Older Adults & Alcohol

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PRESENTER DISCLOSURE

- Presenter: Jonathan Bertram
  - Some slides are from previous SUD guidelines presentations through CCSMH
  - Some slides are from “Alcohol” CAMH Older Adults and Substances Textbook (Author= Presenter)

- Relationships :
  - Grants/Research Support: Substance Use Addiction Program- Virtual Integrated Collaborative Care
  - Speakers Bureau/Honoraria: none
  - Consulting Fees: none
  - Patrons: none
  - Other: n/a

LEARNING OBJECTIVES

- 1. Provide an overview for how older people may be more sensitive to alcohol
- 2. Review some consequences of alcohol use relevant to older adults
- 3. Include a review of screening/managing alcohol use disorder

HOW COMMON IS ALCOHOL USE AMONG OLDER ADULTS? (CAMH IMPROVING OUR RESPONSE 2021)

- Alcohol is the most commonly used and misused substance among Older Adults (65 +) (Kuerbis et al., 2014).
- Approximately 75 per cent of men and 71 per cent of women over 65 drink occasionally or regularly (Canadian Centre on Substance Use and Addiction, 2019).
- Heavy drinking is more common among older adults (aged 55–75) compared with younger adults (Kuerbis et al, 2014)

HOW DOES ALCOHOL AFFECT OLDER ADULTS? (CANADIAN CENTRE ON SUBSTANCE ABUSE, 2014).

- More sensitive to the effects of alcohol with aging
- Slower metabolism
- Drinking the same amount as when they were younger has a greater effect
  - less alcohol dehydrogenase = less breakdown
  - less water = less diluted in the blood
  - due to biological differences, older women are at particular risk for alcohol-related problems

SHORT TERM CONSEQUENCES IN OLDER ADULTS (CAMH IMPROVING OUR RESPONSE 2021)

- Higher risk of intoxication with drinking the same amount as when younger
- Higher risk of acute (short term) cognitive difficulties and problems with balance and coordination
- Higher risk for falls, automobile accidents and other injuries.

MEDICAL CONDITIONS & MEDICATIONS (CAMH IMPROVING OUR RESPONSE 2021)

- Effects of alcohol may be heightened by diabetes, hypertension and dementia.
- Alcohol can also exacerbate several of the following conditions:
  - **Stroke**
  - **High Blood Pressure**
  - **Diabetes**
  - **Osteoporosis**
  - **Memory loss**
  - **Mood disorders**
- Alcohol decreases/intensifies the effectiveness of some medications
- Many medications and over-the-counter products interact with alcohol, including:
  - **Aspirin**
  - **Antihistamines**
  - **Acetaminophen**
  - **Benzodiazepines**
  - **Herbal remedies (St. John's wort)**

LONG TERM CONSEQUENCES (CAMH IMPROVING OUR RESPONSE 2021)

- Impaired judgment and ability to make and carry out decisions expressed in behaviour toward others or vulnerable to others' behaviour (Elder Abuse)
- Hypertension, Diabetes, Nerve damage
- Dementia
- damage to Pancreas, Heart (Failure) and Liver
- Nutritional deficiency of folic acid and thiamine (Memory)
- Mobility problems (Gait Ataxia)
- Depression, Insomnia and Anxiety
- Cancers of Breast, Mouth, Throat, Esophagus and Colorectal
- Sexual dysfunction.

LOW RISK DRINKING GUIDELINES FOR OLDER ADULTS (CCSMH 2019)

- Women: no more than 1 drink on drinking days and no more than 5 drinks per week, with 2 non-drinking days per week.

- Men: no more than 1-2 drinks on drinking days and no more than 7 per week, with 1-2 non drinking days per week

GUIDANCE ON ALCOHOL AND HEALTH CCSA 2023

- **Replaces *Canada's Low-Risk Alcohol Drinking Guidelines* (LRDGs) issued in 2011.**
- Continuum of risk associated with weekly alcohol use: "_"
  - **0 drinks per week** — Not drinking has benefits, such as better health, and better sleep.
  - **2 standard drinks or less per week —** You are likely to avoid alcohol-related consequences for yourself or others at this level.
  - **3–6 standard drinks per week —** Your risk of developing several types of cancer, including breast and colon cancer, increases at this level.
  - **7 standard drinks or more per week** — Your risk of heart disease or stroke increases significantly at this level.
  - **Each additional standard drink** radically increases the risk of alcohol-related consequences.
- **Greater that 2SD per episode "is associated with an increased risk of harms to self and others, including injuries and violence."**

