

# Geriatric Considerations for Alcohol and Cannabis Use Disorders in Older Adults

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# Objectives

Using Case based learning, we will

- ▶ explore the impact of aging on alcohol and cannabis use disorders in late life.
- ▶ discuss screening and assessment tools appropriate for older adults
- ▶ Reflect on best practise in addictions with older adults with or without dementia
- ▶

# Why is Addiction different in the Geriatric Population?

- ▶ Additional care is required when applying DSM-V diagnostic criteria to older Adults
- ▶ significant problems with even low amounts of alcohol intake
- ▶ tolerance and withdrawal need not be present
- ▶ Physiological aging changes include proportion of body fluids (reduced) & metabolism (slower)
- ▶ NB prolongation of neurological consequences
- ▶ Medications
- ▶ Chronic illness/ dementia

# Why is Addiction different in the Geriatric Population?

- ▶ Alcohol not broken down by the liver goes to the rest of the body, including the brain.
- ▶ Alcohol can affect parts of the brain that control movement, speech, judgment, and memory.
- ▶ These effects lead to the familiar signs of intoxication : difficulty walking, slurred speech, memory lapses, and impulsive behavior.
- ▶ Long-term heavy drinking can shrink the frontal lobes of the brain, which impairs thinking

## Signs of an alcohol or drug problem can be mistaken for Signs of Aging

- ▶ Confusion
- ▶ Depression
- ▶ Disorientation
- ▶ Unsteady gait/falls
- ▶ Recent memory loss
- ▶ Loss of interest in activities
- ▶ Social isolation
- ▶ Tremors
- ▶ Irregular heart rate
- ▶ Poor appetite
- ▶ Stomach complaints

# Geriatric Considerations



They keep asking me to change but I can't remember what from!

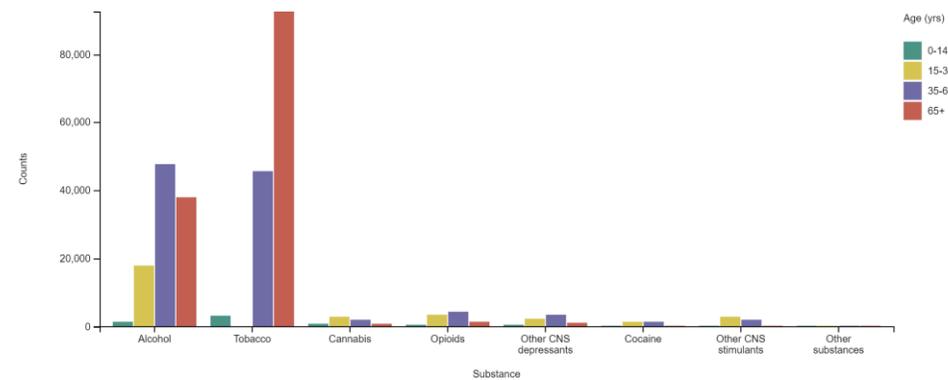
# Reversibility in Alcohol Related Dementia

- ▶ In contrast to other common causes of dementia, it has been suggested that the *decline in cognitive or physical functioning in alcohol-related dementia is relatively non-progressive in abstinent ex-drinkers, or even partially reversible*; this is supported by imaging studies.

Goldman MS. Cognitive impairment in chronic alcoholics. Am Psychol 1983; 38: 1045-54.

# Why be concerned about the older adult?

Substance use-attributable inpatient hospitalizations counts, Canada, 2017



Source: Canadian Substance Use Costs and Harms Scientific Working Group. (2020). Canadian substance use costs and harms visualization tool, version 2.0.0 [Online tool]. Retrieved from <https://csuch.ca/explore-the-data/>

Due to methodological improvements, the 2015-2017 estimates should not be directly compared to estimates for 2007-2014 in the archived database. Data for years 2007-2014 will be updated with these improvements and made available in the online data visualization tool in the near future. For more information, see the User Guide (<https://csuch.ca/explore-the-data/userguide/>).

