An aging population: Caring for older adults with substance use disorders

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Disclosure Information

An aging population: Caring for older adults with substance use disorders

April 26, 2025 1:15 to 2:30 PM

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- No disclosures

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- No disclosures

Learning Objectives

Become familiar with the epidemiology of substance use disorders in older adults

Identify specific considerations when caring for the older adults with SUD, and feel comfortable with the diagnosis and medication management

Identify specific barriers to care for this population, and learn of creative models to increass access to treatment

Patient case

- A 71 year-old male presented to the hospital after being found down outside his apartment. EMS gave naloxone with improvement in symptoms.
- Patient appeared confused, unable to answer orientation questions besides his name. Brought to the hospital for evaluation.

Patient case

Patient is identified in the chart as a patient with dementia only oriented to himself, HTN, CKD. He lives with his partner in Camden, NJ.

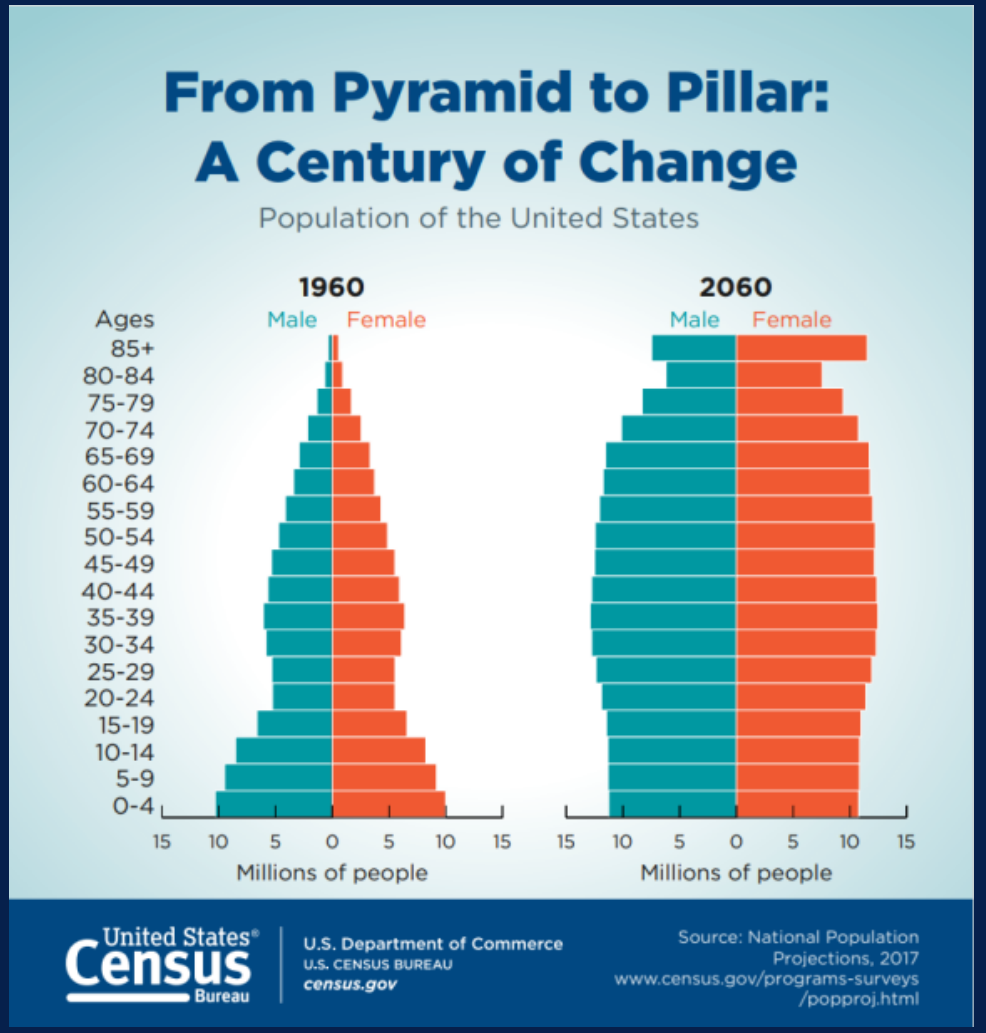
Urine toxicology was done and showed urine was positive for fentanyl. Addiction medicine team was consulted.

How do we care for this patient?

Epidemiologic Trends

At what age does someone become an "older adult?"

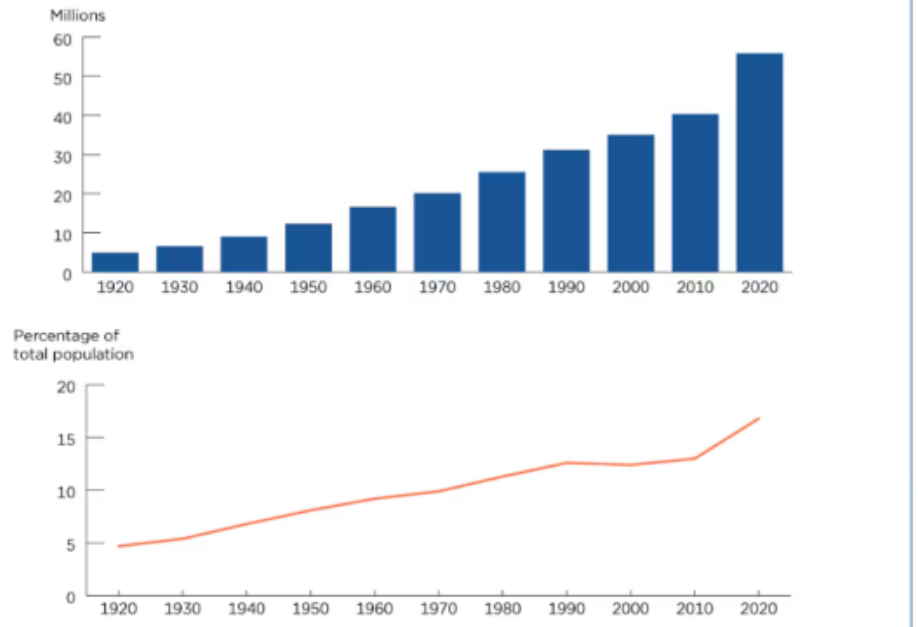
An aging nation



Ortman, Jennifer M., Victoria A. Velkoff, and Howard Hogan. An Aging Nation: The Older Population in the United States, Current Population Reports, P25-1140. U.S. Census Bureau, Washington, DC. 2014.

Over the years

Figure 1.
Population 65 Years and Over by Size and Percentage of Total Population: 1920 to 2020



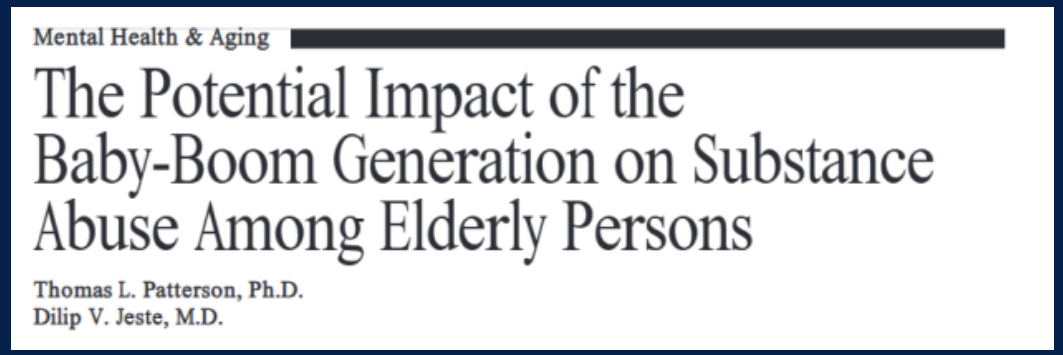
Note: For information on data collection, confidentiality protection, nonsampling error, and definitions, refer to <https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/complete-tech-docs/demographic-and-housing-characteristics-file-and-demographic-profile/2020census-demographic-and-housing-characteristics-file-and-demographic-profile-techdoc.pdf>.

Source: U.S. Census Bureau, Decennial Census of Population, 1900 to 2000; 2010 Census Summary File 1, and 2020 Census Demographic and Housing Characteristics File (DHC).

Figure 1 shows the number and percentage of people age 65 and over in decennial censuses since 1920.

Ortman, Jennifer M., Victoria A. Velkoff, and Howard Hogan. An Aging Nation: The Older Population in the United States, Current Population Reports, P25-1140. U.S. Census Bureau, Washington, DC. 2014.

