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ADDICTION MEDICINE IN LONG-TERM CARE

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FACULTY/PRESENTER DISCLOSURE

» Faculty: Jonathan Bertram

» Relationships with commercial interests:
- Grants/Research Support: none
- Speakers Bureau/Honoraria: none
- Consulting Fees: none
- Other: none

FACULTY/PRESENTER DISCLOSURE

- Faculty: Marilyn White-Campbell

- Relationships with financial sponsors:

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   - CHIR grant "Opiates and Older Adults; A spotlight on the Opioid Crisis among seniors"
   - Health Canada Substance Use Branch Controlled Substances
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   - Speakers Bureau/Honoraria: none
   - Consulting Fees: none .
   - Patents: none
   - Other: none
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- Potential for conflict(s) of interest: None

- Mitigating Potential Bias : None

LEARNING OBJECTIVES

- 1. To address familiar cases of Substance Use Disorders in Long-Term care settings.
- 2. To Demonstrate the overlaps between different substances in the context of challenges with pain sleep and cognitive function.
- 3. To highlight key recommendations from the Canadian guidelines on Substance Use Disorders and older adults.

THE NEW CANADIAN GUIDELINES FOR SUD'S IN OLDER ADULTS

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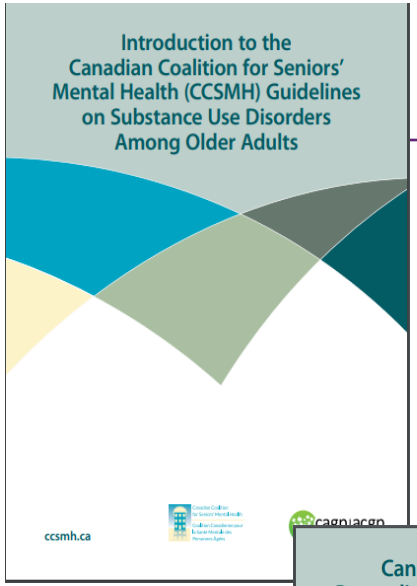
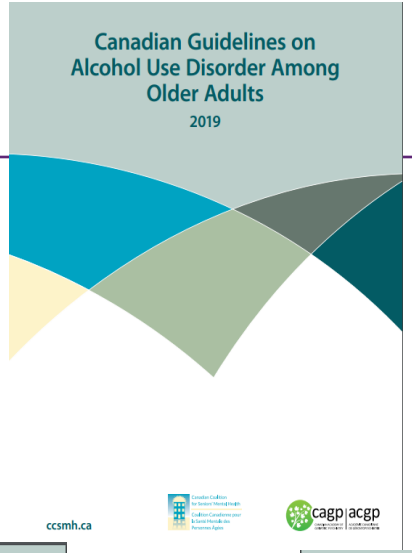
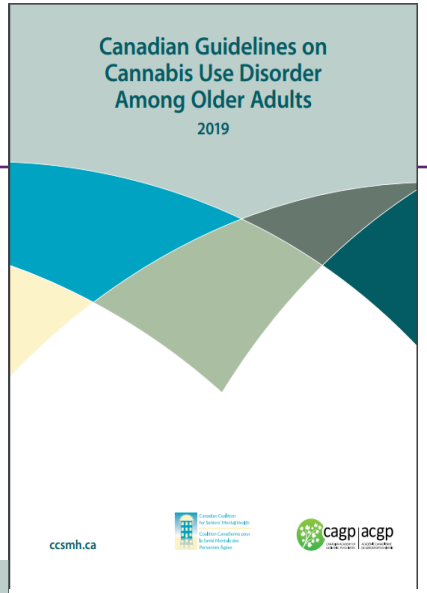
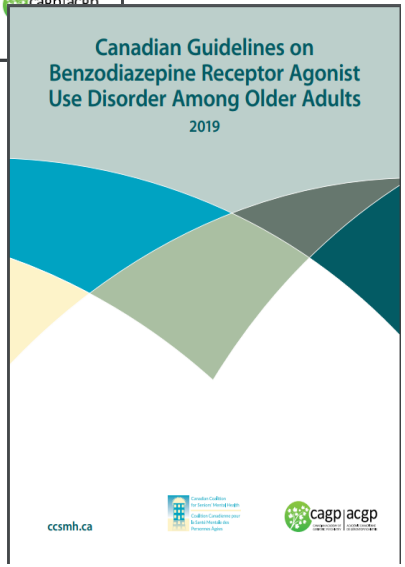
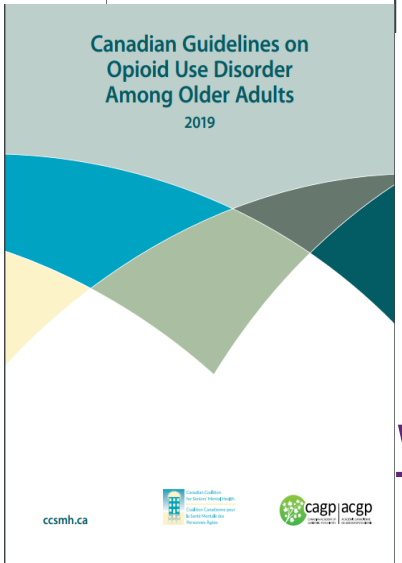
- **Claire Checkland: CCSMH Executive Director**
- **Indira Fernando: Project Coordinator**
- **All 36 Guideline Working Group members**
- **Steering Committee**
- **Co-Leads: Peter Butt, Marilyn White-Campbell, David Conn, David Hogan, Jonathan Bertram, Amy Porath, Dallas Seitz, Launette Rieb & Zainab Samaan**
- **Canadian Centre on Substance Use & Addiction**
- **Baycrest, Bruyere, CAGP, CAMH, CGS, CMHA, NICE, Reconnect (COPA), Fountain of Health**











