



Report of (VA) Consensus Conference: Practice Recommendations for Treatment of Veterans with Comorbid Substance Abuse and PTSD



Executive Summary:

Twenty-two invited participants from the Department of Veterans Affairs (VA) met as a consensus panel in Washington, D.C. on October 22 and 23, 2009. The goal of the Panel was to develop collegial recommendations on how substance use disorder specialists (SUD/PTSD Specialists) who are augmenting VA posttraumatic stress disorder (PTSD) teams and services might be most effective in their clinical practice. Panel members were PTSD clinic directors, experts in general mental health, substance use clinic directors, researchers, and representatives from the National Center for PTSD, the VISN 6 MIRECC and VA Central Office. The conference consisted of a round-table discussion to review published research and expert knowledge of the panel related to intake, screening/early recognition and clinical assessment, treatment planning, and treatment for Veterans with co-occurring SUD and PTSD. The primary sponsor of the conference was the Office of Mental Health Services (OMHS), Department of Veterans Affairs. The deliberations of the panel led to a series of clinical practice recommendations for SUD/PTSD Specialists and others working with this patient population. These recommendations may be summarized:

- The SUD/PTSD Specialist is urged to facilitate systematic and comprehensive assessment and diagnosis of posttraumatic stress disorder and substance use disorders in both SUD and PTSD settings. Diagnostic assessments would be expected to include: clinical interview, formal psychometric instruments identified in the Clinical Practice Guidelines and biochemical measures (e.g., urine screen).
- It is desirable that the SUD/PTSD Specialist consults with, or when appropriate, personally serves as the Principal Mental Health Provider to create an integrated, concurrent treatment plan that addresses motivationally staged, coordinated interventions for SUD and PTSD.
- Until future research evidence might suggest otherwise, the current VA/DoD clinical practice guidelines for PTSD and SUD are appropriate in treating patients who simultaneously meet the diagnostic criteria for these disorders. Nevertheless, since the current VA/DoD clinical practice guidelines for PTSD and SUD were not developed to address the comorbidity, clinical judgment will continue to be needed in deciding which specific treatments to implement, for which patients, and under which treatment conditions.
- In general, treatments for patients with both PTSD and SUD can be effectively delivered concurrently.
- The SUD/PTSD Specialist is urged to employ effective first-stage treatment strategies, such as use of motivational interviewing principles and Seeking Safety (which was

developed specifically for treatment of co-occurring SUD and PTSD and has been shown to be well received by clients).

- Systematic treatment response monitoring (e.g., Brief Addiction Monitor [BAM], PTSD Checklist [PCL]) is essential to continuously obtaining evaluation on the effectiveness of recommended treatments for patients with co-occurring PTSD and SUD.
- The SUD/PTSD Specialist can be an important champion for integrated PTSD/tobacco cessation treatment delivered by the PTSD clinician.

Background:

Approximately one-third of Veterans seeking treatment for substance use disorders also meet criteria for PTSD. In FY 2008, almost 22% of VA patients diagnosed with PTSD also received a SUD diagnosis with rates of 70% seen in patients hospitalized for PTSD. As the conflicts in Afghanistan and Iraq have continued, increasing numbers of Veterans are presenting to VA clinicians with co-occurring diagnoses of substance use disorder and PTSD. Patients diagnosed with both disorders tend to have poorer long-term prognoses for each condition than do those who have one diagnosis without the other.

The overall high rates of co-occurrence between SUD and other mental health conditions, including PTSD, have resulted in specific recommendations for the provision of services to best meet the needs of these individuals. In 2007 the National Quality Forum (NQF) endorsed eleven new consensus standards for the treatment of substance use disorders. Among them is the recommendation that programs offer ongoing, long-term coordinated care for both substance use and any co-occurring conditions. Additionally, the 2008 VHA Handbook on Uniform Mental Health Services requires that VA Medical Centers and Clinics provide coordinated and where possible, concurrent treatment of SUD and other co-occurring conditions, and specifically requires that PTSD programs have the ability to address the needs of Veterans with co-occurring PTSD and SUD.

In light of the high rates of co-occurrence for PTSD and SUD, the impact of the co-occurrence in the response of patients to treatment services, and the new standards of care endorsed by the NQF and the Handbook on Uniform Mental Health Services, an Executive Decision memorandum issued in 2008 established and funded a substance use disorder specialist (SUD/PTSD Specialist) to augment facilities' PTSD treatment teams or services. At the time of the consensus panel meeting approximately 85% of the anticipated 147 SUD/PTSD Specialists had been hired to work directly with PTSD treatment programs at their VAMCs.

In May 2009, the Office of Mental Health Services provided general guidance on the scope of services for the position and emphasized the SUD/PTSD Specialist role to coordinate treatment planning and delivery of SUD services that best meets the needs of patients diagnosed with co-occurring PTSD and SUD. However, preliminary research evidence is limited for both the psychological and pharmacological interventions for co-occurring PTSD and SUD. The National Center for PTSD worked with Drs. John Allen and Daniel Kivlahan to develop a workgroup to clarify to the extent possible clinical guidance for the newly hired SUD/PTSD Specialists.

