Awareness to Recovery Care Pathway for Treatment of **Older Adults** (65 and older) Experiencing Psychoactive Prescription Drug Harms

This high-level care pathway outlines the continuum of care to provide quality treatment for older adults experiencing harms from substance use

The pathway is based on peer-reviewed literature as well as on experiential evidence from subject-matter experts, including representatives from primary care, psychiatry, psychology, geriatrics, anesthesiology, neurology, pharmacy and nursing, and from individuals with lived experience

It is anticipated that this pathway will be adapted to the context and services available where it is being implemented

Pathway Step

AWARENESS

Healthcare professionals should be fully informed of prescription drug risks and possible harms, including substance use disorders

Healthcare professionals prescribing prescription drugs should be aware of the potential for iatrogenic addiction

= Expert opinion

Pathway Step

SCREENING

People over 60 should be screened yearly and when they experience significant life stressors (e.g., retirement, loss of spouse)

Prescreening as part of annual check-up, before new medication is introduced or in response to substance-related problems: clinicians ask seniors about prescriptions or have them bring them to appointment in original containers; ask where they are filled and if they are experiencing side effects

Benzodiazepines (BZ)

2 brief screening questions:

1. *"Over the past 12 months, have you noticed any decrease in the effectiveness of this medication (e.g., on your sleep, anxiety or sadness)?"*
2. *"Have you ever tried to stop taking this medication?"*

Promising Practices

Single question for 21–86 year olds:
"How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"

Drug Abuse Problem Assessment for Primary Care: Computer-based screening instrument in waiting room for 55 and older

- Automatically scores risks
- Generates patient profile for medical reference
- Provides tailored motivational messages and brief advice

Opioids

Screener and Opioid Assessment for Patients with Pain – Revised: predicts which patients living with pain are at risk of opioid abuse

Current Opioid Misuse Measure: monitors for opioid abuse in pain therapy patients

Opioid Risk Tool: predicts risk of opioid abuse among those in pain therapy

Does the individual meet the criteria for having a problem with prescription drug use?

Yes

No

Continue checking in with the individual and monitoring him or her for prescription drug harms at regular intervals

Assess the individuals' readiness to change BZ-adapted Contemplation Ladder

Provide education on harms and resources

Ready

Not Ready

Assess the severity of the harms being experienced; might include referral to an addiction medicine specialist

Pathway Step

ASSESSMENT

- Structured Clinical Interview (SCID) for DSM-III-R
- Diagnostic Interview Schedule (DIS)

Benzodiazepine (BZ) Specific

- BZ Dependence Questionnaire: assesses present state dependence based on behavioural, physiological and cognitive impairments
- Severity of Dependence Scale — BZ: measures psychological dependence related to impaired control, preoccupation and anxiety related to use
- BZ Dependence Self-Report Questionnaire: assesses problematic use, preoccupation, lack of compliance, withdrawal
- BZ Dependence Questionnaire: assesses dependence on a continuum
- BZ Craving Questionnaire: assess severity of craving
- BZ Refusal Self-Efficacy Questionnaire: assesses ability to resist use in variety of scenarios
- BZ Expectancy Questionnaire: assesses beliefs regarding effectiveness
- Qualitative interviews: assess rationale and circumstances for initial and current use, perceptions of others perspectives on use, knowledge of possible side effects, reliance, thoughts on tapering or discontinuation, interest in alternative coping strategies

In collaboration with the individual, determine the appropriate treatment.

Pathway Step

TREATMENT

Treatments tailored to older adults can address age-specific psychological, social and health concerns and contexts to successfully engage and retain individuals in treatment (e.g., no accessibility barriers, topics relevant to life stage such as loneliness, loss, grief and transitions addressed)

Use onset in early adulthood might require more intensive treatment and monitoring and integrated services due to a greater number of medical, psychiatric orsocial co-morbidities

Brief Intervention

- Might incorporate motivational interviewing or cognitive behavioural therapy (CBT)
- Simple letter or meeting intervention via general practitioner can reduce BZ use among older adults with long-term prescriptions; key elements include:
  - Expressing concern over long-term use
  - Highlighting potential side effects
  - Asking individual to reconsider use
  - Providing advice on how to cease use while decreasing chances of withdrawal symptoms
  - Inviting individual to discuss issues further
  - Effects can be enhanced by tailoring letter to social cognitive theory and addressing skills to cope with anxiety and sleep problems

Withdrawal Management

- American Society of Addiction Medicine Treatment Criteria for Addiction, Substance-Related, and Co-Occurring Conditions: detoxification is particularly risky for older adults. 24 hours primary, psychiatric and nursing care in an intensive inpatient-setting is recommended. Once stable, the older adult can return to community for ongoing treatment

Prescription opioids

- Should be managed cautiously and in a medical setting
- Combination of BZ, an antihistamine and a belladonna antispasmodic for mild-to-moderate addiction
- Methadone can be considered for severe dependence
- Buprenorphine (bup) should be used cautiously given its associated risk of respiratory depression

Benzodiazepines

- Beers Criteria: discontinuation warranted whenever possible
- BZ Withdrawal Symptom Questionnaire: patient and physicians responses determine the number and severity of withdrawal symptoms
- Clinical Institute Withdrawal Assessment—Benzodiazepines: assesses type and severity of withdrawal symptoms
- Gradual taper over several weeks preferred over abrupt withdrawal and leads to more successful cessation and long-term abstinence
- A quarter-dose decrease is the maximum reduction that should occur each week

