Substance Use Disorders Among the Elderly: Unique Factors & Treatment Considerations

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Objectives

• Identify trends in substance use disorder and misuse among the elderly

• Identify key developmental considerations

• Identify unique social and biological factors related to substance use disorder among the elderly

• Identify some specific treatment considerations in working with the elderly
Changing Demographics

• Number of Americans 65 years + is projected to double to over 98 million by 2060. The group’s share of the population will rise to nearly 24% from 15%  (Mather, Jacobsen & Pollard, 2015).

• Alaska saw a 52.1% increase in its age 65 years and older population between 1999 and 2009.
  • Top growth rate for any age group in the United States and 3.5 times the national growth rate.

• Alaska Native population 65 and older is estimated to triple between 2000 – 2008.  (Skewes & Lewes, 2016)
## Divorced Among 65 years and Older

(Mathers, Jacobsen, & Pollard, 2015)

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<th>1980</th>
<th>2015</th>
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<tbody>
<tr>
<td>Women</td>
<td>3%</td>
<td>13%</td>
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<td>Men</td>
<td>4%</td>
<td>11%</td>
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Epidemiology

• Alcohol and prescription drug misuse affects up to 17% of maturing adults.

• Estimated that 15% of non-institutionalized mature adults are at risk for alcoholism

• Up to 50% of mature adults residing in nursing & continuing care retirement communities drink at least moderately or have problems related to alcohol abuse.

• Briggs et al (2011)
Unique Developmental Factors & Concerns
Retirement

• As age increases, stressors move from acquiring new roles and responsibilities to giving up new roles and responsibilities.

• Kuerbis & Sacco (2012) provide a thorough review of the complicated relationship of retirement to drinking, but:
  • Those who had significant drinking pattern prior to drinking increased drinking.
  • Retirement planning has a moderating effect.
Bereavement

• Because of increased longevity of mature adults (73 yrs.-Men; 80 yrs.-Women), bereavement has become a salient issue.

• Widowhood: 14 yrs. For women
• 7 yrs. For men

Women living alone

• 27% of women age 65 - 74 years

• 42% of women age 75 – 84 years

• 56% of women age 85 years +

(Mather, Jacobsen & Pollard, 2015)
Bereavement Consequences

• Bereavement has been found to increase the risk of major depression episodes and anxiety-related symptoms and disorders; impaired immune function; increased physician visits; poorer physical health; increased use of alcohol and cigarettes; suicide; and mortality from causes not restricted to suicide.
Falls

• 1 in 3 people 65 years and older fall each year

• Community dwelling: 25 – 40%
• Residential settings: 70%

• Approximately 10% require hospitalization
• Hip fracture: 1/3 of pts. die within 12 mos.

• 50% recovery rate
Falls & Anxiety

• Balance disturbances and symptoms anxiety disorder share central neural circuits.

• Physical insecurity triggered by dizziness and unbalance lead to psychological insecurity, loss of self-confidence, panic and anxiety.

Teixeira, et al. (2016)
Co-morbidity

- Approximately 1/5 of mature adults have a psychiatric disorder:
  - 1/3 of primary care patients
  - 65 – 95% of nursing home patients

Flint (2005)
Anxiety

• Data from 1984 ECA survey found that 7.3% of mature adults reported an incidence of anxiety in past year.

• Bereavement precipitates anxiety in nearly $\frac{1}{4}$ of survivors during first 6 mos. Following death of loved one and $\frac{2}{5}$ of those during second 6 months.

Flint (2005)
Depression

• Prevalence of clinical depression estimated to be from 9% to 49%, including long term facilities.

• Less likely to report saddened mood and crying spells. Instead, tend to present with anorexia, disruption in sleep patterns and fatigue.
Suicide

• Highest rate of completed suicide among all population groups is in mature white men who have become excessively depressed and drink heavily following the death of their spouse.

• Alcohol abuse and problem drinking are found in up to 30% of elderly suicides
  Briggs et al (2011)
Suicide Attempts

• Among 15 to 24 y/o approximately 100 to 200 suicide attempts for every completed act.

