

Project ECHO Personal Care Providers

All Teach, All Learn

Building Skills, Knowledge, and Confidence



Recognize, Respond, Report: Substance Use in Home Care Clients

Presenter:

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March 25, 2026

Land Acknowledgement




Artist Credit: Patrick Hunter

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Metis Peoples. On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.

Introduction



Marilyn White-Campbell,
Geriatric Addiction Specialist Behavioural Supports Ontario,
Behaviour Support for Seniors Program, Baycrest



**“Recognize, Respond, Report:
Substance Use in Home Care Clients”
Canadian Home Care Association
March 25, 2026**

**Marilyn White-Campbell Geriatric Addiction
Specialist, BSO Baycrest Hospital , Toronto
Ontario**

Objectives

- Recognize signs of substance misuse and report changes to the care team**
- Use trauma-informed communication to reduce stigma and build trust**
- Collaborate effectively to support safe, client-centered care and referrals**

“Recognize, Respond, Report: Substance Use in Home Care Clients”



RECOGNIZE .



RESPOND .



REPORT .

Key features of trauma informed care

- **Safety,**
- **Trustworthiness,**
- **Choice, Collaboration, Empowerment.**
- These principles aim to create physically and emotionally safe environments that avoid re-traumatization by prioritizing transparency, shared decision-making, and client validation.

TYPES OF ADDICTIONS

- **ALCOHOL**
- **PRESCRIPTION DRUGS OPIATES/ BENZODIAZEPINES**
- **CANNABIS**
- **ILLICIT DRUGS cocaine , Heroin , crystal meth**
- **NICOTINE**
- **CAFFEINE**
- **GAMBLING (Lottery tickets, bingo, casino etc)**
- **INHALENTS (HUFFING)**
- **INTERNET**
- **FOOD**
- **SHOPPING**
- **SEX**

Signs of an alcohol or drug problem can be mistaken for Signs of Aging

- **Problems sleeping**
- **Poor personal care**, such as not bathing, not eating (or not eating well) or not taking care of health problems
- **Poor Memory Depression** irritability, or confusion
- **Lack of interest** in usual activities,
- **Loss of co-ordination**, falls, slurred speech
- **Tremors and agitation**. signs of alcohol withdrawal,,
- **Falls and Injury**: Frequently dismissed as frailness unsteady gait
- **Problems sleeping**
- **Poor health/ personal care Changes in Appetite / poor nutrition**
- **Memory Loss/Confusion**: Often misattributed solely to dementia.
- **Isolation**: Sometimes mistaken for loneliness or social withdrawal
- **Shaking Tremors**

ALCOHOL USE DISORDER

DSM-5 criteria

DSM-5 defines **alcohol-use disorder** as "maladaptive alcohol use with clinically significant impairment as manifested by at least **two** of the following within any one-year period:

1. tolerance;
2. withdrawal;
3. taken in greater amounts or over longer time course than intended;
4. desire or unsuccessful attempts to cut down or control use;
5. great deal of time spent obtaining, using, or recovering from use;
6. social, occupational, or recreational activities given up or reduced;
7. continued use despite knowledge of physical or psychological sequelae.
8. Failure to fulfill obligation at work , school, or home
9. Use in dangerous situation (driving a car)
10. Continued use despite social or interpersonal problems due to substance abuse.
11. **Craving to use alcohol**

Addiction is not a Choice it's a disease of the brain

- **No one chooses to develop an addiction. It is a treatable medical condition that affects the brain, and like any other health issue is deserving of compassion and care.**

Dopamine Pathways

Serotonin Pathways

Frontal cortex

Striatum

Substantia nigra

Functions

- Reward (motivation)
- Pleasure, euphoria
- Motor function (fine-tuning)
- Compulsion
- Perseveration

