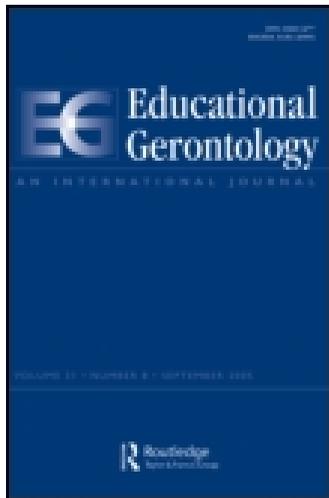


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Substance Abuse Policies in Long-Term Care Facilities: A Survey with Implications for Education of Long-Term Care Providers

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Substance Abuse Policies in Long-Term Care Facilities: A Survey with Implications for Education of Long-Term Care Providers

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The aging of the Baby Boom presents long-term care with many new challenges. Among these are the historically high levels of drug use by this cohort. This study surveyed administrators of licensed skilled nursing facilities in the Commonwealth of Kentucky regarding their perception of current drug use by residents, facility policies and procedures currently in place regarding illicit drug use, and their attitudes toward use of illicit drugs by residents. The results of interviews with 40 administrators or their designees revealed that they have experienced little problem with use or abuse of illegal drugs by residents. Fewer than one-third of the facilities had formal policies in place regarding illegal drug use. Only 10% had any experience with requests for medical marijuana, but almost one in five had a policy on the matter and nearly one-third stated they would support medical marijuana use by some of their residents if the matter arose. These authors recommend the following: (a) that the issue of illicit drug use needs to be addressed now before the situation becomes critical, (b) that administrators and staff need to be educated about recreational drug use and appropriate responses to drug abuse, (c) that screening instruments for drug abuse in this population should be developed and implemented, and (d) that policies regarding medical marijuana need to be adopted by all such facilities.

A major public policy concern in the long-term-care field is the potential burden an aging society will place on the care-giving system and public finances. The *2030 problem* involves the challenge of assuring that sufficient resources and an effective service system are available in

30 years, when the elderly population is twice what it is today. Much of this growth will be prompted by the aging of the Baby Boomers, who in 2030 will be aged 66 to 84—the *young old*—and will number 61 million people. (Knickman & Snell, 2002)

The Institute of Medicine [IOM] (2008) has warned that the American health care system is struggling with the challenge of delivering high-quality services to older adults and also that most of America's health care professionals lack adequate education and training with respect to the health care needs of older adults. "The next generation of older adults will be like no other before it" (IOM, 2008, p. 15). America's aging Baby Boomers will have greater racial and ethnic diversity, higher levels of education, lower levels of poverty, fewer children, higher divorce rates, and more openness regarding their sexual orientation than any previous cohort of American older adults (He & Sengupta, 2005; United States Census Bureau, 2008; IOM, 2008).

In 2011, the first Baby Boomers turned 65, and by 2030 the entire Baby Boom generation of 61 million persons will be 65 or older (Siegel, 1996). Aging Baby Boomers are expected to have a particularly major impact on the delivery of institutional long-term care. The Centers for Disease Control (CDC) predicts the number of nursing facility residents will reach three million by the year 2030, a doubling of current nursing home population (1.5 million residents) (Sahyoun, Pratt, Lentzner, Dey, & Robinson, 2001; CDC, 2008). Though recent policy initiatives at both the Federal and State levels, such as the Money Follows the Person (MFP) program, have attempted to transition nursing home residents out of institutional settings and into home and community based care, it remains likely that institutional care will remain a key component of the long-term care system (Arling, Abrahamson, Cooke, Kane, & Lewis, 2011; Centers for Medicare and Medicaid Services, 2007). As Lehning and Austin (2010, p. 45) have suggested, "the Baby-Boomers have influenced public policy and public institutions throughout their life course, and it is expected that they will have the same effect on long-term care once they encounter the physical, cognitive, and/or mental decline that often accompany old age."

USE OF DRUGS BY ELDERS

The Center for Substance Abuse Treatment [CSAT] (1998) identified abuse of alcohol and prescription drugs among adults 60 and older as one of the fastest growing health problems facing the nation—one that "remains underestimated, underidentified, underdiagnosed, and undertreated" (p. 1). White and Duncan (2008) and Taylor and Grossberg (2012) have suggested that this assessment of substance abuse by elders as limited to alcohol and prescription drugs is no longer valid. These authors argued that increasing attention needs to be paid to the use and possible abuse of illicit drugs by older Americans as Baby Boomers retire (Duncan et al., 2011; Simoni-Wastila & Yang, 2006; White et al., 2011). Given the historically high levels of drug use among this generation, and the possibility that many of them may be continuing that drug use, the impact on the prevalence of drug problems among the elderly population could be substantial.