Aging baby boomers


Mental Health & Aging

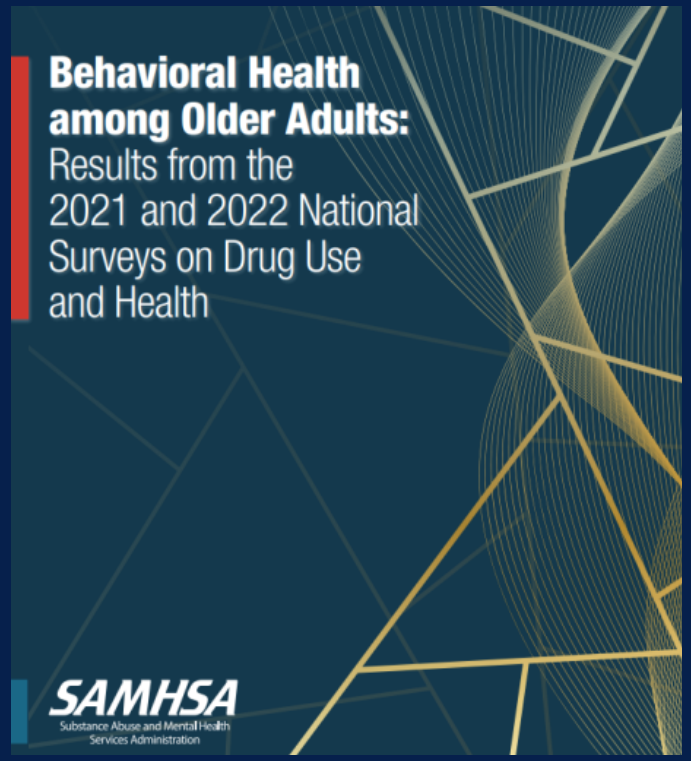
The Potential Impact of the Baby-Boom Generation on Substance Abuse Among Elderly Persons

Thomas L. Patterson, Ph.D.
Dilip V. Jeste, M.D.

- Articles as early as 1999 discuss trends of substance use in baby boomers
- Substance use changes in 1960s-1970s
- People who were using substances in the 1960s are getting older, and continuing or returning to substance use

Patterson, T. L., & Jeste, D. V. (1999). The potential impact of the baby-boom generation on substance abuse among elderly persons. *Psychiatric services*, *50*(9), 1184-1188.

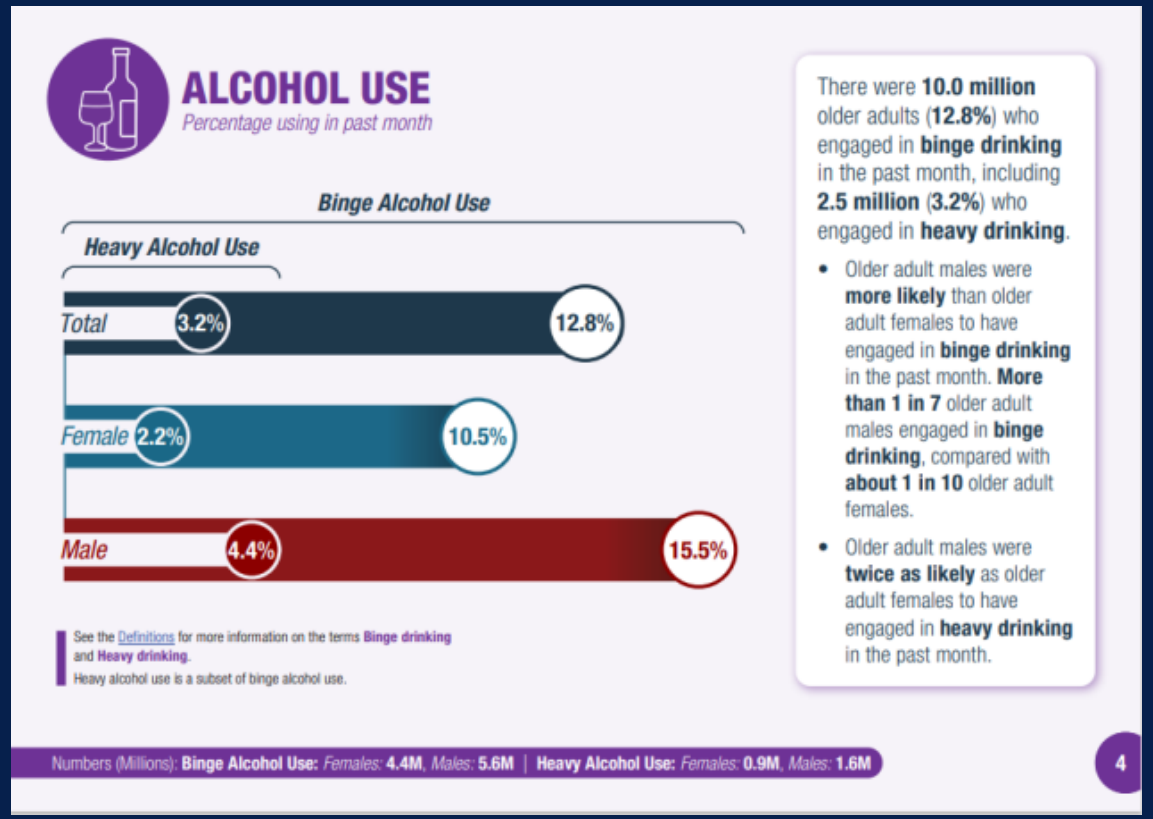
SAMSHA:2021 and 2022 NSDUH



- Looks at substance use and mental health indicators for those age 60 and older
- DOES NOT include older adults living without fixed addresses (those who have homelessness, live in nursing facilities, or who are in jails and prisons)

Substance Abuse and Mental Health Services Administration. (2024). Behavioral health among older adults: Results from the 2021 and 2022 National Surveys on Drug Use and Health (SAMHSA Publication No. PEP24-07-018). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/older-adult-behavioral-health-report-2021-202