VTA

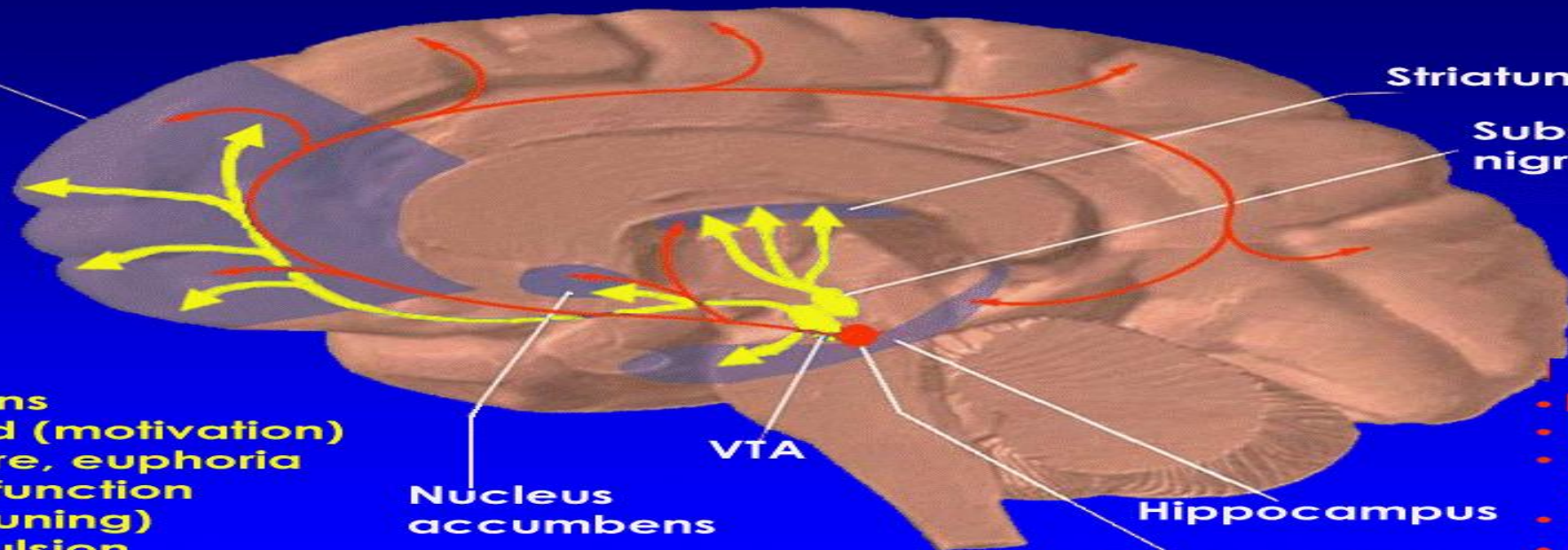
Nucleus accumbens

Hippocampus

Raphe nucleus

- Mood
- Memory processing
- Sleep
- Cognition

NIDA



The Disease Model of Addiction

- **Addiction is a primary chronic disease of the brain**
- **It is disease because drugs modify the chemistry and the structure of cells and circuits involved with reward, motivation, and memory.**
- **In the addictive brain, drugs *hijack* normal learning pathways and activate the rewards circuits in response to drug-associated cues, which leads to cravings and compulsive drug seeking behaviours despite harmful consequences.**
- **The clinical significance of these brain changes is that the addiction, once established becomes a chronic illness with relapses and remissions.**

The Moralizing of Addiction

- **The idea that people with addictions voluntarily choose drugs of addiction doesn't make addiction any less of a disease**
- **There are many chronic diseases such as COPD, HTN, CAD, DM that originate from life style.**
- **Knowing that drugs of abuse can lead to addiction doesn't deter many from experimenting because the majority of people that try drugs don't become addicted.**
- **While the initial choice to use drugs of abuse may have been voluntary, changes to the brain from the use of these drugs make it difficult for the addicted person to stop using.**

Why is Addiction different in the Geriatric Population?

Physiological Changes

- **Slower Metabolism:**
 - Older adults metabolize substances more slowly, meaning they stay in the body longer and can have a greater impact.
- **Reduced Muscle Mass:**
 - A lower percentage of muscle mass compared to body fat can lead to a more concentrated effect of substances, as they are more likely to be absorbed into the bloodstream.
- **Brain Sensitivity:**
 - Brain changes associated with aging can make older adults more susceptible to the effects of drugs, increasing the risk of addiction.

Psychological Factors

- **Social Isolation:**
- **Retirement, loss of loved ones, and physical limitations can lead to social isolation, increasing the risk of substance misuse as a way to cope with loneliness.**
- **Grief and Loss:**
- **Experiencing the loss of a spouse, family, or friends can be a significant trigger for substance misuse.**
- **Chronic Health Conditions:**
- **Older adults are more likely to have chronic health conditions, such as pain, anxiety, and depression, which may lead to reliance on medications or other substances for relief.**
- **Dementia and Cognitive Decline:**
- **The signs of substance misuse can be masked by the symptoms of dementia or other cognitive decline, making it difficult to detect. Alcohol related impairment in some instances may have some element of reversibility**

RECOGNIZE



What to look for when there is an AUD:

- **Evidence of heavy drinking / daily**
- **Drinking above the low risk drinking guidelines**
- **Poor Nutrition**
- **Frequent falls / bruising / fractures**
- **Odour of alcohol/ drinking during visit**
- **Visible empties**
- **Defensive when alcohol is discussed**
- **Neglect of self and environment / smoking/ burns to clothing and furniture**
- **Increased tolerance needing more alcohol to get the same effect**
- **Poor management of funds**

- **Drinking alone or hiding drinking (check the glass)**
- **new or worsening memory / confusion**
- **Incontinence**
- **Poor concentration and executive function**
- **Depression/ irritability / shaking/ withdrawal from alcohol**
- **Poor medication compliance**
- **Concurrent use of medications ie benzodiazepines, opioids , sedative hypnotics**
- **Co use of Cannabis or other substances,**

Table 4: Medical History Findings Related to Excessive Alcohol Intake

Alcohol-related illnesses	Poor nutrition, seizure activity, esophageal/gastrointestinal bleeding, aspiration pneumonia, anxiety, depression, neuropathies, pancreatitis, liver disease
Alcohol-related conditions misinterpreted	Depression, insomnia, nutritional deficiencies, falls as expected problems of aging
Age-related conditions exacerbated by excessive alcohol	Urinary incontinence, gait disturbances, depression, insomnia, delirium
Social history related to excessive alcohol use	Inability to fulfill major obligations, family dysfunction, difficulties with the law
Surgical history: alcohol-related injuries	Motor vehicle collisions, falls, and fractures

Source: Letizia & Reinbolz, 2005

How to identify how much a person is drinking?

