Veterans with Pain and Substance Use Disorders: Opioids Are Not the Only Concern

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Disclosure Statement

- No conflicts of interest to disclose
- Previous research funding from:
  - National Institute on Alcohol Abuse and Alcoholism
  - National Institute on Drug Abuse
  - VA Health Services Research & Development
  - VA Quality Enhancement Research Initiative
- No documented expertise in pain management

Overview

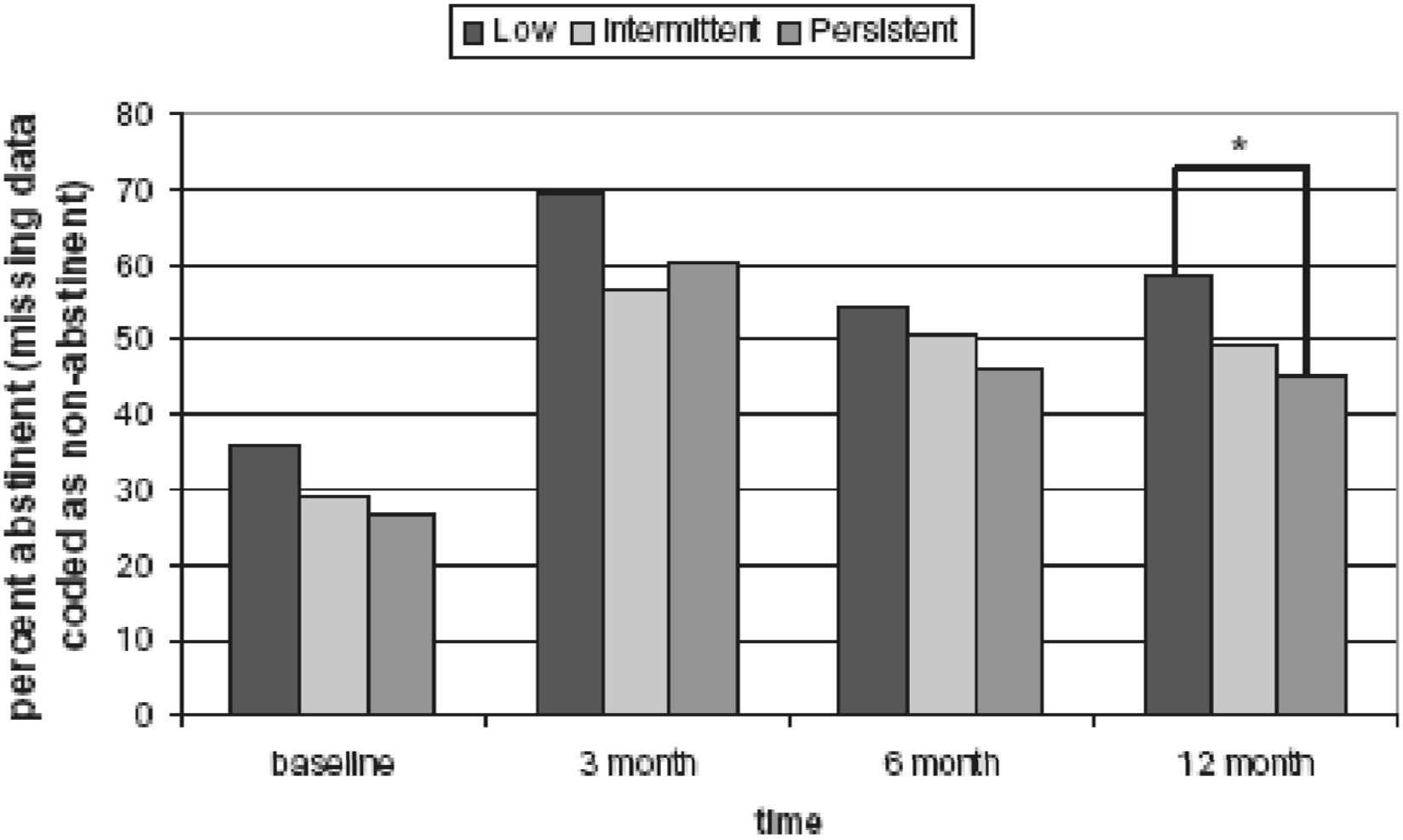
- We need collaboration across settings
- No easy answers to patient complexity
  - But there are some actions to consider
- Opioids are not the only SUD issue
- Big gaps in the evidence-base on pain and SUD
- Shared responsibility to assure access to patient-centered care
- Ethics of harm reduction
- Resources for follow-up

Pain and SUD treatment

- In a sample of 582 Veterans seeking addiction treatment, excluding opioid dependent patients:
  - 33% reported persistent moderate-severe pain
  - 47% reported intermittent pain
- Those with persistent pain:
  - Received less treatment
  - Had poorer abstinence rates at 12 mos
  - Had greater service utilization and higher costs

Caldiero et al., The association of persistent pain with outpatient addiction treatment outcomes and service utilization. Addiction, 2008, 103, 1996-2005.

Association of pain with abstinence over 12-month follow-up



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Challenges; No Magic

- Intoxication
- Relapse
- Patient Motivation
- Ethical Dilemmas
- Safety/Liability
  - Veteran & provider
- Coordination of Care
- Other categories?

What is Motivational Interviewing?

"A collaborative, person centered
form of guiding
to elicit and strengthen
motivation for change"

Miller & Rollnick, Behavioural and Cognitive Psychotherapy, 2009

10 Things Motivational Interviewing is NOT

- The transtheoretical model of change (stages)
- A way to trick people to do what you want
- A technique
- Decisional balance exercises (pros & cons)
- Assessment feedback (e.g., in MET)
- Cognitive-behavior therapy
- Client-centered therapy (non-directive)
- Easy to learn
- Treatment as usual (we are <u>not</u> all doing it now)
- A panacea

Components of Brief Alcohol Intervention (BI)

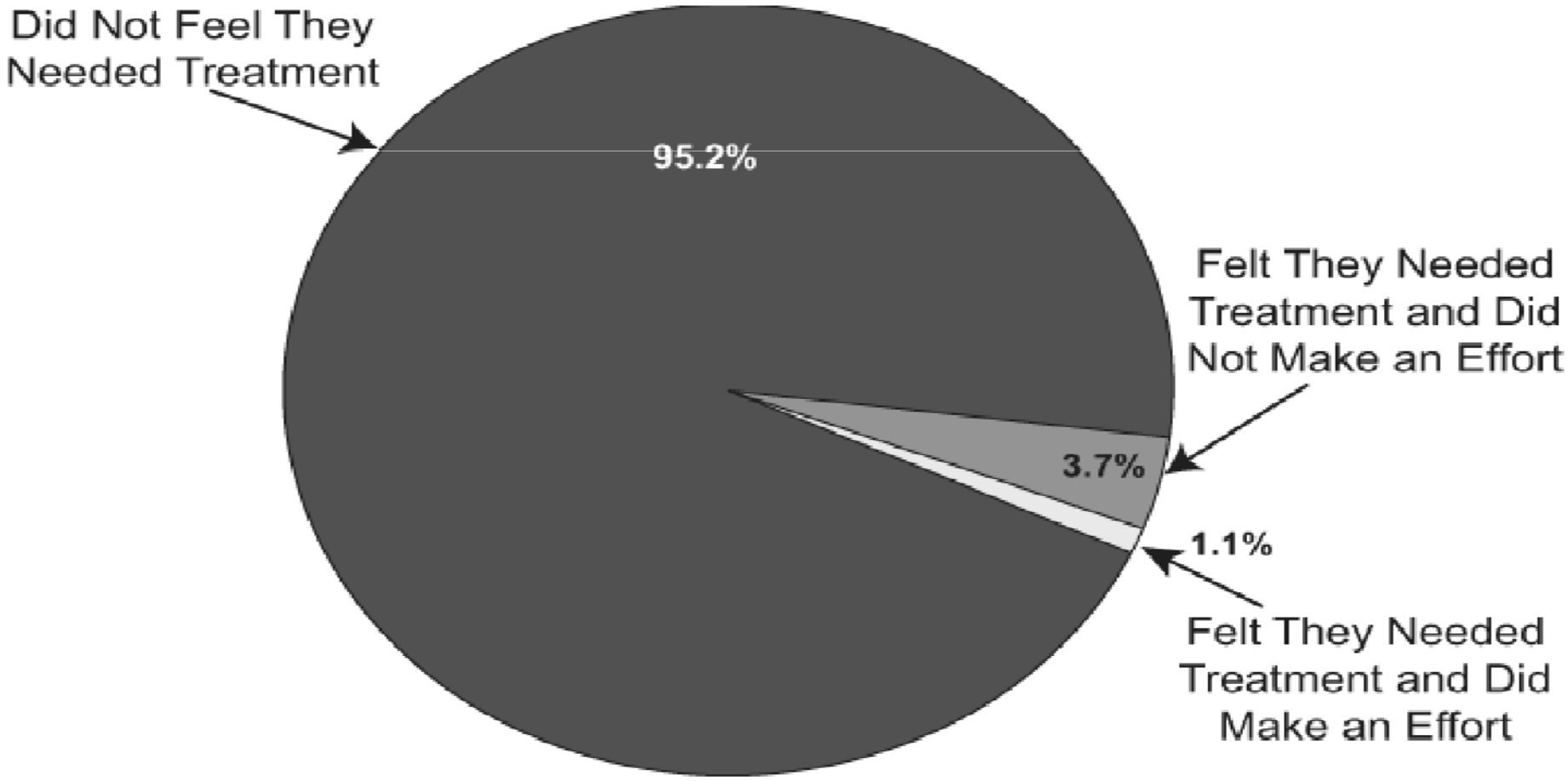
- Advice = documentation of:
  - Advice to abstain, if drinking is contraindicated
  - Advice to drink within limits
- Feedback = documentation of:
  - Personalized feedback linking alcohol use to the patient's specific health issues
  - General feedback linking alcohol to general health
- VA performance measure = advice and feedback
- Offer/encourage specialty referral if indicated

