Older Adults & Substance Use Disorder

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Faculty/Presenter Disclosure

- **Faculty: Jonathan Bertram**
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Mitigating Potential Bias

The information presented in this CME program is based on recent information that is explicitly ‘‘evidence-based’’.

This CME Program and its material is peer reviewed and all the recommendations involving clinical medicine are based on evidence that is accepted within the profession; and all scientific research referred to, reported, or used in the CME/CPD activity in support or justification of patient care recommendations conforms to the generally accepted standards

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Learning Objectives

- 1. provide an overview of Substance Use Disorder issues including the impact of COVID-19 on people with SUD

- 2. review relevant features of screening, education and treatment of Alcohol and Opioid Use Disorder including any COVID-19 related/coincidental updates

- 3. include key points from the CCSMH Older Adult Substance Use Disorder guidelines (2019) for BZRA (BenZodiazepine Receptor Agonist) and Cannabis Use Disorder

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SUBSTANCE USE DISORDER
DSM V Criteria

- Continuing to use substances despite negative personal consequences
- Repeatedly unable to carry out major obligations due to use
- Recurrent use of substances in physically hazardous situations
- Continued use despite persistent/recurring social or interpersonal problems
- Characteristic Tolerance/Withdrawal or the substance is used to avoid withdrawal **(NOT APPLICABLE IN THE CONTEXT OF MEDICALLY SUPERVISED PAIN MANAGEMENT)**

- ***2-3 of the criteria indicates Mild substance use disorder***
- ***4-5 of the criteria indicates Moderate***
- ***6-7 of the criteria indicates Severe***

- Persistent desire or unsuccessful efforts to control/cut down
- Spending a lot of time obtaining, using, or recovering from using opioids
- Using greater amounts or using over a longer time period than intended
- Stopping or reducing important activities due to opioid use
- Consistent use despite acknowledgment of difficulties from using opioids
- ***Craving or a strong desire to use opioids (New criterion added)***

TWO Cohorts among Older Adults

- **LATER IN LIFE**
  - SUD itself may present **insidiously** in Older Adults, often in the setting of Prescription BZRA or Opioid Use Disorder acquired later in life with the **later stage prescribing of BZRA/opioids** for a chronic condition (Kalapatapu & Sullivan 2010).
  - Or acquired drinking during a transition (retirement, change in relationship status, residence)

- **LIFE LONG**
  - There is another cohort of Older Adults, who are the more **traditional "life-long" users** continuing into Older Age, who often have used for many years, availed of **SUD Treatment at various stages** through their lifetime and attending for similar intervention now. (Loftwall et all 2005)

Trends in Older Adult Prescribing (Later in Life)

- Opioids (Cdn Institute Health Information 2022)
  - Decreasing prescribing of opioids among seniors- a reported decline in utilization, from 17.3% in 2017 to 14.9% in 2021.
  - Approximately 32,000 fewer seniors

- Benzodiazepines
  - Older Adults living in a Long Term Care setting (2021) “were 3 times more likely to be prescribed an antidepressant or benzodiazepine” than those living in the community
  - Coincident with increased prescribing of psychotropic drugs in LTC settings during COVID

Harm Reduction- "Street Use" Cocaine, Methamphetamine, Opioids (Life Long?)

- Canadian Drug Summary (CCSA 2022)
  - Only 0.2 % of previous year cocaine use was Older Adults (2019)

- CCSA 2019
  - several jurisdictions across Canada reported an increase over the five years leading up to COVID in the use of methamphetamine among those accessing Harm Reduction services

  - "In 2016–2017, methamphetamine replaced alcohol as the third most commonly used substance by harm-reduction clients in Ontario who accessed services from a variety of provincial, community-based and capacity-building programs."

- COVID-19 skewed stimulant and opioid related hospitalization and death

Canada-U.S. joint white paper: Substance use and Harms during COVID-19 (PHAC and US Dept of Health & Human Services)

- Total of 30,860 opioid-related and 13,575 stimulant-related poisoning hospitalizations (Jan 2016-Dec 2021) in Canada (excluding Quebec).

- 1st year of the pandemic- 27% increase in opioid-related poisoning hospitalizations (April 2020 – March 2021, 5,599 hospitalizations), compared to year prior (April 2019 – March 2020, 4,426 hospitalizations).
  - ***Since then, opioid-related poisoning hospitalizations have continued to increase.***

- 6,164 opioid-related poisoning hospitalizations occurred in 2021.
  - ***17 hospitalizations per day compared to 12 in 2019 and 14 in 2017.***

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Canada-U.S. joint white paper: Substance use and Harms during COVID-19 (PHAC and US Dept of Health & Human Services)

