Quality Standards

Problematic Alcohol Use and Alcohol Use Disorder

Care for People 15 Years of Age and Older

Ontario Health
Quality

About This Quality Standard

The following quality standard addresses **care for people with problematic alcohol use or alcohol use disorder.**

It applies to all health care settings, including primary care, the emergency department, community mental health and addiction, and correctional settings. This quality standard provides guidance on helping people with problematic alcohol use and alcohol use disorder reduce their consumption or abstain from alcohol, and covers screening, assessment, and treatment options that address people's needs and preferences.

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, families, and caregivers know what to ask for in their care
- Help health care professionals know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

Quality standards are developed by the Quality Business Unit at Ontario Health, in collaboration with health care professionals, patients, and caregivers across Ontario.

For more information, contact qualitystandards@ontariohealth.ca.

Values That Are the Foundation of This Quality Standard

This quality standard was created, and should be implemented, according to the Patient Declaration of Values for Ontario. This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients, and serves as a guidance document for those involved in our health care system."

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

Health care professionals and service providers should acknowledge and work toward addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples throughout Canada. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities. This quality standard uses existing clinical practice guideline sources developed by groups that may not include culturally relevant care or acknowledge traditional Indigenous beliefs, practices, and models of care.

This quality standard is underpinned by the principles of recovery, which include hope, wellness, dignity, self-determination, and responsibility as appropriate for the life-stage of the person with problematic alcohol use or alcohol use disorder.[1]

Harm reduction is an approach that focuses on positive change. People who use alcohol should be offered services and supports for their alcohol use free of judgement, coercion, or discrimination, and stopping alcohol use should not be required to receive care. A harm reduction approach supports the person where they are in their journey to change their relationship with alcohol, recognizing that not all people are willing or able to reduce or stop their alcohol consumption even if this is recommended by a health care professional. Harm reduction strategies include: working with the person to reduce their alcohol consumption (e.g., total consumption or drinking days per week), avoid drinking and driving, and optimize their engagement in their care; offering resources

and services for the physical and mental health impacts of alcohol use, regardless of the person's ability or willingness to reduce alcohol use; and connecting people with resources to address inequities in the social determinants of health (e.g., housing, legal services, social supports, employment services).[2]

The delivery of culturally appropriate services is important during interactions with people and their support network. Culturally appropriate services are described as treatments that consider the ethnic and cultural characteristics, experiences, norms, values, behavioural patterns, and beliefs of a target population and that align with the person's treatment goals, recovery, and plan of care.[3] Health care professionals and service providers should take into consideration differences in how cultures and communities may present symptoms of problematic alcohol use and alcohol use disorder. Contextual information from a person's culture, race, ethnicity, or religion will assist in providing appropriate, patient-centred care.[4,5]

Care for people with alcohol use disorder should also take a trauma-informed approach. It is not necessary for the person to disclose their trauma; rather, this approach acknowledges how common trauma is among people who use substances and seeks to connect those interested in treatment with appropriate trauma services. Health care professionals and service providers do not necessarily need to treat the person's trauma, but they should understand how past trauma impacts the person's current experience and offer specialized programs and resources where the person could find help.

Quality Statements to Improve Care

These quality statements describe what high-quality care looks like for people with problematic alcohol use and alcohol use disorder.

Quality Statement 1: Screening

People who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings are screened for problematic alcohol use and alcohol use disorder using a validated tool.

Quality Statement 2: Brief Intervention

People who screen positive for problematic alcohol use are offered a brief intervention.

Quality Statement 3: Comprehensive Assessment

People who may have alcohol use disorder are offered a comprehensive assessment that informs their care plan.

Quality Statement 4: Care Plan

People with alcohol use disorder have an individualized care plan developed in collaboration with their health care professional that includes appropriate services and treatment goals. Care is seamlessly integrated, interprofessional, and provided in primary care or in collaboration with primary care.

Quality Statement 5: Treatment of Alcohol Withdrawal Symptoms

People with alcohol use disorder who have withdrawal symptoms are offered assessment, treatment, and support tailored to the severity of their symptoms.

Quality Statement 6: Information and Education

People with alcohol use disorder and their caregivers are offered information, education, and support appropriate for their needs and preferences.

Quality Statement 7: Psychological and Social Interventions

People with alcohol use disorder are offered information on psychological and social interventions that address their needs and preferences.

Quality Statement 8: Medications to Reduce Alcohol Cravings or Consumption

People with alcohol use disorder have timely access to medications that reduce alcohol cravings or consumption based on their needs and preferences.

Quality Statement 9: Concurrent Mental Health and Substance Use Disorders and Comorbid Physical Health Disorders

People with alcohol use disorder who also have a mental health disorder, physical health disorder, or another substance use disorder are offered treatment for their concurrent and comorbid disorders.

Quality Statement 10: Monitoring, Support, and Follow-Up

People with alcohol use disorder are offered ongoing follow-up with their health care professional on a regular basis to monitor treatment and response.

Table of Contents

Scope of This Quality Standard

This quality standard addresses clinical care for people 15 years of age and older with problematic alcohol use or alcohol use disorder across all care settings and along the mental health and addictions care continuum. The scope of the standard covers screening for problematic alcohol use; a brief intervention; and the assessment, diagnosis, management, and treatment of alcohol use disorder. It addresses how to identify new or worsening symptoms of alcohol use disorder (withdrawal, tolerance, and cravings), and the support, treatment, and management of individuals with concurrent mental health disorders, other substance use disorders, or comorbid physical health conditions. This quality standard does not address the primary prevention of alcohol use, including public health interventions and regulatory policy.

Although this quality standard applies to adolescents and young adults, the statements are mostly based on guideline evidence that focuses primarily on adults (aged 18 years and older) and nonpregnant people. The Ontario Health (Quality) Alcohol Use Disorder Quality Standard Advisory Committee agrees that the guidance in this quality standard is also relevant and applicable to people with alcohol use disorder who are 15 years of age and older and people who are pregnant. Health care professionals and service providers should consider that specialized skills and expertise may be required when providing treatment for specific populations, including children, youth, and pregnant people with alcohol use disorder. If treatment of these or other specific populations is beyond a service provider's expertise, they should consult or work with another health care professional who has appropriate expertise.

Why This Quality Standard Is Needed

Problematic alcohol use and alcohol use disorder result in a substantial amount of preventable illness and premature death in Ontario, and better identification and treatment could improve and save many lives. Almost 80% of Canadians 19 years of age and older consume alcohol, and most do so in moderate amounts.[6] However, problematic alcohol use is common, and in 2015 approximately 3% of Canadian adults met the criteria for alcohol use disorder.[7]

The negative consequences of alcohol consumption are a major health concern and a common cause of death and injury: alcohol accounts for more than half of hospitalizations attributed to substance use in Canada, with about 86,000 hospitalizations resulting from alcohol use in 2018/19.[8] The economic costs of alcohol-

related harms in Canada were estimated to be $14.6 billion in 2014 ($5.34 billion in Ontario), and of that $4.23 billion was direct health care costs ($1.47 billion in Ontario).[9,10,11]

In 2018 in Ontario, approximately 17.6% of people 12 years of age and older reported heavy alcohol consumption on one occasion at least once a month in the previous year.[12] Alcohol use—both alcohol consumption that exceeds the low-risk drinking guidelines and alcohol use disorder—is estimated to account for 9.3% of disability-adjusted life-years lost and 7.1% of all premature deaths in Canada.[7] Alcohol use is the top risk factor for disease burden worldwide for people between the ages of 15 and 49 years, and it is ranked 6 of the top 10 risk factors for disease burden for all Canadians.[13,14]

Alcohol consumption is associated with significant harms: it can lead to impaired motor skills and judgment; cause illness and death; and have negative effects on social, economic, housing, and living conditions that affect a person's health (i.e., the social determinants of health).[15] The short-term risks associated with problematic alcohol use include an increased risk of suicide, death from overdose (usually in conjunction with a sedating drug, but occasionally due to alcohol alone), transmission of sexually transmitted diseases,[16] and preventable injuries. Long-term health risks include increased risks of cancer, liver cirrhosis, diabetes, and cardiovascular disease.[6,13] Problematic alcohol use or patterns of alcohol consumption that cause health problems can lead to absenteeism, unemployment, food insecurity, and unstable housing, and may contribute to an increase in crime.[6,17] Members of disadvantaged groups (e.g., low-income, newcomer, and homeless populations) experience greater harms from their alcohol use than advantaged individuals who consume the same amount of alcohol but have better access to resources.[6,13]

There is a significant stigma associated with alcohol use disorder when people access health care services, creating additional obstacles to accessing treatment.[18] People who identify as women tend to experience stigma in relation to their problematic alcohol use more than people who identify as men, a factor that may affect women's willingness to seek treatment.[18]

