IDENTIFYING AND TREATING ALCOHOL USE DISORDERS

Part Two

BY RANDY SHIVELY, PH.D, AND JOHN HAGAN, MD

Introduction

Alcohol Use Disorder (AUD), as defined in the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition[1], leads tonegative consequences and behavioral disruptions. Alcohol Use Disorder is characterized by the following criteria:

1. Alcohol is taken in larger amounts than was intended.
2. A persistent desire or unsuccessful efforts to cut down on alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol or recover from its affects.
4. Craving or strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major obligations at work, school or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or made worse by the effects of alcohol.
7. Important social, occupational or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations which could be physically hazardous, i.e. driving a car.
9. Alcohol use is continued despite knowledge by the person of persistent or recurrent physical or psychological problems that are caused or made worse by alcohol.
10. Tolerance, as defined by increased amounts of alcohol to achieve intoxication or the desired effect and/or a markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as defined in the Withdrawal Syndrome, where alcohol is used to try to avoid withdrawal symptoms.

To have two or three of these symptoms would place somebody in the Mild Range, to have four to five symptoms would place someone in the Moderate Range, and to have six or more symptoms would place someone in the Severe Range.

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The cravings can be devastating, as many of our inmates have robbed orstolen money to keep their addiction alive. When under the influence of alcohol, they often make costly decisions which keep them bound to the corrections system.

AUD affects every aspect of correctional programming, not only for those engaging in their addiction, but also those inmates who are exposed to all the disruption caused by this behavior and may be tempted by the alcohol use around them. It also creates unpleasant situations for corrections staff who need to respond to behavioral incidents. Unhealthy dynamics occur when individuals with AUD use their addiction to cope with the correction experience.

Because, this habit follows them into the community upon reentry, this points to the urgent need to identify and give treatment options to the incarceratedpopulation. This is a great opportunity to start the process of recovery and to make referrals for Substance Use Disorder (SUD) individuals as they prepare for reentry. Treatment during incarceration, increases the chance for sobriety and success upon release. Forming a support network is key and an optimal time to start building this network is while they are receiving services in jail or prison.

Importance of screening

Screening for Substance Use Disorder has become very important in jails and prisons. One of the problems with current screening is there are no screening instruments available specifically developed for individuals in the criminal justice system.[2] Current screening instruments are almost exclusively self-reporting and it relies on a reliable informant giving accurate screening information. The addict often provides only part of the truth or is in denial of essential facts. Court ordered screening in the past has been seen, by definition, as coercive. Also, many treatment programs across the county have limited resources, resulting costs for screening often passed onto the offender. However, screening is extremely important to identify those who need a more thorough bio-psychosocial assessment to help determine needed levels of treatment.

There are examples of suitable screening tools that can be used with our population (The American Public Health Association, 2008).[3] Most screening tools are short, 4-13

questions, taking about two to ten minutes to administer. However, these questions are invaluable for establishing profiles of symptoms. Examples of short screening tools are the CAGE (4 questions), the Short Michigan Alcohol Screening Test (S—MAST), the Rapid Alcohol Problem Screen (RAPS) and the Alcohol Use Disorder Identification Test (AUDIT). These could all be very helpful in identifyingrisky alcohol-related behaviors which could suggest addiction.

Only those with significant cutoff scores should be further assessed by a more elaborate Bio-psycho-social assessment. This assessment looks at biological factors, psychological factors and social factors that are contributing to alcohol use associated with addiction. This longer assessment will help to identify if there is a disease process occurring which needs further treatment.

Those who have alcohol use problems desperately need both screening and/or assessment so they can be identified and targeted for education and/or treatment. Those not qualifying for treatment efforts will still benefit from education, which may help individuals to identify risk factors for SUD so they may be less likely to develop a full-blown Substance Use Disorder later.

Strategies to reduce relapse

Strategies to reduce relapse are key for inmates with Alcohol Use Disorder who seek abstinence and/or treatment. External monitoring tools are needed in order to gain cooperation to support abstention efforts. If the person cannot abstain for at least six to eight months, the brain cannot clear of fog and confusion.[4] With forced sobriety, the alcoholic will start having clearer thoughts and can benefit from education and treatment efforts. The longer the inmate is abstinent from alcohol, the greater the opportunity for cognitive recovery and receptivity to treatment. [5]

The first strategy that is helpful in corrections is regular contact by probation officers or the court designated monitors of the inmate. These contacts support the inmate and provide accountability. This strategy helps motivate the inmate to stay away from people, places and things associated with using alcohol and buy time for longer sobriety.

The second line of defense is having consistent, meaningful sanctions for relapse. These sanctions should support sober living and educate the inmate on how to embrace sober living and avoid detrimental decisions. Sanctions could be mandated education and/or treatment, attending support group meetings (e.g., AA) and/or doing homework assignments.

