Alcohol Use Disorder: Updates on Treatment, Public Health, and Stigma

Tony Thrasher, D.O., DFAPA
Milwaukee County Behavioral Health Division – Crisis Services
Medical Director
President – American Association for Emergency Psychiatry (AAEP)
HOPE Consortium (Session 2)
Thursday, August 5th, 2021 1130-1230

Contact Information

Dr. Tony Thrasher
Medical Director Crisis Services
Milwaukee County Behavioral Health Division
tony.thrasher@milwaukee countywi.gov
(414) 257-4789

PCS: 414-257-7260
Crisis Line: 414-257-7222

Disclosures - Financial

Source of Research Support and Stock Equity - NONE
Speaker’s Bureau - NONE
Publications: pending Oxford Press “Primer on Emergency Psychiatry”
Grant/Merit Reviews: Advancing a Healthier Wisconsin (AHW)
Insurance Reviews: Medical Advisory Committee (Anthem BC/BS)
Disclosures - Organizational

- External:
  - American Association for Emergency Psychiatry (AAEP)
    - President
  - Wisconsin Psychiatric Association (WPA)
    - Milwaukee Chapter President
  - Statewide WPA/WACEP Task Force (Co-chair)
  - Wisconsin Association of Osteopathic Physicians and Surgeons (WAOPS)
    - President Elect
  - Medical College of Wisconsin Dept. of Psychiatry
    - Associate Clinical Professor

Acknowledgements

Speaker panel and researchers that I have learned a great deal from on the topic...
- Dr. Covault (U CONN)
- Dr. Doniparthi (WI Medical Examining Board)
- Dr. Bohn (Milwaukee)
- Dr. Marlowe (Rogers Behavioral Health)
- Julia Sherman (Wisconsin)
  - Alcohol Policy Project************

Why are we talking about this now?
Favorite Drinking Quote…

“That's the problem with drinking:
✓ - if something bad happens, you drink in an attempt to forget……
✓ - if something good happens, you drink in order to celebrate……
✓ - if nothing happens, you drink to make something happen!”
✓ - Charles Bukowski

My intro to the local issue……

“U.S. Deaths from Alcohol, Drugs, and Suicide hit highest level since record keeping began” — USA Today (3/5/19)

The national rate for deaths from alcohol, drugs and suicide rose from 43.9 to 46.6 deaths per 100,000 people in 2017, a 6 percent increase, the Trust for America’s Health and the Well Being Trust reported Tuesday. That was a slower increase than in the previous two years, but it was greater than the 4 percent average annual increase since 1999.
Recent discussion??

Objectives

1) Overview of current Alcohol Use Disorder - medically
2) Overview of current Alcohol Use Disorder - psychiatrically
3) Current treatments
4) Future directions and Associated Topics
   - Public Health Directions
   - Professionalism and Effect on Us
   - Language and Stigma
DSM-5 Classifications

No more Dependence vs. Abuse
All are Substance USE disorders
Combine to a set of 11 criteria (need 2):
“Tempted With Cocaine, Scotch, Rum”
✓ Tolerance, Withdrawal, loss of Control, Social Consequences, and Risky Behavior
✓ **Mild (2-3 criteria)  **Severe (6 or more)  **Moderate (4-5 criteria)

Neuroanatomy of Addiction

- Mesolimbic dopamine system
  - Ventral tegmentum projections to the nucleus accumbens
- Amygdala
  - Assess whether experience is pleasurable or not
- Hippocampus
  - Records where and when the pleasurable experience occurred
Overview

- One of the CNS depressants, including BZDs and Barbiturates
  - Similar intoxication /withdrawal
  - Cross tolerant
- Main INHIBITORY NT = GABA

- 3rd leading cause of preventable mortality
  - After diet and tobacco

- Lifetime Dependence/abuse
  - 20% for males, 10% for females

Epidemiology – medical
(JAMA, August 2018)

2010: Estimated alcohol related costs in US ($249 billion)
  - 77% attributable to "binge type"

Worldwide it accounts for 5.9% of deaths (7.6% in med, 4% in women)
- CV disease and Diabetes (33.4%)
- GI diseases (16.2%)
- Cancers (12.5%)
**Intoxication**

- Ataxia, slurred speech, disinhibited, odor
- Don’t forget alcoholic hallucinosis!!
- Nystagmus, poor immediate memory
- Pts appearance strongly tied to their tolerance
- **Along with this……you don’t have to be zero to withdraw!!**

**Withdrawal**

- Symptoms due to decrease GABA and increase glutamate
  
  **Early (24-48 hours)**
  - Anxiety, tremor, seizures, some autonoms
  
  **Late (48-120 hours)**
  - Alcoholic hallucinosis (clear sensorium), agitation, delirium, more autonomic instability
  - Delirium Tremens (only delirium tx with BZDs)

