Primary Care Pathway: Alcohol Use Disorder (AUD)

Quick links: Pathway primer | Expanded details | Provider resources | Patient resources

1. Clinical conditions to suspect AUD
- History concerning for increased alcohol use
- Medical or psychiatric comorbidities
- Physical findings
- Social problems
- Personal / family history of AUD

Lab abnormalities to suspect AUD:
- Elevated MCV, ferritin, GGT, bilirubin, AST, ALT (AST>ALT), INR, triglycerides
- Low platelets

Periodic health review

2. Screen
- Quantify # drinks, equivalents/week
- Rule out red flags

< 10 → 2a. Review Canada's Guidance on Alcohol & Health (CGAH)
Consider relevant pathways:
- NAFLD
- Anxiety
- GERD

≥ 10 or if concerned about under-reporting → Consider collaboration with team

2b Alcohol Use Disorders Identification Test (AUDIT)
Consider formal screening for mental illness, if not done, AND screen for multiple high-risk substances use

2b(i) Lower risk (0-7 AUDIT score)
- Review responses of concern
- Educate: CGAH, benefits of reducing intake
- Recommend: Reduce alcohol intake
- Provide written resources
- Consider therapist, PCN/community resources

2b(ii) Moderate risk (8-14 AUDIT score)
- Review responses of concern
- Educate: CGAH, benefits of reducing intake
- Recommend: Reduce alcohol intake
- Provide written resources
- Consider therapist, PCN/community resources

2b(iii)High risk (15+ AUDIT score)
- Counselling

Screen positive for poly substance abuse → Yes → 4. Refer to Rapid Access Addiction Medicine (RAAM)

Re-screen annually

3. Fibrosis (FIB-4) Index
- Order direct on community lab requisition
- If not available on requisition, order CBC, ALT, AST, calculate FIB-4

Reduced risk: < 1.30 → Follow-up: Repeat metabolic workup as clinically indicated, review alcohol consumption/AUDIT score in 3/12

Increased risk: ≥ 1.30 → Physiologic and behavioural / addictions management (DO BOTH)

5. Physiologic assessment

5a Assessment
- Order Labs: Liver tests - ALP, ALT, AST, GGT; liver function tests: INR, bilirubin, albumin; CBC with platelets; HgbA1C, lipids if suspect component of metabolic syndrome
- Order Shear Wave Elastography (SWE - liver stiffness)

Physiologic management

5b Review
- Exam
- Safety
- Consider formalizing diagnosis

5c Red flags
- Acutely jaundiced
- Concern re: decompensated cirrhosis: new onset ascites, bleeding, hepatic encephalopathy
- Lab findings
- Safety
- History of seizure

ED via RAAPID, or refer, or call Specialist Link

6. Behavioural / addictions assessment

3 As: Advise, assist, arrange

6a Assess readiness for change
- Q1: Do you see alcohol use as a health problem you would like to address?
- Q2: Would you like my help in getting support?

Motivational interviewing

6a(i) Pre-contemplative
- Recommend alcohol reduction / cessation
- Educate
- Discuss, provide resources
- Book follow up in 1-6 months

6a(ii) Contem-plative
- Referral to therapist / PCN resources / RAAM
- 3 As
- Book follow up in less than 1 month

6a(iii) Action

Addictions management

PATHWAY PRIMER

Alcohol Use Disorder (AUD) is described as an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences.[1]

Seventy-five per cent of adult Canadians consume alcohol.[2] Most Canadians drink alcohol responsibly; however, alcohol can cause harm to the consumer and, at times, to those around them.

Alcohol is reported as a leading cause of preventable death, disability, and social issues. Certain cancers, cardiovascular disease, liver disease, injuries, and violence have been associated with alcohol use. Alcohol is reported as a leading cause of preventable death, disability, and social issues. In 2020, more than 17,000 deaths in Canada were attributable to alcohol, with $6.27 billion spent on alcohol related health care costs."[3]

Alcohol sales and intake are rising; the COVID-19 pandemic increased alcohol consumption.
Before the pandemic, one in five adult Canadians consistently exceeded the recommended guidelines. After the pandemic, one in five adult Canadians report exceeding them.[4]

Canada's Guidance on Alcohol and Health (CGAH) was published in 2023. This document replaces the previous Low Risk Drinking Guidelines (LRDG).[3]

These guidelines state:

- The risk of harm from alcohol is low for individuals who consume two standard drinks or less per week
- Risk rises to moderate for three to six drinks per week and increasingly high beyond seven drinks per week
- Consuming more than two drinks on one occasion increases the risk of harm to self and others, including injuries and violence

The links for the Canadian clinical guidelines are as follows:

- Visual summary
- Full clinical guidelines

Primary care providers are often the first point of contact for patients seeking medical care; screening for AUD can help identify patients who may be at risk. General triggers that may cause a practitioner to suspect AUD might include:

- A history of increased alcohol use
- A history of AUD
- Social or occupational problems
- Lab abnormalities
- Medical or psychiatric comorbid conditions

There are effective supports and treatments available to patients with AUD.

This pathway aims to provide a standardized, evidence-based, easy-to-use algorithm for identifying and managing AUD in primary care and was developed and reviewed through a collaboration of family medicine, hepatology, addictions medicine, and other primary care and specialty care providers. It is meant to help identify those patients at risk, indicate what investigations are recommended, provide pharmacological and non-pharmacological treatments/supports, and determine when specialty care might be needed.

The pathway is meant for use with adult patients. It does not apply to pregnant or breastfeeding women or youth.

Pregnant women are advised to not drink alcohol during pregnancy as it can cause birth defects and developmental disabilities in the baby. Recommendations for breastfeeding women can be found in the patient resources section.

Although alcohol is the most common substance used by young people, much of its usage is in the form of binge drinking. Additionally, even for the same alcohol consumption, the risk of adverse outcomes is higher for youth than adults.[5] Resources available for youth alcohol disorders are listed in the provider resources section.

EXPANDED DETAILS

1. Conditions that may correlate with Alcohol Use Disorder (AUD)

Clinical conditions to suspect AUD[a] [b]
- History concerning for increased alcohol use
- Personal/family history of AUD
- Chronic pain
- Sleep disorders
- Medical or psychiatric co-morbidities (anxiety, depression, stress)
- Clinical conditions that may be associated with AUD (fatty liver, gastroesophageal reflux disease (GERD), pancreatitis, gastritis, atrial fibrillation, congestive heart failure, hypertension, arrhythmias, peripheral neuropathies, short-term memory loss, dementia, new onset seizures)
- Social problems (relationship issues, work or school absenteeism, financial or housing instability, legal issues related to alcohol use)
- Unintentional injuries, motor vehicle accidents

[a] Shield KD. Chronic Diseases and Conditions Related to Alcohol Use. Alcohol Res 2014; 35(2): 155-171.
[b] Rehm J. The Risks Associated with Alcohol Use and Alcoholism. Alcohol Res Health. 2011; 34(2): 135-143.

Lab abnormalities to suspect AUD[a] *
- Complete Blood Count (CBC): elevated Mean Corpuscular Volume (MCV), low platelets
- Liver enzymes: elevated Aspartate Aminotransferase (AST), Alkaline Transaminase (ALT) (especially AST:ALT 2:1), Gamma-Glutamyl Transferase (GGT), bilirubin
- Coagulation: elevated International Normalized Ratio (INR), prothrombin time (PT)
- Lipids: elevated triglycerides
- Other: elevated uric acid, Fibrosis (FIB-4) Index >1.30

* All of these are non-specific biomarkers; they may be abnormal for several reasons. Clinical correlation is always required.

[a] Tetrault JM. Risky drinking and alcohol use disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis. UpToDate. 2023.

Physical findings to suspect AUD:
- Spider telangiectasia
- Jaundice
- Rhinophyma

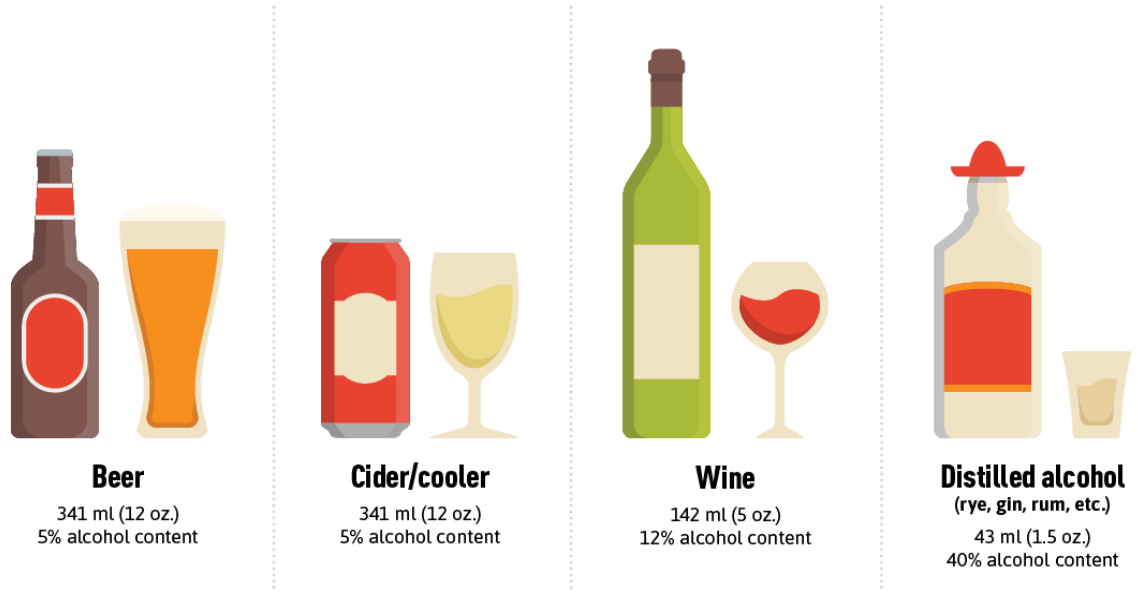
- Palmer erythema
- Dupuytren's contracture
- Hepatosplenomegaly
- Gynecomastia
- Testicular atrophy
- Ascites
- Asterixis

