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Translating science into care

Management of Alcohol Use Disorder

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HRSA
Health Resources & Services Administration

Substance Use Warmline TA Office Hours: Management of Alcohol Use Disorder

October 22, 2020

Lara Chausow, PhD
Data Statistician, Quality Division, Office of Quality Improvement
Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People

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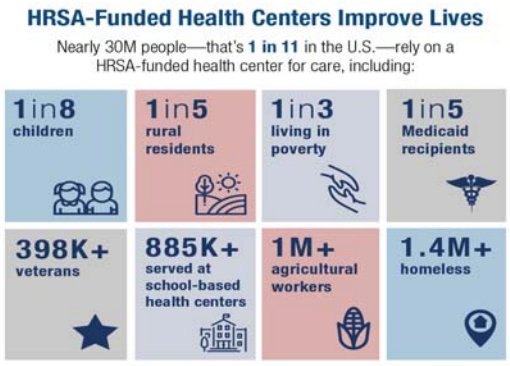
Health Center Program Patients



Source: Uniform Data System, 2019

HRSA Health Center Program

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Health Centers: Substance Use Disorder Services

More than **97% of HCs** providing MH services

325,732 Patients receiving SUD Services

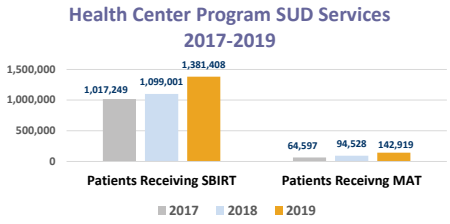
Over **1.8 Million** SUD **Clinic Visits**

SUD and Primary Care Integration

36% Increase in the number of patients receiving SBIRT from 2017-2019

121% Increase in the number of patients receiving MAT services from 2017-2019

32% Health Centers currently providing telehealth for SUD treatment in 2019



Training and Technical Assistance (T/TA) Resources:

- **HRSA SUD and Primary Care Integration Webpage:** https://bphc.hrsa.gov/qualityimprovement/clinicalquality/substance-use-disorder-primary-care-integration
- **UCSF National Clinician Consultation Center's Substance Use Warmline** provides clinician-to-clinician expert consultation addressing integrated behavioral health treatment & chronic pain management; M-F, 9 am to 8 pm ET by phone at 855.300.3595, or by submitting patient cases online (https://nccc.ucsf.edu/clinical-resources/substance-use-resources/)

HRSA Health Center Program

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SAFEST Choice Learning Collaborative

- Fetal Alcohol Spectrum Disorder (FASD) occurs in up to 5% of school-aged children
- Prevent FASD and care for children affected by it by joining the HRSA funded **SAFEST Choice Learning Collaborative** which will enroll Community Health Centers (CHC) in New England (MA, VT, ME, RI, NH, CT) & Upper Midwest (MN, ND, SD, WI, IA, MI) to participate in 10 free virtual Prenatal and/or Pediatric ECHO® sessions from 3/2021 – 2/2022.
  - **Prenatal ECHO** aims to reduce prenatal alcohol exposure by teaching healthcare teams how to screen for and counsel women about the risks of alcohol use during pregnancy
  - **Pediatric ECHO** aims to improve FASD outcomes by training healthcare teams how to identify and care for children and adolescents with suspected or diagnosed FASD
- CHCs will receive a stipend, technical assistance and free continuing education credits
- This is a partnership between Boston Medical Center and Minnesota-based Proof Alliance

For more information on how your CHC can be part of the **SAFEST Choice Learning Collaborative**, email Kendra Gludt at kendra.gludt@proofalliance.org

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Disclosures

I have no financial disclosures.

I will be discussing off-label use of some medications.