- **Ask the question? Do you enjoy alcohol?**
- **Which do you prefer ? Beer wine or spirits?**
- **Establish intake How much do you drink on a typical day?**
- **Daily/ Socially**
- **If person is a poor historian, get collateral information**
- **Observations ie, visible empties, receipts**



Establish alcohol intake: how many standard drinks in a day?

CCSA 2019

For these guidelines, **“a drink”** means:

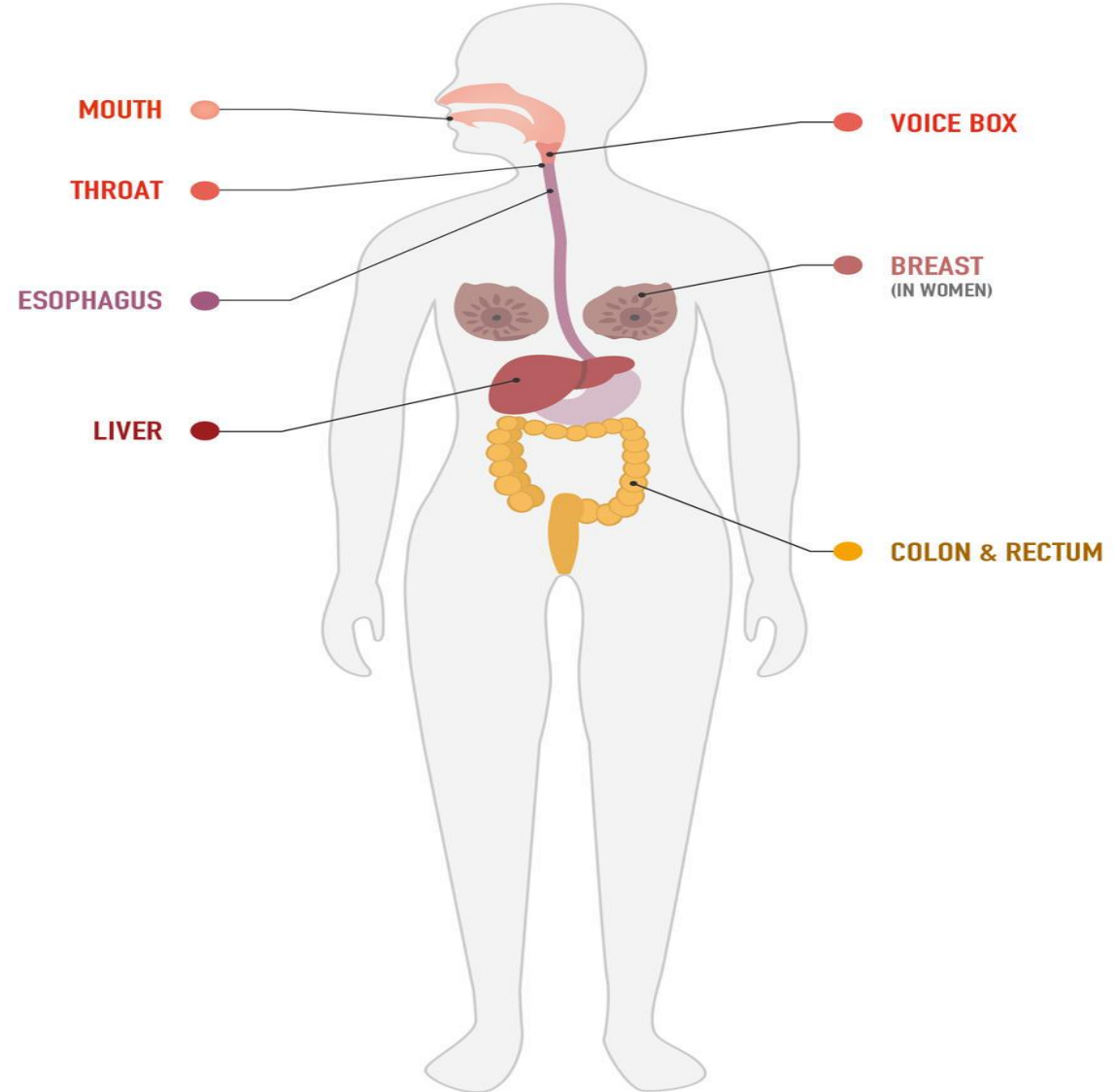


<https://www.cbc.ca/news/health/alcohol-warning-labels-cancer-1.6304816>

Why are we concerned about alcohol

Alcohol is a level one Carcinogen

Cancers Associated with Drinking Alcohol



What is the enabling factor?

- **Enabling** refers to well-intentioned behaviors by family/ friends / caregivers that, in practice, protect a person with an addiction from the negative consequences of their actions, ultimately allowing the addiction to continue, While enabling often stems from love, fear, or a desire to help, it differs from true support because it hinders, rather than helps, the recovery process.
- **Appropriate enabling** is supporting the older where they are at. Using holistic non judgmental approaches to care including harm reduction.
- **Harm reduction philosophy**
 - Decreases risks and harms associated with substance use
 - Offers a pragmatic approach to addressing problems
 - Provides an alternative when abstinence is not realistic, desired or necessary
 - Does not exclude abstinence as a goal

