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CME Day
May 2021

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Promouvoir la santé mentale des personnes âgées en reliant les personnes, les idées et les ressources.

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Substance Use Disorders in the Older Adults: a Review of Clinical Practice Guidelines

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Faculty/Presenter Disclosure

- **Faculty:** David Conn
- **Relationships with financial sponsors:**
  - **Grants/Research Support:** Grants to the Canadian Coalition for Seniors' Mental Health - from Health Canada's Substance Use and Addictions Program (P.I. of Guideline & e-learning projects)
  - **Speakers Bureau/Honoraria:** CCSMH Working Group members received an honorarium for their work on the guideline project
  - **Consulting Fees:** None
  - **Patents**: None
  - **Other:** None

Objectives

At the end of this session, participants will be able to:

- recognize clinical presentations indicative of substance use disorders in the older adult;
- discuss common substance use disorders in older adults; and
- distill the evidence informing approaches to assessment and management of substance use disorders in older adults.

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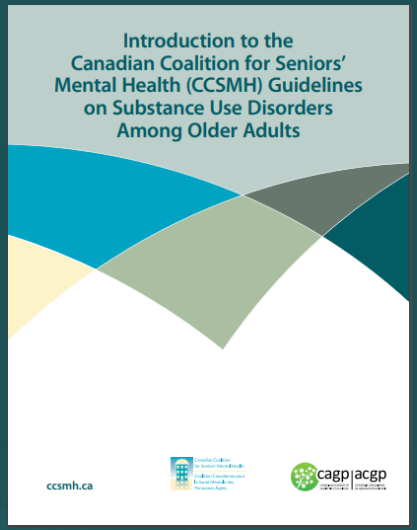
Introduction to the Canadian Coalition for Seniors' Mental Health (CCSMH) Guidelines on Substance Use Disorders Among Older Adults
ccsmh.ca
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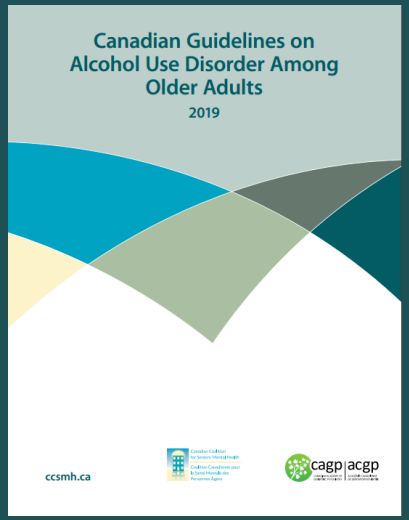
Canadian Guidelines on Alcohol Use Disorder Among Older Adults
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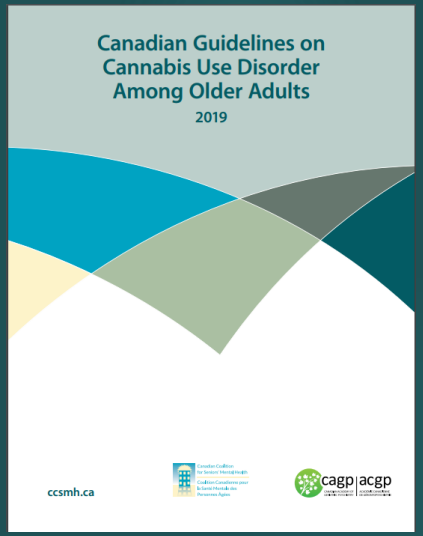
Canadian Guidelines on Cannabis Use Disorder Among Older Adults
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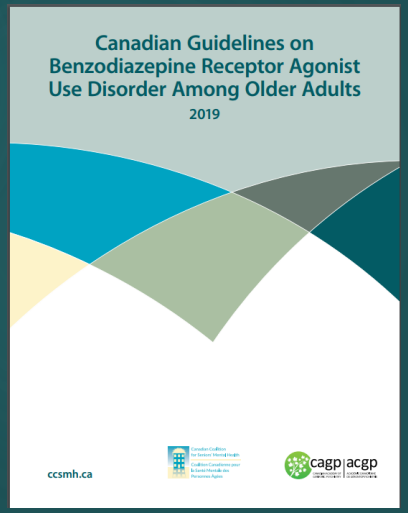
Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder Among Older Adults
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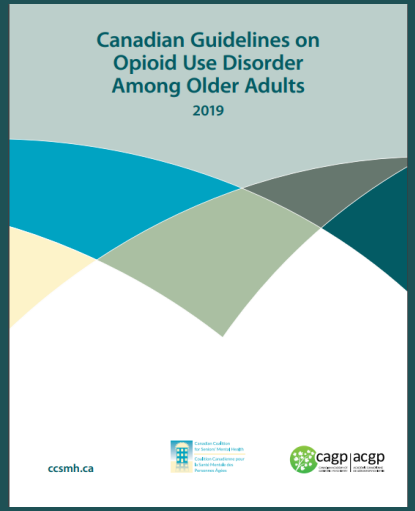
Canadian Guidelines on Opioid Use Disorder Among Older Adults
2019
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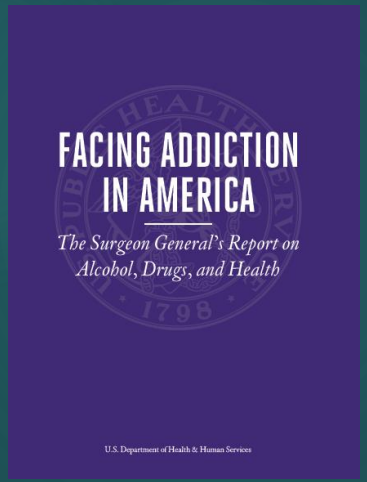
  - Claire Checkland: CCSMH Executive Director
  - Indira Fernando: Project Coordinator
  - All Guideline Co-Chairs & Working Group members
  - Steering Committee
  - Canadian Centre on Substance Use & Addiction
  - Baycrest, Bruyere, CAGP, CAMH, CGS, CMHA, NICE, Reconnect (COPA), Fountain of Health

From the Surgeon General's Report

- "Well-supported scientific evidence shows that addiction to alcohol or drugs is a chronic brain disease that has potential for recurrence and recovery".

