Substance Use Disorders in Older Adults: An Update
Leadership Conf.
Vancouver, Nov. 8, 2019

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Disclosures

- Relationships with commercial interests: **None**
- Potential for conflict(s) of interest:
- **None**

- **Funding:** Funding to the Canadian Coalition for Seniors Mental Health from Health Canada's Substance Use and Addictions Program

Working Group members received an honorarium for their work on the project.

Acknowledgements

- Claire Checkland: CCSMH Director
- Indira Fernando: Project Coordinator
- All Guideline Working Group members
- Steering Committee
- CCSMH & Co-chair K. Rabheru
- Canadian Centre on Substance Use & Addiction
- Baycrest, Bruyere, CAGP, CAMH, CGS, CMHA, NICE, Reconnect (COPA), Fountain of Health

Objectives

Highlight key issues and challenges related to substance use in older adults.

List key recommendations from the Canadian Guidelines for alcohol, benzodiazepine, cannabis and opioid use disorders among older adults in Canada

Identify and **describe** the unique paths, opportunities and challenges in implementation and knowledge translation

What Do We Know About Substance Use In Older Adults?

- SUDs are common in geriatric patients:
  - 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, cognitive impairment, polysubstance use

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.

Why try to get somebody to quit smoking after 50 years? Isn't the damage already done?

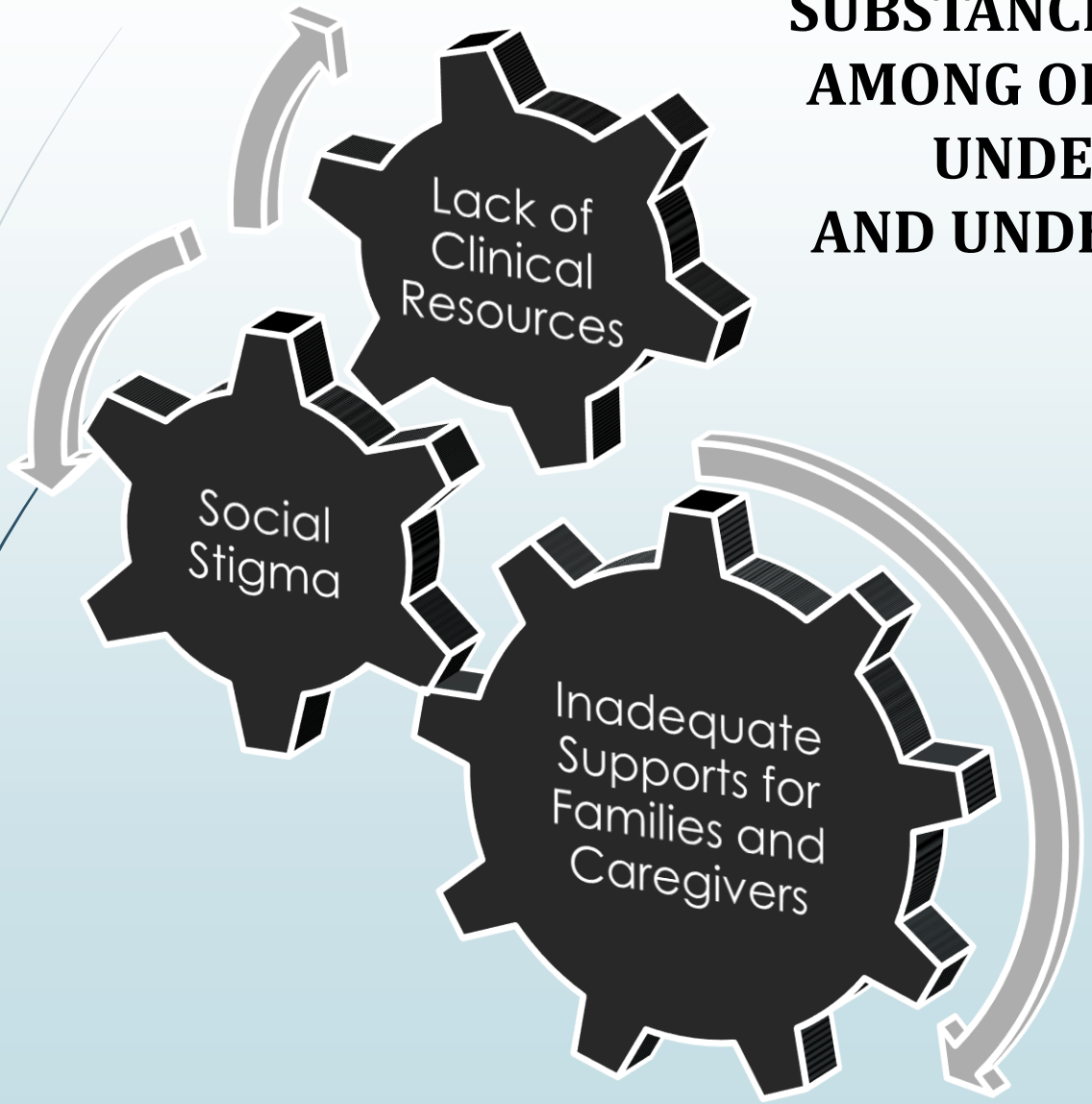
Nothing could be further from the truth!"

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

The baby boom generation was the first generation to be significantly exposed to recreational drugs and reports a higher lifetime prevalence of use and past year use than any generation that precedes them.


ASSOCIATED PRESS
A BABY BOOMER
0:00 / 3:00

Adults Face Unique Barriers

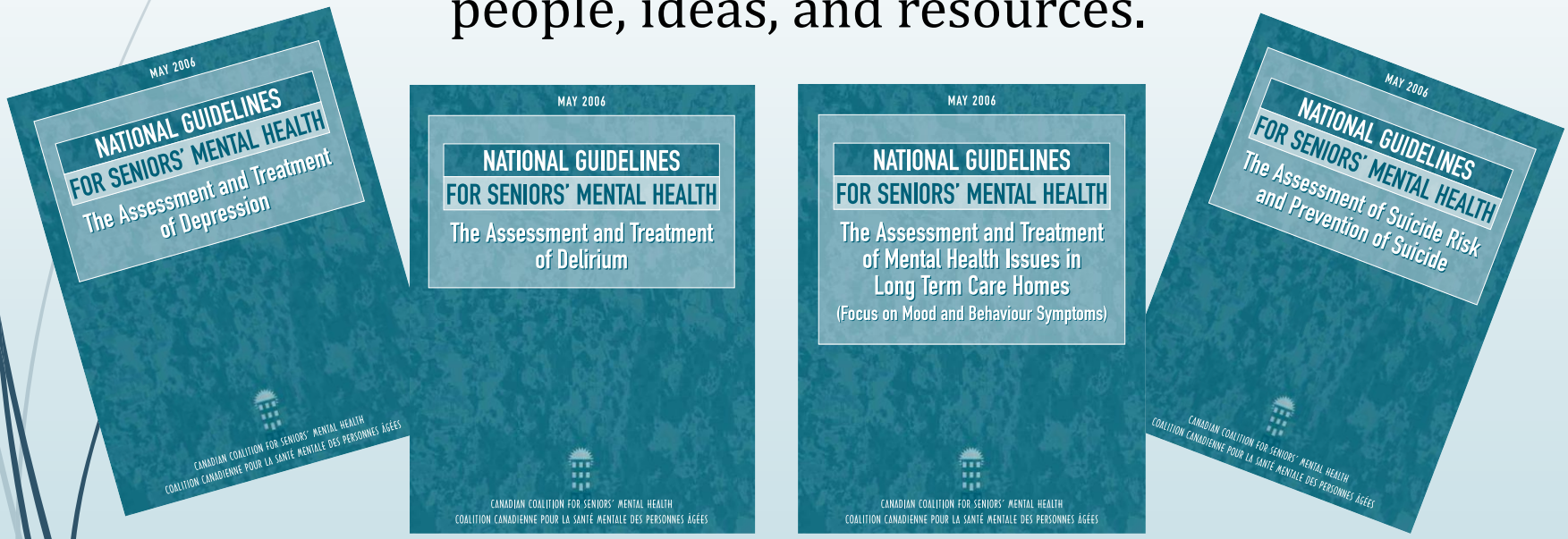


SUBSTANCE USE DISORDER AMONG OLDER ADULTS IS UNDER-STUDIED AND UNDER-IDENTIFIED!

