Alcohol use disorder and high-risk drinking

Clinical Practice Guideline

of Canadians aged 15 years and older drink above low-risk levels

- Alcohol use disorder (AUD): Pattern of heavy alcohol use and loss of control over intake despite negative consequences
- High-risk drinking and AUD frequently go unrecognized and untreated. Effective treatments are available
- Primary care providers are key to early detection and treatment

Overview of clinical pathway

ASK ABOUT ALCOHOL

"Would it be all right for us to talk about your relationship with alcohol?"

- Asking permission builds trust and comfort

SCREENING AND DIAGNOSIS

"In the past year, how often have you had more than 4 drinks (females) or 5 drinks (males) on any 1 occasion?"

- If 1 occasion or more, ask further screening questions (AUDIT-C*)
- For moderate risk of AUD: Provide brief advice on the health risks and suggestions on how to cut back
- For high risk of AUD: Diagnose using DSM-5-TR criteria

ASSESS THEIR GOALS

If moderate or severe AUD, use brief intervention to discuss goals and a tailored plan:

- Stop drinking
- Cut back on drinking
- Reduce harms of drinking

WITHDRAWAL MANAGEMENT

Use PAWSS* and withdrawal history to determine if low or high risk of severe complications (e.g., delirium tremens, seizures):

- Low risk: outpatient; Rx gabapentin, clonidine
- High risk: inpatient; Rx short course of benzodiazepines

LONG-TERM TREATMENT

- Medications: (1st line) Rx naltrexone or acamprosate; avoid SSRIs,* antipsychotics and long-term benzodiazepines
- Psychosocial treatments: Cognitive behavioural therapy, family-based therapy
- Community supports: Supportive recovery programs, peer groups, etc.

**AUDIT-C = Alcohol Use Disorder Identification Test–Consumption*
PAWSS = Prediction of Alcohol Withdrawal Severity Scale
SSRI = selective serotonin reuptake inhibitor

Figure 1: Summary of clinical pathway for alcohol use disorder. DSM-5-TR = *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision.*

Table 2: Summary of recommendations

	Recommendation	Strength of recommendation*	Certainty of evidence[15]
Screening†			
1	When appropriate, clinicians should inquire about current knowledge of and offer education to adult and youth patients about *Canada's Guidance on Alcohol and Health*, in order to facilitate conversations about alcohol use.	Strong	Low
2	All adult and youth patients should be screened routinely for alcohol use above low risk.‡	Strong	Moderate
Diagnosis			
3	All adult and youth patients who screen positive for high-risk alcohol use should undergo a diagnostic interview for AUD using the DSM-5-TR criteria§ and further assessment to inform a treatment plan, if indicated.	Strong	Low
Brief intervention			
4	All patients who screen positive for high-risk alcohol use should be offered brief intervention.	Strong	Moderate
Withdrawal management			
5	Clinicians should use clinical parameters, such as past seizures or past delirium tremens, and PAWSS[16] to assess the risk of severe alcohol withdrawal complications and determine an appropriate withdrawal management pathway.	Strong	Moderate
6	For patients at low risk of severe complications of alcohol withdrawal (e.g., PAWSS < 4), clinicians should consider offering nonbenzodiazepine medications, such as gabapentin, carbamazepine or clonidine for withdrawal management in an outpatient setting (e.g., primary care, virtual).	Strong	Moderate (gabapentin) Low (carbamazepine, clonidine)
7	For patients at high risk of severe complications of withdrawal (e.g., PAWSS ≥ 4), clinicians should offer a short-term benzodiazepine prescription, ideally in an inpatient setting (i.e., withdrawal management facility or hospital). However, where barriers to inpatient admission exist, benzodiazepine medications can be offered in outpatient settings if patients can be closely monitored.	Strong	High
8	All patients who complete withdrawal management should be offered ongoing AUD care.	Strong	Low
Treatment and ongoing care			
Psychosocial treatment interventions			
9	Adult and youth patients with mild to severe AUD should be offered information about and referrals to specialist-led psychosocial treatment interventions in the community.	Strong	Moderate
Pharmacotherapy			
10	Adult patients with moderate to severe AUD should be offered naltrexone or acamprosate as a first-line pharmacotherapy to support achievement of patient-identified treatment goals.	Strong	High
	A. Naltrexone is recommended for patients who have a treatment goal of either abstinence or a reduction in alcohol consumption.		
	B. Acamprosate is recommended for patients who have a treatment goal of abstinence.		
11	Adult patients with moderate to severe AUD who do not benefit from, have contraindications to, or express a preference for an alternate to first-line medications can be offered topiramate or gabapentin.	Strong (topiramate) Conditional (gabapentin)	Moderate (topiramate) Low (gabapentin)
12	Adult and youth patients should not be prescribed antipsychotics or SSRI antidepressants for the treatment of AUD.	Strong	Moderate
13	Prescribing SSRI antidepressants is not recommended for adult and youth patients with AUD and a concurrent anxiety or depressive disorder.	Strong	Moderate
14	Benzodiazepines should not be prescribed as ongoing treatment for AUD.	Strong	High
Community-based supports			
15	Adult and youth patients with mild to severe AUD should be offered information about and referrals to peer-support groups and other recovery-oriented services in the community.	Strong	Moderate