Alcohol Misuse Screening and Brief Alcohol Counseling

Measure	FY10	FY11
Annual Alcohol Misuse Screening w AUDIT-C	97%	97%
Brief Alcohol Counseling within 14 days of AUDIT-C screen positive	69%	77%

The Treatment Engagement Challenge

Past Year Perceived Need for and Effort Made to Receive Treatment among Persons Aged 12+ (2008) - NSDUH

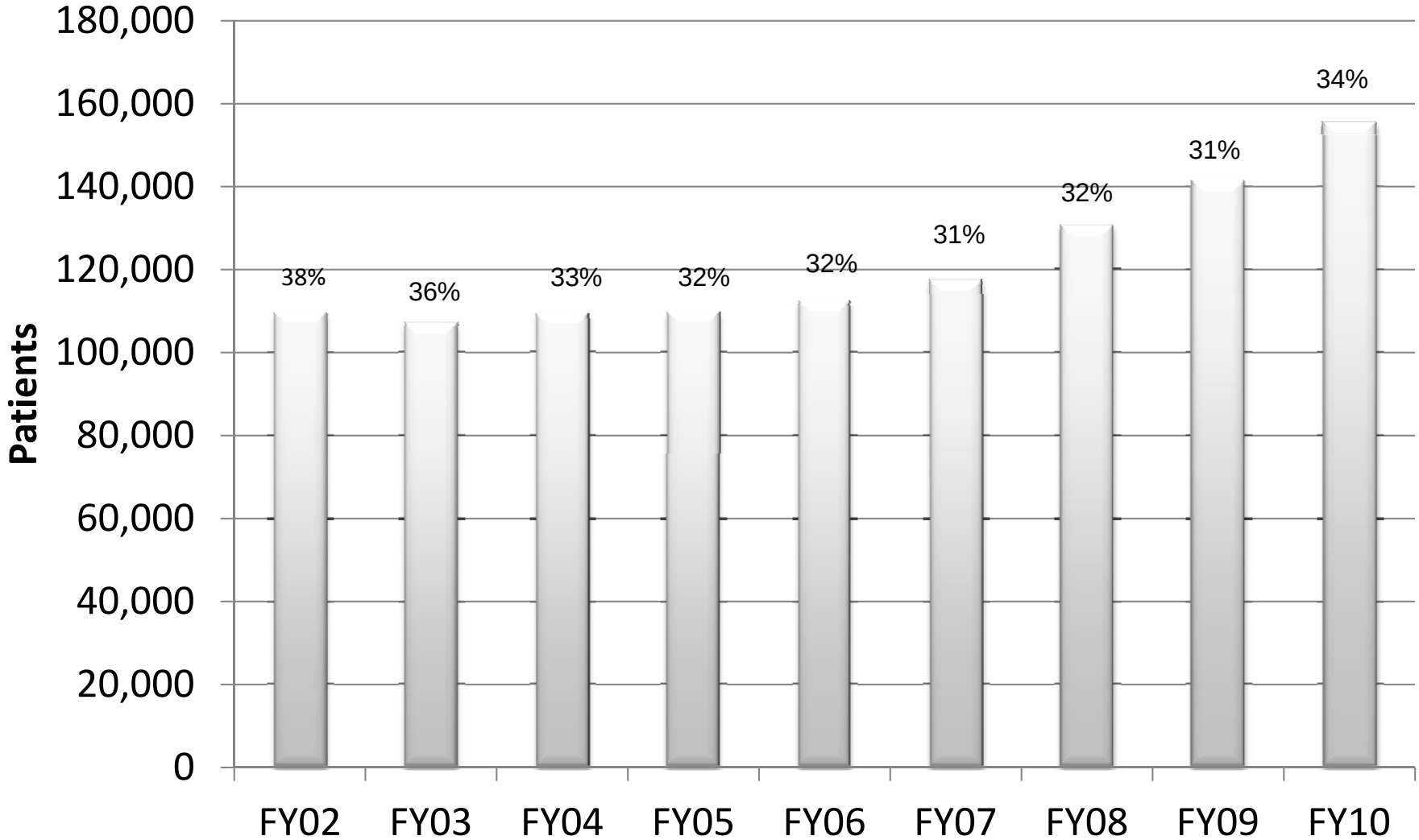


20.8 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use

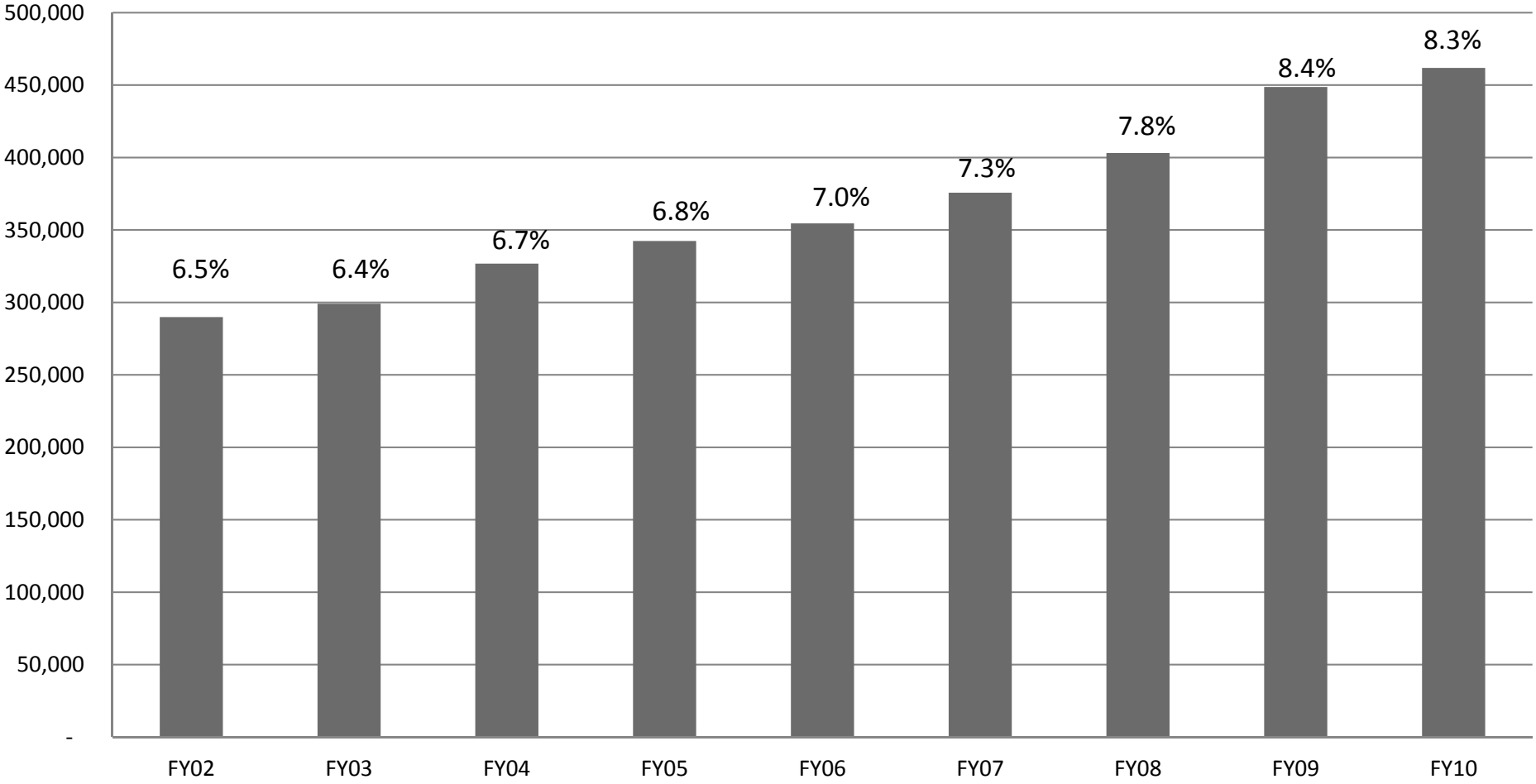
Perceived Barriers to "Treatment"

- Oslin et al VISN 4 MIRECC and VISN 2 CoE
- Primary care patients with alcohol dependence (N=199) in PA and NY; assessed through Behavioral Health Lab
- Reasons to decline referral:
  - not perceiving a need (60%),
  - negative experience/treatment won't work (37%),
  - worries about stigma (35%),
  - logistical concerns (24%),
  - family related concerns (15%).
- Willing to initiate naltrexone in PC – 44%