Canadian Coalition for Seniors' Mental Health (CCSMH)

The mission of the CCSMH is:

To promote the mental health of older adults by connecting people, ideas, and resources.



Guideline Methods

- Interdisciplinary guideline committee was formed including a PWLE for each of the guidelines.
- Literature search:
  - Existing guidelines, meta-analyses, literature review, and website search
  - Databases: Cochrane Library, EMBASE, MEDLINE, PsycInfo, PubMed
- Selected literature appraised with the intent of developing evidence-based, clinically sound recommendations
  - AGREE II used to identify guidelines that are of sufficient quality to inform guideline development

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

BMJ | 26 APRIL 2008 | VOLUME 336

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)

Please NOTE:

- These are HIGHLIGHTS from much more extensive guidelines soon available at www.ccsmh.ca
- Summary versions of the guidelines will be published as a supplement to the Canadian Journal of Geriatrics in March, 2020

Opioid Use Disorder Among Older Adults

Opioids Working Group

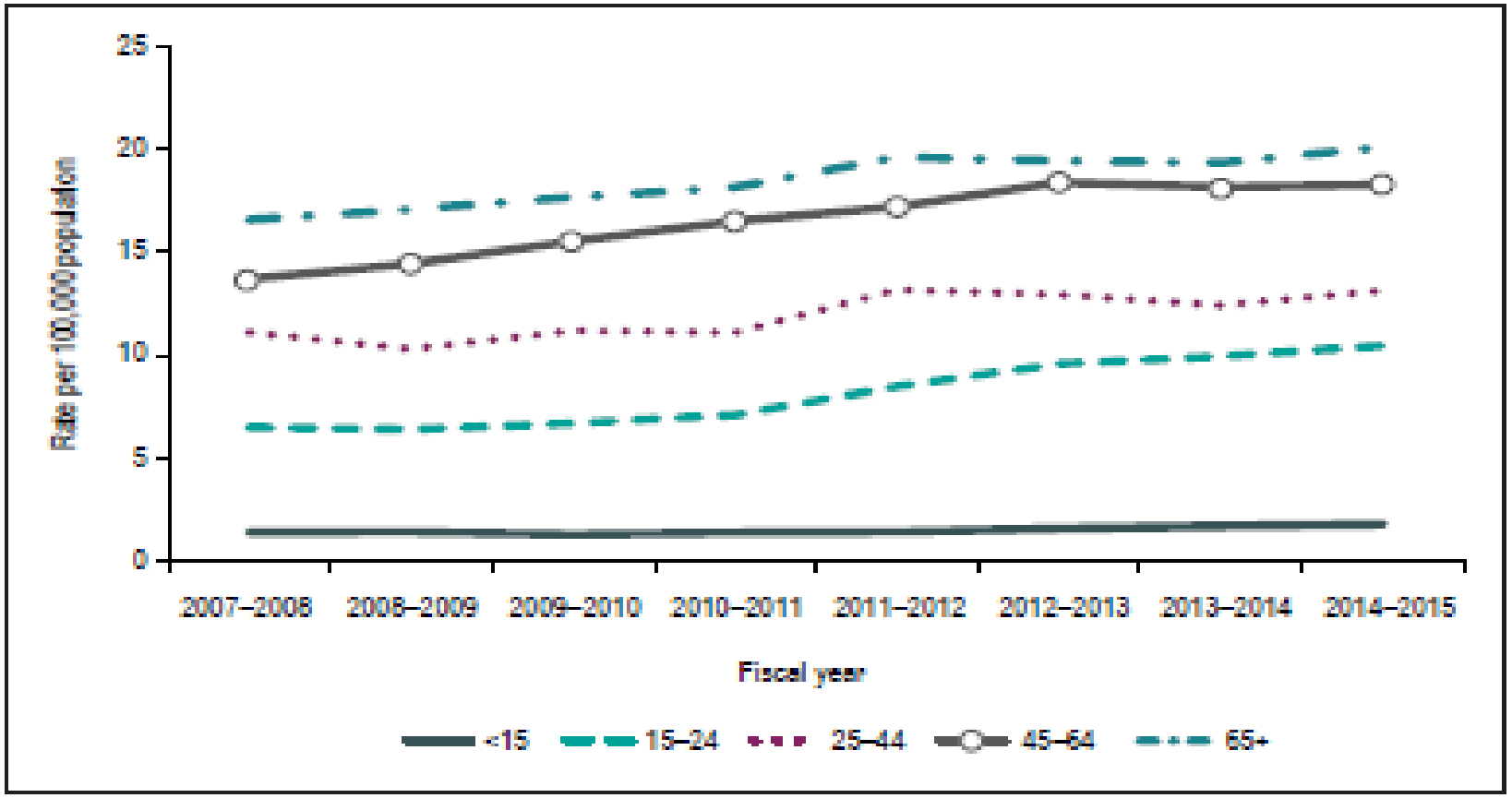
Co-Chairs:

- Launette Rieb: Addiction Medicine, U. British Columbia
- Zena Samaan: Psychiatrist, McMaster

Working Group Members:

- George Budd: Clinical Pharmacist
- Doug Coleman (PLWE): Retired Family Physician, Addiction Medicine Specialist
- Sid Feldman: Family Medicine – COE, U. Toronto
- Andrea Furlan: Physical Medicine and Rehabilitation, U. Toronto
- Lillian Hung: Geriatric Nursing, Vancouver Coastal Health
- Kiran Rabheru: Geriatric Psychiatry, U. Ottawa

Figure 3 Rate of hospitalizations due to opioid poisoning per 100,000 population by age group, Canada, 2007–2008 to 2014–2015



Source
Hospital Morbidity Database, Canadian Institute for Health Information.

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

Two Cohorts in this Population

Long term illicit opioid users, on and off MAT

Prescription opioid exposure later in life, develop OUD

Nursing Role

- Screen, detect patients with substance use, identify risk
- Work with families and interdisciplinary team for assessment, evaluation and treatment
- Educate the patients, families and the public about the evidence of opioid use, drug drug interaction, drug disease interaction, opioid use disorder, overdose, and long-term use
- Track opioid or other substance use for acute and chronic pain conditions
- Ensure patients and families understand safe use, storage, risks and management in overdose

older adults are more vulnerable

- Chronic pain, comorbidities, social problems, psychological issues, depression, cognitive impairment, polypharmacy
- Age-related changes that affect opioid absorption, distribution, metabolism, and elimination
- Co-occurring issues can make screening for opioid use difficult
- Stigma
- Atypical presentations
- Suicidal attempts
- Addiction, prescriber error, patient confusion about medication instructions, dosing errors due to cognitive problems, drug-drug interactions, and metabolic changes

CAGE-AID

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

ASSIST

1. In your life, which of the following substances have you ever used?
2. In the past three months, how often have you used the substances you mentioned ?
3. During the past three months, how often have you had a strong desire or urge to use drug
4. During the past three months, how often has your use of drug led to health, social, legal, or financial problems?
5. During the past three months, how often have you failed to do what was normally expected of you because of your use of drug
6. Has a friend or relative or anyone else ever expressed concern about your use of drug
7. Have you ever tried and failed to control, cut down, or stop using drug?

who.int/substance_abuse/activities/assist

Harm reduction & Trauma-informed care

- Harm reduction services are open to all people who use substances, at any stage of their substance use.
- Ensure support (e.g., connecting to healthcare service) is always available, without necessarily requiring people who **use substances** from stopping use
- 3 Es of Trauma: **E**vent, **E**xperience, **E**ffect
- 4 Rs: **R**ealize the impact, **R**ecognize the sign and symptoms, **R**espond by applying training knowledge and skills, **R**esist re-traumatization

CANADIAN NURSES ASSOCIATION

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Harm Reduction

Harm reduction is a public health approach aimed at reducing the adverse health, social and economic consequences of at-risk activities such as the use of illicit substances.

