Transcript: Older Adults: Substance Misuse Trends and Prevention Strategies

Presenter: Chuck Klevgaard, BSW and Stephanie Asteriades Pyle, PhD
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REBECCA BULLER: I want to welcome you as you enter the room. We're going to get started in just a minute or so.

Great. We're right at the top of the hour, and we will get started in just one minute. It looks like we've got the majority of folks here, and they're coming in fast and furiously. So hang on and I will start in just one minute.

All right, let's get started. Welcome, and good day. You have joined the session on Older Adults-- Substance Misuse Trends and Prevention Strategies with Chuck Klevgaard and Stephanie Asteriadis Pyle. The Great Lakes ATTC, MHTTC, and PTTC are funded by the Substance Abuse and Mental Health Services Administration, or SAMHSA and are funded under the following cooperative agreements.

The opinions expressed in this webinar are the views of the speakers and do not reflect the official position of the Department of Health and Human Services or SAMHSA. The PTTC believes that words matter, and we use affirming language in all our activities.

We have a few housekeeping items. First, if you have technical issues, you can use the chat function and reach out to Rebecca Buller or Jen Winslow, and we'll be happy to assist you. If you have questions for the speaker, if you could put those in the Q&A section, and we will help the presenters get those questions and address them.

At the end of the session, you will be automatically redirected to a short survey, and we would really appreciate it if you could fill it out. It takes about three minutes, and it helps us put together more trainings like this for you. Certificates of attendance will be sent out via email to all who attended the full session. And it can take up to two weeks to receive those certificates.

If you'd like to know more about what we're doing or information on upcoming events, please see our social media pages. And now, I'd like to introduce our presenters. Chuck Klevgaard is a nationally recognized expert in substance misuse prevention and public health and school-based health. Drawing on his experience in collective impact and prevention focused partnerships, he builds the capacity of states, tribes, schools, communities, and cities to use evidence-based substance misuse prevention and intervention strategies.

He specializes in behavioral health support, training, and technical issues and evidence-based alcohol, opioid, and substance misuse programs and policies. And Stephanie Pyle is Emeritus and Former Project Manager for the Center for the Application of Substance Abuse Technologies. Dr. Asteriadis Pyle established Nevada's first substance use disorder library and clearinghouse at the University of Nevada Reno campus, and during her tenure, served as the CO1, or PI, for 36 grants and contracts for substance use prevention for students at UNR and Truckee Meadows Community College and problem gambling prevention for aging populations in Nevada.

I'm going to turn things over to them. And thanks for being here once again.

CHUCK KLEVGAARD: All right. Thank you, Rebecca. Happy to be with you all today. I'm excited about the opportunity to work with my colleague, Stephanie. This has been an interesting journey to learn as well. I can share with you all that I am 62, so I am about to be in this population that we're going to talk about today.

Our objectives are going to be to look at some trends around misuse and some related consequences [AUDIO OUT] spend some time right in the middle looking at some factors that place older Americans, older adults, at risk. We're going to definitely spend some time in the latter part looking at some strategies that are shown to be effective with this population. And as always, we'll talk about how to get started, how to begin and develop some cross-sector collaborations. So give you some ideas about who to work with in this work yet, how you can begin to think about doing some focus with this population.

I want to start with a broader conversation real quickly about working at population-specific prevention. It has long been a goal and a principle of prevention to think about substance misuse by looking at issues around gender, race, ethnicity, orientation, age, and other factors. I think that for many of us around the country, there's still a greater emphasis on working with young populations. And I think that that's been part of our history as a country, part of history of coalition work, part of history of our funders, in some respects.

So I think that's starting to shift. I'm sharing with you that I think the good news is that people are starting to really recognize what that means to look at context. And that context could be cultural. It could be economic status. It could be age. It could be looking at a whole variety of factors about where people live, zip codes that they live in, a focus on social economic determinants and how those interact [AUDIO OUT] a whole bunch of reasons that I think are increasingly important to pay attention to thinking about population-specific prevention in the next decade as we move ahead.

I want to say a couple of other things about targeted prevention. We, again, know looking at very culturally specific and adaptations for populations also

have a lot of evidence for being more effective. So as you listen to this conversation today, think about the ways in which you're already doing work in your community and the ways in which you think about adapting that work for this population.

I want to set the stage a little bit about talking about what's happening just with demographics. We are increasingly becoming a more diverse country. And at the same time, we are starting to look more like Europe. And what I mean by that is that the proportion of our population that is in fact 65 to 84 and 85 and older has grown really rapidly since the 60s. Now, a couple of things contribute to that.

We certainly have a greater life expectancy, and we have bigger generations that are now hitting that Baby Boom generation and the ones that follow are larger generations that are moving into that age group. So know that this is a significant issue that I think will impact us in the years ahead in the way that we do prevention work and provide human services. Just a couple of things to note there on that slide-- you're seeing a little blue bar on the very top, those 85 and older, those adults meaning those that most often need significant kinds of personal care and help are going to double or in some cases in some parts of the country that age group will quadruple.

So we know that just in a very short 20-year period from now, our community is going to look different. And the way in which we prioritize human services and prevention programming is going to have to look different. So we think now is the time to learn about how to do that. This next graph is another sort of swat at this by looking at proportionality.

So just, again, looking at just recent years, you can see that by 2040, one in five Americans will be 65 or older. And that's, again, a very significant shift. I think it has implications politically and economically for our country in the way that we think about younger people are more likely to be engaged in working. Folks in that age group are more likely to be retired or not working.

So we have issues with economic stability in communities that are going to have to be thought through in the years ahead. We know that, again, folks are having fewer children. So younger generations aren't necessarily going to rebuild this population in the same way. So we think looking at the issue of that growing population, what it means for where you live, and proportionality in terms of the proportion of folks who are going to live, work in our communities is also going to shift.

So I want to do a quick poll that will set the stage for us to start this conversation with you all today to learn a little bit about how much knowledge and experience do you have with prevention focused specifically on older adults? So take a moment and participate in this poll with us. I'll give you a few moments to fill this out while we talk about this.