Medication-Assisted Treatment

Benzodiazepines

- Adjunctive medication prior to, during and after BZ discontinuation might help tapering and lead to higher discontinuation rates, but recent meta-analysis in older population revealed no effect of pharmacotherapy

Psychosocial Treatment

- Psychosocial interventions might be preferred over medication-assisted treatment for older adults to avoid drug-drug and drug-disease interactions

SAMSHA Treatment Improvement Protocol Opioid Treatment

- Use of supportive, non-confrontational approaches that build self-esteem, rather than confrontational therapies
- Focus on cognitive-behavioural approaches
- Development of skills for improving social support
- Recruitment of counsellors who are trained and motivated to work with older adults
- Use of age-appropriate pace and content

Benzodiazepines

- Psychological interventions plus a taper schedule and supervised withdrawal results in better discontinuation up to 3 months compared to controls, perhaps especially when interventions target underlying pathology

Pathway Step

RECOVERY AND RELAPSE PREVENTION

SAMHSA: substance abuse relapse prevention guidelines for older adults — group treatment approach in outpatient settings.
4 phases:

1. Analyze previous substance use behaviour
    - Substance Abuse Profile for the Elderly interview: assesses relapse potential and circumstances that trigger or follow substance use
2. Identification of high-risk situations: patients attempt to identify, understand and respond to the antecedents, behaviours and consequences of their substance abuse to help break their behaviour chain
3. Skills training for coping with high-risk situations and relapse
4. Follow-up care: usually informal support (e.g., telephone call check-up) provided for at least 12 months after the program

KNOWLEDGE GAPS

Through our review and consultations to develop the care pathways, we identified a number of knowledge gaps

These gaps are highlighted below to inform further research

Awareness

- Primary care physicians might not be comfortable broaching the topic of substance use
- How can an individual enter the pathway other than via a healthcare professional?
- ** First Do No Harm competencies for health professionals in pain management, drug prescribing, dependency, addiction and abuse might be able to address this gap, but not yet validated or widely accepted.

Screening

- Can be difficult to differentiate between aspects of aging or chronic illness and harms from substance use
- Physicians might not be aware of screening for pseudoaddiction
- How to choose from the 3 opioid screening tools?
- Patients should also be screened for mental health concerns
- The ethical and economic implications of routine urine toxicology tests have not been established
- Currently used prescription opioid misuse screeners for pain management populations lack testing in clinical practice; no evidence for efficacy
- Validity and reliability of 3 opioid screening tools with older adults uncertain as tested among large age range
- Screens don't address age of onset; individuals with earlier onset misuse might require more comprehensive assessment of their substance use and psychiatric histories than those with late-onset, while the latter group might benefit from more thorough evaluations of changes in personal health status and environmental factors that could trigger drug use
- Contemplation ladder used with, but not specifically validated among, older adults
- Which professionals should be performing each of the following steps? Do the pathways differ for a primary care physician versus a mental health or addictions specialist?

Assessment

- Structured Clinical Interview & Diagnostic Interview Schedule may not be realistic for practice due to time consumption and amount of training to administer; assess all substance use disorders and are not specific to prescription drugs
- Published literature hasn't caught up to DSM-V
- DSM criteria principally validated in young and middle-aged populations; criteria concerning failure to fulfill major obligations might be less useful for older adults who might have fewer life responsibilities
- When and how often to reassess individuals?
- BZ scales not specifically validated among older adults except BZ Craving Questionnaire
- How should assessment and treatment for the underlying causes of substance abuse (e.g., pain, trauma) be addressed?

KNOWLEDGE GAPS

Through our review and consultations to develop the care pathways, we identified a number of knowledge gaps These gaps are highlighted below to inform further research

Treatment

Brief Interventions

- No conclusive evidence in relation to prescription opioids and older adults

Withdrawal Management

- Dearth of literature concerning use of bup in older adults for withdrawal management
- No specific recommendations or examples of dosing or tapering schedules for older adults with prescription opioid dependence were found in the empirical literature, despite cautions about dose-related considerations given potential drug-drug interactions, metabolic changes associated with aging, drug-disease complications, pattern and type of opioid used, medication side effects, and withdrawal severity
- BZ Withdrawal Symptom Questionnaire and Clinical Institute Withdrawl Assessment not validated in older adults
- Transfer from short half-life BZ to longer half-life for stabilization generally recommended before tapering, although efficacy not greatly supported in the literature

Medication-Assisted Treatment

- Presently no specific drugs recommended or approved for management of BZ dependence or withdrawal
- Little evience related to medication-assisted treatment (MAT) for prescription opioid harms among older adults

Psychosocial Treatment

- No evidence on the effectiveness of psychosocial treatments for prescription opioid harms as adjuncts to MAT or alone
- CBT + BZ taper long-term effects not conclusive
- There is no evidence about use or effectiveness of residential treatment for opioid or sedative–hypnotic harms

Recovery and Relapse Prevention

- Little information on methods to support older adults in recovery
- SAMHSA guidelines have not been evaluated

Canadian Centre on Substance Abuse
Partnership. Knowledge. Change.