Breakout 1: Engaging with your Patients About Alcohol: Motivational Interviewing and Patient Scripts | Facilitator: Dr. Paul Gross

- How do you streamline the information from intake and also provide therapeutic guidance in the moment vs not having enough time?
  - Nurses are often doing telephone assessments (pre-screening) and lots of people don't have FPs, so notes that we receive are not very indicative of the real situation (all based on what the client has shared with the physician)
    - Some clinics – ask "Do you drink alcohol?" and then "How frequent or how often?", "Have you felt the need to cut down" then "Have you had any symptoms of withdrawal" (same for other substances)
    - Some clinics have ~50 screening questions – lack of time if they are positive on any of the screening tools)
    - Just trying to complete intake (medical history), and then *missing the follow-up piece*
  - Need to be based off of team context & goals – e.g., is it to identify more patients? And make another program in the future to address the therapeutic side of things? Create a place and time to continue the conversation. Sometimes, the moment might be off if the conversation is cut off, but mostly about the *relationship* with the patient.
  - Only time alcohol use is asked about is during the first intake and won't bring it up again UNLESS the reason for the visit is AUD.
  - A clinic local to me is trying to incorporate AUD screening in the ED regardless of the reason for the visit.
  - Balancing building trust/relationship vs screening into AUD (all in the first visit!)
    - [Patient] needs more time and attention, this place is for you, we're here for you, etc. – building that relationship; "I'm glad we can continue this conversation"; "I'm so glad you are able to share"- acknowledge and validating your story/experience, "we're happy to have further questions when you're ready", etc. (AUD or other situations, etc.). Important to strike a balance between going through a checklist
    - Also support the practitioners "we have great people who will be able to chat more about this with you" etc.
    - Acknowledge and offer support
    - First conversation – starting the relationship with the intake
    - Importance is KNOWING that the resource is available (doesn't matter if they take up the resource/support years down the road)
    - Trying to create the safe space and streamlining
    - Potential measure: Trying to track people for further conversations after being screened positive – confirm which and when they chatted with the practitioner as part of a follow-up
  - Looking for tools to create a comfortable environment for folks who are on the fence to be open to seeking help/support

Breakout 2: More about the AUD Guidelines | Facilitator: Nirupa Goel

- Focus on guideline and helping drinking website- https://helpwithdrinking.ca/
- SSRI piece (patients with mental health and substance use)
    - A lot of literature on SSRI and how it impacts alcohol use – a lot of literature mixed on what populations they were conducted (e.g., diagnosed AUD and major depression disorder, others not diagnosed with depression – mixed populations)
    - Results of three most recent big systematic reviews
        - Cochrane, 2018 – included the most studies and most rigorous data analysis. Looked at people diagnosed with AUD and major depressive disorder (with a variety of medication diagnosis). Found that SSRIs did not have any benefit on depressive symptoms. Factors related to alcohol (different measurements) and found that SSRIs have small benefit for two of those outcomes (days abstinent and days heavy drinking) but no different on other 7-8 other outcomes. So very little benefit of SSRIs on drinking outcomes
        - SR 2020 – very similar findings. No benefit on depression symptoms. Didn't find a lot of change in drinking measures like consumption. A lot of literature is very variable, high risk of bias because many sponsored by pharmaceutical companies
        - MA 2021 – very similar findings. No to small benefit for depression. Mentioned studies are poor quality (e.g., patient population studied is low). On some measures SSRIs have some impact on alcohol use with moderate level of confidence. No benefit on some outcomes. With SSRIs there was a slight increase in people having adverse events.
    - If you put all that together – there is very little benefit in using SSRIs in population with AUD and major depression. There are a lot of individual trials and case reports that have been published, so you will hear the opposite from some people. But the literature is very inconsistent and a lot of variability and bias.
    - What do we make for that clinically?
        - Some folks in psychiatry have argued that SSRIs have been a game changer. It's a tool in the toolbox that should absolutely be used when you see benefit. May be cases where you'd consider, e.g. if someone already on it and it's helping them. However, if you have a patient whose AUD is tied to depression, in those cases clinicians would suggest use more caution around figuring out what to prescribe for those patients – knowing that a lot of evidence suggests SSRI does not help at all.
        - No clearcut answer or specific pathway you should always follow. Guideline says best pathway is the refer to concurrent disorder specialist. However, a lot of cities where that doesn't exist and resources are limited. IF you're able to that may be the best route. Counseling is always a good option. There's a lot of nuance and complexity with those patients so may be helpful to dive into complexity of patient and history to tease out how they relate to each other (when did each one start, is there causation relationship between them)
    - Convo with group on their experience with this

