REVIEW ARTICLE

Opioid use in Modern Older People Psychiatry: What is the Evidence?

V M Aziz[1], Rugiyya Saeed[2]

[1]Department of old age psychiatry,Consultant Psychiatrist, FRCPSYCH, United Kingdom, [2]Department of old age psychiatry, MRCPSYCH, Wales Deanery, United Kingdom

ABSTRACT

There has been a recent publicity about the Opioid use in Older People Psychiatry. The authors reviewed current practice by looking at evidence-based prescribing. Despite the risks, opioids can be a valuable tool in treating painand improving quality of life in older adults. Research is needed to explore whether this reflects appropriate pain management for long term care residents and if as required (PRN) medication isused effectively.

Key words: Pain, Opioid, analgesic ladder, and Older people psychiatr**y**

INTRODUCTION

Opioids are strong painkillers best known as treatments for post-surgical and cancer pain. They are also used for conditions that cause chronic pain other than cancer and sometimes for symptoms other than pain. They have a number of important adverse effects, and their use involves a balance of risks and benefits.

This principle is particularly crucial in the older adult population, since opioids play an important role in the treatment of pain, sometimes in the management of behavioral symptoms of dementia, and also in the end of life care. Moreover, yet their use is further complicated due to the multiple comorbidities, polypharmacy, and vulnerability to adverse effects in this age group.

This article will aim to give a brief summary of how opioids are currently being used in old age psychiatry and also consider the current evidence on their usage in older people.

CURRENT OLD AGE PSYCHIATRIC PRACTICE

When choosing an opioid, the practice is to follow the analgesic ladder proposed by the World Health Organization. It is a systematic and graduated approach that starts with non-narcotics, then weak opioids and nonsteroidal anti-inflammatory drugs (NSAIDs), subsequently progressing to stronger medications as required, depending on side effects, and efficacy. However, many older adults have contraindications to NSAIDs and may have comorbidities precluding them from adhering to this approach. In these instances, opioids are relied on more often.

The main indication for opioid use is a pain, and its associated distress, aggression, or agitation, especially after other medications, has been tried first. At present, opioids used can include various drugs such as tramadol, oramorph, butrans transdermal patch, and Fentanyl transdermal patch within BNF limits.

When starting an opioid, there has to be clear documentation of the indication and evidence that the decision to prescribe was after consultation with the patient, family, and

Address for correspondence:
Rugiyya Saeed, MRCPSYCH, Wales Deanery, United Kingdom. E-mail: rugi_ms@hotmail.com

multidisciplinary team (MDT). In patients who lack the capacity to make such a decision, the prescribing pattern has to be discussed and agreed in the best interest meeting with all involved.

It is also good practice for advice to be sought from the pain specialist team on the appropriate usage of opioids in pain management. Oral medication is always considered before alternative routes are considered. In old age psychiatry, the approach is to start at low doses and to titrate up slowly, monitoring for side effects carefully. The initial dose should be considered carefully and is usually about half of the normal adult dose.

Response to medication should be monitored closely by staff, reviewed regularly by the medical team and on a weekly basis by the consultant following MDT discussions, which can include the family and advocate for the patient. For community patients, such monitoring can be done by the general practitioner, district nurse, or community pharmacist.

The continued opioid usage for patients admitted for rehabilitation or respite care in the absence of an indication is not common practice in old age psychiatry. Furthermore, when prescribing opioids toward the end of life, consulting, and working with Palliative Medicine with the involvement of the family and MDT is the current practice in old age psychiatry.

EVIDENCE-BASED PRACTICE

Pain is a multifaceted experience with physical, psychological, social, and spiritual components. It is a common symptom in older persons, which when untreated or under-treated pain can produce significant suffering as well as agitation and behavioral problems in persons with dementia.

However, dementia is often accompanied by impaired communication, complicates the assessment and treatment of pain. Although older people with dementia share the same age-related pathology as other older people, they do not experience the same access to pain relief as their cognitively-unimpaired counterparts.

