VETERANS HEALTH ADMINISTRATION

Office of Health Equity

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OFFICE OF HEALTH EQUITY

Created in 2012

Vision: To ensure that VHA provides appropriate individualized health care to each Veteran in a way that:

–Eliminates disparate health outcomes and

–Assures health equity

OFFICE OF HEALTH EQUITY GOALS

1. **Leadership:** Strengthen VA leadership to address health inequalities and reduce health disparities.
2. **Awareness:** Increase awareness of health inequalities and disparities.
3. **Health Outcomes:** Improve outcomes for Veterans experiencing health disparities.
4. **Workforce Diversity:** Improve cultural and linguistic competency and diversity of the VHA workforce.
5. **Data, Research and Evaluation:** Improve data and diffusion of research to achieve health equity.

VETERAN POPULATIONS

Veterans who experience greater obstacles to health related to:

- Race or ethnicity
- Gender
- Age
- Geographic location
- Religion
- Socio-economic status
- Sexual orientation
- Mental health
- Military era
- Cognitive /sensory / physical disability

OFFICE OF HEALTH EQUITY WEBSITE

https://www.va.gov/healthequity

Harnessing Technology to Increase Access to Couple and Family Treatment for Alcohol Use Disorders among Veterans

CYBERSEMINAR PRESENTERS

Dr. Julianne Flanagan

Director, Enhancing Diversity in Alcohol Research (EDAR) Program

Staff Psychologist, Ralph H. Johnson VAHCS

Dr. Elizabeth Santa Ana

Associate Director & Investigator, Charleston Health Equity and Rural Outreach Innovation Center (HEROIC)

Co-Director, Charleston VA Advanced Fellowship in Mental Illness Research and Treatment (MIRECC)

Staff Psychologist, Ralph H. Johnson VAHCS

Harnessing Technology to Increase Access to Couple and Family Treatment for Alcohol Use Disorders among Veterans

Drs. Julianne Flanagan & Liz Santa Ana

VA HSR&D Cyberseminar

September 13, 2023

Acknowledgements

- No Financial COI
- Discussing off-label use of oxytocin
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Outline

Background

- AUD among Veterans
- Relationships in AUD recovery
- Current gaps & limitations

Research Projects

- Study 1: ABCT+ Oxytocin
- Study 2: B-FIT via Telehealth

Future Directions

- Stage III Efficacy
- Cultural considerations & adaptation
- Therapist training & uptake

Background & Rationale

- AUD prevalence among Veterans is 2x that of civilians
- Approximately 1/6 Veterans in the VAHCS has an AUD diagnosis in their medical record
- Alcohol problems commonly emerge during active duty service and persist following military separation
- The negative reinforcement model (i.e., drinking to cope) has been extensively replicated among Veterans
- Compared to Veterans without AUD, Veterans with AUD have:
  - 2-4 times greater odds of having a mood or anxiety disorder
  - 10 times greater likelihood of having a comorbid drug use disorder
  - 4 times greater odds of making a suicide attempt during their lifetime

Calhoun et al. (2008); Boden et al., (2018); Meadows et al. (2018); Fuehrlein et al., (2018)

Background & Rationale

- Several efficacious AUD treatments exist for individuals
  - Approximately 60-70% of patients relapse following individual treatment.
  - Efficacy is reduced among Veterans; especially true of brief interventions.
  - Nearly half of AUD treatment trials for individuals yield null findings.

- Relationship discord is a common motivator for patients to seek AUD treatment
- Adaptive relationship functioning facilitates successful AUD treatment engagement and outcomes
- Maladaptive relationship functioning interferes with AUD recovery and is a precipitant of relapse
- Two efficacious AUD treatments exist for couples
  - Efficacy is equal to and often better than individual treatment outcomes
  - Behavioral Couples Therapy for Alcoholism and Drug Abuse (BCT)
  - Alcohol Behavioral Couple Therapy (ABCT)

O'Farrell et al. (2006); McCrady et al (2009); Goodell et al., (2020); Witkiewitz et al., (2011); Dutra et al. (2008)

