Canadian Coalition for Seniors' Mental Health
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Canadian Guidelines for Opioid Use Disorders among Older Adults

THE CANADIAN COALITION FOR SENIORS' MENTAL HEALTH

PRESENTED BY

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Disclosures

HEALTH CANADA FUNDED THE CCSMH THROUGH THE SUBSTANCE USE AND ADDICTIONS PROGRAM (SUAP) TO CREATE GUIDELINES FOR THE PREVENTION, ASSESSMENT AND TREATMENT OF FOUR SUBSTANCE USE DISORDERS IN OLDER ADULTS: ALCOHOL, BENZODIAZEPINES, CANNABIS, AND OPIOIDS (PRESENTED HERE)

WORKING GROUP MEMBERS RECEIVED AN HONORARIUM FOR THEIR WORK ON THE PROJECT

DR. RIEB HAS NO CONFLICTS OF INTEREST OR DISCLOSURES

Key Messages

- Prevention works – Can reduce the risk of developing OUD
- Screening tools exist - Validated in older adults
- Older adults do better than younger adults in treatment – so let's treat!

Learning Objectives

List barriers to recognition of OUD in older adults

Explore the risks associated with OUD in older adults

Review guideline recommendations

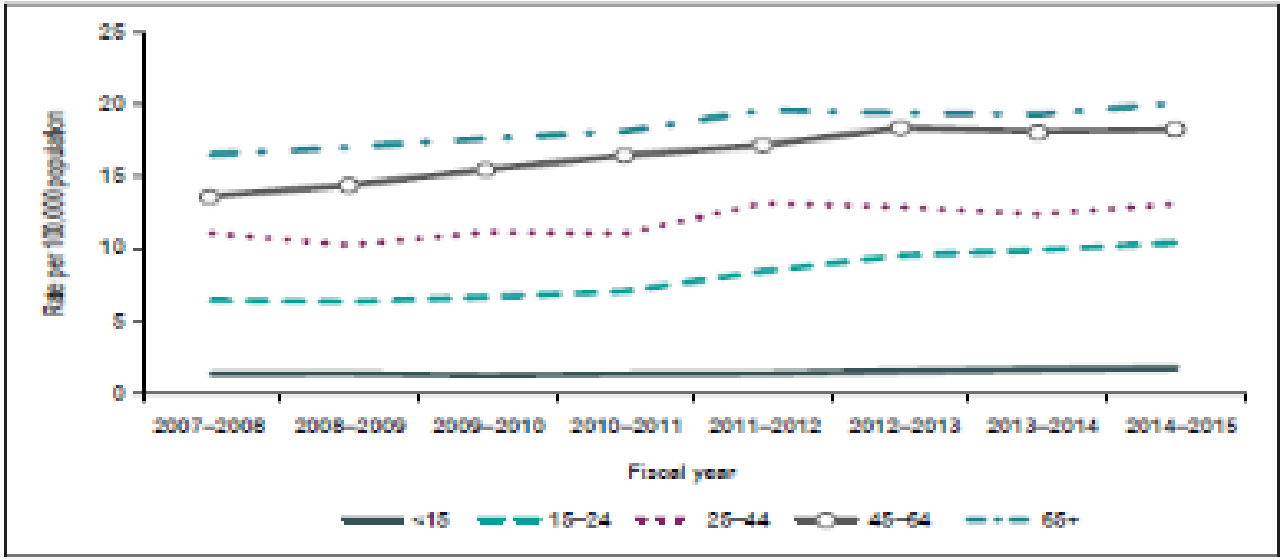
Reflect on guideline relevance

What Do We Know About Opioid Use in Older Adults?

