Substance Use Disorders in Older Adults: Don’t Stop Believin’ that YOU Can Make a Difference

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Presenter Information

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• Conflicts of Interest- None.
Objectives

• Discuss the problem of substance use disorders in older adults
• Describe assessment strategies to identify substance use disorder in older adults
• Examine current treatment options for substance use disorder in older adults
Objectives

• Discuss the problem of substance use disorders in older adults
How Prevalent are SUDs in Older Adults?

• Among persons aged 65 years and above:
  • 9% reported smoking\(^2\)
  • 8% reported excessive alcohol consumption\(^2\)
  • Less than 3% reported “serious psychological distress during the past 30 days)”\(^2\)
• Data from 2007 to 2014 National Surveys on Drug Use and Health indicate that on an average day, 6.0 million older adults drank alcohol, 132,000 older adults used marijuana, and 4,300 older adults used cocaine\(^4\)

How Prevalent are SUDs in Older Adults?

• National Council on Alcoholism & Drug Dependence\(^3\):
  • There are 2.5 million older adults with an alcohol or drug problem.
  • Six to eleven percent of elderly hospital admissions are a result of alcohol or drug problems — 14 percent of elderly emergency room admissions, and 20 percent of elderly psychiatric hospital admissions.
  • Widowers over the age of 75 have the highest rate of alcoholism in the U.S.
  • Nearly 50 percent of nursing home residents have alcohol related problems.
  • Older adults are hospitalized as often for alcohol related problems as for heart attacks.
How Prevalent are SUDs in Older Adults?

- National Council on Alcoholism & Drug Dependence³:
- Nearly 17 million prescriptions for tranquilizers are prescribed for older adults each year.
- Benzodiazepines (anti-anxiety medication) are the most commonly misused and abused prescription medications.
- Although people 65 years of age and older comprise only 13% of the population, they account for almost 30% of all medications prescribed in the United States.
- As a result, older adults are at significant risk for prescription drug abuse and addiction.

How Prevalent are SUDs in Older Adults?

- In addition to prescription medications, many older adults also use over-the-counter (OTC) medicines and dietary supplements, including sharing them with friends.
- Due to increased rate of illness, changes in the body’s capacity to process medications, and the potential for drug interactions, older adults are more likely to experience.
ER Visits Related to Drug Use-2011\(^4\)

- Average day in 2011- 2,056 drug-related ED visits by older adults [aged 65 and above]
- 290 involved illegal drug use, alcohol in combination with other drugs, or nonmedical use of pharmaceuticals.
  - 118 involved prescription or nonprescription pain relievers, 80 of which involved narcotic pain relievers specified by name (e.g., hydrocodone, oxycodone);
  - 48 involved benzodiazepines;
  - 25 involved alcohol in combination with other drugs;
  - 23 involved antidepressants or antipsychotics;
  - 13 involved cocaine;
  - 7 involved heroin;
  - 5 involved marijuana; and
  - 2 involved illicit amphetamines or methamphetamine

Even When Evidence is in Our Face!\(^7\)

- One study found that 21% of adults ages 60 and above screened positive for alcohol dependence
- Among this number, less than 1/3 were identified by their physicians as having “alcohol related problems”
- Other studies suggested that older women are less likely to be screened for alcohol use disorders
How Prevalent are SUDs in YOUR Facility?

- “Mom always had a drink with dinner”
- “Dad loves his beer when he watches TV”
- “My doctor told me a drink will help me relax and unwind before bed”

What does the provider order?
- “May have 6 ounces of wine Q-HS”
- “May have one can beer daily”
- “May have one mixed drink of choice daily Q-HS using 4 oz. liquor”
- “Smoking privileges per facility policy”
- “May use smokeless tobacco ad lib”

But…is it a Problem?

- Decrease in body H₂O → With age– same amount of ETOH which had little effect can cause intoxication
- Changes I body water increase sensitivity and decrease tolerance to ETOH
- Decreased metabolic rate of ETOH in GI tract → blood ETOH levels raised for longer time period- strains liver
- These changes can worsen/trigger problems:
  - Heart problems
  - Risk of CVA
  - Cirrhosis & other hepatic diseases
  - GI Bleeding
  - Depression, anxiety, other MH problems
But is it a Problem?\textsuperscript{6}

- Impact on prescription drugs- polypharmacy
- Illicit drugs can result in:
  - Diminished psychomotor performance
  - Impaired reaction time
  - Impaired coordination/falls
  - Excessive daytime drowsiness
  - Confusion
  - Aggravation of emotional states
  - Amnesia
  - Dependence

Regulation- F-740

- “Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident’s whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders”\textsuperscript{1}
Objectives

• Describe assessment strategies to identify substance use disorder in older adults

Like Every Other Social Problem…
Why Aren’t SUD’s In Older Adults Identified?

