VA

U.S. Department
of Veterans Affairs

Addressing Mental Health and Substance Use Disorders in Veterans

Jennifer Burden, PhD

Deputy Director, Residential Rehabilitation and Treatment Programs, Mental Health Services, Veterans Health Administration

May 2017

DISCLOSURES

- Employed by the Department of Veterans Affairs (VA)
- No commercial financial conflicts of interest
- May reference use of medications that are not FDA-approved indications. For example, Topiramate and gabapentin for treatment of alcohol use disorder

ACKNOWLEDGEMENTS

- Dr. Karen Drexler, National Mental Health Director, Addictive Disorders, Mental Health Services
- Northeastern Program Evaluation Center (NEPEC)

OBJECTIVES

Explain resources and current standards of care for meeting the mental health and substance use disorder treatment needs of Veterans.

- Review of relevant data
- Current standards of care and available resources
- Targeted efforts to address opioid use disorders

BACKGROUND

- Since 1999, opioid pain medicine prescriptions quadrupled without any change in Americans' report of pain.
- From 1999 to 2015, the number of opioid-related overdose deaths quadrupled.
- On average, 91 Americans died of opioid overdose every day.
- 1 in 4 individuals receiving prescription opioids long term report substance use concerns.

Source CDC: https://www.cdc.gov/drugoverdose/epidemic/index.html

"Our "whole health" model of care is a key component of the VA's proposed future delivery system. This model incorporates physical care with psychosocial care focused on the veteran's personal health and life goals, aiming to provide personalized, proactive, patient-driven care through multidisciplinary teams of health professionals."

~David J. Shulkin, MD
(N Engl J Med 2016; 374:1003-1005)

VETERAN POPULATION

- At the end of FY 2015, there were over 21 million Veterans.

- Virginia ranks 7th nationally in total Veteran population with over 783,000 Veterans.

ENGAGEMENT IN VHA SERVICES

- During Q1 FY 17, 8.1% of Veterans receiving care in VHA were diagnosed with a substance use disorder (SUD)
- Almost 32% of those Veterans clinically diagnosed with SUD received specialty SUD services

VHA TRENDS IN SUD

VHA TRENDS IN DRUG USE DISORDER DIAGNOSES (EXCLUDES TOBACCO)

Number of Patients

100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0

FY02 FY03 FY04 FY05 FY06 FY07 FY08 FY09 FY10 FY11 FY12 FY13

Cocaine | Opioids | Cannabis | Amphetamines

VHA CONTINUUM OF MENTAL HEALTH CARE

Primary Care – Mental Health Integration

- Brief Interventions
- Triage/Screening

General Mental Health

- Continuing care
- General Mental Health Services

Outpatient Specialty Care

- Specialty intensive outpatient groups
- Pharmacotherapy
- Intensive Case Management

Residential Programs

- 24/7 supervised intensive specialty treatment.
- Bulk of "inpatient" SUD and PTSD treatment
- No bed side care
- Complex treatment needs

Inpatient

- Acute inpatient mental health

RESIDENTIAL SERVICES IN VHA

- Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) provide a level of care between acute inpatient and outpatient mental health treatment and serve Veterans with complex, co-occurring mental health, substance use, medical, and psychosocial needs.
- 247 Programs with 7,838 operational beds (Q1 FY 2017)

64 SUD RRTPs (1,689 beds)	45 DCHVs (2,229)
42 PTSD RRTPs (728 beds)	41 CWT-TRs (613 beds)
54 GEN RRTPs (2,579 beds)	

- Over 2 Million Bed Days of Care in FY 2016 and over 33,000 unique Veterans served
- MH RRTPs are an essential component of the broader mental health continuum of care.

SNAPSHOT OF RESIDENTIAL DEMOGRAPHIC DATA

- Average age decreasing (48 years old)
- Growing cohort under the age of 35 (21%)
- Increasing rates of co-occurring SUD and mental health diagnoses
  - 87% diagnosed with a SUD
  - 42% diagnosed with PTSD

UNIFORM MENTAL HEALTH SERVICES

- Within VHA national policy defines the scope of services that must be available to all Veterans.

