Stepping up: A B.C. doctor spreads the word about treating alcohol dependence with medication

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Dr. Jeff Harries, seen here at his Penticton, B.C. home on Oct. 11, 2020, has found success treating alcohol-use disorder with medication.

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Jeff Harries knew what most patients went through when they tried to quit drinking: the agony of physical and emotional withdrawal symptoms, including elevated heart rate, nausea, agitation and anxiety, and the revolving door of detox, rehab and relapse.

So when he read in The Lancet about a pill that could curb cravings and reduce drinking, he decided to offer it to one of his patients, who had struggled with severe alcohol-use disorder for nearly 30 years. The results

stunned him.

“It was like this miracle,” says Dr. Harries, a family physician in Penticton, B.C. “He didn’t go to detox or counselling. He just slowly stopped drinking. And he didn’t drink for the rest of his life.”

The patient’s stark recovery prompted Dr. Harries to re-evaluate what he understood about the disorder.

For too long, he says, doctors, including himself, have tried to get their patients to quit or reduce their drinking by shaming, encouraging or berating them. Like many physicians, Dr. Harries was taught in medical school that controlling one’s drinking was a matter of willpower and required strength of character. But he recognized this approach was failing patients. And so the humble, plain-spoken doctor made it his mission to change how physicians view and treat alcohol-use disorder, a diagnosis that includes alcohol abuse and alcohol dependence.

Although there are several inexpensive, effective medications available to help manage patients' drinking, including naltrexone, acamprosate and topiramate, many doctors across the country aren’t aware of them. So over the past three years, Dr. Harries has delivered more than 140 talks to his fellow physicians throughout B.C. and Alberta to raise awareness of them and encourage more compassionate care.

Dr. Harries is in a race against time to share his knowledge with his peers. In April, 2018, he was diagnosed with amyotrophic lateral sclerosis (also known as ALS or Lou Gehrig’s disease), which has a typical survival time of about two to five years after diagnosis. He is starting to lose his ability to speak and will not be able to continue offering his talks much longer, says his wife and mother of nine children, Leona Harries, who is also a general practitioner in Penticton.

Nevertheless, he marvels at the thousands of doctors, health workers and even judges whose minds he has changed through his talks so far. And he muses about his leading role in advocating for patients whom he believes deserve better.

“I still wonder why it’s me, why some schmuck from Penticton is doing this,” he says.

Alcohol is one of the most harmful and costly drugs in Canada, associated with an estimated 18,320 deaths in the country and $5.4-billion in health care costs in 2017, according to a report earlier this year from the Canadian Centre for Substance Use and Addiction. The most recent data from Statistics Canada in 2012 estimated as many as 18 per cent of Canadians, ages 15 and older, met the clinical criteria for alcohol-use disorder during their lifetime. Yet while the

disorder is widespread and its adverse health consequences are well-known, the potential to treat it with medication is much less so.

"It's actually a staggering failure," says Evan Wood, an addiction-medicine clinician and clinical-research scientist at the British Columbia Centre on Substance Use (BCCSU).

While medications for other illnesses are often readily adopted into widespread use, such as statins for preventing heart attacks, this has not been the case for pharmacotherapy for alcohol-use disorder, Dr. Wood says. In Ontario, for example, a 2017 study in the Canadian Family Physician journal found less than 1 per cent of public drug-plan beneficiaries with alcohol-use disorder in the province were given first-line medications.

Part of the reason doctors don't know to prescribe these medications may be because they're generic, which means pharmaceutical companies have no incentive to push them, Dr. Harries says.

But more importantly, he says, changing the way doctors treat people with alcohol-use disorder requires a paradigm shift, untangling long-standing prejudices and stereotypes.

Even now, roughly 15 years since Health Canada approved naltrexone and acamprosate for the disorder, Dr. Harries says medical residents have told him they've been taught the "tried and true" way to manage patients' drinking is to send them to detox and rehab – an approach bolstered by a large industry of private, for-profit rehab facilities, yet which does not work for many.

Medications don't replace the need for counselling, and none of them work for everyone. But with about seven different drugs doctors can prescribe, patients can be offered a broader range of treatment options. If one drug doesn't work, patients may find some success with another, Dr. Harries says. (He says patients can stop taking the drugs within a few months and may only need to use them briefly again if they relapse.)

By treating that early patient with topiramate back in 2003, Dr. Harries recognized what research supports – that alcohol-use disorder has nothing to do with one's moral fibre but is caused by biological dysfunction of the brain. Beyond medications, some researchers are experimenting with neuromodulation treatments, such as deep brain stimulation, to try to quell cravings and reduce patients' alcohol consumption by targeting dysfunctional circuitry of the brain.

When her husband began using medications to treat a patient with alcohol-use disorder, "it just wasn't mainstream by any means," says Leona Harries, with whom he shared a joint practice until the couple closed it after his ALS diagnosis. "This stuff just wasn't being talked about, so he was kind of a lone

soldier."

The first year he decided to share his knowledge and experience beyond his own community, he gave 20 talks to about 200 family doctors, emergency physicians and other front-line health professionals as part of their continuing medical-education programs. Last year, he gave 80 talks to around 2,500 doctors. Though he received stipends for some speaking engagements, much of this was voluntary.

Recently, he also joined forces with the BCCSU, which has expanded his reach. Dr. Harries served on the committee behind BCCSU's provincial guideline, published late last year, for the clinical management of high-risk drinking and alcohol-use disorder. It recommends the drugs naltrexone and acamprosate as first-line pharmacotherapy treatments for alcohol-use disorder and offers guidance to doctors on the evidence and risks of using them, as well as topiramate, gabapentin, disulfiram, baclofen and ondansetron.

This document is by no means the first, nor only, such guideline in the country. But B.C. is leading the way in implementing a new standard of care for patients, in large part because of Dr. Harries's efforts.

"I don't know why, but I seem to be able explain it in a manner that people can change their minds," he says. "And then, once they start … looking at people suffering with this disorder in this new way, it just takes off."