The New Canadian Guidelines on Cannabis Use Disorder Among Older Adults

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Canadian Coalition for Seniors' Mental Health
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None

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None

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Overview of presentation

- Acknowledgements
- Defining Substance Use Disorder
- Substance use among older adults
- Scope of Guidelines Project
- Implications and patterns of use among older adults
- Guideline Recommendations

Acknowledgements

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

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

Cannabis Working Group

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- **Andra Smith:** Neuroscientist, University of Ottawa
- **Rand Teed:** Person with Lived Experience, Director of Drug Class Education/Prevention

- “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?

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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

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

This article is 1 month old

2,213

Nicola Davis

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Wednesday 23 August 2017 06.00 BST

The Continuum of Substance Use

- **Beneficial Use**
- **Substance Misuse**
  - dose/route/frequency intensify
  - balance of benefits/risks change
- **Use Disorders** (consequences)
  - **Dependence** (tolerance/withdrawal/loss of control)

Substance Abuse and Mental Health Services Administration (US); Office of the Surgeon General (US).Washington (DC): US Department of Health and Human Services; 2016 Nov.

Substance Use Disorder
DSM-IV versus DSM-5

	DSM-IV Abuse[a]		DSM-IV Dependence[b]		DSM-5 Substance Use Disorders[c]	
Hazardous use	X	≥1 criterion	–		X	≥2 criteria
Social/interpersonal problems related to use	X		–		X	
Neglected major roles to use	X		–		X	
Legal problems	X		–		–	
Withdrawal[d]	–		X	≥3 criteria	X	
Tolerance	–		X		X	
Used larger amounts/longer	–		X		X	
Repeated attempts to quit/control use	–		X		X	
Much time spent using	–		X		X	
Physical/psychological problems related to use	–		X		X	
Activities given up to use	–		X		X	
Craving	–		–		X	

Substance Use Disorder Among Older Adults

What Do We Know About Substance Use In Older Adults?

- Increased vulnerability to effects of substance due to unique physiological, psychological, social and pharmacological factors
- Frequency and longitudinal use
- Co-morbidities, cognitive impairment, polysubstance use
- Under-identified and under-studied
- Stigma

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Scope of Guideline Project

- The Canadian Coalition for Seniors Mental Health (CCSMH) funded by the Substance Use and Addictions Program (SUAP) of Health Canada 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.

GRADE approach

- The GRADE approach was utilized in the creation of these guidelines.
- Quality of evidence for each recommendation:
  High, Moderate or Low
- Strength of each recommendation:
  Strong or Weak
- Alternative rating for some recommendations = C (Consensus)
  - not based on empirical evidence

Guyatt, Gordon et al. (2008). GRADE: An emerging consensus on rating quality of evidence and strength of recommendations. BMJ (Clinical research ed.). 336. 924-6.

Cannabis

- A plant that contains hundreds of compounds including cannabinoids, which act on the endogenous cannabinoid (endocannabinoid) system.

- Delta-9-tetrahydro-cannabinol (THC) and cannabidiol (CBD) are two cannabinoids that have the most available literature.

Pharmacology

- CB1 is located centrally in the brain.
- CB2 is located primarily peripherally and on the circulating immune system throughout the body.

Pharmacology

- THC binds to CB1 receptors
  - Often producing a high or sense of euphoria.
  - THC is also vasoconstrictive to blood vessels in the heart and brain and as such may increase the risk of cardiovascular events including stroke, cardiac arrhythmia, and myocardial infarction.

- CBD binds primarily to CB2 receptor sites.
  - CBD binds weakly to CB1 receptors and may interfere with the binding of THC, resulting in a lack of euphoric and reinforcing effect

Cannabinoid composition of cannabis plant is wide ranging and varies by strain. Some are higher in CBD and others contain more THC- variety of psychosomatic properties.

Adverse events

- Motor Vehicle Collisions
- Cannabis Use Disorder (CUD)
- Long Term Negative Psychiatric Effects
  - increasing depression, anxiety, worsening post-traumatic stress disorder symptoms, panic attacks, and suicidal ideation, attempts, and completion rates
- Non-fatal Overdose (overdoses in those who have ingested edible cannabis derivative products (e.g., gummy bears)

Indications (Limited Evidence)

- Medical evidence that use of **certain cannabinoids** *may* be beneficial for only a small number of clinical indications:
  - chronic neuropathic pain
  - nausea and vomiting due to chemotherapy
  - seizures
  - spasticity in multiple sclerosis
  - stimulation of appetite in patients with severe weight loss due to AIDS and possibly cancer

The pace and scope of cannabis research may require clinical recommendations, such as those below, to be updated and modified more frequently in order to stay current.

