Health Plan Requirements for Mental Health and Substance Use Screening in Primary Care

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BACKGROUND: Screening for substance abuse and mental health in primary care can improve detection. One way to advance screening is for health plans to require it.

OBJECTIVES: We developed national estimates of the prevalence and type of mental and substance-use condition screening health plans require of primary care practitioners.

DESIGN: In 1999 ($N=434$, response rate=92%) and 2003 ($N=368$, response rate=83%), we conducted a nationally representative health plan survey regarding alcohol, drug, and mental health services, including screening requirements.

PARTICIPANTS: Health plans reported on screening requirements of their top three private insurance products. Products were categorized by type (HMO, POS, or PPO), behavioral health contracting arrangements, tax status, market area population, and region.

MEASUREMENTS: We asked whether primary care practitioners are required to use a general health screening questionnaire (including mental health, alcohol, or drugs items) and/or a screening questionnaire focused on mental health, alcohol, or drug problems.

RESULTS: By 2003, 34% of products had any behavioral health screening requirements. Although there was no increase from 1999 to 2003 in requirements for any kind of behavioral health screening, requirements for using a standard screening instrument declined for mental health but increased for alcohol and drug screening. PPOs showed the largest increase in prevalence of behavioral health screening requirements. Products contracting with managed behavioral health organizations were more likely to require screening.

CONCLUSIONS: Most products do not require behavioral health screening in primary care. More screening could help to improve identification of behavioral health conditions, a first step towards effective treatment.

KEY WORDS: primary care; screening; mental health; substance abuse; health plans.

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INTRODUCTION

Only a fraction of those who need care for mental or substance-use conditions receive treatment, in part, because their need for services is not recognized^{1,2}. Even among those who eventually seek treatment, the median delay from symptom onset to help-seeking is 6 years for alcohol dependence, 8 years for major depression, and 9 years for generalized anxiety disorder³. Screening is a key first step to identify individuals with mental or substance-use conditions who often do not perceive their need for help so that they can be offered treatment. There is a growing emphasis on the role of primary care practitioners in addressing behavioral health problems, and screening for mental and substance-use conditions is one important strategy that primary care practitioners can use to improve problem recognition and shorten the time to start of treatment⁴.

A strategy of screening in primary care settings is fruitful for three reasons: First, primary care practitioners have access to a large segment of the population; in 2001, 68% of adults reported an appointment for routine care within the past year⁵. Second, numerous screening instruments are available. A voluminous literature supports the validity and reliability of mental and substance-use condition screening tools (e.g., AUDIT for alcohol or Zung for depression) and their sensitivity and specificity are equivalent to those used to detect somatic problems⁶. Standard screening questionnaires specifically designed to detect these conditions improve problem detection. Screening questions can be asked as a stand-alone risk assessment or embedded in a general health questionnaire, administered by a practitioner or completed by the patient, and are valuable both in a targeted population and as a universal program. Third, screening is clearly only a first step. While screening alone has not been shown to improve outcomes, screening combined with appropriate interventions has demonstrated benefit^{7–9}. For instance, a screening and brief intervention trial for problem drinkers demonstrated a 30% risk reduction for excessive drinking in the past week after 12 months and 20% fewer emergency department visits after 4 years^{10,11}. Moreover, a recent review showed that collabora-

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tive care, including screening, for depression is effective in improving outcomes^{12,13}.

Despite sound clinical rationale, many primary care practitioners do not screen using standard questionnaires nor do they talk with their patients about emotional problems or substance abuse. A national study reported that among adult primary care patients, 28% had discussed drinking or drug use, and 21% had been asked about depression or anxiety symptoms during routine health visits within the past year^{14,15}. Moreover, providers often fail to consider mental or substance-use conditions in the list of possible problems when patients present with physical complaints^{16,17}.

Low screening levels are inconsistent with the recommendations of expert panels. In 2002, the United States Preventive Services Task Force (USPSTF) recommended depression screening for adults in practices that have systems in place for appropriate continuing care¹⁸. While USPSTF has not revisited their neutral stance on screening for drug problems from the second edition, in 2004, they reaffirmed a recommendation for alcohol misuse screening^{9,18,19}. The gap between current clinical recommendations and present practices is not unique to mental health and substance-use condition screening. For instance, McGlynn and colleagues found that patients received only 52% of all recommended screening services (across a spectrum of medical conditions) for which they were eligible²⁰.