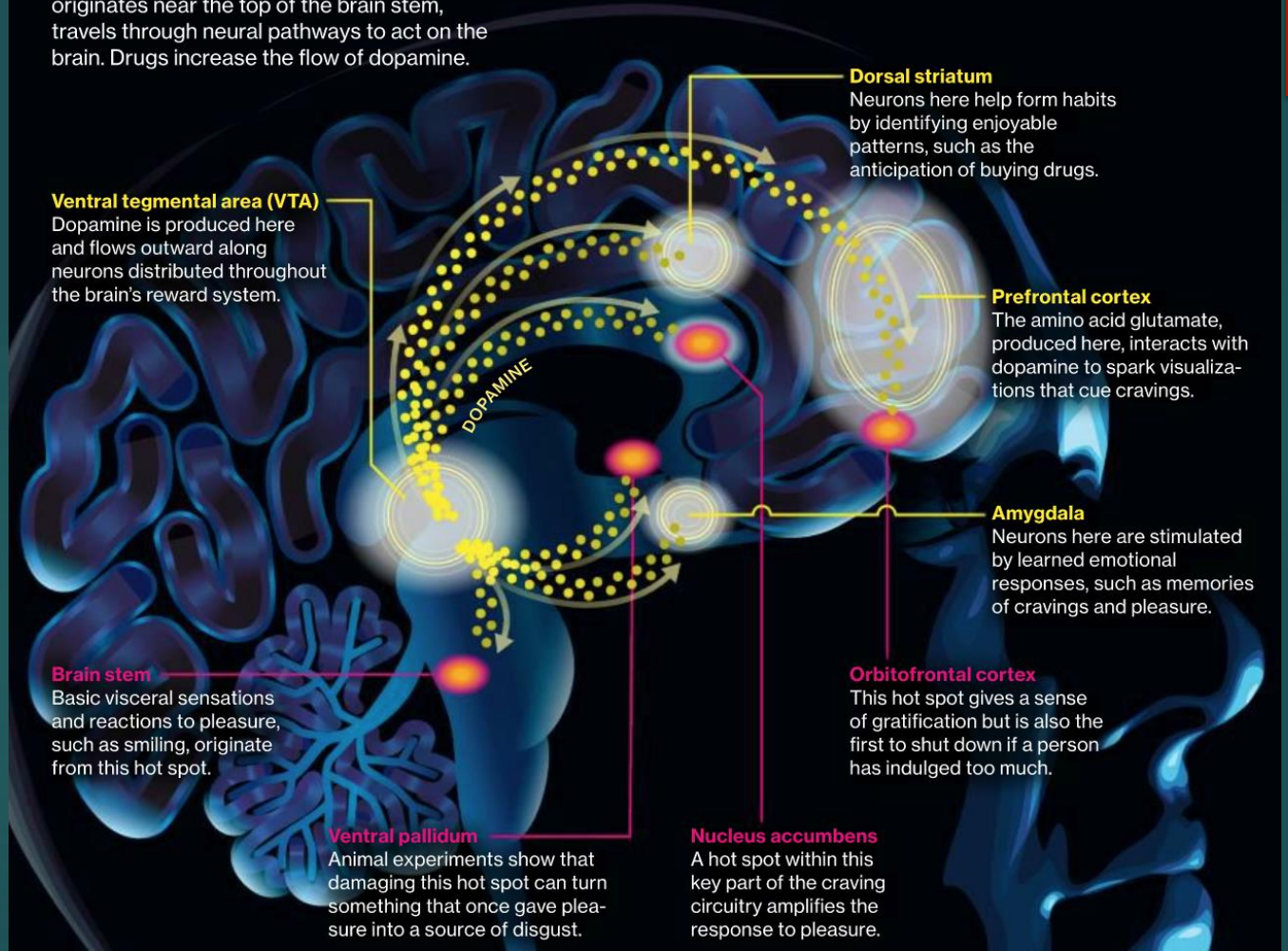


American Society of Addiction Medicine definition of Addiction (2019)

- A treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment and an individual's life experiences

PATHWAYS TO CRAVING

Desire is triggered when dopamine, which originates near the top of the brain stem, travels through neural pathways to act on the brain. Drugs increase the flow of dopamine.



Dorsal striatum
Neurons here help form habits by identifying enjoyable patterns, such as the anticipation of buying drugs.

Ventral tegmental area (VTA)
Dopamine is produced here and flows outward along neurons distributed throughout the brain's reward system.

Prefrontal cortex
The amino acid glutamate, produced here, interacts with dopamine to spark visualizations that cue cravings.

Amygdala
Neurons here are stimulated by learned emotional responses, such as memories of cravings and pleasure.

Brain stem
Basic visceral sensations and reactions to pleasure, such as smiling, originate from this hot spot.

Orbitofrontal cortex
This hot spot gives a sense of gratification but is also the first to shut down if a person has indulged too much.

Ventral pallidum
Animal experiments show that damaging this hot spot can turn something that once gave pleasure into a source of disgust.

Nucleus accumbens
A hot spot within this key part of the craving circuitry amplifies the response to pleasure.

Substance Use Disorder DSM-IV versus DSM-5

	DSM-IV Abuse[a]		DSM-IV Dependence[b]		DSM-5 Substance Use Disorders[c]	
Hazardous use	X	≥1 criterion	–		X	≥2 criteria
Social/interpersonal problems related to use	X		–		X	
Neglected major roles to use	X		–		X	
Legal problems	X		–		–	
Withdrawal[d]	–		X	≥3 criteria	X	
Tolerance	–		X		X	
Used larger amounts/longer	–		X		X	
Repeated attempts to quit/control use	–		X		X	
Much time spent using	–		X		X	
Physical/psychological problems related to use	–		X		X	
Activities given up to use	–		X		X	
Craving	–		–		X	

Risk Factors

- Effects of aging, physiological and psychosocial changes, cognitive impairment
- Genetic factors
- Adverse childhood experiences / Elder abuse
- Environmental factors such as stress, isolation, loneliness, and poverty play additional roles and can be particularly relevant for older adults. (relevant during pandemic)
- In addition, deficiencies in our health care systems, polypharmacy, over-prescribing, and a lack of awareness among older adults of the risks associated with drug use can contribute.

Table 2: Physical Symptom Screening Triggers (Centre for Substance Abuse Treatment, 1998)

- Sleep complaints; observable changes in sleeping patterns; unusual fatigue, malaise, or daytime drowsiness; apparent sedation (e.g., a formerly punctual older adult begins oversleeping and is not ready when the senior centre van arrives for pickup)
- Cognitive impairment, memory or concentration disturbances, disorientation, or confusion (e.g., family members have difficulty following an older adult's conversation, the older adult is no longer able to participate in the weekly bridge game or track the plot on daily soap operas)
- Seizures, malnutrition, muscle wasting
- Liver function abnormalities
- Persistent irritability (without obvious cause) and altered mood, depression, or anxiety
- Unexplained complaints about chronic pain or other somatic conditions
- Incontinence, urinary retention, difficulty urinating
- Poor hygiene and self-neglect
- Unusual restlessness and agitation
- Complaints of blurred vision or dry mouth
- Unexplained nausea and vomiting or gastrointestinal distress
- Changes in eating habits
- Slurred speech
- Tremor, poor motor co-ordination, shuffling gait
- Frequent falls and unexplained bruising

What Do We Know About Substance Use In Older Adults?

SUDs are Common:

21–44% in psychiatric population	**14–21% in geriatric medical population**

Increased vulnerability to effects of substance due to unique physiological, psychological, social and pharmacological circumstances

The challenge of complex clinical presentations

Co-morbidities, frailty, cognitive impairment, polysubstance use

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Canadians have several misperceptions when it comes to substance use among older adults. Some don't think it's an issue at all. Others believe it's too late to improve the quality of life of someone who uses substances in older age.

