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Brief articles

Staff Perceptions of Substance Use Disorder Treatment in VA Primary Care–Mental Health Integrated Clinics☆

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ABSTRACT

Introduction: Guidelines recommend that substance use disorder (SUD) treatment be available in primary care–mental health integrated clinics, which offer mental and behavioral health assessment and treatment in the primary care setting. Despite this recommendation it is unclear what barriers and facilitators exist to SUD treatment being provided in that setting. This work sought to understand current SUD services in such integrated clinics, explore other services may that be appropriate, and identify barriers to such services.
Methods: We conducted qualitative interviews with 23 staff members from integrated clinics at 6 Veterans Affairs medical centers. We transcribed interviews and performed thematic analysis to identify emergent themes.
Results: We identified seven themes affecting staff experience and ability to provide SUD services in the integrated clinic: clinical effectiveness, clinical requirements, regulatory requirements, program goals, proximity of the integrated clinic and SUD services, training on substance use disorder, and role specialization.
Conclusions: VA primary care–mental health integrated clinic staff members do not currently view SUD treatment as the focus of their work, but are open to offering SUD treatment including brief psychological interventions or medication. Several barriers to providing SUD treatment were identified, including the need for additional staff training around appropriate interventions for the integrated clinic setting, additional staffing and space, and a structured implementation strategy to promote the use of SUD treatments.

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1. Background

Substance use disorders (SUDs), including substance abuse and substance dependence, are a common problem in the United States (Kessler et al., 2005). A diagnosis of SUD is based on evidence of impaired control, social difficulties, risky use, and pharmacological criteria such as tolerance and withdrawal (APA, 2013). SUDs occur when the recurrent use of alcohol or drugs results in clinically significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home (APA, 2013).

Like the general U.S. population, veterans of U.S. military service also often struggle with SUDs. Approximately 13% of Veterans Affairs (VA) patients misuse alcohol (Harris, Bryson, Sun, Blough, & Bradley, 2009). The overall 5 year prevalence of diagnosed opioid abuse among VHA enrollees is 1.11%, with an overall prevalence of 3.04% for veterans with an opioid prescription (Baser et al., 2014). The use of other illicit drugs such as cannabis and cocaine is also common among veterans (Harris, Gifford, Hagedorn, & Ekstrom, 2011).

The VA/DoD clinical practice guidelines (CPGs) provide ratings of the evidence for various SUD interventions, which are categorized into four ratings, including "strong for," "weak for," "weak against," and "strong against." The VA/DoD guideline has given a "strong for" rating score to three broad interventions to treat SUDs: screening and brief counseling, psychosocial interventions, and pharmacotherapy (VHA, 2015).

First, population based screening for unhealthy alcohol use as well as a brief alcohol intervention for those with positive screens receives a "strong for" recommendation. This may lead to monitoring, encouraging community support for recovery, and referral to specialty SUD care for addiction treatment for select groups of patients. Second, psychosocial interventions receive "strong for" recommendations for several substance use disorders. Specifically, cognitive behavioral therapy is recommended for alcohol use disorder, cannabis use disorder, and stimulant use disorder. Motivational enhancement therapy is recommended for alcohol use disorder and cannabis use disorder. Recovery-focused approaches such as community reinforcement are recommended for alcohol use disorder and stimulant use disorder. Additional psychosocial interventions recommended for alcohol use disorder include behavioral couple therapy and 12-step facilitation. There is also a recommendation for contingency management for patients with stimulant use disorder. A

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number of medications receive a "strong for" recommendation including four medications for alcohol use disorder (acamprosate, disulfuram, naltrexone, and topiramate) and three medications for opioid use disorder (buprenorphine, methadone, and naltrexone).

Historically, veterans who required SUD treatment were referred to the specialty SUD clinics. However, in an effort to better meet the needs of veterans, the VA now recommends that screening, counseling and basic SUD treatments also be offered in primary care settings as well as mental health care settings (VHA, 2008). Integrated models of primary care and mental health were developed to bridge the gap between mental health care delivered by primary care providers and traditional mental health models (Post, Metzger, Dumas, & Lehmann, 2010). The "primary care–mental health integrated clinic", henceforth referred to as the "integrated clinic", is located in primary care where mental health treatments are provided by mental health workers rather than primary care providers. To facilitate the implementation of the integrated clinics, the VA provided funding starting in 2006 to implement 90 new integrated clinic programs. By 2009, 131 of 139 VA facilities reported operational integrated programs (Post et al., 2010). As of 2016, the VA Mental Health Information System (Trafton et al., 2013) reported that 95% of VA facilities meet the integrated program requirements.