Health care professionals and service providers should be aware of the ways in which sex and gender may play a role in the negative impacts of alcohol use. Sex-related biological characteristics (such as a higher fat-to-muscle ratio and lower body weight) can cause differences in how alcohol is metabolized and how the effects of alcohol are experienced, while gendered expectations at work, at home, and in the community may

influence patterns of consumption. There are also potential consequences associated with alcohol use during pregnancy among people of reproductive age.[19]

The literature shows that adverse experiences or dysfunctional households in childhood, including those in which someone exhibits problematic alcohol use, are associated with poorer health outcomes in adulthood.[20] People who have experienced childhood trauma are more likely to develop problematic alcohol use or alcohol use disorder at an earlier age than those without this history.[18] Those who have, or who have previously had, post-traumatic stress disorder are more likely to have problematic alcohol use that can lead to alcohol use disorder.[18]

There are challenges associated with screening for alcohol use disorder, and questions about alcohol use are asked less frequently by health care professionals than questions about other potential health concerns. The follow-up time required when a person screens positive for problematic alcohol use[21,22] is a barrier to appropriate screening.[23] It can be challenging for health care professionals to engage and establish a rapport with those who screen positive for problematic alcohol use because of the fear of stigma and potential implications associated with disclosing problematic alcohol use.[18]

Ontario is implementing a *Roadmap to Wellness,* a comprehensive strategy to support a mental health and addictions system that enables access to high-quality services across a person's lifespan. The new Mental Health and Addictions Centre of Excellence within Ontario Health will lead system management and coordination of services, and guide quality improvement initiatives to support the implementation of the roadmap. The quality standard for problematic alcohol use and alcohol use disorder can be used to support Ontario's mental health and addictions strategy.

Based on evidence and expert consensus, the 10 quality statements in this standard provide guidance on high-quality care for people with problematic alcohol use and alcohol use disorder to help close the gaps in care identified across the province.

How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources is included below.

For Patients

This quality standard consists of quality statements. These describe what high-quality care looks like for people with problematic alcohol use or alcohol use disorder.

Within each quality statement, we've included information on what these statements mean for you, as a patient.

In addition, you may want to download the accompanying patient guide on alcohol use to help you and your family have informed conversations with your health care providers. Inside, you will find questions you may want to ask as you work together to make a plan for your care.

For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for people with problematic alcohol use or alcohol use disorder.

They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions (Appendix 1) to help you assess the quality of care you are delivering and identify gaps in care and areas for improvement. While it is not mandatory to use or collect data when using a quality standard to improve care, measurement is key to quality improvement.

There are also a number of resources online to help you, including:

- Our patient guide on alcohol use, which you can share with patients and families to help them have conversations with you and their other health care providers. Please make the patient guide available where you provide care
- Our measurement resources, which include our data tables to help you identify gaps in care and inform your resource planning and improvement efforts; our

measurement guide of technical specifications for the indicators in this standard; and our "case for improvement" slide deck to help you share why this standard was created and the data behind it

- Our *Getting Started Guide*, which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- Quorum, an online community dedicated to improving the quality of care across Ontario. This is a place where health care providers can share information, inform, and support each other; it includes tools and resources to help you implement the quality statements within each standard
- Quality Improvement Plans, which can help your organization outline how it will improve the quality of care provided to your patients, residents, or clients in the coming year
- The Health Equity Impact Assessment tool, which can help your organization consider how programs and policies impact population groups differently. This tool can help maximize positive impacts and reduce negative impacts, with an aim of reducing health inequities between population groups

How the Health Care System Can Support Implementation

As you work to implement this quality standard, there may be times when you find it challenging to provide the care outlined due to system-level barriers or gaps. These challenges have been identified and documented as part of the development of the standard, which included extensive consultation with health care professionals and lived experience advisors and careful review of available evidence and existing programs. Many of the levers for system change fall within the purview of Ontario Health, and as such we will continue to work to address these barriers to support the implementation of quality standards. We will also engage and support other provincial partners, including the Ministry of Health or other relevant ministries, on policy-level initiatives to help bridge system-level gaps.

In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

How to Measure Overall Success

The Alcohol Use Disorder Quality Standard Advisory Committee identified some overarching goals for this quality standard. These goals were mapped to indicators that can be used to monitor the progress being made to improve care for people with problematic alcohol use and alcohol use disorder in Ontario. Some indicators are provincially measurable, while some can be measured using only locally sourced data.

Collecting and using data associated with this quality standard is optional. However, data will help you assess the quality of care you are delivering and the effectiveness of your quality improvement efforts.

We realize this standard includes a lengthy list of indicators. We have provided this list so you don't have to create your own quality improvement indicators. We recommend you identify areas to focus on in the quality standard and then use one or more of the associated indicators to guide and evaluate your quality improvement efforts.

See Appendix 1 for additional details on how to measure these indicators and our measurement guide for more information and support.

Indicators That Can Be Measured Using Provincial Data

- Rate of emergency department visits entirely caused by alcohol within the last 12 months per 100,000 population
- Rate of hospitalizations entirely caused by alcohol within the last 12 months per 100,000 population
- Percentage of people who were heavy drinkers in the past year

Indicators That Can Be Measured Using Only Local Data

- Percentage of people with alcohol use disorder who receive care in primary care settings
- Percentage of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings who are screened for problematic alcohol use and alcohol use disorder using a validated tool (see quality statement 1 for more details)
- Percentage of people with alcohol use disorder who report a positive experience of care

- Percentage of people with alcohol use disorder who have a follow-up appointment with a health care professional after leaving the hospital
- Percentage of people with alcohol use disorder and their caregivers who receive information, education, and support appropriate for their needs and preferences (see quality statement 6 for more details)
- Percentage of health care professionals and service providers who receive education about alcohol use disorder

Quality Statements to Improve Care: The Details

1

Screening

People who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings are screened for problematic alcohol use and alcohol use disorder using a validated tool.

Sources: Canadian Coalition for Senior's Mental Health, 2019[24] | Management of Substance Use Disorders Work Group, 2015[17] | National Institute for Health and Care Excellence, 2011,[25] 2014[26]

Definitions

Problematic alcohol use: An amount of alcohol a person consumes that puts them, their family members, or the general public at risk for harm and that increases the person's risk of developing diagnosable alcohol-related health disorders[27] and the risk of premature death.[28] Other consequences associated with problematic alcohol use include professional, personal, financial, and legal problems that can adversely affect a person's health outcomes.[29] The amount of alcohol consumed may affect certain populations (e.g., older adults, youth, or women) differently depending on age, other health conditions, risk of other diseases, and personal circumstances.

Although no amount of alcohol consumption comes with zero risk,[30] Canada's low-risk drinking guidelines recommend[24,27]:

- For women*:
  - Older than 24 years of age, no more than 10 standard drinks per week, with no more than 2 standard drinks per day most days and no more than 3 standard drinks per day on special occasions[27]
  - Older than 65 years of age, no more than 5 standard drinks per week, with no more than 1 standard drink per day most days[24]

- For men*:
  - Older than 24 years of age, no more than 15 standard drinks per week, with no more than 3 standard drinks per day most days and no more than 4 standard drinks per day on special occasions[27]
  - Older than 65 years of age, no more than 7 drinks per week, with no more than 1 or 2 standard drinks per day most days[24]
- Planning non-drinking days every week to reduce your risk of developing problematic alcohol use
- Choosing not to consume alcohol if you are pregnant, planning on becoming pregnant, or breastfeeding[27]
- Encouraging parents to speak with their teenagers about alcohol consumption. If teenaged people choose to drink, they should be supervised by their parents and never drink more than 1 or 2 drinks at a time, and never more than 1 or 2 drinks per week[27]
- Not exceeding the low-risk drinking guidelines for adults if you are 24 years of age or younger, including the special occasion alcohol consumption limit[27]

A single standard alcoholic drink is measured as follows[24,27]:

- Beer: 341 mL or 12 oz, 5% alcohol content
- Cider or cooler: 341 mL or 12 oz, 5% alcohol content
- Wine: 142 mL or 5 oz, 12% alcohol content
- Distilled alcohol (rye, rum, gin, etc.): 43 mL or 1.5 oz, 40% alcohol content

*In the low-risk drinking guidelines, “men” and “women” refer to sex assigned at birth (usually determined by primary sex characteristics), not necessarily gender identity.

Mental health and addictions settings: Refers to the various settings and types of programs that make up the mental health and addictions continuum of care, including community mental health and addictions services (such as day and evening programs and residential addictions services); inpatient hospital mental health facilities; hospital outpatient services; addiction medicine clinics (such as rapid access addiction medicine [RAAM] clinics); primary care; and any other settings where mental health and addictions care is provided.

Other appropriate settings: Other settings where people may be screened for problematic alcohol use by a health care professional or someone who is trained to administer a screening test, such as liver clinics; oncology centres; diabetes clinics; maternity, labour, and delivery settings; cardiology clinics; or criminal justice settings.

