AGEING & ADDICTION

Jonathan Bertram MD CCFP (AM)
Pain & Addiction Medicine

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Faculty/Presenter Disclosure

- Faculty: [*JONATHAN BERTRAM*]
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  - *NONE*

Mitigating Potential Bias

- [*N/A*].
- Refer to “Quick Tips” document

Learning objectives

- Review the literature around Opioid & Opioid Use Disorder related treatment access, morbidity and mortality in Older Adults
- Review the 2019 National Best Practice Guidelines for Opioid Use Disorder in Older Adults through a Case
  - Withdrawal management
  - Maintenance Therapy
  - Carries
- Raise considerations for LTC and Hospice Facilities

Etiology/Epidemiology

Opiates and addiction in older adults

Morbidity/mortality- CCSA 2017

- Rate of use
- Drug-drug interaction
- Hospitalization
- Comorbidity
- Barriers

Older adults (OA)& Opioids

- In Canada, 43.9% of people over the age of 55 have used an opioid
  - **the most frequent mode of use is daily or near daily use at 1.1% (CCSA 2018**

- 75% of substance use related deaths in those over 65 were related to opioid use (UNODC 2018)

- prescription opioids are often the substance of choice for suicide attempts in OA- 33% of opioid poisonings in OA's in Canada (NICE 2018)

Drug-drug interactions

- CIHI, 2013 study: For older adults identified as having an adverse drug-related hospitalization, the third most common drug class was opioids.
- The most common co-occurring toxicity was with BZDs (19%) and the second most common was acetaminophen, including both combination products and acetaminophen alone (14 %).
- The combination of opioids and BZDs significantly increases the risks of harms such as overdose, respiratory depression and death (Karaca-Mandic et al., 2017).

Hospitalization

- **ED/hospitalizations related to adverse drug events- opioids accounted for 9.2%, ranking third behind anti-coagulants and anti-neoplastic agents. (Bayoumi et al, 2014).**
  - Over 20% of these presentations resulted in hospitalizations
- **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).**

Co morbidity

- Older Adults with OUD have higher rates of (Larney 2015)
  - **comorbid mood disorder**
  - **post traumatic stress disorder**
  - **Hep C**
  - **HIV**
  - **chronic pain**

***with twice the risk of death than younger adults with OUD**

Barriers to Identification & Care

- Older Adults are not getting enough treatment (CCSMH 2019)
  - Stigma- rather buy illicit than be dx'd with OUD
  - Privacy- if living with family or dependent on a caregiver
  - Masked sx's- depression, grief, dementia, other medical comorbidities
  - Practitioners undertrained- DSM V

TWO Cohorts to Identify

- **LATER IN LIFE**
- OUD itself may present **insidiously** in Older Adults, often in the setting of Prescription Opioid Use Disorder acquired later in life with the **later stage prescribing of opioids** for a chronic pain condition (Kalapatapu & Sullivan 2010).

- **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 illicitly for many years, availed of **Opioid Agonist Treatment (OAT) at various stages** through their lifetime and attending for similar intervention now. (Loftwall et all 2005)

Approach to Opioid Use Disorders in Older Adults

REVIEW OF OA OUD 2019 GUIDELINES - OAT considerations in the Elderly

Case: Ingrid

- Ingrid is a 70-year old woman with Ontario Drug Benefit (ODB) living on ODSP in Rice Lake.
- She volunteers a past history of use of alcohol, crack, and speaks to only using marijuana now
- Walker for mobility even around the house (Bilat Hip OA & Lumbar spondylolithesis) and receives PSW support for 1 hr per day.
- Oxycodone CR 20 mg PO BID x 15 years for hip pain… now running out of her oxycodone early, often chewing her pills and often appearing intoxicated to her PSW
- Historical management appears to involve a 2 mg twice daily clonazepam regimen.

Identification
OA OUD 2019 GUIDELINES

- Screening for OUD should invoke the use of screening tools such as PDUQ-9, ASSIST, POMI, or even CAGE if others are not accessible

Case: Ingrid (cont'd)

- On further questioning Ingrid attests, in fact, to previously being on MMT but finds the initiation arduous because of the burden of daily observed doses in the first 2 months. She describes her use pattern and difficulties with change by means that would qualify her for moderate-severe Opioid Use Disorder
- She would prefer to pursue alternative means of managing her pain but is more interested in simply getting off her opioids
- She tells you that Opioid Withdrawal isn't going to lead to seizures or any of the issues she remembers with alcohol when she was younger

Withdrawal Management - Medical Supervision

OA OUD 2019 GUIDELINES

- Potentially more problematic for Older Adults because of their physiological state. **Should be offered with medical supervision** (Bertram & Conn 2018)

- Opioid withdrawal management should only be offered in the context of connection **to long-term addiction treatment**, whether in the setting of **opioid discontinuation** or a **trial tapering of opioids**.

- **Induction onto an opioid agonist is recommended over a non-opioid treatment withdrawal management** in older adults with an OUD (CRISM 2018). Withdrawal management is not as effective as OAT and should only be considered if the individual has been informed of their options and intentionally rejects OAT.

