Illustrative Cases of Screening Outcomes and Suggested Care provider Support

Case 1: A 21-year-old has toenail fungus that makes him uncomfortable wearing sandals at church picnics. You, the care provider, ask him, "I discuss the effects of alcohol with all my patients. Negative effects are now known to emerge at lower levels than previously believed. Would it be alright to talk about Canada's Guidance on Alcohol and Health today?" He states: "I don't drink very often and I'd prefer to focus on my toes today." The care provider can: a) note this response in the chart for future inquiry about alcohol; b) move on to focus on the presenting complaint as the patient has requested [Algorithm: row 1, right column].

Case 2: A 55-year-old retiree presents with low mood and feelings of loneliness in the wake of their youngest daughter going to university. They are agreeable to talking about alcohol but, after hearing about Canada's Guidance on Alcohol and Health state that they do not drink regularly stating that, perhaps every month or two, they will drink a maximum 1-2 drinks when out for dinner. Further screening is unnecessary. The care provider can: Provide brief education aimed at reinforcing safer alcohol use [Algorithm: row 2, right column].

Case 3: A 30-year-old carpenter requires a note for their workplace after sustaining an injury while playing softball (sprained ankle). They express a willingness to talk about alcohol and describe limiting drinking to "a can of beer after work" and a "max of 3 drinks" when socializing two or three times per month. They acknowledge drinking "2 or 3" beers before the injury occurred. The care provider asks "Do you feel you have any concerns with your alcohol use, including controlling your use, or that you continue to use alcohol despite it causing significant problems in your work or social relationships, or problems with your physical or mental health?" The patient strongly denies problems of this nature and volunteers "zero" problem taking the month off of drinking in January with their partner when they both felt they were drinking too much over the holidays, and denies health or social problems attributable to alcohol. Further screening for AUD is not indicated at this time. The care provider can: Provide evidence-based advice on progressively increasing risks and strategies to reduce alcohol use. In this specific case, some focus on health effects of 7-10 drinks per week according to the CGAH and greater awareness of injury risk when drinking would be appropriate [Algorithm: row 5, right column].

Case 4: A 22-year-old university student presents to a student health clinic to discuss her oral contraceptive. She is agreeable to talk about alcohol, indicates that she only drinks about once or twice per month, and states that she feels she does not have problems with her alcohol use. However, when alcohol use is quantified with the suggested algorithm, the student describes

heavy drinking nights “often after exams,” and that her friends have put themselves in risky situations during these episodes. She also shares that, on one of these nights, her boyfriend got in a physical altercation outside a bar which was highly out of character for him. The student’s drinking pattern is consistent with the CGAH-identified progressively increasing risks that emerge during episodes of drinking above 2 standard drinks. The care provider should utilize Brief Intervention with a focus on raising awareness and addressing the various risks that can come with heavy episodic or “binge” drinking including risks of traumatic injury, physical and sexual violence. [Algorithm: row 5, right column].

Case 5: A 30-year-old teacher presents to a care provider with a concern of insomnia and anxiousness. They agree to talking about alcohol and describe drinking up to a half a bottle of wine daily, “sometimes more.” The care provider asks “Do you feel you have any concerns with your alcohol use, including controlling your use, or that you continue to use alcohol despite it causing significant problems in your work or social relationships, or problems with your physical or mental health?” The patient describes a single Driving Under the Influence (DUI) charge "a few months ago” and some recognition that alcohol, while temporarily helpful in getting to sleep, probably worsens sleep overall. The care provider can move on to assess for possible AUD diagnosis and offer care accordingly.

- Scenario A) If no diagnosis of AUD is reached [Figure 1: row 5, right column] the physician can: “Provide evidence-based information on alcohol risks and, where appropriate, strategies to reduce alcohol use (Table 2).” Here, Brief Intervention-based strategies for reducing alcohol use can also be provided as well as stressing the importance of avoiding impaired driving, along with close regular (e.g., monthly) follow up to assess progress. For instance, patients who are unsuccessful with cutting down may ultimately be diagnosed with AUD whereas other patients may respond well to brief intervention.
- Scenario B) Alternatively, if a DSM-5 AUD diagnosis is reached [Algorithm: row 5, left column], a discussion about initiation or referral for treatment according to the recommendations of the full CRISM guideline can be initiated depending on AUD severity (mild vs moderate vs severe).

Case 6: A 35-year-old lawyer presents to a care provider having been admitted to hospital for alcohol-attributable pancreatitis the previous week. The patient’s records demonstrate history of asking for help to cut down alcohol use approximately 6 months prior. The need to move directly to an AUD diagnosis is unambiguous given that the “pre-test probability” of an AUD is so high. The care provider should skip screening and move directly to assessing for AUD according to DSM-5 criteria. Full description of how to undertake a DSM-5 diagnosis, and appropriate steps or referrals for AUD treatment, are available in the full CRISM guideline.

Case 7: A 17-year-old attends to a clinician to seeking antibiotics after a minor cut sustained at his weekend landscaping job has become infected. While addressing the presenting complaint, the clinician uses a non-judgemental approach to open up the conversation about alcohol and then states: “Canada’s current guidance highlights that youth alcohol use can be extremely risky for serious harms and recommends youth delay as long as possible. Of course, I am aware that it is not uncommon for young people to start experimenting with alcohol at your age. Have you noticed that some of your friends have begun trying alcohol.” The youth shares that some of his friends have stolen their parent’s alcohol and that one friend has an older brother who has bought them beer. He then describes his own use as limited to once or twice in the last six months and that he has not had any problems. The clinician should use the opportunity to tailor a description of the unique short and long-term risks of under-age drinking including (but not limited to) injuries, violence and worsening academic performance, and make clear that no safe level of youth alcohol use has been defined. They should also indicate a welcomeness to a follow up appointment any time in the future should concerns with alcohol emerge. Special considerations for youth who use alcohol are described in the full CRISM guideline.