Screened: People who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings are assessed for their alcohol use; some guidelines recommend that this be done on an annual basis.[2,24,31] Health care professionals and service providers may use any contact with people to screen for problematic alcohol use, as long as the person gives their consent to be screened. A validated screening tool should be used (such as the Alcohol Use Disorders Identification Test—Consumption [AUDIT-C] or the Global Appraisal of Individual Needs Short Screener [GAIN-SS]).[25]

Validated tool: A screening instrument that uses questions to identify if a person is at risk for or has problematic alcohol use. The screening instrument must be tested for validity, reliability, and sensitivity to be considered validated. There are different validated tools that can be used to screen different populations of people for problematic alcohol use or alcohol use disorder. These tools may include the AUDIT-C, the Fast Alcohol Screening Test (FAST), the Single Item Alcohol Screening Questionnaire (SASQ),[17] and the Global Appraisal of Individual Needs—Short Screener (GAIN-SS).[32] When providers have the option of selecting from several validated tools, they should choose the right tool for the person being screened. These tools will facilitate a conversation with the person and will determine the level of support the person with problematic alcohol use or alcohol use disorder may require.

Rationale

Screening and brief intervention by a health care professional or service provider reduce the risks and complications of problematic alcohol use[33] and can help assess to what degree alcohol is impacting a person's health.[34] Screening tools are used when it is clinically appropriate to identify those with problematic alcohol use and alcohol use disorder.[35] Youth do not benefit from a brief intervention.[18] If youth screen positive for problematic alcohol use, they should be offered a comprehensive assessment (see quality statement 3).[18]

It is important that health care professionals and service providers explain that screening for problematic alcohol use is offered to all people. Assumptions and stereotypes surrounding intoxication and alcohol use are pervasive issues. Health care professionals and service providers need to be aware of, and work toward, eliminating these assumptions and stereotypes. Trust is a fundamental part of the person–professional relationship and is necessary to engage in meaningful and honest discussion about alcohol use.[36] When a health care professional or service provider strives to build a trusting relationship with the patient, the person is more inclined to answer truthfully.

1 **Screening**

Through early identification and screening, people can get help before their alcohol use progresses to a more serious problem. Those who have experienced trauma, adverse childhood experiences such as neglect or abuse, or a mental health condition such as attention deficit disorder, anxiety, depression, or post-traumatic stress disorder, are at an increased risk for alcohol use disorder. These individuals should be screened for problematic alcohol use and alcohol use disorder in settings beyond primary care, including mental health service settings, when their mental health disorder is identified.[22,34]

What This Quality Statement Means

For Patients

When you visit your health care professional for routine checkups, they should ask you a few questions about your use of alcohol.

For Clinicians

Screen people for problematic alcohol use or alcohol use disorder on at least an annual basis, or at intake to mental health and addictions services. If a person is engaging in problematic alcohol use, collaborate with the person on harm reduction approaches, including how they can reduce their alcohol consumption.

For Health Services Planners

Ensure health care professionals and service providers have access to and are properly trained to screen people for problematic alcohol use and alcohol use disorder using a validated tool.

QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings who are screened for problematic alcohol use and alcohol use disorder using a validated tool

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 1.

2

Brief Intervention

People who screen positive for problematic alcohol use are offered a brief intervention.

Sources: Canadian Coalition for Senior's Mental Health, 2019[24] | Management of Substance Use Disorders Work Group, 2015[17] | National Institute for Health and Care Excellence, 2011,[25] 2011 (updated 2014),[18] 2014[26]

Definitions

Problematic alcohol use: An amount of alcohol a person consumes that puts them, their family members, or the general public at risk for harm and that increases the person's risk of developing diagnosable alcohol-related health disorders[27] and the risk of premature death.[28] Other consequences associated with problematic alcohol use include professional, personal, financial, and legal problems that can adversely affect a person's health outcomes.[29] The amount of alcohol consumed may affect certain populations (e.g., older adults, youth, or women) differently depending on age, other health conditions, risk of other diseases, and personal circumstances.

Although no amount of alcohol consumption comes with zero risk,[30] Canada's low-risk drinking guidelines recommend[24,27]:

- For women*:
  - Older than 24 years of age, no more than 10 standard drinks per week, with no more than 2 standard drinks per day most days and no more than 3 standard drinks per day on special occasions[27]
  - Older than 65 years of age, no more than 5 standard drinks per week, with no more than 1 standard drink per day most days[24]

- For men*:
  - Older than 24 years of age, no more than 15 standard drinks per week, with no more than 3 standard drinks per day most days and no more than 4 standard drinks per day on special occasions[27]
  - Older than 65 years of age, no more than 7 drinks per week, with no more than 1 or 2 standard drinks per day most days[24]
- Planning non-drinking days every week to reduce your risk of developing problematic alcohol use
- Choosing not to consume alcohol if you are pregnant, planning on becoming pregnant, or breastfeeding[27]
- Encouraging parents to speak with their teenagers about alcohol consumption. If teenaged people choose to drink, they should be supervised by their parents and never drink more than 1 or 2 drinks at a time, and never more than 1 or 2 drinks per week[27]
- Not exceeding the low-risk drinking guidelines for adults if you are 24 years of age or younger, including the special occasion alcohol consumption limit[27]

A single standard alcoholic drink is measured as follows[24,27]:

- Beer: 341 mL or 12 oz, 5% alcohol content
- Cider or cooler: 341 mL or 12 oz, 5% alcohol content
- Wine: 142 mL or 5 oz, 12% alcohol content
- Distilled alcohol (rye, rum, gin, etc.): 43 mL or 1.5 oz, 40% alcohol content

*In the low-risk drinking guidelines, “men” and “women” refer to sex assigned at birth (usually determined by primary sex characteristics), not necessarily gender identity.

Screen positive: A certain number of positive responses to questions on a validated tool used to identify problematic alcohol use or alcohol use disorder, or a person's self-identification as needing addictions services.

Brief intervention: Either a short session of structured brief advice or a longer, more motivational session (i.e., an extended brief intervention) that is documented in the person’s health record. Both aim to help a person reduce their alcohol consumption, abstain, or initiate harm reduction activities, depending on where they are in their journey. The brief intervention should be carried out by a health care professional or service provider.[25] A brief intervention is not appropriate for people who may have moderate to severe alcohol use disorder,[37] although it may be used when a person does not want to participate in more comprehensive services. Youth need a comprehensive assessment if they screen positive for alcohol use, because a brief intervention does not

improve outcomes for them (see quality statement 3).[18] Health care professionals and service providers with appropriate training may consider using motivational interviewing during the brief intervention, which is an empathetic, client-centred, harm reduction approach used to help the person choose an alcohol consumption goal, assess their readiness for change, and enhance their self-efficacy.[17]

Rationale

The literature demonstrates that people who receive a brief intervention in primary care reduce their alcohol consumption when they have problematic alcohol use or mild alcohol use disorder.[23,24] A brief intervention is a time-limited conversation between the health care professional or service provider and the person with problematic alcohol use that aims to help increase the person's awareness of the consequences associated with alcohol consumption. It usually lasts 5 to 15 minutes.[17,25] During the brief intervention, the person and the health care professional or service provider create a plan that incorporates harm reduction approaches to care. This may include consuming alcohol within safe limits (as outlined in Canada's low-risk drinking guidelines),[27] reducing alcohol consumption, or abstaining from alcohol.[17]

If the health care professional or service provider determines that the person may have a more severe problem with alcohol (e.g., alcohol is causing significant impairment or distress or the person scores higher than 15 on AUDIT-10),[18] they should conduct a comprehensive assessment and create a care plan (see quality statements 3 and 4) in collaboration with the person, ensuring consent is obtained before proceeding with treatment.

What This Quality Statement Means

For People Who Screen Positive for Problematic Alcohol Use

If you screen positive for problematic alcohol use or identify it in yourself, your health care professional or service provider should work with you to help you achieve your goals related to alcohol consumption.

For Clinicians

Offer a brief intervention to people who screen positive for problematic alcohol use. Collaborate with them to help them lower their alcohol consumption or abstain from alcohol. A brief intervention is not appropriate for youth or those who may have moderate to severe alcohol use disorder.

For Health Services Planners

Ensure clinicians have resources to screen people with problematic alcohol use, and provide the tools and training for them to deliver a brief intervention.

QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people 16 years of age and older who screen positive for problematic alcohol use (excluding people who may have moderate to severe alcohol use disorder) who receive a brief intervention within that health care visit

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 1.

3

Comprehensive Assessment

People who may have alcohol use disorder are offered a comprehensive assessment that informs their care plan.

