PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Substance Use Disorders in Older People

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Louis A. Trevisan Disclosures

- Dr. Trevisan has no relevant financial relationship(s) with ACCME defined commercial interests to disclose.

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

Target Audience

- The overarching goal of PCSS is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.

Educational Objectives

- Review the prevalence of substance use disorders in older people.
- Describe the signs and symptoms of substance use and misuse in older people.
- Recognize the psychopharmacology of substance use disorders in older people.
- Assess the relevance and importance of psychotherapeutic intervention in older people.

Case Vignette

- In this presentation, we will examine the case of a 75-year-old Caucasian female, who has been married to the same man for 50 years, and has recently been complaining of feeling more anxious. She has asked her husband for help with this. She has a history of anxiety not otherwise specified (NOS) and is prescribed clonazepam by her primary care physician. Her husband is a retired professor at an Ivy League University and has a complex medical history including chronic pain from peripheral neuropathy treated with extended-release oxycodone 40 mg by mouth every twelve hours. She presents to the emergency department after she became confused, was unable to eat her dinner, and fell into a light sleep at the dinner table while out to dinner with her husband.

- We'll examine other aspects of this case later on in the presentation.

Substance Use Disorders in the Older Population: *Prevalence*

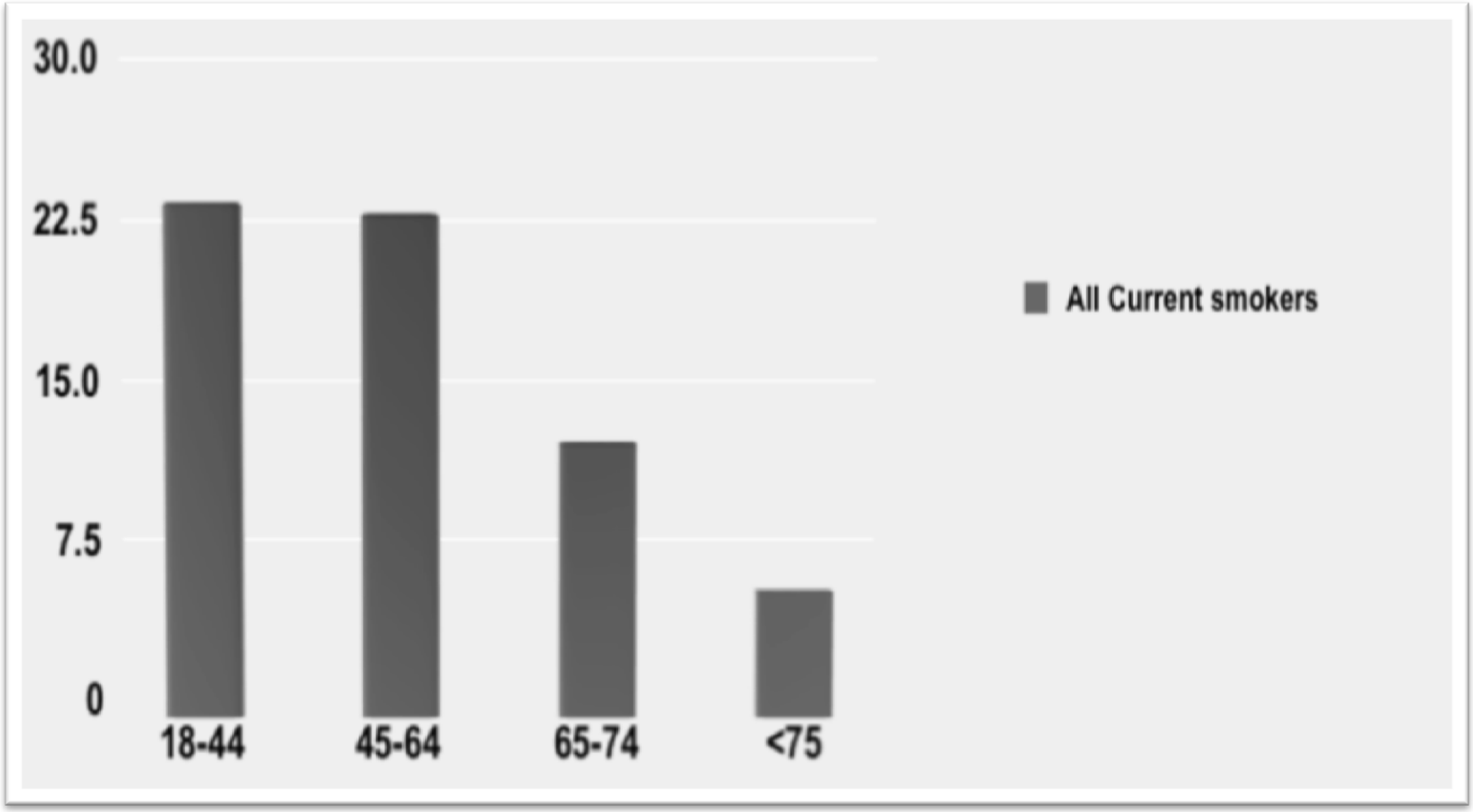
Elderly? Older Population? Geriatric?

- Baby Boomers are those people born between 1946-1964 (53 to 71 years of age). This group will present with more substance use disorders and substance use treatment going forward.
- The use of greater than 65 years old definition to describe the elderly may be somewhat arbitrary?
- The information in this presentation is based on persons older than 50-55 years of age and terminology will vary.

Principal Substances Used in Older Patients

- Tobacco
- Alcohol
- Opioids (non-medical use or nonmedical use of prescription medications and illicit drugs)
- Stimulants, cocaine
- Marijuana
- Others: Sedatives and muscle relaxants

Prevalence of Current Smoking Among Adults United States 2008



Source: Centers for Disease Control and Prevention www.cdc.gov

Alcohol Use in Older Americans

- Older adults have had consistently lower rates of alcohol use, high-risk drinking, and Alcohol Use Disorder (AUD) than younger adults over the past 40 years.
- Between 2001-2002 and 2012-2013 there were substantial and unprecedented proportional increases relative to earlier years in:
  - Alcohol use (22.4%)
  - High-risk drinking (65.2%)
  - AUD (106.7%)

