Substance use disorder in older adults

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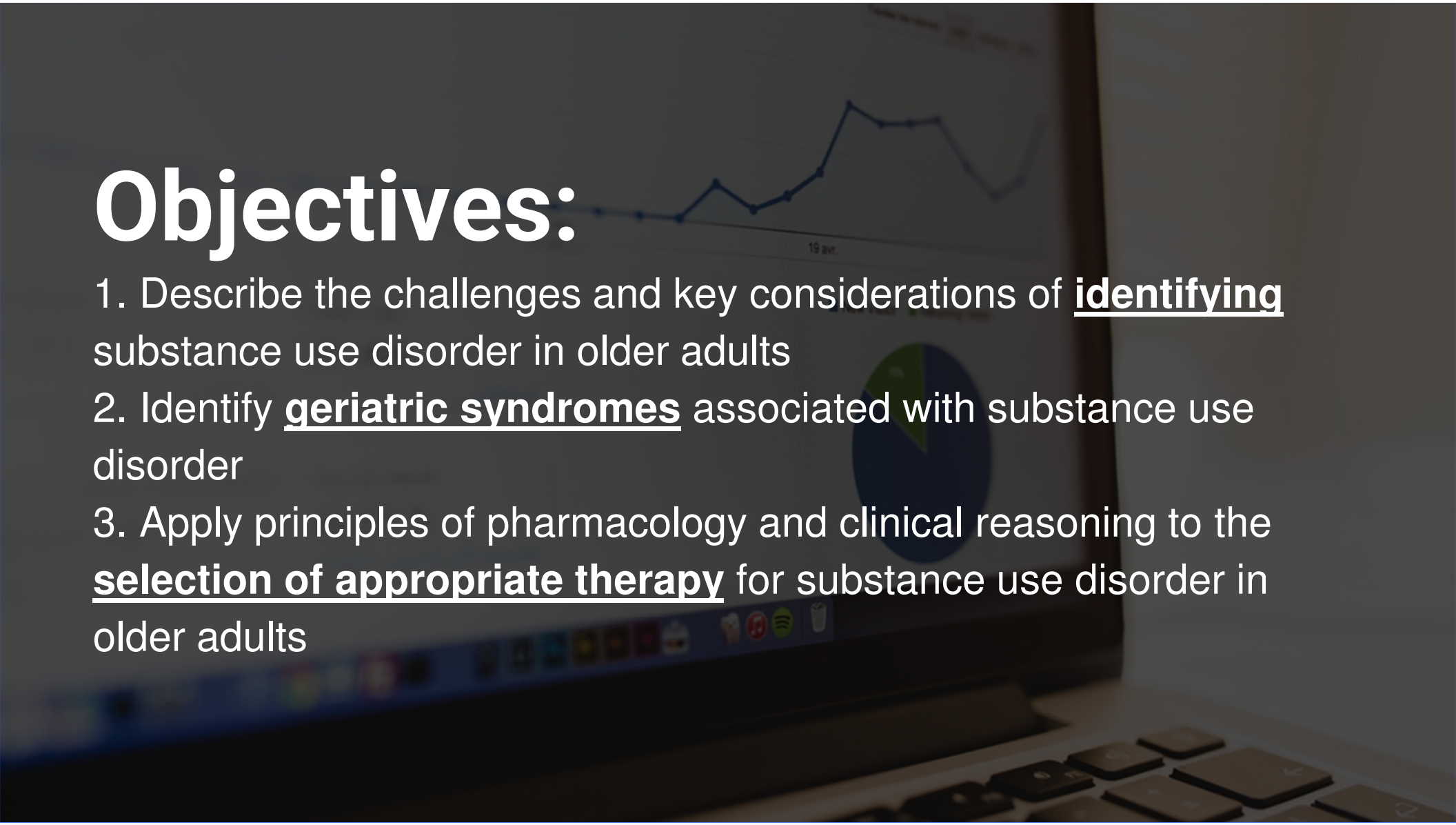
Declarations

Nothing to declare!

