



Ask the Geriatrician

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the
Geriatrician



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SUBSTANCE ABUSE IN THE ELDERLY

“The Invisible Epidemic”





IS IT POSSIBLE TO TEACH AN
OLD DOG NEW TRICKS?



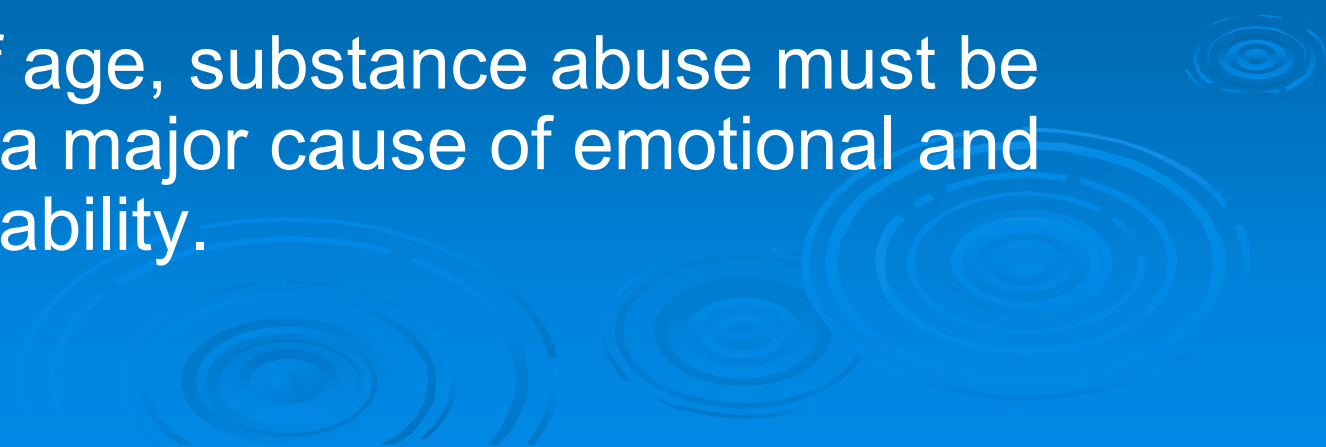
GUIDELINES

All forms of addiction know no age limit.


Don't blame all problems on aging.

Few realize the true extent of substance abuse by the elderly.

Regardless of age, substance abuse must be considered a major cause of emotional and physical disability.



OUTLINE

1. Introduction
 2. Drug abuse and dependence
 3. Scope
 4. Behavioral and social factors
 5. Diagnosis
 6. Treatment
 7. Recovery
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INTRODUCTION

Substance abuse in the elderly is one of the fastest growing health problems facing the country.

Relatively little research on alcohol and drug abuse in the elderly.

Historically, government funding goes to other substance abuse problems and populations.

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INTRODUCTION


Compared to younger adults, substance abuse disorders in the elderly present more often as medical or psychiatric conditions.

Substance abuse in the elderly often goes undetected. Common screening tools might not work; DSM IV criteria may not apply.

There is a prevalent belief it can't be treated.

INTRODUCTION

Maturation of the baby boomer cohort (1946-1964) is changing the clinical landscape. High rates of lifetime drug use in this generation suggest that by 2020 the number of persons 50 or older needing treatment for substance use disorder will double.



DRUG ABUSE AND DEPENDENCE

CHALLENGES:

Elderly patients less likely to report.

Physicians underrecognize and underdiagnose substance abuse disorders in the elderly.



DRUG ABUSE AND DEPENDENCE

DRUG TYPES:

ILLICIT-marijuana, cocaine, inhalants, heroin, and hallucinogens.

PRESCRIPTION- sedative-hypnotics (benzodiazepines) and narcotics (opioids).

OVER-THE-COUNTER-sedatives, laxatives, and analgesics.

HERBAL-caffeine, ephedrine.