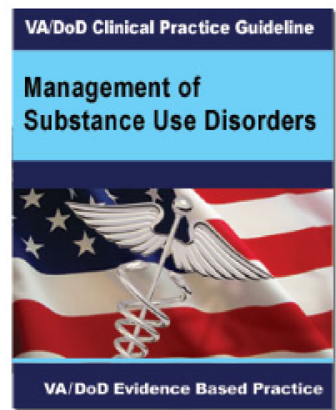
- Addresses key concepts of:
  - Access across the continuum
  - Provision of evidence-based services
  - Pharmacotherapy

U.S. Department of Veterans Affairs

VA/DoD Clinical Practice Guidelines

VA/DOD Clinical Practice Guidelines
More Health Care
QUICK LINKS
Hospital Locator
Zip Code Go
Health Programs
Protect Your Health
A-Z Health Topics
Veterans Crisis Line
1-800-273-8255 PRESS 1

Management of Substance Use Disorder (SUD) (2015)



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.

Disclaimer: This Clinical Practice Guideline is intended for use only as a tool to assist a clinician/healthcare professional and should not be used to replace clinical judgment.

About the CPG	Guideline Links	Patient-Provider Tools	Related Guidelines
The guideline is formatted as two algorithms and 36 evidence-based recommendations: • Module A - Screening and Treatment • Module B	Full Guideline (2015) Clinician Summary (2015) Screening & Treatment Pocket Card (2015) Stabilization Pocket Card (2015)	Patient Summary Substance Abuse Affects Families Brochure Medication-Assisted Treatment for Alcohol Dependence Booklet	Major Depressive Disorder (MDD) Opioid Therapy (OT) for Chronic Pain Post Traumatic Stress Disorder (PTSD) Diabetes Mellitus (DM)

VA-DOD CLINICAL PRACTICE GUIDELINE FOR MANAGEMENT OF SUDS

- Screening and Brief Alcohol Intervention
- Treatment (Pharmacotherapy and Psychosocial Interventions)
  - Alcohol use disorder
  - Opioid use disorder
  - Cannabis use disorder
  - Stimulant use disorder
- Promoting Group Mutual Help Involvement (e.g. AA, NA, Smart Recovery)
- Address Co-occurring Mental Health Conditions and Psychosocial Problems
- Continuing care guided by ongoing assessment
- Stabilization and Withdrawal

SUD	Medications	Psychosocial Intervention
Alcohol	Acamprosate Disulfiram Naltrexone Topiramate Gabapentin*	BCT CBT-SUD CRA MET TSF
Opioid	Buprenorphine Methadone ER-Injectable Naltrexone*	Medical Management** CM/IDC**
Cannabis		CBT/MET
Stimulant		CBT/CRA/GDC +/- CM

**suggested **recommended only with medication*

http://www.healthquality.va.gov/guidelines/MH/sud/

SHARED DECISION MAKING AND MEASUREMENT-BASED CARE

- Shared decision-making guides selection of evidence-based treatments:
  - Clinician provides risks/benefits for a menu of recommended options.
  - Patient makes an informed choice.

- Measure outcome and adjust plan as indicated.
  - For OUD, drug testing is essential, but late.
  - Better to measure risk/protective factors- e.g.:
    - Brief Addiction Monitor (BAM) for substance use disorders.

VHA EFFORTS TO ADDRESS OPIOID USE

- Opioid Safety Initiative
- Opioid Overdose Education and Naloxone Distribution
- Medication Assisted Treatment

OPIOID SAFETY INITIATIVE

- Leverages informatics to inform practice
- Significant decrease in opioid prescribing
- https://www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_OSI.asp

OPIOID EDUCATION AND NALOXONE DISTRIBUTION (OEND)

- Over 78,000 naloxone kits prescribed
- Diffusion of excellence project deploying kits across settings of care

Choose Before You Use

If at all possible, do not use. There is no safe dose of opioids. Help is available, contact your local VA. But if you do use—Choose!

1. Go Slow - Not taking drugs for even a few days can drop your tolerance, making your "usual dose" an "overdose," which can result in death. If you choose to use, cut your dose at least in half.
2. Wait - If you choose to use, wait long enough after you use to feel the effects before you even consider dosing again (regardless if IV, snorting, smoking).
3. Let Someone Know - Always let someone know you're using opioids so that they can check on you. Many who overdose do so when dosing alone.

Buddies take care of Buddies. Share this card with a friend or family member.

www.mentalhealth.va.gov/substanceabuse.asp

(Adapted from the Harm Reduction Coalition, Oakland, CA)
Date Created: 8/14

You are at higher risk for opioid overdose or death when

- You've not used for even a few days, such as when you are in the hospital, residential treatment, detoxification, domiciliary, or jail/ prison.