One potentially effective approach to closing this gap is to have health plans require the recommended service²¹. Among individuals covered by employer-based insurance, 97% are in managed care plans including health maintenance organizations (HMOs), point of service (POS) plans, or preferred provider organizations (PPOs)²². We conducted a national survey of these health plans in 1999 and again in 2003 to determine the prevalence of requirements for primary care practitioners to screen for mental health, alcohol, and drug abuse problems. We aim to answer three questions. First, has the proportion of health plans requiring screening changed from 1999 to 2003? Second, has the type of screening requirement changed? Third, do screening requirements vary by type of insurance product (HMO, POS, or PPO) and behavioral health contracting arrangement (specialty carve-out, comprehensive contracts, or internal)?

METHODS

Data Sources and Sample

A nationally representative health plan survey on alcohol, drug abuse, and mental health services was conducted in 1999 and again in 2003 in 60 market areas across the United States (Horgan et al., 2007, manuscript under review). In 1999, we surveyed 434 health plans, (92% response rate); in 2003, we

Figure 1. Sample selection for 1999 and 2003.

surveyed 368 health plans (83% response rate). This telephone survey included an administrative module addressing behavioral health contracting arrangements, treatment benefits, network management, and provider payment, and a clinical module that addressed primary care screening and treatment, entry into specialty care, utilization management, drug formularies, and other clinically oriented behavioral health topics. Each plan was asked about its top three private HMO, POS, or PPO insurance products with the highest enrollment.

Typically, there were two respondents per plan (executive director for the administrative module and medical director for the clinical module, or their designees). For some national or regional plans, we interviewed respondents at corporate headquarters regarding multiple sites, and some plans referred us to their behavioral health vendor for questions regarding specialty services. Items were asked at the product level within each market-area-specific health plan. Data collection methods were similar for 1999 and 2003. Notwithstanding our high response rates, we conducted a nonresponse analysis; responding plans were slightly less likely to offer only PPO products.

The study is linked to the Community Tracking Study (CTS), a longitudinal study of health system change, funded by the Robert Wood Johnson Foundation²³. The CTS sample design contained strata for large metropolitan, small metropolitan, and nonmetropolitan market areas. Within strata, nearly all sites were randomly selected with probability proportional to size (a few sites selected with certainty). The primary sampling units for our survey were the 60 market areas selected for the CTS to be nationally representative. Our second sampling stage consisted of selecting health plans within market areas. Plans serving multiple markets were defined as separate plans for the study, and data were collected with reference to the market area. Sample selection is depicted in Figure 1.

We categorized products as HMO, POS, or PPO. Contracting arrangements include products with specialty managed behavioral healthcare organization (MBHO) contracts, with comprehensive (combined general medical and behavioral health) contracts, and with internal-only provision (services provided by health plan employees or through a network directly administered by the plan). In addition to survey data, we used 2003 Census Bureau data to estimate market area population and mapped our sites to aggregated Census region²⁴.

Screening Measures

The clinical module included items regarding screening by primary care practitioners for mental health, alcohol, and drug problems. For each insurance product, we assessed whether products required primary care providers to use a general health screening by asking, "Under (product), are primary care practitioners required to use general health screening questionnaires that include questions about mental health problems, alcohol problems, or drug problems?" We also asked "Under (product), are primary care practitioners required to use standard screening questionnaires specifically designed to detect (condition) among at least some of their patients?" to determine if products required the use of a specific instrument. Respondents were asked about specific screening of mental health problems, alcohol problems, and drug problems separately and were cued with the names of specific screening instruments if needed. In our analysis, we judged a product to

have any behavioral health screening requirement if it reported either a general screening requirement or any specific screening requirement for mental health, alcohol, or drug problems. We did not ask which specific instrument plans required, whether plans reimburse for screening, if plans provide questionnaires, or how these requirements impacted provider behavior.

