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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.

Substance Use Disorders among Older Adults: New Challenges and the Road to Creating National Guidelines

ASHOK KRISHNAMOORTHY: MD, MRCPSYCH, FRCPC, ABAM, M.S (NEURO PSYCH)

Disclosures

RELATIONSHIPS WITH COMMERCIAL INTERESTS: **NONE**

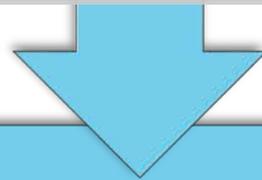
POTENTIAL FOR CONFLICT(S) OF INTEREST: **NONE**

FUNDING: HEALTH CANADA (SUAP) FOR GUIDELINES PROJECT

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

Learning Objectives

Describe issues and barriers unique to older adults with or at risk for substance use disorders



List key recommendations regarding prevention, screening, assessment and treatment of alcohol, opioid, cannabis, and benzodiazepine use disorders in older adults

The CCSMH has been tasked by Health Canada to:

Develop guidelines regarding the **prevention, assessment and treatment** of four SUDs in older adults.

Form a 10-member steering committee, and 4 multidisciplinary working groups of 6 – 8 experts including PWLE

Draft recommendations on **Alcohol, Benzodiazepine, Cannabis** and **Opioid** Use Disorder among older adults

The guidelines are aimed at health care professionals and other stakeholders across Canada

Evidence-based & broad in scope

Reflective of the continuum of settings for care

Acknowledge variation between facilities, agencies, communities, regions and provinces across Canada

Reflective of perspectives of people with lived experience (PWLE)

Alcohol Working Group

Co-Chairs:

- ▶ **Peter Butt**: Addiction Medicine, U. Saskatchewan
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- ▶ **David Hogan**: Geriatric Medicine, U. Calgary

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- ▶ **Morris Goldhar** (PWLE): Engineer (retired)
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Cannabis Working Group

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- ▶ **Lillian Hung**: Geriatric Nursing, Vancouver Coastal Health
- ▶ **Meldon Kahan**: Addiction Medicine, Women's College, U. Toronto
- ▶ **Kiran Rabheru**: Geriatric Psychiatry, U. Ottawa

PROCESS:

Development of Recommendations

- Literature search:
 - Existing guidelines, meta-analyses, literature review, websites
 - 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

PROCESS:

Development of Recommendations

- Working Groups divided into **prevention, assessment, and treatment** subgroups to develop recommendations
- Guidelines recommendations assessed for level of evidence and strength – utilizing GRADE *Categories of Evidence and Strength of Recommendations*
- Recommendations confirmed by consensus (or 75%+ vote) – 2 votes
- Draft documents will be sent out to reviewers for feedback. Working groups will consider the feedback and consider possible modifications.

Involving Persons with Lived Experience

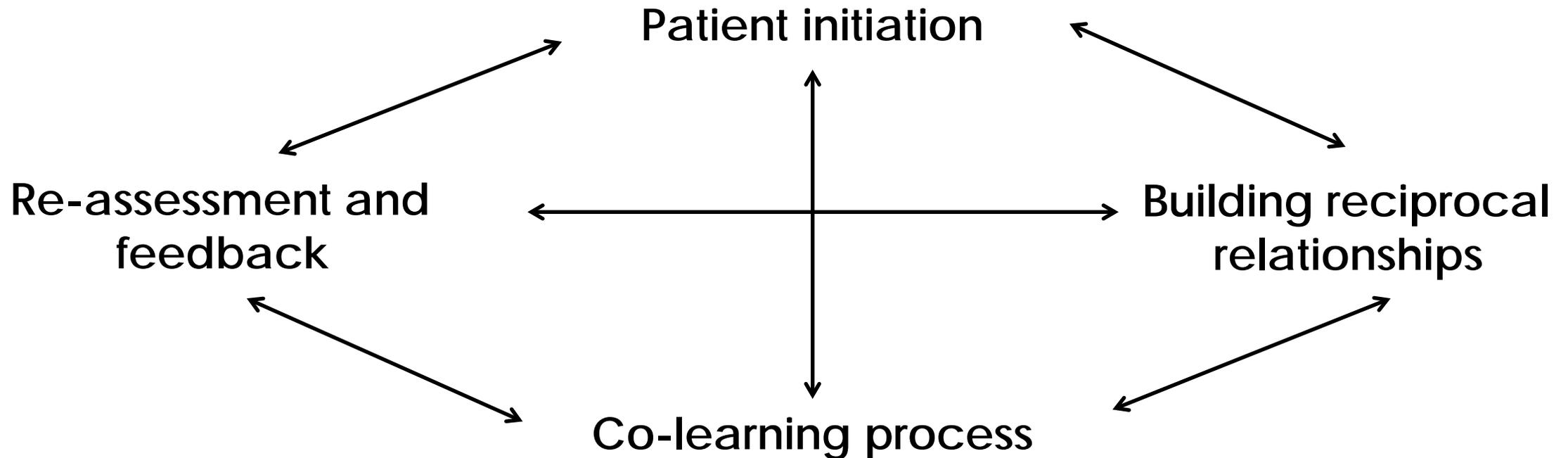


Fig 1. Key themes as they relate to integral components of patient engagement.

<https://doi.org/10.1371/journal.pone.0174329.g001>

(Armstrong et al., 2017)

What Do We Know About Substance Use in Older Adults?





“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!”