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Today's Content

Part I. Unhealthy alcohol use in public health and primary care

Part II. Treatment of alcohol use disorder

Part III. Ambulatory management of alcohol withdrawal

Part IV. Harm reduction approaches to alcohol use

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Learning Objectives

(a) Recognize the detection problem and treatment gap facing patients with alcohol use disorder (AUD)

(b) Relate alcohol use as a critical and potentially modifiable risk factor for clinical outcomes

(c) Expand the toolbox of evidence-based pharmacologic and psychosocial treatment strategies for alcohol use disorder

(d) Describe outpatient withdrawal management and considerations that have been raised in response to an evolving care delivery landscape

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Part I. Unhealthy alcohol use

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Unhealthy alcohol use

- 93,000 deaths (255 per day) and 2.7 million years of potential life lost (29 years lost per death, on average) in the United States each year to excessive alcohol use
- Exceeds deaths from opioid overdoses
- Prevalence and harms are on the rise, especially among certain groups

Esser et al, 2020; Grant BF et al, 2015; White et al, 2020; Katcher, Reiter, & Aragon., 2010

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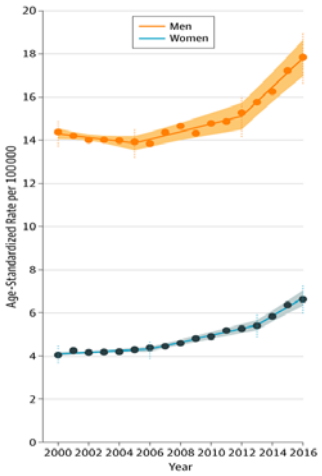
"Reflecting on the consequences of alcohol-related morbidity and mortality through the age range, our findings document an **urgent public health crisis calling for concerted public health action**."

Spillane et al, 2020

Age-Standardized Rates of Alcohol-Induced Death, 2000-2016



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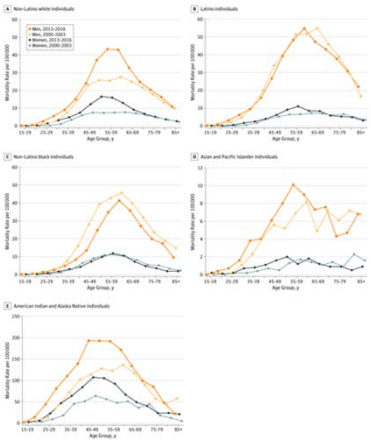
Noteworthy increases in deaths among women, American Indian/Alaskan Native individuals, and younger age groups



Spillane et al., 2020

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People are experiencing increased stress due to the COVID-19 pandemic

Czeisler et al, 2020; Pollard et al, 2020

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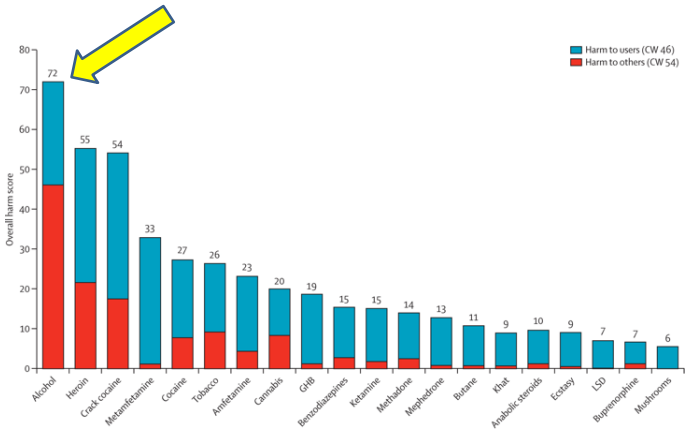
Alcohol use causes most harm compared to other substances



Nutt et al., 2010

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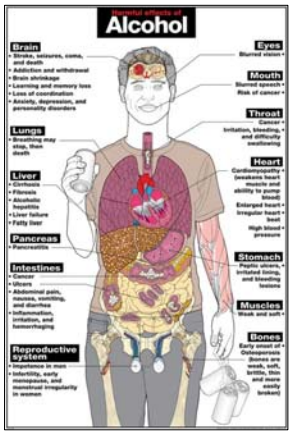
Widespread <u>physical</u> and <u>psychosocial</u> problems



