Canadian Guidelines for Older Adults: Prevention, Assessment and Treatment of Alcohol Use Disorder

Brain Xchange
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FCFP

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.

Disclosures

- Relationships with commercial interests: **None**
- Potential for conflict(s) of interest:
- **None**
- Working Group members were carefully screened for any COI and received an honorarium for their work on the project.

Disclosures

- **Funding:** The Canadian Coalition for Seniors Mental Health was funded by Health Canada's Substance Use and Addictions Program to create a set of four guidelines:
- The prevention, assessment, and management of Substance Use Disorders among older adults for Alcohol, BZRAs, Cannabis, and Opioids.

Acknowledgements

- Claire Checkland (Project Director)
  Indira Fernandez (Project Coordinator)

  Guidelines Steering Committee: D. Conn (chair). P.Butt, M. White-Campbell. J. Bertram, A. Porath, D. Seitz; D. Hogan, Z. Samaan, L. Rieb., K. Rabheru.

- Steering Committee of CCSMH & Co-chair K. Rabheru
- Canadian Centre on Substance Use & Addiction (CCSA)
- Behavioural Supports Ontario Substance Use Collaborative
- Baycrest, Bruyere, CAGP, CAMH, CGS, CMHA, NICE, Reconnect (COPA)
- Reviewers: Dr. S. Davies, Dr. B. Farrell, Dr. M. Kahan, Dr. K. Reimers

- Health Canada – Substance Use and Addictions Program (SUAP)

  The views expressed herein do not necessarily represent the views of Health Canada.

Canadian Coalition for Senior's Mental Health

The Canadian Coalition for Seniors' Mental Health (CCSMH) was established in 2002 and its mission is to *promote the mental health of seniors by connecting people, ideas, and resources.*

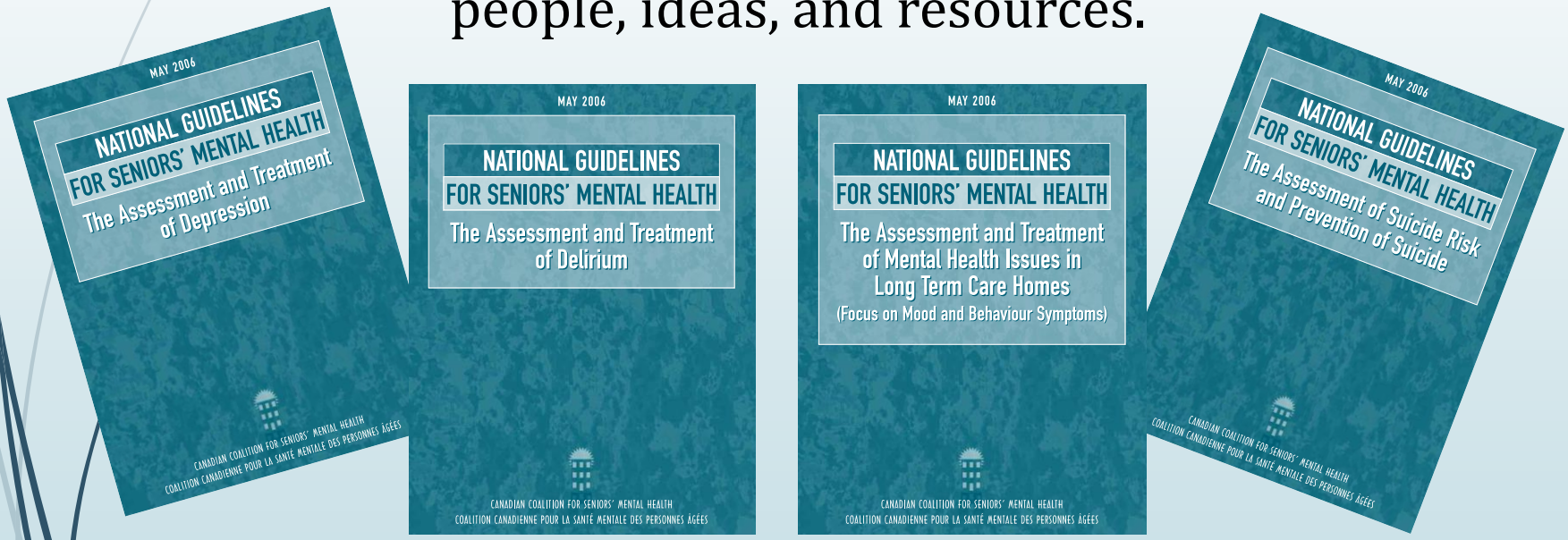
The CCSMH is driven by national representation across 12 organizations.

