THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Medicine

Emergency Care BC
Provincial Health Services Authority

Enhancing Emergency Department (ED) Supports for Patients with Alcohol Use Disorder (AUD)

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I would like to acknowledge my presence on the traditional, ancestral, and unceded tmx̓ʷúlaʔxʷ (land) of the syilx / Okanagan people who have resided here since time immemorial. I recognize, honour, and respect the syilx / Okanagan lands upon which I live, work, and play

Overview of Presentation

- Project Context
- Literature Review
- Supplemental Tools
- Implications
- Conclusion

Project Context

IH "AUD in ED" initiative complete - developed and implemented a regional program through extensive stakeholder engagement

Current phase: scaling and spreading learnings across BC through a provincial lens

Developing a province-wide ED survey to understand current practices and assess transferability of the IH model

https://emergencycarebc.ca/lounge/advancing-care-through-interior-healths-alcohol-use-disorder-initiative/

Background

- Research question: What are the current Emergency Department (ED) practice patterns, resources and gaps in care for the management of Alcohol Use Disorder (AUD) across British Columbia?

- Literature Review Focus: What are the barriers and facilitators to relapse prevention pharmacotherapy for AUD in ED settings, both from provider- and patient-perspectives?

Why This Matters

- AUD is common but undertreated
- EDs are key intervention points
- Fewer than 2% of eligible patients receive anti-craving medications
- Goal: close the gap between evidence and practice

Purpose of the Literature Review

1. Synthesize existing evidence
2. Identify gaps
3. Inform survey development

Methods

Databases: PubMed, Google Scholar, Web of Science, PsycINFO

Keywords: AUD, pharmacotherapy, ED, barriers, facilitators

Focus on implementation and Canadian relevance

3 Studies

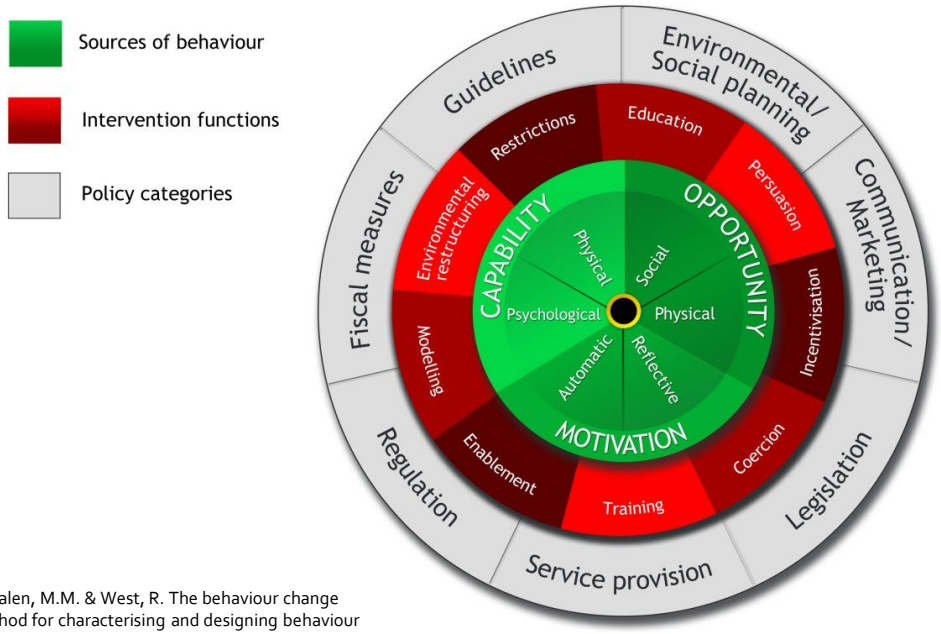
Study 1: Covarrubias et al. (2025)

- **Mixed-methods**: contextual inquiry (*n = 16)* and survey (*n = 160)* in a US ED setting

Covarrubias, I., Dart, H., Adams, L., Moon, J. C., Huo, S., O'Donnell, N., Ebert, J., Fagen, M., Yan, R. (Rachel), Perrone, J., & Delgado, K. (2025). Evaluation of barriers and interventions for emergency department-initiated naltrexone for the treatment of alcohol use disorder. The Journal of Emergency Medicine. https://doi.org/10.1016/j.jemermed.2025.01.001

Study 2: Philippine et al. (2022)

- Qualitative study using Behaviour Change Wheel (BCW) framework
- Participants: ED staff (*n = 25)* at Olive View-UCLA Medical Center
- Three main domains: capability, opportunity, motivation