- Primary care issues
  - Hypertension
  - Diabetes
  - Depression
- Cancer
- Early pregnancy loss
- Trauma
- Falls
- Motor vehicle accidents
- Risky sex
- Interpersonal Violence
- Poor nutrition
- Firearm violence
- Medication interactions
- Suicide
- Adverse childhood events

US Burden of Disease Collaborators, 2013; Sterling et al, 2020

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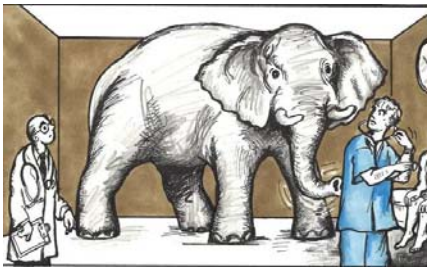
Unhealthy alcohol use goes undetected

- 1 in 6 patients reports being asked about drinking
- USPSTF recommends screenings in primary care settings in adults, and providing persons engaged in at risk or hazardous drinking with brief behavioral counseling interventions (B recommendation)



Bazzi & Saitz, 2018; US Preventive Task Force, 2018; Edelman & Tetrault, 2019

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Example screening questions

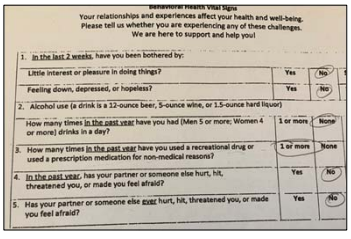
- "Do you sometimes drink beer, wine or other alcoholic beverages?"
- "How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day?"

AUDIT-C

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?	Never (0)	Monthly or less (1)	Two to four times a month (2)	Two to three times per week (3)	Four or more times a week (4)	SCORE
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 to 9 (3)	10 or more (4)	
3. How often do you have six or more drinks on one occasion?	Never (0)	Less than Monthly (1)	Monthly (2)	Two to three times per week (3)	Four or more times a week (4)	
TOTAL SCORE: Add the number for each question to get your total score.						

Maximum score is 12. A score of ≥ 4 identifies 86% of men who report drinking above recommended levels or meets criteria for alcohol use disorders. A score of > 2 identifies 84% of women who report hazardous drinking or alcohol use disorders.



Behavioral Health Vital Signs

Your relationships and experiences affect your health and well-being. Please tell us whether you are experiencing any of these challenges. We are here to support and help you!

1. In the last 2 weeks, have you been bothered by:		
Little interest or pleasure in doing things?	Yes	No
Feeling down, depressed, or hopeless?	Yes	No
2. Alcohol use (a drink is a 12-ounce beer, 5-ounce wine, or 1.5-ounce hard liquor)		
How many times in the past year have you had (Men 5 or more; Women 4 or more) drinks in a day?	1 or more	None
3. How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	1 or more	None
4. In the past year, has your partner or someone else hurt, hit, threatened you, or made you feel afraid?	Yes	No
5. Has your partner or someone else ever hurt, hit, threatened you, or made you feel afraid?	Yes	No

SBIRT
SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT

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AUD treatment gap is massive

- <10% of patients with unhealthy alcohol use receive treatment
- Of those, only about 50% receive pharmacotherapy

Substance Abuse and Mental Health Services Administration, 2010; Cohen E et al, 2007; Wililams et al, 2017

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Part II. Treatment of Alcohol Use Disorder

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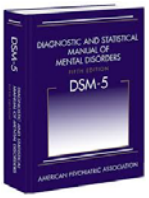
Unhealthy alcohol use

At-risk drinking

Alcohol use disorder



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DSM-5: 2+ symptoms over 12 months indicate alcohol use disorder

In the past year, have you…?	Interpretation	Domain
Had times when you ended up drinking more, or longer than you intended?	Control: exceeded own limits	Impaired control
More than once wanted to cut down or stop drinking, or tried to, but couldn't?	Unable to cut back	Impaired control
Spent a lot of time drinking? Or being sick or getting over the aftereffects?	Compulsion	Impaired control
Experienced craving — a strong need, or urge, to drink?	Craving	Impaired control
Found that drinking — or being sick from drinking — often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	Role failure	Social impairment
Continued to drink even though it was causing trouble with your family or friends?	Consequences: relationship trouble	Social impairment
Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	Gave up meaningful activities	Social impairment
More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	Risk of bodily harm	Risky use
Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	Physical/psychological consequences	Risky use
Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	Tolerance	Physiological criteria
Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	Withdrawal	Physiological criteria