For details on the methodology used to derive estimates, refer to the CSUCH technical report.

Other CNS depressants exclude alcohol and opioids, and other CNS stimulants exclude cocaine.

These estimates do not include costs or counts associated with inpatient hospitalization, day surgery, and emergency department costs or counts in the province of Québec. Therefore, all estimates should be considered conservative.

Inpatient hospitalization counts and costs for Ontario and Manitoba do not include hospitalizations recorded in the Ontario Mental Health Recording System (OMHRS) because this database does not use the ICD-10 classification system. This likely led to an underestimation of inpatient hospitalizations in those provinces.

In allocating hospitalizations for communicable diseases across the three substances that can be injected (opioids, cocaine and other CNS stimulants), the prevalence of heroin use was used to allocate hospitalizations to opioid use. This likely underestimated the number of communicable disease hospitalizations attributable to opioid use by a maximum of 0.28% of total hospitalizations attributable to opioids in 2015, with smaller impacts across other study years and substances. The estimates for communicable diseases should therefore be treated with caution.

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## Substance use-attributable overall costs, Canada, 2017

Substance	All Costs
Alcohol	\$16,625,022,612
Tobacco	\$12,283,543,585
Cannabis	\$3,240,445,388
Opioids	\$5,950,404,361
Other CNS depressants*	\$1,859,922,139
Cocaine	\$3,713,027,449
Other CNS stimulants**	\$1,978,144,341
Other substances***	\$325,705,232

\* *excluding alcohol and opioids*

\*\* *excluding cocaine*

\*\*\* *including hallucinogens and inhalants*

Source: Canadian Substance Use Costs and Harms Scientific Working Group. (2020). Canadian substance use costs and harms visualization tool, version 2.0.0 [Online tool]. Retrieved from <https://couch.ca/reports/the-data/>

Due to methodological improvements, the 2015-2017 estimates should not be directly compared to estimates for 2007-2014 in the archived database. Data for years 2007-2014 will be updated with the most recent and available in the online data visualization tool in the near future. For details on the methodology used to derive estimates, refer to the CSUCH technical report.

Costs due to premature mortality were estimated by calculating future productive years of life lost due to death. See the CSUCH technical report for more detail.

Other CNS depressants exclude alcohol and opioids, and other CNS stimulants exclude cocaine.

These estimates do not include costs or counts associated with hospitalization, day surgery, and emergency department visits or counts in the province of Quebec, and last

hospitalization counts and costs for Ontario and Manitoba do not include hospitalizations recorded in the Ontario Mental Health Recording System (OMHRS) because this database does not use the ICD-10 classification system. This likely led to an underestimation of inpatient hospitalizations in those provinces.

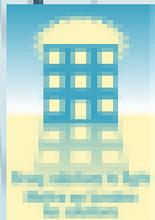
Excluding hospitalizations for communicable diseases across the three substances that can be treated (opioids, cocaine and other CNS stimulants), the prevalence of heroin use was 0.0001% in 2015, 0.0001% in 2016, and 0.0001% in 2017. This is similar across other study years and substances. The estimates for Communicable Diseases (ICD10) should be treated with caution.

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# ALCOHOL USE DISORDER IN OLDER ADULTS

- PREVENTION
- SCREENING
- ASSESSMENT
- TREATMENT



**Canadian Coalition for Seniors' Mental Health**

To promote seniors' mental health by connecting people, ideas and resources.

**Coalition Canadienne pour la Santé Mentale des Personnes Âgées**

Promouvoir la santé mentale des personnes âgées en reliant les personnes, les idées et les ressources.

