AUD in Primary Care

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Objectives

- Review evidence for screening for unhealthy alcohol use
- Compare medication options to assist with treating alcohol use disorder
- Learn about outpatient withdrawal management and risk stratification
- Discuss the importance of integrated behavioral health in managing alcohol use disorders

Disclosures

- None

Alcohol Use Disorder (AUD)

- Previously viewed as Abuse vs Dependence in DSM IV
- Defined as a problematic pattern of use causing clinically significant impairment or distress

TABLE 1

DSM-5 Diagnostic Criteria for Alcohol Use Disorder

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for alcohol.
    b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Specify if:

In early remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least 3 months but for less than 12 months (with exception that Criterion A4, "Craving, or a strong desire or urge to use alcohol," may be met).

In sustained remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use alcohol," may be met).

Specify if:

In a controlled environment: This additional specifier is used if the individual is in an environment where access to alcohol is restricted.

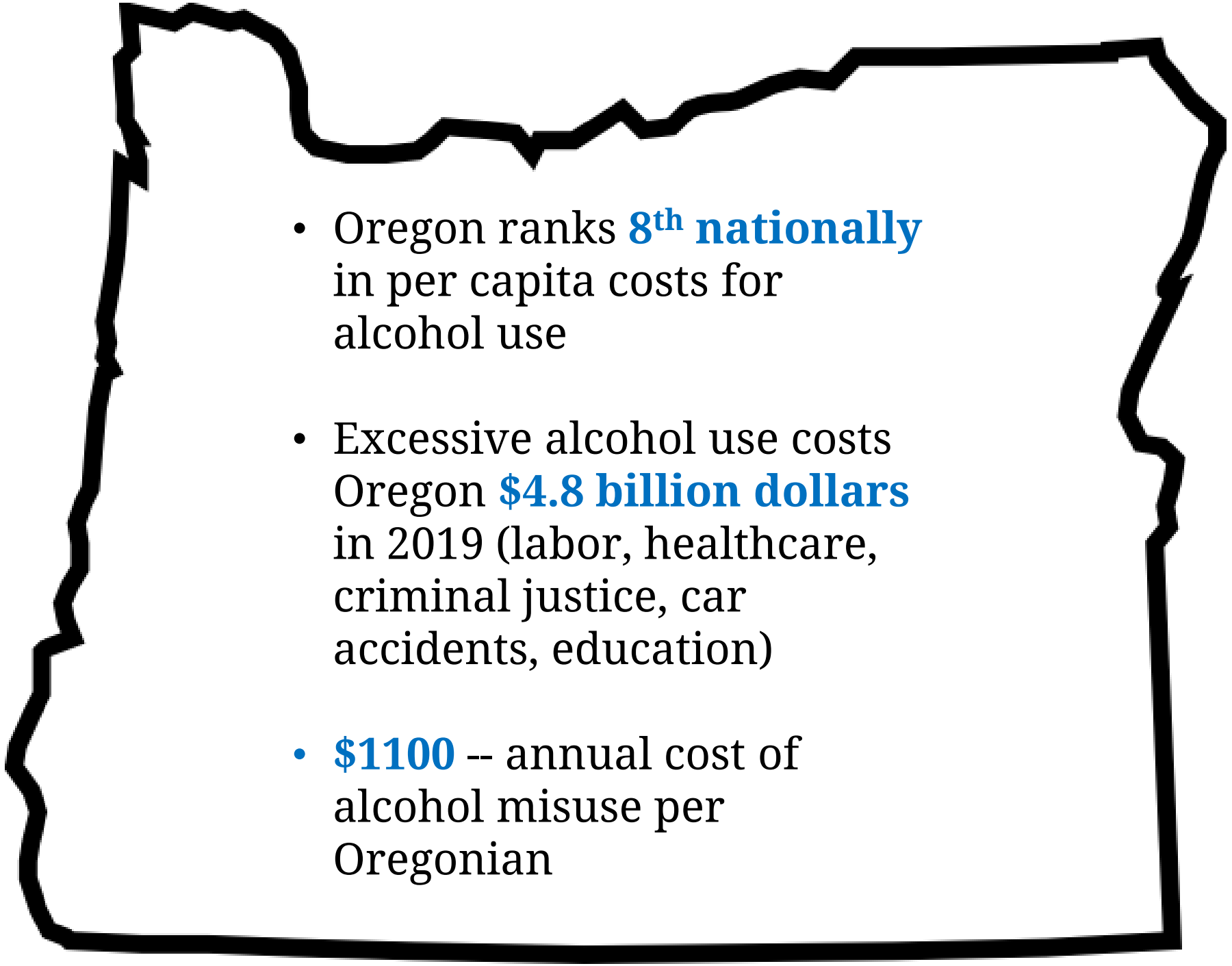
Specify current severity:

Mild: Presence of 2 to 3 symptoms

Moderate: Presence of 4 to 5 symptoms

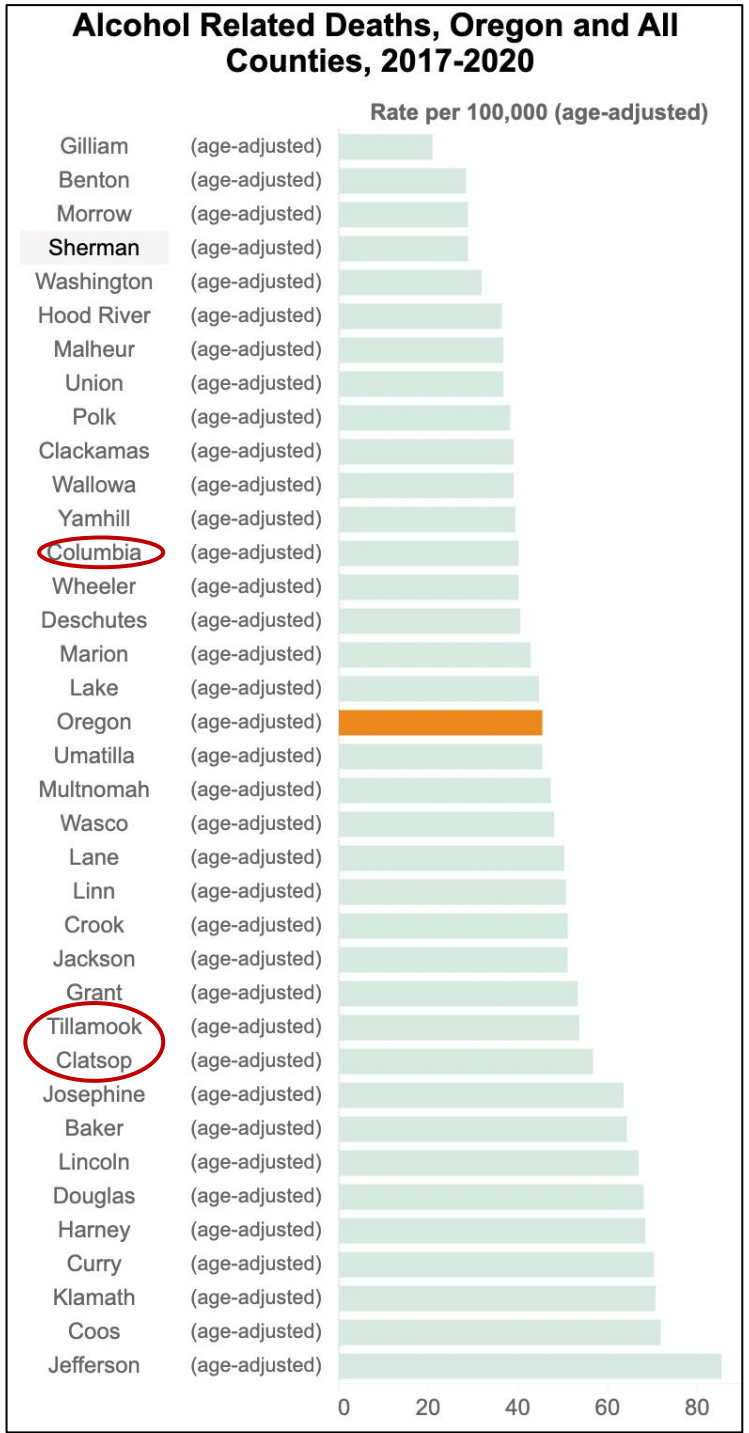
Severe: Presence of 6 or more symptoms

DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed.