2. Screen

Quantify number of drinks, equivalents/week

In Canada, a standard drink is 17.05 millilitres or 13.45 grams of pure alcohol. This is the equivalent of:

- A bottle of beer (12 oz., 341 ml, 5% alcohol)
- A bottle of cider (12 oz., 341 ml, 5% alcohol)
- A glass of wine (5 oz., 142 ml, 12% alcohol)
- A shot glass of spirits (1.5 oz., 43 ml, 40% alcohol)



Source: Health Canada. Canada's Low Risk Alcohol Drinking Guidelines – reproduced with permission

Rule out red flags: Consider contacting Specialist Link Addictions or RAPPID (Referral, Access, Advice, Placement, Information Destination) if patient:

- Has AUD suffering acute delirium
- Seeking support to withdrawal and has history of alcohol withdrawal seizures
- Has significant liver cirrhosis
- Required hospitalization for previous detox
- Has 'safety risks': actively suicidal, driving while impaired, using alcohol while working in a safety sensitive occupation, reporting plans to harm others

2a. <10 - Canada's Guidance on Alcohol and Health (CGAH)

To avoid harm, people in Canada who choose to drink should follow Canada's Guidance on Alcohol and Health (CGAH) which replaced Canada's Low-Risk Alcohol Drinking Guidelines (LRDG).

CGAH provides evidence-based advice on alcohol to support people in making informed decisions about their health.

Key points:

- There is a continuum of risk associated with weekly alcohol use where the risk of harm is:
  - **0 drinks per week** — Not drinking has benefits, such as better health, and better sleep.
  - **2 standard drinks or less per week —** You are likely to avoid alcohol-related consequences for yourself or others at this level.
  - **3–6 standard drinks per week —** Your risk of developing several types of cancer, including breast and colon cancer, increases at this level.
  - **7 standard drinks or more per week** — Your risk of heart disease or stroke increases significantly at this level.
  - **Each additional standard drink** radically increases the risk of alcohol-related consequences.
- Consuming more than 2 standard drinks per occasion is associated with an increased risk of harms to self and others, including injuries and violence.
- When pregnant or trying to get pregnant, there is no known safe amount of alcohol use.
- When breastfeeding, not drinking alcohol is safest.
- No matter where you are on the continuum, for your health, less alcohol is better.[1]

The guidance is based on the latest research on alcohol-related risks and replaces *LRDG* issued in 2011.

The guidance is based on the principle of autonomy in harm reduction and the fundamental idea behind it that people living in Canada have a right to know that all alcohol use comes with risk.

[1] Canada's Guidance on Alcohol and Health, Canadian Centre on Substance Use and Addiction. 2023

2b. *>10 or if concerned about under reporting*

"Population surveys typically produce underestimates of alcohol consumption of approximately 40-50%"[a]

"Heavy drinking and non-routine drinking patterns may be associated with greater under-reporting of alcohol consumption"[b]

[a] Livingston M, Callinan S. Underreporting in alcohol surveys: whose drinking is underestimated?". J.Stud Alcohol Drugs. 2015 Jan;76(1): 158-64.
[b] Boniface S, Kenale J, Shelton N. Drinking pattern is more strongly associated with under-reporting of alcohol consumption than socio-demographic factors: evidence from a mixed-methods study. BMC Public Health. 2014; 14: 1297.

Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT was developed in 1989 and helps identify those at risk of harm from alcohol consumption. It asks ten questions in three areas:

- Alcohol intake
- Markers of alcohol dependence
- Individual experience of harms from alcohol

The World Health Organization (WHO) conducted a worldwide study that showed the AUDIT is the most widely used screening tool for alcohol use. It is validated in different cultures, ages, and socioeconomic settings.

Alcohol Use Disorders Identification Test (AUDIT) - Printable Tool
AUDIT Screen - Website

Although designed for use by health practitioners, it can be self-administered with proper instructions.

It's available in over 40 languages.

Section	AUDIT SCORE / risk assessment	Suggested follow-up	Resources
2b(i)	**0-7** **LOWER risk**	- Review: Responses of concern - Educate: Benefits of reducing intake, CGAH - Recommend: Reduce alcohol intake - Provide written resources - Consider: Community resources, therapist Rescreen yearly	DrugSafe Alcohol - When Zero's the Limit Addictions helpline: 1-866-332-2322 2-1-1 (Information on local community services, can provide referrals to physical and mental health resources, housing, utility, food, and employment assistance as well as crisis interventions) 811 Alberta Health Link (nurse advice and general health information) Drink Less - Handycard CGAH, Public Summary: Drinking Less Is Better (Infographic)
2b(ii)	**8-14** **MODERATE risk**	Same as low risk - O fibrosis (FIB-4) index on community lab requisition if available OR order CBC, ALT, AST and calculate FIB-4 Rescreen every 3-6 months	Fibrosis-4 (FIB-4) Index for Liver Fibrosis or FIB-4 Calculator
2b(iii)	**15+** **HIGH risk**	- Screen for polysubstance abuse (Drug Abuse Screening Test; DAST-10) - Refer to Rapid Access Addiction Medicine (RAAM) if DAST-10 positive - Engage in physiologic AND addictions management (see algorithm)	Alberta Addiction Treatment Centre Directory

****Consider formal screening, if not already done:**
Screen for mental illness

- Depression
  - The Patient Health Questionnaire (PHQ-9) is a commonly used and validated screening tool. The PHQ-9 has a 61 per cent sensitivity and 94 per cent specificity in adults.
- Anxiety
  - Generalized Anxiety Disorder (GAD-7): Reliability of this tool is scored 89.5%, consistency rated at 91
  - For additional anxiety resources, see the Anxiety Primary Care Pathway
- Mood disorders
  - The Mood Disorder Questionnaire (MDQ)
- Adult Attention Deficit Hyperactivity Disorder (ADHD)
  - Adult ADHD Self-Report Scale (ASRS)

Screen for polysubstance use

- Drug Abuse Screening Test (DAST-10)

3. Fibrosis-4 Index (FIB-4)

The Fibrosis-4 Index (FIB-4) is a noninvasive method to estimate the amount of liver scarring and determine which patients require further investigation.

Although liver biopsy is the gold standard for diagnosing liver fibrosis, the testing has some limitations. Sampling errors may occur as the biopsy only measures a small portion of the liver. Also, liver biopsies do have substantial morbidity.[6] The FIB-4 index was tested against other noninvasive markers for liver fibrosis and was found to be superior.[7] In studies, FIB-4 ≥ 2.67 had an 80 per cent positive predictive value and a FIB4 index < 1.30 had a 90 per cent negative predictive value.[10]

A FIB-4 check box will be available on community lab requisitions in the future. In the meantime, you may order it direct on the community lab requisition. If not readily available, order a CBC, ALT, AST and calculate the FIB-4 as shown below:

Calculation: Age ([yr] x AST [U/L]) / ((PLT [10(9)/L]) x (ALT [U/L])(1/2))
Or website: https://www.mdcalc.com/calc/2200/fibrosis-4-fib-4-index-liver-fibrosis

Source: Medscape, https://reference.medscape.com/calculator/326/fib-4-for-noninvasive-diagnosis-of-hepatic-fibrosis

Interpretation:

If FIB-4 ≥ 1.30, the patient is deemed at increased risk of fibrosis.
Patients with alcohol use disorder and ongoing alcohol consumption should have a FIB-4 calculated annually.
If the FIB-4 ≥ 1.30, a shear wave elastography (SWE) is recommended, whether or not the routine 3-year interval has elapsed.

How do the various fibrosis detection tools compare?