# Case Study Mr A

- ▶ 74 year old caregiver
- ▶ Increased drinking with burden of caregiving
- ▶ Multiple ED visits for alcohol falls and intoxication
- ▶ Complicated withdrawal resulting in delirium
- ▶ Increased behaviors while in patient
- ▶ Application to long term care
- ▶ Three weeks after admission pt rallies and discharges AMA
- ▶ several subsequent admissions with same sequelae
- ▶ What are the next steps

## #6 SCREENING

Ensure that screening for AUD in older adults is age appropriate and employs active listening, is supportive, accounts for memory impairment or cognitive decline, is non-threatening, non-judgmental, and non-stigmatizing, and recognizes that DSM-5 criteria will under-identify due to reduced occupational or social obligations.

(GRADE: Moderate, Strength: Strong)

# Screening Tools

- ▶ Alcohol Use Disorders Identification Test (AUDIT)
- ▶ CAGE ( not well tolerated in older adults)
- ▶ Shortened Michigan Alcoholism Test - Geriatric version (SMAST-G)
- ▶ Comorbidity Alcohol Risk Evaluation Tool (CARET)
- ▶ Senior Alcohol Misuse Indicator (SAMI)

# Alcohol Use Disorder Assessment

- ▶ Assessment should be comprehensive
- ▶ Include and follow-up with cognitive assessment



# Alcohol Use Disorder Considerations for admission to LTCH

- ▶ Pre admission status ( active or not active)
- ▶ Treat prior to admission or
- ▶ Treat as part of admission
- ▶ Families may be reluctant to admit there is a drinking issue due to stigma /Fear of refusal for admission
- ▶ risk of unsafe withdrawal upon admission if not disclosed.

## #9 ASSESSMENT

A comprehensive assessment is indicated for all older adults who have an AUD, have signs of harmful use, or who present with acute intoxication. The assessment should include: the use of a standardized alcohol use questionnaire to determine quantity and frequency of alcohol use and potential harms; a comprehensive assessment of medication and other substance use; determination of the presence of another substance use disorder; evaluation of physical, mental, and cognitive capacity, nutrition, chronic pain, social conditions, family/social supports, and overall functioning; collateral history. The assessment should be performed regardless of physical, mental, or cognitive co-morbidities with modifications as deemed appropriate.

(GRADE: Moderate, Strength: Strong)

# #10 ASSESSMENT

Assess older adults with AUD for cognitive impairment using a validated tool every 12 months or as indicated. In cases of cognitive impairment, repeat the cognitive evaluation at 6 and 12 months after a reduction or discontinuation of alcohol, to assess for evidence of improvement. The treatment plan should specify the timeline and procedure for ongoing evaluation of clinical outcomes and treatment effectiveness.

(GRADE: Moderate, Strength: Strong)

# PREVENTION

## Low Risk Drinking Guidelines for Older Adults

- For women 65 or older, no more than 1 standard drink per day with no more than 5 per week in total; for men 65 or older, no more than 1 – 2 standard drinks per day, with no more than 7 per week in total. Non-drinking days are recommended every week. (standard drink = 13.45 grams of pure alcohol – e.g. 5 oz. (142ml) of wine at 12% alcohol)
- Depending upon health, frailty, and medication use some adults should transition to these lower levels before age 65.
- As general health declines, and frailty increases, alcohol should be further reduced to 1 drink or less per day, on fewer occasions, with consideration given to drinking no alcohol.

GRADE: Evidence: Low; Strength: Strong

# Alcohol Use Disorder Treatment

- ▶ Stage and gauge
- ▶ Behavioral and pharmacological
- ▶ Psychosocial support
- ▶ PAWSS (prediction of Alcohol Withdrawal Severity Scale)
- ▶ CIWA-Ar & BZRA's
- ▶ Tapering in controlled settings
- ▶ Thiamine
- ▶ Monitor and follow-up
- ▶ Concurrent care



# #19 TREATMENT

Health care practitioners, older adults, and their families should advocate for adequate access and funding for treatment for AUD, specifically access to pharmacotherapy (naltrexone and acamprosate) and psychosocial therapies.

