Welcome and Sign-In

- Please sign-in by chatting
  - your name,
  - your organization
  - anyone else joining you today
- If you have not yet registered, please email uwictp@uw.edu and we will send you a link

General Disclosures

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

Planner Disclosures

The following series planners have no relevant conflicts of interest to disclose:

- Denise Chang, MD
- Jessica Whitfield, MD, MPH
- Betsy Payn, MA, PMP
- Esther Solano
- Anna Ratzliff MD PhD

Overview of Learning Collaborative

- Audience:
  - Psychiatric Consultants
  - Working or hoping to work in integrated care settings
- Goals:
  - Provide ongoing integrated care education (CME available)
  - Foster learning and support network
  - Support sustainment of integrated care
- Structure:
  - Monthly lunch hour on 2nd Tuesday
    - Didactic topic 20-30 mins
    - Open discussion remainder of time
  - Topics repeat every 6 months

Last Session will be June 2025

Thank you all for attending and supporting UW PCLC!

Alternatives to UW PCLC

- UW PACC
- UW Community-based Fellowship
- Collaborative Care Community through APA
- Conferences:
  - UW Integrated Care Conference
  - Collaborative Family Healthcare Association (CFHA)
  - Academy of Consultation Liaison Psychiatry
  - American Psychiatric Association
  - Mental Health Services Conference

Resources

- AIMS Center office hours
- UW PACC
- Psychiatry Consultation Line
  - (877) 927-7924
- Partnership Access Line (PAL)
  - (866) 599-7257
- PAL for Moms
  - (877) 725-4666
- UW TBI-BH ECHO

Reminders

- Please keep yourself on mute during the didactic
- If you have a question during the presentation (related to the topic or not) please type it in the chat

Integrated Care Training Program

UW Psychiatry & Behavioral Sciences

November 12, 2024

General Concepts for Managing Late Life Behavioral Health Issues in Primary Care

Presenters:

Audrey Eichenberger, MD and Olga Koblova, MD

Speakers Disclosures

No relevant conflict of interest to disclose.

Learning Objectives

- Appreciate the difference between dementia and delirium and be able to start relevant work-up and treatment
- Recognize late-life depression and be able to begin treatment
- Identify anxiety disorders in late life; apply tailored therapeutic interventions.
- Understand substance use patterns in older adults; utilize age-appropriate screening and interventions

Context – Why is this important?

- The U.S. Census Bureau estimates that the number of Americans over the age of 65 will nearly double from 40.3 million in 2010 to a projected 72.1 million in 2030 [1]

- The Institute of Medicine has estimated that, by 2030, 10.1 to 14.4 million Americans aged 65 or older will have mental health or substance use disorders [2]

- In the United States, nearly half of mental health and substance use treatment is provided by primary care providers [3]

DSM-5 Criteria for Major Neurocognitive Disorder (Dementia):

A. Evidence of **significant cognitive decline from a previous level of performance in one or more cognitive domains** (complex attention, executive function, leaning & memory, language, perceptual-motor, or social cognition)

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been significant decline in cognitive function and

2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another qualified clinical assessment

B. The cognitive **deficits interfere with independence in everyday activities** (i.e. at the minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications)

C. The cognitive deficits **do not occur exclusively in the context of delirium**

D. The cognitive deficits are not better explained by another mental disorder (depression, schizophrenia)

DSM-5 Criteria for Delirium:

A. A **disturbance in attention** (i.e. reduced ability to direct, focus, sustain, and shift attention) **and awareness** (reduced orientation to the environment)

