PRACTICE INNOVATION PROGRAM COLORADO
FACILITATING ALCOHOL SCREENING & TREATMENT (FAST)

# Medication Assisted Treatment (MAT) for Alcohol Use Disorder (AUD): An Overview

Presenter: Beka Mullen, MD MPH
Guest Q&A: Ryan Jackman, MD FASAM

Department of Family Medicine

# Objectives

1. Define MAT for AUD and understand the appropriate use in primary care.
2. Describe the FDA approved and off-label pharmacotherapy options for AUD treatment and how they work to treat AUD.
3. Understand the role of behavioral health and other integrated team members in AUD treatment.

# Medication-Assisted Treatment (MAT)

- The use of medications to treat substance use disorders
  - Typically accompanied by psychosocial interventions (counseling, mutual support groups or AA, etc.)
  - Plus other clinical support (resources, care management)
- For alcohol use disorder (AUD), medications focus on altering the reinforcing effects of alcohol use

# Why is this important?

- MAT is known to be effective in treating AUD
  - Leads to reduced heavy drinking
  - Increased days of abstinence
- Psychosocial interventions are helpful, but alcohol use and relapse rates decrease most when these interventions are combined with medications
- However fewer than 1 in 3 patients with AUD receive treatment
  - And **fewer than 1 in 10 patients receive pharmacotherapy** as a part of their treatment
  - *Why is this?* Stigma, lack of knowledge, lack of access to care or treatment, perceived low demand

# Appropriate Patients for MAT

- Not all patients with unhealthy alcohol use should be offered MAT
  - Found to be mostly effective in those with severe disease
  - Psychosocial interventions alone may be effective for those with mild disease
- MAT is indicated for patients with:
  - Current heavy alcohol use and ongoing risk for consequences
  - DSM-5 criteria of *moderate to severe* AUD
  - Motivation to reduce alcohol intake
  - Preference for medication (along with or instead of psychosocial intervention)
  - No medical contraindications

# Reminder: DSM-5 Criteria for AUD

- Recurrent drinking resulting in failure to fulfill role obligations
- Recurrent drinking in hazardous situations
- Continued drinking despite alcohol-related social or inter-personal problems
- Tolerance
- Withdrawal
- Drinking more/more often than intended
- Unable to quit/cut back drinking
- Spent a lot of time drinking or recovering
- Gave up or reduced important activities due to drinking
- Continued drinking despite knowledge of consequences
- Cravings

To diagnose AUD:

- Patient must meet at least 2 criteria in past year
- Mild: 2-3 criteria present
- Moderate: 4-5 criteria
- Severe: 6 or more criteria

# 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: How do they work?

- **Naltrexone** and **acamprosate** both work to decrease alcohol cravings
  - Naltrexone= blocks opioid receptors that are involved in the rewarding effects of drinking and alcohol cravings
  - Acamprosate= stabilizes the glutamate and GABA systems, which reduces the reinforcing reward response with alcohol consumption
    - Helps with symptoms of abstinence-related distress
- **Disulfiram** works by acting as "deterrent"
  - If mixed with alcohol, it inhibits alcohol metabolism and leads to a build-up of acetaldehyde = unpleasant side effects!
  - Typically reserved for those who cannot take acamprosate or naltrexone

# MAT Options for AUD

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

# Medication Considerations

- Medication initiation
  - Is the patient still actively drinking?
- Ease of dosing
  - *Once* daily dosing vs. *three* times daily (or monthly injection)
- Other medical issues
  - Liver disease
  - Kidney disease
  - Heart disease
  - Opioid use
  - Pregnancy

# Naltrexone


- Starting medication:
  - Can start during active alcohol use, however consider waiting until after any withdrawal or 3+ days
- Standard dosing:
  - Once daily pill or monthly injections
- Contraindications:
  - Liver disease (cirrhosis, LFTs > 3x normal)
  - Current (within past 7-10 days) or future opioid use
- Other stuff:
  - Side effects: dizziness, nausea, vomiting
  - Monitoring: liver function, opioid abstinence?
  - Preferred medication choice during pregnancy (category C) or if concurrent opioid use disorder (OUD)


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# Acamprosate (Campral)

- Starting medication:
  - Start when patient is not actively drinking
  - Initiate as soon as possible after stopping alcohol (wait until after withdrawal, which may start 12-24 hours after last drink and last up to 5-7 days, or 3+ days)
- Standard dosing:
  - Three times daily
- Contraindications:
  - Kidney disease (CrCl <= 30)
- Other stuff:
  - Side effects: diarrhea, vomiting, anxiety
  - Monitoring: kidney function, alcohol abstinence?

# Disulfiram (Antabuse)

- Starting medication:
  - Wait until patient has been abstinent for at least 12 hours
- Standard dosing:
  - Once daily
- Contraindications:
  - Severe heart disease, pregnancy
  - Use with caution in liver disease
- Other stuff:
  - Side effects: fatigue, mild drowsiness, headache, rash
    - Significant reaction if mixed with alcohol! Vomiting, flushing, palpitations, and more
  - Monitoring: liver function, alcohol abstinence?


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# How to decide which medication?