• Among 65 y/o (+) 4 suicide attempts for every completed act.

Morin et al (2013)
Medication Use & Misuse
• 82% of adults over 65 years take at least 1 prescription drug.

• 30% of adults over 65 take 8 or more prescription drugs a day.

Briggs et al (2011)
Benzodiazepines

• Make up 17 – 23% of drugs for mature adults.
  • 95% for insomnia and anxiety
  • 5% for general anesthesia, muscle relaxants, or anti-convulsants

Assem-Hilger, Weissgram, Kirchmeyer, Fischer, & Barnas (2009)
According to 2005 National Survey on Drug Use and Health Report, opioids account for the majority of prescription drug related emergency department visits for persons 55 years and older.

This number is projected to double.
Over-the-Counter Medications

• Mature adults utilize more OTC drugs than any other age groups.

• Combination of alcohol and OTC medication is most common source of adverse drug reactions in the elderly.
Prescription Medications

• Estimated that the number of mature adults abusing prescription medications will increase from 1.2% in 2001 to 2.4% by 2020.

• Number of mature adults using psychoactive medications w/o prescription is projected to increase by 190%, from 911,000 in 1999 to 2.7 million in 2020
Physiological Changes with Maturing affecting metabolism and excretion

- Physiological changes that occur naturally with maturing result in increased sensitivity and decreased tolerance to alcohol and drugs.
Increased concentration and longer duration of substances due to:

- Decreased absorption rate in GI system thought to occur as a result of a decreased blood flow to the system.

- Kidney function slows down, resulting in slower excretion of drugs and alcohol.

- Maturing or disease-related changes in liver function resulting in slower metabolic function.
• Decreased lean body mass.

• Decreased body water produces higher concentration of alcohol and drugs.

• Concentration of lipid soluble drugs, particularly benzodiazepines, increases and the effects increase.

• Benshoff, Harrawood & Koch (2003)
Women & Prescription Medication

An estimated 11% of women over 58 years are addicted to prescription medicine.

About 1% of this receive treatment.

Illicit Drug Use

• Illicit drug use by adults, 55 to 59 years, increased from 1.9% in 2002 to 5.0% in 2008.

• Among older adults in SUD tx. there has been a steep reduction in % reporting alcohol as primary drug from 84.2% to 57.2%
  • Heroin and cocaine more frequently reported.

• Tends to be younger drug users who have survived.
Substance Use Disorders & The Elderly
Cohort Effect

- Birth cohorts that had higher rates of illicit drug use in youth or younger adulthood experience higher rates of use as they age than other groups.

- More disposable income and a “quick fix” society.

- Easier access to prescription drugs, advertising have decreased stigma.
Alcohol Use Disorders

• Early Onset:
  • Began before 65 and continues to consume.
  • Represents approximately 2/3 of abusers.

• Late Onset:
  • Onset 65 or after, usually in response to negative life situation.
  • Tend to have fewer physical and mental health issues.
• Problem drinking: 1 – 15%

• Etoh Dependence: 1.6% - 4% up to 17%

• Approximately 11 – 20% of acute care hospital admission among the elderly are alcoholism related.
  • 21% of hospitalized adults over 40 have diagnosis of alcoholism
Early Onset

• Long standing alcohol problems with onset before 40.

• Majority of mature adults receiving SUD tx.

• Higher psychiatric comorbidity
Data from Epidemiological Catchment Area Studies (ECA)

• 3% male alcoholics between 50 and 59 years reported 1st sx. after 49.
  • 15% between 60 and 69 years.
  • 14% between 70 and 79 years.

• 16% female alcoholics between 50 and 59 years reported 1st sx. after 49.
  • 24% between 60 and 69 years.
  • 28% between 70 and 79 years.
Late Onset Drinkers

• More likely to begin drinking or increase drinking in response to loss, retirement, or change in health status.

• More likely to characterize themselves as lonely and report less life satisfaction.