Again, I know historically, some parts of the Midwest here have been focused so heavily on underage drinking, for example, that not only do we focus on one population, we may have focused on a single substance use issue around risky alcohol use or binge drinking. So the idea of focusing on another population with really complicated kinds of issues that are way more complex than just one particular age group and one particular drug are really key. So thank you for sharing the results.

It looks like a lot of you have some experience, which is exciting. Again, that's encouraging for me, knowing that what's ahead for those of us who have 10 or 20 years more to work in the field, we have significant shifts in our very near future in the way that we do this work. So some of you have some knowledge. A lot of you have a little. And a only a handful of you have none.

So I'm super encouraged. So thank you for sharing those results with us. And we'll go ahead and move forward.

In this next piece, we're going to, again, engage you a little differently. We can close out the poll. I'm going to turn this over to my colleague, Steph, who's going to share a little bit more with you about engaging with you about what you think about when you begin to think about the issues with prevention and older adults. So, Steph, over to you.

STEPHANIE ASTERIADIS PYLE: Thank you, Chuck. And thank you so much for inviting me. I'm honored to be here. And I'm so pleased to see so many people wanting to learn more about this really important population in our country. Right now, I'd like to key-in on some of the ideas and pictures that we have in our minds when we think of older adults. After all, as the Baby Boomer generation moves into retirement age, it's expected that by the year 2034, older adults ages 65 and up will outnumber children in the US for the first time in history.

And as the population ages, the demand for health care will increase. Rising rates of alcohol use in adults, older adults, may create additional challenges to an already burdened health care system. So if you will, type in the chat box what images instantly appear in your minds when the term older adults is mentioned. You might also write about how you would describe an older adult or older adults as a group.

REBECCA BULLER: We're seeing responses that say that I think of life experiences as well as generational differences in knowledge and experience. Someone seeing their mom who's getting older and she's becoming more vulnerable. And she's a cancer survivor, and so she's worried about her stability and her future.

Some people are seeing them as keeping busy and active. Catherine said, I just looked in the mirror. Lived long life with wisdom and growing through societal changes. Lots of wisdom and experience. Independent.

Some embrace technology, some are resistant to change. Again, lots and lots of experience and history. Walkers.

STEPHANIE ASTERIADIS PYLE: I like the fact that there's a lot of response about experience, and wisdom, and independence. And sometimes, I think that's typical of the people who attend a webinar like this. They do have a more open mind about older adults and may not have the same generalizations, misconceptions, or myths that people who do not work in a helping field do.

So that's very encouraging. And I think that speaks well to all of you in the audience right now. So let's consider the fact that substance misuse is currently being overlooked and undertreated. And if you think this is related to our generalizations and assumptions about older adults, you may be right.

But bear in mind, not all of us, as you just proved, not all of us are misinformed or make generalizations. Of course not. But enough providers or professionals from all fields and the general public have some false beliefs, which can cause them to overlook this very important population as people who potentially might misuse substances. So they may fail to even ask the questions or to screen them for use.

So now, let's move on to some of the trends the data are showing in substance use among older adults. And this is just a list of what we're going to be looking at as far as trends today-- alcohol use, cannabis use, illicit drug use, overdose, any developing disorders, and mental health. So first, let's take a look at adult use in the past year.

Here, you can see some of the most commonly available data for adults age 50 to 80. Two in three adults age 50 to 80, or 67%, reported drinking alcohol at least occasionally in the last year. Among those who drink, 42% drank monthly or less often. So it's a little bit less than half.

On a typical day of drinking, the majority consumed one or two drinks. That is a pretty healthy norm. 17% had three or four drinks, and 6% had five or more drinks, putting them into binge drinking category. Among older adults who reported drinking any alcohol in the past year, the most commonly reported reasons for drinking including just liking the taste, about half of them, to be social, about another half, to relax, or it's just part of their routine. Other reasons, about 10% was to cope with stress, to help with mood, out of boredom, or to help with pain.

We know that men are more likely than women to report any drinking in the past year. And men are also likely to report a higher daily quantity of consumption. Now, according to guidelines, they're allowed to drink a little bit more, but that doesn't really account to one in five men having three to four drinks of alcohol on a typical day of drinking.

Use of alcohol with other drugs, about 1 in 10 adults age 50 to 80, or 10%, who drank alcohol in the past year said they drank while using other drugs, including marijuana, prescription drugs, tranquilizers, prescription sleeping pills, prescription pain pills, and illicit drugs. Alcohol-related blackouts were more common among those who consumed alcohol while using other drugs--about 20% of those. So what are the implications for this about alcohol, these data about alcohol?

I think it's important to know that alcohol use is actually trending upward over the years, and alcohol use among women is particularly trending up. As an aside, years ago, alcohol and drug use by adolescent girls was far less than adolescent boys. I just dated myself. And then, it began to rise to become more or less equal to that of adolescent boys. And the protective factor of gender for girls went away.

So this same type of trend may be being mirrored in older women compared to older men, with more older women drinking. One epidemiological survey determined that in the US, between 2001 and 2013 among people 65 and older, the rate of alcohol use disorder increased about 107%. So we are seeing, in particular, about 20% of the respondents that drank alcohol four or more times a week. 27% reported having six or more drinks on at least one occasion in the last year.

So risky drinking and binge drinking among older adults has increased in the past decade. And there's actually a binge drinking boom among older people. And that's not a good thing because although it's important to note that enjoying a glass of wine once in a while can be healthy for your heart and gut, drinking too much, as we all know, can put you at higher risk of serious health conditions.

And among those are certain types of cancer, stroke, heart and liver disease, brain damage. In older people, drinking unhealthy levels of alcohol can be even more damaging to health and may cause memory loss, increased blood pressure and balance problems, and worsened mental health. But while we might assume that alcohol is only damaging those who regularly drink above the recommended limits, just remember that any amount of alcohol does have an impact on the consumer.

So moving to the use of cannabis. What we know about the prevalence of cannabis use among older adults age 65 and older is that it's being used for both recreational and medical purposes. Information regarding the safety in this population is an important factor because aging is associated with metabolic changes, multiple morbidities, increases in prescription medication, and an overall decline in functioning.