A conference planning committee was organized in July 2009 by Drs. Matthew Friedman, Larry Lehmann, John Allen, Daniel Kivlahan, and Nancy Bernardy. (For a list of planning committee members, consensus participants and their discipline, see Appendix A.) Prior to the conference, the planning committee also worked with Dr. Allen's Acting Deputy, Dr. Jennifer Burden, to develop a needs assessment questionnaire of provider-perceived challenges and questions. Themes that emerged from the field included: how to sequence care, how to provide integrative services, what to offer for prevention, what evidence-based treatments are recommended, how to optimally coordinate care, and how to support system change. The results of the needs questionnaire helped shape the key questions discussed during the consensus conference.

Prior to the conference Dr. Burden also identified and summarized the existing relevant research literature for conference participants (available to VHA staff under "Clinical Resources" on the Sharepoint site at:

<http://vaww.national.cmop.va.gov/MentalHealth/SUD%20PTSD%20files/Forms/AllItems.aspx>). Her literature search for articles from 1980 to April 2009 using existing databases including PubMed and PsycINFO, focused on prevalence, assessment and treatment of co-occurring SUD and PTSD in review papers, integrated treatment models, pharmacological treatments, clinical considerations, and functional relationships between SUD and PTSD. Forty-one articles met inclusion criteria and an additional eleven studies were included under additional notes (See Appendix B for Dr. Burden's summary of key findings.) This summary was not meant to reflect an exhaustive review of the literature, but rather to provide summary information to support discussion during the conference.

Dr. John Allen opened the conference by providing an overview of the role of the SUD/PTSD Specialists and stating that the goal of the conference was to provide a series of practice recommendations for these clinicians. Secondary goals of the conference were to explore ways of disseminating the recommendations of the consensus panel to the practice community, identify the research gaps, and plan for a follow-up meeting in the next year.

Dr. Larry Lehmann reviewed the strong support from VA Central Office for the treatment of SUD/PTSD, an identified priority, and the implications of the conference. He noted that in addition to addressing the combination of SUD/PTSD, the panel needed to acknowledge other co-occurring disorders such as traumatic brain injury, suicide risk, and depression that all contribute to the complexity of patients receiving services. He also highlighted the significant number of returning Veterans who need tobacco cessation treatment.

The VA/DoD Clinical Practice Guidelines for substance use disorders and for post-traumatic stress disorder (www.healthquality.va.gov) were reviewed by Dr. Daniel Kivlahan and Dr. Matthew Friedman, respectively. Dr. Kivlahan described the algorithmic approach of the guidelines and the pharmacotherapy and psychosocial interventions available for substance use disorders. Dr. Friedman reviewed PTSD guidelines and remarked on the recent consensus conference findings on PTSD/mild Traumatic Brain Injury (mTBI)/Pain, acknowledging that necessary research findings are approximately 3-5 years away but for now the recommendation is to follow the current separate clinical practice guidelines for each condition. He also added that systems problems were identified during that conference and noted the need to find programs that are doing well in order to share their models. During Dr. Friedman's presentation,

preliminary data on the use of the recommended evidence-based PTSD cognitive behavioral treatments (CBT) in individuals with co-occurring PTSD/SUD were presented.

The panel approached its tasks from a predefined agenda of questions (See Appendix C) in a roundtable format: What are the best approaches to enhance early recognition of problems in Veterans presenting for treatment for PTSD/SUD? What are the challenges of treatment planning with a Veteran with co-occurring PTSD and SUD? What do the separate clinical practice guidelines tell us about the most effective PTSD and SUD treatment strategies? The first day, moderated by Dr. Jessica Hamblen of the NCPTSD, was spent delineating what was known and importantly what was not known about clinical assessment, interdisciplinary treatment planning, and treatment of the comorbidity. At the end of the day, the conference planning committee met to synthesize all of the input from the consensus panel participants to present to the group the following morning.

There were few conflicting recommendations among the group. Regarding intake, screening, and assessment, the consensus panel agreed that it would be most appropriate that the SUD/PTSD Specialist facilitate systematic and comprehensive assessment and diagnosis of PTSD and SUD in SUD and PTSD specialty clinic settings. The diagnostic assessment would include a thorough clinical interview, use of instruments mentioned in the Clinical Practice Guidelines, and laboratory tests (e.g., urine screens). The panel concluded that it is not the direct and inherent responsibility of the SUD/PTSD Specialist to perform all intakes but rather to consult with other staff members on how to do these in a comprehensive manner. The existing VA tools to assess Veterans for PTSD and SUD (the PCL and BAM) would be included in the assessment to allow for a comprehensive determination of comorbidity.