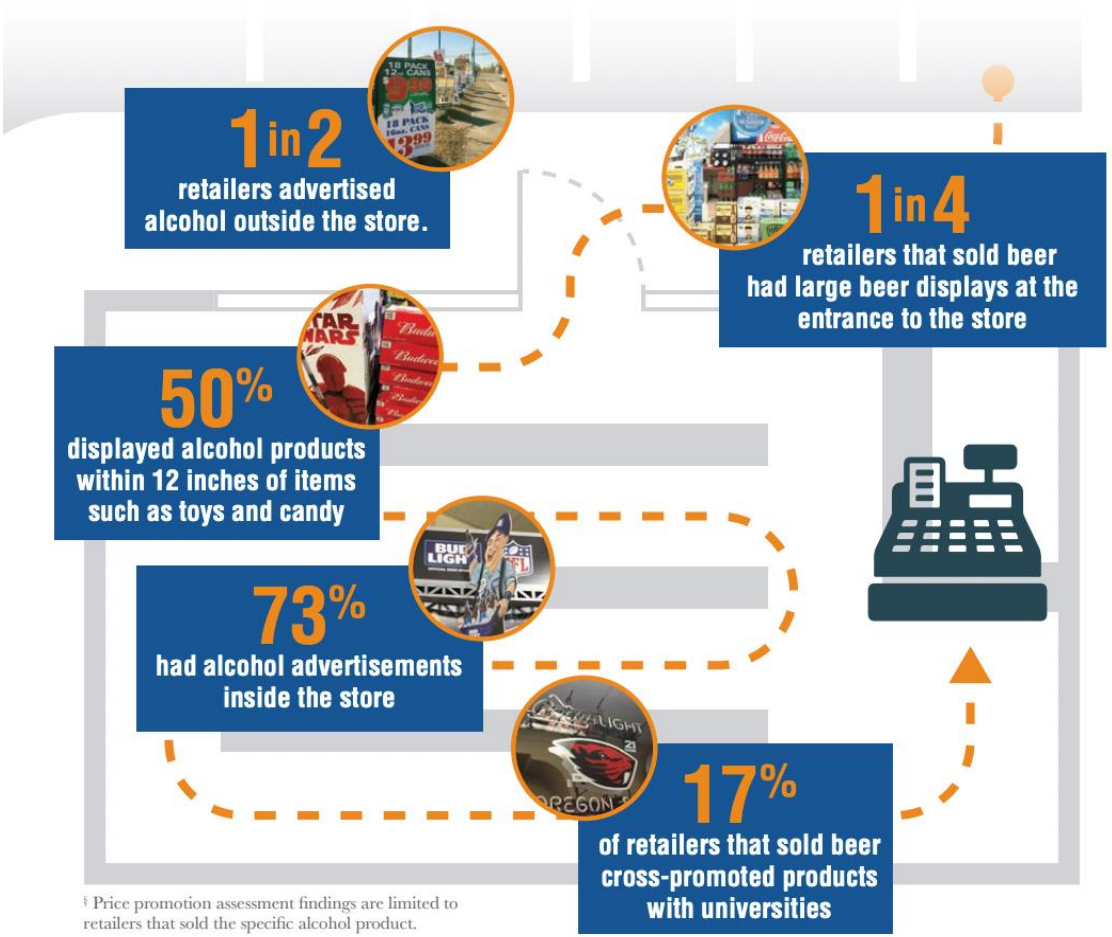
- Oregon ranks **8th nationally** in per capita costs for alcohol use
- Excessive alcohol use costs Oregon **$4.8 billion dollars** in 2019 (labor, healthcare, criminal justice, car accidents, education)
- **$1100** -- annual cost of alcohol misuse per Oregonian

Alcohol Related Deaths in Oregon



Alcohol is Heavily Advertised in Oregon Stores

Findings from the assessment reveal that from the moment customers approach a store to the time they pay at the register, they receive repeated messages to buy alcohol.



§ Price promotion assessment findings are limited to retailers that sold the specific alcohol product.

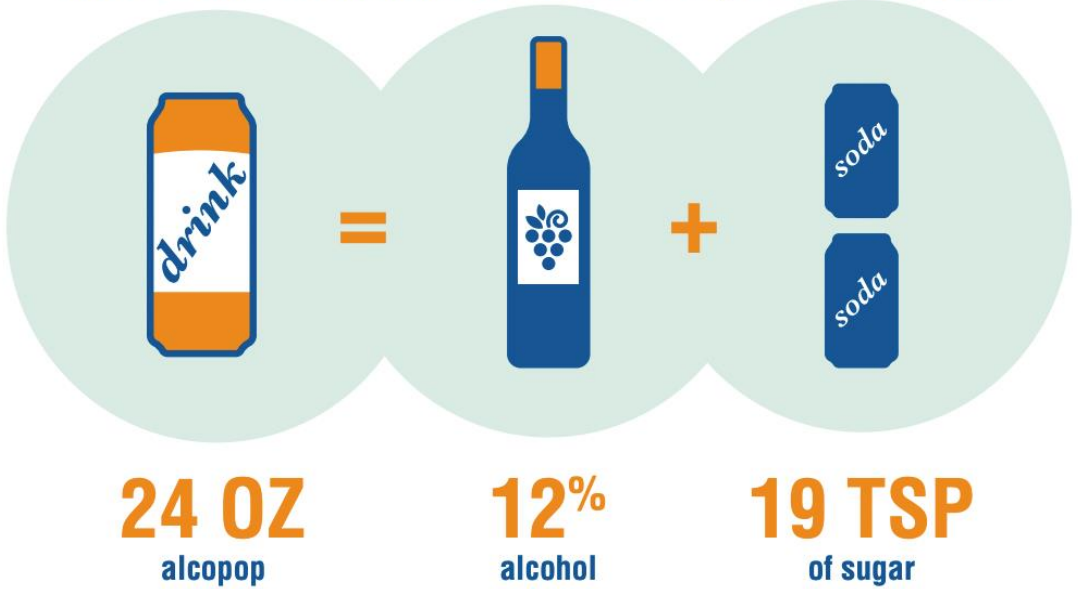
Targeted Alcohol Marketing

Flavored alcohol products that mask the harsh taste of alcohol, including flavored malt beverages, are widely available in retail stores.

The National Institute on Drug Abuse refers to flavored malt beverages as "alcopops" because they are sweet, carbonated drinks offered in a variety of fruit flavors.[20] These widely available drinks may appeal to youth and encourage youth to drink more. More than four out of five retailers in the assessment sold alcopops.

Malt liquor is another alcoholic beverage that masks higher alcohol content with a sweeter or neutral flavor. Malt liquor is heavily marketed to African American, Native American and Hispanic communities.[19]

A 24-ounce flavored malt beverage contains the same amount of alcohol as a bottle of wine and two times the amount of sugar as a can of soda.



Oregon Health Authority Public Health Division, Health Promotion and Chronic Disease Prevention Section. Shining Light on Alcohol Marketing in Oregon, 2020.

Case Example

Patient presents to your office for concerns for stomach pain, fatigue, and depression

Patient found to have blood pressure of 170/100

During your discussion, you find out that the patient is drinking 6-12 cans of beer per night

Based on your screening, you are concerned for unhealthy alcohol use

United States Preventative Services Task Force (USPSTF)

Recommendation Summary

Population	Recommendation	Grade
Adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.	B
Adolescents aged 12 to 17 years	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for alcohol use in primary care settings in adolescents aged 12 to 17 years. See the Clinical Considerations section for suggestions for practice regarding the I statement.	I

Single Answer Screening Questionnaire

Brief health screen

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

How many times in the past year have you had **4** or more drinks in a day? _____

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? _____

Mood:

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

McNeely, et al., 2015

Single Answer Screening Questionnaire

Full Questionnaire

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
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	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