Number of Patients Receiving SUD Specialty Treatment



Annual Prevalence of SUD Diagnoses among VHA Patients



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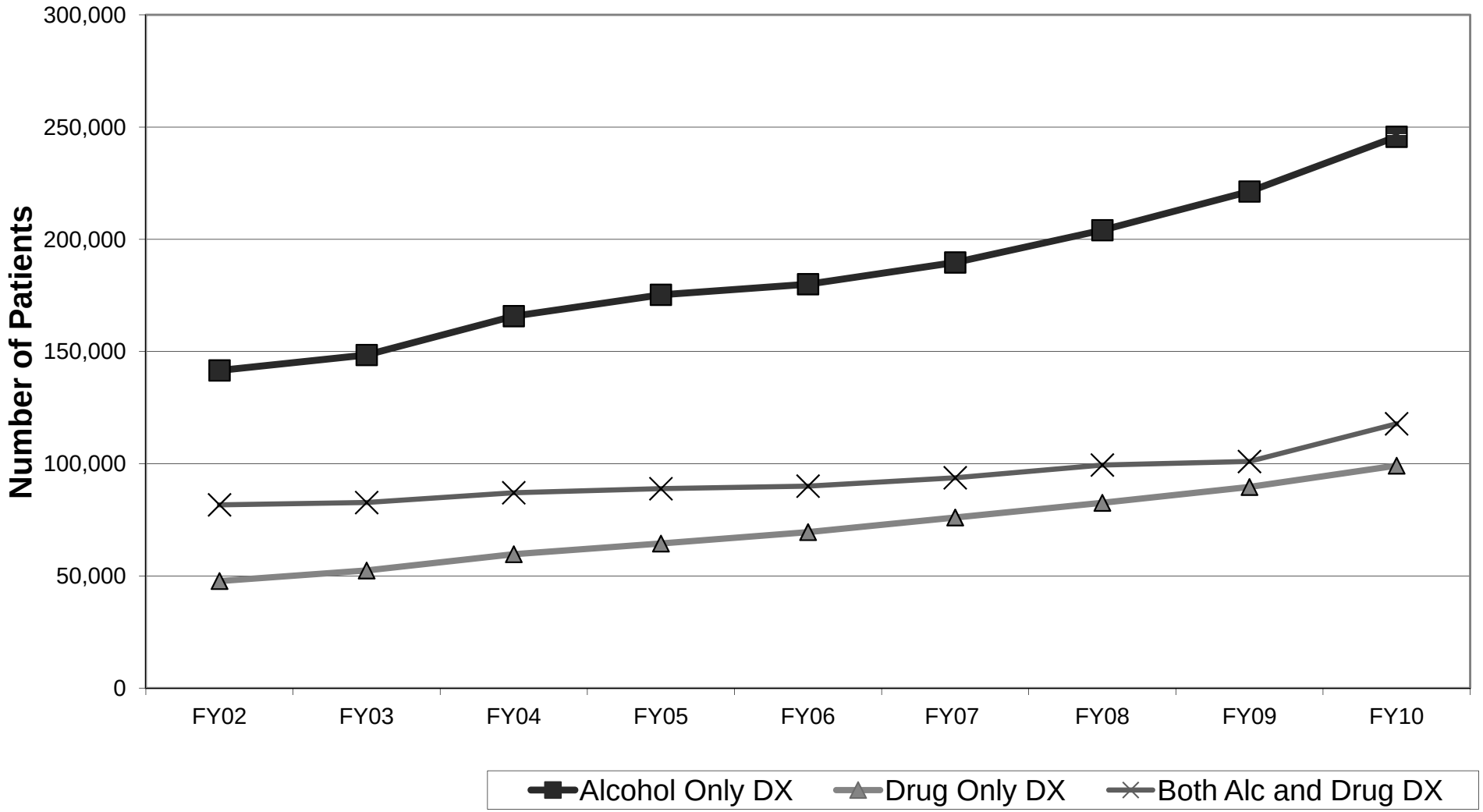
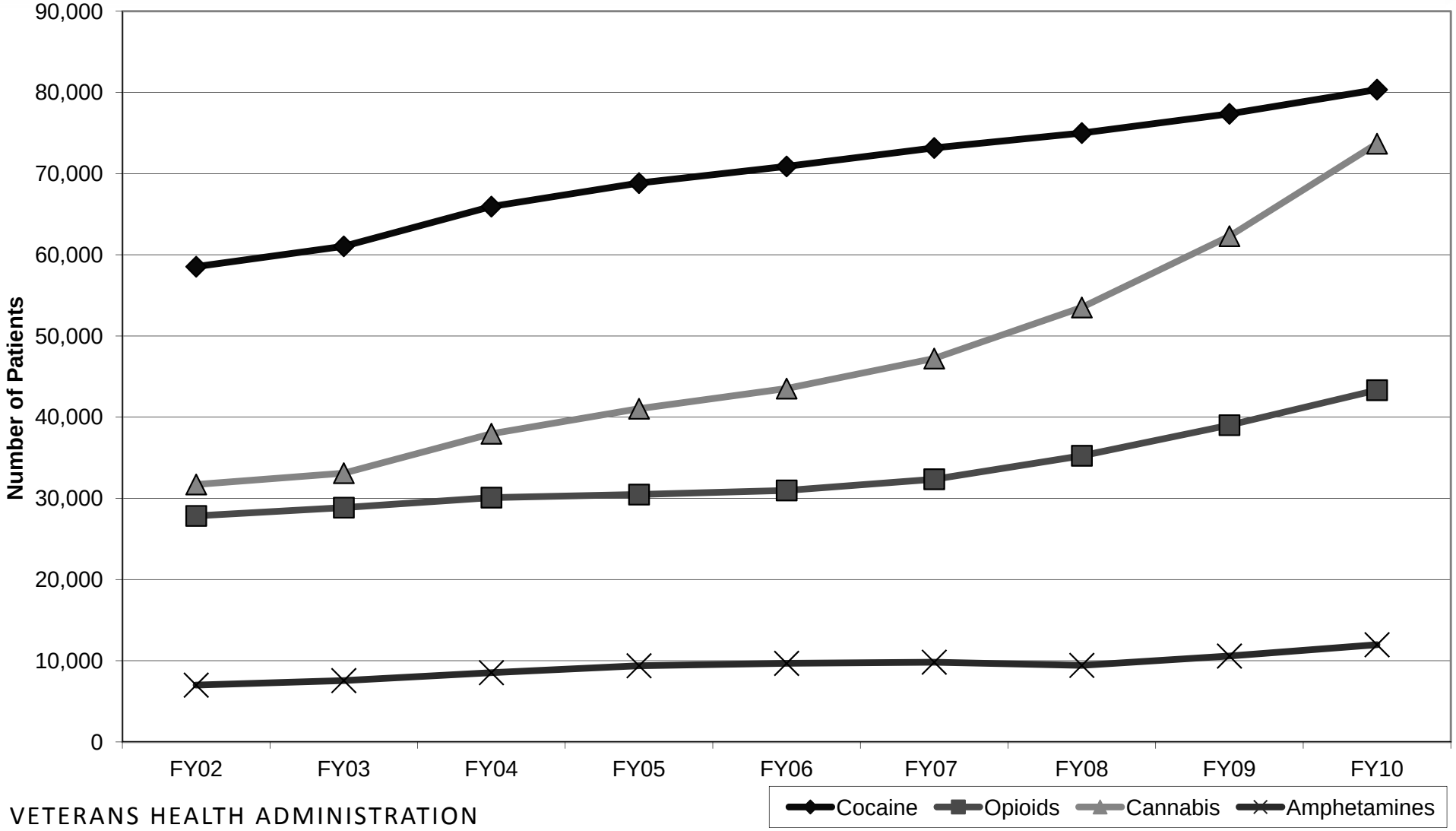
Trends in SUD Diagnoses in VHA



Trends in Specific Diagnoses by Drug



Mental Disorders[1] among OEF/OIF/OND Veterans[2]

Cumulative from 1st Quarter FY 2002 through 3nd Quarter FY 2011

Disease Category (ICD 290-319 code)	Total Number of OEF/OIF/OND Veterans[3]	Change since Q3FY10
PTSD (ICD-9CM 309.81)	197,074	26%
Depressive Disorders (311)	147,659	30%
Neurotic Disorders (300)	126,673	34%
Tobacco Use Disorder (305.1)	**119,248**	***
Affective Psychoses (296)	89,001	32%
Alcohol Abuse (305.0)	**44,611**	***
Alcohol Dependence Syndrome (303)	**41,409**	**33%**
Non-Alcohol Abuse of Drugs (ICD 305.2-9)	**28,776**	***
Specific Nonpsychotic Mental Disorder due to Organic Brain Damage (310)	25,038	25%
Special Symptoms, Not Elsewhere Classified (307)	24,936	35%
Drug Dependence (304)	**21,309**	**38%**

IASP

PAIN® 152 (2011) 488–497

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www.elsevier.com/locate/pain

Systematic review of prevalence, correlates, and treatment outcomes for chronic non-cancer pain in patients with comorbid substance use disorder

