The Complications of Substance Abuse in Older Adults with Mental Illness

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Acknowledgement

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*Includes group exercise, flim clip, and material marked with *
*The person seeking help

- In your waiting room, in your office, in your group meeting, in your hospital room
- Holistic approach
- Involve person’s history, experience
- Specific to gender, age
- Treat with respect
- Mental health and substance use treated as medical concern: destigmatize
*The generations

- The Lost Generation: 1883-1901
- The Greatest Generation: 1901-1924
- The Silent Generation: 1925-1945
- The Baby Boomers: 1946-1964
- Generation X: Early 1960s to 1980s

Each with its own history of major events, adaptations to change, coping styles
*History in our minds*

- The Great Depression
  - Deprivation, scarcity, loss of social contract
- World War II
  - The last Great War: social cohesion, support
- Vietnam War
  - Unpopular war, social conflict, substance use
- Korean Conflict
  - Unknown, unwanted war
*Baby Boomer addiction video
*Group exercise

• With 2-4 others around you, can you list some characteristics of “boomers” that you have encountered personally or professionally?

• Please take about 10 minutes.

• We will take a few minutes to list them as a total group.
*Boomer characteristics

• Can accomplish anything
• Reject authority
• The “Me generation”
• Agents of change
• Sexual revolution
• Spiritual openness: new religions
• Substance and alcohol use
USPSTF: Screen ALL adults for alcohol misuse

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### SCREENING AND BEHAVIORAL COUNSELING INTERVENTIONS IN PRIMARY CARE TO REDUCE ALCOHOL MISUSE

**CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION**

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults aged 18 y or older</th>
<th>Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation</strong></td>
<td>Screen for alcohol misuse and provide brief behavioral counseling interventions to persons engaged in risky or hazardous drinking. Grade: B</td>
<td>No recommendation. Grade: I statement</td>
</tr>
<tr>
<td><strong>Screening Tests</strong></td>
<td>Numerous screening instruments can detect alcohol misuse in adults with acceptable sensitivity and specificity. The USPSTF prefers the following tools for alcohol misuse screening in the primary care setting: 1) AUDIT 2) Abbreviated AUDIT-C 3) Single-question screening, such as asking, “How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 y) or more drinks in a day?”</td>
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<tr>
<td><strong>Behavioral Counseling Interventions</strong></td>
<td>Counseling interventions in the primary care setting can improve unhealthy alcohol consumption behaviors in adults engaging in risky or hazardous drinking. Behavioral counseling interventions for alcohol misuse vary in their specific components, administration, length, and number of interactions. Brief multicontact behavioral counseling seems to have the best evidence of effectiveness; very brief behavioral counseling has limited effect.</td>
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<tr>
<td><strong>Balance of Benefits and Harms</strong></td>
<td>There is a moderate net benefit to alcohol misuse screening and brief behavioral counseling interventions in the primary care setting for adults aged 18 y or older. The evidence on alcohol misuse screening and brief behavioral counseling interventions in the primary care setting for adolescents is insufficient, and the balance of benefits and harms cannot be determined.</td>
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<tr>
<td><strong>Other Relevant USPSTF Recommendations</strong></td>
<td>The USPSTF has made recommendations on screening for illicit drug use and counseling and interventions to prevent tobacco use. These recommendations are available at <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a>.</td>
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For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to www.uspreventiveservicestaskforce.org.
The ‘Invisible Epidemic’

• Abuse of alcohol and prescription drugs among adults 60 and older is one of the fastest-growing health problems in this country.

  ◦ Older adults are more physically vulnerable to the effects of alcohol use.
  ◦ Studies indicate that up to 17% of older adults are affected by these forms of substance abuse – that’s 1 of every 6!
Alcohol and Older Adults

• Problems with alcohol have traditionally been understood in terms of “abuse” and “dependence.”