Sources: American Psychiatric Association, 2017[16] | Canadian Coalition for Senior's Mental Health, 2019[24] | National Institute for Health and Care Excellence, 2011 (updated 2014),[18] 2014,[26] 2010 (updated 2017)[38]

Definitions

May have alcohol use disorder: People who present with problems related to alcohol use, or who are unable or choose not to reduce their alcohol consumption after screening and a brief intervention, should be assessed for alcohol use disorder. People who may have moderate to severe alcohol use disorder, as well as all youth with problematic alcohol use or alcohol use disorder of any severity, require a comprehensive assessment.

Comprehensive assessment: The results of a comprehensive assessment confirm a diagnosis of alcohol use disorder. It should include the following, as applicable:

- History of the present episode, including precipitating factors, current symptoms, and current risks for the person
- Family history of drug and alcohol use
- Developmental history
- Comprehensive substance use history
- Identification and treatment of comorbid nicotine dependence
- Personal and social history, including employment, housing, and social supports
- Experience with legal and/or justice systems
- Psychiatric history
- Medical history
- Biological tests (laboratory tests)

- Mental status examination
- Community supports
- Readiness for change and belief in the ability to change assessments
- Individuals' perspectives on current problems related to alcohol
- Treatment goals and preferences[17]

At least two of the following criteria over a 12-month period are needed to diagnose alcohol use disorder, with severity of symptoms (mild, moderate, or severe) determined by the number of criteria met[4]:

1. Alcohol is taken in larger amounts or over a longer period than intended
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects
4. There is a strong desire or urge to use alcohol (cravings)
5. Recurrent alcohol use results in a failure to fulfill major role obligations at work, school, or home
6. Alcohol use continues, despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use
8. Alcohol use recurs in situations in which it is physically hazardous
9. Alcohol use continues despite knowledge of a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect
    b. A markedly diminished effect with continued use of the same amount of alcohol
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for alcohol
    b. Taking alcohol (or a closely related substance, such as a benzodiazepine) to relieve or avoid withdrawal symptoms

This information may be collected over multiple interactions with the person's primary care professional (family physician and primary care nurse practitioner).

Care plan: A comprehensive care plan is developed in a health care setting in collaboration with the person and outlines the goals of treatment and care. It may include psychological and social interventions or medications, or both. The plan is individualized and based on the comprehensive assessment. The depth of the care plan will depend on the extent of information that is available, as well as on the person's needs and goals. Additions and modifications are made to the care plan as additional information is gathered and the person's responses to clinical interventions are observed.[16] The care plan should take a trauma-informed approach, meaning that health care professionals do not necessarily need to treat the person's trauma but should understand how past trauma impacts the person's current experience and offer information on specialized programs and resources where the person could find help. Care professionals should take into consideration differences in how cultures and communities may present symptoms of problematic alcohol use and alcohol use disorder.[1,20,21] The person with alcohol use disorder may also include caregivers (family members, friends, or supportive people not necessarily related to the person with alcohol use disorder) if they choose when developing their care plan.

Rationale

Health care professionals can make a diagnosis or identify alcohol use disorder by conducting a comprehensive assessment and using the most current *Diagnostic and Statistical Manual of Mental Health Disorders* criteria.[4] The assessment should consider multiple health needs and include detailed information about alcohol consumption, dependence, and alcohol-related problems.[2,18,24]

It is important to assess people for comorbid mental health and physical health disorders that may improve with treatment of alcohol use disorder, as this should inform the overall care plan (see quality statements 4 and 9).[18] The assessment should also ascertain whether the person is experiencing—or is likely to experience—withdrawal symptoms, including any combination of generalized hyperactivity, anxiety, tremor, sweating, nausea, tachycardia, hypertension, or mild pyrexia[38]; this will help health care professionals determine the most appropriate setting for withdrawal management services (see quality statement 5) if the person chooses to proceed with treatment. People with mild alcohol use disorder should be offered additional interventions and services, as appropriate, including follow-up support (see quality statement 10).

What This Quality Statement Means

For People Who May Have Alcohol Use Disorder

Your health care professional should ask you about your physical and mental health, your medical history, and any other substances you are using now or have used in the past. If you have alcohol use disorder, they will use this information and work with you to create a care plan to help you.

For Clinicians

Perform a comprehensive assessment and create a care plan in collaboration with the person that is based on their treatment goals and that addresses alcohol use disorder and other physical and mental health conditions, if applicable.

For Health Services Planners

Ensure systems, processes, and resources are in place to help health care professionals perform a comprehensive assessment for people who may have alcohol use disorder and create a care plan that addresses the person's needs, preferences, and goals.

QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people who may have alcohol use disorder who receive a comprehensive assessment

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 1.

4

Care Plan

People with alcohol use disorder have an individualized care plan developed in collaboration with their health care professional that includes appropriate services and treatment goals. Care is seamlessly integrated, interprofessional, and provided in primary care or in collaboration with primary care.

Sources: American Psychiatric Association, 2018[16] | Management of Substance Use Disorders Work Group, 2015[17] | National Institute for Health and Care Excellence, 2011 (updated 2014)[18]

Definitions

Appropriate services: Treatment for alcohol use disorder can be provided in many settings, including primary care, specialized addictions services, and peer support programs. Some people may benefit from more intensive treatment options such as day/evening care, in-home/mobile services or residential services. It is important to note that most people need to remain in treatment for at least 6 months before it has an impact on their long-term health outcomes.[23] When helping people decide between different treatment options, health care professionals should consider culturally appropriate settings, social determinants of health, and comorbid mental health and physical health disorders.[18] Treatment may focus on harm reduction (e.g., stabilizing one's life), reducing alcohol consumption or abstinence. Services should incorporate culturally appropriate care by considering ethnic and cultural characteristics, experiences, norms, values, behavioural patterns, and beliefs of specific populations and should align with the person's treatment goals and care plan.[3]

Treatment goals: The person and their health care professional should collaborate to determine treatment goals, which may be abstinence from alcohol, a reduction in alcohol use, or elimination of alcohol in high-risk situations (e.g., at work, before driving,

when caring for children).[16] It may also focus on other harm reduction goals such as finding stable or supportive housing.

Care plan: A comprehensive care plan is developed in a health care setting in collaboration with the person and outlines the goals of treatment and care. It may include psychological and social interventions or medications, or both. The plan is individualized and based on the comprehensive assessment. The depth of the care plan will depend on the extent of information that is available, as well as the person's needs and goals (e.g., who can offer ongoing care or provide transition support to people for ongoing care, including rapid access addiction medicine [RAAM] clinics). Additions and modifications are made to the care plan as additional information is gathered and the person's responses to clinical interventions are observed.[16] The care plan should take a trauma-informed approach, meaning that health care professionals do not necessarily need to treat the person's trauma but should understand how past trauma impacts the person's current experience and offer information on specialized programs and resources where the person could find help. Care professionals should take into consideration differences in how cultures and communities may present symptoms of problematic alcohol use and alcohol use disorder.[1,20,21] The person with alcohol use disorder may also include caregivers (family members, friends, or supportive people not necessarily related to the person with alcohol use disorder) if they choose when developing their care plan.

Rationale

The health care professional and person with alcohol use disorder should collaborate and agree on a care plan that is documented in the person's health record.[16] If the person has a primary care professional, management of alcohol use disorder can continue in this setting, which will offer the person continuity of care, immediate access to treatment and follow-up, and reconnection opportunities if the person attends appointments for other health concerns.[39] Treatment from a primary care professional appears to be at least as effective as treatment in specialized addiction programs.[23,39-46] Primary care professionals have the capacity to treat people with alcohol use disorder with a disease-management approach, much like they do other chronic diseases such as hypertension or diabetes.[46]

If the health care professional conducting the assessment and creating the care plan is not providing ongoing care (e.g., if the care plan is created by a health care professional in an emergency department setting), they should ensure rapid, seamlessly integrated access to ongoing, interprofessional, coordinated care (see quality statements 5 to 10).

Rates of no-shows for follow-up appointments can dramatically increase if the person's wait time is longer than 1 to 2 days after the initial visit.[40]

Ongoing treatment can occur in several different settings, including primary care, mental health settings, residential addiction treatment centres, or managed alcohol programs.[39] Some people may benefit from care in a residential addiction treatment centre, including those who are using other substances, those who are homeless or underhoused, those with comorbid disorders, or those with severe alcohol use disorder who are not responding to outpatient treatment.[18] People in all settings should be offered the option to receive psychological and social interventions (see quality statement 7) and medications under the supervision of appropriately trained staff (see quality statement 8).[18]

If treatment is not located in primary care, health care professionals should ensure integrated care and coordination of services including assessment, interventions, and follow-up and coordination with other agencies (including social, vocational, and legal services), if necessary.[17,34,47,48] Clear communication and relaying treatment information among professionals (e.g., through referral letters, care plans, and warm handoffs between members of the health care team in collaboration with the person and family members), with patient consent, should support appropriate and seamless transitions between professionals and care settings. Although not everyone needs a case manager, a person may receive one if their complexity of care warrants it[18]; otherwise, the person should be referred to an appropriate health care professional or service provider.

