**COURSE TITLE:** The Older Adult: The New Face of Addiction

**COURSE INSTRUCTOR:** Ann Eshenaur Spolarich, RDH, PhD, FSCDH

**COURSE CREDITS:** 2.5 CEUs

**COURSE DATE:** May 30, 2022

---

**COURSE DESCRIPTION:** This course will examine the widespread problem of substance abuse and addiction among older adults. Elderly adults present with higher risks for cancer, infections and infectious diseases due to past and continued use of alcohol, tobacco and illicit drugs. The number of adults aged 50 and older with substance abuse disorders is expected to double by 2020 across gender, ethnicity and all age groups. Treatment admissions for substance abuse in this same group have more than doubled since 1992, with estimates continuing to grow as Baby Boomers age. A growing body of research supports that older adults currently engage in recreational drug use, and lifetime use of a variety of substances has increased significantly among Baby Boomers. Dependency on prescription drugs is widespread with a multifactorial etiology. Normal physiologic changes in aging alter drug handling in the body, contributing to increased side effects, toxicities and overdose. Strategies for how to safely manage these patients in the dental setting will be discussed

**LEARNING OBJECTIVES:**

Upon completion of this continuing education course, the participant will be able to:

1. Identify substances that are commonly abused by elderly individuals.
2. Discuss normal physiologic changes of aging and the impact on drug pharmacokinetics.
3. Identify factors that contribute to recreational drug use in older adults.
4. Discuss chronic health conditions that contribute to risk for developing drug dependency.
5. Describe risks for cancer, infections and infectious disease associated with drug use among elderly patients.
6. Discuss assessment strategies used to determine suitability for elderly patients to receive dental treatment safely.
7. Identify strategies that can be used to reduce oral and systemic disease risks among elderly individuals with a history of substance abuse.

**Substance Use/Misuse**

- In Canada, one in seven older adults has experienced an SUD
- Alcohol, cannabis and medications commonly given to older adults to manage pain, anxiety, sleeplessness and depression can have a negative effect on the cognition, emotions and physical health of older adults
- People with a mental illness are twice as likely to have SUD
- A least 20% of people with a mental illness have a co-occurring SUD
- For people with schizophrenia, the number may be as high as 50%
- People with SUD are up to 3 times more likely to have a mental illness
- More than 15% of people with SUD have a co-occurring mental illness
- Misuse, dependency and addiction of substances among seniors is often associated with other mental illnesses including:
    - Depression
    - Generalized anxiety disorder
- May be affected by psychosocial issues often experienced by older adults:
    - Loneliness
    - Bereavement
    - Chronic illness and/or disability

**What substances are abused?**

- Prescription and OTC medications
- opioids
- benzodiazepines
- alcohol
- sleeping preparations
- Alcohol and tobacco = chronic/lifelong dependency
- Marijuana = most commonly abused “street drug” and for medical purposes?
- Cocaine and heroin = use diminishes after age 60

**Which drugs are associated with causing the greatest number of medical problems?**

- Alcohol
- Tobacco
- Cause more medical problems than all other drugs of abuse combined

**Patterns of Substance Abuse**

- Nearly 40% drink alcohol
    - Alcohol use is increasing across older age groups
    - Physiologic changes with aging alter pharmacokinetics
- More likely to die from smoking-related illness
    - Lifetime smoking contributes significantly to:
        - chronic respiratory disease (COPD)
        - heart disease and stroke
        - cancer
        - Alzheimer’s disease
        - Reduced life expectancy

**Dependency on alcohol and prescription drugs is multi-factorial**

- Often occurs as a result of:
    - initial use of medications for chronic pain from disease or injury
    - psychological problems: anxiety, depression, sleeping problems
    - Other factors include loneliness and boredom
- Major Life Events Serve As Triggers

**Prescription Drug Use**

- Patients hide inappropriate prescription drug use
- Visit multiple physicians
- Redundant prescriptions = opioids, sedative hypnotics, benzodiazepines
- Often difficult to distinguish drug effects from disease effects, including cognitive impairments

**Older Adults**

- Normal doses of drug act at overdose levels in the geriatric patient
- Give lower dose
- Verify compliance
- Greater frequency of dosing, less compliance
- Greater number of pharmacies used, greater risk for interactions

