Managing Alcohol Use Disorders and At-risk Drinking in Primary Care

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Handouts

- Screening sheet with brief intervention and DSMV
- AUDIT-10
- Low risk drinking guidelines
- AUD flow-sheet
Overview

- Screening for unhealthy drinking
  - Categorizing: at-risk, mild, moderate or severe alcohol use disorders (AUDs)
- Brief interventions for at-risk drinking and mild AUDs
- Assessing a patient with a moderate or severe AUD
  - Trauma
- Managing patients with a moderate or severe AUD
  - Counsel
  - Prescribe
  - Connect to other resources
- (Billing codes - Ontario, B.C., PEI, NFLD)
Background

• Alcohol use disorders (AUDs) affect about 6-7% of the population
  ◦ About 2.6% of the population have a moderate or severe AUD (Alcohol dependence in the DSM IV)

• Huge burden of disease: Alcohol misuse is responsible for 5.5% of the overall burden of disease, 3rd after HTN and smoking (Shield, 2010)

• Overall costs of alcohol misuse to Canadian society in 2002 was 14.6 billion (CCSA 2007)
  ◦ (CDS- Diabetes total costs in 2000 was 5.9 billion)
Why is screening important?

- Many patients do not seek help
  - Less than 1/3 patients asked MD for help (CASA 2012)
    - 50% said MD was not aware of their AUD
- Patients are frequently in contact with primary care system
  - Studies show about 50% - 75% are interested in treatment if asked
- Interventions are effective
  - Can be initiated with little delay- one of the most important factors in patient engagement
Screening youth

- All patients 10 to 18 at least yearly

- In the past 12 months, have you:
  - Drank any alcohol (more than a few sips)
  - Smoked any marijuana
  - Used anything to get "high".

- CRAFFT (two or more is a positive)
  - C Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or other drugs?
  - R Do you ever use alcohol or other drugs to RELAX, feel better about yourself, or fit in?
  - A Do you ever use alcohol or other drugs while you are ALONE?
  - F Do you ever FORGET things you did while using alcohol or other drugs?
  - F Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
  - T Have you ever gotten into TROUBLE while you were using alcohol or other drugs?
Screening over age 18

- Yearly
- More frequently if at higher risk
  - Mental health problems, life stressors, history of interpersonal trauma, poverty, other SUDs
  - Medical problems associated with alcohol use
    - Gastritis, elevated LEs, injuries etc

Canadian standard drink sizes

- 13.6 grams of alcohol
  - 12 ounces of beer = 341 mls = 1 bottle (5%)
  - 5 ounces of wine = 150 mls (12%)
  - 1.5 ounces of hard liquor = 45 mls (40%)
Screening options: Single item screener

“How many times in the last year have you had (men= 5 or more) (women= 4 or more) drinks in one occasion?”

- Once or more is positive screen
  - 82% sensitive, 79% specific for unhealthy drinking (at-risk and AUDs)
Screening options: AUDIT-C

1. How often do you have a drink containing alcohol?
2. How many standard drinks containing alcohol do you have on a typical day?
3. How often do you have six or more drinks on one occasion?
AUDIT-C

- Positive for unhealthy drinking
  - Men $\geq 4$
    - sensitivity 0.86, specificity 0.89
  - Women $\geq 3$
    - sensitivity 0.73, specificity 0.91
Screening - Other options

- Other options include:
  - CAGE- 2+ is positive
    - Lifetime not active use
    - Misses at-risk drinking
  - T-ACE- alcohol use in pregnancy
    - Tolerance (how many drinks does it take for you to feel high? > 2 is one point)
    - Annoyed
    - Cut-down
    - Eye-opener
  - 2+ is positive screen
Categorizing

- AUDIT-10
  - Screening test
    - Higher sensitivity and specificity for unhealthy drinking (>85%)
    - Can also be used to categorize patients