What This Quality Statement Means

For People With Alcohol Use Disorder

Your health care professional should work with you to create a care plan that includes your treatment goals and appropriate services you can access. This care plan should be based on your needs and be respectful of your culture and personal preferences.

For Clinicians

Collaborate with people with alcohol use disorder on a care plan that provides the most appropriate services and the best care for the person. The care plan should consist of seamlessly integrated care that is interprofessional and coordinated.

For Health Services Planners

Ensure systems, processes, and resources are in place so that health care professionals can develop and regularly update individualized care plans and treatment goals for

people with alcohol use disorder. These systems, processes, and resources should support coordination of care, and treatment goals should be easily communicated to others who provide care to the individual.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with alcohol use disorder who have an individualized care plan that is based on their comprehensive assessment and includes appropriate services and treatment goals
- Percentage of people with alcohol use disorder who have an individualized care plan that was developed collaboratively between the person and their health care professional

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 1.

5

Treatment of Alcohol Withdrawal Symptoms

People with alcohol use disorder who have withdrawal symptoms are offered assessment, treatment, and support tailored to the severity of their symptoms.

Sources: Canadian Coalition for Senior's Mental Health, 2019[24] | Management of Substance Use Disorders Work Group, 2015[17] | National Institute for Health and Care Excellence, 2011 (updated 2014),[18] 2010 (updated 2017)[38]

Definitions

Withdrawal: The physical symptoms that a person may experience when they suddenly reduce or stop consuming alcohol. These symptoms can include any combination of generalized hyperactivity, anxiety, tremor, sweating, nausea, tachycardia, hypertension, or mild pyrexia.[38] Screening tools for alcohol withdrawal may include the Short Alcohol Withdrawal Scale (SAWS), the Global Appraisal of Individual Needs—Short Screener (GAIN-SS), and the Clinical Institute Withdrawal Assessment of Alcohol Scale—Revised (CIWA-Ar).[38]

Assessment, treatment, and support: When a person presents to an acute care setting (e.g., emergency department), they should receive an assessment to evaluate the severity of their withdrawal symptoms, options for psychological and social interventions, and medications to assist with withdrawal symptoms after stopping or reducing their alcohol consumption. Health care professionals should follow evidence-based guidelines[17,38,49] when treating symptoms of alcohol withdrawal. If they do not have experience managing alcohol withdrawal, they should seek guidance from a health care professional experienced in this area, as severe withdrawal can be fatal. When treating withdrawal, the goal of therapy is to proactively minimize symptoms, promote the comfort and dignity of the person, and prevent any medical complications.[38] People with alcohol use disorder experiencing withdrawal symptoms should receive treatment guided by symptom severity.[17] The best current evidence for treatment with medication is the use of benzodiazepines as the treatment of choice to alleviate acute symptoms of

alcohol withdrawal, which may include tremors, restlessness, irritability, nausea, vomiting, and headaches.[38] The selection of benzodiazepines is dependent on many factors, and it is important to consult with an addiction medicine specialist if the health care professional is unsure of which benzodiazepine to choose.

Severity of symptoms: People experiencing withdrawal symptoms should have their symptoms assessed regularly (initially every 1 to 2 hours). Management includes a standardized protocol that takes a symptom-driven approach. Assessment and treatment should continue until symptom severity is in the mild range for several hours. Symptom severity can be determined using a validated scoring system, such as the CIWA-Ar scale or another relevant and validated assessment tool. This assessment will determine whether the person is at risk for withdrawal seizures or delirium tremens, the most severe symptoms associated with alcohol withdrawal.[24,38] Health care professionals managing people who are experiencing alcohol withdrawal should be educated on these validated, standardized, symptom-severity scoring systems.

Rationale

Alcohol withdrawal can have serious health consequences, including death, and it can lead to relapse when left untreated.

Acute care settings should treat alcohol withdrawal efficiently and fully before discharge. People will almost always relapse if their withdrawal is not fully treated, leading to unnecessary morbidity and repeat emergency department visits. If withdrawal is appropriately treated with benzodiazepines, people typically do not need a prescription for more benzodiazepines after discharge. Due to the rare occurrence of withdrawal in youth, there are no data available that recommend medication management in this population. If youth require pharmacological intervention, consult with an addiction medicine specialist.[2] People should not be prescribed benzodiazepines over the long term, because this medication increases the risk of relapse and overdose.[18]

Once acute withdrawal symptoms are treated, people should be offered a comprehensive assessment and care plan (see quality statements 3 and 4), including follow-up care with a primary care professional or addiction medicine specialist [18,38] within 48 to 72 hours.[50]

Health care professionals should use a screening tool (e.g., SAWS, GAIN-SS, CIWA-Ar) to determine whether the person planning to stop using alcohol will need additional support, such as medical management. They should develop a care plan for withdrawal

in collaboration with the person to ensure the person stops using alcohol in a controlled manner.[2,38] Some people with alcohol use disorder may need to attend assisted or supervised withdrawal programs (inpatient or outpatient), depending on the amount of alcohol they consume and whether they have concurrent mental health disorders, other substance use disorders, or comorbid physical health disorders.[47,48] Detailed program standards set out by Addictions Mental Health Ontario are available for withdrawal management.[47] These standards establish expectations for program requirements (such as staff qualifications and staff-to-patient ratios) so that services are delivered consistently across Ontario. Some people do not need planned medical management of their withdrawal symptoms, because they are unlikely to experience these symptoms. The severity of alcohol withdrawal symptoms is not always predictable (it can range from mild to fatal); health care professionals should advise people experiencing alcohol withdrawal to seek medical attention if their symptoms become worse than expected.[18,38]

What This Quality Statement Means

For People With Alcohol Use Disorder

If you have stopped using alcohol and are having symptoms of withdrawal (such as nausea, vomiting, tremors, or irritability), your health care professional should offer you help. Depending on your preferences and how bad your symptoms are, this help might include taking medication or being connected to withdrawal management services.

For Clinicians

Offer people with alcohol use disorder treatment for withdrawal symptoms, as appropriate and in accordance with their symptom severity. People who require medication based on their symptom severity are offered benzodiazepines to alleviate acute symptoms of withdrawal. If the health care professional is unfamiliar with prescribing benzodiazepines for alcohol withdrawal, they should consult with an addiction medicine specialist.

For Health Services Planners

Ensure clinicians have access to psychological and social interventions and medications that help treat withdrawal symptoms from mild to severe.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with alcohol use disorder who experience withdrawal symptoms and who receive assessment, treatment, and support tailored to the severity of their symptoms
- Percentage of people with alcohol use disorder who are discharged from the emergency department after being treated for alcohol withdrawal and have a follow-up visit with their health care professional within 3 days

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 1.

6

Information and Education

People with alcohol use disorder and their caregivers are offered information, education, and support appropriate for their needs and preferences.

Sources: National Institute for Health and Care Excellence, 2011 (updated 2014)[18]

Definitions

Caregivers: Family members, friends, or supportive people not necessarily related to the person with alcohol use disorder. The person with alcohol use disorder must give appropriate consent to share personal information, including medical information, with their caregivers.

Information and education[18]: Health care professionals or service providers should share information and education, using a trauma-informed approach that is culturally appropriate and age-appropriate and that takes into account the person's level of health literacy, to support people with alcohol use disorder and their caregivers. Topics should include:

- Signs, symptoms, and risks of alcohol use disorder
- Treatment options and their side effects
- Self-management strategies, such as monitoring symptoms, participating in meaningful activity, eating well, practising sleep hygiene, engaging in physical activity, and reducing tobacco and other substance use
- Self-care and resilience strategies for the person's support network
- Local resources for support
- Risk of relapse, and early signs and symptoms of relapse

Information and education should be available in a variety of accessible formats. Information for caregivers should be specific to their needs, including the level of their involvement with the person's care.[18]

Rationale

People with alcohol use disorder and their caregivers benefit from trauma-informed, evidence-based information that covers the nature and treatment of alcohol use disorder.[18] This information should be provided at diagnosis, if appropriate, and throughout the person's care journey to align with the different stages of recovery, which may include relapse (see quality statement 10).

People with alcohol use disorder should be provided with unbiased and balanced evidence-based information about psychological and social interventions and medications, as well as the signs and symptoms of alcohol use disorder and relapse. These resources should clearly explain the risks associated with alcohol consumption and the treatments available. Age-appropriate information and education that considers the ethnic and cultural characteristics, experiences, norms, values, behavioural patterns, and beliefs of a target population should be offered.[18]

What This Quality Statement Means

For People With Alcohol Use Disorder

You should be offered education about alcohol use disorder. This information should cover treatment options such as counselling, peer support, and medication (and its side effects), and it should be offered in a format that works best for you. If you want, your caregivers, such as family and friends, can also be offered this education.

