice talking in front of the patient for a hand off

Goals: Effectively uses the curb-side consultation model to communicate with a physician. Can speak sensitively and with clarity about a patient's situation with a physician in front of the patient.

Workshop 2: Evidence-based Therapies and Substance Abuse in Primary Care

Substance Abuse in Primary Care (3 h)

- Chronic illness vs. failure of will
- Role of SA in common illnesses and health behaviors
- The CAGE and other quick screens
- Physician training in identifying and treating substance abuse
- Chronic pain and the dilemmas of pain medication
- What a BHP can add to the care in each case
- Evidence-based approaches to substance abuse in primary care

Goals: Can identify substance abuse problems of patients presenting medical complaints. Can work collaboratively to help patients with SA problems.

Evidence-based Therapies (3 h)

- Role of "evidence" in making treatments credible
- Types of evidence available for approaches we use
- CBT and the therapies of patient activation
- Family and other multi-person approaches in primary care
- The role of solution focused interviewing in patient and provider change
- Role plays to practice
- Working in brief visits and brief treatments

Goals: Able to briefly assess, engage and intervene with adults with behavioral health needs in primary care, using methods supported by evidence. Able to briefly assess, engage and intervene with children with behavior problems using methods supported by evidence.

Workshop 3: Behavioral Health Care for Chronic Illnesses

Across the Lifespan and Child Development and Collaborative Pediatric Practice

Child Development (1 h)

- The role of "milestones" in organizing pediatric decision-making
- Early developmental milestones and the office assessment of them
- Interaction of experience and biology in developmental problems
- Common developmental disorders

Goal: Able to screen children for developmental problems.

Collaborative Pediatric Practice (2 h)

- The unique nature of pediatrics: doctor/patient relationship is (at least) a triangle.
- Engaging parents in promoting health without making them feel judged
- Difficult situations in normal care: bedtime, toileting, feeding, interface with school and learning.
- Learning problems and ADHD
- Special roles for Behavioral Health in pediatric practice

Goal: Able to guide parents on behavioral issues in a culturally acceptable and effective manner.

Chronic Illnesses Across the Lifespan (3 h)

- Symptoms, mechanisms and treatments of:

  Asthma
  Diabetes
  Heart disease
  Irritable bowel syndrome

- Behavioral health needs and mental health co-morbidities for each illness
- Behavioral treatments in evidence based protocols for chronic illnesses
- Group medical visits

Goal: Able to describe an evidence-based biopsychosocial approach for chronic illnesses in primary care.

Workshop 4: The Toolbox and an Overview of Psychotropic Medication in Primary Care

Screening Instruments for Primary Care (2 h)

- Screening vs. diagnosis vs. outcome
- Pediatrics: The Vanderbilt, the Connors, Pediatric Symptom Checklist.
- Communicating with parents and physicians about screening results
- Multi-illness screens, informal screens, PHQ-9, QIDS, SF-12 and -36, the Duke
- Decision-tree for determining next steps after screening

Goal: To be knowledgeable about one child and one adult screening instrument and able to discuss its use with physicians and patients.

Building a Care Management Program in Primary Care (2 h)

- Adults: The chronic illness care movement
- Organizing a care management program
- Enlisting physicians in screening
- Developing a database and reminder system for patients
- Making patient education part of the program

Goal: To be able to begin a care management program in primary care.

Psychotropic Medication Overview (2 h)

- Getting past the either-or of medications vs. therapy

- Pediatrics: When you might suggest considering medication
- Speaking to parents and children about medication
- Common medications given to children, indications, actions and side effects
- BHP role in assessing side effects and communicating with prescriber
- Talking with adults about medication
- Common medications used in adult primary care, indications, actions and side effects
- The necessary role of psychiatry in primary care: consultation and treatment

Goals: To knowledgeably discuss common psychotropic medications with a patient, including indications, effects and side effects. Able to appropriately recommend initiating medication to a PCP.

Workshop 5: Behavioral Medicine Techniques

Health Behavioral Change Strategies (2 h)

- Building the doctor/patient relationship for better health
- Stages of change model
- Motivational interviewing
- Matching approaches to stages of change
- Health behavior change interviewing practice for smoking and obesity

Goal: Able to conceptualize the stage of change of a patient in relation to a health behavior problem and to match motivational approaches to that stage.

Treating the Somatizing Patient (1 h)

- Is the concept of somatization useful?
- Teamwork in providing care
- Language that engages the patient
- The use of uncertainty in uncertain situations

Goal: Able to discuss bodily symptoms that have no medical findings with patients in a way that promotes curiosity and coping in relation to the illness.

Behavioral Medicine Skills (3 h)

- Role of relaxation response therapies
- Sleep promotion skills
- Progressing relaxation and autogenics
- Hypnotic methods without trance
- Biofeedback

Goal: Able to teach patients techniques to calm their bodies' reactivity.

Workshop 6: Families and Culture in Primary Care

Underserved Populations, Culture and Primary Care (3 h)

- Impact of culture on health practices and health beliefs
- Particular health problems of underserved populations
- Looking for a way to improve cultural "fit" when problems arise
- Promoting cultural curiosity and appreciation
- Using interpreters
- Examples from the Worcester Rainbow: multiple Latino groups, Vietnamese, Albanian, Ghanaian

Goal: Able to adapt the approach to specific patients based on knowledge of cultural factors.

Working with Families in Primary Care (2 h)

- The family's role in health
- The importance of a family perspective in addressing problems in health behavior
- Opportunities in regular care (pediatric and adult) to engage family members
- Critical points in care where family involvement is necessary
- Steps in conducting a medical family meeting

Goal: Able to effectively and sensitively conduct a family medical meeting.

Summary (1 h)

- Questions about implementation and finance
- Other questions and discussion

The curriculum is listed in detail because it is designed as a list of the tools, skills, and attitudes that mental health professionals need to be effective as behavioral health clinicians in primary care. We expect that other authors will design other programs and that the difference in content headings will be an important point of conversation in the field.

The evaluation of this program to date has been a combination of feedback from the participants after each workshop session and a final summary evaluation for the course as a whole. For that purpose, we use a retrospective pre-post format in which participants are asked to rate their skill in the core competencies we are teaching before and after the course. The rating is done after the course, so that the judgment of what they knew before the course is informed by their experience of the course. The validity of this form of evaluation has been supported in a recent summary of studies (D'Eon, Sadownick, Harrison, & Nation, 2008). In our program, the improvement of participants' skills has been assessed as significant to better than .05 level for all of the competencies we ask them to report.

Discussion

There is a growing need for the development of programs to teach physicians and psychologists to work together in teams and a similar need for convenient training to equipmental health professionals to work as behavioral health clinicians in primary care. We have tried to offer descriptions of two training programs, one designed to train psychologists and family medicine residents together and the other to train practicing mental health professionals. We suggest that each offers an outline of an approach worth replicating in other settings.

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Integrated Primary Care: Organizing the Evidence

ALEXANDER BLOUNT, Ed.D.

The evidence for bringing behavioral health services into primary care can be confusing. Studies are quite varied in the types of programs assessed, what impacts are assessed, what kind of therapy is offered, for what populations, and on how broad a scale. By organizing the evidence into categories: whether the program is coordinated, co-located or integrated, whether for a targeted or non-targeted patient population, offering specified or unspecified behavioral health services, in a small scale or extensive implementation, programs can be compared more easily. By noting what sorts of impacts are reported–improved access to services, clinical outcome, maintained improvement, improved compliance, patient satisfaction, provider satisfaction, cost effectiveness or medical cost offset–the most comprehensive overall assessment of this important approach to patients' needs can be encouraged.