- A call for Action:
  Increased awareness
  Education & Training
  Guidelines
  Available and accessible age-specific SUD treatments & individualized care

http://www.ccsa.ca/Resource%20Library/CCSA-Substance-Use-and-Aging-Report-2018-en.pdf

thebmj

BMJ 2017;358:j3885 doi: 10.1136/bmj.j3885 (Published 2017 August 21)

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EDITORIALS

Check for updates

Substance misuse in older people

Baby boomers are the population at highest risk

Rahul Rao *visiting researcher*[1], Ann Roche *director*[2]

[1]South London and Maudsley NHS Foundation Trust, London, UK; [2]National Centre for Training and Addiction, Flinders University Faculty of Medicine, Nursing and Health Sciences, Adelaide, Australia

SUBSTANCE USE DISORDERS AMONG OLDER ADULTS ARE UNDER-STUDIED AND UNDER-IDENTIFIED!

Alcohol

Baby boomers' drink and drug misuse needs urgent action, warn experts

By 2020, the number of over-50s receiving treatment for substance misuse problems is expected to double in Europe and treble in the US, say researchers

A 2011 report advised that due to age-related physiological and metabolic changes, older people should drink no more than 11 units of alcohol per week. Photograph: Alamy

This article is 1 month old

2,213

Nicola Davis

@NicolaKSDavis

Wednesday 23 August 2017 06.00 BST

Psychiatry Research 290 (2020) 113142

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Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Letter to the Editor

Avoiding a new epidemic during a pandemic: The importance of assessing the risk of substance use disorders in the COVID-19 era

Annals of Internal Medicine

IDEAS AND OPINIONS

An Epidemic in the Midst of a Pandemic: Opioid Use Disorder and COVID-19

G. Caleb Alexander, MD, MS; Kenneth B. Stoller, MD; Rebecca L. Haffajee, JD, PhD, MPH; and Brendan Saloner, PhD

Guideline Methods

- Interdisciplinary guideline committee x 4 were formed including a PWLE
- Literature search:
  - Existing guidelines, meta-analyses, literature and website search
  - Databases: Cochrane Library, EMBASE, MEDLINE, PsycInfo, PubMed
- Selected literature appraised to develop evidence-based, clinically sound recommendations
- AGREE II used to identify guidelines that are of sufficient quality to inform guideline development
- Recommendations: Prevention, Screening, Assessment and Treatment

GRADE: an emerging consensus on rating quality of evidence and strength of recommendations

Guyatt et al. (2008). BMJ (Clinical research ed.), 336(7650), 924-926.

- **Developed by a widely representative group of international guideline developers**
- **Clear separation between quality of evidence and strength of recommendations**
- **Explicit evaluation of the importance of outcomes of alternative management strategies**
- **Explicit, comprehensive criteria for downgrading and upgrading quality of evidence ratings**

QUALITY OF EVIDENCE

HIGH	Further research is unlikely to change confidence in the estimate of effect
MODERATE	Further research is likely to have an important impact on the confidence in the estimate of effect and may change the estimate
LOW	Further research is very likely to have an important impact on the confidence in the estimate of effect and is likely to change the estimate

Note: *Meta analyses and Randomized Controlled Trials are considered high quality vs. Observational studies which are considered low quality*

STRENGTH OF RECOMMENDATION

STRONG	Strong recommendations indicate high confidence that desirable consequences of the proposed course of action outweigh the undesirable consequences or vice versa.
WEAK	Weak recommendations indicate that there is either a close balance between benefits and down sides (including adverse effects and burden of treatment), uncertainty regarding the magnitude of benefits and down sides, uncertainty or great variability in patients' values and preferences, or that the cost or burden of the proposed intervention may not be justified.

(adapted from Guyatt et al, 2008)

NOTE: Some "consensus" recommendations

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Alcohol Use Disorder in Older Adults

CLINICAL PRACTICE GUIDELINES/CONSENSUS STATEMENTS

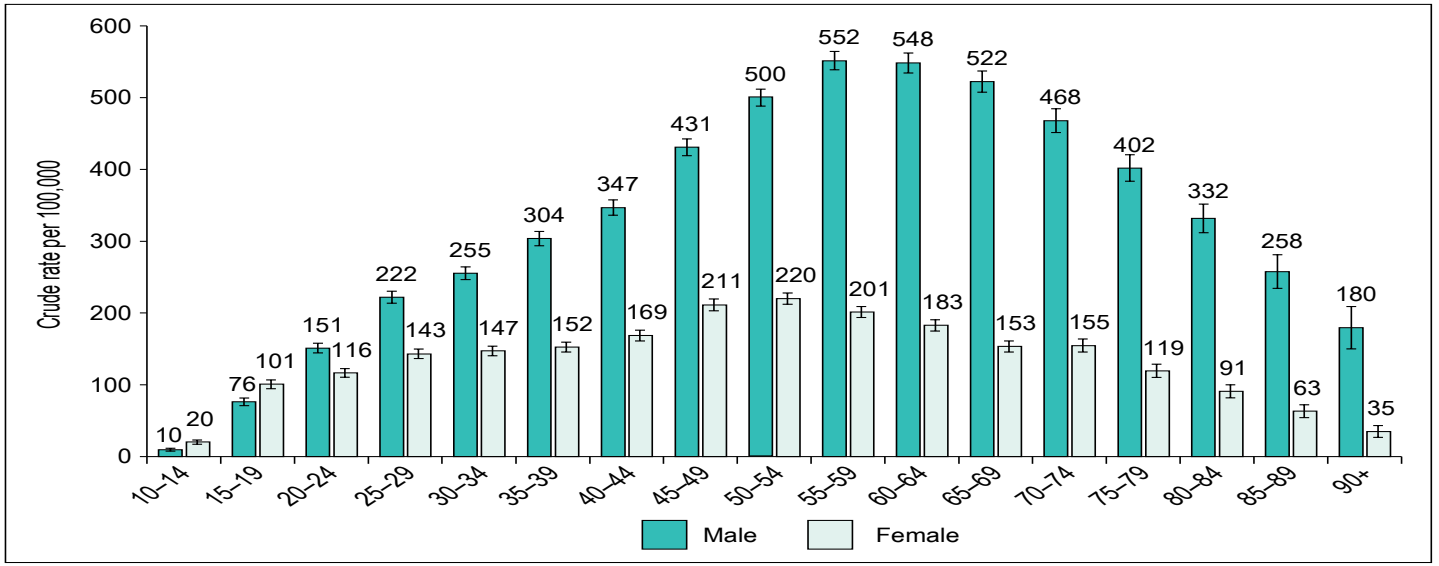
Canadian Guidelines on Alcohol Use Disorder Among Older Adults

