# Substance Use Disorders in Older Adults

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February 1, 2022

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Dr. Merrill, Dr. Mazanderani, and Dr. Davies have no conflicts of interest to disclose.

# Learning Objectives

**Part 1: General concepts**

- Understand current national trends in alcohol and substance use disorders
- Review risk factors and protective factors for substance misuse
- Identify the signs and symptoms of a substance use disorder
- Discuss screening for co-occurring mental health disorders

**Part 2: Alcohol**

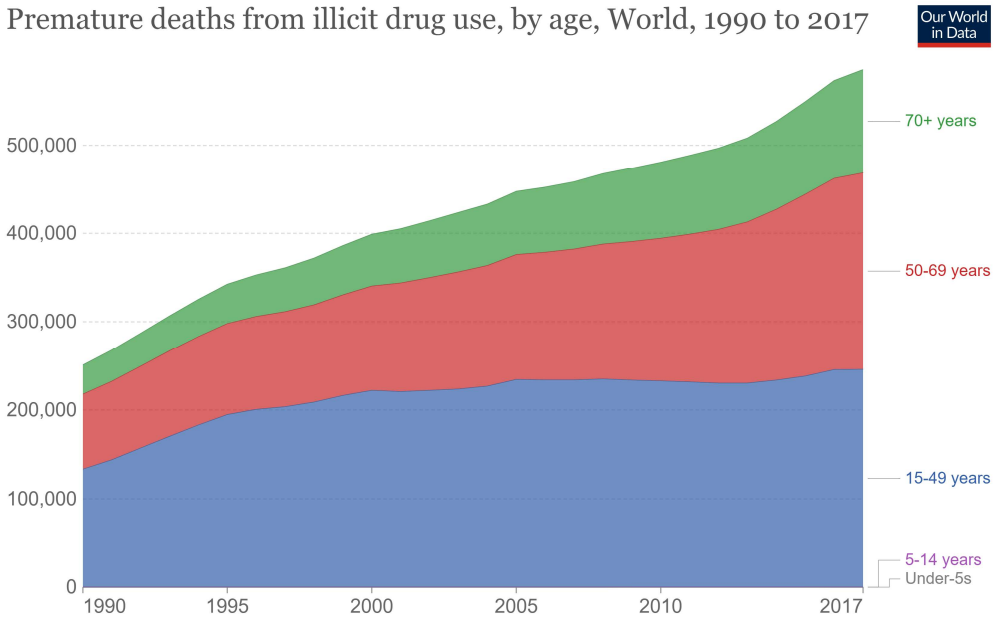
- Screen, assess, and consider pharmacologic treatment for patients with unhealthy alcohol use

**Part 3: Opioids**

- Assess and manage prescription opioids, including assessment and treatment of opioid use disorders

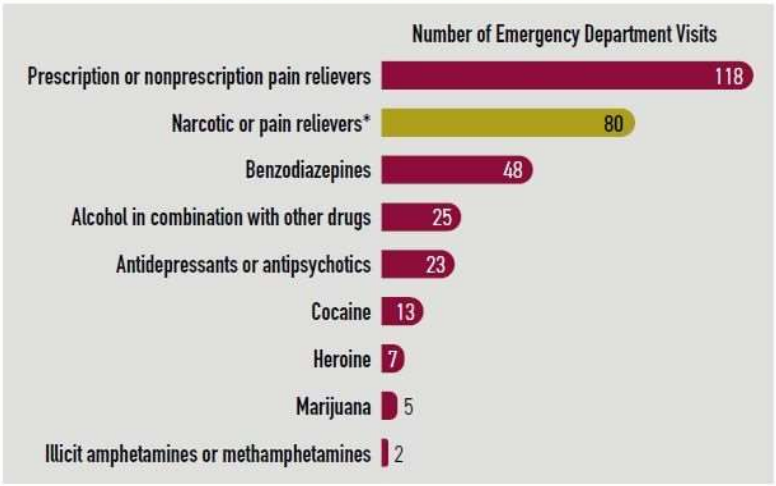
# Part 1: Understanding the Issue

- The number of older adults with SUD is increasing
- The older adult population is becoming more diverse
- Substance misuse among the geriatric population can increase risk of death and other physical harms
- SUDs are generally underdiagnosed in older patients




Other than alcohol and tobacco, **prescription opioids and benzodiazepines** are the most commonly misused substances among older adults.