And so it's important to understand that even though we may have increase in adverse effects because of cannabis, we don't really know a lot about the role

of cannabis in this population because it's mostly studied in younger populations. So we really do need more research into the effects of cannabis on older populations. We also know that older adults with psychiatric disorders are increasingly using cannabis, largely prescribed medical marijuana and CBD, cannabidiol.

And this trend is possibly been driven by the fact that we have reduced stigma. We know we have lifted restrictions in sale and possession. And a lot of articles, ads, we're exposed to a lot of media that says how safe it is. But the reality is we really don't have the research to show the safety. And we need more research.

So some of the information that we need to focus on here is what can we do about it? And those will be covered in strategies later on in this presentation. So looking at trends in past cannabis use, nationally, subgroups in a 2020 study were seen to have experienced marked increases in cannabis use.

I think one of the subgroups would be women. And I think this is something that we're seeing a lot in people with higher family incomes and those with mental health problems to self-treat. The researchers in this particular study also saw an increase in cannabis use among adults who used alcohol. And the risk associated with co-risk they found was higher than the risk of using either one alone. So it multiplies the risk.

And again, we need future research, as the authors stated. And it's also possible that the study had some limitations because older adults may not have had accurate recall of their actual usage. So what are the implications of these data? Marijuana use is now more common among baby boomers than it is for those age 12 to 17.

The latest release of federal drug use strategy survey recently shows monthly marijuana use has skyrocketed among older Americans. The past decade has seen a change in demographics of marijuana use. As recently as the 2000s, teens were more than four times likely to use marijuana than 50 and 60-somethings. But as of 2017, Americans ages 55 to 64 are now slightly more likely to smoke pot on a monthly basis than teens 12 to 17.

So the oldest age group, seniors age 65 and older, has seen steep increases in marijuana use, although 18 to 26 and older are still among the highest age groups. So there's beginning to be a lot of debate about marijuana use because we've tended to focus on younger populations. And now, it may be time that we shift our focus and look at what's happening to Baby Boomers entering their golden years.

You have to remember that Baby Boomers were big supporters and users of pot in their early years in the '60s and '70s, and even mind altering drugs so. That wouldn't be unfamiliar or stigmatizing to them. And so when they do run

into difficulties, such as pain management and mental health issues, they may revert back to what they knew. So much for cannabis.

Now, let's move on to take a look at some illicit drug use in adults, older adults. So as you can see on the slide, illicit drug use among ages 50 or older is projected to increase from 2.2% to 3.1%. And these data are between 2001 and 2020. Well, we're already to 2022, and I looked and checked and we're actually expected-- the expectation was that substance use disorder among older Americans was expected to rise from 2.8 million, as it was in 2002 to 2006, to 5.7 million by 2020.

And I did double check, and it did. And that's double. So the emergence of substance use disorder as a public health concern is warranted. The relatively higher drug use rates of Baby Boomers compared to previous generations and this cohort may experience some negative consequences. And those consequences may be physical. They may be mental health issues. They may be social and family problems.

They may even get involved with criminal justice system, which a lot of people may not consider even as an option for grandma and grandpa. And they may even die from drug overdose. Older adults are more likely than any other age groups to have chronic health conditions and to take prescription medications. And that really complicates the adverse effects of substance use.

So moving on to look at a few specific substances. Looking at opioids, benzodiazepines, and suicide, older adults in one NIDA notes about drug use and its consequences among middle aged or older adults found there are older adults who misused either prescription opioids or benzodiazepines had an increased risk of suicidal thoughts compared with those who use the drugs appropriately. But the difference wasn't statistically significant.

So I'm wondering why they even reported it. However, older adults who misused both opioids and benzodiazepines had a significantly higher risk of suicidal thoughts than those who reported no misuse. Now, you might be asking, are they getting help with that? And that's a really good question.

Now, the horizontal bar chart in front of you shows the percentage of patients 50 or older who reported suicidal thoughts. You can see 25.4% for both opioid and benzodiazepine misuse. So what are the implications of these data among our older adults in the US?

When we look at trends in overdose, moving to the next slide, although we know that the opioid overdose deaths are increasing for older adults, we a little bit less about these deaths compared to those of younger adults. There are disparities by sex, race, ethnicity, and death rates due to opioid overdose among adults age 55 or older. So this particular cross-sectional study that you're looking at found rates for adults 55 and older increased substantially between 1999 and 2019.

We're talking about a huge increase. And the most significant part of this was that the burden of the increase was experienced differentially by sex, and race, and ethnicity. In recent years, risk was most concentrated among non-Hispanic Black men. And beginning in 2013, the rate of opioid overdose deaths for non-Hispanic Black men were substantially higher than overall rates for persons 55 years and older and the rates for other subgroups that were examined in the study.

So we're beginning to see that certain populations are experiencing increased trends in overdose deaths. Some of the factors that might be associated with this data among older adults would be an increased number of chronic conditions, polypharmacy, or using many different medications, greater risks of falls and fractures. We know less about the factors that are associated with opioid overdose deaths among older adults because sometimes those things aren't reported in a way that's meaningful.

If use of opioids results in a fall for instance, what is the cause of death reported? And it isn't always uniform state-by-state or community-by-community. So we really can't trust that the data are representing opioid overdose deaths. And we also can't trust that a fall is really just a fall.

REBECCA BULLER: Stephanie?

STEPHANIE ASTERIADIS PYLE: Yes.

REBECCA BULLER: I'm wondering, we have a couple of questions that fit in with some of the things that you just said. And I'm wondering, when would you like to take those, now? Or would you like to wait and let me know?

STEPHANIE ASTERIADIS PYLE: Well, we might cover some of them when we get to the strategies.

REBECCA BULLER: Some of them are about data.

STEPHANIE ASTERIADIS PYLE: OK.

REBECCA BULLER: The first one is, and I think you just touched on this, what data can we find at more local or regional levels in regard to our older adults?

