Effective Treatment Strategies for Older Adults With Substance Use Disorders

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Today's Presenter

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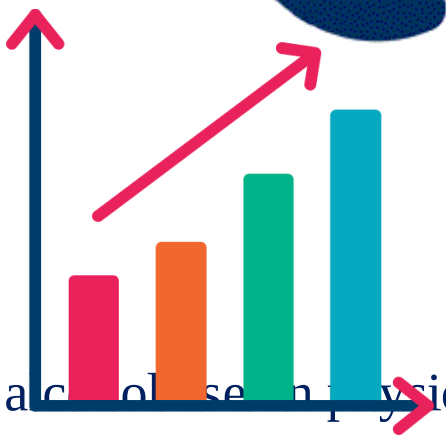
Participants will be able to:

- Discuss the fastest growing population requiring specialized Substance Use Disorder Treatment.
- Understand treatment components necessary to provide an integrated approach to Older Adult Treatment.
- Develop and address the clinical needs necessary to treat this population.

An Aging Population

- Elder care is anticipated to be the fasting growing employment sector within the healthcare industry. The number of people in retirement by 2030 will have doubled from current statistics.
- The number of older persons is projected to exceed 72.1 million persons by 2030. The older adult population is expected to double by the year 2050.
- Substance Use Disorders are often underdiagnosed, misdiagnosed, undertreated, or untreated.
- Until recently, older adults and substance use was not discussed in either the substance abuse or gerontological literature.
- Substance Use Disorder (SUD) among older persons is among the fastest growing health problems in the United States.
- Ageism: coined in mid 60's - describes a tendency for society to assign negative stereotypes to older adults and to explain away their problems as a function of "being old", rather than looking for specific medical, social, or psychological causes.

Prevalence



Adults 50 and over:

- 54 % have used marijuana
- 28 % have misused prescription drugs
- 17 % have used other illicit drug.
- Most of our patients use alcohol. We see the effect of alcohol use on physical health and cognitive functioning.
- People aged 50 and older do not need to use the same quantities of alcohol (or other substances) for there to be a negative impact.
  - They have lower tolerance due to age-related changes.
- Older adults are more likely to misuse medication, forgetting they took it, taking it too often, not taking it when they should, taking the wrong amount.
- Q: There are roughly 58 million people over the age of 65 in the United States. What percentage meet criteria for a Substance Use Disorder?
- A: Recent estimates are that 4% of older adults meet criteria, which is about 2.3 million Americans.

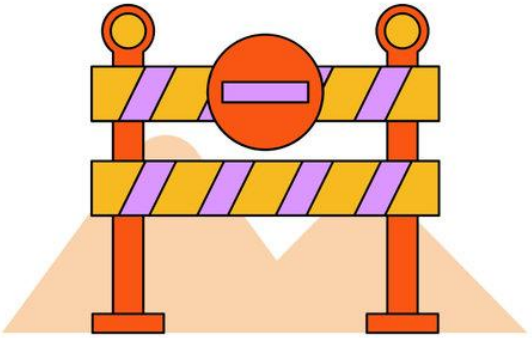
Why Older Adults Seek Residential Treatment

- Family
  - Interventions or boundaries set by family
- ED visits
  - many of our patients come from hospitals or acute rehabilitation centers:
    - Falls!!!
    - Withdrawal Management
    - Liver Disease
    - Wide range of medical complications

What Motivates Older Adults?

- Connections
  - Family (especially grandchildren)
  - Friends
  - Church/Spirituality
  - Community
- Purpose and quality of life
  - Structured and meaningful
- Physical and Cognitive Health

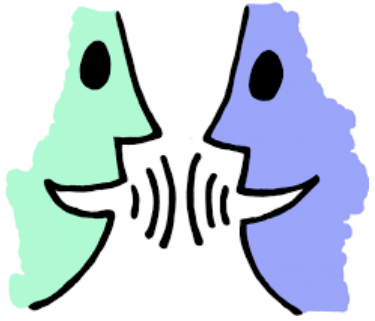
Barriers



- Lack of awareness
- Few treatment providers for older adults
- Co-morbid conditions (Medical and Psychiatric)
- Mobility issues
- Hearing and vision issues
- Stigma
- Denial
- Cognitive Impairment-lack of insight
- **Denial+Cognitive Impairment=High risk**
- Believing it is too late to help - that the person enjoys their alcohol or drugs and not to take that away

