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Dear members of the Senate Special Committee on Aging, my name is William Maurice Redden, MD and I am an Assistant Professor of Geriatric Psychiatry at Saint Louis University School of Medicine. Thank you for allowing me to speak about the rising epidemic of illicit and licit substance abuse/misuse among older adults. This is of particular interest to me as both a clinician and researcher because of my interest in ways to improve cognitive function in late life. One way to do this is to address any potential risk factors that can be removed or modified, including substance use and misuse.

Historically, substance abuse has been considered a problem affecting younger adults that was thought to decrease as one ages. In my experience as a clinician, I have encountered patient abuse of both illicit and licit drugs more often. My colleagues have also made this observation and there has been increased evidence in the literature of this growing problem. There is growing concern about the harmful effects of the substances, and how to treat this unique patient population. The main illicit substances include marijuana, cocaine and heroin; however, an often overlooked problem of prescription, non-prescription and over-the-counter misuse of drugs is also on the rise.

The pattern of use can appear in “early-onset” and “late-onset” users. The former describes individuals with a long history of use that persist as they age, while the latter includes individuals who develop a new habit in late life. Some risks factors that lead to new or continued use in the elderly includes social isolation, financial difficulties, and poor support systems. In most instances, there may be mental health conditions that have not been properly diagnosed and/or treated.

When older adults use illicit substances, even in small amounts, the negative effects can be magnified. This is in part due to a decreased metabolism and comorbid medical conditions that slow the processing of the drugs. In addition, one third of elderly patients take, on average, 5 prescription medications. This increases the risk of drug interactions, which can complicate medical problems. This all leads to increased emergency department visits as well as prolonged hospital stays.

Cocaine and marijuana can greatly affect an individual’s health. The most dangerous consequences of using cocaine include increase risks of heart attack, stroke, and delirium. Marijuana use has been known to increase workload and demand on the heart as well as elevate blood pressure, and impair the immune system. The psychiatric manifestations include precipitating psychosis, leading to delirium and impairing both short-term and long-term memory.

I would like to focus more on the rise of opioid use, including both heroin and prescription opioids. One of the driving forces for this rise includes the increasing prevalence of chronic pain. Prescription opioid

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medications have been the most prevalent treatment option. When access to these medications is not available, older adults have resorted to using someone else's prescription, buying medications off the streets or straightforwardly using heroin. They have also been known to "doctor shop" in order to acquire more medications than actually needed. The overuse and misuse of opioids is of particular concern to geriatric psychiatrists such as myself because it can lead to suicide by self-poisoning. The same factors that lead to drug abuse; social isolation, financial difficulties and mental health illness, also are risk factors for suicide. And now with the increased distribution of prescription opioids, this vulnerable group has lethal means to carry out the intent.

We know that substance abuse/misuse in the elderly is on the rise. The next question is how do we screen and identify those individuals at risk. Most of the available screening tools have been designed for younger patients. Recently, the DSM-V has updated our diagnostic criterion, and we now use the term substance use disorder (SUD) in place of abuse and dependency. However relying solely on the diagnosis of this disorder may exclude older adults who may not meet the criterion based on factors related to aging. For example, older adults may not develop tolerance, which is a hallmark of SUD, due to age-associated physiologic changes the increase the effects of substances. Thus makes diagnosing SUD in the elderly difficult, especially when the clinician already has limited time and some the symptoms of substance use may present as common illness that occurs during late life. Also as with younger adults, older adults may have difficulty recognizing their own substance use as being problematic.

The first step in recognizing that elderly drug abuse as a problem is to consider it a possibility. As clinicians, we are often pressed for time, but there are screening tools, such as CAGE-AID, that are designed to help began the discussion. However once one choses to approach this sensitive issue, it should be done in a gentle and respectful manner. Questions should be asked in a nonjudgmental manner, to help destigmatize substance use and any possible accompanying mental health conditions.

Once elderly patients have been identified as having a substance use disorder, treatment interventions needed be tailored to meet the needs of this unique group. As such, medications that are typically used in younger patients may not be suitable for older adults. This may be in part due to possible comorbid conditions that the elderly may have or to possible drug-drug interactions that could make treatment risks outweigh the benefits. In addition, the evidence is still lacking about the efficacy and safety of these medications for the older population. There is still some debate on whether elderly patients should participate in inpatient-treatment programs geared specifically for the elderly population or

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should they be integrated with younger patients. In choosing the appropriate program, other factors should be considered, such as comorbid medical and psychiatric conditions that need to be addressed during treatment.

Another useful tool for clinicians that most other states have enacted is the use of prescription drug monitoring program (PDMP). These programs vary across settings, but the main purpose is to detect and reduce diversion, abuse and misuse of schedule II prescription medications, such as opioids. Hopefully in the future, all PDMPs will include other prescription medications that have high abuse potential such as benzodiazepines. PDMPs have shown to reduced over-prescription and doctor shopping by patients. They have also helped identify any suspected fraudulent prescribing or illegal activity related to the dispensing of controlled substances. However, one of the main concerns of such programs is a potential invasion of privacy. But information in PDMPs needs to be treated just as well, if not better, than any other medical record.

In conclusion, substance abuse in the elderly is a growing problem and includes illicit and licit substances. The identification of substance use is difficult, but first has to be acknowledged as real possibility. Then, an assessment that is respectful and non-stigmatizing can be approached. Clinicians should be mindful of the roles of comorbid medical and psychiatric conditions when diagnosing and treating elderly patients who exhibit symptoms of substance use. The over-prescribing of opioids for the treatment of chronic pain can contribute to this problem; however, having deterrents in place such as prescription drug monitoring programs and utilizing other methods to treat chronic pain can help clinicians combat this devastating problem.