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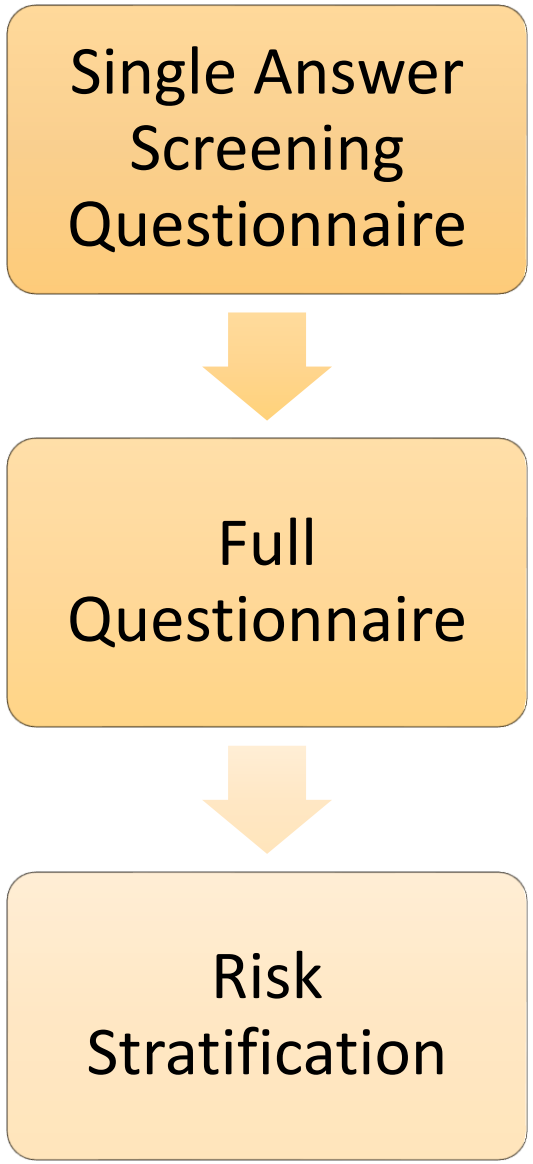


Flentje A, Barger BT, Capriotti MR, Lubensky ME, Tierney M, Obedin-Maliver J, et al. "Screening Gender Minority People for Harmful Alcohol Use." PLoS ONE. 15(4). 2020.

Scoring and interpreting the AUDIT:

Each answer receives a point ranging from 0 to 4. Points are added for a total score that correlates with a zone of use that can be circled on the bottom left corner of the page.

Note: Question #3 on this AUDIT asks about four or more drinks, reflecting the U.S. definition of a standardized drink.

Note: many factors are involved in determining how much alcohol impacts an individual's health. Determining the category of risk should be influenced by clinician judgment. The cut-off scores below are informed by validation studies, real-world experience of implementing the AUDIT into multiple primary care settings, and a gender-inclusive approach to patient care. However, they are offered for guidance only - clinics may choose different cut-off scores.

AUDIT score			
Women, gender minorities, all age ≥65	Men age <65	**Category of risk**	**Indicated action**
0 - 3	0 - 4	**I – Low risk** Low risk of health problems related to alcohol use.	Brief education
4 - 12	5 - 14	**II - Risky** Increased risk of health problems related to alcohol use.	Brief intervention
13 - 19	15 - 19	**III – Harmful** Increased risk of health problems related to alcohol use and a possible mild or moderate alcohol use disorder.	Brief intervention (offer options that include medications and referral to treatment)
20+	20+	**IV – Severe** Increased risk of health problems related to alcohol use and a possible moderate or severe alcohol use disorder.	

Brief education: Informing patients about low-risk consumption levels and the morbidity associated with risky alcohol use.

Brief intervention: Patient-centered discussion that employs Motivational Interviewing principles to raise a patient's awareness of their substance use and enhance their motivation to reduce harm from their use. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention.

If a patient is ready to accept treatment, a referral is a proactive process that facilitates access to specialized care for individuals likely experiencing a substance use disorder. These patients are referred to alcohol and drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. However, treatment also includes prescribing medications for substance use disorder as part of the patient's normal primary care.

More resources: www.sbirtoregon.org

Priorities for Improving Utilization of Clinical Preventive Services

Services (Short Name)	Description	CPB	CE	Total
Childhood immunization series	ACIP childhood immunization series[a]	5	5	10
Tobacco use, brief prevention counseling, youth	Provide interventions to prevent initiation, including education or brief counseling	5	5	10
Tobacco use screening and brief counseling, adults	Screen adults for tobacco use and provide brief cessation counseling and pharmacotherapy	5	5	10
Alcohol misuse screening and brief intervention	Screen adults' misuse and provide brief counseling to reduce alcohol use	3	5	8[b]
Aspirin chemoprevention for those at higher risk of CVD	Low-dose aspirin use for primary prevention of CVD in adults ages 50–59 y with ≤10%, 10-y CVD risk and other factors	3	5	8
Cervical cancer screening	Screen for cervical cancer in women aged 21 to 65 y with cytology (Papanicolaou smear) every 3 y	4	4	8
Colorectal cancer screening	Screen adults aged 50–75 y routinely	4	4	8[b]
Chlamydia and gonorrhea screening	Screen for chlamydia and gonorrhea in sexually active women aged ≤24 y, and in older women at increased risk for infection	3	4	7[b]
Cholesterol screening	Screen routinely for lipid disorders men aged >35 y, and screen younger men and women of all ages who are at increased risk of CHD. Treat with lipid-lowering medications	4	3	7
Hypertension screening	Measure blood pressure routinely in all adults and treat with antihypertensive medication to prevent the incidence of CVD	4	3	7
AAA screening	Screen men aged 65–75 y who have ever smoked 1 time for abdominal aortic aneurysm, using ultrasonography	2	4	6[b]
Healthy diet and physical activity counseling for those at higher risk of CVD	Offer or refer adults who are overweight or obese with additional CVD risk factors to intensive behavioral counseling to promote healthful diet and physical activity	5	1	6
HIV screening	Screen for HIV infection in adolescents and adults aged 15 to 65 y. Frequency varies by risk level	2	4	6[b]
HPV immunization	Administer a 3-dose series of HPV vaccine to all girls aged 11–12 y	3	3	6
Influenza immunization, adults	Immunize all adults against influenza annually	4	2	6[b]
Obesity screening, adults	Screen all adults routinely for obesity. Refer patients with a BMI of ≥30 kg/m^2 to intensive behavioral interventions	5	1	6[b]
Syphilis screening	Screen all persons at increased risk for syphilis infection	1	5	6
Vision screening, children	Screen children routinely between ages 3 and 5 y to detect amblyopia	2	4	6[b]

AAA = abdominal aortic aneurysm; ACIP = Advisory Committee on Immunization Practices; BMI = body mass index; CE = cost-effectiveness; CHD = coronary heart disease; CPB = clinically preventable burden; CV cardiovascular disease; HIV = human immunodeficiency virus; HPV = human papillomavirus; PCV13 = pneumococcal conjugate vaccine—13 pneumococcal serotypes; PPSV23 = pneumococcal polysaccharide vaccine—23 pneumococcal serotypes; Td = tetanus, diphtheria; Tdap = tetanus, diphtheria, and pertussis.

CPB = Clinical preventable burden

CE = Cost Effectiveness

Maciosek MV, et al. Updated Priorities Among Effective Clinical Preventive Services. Ann Fam Med. 2017 Jan;15(1):14-22. doi: 10.1370/afm.2017. Epub 2017 Jan 6. Erratum in: Ann Fam Med. 2017 Mar;15(2):104. PMID: 28376457; PMCID: PMC5217840.

How do you motivate an individual towards reducing their unhealthy alcohol use in a 20-minute office visit?

