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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.

New Cannabis Use Disorder Guidelines for Older Adults

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Disclosure Statement

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FUNDING: FUNDING TO THE CANADIAN COALITION FOR SENIORS MENTAL HEALTH FROM HEALTH CANADA'S SUBSTANCE USE AND ADDICTIONS PROGRAM

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

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Learning Objectives

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

Introduce the draft recommendations about prevention, screening, assessment and management of cannabis use disorders in older adults.

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, clinician education, screening and treatment 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

Substance Use and Older Adults: Key Issues

- 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

Substance Use and Older Adults: Key Issues (cont'd)

- 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 cannabis use (2017 CTADS) than the overall population
  - Overall population: 12.3%
  - Age 65+: 1.6%
- Older adults have a lower past-year prevalence of cannabis use disorder (2012 CCHS-MH) than the overall population
  - 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)

Addiction – Cannabis Use – Stigma

- Don’t Panic Its Organic
- Just a plant
- Things have changed since Cheech and Chong
- Words and Language matter Addiction vs CUD
- Education is important

Check Your Thinking

Is what you are thinking true?

Is it really true? (we lie to ourselves)

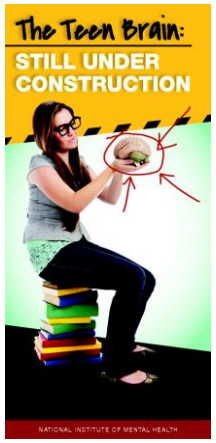
How are you feeling or acting because of how you are thinking?

How would you feel or act if you thought differently?

Brain Development

Prenatal

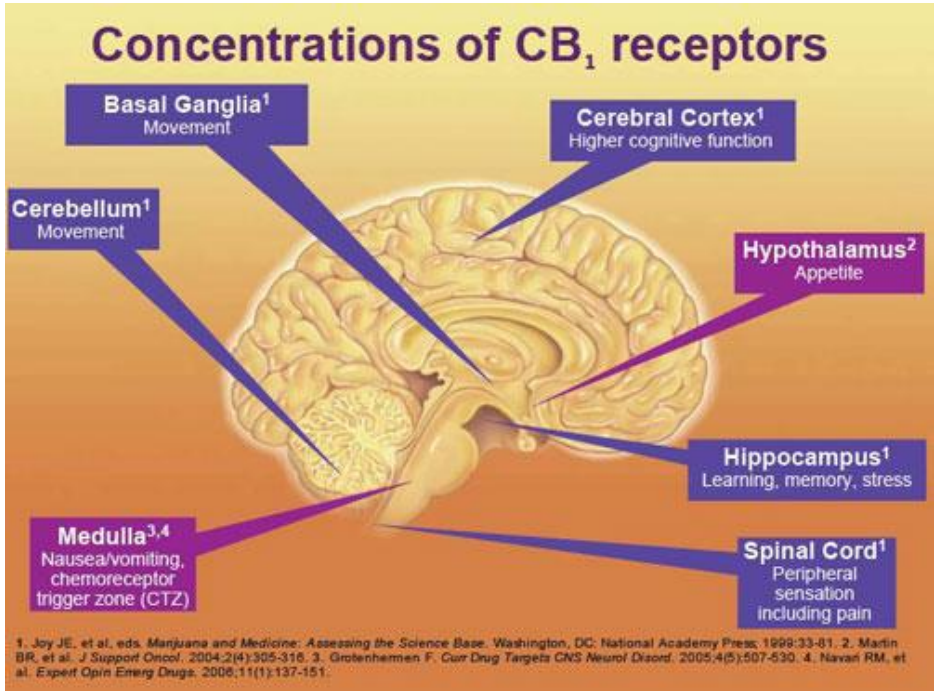
Teen



Adulthood

PFC ✓

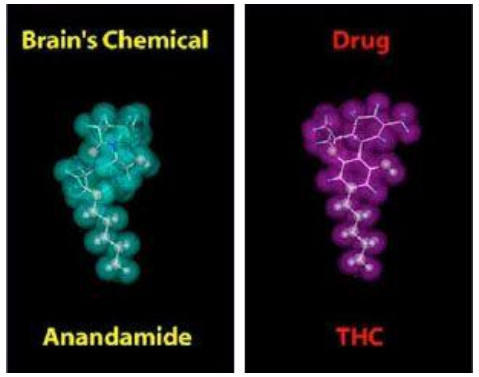
Endocannabinoid System



Helps to Regulate

- Sleep
- Appetite, digestion, hunger
- Mood
- Motor coordination
- Planning/ Starting a movement
- Immune Function
- Reproduction and fertility
- Pleasure and reward
- Pain
- Memory and Learning
- Emotion Regulation
- Temperature regulation

Balance



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Flood

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 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

Draft Recommendations

- The following draft recommendations are based on review and grading of the literature, as well as clinical expertise
- These draft recommendations are not ready to use as practice guidelines
- The final guidelines for each of the SUDs will be released in 2019

Prevention

1. Cannabis should generally be avoided by individuals with:

a) a history of mental disorders, substance misuse or substance use disorder.

b) cognitive impairment, cardiovascular disease, cardiac arrhythmias, coronary artery disease, unstable blood pressure, or impaired balance.