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Alexander Blount, Ed.D., Department of Family Medicine and Community Health, UMass Memorial Health Care, 55 Lake Ave NorthWorcester, MA 01655; Blounta@ummhc.org.

The evidence for bringing behavioral health services into primary care is scattered and can be confusing. A recent summary of the evidence (Hemmings, 2000) seems to offer as many studies in which the process made no difference as it cites studies in which it was effective. Studies are quite varied in types of programs assessed, what impacts are assessed, what kind of therapy is offered, for what populations, and on how broad a scale. The purpose of this article is to offer a conceptual system for assessing the evidence about impacts of integrating behavioral health services into primary care. It will be successful if it contributes to clarifying the discussion about this process, if it allows readers with different concerns to locate the literature that addresses their concerns, and if it encourages future researchers to assess a broader array of the impacts of behavioral health in primary care.

Incorporating behavioral health services into primary medical care would seem so logical as to be almost inevitable. The complaints that patients bring to primary care are predominantly not symptoms of biological disease (Kroenke & Mangelsdorff, 1989). They are symptoms such as chest pain, fatigue, dizziness, headache, edema, back pain, shortness of breath, insomnia, abdominal pain, and numbness (the ten most common) that patients experience as

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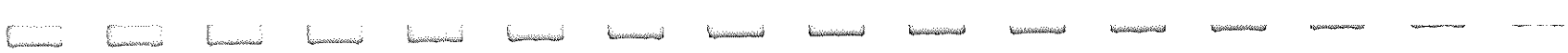
physical but for which a biological cause is found about 25 percent of the time. In addition, there is a substantial rate of psychiatric disorders that present in primary care. Many of these patients will not accept a referral to a mental health provider in another location, making primary medical care the most common venue for treatment of mental health problems (Regier, Narrow, Rae, et al., 1993). Finally, more than half of the patients in primary care could benefit from some health behavior change that most do not make on their physician's advice alone. Randomized controlled trials have shown certain behavioral treatments to be effective in treating depression, anxiety, child behavior problems, insomnia, headache, fibromyalgia, irritable bowel syndrome, hypertension, coronary artery disease, even cancer, and to contribute to greater success in smoking cessation and weight loss. Primary care is the site of enormous need that cannot be addressed in other settings. For many of these needs there are effective behavioral treatments that keep more expensive medical services from being needed if these behavioral treatments are targeted to the patients who need them most (Cummings, Dorken, Pallak, & Henke, 1990). Integrating behavioral health services into primary care is an idea whose time should have already come.

A number of authors have contributed to the discussion of why bringing behavioral health into primary care has not become more common. Some have pointed out that the way our systems of care are organized into different health and mental health infrastructures impedes integration (Blount, 1998; Blount & Bayona, 1994; Coleman & Patrick, 1976). Others have noted that the way mental health providers have been trained to practice needs substantial modification in order to fit in the primary care situation (Blount, 1998; Strosahl, 1998). Several have said that both medical and behavioral health providers have little training or experience in collaboration or teamwork in delivering care. (Banta & Fox, 1972; Glenn, 1987). Finally, the evidence for the integration of behavioral health into primary care that seems so compelling when presented in a piecemeal fashion has not been compelling enough to induce a broad implementation in health systems generally.

The terms "collaborative care" and "integrated care" are growing in use but not in specificity or agreed meaning. Several authors have tried to define integrated care (Blount, 1998; Doherty, McDaniel, & Baird, 1996; Strosahl, 1998). Initially, the reason for such a definition was to help people who were not familiar with integrated care to understand the different forms or levels of integration that are possible. In the present discussion, the categories are generated to show that distinguishing different aspects of the relationship between behavioral health and medical services in collaborative settings allows one to make a much more coherent picture out of the available research findings.

Relationship of Behavioral Health and Medical Providers

The first set of categories that I would like to offer defines the relationship between the medical and behavioral health services in primary care. The categories distinguish between services that are **coordinated**, but exist in different settings, services that are **co-located**, both being provided within the same practice location, and services that are **integrated**. Integrated services have medical and behavioral health (and possibly other) components within one treatment plan for a specific patient or population of patients. Technically, it is possible for services to be co-located but not coordinated or to be integrated but not co-located. Therefore, the most precise definition of these descriptions would be that they are dimensions of collaborative care, not mutually exclusive categories. In practice, however, there is a hierarchy of levels of integration (Doherty, McDaniel, & Baird, 1996). I think it is



legitimate to use them as categories in our attempt to give some order to the research in the field.

When services are **coordinated**, some work has been done so that information is exchanged on a routine basis when patients are in treatment in both settings. The referral from one agency or provider to another is the usual trigger for such an exchange. The process of making programmatic links for information exchange involves some attempt to bridge the differences of culture between a primary care medical service setting and a mental health service setting. Different approaches to confidentiality, to returning phone calls and being interrupted, and different expectations about how actively to intervene in problems make ongoing coordination very difficult and time consuming. It is a process that inevitably stresses and, if it is successful, changes both agencies.

Because coordination takes so much effort when the people with whom a provider is coordinating are not a part of their day-to-day practice, the success or failure of the endeavor depends on the personal commitment to the process of providers. For this reason, large-scale efforts to promote coordination have tended to be unsuccessful. A notable exception is the Hawaii project of Cummings and his colleagues (Cummings, Dorken, Pallak, & Henke, 1990). In this extensive project, targeted populations of primary care patients were referred to specially trained mental health providers who conducted specified treatments. Impacts, mostly measured in utilization and healthcare cost reductions, were very impressive.

Co-location is what its name implies. Behavioral health and medical services are located in the same suite of offices sharing office staff and waiting facilities. Typically, in a co-located setting, there is still a referral process for those cases that begin as medical cases and are later referred for behavioral health services. Co-location fosters communication between behavioral health and medical providers. While one could imagine co-located services that do not involve regular collaboration, the initial anecdotal descriptions of these settings were uniform in describing collaboration as much easier and more common than in separate settings. Medical providers can be better attuned to what behavioral health providers can provide. Behavioral health providers become acculturated to the language and treatment assumptions of primary care. The first full-scale HMO implementation of co-located care (Coleman, Patrick, Eagle, & Hermalin, 1979) found that after behavioral health providers were part of the primary care teams for more than a year, 92% of consultations between behavioral health and medical providers were unscheduled and most were less than five minutes in length. Almost all of this richness in information exchange would not occur if people were not bumping into each other in the halls.

Consultation between behavioral health and medical providers can increase the skill and effectiveness of medical providers in addressing behavioral health issues. Reports have always indicated that medical providers do not provide any fewer behavioral services in co-located settings (Coleman, Patrick, Eagle, & Hermalin, 1979; Katon, 1995); they just enjoy providing these services more. The level of behavioral services overall is raised in terms of number of patients served and the quality of care offered. Medical providers can be more adventurous when engaging in conversations about psychosocial issues, knowing that if they discover a situation that seems beyond their expertise, there is someone down the hall who could be involved within a reasonable period of time.

