DRUG & ALCOHOL FINDINGS *Analysis*

This entry is our analysis of a document considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original document was not published by Findings; click Title to order a copy. The summary conveys the findings and views expressed in the document. Below is a commentary from Drug and Alcohol Findings.

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Canadian guidelines on alcohol use disorder among older adults.

Canadian Coalition for Seniors' Mental Health
Canadian Coalition for Seniors' Mental Health, 2019

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What Canadian experts judged to be the best clinical practice around the prevention, assessment, and treatment of alcohol use disorders in older people.

SUMMARY The Canadian Coalition for Seniors' Mental Health received a grant from Health Canada to create a set of four guidelines on the prevention, assessment, and management of substance use disorders among older people. This analysis outlines recommendations for alcohol. The guidelines for benzodiazepines, cannabis, and opioids have also been added to the Effectiveness Bank.

Alcohol remains the most commonly used and misused substance among older people, with estimates of problem drinking in the United States suggesting it may affect 1–22% of the older population. However, it can be particularly difficult to identify among this cohort as some of the signs and symptoms of risky drinking are associated with age-related problems such as poor mobility, cognitive problems, and falls and fractures.

Heavy drinking among older people can increase the risk of health problems, including hypertension, diabetes, infections, alcoholic liver disease, and gastric ulcers, and the bar for what is heavy or 'excessive' may be lower than for younger people, as older people generally metabolise alcohol at a slower rate, leading to a risk of heightened effects even at relatively low levels of consumption. Furthermore, as older people are often on multiple medications to manage chronic diseases, drinking introduces the risk of harmful interactions between alcohol and drugs.

A guide to the guidelines

The goal of the featured document was to provide useful guidance for clinicians on either preventing the development of alcohol use disorders or optimally assessing and treating older individuals who have developed alcohol use disorders. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines an alcohol use disorder as a problematic pattern of drinking leading to clinically significant impairment or distress. An official diagnosis is made by the presence of at least two symptoms within a 12-month period (unfold the supplementary text). The severity of alcohol use disorder (mild, moderate, or severe) is based on the number of criteria met.

Close supplementary text

In the past year, have you:

1. Had times when you ended up drinking more, or longer, than you intended?
2. More than once wanted to cut down or stop drinking, or tried to, but couldn't?
3. Spent a lot of time drinking? Or being sick or getting over other aftereffects?
4. Wanted a drink so badly you couldn't think of anything else?
5. Found that drinking – or being sick from drinking – often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
6. Continued to drink even though it was causing trouble with your family or friends?
7. Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?
8. More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
9. Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?
10. Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?
11. Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?

Close supplementary text

The quality of evidence for each recommendation was graded high, moderate, or low, where:
• **high** meant further research was unlikely to alter confidence in the effect of the proposed course of action;
• **moderate** meant further research was likely to have an important impact on confidence and may change the estimated effect of the proposed course of action;
• **low** meant further research was very likely to have an important impact on confidence and is likely to change the estimated effect of the proposed course of action.

The strength of each recommendation was also graded:
• **strong** recommendations indicated high confidence that desirable consequences outweigh undesirable consequences;
• **weak** recommendations indicated that there is either a close balance between benefits and downsides (including adverse effects and burden of treatment), uncertainty regarding the magnitude of benefits and downsides, uncertainty or great variability in patients' values and preferences, or that the cost or burden of the proposed intervention may not be justified.

A separate category was created for recommendations which were not primarily based on evidence, but were agreed to represent **best clinical practice**.

Prevention

Any amount of drinking confers *some* risk. Other than total

The size of a standard drink

abstinence, evidence suggests the lowest risk approach is to drink less than 100 g of ethanol (roughly equivalent to 10 standard drinks) per week. [See ▸ sidebar for information on the size of a standard drink in Canada.]

A standard drink is equal to a 341 ml bottle of 5% strength beer, a 142 ml glass of 12% strength wine, or a 43 ml shot of 40% strength spirits.

One Canadian standard drink = 17 ml or 13 g of ethanol.

For older people, the best advice is to limit intake to well below the national low-risk alcohol drinking guidelines, with further reduction if one's individual risk is increased by a personal or family history of an alcohol use disorder, co-occurring physical or mental health problems, or a tendency to drink to cope with life's challenges. As ageing progresses, or if negative consequences evolve, alcohol intake should be further reduced.

