MASSACHUSETTS
HEALTH POLICY COMMISSION

Availability of Co-occurring Disorders Treatment in Massachusetts: Survey Findings and Policy Recommendations

January 16, 2019

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- **Background**
- Survey Methods and Research Questions
- Results
- Recommendations and Next Steps

Basis for Studying the Availability of Providers Treating Co-occurring Mental Illness and Substance Use Disorder

Ch. 52 of the 2016 Session Laws, *An Act Relative to Substance Use, Treatment, Education and Prevention,* charged the HPC, in consultation with DPH and DMH, with assessing the availability of providers treating "dual diagnosis", or co-occurring mental illness and substance use disorder (SUD):

1. Create an **inventory of health care providers capable of treating patients (child, adolescent, and/or adult) with dual diagnoses**, including the location and nature of services offered at each such provider.

2. **Assess sufficiency of and barriers to treatment**, given population density, geographic barriers to access, insurance coverage and network design, and prevalence of mental illness and SUD.

3. **Make recommendations to reduce barriers to care.**

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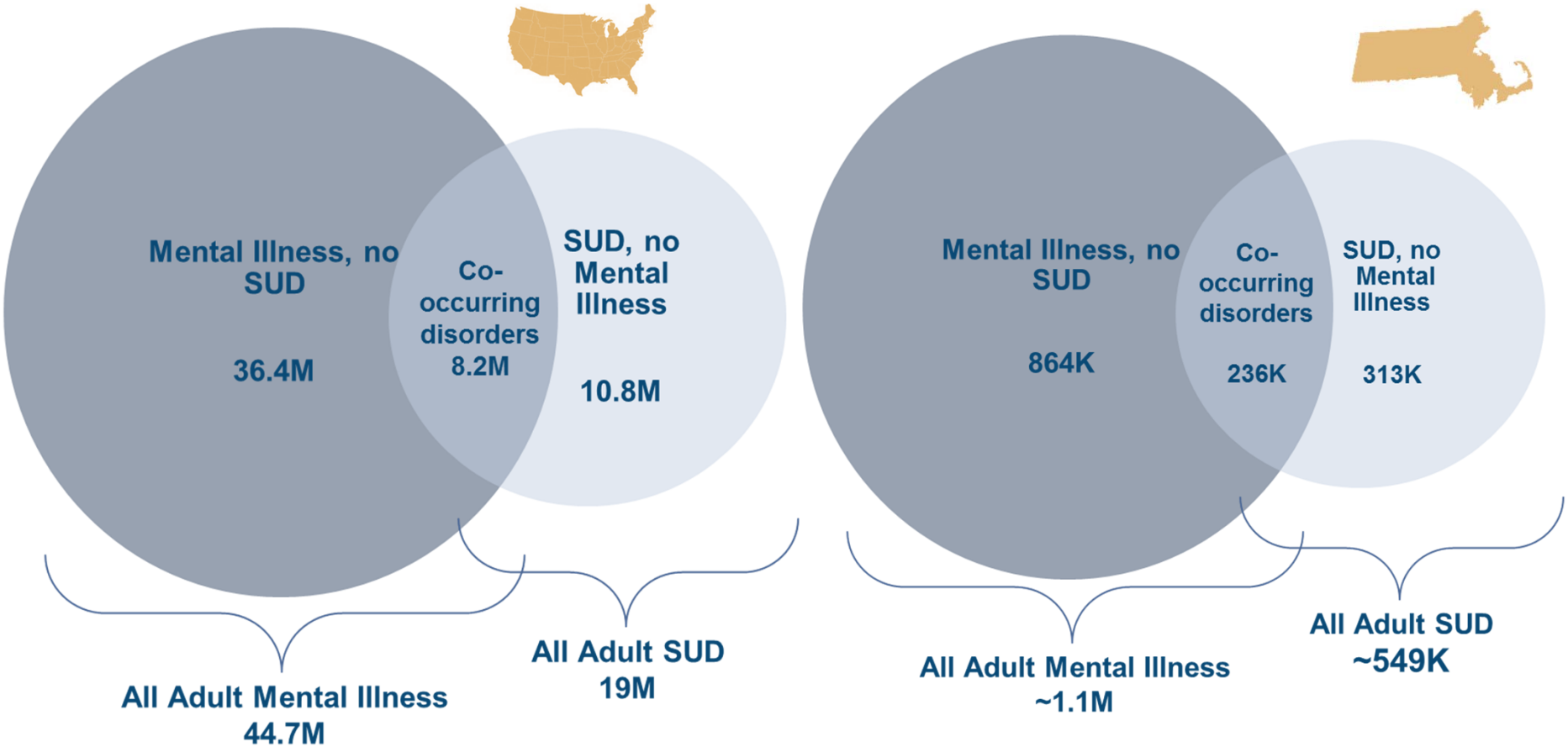
Prevalence of Mental Illness, SUD, and Co-occurring Disorders



Nationally, co-occurring disorders affect ~18% of adults with mental illness and ~43% of adults with SUD. Approximately 20% and 10% of Massachusetts adults reported past year mental illness or SUD, respectively.

Sources:

1. SAMHSA. *Substance Use and Mental Health Indicators in the United States: Results from the 2016 National survey on Drug Use and Health.* "Past Year SUD and Mental Illness among Adults 18 and older, 2016.". September 2017.
2. MA estimations interpolated based on data from: SAMHSA. 2015-2016 National Survey on Drug Use and Health: Model-Based Prevalence Estimates. Available: https://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2016/NSDUHsaePercents2016.pdf

Treatment Rates for Co-occurring Disorders Are Very Low, Especially for People with Serious Mental Illness

Co-occurring SUD with *Any* Mental Illness — **3.4**% of adults

- Approximately **half** did not receive health care services for *either* condition
- Only **~7**% received both mental health care and specialty substance use treatment

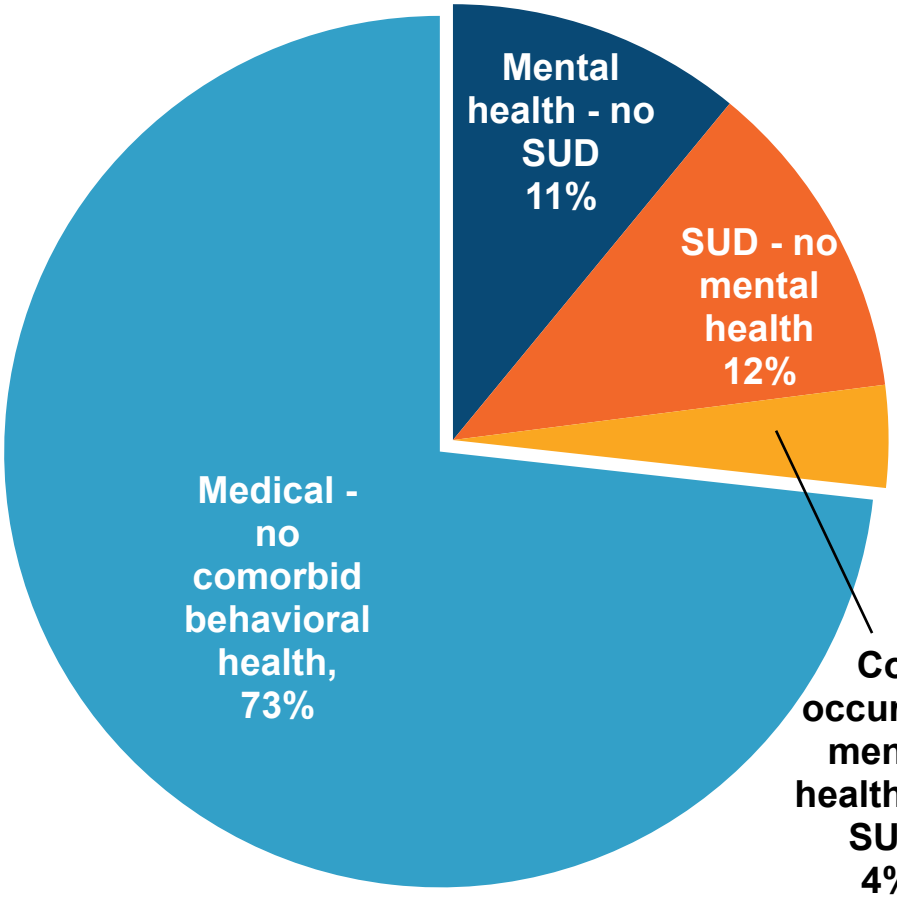
Co-occurring SUD with *Serious* Mental Illness — **1.1**% of adults