When assessing pain in patients with dementia, the first step is an awareness that pain might be present and can be responsible for otherwise unexplained distress and behavioral change. The symptoms of pain expressed by patients with moderate to severe dementia include anxiety, agitation, screaming, hostility, wandering, aggression, failure to eat, and failure to get out of bed. A small number of demented individuals with serious injury may not complain of pain, for example, hip fractures and ruptured appendix.

While tools have been developed to enhance pain assessment in this group of patients, a study carried out by Lichtner *et al*.[1] looking at assessment and management of pain in a cohort of patients across four hospitals in England and Scotland highlighted a need for an efficient method of collecting pain-related information for a patient with dementia, which would form the basis for effective pain management. They identified communication difficulties and timeframes of staff interactions as some of the main issues encountered when assessing pain in patients with dementia. Aside from this, they found no consistent approach in how information of a patient's pain was elicited, given the multidisciplinary environment, requiring collective staff memory, "mental computation," and time to reassemble the patient's pain experience. These issues, in turn, affected the trials of medications used to provide pain relief to these patients and the assessment of their response.

In the pain management of older adults and those with dementia, opioids play an important role. Danishstudy[2] looked at the prevalent use of opioids in elderly with and without dementia in Denmark, which showed that 41% of Nursing Home residents used opioids, while 27.5% of home-living patients with dementia and 16.9% of home-living patients without dementia also used opioids. Among the opioids used, Buprenorphine and Fentanyl were most prevalent in Nursing Home residents and home-living patient with dementia, but less often used by the group without dementia.

Pitkala *et al*.[3] found an 11.1% increase in the prevalence of regular opioid use in nursing homes and assisted living facility residents between 2003 and 2011. The authors concluded this increase in opioid use could be due to improved recognition and treatment of pain in older people. In addition, a moderate increase for analgesic prescribing including opioids over time in the international long-term care population was observed in a systematic review by La Frenais *et al*.[4]

Naples *et al*.[5] studied the use of opioids in older adults in with chronic non-cancer pain, where 6–9% use opioids chronically with a significant small-to-modest improvement in pain intensity and level of function with opioids compared to placebo. Hydrocodone was the identified as the most commonly used opioid in combination with ibuprofen and acetaminophen in this study.

Pain management, including the use of opioids, is often used to reduce behavioral disturbances in patients with dementia. Husebo *et al*.[6] studied the efficacy of pain treatment reducing behavioral symptoms in nursing home residents with moderate to severe dementia, with a significant reduction in levels of agitation at 8 weeks compared to the control group. They also noted a reduction in aggression, overall severity of neuropsychiatric symptoms and pain. The medications included morphine and transdermal buprenorphine. Conversely, a Cochrane review[7] found insufficient evidence to support the safe and efficacious use of opioids for agitation in patients with dementia.

While used often in the treatment of pain and also for behavioral symptoms, the use of opioids comes with pitfalls in the older adult population. There is an increased risk of delirium associated with opioids such as tramadol and mephedrone, with mephedrone showing the highest risk when compared against other opioids.[8] The study by Naples *et al*.[5] reported a 38% increased likelihood of fractures in a dose-response relationship when older adults are given opioids, the falls risk increasing especially when they are used in combination with other medications that affect the central nervous system, such as benzodiazepines and antipsychotics.

According to the Agency for Healthcare and Quality,[9] patients aged 65 and older had the highest rate of opioid-related inpatient stays, and opioid-related emergency visits and inpatient stays were higher for women compared to men. Larney *et al*.[10] also found a higher rate of liver-related and HIV-related deaths among older adults with opioid use disorder in comparison to same-age peers without the opioid-use disorder.