Figure 1. Number of Emergency Department Visits for Drug Misuse on an Average Day for Patients Aged 65 or Older[A]




[A] by selected types of drugs; 2011 DAWN study

* Narcotic pain relievers are a subset of prescription or nonprescription pain relievers.

**Source:** SAMHSA, Center for Behavioral Health Statistics and Quality, Drug Abuse Warning Network (DAWN), 2011. Available at: https://www.samhsa.gov/data/sites/default/files/report_2792/ShortReport-2792.html

## Substance Misuse Risk Factors

- Social isolation
- Environment
- Physical health
- Mental health disorders
- Cognitive decline
- Economic stressors
- Lifetime or family history of SUDs
- High availability of substances
- Retirement (when not voluntary)

## Substance Misuse Protective Factors

- Resiliency
- Supportive relationships
- Supportive networks and social bonds
- Ability to live independently
- Access to basic resources such as safe housing
- Positive self-image
- Well-managed medical care and proper use of medications
- Sense of identity and purpose
- Retirement (when voluntary)

# Barriers to Seeking Treatment

| | | | |
|---|---|---|---|
| Negative Attitudes | Co-occurring Physical and Mental health conditions | Not having awareness of potential risks | Lack of Social Support |
| Accepting Attitudes | Lack of Knowledge | Misinformation about Treatment | Cultural Norms |

# Common Myths and Misconceptions

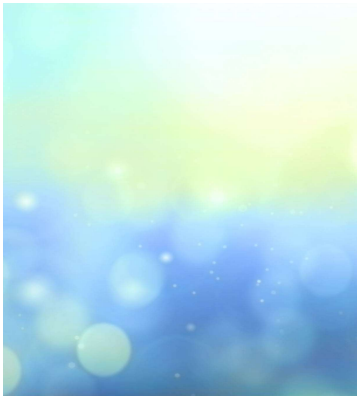
*She is only drinking to deal with her grief, and it's temporary*

*She can't get addicted at her age*

*He enjoys the tobacco smoking, it's his only pleasure in life*

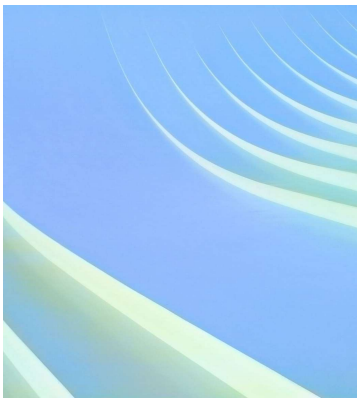
*My father is too old to change*

*He will never change his drinking habit*



## Signs and Symptoms of Substance Use

- Memory problems
- Changes in sleeping habits
- Unexplained bruises
- Irritability, sadness, and depression
- Changes in eating habits
- Wanting to be alone often
- Failing to bathe or keep clean
- Losing touch with loved ones
- Lack of interest in usual activities



## Diagnosing a use disorder: DSM-5 Criteria

**Severity**

Mild (2-3)

Moderate (4-5)

Severe (6+ symptoms)

1. Using in larger amounts or for longer than intended
2. Wanting to cut down or stop using, but not managing to
3. Spending a lot of time to get, use, or recover from use
4. Craving
5. Inability to manage commitments due to use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important activities because of use
8. Continuing to use, even when it puts you in danger
9. Continuing to use, even when physical or psychological problems may be made worse by use
10. Increasing tolerance
11. Withdrawal symptoms