$64,000 Question -

• Insufficient knowledge of the problem- age bias
• Limited research data
• Hurried office visits
• Health care providers with limited knowledge in screening/diagnosis
• Dx. difficult- symptoms of alcoholism and drug dependency in older adults may present as symptoms of other medical and behavioral disorders (diabetes, dementia, and depression)
$64,000 Question

• Shame/secrecy—this is “private”
  • Not just among people with the problem, but their children as well

• Belief that SUDs cannot be successfully treated in older adults
  • 2/3 of individuals with drug/alcohol issues will relapse within 1 year of tx.
  • Among people who met lifetime criteria for SUD—only 43.5% achieved remission

$64,000 Question

• Bias that alcoholism and addiction are not worth treating in this population “He’s 75, let him drink….what else does he have at his age?”
  • SUDs can impact a wide range of health issues—it is about quality of life
  • SUDs as “lubricants” for psychiatric/mental health conditions
Risk Factors

- Emotional/social problems
- Medical problems
- Decreased ADLs/IADLs
- Older men when their wives die
- Medical settings
- Substance use disorders in early life
- Mood or other psychiatric disorder
- Family history
- Psychoactive prescription drug use

Defining Substance Use Disorder
Substance-Related and Addictive Disorders

- Substance-Related Disorders
- Substance Use Disorders
- Substance-Induced Disorders
- Alcohol-Related Disorders
- Alcohol Use Disorder
- Alcohol Intoxication
- Alcohol Withdrawal
- Other Alcohol-Induced Disorders
- Unspecified Alcohol-Related Disorder
- Caffeine-Related Disorders
- Caffeine Intoxication
- Caffeine Withdrawal
- Other Caffeine-Induced Disorders
- Unspecified Caffeine-Related Disorder
- Cannabis-Related Disorders
- Cannabis Use Disorder
- Cannabis Intoxication
- Cannabis Withdrawal
- Other Cannabis-Induced Disorders
- Unspecified Cannabis-Related Disorder
- Hallucinogen-Related Disorders
- Phencyclidine Use Disorder
- Other Hallucinogen Use Disorder
- Phencyclidine Intoxication
- Other Hallucinogen Intoxication
- Hallucinogen Persisting Perception Disorder
- Other Phencyclidine-Induced Disorders
- Other Hallucinogen-Induced Disorders
- Unspecified Phencyclidine-Related Disorder
- Unspecified Hallucinogen-Related Disorder
- Inhalant-Related Disorders
- Inhalant Use Disorder
- Inhalant Intoxication
- Opioid-Related Disorders
- Opioid Use Disorder
- Opioid Intoxication
- Opioid Withdrawal
- Other Opioid-Induced Disorders
- Unspecified Opioid-Related Disorder
- Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
- Sedative, Hypnotic, or Anxiolytic Use Disorder
- Sedative, Hypnotic, or Anxiolytic Intoxication
- Sedative, Hypnotic, or Anxiolytic Withdrawal
- Other Inhalant-Related Disorders
- Unspecified Inhalant-Related Disorder
- Inhalant Use Disorder
- Inhalant Intoxication
- Other Inhalant-Induced Disorders
- Unspecified Inhalant-Related Disorder
- Opioid-Related Disorders
- Opioid Use Disorder
- Opioid Intoxication
- Opioid Withdrawal
- Other Opioid-Induced Disorders
- Unspecified Opioid-Related Disorder
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- Sedative, Hypnotic, or Anxiolytic Use Disorder
- Sedative, Hypnotic, or Anxiolytic Intoxication
- Sedative, Hypnotic, or Anxiolytic Withdrawal
Substance-Related and Addictive Disorders

- Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders
- Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder
- Stimulant-Related Disorders
- Stimulant Use Disorder
- Stimulant Intoxication
- Stimulant Withdrawal
- Other Stimulant-Induced Disorders
- Unspecified Stimulant-Related Disorder
- Tobacco-Related Disorders
- Tobacco Use Disorder
- Tobacco Withdrawal
- Other Tobacco-Induced Disorders
- Unspecified Tobacco-Related Disorder
- Other (or Unknown) Substance–Related Disorders
- Other (or Unknown) Substance Use Disorder
- Other (or Unknown) Substance Intoxication
- Other (or Unknown) Substance Withdrawal
- Other (or Unknown) Substance–Induced Disorders
- Unspecified Other (or Unknown) Substance–Related Disorder
- Non-Substance-Related Disorders
- Gambling Disorder

Assessment Considerations

- Purpose of assessment
  - Screening different than “intent to treat”
- Setting of assessment
- Time allotted for assessment
- IDEALLY– all adults aged 60 and over should be screened for alcohol & prescription drug use
- Rescreen periodically and as clinically indicated