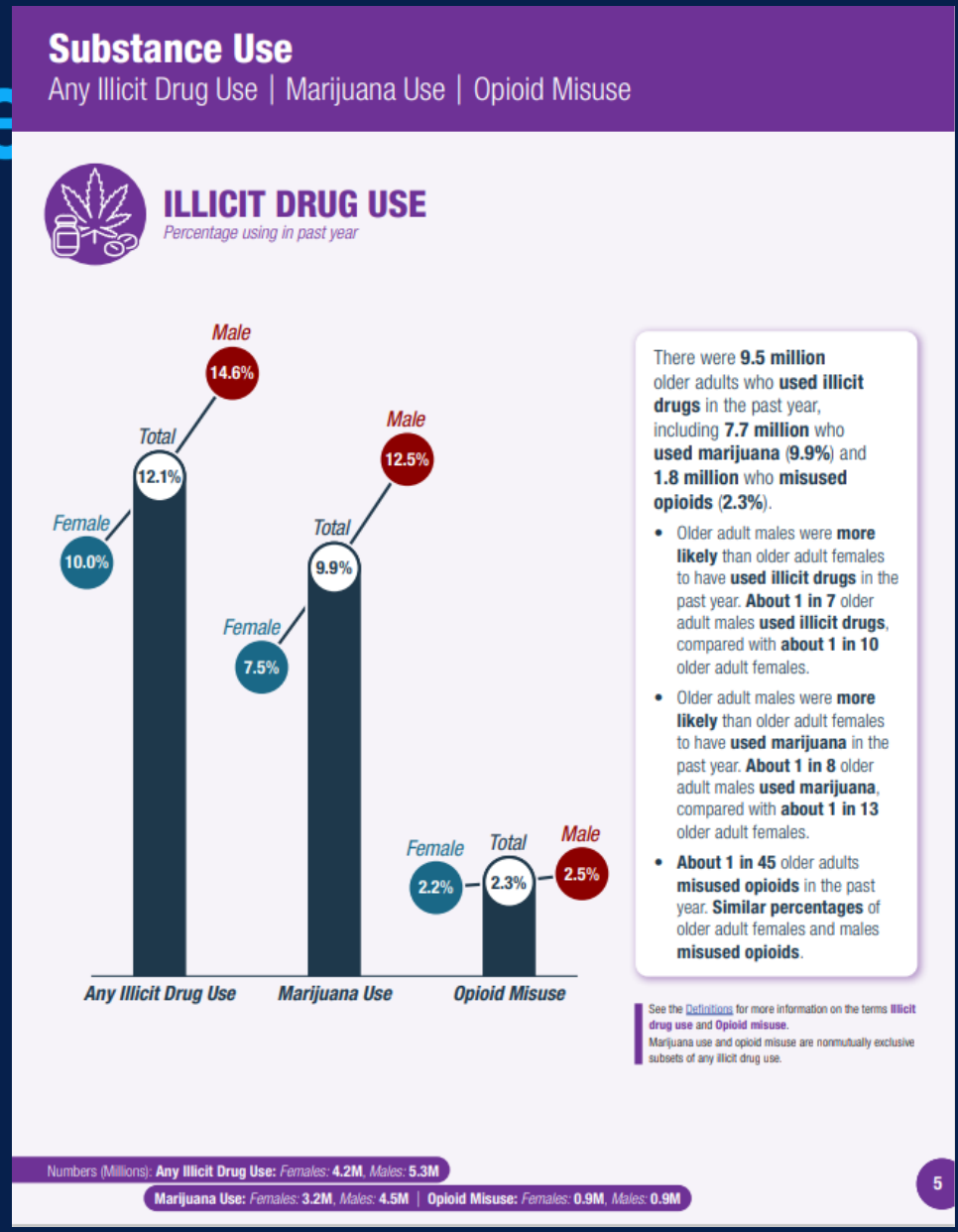
SAMSHA: Alcohol use

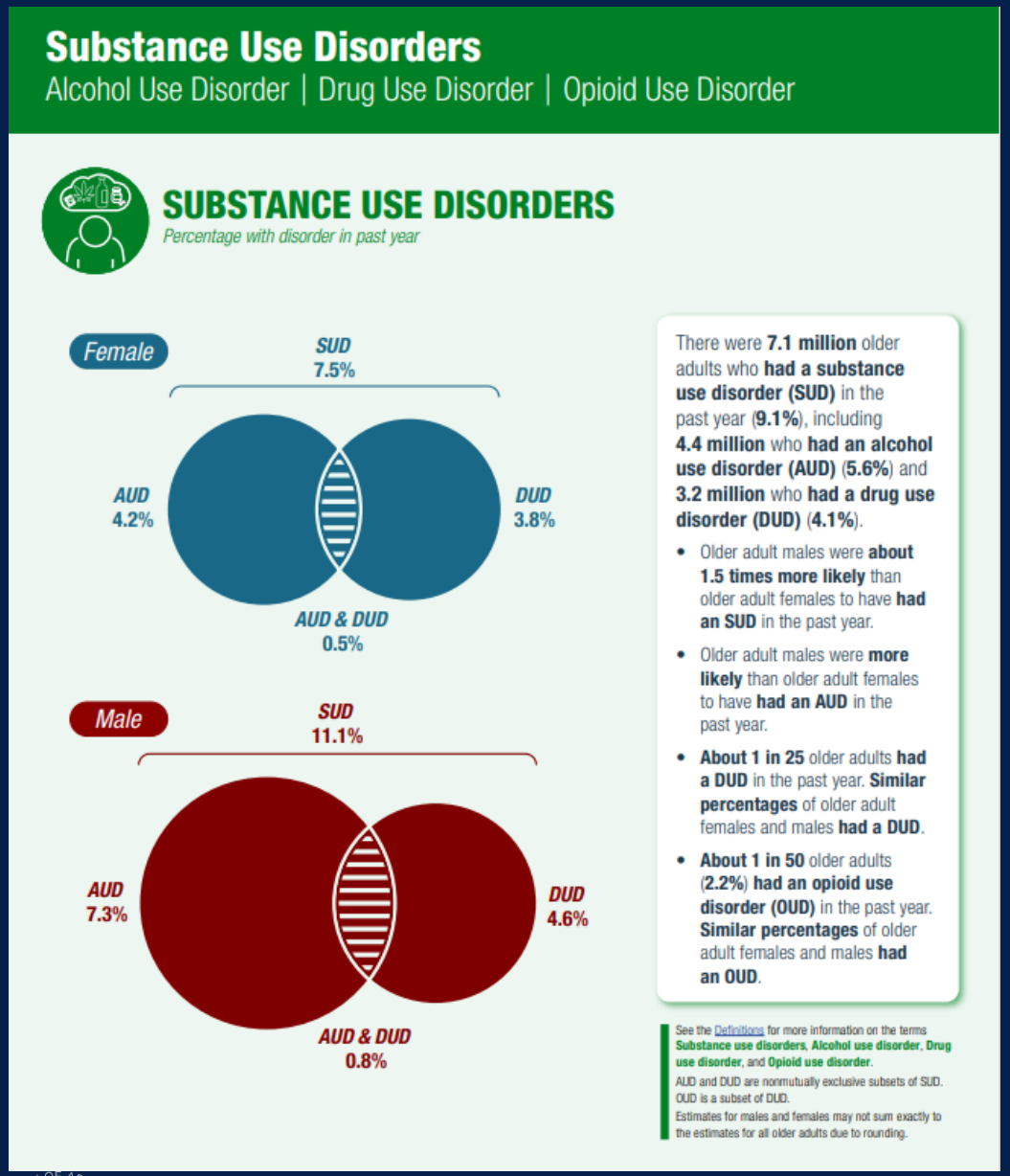


- Alcohol is the most commonly misused substance
- 10.0 million older adults had binge drinking
- 2.5 million with heavy drinking

SAMSHA: Illicit drug use

- 9.5 million older adults used illicit drugs in the past year
- 1.8 million misused opioids
- Males were more likely than females to have substance use
- Drugs considered illicit: Marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamines, misuse of prescription medications



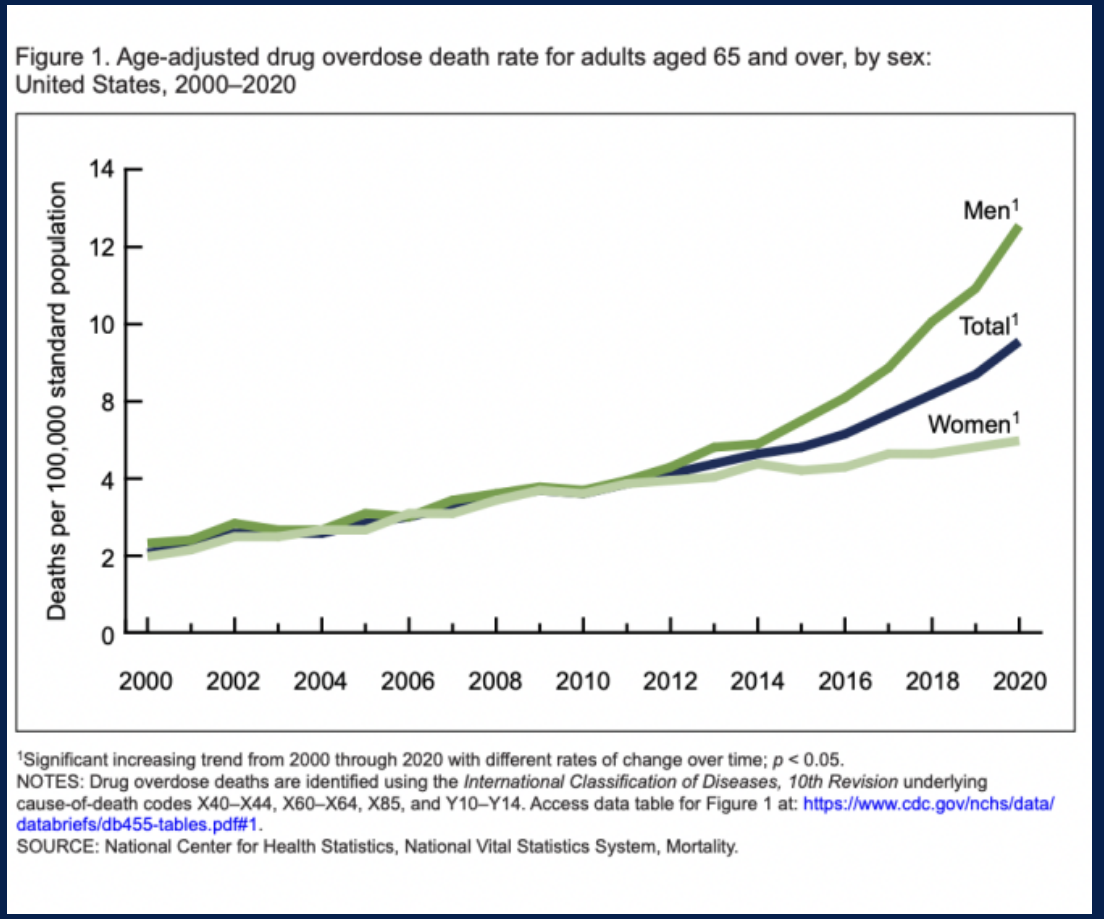


SAMSHA: SUD

- 7.1 million older adults had SUD
- 3.2 million had a drug use disorder
- 4.4 million had AUD