Note: AUD = alcohol use disorder, AUDIT = Alcohol Use Disorders Identification Test, AUDIT-C = AUDIT–Consumption, DSM-5-TR = *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision*, PAWSS = Prediction of Alcohol Withdrawal Severity Scale, SSRI = selective serotonin reuptake inhibitor.
*See Box 3 for details.
†A clinical pathway from screening to treatment is depicted in Figure 2.
‡Suggested screening tests include the Single Alcohol Screening Question,[17] AUDIT[17] and AUDIT-C.[14] Other validated screening tools may be used. Routine annual screening is suggested, although there is a lack of research evidence on the optimal frequency.
§See Table 1 for sample interview questions for DSM-5-TR diagnostic criteria for AUD.[11]

and grading of severity to enable patients to access further AUD care and available evidence.[9] See Appendix 1, Section 3.3 for additional information and supporting evidence on diagnosis.

Brief intervention

Recommendation 4: All patients who screen positive for high-risk alcohol use should be offered brief intervention (strong recommendation, moderate-certainty evidence).

All patients who are identified with high-risk alcohol use from the screening stage should receive a diagnostic interview, followed by brief intervention as the first step in developing a care plan. This includes patients who screen positive for high-risk alcohol use or are diagnosed with an AUD.

Brief intervention that uses the techniques of motivational interviewing can be offered by a variety of health professionals, with demonstrated efficacy after a single 5-minute session.[26] A Cochrane review in 2018 found that brief intervention results in a reduction of alcohol consumption of 20 g per week after 1 year, compared with minimal or no intervention (95% confidence interval [CI] −28 g to −12 g).[26] Several approaches to brief intervention and population-specific considerations are discussed in Appendix 1, Sections 3.4 and 3.5.

Typically, brief intervention involves a short conversation to discuss the patient's health concerns, collaboratively set goals and develop a treatment plan tailored to those goals and patient preferences. As discussed below, the treatment approach for AUD may include withdrawal management, psychosocial interventions and pharmacotherapies.