Peter R. Butt, BA, MD, CCFP(AM), FCFP[1,2], Marilyn White-Campbell, BA, Dip GRT[3], Sarah Canham, PhD[4]; Ann Dowsett Johnston, Eunice O. Indome, PhD Struc Eng, MPH[5], Bonnie Purcell, PhD, C Psych[6,7], Jennifer Tung, PharmD, ACPR, BCGP[8], Lisa Van Bussel, MD, FRCPC[7,9] (for the Canadian Coalition for Seniors' Mental Health)

[1]Department of Family Medicine, University of Saskatchewan, Saskatoon, SK; [2]Saskatchewan Health Authority; [3]Baycrest Health Sciences, North York, ON; [4] College of Social Work, University of Utah, Salt Lake City, UT, USA; [5]School of Public Health and Health Systems, University of Waterloo, Waterloo, ON; [6]London Health Sciences Centre, London, On; [7]Department of Psychology, Western University, London, ON; [8]Grand River Hospital, Kitchener, ON; [9]Parkwood Institute, London, ON

https://doi.org/10.5770/cgj.23.425

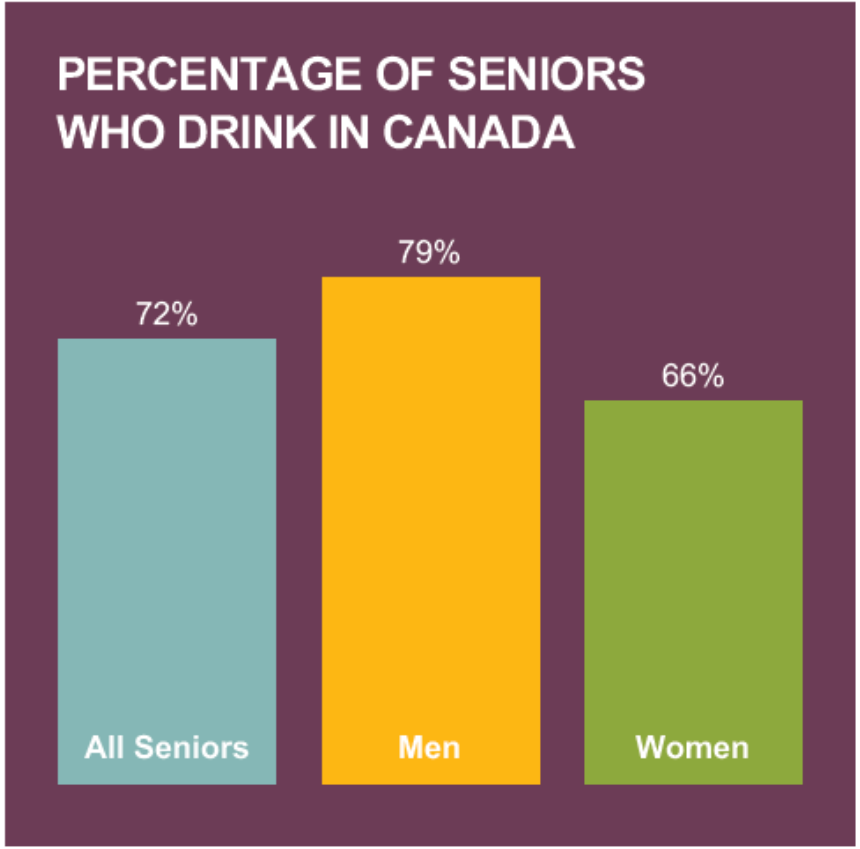
Figure 5 Crude rates for Hospitalizations Entirely Caused by Alcohol per 100,000 population age 10+, by age group and sex, 2015–2016



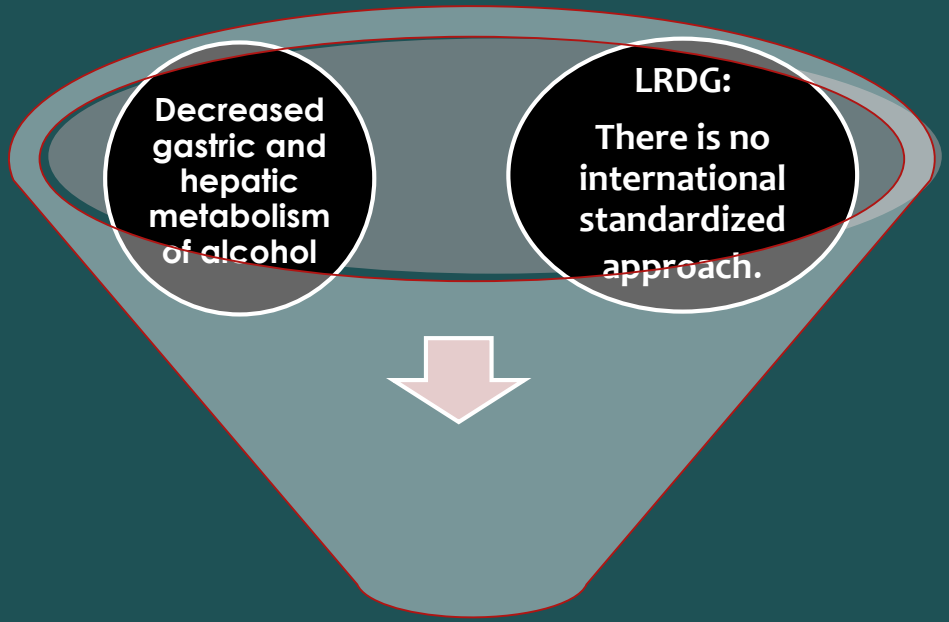
Sources

Hospital Morbidity Database, Discharge Abstract Database, National Ambulatory Care Reporting System and Ontario Mental Health Reporting System, 2015–2016, Canadian Institute for Health Information; population estimates, 2015, Statistics Canada.

According to the 2012 Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) of Canadians aged 65 and older, 72.1% drank alcohol in the 12 months preceding the survey (79.3% of men and 66.3% of women). Of those that indicated drinking, harmful use varied. In 2012, 8.4% of Canadian seniors 65 and older exceeded the limits recommended in Canada's Low Risk Drinking Guidelines (LRDG) for chronic (long-term) health effects. Eleven percent of Canadians aged 65 to 74 exceeded the limits and 3.7%[1] of Canadians aged 75 and older exceeded the limits.



Alcohol Use Disorder in Older Adults



Evolving risk of dementia, strokes, ABIs, increased frailty and risk of falls

Evidence:

- Plethora of expert opinion
- Paucity of older adult population specific evidence
- Most extrapolate from adult literature and clinical experience.