For Clinicians

Offer people with alcohol use disorder and their caregivers information and education on the signs and symptoms of alcohol use disorder, as well as on treatment options that may be appropriate, depending on the person's needs and preferences.

For Health Services Planners

Ensure systems, processes, and resources are in place so that people with alcohol use disorder and their caregivers receive information and education, in multiple formats, that address different needs.

QUALITY INDICATOR:
HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with alcohol use disorder and their caregivers who receive information, education, and support that is appropriate for their needs and preferences

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 1.

7

Psychological and Social Interventions

People with alcohol use disorder are offered information on psychological and social interventions that address their needs and preferences.

Sources: American Psychiatric Association, 2018[16] | Management of Substance Use Disorders Work Group, 2015[17] | National Institute for Health and Care Excellence, 2011 (updated 2014)[18]

Definition

Psychological and social interventions: Nonpharmacological therapies aimed at improving the mental, emotional, and social aspects of a person's health. They help people with alcohol use disorder manage their symptoms, cravings, and other aspects of addiction and recovery. These interventions may include counselling or psychotherapy (e.g., cognitive behavioural therapy, motivational enhancement therapy, multidimensional family therapy),[17,18] mutual-help programs offered in appropriate settings (e.g.,12-Step Facilitation, SMART Recovery, other peer support groups),[17,51] and other supports (e.g., mindfulness meditation, culturally specific approaches).[18,34]

Rationale

The goals of psychological and social interventions are to alleviate psychological distress, reduce consumption or promote abstinence while supporting the person through their alcohol use disorder.[34] Primary care professionals should counsel people with alcohol use disorder at regular follow-up appointments (see quality statement 10). Some people with alcohol use disorder may benefit from additional, more intensive, evidence-based psychological and social interventions from qualified care professionals (e.g., psychotherapy). These may be used alone, in combination with other psychological and social interventions, or in combination with medications (see quality statement 8).

There is limited evidence to support the use of one psychological or social intervention over another. Psychological and social interventions should be age-appropriate and culturally appropriate (considering ethnic and cultural characteristics, experiences, norms, values, behavioural patterns, and beliefs of a specific population), trauma-informed, and based on the person's needs, goals, and desired method of receiving psychological and social interventions.

What This Quality Statement Means

For People With Alcohol Use Disorder

Your health care professional or service provider should offer you information about options for support. These could include counselling, mutual-help programs (treatment programs), or peer support. They will help you choose the option that best suits your needs and preferences.

For Clinicians

Offer people with alcohol use disorder information on evidence-based psychological and social interventions and help them choose the best option for their needs and preferences.

For Health Services Planners

Ensure systems, processes, and resources are in place so that clinicians can help people with alcohol use disorder choose appropriate psychological and social interventions in accordance with their needs and preferences.

QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with alcohol use disorder who receive information on psychological and social interventions that address their needs and preferences

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 1.

8

Medications to Reduce Alcohol Cravings or Consumption

People with alcohol use disorder have timely access to medications that reduce alcohol cravings or consumption based on their needs and preferences.

Sources: American Psychiatric Association, 2018[16] | Canadian Coalition for Seniors' Mental Health, 2019[24] | Management of Substance Use Disorders Work Group, 2015[17] | National Institute for Health and Care Excellence, 2011 (updated 2014)[18]

Definitions

Medications[17]: Pharmacological therapies can be used to help people with alcohol use disorder adhere to an abstinence or alcohol-reduction plan.[18,52] Health care professionals should consider the person's ability to pay for medication (through provincial coverage, employer insurance coverage, or out of pocket) before prescribing one of the following medications.

Naltrexone and acamprosate are the treatment of choice for people with alcohol use disorder, because they have fewer side effects compared with other medications:

- **Naltrexone**—Can be used to reduce alcohol consumption and can be taken while the person is still consuming alcohol; may reduce alcohol cravings[18,24]
- **Acamprosate**—Can be used to achieve abstinence from alcohol and can be taken while the person is still consuming alcohol[18,24]

Disulfiram, topiramate, and gabapentin are other treatment options for people with alcohol use disorder:

- **Disulfiram**—Can be used to achieve abstinence from alcohol but does not help with alcohol cravings. People experience adverse reactions if they consume alcohol while taking this medication.[18,53] There are additional side effects to this medication that should be considered, depending on the person's goals of treatment. There is also limited evidence that this medication is effective when not taken under the supervision of a pharmacist[7]
- **Topiramate**—Can be used to reduce alcohol cravings.[18,53] There are additional side effects to this medication that should be considered based on the person's goals of treatment[44]
- **Gabapentin**—An option only if other medications are contraindicated or ineffective, because gabapentin carries concerns with sedation and misuse[18]; this medication should be used with caution—some patients may misuse it and should be monitored for substance use[53]

Timely access: People with alcohol use disorder are offered medication during their visit with a health care professional, either at diagnosis or at subsequent visits, or they receive medication in the emergency department when they are diagnosed with alcohol use disorder (rather than waiting for an appointment with a health care professional outside of the emergency department setting). If a person is referred to another setting (e.g., to a rapid access addiction medicine [RAAM] clinic), they receive an appointment within 48 to 72 hours[50] of an alcohol use disorder diagnosis and are offered medication. Service providers working in addictions settings who are not authorized to prescribe medication should refer the person to an appropriate regulated health professional. If a person is diagnosed with alcohol use disorder and decides not to proceed with pharmacological treatment, they can access medications at a later time, based on their needs and preferences.

Rationale

Medications may benefit people with alcohol use disorder, from mild to severe. They may be used to reduce alcohol consumption and support abstinence. Medications have the best available evidence for those with moderate to severe alcohol use disorder[17]—medications for those with mild alcohol use disorder should be determined on an individual basis, depending on the person's needs and preferences. Medications are often used in combination with psychological and social interventions (see quality statement 7) to improve the physical and mental health of those with alcohol use disorder.[16,24]

People with alcohol use disorder should receive medications in accordance with their preferences and their goals of treatment, and in alignment with their care plan (see quality statement 4).[17] Naltrexone and acamprosate have the best available evidence for alcohol use disorder treament,[16] and it is within a primary care professional's scope of practice to prescribe these medications. If additional support is required when prescribing medications, the primary care professional should consult with another health care professional who has the required expertise. Other medications that are sometimes used for treating alcohol use disorder include disulfiram, topiramate, and gabapentin.[16,17] Medication dosing should be consistent with guidelines, and side effects should be considered before prescribing the medication.[16,17] A detailed assessment (see quality statement 3) will help determine whether the person is taking any other medications that may interact or are contraindicated for use with alcohol use disorder medications. People with alcohol use disorder who are prescribed medications should be offered counselling on the benefits and risks associated with pharmacological therapy.

All health care professionals should facilitate the continued use of medication for those currently receiving this treatment and facilitate access to medication for those requesting initiation. If a person receiving medication for alcohol use disorder enters an inpatient facility (e.g., a hospital), a residential addiction treatment centre, or a correctional facility, their medications should be continued without disruption.

What This Quality Statement Means

For People With Alcohol Use Disorder

Your health care professional should tell you about medications that could help you. They should let you know about the benefits and risks of each medication and help you decide which medication might work best for you.

For Clinicians

Offer people with alcohol use disorder information on and access to medication options that will work best for them in a time frame that enhances treatment outcomes.

For Health Services Planners

Ensure systems, processes, and resources are in place so that clinicians have the knowledge, skills, and judgment to prescribe appropriate medications to people with alcohol use disorder, in a time frame that enhances treatment outcomes.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with alcohol use disorder who receive timely access to medications (as per the definition above)
- Percentage of people who receive naltrexone or acamprosate among those with alcohol use disorder who receive medications to reduce alcohol cravings or consumption

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 1.

9

Concurrent Mental Health and Substance Use Disorders and Comorbid Physical Health Disorders

People with alcohol use disorder who also have a mental health disorder, physical health disorder, or another substance use disorder are offered treatment for their concurrent and comorbid disorders.

