

Substance Use Disorders in Older Adults

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Objectives

- **Understand the epidemiology of substance use disorders in older adults**
- **Increase ability to effectively diagnose substance use disorder in the older adult population**
- **Be able to recommend effective treatment options for the older adult with a substance use disorder**

A “hidden problem”

- **Lack of screening in primary care**
- **Limited age-appropriate screening tools**
- **Limited guidelines for assessing older adults**
- **Signs and symptoms of harmful use overlap with other conditions**
- **Ageist bias**

Challenges in detecting problematic use

- **Relying on older patient's report of frequency and quantity of substance use can lead to underestimation of the problem**
- **Older adults and family members may not appreciate deleterious consequences of long-time patterns of drinking or drug use**
- **Harm can come from amounts that were not harmful previously**
- **Harm can come from lower amounts of substances**

Psychosocial Contributors

- **Stigma (feelings of shame)**
- **Bereavement and grief issues**
- **Social isolation and loneliness**
- **Reduced self-regard or self esteem**
- **Family conflict and estrangement**
- **Problems in managing time/boredom**
- **Physical pain**

Stages of change

- **Pre-contemplation**
- **Contemplation (primary care is particularly effective in helping)**
- **Determination**
- **Action**
- **Maintenance**
- **Relapse**

The conversation- facilitating contemplation

- **Conversation should emphasize health and relationship benefits of change (Limit conversation in setting of intoxication)**
- **Use family/friends (son) in a positive way**
- **“Undo” shame**
- **Give hope that life can improve**
- **Work together to define the benefits of change**

Motivational Interviewing

- **Build a safe, trusting, and collaborative working relationship**
- **Draw out the person's own internal reasons and arguments for change**
- **Ask questions that invite reflection rather than a simple yes or no**
- **Recognize and highlight a person's strengths, efforts, and past successes**
- **Rephrase or repeat what the person shares and in doing so, express empathy and understanding**
- **Tie together pieces of the dialogue to highlight mixed feelings or emerging readiness**
- **Develop an actionable, flexible strategy when the person is ready**

Alcohol: the most commonly used substance in older adults (for now)

Alcohol Use Disorder in Older Adults

- **Early Onset:** 2/3 of older adults; Men > Women
- **Late Onset:** more likely to be triggered by stressful life event (loss of spouse, retirement, medical disability, pain, sleep problem); Women > Men

Epidemiology alcohol use disorder

- **According to the 2024 National Survey on Drug Use and Health (NSDUH):**
 - **6.8 million people ages 65+ (11.4% in this age group) reported binge drinking in the previous month**
 - **1.5 million people ages 65+ (2.5% in this age group) reported heavy alcohol use in the previous month**
 - **2.9 million people ages 65+ (4.8% in this age group) met the criteria for past-year alcohol use disorder**
- **According to the U.S. Centers for Disease Control and Prevention (CDC), 40.9% of all alcohol-attributable deaths in 2022 and 2023 occurred among people ages 65+**

Screening/diagnostic tools for alcohol use disorder

- **AUDIT-C screen**
- **MAST screen**
- **NIAAA single question screen- How many times in the past year have you had (5 for men/4 for women) drinks in a day?**
- **DSM (used for diagnosis but not screening)**
- **Avoid outdated CAGE**

MAST-G Screen

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

- 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?**

***2 or more “yes” responses indicative of alcohol problem.**

Recognition of AUD- beyond screening

- **Alcohol interferes with a person's ability to function in life domains**
- **Alcohol causes physical, cognitive, behavioral or mood problems**
- **Alcohol as part of a daily routine**
- **Alcohol use as an escape**

Increased risks of alcohol even at “low consumption”

- **Increased vulnerability to physiological effects**
 - **Decreased lean muscle mass**
 - **Decreased total body water**
 - **Less efficient liver enzymes that metabolize alcohol**
 - **Increased effective concentration of alcohol, higher and longer lasting blood alcohol levels**
- **Additional risks**
 - **Alcohol-medication interactions**
 - **Co-morbid chronic illnesses**
 - **Women experience alcohol-related harms at lower levels than men**
 - **Bariatric surgery**

Red flags to trigger thought of alcohol use disorder

- **Bruises, falls**
- **Changes in weight**
- **Memory difficulties, black outs**
- **Depressed mood, anxiety, loss of interest, insomnia, fatigue**
- **Behavioral changes- isolation, avoiding social situations**
- **Non-specific gastrointestinal disturbances**
- **Odor of alcohol or mouthwash on breath**
- **Neglect of personal appearance**
- **Job difficulties**
- **Changes in relationships**