	FIB-4	Ultrasound with SWE
How it's done	Calculated based on ALT, AST, platelets	Accessible in community, provider-dependent
Advantages	Low cost, easy to access	May give clues about advanced disease (portal hypertension, nodularity, splenomegaly)
Limitations	Overestimates (40-50% deemed high risk)	Needs more validation A few months to access Less accurate if body mass index (BMI) > 35 10% indeterminate or high risk

4. Rapid Access Addiction Medicine (RAAM)

Rapid Access Addiction Medicine (RAAM) provides a comprehensive physician and addiction counsellor led program managing all substance and behavioral addiction concerns.
This service provides a combination of medical and psychosocial treatment program, including:

- Anti-craving medication for alcohol, opioids, gambling, and stimulant use disorder
- Coinciding psychiatric and pain management
- Home detoxification services
- Education, skills, and support group programs
- A four-week intensive day treatment program
- Short-term outpatient counselling

- Supports for sexually transmitted infections
- Medical and mental health assessments for detoxification facilities
- Access to clinical trials and research studies

This service also provides additional support groups like:

- Early recovery support
- Relapse prevention
- Trauma-informed support
- Women's support group
- Mindfulness
- CBT (cognitive behavioral therapy) and DBT (dialectical behavior therapy)-informed groups
- Certified Sex Addiction Treatment (CSAT)
- Family support group

***Referral**:*
Self-referral or from any health advocate. Phone or fax.

- Address: 707-10 Ave SW, 3rd floor. Calgary, AB
- Phone: (403) 367-5000; Fax (403) 367-5010
- Hours of operation: Mon-Thur 8:00am to 9:00pm, Fri 8:00m to 5:00pm
- RAAM: Patient brochure

Currently, RAAM can assess patients who are referred by provider or through self-refer within a few days. Patients who self-refer simply attend in person at Sheldon Chumir RAAM office. They are seen on a first come, first serve basis. Whether patients self-refer, or are sent to RAAM via a referral letter from provider, there are considerations to note:

Patient self-referral	Formal referral request by provider
Patient can pick a flexible time to attend walk in assessment	RAAM will persist in trying to get through to patient and may break through resistance if patient ambivalent
Increased 'buy in' for treatment by arranging their own assessment	Record of consult back to referring PCP
There is no communication back to the Primary Care Provider (PCP) – although assessment available through Connect Care	Requires accurate contact number with referral (common reason for 'failed referrals')
Self-referrals often have a high 'no show' rate	Patient must consent to referral

5. Physiologic assessment

5a. Assessment

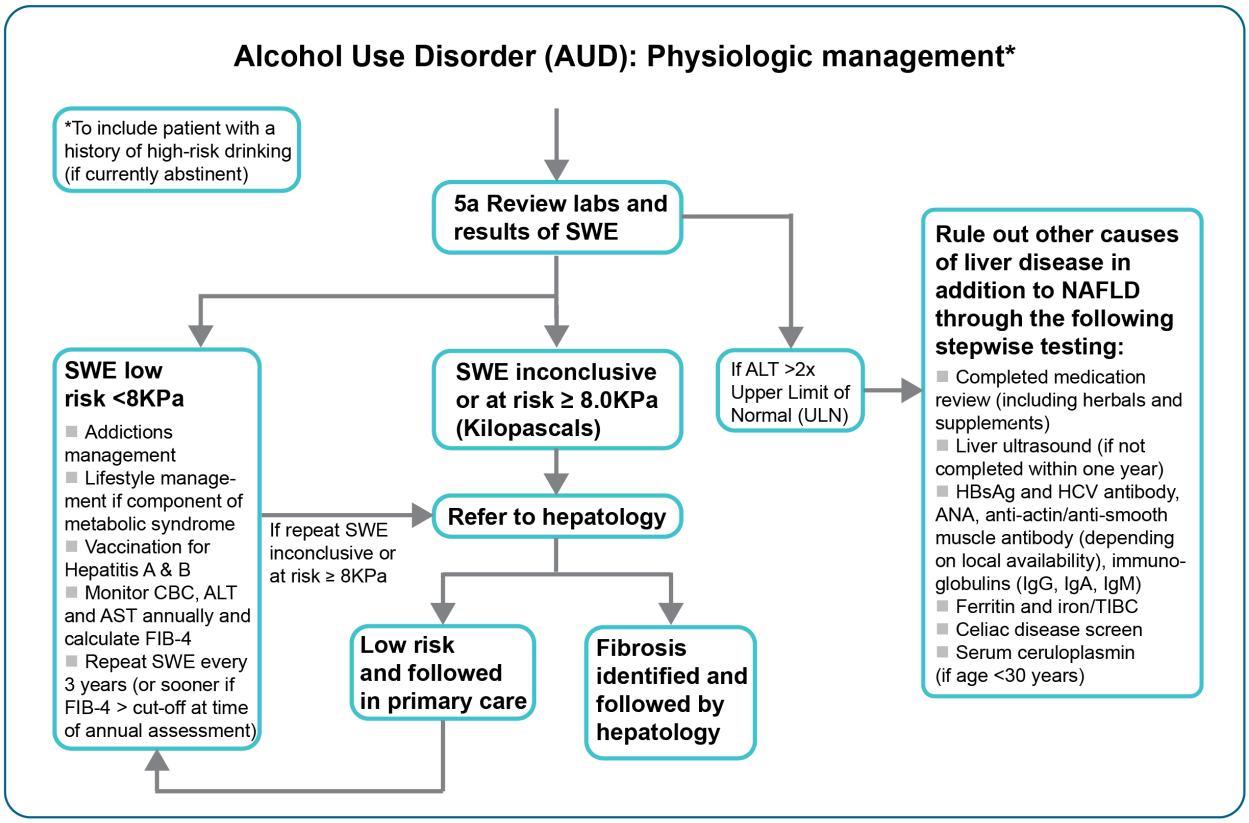
Shear Wave Elastography (SWE): The gold standard for assessing liver stiffness (a measure of liver scarring) without a liver biopsy. EFW Radiology (EFW) and Mayfair Diagnostics radiology groups have fulfilled quality assessment for the Calgary Non-Alcoholic Fatty Liver Disease (NAFLD) pathway SWE measurement. Currently they are the recommended providers for SWE in the Calgary Zone.

- EFW Liver Program Requisition form
- Mayfair Diagnostics General Requisition form

The results may help patients understand the severity of their AUD. This test can be valuable even when the patient has otherwise normal biochemical values.

Sexually transmitted and blood borne infections (STBBI): Consider testing when appropriate.

PHYSIOLOGIC MANAGEMENT



5b. Review

- Screening tools to consider (these are not specific to alcohol induced concerns):
  - Sheehan Disability Scale
  - World Health Organization Disability Assessment Schedule 2.0 (WHODAS)
  - Functional testing:
    Weiss Functional Impairment Self Report
  - Cognitive testing:
    St. Louis University Mental Status Exam (SLUMS) assessment
    Mini-Mental State Examination (MMSE)

- Review safety: Patients with an AUD may present with functional impairments or other deficits that can affect their safety or the safety of those around them. Consider:
  - (Instrumental) activities of daily living (ADL/IADL)
  - Nutritional deficits
  - Falls
  - Cognitive testing
  - Driving assessment

- Safety-sensitive jobs
- Ability to care for dependents

Formalizing a diagnosis of AUD:
- Utilizing the Diagnostic and Statistical Manual of Mental Disorders (DSM) DSM-IV or DSM-V

5c. Red flags and suggested responses

Red flag	Suggested response	Resources
- Acute jaundice - Possible decompensated cirrhosis - New onset ascites - Bleeding - Hepatic encephalopathy - Has AUD, suffering acute delirium - Required hospitalization for previous detox	RAAPID Specialist Link – hepatology (consult within an hour)	RAAPID Repatriation/Transfer Request or 403-944-4488 (Red Deer and south) 403-910-2551 or 1-844-962-5465 (M-F 0800-1700h)
Labs: elevated INR>2	RAAPID Specialist Link: hepatology	RAAPID Repatriation/Transfer Request or 403-944-4488 (Red Deer and south) 403-910-2551 or 1-844-962-5465 (M-F 0800-1700h)
Safety concerns (suicidality, domestic violence, high risk behaviours such as drinking and driving)	Counselling	Local PCN mental health counsellors Distress Centre (403-266-4357) Rural distress line (1-800-232-7288) AHS support line (1-877-303-2642) 2-1-1 (guidance on community supports and services) Talk suicide Canada (1-833-456-4566) (9-8-8) Rapid Access Addiction Medicine (RAAM) (403-367-5000)
History of seizures	Specialist Link – addiction medicine	403-910-2551 or 1-844-962-5465 (M-F 0800-1700h) Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

6. Behavioural / Addictions Assessment

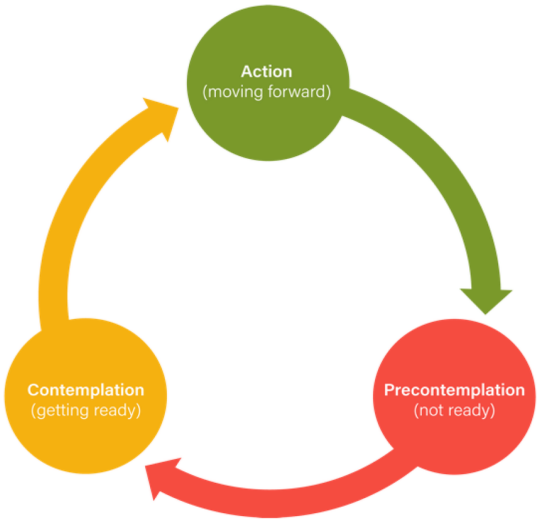
6a. Assess Readiness for Change

Motivational Interviewing (MI)
MI is an evidence-based and systematic approach designed to help physicians structure interventions that are intended to motivate behaviour change in patients.[8] The key qualities of MI are[9]:
- A **guiding** style of communication – it sits between following and directing
- Designed to **empower** people to change – it draws on their own meaning, importance and capacity for change
- Based on a **respectful** and **curious** way of being with people – it facilitates a natural process for change and honors autonomy