Sources: American Psychiatric Association, 2018[16] | Canadian Coalition for Senior's Mental Health, 2019[24] | Management of Substance Use Disorders Work Group, 2015[17] | National Institute for Health and Care Excellence, 2011 (updated 2014)[18]

Definitions

Mental health disorder, physical health disorder, or another substance use disorder: Concurrent mental health disorders commonly include major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder.[18] Physical health disorders related to alcohol use include hypertension, liver disease, and diabetes, but any disorder that requires regular or ongoing care by a health care professional applies. Other substance use disorders include problematic use of illegal drugs, prescription medications, cannabis, or tobacco. Some concurrent and comorbid disorders may remit when alcohol consumption is reduced or stopped, but others may persist and need specific treatment.[18]

Concurrent treatment: Medication and psychological and social interventions for concurrent and comorbid disorders may be administered at the same time as those for alcohol use disorder.[16,17]

Rationale

Many people who have alcohol use disorder also have concurrent and comorbid conditions, such as another substance use disorder, mental health disorders, impulse control disorders (e.g., gambling), and physical health disorders.[16,17] Health care professionals should assess people for concurrent and comorbid disorders, as the presence of another health condition may influence the selection of medication for alcohol use disorder.[16,18,24] Treatment of concurrent and comorbid disorders should not be delayed until the alcohol use disorder is addressed; rather, the disorders should be addressed rapidly and simultaneously. Treating alcohol use disorder can lead to marked improvements in the concurrent and comorbid disorders, and treating the concurrent and comorbid disorders can lead to improvements in the alcohol use disorder. Health care professionals can provide additional information and education to people with alcohol use disorder and their caregivers to enhance their understanding of the relationship between alcohol use and concurrent and comorbid disorders (see quality statement 6). Continued follow-up and monitoring are important to adjust treatment regimens (see quality statement 10).[16,24]

What This Quality Statement Means

For People With Alcohol Use Disorder

If you have a mental health or other medical condition, or if you use other substances, your health care professional should offer you treatment for these conditions too.

For Clinicians

Offer people diagnosed with alcohol use disorder who have concurrent mental health disorders, substance use disorders, or comorbid physical health disorders psychological and social interventions and medications that will help treat the concurrent and comorbid disorders.

For Health Services Planners

Ensure systems, processes, and resources are in place so that people receiving treatment for alcohol use disorder can receive concurrent treatment for mental health disorders, substance use disorders, or physical health disorders.

QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with alcohol use disorder and a mental health disorder, physical health disorder, or another substance use disorder who receive treatment for their concurrent and comorbid disorders

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 1.

10

Monitoring, Support, and Follow-Up

People with alcohol use disorder are offered ongoing follow-up with their health care professional on a regular basis to monitor treatment and response.

Sources: Management of Substance Use Disorders Work Group, 2015[17] | National Institute for Health and Care Excellence, 2011 (updated 2014)[18]

Definitions

Regular basis: Initial follow-up should occur 48 to 72 hours[50] after diagnosis of alcohol use disorder, and follow-up appointments should be pre-booked for subsequent weeks. The length of time between appointments will be determined collaboratively between the person with alcohol use disorder and the health care professional at a schedule that is convenient for both. People should continue to engage with their health care professional for a minimum of 6 months following their diagnosis to assist with treatment continuity and increase the likelihood of improved outcomes.

Treatment and response: Treatment is the consistent use of psychological and social interventions and/or medications, mutually agreed upon by the health care professional and the person with alcohol use disorder.[18] Response to psychological and social interventions and/or medication includes treatment adherence, improved quality of life, improved health status, and improved daily functioning.

Rationale

Alcohol use disorder is a chronic condition, and relapse is common, even if the person's alcohol use is being managed or the person is following their care plan.[17] Monitoring withdrawal symptoms during follow-up appointments can identify the potential for relapse. Relapse occurs when a person has stopped consuming alcohol for a length of time, then begins consuming alcohol again in a harmful manner. Relapse is part of the

recovery process and indicates that the care plan needs to be adjusted or changed for the person to continue their recovery.[17]

Health care professionals should assess the person's response to treatment (psychological and social interventions and medications), consistency of medication use, side effects of medication, new or emerging symptoms, comorbid disorders, and treatment goals.[17,47,54] This can be done in the primary care setting or by a care professional in a community mental health and addictions setting, depending on the person's preference. If the person has multiple care professionals, it is important that they communicate with one another. People have the choice to continue with follow-up care or stop treatment at any time.

What This Quality Statement Means

For People With Alcohol Use Disorder

Your health care professional should make appointments to see you regularly to make sure your treatments are working. If they're not working, your health care professional should work with you to change your care plan, keeping in mind your needs and preferences. If you want, you can invite your caregivers to these appointments too.

For Clinicians

Schedule follow-up appointments to ensure ongoing monitoring and support for people with alcohol use disorder. Assess the person's response to psychological and social interventions and/or medications and make changes to the care plan as needed in collaboration with them.

For Health Services Planners

Ensure systems, processes, and resources are in place so that people with alcohol use disorder are monitored on an ongoing basis by their health care professional until treatment consistency and the desired response are achieved.

QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with alcohol use disorder who receive ongoing follow-up with their health care professional to monitor treatment and response for a minimum of 6 months post-diagnosis

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 1.

Appendices

Appendix 1. Measurement to Support Improvement

The Alcohol Use Disorder Quality Standard Advisory Committee identified some overarching goals for this quality standard. These goals were mapped to indicators that can be used to monitor the progress being made to improve care for people with problematic alcohol use and alcohol use disorder. Some indicators are provincially measurable, while some can be measured using only locally sourced data.

Collecting and using data associated with this quality standard is optional. However, data will help you assess the quality of care you are delivering and the effectiveness of your quality improvement efforts.

We realize this standard includes a lengthy list of indicators. We've given you this list so you don't have to create your own quality improvement indicators. We recommend you identify areas to focus on in the quality standard and then use one or more of the associated indicators to guide and evaluate your quality improvement efforts.

To assess equitable delivery of care, you can stratify locally measured indicators by patient socioeconomic and demographic characteristics, such as age, education, gender, income, language, and sex.

Our measurement guide for the *Problematic Alcohol Use and Alcohol Use Disorder* quality standard provides more information and concrete steps on how to incorporate measurement into your planning and quality improvement work.

How to Measure Overall Success

Indicators That Can Be Measured Using Provincial Data

Rate of emergency department visits entirely caused by alcohol within the last 12 months per 100,000 population

- Denominator: total number of people 10 years of age and older
- Numerator: number of emergency department visits with wholly alcohol-attributable conditions among people 10 years of age and older within the last 12 months
- Data source: National Ambulatory Care Reporting System

Rate of hospitalizations entirely caused by alcohol within the last 12 months per 100,000 population

- Denominator: total number of people 10 years of age and older
- Numerator: number of hospitalizations with wholly alcohol-attributable conditions among people 10 years of age and older within the last 12 months
- Data sources: Discharge Abstract Database, Hospital Morbidity Database, National Ambulatory Care Reporting System, Ontario Mental Health Reporting System

Percentage of people who were heavy drinkers in the past year

- Denominator: number of people 12 years of age and older who responded to survey questions about their alcohol use in the past 12 months
- Numerator: number of people whose survey responses indicate they are heavy drinkers
- Data source: Canadian Community Health Survey
- Note: the survey sample is weighted so that results are estimates of the total population

Indicators That Can Be Measured Using Only Local Data

Percentage of people with alcohol use disorder who receive care in primary care settings

- Denominator: total number of people with alcohol use disorder
- Numerator: number of people in the denominator who receive care in primary care settings
- Data source: local data collection

Percentage of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings who are screened for problematic alcohol use and alcohol use disorder using a validated tool

- Denominator: total number of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings
- Numerator: number of people in the denominator who are screened for problematic alcohol use and alcohol use disorder using a validated tool
- Data source: local data collection

Percentage of people with alcohol use disorder who report a positive experience of care

- Denominator: total number of people with alcohol use disorder
- Numerator: number of people in the denominator who report a positive experience of care
- Data source: local data collection

Percentage of people with alcohol use disorder who have a follow-up appointment with a health care professional after leaving the hospital

- Denominator: total number of people who spend time in hospital for their alcohol use disorder
- Numerator: number of people in the denominator who have a follow-up appointment with a health care professional after leaving the hospital
- Data source: local data collection

Percentage of people with alcohol use disorder and their caregivers who receive information, education, and support appropriate for their needs and preferences

- Denominator: total number of people with alcohol use disorder and their caregivers
- Numerator: number of people in the denominator who receive information, education, and support that is appropriate for their needs and preferences
- Potential stratification:
    - People with alcohol use disorder
    - Caregivers of people with alcohol use disorder
- Data source: local data collection

Percentage of health care professionals and service providers who receive education about alcohol use disorder

- Denominator: total number of health care professionals and service providers
- Numerator: number of people in the denominator who receive education about alcohol use disorder
- Data source: local data collection

How to Measure Improvement for Specific Statements

Quality Statement 1: Screening

Percentage of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings who are screened for problematic alcohol use and alcohol use disorder using a validated tool

- Denominator: total number of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings
- Numerator: number of people in the denominator who are screened for problematic alcohol use and alcohol use disorder using a validated tool
- Data source: local data collection
- Note: this indicator can also be used to measure overall success

Quality Statement 2: Brief Intervention

Percentage of people 16 years of age and older who screen positive for problematic alcohol use (excluding people who may have moderate to severe alcohol use disorder) who receive a brief intervention within that health care visit