Our Language is Important

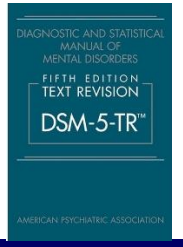
- There is a significant stigma with older adults regarding Substance Use and Psychiatric Disorders.
- Terms not to use:
  - Addict
  - Alcoholic
  - Drug Abuse
  - Drug Addict
- Many patients have a hard time saying, “Hi I’m (Name), and I’m an alcoholic.”
- They resonate with the DSM5 Criteria for Substance Use Disorder.
- Instead use: Person with Substance Use Disorder
  - Alcohol Use Disorder
  - Opiate Use Disorder
  - Stimulant Use Disorder
- Person in recovery



Substance Use Disorder: Diagnostic Criteria (DSM-5-TR)

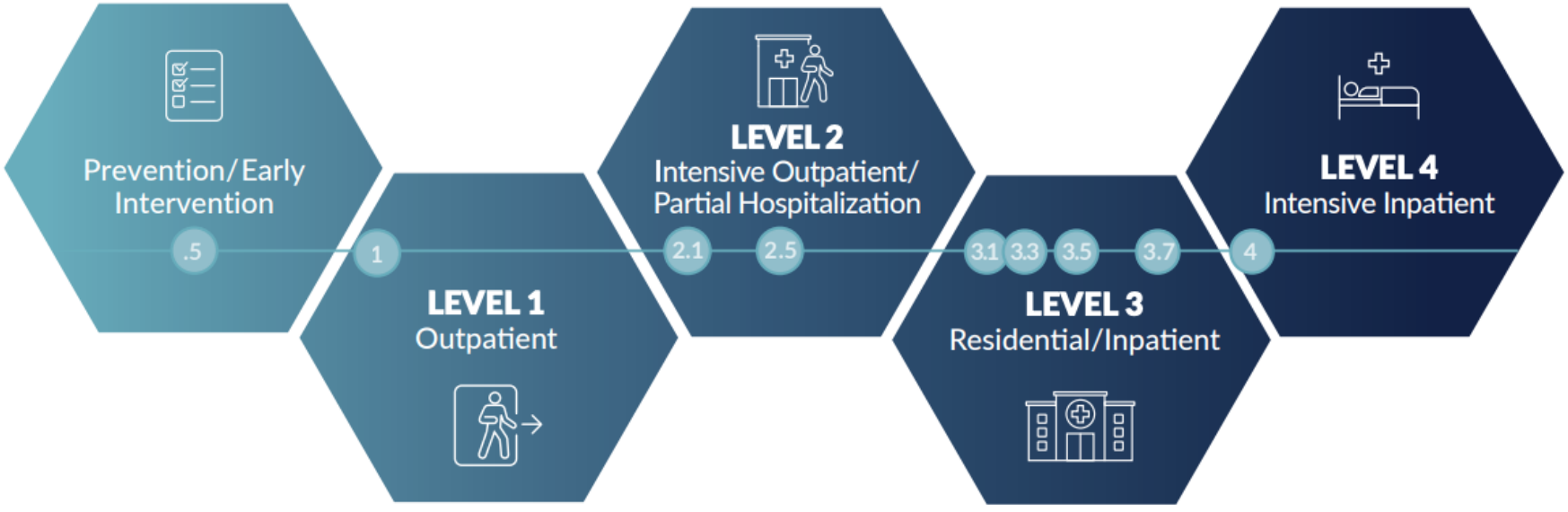
- *Using larger amounts or for longer than intended.
- Desire or unsuccessful attempts to cut down or control use.
- Spending a lot of time getting, using, or recovering from use of the substance.
- Cravings and urges to use the substance.
- Not managing to do what you should at work, home, or school due to use.
- Continuing to use, even when it causes problems in relationships.
- Giving up important social, occupational, or recreational activities.
- Repeated use in hazardous situations.
- Continuing to use, even when you know you have a physical or psychological problem that could exacerbated by the use.
- *Needing more of the substance to get the effect you want (tolerance).
- Development of withdrawal symptoms, which can be relieved by taking more of the substance.

