

Addressing Addiction Among Older Adults

Thursday, April 21, 2016



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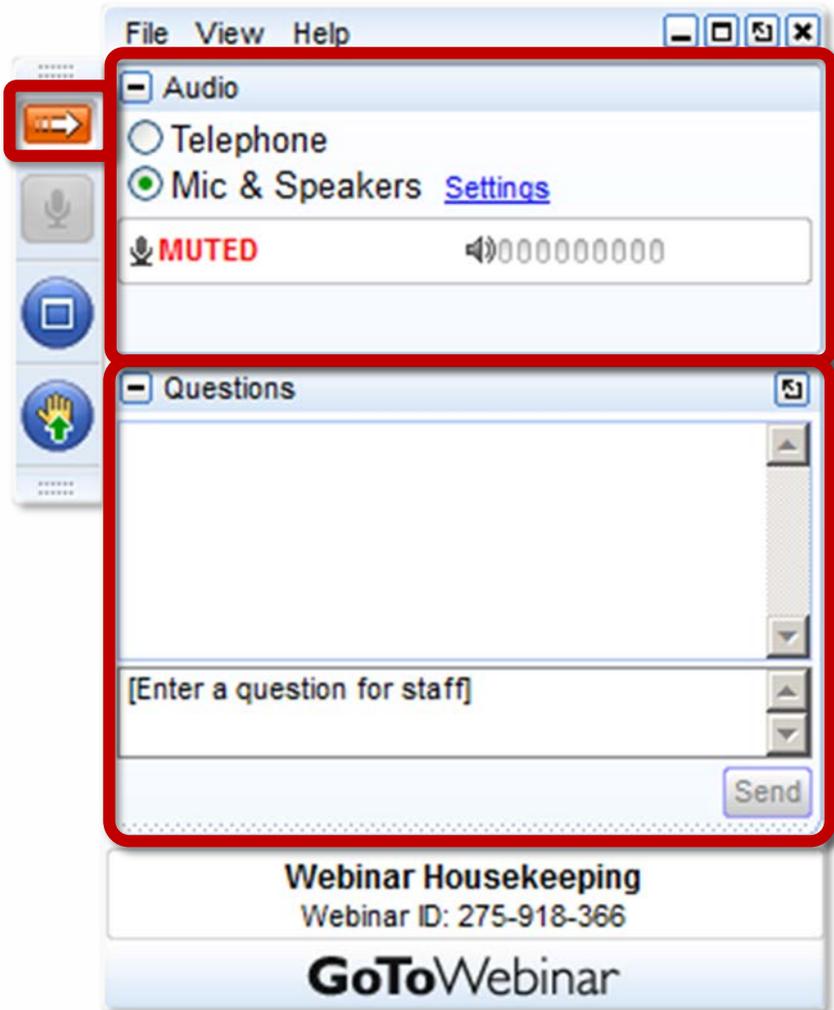
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SAE & Associates:
Older Adults and Addiction

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THE PROBLEM

- Adults 65+ will increase from 43.1 million in 2016 to 72.1 million by 2030.
- Currently, about 25% have a Mental Health or Substance Use (MH/SU) problem.
- Among adults 60+, SU, particularly of alcohol and prescriptions drugs, is one of the fastest growing health problems facing the country.
- Abuse of heroin and other opioids occurs in those who abused opiates in younger years.
- Primary care and other essential providers are not trained in MH or SU

www.aoa.ac/gov/aging_statistics/index.aspx

Karel MJ1, Gatz M, Smyer MA. Aging and mental health in the decade ahead: what psychologists need to know. *Am Psychol.* 2012 Apr;67(3):184-98.

Institutes of Medicine (2012). The mental health and substance use workforce for older adults. In whose hands. www.iom.edu/reports/2012





AGEISM – Collusion

- In the United States there is widespread stereotypic revulsion and fear about growing old.
- Family collude or ignore substance misuse by older family members:
 - “Grandmother’s cocktails keep her happy”
 - “Dad is old. What difference does it make?”
- Older people internalize these stereotypes
 - Avoid seeking mental health and substance abuse care
 - Fear of being classified as “senile” or “crazy”
- Providers may not acknowledge the need for SU treatment
 - Common belief that quality of life will remain poor for older people even if successfully treated for SU
 - Not worth the effort involved in treating or changing behavior: “They will die soon”
- Pharmaceutical companies
 - Drug trials routinely exclude subjects 60+
 - Without this input there is no way clinicians can predict adverse reactions.