GRADE: Consensus

# TREATMENT

- ▶ Naltrexone and acamprosate pharmacotherapy can be used to treat AUD in older adults, as indicated, with attention to contraindications and side effects. Naltrexone may be used for both alcohol reduction and abstinence, while acamprosate is used to support abstinence. In general, start at low doses and titrate slowly, with attention to open communication with the patient. Initiation may be done in the home, hospital, during withdrawal management, or in long-term care with subsequent transition to an appropriate placement.

- ▶ [GRADE: Evidence: High; Strength: Strong]

# Naltrexone (Revia)

- ▶ Well tolerated
- ▶ NOW AVAILABLE on ODB formulary
- ▶ Safety:
  - ▶ No major liver side effects if the patient “sampled” alcohol  
Only half as likely to relapse
- ▶ Compliance/Adherence:
  - ▶ Older patients more likely than younger to take Naltrexone regularly(Oslin, 2002);less likely to relapse than younger;
  - ▶ better attendance at therapy sessions than younger patients taking naltrexone

NB Older adults appear to respond well to a medically oriented program that is supportive and individualised

# KINDLING EFFECT OF WITHDRAWAL

- ▶ Increasing severity of withdrawal following repeated withdrawal episodes
- ▶ Increasing risk of seizures on withdrawal with increasing number of withdrawal episodes
- ▶ Progressive brain damage excitatory neurotransmitters with each withdrawal episode
- ▶ May lead to permanent brain damage (dementia)
- ▶ Prompt treatment with benzodiazepines to prevent seizures may prevent further damage
- ▶ Thiamine

# Withdrawal cognitively impaired

- ▶ Never initiate withdrawal with out medical supervision
- ▶ If no history of complicated withdrawal Primary care can monitor
- ▶ Weekly Taper alcohol intake slowly no more than 10 % of intake or 1 standard drink per week
- ▶ Behaviors around reduced amounts?
- ▶ redirect offer non alcohol based beverages
- ▶ Cautious use of dealcoholized beverages with cognitively impaired not to be used instead of **unless the person is already withdrawn from alcohol**

# Case study: Mr A

- ▶ Next steps
- ▶ planned admission with consideration to need for supported withdrawal
- ▶ Delirium
- ▶ Approaches to care included one to one
- ▶ Use of anti craving medications
- ▶ Discharge home with follow-up with addiction medicine
- ▶ No relapse for two months until medications were stopped
- ▶ Abstinence resumed with initiation of Naltrexone
- ▶ Mr. A improved cognitively , was able to get drivers license back
- ▶ Improved relationships

# #17 TREATMENT

As a harm reduction strategy for older adults in controlled environments, where medical withdrawal is not available or deemed appropriate, it is recommended that a managed alcohol taper be considered. Individualize the taper by 1 standard drink every 3 days (aggressive tapering), weekly (moderate tapering), or every 2-3 weeks (mild tapering) with CIWA-Ar monitoring to keep the withdrawal symptom score < 10. The approach should be individualized, incremental, and with an indeterminate timeline.

**GRADE:** Consensus

# Alcohol Use Disorder Considerations for admission to LTCH

- ▶ Pre admission status ( active or not active)
- ▶ Treat prior to admission or
- ▶ Treat as part of admission
- ▶ Families may be reluctant to admit there is a drinking issue due to stigma /Fear of refusal for admission
- ▶ risk of unsafe withdrawal upon admission if not disclosed.

# How to support transitions to long term care

- ▶ Ensure supported withdrawal of substance with follow-up
- ▶ Include plan for smokers to ensure safe transition
- ▶ Use of Addiction medicine to manage more complex pts

