Dartmouth-Hitchcock KNOWLEDGE MAP™

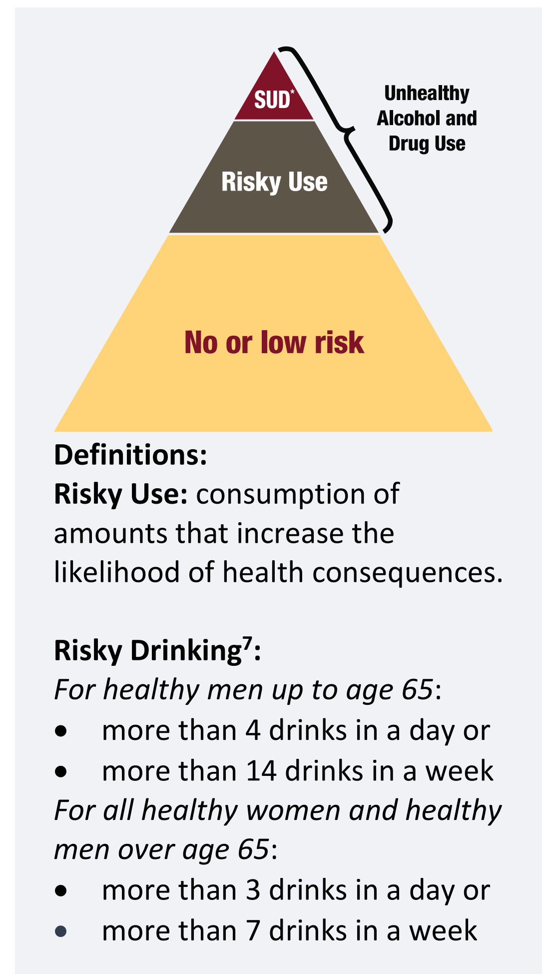
Unhealthy Alcohol and Drug Use

Clinician Guide

Introduction

Substance use, including alcohol and other drug use, occurs on a continuum from no use or low risk use to risky use to substance use disorders (SUDs). Risky use and SUDs exact an enormous toll on individuals, families, and communities. The number of Americans with an SUD is comparable to the number diagnosed with diabetes and 1.5 times the prevalence of all cancers combined.[1,2] This doesn't include the millions using substances in an unhealthy way who are at greater risk of harm to themselves and others, and are at risk of progressing to a SUD. Despite the scale of the problem, these health conditions receive less research investment, coverage in clinical training, and clinical attention than do other chronic illnesses.

Addiction is a chronic disease of the brain affecting the reward system, learning, decision making, and self-control- not simply a choice or personal failing.[3] These changes help explain why individuals with addiction are unable to stop using drugs or alcohol despite negative consequences, and why the risk of relapse persists long after discontinuing use. As with other chronic relapsing medical conditions, evidence-based treatment (both medication and counseling) is effective in managing the symptoms of SUDs and reducing risk of relapse- yet only 1 in 10 people with a SUD receive treatment.[4] Reasons for this treatment gap include limited access to care, shame or stigma, and lack of recognition by clinicians. Integrating SUD treatment into primary care is key to addressing this gap. With support from the Collaborative Care Model [5] (behavioral health clinician (BHC) and consulting psychiatrist), primary care clinicians can treat SUDs in an integrated approach with the mental and physical health issues that commonly co-occur with them. Complex patients can be referred to specialists using a chronic care model coordinated with primary care. Screening can identify risky use and mild SUD, where brief intervention and follow-up are effective in reducing risk and progression.



Definitions:

Risky Use: consumption of amounts that increase the likelihood of health consequences.