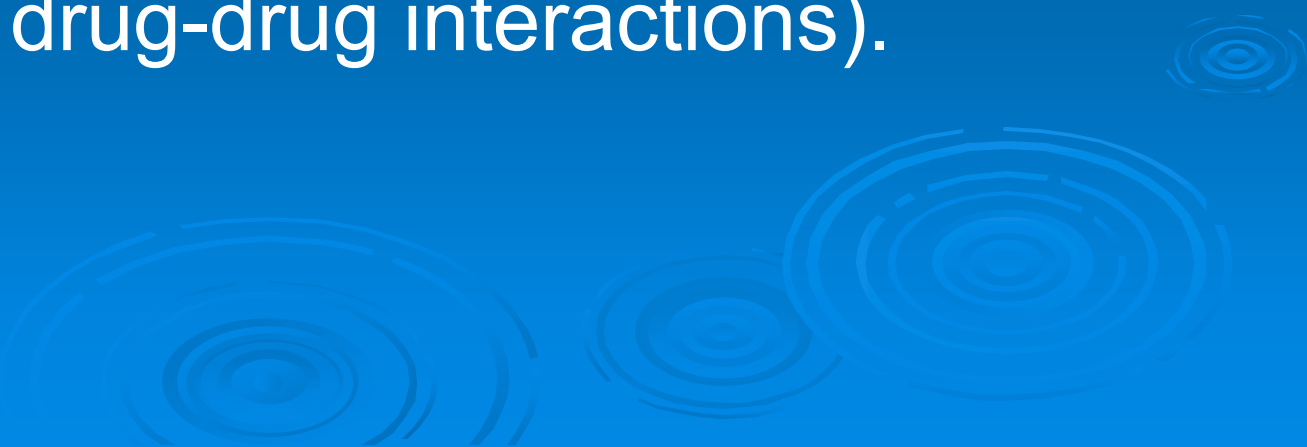
DRUG ABUSE AND DEPENDENCE

Abuse of illicit drugs relatively uncommon but prescription drug abuse in the elderly is common. Elderly heroin abusers prevalence 0.5-1.1% v elderly outpatient prescription narcotic abusers 11.4%.

Elderly use prescription drugs 3x more frequently than the general population; OTC use is even more extensive.

DRUG ABUSE AND DEPENDENCE

The aging process with its physiological changes, accumulating health problems, and other psychosocial stressors makes prescription drug use both more likely and more risky (decreased 'reserve', decreased drug clearance, increased CNS sensitivity, drug-drug interactions).



DRUG ABUSE AND DEPENDENCE

83% of adults over 65 take at least one prescription drug.

30% of those over 65 take eight or more prescription drugs daily.

Polypharmacy often caused by excessive duration of therapy and “failure to communicate” between clinicians.

Among the elderly: 17-25% take sedative-hypnotics; 18% have been prescribed an opioid analgesic. Even when taken as prescribed tolerance, dependence and toxicity may develop.

DRUG ABUSE AND DEPENDENCE


Motivation for the elderly to abuse drugs may be similar to the motivation for adolescents. Both groups:

- 1) Must negotiate uncertain and changing roles and self-concepts.
- 2) Drugs are easily available to both groups.
- 3) Progress from milder to more powerful drugs in adolescents often parallel steps to addiction in elderly.

SCOPE

In the community evidence of significant abuse of illicit drugs in the elderly is remarkably low, perhaps due to denial, selective recall, and selective mortality.

Initiation of illicit drug abuse in the elderly is extremely rare.

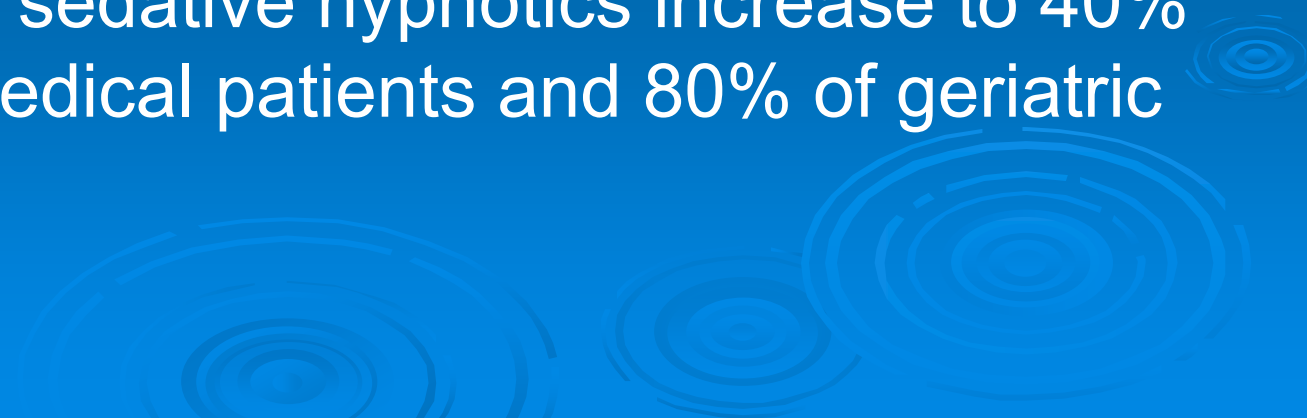
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SCOPE

Early studies among persons older than 60 years noted 20% of women and 17% of men had regularly used a psychoactive drug.

