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Comparative utilization of pharmacotherapy for alcohol use disorder and other psychiatric disorders among U.S. Veterans Health Administration patients with dual diagnoses

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ABSTRACT

Patients with alcohol use disorder (AUD) and another co-occurring psychiatric disorder are a vulnerable population with high symptom severity. Such patients may benefit from a full arsenal of treatment options including pharmacotherapy. Receipt of AUD pharmacotherapy is generally very low despite recommendations that it be made available to every patient with AUD, including those with co-occurring disorders. Little is known about pharmacotherapy rates for AUD compared to other psychiatric disorders among patients with dual diagnoses. This study compared rates of pharmacotherapy for AUD to those for non-substance use psychiatric disorders and tobacco use disorder among patients with dual diagnoses in the U.S. Veterans Affairs (VA) healthcare system. VA data were used to identify patients with AUD and another psychiatric disorder in fiscal year 2012, and to estimate the proportion receiving pharmacotherapy for AUD and for each comorbid condition. Among subsets of patients with AUD and co-occurring schizophrenic, bipolar, posttraumatic stress or major depressive disorder, receipt of medications for AUD ranged from 7% to 11%, whereas receipt of medications for the comorbid disorder ranged from 69% to 82%. Among patients with AUD and co-occurring tobacco use disorder, 6% received medication for their AUD and 34% for their tobacco use disorder. Among patients with dual diagnoses, rates of pharmacotherapy for AUD were far lower than those for the comorbid disorders and contrary to evidence that medications for AUD are effective. Additional system-wide implementation efforts to identify and address patient- and provider-level barriers are needed to increase AUD pharmacotherapy in this high-need population.

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Alcohol use disorder (AUD) affects approximately 8.5% of U.S. adults (Grant et al., 2004a) and is associated with substantial societal and personal costs (Schuckit, 2009; Rehm et al., 2014). Excessive alcohol consumption accounts for 10% of deaths among working-age adults in the U.S. (Stahre et al., 2014) and is estimated to have annual economic costs of more than $300 billion, primarily due to losses in productivity (Bouchery et al., 2011). Further, AUD exacerbates a wide range of medical and other psychiatric conditions (Schuckit, 2009; Falk et al., 2006; Kelly and Daley, 2013).

Individuals with AUD are twice as likely to have a non-substance use psychiatric disorder, three times as likely to have tobacco use disorder and over 10 times as likely to have a drug use disorder than individuals with no AUD (Falk et al., 2006; Grant et al., 2004b;

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Stinson et al., 2005). Such comorbidity can add to symptom severity and result in poorer prognosis and treatment outcomes (Kelly and Daley, 2013; Baca and Yahne, 2009). Patients with AUD and another co-occurring psychiatric disorder may require more intensive, multi-faceted treatment combining pharmacotherapy, psychotherapy and/or behavioral interventions (Kelly and Daley, 2013; Baca and Yahne, 2009; Kessler et al., 2005; Petrakis et al., 2002).

Effective medications are available for AUD (American Society of Addiction Medicine, 2012) and many other psychiatric disorders. Further, although studies of pharmacotherapy among patients with AUD and another co-occurring psychiatric disorder are limited, evidence suggests that efficacious medications for AUD and other psychiatric conditions are effective for dually diagnosed patients (Baca and Yahne, 2009; Tiet and Mausbach, 2007; Yuodelis-Flores et al., 2010). Therefore, AUD and co-occurring psychiatric disorders should be treated concurrently, ideally in the same integrated treatment program (Kelly and Daley, 2013; Baca and Yahne, 2009; National Institute on Alcohol Abuse and Alcoholism, 2007 (October 2008 medications update); O'Brien et al., 2004).

Although pharmacotherapy is widely recognized as a critical component of evidence-based care for AUD based on its effectiveness for reducing drinking and associated decreases in health care utilization and costs (Baser et al., 2011; Mark et al., 2010), only 3–10% of individuals with AUD receive medication treatment, depending on the healthcare system (Mark et al., 2009; Thomas et al., 2013). The largest integrated healthcare system in the U.S., the Veterans Affairs healthcare system (VA), has implemented nationwide clinical practice guidelines that specify that pharmacotherapy options should be discussed with all patients with AUD and offered if not contraindicated (Department of Veterans Affairs (VA) and Department of Defense (DoD), 2009b). These guidelines explicitly state that for patients with AUD and another co-occurring psychiatric disorder, AUD medications should be offered in addition to indicated medications for the co-occurring disorder(s). Further, the VA Handbook stipulates that other psychiatric disorders "must never be a barrier to treating patients with substance use disorders" (Department of Veterans Affairs, 2008).