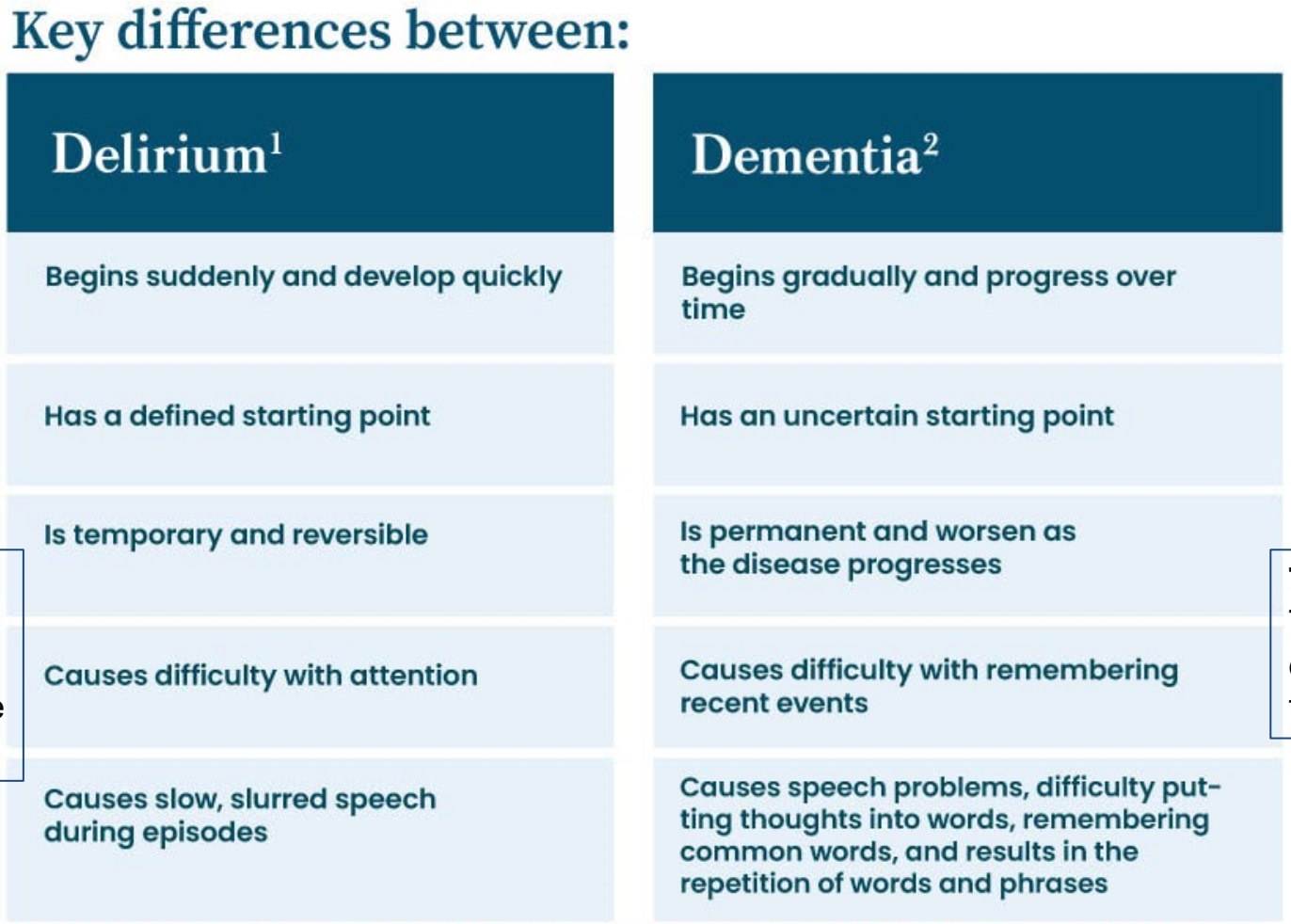
B. The **disturbance develops over a short period of time** (usually hours to a few days), **represents a change from baseline** attention and awareness, and **tends to fluctuate** in severity during the course of the day

C. An additional disturbance in cognition (i.e. memory deficit, disorientation, language, visuospatial ability, or perception)

D. The disturbances in criteria A and C are not better explained by another preexisting, established, or evolving neurocognitive disorder

E. There is evidence from the history, physical exam, or labs that the disturbance is a **direct physiological consequence** of another medical condition, substance intoxication, or withdrawal, or exposure to a toxin, or is due to multiple etiologies

Dementia vs. Delirium – Key Differences:



Treatment: Treat the underlying cause of the delirium

Treatment: There is no definitive treatment

https://www.aplaceformom.com/image/web-lighthouse/prod/difference-between-delirium-and-dementia.jpeg?t=default

I suspect cognitive impairment… now what?

- Perform a **physical exam and cognitive assessment** (i.e. Mini-Cog, MMSE, SLUMS, or MOCA)
- Collect **labs** to rule-out reversible causes:
  - Thyroid function tests, vitamin B12 level, and, based on individual considerations, can consider CBC, electrolytes, HIV, syphilis, folate, UA
- If you have concern for dementia, consider **structural brain imaging**
  - MRI generally preferred due to greater sensitivity and no radiation
  - CT is still reasonable if patient cannot tolerate MRI or when hemorrhage or stroke must be ruled out quickly
  - Imaging findings vary across dementia subtypes, but cerebral atrophy to a greater extent of that seen in normal aging is characteristic of neurodegenerative dementia
- Referral for **neuropsychological testing** can help decipher etiology of diagnosis and determine functional limitations
- Screen for independence with activities of daily living by using tools, such as the Katz Index of Independence in Activities of Daily Living, or by referral to OT/PT/ST

Mini-Cog©

Instructions for Administration & Scoring

ID:_____Date:_____

Clock Drawing

ID:_____Date:_____

Step 1: Three-Word Registration

Look directly at person and say, ***"Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now."*** If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: ***"Next, I want you to draw a clock for me. First, Put in all of the numbers where they go." When that is completed, say, "Now set the hands to 10 past 11."***

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

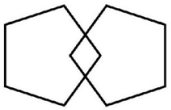
Ask the person to recall the three words you stated in Step 1. Say, ***"What were the three words I asked you to remember?"*** Record the word list version number and the person's answers below.

MINI MENTAL STATE EXAMINATION (MMSE)

Name:

DOB:

Hospital Number:

One point for each answer	DATE:		
ORIENTATION Year Season Month Date Time	...../ 5	...../ 5	...../ 5
Country Town District Hospital Ward/Floor	...../ 5	...../ 5	...../ 5
REGISTRATION Examiner names three objects (e.g. apple, table, penny) and asks the patient to repeat (1 point for each correct. THEN the patient learns the 3 names repeating until correct).	...../ 3	...../ 3	...../ 3
ATTENTION AND CALCULATION Subtract 7 from 100, then repeat from result. Continue five times: 100, 93, 86, 79, 65. (Alternative: spell "WORLD" backwards: DLROW).	...../ 5	...../ 5	...../ 5
RECALL Ask for the names of the three objects learned earlier.	...../ 3	...../ 3	...../ 3
LANGUAGE Name two objects (e.g. pen, watch).	...../ 2	...../ 2	...../ 2
Repeat "No ifs, ands, or buts".	...../ 1	...../ 1	...../ 1
Give a three-stage command. Score 1 for each stage. (e.g. "Place index finger of right hand on your nose and then on your left ear").	...../ 3	...../ 3	...../ 3
Ask the patient to read and obey a written command on a piece of paper. The written instruction is: "Close your eyes".	...../ 1	...../ 1	...../ 1
Ask the patient to write a sentence. Score 1 if it is sensible and has a subject and a verb.	...../ 1	...../ 1	...../ 1
COPYING: Ask the patient to copy a pair of intersecting pentagons 	...../ 1	...../ 1	...../ 1
TOTAL:	...../ 30	...../ 30	...../ 30

