

# Substance Use Disorders in Elderly Adults

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# Disclosures

- I have no conflicts of interest.



# Objectives

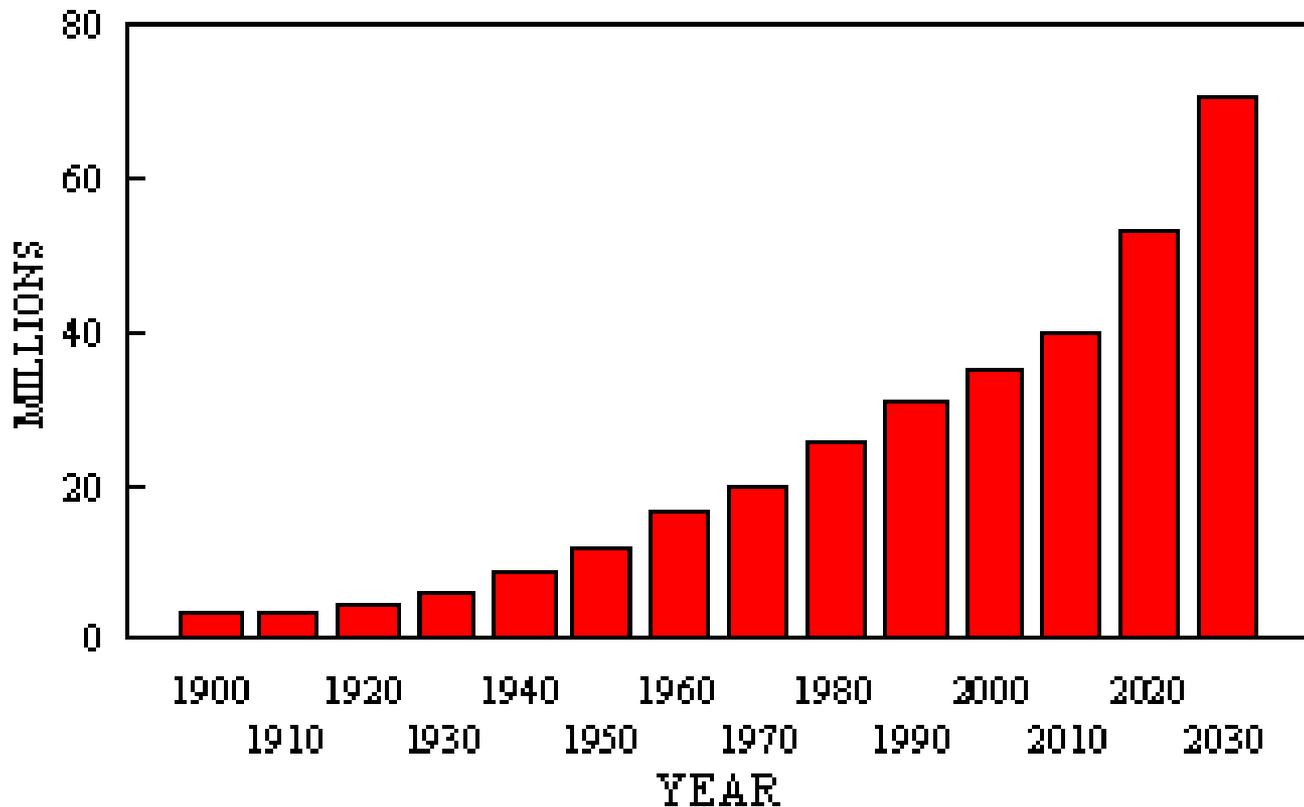
- To discuss epidemiology, screening, and treatment considerations substance use disorders in the elderly.
- To discuss common classes of substances used by the elderly.
- To describe the model of care of elderly patients with substance use disorders in the Palo Alto VA.