- Approximately **one third** did not receive health care services for *either* condition
- Only **1-2%** received **both** mental health care and specialty substance use treatment

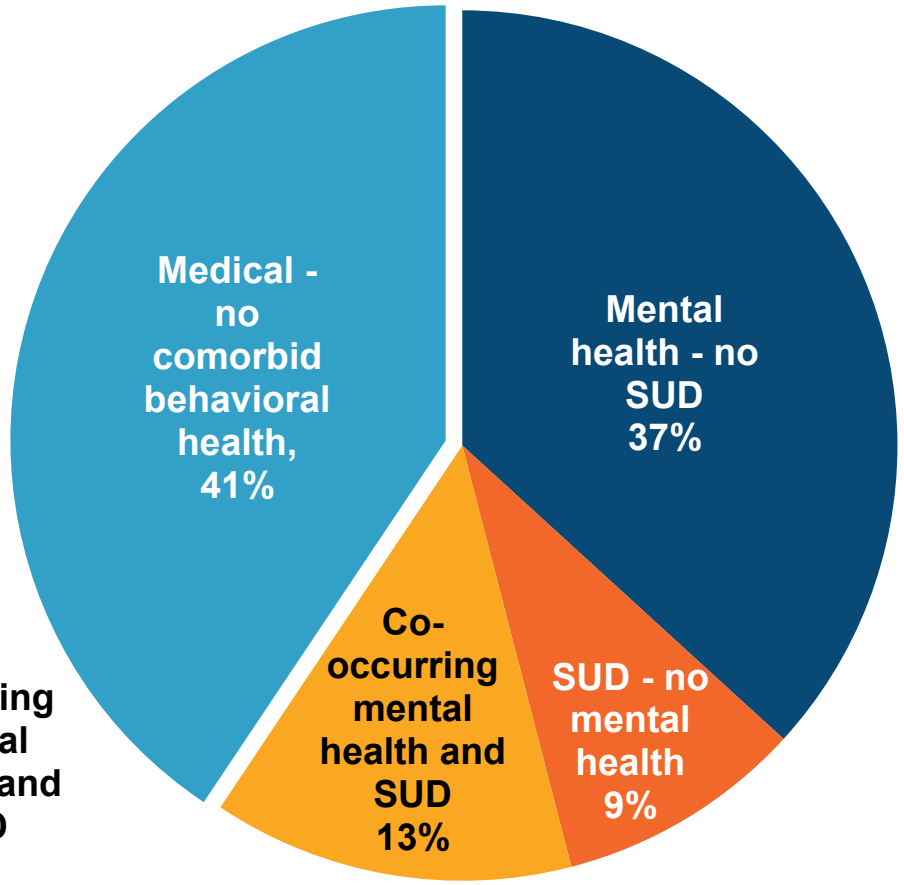
Source: SAMHSA. *Substance Use and Mental Health Indicators in the United States: Results from the 2016 National survey on Drug Use and Health.* September 2017.

Co-occurring Mental Health and SUD Comorbidities Were Identified in 6% of Massachusetts Acute Hospital Visits in 2016 (Combined Inpatient and ED)

Adult Emergency Department Visits by Diagnosis Type, FY2016; n= 1,929,455



Adult Inpatient Discharges by Diagnosis Type, FY2016; n=649,278



Source: HPC analysis of Center for Healthcare Information and Analysis Hospital Inpatient Discharge and Emergency Department Databases, 2016.
Notes: Data limited to adults eighteen and older. Mental health and SUD diagnoses were identified using the ICD-10 CCS categories in primary, admitting, discharge or secondary diagnosis fields. Co-occurring disorders were identified by records where the discharge included both a mental health and SUD diagnosis in any of the diagnosis fields. The discharges include all discharges including both those for primary medical conditions, and those with primary mental health or SUD conditions.

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Importance of Integrating Treatments for Mental Illness and SUD

- Patients with mental illness are at higher risk than the general population for SUD, and vice versa.[1]
- The clinical presentations of mental illness and SUD can confound each other: without proper training in recognizing both, providers may misinterpret symptoms, misdiagnose patients, and provide suboptimal treatment.[2]
- Complications of untreated mental illness and substance use:
  - Self-medication by individuals with untreated or under-treated mental illness can affect the presentation and severity of their psychiatric symptoms.[3]
  - Patients with untreated or under-treated SUD are more likely to violate the rules of psychiatric programs or facilities and to drop out of treatment.[4]

→ **Treatment of one while screening for and, as appropriate, treating the other produces optimal care.**

Sources:

1. Merikangas KR, et al. (1998). Comorbidity of substance use disorders with mood and anxiety disorders: results of the International Consortium in Psychiatric Epidemiology, *Addictive Behaviors*, 23, 893-907.
2. Crawford V, Crome IB, & Clancy C (2003). Co-existing problems of mental health and substance misuse (dual diagnosis): a literature review. *Drugs: Education, Prevention, and Policy*, 10, S1-S74.
3. Comorbidity: Substance Use Disorders and Other Mental Illnesses. North Bethesda, MD: National Institute of Drug Abuse; 2018 Aug 1. Available from: https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/drugfacts-comorbidity.pdf
4. Case N (1991). The dual-diagnosis patient in a psychiatric day treatment program: a treatment failure. *Journal of Substance Abuse Treatment*, 8 69-73.

Comprehensive Care for People with Co-occurring Disorders

SAMHSA's *Treatment Improvement Protocol (TIP) 42* recommends the following as essential roles and services for people with co-occurring disorders:

1. Screening, assessment, and referral for persons with co-occurring disorders
2. Physical and mental health consultation
3. Prescribing onsite psychiatrist
4. Medication and medication monitoring
5. Psychoeducational classes
6. Onsite modified mutual self help groups
7. Offsite dual recovery mutual self-help groups

Source: Substance Abuse Treatment for Persons with Co-occurring Disorders: Treatment Improvement Protocol (TIP) Series No. 42. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2013 Jul. Available from: https://store.samhsa.gov/system/files/sma13-3992.pdf.

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Facility and Clinician Licensure Responsibilities Are Distributed Across Multiple State Agencies

Office of Consumer Affairs and Business Regulation

Division of Professional Licensure (DPL)

- **Board of Registration of Psychologists**
  Psychologists
- **Board of Registration of Social Workers**
  LCSW, LICSW
- **Board of Registration of Allied Mental Health and Human Services Professionals**
  LMHC, psychiatric rehabilitation counselor

Executive Office of Health and Human Services

- **Board of Registration in Medicine (BORIM)**
  MD, DO
- **Department of Public Health (DPH)**
  - **Bureau of Health Professions Licensure**
    - **Board of Registration in Nursing**
      RN, APRN
  - **Bureau of Healthcare Safety and Quality (BHCSQ)**
    - **Division of Healthcare Facility Licensure and Certification (DHCFLC)**
      All outpatient and inpatient health care facilities
  - **Bureau of Substance Addiction Services (BSAS)**
    Inpatient SUD treatment facilities including detoxification and residential rehabilitation; acute services; and outpatient facilities serving given volume of patients or providing given threshold of intensity of care
    LDAC
- **Department of Mental Health (DMH)**
  Psychiatric hospital inpatient and clinically intensive residential facilities treating voluntarily or involuntarily committed patients