Recommendation: PREVENTION

Low Risk Drinking Guidelines for Older Adults

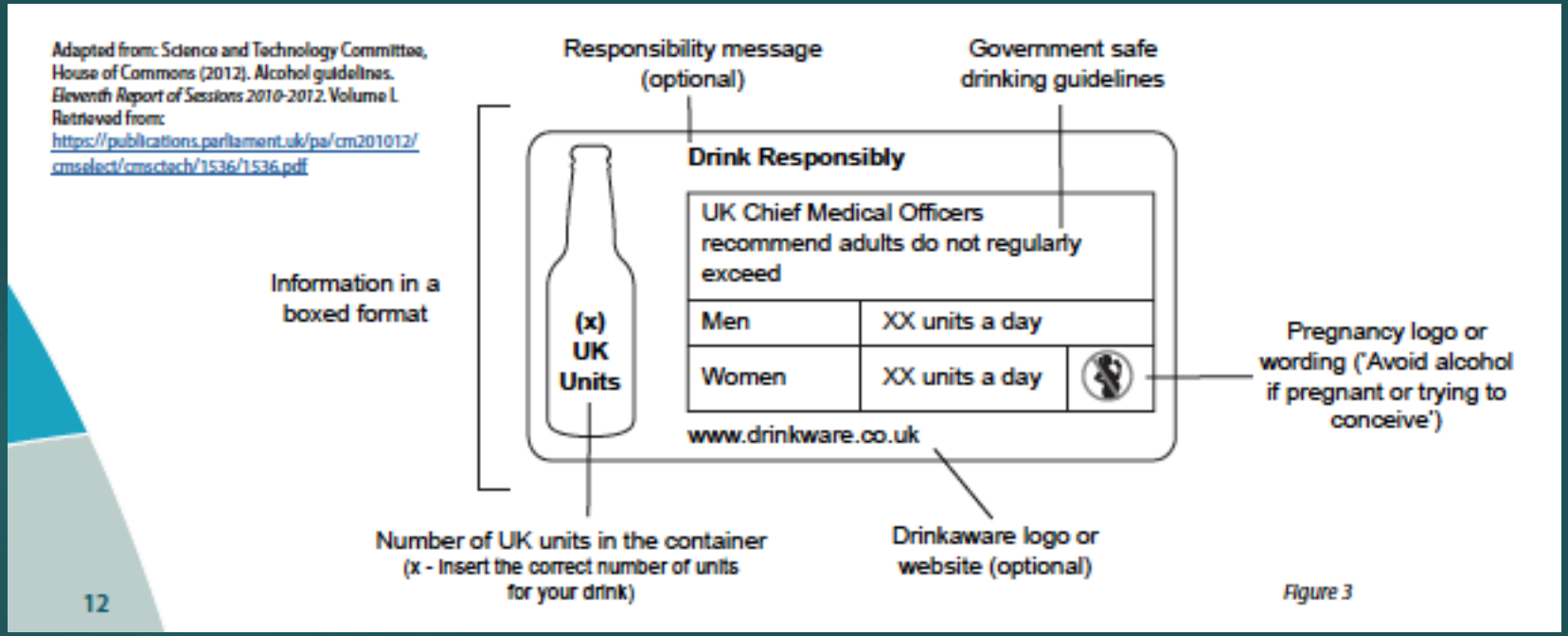
- For women 65 or older, no more than 1 standard drink per day with no more than 5 per week in total; for men 65 or older, no more than 1 – 2 standard drinks per day, with no more than 7 per week in total. Non-drinking days are recommended every week.
- Depending upon health, frailty, and medication use some adults should transition to these lower levels before age 65.
- As general health declines, and frailty increases, alcohol should be further reduced to 1 drink or less per day, on fewer occasions, with consideration given to drinking no alcohol.

GRADE: Evidence: Low; Strength: Strong

LRDG Comparison: Maximum Limits - Canada

- General Population
  - Men:
    - 3 drinks/day, 15 per week
  - Women
    - 2 drinks/day, 10 per week
- Older Adults
  - Men:
    - 1-2 drinks/day, 7 per week
  - Women
    - 1 drink/day, 5 per week

Labelling is recommended



SCREENING

- Ensure that screening for AUD in Older Adults is age appropriate; employs active listening; is supportive; uses a health or medical frame; 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 reduced occupational or social obligations.

[GRADE: Evidence: Moderate; Strength: Strong]

SCREENING

- All patients (including older adults) should be screened for alcohol use at least annually (as part of his or her regular physical examination). Screening should be conducted more frequently if consumption levels exceed the low risk drinking guidelines, if symptoms of an Alcohol Use Disorder evolve, if caregivers express concern, or if the older person is undergoing major life changes or transitions.

- (GRADE: Evidence: Moderate; Strength: Strong)

SCREENING TOOL	GERIATRIC SPECIFIC	TIME TO ADMINISTER (IN MINUTES)	PROS	CONS
Alcohol Use Disorders Identification Test (AUDIT)	No	5-10	• Assesses hazardous and harmful alcohol use • Provides information about quantity and frequency of use • Assesses for negative alcohol-related consequences	• Requires intact memory and mental calculation • Does not consider age-specific risks or differential presentation • Is face-valid, therefore easy to deny
CAGE	No	1-2	• Brief • Easy to administer from memory • Easy to score	• Originally designed for use with adults and ineffective for older adults • Only assesses for AUD • Is face-valid and fairly confrontational, therefore easy to deny or elicit defensiveness
Shortened Michigan Alcoholism Test – Geriatric version (SMAST-G)	Yes	2-5	• First geriatric-specific screening tool • Assesses for potential reasons for, and associated problems with, alcohol use	• Only assesses for AUD • Is face-valid, therefore easy to deny • Some questions require insight or self-awareness of a problem
Comorbidity Alcohol Risk Evaluation Tool (CARET)	Yes	2-5	• Provides information about quantity and frequency of use • Incorporates questions about medical conditions, medication use, and functional status	• Requires intact memory and mental calculation • Not readily available to clinicians; must contact author • Computer-scored
Senior Alcohol Misuse Indicator (SAMI)	Yes	2-5	• Geriatric specific screening tool that is non-confrontational and preserves therapeutic alliance • Designed for geriatric outreach clinicians • Gentle, non-judgmental language with open-ended questions	• Challenging to score • Few studies beyond the initial validation studies by the author

Table 1. Screening tools used with the older adult population

TREATMENT

- As a harm reduction strategy for frail older adults in controlled environments, it is recommended that a managed alcohol taper be considered. This avoids the risk of acute withdrawal in residential settings or upon transfer to long term care.
- 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 time line.
- (GRADE: Consensus)

TREATMENT

- 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]

TREATMENT

- 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 treatment itself.