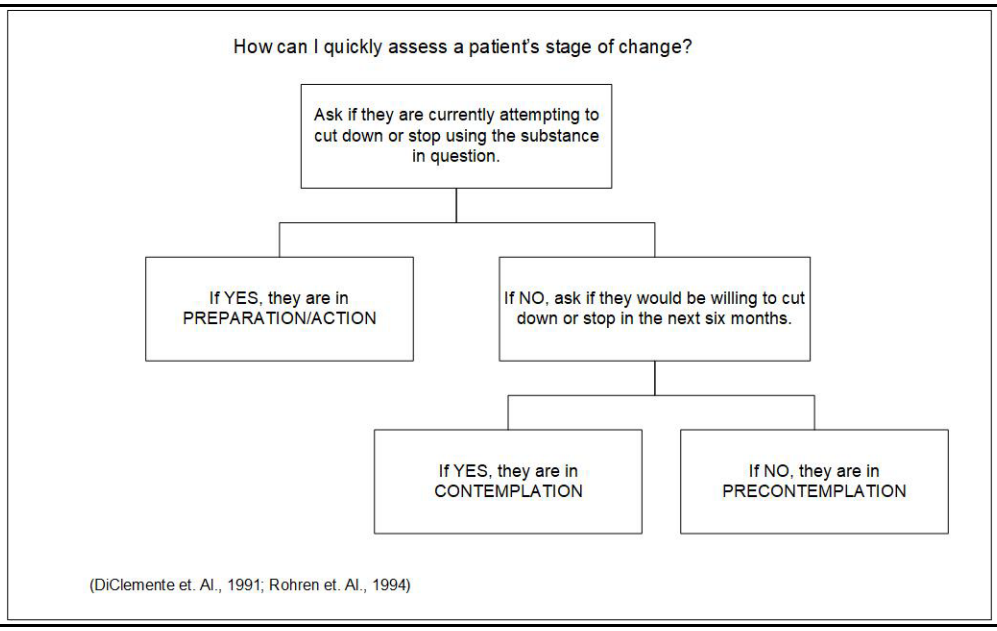
MI is perceived as being particularly useful for patients who are reluctant or ambivalent about changing their behaviour. It is said not to be centrally defined by technique but rather by its spirit as a facilitative style for building strong interpersonal relationships.[10]
Useful resources on the application of Motivational Interviewing techniques are listed in provider resources.

The Stages of Change

The MI approach is most often used together with principles of the *Stages of Change Model*.[11] This model identified five elements of the change process: *Pre-contemplation, contemplation, preparation*, *action*, and *maintenance*. Also known as the transtheoretical model (TTM), it describes readiness to change as an important mediator of behavioural change. Through consideration of the pros and cons of making a change, readiness becomes a dynamic process that can result in ambivalence. Exploration and resolution of this ambivalence -- where the patient is conflicted in their reactions, beliefs or feelings about their behaviour -- plays an important role in motivational interviewing. For the purpose of this pathway, focus is placed on practicality through intervention at three core stages of change: pre-contemplation, contemplation and action.



Source: Opsal et al. (2019). Modified Transtheoretical (Stages of Change) Model. [image]. *Substance Abuse Treatment, Prevention, and Policy. 14*:47.



Source: Centre for Addictions and Mental Health. (2021). *Influencing Motivation to Change: The importance of assessing motivation to change.* CAMH. https://www.camh.ca/en/professionals/treating-conditions-and-disorders/fundamentals-of-addiction/f-of-addiction--motivation-and-change

- Consider:
  - Ambivalence about Change[12]: A degree of ambivalence regarding making changes, confidence regarding success or readiness to change, is said to be inevitable. Interest and level of ambivalence correlates with the stages of change. A higher level of ambivalence may indicate a higher need for counselling.

Stage of Change	Level of interest in change	Level of ambivalence

Precontemplation	Low	Low
Contemplation	Rising	Highest
Preparation/Action	High	Low

- Motivation for change: Readiness rulers can help to assess motivation to make a change by determining how important it is to the patient, how confident they are about being successful and how ready they are.[13] Follow up with questions such as:
  1) Why are you at X and not at a ___ (higher #)?
  2) What would it take to go from X to ___ (one # higher)?

Importance

1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10 (1= not important; 10= very important), how important is it for you to make a change?

Confidence

1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10 (1= not confident; 10= very confident), how confident are you that you can make a change?

Readiness

1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10 (1= not ready; 10= very ready), how ready are you to make a change?

- Tailor intervention to stage of change

6a(i). Precontemplation	6a(ii). Contemplation	6a(iii). Action
Patient has little or no motivation to change their behaviour as they do not view themselves as having a problem. Intervention ○ Validate lack of readiness ○ Encourage self-exploration, not action ○ Promote re-evaluation of current behaviour ○ Explain and personalize risks ○ Recommend reduction or cessation ○ Clarify that the decision is theirs ○ Discuss and share resources	Patient is ambivalent about change. They may have considered changing their behaviour but have not invested effort into making the change. Intervention ○ Explore ambivalence and evaluate pros/cons of change ○ Identify and promote alternative perspectives to increase patient's confidence in their ability to change ○ Identify reasons for change/ risks of not changing ○ Encourage referral to therapist/ PCN resources/RAAM	Patient is actively involved in making a change. They often require some form of outside assistance to support them to reach their goal. Intervention ○ Develop a realistic plan for making a change and to take steps toward change ○ Strengthen self-efficacy for dealing with obstacles. ○ See 'Addictions Management' section

- Refer as appropriate
  - Access Mental Health Resource Database: This tool lists more than 1,000 local resources, both within and outside Alberta Health Services (AHS). The database can be searched by diagnosis, such as substance use disorder as well as level of care recommended from the LOCUS assessment.
  - Level of Care Utilization System (LOCUS): An assessment and placement instrument. LOCUS assesses the appropriate level of care (i.e., treatment services) that a patient requires.

Additional questions

1) **What if patient declines referral?** Ensure patient is aware that the conversation can be revisited should they wish to discuss this again. Recognize signs of resistance to change such as:
   - "Yes but…" statements
   - Outright anger
   - Forgetting or not showing up to appointments

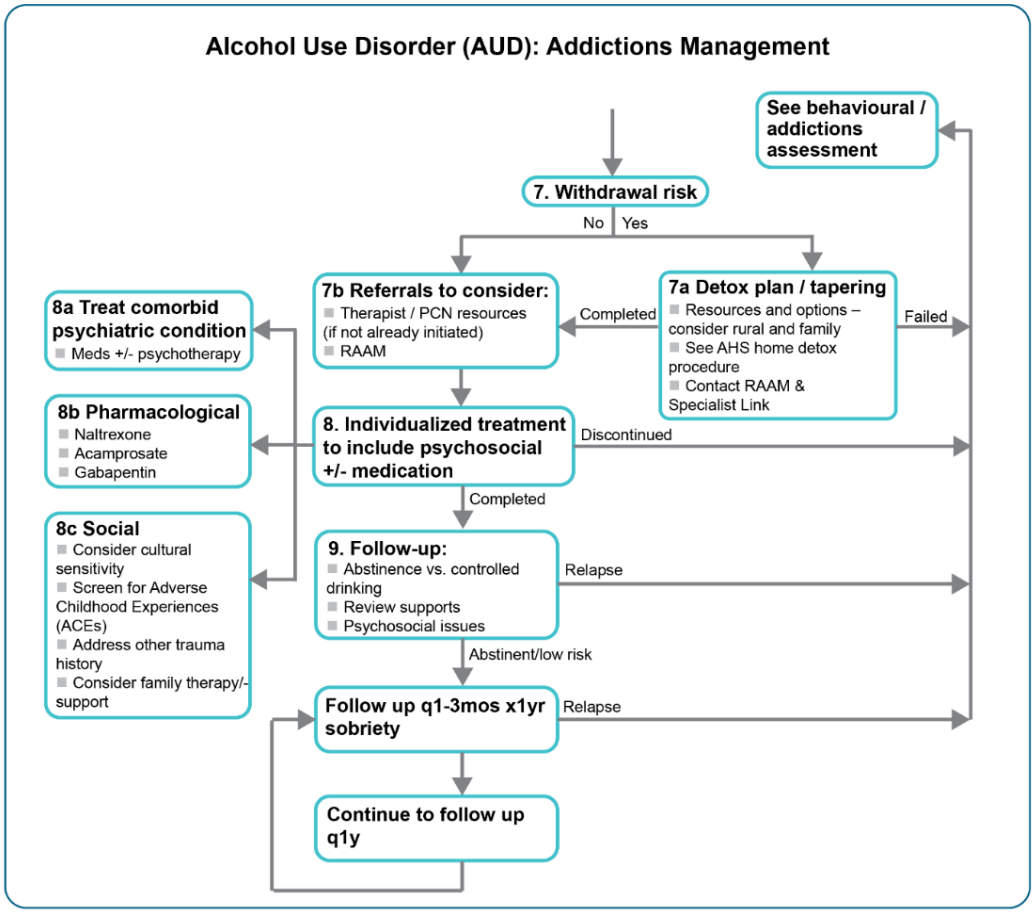
   Use 'Stages of Change' resources to determine motivation to change and match intervention accordingly. See also 'Working with Resistance' section in the linked resource.
2) **What is the role of the medical home in the care of patients referred to RAAM?** Book a follow-up with the patient to ensure that the referral is meeting their needs. See the following one-page Quick References by AHS Enhancing Concurrent Capability:
   - What are the roles in transitions of care?
   - How do we follow-up after transition?