Many older adults struggle with substance use issues

21% - 44% in psychiatric population

14% - 21% in geriatric medical population

Substance use can have negative effects on various comorbidities

e.g. Dementia, cancer, liver disease

e.g. mood disorders, suicidality, CVD, HIV, sleep apnea

More vulnerable to the effects of substances



EDITORIALS

Substance misuse in older people

Baby boomers are the population at highest risk

Rahul Rao *visiting researcher*¹, Ann Roche *director*²

¹South London and Maudsley NHS Foundation Trust, London, UK; ²National Centre for Training and Addiction, Flinders University Faculty of Medicine, Nursing and Health Sciences, Adelaide, Australia

Substance Use Trends among Older Adults

- In both the UK and Australia, risky drinking is declining, except among people aged 50 years and older
- There is also a strong upward trend for episodic heavy drinking in this age group
- In Australia, the largest percentage increase in drug misuse between 2013-2016 was among people aged 60 and over – mainly Rx drug
- Increasing proportion of women drinking in later life

Substance Use Trends among Older Adults

- Treatment programs adapted for older people have been associated with better outcomes than those aimed at all age groups
- The challenge of complex clinical presentations:
 - Co-morbidities, cognitive impairment, polysubstance use
- Need for better education of clinicians, treatment options

Alcohol

Baby boomers' drink and drug misuse needs urgent action, warn experts

By 2020, the number of over-50s receiving treatment for substance misuse problems is expected to double in Europe and treble in the US, say researchers



This article is 1 month old

2,213

Nicola Davis

@NicolaKSDavis

Wednesday 23 August 2017 06.00 BST



i A 2011 report advised that due to age-related physiological and metabolic changes, older people should drink no more than 11 units of alcohol per week. Photograph: Alamy

Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016

GBD 2016 Alcohol Collaborators*

Summary

Background Alcohol use is a leading risk factor for death and disability, but its overall association with health remains complex given the possible protective effects of moderate alcohol consumption on some conditions. With our comprehensive approach to health accounting within the Global Burden of Diseases, Injuries, and Risk Factors Study 2016, we generated improved estimates of alcohol use and alcohol-attributable deaths and disability-adjusted life-years (DALYs) for 195 locations from 1990 to 2016, for both sexes and for 5-year age groups between the ages of 15 years and 95 years and older.



Lancet 2018; 392: 1015–35

Published Online

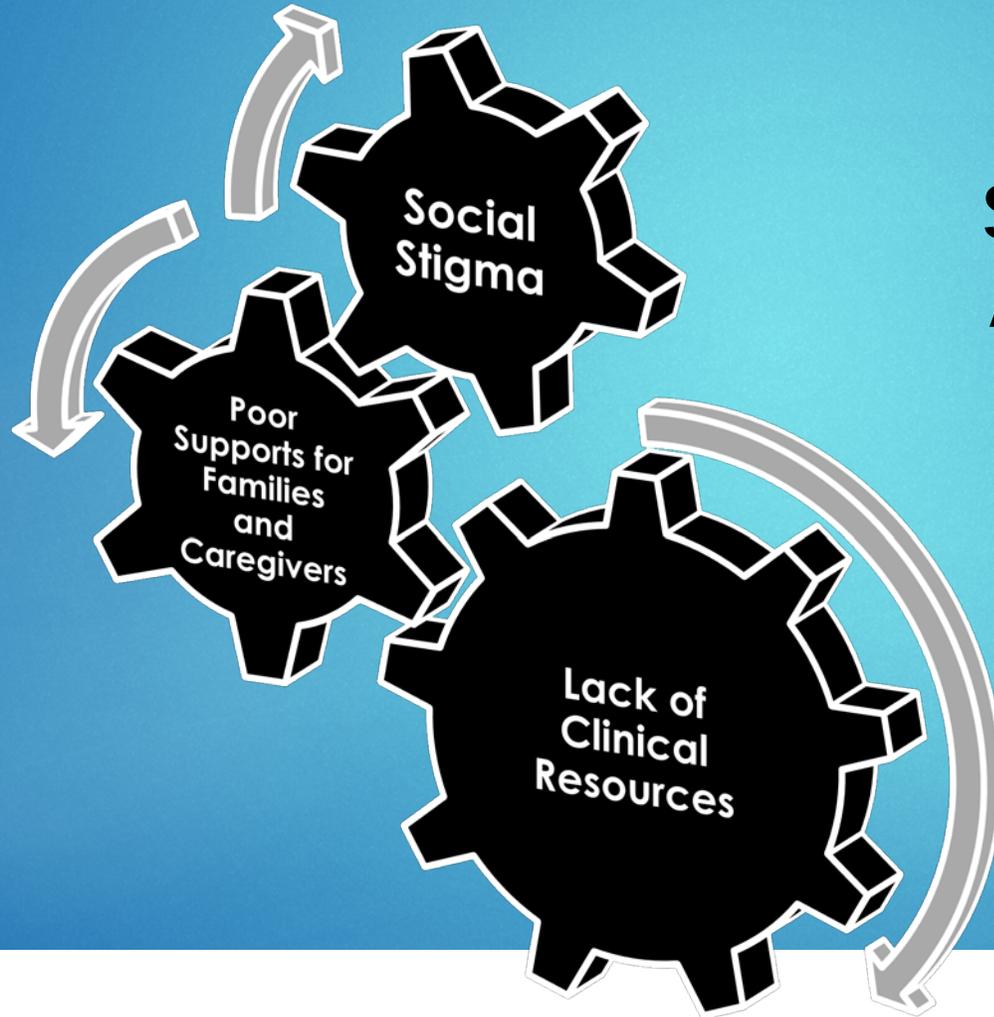
August 23, 2018

[http://dx.doi.org/10.1016/](http://dx.doi.org/10.1016/S0140-6736(18)31310-2)

[S0140-6736\(18\)31310-2](http://dx.doi.org/10.1016/S0140-6736(18)31310-2)

This online publication has been corrected. The corrected version

Older Adults Face Unique Barriers when Navigating the Substance Use World...