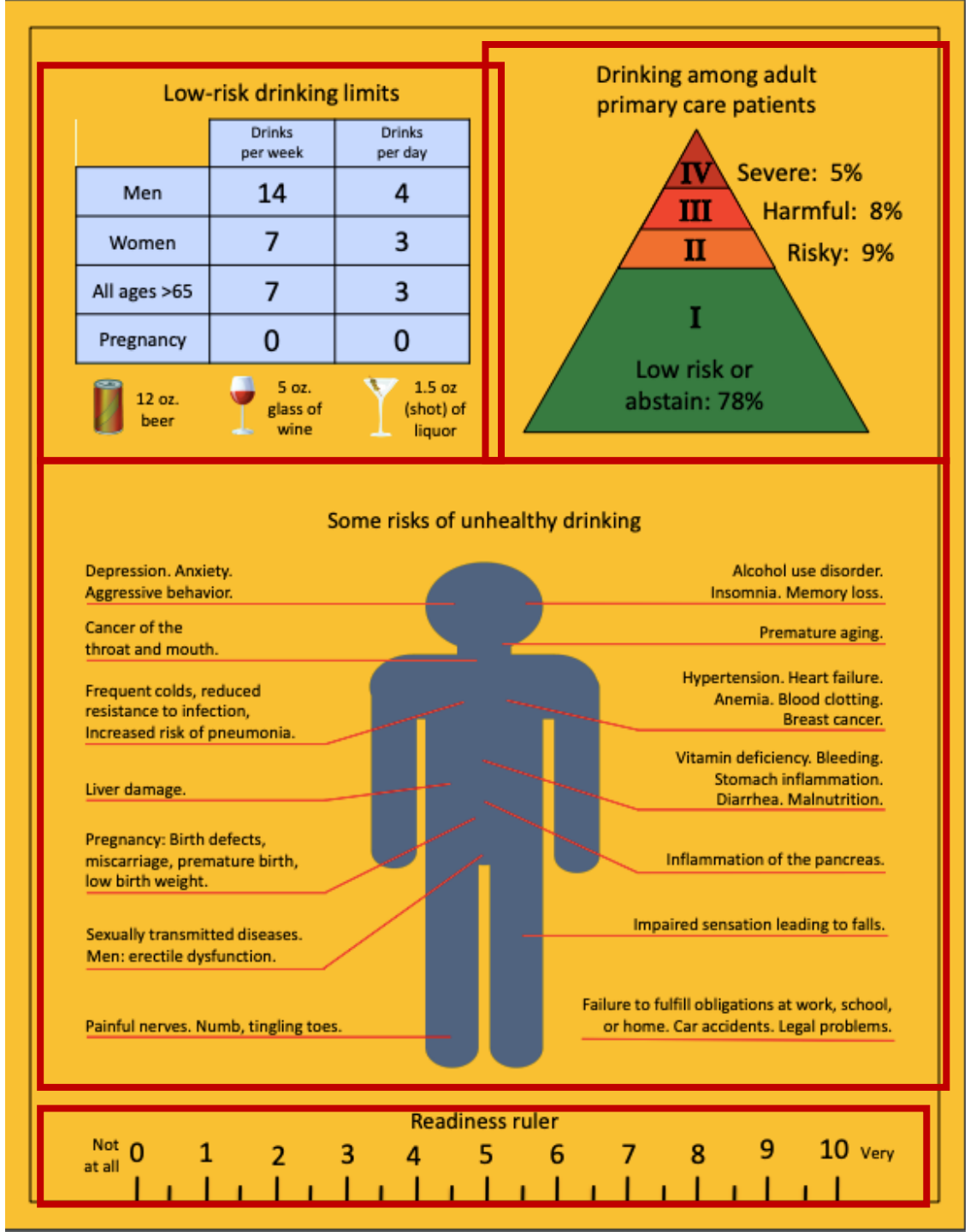


SBIRT (Screening, Brief Intervention, and Referral to Treatment)

Clinical framework to guide discussion around reducing unhealthy drinking, or identify dependence

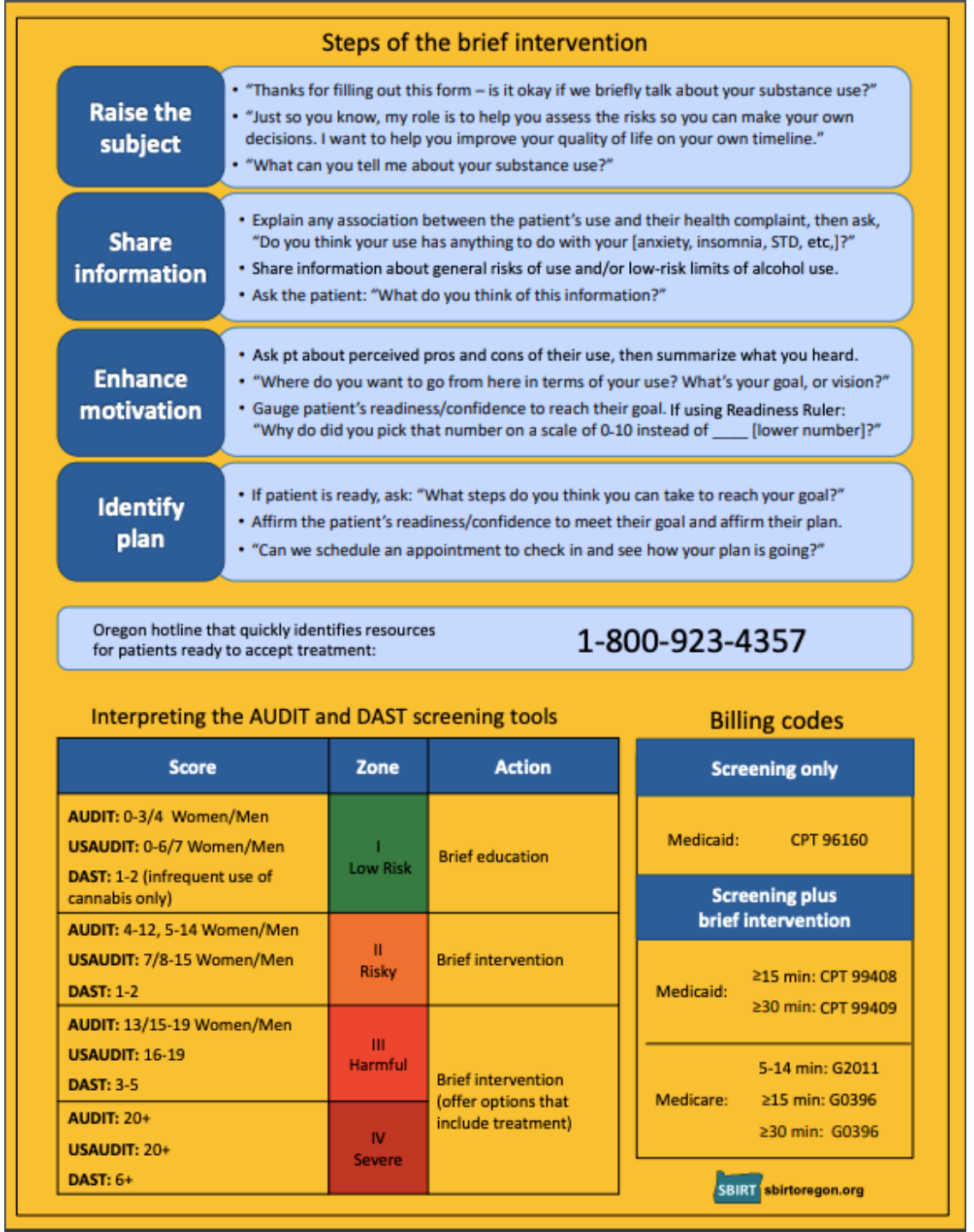
Allows clinician to provide objective consequences in non-judgmental manner

- Review recommendations for safe drinking limits
- Based on their total AUDIT score, can match their risk category
- Review the long-term sequelae of alcohol use
- Assess readiness to change with Readiness ruler



- Framework of phrases to help guide the brief intervention

- Prompts you for discussing next step in treatment



Steps of the brief intervention

Raise the subject

- "Thanks for filling out this form – is it okay if we briefly talk about your substance use?"
- "Just so you know, my role is to help you assess the risks so you can make your own decisions. I want to help you improve your quality of life on your own timeline."
- "What can you tell me about your substance use?"

Share information

- Explain any association between the patient's use and their health complaint, then ask, "Do you think your use has anything to do with your [anxiety, insomnia, STD, etc,]?"
- Share information about general risks of use and/or low-risk limits of alcohol use.
- Ask the patient: "What do you think of this information?"

Enhance motivation

- Ask pt about perceived pros and cons of their use, then summarize what you heard.
- "Where do you want to go from here in terms of your use? What's your goal, or vision?"
- Gauge patient's readiness/confidence to reach their goal. If using Readiness Ruler: "Why do did you pick that number on a scale of 0-10 instead of ____ [lower number]?"

Identify plan

- If patient is ready, ask: "What steps do you think you can take to reach your goal?"
- Affirm the patient's readiness/confidence to meet their goal and affirm their plan.
- "Can we schedule an appointment to check in and see how your plan is going?"