MMSE scoring
24-30: no cognitive impairment
18-23: mild cognitive impairment
0-17: severe cognitive impairment

OME Oxford Medical Education

FAST Scale:

Stage	Stage Name	Characteristic	Expected Untreated AD Duration (months)	Mental Age (years)	MMSE (score)
1	Normal Aging	No deficits whatsoever	--	Adult	29-30
2	Possible Mild Cognitive Impairment	Subjective functional deficit	--		28-29
3	Mild Cognitive Impairment	Objective functional deficit interferes with a person's most complex tasks	84	12+	24-28
4	Mild Dementia	IADLs become affected, such as bill paying, cooking, cleaning, traveling	24	8-12	19-20
5	Moderate Dementia	Needs help selecting proper attire	18	5-7	15
6a	Moderately Severe Dementia	Needs help putting on clothes	4.8	5	9
6b	Moderately Severe Dementia	Needs help bathing	4.8	4	8
6c	Moderately Severe Dementia	Needs help toileting	4.8	4	5
6d	Moderately Severe Dementia	Urinary incontinence	3.6	3-4	3
6e	Moderately Severe Dementia	Fecal incontinence	9.6	2-3	1
7a	Severe Dementia	Speaks 5-6 words during day	12	1.25	0
7b	Severe Dementia	Speaks only 1 word clearly	18	1	0
7c	Severe Dementia	Can no longer walk	12	1	0
7d	Severe Dementia	Can no longer sit up	12	0.5-0.8	0
7e	Severe Dementia	Can no longer smile	18	0.2-0.4	0
7f	Severe Dementia	Can no longer hold up head	12+	0-0.2	0

Treatment Approach in Dementia:

- Pharmacological:
  - Acetylcholinesterase inhibitors (donepezil, galantamine, rivastigmine) are indicated for all stages of Alzheimer's disease and in Parkinson's disease and can be used in Lewy Body Dementia
  - Memantine is approved for moderate to severe Alzheimer's disease
- Consider referral to neurology for assistance in work-up and management and if patient is interested in pursuing monoclonal antibody treatment (i.e. Lecanemab)
- Explore patient goals and determine surrogate decision-maker
- Consider palliative care
- Assess for caregiver burden
- Consider OT/PT/ST involvement

Tung EE, Walston V, Bartley M. Approach to the Older Adult With New Cognitive Symptoms. Mayo Clin Proc. 2020 Jun;95(6):1281-1292. doi: 10.1016/j.mayocp.2019.10.013. PMID: 32498781

Takeaways: Dementia vs. Delirium

- *Dementia begins gradually and progresses over time and involves significant cognitive decline from a previous level of performance in one or more cognitive domains and delirium begins suddenly and involves disturbances in attention and awareness and fluctuations over the course of the day*
- *The treatment for delirium is treatment of the cause of the delirium, whereas there is no definitive treatment for dementia*
- *Acetylcholinesterase inhibitors and memantine can be considered within the treatment approach for dementia management*

Late-Life Depression:

- It is not normal to be depressed in older age!
- Untreated Depression can:
  - lead to disability
  - worsen symptoms of other illnesses
  - lead to premature death
  - result in suicide
- According to the AAGP, the most common symptoms of late-life depression include:
  - persistent sadness (lasting two weeks or more)
  - feeling slowed down
  - excessive worries about finances and health problems
  - frequent tearfulness
  - feeling worthless or helpless
  - weight changes
  - pacing and fidgeting
  - difficulty sleeping
  - difficulty concentrating
  - physical symptoms such as pain or GI problems
  - withdrawal from regular social activities

https://aagponline.org/patient-article/depression-in-late-life-not-a-natural-part-of-aging/

Diagnosis of Late-Life Depression:

- Older adults can be screened for depression using instruments, such as PHQ-2, PHQ-9, Geriatric Depression Scale, or Cornell Scale for Depression in Dementia, and acute safety can be screened for with Columbia Suicide Severity Rating Scale

- Differential diagnosis may include bipolar depression (screening tools include Mood Disorder Questionnaire – MDQ and Composite International Diagnostic Interview – CIDI), bereavement or grief, sleep apnea, hypothyroidism)

Geriatric Depression Scale (Short Form)

Patient's Name: _____ Date: _____

Instructions: Choose the best answer for how you felt over the past week.