- Category determines management approach
Categorizing

- AUDIT-10- handout
  - < 8 (< 6 for women) = lower risk drinking
    - Low risk drinking guidelines (LRDG)
  - 6 to 13 for women, 8 to 15 for men = unhealthy drinking (at-risk drinking or mild AUD)
    - Brief intervention
  - >13 for women, >15 for men = AUD (likely moderate or severe AUD)
    - AUD flow-sheet
Low risk drinking guidelines

- Review low risk drinking guidelines
  - Women:
    - 10 drinks a week, with no more than 2 drinks a day most days, up to 3 for special occasions
  - Men:
    - 15 drinks a week, with no more than 3 drinks a day most days, up to 4 for special occasions
  - Elderly - American guideline (no Canadian guideline)
    - Men - no more than one per day
    - Women - less than one per day on average
At-risk Drinking and Mild AUDs

- Brief counseling interventions for patients with mild AUDs are very effective
  - Bertholet et al 2005: Systematic review and meta-analysis of 5639 patients in 17 trials
    - Patients presenting to primary care NOT seeking help for alcohol-related problems
    - BI in primary care is effective at reducing alcohol consumption at 6 and 12 months (by average 4 drinks per week)
    - BI consisted of counseling intervention between 5 and 15 minutes, written materials, offer of follow-up session(s)
Brief Intervention

- Give feedback and advice. Encourage responsibility. Demonstrate empathy.
  - Review the Low Risk Drinking Guidelines
  - Make it personal: link to health, employment or social consequences in patient’s life
  - Determine patient’s goals
  - Advise patient to reduce drinking and give advice from LRDG
  - Offer a follow-up in 4 to 6 weeks
Alcohol Use Disorder (AUD)

- Share diagnosis with the patient
- Advise to reduce or stop drinking
- **Emphasize the effectiveness of treatment**
  - “Reducing how much you drink can be difficult. But we do have treatments (medication and counseling) available that make it easier.”
- Book back for a further assessment
  - “I’d like to talk to you some more about your alcohol use. How do you feel about coming back to see me for an assessment?”
  - Book a 30-60 minute assessment, ideally within next 1-2 weeks
    - Be prepared for no-shows- about 25% won’t show
Not Ready

• Declines appointment
  ◦ Safety- drinking and driving, children in home
  ◦ Offer lab tests
  ◦ Can try MI techniques- pros and cons of alcohol use
  ◦ “If you change your mind, I am happy to help”

• No-shows
  ◦ Safety- drinking and driving, children in home
  ◦ Seek to re-engage
    • Many reasons for no-shows besides ambivalence about change
Assess

- **History**
  - A complete history of alcohol use
    - Need for medical detoxification
  - Other substances
  - Past medical history;
    - Psychiatric history - present symptoms
  - Psychosocial history, including childhood, adolescence, adulthood, living situation, education, work, income etc;
    - Trauma
  - Family history: psychiatric disorders including addiction;
  - Review of systems
  - Make a diagnosis using DMSV criteria
Assess Substance Use

- Alcohol
  - Amount, duration, frequency, daily pattern of use (time of first drink)
  - Tolerance, withdrawal
  - Cravings, consequences, quit attempts
- Ask about other substances (tobacco, cannabis, opioids, stimulants, benzodiazepines etc)
- IVDU- ever, even once
Determine Need for Medical Detoxification

- Need for medical detoxification: Patients who drink heavily daily, and drink to relieve withdrawal symptoms
  - *Inpatient detox: All patients with past alcohol withdrawal seizures or severe withdrawal require inpatient medical detoxification.*
  - *Day detox - carefully selected patients*
    - No significant medical or psychiatric co-morbidities
    - No poly-substance use
    - Stable home situation with partner or friend to monitor
    - (Under age 60)
- *Non-medical detox*
  - Can go at least 3-4 days without drinking, and only have mild withdrawal symptoms
  - *However, as withdrawal can be unpredictable, advise all patients to go to the ED if they develop more significant symptoms.*
- Home detoxification with benzodiazepines is unsafe
Mental Health History

- Mental health history
  - 40% have concurrent mental health disorder
  - Ask all patients about previous mental health problems and present symptoms
  - Treat mood and anxiety disorders if the disorder appears to be underlying (pre-dates the AUD and persists in periods when patient is abstinent)
    - CBT
    - SSRIs, SNRIs
  - Refer more complicated patients
What is Trauma?

