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Substance Use Disorders in Late Life: The Next Silver Tsunami

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Introduction

Over the next few decades the percentage of population of individuals 65 years and older in the United States is projected to increase from 13% to 25% of the total population [1]. These older adults are thought to be an at-risk population for psychoactive drug use [2]. Available evidence indicates that approximately one in four older adults has used a psychoactive medication with an abuse potential and it is postulated that by 2020 there will be approximately 2 million older adults with substance use disorders [3,4].

Epidemiology

It is estimated that between one-quarter to one-half of individuals ≥ 65 years in age currently drink alcohol [5]. One national survey found that approximately 13% of older men and 8% of older women reported at-risk use of alcohol [6]. A recent national survey indicates that 14.1% individuals who are ≥65 years in age use tobacco [7]. Another national survey showed that 0.7% of adults aged ≥65 years used marijuana and 0.04% used cocaine within the past year whereas the numbers of older adults using inhalants, hallucinogens, methamphetamine and heroin was <0.2% [8]. It is noted that 3.3% of women and 0.8% of men aged ≥65 years who live in the community meet the DSM-IV criteria for past-year benzodiazepine dependence [9]. There is emerging evidence for the increase in non-medical use of opioids among older adults with a current prevalence rate of approximately 1.4% [10].

Risk factors and Outcomes

Risk factors for substance use among older adults include a previous history of substance abuse, comorbid psychiatric illness and the presence of cognitive impairment [11]. The mitigating factors include being currently married and having a religious affiliation.

The presence of substance use disorders in older adults is associated with worse medical outcomes and greater economic burden for care [3]. Long term use of psychoactive substances results in central nervous system adverse effects, the development of physiological dependence and the development of withdrawal symptoms when these drugs are discontinued abruptly. It can also result in the development of medical disorders including cardiac, hepatic and renal disease at rates greater than what are identified in younger individuals [12]. In addition, these individuals have greater rates of psychiatric disorders including depression, rates of suicides and dementia [13]. The overall cost to healthcare from substance use disorders in the United States is estimated to be over $100 billion per year with the associated cost for the care of older adults with substance use disorders being significantly higher due to the greater rates of comorbidities among these individuals [14].

Assessment

Unfortunately, substance use disorders among older individuals are poorly diagnosed [14]. Common barriers to the under-diagnosis include insufficient knowledge of these disorders, denial of the condition, stigma and/or the shame of using substances with abuse potential. In addition, reluctance to seek professional help, a lack of financial resources, lack of social support, the presence of comorbid conditions, limited time spent with primary care physicians and ageist attitudes towards mental health issues among older adults contributes to the inaccurate diagnosis these disorders. Furthermore, commonly used diagnostic criteria like the DSM-IV text revision (TR), tend to underestimate the prevalence of substance use disorders among older adults [15].

Treatments

Although available data indicates that older adults respond to substance use treatments as well as younger adults there is a dearth of controlled data for the management of substance use disorders in older adults [16]. However, it is recommends that brief intervention strategies and motivational counseling should be the initial step in the treatment of older individuals with substance use disorders [14]. Specialized treatment programs are reserved for cases where less intensive stratégies do produce the desired benefit. These treatments modalities should be non-confrontational and supportive with strategies that address age-specific psychological, social and health concerns having a greater chance of success among these individuals [2]. Although acamprosate, buprenorphine, bupropion, disulfiram, methadone, naltrexone, nicotine and varencline are US Food and Drug Administration (FDA)-approved medications to treat substance use disorders in younger individuals there are no drugs that are currently approved for use in older adults with substance use disorders [17].

Future Plans

If we are to improve the care of older adults with substance use disorders then there is an urgent need to refine the current diagnostic criteria to include provision for making age-appropriate diagnoses of substance use disorders. Additionally, screening instruments that are specific to the assessment of different types of substance use disorders in older individuals, such as the SMAST-G and AUDIT-5 should be used more frequently in clinical practice [18]. Furthermore, new interventions or medication trials specific to older adults will enable the development of evidence-based management protocols to optimize the care of these individuals. Multicomponent management strategies that have shown success in the care of older at-risk alcohol users should be extended to the care of older adults who use other psychoactive substances [19]. Majority of older adults with substance use disorders are evaluated by primary physicians. Hence the assessment of these

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individuals should begin in the primary care physician's office [20]. In addition, these individuals should receive close follow-up with frequent telephone contact from the clinic staff to motivate them to reduce their use of substances [21]. Furthermore, studies that evaluate means to improve access to healthcare will motivate older adults with substance use disorders to see treatment who might otherwise not seek treatment due to various psychosocial issues [22].