Recommendation 1. Women over the age of 65 should drink no more than one standard drink per day and no more than five alcoholic drinks per week. Men 65 years and older should drink no more than two standard drinks per day and no more than seven per week in total. Non-drinking days are recommended every week.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 2. Labelling can raise awareness of the risks associated with alcohol, for example indicating the alcohol content of products, national low-risk drinking guidelines, and alcohol-related risks and harms.
Quality of evidence: low
Strength of recommendation: strong

Recommendation 3. Due to the risks of cognitive impairment among chronic heavy drinkers, a daily 50 mg thiamine supplement is recommended as a harm reduction strategy. [See ▸ sidebar for further information on cognitive impairment caused by heavy drinking.]
Quality of evidence: low
Strength of recommendation: strong

Cognitive impairment caused by heavy drinking

Heavy alcohol consumption depletes the body's stores of thiamine (also known as vitamin B1), which is essential for maintaining functioning of the nervous system.

Cognitive problems caused by a lack of thiamine include:
- Wernicke's encephalopathy: "a neurological emergency" with symptoms including abnormalities associated with eye movement, gait, and balance.
- Korsakoff's syndrome: experienced by patients who suffered from Wernicke's encephalopathy but did not receive immediate and adequate treatment with thiamine replacement therapy; the most obvious symptom is global amnesia, a sudden, temporary episode of memory loss and/or confusion.
- Wernicke-Korsakoff's syndrome: the presence of both Wernicke's encephalopathy and Korsakoff's syndrome.

Screening

The consumption of alcohol, tobacco, and illicit drugs should be reviewed and discussed on an annual basis with primary care providers (eg, general practitioners). Discussions about these topics should be normalised and approached in a simple, neutral, straightforward manner. If the quantity, frequency, context, or consequences of alcohol use are of concern, a validated screening test should be used. The more comfortable the primary care provider is in engaging in the conversation, the more likely they are to find meaningful information related to the patient's health.

Recommendation 4. All patients (including older adults) should be screened for alcohol use problems at least annually (ie, as part of his or her regular physical examination) and at transitions of care (eg, admission to hospital). Screening should be conducted more frequently if consumption levels exceed the low-risk drinking guidelines, there are symptoms of an alcohol use disorder, there is a family history of alcohol use disorder, the patient currently experiences anxiety and/or depression, caregivers express concern, or the older adult is undergoing major life changes or transitions.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 5. 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 specialised programmes.
Quality of evidence: high
Strength of recommendation: strong

Recommendation 6. Ensure that screening for alcohol use disorders in older adults is age appropriate and that the person screening employs active listening, is supportive, accounts for memory impairment or cognitive decline, is non-threatening, non-judgmental, and non-stigmatising, and recognises that DSM-5 diagnostic criteria will under-identify drinking problems among older people due to some screening questions potentially becoming less relevant to this cohort (eg, impact of drinking on occupation and social obligations).
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 7. Clinicians should seek consent to discuss the patient's alcohol use and its impact with family, friends, and other caregivers.
Quality of evidence: low
Strength of recommendation: strong

Recommendation 8. Older people who screen positive for an alcohol use disorder should then be assessed by an appropriately trained health care provider.
Quality of evidence: moderate
Strength of recommendation: strong

Assessment

When a person has screened positive for an alcohol use disorder, an assessment to gather more details logically follows, based on which an individualised treatment plan should be recommended, negotiated, and implemented, depending upon available resources. The assessment should inform not only the treatment process but also the services required after treatment to ensure longer-term success.

Recommendation 9. A comprehensive assessment is suggested for all older adults who have an alcohol use disorder, have signs of harmful use, or who present with acute intoxication. The assessment should include: the use of a standardised 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; and discussions with relatives, friends or caregivers in order to 'fill in any gaps' in the patients' medical history. The assessment should be

performed regardless of physical, mental, or cognitive co-morbidities with modifications as deemed appropriate.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 10. Older adults with alcohol use disorders should be assessed annually for signs of cognitive impairment using a validated tool. Where this is detected and the patient reduces or stops their drinking, assessments should be repeated six and 12 months later to look for signs of improvement. The treatment plan should specify the timeline and procedure for ongoing evaluation of clinical outcomes and treatment effectiveness.
Quality of evidence: moderate
Strength of recommendation: strong

Treatment

The term 'alcohol use disorder' covers a spectrum of experiences and symptoms from mild, to moderate, to severe, which can be affected by co-occurring mental health, physical, and social issues. It is recommended that a range of treatment approaches and settings are used to best match the patient to necessary services.

