Opioids and Older Adults METAPHI COP meeting

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Baycrest

Letters of Lived Experience

An excerpt from the Behavioural Supports Ontario Provincial Pulse Newsletter (Issue 4)

- A member of the BSO Provincial Coordinating Team sat down with Sylvia to hear about her experience with addiction. Sylvia hopes that sharing her story will help others…
- I have had pain for many years due to Osteoarthritis and Diabetic Neuropathy. After back surgery about 10 years ago, I was prescribed the Fentanyl patch. Over time, the Fentanyl no longer controlled the pain and I was prescribed higher and higher doses. I figured I would take this medication for the rest of my life and I sure didn't expect what lay ahead. I was in my early 60‟s, living alone in a rural area when I began experiencing problems with walking and in turn falling frequently. Looking back, I was living in a haze. I thought I was functioning well, but I didn't go out often. I kept to myself; watching TV and going on my computer. Really, I became quite isolated.
- Eventually I was connected to an Intensive Geriatric Service Worker and a Seniors at Risk Worker from the Canadian Mental Health Association (CMHA). They referred me to Marilyn White-Campbell, a Geriatric Addiction Specialist. Marilyn was concerned about my medications and explained the risks that were involved, especially as I got older. She suggested that sometimes medications "can do more to you than for you" and that there are unwanted side effects, such as falls and withdrawal symptoms

- . On one occasion, a patch fell off me and I immediately noticed the withdrawal. Another time I accidently had 2 patches on at once and ended up in the hospital due to overdose. Marilyn helped to create a plan for how I could get off opioids, yet still have pain relief. As it is not possible to slowly wean from a patch, the plan involved staying overnight at a local health facility where I could be under medical supervision during the withdrawal period. I was admitted the day before we stopped the Fentanyl patch. The next day the patch was removed in the morning and all I had for pain was Tylenol. The withdrawal was terrible. I couldn't sit still. I felt like ants were crawling through my veins. I paced for hours and was awake all night, was very nauseous and began twitching. The staff were very supportive and helped me through this process. The next day, as planned, I was taken to the Rapid Access Addiction Medicine Clinic at the Women's College Hospital's Substance Use Clinic. I met with Dr. Kahan who specializes in substance use. He prescribed buprenorphine (an opioid replacement treatment). I was admitted to the hospital overnight so that I could be monitored and supported. Amazingly my withdrawal symptoms subsided and I went home the next day. I was off the Fentanyl patch! I can't believe the experience! I never thought when I was initially prescribed pain medication years ago that I would have to go through a withdrawal program. I am so thankful for the help that I was offered and the support provided by the addictions experts. I feel so much better! My thinking is no longer cloudy, I am not falling like I was, my pain is much better controlled and I am socializing again!

SYILVIA’S STORY

- Sylvias Story (1) (2).mp4

Behavioural Supports Ontario

Opioids and the elderly: Overview

- Osteoarthritis is a major cause of disability
- POWER study: 31% of women aged 75+ and living at home have ADL limited by OA pain
- Limited treatment options (eg NSAIDs)
- Opioids should be considered in elderly patients who are disabled by chronic pain and haven’t responded to alternatives
- But little evidence of long-term benefit from opioid therapy
- Benefits often modest, and negated by sedation, fatigue, hyperalgesia
- **Therefore opioid prescribing should be viewed as a therapeutic trial**

Opioids: Indications

- Well-defined biomedical pain condition eg severe OA
- Non-opioid treatments ineffective, not tolerated, or contraindicated

Contraindications, precautions

- Current or past history of substance use disorder
- Cognitively impaired and living alone
- Current, active anxiety, mood disorder
- High risk for falls

Prior to prescribing…

- Ask about current/past use of alcohol and other drugs
- Ask about mood
  - Concurrent anxiety or mood disorder heightens pain perception and blunts response to opioids
- Check renal, respiratory status
  - Opioids increase risk of sleep apnea
  - Morphine contraindicated in renal insufficiency