  Lost tolerance = higher risk for overdose (OD).
- You use multiple drugs or multiple opioids, especially: downers/ benzodiazepines/ barbiturates, alcohol, other opioids, cocaine (cocaine wears off faster than the opioid).
- You have medical problems (liver, heart, lung, advanced AIDS).
- You use long-acting opioids (such as methadone) or powerful opioids (such as fentanyl).
- You use alone, and don't let someone know you are using opioids.

Ask a VA clinician if a naloxone kit is right for you

Important considerations:

- During an overdose the user cannot react, so someone else needs to give naloxone.
- Encourage family and significant others to learn how to use naloxone (see "Overdose Resources" section).
- If you have a naloxone kit, tell family and significant others where you keep it.
- Store naloxone kit at room temperature, out of the heat and light (e.g., do not store in your car), otherwise naloxone will lose its effectiveness.

CHOOSE BEFORE YOU USE

OPIOID OVERDOSE PREVENTION

Overdose Resources

SAMHSA Opioid Overdose Prevention Toolkit
- Contains safety advice for patients and resources for family members
  http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742

Community-Based Overdose Prevention and Naloxone Distribution Program Locator
- Identifies programs outside of the VA that distribute naloxone
  http://hopeandrecovery.org/locations/

Prescribe to Prevent
- Patient resources and videos demonstrating overdose recognition and response, including naloxone administration
  http://prescribetoprevent.org/video/

EFFORTS TO SUPPORT ACCESS TO MEDICATION ASSISTED TREATMENT (MAT)

- 34.5% of Veterans with an Opioid Use Disorder received MAT
- Encouraged across all settings of care
- Academic Detailing campaign to support implementation
- Next Steps – implementation of Stepped Care Model

Models for MAT for OUD in General Care

ORIGINAL INVESTIGATION

HEALTH CARE REFORM

Collaborative Care of Opioid-Addicted Patients in Primary Care Using Buprenorphine

Five-Year Experience

Daniel P. Alford, MD, MPH; Colleen T. LaBelle, RN; Natalie Kretsch, BA; Alexis Bergeron, MPH, Michael Winter, MPH; Michael Botticelli, MEd; Jeffrey H. Samet, MD, MA, MPH

Published in final edited form as:
Am J Med. 2013 January ; 126(1): 74.e11–74.e17. doi:10.1016/j.amjmed.2012.07.005.

ORIGINAL ARTICLE

ONLINE FIRST

Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence

A 2-Phase Randomized Controlled Trial

Roger D. Weiss, MD; Jennifer Sharpe Potter, PhD; David A. Fiellin, MD; Marilyn Byrne, MSW; Hilary S. Connery, MD, PhD; William Dickinson, DO; John Gardin, PhD; Margaret L. Griffin, PhD; Marc N. Gourevitch, MD, MPH; Deborah L. Haller, PhD; Albert L. Hasson, MSW; Zhen Huang, MS; Petra Jacobs, MD; Andrzej S. Kosinski, PhD; Robert Lindblad, MD; Elinore F. McCance-Katz, MD; Scott E. Provost, MSW; Jeffrey Selzer, MD; Eugene C. Somoza, MD, PhD; Susan C. Sonne, PharmD; Walter Ling, MD

A Randomized Trial of Cognitive Behavioral Therapy in Primary Care-based Buprenorphine

David A. Fiellin, MD[a], Declan T. Barry, PhD[b], Lynn E. Sullivan, MD[a], Christopher J. Cutter, PhD[a], Brent A. Moore, PhD[b], Patrick G. O'Connor, MD, MPH[a], and **Richard S. Schottenfeld, MD[b]**

[a]Department of Internal Medicine, Yale University School of Medicine, New Haven, Conn

[b]Department of Psychiatry, Yale University School of Medicir

SUBSTANCE ABUSE
2016, VOL. 37, NO. 1, 20–24
http://dx.doi.org/10.1080/08897077.2015.1129388

BRIEF REPORT

OPEN ACCESS

Project ECHO (Extension for Community Healthcare Outcomes): A new model for educating primary care providers about treatment of substance use disorders

Miriam Komaromy, MD[a], Dan Duhigg, MBA, DO[a], Adam Metcalf, LISW[b], Cristina Carlson, PMHCNS-BC[a], Summers Kalishman, PhD[a], Leslie Hayes, MD[c], Tom Burke, BS[a], Karla Thornton, MPH, MD[a], and Sanjeev Arora, MD[a]