In the area of treatment planning, the panel recommended that the SUD/PTSD Specialist consult with or, when appropriate, serve as the Principal Mental Health Provider as specified in the Uniform Mental Health Services Handbook to formulate an integrated, concurrent treatment plan that addresses motivationally staged and coordinated interventions for PTSD and SUD. As noted previously, the panel concluded that it is not the expectation that the SUD/PTSD Specialist serve as the Principal Mental Health Provider for every Veteran with co-occurring SUD and PTSD nor would this determination be based solely on the level of complexity or severity of the concerns presented by the Veteran. Several factors can be considered in determining whether the SUD/PTSD Specialist would serve as the Principal Mental Health Provider. One primary consideration would be the extent of the Specialist's role in providing direct clinical care to the Veteran. The Specialist would, as clinically indicated, systematically monitor treatment response by using the PCL and the BAM for patients on their caseload and facilitate use of these measures for monitoring by training other providers. Additionally, it is recommended the SUD/PTSD Specialist serve as a functional member of both the PTSD team and of the appropriate SUD treatment teams (selectively at facilities with multiple SUD teams) to facilitate coordination of services.

The consensus panel recommended that pending adequate randomized trials of interventions for this clinical population the most appropriate clinical guidance is captured by the current VA-DOD clinical practice guidelines for SUD and PTSD. It was also recommended that the SUD/PTSD Specialist employ effective clinical approaches, such as motivational interviewing techniques and Seeking Safety. One challenge that practitioners face is understanding the complementary recommendations in the two guidelines. The panel also noted concerns raised in

the literature about the vulnerability of patients with co-occurring PTSD and SUD who are more clinically complex than those with either disorder alone. It would be useful to develop a brief clinical decision support tool that brings together the two guidelines in a way that clinicians can use efficiently. Clinical research will need to identify what modifications, if any, need to be made to the current evidence-based treatment recommendations for each condition. At this time, systematic treatment monitoring using the PCL and the BAM can help to provide individualized information about the effectiveness of treatments for each Veteran.

The recommendations of the consensus panel with regard to clinical intake, screening and assessment, treatment planning, and treatment of the comorbidity of PTSD and SUD are presented in more detail below:

1. Intake, Screening and Assessment Issues

Dr. Kivlahan provided an overview of the current approaches to screening for PTSD and SUD that are performed throughout the system, depending on where a patient presents for care. The 3-item Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) screen is used to identify alcohol misuse that poses risks of negative health consequences. The 4-item PC-PTSD screen for PTSD is also administered annually through a clinical reminder and currently OEF/OIF Veterans with a primary diagnosis of PTSD are receiving more frequent monitoring through the PCL. More thorough assessment typically occurs in specialty clinics and provides data that inform possible needs for additional services. At this time in SUD specialty care, it is unlikely that PTSD would be systematically assessed with a Clinician Assessment of PTSD (CAPS) or other structured interview; however clinical diagnoses are expected as part of a comprehensive biopsychosocial assessment. The panel recommended that the role of the SUD/PTSD Specialist be to facilitate systematic assessment across settings, including education or supervision for other providers if needed. It may also be necessary to offer training for the Specialists themselves since not all of the SUD/PTSD Specialists that have been hired have the necessary backgrounds to support training other providers.

Several educational issues were raised related to assessment and ongoing monitoring of co-occurring PTSD and SUD. The consensus panel stressed the need for education targeted to providers to clarify the appropriate use and clinical interpretation of the PCL and the BAM. This may be particularly needed in rural CBOCs and in the primary care settings where initial screening often occurs. It is also important to disseminate clinical practice recommendations to the clinicians and the PCT teams. This effort can be coordinated with the PTSD Mentoring Program and the VISN SUD Representatives. SUD/PTSD Specialists can help educate providers about the VA screening process and the appropriate follow-up for those who screen positive. Training would cover the informed consent process and use of a breathalyzer and urine toxicology screens. It is important that the VISN Mental Health Liaisons, VISN SUD Representatives and facility leadership be fully informed about the nature of the SUD/PTSD Specialist positions and workload documentation (e.g., appropriate stop codes) associated with their services.

The consensus panel recognized the need for systematic and ongoing patient/family education from screening through diagnosis through treatment that includes information on the comorbidity of PTSD and SUD with a focus on recovery. Pamphlets that provide information for Veterans

and their family members about the co-occurring disorders and options for their treatment would be a valuable educational tool.

2. Treatment Planning

The panel thought that it was important to emphasize that a master treatment plan is required by the Handbook with patient and, if possible, family involvement and coordination between SUD and PTSD staff. The development of a CPRS treatment plan model vetted by providers that is flexible enough to address characteristics for different treatments would be most helpful. The panel agreed that the Handbook requirement for a Principal Mental Health Provider provides an opportunity for the care of Veterans with co-occurring SUD and PTSD to be overseen and coordinated allowing for review of diagnoses and assessment of readiness for treatment.

One observed systems issue is the difficulty that some Specialists encounter in trying to coordinate treatment services between PTSD and SUD providers. Practitioners spoke of the time required to meet with other departments to plan coordinated care. They also emphasized that because they often do not receive clinical workload credit for such time spent as consultants, there are disincentives to consult and promote collaborative care. The recommendation was made that the SUD/PTSD Specialist serve as a functional member of both SUD and PTSD teams, attend both team meetings, and serve as a “bridge” between the two specialty clinics to ensure that patients remain “connected” to both treatment teams. There also may be a need for culture change in some departments. For example, some treatment providers still require patients to be abstinent before initiating treatment rather than considering each patient’s specific needs and capacities.

