PRACTICE INNOVATION PROGRAM COLORADO

FACILITATING ALCOHOL SCREENING & TREATMENT (FAST)

Alcohol Use Disorder (AUD): Treatment Overview and Stigma

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Objectives

By the end of the presentation, participants should be able to:

- Understand the neurobiology and physiology basics of alcohol dependence
- Review AUD treatment options
- Report and understand how stigma impacts AUD

Pathogenesis of Alcohol Dependence

- Complex interplay of biologic, psychological, and socio-environmental factors
- Genetics
  - Accounts for up to 50% of vulnerabilities related to AUD
- Environment
- Personality
- Cognitive and mood disorders

Pathogenesis of Alcohol Dependence

- With repeated use, there is a decreased response to the same dose
  - Tolerance develops
- Likely because GABA, glutamate, dopamine receptors become less sensitive to Etoh
  - Receptors may also be down-regulated (fewer receptors available for binding)
- These changes impact the development of dependence

MAT Options for AUD

- Three “first-line” medications for outpatient setting:
  - Naltrexone (Vivitrol)
  - Acamprosate (Campral)
  - Disulfiram (Antabuse)… kind of
- **Naltrexone** (oral) and **acamprosate** are most strongly supported in evidence to reduce alcohol use
  - One is not necessarily thought to be more effective than the other

“First-line” = FDA approved

MAT Options for AUD

- Second-line medications:
  - Topiramate (Topamax)
  - Baclofen (Gablofen)
  - Ondansetron (Zofran)
  - Gabapentin (Neurontin)

MAT Options for AUD: Topiramate/topamax

- Anticonvulsant used for migraines, seizures
- Second-line medication for AUD
  - Not FDA approved
  - Typically reserved for when naltrexone or acamprosate don’t work
- Mechanism of action
  - Facilitates GABA receptors
  - Likely decreases alcohol reinforcing effects by reducing dopamine release

MAT Options for AUD: Topiramate/topamax

- Dose
  - 25-150 mg twice per day
  - Start at 25 or 50 mg/day, slowly increase
- Efficacy
  - Multiple clinical trials have found topiramate to reduce heavy drinking in AUD
  - Can also help achieve abstinence
- Associated with many negative side effects
  - Cognitive impairment, paresthesia, weight loss, fatigue

DEI considerations for AUD

- Despite relatively uniform rates of substance use…
  - Racial/ethnic minorities often suffer more social and legal consequences from substance use
- Treatment impacts
  - Confounded by issues of stigma, insurance, SES, interaction with criminal justice system
  - Access: Lower rates of brief interventions among racial minorities
  - Outcomes: Black and Latinx patients are more likely to report lower retention in substance use programs

Stigma of substance use disorders

- Mark of shame, disgrace
  - Associated with negative attitudes and beliefs
  - People are blamed for their disease
  - Impacted by exposure and experience to disease state

- It exists!
  - General public (over half attributes AUD to one's "own bad character")
  - Internally
  - By health care professionals

Stigma of substance use disorders

- Addiction is often thought of differently than other chronic diseases
  - Diabetes, heart failure
  - Considered to be a personal failure
  - Remember thought to be up to 50% heritable
- Substance use disorders impact the brain
  - Cause a tremendous positive reinforcement loop
  - Evidence of visible changes in the brain associated with judgement, decision making, learning, memory
  - Lead to compulsive use despite harm

Stigma

- Why it matters: causal attribution beliefs
  - If you think there is high controllability of a disease, this causes more intolerant judgements and attitudes
- Alcohol is not an ordinary substance of abuse
  - Legal!
  - Integrated into culture

Stigma Consequences

- Diagnosis
  - Delayed, difficult
- Treatment and Recovery Outcomes
  - Delayed treatment
  - Impact on healthcare delivery and treatment
    - Poor communication, avoidance
    - Decreased patient empowerment and self-esteem
  - Decreased recovery
- Public support
  - Access to funding, resources, programs

Anti-Stigma tools

- Training and education (patients and providers)
  - Pathophysiology of addiction
  - Treatability; appropriate and realistic treatment goals
  - Emphasis on dignity and compassion
  - Increases self-efficacy of both patients and providers
- Exposure
  - Contact hypothesis: more tolerant and more positive attitudes
- Language
  - Person-first language
  - Don’t define people by their disorder

Anti-Stigma tools

- Standardized screening
  - *“I am going to ask you a few questions related to your drinking habits. I ask all my patients these questions so I can provide the most appropriate counseling or care.”*
- Support and infrastructure to address AUD
  - Organizational: role support, supervision, ability to consult expert
  - Enhances health care professionals self-esteem and feelings of empowerment to address AUD

Anti-Stigma tools: Language matters

Consider using these recommended terms to reduce stigma and negative bias when talking about addiction.

Instead of...	Use...	Because...
Addict **User** **Substance or drug abuser** **Junkie** **Alcoholic** **Drunk** **Substance dependence** **Former addict** **Reformed addict**	• Person with opioid use disorder (OUD)/SUD or person with opioid addiction • Patient • Person in recovery or long-term recovery **For heavy alcohol use:** • Unhealthy, harmful, or hazardous alcohol use • Person with alcohol use disorder	• Person-first language. • The change shows that a person "has" a problem, rather than "is" the problem.[7] • The terms to avoid elicit negative associations, punitive attitudes, and individual blame.[7]

Anti-Stigma tools: Language matters

Habit	• Substance use disorder • Drug addiction	• Inaccurately implies that a person is choosing to use substances or can choose to stop.[5] • "Habit" may undermine the seriousness of the disease.
Abuse	**For illicit drugs:** • Use **For prescription medications:** • Misuse, used other than prescribed	• The term "abuse" was found to have a high association with negative judgments and punishment.[8] • Legitimate use of prescription medications is limited to their use as prescribed by the person to whom they are prescribed. Consumption outside these parameters is misuse. • Consider the motivation and intent of misuse (e.g., level, reasons) to determine whether the specific instance suggests SUD.

Anti-Stigma tools: Language matters

Clean	**For toxicology screen results:** • Testing negative **For non-toxicology purposes:** • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not currently or actively using drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.[9] • Set an example with your own language when treating patients who might use stigmatizing slang. • Use of such terms may evoke negative and punitive implicit cognitions.[7]
Dirty	**For toxicology screen results:** • Testing positive **For non-toxicology purposes:** • Person who uses drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.[9] • May decrease patients' sense of hope and self-efficacy for change.[7]

Acknowledging our own stigma: Self reflections

- Do I have assumptions about those with addictions?
  - What are your personal beliefs about why people become addicted? Do you believe it's because they are weak, lazy, immoral?
- Do I accept certain types of addictions more than others?
- Do I think recovery should look a certain way?

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Thank you!

Questions?

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