The assessment should be performed regardless of physical, mental, or cognitive co-morbidities with modifications as deemed appropriate. [**GRADE: Evidence: Moderate; Strength: Strong**]

RECOMMENDATION #10:

Assess older adults with AUD for cognitive impairment using a validated tool every 12 months or as indicated. In cases of cognitive impairment, repeat the cognitive evaluation at 6 and 12 months after a reduction or discontinuation of alcohol, to assess for evidence of improvement. The treatment plan should specify the timeline and procedure for ongoing evaluation of clinical outcomes and treatment effectiveness. [**GRADE: Evidence: Moderate; Strength: Strong**]

RECOMMENDATION #11:

The least intrusive or invasive treatment options, such as behavioural interventions, should be explored initially with older adults who present with a mild AUD. These initial approaches can function either as a pre-treatment strategy or as treatment itself.
[**GRADE: Evidence: High; Strength: Strong**]

RECOMMENDATION #12:

Routinely offer alcohol behavioural intervention and case management with pharmacological treatment (e.g., anti-craving medication) as it may improve the efficacy of primary care treatment.
[**GRADE: Evidence: Moderate; Strength: Strong**]

RECOMMENDATION #13:

Naltrexone and acamprosate pharmacotherapy can be used to treat AUD in older adults, as indicated, with attention to contraindications and side effects. Naltrexone may be used for both alcohol reduction and abstinence, while acamprosate is used to support abstinence. In general, start at low doses and titrate slowly, with attention to open communication with the patient. Initiation may be done in the home, hospital, during withdrawal management, or in long-term care with subsequent transition to an appropriate placement.
[**GRADE: Evidence: High; Strength: Strong**]

RECOMMENDATION #14:

All older adults with AUD, and their caregivers and support persons, should be offered psychosocial treatment and support, as indicated, as part of a treatment plan. [**GRADE: Evidence: Moderate; Strength: Strong**]

RECOMMENDATION #15:

Use the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) to screen for those requiring medical withdrawal management (prior delirium, seizures, or protracted withdrawal). Patients who are in poor general health, acutely 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 medically-managed and monitored intensive treatment or hospital settings.
[**GRADE: Evidence: High; Strength: Strong**]

RECOMMENDATION #16:

In the management of alcohol withdrawal in older adults, it is best to use the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) symptom score with protocols using a shorter-acting benzodiazepine such as lorazepam. One should also pay close attention to comorbidities to avoid complications.
[**GRADE: Evidence: High; Strength: Strong**]

RECOMMENDATION #17:

As a harm reduction strategy for older adults in controlled environments, where medical withdrawal is not available or deemed appropriate, it is recommended that a managed alcohol taper be considered. Individualize the taper by 1 standard drink every 3 days (aggressive tapering), weekly (moderate tapering), or every 2–3 weeks (mild tapering) with CIWA-Ar monitoring to keep the withdrawal symptom score < 10. The approach should be individualized, incremental, and with an indeterminate timeline.
[**Consensus**]

RECOMMENDATION #18:

To prevent the development of Wernicke's encephalopathy during withdrawal, at least 200 mg of parenteral thiamine (IM or IV) should be administered daily for 3–5 days. [**GRADE: Evidence: Low; Strength: Strong**]

RECOMMENDATION #19:

Health care practitioners, older adults, and their families should advocate for adequate access and funding for treatment for AUD, specifically access to pharmacotherapy (naltrexone and acamprosate) and psychosocial therapies. [**Consensus**]

RECOMMENDATION #20:

Treatment response for AUD should be monitored though laboratory measures such as gamma-glutamyl transferase (GGT) and Mean Cell Volume (MCT). [**GRADE: Evidence: Moderate; Strength: Strong**]

RECOMMENDATION #21:

The severity and management of concurrent physical and mental health conditions (including co-occurring psychiatric disorders, suicide risk, and cognitive disorders), as well as significant social transitions in the individual or family, should continue to be reviewed and monitored regardless of continuance, reduction, or cessation of alcohol use. [**GRADE: Evidence: Moderate; Strength: Strong**]

RECOMMENDATION #22:

Peri-operative elective surgical management should include medically supported withdrawal or alcohol use taper pre-operatively, with post-operative treatment and consideration of anti-craving medication. [**GRADE: Evidence: Low; Strength: Strong**]