Recommendation 11. For older people with a mild alcohol use disorder, the least intrusive or invasive treatment options should be explored, such as behavioural or psychosocial interventions. These approaches can function either as a pre-treatment strategy or as treatments in themselves.
Quality of evidence: high
Strength of recommendation: strong

Recommendation 12. Routinely offer behavioural interventions and case management along with pharmacological treatment (eg, anti-craving medication) in a primary care setting as this may improve outcomes.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 13. Naltrexone and acamprosate can be used to treat alcohol use disorders in older people – naltrexone for reducing alcohol use and promoting abstinence, and acamprosate for supporting abstinence. In general, start at low doses and adjust slowly to find a balance between getting the best response with minimal or no adverse effects. This may be done in the home, hospital, during supervised withdrawal, or in long-term care with subsequent transition to an appropriate placement.
Quality of evidence: high
Strength of recommendation: strong

Recommendation 14. Offer older people (as well as their caregivers and family) psychosocial treatment and support as part of a treatment plan.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 15. Use the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) to screen for those requiring medically-supervised withdrawal (eg, people with prior episodes of delirium, seizures, or protracted withdrawal). Patients who are in poor general health, 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 intensive treatment or hospital settings.
Quality of evidence: high
Strength of recommendation: strong

Recommendation 16
When managing alcohol withdrawal in older adults, a [symptom-triggered] approach is recommended, involving the prescription of a shorter-acting benzodiazepine such as lorazepam and the use of the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) to monitor severity of withdrawal. Close attention should be paid to co-occurring conditions to avoid complications. [See ▸ sidebar for further information on managing withdrawal.]
Quality of evidence: high
Strength of recommendation: strong

Recommendation 17. Where medical withdrawal is not available or appropriate, a managed alcohol taper should be considered as a harm reduction strategy: reducing by one standard drink every three days (aggressive tapering), weekly (moderate tapering), or every 2–3 weeks (mild tapering). The CIWA-Ar should be used to ensure the score for withdrawal symptoms is kept below 10. The approach should be individualised and incremental.
Consensus that this represents best clinical practice

Managing withdrawal

The symptom-triggered protocol is recommended by the UK's health advisory body, NICE, and consists of monitoring patients and providing medication only when symptoms of alcohol withdrawal develop.

Symptoms can be identified with a validated assessment tool, the revised Clinical Institute of Withdrawal Assessment Scale. This scores the severity of nausea, sweating, agitation, headache, anxiety, tremor, sensory disturbances, and disorientation. Repeated scoring at suitable intervals monitors the response to treatment and helps determine if further medication is needed.

Recommendation 18. To prevent the development of problems with cognitive functioning (eg, Wernicke's encephalopathy) during withdrawal, at least 200 mg of thiamine should be administered daily for 3–5 days via injection.
Quality of evidence: low
Strength of recommendation: strong

Recommendation 19. Health care practitioners, older people, and their families should advocate for adequate access and funding for treatment for alcohol use disorders, and specifically access to pharmacological and psychosocial therapies.
Consensus that this represents best clinical practice

Recommendation 20. The patient's response to treatment in terms of alcohol consumption should be monitored though blood tests (eg, gamma-glutamyl transferase and mean cell volume).
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 21. Regardless of drinking status (ie, whether drinking has continued, been reduced, or stopped), co-occurring physical and mental health conditions, and significant social transitions for the individual or family should continue to be reviewed and monitored.

Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 22. People undergoing surgery should be offered medically-supported withdrawal or alcohol tapering beforehand, and anti-craving medication afterward.
Quality of evidence: low
Strength of recommendation: strong

The authors' conclusions

Recovery is a process, not an event; more support than is currently provided *should* be offered to older people. This cohort needs a continuum of care that matches the severity of symptoms, life circumstance, concurrent mental and physical health issues, and social transitions they experience, and the clinician should be considered a partner in the person's recovery journey.

FINDINGS COMMENTARY The featured guideline was created with Canadian clinicians in mind, providing evidence-based recommendations on how to prevent, assess, and treat alcohol use disorders. However, the findings may also have relevance beyond North America. A separate document detailing the methodology said the development of the guidelines had been based on studies and documents published in the English language, but not necessarily limited to a Canadian setting.

One of the important points made early in the guideline is the different and disproportionate level of harm older people are exposed to when they drink, for example because of poor health, the interaction between alcohol and medication, and the body being slower to process alcohol. According to the featured guideline, the advice in Canada is to drink "well below" low-risk drinking guidelines – no more than five drinks per week for women over the age of 65 versus 10 drinks per week for women below this age, and no more than seven drinks per week for men over the age of 65 versus 15 drinks per week for men below this age. In the UK, both men and women are advised not to drink more than 14 units per week (roughly equivalent to six pints of beer or six glasses of wine). There are currently no low-risk drinking guidelines for older people specifically.

