OLDER ADULTS & DEPRESCRIBING: CONTEMPLATION, ASSESSMENT & TREATMENT

Jonathan Bertram

Faculty/Presenter Disclosure

- **Faculty:** Jonathan Bertram

- **Relationships with commercial interests:**
  - **Grants/Research Support:** NONE
  - **Speakers Bureau/Honoraria:** NONE
  - **Consulting Fees:** NONE
  - **Other:** NONE

Disclosure of Commercial Support

- **<u>Potential for conflict(s) of interest</u>: NONE**

Mitigating Potential Bias

- N/A

Objectives

- • To confront complications of de-prescribing in older adults
- • To consider approaches to related difficult conversations
- • To discuss screening tools for controlled substance use in Older Adults
- • To address pharmacotherapeutic and non-pharm strategies

CMAJ Guidelines 2017

- Always prescribe the lowest effective dosage of opioid medication. Doses >50 morphine milligram equivalents (MME) per day warrant careful reassessment and documentation.
- Doses >90 MME per day warrant substantive evidence of exceptional need and benefit.
- Order at least annual random urine drug testing (rUDT) and/or random pill counts for all adult patients on long-term opioids, sedatives or stimulants.

HOSPITALIZATION AND DEATH

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

- **In Canada adults 65 and older had the highest opioid-related hospitalization rates in 2014–2015 (CIHI 2016).**
  - Accidental poisonings, especially during therapeutic use, accounted for the highest proportion of hospitalizations (55%) in this population.

- **142% increase in days spent in the hospital due to opioid use disorders among older adults, between 2006 to 2011 (Young & Jesseman, 2014).**

Case: Arthur (67)– part-time bookkeeper

- Arthur lives alone in a 3rd floor apartment near Eglinton & Don Mills
- His use of prescription opiates first started after experiencing pain secondary to gallstones 10 years ago. A cholecystectomy was recommended but Arthur feared taking time off work without pay.
- The intermittent episodes led to the use of hydromorphone as prescribed by his gastroenterologist at the outset and continued by his FMD
- His family MD retired a few years ago and he sees different walk-in doctors.

Case: Arthur (cont'd)

- He describes breakthrough pain that presents up to five times per day, he uses a 12 mg long acting hydromorphone tab in response and has been using regular hydromorphone for the last 5 years.
- He has used diazepam through walk-in MD's- a renewal of 60 tabs per month: 3 tabs per day (10 mg diazepam) most days per week first started by a psychiatrist 20 years ago.
- While he has no identified mobility issues he admits that getting up to his apartment and getting around town is challenging

CASE:

- Would you endorse continuing benzodiazepines in the previous case?
- If so how might you mitigate the risk?
- If not what risks are you anticipating?

WHAT ELSE ISN'T ARTHUR TELLING YOU

Screening Older Adults

- Older adults are less likely to be screened for substance use (Duru, 2010)

- Common perception among older adults that symptoms experienced by the use of alcohol or drugs are seen as a part of normal aging

Approaches (Duru)

- *Supportive, non-confrontational* Older adults are known to respond more to a supportive, non-confrontational approach than more assertive styles of assessment and intervention.

- *Focus on facts* The focus should be on the facts of substance use rather than questioning the person's judgment (eg, do you have a drinking or drug use problem?).
  - **Arthur first started using HM in response to stressors in his life (because Diazepam wasn't something he used in the morning) but now uses regularly in the morning before going to work to prevent withdrawal.**

- *Which symptoms are the indication* Nonjudgmental: asking a patient whether they sometimes take an extra pill to fall asleep or to cope with pain before asking about running out of medication early, or borrowing medications from others

Opioid Use Disorder Screening

- Screening tools exist - Validated in OAs
  - P(atient)D(rug)U(se)Q(uestionnaire)
    - validated in practitioner interview