- Trauma: an event that overwhelms an individual’s resources for coping
  - “Trauma is when we have encountered an out-of-control, frightening experience that has disconnected us from all sense of resourcefulness or safety or coping or love.” Tara Brach, 2011
  - Two people can experience the same event differently
    - Can profoundly effect how an individual views the world and interacts with others
  - Most damaging is repetitive, interpersonal, younger age
    - E.g. young child repetitively physically abused by family member
Trauma Link with Addiction

- Adverse Childhood Experiences (ACE) study by Kaiser Permanente health group in the US
  - Determine why certain risk factors and diseases clustered in individuals
    - Smoking, alcohol abuse, high risk sexual behaviours, mood disorders
  - Enrolled 17,000 patients from 1995 to 1997 in a study
    - Confidential questions about childhood maltreatment and family dysfunction
      - Abuse, neglect, household dysfunction and disruption (parent with SUD, intimate partner violence, loss of parent to divorce/incarceration_death)
      - Current health status and behaviors
  - Then followed these patients over time
SUDs in Adults: Active AUD, Ever Illicit Drug Use

Risk of Adult Substance Abuse Increases with more Adverse Childhood Experiences (ACEs)

Self-Report: Alcoholism

Self-Report: Illicit Drugs

Source: Dube et al., 2002

Source: Dube et al., 2003
ACEs

- Researchers estimate that ACEs are responsible for $\frac{1}{2}$ to $\frac{2}{3}$ explanation for substance use disorders

- Other factors
  - Genetics
  - Mental health disorders
  - Environmental stressors (e.g. job loss, relationship difficulties)
  - Other environmental factors like substance social acceptability and availability
Why Do ACEs Increase Risk of Addiction?

- Those with history of ACEs have abnormal neuro-development
  - Dysfunction in dopamine and serotonin pathways
  - Problems with affect-regulation, attachment, identity, sense of meaning (Complex PTSD)
  - High levels of anxiety, depression, suicidality
- Dopamine pathways- reward, pleasure, salience
  - Dopamine release from substances of abuse is often 5-10x greater than physiological
  - For the first time ever enough for those with trauma to feel happy, at ease
    - “Two drinks short of normal”
  - However, over time brain responds by decreasing dopamine release and dopamine receptors
    - Leads to tolerance and withdrawal
Why Should We Ask About Trauma?

- Addiction and mental health outcomes are better when trauma is treated (Najavits 2013- review article)
  - Best outcomes in concurrent, combined program such as Seeking Safety
Taking a Trauma History

- Inquire about trauma
  - Appropriate time - might not be the first visit
  - Sensitive manner - respects a patient’s right to choose to disclose and seek treatment.
  - Do not ask for details about the trauma
    - Need to know enough to connect with appropriate treatment
Taking a Trauma history

- Sample inquiry:
  - We know that many people with addictions had difficult things happen in childhood such as abuse, or adulthood like domestic violence.
    - Coping with the effects of the trauma is often a reason people use substances.
  - Getting treatment for these traumas can often help with the addiction as well.
  - If something has happened to you, I can help connect you to treatment if that is something you are interested in.
  - However, these things can be difficult to talk about and if you are not ready, I understand.
Trauma Treatment

- Link patients who are interested in treatment to integrated addiction and trauma therapy programs (Seeking Safety)
  - Jean Tweed Toronto
- Even if patient declines treatment, studies show acknowledging the role of trauma is itself therapeutic for the patient
  - Reduces drop-out rates (Elliot 2005)
  - Encourages help-seeking (Brown 2000)
Assess: Exam and Labs

- Targeted physical exam
  - Vitals, mental status exam, brief neurological exam
  - Signs of liver dysfunction

- Lab tests
  - CBC, GGT, AST, ALT
  - Do additional labs if indications of liver dysfunction
  - If IVDU ever- Hep C, Hep B, HIV (or in 1945 to 1965 birth cohort)
Reporting to the MTO

- Ask all patients who drive, if they drink and drive.
- Report if any of the following:
  - Patient reports (or family member reports that patient is) drinking and driving
  - Patient drinks throughout the day and drives
  - Patient drove to the clinic intoxicated
  - Patient has experienced withdrawal seizures and is still drinking
Making the DSMV diagnosis

1. **Impaired control:**
   - (1) taking more or for longer than intended, (2) unsuccessful efforts to stop or cut down use, (3) spending a great deal of time obtaining, using, or recovering from use, (4) craving for substance.

