U.S. Department of Veterans Affairs

Addictive Disorder Treatment in VA

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OBJECTIVES

1. Provide an overview of addiction trends at the state and regional level.
2. Provide an overview of best practices in the treatment of addiction issues.
3. Identify VA's approach in treating addiction issues and discuss VA's treatment resources.

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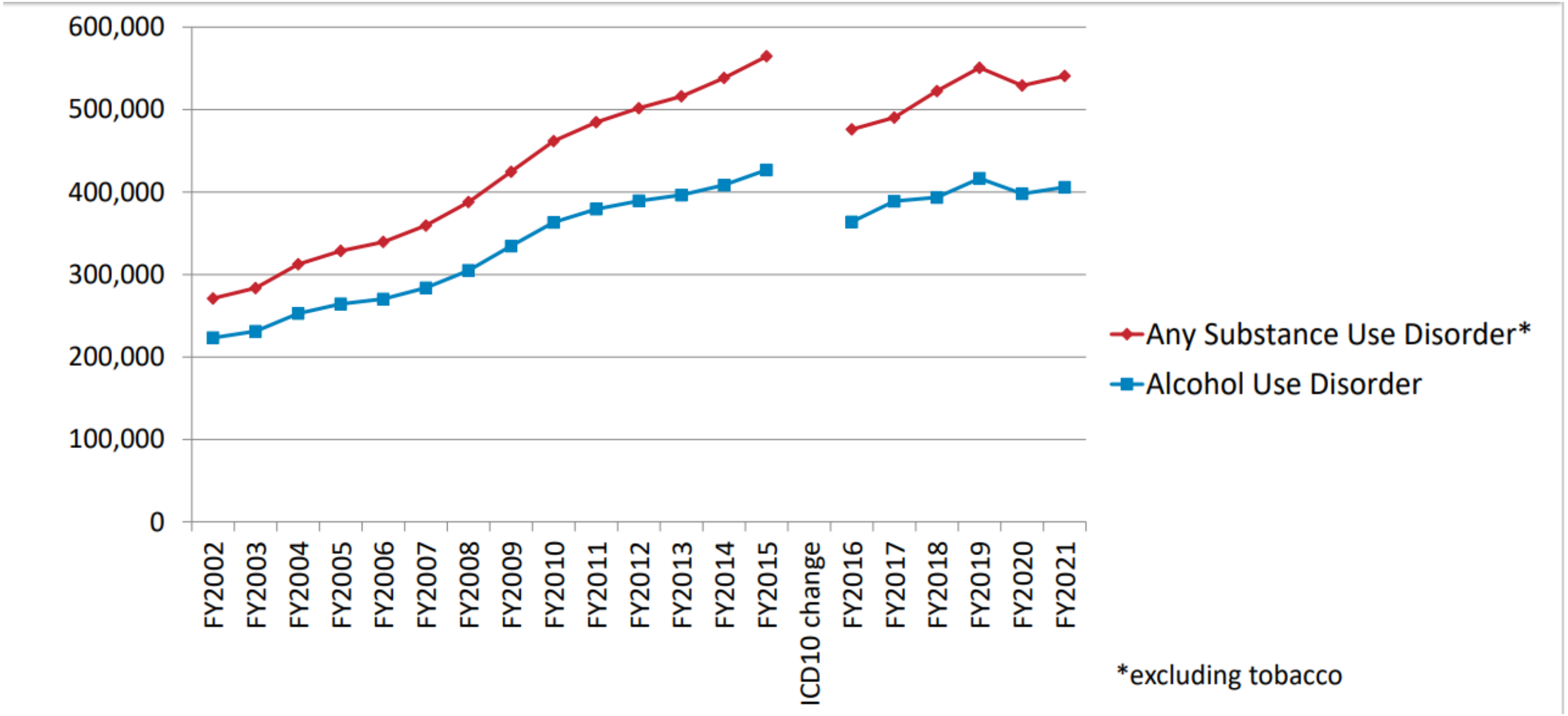
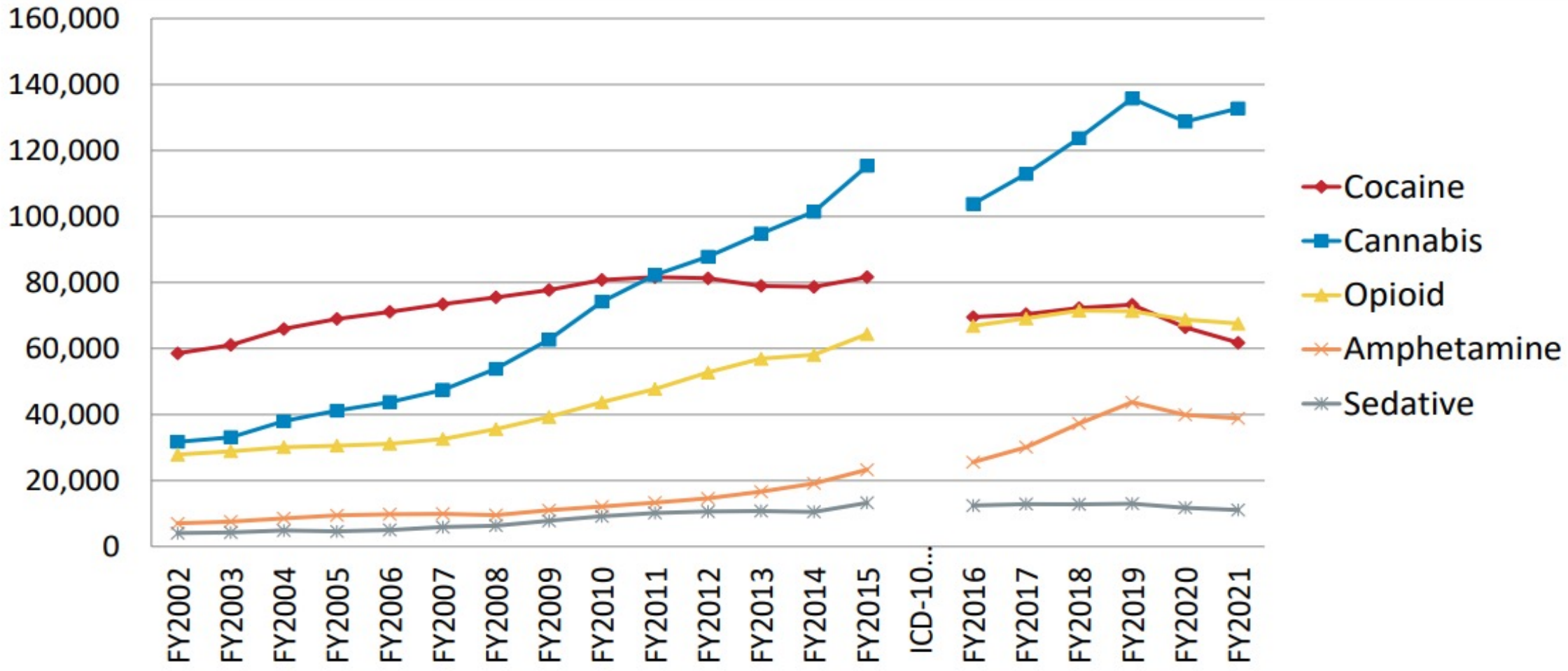
Substance Use Trends