NCHS Report 2022

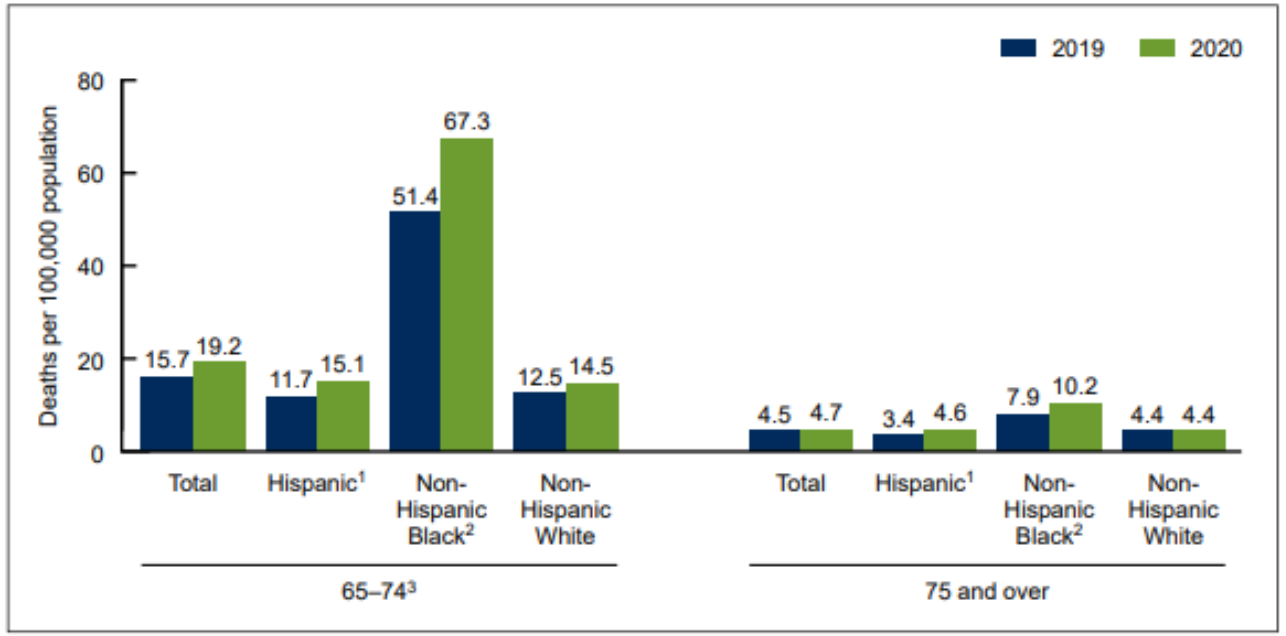
- In 2020, 5209 overdose deaths reported in those greater than 65
- Over 20 years from 2000 to 2020, the rate of overdose death rose from 2.4 per 100,000 to 8.8 per 100,000



Kramarow EA, Tejada-Vera B. Drug overdose deaths in adults aged 65 and over: United States, 2000–2020. NCHS Data Brief, no 455. Hyattsville, MD: National Center for Health Statistics. 2022. DOI: https://dx.doi.org/10.15620/cdc:121828

Racial disparities in overdose deaths

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



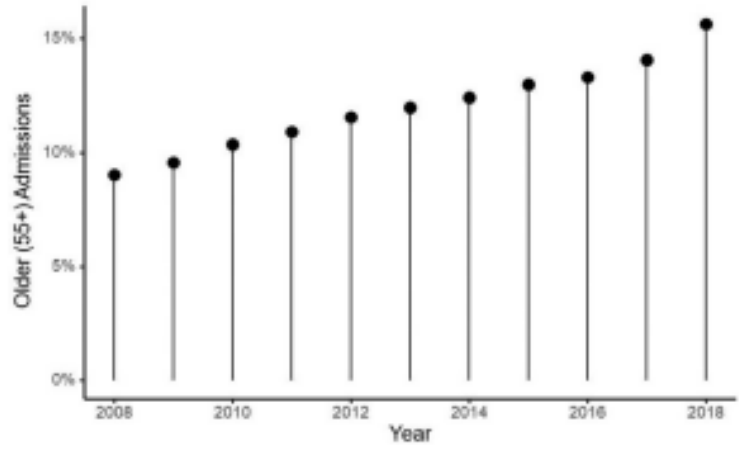
[1]Rates were significantly lower than rates for non-Hispanic Black men in 2019 and 2020; $p < 0.05$.
[2]Rates were significantly higher than rates for non-Hispanic White men in 2019 and 2020; $p < 0.05$.
[3]Rates for 2020 were significantly higher than 2019 for all groups; $p < 0.05$.
NOTES: Total includes 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.

Kramarow EA, Tejada-Vera B. Drug overdose deaths in adults aged 65 and over: United States, 2000–2020. NCHS Data Brief, no 455. Hyattsville, MD: National Center for Health Statistics. 2022. DOI: https://dx.doi.org/10.15620/cdc:121828

Are older adults getting treatment?

Older Adult Substance Use Treatment First-Time

FIGURE 1. Percent of admissions that are for older adults (55 years or older) between 2008 and 2018.

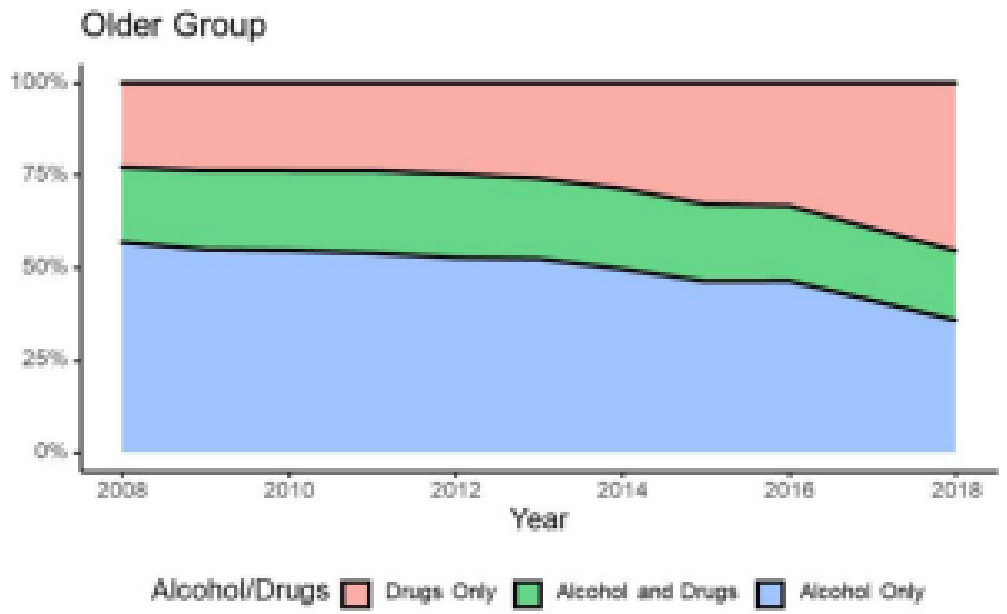


- Review of admissions of TEDS from SAMSHA from 2008 to 2018
- Number of older adult admissions increase by 190%

Weber A, Lynch A, Miskle B, Arndt S, Acion L. Older Adult Substance Use Treatment First-Time Admissions Between 2008 and 2018. *American journal of geriatric psychiatry*. 2022;30(10):1055-1063. doi:10.1016/j.jagp.2022.03.003

What are people entering treatment for?

FIGURE 2. Percent of first admissions for alcohol only, drug and alcohol, and drug for older adults (55 years or older) between 2008 and 2018.