ALL AVAILABLE FOR DOWNLOAD AT WWW.CCSMH.CA

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*

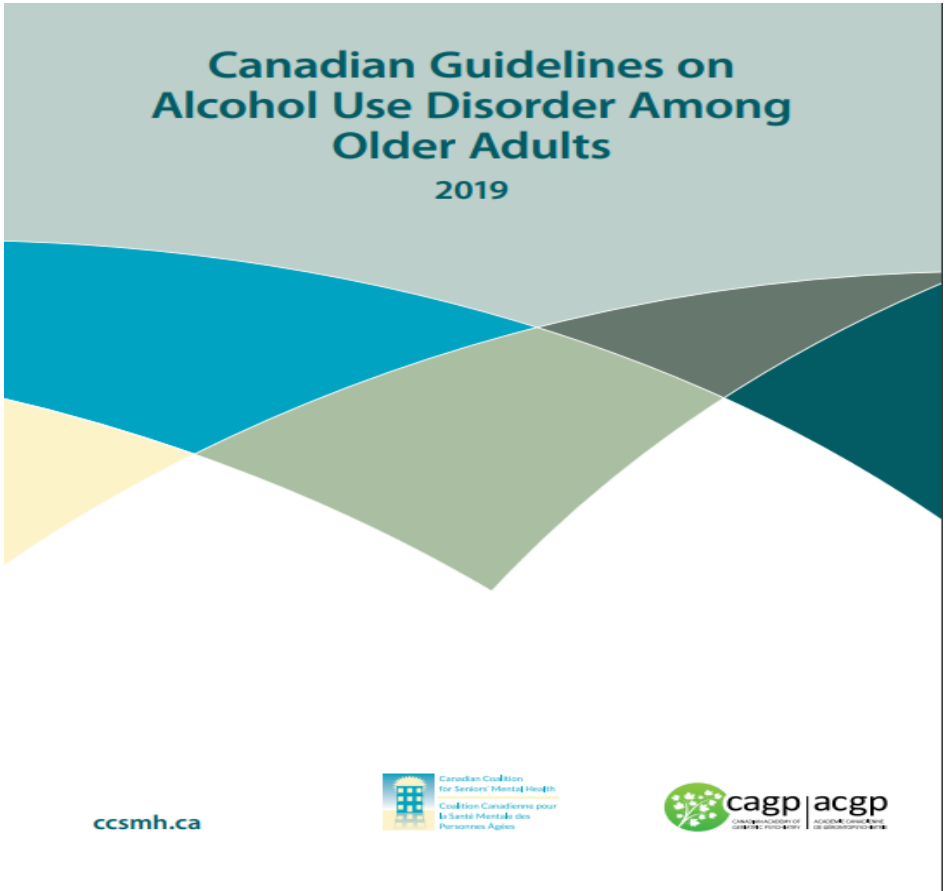
STRENGTH OF RECOMMENDATION

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)