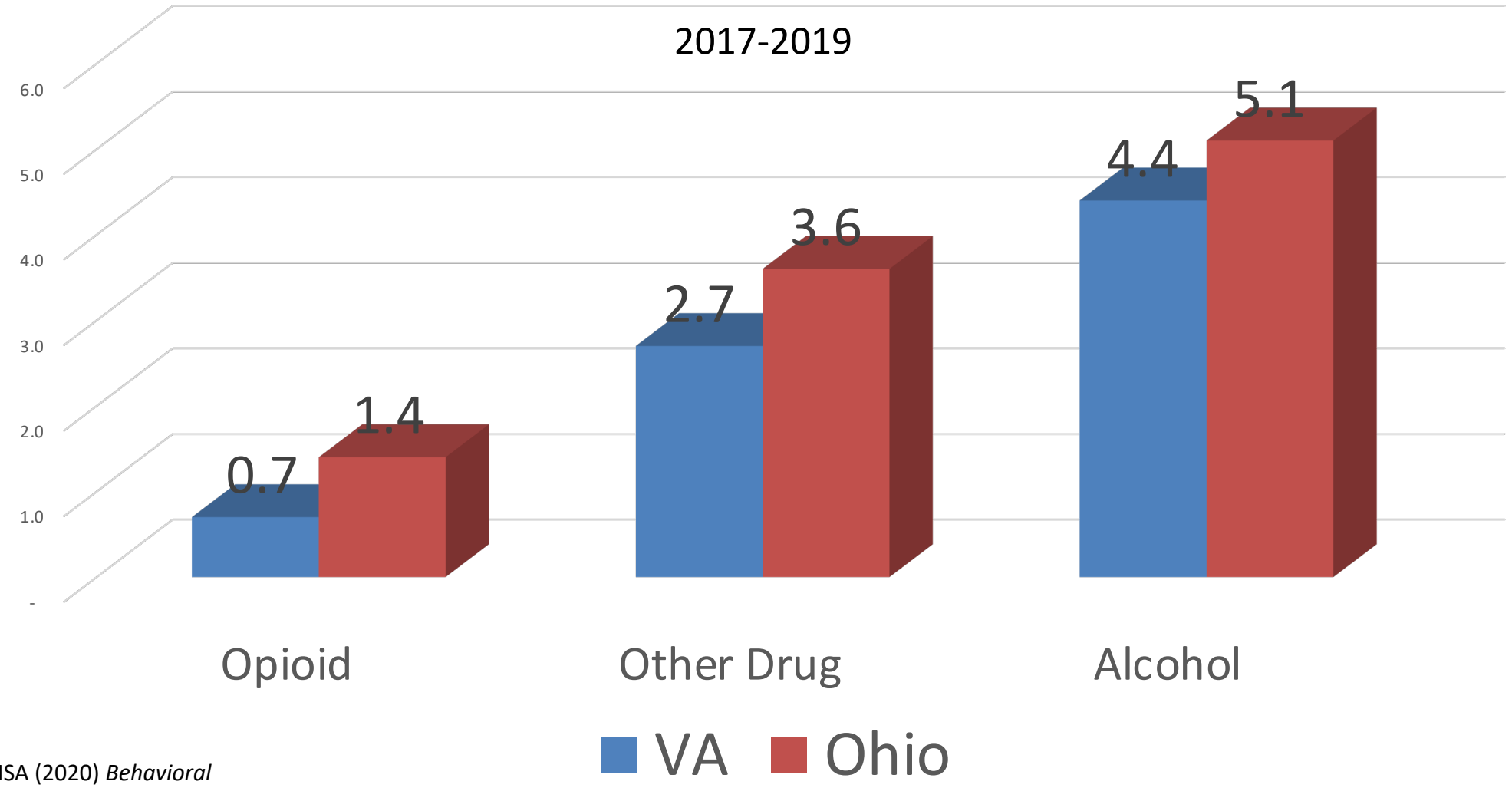
VA TRENDS IN SUBSTANCE USE DISORDERS



VA TRENDS IN SUBSTANCE USE DISORDERS



ANNUAL AVERAGE PREVALENCE OF SUBSTANCE USE DISORDER



Ohio Data from SAMHSA (2020) *Behavioral Health Barometer: Ohio, Volume 6*

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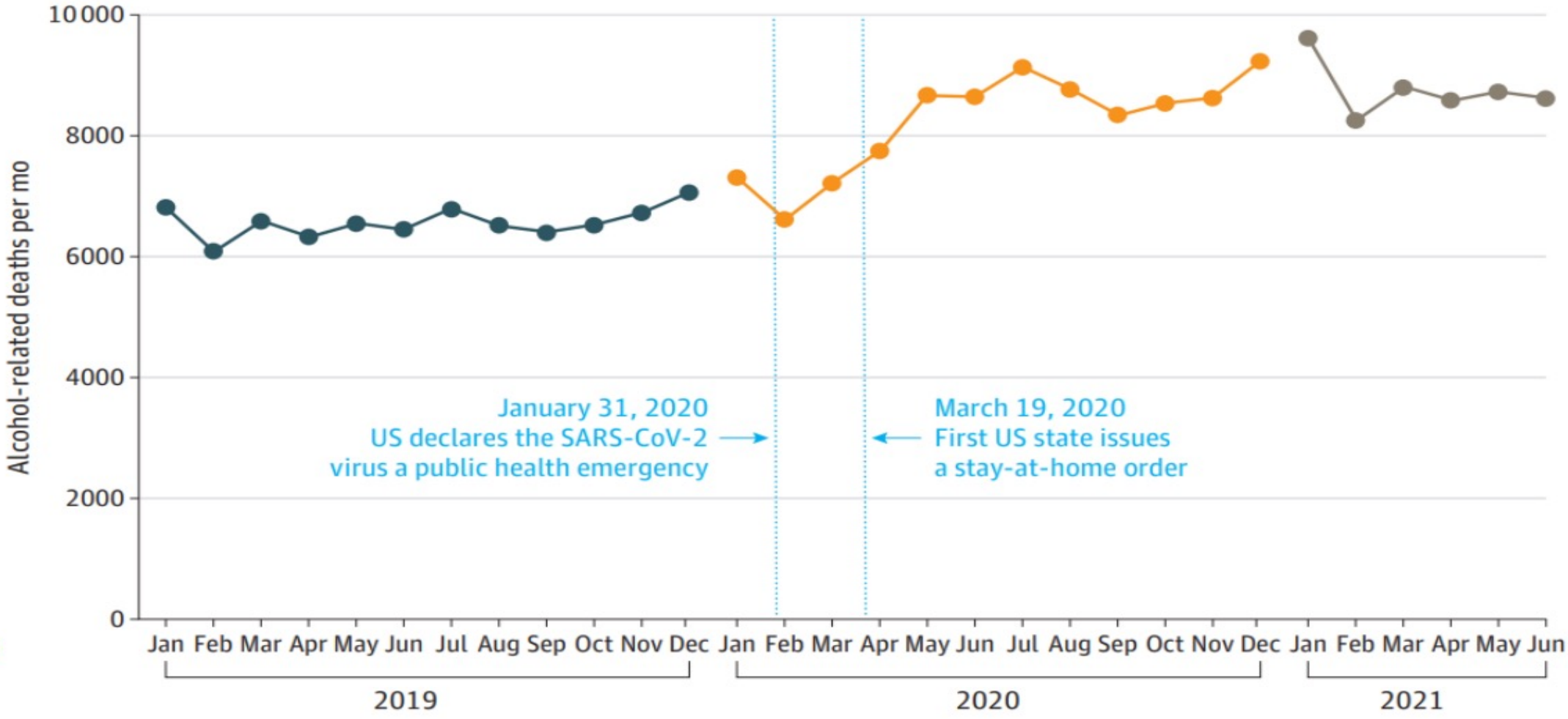
Substance Use and Mortality