The fact that behavioral health services are accessed by referral from the primary care physician means that the problems of patients failing to keep behavioral health appointments is improved but not eliminated in co-located settings. In a Family Medicine residency practice in Fitchburg, MA, in

which behavioral health providers are regularly present and available in the practice, an introduction of the behavioral health provider (BHP) to the patient made by the primary care provider (PCP) proved to make a significant difference in patients keeping a first appointment with the BHP. For the first 100 patients tracked, if the PCP introduced the patient to the BHP at the time a visit to the BHP was recommended, 76% kept the first behavioral health appointment. If the PCP scheduled the appointment for the patient with the BHP but did not make the introduction, 44% kept the first appointment (Apostoleris, 2000).

Integrated care describes care in which there is one treatment plan with behavioral and medical elements, rather than two treatment plans. Sometimes this is done because the treatment plan is delivered by a team that works together very closely, and sometimes it is done by pre-arranged protocol. When a team works together regularly in delivering care, it usually is serving a particular population in which psychosocial needs are almost universal. When a pre-arranged protocol is used, it is usually treatment for a particular disease or condition in which the behavioral health part of care is crucial to delivering the highest quality care.

An example of the first form of integrated care is a team serving homeless and formerly homeless mothers and children in Worcester, Massachusetts. The team is led by a family physician and includes a psychologist who specializes in children and families, and two "family advocates," one of whom is also the team coordinator. The team meets two and a half days weekly at a federally funded health center serving a very diverse population in an underserved area of town. The psychosocial aspects of the patients' lives take up most of the visits they make to the team. While over 90% meet criteria for a DSM-IV diagnosis, very few would ever go to a mental health center for services. They come to see their doctor for all their problems, though they will work with whoever is on the doctor's team. The team approaches every patient visit as an opportunity for some sort of psychosocial therapy. Often the physician brings the psychologist in to join in addressing a problem that a patient brought. They can interview family members separately or together, depending on the situation. The family advocates play multiple roles. In addition to serving as translators, they facilitate the connections between the patients and the team by helping patients understand the practices of the team and helping the providers understand the life experience of patients. They also make connections between patients and the resources in the community.

An example of integrated care by prearranged protocol is seen in the "disease management" or "chronic illness" approach to depression. With support from federal and large foundation sources, programs are springing up around the country. They are characterized by regular use of screening and outcome assessment for the illness being addressed, a standard set of protocols for addressing the illness, a database to track the care of patients screened into the program, and a staff member designated as managing the program under the direction of a cooperating group of providers. While in some settings the disease management program is a coordinated program between a primary care practice and a separate mental health agency, the studies on which the effort is modeled (Katon, 1995; Katon, von Korff, Lin, et al., 1995) were fully integrated and the overall effort is in the direction of integration.

By distinguishing between coordinated, co-located, and integrated care, it is possible to be much clearer about what clinical practices are represented when collaborative programs are discussed. This also helps us know what sort of advantages of particular programs to expect. We will see below that efficacy research favors integrated programs, but this is partially because the advantages

of coordinated and co-located programs tend not to be valued as outcomes in randomized controlled trials.

Relationship of Services to Populations

The next set of categories that can be useful in sorting the results of efforts at integrated care is the distinction between **targeted** and **non-targeted** programs. Targeted programs are aimed at specific populations, whereas non-targeted programs are aimed at any patient identified as needing behavioral health services within a practice. Most randomized controlled trials are targeted for specific populations. That gives us a body of evidence for targeted services. Targeted services also have the advantage of increased patient acceptance because they can be presented as fitting the patient's specific needs, as opposed to being a general service that should be added because the patient is psychologically troubled in some way.

Specificity of Services Provided

We might further distinguish between **specified** and **unspecified** treatment modalities. Specified treatment is a particular approach or set of procedures that is offered to all the patients under consideration. Unspecified treatment means that the treatment offered depends on the particular skills and judgment of each providing clinician. To know that a patient received therapy does not give any information about what was done. In randomized controlled trials, the treatment that is offered is usually carefully specified. In more general evaluations of coordinated or co-located care, the treatment that is delivered is likely to be unspecified. When the treatment is unspecified, it is very difficult to compare what is offered in one setting with what is offered in another.

Finally, I believe it is useful to distinguish between **extensive** and **small-scale** implementations. Isolated implementations are programs developed in one or a very few settings. They are usually offered in the literature as potential models for other similar settings. Extensive implementations are similar across settings and usually centrally designed. They are much more difficult to manage, because contingencies and personnel in different settings are variable. They are more difficult to replicate, but are more appropriate models for consideration in health system design. They are also better at producing large numbers of patient interactions for evaluation and research.

Reconsidering "Outcomes"

I want to suggest that there is an array of possible impacts of behavioral health treatment in primary care, and that authors tend to report those impacts that are most valued by their intended audience, sometimes giving observed impacts that are not as valued brief mention or no mention at all. The array of impacts includes improved **access** to mental health services, increased **patient satisfaction** with medical services, improved medical **provider satisfaction**, improved **patient compliance** with treatment regimens, improved **clinical outcome** for patients, **maintained improvement** in clinical outcome, increased **cost effectiveness** in service delivery and actual **offset of medical costs** by the addition of behavioral health services.

Wayne Katon and his colleagues (Katon et al., 1995) conducted a much-cited study of integrated care for depression that was reported in the Journal of the American Medical Association. They reported that for patients with major depression in the integrated program, 74% later met criteria for clinical improvement while only 44% of similar patients in the usual care group met the criteria. There was no significant difference for "minor depression" patients between groups, with a high rate of about

60% meeting criteria for improvement in both groups. They further reported that both major depression and minor depression patients in the study were more likely to comply with medication regimes and both were more likely to rate the medication as helping than usual care patients. In a different paper on the same data, Katon (1995) mentions that the study patients had slightly lower total medical costs during the time that the study assessed compared to the usual care patients ($1750 vs. $2000). He also mentioned that 80% of the providers involved in the study reported that they enjoyed treating depressed patients more after the experience of the study program. Finally, in a talk given in 1995, Katon mentioned that over 90% of the patients who were offered the integrated program accepted and completed the program. This is significantly better access to care than any setting in which patients were referred for mental health therapy that was separate from their medical care. Katon's treatment of the impacts of the study is more complete than most, and certainly much more complete than the "bottom line" summaries that are abstracted for reviews of the literature. Even he, however, does not include all of the impacts of the program in the major paper on the study.

Mental health referral is not part of accepted care-seeking for important populations

Access is one impact that is easiest to achieve by co-locating services, but one that is rarely mentioned in reports. Dr. David Satcher, the former Surgeon General of the United States, in his recent report on mental health (2001), highlighted access as a major concern. The report noted that referral to mental health services is not an effective way to engage certain groups. Some groups culturally do not define their psychosocial difficulties as reasons to go to a "mental health" service. For the first time, the report defines the fact that these groups get less mental health service as a problem of the delivery of services rather than a problem of the groups themselves. For "difficult to engage" groups, locating behavioral health services as part of primary care has been proven to be a way of significantly increasing access. Any discussion of equity in the provision of healthcare should include co-location of behavioral health services in primary care when access to care is considered.