## Clinical Considerations for Diagnosing SUD

- Older adults may need less of a substance to feel its effects
- Role responsibilities may be different because of life-stage changes, like retirement
- Older adults may not realize their substance use is related to social or interpersonal problems
- Older adults may participate in fewer activities, making it difficult to know whether a reduction in activities is related to substance use
- Older adults may not understand that their use is harmful, especially when using substances in smaller amounts.
- Older adults may not realize their substance use is related to physical (e.g., gastrointestinal distress) or mental problems (e.g., anxiety).
- Because of increased sensitivity to substances with age, older adults may have lowered tolerance depending on the substance used.
- Withdrawal symptoms among older adults can be less obvious and more drawn out

## Co-Occuring Mental Health Disorders

- Depression
- Anxiety
- PTSD and Trauma

# Screening Tools

| CO-OCCURING CONDITIONS | |
|---|---|
| Depression | • PHQ-9<br>• Geriatric Depression Scale (GDS) |
| Anxiety | • GAD-7<br>• Geriatric Anxiety Scale (GAS) |
| PTSD, Trauma symptoms, and elder abuse | • PTSD Checklist for DSM-5<br>• Primary Care PTSD Screen for DSM-5<br>• Elder Abuse Suspicion Index (EASI) |
| Cognitive Impairment | • Mini-Cog<br>• Montreal Cognitive Assessment (MoCA) |

# Mental Health Services

- Motivational enhancement
- Cognitive–behavioral therapy
- Individual and group therapy
- Mutual help programs
- Pharmacological treatments
- Couples and family therapy
- Brief advice or targeted education
- Telephone-based brief interventions
- Outpatient/Inpatient treatment

## Take home points

- Substance use is increasing among geriatric populations, and is associated with negative health outcomes
- Reduce barriers to care by providing person-centered care
- Signs and symptoms of SUD may be subtle and can manifest as medical or mental health disorders
- SUD criteria may not fully apply to older adults
- Older adults can benefit greatly from routine screening and treatment of co-occurring mental health disorders

## Thank you!

Questions?

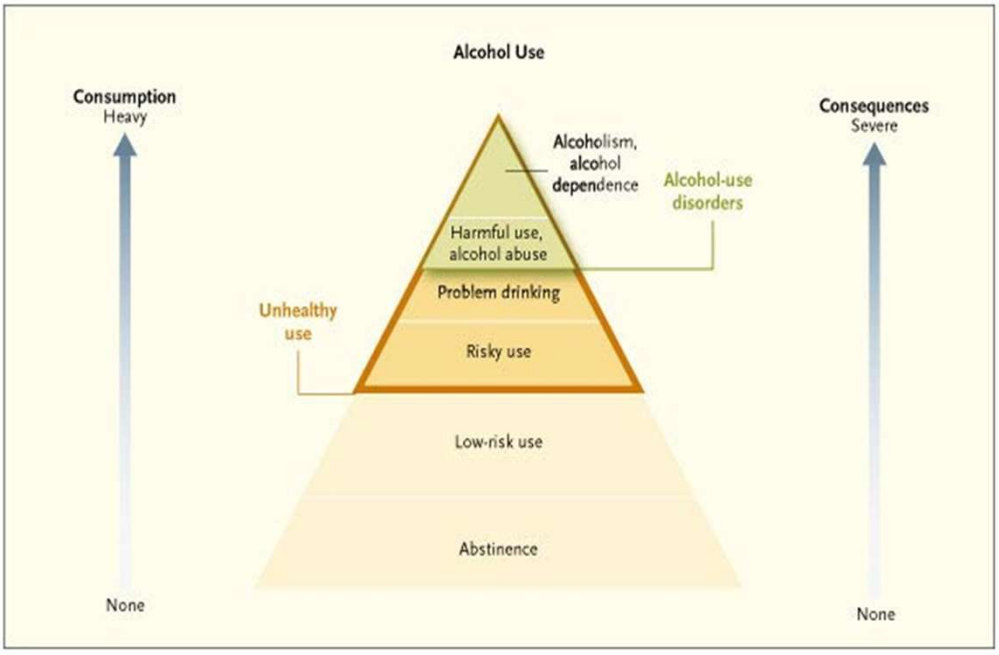
# Unhealthy Alcohol Use in Older Adults

- Screening to identify unhealthy alcohol use
- Have a conversation about alcohol use
- Diagnosing alcohol use disorder (AUD)
- Brief intervention for at-risk drinkers (no AUD)
- Options for making a change in drinking
- Pharmacotherapy for alcohol use disorder