What are your facility policies?
Do you screen?
CAGE Questionnaire

- Have you ever felt you should Cut down on your drinking?
- Have people Annoyed you by criticizing your drinking?
- Have you ever felt bad or Guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

Scoring:

Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

Assess Type, Amount, Frequency

- May be useful, but tends to be underreported (all age groups)
- Remind what a “standard drink” is:

<table>
<thead>
<tr>
<th>12 fl oz of regular beer</th>
<th>8-9 fl oz of malt liquor (shown in a 12 oz glass)</th>
<th>5 fl oz of table wine</th>
<th>1.5 fl oz shot of 80-proof spirits (“hard liquor” — whiskey, gin, rum, vodka, tequila, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEER</td>
<td>about 5% alcohol</td>
<td>about 7% alcohol</td>
<td>about 12% alcohol</td>
</tr>
<tr>
<td></td>
<td>about 40% alcohol</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Alcohol Use Disorder Identification Test (AUDIT)

1. How often do you have a drink containing alcohol?
   (0) Never
   (1) Monthly or less
   (2) 2-3 times a month
   (3) 2-3 times a week
   (4) 4 or more times a week

2. How many units of alcohol do you have on a typical day when you are drinking?
   (0) 5 or 6
   (1) 7, 8, or 9
   (2) 10 or more

3. How often do you have 4 or more units if female, or 8 or more units if male, on a single occasion in the past year?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

4. How often during the past year have you found that you were not able to stop drinking once you started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the past year have you felt the need to cut down or cut off drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the past year have you had a hangover or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the past year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

Total score:

AUDIT-5 performs as well as full-length AUDIT and CAGE Questionnaire

Use with Higher Suspected Risk of Alcoholism

- More than five positive answers in this test is indicative of alcoholism
- Also, questions 8, 19, and 20 are each considered indicators of alcoholism if answered positive
Drug Abuse Screening Test (DAST)

<table>
<thead>
<tr>
<th>DAST-10</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>Low</td>
<td>1-2</td>
</tr>
<tr>
<td>Intermediate</td>
<td>3-6</td>
</tr>
<tr>
<td>(likely meets</td>
<td></td>
</tr>
<tr>
<td>DSM criteria)</td>
<td></td>
</tr>
<tr>
<td>Substantial</td>
<td>6-8</td>
</tr>
<tr>
<td>Severe</td>
<td>9-12</td>
</tr>
</tbody>
</table>

These questions refer to the past 12 months.

1. Have you used drugs other than those required for medical reasons?
   - Yes
   - No

2. Do you abuse more than one drug at a time?
   - Yes
   - No

3. Are you always able to stop using drugs when you want to?
   - Yes
   - No

4. Have you had “blackouts” or “flashbacks” as a result of drug use?
   - Yes
   - No

5. Do you ever feel bad or guilty about your drug use?
   - Yes
   - No

6. Does your spouse (or parents) ever complain about your involvement with drugs?
   - Yes
   - No

7. Have you neglected your family because of your use of drugs?
   - Yes
   - No

8. Have you engaged in illegal activities in order to obtain drugs?
   - Yes
   - No

9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
   - Yes
   - No

10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?
    - Yes
    - No

“Other” Signs that Warrant Further Assessment

- Excessively worrying about whether prescription psychoactive drugs are "really working" to alleviate numerous physical complaints; complaints that the drug prescribed has lost its effectiveness over time (evidence of tolerance)

- Displaying detailed knowledge about a specific psychoactive drug and attaching great significance to its efficacy and personal impact

- Worrying about having enough pills or whether it is time to take them to the extent that other activities revolve around the dosage schedule
“Other” Signs that Warrant Further Assessment

• Continuing to use and to request refills when the physical or psychological condition for which the drug was originally prescribed has or should have improved (e.g., prescription of sleeping pills after the death of a loved one); resisting cessation or decreasing doses of a prescribed psychoactive drug

• Complaining about doctors who refuse to write prescriptions for preferred drugs, who taper dosages, or who don't take symptoms seriously

• Self-medicating by increasing doses of prescribed psychoactive drugs that aren't "helping anymore" or supplementing prescribed drugs with over-the-counter medications of a similar type

• Rating social events by the amount of alcohol dispensed

“Other” Signs that Warrant Further Assessment

• Withdrawing from normal and life-long social practices
• Cigarette smoking
• Involvement in minor traffic accidents (police do not typically suspect older adults of alcohol abuse and may not subject them to Breathalyzer and other tests for sobriety)
• Sleeping during the day
• Bruises, burns, fractures, or other trauma, particularly if the individual does not remember how and when they were acquired
• Drinking before going to a social event to "get started"; gulping drinks, guarding the supply of alcoholic beverages, or insisting on mixing own drinks
• Changes in personal grooming and hygiene
• Expulsion from housing
• Empty liquor, wine, or beer bottles or cans in the garbage or concealed under the bed, in the closet, or in other locations
Approach to Assessment