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

DRAFT RECOMMENDATIONS

- The following are **DRAFT** guidelines, based on review and grading of the literature, as well as clinical expertise
 - **Only highlights** presented here
 - **Not ready to use** as practice guidelines
- The final guidelines for each of the SUDs will be released end of Summer 2019

Stay Tuned & Stay in Touch

Opioid Use Disorder In Older Adults

Opioid Use Disorder in Older Adults

- ✓ Research on OUDs in OAs have primarily taken place in the U.S. where more studies have focused on problematic Rx Opioid use or Methadone Tx.
- ✓ For adults 65+ with OUD: No previous guidelines, systematic reviews or RCTs

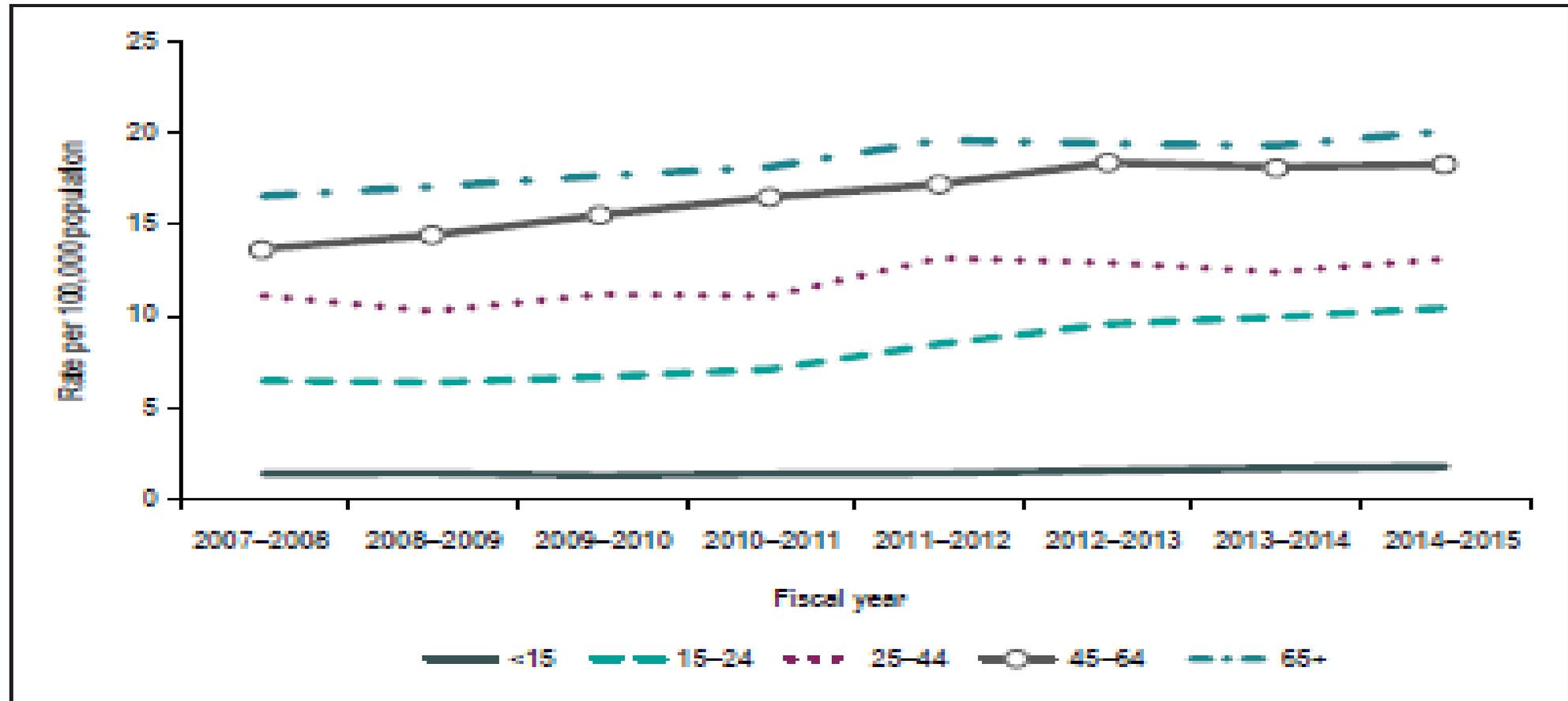
Two Cohorts in this Population

Long term illicit opioid users, on and off MAT



Prescription opioid exposure later in life, develop OUD

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.

Prevention: Opioid Use Disorder

- In most circumstances, avoid prescribing opioids for OAs with chronic non-cancer pain (CNCP)...
 - If doing so, explain the risks and benefits to the patient, initiate and maintain opioids at lower doses than for younger adults, and discontinue if function does not improve, or if adverse effects arise.
- Dispense naloxone kits to anyone using opioids for any reason (CNCP, OUD, etc.), and train household members on use.

Screening: Opioid Use Disorder

- OAs should be screened for OUD using validated tools if appropriate (e.g. CAGE-AID, ASSIST, PDUQp).
- Medication reviews and urine drug screens should be utilized if the patient is on opioids for chronic non-cancer pain for any reason.