Statistical Analysis

The data are weighted and represent national estimates of health plans' private insurance products in the continental United States. Statistical analyses were implemented using SUDAAN software to allow accurate estimation of the sampling variance given our complex sampling design²⁵. We used *t*-tests to compare estimates across years. We also constructed four logistic regression models. The first model, which includes all products, has, as its dichotomous dependent variable, any (general or specific) required screening. The other three models, conditional on requiring any screening, predict whether required screening is general only or involves specific screening (specific only or specific plus general), with separate models for mental health, alcohol, and drug abuse screening. Key explanatory variables in all models are listed in Table 1 and include product type, contracting arrangement, tax status, region, and market area population.

Sample Characteristics

Sample characteristics are described in Table 1. In 1999, HMO products were most common (40.6%) followed by PPO and POS products. In 2003, the product types were closer to equal thirds, although POS plans were slightly more prevalent. Contracting with a specialty MBHO predominated, increasing from 59.8% in 1999 to 72.7% in 2003.

Table 1. Sample Characteristics

Characteristics	Percent of products	
	1999	2003
Product type		
HMO	40.6	29.3
POS	23.7	35.9
PPO	35.7	34.8
Contracting arrangement		
Internal	24.7	15.2
Specialty	59.8	72.7
Comprehensive	15.5	12.1
Tax status		
Nonprofit	22.3	14.4
For profit	77.7	85.6
Region		
West	22.1	18.9
Northeast	10.1	10.4
Midwest	28.0	27.2
South	39.9	43.5
Market area population		
<1 million	80.2	80.0
1–2 million	9.3	10.3
2–4 million	8.0	7.0
>4 million	2.6	2.8
Total products, unweighted	752	767
Total products, weighted	6,059	7,530

Table 2. Change in Screening Requirements 1999–2003

Requirements	1999; % (SE)	2003; % (SE)	Change
Weighted N	5,302	6,385	
Any Behavioral Health Screening	31.6% (2.8)	34.0% (1.9)	2.4%
Of those with any screening, specific screening for			
Mental Health	29.5% (7.3)	14.4% (2.3)	–15.1%*
Alcohol	32.9% (4.4)	78.4% (3.0)	45.4%†
Drugs	7.6% (1.7)	77.9% (3.1)	70.3%†

Unweighted n for 1999 was 752 and for 2003 was 767. Percents exclude missing. The percent missing was between 13 and 15% for both years in mental health, alcohol, and drug screening. Significant cross year changes represented by * $p < .05$; † $p < .001$

RESULTS

Change in Screening Requirements

From 1999 to 2003, the proportion of insurance products with any behavioral health screening requirements remained largely unchanged with 34.0% of products requiring some type of screening for mental health, alcohol, or drug abuse in 2003 (Table 2). Among products with any behavioral health screening requirement, the proportion requiring the use of a specific mental health screening instrument decreased from 29.5% in 1999 to 14.4% in 2003. In contrast, the proportion requiring specific screening for alcohol or drug problems increased to over three-quarters of products. When products require a specific screen, they almost always also require general screening (data not shown).

Product type was strongly associated with the change in prevalence of screening requirements (Table 3). From 1999 to 2003, PPO products appear to have caught up with their HMO and POS counterparts in the proportion requiring screening. The percentage of PPO products with any behavioral health screening requirement went from 18.7 to 34.4%. HMO products had a decrease, and POS products did not have a significant change in behavioral health screening requirements. Among those products with a behavioral health screening requirement, all product types demonstrated significant increases in the percent requiring specific instruments for

alcohol and drugs, while POS products showed significant decreases in requiring specific mental health screening.

Among products with specialty contracting, requirements for behavioral health screening increased among those with specialty contracts and decreased among those with comprehensive contracts. Among those products with a behavioral health screening requirement, both products with specialty contracts and those with internal management showed increased requirements for a specific screen for alcohol and drugs from 1999 to 2003.

Predictors of Screening Requirements

Predictors of any screening requirement in 2003 included product type, contracting arrangement, and region according to our multivariate models. POS products were less likely than HMOs (OR=0.69 95%, CI=0.47–1.00) to have any screening requirement when controlling for plan type, tax status, region, and market size (Table 4). Products with a behavioral health specialty contract were much more likely to have a screening requirement than those with internal arrangements (OR=3.67 95%, CI=1.59–8.45), and those with comprehensive contracting were much less likely to have any screening requirement (OR=0.28 95%, CI=0.09–0.93). Products in the Midwest were the most likely to require any screening. Tax status and market area population variables were not significant.

