Addressing Co-occurring Disorders Among Older Adults

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Goals of Presentation

- Understand Demographics and Trends
- Assess Cognitive Impairment
- Learn Brief Assessment Strategies
- Refine Communication Strategies
- Increase Empathy - SECURE Project
- Increase Comfort and Expertise
- Improve Treatment for Clients

Demographics of the Elderly Population

- 76M “baby-boomers” will reach 65 between 2010 and 2030
- By 2030 older adults will account for 20% of population, up from 13% in 2009
- Elderly, minority population will increase to 25% by 2030, up from 16% in 1998
- Life expectancy (all races) – 80.9 for women, 76 for men (http://www.cdc.gov/nchs/data/hus/hus11.pdf#022)

Alcohol Abuse in Older Adults

www.psychiatrictimes.com/p990454.html

- 3-9% meet criteria of heavy drinking
- Risky drinking = 7 drinks/week or 3 in one day
- Heavy drinking = 12-21 drinks/week
- 15% ER admits for 65+ alcohol-related
- 20% psychiatric admits alcohol-related
- 17% have a substance use disorder

Two Types of Geriatric Alcoholics

www.oasas.state.ny.us/AdMed/pubs/FYIInDepth-Elderly.htm

- "Hardy Survivors" (60%) early onset, long term abusers, made it to 65, but have more problems
- "Late Onset" (40%) folks triggered by retirement, loss of loved ones, health concerns, reduced income, sleep problems, or family conflict.
- "Late Onset" group fewer health problems

NIAAA Recommendations for Daily Alcohol Usage (1995)

- Men - No more than two drinks per day
- Women - No more than one per day
- Men/women over age 65 - No more than one for men and ¾ for women
- Risky drinking – more than 7 per week or 3 drinks in a single day
- A drink contains one ounce of alcohol
  - 12 oz of beer; 1 oz of spirits; 4-6 oz. wine

Alcohol Toxicity and Older Adults Kennedy (2000)

- Lower levels of ETOH affect more
- Less total body water
- Diminished liver functioning/clearance
- Blood-brain barrier permeated easily
- Increased receptor sensitivity in brain
- Tolerance decreases with age

Illicit Drug Abuse in Elderly AARP

http://www.aarp.org/health/conditions-treatments/info-06-2010/i41-health.html

- Rates have traditionally approached 1% <
- 2010 – only 1.5% > 75, but 60% were between 50-55. Baby boom effect?
- Illicit drug usage on rise in both 50-64 age population and 65+.
- 50+ age group: 28.1% used in 2003; 35.8% used in 2008.
- 51.1% of 50-64 group has used illict drugs, while 13.3% of 65+ used.

Shifting Trends

- 50-64 year age group uses more than 65+ in all categories of drugs
- 50+ population more positive attitudes about treatment than 65+ year olds.
- Less stigma perceived in younger group
- Assessment and treatment options sparse

Over the Counter (OTC) Meds

Kennedy (2000)

- 67% elderly take OTC meds daily
- Interaction effects
- Side effects can cause difficulties
  - Antihistamines can cause confusion
  - Cold meds increase blood pressure
  - Caffeine causes anxiety and agitation
  - Pain meds hard on liver, kidneys, & gut
    - Tylenol, Aleve, Motrin, etc.

Medication Misuse NIDA Research Report

- Most commonly abused are opioids, CNS depressants, and stimulants.
- On average, older adults take 5 prescriptions and 1 OTC med daily
- 17% elderly misuse prescription meds
- Misuse occurs when med taken in way that was not prescribed.

Reasons for Medication Misuse

- 3x less likely to follow directions Patterson et al. (1999)
- Frequently misunderstand directions
- Interaction effects
- Doses too high and unchecked over time
- “More is better”
- Financial concerns
- Helps manage emotional states
- Difficulty identifying different medications

Prevalence of Mental Illness in Elderly Population www.aagponline.org/prof/facts_mh.asp

- Elderly represent 13% of population with mental illness
- 20% 60 and older suffer from mental illness per WHO (2013)
- Cognitive, Mood, and Anxiety
- Highest rate of suicides in older pop
- Age 85+ highest rate of all

Access to Mental Health Services

www.aagponline.org/prof/facts_mh.asp

- Only 3% receive specialty MH services
- 50% receive MH service from PCP
- 7% inpatient psychiatric hospitalization
- 6% community mental health services
- 9% private mental health services

Prevalence Rates of COD

Bogunovic (2012)

http://www.psychiatrictimes.com/geriatric-psychiatry/substance-abuse-aging-and-elderly-adults

- 21-66% elderly population
- 25% comorbid depression
- 10-15% comorbid cognitive disorders
- 10-15% anxiety disorders

Physical Comorbidity TIP 26

- Increased risk of hypertension and cardiac disease
- Increased risk of hemorrhagic stroke
- Impaired immune system
- Cirrhosis and other liver disease
- Decreased bone density
- GI bleeding
- Malnutrition
- *90% 65+ alcoholics have major health prob.
- *25% have COPD & 25-60% have dementia

* Kennedy (2000)

Cognitive Impairment Issues

- Alcohol and/or drug misuse/abuse
- Trauma from falls
- Car accidents
- Poor nutrition
- Wernicke-Korsakoff Syndrome Smith & Atkinson (1997)
- Assess with MMSE, MOCA, dementia rating scales, and history.
- Formal testing may be needed.