- Rates of both opioid- and stimulant-related poisoning hospitalizations remained high in British Columbia, Saskatchewan and Alberta, followed by Territories and Ontario (2021)
  - ***88% of poisoning hospitalizations involving opioids and 85% of poisoning hospitalizations involving stimulants occurred in British Columbia, Alberta, and Ontario.***

- 2,387 stimulant-related poisoning hospitalizations occurred in 2021.
  - ***7 hospitalizations per day compared to 5 in 2016 and 6 in 2019***

- ***"Among accidental stimulant-related poisoning hospitalizations, a larger proportion involved fentanyl or fentanyl analogues (32%) than among intentional (8%) poisonings. "***

Canada-U.S. joint white paper: Substance use and Harms during COVID-19 (PHAC and US Dept of Health & Human Services)

5 Domains of a Model of Care intersecting with Older Adults' Barriers to Identification & Care

- 5 Domains of a Conceptual Model of Care for SUD in the wake of COVID 19
  - **Substance use as a means of coping**
  - **Changes in social support and networks**
  - **Changes in availability and accessibility of services related to substance use and harms**
  - **Increased risk of COVID-19 transmission among people who use substances**
  - **Increased risk of severe outcomes among people who use substances**
- Older Adults are not getting enough treatment (CCSMH 2019)
  - Stigma- rather acquire covertly or buy illicit than be dx'd with SUD
  - Privacy- if living with family or dependent on a caregiver
  - Masked sx's- depression, grief, dementia, other medical comorbidities
  - Practitioners undertrained- DSM V

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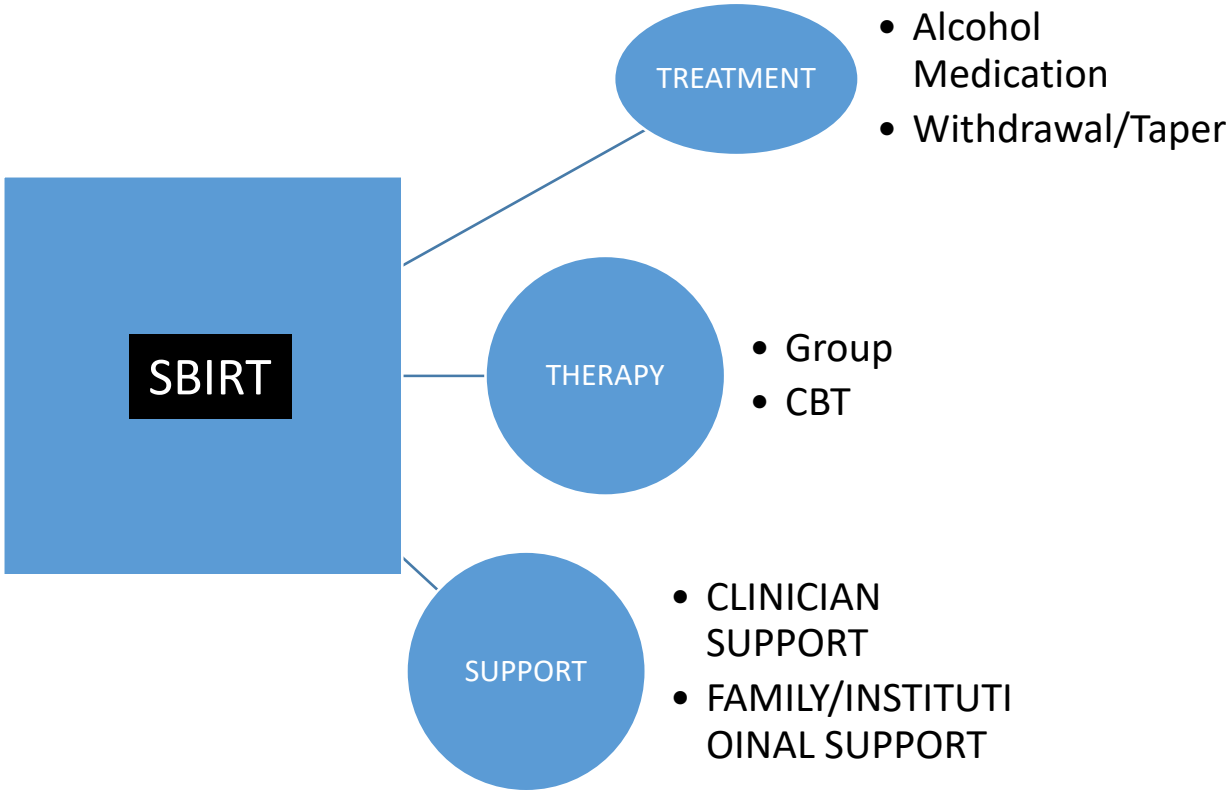
SCREENING, BRIEF INTERVENTION, & referral to TREATMENT (SBIRT)-

