UNC SON ECHO ABC for MOUD

Addiction and Behavioral Clinic for Medication for Opioid Use Disorder Treatment

SUBSTANCE USE DISORDERS AND THE OLDER ADULT

LESLIE SHARPE, DNP, FNP-BC

FNP HUB TEAM MEMBER

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From the presentation through PCSS: Substance Use Disorders in Late LIfe

Objectives

Identify risks for substance use disorders in the older adult

Apply knowledge of age-related pharmocodynamic and pharmacokinetic changes for the elderly population that affect medication selection and dose adjustment.

The State of Things

Over 40 percent of older adults have chronic pain that is often treated with opioids (18 million)

From 2000 to 2010, the percent of clinic visits at which an opioid was used rose from 4.1% to 9.0% (**more than doubled**)

The prevalence of older adults (65+) misusing opioids is low (1%), but the increasing trends are concerning.

Older adults report misuse of painkillers more than any other type of prescription drug.

OIG (2017) found that more than 500,000 Medicaid beneficiaries with opioid prescriptions received excessively high dosages, issued over extended periods of time (despite CDC guidelines recommending otherwise).

Substance use disorders in late life are underdiagnosed and under-treated.

Alarming Trends

In a poll of more than 2,000 adults between the ages of 50 and 80 found nearly **30% had a prescription for an opioid filled within the last two years**

- Arthritis
- Back pain
- Surgery
- Injury

86% indicated they kept the leftover pills for future use

Less than 50% of time providers shared information about risk of addiction, risk of overdose, and disposal of medications

Hydrocodone-containing opioid combinations are rapidly becoming the most commonly prescribed.

Opioid misuse was associated with an increased number of chronic conditions, greater injury risk, and higher rates of alcohol dependence and mental health diagnoses.

Late life risk factors for SUD

Previous history of SUD (including relapse)	Comorbid psychiatric illness	Cognitive impairment	Family history of SUD
Involuntary retirement	Loss (spouse, friend)	Worsening physical health	Availability of substances
Male gender	High school education or beyond	Chronic physical illness or pain	Being a caregiver

Protective Factors

Married

Religious affiliation

Late-life onset

Good social support

Resiliency

Demonstrated ability to live independently

Good sense of identity & purpose

DSM-5 Criteria for Diagnosis of SUD in older adults

Lehmann, S., et al., (2018), New England Journal of Medicine.

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 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 is the 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

Studies regarding **treatment** of OUD and older adults (systematic lit review)

Older drug users are growing in number and have a unique profile, with **many presenting for treatment for the first time aged 50–70 years**.

Opioid treatment numbers are decreasing, however the **average age of treatment admissions is increasing**

Problematic drug use (of which opioids make up the largest proportion) had been incorrectly assumed to end as patients age.

There is no consensus on what old is!

Two distinct types of older opioid substance users exist (early/late onset),

Older clients achieve better treatment outcomes than younger counterparts

Older women achieve better treatment outcomes than men.

Carew and Comiskey (2018)

Screening

NIDA *Quick Screen* Question: In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol ☐ For men, 5 or more drinks a day ☐ For women, 4 or more drinks a day					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

Physiologic and pharmacokinetic changes in the elderly and consequences

- Increased risk of falls
- Decreased hepatic clearance
- Decreased renal clearance
- Increased sensitivity to extrapyramidal symptoms
- Increased sensitivity to anticholinergic medications
- Vulnerability to medication toxicity

Buprenorphine + naloxone: Geriatric considerations

Buprenorphine + naloxone

- Half-life is **not** altered with renal or hepatic impairment
- For moderate OUD, as effective as methadone
- Lower misuse potential than methadone (due to ceiling effect and naloxone presence)
- Still done know as much as we do about methadone
- At least one study has been done that found low dose buprenorphine has been safe and well-tolerated in older adults

Naltrexone: Geriatric considerations

- Injection (380 mg) every 28 days
- Highly motivated individuals
- May be useful if individuals do not want prescriptions to show up on PDMP
- May be helpful for those who want to avoid new dependence on a medication after being in recovery.

Methadone: Geriatric considerations

Methadone—you may not be prescribing, but if your patient is on methadone…

- Older adults may do better with methadone than younger individuals with OUD
- Risk of increased sedation and polypharmacy
- Monitor for falls
- Caution if using concomitant antidepressant or antipsychotic due to QTc prolongation.
- Constipation—think about bowel regimen as part of management

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