It was also recommended that “potential best practice models” specific to the role of the SUD/PTSD specialist be identified and shared with the field. Core elements that are contributing to clinical success and that share a recovery focus could be identified and maintained. It is noted that potential best practice models can be found not just in the more complex facility settings; different practice models may work best in different clinical settings. Smaller VA Medical Centers and Community Based Outpatient Clinics can be encouraged to share their models of care as “Potential Best Practices” with VHA administration and other facilities. This has not yet been done and is an immediate, easily accomplished priority that can be shared through the SUD/PTSD Specialist conference calls, through the VISN MH Lead calls, the VISN SUD lead calls and through SharePoint sites.

Finally, it was recommended that the SUD/PTSD Specialist systematically monitor treatment response using the PCL and the BAM for patients on their caseload, as clinically indicated, and that they facilitate use of those instruments by other providers. It is not the responsibility of the Specialists to monitor all cases, but the Specialists can advocate and promote this practice among other providers. Again, some responsibility for training staff may be appropriate for the Specialist and the Specialist can be an advocate for more measurement-based care.

3. Treatment

The consensus panel stressed that the SUD/PTSD specialist use effective engagement strategies, such as motivational interviewing style, assessment of readiness characteristics and employment of first-stage stabilization therapies such as Seeking Safety. It was recognized that Seeking

Safety is often employed as a cognitive-behavioral, relapse prevention group model and that it provides a framework for treating the two disorders together. Clinicians like it, are familiar with it, and believe that it fits the culture. It is a widely-implemented approach that has been used with complex PTSD/SUD patients across settings. However, as discussed below, Seeking Safety is not currently recommended by either the VA/DoD PTSD or SUD clinical practice guidelines. Seeking Safety appears as effective as women's health education and relapse prevention for reducing symptoms of PTSD, but these have not been established independently as evidence based treatments for PTSD. Randomized controlled trials comparing Seeking Safety to the two guideline recommended CBT treatments for PTSD (PE and CPT) have yet to be conducted. Thus, it was agreed that while it is sufficient for some patients as a way to promote reductions in symptoms and remission from both disorders, for other patients Seeking Safety is best used as a targeted first-stage therapy in advance of other interventions for PTSD (such as PE and CPT) and SUD (e.g., addiction focused pharmacotherapy and/or guideline recommended psychosocial interventions). The panel also noted that as yet there are no empirical studies exploring the topic of sequencing of treatments for PTSD/SUD patients, and, therefore, the question of which treatments are needed and in what order requires clinical judgment and careful monitoring of treatment response. The consensus panel noted that Seeking Safety can be an important option among a menu of treatment services for patients not ready or not appropriate to engage in an evidence-based treatment for PTSD. The panel recognized that there are a variety of other psychosocial treatment models to be considered that were developed specifically for PTSD/SUD comorbidity and that have been the subject of at least one pilot study, including Concurrent Treatment of PTSD and Cocaine Dependence (Brady et al.), Transcend (Donovan et al.), and CBT for PTSD in Addiction Programs (McGovern et al.). Some treatment models were not originally designed for PTSD/SUD but have been studied in this population (e.g., Acceptance and Commitment Therapy). Such models may hold promise in VA treatment of PTSD/SUD and future rigorous research on them is encouraged to evaluate this potential.

The consensus panel deliberated about whether or not treatment of SUD best precedes that of PTSD in patients who have both conditions. The review of the limited available research does not suggest the necessity of fully stabilizing SUD in patients before they receive any services for PTSD. The literature does not support such routine sequencing rather expert consensus supports services for both disorders simultaneously and in a coordinated manner with careful clinical monitoring. For some patients, acute stabilization of severe substance dependence (e.g., withdrawal management; risk of danger to self or others) may be indicated before more active PTSD intervention can be initiated, with the rationale for this strategy carefully discussed with the patient.

The consensus panel agreed that active and direct discussion between providers is essential, recognizing that review of the medical record is not sufficient for communicating with colleagues on complex co-occurring cases. The consensus panel added that it is important to provide Veteran-centered care that prioritizes and incorporates the patient's readiness for treatment, motivation, goals and preferences and that includes family members as much as possible in the process. There was consensus that the use of a motivational interviewing style with this cohort may be helpful in engaging these patients and clarifying their treatment goals.

The current VA/DoD clinical practice guidelines (www.healthquality.va.gov) for SUD and PTSD offer general assessment and treatment guidance. There was consensus that the current

VA/DoD clinical practice guidelines for PTSD and SUD can be followed until new research suggests other approaches or demonstrates that current clinical practice guidelines are ineffective or inappropriate for this complex population.