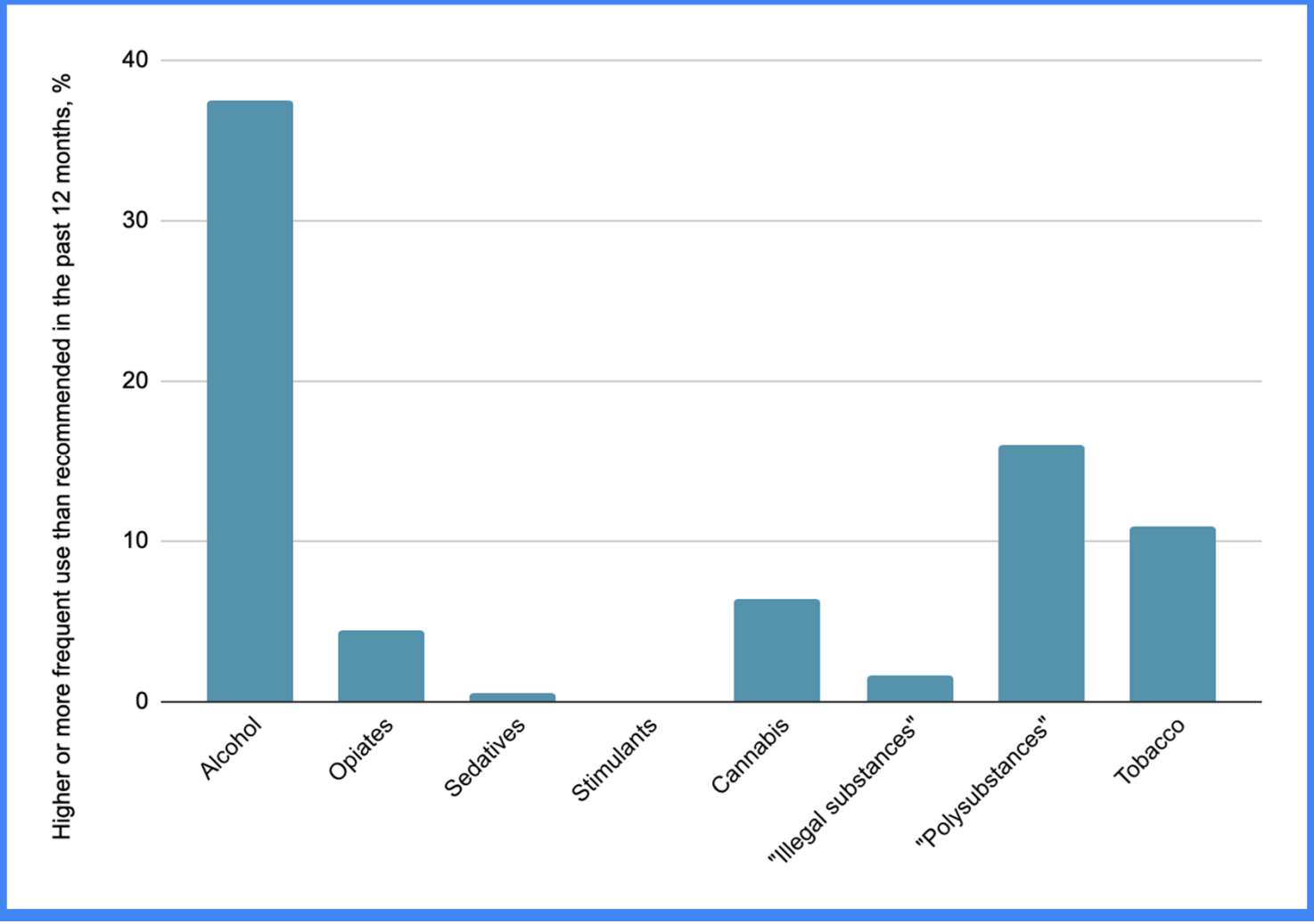


Objectives:

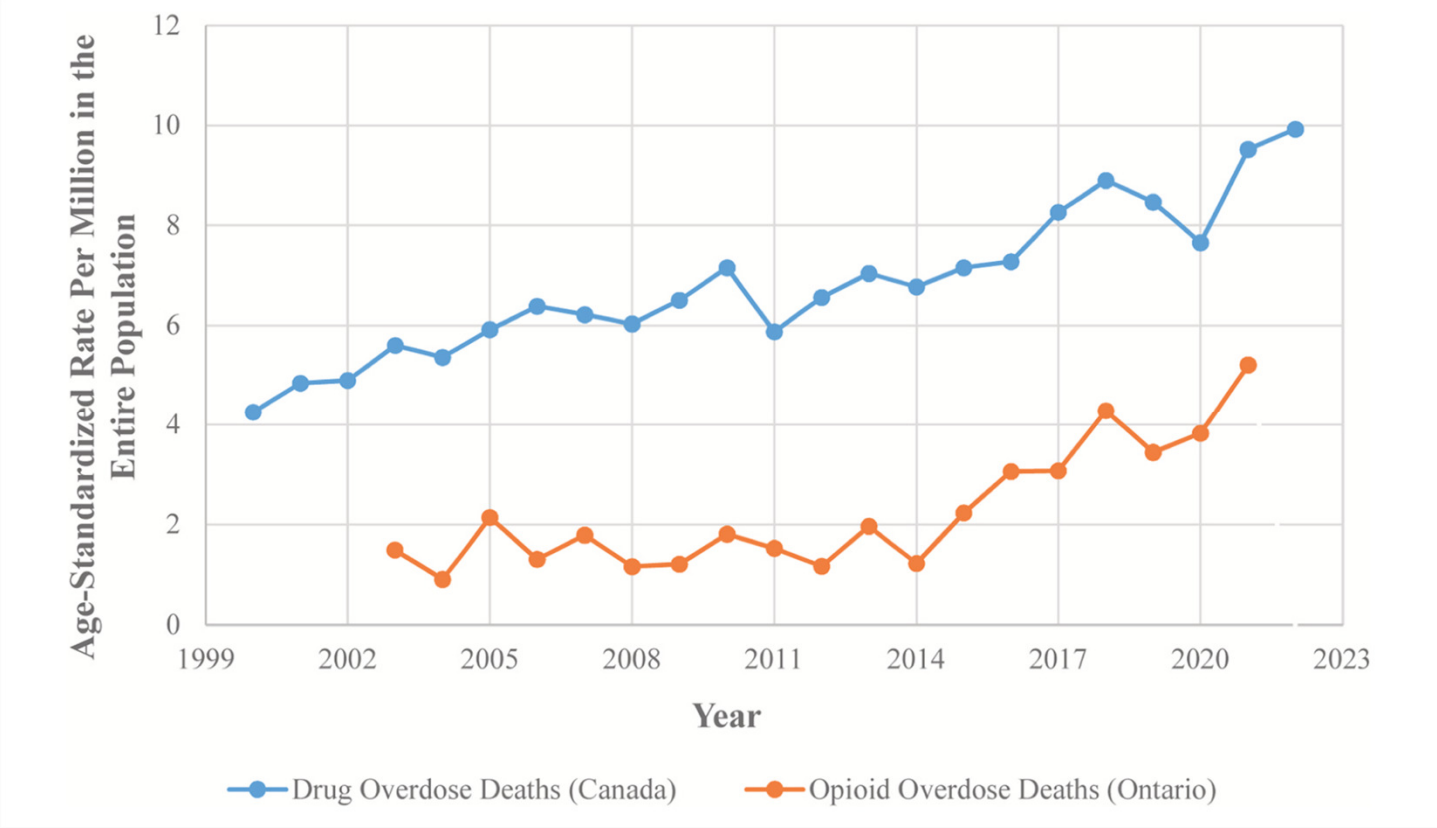
1. Describe the challenges and key considerations of **identifying** substance use disorder in older adults
2. Identify **geriatric syndromes** associated with substance use disorder
3. Apply principles of pharmacology and clinical reasoning to the **selection of appropriate therapy** for substance use disorder in older adults