College of Family Physicians of Canada **(cfpc.ca)**



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Approach to Screening

- Non judgmental language
- Assume substance is being used- reframe overuse as normal
- Focus on physical symptoms coincident or consequent to use

*Refer to the SAMI (Senior Alcohol Misuse Indicator) for an outline on approach and language

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BRIEF INTERVENTION

- Brief intervention can work for a variety of substances
- Decreased use, binging, sustainable beyond 1 year (Fleming, 1999)
- Least intrusive intervention, appropriate even in acute settings

Table 5 NIAAA advise and assist brief intervention[35]

- State your assessment conclusions and recommendations clearly (eg, "you are drinking more than is medically safe")
- Assess the patient's readiness to reduce level of use
- Negotiate a drinking goal
- Generate a plan to meet the goals
- Provide educational materials developed by the NIAAA (include risks particular to patients with anxiety disorders)
- Follow up and reassess progress toward goals at the patient's next visit

NIAAA, National Institute on Alcohol Abuse and Alcoholism.

ALCOHOL USE DISORDER

Alcohol screening tools

Table 2. Common alcohol use screening instruments validated for clinical use.

Instrument	Population	Sensitivity	Specificity	Number of items	Time to administer (minutes)
AUDIT Alcohol Use Disorders Identification Test	Adults	81%	86%	10	2
CAGE Questionnaire	Adults and adolescents	75%	92%	4	1
SMAST Self-Administered Michigan Alcoholism Screening Test	Adults and adolescents	90–98%	57–82%	13	8
ARPS Alcohol-Related Problems Survey	Adults >65	82%	82%	18	10

Adapted from Fink A, Tsai MC, Hays RD, et al.[20] National Institute on Alcohol Abuse and Alcoholism,[21] Bradley KA, Bush KR, Epler AJ, et al.,[22] Aertgeerts B, Buntinx F, Kester A,[23] Hoeksema HL, de Bock GH.[24]

- Increasing evidence for **Senior Alcohol Misuse Indicator (SAMI)**
- Most generalizable tool is **GMAST**- can also be used for **benzodiazepine use**
- Another tool for Older Adult Alcohol screening is **ARPS**

CCSMH 2019
Low Risk Drinking Guidelines for Older Adults

- Women: no more than 1 drink on drinking days and no more than 5 drinks per week, with 2 non-drinking days per week.

- Men: no more than 1-2 drinks on drinking days and no more than 7 per week, with 1-2 non drinking days per week

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CCSA 2023
Guidance on Alcohol and Health

- Replaces *Canada's Low-Risk Alcohol Drinking Guidelines* (LRDGs) issued in 2011.
- Based on principle of autonomy in harm reduction and "the fundamental idea behind it that people living in Canada have a right to know that all alcohol use comes with risk."
- Continuum of risk associated with weekly alcohol use: "_"
  - **0 drinks per week** — Not drinking has benefits, such as better health, and better sleep.
  - **2 standard drinks or less per week —** You are likely to avoid alcohol-related consequences for yourself or others at this level.
  - **3–6 standard drinks per week —** Your risk of developing several types of cancer, including breast and colon cancer, increases at this level.
  - **7 standard drinks or more per week** — Your risk of heart disease or stroke increases significantly at this level.
  - **Each additional standard drink** radically increases the risk of alcohol-related consequences.
- Greater that 2SD per episode "is associated with an increased risk of harms to self and others, including injuries and violence." (Ministry of Transport??)

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Pharmacotherapy
Alcohol Use Disorder

- **Naltrexone**: caution with increased hepatic enzymes
- **Acamprosate:** caution with reduced renal function
- **Avoid Disulfiram unless supported by Specialist Care**- Disulfiram-Ethanol reaction carries greater risk A/E- Fatality in Older Adults

- 2nd line medications are all off-label with greater favour/popularity in practice for some over others and include **Gabapentin** (Renal, Falls, Edema); **Topiramate** (Extended Schedule of Titration 8/52 & Robust S/E profile); **Baclofen** (Risk of Dependence, Effective in Cirrhosis); **Prazosin; Varenicline; Odansetron**

Withdrawal Management

- Medically supervised management of withdrawal encouraged in Older Adults

- Use the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) to screen for those requiring medical withdrawal management (CCSMH 2019)
  - Lower Threshold for developing Alcohol Hallucinosis, Delerium Tremens, and Seizure

- 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 (CCSMH 2019)
  - Close f/u when prescribing ambulatory Benzodiazepines, if eligible, to prevent adverse short term s/e's and potential dependence long term

Cognitive Behavioural Therapy

- Age tailored CBT for AUD has shown increasing effectiveness in 65+ (Veteran's AUD CBT- Schonfeld 2000)

- Increasing Integrated Care Pathways for Alcohol (AUD) and Depression (MDD) with blended curriculum for AUD-MDD and co-initiation of anti-craving meds & SSRI (DA VINCI- HQ0 2016)
  - CAMH has an ongoing program from 2014-present

- Increasing utilization of iCBT- Abiliti, MindShift, Breaking Free Online for Addiction (Ontario)

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Opioid use disorder

Treatment Opioid Use Disorder

Q: What medications are most safe and effective in treatment of OUD in OAs?