Treatment for AUD

- **Medications- MAUD**
- **Socialization**
- **Alcoholics Anonymous**
- **Smart Recovery**
- **Recovery housing**
- **Outpatient program- intensive versus weekly**
- **Inpatient program- most are 28-30 days**

Medications for AUD

Naltrexone- opiate receptor blocker

- **Oral and injectable formulations**
- **Can be used to decrease drinking/prevent binge drinking**
- **Number needed to treat 9-18 for abstinence**

Acamprosate- increases glutamate/lowers GABA

- **Taken 3 times a day and diarrhea as side effect may limit use**
- **American trials mixed effectiveness- 24 randomized controlled trials; number need to treat 9-12 for abstinence**

Disulfiram-Inhibits acetaldehyde dehydrogenase; negative impact deterrent

- **No randomized clinical trial has shown effectiveness**
- **Useful in special populations as an adjunct- professionals**
- **May be useful if part of directly observed therapy**

Off label- topiramate, gabapentin, spironolactone

Patient vignette- alcohol

- **BR is a 82F brought to the ER by neighbor with “syncope”, but it is noted that she has alcohol on her breath and her BAL is 228 mg/dl. When confronted she becomes tearful. Her son goes to her home and finds hidden miniatures throughout her apartment.**
- **How do you approach caring for her?**