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Brief counseling intervention is effective for at-risk drinking

10-15 minutes of counseling:

- Ask permission to raise the subject
- Relate drinking behavior to problems
- Elicit motivations for change
- Set a drinking goal
- Support efforts
- Refer to cognitive behavioral therapy or a mutual help group
- Arrange close follow-up

National Institute on Alcohol Abuse and Alcoholism (NIAAA), 2005

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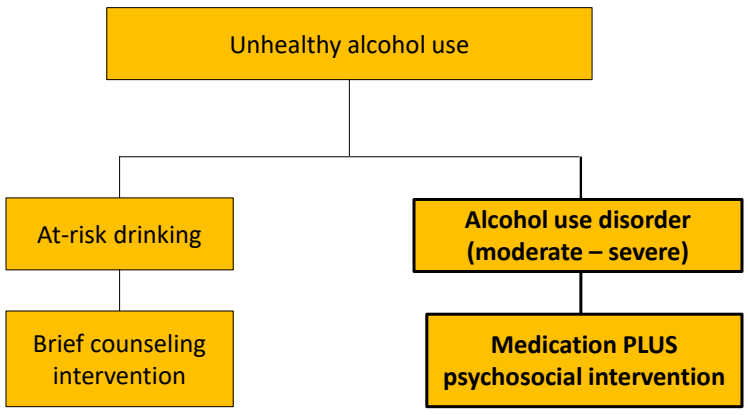

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FDA-approved medications for AUD: Naltrexone

Dosage	• Oral 50 mg/day • Intramuscular 380 mg/month
Mechanism	Opioid receptor antagonist that reduces rewarding effects of alcohol
	• Number Needed to Treat (NNT) = 20 to prevent return to any drinking • NNT = 12 to prevent return to heavy drinking
Pros	• OK to use if actively drinking • Daily oral AND long-acting injectable options • Cheap and available

Cons	• Gastrointestinal effects, headache
	• Liver concerns
	  • Avoid if Child-Pugh C or greater, or alanine aminotransferase (AST)/aspartate aminotransferase (ALT) >5x upper limit of normal
	  • Monitor live function tests baseline, 6 mo, annually
	• Abstinence from opioids prior to initiation
	• Opioids not as effective for emergency analgesia

Jonas, JAMA, 2014; Rosner et al, 2010

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FDA-approved medications for AUD: Acamprosate

Dosage	666 mg orally three times a day
Mechanism	Modulates glutamate neurotransmission
	Maintains abstinence, NNT = 9 to prevent return to any drinking in 8-24 weeks
Pros	• Safe for the liver • Can use in setting of opioid use

Cons	• TID adherence
	• Requires renal dosing
	  • 50% reduction for moderate renal impairment
	  • Contraindicated if CrCl<30
	• Diarrhea
	• Takes 5-8 days for full effect
	• For patients with goal of abstinence

Rosner et al, Cochrane Database Syst Rev, 2010

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FDA-approved medications for AUD: Disulfiram

Dosage	250-500 mg by mouth daily
Mechanism	Inhibits aldehyde dehydrogenase Causes aversive alcohol-disulfiram reaction
Pros	Use in highly structured environment (e.g. opioid treatment program) or for patients with history of success with disulfiram
Cons	• Very unpleasant • Adherence critical • Must have goal of abstinence • Concerning in setting of pregnancy, CAD, severe mental illness • Liver concerns

Skinner et al, 2014

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Non-FDA approved for AUD: Topiramate