Through the leadership of the CCSMH steering committee and collaborative partners across Canada, we strive to achieve the following objectives:
Education, Advocacy / Public Awareness, Research, Best Practices - Assessment & Treatment, Family Caregivers & Human Resources.

Canadian Coalition for Seniors' Mental Health (CCSMH)

The mission of the CCSMH is:

To promote the mental health of older adults by connecting people, ideas, and resources.



Objectives

Highlight key issues and challenges related to substance use in older adults.

List key recommendations from the OA Canadian Guidelines for Alcohol Use Disorder prevention, screening, assessment and treatment

Identify and **describe** the unique paths, opportunities and challenges in implementation and knowledge translation

Canadians have several misperceptions when it comes to substance use among older adults.

Some don't think it's an issue at all. Others believe it's too late to improve the quality of life of someone who uses substances in older age.

Why try to get somebody to quit smoking after 50 years? Isn't the damage already done?

Nothing could be further from the truth!"

http://www.ccsa.ca/Resource%20Library/CCSA-Substance-Use-and-Aging-Report-2018-en.pdf

What Do We Know About Substance Use In Older Adults?

- **SUDs are common in geriatric patients:**
  - **21–44% in psychiatric population**
  - **14–21% in geriatric medical population**

- **Increased vulnerability to effects of substance due to unique physiological, psychological, social and pharmacological circumstances**

The challenge of complex clinical presentations
  - **Co-morbidities, cognitive impairment, polysubstance use**

The baby boom generation was the first generation to be significantly exposed to recreational drugs and reports a higher lifetime prevalence of use and past year use than any generation that precedes them.

thebmj

BMJ 2017;358:j3885 doi: 10.1136/bmj.j3885 (Published 2017 August 21)

EDITORIALS

Check for updates

Substance misuse in older people

Baby boomers are the population at highest risk

Rahul Rao *visiting researcher*[1], Ann Roche *director*[2]

[1]South London and Maudsley NHS Foundation Trust, London, UK; [2]National Centre for Training and Addiction, Flinders University Faculty of Medicine, Nursing and Health Sciences, Adelaide, Australia

Alcohol

Baby boomers' drink and drug misuse needs urgent action, warn experts

By 2020, the number of over-50s receiving treatment for substance misuse problems is expected to double in Europe and treble in the US, say researchers