Background & Rationale

- Lack of diversity in patients & investigators
  - Race, ethnicity, SES, gender identity, sexual orientation…
- Low provider density and wait times
  - Couples trained providers are rare, even more so in the AUD field
  - Learning new modalities is not always, or sufficiently, supported systemically
  - Rural Veterans are not at higher risk for AUD, but have less access to treatment
- Exorbitant cost in the community
- Challenging patient commitment
  - BCT is 24 sessions long; ABCT is 12 (90 minute) sessions
  - It's not better with non SUD modalities. IBCT, commonly used at VA, is 26 sessions
- Poor uptake across settings
  - One study found that less than 25% of clinicians (N 325) had used ABCT in the 14 months following formal training in the modality.
  - Obstacles such as time burden and needing to schedule both parties to present in person to clinic simultaneously are commonly cited
  - Stigma related to treating AUD among dyads
- <u>Increased access to effective, evidence-based dyadic interventions for AUD is urgently needed</u>

Houck et al., (2016); Schonbrun et al. (2012); McCrady et al. (2019); McCrady et al. (2011)

Study 1

Healing Alcohol Recovery Together (HEART)

Enhancing Alcohol Behavioral Couple Therapy with Oxytocin

- NIAAA (R01AA027212; NCT03846505)
- September 2018- present (final follow-ups)
- Collaborators: Drs. Barbara McCrady, Paul Nietert, Liz Santa Ana, & Jane Joseph

(Flanagan, Joseph, Nietert, Back, & McCrady, 2018)

ABCT Model

- ABCT employs cognitive behavioral techniques to:
  1) Reduce alcohol consumption
  2) Enhance partners' skills to facilitate recovery via improved communication, managing cravings together, etc.
  3) Improve relationship functioning & satisfaction
- Well-established efficacy among civilians
- Hypothesized target engagement is also supported
  - Reductions in drinking associated with increases in partner coping, conflict resolution, and support behaviors.
  - Abstinence and consumption six months after treatment was predicted by greater pretreatment relationship quality, and higher relationship satisfaction is associated with better ABCT completion.
  - Higher relationship satisfaction is associated with fewer drinking urges overall and greater reduction in drinking urges during treatment.

Houck et al., (2016); Schonbrun et al. (2012); McCrady et al. (2019); McCrady et al. (2011)

Study Objectives

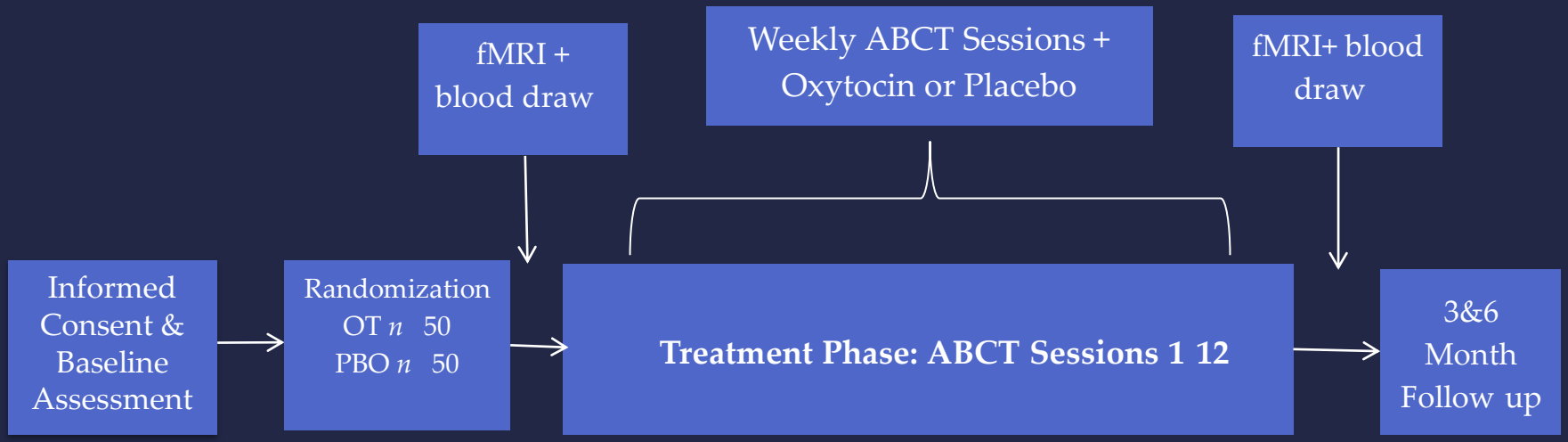
- **Aim 1:** Compare the efficacy of ABCT with oxytocin vs. placebo in reducing alcohol consumption.

- **Aim 2:** Compare the efficacy of ABCT with oxytocin vs. placebo in improving relationship functioning.