Mild (2-3), Moderate (4-5), Severe (6+)



ASAM Continuum of Care

ADULT



.5 Early Intervention
1 Outpatient Services
2.1 Intensive Outpatient Services
2.5 Partial Hospitalization Services
3.1 Clinically Managed Low-Intensity Residential Services
3.3 Clinically Managed Population-Specific High-Intensity Residential Services
3.5 Clinically Managed High-Intensity Residential Services
3.7 Medically Monitored Intensive Inpatient Services
4 Medically Managed Intensive Inpatient Services

SUD Warning Signs

- Agitation
- Altered liver function
- Anemia
- Anxiety
- Changes in mental abilities
- Changes in eating habits, not eating as much
- Decline in personal cleanliness
- Depression
- Drinking in spite of warning labels on prescription drugs
- Fall/Falls
- Fatigue or weakness
- Hostility/violence
- Incontinence
- Increased confusion
- Irritability
- Lapses in memory
- Loss of friends or not staying in touch
- Loss of interest in favorite activities
- Marital problems
- Memory impairment
- Mood swings
- Not being oriented to date, time and place
- Panic attacks
- Problems sleeping and/or sleeping more during the day
- Repeated falls
- Selling possessions
- Slurred speech
- Smell of alcohol on breath
- Solitary or secretive drinking
- Unable to complete ADLs
- Unexplained burns/bruises

Common Presenting Biopsychosocial Problems

- Substance Use Disorders, primarily Alcohol, Benzodiazepines and Opiates.
  - Prescribed addictive medication to treat co-morbid conditions (anxiety, pain)
  - Vicious cycle
- Co-Occurring Mental Health
  - Older adults tend to minimize mental health symptoms or don't disclose, particularly trauma history
- Chronic Pain
- Medical complications and ambulation issues
- Grief and Loss
- Loss of Purpose
- Isolation & Loneliness
- Cognitive Impairment
  - Alcohol or Substance-Induced cognitive concerns is more common than you might think
- Suicidal Ideation, Thoughts of Death

Psychological Considerations for Older Adults with Substance Use Disorders

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Co-Occurring Disorders (CODs)

- COD (Dual Diagnosis): Individuals diagnosed with both a Substance Use Disorder (SUD) and a psychiatric disorder.
- 60%-70% of individuals with an SUD meet criteria for psychiatric disorder
- 25%-50% of individuals with a psychiatric disorder meet criteris for a SUD
- Mood disorders, anxiety disorders, and trauma related disorders are the most common diagnoses in the older adult population.

Co-Occurring Disorders (CODs) in Older Adults

- Self medication can lead to dependence or loss of control.
- Substance use can induce mental health conditions or exacerbate pre-existing conditions.
- Substance use can exacerbate pre-existing conditions.
- Prescribed addictive medications to treat co-morbid conditions like anxiety, pain, etc can contribute to SUD's.
- Co-occurring conditions must be managed in treatment.
- Cognitive impairment

Contributing Factors

- Genetics
- Family
- Environment
- Life Stress
- Trauma
- Loss

Psychological Assessment

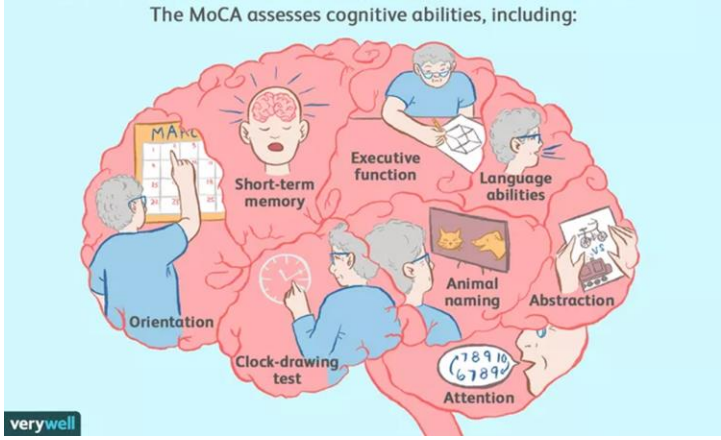
- Diagnostic/Psychological evaluation should include:
  - Mental health symptoms
  - Substance use history
  - Interaction between mental health symptoms & substance use
  - Psychosocial history
  - Family history
  - Medication and treatment history
  - Trauma history
  - Safety assessment/safety planning
  - Personality traits and personality testing if indicated
  - Neurocognitive screening