STEPHANIE ASTERIADIS PYLE: I'm most familiar with where we go in the state of Nevada. And we would look at the medical examiner rates. And Nevada is in the process of trying to clarify what the medical examiners are reporting, causes of death, so that those really important facts can be teased out. And I'm not really sure what other states are doing, but I can say this is a really good thing for those of you who are in your individual states to look into.

Who provides the data, and what exactly are they providing? Chuck, do you have anything to add about those?

CHUCK KLEVGAARD: We're going to give you some suggestions towards the end about organizations that are holders of the data and also holders of the work that's likely being planned or being done already. So we'll talk about different kinds of more 21st century partnerships to think about and different kinds of groups at state and local levels that likely have some data.

We were, again, encouraged by how much data we found, but also discouraged by how often some of these federal data sources don't do specialized reports for this population. They're just not used to doing that. So they do it every five years instead of every year.

So some of this data, as we agree with you, is feeling like it's already two or three years old. Some of the bigger organizations at the federal level haven't recognized this conversation.

STEPHANIE ASTERIADIS PYLE: Someone just mentioned in the chat that their state was working with emergency room data. But this isn't the same as what the medical examiners reports. And hopefully, the medical examiners are taking into account what happens in the ER, but we don't know the process sometimes. And I guess the important thing would be to clarify that where you have the power in your own state.

REBECCA BULLER: All right. Well, if you'd like, I'll hold the other questions until we get a little further in.

STEPHANIE ASTERIADIS PYLE: OK. Well, moving to what we do know, we know that substance use disorders among older persons are among the fastest growing health problems in the US. And despite this, elderly remain underestimated, underidentified, underdiagnosed, and undertreated, pretty much just like everybody else.

And older individuals are using illicit drugs and meeting criteria for substance use disorders at higher rates than previous geriatric cohorts. And this results in negative impacts on their medical and psychiatric conditions if they have them. And many of them do.

Just to look at older and more vulnerable-- I guess we can see by this slide that there's robust evidence showing increased number of older adults will need substance use disorder care in the coming decades. And the previous slide showed data with older adults with a substance use disorder had doubled by 2020. And there will be increased demands on the treatment system.

So we will need expansion of treatment facilities and development of effective service programs. And I look back at we've just gone through several years of

COVID, and one good thing that happened there was the increased use of telehealth, and the acceptability, and the fact that it's reimbursable now. And so we do have more ways for people, but that can't fill the entire gap between treatment needed and treatment provided. So there are a lot of things to think about with this situation.

Another aspect is substance use disorders in older adults, they may be a continuation of use that began in younger years. But for some, especially those that begin using during a transition or a losses, such as health declines or loss members of the social group, loss of mobility, loss of independence, chronic pain, those things, they may become new users of substances. And we would call that late-onset as opposed to early-onset.

Older adults are more likely to have other conditions or situations that impact their use. They do have more adverse effects from psychoactive medications. They may use sedatives or benzodiazepines more. And that has been associated with risk of falls in older populations. And when you combine alcohol and prescription medications, the effects are even more detrimental.

In fact, a national Medicare study of Medicare beneficiaries, heavy drinking more than doubled the risk for hip fractures. And all of those lead to costly hospital admissions and lengthy stays. I mentioned earlier, we were talking about early-onset and late-onset.

We didn't discuss problem gambling among trends, but gambling in older women as a perfect example of late-onset because late in life when women are left bereft with a shrinking social group, they often turn to either alcohol or, amazingly, gambling. And part of it is the excitement of it, and part of it is the social aspect. But we are seeing a lot of older women, just as an aside, who become problem gamblers at a later age.

Moving to co-occurrence. As you can see, dual diagnosis, for obvious reasons, is going to be a growing problem among older adults. One in 10 primary care patients with depression, anxiety disorder, or at-risk alcohol use experiences suicidal ideation. One study in the American Journal of Geriatric Psychiatry found the prevalence of older adults with comorbid substance abuse and mental disorders varies by population, but ranges from 7% to 38% of those with psychiatric illness, and from 21% to 66% of those with substance use disorder.

Depression and alcohol use are the most commonly cited co-occurring disorders in older adults. And dual diagnosis in older adults is associated with increased suicidality and greater inpatient and outpatient service utilization. As usual, data on treatment are limited, but there are recommendations that have been adapted from evidence-based treatment of younger adults.

Not sure how appropriate that is, but it's what we have-- older adults with substance use and older adults with mental health problems. So there's that.

So dual diagnosis among older adults is a concern, and we need well-designed prevention, early intervention, and treatment studies that really specifically identify co-occurring disorders in older adult populations because it's the database that we are missing.

Speaking specifically to problem gambling in older adults, it's very common for older adults who receive treatment for substance misuse to suddenly develop a different problem such as problem gambling. And it's not uncommon to switch from the treatment substance or behavior to a different, and often not previously tried, substance or behavior. And one more important thing to note is that certain medications, such as some medications for restless legs syndrome which happens to be very common among older adults and commonly treated with medication, those medications may have side effects that initiate either compulsive gambling or compulsive shopping.

Now, a well-informed provider is going to be on the lookout for and ask specific questions during the initial adjustment to the medication for restless leg syndrome. But it's also good for friends and family to be on the alert for those signs, too. Moving on to a little bit more about older adults and suicide.

On this slide, we see some of the important data concerning older adults and suicide. And the risk and protective factors are an important approach to preventing suicide because suicide prevention efforts seek to reduce the risks for suicide and strengthen the factors that protect individuals from suicide. A few examples of the risk factors may be depression and other mental health problems, including problem gambling.

And treatment is paramount. Substance use problems, including prescription medication, again, treatment and ongoing maintenance support is paramount. For physical illness, disability, and pain, which comprise another set of risk factors, yes, treatment for all of these is important. But many chronic illnesses or conditions among older people are brought on or exacerbated by physical inactivity, by lack of healthy, nutritious food.

Treatment by primary care is very important, as is healthy eating and exercise. So you need all of them. And what I'm saying is that a lot of the chronic issues that adults have can be solved before they happen with activity, with diet and exercise, and regular checkups. That's not to say that they don't occur anyway.