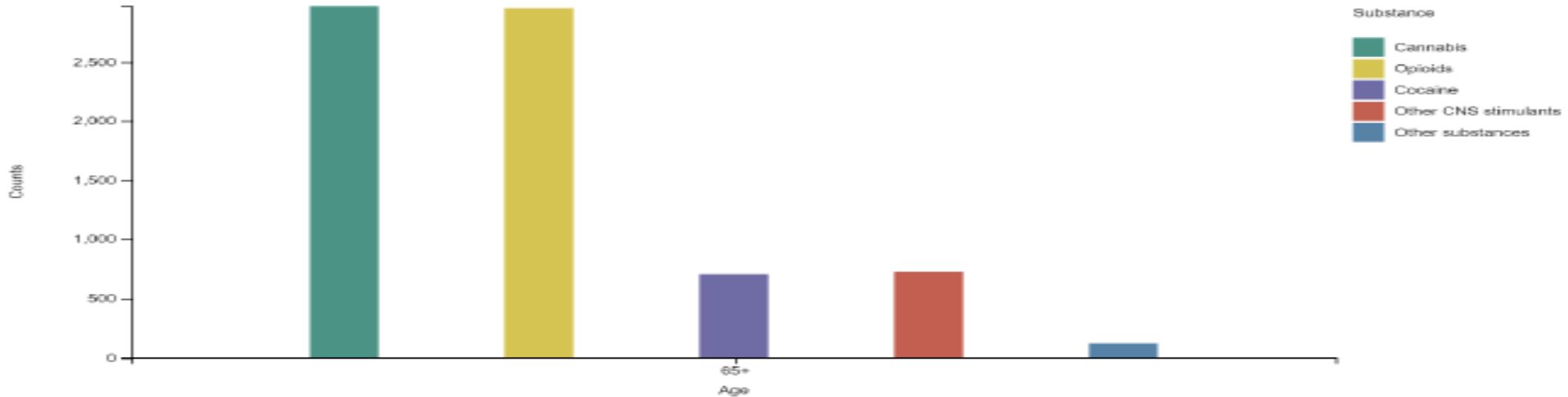
# Cannabis and Older Adults Considerations

## Geriatric

- ▶ Effects on Cognition
- ▶ Pain management
- ▶ Driving/ impairment

# Cannabis & older Adults

## Substance use-attributable emergency department visits counts, Canada, 2017



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Who uses cannabis more? Youth or older adults?

- ▶ Older adults account for the largest number of new users of cannabis since legalization

# Why is this happening

- ▶ Older adults are among the top new users of Cannabis
- ▶ Older adults are seeking alternatives for treatment of pain
- ▶ Edibles
- ▶ Car accidents
- ▶ Hyperemesis syndrome

# Quick Summary - CUD Guideline recommendations for Older Adults (OA)

## PREVENTION & EDUCATION

- 1 Use in Psych/SUD/CI/CVD should be avoided
- 2 Counsel on Adverse Effects/Events/Psych Comorbidity and Proper Medical Indication
- 3 Provide counselling to **both** OA & Caregivers
- 4 OA more susceptible to dose-related adverse events
- 5 Counsel on possible increased risk with higher THC
- 6 Counsel on Risks associated with different modes of use of cannabis and cannabis products
- 7 Avoid illegal synthetic cannabinoids (e.g. K2 & SPICE)
- 8 Risk of cannabis-induced impairment especially if cannabis-naïve or titrating to a new dose
- 9 Potential long-term effects of frequent cannabis use include respiratory, precancerous changes, CI, Psych especially when high THC used
- 10 Cannabis Impairment
  - driving up to 24 hours
  - cannabis and alcohol should be avoided
  - dangerous to ride as a passenger with a driver who has used previous 24 hours
- 11 Counsel on the signs, symptoms, and risks of Cannabis Withdrawal (CW)

# Quick Summary - CUD Guideline recommendations for Older Adults (OA)

## ASSESSMENT & RECOGNITION

- |    |   |
|----|---|
| 12 | Obtain non judgmental histories about signs & sx's of CUD that may be similar to age-related CNS changes  |
| 13 | Screen for :<br>- use of all cannabis and cannabinoids, tobacco, alcohol, and other drugs<br>- amount, type, and frequency of cannabis or cannabinoid using CUDIT |
| 14 | Symptoms of aging can overlap with CUD  |
| 15 | a) Assess for modes of use<br>b) Assess for frequency and dosage  |
| 16 | Assess for CW in CUD; care with pace of reduction of cannabis   |
| 17 | Assess for Cannabis Hyperemesis Syndrome  |