SOME ARE "CONSENSUS" RECOMMENDATIONS

Alcohol Use Disorder in Older Adults



ALCOHOL SCREENING TOOLS (CCSMH 2018)

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 a new tool- SAMI
  https://www.porticonetwork.ca/documents/21686/0/SAMI+fillable/f6668443-559f-4ad8-9e5f-6de47a38e70a
- Most generalizable tool is GMAST- can also be used for benzodiazepine use
- Another tool for Geriatric Alcohol screening is ARPS

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 ALCOHOL USE DISORDER

- Q: Can pharmacotherapy be used in the treatment of AUD in OA's?
- A: Yes.
- Level 1 evidence for adults applies to older adults, with more attention required to contra-indications and potential side effects
- Naltrexone: caution with increased hepatic enzymes
- Acamprosate: caution with reduced renal function
- Start low, go slow. Attention to communication, interaction and setting

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.** **(standard drink = 13.45 grams of pure alcohol – e.g. 5 oz. (142ml) of wine at 12% alcohol)**

- **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

RATIONALE FOR OLDER ADULT RECOMMENDATIONS

- Physiological and metabolic changes associated with aging account for a 33% increase in BAC vs. younger adults
- Increased vulnerability with regards to cognition, falls and frailty require additional consideration
- Therefore a 50% reduction from the younger adult population would be prudent

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

CASE STUDY

Mr. C

- Hx of alcohol use, cannabis and nicotine dependence
- Currently Covid Positive
- Leaves residence to purchase alcohol cigarettes and cannabis
- Home is now on full outbreak and you have asked him to stop going out.

Medical Hx

- Bi-polar disorder
- COPD
- Osteoarthritis
- Uses manual wheel chair

USE OF ANTI-CRAVING MEDICATION

Recommendation #12

Routinely offer pharmacological treatment (e.g., anti-craving medication) with alcohol behavioural intervention and case management in moderate and severe AUD, 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]

MANAGED ALCOHOL TAPER

Recommendation #17

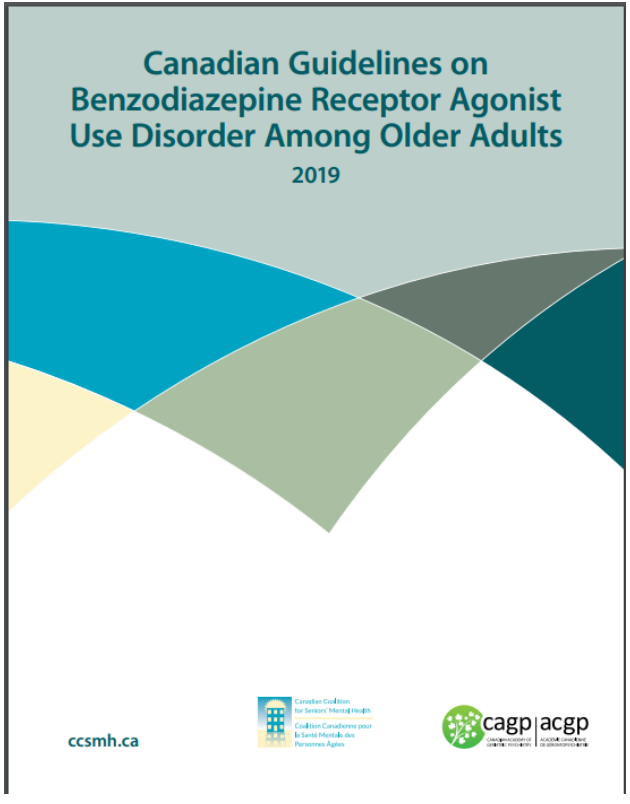
As a harm reduction strategy for older adults in controlled environments, where medical withdrawal is not available or deemed appropriate, it is recommended that a managed alcohol taper be considered. Individualize the taper by 1 standard drink every 3 days (aggressive tapering), weekly (moderate tapering), 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]

WHEN DO YOU NEED MEDICALLY SUPPORTED WITHDRAWAL?

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]

BENZODIAZEPINES



- **Increased vulnerability to effects of substance due to unique physiological, psychological, social and pharmacological factors**
- **Frequency and longitudinal use**
- **Co-morbidities, cognitive impairment, polysubstance use**
- **Under-identified and under-studied**
- **Stigma**

Canadian Coalition for Seniors' Mental Health
To promote seniors' mental health by connecting people, ideas and resources.
Coalition Canadienne pour la Santé Mentale des Personnes Âgées
Promouvoir la santé mentale des personnes âgées en reliant les personnes, les idées et les ressources.