ALCOHOL USE DISORDER

TWO COHORTS OF ALCOHOL USE DISORDER (AUD) AMONG OLDER ADULTS

- **LATER IN LIFE**
  - AUD itself may present **insidiously** in Older Adults, often in the setting of acquired drinking during a transition (retirement, change in relationship status, residence) (Bertram et al, CAMH 2021)
- **LIFE LONG**
  - There is another cohort of Older Adults, who are the more **traditional "life-long" users** continuing into Older Age, who often have used for many years, availed of A**UD Treatment at various stages** through their lifetime and attending for similar intervention now. (Loftwall et all 2005)

ALCOHOL SCREENING TOOLS

Table 2. Common alcohol use screening instruments validated for clinical use.

Instrument	Population	Sensitivity	Specificity	Number of items	Time to administer (minutes)
AUDIT Alcohol Use Disorders Identification Test	Adults	81%	86%	10	2
CAGE Questionnaire	Adults and adolescents	75%	92%	4	1
SMAST Self-Administered Michigan Alcoholism Screening Test	Adults and adolescents	90–98%	57–82%	13	8
ARPS Alcohol-Related Problems Survey	Adults >65	82%	82%	18	10

Adapted from Fink A, Tsai MC, Hays RD, et al.[20] National Institute on Alcohol Abuse and Alcoholism,[21] Bradley KA, Bush KR, Epler AJ, et al.,[22] Aertgeerts B, Buntinx F, Kester A,[23] Hoeksema HL, de Bock GH.[24]

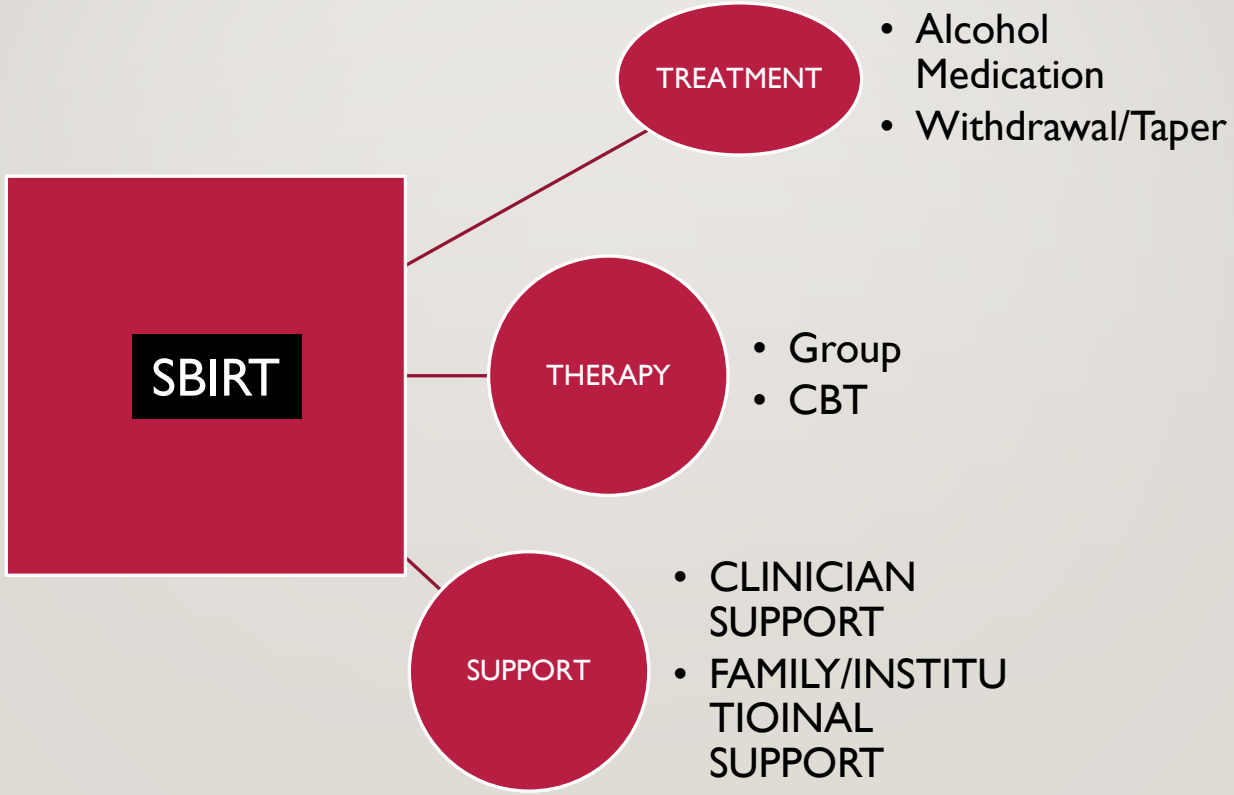
- Increasing evidence for **Senior Alcohol Misuse Indicator (SAMI)**
- Most generalizable tool is **GMAST**- can also be used for **benzodiazepine use**
- Another tool for Older Adult Alcohol screening is **ARPS**