**Drugs and Falls**

- Many drugs increase risk for falling
    - Antihypertensives (orthostatic hypotension)
    - Antidepressants
    - Sedative hypnotics
    - Antipsychotics
    - Benzodiazepines
    - Opioids
    - NSAIDS
    - *Alcohol
- Risk assessment and prevention

**Which drugs do older adults use?**

- Dependent on drugs prescribed for:
    - Joint pain
    - Sleeping problems
    - Injuries from falls
- 20% of those age 65+ take analgesics several times per week
    - Rates of abuse or addiction in those with chronic pain is 18%
- Commonly Abused Prescription Medications
    - Opioid analgesics = most common
    - CNS depressants
    - benzodiazepines

    - barbiturates
    - CNS stimulants
    - amphetamine
    - methylphenidate
- Non-medical use of prescription drugs abused more often than cocaine, heroin, hallucinogens and inhalants combined

**Benzodiazepine Use Disorder**

Popular BDZ Drugs = Schedule IV Substances

- chlordiazepoxide (Librium)
- diazepam (Valium)
- lorazepam (Ativan)
- oxazepam (Serax)
- alprazolam (Xanax)
- triazolam (Halcion)
- sedative hypnotic/sleeping pill
- midazolam (Versed) = "dazzle"
    - Preoperative sedation
    - Induction of general anesthesia

**Indications for BDZs in Older Adults**

- Chronic anxiety
    - Should assess for depression
- Prescribe antidepressants with slow discontinuation of BDZs
- Depression
- Sleep disturbance
    - Chronic insomnia significant problem in elderly
    - Rarely improves with long-term use of BDZs
    - Nightly use of BDZs lose effectiveness after 3-6 months (tolerance)
    - Requires steadily increasing doses to initiate sleep
    - Long-term use produces significant physical dependence or addiction
- Despite wide-spread agreement that BZRAs should be avoided whenever possible in older adults, these medications continue to be frequently prescribed.
- Recent Canadian data suggest high rates of use persist among older adults, especially females, with 18.9% of older females reporting past-year use (Statistics Canada, 2016).
- The guidelines emphasize alternative non-pharmacological treatment approaches for the treatment of anxiety and insomnia and give advice on how to deprescribe these medications which generally requires gradual dosage reduction over many months to avoid severe withdrawal symptoms.

**Complications of BDZs**

- Exacerbates chronic medical problems
    - COPD, GERD
- Increases length of stay and morbidity in hospitalized patients
- Higher rates of MVA and falls

- Significant additive effect with other sedative hypnotic drugs (opiates, alcohol)
- Prolonged half-life predisposes to easy intoxication
- Withdrawal syndrome occurs after stopping (similar to alcohol withdrawal)
- Withdrawal often happens following admission to hospital for other medical reason (e.g. surgery)

**Treatment for BDZ Use Disorder:**

- Detoxification and withdrawal
- Appropriate therapy for psychiatric problems
- Long-term addiction treatment (e.g. AA, NA)
- If less than 2 years of life remaining, remain on BDZs but monitor dosages

***Beers Criteria**

3 lists of medications that pose potential risks outweighing potential benefits for people 65 and older

  - Benzodiazepines are to be avoided for treatment of: Insomnia, Agitation, Delirium

**23 Recommendations**

**Recommendation #1:** Long-term use of BZRAs (> four weeks) in older adults should be avoided for most indications because of their minimal efficacy and risk of harm.

**Recommendation # 4:** An assessment of risk for BZRA use disorder and other potential adverse effects from these agents should be done prior to prescribing a BZRA.

**Recommendation #5:** If a BZRA is being considered, the older adult should be informed of both the limited benefits and risks associated with use, as well as alternatives, prior to deciding on a management plan.

**Recommendation #8:** Health-care providers and organizations should consider implementing interventions to decrease inappropriate use of BZRAs in their practice settings.

**Recommendation #11:** Clinicians should be aware that BZRAs are prescribed more frequently to women and the potential implicit bias that may lead to inappropriate use.

**Recommendation #12:** All older adults should be asked about current and past consumption of substances that might lead to substance use disorders, including BZRAs, during periodic health examinations, admissions to facilities or services, perioperative assessments, when considering the prescription of a BZRA, and at transitions in care.