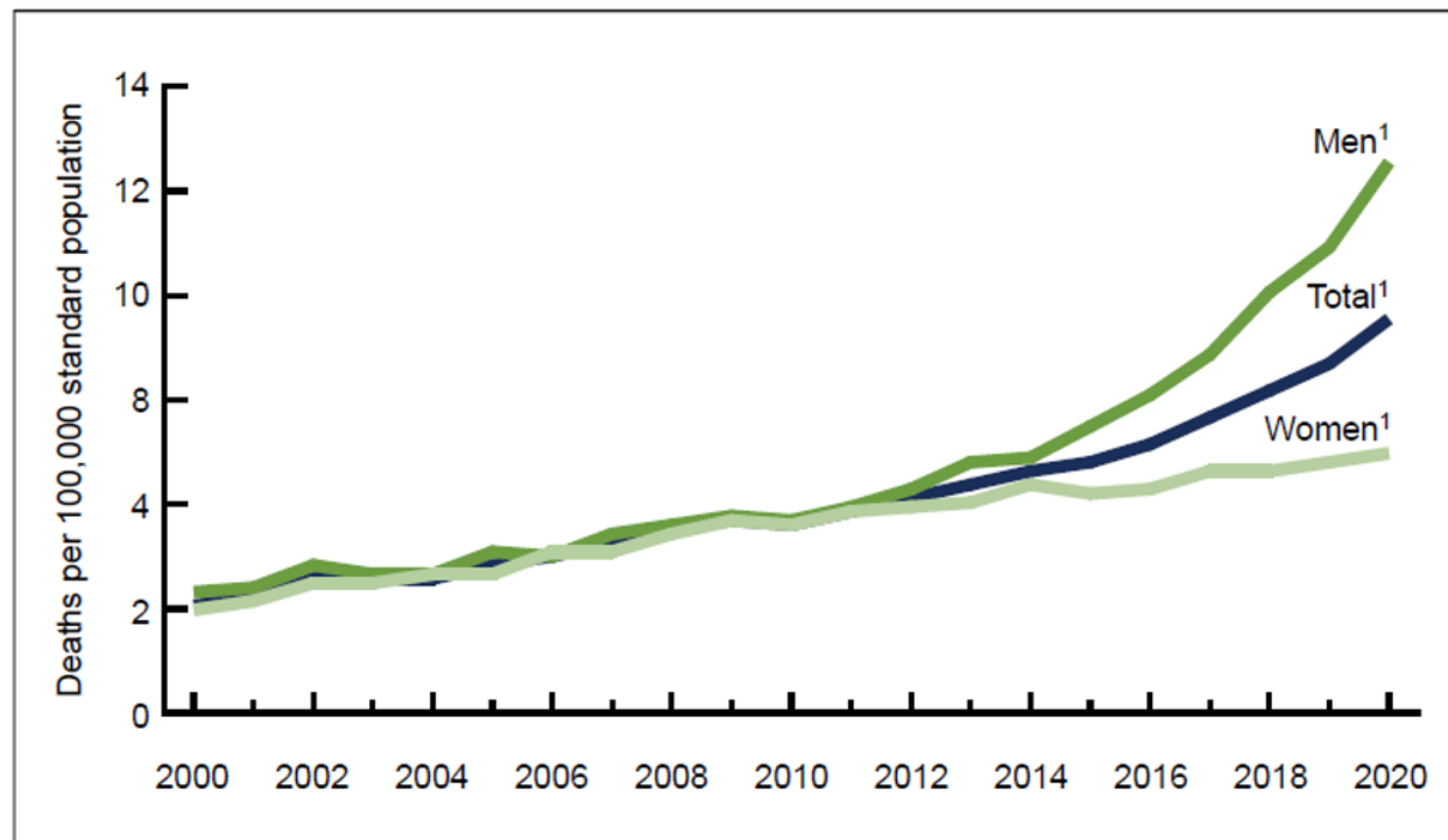
Patient vignette-alcohol

- **RT is a 79M successful businessman with HTN and recurrent depression with poor sleep and worries about his memory. You learn that he has two “stiff drinks” every evening and often has a third after a stressful day. He is defensive about his drinking because this has been a longstanding pattern that he enjoys.**
- **How concerned are you about his drinking?**

Epidemiology opioid use disorder

- **In 2020–2021, 12.8 percent of adults aged 65 and older, on average, filled at least one outpatient opioid prescription, and 4.4 percent had four or more prescription fills during the year**
- **Opioid use disorder in adults 65 and older more than tripled between 2013 and 2018 from 4.6 to 15.7 per 1,000 beneficiaries**
- **Use of medications for opioid use disorder among older adults increased from 4.8% in 2017 to 7.5% in 2019 and 15.0% in 2022**

Figure 1. Age-adjusted drug overdose death rate for adults aged 65 and over, by sex:
United States, 2000–2020