   The LOCUS instrument highlights that the most intense level of care is required if, independently of other parameters, the patient demonstrates extreme levels of:
   - **Risk of harm**: Consider the patient's potential to cause significant harm to themselves or others (i.e., suicidal or homicidal behaviour).
   - **Functional status:** The patient's ability to fulfill social responsibilities, interact with others, maintain physical functioning and their capacity for self-care (i.e., extreme deterioration or complete withdrawal from social interactions, neglect of personal hygiene, inability to maintain personal responsibilities).
   - **Medical, addictive, and psychiatric co-morbidity:** Co-existing medical illness, substance use disorder or psychiatric disorder in addition to the condition most readily apparent (i.e., significant conditions that are poorly controlled or uncontrolled).
3) **When is inpatient treatment warranted?** The full Level of Care Utilization System (LOCUS) instrument can be found in the provider resources section.
4) **How does the interplay between economic and cultural issues impact substance use/ethyl alcohol (ETOH) abuse?** See Addictions Management section of AUD pathway for principals of working with several specific populations. Specialist Link provides a series of four short videos that discuss cultural competency in health care and how it affects providers' encounters with patients. See the provider resources section.
5) **Is there a duty to report a patient diagnosed with alcohol use disorder?** Consider the Code of Ethics and Professionalism and doing what's in the best interest of the patient and the public; this would mean a case-by-base evaluation and determination of safety risk. The Alberta government states that "Health care professionals are not required by law to report medically-at-risk drivers, but you are encouraged to report your concerns. When a physician, optometrist or other health care professional report a medically-at-risk driver, they are protected against liability challenges through section 60 of the Traffic Safety Act."
6) **What are the considerations when deciding if group therapy (Alcoholics Anonymous - AA, Smart, etc.) is the right choice over inpatient intensive treatment (Claresholm or private clinics)?** Alcoholics Anonymous (AA) is a mutual support group, commonly recognized as a 12-step program for individuals struggling with alcohol use disorder (AUD). Researchers and healthcare professionals are often divided regarding the effectiveness of AA in treating AUD. Some key considerations regarding the program's effectiveness are:

- Limited scientific evidence: AA is not a formal treatment program involving more conventional methods like professional therapy or medication, which presents a barrier to conducting rigorous scientific studies (e.g., controlled clinical trials) to assess effectiveness.
- Anecdotal and self-reported benefits: Many individuals find value in the fellowship, peer support, and the 12-step program's spiritual and psychological aspects. They report recovery from AUD as a direct result of their involvement in AA, with positive outcomes that include sobriety and improved quality of life.
- Variable success rates: Factors such as commitment, motivation, social support network, and the severity of AUD may determine an individual's success with AA. Some may achieve long-term sobriety, while others may struggle to maintain abstinence.
- Co-occurring treatments: To address AUD comprehensively and potentially yield better results, many individuals combine AA with other forms of professional treatment, such as counseling, therapy, or medications.
- Criticisms and limitations: AA may not be suitable for everyone, particularly those who are not comfortable with its spiritual components or those seeking treatments with a scientific foundation. Additionally, individuals may have underlying mental health issues that require specialized care, giving rise to concerns over the lack of professional oversight in AA.

Individualized treatment plans that consider a person's unique needs and preferences should be explored. While AA may work well as part of a broader treatment plan, it may be an adjunct rather than a sole solution for patients. If further support is warranted, counsellors through Adult Addiction Services/RAAM should be approached to facilitate further exploration into residential treatment.

ADDICTIONS MANAGEMENT



7. **Withdrawal risk:** Up to 50 per cent of individuals with long-term alcohol dependence will experience some degree of withdrawal upon cessation of alcohol use. Symptoms of alcohol withdrawal typically begin 6-24 hours after the last intake of alcohol and reach peak intensity at 24-48 hours, with resolution of symptoms within 5-7 days.[14]
   How to determine individual risk?
   - The Prediction of Alcohol Withdrawal Severity Scale (PAWSS)[15]
   - A validated tool to estimate risk of severe withdrawal.
   - Scores <4 = low risk; 4 and over = high risk.

7a. Detoxification plan and tapering

There are several different options in Calgary and surrounding area to support detoxification. These resources can be found in the provider resources.

Alberta Health Services (AHS) at home detoxification procedure:
AMBULATORY ALCOHOL AND SUBSTANCE WITHDRAWAL MANAGEMENT INCLUDING INDUCTION OF OPIOID AGONIST TREATMENT Procedure HCS-270-01 (ahsnet.ca)

7b. Referrals to consider

- **Rapid Access Addiction Medicine (RAAM)** (403-367-5000)
- **Specialist Link Addictions Medicine** (403-910-2551) (1-844-962-5465)
- **Counselling resources:**
  - Local PCN mental health counsellors
  - Distress Centre (403-266-4357)
  - Rural distress line (1-800-232-7288)
  - AHS support line (1-877-303-2642)
  - 2-1-1 (guidance on community supports and services)
  - Talk suicide Canada (1-833-456-4566) (9-8-8)
  - Access Mental Health (403-943-1500 or 1-844-943-1500)
  - Employee Assistance Programs (EAP)
- **Addiction or alcohol-specific supports**:
  - Alcoholics Anonymous (12-step abstinence program)
  - SMART Recovery
  - In the Rooms
  - The Daily Pledge

8. Individualized treatment to include psychosocial +/- medication

Up to 80 per cent of patients AUD can safely detoxify and taper their alcohol use in an outpatient care setting. This method is less disruptive to work and home life for patients. Studies have shown that 70%+ patients complete outpatient treatment, and 50 per cent of patients are able to meet long term goals of abstinence or reduced alcohol consumption.[16]

Outpatient withdrawal management may be considered in the following circumstances:

- PAWSS score < 4 (see withdrawal risk information)

- Absence of contraindications, including: Severe or uncontrolled medical conditions (including but not limited to diabetes, chronic obstructive pulmonary disease - COPD, heart failure), acute confusion or cognitive impairment, acute illness, suicidal ideation or psychosis, concurrent severe drug use disorder (excluding tobacco), history of withdrawal seizures or delirium
- Reliable support person who can monitor withdrawal symptoms for initial 3-5 days and ensure adherence to medications
- Stable housing environment
- Ability to take oral medications

General considerations:
- Provide educational resources to patient and family, such as Alcohol Detoxification and Withdrawal: Care Instructions.
- Daily evaluation of patient for the first 3-5 days is ideal, whether in person or by remote means. Vital signs, withdrawal symptoms, hydration, cognition, sleep, general physical and emotional condition may be assessed.
- Recommend over the counter medications, such as folic acid (400mcg-1mg per day), thiamine (100mg per day), increased fluids/electrolytes.
- Patients should be advised not to drive until all withdrawal symptoms subside.
- Provide support and referrals to community resources or employee assistance programs.

MEDICATIONS

Health Canada's only approved medication class for alcohol withdrawal is benzodiazepines. These agents do have documented side effects, can potentiate the effects of alcohol if used concurrently, and have a potential for dependence, diversion, and non-medical use. If prescribed, it is recommended that limited prescribing (five to seven days) with fixed doses be considered.

Many other countries use alternate agents, including anticonvulsants which provide unique advantages over benzodiazepines in some patients. Evidence for these agents preventing seizures or delirium tremens is lacking, however, and therefore they should only be used in patients at low risk of these complications. Medication choice is based on the Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar) (see below):

Medication	Dose/frequency	Considerations/side effects	Resources/other
Benzodiazepines – for CIWA-Ar 10-15: **Diazepam** **OR** **Chlordiazepoxide**	 10mg q6h x 24 hours 10mg q8h x 24 hours 10mg q12h x 24 hours 10mg qhs x one dose 50mg q6h x 24 hours 50mg q8h x 24 hours 50mg q12h x 24 hours 50mg qhs x one dose	Additive drowsiness, respiratory depression with concurrent alcohol use or other central nervous system depressants. Potential for misuse, dependence, and diversion	Consider daily dispensing of medication in appropriate situations May provide an extra 5 dose for prn symptom dosing*
For CIWA-Ar < 10: **Gabapentin**	 300mg q6h x 24 hours 300mg q8h x 24 hours	Reduce dose with renal impairment Common side effects: dizziness, drowsiness, ataxia, edema	May provide an extra 5 doses for prn symptom dosing*

	300mg q12h x 24 hours 300mg qhs		May consider continued treatment to support sobriety longer term
For patient intolerant to gabapentin, CIWA-Ar < 10: **Carbamazepine**	200mg q6h x 24 hours 200mg q8h x 24 hours 200mg q12h x 24 hours 200mg qhs	Many drug-drug interactions Common side effects: dizziness, drowsiness, itching. Serious side effects: blood dyscrasias, toxic epidermal syndromes, hepatotoxicity	May provide an extra 5 doses for prn symptom dosing* Cautious approach for patients of Asian decent due to higher prevalence of genetic alleles that predispose to carbamazepine toxicity