• These diagnostic labels have been found to be less than fully adequate to describe older adults drinking problems.
Alcohol Abuse

• “A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by 1 or more of the following, occurring within a 12-month period; AND these symptoms have never met criteria for Alcohol Dependence.”
Diagnosing Alcohol Abuse

1. Recurrent associated *failure to fulfill major role obligations* at work, school, or home
2. Recurrent use in situations in which it is *physically hazardous*;
3. Recurrent alcohol-related legal *problems*;
4. Continued use despite persistent or recurrent *social / interpersonal problems* caused or exacerbated by the effect of the alcohol.
Alcohol Dependence

• “A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by 3 or more of the following [7 criteria], occurring at any time in the same 12-month period.”
Diagnosing Alcohol Dependence

1. **Tolerance** - (need more, payoff less);
2. **Withdrawal** - (symptoms experienced, or use to avoid such);
3. **More** use, or **more frequent** use, than intended;
4. **Craving**, or **unsuccessful efforts** to cut down or control use;
5. Significant **time investment** in use and related activity;
6. Important **social, occupational or recreational** activities are given up or reduced;
7. Continued use despite knowledge of a physical or **psychological problem that is likely to have been caused or exacerbated by the substance.**
Alcohol and Older Adults

- More helpful to differentiate older adults as either **at-risk drinkers** or **problem drinkers**.

  - **At-risk drinker**: Pattern of using alcohol, although not yet causing problems, may bring about adverse consequences, either to the drinker or to others.

  - **Problem drinker**: Pattern of using alcohol meets the more traditional criteria for alcohol abuse or dependence.
Alcohol Use Recommendations

• Older men:
  – ≤ 1 drink per day
  – ≤ 2 drinks on any drinking occasion (e.g., holiday, family event, etc.)

• Older women:
  – Less than recommendations for men
Adverse Drug-Alcohol Interactions

- **Lithium toxicity** for individuals taking medication for *Bipolar Disorder*

- Increased central **nervous system depression** for individuals taking *tricyclic antidepressants* ([imipramine (Tofranil), amitriptyline (Elavil) and nortriptyline (Pamelor)])

- **Potentially lethal** for individuals taking *benzodiazepines* ([Xanax, Librium, Klonopin, Valium, Dalmane, Ativan]) or *barbiturates* ([Phenobarbital, Pentothal, Nembutal, Seconal])

- Dizziness, fainting, confusion or depression when alcohol used with *antihistamines* ([Benadryl, loratadine/Claritin])
Prescription Drugs

• Age $\geq 65$: Consume more prescription and over-the-counter medications than any other age group in this country.

• *Misuse and abuse of prescription drugs is prevalent among older adults not only because more are prescribed but because aging makes the body more vulnerable to drugs’ effects.*
Prescription Drugs - Benzos

- Risk of dependence: Long-term benzodiazepine use with older adults not recommended
  - *Should be used* ≤ 4 months
  - May be prescribed for anxiety symptoms
  - Include: Xanax, Librium, Klonopin, Valium, Dalmane, Serax and Ativan
Prescription Drugs - Benzos

- Longer-acting benzos (*e.g.*, Dalmane) may:
  - accumulate within body, produce residual sedation and other unwanted effects:
    - Impaired attention or motor coordination (*with increased falls or car accidents*)
    - Decreased memory or other cognitive functioning,
- Shorter-acting medications (*e.g.*, Serax or Ativan):
  - better than longer-acting meds, to better manage the risks of toxicity and addiction.
Prescription Drugs - Sedative/Hypnotics

- Often prescribed to help with sleep problems, but
  - High risk for tolerance and addiction

- Ideally:
  - Up to 7-10 days
  - Lowest helpful dose
  - Frequent monitoring/reevaluation
  - Sleep hygiene & behavioral interventions
    - Use bedtime rituals & relaxation techniques, limit daytime naps, use bedroom only for sleep or sex (no TV), avoid alcohol & caffeine, reduce evening fluids and heavy meals, limit evening exercise.
Prescription Drugs - Antihistamines

• Older adults more susceptible to negative outcomes from the anticholinergic effects of antihistamines:
  – E.g., fainting, dizziness, central nervous system depression, and confusion.

• Older adults who live alone should not take antihistamine medications.
Identifying & Diagnosing Substance Problems

• Typically identified through screening process, a set of questions in interview or self-rating session.