Treatment: Opioid Withdrawal Management

- Opioid withdrawal management should only be offered in the context of connection to long-term addiction treatment.
- Induction onto an opioid agonist is recommended over a non-opioid treatment for withdrawal management. If a trial of tapering is attempted, there should be the option to go on longer-term opioid agonist or antagonist therapy.
- Buprenorphine-naloxone (BUP-NX) should be considered first line for opioid withdrawal management in OAs. Methadone is an alternative that may be used, however consider the added risk of adverse events.
- For symptom control during opioid withdrawal management, adjuvant medications (see comments) should be used with caution due to medical co-morbidities and other concerns related to older age.

Treatment: Medication Assisted Treatments (MAT)

- Buprenorphine maintenance treatment (BMT) should be considered first line for opioid agonist therapy (OAT).
- Methadone maintenance treatment (MMT) should be considered for those who cannot tolerate BMT or in whom BMT has been ineffective.
- If renal function is adequate, daily witnessed ingestion of slow-release oral morphine (SROM), may be considered with caution for those in whom BMT and MMT have been ineffective or could not be tolerated. Careful supervision of initiation onto short acting morphine first is recommended prior to transition to SROM.

Treatment: Medication Assisted Treatments (MAT)

- For OAs with OUD for whom opioid agonist treatment (OAT) is contraindicated, unacceptable, unavailable, or discontinued and who have established abstinence for a sufficient period of time, naltrexone may be offered as MAT.
- Avoid benzodiazepines, and other sedative-hypnotics in OA on OAT. If already on OAT and using one of these substances tapering the substance rather than abrupt cessation is recommended.
- Early take-home dosing for BMT (compared to MMT) may be considered, including home induction in patients who are low risk, if they find it difficult to attend the office in withdrawal, and if the patient has social supports at home.

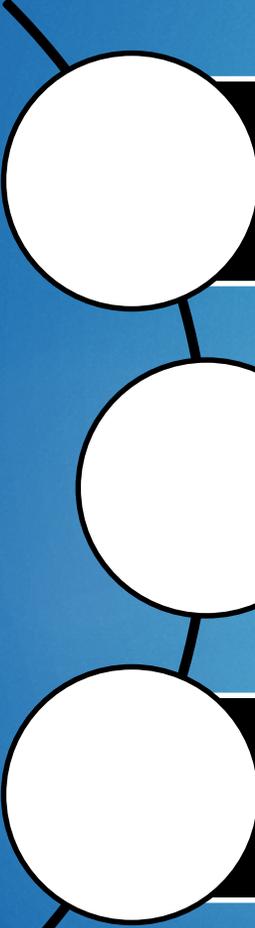
Dose/protocol Adjustments Needed in Older Adults

- Reduce initial doses of MATs (e.g. by 25-50%), slow dose escalation frequency (e.g. by 25-50%), use the lowest effective dose to suppress craving and withdrawal symptoms, and monitor closely (especially for sleep apnea and sedation with OAT).
- The threshold to admit an OA with social, psychological, or physical comorbidities to either residential or hospital care for opioid withdrawal management or induction onto MAT may be lower than for a younger adults.
- In OAs on MAT requiring management of mild to moderate acute pain, or chronic non-cancer pain, non-medication and non-opioid strategies are recommended. For severe acute pain that has been unresponsive to non-opioid strategies, a short acting opioid in addition to OAT may be considered in OAs for a short duration (1-7 days) and taper if necessary (1-7 days).

Treatment: Psychosocial Interventions

- Psychosocial interventions should be offered concurrently with MAT, at a pace appropriate for age and patient needs but it should not be viewed as a mandatory requirement for accessing MAT.
- Offer contingency management (CM) in opioid treatment program if available and preferred by patient.

Key Messages in OUD



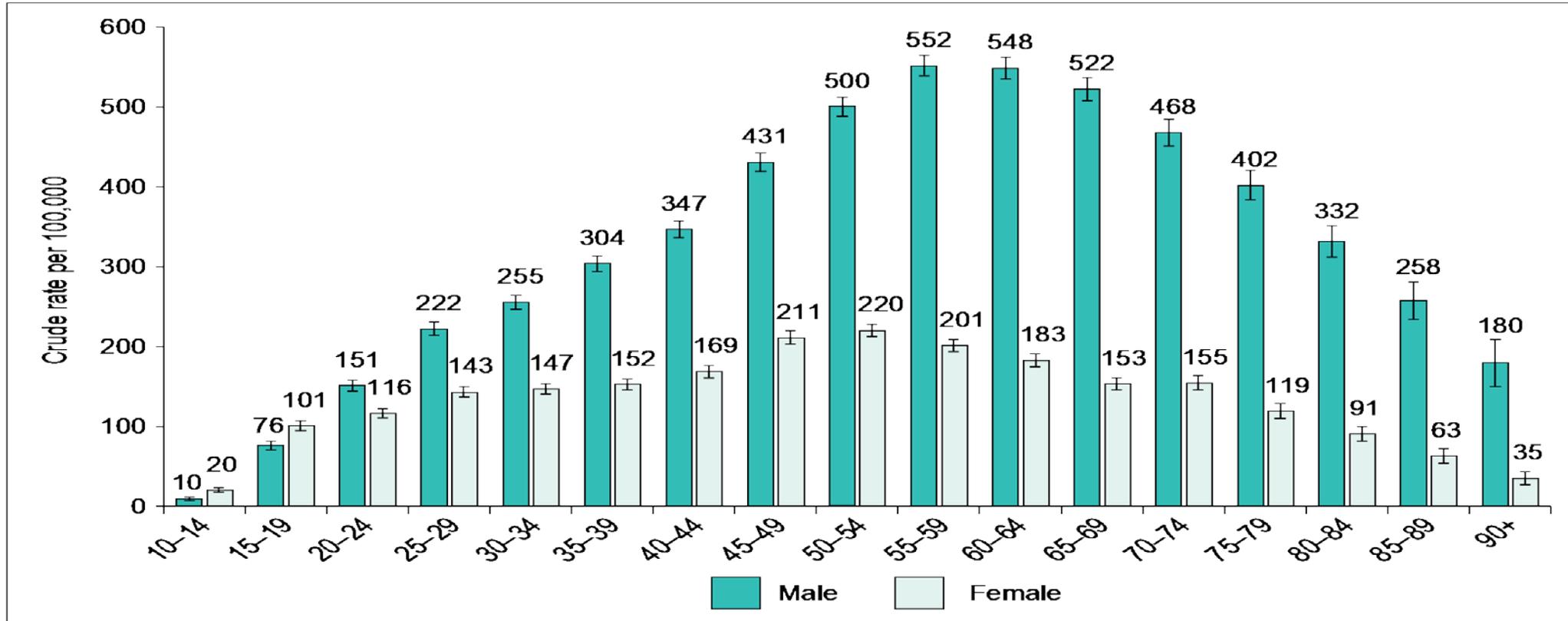
Prevention works – Can reduce the risk of developing OUD