Cannabis Timeline

But in both Canada and the United States, more and more older adults are using marijuana in some form — the percentage of Ontarians over 50 who used pot in the past year nearly tripled over the last 10 years, and has risen fivefold since 1977.

Ontario: People over 50 who used cannabis in the last year, 1977-2015 (%)

Source: Centre for Addiction and Mental Health Get the data

Cannabis Challenges

- Physicians have different views on cannabis
- Patients tend to have mixed information about cannabis and its uses
- Multiple Narratives
- Limited evidence based literature on cannabis and cannabis use disorder (CUD) among older adults

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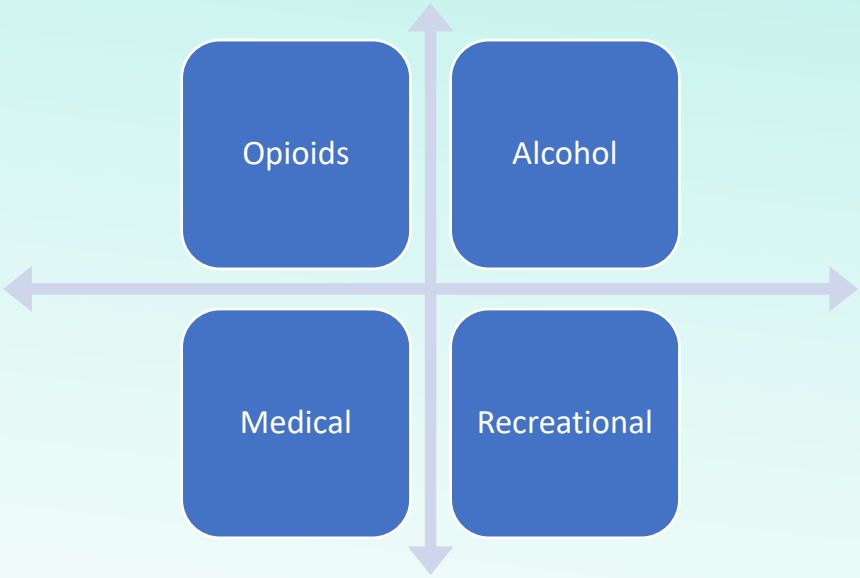
MULTIPLE & CHANGING NARRATIVES

Intersection of use



- Intersection between medical and recreational use

  (Canadian Science Policy Centre- August 20th 2018)

  http://sciencepolicy.ca/news/marijuana-and-older-adults-so-many-burning-questions

Implications for practice

- Decisions based on changing social norms
- Seeking Cannabis through retail and black market
- Accessing based on convenience
- Recreational vs Therapeutic
- Reduced Stigma

Challenges in Practice

- Healthcare providers face challenges mitigating risks due to:
  - the lack of literature on cannabis and cannabis use disorder (CUD)
  - the only recent emergence of guidelines
  - the lack of findings on objective consequences of cannabis use

- Distinction between "therapeutic" vs "recreational" is increasingly ambiguous with lack of standardization between providers

- Difficult to strategically examine literature on Medical Cannabis and Recreational Cannabis

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-naive 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)

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 : - use of all cannabis and cannabinoids, tobacco, alcohol, and other drugs - 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 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

Prevention & Education : Recommendation #1

- Cannabis should generally be avoided by older adults who have:

- a) A history of, or are currently experiencing, mental health disorders, problematic substance use, or Substance Use Disorder (SUD).

- b) Cognitive impairment, cardiovascular disease, cardiac arrhythmias, coronary artery disease, unstable blood pressure, or impaired balance.

