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Substance Use Disorders in Older Adults: Overview and Future Directions

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Abstract:

Knowledge of substance use disorders (SUD) in adults ages 65 and older is limited. This article presents an overview of epidemiology, service use, and clinical considerations on SUD in older adults and suggests future directions. SUD prevalence is lower in older versus younger adults, as are treatment rates among those with SUD. SUDs may be difficult to recognize and treat in older adults due to the presence of other psychiatric and general medical disorders. Better integration of SUD and general medical treatment, and increased attention to social determinants of health, are important future directions for research and treatment of SUD in elders.

Key Words:

substance use disorders, SUD, epidemiology, treatment, integration

By 2030, one in five Americans is projected to be ages 65 years or older. Yet knowledge of substance use and substance use disorders (SUD) in this cohort lags behind knowledge about the same issues in younger age groups. This article briefly summarizes data on the epidemiology, service use, and clinical considerations of substance use and SUDs in older adults, and suggests future directions.

Epidemiology

Older adults have lower prevalence of substance use than younger adults, which may lead clinicians to think that older adults do not use psychoactive substances or develop SUD. However, data from the National Survey on Drug Use and Health (NSDUH), an annual nationally representative study of the U.S. population ages 12 and older, show that drug use among adults ages 65 and older increased from 19.3 percent in 2012 to 31.2 percent in 2017 (Center for Behavioral Health Statistics and Quality, 2019). Furthermore, recent cohorts of individuals ages 65 and older tend to show a higher prevalence of lifetime substance use than that seen in prior generations (Chhatre et al., 2017).

The 2018 NSDUH estimated that for adults ages 65 and older the prevalence of alcohol, tobacco, cannabis, and opioid (including prescription opioids) use in the past twelve months were 43 percent, 14 percent, 4.1 percent, and 1.3 percent, respectively. The twelve-month prevalence of alcohol use disorder (AUD) and drug use disorder (DUD) (the NSDUH does not publish disaggregated information on specific drugs for adults ages 65 and older), were 1.6 percent and .4 percent, respectively. These findings are consistent with the results of the National Epidemiological Survey and Related Conditions-III (NESARC-III), which estimated the prevalence of AUD and DUD at 2.3 percent and .8 percent, respectively (Grant et al., 2015; Grant et al., 2016).

In most cases, SUD in older adults start earlier in life. True incidence, i.e., new onset, is rare (Compton et al., 2007). As in younger adults, being white, male, divorced or widowed, and disabled, and having lower educational attainment, increases the prevalence of SUD (Chhatre et al., 2017).

Service Utilization

Despite the numerous associated adverse consequences, many individuals with SUD, including older adults, have long delays in seeking treatment or never receive treatment (Blanco et al., 2013; Compton et al., 2007). For example, the National Epidemiological Survey on Alcohol and Related Conditions found that among individuals with SUD, the lifetime probability of seeking treatment was 90 percent for drug dependence, 60 percent for drug abuse, 54 percent for alcohol dependence, and 16 percent for alcohol abuse. However, in more than 50 percent of cases, treatment was sought more than ten years after disorder onset.

Belonging to an older cohort decreased the probability of ever receiving treatment (Blanco et al., 2015). Consistent with this study, NSDUH data indicate that among adults ages 65 and older with SUD, in 2018, 24 percent received treatment for drug use

disorders, and 16.8 percent received treatment for alcohol use disorders (Center for Behavioral Health Statistics and Quality, 2019). The NSDUH does not publish disaggregated treatment data on individuals ages 65 and older. However, the Treatment Episode Data Set (TEDS), which collects data on publicly funded substance use treatment admissions, found that individuals ages 65 to 69 represented only 1.18 percent of the total admissions. Among those admitted, 38.8 percent were for alcohol, 33 percent for opioids, and 5 percent for cocaine (TEDS-2017, 2017).

The unmet need for SUD treatment among older adults underscores the critical importance of identifying the determinants of SUD treatment. One way to understand those determinants is to use Andersen's Healthcare Utilization Model. Andersen's model groups determinants of healthcare use into three components: predisposing factors, such as demographic characteristics, education, and beliefs toward healthcare; enabling factors, which entail conditions that facilitate or impede service use, such as income, access, and transportation; and, objective and perceived need for treatment.

Some predisposing factors, such as age and knowledge, may be less favorable for older than younger adults. For example, due to feelings of isolation and shame (Kuerbis and Sacco, 2013), older adults often prefer treatment settings geared toward individuals of their same age, rather than settings with broader age ranges. Being married, of minority racial or ethnic ancestry, having attained less than a high school education, and earlier age of SUD onset also tend to lower treatment rates (Blanco et al., 2015). Lack of knowledge about services available can also impede treatment-seeking among older adults (Choi et al., 2014). By contrast, having had previous treatment contact for SUD tends to increase the probability of seeking treatment for another SUD.

