Coming of Age: Prevention Education, Effective Screening, and Diagnosis for an Aging Population

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Cynthia McQuown, LPCC-S, LICDC
Ohio Citizen Advocates for Addiction Recovery Board Member
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
- Diagnosis and Co-occurring conditions - challenges
Beach Ball
What do these symptoms mean?
Alcohol and medication misuse is easy to identify in older adults. FALSE.

- Medication/alcohol misuse/abuse MIMICs the normal signs of aging, conditions commonly diagnosed in older adults (dementia). Common “signs” associated with aging: forgetfulness, mental confusion, shakiness, unsteady movement, loss of coordination, sleeping more or having difficulty sleeping.

- Often times the misuse/abuse is unintentional, related to lack of knowledge about risk of interactions and of impact of aging physiology on part of BOTH the consumer and caregiver.
Co-occurring issues

- **Physical**
  - Pain conditions
    - Arthritis
    - Nerve pain
  - Diabetes
  - Insomnia/sleep apnea
  - Hypertension

- **Behavioral health**
  - Anxiety
  - Depression - 16% lifetime prevalence in +50

- **Cognitive**
  - Cognitive impairment/MCI
  - Alzheimers
Continuum of Use

- Proper use
- 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

6/14/2018
“Any symptom in an elderly patient should be considered a drug side effect until proved otherwise.”

J. Gurwitz et al.; Brown University, 1995
Abuse of alcohol and prescription drugs among older adults 60 and older is one of the fastest growing health problems today. TRUE

☐ 2.5 million older adults have problems related to alcohol.
☐ Estimates suggest that by 2020, that number will reach 5 million.
☐ Older people are hospitalized more frequently for alcohol related problems than for heart attacks.
☐ The drug of first choice in the older population is TOBACCO. Tobacco use is associated with development of Alzheimer’s disease in individuals WITHOUT genetic predisposition. The number two drug is alcohol.
☐ 20% of older adults receiving treatment for medical, surgical or psychiatric difficulties are alcoholics or problem drinkers
Less is more........

Everything slows down with age, except the time it takes cake and ice cream to reach your hips.
University of Florida Health

- https://www.youtube.com/watch?v=YeAwaM5usvg
Older Adults: Uniquely Vulnerable

- Overrepresented in number of prescriptions
- Physiological changes increase drug sensitivity
- Physical changes collide with drug effects
- Unlikely to have prevention education
- Underidentified and pain undertreated
Diagnostic Issues and Case Discussion
DSM-V Substance Use Disorder

- Mild
- Moderate
- Severe
# Applying DSM Criteria to Older Adults

<table>
<thead>
<tr>
<th>Tolerance</th>
<th>Even low intake may cause problems due to body changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawal</td>
<td>May not develop physiological dependence (eg late onset)</td>
</tr>
<tr>
<td>Use in larger amounts or for longer than intended</td>
<td>Cognitive impairment interferes with self-monitoring</td>
</tr>
<tr>
<td>Desire to cut down or control use</td>
<td>Same across life span</td>
</tr>
<tr>
<td>Time in obtaining substance or getting over effects</td>
<td>Negative effects with relatively low use</td>
</tr>
<tr>
<td>Activities given up or reduced</td>
<td>May have fewer activities</td>
</tr>
<tr>
<td>Use despite knowledge of problems</td>
<td>May not know problems are related to use</td>
</tr>
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</table>
# Early vs. Late Onset

<table>
<thead>
<tr>
<th>Early Onset</th>
<th>Late Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong> Earlier-teens</td>
<td><strong>Age:</strong> after 45</td>
</tr>
<tr>
<td><strong>Gender:</strong> more men than women</td>
<td><strong>Gender:</strong> more women than men</td>
</tr>
<tr>
<td><strong>SES:</strong> tends to be lower</td>
<td><strong>SES:</strong> tends to be higher</td>
</tr>
<tr>
<td><strong>Drinking in response to stressors:</strong> Common</td>
<td><strong>Drinking in response to stressors:</strong> Common</td>
</tr>
<tr>
<td><strong>Family Hx:</strong> more prevalent</td>
<td><strong>Family Hx:</strong> Less prevalent</td>
</tr>
<tr>
<td><strong>Health:</strong> more problems related to</td>
<td><strong>Health:</strong> not as severe as pertains to</td>
</tr>
</tbody>
</table>
A person’s primary care physician would be able to tell a person if he or she had a problem with alcohol and/or medication. FALSE.