ALCOHOL RELATED MORTALITY

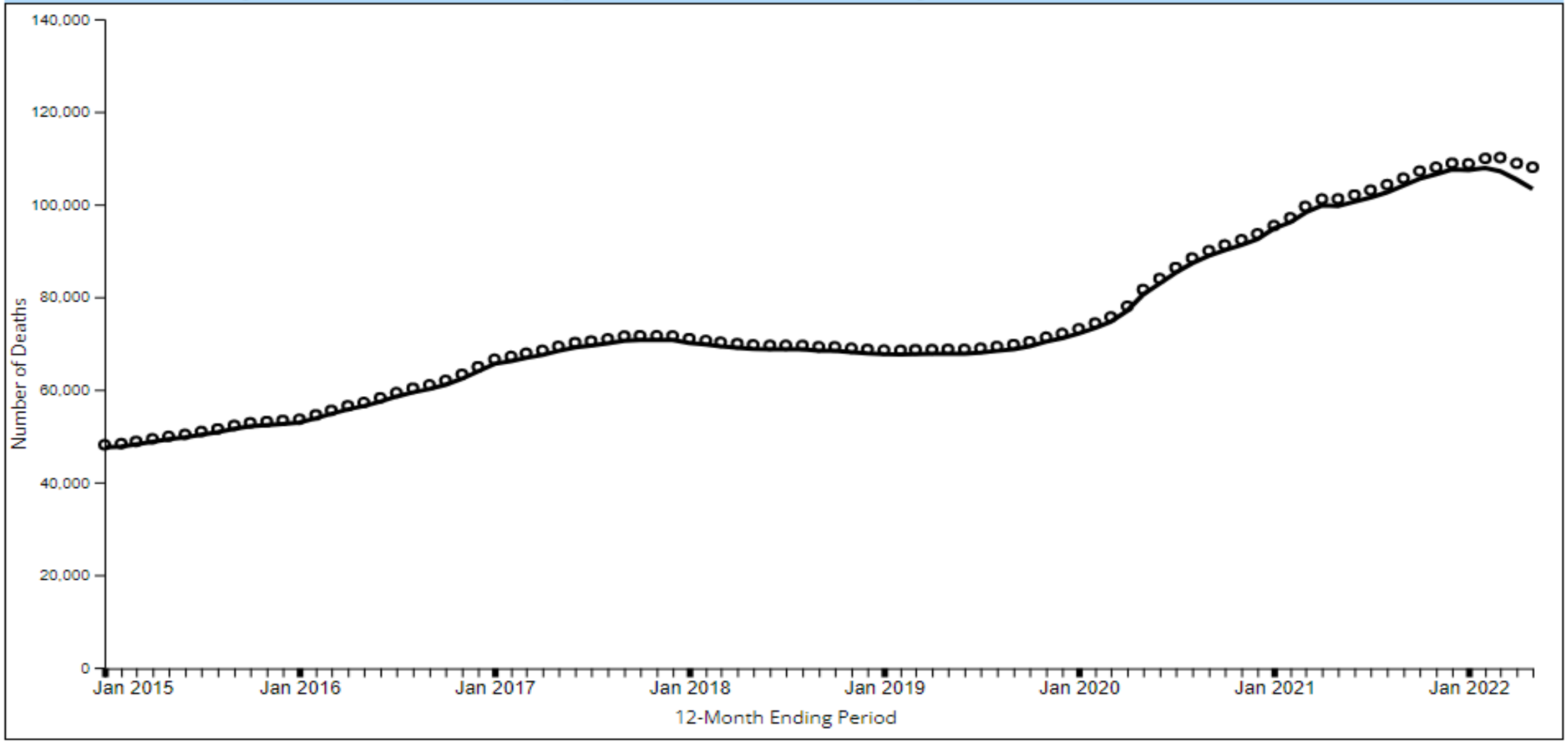
Alcohol-Related Deaths During the COVID-19 Pandemic

