Alcohol Abuse and Illicit Drug Use in PACE population

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Consequence of Substance Abuse

1 ugly actress
1 insane actor
1 braindead singer

Don’t do DRUGS!
Seriously.*

* If you are ugly, insane or braindead you’re already screwed so huff away.
The Sleeper
SUBSTANCE ABUSE IN THE ELDERLY

• In the elderly, negative health consequences of alcohol, psychoactive medications, illicit drugs, and nicotine have been demonstrated at consumption levels previously thought of as light to moderate.

• Elderly adults are particularly vulnerable to the cognitive and physical effects of these substances.

• Treatment leads to reductions in substance use and improvement in general health.
OBJECTIVES

• Recognize the extent and consequences of substance abuse in the elderly
• Know how to utilize screening tools effectively during a brief office visit
• Identify modifiable risk factors that contribute to the increased likelihood of injury, hospitalization and death among older adults with alcohol use issues
• Describe appropriate interventions and community resources for older adults with alcohol use issues
Risk Factors for Late Life Substance Abuse

- Social isolation
- Depression, Grief
- Pain
- Stress
- Financial pressure
USE OF ALCOHOL
BY ELDERLY PERSONS

Studies have reported a range of:
- 2% to 4% for alcohol abuse
- 3% to 9% for heavy drinking
- 10% to 22% for daily drinking
- 31% to 58% for abstinence
The Age Wave is cresting

- First ‘Baby Boomers’ just turned 65
- This generation used illicit drugs in youth
- Continue to use their drugs into older adulthood
- Different from previous generations
SUBSTANCE DEPENDENCE

• Any use that imparts significant disability and warrants treatment

• Older problem drinkers are identified less often by clinicians and are less often referred for treatment than are their younger counterparts
AT-RISK USE

Any use of a substance at a quantity or frequency greater than a recommended level

The recommended upper limit of alcohol consumption for elderly adults:

No more than 1 standard drink per day

No more than 2 episodes of binge drinking ($\geq 4$ drinks/day) in a 3-month period
PROBLEM USE AND LOW-RISK USE

• Problem substance use—consumption of any amount of an abusable substance that results in at least one problem

• Low-risk or moderate use—that which falls within the recommended guidelines for consumption and is not associated with problems
ABSTINENCE

- Person consumed no alcohol in the previous year
- Obtain history of past use
- Determine reason for abstinence:
Drowning in the bottle
CULTURAL AND DEMOGRAPHIC FACTORS IN SUBSTANCE USE

• The prevalence of alcohol-related problems is much higher for older men than for older women
  ➢ Among younger adults, more women are presenting for treatment
  ➢ Similar patterns are seen with illicit drug use, except that benzodiazepines are much more commonly used by older women than by older men

• Conclusions are less clear from the few studies addressing the effect of ethnicity
  ➢ Risk factors more relevant than ethnicity are increased leisure time and higher disposable income
Psychiatric Co-Morbidity

• Higher risk for substance use among those with psychiatric disorders
  – Depression or anxiety disorders
  – Other psychiatric comorbidities
  – Personality disorders
• Dual diagnosis
  – Substance use disorder + another major psychiatric disorder
• May present with complex clinical histories and symptoms
  – Diagnosis challenging
  – Intoxication and withdrawal symptoms may be mistaken for other psychiatric or medical symptoms
• Contact with health care system is opportunity to intervene
• Earlier detection and intervention prevents problems
ILLICIT DRUG USE AMONG THE ELDERLY

A study in the general population found that 2.88% of elderly men and 0.66% of elderly women had a lifetime history of illicit drug use.

A more recent study of elderly veterans found 25% had a primary drug problem or concurrent drug and alcohol problems.
Why is it under-diagnosed?

• Selection Bias
  – Surveys miss nursing homes
  – Poorer recall

• Ageism
  – “Granny’s cocktails make her happy”
  – “He won’t be around much longer anyway”

• Under-recognized
  – Alcoholism recognized in only a third of hospitalized older adults

• Symptoms of AUD may mimic symptoms of other disorders
  – Depression, dementia
  – Diabetes

IDENTIFYING SUBSTANCE USE DISORDERS

• **Clinical examination** is the most valuable tool

• **Screening instruments** help increase the sensitivity and efficiency of the diagnosis

• **Laboratory testing:** Any combination of macrocytic anemia, thrombocytopenia, and elevated $\gamma$-glutamyl transferase → further screening
Michigan Alcohol Screening Test

- 24 Question
- Score
AUDIT

• 10 Questions
• Score 0-40
• Score > 8 strong likelihood of harmful use
THE AUDIT-C

• Q1: How often did you have a drink containing alcohol in the past year?