* An increase in intensity or emergence of the following symptoms may trigger use of a single dose of medication: anxiety, tremor, sweating, nausea/vomiting, headache, disorientation, agitation, or auditory/visual/tactile disturbances. **MAX one extra dose per 24-hour period.**

8a. Treat Co-Morbid Psychiatric Conditions

Psychiatric condition	Screening tools	Treatment guidelines and other resources
Anxiety	Self-Test for Anxiety	Anxiety Primary Care Pathway
Depression	Patient Health Questionnaire (PHQ-2 & PHQ-9)	Guideline for the Treatment of Depression Across Three Age Cohorts Depression in adults: treatment and management
Attention Deficit and Hyperactivity Disorders (ADHD)	Adult ADHD Self-Report Scale (ASRS-V1.1) Symptom Checklist	Canadian ADHD Practice Guidelines Adult ADHD - Pharmacotherapy Treatment and Management of ADHD in Adults
Mood Disorders	Mood Disorder Questionnaire (MDQ)	Guidelines for the Management of Patients with Bipolar Disorder Bipolar Disorder: Assessment & Management
		Counselling resources: ○ Local PCN mental health counsellors ○ Distress Centre (403-266-4357) ○ Rural distress line (1-800-232-7288) ○ AHS support line (1-877-303-2642) ○ 2-1-1 (guidance on community supports and services) ○ Talk suicide Canada (1-833-456-4566)(9-8-8) ○ Rapid Access Addiction Medicine (RAAM) (403-367-5000) ○ Employee Assistance Programs (EAP)

8b. Pharmacological

Health Canada has approved three medications for the treatment of AUD:

- Naltrexone
- Acamprosate
- Disulfiram

Both naltrexone and acamprosate assist with reduced drinking or alcohol abstinence. Naltrexone has shown a benefit in reducing the number of patients who return to heavy drinking.[17] Acamprosate may be more effective in maintaining abstinence.

Disulfiram is now considered a second-line agent as it can only be used for patients who can maintain complete alcohol abstinence, including from other sources such as mouthwash and cough/cold preparations.[18] Generally adherence rates to disulfiram are low unless it is administered under structured or supervised conditions. However, some patients may be interested in using this agent for avoidance of alcohol in certain circumstances or occupations.[19]

Off-label use of other medications such as gabapentin or topiramate may be useful when first-line agents have failed, based on patient preference, or based on comorbidities. These agents should be considered second-line treatments. Continue pharmaceutical treatment six-12 months at least, longer if well tolerated and beneficial.

Drug	Dose	Cautions and contraindications	Common side effects	Other notes
Naltrexone	50mg daily	Liver impairment (caution) Acute hepatitis, liver failure, concomitant opioid use (contraindications)	Drowsiness, nausea, insomnia, dizziness	Liver function testing required
Acamprosate	666mg tid	Renal impairment (dose reduction CrCl 30-50ml/min; contraindicated at CrCL<30ml/min)	Diarrhea (wanes over time), nausea	Requires special authorization in Alberta Drug Special Authorization Request
Disulfiram	125-500mg qd	Caution with concurrent diabetes, hypothyroidism, seizure disorders, nephritis, hepatic insufficiency or cirrhosis. Contraindications: concurrent alcohol or metronidazole intake, severe myocardial disease, coronary occlusion, active psychosis	Drowsiness, fatigue, metallic after taste, dermatitis. Rare hepatotoxicity.	Not currently available in Canada except through specialty compounding. Pt must abstain from alcohol at least 12 hours prior to the first dose. Disulfiram reaction can occur with alcohol intake up to 2 weeks after the last dose Liver function testing and CBC need to be monitored
Gabapentin	300-600mg tid	Renal impairment requires dose adjustment.	Dizziness, drowsiness, ataxia, peripheral edema, cognitive changes (especially in the elderly)	Diversion or misuse has been rarely reported
Topiramate	25-150mg bid (start at 25-50mg daily with	Renal disease (caution), history of kidney stones (contraindication), metabolic acidosis (contraindication)	Cognitive dysfunction, taste disturbance, anorexia, paresthesia, dizziness, renal stones	

	dose increases at weekly intervals as tolerated)			
***Baclofen**	*Has shown promise. See Baclofen for the Treatment of Alcohol Use Disorder | AAFP for more information.			

8c. Social

- Consider cultural sensitivity: Cultural sensitivity refers to knowledge, skills, attitudes and beliefs that enable people to work well with people in cross-cultural settings. It bares more depth than solely the acceptance of cultural differences. In healthcare, cultural competence acknowledges a patient's language and culture as tools to improve their outcomes.

Providing ethical care: Indigenous Peoples
The British Columbia Centre for Substance Use (BCCSU) *Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder* describe that research has highlighted the important role of culturally safe and informed approaches to reduce disparities in substance use care for Indigenous populations. Their guidelines identify several literature-based principles of providing ethical care to Indigenous Peoples:

- Respecting the individual and their authority over their own health and healing journey;
- Practising conscious communication, active listening, and paying close attention to how a person responds to questions and conversation, both in their speech and body language, to ensure patient comfort and safety;
- Using interpreters if fluency in English or French is a barrier to communication;
- Involving family members in decision-making and as key sources of support, and respecting an individual's definition of family, which can include many extended relations;
- Recognizing that some individuals may prefer alternative methods for communicating and receiving information about their health — the practice of "offering truth" and honouring a patient's decision on the type of information they wish to receive and how they wish to receive it may be helpful in this context;
- Practising non-interference in a patient's decision-making, unless there has been a clear misunderstanding — strong advice or persuasive language from a person in a position of power (i.e., clinician to patient) can be interpreted as coercive; and
- Respecting Indigenous Peoples have the inherent and recognized right to access cultural practices as part of their health care.

Source: British Columbia Centre for Substance Use (BCCSU). (2019) *Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder.* Retrieved from: https://www.bccsu.ca/wp-content/uploads/2021/01/AUD-Guideline.pdf

Guidelines and/or further information on treating AUD in specific populations are available. Although providing a comprehensive list is beyond the scope of this document, populations of interest may include:

- Older adults: See Canadian Guidelines on AUD Among Older Adults
- Pregnant women: Alcohol use disorders in pregnancy

- Screen for Adverse Childhood Experiences (ACEs): Screening for adverse childhood experiences is an integral component of trauma informed care. It can help inform treatment because of the connection between adverse childhood experiences, social issues, and adult mental and physical health.
  - Adverse Childhood Experiences Questionnaire (ACE-Q) – www.novopsych.com.au. Given the known hereditary component of AUD, it is not uncommon that a patient with AUD will present with ACEs. Among patients with addictions, the rate of having at least one ACE is said to ranges from 85.4%–100%.[20]
- Address other trauma history: A trauma informed approach involves providing a service by understanding, anticipating and responding to the specific needs, issues and expectations of survivors of trauma.

- Consider family therapy/support: The functioning of the family as a whole can be harmed by AUD and family members' actions may exacerbate problematic drinking. Equally, families play a key role in recovery from AUD, and recovery has a positive impact on family members and family functioning.
  - Access Mental Health Resource Database can be used to find family therapy/support services that are convenient for the patient. (Select Family Therapy from the dropdown list under 'Service Types').
  - Al-Anon is made up of people who are, or have been, affected by someone else's drinking. A list of meetings, both in-person and online, is available on the website.
  - Alateen is a fellowship of young Al-Anon members, usually teenagers, whose lives have been affected by someone else's drinking. For a list of Alateen meetings, patients and/or their families will need to download the Al-Anon app on their mobile device.

9. Follow-up

- Abstinence versus controlled drinking: Recent evidence review[21] shows that there is a role for controlled drinking (CD) in treatment of AUD, without inferior outcomes to abstinence-based approaches in specific contexts. In the review, in light of field experience with the abstinence paradigm, CD was concluded to be a potential option after abstinence has not been achieved or if patients are not at all willing to stop drinking altogether. See below:

Treatment approach	Comparative outcome: CD vs Abstinence
Patients with controlled, low-risk use of alcohol	No statistically significant difference
Goal-specific treatment interventions	No statistically significant difference, equal efficacy.
No specific goal or abstinence-based treatment interventions	More likely to achieve low-risk drinking when aiming for abstinence.

  - Results on social parameters, improvements in drinking severity, relapse into heavy drinking and drinks per drinking day indicated equal efficacy of either treatment modality.
  - Importantly, patients were more likely to achieve controlled, low-risk use of alcohol when patients aim for drinking within recommended, low-risk limits than following a self-defined reduction.
  - Practice tip: If patient is resistant to abstinence, provide definite suggestions for parameters of controlled drinking i.e., "While my best advice is for you to abstain from alcohol altogether, I feel you should limit your consumption to less than five drinks per week, and no more than two drinks at a time."
- Review supports: Supports can be reviewed using the eight-dimension framework[22] that describes all aspects of patient-centered care, as described by the Picker Institute.