Figure. Monthly Alcohol-Related Deaths Among People 16 Years and Older

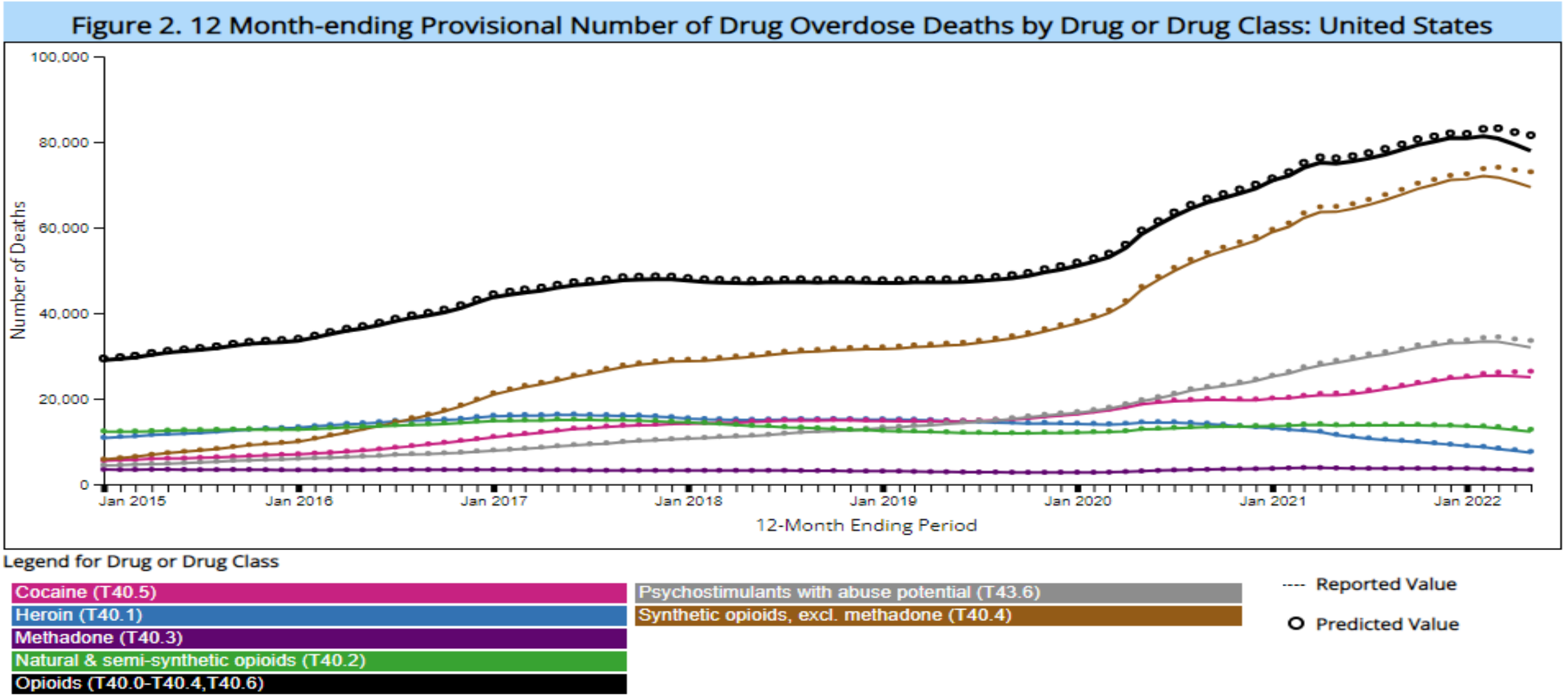


NATIONAL OVERDOSE TRENDS

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States

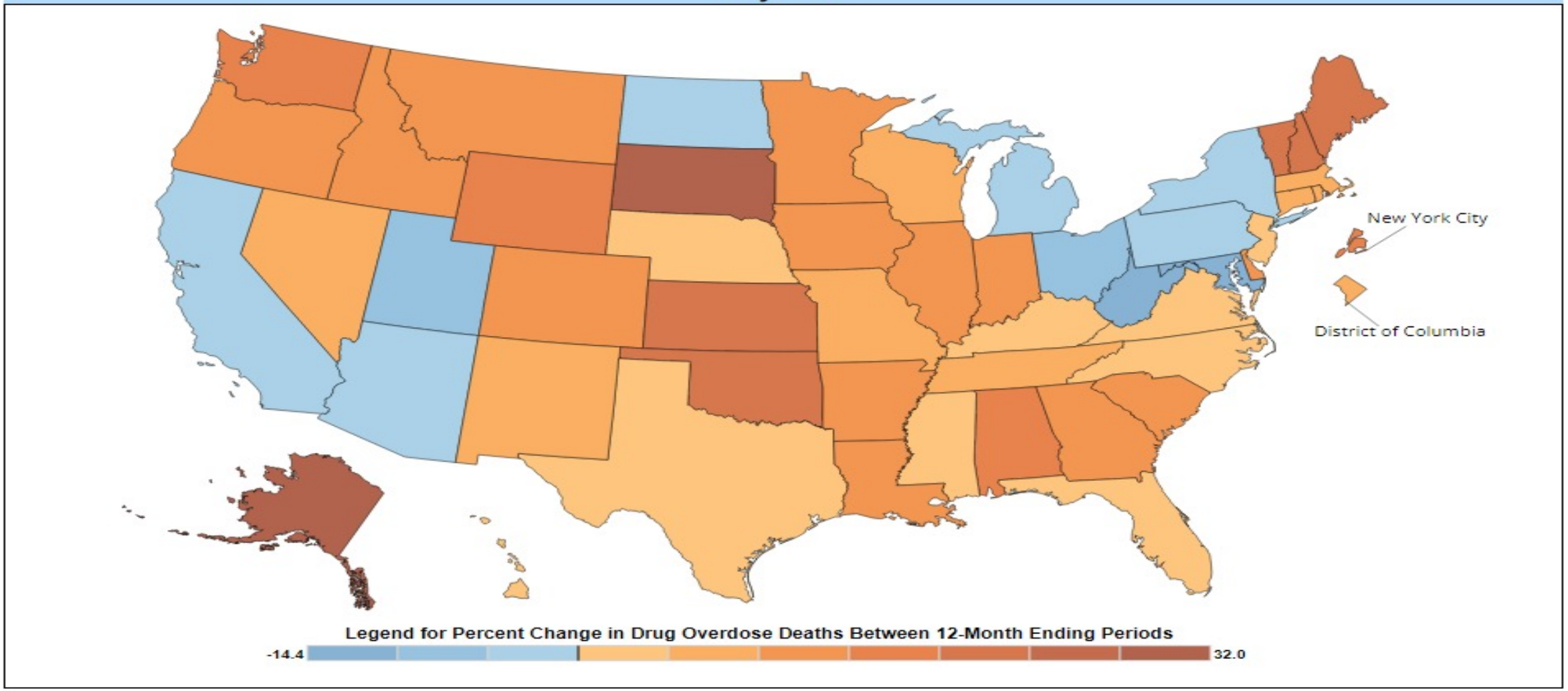


NATIONAL OVERDOSE TRENDS



NATIONAL OVERDOSE TRENDS

Figure 1b. Percent Change in Reported 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: May 2021 to May 2022



NATIONAL OVERDOSE TRENDS

	ALL DRUGS	HEROIN	NAT & SEMI – SYNTHETIC	METHADONE	SYNTHETIC OPIOIDS	COCAINE	OTHER PSYCHO-STIMULANTS (mainly meth)
3/2020*	75,702	14,136	12,342	2,828	**40,708**	**17,530**	**18,004**
3/2021*	99,567	12,733	14,061	3,893	**63,389**	**20,780**	**27,435**
4/2022*	108,174	7,954	13,035	3,450	**72,935**	**26,048**	**33,638**
Percent Change 3/20-4/22	**42.9%**	**43.7%**	**5.6%**	**22.0%**	**79.2%**	**48.6%**	**86.8%**

*NCHS Provisional drug-involved overdose death counts are PREDICTED VALUES
https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

VETERAN DRUG OVERDOSE MORTALITY

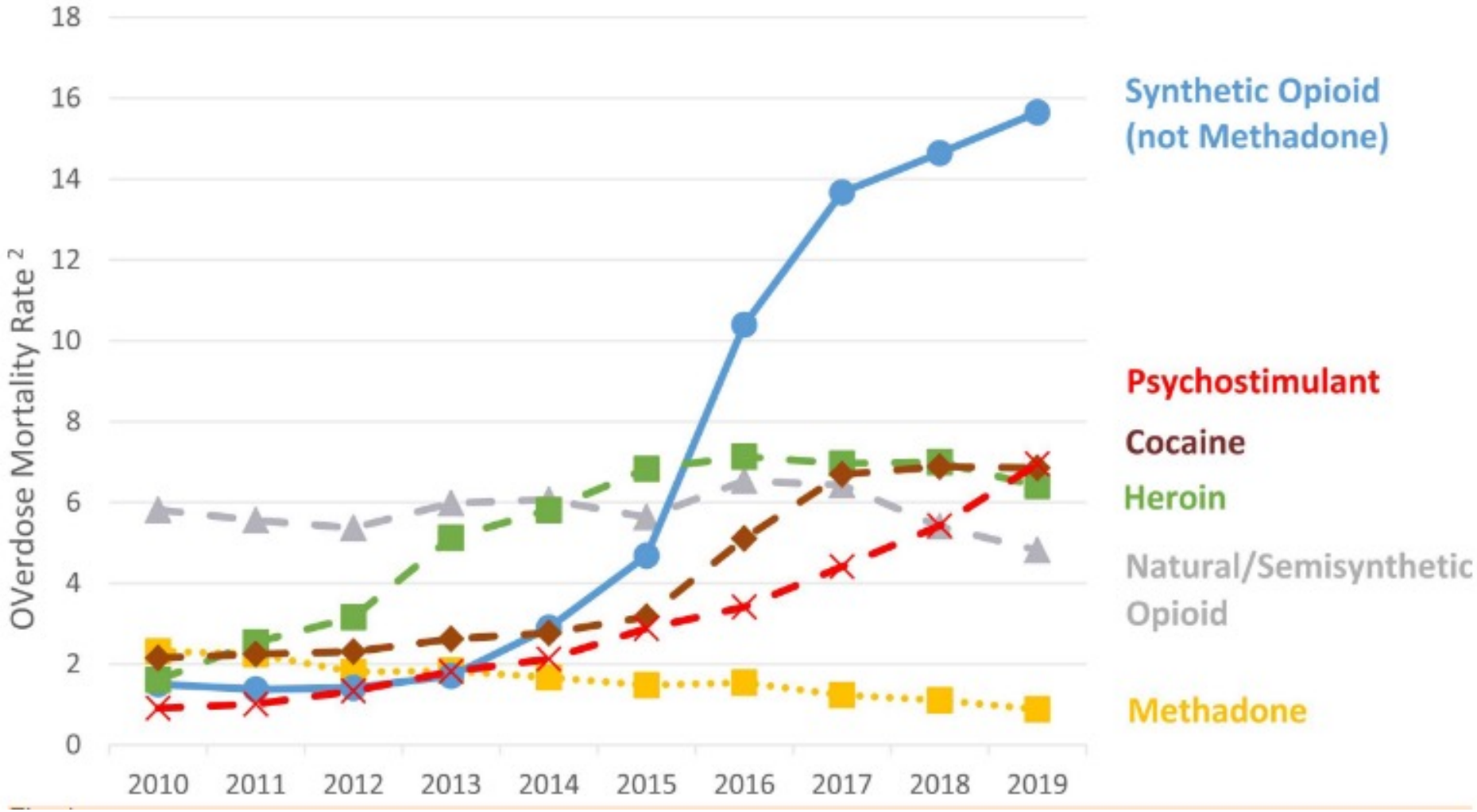
Age-adjusted rate of drug overdose mortality among Veterans increased by:

- 53% overall
- **93% for opioid overdoses**
- **333% for stimulant overdoses**
  - 219% for cocaine
  - 669% for psychostimulants

Table 1
Veteran Overdose Mortality Rates,[a] 2010–2019, Overall and by Drug Type[b].