- **Aim 3:** Use neuroimaging techniques to determine the effects of treatment on corticolimbic connectivity in response to alcohol and relationship conflict cues.

Study Design

- Final N=97 couples with AUD
  - 1:1 randomization stratified on gender & AUD severity
- Use of couples imaging paradigm
- Phosphatidylethanol (PEth) & ethyl glucuronide (EtG)
- March 2020 transition to fully remote implementation



Sampling Plan

Primary Inclusion

- One partner within each dyad must:

1) Meet DSM-V diagnostic criteria for current AUD (Quick-SCID)

Additional Inclusion

2) Cognitive functioning sufficient to provide informed consent and participate accurately (≥ 26 on the Mini-Mental Status Exam [MMSE])
3) Relationship duration ≥ 6 months
4) Stable dose of psychotropic medications for ≥ 4 weeks

Exclusion

1) Psychiatric conditions requiring a higher level of care (i.e., psychotic or bipolar disorders)
2) Suicidal or homicidal ideation/intent
3) Alcohol withdrawal (CIWA-Ar >8)
4) History of seizures
5) Severe and unilateral IPV
6) Pregnancy
7) Drug use disorders acceptable provided AUD is substance of choice
8) Additional exclusion specific to fMRI

Sample Characteristics

Variable	Total Sample % or (mean + SD)
Age (years):	40.69 + 12.48
Gender (women):	*n* = 99 (51%)
Race:	*n* = 175 (90.2%)
Ethnicity:	*n* = 9 (4.6%)
Veteran:	*n* = 25 (12.9%)
Dyadic Adjustment Scale (DAS)	105.48 + 18.92
CTS-2 Psych Victimization (past 6 months)	23.00 + 24.51
CTS-2 Physical Victimization (past 6 months)	1.21 + 4.31
Severe AUD	*n* = 77 individuals (39.7%)
AUD Concordance	*n* = 48 couples (49.5%)
AUDIT	13.33 + 8.93
TLFB:	
% PDD	54.20 + 33.92
% PHDD	29.70 + 33.72

Telehealth Transition

- General couple therapy is non-inferior via telehealth
- Early skepticism on the study team
  - Feared loss of non verbals
  - Loss/dilution of alcohol intoxication cues (gait, smell) in virtual context
  - Procedural uncertainty
- Scarcity of AUD trials examining telehealth interventions in any population
  - An NIH Reporter search in 2022 revealed only 20 telehealth study results. Once center cores and one fellowship supplement were removed to avoid duplication, 10 projects remained. That's less than 1% of NIAAA funded projects.
- By May 2020 alone, telehealth visits increased 1000x to 120,000/ month at VA
- Final 2/3s of HEART sample completed fully remotely
  - Retention among in person couples 67%
  - Retention in full sample improved to 79.4% following telehealth adaptation
  - Out of state participation
  - No requirement for partner co location during session
  - Challenges & distractions (and, we get a glimpse into patients' real life)
  - Assessment & management of IPV (0 disenrollments or AEs related to IPV)

Lin et al., (2019); Young et al. (2012); Baca et al. (2007)

ABCT via Telehealth

Selected Quotes from Participants
It really worked for us. Telehealth provided an extremely positive experience for us. Without it, you never would have been able to take part in this study, which has been life changing.
Teleheath therapy was a very positive experience. It was more convenient and comfortable and we received high quality therapy that was very valuable for our relationship.
Loved the convenience
I'm old school. I THINK I would have liked in-person better because I'm a people person. I like face to face. But with [partner]'s work schedule, it just wasn't feasible. This was so convenient though!
This made everything so much easier to share and I was more comfortable in my own home
It can be easier to open up to someone who isn't physically in front of you
It's a great option for working parents who have difficulty finding time between work and kids
I think that it really helped our relationship by both of us making an exerted effort to do better through communication
Few excuses to cancel, we always have access
Increased ease of scheduling, access to services that might not be readily available locally
Our lives have been a mess with moving and work schedules and our separation, so it's just been nice and convenient and safe during COVID to participate remotely. We've really profited from the experience with Kristen and Dr. Lozano.
Why not?