- Symptoms of substance use disorders often are overlooked or misdiagnosed as depression, dementia, and other health problems associated with aging. *Alcohol abuse creates and exaggerates medical and psychological problems.*
- Many older adults see more than one physician, may not inform physician of all medications being taken, including OTC medication.
- Questioning patients about alcohol consumption may not occur—health care professionals tend to see changes in mental and physical health status, but do not address the possibility of alcohol abuse/addiction as a cause of these changes.
- **Opioid manufacturers market their products for uses that they lack solid scientific data on the effectiveness and safety for older adults.**
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).
Is this old......
Or this?
Although 87% of older adults see a physician regularly, it is estimated that 40% of those who are at risk do not self-identify or seek help for substance abuse problems (Raschko, 1990). Conversely, physicians have been shown to miss the diagnosis of alcoholism in older adults, compared to identification in younger adults; literature reports those at risk for substance abuse are unlikely to be identified, regardless of frequency of contact. (Colleran, 2002)

94% miss diagnosis of alcoholism (CSAT)

Double denial (Kagan & Shafer, 2001)

Diagnostic criteria

Screening tools-use of a single screening tool may miss either long term alcohol users (AUDIT) or those with current risky levels

No standard definition of risk (alcohol)
Asking about medicine

- Asks every visit: 63.92%
- Asked in past year: 21.31%
- Has never asked: 8.23%

Physician Inquiry about medication
Asking about alcohol

- Asks every visit
- Asked in past year
- Has never asked

Cornerstone Psychological and Counseling Services
www.cornerstonetoday.com
The Abuse of alcohol and prescription drugs among adults 60 and older is one of the fastest growing health problems facing the nation—one that “remains underestimated, underidentified, underdiagnosed, and undertreated.”

CSAT, 1998
New Realities of Aging

- Aging is just living
- 100 million shades of gray
- Contributors NOT burdens
- Aging and longevity
- **Perceptions don’t match reality**
What’s in a number?

- Paul McCartney now....when I’m 74
And now......50 years later??
Case Review

David

- Pet loss
  - Wife is concerned
  - Doctor told me “you are dependent on alcohol, not an alcoholic”
  - Btw-was hospitalized for throwing up blood

Melissa

- History of chronic pain
- Alcohol use and medication for pain
- Married, stay at home mother, husband is physician
- Husband confronting her about use since he stopped alcohol use

6/14/2018

Cornerstone Psychological and Counseling Services
www.cornerstonetoday.com
Screening Older Adults
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

(Simon-Wastila, Yang, 2006)
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
  - Tool kit available from SAMHSA
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)
  - See BRITE, Schonfeld, 2010
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.americangeriatrics.org
Interventions
Interventions

- Prevention
  - Prevention BINGO
  - LIFEPOUCH
  - Project DUMP/Deterra Bags
  - Quick Screen
  - GAB groups
  - Screening Days
  - Lunch and Learn

- Treatment
  - Peer Recovery Support Services
  - Consider special needs-sensory/mobility
  - Integrative care
  - Recovery housing
PREVENTION BINGO

☐ 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 12 step “recipe”

Four key ingredients:

- Support, goal direction, and structure that emphasizes abstinence and the importance of strong bonds with family, friends, work, and religion
- Participation in substance-free social activities
- Identification with abstinence oriented role models and a consistent belief system that espouses a substance-free lifestyle
- Emphasis on bolstering members’ self efficacy and coping skills and helping others overcome substance use problems

12 Step Outcomes

- Delay in participation and dropout from SHGs foreshadows poorer substance use outcomes.
- Participation in SHGs can substitute for, bolster, and help to explain the benefits of treatment; it can also reduce health care utilization and costs.
- Less religious individuals appear to benefit from SHGs as much as do individuals who are more religious.
- Individuals who are court ordered to participate in SHGs benefit as much as do non mandated individuals.
- SHGs contribute to better substance use outcomes by providing support, goal direction, exposure to abstinent role models, reward for building substance free activities, and a focus for building self-confidence and coping skills.

Misconceptions

- False information spreads faster than truth
  - The “Christopher Columbus” concept
  - Confirmation bias-Facebook philosophy....the more you like something the more of that you see, which gives you a world view that is distorted in the direction of your beliefs....
- Change blindness
- Habituation
Chinese characters for crisis

JFK: “when written in chinese, the word crisis is composed of two characters, one represents danger, the other represents opportunity.”

The truth is.... “The explication of the Chinese word for crisis as made up of two components signifying danger and opportunity is due partly to wishful thinking, but mainly to a fundamental misunderstanding about how terms are formed in Mandarin and other Sinitic languages.” -Victor H. Mair

☐ It is scary how easily we take things at face value and accept them as “truths” or “facts” without ever doing the proper research.
The NEXT frontier....
September 8, 2018

- It’s as easy as 1-2-3
  - 1-book an appointment
  - 2-doctor evaluation
  - 3-ohio marijuana card
  - SCHEDULE NOW

www.ohiomarijuanacard.com
## Qualifying conditions

- Post traumatic stress disorder
- Inflammatory bowel disease
- Intractable pain
- Parkinson’s Disease
- Multiple Sclerosis
- Spinal Cord Disease or Injury
- Ulcerative Colitis
- Traumatic Brain Injury
- Sickle Cell Anemia
- HIV
- Tourette’s Syndrome
- Chronic Pain
- Glaucoma
- Fibromyalgia
- Cancer
- Crohn’s Disease
- ALS
- Epilepsy
- Hepatitis C
- AIDS
- Chronic Traumatic Encephalopathy
- Alzheimer’s Disease
Use of Medical Marijuana for PTSD: A Review of Current Literature

