Diagnosis and Treatment Retention Podcast
Episode Three: Engaging and Retaining Patients in Treatment

NOTE: Please be sure to download the provider and patient handouts that accompany this activity, at the website.

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Ilana Hardesty: Welcome to *Managing Unhealthy Alcohol Use in Clinical Practice*, Boston University's new podcast discussing best practices in the diagnosis and treatment of alcohol use disorder. I'm Ilana Hardesty, your moderator. This series consists of three episodes. If at any point you want more information on receiving credit for this course, please visit the website that is linked in the podcast description. There are also resources that accompany this series. All of them can be found at that website. In this final episode, I'll be speaking with Dr. Daniel Alford, a primary care physician and an addiction medicine specialist, and Annie Potter, a nurse practitioner and addiction specialist. Both see patients at Boston Medical Center and are on faculty at Boston University. And we'll again hear from Jeanette, a patient in recovery from alcohol use disorder. We'll be discussing the long-term management of patients with alcohol use disorder: how to engage them, retain them in treatment, and monitor them.

Let's start by returning to last episode's case with patient Robert Sterling, a 42-year-old man with a newly diagnosed severe alcohol use disorder. Robert presents for a follow up appointment with his primary care physician. At his previous visit, he was started on oral daily naltrexone and educated about the potential benefits of attending Alcoholics Anonymous meetings. His main motivation to stop drinking was to save his marriage and be a good father for his daughter, Stephanie.

Dr. Alford: Hi, Mr. Sterling, good to see you again.
Robert: Good to see you.
Dr. Alford: So, let me see. Last time we started you on naltrexone and we also discussed going to an AA meeting…how has it been going?
Robert: Not good…I took the medication for a couple of weeks and it didn't help…plus I kept forgetting to take it.

Dr. Alford: What about the AA, did you attend any AA meetings?
Robert: I went a couple of times with my neighbor, George – he's been going for years – but, honestly, I didn't see the point. Why do I need to listen to other people's problems when clearly I have my own? Oh, and by the way, you can probably see in my chart that I ended up in urgent care a couple of months ago with really bad bronchitis? Well the ER doctor said that you put alcohol abuse in my chart, and then I just feel like he wanted me out of there. That just made me want to stop any treatment.
Dr. Alford: I'm sorry that happened, and I can see why you're upset. And you sound pretty down…
Robert: Yeah, well…my wife kicked me out because of the drinking. I'm living with my brother, which is a total drag, and I only get to see Stephanie on the weekends now.
Dr. Alford: That all sounds terrible, and I'm sorry to hear that.

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Ilana Hardesty: Before we talk about Robert's experience with alcohol use disorder treatment, Dr. Alford, can you comment on his negative encounter in urgent care?

Dr. Alford: So unfortunately, what Robert experienced in that urgent care center is not uncommon. And there have been numerous studies over the years that have looked at the impact of stigma on individuals seeking treatment for their alcohol use disorder. In fact, a systematic review, including international studies, looked at public beliefs about various substance-unrelated mental disorders compared to alcohol use disorder, and found that those suffering with an alcohol use disorder were held more responsible for their condition, were perceived as more dangerous, and were more likely to provoke negative reactions. A recent review found that stigma towards individuals with alcohol use disorders becomes an important barrier to those patients with alcohol use disorder seeking treatment.

Ilana Hardesty: In Episode Two, we introduced Jeanette, a patient in recovery from alcohol use disorder. Let's hear about her experience with stigma when she presented to an emergency room for care.

Jeanette: I had one altercation. I was going to the emergency, and the attending nurse or the administrative nurse that sees you, triage – she was very, very rude to me. And she says, "Well, you're not supposed to be drinking, are you drunk?" To that effect. And at that point, I just, you know, didn't say anything, but I did tell my primary about it. And the thing was, is that I was there at the emergency, not because I was drinking, it was because of something else. Alcohol had nothing to do with it. But when she read my chart, she automatically assumed that I was

drinking and I was, you know, drunk. I just know that now that if someone is rude to me like that, I know that I can speak up for myself and say what I need to say, and to let them know that they have no right to judge me. Everybody has issues. Everybody has problems.

Ilana Hardesty: Dr. Alford, what's your reaction to Jeanette's experience in the emergency room?

Dr. Alford: So again, it's unfortunate that Jeanette experienced stigma when she was seeking help, in this case in the emergency room, but fortunately she was able to advocate for herself despite experiencing this stigma. But remember, as I described earlier, stigma can actually prevent individuals with an alcohol use disorder from either seeking treatment or continuing treatment. We also need to remember that not all patients with an alcohol use disorder are still drinking. In fact, Jeanette is in sustained long-term recovery and doing quite well, and presented with a completely unrelated problem. So, I think we need to be cautious. We need to think about what we're saying and trying to avoid stigmatizing language, but also don't assume that everybody with an alcohol use disorder is coming in with an alcohol-related problem, or is actively drinking.