Screening tools exist - Validated in OAs

OAs do better than younger adults in treatment

Alcohol Use Disorder in Older Adults

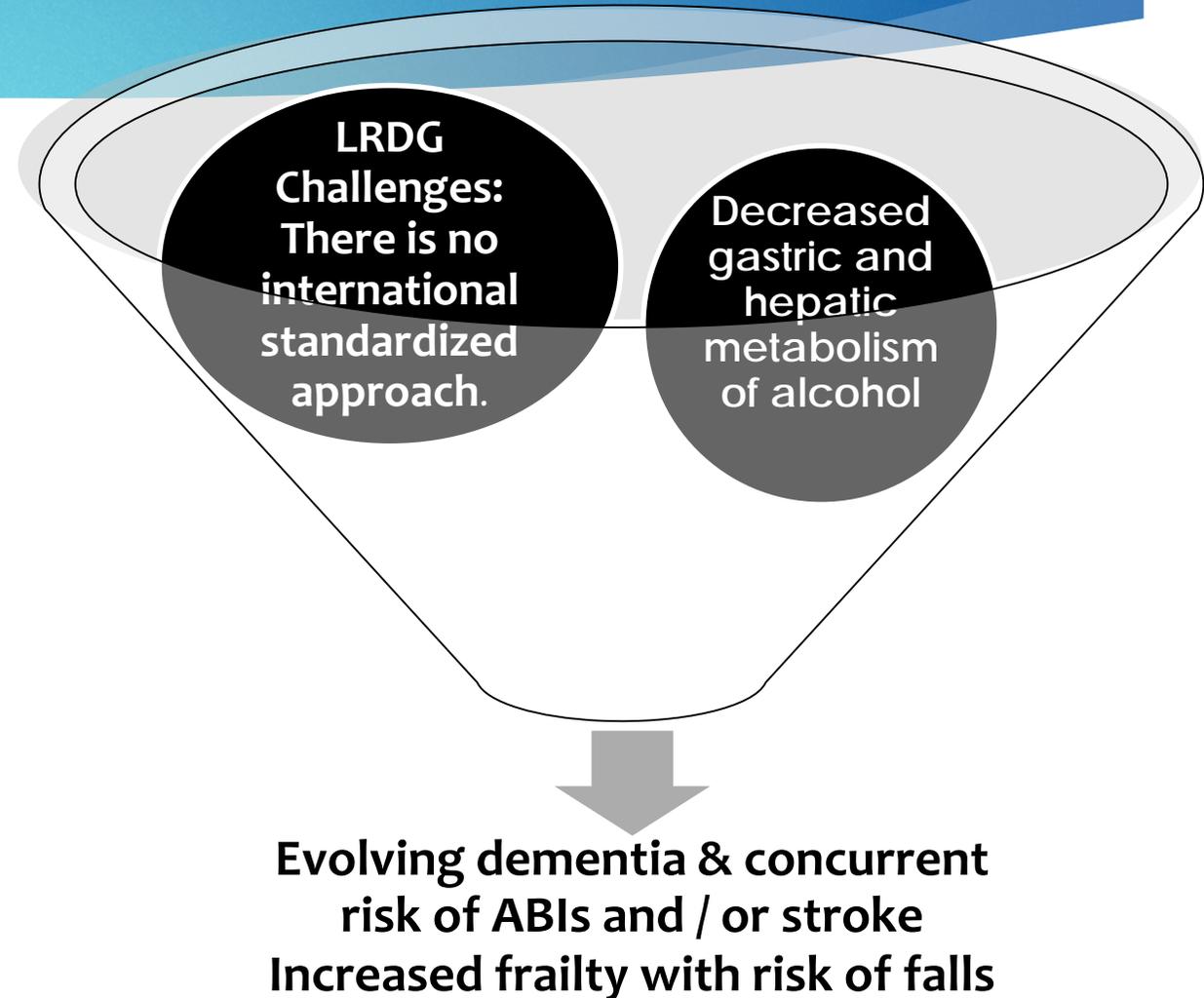
Figure 5 Crude rates for Hospitalizations Entirely Caused by Alcohol per 100,000 population age 10+, by age group and sex, 2015–2016



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

- There is a plethora of expert opinion and clinical guidance and yet a paucity of older adult population specific evidence.
- Most extrapolate from adult literature and clinical experience.



