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Bringing Patient-Centered Care to Patients with Alcohol Use Disorders

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Alcohol use disorders (AUDs) are common, chronic conditions affecting more than 10% of US adults.¹ AUDs include a spectrum of problems due to impaired control over drinking and are a major contributor to disability and death in the US.² However, patients with AUD receive poorer quality care than patients with any other common chronic condition.³ Most patients with AUD do not receive treatment, and medications for AUD are particularly under-utilized.⁴ The systematic review and meta-analysis by Jonas and colleagues in this issue of *JAMA* has the potential to substantially increase awareness and use of pharmacotherapy for AUD.⁵ The most important benefit of this review, however, will be if it leads to more patient-centered care for AUD.

Patient-centered care and shared decision making are essential for delivery of high quality mental health and substance use disorder treatments.³ Shared decision making requires a dialogue between patients and clinicians aimed at: 1) helping patients better understand their medical conditions and the need to make treatment decisions; 2) providing information about the benefits and adverse effects of treatment options; 3) supporting patients while they clarify their values and preferences and make a decision, even if for no treatment; and 4) providing support while patients implement their decisions.^{6,7} For patients with impaired decisional capacity due to their illness, shared-decision making includes working with family, caregivers, or other people who support the patient. Patient decision aids, which provide up-to-date information on treatment options and support patient-clinician

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communication about patient preferences, are often used to support shared decision making and increase patient-centered care.⁸

Current medical management of AUD is usually in stark contrast to concepts of patient-centered care. In the U.S., patients with AUD are typically offered referral to a single type of AUD treatment—group-based, abstinence-oriented treatment programs relying on the 12-step principles of Alcoholics Anonymous (AA). While many patients report benefit from these programs, most programs are not staffed by clinicians who can prescribe medications to treat AUD and most do not offer evidence-based behavioral treatments.⁹ In addition to medications that improve drinking outcomes,⁵ at least four types of one-on-one behavioral treatments for AUD are effective—Cognitive Behavioral Therapy, Motivational Enhancement Therapy, Behavioral Couples Therapy, and 12-Step Facilitation.^{10,11} Moreover, no single behavioral treatment is superior to all others. This is exactly the type of situation when shared decision making is most valuable.⁷ However, many health care professionals do not realize there are treatment options for AUDs. As a result, most patients are offered referral to a single treatment, i.e. programs based on 12-step principles, without consideration of patient preferences.

The review by Jonas and colleagues⁵ provides critical information about the efficacy and adverse effects of AUD pharmacotherapy needed for shared decision making and patient decision aids. The authors evaluated 122 randomized trials and 1 cohort study (total 22,803 participants). Most of the studies assessed acamprosate (27 studies, N=7,519) and/or naltrexone (53 studies, N=9,140), which are FDA approved for the treatment of AUD. Jonas and colleagues report that the efficacy of the oldest and best known FDA-approved medication for AUD—disulfiram—was not supported by randomized placebo controlled trials, whereas four medications—naltrexone, acamprosate, topiramate and nalmefene—improved drinking outcomes. Most studies evaluated AUD medications when added to repeated behavioral interventions in patients who were abstaining when the medication was initiated. Mimicking the behavioral interventions used in these studies in routine clinical practice could prove challenging. For example, one of the simplest behavioral interventions required 9 visits over 16 weeks,⁵ more frequent contacts than are typically offered in primary care management of other common medical and psychiatric conditions.¹² Future research is needed on the efficacy of medications for AUD when patients want to reduce drinking but do not have a goal of abstaining and to determine whether medications have efficacy when provided without frequent behavioral interventions.

Shared decision making for AUD can be integrated into primary care. Primary care clinicians should assess AUD severity, medical and psychiatric comorbidities, reasons patients may or may not want to change their drinking, and whether they want help doing so. When establishing the diagnosis of AUD it is important to note that AUD is no longer divided into alcohol abuse and dependence, but is now recognized as a single continuum. The new DSM-5 diagnostic criteria for AUD rely on a count of 11 criteria, with severity assessed based on the number of criteria a patient meets: mild (2-3), moderate (4-5) and severe (6-11) AUDs.^{13,14} Clinicians and patients should discuss ambivalence towards change, patient goals (e.g. abstinence vs decreasing drinking vs no change), preference for group-based, one-on-one, and/or medication treatments, as well as differences in the privacy

and cost of different treatments. Some patients may prefer the privacy of mutual help groups or community treatment programs that are not documented in electronic health records. Patients with mild AUD (2-3 criteria) can be offered behavioral therapies, mutual help (e.g., AA), and usual AUD treatment programs. Patients meeting 4 or more criteria can be offered medications in addition to behavioral therapies. Those who are not yet interested in changing, might be willing to engage in counseling aimed at helping them consider the effects of drinking on their lives and health (e.g., Motivational Enhancement Therapy). Patient decision aids can support shared decision making about AUD treatment.

