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ECHO: ADDRESSING UNHEALTHY ALCOHOL USE AMONG INDIVIDUALS WITH OPIOID USE DISORDER

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ECHO: Addressing Unhealthy Alcohol Use among Individuals with Opioid Use Disorder [video transcript]

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Thank you so much, Charlotte, and unmuted, I think, yeah, okay. And thank you so much for the opportunity to join you all today. This is always a really energizing conversation, and I hope it will be a conversation. So please feel free to jump in. I have no conflicts of interest to disclose. I have funding support from NIH. And that's it. So I like to start this conversation with orienting us and grounding us in a clinical case. And I know we'll talk about one at the later in this discussion. But this is a patient of mine, who I've had the pleasure of taking care of for almost a decade now. Susan is and I've changed her name to make sure that we protect her privacy. Susan is a 52 year old woman with well controlled HIV on antiretroviral therapy, untreated Hepatitis C and depression. And she had been referred to me by her HIV provider for treatment of her substance use. And her story began when she was a teenager and she started experimenting with alcohol and marijuana use, which is not so uncommon. She had a really significant car accident on prom night as a high school student. And during that, because of that accident, ended up in intensive care had major facial reconstruction, and resulted with chronic headaches and pain after a six week hospital stay. In that setting, she was prescribed opioids to control her pain condition. And she ultimately lost control of her oxy codon that she was taking 30 milligrams of twice a day that then ultimately transitioned into heroin use and by injection. She was diagnosed with AIDS in the setting of having thrush. And when she came to me she had concurrent alcohol use, she was drinking up to one and a half pints of vodka a day. She had had multiple emergency department visits and hospitalizations, and really had had strange much of her family members and also health care providers who really didn't know how to help her. I was fortunate that I was able to offer her effective treatment with buprenorphine for her opioid use disorder. And she did very well from an overview standpoint, but continued to have ongoing alcohol use. So I share her story because I think it's really relevant for thinking about

first, how do we characterize her alcohol use? And what's our framework to think about it? What are the potential consequences of her alcohol use? And then what are treatment options to guide our conversation? So first, how do we characterize her alcohol use? So I always start these conversations with a reminder of the pyramid, right, and we think about and this is informed by the late Dr. Rich seats, where we think about the lower levels of alcohol use at the base of this pyramid here being more common where there's lower risk or no alcohol use at all. So you can imagine this is drinking below standard guidelines. This is, you know, those who are abstinent, how you think about lower risk or at risk alcohol use will vary depending on the underlying conditions of an individual, but this is thinking about it and you know, typical, healthy adults, right as they think about these thresholds that we'll review in a second, if you have cirrhosis, for example, any alcohol use is harmful right? And so you have to characterize this in the context of the individual that you're thinking about. But when we think about at risk, alcohol use and alcohol use disorder this together makes up what we think about as unhealthy alcohol use this is the presence of alcohol use that can contribute to harm for an individual. That standard and I AAA criteria, the National Institute on Alcohol Abuse and Alcoholism criteria for defining at risk alcohol use and individuals who are otherwise healthy is listed here. So for men who are less than or equal to 65 years old, they you know, exceeding more than four drinks per occasion or 14 drinks per week, and for women and men, over 65 years old, exceeding two Three drinks per occasion, or seven drinks per week is considered to be at risk. And then when we think about the top of the pyramid, this is where we have the greatest consequences from alcohol use this is the least common pattern. But this is evidenced by what we call the three C's evidence of craving, loss of control, and adverse constant use, despite adverse consequences. And when we think about how you define that, that's going to be based on the presence, at least two of the following criteria over the past year, you can see these listed here, I won't necessarily read them all. But really, again, they're manifestations of craving, loss of control and adverse consequences. And particularly, what you want to note is there's the evidence of withdrawal, some syndrome, tolerance, and then the craving, that's the key Hallmark. And then these are all manifestations of using when it's been demonstrated to be problematic, and that individuals life to continue to consume alcohol. When we think about the severity of an alcohol use disorder, the presence of two or three criteria is consistent with a mild use disorder, four or five as moderate, and then six to 11, is considered a severe alcohol use disorder. And Susan, unfortunately, is not a unique individual. These are data pulled from the National Survey on Drug Use on health from 2021. This is the latest data that are available from this national survey. And looking at individuals who are ages 12 years or older, and had a past year substance use disorder, we can see that 22 point 2 million individuals have the 29 point 5 million individuals en us who had an alcohol use disorder, this proportion here only had an alcohol use disorder, but 7.3 million of individuals with an alcohol or you know had a