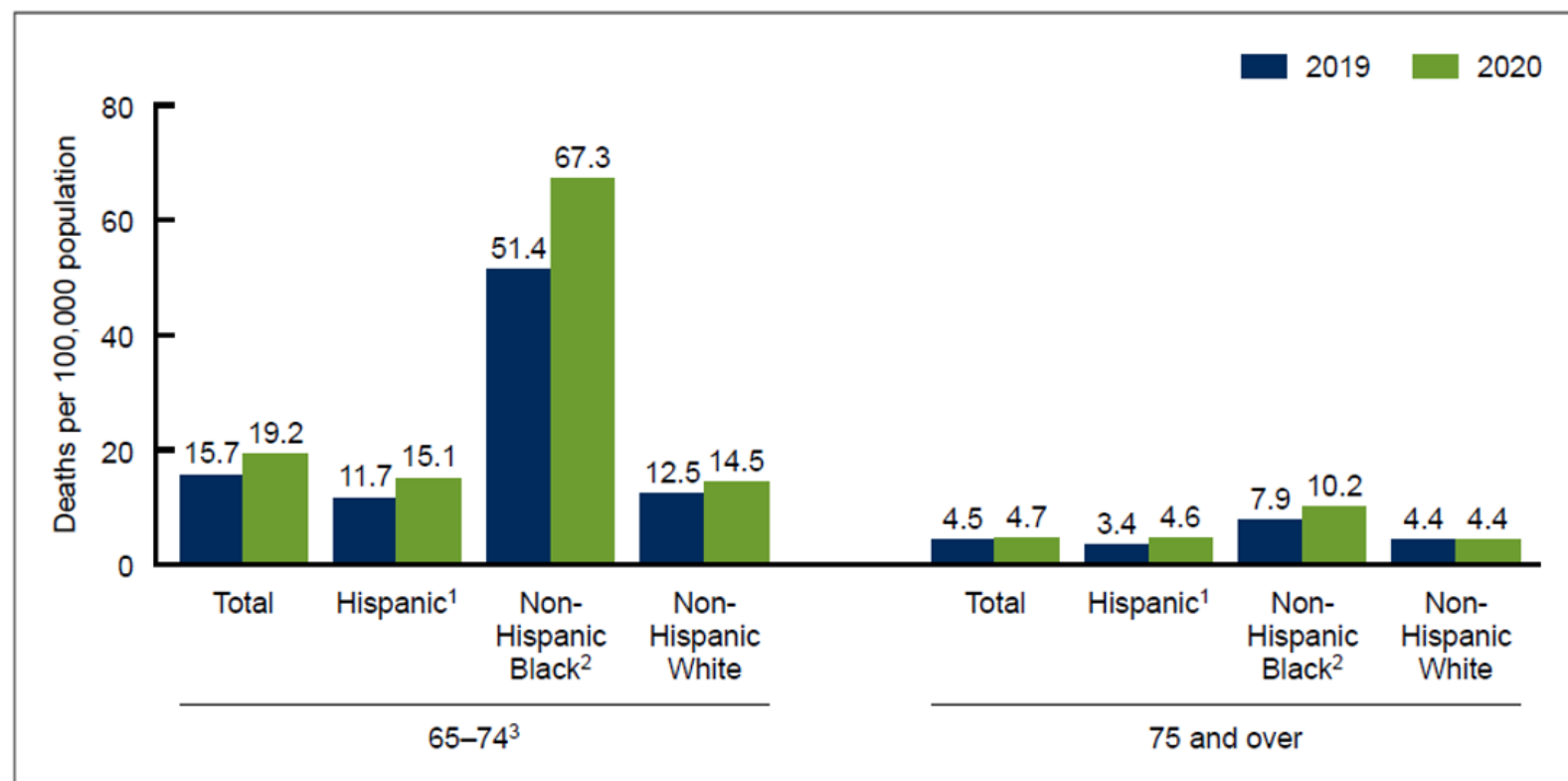


¹Significant increasing trend from 2000 through 2020 with different rates of change over time; $p < 0.05$.

NOTES: Drug overdose deaths are identified using the *International Classification of Diseases, 10th Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Access data table for Figure 1 at: <https://www.cdc.gov/nchs/data/databriefs/db455-tables.pdf#1>.

SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Figure 2. Drug overdose death rate for men aged 65 and over, by age group, race and Hispanic origin, and year: United States, 2019–2020



¹Rates were significantly lower than rates for non-Hispanic Black men in 2019 and 2020; $p < 0.05$.

²Rates were significantly higher than rates for non-Hispanic White men in 2019 and 2020; $p < 0.05$.

³Rates for 2020 were significantly higher than 2019 for all groups; $p < 0.05$.

NOTES: Total includes races and origins not shown separately. Data for categories other than non-Hispanic White and non-Hispanic Black should be interpreted with caution because of inconsistencies in reporting race and ethnicity on death certificates, censuses, and surveys. Drug overdose deaths are identified using the *International Classification of Diseases, 10th Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Access data table for Figure 2 at: <https://www.cdc.gov/nchs/data/databriefs/db455-tables.pdf#2>.

SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

American Geriatrics Society Beers Criteria

- **Avoid NSAIDs, muscle relaxants and tramadol**
- **Avoid opioids if history of falls or fracture, constipation, or prescribing other sedating medications**
- **Avoid tricyclics- amitriptyline**

Patient vignette-opioid

- **KL is a 67F retired nurse who had right total knee replacement complicated by joint infection requiring prolonged course of antibiotics, hardware removal with spacer and finally replacement of hardware. She has been on oxycodone 15 mg four times daily for 4 months.**
- **She sees orthopedics in f/u and is told she should not be on any further opioids as she is now 2 weeks out since the last surgery. She is told to take ibuprofen**
- **Is this appropriate medical care?**

Patient vignette-opioid.

- **EB is a 72M who comes for initial primary care visit accompanied by his daughter. He has not seen a primary care provider in over 15 years. In reviewing his past history, you find 2 ED visits in the past year related to opioid overdose. He only wants to discuss his knee pain. How should you care for him?**

Epidemiology cannabis use

- **Prevalence of past-month cannabis use among older adults 65 years or older increased significantly from 4.8% (95% CI, 3.9%-5.9%) in 2021 to 7.0% (95% CI, 6.2%-8.0%) in 2023**
- **Adults with the highest incomes initially had the lowest prevalence of cannabis use vs other income levels, but by 2023, they had the highest prevalence**
- **Prevalence of tobacco and excess alcohol use higher among older adults who use cannabis**
- **People with chronic diseases, particularly multiple chronic diseases, had an increased prevalence in use**

Han BH, Yang KH, Cleland CM, Palamar JJ. Trends in Past-Month Cannabis Use Among Older Adults. JAMA Intern Med. 2025;185(7):881–883.
doi:10.1001/jamainternmed.2025.1156

Cannabis use and emergency visits among older adults in California

- **Cannabis related ED visit rate for adults > age 65, increased from 20.7/100,000 visits in 2005 to 395.0 per 100,000 ED visits in 2019, a 1804% increase**