• Increased amount of free time and lessening of role responsibilities may serve as etiological factors.
Late Onset Drinkers (Cont.)

• Mild abuse and more successfully treated

• Tend to have better prognosis for recovery.

• Most under-recognized population

• Menninger (2002); Benshoff, Harrawood, & Koch (2003)
Barriers to Treatment
Treatment Concerns

• Decreased mobility- lack of access

• Sight and Hearing decline

• Treatment that focuses on the “causes” tends to be more effective.

• 90% of those at risk for alcohol dependence never receive substance abuse services
Contributing to Failure to Identify

• Criteria used for assessing not as applicable to elderly

  • Not as active in mainstream activities

  • Less likely to get into trouble with law

  • Retired- less chance of drinking/drug use causing employment difficulties

  • May attribute signs to aging or other conditions
Barriers to identification

• More likely to hide use due to stigma and shame.

• Family complicity:
  • “Grandma’s cocktails are the only things that make her happy.”
  • “What difference does it make- they won’t be around much longer anyway.”

• Family member embarrassment
Ageist Attitudes & Beliefs

• Older people are too old to change their behavior

• It’s not worth devoting time and energy to older people who are towards the end of their life span.

• Belief that it's wrong to deprive older people of their “last pleasures in life.”

• Older people don’t have sex or drink too much.
Suggestions for Assessment & Treatment
Screening & Assessment

• Lost opportunities in just asking/inquiring

• As opposed to inquiring about units of alcohol consumed; inquire into episodes/events of drinking and how long alcohol lasts.

• Use “disarming” statements – “I always ask people about their drinking practices because it is important to be able to talk about all aspect’s of one’s life.” Hanson & Gutheil (2004)

• Recognized screening instruments include: CAGE, AUDIT, and MAST.
Recognize “Red Flags” unique to the developmental period

• Loss is a high risk period

• Transition following retirement is high risk period

• Loss of balance, coordination, and changes in mental functioning, directly or indirectly related to the use of alcohol frequently account for falls (Ferri, 2005).

• Being prone to accidents is considered to be a red flag for potential alcohol abuse.

• Skin changes associated with trauma may indicate alcohol abuse.
Assessment & Screening

• Assess for Over the Counter and prescription medication use

• Use Prescription Drug Monitoring Program if accessible.
Treatment

• Elderly patients do as well, if not better than other age cohorts in treatment.

• Elder specific treatment, if available, tends to have better outcomes.

Treatment Models

• Cognitive Behavioral Treatment has been demonstrated to be effective in reducing alcohol and drug use.

• Although the data is elusive, use of support groups such as A.A. provide social support resources and opportunities for spirituality.

What have learned?

• Referral Education Assessment & Prevention (REAP)

• Screening Brief Intervention and Referral to Treatment (SBIRT)

• Geriatric Addictions Program (GAP)
Brief Intervention & Motivational Interviewing

- **Feedback** - Patients risk based on screening; Reasons for drinking

- **Responsibility** - Patient choice; Key motivators may be maintaining independence, physical health, financial security, mental capacity

- **Advice** - to change behavior

- **Menu** - strategies based on patients need

- **Empathy** - professional stance, warm, accepting, non-confrontational

- **Self efficacy** - reliance on one’s own resources
Reminiscence

- Although not recognized as evidence-based practice for substance abuse treatment, reminiscence therapy is recognized as a form of treatment for elderly in addressing other challenges.

- Developmentally appropriate
Reminiscence (Cont’d)

• In qualitative study of service providers conducted by Wadd & Galvani (2014) practitioners indicated that allowing older clients to reminisce was helpful in developing trust and the relationship.

• *A cautionary note on reminiscence in the service of “bitterness revival.”
SAMHSA Guidelines for Working with Elderly

• Inclusion of adult children if they can play a critical role in treatment

• Inclusion of friends if it is appropriate

• Limitation of participants to 2 family members to minimize confusion and stigma

• Exclusion of younger family members

• Avoid labeling but use sensitivity in working with family.
Thank you for your Interest and Attendance