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / NO	
2.	Have you dropped many of your activities and interests?	YES / NO	
3.	Do you feel that your life is empty?	YES / NO	
4.	Do you often get bored?	YES / NO	
5.	Are you in good spirits most of the time?	YES / NO	
6.	Are you afraid that something bad is going to happen to you?	YES / NO	
7.	Do you feel happy most of the time?	YES / NO	
8.	Do you often feel helpless?	YES / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	YES / NO	
10.	Do you feel you have more problems with memory than most?	YES / NO	
11.	Do you think it is wonderful to be alive?	YES / NO	
12.	Do you feel pretty worthless the way you are now?	YES / NO	
13.	Do you feel full of energy?	YES / NO	
14.	Do you feel that your situation is hopeless?	YES / NO	
15.	Do you think that most people are better off than you are?	YES / NO	
		TOTAL	

Scoring:

Assign one point for each of these answers:

1. NO	4. YES	7. NO	10. YES	13. NO
2. YES	5. NO	8. YES	11. NO	14. YES
3. YES	6. YES	9. YES	12. YES	15. YES

A score of 0 to 5 is normal. A score above 5 suggests depression.

Source:

- Yesavage J.A., Brink T.L., Rose T.L. et al. Development and validation of a geriatric depression screening scale: a preliminary report. J. Psychiatr. Res. 1983; 17:37-49.

Treatment of Late-Life Depression:

- According to AAGP, when it is properly diagnosed and treated, more than 80% of those suffering from depression recover and return to normal lives

- **Psychotherapy:**
  - CBT and interpersonal therapy are first-line in mild depression
  - Psychodynamic and supportive therapy can also be effective
  - In moderate-severe depression, pharmacotherapy is recommended and the combination of psychotherapy + pharmacotherapy is most effective
- **Pharmacotherapy:**
  - SSRIs are first-line:
  - Sertraline has best evidence for tolerability and efficacy but there is good evidence for escitalopram and citalopram
  - Start low and go slow and treatment response can take up to 16 weeks
  - When SSRIs are contraindicated or poorly tolerated, other classes of antidepressants can be used, such as mirtazapine or SNRI like venlafaxine
  - Side effects from all antidepressants are more common in all older adults; SSRIs associated with falls and hyponatremia
- **ECT** – effective and well-tolerated in older people

Allan, C. L., & Ebmeier, K. P. (2013). Review of treatment for late-life depression. *Advances in Psychiatric Treatment*, *19*(4), 302–309. doi:10.1192/apt.bp.112.010835

Takeaways: Late-Life Depression

- *Late-life depression is common, underrecognized, and undertreated*
- *It is associated with high morbidity and mortality*
- *Psychotherapy, such as CBT and interpersonal therapy, is an efficacious option*
- *SSRIs are a good first-line strategy with particularly strong evidence for sertraline in terms of efficacy and tolerability*

Allan, C. L., & Ebmeier, K. P. (2013). Review of treatment for late-life depression. *Advances in Psychiatric Treatment*, *19*(4), 302–309. doi:10.1192/apt.bp.112.010835

LATE-LIFE ANXIETY DISORDERS

Which pair of anxiety disorders is most frequently seen among older adults?

A. Panic disorder and agoraphobia

B. Acute stress disorder and posttraumatic stress disorder

C. Phobias and generalized anxiety disorder

D. Somatization disorder and substance- induced anxiety disorder

E. Obsessive-compulsive disorder and anxiety disorder not otherwise specified

Which pair of anxiety disorders is most frequently seen among older adults?

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D. Somatization disorder and substance- induced anxiety disorder

E. Obsessive-compulsive disorder and anxiety disorder not otherwise specified

Lenze, E. J., & Wetherell, J. L. (2011). A lifespan view of anxiety disorders. *Dialogues in clinical neuroscience*, *13*(4), 381–399. https://doi.org/10.31887/DCNS.2011.13.4/elenze

Epidemiology

- Up to 15 % of community-dwelling older adults
- Up to 30% prevalence in medical settings
- Over 50% of older adults may report anxiety symptoms - often subsyndromal anxiety
- Just over ⅓ of older adults with anxiety disorders receive treatment
- Typically present in early life
- ~50% of GAD cases in older adults are diagnosed after age 50
- More common in women
- The highest racial prevalence: Non-hispanic white and Latinos

Wolitzky-Taylor, K. B., Castriotta, N., Lenze, E. J., Stanley, M. A., & Craske, M. G. (2010). Anxiety disorders in older adults: a comprehensive review. *Depression and anxiety*, *27*(2), 190–211. https://doi.org/10.1002/da.20653

Generalized Anxiety Disorder

- Excessive, multiple, uncontrollable worries
- 1.6-9% prevalence; comorbid GAD is x3 more prevalent than “pure GAD”
- Early onset GAD: more severe and impairing
- Late-onset GAD: related to medical comorbidities, worse QOL
- Most common treatment setting: primary care

Flint A. J. (2005). Generalised anxiety disorder in elderly patients : epidemiology, diagnosis and treatment options. *Drugs & aging*, *22*(2), 101–114. https://doi.org/10.2165/00002512-200522020-00002

Specific Phobias

What kind of anxieties do the elderly have?

Anxieties in the elderly can be very different from those experienced by people of other ages.

Fear of falling

Fear of memory loss

Fear of illnesses

Fear of break-ins or burglars

Fear of loneliness

Fear of being dependent

Fear of death

www.whiteswanfoundation.org

Fear of Falling

- 20.8-85% prevalence in community-dwelling older adults
- 20-39% overall prevalence vs 40-73% in older adults with the history of falls
- 30% of older adults fall each year
- 50% of older adults decrease or stop activities due to fear of falling
- Diagnostic consideration: agoraphobia vs specific phobia (fear of injury or ambulation)

MacKay S, et al. (2021). Fear of Falling in Older Adults: A Scoping Review of Recent Literature. Can Geriatr J, 24(4):379-394. doi: 10.5770/cgj.24.521. Öztürk, G.B., et al. (2021). Prevalence and Associates of Fear of Falling among Community-Dwelling Older Adults. The Journal of nutrition, health and aging, 25 (4), 433-439. https://doi.org/10.1007/s12603-020-1535-9.