Ilana Hardesty: Now let's get back to Robert Sterling's case. Annie, how would you address this patient's negative experience with alcohol use disorder treatment, including both medication and AA? And how do you keep patients engaged in treatment, since there's not a miracle cure?

Annie Potter: I like to highlight patients' strengths and some of the motivations for their treatment and making sure that motivation is coming from within. In the case of Robert, it seems like his motivation is to keep the family unified, in staying with his wife and also being a good father to his daughter, Stephanie. What I would congratulate him on is trying to attend an AA meeting, but also knowing that one meeting is not exemplary of the whole program itself. And perhaps he should try it again or yet try another meeting. When talking about the medication, it seems like forgetting to take it was one of the challenges. In this case, I might ask if he would be open to trying long-acting injectable naltrexone, which takes one thing out of his daily regimen to remember; and really highlighting his strengths because it seems like he is pretty down and feeling as though none of the treatment options are working for him at this time.

Dr. Alford: So, Annie, those sound like really important general principles. But what about for the individual patient? Is there a way to think about treatment plans when you're sitting across from a specific patient?

Annie Potter: I think many times when we're talking about a specific treatment plan, I like to make it very individualized to the person. And one way that I do that in making a personal plan is perhaps asking about three goals that they have in their life to repair some of their social relationships or responsibilities that they have to fulfill. And so, in that way, it kind of takes it away from an all or nothing of you achieve success when you are abstinent from alcohol and you are a "failure" when you are drinking alcohol. And so really highlighting to Robert, not forgetting who he was as a person, because I think much of his identity is then encapsulated with alcohol. And so for Robert, I would ask, "What are three goals that you have in your life that you would like to attain that is not necessarily related to addiction?" So that could be retaining back his job, repairing relationships with his wife. And I use that as ways and bench-markers to show that we're looking for progress and not perfection.

Ilana Hardesty: Dr. Alford, it sounds like this patient is quite depressed. How would you assess and manage that depression in the setting of his alcohol use disorder?

Dr. Alford: Yeah, I agree with you. And I think whenever I have a patient with a substance use disorder, including alcohol use disorder, I think about co-occurring mental illness, because patients with use disorders commonly have depression or anxiety or PTSD, for example. And there are reasons why there's so much overlap. I mean, one is that there are common risk factors that can contribute to both alcohol use disorders and other mental health conditions. Certainly, there is a genetic component, so it may run in families, but there are also environmental factors such as stress or trauma. So, it's certainly something to think about and we'll want to manage them together.

But there are some other potential reasons why there may be co-occurring illnesses. One is that mental illnesses can contribute to substance use and substance use disorders. That is, some people use substances to feel better. That is, they have an underlying depression or anxiety and they feel better when they drink or use drugs. But we also know that substance use in and of itself can contribute to the development of other mental health disorders. And so sometimes we talk about substance-related mental illness and sometimes we talk about substance-independent disorders. But they both need to be treated simultaneously, and no longer do we think like we need to get the person in remission from their substance use before we can treat their depression. We should really be treating them simultaneously. And, you know, we talk about medications, especially for treating depression, anxiety and so forth. And we've talked about medications for alcohol use disorder. But there are certainly behavioral therapies that will treat both as well, such as cognitive behavioral therapy, which is a type of talk therapy that's aimed at helping people learn how to cope with difficult situations by challenging irrational thoughts and really working to change behaviors. There's also dialectical behavior

therapy or DBT, and that's using concepts of mindfulness and acceptance. And it really teaches skills – how to control intense emotions and reduce harmful behaviors.

Ilana Hardesty: Robert was forgetting to take the daily medication. Annie, you mentioned injectable naltrexone as a possible solution. Do you think this is a good option for this patient?

Annie Potter: So really when we're talking about naltrexone, it is recommended that patients move to the long-acting injectable formulation as we see improved compliance and retention into treatment. It is an injection that is received at a health care setting every 28 days.

Ilana Hardesty: Can you talk about the logistics of offering injectable monthly naltrexone?