Oregon hotline that quickly identifies resources for patients ready to accept treatment: **1-800-923-4357**

Interpreting the AUDIT and DAST screening tools

Score	Zone	Action
AUDIT: 0-3/4 Women/Men **USAUDIT:** 0-6/7 Women/Men **DAST:** 1-2 (infrequent use of cannabis only)	I Low Risk	Brief education
AUDIT: 4-12, 5-14 Women/Men **USAUDIT:** 7/8-15 Women/Men **DAST:** 1-2	II Risky	Brief intervention
AUDIT: 13/15-19 Women/Men **USAUDIT:** 16-19 **DAST:** 3-5	III Harmful	Brief intervention (offer options that include treatment)
AUDIT: 20+ **USAUDIT:** 20+ **DAST:** 6+	IV Severe	

Billing codes

Screening only	
Medicaid:	CPT 96160
Screening plus brief intervention	
Medicaid:	≥15 min: CPT 99408 ≥30 min: CPT 99409
Medicare:	5-14 min: G2011 ≥15 min: G0396 ≥30 min: G0396

SBIRT sbirtoregon.org

Case Example

- Based on your screening, you explore motivations for change, and encourage the patient to consider starting medications

- The patient declined starting meds, desires to continue to drink

The Pre-Contemplative Patient

Focus on harm reduction and safer use strategies

Be prepared before you drink

- Take your meds, eat something, have a glass of water before your first drink of the day
- Let your friends and family know where you'll be drinking

The Pre-Contemplative Patient

Drink in safe places

- Avoid being overheated during the summer, or stay warm during the winter
- Drink with people you trust in case of emergencies

Track your drinks

- Hold on to the can pull-tabs
- Mark your bottles or pour out specific amounts

Cutting back

- See how much you're drinking on average, and can consider making a goal to drink less per day

The Pre-Contemplative Patient

Mixing and diluting your drinks

- Pre-mix with juice or soda to dilute the alcohol

Hydrate well before and after each drink

Counting your drinks

Alcohol comes in different strengths and different container sizes. This can make it hard to figure out which products have more or less alcohol overall. Knowing the number of standard drinks can help you compare different products and track how much alcohol you are drinking.

University of Victoria
Canadian Institute for Substance Use Research

Beer

8% 355 mL can
= 1.5 standard drinks

5.5% 473 mL can (tallboy)
= 1.5 standard drinks

7% 473 mL can (tallboy)
= 2 standard drinks

Wine

12.5% 750mL bottle
= 5.5 standard drinks

14% 750mL bottle
= 6 standard drinks

Hard liquor

40% 375mL bottle (mickey)
= 9 standard drinks

40% 750mL bottle (26-er)
= 17.5 standard drinks

45% 375mL bottle (mickey)
= 10 standard drinks

Sherry (fortified wine)

18% 750mL bottle
= 8 standard drinks

20% 750mL bottle
= 9 standard drinks

cmaps.ca

drinkcalculator.cisur.ca

Counting your drinks

The following sources of alcohol often include ingredients that are not meant for consumption and can cause serious extra harm to your body.

University of Victoria
Canadian Institute for Substance Use Research

Hand sanitizer

240mL bottle (70%)
= 9 standard drinks

350mL bottle (70%)
= 13 standard drinks

1L bottle (70%)
= 36 standard drinks

Mouthwash

250mL bottle (27%)
= 4 standard drinks

500mL bottle (27%)
= 8 standard drinks

1L bottle (27%)
= 16 standard drinks

Rubbing alcohol

500mL bottle (70%)
= 20.5 standard drinks

500mL bottle (91%)
= 26.5 standard drinks

Warning

The alcohol in rubbing alcohol (isopropyl) is not the same as the alcohol in beverage alcohol (ethanol) and can cause serious harm to your body and death.

cmaps.ca

drinkcalculator.cisur.ca

Case example

The patient comes back in 2 weeks, and is still drinking the same amount as prior

Open to idea of trying medications

Reports has a history of requiring hospitalizations for alcohol withdrawal, but absolutely wants to avoid hospitalization this time around

Has started to meet with behavioral health for support

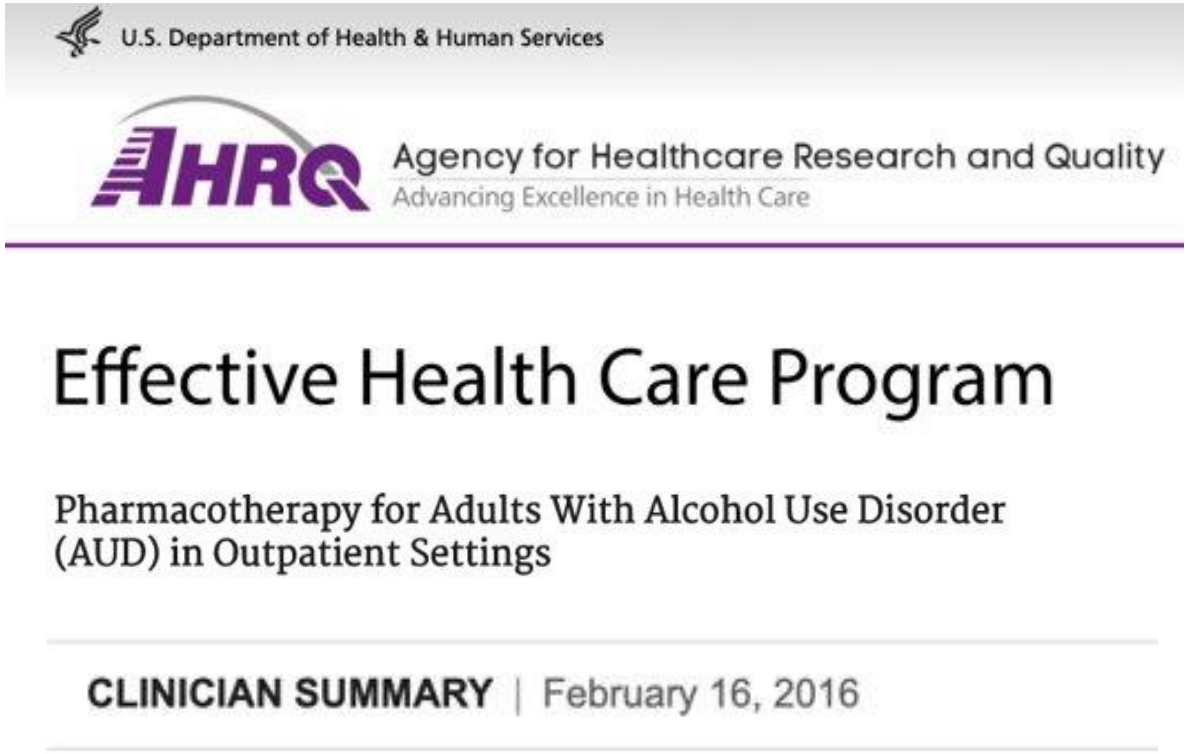
Central City Concern

AUD- medications and ambulatory withdrawal

Amanda Risser, MD MPH- Addiction Medicine, Family Medicine
Sr. Med. Dir. of SUD Services, Central City Concern

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

Good guidelines exist: AHRQ, VA



Access AHRQ HERE
Access VA guidelines HERE

Table 3: Mechanism of Action of Medications Used in the Treatment of AUD and Their Adverse Effects

Medication	Adult Dosing	Mechanism of Action	Common Adverse Effects	Contraindications
Acamprosate	Oral: 666 mg (two 333-mg tablets) 3 times per day	Modulates hyperactive glutamatergic n-methyl-d-aspartate receptors	• Anxiety • Diarrhea • Vomiting	Severe renal impairment[a]
Naltrexone	• Oral: 50 to 100 mg per day • Intramuscular: 380 mg per month	• Opioid antagonist that competitively binds to opioid receptors and blocks the effects of endogenous opioids such as β-endorphin • Decreases the craving for alcohol	• Dizziness • Nausea • Vomiting	• Liver failure • Acute hepatitis and precautions for other hepatic disease
Disulfiram	Oral: 250 to 500 mg per day	• Expectation or experience of an adverse response to alcohol consumption • Inhibits ALDH2, causing accumulation of acetaldehyde during alcohol consumption, which, in turn, produces various adverse effects such as nausea, dizziness, flushing, and changes in heart rate and blood pressure	• Drowsiness • Metallic or garlic taste in mouth	• Severe myocardial diseases • Psychoses • Liver failure • Hypersensitivity to thiuram derivatives
Topiramate[b,c]	Oral: 25 to 400 mg per day	Blocks voltage-dependent sodium channels, augments the activity of the neurotransmitter γ-aminobutyrate, antagonizes certain subtypes of the glutamate receptor, and inhibits the carbonic anhydrase enzyme	• Paresthesia • Anorexia • Dizziness • Somnolence • Psychomotor slowing • Abnormal vision • Fever	None

[a]Dose adjustment for moderate renal impairment.
[b]This medication has not been approved by the FDA for the treatment of alcohol dependence, alcohol abuse, or AUD.
[c]The prescribing information sheet for topiramate lists warnings for several serious adverse effects. These include warnings for acute myopia and secondary angle closure glaucoma, suicidal behavior and ideation, and fetal toxicity. Clinicians are advised to refer to the prescribing information sheet for additional information on adverse effects.
ALDH2 = aldehyde dehydrogenase 2

NNT for Alcohol Use Disorder (AUD)

condition	treatment	Outcome you want to prevent:	NNT
High blood pressure when you have diabetes	Blood pressure mediction s	Death in next 10 years.	15
Clot in leg	Warfarin X 1 year	Clot in lung	22
High cholesterol	Statin	Death in one year	163
Nonfatal opioid OD	methadone or buprenorphine	Death in one year	< 3
Heart attack	Aspirin	Death over next 30 d	25
AUD	**Acamprosate**	**Return to any drinking**	**12**
AUD	**Naltrexone**	**Return to any drinking**	**20**
AUD	**Naltrexone**	**Return to HEAVY drinking**	**12**

Can I manage alcohol withdrawal for outpatients?