Han BH, Brennan JJ, Orozoco, et al. Trends in emergency department visits associated with cannabis use among older adults in California, 2005-2019. J Am Geriatr Soc 2023 Jan 9. doi: 10.1111/jgs.18180

Impact of Cannabis on Physical and Mental Health

- **Older adults often see cannabis as “safer” alternative to alcohol, opioids, or pharmaceutical medications**
- **Short term use is associated with impaired short-term memory, impaired judgment/motor coordination/driving skills**
- **Increased anxiety**
- **Paranoia and psychosis have dose-response effect**

Patient vignette-cannabis

- **CR is 82M with HTN and GERD and with recurrent depression which is being treated with 2 different antidepressants. His depression is much improved, but he continues to experience anxiety and stress, primarily related to worries about his wife's cancer and her poor health. He reports that he has decided to go to a marijuana dispensary and try cannabis to see if it can help his mood and his anxiety**
- **How do you respond?**

Epidemiology cocaine use

- **According to the 2021 National Household Survey on Drug Abuse (NHSDA):**
 - **among adults aged 65 and older, 11.3% had ever ingested cocaine, 0.4% had done so in the last year, and 0.2% had done so in the last 30 days**
 - **among adults ages 60-64 25.3% had ever used cocaine, 0.6% in the last year, and 0.2% in the last 30 days**

Patient vignette-cocaine

- **KT is a 70M seen for initial visit. He has a history of Type 2 diabetes mellitus and hypertension. He lives with his wife and has 3 grown daughters and 8 grandchildren that he sees regularly. He enjoys watching sports and getting together with friends every Friday night to play pinochle and most times there is crack cocaine use- “we just unwind and have a good time”.**
- **How should you address cocaine use? What if he instead drank 3-4 beers to unwind?**

Epidemiology benzodiazepine use

- **In US, from 2015 to 2024:**
 - a total of 24,909,430 adults aged 65 years or older filled 1 or more benzodiazepine prescriptions; approximately two thirds were female**
 - Overall benzodiazepine use decreased from 14.1 to 11.5 per 100 persons**

Olfson M, Xie F, Bushnell G, Cruz N, Hua J, Miles J, Crystal S. Benzodiazepine Prescriptions to Older Adults in the United States, 2015 to 2024. *Ann Intern Med.* 2026 Jul 7. doi: 10.7326/ANNALS-25-05594. Epub ahead of print. PMID: 42407068.

Benzodiazepine Prescribing in Older Adults

- **What are the reasons?**
 - Anxiety symptoms, anxiety disorders, depression with anxiety, sleeplessness
- **What are the problems?**
 - Often prescribed for years, without good indication of continuing need
 - Often prescribed for symptoms, without recognition of the true underlying cause: e.g. depression, normal worry, cognitive impairment
 - Increased frequency of adverse effects with aging, polypharmacy and use of meds with long half-lives

Key phrases: Introduce deprescribing

“Our bodies change over time. Certain medicines may cause new side effects.”

“Reducing your medicines may help you feel better.”

“You’re falling / sleepy during the day / have memory problems / have incontinence. These problems are worsened by your sleeping pill.”

Deprescribing

- **Emphasize that you will not withdraw appropriate care: “I understand that I need to treat your symptoms, but we need to do so without causing you other problems.”**
- **Reassure that you will monitor closely for symptoms recurrence: “We’ll reduce the medicine very slowly and will stay in close contact to watch for returning symptoms.”**

Benzodiazepine tapering

Initial Considerations

- **Use scheduled rather than prn dosing**
- **Consider switching to a longer-acting benzodiazepine**
- **Schedule follow-ups every 2-4 weeks- can be telemedicine or phone call**

Tapering Considerations

- **Reduce total daily dose (TDD) by 10-25% to start**
- **Continue reducing TDD by 10-25% every 2-4 weeks**
- **For patients on supra-therapeutic doses consider initial reduction of 25-30%**