Organizing the Evidence

Perhaps we should start our re-examination of the evidence by being clear about what literatures we are *not* discussing. There are a number of types of papers that are relevant to this field but are not under consideration here. These include: papers identifying and quantifying the behavioral health needs of primary care populations, papers describing behavioral health treatment in primary care in which only medical providers are involved, papers describing the efficacy of various types of behavioral health treatments in specialty mental health settings, papers studying the impact of psychosocial treatments on physical illness when these treatments were not delivered in primary care, papers comparing the efficacy of psychopharmacological treatments to psychosocial treatments unless both treatments are conducted in primary care, papers in which the behavioral health intervention involves only consultation to the medical provider, and cost offset studies in which there is no coordination between behavioral health and medical treatments. An excellent account of these literatures can be found in Simon and von Korff's well-organized summary (1997).

No review of the evidence can claim to be truly comprehensive. This is a particularly difficult area to review because there are so many possible types of studies that might be relevant. The present discussion can only claim to offer a system for categorizing much

TABLE 1

Impacts of Behavioral Health Services in Primary Care

	Coordinated				Co-located				Integrated			
	Non-Targeted		Targeted		Non-Targeted		Targeted		Non-Targeted		Targeted	
	Unspec.	Specified	Unspec.	Specified	Unspec.	Specified	Unspec.	Specified	Unspec.	Specified	Unspec	Specified
Small Scale				41:A,H	9:A- 10:A- 11:A- 12:A 13:A- 14:A-,G 15:A- 16:A 18:A- 19:A- 20:A,B- 22:A- 23:A 24:A- 27:A,E 28:C,D 30:C,F,G 31:C,G 32:A 33:D 36:C 43:A-,G 44:D 46:A,C,D 48:A-,G 52:H 54:A 56:A,C,D 62:C 63:A,C,H	21:A,B- 26:A	45:A,G 61:A,C,D,E	1:A 2:A,B- 3:A,B 4:A 5:A,C 6:A,B,E 7:A 8:A- 17:A,G 50:A				21:A,C,E 42:A,B,E 47:A,C,D,H 51:A,C,D,E,F,G 56:A,B,E 57:A,G 59:A,C,D,E,F,G 60:A,B,C,E,F
Extensive				55:A,E,F,G,H	49:A,B-,C,G 53:A 58:A,F,G			25:A,E,F				

A = improved clinical outcome
B = maintained improvement
C = improved patient satisfaction
D = improved provider satisfaction
E = improved compliance
F = improved access to treatment
G = improved cost effectiveness
H = medical cost offset

Letter followed by " - " indicates reported failure to demonstrate that impact.

** See Appendix for the citation corresponding with numbers 1-63*

of the available evidence. The categories can be useful, even if I have failed to locate many studies. The studies collected here were collected by Medline search and by reviewing the following summary articles: Blount, 1998; Evers-Szostak, 2000; Hemmings, 2000; Klinkman & Okkes, 1998; Maruish, 2000; Peek & Heinrich, 2000; Strosahl, 1998.

We can now return to the evidence with tools that will help us understand what set of practices the evidence endorses and where the evidence is poorly focused in relation to the needs and practice of collaborative care in the "real world." The studies Table 1 are cited with the types of impacts they report prominently. Closer study of some might uncover other impacts and most do not assess some impacts, such as access, that are commonly present. It is also important to point out that others have sorted the evidence differently. For good orientations to the field and to the larger context around the evidence see Blount, 1998; deGruy, 1997; Peek & Heinrich, 2000; Strosahl, 1998.

There have been few studies of **coordinated** care. It is hard to maintain care that is coordinated across any population using any form of behavioral health treatment, and the impact of such a program would be very difficult to assess. The studies that have been attempted have assessed the impact of **targeted** care for particular populations when the type of care is **specified** as problem-oriented brief therapy.

The practice of adding a mental health clinician to a practice and treating whomever is referred by the physicians in the practice constitutes behavioral health care that is **co-located, non-targeted**, and **unspecified**. Hemmings cites eleven studies in which it was found that this practice made no difference in clinical outcome, as well as studies in which there was significant outcome. His survey includes several studies in which the counselors in the primary care practice would be considered para-professionals. Within this decidedly mixed picture, studies have commonly found improved patient and provider satisfaction and general improvement in the cost effectiveness of care. This is usually demonstrated by the reduction of what is considered inappropriate care such as non-emergency ER visits.

There are only two studies that assess behavioral health services that were **co-located** in primary care, served a non-targeted population but gave everyone a **specified** treatment such as cognitive behavioral therapy. In these non-targeted programs, there is an assumption of some homogeneity among the primary care patients referred. Even the most enthusiastic proponents of a form of therapy tend to refrain from claiming that it is right for every person with any sort of problem.

It is also uncommon for a program **co-located** in primary care to offer a **targeted** population of patients an **unspecified** form of behavioral health treatment. In one study listed, the program helped women cope with the impact of mastectomy; a behavioral health service, but not really a type of therapy. Another study of the process of introducing behavioral health into primary care offered co-located services for a screened and targeted group. A small staff of behavioral health providers who were trained to work in primary care provided the therapy they thought appropriate to each patient (Beck & Nimmer, 2000). Because the study assessed a program as a whole rather than as a therapy, the article looks at a wider array of impacts than the usual RCT.

When a program is **co-located**, providing a **specified** behavioral health treatment to a **targeted** group of patients, clinical effectiveness tends to be almost universal, across a variety of patient groups. Many of these are the psychopharmacology vs. psychosocial therapies studies. In almost all, the psychotherapy is specified and is as efficacious as drug treatment, though taking longer to achieve its impact. In some of the studies, combined therapies are best.

Randomized controlled trials tend to study programs that are **integrated**, **targeted**, and **specified**. Some of these studies are focused on mental health services integrated into primary care, but many are focused on developing treatment protocols for specific illnesses. These may be "psychiatric" illness, such as anxiety or depression; psychological problems presenting physically (somatizing); or other conditions with an important psychosocial component, such as chronic pain, irritable bowel syndrome, asthma, or hypertension. Many of the "mental health" interventions are specific to the etiology of illness as understood by the researcher. These studies focus on what is done by the medical/behavioral health team rather than focusing on the discipline of the behavioral health provider. It is more important that the person delivering the interventions be skilled in caring for the specific illness than they be trained in any specific discipline.

The cell for **integrated** programs that are **non-targeted** is empty. It is hard to imagine creating a program that is truly integrated and useful for any patient referred. There can be regular clinical routines, however, such as introducing the patient to the BHP by the PCP, joint interviews between BHP, PCP, and patient, and joint record keeping regularly reviewed by both providers, that make a program feel integrated to a patient even when the providers experience co-located, parallel treatments. It is hard to assess the efficacy of clinical interventions such as matching the ostensible definition of the patient's treatment by the BHP to the patient's understanding of the etiology of his or her illness. On the other hand, if the patient believes s/he has a "medical" problem, treatment probably will be more effective if the BHP's involvement is defined as part of a medical regimen designed and monitored by the PCP.

There are programs that are **integrated**, **targeted**, and **non-specified**, though they tend to be represented in the literature in program descriptions rather than in outcome studies. The program for the homeless in Worcester described above is an example. It is targeted to homeless women and their children. It is fully integrated. Each patient receives psychosocial treatment based on an assessment of his or her need, not on a protocol. Another example is the program for obese children described by Davis and Biltz (1998).

Programs that can legitimately be termed **extensive** implementations are still rare. In addition to the Hawaii program of Cummings et al., there is a study of many sites in the U.K., a multi-site QI program, a meta-analysis from the Cochrane Database, and an implementation from a large HMO. This is the cell that has the largest implications for health policy makers and one that could use greater attention by authors, even if their programs do not meet the criteria of the RCT.