Withdrawal Management - symptom control

OA OUD 2019 GUIDELINES

- During opioid withdrawal management, symptom control medications can be used (CPSO 2011)
- BUT expert application of these medication should exercised due to medical comorbidities, side effect risk, and other concerns related to older age
- Clonidine- Hypotension

Buprenorphine for Withdrawal FIRST LINE

OA OUD 2019 GUIDELINES

- Buprenorphine-naloxone should be offered as first line for opioid withdrawal management in older adults.

- Methadone can be considered as an alternative but with an understanding of the added risk of heightened unintentional overdose on Methadone compounded in Older Adults

Buprenorphine Maintenance FIRST LINE

OA OUD 2019 GUIDELINES

- **Buprenorphine Maintenance** should be considered **first-line therapy for OUD** in **older adults**.
  - No comparisons of BMT to MMT in Older Adults and only one study referred to the unique consideration for Buprenorphine, however only in the setting of lower risk for respiratory depression (Burgos-Chapman et al, 2016).

- **Methadone maintenance treatment** is subsequently the **alternative** for older adults who don't respond to or cannot tolerate buprenorphine maintenance

- **ALWAYS consider these options in the setting of what the individual seeking treatment prioritizes for themselves and informing their decision with as much support as possible (CRISM 2018).**

OAT- other consideration

OA OUD 2019 GUIDELINES

- SROM is an alternative if a client is not wanting BMT or MMT (with adequate renal function- older adult specific) but is a weak recommendation as in CRISM
- Naltrexone ought only to be offered for those older adults for whom opioid agonist treatment is contraindicated, unacceptable, unavailable, or discontinued and established abstinence for a sufficient period of time
- There is no evidence or examination of newer formulations such as Injection Depot or Subdermal injection Buprenorphine that have now been issued for the mainstream population in Canada.

Case: Ingrid (cont'd)

- Ingrid agrees to start Buprenorphine
- She is nervous about her withdrawal and is making the case for aggressive dosing
- She is only willing to attend a more supervised setting other than your clinic if she "really needs it"

Maintenance Treatment induction and dose titration

OA OUD 2019 GUIDELINES

- initial doses of medications for OUD should be 25-50% of regular initial doses and the escalation dose frequency should be 25-50% using the lowest effective dose to suppress craving, w/d, drug use with more stringent supervision (OA OUD 2019 Guidelines)

- threshold to admit an older adult for opioid withdrawal (including transdermal buprenorphine) or induction onto OUD medications should be lower than for a younger adult

Missed doses in the context of mobility/access

- Flexible take-home dosing when taking Older Adult considerations into account is encouraged with BMT.
  - Inability to attend pharmacy
  - Missed dose-related withdrawal
  - Frailty
- **Take home BMT doses in the presence of social supports help address:**
  - Age-related mobility issues, isolation, abuse, lack of family support, support-intensive burden of getting an OA to the pharmacy, the risks related to withdrawal if obtaining observed doses are delayed
- Methadone considerations can only be taken into account in the setting of supervised administration at home, and early take home doses,

Case: Ingrid– BZD management

- What should you do about Ingrid's clonazepam?

Considerations for BZD's, Z-drugs, Alcohol

- If on ETOH, BZD, other SEDHYPNOTICS- slow taper rather than cessation **(OA OUD 2019 GUIDELINES)**
- Attempt taper of benzodiazepines regardless of level of take home doses; particularly if diazepam is high- 50 mg per day
- Do not provide take-home doses for patients who do not permit contact with the opioid or benzodiazepine prescriber
- Consent isn't required to contact the non-MMT prescriber in cases of imminent risk of harm

Benzodiazepine considerations- managing BZD dose reduction

- Observational study documented reduced symptoms of depression in MMT patients who were tapered off benzodiazepines and started on antidepressant therapy (Schreiber et al. 2008).

- Gabapentin/pregabalin co-administration during taper provide for some interim mood stability and withdrawal attenuation (24 weeks) (Sabioni, Bertram, Le Foll 2015)

Treatment of Benzodiazepine dependence or misuse:

- (1) inpatient detoxification and medicalized aftercare
- (2) outpatient withdrawal taper
  - As effective in elderly as in youth (Schweizer, 1989)
- (3) treat secondary psychiatric problems like anxiety or insomnia
- (4) long-term low dose benzo maintenance
- (5) AA or NA

LTC/Hospice Facilities

consideration

Policy on OAT

- While no evidence exists in the literature for the outcomes from facilitating OAT in Long Term Care and Hospices, the shift towards changing policy and having support for OAT initiation are already being realized in Long Term Care organizations across the country (e.g. Advantage Ontario).
- The ability to adapt policy to Buprenorphine is far greater, although when considering SROM vs Methadone, LTC and Hospice staff are far more likely to have experience, scope of practice, and familiar attitudes towards SROM.

LTC as a safer space

- Older Adult facilities as spaces for OAT initiation and continuation in the event of discharge, for those individuals with OUD upon admission- hospital, residential treatment, long term care, but also, non-medical facilities with access to medical care such as prisons and shelters.

- When considering the hazards of concurrent use of alcohol, benzodiazepines, and other sedative-hypnotics when combined with opioid agonist treatment, there is an opportunity to support careful tapering and medically observe and support safe withdrawal management in an inpatient or long term care facility

jonathan.bertram@camh.ca

THANK YOU

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