Social isolation is another risk factor among older adults. Locating programs for social isolation actually is pretty easy, but getting an older adult to attend may be pretty difficult. If they have physical limitations, or shyness, or it's something unfamiliar, or sometimes, it's just they don't want to. And some strategies that Chuck's going to talk about later can help with how you might approach those.

Protective factors are mentioned briefly here and covered in more detail later-- care for mental health and physical problems, social connectedness needs to be maintained and built, especially among older adults, and developing and teaching skills in coping and adapting to change. This may consist of new learning skills or new ways of doing things.

So there are strategies that can be used. As you can see, these issues may appear to be simple when we started, but I'm now going to turn the floor over to Chuck for a poll and to expand on the complexity of the issue.

CHUCK KLEVGAARD: All right. We'll talk about interactions in just a second. Want to take another moment to engage you all in terms of thinking about factors. We've spent a lot of time in the last hour now talking about a number of different issues with regard to demographic change, and risk, and use, and some of what's driving that.

So as we move into this next section, we're going to go into to more of these issues. So I want to do a quick poll and ask you to say a little bit about which of these troubles you the most. So you can pick the one that you're most worried about when you think about older adults and substance use issues and the related consequences that are much more significant and severe in pretty quick ways. Which of these issues trouble you the most?

All right. Let's go ahead and publish results, and then we'll start diving into this a little bit.

REBECCA BULLER: It should be up there, Chuck. Can you see it?

CHUCK KLEVGAARD: I sure do. Thank you so much. So seeing lots of folks with all the above. Boy, I would agree. Hearing that each of these issues for a variety of reasons can't be thought of in isolation because they have relationships to each other in such significant ways, which will share that in just a moment. So I agree with the idea of thinking of all the above ought to be things on our radar screen.

So in terms of sensitivity, that has a little bit to do with metabolism of alcohol and other drugs, in particular psychoactive drugs if folks are prescribed certain kinds of prescriptions. Metabolism changes significantly between those years of between 50, 60, 70. I can tell you my own grandfather experienced pretty serious what we would call reverse tolerance.

He would, in his retirement, stand at the little local bar in town and when he was probably 40 or 50, he could probably drink six to eight glasses of beer. And then he would stumble his way home. Towards the end as he got to be 70 years old, he could have one beer and then lose his balance. So very significant differences in what-- again, reverse tolerance. And that happens not just with alcohol, but with all kinds of issues that relate to metabolism.

Lots of issues with health problems that Steph hit on in terms of chronic health conditions that interact with some of the use issues, and again, how common loss and isolation is. I really appreciate Steph offering so many examples of loss because it may be loss of a partner, but it may be loss of independence. It may be loss of mobility. It may be loss of sort of interacting with people in your profession or career.

It could be all kinds of loss that could, in fact, trigger and telescope someone into a substance use problem for sure. Cognitive and functional impairments can make it harder to detect. So again, the notion of thinking carefully about screening and the way that we do screening in respectful ways is really critical in terms of being able to understand and tease out what's happening in somebody's life as these interactions between these issues are all happening.

And again, we'll talk in a moment more about medication. So we can close the poll out. So for those of you who want to do that deeper dive into physiological issues, we're really talking about changes in metabolism that happened. So pharmacokinetics of alcohol and other substances-- if you can say that word in the afternoon-- increasing the susceptibility about not only the euphoria, but other kinds of harmful effects of use all change as that metabolism changes.

And maybe the example of my grandfather who went from being able to drink eight beers to drinking one or two and then not being able to stand. And I think, again, that led to all kinds of dangerous issues for him. Being able to make his way home, even though it was two blocks, was much more dangerous for him.

So thinking about older adults being more likely than young people to have chronic health conditions-- so while it's dangerous for anyone of any age to have co-occurring issues with health and mental health and use, it's compounded when folks have these issues when they're older adults because it's far more likely to interact with prescription medications as well as issues with regard to metabolism and balance. And the consequences are much greater. Again, if you take a fall when you're 30, it is nothing like taking a fall when you're 60 or 70.

So all of that physiological issue I think is worth exploring in some depth when you talk with folks in your community. You think about the population of psychoactive drugs-- now, again, what we're talking about there, the likelihood that somebody might be taking Xanax, or Zoloft, or Prozac, or Celebrex, or Lexapro. There's so many of those these days-- women being more likely to be prescribed some of those than men. But again, as older adults move into that cohort, they're far more likely to be prescribed psychoactive medications.

And they're more likely to, then, increase the likelihood that they will use non-medically. So as they learn how to use the substance for what it was prescribed for, they're also learning behaviors about how to use it to deal with

other issues. So they may have been prescribed it for anxiety, but they might also use it as a related issue to deal with boredom or sadness.

So we know overwhelmingly that psychoactive medications present some significant challenges and risk for this population because of the sheer number of folks who are prescribed and then that learned behavior about I can use it as prescribed, I can also use it with all kinds of other mental health conditions that I'm trying to struggle with. I might also be using alcohol on top of it.

So all of that stuff makes this graph, the tying up what you heard Steph talk about in the last hour is that you can't isolate these issues with this population. We know that they interact in both ways. So somebody may be engaged in some at-risk drinking that then creates a problem with their sleep pattern. The fact that they're not sleeping creates the likelihood that they're getting depressed and their suicidal ideation goes up.

So you hear-- from the top of the left column to the bottom of the right, there's an arrow. In the same way, you think about an issue on the right where there's a mental condition or disorder where somebody is actually drinking or using cannabis to deal with the emotions or the effects of trying to struggle with that mental disorder. So you see an arrow on the top right going down and dealing with drugs or cannabis and illicit drugs or prescriptions to try to handle and deal with and alleviate symptoms from a situation on the right.

So in this graph, I think it just ties up so much of what Steph talked about for me is that it's really important that we carefully consider the ways that all of these issues interact. So at-risk drinking, cannabis, illicit drugs, and prescriptions and its relationship to consequences, health problems, suicide, and mental disorders. Lots of, again, very complicated interactions and issues back and forth.