Kydd A1, Fleming A. Ageism and age discrimination in health care: Fact or fiction? A narrative review of the literature. *Maturitas*. 2015 Aug;81(4):432-810.1016/j.maturitas.2015.05.002. Epub 2015 May 18.





UNDER THE RADAR: Diagnostic Challenges

- Physicians tend to spend little time with an older patient. Abbreviated office visits insufficient to identify underlying or potential SU problems.
- Cognitive, functional, and sensory impairments may complicate detection and diagnosis of behavioral health and substance use conditions.
- Symptoms of alcohol misuse is easily hidden
 - Presents in a manner similar to other diseases common as one ages
- Clinicians tend to overlook alcohol misuse in older persons with higher socioeconomic status
- Belief that alcoholics must be heavy drinkers

Losing objectivity: An older person may remind a clinician of a parent or grandparent; check your counter-transference!

www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/older-adults





INVISIBLE IN PLAIN SIGHT – Older Substance Using Adults

- Isolation - No longer in the workforce, with smaller social networks to observe changes or problem behaviors and provide support and recognition of misuse.
- Less likely to drive a car – Those who do drive under the influence or intoxicated are more likely to be stopped and identified with a substance problem; they and family are made aware of the substance problem with its legal ramifications. Those who do not drive are less likely to be identified socially and legally in need of care.
- Losses that occur, e.g., the death of a spouse, may trigger or worsen depression and lead to severe, debilitating symptoms that may complicate, trigger or mask substance misuse.
 - A major depression may be interpreted as normal grief.

Older adults who "self-medicate" with alcohol or prescription drugs are more likely to characterize themselves as lonely and having lower life satisfaction

Amoako EP Richardson-Campbell L, Kennedy-Malone L. (2003). Self-medication with over-the-counter drugs among elderly adults. *Gerontol Nurs*; Aug 29(8):10-15,





ACT LIKE A LADY: Women and Substance Misuse

Social stigma regarding addictions is greater for older women than men:

- Frequently better at concealing alcohol or drug misuse.
- Tend to drink less often in public places. They often drink alone and unobserved during and after.
- Are more likely to have had a problem-drinking spouse, to have lost their spouses to death, to have experienced depression, and to have been injured in falls.
- Women are prescribed more, and consume more psychoactive drugs, particularly benzodiazepines, than older men and are more likely to be long-term users of these substances. Length of prescribed time heightens the potential for substance misuse.
- Physicians tend to under-assess signs/symptoms of MH/SU in older women.

If a woman attributes her alcohol problems to a breakdown in morals, she is not likely to seek substance abuse treatment.





ADDICTION AND SLEEP

- 25% of older adults report a sleep problem which heightens their risk for self medication and substance misuse.
- Prevalence for comorbid psychiatric conditions is significantly higher in individuals with diagnosed sleep apnea.
- Multiple medications/substances for medical/psychiatric problems negatively impact on sleep. They include:
 - Alcohol
 - CNS stimulants
 - Beta blockers
 - Bronchodilators
 - Calcium channel blockers
 - Decongestants
 - Stimulating antidepressants
 - Thyroid hormones
 - Over-the-counter or herbal remedies

Poor sleep is associated with poor physical and/or mental health and diminished quality of life.





COMORBIDITY IN OLDER ADULTS

- Comorbidities that can complicate assessment and diagnosis of alcohol or substance misuse:
 - medical issues
 - cognitive impairment
 - mental health disorders
 - sensory deficits
 - lack of mobility
- Older persons with comorbidities may be discouraged from pursuing treatment for their substance abuse problems:
 - Discouraged from attending evening Alcoholics Anonymous (AA) meetings, if they cannot walk flights of stairs or drive after dark
 - Screened out of treatment programs because of poor cognitive tests or because health professionals do not think they will benefit.
 - Treatment programs may not have the facilities to accommodate their special functional needs.
 - Programs may not accept medicated older adults with mental health disorders.

Fillenbaum GG, Pieper CF, Cohen HJ, Cononi-Huntley JC, Guralnik JM (2000). Comorbidity of five chronic health conditions in elderly community residents: determinants and impact on mortality. *J Gerontol Sci Med Febl* 55(2):M84-89.