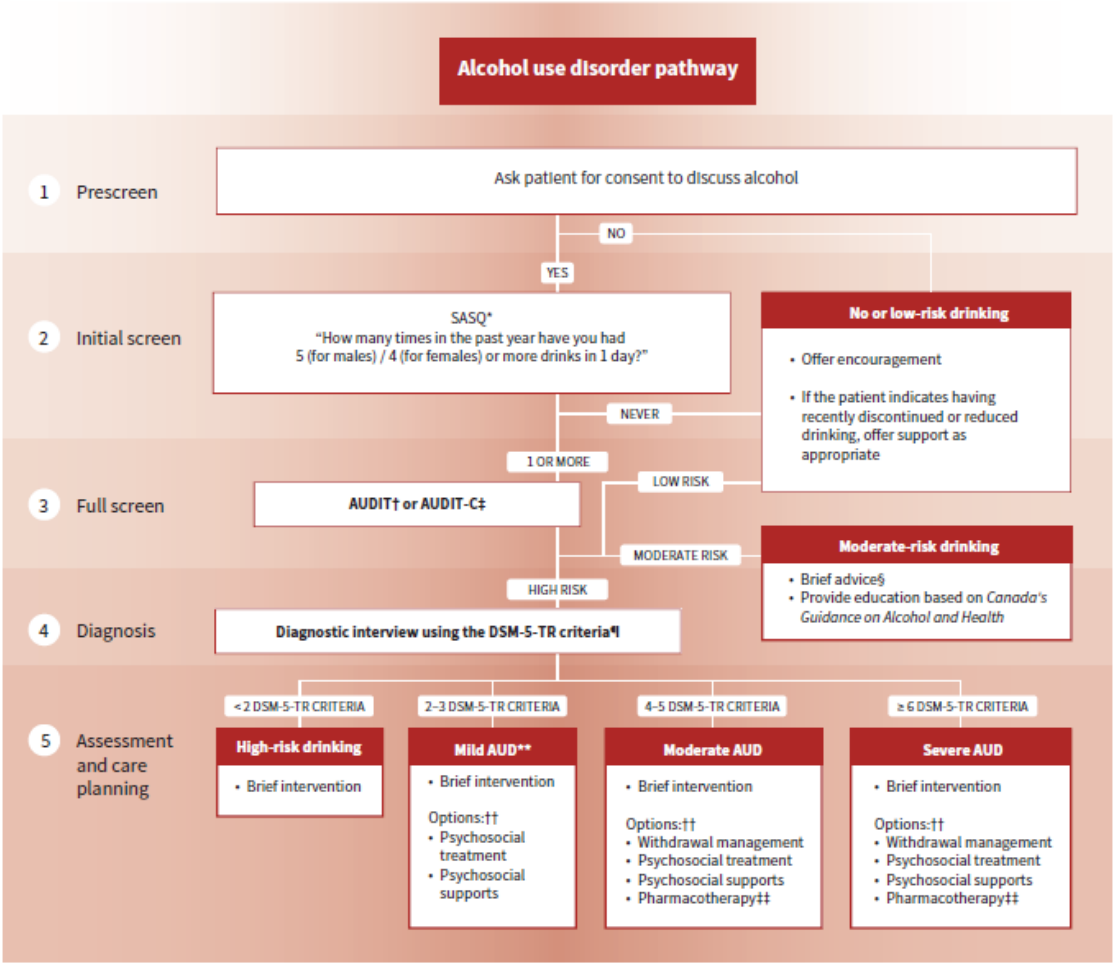

Figure 2: Alcohol use disorder (AUD) care pathway. Note: AUDIT = Alcohol Use Disorders Identification Test, AUDIT-C = AUDIT–Consumption, DSM-5-TR = *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision*, SASQ = Single Alcohol Screening Question. *See Appendix 1, Section A2.2. †See Appendix 1, Box 10. ‡See Appendix 1, Box 11. §Brief advice consists of clinician-led feedback on the effects of alcohol, benefits to reducing, and strategies to reduce drinking.[2] ¶See Appendix 1, Box 5. **Previously labelled as "alcohol abuse" in DSM-IV. ††Based on patient's goals and preferences. ‡‡First-line pharmacotherapies are naltrexone and acamprosate.

AUD may present for care. Effective pharmacotherapies should be paired with evidence-based psychosocial treatments and supports where possible and according to patient goals.

Recommendation 12: Adult and youth patients should not be prescribed antipsychotics or selective serotonin reuptake inhibitor (SSRI) antidepressants for the treatment of AUD (strong recommendation, moderate-certainty evidence).