[GRADE: Evidence: Moderate; Strength: Strong]

Prevention & Education : Recommendation #2

- Clinicians should be aware that

- a) The current evidence base on the medical use of cannabis is relatively limited. Most derivative products have not been approved as therapeutic agents by Health Canada, with the exception of two pharmaceutical grade cannabinoid products. [GRADE: Evidence: High]

- b) The common signs and symptoms associated with cannabis use, cannabis-induced impairment, cannabis withdrawal, CUD, and common consequences of problematic cannabis use. [GRADE: Evidence: High]

- c) The potential adverse effects of cannabis use in older adults include changes in depth perception risking balance instability and falls, changes in appetite, cognitive impairment, cardiac arrhythmia, anxiety, panic, psychosis, and depression. [GRADE: Evidence: Moderate]

- d) Mental health disorders which are commonly comorbid with CUD such as depression, anxiety, and schizophrenia/psychosis. [GRADE: Evidence: Moderate]

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

Prevention & Education : Recommendation #3

- In order to support the retention of information, clinicians should provide education and counselling with regard to cannabis and cannabinoids to older patients and their family members/caregivers both verbally and in writing.

[GRADE: Consensus]

Prevention & Education : Recommendation #4

- Clinicians should counsel patients, caregivers, and families to be aware that older adults can be more susceptible than younger adults to some dose-related adverse events associated with cannabis use.

[GRADE: Evidence: High; Strength: Strong]

Prevention & Education : Recommendation #5

- Clinicians should advise patients, caregivers, and families about potentially increased risks associated with higher potency delta-9-tetrahydro-cannabinol (THC) extracts, or higher potency strains of cannabis when compared to those with lower THC content.

[GRADE: Evidence: Low; Strength: Strong]

Adverse Effects of THC	Acute	Chronic
Dry Mouth	✔	
Dizziness	✔	
Drowsiness	✔	
Psychoactivity	✔	
Perceptual alterations (i.e. depth)	✔	
Headaches	✔	✔
Changes in Bowel habits	✔	✔
Short-term memory impairment	✔	✔

Attention impairment	✔	
Palpitations/arrhythmias	✔	
Tachycardia	✔	
Postural Hypotension	✔	
Appetite changes	✔	
Falls	✔	✔
Nausea/Vomiting	✔	✔

Important adverse effects of chronic use of THC missing from the table above:

- chronic bronchitis with cough and phlegm
- impaired work or school performance
- greater risk of accidents at work and driving,

Adverse Effects of CBD	Acute	Chronic
Dry Mouth	✔	
Dizziness	✔	
Drowsiness	✔	
Psychoactivity		
Perceptual alterations (i.e. depth)	✔	
Headaches	✔	

Changes in Bowel habits	✔	
Short-term memory impairment		
Attention impairment		
Palpitations/arrhythmias		
Tachycardia		
Postural Hypotension		
Appetite changes	✔	
Falls		
Nausea/Vomiting	✔	

Adverse effects of chronic CBD are largely unknown so far.

Prevention & Education : Recommendation #6

- Clinicians should advise patients, caregivers, and families of risks associated with different modes of use of cannabis and cannabis products (e.g., smoking, vaporizing, oils, sprays, etc.) and counsel patients on these risks.

[GRADE: Evidence: Moderate; Strength: Strong]

Risks associated with chronic use of inhaled formulations include but are not limited to increased risk for bronchospasm mediated by bronchial irritation. Certain cannabis oil pens are made using butane, a carcinogen (Miller et al., 2016)

Based on clinical experience, patients rarely report cognitive side effects when using topical cannabis derivatives for pain, especially CBD-only products, so it may be a lower risk starting point for those without contraindications who wish to try a cannabis product

Prevention & Education : Recommendation #7:

Clinicians should educate patients to avoid illegal synthetic cannabinoids (e.g., K2 and SPICE,) because of the potential to cause serious harm.

[GRADE: Evidence: Low; Strength: Strong]

Using these products can lead to severe health problems such as seizures, irregular heartbeat, and hallucinations (Gunderson et al., 2012; Seely et al., 2012; Harris & Brown, 2013; van Amsterdam et al., 2015). In rare instances, death can occur (Seely et al., 2012; Harris & Brown, 2013; van Amsterdam et al., 2015).

Prevention & Education : Recommendation #8

- Clinicians should educate patients on the risk of cannabis-induced impairment especially if the patient is cannabis-naive or titrating to a new dose. It is recommended that the starting dose should be as low as possible and gradually increased over time if needed.

[GRADE: Evidence: High; Strength: Strong]

Prevention & Education : Recommendation #9

- Clinicians should counsel patients on the potential long-term effects of frequent cannabis use including respiratory problems, precancerous epithelial changes, and cognitive impairment. Patients should also be counselled on the risk of exacerbation of mental health conditions with CUD, especially when high THC strains are used.