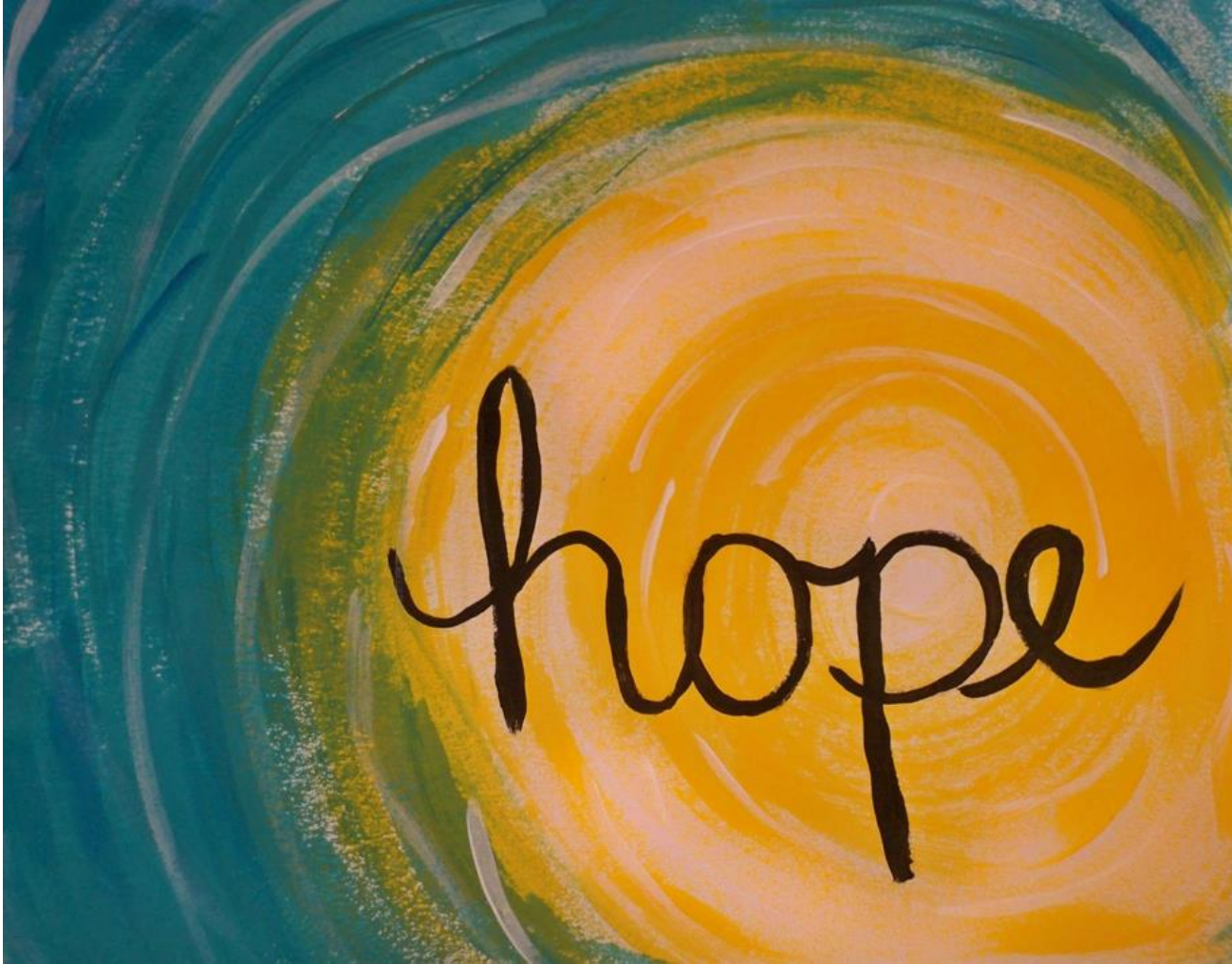
Patient vignette-benzodiazepines

- **LK is an 80F with long history of episodic anxiety and low mood and insomnia- prescribed temazepam for 30 years. She has 6 month history of low mood, panicky feelings, crying spells, anxiety, poor appetite; can't multitask or concentrate. Medications are- temazepam 30mg qhs, trazodone 50mg qhs, tramadol 50mg prn pain, gabapentin 800mg three times a day.**

Summary

Treatment approach for older adults

- **Don't enable**
- **Confront with compassion**
- **Remove shame**
- **Build self-esteem**
- **Give encouragement/hope**
- **Undo isolation**
- **Work on coping skills**
- **Facilitate finding new ways to stay busy with use of peers**





Provides support to prescribers and their practices, pharmacists, and healthcare teams in addressing the needs of their patients with substance use disorders and chronic pain management.

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- Technical assistance to practices implementing or expanding office-based addiction treatment services
- MACS TeleECHO™ Clinics: collaborative medical education through didactic presentations and case-based learning

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