Clinician Education

2. Clinicians should be aware of the following:

a) The current evidence base on the medical use of cannabis is relatively limited, and cannabis has not been approved as a therapeutic agent by Health Canada. Clinicians should keep informed about new research evidence regarding possible indications for its use.

b) The common symptoms and signs associated with cannabis use, cannabis impairment, CUD and common consequences of cannabis misuse.

c) The common adverse effects of cannabis in older adults and effects, such as immobility, instability, falls, incontinence, cognitive impairment and nutritional disturbance.

d) Psychiatric conditions which are commonly comorbid with CUD such as depression, anxiety, and schizophrenia.

Moderate Evidence

- Reduce nausea and vomiting during chemotherapy
- Improve appetite in people with HIV/AIDS
- Reduce Muscle Spasms in Multiple Sclerosis

- Limited evidence of reduced chronic pain
- Complicated by doses and ratios of CBD:THC
- Routes of administration = smoking, vaporizing, vaping, edibles, topicals, concentrates, oils, sprays

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.

Perception

People's perceptions about the drugs they use are often very coloured by what they like about the drug.

Clinician Education

3. Clinicians should provide education and counselling with regard to cannabis and cannabinoids to patients and their caregivers both verbally and using written or online resources when needed.

4. Clinicians should counsel patients to be aware that older adults can be more susceptible than younger adults to some dose-related adverse events associated with cannabis use.

Clinician Education

5. 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.

6. Clinicians should be aware of risks associated with different modes of use of cannabis and cannabis products (e.g. smoking, vaporizing, oils, sprays, etc.) and counsel patients on these risks.

Clinician Education

7. Clinicians should educate patients to avoid illegal synthetic cannabinoids (e.g. K2 and SPICE) because of the potential to cause serious harm.

8. Clinicians should educate patients on the risk of impairment, especially when initially starting cannabis or titrating to a new dose. It is recommended that the starting dose should be as low as possible and gradually increased over time if needed.

Clinician Education

9. Clinicians should counsel patients on the potential long-term effects of frequent cannabis use including: respiratory problems, precancerous epithelial changes, cognitive impairment, mental health conditions and CUD, especially when high THC strains are used.

Brain Health

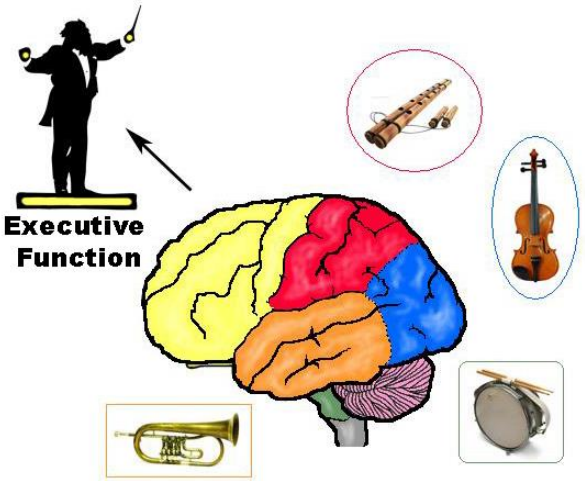
- Cannabis **Can** Be Addictive
- 9% of users overall,
- 17% of those who begin use in adolescence

- Cannabis use disorder develops faster than for alcohol or tobacco

- Cognition can be impacted, in particular emotional regulation, motivation, reward and executive functioning.

Executive Functioning

- The ultimate mental activity.



- Memory, processing speed, judgment, planning, decision making, social conduct, organization, anticipation, goal establishment, monitoring results and use of feedback.

- The PFC is the "dashboard" of the brain.

Clinician Education

10. Clinicians should advise patients that:

a) Depending on mode of consumption and THC concentration, 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 synergistic impairment and risks for driving so should be avoided.

c) It is dangerous to ride as a passenger with a driver who has recently used cannabis.