Stepwise approach:

1) Any contraindications?
   - *Liver, kidney, or heart disease? Pregnancy? Opioid use?*
2) Is the patient actively drinking and unable to stop?
   - *If yes: naltrexone may be best; If no: any option!*
3) Finally, any concerns about medication adherence?
   - *If yes: once daily dosing or even monthly injections may be best*

# Follow-up

- After starting MAT, provide frequent visits initially
  - To provide patient support, resources, and monitor treatment response
  - Consider weekly visits for at least the first month, and then at least monthly visits after
- Once patient and situation has stabilized, consider spacing visits to every 3-6 months

# Treatment Goals

- Abstinence is the primary treatment goal
  - Acceptable alternative: Reduction of heavy drinking (fewer episodes of ≥ 5 drinks/day for men and ≥ 4 drinks/day for women)
- Treatment is not considered a failure after one relapse or return to heavy drinking
  - AUD is a chronic, relapsing disease
  - It takes weeks to months for these medications to have effects

# Treatment Goals

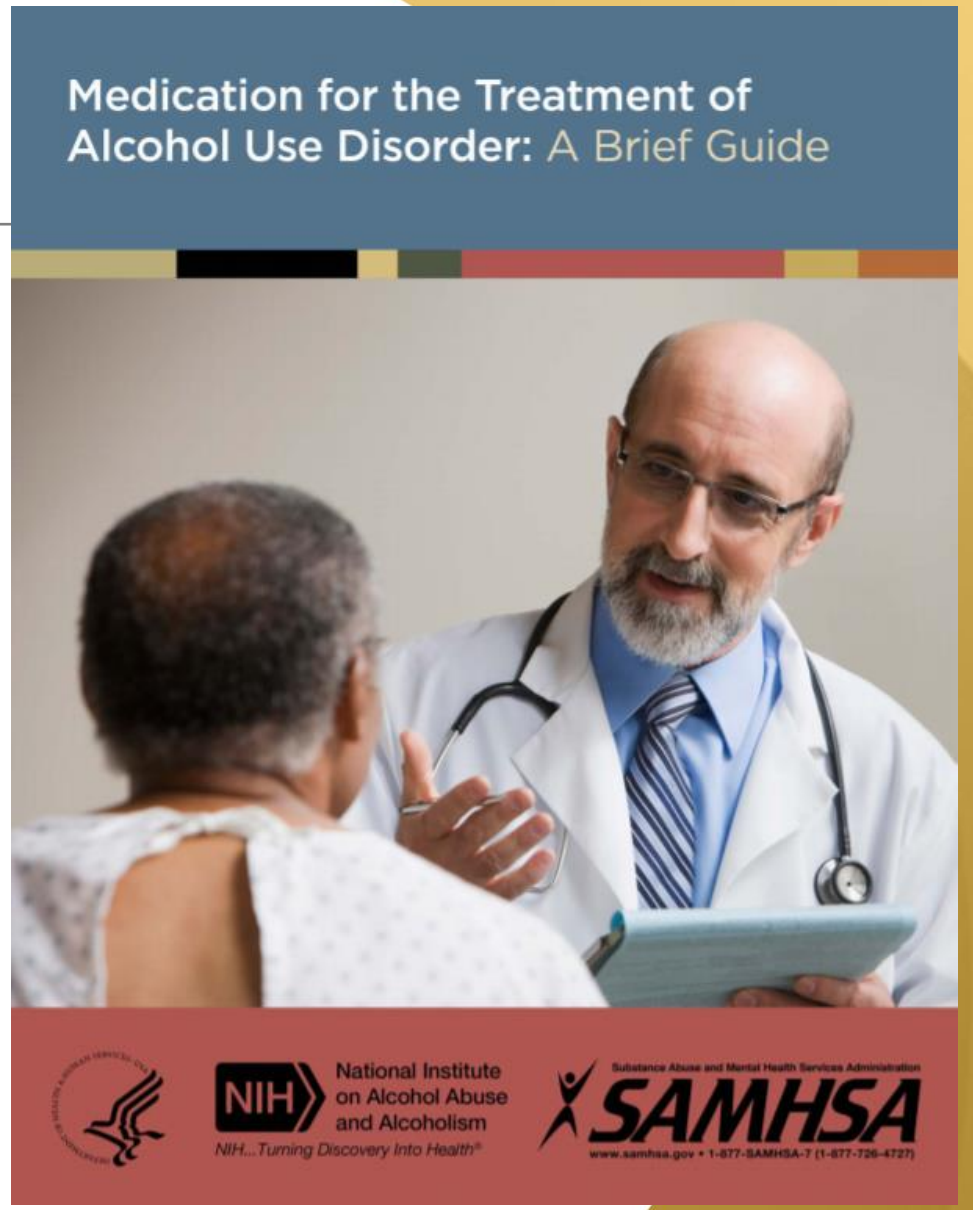
- MAT should ideally be continued for at least 1 year
  - This duration has been shown to reduce risk of relapse
  - Note: medications stop working after patient discontinues them
- Consider psychotherapy for at least 6 months-1 year

# Role of Behavioral Health in MAT

- Likely helpful in all AUD patients, but may be particularly helpful for those with concurrent mood disorders
  - Consider as monotherapy in mild disease
  - Not absolutely necessary in order to prescribe
- Provides clinical behavioral health services
  - Assistance with diagnosis of AUD
  - Counseling and support
  - Can also help address mood symptoms and behavioral factors contributing to alcohol use
- Other integrated team members?
  - Social worker, care management, pharmacy

# Resources

- SAMHSA
- NIAAA.nih.gov
- AHRQ website
  - https://effectivehealthcare.ahrq.gov/products/alcohol-misuse-drug-therapy

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# Upcoming FAST Webinars

- **11/11 at 12 pm:** Alcohol Use Disorder (AUD) Treatment Monitoring and Follow-up in Primary Care

# Thank you!

Questions?

Rebecca (Beka) Mullen, MD MPH

Rebecca.mullen@cuanschutz.edu

Department of Family Medicine