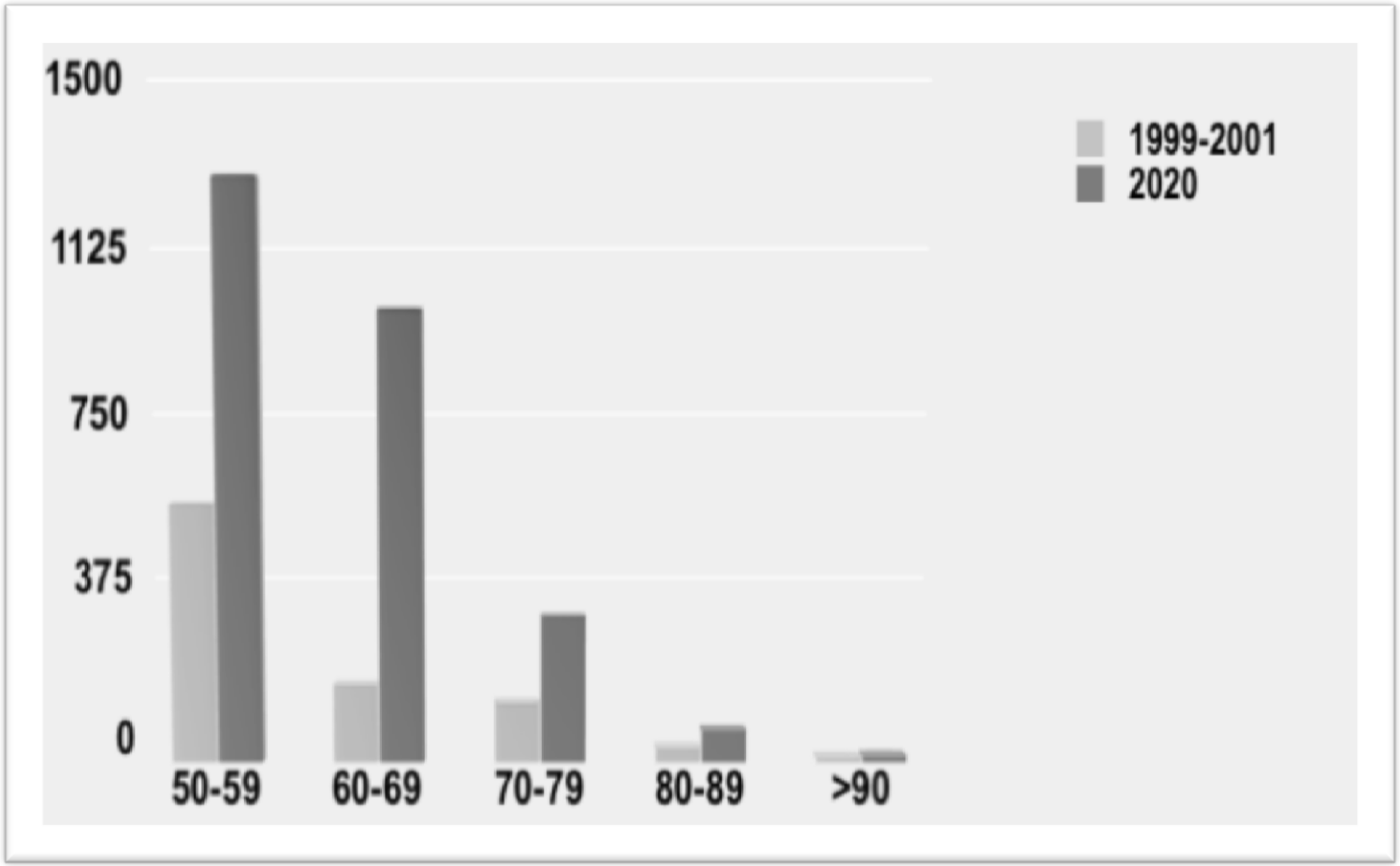
Hasin DS, Stinson FS, Ogburn E, Grant BF. 2007.
Johnston, L. D., O'Malley, P. M., Miech, R. A.,. Bachman, J. G., & Schulenberg, J. E. (2015)
Grant BF, Dawson DA, Stinson FS, Chou SP, Dufour MC, Pickering RP. 2004

Projections for Alcohol Use in Older Americans

- The projected increase in the older population from 40 million in 2010 to 80 million in 2030 could produce a substantial increase in the absolute number of older adults with high-risk drinking and AUD

Ortman JM, Velkoff VA, Hogan H. 2014

Actual and Projected Non-Medical Use of Prescription Psychotherapeutics



Colliver et al. Projecting Drug Use Among Aging Baby Boomers in 2020. Ann Epidemiol 2006;16:257–265.

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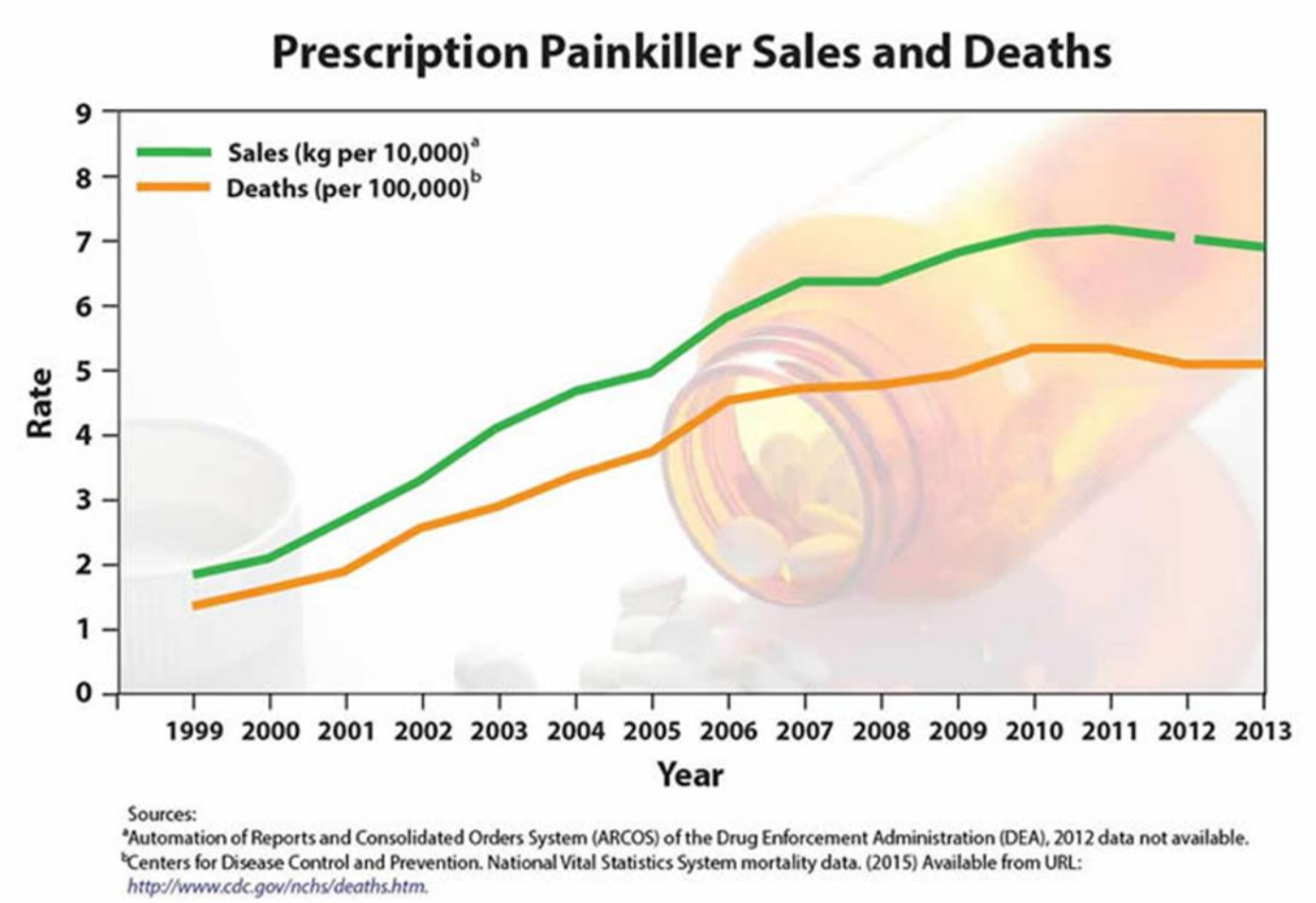
The Prescription Medication Problem

- Americans = 4.6% of the world's population
- Americans consume 80% of the global opioid supply
- Americans consume 99% of the global hydrocodone supply
- Americans consume 66% of the world's illegal drugs
- Overall increase from 2000 to present in opioid consumption = 149%
- Increase of:
  - 222% for morphine
  - 280% for hydrocodone
  - 319% for hydromorphone
  - 525% for fentanyl base
  - 866% for oxycodone
  - 1,293% for methadone