1. Check that patient preferences are guiding treatment goals.
2. Provide information and education that is accessible and understandable.
3. Keep all healthcare professionals involved in delivery of care informed.
4. Offer emotional support to mitigate any accompanying anxiety or depression.
5. Pay attention to physical comfort (e.g. pain, difficulties sleeping or breathing).
6. Identify opportunities to involve friends and family in care.
7. Ensure regular/adequate transfer of information between organizations for continuity and transition.
8. Consider whether access to care is affordable and locations are accessible.

- Psychosocial issues: The Distress Thermometer (DT) was developed by National Comprehensive Cancer Network's (NCCN) to help providers identify and address the experiences that may make it harder to cope with symptoms or treatment of cancer. It is a self-reported tool using a 0-to-10 rating scale to screen for symptoms of distress. The tool also prompts the patient to identify sources of distress using a Problem List and facilitates appropriate psychosocial support and referrals.[23] The Distress Thermometer is a free resource and available in 71 languages through the National Comprehensive Care Network.

BACKGROUND

About this pathway

- The pathway is intended to provide evidence-based guidance to support primary care and specialty care providers in caring for adult patients with AUD within the medical home. It is not indicated for suspected AUD in pediatric/youth, pregnant or breastfeeding populations, as these subpopulations may have unique considerations. Consider a Specialist Link call to hepatology or addictions medicine for advice on this population. For geriatric addictions, consider referral to the SAILL Program.

Authors and conflict of interest declaration

- This pathway was developed by leveraging the collective knowledge, experience and expertise of many individuals. See a full list below. For more information, please email info@calgaryareapcns.ca

Membership	Names	
Executive Core Planning Committee	Abdel Aziz Shaheen, MBBCh MPH FRCPC* Mark Swain, MD MSc FRCPC FAASLD FCAHS Monty Ghosh, MPH MSc MD FRCPC* Niki Panich, MD CCFP FCFP MS(MDSA) MSx* Rick Ward, MD CCFP FCFP** Val Kiss, MSc	
Working Group Members	Alexandra Medellin, MD FRCPC Brendan Diederichs, MD FRCPC Brendan Murphy, Patient Advisor Cheryl Withey, RN David Tano, MD FRCPC David Whitsitt, PhD R. Psych Ian Johnston, MBChB BSc (Hons) CCFP* Jane Ballantine, MD Karen Parker, NP MSc	Karen Seigel, MD CCFP* Lana Fehr, MD CCFP Laura O'Neill, MD CCFP* Ling Mu, MD CCFP Monica Sargious, MD CCFP FCFP Ruth Weir, MD CCFP Sarah Lonz, RN BScN Stacy Rennie, BSW RSW Van Nguyen, MD CCFP(AM)
Provincial Advisory Committee	Andie Bains, MD CCFP Bronwyn White, MN RN Christine Luelo, MD CCFP Christopher Burnie, BScKin MScPT Chris McIntosh, DSocSci David Hodgins, PhD R. Psych FCAHS Don Wilson, MD CCFP Gary F Teare, PhD MSc DVM Ishan Sharm, MD CCFP Jennifer Weekes, MD CCFP Juan Gonzalez Abraldes, MD PhD	Julie Robison, BN RN Kay Rittenbach, PhD Leanne Reeb, MBA Linda Slocombe, MD CCFP Meredith Borman, MD PhD FRCPC Paula Zacharias, BN MHS Puneeta Tandon, MD FRCPC Rachel Han Savoie, MD CCFP Robert Smith, BSc MHSc Tim Ayas, MD FRCPC CCFP MPH BSc Wendi Keller, NP MSN
Business Support	Bahigi Fyith: Senior Advisor, Alberta Health Services Faun Lusty: Medical Writer, Calgary and Area Primary Care Networks Keith Bradford: Director of Communications, Calgary and Area Primary Care Networks Kizzann Sammy: Senior Consultant, Calgary and Area Primary Care Networks Licia Torneiro: Administrative Support, Alberta Health Services Melissa Worrell: Medical Writer, Calgary and Area Primary Care Networks	

*Indicates Working Group/Project Leads
** Executive Planning Group Chair

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  - The Alberta Health Addiction and Mental Health fund, which aims to support primary care teams to improve capacity and capability to deliver addiction and mental health services to their patients; and
  - The Understanding and Responding to the COVID-19 Pandemic Effect on the Magnitude of Alcohol-Related Liver Disease in Alberta: CIHR Operating Grant. Granted to Dr. Abdel-Aziz Shaheen and his team.

Pathway review process, timelines

- Primary care pathways undergo scheduled review every three years, or earlier if there is a clinically significant change in knowledge or practice. The next scheduled review is September, 2026. If you have any questions or concerns about this pathway, please email info@calgaryareapcns.ca with “AUD Pathway” in the subject line.

DISCLAIMER

This pathway represents evidence-based best practice but does not override the individual responsibility of health care professionals to make decisions appropriate to their patients using their own clinical judgment given their patients’ specific clinical conditions, in consultation with patients/alternate decision makers. The pathway is not a substitute for clinical judgment or advice of a qualified health care professional. It is expected that all users will seek advice of other appropriately qualified and regulated health care providers with any issues transcending their specific knowledge, scope of regulated practice or professional competence.

PROVIDER RESOURCES

Advice options

- Non-urgent telephone advice connects family physicians, nurse practitioners and specialists in real time via a tele-advice line. Family physicians, nurse practitioners and specialists can request non-urgent advice from a hepatologist or addiction medicine specialist, at specialistlink.ca or by calling 403-910-2551. This service is available from 8 a.m. to 5 p.m. Monday to Friday (excluding statutory holidays). Calls are returned within one (1) hour.
- Non-urgent hepatology is available across the province via Alberta Netcare eReferral Advice Request (responses are received within five calendar days). View https://www.albertanetcare.ca/eReferral.htm for more information.

General resources	**Location**
Canada's Guidance on Alcohol and Health (CGAH)	https://www.ccsa.ca/canadas-guidance-alcohol-and-health-final-report
Canadian Research Initiative in Substance Misuse. Canadian Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder	www.helpwithdrinking.ca
Canadian clinical guidelines	www.cmaj.ca/content/cmaj/195/40/E1364/F1.large.jpg www.cmaj.ca/content/cmaj/suppl/2023/10/11/195.40.E1364.DC1/230715-guide-1-at.pdf
Anxiety Primary Care Pathway	https://www.specialistlink.ca/assets/pdf/CZ_Anxiety_pathway.pdf
Access Mental Health Resource Database	https://www.specialistlink.ca/access-mental-health-resource-database
Level of Care Utilization System (LOCUS)	https://cchealth.org/mentalhealth/pdf/LOCUS.pdf
Canadian Guidelines on AUD Among Older Adults	https://ccsmh.ca/wp-content/uploads/2019/12/Final_Alcohol_Use_DisorderV6.pdf
Alcohol use disorders in pregnancy	https://pubmed.ncbi.nlm.nih.gov/25747924/
Screening tools	
Alcohol Use Disorders Identification Test (AUDIT) - Form	https://nida.nih.gov/sites/default/files/files/AUDIT.pdf
Alcohol Use Disorders Identification Test (AUDIT) - Website	https://auditscreen.org/
Alcohol Use Disorders Identification Test (AUDIT) - Translations	https://auditscreen.org/translations/
Fibrosis-4 (FIB-4) Index for Liver Fibrosis	https://www.mdcalc.com/calc/2200/fibrosis-4-fib-4-index-liver-fibrosis
FIB-4 Calculator	https://www.omnicalculator.com/health/fib-4
Patient Health Questionnaire (PHQ-9)	https://www.albertahealthservices.ca/frm-19825.pdf
Generalized Anxiety Disorder - 7 (GAD-7)	https://myhealth.alberta.ca/Health/pages/conditions.aspx?hwid=abn2339
The Mood Disorder Questionnaire (MDQ)	https://www.ohsu.edu/sites/default/files/2019-06/cms-quality-bipolar_disorder_mdq_screener.pdf
Adult ADHD Self-Report Scale (ASDS)	https://www.caddra.ca/wp-content/uploads/ASRS.pdf
Drug Abuse Screening Test (DAST-10)	https://cde.nida.nih.gov/sites/nida_cde/files/DrugAbuseScreeningTest_2014Mar24.pdf
Prediction of Alcohol Withdrawal Severity Scale (PAWSS)	https://www.researchgate.net/figure/Prediction-of-Alcohol-Withdrawal-Severity-Scale-PAWSS-tool_fig1_277080645
Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar)	https://www.ci2i.research.va.gov/paws/pdfs/ciwa-ar.pdf