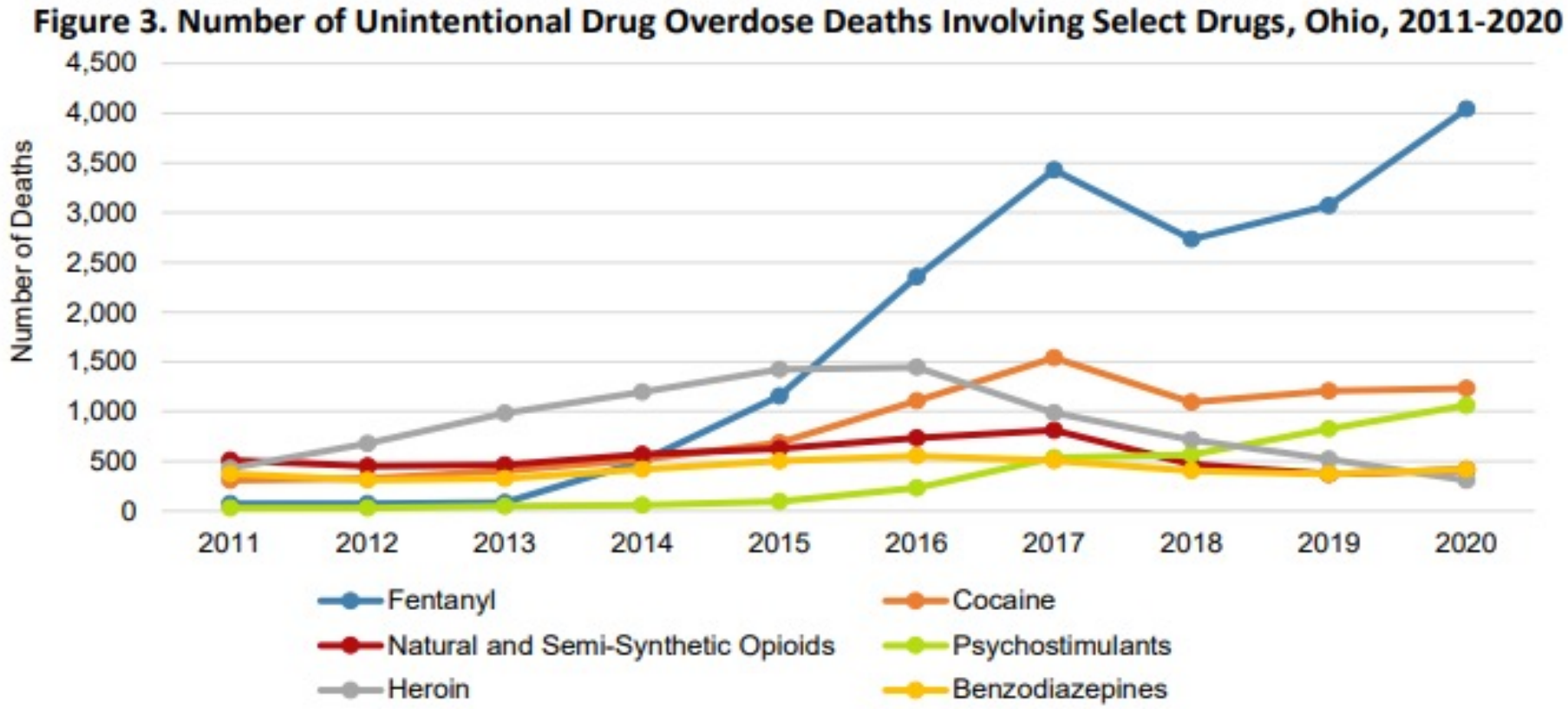
	All drug overdose			Opioid overdose			Stimulant overdose		
	2010 Rate	2019 Rate	Change from 2010 to 2019	2010 Rate	2019 Rate	Change from 2010 to 2019	2010 Rate	2019 Rate	Change from 2010 to 2019
All Veterans	19.8	30.3	53.2%*	11.1	21.5	93.4%*	3.0	12.9	333.4%*
Sex									
Female	17.9	18.0	0.4%	8.9	11.3	26.3%*	1.9	5.2	168.0%*
Male	20.3	32.8	61.2%*	11.7	23.6	102.5%*	3.1	14.3	361.1%*
Age group (years at death)									
18–24	16.8	16.0	-4.7%	12.1	12.2	1.0%	–[c]	5.7	–
25–34	22.3	38.7	73.4%*	13.8	31.4	127.9%*	2.7	13.7	402.4%*
35–44	21.3	41.8	96.2%*	11.7	29.9	156.6%*	3.2	17.9	454.0%*
45–54	32.2	31.1	-3.4%	17.0	21.0	23.3%*	5.9	14.6	148.8%*
55–64	20.9	41.0	96.7%*	10.2	25.3	147.8%*	4.3	20.5	374.4%*
65+	3.5	9.3	167.2%*	1.1	5.0	337.8%*	0.2	3.9	1490.2%*
Geographic region[d]									
Midwest	20.0	33.6	67.8%*	10.7	24.3	125.6%*	2.9	12.5	334.8%*
Northeast	22.4	52.8	136.1%*	11.9	43.9	267.9%*	3.6	20.8	483.5%*
South	17.7	24.9	40.6%*	10.1	17.7	74.9%*	2.5	10.8	336.3%*
West	22.5	27.3	21.5%*	13.0	15.4	17.7%	3.8	13.5	255.2%*
Race[e]									
American Indian, Alaskan Native	23.3	22.7	-2.6%	11.7	10.4	-10.5%	–	11.0	–
Asian, Hawaiian, or Pacific Islander	15.6	17.4	11.4%	7.8	9.6	22.7%	4.6	8.1	77.2%
Black	16.5	34.5	109.4%*	6.6	22.1	236.3%*	7.8	20.6	164.7%*
Multiple Races	17.2	69.5	304.1%*	7.9	48.0	510.1%*	–	34.6	–
White	15.6	21.5	37.4%*	8.3	14.2	70.2%*	1.9	8.7	358.2%*
Ethnicity[f]									
Hispanic	17.4	20.5	18.1%	10.0	13.1	31.2%*	3.6	9.4	165.3%*
Not Hispanic	15.4	24.0	55.4%*	7.9	15.7	99.6%*	2.5	10.8	322.3%*
Recent Use of VHA Services[g]									
Yes	37.0	41.7	12.8%*	21.0	29.7	41.2%*	5.3	18.0	242.3%*
No	15.6	25.7	65.1%*	8.7	18.3	108.9%*	2.4	10.7	356.0%*

VETERAN DRUG OVERDOSE MORTALITY BY SUBSTANCE



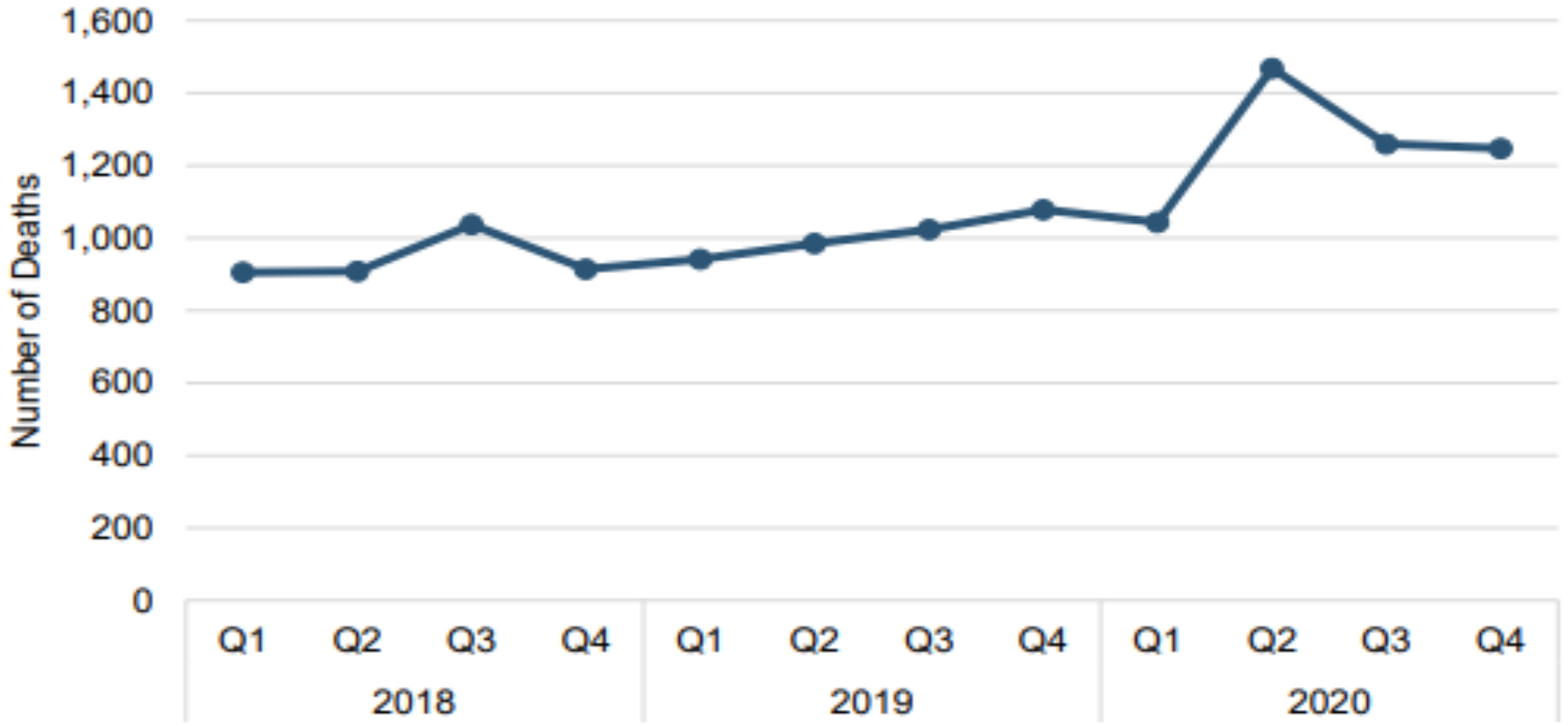
https://linkinghub.elsevier.com/retrieve/pii/S0376-8716(22)00033-3