Risky Drinking[7]:

For healthy men up to age 65:

- more than 4 drinks in a day or
- more than 14 drinks in a week

For all healthy women and healthy men over age 65:

- more than 3 drinks in a day or
- more than 7 drinks in a week

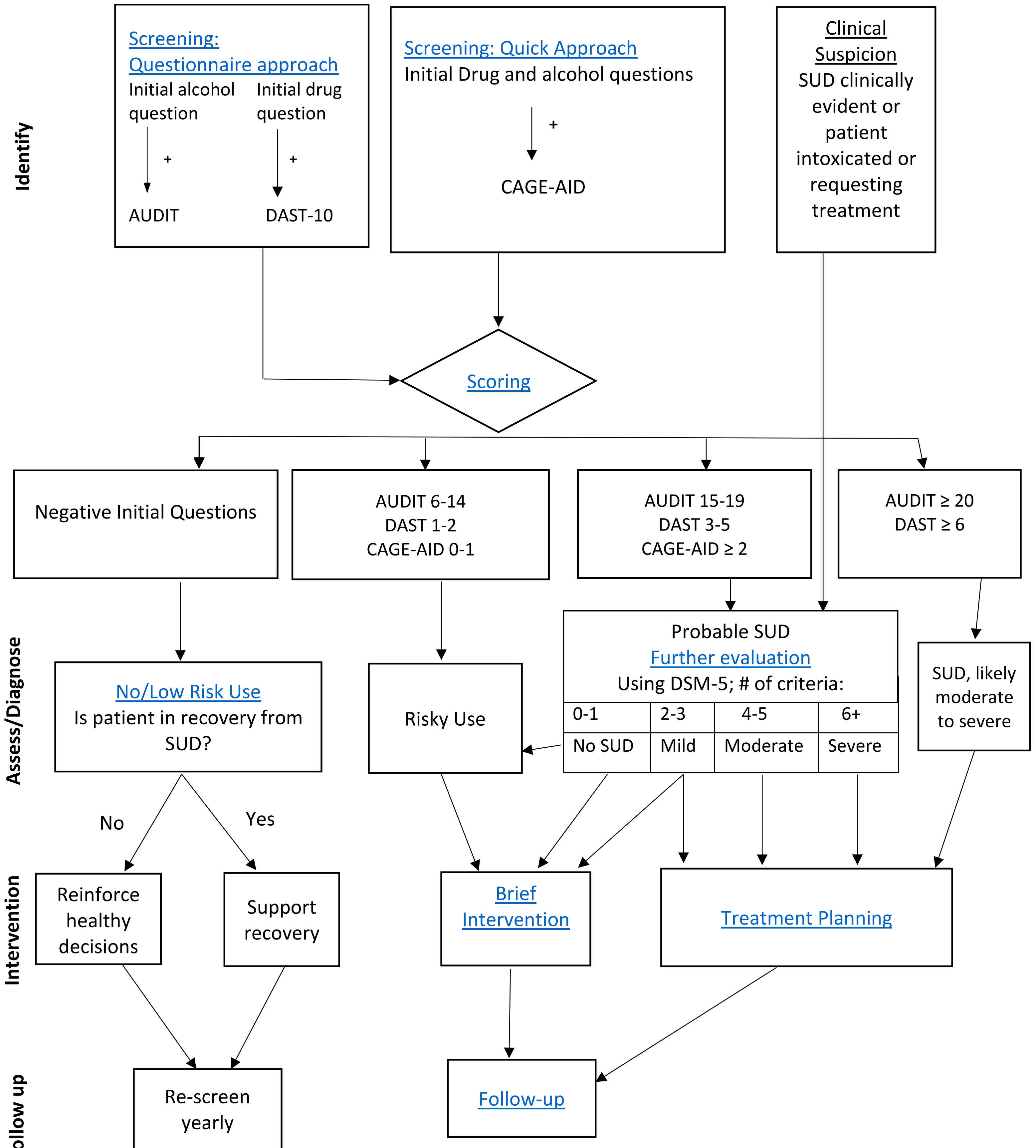
This document summarizes a primary care approach to the detection and management of risky alcohol and drug use and SUDs. Its content is built into the eDH unhealthy drug and alcohol use smartsets. It is meant to be a brief overview, and the reader is referred to the source documents for further details:

MA-SBIRT (Massachusetts Screening, Brief Intervention and Referral to Treatment) Clinician's Toolkit[6]

Helping Patients Who Drink Too Much: A Clinician's Guide[7]

Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health[8]

Algorithm: Recognizing and Managing Alcohol and Substance Use Disorders in Primary Care



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Patient Identification

Heavy alcohol or drug use or an SUD may be suspected based on patient presentation (signs of intoxication or medical, psychological, social, or occupational consequences of substance use) or a patient requesting treatment. A potential SUD should also be investigated in patients prescribed controlled substances if there are:

- Multiple controlled substances or multiple prescribers, which may be identified through the Prescription Drug Monitoring System (PDMP)
- Discordant results on urine toxicology testing
- Taking or craving more drug than prescribed or difficulty controlling use (including requests for early refills or reporting lost medications)
- High opioid dosage (>50 mg morphine/day or equivalent (30 mg oxycodone))
- Depression, Anxiety, PTSD or history of SUD[9]

Because SUDs often go unrecognized, screening is recommended. We recommend 2 strategies (questionnaire and screening approach, below):

Screening: Questionnaire Approach (preferred)

Electronic questionnaires are administered yearly through myDH or tablets. Positive responses to initial questions (see below in Quick Approach) trigger more in-depth (10 question) surveys: AUDIT for alcohol and DAST for other substance use. AUDIT score≥6 or DAST≥1 will trigger best practice advisories in eDH that include the patient's score and clinical interpretation. BPAs link to smartsets which provide decision support and resources.

Screening: Quick Approach- an easy to memorize approach when questionnaires aren't used

Ask about alcohol and drug use:

- Do you sometimes drink beer, wine or other alcoholic beverages? If yes, how many times in the past year have you had 5 or more drinks (4 or more for all women or men over 65) in a day? (one drink=12oz beer, 5oz wine or 1.5 oz spirits).
- How many times in the past year have you used marijuana or an illegal drug or used a prescription medication for non-medical reasons?

If one or more to either question, use the CAGE-AID (CAGE-Adapted to Include Drugs) to assess for risk of SUD

- ☐ Have you ever felt that you ought to **Cut Down** on your drinking or drug use?
- ☐ Have people **Annoyed** you by criticizing your drinking or drug use?
- ☐ Have you ever felt bad or **Guilty** about your drinking or drug use?
- ☐ Have you ever had a drink or used drugs first thing in the morning **(Eye-Opener)** to steady your nerves or get rid of a hangover?

Score one point for each positive response.

<u>Scoring of Screening Instruments:</u> Results determine next steps (below)

- Negative Initial Questions →No/Low Risk→Reinforce healthy decisions/support recovery
- AUDIT ≤14, DAST ≤ 2, CAGE-AID ≤ 1→Risky Use→Brief Intervention
- AUDIT 15-19, DAST 3-5, CAGE-AID≥2→Probable SUD→Further evaluation/Offer treatment
- AUDIT≥20, DAST≥6→ SUD, probably moderate to severe→Encourage treatment

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Further Evaluation: Assessment for a Substance Use Disorder Using DSM-5

DSM-5 defines SUD as meeting 2 or more of the adapted criteria below.

- ☐ Taking substance more or longer than intended
- ☐ Inability to cut down or stop
- ☐ Spending a lot of time getting/using/recovering
- ☐ Cravings and urges
- ☐ Not meeting responsibilities at home, work, school
- ☐ Continued use despite causing problems in relationships
- ☐ Giving up important social, occupational, recreational activities
- ☐ Recurrent use leading to danger
- ☐ Continued use when causing or worsening a physical or psychological problem
- ☐ Tolerance (needing more to get same effect)
- ☐ Withdrawal symptoms relieved by taking more

Number of criteria:	0-1	2-3	4-5	6+
Interpretation:	No SUD	Mild SUD	Moderate SUD	Severe SUD

Interventions

No/Low Risk

For alcohol, advise staying within the healthy drinking limits (4 or less/day and 14 or less/week for men<65, 3 or less/day and 7 or less/week for women or men>65). Recommend lower limits or abstinence if the patient has a health condition exacerbated by alcohol or takes medications that interact with alcohol. Advise against drinking during pregnancy.