OLDER PERSONS FREQUENTLY SELF-MEDICATE

- Each year, adverse drug events (ADEs) - harm resulting from the misuse of medication - result in over 177,000 visits to emergency departments by older adults.
- Older adults often hide information from physician and self-medicate to avoid perceived social stigma and being judged.
- They swap drugs with friends/relations to save money.

The cost for treating preventable ADEs among Medicare enrollees has been estimated at \$887 million annually.

Dowling GJ, Weiss SR, Condon TP. Drugs of abuse and the aging brain (2008) Drugs of abuse and the aging brain. *Neuropsychopharmacology* 33(2):209-218.

Baillargeon L, Landreville P, Verrault R, Beauchemin JP, Gregoire JP, Morin CM. (2003) Discontinuation of benzodiazepines among older insomniac adults treated with cognitive-behavioral therapy combined with gradual tapering: A randomized trial. *CMAJ* 169:1015-1020





INDISCRIMINATE USE OF OVER-THE-COUNTER MEDICATIONS

- ✓ Antidepressants
- ✓ Anti-hypertensives
- ✓ Antihistamines
- ✓ Tranquilizers

- Some commonly used herbal remedies can be dangerous:
 - St. John's Wort: interferes with effectiveness of prescription drugs used to treat heart disease, seizures, transplant rejection
 - Chaparral and Germander: shown to cause liver damage (sale of Germander is forbidden in France)
 - Yohimbe: can contribute to renal failure, seizures and death
 - Ma huang: can increase risk for nerve damage, stroke and memory loss.





DEARTH OF GERIATRIC MH/SU PROVIDERS

General MH/SU providers are not trained in geriatrics care

- Primary care and other essential providers are not trained in either MH OR SU. Geriatric MH/SU specialists, who are the most highly trained to handle complex MH/SU cases, are in very short supply.
- No financial incentives encourage geriatric MH/SU providers to enter and stay in the field in geriatric care, and there is little support or mentorship for people who pursue this specialization.





ESSENTIALS FOR EFFECTIVE DELIVERY OF MH/SU SERVICES TO OLDER ADULTS

- Systematic outreach and diagnosis for treatment and access to care.
- Patient and family education on self-management and supportive interventions.
- Provider accountability for outcomes with early detection, treatment and referral.
- Close follow-up and monitoring to prevent relapse and to provide ongoing counseling, encouragement, education and assess motivation.
- Patient-centered care with location easily accessed by patients:
 - in primary care setting,
 - senior centers, and
 - individuals' homes.
- Coordinated by trained personnel with access to specialty consultation and knowledge of differential assessments and diagnosis.
- Care managers are critical to effective treatment and outcome to prevent gaps-in-care and appropriate transitions and pain management support.





WHY IS GERIATRIC SU TRAINING VITAL?

- Age alters the way people metabolize alcohol and drugs. Knowledge about the bio-chemical process and effects on behaviors and symptoms is essential.
- Commonly used medications may worsen physical or mental health problems and increase an older person's risk for dangerous overdose.
- Drug-to-drug interaction.
- Drug-to-disease interaction.
- Drug-to-alcohol interaction.
- Alcohol to disease interaction.
- What drugs are habit-forming?
- What are specific drug interactions/side effects?





WHEN EVALUATING A NEW SIGN OR SYMPTOM IN AN OLDER PERSON

Consider the following:

- ✓ Could the symptom be caused by too much or too little of a drug?
- ✓ Could the symptom be caused by an interaction between drugs?
- ✓ Could the symptom be caused by the way the drug is being taken?
- ✓ Are all the drugs absolutely essential or could some non-drug therapy be tried?
- ✓ Can any dosages be reduced? Can the regimen be simplified?





PRACTICAL BARRIERS TO TREATMENT

- **Transportation limitation scenarios**
 - Available to go to hospital but not to AA/ aftercare or evening programs - Rural communities lack public transportation as well as venues for treatment and support.
 - Accessing transportation in poor urban communities may be dangerous
- **Shrinking social support network**
- **Few programs have specialists in geriatrics**
 - Not designed to accommodate functional disabilities e.g. hearing loss or ambulation problems.
- **Financial limitations**
 - Carving out of mental health services from physical health services under managed care can prevent older adults from receiving inpatient substance abuse treatment or being accurately assessed for medical necessity due to substance misuse.