Conclusion

Collaborative care has been shown to be predictably efficacious and effective if the type of relationship between mental health and medical providers, the population served, and the type of service provided is adequately specified. The types of outcomes that can be demonstrated are predictable. The tendency to privilege certain types of outcomes over others misses the fact that different constituencies will be interested in different sorts of outcomes. Advocates for equity in healthcare should be interested in access. Health plan marketers could be interested in patient satisfaction. Administrators interested in provider retention could be interested in provider satisfaction. Everyone interested in the cost of healthcare should be interested in cost effectiveness and cost offset. This is in addition to the universal interest in clinical outcome, both demonstrated efficacy and effectiveness in practice.

We need to make our descriptions of collaborative or integrated care more precise

to avoid confusion and to make comparison of programs more reliable. In addition, we need to broaden the array of outcomes reported in any literature about collaborative care. This will make it easier to discuss the utility of this sort of care with the varied constituencies that have an interest in it.

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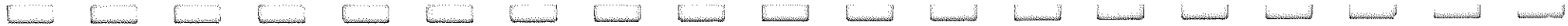

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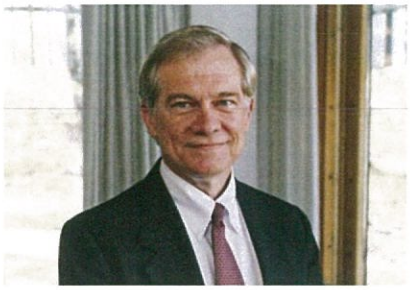

Robert E. Drake, MD, PhD

Andrew Thompson Professor of Psychiatry
Professor of Community and Family Medicine
Director, Dartmouth Psychiatric Research Center

Dartmouth Psychiatric Research Center
Rivermill Commercial Center, Suite B4-1
Lebanon, NH 03766Phone: 603-448-0263
E-mail: Robert.E.Drake@Dartmouth.edu

EDUCATION

Princeton University, BA 1971
Duke University, PhD 1977
Duke University, MD 1978

PROFESSIONAL INTERESTS

Dr. Drake works actively as a clinician in community and mental health centers and has been developing and evaluating innovative community programs for persons with severe mental disorders. He is well known for his work on co-occurring substance use disorder, severe mental illness and vocational rehabilitation. His over 500 publications cover diverse aspects of adjustment and quality of life among persons with severe mental disorders and those in their support system.

Evidence-based Treatment of Co-occurring Substance Use Disorder

Bob Drake
Dartmouth Psychiatric Research Center

September, 2014

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History

1980: identification/ description

1990: integrated treatments

2000: implementation of EBP

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1. Co-occurring Disorders are Common

50% or more of people with serious mental illnesses have co-occurring substance use disorders.

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Vincent van Gogh

Self Portrait, Vincent van Gogh, 1889

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Willem deKooning

Self Portrait, Willem deKooning, 1984 - Dutch-American

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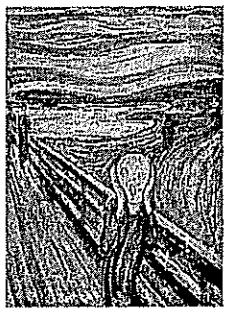
Edvard Munch



The Scream, Edvard Munch, 1893 - Norwegian

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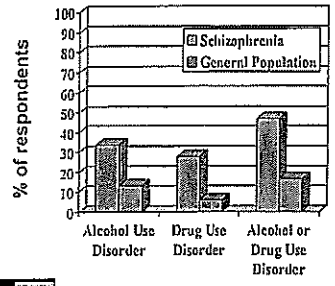
Prevalence of Co-occurring Disorders

ECA Study



Regier et al., JAMA, 1990

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2. Co-occurring Disorders are Costly

Costs

- Subjective
- Psychosocial
- Familial
- Legal
- Health
- Victimization
- Housing
- Mental health

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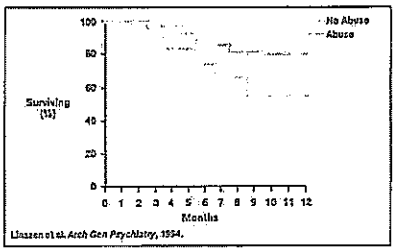
Survival Curves

Survival Curves of Time Until Psychotic Relapse by No Abuse & Abuse of Cannabis



Linszen et al. *Arch Gen Psychiatry*, 1994.

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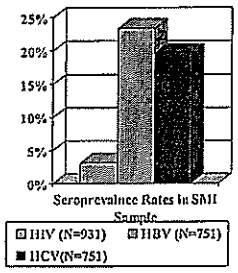
Medical Complications of Co-occurring Substance Use

HIV and Hepatitis B & C



Persons with Substance Use Disorders had

- 2.95 (1.25-6.86) increased risk of HIV
- 1.74 (1.20-2.51) increased risk of HBV
- 2.42 (1.62-3.63) risk of HCV

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Rosenberg et al., Am J Public Health, 2001

Cost of Treatment

Massachusetts Medicaid		
Treat for substance use (N=1,493	Not treated for substance use (N=4,394)	No substance use (N=10,509)
$22,917	$20,049	$13,930

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Dickey & Azeni, Am J Public Health, 1996

3. Parallel Treatment is Ineffective

- High dropout rate
- Less than 10% get both services
- Poor communication
- Interventions not modified
- Poor outcomes

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4. Integrated Treatment Works

- Combined mental health addiction treatment delivered by one provider or team
- Tailored for co-occurrence

46 controlled studies

Drake et al., JSAT, 2008

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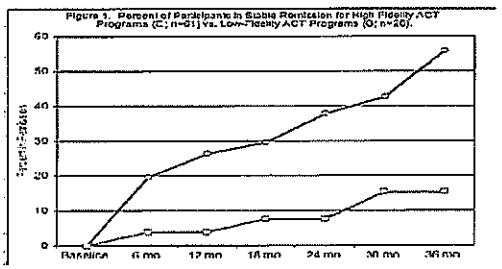
Integrated vs. Non-integrated Treatments



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McHugo et al, 1999

Principles of Integrated Treatment

- Integration
- Assertiveness
- Stage-wise treatments
- Comprehensiveness
- Long-term perspective
- Algorithms

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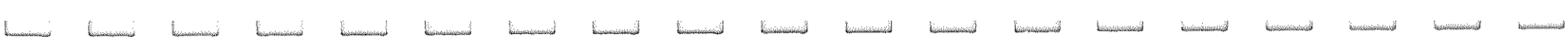

Fidelity is Important

- Programs that faithfully implement the key elements of an EBP have better outcomes
- Correlations 0.3-0.5

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NH ACT Study

	High ACT Fidelity	Low ACT Fidelity
Treatment Dropouts	15%	30%
Substance Use in Remission	58%	13%
Hospital Admissions	2.87	4.69

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McHugo, 1999

5. Recovery is Multi-dimensional

- Recovery is the norm
- Different dimensions
- Dimensions are weakly correlated

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Recovery Index

- Living independently
- Controlling symptoms
- Actively managing substance abuse
- Work competitively
- Socializing with non-substance users
- Expressing life satisfaction