Nicola Davis

@NicolaKSDavis

Wednesday 23 August 2017 06.00 BST

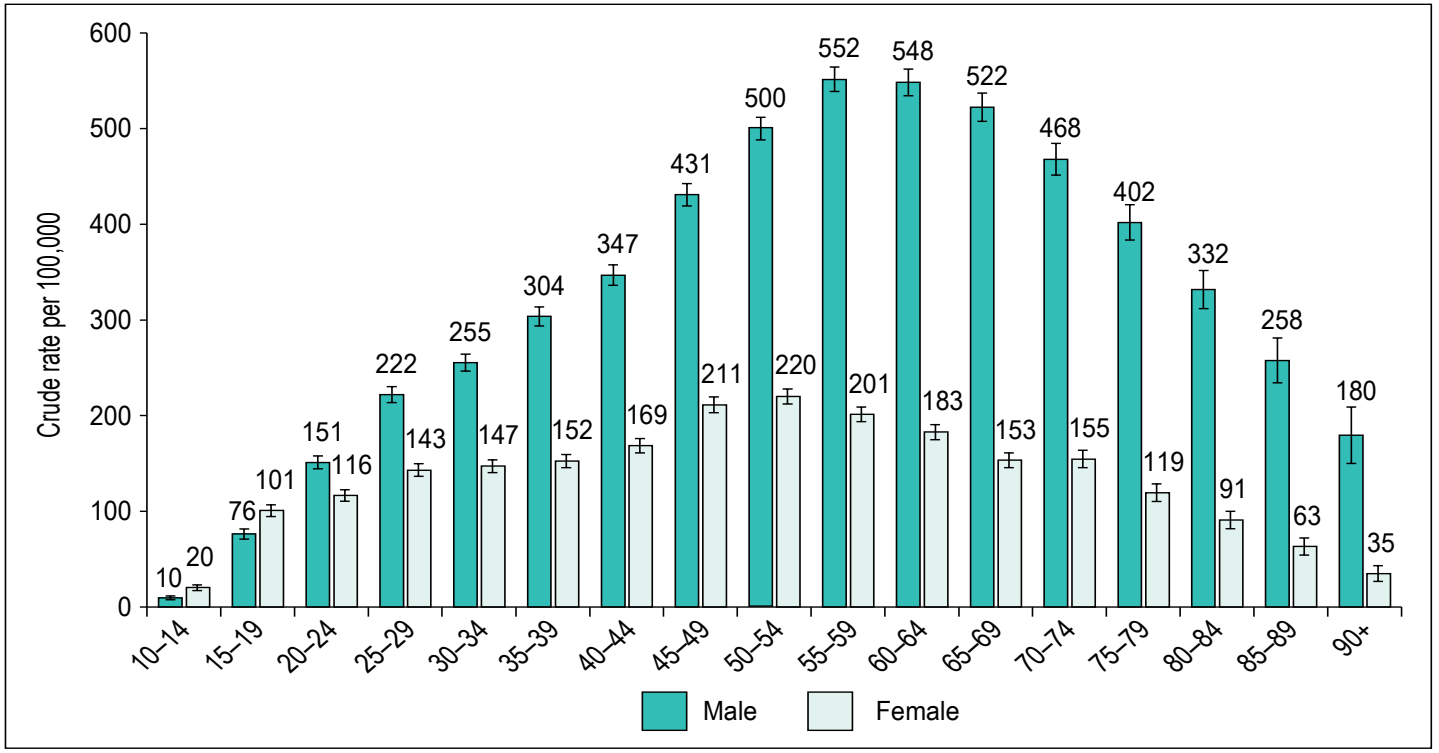
A 2011 report advised that due to age-related physiological and metabolic changes, older people should drink no more than 11 units of alcohol per week. Photograph: Alamy

Which substance do you believe is currently causing the most harm to older adults in Canada ?