Cognitive Impairment

- Over 80% of the older adults who have come into the older adult program have shown cognitive impairment
- Montreal Cognitive Assessment (MoCA)
  - Baseline, repeat 3-4 weeks
- Most return to baseline functioning takes place in first week of abstinence
- Rate of return levels off at 3-6 weeks.
  - Helpful for patients to hear this.
  - Will it resolve? Is it caused by Substance Use? Is there any family history of cognitive decline?
- Long-term abstinence – possible slow gains over the course of 5 years
- Referral for further, more in-depth neuropsychological testing is appropriate

Montreal Cognitive Assessment (MoCA)

- Brief (~10 min) screening measure to detect cognitive impairment
  - One of the best screening tools for the detection of MCI
- No longer open source
- Originally normed on ages 55+
- Requires training/certification
  - Only health professionals with expertise in cognitive fields should interpret results.
- Current versions:
  - MoCA 8.1, 8.2, 8.3 for repeated assessment
  - Blind/Telephone, Hearing Impairment
  - 19 languages
  - iPad & Telehealth Administration



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Medical Considerations for Older Adults with Substance Use Disorders

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Co-occurring Medical Considerations

- Central Nervous System
- Ambulation Issues
- Muscle Atrophy/deconditioning
- Liver Disease
- Diabetes
- Neuropathy
- Hypertension
- Heart Conditions
- Chronic Pain Conditions

CNS

- Alcohol/Sedatives/hypnotics/opioids increase risk of falls
- Alcohol/Sedatives/hypnotics may produce antegrade amnesia impairing learning of new information
- Acute toxicity includes sedation, psychomotor impairment, and memory problems

Liver

- Swelling-stomach area, legs
- Jaundice
- Fatigue
- Dark Urine
- Pale stool
- Fluid retention

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Treatment for Liver Disease

- Medications like diuretics and laxatives
- Paracentesis for ascites-removes fluid from the abdomen
- Liver transplant in most progressed liver disease

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Chronic Pain Conditions

- Previous surgeries
- Neuropathic Pain
- Injuries
- Arthritis

Treating Chronic Pain

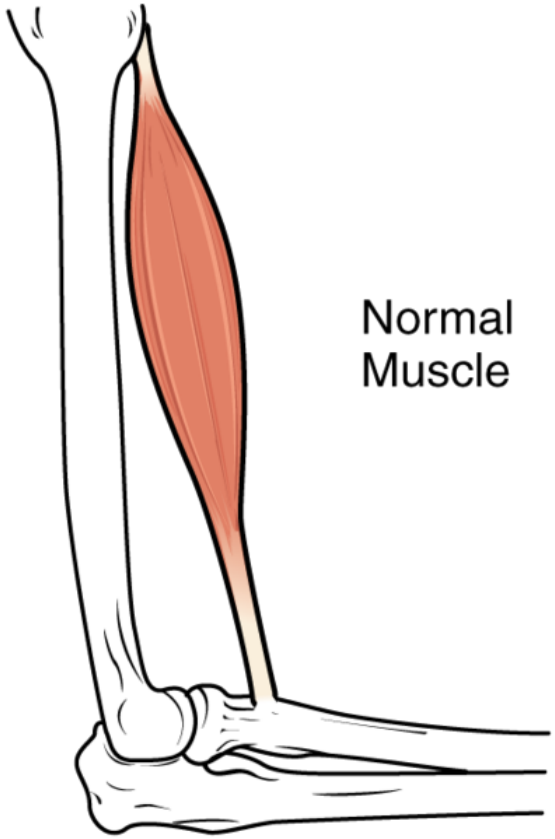
- Proper medical professionals
- Acupuncture
- Massage
- TENS-Transcutaneal Electrical Nerve Stimulation
- Support Groups
- Non addictive medications
- Adequate Sleep
  - Proper sleep hygiene-same time to sleep and same wake up, limit caffeine, limit screen time, meditation, non addictive sleep aids
- Proper nutrition-non-inflammatory diet
- BE ACTIVE!!!
  - Exercise-but know limitations
  - Physical Therapy
  - Personal Training