2. **Social impairment:**
   - (5) failure to fulfill major obligations due to use, (6) continued use despite problems caused or exacerbated by use, (7) important activities given up or reduced because of substance use.

3. **Risky use:**
   - (8) recurrent use in hazardous situations, (9) continued use despite physical or psychological problems that are caused or exacerbated by substance use.

4. **Pharmacologic dependence:**
   - (10) tolerance to effects of the substance, (11) withdrawal symptoms when not using or using less.*

2-3 = mild AUD, 4-5 = moderate AUD, 6+ = severe AUD
Making the DSMV Diagnosis

- Mild AUD
  - Typically drink less than 40 drinks per week and do not have major withdrawal symptoms.
  - Alcohol has some harmful effects on their life.

- Moderate AUD
  - May be drinking daily or drinking intermittently but heavily (binge drinking)
  - May have some withdrawal symptoms
  - Alcohol has harmful effects on their life

- Severe AUD
  - Typically drinking daily and consuming more than 40 drinks per week
  - Often have severe withdrawal symptoms
  - Significant life consequences
Manage

- AUDs - as a **chronic disease**
  - Repeated alcohol use leads to persistent changes in reward pathways in the brain
  - Established environmental and genetic risk factors
  - Responds to behavioural therapy, modification of underlying risks factors, and medications
  - Patients often have many cycles of remission and relapse before long term remission
    - At risk of relapse with life stressors
More Severe AUDs: Manage

- Until recently, little evidence for effectiveness of primary care treatment of more severe AUDs
  - Fewer studies
  - Mixed results
- Recommendation: refer to specialized treatment
  - Limitations of specialized addiction care
    - Patients decline referrals, have high no-show rates and loss to follow-up
      - 50-75% do not show up for the first appointment
    - Many do not provide medical treatment
      - Some have strong bias against medical treatment
Recent Studies

- Primary care management is effective
  - Ongoing brief counseling sessions and medications in primary care is effective (O’Malley 2003) (Lee 2012) (Ernst 2008)
- Combine trial 2006: 1400 patients examined nine combinations of pharmacotherapy, placebo and behavioural interventions.
  - Found that naltrexone and medical management had one the three best outcomes.
  - Medical management= what a primary care physician without specialized addiction training would offer in a clinic visit
Effectiveness Studies

- Some evidence that primary care treatment in “real world” settings (patients’ own primary care clinic) outperforms specialized care.
- Randomized clinical trial of 160 veterans with alcohol dependence (VA trial) (Osli 2014)
  - Primary care-based alcohol care management with counseling and medications (Naltrexone) in patient’s own primary care clinic
  - Or referred to specialized addiction outpatient care (treatment as usual)
  - Primary care-based ACM increased retention in treatment
    - 1st month 60% primary care vs 25% specialized care
    - 6th month 42% primary care vs 12% specialized care
  - Primary care-based ACM greater increase in days without heavy drinking from about 45% in both groups to:
    - 45% to 82% in primary care
    - 45% to 72% specialized care
Manage: moderate or severe AUDs

- Counsel
  - Determine goals, develop a plan, problem-solve (barriers to change, triggers, cravings), give advice
- Prescribe
  - Create and review medication adherence plan
- Connect to other resources
Counsel

- Therapeutic relationship is one of the most important factors in patient engagement with treatment
  - Empathy, openness, flexibility
- Acknowledge:
  - Behaviour change is very difficult particularly when coupled with an addiction
  - Difficulties in patient’s life
- Be aware of the incredible amount of shame and guilt patients feel about their addiction
  - Studies show this is a barrier to help seeking
Counsel