Harm Reduction and Illicit Substance Use: Implications for Nursing [PDF, 1.2 MB] (CNA discussion paper, Updated 2017)

Harm Reduction and Substance Use (CNA, Canadian Association of Nurses in HIV/AIDS Care, & Harm Reduction Nurses Association joint position statement, 2018)

- Harm Reduction for Non-Medical Cannabis Use [PDF, 669.3 KB] (2017)
- Focus on Harm Reduction for Injection Drug Use in Canadian Prisons: A Supplement to CNA's Harm Reduction Discussion Paper [PDF, 216.3 KB] (2016)

Fact Check: Dispelling Myths About Supervised Consumption Sites [PDF, 149.3 KB] (2017)

Five-part webinar series — *Substance Use Trends in Canada: What Nurses Need to Know* (2017)

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PREVENTION

- *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 or less, and rarely more than 7 days.* **GRADE Quality: Moderate; Strength: Strong**

PREVENTION

- *In most circumstances, avoid prescribing opioids for older adults with chronic non-cancer pain (CNCP). For severe pain not responsive to non-opioid therapy in patients without a history of SUD and without active mental illness a trial of opioid treatment may be considered …and discontinue if function does not improve, or if adverse effects arise.* **GRADE Quality: Moderate; Strength: Strong**

PREVENTION

- *In older adults with polypharmacy or co-morbidities that increase the risk of opioid overdose… the lowest effective opioid dose should be used and tapering the opioid and/or other medications should be considered.* **GRADE Quality: Moderate; Strength: Strong**

ASSESSMENT

- *Older adults should be screened for 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 on opioids for chronic non-cancer pain or OUD.* **GRADE Quality: Low; Strength: Strong**

ASSESSMENT

- *Identify a diagnosis of OUD through completing a comprehensive assessment …In addition, a detailed physical exam needs to be done looking for the signs of withdrawal and sequelae of substance use. Laboratory and other investigations (including urine drug tests) should be performed appropriate to the medical conditions identified…***GRADE – Quality: Moderate; Strength: Strong**

TREATMENT

- *Buprenorphine maintenance should be considered first line pharmacotherapy for the treatment of OUD.*

GRADE Quality: Moderate; Strength: Strong

- *Methadone maintenance treatment may be considered for those older adults who cannot tolerate buprenorphine or in whom it has been ineffective.*

GRADE Quality: Moderate; Strength: Strong

TREATMENT

- *If renal function is adequate, daily witnessed ingestion of slow-release oral morphine, may be considered with caution for those older adults in whom buprenorphine and methadone have been ineffective or could not be tolerated. Careful supervision of initiation onto short-acting morphine first is recommended, prior to transition to maintenance with the long-acting 24-hour formulation*

GRADE Quality: Low; Strength: Weak

TREATMENT

- *For older adults with OUD for whom opioid agonists are contraindicated, unacceptable, unavailable, or discontinued and who have established abstinence for a sufficient period of time, naltrexone may be offered.*

GRADE Quality: Moderate; Strength: Weak

TREATMENT

- *Psychosocial interventions, should be offered concurrently with medications for an OUD, at a pace appropriate for age and patient needs but it should not be viewed as a mandatory requirement for accessing pharmacotherapy.*

GRADE Quality: Moderate; Strength: Strong

Cannabis Use Disorders in Older Adults

Cannabis Working Group

Co-Chairs:

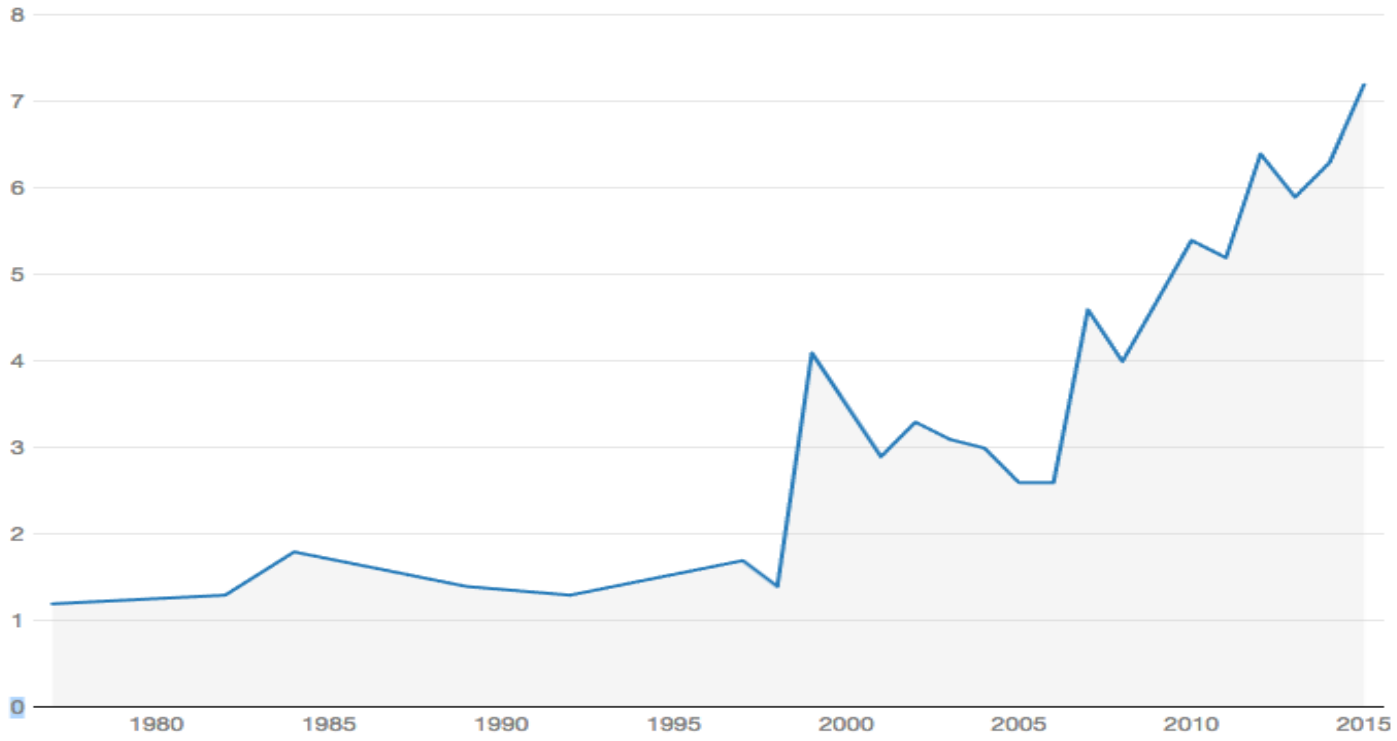
- **Jonathan Bertram**: Addiction Medicine, Centre for Addiction and Mental Health (CAMH)
- **Amy Porath**: Director of Research, Canadian Centre on Substance Use and Addiction (CCSA)
- **Dallas Seitz**: Geriatric Psychiatry, Queen's University

Working Group Members:

- **Harold Kalant**: Pharmacology & Toxicology, U. Toronto
- **Ashok Krishnamoorthy**: Geriatric Psychiatry, U. British Columbia
- **Jason Nickerson**: Scientist, U. Ottawa
- **Amanjot Sidhu**: Geriatrician, Hamilton Health Sciences
- **Andra Smith**: Psychology, U. Ottawa
- **Rand Teed** (PWLE): Drug and Alcohol Counselor

But in both Canada and the United States, more and more older adults are using marijuana in some form — the percentage of Ontarians over 50 who used pot in the past year nearly tripled over the last 10 years, and has risen fivefold since 1977.