- [GRADE: Evidence: High; Strength: Strong]

Benzodiazepine Receptor Agonist Use Disorder in Older Adults

CLINICAL PRACTICE

Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder Among Older Adults

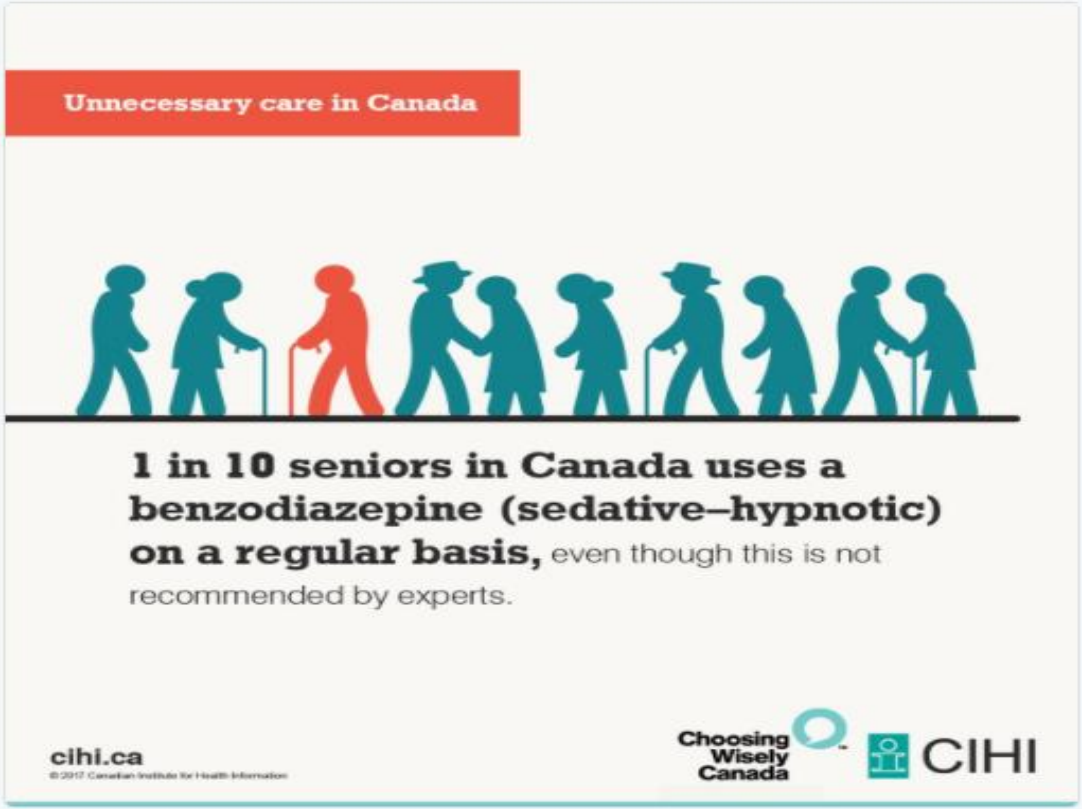
David K. Conn, MB, BCH, BAO, FRCPC[1,2], David B. Hogan, MD, FACP, FRCPC[3,4], Lori Amdam, BScN, MSN[5], Keri-Leigh Cassidy, MD, FRCPC[6], Peter Cordell, MD[7], Christopher Frank, MD, FCFP(COE)[8], David Gardner, PharmD, MSc[6], Morris Goldhar, CET, Joanne M-W Ho, MD, FRCPC[9], Christopher Kitamura, MD, FRCPC[1], Nancy Vasil, MD, CSQ, FRCPC[10]

[1]Baycrest Health Sciences, North York, ON; [2]Department of Psychiatry, University of Toronto, Toronto, ON; [3]Brenda Strafford Centre on Aging, O'Brien Institute for Public Health, Cumming School of Medicine, University of Calgary, Calgary, AB; [4]Department of Medicine, Cumming School of Medicine, University of Calgary, Calgary, AB; [5]Canadian Coalition for Seniors Mental Health, Markham, ON; [6]Department of Psychiatry, Dalhousie University, Halifax, NS; [7]Department of Psychiatry, McMaster University, Hamilton, ON; [8]Department of Family Medicine, Queen's University, Kingston, ON; [9]Department of Medicine, McMaster University, Hamilton, ON [10]Department of Psychiatry, University of Montreal, Montreal, QC

https://doi.org/10.5770/cgj.23.419

CIHI_ICIS @CIHI_ICIS · 18h

Don't use benzodiazepines in #seniors as the first choice for insomnia, agitation or delirium. #choosingwisely bit.ly/2rQ57G1



BZRAs Challenges

- Physicians have very different views on these medications
- Patients tend to have relatively positive feelings about this group of medications
- Existing guidelines frequently recommend benzodiazepine use only for short periods of time (especially in older adults). This often contradicts current clinical practice e.g. in care of people with longstanding mental disorders.
- Limited literature on benzodiazepine use disorder among older adults – more literature on over prescribing, adverse effects etc.

Characteristics of long-term BZRA use

- Older age, female, lower income, single
- Comorbidities - psychiatric and medical
- Use of short acting, high potency BZD e.g. alprazolam, lorazepam, oxazepam
- Receiving prescriptions for more than one BZD concurrently
- "Volume" of the initial or overall BZD prescriptions- overall prescribed dosage
- Previous BZD use
- Dose escalation is associated with a greater number of prescribers, concurrent SUD

Kurko et al. European Psychiatry (2015); 30:1037-1047,
Cunningham et al. Health Policy (2010), 97(2-3), 122–129.

PREVENTION

- Long-term use of BZRAs (> 4 weeks) in older adults should be avoided for most indications because of their minimal efficacy and risk of harm. Older adults have increased sensitivity to BZRAs and decreased ability to metabolize some longer-acting agents, such as diazepam. All BZRAs increase the risk of cognitive impairment, delirium, falls, fractures, hospitalizations, and motor vehicle crashes. Alternative management strategies for insomnia, anxiety disorders, and the behavioural and psychological symptoms of dementia (BPSD) are recommended.

[GRADE: Evidence: Moderate; Strength: Strong]

PREVENTION

- Health care providers and organizations should consider implementing interventions to decrease inappropriate use of BZRAs in their practice settings. These include medication reviews, prescribing feedback, audits and alerts, multidisciplinary case conferences, and brief educational sessions. Regulators, health authorities, and professional organizations should consult with clinical leaders and older adults to develop and implement policies that aim to minimize inappropriate use of BZRAs.

[GRADE: Evidence: Low; Strength: Strong]

PREVENTION

- Clinicians should be aware that BZRAs are prescribed more frequently to women and the potential implicit bias that may lead to inappropriate use.

[GRADE: Evidence: Low; Strength: Weak]

ASSESSMENT

- Assessment of older adults suspected of having a BZRA use disorder should include indication, dose, duration, features indicative of BZRA use disorder, readiness to change, and presence of both medical and psychiatric comorbidities, including any other past or current substance use or misuse.

[Consensus]

TREATMENT

- A person-centred, stepped-care approach to enable the gradual withdrawal and discontinuation of BZRAs should be used. Clinicians and patients should share in:

a) planning and applying a gradual dose reduction scheme supported by appropriate education of the patient;

b) identifying and optimizing alternatives to manage the underlying health issue(s) that initiated or perpetuated the use of BZRAs;

c) developing strategies to minimize acute withdrawal and managing rebound symptoms as needed; and

d) establishing a schedule of visits for reviewing progress.