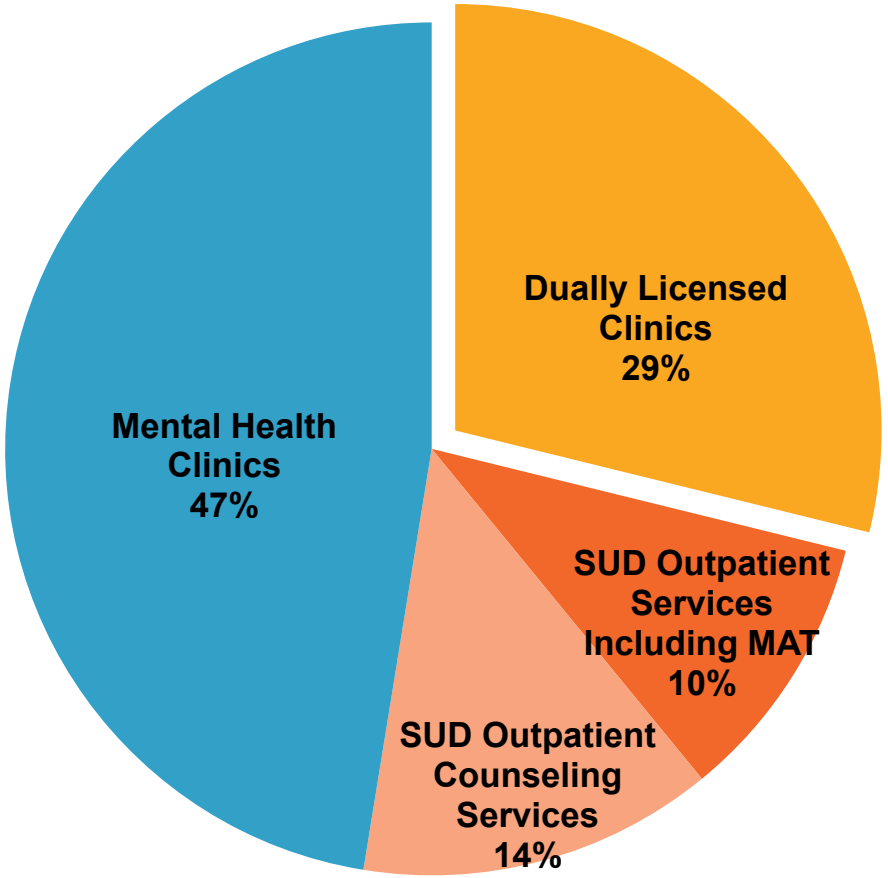
Challenges of a multi-pronged licensure system include:

- Billing and coding differences
- Administrative burden on providers maintaining multiple licenses

Note: some settings of care for mental illness, SUD, and co-occurring disorders are not included in this chart (e.g., VA care, public health hospitals, and section 35 units).

Only 29% of Behavioral Health Clinics and Counseling Sites Are Licensed to Treat Both Mental Illness and SUD

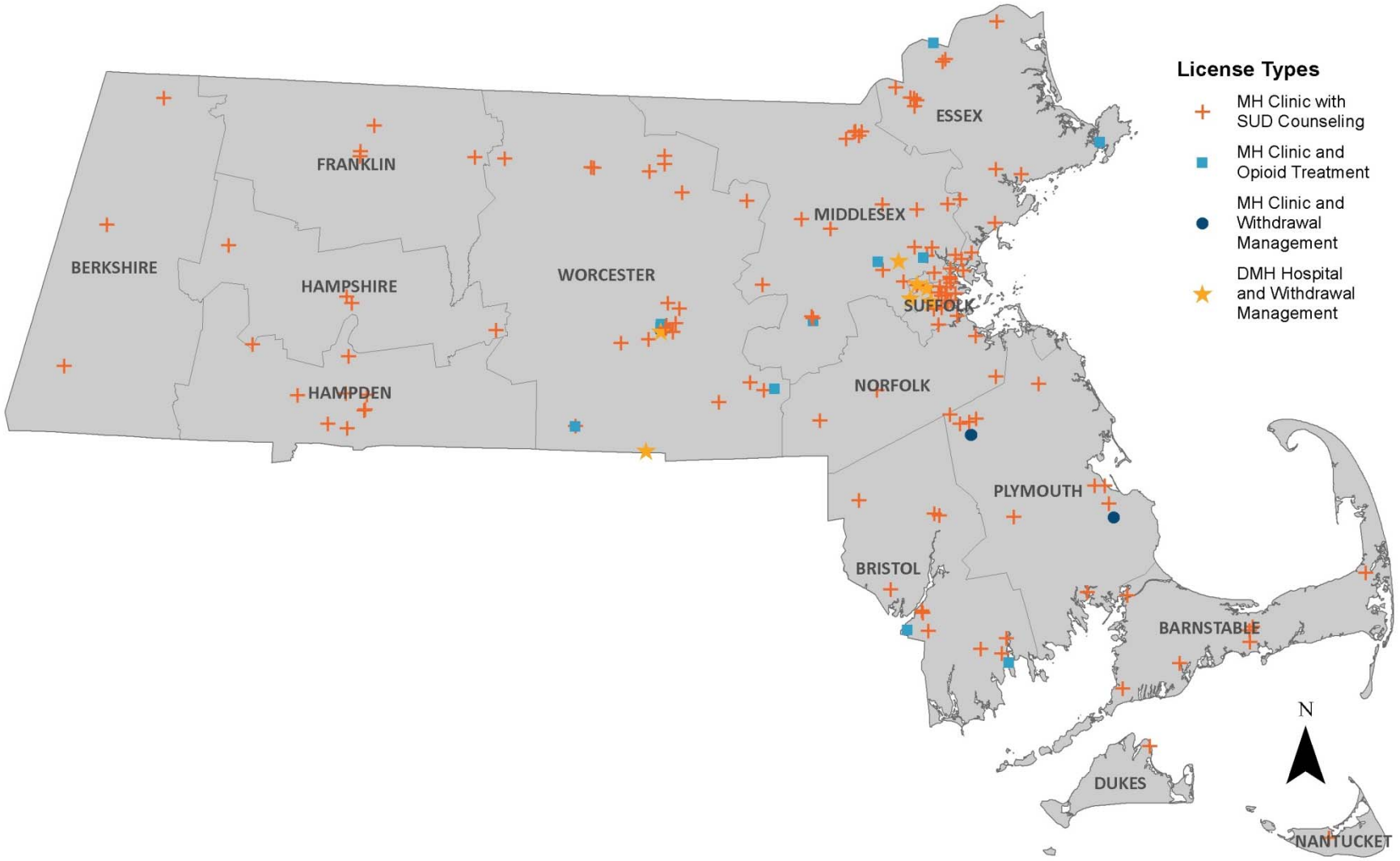
N (all license types)=586



- Mental health clinics without an SUD license represent 50% of providers
  - These sites may still treat patients with SUD, per individual staff members' clinical licenses
- Clinics with dual licensure follow BSAS requirements for staffing and treatment protocols