What’s the big deal?

Canadian Substance Use Survey 2023 results (age 55+)

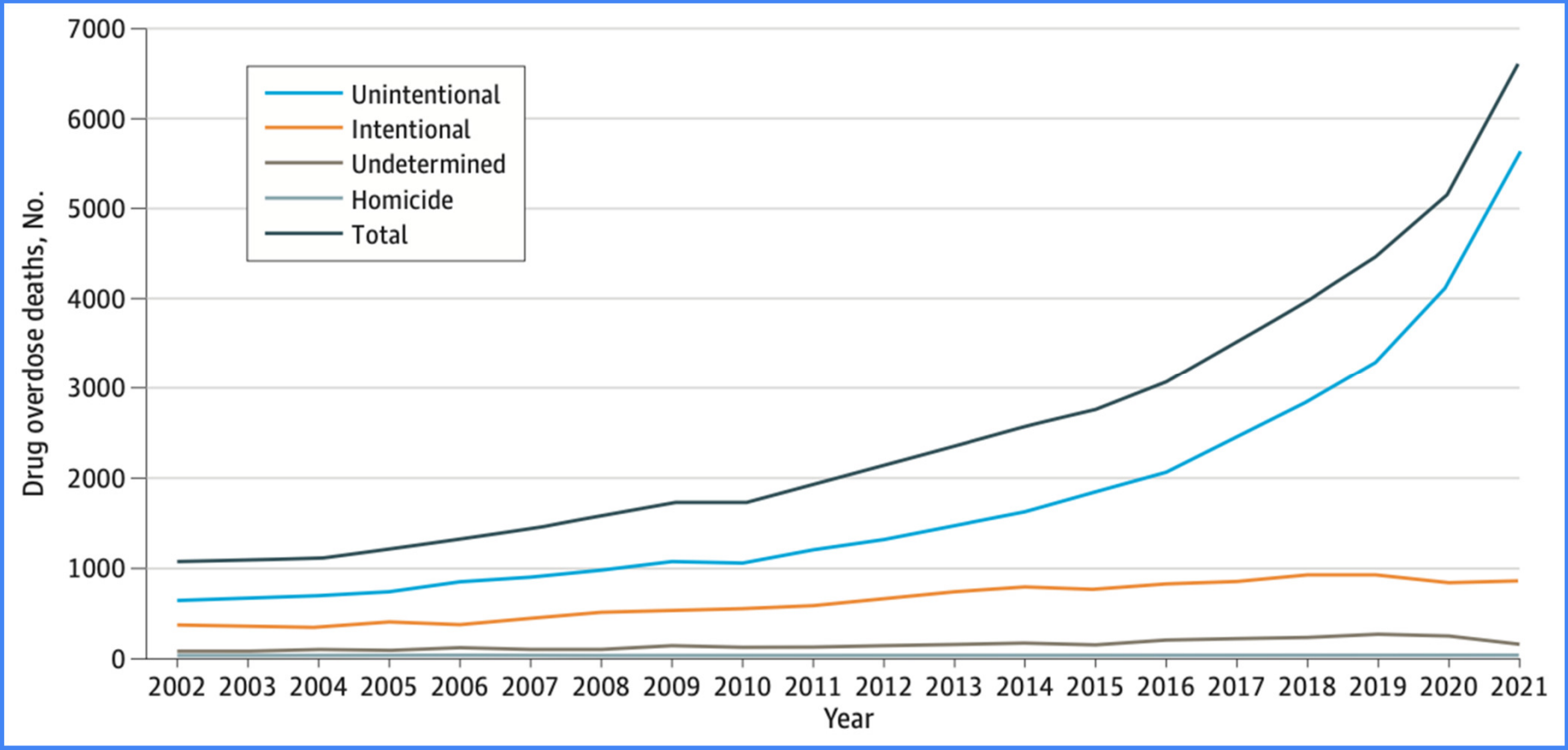


Death rate **more than doubled** for older Canadians in the past 20 years



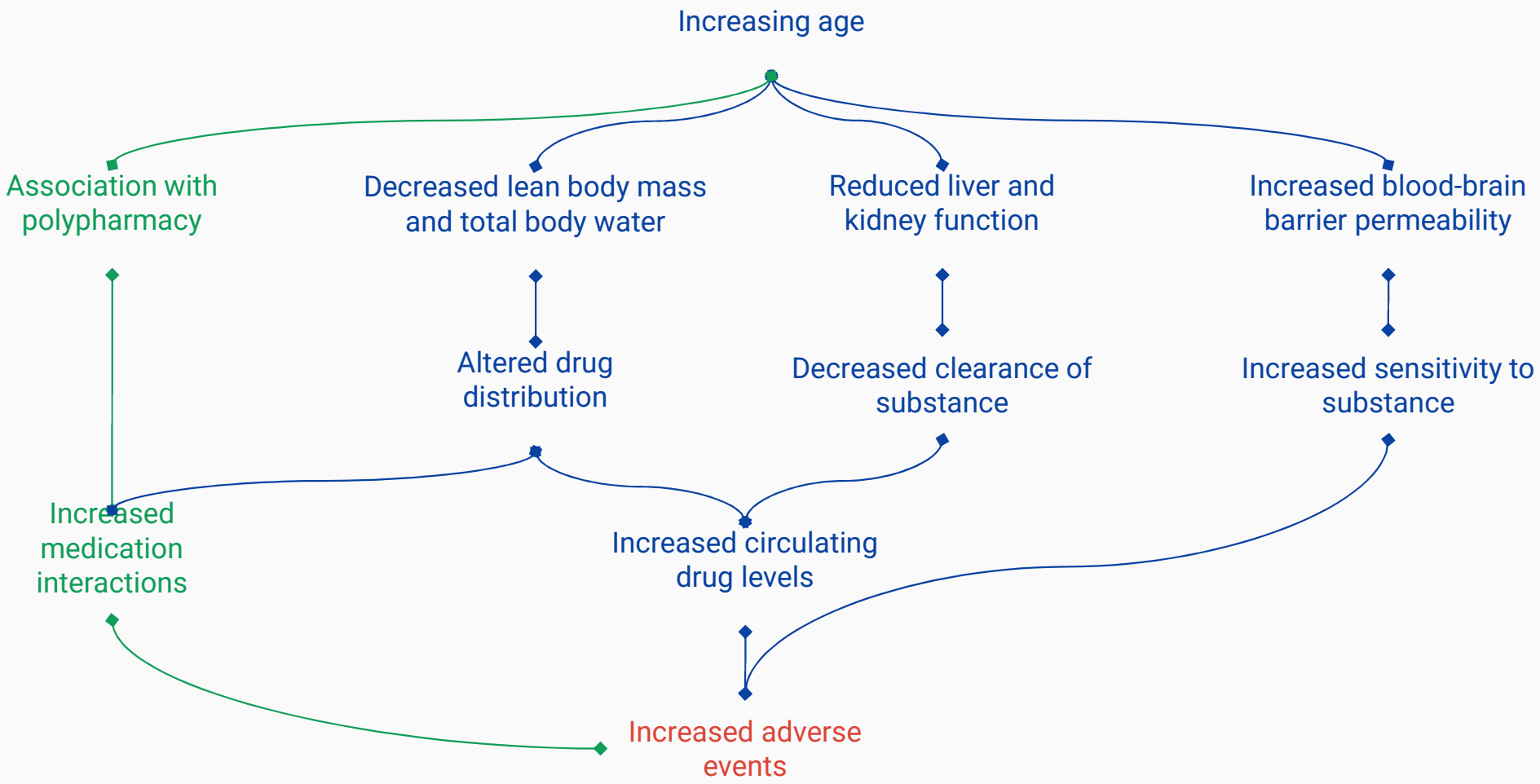
Imtiaz S, Ali F, Kaminski N, Russell C, Rehm J. Trends in drug overdose deaths among adults 65 years of age and older in Canada (2000–2022). Drug Alcohol Depend Rep. 2024 Jul 2;12:100254.