**Complications**

- Anterograde blackouts
- Peripheral neuropathy
- Cerebellar degeneration
- Alcoholic gastritis
- Fatty liver / cirrhosis
- Pancreatitis
- Cardiomyopathy
- Wernicke/Korsakoff’s
- Other Dementias/Amnestic Syndromes
“Risk of Suicide Following an ER Admission”

April 2018: electronic study of 2.8 million visits
- Alcohol based visits
- Need for comprehensive assessment on anyone showing in this fashion
- Long term risk over time
- Short term risks can oscillate

Medications for AUD

Highly under prescribed
- Less than 9% of those needing them receive a FDA approved script (JAMA August 2018)
- VA pilot to fix this only resulted in a script rate of 3.4%
**Indicated meds often NOT used in lieu of benzodiazepines

Indicated Medications?

1) Disulfiram (Antabuse)
   - Aldehyde DHG
   - Calcium carbimide: similar to disulfiram
2) Naltrexone (ReVia) (Vivitrol IM)
   - Prevent positive feedback (“the high”)
   - Mu opioid antagonist
3) Acamprosate (Campral)
   - Prevent negative feedback (“the craving”)
   - GABA agonist as well as NMDA antagonist
<table>
<thead>
<tr>
<th><strong>Disulfiram</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“state of enforced sobriety”</strong></td>
<td></td>
</tr>
<tr>
<td>250-500mg daily</td>
<td></td>
</tr>
<tr>
<td>Better study results when highly supervised</td>
<td></td>
</tr>
<tr>
<td><strong>Often better with REDUCTION of drinking, not abstinence</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Naltrexone (oral)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>50mg / day</td>
<td></td>
</tr>
<tr>
<td>Good all-around data, including that of binge drinking</td>
<td></td>
</tr>
<tr>
<td>N/V and fatigue are main side effects</td>
<td></td>
</tr>
<tr>
<td>Careful if using with patients on opioids!</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Naltrexone (long acting)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>380mg monthly</td>
<td></td>
</tr>
<tr>
<td>Vivitrol</td>
<td></td>
</tr>
<tr>
<td>Decrease drinking days and increase total abstinence</td>
<td></td>
</tr>
<tr>
<td>Increase interest as of late to many AODA programs...</td>
<td></td>
</tr>
</tbody>
</table>
**Acamprosate**
- 333mg tablets
- 666mg po TID (complicated regimen)
- Be wary of kidney issues (not liver)
- Works on craving....not the “high”
- Orphan designation for Fragile X

---

**NON-FDA covered**

**Nalmefene**
- Mu and delta opioid antagonist
- Kappa opioid partial agonist
- European approved

**Baclofen**
- GABA agonist
- Ddly better at lower dosing and with those who were heavier use
- Many more side effects than the rest (sedation, dizzy, headache, cognitive)

---

**NON-FDA covered (cont.)**

**Gabapentin**
- Very LITTLE data, but highly used off label for MANY things
- Data on misuse (worse with EtOH)
- Added to PDMP

**Topiramate**
- Decent data on decreased drinking days
- Some studies beat Naltrexone head to head pertaining to binge drinking
- However, higher incidence of side effects
Other than meds.......

How else can we address this locally?

Particularly given some of our area’s cultural peculiarities on this topic!

“Involuntary commitment is only permissible when there is an EXTREME likelihood that if the person is NOT confined he will do IMMEDIATE harm to himself or others.”
Misperceptions & Errors:

- Style & level of drinking is unrelated to alcohol problems.
- Heavy drinkers are different and unaffected by policy interventions.
- Heavy alcohol use has an impact on very few people.
- Exclusive focus on chronic alcohol-related illness, neglecting injuries.
- “Delusion” that the favored beverage is not alcohol!
Addressing this in a Public Health Fashion

**Available** - Commercial Access (aka Outlet Density)
  - & Social Access

**Attractive** - Marketing, Advertising

**Acceptable** – Social Norms

**Affordable** - Tax

Wisconsin Alcohol Oversight

Wisconsin does **NOT** have:
- Alcohol Beverage Control Board
- Review/regulation of alcohol products sold in Wisconsin
- A system to recall alcohol
- Agreement on what's considered food and/or alcohol

Municipalities are responsible for:
- Licensing on-premise alcohol sales & off-premise retail sales
- Licensing "operators" bartenders
- Licensee discipline
- Alcohol-related local ordinances can cover other concerns not in conflict with state law

State Government is responsible for:
- Alcohol taxation
- Setting minimum standards for licensees
- Creating minimum applications. Issue licenses to wholesalers, vessels, airports & county-owned facilities