# Part 1: Epidemiology, Screening, and Treatment Considerations of SUDs in the Elderly



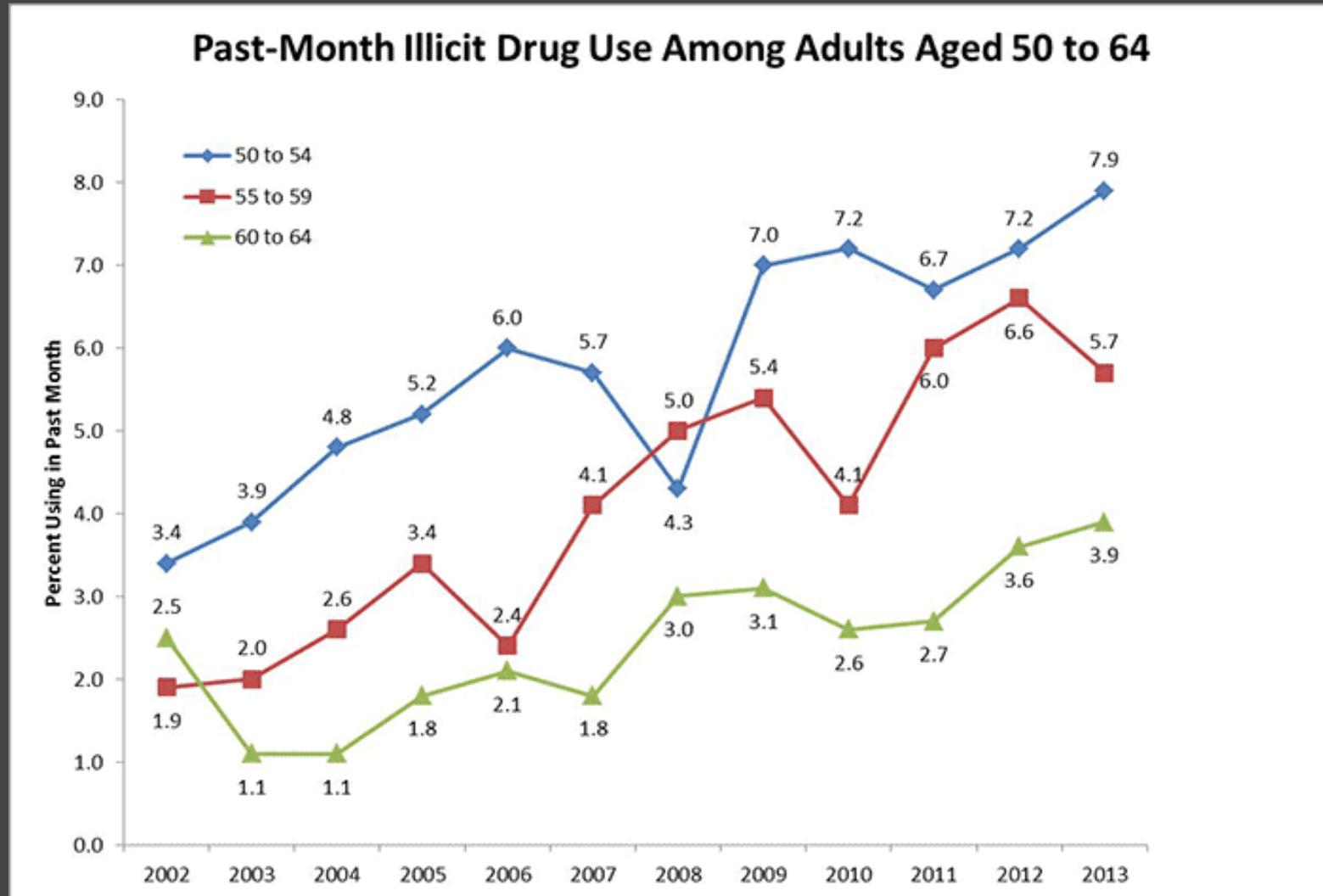
# The elderly population is booming!

**Growth of the Elderly Population**  
1900 to 2030



Source: U.S. Bureau of the Census

# Substance Use Increase in Older Adults



Source: drugabuse.gov

# Substance Use Increase in Older Adults

- In 2002-06:
  - 2.8 million (annual average) adults 50+ with substance use disorders
- In 2006-08:
  - 4.3 million (annual average) adults aged 50+ with substance use disorders
- By 2020, expected to rise to 5.7 million.

# Vulnerabilities to Substance Abuse Among Older Adults

- Loneliness
- Impaired cognition
- Impaired self care
- Diminished mobility
- Chronic pain
- Impaired sensory capacities
- Poor physical health
- Poor economic and social supports
- Losses
- Role changes
- Complex medical issues



# Misconceptions about Substance Use in Older Adults

- Older adults do not use illicit drugs.
- Older adults should be allowed to do what they want.
- Older adults are not good candidates for treatment.
- Substance abuse is “understandable” in the context of poor health and changing circumstances.

# Potential Clues to Substance Use Among Older Adults

- Medical and psychiatric
  - Headaches
  - Incontinence
  - Loss of motivation
  - Depression
  - Anxiety
  - Mood swings
  - Memory problems
  - Confusion
  - Blackouts
  - Poor or unusual response to medications
- Psychosocial
  - Family or marital discord
  - Impaired self care
  - New difficulties with ADLs
  - Falls or other injuries
  - Doctor-shopping
  - Drug-seeking behaviors

# Comorbid SUDs and Psychiatric Disorders

- Interactive and mutually sustaining.
- Rates range from 20-66%
- Associated with:
  - Increased suicidality
  - Increased functional and cognitive impairment
  - Greater inpatient and outpatient service utilization
  - Greater resistance to treatment of either condition
- Depression and alcohol use disorders are most common combination.