The clinical practice guidelines for PTSD approved in 2004 are currently under revision but recommended as first line treatments, cognitive-behavioral therapy including cognitive processing therapy, prolonged exposure, and eye movement desensitization and reprocessing. In a randomized controlled trial of cognitive processing therapy and prolonged exposure conducted in civilian women, substantial and clinically significant treatment gains were achieved in both treatments and maintained at the end of a five-year follow-up (Resick, Nishith et al. 2002). Outcome data from the PTSD treatment program in Cincinnati and from Dr. Edna Foa's clinic in Philadelphia provide preliminary support for the clinical feasibility and acceptability of delivering exposure-based PTSD treatments. These pilot data indicate that some Veterans with PTSD and concurrent SUD can benefit as much from either prolonged exposure or cognitive processing therapy as do Veterans having PTSD alone. In summary, there was agreement that Veterans who experience SUD, along with PTSD, can be afforded the opportunity for informed consideration to receive the two best evidence-based treatments in the VA/DoD practice guidelines for PTSD, prolonged exposure therapy or cognitive processing therapy.

The new VA/DoD clinical practice guidelines for management of SUD are formatted as five algorithms to delineate the critical decision points and provide clear and comprehensive evidence-based recommendations. The recommendations include initiation of an addiction-focused psychosocial intervention with consideration of the patient's prior treatment experience and patient preference, the use of motivational interviewing style and emphasis on common elements of effective interventions, an emphasis on consistent predictors of successful outcomes and strategies to promote active involvement in available mutual help programs.

The SUD guideline recommends the following addiction-focused psychosocial interventions that have empirical support and can be initiated based on locally available expertise: behavioral couples therapy, cognitive behavioral coping skills training, the community reinforcement approach, contingency management/motivational incentives, motivational enhancement therapy, and twelve-step facilitation. The addiction-focused interventions should be coordinated with evidence-based interventions for other biopsychosocial problems to address concurrent problems and be provided in the least restrictive setting necessary for safety and effectiveness.

The SUD clinical practice guidelines also recommend that tobacco cessation treatment should be offered to patients with nicotine dependence. The panel considered SUD/PTSD Specialists to be potentially effective promoters of integrated PTSD/tobacco cessation treatments delivered by the PTSD clinicians.

The SUD/PTSD Specialist can also encourage adherence to the VA/DoD Clinical Practice Guidelines for management of SUD by encouraging adherence to addiction-focused pharmacotherapy recommendations. Naltrexone and disulfiram should be offered as a treatment strategy for alcohol use disorders, if indicated, and there is some preliminary evidence they may have some direct benefit for PTSD symptoms. Buprenorphine/naloxone should be encouraged when clinically indicated for opiate dependence, which, in the opinion of the panel, tends to be under diagnosed. Benzodiazepines alleviate alcohol withdrawal but lack evidence of efficacy for

treating the symptoms of PTSD and after detoxification benzodiazepines are generally not advised in patients with a SUD.

In the case of medication management, it is critical to provide adequate dosage and adherence monitoring. Although many practitioners know to “start low and go slow,” often, practitioners fail to titrate up to fully beneficial doses of medication. There may need to be risk-benefit profiles established before selection/prescription of medications. Two selective serotonin reuptake inhibitors (SSRIs), sertraline and paroxetine have FDA approval as first-line recommended treatments in PTSD. There was consensus that they can be considered for Veterans with PTSD with or without co-occurring SUD. It was considered critical that the SUD/PTSD Specialist build a working relationship with pharmacotherapy prescribers in both clinical settings.

There may be several key treatment domains that require attention to inform treatment plan adjustments. These concerns could be reflected in provider educational materials and include how to manage partial responders or those who are not adherent with treatment and how to address problems with pain, cognitive deficits or executive functioning; depression, insomnia; and polypharmacy.

Given the lack of clinical trials, it was strongly recommended that systematic monitoring of ongoing treatment be carried out routinely. The importance of measurement and monitoring outcomes was strongly endorsed. The effectiveness of treatments that are delivered need to be continually assessed. Information from such evaluations will be useful to guide practice until randomized clinical trials can provide more rigorous data. This is especially pertinent when the patient is not progressing after an adequate trial of recommended treatment. Finally, providers need to discontinue medications when they are not effective. Polypharmacy remains a significant concern for patients with PTSD and other comorbidities.

4. The Role of the SUD/PTSD Specialist

Various concerns from the consensus panel were related to the issue of workload capacity for the SUD/PTSD Specialist. Currently many clinicians serving in this position do not have protected administrative time to provide the education, prevention, training, coordination and consultation recommended by this panel. It is not optimal for them to exclusively provide direct patient care, but some direct care is essential to enhance integrated care throughout the facility. Their role in the area of intake, screening and assessment was designed to be of a “hybrid” nature wherein they conduct some direct treatment, assess the environment, assist with triage, consult and train other personnel. Their positions are not designed to create isolated “tracks” within clinical teams, but to provide the opportunity to be change agents that foster effective coordination across settings. They can provide the “glue” between the two specialty departments, SUD and PTSD.