## MANAGEMENT

- |    |   |
|----|---|
| 18 | Manage CUD using SBIRT model  |
| 19 | Consider Peer Support for CUD management  |
| 20 | Support either Harm Reduction or Relapse Prevention with CBT, MI, MBRP, MET, CM |
| 21 | Little evidence for Pharmacotherapy with CW or CUD                              |
| 22 | Consider Residential Tx if unable to reduce with other tools                    |

# *Does Cannabis can help manage behavioural symptoms of people with dementia.*

- ▶ According to the Alzheimer Society of Canada, a few clinical trials have shown Cannabis to be helpful in managing behavioural symptoms of people with dementia, including agitation and physical response behaviours/expressions., but only in some cases. In fact, some studies have shown that long-term Cannabis use may be harmful and is associated with cognitive difficulties.

Alzheimer Society of Canada

<https://www.ccsa.ca/early-and-regular-cannabis-use-strong-predictor-cognitive-impairment>

# What are the risks of using Cannabis?

- Worsening Cirrhosis if you have liver disease
- Risk for unintentional poisoning
- Risk of nervousness, feeling suspicious, disturbed thinking, panic attacks and can lead to a mental illness
- Risk of severe vomiting
- Risk of worsening a psychotic disorder or schizophrenia
- Developing or worsening breathing problems, including an increased risk of developing long term health problems such as chronic bronchitis and shortness of breath
- Use of Cannabis is known to affect cognition

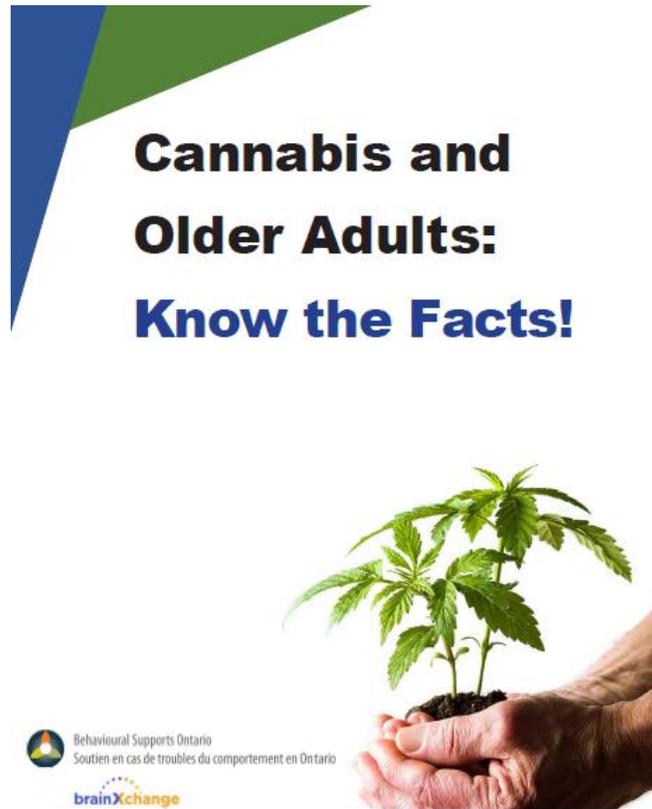


# Resources

- ▶ Geriatric Addiction Rounds Second Tuesday of the month Noon to 1:00 pm
- ▶ Email [Mwhite-Campbell@Baycrest.org](mailto:Mwhite-Campbell@Baycrest.org)
- ▶ Geriatric Addiction rounds Archives <https://brainxchange.ca/Public/Special-Pages/Search?searchtext=substance+use+collaborative+&searchmode=anyword>
- ▶ Cannabis and Older Adults Know the Facts
- ▶ [https://brainxchange.ca/Public/BSO/Files/Substance-Use/Cannabis-Older-Adults-Know-the-Facts\\_Accessible\\_Fl.aspx](https://brainxchange.ca/Public/BSO/Files/Substance-Use/Cannabis-Older-Adults-Know-the-Facts_Accessible_Fl.aspx)