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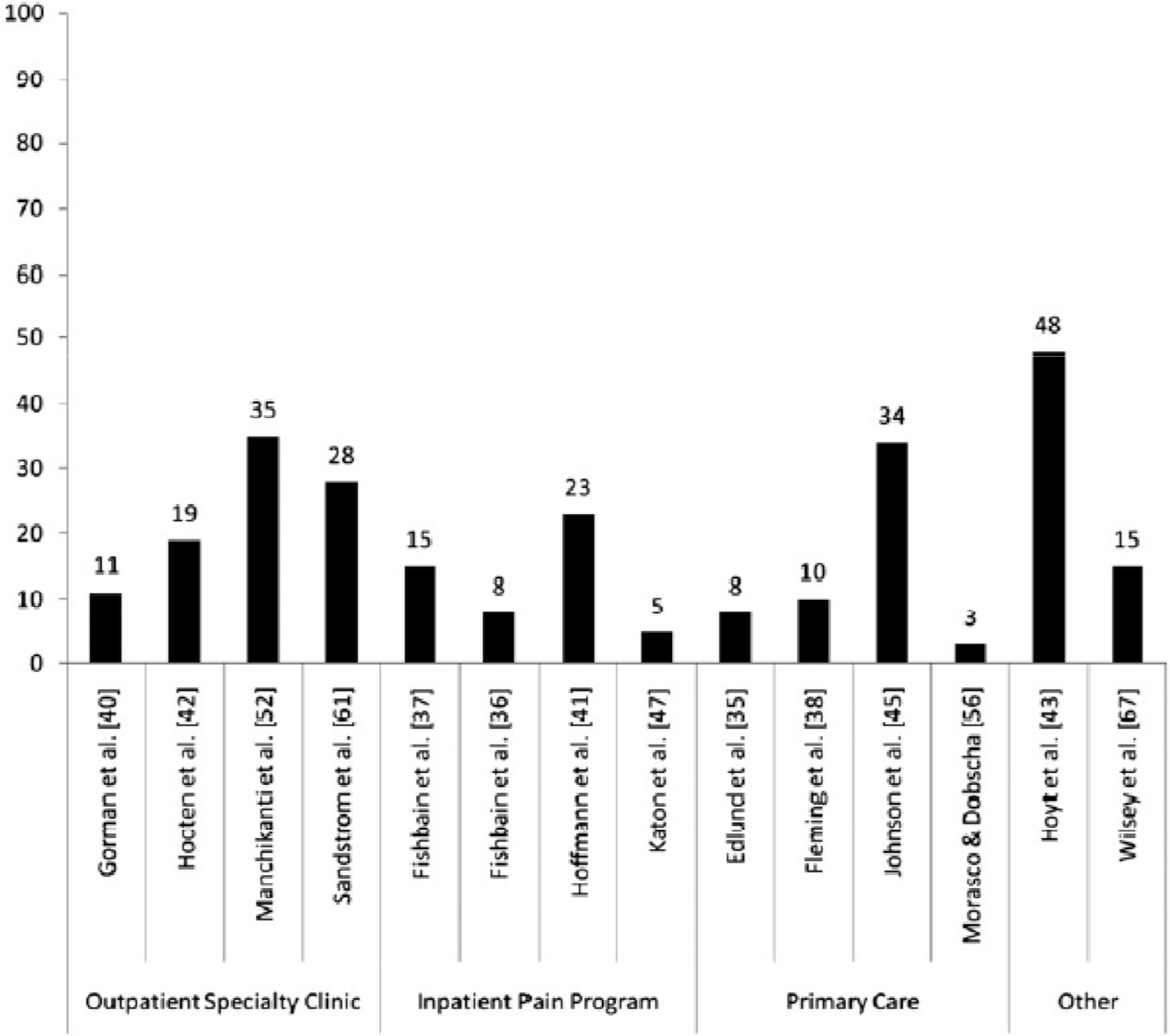
[b] Mental Health and Clinical Neurosciences Division, Portland VA Medical Center, USA
[c] School of Professional Psychology, Pacific University, USA
[d] Department of Anesthesiology and Pain Medicine, University of Washington School of Medicine, USA
[e] Portland Center for the Study of Chronic, Comorbid Medical and Psychiatric Disorders, Portland VA Medical Center, USA

Panel A. Current substance use disorder.



Morasco et al. ~Conclusions

- No demographic or clinical factors that consistently differentiate CNCP patients with or w/o SUD
- SUD patients appear to be at greater risk for aberrant medication-related behaviors
- More likely to get opioid meds and at higher doses
- Do not significantly differ in response to treatment
- Limited data on predictors of treatment outcome
- Quality of the evidence across research questions almost uniformly rated low to very low
- Advice: monitor and adapt treatment accordingly

A Treatment Resources

Online screening for alcohol and rug problems and self-help nformation are available at My IealthE Vet:

- **www.myhealth.va.gov**

f you are having any thoughts of arming or killing yourself, please et your provider know immediately r contact:

- **National Suicide Hotline**
  1-800-273-TALK (8255)
- **Suicidepreventionlife line.org/Veterans/**

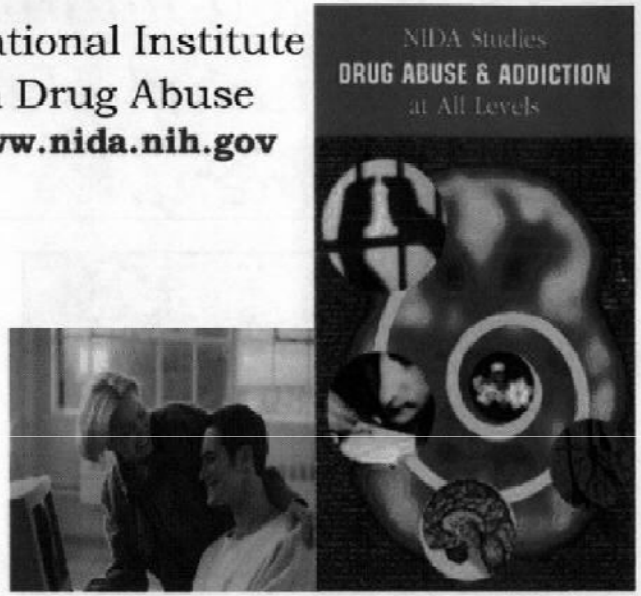
f you are experiencing any ymptoms of withdrawal please talk vith a provider today or go to the mergency room for further valuation.

o schedule an appointment with he Substance Use Disorders Treat-nent Program, refer to contact infor-nation below:

ubstance Use Disorders Treatment rogram
Iome Town VA Medical Center
111 Main Street
nytown, US 12345
hone: 123-456-7890
oll-Free: 1-234-567-8910

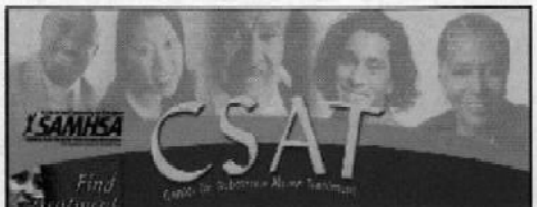
Additional Resources

National Institute on Drug Abuse
www.nida.nih.gov

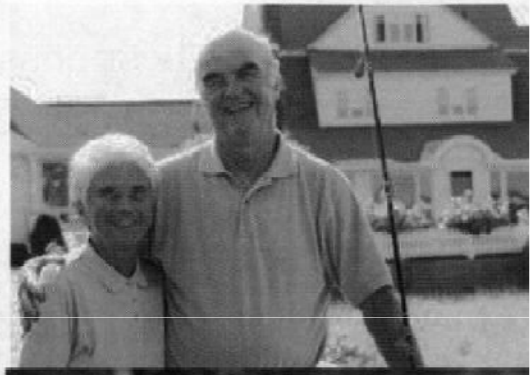


Center for Substance Abuse Treatment/Substance Abuse & Mental Health Services Administration
www.csat.samhsa.gov

NEED A TREATMENT REFERRAL?
1-800-662-HELP
findtreatment.samhsa.gov



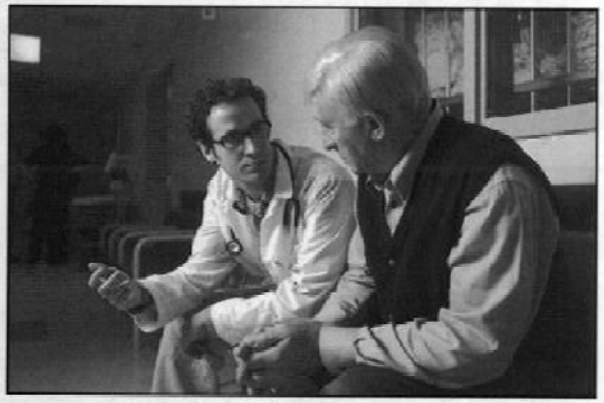
Home Town VA Medical Center



Drug Use: Get the Whole Picture

Tell Your Doctor About ALL The Drugs You Use

To give you the best possible care, your doctor needs to know about any and all drugs you are taking, including tobacco, alcohol, illicit drugs, and over-the-counter and prescription medications — even those not prescribed for you.



The VA is committed to assisting Veterans. You should not worry about being denied appropriate medical or mental health care if you seek out treatment for a substance use concern.

Without the whole picture, you might not get the whole treatment.

Problems with drugs or alcohol are:

Common — 10 to 15 percent of all individuals will experience them at some point in their lifetime.

Can harm you or those close to you in terms of health, happiness, and/or family relationships, among other things.

Are treatable with success rates similar to treatments for heart disease, hypertension, diabetes, and asthma.

What to expect from the VA Substance Use Treatment Program:

- Help for withdrawal.
- Choices in treatment.
- Outpatient or residential treatment based on your needs.
- Treatment shown by research to be effective.
- Access to FDA-approved medications for addictions.
- Care for other mental health concerns you may have, including PTSD and depression.
- Ongoing care based on your needs.
- Referrals for additional services.

Some Comments From Veterans:

"I found that being open about my drug usage has helped me tremendously. I can now face tomorrow."
-Clarence

"I was nervous about speaking up about my drug use, but I'm glad I did. I told my doctor about my prescription pill abuse and he helped me get into a detox program. Now I get the treatment I need and I have my life again."
-Brian

"Once a part of the substance abuse program you realize that you are not alone. The fellowship is great!"
-Mike

http://www.healthquality.va.gov

The guideline describes the critical decision points in the Management of Substance Use Disorder and provides clear and comprehensive evidence based recommendations incorporating current information and practices for practitioners throughout the DoD and VA Health Care systems. The guideline is intended to improve patient outcomes and local management of patients with substance use disorder.