**Recommendation #13:** Health-care practitioners should be aware of and vigilant to the symptoms and signs of substance use disorders, including BZRA use disorder. Particular attention should be paid to this possibility when assessing common conditions encountered in older adults, such as falls and cognitive impairment.

**Recommendation #15:**

a. Multiple substance use is common and should be considered and inquired about in all older adults with a BZRA use disorder

b. Health-care practitioners should avoid prescribing BZRAs concurrently with opioids whenever possible.

c. The combination of a BZRA with alcohol should be avoided.

**Opioid Use Disorder**

- In Canada, older adults are the group at greatest risk for opioid-related hospitalizations.
- Most opioid poisonings in older adults in Canada are accidental although intentional overdoses are not uncommon.
- The Guidelines provide advice on how to prevent Opioid Use Disorder by limiting the prescription of opioids in the treatment of acute and chronic pain.
- For older adults with Opioid Use Disorder the guidelines support the use of opioid maintenance treatment when required.

**Not All Pain is the Same**

- Not all pain responds to same medications
- When should treatment be intensified?
- Unresolved pain or continued complaints of pain despite escalating doses of prescription opioids:
- Disease progression
- Self-medication of co-morbid psychiatric and/or physical complaints
- Diversion
- Pseudo-addiction = providing analgesia stops behaviors

**Patient Variables**

- Altered CYP450 liver enzymes
- Reluctance to report adequate pain relief
- Fear that care will be reduced
- Fear that clinician will stop searching for underlying cause of pain
- Misconceptions or misunderstanding regarding opioid treatment

**How do older adults get pain meds?**

- Multiple providers/prescribers
- Obtained from well-meaning friends and relatives
- Not from drug dealer
- Obtain large quantities from one provider

**Warning Signs of Abusing Prescription Pain Medications**

- Multiple medical problems
- Higher than average incidence of chronic pain
- Experience common mood disorders
- Multiple prescribers
- Insist on controlled substance during first office visit
- Physician shopping
- Keep pain appointments but miss other appointments
- Appear grossly disheveled or impaired
- Request early refills
- Report pain med prescription as lost or stolen

**Challenges to Clinicians**

Elderly often have comorbid medical problems, including cognitive or psychiatric illness

- Diagnostic criteria for assessment geared toward younger people
- Signs and symptoms may be misinterpreted as products of normal aging
- Polypharmacy
- Normal physiologic changes of aging
- Clinicians underestimate level of risk among patients, especially those with chronic pain

**Warning Signs that Chronic Opioid Use has Progressed to Abuse Disorder**

**Red flag warnings:**

- Deteriorating functioning at work/home
- Multiple episodes of lost prescriptions
- Refusal to comply with monitoring
- Using medications in ways other than prescribed
- Using other drugs
- Legal problems

**Yellow Flag warnings**

- Missed appointments
- Requesting specific medications
- Occasionally increasing dose
- Obtaining similar medications from other sources
- Complaints of needing more medication

**Opioid Use Disorder**

- In Canada, rates of hospital admission from opioid poisoning have been higher for older adults (>65) than younger adults for decades, only recently surpassed by younger non-medical opioid users.
- Opioid use disorder (OUD) among older adults is a growing concern.
- People >50 years accounted for 39% of deaths from drug use worldwide (2015)
- Of those deaths in older adults (age ≥ 65), approximately 75% were linked to the use of opioids
- Canadian Statistics: Opioids
- 43.9% of adults > 55 years of age have used a prescription opioid
- 1.1% of that group have done so daily (or almost daily) in the last year.
- People over 65 years have consistently received more new opioid prescriptions and have a higher proportion that go on to long-term opioid therapy (24.8%) than any other age group.
- From 2007 to 2015, hospitalizations for opioid overdose (referred to as poisonings) in Canada were consistently higher in older adults than in any other age cohort.
- Older-adult admissions are almost double that of 15 to 24-year-olds (over 20 per 100,000) and represent 30% of all admissions to hospital for opioid poisoning.
- Most opioid poisonings in adults in Canada are accidental; 30% are intentional.
- Opioid misuse in older adults was associated with increased odds of suicidal ideation.