Study 2

B-FIT

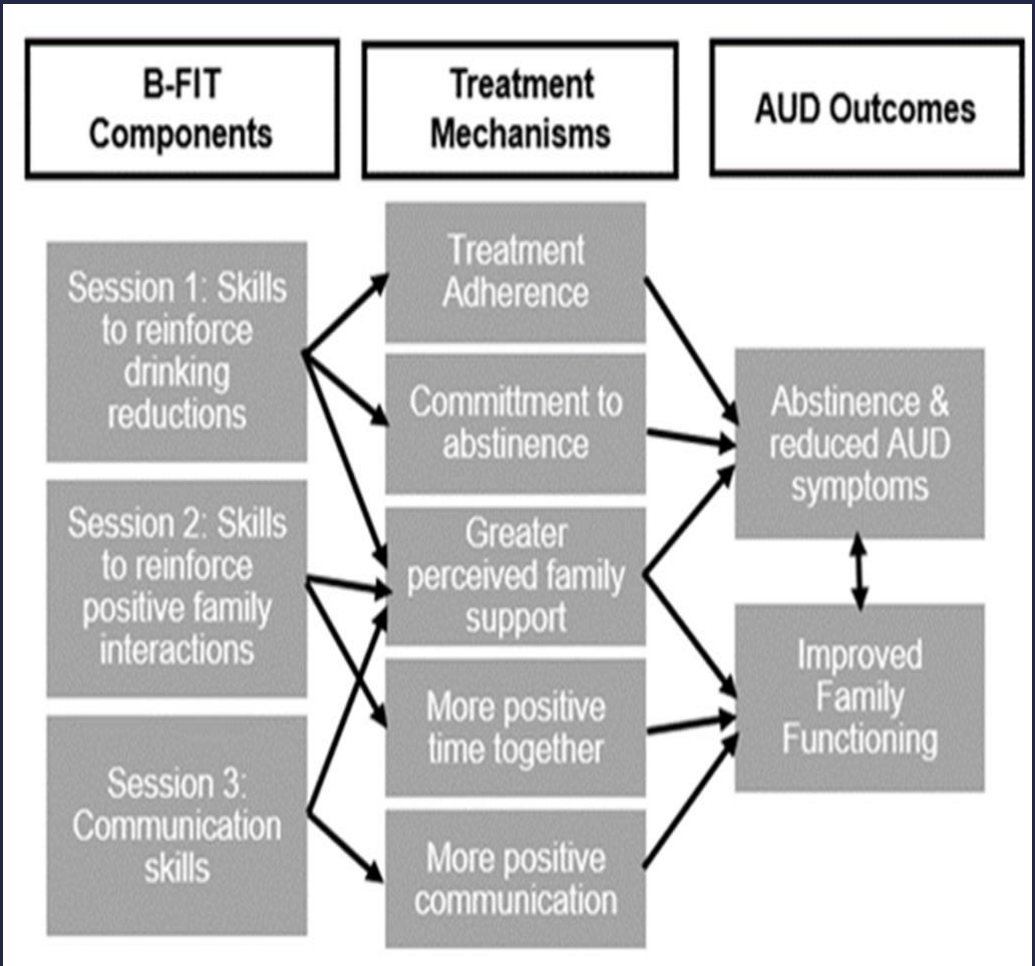
Evaluating the Efficacy of Telehealth-Delivered Brief Family Involved Treatment (B-FIT) for Alcohol Use Disorder among Veterans

- NIAAA (R01AA029679; NCT05674409)
- September 2023-September 2028
- Collaborators: Drs. Barbara McCrady, Paul Nietert, Michaela Hoffman, Liz Santa Ana, & Brandi Fink

Barriers

- Time, scheduling, privacy, childcare, cost, transportation
- Some Veterans, including women, prefer not to engage with VA
- VA Couple & Family clinics sometimes exclude Veterans with SUD
  - Sometimes that's necessary, such as in situations with legal or safety issues
  - Stigma leading to sequential approach (get sober, then work on relationships)
- STAR/SUD clinics don't often offer dyadic interventions
  - Staffing challenges generally
  - Scarcity of couples-trained providers
  - It's a time burden to learn and implement new modalities
- A brief dyadic modality to enhance current offerings might bridge these gaps

B-FIT Model



Three core components of ABCT were distilled to create the B-FIT modality:

1) Increase family support for drinking change
2) Increase positive and decrease negative family exchanges
3) Improve communication

<u>B-FIT is designed to be an adjunct treatment modality</u>

R34AA023304; McCrady et al. (2023)