- Titrate up to 300mg/day over 8 weeks: Wk1 25 mg qhs, Wk2 25 mg BID, Wk3 50 mg BID, Wk4 75 mg BID, Wk5 100 mg BID, Wk6 150 BID
- Beneficial for people with seizures, insomnia
- Significant adverse effects of cognitive impairment, paresthesia, sedation, appetite suppression
- Cannot abruptly discontinue
- May combine with Naltrexone

Guglielmo et al, 2015; Blodgett et al, 2014

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Non-FDA approved for AUD: Gabapentin

- Studied at 900-1800 mg/day with mixed evidence
- May be useful for people with h/o withdrawal
- Can also use for non-severe alcohol withdrawal
- Dose adjust for CKD
- May combine with Naltrexone
- May be helpful with neuropathic pain, insomnia
- Misuse potential?

Johnson et al., JAMA, 2006; Mason et al.; Falk et al., 2019; Anton et al., 2020

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Non-FDA approached for AUD: Baclofen

- Safe for use in liver failure, but mixed evidence
- In 165K patients in France treated with meds for AUD, baclofen was associated with hospitalization (HR 1.1) and mortality (HR 1.3) in dose response relationship
- Concern for very significant harms

Ciagnot et al, 2018

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Psychosocial Treatments

Clinical trials have not found any one intervention to be superior to the others

Which talking therapies work for people who use drugs and also have alcohol problems? Cochrane Review, 2018

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Psychosocial Treatments

AA & 12-step programs:

- A recent review appeared to report AA effectiveness in >10K people
- Studies tested AA in conjunction with psychotherapy, and had substantial risk of bias

Kelly, Humphreys, & Ferri, 2020

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Virtual recovery resources

- Online support groups
  - 12-step, e.g. AA
  - SMART Recovery
  - LifeRing
  - Moderation Management
  - Women for Sobriety
  - And more
- Apps
- Podcasts

Links to more resources:

- American Society for Addiction Medicine's guidance on promoting support group attendance during Covid-19
- Accessing treatment through telehealth by National Institute on Alcohol Abuse and Alcoholism

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Leverage shared decision-making for treatment

NIAAA ALCOHOL TREATMENT NAVIGATOR
Pointing the way to evidence-based care

National Council for Behavioral Health, 2018

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Part III. Ambulatory management of alcohol withdrawal

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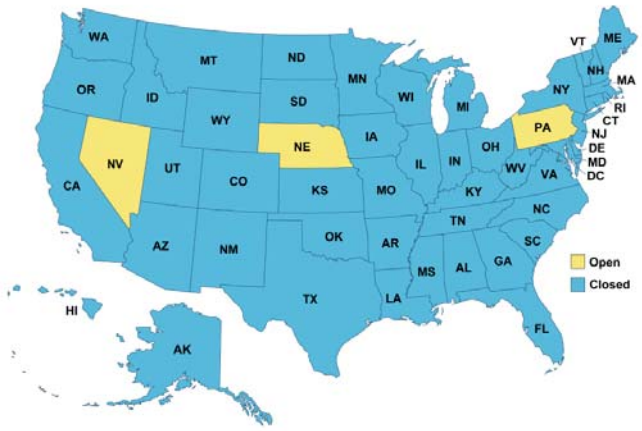
Map 2: States That Have Closed Off-Premise Establishments During COVID-19 (as of 4/13/2020)



State Alcohol-Related Laws During the COVID-19 Emergency for On-Premise and Off-Premise Establishments, NIAAA.

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Assessing safety of ambulatory withdrawal management

Can the patient be safely monitored in an ambulatory care setting or at home?	Does the patient need inpatient care?
• Does the patient have safe housing and support? • Can the patient maintain telephone-based contact? • Can the patient follow medication instructions? Take orally? • Does your clinic have the capacity to provide remote monitoring and/or accessibility for patients with alcohol withdrawal syndrome?	• Are they at risk of severe or complicated withdrawal? • Does the patient have a history of seizures or delirium tremens? • How severe are their symptoms? • Does the patient have acute illness, medical co-morbidities or co-occurring substance use likely to complicate their withdrawal treatment? • Age 65 or over? • Pregnant?