Wisconsin does **NOT** have:
- Alcohol Beverage Control Board
- Review/regulation of alcohol products sold in Wisconsin
- A system to recall alcohol
- Agreement on what's considered food and/or alcohol
Alcohol Outlet Density?
Where you BUY alcohol…and how it clusters DOES COUNT

Alcohol Licensing in WI:
• No inherent right, but.....
• Once awarded, it may NOT be suspended, non-renewed, or revoked without significant CAUSE

Options
1) Targeting Over Serving
• Overserving is illegal but hard to prosecute
• Waukesha County found 10% of OWI from 1 licensee
• Dane County found 80% of all licensees never cited

2) Sober Server
• As it stands, intoxicated individuals CAN LEGALLY serve alcohol in Wisconsin
• Appleton, City of Waukesha, and Wausau limit degree of impairment

More Options
3) Public Impairment Ordinances
• Menomonie, La Crosse, and Ashwaubenon have ordinances that make it ILLEGAL to be intoxicated in public

4) Alcohol Taxes
• "Addiction 09, Wagenaar and Salois" clear direct relationship between price/tax and level of consumption
• Studies in Alaska note direct correlation:
  • Taxes on Alcohol............PASS THROUGH to actual beverage prices
5) Sign Codes
- Have codes limiting the amount of alcohol advertising in windows or the site (https://law.wisc.edu/wapp/municipal_policies.html)

6) Limiting “free” Access
- Earlier drinking age tied to having it stolen from / purchased by family
- Communities using “fridge locks” as well as limiting “garage shopping”

Stigma and Language

What is Stigma?
Stigma in the Population

Review by Schomerus et al in Alcohol and Alcoholism Vol 46, December 2010

Alcohol Dependence as a Mental Illness
Reviewed 504 Documents that compared the view of alcohol use disorder among other mental health issues

Surveys asking if diseases were a mental illness:
- US: Schizophrenia (88%) Depression (68%) Alcoholism (49%)
- New Zealand: Schizophrenia (95%) Depression (70%) Alcoholism (32%)
- Brazil: Schizophrenia (57%) Alcoholism (19%)

Blame
US: Alcoholics: 66% “are to blame” for their condition (1998), lowered to 54% in 2003
- Compared to 4-13% “are to blame” if the dx is depression, panic attacks, schizophrenia, or dementia

Stigma in Medicine?

Medical Education
- Initial hypothesis was that stigma towards people with substance use disorder was due to lack of skills training
- Johns Hopkins found that Residents’ attitudes Worsen over time
- Less Satisfaction caring for AODA patients
- Increased belief that AODA patients were over-using resources
- European multicenter study (doctors, nurses, social workers)
- Staff with less than 10 years experience had more positive attitudes towards AODA patients

“Hidden Curriculum”

DEFINITION: “Attitudes of training staff passed on to trainees”
- Didactics looking at learning about attitudes and how to improve attitudes
- Reflection papers, Qualitative coding
- Coding for stigmatizing & non-stigmatizing language
- Led to increased understanding and respect

Substance Abuse Attitude Survey
Example questions:
- “Alcohol is a weak will problem”
- “An alcohol dependent person cannot be helped until he/she has hit rock bottom”
- “Alcohol and drug abusers should only be treated by specialists in that field”

CREDIT TO DR. MARLOWE, ROGERS BEHAVIORAL HEALTH
More suggestions (Marlowe)

Remember the predominant emotion for patients seeking AODA treatment is Shame.
Take an alternate approach: pts used to providers/family/friends reacting with anger
Discuss Goals for Treatment: focus on CHANGE AREAS

When asking substance history: get details about what was successful during past periods of sobriety, how can it be recreated?

Compare to the TBI individual: active addiction also affects PFC poor impulse control........ + dysregulation + ambivalence. Do we treat them the same?

Suggestions Socially

Associated Press
AP Stylebook updates
“Addict” should no longer be used as a noun
“Dependence” cannot be used as a synonym for addiction
Describe it as substance USE, not “problem”
Are you using “person first” language?
- The person has the problem. NOT the person is the problem.
  Example: a 46 y/o alcoholic vs a 46 y/o patient with alcohol use disorder

Are you conflating substance use and substance use disorder?
- Pertains to helping with prevention, especially with coding and “labels.”

Are you using technical language with a single, clear meaning instead of colloquialisms or words with inconsistent definitions?
- Negative urine drug screen vs Clean Urine

Conclusions

1) Large local issue for both medical providers and overall mental health
2) Many different treatment options available, yet under utilized!
Conclusions (cont.)

3) Some of this under utilization can be tied to:
   - Stigma
   - Concerns over professionalism
   - Public Health effects
4) We have to be more vigilant to this than others due to the cultural items in our area!

Thank you for your time!

“The test of a first rate intelligence is the ability to hold two opposed ideas in the mind at the same time, and still retain the ability to function.”
   - F. Scott Fitzgerald