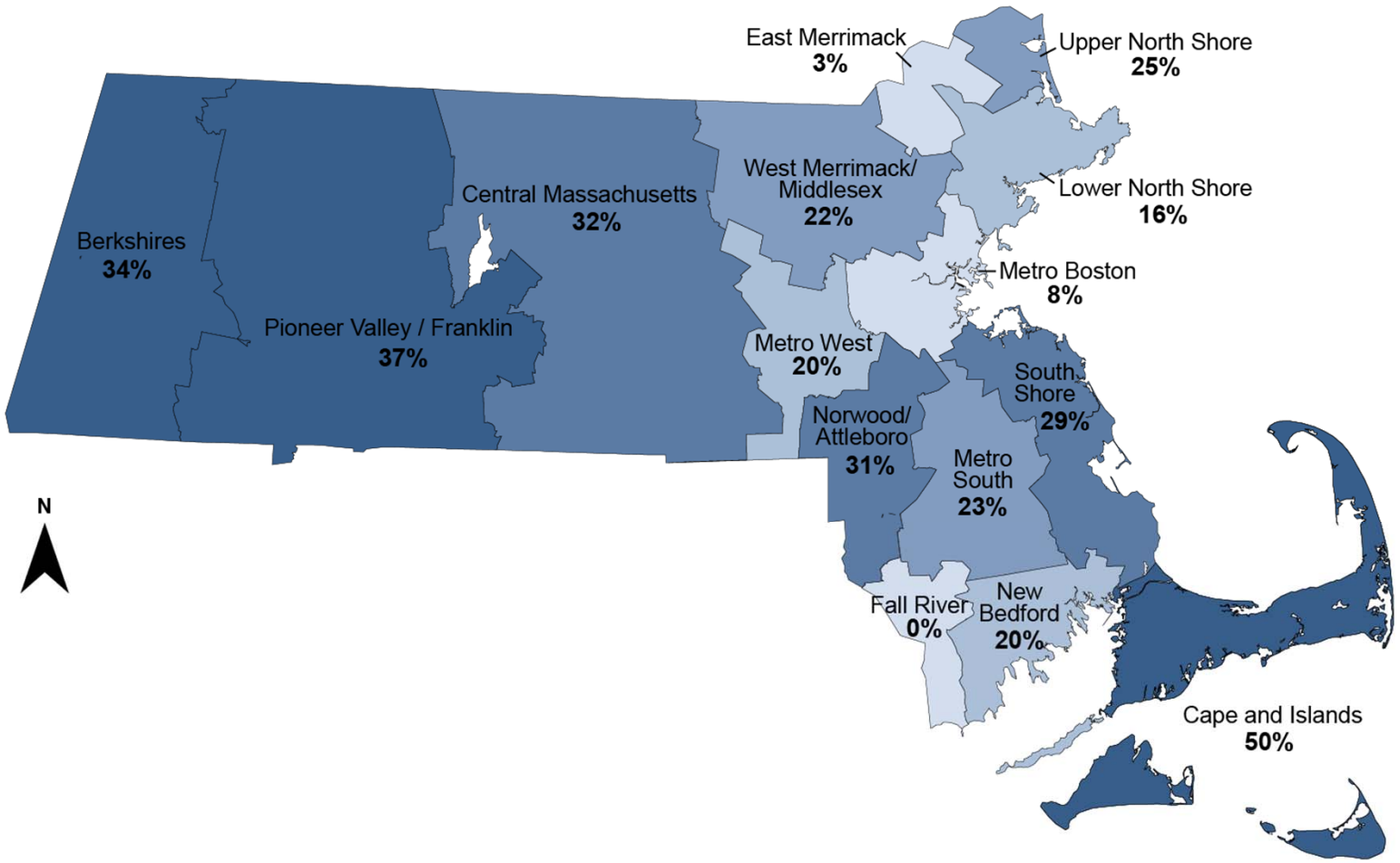
Source: HPC analysis of DPH (Division of Health Care Facility Licensure and Certification and Bureau of Substance Addiction Services) licensing data.
Note: while community health centers (CHC) that have mental health or SUD licenses are included, any CHC or primary care provider not licensed as a mental health or SUD clinic is not included, regardless of whether it provides prescribing for mental health or SUD.

Locations of All Dually Licensed Provider Sites in Massachusetts, 2018



Source: HPC analysis of DPH (Division of Health Care Facility Licensure and Certification and Bureau of Substance Addiction Services) and Department of Mental Health licensing data.

Percent of Population Over 18 Who Live More Than a 15 Minute Drive from the Nearest Dually Licensed Clinic, 2018



Note: There are 15 HPC regions, which are based on patterns of patient travel for inpatient care. For more information on how HPC created these regions, please see: http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-technical-appendix-b3-regions-of-massachusetts.pdf. Driving distance is based on HPC analysis of population by zip code from American Community Survey, 5 year estimates, 2016, U.S. Census Bureau

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Methodology of HPC's Survey of Providers Treating Co-occurring Disorders

- HPC combined data from **commercial payers' provider directories** and data from the Substance Abuse and Mental Health Services Administration (**SAMHSA**) with **state licensing data** from **DMH** and multiple bureaus within **DPH**.
- HPC cross-referenced these files by address and provider name to identify the number of licensed provider sites by type(s) of license and HPC region.
- HPC contracted with a vendor to survey providers to determine:
  - services provided
  - populations served
  - the extent to which services specifically for co-occurring disorders are provided
  - barriers to providing integrated care for co-occurring disorders
- The survey received responses from 405 sites of service, representing slightly more than 50% of licensed behavioral health treatment sites in Massachusetts.
- In addition, the survey received responses from 170 independent clinicians in active practice who represent an important component of commercial payers' behavioral health provider networks.

Survey Research Questions

Populations Served

- To what extent are behavioral health providers treating patients with co-occurring disorders?
- Do providers explicitly exclude patients with co-occurring disorders?
- Are there certain populations (e.g., by age group, specialized need, or diagnoses) for which there are fewer organizations or clinicians providing services?
- Are there levels of care (e.g., inpatient, intensive outpatient, etc.) for which services for people with co-occurring disorders are less available?

Integrated Services Available

- To what extent is care provided in an integrated setting?
- Are SUD providers able to provide or arrange for mental health prescribing?
- Are providers who treat co-occurring disorders able to provide or arrange for SUD prescribing (e.g., methadone, buprenorphine, naltrexone)?

Barriers

- What do providers perceive as the major barriers to care for this population?
- How does language affect ability to provide care?
- What are wait times for initiating care? How does this vary by language, geography and services?
- Are staff trained on co-occurring disorders?
- What administrative, insurance and payment issues impact availability of care?

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Topic Areas of Survey Findings

Licensing and Regulation

- Number of providers offering services for mental illness, SUD, or both, versus those licensed to do so

Integrated Care Models

- Providers' prescribing arrangements for psychiatric medication and MAT
- Wait times for MAT

Workforce

- Wait times for patients who do not speak English
- Staff trained in co-occurring disorders care

Payment

- Payment rate disparities
- Payment policy barriers to integration (e.g. no same day billing)

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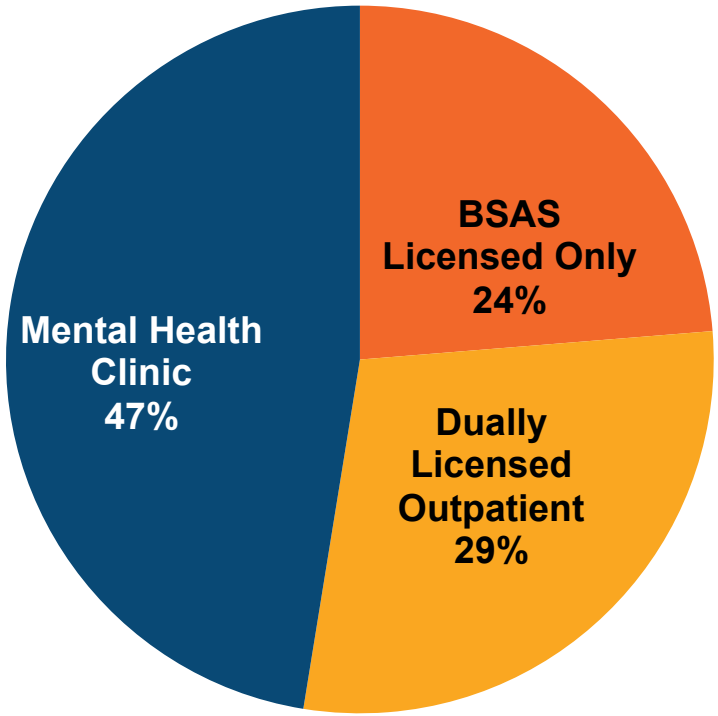
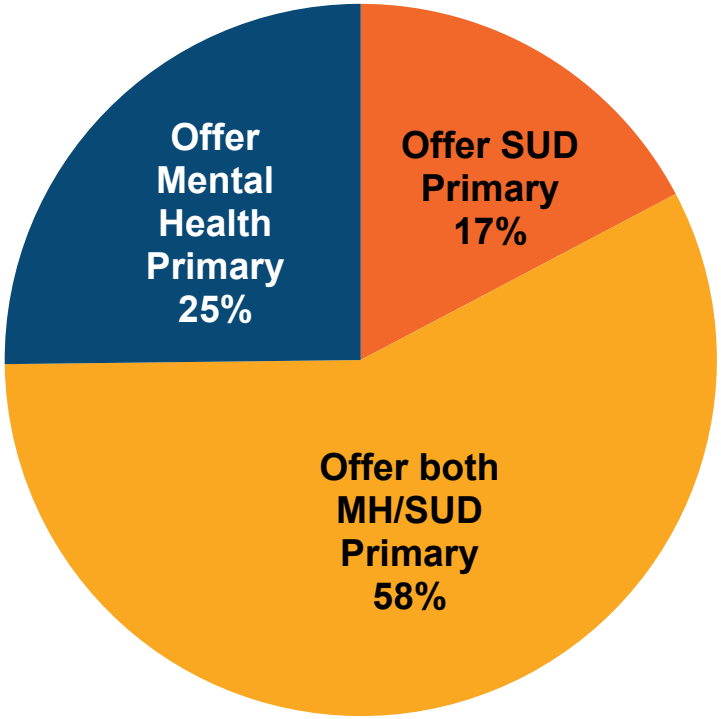
Survey Respondents Reported Offering Both Mental Health and SUD Services at a Higher Rate Than the Dual Licensure Rate Would Suggest