**Alcohol is the most common substance use issue in older adults:**

- 50% of adults over 65 consume alcohol
- 14.5% of those who drink have unhealthy use
- 53% of those who drink had hazardous or harmful drinking

- Alcohol metabolism less efficient - smaller amounts can be problematic, withdrawal lasts longer
- Binge drinking and treatment admissions increasing
- Under-diagnosed – presents as medical and mental health issues, or as medications not working




# Alcohol Screening

USPSTF recommends primary care alcohol screening.

**"Do you sometimes drink alcoholic beverages?"**

**If no, assess for prior issues:**
"Have you ever had problems with alcohol?"
"What made you decide not to drink?"

**If yes:**
"How many times in the last year have you had 5 (4 for women, >65 yo) or more drinks in a day?"
82% sensitive, 79% specific for **unhealthy alcohol use**

>4 (3) drinks/day, 14 (7) drinks/week – may need math!

* Alcohol screening tests specific to older adults exist, but are longer (e.g. Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G)

## Assess for Alcohol Use Disorder

- **Have a conversation about unhealthy alcohol use:**
  - "Tell me more about your alcohol use" or "where does alcohol fit into your life?"
  - "What are some of the good things about alcohol?"
  - "What are some of the less good things?"
  - Prior treatment of any kind is important to identify
  - Listen for reasons to drink (coping, pain, mental health)
- **Demonstrate curiosity and a non-judgmental stance**
- **Goals are to have a supportive conversation and identify those with alcohol use disorder**

## Alcohol Use Disorder – DSM-5

- Larger amounts than intended
- Persistent desire to cut down or quit
- Use despite knowledge of harms
- Time spent taking, obtaining, recovering
- Failure to fulfill role obligations
- Use despite interpersonal consequences
- Reduced social, recreational activities
- Use in hazardous situations
- Craving
- Tolerance
- Withdrawal

**SEVERITY**

**No SUD: 0-1**
**Mild: 2-3**
**Moderate: 4-5**
**Severe: >5**

Moderate-severe SUD ≈ alcohol dependence (DSM-IV)

## Alcohol Use Disorder in Older Adults

- Drinking to cope with mental health issues
  - Depression, anxiety, PTSD, cognitive decline
- Drinking interacts with medical issues
  - Pain, HTN, sleep, mobility risk, GERD, liver disease
- Drinking to cope with isolation – listen for changes in support system, environment, activities, livelihood
- Polypharmacy is a key risk, especially CNS meds
- Stigma is a barriers to seeking treatment
- Addressing these issues is key to treating older adults

## Brief Intervention for At-Risk Drinkers

- Summarize patient's pros and cons of drinking
- For key medical issues (HTN, sleep, depressions, etc.)
  - "What do you know about the health effects of alcohol?"
  - "Can I let you know some other effects?"
  - "What do you think about that?"
- Ask permission to educate or advise
  - "I am concerned about your drinking because…"
  - "Quitting or cutting down would be safer for your health"
- Assess readiness to change
  - "What would you like to do about your drinking?"
  - Cut down? Stop? Make no change now?

