Geriatric Behavioral Health Conference

Substance Use Disorders In the Geriatric Population

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DISCLOSURE

- **Dr. Davids and Dr. LeMasters do not have any financial relationships with commercial interest companies to disclose.**

- **We will not be discussing off-label use of a commercial product.**

Learning Objectives

- Define Substance Use Disorders
- Understand ways in which to screen substances use disorders in the geriatric population
- Common substances of misuse
- Treatment of substance use disorders in the geriatric population

- 67 year female brought in for evaluation to the ER by her two siblings with chief complaint of passive suicidal ideation. The patient reports she is originally from the area, but has been living in a rural town of 500 people about 2 hours away since she was married over 20 years ago. She reports that she lost her job as a agricultural company administrator in the fall because of budget shortfalls. Though this did cause an increase in her anxiety, it became much worse when her husband recently asked for a divorce. They have continued to live in the same home over the last two months. Her siblings add in that they recently learned he had been abusive to her for years, which continued after the recent end of their relationship. They learned of the abuse over the weekend and decided to pick her up so she could move in with one of them going forward. On arrival her siblings notice that she has some difficulty getting around, noting that she is weak and seems somewhat unsteady on her feet. On the drive home she admits that she had thoughts of ending her life over the past few weeks.

What do you want to know?

- Past self harm or suicide attempts?
- Past hospitalizations?
- Past psychiatric diagnoses and treatment?
- Substance use?
- Are you currently suicidal and do you have a plan?

- She denies any past psychiatric treatments to include diagnoses, medications, and hospitalizations. She has never attempted suicide, but has experienced thoughts of self-harm for the first time in her life since the separation. She does admit that she drinks at a small local bar with friends 2-3 times a week, consuming 1-2 vodka sodas on each occasion. She said this has not increased in comparison to past intake levels, but denies drinking to intoxication. She also denies history of increased intake, symptoms of withdrawal, substance use treatment, illicit substance use. It is notable that she admits at times having thoughts that she is better off dead when she is drinking, though she has not acted on these thoughts. Given this story, her siblings to not feel comfortable bringing her home until she has been observed over a longer periods of time. She agrees to admission to inpatient psychiatry.

- She was admitted to the inpatient psychiatric unit where nursing immediately notes an unsteady gait and vomiting. Labs reveal electrolyte abnormalities and ETOH level of 200.
- Internal medicine evaluated and had concern for Wernicke's encephalopathy, admitted to med/surg. Over the course of the next 5 days she did receive full workup for Wernicke's encephalopathy, which was negative, but over that span she did experience significant withdrawals including visual hallucinations.

Learning Points

- Don’t forget to screen for suicidality and substance abuse.
- Patients may minimize social stressors, substance use, mental health symptoms for a variety of reasons.
- If your alarm bells are going off, listen to them.

What is a Substance Use Disorder?

- Per the DSM-5:
- Substance is often taken in larger amounts or over a longer period than intended
- Persistent desire or unsuccessful efforts to cut down or control use
- A great deal of time is spent in activities necessary to obtain the substance or recover from its effects

- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

DSM-5 Continued

- Craving or a strong desire or urge to use
- Recurrent use resulting in a failure to fulfill major obligations at work, home, or school
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by effects of use
- Important social, occupational, or recreational activities given up or reduced due to use

- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing

DSM-5 Continued

- Recurrent use in situations in which it is physically hazardous
- Use is continued despite knowledge of having ongoing or recurrent physical or psychological problems that are likely caused by or worsened by the substance use

DSM-5 Continued

- Tolerance: A need to use increased amounts of alcohol needed to achieve intoxication or desired effect OR a diminished effect with continued use of the same amount of a substance
- Withdrawal: varies based on substance. For alcohol: autonomic changes, tremor, insomnia, GI upset, hallucinations, agitation, anxiety, possible seizures

DSM-5 Continued

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6 or more symptoms

Substance Use Disorders in the Geriatric Population are often overlooked

- Patients are stereotyped as young
- Providers may be embarrassed to ask
- Patients may fear judgment and under report their use

Why should we be concerned?

- Ongoing, undiagnosed substance use further complicates co-occurring medical problems
- Patients are at higher risk for falls and delirium
- Substance use worsens co-occurring psychiatric diagnosis and may increase the risk of suicide
- Older adults take more prescribed and over-the-counter medications than younger adults, increasing the risk for harmful drug interactions and misuse

Kennedy GJ, Efremova I, Frazier A, et al. The emerging problems of alcohol and substance abuse in late life. J Soc Distress Homel. 1999;8(4):227–239

Substance Use Breakdown

- Out of all geriatric psychiatric patients with Substance Use Disorders admitted between 1999-2009:
  - 73.3% alcohol related disorders
  - 11% sedative-hypnotic use disorders
  - 2.9% opioid use disorders
  - 1% cannabis use disorders