Clinics that are licensed only to provide mental health services are allowed to treat SUD, as their individual clinicians' professional licenses authorize them to treat *any* behavioral health diagnoses. While these sites may choose not to pursue parallel BSAS licensure, they still serve patients with co-occurring disorders.*

Licensed Clinic By Types, as of October 2018, N=586



Survey respondents by Primary Service, N=405



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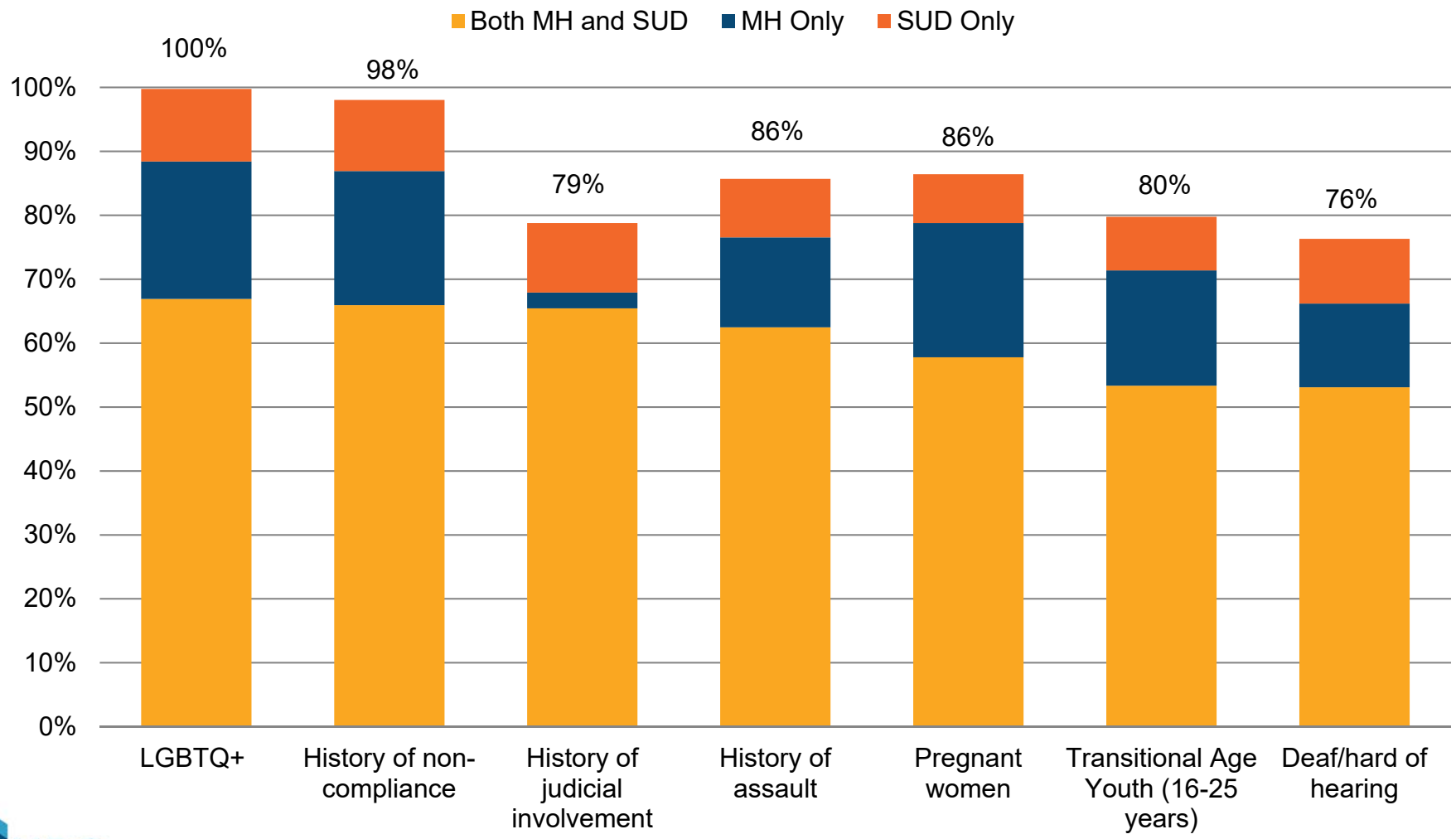
* This situation is also true for clinics that are licensed to provide SUD services and do not seek parallel mental health clinic licensure.