  - Questionably validated in self-report

Alcohol Screening and Assessment tools

- SAMI Senior Alcohol Misuse Indicator
- GMAST Geriatric Michigan Alcohol Screening Tool

https://www.porticonetwork.ca/documents/21686/0/SAMI+fillable/f6668443-559f-4ad8-9e5f-6de47a38e70a

Examples of language from Senior Alcohol Misuse Indicator (SAMI)

- Have you recently (in the last few months) experienced problems with any of the following:
- Appetite or weight…Sleep…Difficulties with memory?
- Do you enjoy wine/beer/spirits? Which do you prefer?
- As your life has changed, how has your use of wine/beer/spirits changed?
- You mentioned that you have difficulties with… [from answers to questions 1 a) and b)]. I am wondering if you think that wine/beer/spirits might be connected?

Cannabis Screening

- CUDIT= not yet validated in older adults
- Cannabis Use Disorder Identification Test

Increasing Cannabis use

- 2006/07 to 2012/13 (USA)
- 57.8% relative increase for adults aged 50-64
- 250% relative increase for those aged ≥ 65

- *6.9% of older cannabis users met criteria for cannabis abuse or dependence, and the majority of the sample reported perceiving no risk or slight risk associated with monthly cannabis use (85.3%) or weekly use (79%).
    - (Kaskie et al, 2017)

CHOI ET AL, 2016

- Of a 50+ age group, 3.89% were past-year marijuana users and 0.68% had marijuana use disorder.
- Marijuana users, especially those with marijuana use disorder (17.54% of past-year users), had high rates of mental and other substance use disorders.
- Controlling for other potential risk factors for stress, including health status and mental and other substance use disorders, marijuana use and use disorder were still significantly associated with more life stressors and lower perceived social support, possibly from low levels of social integration
- *** 28% of Canadians reported having used cannabis regularly in the past 3 months (Health Canada, 2013)**

WHAT ABOUT HIS OPIOIDS?

Difficult conversations

- When they don't admit to /or don't have **that** problem…

- Discussing in context of the help they are seeking- Arthur probably can identify **pain** and **withdrawal**
- Informing the individual of the objective consequences of use regardless of nature of use

Opioid withdrawal in Older Adults

- Outpatient management may not be appropriate for older individuals who are frail, live alone with limited family support or who have multiple medical problems and prescribed medications (Liskow et al, 1989).

- Withdrawal management in an outpatient setting from any addictive substance could pose significant risks for older adults, such that withdrawal management should be carefully supervised, ideally in hospital (Conn & Bertram, 2018) or an adequately supervised setting

DISCONTINUATION

- Opioid Discontinuation Programs (Frank, 2017) Pain > 3 months
- Interdisciplinary programs- 11 fair quality… 20 poor
- Behavioural interventions- 3 good quality… 3 poor
- All other interventions (including Bup-assisted and Detox programs) … 18 poor

Table 1. Effectiveness of Strategies to Reduce or Discontinue LTOT (*n* = 67 studies)