Prior to prescribing

- Assess risk of falls
- Taper benzodiazepines
- Ask about impact of pain on ADL
  - Walking, visits to family & friends etc
- Have patient rate pain severity on 0-10 scale
  - At rest, with activity

Warnings to patient and family

- Don’t drink alcohol during initial titration
- Be careful with activity in few days after dose increase, especially at night
- Tell the doctor immediately if sedation or falls
- Never take more than prescribed
- Keep opioids safely stored, especially if adolescents or young adults in the house

Office visits during titration

- See patient before each dose increase
- Ask about compliance (taking more or less than prescribed)
- Ask about changes in:
  - Social visits, ADL
  - Pain ratings 0-10 scale, at rest and with activity
  - Mood
  - Sedation, dizziness
  - Unsteadiness, falls
  - Constipation, nausea (constipation can be the cause of agitation in elderly)

Office visits (2)

- Ask family member or caregiver about opioid response if feasible
  - They are often more likely than the patient to observe sedation or improved activity
- Provide advice on pacing-eg walking:
  - How far, how fast, rest breaks

General principles

- Elderly at high risk for sedation and falls:
  - Lower serum binding, slower hepatic clearance, less CNS reserve
- Initial dose - no more than one-half that of younger adults
- Interval between dose increases should be at least twice as long as in younger adults
- Even slower titration in:
  - frail elderly
  - on sedating meds
  - renal, hepatic or cardio-respiratory impairment

Minimizing risk of falls

- Do not prescribe to cognitively impaired patients unless dispensed by caregiver
- Taper benzodiazepines
- Avoid use of opioids at night
- If pain wakes patient up:
  - Use small IR opioid dose
  - Take extra precautions when getting out of bed

Minimizing risk of sedation, overdose

- Taper benzodiazepines
- Warn patients to avoid alcohol
- Warn: no extra doses
- Warn family to contact MD or emergency services at first sign of overdose:
  - Slowed speech, ‘nodding off’ when engaged in conversation for more than a few minutes
- If on a high dose, give take-home naloxone

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Opioid use disorder: Clinical features

- High opioid dose for underlying pain condition
- Runs out early, acquires opioids from other sources
- Very attached to drug, strong resistance to tapering or switching opioid
  - ‘Opioid only takes edge off pain, but I’ll die if you stop prescribing it’
- Sometimes binges on drug

Clinical features

- Current or past history of problematic use of alcohol or other drugs
- Depressed, anxious
- Poor and deteriorating functioning
- Concern expressed by family members
- Recurrent, frightening withdrawal symptoms

HAVING THE CONVERSATION ON OPIATE USE DISORDER

- ARE THE OPIATES DOING MORE TO YOU THAN FOR YOU?
- SOMETIMES MORE IS NOT BETTER (HYPERALGESIA)
- OLDER ADULTS HAVE SPECIAL CONSIDERATIONS
- WHAT ARE THE NON PHARMACOLOGICAL APPROACHES
- PHYSIO, MEDIATION MINDFULNESS

Geriatric considerations for Dementia

- Pain can be a cause of behavior and agitation
- Use of ABBY PAIN scale
- PAIN AID
- MOCA for baseline

Appendix 5: Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

How to use scale: While observing the resident, score questions 1 to 6

Name of resident:

Name and designation of person completing the scale:

Date: Time:

Last pain relief given was: at: hours

Q1. Vocalisation
eg. whispering, groaning, crying

Absent – 0 Mild – 1 Moderate – 2 Severe – 3 **Q1** ☐

Q2. Facial Expression
eg. looking tense, frowning, grimacing, looking frightened

Absent – 0 Mild – 1 Moderate – 2 Severe – 3 **Q2** ☐

Q3. Change in Body Language
eg. fidgeting, rocking, guarding part of body, withdrawn

Absent – 0 Mild – 1 Moderate – 2 Severe – 3 **Q3** ☐

Q4. Behavioural Change
eg. increased confusion, refusing to eat, alteration in usual patterns