Patient-centered management of AUD will need to be integrated into both primary care and general mental health care. Patients with uncomplicated AUD can be managed in primary care by integrated primary care-mental health teams, whereas more complex or severely affected patients might benefit from mental health specialty care. However, providing shared decision making and caring for patients with AUD as part of primary or mental health care will require increased clinical capacity. Innovative new systems of team-based care for AUD,¹⁵ like those used for other chronic disease management,¹² will be needed to meet the demands of engaging patients in AUD care, assessing the severity of their AUD and comorbidity, offering them evidence-based treatments, and monitoring their response to treatment.

Although primary care and mental health clinicians will eventually share in the management of AUD, general mental health clinicians should take the lead in incorporating evidence-based AUD treatments into their care. This will require support from addiction medicine colleagues since many general mental health clinicians do not currently provide treatment for AUD. However, with support they can offer both medications and effective behavioral therapies for AUD, and promote integration of AUD care into primary care settings. Moreover, primary care clinicians might be reluctant to provide care for AUD if their mental health colleagues are not yet comfortable managing AUD.

Treatment of AUD is considered an Essential Health Benefit under health care reform. More patients with AUDs will have insurance, which could increase their access to evidence-based treatments for AUDs.¹⁶ The article by Jonas and colleagues should encourage patients and their clinicians to engage in shared decision making about benefits and risks of AUD treatment options. By identifying four effective medications for AUD, the authors highlight treatment options for a common medical condition for which patient-centered care is not currently the norm. Patients with AUDs should be offered options including medications, evidence-based behavioral treatments for AUD, and mutual support for recovery. Moreover, patients with AUD should expect shared decision making about the best option(s) for them.

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References

1. Dawson DA, Goldstein RB, Grant BF. Differences in the profiles of DSM-IV and DSM-5 alcohol use disorders: implications for clinicians. *Alcohol Clin Exp Res*. Jan; 2013 37(Suppl 1):E305–313. [PubMed: 22974144]
2. U.S. Burden of Disease Collaborators. The State of US Health, 1990-2010: Burden of Diseases, Injuries, and Risk Factors. *JAMA*. Jul 10.2013 Jul 10 [Epub ahead of print].
3. Institute of Medicine. Improving the quality of mental health care for mental and substance-use conditions. The National Academies Press; Washington DC: 2006.
4. Harris AH, Oliva E, Bowe T, Humphreys KN, Kivlahan DR, Trafton JA. Pharmacotherapy of alcohol use disorders by the Veterans Health Administration: patterns of receipt and persistence. *Psychiatr Serv*. Jul; 2012 63(7):679–685. [PubMed: 22549276]
5. Jonas DE, Amick H, Feltner C, et al. Pharmacotherapy for Adults with Alcohol-Use Disorders in Outpatient Settings: a Systematic Review and Meta-analysis. *JAMA*. 2014 in press.
6. Legare F, Witteman HO. Shared decision making: examining key elements and barriers to adoption into routine clinical practice. *Health Aff (Millwood)*. Feb; 2013 32(2):276–284. [PubMed: 23381520]
7. Barry MJ, Edgman-Levitan S. Shared decision making--pinnacle of patient-centered care. *N Engl J Med*. Mar 1; 2012 366(9):780–781. [PubMed: 22375967]
8. Stacey DLF, Col NF, Bennett CL, Barry MJ, Eden KB, Holmes Rovner M, Llewellyn Thomas H, Lyddiatt A, Thomson R, Trevena L, Wu JHC. Decision aids for people facing health treatment or screening decisions. *Cochrane Database of Syst Rev*. 2014
9. Carroll KM. Dissemination of evidence-based practices: how far we've come, and how much further we've got to go. *Addiction*. Jun; 2012 107(6):1031–1033. [PubMed: 22324509]
10. National Institute for Health and Clinical Effectiveness. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. UK National Health Service (NHS); 2011.
11. VA Office of Quality and Performance. [Accessed April 11, 2014] VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders. Version 2.02009. <http://www.healthquality.va.gov/guidelines/mh/sud/index.asp>
12. Katon WJ, Lin EH, Von Korff M, et al. Collaborative care for patients with depression and chronic illnesses. *N Engl J Med*. Dec 30; 2010 363(27):2611–2620. [PubMed: 21190455]
13. Hasin DS, O'Brien CP, Auriacombe M, et al. DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale. *Am J Psychiatry*. Aug 1; 2013 170(8):834–851. [PubMed: 23903334]
14. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th Edition. American Psychiatric Association; 2013. DSM-5
15. Oslin DW, Lynch KG, Maisto SA, et al. Randomized Clinical Trial of Alcohol Care Management Delivered in Department of Veterans Affairs Primary Care Clinics Versus Specialty Addiction Treatment. *J Gen Intern Med*. Sep 20.2013
16. McCrady BS. Health-care reform provides an opportunity for evidence-based alcohol treatment in the USA: the National Institute for Health and Clinical Excellence (NICE) guideline as a model. *Addiction*. Feb; 2013 108(2):231–232. [PubMed: 23075264]