If the patient is in recovery from past SUD: congratulate them, ask how long they have been in recovery, ask whether they attend support groups or need counseling/support.

Brief Intervention (BI) for Risky Substance Use

A BI is a conversation with a patient using education and motivational interviewing techniques (see p. 22-25 MA-SBIRT) to enhance a patient's motivation to change their substance use. For risky use or mild SUD, the goal is to reduce (to healthy drinking limits) or eliminate use (for illicit drugs, or consequences from or inability to cut down on alcohol). The Brief Negotiated Interview approach is summarized here. The NIAAA Clinician's Guide uses a more directive approach.

BI Steps (see p 9-10 and 20-21 MA-SBIRT and these videos for more detail)

1. Raise the Subject
   - Ask permission to discuss the patient's questionnaire results/drinking/drug use
2. Provide feedback- avoiding judgement and labels
   - Share AUDIT/DAST/CAGE-AID scores and responses, expressing concern
   - Ask patient about use and any negative consequences
   - Explore possible connections to health and social problems (review list on pamphlet)
   - Ask about perceived benefits of alcohol/drug use; is the patient enjoying the effect, or using to escape or self-medicate?
   - Use reflective listening; summarize and restate in patient's own words
   - Offer clear advice to cut back (e.g. reviewing healthy drinking limits) or eliminate use
3. Enhance motivation
   - Ask readiness (and perhaps importance and confidence) for making changes, using 0-10 scale
   - Elicit other reasons for changing

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4. Negotiate a plan
   - Ask what the patient is ready to do now- negotiate a goal
   - Identify strengths and supports, offer resources
   - Provide patient information (hard copy, or add to after visit summary (AVS) from smartset)
   - Thank patient, negotiate follow-up

Treatment Planning for Substance Use Disorder

For patients with a SUD, the communication techniques of the BI are used to motivate patients to both eliminate use and seek further help. The treatment plan depends on severity of SUD, comorbidities, social context, resources, clinician judgment and patient preference. Many patients can be managed in primary care with medications, counseling, self-management tools, mutual support groups, and frequent follow-up with the PCP and BHC. Consider referral for additional evaluation and treatment by an addiction specialist or program for more complex patients and those not responding to initial approaches. A minority of patients may require medically managed withdrawal (detoxification) from alcohol (those with current or past significant or bothersome withdrawal symptoms). Many patients can have withdrawal managed with chlordiazepoxide or gabapentin as an outpatient if they can be supervised by a friend or family, with close follow-up. Patients with severe symptoms, past withdrawal seizures or DTs, comorbidities, pregnancy, or lack or social support should be treated inpatient.

Treatment Options

- Medications to Reduce Craving and Relapse for Alcohol should be offered in mod-severe AUD
  - Naltrexone (po or Vivitrol monthly injection)- first line anti-craving agent. Can also be used by patients with mild or no AUD wanting help reducing use, including as needed dosing before going out drinking (the “Sinclair Method”[10,11]).
  - Acamprosate- consider this or gabapentin for patients with ongoing anxiety, insomnia, irritability/protracted abstinence syndrome
  - Disulfiram- an aversive agent that should only be used in young, healthy, highly motivated patients- ideally under supervision
  - Non FDA approved: gabapentin and others
  - Acamprosate or gabapentin can have additive benefit when combined with naltrexone
- Medications to Reduce Craving and Relapse for Opiates should be strongly recommended
  - Buprenorphine: can be prescribed by PCP with a waiver (free online training). See the DH guideline “Primary Care Based Treatment of OUD”
  - Methadone: requires a licensed program
  - Naltrexone (Vivitrol form): for highly motivated patients and/or supervised settings, after achieving abstinence from opioids
- Primary Care based Counseling by PCP and BHC. “Medication Management Counseling”:
  - Ask about alcohol/substance use and/or craving- are they meeting their goals?
  - Ask about medication adherence, side effects (if on med)
  - Ask about mutual support or other counseling attendance, and facilitate involvement
  - Help pts to recognize and cope with relapse precipitants and craving
  - Advise pts to develop a plan to manage early relapse
  - Facilitate positive lifestyle changes
  - Manage depression, anxiety and other comorbidities
  - Consider monitoring with urine ethyl glucuronide (for alcohol) or urine drug testing