Cannabis Impairs Driving Ability

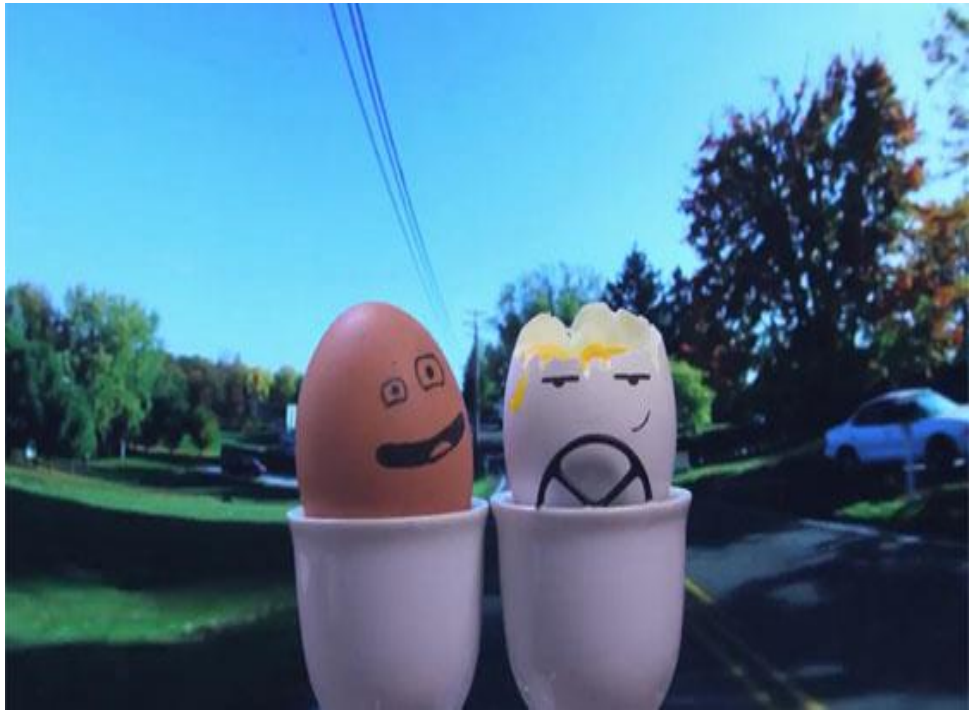


Image reproduced with permission from Arrive Alive – Ontario Student against Impaired Driving.
'Eggs on Weed'

- Attentional focus, information processing, motor coordination, reaction time are all impaired.
- Driving slower, reduced control with increased task complexity = lane weaving, slower reaction times, impaired divided attention, reduced critical tracking test performance.

Clinician Education

11. Patients should be provided with information about the signs, symptoms and risks of cannabis withdrawal.

Screening

12. Clinicians should initiate non-judgmental discussions related to cannabis use. Careful histories should be obtained from patients about signs and symptoms of CUD that may be similar to those of age-related nervous system changes, such as drowsiness, dizziness, memory impairment and falls.

Screening

13. All patients regardless of age should be screened for:

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

b) the frequency and amount of cannabis use by those older adults who acknowledge any use. Those who acknowledge any **recent** use (any in the past month) should then go on to targeted screening using the Cannabis Use Disorder Identification Test (CUDIT)

Screening

14. Clinicians should be aware that the diagnostic accuracy of some screening tools may be variable given that the symptoms of aging may overlap with those of CUD.

Assessment

15. Assessment of CUD in older adults should evaluate:

a) modes of use: i.e., eating, smoking, vaping, using oils, use of extracts, topicals, etc. and consider the risks/benefits/harms of all that apply to their patient.