Helping vs. Enabling

Geriatric Considerations

- **Is there A diagnosis of Dementia? FTD / Alzheimer's/**
- **Enabling appropriately encourage reduction of Alcohol**
- **Don't shame scold the person for their substance use.**
- **Encourage proper nutrition**
- **Ask them to be at their best when you come to visit/ provide care.**
- **No drinking during professional visit. (if able)**
- **Reinforce positive behaviour**
- **Do not refuse to give care unless it is not safe to do so**
- **Make associations between health and substance use**
- **Call 911**

TRADITIONAL Approaches

- **Covering up mistakes: Making excuses for the person (e.g., calling their employer to say they are sick when they are hungover).**
- **Providing financial support: Paying rent, bills, or giving cash, which often funds the addiction.**
- **Taking over responsibilities: Doing the person's work, chores, or fixing problems they caused, allowing them to avoid the consequences of their behavior.**
- **Denying the severity: Downplaying the problem, pretending it does not exist, or justifying the behavior.**
- **Avoiding conflict: Giving in to demands to maintain peace, which continues the cycle of addiction**

Geriatric Considerations



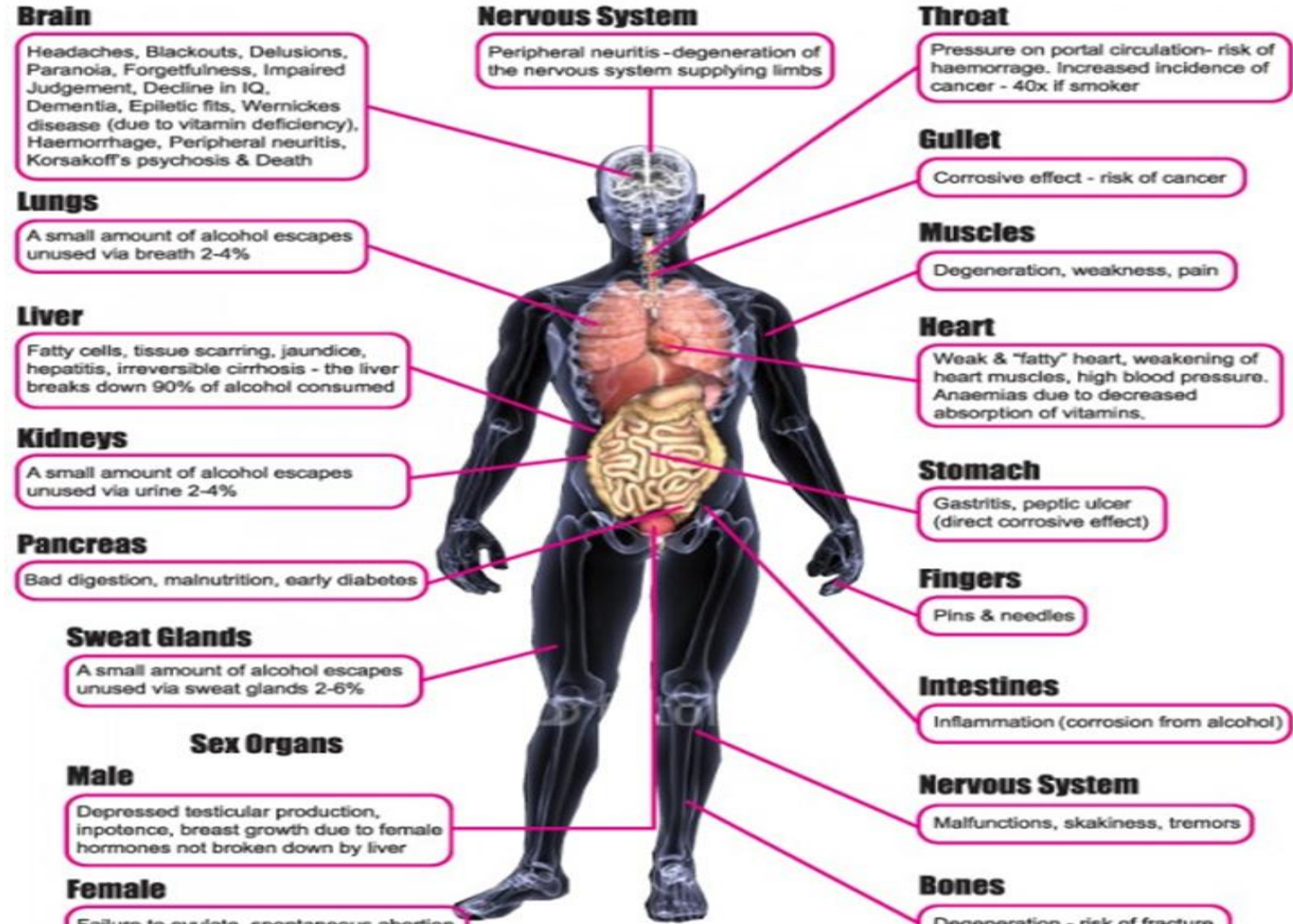
They keep asking me to change but I can't remember what from!

Why is Addiction different in the Geriatric Population?