[GRADE: Evidence: Moderate; Strength: Strong]

Prevention & Education : Recommendation #10

Clinicians should advise patients, caregivers, and families that:

- a) Cannabis may impair the ability to safely drive a motor vehicle for up to 24 hours.
- b) The use of both cannabis and alcohol together results in synergistic impairment, increases risks for driving, and should be avoided.
- c) It is dangerous to ride as a passenger with a driver who has used cannabis within the previous 24 hours.

[GRADE: Evidence: High; Strength: Strong]

Prevention & Education: Recommendation #11

- Patients, caregivers, and families should be provided with information about the signs, symptoms, and risks of cannabis withdrawal.

[GRADE: Evidence: High; Strength: Strong]

Cannabis Withdrawal Checklist (Budney et al 2003)

- Shakiness/tremulousness
- Depressed mood
- Decreased appetite
- Nausea
- Irritability
- Sleep difficulty
- Increased anger.
- Sweating
- Craving to smoke marijuana, Restlessness
- Nervousness/anxiety
- Increased aggression
- Headaches
- Stomach pains
- Strange dreams

Recognition & Assessment: Recommendation #12

- Clinicians should initiate non-judgmental discussions related to cannabis and cannabinoid use. Careful histories should be obtained from patients, caregivers, and families about signs and symptoms of CUD that may be similar to those of age-related nervous system changes, such as drowsiness, dizziness, memory impairment, and falls.

[GRADE: Evidence: High; Strength: Strong]

Recognition & Assessment: Recommendation #13

All patients regardless of age should be screened for:

- a) The use of non-medical and medically authorized cannabis and cannabinoids, and illicit synthetic cannabinoids as well as tobacco, alcohol, and other drugs. **[GRADE: Evidence: Low; Strength: Strong]**

- b) The amount and type of cannabis or cannabinoid used, and its frequency, by those who acknowledge any use. Those who acknowledge any recent use (any in the past month) should then go on to targeted screening using the Cannabis Use Disorder Identification Test (CUDIT). **[GRADE: Evidence: Low; Strength: Strong]**

Cannabis

The Cannabis Use Disorder Identification Test – Revised (CUDIT-R)

Have you used any cannabis over the past six months? **YES / NO**

If **YES**, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use over the past six months:

1.	**How often do you use cannabis?**				
	Never 0	Monthly or less 1	2–4 times a month 2	2–3 times a week 3	4 or more times a week 4
2.	**How many hours were you "stoned" on a typical day when you had been using cannabis?**				
	Less than 1 0	1 or 2 1	3 or 4 2	5 or 6 3	7 or more 4
3.	**How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?**				
	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
4.	**How often during the past 6 months did you fail to do what was normally expected from you because of using cannabis?**				
	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
5.	**How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis?**				
	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
6.	**How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?**				
	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
7.	**How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children:**				
	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
8.	**Have you ever thought about cutting down, or stopping, your use of cannabis?**				
	Never 0		Yes, but not in the past 6 months 2		Yes, during the past 6 months 4

Scores of 8 or more indicate hazardous cannabis use.
Scores of 12 or more indicate a possible cannabis use disorder, for which further intervention may be required.

For further interpretation see:
Adamson S, Kay-Lambkin F, Baker A, et al. An improved brief measure of cannabis misuse: The Cannabis Use Disorders Identification Test – Revised (CUDIT-R). Drug Alcohol Depend 2010: (In Press).

Recognition & Assessment: Recommendation #14

- Clinicians should be aware that the diagnostic accuracy of some screening tools may be variable given that some of the symptoms of aging may overlap with those of CUD.

[GRADE: Evidence: Moderate; Strength: Weak]

Recognition & Assessment: Recommendation #15

Assessment of CUD in older adults should evaluate:

- a) Modes of use: i.e., ingesting, smoking, vaping, use of extracts, topicals, nabilone, and nabiximols, etc., and consider the risks/benefits/harms of all that apply to the patient. **[GRADE: Evidence: High; Strength: Strong]**

- b) Frequency and dosage. **[GRADE: Evidence: High; Strength: Strong]**

Smoking adversely affects respiratory health outcomes and poses the greatest health risk.

The use of edible cannabis, liquids, and oils may eliminate respiratory risk but these forms of administration introduce the risk of potential use of larger than intended doses because of the delayed onset of effect

Recognition & Assessment : Recommendation #16

Clinical assessment of CUD in older adults should evaluate the signs and symptoms of cannabis withdrawal, with consideration that the rapid reduction or abrupt discontinuation of cannabis use may also be associated with withdrawal symptoms.