As Baby Boomers age, nursing facilities and their staff will face the challenge of providing services to a cohort of Americans that differs from previous generations in terms of their history of drug use and abuse. Previous research provides evidence that, while illicit drug use has not been a primary policy issue facing the long-term care system in the past, the use of illicit drugs within nursing facilities has the potential to be a significant issue in the future. Favaro (2007), in her report on seniors who smoke pot, noted that "... Baby Boomers, who decades

ago discovered recreational drugs, are bringing them along into their golden years. Like the grandfather in the film 'Little Miss Sunshine' who coped with the angst of aging by snorting cocaine. It's a very new picture of illicit drug use in North America" (Favaro, 2007, p. 241). It remains, of course, to be seen how many Baby Boomers will continue their earlier patterns of drug use in later life. Diuguid (2011, p. 1) writes that "the habits that many of the self-indulgent Baby Boomers developed as they came of age in their 20s have continued through raising families, jobs, and living in the sandwich of getting adult children through college and older parents into retirement, through illnesses or their final days."

It also should be noted that the increase found in marijuana use (White, Duncan, Nicholson, Bradley, & Bonaguro, 2011) may not only be a result of trends that emerged in the 1960s and 1970s, but it may also represent increased use of medical marijuana in more recent years. While it is unlikely that medical marijuana users will develop an abuse problem, the likelihood that their numbers are increasing is a situation that could present important issues for professionals working with these users, especially in skilled nursing facilities or other residential settings (Rashidian & Martin, 2010).

RESEARCH OBJECTIVES

This study examined how prepared skilled nursing facilities within the Commonwealth of Kentucky are for the coming influx of aging boomers and some of their anticipated behaviors. Duncan, Nicholson, White, and Bonaguro (2009); Duncan, Nicholson, White, Bradley, and Bonaguro (2011); White and Duncan (2008); and White et al. (2011) demonstrated significant increases in the use of illicit drugs among adults 55 years of age and older. There currently exists no published research examining how skilled nursing facilities currently deal with, or expect to deal with, a significant influx of adults using illicit drugs. Thus we proposed to do the following:

- Examine whether illicit drug use is perceived as a current issue among administrators of residential facilities in the Commonwealth.
- Survey what policies/procedures are currently in use by residential facilities in the Commonwealth.
- Determine what attitudes administrators have regarding the use of illicit drugs by residents within their facilities.

METHODS

A current list of residential long-term care facilities was obtained by visiting the website of the Kentucky Cabinet for Health and Family Services, which provided a sampling frame of all licensed facilities serving senior citizens in the Commonwealth ($n = 408$). The survey was developed by the research team by harvesting items from the national Nursing Home Survey on Patient Safety (Agency for Healthcare Research and Quality, 2010), and the 2004 National Nursing Home Survey Facility Questionnaire (Centers for Disease Control, 2004, 2008). Items concerning illicit drug use and facility policies were developed by the team members. The completed survey was reviewed by a licensed nursing home administrator for content and clarity.

Interviews were conducted via telephone with the administrator or their designee at each facility. Phone contacts were attempted during March and April of 2012 using the number listed

in the spreadsheet available from the Kentucky Cabinet for Health and Family Services. This spreadsheet lists every licensed long-term care facility in the Commonwealth of Kentucky. At the time of the study, there were 283 total facilities with skilled or nursing beds. An invitation-to-participate letter describing the survey and purpose, along with human subjects' approval, was mailed to the street address provided by the Cabinet. If available, the name of the director was also included in the invitation letter.

Each facility was then contacted at least twice to attempt to talk with the nursing facility director or their designee. We were able to complete 40 interviews for a response rate of 14.1%. Given the short time frame, the fact no other procedures were included to encourage participation aside from the single invitation letter, and the fact we were contacting busy professionals, the low response rate is not surprising. It clearly, however, represents a challenge when interpreting the results.

The gender of the respondents was 10 (25%) males, 29 (72.5%) females, and 1 (2.5%) unspecified. Respondents ranged in age from 26 to 71, with a mean of 50.28 years of age. They had an average of 23.74 years of experience working in long-term care. Highest degree obtained was associate degree 3 (7.5%), bachelors degree 23 (57.5%), and masters degree 14 (35%).

The percentage of residents who have a diagnosis of substance use disorder range from 0 to 10%, with a mean of 0.87%. When asked what percentage of current residents the administrator believed should have such a diagnosis, the estimates ranged again from 0 to 10% but with a mean of 0.62%.

Only two (5%) of the facilities have a specialty program for residents with a substance abuse problem. Six (15%) respondents, however, reported that their facility has a service for residents who have a problem with abuse of alcohol. A service for residents who have a problem with abuse of illegal drugs was reported by 7 (17.5%) facilities. A service for residents who have a problem with abuse of prescription drugs was reported by 7 (17.5%) facilities.

Six (15%) of the facilities have experienced problems with residents obtaining alcohol. Of these six facilities, two reported that residents obtained the alcohol on their own, all six reported residents obtaining alcohol from family members, five reported residents obtaining alcohol from friends, and none reported residents obtaining alcohol from staff.

Three (7.5%) facilities have experienced problems with residents obtaining illegal drugs. Of these, two were reported to have obtained the drugs on their own, two obtained drugs from family members, three obtained drugs from friends, and none obtained illegal drugs from staff.