- Alcohol not broken down by the liver goes to the rest of the body, including the brain.
- Alcohol can affect parts of the brain that control movement, speech, judgment, and memory.
- These effects lead to the familiar signs of intoxication : difficulty walking, slurred speech, memory lapses, and impulsive behavior.
- Long-term heavy drinking can shrink the frontal lobes of the brain, which impairs thinking

Long term consequences of Alcohol use In OA

- Physical dependence.
- Cognitive impairment, dementia
- Wernicke's Korsakoff's syndrome , ataxia
- poor nutrition & heavy alcohol use



KINDLING EFFECT OF WITHDRAWAL

- Increasing severity of withdrawal following repeated withdrawal episodes
- Increasing risk of seizures on withdrawal with increasing number of withdrawal episodes
- Progressive brain damage excitatory neurotransmitters with each withdrawal episode
- May lead to permanent brain damage (dementia)
- Prompt treatment with benzodiazepines to prevent seizures may prevent further damage
- Thiamine

Reversibility in Alcohol Related Dementia

- In contrast to other common causes of dementia, it has been suggested that the ***decline in cognitive or physical functioning in alcohol-related dementia is relatively non-progressive in abstinent ex-drinkers, or even partially reversible***; this is supported by imaging studies.

Goldman MS. Cognitive impairment in chronic alcoholics. Am Psychol 1983; 38: 1045–54.

Substance Use Disorders in Dementia

Alcohol and Dementia

Reversible?

- Abstinence fosters stability in alcohol-induced cognitive impairment, with possibility of improvement in ~20% of people (Oslin, 2003; Weytingh, 1995)
- In contrast to other dementias, ***the decline in cognitive functioning in alcohol-related dementia is relatively non-progressive in abstinent ex-drinkers, or partially reversible***; supported by imaging studies. (Goldman MS. Cognitive impairment in chronic alcoholics. Am Psychol 1983; 38: 1045–54.)

CIWA Alcohol

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED (CIWA-AR)

Patient: _____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: _____

Blood pressure: _____

NAUSEA AND VOMITING — Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

- 0 no nausea and no vomiting
1 mild nausea with no vomiting

2 intermittent nausea with dry heaves

3 constant nausea, frequent dry heaves, and vomiting

TREMOR — Arms extended and fingers spread apart.

Observation.

- 0 no tremor
1 not visible, but can be felt fingertip to fingertip

2 moderate, with patient's arms extended

3 severe, even with arms not extended

PAROXYSMAL SWEATS — Observation.

- 0 no sweat visible
1 barely perceptible sweating, palms moist

2 beads of sweat obvious on forehead

3 drenching sweats

ANXIETY — Ask "Do you feel nervous?" Observation.

- 0 no anxiety at ease
1 mild anxious

2 moderately anxious, or guarded, so anxiety is inferred

3 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION — Observation.

- 0 normal activity
1 somewhat more than normal activity

2 moderately fidgety and restless

3 paces back and forth during most of the interview, or constantly thrashes about

The CIWA-AR is not copyrighted and may be reproduced freely.

Tullman, J.T.; Szymon, P.; Schmeidler, J.; Baran, C. S.; and Nelson, J.M.
Assessment of alcohol withdrawal: the revised Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-AR). *Journal of Clinical Psychopharmacology*, 1994, 14(2), 105-110.

TACTILE DISTURBANCES — Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.

- 0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

AUDITORY DISTURBANCES — Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

- 0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES — Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

- 0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD — Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

- 0 no present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM — Ask "What day is this? Where are you? Who am I?"

- 0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Patients scoring less than 10 do not usually need additional medication for withdrawal.

Total CIWA-AR Score _____

Rater's Initials _____

Maximum Possible Score 67

Alcohol Withdrawal and Older Adults

- Withdrawal takes longer up to two weeks
- Complicated by medical health
- May be at increased risk for delirium
- Increased risk for falls

SEVERE WITHDRAWAL: DELIRIUM TREMENS

- Severe withdrawal can progress to delirium tremens
- **5% cases**
- onset 2-4 days after last drink
- delirium= hallucinations, agitation, disorientation and confusion
- autonomic overdrive= tremor, fast heart-rate, high blood pressure, fever, and sweating
- **medical emergency with risk of death of 5%**

RESPOND



Withdrawal cognitively impaired

- **Never initiate withdrawal with out medical supervision**
- **If no history of complicated withdrawal Primary care can monitor**
- **Taper alcohol intake slowly no more than 10 % of intake or 1 standard drink every two weeks**
- **Note behaviors around reduced amounts?**
- **redirect offer snacks water / juice**
- **Use of non alcohol based beverages as part of a taper not instead of alcohol**

Key Points



“Recognize, Respond, Report. Fire Use in Home Settings”

RECOGNIZE .

RESPOND .

REPORT .



With cognitive impairment & SUD' how can you support?

- **Recognise: Identify what do you see?**
- **What do you hear from the person.**
- **What are the Risks?**
- **Do not remove alcohol as this may precipitate withdrawal**
- **Respond: determine safety, call 911**
- **if evidence of Injury or confusion or risk ie suicidal ideation**
- **Report Inform your supervisor**

CASE : Mrs A

- **72 year old female recently widowed. Hx; NIDD, Hypertension, mild cognitive impairment. Previously drank wine socially with her husband. When her husband was alive they attended church regularly and were socially active. Since his death she has increased her drinking daily. You notice she is becoming forgetful and is not eating well, the apartment is less tidy. She is not changing her clothes & not bathing.**
- **Today when you come to give her care she is lying on the floor. She asks you to help her get up. Her speech is slurred and you notice a half empty bottle of wine on the kitchen table and another bottle of wine on the end table. She has a bruise on her forehead and her hand is swollen and bruised.**

How do you proceed?