World View on Opioid Use in Older Adults

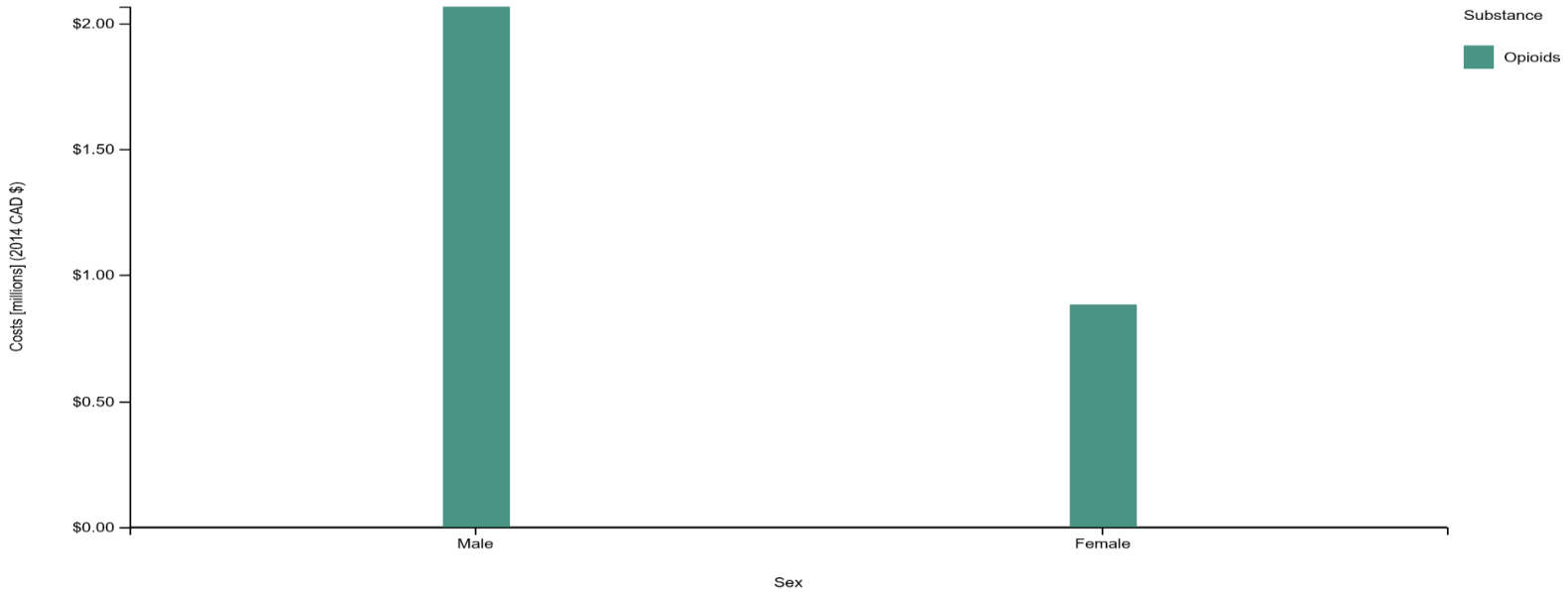
- Globally in 2015, 39% of the deaths due to substance use occurred in those over 50 years old
- Of those over age 65, 75% of the deaths were related to opioid use (UNODC, 2018)
- Prescription opioids are often the substance of choice for suicide attempts in older adults – 33% of opioid poisonings in older adults in Canada are intentional (NICE 2018)
- Opioid misuse is associated with increased suicidal ideation in older adults (Schepis, 2019)

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.

Substance use-attributable inpatient hospitalizations costs due to intentional injuries, ages 65+, Canada, 2014



Source: Canadian Substance Use Costs and Harms Scientific Working Group. (2019). Canadian substance use costs and harms visualization tool, version 1.0.2 [Online tool]. Retrieved from https://csuch.ca/explore-the-data/

For details on the methodology used to derive estimates, refer to the CSUCH technical report.

These estimates do not include costs or counts associated with inpatient hospitalization, day surgery, and emergency department costs or counts in the province of Québec. Therefore, all estimates should be considered conservative.

