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Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover

A Life in the Community for Everyone

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Older Americans Behavioral Health Technical Assistance Center

Funded by SAMHSA in collaboration with AoA

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Welcome

OLDER AMERICANS
Behavioral Health
Technical Assistance Center

Prescription Medication Misuse and Abuse Webinar

Welcome and Introductions

Co-Scientific Directors

Stephen Bartels, MD, MS

Frederic Blow, PhD

Older Americans Behavioral Health TAC Overview

- **Timeframe**
  - September 2011 – March 2013
- **10 Webinars**
- **14 Fact Sheets/Issue Briefs**
- **TCE Grantee Meeting**
  - January 9 - 10, 2012
- **Policy Academy Regional (PAR) Meetings**
  - Five meetings across the U.S. beginning in March 2012

Webinar Series Overview

- **For TCE Grantees**
  - Prescription Medication Misuse/Abuse – Today
  - Suicide Prevention – February 15, 2012
  - Alcohol Misuse/Abuse
  - Partnerships: Key to Success
  - Sustainability & Financing
- **For Aging Services Network**
  - Depression, Anxiety, Suicide Prevention
  - Prescription Med & Alcohol Misuse
  - Reaching & Engaging Older Adults
  - Sustainability & Financing
  - Family Caregiver as Clients & Partners in Care
- **All webinars will be archived and available on SAMHSA, AoA, and NCOA's websites**

Webinar Learning Objectives

- To understand why psychoactive medication misuse/abuse is a growing and significant problem among older adults
- To identify instruments that can be used for prescreening and screening older adults for medication misuse and abuse
- To apply the evidence-based program—Screening and Brief Intervention and Referral to Treatment (SBIRT)—to psychoactive medication misuse/abuse

Webinar Learning Objectives

- To briefly describe the FL BRITE program as an example of successful implementation of SBIRT for medication misuse/abuse among older adults
- To develop strategies to embed SBIRT screening into existing service delivery systems
- To discuss the role of the physician and pharmacist

Overview of the Problem

Stephen Bartels, MD, MS

Kathleen Cameron, RPh, MPH

The Demographic Imperative

- 13 percent of U.S. population age 65+; expected to increase up to 20 percent by 2030
- 78 million ‘Baby Boomers’ (born from 1946-1964) in “Census 2000”
  - Second wave ‘Baby Boomers’ (now aged 35-44) contains 45 million
- Individuals aged 85 and older are the fastest growing segment of the population.

www.census.gov

Substance Abuse and Older Adults

#1 Most common addiction:
Nicotine (~18-22%)

#2 Alcohol (~2-18%)

#3 Psychoactive Prescription Drugs (~2-4%)

#4 Other Illegal Drugs (marijuana, cocaine, narcotics) (<1%)

Polling Question

- **Approximately what percentage of older adults use psychoactive medications with abuse potential?**
  - **A. 10%**
  - **B. 25%**
  - **C. 50%**
  - **D. 75%**

Prevalence of Use and Misuse of Psychoactive Medications

- At least one in four older adults use psychoactive medications with abuse potential (Simoni-Wastila, Yang, 2006)
- 11% of women > 60 years old misuse prescription medication (Simoni-Wastila, Yang, 2006)
- 18-41% of older adults are affected by medication misuse (Office of Applied Studies, SAMHSA, 2004)

Growing Problem

- By 2020, non-medical use of psychoactive prescription drugs among adults aged >=50 years will increase from 1.2% (911,000) to 2.4% (2.7 million) (Colliver et al, 2006)
- In 2004, there were an estimated 115,803 emergency department (ED) visits involving medication misuse and abuse by adults aged 50 or older
- In 2008, there were 256,097 such visits, representing an increase of 121.1 percent (SAMHSA, DAWN Report, 2010)

Polling Question

- **What type of psychoactive medication is associated with the most emergency department visits related to prescription medication misuse among older adults?**
  - **A. Antidepressants**
  - **B. Sedatives/tranquilizers**
  - **C. Pain relievers**
  - **D. Stimulants**

Emergency Department (ED) Use Related to Misuse/Abuse

- One fifth of ED visits involving prescription medication misuse/abuse among older adults were made by persons aged 70 or older
- Medications involved in ED visits made by older adults:
  - Pain relievers (43.5%)
  - Medications for anxiety or insomnia (31.8%)
  - Antidepressants (8.6%)
- What happened after ED visit?
  - 52.3% were treated and released
  - 37.5% were admitted to the hospital