• Ideally, those over age 60 should be routinely screened as part of regular physical examination.
Identifying & Diagnosing Problems

• Screening or rescreening for substance use problems could potentially be triggered by any of the following:
  – Sleep complaints, changes, or drowsiness
  – Memory/concentration disturbances
  – Disorientation or confusion
  – Malnutrition, seizures, abnormal liver functions
  – Persistent irritability, somatic complaints
  – Poor hygiene, self-neglect
Identifying & Diagnosing Problems

- **Triggers, cont:**
  - Unusual agitation or restlessness
  - Incontinence, urinary difficulties
  - Blurred vision, dry mouth
  - Unexplained nausea, vomiting, other GI distress
  - Changes in eating habits
  - Slurred speech, tremors, falls, bruising
  - Impaired coordination, shuffling gait
Identifying & Diagnosing Substance Problems

• **Formal screening instruments include:**
  
  – CAGE Questionnaire *(4-item/ Ewing, 1984)*
  
  
  – AUDIT *(10-item Alcohol Use Disorders Identification Test/ Babor et al, 1992)*
CAGE (Ewing, 1984)

- Have you ever felt the need to **cut** down on your drinking or drug use?

- Have you ever been **annoyed** at criticism of your drinking or drug use?

- Have you ever felt **guilty** about something you’ve done when you were drinking or high from drugs?

- Have you ever had a morning **eye-opener** to control the shakes?
CAGE scoring

• 2 or more “yes” answers = probable alcohol dependence

• 1 “yes” answer = probable alcohol problem
MAST-G * (Blow et al, 1992)

In the past year:

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 didn’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?
MAST-G  *(Blow et al, 1992)*

**In the past year:**

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?
MAST-G scoring

• *If the person answered “yes” to two or more questions, encourage a talk with the doctor.*

• *Source: University of Michigan Alcohol Research Center, Michigan Alcohol Screening Test (MAST-G). © The Regents of the University of Michigan, 1991*
AUDIT *(Babor et al, 1992)*

How often do you have a drink containing alcohol?

(0) Never  (1) Monthly or less  (2) 2 to 4 times/month  (3) 2 to 3 times/week  
(4) 4 or more per week

How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2  (1) 3 or 4  (2) 5 or 6  (3) 7 to 9  (4) 10 or more

How often do you have six or more drinks on one occasion?

(0) Never  (1) Less than monthly  (2) Monthly  (3) Weekly  (4) Daily or almost daily

How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never  (1) Less than monthly  (2) Monthly  (3) Weekly  (4) Daily or almost daily
AUDIT (Babor et al, 1992)

How often during the last year have you failed to do what was normally expected of you because of your drinking?
(0) Never  (1) Less than monthly  (2) Monthly
(3) Weekly  (4) Daily or almost daily

How often during the last year have you needed a drink in the morning to get yourself going or to steady your nerves after heavy drinking?
(0) Never  (1) Less than monthly  (2) Monthly
(3) Weekly  (4) Daily or almost daily

How often during the past year have you had a feeling of guilt or remorse about things you had done while drinking?
(0) Never  (1) Less than monthly  (2) Monthly
(3) Weekly  (4) Daily or almost daily
AUDIT (Babor et al, 1992)

How often during the last year have you been unable to remember what happened the night before when you had been drinking?
(0) Never          (1) Less than monthly          (2) Monthly
(3) Weekly          (4) Daily or almost daily

Have you or someone else been injured as a result of your drinking?
(0) No   (2) Yes, but not in the last year   (3) Yes, during the last year

Has a relative, friend, doctor, or other advisor been concerned about your drinking, or suggested that you cut down?
(0) No   (2) Yes, but not in the last year   (3) Yes, during the last year
AUDIT scoring

Note to clinician: The first 3 items are intended to determine Hazardous Alcohol Consumption, indicating 1. Frequency of drinking, 2. Typical quantity, and 3. Frequency of heavy drinking. The next 3 items are intended to determine Dependence Symptoms, indicating 4. Impaired control over drinking, 5. Increased salience of drinking, and 6. Morning drinking. The last 4 items are intended to determine Harmful Alcohol Consumption, indicating 7. Guilt after drinking, 8. Blackouts, 9. Alcohol-related injuries, and 10. Others concerned about drinking.