Canadian Centre on Substance Use and Addiction

University of Victoria | Canadian Institute for Substance Use Research

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 or RCTs

Two Cohorts in this Population

Long term illicit opioid users, on and off MAT

Prescription opioid exposure later in life, develop OUD

Most older adults with OUD start with Rx

- In one study of patients up to age 75 hospitalized with OUD, 46% began their addiction with a "legitimate prescription" (Canfield 2010)
- Older adults may be involved with diversion of their opioid medications for financial gain (Inciardi, 2009)
- Older adults with OUD have higher rates of comorbid mood disorder, post-traumatic stress disorder, hepatitis C, human immunodeficiency virus, and chronic pain which increases the cost of care,(Larney, 2015)
- Older adults with opioid use disorder appear to be at twice the risk of death compared to younger adults with the disorder (Larney et al., 2015).

Prevalence of OUD in Older Adults?

- Past year prevalence of OUD in older adults in the US is 0.8% (SAMHSA, 2017)
- Prevalence of OUD in Canada is not well tracked
- Inadequate diagnostic identification and coding by health providers

- Estimates:
  - Almost 44% of Canadians over age 50 have used a prescription opioid, among whom 1.1% are daily users (CCSA 2018)
  - Only one study approximating DSM IV Drug Use Disorders in adults 0.5% (CCHS 2012)

Key Barriers to Identification and Care

- **Stigma** – rather buy illicit opioids than get Dx with OUD
- **Privacy** – if living with family or dependent on a caregiver
- **Gender, race, class** – white, upper economic class women least identified
- **Masked symptoms** – depression grief, dementia, medical co-morbidities
- **Practitioners undertrained** (DSM 5 adjustments), therapeutic nihilism

Guideline Methods

Methods

Literature search:

- Existing guidelines, meta-analyses, literature reviews, RCTs, cohort trials
- Databases: Cochrane Library, EMBASE, MEDLINE, PsycInfo, PubMed
- AGREE II used to identify guidelines that were of sufficient quality to inform guideline development

Methods

- Guidelines recommendations assessed using GRADE *Categories of Evidence and Strength of Recommendations*
- Recommendations confirmed by consensus of 8 member working group
- Draft documents sent out to reviewers for feedback and then modified
- 32 recommendation total – will be released in the next few months

What are the Recommendations?

OUD in OA - Recommendations: 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**
- *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

- *Patients and their families should be advised to store opioids safely, never to share their medication, and to return un-used medication to the pharmacist for disposal.* **GRADE Quality: Low/Strength: Strong**
- *Pharmacists and nursing staff are advised to inform the prescriber if there are concerns with co-prescribing, adherence to treatment, or intoxication.* **GRADE Quality: Low/Strength: Strong**
- *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**

Prevention

- Once the decision is made to reduce the opioid dose, a slow out-patient tapering schedule (e.g. 5% drop every 4-8 weeks) is preferable to more rapid tapering. A faster taper schedule may be attempted under special circumstances of medical need if in a treatment setting with medical supervision. **GRADE: Quality Low/Strength: Weak**
- *Dispense naloxone kits to anyone using opioids regularly for any reason (CNCP , OUD, etc.), and train household members and support staff on use.* **GRADE Quality: Low/ Strength: Weak**
- *Include skilled pharmacists and/or nurses on teams to educate patients on appropriate opioid and other medication use.* **GRADE Quality: Low/Strength: Weak**
- *Older adults with or at risk for OUD should be given advice on strategies to reduce the risk of opioid overdose, and information on supervised consumption sites if available in the community.* **GRADE Quality: Moderate/Strength: Strong**

Screening and 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**
- *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**

Assessment

- *A full explanation of findings and diagnosis needs to be given to the patient, and if appropriate to caregivers, and therapeutic optimism provided (i.e. hope given that addiction is a treatable disorder and that older adults, and especially older women, typically have better treatment outcomes than younger adults).* **GRADE: Consensus**