Despite the large volume of research focused on SUDs, there is little known about evidence or staff perceptions of SUD treatment provided in integrated clinics. There are no published VA studies and very few studies outside the VA that examine the use of evidence-based treatments for alcohol, opioid or other illicit drug use in the integrated clinics. Chan, Huang, Sieu, & Unutzer (2013) found that among patients in the integrated clinic, one-third were not screened for substance use. Furthermore, of those who screened positive, only one-third received referrals for substance abuse treatment or obtained access to appropriate treatment. The authors highlighted the need to equip primary care providers with brief interventional skills, the need to integrate mental health and SUD services, and to continue efforts to improve access to SUD treatment.

Additional research supports the need to enhance access to SUD services for those patients with SUD. Maust, Mavandadi, Klaus, & Oslin (2011) found that primary care patients who screened positive for depression or PTSD had significantly higher odds of being referred to additional services than for patients with positive screen for alcohol use. Similarly, Shiner et al. (2014) found that primary care patients with positive screens for depression or PTSD who were seen in mental health clinics received guideline concordant treatment whereas few patients who screened positive for alcohol misuse received guideline recommended care in any setting. Barry, Epstein, Fiellin, Fraenkel, & Busch (2016) recently published findings of a US Web-based survey for persons diagnosed with SUD who are not currently in treatment. Through the use of vignettes, participants appear to be more willing to enter treatment in a primary care setting than a SUD specialty clinic (Barry et al., 2016). These findings support that SUD treatment may not be appropriately addressed in primary care–mental health integrated clinics. As a first step to understand SUD treatment in VA primary care–mental health integrated clinics, we conducted qualitative interviews with integrated clinic staff members to explore their perceptions about current SUD services and identify barriers and facilitators to providing evidence-based SUD treatments.

2. Methods

The study was reviewed and approved by the Dartmouth Committee for the Protection of Human Subjects.

2.1. Sampling

Staff members at six VA facilities participated in this study. To identify sites, we first solicited the facilities where each of the three VA endorsed integrated care models were developed. These models include Co-located Collaborative Care, Behavioral Health Laboratory, and Translating Initiatives in Depression into Effective Solutions (Chang et al., 2013). Second, we solicited one additional VA facility which has implemented each of the three endorsed models. We used purposive sampling to identify study participants at each of the six sites. For initial contact at the six sites, we emailed the lead for primary care–mental health to invite staff at the site to participate in the research study. In our correspondence, we described the goals of the study and our interest in conducting a site visit to talk with various integrated clinic staff members about the current use of substance use disorder treatment services. The lead identified additional staff members to approach and arranged a schedule during a 2 day site visit. Informed consent was obtained prior to the interview.

2.2. Participants

Participants included 23 staff members of the integrated clinic including psychologists, registered nurses, nurse practitioners, psychiatrists, and care managers.

2.3. Development of the interview guide

A multidisciplinary team of researchers (mental health clinicians, health services and implementation researchers) developed a semi-structured interview guide. The interview guide was informed by a previously developed framework, PARIHS (Harvey et al., 2002; Kitson, Harvey, & McCormack, 1998; Kitson et al., 2008; McCormack et al., 2002; Rycroft-Malone, Harvey, et al., 2002; Rycroft-Malone, Kitson, et al., 2002; Stetler, Damschroder, Helfrich, & Hagedorn, 2011). The PARIHS framework posits that the success or failure of an implementation effort can be explained through the relationship of three dimensions: evidence, context, and facilitation (Rycroft-Malone, Kitson, et al., 2002). 'Evidence' is the agreed upon knowledge of effectiveness; 'Context' is the environment or setting in which the health care activities occur; and 'Facilitation' has been defined as, "a technique by which one person makes things easier for others," through "support to help people change their attitudes, habits, skills, ways or thinking, and working" (Kitson et al., 1998). General topics covered in the interview guide include: role in the PC-MHI; familiarity with SUD treatments; SUD treatments currently offered in PC-MHI; role/involvement in treating veterans with SUD; familiarity with SUD policies; use or presence of an integrated care model; extent to which SUD treatments not currently offered might be delivered; and facilitators and barriers to SUD treatment in the PC-MHI.

2.4. Interview process

We conducted 30–60 minute semi-structured interviews to learn about substance use disorder treatments provided in the integrated clinic setting. Staff members were asked similar questions during the interview, although we did tailor some follow-up questions based on the individual's role in the clinic (e.g., prescriber, therapist, registered nurse, etc.). In general, the interviews were designed to allow respondents to articulate their opinions and experiences completely before the interviewer moved on to the next topic or concept. When needed, the interviewer used prompts such as "tell me more" or "do you have anything more to add?" to solicit additional information. The interviews were conducted by a psychiatrist and implementation scientist between May 2014 and June 2014. All interviews were recorded. Audio recordings from the interviews were transcribed and any identifying information was deleted from the files.

2.5. Analysis

We conducted both inductive and deductive qualitative coding using the interview transcripts. A doctoral level researcher (LZ)