Ontario: People over 50 who used cannabis in the last year, 1977-2015 (%)



Source: Centre for Addiction and Mental Health Get the data

- Overall 18% of Canadians reported using cannabis in the first quarter of 2019, up from 14% in 2018
- Some of these new cannabis consumers were first-time users, while others were former cannabis users who reinitiated 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 and rates went from 9% to 14% from 2018 to 2019

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

PREVENTION

- **Clinicians should be aware of the following:**
- **c) The clinician needs to know the common adverse effects of cannabis in older adults and to counsel patients about these adverse effects, such as immobility, instability, falls, incontinence, cognitive impairment and nutritional disturbance.**

[GRADE: Evidence: Moderate; Strength: Strong]

Adverse Effects of THC
Dry Mouth
Dizziness
Drowsiness
Psychoactivity (subjective increase in anxiety symptoms, paranoia, euphoria)
Behavioral and mental health problems (increased with higher THC preparations)

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]**

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

- **The SBIRT (Screening, Brief Intervention, and Referral to Treatment) approach should be considered for assessing and managing CUD similarly to other SUDs.**

- **[GRADE: Evidence: Low; 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]

TREATMENT

- **Accredited residential treatment should be considered as appropriate for treating CUD if the individual is unable to effectively reduce or cease their cannabis use.**

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

Alcohol Use Disorders in Older Adults

Alcohol Working Group

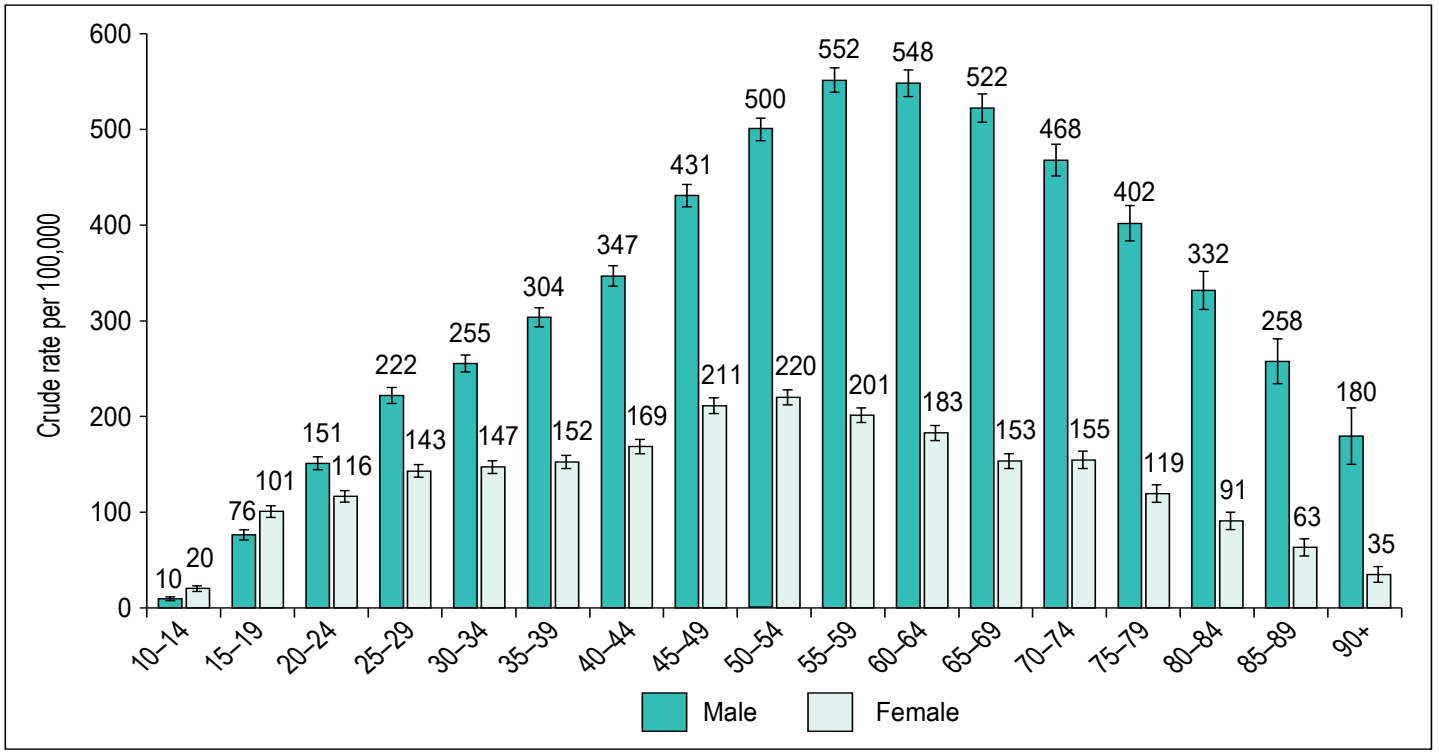
Co-Chairs:

- **Peter Butt**: Addiction Medicine, U. Saskatchewan
- **Marilyn White-Campbell**: Addiction Specialist, COPA/Reconnect

Working Group Members:

- **Lisa Van Bussel**: Geriatric Psychiatry, U. Western Ontario
- **Sarah Canham**: University Research Associate, SFU
- **Ann Dowsett-Johnston** (PWLE): Journalist, Recovery Advocate
- **Eunice Indome**: Student Member, U. Waterloo
- **Bonnie Purcell**: Clinical Psychologist, London Health Sciences Centre
- **Jennifer Tung**: Pharmacist, GeriMedRisk