(SAMHSA, DAWN Report, 2010)

Adverse Drug Events (ADEs)

	Percentage/ Frequency	Source
Hospital admissions for ADEs	10% - 17%	Hayes, et al., 2007.
Preventable ADEs	42%	Gurwitz, et al., 2005
Preventable serious, life-threatening or fatal ADEs	61%	
Increased risk of ADE when taking 2 medications	13%	Goldberg, et al., 1996.
……when taking 5 medications	38%	
……when taking 7+ medications	82%	
ADEs resulting in death between 1976-1997	29%	Kelly, 2001.
Increased risk of falling when taking a psychotropic drug	71%	Le Couteur, et al., 2004.

What Are Medication Misuse, Abuse and Dependence?

Misuse by Patient

- Dose level more than prescribed
- Longer duration than prescribed
- Used for purposes other than prescribed
- Used in conjunction with other meds/alcohol
- Skipping/hoarding doses

Misuse by Practitioner

- Prescription for inappropriate indication
- Unnecessary high dose
- Failure to monitor/fully explain appropriate use

(Source: DSM IV)

What Are Medication Misuse, Abuse and Dependence?

Abuse by Patient

- Use resulting in declining physical/ social function
- Use in risky situations
- Continued use despite adverse social or personal consequences

Dependence

- Use resulting in tolerance or withdrawal symptoms
- Unsuccessful attempts to stop or control use
- Preoccupation with attaining or using the drug

(Source: DSM IV)

Polling Question

➔ **What are some key risk factors for medication misuse and abuse among older adults?**

Who is at greatest risk for medication misuse/abuse?

- Factors associated with prescription drug misuse/abuse in older adults
  - Female gender
  - Social isolation
  - History of a substance abuse
  - History of or mental health disorder – older adults with prescription drug dependence are more likely than younger adults to have a dual diagnosis
  - Medical exposure to prescription meds with abuse potential

(Source: Simoni-Wastila, Yang, 2006)

Prescription Drug Abuse in Older Adults

- Reduced ability to absorb & metabolize meds with age
- Increased chance of toxicity or adverse effects
- Med-related delirium or dementia wrongly labeled as Alzheimer's disease

“Symptoms” of Medication-Related Problems Due to Misuse/Abuse

- Confusion
- Depression
- Delirium
- Insomnia
- Parkinson’s-like symptoms
- Incontinence
- Weakness or lethargy
- Loss of appetite
- Falls
- Changes in speech

Signs of Drug Misuse/Abuse

- Loss of motivation
- Memory loss
- Family or marital discord
- New difficulty with activities of daily living (ADL)
- Difficulty sleeping
- Drug seeking behavior
- Doctor shopping

Identifying High Risk Older Adults

- Use of certain medications (e.g., warfarin, digoxin, diurectics, psychoactive meds, analgesics)
- 4 or more medications
- Certain chronic conditions (e.g., diabetes)
- Evidence of medication misuse
- Chronic alcohol use

Medications to Target in Substance Abuse Interventions

- **Central Nervous System (CNS) Depressants** – Antianxiety medications, tranquilizers, sedatives and hynotics
  - Benzodiazepines
  - Barbiturates
- **Opioids and Morphine Derivatives**—Narcotic analgesics/pain relievers
  - Codeine, hydrocodone, oxycodone, morphine, fentanyl, meperidine

Sedative Misuse/Abuse

- Self-medicate hurts, losses, affect changes
- Older patients prescribed more benzodiazepines than any other age group

- Behavioral pharmacological profile similar to benzodiazepines
  - Drug liking, good effects, monetary street value
- Recommended for short-term use, many taken long-term
- May cause hazardous confusion & falls