- Alcohol
- Benzodiazepines
- Cannabis

- Opioids
- Nicotine
- Other

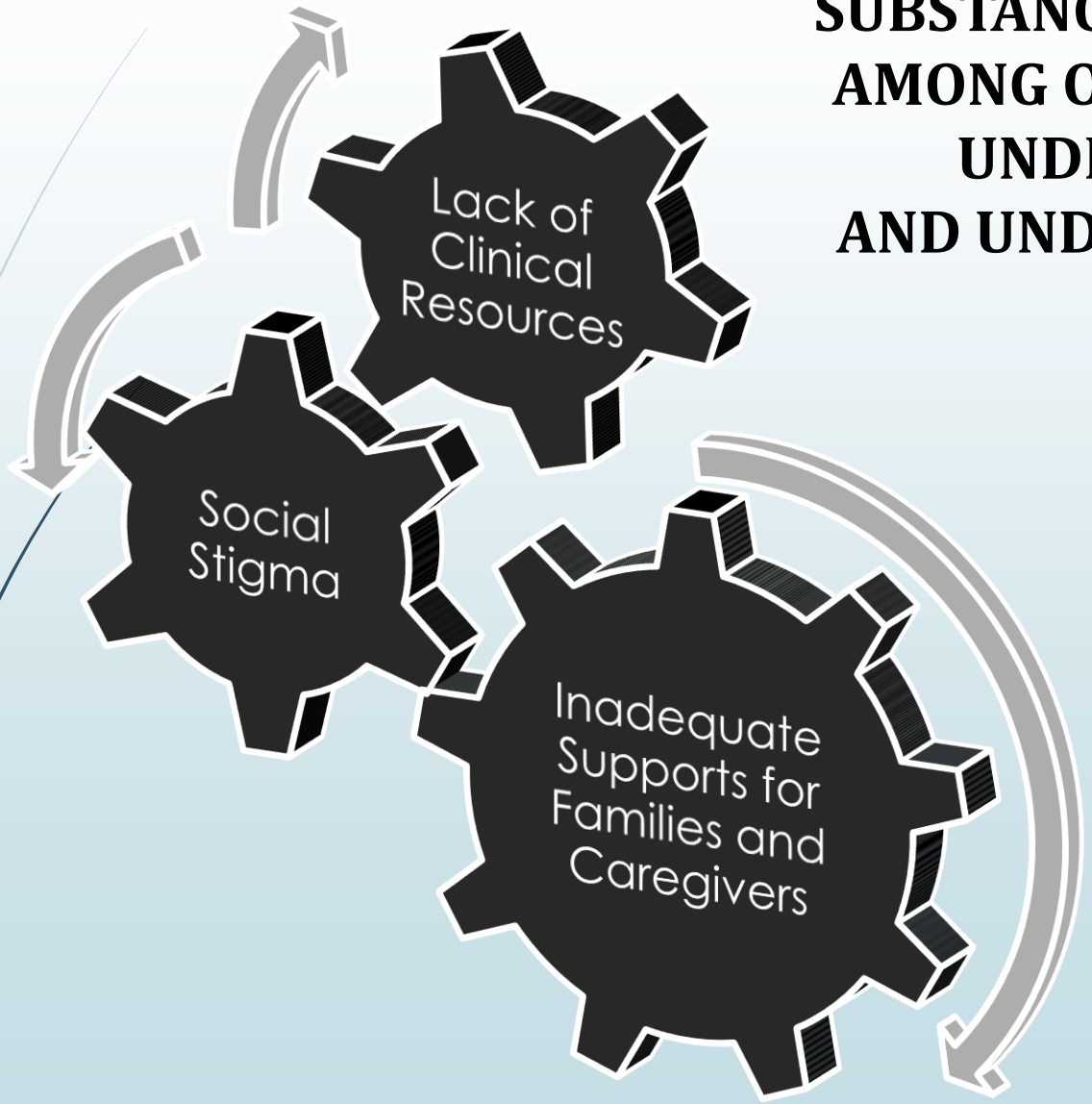
Figure 5 Crude rates for Hospitalizations Entirely Caused by Alcohol per 100,000 population age 10+, by age group and sex, 2015–2016



Sources

Hospital Morbidity Database, Discharge Abstract Database, National Ambulatory Care Reporting System and Ontario Mental Health Reporting System, 2015–2016, Canadian Institute for Health Information; population estimates, 2015, Statistics Canada.

Older Adults Face Unique Barriers



SUBSTANCE USE DISORDER AMONG OLDER ADULTS IS UNDER-STUDIED AND UNDER-IDENTIFIED!

Guideline Methods

- Interdisciplinary guideline committee was formed including a PWLE for each of the guidelines.
- Literature search:
  - Existing guidelines, meta-analyses, literature review, and website search
  - Databases: Cochrane Library, EMBASE, MEDLINE, PsycInfo, PubMed
- Selected literature appraised with the intent of developing evidence-based, clinically sound recommendations
  - AGREE II used to identify guidelines that are of sufficient quality to inform guideline development

GRADE: an emerging consensus on rating quality of evidence and strength of recommendations

BMJ | 26 APRIL 2008 | VOLUME 336

Developed by a widely representative group of international guideline developers

Clear separation between quality of evidence and strength of recommendations

Explicit evaluation of the importance of outcomes of alternative management strategies

Explicit, comprehensive criteria for downgrading and upgrading quality of evidence ratings

QUALITY OF EVIDENCE

HIGH	Further research is unlikely to change confidence in the estimate of effect
MODERATE	Further research is likely to have an important impact on the confidence in the estimate of effect and may change the estimate
LOW	Further research is very likely to have an important impact on the confidence in the estimate of effect and is likely to change the estimate

Note: *Meta analyses and Randomized Controlled Trials are considered high quality vs. Observational studies which are considered low quality*

STRENGTH OF RECOMMENDATION

STRONG	Strong recommendations indicate high confidence that desirable consequences of the proposed course of action outweigh the undesirable consequences or vice versa.
WEAK	Weak recommendations indicate that there is either a close balance between benefits and down sides (including adverse effects and burden of treatment), uncertainty regarding the magnitude of benefits and down sides, uncertainty or great variability in patients' values and preferences, or that the cost or burden of the proposed intervention may not be justified.