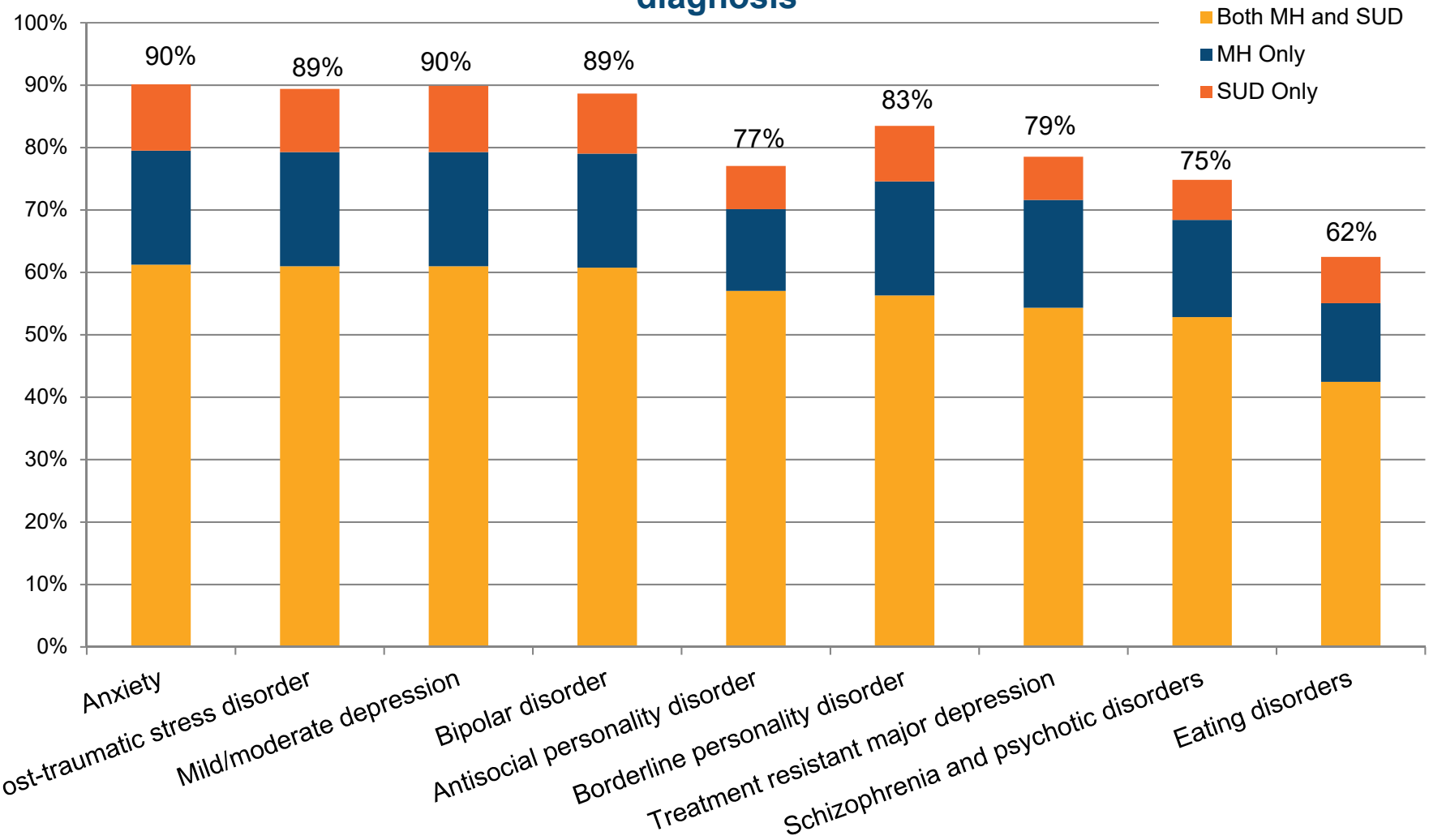
Providers Reported Different Rates of Treating Particular Vulnerable Populations

Percentage of responding providers that treat vulnerable populations



Providers Reported Different Rates of Treating Particular Mental Illnesses

Percentage of responding providers that treat a given mental health diagnosis



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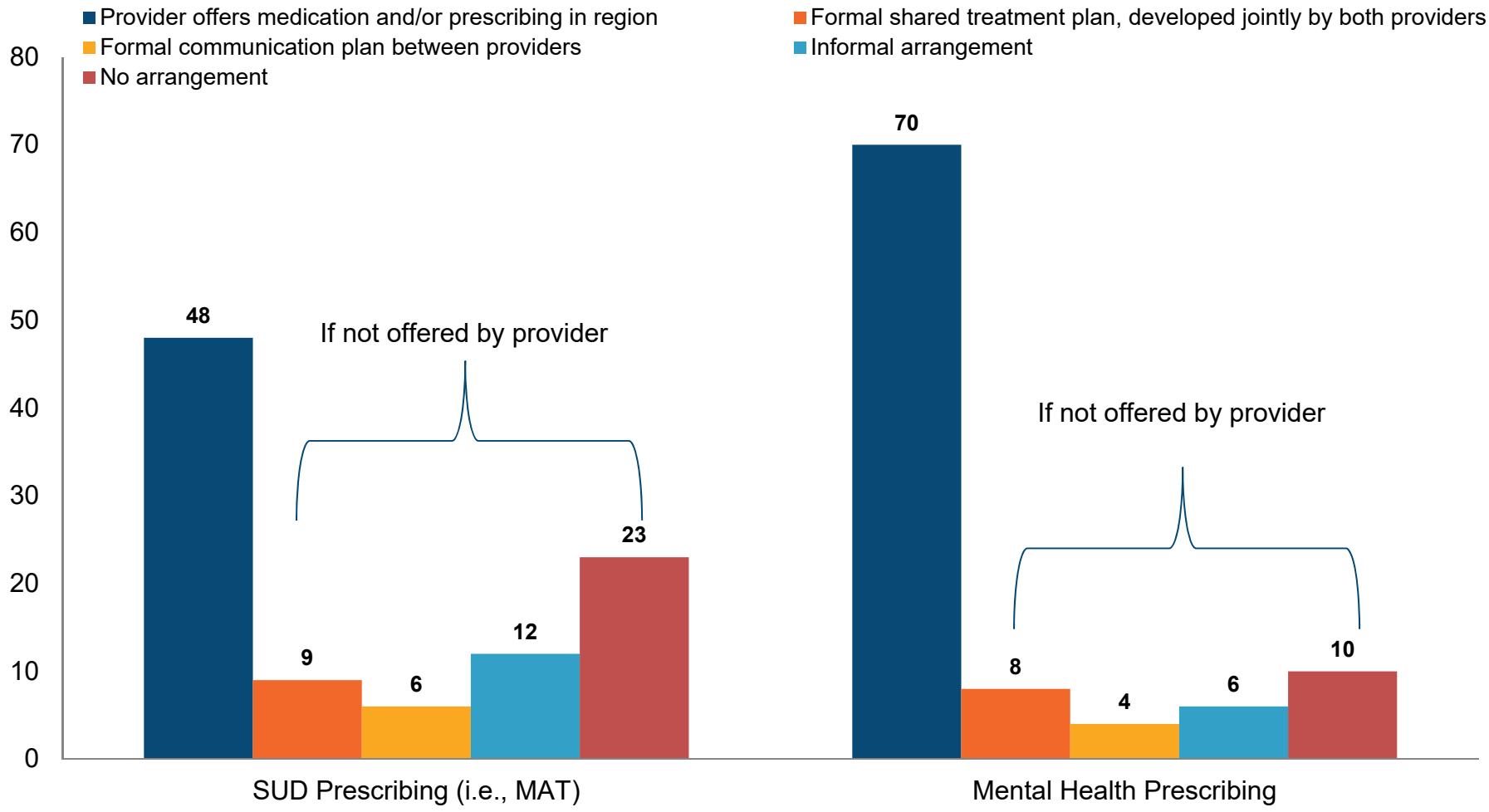
Note: a similar analysis on substance treated showed little variation by substance.

Providers Reported a Range of Prescribing Arrangements: Some Have No Arrangements for Providing Medication

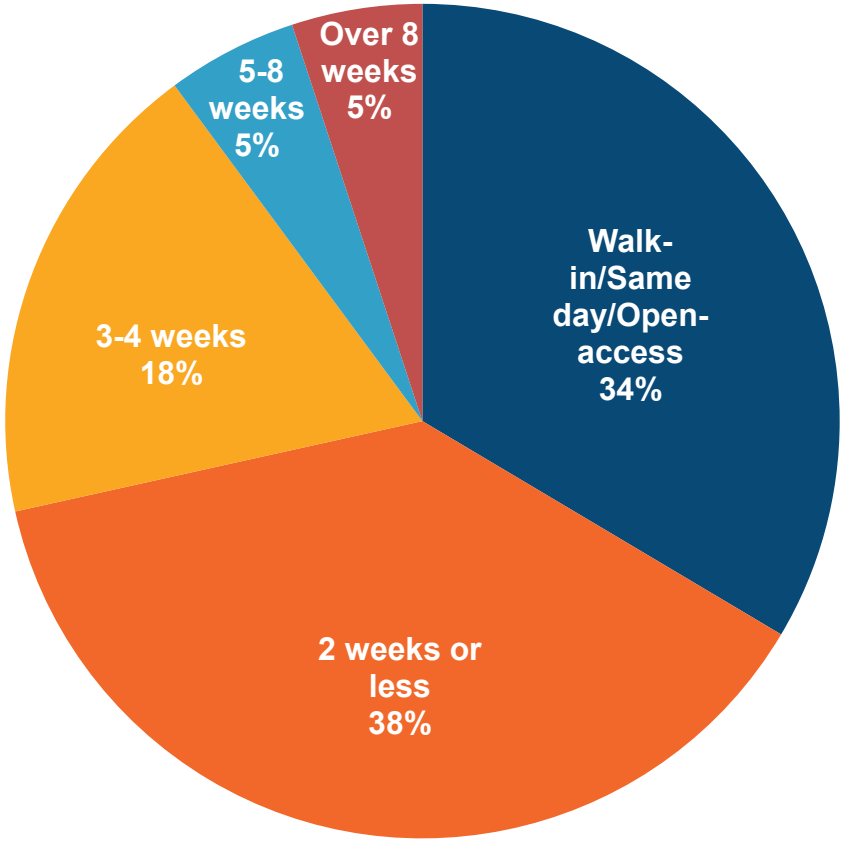
Prescribing and medication arrangements at providers who report serving co-occurring disorder (n=98*)