So we do want to move into strategies, Steph. So I'll mention some of the first ones, and then I'll invite you into the conversation to talk about some of the others. You've heard a lot of just general conversation around building awareness. And I love the idea that I think that if you're going to go to a registry and look for a program, a strategy, an evidence-based practice that's been studied to be effective with this population, you'll find some.

But it's scant, and the evidence for universal prevention in this population is even more scant because it's harder to find generalized ways of doing that awareness building. So I think starting with creating that awareness in your community about what we just spent the last hour going over is well worth the effort to raise awareness about putting this population on the radar screen for coalitions, for health departments, for primary care docs, for all kinds of folks that interact with these folks to have a better understanding.

There's certainly evidence that health education programs have increased knowledge regarding unhealthy alcohol use. So I'll share with you some examples when we get to resources about state departments of public health or other kinds of specific state and local health public health agencies that have developed awareness programs specifically targeting healthy drinking as you age. Now, you think about that message for underage wouldn't fit.

That feels really sort of anti-intuitive for us as we think about prevention is we're never encouraging healthy use of a substance, whereas when we're talking about older adults, the use is likely already there. So we're talking about how to avoid risk, how to avoid harm, how to avoid interactions, how to avoid danger with regard to falls. So all of the consequences are more immediate in that person's life to focus on reducing harm in that sense is part of that.

And, Steph, I'll transition to a little bit on health literacy and then we'll stay there with that, and then we'll go to the next set of strategies. So say a little--

STEPHANIE ASTERIADIS PYLE: OK.

CHUCK KLEVGAARD: Go ahead.

STEPHANIE ASTERIADIS PYLE: Thank you. Health literacy-- what is it?

[LAUGHS]

Actually, the CDC has taken this ball and run with it. And the reason is, according to the CDC, 71% of people over age 60 had difficulty in using print materials. 80% had difficulty using documents such as forms or charts. 68% had difficulty with interpreting numbers and doing calculations.

Strategies for providing information include empowering older adults, providing trusted sources of information, using a variety of methods for providing information to accommodate different learning styles, making health messages clear, concise, and solution-oriented, and, of course, what we already do, accommodating people with cognitive, visual, or hearing challenges But one of the biggest things that the CDC has done is they have published new definitions for personal health literacy and organizational health literacy.

Now, personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. And organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform

health-related decisions and actions for themselves and others. These new definitions do some very important things.

They emphasize people's ability to use health information rather than just understand it. So they have to have the ability to use it. They focus on the ability to make well-informed decisions, rather than appropriate ones. And they acknowledge that organizations have a responsibility to address health literacy. And so it also promotes health equity, which is a very important issue now.

So my suggestion is that anyone providing health care to older adults should go to the CDC's website. And you can just Google CDC health literacy. There's a link in our resource list also. And they have plenty of tools and details on how individually and as an organization you can cover this base for yourself and your organization. And, Chuck, I'll let you go on with the next strategies if that's OK.

CHUCK KLEVGAARD: So thinking about some of the things we know about prescription prevention, prescription drug prevention, more in the last decade of what we learned that prescriber education is really an important practice. So where there are strong evidence for specific kinds of intervention working with one population or with a certain drug or drug-using behavior, we know that we can generalize somewhat when there's a lack of evidence. So prescriber education has been studied some with this population, but generally, we know it to be an effective strategy because of where it's been used elsewhere.

So I advocate for the use of evidence-based practice that are based on research when the studies haven't been done with specific populations. And I think as Steph and I looked and scanned and dove into finding evidence-based strategies, I think we had, in some cases, needed to rely on the ways in which we looked at strategies for other populations that have been affected. So prescriber ed makes tons of sense to me to educate prescribers.

Medication management also makes some sense as well. I think that in the way that we're educating folks both from that prescriber side, but also from the consumer side or the patient side of things of helping folks understand the relationship and interactions of the way that they're dealing with medications, helping folks learn different ways to keep track of medications to be able to learn and to track both the effect on their mood, and their health, and their physical mobility, and their balance, and all kinds of ways of helping folks better understand and keep track of what's going on with the ways that they're using prescriptions and medications.

Lots of evidence about motivational interviewing. Even with this population, we were pleased to find that there's a fair amount of evidence specifically studying older adults and the use of motivational interviewing. Obviously, the challenge comes in with regard to whether older adults use specialized

services or not. We have opportunities with young people and middle-aged adults interact in lots of different sectors and different places and different kinds of agencies. Older adults are far less likely to use specialized services with regard to psychiatric care or special kinds of health-related services, more likely to use their primary care doc for most everything.

So they're using a single relationship most of the time for their health care. So making sure that we understand locally or in the county where you live where folks are accessing care and thinking about putting these kinds of interventions in those settings so that we figure out where folks are going because, again, they're not going to 10 places. They're probably going to one or two. Screening and brief intervention, again, there's a fair amount of evidence that's there, even studied directly with this population.

We're going to share in a few moments a handout with you that will help you and direct you to better understanding the data, the risk and protective factors, as well as some of these interventions in terms of how they've been studied. I like the idea of a lot of training family and friends. We're going to play a short clip in a moment of a news story for you that talks about the ways in which you can do that.

And so we'll bounce back to that one in a moment in terms of strategies as well.

STEPHANIE ASTERIADIS PYLE: Chuck, could I just say one more thing about the medication management?

CHUCK KLEVGAARD: Sure, go ahead.

STEPHANIE ASTERIADIS PYLE: OK. So the data showed that two in five adults age 50 to 80, 41%, take two to four prescription medications. 23% take more than five, and 52% take two or more non-prescription medications. Only 29% of those have had a comprehensive medication review, CMR.

So medication reviews for older adults is an evidence-based practice. It has been identified as a best practice program, and they often include state-sponsored free medication reviews. And if you want to know more about how those work and the importance of them, then we have a link for that in our resources. But it is very important.

Most adults take a lot of medications, and most of them never get a comprehensive medication review by a certified geriatric pharmacist. So that's a very, very important thing to really add in there. And that's my $0.02 about medication management.