• Q2: How many drinks did you have on a typical day when you were drinking in the past year?

• Q3: How often did you have 6 or more drinks on one occasion in the past year?
CAGE Tool for Alcohol Abuse
Drinking Guidelines

Over age 65 years:

- 1 standard drink/day for men
- Less for women
- No more than 2 drinks on any one occasion
- No more than 7 drinks per week

"My doctor said only one glass of alcohol per day. I can live with that."

NIAAA 2005
Sensitivity to alcohol with age

A standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are standard drink equivalents. These are approximate, as different brands and types of beverages vary in their actual alcohol content.
RISKS ASSOCIATED WITH SUBSTANCE ABUSE

• Excess physical disability
• Mental health problems including dementia
• Social and relationship problems
• Economic problems
Talking to patient about alcohol and other substance use
The 5 “A’s”

• ASK about alcohol and drug use
• ADVISE all patients to quit
• ASSESS willingness to change
• ASSIST patients in quitting
• ARRANGE for follow-up
ADVISE all patients to quit

- A strong recommendation to change substance use is essential
- "Based on the screening results, you are at high risk of having or developing a substance use disorder. It is medically in your best interest to stop your use of [insert specific drugs here]."
- Recommend quitting before problems (or more problems) develop
  - Give specific medical reasons
  - Medically supervised detoxification may be necessary
Motivating patients not yet ready to quit: The 4 “R’s”

- RELEVANCE to that patient
- RISKS of continuing to use
- REWARDS of quitting
- REPETITION at each encounter
Care Plan Development

- Participants Goals and Objectives
- Expectations
- Reality

SMART (Specific, Measurable, Achievable/Agreed to, Realistic, Time-bound)

Georgia Komblatt, RN, BSN, Healthcare Consultant
Using a Structured Care Plan
Will

• Ensure the needs and expectations of the participant are considered
• Help focus the development of goal to best met the needs and preference of care for the participant
  – Longevity
  – Functional
  – Comfort
SBIRT

(Screening, Brief Intervention, Referral for Treatment)

• Targets the often overlooked middle of the pyramid and also
• Has the benefit of frequently identifying those at the top end as well.
2 randomized, controlled trials of advice protocols in primary care settings showed that:

- Older adults can be engaged in brief intervention protocols
- The protocols are acceptable to this population
- There was a substantial reduction in drinking among the at-risk drinkers receiving the interventions compared with a control group
Brief Intervention

- Motivate patients to change problem behavior
- Multiple brief sessions
- 5 minutes during office visit
- Bridge to treatment or sufficient itself
- Same impact as more extensive counseling
- Most cost effective

Weaver & Cotter 1998
TREATMENT ENGAGEMENT AND TREATMENT OPTIONS

• The most important aspect of treating an older adult who is misusing a substance is to engage the patient in the intervention

• The spectrum of interventions:
  - Prevention and education for persons who are abstinent or low-risk drinkers
  - Minimal advice or brief structured interventions for at-risk or problem drinkers
  - Formalized alcoholism treatment for drinkers who meet criteria for abuse or dependence
OUTPATIENT MANAGEMENT

• For older adults, peer-specific group activities are superior to mixed-age group activities

• Outpatient rehabilitation usually needs to address issues of time management
  ➢ Abstinence reduces the time spent in maintaining the substance-use disorder
  ➢ Management of this time, which is often the greater part of a patient’s day, is critical to the prognosis

• Commend patients for cutting down on use as well as for stopping—especially with medications such as benzodiazepines
12-Step Groups

12 Steps

(1) We admitted we were powerless over alcohol— that our lives had become unmanageable.
(2) Came to believe that a power greater than ourselves could restore us to sanity.
(3) Made a decision to turn our will and our lives to the care of God as we understood him.
(4) Made a searching and fearless moral inventory of ourselves.
(5) Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
(6) Were entirely ready to have God remove all these defects of character.
(7) Humbly asked Him to remove our shortcomings.
(8) Made a list of all persons we had harmed and became willing to make amends to them all.
(9) Made direct amends to such people wherever possible, except when to do so would injure them or others.
(10) Continued to take personal inventory and when we were wrong promptly admitted it.
(11) Sought through prayer and meditation to improve our conscious contact with God as we understood him, praying only for knowledge of His will and the power to carry that out.
(12) Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

These steps are from the book, “Alcoholics Anonymous.”