Absent – 0 Mild – 1 Moderate – 2 Severe – 3 **Q4** ☐

Q5. Physiological Change
eg. temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor

Absent – 0 Mild – 1 Moderate – 2 Severe – 3 **Q5** ☐

Q6. Physical Changes
eg. skin tears, pressure areas, arthritis, contractures, previous injuries

Absent – 0 Mild – 1 Moderate – 2 Severe – 3 **Q6** ☐

- **Add scores for 1 – 6 and record here:** **Total pain score** ☐
- **Now tick the box that matches the Total**

☐ **0–2 – No Pain** ☐ **3–7 – Mild** ☐ **8–13 – Moderate** ☐ **14+ – Severe**

- **Finally tick the box which matches the type of pain**

☐ **Chronic** ☐ **Acute** ☐ **Acute on Chronic**

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B. Funded by the JH & JD Bunn Medical Research Foundation 1998 – 2003

Modified Abbey Pain Scale (Follow on assessment form)

	Date and time	Date and time	Date and time	Date and time	Date and time	Date and time	Date and time	Date and time	Date and time	Date and time
VOCALISATION eg. whispering, groaning, crying Absent – 0 Mild – 1 Moderate – 2 Severe – 3										
FACIAL EXPRESSION eg. looking tense, frowning, grimacing, looking frightened Absent – 0 Mild – 1 Moderate – 2 Severe – 3										
CHANGE IN BODY eg: fidgeting, rocking, guarding part of body, withdrawn Absent – 0 Mild – 1 Moderate – 2 Severe – 3										
BEHAVIOURAL CHANGE eg: increased confusion, refusing to eat, alteration in usual patterns) Absent – 0 Mild – 1 Moderate – 2 Severe – 3										
PHYSIOLOGICAL CHANGES eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor Absent – 0 Mild – 1 Moderate – 2 Severe – 3										
PHYSICAL CHANGES eg: skin tears, pressure areas, arthritis, contractures, previous injuries Absent – 0 Mild – 1 Moderate – 2 Severe – 3										
Total score =										
Signature of person										

The Abbey Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs, for example, patients with dementia, cognition or communication issues. The scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential.

The Australian Pain Society recommends the pain scale should be used as a movement-based assessment. Therefore observe the patient while they are being moved, during pressure area care, while showering, etc. Complete the scale immediately following the procedure and record the results on the Abbey Pain tool chart.

A second evaluation should be conducted 1 hour after any intervention taken. If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate. Complete the scale hourly until the patient scores mild pain then 4 hourly for 24 hours treating pain if it recurs.