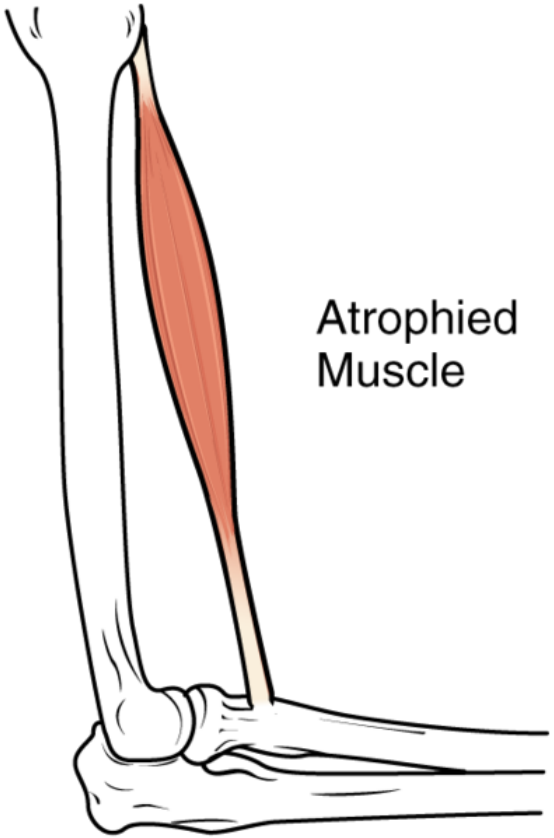
Ambulation

- Walker, wheelchair, cane
- Various reasons including muscle deconditioning/atrophy
- Neuropathy
- Previous falls/injuries

Muscles

- Muscle atrophy is decrease in mass of muscles
- Muscle atrophy leads to muscle weakness since force is dependent on mass
- Inactivity and poor nutrition leads to muscle atrophy


Normal
Muscle


Atrophied
Muscle

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Treatment of Muscle Atrophy

- Improve nutrition
- Exercise/Physical Therapy
- Strength training

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What do we do with all this information?

Integrated Model of Evidence-Based Treatment

- Individual Therapies
  - CBT, DBT, MI, ACT, EMDR, CPT, IFS, etc.
- Family Therapy
- Group Therapies
  - Grief and Loss, ACOA, Trauma, Relapse Prevention, Psychoeducation
- 12-Step Meetings
- Wellness Groups
- Physical Therapy
- Personal Training

`Chronic Pain Program

  - Medical Massage, Acupuncture, Process Group, Medication Management, non-medication based interventions
- Spiritual Assessment and Counseling
- Psychological and Neurocognitive Testing
- Neurofeedback-learn to control brain activity
- Alpha Stimulation-device that uses cranial electrotherapy to treat anxiety, depression, chronic pain and insomnia
- Biofeedback-mind/body technique to help people learn to control involuntary body functions, such as heart rate
- Psychiatric Evaluation/Medication Management

Interdisciplinary Treatment Team

- Medical
- Psychological
- Clinical
- Family
- Psychiatry
- Spiritual Leaders
- Recreation
- Nutrition
- Social and Systemic (Caregiver)

- Treating the whole person: Physical, Emotional, Spiritual, Medical, Recreational, Nutritional, Social and Systemic (Caregiver)
- Frequent case consults, team meetings, discussions, etc.
- Aftercare planning considers all treatment modalities needed for continued integrated care.

Interdisciplinary Communication

- Interdisciplinary vs. Multidisciplinary (Salad vs. Stew)

Multiple but distinct disciplines

Interaction among disciplines to achieve integrated understanding

Continuing Care is Prevention!

- Extended Care
- PHP (SUD and/or Mental Health)
- IOP
- OP – Referrals to therapists specializing in individual needs
  - Grief, Trauma, SUD, EMDR, CPT, etc.
- Sober Living
- Recovery Coaching/Monitoring
- Recovery Support Services-72 Hour Re-integration and Case Management
- Independent vs. assisted living vs. skilled nursing/memory care
- Family involvement
- Addiction knowledgeable Physicians
  - Psychiatry, PCPs, specialists
- Neuropsychological Follow-up

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Questions?