New Cannabis Use Disorder Guidelines for Older Adults

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Working Group Members

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Learning Objectives

1. Describe issues and barriers unique to older adults with or at risk for cannabis use disorders.
2. Introduce the draft recommendations about prevention, screening, assessment and management of cannabis use disorders in older adults.
3. Elaborate on the relevance of the guidelines and the process of incorporating the voice of those with lived experience.
Project Overview

- Develop evidence-informed guidelines for the prevention, assessment and management of four substance use disorders (SUDs) in older adults:
  - cannabis, alcohol, benzodiazepine and opioids

- Project governance:
  - 10-member steering committee and four multidisciplinary working groups of 6–8 experts, including people with lived experience

- Guidelines aimed at healthcare professionals and other stakeholders across Canada

- Robust knowledge mobilization strategy
Many older adults struggle with substance use issues.

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
Treatment programs adapted for older adults have been associated with better outcomes than those aimed at all age groups

Need for better education of healthcare professionals

Stigma

Limited supports for caregivers and families

Limited research focussed on substance use and older adults
Cannabis Use and CUD Among Older Adults

- Older adults have a lower past-year prevalence of past-year cannabis use (2017 CTADS)
  - Overall population: 12.3%
  - Age 65+: 1.6%
- Older adults have a lower past-year prevalence of cannabis use disorder (2012 CCHS-MH)
  - Overall population: 6.8%
  - Age 55+: 2.6%
- 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)
Current Context

- Legalization of non-medical and medical cannabis use
- Medical use of opioids and benzodiazepines for pain or anxiety and its associated harms is a motivation for exploring medical use of cannabis
- Increasing messaging that cannabis is a product with no or minimal risks
- Limited research focussed on effects of cannabis (both medical and non-medical) on older adults
Method: Developing Recommendations

- 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 a sufficient quality to inform guideline development

- Recommendations confirmed by consensus (or 75%+ vote) – 2 votes

- Draft documents will be sent out to peer-reviewers for feedback
The following draft recommendations are based on review and grading of the literature, as well as clinical expertise (only highlights are presented).

These draft recommendations are not ready to use as practice guidelines.

The final guidelines for each of the SUDs will be released in 2019.
“Clinicians should be aware of the:

a) 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) common symptoms and signs associated with cannabis use, impairment, CUD, and common consequences of cannabis misuse;

c) common adverse effects of cannabis in older adults and counsel patients about these adverse effects, such as immobility, instability, falls, incontinence, and cognitive impairment; and the

d) common comorbid psychiatric conditions association with CUD and assess patients appropriately for these conditions
“Clinicians should advise patients that:

a) Depending on the mode of consumption and THC levels, cannabis may impair the ability to safely drive a motor vehicle for up to 24 hours;

b) the use of both cannabis and alcohol together results in increased impairment and driving should be avoided;

c) it is dangerous to ride as a passenger with a driver who has recently used cannabis.”
“All patients, regardless of age, should be screened for the:

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

b) frequency and amount of cannabis used. Older adults who acknowledge any recent use (any in the past month) should then go on to targeted screening using the CUDIT.”
Management

“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.”

“Screening, Brief Intervention and Referral to Treatment (SBIRT) should be adopted as a framework for approaching cannabis treatment in the setting of SUD intervention. The SBIRT approach should be considered for assessing and managing CUD similar to other SUDs.”
The Consumer Perspective

Rand Teed B.A., B.Ed., ICPS, CCAC
Former stoner
Currently in recovery for 46 years
Some Food for Thought...
Check Your Thinking

Is what you are thinking true?

Is it really true? (we lie to ourselves)

How are you feeling or acting because of how you are thinking?

How would you feel or act if you thought differently?
Cannabis is not a “Just”

Although many may think that it is “just marijuana”……

It has as much capacity to damage relationships as any other drug.

THC is an emotional anesthetic.
People’s perceptions about the drugs they use are often very coloured by what they like about the drug.
Interruption of Needs
They develop a strong emotional relationship with their drug and it takes strong information to change that thinking.
When we ask someone to give up their drug of choice we are asking them to give up the only thing they have that “works” for them.
Most people know that what they are doing is, at some level, hurting them; that is an intellectual process.

There is usually a much deeper hurt that is emotional and their drug is not making them feel better it is making them feel less.

If we are going to ask them to stop using their drug we have to offer something that is going to make them feel OK.
Thank You

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Save the Date!

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- Registration opens March 2019
- #CCSAConference