A: **1. Buprenorphine**
2. Methadone

+ good safety profile in younger adults

+ respiratory ceiling effect, lower OD potential

+ readily available, cost coverage for those on assistance

- lack of studies in OAs

(BUPRENORPHINE) Bernese method

- **prescribing of buprenorphine in a "micro dose" (0.5 mg) with daily incremental increases to dose on 7-14 day schedule typically**
- **can continue to use other opioids (either prescribed or illicit) until a therapeutic dose of buprenorphine achieved**
- **avoids going through opioid withdrawal in order to be eligible for traditional buprenorphine induction**
- **avoidance of precipitated withdrawal when initiating buprenorphine prematurely**

Treatment Opioid Use Disorder

Q: What off-label agents are possible in treatment of Severe OUD in OAs?

A: 3. Slow-release oral morphine (SROM)

based on + once daily witnessed ingestion, open capsule and sprinkle
+ efficacy in younger adults who cannot tolerate other MATs

- Lack of studies in OAs

(CAMH- Canadian Opioid Use Disorder Guidelines 2021)
Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder
https://www.camh.ca/-/media/files/professionals/canadian-opioid-use-disorder-guideline2021-pdf.pdf

Treatment Opioid Use Disorder

Q: What off-label agents are possible in treatment of Mild OUD in OAs?

A: 4. Naltrexone FOR MILD OUD

based on + lack of drug-drug interactions and psychiatric impairment

- cost and access barriers exist currently in Canada

- case reports of precipitated delirium

- Lack of studies in OAs

PRESCRIBING IN COVID & FENTANYL ERA

- Introduction of injectable Buprenorphine
  - Sublocade- monthly subcutaneous injection (Bup 8 mg or higher) ++ utilized
  - Probuphine- discontinued (expensive)

- COVID-19 Opioid Agonist Treatment Guidance
  - https://www.camh.ca/-/media/files/covid-19-modifications-to-opioid-agonist-treatment-delivery-pdf.pdf

- Methadone treatment for people who use fentanyl: Recommendations
  - https://www.metaphi.ca/wp-content/uploads/Guide_MethadoneForFentanyl.pdf

BZRA use disorder

Key Recommendations

Older adults who are receiving a BZRA should be:

- a) educated and provided the opportunity to discuss the on-going risks of taking BZRAs
- b) encouraged to only take the BZRA for a short period of time (2 to 4 weeks or less) at the minimally effective dose
- c) monitored during the course of their prescription for evidence of treatment response and effectiveness, current and potential adverse effects, concordance with the treatment plan, and/or the development of a BZRA use disorder
- d) supported in stopping the drug, which may require a gradual reduction until discontinued

Key Recommendations

- Older adults with a BZRA use disorder whose drug use is escalating in site of medical supervision, have failed prior efforts to withdraw their BZRA, are at risk for relapse or harm, and/or suffer from significant psychopathology should be considered for referral to a specialty addiction or mental health service

Cannabis Use Disorder

Cannabis Screening

- CUDIT (Cannabis Use Disorder Identification Test)
- CAST (Cannabis Abuse Screening Test)

Behavioural THERAPY- first line

- Mindfulness Based Relapse Prevention
- Motivational Interviewing
- Cognitive Behavioural Therapy

***increasing evidence with Cannabis-tailored CBT-MET (Motivational Enhancement Therapy) curriculum piloted at CAMH**

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Pharmacotherapy- adjunctive

- As a complement to more established first line treatments may be helpful in reducing cannabis withdrawal symptoms and cannabis cravings
  - Gabapentin
  - NAC (N-Acetyl Cysteine- used off-label in some Addictive Process Treatment)
  - Nabilone (limited studies over shortened timeline (4 weeks) for withdrawal)

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CCSMPA LA COALITION CANADIENNE POUR LA SANTÉ MENTALES DES PERSONNES ÂGÉES

CCSMH Cannabis and Older Adults

***MOC and MainPro+ accredited e-learning**

Module topics include;

- Neuropharmacology and drug interactio
- Cannabis evidence
- Modes of use, dosing and accessing cannabis
- Adverse effects, safer cannabis use, and CUD
- Developing a treatment plan
- Regulations and guidelines
- And more!

- Target audience is physicians, NPs and other healthcare providers and healthcare students.
- no cost to learners

For more information please visit:

https://ccsmh.ca/cannabis-and-older-adults-project

email info@ccsmh.ca

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Thank you!