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- Patient Self-Management Resources and Mutual Help Groups (AA, NA, Smart Recovery)
- Specialty Treatment
  - Outpatient: individual and group counseling, family therapy
  - Intensive Outpatient Programs
  - Inpatient/Residential
- Harm Reduction
  - Provide patients who have OUD with naloxone (e.g. Narcan nasal spray)
  - Teach patients who inject drugs how to prevent infections
    - Infection prevention hand out (CDC)
    - Refer to a Syringe Service Program (aka needle exchange)

Follow-up/Relapse Prevention

Regular follow-up and a supportive patient-physician relationship can be therapeutic, and brief interventions are more effective when done iteratively over time. Check in about substance use or recovery at each visit. Was the patient able to meet and sustain their goal?

Yes:

- Reinforce and support continued success
- Encourage patient to return if they lapse from their goal
- For **Risky Use**: renegotiate drinking goals as indicated, rescreen annually
- For **SUD**: medical management counseling, above

No:

- Acknowledge that change is difficult
- Support positive change and address barriers
- Relate substance use to medical or other problems as appropriate
- Consider engaging significant others
- Renegotiate the goal and plan:
  - **Risky Use**: consider a 2-week trial of abstinence, reassess the diagnosis (inability to cut down or stop is one of the DSM-5 criteria)
  - **SUD**: See relapse as a “learning experience” (what was the relapse trigger? How can it be avoided in the future?). Consider more intensive interventions and address coexisting medical and psychiatric disorders

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Appendices

Appendix 1: Medication Assisted Treatment for Alcohol (FDA approved)

(see NIAAA Guide p13-23 for details)

