

From NIAAA
**THE HEALTHCARE PROFESSIONAL'S
CORE RESOURCE ON ALCOHOL**
Knowledge. Impacts. Strategies.

Are You Prepared to Talk With Patients About Alcohol?



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APA CE Disclosures

There is no content in this presentation that presents a conflict of interest, including any financial interest, for Dr. Laura Kwako or Dr. Thekla Brumder Ross.

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Our Goal

*To help you feel confident and
equipped with resources to address
the continuum of alcohol use
with all those in your care.*

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Today's Talk

- Alcohol and patient care: What's amiss?
- Is your patients' alcohol use complicating their treatment?
- Stigma: A pervasive barrier to care
- The brain in addiction and recovery
- Evidence-based treatments
- Let's empower you to act

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Today's talk draws largely from the NIAAA Healthcare Professional's Core Resource on Alcohol

- 14 concise, user-friendly articles
- Basic knowledge, clinical impacts, and patient care strategies
- Developed with 70 contributors

(more on this later)



www.niaaa.nih.gov/CoreResource



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Alcohol and healthcare: What's amiss?

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Heavy drinking and alcohol-related problems are common and consequential

- About **1 in 4** U.S. adults **drinks heavily**, and about **1 in 9** has **alcohol use disorder (AUD)**.
- Alcohol causes or worsens **more than 200 health conditions** and thus often may contribute to a person's presenting concern (e.g., anxiety, depression, insomnia, +).
- Alcohol is a **leading cause of preventable death** in the U.S., contributing to about 178,000 deaths/year.

Sources: NIAAA [Alcohol Facts & Statistics](#) and the Core Resource [Topic 5: Medical Complications](#)

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And yet—alcohol is often overlooked in healthcare training and practice

- **Only 32%** of U.S. doctoral-level clinical psych programs provide **specialized practice opportunities** in addictions.
- **Only 34%** of master's-level clinical psychologists report completing a **specific course in addictions**.
- **Only 2.6%** of PCPs use **validated alcohol screening tools**.
- **Only 20%** of people who disclose heavy drinking in a medical checkup are **advised to cut down**.
- **Only 2%** of people with AUD receive **easily prescribed, non-addicting, FDA-approved medications for AUD**.

Sources: [Burrow-Sánchez et al. 2020](#); [Chatterton et al. 2022](#); [Mintz et al. 2021](#); [McKnight-Eily et al. 2020](#); [Han et al. 2021](#)

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The good news

Be optimistic! You can:

- **Take 3 efficient steps** to screen, assess, and give brief advice
- **Promote lasting change** with evidence-based therapies
- **Pair with prescribers** for medications to reduce relapse

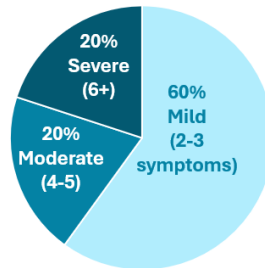
And your patients:

- **Expect to be asked** about alcohol and may be open to change
- **Don't need to hit rock bottom**; changing sooner is better
- May have setbacks, but **most reduce their drinking** over time

Sources: Core Resource articles on [Screening](#), [Brief Intervention](#), [Treatment](#), and [Recovery](#)

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**Perspective: Most patients with AUD have a
mild or moderate level of severity**



Alcohol use disorder (AUD) severity levels
 (and # of AUD symptoms)
 among people aged 12 and older

Source: [2022 National Survey on Drug Use and Health, Table 5.2B](#)

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Poll #1

Do you suspect that some of your
 patients have alcohol problems
 that have not been discussed?

- A) Yes
- B) No

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Is your patients' alcohol use complicating their treatment?

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Comorbidities are common

Estimated lifetime prevalence of AUD in people with¹

- Any anxiety disorders = 20 to 40%
- Major depressive disorder = 10 to 60%
- Post-traumatic stress disorder = 35 to 55%
- Personality disorders = 52 to 77%
- ADHD = 19 to 26%
- Other substance use disorders = 23 to 47%
- Bipolar disorders = 24 to 44%
- Psychotic disorders = 12 to 34%

And among those with AUD, ~40 to 90% have a sleep disorder²

¹Castillo-Carniglia A et al. [Psychiatric comorbidities in alcohol use disorder](#). 2019

²Chakravorty S et al. [Alcohol Dependence and Its Relationship With Insomnia and Other Sleep Disorders](#). 2016

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Causes of co-occurrence

- **Drinking to cope:** Pre-existing psychiatric disorders may motivate people to drink to cope with psychiatric symptoms, even if it makes the problems worse.
- **At-risk alcohol use:** Adolescent drinking and heavy drinking patterns may predispose people to psychiatric disorders.
- **Other shared risk factors:** AUD and other psychiatric disorders often share genetic risks and environmental vulnerabilities such as trauma and adverse childhood experiences.