CHUCK KLEVGAARD: I think a perfect transition, Steph, into one of the things that we can all do, regardless of where you're at, is having the conversation and raising the awareness. But to do that, I think you have to be

aware of some of the facts and take on the role of dispelling misinformation or myths. So we will bring up a poll and begin to explore some of what we know as a yes or no, if you believe this to be true or not true. And then we'll spend a little bit of time in a moment with Steph talking about each one of these.

REBECCA BULLER: Please note, there are actually four questions in the poll. So you just have to scroll to get to the last question.

CHUCK KLEVGAARD: As these are coming in, Steph, I'm super encouraged by what we're already seeing. I think that one of the things that's helpful for people to think about with these questions and the conversation that Steph will lead into in just a moment is if we ask this slightly different way-- we asked about what we know as preventionists about this. If you asked the question differently and said, what does your community think about this statement in terms of where you live?

What are the local folks-- what would they say in terms of where you live, your neighborhood, what would they say, I think the answers would look a little different.

STEPHANIE ASTERIADIS PYLE: Yes. I-- let's see, don't see the bottom two questions is my problem. The first two are pretty encouraging. But I can't see what the results are for the bottoms.

REBECCA BULLER: Can you use the slide on the right hand side and scroll down?

STEPHANIE ASTERIADIS PYLE: Oh, yes. I can. [LAUGHS]

REBECCA BULLER: Good.

STEPHANIE ASTERIADIS PYLE: Thank you.

REBECCA BULLER: You're welcome.

CHUCK KLEVGAARD: You can also make that box bigger by grabbing the bottom dragging.

STEPHANIE ASTERIADIS PYLE: Yes. So just to go through these, I think. Are we finished with the actual poll? OK. So signs of alcohol or drug use in older adults are often mistaken for signs of aging or chronic illness. Yes. I actually had a doctor, I told him some symptoms, and he said, well, you are getting older.

And I thought, really? From my health care professional? Older people are more likely than younger people to admit to having a problem. No. They were raised in an era where they are less likely to report a problem.

When a person's been taking a prescribed medication for years, there's no reason for it to be re-evaluated just because the person's older. No. Body metabolism, as Chuck said, changes. And a lot of things change, and we need regular reviews for our medication.

And last, older adults with a drug problem have likely been using continuously since they were young. As we learned about, early onset, late onset, no, that is not the case. Late onset addiction in adults, older adults, accounts for about one third, and more women. So we can move on. You all did good.

CHUCK KLEVGAARD: All right. So poll number four asks us five different questions. Oops, let me back up.

REBECCA BULLER: Again, just know, like Chuck said, there are five questions. So you can scroll or make the box bigger to see them all.

STEPHANIE ASTERIADIS PYLE: And once again, that's looking like everyone's doing a great job for the most part. We have a little tie in number one. I'm going to go ahead and start responding. For number one, more than half of all older people have memory problems or dementia. No.

The majority of older people have brains that work normally. We all have issues of forgetfulness. In fact, even at the oldest old, less than 30% have dementia. And that's 80 or over. For number two, older adults residing in nursing homes don't develop drug and alcohol problems. Well, no.

They do develop problems. And only an estimated 7% of older people are in nursing homes. Women are three times more likely to be among them. But they still need to be monitored for ATOD use as they are still at risk.

Polypharmacy can lead to a change in mental status. Yes, it can. Multiple medications have the potential to interact, and some of these side effects, such as delirium, confusion, depression, general malaise, dizziness, lightheadedness can be mistaken for aging. But it can be attributed to polypharmacy.

The body's reaction to changes in medications remains constant with advancing age. No. As Chuck outlined so brilliantly, our physiology changes, our metabolism changes. And that is not true. And finally, if an older person says that a behavior is his or her last remaining pleasure, it's generally best to allow the person to continue as long as others aren't at risk.

No. Stopping substance misuse and addictive behaviors can increase an adult's quality of life and bring them back into a sense of well-being. So we don't want to give up on them just if they give up on themselves. So I think everybody did a remarkable job on that. You know your older people. Chuck, would you like to lead into the--

CHUCK KLEVGAARD: Yeah, thanks for engaging us on that. Again, we want to play a short video. We're going to get to some additional Q&A in just a moment. So if the video will play-- and it looks like it's not loading. So let me try one more thing.

I can try playing it directly from the site instead since it won't load in the-- and then we're going to hear a little ad, of course, probably because we're going to YouTube. So hold on one second.

[VIDEO PLAYBACK]

PRESENTER: Everybody loves pizza.

[MUSIC PLAYING]

And at Paestro, we're creating the future of pizza.

[END PLAYBACK]

CHUCK KLEVGAARD: All right. I'm going to do some quick debriefing of that video. I like it because it's something that you can use. You can use it with your team, with your public health department, you can play it for your coalition. It went over a lot, a ton of what Steph talked about in the first hour as well as some of the things that we just covered recently. And it makes the case, I think, in a very credible way for how to have the conversation in a compassionate, sensitive, respectful way as well.

So I really like the video. We are going to leave that link in there for you so that you can think about how to use it in the ways that you want to or need to. Say something about partnerships, and then we'll move right into a Q&A so we get a chance to get to some of those questions that folks have been sitting on.

I mentioned this earlier, that many states and city departments on aging are the great resources to start with to see what's already happening, what's already been done, what data do they have, begin to look at, again, what sort of campaign strategies, intervention, services-- consider all of those questions that we spent time looking at. Are they looking at training professionals in motivational interviewing or screening?

Are they working with primary care? Are they working with other kinds of senior services or centers? So starting with these kinds of partnerships, starting with state and city departments on aging, looking at health centers, looking at senior services or centers that specifically focus on this population that have specialized care. Primary care is, again, still a major source of where older adults go for all kinds of answers.

Think about specialized workers. And this is the next wave of us getting ready to do this. A lot of the workforce development that's happening in the next five years is happening with geriatric psychiatrists, gerontology nurses, geropsychologists, and gereological social workers. So I think if you can say, again, all of those words, find those folks, find out what sort of training is happening for them and with them.