Delirium versus Dementia

- Critical to accurately assess
- Dementia is chronic, progressive, and largely irreversible impairment.
- Dementia caused by Alzheimer's, vascular disease, and alcoholism.
- Delirium is potentially life threatening, requires immediate treatment, and generally has acute and/or transitory symptoms.
- Delirium caused by medications, chemicals, surgical interventions, dehydration, etc.

Potentially Reversible Cognitive Symptoms

Attix & Welsh-Bohmer (2006)

- Hypothyroidism
- Vitamin B12 Deficiency
- Thiamine Deficiency
- Depression Related Cognitive Dysfunction
- Sleep Disordered Breathing
- Medication Side Effects

Medication Effects Attix & Welsh-Bohmer (2006)

- Antidepressants – positive/negative
- Sedatives/Hypnotics
  - Impaired memory, learning, slowed psychomotor speed
- Antihypertensives – attention, memory
- Anticonvulsants – attention, concentration
- Antihistamines – attention, memory, reaction time and vigilance, especially 1st generation

Indicators of Geriatric Substance Use Disorders TIP 26

- Sleep complaints
- Cognitive impairment
- Seizures, malnutrition, muscle wasting
- Liver function abnormalities
- Persistent irritability
- Unexplained somatic complaints, hypothermia
- Incontinence, urinary difficulties
- Poor hygiene & self neglect

Indicators continued…

- Unusual restlessness & agitation
- Blurred vision or dry mouth
- Unexplained vomiting, nausea, GI diff.
- Changes in eating habits
- Slurred speech
- Tremor, uncoordination, shuffling gait
- Frequent falls and unexplained bruising
- Depression/anxiety
- Social withdrawal Kennedy (2000)

Elements of Assessment

- Thorough biopsychosocial *and* physical
- Mental Status Exam & Observations
- Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)
- Mental Health history/screening
- Substance Use history/screening
- Obtain collateral information, if possible
- *ASAM & DSM-IV-TR* considerations

Additional Questions to Ask

- How does your chemical usage help you?
- How can family/friends be helpful to you to make changes?
- What difficult behaviors did you change in past?
- Do you ever think that a change might be helpful?
- Ask about any health changes or new diagnoses
- Ask about allergies, especially drugs used to treat CD and mental health issues
- Has anything unusual or significant happened?

Brief Screening Instruments

- AUDIT – WHO (1992)
- S-MAST-G – Blow (1998)
- CAGE/CAGE-AID – Ewing (1984)
- PHQ-9 (2001)
- Zung Scales – depression and anxiety
- TIP 26 has good instruments to use
- Pros and Cons

Functional Assessment of ADLs and IADLs Attix & Welsh-Bohmer (2006)

- Functional capacity – range of everyday skills/abilities that enable person to live independently within home/community
- ADLs – basic self care, dressing, grooming, toileting, getting out of bed
- IADLs – more cognitively complex activities, including finance management, laundry, transportation, health care decisions, and medication management
- TIP 26 has assessment instruments to help

Barriers to Identifying CD/COD in Older Adults TIP 26

- Ageism – negative stereotypes
- Lack of awareness by everyone
- Professionals lack expertise and miss COD
- Co-morbidity – medical/psychiatric
- Special Populations – women, minorities, the homebound, and disabled
- Psychosocial issues

The Older Adult Perspective on the World Mary Pipher (1999) *Another Country*

- Self-sacrifice seen as a virtue
- Psychology has language for self-analysis, freedom, and actualization of the self.
- Older adults have language about loss of self for greater good, about duty, submission, and community
- Pride – talking about problems may shame
  - "None of your business"
  - "I can take care of myself"

Why Older Adults Don't Like Therapy

Mary Pipher (2003)

- Why pay for therapy when you can buy something you *really* need?
- Never occurs to them to seek therapy
- Pretend problems don't exist – self-protective
- Stigma – avoids labels, shame, defeat
- Taught to suffer silently, "make do"
- Keep problems in family
- Tend to give/receive support indirectly

Asking Questions

- Genuine, non-threatening, non-judgmental
- Older adults very sensitive to stigma
- Accept “medical” perspective better than “psychological” or “addiction”
- Empathy and active listening best
- Consider context in which questions asked
- Motivational enhancement techniques helpful
- “Helpful vs. Not so helpful”

Future Trends

- Usage will increase as population ages
- Treatment options very limited – only 7% providers have older adult specific
- Medical marijuana more accepted
- More integration of care providers
- Assessment and brief interventions help

Takeaways

- Remain empathic, flexible, hopeful, and understanding – change can occur!
- Coordinate more closely with PCP and other providers
- Educate clients, families, and ourselves
- Don't be reluctant to ask questions
- Monitor ourselves/others for inaccurate assumptions
  - "He's just getting old"
  - "I'd probably use if I were them too!"
  - "Oh that's just Uncle Henry!"
  - "What's the use? She's so old anyway"

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