- Primary substance at admission now more commonly substance only, surpassing alcohol only, and combined alcohol and drug use

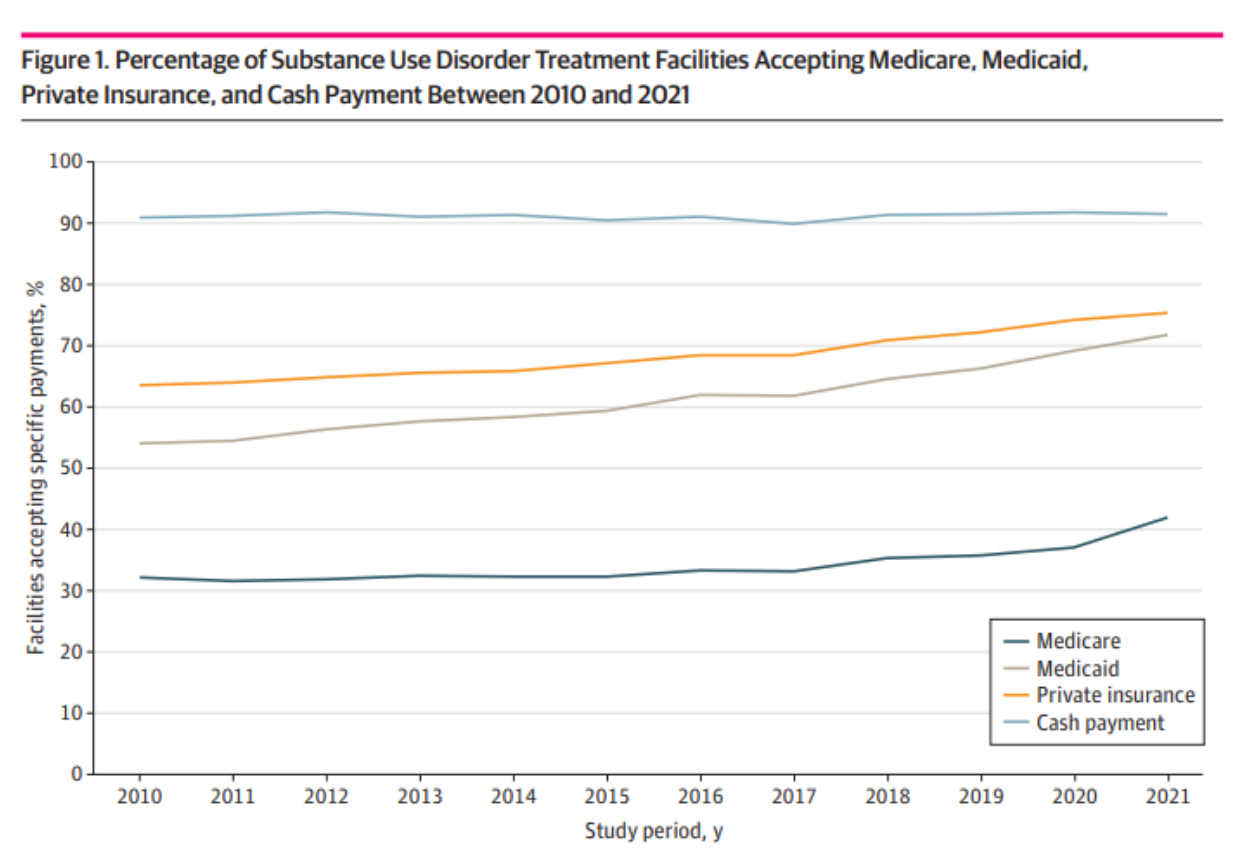
Weber A, Lynch A, Miskle B, Arndt S, Acion L. Older Adult Substance Use Treatment First-Time Admissions Between 2008 and 2018. *American journal of geriatric psychiatry*. 2022;30(10):1055-1063. doi:10.1016/j.jagp.2022.03.003

Referral sources for treatment

- Review of 2008 to 2018 TEDS admissions
- Reviewed referral sources in older adult admissions
  - Individual/self-report: 42.30%
  - Criminal Justice: 29.70%
  - Other health care provider: 11.26%
  - Other community organization 9.88%

Weber A, Lynch A, Miskle B, Arndt S, Acion L. Older Adult Substance Use Treatment First-Time Admissions Between 2008 and 2018. *American journal of geriatric psychiatry*. 2022;30(10):1055-1063. doi:10.1016/j.jagp.2022.03.003

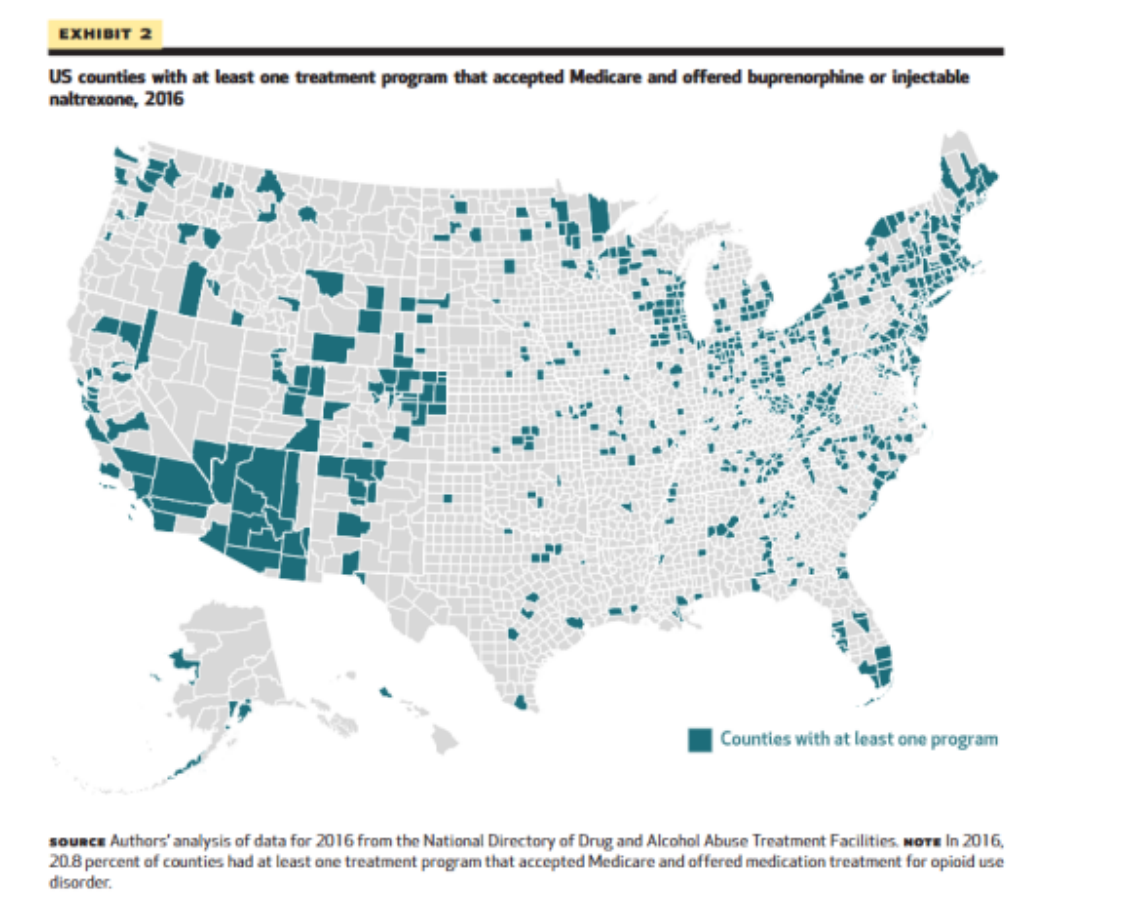
Who is paying for treatment?



- Data on licensed SUD treatment facilities for all US counties listed in National Directory of Drug and Alcohol Abuse Treatment Programs 2010 to 2021
- Medicare beneficiaries have less geographic accessibility to SUD treatment facilities

Cantor JH, DeYoreo M, Hanson R, et al. Patterns in Geographic Distribution of Substance Use Disorder Treatment Facilities in the US and Accepted Forms of Payment From 2010 to 2021. *JAMA network open*. 2022;5(11). doi:10.1001/jamanetworkopen.2022.41128