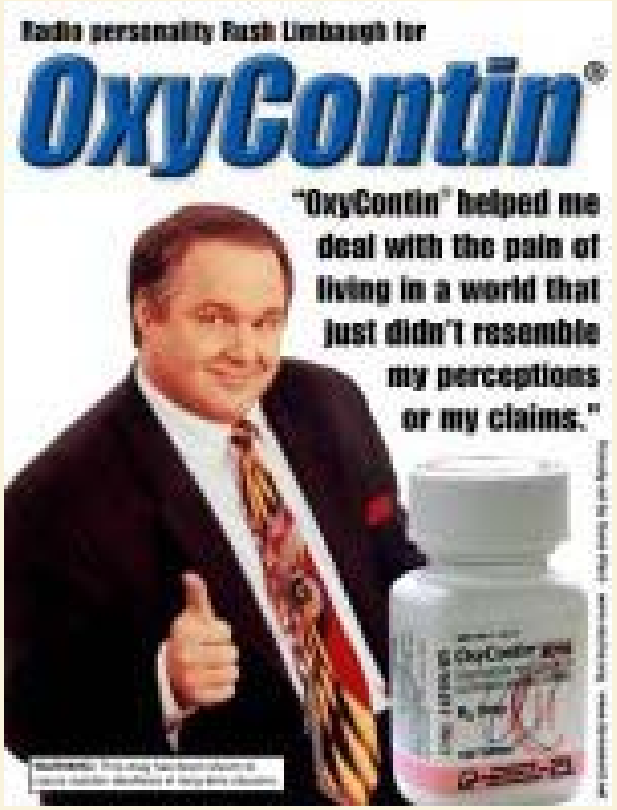
Prescribing and Use Patterns for Benzodiazepines

- Older primary care patients (aged >/= 60) who received new benzodiazepine prescriptions from primary care physicians for insomnia (42%) and anxiety (36%)
- After 2 months, 30% used benzodiazepines at least daily
- Both those continuing and those not continuing daily use reported significant improvements in sleep quality and depression, with no difference between groups in rates of improvement
- A significant minority developed a pattern of long-term use

(Source: Simon & Ludman, 2006)

Opioid Misuse/Abuse

- Use pain med to sleep, relax, soften negative affect
- Dose requirement reduced with age
  - Reduced GI absorption
  - Reduced liver metabolism
  - Change in receptor sensitivity
- Short-acting are the most easily & widely available
- Defeat extended-release mechanism
- Problems
  - Sedation, confusion
  - Respiratory depression



Opioid Analgesics

➔ **Potential Health Consequences/Intoxication Effects**

- Pain relief
- Euphoria
- Drowsiness, sedation
- Falls/fractures
- Nausea
- Constipation
- Confusion
- Respiratory depression and arrest
- Unconsciousness

Alcohol and Medication Misuse

An estimated one in five older adults may be affected by combined difficulties with alcohol and medication misuse.

Alcohol-medication interactions may be a factor in at least **25% of ED admissions** (NIAAA, 1995).

Medication and Alcohol Interactions

➔ Medications with significant alcohol interactions

- Benzodiazepines
- Other sedatives
- Opiate/Opioid Analgesics
- Some anticonvulsants
- Some psychotropics
- Some antidepressants
- Some barbiturates

(Source: Bucholz et al., 1995; NIAAA, 1998)

Alcohol-Medication Interactions

- Short term use - Increases the availability of medications causing an increase in harmful side effects
- Chronic use – Decreases the availability of medications causing a decease in effectiveness
- Enzymes activated by alcohol can transform medications into toxic metabolites and damage the liver, e.g., acetaminophen (Tylenol)
- **Magnify the central nervous system effects of psychoactive medications**

Screening for Psychoactive Medication Misuse/Abuse

Frederic Blow, PhD

Kristen Barry, PhD

CSAT SBIRT Initiative

- Designed for implementation in medical settings
- Major focus on “nondependent” substance use
- Emphasize simple screening followed by one session of brief advice/brief intervention, educational, motivational interviewing
- Refer to Treatment for “deep end’ services and other care, as needed
- Competitive 5 year grants awarded to states (Governor) – Cohorts in 2003, 2006, 2008

Evidence for SBIRT

Screening, Brief Interventions and Referral to Treatment (SBIRT)

Large body of research on screening and brief interventions for at-risk and problem alcohol use in:

- Primary Care: *Bien et al. 1993; Burke et al. 2003; Dunn et al. 2001; Whitlock et al. 2004*
- Emergency Care: *Havard, et al, 2008*
- Psychiatric Emergency Care: Barry, et al, 2006; Milner, et al, 2008

Florida BRITE Project:
BRief Intervention and Treatment for Elders

- ➔ Only SBIRT focused on older adults
- ➔ Based on state-funded pilot project (2004-07)
  - Schonfeld et al (2010) Am. Journal of Public Health
- ➔ CSAT grant to Florida
  - Five years: Oct. 2006-Sept. 2011
  - Provide large scale brief screening and for positive screens, brief advice/intervention session(s)

