Introduction to Older Adults and Substance Use

Fact Sheet 1

11/1/2011

Prepared by: The Addictions Sub Group of the SHRTN Collaborative Geriatric Mental Health, Addictions and Behavioural Issues Community of Practice

Elizabeth Birchall, *Community Outreach Programs in Addictions (COPA)*
Julia Baxter, *St. Joseph's Healthcare Hamilton – Halton Geriatric Mental Health and Addiction Outreach & Halton ADAPT*
Jennifer Barr, *Centre for Addictions and Mental Health (CAMH)*
Jan Haycock, *Sister Margaret Smith Centre, St. Joseph's Care Group*
Dallas Smith, *Lifestyle Enrichment for Senior Adults (LESA) Centretown Community Health Centre*
Karen Parsons, *Peel Addiction Assessment and Referral Centre (PAARC)*
Bonnie Franklin, *Hamilton Public Health Services, Alcohol, Drug and Gambling Services, Older Wiser Lifestyles (OWL)*
Dr. William Jacyk, *Internal and Addiction Medicine, Homewood Health Centre*
Robin Hurst, *Seniors & Mental Health, Saint Elizabeth*
Sarah Clark, *Knowledge Broker, Alzheimer's Knowledge Exchange (AKE)*

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WHY AGE SPECIFIC APPROACHES TO MANAGING SUBSTANCE USE

Substance Use:

- Many older adults begin to have problems with their substance use during times of transition or loss (e.g. forced retirement, bereavement, new or escalating health concerns, loss of independence)
- Their relationship to the substance is based on an emotional need to feel better or deal with loss
- Some older adults cannot access and/or do not feel comfortable in mainstream addictions services
- Problems with substance use are often not recognized by health and community service providers so help is not offered
- The older generation is more likely to experience self stigmatization which reduces the chance of seeking treatment and service

Health and Aging

- Older adults often have complex and/or chronic health conditions that require they take pharmaceutical medications that can interact with each other and non prescribed substances (e.g. alcohol, marijuana)
- Older adults metabolize substances in a different way
- Psychosocial factors such as boredom, loneliness and homelessness are linked to higher alcohol use (Royal College of Psychiatrists, 2011)
- Anecdotal clinical experience is that elderly have more prolonged and severe withdrawal than younger patients, and are more likely to develop complications such as delirium
- It is not uncommon to find that older people with chronic substance misuse have had multiple head injuries resulting in symptoms of acquired brain injury that is affecting their reasoning and decision making capabilities.
- Older adults with some degree of cognitive impairment and/or functional losses are often misdiagnosed with dementia when in fact there may be a substance misuse or addictions issue.

OLDER ADULT SPECIFIC APPROACHES

Goals

- The end goal of abstinence is not necessary or realistic for many older adults with substance use problems. Instead a harm reduction goal that is related to quality of life improvement as defined by the older person is the aim
- Treatment/counseling should be focused on what can make life better, more comfortable and happier, not only on the substance use

Screening and Assessment

- Problematic use is not defined by amount but by the negative effect on the person's daily life
- When working with older adults, a full and thorough history is always the first step and as a matter of course substance use should be part of this discussion
- If an older person presents with repeated falls, head injuries and/or failure to thrive a discussion of use of substances should be initiated in a non threatening way as part of a comprehensive history
- There are some particular risk factors for older adults that clinicians should be aware of, these include depression, recent loss of loved ones, isolation and chronic painful illnesses (Atkinson, 2002 in Royal College of Psychiatrist, 2011)
- Although some diagnostic criteria may not be sensitive to differences of aging screening tools are available (e.g. The Short Michigan Alcoholism Screening Test –Geriatric Version), and screening for alcohol, medication and other drug use should be part of medical assessment. A full list of screening and assessment tools is available in Improving our Response to Older Adults, CAMH, 2008