Panic Disorder

- Repeated, unexpected panic attacks, ongoing worry about having more attacks, and avoidance of situations thought to trigger them
- Tend to peak within 10 minutes and end after 30 minutes
- Generally lower prevalence than early adulthood: 0.4%-2.8%
- Late-onset is rare
- F:M=2:1

Aggarwal R, Kunik M, Asghar-Ali A. (2017). Anxiety in Later Life. Focus, 15(2):157-161. doi: 10.1176/appi.focus.20160045.

Agoraphobia

- Epidemiological Catchment Area study: 1-month prevalence of < 1.4% in people over 65
- Study of 12,792 people over 55: prevalence = 0.61%
- Often no history of panic disorder
- Often is precipitated by physical illness or traumatic events
- Comorbid depression is often 2ry to functional impairment due to agoraphobia
- Causes moderately severe social dysfunction
- Underdiagnosed due to isolation / family acceptance

Ritchie, K., et al. (2013). Late-Onset Agoraphobia: General Population Incidence and Evidence for a Clinical Subtype. *American Journal of Psychiatry*, *170*(7), 790–798. https://doi.org/10.1176/appi.ajp.2013.12091235
McCabe, L., et al. (2006). Prevalence and correlates of agoraphobia in older adults. *The American journal of geriatric psychiatry*, *14*(6), 515–522. https://doi.org/10.1097/01.JGP.0000203177.54242.14

Comorbidities

- Depression - up to 25% of older adults with anxiety disorders
- Cognitive decline - may be a part of dementia prodrome; 20-40% of patients with dementia have anxiety symptoms
- Parkinson's disease: 20-35% comorbid with anxiety
- Stroke: up to 25% post-stroke or post-TIA
- Other physical conditions: COPD, cancer, heart disease, chronic pain, hyperthyroidism, hypercalcemia, hypoxia, temporal lobe lesion

Screening Tools

Specific to older adults:

- Geriatric Anxiety Scale
- Geriatric Anxiety Inventory
- Adult Manifest Anxiety Scale
- Rating Anxiety in Dementia (includes caregiver interview)
- CIDI65+ (Composite International Diagnostic Interview)- assesses for panic disorder, agoraphobia, GAD, social and specific phobias, OCD and PTSD

Developed for use in younger patients but validated in older adults:

- State Trait Anxiety Inventory
- Beck Anxiety Inventory
- Penn State Worry Questionnaire

Pharmacotherapy

- 1st line:
  - SSRIs and SNRIs
    - Increased risk for SE: hyponatremia, falls, GI bleed; hypertension (SNRIs)
- GAD:
  - buspirone
- Off label:
  - mirtazapine
  - gabapentin/pregabalin,
  - antipsychotics,
  - TCAs and MAOIs
- BZs: not recommended (taper to discontinue)

Psychotherapy

- ➔ Cognitive-Behavioral Therapy
- ➔ Mindfulness-based therapies
- ➔ Acceptance and Commitment Therapy
- ➔ Relaxation Therapy
- ➔ Combination CBT + Cognitive Rehabilitation Training
- ➔ Group therapies
  - PHP / IOP programs

Takeaways: Anxiety Disorders

- *Anxiety disorders are common but underdiagnosed, morse likely to be related to underlying health conditions, often comorbid with depression*
- *1st line pharmacologic treatment for anxety disorders is SSRIs & SNRIs; 1st line psychotherapy - CBT.*

SUBSTANCE USE DISORDERS (SUD) IN OLDER ADULTS

Which of the following is the most common factor complicating the diagnosis and treatment of SUDs in older adults?

A. Higher prevalence of illicit drug use
B. Greater likelihood of co-occurring medical conditions
C. Stronger social support networks
D. Reduced biological sensitivity to drugs and alcohol
E. Low rates of prescription medication use

Which of the following is the most common factor complicating the diagnosis and treatment of SUDs in older adults?

A. Higher prevalence of illicit drug use

B. Greater likelihood of co-occurring medical conditions

C. Stronger social support networks

D. Reduced biological sensitivity to drugs and alcohol

E. Low rates of prescription medication use

SAMHSA (Substance Abuse and Mental Health Services Administration). Older Adults and Substance Use.
Blazer, D. G., & Wu, L. T. (2009). The Epidemiology of Substance Use and Disorders Among Middle Aged and Elderly Community Adults: National Survey on Drug Use and Health.
Kuerbis, A., Sacco, P., Blazer, D., & Moore, A. A. (2014). Substance Abuse Among Older Adults

Epidemiology

- Drug use among older adults has been trending up: rate of SUDs in older adults more than doubled from 2007 to 2020
- Baby boomers (in 2024, current ages 60-78 y/o, or born 1946-1964)
- Increased propensity for drug abuse
- Demographic changes: older adults ~1 in 5 Americans by 2030 (73.1 million people)
- Results from the 2021 and 2022 National Surveys on Drug Use and Health (SAMHSA, 20241):
  - 12.4% used tobacco (1 in 8, M>F)
  - SUD: 9.1% older adults
    - AUD: 5.6% (4.4 million) [M:F=1.5]
    - DUD: 4.1% (3.2 million) (M~=F)
  - Binge alcohol use: 12.8% (M>F)
  - Heavy alcohol use: 3.2%
  - 9.9% used cannabis (>smoking, M>F)
  - 2.3% misused opioids