Specific roles for the SUD/PTSD Specialists were encouraged by the consensus panel. These include diagnosis, assessment and monitoring of SUD and PTSD and providing treatment to Veterans with co-occurring SUD and PTSD. It was recommended that Specialists consider an approximately balanced allocation of their time with 60% devoted to direct clinical care and 40% to other duties. Consultation to other team members treating SUD/PTSD and managing subthreshold SUD is an important activity for the Specialist as is stimulating education and

training for providers, other services, Vet Centers, CBOCs, patients and family members. It is also recommended that the SUD/PTSD Specialist work with leadership on issues such as program redesign, improved treatment access, program development and case finding strategies. Finally, given the diversity of training backgrounds for providers in these positions, it is important that the SUD/PTSD Specialist be provided time and support for professional development, attendance at meetings including the VA National Mental Health Conference and participation in various professional organizations related to PTSD and/or SUD.

There appears to be a system-wide need to provide local, VISN and national support for VA clinicians who are delivering interdisciplinary care. Currently, no consistent encounter-based workload credit (e.g., for resource allocation through VERA) is given to clinicians who manage or review cases indirectly with other providers. If administrative time was consistently appropriated for clinical care coordination activities, it would encourage and promote collaborative care. Such a change would then help clinicians invest the time to utilize consultation resources that are available within VA including Evidence-Based Psychotherapy Coordinators and trained supervisors of specific evidence-based treatment practice rollouts by the Office of Mental Health Services.

Finally, the group acknowledged that OEF/OIF veterans may have multiple case managers and providers in different teams. Consistent with the Handbook, the consensus panel advocated that a Principal Mental Health Provider be identified who is responsible for the coordination of care for each Veteran with a diagnosed comorbidity. In some, but not all, cases this responsibility will fall to the SUD/PTSD Specialist. This is to ensure that interdisciplinary care is afforded in the most coordinated manner for the patient and his/her family.

Conclusions: The conference planning committee presented a draft summary to the panel on the second day during which recommendations were developed, based on the best available scientific evidence and expert clinical experience. The recommendations were to guide clinical practice for the treatment of Veterans suffering from co-occurring PTSD and SUD. This document is the panel's consensus statement, prepared for review before release of guidance to the field.

The October 2009 conference was seen as an important first step in developing treatment recommendations for SUD/PTSD Specialists with broader implications for treatment services in SUD and PTSD specialty clinics. Given the current evidence, it is recommended that the existing VA/DoD clinical practice guidelines be followed as the initial foundation for treatment of Veterans with PTSD and SUD, with adjustments informed by ongoing monitoring of treatment response for both conditions. It is also important to recognize that there is no inherent reason to sequence the treatments rather than to provide them concurrently and in an integrated manner. Clearly there is pressing need for clinical trials of both medication and psychological interventions to evaluate the effectiveness of treatment strategies overall and for subgroups of patients. It is important to consider patient severity and complexity in any clinical decision-making. Further evidence is needed to develop guidance for treatment adjustments that might be essential when both conditions exist and when alteration or augmentation of current practice guidelines appears necessary

What then are the next steps?

A number of specific recommendations were made that can be implemented now. They include:

1. Identification of “potential best practice” SUD/PTSD models of care in VA developed in facilities of different sizes and levels of complexity; identify those “best practices” that address the comorbidity across different clinical settings such as Vet Centers, and CBOCs. Such information can readily be shared with the field and quickly improve practice.
2. Creation and promotion of workload incentives to ensure that clinicians have the time required to manage, collaborate and use consultation services for clinical care coordination for these complex patients. These collaborations can include facilitation of communication and treatment planning across rehabilitation, pain, substance use disorder, and mental health service providers. The key to this process is sufficient and appropriately allocated time required for collaboration as it is key to treatment delivery.
3. Development and dissemination of information in consultation with the Rural Health Initiative to clarify distinctive issues that arise for this population of patients in the rural health setting.
4. Ongoing monitoring of treatment response among patients with the comorbidity to examine variables such as outcomes from psychosocial treatment, prescribed medications, health care utilization, and no-show rates. The expertise to do this already exists and it is important to have a strong, clear understanding of this patient cohort.
5. Importantly, feedback from OEF/OIF Veterans has demonstrated the importance of including family members not only in treatment planning and treatment but also in providing support to family members. Behavioral Couples Therapy is a recommended treatment in the SUD Clinical Practice Guidelines, with emerging evidence in PTSD. Encouraging family treatments in SUD and PTSD Specialty Clinics can greatly enhance expectation of recovery and implementation is encouraged as soon as possible.
6. Educational resources for providers, patients and families are needed to explain the meaning of a positive screen and offer information on treatment alternatives. These can then be catalogued for easy access and distribution. Resources may also include websites that can reach a broad audience as well as brochures that are easily accessed and/or distributed in the clinic setting to support recovery expectations. Several resources already exist to support clinicians working with patients with the comorbidity and include useful information for patients and families. They include websites such as:
 - the National Center for PTSD website (www.ptsd.va.gov)
 - the VA Mental Health’s OEF/OIF website (www.mentalhealth.va.gov/OEFOIF),
 - the MyHealthVet website (www.myhealth.va.gov),
 - SUD and SUD PTSD Sharepoint files at
(<http://vaww.national.cmop.va.gov/MentalHealth/default.aspx>)
7. A community of practice Outlook list (VHA MH SUD PTSD Group) and SharePoint site indicated above will allow participants an opportunity to access resource information and query

one another for advice in handling specific problems. To complement these resources, it is essential that recommended outcome measures be implemented to capture improvements in clinical outcomes. Finally, consultation models would greatly enhance patient care and decrease systems issues and can be shared and disseminated to the field.

