Substance Use Disorders and Older Adults-Entering the Grey Zone

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Seeing clearly through the grey zone...

Substance use disorders across the lifespan:

- What are the barriers that interfere with identifying SUDs in the +65 age group
- What Co-occurring conditions make differential diagnosis a challenge
- What screening tools are well suited for +65 age group
- Special issues-retirement, medical marijuana
Grey Zone: aging 101
Among Ohioans age 60 and older, the dramatic growth has been among those 75 and older. The largest gains have been in suburban counties adjacent to larger urban areas.

Only about 4.5% of all older Ohioans are in a nursing home, a drop of over 1% from 2000. Many elders are living in the community with support from family and home health services (aging in place).

Life expectancy in 1900=46.3/48.3 (men/women)

Life expectancy 2010=75.7/80.8

Source: Ohio Department of Aging/CRS Report for Congress Life expectancy in the U.S.
Four Key Signs of Aging
New Realities of Aging

- Aging is just living
- 100 million shades of gray
- Contributors NOT burdens
- Aging and longevity
- Perceptions don’t match reality

The NEW normal.....

- 2/3rd’s of those who have EVER lived beyond 65 years, are LIVING NOW
- Medical advances contribute to longer life, healthier life, older ages
- Never before have humans experienced the longevity of today
- Medical science, economies, our world, our addiction treatment centers are UNDERPREPARED for the needs of our aging population
stereotypes

- Ours vs. those of older adults
  - Impact of viewing aging as decline/decrepit
  - Impact of viewing aging as feeble/frail

- Carstensen, et. al, 2011-emotional stability and well-being improve with age
- Rates of depression and anxiety in later life may actually be lower for older adults than rates for younger and middle aged adults (Blazer, 2010)
Key to working with older adults

- Move from certainty to curiosity
  - The same approach to all clients: approach with curiosity to understand the individual as fully as possible
  - Aging is a PROCESS rather than a STATE-
  - **CHRONOLOGICAL AGE IS OFTEN THE LEAST USEFUL THING TO KNOW ABOUT A PERSON**
Definitions of aging

- Chronological
- Functional
- Psychosocial
- Organizational
- Lifespan developmental approach

Sterns and Doverspike, 1986
Normative vs. abnormal aging

- Older adults may misattribute problems as being
  - Global (because of aging)
  - Stable (because of age and stuck with it for the rest of my life/it is down hill from here)
  - Internal (because of my age)
Age categories

- Young old (65-74 years old)
- Oldest old (76 and above)

(Neugarten, et al., 1961)

Why do we care?

- More women than men
- Oldest old growing the fastest
- Impact of cohort effect, greatest generation, boomers,
Ageism

Originally term coined by Butler 1967

Ageism is a term first coined by Robert Butler in 1969 “Ageism can be seen as a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplished this with skin color and gender” (Butler, 1973, p. 12).
Facts about aging and substances

- Older adults are frequent users of prescribed and OTC medications
- Prevalence of illicit drug use is on the rise, with the aging of the “baby boomer” generation (1946 – 1963)
- Changes associated with aging serve as both risk factors for substance misuse and are aggravated by substance use
- Existing diagnostic criteria for substance use disorders may miss or under identify older adults substance use disorders
- Today’s older adults did not receive prevention education growing up
- Older adults may be difficult to assess due to perceptual/cognitive issues
- Hepatitis C-elevated risk for Boomer Generation
Common misconceptions about aging and how it can interfere with identifying SUDS
Misconceptions about aging and substance use disorders
Continuum of Use

- Proper use
- Misuse

Misuse

By Patient:
- Dose +/−
- Skipping dose/hoarding
- Mixing
- Use with alcohol

By Doctor:
- Dose too high/low
- Not explaining regimen (supper/dinner)
- Not knowing all meds

More meds means more potential for problems—can lead to abuse/addiction
Opiate use in Ohio

- Drug overdoses have increased in Ohio by 372% from 1999 to 2010
- Prescribed opioids such as Oxycontin and hycrocodone (Vicodin) are involved in more overdose deaths than heroin and cocaine combined
- 3 of 4 overdoses caused by Rx painkillers
- 30% in age group 45-54; 11% in age group 55-64; and 3% in over 65 age group (47% of overdoses in over 45 age range)