Source: NIAAA Core Resource [Topic 7: Mental Health Issues](#)

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Effects of co-occurrence

Overlapping symptoms can complicate your diagnoses.

- **AUD symptoms can significantly overlap** with other psychiatric disorders (e.g. sleep and mood disturbances from cycles of alcohol intoxication, withdrawal, and craving).
- **Key tool:** A timeline of your patient's symptoms is a key tool for a differential diagnosis. (See Core Topic 7 for details.)

Untreated alcohol issues will likely compromise outcomes.

- **Mutual impact:** AUD and other mental health disorders may exacerbate each other, producing poorer outcomes.
- **Serious consequences:** Without adequate treatment, this pattern may result in higher rates of hospitalization and suicide.

Source: NIAAA Core Resource [Topic 7: Mental Health Issues](#)

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Poll #2

What is the primary challenge you face when discussing alcohol use with your patients?

- A) Lack of time
- B) Insufficient knowledge about alcohol use disorder
- C) Patient reluctance to discuss alcohol use
- D) Stigma and judgment
- E) (Not yet discussing alcohol use with patients)

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**Stigma: A pervasive
barrier to care**

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Stigma: A pervasive barrier to better care

- **How it feels:** People with AUD can feel **isolated and rejected**. They have come to believe negative attitudes and false beliefs about AUD picked up from others. Those in recovery may feel stigmatized for not drinking because alcohol is normalized in our country.
- **What makes it worse:** Even healthcare professionals may hold **false beliefs** that patients with AUD have character flaws, have chosen their condition and have complete control over it, and just need willpower to cut down or quit.
- **How stigma derails help-seeking:** The **more stigma** perceived by a person with AUD, **the less likely** they are to seek treatment.

Source: Core Resource [Topic 4: Stigma](#) (1)

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You can reduce stigma for patients with AUD

- **Ask everyone:** Routinely screen all patients for heavy drinking and assess for AUD in those who screen positive. Tell patients you ask everyone.
- **Use non-stigmatizing language:** e.g. alcohol use disorder, people with AUD, *NOT* alcoholism, alcoholic.
- **Explore their understanding** about their alcohol use and its consequences **before** offering a diagnosis.
- **Educate** them that evidence-based treatment is available, change is possible, and MOST people with AUD recover or markedly improve.
- Consider finding a **prescriber for AUD medications** as "foot in the door" to specialist treatment if needed.
- **Encourage patient autonomy** by involving them in decisions about next steps.

Source: Core Resource [Topic 4: Stigma](#) (2)

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The brain in addiction and recovery

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Brain changes in people with AUD make it hard for them to stop drinking

Alcohol is dually reinforcing. In the brain, alcohol initially:

- ⬆ **activates** the **reward** system that mediates pleasure and
- ⬇ **reduces** activity of systems that mediate **stress, anxiety,** and **emotional pain.**

But repeated, excessive alcohol use can lead to addiction, in which the scenario flips and the brain shows:

- ⬇ **reduced reward system** activity and
- ⬆ **more stress systems** activity—leading to more anxiety and emotional pain.

This is a recipe for misery. People drink to reduce the significant emotional and physical discomforts of withdrawal.

Source: NIAAA Core Resource [Topic 3: Neuroscience](#)

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Brain changes in AUD make it hard for people to handle urges to drink

- Alcohol disrupts function in the brain's prefrontal cortex areas involved in **executive function, impulse control, decision-making, and emotional regulation.**
- When people become preoccupied with drinking alcohol, their **cognitive control neurocircuits** can **struggle to regulate** urges to drink, particularly when under stress.
- Alcohol also can **directly damage these brain circuits**, making it even harder to regulate urges.

(Hold on—there's hope.)

Source: NIAAA Core Resource [Topic 3: Neuroscience](#)

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But—brain plasticity can be harnessed to help the brain heal from AUD

The extent of the brain's capacity to return to 'normal' following long-term sobriety is not fully understood, however:

- At least some **AUD-induced brain changes**—and the changes in thinking, feeling, and behaving that accompany them—**can improve and possibly reverse with months of abstinence.**
- Even in individuals with lingering alterations in brain circuitry and function due to AUD, there is evidence that **other circuits can compensate** to help restore compromised function.