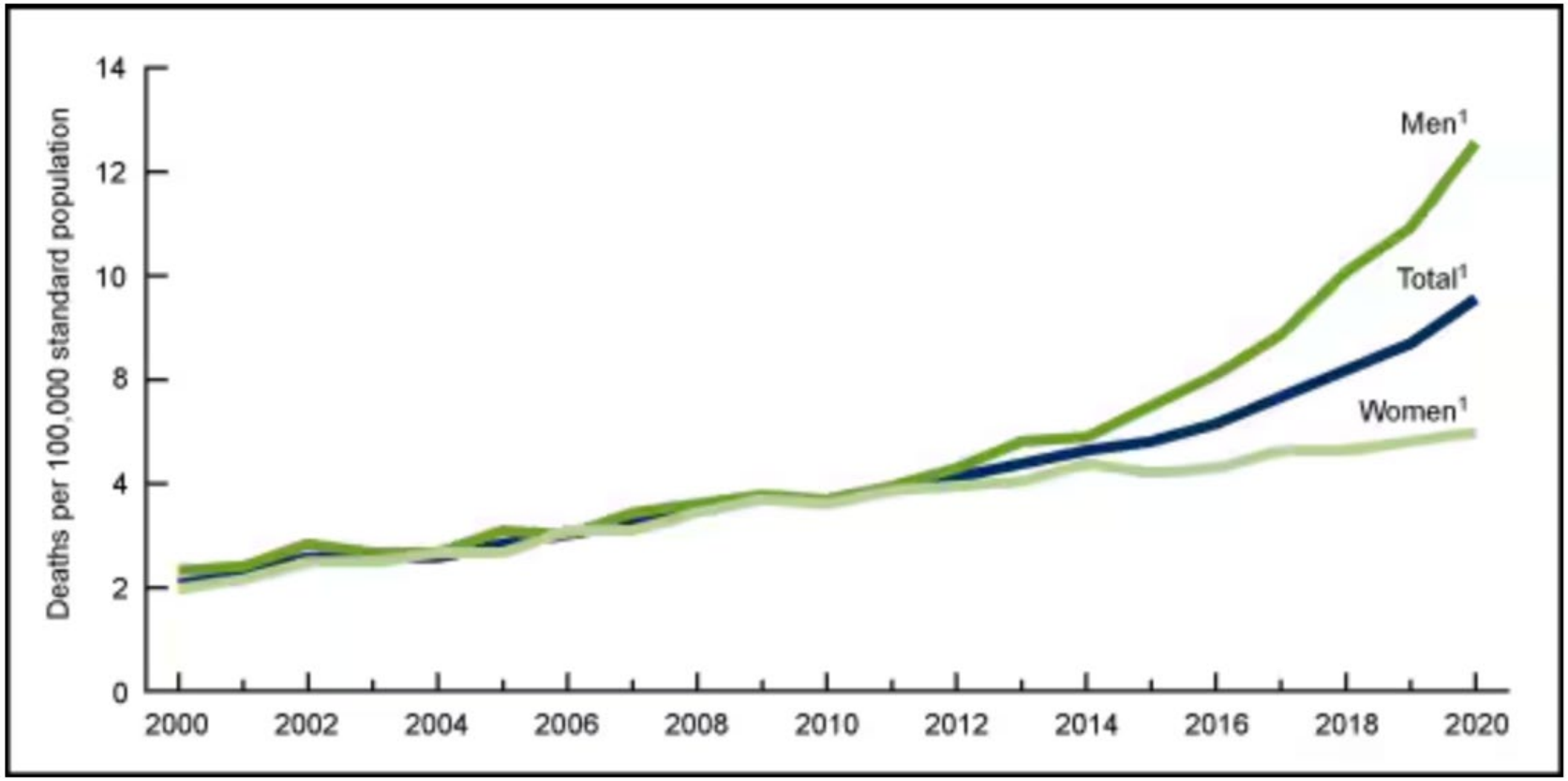
[1]https://www.samhsa.gov/data/sites/default/files/reports/rpt45341/2022-nsduh-older-adult-info.pdf
[1]doi:10.1001/

Epidemiology - Hospitalization & Disability

TEDS 2017: older adults 65+ admitted to substance abuse Tx	2007: 0.7% 2017: 1.3%
	Percent of Admissions of Older Adults
Alcohol (incl. alcohol use only and poly-substance use)	52%
Opiates	25%
Cocaine	5%
Sedatives	3%

Mortality due to SUDs

Age-adjusted drug overdose death rate for adults aged 65+ in the United States, 2000–2020