- Source: Dombrowski D, Norrell N, Holdroyd S. Substance use disorders in elderly admissions to an academic psychiatric inpatient service over a 10-year period. Journal of Addiction. Volume 2016, Article ID 4973018

Understanding Alcohol Use

- Equivalent of about 0.5 oz of alcohol is considered one drink
  - 12 oz of regular beer
  - 5 oz of wine
  - 1.5 oz of distilled spirits
- National Institute on Alcohol Abuse and Alcoholism in the elderly recommends the following for healthy people who do NOT take medication
  - One drink a day on average for an elderly man. No more than 2 drinks at any one time.
  - Women should drink even less.
  - People taking medication should further limit use or should not drink at all
  - According to the Dietary Guidelines, adults who do not drink alcohol should not start drinking for any reason.

Source: National Institute of Alcohol Abuse and Alcoholism, www.niaaa.nih.gov and SAHMSA TIP 26

https://health.gov/our-work/food-nutrition/2015-2020-dietary-guidelines/guidelines/appendix-9/. Accessed 9/30/2020

Alcohol Use Continued

- Early onset drinkers:
  - 2/3 of older patients
  - Psychiatric co-occurring are common
  - Severe medical complications secondary to heavy use
- Late onset drinkers:
  - Often triggered by stressful life event
  - More mild cases with fewer medical problems
  - More amenable to treatment

Increased Impact of Alcohol in the Geriatric Population

- Increased Blood Alcohol Concentration because:
  - Decreased lean body mass
  - Decreased total body water
  - Decreased gastric alcohol dehydrogenase
  - Alcohol and drugs more intoxicating in geriatric patients

Social Factors Contribute to Drinking

- Play an important role in the initiation of AUD(Alcohol Use Disorder)

- Difficult experiences filled with:
  - Loss
  - Physical limitation
  - Isolation
  - Loss of income
  - Loss of occupation

Medical Complications of Alcohol in Geriatric Patients

- Cirrhosis: 60% 1 year death rate > age 60 vs 7% in younger population
- Heart problems (coronary artery disease, and atrial fibrillation)
- Increase in cancers
- Thrombocytopenia
- Neurologic complications (stroke, dementia, Wernicke's encephalopathy)

Assessment May Include:

- Skillful Interviewing, willing to ask difficult questions
- Psychiatric evaluation
- Neurological evaluation
- Social Evaluation
- Evaluation of motivation to change
- Functional Evaluation

Screening Tools

- Questions about quantity and frequency
  - How many days does the individual drink?
  - Maximum number of drinks on any given occasion
- Instruments:
  - CAGE
  - AUDIT-C
  - MAST-G

AUDIT-C

AUDIT-C

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?					**SCORE**
Never (0)	Monthly or less (1)	Two to four times a month (2)	Two to three times per week (3)	Four or more times a week (4)	_____
2. How many drinks containing alcohol do you have on a typical day when you are drinking?					
1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 to 9 (3)	10 or more (4)	_____
3. How often do you have six or more drinks on one occasion?					
Never (0)	Less than Monthly (1)	Monthly (2)	Two to three times per week (3)	Four or more times a week (4)	_____
TOTAL SCORE Add the number for each question to get your total score.					_____

Maximum score is 12. A score of ≥ 4 identifies 86% of men who report drinking above recommended levels or meets criteria for alcohol use disorders. A score of > 2 identifies 84% of women who report hazardous drinking or alcohol use disorders.

Protective Factors

- Married
- Supportive, safe living environment
- A provider with knowledge of addiction supervising diverse medications
- Adequate income to meet needs (medical expenses likely to far exceed those of younger adult)
- Annual substance abuse screening including psycho-education. (SAMHSA recommends for 60+)
- Wellness factors including eating, sleeping, exercise, spirituality.
- Linkage to age-specific groups and activities
- Access to transportation

Source: SAMHSA 2015

Treatment and Intervention

- Brief Advice
- Brief Interventions
- Facilitates treatment entry and change in behavior
- Referral Management

Brief Interventions

- Brief interventions aim to identify a real or potential alcohol problem and motivate an individual to do something about it

- Not designed to treat people with serious dependence

Brief Interventions

- Avoid the use of pejorative, labeling words such as “alcoholic” and “abuse”
- The WHO (World Health Organization) has a manual online which outlines brief interventions
- Example Script: "I have looked over the results of the questionnaire you completed a few minutes ago. If you remember, the questions asked about how much alcohol you consume, and whether you have experienced any problems in connection with your drinking. From your answers it appears that you may be at risk of experiencing alcohol-related problems if you continue to drink at your current levels. I would like to take a few minutes to talk with you about it.”