CHALLENGES IN TREATMENT SU IN ETHNIC OR CULTURAL MINORITY POPULATIONS

- Older minority adults in urban areas get health care delivered in busy hospital settings, reducing the likelihood of a comprehensive assessment and detection of alcohol or substance misuse.
- In order to access services, non-native English speakers with low language proficiency may need an interpreter or a family member who can serve as an interpreter. Non-direct communication effect disclosure and detection.
- Interpreters may un-intentionally bias their communications – Family pride, avoiding perceived social stigma, social/cultural roles- and thus reduce detection and treatment.
- Nationally, non-English-speaking ethnic cultural minorities have been at a disadvantage in treatment and therapy. Research shows evidence of:
 - Discrimination,
 - Culturally inappropriate prevention and treatment, and
 - Ignorance of belief system.

Cultural competence is crucial when the treatment provider has a different ethnic or cultural background than the client and with little awareness of acculturation factors and stressors.

<http://now.uiowa.edu/2013/06/states-show-large-racial-disparities-drug-treatment-success-rates>





A BIT OF GOOD NEWS, MOVING US ALL FORWARD

- Older adults are more likely to complete treatment and have outcomes that are as good as or better than younger adults.
- Communities that implement “gatekeepers” can watch for and report signs of depression and other psychiatric disorders (often exacerbated by substance misuse).
 - Postal carriers,
 - Police,
 - Apartment managers, and
 - Shopkeepers.

Supporting Mental Health First AID in the Community!





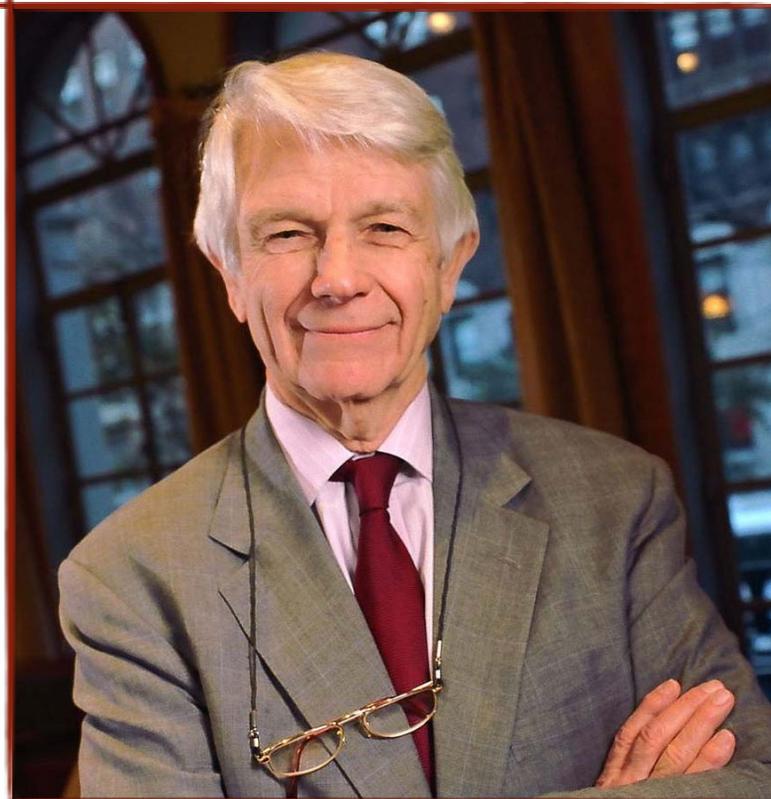
The breadth and magnitude of inadequate geriatric mental health and substance treatment workforce training and providers have grown to such proportions, that no single approach, nor a few isolated changes in disparate federal agencies or programs, can adequately address the issue. Overcoming these challenges will require focused and coordinated action by all.

Institutes of Medicine, 2008





Dedicated to Robert Butler, M.D. (1927 – 2010), a world renowned gerontologist, psychiatrist and Pulitzer prizewinning author of *Why Survive? Growing Old In America*. He was founder of both the National Institute of Aging and the International Longevity Center (ILC).



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Questions?

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