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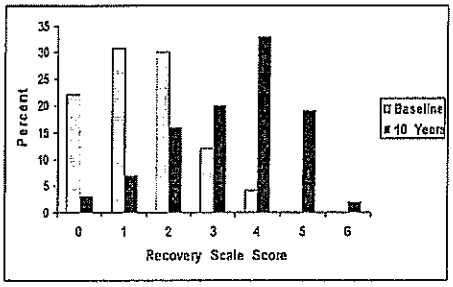
Recovery Score by Year



Distribution of Composite Recovery Scores at Baseline & 10 Years

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6. Specific Interventions

- Psychiatric symptoms
- Substance abuse
- Housing
- Employment
- Relationships
- Life satisfaction

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7. Treatments

Specific Treatments for Co-occurring Substance Use Disorders

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Specific Interventions

- Individual counseling: 7 studies
- Group counseling: 8 studies*
- Family psychoeducation: 1 study
- Intensive outpatient program: 2 studies
- Residential treatment: 12 studies *
- Case management: 11 studies
- Contingency management: 6 studies *
- Legal interventions: 5 studies
- Peer support: 1 study
- Medications: 2 studies

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*Effective for substance use disorder Drake et al., 2008

8. Relapse Prevention

No controlled studies

Correlates:

- Safe housing
- Employment
- Social supports
- Treatment relationship

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9. Importance of Employment

- Substance abuse is uncorrelated with employment
- Supported employment is effective with people who have dual disorders
- The nature of recovery
- Relationship to costs

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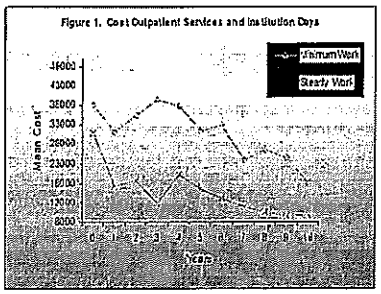
Mueser et al 2011

Cost Savings



Each person with a SMI who becomes employed achieves an average savings in health costs of $5,000 per year

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Bush et al. 2009

Average Cost Savings

$160,000 over 10 years
for each client who
becomes a steady worker

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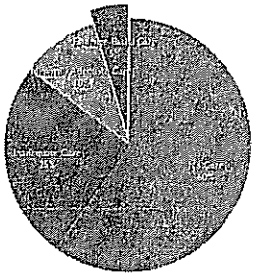
10. Implementation Research

The 95% Problem



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Vitamin C for Scurvy

An Early Randomized Trial

- Methods: Four-ship voyage to India in 1601. In one ship, sailors received 3 teaspoons of lemon juice per day
- Results: At halfway point, no sailors had died in the treatment group. In the control group 110 of 278 (40%) had died of scurvy

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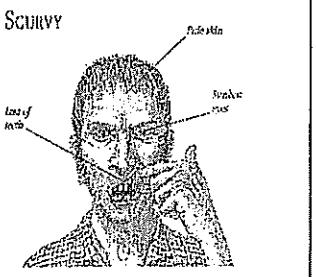
Source: Bervick, JAMA, 2003

Dietary Standards

The British Navy Adopted Dietary Standards for Scurvy:

(a) 1602
(b) 1625
(c) 1697
(d) 1795



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S. Blasiy, Man-of-War (1993).

Quality Improvement (QI)

Trends in Health Care

- Passive diffusion
- Guidelines and systematic reviews
- Adaptations of quality control from industry
- Systems reengineering

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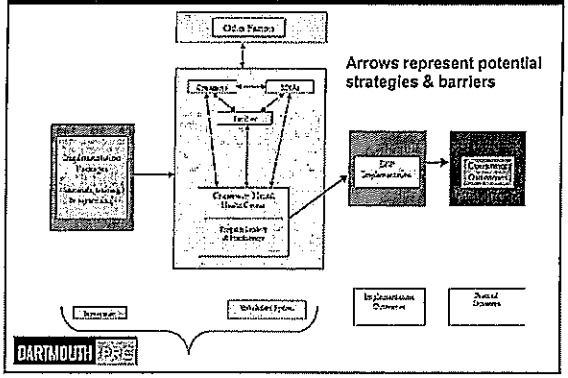
Implementation Model



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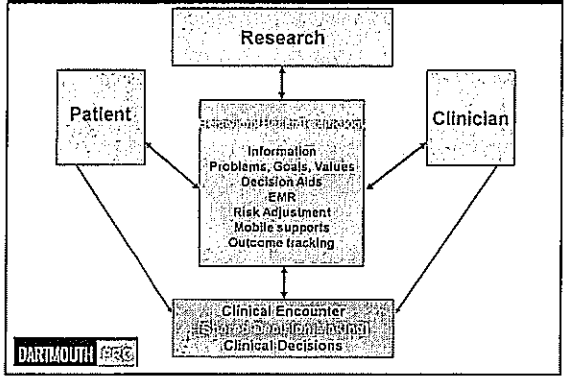
Evidence-based medicine & shared decision making



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11. Current Research

- Groups, housing, contingency management
- Implementation
- Technologies
- Shared decision making
- Family/social support interventions
- Trauma interventions
- Smoking cessation
- Medications

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Conclusions

- 30 years of COD research
- Steady treatment improvements
- Integrated treatment is effective
- Individualized treatment algorithms
- Implementing evidence-based practices

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Financial Support to PRC

- Grants from NIDA, NIAAA, NIMH, NIDRR, SSA, RWJF, SAMHSA
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- Deborah Becker

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SPECIAL ARTICLE

Management of persons with co-occurring severe mental illness and substance use disorder: program implications

ROBERT E. DRAKE, KIM T. MUESER, MARY F. BRUNETTE

Psychiatric Research Center, Dartmouth Medical School, 2 Whipple Place, Suite 202, Lebanon, NH 03766, USA

Adults with severe mental illness have extraordinarily high rates of co-occurring substance use disorders, typically around 50% or more, which adversely affect their current adjustment, course, and outcome. Separate and parallel mental health and substance abuse treatment systems do not offer interventions that are accessible, integrated, and tailored for the presence of co-occurrence. Recent integrated interventions for this population have the specific goal of ameliorating substance use disorder and the general goal of improving adjustment and quality of life. The authors overview the current research and offer guidelines related to mission and philosophy, leadership, comprehensive reorganization, training, specific programs, and quality improvement.

Key words: Dual diagnosis, severe mental illness, substance use disorder, integrated interventions

(World Psychiatry 2007;6:131-136)

The ubiquitous interconnections and adverse interactions between mental illnesses and substance use disorders have been documented for over 25 years (1,2). The large population of persons with co-occurring disorders is enormously heterogeneous in regard to type and severity of mental illness and substance use disorder, psychosocial skills and supports, and many other factors (3,4).

Providing services for persons with co-occurring disorders presents a dilemma. In the traditional system of parallel substance abuse and mental health services, few clients are able to access needed treatments for both disorders, and the services are rarely tailored to address the common interactive elements of co-occurrence (5). Therefore, clinicians and researchers have developed a number of strategies that combine, or integrate, mental health and substance abuse interventions. Recent reviews have identified dozens of controlled studies examining a range of psychosocial interventions (6-8) or pharmacological interventions (9) for these people. In addition, the National Evidence-Based Practices Project studied in detail the process of implementation of services for people with co-occurring disorders across several treatment settings (10). Only a few years ago, clinical guidelines called for integrating mental health and substance abuse interventions generically, without specific guidelines for clinical subgroups (11). In this article, we overview recent research and consider the implications for programs providing services to adult clients who have severe mental illness and substance use disorder.