American Society of Addiction Medicine, 2020

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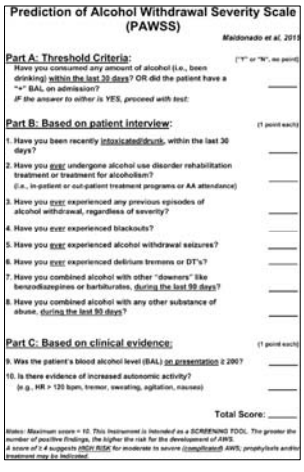
Who will develop severe withdrawal?

- History of delirium tremens (DT) most predictive in hospitalized patients
- Prediction of Alcohol Withdrawal Severity (PAWSS) is a screening tool to predict severe withdrawal in a medically ill patient
- PAWSS Scores ≥4 suggest high risk. Prophylaxis and/or treatment may be indicated



Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

Maldonado et al, 2015

Part A: Threshold Criteria: ("Y" or "N", no point)

Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days? OR did the patient have a "+" BAL on admission? _____

IF the answer to either is YES, proceed with test:

Part B: Based on patient interview: (1 point each)

1. Have you been recently intoxicated/drunk, within the last 30 days? _____
2. Have you ever undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? (i.e., in-patient or out-patient treatment programs or AA attendance) _____
3. Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity? _____
4. Have you ever experienced blackouts? _____
5. Have you ever experienced alcohol withdrawal seizures? _____
6. Have you ever experienced delirium tremens or DT's? _____
7. Have you combined alcohol with other "downers" like benzodiazepines or barbiturates, during the last 90 days? _____
8. Have you combined alcohol with any other substance of abuse, during the last 90 days? _____

Part C: Based on clinical evidence: (1 point each)

9. Was the patient's blood alcohol level (BAL) on presentation ≥ 200? _____
10. Is there evidence of increased autonomic activity? (e.g., HR > 120 bpm, tremor, sweating, agitation, nausea) _____

Total Score: _____

Notes: Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of AWS. A score of ≥ 4 suggests HIGH RISK for moderate to severe (complicated) AWS; prophylaxis and/or treatment may be indicated

Wood et al, 2018; Maldonado et al, 2014

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Medications for outpatient withdrawal management

- **Benzodiazepines**
  - Prevent seizures so generally considered 1st line
  - Consider reserving for patients with history or risk of severe withdrawal
  - Significant concerns for delirium, CNS depression and misuse
  - Longer-acting (chlordiazepoxide) preferred
  - Shorter-acting without active metabolites (lorazepam) preferred for impaired liver function or risk of oversedation
- **Gabapentin**
  - As effective as benzodiazepines in treating symptoms other than seizures and DT
  - Best as adjunct or for mild-moderate alcohol withdrawal symptoms in low risk patients
  - Can continue for maintenance treatment of AUD
  - 1200mg/day in divided doses tapered over 4-6 days
- **Carbamazepine**
  - As adjunct or for lower risk patients who do not tolerate gabapentin
  - More side effects, e.g. dizziness, drowsiness, nausea, drug interactions
  - 800mg/day in divided doses tapered over 5-9 days

Gasper & DiPaula, 2020

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Example protocols

Outpatient Fixed Schedule Benzodiazepine Dosing Protocol[11]

	Chlordiazepoxide	Lorazepam
Day 1	25-50mg every 6 hours	2mg every 8 hours
Day 2	25-50mg every 8 hours	2mg every 8 hours
Day 3	25-50mg every 12 hours	1mg every 8 hours
Day 4	25-50mg at bedtime	1mg every 12 hours
Day 5	25-50mg at bedtime	1mg at bedtime

Gasper & DiPaula, 2020; Muncie et al, 2013

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Example protocols

Gabapentin is dosed as 600mg PO TID plus an additional 600mg prn once daily for the first week, followed by a 300mg taper after the first week

Taper schedule:

Days	Gabapentin Monotherapy (fixed schedule dosing)
1	1,200mg BID plus 1,200mg x1 prn
2-7	600mg TID plus 600mg x1 prn
8	300mg TID
9	300mg BID
10	300mg qday