Prevention: Alcohol Use Disorder

- 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.

Screening: Alcohol Use Disorder

Ensure that screening for AUD in older adults is:

- age appropriate;
- employs active listening;
- is supportive;
- uses a health or medical frame;
- accounts for memory impairment or cognitive decline;
- is non-threatening, non-judgemental and non-stigmatizing; and
- recognizes that DSM 5 criteria will under-identify due to reduced occupational or social obligations.

Assessment: Alcohol Use Disorder

- Assess for cognitive impairment using MOCA (or other appropriate, validated tools).
- When there is a reduction or discontinuation of alcohol repeat the cognitive screen at 6 and 12 months to assess for improvements.
- The treatment plan should specify the timeline and procedure for ongoing evaluation of clinical outcomes and treatment effectiveness.

Treatment: Alcohol Use Disorder

- Use PAWS to screen for those requiring medical detox (prior delirium, seizures or protracted withdrawal).
- Patients who are frail, acutely suicidal, have dementia, are medically unstable or who need constant one-on-one monitoring should receive 24-hour primary medical/psychiatric/nursing inpatient care in medically managed and monitored intensive treatment or hospital settings.

Key Messages in AUD

- Establish an objective approach to modify current guidelines for older adults
- Place the approach and knowledge translation (KT) in a Canadian context
- Address the transitional process
- Aim to reduce morbidity and mortality related to alcohol use

Cannabis Use Disorder in Older Adults

Dr. Ashok Krishnamoorthy

Epidemiology of Cannabis Use and CUD Among Older Adults

Older adults have a lower past-year prevalence of past-year cannabis use

- Overall population: 12.3% vs. Age 65+: 1.6%

Older adults have a lower past-year prevalence of CUD (2012 CCHS-MH)

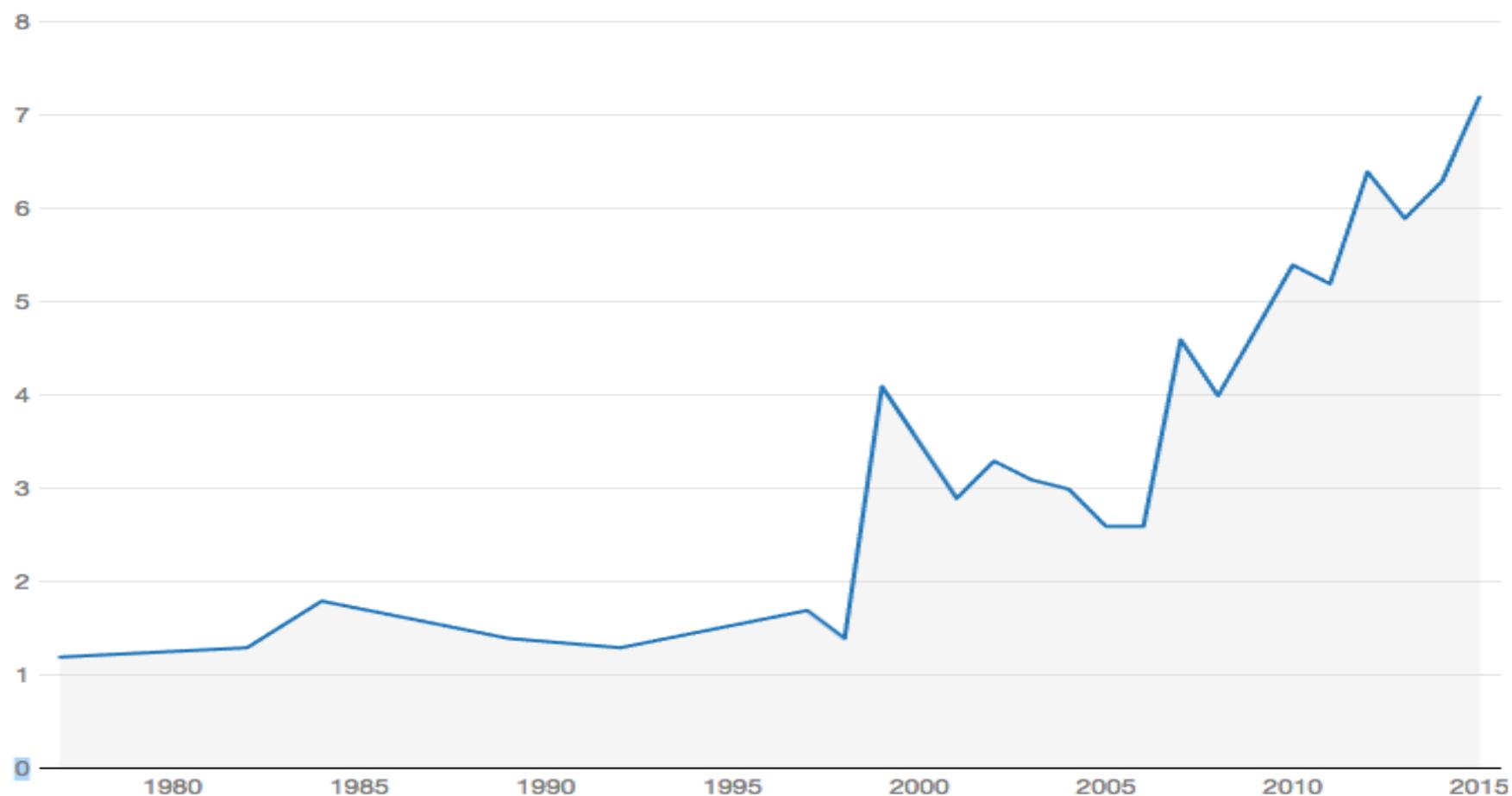
- Overall population: 6.8% vs. Age 55+: 2.6%