[GRADE: Evidence: Moderate; Strength: Strong]

TREATMENT

- **Psychological interventions such as CBT should be considered during efforts to withdraw BZRAs as they can improve the older adult's experiences and increase the likelihood of stopping the BZRA.**

- **[GRADE: Evidence: High; Strength: Strong]**

TREATMENT

- **Substituting a** pharmacologically **different drug as a specific intervention to mitigate BZRA withdrawal symptoms during gradual dose reduction is not routinely recommended**

[GRADE: Evidence: Moderate; Strength: Strong]

EMPOWER brochure

www.criugm.qc.ca/fichier/pdf/BENZOeng.pdf

- quiz (myths)
- education
  - risks
  - alternatives (non-pharm for anxiety and sleep)
- consumer story
- tapering schedule
- Qs to ask your HCP

Cannabis Use Disorder in Older Adults

CLINICAL PRACTICE GUIDELINES/CONSENSUS STATEMENTS

Canadian Guidelines on Cannabis Use Disorder Among Older Adults

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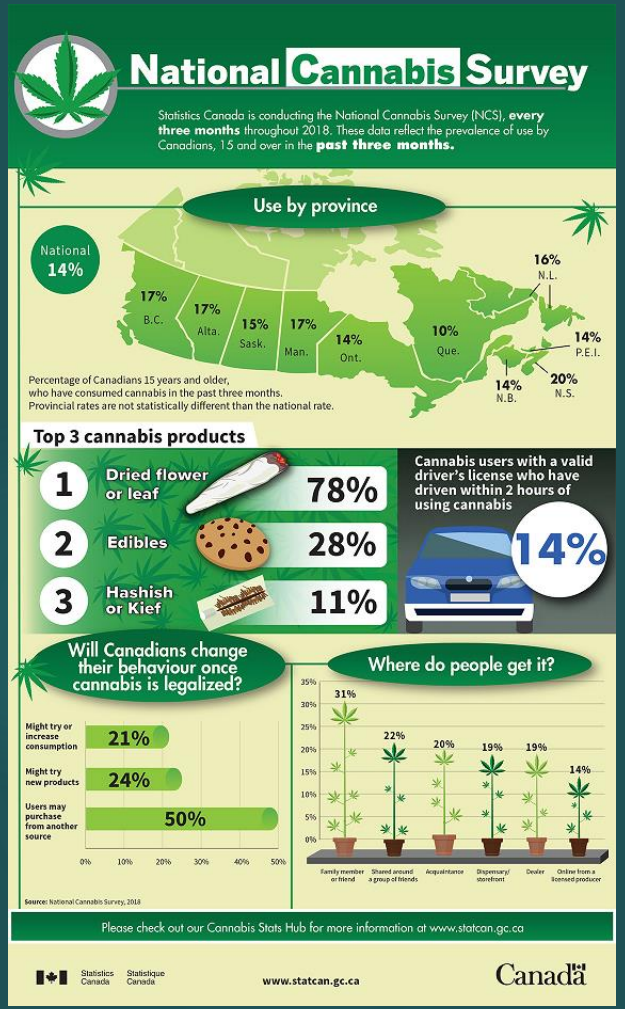


- More Canadians began to use cannabis in the first quarter of 2019.
- Some of these new cannabis consumers were first-time users, while others were former cannabis users who tried cannabis again post-legalization.
- Results suggest that first-time users in the post-legalization period are older.
- Half of new users were aged 45 or older, while in the same period in 2018, this age group represented about one-third of new users.

MARIJUANA

Seniors turning to cannabis for relief – and businesses are all in

Hope Bobowski, 79, at her Keremeos B.C. home on April 14, 2017.

JEFF BASSETT/THE GLOBE AND MAIL

Recommendations

- Cannabis use has health risks best avoided by abstaining
- Delay taking up cannabis use until later in life
- Identify and choose lower-risk cannabis products
- Don't use synthetic cannabinoids
- Avoid smoking burnt cannabis—choose safer ways of using
- If you smoke cannabis, avoid harmful smoking practices
- Limit and reduce how often you use cannabis
- Don't use and drive, or operate other machinery
- Avoid cannabis use altogether if you are at risk for mental health problems or are pregnant
- Avoid combining these risks

Reference

Fischer, B., Russell, C., Sabioni, P., van den Brink, W., Le Foll, B., Hall, W., Rehm, J. & Room, R. (2017). Lower-Risk Cannabis Use Guidelines (LRCUG): An evidence-based update. *American Journal of Public Health, 107*(8). DOI: 10.2105/AJPH.2017.303818.

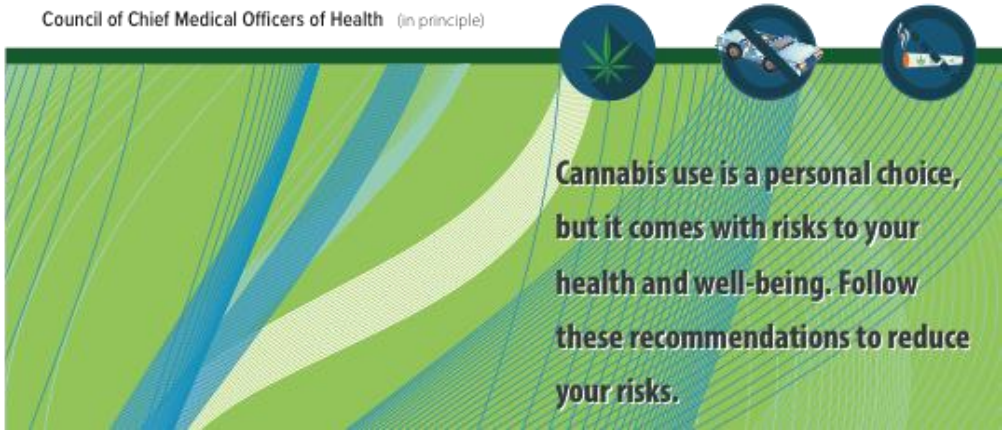
Endorsements

The LRCUG have been endorsed by the following organizations:

Association Médicale Canadienne · Canadian Medical Association · CPHA ACSP · CSAM SMCA (Canadian Society of Addiction Medicine / La Société Médicale Canadienne sur l'Addiction) · camh (Centre for Addiction and Mental Health) · Canadian Centre on Substance Use and Addiction / Centre canadien sur les dépendances et l'usage de substances

Council of Chief Medical Officers of Health (in principle)

Canada's Lower-Risk Cannabis Use Guidelines (LRCUG)



KEY POINTS FOR THIS GUIDELINE

- The evidence base for harms and potential benefits associated with cannabis use in older adults is limited but growing.
- Given that the adverse effects of cannabis may vary considerably based on routes of administration and subtype of strain, as well as the lack of evidence regarding older adults, we have developed these guidelines utilizing a cautionary approach.
- Hopefully as research advances and capacity improves in the upcoming years, the risks and benefits of cannabis use among older adults, as well as the risk of developing Cannabis Use Disorder, will be better understood.

Prevention

- The current evidence base on the medical use of cannabis is relatively limited, and cannabis and most derivative products have not been approved as therapeutic agents by Health Canada, with the exception of two pharmaceutical grade cannabinoid products. Clinicians should keep informed about new evidence regarding possible indications and contraindications for cannabis and cannabinoid use.