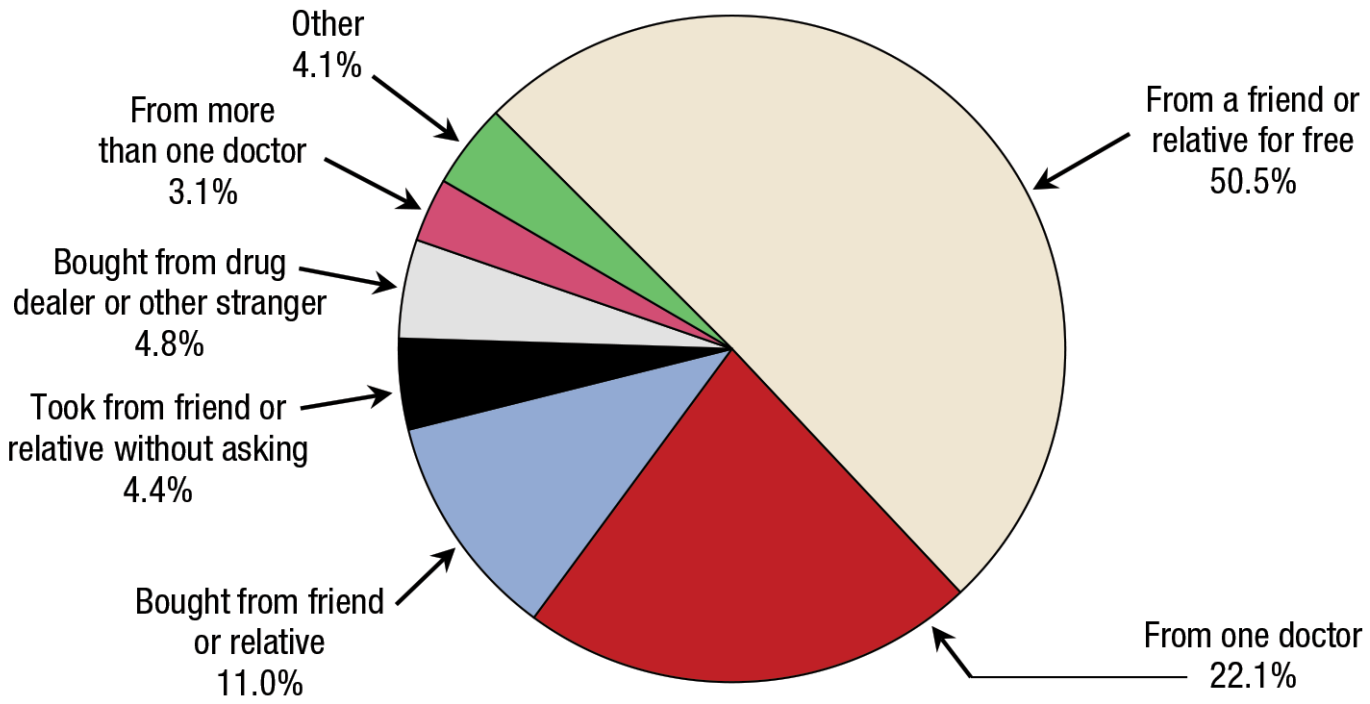
The Older Patient with Prescription Opioid Use Disorder

- Multiple medical problems
- Higher incidence of chronic pain
- Common mood disorders
- Misunderstand directions: misuse vs use disorder
- Multiple prescribers
- Rationalization and denial among family members, peers or care providers
- Deficits presumed to be due to age
- Interaction with alcohol or other drugs
- Over representation of female

Prescription Painkillers Sales and Deaths

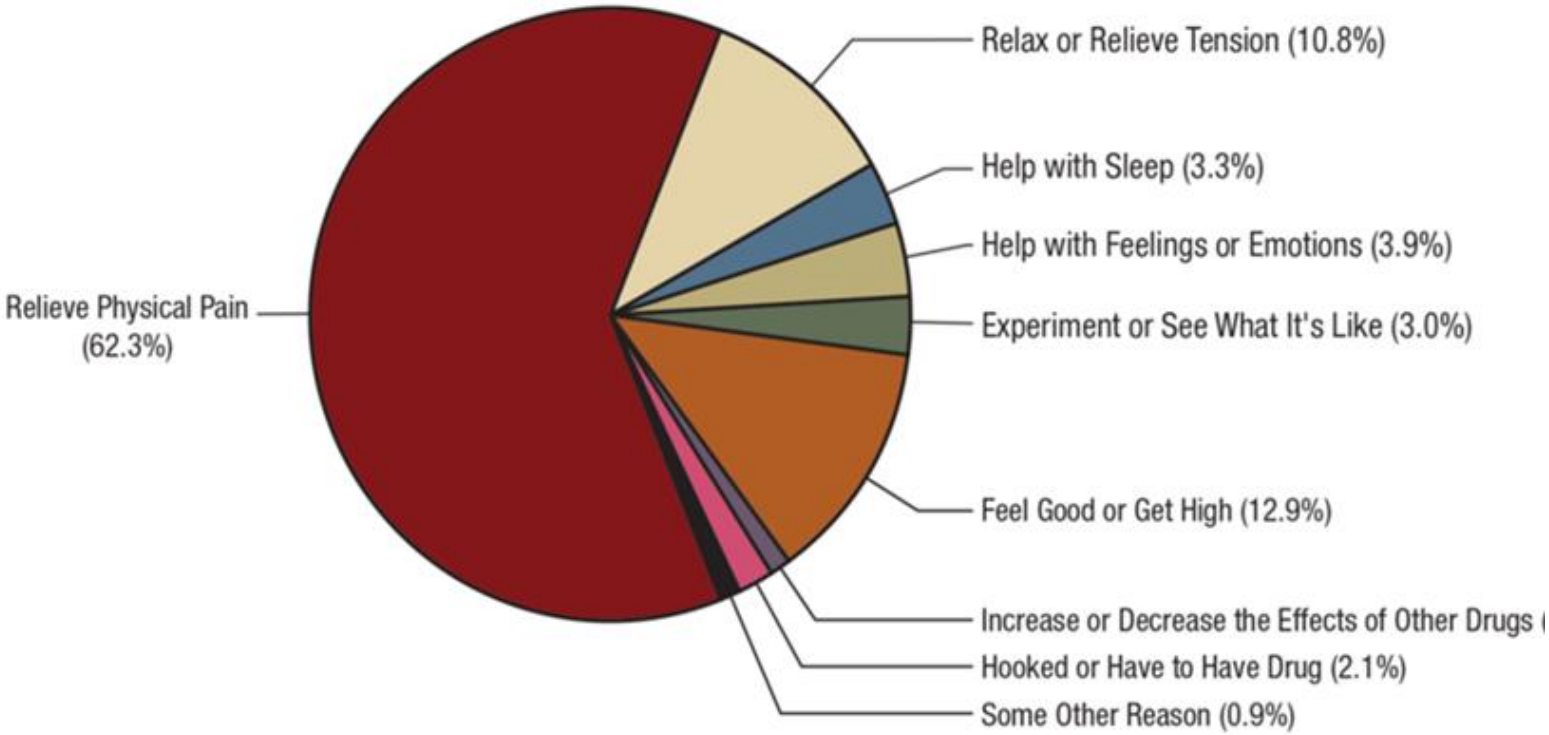


Source of Prescription Pain Relievers for the Most Recent Nonmedical Use Among Past Year Users Ages 12 or Older: Annual Averages, 2013 and 2014



SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2013 and 2014.

Main Reason for the Most Recent Prescription Pain Reliever Misuse among People Ages 12 or Older Who Misused Prescription Pain Relievers in the Past Year: Percentages (NSDUH 2016)



11.5 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year

https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#fig33

Clinical Pearls: Recognition of Misuse of Prescribed Medications

- Any symptom in an older adult should be considered a medication side effect until proven otherwise.
- Falls: sedative hypnotics, opioid pain meds
- GI distress: alcohol
- Incontinence: alcohol, sedative hypnotics
- Constipation: opioids
- Depression: alcohol, opioids
- Anxiety: steroids, alcohol withdrawal
- Confusion: any CNS agent
- Insomnia