Treatment: Withdrawal Management

- *Opioid withdrawal management should only be offered in the context of connection to long-term addiction treatment.* **GRADE Quality: Moderate/Strength: Strong**
- *Induction onto an opioid agonist is recommended over a non-opioid treatment withdrawal management in older adults with OUD. If a trial of tapering is attempted, there should be the option to go on longer-term opioid agonist or antagonist therapy.* **GRADE Quality: Moderate/Strength: Weak**
- *Buprenorphine-naloxone should be considered first line for opioid withdrawal management... Methadone is an alternative that may be used, however consider the added risk of adverse events.* **GRADE Quality: Moderate/Strength: Weak**
- *For symptom control during opioid withdrawal management, adjuvant medications can be used in a time limited fashion but with caution...* **GRADE Quality: Moderate/Strength: Weak**

Treatment: Pharmacotherapy

- *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**
- *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: Pharmacotherapy

- *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: Pharmacotherapy

- *Offer medications for an OUD in the context of connection to long-term addiction, mental health and primary care treatment where careful monitoring and dose titration can occur.* **GRADE Quality: Moderate/Strength: Strong**
- *Advise patients that the use of alcohol, benzodiazepines and other sedative-hypnotics is hazardous when combined with opioid agonist treatment…slow tapering of the substance(s) (to elimination if possible) rather than abrupt cessation is recommended. If …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**
- *Early take-home dosing of buprenorphine may be considered, including home induction in patients who are low risk, if they find it difficult to attend the office...**GRADE Quality: Low/Strength: Weak***

Dose/protocol adjustments needed in older adults

- *Reduce initial doses of medications for OUD (e.g. by 25-50%), slow dose escalation frequency (e.g. by 25-50%), use the lowest effective dose to suppress craving, withdrawal symptoms and drug use, and monitor closely...* **GRADE Quality: Low/Strength: Strong**
- *The threshold to admit an older adult with social, psychological, or physical comorbidities to either residential or hospital care for opioid withdrawal management or induction onto medications for OUD should be lower than for a younger adult.* **GRADE: Quality: Moderate/ Strength: Strong**
- *…For severe acute pain that has been unresponsive to non-opioid strategies, a short acting opioid in addition to opioid agonist treatment may be considered for a short duration (1-7 days) and taper if necessary (1-7 days).* **GRADE Quality: Moderate/Strength: Weak**

Treatment: psychosocial interventions

- *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**
- *Contingency management may be offered as part of opioid treatment programs, if preferred by the patient.* **GRADE Quality: Moderate/Strength: Weak**
- *Traditional healing practices used by indigenous communities can be integrated with buprenorphine treatment to improve outcomes for OUD.* **GRADE Quality: Low/Strength: Weak**

Setting

- *…for patients with **more severe or complex** disorders it is recommended that personnel or teams with advanced SUD 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**
- *Older adults with OUD who are admitted to a hospital, drug and alcohol treatment facility, or non-medical facility with access to medical care (e.g. prisons and shelters) should be given OAT at the onset of withdrawal if requested (advisable within 1-3 days), with bridging pharmacological treatment on discharge with confirmed transfer of care.* **GRADE Quality: Moderate/Strength: Strong**

System Issues

- *The cost of medically recommended pharmacological and non-pharmacological treatment for OUD in older adults should be covered by the public health plan.*

  GRADE Quality: Moderate/Strength: Strong

Conclusion

- Older adults are susceptible to adverse health consequences of opioid use and an increasing number of older adults are presenting with OUD
- There is a growing need for opioid prevention, assessment and treatment recommendations for older adults as the population in Canada ages
- We hope practitioners will find this guideline a practical and useful clinical aide, and that the community at large will find it a helpful education resource

Key Messages for OUD

- Prevention works – Can reduce the risk of developing OUD
- Screening tools exist - Validated in older adults
- Older adults do better than younger adults in treatment – so let's treat!

Opioid Working Group

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The views expressed herein do not necessarily represent the views of Health Canada.

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Questions?