The third strategy is using frequent and random drug testing through probationary periods. This keeps the offender thinking about their sobriety and consequences. Positive tests may lead to more treatment sessions or jeopardize parole.

Finally, these external monitoring tools can be very effective when they take place as part of an education or treatment program. Getting inmates to see the need for sober supports, clear thinking and community resources to assist with cravings will reducerelapses. Most individuals with AUD do not volunteer for education and/or treatment; but given a mandate, they discover the wisdom in getting help to battle their problem.

Treating Alcohol Use Disorder

Individuals with AUD are often unable to stop drinking once they start. They build up a tolerance and need more alcohol to experience the same euphoria. When they suddenly stop drinking, they can have uncomfortable withdrawal symptoms, which may include sweating, irritability, restlessness, nausea, sweating, tremors and hallucinations.[6] They may continue to drink to alleviate these symptoms.

Maintaining an AUD person in treatment the first three months of abstinence is one of the biggest problems for treatment professionals. Rates of dropout during this time range from 50% to 80%. The first year sober from alcohol dependence has the highest rates of relapse.[7] Treatment providers must give external supports to help keep the person sober and link them to sober resources.

There is extreme heterogeneity of individuals with AUD. Most people who drink alcohol do not develop this disorder and most people with this disorder do not seek treatment.[8] Only one in ten people with a SUD receive any type of specialty treatment. It may be lower in the criminal justice population. According to the DSM-5, there are 2,048 potential symptom combinations that would meet the criteria for AUD. This illustrates why one treatment or set of treatments will not help specific individuals with the disorder.[9] The professional must do a

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thorough assessment and then individualize key treatment components.

A wide range of behavioral and psychological treatments are available for AUD and many treatments are equally effective in supporting abstinence or drinking reduction goals. [10,11,12,13] Treatments with the best outcomes range from brief interventions and include motivational interviewing (MI), to operant conditioning approaches, including contingency management (CM). Longer treatment approaches are Cognitive Behavioral Therapy (CBT) approaches, including Dialectical Behavioral Therapy (DBT).

Cognitive Behavioral Therapy is one of the most studied approaches and begins with an analysis of alcohol use for the individual and then clarifies patterns of thoughts, feelings and behaviors that are most associated with excessive drinking.[14]

Contingency Management has had modest research support and considers drinking behavior theresult of reinforcement learning. Behaviors that are rewarded will increase in frequency. CM is structured behavior therapy in which pre-established goals are set with specific rewards, such as monetary rewards, given for progresstoward goals. There are frequent checks for alcohol use.

Motivational Interviewing is client-centered and aims to increase the motivation to change by exploring and resolving ambivalence toward sobriety.[15] It aimsto change the decision-making that led to abusive drinking habits. Its main concepts are to express empathy, resolve ambivalence, roll with resistance and support self-efficacy. It can be set up as brief therapy, from one to four sessions. It can complement longer approaches, such as CBT.

Systematic reviews and meta-analyses of brief interventions have found the following to be effective: self-monitoring of alcohol use, increased awareness of high-risk situations, training in cognitive behavioral techniques (which stress coping with potential drinking situations), life skills training, communication training and coping skills training. These can be delivered in individual or group settings and can be extended to families and couples.

Also, Dialectical Behavioral Therapy in the form of acceptance and mindfulness interventions are increasingly being used to target AUD.[16] Parts of DBT include learning to develop a nonjudgmental approach to self and others,

acceptance of momentary experiences that promote sobriety and learning to live in the present. DBT presents many techniques which can be learned and practiced when an individual is calm, so when the individual is in a stressful situation or experiences negative emotions, risk can be lowered with an arsenal of weapons against relapse.

Many of these brief interventions, cognitive behavioral approaches and mindfulness exercises are being placed on computerized, web-based mobile interventions.[17,18,19] For example, the National Institute on Alcohol Abuse and Alcoholism has developed the *Take Control* computerized intervention that includes motivational interviewing and coping skills training designed to give psychosocial support and to increase adherence to pharmacotherapy trials.[20] These mobile interventions can be utilized by individuals with AUD in rural areas.

As one recovering alcoholic states, "The disease begins in the heart and not in the head."

Although not a therapy, Alcoholics Anonymous (AA) meetings have been found to be associated with recovery from AUD even in the absence of formal treatment.[21] For some people, AA provides a great learning experience on how to change one's life to support sobriety by hearing other alcoholics' stories of successes and failures. The 12 step model becomes a springboard for practicing principles of recovery. It is a place where one can feel accepted and learn from those who have fought through critical periods of abstinence. Motivation to change and having a social network that supports abstinence are both factors associated with treatment effectiveness.[22]

Finally, for any inmate suffering from AUD, hope becomes a cornerstone for anything and everything that is positive in recovery.[23] As one recovering alcoholic states,

"The disease begins in the heart and not in the head. We can't think our way out alone, because healing from a troubled past must begin in our hearts first. Facing life without a substance or drinking can only be attempted when there is hope. The good news is that hope is free: anyone can have hope. But, they need to look for it."