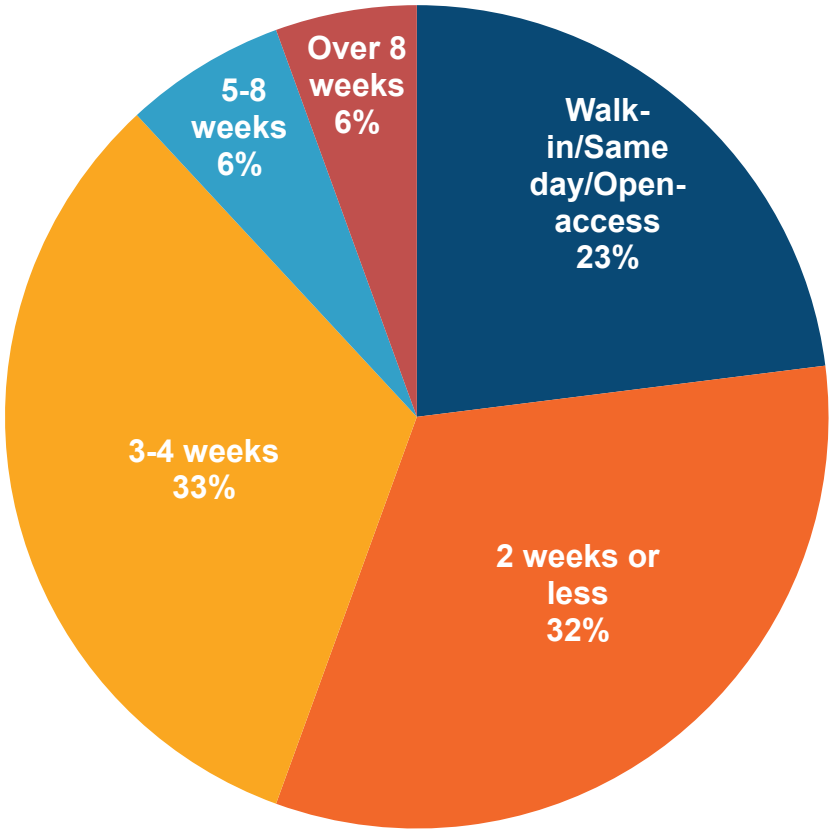
*Of all survey respondents that reported offering outpatient services for mental health and SUD, 98 responded to both 1) a question about SUD prescribing and 2) about mental health prescribing.

Patients at Responding Providers' Sites Face Longer Waits for Co-Occurring Disorders Care If They Do Not Speak English

Time to First Appointment for Adults with Co-occurring Disorders who speak English



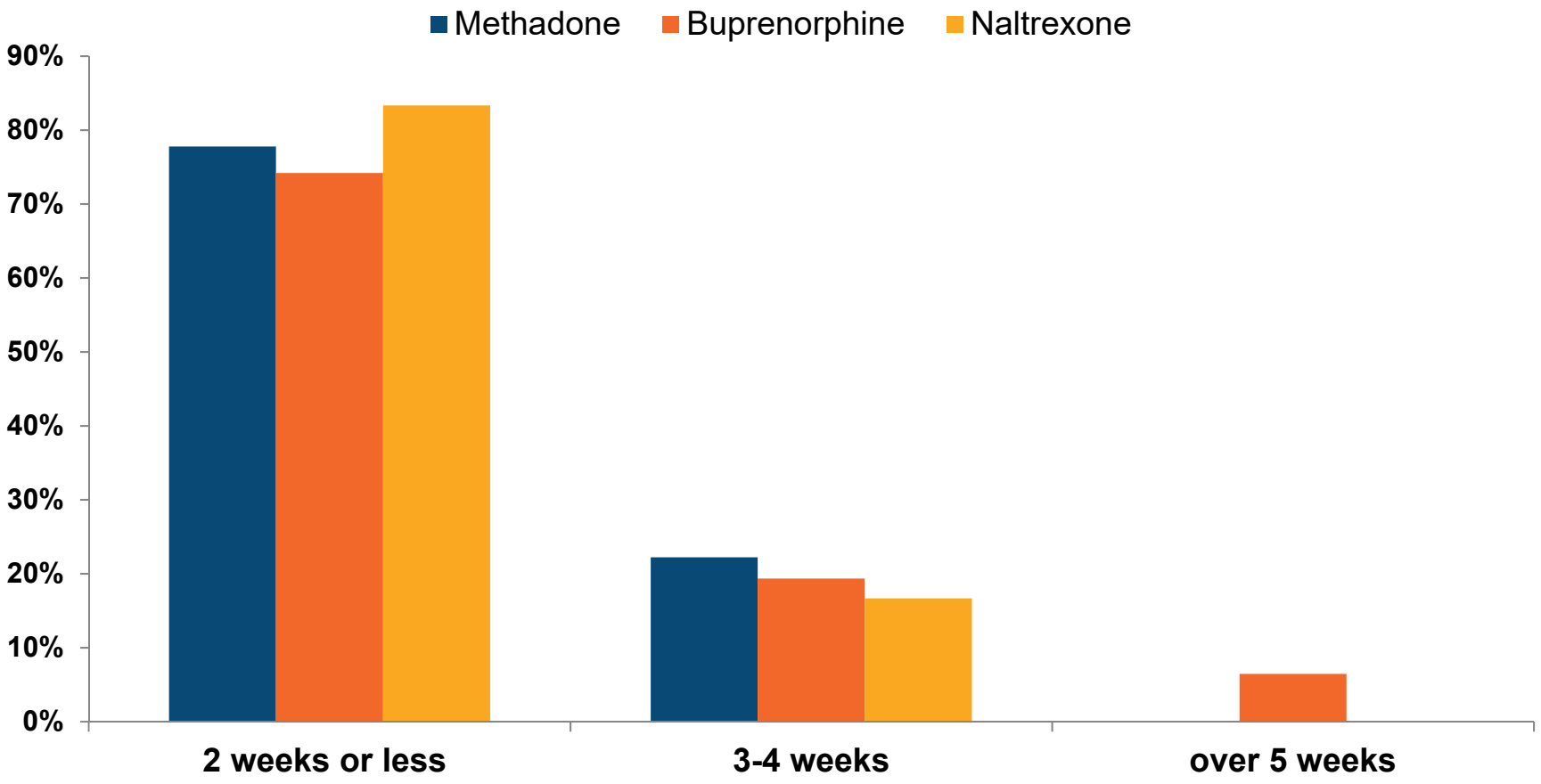
Time to First Appointment for Adults with Co-occurring Disorders who do not speak English



Note: the survey did not distinguish between prescribing versus non-prescribing services within questions about access based on language needs.