# Which Choice is Best?

**Reasons some people decide to cut down…**

Few problems; able to drink less in the past; like drinking but want to lose weight; see if cutting down and setting a limit would work

**Reasons some people decide to stop drinking…**

Health risks; hard to control drinking; cutting back hard; found non-drinking friends and activities; family history

**Reasons some people decide not to change…**

Need buy-in from partner before changing; decided to track drinking instead; get help with sleep or mood first and see if drinking improves

# Menu for Alcohol Use Disorder Treatment

Set a drinking goal (none is safest)

- Measure drinks, alternate drinks, eat first, etc.
- Many tools at www.rethinkingdrinking.niaaa.nih.gov

Counseling (1-on-1 or couples)

- Often skills-based (CBT, CRA, etc) or motivational (MI)
- Addresses drinking to cope

Group-based alcohol treatment (“rehab”)

- Outpatient, IOP, residential (often 12-step focused)

Peer support programs (AA, Smart Recovery, etc.)

Medication for alcohol use disorder

## What We Know from Research

- **Most people get better** – they take different paths
- No one treatment is best for everyone
- People do not need to hit "rock bottom" to change
- Counseling helps 2 of 3 people
- Outpatient programs work as well or better than inpatient programs for most people
- AA helps people who want to stop drinking – other peer support programs not as well studied
- Stopping drinking is surest was to prevent problems

## Pharmacotherapy for Alcohol Use Disorder

Offer to those with moderate-severe AUD

Goals: **abstinence** vs **reduction** in heavy drinking days

- Number of heavy drinking days (≥5 for men, ≥4 for women) most closely associated with negative life consequences
- Experts recommend treatment for at least 6 months

Assess withdrawal risk – do they need medical detox?

- Those with prior complications need inpatient support
- Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

# Naltrexone
(Revia PO, Vivitrol IM)

- First line for most AUD patients not taking opioids
- Blocks mu opioid receptors
- Safe in active drinkers – moderates heavy use
- Safe with AST/ALT < 5 X ULN (few data in decompensated cirrhosis)
- Daily oral or monthly IM formulations
- Side effects: nausea > headache, dizziness often improve with continued use. Can lower to 25 mg PO.
- Injection site reactions can occur with IM formulation

# Acamprosate (Campral)

- Generally second line treatment due to dosing - likely as effective as naltrexone
- Affects glutamate, NMDA (withdrawal, reward)
- Dose is 666 mg TID
- Consider in abstinent patients - reduces return to use
- Safe in liver disease, but adjust dose in renal failure
- Side effects include diarrhea, nervousness, fatigue, which improve with continued use

# Disulfiram (Antabuse)

- Not usually recommended unless dosing can be supervised in highly motivated patients
- Causes build-up of toxic alcohol metabolite, so **must be abstinent to initiate**
- Dosed daily and active up to 14 days
- Side effects mild: fatigue, headache

## Non-FDA Approved Medications

### Gabapentin

(1800 mg per day divided)

- In post-acute withdrawal setting, increased abstinence and decreased heavy drinking with 12 weeks of treatment, with sustained benefit at 6 months
- Large trial of long-acting gabapentin showed no benefit
- Another trial found large effect in those with greater alcohol withdrawal severity, not with less withdrawal
- Gabapentin/naltrexone better than naltrexone alone
- Consider especially in those with alcohol withdrawal and/or a separate indication for gabapentin

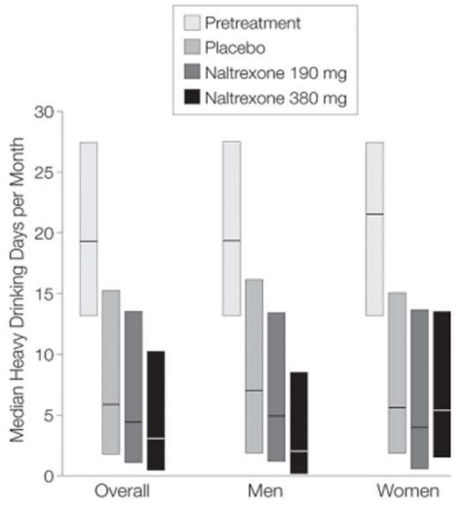
### Topiramate (Glutamate, GABA)

- Effective in multiple RCTs in reducing drinking
- Look out for cognitive impairment, sedation, kidney stones
- Consider in those with another indication for topiramate

### Prazosin (alpha-1 adrenergic antagonist)

- Effective for PTSD symptoms in multiple trials
- Effective in single trial of AUD without PTSD
- Consider especially in those with PTSD

**Median Heavy Drinking Days per Month for Each Treatment Group Overall and by Sex**




Garbutt, J. C. et al. JAMA 2005;293:1617-1625.