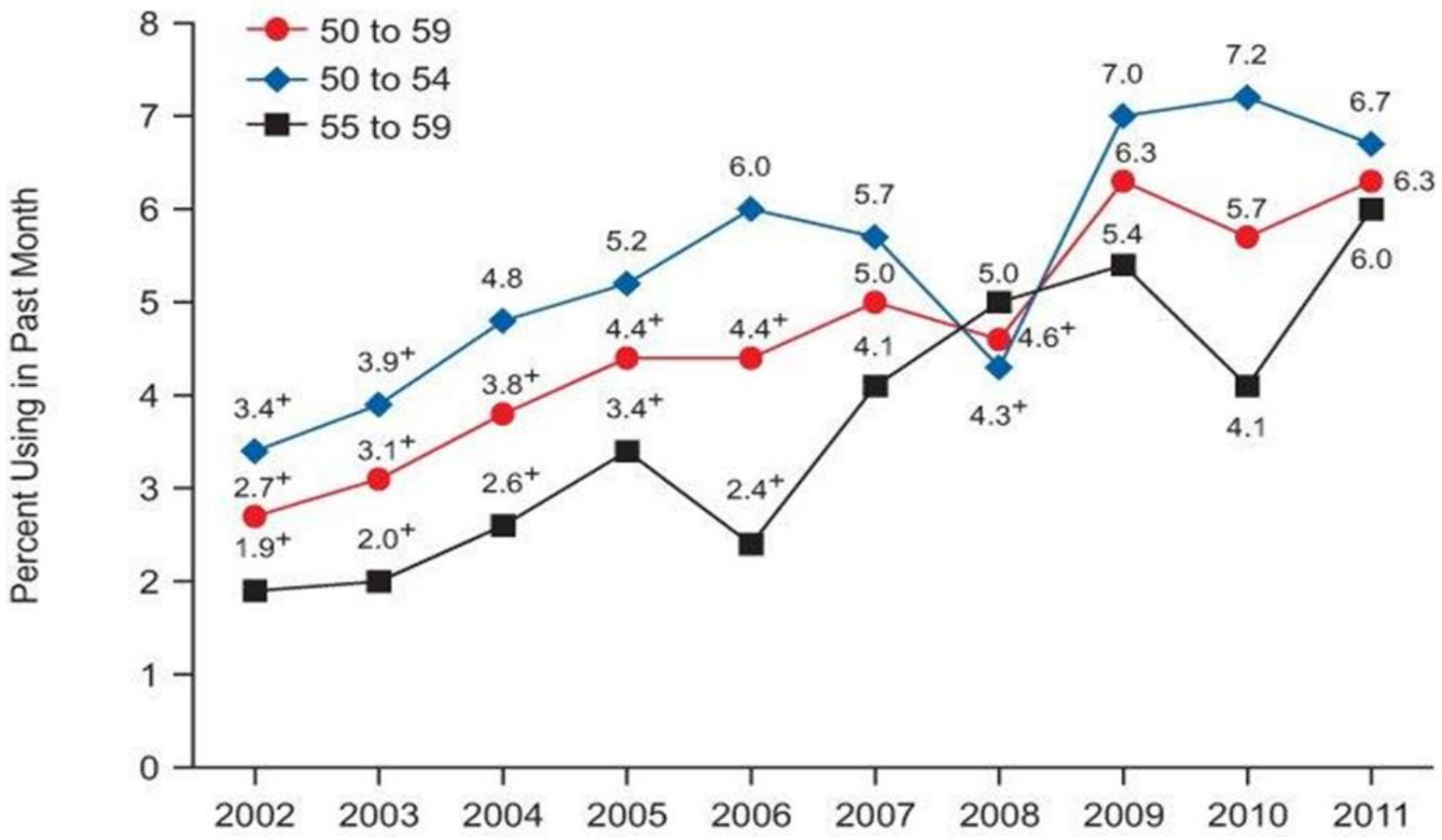
http://docplayer.net/46269373-Safe-medication-use-in-the-older-adult.html

Medication Misuse

- Extra doses, missed doses, not filling prescriptions, not understanding directions, incorrect timing
- Risk Factors
  - Female
  - Social isolation
  - Polypharmacy and multiple prescribers
  - Prescribed drugs with abuse potential
  - Chronic medical problems
  - History of substance use or psychiatric disorder

Simoni-Wastila & Yang, A, 2006.

Past Month Illicit Drug Use Among Adults Age 50-59



https://www.datafiles.samhsa.gov/study/national-survey-drug-use-and-health-nsduh-2011-nid13563

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Marijuana

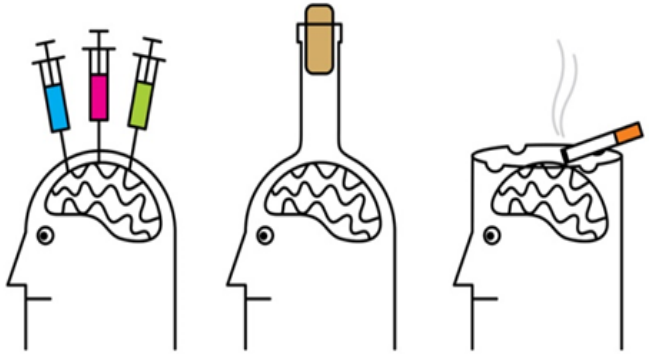
- Previous national surveys: 2% of North American individuals aged 50 or older used illicit drugs around the turn of the 21st century.
- Overall use of any illicit drug will increase from 2.2% to 3.1%, baby boomer marijuana users will triple in the next decade.

Blow FC, Barry KL. 2012
Colliver JD, Compton WM, Gfroerer JC, Condon T. 2006

Barriers to Identification of Substance Use in Older Adults

Physician Factors

- Stereotypes about substance use disorder
- Stereotypes about older adults
- Lack of knowledge about treatment



Patient Factors

- Denial
- Shame and guilt

Diagnostic Factors

- Co-morbid medical conditions - may obscure or be used to explain symptoms of substance use disorder
- Age related changes - falls, anemia, neuropathy, altered cognition
- Fewer overt warning signs
- DSM criteria less applicable

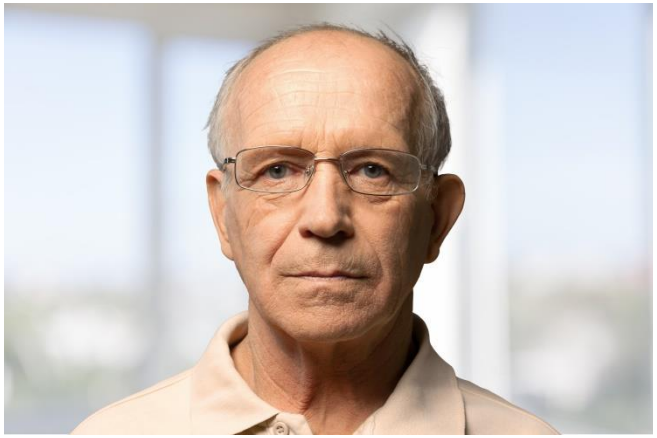
Early Onset AUD in Older Adults

- Early-onset AUD
- Drinking before 60 years of age
- 2/3 of older problem drinkers
- Chronic, alcohol related medical problems
- Positive family history for alcohol use disorder
- Serious psychiatric comorbidities-particularly major affective disorders (US Dept. HHS 1991).
- Less socially adjusted
- More antisocial characteristics
- May have intractable course
- More legal problems
- Need more medically focused intensive treatment for their addiction.

Oslin et al. 2002, Lemke et al. 2003, Satre et al. 2004

Late Onset AUD in Older Adults

- Older alcohol use disorder patients are more responsive to treatment regardless of age of onset. Drinking began after 60 years of age
- Fewer physiological consequences of disease process due to shorter duration of use
- Often begin alcohol misuse after a stress-related event
- Loss (spouse, job, home)
- Milder clinical picture
- More emotionally stable
- Better adherence to treatment
- Lower recidivism rate
- More social support
- Greater life satisfaction



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Oslin et al. 2002, Lemke et al. 2003, Satre et al. 2004

Psychosocial Stressors in Aging

- Role and status change, especially retirement
- Income changes
- Physical health decline
- Cognitive changes
- Widowhood
- Shrinking social networks
- Loss of independence

Summary

- Older populations of patients are changing
- Increasing age cut offs
- No longer defined merely by age, but more likely by health status and psychosocial factors
- Older patients use many different substances including:
  - Alcohol
  - Opioids
  - Prescription medications
  - Illicit drugs

Substance Use Disorders in the Older Population: *Screening and Evaluation*

Evaluation of Tobacco Use Disorder

- Fagerstrom Test for Nicotine Dependence (FTND)
- Heaviness of Smoking Index (HSI)
- Modified Cigarette Evaluation Questionnaire (mCEQ)
- Cigarette Dependence Scale (CDS-12 and CDS-5)