OHIO DRUG OVERDOSE BY SUBSTANCE



Ohio Department of Health, Bureau of Vital Statistics, *2020 Ohio Drug Overdose Data: General Findings.*

Figure 2. Number of Unintentional Drug Overdose Deaths by Quarter, Ohio, 2018-2020



Ohio Department of Health, Bureau of Vital Statistics, *2020 Ohio Drug Overdose Data: General Findings.*

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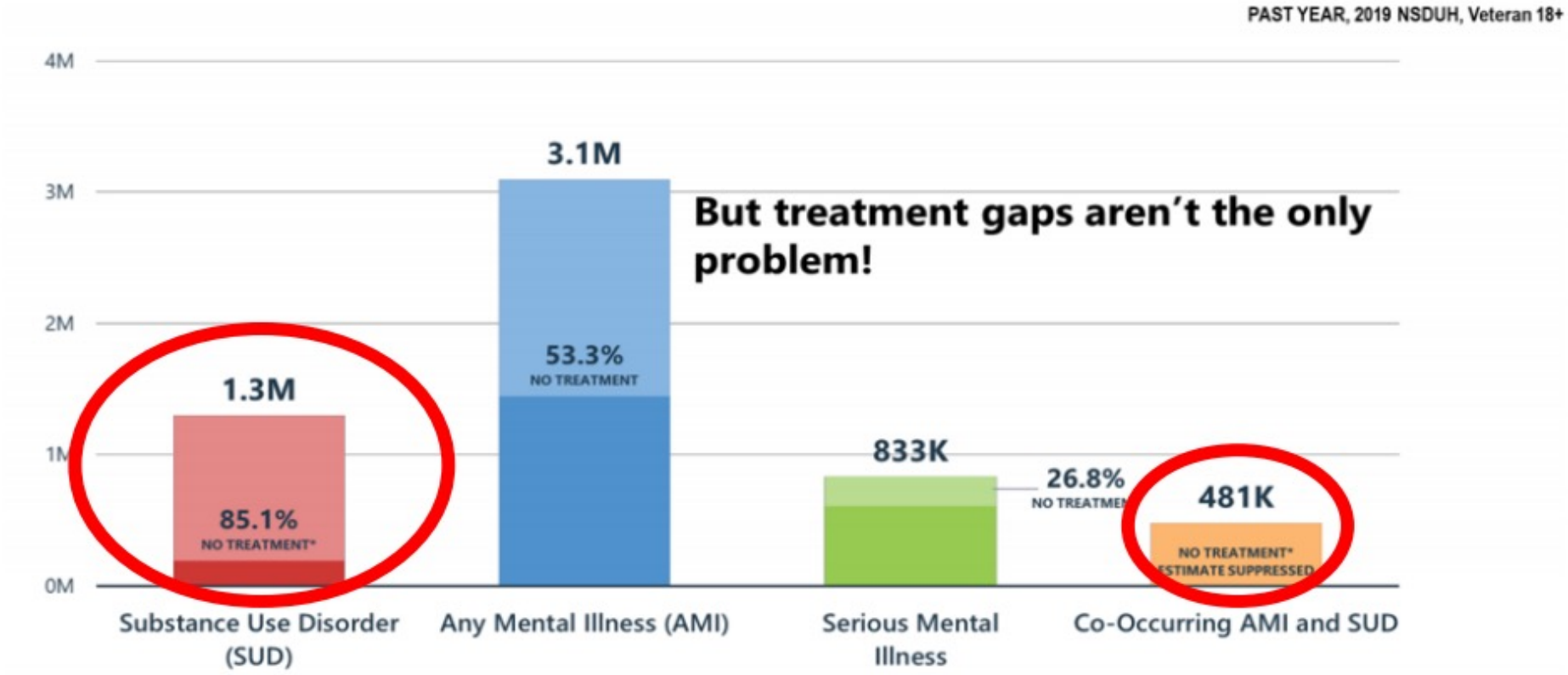
Treatment Engagement

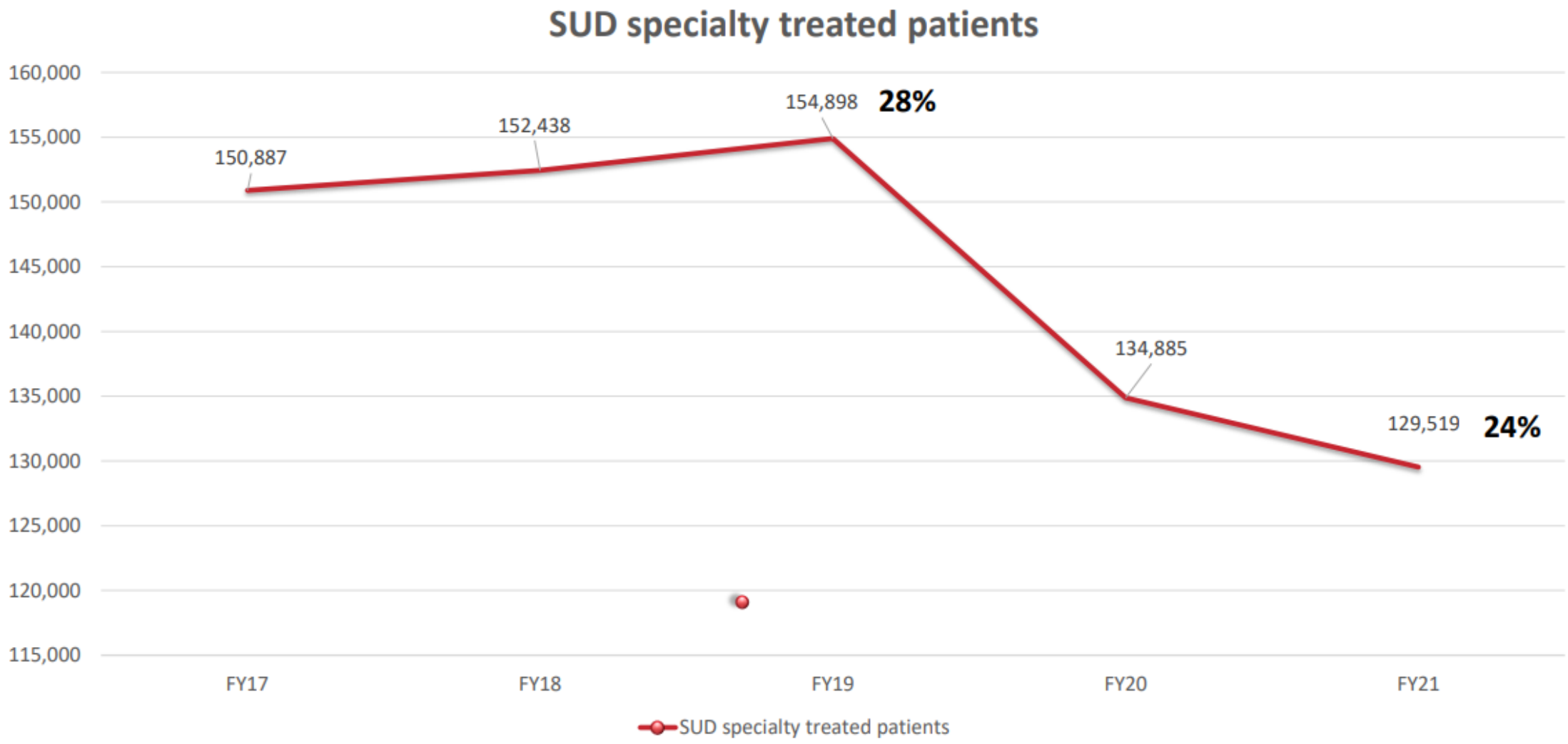
Mental and Substance Use Disorders Among Veterans: High Prevalence/Huge Treatment Gaps