CASE STUDY

» 85 year old woman. PTSD, persistent depressive disorder and mild cognitive impairment. Currently on Lorazepam 1 mg tid for anxiety/flashbacks. Insists she "can't manage" without the lorazepam. Has begun asking co-residents for their "anxiety meds", sometimes hoards her lorazepam to use "extra" for sleep.

ACUTE COGNITIVE CHANGES

- Clegg and Young (2010) carried out a systematic review of drugs to be avoided in people at risk of delirium. Delirium risk appeared to be increased by BZDs, opioids in addition to dihydropyridines (calcium channel blockers) and possibly by antihistamines.

KEY RECOMMENDATIONS

- (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.

- Appropriate first-line non-pharmacological options for the treatment of insomnia and anxiety disorders include cognitive behavioural therapies (CBTs) provided in various formats

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


Canadian Guidelines on
Benzodiazepine Receptor Agonist
Use Disorder Among Older Adults
2019
ccsmh.ca
cagp | acgp

CANNABIS SCREENING
(CCSMH 2018; CEP 2018)

- CUDIT (Cannabis Use Disorder Identification Test)

- CAST (Cannabis Abuse Screening Test)

Cannabis

The Cannabis Use Disorder Identification Test – Revised (CUDIT-R)

Have you used any cannabis over the past six months? **YES / NO**

If **YES**, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use over the past six months:

1.	**How often do you use cannabis?**				
	Never 0	Monthly or less 1	2–4 times a month 2	2–3 times a week 3	4 or more times a week 4
2.	**How many hours were you "stoned" on a typical day when you had been using cannabis?**				
	Less than 1 0	1 or 2 1	3 or 4 2	5 or 6 3	7 or more 4
3.	**How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?**				
	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
4.	**How often during the past 6 months did you fail to do what was normally expected from you because of using cannabis?**				
	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
5.	**How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis?**				
	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
6.	**How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?**				
	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
7.	**How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children:**				
	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
8.	**Have you ever thought about cutting down, or stopping, your use of cannabis?**				
	Never 0		Yes, but not in the past 6 months 2		Yes, during the past 6 months 4

Scores of 8 or more indicate hazardous cannabis use.
Scores of 12 or more indicate a possible cannabis use disorder, for which further intervention may be required.

For further interpretation see:
Adamson S, Kay-Lambkin F, Baker A, et al. An improved brief measure of cannabis misuse: The Cannabis Use Disorders Identification Test – Revised (CUDIT-R). Drug Alcohol Depend 2010: (In Press).

PREVENTION & EDUCATION : RECOMMENDATION #1

- Cannabis should generally be avoided by older adults who have:
- a) A history of, or are currently experiencing, mental health disorders, problematic substance use, or Substance Use Disorder (SUD).
- b) Cognitive impairment, cardiovascular disease, cardiac arrhythmias, coronary artery disease, unstable blood pressure, or impaired balance.

PREVENTION & EDUCATION : RECOMMENDATION #2

- Clinicians should be aware that

- a) The current evidence base on the medical use of cannabis is relatively limited. Most derivative products have not been approved as therapeutic agents by Health Canada, with the exception of two pharmaceutical grade cannabinoid products. [GRADE: Evidence: High]

-

- c) The potential adverse effects of cannabis use in older adults include changes in depth perception risking balance instability and falls, changes in appetite, cognitive impairment, cardiac arrhythmia, anxiety, panic, psychosis, and depression. [GRADE: Evidence: Moderate]

PREVENTION & EDUCATION : RECOMMENDATION #8

- **Clinicians should educate patients on the risk of cannabis-induced impairment especially if the patient is cannabis-naive 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.**

BEHAVIOURAL THERAPY- FIRST LINE

- Mindfulness Based Relapse Prevention
- Motivational Interviewing
- Cognitive Behavioural Therapy
- *increasing evidence with Cannabis-tailored CBT curriculum that we have piloted at CAMH

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 4 weeks for withdrawal)

OPIATES


Canadian Guidelines on
Opioid Use Disorder
Among Older Adults
2019
ccsmh.ca
Canadian Coalition for Seniors' Mental Health
Coalition Canadienne pour la Santé Mentale des Personnes Âgées
cagp | acgp

HOSPITALIZATION & DEATH

- In Canada adults 65 and older had the highest opioid-related hospitalization rates in 2014–2015 (CIHI 2016).
  - Accidental poisonings, especially during therapeutic use, accounted for the highest proportion of hospitalizations (55%) in this population.
  - Older Adults accounted for nearly a quarter of hospitalizations for opioid poisoning during this period, even though this age group represents only 16% of the Canadian population.
- 142% increase in days spent in the hospital due to opioid use disorders among older adults, between 2006 to 2011 (Young & Jesseman, 2014).
- CIHI, 2013 study: For older adults identified as having an adverse drug-related hospitalization, the third most common drug class was opioids.