In the regressions predicting specific mental health, alcohol, and drug abuse screening requirements (conditional on having any screening), product type predicted specific screening requirements: PPO and POS products were more likely to have specific alcohol or drug screening requirements than HMOs, and PPOs were more likely to require specific mental health screening. Products with a specialty contract were much less likely than those with internal arrangements to require the use of a specific screen. Other characteristics that predicted having a specific mental health screening requirement were nonprofit tax status and a market size of 1–2 million people. For alcohol and drug specific screening, for-profit products were much more likely to require a specific screen. Northeast or Midwest region also was associated with lower likelihood of specific alcohol or drug screening requirements among products with any screening requirement.

Table 3. Screening Requirements by Plan Type and Contracting Arrangement

Requirements	HMO		POS		PPO		Specialty		Comprehensive		Internal	
	1999; % (SE)	2003; % (SE)	1999; % (SE)	2003; % (SE)	1999; % (SE)	2003; % (SE)	1999; % (SE)	2003; % (SE)	1999; % (SE)	2003; % (SE)	1999; % (SE)	2003; % (SE)
Weighted N	1,886	1,855	1,339	2,364	2,077	2,166	2,962	4,510	864	912	1,476	963
Any behavioral health screening	47.6% (3.1)	38.0% (3.7)*	29.2% (5.1)	30.5% (2.5)	18.7% (2.7)	34.4% (2.2)*	35.7% (4.2)	42.2% (2.4)‡	28.8% (4.0)	9.2% (5.3)‡	25.1% (3.7)	19.2% (6.5)
Of those with any screening, specific screening for												
Mental health	22.9% (5.1)	19.5% (3.5)	47.2% (11.7)	11.2% (2.2)†	26.9% (9.1)	12.7% (2.4)	14.2% (5.7)	11.1% (1.9)	–	–	58.5% (11.4)	51.7% (22.0)
Alcohol	18.9% (3.2)	68.0% (3.1)*	38.4% (4.4)	84.6% (6.5)*	59.9% (5.6)	82.3% (4.2)†	27.6% (5.2)	80.3% (3.4)*	–	–	33.5% (9.2)	92.1% (4.1)*
Drugs	5.4% (1.0)	67.9% (3.2)*	11.1% (3.2)	83.1% (6.5)*	10.1% (4.2)	82.2% (4.3)*	4.4% (1.3)	79.8% (3.4)*	–	–	12.0% (3.6)	91.1% (4.9)*

Percent (%) exclude missing which ranged from 0–20%; significant cross year changes represented by * $p < .001$; † $p < .01$; ‡ $p < .05$
 – Cells too small for accurate estimate

Table 4. Logistic Regression Models for any Screening Requirement (All Products) and for Specific Mental Health, Alcohol, and Drug Screening Requirements Conditional on any Screening Requirement, 2003

Requirements	Any	Of those with any screening, require specific screening for...		
		Mental health	Alcohol	Drug
Independent variables	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
Product type				
HMO (reference)	1	1	1	1
POS	0.69 (0.47–1.00)*	0.58 (0.20–1.67)	3.7 (1.57–8.72)†	2.9 (1.34–6.29)†
PPO	1.48 (0.80–2.72)	2.00 (1.31–3.04)†	1.74 (1.3–2.34)‡	1.57 (1.18–2.08)†
Contracting arrangement				
Internal (reference)	1	1	1	1
Specialty contract	3.67 (1.59–8.45)†	0.04 (0.01–0.15)‡	0.14 (0.05–0.39)‡	0.31 (0.12–0.85)*
Comprehensive contract	0.28 (0.09–0.93)*	–	–	–
Tax status				
Nonprofit (reference)	1	1	1	1
For profit	1.14 (0.55–2.40)	0.01 (0–0.02)‡	3.55 (1.49–8.47)†	5.66 (2.4–13.34)‡
Region				
West (reference)	1	1	1	1
Northeast	1.30 (0.73–2.32)	0.14 (0.01–1.36)	0.20 (0.06–0.66)†	0.12 (0.03–0.44)†
Midwest	1.81 (1.01–3.27)*	0.23 (0.02–2.55)	0.28 (0.09–0.90)*	0.19 (0.06–0.67)*
South	0.91 (0.49–1.70)	0.61 (0.08–4.36)	1.12 (0.3–4.16)	0.80 (0.2–3.23)
Market area population				
>4 million (reference)	1	1	1	1
2–4 million	1.06 (0.57–2.00)	0.37 (0.03–4.12)	0.57 (0.16–2.08)	0.74 (0.21–2.63)
1–2 million	1.06 (0.47–2.37)	9.66 (1.10–84.67)†	0.35 (0.09–1.30)	0.44 (0.12–1.52)
<1 million	0.86 (0.52–1.40)	2.74 (0.46–16.21)	0.49 (0.18–1.32)	0.59 (0.24–1.45)
Number in model	665	222	222	222
unweighted	(6,385)	(2,088)	(2,088)	(2,088)
(weighted)				