Do you pick her up?

Do you give her a drink if she asks for it?

Case #1 – Mr. A Alcohol and Dementia

- **Male 60-65**
- **Married**
- **Three children**
- **University educated**
- **Professional left practice due to memory issues**
- **Plays piano daily**
- **Family hx of alcoholism**
- **Aware of his memory loss (father had Alzheimer's)**



Substance Use

- Admits to drinking 2 standard drinks (SD) per day
- Drinks - 12 SDs per day (10 beers and 2 glass of wine)
- Increases to 1 bottle of wine on weekends (Thursday-Sunday)
- Goes to a club daily for exercise
- Elderly mother buys alcohol for him once a week
- Frequents local bars drinks only 2 beers at each location



Beer
341 ml (12 oz.)
5% alcohol content



Cider/cooler
341 ml (12 oz.)
5% alcohol content

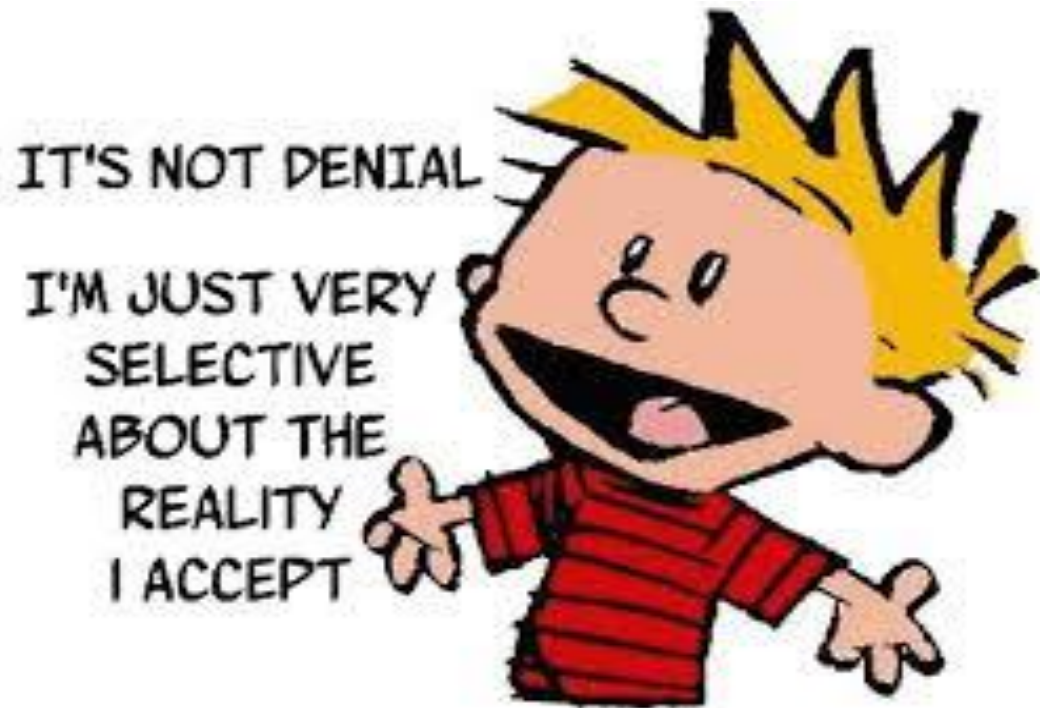


Wine
142 ml (5 oz.)
12% alcohol content



Distilled alcohol
(rye, gin, rum, etc.)
43 ml (1.5 oz.)
40% alcohol content

Mr. A denies he has a problem. I only drink two beers! How do you support?



How do you provide compassionate care when there is no motivation to change?

- What are the next steps?
- What are the ethical implications of the wife (SDM) forcing him to go to long term care?
- What are the physical concerns if the wife stops providing alcohol?
- What are some options?

Preparation for Treatment



Options

- Therapeutic Lie
- Use of slow taper using dealcoholized beverage switch out one every two weeks
- Use of Anticraving medications to support reduction
- Ensure proper nutrition



Outcome: Mr A is abstinent in 3 months still not eating, has cognitively declined, needs long term care