* No Treatment for SUD is defined as not receiving treatment at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail.

SAMHSA
Substance Abuse and Mental Health Services Administration

VETERAN TREATMENT ENGAGEMENT



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VA Priorities in Addressing Substance Use Disorders

VA PRIORITIES

- Harm Reduction
  - Overdose Education and Naloxone Distribution
  - Fentanyl Test Strips
  - Sterile Syringe Program
- Stepped Care Model
- Evidence-Based Treatment
  - Opioid Pharmacotherapy
  - Alcohol Pharmacotherapy
  - Psychosocial/Psychotherapeutic Interventions

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Harm Reduction

OPIOID OVERDOSE EDUCATION AND NALOXONE DISTRIBUTION

- Risk mitigation initiative to prevent opioid-related overdose deaths.
  - Provide opportunities to discuss risk of opioids
  - No cost to at risk VHA patients (no copays for veterans)
- Overdose Education
  - Education patients and potential bystanders on how to prevent, recognize, and respond to overdose

- Target Populations
  - Opioid Use Disorder
  - Stimulant Use Disorder
  - Veterans prescribed opioids
  - Recent discontinuation of opioids
  - History of overdose

- Special Initiatives
  - VA Police
  - Homeless Outreach
  - Justice Outreach

STERILE SYRINGE PROGRAM

- Distribution of syringes/disposal/exchange
- Prevision of preventive/risk mitigation strategies
- Linkage to SUD care
- Reduction in infectious disease transmission

STERILE SYRINGE PROGRAM

☑ SSPs do:

- SSPs are associated with an estimated 50% reduction in HIV and HCV incidence
- When combined with medications that treat opioid dependence (also known as medication-assisted treatment), HCV and HIV transmission is reduced by over two-thirds
- SSPs serve as a bridge to other health services, including HCV/HIV testing and treatment and MAT for opioid use disorder
- SSPs prevent overdose deaths by teaching PWID how to prevent overdose and how to recognize, respond to, and reverse a drug overdose

☒ SSPs do not:

- Increase substance use. New users of SSPs are 5x more likely to enter drug treatment and 3x more likely to stop using drugs than those who don't use the programs.
- Increase syringe litter. SSPs protect first responders and the public by providing safe needle disposal and reducing the presence of discarded needles in the community.
- Increase crime. Studies in Baltimore and New York City have also found no difference in crime rates between areas with and areas without SSPs.

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Evidence-Based Treatment: What Really Works?

TREATMENT OF ALCOHOL USE DISORDER

- Medication Approved in the United States to Treat Alcohol Use Disorder
  - Disulfiram (Antabuse): 1949
  - Naltrexone (ReVia): 1994
  - Acamprosate (Campral): 2004
  - Long-Acting Naltrexone (Vivitrol): 2006
- Medication with strong evidence in effectiveness with Alcohol Use Disorder
  - Topiramate (Topamax)

TREATMENT OF ALCOHOL USE DISORDER

- Stronger evidence
  - Naltrexone (Anton et. al., 2006; Jonas, et. al., 2014)
  - Topiramate (Blodgett, et. al., 2014; Batki, et.al., 2014)

- Weaker evidence
  - Disulfram
  - Acamprosate

TREATMENT OF ALCOHOL USE DISORDER

- Psychosocial/Psychotherapeutic Interventions
  - Behavioral Couples Therapy
  - Cognitive Behavioral Therapy
  - Community Reinforcement Approach
  - Motivational Enhancement Therapy
  - 12-step Facilitation

- Behavioral Couples Therapy (BCT)
  - Reduce alcohol use
  - Improve relational satisfaction
  - Delivers a series of behavioral assignments geared at:
    - Increasing positive feelings
    - Shared activities
    - Constructive communication

TREATMENT OF ALCOHOL USE DISORDER

- Cognitive Behavioral Therapy (CBT)
  - Modify thinking and behavior related to alcohol use
  - Change areas of life functionally related to alcohol use
  - Strengthen coping skills
  - Improve mood and interpersonal functioning
  - Enhance social support
  - Delivered in individual and/or group modalities

- Community Reinforcement Approach (CRA)
  - Focus on environmental contingencies that influence behavior
  - Utilize family, social, recreational, and occupational events to support behavior change
  - Learn new coping strategies
  - Involving significant others
  - May include incentives

- Motivational Enhancement Therapy (MET)
  - Heighten awareness of ambivalence about change
  - Promote commitment to change
  - Enhance self-efficacy
  - Incorporate significant other

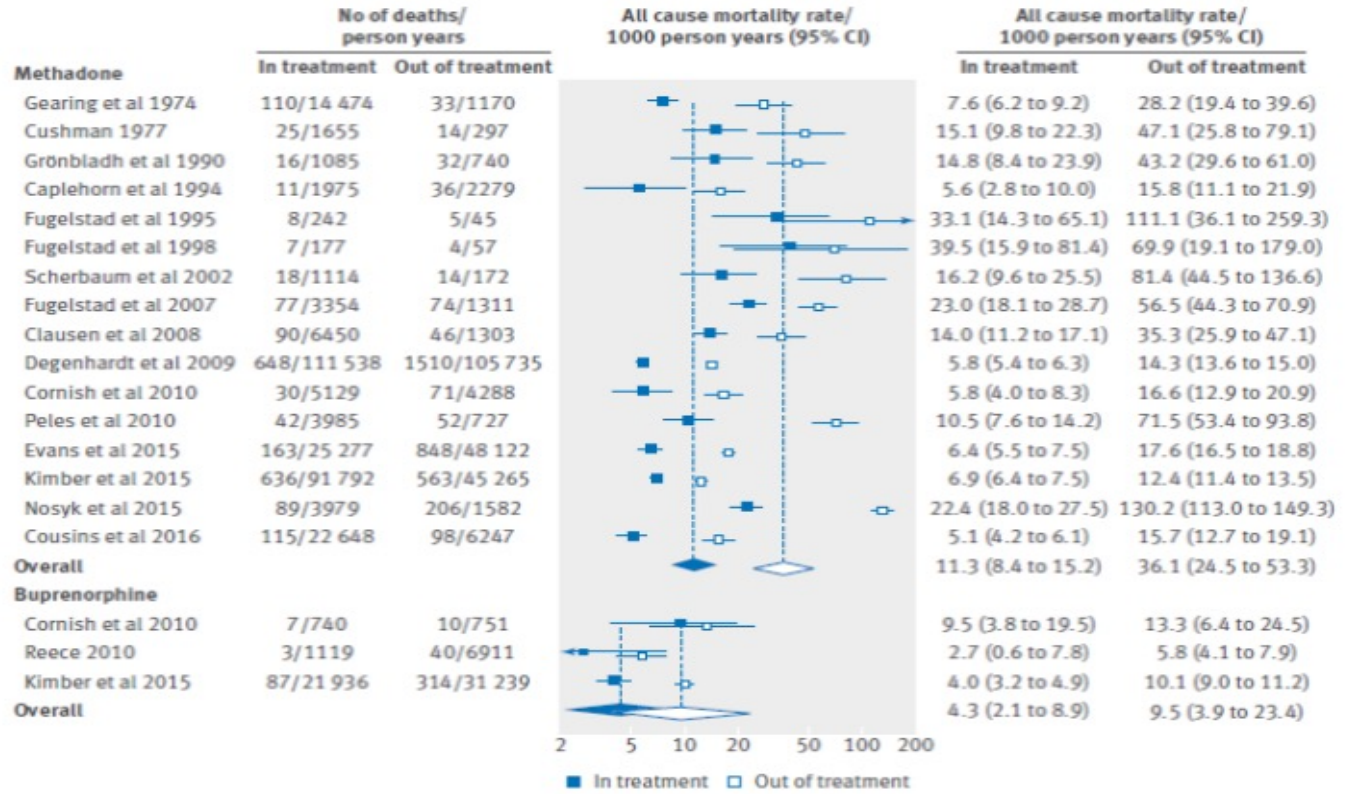
- 12-Step Facilitation (TSF)
  - Increase involvement with AA/other mutual help resources
  - Review of using behavior
  - Introduction of 12-step material
  - Plan for recovery/homework