Special Considerations

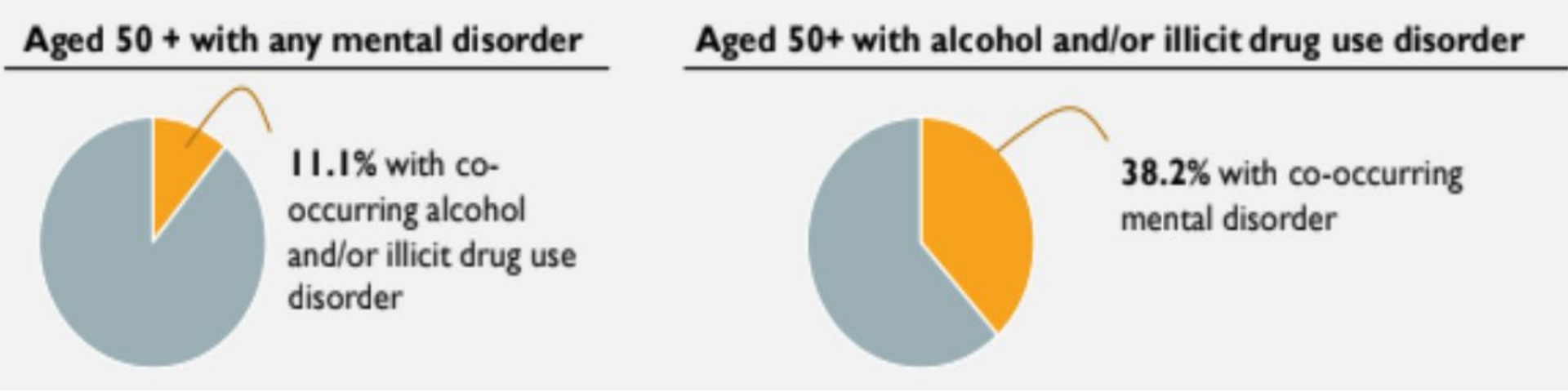
Physiological Changes	Substance Use-Associated Risks
↓ % of lean body mass	Mood & anxiety disorders (i.e., depression, anxiety, and PTSD)
↓ total body water	Sleep disruption & sleep disorders
↑ blood brain barrier permeability	Cognitive impairment
Slower drug metabolism	Hepatic complications
Slower drug excretion	Drug interactions with medications (i.e., slower metabolism)
Altered pharmacodynamics	Greater physical disability (liver disease, cardiomyopathy, falls)
Age-related changes in the brain (increased brain sensitivity)	More severe withdrawal

Age of Onset

Early onset	Late onset (>55 y/o)
~2/3	~1/3
Men > Women	Women > Men
Prior history of AUD	Escalating use is often in setting of major life changes (retirement, bereavement)
Psychiatric and medical co-morbidities are common	Appear psychologically & physically healthier
More resistant to treatment	More amenable to treatment

SUDs and Psychiatric Comorbidity

- Limited research
- High correlation between substance use and psychiatric comorbidity (MDD or other affective disorders, anxiety disorders, etc.)
- 2015-2018 National Survey of Drug Use and Health (data from community-dwelling adults):



Choi NG, DiNitto DM. Characteristics of Mental Health and Substance Use Service Facilities for Older Adults: Findings from U.S. National Surveys. Clin Gerontol. 2022 Mar-Apr;45(2):338-350. doi: 10.1080/07317115.2020.1862381. Epub 2020 Dec 27. PMID: 33357066; PMCID: PMC11143471.

Diagnostic Challenges: Signs of Possible SUDs

Domain	Signs
Psychiatric symptoms	Sleep disturbances, frequent mood swings, persistent irritability, anxiety, depression
Physical symptoms	Nausea, vomiting, poor coordination, tremors
Physical signs	Unexplained injuries, falls or bruises, evidence of self-neglect (e.g., poor hygiene)
Cognitive changes	Confusion and disorientation, memory impairment, daytime drowsiness, impaired reaction time
Social and behavioral changes	Withdrawal from usual social activities, family discord, premature requests for refills of prescription medications

Lehmann SW, Fingerhood M. (2018). Substance-use disorders in later life. *N Engl J Med,* 379(24):2351-2360. https://www.nejm.org/doi/full/10.1056/NEJMra1805981

Diagnostic Challenges: DSM-5-TR

DSM-5-TR Criterion	Application for Older Adult
Excessive time spent to obtain, use, or recover from subst.use	Same
Use continues despite persistent or recurrent social or interpersonal problems	Same
Recurrent use in physically hazardous situations	Same + older adult may be at ↑risk for impaired driving vs older adults with mobility limitations may be less exposed to hazardous situations
Continued use despite persistent or recurrent physical or psychological problem	Same; medical consequences can be serious, including confusion, falls with injury, and psychiatric Sx
Craving for the substance	Older adults with entrenched habits may not recognize cravings
Substance taken in greater amount than intended	Unchanged amount but worse impairment (esp. cognitive). Cognitive impairment can prevent adequate self-monitoring

Diagnostic Challenges: DSM-5-TR

DSM-5-TR Criterion	Application for Older Adult
Persistent desire or unsuccessful effort to cut down or control use	Older adult may not realize that use is problematic, especially if long-term use
Failure to fulfill major role obligations at work, school, or home	Role obligations may not exist because of life-stage transitions (older adult may be retired or may be living alone)
Important social, occupational, or recreational activities are stopped/↓	Effect of substance use on social roles is less obvious if older adult is no longer working. Ol adults may engage in fewer activities regardless of substance use
Tolerance (↓ effect with same dose/need to ↑dose)	Because of increased sensitivity to substances as they age, older adults will seem to have lowered rather than increase in tolerance. Symptomatic impairment may occur without the obvious need for increasing the amount.
Withdrawal syndrome occurs or substance is taken to prevent it	Withdrawals syndrome can occur with more subtle symptoms such as confusion. Late-onset substance users may not develop physiologic dependence.