(adapted from Guyatt et al, 2008)

ALCOHOL USE DISORDER IN OLDER ADULTS

- PREVENTION
- SCREENING
- ASSESSMENT
- TREATMENT

Alcohol Working Group

Co-Chairs:

- **Peter Butt**: Addiction Medicine, U. Saskatchewan
- **Marilyn White-Campbell**: Addiction Specialist, COPA/Reconnect

Working Group Members:

- **Lisa Van Bussel**: Geriatric Psychiatry, U. Western Ontario
- **Sarah Canham**: University Research Associate, SFU
- **Ann Dowsett-Johnston** (PWLE): Journalist, Recovery Advocate
- **Eunice Indome**: Student Member, U. Waterloo
- **Bonnie Purcell**: Clinical Psychologist, London Health Sciences Centre
- **Jennifer Tung**: Pharmacist, GeriMedRisk

Alcohol Use Disorder in Older Adults

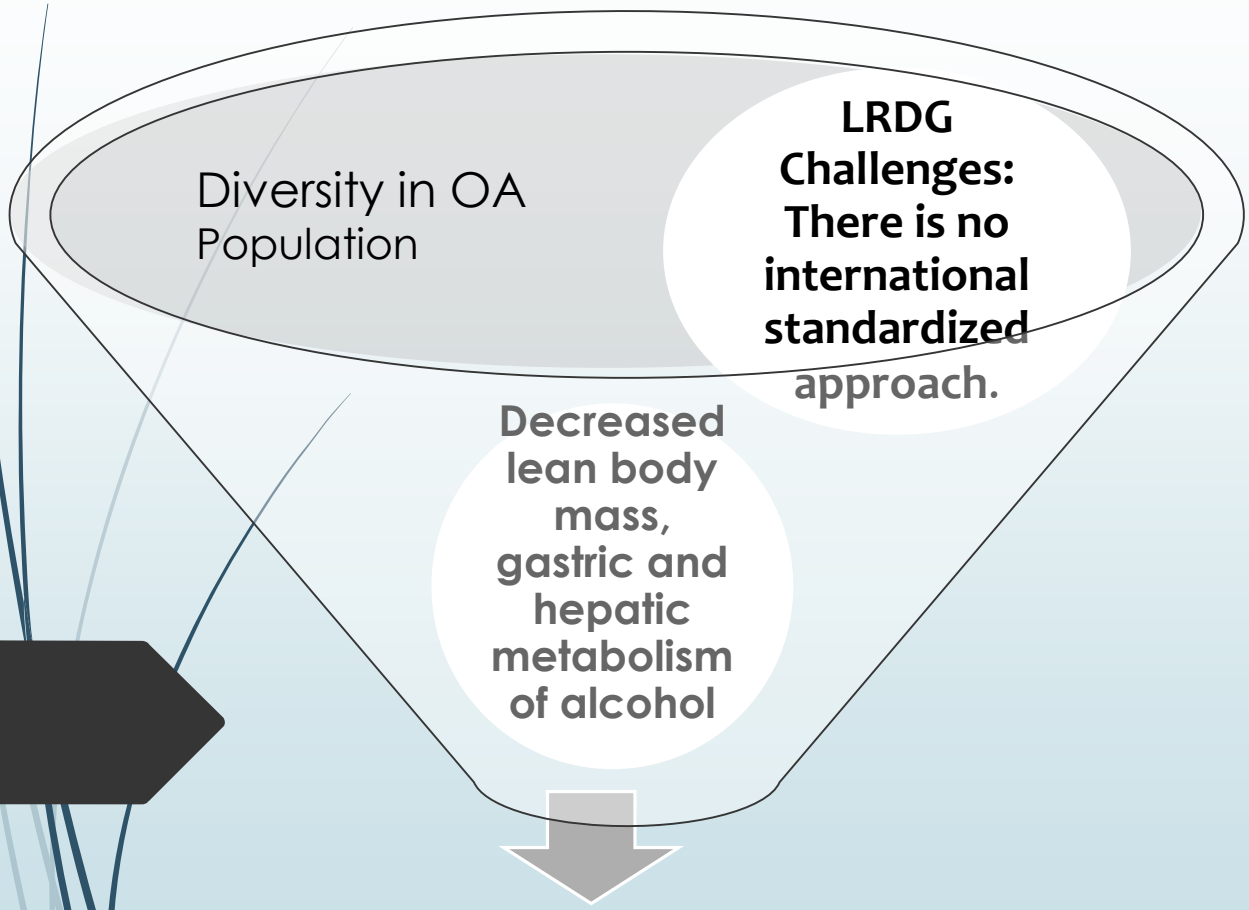
There is a plethora of expert opinion and clinical guidance and yet a paucity of older adult population specific evidence.