BRITE

- BRITE was offered in medical, aging, psychiatric, substance abuse services
- BRITE expanded from 4 sites (4 counties) to 21 sites in 15 counties
- Challenge: Prescription drug misuse

BRITE

- In the first two years, 6,205 people were screened by BRITE providers
  - Not all sites were “up and operating yet”
- Screening took place in:
  - Hospital emergency rooms
  - Urgent care centers & clinics
  - Primary care practices
  - Aging services
  - Senior housing
  - Private homes

Screening and Assessment

- Everyone who was eligible and consenting got a very brief prescreen (Patient Health Questionnaire -2 (PHQ2), 4 questions on alcohol and drugs)
- If positive, ASSIST administered
- If positive, GPRA items administered
- Begin Brief Intervention after assessment
- A small sample were selected for 6 month follow-up

Proportion of SBIRT Services in BRITE Project

70% - Screening and feedback only

27% - Brief Advice/Brief Intervention

2% - Brief Treatment

2% - Referral for specialty services

Demographics

- 54% Caucasian
- 27% African American
- 18% Hispanic
- 1% “other” racial and ethnic groups
- 63% women
- Average age = 71.5 years

Primary Substances Used

69.6% - Alcohol

18.9% - Prescription Drugs (not necessarily psychoactive meds)

7.3% - Illicit drugs

4.6% - Other

Alcohol & Drug Use by Age Group in prior 30 days

	55 - 65	66-75	76-85	>85
	Mean (n)	*Mean (n)*	*Mean (n)*	*Mean (n)*
# days alcohol	10.72 (687)	8.04 (451)	7.23 (304)	8.79 (151)
# days 5+ drinks (intoxicated)	5.66 (519)	3.50 (321)	2.91 (219)	1.74 (111)
# days 4 or fewer drinks but felt "high"	5.80 (512)	5.70 (322)	5.16 (222)	8.23 (115)
# days prescrip. or illegal drugs used	5.91 (685)	5.99 (450)	6.90 (308)	7.46 (151)

Depression is Frequently Identified with PHQ-2

S-GDS	Frequency	%
None to mild	215	13.8
Moderate	1178	75.7
Serious level	146	9.4
Missing	18	1.2
Total	1557	100.0

Barriers to Implementation of SBIRT for Older Adults

- ➔ Provider Issues
  - Knowledge
  - Comfort with screening, interventions
  - Clinical practice time crunch
  - Reimbursement (‘procedure-oriented system’)
- ➔ External Issues
  - State laws
- ➔ Patient Issues
  - Social stigma
  - Lack of internal and external resources

What We Know

- Screening and BIs are efficacious and effective
- There are proven methods to implement SBIRT in primary care, psychiatric emergency settings, medical emergency settings, and senior settings
- Older and younger adults benefit from non-judgmental, motivational interventions to change alcohol use/medication misuse
- Some settings are beginning to have billing codes for BI

Take Home Message

- Non-judgmental screening, brief interventions, and brief and formalized treatments work!!
- Our older patients and clients and their families can reap great benefits from the use of these programs and this model

Prescreening: Critical First Step

- Generally identifies at-risk or potentially harmful substance use
- SAMHSA Treatment Improvement Protocol #26 recommends universal prescreening/screening
  - Every person age 60+ should be screened for alcohol and psychoactive prescription drug misuse
  - Screen/rescreen: symptoms; major life changes
- Can be imbedded in agency's health screening questions

Prescreen (cont.)

Targets major classes of medications with most risk for misuse/abuse

- Opioid analgesics/pain relievers
- CNS depressants- benzodiazepines, barbiturates

Prescreen questions developed by the previous SAMHSA Older Americans TAC

- adapted from the NIDA ASSIST
- BRITE prescreen
- Other instruments (e.g. Drug Abuse Screening Test -DAST)

Prescreen Questions: Psychoactive Prescription Medications (similar prescreen for alcohol)

- **During the past 3 months, have you used any prescription medications for pain for problems like back pain, muscle pain, headaches, arthritis, fibromyalgia, etc.?** __Yes __No
- **If yes, what medication(s) for pain do you take?**

  _____
- **(For interviewer) Is this medication(s) on the targeted list of pain medications? ___Yes ____No** If Yes, this is a positive prescreen.
- **During the past 3 months, have you used any prescription medications to help you fall asleep or for anxiety or for your nerves or feeling agitated? __Yes __No** If Yes, this is a positive prescreen.