Scoring / Interpretation:
The AUDIT is scored by simply adding the numbers designated for each item by the test-taker. A total score greater than 11 indicates the likelihood of a problem, and the high probability of a diagnosis of either Alcohol Abuse or Alcohol Dependence.
Identifying Substance Problems

- *Screening need not always be formal*
  
  - Family members, friendly visitors, Meals-on-Wheels volunteers, healthcare providers and other caretakers can also include screening questions (direct, or indirect) in their normal conversations with older adults
Talking to older person who has problem with alcohol or medications

- Understanding and reframing the condition as a disease
- Debunking some myths
- Be aware of the signs
- Know how to access help
- What to say (or not) and when
A Positive Screen Should Trigger Formal Assessment

- Assessment should include the following:
  - Substance use
  - Level of functioning
  - Cognitive dysfunction
  - Medical status
  - Sleep disorders
  - Depression or other mental illness
  - Stage of Readiness to Change
Diagnostic Difficulties

- Substance intoxication and withdrawal can mimic many psychiatric and cognitive disorders
  - Alcohol/opiate/sedative-hypnotic intoxication $\sim=$ depressive disorders
  - Alcohol/opiate/sedative-hypnotic withdrawal $\sim=$ anxiety disorders
  - Alcohol/opiate/sedative-hypnotic intoxication $\sim=$ dementia (cognitive impairment of memory, language recognition, executive functioning)
Name That Diagnosis!

Some challenges in diagnosing co-occurring Mental Health and Substance Use Disorders

(or, “I can name that diagnosis in ______#_____ symptoms”)
The symptom . . .
Auditory, visual, or tactile illusions in the absence of delirium

What’s the diagnosis?

- One of any number of Thought Disorders?
  - Psychotic Disorder, NOS?
  - Schizophrenia?
  - ?
Or could the diagnosis be . . .

- Alcohol or Sedative / Hypnotic / Anxiolytic Withdrawal With Perceptual Disturbances
The symptom . . .

Hallucinations in the absence of intact reality-testing

What’s the diagnosis?

- One of any number of Thought Disorders?
  - Psychotic Disorder, NOS?
  - Schizophrenia?
  - ?
Or could the diagnosis be . . .

- Substance-Induced Psychotic Disorder, with Hallucinations

  (the “substance” may include Alcohol, or Sedatives / Hypnotics / Anxiolytics)
The symptom . . .

“Transient visual, tactile, or auditory hallucinations / illusions”

What’s the diagnosis?

- One of any number of *Thought Disorders*?
  - Psychotic Disorder, NOS?
  - Schizophrenia?
  - ?
Or could the diagnosis be . . .

- Alcohol Withdrawal
- Sedative / Hypnotic / Anxiolytic Withdrawal
The symptom . . .

“Mood lability, inappropriate sexual behavior”

What’s the diagnosis?

- Bipolar Disorder?
Or could the diagnosis be . . .

- Alcohol Intoxication

- Sedative / Hypnotic / Anxiolytic Intoxication
Stages of Change

(Prochaska, Norcross, & DiClemente)

Precontemplation

Contemplation

Preparation

Action

Maintenance

Relapse / Recycle
Evaluating Stages of Change

• **Precontemplation** *(Denial)*
  – “What problem? I’m not thinking about it.”
  – “I don’t need (or want) to change.”

• Hallmark attitude:
  – “Who, me?”
Evaluating Stages of Change

- **Contemplation (Ambivalence)**
  - “I wonder if I might have a problem? I’m thinking about it but not ready to decide anything yet.”
  - “I’m thinking about change; I might change.”

- **Hallmark attitude:**
  - “I might have a problem.”
Evaluating Stages of Change

• Preparation / Determination (Admission)
  – “I have a problem.”
  – “I’ve decided to change; I’m developing plans.”

• Hallmark attitude:
  – “I’m planning for change.”
Evaluating Stages of Change

• **Action** *(Taking steps / Making changes)*
  –  “I have a problem and I’m ready to do something about it.”
  –  “I’m actively making changes based on my plans.”