[GRADE: Evidence: High; Strength: Strong]

PREVENTION

- Clinicians should be aware of the following:

The potential adverse effects of cannabis use in older adults, such as changes in depth perception risking balance instability and falls, changes in appetite, cognitive impairment, cardiac arrhythmia, anxiety, panic, psychosis, and depression.

[GRADE: Evidence: Moderate; Strength: Strong]

Prevention

- Clinicians should counsel patients to be aware that older adults can be more susceptible than younger adults to some dose-related adverse events associated with cannabis use.

- [GRADE: Evidence: High; Strength: Strong]

Prevention

- Clinicians should educate patients on the risk of impairment, especially when initially starting cannabis or titrating to a new dose. It is recommended that the starting dose should be as low as possible and gradually increased over time if needed.

- [GRADE: Evidence: High; Strength: Strong]

Screening

All patients regardless of age should be screened for:
a) the use of non-medical and medically authorized cannabis and cannabinoids, and illicit synthetic cannabinoids as well as tobacco, alcohol, and other drugs.
[GRADE: Evidence: Low; Strength: Strong]

b) the amount and type of cannabis or cannabinoid used, and its frequency, by those who acknowledge any use. 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).
[GRADE: Evidence: Low; Strength: Strong]

TREATMENT

- It is recommended that a variety of psychosocial approaches be considered for harm reduction or relapse prevention including: Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Mindfulness Based Relapse Prevention (MBRP), Motivational Enhancement Therapy (MET), and Contingency Management (CM).

- [GRADE: Evidence: Moderate; Strength: Strong]

Treatment

Peer support programs should be considered for individuals with CUD.

[GRADE: Evidence: Moderate; Strength: Strong]

TREATMENT

There are currently no established pharmacological treatments that have been demonstrated to be safe and effective for either Cannabis Withdrawal symptoms or Cannabis Use Disorder.

[CONSENSUS]

CCSMH
CANADIAN COALITION FOR SENIORS' MENTAL HEALTH

CCSMPA
LA COALITION CANADIENNE POUR LA SANTÉ MENTALES DES PERSONNES ÂGÉES

E-learning Modules for Cannabis and Older Adults
Launch anticipated January 2022

E-learning for physicians, other healthcare providers and healthcare students

Project funded by Health Canada

Modules developed by clinical experts

MainPRO and MOC Accredited

Topics covered include;

- History of cannabis and legalization
- Neuropharmacology of cannabis
- Drug interactions
- How to talk to patients about cannabis
- Prescribing/authorizing cannabis
- Safety and risks of cannabis
- Cannabis use disorder/harm reduction

Opioid Use Disorder in Older Adults

CLINICAL PRACTICE

Canadian Guidelines on Opioid Use Disorder Among Older Adults

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Opioid Use Disorder in Older Adults

- Research on OUDs in OAs have primarily taken place in the U.S.A. where more studies have focused on problematic Rx Opioid use or Methadone Rx

- For people 65+ years old with OUD: No previous guidelines, systematic reviews or RCTs

Long Term opioid user on MAT

Prescription opioid exposure later in life, develops OUD

Two Cohorts in this Population

PREVENTION

- 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.

[GRADE: Evidence: Moderate; Strength: Strong]

PREVENTION

- 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.

[GRADE: Evidence: Moderate; Strength: Strong]

PREVENTION

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

[GRADE Evidence: Low; Strength: Weak]

SCREENING

- 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

[GRADE Evidence: Low; Strength: Strong]

TREATMENT

- Buprenorphine-naloxone should be considered first line for opioid withdrawal management in older adults. Methadone is an alternative that may be used, however consider the added risk of adverse events.

[GRADE Evidence: Moderate; Strength: Weak]

Treatment

- Buprenorphine maintenance should be considered a first-line treatment for an OUD in older adults

[GRADE Quality: Moderate; Strength: Strong]

TREATMENT

- Advise patients that the use of alcohol, benzodiazepines, and other sedative-hypnotics is hazardous when combined with opioid agonist treatment. If the older adult is living in the community and is already physiologically dependent on one of these substances, then slow tapering of the substance(s) (to elimination if possible) rather than abrupt cessation is recommended. If the patient is in hospital, residential treatment, or a long-term care setting and medically managed by an experienced provider, detoxification can progress more rapidly, concurrent with the initiation or stabilization on medications for OUD.

[GRADE Quality: Moderate Strength: Strong]

TREATMENT

- If experienced, clinicians may manage older adults with a mild-to moderate OUD; however, for patients with more severe or complex disorders, it is recommended that personnel or teams with advanced substance use disorder management skills be accessible to support clinicians and to enhance their capacity to care for patients in all settings. The threshold for an admission to hospital or drug and alcohol treatment facility under the care of an Addiction Medicine Specialist is lower than for younger adults, and closer follow-up is needed on discharge to ensure appropriate community-based support.

[GRADE Quality: Moderate; Strength: Strong]

Concluding Points

- Older adults in Canada and other countries are experiencing substance-related problems in increasing numbers. However, these problems are often unrecognized and untreated. As a result substance use disorders among older adults have been termed an "invisible epidemic".
- Polypharmacy is prevalent in older adults and therefore the risk of misusing prescription and over-the-counter medication rises with aging.
- Numerous barriers to the detection of substance use disorders among older adults exist
- Many clinicians fail to routinely explore the possibility of alcohol and substance misuse among their older patients.
- Screening processes should be senior-friendly and take into account the sensitivities of older adults, including concerns about stigma. The process should also consider sensory, cognitive, cultural and environmental issues.

Concluding Points (cont)

- A comprehensive assessment is essential including a full history of substance / medication use; co-morbid medical and psychiatric illness; social and family history, functional assessment and cognitive evaluation.
- There is an urgent need for better training of health professionals and students, which will hopefully lead to improvements in the prevention, detection and care of older people with substance misuse and substance use disorders.
- Great need for more age-specific SUD services across the country

GOING BEYOND THE GUIDELINES

Key KT Products and Tools – www.ccsmh.ca

- Press release January 2020
- Webinars: BrainXchange
- Community Brochures & Info Sheets
- Guidelines available for online download
- Online summary with links to useful tools / resources

What Older Adults Need to Know About Drinking Alcohol

LEARN MORE +
SEEK ADVICE

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Coalition Canadienne pour la Santé Mentale des Personnes Âgées

Benzodiazepine Use Among Older Adults

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Coalition Canadienne pour la Santé Mentale des Personnes Âgées

How will you implement these guidelines in your setting or organization?

- Questions ?
- Comments
- Concerns
- Ideas
- Feedback

Thank You !

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If you're interested in joining, please go to: www.ccsmh.ca

Dr. David Conn: Co-Chair, CCSMH

Dr. Kiran Rabheru: Co-Chair, CCSMH

Ms. Claire Checkland: Executive Director, CCSMH