Hence, as Gold[11] states, prescribing opioids for older adults are a balancing act. The decision to prescribe has to be based on weighing the benefits of improving the quality of life of the patient and the possible side effects of opioids. Alternatives to opioids always have to be considered first, such as topical pain agents, massage, and acupuncture. This is reiterated by the Royal College of Psychiatrists,[12] where they advise cautious approach is advised, with the need for clear documentation of the anticipated risks and benefits of any treatment due to older people being a vulnerable group. They also advise obtaining the advice of a prescribing clinician with greater expertise if the medicine to be used does not have an extensive evidence base to support its use for the proposed indication, for instance, the use of opioids in the management of agitation as described previously.

CONCLUSION

Despite the risks, opioids can be a valuable tool in treating pain and improving quality of life in older adults. The incidence of chronic pain increases with age, and this, in turn, becomes more challenging to manage when paired with a diagnosis of dementia. Opioids can help older adults maintain their independence, which is a key predictor of health, and can treat debilitating pain that might otherwise leave individuals immobilized and housebound. Prescribers serve a critical role in weighing the benefits and risks of opioid use in the older adult population and treating individuals through responsible prescribing practices.

Research is needed to explore whether this reflects appropriate pain management for LTC residents and if PRN medication is used effectively.

REFERENCES

1. Lichtner V, Dowding D, Allcock N, Keady J, Sampson EL, Briggs M, *et al*. The assessment and management of pain in patients with dementia in hospital settings: A multi-case exploratory study from a decision making perspective. BMC Health Serv Res 2016;16:427.
2. Jensen-Dahm C, Gasse C, Astrup A, Mortensen PB, Waldemar G Frequent use of opioids in patients with dementia and nursing home residents: A study of the entire elderly population of Denmark. Alzheimers Dement 2015;11:691-9.
3. Pitkala KH, Juola AL, Hosia H, Teramura-Gronblad M, Soini H, Savikko N, et *al*. Eight-year trends in the use of opioids, other analgesics, and psychotropic medications among institutionalized older people in Finland. J Am Med Dir Assoc 2015;16:973-8.
4. La Frenais FL, Bedder R, Vickerstaff V, Stone P, Sampson EL Temporal trends in analgesic use in long-term care facilities (LTC): A systematic review of international prescribing. J Am Geriatr Soc 2018;66:376-82.
5. Naples JG, Gellad WF, Hanlon JT. Managing pain in older adults: The role of opioid analgesics. Clin Geriatr Med 2016;32:725-35.
6. Husebo BS, Ballard C, Sandvik R, Nilsen OB, Aarsland D. Efficacy of treating pain to reduce behavioural disturbances in residents of nursing homes with dementia: Cluster randomised clinical trial. BMJ 2011;343:d4065.
7. Brown R, Howard R, Candy B, Sampson EL Opioids for agitation in dementia. Cochrane Database Syst Rev 2015;5:CD009705.
8. Swart LM, van der Zanden V, Spies PE, de Rooij SE, van Munster BC. The comparative risk of delirium with different opioids: A systematic review. Drugs Aging 2017;34:437-43.
9. Agency for Healthcare Research and Quality. Patient characteristics of Opioid-Related Inpatient Stays and Emergency Department Visits Nationally and by State; 2014. Available from: https://www.hcup-s.ahrq.gov/reports/statbriefs/sb224-Patient-Characteristics-Opioid-Hospital-Stays-ED-Visits-by-State.pdf. 09.07.2018
10. Larney S, Bohnert AS, Ganoczy D, Ilgen MA, Hickman M, Blow FC, *et al*. Mortality among older adults with opioid use disorders in the veteran's health administration, 2000-2011. Drug Alcohol Depend 2015;147:32-7.
11. Gold J. Prescribing opioids to seniors: It's a balancing act. Kaiser Health News; 2017. Available from: http://www.khn.org/news/prescribing-opioids-to-seniors-its-a-balancing-act. 09.07.2018
12. Royal College of Psychiatrists CR210. Use of Licensed Medicines for Unlicensed Applications in Psychiatric Practice. 2nd ed. 2017. Available from: https://www.bap.org.uk/pdfs/CR210-December2017.pdf 09.07.2018.

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