The guideline is formatted as five algorithms, with annotations:

- Algorithm A - Screening and Initial Assessment for Substance Use Disorder
- Algorithm B - Management of SUD in Specialty SUD Care
- Algorithm C - Management of SUD in (Primary) General Healthcare
- Algorithm P - Addiction-Focused Pharmacotherapy
- Algorithm S - Stabilization and Withdrawal Management

Caveats on Guidelines

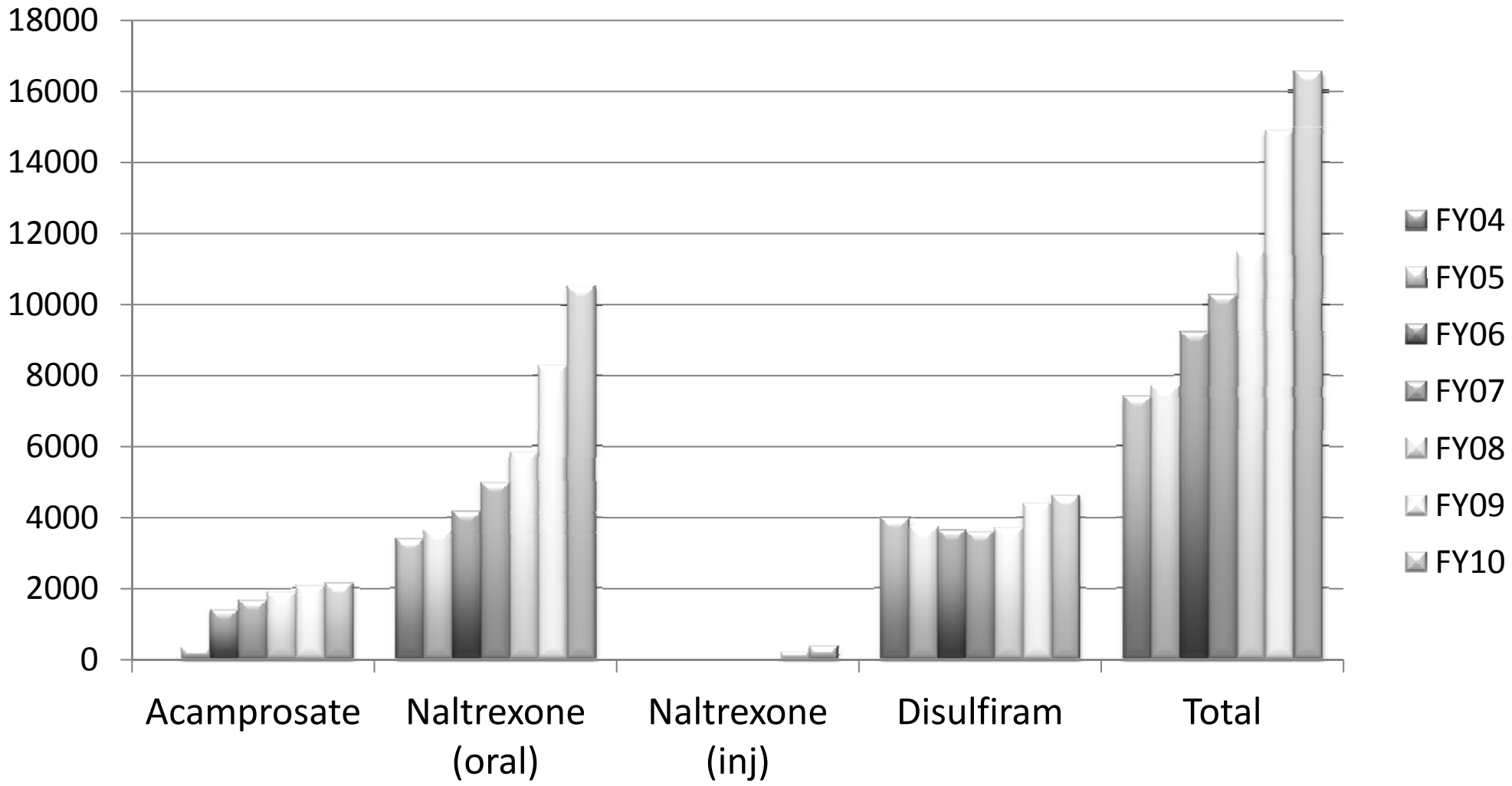
- An aid in decision making, but strength of evidence is variable
- Where scientific data were lacking , recommendations were based on the clinical experience of the Working Group
- This should not prevent providers from using their own clinical expertise in the care of an individual patient

Key Principles from VA/DoD Guidelines

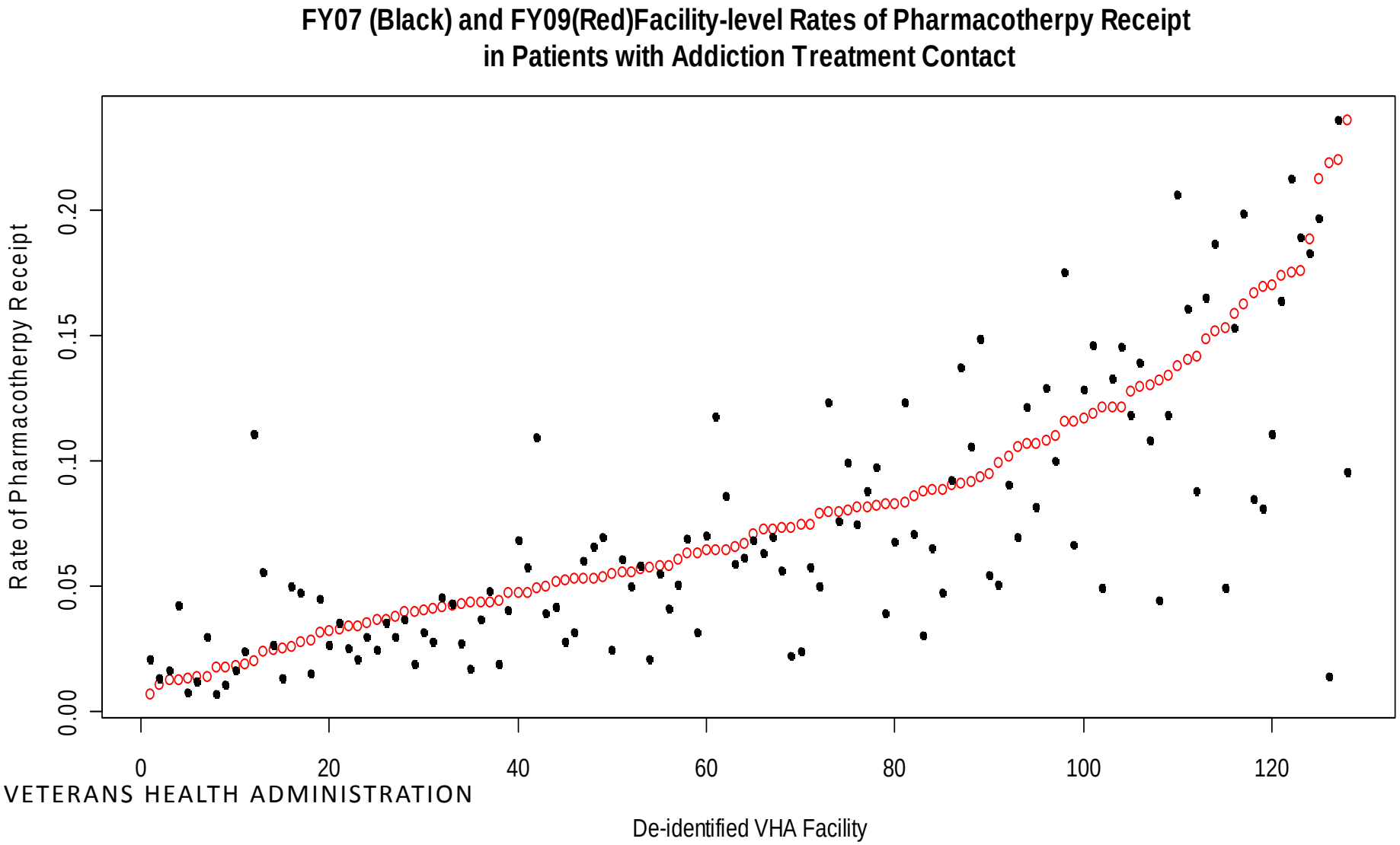
- Pharmacotherapy and psychosocial interventions are important treatment options for Veterans with SUD.
- Regardless of the particular intervention chosen, **use motivational interviewing style** during therapeutic encounters with patients and emphasize the **common elements** of effective interventions
  - promoting a therapeutic relationship,
  - enhancing patient motivation to stop or reduce substance use,
  - improving self-efficacy for change,
  - strengthening coping skills,
  - arrange added benefits of recovery, and
  - enhancing social support for recovery