concurrent alcohol and drug use disorder. So really, quite a few, right, this is a big problem. Here just to be complete, you can see that 24 million people had a drug use disorder. And again, it's this middle intersection where this middle green, where you see that intersection of those impacted by both. And these numbers have gotten worse in recent years. And this is an important problem, right? Just why and then we know that either of these conditions alone is concerning and associated a range of adverse outcomes. But there are specific interactions between opiates and alcohol. how that manifests in the setting, for example of alcohol with methadone dosing, there's some variable data and the late Mary Jean Creek has done some work around this. But we know there are synergistic effects such that they both contribute to respiratory depression and worsening psychiatric neuropsychiatric outcomes. So what are the potential consequences of her alcohol use? I hope that gave you a framework for thinking about how we characterize her alcohol use. And clearly she meets evidence of an alcohol use disorder based on her story. But I didn't go through in great detail. But it was very evident when seeing her that and based on her history that she had evidence of a significant alcohol use disorder. So we need to think about what are these consequences? And how does that manifest for her and others. So first, there are data from a number of studies that when individuals are consuming alcohol, when they're trying to also engage in treatment for an opioid use disorder, they're less likely to stay engaged in that treatment and continue on the opiate agonist therapy. And similarly, it interrupts treatment for other chronic health conditions and primary care services, colon cancer screening, for example, we know all of that is worse when patients have comorbid, alcohol and opioid use disorder. There's increasing risk of overdose and death, HIV risk and other infectious complications, medical comorbidities, adverse effects as it relates to quality of life and psychiatric illness. And on in the next few slides, I'll give you some examples based on data for that, but this is kind of how I think about on these different buckets that this concurrent, unhealthy alcohol use and opioid use, really is problematic in many domains. So here most importantly is one slide just to bring home that point that alcohol use in the context of ongoing injection drug use contributes to a risk of death. This was a study out of Vancouver group that looked at 25 over 2500 individuals who inject drugs 31% in this cohort study reported heavy episodic are also called binge but we try not to use the term binge because it's more stigmatizing reported alcohol use. And in this study heavy ever Select alcohol use was associated with a 41% increase in mortality risk compared to those who did not do that. These are data from the CDC looking at co involvement of alcohol and opiate overdose deaths. And this has also been an important problem. These are data. This paper is published now a couple years ago in JAMA Network open, and you can see increasing rates of death for opioids alone, these are all opioid deaths. These are benzo Deza, pain involved deaths, and then alcohol involved deaths. And then I think what's important to note here is looking at the call involvement of the benzos and alcohol.

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Ingestion in the context of opioid uses, we see the steady presence of alcohol in the context of opioid use. And it's such that one in seven opioid related deaths involve drinking alcohol a few hours before that overdose event. And so really just an a very important problem. alcohol use is also an independent risk factor for HIV. And this we can think about being mediated by sexual risk behaviors, drug use practices, and then also potentially via immunosuppression, because we know opioids and alcohol both are immunosuppressive. And these are data this is an old study published back in 2011. But I think it's really illustrative of this point, where we're using data from the AIDS link to intravenous experience, the alive cohort, and on data from 50, over 1500, Black individuals who inject drugs, can see that there's this nice, unfortunately, dose response effect when we look at risk of HIV associated with alcohol. So for increasing levels of alcohol use, and as measured by drinks per week, and the prior two years, we can see an increasing risk of HIV acquisition. And then lastly, when we think about alcohol use and Hepatitis C, it's really important to think about what are the synergistic effects on the liver health and alcohol use disorder is associated with a 3.3 fold risk for progression of liver disease among people with Hepatitis C. And so again, an important opportunity to think about when we're thinking about the overall health of a patient in front of us and opportunities to treat them as really not to delay treating the Hepatitis C. So next, just to think through what are her treatment options, and what can we do about a patient like her when they're in front of us? First, there's guidelines that recommend screening, brief intervention and treatment. This is just a reminder that the US Preventive Services Task Force, we really recommends this that we are screening individuals in routine settings for unhealthy alcohol use. And the US audit has been recently updated to this takes the audit that has been used internationally and tailors that a little bit more to the US population. I'll show you that in an upcoming slide. This is a really nice publication from SAMSA, that's readily available online, I'm happy to provide any of these resources for anybody who wants to find them. That just talks through how to screen properly, how to score it, and then what to do. We'll talk through that in a couple of slides. And then this is another really nice publication from SAMSA on the medication for treatment of alcohol use disorder and walking us through what are the different medication of it at the evidence based medication treatment options and how to think about risks and benefits for patients and contraindications and prescribing. And I should say I was laughing I call it a brief guide. It's many pages, but it's really digestible. So don't be scared by the length, it's really a nice resource to take a look at. And then the NIH AAA has recently updated their resources online. And so just a shout out to take a look at these. If you're looking for resources to provide, you know, for yourself for colleagues, and then also for patients, this is a great resource. So how do you screen for unhealthy alcohol use? There's many different tools out there. But this is one that's