B-FIT via Telehealth

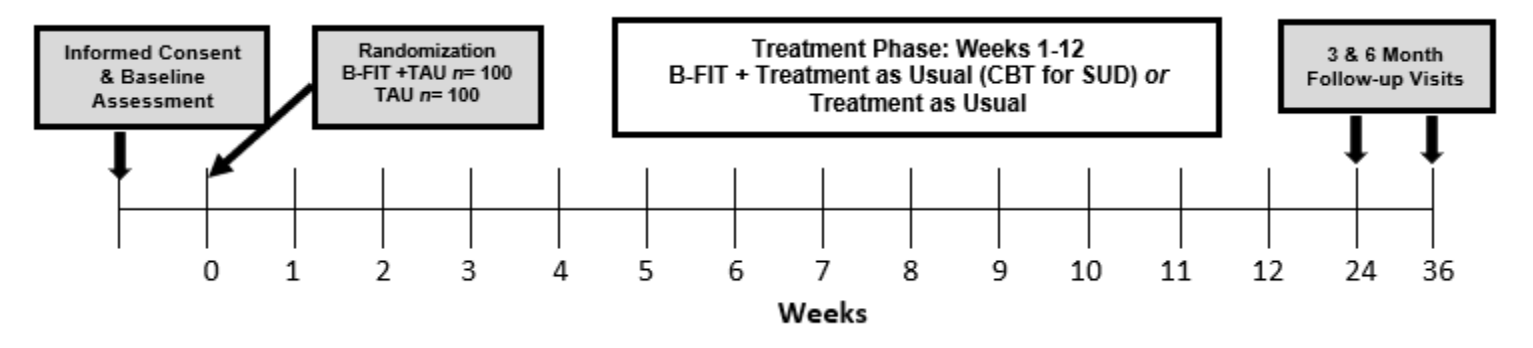
Selected VA Provider Quotes
• *"Sig other can help the veteran plan for high-risk situations and provide instrumental support."*
• *"Reduce interfering behaviors by the significant other, help them have a plan to support each other."*
• *"Improve their motivation to reduce/abstain, assist in finding non-substance related activities"*
• *"The VA's couples and family clinic is reluctant to work with AUD; they would prefer that the vet deals with their AUD issues in STAR."*
• *"Reduce sig other's recovery-interfering behaviors (e.g., accommodating/enabling use) and risk/precipitating factors (e.g., loneliness, relationship conflict)."*
• *"Sig others benefit by learning what recovery looks like, developing empathy for what their Veteran is going through, and learning how to take care of themselves during the Veteran's recovery process."*
• *"Partners and family often do not understand triggers to drinking and think the vet should "just get over it"…This might help them change dysfunctional patterns in the household."*

Study Objectives

- **Aim 1:** Compare the efficacy of B-FIT+TAU vs. TAU alone in reducing alcohol consumption.
- **Aim 2:** Compare the efficacy of B-FIT+TAU vs. TAU alone in improving family functioning.
- **Aim 3:** Compare the efficacy of B-FIT+TAU vs. TAU alone in improving treatment satisfaction, adherence, and retention.

Study Design

- N=200 Veterans with AUD + their co-participants
- 1:1 open randomization
- Assessment plan consistent across randomization groups
- Oversampling women Veterans (50/50 IPs)
- Fully remote implementation



Sampling Plan

Veteran Inclusion

1) Meet DSM-V diagnostic criteria for current AUD (Quick-SCID)
2) Have 2 or more heavy drinking days (≥5 for men, ≥4 for women) in the past 60
3) Have an adult family member who is willing to participate
4) Cognitive functioning sufficient to provide informed consent and participate accurately (≥ 26 on the Mini-Mental Status Exam [MMSE])
5) Stable dose of psychotropic medications for ≥ 4 weeks

Co-Participant Inclusion

1) Not receiving or seeking treatment for their own alcohol or drug problem
2) Report total AUDIT scores <8
3) Report total DAST scores <3