• Screening in confidential setting
• Non-threatenng/ non-judgmental manner
• Older adults may be sensitive to the stigma associated with alcohol and drug abuse- more willing to accept a "medical" as opposed to a "psychological" or "mental health" diagnosis as an explanation for their problems
• Prefacing questions with a link to a medical condition can make them more palatable. For example, “This information may help your doctor to figure out why you are having these symptoms” or “Sometimes, non-prescription medications can impact the way a prescription medication works.”
• Avoid stigmatizing terms like alcoholic or drug abuser during these encounters.

Objectives

• Examine current treatment options for substance use disorder in older adults
Intervention

- Limited studies on intervention in older adults in general---even less for institutionalized older adults
- Feedback on assessment—who is going to do it?
- Consider minimally intensive approaches first
- May not meet full criteria for a substance use disorder (SUD)—but drinking may be a problem for them nonetheless (co-morbidities, medications, etc.)

Transtheoretical Model (a.k.a., “Stages of Change”) Prochaska and DiClemente

The Stages of Change Model
Brief Motivational Interventions

- **Motivational Interviewing**
  - A way to interact with substance-using clients—can help resolve the ambivalence that prevents clients from realizing personal goals
  - Builds on Carl Rogers' optimistic and humanistic theories about people's capabilities for exercising free choice and changing through a process of self-actualization
  - The therapeutic relationship is a democratic partnership.
  - Motivational interviewing is directive, with a goal of eliciting self-motivational statements and behavioral change from the resident in addition to creating client discrepancy to enhance motivation for positive change

Motivational Interviewing

- A counseling style based on the following assumptions:
  - Ambivalence about substance use (and change) is normal and constitutes an important motivational obstacle in recovery
  - Ambivalence can be resolved by working with your client's intrinsic motivations and values
  - The alliance between you and your client is a collaborative partnership to which you each bring important expertise
  - An empathic, supportive, yet directive, counseling style provides conditions under which change can occur
    - *Direct argument and aggressive confrontation may tend to increase client defensiveness and reduce the likelihood of behavioral change*
Screening, Brief Intervention, and Referral to Treatment (SBIRT)\textsuperscript{9}

• Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.

• Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.

• Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.


SBIRT Process
SBIRT Model Matrix

Note: “ATOD Use” refers to combined alcohol, tobacco, and drug use. “ATOD Use +” refers to alcohol, tobacco, drug use, and other behavioral risk factors (e.g., poor diet, physical inactivity).

Brief Interventions & Brief Therapies for Substance Abuse
What “NOT” to do…

1. Ordering or directing
2. Warning or threatening
3. Giving advice, making suggestions, or providing solutions prematurely or when unsolicited
4. Persuading with logic, arguing, or lecturing
5. Moralizing, preaching, or telling clients their duty
6. Judging, criticizing, disagreeing, or blaming
7. Agreeing, approving, or praising
8. Shaming, ridiculing, labeling, or name-calling
9. Interpreting or analyzing
10. Reassuring, sympathizing, or consoling
11. Questioning or probing
12. Withdrawing, distracting, humoring, or changing the subject

Where to Find Help

• SAMHSA’s National Helpline, 1-800-662-HELP (4357), (also known as the Treatment Referral Routing Service) or TTY: 1-800-487-4889 is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individuals and family members facing mental and/or substance use disorders

• American Psychological Associations “Help Center”

• Psychology Today “Find a Therapist”
  https://www.psychologytoday.com/us/therapists
Where to Find Help

- Reach out to other facilities... who do they use?
- What is their reputation?
- Community agencies
- Psychiatrists/psychologists/Psychiatric-Mental Health Nurse Practitioners

“Next Steps” for Implementation

- Identify a champion in your facility who believes that it is never too late for a resident to live the kind of life she/he wants to live!
- Doesn’t have to be a social worker, could be a nurse, recreation therapist, etc.
- PROVIDE TRAINING!
  - Peter Baeklund tells of a conversation between a Chief Financial Officer (CFO) and a Chief Executive Officer (CEO) which captures the importance of providing your staff with an exceptional program of continuing education.
    - A CFO asks a CEO: “What happens if we invest in developing our people and then they leave us?”
    - The CEO responds: “What happens if we don’t and they stay?”
Key Takeaways

• Substance abuse does occur in older adults
• Identification/assessment essential
• It’s never too late to treat!

“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.”

- Margaret Mead
References


ARE THERE ANY QUESTIONS?

I HOPE NOT