Products with comprehensive contracting arrangements were excluded from conditional regressions due to the small number that had any screening requirement (unweighted $n=4$)

Significance represented by * $p<.05$; † $p<.01$; ‡ $p<.001$

DISCUSSION

The proportion of private insurance products that required primary care practitioners to screen for mental or substance-use conditions remained largely unchanged on an overall basis with about a third reporting a requirement. However, there

was an increase among PPO products and decrease among HMO products from 1999 to 2003. This increase among PPO products is likely to have a disproportionately larger impact on patients' experience because the proportion of health plan enrollment in PPOs grew dramatically during this time period. In 1999, 39% of workers with job-based coverage were in PPOs. This increased to 54% in 2003 and is estimated to have reached 61% in 2005²². It is also noteworthy that behavioral health contracting arrangements vary by product type. In 2003, over 80% of HMO and POS products contracted with specialty MBHOs, compared to about half of PPOs (Horgan et al., 2007, manuscript under review).

Nonetheless, in 2003 nearly two-thirds of all products did not have screening requirements, although over 90% offer coverage for behavioral health treatment (Horgan et al., 2007, manuscript under review). This represents a missed opportunity to improve identification of mental and substance-use conditions and encourage practice patterns that are adherent with evidence-based guidelines. Establishing standards for acceptable practice consistent with the recommendations of government panels and professional organizations is an important first step in improving prompt identification of mental and substance-use conditions.

Influences on Screening Requirements

Health plans may have been reluctant to require screening for mental and substance-use conditions for several reasons. First, conducting screening is difficult to monitor, in part, because substance-use screening procedures only recently have had procedure codes adopted. Currently, tracking the delivery of mental and substance-use condition screening would require chart review or patient surveys rather than less costly administrative data analysis. Moreover, chart review and patient surveys might underestimate screening because providers might not document negative screens and patients may not recall what questions they were asked. Second, health plans may consider screening requirements an unnecessary burden to place on primary care practitioners with whom they must maintain a working relationship. Health plans already enforce rules for claims submission, referral networks, and formularies. Specifying patterns of practice may be perceived as excessive management. Third, plans may not view primary care practitioners as gatekeepers to the behavioral health services sector. In contrast to their policies for referring somatic complaints, health plans often establish call centers for behavioral health that are independent of primary care.

One might anticipate that more plans will require screening in the future. In 2004, the National Committee for Quality Assurance (NCQA) introduced a new measure, identification of alcohol and other drug services²⁶. Health plans motivated to improve their performance in the NCQA's high-visibility system of quality performance may turn to primary care providers to enhance their screening efforts. Moreover, the recent Institute of Medicine report on the quality of care for mental and substance-use conditions highlights the need for greater integration between general medical and specialty mental health service sectors⁴.

Other changes affect primary care providers more directly and may help to make mental health and substance-use condition screening a sustainable and widely-diffused preventive service. The addition and utilization of procedure codes for

alcohol and other drug screening would allow screening to be tracked through claims data and provide a mechanism for reimbursement. In addition, at least one large insurer has instituted incentive payments to primary care practitioners for performing depression screening in the context of a disease management program.

