Efficacy of Medication for Alcohol Dependence

Naltrexone and acamprosate are two medications that are FDA-approved for the treatment of alcohol dependence. Meta-analyses of studies on the impact of these medications have demonstrated positive effects on outcomes, especially effects of acamprosate on abstinence-related outcomes and beneficial effects of naltrexone on heavy drinking-related outcomes. Based on the accumulated evidence of the effectiveness of these medications, they received strong recommendations as evidence-based treatments for alcohol dependence in the National Quality Forum’s National Voluntary Consensus Standards for the Treatment of Substance Use Conditions, as well as the VA/Department of Defense Clinical Practice Guidelines for Management of Substance Use Disorders. Based on these guideline recommendations, the “VA Uniform Mental Health Services Handbook” states that naltrexone and acamprosate should be offered and available to all Veterans diagnosed with alcohol dependence, if not medically contraindicated. Also noteworthy is that a recent meta-analysis of seven placebo-controlled randomized trials of a newer medication, topiramate, found it had a more positive overall effect size than that from the first seven trials of naltrexone. Thus, it is a very promising medication.

Despite the accumulated evidence, clinical practice guideline recommendations, and VA policy, implementation of these medications within the VA healthcare system has been low overall, and highly variable. Among the more than 200,000 VA patients with a documented alcohol dependence diagnosis, less than 6% have received an approved medication. The majority of VA patients with alcohol dependence diagnoses (65%) are never seen in specialty substance use disorder clinics. However, even among those seen in specialty clinics, prescribing rates remain below 10%, with rates varying from 0% to 21% across facilities. Extremely low prescribing rates and significant variation across facilities suggest that significant gaps exist in access to these medications.

Although medications are not generally considered a stand-alone treatment for alcohol dependence and will not be effective for all patients, there is considerable consensus that they should be part of the menu of effective treatments offered and available to patients with alcohol dependence. Particularly in primary care, where standard treatment usually involves a referral to specialty SUD care (which many patients do not follow through with due to various barriers), medication therapy provides a treatment option to bridge the gap between treatment need and treatment access.
local and national clinical champions, a dashboard to identify patients on their caseload with alcohol dependence diagnoses, and audit and feedback regarding their own prescribing practices. Veterans with alcohol dependence diagnoses will receive educational material by mail prior to upcoming primary care appointments.

• **The Alcohol Care Manager (ACM):** ACM is a collaborative care model for the management of adults with alcohol dependence in primary care. Regular visits over 4-6 months focus on goal setting, monitoring progress, and promoting other resources, such as AA and pharmacotherapy. An SUD-QUERI investigator recently completed a randomized, controlled trial of ACM that demonstrated significantly greater rates of engagement in treatment, receipt of alcohol dependence medications, and reductions in heavy drinking compared to referral to SUD specialty care. SUD-QUERI investigators are planning a project to implement the ACM across multiple facilities using provider training, academic detailing, and external facilitation.

• **Academic Detailing for Alcohol Dependence Pharmacotherapy:** VA’s Office of Patient Care Services funded an academic detailing pilot project that developed and implemented programs in two regional VISNs to influence the pharmacological treatment of several mental health and addictive disorders, including alcohol dependence. The Academic Detailing Program sent clinical pharmacist detailers to 49 facilities across VISNs 21 and 22 in order to educate, motivate, and enable key healthcare providers to identify and manage the range of hazardous alcohol use, especially to facilitate more active consideration of pharmacological treatment options for alcohol dependence. This program has received positive attention from VA Central Office and is being expanded. SUD-QUERI is developing an evaluation targeted at understanding the effectiveness, mediators and moderators of effectiveness, and costs of this implementation strategy in order to inform its expansion.

Although these interventions vary, the evaluation planned for each will allow for an assessment of the effects of the interventions on provider prescribing practices, as well as aspects of the interventions that were viewed as most impactful, feasible, and acceptable by providers. All of the evaluations also include an estimation of the cost of implementation. This detailed information, along with the close collaborations established between MHS/MHO and SUD-QUERI researchers, will allow MHS/MHO to employ evidence-based implementation strategies to promote access to pharmacotherapy.

### How Do I Learn More?

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### Web Resources

SUD-QUERI offers educational and implementation tools at the following website:

[www.queri.research.va.gov/sud/wwd/alcohol/default.cfm](http://www.queri.research.va.gov/sud/wwd/alcohol/default.cfm)

For more information about the QUERI program in general, and to link to all of the individual QUERI Centers, please go to  
[www.queri.research.va.gov](http://www.queri.research.va.gov)

### The SUD-QUERI Executive Committee

Each QUERI Center is led by a research expert and a clinician. The research expert and Director for SUD-QUERI is **Alex Sox-Harris, Ph.D.** The Clinical Coordinator is **Elizabeth Gifford, Ph.D.,** and the Implementation Research Coordinators are **Hildi Hagedorn, Ph.D., Matthew Boden, Ph.D., and Andrea Finlay, Ph.D.** The Executive Committee includes other experts in the field of substance use disorders: Paul Barnett, Ph.D.; Thomas Berger, Ph.D.; Katharine Bradley, M.D.; Geoff Curran, Ph.D.; Lori Ducharme, Ph.D.; John Finney, Ph.D. (Research Coordinator Emeritus); Adam Gordon, M.D.; Kim Hamlett-Berry, Ph.D.; Daniel Kivlahan, Ph.D.; Thomas Kosten, M.D. (Research Coordinator Emeritus); Dean Krahm, M.D.; Dave Oslin, M.D.; Robert Rosenheck, M.D.; Mark Shelhorse, M.D.; and Ken Weingardt, Ph.D.