Studies, *n*	Participants, *n*	Description	Results*	Quality Ratings
Interdisciplinary pain programs (28, 30, 32, 33, 36, 37, 42, 44-50, 52, 54, 55, 58, 63, 64, 67, 69, 70, 74, 77-81, 86, 88)				
31	9915	Programs delivered interdisciplinary pain care with heterogeneity of program components, personnel, and duration (range, 1–8 wk) 21 outpatient studies, 8 inpatient studies, and 2 studies in both settings Opioid discontinuation mandatory in 22 studies; goal of dose reduction in 5 studies Mean program completion rate, 85% (range, 76%–100%)†; 25 studies	Mean opioid discontinuation rate, 87% (range, 29%–100%); 20 studies	Fair: 11 studies Poor: 20 studies
Buprenorphine-assisted dose reduction (25-27, 34, 35, 59, 71, 72, 75, 83)				
10	470	Studies transitioned patients from LTOT to buprenorphine with heterogeneity of induction protocol, dose, and duration of therapy 5 outpatient studies, 2 inpatient studies, and 3 studies in both settings 4 studies included only patients who had successfully transitioned to buprenorphine	Mean opioid discontinuation rate, 91% (range, 33%–100%); 6 studies	Poor: 10 studies
Behavioral interventions (61, 65, 66, 76, 85, 90, 91)				
6	238	Studies tested heterogeneous behavior-based and cognitive behavior-based therapies, including CBT, meditation, and other CIH methods All studies in outpatient settings; 3 of 6 in primary care settings Goal of opioid discontinuation in 1 study; goal of dose reduction in 1 study	Mean opioid discontinuation rate, 21% (range, 6%–55%); 5 studies	Good: 3 studies Poor: 3 studies
Other outpatient programs (39-41, 73, 84)				
5	1169	2 studies of systemwide interventions in primary care, 2 studies of outpatient specialty care, and 1 study of outpatient medical marijuana treatment Goal of dose reduction in 3 studies	Mean opioid discontinuation rate, 20% (range, 12%–44%); 3 studies	Poor: 5 studies
Other interventional programs (29, 56, 57, 87)				
4	308	2 studies of an implantable device, 1 study of detoxification under anesthesia, and 1 study of lidocaine infusion Goal of opioid discontinuation in 3 studies	Mean opioid discontinuation rate, 70% (range, 33%–79%); 3 studies	Poor: 4 studies
Detoxification (31, 38, 62, 82)				
4	200	Interventions supported opioid dose reduction with symptomatic medications (e.g., clonidine and benzodiazepines) 2 outpatient studies, 1 inpatient study, and 1 study in both settings	Mean opioid discontinuation rate, 91% (range, 91%–100%); 3 studies	Poor: 4 studies
Ketamine-assisted dose reduction (51, 60, 68, 89)				
4	168	Studies examined oral, intravenous, and subcutaneous administration of ketamine 1 outpatient study, 1 inpatient study, and 2 studies in both settings Goal of opioid discontinuation in 1 study; goal of dose reduction in 3 studies	Opioid discontinuation rates of 18% and 27% in 2 studies	Poor: 4 studies
Acupuncture (43, 53, 92)				
3	78	2 studies of electroacupuncture; 1 study of auricular acupuncture 1 outpatient study, 1 inpatient study, and 1 study in both settings Goal of opioid discontinuation in 2 studies	Opioid discontinuation rates of 66% and 86% in 2 studies	Fair: 2 studies Poor: 1 study

CBT = cognitive behavioral therapy; CIH = complementary and integrative health; LTOT = long-term opioid therapy.
* Among studies reporting opioid discontinuation rates.
† Among studies reporting program completion.

Abstinence

- Taper opioids with sufficient support and pain management alternatives
- … Often resource dependent: physiotherapy, psychotherapy, w/d considerations
- Risk of Relapse significantly higher without sustainable treatment
- Older Adult patients can experience prolonged subacute withdrawal symptoms and de-stabilization of medical comorbidities
  - Anxiety, depression, fatigue, insomnia
  - Cravings

Bzd management in comorbid opioid use & use disorder

OPIOIDS

- Indications in setting of high dose opioid use (CMAJ 2017)
- Indications in MMT (Methadone) initiation (CPSO 2011)
- Consideration in BMT (Buprenorphine) initiation (CAMH 2011)

- DO NOT TAPER BZD AND OPIOIDS CONCURRENTLY
- Taper BZD before MMT initiation (CPSO 2011)
- If not acutely unstable, consider BZD taper after Opioid Agonist Treatment (OAT) stablization
  - BMT PREFERRED

SO WHAT DO WE DO ABOUT ARTHUR'S BENZOS?

Opioid-BZD (Benzodiazepine) interactions

- CIHI, 2013 study: For older adults identified as having an adverse drug-related hospitalization, the third most common drug class was opioids.

- The most common co-occurring toxicity was with BZDs (19%) and the second most common was acetaminophen, including both combination products and acetaminophen alone (14 %).