- Denominator: total number of people 16 years of age and older who screen positive for problematic alcohol use (excluding people who may have moderate to severe alcohol use disorder)
- Numerator: number of people in the denominator who receive a brief intervention within that health care visit
- Data source: local data collection

Quality Statement 3: Comprehensive Assessment

Percentage of people who may have alcohol use disorder who receive a comprehensive assessment

- Denominator: total number of people who may have an alcohol use disorder (i.e., people who present with problems related to alcohol use or who are unable or choose not to reduce their alcohol consumption after screening and a brief intervention)
- Numerator: number of people in the denominator who receive a comprehensive assessment
- Data source: local data collection

Quality Statement 4: Care Plan

Percentage of people with alcohol use disorder who have an individualized care plan that is based on their comprehensive assessment and includes appropriate services and treatment goals

- Denominator: total number of people with alcohol use disorder who have a comprehensive assessment
- Numerator: number of people in the denominator who have an individualized care plan that is based on their comprehensive assessment and includes appropriate services and treatment goals
- Data source: local data collection

Percentage of people with alcohol use disorder who have an individualized care plan that was developed collaboratively between the person and their health care professional

- Denominator: total number of people with alcohol use disorder who have an individualized care plan
- Numerator: number of people in the denominator whose individualized care plan was developed collaboratively between the person and their health care professional
- Data source: local data collection

Quality Statement 5: Treatment of Alcohol Withdrawal Symptoms

Percentage of people with alcohol use disorder who experience withdrawal symptoms and who receive assessment, treatment, and support tailored to the severity of their symptoms

- Denominator: total number of people with alcohol use disorder who experience withdrawal symptoms
- Numerator: number of people in the denominator who receive assessment, treatment, and support tailored to the severity of their symptoms
- Potential stratification: severity of withdrawal symptoms
- Data source: local data collection

Percentage of people with alcohol use disorder who are discharged from the emergency department after being treated for alcohol withdrawal and have a follow-up visit with their health care professional within 3 days

- Denominator: total number of people with alcohol use disorder who are discharged from the emergency department after being treated for alcohol withdrawal

- Numerator: number of people in the denominator who have a follow-up visit with their health care professional within 3 days
- Data source: local data collection
- Note: This indicator does not demonstrate whether the visit with the health care professional was related to the treatment received

Quality Statement 6: Information and Education

Percentage of people with alcohol use disorder and their caregivers who receive information, education, and support that is appropriate for their needs and preferences

- Denominator: total number of people with alcohol use disorder and their caregivers
- Numerator: number of people in the denominator who received information, education, and support that is appropriate for their needs and preferences
- Potential stratification:
    - People with alcohol use disorder
    - Caregivers of people with alcohol use disorder
- Data source: local data collection
- Note: this indicator can also be used to measure overall success

Quality Statement 7: Psychological and Social Interventions

Percentage of people with alcohol use disorder who receive information on psychological and social interventions that address their needs and preferences

- Denominator: total number of people with alcohol use disorder
- Numerator: number of people in the denominator who receive information on psychological and social interventions that address their needs and preferences
- Data source: local data collection
- Note: the target of this indicator is not 100%, because patients may choose not to receive the information

Quality Statement 8: Medications to Reduce Alcohol Cravings or Consumption

Percentage of people with alcohol use disorder who receive timely access to medications

- Denominator: total number of people with alcohol use disorder
- Numerator: number of people in the denominator who receive timely access to medications (immediately at diagnosis in emergency department or primary care

settings or at subsequent visits in primary care settings, or within 48 to 72 hours after diagnosis if referred to another care setting)
- Data source: local data collection

Percentage of people who receive naltrexone or acamprosate among those with alcohol use disorder who received medications to reduce alcohol cravings or consumption

- Denominator: total number of people with alcohol use disorder who receive medications to reduce alcohol cravings or consumption
- Numerator: number of people in the denominator who receive naltrexone or acamprosate
- Potential stratification:
  - People who receive naltrexone
  - People who receive acamprosate
- Data source: local data collection

Quality Statement 9: Concurrent Mental Health and Substance Use Disorders and Comorbid Physical Health Disorders

Percentage of people with alcohol use disorder and a mental health disorder, physical health disorder, or another substance use disorder who receive treatment for their concurrent and comorbid disorders

- Denominator: total number of people with alcohol use disorder and a mental health disorder, physical health disorder, or another substance use disorder
- Numerator: number of people in the denominator who receive treatment for their concurrent and comorbid disorders
- Data source: local data collection

Quality Statement 10: Monitoring, Support, and Follow-Up

Percentage of people with alcohol use disorder who receive ongoing follow-up with their health care professional to monitor treatment and response for a minimum of 6 months post-diagnosis

- Denominator: total number of people with alcohol use disorder
- Numerator: number of people in the denominator who receive ongoing follow-up with their health care professional to monitor treatment and response for 6 months post-diagnosis
- Data source: local data collection

Appendix 2. Glossary

Alcohol use disorder: According to *The Diagnostic and Statistical Manual of Mental Disorders,* 5th edition, the term "alcohol use disorder" is characterized by a cluster of behavioural and physical symptoms that may include withdrawal, tolerance, and cravings.[4] Alcohol use disorder is defined as a problematic pattern of alcohol use (occurring over a 12-month period) leading to clinically significant impairment or distress, as manifested by at least two of the following, with severity of symptoms—mild, moderate, or severe—based on the number of criteria met[4]:

1. Alcohol is taken in larger amounts or over a longer period than intended
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects
4. There is a strong desire or urge to use alcohol (cravings)
5. Recurrent alcohol use results in a failure to fulfill major role obligations at work, school, or home
6. Alcohol use continues, despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use
8. Alcohol use recurs in situations in which it is physically hazardous
9. Alcohol use continues despite knowledge of a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect
    b. A markedly diminished effect with continued use of the same amount of alcohol
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for alcohol
    b. Taking alcohol (or a closely related substance, such as a benzodiazepine) to relieve or avoid withdrawal symptoms

Health care professional: Regulated professionals, such as nurses, nurse practitioners, pharmacists, physicians, physiotherapists, psychologists, occupational therapists, social workers, and specialists.

Primary care: A setting where people receive general health care (e.g., screening, diagnosis, and management) from a regulated health care professional whom the person can access directly without a referral. This is usually the primary care physician, family physician, nurse practitioner, or other health care professional with the ability to make referrals, request biological testing, and prescribe medications.[17,18]

Problematic alcohol use: The amount of alcohol a person consumes that puts them, their family members, or the general public at risk for harm and that increases the person's risk of developing diagnosable alcohol-related health disorders[27] and the risk of premature death.[28] Other consequences associated with problematic alcohol use include professional, personal, financial, and legal problems that can adversely affect a person's health outcomes.[29] The amount of alcohol consumed may affect certain populations (e.g., older adults, youth, or women) differently depending on age, other health conditions, risk of other diseases, and personal circumstances.

Although no amount of alcohol consumption comes with zero risk,[30] Canada's low-risk drinking guidelines recommend[24,27]:

- For women*:
  - Older than 24 years of age, no more than 10 standard drinks per week, with no more than 2 standard drinks per day most days and no more than 3 standard drinks per day on special occasions[27]
- Older than 65 years of age, no more than 5 standard drinks per week, with no more than 1 standard drink per day most days[24]
- For men*:
  - Older than 24 years of age, no more than 15 standard drinks per week, with no more than 3 standard drinks per day most days and no more than 4 standard drinks per day on special occasions[27]
  - Older than 65 years of age, no more than 7 drinks per week, with no more than 1 or 2 standard drinks per day most days[24]
- Planning non-drinking days every week to reduce your risk of developing problematic alcohol use
- Choosing not to consume alcohol if you are pregnant, planning on becoming pregnant, or breastfeeding[27]
- Encouraging parents to speak with their teenagers about alcohol consumption. If teenaged people choose to drink, they should be supervised by their parents and never drink more than 1 or 2 drinks at a time, and never more than 1 or 2 drinks per week[27]
- Not exceeding the low-risk drinking guidelines for adults if you are 24 years of age or younger, including the special occasion alcohol consumption limit[27]

A single standard alcoholic drink is measured as follows[24,27]:

- Beer: 341 mL or 12 oz, 5% alcohol content
- Cider or cooler: 341 mL or 12 oz, 5% alcohol content
- Wine: 142 mL or 5 oz, 12% alcohol content
- Distilled alcohol (rye, rum, gin, etc.): 43 mL or 1.5 oz, 40% alcohol content

*In the low-risk drinking guidelines, “men” and “women” refer to sex assigned at birth (usually determined by primary sex characteristics), not necessarily gender identity.

Service providers: Unregulated providers—such as addiction workers, behavioural support workers, personal support workers, recreational staff, addictions workers, volunteer providers, or spiritual care staff—who provide care to people with problematic alcohol use and alcohol use disorder.

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