really widely used in the VA, nationally and Kaiser system and we use it in our local health system. And it's built into our epic. It's asking for three items around unhealthy alcohol use and unlike things like the cage, which really are used to identify higher levels of alcohol use and dependence and I think some like including myself believe the language is a bit stigmatizing. This really just gets at consumption. So what are and how often do you have a drink containing alcohol? How many drinks containing alcohol do you have it on a typical day you are drinking? And how often do you have X number or more drinks on One occasion and you have to substitute the number there based on whether or not you're speaking to a woman or a man and I would use woman or man based on sex at birth because of that distribution. And then here, what you can see just this is pulled out from that SAMSA guide, is how to score that. So here is the distribution of the scores. Of course, as you increase the US audit SSI score, then there's increasing concerns of that level alcohol use. But what's really helpful to think about is, depending on where somebody falls, what is going to be the most appropriate type of intervention to offer. So somebody has lower risk or no use of alcohol, providing, you know, cleaning that screening, and then providing feedback that that's great, you know, hope you can maintain that that's really a good, you know, that's helpful for your health. And providing that feedback is, you know, what's going to be indicated there. For those who fall into this pattern where they have an audit score of seven or eight to 15, depending on their sex, offering a brief intervention, we'll talk about that in a couple of slides. And then as you get to these higher levels of alcohol use is offering more resources and providing treatment is really most appropriate. So what is the spectrum of options that are hopefully available to you with partners or within your own sites, we think about counseling interventions, its brief interventions, motivational enhancement therapy, cognitive behavioral therapy, contingency management, there's increasing availability of online resources as well. And then there's some medications and we'll talk about each of these a little bit. Ups. So brief interventions, this I love this figure, and this is pulled from rich states, his New England Journal of Medicine paper back in 2005. But it's really quite relevant. So thinking about these brief interventions that can be offered and 1520 minute session with a patient we talk about, you really try to have a patient centered conversation. To hear their perspective about the problem, you express your concern and provide clear advice. You provide feedback about drinking norms, and you link it to their current problems to make it salient right, to make that connection of why they might make a change if they're not thinking about it. express empathy reinforced change as a possibility and acknowledge the patient's responsibility in this right and their choice. And then really want to empower them. So provide a menu of options for promoting change to have a healthier pattern of alcohol use, and work with them to anticipate and discuss difficult situations, and then set a goal and arrange follow up so that they feel like there's that accountability, that safe place that they can come back to you and talk through how their progress has gone. What's important to

know is that in the general population, patients who receive a brief intervention drunk on average three and a half drinks per week, less at 12 months compared to baseline. Those are data from a large study. And there are some data to support use of brief interventions among individuals receiving treatment for opioid use disorder. But certainly there's a lot of opportunity to improve our approaches in this context. And then thinking about medication. So I focus on brief intervention, because that's going to be what's most relevant for most populations, then there's, of course, motivational enhancement, enhancement therapy, cognitive behavioral therapy, contingency management, which is the use of rewards to incentivize to incentivize behavior change. And these can be done in partnership with trained specialists. In terms of thinking about medications for alcohol use disorder, it's really easy. Unfortunately, we only have three FDA approved options. So it's not a long list, right? It's a lot easier to treat alcohol use disorder than many other conditions like hypertension, diabetes, HIV, etc. These are really, you know, we have three FDA approved options. And that's it. So we should all be familiar with them, that I saw from is the one that everybody thinks about that's also called Antabuse, that is the deterrent. So that causes people to have adverse effects if they drink. So it's really great for that person who's motivated for abstinence or has somebody who can help support them in taking that medication, depending on their preferences. It can proceed has some mixed data for its use and is also a three time a day medication. So that can be a little bit complicated, but it's safe in the context of liver disease, so it might be an appropriate option to try. And then naltrexone comes in oral and injectable formulations. And those are that's a helpful medication to promote abstinence, but also to just reduce return to heavy drinking and and amount of heavy drinking, and that is the one I personally prescribe most. Typically, for patients, there's a spectrum of non FDA approved medications that have mixed data. And I think Topiramate among this list is the one that is approved. Sorry, has the strongest data to support it to use and is also among the recommended treatment options in some clinical guidelines that's specific to the VA. So just to know, if you're gonna think about a non FDA approved medication, Topiramate seems to be kind of top of that list. And then these are the others with increasing amounts of data to support their use and potential benefits.

