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COVID-19 IMPACT: DEALING WITH THE HIDDEN EPIDEMIC OF ALCOHOL USE DISORDER

Webinar date: **April 15, 2021**
Recording and slides: https://ubccpd.ca/covid-19-impact-dealing-hidden-epidemic-alcohol-use-disorder

Disclaimer: Information on COVID-19 is rapidly changing and much of the research is preliminary. Assessment and management protocols are suggestions only; they do not take the place of clinical judgement. Please check with your own health authorities and local medical health officers as policies and support for the suggested approaches to patient care may vary between regions.

This summary was prepared by Dr. Birinder Narang and not by the speakers.

Webinar Summary

Slides by Dr. Paxton Bach - Summary

- **Canadian Substance Use Costs & Harms**
  - 2017 – Substance use costs Canadians $46 Billion/year
    - Driven by alcohol $16 billion and tobacco ~$12 billion/year
    - Cost is a combination of healthcare, lost productivity, criminal justice and other direct costs
- **Alcohol Use Disorder (20%) in Canada**
  - Nearly 20% of Canadians will meet criteria of AUD at some point in their lives
    - 3% in the last 12 months
- **Changes During the COVID-19 Pandemic**
  - In 2021, 66% of Canadians reported consuming alcohol in the previous month
    - 24% of these have increased consumption
    - 22% have decreased consumption
  - 18% consumed 5+ drinks on drinking days (significant increase)

        - Pre-pandemic rates were 11%
    - Reasons include: Boredom, stress, convenience, loneliness, insomnia

COVID Impact Introductions

Dr. Sophie Waterman – Family Physician - Port Hardy Experience

- Indigenous populations closed their reserves and managed COVID very well.
- The burden of substance use disorder became quite apparent. People were swimming across rivers to get their substances – was shocking to Band Council. They discussed managed alcohol programs, saw an evolution of harm reduction understanding, and have now developed managed alcohol programs (MAP) now in conjunction with First Nations Health Authority.
- Emergency presentations and RCMP interactions have decreased.

Dr. Julius Elefante – Psychiatry Perspective in Concurrent disturbances

- Interruption to service delivery in outreach services, group counselling services, etc.
- Worsening mood disorders and psychotic disorders
- Patients are in a "pressure cooker environment", prediction of worsening of mental health as pandemic continues

Dr. Andrew Yamada – Medical Lead – Fraser Health Rapid Access + Withdrawal Management

- Range of severity from Alcohol Use Disorder in Surrey – suburban, varying socioeconomic status
- Has already been a significant problem within Fraser Health region

Takeaways from managing alcohol use disorder in the pandemic

- You don't know what you don't ask (i.e., domestic violence). If you don't ask about it, you won't learn about it. You want to use this same principle for alcohol use disorder.
- Many evidence-based treatments are available now to treat alcohol use disorder
- BCCSU – High-risk Drinking and Alcohol Use Disorder is a reference that all practitioners should refer to
- Screening tools – single answer screening test is the easiest to integrate into your practice.
    - "How many times have you had more than 3 drinks (women) or 4 drinks (men) in one setting".
- Make sure to use normalizing questions when asking about the patient's AUD to build trust with patient as it reduces fear of being judged.

Question & Answers - Management

Q: In a virtual setting, once identifying that a patient is at risk or may have Alcohol Use Disorder, what is the next step?

A: Explore AUD with patient from a point of curiosity, look at patterns and how things started and assess how they have changed. Clarifying details is important, i.e., standard drinks and clarifying the DSM diagnosis.

Think about, how does the drinking fit along the criteria? You may need to have different appointments to address different elements. Identifying their goals is important. It is human nature to tell people what they want to hear, there is a chance that patients have felt stigmatized.

Q: What is your approach to management? What are the 1st line and 2nd line medications?

A: Once you have a diagnosis and patient is seeking help, there are three things to consider for an approach:

1. How do we risk stratify patient, how are we managing withdrawal safely?
2. Post withdrawal, how will we support them in their goals (i.e., reduction of use vs abstinence)?
3. Psychosocial component, how do we support patient?

Risk Stratification:

- Few tools that are out there and the most common tool – PAWS scale (Prediction of alcohol withdrawal severity) – does a good job at selecting outpatients who are at low risk for complicated withdrawal (DT, seizure, high dose of benzos). Score of < 4 is overly sensitive for someone to have low risk.
- Resources can also play a role, i.e., availably of detox beds.
- Sometimes it is clear whether someone is low risk or high risk, in the middle can be challenging, RACE line is available to help with this. There is a 24/7 addiction line.