Prominent enabling factors for older adults are stigma and stereotyping. Societal norms tend to reinforce the perception that older adults do not have SUD (Kuerbis and Sacco, 2013). This belief can be internalized by older adults, leading them to avoid treatment. On the positive side, because individuals ages 65 and older are eligible for Medicare, insurance is less often a barrier to care.

Need factors can also contribute to treatment delay. Individuals ages 65 and older have lower odds of perceived treatment need than younger individuals, and often report a lack of readiness to stop using substances as one of their primary reasons to not seek treatment (Choi et al., 2014). As a result, older adults are more likely to be referred to SUD treatment from other sources such as community social service providers than from healthcare providers (Sahker et al., 2015).

Clinical Considerations

SUD can be difficult to recognize in older adults and lead to treatment delays due to medical comorbidity, neurocognitive impairment, and functional decline (Seim et al., 2020). A key consideration in the treatment of older adults with SUD is that they often have co-occurring general medical illnesses (Wu and Blazer, 2014). Substance use can complicate the course and management of existing illnesses and they, in turn, can worsen the consequences of substance use and SUD.

'A SECOND IMPORTANT DIRECTION WILL BE INCREASING ACCESS TO AND RETENTION IN TREATMENT.'

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The effects of tobacco and alcohol, the two most commonly used drugs, on multiple organs, are well known. Other drugs, such as opioids and benzodiazepines can cause or exacerbate respiratory depression. Injection drug use can cause a variety of infections (e.g., endocarditis), which are more likely to occur in individuals with general medical conditions. Substance use also can trigger or intensify medical conditions such as diabetes or cardiovascular disease, which are common among older adults (Satre, 2015).

In addition to general medical disorders, older adults also can have other mental co-occurring disorders. Although the prevalence of most psychiatric disorders, including SUD, decreases with age, older adults have an increased risk of dementia, which can amplify the deleterious effects of substance use (Pascal de Raykeer et al., 2018; Lin et al., 2011). Furthermore, slower liver metabolism, decreased lean body mass, age-related brain changes, and interactions with medications can increase sensitivity to the effects of drugs among older individuals and the risk of neurotoxicity and drug-related adverse events (Satre, 2015). Cognitive impairment related to SUDs and sedation resulting from the use of psychotropic medications are associated with a greater risk of falls and hip fractures (Lin et al., 2011).

Future Directions

At present, SUD treatment for older adults is based on clinical experience and on studies conducted in younger populations, as most clinical trials for SUD tend to exclude older adults (Blanco et al., 2008; Blanco et al., 2015; Okuda et al., 2010). An important future direction will be to expand the evidence-base for the treatment of

older adults. This could include new clinical trials with less restrictive inclusion criteria, use of electronic medical records and observational studies, and simulations, as well as a combination of all these approaches (Blanco et al., 2017).

A second important direction will be increasing access to and retention in treatment. Ambulatory difficulties or restricted access to transportation can limit treatment access for older adults. However, the extraordinary expansion of telehealth associated with COVID-19 may change that situation (Blanco, Wall and Olfson, 2020). While some of those changes may be reverted, telehealth will likely continue to be a widely available delivery modality, particularly if covered by Medicare, based on its capacity to provide more convenient access to a broader selection of clinicians, and with possibly expanded hours.

Also, there is a need to improve the integration of mental health and general health services. This would lead to more person-centered care and decrease the need for multiple appointments, which can be particularly challenging for older adults. Collaborative models of care can achieve this goal either in-person or with the use of digital technologies (Ramuji et al., 2019).

Finally, a third important direction will be to ensure increased attention to social determinants of health (Blanco et al., 2020). Gender and racial inequities and stigma increase the risk of SUD at all ages and can act as a powerful barrier to treatment. Lack of social support, which often increases with age, can increase the risk for and worsen the course of, SUD. Housing, the built environment and other neighborhood characteristics also can be powerful determinants of substance use and access to treatment. Developing and implementing evidence-based approaches to social determinants of health will be key to improving the health of older adults and decreasing the risk of SUDs.

Conclusion

Substance use and SUD have lower prevalence in older adults than in the general population, but also are associated with very low rates of treatment-seeking and require specific clinical considerations. Strengthening the evidence base for the treatment of SUD, expanding service delivery modalities, improving integration with general medical treatment, and increasing attention to social determinants of health are promising future directions for research and treatment of SUD in older adults.

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