Source: Ohio Department of Health, vital statistics
Opiates and elderly

- Number of older Americans seeking treatment for opiate abuse increased from 6.8% to 12% (1995-2002)
  
  Source: SAMHSA, retrieved from www.about.com, 9/14/2012

- Use of opioids found to:
  - Increase the risk for fractures
  - Increase the risk for all cause mortality (oxycodone) after 30 days
  - Increase cardiovascular risk (codeine) after 180 days

  Source: Solomon, 2010. Archives of Internal Medicine
Treatment help is NEEDED

- By 2020, number of adults 50+ in need of substance abuse treatment is expected to double from 2.8 million (average 2002 to 2006 annual average) to 5.7 million
- National Survey of Substance Abuse Treatment Services (N-SSATS) showed in 2009 FEWER facilities offer special programs or groups for older adults than in 2004

Source: DASIS, 2012
Co-occurring issues that impact differential diagnosis of SUDS
Common Co-Occurring Issues

- **Physical**
  - Pain conditions
    - Arthritis
    - Nerve pain
  - Diabetes
  - Insomnia

- **Behavioral health**
  - Anxiety
  - Depression
  - Cognitive impairment

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Pain and Aging

- Prevalence ranges from 36 to 80%
- One of most common complaints
- Often multiple medical problems; multiple sources of pain
- Common cause = musculoskeletal disorders;
- Complications = depression, fatigue, sleep disruption, gait disturbance, decreased socialization, polypharmacy
- Challenges = geriatric physiology, patient assessment

Source: Freedman, 2002
Chronic Pain

- Prevalence ranges from 25% to 50%
- Persistent pain associated with:
  - Physical and role disability
  - Psychological distress
  - Increased health care utilization and cost

Source: Turner, Ersek, & Kemp, 2005
Barriers to effective identification and treatment of pain in older adults

- Older adult and provider stereotype: “pain as normative part of aging”
- Older adults underreporting
- Inadequate clinical trials using older adults
- Multiple comorbidities
- Polypharmacy
- Cognitive issues
- LACK of provider knowledge of above
Mood and Pain

- **Depression** - Improving depression reduces arthritis pain in older adults, Lin, et. al., 2003

- **Anxiety** - Anxiety increases pain perception

- **Negative Affect** - Self-report stress scales and health ratings contain a significant negative affect component, though not strongly, or consistently related to long term health outcomes, Watson & Pennebaker, 1989
Self Rated Health

- Pain interventions designed to improve mood and that offer opportunities for knowing participation have greater impact on overall health than those that target only pain and disability

Source: Siedlecki, 2006
Cognitive Behavioral Tx

- Life satisfaction predicted, along with age, by internal coping strategy: Positive Attitudes

  “…cognitive behavioral strategy which relies on the intention of positive thinking, the avoidance of constantly thinking at the illness, and the intention to take life in own hands, the realization of shelved dreams and wishes, the resolving of cumbering situations of the past and doing all that what pleases is of outstanding importance for patients with chronic diseases to cope.”

Source: Bussing, et. al., 2010
CDSM

☐ Chronic Disease Self Management
   ■ Group
   ■ Peer led
   ■ Evidenced based
Under reporting

☐ How do YOU define pain

☐ Personal beliefs may influence both the interpretation and reporting of pain
Under treating

- Lack of proper assessment or geriatric specific assessment tools
- Potential risks of polypharmacy
- Misconceptions regarding efficacy of non pharmaceutical interventions and elderly attitudes about these treatments

Source: Gagliese & Melzack, 1997
Pain Assessment

- Comprehensive history
- Assessment tools, scales, etc.-many developed using younger adults
  - Need to consider sensory impairment, cognitive impairment, co-morbidity, functional status, performance of ADLs
Who is at greatest risk for medication misuse/abuse?