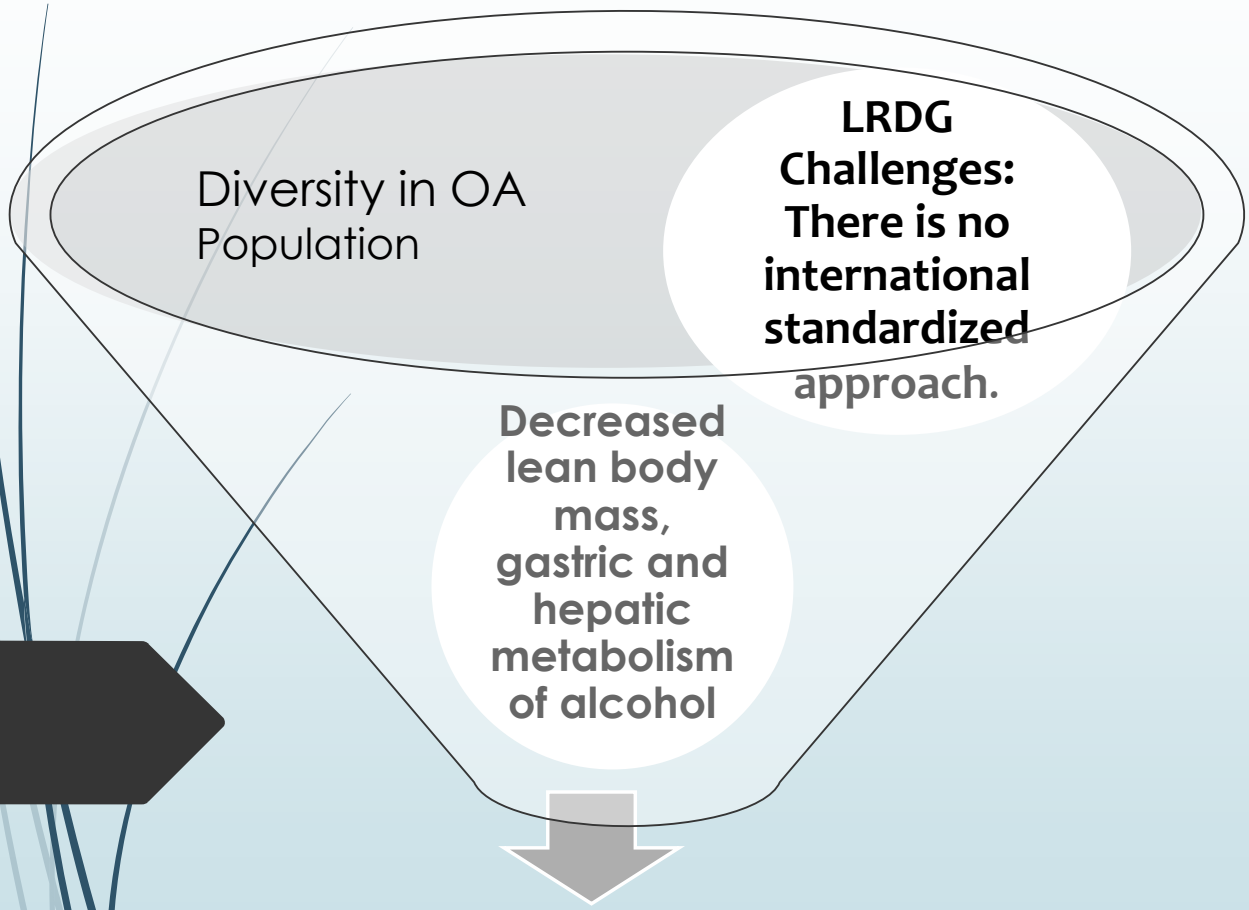
Figure 5 Crude rates for Hospitalizations Entirely Caused by Alcohol per 100,000 population age 10+, by age group and sex, 2015–2016



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.

Alcohol Use Disorder in Older Adults



Evolving dementia & concurrent risk of ABIs and / or stroke
Increased frailty with risk of falls

AUD in OAs

There is a plethora of expert opinion and clinical guidance but a paucity of older adult population specific evidence.

Most advice extrapolates from adult literature and clinical experience.

PREVENTION #1

Low Risk Drinking Guidelines for Older Adults, 65 and older

A - For women, no more than 1 standard drink per day with no more than 5 per week in total; for men 65, 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: Moderate, Strength: Strong)

SCREENING #4

All patients (including older adults) should be screened for alcohol use at least annually (i.e., 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: Moderate, Strength: Strong)

TREATMENT # 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 treatment itself.

[GRADE: High; Strength: Strong]

TREATMENT #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: High; Strength: Strong]

TREATMENT # 17

As a harm reduction strategy for frail older adults in controlled environments, where medical withdrawal is not available or deemed appropriate, 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.

Benzodiazepine Receptor Agonist Use Disorder in Older Adults

Benzodiazepine Working Group

Co-Chairs:

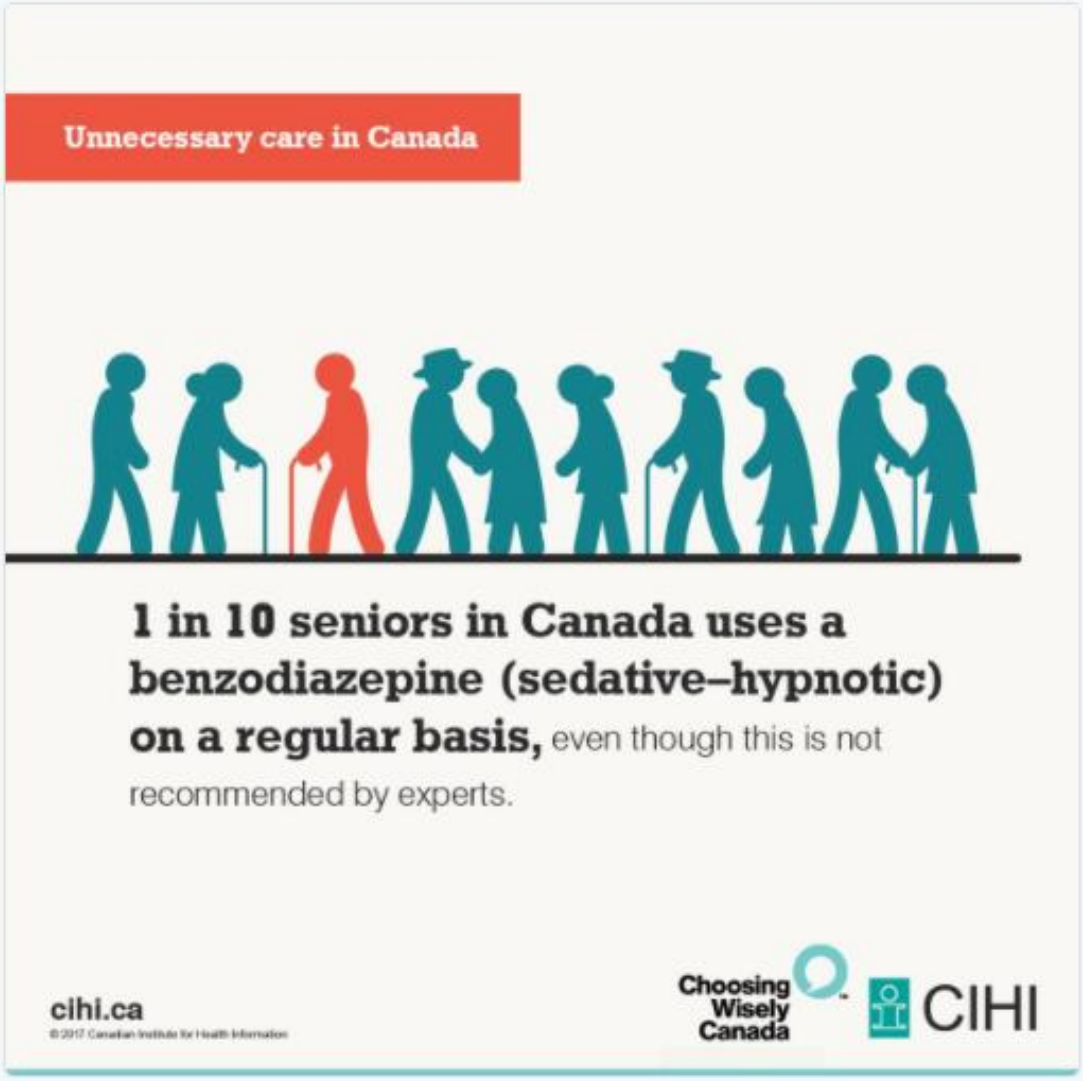
- David Conn: Geriatric Psychiatry, Baycrest Health Science/U. Toronto, Co-Cha
  CCSMH
- David Hogan: Geriatric Medicine, U. Calgary

Working Group Members:

- Lori Amdam: Nursing, British Columbia
- Keri-Leigh Cassidy: Geriatric Psychiatry, Dalhousie University
- Peter Cordell: Psychiatry Resident, McMaster
- Chris Frank: Family Medicine - COE, Queen's University
- David Gardner: Pharmacy, Dalhousie University
- Morris Goldhar (PWLE): Engineer (retired)
- Joanne Ho: Geriatric Medicine, McMaster University
- Chris Kitamura: Geriatric Psychiatry, Baycrest
- Nancy Vasil: Geriatric Psychiatry, Université Montréal