32 Recommendations

**RECOMMENDATION #1:** In order to avoid the risk of developing an OUD, older adults with acute pain in whom opioids are being considered should receive the lowest effective dose of the least potent immediate release opioid for a duration of ≤ 3 days and rarely > 7 days.

**RECOMMENDATION #3:** Patients and their families should be advised to store opioids safely, never to share their medication, and to return unused medication to the pharmacist for disposal.

**RECOMMENDATION #4:** Pharmacists and nursing staff are advised to inform the prescriber if there are concerns with co-prescribing, adherence to treatment, or intoxication.

**RECOMMENDATION #5:** In older adults with polypharmacy or comorbidities that increase the risk of opioid overdose (e.g., benzodiazepine use, renal failure, sleep apnea), the lowest effective opioid dose should be used and tapering the opioid and/or other medications should be considered.

**RECOMMENDATION #7:** Dispense naloxone kits to anyone using opioids regularly for any reason (CNCP, OUD, etc.), and train household members and support staff on use.

**RECOMMENDATION #8:** Include skilled pharmacists and/or nurses on teams to educate patients on appropriate use of opioids and other medications.

**RECOMMENDATION #9:** Older adults with or at risk for an OUD should be given advice on strategies to reduce the risk of opioid overdose and information on supervised consumption sites, if available in the community.

**RECOMMENDATION #10:** Older adults should be screened for an OUD using validated tools, if appropriate (e.g., CAGE-AID, ASSIST, PDUQp, ORT, POMI, COMM). Medication reviews and urine drug screens should be utilized if the patient is taking opioids for CNCP or an OUD.

**Should we use opioids in older adults?**

- Frequent occurrence of both cancer and non-cancer persistent pain
- opioid analgesics are appropriate for moderate to severe persistent pain
- Challenges: factors involved in making appropriate choices, monitoring the beneficial effects of pain relief and managing side-effects
- Goals of using opioids = improved function and quality of life

**Opioids and End of Life Care**

- In the geriatric population, the assessment of pain requires measurement of:
    - pain intensity
    - delineation of opioid responsiveness
    - clarification of the impact of pain on patients‘psychological, social, spiritual, existential domains

**Alcohol Use Disorder**

- Alcohol is the most commonly used and misused substance among older adults.
- Alcohol Use Disorder (AUD) and risky alcohol consumption is common among older adults.
- In Canada rates of hospitalization entirely due to alcohol are highest in groups between the ages of 50 to 75.

- Clinical Guidelines recommend Low Risk Drinking Guidelines for Older Adults that are 50% lower than those for adults under the age of 65.

**Physiologic Considerations**

- Older Adults More Sensitive to Effects
- Metabolize alcohol more slowly
- Alcohol stays in body longer
- Decreased body water = alcohol more concentrated
- Aging lowers body's tolerance for alcohol
- Experience effects more readily (eg. slurred speech, lack of coordination)
- Older people develop problems with alcohol even if drinking habits have not changed

**National Institute on Alcohol Abuse and Alcoholism**

- Sensible limits to alcohol intake may not apply to older people
- Age related changes in metabolism
- Advancing ill health
- Increased sensitivity to effects of alcohol
- Older people should not consume more than 1 drink per day (no more than 2 on special occasions)
- 5 oz wine; 12 oz beer; 1.5 oz spirits
- Limits appropriate to age have not been established for older people
- Limits are likely to be lower

**Exceeding Limits of Alcohol Use**

- Monthly use = more than 30 drinks per month
- Heavy episodic drinking = 4 or more drinks in a single day during a typical month
- Older women = no more than one drink per day or seven drinks per week

**Alcohol Misuse by Older Women**

- Older women are at higher risk for alcohol problems because:
- Live longer than men
- Face other losses (spouse, children, friends)
- Loss leads to loneliness and depression
- Physiologic differences from men
- Unhealthy drinking behaviors

**Risk factors associated with greater likelihood of unhealthy drinking:**

- Higher education
- Higher income
- Better health status
- Male sex
- Younger age
- Smoking
- White

- Divorced, separated or single
- Self-reported depressive symptoms*

**Consequences of Chronic Alcoholism in Older Adults**

Systemic Health Problems:

- Liver damage/cirrhosis
- Peripheral neuropathies
- Damaged:
- Pancreas
- Heart
- Muscles
- Bone marrow
- Bone
- Increased risk for certain cancers and immune system disorders

Psychological:

- Isolation
- Depression
- Anxiety
- Suicide

Other:

- Caregiver burnout
- Legal problems
- DUI (same as younger people)
- Criminal behavior (< than younger people)

**Late-Life Depression and Alcoholism**

- Increases risk of depressive symptoms
- Increases likelihood for poor mental and physical health outcomes in elderly
- Depressive symptoms are often overlooked or misdiagnosed
- Many older adults who have problems related to alcohol use do not meet alcohol abuse/dependence criteria*

**Screening for Alcohol Use**

22 Evidence-Based Recommendations

**Recommendation #1:** For women 65 years of age or older, no more than 1 standard drink per day, with no more than 5 alcoholic drinks per week, is recommended; for men 65 years of age or older, no more than 1–2 standard drinks per day, with no more than 7 per week in total, is recommended. Non-drinking days are recommended every week.

**Recommendation #2:** Increase awareness of the risk of alcohol use through labeling that indicates:

a. Standard drink content of the product;

b. National Low Risk Drinking Guidelines for both adults and older adults; and

c. A warning of alcohol related risks and harms.

**Recommendation #3:** As a harm reduction strategy for chronic heavy drinkers, it is recommended that at least 50 mg of thiamine supplementation daily be used to prevent Wernicke-Korsakoff syndrome, progressive cognitive decline, and increased frailty.
**Recommendation # 4:** All patients should be screened for alcohol use at least annually (i.e., as part of his or her regular physical examination) and at transitions of care (e.g., admission to hospital). Screening should be conducted more frequently if:

- consumption levels exceed the low-risk drinking guidelines;
- there are symptoms of an AUD;
- there is a family history of AUD;
- the patient currently experiences anxiety and/ or depression;
- caregivers express concern; or
- the older adult is undergoing major life changes or transitions.

**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 specialized programs.
**Recommendation #6:** 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 potentially reduced occupational or social obligations.
**Recommendation #7:** Request consent to discuss the patient's alcohol use and its impact with family, friends, and other caregivers.
**Recommendation #8:** Older adults who screen positive for an AUD should be assessed by an appropriately trained health-care provider.
**Recommendation #9:** 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.

**Nicotine Use Disorder**

- Elderly smokers are more likely to die from smoking-related illness
    - smoking for longer periods of time
    - tend to be heavier smokers
- Less likely than younger smokers to believe that smoking harms their health
- Smokers also have a significantly reduced life expectancy

**Challenges with Quitting in Older Smokers**

- Do not quit smoking because "offers no benefit" at an advanced age

- Obstacles brought up by older adults for not quitting are based on incorrect information
- Some believe there are potential health risks from cessation aids like nicotine replacement therapy
- Strong evidence that smoking cessation adds years and quality to life

**Cessation Aids**

**Cannabis**

- The baby boomer generation has a higher lifetime prevalence of use and past year use of cannabis than any previous generation of older adults.
- Despite a lack of empirical evidence, an increasing number of older adults are turning to cannabis in the hopes of coping with a variety of illnesses and symptoms such as chronic pain.
- Recent legalization of non-medical cannabis use in Canada and subsequent increase in public interest among older adults, have driven the need for health professionals to be aware of the most recent research on the use of cannabis for medical and non-medical purposes.
- The guidelines emphasize the potential risks associated with cannabis use among older adults and highlight the urgent need for more research.