Screening Tests for Alcohol Use Disorder

- Michigan Alcoholism Screening Test- Geriatric Version (MAST-G)
- Short version of Michigan Alcoholism Screening Test-Geriatric (SMAST-G)
- Alcohol Use Disorders Identification Test (AUDIT)
- Alcohol Use Disorders Identification Test- 5 items (AUDIT-5 or AUDIT-PC)
- Alcohol Use Disorders Identification Test- Consumption (AUDIT-C)
- CAGE
- Alcohol-Related Problems Survey (ARPS)

Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G)	Yes (1)	No (0)
1) When talking with others, do you ever underestimate how much you actually drink?		
2) After a few drinks, have you sometimes not eaten or been able to skip a meal because you don't feel hungry?		
3) Does having a few drinks help decrease your shakiness or tremors?		
4) Does alcohol sometimes make it hard for you to remember parts of the day or night?		
5) Do you usually take a drink to relax or calm your nerves?		
6) Do you drink to take your mind off your problems?		
7) Have you ever increased your drinking after experiencing a loss in your life?		
8) Has a doctor or nurse ever said they were worried or concerned about your drinking?		
9) Have you ever made rules to manage your drinking?		
10) When you feel lonely does having a drink help?		
TOTAL SCORE:		

For clients who answer 'Yes' to two or more of the S-MAST-G questions, a complete assessment of their alcohol use should be made.

AUDIT-C

1. How often do you have a drink containing alcohol?
   (0) Never (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) None (1) 1or 2 (2) 3 or 4 (3) 5 or 6 (4) 7 or more

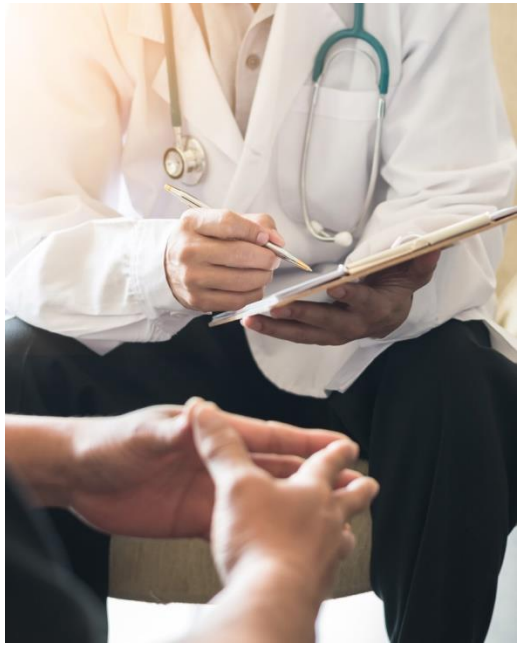
3. How often do you have: (men) five or more drinks on one occasion? (for women) four or more drinks on one occasion?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

Scoring: Comprehensive Evaluation if there is: A score of 3 or more points on questions 1 through 3 OR a report of drinking 4 or more drinks on one occasion

Aalto, et al, 2011

CAGE

1. Have you ever felt you should **c**ut down on your drinking?
2. Have people **a**nnoyed you by criticizing your drinking?
3. Have you ever felt bad or **g**uilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**e**ye opener)?



Scoring:

Comprehensive evaluation if there is: A “yes” answer to one of questions

Screening for Potential Rx-Opioid Misuse and Opioid Use Disorder

- Validated in Elderly
  - Screening Tool of Older Persons' potentially inappropriate Prescriptions (STOPP)
- Other screening tests
  - Screener and Opioid Assessment for Patients with Pain-revised (SOAPP-R)
  - Current Opioid Misuse Measure (COMM)
  - Drug Assessment Screening Tool (DAST)

Gallagher and O'Mahony 2008

Summary

- There are many useable screening instruments to help the clinician ascertain substance use in the older population.
- Self administered
- Clinician administered
- Remember to ASK about substance use in this population

Substance Use Disorders in the Older Population: *Treatment*

General Principles

- Age specific treatment appears to potentiate treatment effects (treatment matching) in older adults.
- Treatment considerations
- Biological:
  - Co-morbid medical illness
  - “Start low, go slow”
- Psychotherapeutic:
  - Stage of life factors
  - Cognitive abilities
- Social:
  - Family interventions
  - Group

Kofoed, L.; Tolson, R.; Atkinson, R.; Toth, R.; and Turner, J. 1987
Kuerbis, A and Sacco, P 2012

Tobacco Use Disorder

- Biological Treatments
  - Nicotine replacement therapy
    - Patch
    - Gum
  - Other Medications

Nicotine Replacement Therapy

Form	Advantages	Disadvantages
Transdermal Patch	Provides Steady level of nicotine; easy to use; unobtrusive; available without prescription	Patient cannot adjust dose if craving occurs; nicotine released more slowly than in other products
Nicotine Polacrilex gum	Patient controls dose; oral substitute for cigarettes; available without prescription	Proper chewing technique needed to avoid side effects and achieve efficacy; user cannot eat or drink while chewing the gum; can damage dental work; difficult for denture wearers to use
Vapor inhaler	Patient controls dose; hand to-mouth substitute for cigarettes	Frequent puffing needed; device visible when used
Nasal spray	Patient controls dose; offers most rapid delivery of nicotine and the highest nicotine levels of all nicotine-replacement products	Most irritating nicotine replacement product to use, device visible when used

Modified from: Int J Health Sci (Qassim). 2016 Jul; 10(3): 425–435.

Other Medications

Varenicline

- Oral administered Alpha4-Beta2 nicotinic ACH receptor partial agonist
- Antagonizes nicotine response
- No dose adjustment in older adults

Bupropion SR

- Antidepressant - Weak inhibitor of dopamine uptake
- Well-tolerated, Advanced age in one study was reported as a positive predictive factor

