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 cannabis 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 cannabis 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 cannabis. The guidelines for alcohol, benzodiazepines, and opioids have also been added to the Effectiveness Bank.

## A guide to the guidelines

The goal of the featured document was to provide useful guidance for clinicians on either preventing the development of cannabis use disorders or optimally assessing and treating older people who have developed cannabis use disorders. The term 'cannabis use disorder' refers to a problematic pattern of cannabis use leading to clinically significant impairment or distress. According to DSM-5 criteria, cannabis use disorder is indicated by the presence of at least two pre-defined symptoms or adverse effects within a 12-month period (unfold the supplementary text). Mild cannabis use disorder is evidenced by the presence of 2–3, moderate cannabis use disorder by 4–5, and severe cannabis use disorder by six or more. DSM-5 criteria may under-identify substance use problems among older people due to some screening questions potentially becoming less relevant to this cohort (eg, impact of substance use on occupation and social obligations).

Close supplementary text

1. Cannabis is often taken in larger amounts over a longer period than was intended.
2. There is a persistent desire or insignificant effort to cut down or control cannabis use.
3. A great deal of time is spent in activities necessary to obtain cannabis, use cannabis, or recover from its effects.
4. Craving or a strong desire or urge to use cannabis.
5. Recurrent cannabis use resulting in failure to fulfil major role obligations at work, school, or home.
6. Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis.
7. Important social, occupational, or recreational activities are given up or reduced because of cannabis use.
8. Recurrent cannabis use in situations which are physically hazardous.
9. Cannabis use is continued despite knowledge of having persistent or recurrent physical or psychological problems that are unlikely to have been caused or exacerbated by cannabis.
10. The person builds a tolerance for cannabis, by either a need for markedly increased amounts of cannabis to achieve intoxication and desired effect or a markedly diminished effect with continued use of the same amount of cannabis.
11. Symptoms of withdrawal are relevant or cannabis (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Close supplementary text

The evidence base around the harms and potential benefits associated with cannabis use in older people is limited but growing. Given that the adverse effects of cannabis may vary considerably based on routes of administration and types of cannabis, these guidelines were developed using a cautionary approach.

The quality of evidence for each recommendation in the guideline was graded high, moderate, or low, where:
• **high** meant further research was unlikely to change 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

**Recommendation 1.** Cannabis should generally be avoided by older people who have:
• a history of, or are currently experiencing, mental health problems, substance use problems, or substance use disorders;
*Quality of evidence: moderate*
*Strength of recommendation: strong*
• cognitive impairment, cardiovascular disease, an irregular heartbeat, coronary artery disease, unstable blood pressure, or problems with balance.

*Quality of evidence: moderate*
*Strength of recommendation: strong*

**Recommendation 2.** Clinicians should be aware of the following:
• the current evidence base on the medical use of cannabis is relatively limited, and only two pharmaceutical-grade products containing the psychoactive substances found in cannabis have been approved by Health Canada;
*Quality of evidence: high*
*Strength of recommendation: strong*
• the common signs and symptoms associated with cannabis use, cannabis-induced impairment, cannabis withdrawal, cannabis use disorders, and common consequences of problem cannabis use;
*Quality of evidence: high*
*Strength of recommendation: strong*
• the potential adverse effects of cannabis use in older people, such as changes in depth perception risking instability and falls, changes in appetite, cognitive impairment, an irregular heartbeat, anxiety, panic, psychosis, and depression;
*Quality of evidence: moderate*
*Strength of recommendation: strong*
• mental health problems which are commonly present among people with cannabis use disorders include depression, anxiety, and schizophrenia/psychosis.
*Quality of evidence: moderate*
*Strength of recommendation: strong*

**Recommendation 3.** In order to make the information easier to understand and remember, clinicians should provide education and counselling to older patients and their family members/caregivers both verbally and in writing.
*Consensus that this represents best clinical practice*

**Recommendation 4.** Clinicians should counsel patients, caregivers, and families that older adults can be more susceptible than younger adults to some dose-related adverse events associated with cannabis use.
*Quality of evidence: high*
*Strength of recommendation: strong*

**Recommendation 5.** Clinicians should advise patients, caregivers, and families about potentially increased risks when using higher-potency cannabis. [The strength or potency of cannabis is determined by the amount of tetrahydrocannabinol (known as 'THC') it contains. THC produces the 'high' associated with cannabis, and another major component 'CBD' produces the sedative and anti-anxiety effects.]
*Quality of evidence: low*
*Strength of recommendation: strong*

**Recommendation 6.** Clinicians should advise patients, caregivers, and families of risks associated with different modes of use (eg, smoking, vaporising, oils, sprays, etc.) and counsel patients on these risks.
*Quality of evidence: moderate*
*Strength of recommendation: strong*

**Recommendation 7.** Clinicians should educate patients to avoid synthetic forms of cannabis (eg, K2 and spice) because of the potential to cause serious harm. [See ▸ sidebar for further information on synthetic forms of cannabis.]
*Quality of evidence: low*
*Strength of recommendation: strong*