**Medication for Addiction Treatment (MAT)**

Medications are used to:

- control drug cravings
- relieve symptoms of withdrawal
- prevent relapses

**Health Canada Approved Drugs for AUD**

- Disulfiram - Interferes with alcohol metabolism pathway
    - Effective at prolonging abstinence if taken under daily supervision
- Naltrexone - Mu receptor antagonist
    - Blocks euphoric effects of alcohol
    - Helps achieve abstinence and reduce heavy drinking to lower risk levels
- Acamprosate - More effective if started after detoxification
    - Effective if the target is abstinence
    - Not as effective if target is to reduce heavy drinking

**MAT for OUD**

- Buprenorphine = partial opiate agonist
    - Relieves symptoms of withdrawal and cravings without producing a high
    - Safest of the opioid medications
    - Suboxone is a sublingual strip or pill
- Methadone = full opioid agonist
    - Used for severe addiction to opioids where Suboxone does not sufficiently relieve withdrawal symptoms
    - Relieves symptoms of withdrawal and cravings

- Hydromorphone
    - Can be prescribed to prevent withdrawal and cravings in the most severe cases where persons on methadone continue to relapse

February 2022

- Health Canada approved diacetylmorphine (heroin) a new treatment for adults with severe OUD
- Pharmascience, Inc. based in Montreal
- Available to those enrolled in Injectable Opioid Agonist Treatment (IOAT) program
- Only available to those who have failed previous attempts at opioid agonist therapy, including methadone
- Caveat: most are smoking opioids = not injecting

**MAT for Nicotine use Disorder**

- Nicotine replacement products including gum, patches, lozenges and inhalers (sprays or vapes)
- Allow smokers to stop smoking without suffering withdrawal and cravings
- Champix is a partial agonist
- Blocks the nicotine receptors in the brain, reducing withdrawal symptoms and craving.
- Wellbutrin is an antagonist at the nicotine receptor
- Blocks any nicotine effect
- Mecamylamine (an antihypertensive) is being studied.

**Screening for Drug and Alcohol Use**

Who should be screened?

- Every 60-year-old should be screened for alcohol and prescription drug abuse as part of his or her regular physical examination
- Screen if physical symptoms are present and/or if older person is undergoing major life changes or transitions

**Difficulties with Identifying Substance Abuse**

- Identifying abuse complicated by the number of other conditions with similar symptoms
- Warning signs can be easily confused with or masked by concurrent illnesses and chronic conditions or dismissed as symptomatic of old age
    - sleep problems, falls, anxiety, confusion

**Asking Screening Questions**

- Confidential setting
- Nonthreatening, nonjudgmental manner
- Elderly are acutely sensitive to the stigma associated with alcohol and drug abuse
- Avoid using stigmatizing terms like alcoholic or drug abuser
- More willing to accept a "medical" as opposed to a "psychological" or "mental health" diagnosis as an explanation for their problems
- Preface questions with a link to a medical condition

- "I'm wondering if alcohol may be the reason why your diabetes isn't responding as it should?"
- "Sometimes one prescription drug can affect how well another medication is working. Let's go over the drugs you're taking and see if we can figure this problem out."
- Demonstrate empathy
- Avoid using euphemisms that minimize the problem
- Older adults likely to engage in denial and rationalization as younger adults
- Those who are inadvertently misusing a prescription drug or who are unaware that their customary drink before dinner may now be causing problems are unlikely to be defensive about acknowledging the need to change*
- Impaired cognition = difficult to obtain complete/accurate answers
- Respect autonomy, but collateral participation from family members or friends may be necessary in situations where a coherent response is unlikely
- First ask for the older adult's permission to question others on their behalf
- Asking Screening Questions
- Screen collaterals in private using a nonconfrontational approach
- "I'm concerned about your father's deteriorating condition and wonder if his use of alcohol may be having a negative impact. Have you or anybody else in the family had any concerns about his drinking?"
- Because circumstances differ within families, family members may not know or may be unwilling to respond honestly to that query

**Putting It All Together**

**Lifelong Habits**

- Risks:
    - Oropharyngeal and other cancers
    - Oral/Systemic infections
        - Infectious diseases
- Substance abuse/addiction
- Contributing Factors:
    - Alcohol use
    - Smoking/tobacco use
    - Recreational drug use
    - Unprotected sexual activity
    - Cognitive impairment
    - Limited health education about and knowledge of health consequences
    - Failure of healthcare professionals to assess risk behaviors
- Preventive Strategies:
    - Take and record vital signs at every visit
    - Discuss adverse health consequences associated with habits
    - Obtain liver function test if Hx of chronic alcohol abuse
    - Obtain cardiac testing if suspected or Hx of IV drug abuse
    - Obtain testing for infectious diseases: HIV, hepatitis, STDs
    - Defer treatment if patient is under the influence