Except for cardiovascular medications, analgesics and psychotherapeutic agents were drugs most used by older adults.

Prevalence of sedative hypnotics increase to 40% of elderly medical patients and 80% of geriatric inpatients.



SCOPE

Risk Factors for prescription medication misuse/abuse by older adults:

Female

Social isolation

History of psychiatric or substance use disorder

Polypharmacy

Chronic medical problems



BEHAVIORAL AND SOCIAL CORRELATES

Many factors contribute to the addictive potential of prescription drugs in the elderly:

1. “Passivity” of the dependent senior; (“double prescribing”).
2. Poor communication regarding dosing.
3. Sharing/swapping medications among elderly peers.
4. All medications in one container.

BEHAVIORAL AND SOCIAL CORRELATES

5. Misuse/abuse of OTC (over-the-counter) medications: no physician direction and drug-drug interactions. Most common OTC drugs are sedatives, laxatives, and analgesics.
6. “Do something” prescribing: older patient expects a result; doctor wants to uphold patient-physician contract.
7. Defensive prescribing: physician prescribing medications to reassure staff and family.

DIAGNOSIS

Most common presentations of drug misuse or abuse in the elderly are toxicity and withdrawal.

Since the sedative-hypnotics are the most commonly prescribed drugs they are the most likely to be abused/misused.

TOXICITY appears as sedation, confusion, dysequilibrium, and stupor.

WITHDRAWAL manifests as anxiety/agitation, sleep problems, tremors, muscle cramps, perceptual distortions, and possibly seizures.

DIAGNOSIS

When these symptoms emerge a thorough history from the patient and ideally the family is critical.

Urine or blood toxicity screens can be helpful/confirmatory.



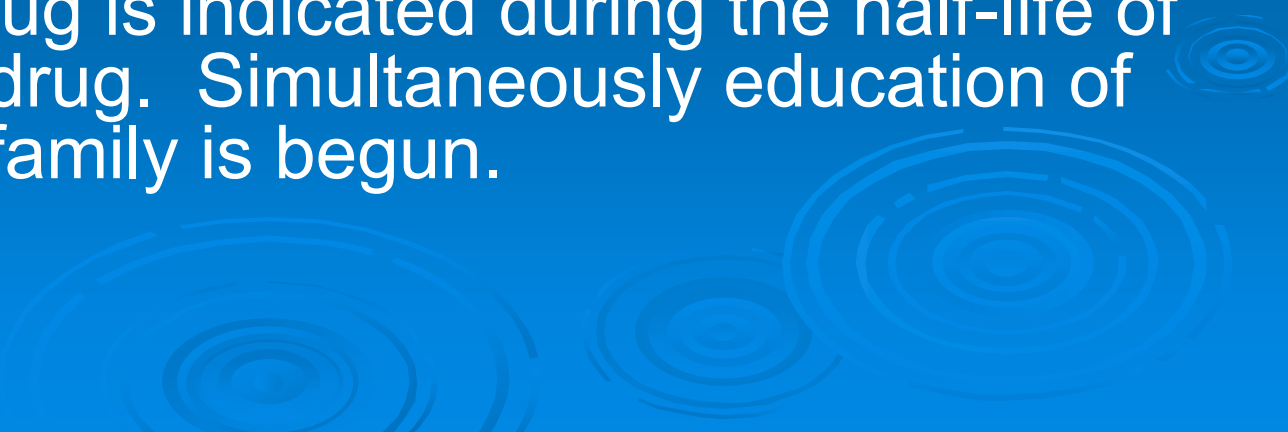
TREATMENT

Frailty of the elder adult dictates treatment errs on the side of being conservative.

Early hospitalization recommended for toxicity: gastric evacuation, charcoal lavage, and close monitoring.