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Study 3: Forsgren et al. (2024)

- Follow-up to Philippine et al. (2022), focused on patient perspectives
- Interviews with patients (*n = 28)* offered naltrexone in ED

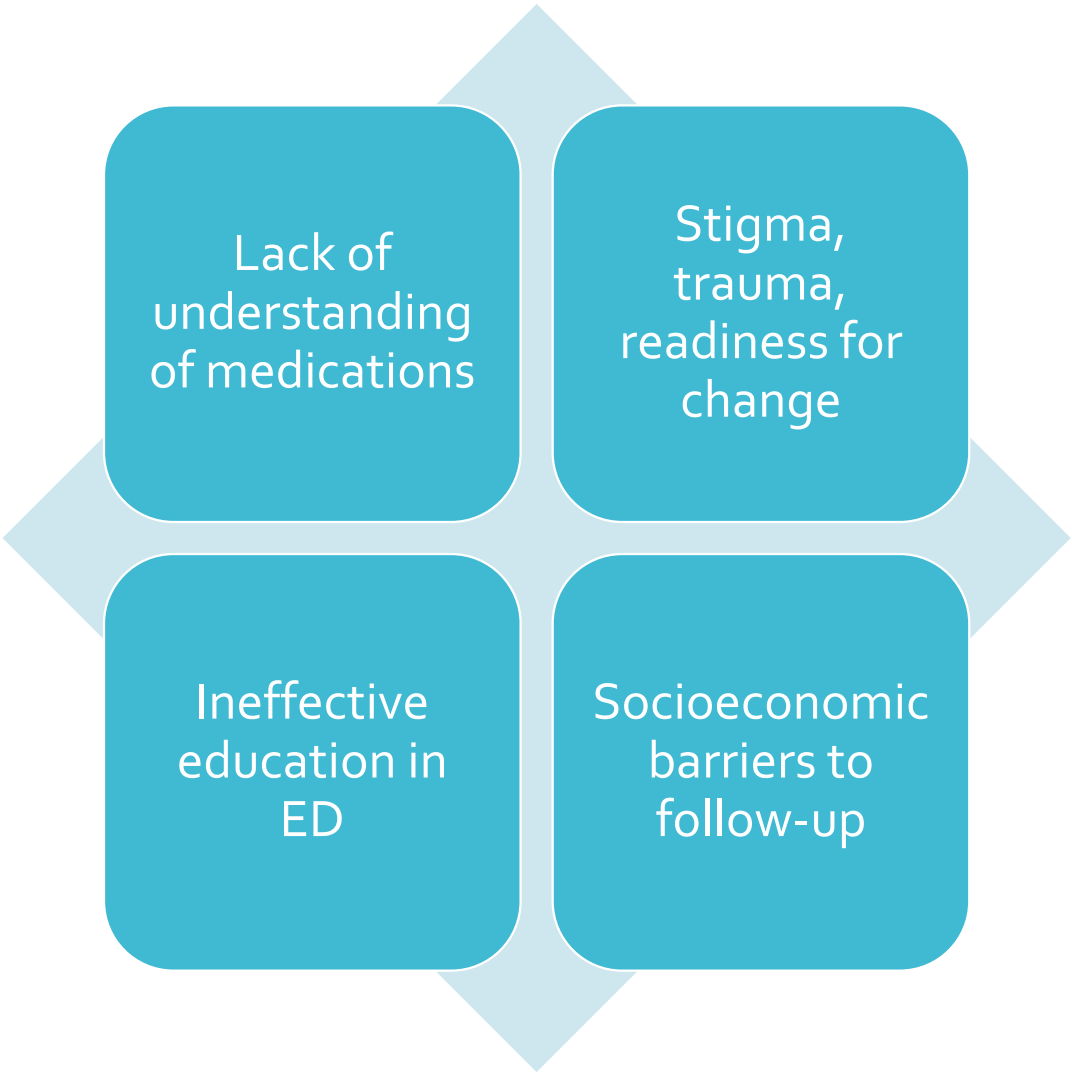
Forsgren, E., Steiger, A., Perez, Y., Salazar, D., McCollough, M., & Taira, B. R. (2024). Patient perspectives on emergency department initiation of medication for alcohol use disorder. Academic Emergency Medicine, 31(5), 471–480. https://doi.org/10.1111/acem.14758

Common Themes from 3 Studies

Key Barriers (Provider-Perspective)