How to write the prescription:
Rx: Gabapentin 600mg tabs, take as directed, #30, NR

Verbalized or printed instructions for the patient:
Day 1: Take 2 tabs twice daily plus an additional 2 tabs if needed the first day
Days 2-7: Take 1 tab three times daily plus an additional 1 tabs if needed
Day 8: Take ½ tab three times daily
Day 9: Take ½ tab twice daily
Day 10: Take ½ tab once at bedtime

*Consider 1200mg/day in divided doses tapered over 4-6 days, e.g. 600mg TID or 300mg QID

Sample protocol courtesy of ASAM and Dr. Brian Hurley, disclaimer

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Example protocols

Carbamazepine is dosed 200mg PO QID x 72º followed by a 200mg reduction q72º

Taper schedule:

Days	Carbamazepine Monotherapy (fixed schedule dosing)
1-3	200mg QID
4-6	200mg TID
7-9	200mg BID
10-11	200mg qHS

How to write the prescription:
Rx Carbamazepine 200mg tabs, take 1 QID x3d, then 1 TIDx3d, then 1 BID x3d, then 1 qHS x3d, #30, NR

Verbalized or printed instructions for the patient:
Days 1-3: Take 1 four times throughout the day
Days 4-6: Take 1 three times throughout the day
Days 7-9: Take 1 twice a day
Days 10-11: Take 1 at bedtime

Sample protocol courtesy of ASAM and Dr. Brian Hurley, disclaimer

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Monitoring considerations

- Reassess patient frequently, ideally daily, for symptoms and medication reconciliation
- Family member or close contact can help monitor patient and dose medications
- If patient not at risk for severe withdrawal, may not need medications if > 24 hours with no or mild symptoms
- Consider dispensing limited supply q24-72 hours depending on patient risks and adherence

TABLE 1. Alcohol Withdrawal Severity.

Severity Category	Associated CIWA-Ar Range*	Symptom Description
Mild	CIWA-Ar < 10	Mild or moderate anxiety, sweating and insomnia, but no tremor
Moderate	CIWA-Ar 10-18	Moderate anxiety, sweating, insomnia, and mild tremor
Severe	CIWA-Ar ≥19	Severe anxiety and moderate to severe tremor, but not confusion, hallucinations, or seizure
Complicated	CIWA-Ar ≥19	Seizure or signs and symptoms indicative of delirium – such as an inability to fully comprehend instructions, clouding of the sensorium or confusion – or new onset of hallucinations

*Throughout this document, we provide examples for withdrawal severity using the CIWA-Ar, although other scales can be used. Regardless of the instrument used, there is a wide variety in the literature and in practice as to which scores best delineate mild, moderate and severe withdrawal. Classification of withdrawal severity is ultimately up to the judgment of clinicians and the choice of reference range may be based on their particular patient population or capabilities.

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Short Alcohol Withdrawal Scale (SAWS)

- Patient-administered tool to assess the severity of alcohol withdrawal.
- Patients indicate how they have felt in the previous 24 hours. Moderate to severe withdrawal ≥ 12 points.
- Clinicians can also use Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar)

Item	*None (0 points)*	*Mild (1 point)*	*Moderate (2 points)*	*Severe (3 points)*
Anxious				
Feeling confused				
Restless				
Miserable				
Problems with memory				
Tremor (shakes)				
Nausea				
Heart pounding				
Sleep disturbance				
Sweating				

Elholm et al, 2010

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Ambulatory management of alcohol withdrawal

- Transition to higher level of care if any escalating symptoms, CIWA>20, SAWS>16, distress, altered mental status or seizure
- Duration of treatment may last between 1-7 days
- Recommend regular diet, hydration, safe and relaxing environment, and consider multivitamin containing thiamine and folate
- Don't forget medications for AUD!