JAMA



# Pharmacotherapy is Underutilized

- Prescribed for <9% of Americans with moderate-severe alcohol use disorder
- Relapse rates are high (80% within one year) after non-pharmacologic treatment
- Effect size of pharmacotherapy for alcohol use disorder comparable to antidepressants
- Placebo effect appears strong

## "But I Don't Have Time for All This!"

Busy clinicians worry they don't have time to provide good SUD assessment and treatment

### Ways to make it work in primary care:

- Don't do it all today - conversations happen over time
- Use a problem list – where did the conversation end?
- Track plans – note when not revisited to remind yourself
- Reduce education and focus on the "why" of change
- Make an extra appointment about options for getting help

## Take home points

SCREEN FOR UNHEALTHY USE WITH SINGLE QUESTION

IF POSITIVE, ASSESS FOR ALCOHOL USE DISORDER

HAVE A CONVERSATION ABOUT PATIENT CONCERNS, GOALS, AND OPTIONS

PERFORM A BRIEF INTERVENTION FOR THOSE WITH UNHEALTHY ALCOHOL USE

PRESCRIBE PHARMACOTHERAPY FOR MODERATE-SEVERE ALCOHOL USE DISORDER!

# Opioids and Older Adults

- Screening and diagnosis
- Medications and why they work
- Is it OUD or chronic pain or both?

## Understanding the Issue

Adults > 65 have increasing rates of opioid use disorder and opioid-related ED and hospital visits.

Older adults are at particularly high risk for negative health outcomes:

Increased risk of injury and falls
Cognitive impairment
Medication interactions
Overdose, which can be fatal
Suicide
Liver and heart disease
Sleep problems

# Screen

**USPSTF (Grade B):**

Screen by asking questions about unhealthy drug use in adults 18 years or older.

Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

**Caveat:**

No direct evidence that screening is beneficial, and studies have found that brief interventions are NOT effective for substances other than alcohol.

**Nonetheless:**

Screening is reasonable – helps identify comorbidities, inform use of medications, diagnose related conditions.

# Diagnosing a use disorder: DSM-5 Criteria

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*Do not apply if caused by a medication taken as prescribed.*