Some Responding Providers Reported Delays Over Two Weeks to First Appointments for Medication for Addiction Treatment (MAT)

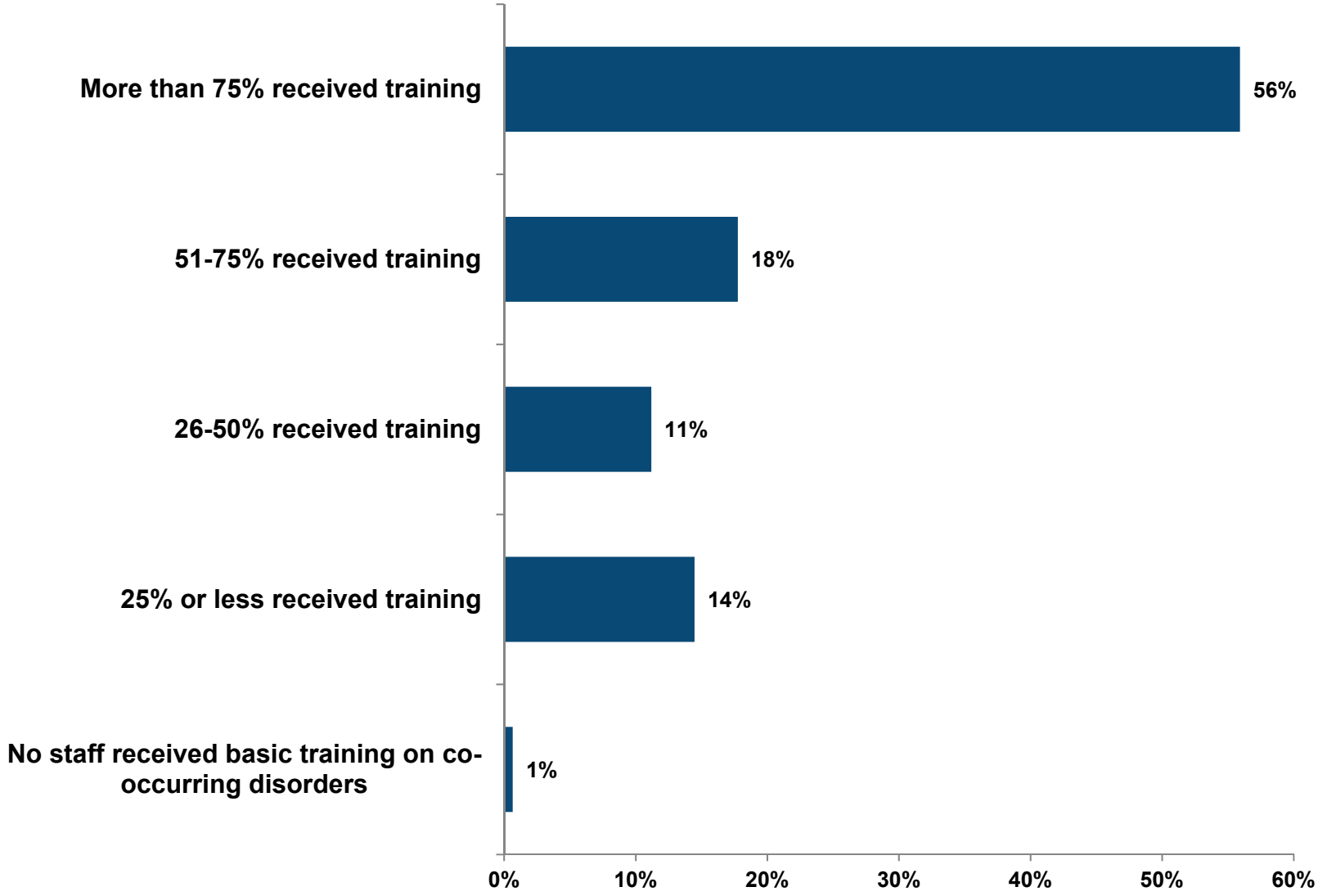
Time to first appointments for MAT for people with co-occurring disorders, by type of MAT



Note: The survey question did not distinguish whether first appointments were for assessment or medication initiation. Extended release naltrexone can precipitate acute withdrawal so delay until first dose is appropriate for patients still withdrawing from opioids.

The Majority of Providers Reported That More Than 75% of Their Staff Received Basic Training on Co-occurring Disorders

Staff with Basic Training on Co-occurring Disorders, Percent of Responses



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Draft Policy Recommendation Areas

Licensing and Regulation

Integrated Care Models

Workforce

Data, Infrastructure and Payment Support

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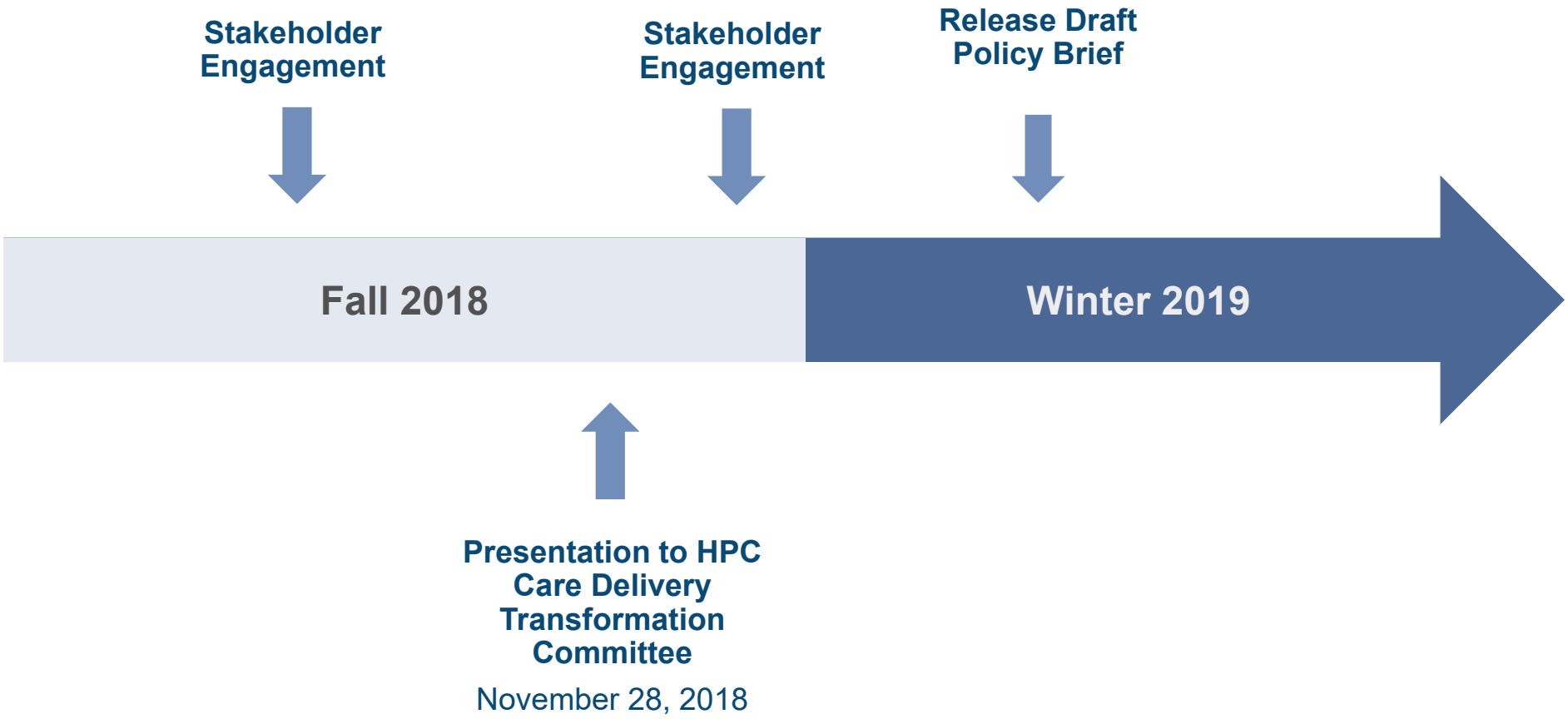
Next Steps


Stakeholder Engagement
Stakeholder Engagement
Release Draft Policy Brief
Fall 2018
Winter 2019
Presentation to HPC Care Delivery Transformation Committee
November 28, 2018