**Recommendation 8.** Clinicians should educate older patients on the risk of cannabis impeding their ability to carry out certain functions in their daily lives (known as 'functional impairment'). This is especially relevant if the patient is new to using cannabis or getting used to a new amount or strength. The starting 'dose' should be as low as possible, and if an increase is desired, the dose should be gradually increased over time.
*Quality of evidence: high*
*Strength of recommendation: strong*

### 'Spice' and other synthetics

Cannabis contains two key components:
• 'THC' (tetrahydrocannabinol), which produces the 'high'
• 'CBD' (cannabidiol), which produces the sedative and anti-anxiety effects

Synthetic forms of cannabis contain chemicals that aim to copy the effects of THC in cannabis, but the effects of synthetic cannabis can be quite different (and often stronger): firstly, because synthetic production makes it easier to manipulate the amount of the THC-like chemical; and secondly, because of the absence of the moderating equivalent of CBD.

**Recommendation 9.** Clinicians should counsel patients on the potential long-term effects of frequent cannabis use including respiratory problems. Patients should also be counselled on the risk of cannabis use disorders exacerbating mental health problems, particularly when higher-potency cannabis is used.
*Quality of evidence: moderate*
*Strength of recommendation: strong*

**Recommendation 10.** Clinicians should advise patients, caregivers, and families that:
• cannabis may impair their ability to drive a motor vehicle safely for up to 24 hours;
*Quality of evidence: high*
*Strength of recommendation: strong*
• cannabis and alcohol interact, causing impairment and increasing risks when driving, and their use at the same time should be avoided;
*Quality of evidence: high*
*Strength of recommendation: strong*
• it is dangerous to ride as a passenger with a driver who has used cannabis within the previous 24 hours.
*Quality of evidence: high*
*Strength of recommendation: strong*

**Recommendation 11.** Patients, caregivers, and families should be provided with information about the signs, symptoms, and risks of cannabis withdrawal.
*Quality of evidence: high*
*Strength of recommendation: strong*

## Screening

Clinicians may underestimate the likelihood of problematic substance use or a substance use disorder among older adults. It is therefore important to conduct a comprehensive history of current and past use of substances, including cannabis and chemicals found in cannabis (known as 'cannabinoids'). A comprehensive assessment is recommended when a substance use disorder is suspected.

**Recommendation 12.** Clinicians should initiate discussions about cannabis and cannabinoid use, and

participate in a non-judgemental way. The medical histories of patients should be taken, speaking where relevant to patients, caregivers, and families. The clinician should cover signs and symptoms of cannabis use disorders that may be similar to those of age-related nervous system changes, such as drowsiness, dizziness, memory impairment, and falls.
*Quality of evidence: high*
*Strength of recommendation: strong*

**Recommendation 13.** Regardless of age, all patients should be screened for:
• the use of non-medical and medically-authorised cannabis and cannabinoids, synthetic cannabis, tobacco, alcohol, and other drugs;
*Quality of evidence: low*
*Strength of recommendation: strong*
• the amount and type of cannabis or cannabinoid used, and its frequency; 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).
*Quality of evidence: low*
*Strength of recommendation: strong*

**Recommendation 14.** Clinicians should be aware that the diagnostic accuracy of some screening tools may be variable given that some of the symptoms of ageing may overlap with those of cannabis use disorder.
*Quality of evidence: moderate*
*Strength of recommendation: weak*

## Assessment

**Recommendation 15.** Assessments should include:
• modes of use (eg, ingesting, smoking, use of extracts), and the risks, benefits, and harms of all that apply to the patient;
*Quality of evidence: high*
*Strength of recommendation: strong*

• frequency and dosage.
*Quality of evidence: high*
*Strength of recommendation: strong*

**Recommendation 16.** When assessing the signs and symptoms of cannabis withdrawal, clinicians should acknowledge that rapidly reducing or stopping cannabis use may also be associated with withdrawal symptoms.
*Quality of evidence: high*
*Strength of recommendation: strong*

**Recommendation 17.** When assessing patients, clinicians should be aware of the association between chronic cannabis use and cannabis hyperemesis syndrome (severe bouts of vomiting), especially with high-potency cannabis.
*Quality of evidence: high*
*Strength of recommendation: strong*

## Treatment

The following section focuses on the treatment of older adults who have developed cannabis use disorders.

**Recommendation 18.** The screening, brief intervention, and referral to treatment (SBIRT) approach should be considered for assessing and managing cannabis use disorders.
*Quality of evidence: low*
*Strength of recommendation: strong*

**Recommendation 19.** Peer support programmes should be considered for people with cannabis use disorders.
*Quality of evidence: moderate*
*Strength of recommendation: strong*

**Recommendation 20.** A variety of psychosocial approaches should be considered for the purpose of harm reduction or relapse prevention, including cognitive-behavioural therapy, motivational interviewing, relapse-prevention based on mindfulness, motivational enhancement therapy, and contingency management.
*Quality of evidence: moderate*
*Strength of recommendation: strong*

**Recommendation 21.** There are currently no pharmacological treatments considered safe and effective for treating cannabis use disorders or alleviating symptoms of withdrawal.
*Consensus that this represents best clinical practice*

**Recommendation 22.** Residential treatment should be considered appropriate for treating cannabis use disorders if the older person is unable to effectively reduce or cease their cannabis use.
*Quality of evidence: low*
*Strength of recommendation: strong*

## The authors' conclusions

While it is clear that older people use cannabis, there is less clarity around what motivates older people to use it, how common it is across the life course, and how factors unique to ageing may positively or negatively impact on patterns of use and associated harms.