# Older adult Substance Use Collaborative Cannabis and Older Adults Know the FACTS!

<https://brainxchange.ca/Public/Resource-Centre-Topics-A-to-Z/Substance-Use.aspx>



POCKET GUIDES [https://www.nicenet.ca/product-](https://www.nicenet.ca/product-page/management-of-alcohol-use-disorders-in-older-adults-)  
[page/management-of-alcohol-use-disorders-in-older-adults-](https://www.nicenet.ca/product-page/management-of-alcohol-use-disorders-in-older-adults-)

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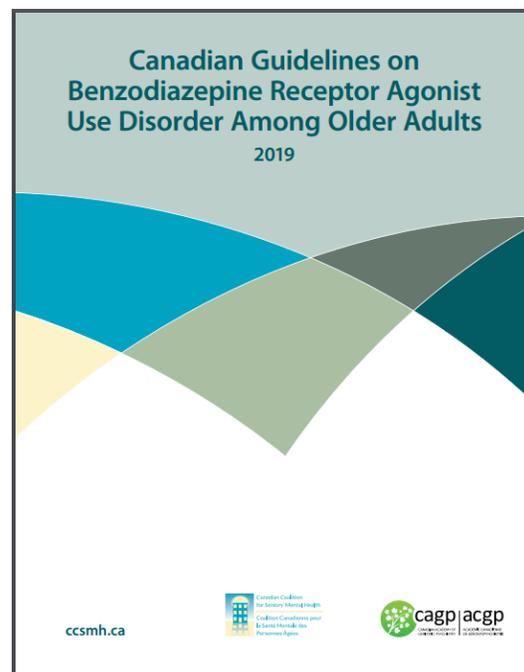
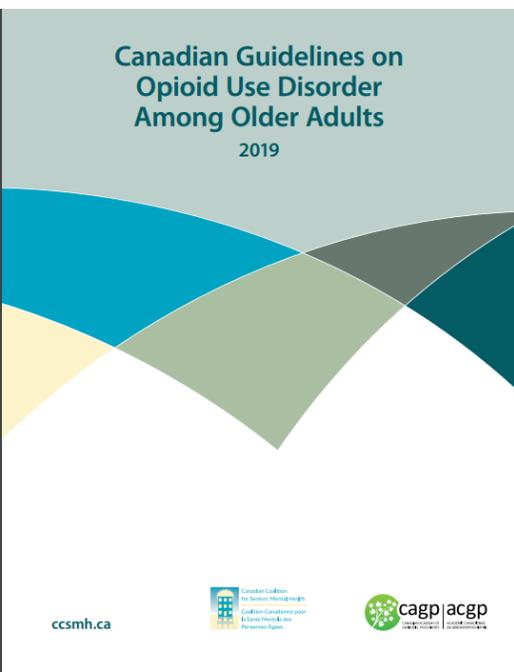
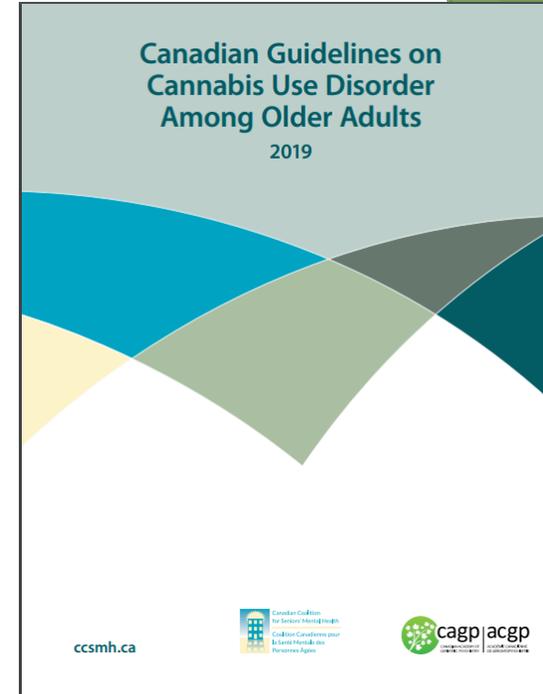
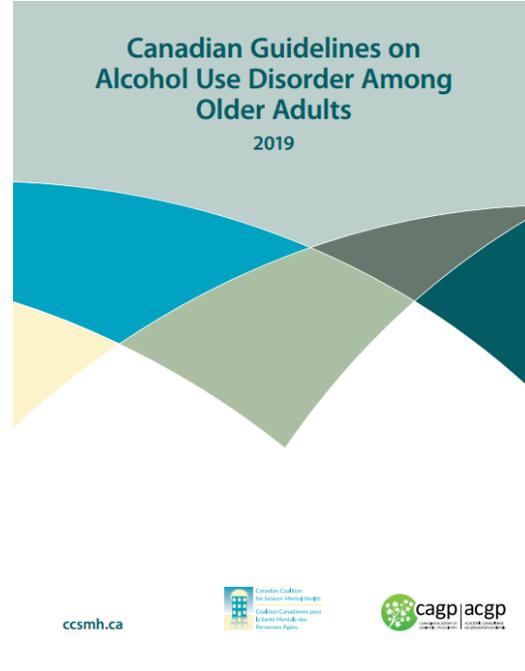
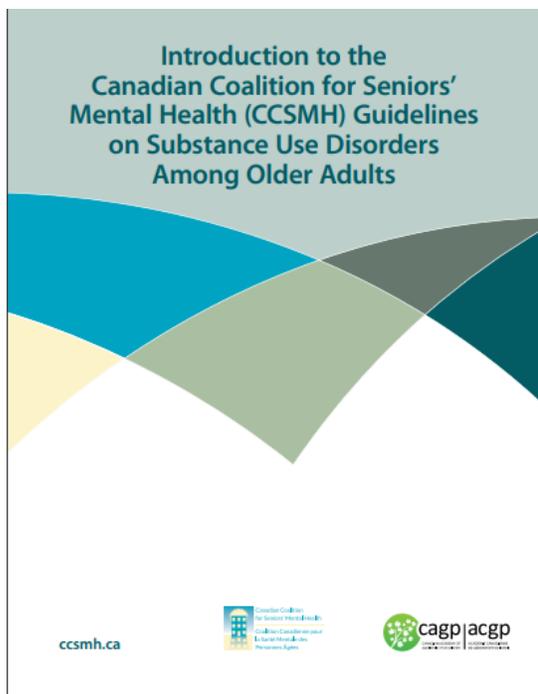
**MANAGEMENT OF  
ALCOHOL USE  
DISORDERS IN  
OLDER ADULTS:**

What Doctors Need to Know

o-know

**OPIOIDS,  
BENZODIAZEPINES  
AND THE ELDERLY:**

A pocket guide



All available for  
download at  
[www.ccsmh.ca](http://www.ccsmh.ca)

# Screening tools

- ▶ SAMI Senior Alcohol Misuse Indicator  
<https://www.porticonetwork.ca/documents/21686/0/SAMI+fillable/f6668443-559f-4ad8-9e5f-6de47a38e70a>
- ▶ MOCA <https://www.mocatest.org/>
- ▶ GDS <https://consultgeri.org/try-this/general-assessment/issue-4.pdf>
- ▶ Morse Falls Scale  
<http://www.networkofcare.org/library/Morse%20Fall%20Scale.pdf>
- ▶ Fagerstrom Nicotine Dependence Scale  
[http://ndri.curtin.edu.au/btitp/documents/Fagerstrom\\_test.pdf](http://ndri.curtin.edu.au/btitp/documents/Fagerstrom_test.pdf)