Paradigm shift

Moving the management of alcohol use disorders from specialized care to primary care

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Almost 20 years ago research indicated that brief interventions[1] in primary care settings helped patients with at-risk drinking and milder alcohol use disorder (AUD) reduce heavy drinking.[2] More recent meta-analyses have overwhelmingly confirmed this finding.[3,4] However, evidence showed that brief interventions were not effective in helping those with more severe AUD reduce or stop drinking.[5] As a result, addictions organizations recommended that primary care physicians use the SBIRT (Screening, Brief Intervention and Referral to Treatment) model,[1] and that those with more severe AUD should be referred for specialized treatment.

Limitations of specialized care

However, referral for specialized treatment poses problems. First of all, many patients with AUD do not access or remain engaged with specialized care.[6] This is partly owing to low referral rates: a study done in the US Veterans Affairs medical system found that primary care providers were 10 times less likely to refer patients with alcohol misuse for specialized treatment than they were to refer patients with depression or posttraumatic stress disorder.[7] It is also a result of high rates of missed appointments. Studies of addiction medicine services have found no-show rates of 30% to 75% for initial appointments and 15% to 50% for follow-up appointments.[8,9]

Studies have identified reasons for missed appointments that apply to specialized addiction care. One is the delay between the referral and the appointment; no-show rates dropped from 52% to 18% when wait times were reduced from 13 days to 0 days in a mental health clinic.[10] Other reasons include financial concerns and transportation costs, lack of a therapeutic alliance with the provider, ambivalence about treatment, and concurrent mental health problems.[11-14] As well, many patients with AUD have negative experiences with the health care system.[15,16] This might play a role in missed appointments, as higher patient perception of stigma is associated with lower help seeking.[17]

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There are other limitations to specialized addiction care. Many specialized addiction programs focus solely on psychosocial treatments and do not provide pharmacotherapy.[6,18] Some abstinence-based programs actively discourage pharmacotherapy for addiction treatment.[19] The few programs that do provide pharmacotherapy and psychosocial treatment have limited capacity and cannot accommodate the estimated 641 000 Canadians[20] with more severe AUD.

Benefits of primary care management

As a result, researchers shifted their attention to primary care. It appears to be a logical choice. There are many opportunities to intervene because patients are frequently in contact with the primary health care system. There is no or minimal delay to starting an intervention. If patients are lost to follow-up, they reconnect with primary care for another reason and can re-engage with treatment. Primary care clinics are typically more convenient and less costly for patients to access, as they are often closer to their homes than specialized addiction clinics are. Primary care providers, unlike many specialized programs, are able to prescribe medications in addition to counseling. And finally, primary care providers often have strong therapeutic relationships with their patients,[21] an important factor in treatment outcomes in addiction medicine.[22,23]

Longitudinal care. The nature of family medicine makes it well suited to management of AUD. Patients with AUD require complex longitudinal care: ongoing counseling to encourage behavioural change and adherence to medications; assistance with connecting to other resources; coordination of care; and medical management (MM) of complications from alcohol use. Family physicians are trained experts in all of these areas and employ these skills regularly when they care for patients with chronic conditions such as diabetes, depression, cardiac disease, and obesity. Studies consistently demonstrate that family physicians provide good care to patients with chronic diseases.[24,25]

Effective MM. Recent research[26-28] confirms that primary care management of more severe AUD is effective. Several studies have compared primary care management and specialized care head to head. A small trial

randomized patients to "advice and clinical management techniques commonly used by primary care providers"[29] along with naltrexone, or to standard specialty addiction treatment. They found similar outcomes in the 2 groups. In the much larger COMBINE (Combined Pharmacotherapies and Behavioral Interventions) trial,[30] researchers sought to determine if MM was efficacious without additional specialized addiction care. Medical management

> was specifically constructed to be implemented by medically trained practitioners in nonspecialty settings. Each visit includes evaluations of medication safety and adherence, monitoring of alcohol use and direct advice to the patient for achieving full recovery.[31]

Of the 9 different treatment combinations (MM with and without additional specialized addiction counseling, and with medications or with placebo), none was more effective than MM with naltrexone.

Increased retention. Some preliminary evidence indicates that "real-world" primary care treatment of addictions might outperform specialized care.[32] Researchers randomized 163 American veterans with alcohol dependence (more severe AUD) to primary care management with additional counseling at the veterans' own primary care clinics or to specialized care at addiction clinics. Both groups experienced a decrease in heavy drinking days from baseline, but the drop was one-third greater in primary care. The researchers attributed most of the difference in outcomes to increased retention in treatment in the primary care group compared with the specialized care group (42% versus 12%) and to increased rates of naltrexone use in the primary care group.

Scope and capacity. Does primary care have the capacity to care for these patients? This is a legitimate concern for an already heavily burdened primary care system. Undoubtedly, addressing the underlying AUD will initially take more time and resources. (Some provinces provide compensation for this outlay; in Ontario, primary care providers can bill 2 "outside the basket" time-based codes when they treat a patient's AUD.) However, without the intervention of family physicians, many patients with AUD will never get treatment, particularly in remote communities. Family physicians are already caring for many of these patients. Prescribing medications for AUD and providing them with counseling is well within the scope of practice for family doctors. As well, evidence-based treatment of AUD should lead to reduced health care use[33] and costs.[34]

Conclusion

As primary care treatments are effective, and specialized addiction care has poor access and retention, we recommend that family doctors use a primary care treatment model to manage patients with moderate and severe AUD. Family physicians should offer frequent, brief (10 to 30 minutes) counseling sessions, prescribe AUD medications, and connect patients with other addiction and mental health services. If patients connect with specialized addiction care, family physicians should remain involved and assist in the coordination of care.

Family physicians should recognize that behaviour change is very difficult, particularly when coupled with an addiction. Like smoking cessation, relapse rates for AUD are high and patients often go through many cycles of relapse and remission before achieving their long-term goals. Physicians should remain supportive and seek to re-engage patients who relapse.

We review screening and assessment (**page 509**)[35] and the primary care MM (counsel, prescribe, connect) approach (**page 515**)[36] in more depth in this issue.

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Competing interests
Dr Kahan has received honoraria from Reckitt-Benckiser for continuing medical education events on Suboxone (buprenorphine-naloxone).

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