- enhancing social support for recovery

Patients Prescribed FDA Approved Medications for AUD



FY07-09 Changes in AUD Pharma. IN SUD Specialty Care



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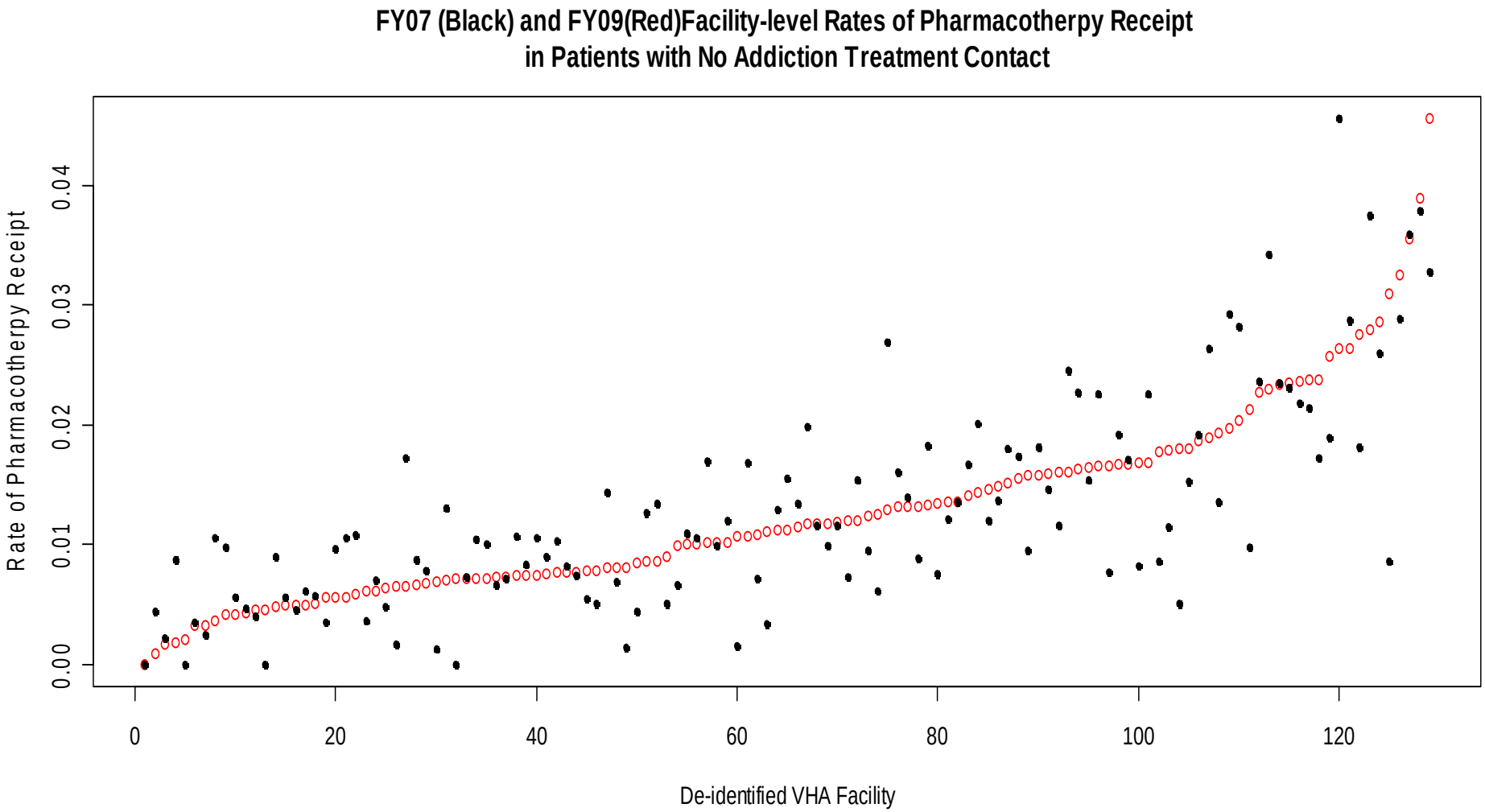
FY07-09 Changes in AUD Pharma. Outside of SUD Specialty Care

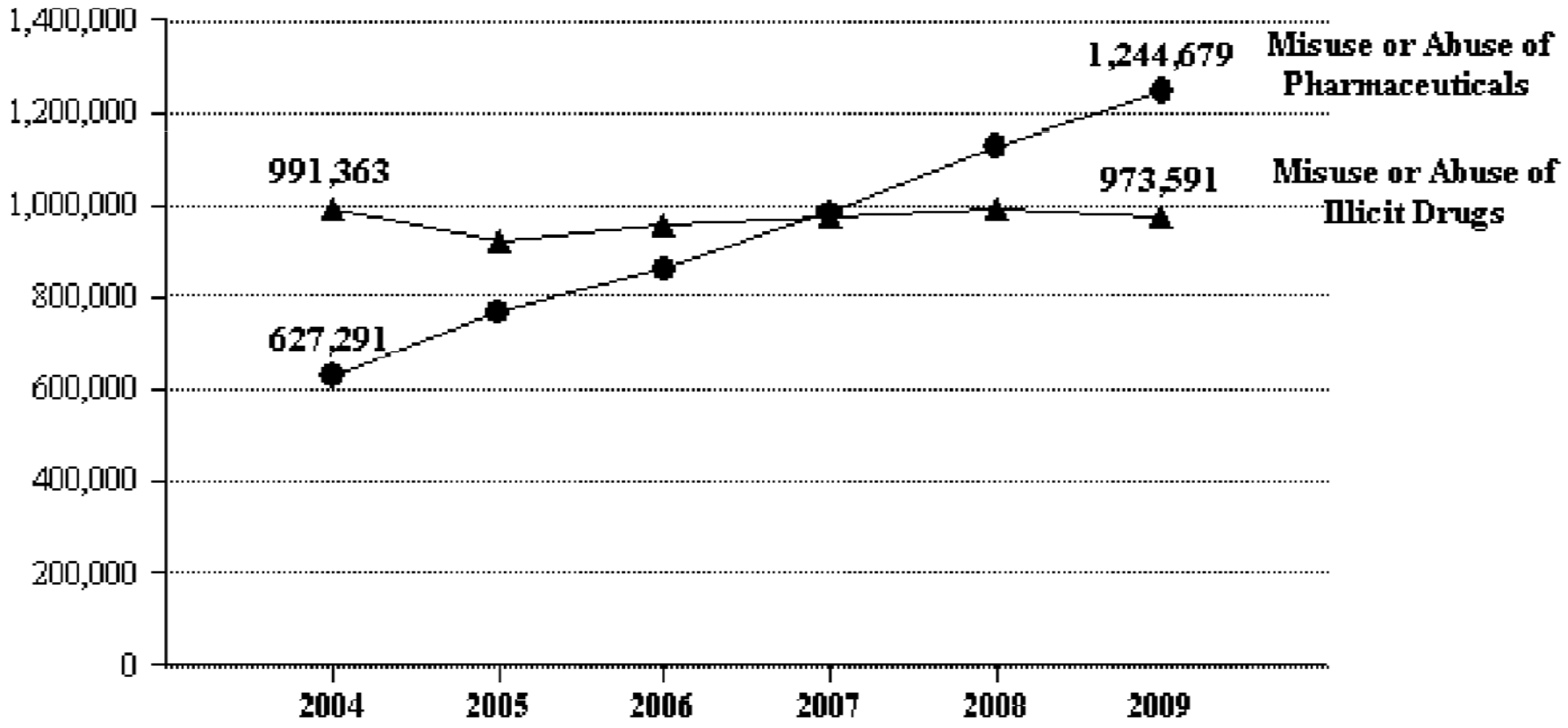


Change in Opioid Agonist Pharmacotherapy FY09-10

Year	Opioid Diagnosis	Treated* (num)	Diagnosed (denom)	National	Facility Median
FY09	Dependence	10681	34736	30.1%	18.1%
FY10	Dependence	12149	38484	31.6%	21.0%
		+1468	+3748	+1.5%	+2.9%

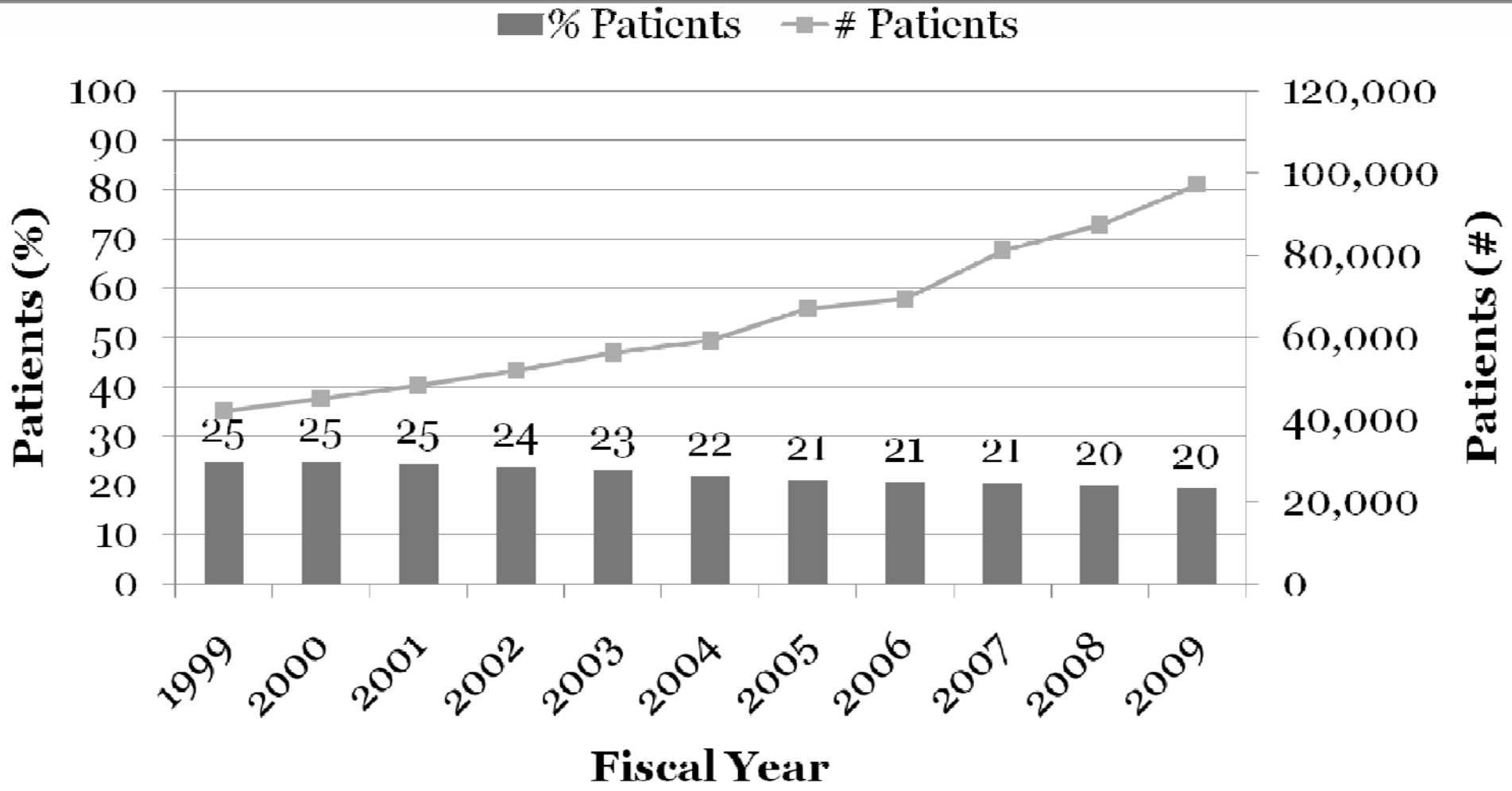
- Includes office based care (buprenorphine/naloxone),
- Opioid Treatment Program (methadone or buprenorphine/naloxone),
- or fee basis care