Factors associated with prescription drug misuse/abuse in older adults:
- Female gender
- Social isolation
- History of a substance abuse
- History of or mental health disorder – older adults with prescription drug dependence are more likely than younger adults to have a dual diagnosis
- Medical exposure to prescription meds with abuse potential

(Source: Simoni-Wastila, Yang, 2006)
Alternatives/adjuncts to opiates

- Nonopioid analgesics
- Biofeedback
- Nonpharmalogic
  - Cbt, exercise tx, complementary med

Screening Older Adults
OPIATE RISK ASSESSMENT

- Useful to identify who is at risk for opiate addiction
- Beneficial to support physician treating patients who have appropriate need for opiate medications
Screening for Opiate Use Risk

- SOAP
- ORT
- D.I.R.E
- COMM

Screening Tools

- Alcohol Use Disorder Identification Test (AUDIT)-see NIAAA
- CAGE-public domain
- Geriatric MAST-public domain
- IMADUS (Gerald Shulman)
- Alcohol Related Problem Survey (ARPS)
Low Risk

- Low risk=no more than one per day and max of 2 drinks on any drinking occasion (NIAAA recommendations)
- 0 CAGE score
- No evidence of dysfunction related to drinking
- Not using medications that interact adversely with alcohol or have conditions that alcohol may trigger or make worse

Source:  www.americangeriatrics.org
At Risk Drinking

- On average, >1 drink per day, or >7 drinks per week, or >3 on heavier drinking occasions
- Or any drinking and >0 CAGE score
- Evidence of drinking-related dysfunction
- Using alcohol and medications in combinations that might interact adversely
- Using alcohol and having conditions that may be triggered or worsened by alcohol

Source: www.americangeriatricians.org
What do these symptoms mean?

- Sleep complaints, changes in sleep patterns, daytime sleepiness, unusual fatigue
- Cognitive impairment, memory or concentration disturbances, disorientation or confusion
- Seizures, muscle wasting, malnutrition
- Liver function abnormalities
- Persistent irritability and altered mood, depression, and anxiety
- Poor hygiene and self-neglect
- Unexplained complaints about chronic pain or other somatic complaints
What do these symptoms mean?

- Incontinence, urinary retention, difficulty urinating
- Unusual restlessness and agitation
- Complaints of blurred vision or dry mouth
- Unexplained nausea and vomiting or GI distress
- Changes in eating habits
- Slurred speech
- Frequent falls and unexplained bruising
- Tremor, motor uncoordination, shuffling gait
Diagnostic Problems

- Ms. A
- Mr. W
- Mrs. M
- Mrs. P
DSM Diagnostic Criteria and Older Adults-Special Consideration

- Tolerance - Older adults may have problems with even low intake due to increased sensitivity to alcohol and higher blood alcohol levels.
- Withdrawal - Many late onset alcoholics do not develop physiological dependence.
- Progression - Increased cognitive impairment can interfere with self-monitoring; drinking can exacerbate cognitive impairment and monitoring.
- Efforts to cut-down/quit - Same issues across the lifespan.
DSM Diagnostic Criteria and Older Adults-Special Consideration

- Time seeking, using, and recovering from effects-Negative effects can occur with relatively low use
- Giving up activities due to use-May have fewer activities/responsibilities, making detection of problems more difficult
- Continued use despite physical/psychological conditions made worse-May not know or understand that problems are related to use
Special topics
Overview: Vulnerability

- Overrepresented in number of prescriptions
- Physiological changes increase drug sensivity
- Physical changes collide with drug effects
- Unlikely to have prevention education
- Underidentified and pain undertreated
Retirement?
LIFE TRANSITIONS

- Older adults can experience difficulty with life transitions revolving around:
  - Physical independence
  - Psychological independence
“Medical” Marijuana
“Simply acceding to patient demands for a treatment on the basis of popular advocacy-without comprehensive Knowledge of an agent does not adhere to the ethical standard of Medical care.”

GOAL: To increase awareness about older adults risk of medication mismanagement, both prescribed and OTC, alcohol and medication interactions, and abuse of alcohol/medications

Create a prevention program designed to engage older adults and caregivers while increasing knowledge about risk and impacting attitudes about substance use
The NEXT frontier....
“Any symptom in an elderly patient should be considered a drug side effect until proved otherwise.”

J. Gurwitz et al.; Brown University, 1995
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