- NO large-scale, randomized, controlled study investigating efficacy of marijuana and PTSD symptomatology
- Correlation between PTSD and problematic cannabis use—may decrease symptoms at cost of increasing risk for a cannabis use disorder
- Neurobiological and animal studies suggest may help with arousal in amygdala

Do no harm

☐ Reuter’s Health News, August 14, 2017

- “little evidence shows cannabis helps chronic pain or PTSD”

- Review of 27 articles on use of medical marijuana for pain, 5 studies of cannabis for PTSD

- Not enough high quality research to produce conclusive evidence of the benefits or harms of cannabis for pain or PTSD, the two conditions people most commonly seek medical marijuana for in the U.S.
National Center for PTSD

- Negative coping and PTSD
  - Substance abuse
  - Avoiding others
  - Staying always on guard
  - Avoiding reminders of the trauma
  - Anger/violent
  - Dangerous behavior
  - Working too much

- www.ptds.va.gov, retrieved 3-30-2018
Marijuana is harmless

☐ Side effect of opiate epidemic is that no one is paying attention to what has been occurring in the background
  ■ Changes in perceptions of harmfulness
  ■ Grassroots efforts to legalize “medical” marijuana
  ■ It’s “natural”
  ■ 2nd hand smoke?
Addressing cannabis requires care and embracing the complexity...

- The use of “medical” may be construed as beneficial
- Marijuana is often associated with “natural”, “harmless”
Marijuana

Facts

- Marijuana use has increased over the past several years as the perception of its risk has declined
- Rates of initiation in youth, the ones most vulnerable to problems. Cannabis in adolescence is associated with adverse academic, occupational, cognitive, psychiatric and substance use outcomes.

Truth

- Marijuana use is associated with mental health disorders such as: depression, anxiety and suicidal thoughts among adolescents
- Marijuana impairs short-term memory, judgment and motor coordination and causes slowed reaction time
- Marijuana withdrawal symptoms-anxiety, irritability, sleep difficulty, cravings, strange nightmares
- Marijuana smoke irritates the lungs, can cause respiratory problems
  - www.attcnetwork.org/marijuanalit

- www.drugabuse.gov
Marijuana is the next treatment for Opiate addiction

“Marijuana legalization could help offset the opioid epidemic, studies find”  Mark Lieber, CNN

Cites JAMA Internal Medicine study

- Comparing opioid prescriptions under Medicare D and opioid prescriptions covered by Medicaid in states with and without medical cannabis laws
- In medical marijuana states, fewer opioid prescriptions were written
  - Lead author in the Medicare study, David Bradford, professor of public administration and policy at the University of Georgia: "Unlike opioids, marijuana has little addiction potential and virtually no deaths from marijuana overdose have been reported in the United States.

www.cnn.com retrieved April 2, 2018
Drug interactions

National Survey of Drug Use and Health (NSDUH) from 2002-2014 the number of adults aged 50-64 who reported past year use of cannabis *tripled* from 2.9 to 9 percent.
Generational Shift

- "...the population of older Americans in 2006 contained greater proportions of persons who had used or continued to use illicit drugs than did older Americans in 1985."

- White, et al., 2011
Baby boomers

- The National Survey on Drug Use and Health Report, December 2009, indicates that 4.5 million adults aged 50 and over (4.7%) had used an illicit drug in the period between 2006 and 2008 when data was gathered. The most commonly used substance among the 50-54 and 50 to 59 age groups was marijuana. Non-medical use of prescription drugs was more common in the 65 and older age group.

- Illicit drug use peaked in the U.S. in 1979 when baby boom cohort was 15-33 years old-at that time only 10% of current illicit drug users were +35

- 1995-49% of the baby boom cohort (when they were 31-49) had lifetime illicit drug use compared to only 11% of the +50 cohort
Cannabis Concerns for Aging Adults

- Health harms
- Drug interactions
- Memory effects
- Identification of misuse
Health Harms

- Respiratory issues, linked to airway injury and chronic bronchitis
- Increases heart rate, can reduce blood flow to heart in susceptible individuals,
Drug Interactions

- Cannabis may affect blood sugar (medication interactions for those on diabetes medication)
- Cannabis may increase amount of drowsiness caused by benzodiazepines, barbiturates and narcotics, and alcohol (drug interactions for those taking anti anxiety, anti depressants, pain medicine)
- Cannabis may affect blood pressure
THC good for aging brain?

- Low dose of delta-9 tetrahydrocannabinol given to young, mature, and aging mice
- Mature mice show improvement on behavioral tests of memory and learning

“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.”

Contact information

☐ Cindy McQuown, LPCC-S, LICDC, Ohio Citizen Advocates for Addiction Recovery

☐ Cornerstone Psychological and Counseling Services

☐ Medina, Ohio

☐ cmccg33@Hotmail.com
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  www.pathwayscourses.samhsa.gov
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☐ National Institutes of Health, Pathways to Prevention Workshop: The role of opioids in the treatment of chronic pain, September 29-30, 2014
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☐ [www.americangeriatricsociety.org](http://www.americangeriatricsociety.org)