- The combination of opioids and BZDs significantly increases the risks of harms such as overdose, respiratory depression and death (Karaca-Mandic et al., 2017).

BZD USE DISORDER IN PRACTICE Soyka 2015, ashton 2002

- They may have anxiety symptoms, panic attacks, agoraphobia, insomnia, depression, or increasing physical symptoms, despite continuing to take benzodiazepines.
- They take hypnotic agents during the day
- They become anxious in between doses (even of short acting BZDs) they may carry their tablets around with them and may take an extra dose before an event that is anticipated to be stressful

TREATMENT:

BENZODIAZEPINE USE DISORDER
BENZODIAZEPINES CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE

Table 5. Management of Benzodiazepine (BZD) Withdrawal.

Situation	Treatment Approach	Level of Evidence
Approach to BZD dependence in general	Gradual withdrawal over a period of several weeks or months	High
Use of several BZDs or sedatives	Switch to use of only one BZD for detoxification (diazepam)	Good
Choice of BZD for detoxification	Switch to a long-acting BZD (diazepam)	Low
BZD withdrawal in a patient receiving opioid maintenance therapy	Adjustment of opioid dose to prevent opioid withdrawal; switch to a partial agonist (buprenorphine)	Good for adjustment of opioid dose; moderate for switch to partial agonist
Concomitant pharmacotherapy for BZD withdrawal	Carbamazepine, 200 mg twice a day	Moderate
Sleep disorders	Antidepressants, antihistaminergic drugs, melatonin; improved sleep hygiene, sleep restriction, relaxation techniques	Moderate
Other drugs for treatment of withdrawal symptoms	Pregabalin, gabapentin, beta-blockers; flumazenil	Low for pregabalin, gabapentin, and beta-blockers; experimental for flumazenil
Psychotherapy	Cognitive behavioral therapy and other approaches	Good

INPATIENT

- Consider in clients who are more complex, need more intensive support, increased seizure risk
- Older Adults should, where available, be considered for inpatient withdrawal management (Conn & Bertram SUIC 2018)
- Diazepam vs Carbamazepine (CAMH withdrawal treatment protocol 2017)

OUTPATIENT TAPER

- Rotate to long acting benzodiazepine such as Diazepam (Ashton 2005)… UNCLEAR
- Slow taper as effective in elderly as in youth (Schweizer, 1989)
- ?Long-term low dose benzodiazepine maintenance (Sabioni et al 2015)

Tannenbaum 2014

WEEKS	TAPERING SCHEDULE							
	MO	TU	WE	TH	FR	SA	SU	
1 and 2								
3 and 4								
5 and 6								
7 and 8								
9 and 10								
11 and 12								
13 and 14								
15 and 16								
17 and 18								

TAPER principles (Soyka 2017, NEJM)

- Often determined by a person's capacity to tolerate symptoms
- Recommendations range from reducing the initial benzodiazepine dose by 50% every week to reducing the daily dose by between 10% and 25% every 2 weeks
  - CONSIDER LONGER
- If possible, tapering as the focus of the appointment should be avoided in order to prevent the withdrawal treatment from becoming the patient's "morbid focus"

Tapering in practice

- Explain to patient and family that tapering usually results in improved **energy, cognition and mood**
- See patient regularly
- At each office visit, discuss functional outcomes
- Improvement in these areas is a platform for reduction

Supporting Arthur's Taper

- Tapering Dosette
- Pharmacy- Home Delivery system

- CCAC nurse/PSW reconciling dosette pills randomly
- Possible observed "home" doses

- See patient weekly- monthly and fax in care directive and prescription to pharmacy and CCAC

OUTPATIENT Rx

(Sabioni, Bertram, Le Foll- Current Pharmaceutical Design June 2015)

- Evidence for off label use of Pregabalin (adjuvant to manage withdrawal)
- Trials that endorse the use of gabapentin and carbamazepine
- Isolated evidence for the use of Flumazenil [with clonazepam conversion x 12 weeks] (blocking therapy] (1 study)

Psychotherapy (STRUCTURED CBT-ONTARIO)

Safer Alternatives

- Silos of policy aren't helping, alternatives need to be funded
- Sedative-hypnotics
  - $32,452 USD
- Cognitive Behavioural Therapy for Insomnia
  - $19,442 USD

- **Policy changes need to fund alternatives**

CaDeN Canadian Deprescribing Network

ReCaD Réseau canadien pour la déprescription

Tannenbaum C, et al. *Drugs Aging* 2015;34:305-14.

