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Guidelines & Protocols Advisory Committee

BC Guideline Summary: High-Risk Drinking and Alcohol Use Disorder

Scope

The BC guideline: High-Risk Drinking and Alcohol Use Disorder aims to outline the identification and clinical management of high-risk drinking and alcohol use disorder in adults (individuals aged 25 years and older) and youth (individuals aged 10-24 years).

Key Recommendations

Practitioners should examine their preconceptions or biases regarding alcohol use, who uses it, and how it is used. Differentiate between high-risk alcohol use and alcohol use disorders. Consider how to investigate and communicate alcohol related diagnoses, being mindful of potential stigmatization and bias in care. See associated documents for examples.

Screening and Brief Intervention

1. Screen all patients routinely for alcohol use above low-risk limits. *[Certainty of Evidence: Low, Strength of Recommendation: Strong.]*
2. Screen youth patients for alcohol use with the *Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) instrument* (see associated documents) or the *U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA) Screening Tool*. *[Certainty of Evidence: Moderate, Strength of Recommendation: Strong.]*
3. To facilitate discussions about alcohol use, when appropriate, ask patients about current knowledge of and offer education about *Canada's Guidance on Alcohol and Health*. *[Certainty of Evidence: Low, Strength of Recommendation: Strong.]*
4. Assess patients who screen positive for high-risk alcohol use or for AUD (See *DSM-5-TR Diagnostic Criteria for Alcohol Use Disorder*). *[Certainty of Evidence: Low, Strength of Recommendation: Strong.]*
5. Use brief intervention for all patients who screen positive for alcohol use at moderate or high-risk limits but who do not meet the criteria for AUD (see Figure 1: Quick Guide to Outpatient Treatment of Alcohol Use Disorder). *[Certainty of Evidence: Moderate, Strength of Recommendation: Strong.]*
6. Consider using a *motivational interviewing-based approach with patients* to support achievement of treatment goals. *[Certainty of Evidence: Moderate, Strength of Recommendation: Strong.]*

Withdrawal Management

7. Use *Prediction of Alcohol Withdrawal Severity Scale (PAWSS)* to help select the most appropriate withdrawal management pathway. PAWSS is a validated tool for assessing the risk of severe complications of alcohol withdrawal. See associated documents for criteria. *[Certainty of Evidence: Moderate, Strength of Recommendation: Strong.]*
8. For patients at low risk of severe complications of alcohol withdrawal (ie., PAWSS < 4), consider prescribing alternatives to benzodiazepines, e.g., gabapentin, carbamazepine and/or adjuvants such as clonidine for withdrawal management in an outpatient setting. [Certainty of Evidence: Moderate (gabapentin) Low (carbamazepine, clonidine), Strength of Recommendation: Strong.]
9. Do not prescribe benzodiazepines as ongoing treatment for AUD. *[Certainty of Evidence: High, Strength of Recommendation: Strong.]*
10. For patients at high risk of severe withdrawal complications (ie., PAWSS ≥ 4), offer a short-term benzodiazepine prescription. This is ideally completed in an inpatient setting (i.e., a withdrawal management facility or hospital). Where inpatient admission is not available, benzodiazepine medications can be offered to patients in outpatient settings if they can be closely monitored and supported. *[Certainty of Evidence: High, Strength of Recommendation: Strong.]*
11. When possible, patients who complete withdrawal management should be offered continuing care. Withdrawal management is a short-term intervention that does not resolve the underlying medical, psychological, or social issues of AUD and should be considered a bridge to continuing care. *[Certainty of Evidence: Low, Strength of Recommendation: Strong.]*
12. Patients should not be prescribed antipsychotics or selective serotonin reuptake inhibitors (SSRI) antidepressants if the primary reason is for the treatment of AUD. If SSRI antidepressants are prescribed for individuals with co-occurring mood disorders. Clinicians and patients should be alert to the risk of increased alcohol cravings and use with SSRI therapy and discontinue as appropriate.[1] *[Certainty of Evidence: Strong, Strength of Recommendation: Moderate.]*

Continuing Care

13. Consider offering naltrexone or acamprosate to adult patients with moderate to severe AUD. These are first-line pharmacotherapy agents that may support patient-identified treatment goals.
    a. Naltrexone is recommended for patients who have a treatment goal of either abstinence or a reduction in alcohol consumption. *[Certainty of Evidence: High, Strength of Recommendation: Strong.]*
    b. Acamprosate is recommended for patients who have a treatment goal of abstinence. *[Certainty of Evidence: High, Strength of Recommendation: Strong.]*
14. Consider offering topiramate to adult patients with moderate to severe AUD who do not benefit from or have contraindications to first-line medications. Some patients may express a preference for topiramate or gabapentin.
    a. Topiramate. *[Certainty of Evidence: Moderate, Strength of Recommendation: Strong.]*
    b. Gabapentin. *[Certainty of Evidence: Low, Strength of Recommendation: Conditional.]*
15. Consider providing information about and referrals to specialist-led psychosocial treatment interventions to all patients with AUD. See the resource section for referral and specialist information. *[Certainty of Evidence: Moderate, Strength of Recommendation: Strong.]*
16. Consider providing all patients with AUD information about and referrals to peer-support services, harm reduction interventions and/or other recovery-oriented services in the community. *[Certainty of Evidence: Moderate, Strength of Recommendation: Strong.]*