The frequency of cannabis use for medical purposes is lower among older adults, despite an increase in the indicators for such use (e.g. chronic pain)

As age increases, cannabis use and dependence tends to decrease
(possible cohort effect)

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 (%)



Current Context: Cannabis

- Legalization of non-medical and medical cannabis use
- Controlled substance use (Opioids, Benzos) in the setting of pain/anxiety is driving a motivation for exploring medical use of cannabis
- Increasing messaging that cannabis is a product with no/minimal drawbacks
- Limited research focussed on effects of cannabis (both medical and non-medical) among older adults

Filters

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Limited quantity

HOUSEPLANT SATIVA

HOUSEPLANT by Canopy Growth Corporation
THC 19-21% CBD 0-0.07%
(estimated potency)



Limited quantity

FLIX N CHILL

Xscape by Canntrust Inc.
THC 20-22% CBD 0-1%
(estimated potency)



BC ICE CREAM

FLOWR by The Flowr Group
THC 16-18% CBD 0.01-0.02% (estimated potency)



BLUE CHEESE PRE-ROLL

Whistler Cannabis Co. by Whistler Medical
THC 16-26% CBD 0.01-0.05% (estimated potency)

Prevention: Cannabis Use Disorder

“Clinicians should be aware of:

- a) the current evidence base on the medical and non-medical use of cannabis and that cannabis is not an approved therapeutic product by Health Canada.
- b) the common symptoms and signs associated with cannabis use, impairment, cannabis use disorder, and common consequences of cannabis misuse”

Prevention: Cannabis Use Disorder

“Clinicians should advise patients that:

- a) cannabis impairs the ability to safely drive a motor vehicle and should be avoided when you are going to drive
- b) the use of both cannabis and alcohol together results in increased impairment and risks for driving and should be avoided.
- c) they should refrain from riding as a passenger with a driver who has used has recently used cannabis.”

Screening: Cannabis Use Disorder

“ All Patients regardless of age should be screened for:

a) the use of non-medical and medical cannabis, and synthetic cannabinoids as well as tobacco, alcohol and other drugs.

b) the frequency and amount of cannabis used where all older adults should be asked about cannabis use and those who acknowledge any recent use (any in the past month) should then go on to targeted screening using the CUDIT”

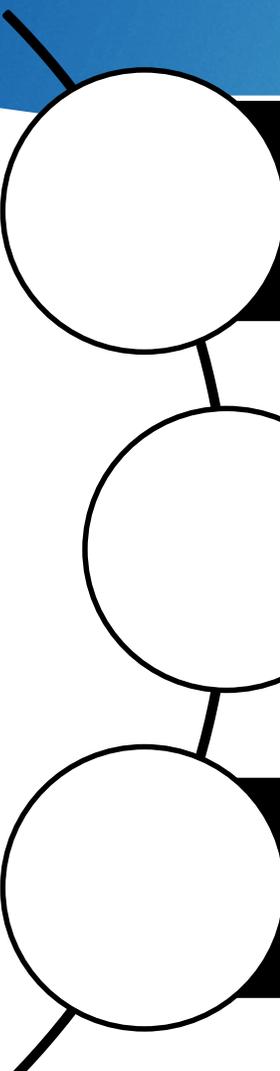
Education

- ▶ Clinicians should advise patients about potentially increased risks associated with higher potency THC extracts (including THC extracts such as Shatter, Wax, Dabbing, Budder etc.), or higher potency strains of cannabis when compared to those with lower THC content

Management: Cannabis Use Disorder

“Clinicians should be aware that the discontinuation of cannabis use may be associated with withdrawal symptoms and know the signs and symptoms of cannabis withdrawal”

Key Messages in CUD



It is known that certain groups of individuals should completely avoid non-medical and medical use of cannabis.

Older adults who have been using non-medical cannabis may be reluctant to discuss previous use as it would have been illegal, which could potentially compromise effective care.

There are significant gaps in our understanding of the effects of cannabis use among the older population.



Editor's key points

▶ Although cannabinoids have been promoted for an array of medical conditions, the evidence base is challenged by bias and a lack of high-level research. Two large evidence synopses suggested that only 3 conditions have an adequate volume of evidence to inform prescribing recommendations: chronic pain, nausea and vomiting after chemotherapy, and spasticity.

Systematic review of systematic reviews for medical cannabinoids

Pain, nausea and vomiting, spasticity, and harms

G. Michael Allan MD CCFP Caitlin R. Finley MSc Joey Ton PharmD Danielle Perry
Jamil Ramji Karyn Crawford MLIS Adrienne J. Lindblad ACPR PharmD
Christina Korownyk MD CCFP Michael R. Kolber MD CCFP MSc

Findings

- ▶ reasonable evidence that cannabinoids improve nausea and vomiting after chemotherapy
- ▶ They might improve spasticity (primarily in multiple sclerosis)
- ▶ There is some uncertainty about whether cannabinoids improve pain, but if they do, it is neuropathic pain and the benefit is likely small
- ▶ Adverse effects are very common, meaning benefits would need to be considerable to warrant trials of therapy.