# Treatment for OUD in Older Adults

**Goals of medication:**

Prevent opioid withdrawal and cravings

Reduce the risk of overdose

**Methadone****

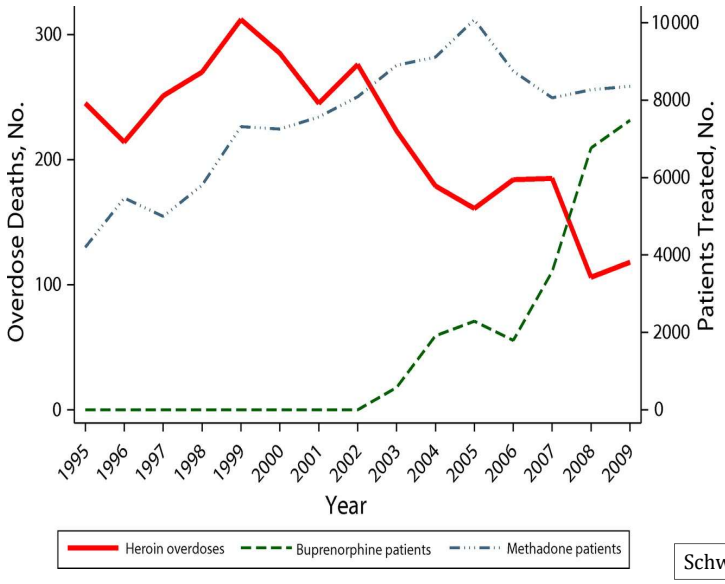
**Buprenorphine-naloxone****

**XR Naltrexone**

**(Naloxone**)**

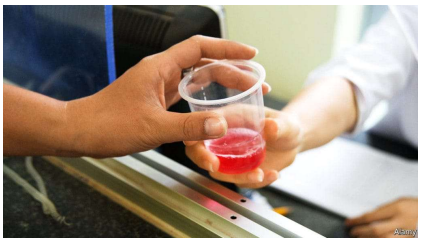
**WHO essential medications

## Opioid agonist treatments and heroin overdose deaths: Baltimore, Maryland, 1995-2009




Schwartz, AJPH, 2012

## Methadone



Highly regulated, illegal to prescribe for OUD in primary care

## Buprenorphine-naloxone

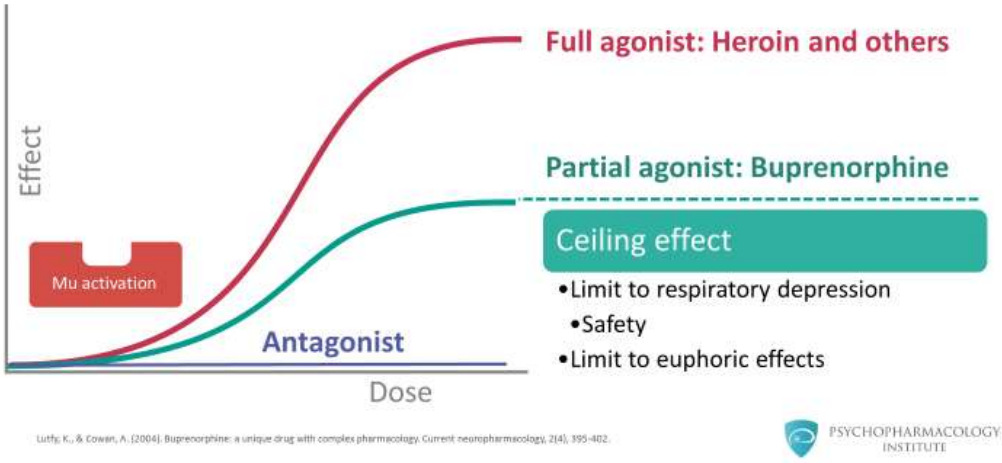

Can be prescribed in general practice, lowering barriers to treatment

**Similar** decrease in cravings and remission of substance use.

**Both protect against overdose**, but suboxone may have lower mortality risk.

In general, higher treatment retention rates with methadone.

## Why is Overdose Potential Low with Buprenorphine?



## Naltrexone


Usually given as a monthly injectable

More difficult to start, but effective if you can.

Limited research on older adults with OUD, but found to be safe and acceptable in older adults with AUD

## ***Naloxone***


Can rapidly reverse overdoses
(older adults are at increased risk of opioid overdose)

Safe and effective in older adults

## Is it chronic pain, opioid use disorder, or both?

**Common threads:**

- Similar risk factors and neurobiology
- Chronic, recurrent conditions
- Treatment involves medication, self-management, and social support

**Questions to explore:**

Are you concerned about addiction or loss of control? Are others concerned?

Do you sometimes have worse pain and take more medication, then go without later?

Have you wanted to cut down or quit? Why?

Do you find yourself thinking a lot about your pain medication?

Is reduced function a result of pain or opioids?