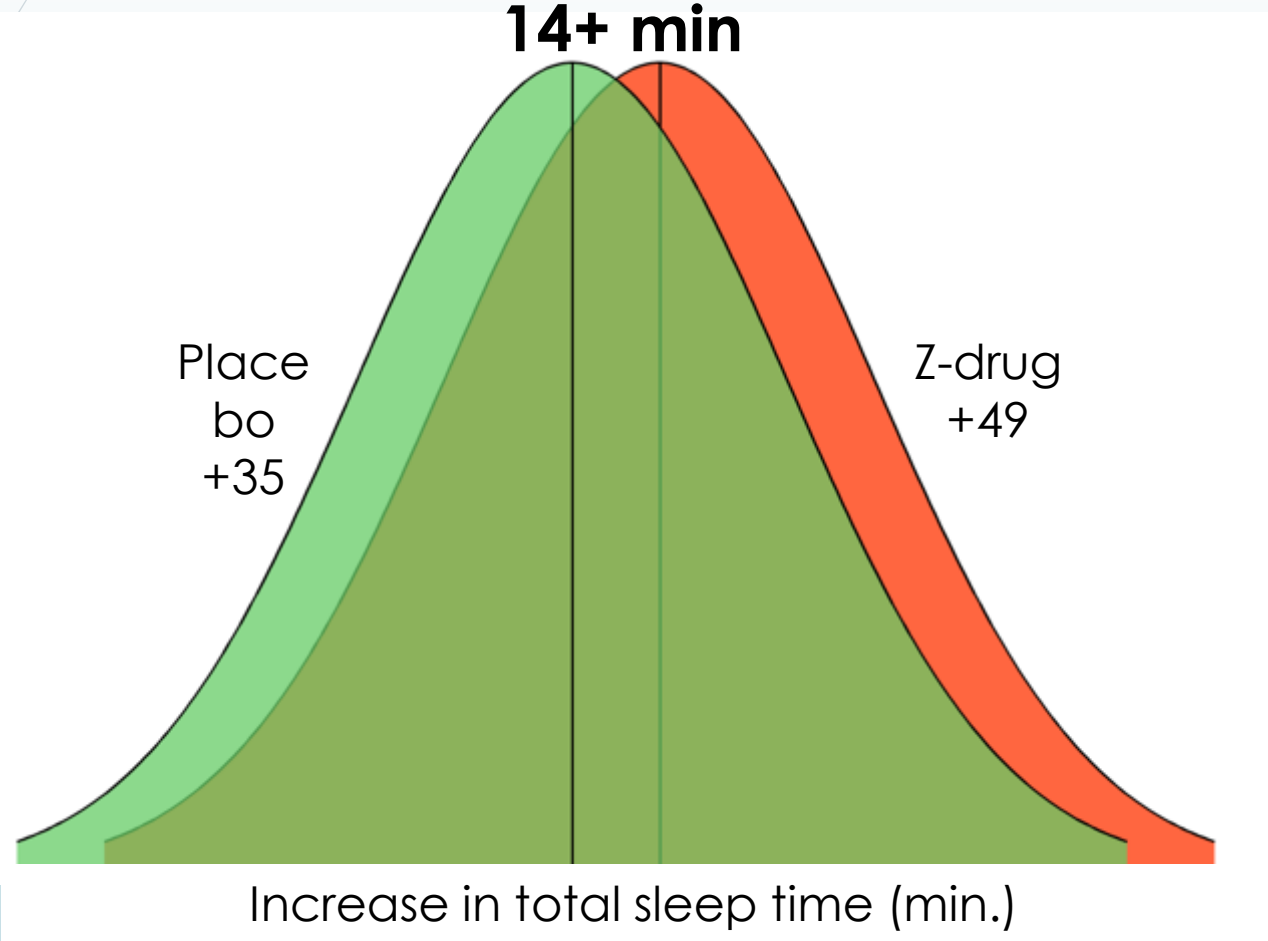
CIHI_ICIS @CIHI_ICIS · 18h

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



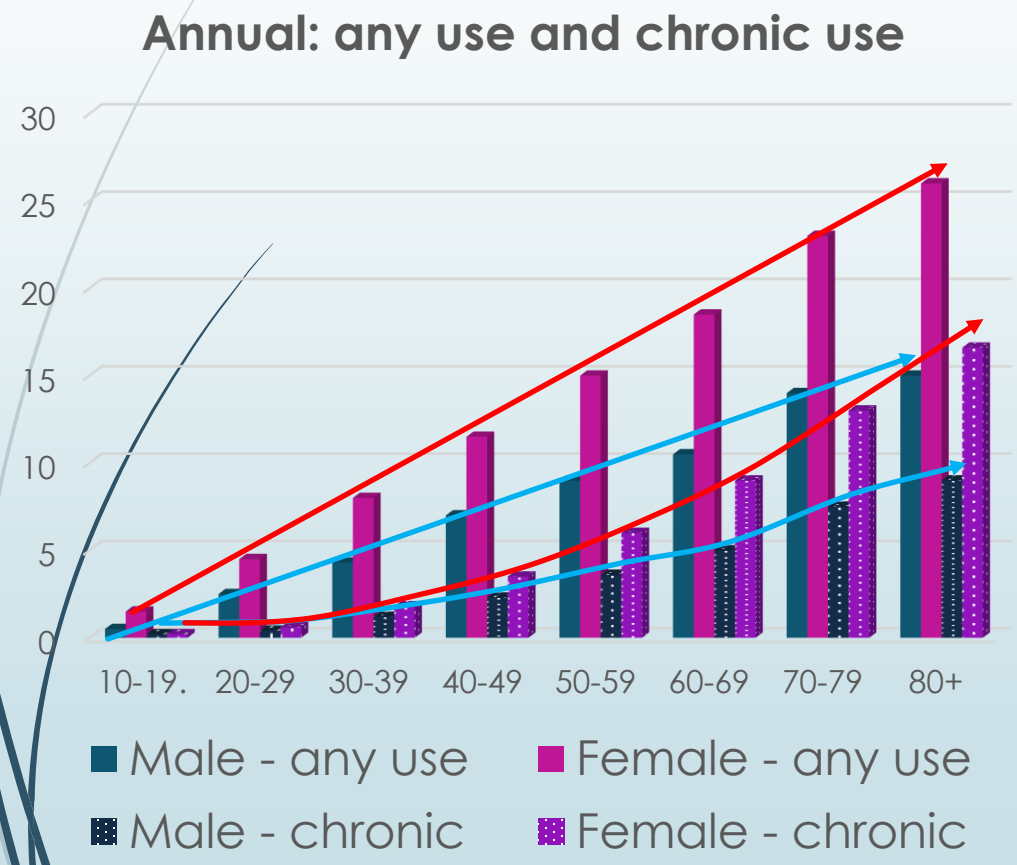
Systematic Review: Total Sleep Time

Z-drugs in insomnia



Huevo-Medina et al. BMJ 2012

Aging & benzodiazepine use

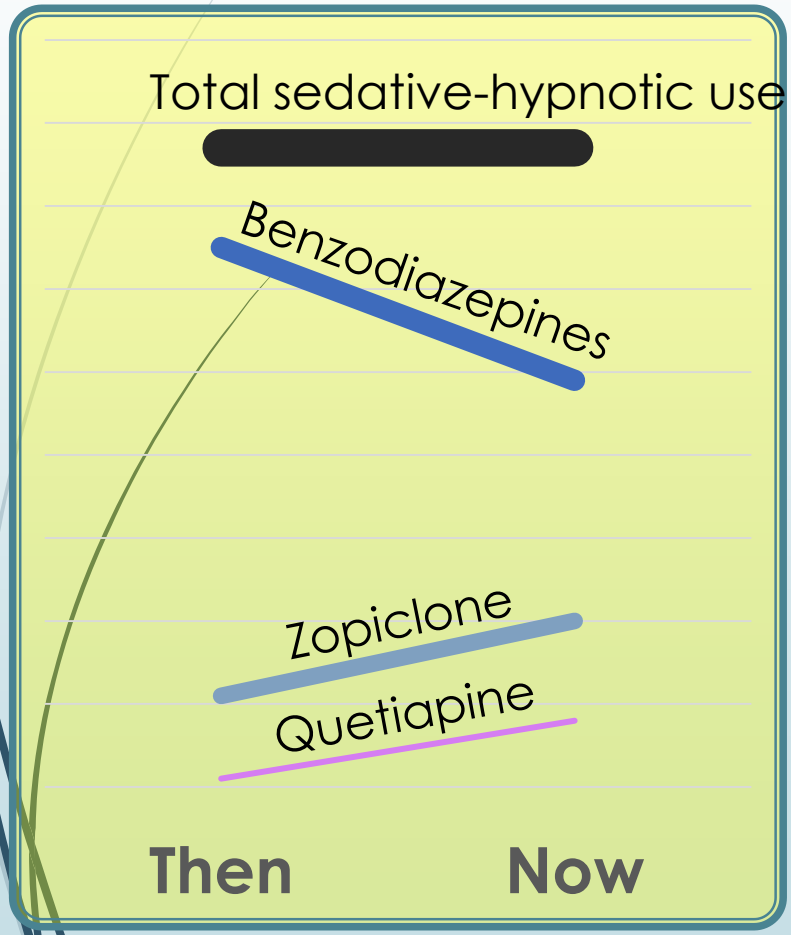


British Columbia 2006
Cunningham et al. Health Policy 2010

Persistent use
1 in 2 “chronic users” in 1996 also “chronic users” in 2006

Implicit bias
Females presenting with insomnia or anxiety **more** likely to be prescribed BZRA.

Alternatives to benzodiazepines



First-line recommended therapy for anxiety and insomnia:

CBT

CBTi

Hendriks et al ., 2008; Ursuliak et al ., 2008; Soyka, 2017
Qaseem et a 2016; Riemann et al ., 2017

PREVENTION

RECOMMENDATION #1:

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

RECOMMENDATION #3:

A BZRA should only be considered in the management of insomnia or anxiety after failing adequate trials of non-pharmacological interventions or safer pharmacological alternatives OR for short-term bridging until more appropriate treatment becomes effective.

[GRADE: Evidence: Moderate; Strength: Strong]

PREVENTION

RECOMMENDATION #5:

If a BZRA is being considered, the older adult should be informed of both the limited benefits and risks associated with use, as well as alternatives, prior to deciding on a management plan. [Consensus]