ED Visits for Misuse or Abuse of Pharmaceuticals (2004 to 2009)



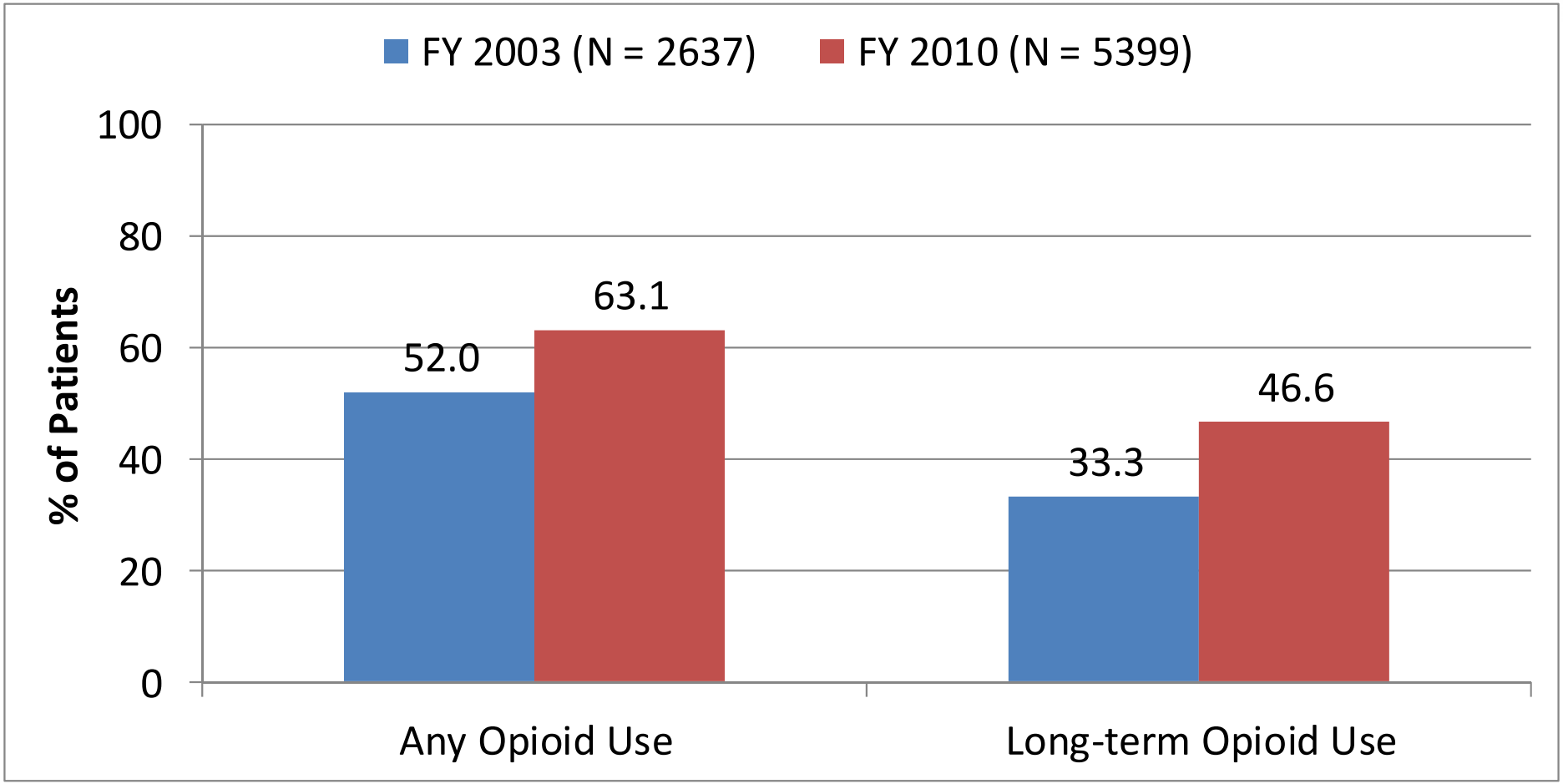
Estimated data from the Drug Abuse Warning Network (DAWN).

Chronic Benzodiazepines* and PTSD



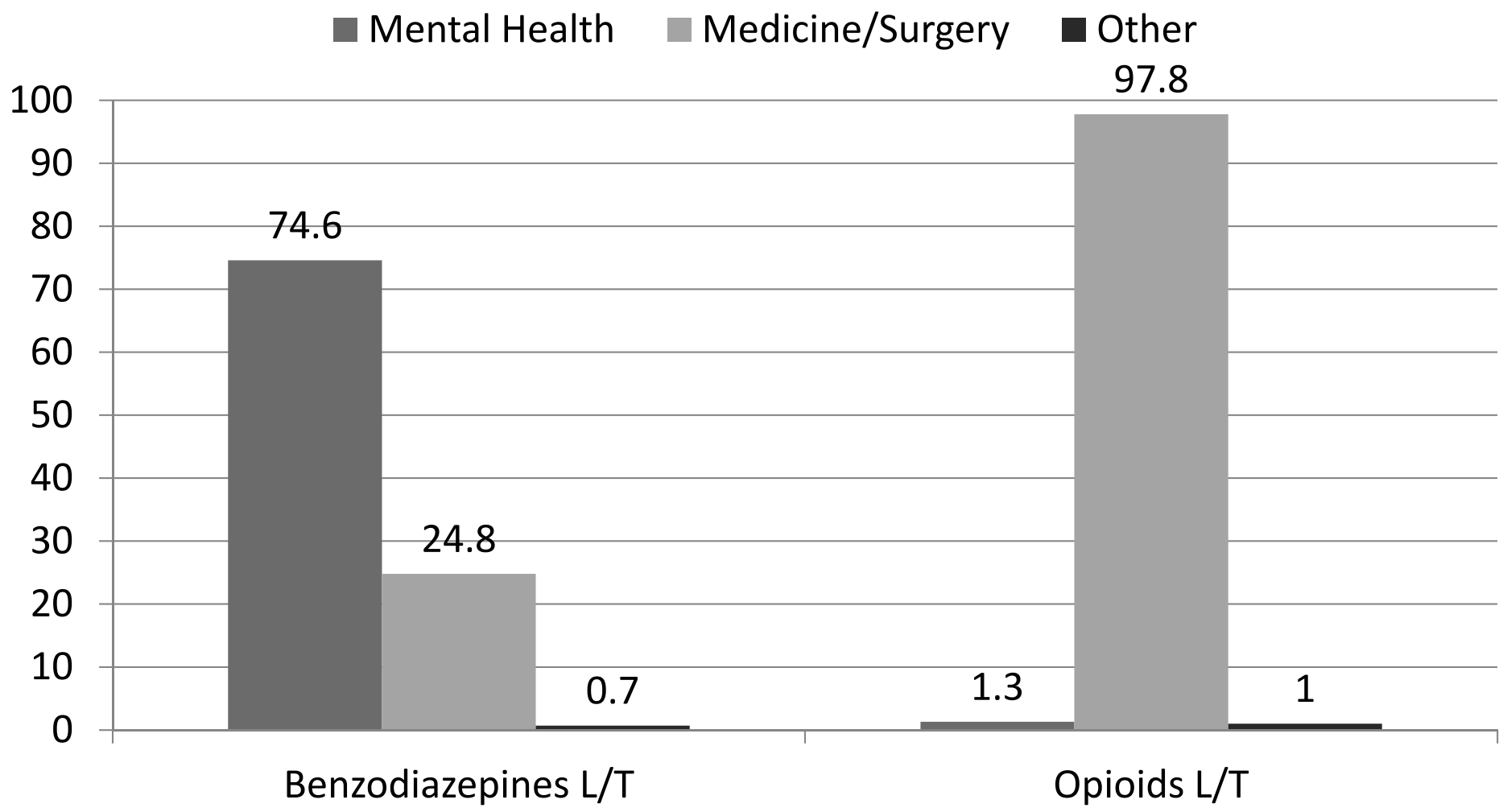
*> 90 days of continuous refill in the fiscal year