Evidence informing the featured guideline was mostly graded as being of moderate (10 occurences) or high (5) quality, and the expert panel designated all recommendations as courses of action we can have a strong level of confidence in (20) or recommendations that constitute best clinical practice (2). Recommendations grounded in robust research and about which experts have a high level of confidence (ie, graded 'high' and 'strong' using the authors' terminology) were:
• Ask older people about their drinking in all care settings.
• Opt for the least intrusive or invasive treatment options for people with a mild alcohol use disorder (eg, behavioural interventions).
• Consider naltrexone and acamprosate for treating alcohol use disorders; start at low doses and adjust slowly.
• Screen for people requiring medically-supervised withdrawal, and patients who need intensive treatment in hospital settings.
• Use a symptom-triggered approach to manage withdrawal, including the use of a shorter-acting benzodiazepine such as lorazepam.

UK statistics on drinking behaviour, alcohol-related hospital admissions, and alcohol-related deaths show that older people drink less and are less likely to exceed the recommended drink limits than younger adults but are more likely to experience high levels of alcohol-related harm, and between the ages of 55 and 74 have the highest rates of alcohol-related deaths.

In Scotland, strategic direction for tackling alcohol-related harm comes in the form of a national strategy and alcohol framework. Since the UK Government's 2012 alcohol strategy expired, there has been no such direction for England and Wales. In the gap created by this sits the 2016 Modern Crime Prevention Strategy which identified drugs and alcohol as two key drivers of crime and disorder – naturally a context which prioritises the consideration of drugs and alcohol as criminal justice rather than public health issues.

A 2018 review conducted by UK researchers examined the effectiveness of alcohol interventions for older people, finding few studies to draw on. Of the seven studies included, six were conducted in the United States and one in Denmark. Every intervention was associated with improvements in at least one area of alcohol consumption or frequency of consumption, but not always to a statistically significant level. Effective psychosocial interventions included counselling and advice on risky behaviours, education, and personalised risk reports. However, the lack of detail in studies prevented the reviewers from understanding which elements of the interventions were effective.

Several years ago, the VINTAGE project tried to fill the gap in understanding around older people and harmful drinking by collecting and analysing best practice in Europe. In 2012, the published results indicated that:
• new programmes were needed, and would ideally cater to the diversity of factors affecting older people and their drinking, including differences along gender lines;
• screening and intervention techniques were increasingly being researched, but not being integrated to the same extent into practice;
• there was an overall lack of evidence and initiatives to support older people within their communities;
• public awareness about the effects of drinking among people who are older was growing, although a critical mass demanding higher levels of awareness and public health intervention had yet to be reached.

One theme evident from the evidence base is the relative neglect of older people in alcohol awareness campaigns and policies compared with young and 'under-age' people. Indeed, while young people and young adults were mentioned 31 times in the UK government's 2012 alcohol strategy (summarised in the Effectiveness Bank), there were zero mentions of older people.

Older people are also at a disadvantage when it comes to treatment and support. A report funded by Alcohol Research UK (now Alcohol Change UK) examined the accessibility and suitability of residential alcohol treatment for older adults, finding that three out of four residential facilities in England were excluding older adults on the basis of arbitrary age

limits – presenting a major barrier to older people securing a place in residential treatment, and conflicting with the message from the National Treatment Agency for Substance Misuse (now absorbed in Public Health England) in 2012 that residential treatment is a vital component of the treatment system to which "anyone who needs it should have easy access". While the Alcohol Research UK study could not find out why centres were imposing age limits, conversations with service managers suggested it could be due to an assumption that the care needs of an older adult would be higher and therefore not be able to be met in the existing treatment setting.

Given their high level of contact with older people, social workers are considered ideally placed to identify and intervene with drinking problems in this population. However, studies from around the world have shown that alcohol problems in older people frequently go undetected or ignored. Informed by the perspectives of older people receiving alcohol treatment and practitioners who specialise in working with older people, a UK study highlighted the key issues for social workers, which are also applicable beyond the social work profession:

1. The stigma attached to older people's drinking problems is generally greater than that for younger people, and can motivate older people to conceal their drinking. Practitioners should consider embedding drinking questions in the context of other health behaviours, and avoid the use of stigmatising words such as 'alcoholic'.
2. Social workers should be alert to signs of abuse in older people where they or those who care for them have a drinking problem, and be aware that signs of 'elder abuse' such as bruising, agitation, withdrawal, depression, and malnourishment can be mistakenly attributed to an older person's alcohol problem and vice versa.
3. There is a need to challenge ageist attitudes and myths relating to older people's alcohol consumption, including the idea that an intervention is not needed because the patient is too old, may not have long to live, or that drinking is one of their remaining pleasures in life.
4. Social care professionals should consider the balance of 'risks' and 'rights' in older people with alcohol problems, which may come into play, for example, if an older person needs help with purchasing alcohol.

The Tilda Goldberg Centre for Social Work and Social Care, which is home to the Substance Misuse and Ageing Research Team, has produced a pocket guide of essential information for social workers about working with older people who drink.

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