Q: Choice of medications for goal of abstinence:

A: BCCSU Guidelines outlines the pharmacotherapies. For the goal of abstinence, Naltrexone and Acamprosate can be used for Alcohol Use Disorder. Naltrexone is also used with sertraline in concurrent disorders in alcohol and mood disorders and work well together. Gabapentin can also be used. Disulfiram is not used and Topiramate is off label as a second line.

For someone whose goal is to cut back on drinking, but not achieve abstinence, Naltrexone may be a better option. For someone whose goal is abstinence, Acamprosate may be better. Naltrexone has the benefit of being more convenient as it is only one pill/day and reassess in 3-6 months. Dual therapy with Naltrexone and Acamprosate can always be used. Gabapentin also has an abuse potential, side effects

and lots of off label uses. That medication can have a lot of vague inertia that leads to ongoing re-prescription from different providers. Data is not strong for Ondansetron and Baclofen.

Q: Do you expect further research with psychedelic assisted treatment programs?

A: Yes, psychedelic assisted treatment is a hot topic of research.

Q: Recommendations for supporting moderation vs abstinence?

A: Getting buy-in for harm reduction has difficulties for providers and patients. For some, complete abstinence of alcohol may be impossible, however, the cultural message has always been abstinence. A lot of people need permission for a different end point.

Brief interventions can be valuable. What are your goals? What is the motivation? I.e. chronic gastritis, e which could be motivation to cut down on Alcohol use.

If someone has achieved abstinence, some population may be able to return to social drinking, others won't' be able to. Important to have ongoing dialogues about it.

Q: Can someone stay on Naltrexone indefinitely?

A: There have been no real trials/long term data for Naltrexone. Explore what else is going on in the patient's life to trigger that question. What is leading to substance use?

Q: "Recovery Capital" – is it possible?

A: Managed alcohol programs can be helpful. We do not want to deny patients when they are in need of support. Meet them where they are and use your motivational interviewing. Assess the environment surrounding the patient. It is not up to physician to necessarily make that determination/firm decisions but can help create an informed discussion with the patient. Always be cognizant of our own biases when we assess patients.

Q: Patients have Naltrexone 50 mg po bid + Gabapentin, has reduced their drinking but not abstinent?

A: Target dose is 50 mg po daily, but evidence does exist for 75 mg-100. There is likely incremental benefit, however, there is potential for further adverse effects as well. Data around combinations is scarce.

Resources:

- BCCSU
    - High-Risk Drinking and Alcohol Use Disorder of Resource
    - **BCCSU 24/7 Addition Medicine Clinical Support Line**: 778-945-7619
    - BC ECHO on Substance Use – Alcohol Use Disorder
    - The podcast of the BC ECHO on Substance Use
- **MD CALC:** Prediction of Alcohol Withdrawal Severity
- RACE **Line:** 604-696-2131
- BC Government Virtual Mental Health Supports
- Canadian Mental Health Association COVID-19 Mental Health Supports – BC Division
- 310Mental Health Support **Line**: 310-6789
    - For emotional support, information, and resources specific to mental health
- 1-800-SUICIDE **Line**: 1-800-784-2433
    - If you are experiencing feelings of distress or despair, including thoughts of suicide.
- KUU-US Crisis Response Service **Line**: 1-800-588-8717
    - For culturally aware crisis support for Indigenous peoples in B.C.
- B.C. Alcohol and Drug Information and Referral Service **Line**: 1-800-663-1441
    - Provides resources and support for B.C. residents who need support with any kind of substance use issue.
- BC COVID-19 Mental Health Network:
    - Access free, phone-based, short-term support with a counsellor.
    - Email bccovidtherapists@gmail.com to receive appointment time.

Thanks to the speakers on the video:

- **Dr. Sophie Waterman:** MD, CFPC, Physician Lead for the Managed Alcohol Program which was started by the Gwa'sala-'Nakwaxda'xw First Nation, Physician Lead for the North Island Rural Birth Program and operates a full-time family and emergency medicine practice.
- **Dr. Julius Elefante:** MD, FRCPC, Clinical Instructor for the University of British Columbia, Psychiatrist at SPH, VGH, the West End Mental Health Team, and the Burnaby Centre for Mental Health and Addiction.
- **Dr. Andrew Yamada**: MD, CCFP, Medical Lead - Fraser Health Rapid Access Clinics, Withdrawal Management Programs and Youth Programs. Clinical work: Surrey Memorial Addiction Consult Service, Fraser South RAAC, Creekside Withdrawal Management Center, Quibble Creek OAT Clinic, Surrey Intensive Case Management Team, and Surrey Managed Alcohol Program
- **Dr. Paxton Bach:** MD, MSc, FRCPC, FASAM, Clinical Assistant Professor, Department of Medicine, University of British Columbia.

- **Dr. Christie Newton**: MD, CCFP, FCFP, Associate Professor, Associate Head Education and Engagement, Medical Director UBC Health Clinic, UBC