Medicare and medications for OUD

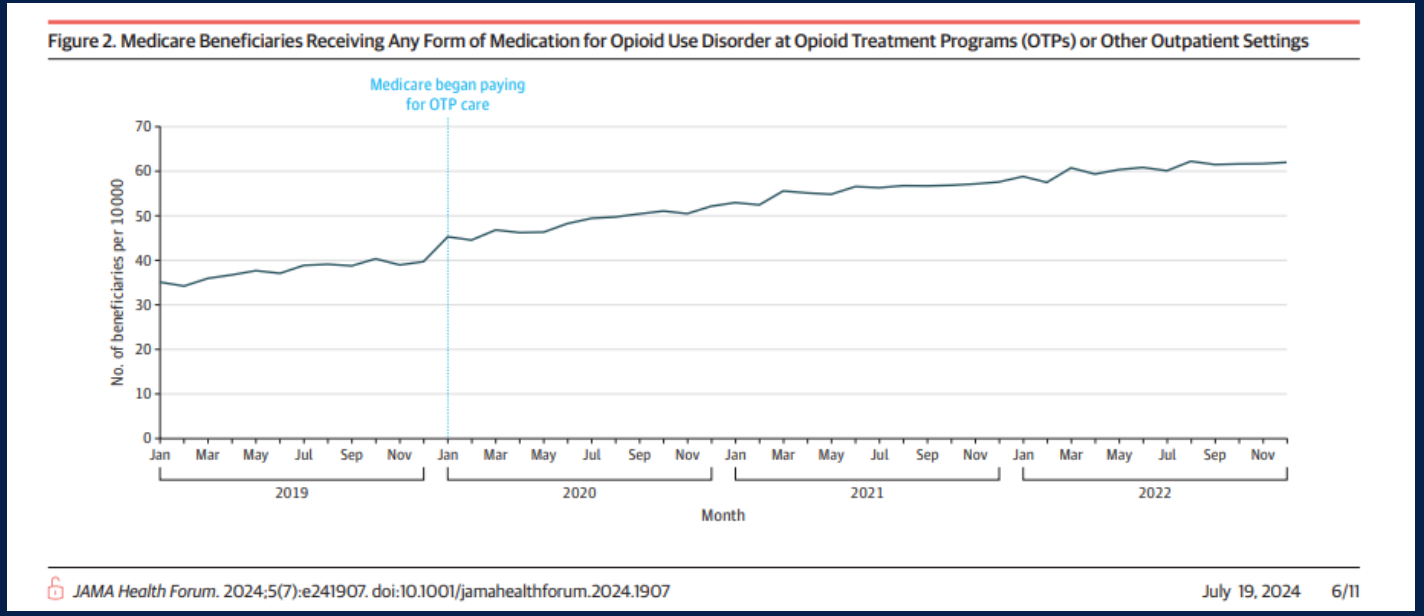


- 2007 to 2016 survey data from National Survey of Substance Abuse Treatment Services
- Looked at services that accepted Medicare as a form of payment and that offered buprenorphine or injectable naltrexone
- Did not include methadone

Harris SJ, Abraham AJ, Andrews CM, Yarbrough CR. Gaps In Access To Opioid Use Disorder Treatment For Medicare Beneficiaries. *Health affairs*. 2020;39(2):233-237. doi:10.1377/hlthaff.2019.00309

The SUPPORT Act

- Starting January 1, 2020, methadone treatment covered by Medicare for the first time
- Bundled payment for episodes of care



Nakamoto CH, Huskamp HA, Donohue JM, Barnett ML, Gordon AJ, Mehrotra A. Medicare Payment for Opioid Treatment Programs. *JAMA Health Forum.* 2024;5(7):e241907. doi:10.1001/jamahealthforum.2024.1907

Summary

Rate of substance use in older adults is rising

Racial disparities in prevalence of SUD and overdose death rates

7.1 million adults 60 and older have SUD

Less than 10% of older adult patients are receiving treatment

Medicare started payment for OTPs in 2020, and there has been an increase in number of adult patients accessing treatment

Screening and diagnosis

Patient case

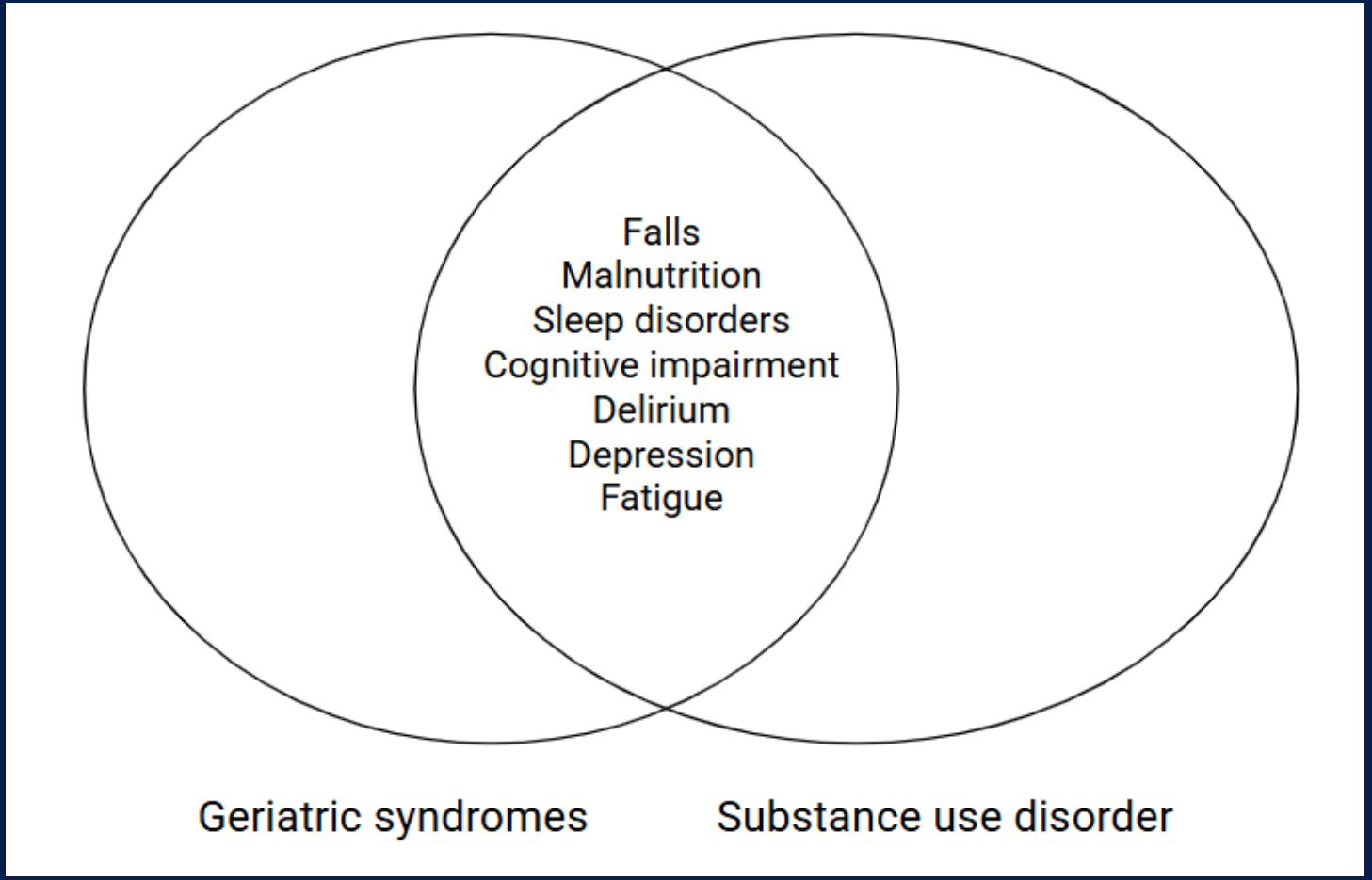
- A 71 year-old male presented to the hospital after being found down outside his apartment. EMS gave naloxone with improvement in symptoms.
- Patient appeared confused, unable to answer orientation questions besides his name. Brought to the hospital for evaluation.

USPSTF Recommendations

Recommendation Summary

Population	Recommendation	Grade
Adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)	B

What does it look like in an older adult?



Potential signs of substance use

- Changes in mood
- Sleep disturbances
- Unexplained injuries/falls
- Self-neglect
- Cognitive changes
- Daytime drowsiness
- Social and behavioral changes, withdrawal from regular activities

Broad differential for all the above!