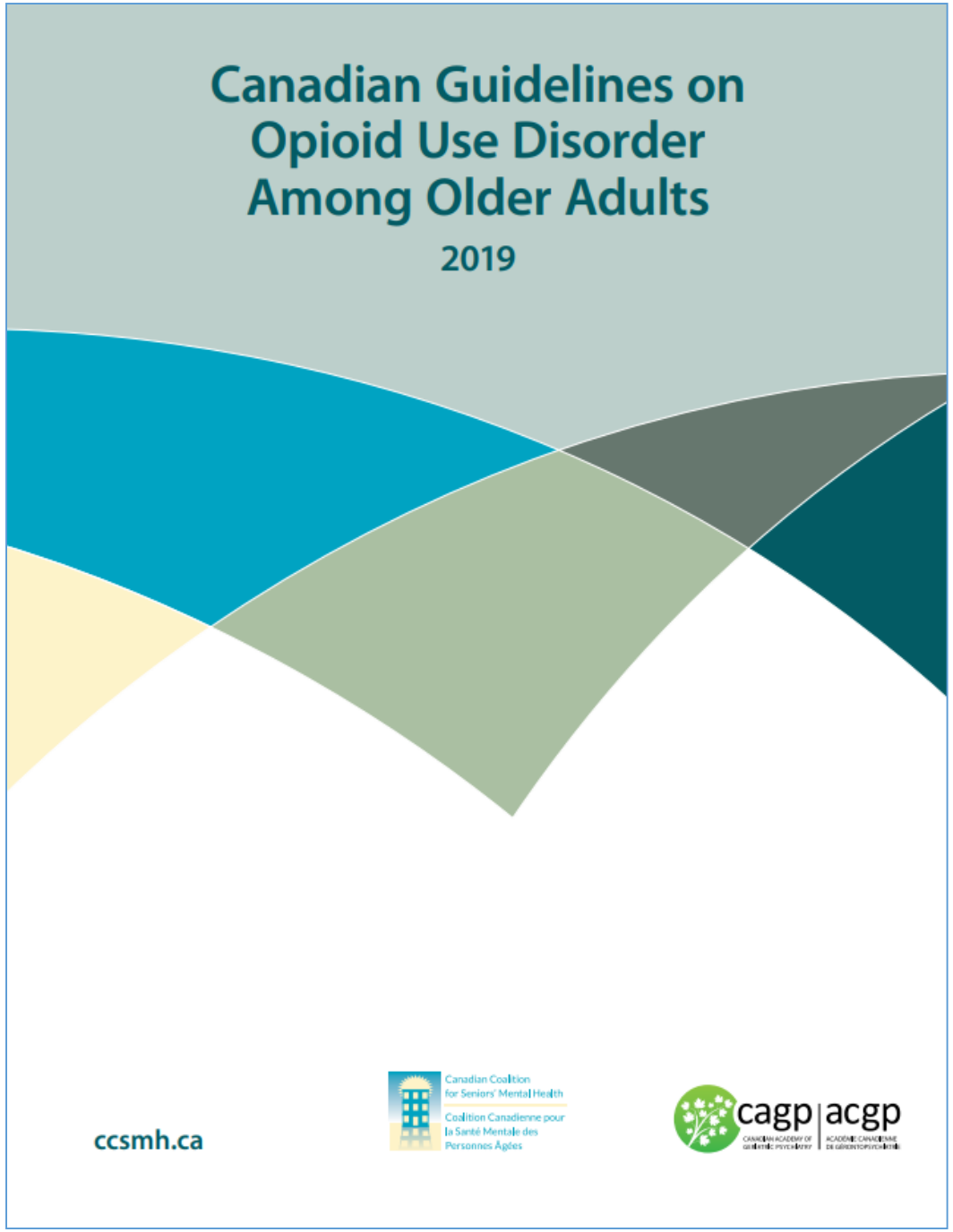
If the pain/distress persists, undertake a comprehensive assessment of all facets of the patients care and monitor closely over 24 hours including further intervention undertaken.

If there is no improvement in that time, then it is essential to notify the GP of ongoing pain scores and actions taken.

Modified from Hywel Dda University Health Board NHS 2013; Wales, UK

PAINAID: Pain Assessment in Advanced Dementia

Breathing, independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperven-tilation. Cheyne-stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling, or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract, or reassure.	
			TOTAL:	



RECOMMENDATION #25:

The threshold to admit an older adult with social, psychological, or physical comorbidities to either residential or hospital care for opioid withdrawal management or induction onto medications for an OUD should be lower than for a younger adult.
[GRADE: Quality: Moderate; Strength: Strong]

RECOMMENDATION #27:

Psychosocial interventions should be offered concurrently with medications for an OUD, at a pace appropriate for age and patient needs, but they should not be viewed as a mandatory requirement for accessing pharmacotherapy.
[GRADE Quality: Moderate; Strength: Strong]

RECOMMENDATION #32:

The cost of medically-recommended pharmacological and non-pharmacological treatment for an OUD in older adults should be covered by the public health plan.
[GRADE Quality: Moderate; Strength: Strong]

Questions to Ask Your Healthcare Provider When Being Prescribed an Opioid

To start a conversation, here are some questions you can ask your healthcare provider about opioid medicines before taking them (or if you are already taking them):

1. What is the goal of being on this medication?
2. What are the possible benefits and harms of this medication?
3. Can it affect my memory or cause me to fall?
4. How long will I have to take this medication for?
5. Can I stop or reduce the dose of this medication when I want to?
6. Who do I follow-up with about this medication and when do I follow-up?