Source: WHO: http://www.who.int/substance_abuse/activities/sbi/en/

Interventions in Geriatric Patients

- Avoid confrontational approaches
- Communicate with empathy in a straightforward, simple manner
- Pay attention to what is important to patients and motivate them (Motivational Interviewing)
- Involve family members or other social support whenever possible

Detoxification in Elderly Patients

- Confusion (rather than tremor) is an early withdrawal sign
- Duration of withdrawal/hallucinosis increased
- Rule out Delirium Tremens in confused patients
- Replace electrolytes and nutrients
- Use short acting benzodiazepines (lorazepam, oxazepam)
- Symptomatology monitored with Clinical Institute Withdrawal Assessment for Alcohol (CIWA)
- In the emergency setting, it is imperative to give thiamine, folate and multivitamins early.

Source: LeRoux C, Tang T, Drexler K. Alcohol and Opioid Use Disorder in Older Adults: Neglected and Treatable Illnesses. Curr Psychiatry Rep(2016) 18:87

A Note About Wernicke's Encephalopathy

- Clinically the classic triad is: ocular findings, cerebellar dysfunction and confusion
- Thiamine needs to be given BEFORE glucose to avoid Wernicke's encephalopathy because glucose depletes thiamine in the body.
- If Wernicke's is suspected, immediate, high dose thiamine is required, some suggest 200mgTID, IV or IM for 3-5 days

Source: Gavin et al. EFNS guidelines for diagnosis, therapy, and prevention of Wernicke encephalopathy. Eur J Neurol. 2010;17(12):1408-18.

Treatment Strategies

- Age-specific psychosocial approaches are indicated for persons who are not affected with dementia
- Psychotherapy
- Medication management
- Self help groups
- Crisis Management may be needed

Pharmacology

- 3 FDA approved medications for AUD:
  - naltrexone
  - acamprosate
  - disulfiram
- Disulfiram is generally not recommended in older adults

Sedative-Hypnotic Use

- 20% of patients in intermediate care facilities received benzodiazepines (87% as a standing order)
- 41% of psychotropic drug orders in nursing homes are antianxiety agents (mainly benzodiazepines)

Source: Beers M, Avorn J, Soumerai S.B., Everitt DE, Shermann DS, Salem S. Psychoactive medication use in intermediate – care facility residents. JAMA 1988; 260: 3016-20.

Source: Beardsley RS, Larson DB, Burns BJ, Thompson JW, Kamerow DB. Prescribing of psychotropics in elderly nursing home patients. J Am Geriatr Society 1989; 327-30.

Sedative-Hypnotic Use

- A 2004 study revealed 13% of nursing home residents took benzodiazepines
- Of those residents, 42% did not have an appropriate indication
- This practice was more common in patients that were female, Caucasian, and/or had behavioral disturbance

Source: Stevenson, Decker, Dwyer, Huskamp, Grabowski, Metzger, Mitchell. Antipsychotic and benzodiazepine use among nursing home residents: findings from the 2004 National Nursing Home Survey. American Journal of Geriatric Psychiatry: Dec 18, 2010.

Why are sedatives in the elderly concerning?

- Absorption: slower
- Protein binding: elderly patients with low albumin have increased sedation
- Metabolism: slower hepatic metabolism in the elderly; several benzodiazepines have a complicated liver metabolism
- Older patients are at risk of BZD-related harms
  - Fractures
  - Falls
  - Sedation

Take a multifaceted stepwise approach when deprescribing benzodiazepines in older patients. Drugs Ther Perspect 35, 72–76 (2019)

Benzodiazepines

- Sedation
- Cerebellar toxicity
- Cognitive impairment
- Psychomotor impairment
- The longer a person is prescribed these medications, the more likely they are to develop misuse
- The longer they are prescribed these medications, the harder it is to taper off

How to discontinue Benzodiazepines

- Gradual taper of benzodiazepines is best, especially if medication has been taken chronically, recommendations vary but generally reducing dose by 12-25% every week to month
- Slower clearance of medication attenuates withdrawal symptoms, thus elderly patients *may* report fewer symptoms
- The severity of the distress experienced by a patient during withdrawal is associated with high levels of anxiety, lower educational levels, lower baseline health-related Quality of life, and low levels of social support

Guidelines for Prescribing Benzodiazepines

- Prescribe only small dosages
- Prescribe benzodiazepines without active metabolites
- Avoid prescribing benzodiazepines to confused patients or to patients with dementia
- Prescribe benzodiazepines for short periods of time, if at all
- Be aware of potential interaction amongst CNS depressant substances

Salzman C et al. Clinical Geriatric Psychopharmacology, 3rd Edition,1998, William & Wilkins 343-355.