• Hallmark attitude:
  –  “I’m making changes.”
Evaluating Stages of Change

• **Maintenance** (*Continuing what works*)
  – “I’m stabilized and doing well. How can I support my ongoing recovery?”
  – “I made the changes I want; now I’m maintaining my gains.”

• **Hallmark attitude:**
  – “I now do this.”
Evaluating Stages of Change

• Relapse / Recycle (Trying again)
  – “I’m stabilized but have relapsed. How can I get back into active recovery?”

• Lapse, Slip, Relapse . . .
  – “The only wasted relapse is one that is not learned from to strengthen recovery moving forward . . .”
*Boomers and prescription pills
How Do People Change?

What 50 years of research has shown . . .

A. Relationship with an agent of change (therapist, doctor, case manager, sponsor, pastor, friend, family member, etc.)
B. Treatment modality (technique, method, model of change)
C. Individual change factors (including willingness and readiness to change)
D. Individual’s belief that change is possible (hope, confidence)

www.talkingcure.com
Effective Treatment and Support Strategies
**Four-Quadrant model to understand & inform effective treatment**

<table>
<thead>
<tr>
<th></th>
<th>Low substance (abuse)</th>
<th>High substance (dependence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low psychiatric (psychiatrically complicated)</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>High psychiatric (SPMI)</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
Effective Treatment and Support Strategies

• Less intensive treatment options should be explored first with older substance abusers, including:
  – Brief intervention
  – Intervention
  – Motivational counseling
Older Adult ‘Brief Intervention’

1. Customized feedback on screening questions
2. Discussion comparing to norms
3. Reasons for drinking/using
4. Consequences of heavier drinking/use
5. Reasons to cut down or quit
6. Sensible limits, & reduction/quit strategies
7. Signed “use agreement”
8. Coping strategies for at-risk situations
9. Overall summary
Older Adult ‘Intervention’

• Traditional intervention approach involves several significant people in substance abuser’s life confronting person with firsthand experiences of substance use

• Formal interventions include progressive interaction by a counselor with the family / friends for at least 2 days prior to meeting together with substance abuser
Older Adult ‘Intervention’

• *Limit to 1 or 2 relatives or close associates, plus counselor*
  – More people can overwhelm or confuse an older person

• *Do not include grandchildren*
  – Many older adults resent their substance-use problems being aired in the presence of much younger relatives
Motivational Counseling

- Acknowledges differences in readiness to change, meets older adults where they are at
- Respectfully explores the substance user’s own reckoning of the situation as the starting point
- Helps identify associated negative consequences in a nonconfrontational manner
- Seeks to shift perceptions and magnify internal motivation for change
- Empowers self-generated solutions and cheer-leads incremental progress
Motivational Counseling Principles

• Express empathy
• Avoid argumentation
• Roll with resistance
• Develop discrepancy
• Support self-efficacy
Motivational Counseling Strategies

1) Ask Open-Ended Questions

2) Listen Reflectively

3) Affirm (to build relationship)

4) Summarize (to check if on the same track)

5) Elicit change talk (try to get client to talk change, and then argue for change)
Effective Treatment and Support Strategies

• Outpatient treatment - involve older adult’s primary care physician

• Outpatient treatment of older adults, especially with co-occurring mental health disorders - include supportive case management
Effective Treatment and Support Strategies

• More intensive treatment options should be utilized as indicated, adjusted for needs of older adult patients:
  – Medically assisted detoxification
  – Sub-acute detoxification
  – Residential treatment
Older Adult Treatment features:

1. Supportive, non-confrontational, age-specific groups
2. *Focus on coping with depression, loneliness, loss and bereavement*
3. Focus on rebuilding social support networks
4. *Appropriate pacing and content*
5. Interested & experienced treatment staff
6. *Linkages with medical services & case management*
Older Adult Treatment principles:

a) Age-specific settings where feasible

b) *Culture of respect*

c) Holistic approach to treatment emphasizing age-specific psychological, social and health issues

d) *Flexibility*

e) Adaptable to gender, as needed
Resources


More Resources