- Enhance motivation - use MI techniques
- Give advice to change, present menu of change options
- Determine patient’s goals
  - Reduced drinking is reasonable goal for mild or even moderate AUD (and few life consequences)
  - Some should be strongly encouraged to target abstinence
    - Pregnant women
    - Patients with health conditions exacerbated by alcohol
    - Patients with severe AUD or those who are unable to reduce their heavy drinking
- Determine barriers to change
Counsel

- Help patient develop coping mechanisms
  - Avoiding triggers- people, places, things
  - Enhancing support network
  - Developing and practicing refusal skills
    - Help patient problem-solve and come up with solutions
      - E.g. “Your work friends drink heavily when you go out with them on Friday nights. Have you thought what you will do in that situation?”
  - Coping with cravings
Coping with Cravings

- Delay technique:
  - "I will not act on this craving right away. I will wait 5 (or 10 or 15) minutes to decide whether to act on this craving."

- Distract technique:
  - Prepare a list of distractions ahead of time e.g. call a friend or sponsor, go for a walk or run, do some housecleaning. Select from list of distractions when having a craving.

- Urge surfing technique:
  - “Picture the urge as an ocean wave, and imagine yourself surfing, using your breath as the surfboard...Ride this wave through its peak and its decline, without being submerged or ‘wiped out by its enormity’” (Bowen 2010)
Counsel

- Provide practical advice
  - Make recovery your top priority in first few months
  - Find methods to reduce stress such as exercise, meditation; eat and sleep at regular hours
  - Spend time with supportive family and friends
  - Have a contingency plan to interrupt a slip or relapse
Counsel

- Advice for patients who would like to reduce drinking:
  - Use the LRDG handout
    - Start drinking later in the evening or night
    - Have non-drinking days
    - Take a time out between drinks
    - Alternate alcoholic drinks with non-alcoholic drinks
  - Eat before and while drinking
  - Record drinks on a calendar or log book
Counsel: Specific Plan

- Help patient create a specific quit/reduce plan
  - Quitting
    - Set quit date
    - Detoxification plan if needed
      - Integrated into treatment plan
  - Reducing
    - “This week I will start reducing my drinking to maximum 3 per day. I will not drink alone. I will not have my first drink until 7pm. I will record my drinks on my day-planner.
    - Next month I will limit my maximum to 2 drinks per day and no more than 14 per week.”
Prescribe

- Moderate or severe AUDs
  - First-line medications are naltrexone (revia), acamprosate (campral) and disulfiram
  - Recent meta-analysis JAMA (Jonas 2014)
    - Acamprosate: NNT for abstinence is 12
    - Naltrexone: NNT to prevent heavy drinking is 12 and 20 to achieve abstinence
      - For comparison
        - NNT with statin for secondary prevention of non-fatal cardiac event is 25-40
        - NNT for primary prevention is 60
  - Disulfiram is effective when taken under supervision (Jorgenson 2011)
Prescribe

- Naltrexone
  - Block opioid receptor and reduces euphoric effect from drinking
  - Reduces heavy drinking and helps patients achieve and maintain abstinence
  - Do not need to abstain from alcohol prior to starting
  - Side effects - nausea, elevated liver enzymes
  - Contra-indications
    - On opioids
    - Liver dysfunction
    - Elevated liver enzymes - AST ALT (>3x normal)
    - Pregnancy
  - Dosage: 25mg x 3d (reduce GI effects, then increase to 50mg/day, to max 150mg per day
  - Monitoring: check LE at baseline, 4 w, then q 3 m
Prescribe

- Acamprosate
  - Antagonizes glutamate receptors (excitatory neurotransmitter)
  - Does not reduce heavy drinking
  - Helps patients maintain abstinence
    - Only effective if patients have been abstinent for at least several days
  - Side effects: nausea, agitation
  - Contraindications:
    - Significant renal disease
    - Pregnancy
  - Dosage: 666 mg tid, reduce dose to 333mg tid for renal impairment or weight less than 60 kgs
Prescribe