Summary

The work of the consensus conference panel is a first step in a process of providing practical clinical treatment guidance to SUD/PTSD Specialists working with Veterans with co-occurring PTSD and SUD.

For now, the recommendation of the consensus panel is for clinicians to recognize the early stage of literature in this area; to use clinical judgment when applying different models (especially when considering high-risk PTSD/SUD patients); and to follow the principles and recommendations of the current specialized VA/DOD clinical practice guidelines for SUD and PTSD and Chronic Pain. These recommendations will be reviewed and modified as new scientific evidence develops and via ongoing discussion with the SUD/PTSD Specialists.

These recommendations need to be disseminated to the field quickly, to assist with informing treatment of Veterans with the co-occurring presentations and to promote ongoing discussion with the SUD/PTSD Specialists.

Appendix A

Planning Committee Members and Conference Attendees

Planning Committee Members (and location):

Dr. Matthew Friedman – NCPTSD

Dr. Larry Lehmann - VACO

Dr. John Allen - VACO

Dr. Nancy Bernardy - NCPTSD

Dr. Dan Kivlahan - SUD

Dr. Jennifer Burden – SUD

Mr. Marty Oexner - EES

Conference Attendees:

Dr. Jessica Hamblen – NCPTSD - Moderator

Dr. Sharon Baker – SUD

Dr. Deborah Brief - MH

Dr. Michelle Drapkin – SUD/PTSD

Dr. Chad Emrick – SUD/PTSD

Dr. Elizabeth Gifford - SUD

Dr. David Joseph - SUD

Dr. Thomas Kosten – SUD

Dr. John Krystal - SUD

Dr. Harold Kudler – MIRECC

Dr. Miles McFall – PTSD/SUD

Dr. Lisa Najavits - SUD/PTSD

Dr. David Oslin - MH

Dr. Edgardo Padin - MH

Dr. Ismene Petrakis - SUD

Dr. Josef Ruzek – NCPTSD - MH

Appendix B

Co-Occurring SUD and PTSD: General Summary Points Based on the Scientific Literature

This summary was not meant to reflect an exhaustive review of the literature, but rather to provide summary information in advance to support discussion during the conference.

A table summarizing selected relevant studies was provided in advance to conference participants and is available to VHA staff under “Clinical Resources” on the Sharepoint site at: <http://vaww.national.cmop.va.gov/MentalHealth/SUD%20PTSD%20files/Forms/AllItems.aspx> Updates and comments on the table can be posted and viewed in a new document at that site.

- Co-occurring SUD and PTSD is associated with: more severe PTSD symptoms, the higher the rates of other co-occurring Axis I and II disorders, the higher the rates of medical problems, and the greater the likelihood of relapse (Najavits, 1997; Ouimette and Brown, 2002; Brady, 2001).
- Rates of co-occurrence are high: Men with PTSD are 5 times more likely to have a SUD compared to the general population. Women with PTSD are 1.4x (Helzer et al., 1987).
- Lifetime prevalence of PTSD among individuals seeking SUD treatment have been reported as high as 50%. Population based data are lower. Review of VA diagnoses for FY 2008 indicates that 22% of Veterans with PTSD have a co-occurring SUD diagnosis and 25% of Veterans with a SUD have a co-occurring PTSD diagnosis.
- Data suggest that there is a relationship between SUD symptoms and PTSD symptoms such that improvement in PTSD symptoms is related to overall improvement in SUD symptoms. This relationship does not appear to be reciprocal. These findings are often discussed in the context of a self-medication hypothesis for the relationship between SUD and PTSD. (See Brady, Back & Coffey, 2004 for a review).
- The literature, in general, provides support for improved SUD and PTSD symptoms when individuals are provided treatment. No findings indicated harm to clients provided integrated treatment for co-occurring SUD and PTSD and was overall consensus that both conditions - ought to be addressed. There are findings that support provision of integrated treatment for SUD and PTSD both as an adjunct to existing SUD treatment services or as stand-alone treatments. However, the data are limited making it difficult to clearly identify one specific treatment as the “gold standard”. The following treatments were reviewed:
 - Seeking Safety
 - Seeking Safety + Exposure
 - ACT
 - TRANSCEND
 - TARGET

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- Contingency Management
 - Behavioral Couples Therapy
 - Meditation
 - Concurrent Treatment of PTSD and Cocaine Dependence (Exposure)
 - CBT for Co-Occurring SUD and PTSD
 - TREM
- Studies examining both patient characteristics and clinician concerns indicate that one central feature may be the high rate of other co-occurring disorders among this cohort and not just SUD and PTSD alone. A key component of this seems to be the likelihood of more severe symptom presentation (e.g., history of suicide attempts, inpatient psychiatric hospitalizations).