Opioid Rx Among PTSD Patients with Long-term Benzodiazepine Rx (VISN 20)



Mean days of LT overlap = 238 (SD = 97)

Setting for Long-term Prescribed BZD and Opioids in FY 2010 (n = 2,516 in VISN 20)



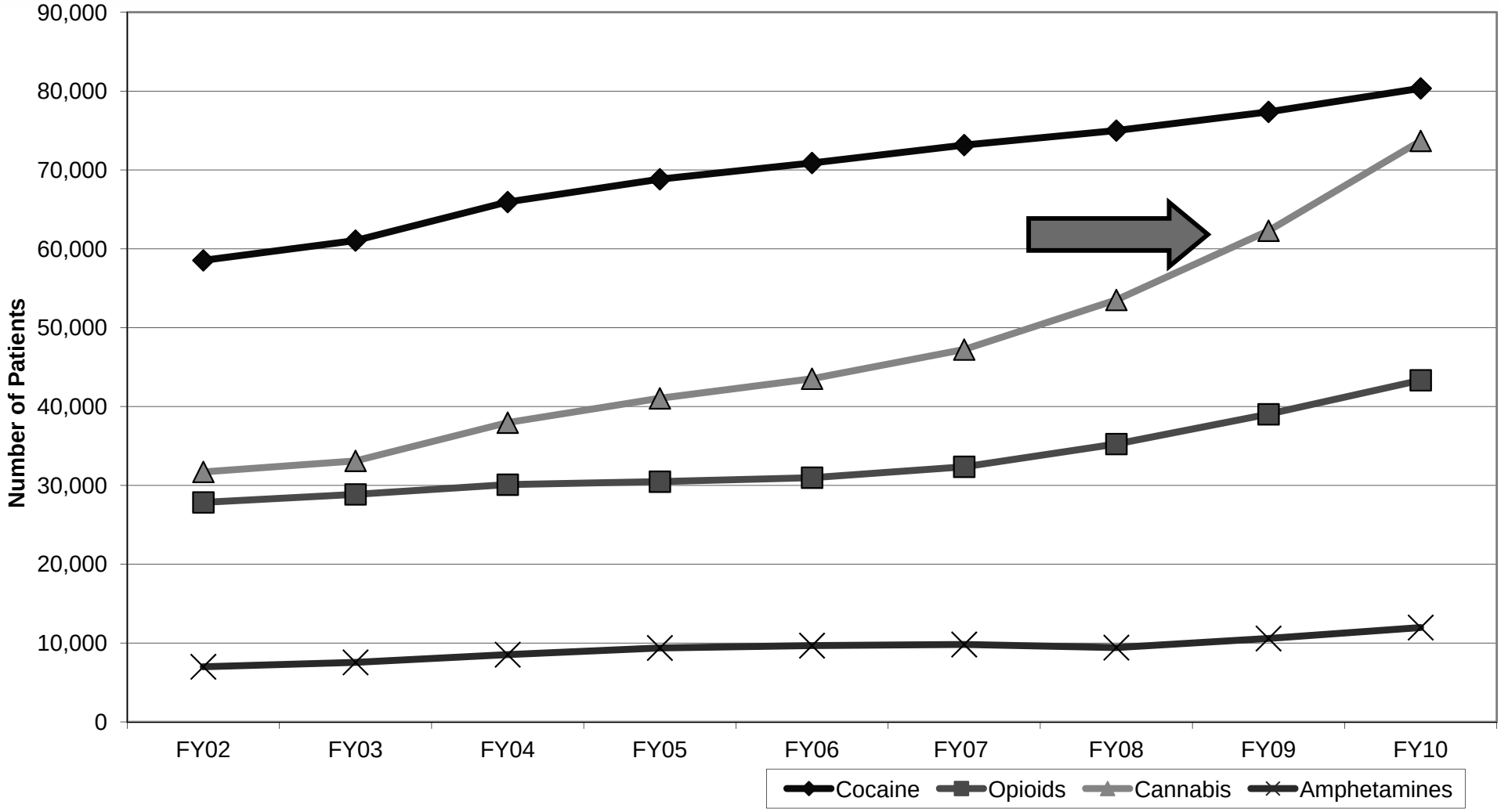
Slide 33

DRK1 confused aboiut which sample - patients with both LT BZ and opioids? Might help to indicate a common n in title?
Daniel Kivlahan, 8/13/2011

Challenges with Benzos/Opioids

- In VISN 20, nearly 1 in 6 men and 1 in 4 women with PTSD were prescribed benzodiazepines >90 days in FY 2010.
- Among men and women,
  - Adjusted prevalence of > 90 days' supply of benzodiazepines rose 1% and 5%, respectively
  - Number prescribed > 90 days' supply increased 200% and 270%, respectively
- Approximately 47% of patients prescribed BZD long-term were also prescribed opioid analgesics long-term.

Drug Diagnoses Over Time



Directive 2011-004

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 2011-004

January 31, 2011

ACCESS TO CLINICAL PROGRAMS FOR VETERANS PARTICIPATING IN STATE-APPROVED MARIJUANA PROGRAMS

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy regarding access to clinical programs for patients participating in a State-approved marijuana program.

Directive 2011-004

- **POLICY**: It is VHA policy to prohibit VA providers from completing forms seeking recommendations or opinions regarding a Veteran's participation in a State marijuana program.

Directive 2011-004

- VHA policy does not administratively prohibit Veterans who participate in State marijuana programs from also participating in VHA substance abuse programs, pain control programs, or other clinical programs where the use of marijuana may be considered inconsistent with treatment goals.

Directive 2011-004

- While patients participating in State marijuana programs must not be denied VHA services, the decisions to modify treatment plans in those situations need to be made by individual providers in partnership with their patients.
- VHA endorses a step-care model for the treatment of patients with chronic pain: any prescription(s) for chronic pain needs to be managed under the auspices of such programs described in current VHA policy regarding Pain Management

Possession

- *Note: Possession of medical marijuana by Veterans while on federal property places them at risk for violations of the Controlled Substances Act; the Department of Justice has communicated to the Department of Veterans Affairs its commitment to enforcing the Controlled Substances Act.*

Supplemental Information

Office of Patient Care Services

Clinical Considerations Regarding Veteran Patients Who Participate in State-Approved Marijuana Programs

December 20, 2010

Clinical Considerations

- If a patient provides evidence of State-approval for the use of Marijuana, the VA provider should:
  - Request the Veteran's written release for information from the non-VA prescriber of marijuana
  - Given written release, the VA provider should initiate contact with the non-VA provider to assure open communication and coordination of care
  - Document medical marijuana prescription as a non-VA medication in CPRS
- Understand the prescription and closely monitor adherence

Clinical Considerations

- Policy prohibits denying Veterans access to <u>most</u> clinical programs <u>solely</u> because of their participation in State-approved marijuana programs
- VHA Pain Management Program Office strongly supports this policy
- Decisions about the use of opioid analgesics need to balance Veteran rights to pain management and Veteran safety

Accessing SUD Services: What to Expect

- Policy changes to increase access to SUD Services – Deputy Undersecretary (DUSHOM) Memo
- VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers
- VHA Handbook 1162.01, Mental Health Residential Rehabilitation Treatment Programs

Management Principles for SUD: DUSHOM Memo 11/07

1. Facilities must not deny **clinically appropriate** care because veterans are intoxicated, actively using substances including non-prescribed controlled substances, or experiencing withdrawal.
2. All facilities must make medically supervised withdrawal management available when clinically indicated.

Management Principles for SUD: DUSHOM Memo 11/07

3. Appropriate SUD care must not be denied or delayed for veterans only on the basis of:
   - Length of current abstinence
   - # or recency of previous treatment episodes
   - Use of prescribed controlled substances
   - Legal history
   - Other co-occurring Mental Health conditions.
4. Every facility must meet the care needs of veterans with co-occurring SUD and PTSD or other MH conditions by providing an integrated dual diagnosis program
   - with services in one setting or closely coordinated across programs.

National Ethics Committee VHA (March 2010)

- Focused on Vets on long term oxygen therapy (LTOT) who continue to smoke
- Is clinician morally or legally responsible for any subsequent harm from fire?
- Shared decision making based on non-coercive discussion of risks and benefits
- Applicable harm reduction techniques
- Terminate LTOT only in consultation with multidisciplinary team and Ethics Consultation Service

Harm Reduction Coalition: Basic Principles

- People may “choose” harmful behavior
- Risk reduction seeks to minimize the degree of harm
- Health behavior is complex and on a continuum of safety
- Quality of life, not “compliance”, is the criterion of success
- Non-judgmental, non-coercive availability & provision of services helps patients reduce risk
- Patients are the primary agents of reducing risk
  - Risk reduction empowers patients

Summary

- We need collaboration across settings
- No easy answers to patient complexity
  - But there are some actions to consider
- Opioids are not the only SUD issue
- Big gaps in the evidence-base on pain and SUD
- Shared responsibility to assure access to patient-centered care
- Ethics of harm reduction

Resources

- http://www.mentalhealth.va.gov/substanceabuse.asp
  - Includes self-screening brochure
- VA/DoD SUD Guideline
  - www.healthquality.va.gov
- QUERI toolkit for AUDIT-C and brief counseling http://www.queri.research.va.gov/tools/alcohol-misuse/alcohol-counseling.cfm
- **Behavioral Health Lab (BHL) weekly call.**
  - **T**uesday 2:00pm EST; software questions and technical assistance. **1-800-767-1750, access code 31307#**
- VHAANN HSRD PC-MH Integration –
  - Maureen Metzger list owner
- daniel.kivlahan@va.gov