This new-found hope is what allows the person with AUD to find the strength to seek out treatment and stay in treatment when everything in their being wants to use alcohol or to run from their sober supports.

Treating "Alcohol Withdrawal Syndrome" (AWS)

It is important to recognize the onset of symptoms of alcohol withdrawal syndrome.[24] Early symptoms may include insomnia, nausea and vomiting. Hand tremors, psychomotor agitation (movements or actions that serve no purpose) and anxiety follow. If the condition worsens, individuals begin to suffer fight or flight symptoms, hallucinations and seizures. The strongest predictor for AWS is a personal or family history of past episodes of AWS.

Alcohol is a central nervous system inhibitor. The actions of GABA neurons, which inhibit activity throughout the brain, are increased by alcohol ingestion. The brain becomes tolerant of the increased suppressive activity of the GABA neurons. It adapts by expressing more excitatory NMDA receptors to compensate for the continued suppression of the GABA neurochemicals. When alcohol is removed, the GABA neurons cease their sedating effect throughout the brain. This results in global overstimulation. Within 8 to 72 hours, half of all AUD patients suffer symptoms of alcohol withdrawal syndrome (AWS) with an alcohol decrease or cessation. 5%of these patients will suffer severe symptoms, including seizures or delirium tremens.

The Clinical Institute Withdrawal Assessment of Alcohol Scale is commonly used to judge severity of AWS and to guide therapy. This tool measures ten domains of nervous system hyperactivity through observation and questions. Observations include tremors, sweats and agitation. Questions assess symptoms of nausea, anxiety, tactile, auditory and visual hallucinations, headache and disorientation. Answers and observations are ranked on a numbered scale, and the score is tallied. Individuals who score less than ten usually do not need medication to treat withdrawal. Individuals who score twenty orabove are at high risk for severe withdrawal and generally require hospitalization in order to safely treat AWS.

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The setting and tools used to treat an individual suffering from AWS depend on the severity of symptoms. Mild withdrawal can be managed at home or in a social detox setting. Moderate withdrawal is best handled in a medical outpatient setting, where medical professionals can make frequent assessments and determine effectiveness of therapy as well as the risk and benefit of escalating doses of sedatives. Severe withdrawal most often requires admission to a hospital and may include an ICU stay.

Standardized medication administration protocols are commonly used to match treatment with AWS severity. Benzodiazepines drugs, such as Valium, Ativan, Librium and Xanax, remain the medications of choice to manage withdrawal symptoms and to prevent seizures during AWS. Phenobarbital can be added to this regimen if first-line drugs are ineffective. Gabapentin, an antiseizure medication which has shown benefit in AWS, can be used in protocols in selected patients with moderate withdrawal symptoms who may be able to be managed outside of an inpatient setting.

In treating AWS, the goals are relief of immediate symptoms, prevention of complications and initiation of rehabilitation. Each system treating individuals who are suffering AWS will need to develop and implement screening and assessment tools to identify and correctly gauge the severity of AWS and should set thresholds for safe treatment in community/social detox, medical detox and inpatient settings.

Implications for the Field

Screening, assessment and identification of substance use problems is key to getting an individual to start education and treatment early in prison so connections can be made for aftercare in the community. This keeps a steady continuum of care needed for successful recovery.

It is important corrections systems use strategies of external controls to increase sobriety, which allows "the fog to clear" from the clouded mind. Only then does the inmate see the need for help and have a solid base to benefit from education and treatment.

There are many psychological and medical therapies which can be individualized. These therapies can help treat the urge to use, the severity of withdrawal symptoms and the threat of relapse. Without slowing the disease and teaching management and coping strategies, inmateswill continue to be ravaged by the effects of alcohol. Once cirrhosis of the liver sets in and late stage effects of the disease are realized, treatment options dwindle.

If Substance Use Disorder is not identified, assessed and treated while incarcerated, alcohol will continue to destroy lives and add to the costs of correctional care. In addition, the disease will continue to influence bad choices and criminal acts, which further frustrate both the offender and the system.

The good news is across the nation, the corrections profession is increasing substance use treatment and education programs in jails and prisons. This offers help and hope to those with AUD. With good assessment practices and availability of education and treatment programs, progress is being made. ACA is one organization on the cutting edge of adopting policies and procedures to help support these efforts.

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ENDNOTES

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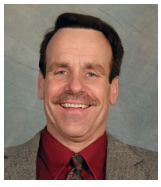

Randy Shively, Ph.D., is Director of Research and Clinical Development for Alvis in Columbus, Ohio. He also has a private practice where he serves individuals with developmental disabilities, mental health, substance abuse and sex offending issues. He was awarded the 2016 Peter Lejins Research Award by the American Correctional Association and has been instrumental in drafting national policies in corrections in the clinical area for ACA.

John Hagan, M.D.