Annie Potter: Some of the logistics would be that the medication is generally ordered through a specialty pharmacy and because it is proprietary, will require, most likely, a prior authorization. It needs to be refrigerated. And so, making sure you have a place to keep medications safe in storage. It does need to be reconstituted, and so for that, you will need to remove the medication from the refrigerator to bring it to room temperature prior to administration. Some of the common side effects of the injection might be some injection site reaction and sensitivity. And so, you know, making sure that we are injecting it in an area where there is enough muscle to make it comfortable during the injection process.

Ilana Hardesty: How do you talk to patients about starting the injectable?

Annie Potter: We have many patients who have a fear of needles and injections. So really talking through what the expectations are. When talking about medications for alcohol use disorder, I really like to press home that it's not a miracle cure. It's part of a comprehensive treatment plan, that you're not going to get the injection and walk out and think, "Oh, I never want to have another drink again." And I set these expectations so that patients know that some of the work comes from within. And it's not all of the medication that's carrying their recovery. And I think this really highlights, so that people don't come back and feel as though, "oh, well, the medication didn't work for me," because what we're really looking at is the number of heavy days of drinking that has declined, not complete cessation all at once.

Dr. Alford: So, Annie, I have a question for you. It sounds like, you know, this is an incredibly convenient way to take a medication, that is, a monthly injection. My question is, do people return? Do they come monthly for the injection or do they kind of drop out of care? What's the retention rate, do you think, of the injectable as opposed to the daily medication where, you know, they need to keep in touch, mostly, to get refills and so forth? And so there seems to be

some kind of forced retention or contact, although I know people stop taking those medications, too, and leave treatment. But is there a problem with people leaving treatment when they're getting monthly injections?

Annie Potter: Yeah, that's a great question. One of the things that I see is that you also have that medical intervention. And even if patients decide to discontinue medication for whatever reason that may be, that they may want to still come back and seek treatment because they're receiving some sort of support with that rapport that you have developed over time. What I tell patients when we start the medication is, "if you at any time decide this is not the right medication for you, rather than stopping and going away, please engage me so we can talk about different modalities, methods, other medications that we can use to support you." I find that many patients, when they are struggling, they may feel embarrassed or don't want to come and talk about their problems. I've had patients say to me, "You always see me at my worst. I wanted you to see me at my best." And I always say, "I'm here to support you wherever you are in your journey." And so in that way, with patients on injectable naltrexone, I do also like to make sure they have a supply of oral medications on hand for reasons such as if they were to have an unexpected emergency that called them out of town, that they still feel as though they have a supply of medication. And this was a great lesson that was learned during the novel COVID-19 pandemic, where people were not able to come in to receive their medication early on. And so, we were giving enough medication by oral tablets in order to support them.

Ilana Hardesty: In Episode Two, we heard about the different medication options. I'm curious what you would suggest for Robert if he doesn't want to try the naltrexone again?

Annie Potter: There are three FDA-approved medications for the treatment of alcohol use disorder. And so, the first one we've already spoken about, which is naltrexone. For somebody recently taking opioids, and by recent I mean in the last seven to 10 days, that might be not a great option because it is an opioid antagonist. And so, people do need to have a sustained period of time off of opioid medications or they will go into severe withdrawal.

So the other two medications that are approved: the first one is acamprosate. It is dosed at two tablets three times a day. It is renally metabolized. So, for people with chronic kidney disease, you do want to make sure that it is in compliance with renal dosing. One of the challenges I see with acamprosate is how often you need to take it and how many pills that might be. You know, that is six tablets a day in addition to other chronic medications that patients may be taking. The third medication that many people are aware of and is really kind of what people think of when we think of medication for alcohol use disorder is disulfiram. And disulfiram is a

medication that blocks the breakdown of certain parts of the alcohol so that it builds up in your body, causing an adverse reaction, such as severe nausea, vomiting. With disulfiram, patients do need to abstain from anything with alcohol in it. So that might be cooking wine, cologne, different kinds of disinfectants that might have alcohol in it, to prevent having any adverse reaction.

Ilana Hardesty: If you were to start Robert on acamprosate, how would you keep him engaged in care?

Annie Potter: I think with any of these medications, I really tell people that the hard work is done outside of the medical visit. And so, when starting on acamprosate, really monitoring him and asking about how things are going in his life. You know, "Are you getting back on with employment? How is your relationship with your wife, your friends, your family?" Implementing relapse-prevention strategies to decrease recurrence of use. The other thing I like to highlight in making it a patient strength-focused visit is if he decreased any alcohol intake, that is also a marker of success. And so, we want to really monitor patients not only for adhering for the treatment, benefits they may have socially or physiologically, psychologically, but also making sure that they are achieving those personal goals we talked about earlier as a marker. Again, so that we are highlighting patients' strengths because I think a lot of times they feel as though any kind of alcohol consumption is deemed as a failure. And so many patients may not want to come back, thinking that we would read them the riot act when they come in for a medical visit. I also like to highlight and have patients remember who they were as a person, as continued motivation for engagement and treatment, and taking the focus away from use to tangible progress has really helped encourage patients remain in treatment and remain committed to decreasing or remission from alcohol use.