- **Disulfiram**
  - Blocks conversion of acetaldehyde to acetate and causes build-up of acetaldehyde
    - Sweating, palpitations, hypotension, can be fatal (rare)
  - Effective when taken under supervision
    - Better evidence than naltrexone and acamprosate in head to head trial
  - Side effects: Hepatitis, neuropathy, depression, psychosis
  - Contra indications: elderly, cardiac disease, liver dysfunction, psychosis, cognitive dysfunction, pregnancy
  - Dosage: 250 mg/d (range 125mg to 500 mg)
    - MUST be abstinent for at least 2 days prior to initiation
    - Reaction can happen up to 7 days after stopping medication
Prescribe

• Off-label medications-
  ◦ Topiramate, ondansetron, baclofen
  ◦ Gabapentin for sub-acute withdrawal
EAP requirements

- Naltrexone:
  - Alcohol dependence and in counseling

- Acamprosate:
  - Alcohol dependence and in counseling
  - Abstinent for at least 4 days
  - Contraindication or side effect from naltrexone

- Disulfiram- no coverage but cheap ($20 per month)
  - Must be compounded- pharmacy.ca
Connect

- Connect to additional resources
  - Ideally within same clinic setting
    - No-show rates are high outside of clinic setting
      - Remain persistent

- Addiction referral services
  - DART- http://www.drugandalcoholhelpline.ca/
  - MAARS- 416-599-1448
  - CAAS- 1-855-505-5045
Connect- Counselors

- Counselors
  - Should have specific addiction counseling training such as
    - Relapse-prevention therapy, behavioural counseling, motivational therapy and CBT for addictions
  - Couple therapy
    - Behavioral couple therapy for addictions has most evidence
      - One partner without SUD
  - Family therapy for youth
    - Several programs such as multi-dimensional family therapy show positive outcomes
Connect- Case Management

- Support workers
- Support organizations
  - e.g. COPA
    - Age 55 and older with an addiction
    - Support, counseling, outreach, case management, crisis (within 24 hours), psychiatric assessments
    - [http://www.copacommunity.ca/?q=Our-Services](http://www.copacommunity.ca/?q=Our-Services)
    - Referral from HCP, self-referral, etc
Connect - Day & Residential treatment

- Day and residential treatment programs
  - Most are 21 days with ongoing aftercare
  - Drop-out rates are very high, but for those who complete
    - 1/3 are abstinent at one year
    - The remainder show some reductions in alcohol use
  - Careful with programs that are “abstinence based”
Connect- Mutual Support

- Mutual support groups such as AA, SOS
  - May improve outcomes as patients who engage, do well
    - Unclear if causation or correlation
  - Advantages
    - No wait list, informal social support, available after hours
  - How to: during visit-go to website-
    - Patient can call from your office
    - Print off page with phone number
Connect- Concurrent Services

- Concurrent disorders
  - Patients do best with integrated and concurrent services
  - Can be difficult to access
    - CAMH- CAITS program- patients to self-refer via intake phone line
    - Fred Victor- requires physician referral
- Trauma services- concurrent and integrated
  - Seeking Safety program
Connect- Addiction Medicine Physician

- Addiction medicine specialists
  - For more complex patients
  - Those not improving in primary care
  - Patients who need detox
Billing for AUDs

- Ontario:
  - “Outside the basket codes” for capitation models
    - A680- minimum 50 minutes
      - First assessment only
    - K680- minimum 20 minutes
      - First or ongoing assessments
      - Same specific requirements as A680
      - Can bill multiples e.g. 2 units K680

- B.C., NFLD, PEI
  - Have addiction specific codes
Summary

- At-risk drinking and AUDs are very common in Canadian society
- Primary care interventions are effective
- Screen and categorize using AUDIT-10
- Management has three components
  - Counsel with goal setting, problem-solving and practical advice
  - Prescribe anti-alcohol medications for moderate and severe AUDs
  - Connect to other resources such as counselors, support groups, trauma services, concurrent mental health treatment and addiction medicine services