Other substances

- Opioids



- Cannabis



- Illicit substances crack cocaine ,
- Methamphetamine



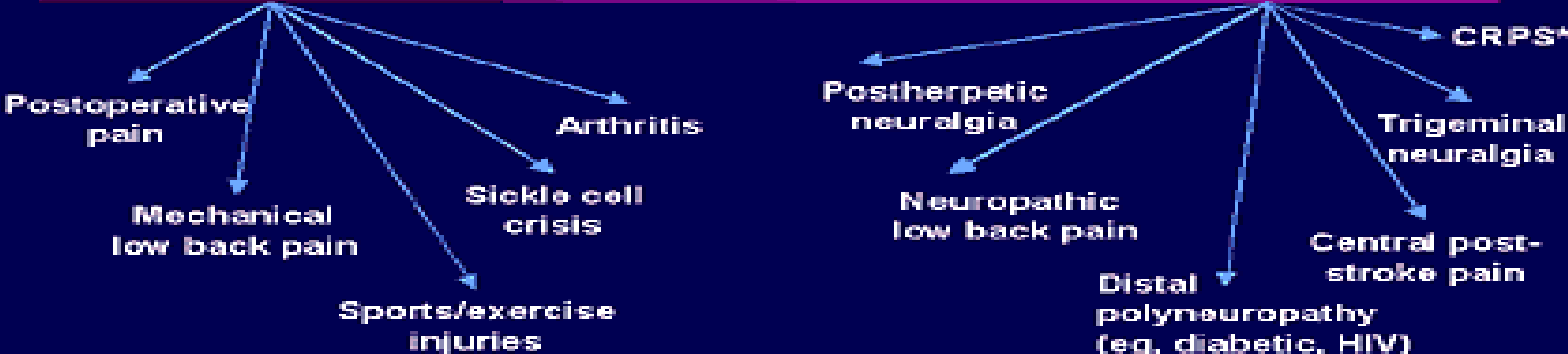
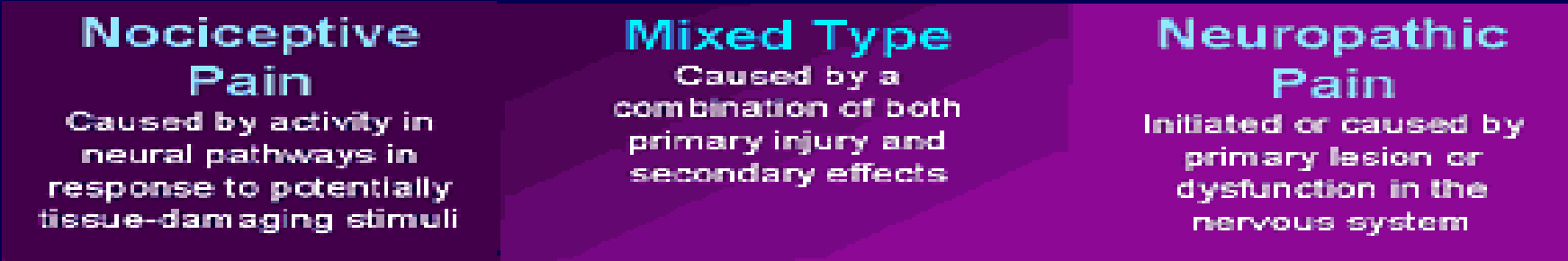
Opioids



- Naloxone kit on premises
- Are the opioids prescribed or from other sources?
- Is person taking more than prescribed?
- How do you know if they are taking more than prescribed?
- Who is visiting? Are there pills missing after visits?
- Is the pain being managed?
- Drug seeking vs pain relief seeking?
- Monitor medication use of timed pill minders can be useful

Pain

Nociceptive vs Neuropathic Pain



*Complex regional pain syndrome

Opioid toxicity

SIGNS OF A FENTANYL OVERDOSE

- Severely slowed or stopped breathing
- Blue lips and skin color
- Cold, clammy skin
- Markedly constricted pupils
- Stupor
- Seizures
- Loss of consciousness
- Coma



Opioid withdrawal

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ Date and Time: ____/____/____:_____	
Reason for this assessment: _____	
Resting Pulse Rate: _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	GI Upset: over last 1/2 hour 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: over past 1/2 hour not accounted for by room temperature or patient activity. 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	Tremor: observation of outstretched hands 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness: Observation during assessment 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	Yawning: Observation during assessment 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible.	Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness. 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches: if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing: Not accounted for by cold symptoms or allergies 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	<p style="text-align: right;">Total Score _____</p> <p style="text-align: center;">The total score is the sum of all 11 items</p> Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

Mrs. O

- Long standing history of chronic pain
- Daily use of opioids
- Lately she has been using more than prescribed
- You arrive and she is sitting in her chair and appears to be nodding off.
- Not responsive when you call her name
- You notice the pill bottle is empty and you know the px was filled one week ago.

What is the first thing you do if you suspect opioid toxicity?

- ADMINISTER NALOXONE



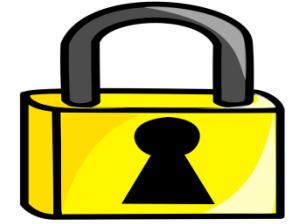
RESPOND



Cannabis toxicity

- Individuals who have consumed too much Cannabis will often report feeling really sleepy, anxious, fearful, nervous and / or having visions. People will often feel nauseous and may have vomiting that won't stop. This is referred to as **HYPEREMISIS SYNDROME**. If a resident experiences any of these symptoms, have nursing assess and physician monitoring. If symptoms persist transport to Emergency Department.
- It is important to note that different forms of Cannabis may impact you differently and can react with other medication you are taking. It is not a good idea to mix Cannabis with other medications or alcohol.

Safety Tips



- Residents need to keep their Cannabis for personal use in a locked box or container.
- Just like all prescription medication, if prescribed Cannabis - don't share it. Also, if your name is not on the bottle / container - don't use it.
- Don't store edibles in see through containers where it is easy to see the contents of the bottle.
- Keep Cannabis out of reach and out of view from other residents and especially children.
- Different forms of Cannabis may impact the person differently and can react with medication you are taking. Avoid mixing Cannabis with other medications or alcohol.
- CBD can cause drowsiness, which may increase risk of falling. Take precautions and ensure someone is with the resident if consuming Cannabis.
- concern for residents who drive high. It is advisable to not drive for at least 24 hours after using Cannabis.