Zhao, Q., et.al., 2011
Elhassan, A, & Chow, R, D. 2007

Psychosocial Treatments for Tobacco Use Disorder

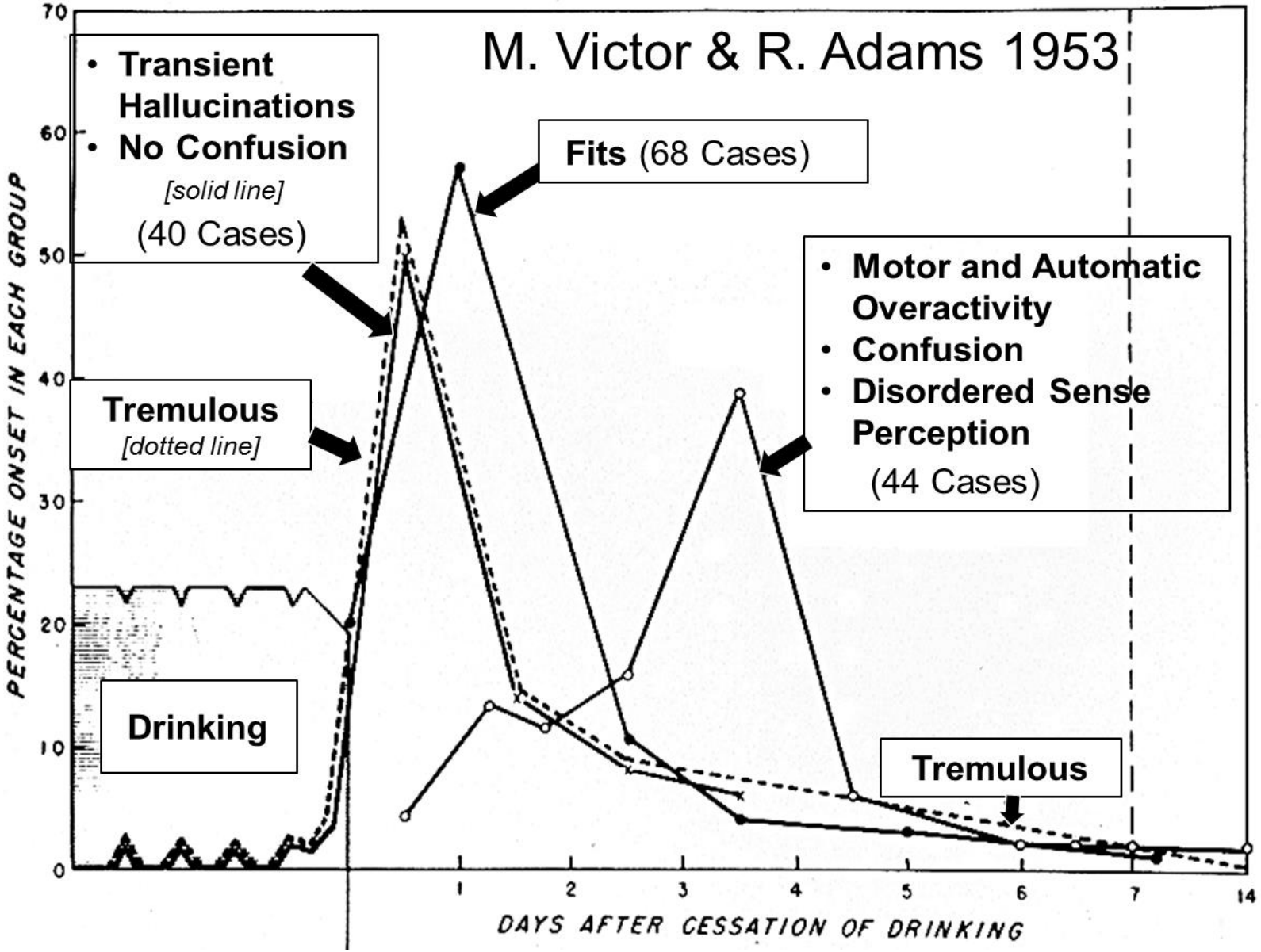
- Behavioral Treatments
  - Cognitive Behavioral Therapy (CBT)
  - Brief Interventions
- Social Treatments
  - Groups
  - Epidemiological

Alcohol Use Disorder

- Biological Treatments
  - Withdrawal Management (i.e. detoxification)
  - Treatment Medications
    - Naltrexone
    - Acamprosate
    - Disulfiram

Alcohol: Treatment of Withdrawal

- Older patients at higher risk for delirium, prolonged confusion, falls
- Onset of symptoms may be delayed, with confusion, rather than tremor as the major sign
- Inpatient treatment is indicated if history of severe withdrawal or significant medical co-morbidity
- A post acute phase including periodic confusion may continue for weeks to months
- Older Adults and Alcohol www.agingincanada.ca/best practice7.html 2004


M. Victor & R. Adams 1953
• Transient Hallucinations
• No Confusion
[solid line]
(40 Cases)
Fits (68 Cases)
• Motor and Automatic Overactivity
• Confusion
• Disordered Sense Perception
(44 Cases)
Tremulous
[dotted line]
Drinking
Tremulous
PERCENTAGE ONSET IN EACH GROUP
DAYS AFTER CESSATION OF DRINKING
0
10
20
30
40
50
60
70
1
2
3
4
5
6
7
14

Medications for the Treatment of Alcohol Use Disorder

Naltrexone (oral)	Naltrexone (injectable)	Acamprosate	Disulfiram
50 mg daily.	380 mg once monthly	666 mg TID; or 333 mg TID in moderate renal impairment (CrCl 30 to 50 mL/min)	250 mg daily (range 125 mg to 500 mg)
Recommendations			
Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, administer a naloxone challenge test. Evaluate liver function. Laboratory Follow-up: Monitor liver function.	**Patients must be opioid-free for a minimum of 7 to 10 days before starting**. Pretreatment with oral naltrexone is not required before using injectable naltrexone. Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition. Laboratory follow-up: Monitor liver function.	Evaluate renal function. Establish abstinence.	Evaluate liver function. Warn the patient (1) not to take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose and (2) to avoid alcohol in the diet (e.g., sauces and vinegars), over-the-counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash). Laboratory Follow-up: Monitor liver function.

Treatment of Alcohol Use Disorder

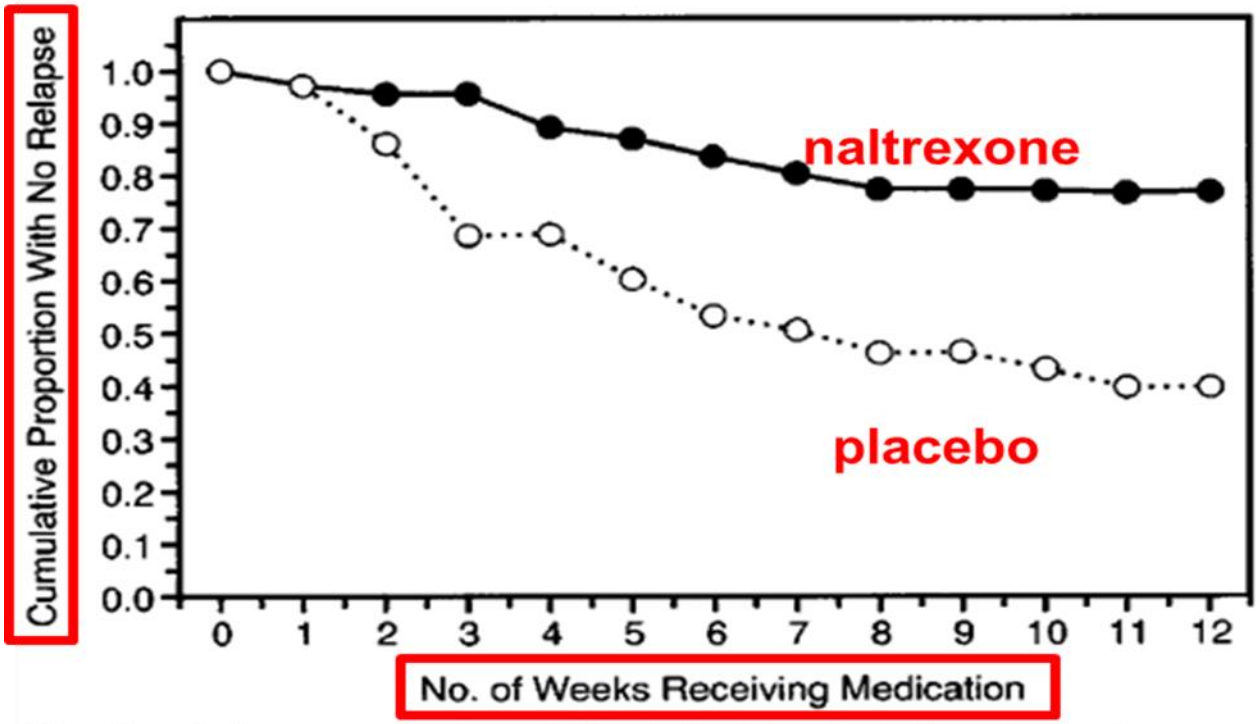
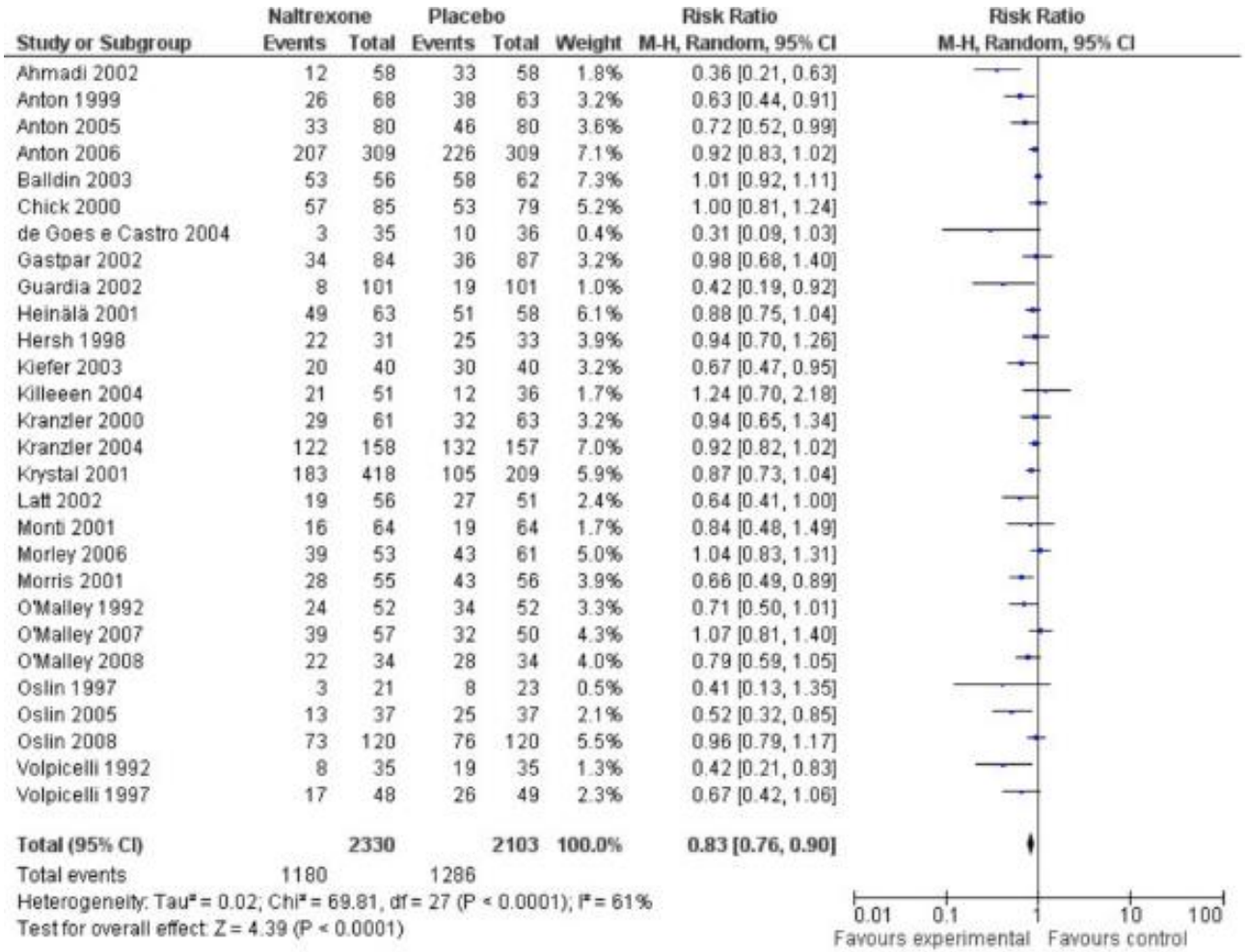