The requirement for specific screening also changed from 1999 to 2003 with a decrease for mental health and increase for alcohol and drugs in the proportion of products requiring a specific screening questionnaire. A large body of literature supports the validity of specific instruments such as CAGE or AUDIT⁷. Moreover, government agencies have promoted screening and brief intervention as a mechanism to improve detection and reduce morbidity and mortality from excessive drinking²⁷. Several studies have demonstrated that standard screening questionnaires have significantly better sensitivity over less formal means of problem recognition⁶. Recent clinical practice guidelines have sought to maintain specific screening, while reducing the burden it imposes. In 2005, the National Institute on Alcohol Abuse and Alcoholism recommended screening with one question, reducing the time required to fit screening into brief primary care visits²⁸. The decrease in specific mental health screening may represent a shift toward embedding screening in general health questionnaires, but our data do not permit this type of analysis.

On the face of it, health plans seem to have required specific screens for alcohol and drugs. It is possible, however, that general screening questionnaires incorporate specific screening instruments. Standardized instruments such as the AUDIT can be appropriately incorporated into a broader questionnaire²⁹, and self-reporting on consumption may be enhanced when alcohol questions are embedded in a general context³⁰. Our data do not allow us to determine if general screening questionnaires include "ad hoc" questions with a specific screening instrument used as a complement or if an entire specific screening instrument is embedded in the general questionnaire.

Products with specialty behavioral health contracts were more likely to have any screening and less likely to have specific screening requirements than products with internal behavioral health services. Multiple reasons for this finding are plausible. First, contracting with a specialty organization may reflect a greater focus on behavioral health and more interest in identifying people with these problems. MBHOs have specialized expertise, designated resources, systems to ensure that patients get to the right providers, and specific programs for users of drugs and alcohol. Plans may believe that primary care practitioners will be more amenable to screening when it is clear where to refer patients who need specialized help. Second, health plans with specialty contracts frequently have capitated contracts³¹ and may seek more actively to identify enrollees with behavioral health problems in order to refer them to the specialty vendor who is being paid to provide needed services on a population basis. At the same time, concerns have been raised that contracting with MBHOs may further separate behavioral health care from other medical care. However, little is known about the extent to which this arrangement typically affects the already existing fragmentation of care.

As noted in the Institute of Medicine report on crossing the quality chasm in behavioral health care, there is a significant need for improved detection, diagnosis, and assessment in both general medical and specialty behavioral health settings⁴.

Increasing the use of standardized instruments and improving the effectiveness of dissemination activities to increase "uptake" of evidence-based practices is an essential first step. Our study found that an increasing proportion of health plans are requiring mental health and substance use screening in primary care, suggesting a growing emphasis on this area of practice. However, two-thirds of plans still do not. Future research should explore factors that influence adoption of screening requirements, how health plans monitor and enforce such requirements (Granick et al., 2007, manuscript under review), and—perhaps most importantly—effects on actual clinical practice when requirements are implemented.

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REFERENCES

1. Wang PS, Lane M, Olfson M, et al. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatr*. 2005;62(6):629–40.
2. Substance Abuse and Mental Health Services Administration. Overview of Findings from the 2004 National Survey on Drug Use and Health. Rockville, MD: Department of Health and Human Services; 2005.
3. Wang PS, Berglund P, Olfson M, Pincus HA, Wells KB, Kessler RC. Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatr*. 2005;62(6):603–13.
4. Institute of Medicine. Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC: The National Academies Press; 2005.
5. Greenblatt J. Trends in access to routine care and experiences with care. 2001. [internet] 2003 [cited 2006 January, 30th]; Available from: <http://www.meps.ahrq.gov/papers/st14/stat14.pdf>.
6. Fiellin DA, Reid MC, O'Connor PG. Screening for alcohol problems in primary care: a systematic review. *Arch Intern Med*. 2000;160(13):1977–89.
7. Pignone MP, Gaynes BN, Rushton JL, et al. Screening for depression in adults: a summary of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2002;136(10):765–76.
8. Gilbody S, House AO, Sheldon TA. Screening and case finding instruments for depression. *Cochrane Database Syst Rev*. 2005;4:4.
9. Whitlock EP, Polen MR, Green CA, Orleans T, Klein J. Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: a summary of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2004;140(7):557–68.
10. Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. *Alcohol Clin Exp Res*. 2002;26(1):36–43.
11. Fleming MF, Barry KL, Manwell LB, Johnson K, London R. Brief physician advice for problem alcohol drinkers. A randomized controlled trial in community-based primary care practices. *JAMA*. 1997;277(13):1039–45.