And a look at our neighbours…



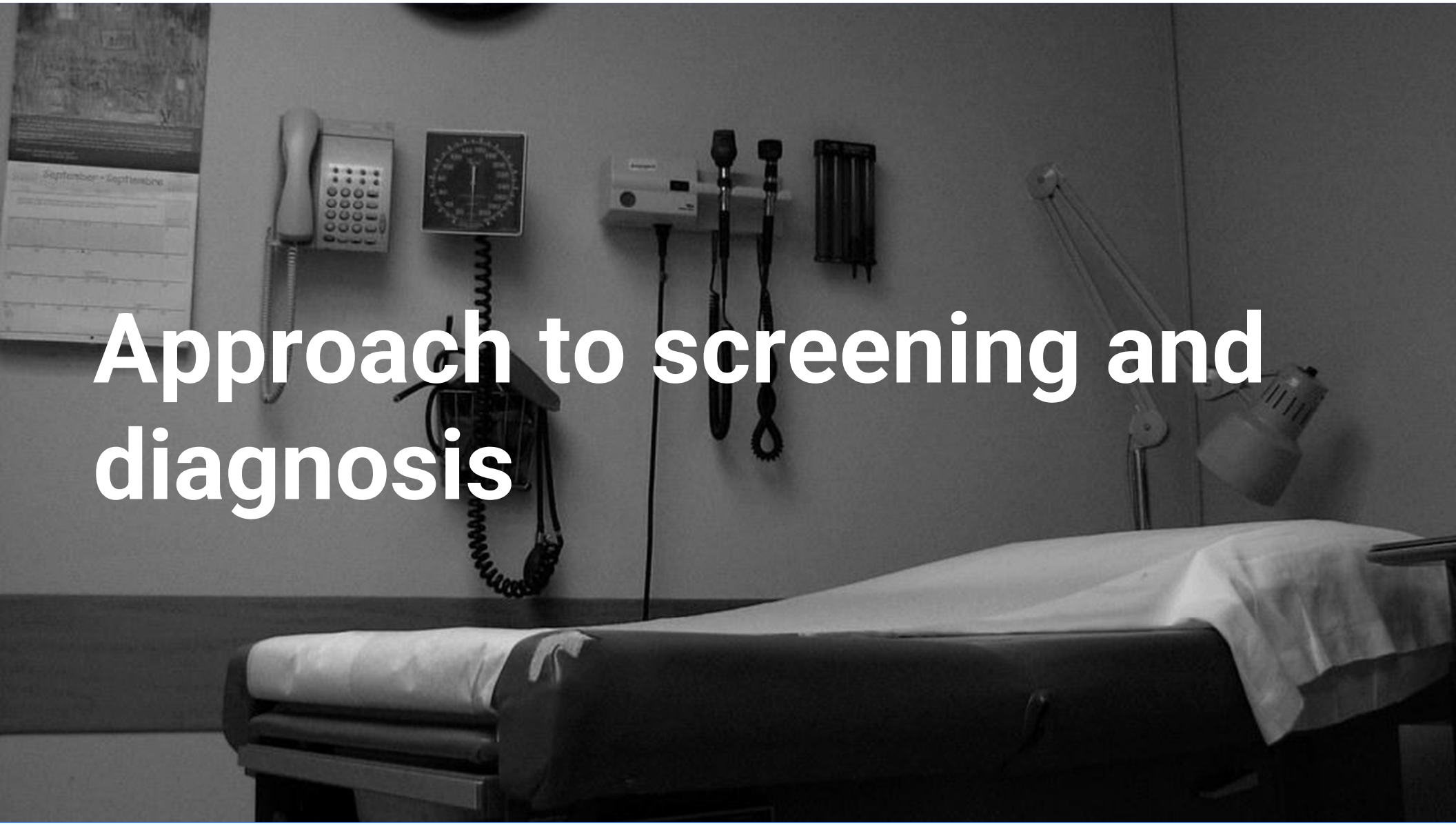
Humphreys K, Shover CL. Twenty-Year Trends in Drug Overdose Fatalities Among Older Adults in the US. **JAMA Psychiatry.** 2023 May 1;80(5):518-520.

Physiology of aging and substance use



Associated “badness”

- ED visits and hospitalizations, discharge to LTC
- Falls, fractures
- Cognitive impairment (acute delirium and chronic dementia)
- Exacerbations of medical and psychiatric comorbidities (A fib, heart failure, liver disease, CVD, depression, anxiety, etc)
- Metabolic derrangements (electrolyte disturbances, kidney injury, liver injury etc)
- Malnutrition, weight loss
- Constipation, urinary retention
- Immunocompromise
- Increasing frailty



Approach to screening and diagnosis

Table 1. Use of DSM-5 Criteria for the Diagnosis of Substance-Use Disorder in Older Adults.*

DSM-5 Criterion	Application of Criterion for Older Adult
Substance taken in greater amount than intended	Older adult may be impaired using the same amount taken when younger
There is persistent desire or unsuccessful effort to cut down or control use	Older adult may not realize use is problematic, especially with long-term use
There is excessive time spent to obtain, use, or recover from the substance	Same
There is craving for the substance	Same
Repeated use leads to inability to perform role in the workplace or at school or home	Role impairment is less pertinent; older adult may be retired and may be living alone
Use continues despite negative consequences in social and interpersonal situations	Same
Valued social or work-related roles are stopped because of use	Effect of substance use on social roles is less obvious if older adult is no longer working
Repeated substance use occurs in potentially dangerous situations	Same; older adult may be at increased risk for impaired driving
Substance use not deterred by medical or psychiatric complication	Same; medical consequences can be serious, including confusion, falls with injury, and psychiatric symptoms
Tolerance develops: increasing amount is needed to obtain effects	Symptomatic impairment may occur without an obvious need for increasing the amount
Withdrawal syndrome occurs or patient takes substance to prevent withdrawal	Withdrawal syndrome can occur with more subtle symptoms such as confusion

* DSM-5 denotes *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition.