Fig 2.—*Relapse rates (as defined in the text) for the naltrexone hydrochloride- (closed circles) and placebo-treated (open circles) groups across the 12 weeks of the study.*

Defined alcohol relapse as follows: (1) reporting drinking 5 or more days within 1 week; (2) reporting five or more drinks per drinking occasion; or (3) coming to the treatment appointment with a blood alcohol concentration above 100 mg/ dL."

Volpicelli, J.R., et al., Naltrexone in the treatment of alcohol dependence. Archives of general psychiatry, 1992. 49(11): p. 876-880.

Naltrexone Efficacy for Heavy Drinking



Study or Subgroup	Naltrexone Events	Naltrexone Total	Placebo Events	Placebo Total	Weight	Risk Ratio M-H, Random, 95% CI
Ahmadi 2002	12	58	33	58	1.8%	0.36 [0.21, 0.63]
Anton 1999	26	68	38	63	3.2%	0.63 [0.44, 0.91]
Anton 2005	33	80	46	80	3.6%	0.72 [0.52, 0.99]
Anton 2006	207	309	226	309	7.1%	0.92 [0.83, 1.02]
Balldin 2003	53	56	58	62	7.3%	1.01 [0.92, 1.11]
Chick 2000	57	85	53	79	5.2%	1.00 [0.81, 1.24]
de Goes e Castro 2004	3	35	10	36	0.4%	0.31 [0.09, 1.03]
Gastpar 2002	34	84	36	87	3.2%	0.98 [0.68, 1.40]
Guardia 2002	8	101	19	101	1.0%	0.42 [0.19, 0.92]
Heinälä 2001	49	63	51	58	6.1%	0.88 [0.75, 1.04]
Hersh 1998	22	31	25	33	3.9%	0.94 [0.70, 1.26]
Kiefer 2003	20	40	30	40	3.2%	0.67 [0.47, 0.95]
Killeeen 2004	21	51	12	36	1.7%	1.24 [0.70, 2.18]
Kranzler 2000	29	61	32	63	3.2%	0.94 [0.65, 1.34]
Kranzler 2004	122	158	132	157	7.0%	0.92 [0.82, 1.02]
Krystal 2001	183	418	105	209	5.9%	0.87 [0.73, 1.04]
Latt 2002	19	56	27	51	2.4%	0.64 [0.41, 1.00]
Monti 2001	16	64	19	64	1.7%	0.84 [0.48, 1.49]
Morley 2006	39	53	43	61	5.0%	1.04 [0.83, 1.31]
Morris 2001	28	55	43	56	3.9%	0.66 [0.49, 0.89]
O'Malley 1992	24	52	34	52	3.3%	0.71 [0.50, 1.01]
O'Malley 2007	39	57	32	50	4.3%	1.07 [0.81, 1.40]
O'Malley 2008	22	34	28	34	4.0%	0.79 [0.59, 1.05]
Oslin 1997	3	21	8	23	0.5%	0.41 [0.13, 1.35]
Oslin 2005	13	37	25	37	2.1%	0.52 [0.32, 0.85]
Oslin 2008	73	120	76	120	5.5%	0.96 [0.79, 1.17]
Volpicelli 1992	8	35	19	35	1.3%	0.42 [0.21, 0.83]
Volpicelli 1997	17	48	26	49	2.3%	0.67 [0.42, 1.06]
Total (95% CI)		**2330**		**2103**	**100.0%**	**0.83 [0.76, 0.90]**
Total events	1180		1286			

Heterogeneity: Tau² = 0.02; Chi² = 69.81, df = 27 (P < 0.0001); I² = 61%
Test for overall effect: Z = 4.39 (P < 0.0001)

Rösner S, Hackl-Herrwerth A, Leucht S, Vecchi S, Srisurapanont M, Soyka M. Opioid antagonists for alcohol dependence. Cochrane Database of Systematic Reviews 2010, Issue 12. Art. No.: CD001867. DOI: 10.1002/14651858.CD001867.pub3.

Psychosocial Treatments: General Considerations

- Age specific treatment more effective
- Address issues of loss and isolation
- Teach skills to rebuild social supports
- Slower pace
- Experienced staff
- Be alert to cognitive changes

Brief Intervention for At-risk Drinking in Older Populations

- Generally two or three 10-15 min sessions
- Education, assessment, feedback
- Use of motivational strategies, goal setting, behavior modification techniques
- Several trials in older adults as well
- Project Guiding Older Adult Lifestyles (GOAL)
  - The older adults who received the physician intervention demonstrated a significant reduction in 7 day alcohol use, episodes of binge drinking, and frequency of excessive drinking.
- Health Profile Project
- Staying Healthy Project
- Shown effective for decreasing alcohol consumption

Brief Treatment/Intervention

F.R.A.M.E.S

- **F**eedback from the assessment
- Personal **R**esponsibility for change
- **A**dvice to change
- **M**enu of change options
- **E**mpathic counseling style
- Enhanced client **S**elf-efficacy/ongoing follow-up

Alcohol Use Disorder: Psychotherapeutic Treatments

Examples:

- Relapse prevention
- Motivational Interviewing
- Motivational enhancement
- Individual psychotherapy
- CBT
- Twelve Step Facilitation