RESEARCH ON CO-OCCURRING SEVERE MENTAL ILLNESS AND SUBSTANCE USE DISORDER

Definitions

"Severe mental illness" is a widely used expression that includes diagnosis, disability, and duration (12,13). In the U.S., most public mental health programs require these criteria for admission, which closely parallel Social Security Administration criteria for disability payments and public insurance (14). Diagnosis encompasses major mental disorders, such as schizophrenia, severe bipolar disorder, and severe depression. Disability indicates serious inability to meet adult role requirements, such as functioning in work, relationships, and self-care. Duration usually entails at least two years of disability. Major mental disorders and substance use disorders are usually defined according to the standard nomenclature of the Diagnostic and Statistical Manual (15). Substance use disorders include abuse or dependence on alcohol or other psychoactive drugs, including prescribed medications used in greater amounts than indicated (and usually excluding nicotine use disorder). Several terms, including dual diagnosis, dual disorders, and co-occurring disorders, are widely used to describe clients who have co-occurring severe mental illness and substance use disorder. In this article, we use these three terms interchangeably.

Interventions for mental illness and substance use disorder include treatments and rehabilitation. Treatments are medications or psychosocial strategies aimed at controlling or eliminating the symptoms or causes of illness or disorder; rehabilitation interventions are intended to improve skills and supports to enable persons to overcome the disabilities associated with illness or disorder. Treatment and rehabilitation overlap considerably.

Recovery has become a dominant concept in the health care system, but has not been consistently defined. It refers to a process of overcoming illness, rather than merely controlling symptoms, and moving beyond illness to pursue a satisfying and meaningful life (16-19). The term recovery is variously used for inspiration, advocacy, service development, policy, and other purposes. It often implies func-

tional outcomes, such as personally meaningful activities and relationships, but also refers to an individual's process of building hope and autonomy.

Prevalence

All mental illnesses, including mood, anxiety, personality, and schizophrenia-spectrum disorders, are associated with an increase in co-occurring substance use disorder compared to the general population (20-22). Furthermore, individuals with the most severe psychiatric disorders tend to have the highest rates of co-occurring substance use disorders. For example, in the largest general population survey of comorbidity conducted to date, the rate of lifetime alcohol or drug use disorder in the general population was approximately 17%, compared to 47% for people with schizophrenia, 56% for people with bipolar disorder, and about 30% for people with another mood disorder or an anxiety disorder (21). These prevalence rates are consistent with many other surveys of people with schizophrenia or bipolar disorder, which indicate lifetime prevalence rates for substance use disorders of about 50% (23-25) and rates for current or recent substance disorder in the range of 25-35% (26-28).

Demographic, family history, and personality characteristics of individuals prone to substance use disorders are similar in persons with severe mental illness and in the general population. Male sex, younger age, lower levels of education, and single marital status are all related to higher vulnerability to substance use disorders, with race/ethnicity often related to the type of substance misused but not the overall prevalence rate (24). Family history of substance use disorder is related to substance use disorder in persons with severe mental illness (29,30), as well as history of conduct disorder and adult antisocial personality disorder (31,32). Individuals with severe mental illness living in urban vs. rural areas do not tend to differ in overall rates of substance use disorder, although the types of substances may vary as a function of their market availability (33). Setting is also related to prevalence (34): individuals with severe mental illness receiving emergency or acute care treatment, as well those who are homeless (35,36) or incarcerated (33,37), have increased rates of substance use disorder.

Psychosocial interventions

Many recent reviews have addressed the rapid development of psychosocial interventions for people with dual diagnosis (6-8,38). The most recent systematic review identified 45 independent controlled clinical trials (7). Despite methodological problems, these studies show the following: a) there is inconsistent evidence to support any individual psychotherapy intervention; b) peer-oriented group interventions directed by a professional leader, despite heterogeneity of clinical models, are consistently effective in helping clients to reduce substance use and to improve other outcomes; c) contingency management also appears to be effective in reducing substance use and improving other outcomes, but has been less thoroughly studied and rarely used in routine programs; d) long-term (one year or more) residential interventions, again despite heterogeneity of models, are effective in reducing substance use and improving other outcomes for clients who have failed to respond to outpatient interventions and for those who are homeless; e) intensive case management, including assertive community treatment, consistently improves residential stability and community tenure, but does not consistently impact substance use; and f) several promising interventions, including family psychoeducation, intensive outpatient programs, self-help programs, and jail diversion and release programs, have received minimal research attention but warrant further study.

Pharmacological interventions

Pharmacological management of both the psychiatric and the substance use disorder is an important foundation of the treatment of clients with co-occurring severe mental illness and substance use disorder. In all of the above psychosocial studies, clients in psychosocial treatment research also received medication management, which was rarely accounted for in analyses. Research on the effects of medications themselves, however, is in its infancy. Thus far research suggests two main points. First, medications shown to be effective for the treatment of alcohol disorders in the general population, such as disulfuram and naltrexone, are probably effective also in clients with serious mental illness (9,39). Second, some medications that treat the mental illness may lead to reduction in the severity of the substance use disorder. Antidepressants appear to reduce not only symptoms of depression but also alcohol use in clients with major depression and alcohol disorder (40). Mood stabilizers are active not only on mania but also on alcohol use in clients with bipolar disorder and comorbid alcohol dependence (41,42). Typical antipsychotics improve the symptoms of schizophrenia but have little effect on co-occurring substance use. Most of the newer (atypical) antipsychotics are equally effective as the typical antipsychotics in improving schizophrenia symptoms and may offer some benefit in reducing craving or substance use, but research is preliminary (43). Clozapine is clearly the most powerful drug in treating schizophrenia symptoms and, at least in quasi-experimental studies, appears to be at the same time the most effective antipsychotic medication in relation to substance use.

Implementation of dual diagnosis programs

Experience with demonstration projects (44) as well as the recent National Evidence-Based Practices Project (10,45)

identify several factors that are critical for successful implementation and maintenance of dual diagnosis programs. These include clear guidelines regarding mission and philosophy, active leadership, comprehensive reorganization, longitudinal training and supervision, and quality improvement.

Course, outcomes, and recovery

As has been clear for many years, the natural course of severe mental illness for most people trends toward improvement, remission of symptoms, and recovery of functioning and quality of life over time, provided the affected individual does not suffer early mortality related to the illness (46). The same is true for individuals with alcohol use disorders (47). For individuals with co-occurring disorders, there has been little longitudinal evidence, though 3-year follow-ups do indicate steady improvements (48-50). Our recent 10-year prospective follow-up shows that steady movement toward recovery is the modal path (51). In this study, dual diagnosis clients themselves identified recovery outcomes and cutoffs: living independently, working in a competitive job, having regular contact with friends who were not substance users, expressing positive quality of life, actively managing substance use disorder, and controlling psychiatric symptoms. The major findings were the following: a) clients improved on all of these outcomes steadily over 10 years, b) the six domains were minimally related to one another, and c) the timing and sequence of movement toward recovery varied widely across clients. In other words, some became employed first, while others made progress in other domains first. We interpreted these findings to mean that recovery is expectable and normative, and that recovery occurs in individual patterns, domains, and rates. We also found that early mortality was common among those who did not attain remission of their substance use disorders (51).