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But when we're thinking about medications in the context of somebody who has a concurrent alcohol and opiate use disorder, really thinking about the importance of prioritizing opiate agonist treatment that's like first and foremost, to get patients on treatment. And what's important to know is that patients that with diagnoses consistent with alcohol use disorder, unfortunately, are less likely to receive a medication for opioid use disorder such as buprenorphine or methadone, and it gets in the way of that they're less likely to receive buprenorphine or methadone, but they're more likely to receive naltrexone compared to

psychosocial treatment alone. But unfortunately, that is not best practice, because people nerfing and methadone are associated the greatest likelihood of treatment retention. So even though there have been some data that Naltrexone is effective to address, alcohol and opioid use disorder, and it's FDA approved in that context, it does seem that for these patients who are acceptable or accepting of buprenorphine and methadone, that was really the best approach. And, again, do not stop opiate agonist treatment if somebody is consuming alcohol that would not be in their best interest. This was a paper published in JAMA Network open back in 2021. And they looked at individuals, all participants and then participants with a recent alcohol use disorder claim and then participants without a recent AUD claim. And you can see here when they looked at the different medications, buprenorphine methadone, and then the different formulations on naltrexone, highlighting here, those with an alcohol use disorder claim, patients are all doing better in terms of not having an alcohol related event when they're prescribed medications for their opioid use disorder. So really just to emphasize the point, don't stop their medications for their opioid use disorder if they're consuming alcohol. And then just to emphasize the point that we know that integrated care reduces barriers. So we talk about one stop shopping and kind of trying to bring everything as much as we can, to the patients where they are coming right. And so breaking down those barriers, and those silos. This was a paper just highlighting this point of looking at HIV and opioid use disorder care, a systematic review published in AIDS by Ben Oldfield, that's found evidence to support that some work focusing on looking at Hep C treatment in the context of opioid use disorder treatment and benefits of that. And then this is looking at treatment of opioid and alcohol use disorders in primary care. There's just a number of different studies that show again, we want to make things as easy for patients as possible, and meet them where they are and offer them treatment services for their different conditions and treat them as a whole individual. I think everyone is on board with that and understands that we looked at an integrated stepped care model in addressing alcohol use in the context of HIV and VA based HIV clinics. And I won't go through this in detail if you're interested. I have the references listed here. But we found that a model that included an interdisciplinary approach with induction physician seen individuals with alcohol use disorder and HIV followed by a clinical psychologist intervention and motivational enhancement therapy. And then for those who didn't respond and reduce their alcohol use, getting them to a higher level of care was an A promising approach for reducing alcohol use and actually improving HIV related outcomes. And again, just consistent with this idea of get as much as we can to patients where they're at. I want to really emphasize the importance of harm reduction. So thinking about, you know, if we, you know, make the analogy that for somebody with diabetes, we don't punish them if they're not eating and exercising all the time and perfectly and have an uncontrolled sugar, right. And so, we should follow the same approach for all patients right and including when they're using substances and trying to

help them be as healthy as they can be. With and their goals and helping them achieve that. And so providing overdose education and Naloxone of course is essential, preventing and treating HIV and other conditions offering PrEP, for example, or getting them connected to care if they have if they're positive, treating their Hepatitis C, right. So, as an HIV clinician, you know, some of my patients who have ongoing substance use and pretty intense addictions have very well controlled HIV, right. And I think the data supports that same for Hepatitis C. So just even if there's ongoing substance use not to or alcohol use not to withhold treatment, right, we can help prevent that risk of liver, cirrhosis and decompensation. If we treat that Hepatitis C. And then, of course, to just think about other basic things we can be doing for our patients such as vaccination. You know, I think we're all thinking about vaccines more these days with COVID. But thinking about vaccinations for lots of different conditions that we can offer our patients. So just to close out before we turn to the case, and loop back to Susan, my patients, so she is somebody for her alcohol use. She has continued to have ongoing alcohol use over the years, but what she does is she'll have an episode of heavy episodic drinking. She goes into the emergency department, she quickly reaches out for help. We have tried to. We've tried different medications over the years for her that have not been necessarily as effective. But overall she has been engaging. He has been consistently engaged in her treatment for opioid use disorder with her buprenorphine and done incredibly well with that. She goes to mutual help. She's doing yoga multiple times a week and walking and comes in as hard just a couple of weeks ago and comes in with the beautiful pictures of her Gerber Baby grandchildren and is thriving. She's had her Hepatitis seat treated, she's been reducing her tobacco use and the main things we're working on right now we're getting her colon cancer and breast cancer screening. So she's it's she's taught me a lot over the years and thank you for listening to our story with me as we have this conversation. So let's stop there.

[End Transcript]