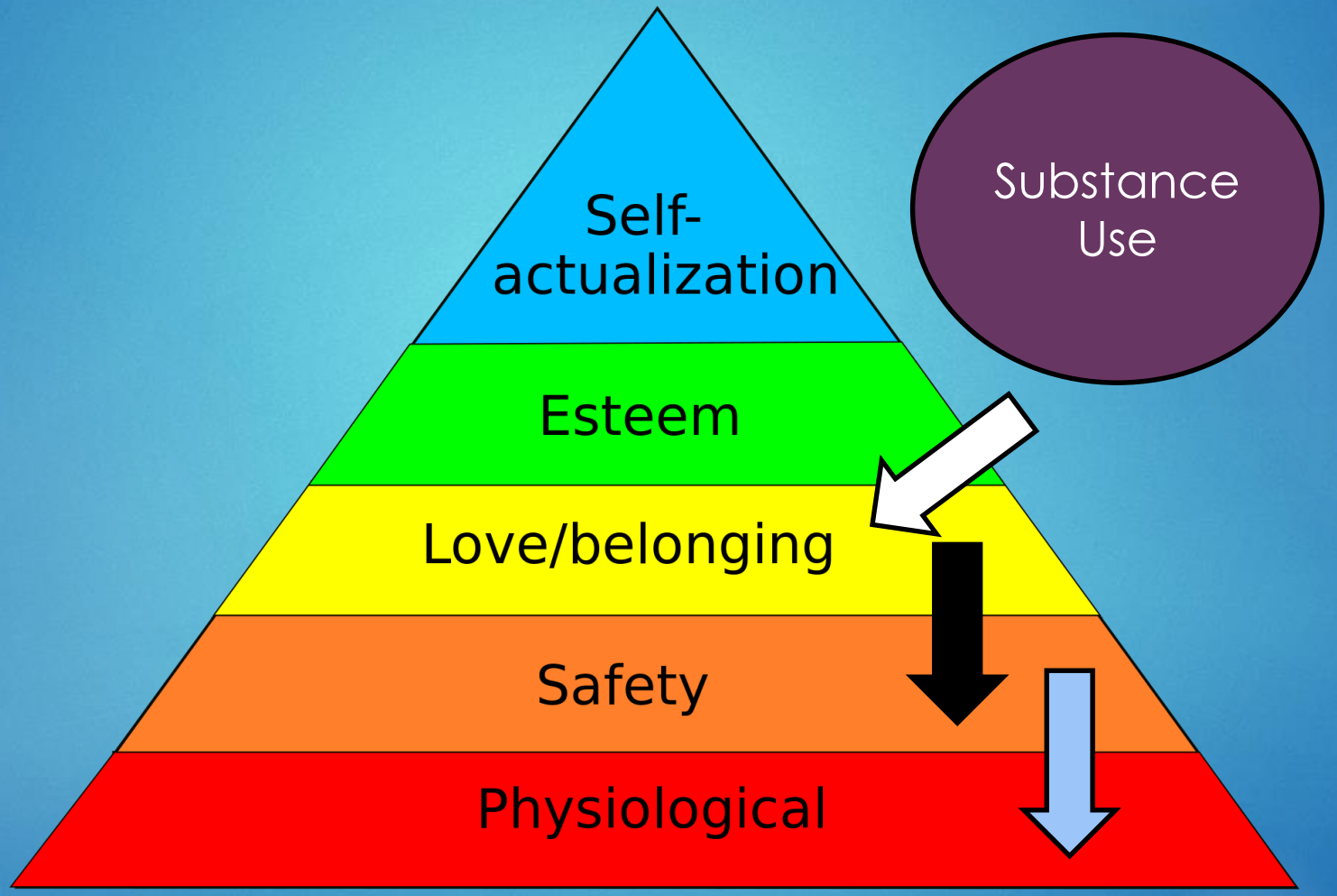
b) Frequency and intensity of use.

Treatment

16. Clinicians should be aware that the rapid reduction or abrupt discontinuation of cannabis use may be associated with withdrawal symptoms and should know the signs and symptoms of cannabis withdrawal.

17. Clinicians should be aware of the risk of cannabis hyperemesis syndrome in association with chronic cannabis use, especially with higher potency preparations.

Interruption of Needs



Connection

They develop a strong emotional relationship with their drug and it takes strong information to change that thinking.

New Relationship

When we ask someone to give up their drug of choice we are asking the to give up the only thing they have that “works” for them.

Treatment

18. SBIRT (Structured Brief Intervention and Referral to Treatment) should be adopted as a framework for approaching CUD treatment. The SBIRT approach should be considered for assessing and managing CUD similarly to other SUDs.

19. Peer support programs should be considered for individuals with CUD.

Treatment

20. It is recommended that a variety of psychosocial approaches be considered for harm reduction or relapse prevention including: Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Mindfulness Based Relapse Prevention (MBRP), Motivational Enhancement Therapy (MET) and Contingency Management.

Treatment

21. Mindfulness Based Relapse Prevention demonstrates reasonable effectiveness in the reduction or abstinence from cannabis in either post-intensive inpatient or outpatient treatment.

22. There are currently no established pharmacological treatments that have been demonstrated to be safe and effective for either Cannabis Withdrawal symptoms or CUD.

Mindfulness

- Being aware of the present moment, accepting and acknowledging it, without getting lost in the thoughts or emotional reactions of that moment.

- Helps to reduce our tendency to react emotionally and ruminate on negativity.

Treatment

23. Accredited residential treatment centres should be considered as appropriate for treating CUD if the individual is unable to effectively reduce or cease their cannabis use.

Alternative Safety

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.

Next Steps

- External peer review of guidelines
- Working Group voting on final recommendations
- Dissemination and knowledge mobilization

Save the Date!

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- CCSA's Issues of Substance is Canada's premiere conference for the substance use and addiction field
- Registration now open!
- Call for Late-breaking abstracts opening in July 2019
- #CCSAConference

Thank You

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