- Avoid sedation, anti-anxiety medications and opiates with alcohol
- Avoid vasoconstrictors if under influence of cocaine/stimulants
- Provide tobacco cessation education: Ask, Advise, Refer
- Set quit date
- Recommend/prescribe medications for cessation therapy
- Provide information about help-lines
- Conduct regular oral cancer examinations
- Teach patients to conduct oral cancer self-examinations
- Educate patients about oral and systemic complications of drug use
- Refer patients with drug addiction to appropriate healthcare professionals for evaluation and treatment
- Encourage safe-sex practices in sexually active patients
- Encourage patients to engage in outside activities to improve quality of life and reduce substance abuse and other risk behaviors

**Oral Health Considerations**

- Many abused substances cause xerostomia
- Opportunistic infections
- Fungal, viral, bacterial infections
- Traumatic aphthous ulcers
- lack of interest in performing daily self-care
- increased caries and gingival disease
- lack of interest/motivation to seek treatment
- Excellent candidates for power brushing, interdental cleaning, irrigators, fluorides, antimicrobial therapies, remineralization therapies

**Risk Reduction for Falls**

- Falls due to CNS impairment
- Falls dramatically increase risk for fracture
- Does your operatory pose risk for falling?
- Are you prepared to manage someone who falls?

**Helpful Resources**

Government of Canada. Using Substances as an Older Adult.
https://www.canada.ca/en/public-health/services/health-promotion/aging-seniors/using-substances-older-adult.html

Active Aging Canada. Cannabis and Older Adults.
https://www.activeagingcanada.ca/

Canadian Centre on Substance Abuse and Addiction
A Guide to Cannabis for Older Adults
https://ccsmh.ca/wp-content/uploads/2020/09/CCSA-Cannabis-Use-Older-Adults-Guide-2020-en-copy.pdf

**Canadian Coalition for Seniors' Mental Health**

## Alcohol Use Disorder

Tools for Seniors and Families:

Alcohol and Older Adults Infographic:
https://ccsmh.ca/wp-content/uploads/2021/05/CCSA-Alcohol-and-Older-Adults-Poster-2020-en.pdf

Alcohol Use Among Older Adults brochure:
https://ccsmh.ca/wp-content/uploads/2020/09/CCSMH_Alcohol_brochure_ENG.pdf

Tools for Clinicians:

Canadian Guidelines on Alcohol Use Disorder Among Older Adults (2019):
https://ccsmh.ca/wp-content/uploads/2019/12/Final_Alcohol_Use_DisorderV6.pdf

Canadian Guidelines on Alcohol Use Disorder Among Older Adults (published 2020):
https://ccsmh.ca/wp-content/uploads/2020/09/Alcohol-CGJ-March-2020.pdf

## Benzodiazepine Use Disorder

Tools for Seniors and Families:

Benzodiazepine Use Among Older Adults brochure:
https://ccsmh.ca/wp-content/uploads/2020/09/CCSMH_BZRA_brochure_ENG.pdf

Tools for Clinicians:

Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder Among Older Adults PDF (2019):
https://ccsmh.ca/wp-content/uploads/2020/01/Benzodiazepine_Receptor_Agonist_Use_Disorder_ENG_Jan-24.pdf

Online Resources for Benzodiazepine Use Disorder:
https://ccsmh.ca/substance-use-addiction/benzo/resources/

## Opioid Use Disorder

Tools for Seniors and Families:

Opioid Use Among Older Adults brochure:
https://ccsmh.ca/wp-content/uploads/2020/09/CCSMH_Opioid_brochure_ENG.pdf

Tools for Clinicians:

Canadian Guidelines on Opioid Use Disorder Among Older Adults PDF (2019)
https://ccsmh.ca/wp-content/uploads/2019/11/Canadian_Guidelines_Opioid_Use_Disorder_ENG.pdf

Online Resources for Opioid Use Disorder
https://ccsmh.ca/substance-use-addiction/opioids/resources/

Canadian Guidelines on Opioid Use Disorder Among Older Adults (published 2020)
https://ccsmh.ca/wp-content/uploads/2020/09/Opioid-CGJ-March-2020.pdf