# Treatments and Interventions

- Need to take into consideration:
  - Age-related brain and physiological changes
  - Differences in the types of substances abused by older people
  - Different settings or contexts of substance use
  - Comorbid psychiatric and medical disorders

# Treatment and Interventions

- Compared with younger adults, older adults:
  - Are just as likely to engage in treatment.
  - Appear to respond comparably well.
  - Have better attendance at therapy sessions and greater adherence to medications.
  - Are more likely to report positive attitudes towards mental health and help-seeking.
- Older adults can be treated in mixed-age treatment settings.
  - Psychotherapeutic approaches have to be age-appropriate and delivered on an individual basis.

# Treatment and Interventions

- Relapse Prevention
  - Requires a shift in focus to address the special needs of this population.
    - Ie. identifying cues and triggers specific to this population, including social isolation and negative emotional states.
  - Example: group treatment approach that incorporates cognitive behavioral and self-management strategies delivered in 4 phases:
    1. Analysis of previous substance use behavior
    2. Identification of high-risk substance abuse situations for patients.
    3. Skills training
    4. Continuing care and follow-up.

# Intervention Strategies for Older Adults with SUDs

1. Be cognizant that even small amounts of drug/alcohol use can lead to excessive disability and poor functioning.
2. Note the clinical presentation of older adults with SUDs may be atypical or masked by comorbid medical or psychiatric illness.
3. Alcohol/drug detoxification may be needed, depending on the level of use, severity of withdrawal symptoms, and comorbid medical conditions.
4. Be cognizant of cognitive impairment's potentially interfering effects with therapeutic interventions.
5. A urine toxicology screen is a useful tool to confirm report of drug use or abstinence.

# Part 2 – Specific Substance of Abuse and the Elderly

- A. Alcohol
- B. Cannabis
- C. Opiates
- D. Benzodiazepines
- E. Methamphetamine/cocaine



# Alcohol

- Generally, alcohol consumption decreases with age.
- However, elderly people can safely tolerate lower amounts of alcohol than younger people.
- National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommended guidelines for adults >65:
  - No more than 2 drinks on a given day ( 1 drink for women)
  - No more than 7 drinks per week



# Alcohol

- Abstinent
  - 60-70% of older adults
- Low-risk drinkers
  - alcohol use with no problems
  - Intervention: prevention/education
- At risk drinkers
  - Drinking more than NIAAA recommended amounts
  - Increased chance of problems/complications
  - Intervention: minimal advice or brief structured intervention
- Problem drinkers
  - Experiencing adverse consequences
  - Intervention: Formalized alcohol treatment programs
- Dependent drinkers
  - Loss of control, physiologic dependence
  - Intervention: Detoxification, formalized alcohol treatment programs

# Alcohol

- 2/3 of elderly alcoholics are early-onset
  - Onset of drinking in 20s or 30s
  - More likely to experience alcohol-related medical and psychiatric problems
  - Less amenable to treatment than late-onset elderly alcoholics or social drinkers who are drinking more because of bereavement or other loss.

# Alcohol

- Physiological Adverse Effects
  - Higher risk of pancreatitis
  - Cirrhosis
  - Hepatitis
  - Stroke
  - Several types of cancer (mouth, breast, colorectal, liver, etc.)
  - Lack of vitamin absorption, leading to malnutrition and chronic diarrhea
  - Cardiomyopathy, atrial fibrillation, and hypertension
  - Impaired motor skills
  - Falls/injuries
- Psychiatric Adverse Effects
  - Alcohol-induced mood disorder
  - Pseudodementia from mood disorder
  - Suicide
  - Alcohol-induced cognitive impairment
  - Sleep problems
  - Diminished overall functioning

# Alcohol – Screening

- Start with: “How often do you have a drink that contains alcohol?”
- Follow up with: “How many days a week do you drink, and how many drinks per day?”
- Can follow up with screening questionnaires, such as:
  - Michigan Alcohol Screening Test – Geriatric Version (MAST-G)
  - CAGE
  - Alcohol Use Disorders Identification Test (AUDIT)

# Cannabis

- 2008 National Survey on Drug Use and Health
  - 2.8% of adults aged 50+ were past-year cannabis users
    - 23% of these had used marijuana on >50% of the days over the past year
  - Past-year users significantly more likely to be younger (50-64 y.o.), black, not married, have < high school education, and have significantly higher psychological distress score.
  - Cannabis users were more likely to smoke cigarettes, engage in binge drinking, and use other substances.



# Cannabis

- “Medical” marijuana has been heavily marketed by the cannabis industry for various medical conditions
  - Older adults suffering from serious medical problems may be attracted to this.