DSM5 for older adults

- Traditional criteria used may not be easy to assess for older adult patients
- Screening methods may not capture older adult patients with SUD

Table 1. Use of DSM-5 Criteria for the Diagnosis of Substance-Use Disorder in Older Adults.*

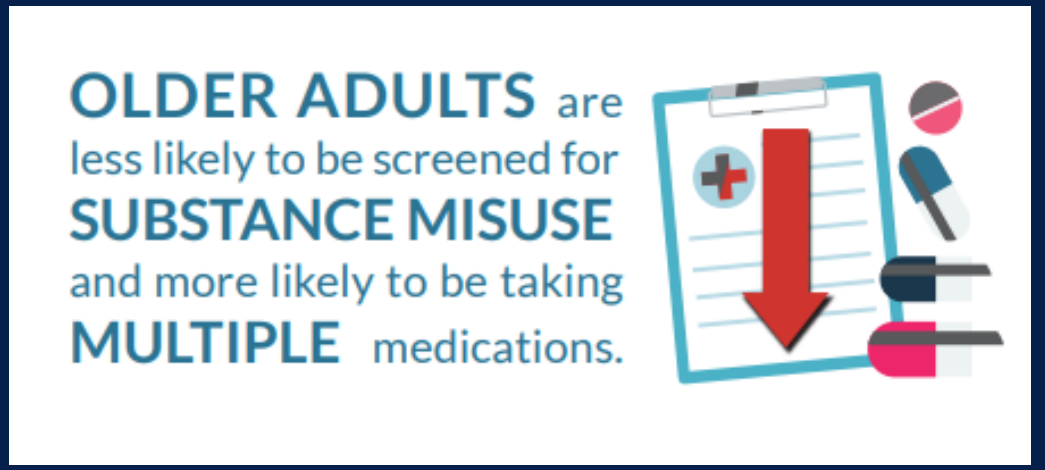
DSM-5 Criterion	Application of Criterion for Older Adult
Substance taken in greater amount than intended	Older adult may be impaired using the same amount taken when younger
There is persistent desire or unsuccessful effort to cut down or control use	Older adult may not realize use is problematic, especially with long-term use
There is excessive time spent to obtain, use, or recover from the substance	Same
There is craving for the substance	Same
Repeated use leads to inability to perform role in the workplace or at school or home	Role impairment is less pertinent; older adult may be retired and may be living alone
Use continues despite negative consequences in social and interpersonal situations	Same
Valued social or work-related roles are stopped because of use	Effect of substance use on social roles is less obvious if older adult is no longer working
Repeated substance use occurs in potentially dangerous situations	Same; older adult may be at increased risk for impaired driving
Substance use not deterred by medical or psychiatric complication	Same; medical consequences can be serious, including confusion, falls with injury, and psychiatric symptoms
Tolerance develops: increasing amount is needed to obtain effects	Symptomatic impairment may occur without an obvious need for increasing the amount
Withdrawal syndrome occurs or patient takes substance to prevent withdrawal	Withdrawal syndrome can occur with more subtle symptoms such as confusion

* DSM-5 denotes *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition.

Longo DL, Lehmann SW, Fingerhood M. Substance-Use Disorders in Later Life. *The New England journal of medicine*. 2018;379(24):2351-2360. doi:10.1056/NEJMra1805981

Screening

- Few validated screening tools for those 65 and older
- Medicare Annual Wellness Visit requires review of social history including "alcohol, tobacco, and illegal drug use history"



Substance Abuse and Mental Health Services Administration. Treating Substance Use Disorder in Older Adults. Treatment Improvement Protocol (TIP) Series No. 26, SAMHSA Publication No. PEP20-02-01-011. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

Alcohol Screening

- Senior Alcohol Misuse Indicator (SAMI)
  - Assesses symptoms of alcohol use that may affect older adults
- Short Michigan Alcoholism Screening Test – Geriatric Version (SMAST-G)
  - Questions more tailored to older adults
  - "Have you ever increased your drinking after experiencing a loss in your life?"
  - "When you feel lonely, does having a drink help?

Screening for multiple substances

- Tobacco, Alcohol, Prescription medication, and other Substance use tool (TAPS)
  - Uses electric format if patient answering alone
  - Can also be administered by clinician
- NIDA Quick Screen 1.0
  - Requires screener to ask questions
  - Prompts NIDA-Modified ASSIST if patient has positive screen

Treatment

Alcohol use

Table 3. Treatment of Alcohol-Use Disorder in Older Patients.

Indication and Medication	Onset of Action	Rate of Metabolism	Metabolized by Liver	Dose*
				mg
Treatment of alcohol withdrawal				
Chlordiazepoxide	Intermediate	Long	Yes	25–50
Diazepam	Fast	Long	Yes	5–10
Lorazepam	Intermediate	Intermediate	No	1–2
Oxazepam	Slow	Short	No	15–30
Long-term management†				
Naltrexone			Yes	25–50, daily
Acamprosate			No	666, three times a day
Disulfuram			Yes	500, daily

* Dosing frequency for the treatment of alcohol withdrawal should be based on assessment of alcohol withdrawal symptoms.

† Naltrexone is an opioid-receptor antagonist, acamprosate is a possible partial *N*-methyl-D-aspartate (NMDA) receptor agonist, and disulfuram is an acetaldehyde dehydrogenase inhibitor.

- Impairment happens at lower levels of alcohol consumption
- AUD increases risk of hospitalization in older adults
- Withdrawal symptoms may be different – more likely to present with confusion first
- No specific treatment for withdrawal management

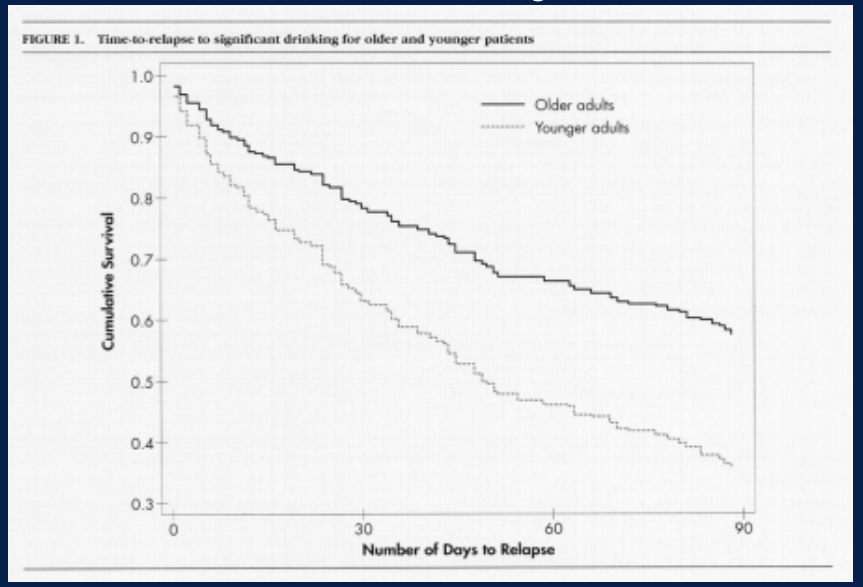
Longo DL, Lehmann SW, Fingerhood M. Substance-Use Disorders in Later Life. *The New England journal of medicine.* 2018;379(24):2351-2360. doi:10.1056/NEJMra1805981

FDA approved medications

Medication	Dose	Metabolism	Considerations
Naltrexone	50mg/380mg for long-acting injectable	Liver	• Opioid antagonist – cannot be on full opioid agonists • Need to discontinue if patients have elective surgical procedures (knee/hip replacement, hernia, etc) • Closer monitoring of LFTs
Acamprosate	666mg three times daily	Kidney	• Pill burden is biggest issue • Potential for use in patients with decompensated cirrhosis
Disulfuram	500mg daily	Liver	• Side effect profile with return to drinking

Age specific treatment?

- Early studies in the VA showed older adults potentially 2 times more likely to report abstinence in the older adult specific program
- Older adults (>55) were less likely to have clinically significant return to alcohol use



Kashner, T. Michael, et al. "Outcomes and costs of two VA inpatient treatment programs for older alcoholic patients." *Psychiatric Services* 43.10 (1992): 985-989.

Oslin, David W., Helen Pettinati, and Joseph R. Volpicelli. "Alcoholism treatment adherence: older age predicts better adherence and drinking outcomes." *The American Journal of Geriatric Psychiatry* 10.6 (2002): 740-747.

Opioid use

- Early-onset vs. Late-onset use
- Prescription misuse vs non-prescribed opioid use
- Differences in tolerance
- Evaluate for chronic pain and underlying etiologies

FDA medications for OUD

Medication	Pros	Cons
Methadone	• Familiar to many older adults • Great variability with doses • Long history of evidence as MOUD	• Logistical challenges • Potential risk of oversedation • With polypharmacy, risk of prolonged QTc is higher • Not able to receive in many PALTC settings
Buprenorphine	• Logistically easier than methadone • Lower risk of sedation/respiratory depression • Less stigmatization	• Sublingual film packaging hard to open • Insurance coverage issues if using lower dose formulation (mcg doses) • Limited titration of dosing
Naltrexone	• Less frequent in terms of dosing as injectable medication • No pill burden	• IM injection • Potential for complication if patient has reason to need full opioid agonists • Less evidence in effectiveness

Methadone vs. buprenorphine

- Less data for buprenorphine in older adults compared to methadone in older adults
- Doses of methadone may need to be changed as patients age
- Patient preconceived notions of methadone
- Buprenorphine may be potentially safer for patients with significant medical comorbidities

Post-acute long-term care and methadone

- Significant barriers to patients on methadone being accepted to post-acute long-term care facilities
- Limitations include:
  - No local facility
  - Logistical barriers
  - Stigma
  - Lack of education

ADA protections for OUD

3) Does the ADA protect individuals who are taking legally prescribed medication to treat their opioid use disorder?