The ASAM
CLINICAL PRACTICE GUIDELINE ON
Alcohol Withdrawal Management

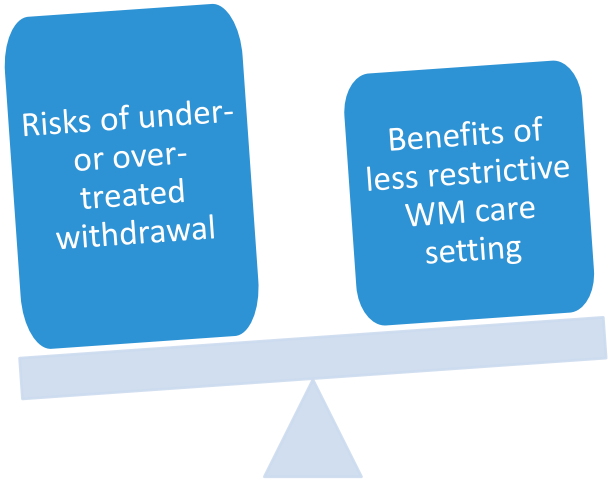
Alvanzo, A., Kleinschmidt, K., Kmiec, J.,
Kolodner, G., Marti, G., Milio, L., Murphy, W.,
Tirado, C., Waller, C., Nelson, L.

These slides prepared by:
David Lawrence MD
OHSU DGIMG, Section of Addiction Medicine
Assoc. Medical Director, Hooper DSC, Central City Concern

Who isn't appropriate for ambulatory WM?

Pattern of use

- 17+ daily standard drinks
- Concurrent benzodiazepine dependence or withdrawal



Recovery capital

- Unable to obtain transportation or housing
- Family/friends not supportive of WM process
- Low level of cooperation, reliability, or commitment
- Significant risk of imminent return to use

Current & Historic Withdrawal severity

- Severe withdrawal
- Withdrawal seizure or delirium in past year

Comorbid medical issues

- Active or potentially destabilizing medical or psychiatric problem
- Cognitive impairment
- Suspected head injury
- Unable to take oral medication
- Pregnancy
- Other inpatient indication

Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence. NICE. 2011.

What support and follow up is needed?

Supportive care instructions including:

- Followup schedule
- Symptoms to expect, how to monitor them, when to seek on-call care
- Creation of a low-stimulation, reassuring environment
- Hydration with non-caffeinated drinks
- Multivitamin, thiamine
- WM medication administration instructions

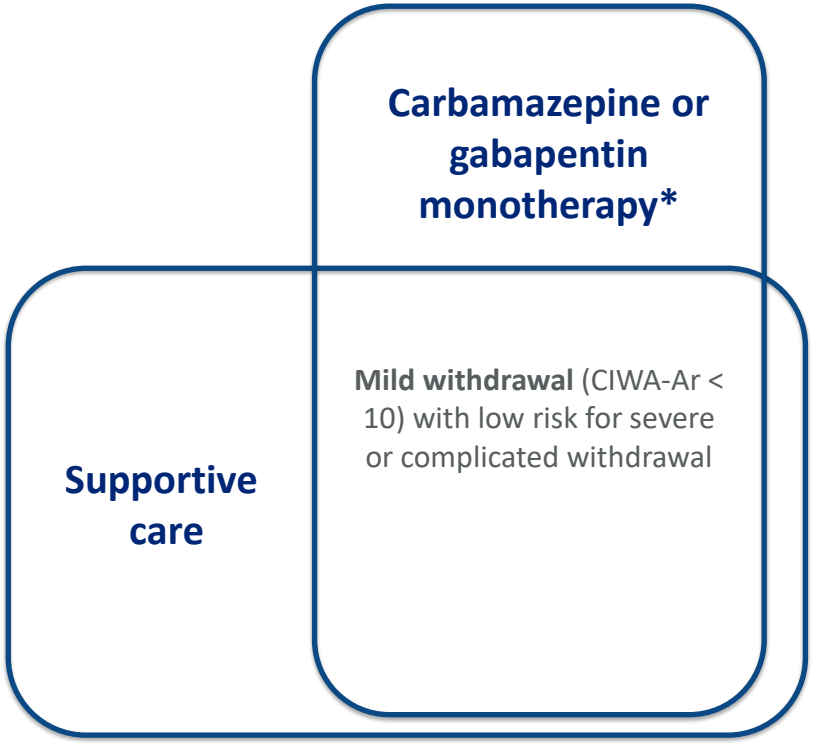
Treatment of alcohol use disorder:

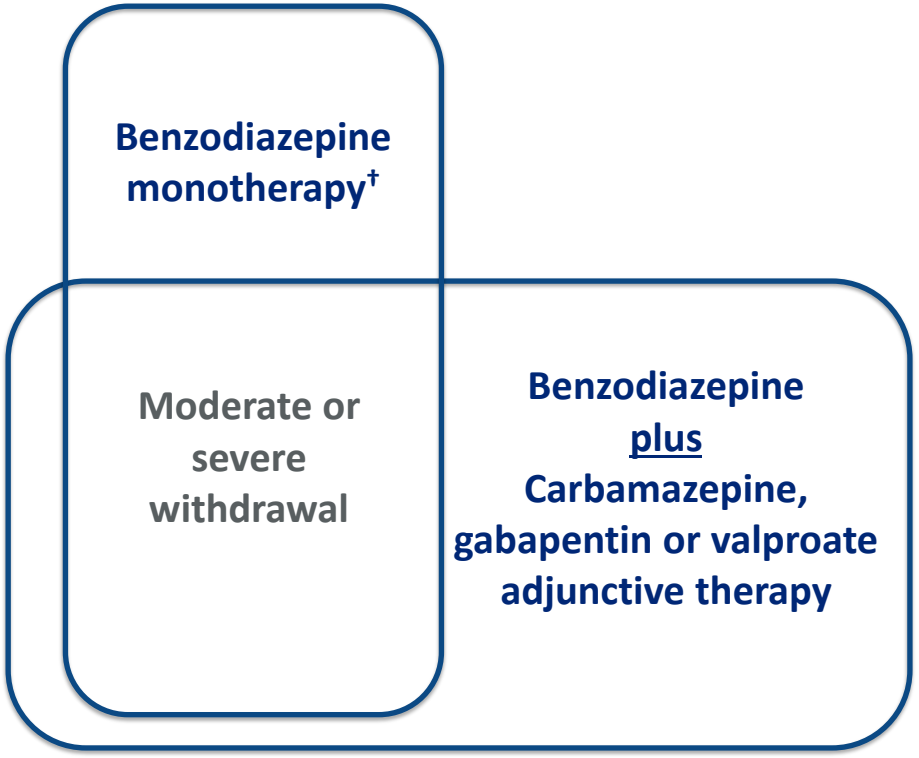
- Naltrexone, acamprosate, gabapentin, disulfuram
- SUDs treatment resources
- Mutual support resources

Daily in-person (may alternate with virtual) monitoring (x5 days) should include:

- General condition, vitals, hydration, orientation, sleep and emotional status, substance use
- Blood alcohol concentration (if available)
- Objective withdrawal scale assessment (e.g. CIWA, SAWS)
- Indications for higher level of care:
    - Severe and un-resolving tremor despite multiple doses of medication
    - Persistent vomiting, hallucinations, confusion, seizure, agitation
    - Worsening underlying medical or psychiatric conditions
    - Over-sedation
    - Return to alcohol use
    - Syncope or unstable BP or HR

Which WM medication to offer?





