EDITORIAL AND COMMENT

Increasing Prevalence of Alcohol Use Disorders: Meeting the Challenge in Primary Care

Commentary on Williams et al., Barriers to and Facilitators of Alcohol Use Disorder Pharmacotherapy in Primary Care: A Qualitative Study in Five VA Clinics

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In a national study of alcohol consumption, DSM-IV alcohol use disorders (AUD) increased significantly in most socioeconomic and demographic groups from 2001/2002 to 2012/2013.¹ Over this period, the prevalence of AUD rose from 8.5% to 12.7% of the population, or an estimated 29.9 million Americans. The rise in AUD reflects not only diverse socioeconomic factors, but also the failure of the health care system to diagnose and address this condition despite significant associated morbidity and mortality.² Access to specialty care for AUD has been notoriously poor, and demand has far outstripped capacity.³ A logical approach to meet this demand is to increase the role of primary care in managing AUD by prescribing effective medication for this common condition. However, surprisingly little research has been conducted on factors influencing the willingness of primary care physicians to prescribe these medications.

The rigorous qualitative study by Williams and colleagues in this issue of *JGIM* offers valuable insight on initiatives designed to promote primary care treatment of AUD.⁴ As is typical of qualitative studies, the sample size is small—24 clinicians from five primary care clinics within one large VA system—because enrollment ended when new information was no longer being elicited. The authors' analysis revealed barriers to treating AUD that echo those that have been described previously,⁵ including poor training, limited organizational support, belief that specialists provide this care, and the stigma of alcohol addiction. Conversely, themes reflecting facilitators included interest in learning how to prescribe AUD medications, the value of consultation or onsite shared care from addiction specialists, and integrated behavioral health support.

Intriguing additional insights emerged from the authors' use of a social marketing framework to distinguish respondents who were more willing (or interested) to address a behavior or activity from those who were less willing. More receptive clinicians regarded medications for AUD as an important initial step in managing AUD, and noted that onsite primary care management may be better accepted and less stigmatizing than specialty care. Unwilling clinicians were skeptical about the effectiveness of medications for AUD and concerned about the excessive time needed to manage AUD along with associated psychosocial problems in the context of other heavy clinical demands.

A recurring theme was the need for access to specialty support, especially within the primary care practice, not only for assistance with managing medications to treat AUD, but also for behavioral counseling. Multiple federal agencies have been promoting comprehensive, integrated care for alcohol and substance use. The Substance Abuse and Mental Health Services Administration offers resources for professionals regarding medication-assisted therapy for alcohol use, while the Agency for Healthcare Research and Quality's Academy for Integrating Behavioral Health and Primary Care and the Veterans Health Administration have been promoting primary care models that integrate mental health/behavioral counseling to deliver more holistic care. Currently, financial support for these integrated models of care, especially in the community, is limited, but the move toward accountable care organizations may make this expenditure worthwhile, especially considering the costly complications associated with AUD.²

However, in many community-based settings, access to behavioral and addiction specialty services is extremely limited. With increasing congressional interest in supporting telehealth, as demonstrated by a variety of new bills under consideration, it is possible to envision a day when compensation will be offered for addiction and behavioral specialists to provide remote consultation to primary care clinicians as well as directly to patients. The value of telehealth support for primary care clinicians in disease management has been

demonstrated for other conditions such as chronic hepatitis C and remote counseling for patients with mental health conditions. Again, these models of care must be financially viable to permit their broad adoption to meet the enormous need for management of AUD and other substance use disorders.

Although several authors of this paper have contributed to the literature on integrating screening and brief intervention (SBI) for alcohol misuse into primary care,⁶ this important component of the continuum of care for AUD was not directly addressed in this qualitative study. According to a systematic review, all guidelines for addressing harmful use of alcohol, including AUD, endorse SBI as an effective intervention, but implementation continues to be a challenge due to competing needs and lack of training.⁷ However, as the authors point out, the COMBINE study demonstrated that medical management with naltrexone was equally effective in reducing heavy drinking days with or without counseling by an alcohol treatment specialist.⁸ Because a decade has passed since the COMBINE study was published, the study by Williams and colleagues raises concerns about slow adoption of the COMBINE findings within primary care.

This delayed adoption reflects, in part, an ongoing challenge in educating clinicians about managing alcohol misuse and other substance use disorders. A training program for faculty and residents that featured repeated educational programs on managing substance use still failed to increase faculty confidence in prescribing medications for substance use disorders.⁹ With the move toward value-based care, however, there are several quality measures for evaluating patient initiation of and engagement in alcohol and other drug dependence treatment, which may increase the impetus toward developing effective and sustainable programs to train and support primary care clinicians in managing AUD and other substance use disorders. As endorsed by the authors, this training must also address the stigma around alcohol misuse that leads both clinician and patient to avoid dealing with it, despite risks to the patient's health and well-being.

To achieve more efficient and comprehensive care, models of care that engage addiction and behavioral specialists should support management of multiple substance use disorders. As endorsed by Park and Friedmann, "prescribing" clinicians should be able to provide medical management for both AUD and opioid dependence.¹⁰ Given the pivotal role of primary care in all aspects of health care, policymakers,

payers, and administrators should prioritize training, integrated expertise, and financial support to improve primary care management and outcomes for persons with diverse types of substance use disorders.

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