Most clinicians extrapolate from adult literature and clinical experience to provide care. These guidelines will either validate that practice, or provide evidence to direct change.

Alcohol Use Disorder Prevention

- Low Risk Drinking Guidelines
- Risk related to alcohol use increases with age, co-morbidities and medications
- Long term drinkers may acquire consequences from their chronic use.
- Previously light drinkers may escalate their use due to boredom, loneliness, sequential losses, grief or coping with other issues.

Alcohol Low Risk Drinking Guidelines in Older Adults



Evolving dementia & concurrent risk of ABIs and / or stroke
Increased frailty with risk of falls

Complexity challenges guidance and communication

Need to establish clear criteria for risk

OA population diversity

Changes in metabolism and physiology with age

Increasing levels of vulnerability over time

#1 PREVENTION

Low Risk Drinking Guidelines for Older Adults, 65 and older

For women, no more than 1 standard drink per day with no more than 5 per week in total; for men, 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.

(GRADE: Moderate, Strength: Strong)

#1A PREVENTION

Low Risk Drinking Guidelines for Older Adults, 65 and older

B) Depending upon health (dementia, Parkinson's Disease, hemorrhagic stroke, epilepsy, cardiac dysrhythmias, hypertension, sleep apnea, COPD, liver disease, pancreatitis, GI and breast cancers), frailty (compromised balance and frailty), and medication use (bzd, opioids, gabapentinoids, sedating antidepressants) some adults should transition to these lower levels before age 65.

(GRADE: High, Strength: Strong)

#1B PREVENTION

Low Risk Drinking Guidelines for Older Adults, 65 and older

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: Low, Strength: Strong)

#2 PREVENTION: LABELLING

- Increase awareness of the risk of alcohol use through labelling that indicates:

- A. Standard Drink content of the product
- B. Low Risk Drinking Guidelines for both adults and older adults
- C. A warning of alcohol related risks and harms

  (cancer, addiction and teratogenicity)

(GRADE: Low, Strength: Strong)

#3 PREVENTION: THIAMINE

- As a harm reduction strategy for chronic heavy drinkers, use at least 50 mg of thiamine per day to prevent Wernicke-Korsakoff syndrome, progressive cognitive decline and increased frailty.

(GRADE: Low, Strength: Strong)

#4 SCREENING

- All patients should be screened for alcohol use at least annually and at transitions of care. Screening should be conducted more frequently if consumption exceeds LRDGs, there are symptoms of an AUD, there is a family history of AUD, they have anxiety or depression, caregivers express concern, or they are undergoing major life changes or transitions.

(GRADE: Moderate, Strength: Strong)

#5 SCREENING

Older adults should be asked about alcohol use in all care settings including: hospitals, rehabilitation facilities, home health care, community services, assisted living and long-term care facilities, and specialized programs.

(GRADE: High, Strength: Strong)

#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
- Shortened Michigan Alcoholism Test – Geriatric version (SMAST-G)
- Comorbidity Alcohol Risk Evaluation Tool (CARET)
- Senior Alcohol Misuse Indicator (SAMI)

#7 SCREENING

Request consent to discuss the patient's alcohol use and its impact with family, friends, and other caregivers.

(GRADE: Low, Strength: Strong)

#8 SCREENING

Older adults who screen positive for an AUD should be assessed by an appropriately trained health care provider.

(GRADE: Moderate, Strength: Strong)

#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)

#11 TREATMENT

The least intrusive or invasive treatment options, such as behavioural interventions, should be explored initially with older adults who present with a mild AUD. These initial approaches can function either as a pre-treatment strategy or treatment itself.

(GRADE: High, Strength: Strong)

#12 TREATMENT

Routinely offer alcohol behavioural intervention and case management with pharmacological treatment (e.g., anti-craving medication) as it may improve the efficacy of primary care treatment.

(GRADE: Moderate, Strength: Strong)

#13 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: High, Strength: Strong)

#14 TREATMENT

All older adults with AUD, and their caregivers and support persons, should be offered psychosocial treatment and support, as indicated, as part of a treatment plan.