- A.A., N.A., C.A.
- Group format
- Anonymous
- No cost
- No affiliations or endorsement
- Different groups have different characteristics
  - “Gray A.A.” for Older Adults
Which of the following characteristics of attendees is the best predictor of success in Alcoholics Anonymous?

• A. Male gender
• B. Christian religious denomination
• C. Frequency of meeting attendance
• D. NO history of depression
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Success with 12-Step

• More groups=more abstinence
• No threshold, but at least 2 meetings/week best
• Not affected by
  – Gender
  – Religion
  – Psychiatric diagnosis
  – Novice
Addiction Counseling

- Motivational Interviewing
- Network therapy
- Family therapy
- Supportive psychotherapy
- Building Social Networks
- Twelve-Step facilitation
- Perceptual Adjustment Therapy
- Rational Recovery
- Medication Management
- Brief Intervention
ALCOHOL WITHDRAWAL

• Early symptoms: tachycardia, diaphoresis, tremulousness, and hypertension

• May progress to overt delirium, psychosis, seizures

• Interventions:
  - Oral oxazepam or another benzodiazepine is the most common intervention
  - IV lorazepam (off-label), followed by oral taper, is the most expedient intervention

• Be vigilant for evidence of withdrawal in patients hospitalized for elective surgery or a condition unrelated to the substance problem
INPATIENT DETOXIFICATION

• Consider for patients with severe dependency, withdrawal potential, or significant medical or psychiatric comorbidity

• To achieve detoxification:
  - Place the patient on the minimum amount of drug that suppresses withdrawal symptoms
  - Decrease dosage by 10% every 3 half-lives
  - Provide supportive counseling via groups, psychosocial support, and 12-step programs
Treatment in Older Adults

• **Focus on coping**
  – Depression, loneliness
  – Losses

• **Rebuild social support network**
  – Socialization groups
  – Alumnae meetings

• **More compliant**

• **Outcomes as good or better than younger patients**
Treatment Works

- Sustained remission rates of up to 60%
  - Better success than treatment of hypertension, diabetes
- Every $1 spent on treatment saves $7 in costs to society
- Lots of new research
CASE 1 (1 of 4)

• A 76-year-old woman lives with her husband in a senior apartment

• She has nearly fallen on 3 occasions during the previous 6 months. In each instance she averted the fall by grabbing hold of something.

• She has moderate visual impairment due to macular degeneration and osteoarthritis involving several joints, especially the left hip and knee.
• The patient takes pride in not having to take any medications.
• She has 1 mixed drink before dinner almost every day and has a glass of wine with dinner 2 to 3 times each week.
• Alcohol, combined with impaired vision and the effects of arthritis on balance and gait, is suspected as a possible cause of the near-falls. She has not been treated previously for an alcohol-use disorder.
CASE 1 (3 of 4)

Which of the following is the most appropriate first step in the care of this patient?

(A) Treat with naltrexone, 50 mg once daily for 12 weeks.

(B) Treat with disulfiram, 200 mg once daily until drinking is reduced.

(C) Provide information about risks and advise her to reduce her drinking.

(D) Refer to an age-specific residential treatment center.

(E) Refer to a self-help group such as Alcoholics Anonymous.
CASE 1 (4 of 4)

Which of the following is the most appropriate first step in the care of this patient?

(A) Treat with naltrexone, 50 mg once daily for 12 weeks.

(B) Treat with disulfiram, 200 mg once daily until drinking is reduced.

(C) Provide information about risks and advise her to reduce her drinking.

(D) Refer to an age-specific residential treatment center.

(E) Refer to a self-help group such as Alcoholics Anonymous.
CASE 2 (1 of 3)

- A 73-year-old man comes for a Pre-PACE assessment. He has hypertension, mildly abnormal cholesterol levels, and osteoarthritis.
- His medications are hydrochlorothiazide 25 mg/day, lisinopril 5 mg/day, and ibuprofen 200–400 mg as needed for joint pain.
- The patient exercises and watches his diet carefully.
- For several years he has had 3 glasses of red wine with dinner most evenings. He remarks that he read that alcohol may lower the risk of coronary artery disease and stroke. His blood pressure is 166/87 and has been somewhat difficult to control.
CASE 2 (2 of 3)

Which of the following is the most appropriate advice for this patient regarding his current drinking pattern?

(A) It is safe for him to continue.
(B) It may increase longevity.
(C) It may raise his low-density lipoprotein levels.
(D) It may exacerbate his hypertension.
(E) It places him at risk of alcoholism.
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ACKNOWLEDGMENTS

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Alcohol and Aging Awareness Group (AAAG)

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Questions?