ASSESSMENT

RECOMMENDATION #13:

Health care practitioners should be aware of and vigilant to the symptoms and signs of substance use disorders, including BZRA use disorder. Particular attention should be paid to this possibility when assessing common conditions encountered in older adults, such as falls and cognitive impairment. [Consensus]

TREATMENT

RECOMMENDATION #16:

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

RECOMMENDATION #17:

Abrupt discontinuation of a BZRA after intermediate to long-term use (> 4 weeks) in individuals with BZRA use disorder should be avoided due to the risk of withdrawal symptoms, substance dependence reinforcement, rebound phenomena, and/or higher likelihood of relapse with resumption of BZRA use. [GRADE: Evidence: Moderate; Strength: Strong]

TREATMENT

DURATION OF USE	RECOMMENDED TAPER RATE	RECOMMENDED TAPER DURATIONS
< 2 to 4 weeks	N/A	N/A
4 weeks to 6 months	10% to 25% of current BZRA dose every 1 to 2 weeks (consider slower rate at end)	1 to 3 months
> 6 months	10% of current BZRA dose every 2 to 4 weeks (slower rate at end)	3 to 6 months

TREATMENT

RECOMMENDATION #21:

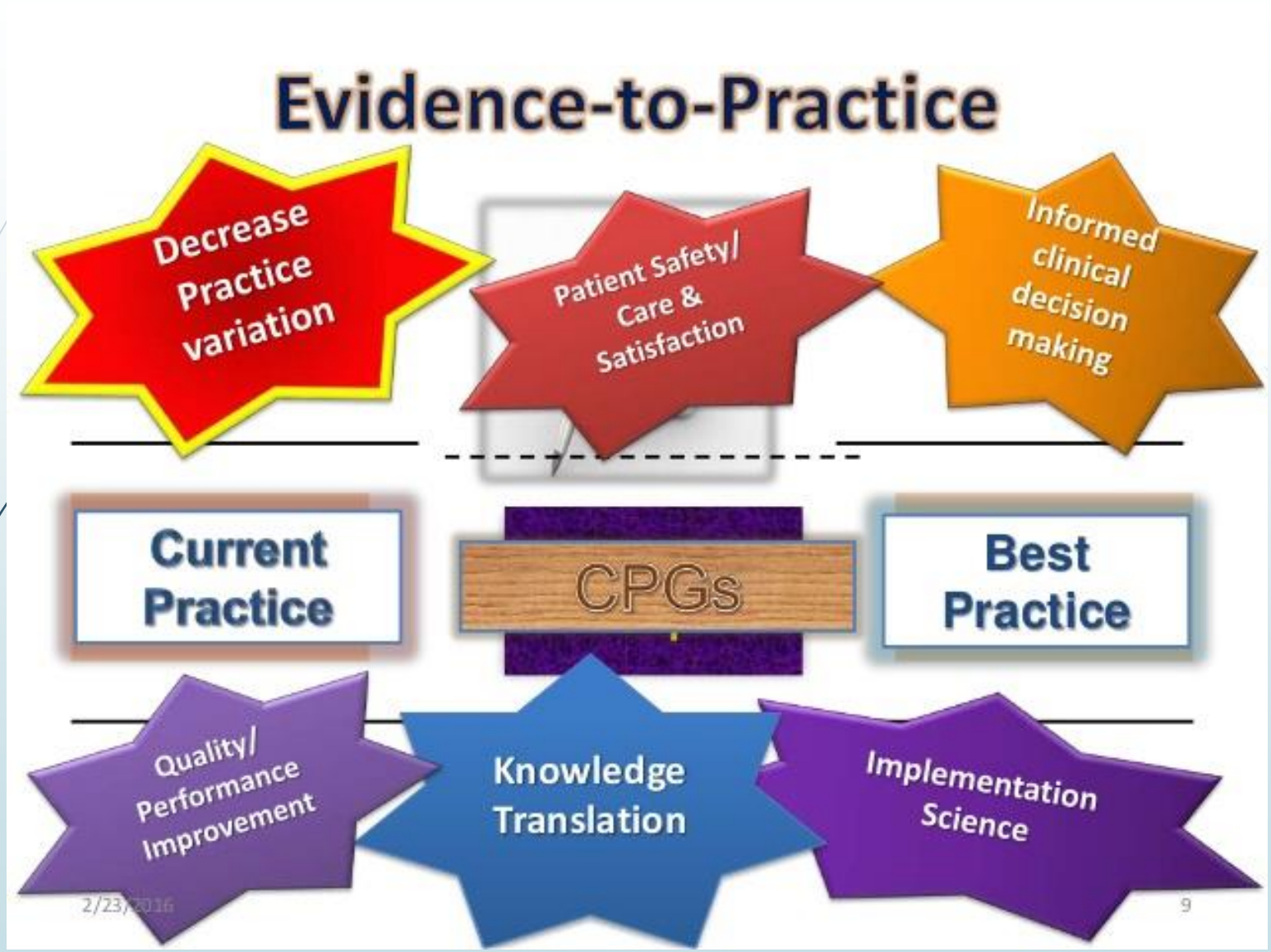
Psychological interventions such as CBT should be considered during efforts to withdraw BZRAs as they can improve the older adult's experiences and increase the likelihood of stopping the BZRA. [GRADE: Evidence: High; Strength: Strong]