*If risk for worsening withdrawal while away from the treatment setting, benzodiazepine monotherapy also appropriate

† If BZD contraindicated, CBZ or GABA monotherapy are appropriate alternatives

- **Generally, protocols follow a 4-6 day dose taper schedule**

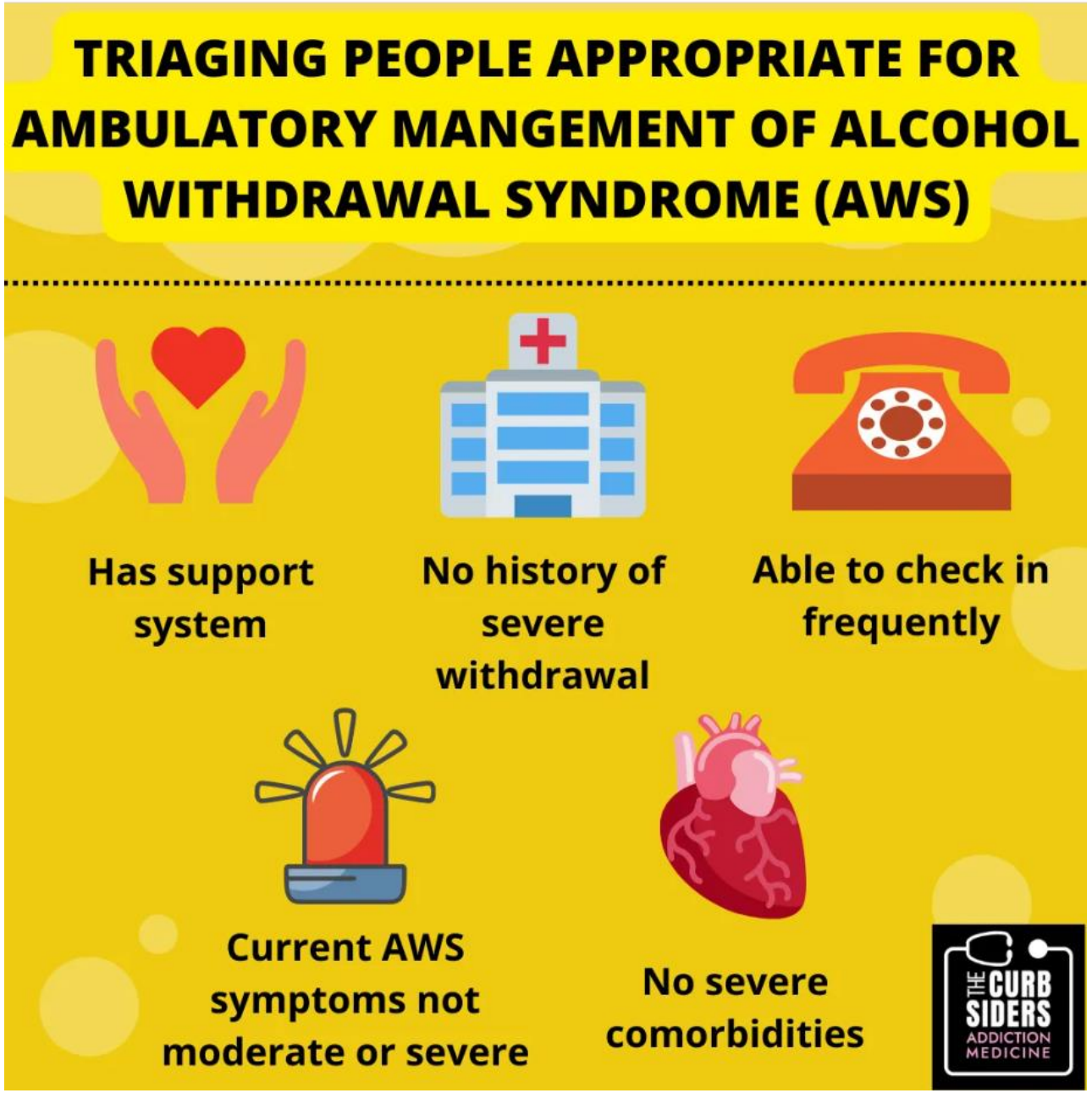
Check out Curbsiders!

ADDICTION MEDICINE PODCAST

#2 Get in the Spirit of Ambulatory Alcohol Withdrawal

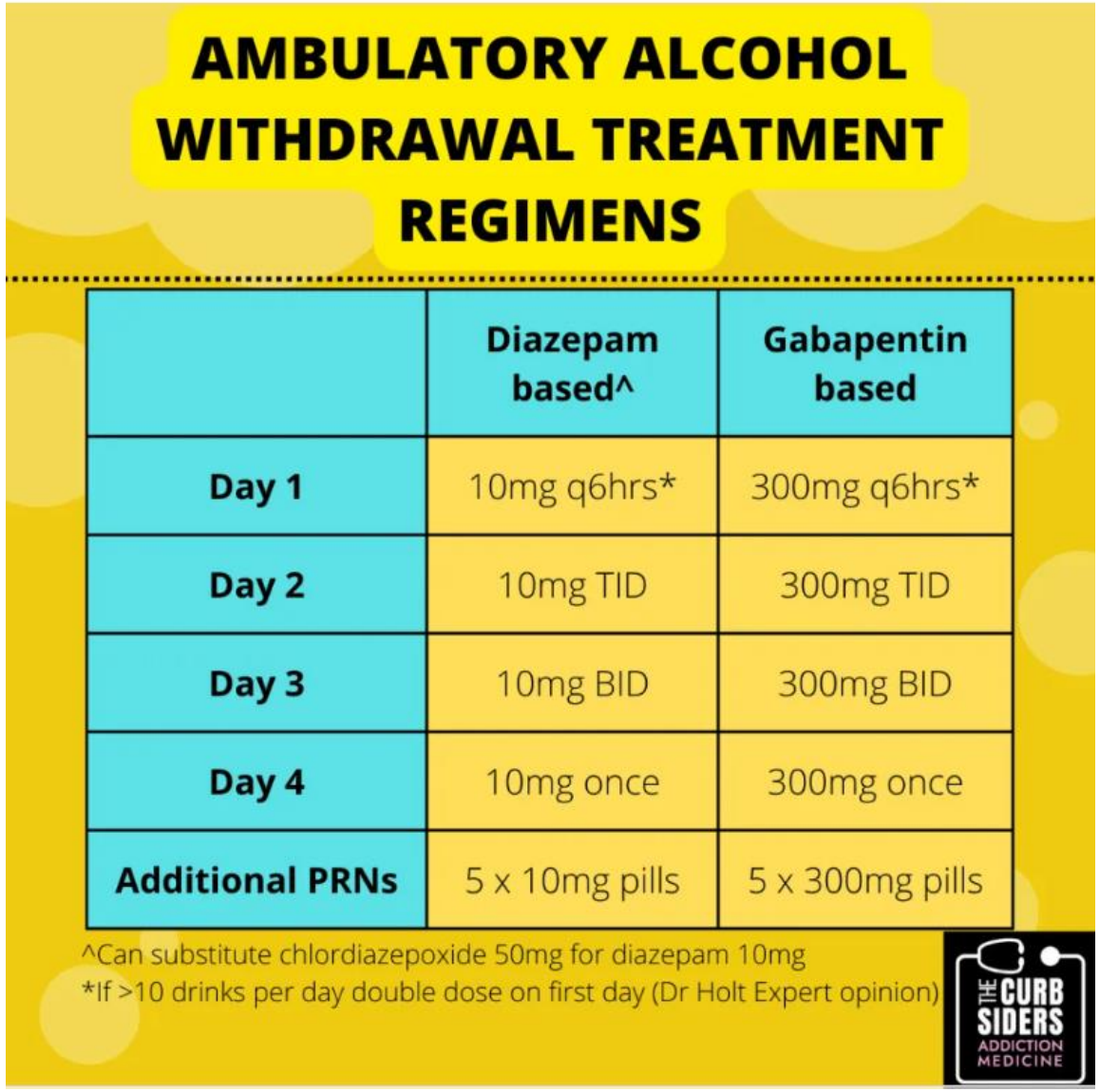
July 14, 2022 | By Shawn Cohen

Access HERE.



A simpler taper protocol:

- 4/3/2/1
- The Curbsider expert will work on ambulatory treatment for folks drinking more than we generally do but stressed social support and baseline withdrawal.