Stimulant over dose

- Meth & Crack are very activating with a short high followed by extreme low
- Psychotic / agitation/ twitching/
- may not wake up when aroused.
- skin tone may be bluish or grayish.
- breathing may be slow, shallow, or erratic.
- temperature may be elevated.
- snoring loudly.
- gurgling or choking sounds.
- Ensure quiet environment
call 911
- Stay with the person

WHY DO WE REPORT ?



Why Report?

- Safety of client and staff
- Allows organization to set policies to support your work
- Opportunity to discuss approaches to care
- Allows you options allows you to support best practise and provide best practise care
- Opportunity to add resources for your client
- Use of Addictions services provincial RAAM clinics
- Outreach programs
Invites further investigations to diagnose

Thank you for listening



Resources

- For more information about Cannabis use and its risks and benefits, the following websites are recommended:

Canadian Coalition for Seniors Mental Health CCSMH https://ccsmh.ca/wp-content/uploads/2020/09/CCSMH_Cannabis_brochure_ENG.pdf

FOR CARE GIVERS <https://ccsmh.ca/areas-of-focus/cannabis-use-2/older-adults-and-care-partners/>

<https://ccsmh.ca/substance-use-addiction/cannabis-guidelines/>

https://ccsmh.ca/wp-content/uploads/2020/01/Cannabis_Use_Disorder_ENG_WEB_Jan-21.pdf

Cannabis and Older Adults Know the Facts BSO BrainXchange Older Adult Substance Use Collaborative
https://brainxchange.ca/Public/BSO/Files/Substance-Use/Cannabis-Older-Adults-Know-the-Facts_Accessible_Fl.aspx

Active Aging Canada: <https://www.activeagingcanada.ca/participants/projects/cannabis-and-older-adults.htm>

10 Ways to Reduce Risks to Your Health When Using Cannabis: <https://www.camh.ca/-/media/files/pdfs---reports-and-books---research/canadas-lower-risk-guidelines-cannabis-pdf.pdf>

The Straight Dope on Cannabis and Older People: <https://www.ryerson.ca/content/dam/crnc/knowledge/infocus/factsheets/InFocus-Marijuana.pdf>

Cannabis and your Health, Government of Canada: <https://www.canada.ca/en/services/health/campaigns/cannabis/health-effects.html>

Medical Cannabis: A Guide to Access, Arthritis Society of Canada: <https://arthritis.ca/getmedia/1148862d-d223-4a78-9b06-483532041d2c/Medical-Cannabis-Brochure-2018-EN-WR.pdf>

Ontario's Doctors Help You Make Informed Decisions: Clearing the Air About Adult Use Cannabis, Ontario Medical Association:

Canadian Guidelines for Substance Use Disorders in Older Adults

- <https://vimeo.com/347306120>
- <https://vimeo.com/358887906>
- <https://brainxchange.us8.list-manage.com/track/click?u=42d3dda06d31f20b2d894f558&id=a92c4c600a&e=28281069dc>

- For more information about Cannabis use and its risks and benefits, the following websites are recommended:

Canadian Coalition for Seniors Mental Health CCSMH

https://ccsmh.ca/wp-content/uploads/2020/09/CCSMH_Cannabis_brochure_ENG.pdf

FOR CARE GIVERS <https://ccsmh.ca/areas-of-focus/cannabis-use-2/older-adults-and-care-partners/>

<https://ccsmh.ca/substance-use-addiction/cannabis-guidelines/>

Contact information

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Discussion / Q&A



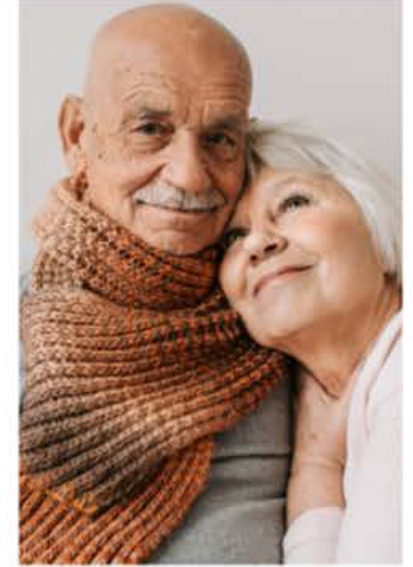
Marilyn White-Campbell,
Geriatric Addiction Specialist Behavioural Supports Ontario,
Behaviour Support for Seniors Program, Baycrest



APRIL 7 | TORONTO, ON

NATIONAL CAREGIVER DAY SYMPOSIUM

Caregiving Across Ages and Stages



Attend In-Person or Join Virtually for a heartfelt day dedicated to honouring the amazing caregivers who support individuals across all ages and stages of life.

For more information visit:

cdnhomecare.ca/national-caregiver-day-symposium-2026

Upcoming Sessions

Project ECHO
Personal Care Providers

All Teach, All Learn
Building Skills, Knowledge, and Confidence



Consent, Understanding, and Care: Recognizing Mental Capacity for Personal Care Providers

April 15, 2026 | 12:00 pm – 1:00 pm (ET)

Laura Tamblyn-Watts, CanAGE

Observation to Action:

Responding to Abuse and Neglect in Home Care Clients

May 13, 2026 | 12:00 pm – 1:00 pm (ET)

Laura Tamblyn-Watts, CanAGE



cdnhomecare.ca/chca-project-echo-personal-care-providers