# Cannabis

- Adverse Effects
  - Anxiety or panic attacks (worse in elderly and women)
  - Impaired cognition (particularly short term memory and executive functioning)
  - Onset or exacerbation of pre-existing mood or psychotic disorders
  - Diminished overall psychosocial functioning

# Opiates

- Elderly heroin users in need of treatment are projected to increase over the next decades.
- Older patients on methadone maintenance treatment have poorer overall health status than younger people on same level of addiction.
- Prescription opioid abuse is increasingly common.
  - Chronic opioid use can dull cognition, diminish functioning, and cause misdiagnoses of dementia or depression.



# Benzodiazepines

- Adverse Effects in the Elderly:
  - Impaired cognition
  - Falls → Fractures
  - Driving accidents
  - Delirium
  - Dependence

# Benzodiazepines

- Prevalence 12-32% in elderly
  - 57-59% in those with psychiatric disorders
- Best treatment approach to benzodiazepine dependence is gradual withdrawal with psychotherapy

# Methamphetamine

- High degree of use in the northern California.
- Individuals use for a greater number of years before seeking treatment.
- Methamphetamine causes persistent psychiatric symptoms (neurotoxic effects last months/years)
  - Cognitive impairment (Inattention, working memory problems, executive functioning deficits)
  - Psychosis (persecutory delusions, auditory hallucinations)
    - Can lead to paranoid and violent behaviors
  - Persistent anhedonia

# Part 3 – Integrated Care of SUDs of the Elderly in the Palo Alto VA System



# Levels of Care

- Outpatient Mental Health Clinics
- Inpatient Psychiatry Units
- Addiction Treatment Services (ATS) Programs
  - Intensive Outpatient (IOP)
  - Foundations of Recovery (FOR)
  - First Step
- Homeless Veterans Recovery Program (HVRP)

# Outpatient Mental Health Clinics

- Not focused specifically on substance abuse, but cover substance abuse issues in the context of general mental health care.
- Psychiatry, psychology, social workers, NPs, etc.
- Many VA satellite clinics all over Northern California
  - Ie. San Jose, Menlo Park, Oakland, San Bruno, Martinez, San Francisco, etc.

# Inpatient Mental Health Units

- Useful for stabilization of acute psychiatric issues and detox.
- Palo Alto VA has 55 beds, divided into 3 units of 20, 20, and 15 beds.
  - One unit (B) is focused on the geriatric patients and women, the other units are for general male adults.
- Each unit has 2 psychiatrists, 1 psychologist, 1-2 social workers, 2-4 nurses, 1 recreational therapist, other support staff.

# Addiction Treatment Services (ATS) Programs

- FOR, First Step, and IOP
- Principle of milieu therapy.
  - Peers providing feedback to peers.
- Routine urine drug testing.
- No opiates (except replacement therapy) or benzos.
- Elderly people get same basic treatment as everyone else, but accommodations for special needs (ie. medical frailty, sensory impairments, etc.) are made as needed.

# ATS Programs

- Foundations of Recovery (FOR)
  - 28 days
  - Have contracts, have to pass certain benchmarks to move from one phase to the next.
  - Can take medically and psychiatrically complicated patients.
  - 1 psychiatrist, 1 psychologist, 2 social workers, 1 rec therapist, 24 hr nursing, half-time general medicine doctor.
  - Maximum census is 20.

# ATS Programs

- First Step
  - 90-day residential program in Menlo Park
  - More intense and confrontational than FOR
  - More opportunity to do individual therapy (weekly meetings with psychologist or psychotherapist)
  - 2-3 psychologists, 1+ psychiatrists, 3-4 social workers
  - Maximum census 30

# ATS Programs

- Intensive Outpatient (IOP)
  - 28 day program
  - 3 groups a day, 3 days a week (MWF)
  - Live at home or sober living environment.

# Homeless Veterans Recovery Program (HVRP)

- A program to help homeless veterans find housing and employment.
- Not under ATS – not strictly a substance use program
- Has a substance use component
  - Do relapse prevention and CBT classes focused on substance abuse issues.

# Elements of Integration in the System

- Common electronic medical record (across all of the United States)
- Same site of care for some programs
  - Ie. FOR is in same building as inpatient psychiatry
  - Allows for easy access and communication between teams
    - Ie. ATS social worker checking to see progress of a patient's detox before transitioning to FOR
- Cross-over of staff between ATS and mental health programs
  - Ie. A psychologist working in both FOR and inpatient psychiatry at the same time, with responsibilities in each domain.

# Points of entry into ATS (Addiction Treatment Services) Programming

- Self referral
- Referral from outpatient clinics
- Referral from inpatient medical/surgical units
- Referral from inpatient psychiatry
- Referral from any other VA program

# Questions??

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