TABLE 1

SUBSTANCE USE SCREENING TOOLS USED WITH OLDER ADULTS

Substance	Tool
Alcohol	Cut down, Annoyed, Guilty, Eye-opener (CAGE; 4 items, *yes/no*)
	Alcohol Use Disorders Identification Test (AUDIT; 10 items)
	AUDIT-Consumption (AUDIT-C; first three AUDIT items)
	Michigan Alcoholism Screening Test (MAST; 25 items), shorter version (SMAST), and geriatric version (GMAST; 13 items)
	Senior Alcohol Misuse Indicator (SAMI)
Cannabis	Cannabis Use Disorder Identification Test-Revised (CUDIT-R)
Various substances	Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST; 8 items)
	National Institute on Drug Abuse-adapted version (NIDA) Drug Use Screening Tool
	Drug Abuse Screening Test (DAST; 10, 20, 28 items)
Co-occurring conditions	Comorbidity Alcohol Evaluation Tool (CARET)
Brief assessments	Questions assessing severity of use, frequency, presence of physical and/or psychological factors

GMAST

- Sensitivity 93%, Specificity 65%
- 24 questions, score of “yes” to $\geqslant$ 5 questions is a positive screen
- Highlights impacts of alcohol, particularly in retirees

eASSIST-Lite

- Sensitivity 95%, Specificity 79-93%
- Developed by WHO. Adapted to an online rapid version (3-5 mins).
- Once online screen is complete, links for resources are provided.
- Focus on smoking, alcohol, cannabis, stimulants, sedatives/sleep aids and opiates.

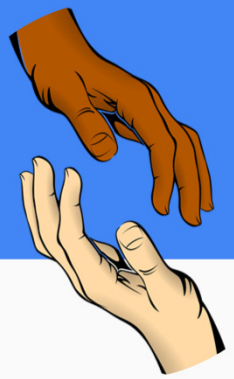
Real life treatment tips

SBIRT Approach

Florida Brief Intervention and Treatment for ELDERS (BRITE) Project

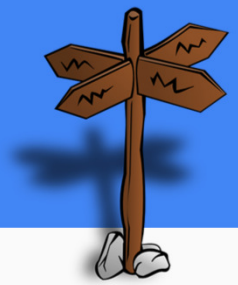
Screening

Questions re: alcohol use, prescription meds, OTC meds, illicit drugs, depression and suicide. Specific tools included GMAST and GDS.



Brief Intervention

Education re: high-risk situations, medical implications of substance use. Motivational interviewing re: substance use reduction strategies.



Referral to Treatment

Referral to provider or program for pharm and non-pharm management of specific flagged substance.

30 day follow-up:

GMAST positive screens: **80%** ↓

Prescription med misuse chart flags: **30%** ↓

Utilization of SUD treatment programs: **3x** ↑

Pharmacotherapy for Alcohol use disorder

Naltrexone

- Caution with chronic liver disease, but weight risk-benefit ratio
- Avoid with opioids
- CYP3A4 interactions! (check your antibiotics, antifungals, antiepileptics, etc)

Don’t forget to refer for psychosocial supports!

Acamprosate

- Caution with CKD
- Pill burden – TID dosing, larger pill size, can’t be crushed
- Remember sick-day counselling to avoid compilation of AKI risk-factors

Disulfiram

- Avoid – risk of severe volume depletion and electrolyte disturbances

Pharmacotherapy for Opiate use disorder

Suboxone

- Must be SL (watch out for following instructions… can't swallow)
- Risk of tooth decay
- Watch hepatic function
- Think about sublocade!

Don't forget!

1. Naloxone kit at discharge (patient, family, caregiver, etc)
2. Psychosocial support referral
3. ***Rapid*** tolerance decline following withdrawal. Patients NEED to understand!

Methadone

- Watch QTc. Lots of med interactions (CYPs)!!
- Avoid in liver disease
- Lipophilic (longer half-life in older adults)
- Dose reduction schedule (2-4 days missed = ½ dose, 5 days = restart)

Kadian

- Avoid in CKD
- Harsh dose reduction schedule (2 missed days = 40% reduction, 3 = 60%, 4 = 80%, 5 = restart)

Rapid Access Addiction Clinic

1081 Burrard Street Vancouver, BC, V6Z 1Y6

Phone: 604-806-8867 | Fax: 604-297-9678

About Us

The Rapid Access Addiction Clinic (RAAC) is an outpatient stabilization clinic supporting patients seeking treatment for substance use disorders. The RAAC offers short-term support for stabilization before transferring patients to community care providers for ongoing monitoring, support, and rehabilitation.

We provide a safe space where you can get help from a physician, nurse or social worker for your substance use and/or addiction.

Our team can help provide you with the tools to support your goals.

All Services are free.

No ID or CareCard? No problem! Let us know and we can help.

What We Offer

Specialized addiction medicine support including:

- Assessment.
- Withdrawal management.
- Opiate agonist therapy including Suboxone, Methadone and Kadian.
- Alcohol relapse prevention.

Nursing care:

- Physical and mental health assessment.
- Monitoring treatment progress.
- Help to manage withdrawal symptoms.
- Treatment option education.
- Harm reduction education and supplies.

Peer support:

Peers provide empathetic, knowledgeable and understanding shoulders to lean on.