12. **Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ.** Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Arch Intern Med.* 2006;166(21):2314–21.
13. **Bower P, Gilbody S, Richards D, Fletcher J, Sutton A.** Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. *Br J Psychiatr.* 2006;189:484–93.
14. **Edlund MJ, Unutzer J, Wells KB.** Clinician screening and treatment of alcohol, drug, and mental problems in primary care: results from healthcare for communities. *Med Care.* 2004;42(12):1158–66.
15. **D'Amico EJ, et al.** Identification of and guidance for problem drinking by general medical providers: results from a national survey. *Med Care.* 2005;43(3):229–36.
16. **Wenrich MD, Paauw DS, Carline JD, Curtis JR, Ramsey PG.** Do primary care physicians screen patients about alcohol intake using the CAGE questions? *J Gen Intern Med.* 1995;10(11):631–4.
17. **Borowsky SJ, Rubenstein LV, Meredith LS, Camp P, Jackson-Triche M, Wells KB.** Who is at risk of nondetection of mental health problems in primary care? *J Gen Intern Med.* 2000;15(6):381–8.
18. **U.S. Preventive Services Task Force.** Screening for depression: recommendations and rationale. *Ann Intern Med.* 2002;136(10):760–4.
19. **U.S. Preventive Services Task Force.** Guide to Clinical Preventive Services, 2nd edition ed. Baltimore, MD: Williams & Wilkins; 1996.
20. **McGlynn EA, Asch SM, Adams J, Keesey J, et al.** The quality of health care delivered to adults in the United States. *New Engl J Med.* 2003;348(26):2635–45.
21. **Baker LC, Hopkins D, Dixon R, Rideout J, Geppert J.** Do health plans influence quality of care? *Int J Qual Health Care.* 2004;16(1):19–30.
22. **Gabel J, Claxton G, Gil I, et al.** Health benefits in 2005: premium increases slow down, coverage continues to erode. *Health Aff.* 2005;24(5):1273–80.
23. **Kemper P, Blumenthal D, Corrigan JM, et al.** The design of the community tracking study: a longitudinal study of health system change and its effects on people. *Inquiry.* 1996;33(2):195–206.
24. **United States Census Bureau.** P.D. Table 1: Annual Estimates of the Population of Metropolitan and Micropolitan Statistical Areas: April 1, 2000 to July 1, 2003 (CBSA-EST2003-01). 2005 [cited 2005 11/8/05]; Available from: http://www.census.gov/population/www/estimates/Estimates%20pages_final.html.
25. **Research Triangle Institute.** SUDAAN User's Manual: Release 8.0. 2002, Research Triangle Park, NC: Research Triangle Institute.
26. **National Committee on Quality Assurance.** NCQA Releases HEDIS 2004, 10 New Measures Address Public Health, Service Issues. [internet] 2003 July 1, 2003 [cited 2006 February 2nd]; Available from: <http://www.ncqa.org/communications/news/Hedis2004.htm>.
27. **Sullivan E, Fleming MF.** A Guide to Substance Abuse Services for Primary Care Clinicians. Treatment Improvement Protocol. Rockville, MD: Department of Health and Human Services; 1997.
28. **National Institute on Alcohol Abuse and Alcoholism.** Helping Patients With Alcohol Problems: A Clinician's Guide. Vol. 2005. National Institute on Alcohol Abuse and Alcoholism; 2005.
29. **Daeppen JB, Yersin B, Landry U, Pecoud A, Decrey H.** Reliability and validity of the Alcohol Use Disorders Identification Test (AUDIT) imbedded within a general health risk screening questionnaire: results of a survey in 332 primary care patients. *Alcohol Clin Exp Res.* 2000;24(5):659–65.
30. **Wilcox S, King AC.** Alcohol consumption in older adults: a comparison of two assessment methods. *J Appl Gerontol.* 2000;19(2):170–80.
31. **Garnick DW, Horgan CM, Hodgkin D, et al.** Risk transfer and accountability in managed care organizations' carve-out contracts. *Psychiatr Serv.* 2001;52(11):1502–9.