Magill, M & Ray, L. 1993
Dupree, L & Schonfeld, L & Dearborn-Harshman, K & Lynn, N 2008

Alcohol Use Disorder: Social Treatments

Examples:

- Group
- 12 Steps
- CBT
- Rational Recovery
- Family Interventions

DHHS (Department of Health and Human Services) Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach Loose Leaf – 2005

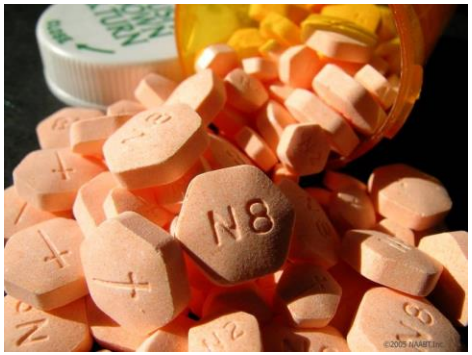
Methadone for Opioid Use Disorder in Older Adults

- 5%-6% of patients receiving methadone maintenance treatment (MMT) are over 55.
- Elderly may do better in treatment than younger patients in MMT
  - Have similar rates of medical and psychiatric problems
  - More likely to be married
  - Overall did significantly better in treatment.
- Increased risk of sedation with polypharmacy
- Increased risk of QTc prolongation and torsades de pointes
- Constipation

Firoz and Carlson; The American Journal of Geriatric Psychiatry, Vol.12, Issue 5, pages 539-541, 2004.

Buprenorphine for Opioid Use Disorder in Older Adults

- Partial opioid agonist
- Low abuse potential
- Plateau effect (above 32 mg dose)
- Half life is not altered with impaired renal or hepatic function*
- Poor oral bioavailability
- Sublingual (under the tongue) with absorption through the oral mucosa
- Slow dissociation rate
- Prolonged therapeutic effect - so can be given every other or every third day
- It is as effective as methadone for people with moderate use disorders, and possibly those with more severe use disorders**



*Pergoizzi et. al. Pain Pract. 2008
**Hulse et al. 2002, p. 91

Naltrexone for Opioid Use Disorder in Older Adults

Who might benefit from naltrexone?

- Highly motivated individuals
- Individuals with opioid use disorder in full remission who are employed and socially functioning
- Those recently detoxed from methadone or buprenorphine maintenance
- Those who are leaving prison
- Those who are leaving residential treatment settings
- Those who sporadically use opioids but are not on methadone or buprenorphine maintenance
- Those not eligible for methadone or buprenorphine maintenance
- Those in a long waiting period for methadone or buprenorphine maintenance
- Adolescents not wishing to go on methadone or buprenorphine maintenance

Summary

- Treatments are available
- Start Low and Go Slow in older populations
- Age specific treatment appears to be more efficacious in general and should be combined with pharmacologic treatment when possible.
- Age specific treatments include building relations and support, use of less confrontation, an and older adult only environment.

*Kuerbis A1, Sacco P. 2013

Case Vignette

- 75-year-old Caucasian female, who has been married to the same man for 50 years, has recently been complaining of feeling more anxious and has asked her husband for help with this. She has a history of anxiety NOS and is prescribed clonazepam by her primary care physician. Her husband is a retired professor at an Ivy League University and has a complex medical history including chronic pain from peripheral neuropathy treated with extended-release oxycodone 40 mg by mouth every twelve hours. She presents to the emergency department after she became confused, was unable to eat her dinner and fell into a light sleep at the dinner table while out to dinner with her husband.

Case Vignette

- Upon arrival to the emergency room she required intubation and was given naloxone IV. Her urine toxicology screen was positive for opioids and benzodiazepines. Her breathalyzer was 0.04g/dl. She is stabilized and admitted and detoxified (weaned off of her opioid pain medications with little problem). She is maintained on her clonazepam and transferred to the psychiatry inpatient unit.

Case Vignette - Summary

- Older adults can and often do misuse prescription medications.
- Mixing alcohol, opioids and benzodiazepines is never a good idea and use of these medications should be scrutinized and monitored closely in the older adult.
- Even smaller amounts of alcohol at levels that are subthreshold for legal intoxication can be deadly in the elderly or medically compromised when combined with benzodiazepines and/or opioids.

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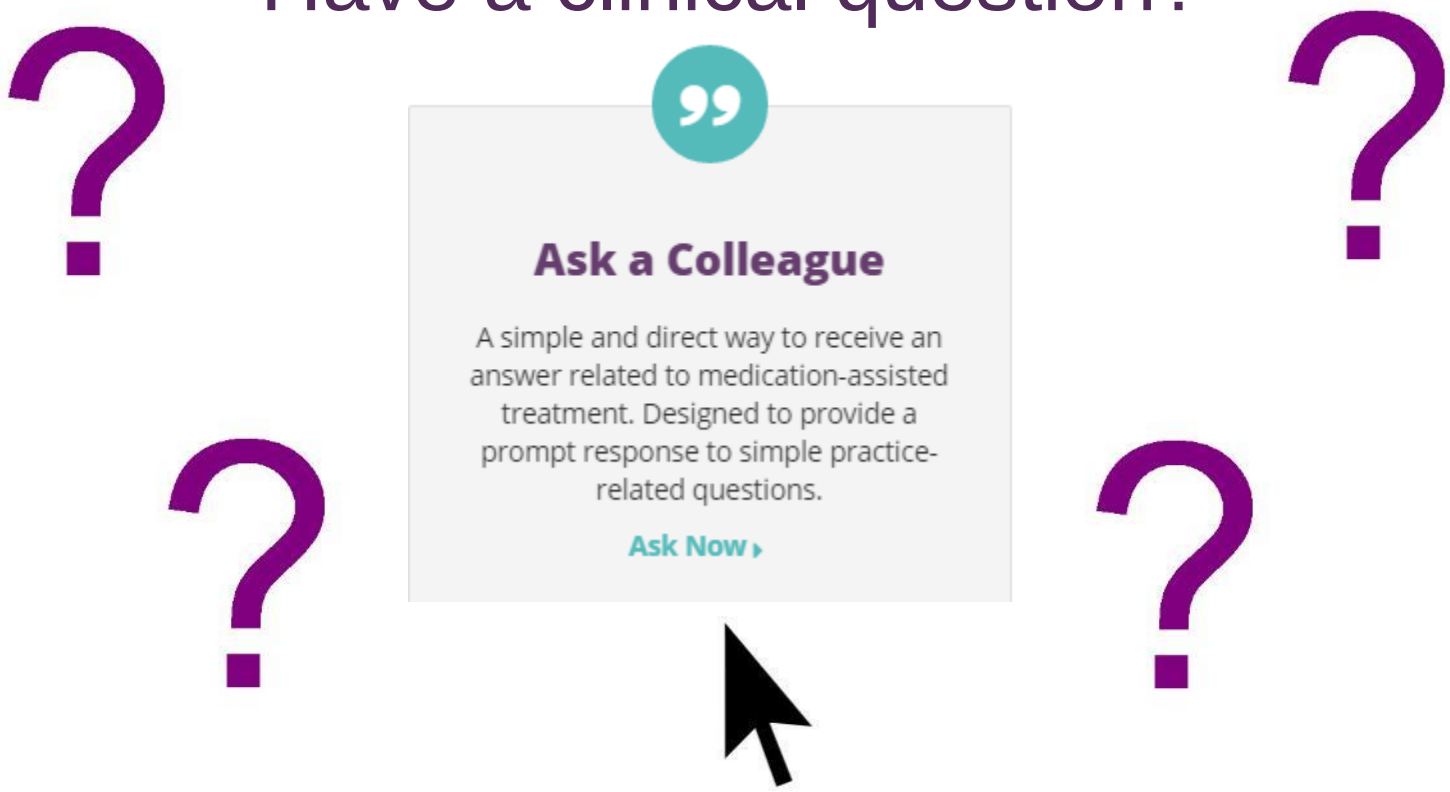

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Funding for this initiative was made possible (in part) by grant nos. 5U79TI026556-02 and 3U79TI026556-02S1 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.