While rates of guideline-congruent pharmacotherapy for AUD among patients with other co-occurring psychiatric disorders are unknown, as of 2009, only 3.4% of all VA patients with documented AUD received a medication approved by the U.S. Food and Drug Administration (FDA) for treatment of AUD (Harris et al., 2012) and 1.0% received topiramate, which has recently been shown to be effective for reducing drinking (Arbaizar et al., 2010; Blodgett et al., 2014) and is being used increasingly to treat AUD (Del Re et al., 2013). In contrast, the vast majority of VA patients with schizophrenia (82%), bipolar disorder (75%), posttraumatic stress disorder (PTSD; 60%), and major depressive disorder (95%) receive related medications (U.S. Government Accountability Office, 2014; Kilbourne et al., 2005; Bernardy et al., 2012; Leslie and Rosenheck, 2003). Possible reasons for this discrepancy are provider perceptions that AUD medications are ineffective or that patients want treatment only for their non-substance use psychiatric disorders (Carey et al., 2000; Harris et al., 2013; Abraham et al., 2009; Thomas and Miller, 2007). However, receipt of medications for tobacco use disorder is relatively high (~40% among smokers) (Gifford et al., 2013), despite inferior efficacy (Jonas et al., 2014; Stead et al., 2012) and some of the same initial implementation barriers to prescribing as for medications for AUD (e.g., medication restrictions, lack of provider training/knowledge) (Harris et al., 2013; Smith et al., 2010).

Little is known about the comparative utilization of pharmacotherapy for AUD and non-substance use psychiatric disorders or tobacco use disorder among patients with dual diagnoses. Patients with AUD and another co-occurring psychiatric disorder may tend to have the greatest complexity of symptoms, be least likely to engage in psychosocial interventions and benefit most from a full arsenal of treatment options including pharmacotherapy (Kelly and Daley, 2013; Baca and Yahne, 2009; Kessler et al., 2005; Merikangas and Kalaydjian, 2007; Kelly et al., 2012). This study aimed to describe rates of receipt of guideline-congruent medication for AUD compared to non-substance use psychiatric disorders and tobacco use disorder among VA patients with dual diagnoses.

1. Methods

1.1. Sample and data sources

This cross-sectional study included VA patients who had an AUD and a comorbid non-substance use psychiatric disorder or tobacco use disorder documented in their electronic health record (EHR) in fiscal year 2012 (FY12). Diagnoses were identified based on primary or secondary International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes from the VA's National Patient Care Database (NPCD) inpatient and outpatient files. Sociodemographic characteristics of the study sample were also determined from the NPCD. Any utilization of medications for each condition of interest in FY12 was determined based on inpatient and outpatient pharmacy benefits data from the VA Decision Support System (DSS).

2. Measures

2.1. Clinical diagnoses of interest

AUD was identified using ICD-9-CM codes 291.XX, 303.XX, 305.0-305.03, 535.3 or 571.1 (National Committee for Quality Assurance, 2013). Although alcohol pharmacotherapy is approved by the FDA to treat alcohol dependence, patients with any AUD—including abuse or dependence—were considered the target population for alcohol pharmacotherapy in this study for several reasons. First, alcohol abuse and dependence no longer exist as separate disorders in standard classification of mental health disorders in the U.S. (Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013)). Second, clinical distinction between alcohol abuse and dependence may not be reliable, given that patients often have alternating or concurrent diagnoses of abuse and dependence documented in the EHR (Fernandes-Taylor and Harris, 2012). Finally, the target population of patients with any AUD is consistent with quality measures for alcohol pharmacotherapy being used in the VA Mental Health Information System as well as with previous studies of alcohol pharmacotherapy in VA (Harris et al., 2012; Fernandes-Taylor and Harris, 2012; Iheanacho et al., 2013). Codes for diagnoses of alcohol abuse or dependence "in remission" were included because patients in treatment are sometimes coded this way even though complete, sustained remission has not been achieved.

Co-occurring other psychiatric disorders included: *schizophrenia* (ICD-9-CM 295.XX), *bipolar disorder* (ICD-9-CM 296.0-296.19, 296.4–296.89), *posttraumatic stress disorder* (PTSD; ICD-9-CM 309.81), *major depressive disorder (*ICD-9-CM 296.20-296.25, 296.30-296.35, 298.0, 311) and *tobacco use disorder* (ICD-9-CM 305.1).

2.2. Medication receipt

A dichotomous indicator of any medication receipt for each condition of interest was constructed based on the patient had at least one prescription filled (regardless of quantity, days' supply, or dosage) in FY12. Medications for each condition of interest (Table 1)

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