Appendix C

Agenda for Consensus Conference on Practice Recommendations for Treatment of Veterans with Comorbid Substance Use Disorder and PTSD Consensus

October 22 and 23, 2009

Purpose: To develop practice recommendations on how substance use disorder specialists augmenting PTSD teams and services can be most effective in treating comorbid substance use disorders in Veterans being served by these teams. Department of Veterans Affairs experts and health care professionals will meet to review expert opinion as a complement to the state of the science in SUD/PTSD and make recommendations that impact health care services, education, and systems coordination.

Thursday, October 22 – Overview/Agreement of Findings

- | | |
|-------------|---|
| 8:00 – 8:05 | Opening Comments/Housekeeping Items – Marty Oexner, EES |
| 8:05 – 8:15 | Inside VACO Perspective – Dr. Larry Lehmann |
| 8:15 – 8:30 | Welcome and Introductions of moderator/attendees – Dr. Dan Kivlahan |
| 8:30 – 8:45 | Overview, Review of SUD/PTSD Clinicians’ roles and Goals of Consensus – Implications of Conference – Dr. John Allen |
| 8:45 – 9:15 | Review of Clinical Practice Guidelines – Dr. Dan Kivlahan and Dr. Matthew Friedman |
| 9:15 – 9:30 | Current Needs- Results from Literature Review – Dr. Jennifer Burden |

Round Table Discussions – Clinical Recommendations, Systems Issues, Priorities and Outcomes

9:30 – 10:30

INTAKE, SCREENING/EARLY RECOGNITION AND ASSESSMENT

ROUND TABLE QUESTIONS: Review guidance on positive SUD/PTSD screens at intake. What might clinicians do to increase early recognition of problems? What are the best approaches to assess comorbid SUD/PTSD? Are there questions/tools clinicians might need to add to their assessment for symptoms/functional problems? What is recommended to clinicians to assess common comorbidities such as pain, insomnia, depression, nicotine dependence? What are the systems issues? What does the current knowledge tell us and what are the challenges and outcomes priorities?

10:30 – 10:45 Break

10:45 – 12:15 **TREATMENT PLANNING**

ROUND TABLE QUESTIONS: What are the challenges of initial and ongoing treatment planning with a patient with comorbid SUD/PTSD? What can we do to overcome them? What are the systems issues? What does the current knowledge tell us and what are the outcomes priorities? Are there questions/tools clinicians may need to add to treatment planning when addressing comorbid SUD/PTSD? How ought treatment planning be altered to address symptoms/ functional problems? How address common comorbidities (pain, insomnia, nicotine) in the plan? What might go wrong if you ignore the presence of the other condition? How do we adjust treatment planning for nonresponse? What is recommended for ongoing monitoring besides quarterly PCL and Brief Addiction Monitor during first 30-120 days?

12:15 – 1:30 p.m. Lunch (On your own)

1:30 – 3:30 **TREATMENT**

ROUND TABLE QUESTIONS: What do the practice guidelines tell us about the most effective SUD/PTSD treatment strategies and settings? What are the challenges of treatment with a patient with comorbid SUD/PTSD? What happens when you add pain, depression, insomnia, nicotine dependence and other comorbidities? Are there adjunct interventions that work for comorbid SUD/PTSD (e.g., skills training)? Would clinicians need to change the content and format of evidence-based treatments such as CPT, PE? Are there modifications to be recommended? Are there certain treatment strategies or interventions that may improve outcomes for comorbid symptoms? What are the systems issues? What does the current knowledge tell us and what are the challenges and outcomes priorities?

3:30 – 3:45 Break

3:45 – 5:00 **TREATMENT (continued) – Medication Management**

ROUND TABLE QUESTIONS: What do the practice guidelines tell us about the most effective SUD/PTSD medication strategies, including adherence issues? What is useful in the treatment of a patient with comorbid SUD/PTSD? Does it alter rehabilitation? What medications are not recommended? What are the systems issues? What does the current knowledge tell us and what are the challenges and outcomes priorities?

- 5:00 – 5:15 Wrap-up/Plan for tomorrow
- 5:30 – 6:30 p.m. Wrap-up with Planning Workgroup/Preparation for tomorrow

Friday, October 23 - Development of Practice Recommendations- Outcomes

- 8:15 – 8:45 a.m. Moderator – Summarize Key Points of First Day Discussion, Overview of Plan for the Morning
- 8:45 – 9:45 Development of Clinical Recommendations, Systems Issues, Priorities and Outcomes
- 9:45 – 10:00 Break
- 10:00 – 11:00 Continued
- 11:00 – 12:00 Implementation Strategies/Next Steps/Outcomes – Challenges and Knowledge
- 12:00 – 12:30 p.m. Conclusions