After stabilization from overdose next challenge is to manage withdrawal symptoms.

Support and taper with the medication or a substitute drug is indicated during the half-life of the abused drug. Simultaneously education of patient and family is begun.

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TREATMENT

Careful outpatient monitoring to prevent relapse.

Collaboration with local pharmacy and PCP.

Vigilant monitoring for alcohol and OTC medications in addition to the use/abuse of prescription drugs.

Pain management can be complicated.

TREATMENT

BRIEF INTERVENTIONS

REFERRAL TO SPECIALIST CARE

PHARMACOTHERAPY



TREATMENT

BRIEF INTERVENTIONS - varies from unstructured interactions in the physician's office to formal therapy.

BRENDA model:

- Biopsychosocial evaluation

- Reporting the assessment to the patient

- Empathy

- Needs identification

- Direct advice

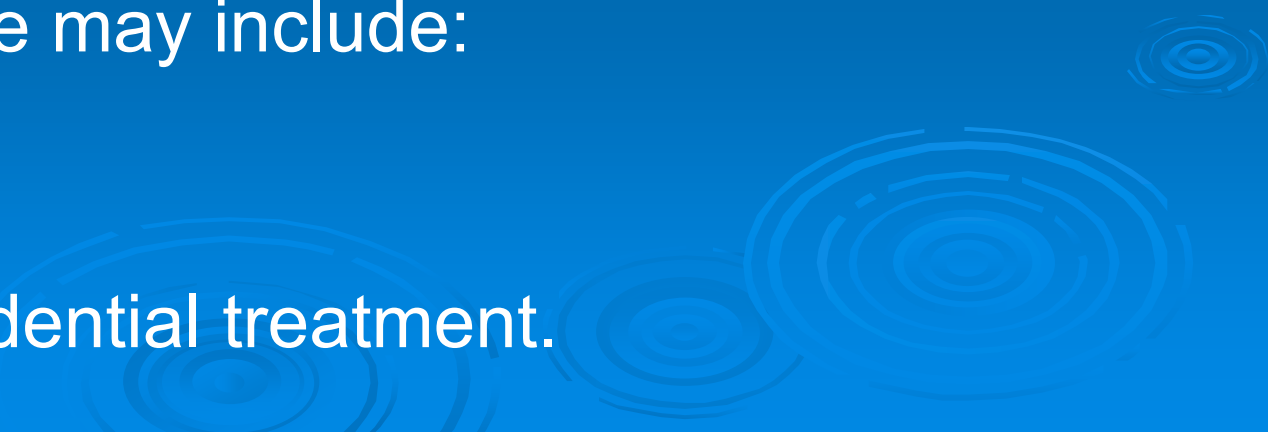
- Assessment of patient reaction to advice

TREATMENT

REFERRAL TO A SUBSTANCE ABUSE SPECIALIST OR
INPATIENT TREATMENT:

Referral is appropriate if patient has:
a history of complicated withdrawal or
complicated underlying medical condition.

Specialized care may include:
detoxification
day hospital
long-term residential treatment.

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TREATMENT

PHARMACOTHERAPY:

Sedative-hypnotic abuse- after taper or detoxification, treat symptoms (anxiety, insomnia) ideally with nonaddictive agents (Buspar, Melatonin).

Opioid abuse/dependence-

Naltrexone-opioid antagonist to prevent relapse.

Methadone-opioid agonist

Buprenorphine-opioid partial agonist

RECOVERY

Evidence indicates age specific programs for older alcoholics significantly improve abstinence rates at 6 and 12 months.

Older age >55 have fewer problems and better outcomes with opioid treatment.



TAKE HOME CONCLUSIONS

Be mindful of prevalence of substance abuse in seniors and physiological vulnerability of the elderly.

Always be screening: medication reconciliation, collateral history from family.

Brief interventions are powerful.

Age-specific treatment generally has better outcomes. “One size” does not fit all.

Address phase of life issues, esp. loss.

TO CHOOSE WHAT IS DIFFICULT
ALL ONE'S DAYS, AS IF IT WERE
EASY, THAT IS FAITH...

W.H. Auden



RESOLVE TO PERFORM WHAT YOU
OUGHT; PERFORM WITHOUT FAIL
WHAT YOU RESOLVE.

Benjamin Franklin

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Q&A



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