Source: NIAAA Core Resource [Topic 3: Neuroscience](#)

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Evidence-based treatment helps the whole person heal

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Two types of professionally-led treatment help the brain heal from AUD

Psychotherapy: Neuroimaging studies show that behavioral health interventions for AUD can **normalize activity** in the reward and stress circuitry of the brain, while **strengthening cognitive networks** that help inhibit the urge to drink. (More on the interventions to come.)

Medications for AUD: Several options for non-addicting medications for AUD facilitate healthy brain changes by helping people to quit or cut down significantly, which may **allow behavioral healthcare to be applied** to best advantage.

Source: NIAAA Core Resource [Topic 3: Neuroscience](#)

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Integrating treatments improves care

- **Quitting drinking** on its own often leads to clinical **improvement** of co-occurring mental health disorders.
- But **treatment for psychiatric symptoms alone** generally is **not enough** to reduce alcohol consumption or AUD symptoms.
- **Integrated treatment** of AUD and co-occurring psychiatric disorders **tends to lead to better results** than fragmented approaches.
- **Combining medications for AUD and behavioral healthcare** for people with dual diagnoses often produces **superior outcomes** than either treatment alone.

Source: NIAAA Core Resource [Topic 7: Mental Health Issues](#)

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Medications for AUD can promote recovery

Medications for AUD are **non-addicting** and **can promote abstinence** and **reduce relapses**. But they are **vastly underused**. Three are **FDA-approved**:

- **Acamprosate** alleviates the emotional discomfort and insomnia that can happen as the brain adjusts to abstinence.
- **Naltrexone** works by blocking the opioid receptors in the brain that are involved in the rewarding effects of alcohol.
- **Disulfiram** blocks an enzyme involved with alcohol metabolism and causes physical discomfort when alcohol is consumed.

Also, the anticonvulsants **topiramate** or **gabapentin** may be offered **off-label** to patients who have not responded well to naltrexone and acamprosate.

Pair with a prescriber to provide more choices for patients! (more later)
As with antidepressants, if one doesn't work, try another.

Sources: NIAAA Core Resource [Topic 11: Evidence-based treatment](#); The [American Psychiatric Association Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder](#), 2018.

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Let's empower you
to act

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We can help you to:

- **Fill training gaps** with the NIAAA Core Resource, to include basic knowledge, clinical impacts, and patient care strategies.
- **Provide brief alcohol screening, assessment, and advice** with a 3-step workflow using evidence-based tools and tips.
- **Learn about AUD-focused therapy** approaches to consider applying in your practice.
- **Locate collaborators**—including specialist prescribers, programs, and therapists—to create a flexible treatment plan with the ingredients of an evidence-based, quality program.

Source: [Substance Abuse Intensive Outpatient Programs: Assessing the Evidence](#), 2014

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Foundational Knowledge and Clinical Impacts



Foundational Knowledge

- The Basics
- Risk Factors
- Neuroscience
- Stigma



Alcohol's Clinical Impacts

- Medical Complications
- Alcohol-Medication Interactions
- Mental Health Issues
- Alcohol Use Disorder

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Individual- and Practice-Level Strategies



Strategies for Prevention and Treatment

- Screen and Assess
- Conduct a Brief Intervention
- Recommend Evidence-Based Treatment
- Make Referrals
- Support Recovery



Putting It All Together

- Promote Practice Change
- Roadmap: How to Apply the Core Resource in Clinical Practice

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The Core offers a 3-step workflow for evidence-based alcohol screening and follow up

Step 1: Screen for heavy drinking (Yes/No)

Step 2: Advise (if No) or Assess for AUD (if Yes)

Step 3: Ask permission to give advice; proceed if yes

Source: NIAAA Core Resource [Topic 9: Screen and Assess](#) & [Topic 10: Brief Intervention](#)

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Source: NIAAA Core Resource [Topic 9: Screen and Assess](#) & [Topic 10: Brief Intervention](#)

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Step 1: Screen for heavy drinking

Do use: 1 of 2 brief, validated screens recommended by USPSTF:

- **Single NIAAA question:** "How many times in the past year have you had 4 or more (women)/5 or more (men) drinks in one day?" (1+ = positive) - **OR-**
- **The AUDIT-C** (3 scored questions about drinking quantity and frequency)

Do NOT use:

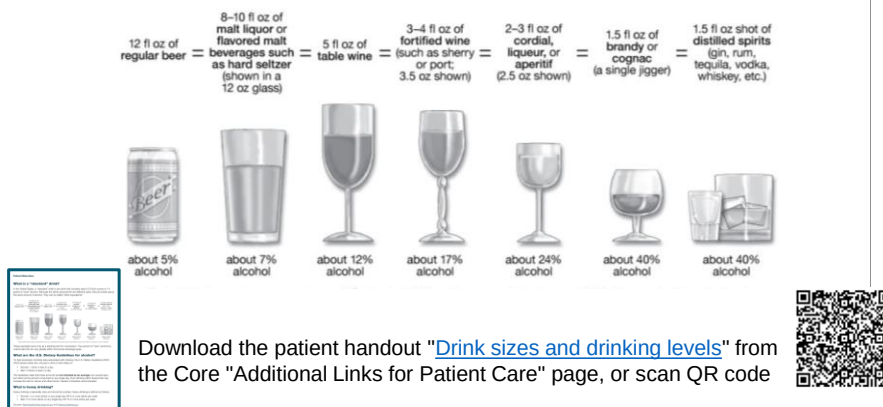
- **Yes/no or leading questions:** "You don't drink often, do you?"
- **The outdated "CAGE,"** which misses at-risk patients without adverse consequences who still need a brief intervention

Source: Core Resource [Topic 9: Screen and Assess](#)

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The basics: What counts as a drink?

In the U.S., a "standard drink" is any drink that contains 14 grams, or about 0.6 fluid ounces, of "pure" ethanol. Each of the drinks shown here contains an equivalent amount of alcohol.



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The basics: What counts as heavy drinking?

These heavy drinking patterns markedly raise risks for alcohol-related harm:

- **For women**—4 or more drinks on any day or 8 or more per week
- **For men**—5 or more drinks on any day or 15 or more per week



Download the patient handout "[Drink sizes and drinking levels](#)" from the Core "Additional Links for Patient Care" page, or scan QR code



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Step 2: Advise or assess

- **If NO heavy drinking:** Advise staying within the U.S. Dietary Guidelines of 1 drink (women) or 2 drinks (men) on any day or abstaining; no further steps.
- **If YES to heavy drinking:** Get typical weekly average and **assess for AUD** with "The Alcohol Symptom Checklist."



- Clinically validated, self-report, simple yes/no form
- Allows you to identify DSM 5 AUD and level of severity.



Source: Core Resource [Topic 9: Screen and Assess](#)

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The Alcohol Symptom Checklist is based on the 11 DSM-5 AUD symptoms.

"Yes" answers can be openers to help you enhance motivation to change.

In the past 12 months...

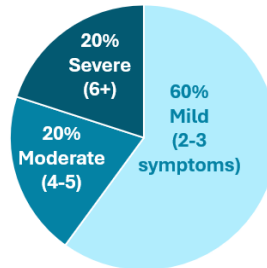
1. Did you find that drinking the same amount of alcohol has less effect than it used to or did you have to drink more alcohol to get intoxicated?	No ☐	Yes ☐
2. When you cut down or stop drinking did you get sweaty or nervous, or have an upset stomach or shaky hands? Did you drink alcohol or take other substances to avoid these symptoms?	No ☐	Yes ☐
3. When you drank, did you drink more or for longer than you planned to?	No ☐	Yes ☐
4. Have you wanted to or tried to cut back or stop drinking alcohol, but been unable to do so?	No ☐	Yes ☐
5. Did you spend a lot of time obtaining alcohol, drinking alcohol, or recovering from drinking?	No ☐	Yes ☐
6. Have you continued to drink even though you knew or suspected it creates or worsens mental or physical problems?	No ☐	Yes ☐
7. Has drinking interfered with your responsibilities at work, school, or home?	No ☐	Yes ☐
8. Have you been intoxicated more than once in situations where it was dangerous, such as driving a car or operating machinery?	No ☐	Yes ☐
9. Did you drink alcohol even though you knew or suspected it causes problems with your family or other people?	No ☐	Yes ☐
10. Did you experience strong desires or craving to drink alcohol?	No ☐	Yes ☐
11. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	No ☐	Yes ☐



Source: Halgren KA et al. Alcohol Clin Exp Res. 2022 Mar;46(3):458-467.

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Reminder: The number of symptoms reflects AUD severity. Most AUD is mild or moderate.



Alcohol use disorder (AUD) severity levels
 (and # of AUD symptoms)
 among people aged 12 and older

Source: [2022 National Survey on Drug Use and Health, Table 5.2B](#)

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Step 3: Brief advice

Ask permission to provide advice, then offer these messages:

For those with heavy drinking and no AUD:

- "You're drinking at a level that could be contributing to your *[name the psychiatric concern(s)]*."
- "I strongly recommend that you think about cutting down (or quitting) and I'm willing to help."

For those with AUD:

- "I believe you have alcohol use disorder, and it may be contributing to your *[name the psychiatric concern(s)]*."
- "I strongly recommend that you think about quitting drinking and I'm willing to help." If hesitant to quit, negotiate individualized drinking goals.
- Discuss treatment options and consider a referral for medications for AUD or specialty care.