Resource: ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, 2020

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Part IV. Harm Reduction Approaches

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Harm reduction techniques

- Avoid mixing alcohol with other substances, especially CNS depressants
- Pre-plan intoxication periods and the circumstances: Plan ride, bring condoms, log out of internet
- Count # of drinks and pay attention to the size of drink
- Spread out drinks over time
- Use pocket breathalyzer to monitor self, especially before driving
- Alternate drinks with non-alcoholic ones
- Eat before and during drinking
- Add ice to drink
- OK to continue most prescribed medications, except sedatives and disulfiram

Comprehensive primary care for people who use drugs and alcohol. California Society of Addiction Medicine Workshop, September 2020.

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Primary care for people who drink alcohol

- Up to date cancer screening
- Screening: IPV, Falls, Cognitive, Depression, CV Risk
- Heavy alcohol prompts osteoporosis screening before age 65
- Vaccines: PPV-23 x 1 19-64yo and x2 >65yo, Tdap, HAV, HBV, Tetanus, HPV
- Consider TB risk
- Assess nutritional status
- Review medications for interactions with alcohol
- Assess for other substance use including tobacco
- Offer family planning

California Society for Addiction Medicine, 2020

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Words matter in order to reduce stigma

Use person-first language	Use clinically-accurate language
• "Person who drinks alcohol" rather than "alcoholic" or "drunk"	• "Alcohol use disorder," "unhealthy alcohol use," or "high-risk alcohol use" rather than "alcohol abuse" • "Remission" rather than "sober" • "Recurrence" rather than "relapse"

Kelly & Westerhoff, 2010; National Institute on Drug Abuse, 2020

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Summary Points: Management of Alcohol Use Disorder

1. Screen all adults for unhealthy alcohol use
2. Use brief counseling for at-risk drinking AND prescribe medications for alcohol use disorder
3. Apply a patient-centered approach to medical and psychosocial treatment selection based on goals and co-morbidities
4. Consider outpatient withdrawal management for patients without history and symptoms of severe withdrawal
5. Treat alcohol use disorder even when abstinence is not the goal

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Our services are accessible via phone or website

Substance Use
Evaluation and management

National Warmline: (855) 300-3595
California Substance Use Line: (844) 326-2626

HIV/AIDS Warmline
HIV testing, ARV decisions, complications, & co-morbidities

(800) 933-3413

Perinatal HIV Hotline
Pregnant women with HIV or at-risk for HIV & their infants

(888) 448-8765

PrEPline
Pre-exposure prophylaxis for persons at-risk for HIV

(855) HIV-PrEP

Hepatitis C Warmline
HCV testing, staging, monitoring, & treatment

(844) 437-4636 or (844) HEP-INFO

PEPline
Occupation & non-occupational exposure management

(888) 448-4911

Questions can also be submitted securely via nccc.ucsf.edu

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Reduction of drinking: An appropriate clinical outcome

- Reductions in drinking levels (grams of ethanol per day) associated with decreased SBP, LFT improvements, better QOL and medication effects
- Reductions may align more with patient's goals, recognize more people as being successfully treated, encourage more clinician confidence and encourage future medication development
- Other studies prioritize reduction in alcohol-related harm over abstinence or use reduction

Witkiewitz et al., 2018; Witkiewitz et al., 2019; Falk et al., 2019

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What is an optimal outcome in alcohol use disorder treatment?

- Total abstinence is a high standard for evaluating success
- Decrease the number of days drinking
- Decrease the number of days with heavy drinking
- Decrease the number of drinks per day
- Minimize physical, psychological, financial, and social harm

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Updated definitions for research are non-abstinence based

Remission from alcohol use disorder as defined by DSM-5 criteria
Requires that the individual not meet any AUD criteria (excluding craving). Remission from AUD is categorized based on its duration: initial (up to 3 months), early (3 months to 1 year), sustained (1 to 5 years), and stable (greater than 5 years).

Recovery from alcohol use disorder
Recovery is a process, achieved if both remission from AUD and cessation from heavy drinking are maintained over time. Recovery is often marked by the fulfillment of basic needs, enhancements in social support and spirituality, and improvements in physical and mental health, quality of life, and other dimensions of well-being.

NIAAA
National Institute on Alcohol Abuse and Alcoholism

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