- Lack of screening protocols & role clarity
- Low confidence prescribing naltrexone
- Concerns over follow-up
- Motivation: burnout, stigma, powerlessness

Key Barriers (Patient-Perspective)



Key Facilitators

- Being offered treatment in the first place
- Nonjudgmental, compassionate staff
- Standardized pathways (order sets, navigators)
- Continuing education for ED staff
- Institutional support

Gaps in Literature

- Minimal Canadian research
- Limited data on medications other than naltrexone (e.g. acamprosate, topiramate, gabapentin)
- Limited generalizability
- Small sample size
- Few patient voices in existing data

Supplemental Tool #1: Guideline Comparison Table

- Guidelines compared: BCCSU, GPAC, CMAJ, GRACE-4, Meta-Phi, Interior Health
- Covered medications: naltrexone, acamprosate, topiramate, gabapentin, disulfiram
- Table details: dosing, contraindications, evidence strength, follow-up, barriers/facilitators

Medication	Guideline	Intended Audience	Dosing Recommendations	Benefits	Harms	Suggested Follow up	Facilitators	Barriers	Evidence-based versus Alternative Pharmacotherapy
Naltrexone	BCCSU	Primary care	Start: 12.5mg BID for 3 days Titrate: to 50mg OD over 2 weeks as tolerated	-Particularly effective in preventing return to heavy drinking following a temporary lapse to AU -Reduces cravings in some individuals -Recommended for patients who have a treatment goal of either abstinence or a reduction in alcohol consumption	-Contraindicated: acute hepatitis, liver failure, naltrexone hypersensitivity, any current opioid use (Rx or nonmedical), acute opioid withdrawal -Cautioned Use: renal impairment, severe hepatic impairment, concomitant use of other potential hepatotoxic drugs, pregnancy and breastfeeding, adolescent patients (<18) -Side effects: somnolence, nausea, vomiting, decreased appetite, abdominal pain, insomnia, dizziness	-Increased monitoring if patient has hepatic impairment -Recommended that clinicians routinely check in and provide support with medication adherence and other patient-defined treatment goals through medical management and regular follow-up visits -Liver function tests (LFT) should be assessed at treatment initiation, and again at 1, 3, and 6 months. If LFTs are elevated at baseline, more frequent monitoring is indicated	-High levels of craving and a family history of AUD -May be more effective in individuals who smoke tobacco or use electronic cigarettes	-Classified as *Limited Drug Coverage* – prescribers must submit a Collaborative Prescribing Agreement (CPA) for coverage -> OUTDATED***Review this	Evidence-based
	GPAC	Primary Care	Initial: 12.5 - 25 mg PO daily x 102 weeks Usual/target: 50 mg PO daily Maximum: 100 mg PO daily	- NNT = 20 to prevent return to any drinking (relapse) - NNT = 12 to prevent return to heavy drinking	-Side effects (Most common): nausea, headache, dizziness -Other: sleep disturbances, decreased appetite, abdominal pain, elevated liver enzymes (dose related) - ADRs are generally mild, subside over time, may be avoided if naltrexone started at lower dose and/or if patient is abstinent from alcohol. - has capacity to cause dose-related hepatocellular injury. Contraindications: Naltrexone hypersensitivity, Current opioid use, including prescribed opioids (e.g., opioid agonist treatment) or illicit opioids	- LFTs at initiation, 1 mo, 3 mo and 6 mo. More frequent monitoring if LFTs elevated - Due to risk of hepatic injury, advise patients on signs of acute hepatitis and to stop treatment if symptoms appear.	-Safe to start while using alcohol. May increase effectiveness and decrease adverse events if started 3-7 days in advance -Treatment should not be attempted until patient has remained opioid free 7-10 days	- IM naltrexone not available in Canada	Evidence-based

Supplemental Tool #2: GRADE Evaluation Summary Table

BCCSU, CMAJ, GPAC:
Strong recommendations
- based on **outpatient** care context

GRACE-4 & Meta-PHI:
Weaker recommendations
- reflect **ED-specific** lens and indirect evidence

Implications for Our Survey

- Guide survey content: clinician comfort, role clarity, patient barriers
- Focus on real-world barriers in BC EDs
- Identify actionable areas for improvement

Next Step: Survey Development

- Guided by literature review and expert feedback
- Includes clinical sensibility and cultural safety checks

Call to Action

We want to hear from YOU!

Keep an eye out for our survey – your participation would be greatly appreciated

Q&A

- Thanks for listening – any questions? ☺
- Get in touch with us:
  - ECBC@PHSA.ca

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