Source: Core Resource [Topic 10: Brief Intervention](#)

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After your brief advice:

- **Offer support.** Ask what the patient thinks of the information. Express empathy and encourage autonomy.
- **Build motivation.** Explore reasons for change, listening for patient's own reasons. Use AUD symptoms as openers if applicable.
- **Identify next steps.** Work together to develop a plan for change. Consider a referral to prescribers for medications.
- **Share patient resources.** (See upcoming slides.)

Call to action: Follow up with evidence-based AUD-focused therapies!

Source: Core Resource [Topic 10: Conduct a Brief Intervention](#); [How to Apply the Core Resource in Clinical Practice](#)

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Broadly, AUD-focused behavioral health treatments aim to help patients to:

- Set goals
- Identify triggers that could prompt drinking
- Develop skills to stop or reduce drinking
- Manage emotions and stress
- Build relationships that will support treatment goals

Source: NIAAA Core Resource [Topic 11: Evidence-based treatment](#)

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A variety of evidence-based therapies for AUD are about equally effective.

AUD-focused therapies apply approaches including:

- Cognitive-behavioral therapy (CBT)
- Motivational enhancement therapy (MET)
- Acceptance- and mindfulness-based interventions
- Contingency management approaches
- Couples and family counseling
- Mutual support group facilitation therapies

Sources: NIAAA Core Resource [Topic 11: Evidence-based treatment](#), [Substance Abuse Intensive Outpatient Programs: Assessing the Evidence](#), 2014

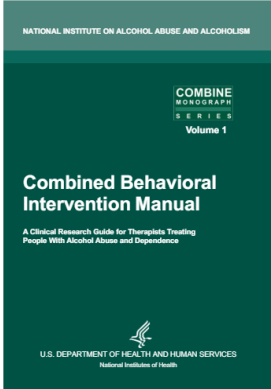
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Learn evidence-based therapies for AUD with a FREE manual used in clinical trials!



Includes CBT, MET, change plans, and pull-out procedures for:

- Coping with cravings
- Drink refusal skills
- Communication skills
- Social and recreational counseling
- Medication adherence
- And more!

Learn about the methods and seek more training as needed!



Available from NIAAA Core Resource [Additional Links for Patient Care](#) or scan the QR code.

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Patient resources: Online interactive tools adapted from clinical trial manual





- **Pros & cons checklist:** Weigh the **reasons for and against** making a change.
- **CBT modules:** Learn ways to **handle urges to drink** and **refuse drink offers**.
- **Change plan:** Solidify **goals**, set **timing**, and list **reasons** for change, **strategies** to use, **people** who can help, signs of success, possible **roadblocks**, and **ways to handle** them.

Find under "Tools" then "Worksheets" on RethinkingDrinking.niaaa.nih.gov



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Patient resources: e-Health options

Samples of e-health tools developed with NIAAA funding:

- **CBT4CBT**—A **self-guided, web-based cognitive behavioral therapy program** that teaches skills to help people stop or reduce drinking; health professionals can provide a prescription.
- **CheckUp & Choices**—A **digital self-help program** to guide people in deciding whether to change their drinking habits and developing skills to make a change.
- **More to come**

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Patient resource: A "Decision Aid"

Options for people
who are thinking
about their drinking



Kaiser Permanente

This 40-page booklet was developed by Kaiser Permanente with funding from NIAAA.

Part 1: What choice is best for you?

Part 2: What are your options?

Part 3: What do you want to do?

The [Decision Aid](#) can be downloaded from the NIAAA Core Resource "[Additional Links for Patient Care](#)" section or scan the QR code.



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Find collaborators when needed

Different patients need different options. The NIAAA *Alcohol Treatment Navigator* can **help you and your patients** find a range of choices, including outpatient options with flexibility and privacy that may reduce stigma.

- **Locate prescribers** for AUD medications that can help prevent relapse and give your patients a better chance to benefit from your therapy.
- **Locate high quality AUD treatment programs** and inform your patients that *intensive outpatient programs are as effective as residential*.*
- **Locate therapists with a specialty in AUD-focused treatment** if you feel it would be helpful to complement your care.



AlcoholTreatment.niaaa.nih.gov

*Source: [Substance Abuse Intensive Outpatient Programs: Assessing the Evidence](#), 2014



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Poll #3

What additional resources or training would help you feel more prepared to address alcohol use with your patients?

- A) More information on medications for AUD
- B) Workshop on overcoming stigma
- C) Training on specific therapeutic approaches for AUD
- D) All of the above

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Questions?

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