Effect of cannabis use in people with chronic non-cancer pain prescribed opioids: findings from a 4-year prospective cohort study

- ▶ no evidence of a temporal relationship between cannabis use and pain severity or pain interference
- ▶ no evidence that cannabis use reduced prescribed opioid use or increased rates of opioid discontinuation
- ▶ Cannabis use was common in people with chronic non-cancer pain who had been prescribed opioids
- ▶ People who used cannabis had greater pain and lower self-efficacy in managing pain
- ▶ there was no evidence that cannabis use reduced pain severity or interference or exerted an opioid-sparing effect

▶ [Lancet Public Health](#). 2018;3(7):e341-e350

Medical Marijuana Users are More Likely to Use Prescription Drugs Medically and Nonmedically

Caputi, Theodore L. BS; Humphreys, Keith PhD

Journal of Addiction Medicine 12(4), July/August 2018, p 295-299

- ▶ medical marijuana patients are more likely to use prescription drugs than medical marijuana nonusers
- ▶ major doubts about the common interpretation of negative ecological correlations that medical marijuana users replace medical marijuana for prescription drugs
- ▶ a significant association between medical marijuana use and nonmedical pain reliever use, nonmedical stimulant and tranquilizer use as well.

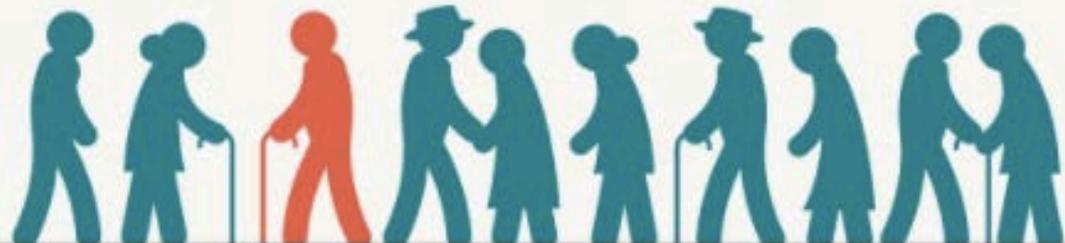
Benzodiazepine Use Disorder in Older Adults



CIHI_ICIS @CIHI_ICIS · 18h

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

Unnecessary care in Canada



1 in 10 seniors in Canada uses a benzodiazepine (sedative-hypnotic) on a regular basis, even though this is not recommended by experts.

cihi.ca

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Choosing
Wisely
Canada



CIHI

Current Context: Benzodiazepines

- ✓ 3-9% of CDN adults:
(RFs older age, female, single, low income, poor health)
- ✓ Women 2x as likely to be Rx BZD
...even when presenting with the same symptom.
More long term use in women.
- ✓ **Women...are over-medicalized...the health sector has difficulty distinguishing...natural processes and sickness” (Health Canada)**

Prevention: Benzodiazepine Use Disorder

“Duration of use of >4 weeks should be avoided

- poor effectiveness: harm ratio
- PK and PD changes in older persons increased vulnerability to adverse effects: cognitive impairment, delirium, falls, fractures, dependence, withdrawal syndrome, disinhibition and motor vehicle crashes
- use alternative strategies for insomnia, anxiety, BPSD”

Prevention: Benzodiazepine Use Disorder

“Inform of limited benefits, risks, & alternatives before setting management plan.

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

Assessment: Benzodiazepine Use Disorder

“Fully assess people with suspected BZRA use disorder

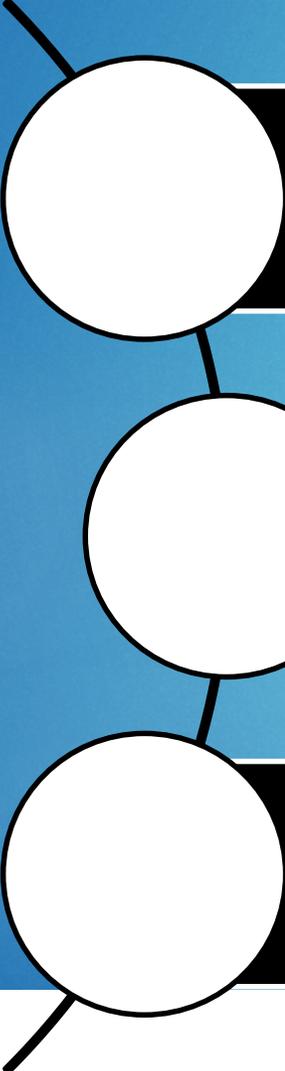
Assessment of an older person suspected of BZRA use disorder should include indication, dose, duration, features indicative of BZRA use disorder, readiness to change, and presence of both medical and psychiatric co-morbidities including any other past or current substance misuse.”

Management: Benzodiazepine Use Disorder

“Avoid adding new drugs to support BZRA tapers

Use of a pharmacologically different drug should not be used routinely as a specific intervention to mitigate BZRA withdrawal symptoms during gradual BZRA dose reduction”

Key Messages in BZRA Use Disorder



Prevention of BZD misuse is achievable!

Optimal prescribing needs to be evaluated against a continuum of prescription drug use

Deprescribing interventions are effective

We need to create awareness in terms of seniors' attitudes toward their medications.

We must consider the difficulty patients may encounter when seeking non-stigmatized care for a SUD

Final Thoughts

People's perception of risk is a key factor in their decision to use substances—and this confirms the need for enhanced awareness by clinicians to assess this factor

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

In Closing...

- Thank you for being here today!
- Have all your questions been answered?
- We would value your feedback on this presentation.
- Please consider joining the CCSMH!

www.ccsmh.ca



We are
looking for
new
affiliates at
the CCSMH!

Acknowledgements

- Claire Checkland (CCSMH Director)
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The views expressed herein do not necessarily represent the views of Health Canada.

Questions?

Knowledge isn't power,
applied knowledge is power.

Eric Thomas

quote fancy