(GRADE: Moderate; Strength: Strong)

#15 TREATMENT

Use the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) to screen for those requiring medical withdrawal management (prior delirium, seizures, or protracted withdrawal). Patients who are in poor general health, acutely suicidal, have dementia, are medically unstable, or who need constant one-on-one monitoring should receive 24-hour medical, psychiatric, and/or nursing inpatient care in medically-managed and monitored intensive treatment or hospital settings.

(GRADE: High; Strength: Strong)

#16 TREATMENT

In the management of alcohol withdrawal in older adults, it is best to use the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) symptom score with protocols using a shorter-acting benzodiazepine such as lorazepam. One should also pay close attention to comorbidities to avoid complications.

GRADE: High; Strength: Strong

#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

#18 TREATMENT

To prevent the development of Wernicke's Encephalopathy during withdrawal, at least 200 mg of parenteral thiamine (IM or IV) should be administered daily for 3–5 days.

GRADE: Low; Strength: Strong

#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

#20 TREATMENT

Treatment response for AUD should be monitored though laboratory measures such as gamma-glutamyl transferase (GGT) and Mean Cell Volume (MCT).

GRADE: Moderate; Strength: Strong

#21 TREATMENT

The severity and management of concurrent physical and mental health conditions (including co-occurring psychiatric disorders, suicide risk, and cognitive disorders), as well as significant social transitions in the individual or family, should continue to be reviewed and monitored regardless of continuance, reduction, or cessation of alcohol use.

GRADE: Moderate; Strength: Strong

#22 TREATMENT

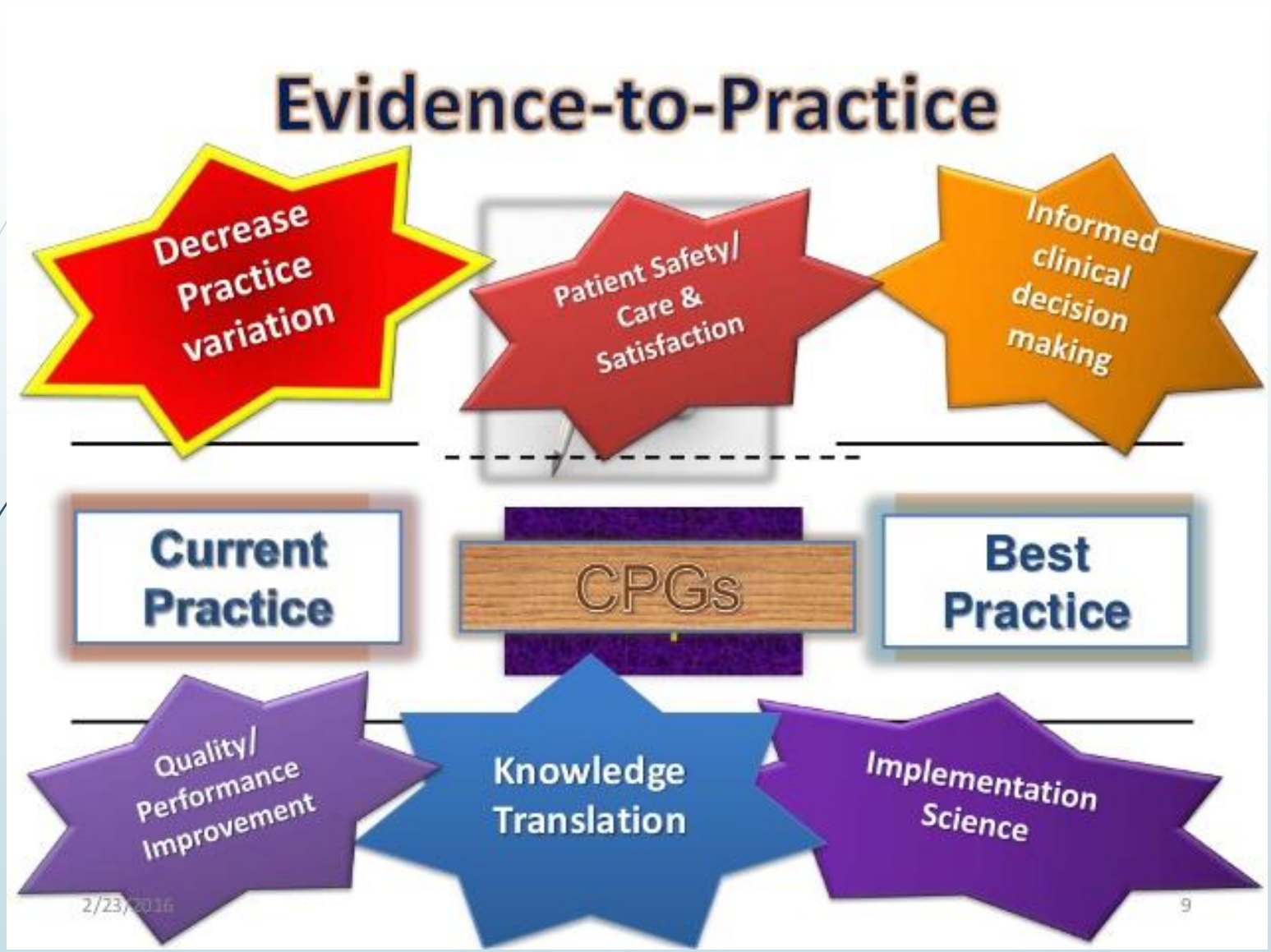
Peri-operative elective surgical management should include medically supported withdrawal or alcohol use taper pre-operatively, with post-operative treatment and consideration of anti-craving medication.