Non-specific screening tools	
Sheehan Disability Scale	https://www.jolietcenter.com/storage/app/media/sheehan-disability-scale.pdf
World Health Organization Disability Assessment Schedule 2.0 (WHODAS)	https://www.psychiatry.org/File Library/Psychiatrists/Practice/DSM/APA_DSM5_WHODAS-2-Self-Administered.pdf
Weiss Functional Impairment Self Report	http://www.shared-care.ca/files/Weiss_Functional_Impairment_Self-Report.pdf
St. Louis University Mental Status Exam (SLUMS)	https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/pdfs/english-canada.pdf
Mini-Mental State Examination (MMSE)	https://cgatoolkit.ca/Uploads/ContentDocuments/MMSE.pdf
Adverse Childhood Experiences Questionnaire (ACE-Q)	https://novopsych.com.au/assessments/diagnosis/adverse-childhood-experiences-questionnaire-ace-q/
Distress Thermometer (DT)	https://www.nccn.org/docs/default-source/patient-resources/nccn_distress_thermometer.pdf?sfvrsn=ef1df1a2_8
Requisition forms	
EFW Liver Program Requisition	https://www.efwrad.com/referrers/requisition-forms/
Mayfair Diagnostics General Requisition	https://www.radiology.ca/requisition-forms/
Drug Special Authorization Request	https://idbl.ab.bluecross.ca/idbl/DBL/60015.pdf
RAAPID Repatriation/Transfer Request	https://www.albertahealthservices.ca/frm-18565.pdf
Youth addiction resources	
Addiction Helpline	Phone: 1-866-332-2322 (toll free within Alberta) https://www.albertahealthservices.ca/findhealth/service.aspx?Id=1008399
Adolescent Day Treatment Program and Counselling	Phone: 403-297-4664; 403-943-1500 (Access Mental Health) https://www.albertahealthservices.ca/findhealth/Service.aspx?serviceAtFacilityId=1102604
Cochrane Addiction Services - Youth Outpatient Counselling	Phone: 403-851-6111 https://www.albertahealthservices.ca/findhealth/Service.aspx?serviceAtFacilityId=1093784
Addiction and Mental Health Clinic – Strathmore	Phone: 403-361-7277 https://www.albertahealthservices.ca/findhealth/facility.aspx?id=1004516
Adult addiction services	
Alberta Addiction Treatment Centre Directory	https://www.abaddictiontx.ca/directory
Addiction Helpline	Phone: 1-866-332-2322 (toll free within Alberta) https://www.albertahealthservices.ca/findhealth/service.aspx?Id=1008399
2-1-1	https://ab.211.ca/
8-1-1	https://www.albertahealthservices.ca/findhealth/service.aspx?Id=1001957&facilityId=1011654
Referral, Access, Advice, Placement, Information & Destination (RAAPID)	https://www.albertahealthservices.ca/info/Page13345.aspx
Rapid Access Addiction Medicine (RAAM)	https://www.albertahealthservices.ca/findhealth/Service.aspx?id=1080798&serviceAtFacilityID=1126612
Behavioural assessment/intervention	
MI techniques - Facilitating behaviour change in the general practice setting.	https://www.racgp.org.au/afp/2012/september/motivational-interviewing-techniques
CAMH/TEACH Motivational Interviewing (MI) Basics	https://cfpcn.sharepoint.com/sites/CZSpecialtyIntegrationTG/Pathways Working Group/4. Pathways in Development/Alcohol Use Disorder/Behavioral & Addictions Working Group/Resources for Expanded Details/MI Basics.pdf

The Motivational Interview (CFP Article)	https://www.cfp.ca/content/53/11/1895?ijkey=2d0af13b26f6fcd2e4287ce5d325bc8599cd0a5e&keytype2=tf_ipsecsha
The Motivational Interview: In practice (CFP Article)	https://www.cfp.ca/content/53/12/2117
Influencing Motivation to Change	https://www.camh.ca/en/professionals/treating-conditions-and-disorders/fundamentals-of-addiction/f-of-addiction---motivation-and-change
A 'Stages of Change' Approach to Helping Patients Change Behaviour	https://www.aafp.org/pubs/afp/issues/2000/0301/p1409.html
Clinical practice supporting resources	
What are the roles in transitions of care?	https://www.albertahealthservices.ca/assets/info/amh/if-amh-ecc-what-are-the-roles-in-transitions-of-care.pdf
How do we follow-up after transition?	https://www.albertahealthservices.ca/assets/info/amh/if-amh-ecc-how-do-we-follow-up-after-transition.pdf
Cultural competency	
Social and Cultural Contexts of Alcohol Use: Influences in a socio-ecological framework.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4872611/
What is cultural sensitivity?	https://www.albertahealthservices.ca/assets/info/amh/if-amh-ecc-what-is-cultural-sensitivity.pdf
Specialist Link – Cultural Competency Series	https://www.specialistlink.ca/cultural-competency-videos
Trauma-informed practice	
An introduction to trauma informed practice	https://camh.ca/en/professionals/professionals--projects/immigrant-and-refugee-mental-health-project/webinars/support-and-treatment-considerations/an-introduction-to-trauma-informed-practice
What does it mean to be trauma informed?	https://www.albertahealthservices.ca/assets/info/amh/if-amh-ecc-what-does-it-mean-to-be-trauma-informed.pdf
Detox Resources: Calgary Based	
Rapid Access Addiction Medicine (RAAM) 403-367-5000	AHS funded; 4-week intensive day treatment program. Accommodates men and women over 18 years of age.
Specialist Link Addictions www.specialistlink.ca	Tele-advice provided within an hour of your call. Available M-F 0800-1700h.
Alpha House 234-7388 ext. 2	Provincially funded; 42 beds for detoxification and withdrawal management generally over 5-7 days. Accommodates men and women over 18 years of age.
Renfrew Recovery 403-297-3337 or 1-866-332-2322	AHS funded. 40 beds for medically supervised detoxification. Patients must present to facility by 0745h in the morning.
Simon House 403-247-2050	12-step based program.12-week residential program; privately funded. Men only. Indigenous supports available.
Fresh Start Recovery Centre 403-387-6266 or 1-844-768-6266	Provincially funded. 50 bed facility in Calgary for men based on 12-step model. 23-bed facility in Lethbridge for men and women based on 12-step model.
Recovery Acres Calgary Society (RACS)	Provincially funded inpatient and outpatient services for men and women over 18 years old. Clients must be five days sober for admission.
Aventa 403-245-9050	Adult women only, concurrent capable live-in treatment services. Costs covered by Alberta Health care. Priority for pregnant women or those women at risk. Five days abstinence required for admission.
Alcove 403-984-2707	Adult women only, concurrent mental health disorders. 12-week residential treatment program. Unique program allows women and their children to remain together during treatment. Online treatment program available as well. Provincially funded.
Calgary Dream Centre 403-243-5598	Adult men's seven-week recovery program, transitional housing program available. Adult women transitional housing program available.
SMART Clinic 403-769-0111	Provincially funded. Outpatient addiction recovery centre.
Detox Resources: Southern Alberta	

Lander Treatment Centre 403-625-1395	Located in Claresholm. AHS funded 48-bed co-ed facility. Program length is 18-24 days.
Foothills Detox Centre 403-553-4466	In Fort Macleod. AHS-funded; patients do phone interview for admission. General stay is five days; accommodates men and women over 18.
Claresholm Centre for Mental Health and Addictions 403-682-3527	AHS funded 108-bed inpatient facility with additional 40 space outpatient program. Manages patients with substance abuse and stable mental health disorders.

PATIENT RESOURCES

Information

Resource type	Resource name	URL
Website/pdf	Canadian Research Initiative in Substance Misuse. Canadian Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder. October 2023.	www.helpwithdrinking.ca
Handout	Mixing Alcohol and Breastfeeding	https://resources.beststart.org/wp-content/uploads/2018/11/A28-E.pdf
Handout	Drink Less - Handycard	https://auditscreen.org/cmsb/uploads/drink_less_handycard.pdf
Infographic	Drinking Less is Better	https://www.ccsa.ca/sites/default/files/2023-05/CGAH-Drinking-Less-is-Better-en.pdf
Handout	Alcohol Detoxification and Withdrawal: Care Instructions	https://myhealth.alberta.ca/Health/aftercareinformation/pages/conditions.aspx?hwid=ut3141

Services available

Service type	Service name	URL
Helpline	Addiction Helpline	Phone: 1-866-332-2322 (toll free within Alberta) https://www.albertahealthservices.ca/findhealth/service.aspx?Id=1008399
Community Supports Directory	2-1-1	https://ab.211.ca/
General Helpline	Health Link 811	https://www.albertahealthservices.ca/findhealth/service.aspx?Id=1001957&facilityId=1011654
Self-referral clinic	Rapid Access Addiction Medicine (RAAM)	https://www.albertahealthservices.ca/findhealth/Service.aspx?id=1080798&serviceAtFacilityID=1126612
Family Support	Al-Anon	https://al-anon.ab.ca/
Family Support (teen)	Alateen	https://al-anon.org/newcomers/teen-corner-alateen/
Crisis Support	Distress Centre	Phone: 403-266-4357 https://www.distresscentre.com/
Crisis Support	Rural Distress Line	Phone: 1-800-232-7288
Crisis Support	Talk Suicide Canada	Phone: 1-833-456-4566 https://talksuicide.ca/
Non-Urgent Intervention	Access Mental Health	Phone: 403-943-1500 or Tollfree: 1-844-943-1500 https://www.albertahealthservices.ca/services/Page11443.aspx
Support Group	Alcoholics Anonymous Calgary	https://calgaryaa.org/
Helpline for Indigenous People	Hope for Wellness Helpline	https://www.hopeforwellness.ca/
Non-Urgent Intervention	Substance Abuse in Later Life (SAILL) Program	https://www.albertahealthservices.ca/services/page13240.aspx

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