	Naltrexone (Depade®, ReVia®)	**Extended Release Injectable Naltrexone** (Vivitrol®)	**Acamprosate** (Campral®)	**Disulfiram** (Antabuse®)
Action	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking.	Same as oral naltrexone, 30–day duration.	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear.	Inhibits intermediate metabolism of alcohol causing a buildup of acetaldehyde and reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol.
Contraindications	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure.	Same as oral naltrexone, plus inadequate muscle mass for deep intramuscular injection; rash or infection at the inspection site.	Severe renal impairment (CrCl ≤ 30 mL/min).	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease; hypersensitivity to rubber (thiuram) derivatives.
Precautions	Other hepatic disease; renal impairment; history of suicide attempts or depression. If opioid analgesia is needed, larger doses may be required and respiratory depression may be deeper and more prolonged. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see www.niaaa.nih.gov/guide.	Same as oral naltrexone, plus hemophilia or other bleeding problems.	Moderate renal impairment (dose adjustment for CrCl between 30 and 50mL/min); depression or suicidal ideation and behavior. Pregnancy Category C.	Hepatic cirrhosis or insufficiency; cerebrovascular disease or cerebral damage; psychoses (current or history); diabetes mellitus; epilepsy; hyperthyroidism; renal impairment. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see www.niaaa.nih.gov/guide.
Serious adverse reactions	Will precipitate severe withdrawal if the patient is dependent on opioids; hepatotoxicity (although does not appear to be a hepatotoxin at the recommended doses).	Same as oral naltrexone, plus infection at the injection site; depression; and rare events including allergic pneumonia and suicidal ideation and behavior.	Rare events include suicidal ideation and behavior.	Disulfiram-alcohol reaction, hepatotoxicity, optic neuritis, peripheral neuropathy, psychotic reactions.
Common side effects	Nausea, vomiting, decreased appetite, headache, dizziness, fatigue, somnolence, anxiety.	Same as oral naltrexone, plus a reaction at the injection site; joint pain; muscle aches or cramps.	Diarrhea, somnolence.	Metallic after-taste, dermatitis, transient mild drowsiness.
Examples of drug interactions	Opioid medications (blocks action).	Same as oral naltrexone.	No clinically relevant interactions known.	Anticoagulants such as warfarin; isoniazid; metronidazole; phenytoin; any nonprescription drug containing alcohol.
Usual adult dosage	***Oral dose:*** 50 mg daily. ***Before prescribing:*** Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, administer a naloxone challenge test. Evaluation liver function. ***Laboratory followup***: Monitor liver function.	***IM dose:*** 380 mg given as a deep intramuscular gluteal injection, once monthly. ***Before prescribing:*** Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition. ***Laboratory followup***: Monitor liver function.	***Oral dose:*** 666 mg (two 333-mg tablets) three times daily; ***or*** for patients with moderate renal impairment (CrCl 30 to 50 mL/min), reduce to 333 mg (one tablet) three times daily. ***Before prescribing:*** Evaluate renal function. Establish abstinence.	***Oral dose:*** 250 mg daily (range 125 mg to 500 mg). ***Before prescribing:*** Evaluate liver function. Warn the patient (1) not to take disulfiram for at least 12 hours after drinking and that a disulfiram–alcohol reaction can occur up to 2 weeks after the last dose and (2) to avoid alcohol in the diet (e.g., sauces and vinegars), over the counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash). ***Laboratory followup***: Monitor liver function.

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Appendix 2: Medication Assisted Treatment for Alcohol (off label/not FDA approved)

Gabapentin: blocks α-2-δ-1 subunit of pre-synapatic calcium channels→ decreased glutamate. Decreases withdrawal symptoms[12], improves insomnia, dysphoria and craving, and reduces alcohol consumption.[13] More effective in reducing relapse in patients with withdrawal symptoms[14]

- 300 tid→600 tid (600 more effective)
- Side effects: sedation, dizziness, headache, weight gain
- Safe in liver disease, but need to renally dose
- Some concern for abuse potential, potentiates opioids

Other Medications (to consider depending on comorbid conditions):

- **Baclofen**: mixed evidence: helps withdrawal[15] and may help craving and reduce consumption[16]. Safe in cirrhosis.
- **Topiramate**: effective, but use limited by side effects and slow uptitration[17, 18, 19]
- **Varenicline**: decreases heavy drinking in male smokers[20]

Appendix 3: Patient Self-Management Resources and Mutual Support Groups

- Alcoholics Anonymous: www.aa.org
- Narcotics Anonymous: http://na.org/
- Self-Management Addiction Recovery Program: www.smartrecovery.org
- Digital device Applications (Apps)
  - Step Away- research based and proven effective. (monthly subscription fee)
  - Connections (CHESS)- continuing relapse prevention support (free)
  - recoveryBox- based on 12 step programs (fee for enhanced version)
  - Sober Grid- social network and sobriety counter (fee for enhanced version)
  - NoMo- sobriety clocks and other tools (free)

Appendix 4: Treatment Options (specialty treatment outside of primary care)

- http://www.dartmouth-hitchcock.org/alcohol_drug.html DH guide to options in NH and VT, arranged by treatment intensity (including the DH Addiction Treatment Program)
- http://nhtreatment.org/ Recent comprehensive guide to options in NH
- https://findtreatment.samhsa.gov/ National directory
- 211 http://www.vermont211.org/ http://www.211nh.org/
- Substance related crises 1-844-711-4357 (HELP)

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