GRADE: Low; Strength: Strong

FUTURE DIRECTIONS

- Approaches to create and improve a seamless continuum of care for AUD for older adults that extends from screening to recovery.
- Efficacy of oral thiamine supplementation to prevent Wernicke-Korsakoff in ongoing chronic, heavy drinkers and clinical practice guidelines on thiamine dosages and routes of administration in alcohol withdrawal.
- Approaches to AUD counselling and supports specific to older adults.
- Efficacy and best practice approaches for managed alcohol tapering as opposed to medical withdrawal.
- Role of alcohol in falls in older adults.

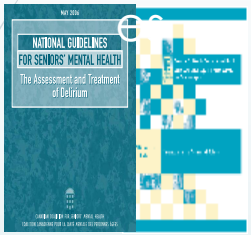
KNOWLEDGE TRANSLATION

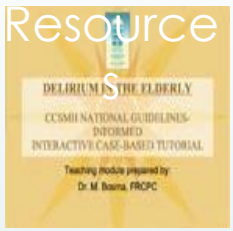

Evidence-to-Practice
Decrease Practice variation
Patient Safety/ Care & Satisfaction
Informed clinical decision making
Current Practice
CPGs
Best Practice
Quality/ Performance Improvement
Knowledge Translation
Implementation Science

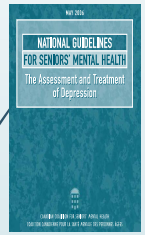
KNOWLEDGE TRANSLATION PRODUCTS

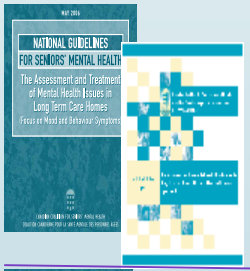
National Guidelines | Clinical Pocketcards | Education Resources | Client Resources | Other

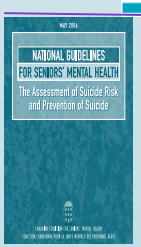
Suicide
MH in LTC
Depression
Delirium



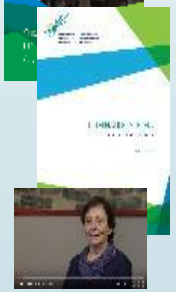








Discharge Planning | Cancer Care | MH Services for Seniors



LET'S GO BEYOND THE GUIDELINES TO KNOWLEDGE TRANSLATION & CLINICAL IMPLEMENTATION

Key KT Products and Tools

- **Webinars:**

Clinical & Community based!

- **Community Brochures & Info Sheets**
- **Clinical Pocket Cards**
- **Guidelines available for online download**

How Will YOU Implement These Changes in Your Organization?

Join CCSMH!

If you're interested in joining, please contact: www.ccsmh.ca

David Conn: Co-Chair, CCSMH

Claire Checkland: Director, CCSMH

Canadian Coalition for Seniors' Mental Health

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


THANK YOU!
Any Questions?
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