Case example

Patient tries a diazepam taper, and then also uses acamprosate for 4 weeks

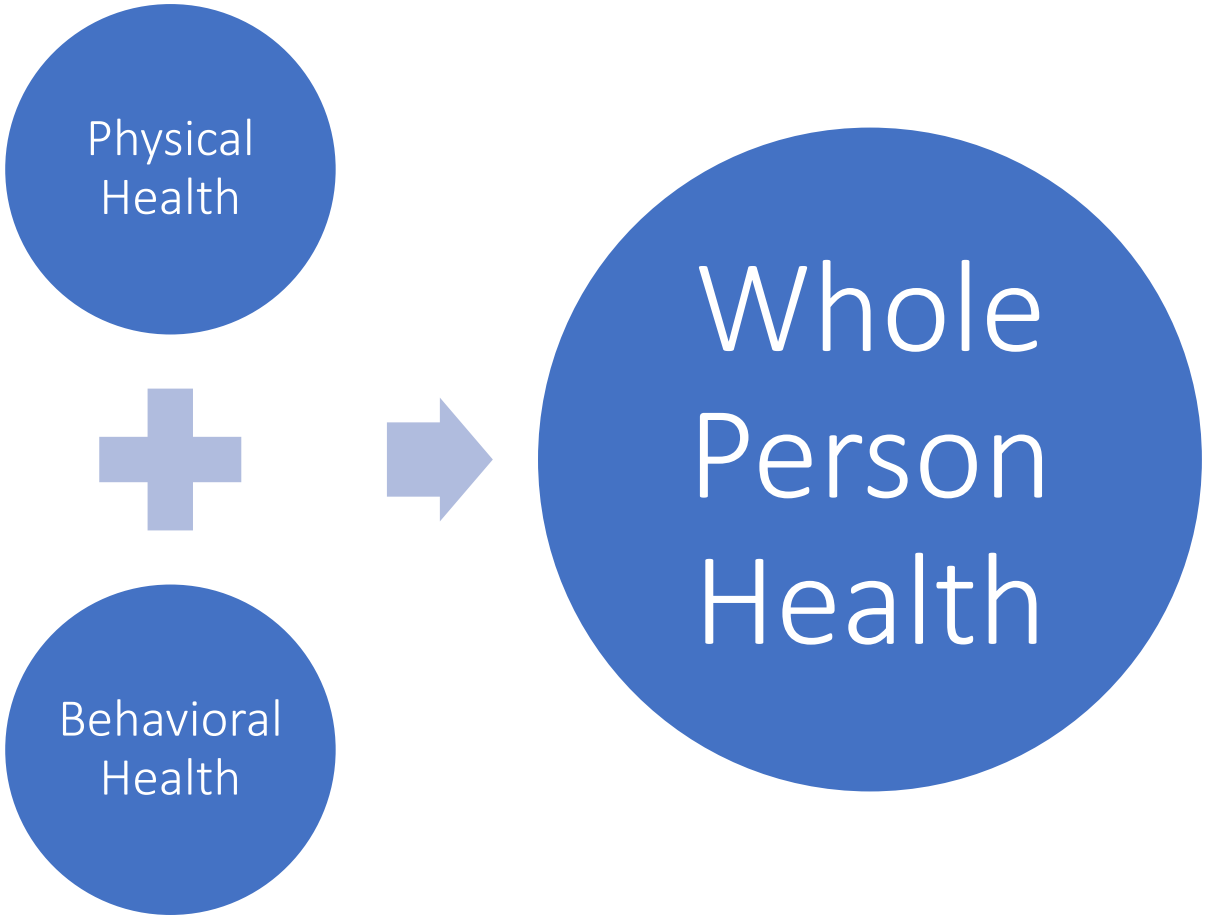
Unfortunately, unable to stop drinking completely

Further complicated by subsequently receiving a DUI, and loses their job from missing so much time off work

Comes back motivated to stop drinking

Patient desires to go to detox

An Integrated Health Approach to AUD Care



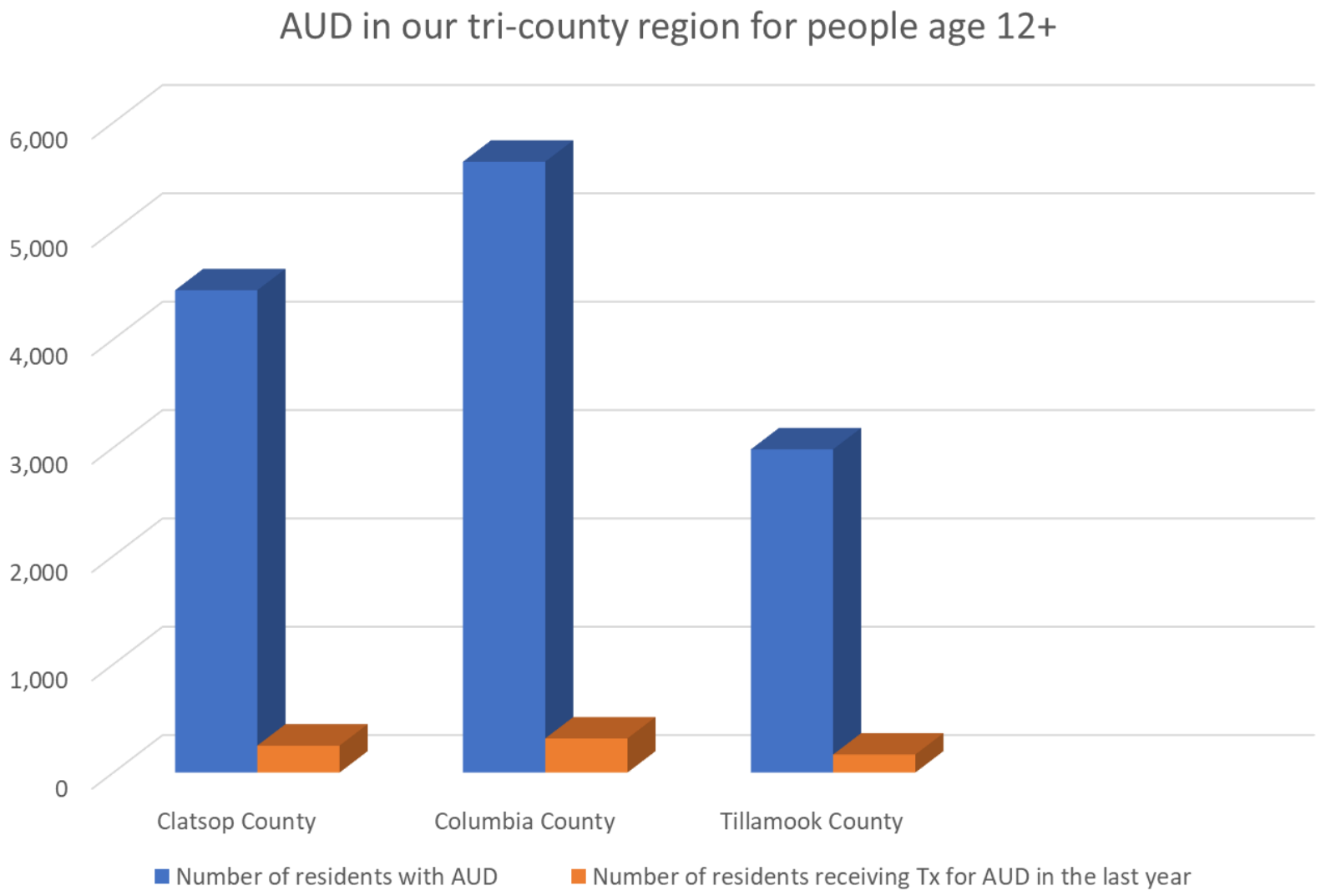
Case example

- Goes to detox and transitioned to residential facility
- Started on Vivitrol (naltrexone) injection

- After discharge from residential, returned to using alcohol 2 weeks afterwards

- However, patient has found engaging with BHC weekly for support beneficial towards staying motivated

Oregon Substance Use Disorder Services Inventory and Gap Analysis



An Integrated Health Approach to AUD Care

- Primary Care is often the first line of intervention
- Medications can be helpful
- Change is complicated and different for everyone
- People go and stay where they feel wanted and understood
- An early sense of *working together* improves retention
- More than any other factor, the perceived quality of the therapeutic alliance is predictive of positive outcomes

Role of the BH Provider

Engagement

Engagement

Engagement

Engagement

Engagement

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Resisting the Righting Reflex

“The opposite of addiction is not sobriety. The opposite of addiction is connection” - Johann Hari

Getting upstream: Audience discussion

How do we create meaningful opportunities for people so that alcohol and drug use aren’t valid options for people in the first place?

Summary

- Screening for unhealthy alcohol use can be simple, cost effective, and begin the conversations to motivate individuals to reduce their use
- Focus on naltrexone and acamprosate as 1st line therapies for AUD
- Consider outpatient alcohol withdrawal management if patient is more mild to moderate risk
- Integrated behavioral health care can enhance therapeutic alliance, and increase engagement retention

Thank you!

Questions?

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