Recommendation 13: Prescribing SSRI antidepressants is not recommended for adult and youth patients with AUD and a concurrent anxiety or depressive disorder (strong recommendation, moderate-certainty evidence).

Early in the guideline development process, the committee identified that polypharmacy was common among people with AUD and that these patients are routinely offered pharmacotherapies

Table 3: Pharmacotherapy for alcohol use disorder*†

	First-line options		Second-line options	
Characteristic	**Naltrexone**	**Acamprosate**	**Topiramate**	**Gabapentin**
Efficacy	NNT to prevent return to heavy drinking is 12 (95% CI 8 to 26)[18] NNT to prevent return to any drinking is 20 (95% CI 11 to 500)[18] Reduced craving (Hedges' g = 0.144 [small effect size], 95% CI 0.045 to 0.244)[19]	NNT to prevent return to any drinking is 12 (95% CI 8 to 26)[18] Increased days abstinent by 11 d (95% CI 5.08 to 16.81)[20]	Decreased heavy drinking days by 9.0% (95% CI −15.3% to −2.7%)[18] Decreased drinking days by 6.5% (95% CI −12.0% to −1.0%)[18] Increased the odds of maintaining abstinence up to 12 mo (OR 1.88, 95% CI 1.06 to 3.34)[21]	Decreased % heavy drinking days (Hedges' g = 0.5478 [medium effect size], 95% CI 0.0145 to 1.0812)[21]
Concurrent alcohol use	Safe to start while using alcohol, but may be more effective after withdrawal management	Safe to start while using alcohol, but may be more effective after withdrawal management	Safe to start while using alcohol	Safe to start while using alcohol, but may be more effective if patients are abstinent for ≥ 3 d
Contra-indications	• Naltrexone hypersensitivity • Any current opioid use (prescribed or nonmedical) • Acute opioid withdrawal • Acute hepatitis or liver failure	• Acamprosate hypersensitivity • Severe renal impairment • Breastfeeding	• Topiramate hypersensitivity • Pregnant or planning pregnancy • Narrow-angle glaucoma • Nephrolithiasis	Gabapentin hypersensitivity
Cautions	• Renal impairment • Severe hepatic impairment • Concomitant use of other potentially hepatotoxic drugs • Pregnancy and breastfeeding† • Youth patients aged < 18 yr†	• Moderate renal impairment • Youth patients aged < 18 yr and older patients aged > 65 yr† • Pregnancy†	• Concomitant use of valproic acid • Conditions or therapies that predispose to acidosis	• Renal impairment • Pregnancy and breastfeeding† • Youth patients aged < 18 yr and older patients aged > 65 yr† • Concomitant use of opioids and other central nervous system depressants • Compromised respiratory function • Neurological disease or cognitive impairment
Adverse effects	Nausea, headache and dizziness Starting at low dose or abstinence can reduce adverse effects	Diarrhea, vomiting and abdominal pain	Psychomotor slowing, difficulty concentrating, speech or language problems, somnolence, fatigue and mood disturbance Starting at low dose and titrating up can reduce adverse effects	Ataxia, slurred speech and drowsiness
Dosing	Start: 25 mg OD for 3 d Titrate: to 50 mg OD over 2 wk as tolerated	2 × 333 mg tablets TID	Titrate: to 2 × 50 mg tablets BID over several weeks as tolerated	Start: at 100–300 mg TID Titrate: PRN to 1800 mg max daily

Note: BID = twice daily, CI = confidence interval, NNT = number needed to treat, OD = once daily, OR = odds ratio, PRN = as needed or when necessary, TID = 3 times daily.
*There are limited data to support combination pharmacotherapy. Single-medication trials are suggested at first. Suggested duration is 6 months or longer. We gathered information for contraindications, cautions, adverse effects and dosage from the cited clinical trials and Health Canada–approved product monographs.
†Safety and efficacy have not been well established in these patient populations. Careful assessment of benefit and risks, fully informed patient consent and more frequent monitoring are advised.