OUD diagnostic criteria can be difficult to apply clearly in patients on high dose opioids for chronic pain

## Rationale for Switching to OUD Rx

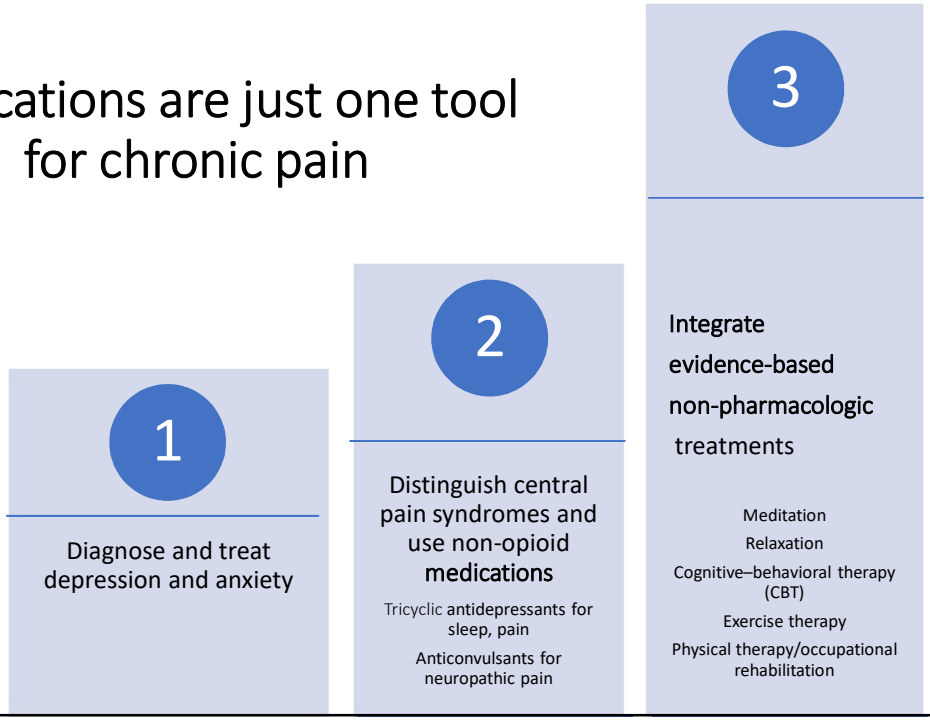
- Medication treatment for OUD with **buprenorphine** or **methadone** is safer than high dose opioids
- Data is limited, but many patients do well with a transition to OUD treatment
- Side effects from opioids, like sedation and withdrawal, are often reduced, increasing function
- Stabilizing the patient's opioid systems allows for other forms of pain treatment

## Who Should Switch to Buprenorphine?

- Anyone with an opioid use disorder that is leading to unsafe medication use – yes!
- Patients with opioid use disorder and chronic pain whose function has not improved with high dose chronic opioid therapy – yes
- Any patient with opioid use disorder on high dose opioids – probably
- Any patient on high dose opioids – maybe*
- Patients getting functional improvement with low dose opioids – no (maybe taper, maybe not)

* Most buprenorphine products not FDA approved for pain treatment

## Medications are just one tool for chronic pain




## Take home points

- The opioid epidemic has impacted all demographic groups, including older adults
- OUD treatment with buprenorphine or methadone is highly effective
- Conversations to diagnose OUD are important
- Learn to treat OUD with buprenorphine
- Don't forget to treat chronic pain effectively

# References and Resources:

Blow, Frederic C. **TIP 26: Substance Abuse Among Older Adults: Treatment Improvement Protocol** (TIP) Series 26. *https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-011%20PDF%20508c.pdf* accessed 1/25/2022

Wilson SR, Knowles SB, Huang Q, Fink A. **The Prevalence of Harmful and Hazardous Alcohol Consumption in Older U.S. Adults**: Data from the 2005–2008 National Health and Nutrition Examination Survey (NHANES). *J Gen Intern Med*. 2014;29(2):312-319. doi:10.1007/s11606-013-2577-z

Gazelka HM, Leal JC, Lapid MI, Rummans TA. **Opioids in Older Adults: Indications, Prescribing, Complications, and Alternative Therapies for Primary Care.** *Mayo Clin Proc*. 2020;95(4):793-800. doi:10.1016/j.mayocp.2020.02.002