Social work support with:

- Applications for treatment programs and financial aid.
- Bridging to other community services, primary care physician.
- Support in accessing housing/shelters.
- Crisis intervention and referral to drug or alcohol counseling.

How To Access Us

RAAC accepts referrals from community providers, doctors, nurses, social workers as well as self-referrals.

A Care Card is not required.

Patients seeking treatment for the following substance use disorders can be referred:

- Opioid Use Disorder.
- Alcohol Use Disorder/Alcoholism.
- Benzodiazepine (benzo) reliance.
- Nicotine addiction/reliance.
- Stimulant addiction/reliance.

Additional resources and links

Vancouver Community Older Adult Mental Health and Substance use program

- Criteria: 65+, requiring specialized care for “Recently developed mood-related symptoms, anxiety, psychosis and/or problematic substance use… and the coexistence of impairments in multiple domains related to the aging process: physical, cognitive, social and functional, which complicate their psychiatric care and are complicated by poor primary treatment response, risk of relapse, or poor treatment adherence.”
- Referral required. **Not for patients with cognitive impairment.**

Local community health units

Online resources:

- Canadian Coalition for Seniors’ Mental Health (CCSMH)
  - https://ccsmh.ca
- Canadian Centre on Substance Use and Addiction (CCSA)
  - https://www.ccsa.ca/en
- Centre for Addiction and Mental Health (CAMH)
  - https://www.camh.ca/

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Thank you!

Questions?
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G-MAST Screening

After drinking, have you ever noticed an increase in your heart rare or beating in your chest?

When talking with others, do you ever underestimate how much you actually drink?

Does alcohol make you sleepy so that you often fall asleep in your chair?

After a few drinks, have you sometimes not eaten or been able to skip a meal?

Does having a few drinks help decrease your shakiness or Tremors?

Does alcohol sometimes make it hard for you to remember parts of the day or night?

Do you have rules for yourself that you won't drink before a certain time of the day?

Have you lost interest in hobbies or activities you used to enjoy?

When you wake up in the morning, do you have trouble remembering the night before?

Does having a drink, help you sleep?

Do you hide your alcohol bottles from Family members?

After a social gathering, have you ever felt embarrassed because you drank too much?

Have you ever been concerned that drinking might be harmful to your health?

Do you like to end an evening with. a nightcap?

Did you find your drinking increased after someone dose to you died?

In general, would you prefer to have a few drinks at home rather than go out to social events?

Are you drinking more now than in the past?

Do you usually take a drink to relax or calm your nerves?

Do you drink to take your mind off your problems?

Have you ever increased your drinking after experiencing a loss in your life?

Do you sometimes drive when you have had too much to drink?

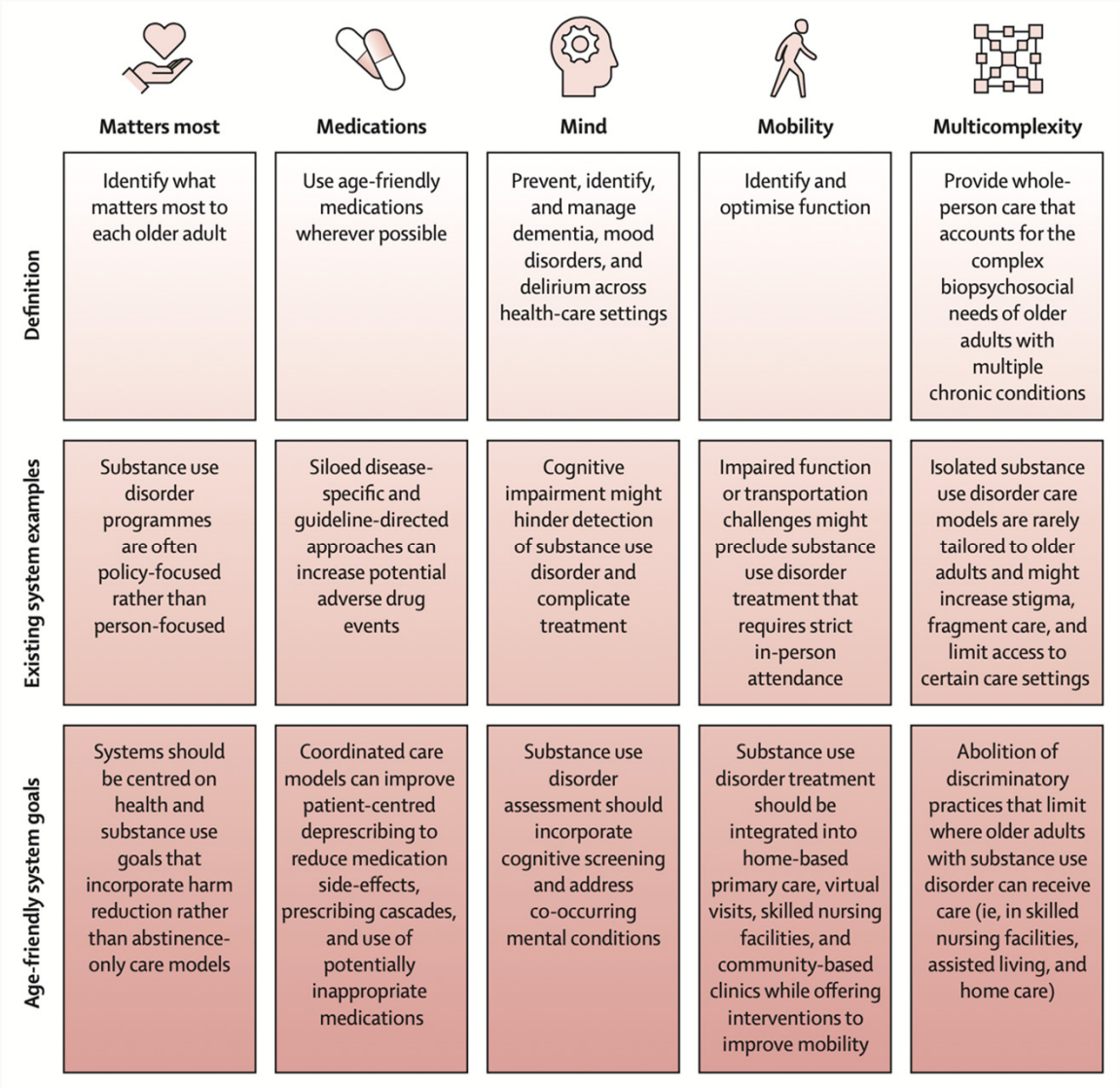
Has a doctor or nurse ever said they were worried or concerned about your drinking?