TREATMENT

RECOMMENDATION #22:

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]

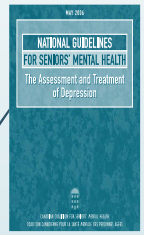
KNOWLEDGE TRANSLATION


Evidence-to-Practice
Decrease Practice variation
Patient Safety/ Care & Satisfaction
Informed clinical decision making
Current Practice
CPGs
Best Practice
Quality/ Performance Improvement
Knowledge Translation
Implementation Science

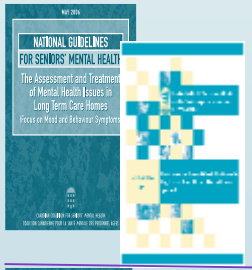
KNOWLEDGE TRANSLATION PRODUCTS

National Guidelines | Clinical Pocketc | Educatio n | Client Resour | Other Resour

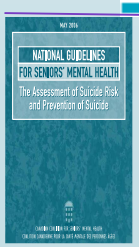
Suicide
MH in LTC
Depression
Delirium

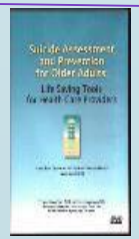













Discharge Planning
Cancer Care
MH Services for Seniors




Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder Among Older Adults

2019

Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder Among Older Adults

Rationale

Despite consensus that benzodiazepine receptor agonists (BZRAs) should be avoided whenever possible in older adults (Kuhn-Thiel et al., 2014; American Geriatrics Society, 2019), clinicians continue to frequently prescribe these medications in this patient population. Recent Canadian data suggest high rates of use persist among older adults, especially females, with 18.7% of females reporting past-year use (Statistics Canada, 2016). There is evidence, however, that the overall rate of use of BZRAs is gradually dropping in Canada. Davies et al. (2018) reported that the prescription rate for benzodiazepines among Ontario residents aged 65 and over declined from 23.2% in 1998 to 14.9% in 2013. A Quebec study of older adults reported that 9.5% of those taking benzodiazepines met Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for substance dependence (Voyer et al., 2010).

Minimizing BZRA Use and Preventing BZRA Use Disorder

Strategies to prevent BZRA use disorder include avoiding the initial prescription of BZRAs, particularly if consumption of these agents would place the older adult at high risk for harm, and following good prescribing practices when they are used. Informed older patients and well-trained prescribers, supported by a health care system that offers ready access to non-pharmacological alternatives, are required to achieve these aims.

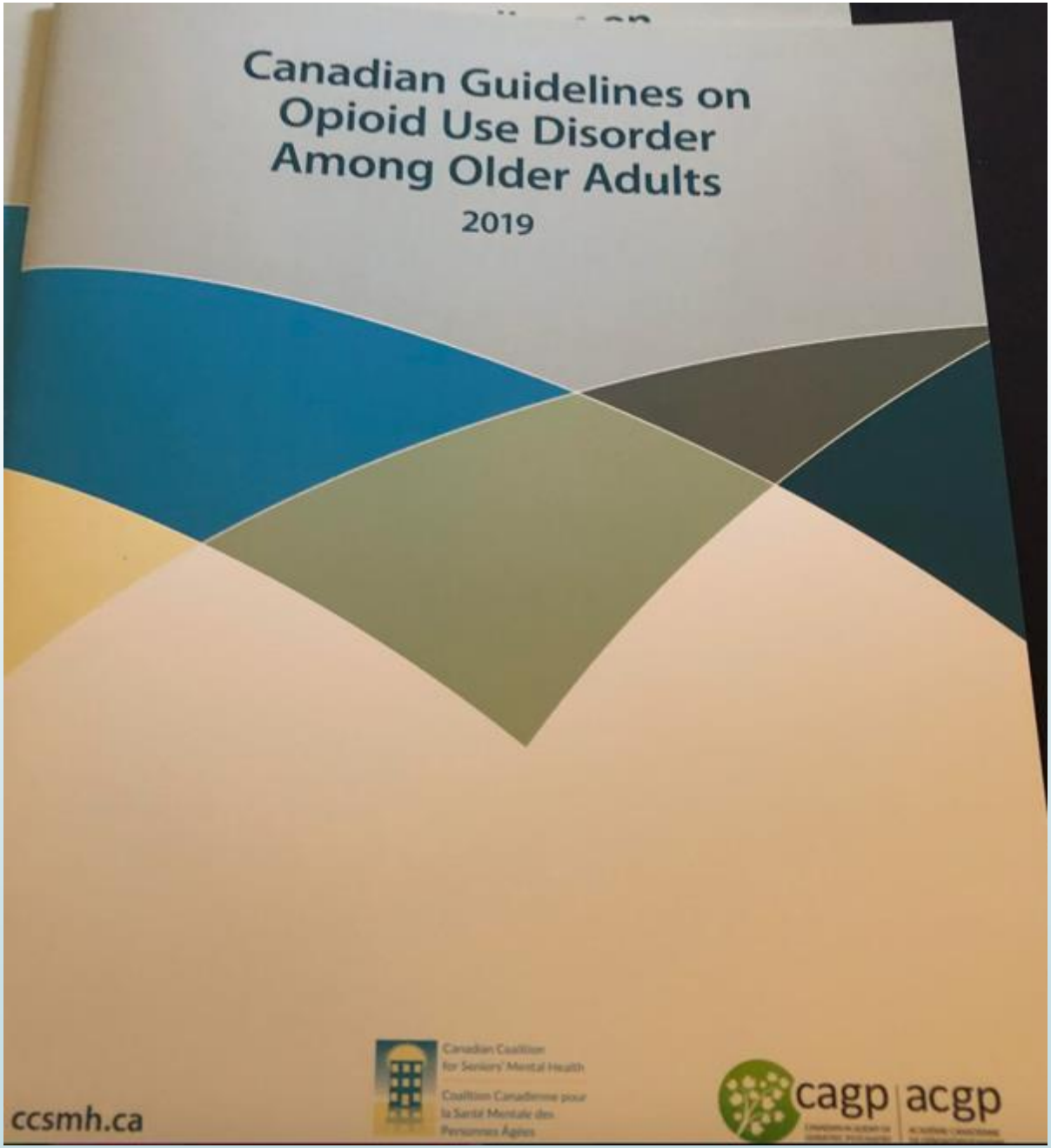
RECOMMENDATION #1:

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]

BZRAs are not first-line agents for the treatment of anxiety, insomnia, or BPSD in older adults because of their minimal efficacy and concerns about adverse effects (el-Guebaly et al., 2010; Vaapio et al., 2015; Gage, 2016; Jansen et al., 2016). These drugs are included in commonly used lists of medications to avoid in older adults (Hamilton et al., 2011; Kuhn-Thiel et al., 2014; American Geriatrics Society, 2019).

Age-related changes in pharmacokinetics and pharmacodynamics result in a greater risk of adverse effects with BZRAs in older adults at doses lower than cited as effective (Tamblyn et al., 2005; Vaapio et al., 2015). Adverse effects include falls, fractures, cognitive impairment, delirium, incontinence, respiratory depression, and unplanned hospitalization (American Geriatrics Society, 2009; Assem-Hilger et al., 2009; Lin et al., 2017). BZRAs can also negatively affect driving skills and are associated with higher motor vehicle crash rates at all ages (Leufkens & Vermeeren, 2009; Kang et al., 2012).

Prescribers need to be aware of how frequently and quickly dependency on BZRAs can develop. As many as 15% of regular users have been found to be dependent after 4 months and 50% after 2 years of use, with some sources citing even higher rates (el-Guebaly et al., 2010). Efforts to reduce physiological dependency would include minimizing dosages, prescribing only for short periods of time, and/or only using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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.


THANK YOU!
Any Questions????