APPROACH TO SCREENING

- Non judgmental language
- Assume substance is being used- reframe overuse as normal
- Focus on physical symptoms coincident or consequent to use

SCREENING, BRIEF INTERVENTION, & REFERRAL TO TREATMENT (SBIRT)-

COLLEGE OF FAMILY PHYSICIANS OF CANADA **(CFPC.CA)**



BRIEF INTERVENTION

- Brief intervention can work for a variety of substances
- Decreased use, binging, sustainable beyond 1 year (Fleming, 1999)
- Least intrusive intervention, appropriate even in acute settings

Table 5 NIAAA advise and assist brief intervention[35]

- State your assessment conclusions and recommendations clearly (eg, "you are drinking more than is medically safe")
- Assess the patient's readiness to reduce level of use
- Negotiate a drinking goal
- Generate a plan to meet the goals
- Provide educational materials developed by the NIAAA (include risks particular to patients with anxiety disorders)
- Follow up and reassess progress toward goals at the patient's next visit

NIAAA, National Institute on Alcohol Abuse and Alcoholism.

ALCOHOL USE DISORDER- DSM V CRITERIA
2-3 MILD; 4-5 MODERATE; 6-7 SEVERE

- Continuing to use substances despite negative personal consequences
- Repeatedly unable to carry out major obligations due to use
- Recurrent use of substances in physically hazardous situations
- Continued use despite persistent/recurring social or interpersonal problems
- Characteristic Tolerance/Withdrawal
- Persistent desire or unsuccessful efforts to control/cut down
- Spending a lot of time obtaining, drinking, or recovering from drinking
- Using greater amounts or using over a longer time period than intended
- Stopping or reducing important activities due to alcohol
- Consistent use despite acknowledgment of difficulties from drinking
- ***Craving or a strong desire to use***

WITHDRAWAL MANAGEMENT

- Benzodiazepines, if eligible, to minimize withdrawal symptoms and protect against complicated withdrawal (delirium, seizure, hallucinosis)

- Looking to protect against the development of Wernicke's encephalopathy (thiamine deficiency) by supplementing with thiamine (IM or IV) over 3–5 days (CCSMH 2019)

- Medically supervised management of withdrawal encouraged in Older Adults

PHARMACOTHERAPY ALCOHOL USE DISORDER

- **Naltrexone**: caution with increased hepatic enzymes
- **Acamprosate:** caution with reduced renal function
- **Avoid Disulfiram unless supported by Specialist Care**- Disulfiram-Ethanol reaction carries greater risk A/E- Fatality in Older Adults

- 2nd line medications are all off-label with greater favour/popularity in practice for some over others and include **Gabapentin** (Renal, Falls, Edema); **Topiramate** (Extended Schedule of Titration 8/52 & Robust S/E profile); **Baclofen** (Risk of Dependence, Effective in Cirrhosis); **Prazosin; Varenicline; Odansetron**

COGNITIVE BEHAVIOURAL THERAPY ALCOHOL USE DISORDER

- Age tailored CBT for AUD has shown increasing effectiveness in 65+ (Veteran's AUD CBT- Schonfeld 2000)

- Increasing Integrated Care Pathways for Alcohol (AUD) and Depression (MDD) with blended curriculum for AUD-MDD and co-initiation of anti-craving meds & SSRI (DA VINCI- HQ0 2016)
  - CAMH has an ongoing program from 2014-present

- Increasing utilization of iCBT- Abiliti, MindShift, Breaking Free Online for Addiction (Ontario)

PRIMARY CARE PAIN & ADDICTION HUB @CAMH

SEE FAMILY DOCTOR FOR REFERRAL- IPARC@CAMH.CA

- Through a low-threshold, rapid access referral pathway for team-based care, the Hub connects directly to patients in primary care while engaging and training community healthcare providers to manage addiction and chronic pain.

- The CAMH Primary Care Pain and Addiction Hub takes a shared-care approach in which our team takes on more complex management of cases while providing comprehensive support to both healthcare providers and patients.

- It aims to provide continuous guidance for both patients and providers through a blend of relationship-based care and access to a streamlined digital care pathway.

THANK YOU!