CASE STUDY

- Male 67 year old living in LTCH two years
- severe osteoarthritis with severe contractures
- Behaviours around medication management
- heavy smoker
- Former long distance truck driver
- History of alcohol benzo and opiate abuse
- Offered in patient withdrawal d/c because he could not smoke outside
- Induction to suboxone micro dosing managing well

TREATMENT OPIOID USE DISORDER

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

A: 1. Buprenorphine
2. Methadone

based on
+ good safety profile in younger adults
+ respiratory ceiling effect, lower OD potential
+ pain relief when switching from prescription opioids
+ positive effect on mood (kappa receptor antagonist)
+ patient acceptability (once induced – which can be a barrier)
+ readily available, cost coverage for those on assistance
- lack of studies in OAs

TREATMENT OPIOID USE DISORDER

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

A: 3. Naltrexone

based on

+ good safety profile and efficacy in younger abstinent adults
+ lack of drug-drug interactions and psychiatric impairment
+ monthly injectable formulation available
- cost and access barriers exist currently in Canada
- 8% abscess rate for EX-NTX in younger adults
- case reports of precipitated delirium
- Lack of studies in OAs

TREATMENT OPIOID USE DISORDER

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

A: 4. Slow-release oral morphine (SROM)

based on

+ once daily witnessed ingestion, open capsule and sprinkle
+ efficacy in younger adults who cannot tolerate other MATs
+ access and patient acceptability
+ may decrease stigma in care facilities
- costly compared to methadone, but less expensive than iOAT
- divertible and injectable if not witnessed ingestion
- toxic metabolite build up if renal impairment
- Lack of studies in OAs

OPIOID WITHDRAWAL IN OLDER ADULTS

- Outpatient management may not be appropriate for older individuals who are frail, live alone with limited family support or who have multiple medical problems and prescribed medications (Liskow et al, 1989).

- Withdrawal management in an outpatient setting from any addictive substance could pose significant risks for older adults, such that withdrawal management should be carefully supervised, ideally in hospital (Conn & Bertram, in press) or an adequately supervised setting

TREATMENT

- **Alcohol, benzos, sedative-hypnotics is HAZARDOUS with opioids.**
- **In the community slow taper NOT abrupt cessation is recommended.**
- **In hospital, residential treatment, or a long-term care setting and medically managed by an experienced provider, detoxification can progress more rapidly**
- **[GRADE Quality: Moderate Strength: Strong]**


QUESTIONS

RESOURCES

OTN ARCHIVED GERIATRIC ADDICTION ROUNDS BrainXchange website
http://brainxchange.ca/Public/Collaboration-Space-Login-Register.aspx

To register for geriatric addiction rounds contact
amilitante@cmhaww.ca

CCSMH

More about the Canadian Coalition for Seniors' Mental Health (CCSMH)

Since 2002, The CCSMH has been hard at work ensuring that seniors' mental health is recognized as a key Canadian health and wellness issue. The CCSMH is led by 2 co-chairs from the Canadian Academy of Geriatric Psychiatry, and a steering committee of 12 organizations from across Canada, representing healthcare providers, consumers, family and caregivers, and policy makers.

For more information on the CCSMH or to access valuable resources to share with patients and colleagues, visit our website at CCSMH.ca. While you're there, consider joining as an Affiliate (it's free!) and will help you stay up-to-date on our latest news and initiatives!

Alcohol guidelines webinar

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

Link to the guidelines
https://ccsmh.ca/substance-use-addiction/

Addictions Older Adults physician pocket guides
https://www.nicenet.ca/tools

THANK YOU FOR LISTENING

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CAMH- Concurrent Outpatient Medical & Psychosocial Addiction Support Services (COMPASS)

CAMH Integrated Pain & Addiction Recovery Clinic (iPARC)

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