- It's a big claim and the research is interesting. Seems like there might be something else going on – might be some way of dividing up the patients and understanding the path of physiology rather than just take away "never use SSRIs if AUD is present". Think it's a plausible association. Not sure how to apply it because with some diagnoses there aren't other options than SSRIs – in those cases would I not offer medications? Or only naltrexone or counseling on its own without anything else?
- Hard to translate these nuances into practice
- Response: need to have a tool to offer these patients, understand the challenges
- Anecdotally, most patients are probably already on
- Amazing that we're even having this convo around using medications to treat AUD and go into challenges of how much of an effect a certain medication might have on treating AUD. One thing that plays biggest role is level of motivation for a patient to engage in a care plan, would imagine that a medication like an SSRI could be very helpful in reducing some of their symptoms so they could have even more engagement in their alcohol treatment plan. Not like they could just get medication and that would magically affect their motivation to engage in alcohol changes. A patient example who doesn't have understanding/acceptance of how alcohol is impacting their life. A physician prescribed medication to assist them as the prepare to make changes with alcohol. As a counselor, happy to be a part of the clinic to assist the patient to raise their awareness around how they want to move forward and develop insight into what their relationship with the substance looks like and prepare for changes in their life.
- Helping someone manage depression can provide motivation to address AUD. And visa versa. Work on reducing or abstinence, and then opens up space to work on moods.
- Lesson: you do have to treat both, but so interconnected, and as a clinician need to monitor both to see how they're impacting each other and making sure medication you're prescribing is not having a NEGATIVE impact on the other. E.g., if you have a patient who game in already on an SSRI.

- What are the actual risks of different levels of drinking (based on the new recommendations for at-risk drinking
  - Details on what to expect when getting care (re: screening, diagnosis, treatment planning) - https://helpwithdrinking.ca/getting-help/what-to-expect/
  - Alcohol risk profile – Canada's guidance on alcohol and health, that gives you the risk profile for all kinds of different risk factors
  - Came from previously called low risk guidelines
  - Different from AUD – it is one of the conditions that you're at risk for if you're drinking at one of these levels. However, screening tests for AUD are focused on 7 or more – so AUD is almost off the charts relative to this diagram. If you go into screening tools for AUD, you can go into screening tools to give a pretty high accuracy level for someone who might have AUD. To get into severity, you'd have to use the AUDIT or AUDSIT C. How many times do you drink.

Breakout 3: Medication Selection and Timing (Naltrexone) | Facilitator: Dr. Roland Engelbrecht

- Engagement with patient
  - Best to discuss with patient what urges them to drink to prescribe proper medication
  - Discussion about lifestyle will help determine which medication to prescribe and dosage instructions
  - Finding out if there are other disorders the patient is experiencing
  - Helps find out the patient's goal towards their AUD
    - Can help determine where to start with their treatment
  - Regular follow ups- Every 2 weeks; 1 week follow up if patient has anxiety
  - Setting goals and targets to help patients with their progress
    - "Drinking Diary"
      - Helps show visible evidence of the patient's progress on reducing their drinking
      - Presents how much they are drinking
      - A method for self-reflection
      - A method for measurement
  - The level of engagement between the physician and patient will be a big contributor to their AUD journey
    - Support system
- Selecting Medication
  - First-line options- Acamprosate and Naltrexone
    - Naltrexone is the most commonly prescribed
      - Peak is 90 mins
      - Effectiveness is dependent on when it's taken
      - High rebound effect; take it if you need it
  - Second-line options – Topiramate and Natasine
- Combination of prescribing medication
  - Start with one that is most likely to work > then trial and error
    - New combo if no improvement after 2 weeks
  - Targets multiple disorders
  - Common medication combo is Naltrexone and Gabapenten
- Cross disorders
  - Scenario: Patient has disorder with AUD + Cannabis
    - Most patients use cannabis for anxiety and/or insomnia
      - Insomnia is the big cause for relapse; Dr. Engelbrecht targets to treat sleep/insomnia disorder as the main priority first, AUD as second until improvement seen in insomnia
        - Can't have proper sleep if you don't have good sleep hygiene
  - Gambling is one of the most common addictive disorders experienced with AUD

Breakout 4: Accessing Additional Supports | Facilitator: Zak Matieschyn

- Challenges to consider/address
  - "What happens next" after diagnosing AUD? Most communities have AA meetings, but not much access to anything else.
  - Scarcity / barrier from finding the connections
  - Wait time (referrals) / mental health access (counselling – trauma-specific therapies)
  - Preconceived notions of AA groups. But there are other "accountability" groups (e.g. mindfulness) that are seen as very helpful. People are beginning to understand the need of diverse programs.
  - Basic knowledge is missing. Examples: the misconceptions that "quitting alcohol too soon is dangerous". "Myth busting" needed / education in the community.
  - Limited capacity / lack of staff who can educate the communities.
    - Example in one of the small communities: model of care: multidisciplinary (in-house services). Mandate to serve the community on top of health care. (Focus: people over 65yrs old / people with AUD).
  - One of the barriers could be the history of the organization that offers help: biases / past experiences (coming from personal experiences or other family members).
- Improving access to additional supports
  - Care centred around patient having autonomy and decision-making power, allowing them to be part of their care plan. And meeting people where they are at. A way of addressing this is using posters and encouraging people to talk about alcoholism and Doctors using harm-reduction approach.
  - Understanding the complexity of AUD.
  - Addressing Indigenous-specific needs = trying to help people reconnect with their culture should be part of the healing process. There is a gap in the system that is frustrating for the community.
  - Regional and rural considerations to support AUD
  - Social determinants of health = very important to support further
  - Variability of accessing specific care and resources