Geriatric-Specific Screening Tools

Instruments	Characteristics	Clinical Usefulness
MAST-G (Michigan Alcoholism Screening-Geriatric), Short-MAST, Brief MAST	22-item yes/no self-report; questions specific to elderly; sensitivity 93%, specificity 65%.	1st line; designed to identify a population that drinks less than heavy drinkers
ARPS, shARPS (Alcohol-related problems survey vs. short version)	60 items vs 17; self-report; classifies patients as non hazardous, hazardous, or harmful drinkers; good sensitivity 92-93%, specificity 51-63% (less for short version).	Designed to comprehensively assess alcohol use and its potential health effects in older adults, taking into account age-related vulnerabilities. Shorter version is for a quicker assessment.
ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)	8 sets of questions, administered by a health professional; sensitivity ranges from 54–97% and its specificity ranges from 50–96%, depending on the substance	Useful in a variety of settings;helps identify the level of risk associated with each substance

Drew, S., et al., (2010), Current Psychiatry

Berks J, McCormick R. Screening for alcohol misuse in elderly primary care patients: a systematic literature review. 2008. In: Database of Abstracts of Reviews of Effects (DARE): Quality-assessed Reviews [Internet]. York (UK): Centre for Reviews and Dissemination (UK); 1995-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK75528

SUDs: Treatment Approach & Modalities

Tx Approaches
Non-confrontational
Focusing on (re)-building self-esteem
Teaching skills to cope with depression, lonelineless, loss, life stage transitions
Focusing on (re)-building social networks
Individually tailored content and pace
Hiring staff interested/experienced working with older adults
Providing linkages with medical services and community-based services

Tx Modalities
Cognitive-behavioral treatment
Motivational interviewing
Group-based treatment
Individual counseling
Medical/psychiatric treatment
Marital/family involvement/therapy
Case management
Community-linked services

SUD Tx: Benefits of Age-Specific Treatment Programs

- Changing social roles (less concern with employment, family formation)
- Unique challenges in social roles
  - > widowed, shrinkage of friendship networks, lack of means for increasing income, cognitive and physical decline
- Increased comfort in disclosing and discussing problems with same-age peers

Rothrauff, T. C., Abraham, A. J., Bride, B. E., & Roman, P. M. (2011). Substance abuse treatment for older adults in private centers. Substance abuse, 32(1), 7–15. https://doi.org/10.1080/08897077.2011.540463

SUD Tx: BRITE model

BRief Intervention and Treatment for Elders (BRITE)

Pilot program 2004-2007, modeled on SBIRT: Involved older adults who screened positive for needing brief SUD intervention.

Components:

- Education
- Motivational interviewing
- Age-appropriate information: coping mechanisms, prevention, recognizing high-risk situations.

Results:

- Lower SMAST-G scores
- Nearly 30% of participants had fewer flags for prescription misuse.
- Large decrease in depression and suicide risk scores.

Schonfeld L, Hazlett RW, Hedgecock DK, Duchene DM, Burns LV, Gum AM. Screening, Brief Intervention, and Referral to Treatment for Older Adults With Substance Misuse. Am J Public Health. 2015 Jan;105(1):205-211. doi: 10.2105/AJPH.2013.301859. PMID: 24832147; PMCID: PMC4265906

Takeaways: SUDs in Older Adults

- *Physiologic changes in aging predispose for increased risk of negative health outcomes due to substance misuse and abuse*
- *Older adults are often underdiagnosed and misdiagnosed*
- *Treatment programs specific for older adults may have better outcomes*

References:

1. Conroy, M. L., Meyen, R. A., Slade, M. D., Forester, B. P., Kirwin, P. D., & Wilkins, K. M. (2021). Predictors for Matriculation into Geriatric Psychiatry Fellowship: Data from a 2019-2020 National Survey of U.S. Program Directors. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 45(4), 435–439. https://doi.org/10.1007/s40596-021-01413-2
2. Juul, D., Colenda, C. C., Lyness, J. M., Dunn, L. B., Hargrave, R., & Faulkner, L. R. (2017). Subspecialty Training and Certification in Geriatric Psychiatry: A 25-Year Overview. The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry, 25(5), 445–453. https://doi.org/10.1016/j.jagp.2016.12.018
3. Adams, S. & Vanderhoef, D. (2021). The Critical Role of Primary Care Providers in Meeting Mental Health Needs in 2021. The Journal for Nurse Practitioners., 17(1), P3-4. https://www.npjournal.org/article/S1555-4155(20)30656-5/fulltext#:~:text=Therefore%2C%20PCPs%20are%20the%20first%20point%20of%20access,critical%20providers%20in%20meeting%20mental%20health%20treatment%20needs.

Additional Free Resources for Washington State Healthcare Providers

*No cost

EDUCATIONAL SERIES:

- AIMS Center office hours
- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO UW PACC
- UW TelePain series About TelePain (washington.edu)
- TeleBehavioral Health 101-201-301-401 Telehealth Training & Support - Harborview Behavioral Health Institute (uw.edu) | bhinstitute@uw.edu

PROVIDER CONSULTATION LINES

- UW Pain & Opioid Provider Consultation Hotline Consultation (washington.edu) – 844-520-PAIN 7246)
- Psychiatry Consultation Line - (877) 927-7924
- Partnership Access Line (PAL) (pediatric psychiatry) - (866) 599-7257
- PAL for Moms (perinatal psychiatry) - (877) 725-4666

Questions and Discussion

- Ask questions in the chat or unmute yourself