Dr. Alford: This patient tried a meeting or two of AA and didn't like it, and we talked about the importance of going to multiple different meetings in order to find one that you can feel comfortable at or that there are people that you can relate to. So I think he certainly could try AA again. But how about the whole issue around being on medications to treat alcohol use disorder and going to AA? I thought they were against the use of medications, as a program.

Annie Potter: Yeah. I mean, I'll hear a lot of times patients will say, you know, "I don't like to disclose that I'm on medication for treatment. My sponsor or people in my group might not be supportive of that." And so there's two ways. I think AA is most synonymous with peer support recovery. We know that there are other models, as well, that it's not just the 12-step program.

For example, there is Smart Recovery that follows CBT or cognitive-based therapy. There are groups for parents that are in recovery that might be helpful. There's also peer support groups that follow a Buddhist philosophy called Refuge Recovery. And so, it's not a one size fits all. And I also let patients know that disclosing what medications you are on is very personal, and it's not something that is required for you to do. I don't see patients who are living with, let's say, diabetes, for example, when they go to a nutritional support group disclosing their medication regimen. So I think overall, the decision to disclose your medication regimen is personal.

Ilana Hardesty: Dr. Alford, how do you talk to patients about staying in treatment, or talk to them if you think they've stopped treatment prematurely?

Dr. Alford: I think historically people felt, oh, I can go to detox and be done with it. And we know that there is, you know, over 90% relapse rates after a detox; close to probably 95 or even higher. And it's not that individuals aren't motivated at the time that they're discharged from detox, but it's just we know that there have been chronic brain changes that have occurred that put people at risk for relapse. And so, along with reeducating the patient about the importance of long-term treatment and that there are no quick fixes, I want to get a better understanding of, you know, what they're thinking. Why did they feel that treatment was no longer needed? And sometimes it's coming from within and sometimes it's coming externally from family members who say, "Why are you still on that treatment? You don't need that anymore. Why are you still going to AA meetings? You shouldn't need that anymore." So it's really important to explore: what's the rationale for someone to finish treatment even when they are benefiting from it, to be able to better address it.

Annie Potter: I agree. I think a lot of treatment discontinuation is from external forces and stigma and possibly pressure. In my practice I see a lot of younger adults and some young female-identifying individuals will want to discontinue treatment. And when I ask about why, they'll say, "Oh, you know, I think it's just time." But when I parse it out a little more, it turns out, you know, they're thinking about conception or they're thinking about going into a

profession where they feel as though if they were found to be on medication for alcohol use disorder, that it would negatively affect them. And so really parsing through and knowing that, you know, engaging in support is never a bad thing. I always tell people, you know, when you come in and see me, if it's not for alcohol use, then it's to remember that you have other primary care needs. I want to make sure you're getting your cancer screening, that we're managing other chronic conditions that you may have in order to improve wellness. Because we don't want people to be engaged in care and achieve recovery and feel as though that is the finish line. And so we miss a lot of other recommended health screenings.

Dr. Alford: So we've covered a lot. And it is my hope that you're now more confident in identifying evidence-based approaches to screening and assessing adult patients who have the full spectrum of unhealthy alcohol use. And that includes at-risk drinking and those with an alcohol use disorder. That you are better able to recognize that alcohol use disorder is a treatable medical condition, and the value in collaborating with an interprofessional treatment team when needed. That you are more confident in employing motivational interviewing counseling techniques to help resolve your patients' ambivalence and enhance motivation to initiate and to maintain treatment for their alcohol use disorder. And finally, that you are more comfortable utilizing strategies to engage and retain patients with alcohol use disorder in long-term treatment.

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Ilana Hardesty: Thank you, Dr. Daniel Alford and Annie Potter, for joining me today. Thanks as well to our patient in recovery, Jeanette. And thank you for listening to *Managing Unhealthy Alcohol Use in Clinical Practice*, Boston University's new podcast discussing best practices in the diagnosis and treatment of alcohol use disorder. This educational activity is funded by an educational grant from Alkermes. Production by Rococo Punch. Please visit the website linked in the program description for visuals, resources, and other relevant materials. To receive credit, you'll need to listen to all three episodes and then go to the website to complete a post-test and evaluation. I'm Ilana Hardesty. Thanks for listening.

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