- Effectiveness
  - All with modest effect size
  - All mostly comparable to one another in various outcomes
    - Decreasing amount of alcohol consumed/day
    - Decreasing number of days alcohol is consumed
    - Periods of abstinence
  - ***Only consistent variable that leads to positive outcomes consistently is length of stay in treatment.

- Medication
  - Methadone
  - Buprenorphine (Suboxone, Sublocade)
  - Naltrexone/Vivitrol

Medications for OUD Reduces Mortality for Those with OUD

- Retention in methadone and buprenorphine treatment is associated with reduced overdose and all-cause mortality



	No of deaths/ person years		All cause mortality rate/ 1000 person years (95% CI)	
	In treatment	Out of treatment	In treatment	Out of treatment
Methadone				
Gearing et al 1974	110/14 474	33/1170	7.6 (6.2 to 9.2)	28.2 (19.4 to 39.6)
Cushman 1977	25/1655	14/297	15.1 (9.8 to 22.3)	47.1 (25.8 to 79.1)
Grönbladh et al 1990	16/1085	32/740	14.8 (8.4 to 23.9)	43.2 (29.6 to 61.0)
Caplehorn et al 1994	11/1975	36/2279	5.6 (2.8 to 10.0)	15.8 (11.1 to 21.9)
Fugelstad et al 1995	8/242	5/45	33.1 (14.3 to 65.1)	111.1 (36.1 to 259.3)
Fugelstad et al 1998	7/177	4/57	39.5 (15.9 to 81.4)	69.9 (19.1 to 179.0)
Scherbaum et al 2002	18/1114	14/172	16.2 (9.6 to 25.5)	81.4 (44.5 to 136.6)
Fugelstad et al 2007	77/3354	74/1311	23.0 (18.1 to 28.7)	56.5 (44.3 to 70.9)
Clausen et al 2008	90/6450	46/1303	14.0 (11.2 to 17.1)	35.3 (25.9 to 47.1)
Degenhardt et al 2009	648/111 538	1510/105 735	5.8 (5.4 to 6.3)	14.3 (13.6 to 15.0)
Cornish et al 2010	30/5129	71/4288	5.8 (4.0 to 8.3)	16.6 (12.9 to 20.9)
Peles et al 2010	42/3985	52/727	10.5 (7.6 to 14.2)	71.5 (53.4 to 93.8)
Evans et al 2015	163/25 277	848/48 122	6.4 (5.5 to 7.5)	17.6 (16.5 to 18.8)
Kimber et al 2015	636/91 792	563/45 265	6.9 (6.4 to 7.5)	12.4 (11.4 to 13.5)
Nosyk et al 2015	89/3979	206/1582	22.4 (18.0 to 27.5)	130.2 (113.0 to 149.3)
Cousins et al 2016	115/22 648	98/6247	5.1 (4.2 to 6.1)	15.7 (12.7 to 19.1)
Overall			11.3 (8.4 to 15.2)	36.1 (24.5 to 53.3)
Buprenorphine				
Cornish et al 2010	7/740	10/751	9.5 (3.8 to 19.5)	13.3 (6.4 to 24.5)
Reece 2010	3/1119	40/6911	2.7 (0.6 to 7.8)	5.8 (4.1 to 7.9)
Kimber et al 2015	87/21 936	314/31 239	4.0 (3.2 to 4.9)	10.1 (9.0 to 11.2)
Overall			4.3 (2.1 to 8.9)	9.5 (3.9 to 23.4)

Fig 2 | All cause mortality rates in and out of opioid substitution treatment with methadone or buprenorphine and overall pooled all cause mortality rates, 1974-2016. Area of each square is proportional to study weight in meta-analysis. Horizontal lines represent exact 95% confidence intervals based on Poisson distribution. Diamonds represent pooled all cause mortality rates during periods in and out of treatment across all methadone or buprenorphine cohorts estimated from bivariate random effects meta-analysis on log transformed rates in both treatment periods

2017-Sordo et al.-BMJ Open

- Psychosocial/Psychotherapeutic Interventions
  - None are effective as a standalone or as an adjunct to Medication Assisted Treatment
  - Possible effect on other substance use alongside opioids

TREATMENT OF STIMULANT USE DISORDER

- Medication

TREATMENT OF STIMULANT USE DISORDER

- Psychosocial/Psychotherapeutic Interventions
  - CBT
  - CRA
  - Contingency Management (CM)

- Contingency Management
  - Individual Protocol focus on a target behavior (e.g.-abstinence)
  - Measure the target behavior objectively and frequently (e.g.-urine drug testing)
  - Provide immediate, tangible, desirable reinforcement for consistent behavior
  - Withhold reinforcement when the target behavior occurs
  - Escalate the size of the reinforcement for consistent behavior

- CM Protocol
  - Patients earn prizes of varying magnitude based on draws from “fishbowl”
  - The fishbowl contains 500 prize slips
    - 250 “Good Job!”
    - 209 “Small” =$1
    - 40 “Large” = $20
    - 1 “Jumbo” = $100
  - Draws start at 1 and escalate, capped at 8
  - When abstinence not verified, no draws earned and reset back 1.

- CM effectiveness
  - Mean effect size between .42 and .58 (CBT is between .20-.30 (Dutra, et. al., 2008))
  - Maintains internal motivation past 12 weeks
  - 22% greater likelihood of abstinence 24 week post-treatment
  - Effects maintained as long as 1 year

TREATMENT OF CANNABIS USE DISORDER

- Medication

TREATMENT OF CANNABIS USE DISORDERS

- Psychosocial/Psychotherapeutic Intervention
  - Weak Evidence for:
    - CBT
    - MET

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Addiction Care in VA in Ohio

STEPPED CARE MODEL

- “Any time, any place.”
- “No wrong door.”
- Primary Care/ED access
- Outreach

CONTINUUM OF CARE

- Non-intensive Outpatient
  - All VA sites including Vet Centers
- Intensive Outpatient
  - All VA Medical Centers
  - Some Community-based Outpatient Clinics
  - Day/Evening
  - In-person/Virtual

RESIDENTIAL TREATMENT

- Cleveland
  - National Women's Treatment Program (1 of 2 nationwide)
  - Only Gambling Treatment Program
- Chillicothe
- Dayton
- Cincinnati (Ft. Thomas, KY)