While the perception that cannabis use poses a significant risk has decreased, it is associated with adverse effects and increased risk for mental health problems, which may be compounded by the realities of ageing (eg, changes in the way cannabis is processed by the body, and a higher prevalence of overlapping health problems).

Clinicians should be aware that older people *are* using cannabis, probably have questions, and deserve evidence-based answers and guidance. The featured guidelines provide recommendations on the basis of available evidence and the experience of clinical experts, but acknowledge that gaps in the evidence clearly exist.

Clinicians should discuss cannabis use with their patients – helping to promote healthy behaviours and to identify potential harms or problematic use that warrants a follow-up or intervention. They

should also be mindful of the social context within which cannabis – a widely-used, widely-available, and (in Canada) legal substance – is situated. This includes anecdotal narratives about its medicinal properties, which although potentially promising, are largely unsubstantiated and open to exploitation. In addition to this, the reality that cannabis occupies a counter-culture image that is now being commercialised as legal markets open up poses a risk for older people to be specific demographic targets in cannabis marketing.

Regulation and quality control within a legal market have arguable benefits for reducing certain harms, but the implications for rates of use remain unknown for the older adult population, even in jurisdictions with a longer history of legal, non-medical cannabis use.

**FINDINGS COMMENTARY** The legal status of cannabis differs between the UK and Canada, providing different backdrops to the question of how to treat cannabis use disorders. Canada legalised the medicinal use of cannabis in 2001, and in 2018, legalised the production, possession, acquisition, and consumption of cannabis for recreational purposes. In contrast, UK law designates cannabis as a controlled 'Class B' substance, with legal penalties for possession, supply, and production. In 2009, the Association of Chief Police Officers issued new guidance, advising officers to take an escalating approach to the policing of cannabis possession for personal use: (1) a warning; (2) a penalty notice for disorder; and (3) arrest. This three-tiered approach was designed to be "ethical and non-discriminatory", but also to reinforce the "national message that cannabis is harmful and remains illegal".

The guidelines acknowledged that there may be potential benefits as well as harms to using cannabis, however, the document did not go into any detail about what the benefits might be. This may be due at least in part to the position of the funder, Health Canada, which "does not endorse any health claims about the medical use of cannabis or any health benefits associated with it".

Cannabis is the most widely used illegal drug in Europe, and many seemingly enjoy cannabis without it leading to any significant negative social or health effects. However, numbers entering treatment for cannabis use problems have been on the rise (both in the UK and the rest of Europe), while heroin treatment numbers have fallen. According to Public Health England, this is not because more people are using cannabis, but perhaps because services relieved of some of the recent pressure of opiate user numbers are giving more priority to cannabis, because they are making themselves more amenable to cannabis users, and because of emerging issues with stronger strains of the drug.

According to the two main diagnostic manuals used in Europe and the USA, problem cannabis use can develop into a cannabis use disorder or cannabis dependence, identifiable by a cluster of symptoms including: loss of control; inability to cut down or stop; preoccupation with use; neglecting activities unrelated to use; continued use despite experiencing problems; and the development of tolerance and withdrawal. This level of clinical appreciation for cannabis use problems didn't exist when researcher and writer William L. White entered the addictions field half a century ago:

> *"When I first entered the rising addiction treatment system in the United States nearly half a century ago, there existed no clinical concept of cannabis dependence and thus no concept of recovery from this condition. In early treatment settings, cannabis was not consider[ed] a "real" drug, the idea of cannabis addiction was scoffed at as remnants of 'Reefer Madness,' and casual cannabis use was not uncommon among early staff working in addiction treatment programs of the 1960s.*

Many in the field remain sceptical of the idea of cannabis dependence, specifically whether problem users at the severe end experience physiological withdrawal. However, reviewing what they believe is mounting evidence, authors of "The cannabis withdrawal syndrome" suggest there can be confidence in the existence of a "true withdrawal syndrome" – albeit one that differs qualitatively from the "significant medical or psychiatric problems as observed in some cases of opioid, alcohol, or benzodiazepine withdrawals". In the case of cannabis, the main symptoms are primarily emotional and behavioural, although appetite change, weight loss, and some physical discomfort are reported. A brief review aimed at practitioners in UK primary care provides guidance on how to manage symptoms of withdrawal among patients trying to stop or reduce their cannabis use.

Last published in 2017, there is no more important document for UK clinicians involved in treating problem substance use than the so-called 'Orange guidelines', which includes a section on how to treat older people. Why "Cannabis is worth bothering with" is the subject of an Effectiveness Bank hot topic.

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