Make sure they're aware of all the things we just covered in this, as well as think about associations like the American Geriatric Society. There's also journals specifically focused on this population, a number of journals that we could recommend and point you to. So think about partnerships. You don't have to do this alone.

So know that, again, accessing this population is a significant bigger challenge than it is with other age groups, so knowing that you'll likely have to figure out how to have access to this population by considering the populations and the groups that are already working with them. So Steph, say something about the handout and then let's take some questions.

STEPHANIE ASTERIADIS PYLE: OK. We put together as many resources as we encountered for this particular webinar. But I'd like to say, it's not comprehensive. It isn't all that is out there. But some of the primary sources are.

And of course, I'm willing to be a resource if you're having trouble finding something. And I'm sure Chuck is too as well as the others who are involved here. But if you do have questions about them, hopefully, none of the links are broken and that will give you some good starting information.

CHUCK KLEVGAARD: Sorry about that. I went the wrong direction. Here we go. All right. Our tech team is going to throw some questions at us.

REBECCA BULLER: All right. Well, Dion has asked, does illicit drug use include drugs that were initially prescribed by a doctor, created an addiction, and now their only recourse for getting more is through underground markets?

CHUCK KLEVGAARD: Absolutely. There's evidence that that's true. I think it's been studied in more urban areas in terms of looking at where prescriptions started with some populations, white older men of a certain age, my age in that case, who maybe started using prescriptions, whereas in more urban areas and different parts of the country, some populations have been using heroin earlier. And they may be using heroin and have moved on to fentanyl as OxyContin and other opioids became far less accessible to folks.

So both are true. So depending on where you live and what race, ethnicity, gender issues interact, it's important to know. If you're in Chicago, it looks different than it does in Baltimore, or San Francisco. If you're in a rural area,

access and availability to illicit substances is a different ballgame. So I think that it's important to study where you're at and think about how much place matters with regard to trajectories of prescription drugs to heroin, to fentanyl, might be true, but it might be just as true that heroin is already on the scene.

STEPHANIE ASTERIADIS PYLE: And don't you think there's another aspect to this is that inappropriate prescribing that happened maybe not so recently, but in the beginning of this whole drug crisis, opioid crisis, there was prescribing going on without screening patients for the possibility that they were at risk, and then stopping medications without withdrawing them appropriately. And I'm sure hoping that that's being taken care of by educating doctors and other care providers better. But I don't know that.

CHUCK KLEVGAARD: The example you gave earlier about benzodiazepines is a great one, Steph. I think that 10 years ago, it was not well known that using benzodiazepines and OxyContin or a psychoactive substance was really dangerous with regard to overdose. We're learning more about its relationship to suicidality as well. But even a little bit of alcohol use and a benzodiazepine is pretty dangerous. And I don't think many prescribers take the time to talk about that even today.

STEPHANIE ASTERIADIS PYLE: Yeah.

REBECCA BULLER: Dion also asked, as a recovering addict-- alcoholic for three decades-- I've wondered whether anyone is studying relapse rates among older adults with significant recovery time as a result of being prescribed potentially addicting medications for diseases of aging.

STEPHANIE ASTERIADIS PYLE: My impression from what I've heard is that older adults who go into treatment are very successful.

REBECCA BULLER: OK.

STEPHANIE ASTERIADIS PYLE: I can't quote anything, that's just through reading. But I'm sure I could find citations if you like.

CHUCK KLEVGAARD: And I think that varies a little. I think the field itself is trying to figure out how to better serve women, for example, in treatment and the same issues here. There are very different cultural issues that would show up if you're trying to successfully engage an older adult in treatment. There are different issues with regard to social networks, for example.

And all of the complicated issues we've mentioned at the beginning of this webinar are things that would need to be woven into a treatment plan. So I think that they're still catching up on how to better culturally and appropriately deliver treatment services. But Steph is right that you can absolutely be successful in recovery at any age. And the evidence is clear that folks can go into recovery and be successful at 65 or 85.

REBECCA BULLER: We have a quick question, but was CBD products included in the cannabis data?

STEPHANIE ASTERIADIS PYLE: Very minimally. I mentioned it in one sentence.

REBECCA BULLER: Let's keep going. We've got just a couple of minutes, and I have a few things to say. How can we get community to recognize the issue and agree to help and correct it and get behind prevention efforts? That's a big question.

STEPHANIE ASTERIADIS PYLE: Well, personally, I'm a big proponent of prevention coalitions taking on changing their communities' ways of thinking and social norms. And I think that is one excellent beginning because you need to change communities and the way they're thinking. And the coalitions do a great job of that.

CHUCK KLEVGAARD: Yep. I think Steph's avenue there is a great one. I think the other thing that folks get trapped in is a dead end with regard to limited funding streams. If you're just going to rely on DFCs, for example, you might be always directed to deal with underage restriction, underage drinking as a priority and maybe one other drug you can deal with. But the idea of really doing a data driven, community-level assessment and focusing prevention on populations is something that, again, has always been a principle in prevention, but I see more and more funders asking people to do that and to be able to have data to support the decisions of how they're going to engage their community in prevention and which populations matter the most.

I see the CDC doing that in much more rapid ways. So encouraging coalitions to branch out around the ways in which they think about funding sources is one of the things that they can do because I think that often is a barrier that's misperceived-- that there's no money for doing with this population. That's not true.

REBECCA BULLER: Well, we've out of time. I'd like to just take a moment and share my screen and let folks know that there's more out there for you. And we would love to have you visit our social media sites, our websites, our Facebook page. And you can get more information about all of the activities that are sponsored by the Great Lakes PTTC.

We've got some upcoming events. I'm going to send all of this information to you in an email so you don't rush to write it down. There's some great things coming up. We are going to be looking at trends with girls and women, kind of a sister webinar to the one you've just experienced. And then again, you will be redirected to a short survey. Another way to do it is to copy and paste the URL here or scan the code.

But no worries on that. You should all be redirected. And we want to thank you. Thank you so much for being here, for participating. And it sure looks as though folks felt that this was really helpful. So thank you to both Chuck and Stephanie.