Prescription drug use

- Elderly patients account for 30% of prescriptions, mainly benzodiazepines and prescription opioids
- One forth of patients in intermediate care facilities are on benzodiazepines
- Rates of benzodiazepine and opioid prescriptions in those 65+ have continued to increase from 2006-2007 to 2014-2015
  - Benzodiazepines from 4.8% to 6.2%
  - Opioids from 5.9% to 10%
  - Benzodiazepines and opioids combined from 1.1% to 2.7%
- The more medications a patient takes, the more likely the medications will be taken improperly

Source: Beers, Avorn et al 1995

Source: Rhee. Coprescribing of Benzodiazepines and Opioids in Older Adults. The Journals of Gerontology December 2019.

Opioids

Opioids

- Opiates: Derived from Opium. Heroin is derived from Opium.

- Opioids: Initially referred to synthetics, now generally refers to synthetic, natural and semi-synthetics

Most commonly misused opioid medications

- Oxycodone (OxyContin)
- Oxycodone/acetaminophen (Percocet)
- Hydrocodone (Vicodin)

(Prescription Drugs April 13, 2010)

Signs of Opioid Misuse

- Confusion
- Depression
- Delirium
- Insomnia
- Parkinson’s-like symptoms
- Weakness or lethargy
- Loss of appetite
- Falls
- Changes in speech; slurring

Signs of Opioid Misuse Continued

- Loss of motivation
- Memory loss
- Family or marital discord
- New difficulty with activities of daily living (ADL)
- Drug seeking behavior
- Doctor shopping
- ****Always Check the Physician Monitoring Program (PMP) Before Prescribing! ****

Medication Assisted Treatment

- Naltrexone: Oral and Long acting injectable
- Mu-opioid receptor Antagonist
- Paucity of research for IM Naltrexone in older adults

Medication Assisted Treatment

- **Buprenorphine**: is a partial mu-opioid receptor agonist with a very high affinity for the mu-opioid receptor
  - Comes in several formulations (SL, Buccal)
  - Must be prescribed by a provider with a DEA X waiver
  - Must be administered when patient is exhibiting symptoms of withdrawal or has already completed withdrawal. In the setting of active intoxication, may precipitate a withdrawal

Medication Assisted Treatment

- **Methadone**: A full mu-opioid receptor agonist
  - May only be dispensed from federally regulated opioid treatment programs “methadone clinics”
  - Monitoring required for sedation and respiratory depression
  - May cause CNS depression if used with alcohol, sedatives, hypnotics, or opioids.

Naloxone

- Naloxone: Opioid Antagonist
- Patients receiving MAT should have an emergency naloxone kid prescribed
- Consider discussing Naloxone in patients on high dose opioids
- Helpful to engage the patient's family on overdose risk and availability of Naloxone

Marijuana

- The medical use of marijuana is legalized in 33 states and DC
- Recreational use is legalized in 11 states
- Use remains federally illegal
- Paucity of research in use in older adults

Mahvan TD, Hilaire ML, Mann A, Brown A, Linn B, Gardner T, Lai B. Marijuana Use in the Elderly: Implications and Considerations. Consult Pharm. 2017 Jun 1;32(6):341-351. doi: 10.4140/TCP.n.2017.341. PMID: 28595684.

Marijuana

- Acute adverse impact of marijuana use:
  - Anxiety
  - Dry mouth
  - Tachycardia
  - High blood pressure
  - Palpitations
  - Wheezing
  - Confusion
  - Dizziness

Volkow ND, Baler RD, Compton WM, Weiss SRB, 2014. Adverse health effects of marijuana use. N. Engl. J. Med 370, 2219–2227

Marijuana

- Between 2015-2016, prevalence of past year use was 9% in adults ages 50-64 and 2.9% in adults 65 and older
- Based on the National Survey on Drug Use and Health
- Other substance use disorders and misuse of prescription medications were higher in people who used marijuana compared to non-users
- Some concern that older adults who use MJ medically have a higher rate of recreational use too

Han BH, Palamar JJ. Marijuana use by middle-aged and older adults in the United States, 2015-2016. Drug Alcohol Depend. 2018 Oct 1;191:374-381

Choi NG, DiNitto DM, Marti N, 2017a. Nonmedical versus medical marijuana use among three age groups of adults: associations with mental and physical health status. Am. J. Addict 26, 697–706.

Tobacco Use

- Tobacco use is the leading cause of cancer and death from cancer.
- There is no safe level of tobacco use.
- People who quit smoking, regardless of their age, have gains in life expectancy compared with those who continue to smoke.
- The NCI quitline, 1-877-44U-QUIT (1-877-448-7848), is available Monday through Friday, 9:00 a.m. to 9:00 p.m. ET.

Source: NIH National Cancer Institute: https://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco Accessed on 9/30/2020

Thank you

- Questions?

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- Source: Beers M, Avorn J, Soumerai S.B., Everitt DE, Shermann DS, Salem S. Psychoactive medication use in intermediate – care facility residents. JAMA 1988; 260: 3016-20.
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