[GRADE: Evidence: High; Strength: Strong]

Cannabis withdrawal syndrome (CEP 2018)

- Emerges between 1-3 days of abstinence
- Peak between 2-6 days and lasts up to 14 days

Cannabis Withdrawal

- **The cannabis withdrawal syndrome: current insights (Bonnet & Preuss 2017)**

- Regular cannabis intake is related to a desensitization and downregulation of human brain cannabinoid 1 (CB1) receptors.
- Starts to reverse within the first 2 days of abstinence and the receptors return to normal functioning within 4 weeks of abstinence,
- Severity of CWS highly varies.

Recognition & Assessment : Recommendation #17

- When assessing patients, clinicians should be aware of the risk of cannabis hyperemesis syndrome in association with chronic cannabis use, especially with higher potency preparations.

[GRADE: Evidence: High; Strength: Strong]

Cannabis hyperemesis syndrome (CHS)- Sullivan 2010 (CEP 2018)

- Chronic, heavy use of cannabis (ANY KIND OF EXPOSURE)
- Recurrent episodes of severe nausea and intractable vomiting;
- Abdominal pain;
- Temporary relief of symptoms by taking a hot bath or shower
- Resolution of the problem when cannabis use is stopped.
- *Hypovolemic complications in Older Adults

- It is uncertain whether any of the antinauseant, antiemetic **(odansetron)**, analgesic, antisecretory, prokinetic or sedative medications **(haloperidol 5 mg IV or BZD)** really help.
- **Smoking marijuana during an episode appears not to help**
- Roelofs et al (2005) suggested large doses of risperidone.
- Some literature on 15 CHS patients with **topical capsaicin** (Dezieck et al, 2017) (supplied in concentrations of 0.025 to 0.1 percent) applied once in a thin film over the abdomen

Management: Recommendation #18

- The Screening, Brief Intervention, and Referral to Treatment) (SBIRT)approach should be considered for assessing and managing CUD similarly to other SUDs.

[GRADE: Evidence: Low; Strength: Strong]

Management: Recommendation #19

- Peer support programs should be considered for individuals with CUD.

[GRADE: Evidence: Moderate; Strength: Strong]

Management: Recommendation #20

- It is recommended that a variety of psychosocial approaches be considered for harm reduction or relapse prevention including: Cognitive Behavioural Therapy (CBT), Motivational Interviewing (MI), Mindfulness Based Relapse Prevention (MBRP), Motivational Enhancement Therapy (MET), and Contingency Management (CM).

[GRADE: Evidence: Moderate; Strength: Strong]

Management: Recommendation #21

- There are currently no established pharmacological treatments that have been demonstrated to be safe and effective for either cannabis withdrawal symptoms or CUD.

[Consensus]

Pharmacotherapy- adjunctive

- As a complement to more established first line treatments may be helpful in reducing cannabis withdrawal symptoms and cannabis cravings
  - Gabapentin (low quality evidence)
  - NAC (N-Acetyl Cysteine- used off-label in some Addictive Process Treatment)
  - Nabilone (limited studies over 4 weeks for withdrawal)

Management: Recommendation #22

- Accredited residential treatment should be considered as appropriate for treating CUD if the individual is unable to effectively reduce or cease their cannabis use.

[GRADE: Evidence: Low; Strength: Strong]

KEY RECENT DOCUMENTS

- Canadian Centre on Substance Use and Addiction (CCSA). (2018). Substance use in Canada: Improving quality of life substance use and aging. Retrieved from http://www.ccsa.ca/Resource%20Library/CCSA-Substance-Use-and-Aging-Report-2018-en.pdf

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- Kalant, H., & Porath, A. (2016). Clearing the smoke on Cannabis: Medical use of Cannabis and Cannabinoids - An Update. Retrieved from http://www.ccdus.ca/Resource%20Library/CCSA-Medical-Use-of-Cannabis-Report-2016-en.pdf#search=all%282016%29

Non Medical Cannabis Clinical Tool (2018)

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-naive or titrating to a new dose
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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)

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 : - use of all cannabis and cannabinoids, tobacco, alcohol, and other drugs - 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 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

Questions

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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.

If you would like to be a member join us!

You can reach us through:

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