Treatment/Counseling

- Harm Reduction must be approached in a broad fashion, looking primarily at reducing the harm to quality of life (e.g. using a taxi to get to the liquor store in the winter to reduce the chance of breaking a hip)
- Treatment and/or counseling must begin with a conversation about the person's daily life and feelings, with the role of the substance(s) as an aspect of the person's whole life
- Isolation and marginalization must be addressed through practical and psychosocial methods (e.g. ensuring appropriate personal care services through CCAC and involvement in social activities such as day programs, outings and groups)
    - Health Canada (2002) states best practices identified through research demonstrates that treatment of high need older adults includes:

- a harm reduction and holistic problem solving approach,
- home visiting known as “outreach”
- intensive case management and
- social and recreational programs

KEY FACTS

Demographics:

- We have an aging population, the proportion of those aged 65 years and older has almost doubled in the last fifty years from 7.7 percent to13 percent in 2006; 13.6 percent in Ontario (Statistics Canada, 2007)
- Population projections indicate that by 2036 almost a quarter (24.5%) of the Canadian population will be 65 years or older (Statistics Canada, 2007)
- ‘Baby boomers’ are the largest age cohort in Canada and the oldest baby boomers are now entering their retirement years (Statistics Canada, 2007)

Substance Use:

- A US study has estimated that the number of adults 50 years and older requiring substance abuse treatment will more than double by 2020 driven in part by the increase in the number of older adults with illicit drug problems and the non-medical use of prescription drugs (Gfroerer et al., 2003)
- 6-10% of older adults who drink will experience problems (CAMH 2008)
- 20% of men 55 to 64 years, 12 % 65 to 74 years and 5% over 75 years were considered heavy drinkers (5 or more drinks on a single occasion at least once per month in the last year) (The Canadian Community Health Survey 2003)
- In Ontario, there has been a significant upward trend in past year alcohol use by those aged 65 years and older from 58.5 percent in 1997 to 73.5 percent in 2007(Ialomiteanu et al., 2009)
- Low Risk Drinking Guidelines recommend no more than two standard drinks on any one day and no more than fourteen drinks per week for men and 9 drinks per week for women
- The guidelines advise that people drink less or not at all if they are using medications, have health problems or are planning to drive or use complex machinery.
- Older adults are generally less likely to report drinking harmfully however across Canada, 10.9 percent and 13.6 percent of those aged 65-74 and 75+ years respectively report exceeding low risk drinking guidelines (Adlaf, 2005)
- The DSM-IV diagnostic criteria can be inadequate for diagnosing older adults with substance use problems (Oslin & Holden, 2001 in Royal College of Psychiatrists, 2011)

- Alcohol and prescribed and over the counter psychoactive medications are currently the drugs of most concern for seniors (Christensen, Low & Anstey, 2006)
- The number of seniors with a history of illicit drug use is projected to increase as the baby boomer generation, the first generation with significant exposure to recreational drugs, ages (Shah & Fountain, 2008)
- Cannabis is increasingly prevalent in older populations with the new cohort of ageing "baby boomers"
- Cannabis use by Ontarians aged 50 years and older has increased significantly, from 1.4 percent in 1998 to 4.6 percent in 2007 (Ialomiteanu et al, 2009)

Impact of Substance Use:

- Older adults have a higher blood alcohol concentration than younger people after consuming an equal amount of alcohol (Barnes et al., 2010; National Institute on Alcohol Abuse and Alcoholism, 1998; Simoni-Wastila & Yang, 2006)
- Older adults who continue the same pattern of drinking into their senior years may not be aware that they have less tolerance than when they were younger
- Older adults who continue to use illicit drugs such as cannabis, heroin and cocaine are also at risk when these substances are mixed with medications for physical health problems (Boddiger, 2008)
- Alcohol commonly accompanies/exacerbates mental health issues:
    - seniors who experience depression are 3-4 times more likely to develop alcohol-related problems
    - Alzheimer Disease and other forms of dementia (alcohol/vascular) can combine with a long history of depression
- Depression is both a precursor and consequence of heavy drinking (Statistics Canada, 2004)

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