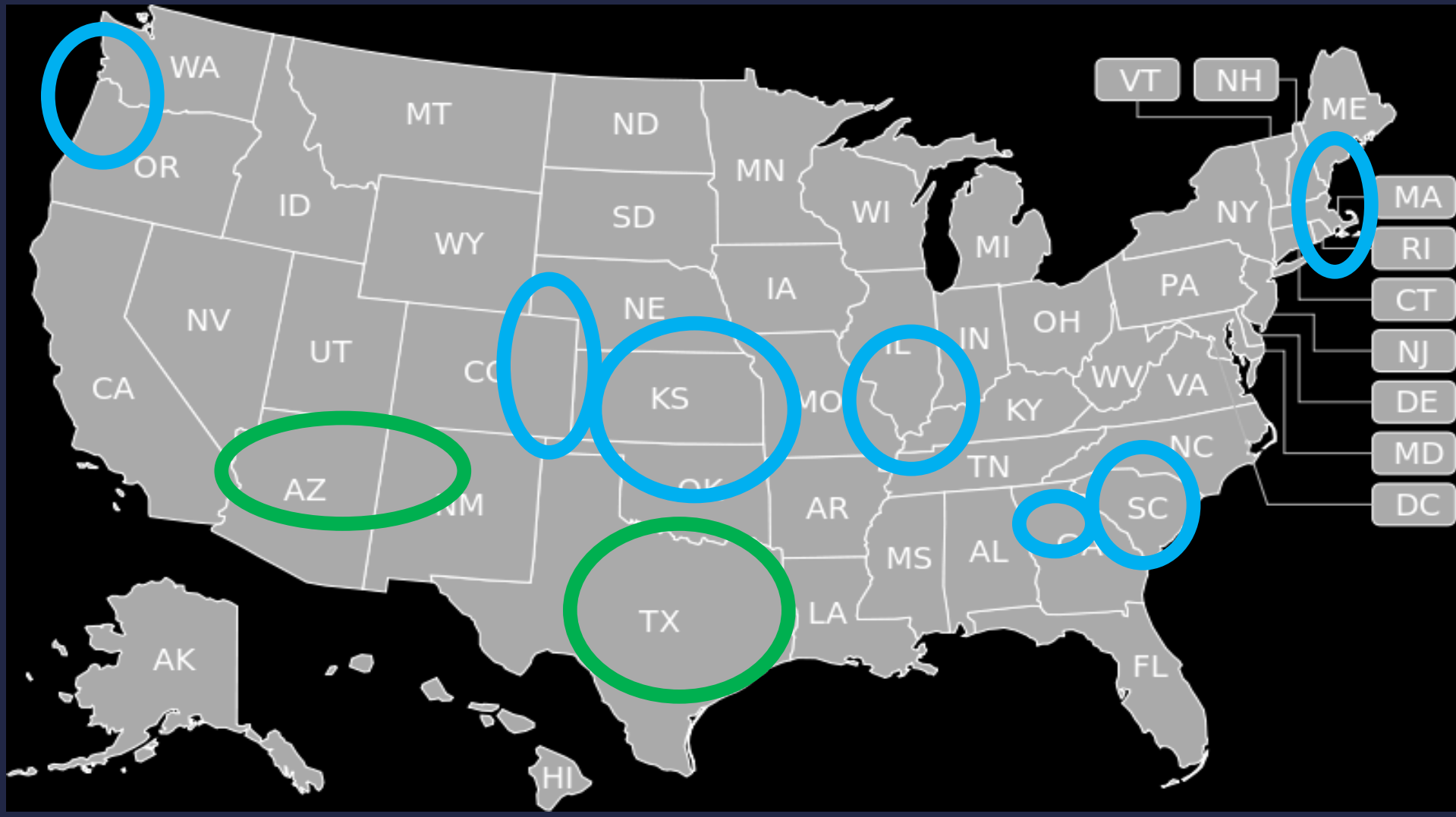
* Co-participant can be a partner, adult family member, peer, etc.

Exclusion

1) Psychiatric conditions requiring a higher level of care (i.e., psychotic or bipolar disorders)
2) Suicidal or homicidal ideation/intent
3) Alcohol withdrawal (CIWA-Ar >8)
4) Severe and unilateral IPV
5) Drug use disorders acceptable provided AUD is substance of choice

Recruitment

- Geographically varied social media campaigns
- Much ground left to cover
- No wrong doors
  - Materials emphasize relationship challenges and/or alcohol use problems
  - Veterans + co participants do not need to be co located!



Recruitment Materials

Future Directions

- Cultural considerations & adaptation
  - Toward improved integration with cultural (& lived experience) factors contributing to AUD risk & resilience
    - Military specific considerations & catching AUD earlier in its etiology
    - Working with LGBTQ+ patients
    - Considerations of historical, race based, and other trauma experiences
  - Occurs on a case by case basis via therapist & patient initiative
  - Much room for evidence based adaptation
- Stage III Efficacy
  - Several Stage II trials completed of ABCT among civilians
  - Where do we go from here?
- Therapist training & uptake
  - At the training level
  - Of providers with varying credentials and roles

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DEPARTMENT OF VETERANS AFFAIRS
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Thank you

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