PREVENTION

1. To risk of OUD development in OA with acute pain:

- Use lowest effective dose of the least potent immediate release opioid
- **Duration: ≤ 3 days BUT rarely > 7 days**

[GRADE: Evidence: Moderate; Strength: Strong]

PREVENTION

1. Consider implementing interventions to decrease inappropriate use of BZs in their practice settings
2. In OA with polypharmacy or comorbidities e.g. sleep apnea
   - ↑ risk of opioid overdose
   - **Use the lowest effective opioid dose**
   - **Consider tapering the opioid and/or other medications**

[GRADE: Evidence: Moderate; Strength: Strong]

TREATMENT

- Alcohol, benzos, sedative-hypnotics is **HAZARDOUS** with opioids.
- In the community slow taper NOT abrupt cessation is recommended.
- In hospital, residential treatment, or a long-term care setting and medically managed by an experienced provider, detoxification can progress **more rapidly**

[GRADE Quality: Moderate Strength: Strong]

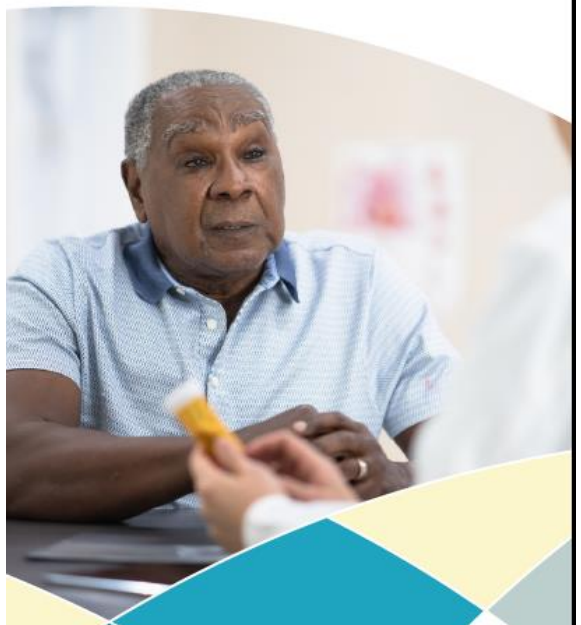
What Older Adults Need to Know About Drinking Alcohol

LEARN MORE +
SEEK ADVICE

ccsmh.ca

Canadian Coalition for Seniors' Mental Health
Coalition Canadienne pour la Santé Mentale des Personnes Agées

Benzodiazepine Use Among Older Adults



LEARN MORE +
TAKE ACTION

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Canadian Coalition for Seniors' Mental Health
Coalition Canadienne pour la Santé Mentale des Personnes Agées

What Older Adults Need to Know About Cannabis

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Opioid Use Among Older Adults

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Canadian Coalition for Seniors' Mental Health
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Resources

Community Outreach Programs In Addictions (COPA)

(Organization: Reconnect Community Health Services - Mental Health and Addiction Services www.reconnect.on.ca)

CCSMH Canadian Guidelines for SUD's in Older Adults https://ccsmh.ca/substance-use-addiction/

National Initiative for Care of the Elderly https://www.nicenet.ca/tools

(Scroll and download tools for Pocket Guides Alcohol and Opiates)

CCSA Low Risk Drinking Guidelines for Older Adults poster https://www.ccsa.ca/sites/default/files/2020-12/CCSA-Alcohol-and-Older-Adults-Poster-2020-en.pdf

Canadian Deprescribing Network (including EMPOWER brochure): https://www.deprescribingnetwork.ca


Questions

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