PROGRAM IMPLICATIONS

Mission and philosophy

The clearest implication of the research on prevalence is that all programs for people with severe mental disorders should be considered dual diagnosis programs. Clients with co-occurring disorders are the norm rather than the exception. Every mental health clinician and every mental health program should embrace this reality and adopt reasonable modifications. Specialty teams will simply not suffice, because many clients will be left undiagnosed, untreated, and without needed supports for recovery. Further, many programmatic elements will not be tailored for the needs of dually disordered clients.

Longitudinal research shows that recovery is not only possible but appears to be the modal process for people with dual diagnoses. Nevertheless, many clients, families, and clinicians experience severe short-term problems and, for understandable reasons, manifest discouragement, hopelessness, and despair. They often have little or no information regarding the availability of effective treatments and the possibilities for long-term recovery. These findings imply an ethical imperative to provide education and hope. Hope is an essential aspect of the process of recovery (52-54). Accordingly, hopefulness and a realistic expectation of dual recovery inform the philosophy of dual diagnosis treatment. All clients can be seen as having potential to recover, and all clinicians can be helpful by conveying a realistic message of optimism regarding long-term recovery.

Leadership

The change from a single diagnosis to a dual diagnosis orientation requires many people to modify their attitudes, knowledge, and behaviors. This will not occur quickly. Above all it necessitates leadership. Based on the National Evidence-Based Practices Project (10) and other experiences (44,55), we recommend that leadership be construed in tiers of responsibility. At the ground level, all clinicians, clients and families have roles to play. They need to believe in dual recovery, become educated about their respective roles, and develop the skills and supports to facilitate recovery. They also need to be empowered to help plan and direct the changes. At the level of program managers, supervisors and trainers, leadership involves carefully planning to modify many programs and to facilitate learning for all staff. At the level of director and governance, leaders need to articulate vision, values and commitment. They also need to direct the strategy to insure that organizational structures (e.g., medical records) and finances support the changes.

Comprehensive reorganization

Dual diagnosis typically ramifies into many areas of one's life, and research shows that recovery encompasses different pathways, domains, styles, preferences and timing from one individual to the next. An individualized approach to intervention needs to address several areas of recovery, offer education and intervention choices, and be based on shared decision-making (56). This level of individualization will permit each client to pursue a path that he or she believes in.

Further, all programs need to be modified to insure that they are optimally helpful for clients with dual disorders. For example, medication management needs to avoid dangerous interactions and potentially addictive medications, such as benzodiazepines (57). Supported employment services need to focus on jobs and supports that enhance abstinence (58). Skills training needs to address managing drug purveyors as well as making friends (59).

Training

Training should address the generic needs of all staff as well as the needs of those who are specialists. Because of the high prevalence of substance use disorders in people with severe mental illness, all clinicians need basic training in working with dually diagnosed individuals (60). This includes information about the interactions between substance use and psychiatric illness, clues and instruments for recognizing and assessing substance use problems, an understanding of the concepts of stages of change (61) and stages of treatment (62), treatment planning skills, strategies for engaging clients in treatment and enhancing their motivation for sobriety, and the principles of collaborating with family members and other significant persons in treatment (59). In addition, clinicians who specialize in the treatment of persons with a dual disorder need to develop additional expertise in specific therapeutic modalities, including individual cognitive-behavioral therapy, group-based motivational and skills training approaches, family therapy, as well as skills for addressing common problem areas such as housing instability, legal problems, health problems, and trauma/victimization (59,63,64).

Special programs: group counseling and housing

Peer-oriented groups are the centerpiece of dual diagnosis treatment. The evidence shows that groups are the most effective first-line intervention to help people recover from co-occurring substance use disorder. The groups can be organized in different ways, using different models, meeting at different intensities, and for clients at different stages of recovery. There is as yet no evidence that one type of group is more effective than another; the key is steady attendance for several months, probably at least a year. Therefore, we recommend offering several options so that clients can find a group in which they feel comfortable.

Long-term residential treatment is the only established intervention for clients who do not respond to outpatient integrated treatments. As with group interventions, effective residential treatment programs vary considerably. The common elements of effective programs include flexible entry and discharge, integrated treatment for mental health and substance problems, a focus on employment and other aspects of rehabilitation, graduated approaches to lapses or relapses, and expected tenure of one year or more (65).

Of course, not all clients want or qualify for long-term residential treatment, and programs probably need a variety of other housing approaches (66). For example, a "housing first" approach helps many clients to escape from homelessness and to become motivated for further goals (67). There is also some evidence for a continuum approach to housing (68). Because housing is a primary goal for many clients and the evidence for specific approaches is not strong, providing multiple options makes sense here also.

Quality improvement

Another critical element of organization is quality improvement. This can take many forms, but most current approaches involve system engineering, data-based supervision, computerized medical records, electronic decision support systems, fidelity reviews, and intensive review of individual clients who are not making progress (69). A full discussion of quality improvement mechanisms is beyond the scope of this paper, but commitment to quality improvement is essential for successful program implementation.

CONCLUSIONS

As the literature on dual diagnosis continues to develop rapidly, programmatic implications for treating clients with co-occurring disorders become more specific. This paper overviews several steps that all mental health leaders should consider, including efforts to reconfigure mental health programs into dual recovery programs. We strongly urge further research with greater standardization and methodological rigor to move this field ahead (70).

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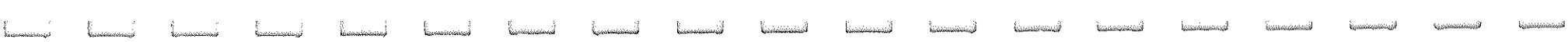

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Chris Herren was a high school basketball legend from Fall River, Massachusetts, who scored over 2,000 career points while at Durfee High School and was named to the 1994 McDonald's All-American team. Herren realized his lifelong dream of playing in the NBA when he was drafted by the Denver Nuggets in 1999 and then was traded to his hometown team, the Boston Celtics in 2000. After suffering a season-ending injury as a Celtic, Herren went on to play in five countries including Italy, Poland, Turkey, China, and Iran.

Herren struggled with substance abuse for much of his basketball career. Alcohol and drug-free since August 1, 2008, he has refocused his life to put his sobriety and family above all else. He shares his harrowing story of abuse and recovery in his memoir, *Basketball Junkie*, as well as in numerous interviews throughout the Emmy nominated ESPN Films documentary *Unguarded*, of which he is the subject. In June of 2009, he launched Hoop Dreams with Chris Herren, a basketball player development company that offers basketball training, camps, and clinics to top basketball prospects in New England.

Off the court, Chris Herren continues to share his story with audiences in the hopes of reaching just one person and making a difference in his or her life. In inspiring presentations, he draws on his own history to convince audiences that it is never too late to follow your dreams and urges audience members to overcome their setbacks and start making the right choices.

To support this vision, he founded The Herren Project, a nonprofit organization dedicated to providing treatment navigation, educational and mentoring programs to those touched by addiction and to educate people of all ages on the dangers of substance abuse. In 2012 The Herren Project launched a national anti-substance abuse campaign, Project Purple, to encourage people of all ages to stand up to substance abuse. Since 2012, it is estimated that over 300,000 teens nationwide have taken the pledge to make good choices, standing up and together against drugs and alcohol. The Herren Project continues to make a significant impact nationwide one person, one family at a time.

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