UNIVERSAL PRINCIPLES

- Client centred approach
- Primarily ddress related problems like anxiety or insomnia eg Melatonin, Trazodone, SSRI , PSYCHOTHERAPY
- Consider inpatient/supervised tx if dangerous w/d
- Stick to one BZD during taper
- Consider adjuvant therapy if difficult w/d post detox or during taper
- Engagement with community supports such as Alcoholics Anonymous or SMART recovery
- Optimizing functional and clinical stability is the goal

Bzd management in comorbid substance use disorder

ALCOHOL

- DO NOT TAPER BZD AND ALCOHOL CONCURRENTLY
- Because of Seizure Risk, advisable to consider inpatient management
- First line Alcohol Anti Craving Medications are compatible with inpatient BZD detox or outpatient adjuvant management (CAMH PORTICO 2014)
- Gabapentin is an off label anti-craving medication

Changing Behaviour/Reducing Impact: Anti-Craving Medications

- Most effective medications in our clinic:
  - ***Naltrexone* 6$ per day BEST EVIDENCE 65 YRS + *CONTRAINDICATED in Opioid Users***
  - ***Acamprosate* 6 $ per day (FIRST LINE FOR ABSTINENCE, OFF LABEL FOR REDUCTION)**

- Moderately effective medications in our clinic
  - ***Gabapentin* affordable (SECOND LINE FOR ABSTINENCE & REDUCTION)** *off-label*

  - ***Topamax* affordable** *off label* **CONCERNING SIDE EFFECTS in ELDERLY**
  - ***Baclofen* affordable** *off label* **CONCERNING SIDE EFFECTS in ELDERLY**
  - *Antabuse* **NOT RECOMMENDED FOR ELDERLY**

DRAFT - Older Adult Guidelines KT PHASE JANUARY 2019- CCSMH website

- Women: no more than 1 drink on drinking days and no more than 5 drinks per week, with 2 non-drinking days per week.

- Men: no more than 1-2 drinks on drinking days and no more than 7 per week, with 1-2 non drinking days per week

Canadian Coalition for Seniors' Mental Health
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.

Bring solutions to light
Mettre en lumière les solutions

TAKE HOME MESSAGES:

- **(1) Benzodiazepines can be useful in the short term BUT long term use carries high risk of adverse effects including substance use disorder**
- **(2) Probe symptoms first, substance second**
- **(3) Address secondary problems like anxiety or insomnia**
- **(4) Outpatient taper or Inpatient detox and medicalized aftercare- preventing seizure risk**
- **(5) Consider Monitored tapering- dosettes, community health workers**
- **(6) Engage CBT/12 step/SMART recovery**
- **(7) Client centred care: main goal of treatment is to optimize clinical and functional stability**

CONCLUSION

- Safety of de-prescribing cannot be realized without supporting the threat related to removing opioids, bzd's, substances

- Improve how we select people … Improve how we support people

Thank You

- **jonathan.bertram@camh.ca**
- OTN assessments through CAMH Addiction Medicine Service & Bowmanville Clinic

- Bowmanville Pain/Addiction Assessment
  - 222 King St, Bowmanville Family Health Organization
  - **Physician or Self referral for Addictions only**
  - **Physician Referral for Pain AND Addictions**

- **Access CAMH contact** (416) 535-8501, press 2
- **Fax referrals to Access CAMH:** 416-979-6815. ATTN- Dr Bertram