Definitions for Positive Prescreen

Alcohol misuse (age 60+):

As a preventive intervention strategy we are conservatively setting the drinking limit at a slightly higher level than recommended by the NIAAA. This study sets the limit to enter the study at:

- **10 drinks/week for women age 60+,** and
- **14 drinks/week for men age 60+**

- **Medication misuse**

  Use of/problems with psychoactive medications (e.g. benzodiazipines)

- **Combination: use of alcohol and psychoactive medications together**

Screening Questions

- **What prescription medication(s) do you take for pain?**

  Positive Screen = If this pain medication is on the targeted list and the client answered Yes to Question 23 about the use of alcohol, this is a positive screen for the combination of alcohol and a psychoactive medication. If this pain medication is on the targeted list, then continue with the following questions.

- **In the past 3 months, how often have you used the medication(s) you mentioned for pain for reasons and doses other than prescribed?**

  ___ Never (0)

  ___ Once or Twice (2)

  ___ Monthly (3)

  ___ Weekly (4)

  ___ Daily or Almost Daily (6)

Screening Questions

For any recent non-medical pain medication use (for reasons or doses other than prescribed), ask the following questions.

- **In the past 3 months, how often have you had a strong desire or urge to use the medication(s) you mentioned for pain?**

  ___ Never (0)

  ___ Once or Twice (2)

  ___ Monthly (3)

  ___ Weekly (4)

  ___ Daily or Almost Daily (6)

- **During the past 3 months, how often has the use of the medication(s) you mentioned for pain led to problems related health, social, legal, or financial issues?**

  ___ Never (0) ___ Once or Twice (4) ___ Monthly (5)

  ___ Weekly (6) ___ Daily or Almost Daily (7)

Screening Questions

- **During the past 3 months, how often have you failed to do what was normally expected of you because of your use of the medication(s) for pain/anxiety you mentioned?**

  ___ Never (0)

  ___ Once or Twice (5)

  ___ Monthly (6)

  ___ Weekly (7)

  ___ Daily or Almost Daily (8)

- **Has a friend of relative ever expressed concern about your use of the medication(s) for pain/anxiety you mentioned?**

  ___ No, Never (0)

  ___ Yes, but not in the past 3 months (3)

  ___ Yes, in the past 3 months (6)

Screening Questions

- **Have you ever tried and failed to control, cut down, or stop using the medication(s) for pain/anxiety you mentioned?**

  ___ No, Never (0)

  ___ Yes, but not in the past 3 months (3)

  ___ Yes, in the past 3 months (6)

Screening Score

- For pain medications and/or medications for anxiety, add up the scores received for questions
- Determines level of risk
- Clients in the Moderate and High Risk level should receive a structured workbook-driven Brief Intervention

Recommendations for Screening

- ➔ Ask direct questions
- ➔ Preface questions with link to medical/health conditions
- ➔ Imbed with other health screening questions (e.g. exercise, nutrition, medical conditions, smoking)
  - Examples: During registration, intake, assessment for services, wellness programs, yearly questionnaire
- ➔ Do not use ‘stigmatizing’ terms

Role of the Physician and Pharmacist

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Impact on Healthcare Providers

- Medication misuse causes adverse health consequences for patient
- Worsens prognosis of coexisting medical and/or psychiatric conditions
- Significant proportion of practice is dealing with consequences of unrecognized/untreated addiction
- Leads to practitioner frustration

Physician Detection of High Risk Individuals

- Medication history/observation
  - Excessive use of medications
  - Use of high risk medications
  - Medication errors
  - Information from family or caregivers can be very valuable
- Patient medication profile
- Brown bag program
- Computer assisted medication list review

Role of the Pharmacist

Why?

- Knowledgeable – Can provide information and education for older adults, caregivers and providers
- Accessible
- Can communicate with physicians about medication-related problems

➔Partners

- Community/retail pharmacist
- Geriatric or senior care pharmacist
- Schools of pharmacy

Where can you find a Senior Care Pharmacist?

- American Society of Consultant Pharmacists
  - www.ascp.com/find-senior-care-pharmacist
- Certified Geriatric Pharmacist
  - www.ccgp.org/consumer/locate.htm

Psychoactive Medication Misuse/Abuse

Questions and Answers

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