Conclusions

The population of older adults in the United States is growing at an appreciable rate and this phenomenon has been dubbed the 'Silver Tsunami.' Associated with the growth of the aging population is the evidence for the significant growth of older adults who are using psychoactive substances. This substantial growth in the number of older adults who are using substances can be termed the 'Second Silver Tsunami.' Current evidence indicates that the care of these individuals is limited, with poor healthcare outcomes and staggering cost of care. If we need to improve the care of these individuals, there is a urgent need to refine current diagnostic criteria, initiate new treatment trials and provide greater access to care for these individuals. By adapting a proactive strategy for the care of older adults with substance use disorders, we may not to prevent the 'Second Silver Tsunami' but at least we can mitigate its aftermath.

References

1. http://www.aoa.acl.gov/Aging_Statistics/index.aspx
2. Wu LT, Blazer DG (2011) Illicit and nonmedical drug use among older adults: a review. J Aging Health 23: 481-504.
3. Simoni-Wastila L, Yang HK (2006) Psychoactive drug abuse in older adults. Am J Geriatr Pharmacother 4: 380-394.
4. Substance Abuse and Mental Health Services Administration (2005) The DASIS report: adults aged 65 or older in substance abuse treatment. Rockville, MD.
5. Caputo F, Vignoli T, Leggio L, Addolorato G, Zoli G, et al. (2012) Alcohol use disorders in the elderly: a brief overview from epidemiology to treatment options. Exp Gerontol 47: 411-416.
6. Blazer DG, Wu LT (2009) The epidemiology of at-risk and binge drinking among middle-aged and elderly community adults: National Survey on Drug Use and Health. Am J Psychiatry 166: 1162-1169.
7. Blazer DG, Wu LT (2012) Patterns of tobacco use and tobacco-related psychiatric morbidity and substance use among middle-aged and older adults in the United States. Aging Ment Health 16: 296-304.
8. Blazer DG, Wu LT (2009) The epidemiology of substance use and disorders among middle aged and elderly community adults: national survey on drug use and health. Am J Geriatr Psychiatry 17: 237-245.
9. Préville M, Boyer R, Grenier S, Dubé M, Voyer P, et al. (2008) The epidemiology of psychiatric disorders in Quebec's older adult population. Can J Psychiatry 53: 822-832.
10. Blazer DG, Wu LT (2009) Nonprescription use of pain relievers by middle-aged and elderly community-living adults: National Survey on Drug Use and Health. J Am Geriatr Soc 57: 1252-1257.
11. Voyer P, Préville M, Cohen D, Berbiche D, Béland SG (2010) The prevalence of benzodiazepine dependence among community-dwelling older adult users in Quebec according to typical and atypical criteria. Can J Aging 29: 205-13.
12. Reid MC, Anderson PA (1997) Geriatric substance use disorders. Med Clin North Am 81: 999-1016.
13. Saunders PA, Copeland JR, Dewey ME, Davidson IA, McWilliam C, et al. (1991) Heavy drinking as a risk factor for depression and dementia in elderly men. Findings from the Liverpool longitudinal community study. Br J Psychiatry 159: 213-216.
14. SAMHSA (1998) U.S. Department of Health and Human Services, Substance Abuse Among Older Adults, Treatment Improvement Protocol Series 26, DHHS Publication No. (SMA) 98-3179.
15. Patterson TL, Jeste DV (1999) The potential impact of the baby-boom generation on substance abuse among elderly persons. Psychiatr Serv 50: 1184-1188.
16. Blow FC, Walton MA, Chermack ST, Mudd SA, Brower KJ (2000) Older adult treatment outcome following elder-specific inpatient alcoholism treatment. J Subst Abuse Treat 19: 67-75.
17. Oslin DW, Pettinati H, Volpicelli JR (2002) Alcoholism treatment adherence: older age predicts better adherence and drinking outcomes. Am J Geriatr Psychiatry 10: 740-747.
18. Blow FC, Brockmann LM, Barry KL (2004) Role of alcohol in late-life suicide. Alcohol Clin Exp Res 28: 48S-56S.
19. Christensen H, Low LF, Anstey KJ (2006) Prevalence, risk factors and treatment for substance abuse in older adults. Curr Opin Psychiatry 19: 587-592.
20. Blow FC, Serras AM, Barry KL (2007) Late-life depression and alcoholism. Curr Psychiatry Rep 9: 14-19.
21. Lin JC, Karno MP, Tang L, Barry KL, Blow FC, et al. (2010) Do health educator telephone calls reduce at-risk drinking among older adults in primary care? J Gen Intern Med 25: 334-339.
22. Kuerbis A, Sacco P, Blazer DG, Moore AA (2014) Substance abuse among older adults. Clin Geriatr Med 30: 629-654.