Behavioral health treatment barriers and preferences of primary care patients with chronic pain and alcohol use

Katherine A. Buckheit[a], Jacob Scharer[a], Travis A. Loughran[b], Gregory P. Beehler[c,d], Dezarie Moskal[c,d], Jennifer S. Funderburk[a,e,f]

[a]VA Center for Integrated Healthcare, Syracuse VA Medical Center, Syracuse, NY
[b]Orlando VA Healthcare System, Orlando, FL, USA
[c]VA Center for Integrated Healthcare, VA Western New York Healthcare System, Buffalo, NY, USA
[d]School of Public Health and Health Professions, University at Buffalo, Buffalo, NY, USA
[e]Department of Psychology, Syracuse University, Syracuse, NY, USA
[f]Department of Psychiatry, University of Rochester, Rochester, NY, USA

Context

- Chronic pain and risky alcohol use are highly comorbid yet are most often treated separately[1-5]
- Incorporating patient preferences can increase treatment utilization[6] yet little is known about pain/alcohol treatment preferences

Aims

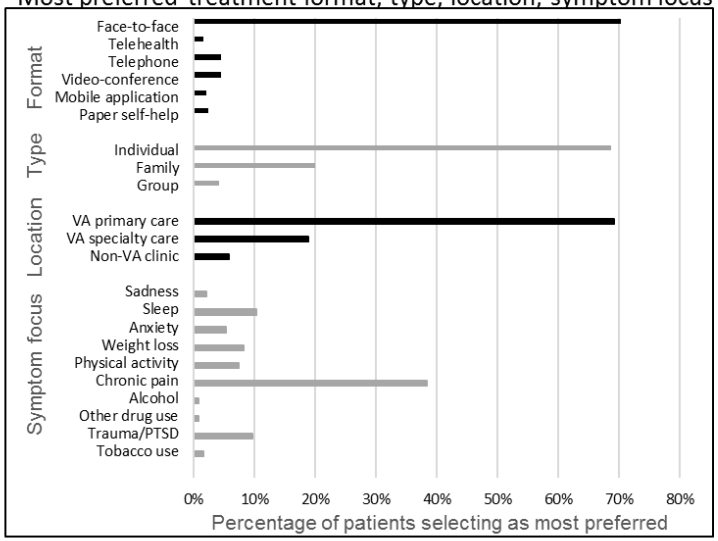
1. Describe treatment preferences and barriers of primary care patients with chronic pain and alcohol use
2. Test for differences in treatment barriers by alcohol risk level

Method

- Chart review + survey of 371 primary care Veterans with past-year alcohol use + chronic musculoskeletal condition
- *Treatment preferences*: format, type, location, symptom focus
- *Treatment barriers*: readiness to change pain/alcohol use (0-10)[7], alcohol treatment barriers (0-70)[8], pain-alcohol beliefs (0-6)[9], attitudes toward behavioral health (0-30)[10] and medical (0-105)[11] treatment
- *Alcohol risk:* Alcohol Use Disorders Identification Test (AUDIT; 0-40)[12]
- *Data analysis:* frequencies and non-parametric Chi-squared tests (aim 1), multivariate generalized linear models (aim 2)

Results

Most preferred treatment format, type, location, symptom focus



Means (SD) of treatment barriers by alcohol risk group

	No risk (AUDIT = 0) *n*=79	Low risk (AUDIT=1-7) *n*=246	High risk (AUDIT ≥ 8) *n*=49
Readiness-alcohol[a]	1.51 (3.06)	1.63 (2.77)	4.09 (3.75)
Readiness-pain[a]	5.86 (3.23)	5.63 (2.92)	6.21 (2.56)
Alcohol barriers[b]	35.80 (12.96)	35.98 (10.22)	35.72 (11.45)
Pain-alcohol beliefs[b]	0.08 (0.45)	0.45 (0.95)	1.95 (1.93)
Attitudes-behavioral[a]	19.40 (5.74)	21.34 (4.71)	21.79 (5.27)
Attitudes-medical[a]	77.00 (21.44)	80.12 (14.38)	75.60 (14.86)

Note. [a] higher score=lower barrier; [b] higher score=greater barrier

Results (cont.)

Patients were primarily White (74%) males (88%)

Aim 1

Analyses showed significant preferences for:

- face-to-face format (70.3%, $p < .001$)
- individual type (68.7%, $p < .001$)
- primary care location (69.2%, $p < .001$)
- chronic pain focus (38.4%, $p < .001$)

Aim 2

Patients with high-risk alcohol use reported

- more readiness to change alcohol use ($F = 16.18$, $p < .001$) than low/no risk patients
- stronger pain-alcohol beliefs ($F = 42.23$, $p < .001$) than low/no risk patients
- more favorable attitudes toward behavioral health treatment ($F = 3.50$, $p = .03$) than no risk patients

Conclusions

- Primary care patients with chronic musculoskeletal pain and alcohol use showed clear treatment preferences
- Those with high-risk alcohol use report differences in treatment barriers that may impede (i.e., pain-alcohol beliefs), or facilitate (i.e., readiness, attitudes) treatment engagement
- Incorporating patient perspectives may optimize behavioral health treatment i.e., by incorporating interventions for patient-identified symptom focus

See handout for additional information.
Contact: katherine.buckheit@va.gov

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