Have you ever made rules to manage your drinking?

When you feel lonely does having a drink help?

ASSIST-Lite Screening

In the past 3 months	Yes	No
1. Did you smoke a cigarette containing tobacco? 1a. Did you usually smoke more than 10 cigarettes each day? 1b. Did you usually smoke within 30 minutes after waking? Score for tobacco (count "yes" answers) 0 Risk category: 0 = Low, 1-2 = Moderate, 3 = High	☐ ☐ ☐	☐ ☐ ☐
2. Did you have a drink containing alcohol? 2a. On any occasion, did you drink more than 4 standard drinks of alcohol? 2b. Have you tried and failed to control, cut down or stop drinking? 2c. Has anyone expressed concern about your drinking? Score for alcohol (count "yes" answers) 0 Risk category: 0-1 = Low, 2 = Moderate, 3-4 = High	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
3. Did you use cannabis? 3a. Have you had a strong desire or urge to use cannabis at least once a week or more often? 3b. Has anyone expressed concern about your use of cannabis? Score for cannabis (count "yes" answers) 0 Risk category: 0 = Low, 1-2 = Moderate, 3 = High	☐ ☐ ☐	☐ ☐ ☐
4. Did you use an amphetamine-type stimulant, or cocaine, or a stimulant medication not as prescribed? 4a. Did you use a stimulant at least once each week or more often? 4b. Has anyone expressed concern about your use of a stimulant? Score for stimulants (count "yes" answers) 0 Risk category: 0 = Low, 1-2 = Moderate, 3 = High	☐ ☐ ☐	☐ ☐ ☐
5. Did you use a sedative or sleeping medication not as prescribed? 5a. Have you had a strong desire or urge to use a sedative or sleeping medication at least once a week or more? 5b. Has anyone expressed concern about your use of a sedative or sleeping medication? Score for sedatives (count "yes" answers) 0 Risk category: 0 = Low, 1-2 = Moderate, 3 = High	☐ ☐ ☐	☐ ☐ ☐
6. Did you use a street opioid (e.g. heroin) or an opioid-containing medication not as prescribed? 6a. Have you tried and failed to control, cut down or stop using an opioid? 6b. Has anyone expressed concern about your use of an opioid? Score for opioids (count "yes" answers) 0 Risk category: 0 = Low, 1-2 = Moderate, 3 = High	☐ ☐ ☐	☐ ☐ ☐
7. Did you use any other psychoactive substances? If yes, what did you take? *(Not scored, but prompts further assessment)*	☐	☐


Matters most
Medications
Mind
Mobility
Multicomplexity
Definition
Identify what matters most to each older adult
Use age-friendly medications wherever possible
Prevent, identify, and manage dementia, mood disorders, and delirium across health-care settings
Identify and optimise function
Provide whole-person care that accounts for the complex biopsychosocial needs of older adults with multiple chronic conditions
Existing system examples
Substance use disorder programmes are often policy-focused rather than person-focused
Siloed disease-specific and guideline-directed approaches can increase potential adverse drug events
Cognitive impairment might hinder detection of substance use disorder and complicate treatment
Impaired function or transportation challenges might preclude substance use disorder treatment that requires strict in-person attendance
Isolated substance use disorder care models are rarely tailored to older adults and might increase stigma, fragment care, and limit access to certain care settings
Age-friendly system goals
Systems should be centred on health and substance use goals that incorporate harm reduction rather than abstinence-only care models
Coordinated care models can improve patient-centred deprescribing to reduce medication side-effects, prescribing cascades, and use of potentially inappropriate medications
Substance use disorder assessment should incorporate cognitive screening and address co-occurring mental conditions
Substance use disorder treatment should be integrated into home-based primary care, virtual visits, skilled nursing facilities, and community-based clinics while offering interventions to improve mobility
Abolition of discriminatory practices that limit where older adults with substance use disorder can receive care (ie, in skilled nursing facilities, assisted living, and home care)