Yes, if the individual is not engaged in the illegal use of drugs. Under the ADA, an individual's use of prescribed medication, such as that used to treat OUD, is not an "illegal use of drugs" if the individual uses the medication under the supervision of a licensed health care professional, including primary care or other non-specialty providers.[10] This includes medications for opioid use disorder (MOUD) or medication assisted treatment (MAT). MOUD is the use of one of three medications (methadone, buprenorphine, or naltrexone) approved by the Food and Drug Administration (FDA) for treatment of OUD;[11] MAT refers to treatment of OUD and certain other substance use disorders by combining counseling and behavioral therapies with the use of FDA-approved medications.[12]

Example A

A skilled nursing facility refuses to admit a patient with OUD because the patient takes doctor-prescribed MOUD, and the facility prohibits any of its patients from taking MOUD. The facility's exclusion of patients based on their OUD would violate the ADA.

Opioid Use Disorder | ADA.gov

Summary

Older adult patients should also be screened for SUD, and general screening tools can be used

SUD may look different in older adults due to comorbidities and medical complexities

Treatment should be offered to older adults! Older adults often do better compared to younger adult patients

All FDA approved medications can be used, need to consider risks and benefits of each medication

Consider the setting where patients will be receiving medications

Models of care

Older adult group visit model

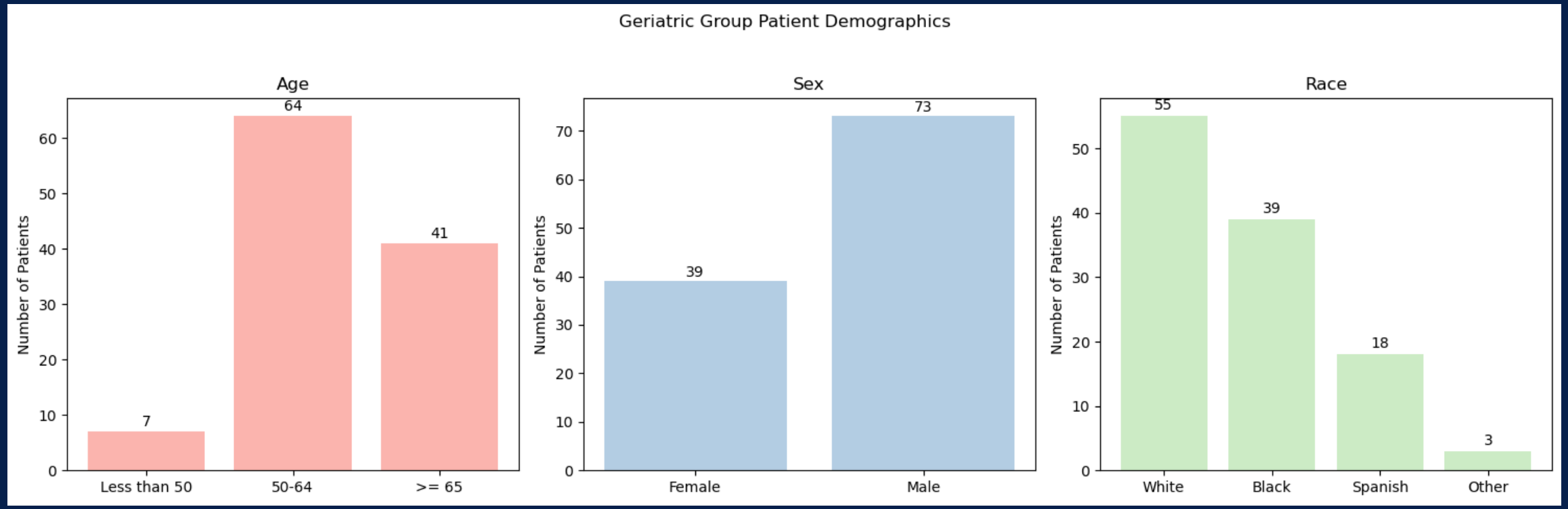
Provider:
Addiction Physician/Geriatrician
Addiction Fellow
Family Medicine Residents
Medical students

Clinical pharmacist

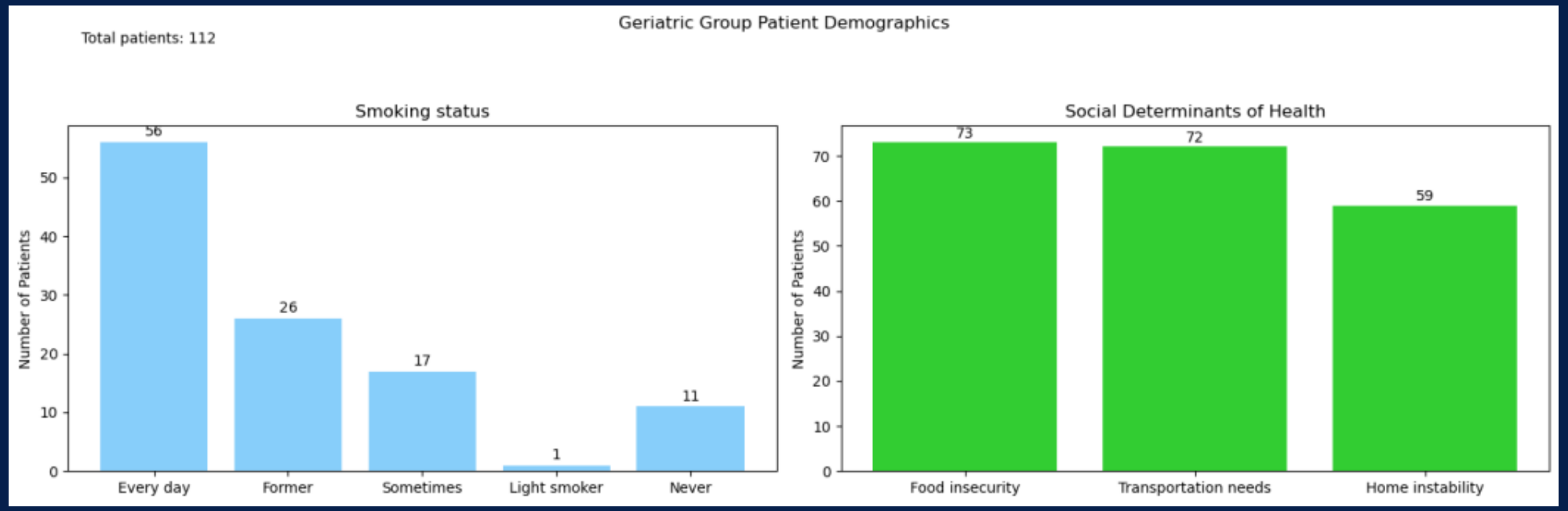
Clinician:
LCSW
Peer Recovery Specialist
Psychology intern

Addiction navigation specialist

From 10/1/2022 to 2/17/2025, total of 112 patients participated in group



Social determinants



Group dynamics

- Combination of patients with alcohol, opioid, stimulant, and benzodiazepine use disorders
- Patients at different points in their recovery
- Participation frequency varies from weekly to monthly visits
- Some patients come only for the group visit and do not see a provider at each visit

Successes and challenges

Direct consultation in PALTC

Barriers to care in PALTC setting

- STIGMA
- Transitions of care
  - Reliance on medical transportation
  - In-person intake at OTP
  - Dose adjustments require OTP visit
  - Staffing from PALTC to transport methadone

Successes and challenges

Next steps…

Initiation of methadone in NJ 10:161B-11.6 Admissions and assessment section C state:

"An opioid treatment program shall conduct a complete physical examination, a medical history including drug use and current medications, treatment history and personal history before dispensing or administering medication. A program physician or other licensed independent practitioner authorized under New Jersey statues shall conduct a complete physician examination…"

Summary

- There is a rising rate of older adults with substance use disorders
- Older adult patients are interested in treatment, and may do better than younger adults in treatment and recovery
- Older adults pose certain challenges in screening, diagnosis, and treatment that may require certain considerations
- Consider using geriatric principles of multidisciplinary models of care to create spaces to meet patient needs

Questions and Comments

References

1. Ortman, Jennifer M., Victoria A. Velkoff, and Howard Hogan. An Aging Nation: The Older Population in the United States, Current Population Reports, P25-1140. U.S. Census Bureau, Washington, DC. 2014
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