Seven (17.5%) have experienced problems with residents improperly obtaining prescription drugs. Of these, five were reported to have obtained prescription drugs on their own, six obtained prescription drugs from family members, one obtained prescription drugs from friends, and none obtained prescription drugs from staff.

Twelve (30%) facilities have implemented policies or procedures addressing nonmedical use of drugs. When asked to rate on a scale from 1 (*not at all well*) to 5 (*very well*) how well those policies were working, 8 (66.7%) facilities rated them at 5 and 4 (33.3%) facilities at 4.

Respondents were asked, "What does your facility do if you suspect that one of your residents is using drugs, including alcohol, . . ." The most common response ($n = 23$, 57.5%) was to consult the resident's physician. Notifying the resident's family and discharging the resident were both reported by 7 (17.5%) respondents.

Respondents were also asked, "If you suspect a patient has a substance use disorder, what does your facility do?" The most frequent response ($n = 19$, 47.5%) was to contact the resident's physician. The next most frequent response ($n = 13$, 32.5%) was to refer to an external treatment

resource. Other responses were to discharge the resident ($n = 4$, 10%); to notify nurses and other caregivers ($n = 3$, 7.5%); to transfer the patient ($n = 2$, 5%); to notify the family ($n = 2$, 5%); and to notify the police ($n = 2$, 5%).

If a resident has a substance use disorder, 5 (12.5%) respondents reported their facility provided services inside the facility. Most of the respondents ($n = 31$, 77.5%) stated that they referred to an outside service. Four (10%) don't know what they would do in such a case.

Sixteen (40%) respondents stated that during admissions their facility used assessments for substance abuse. Additionally, 27 (67.5%) report that during admissions they ask family or others about the resident's possible substance use. Two (5%) reported that they use the CAGE to screen for substance abuse during admissions. Two (5%) reported using the AUDIT-M. None reported use of the S-MAST-G. Eight (20%) reported that they used some other assessment during admissions.

Asked whether any resident, prospective or current, had asked to use marijuana medically in their facility, 4 (10%) answered yes. Seven (17.5%) reported that their facility has a policy regarding medical marijuana. In response to the question of whether they would support the use of medical marijuana by some of their residents, 13 (32.5%) replied yes.

CONCLUSIONS

The respondents reported little problem with use or abuse of illegal drugs by residents in their facilities. Fewer than one-third of the facilities had formal policies in place regarding illegal drug use, and the most frequent response when problems arose appears to be referring the matter to the resident's physician. Only 10% had any experience with requests for medical marijuana, but almost one in five had a policy on the matter; and nearly one-third stated they would support medical marijuana use by some of their residents if the matter arose.

DISCUSSION

The low response rate for this survey limits our ability to draw any firm generalizations, but as was the case with Wright and Hyner's (2011) similarly small sample of administrators, we feel that some fairly robust conclusions can be drawn. The busy nature of the job of a nursing home administrator can be a serious barrier to collecting data from this subject population. The present study was also unable to offer any inducement for administrators to take time from their schedules to participate, which may have contributed to the low response rate.

These results do, however, suggest that long-term care administrators in Kentucky do not perceive use of illegal drugs to be a major problem among residents of skilled nursing facilities. Nor do our results suggest that they are preparing for the predicted increase in such use among this population as the Baby Boomers age. While it may be true, as Martin (2008) states, that compliance with the laws covering controlled drugs is a constant focus of long-term care facilities, that focus would seem to be on prescription drugs and their potential for misuse or abuse rather than on recreational drugs.

Past studies have shown that nursing home staff are not generally knowledgeable regarding mental health problems (Caston, 1983); alcohol problems (Peressini & McDonald, 1998); or substance abuse problems in general (Kane & Green, 2009). This lack of knowledge is associated with a

common failure to intervene with, or refer for treatment, nursing home residents with psychiatric or addiction problems. Our findings and the pattern of higher drug usage in the Baby Boom generation would seem to clearly suggest that the need for long-term care personnel to be educated regarding drugs and drug abuse is becoming increasingly important.

Peressini and McDonald (1998) report that continuing education intended to improve practitioners' attitudes, knowledge, and competencies in this area can have positive effects in improving resident care. This is consistent with the findings of Klegon (1980) and others that practitioners in gerontological care tend to be open to more specialized training and increased professionalism. Caston (1983), on the other hand, warns that education alone is unlikely to solve such problems, and that institutional barriers to action need to also be addressed at the level of organization and policy. This gives emphasis to the importance of our finding that few of the long term care administrators reported having policies in place regarding illegal drug use or abuse by residents.

We would offer the following recommendations for consideration by nursing home administrators and gerontological educators:

First, it would seem advisable for future surveys of this nature to be conducted as face-to-face interviews to improve the response rate.

Second, the time for preparing for the likely influx of larger numbers of recreational drug using and abusing residents is now, if it has not already passed.

Third, both administrators and patient care staff in skilled nursing facilities need to be educated about recreational drugs and their use and abuse as well as appropriate responses to abuse. Hanlon, Schmader, and Semla (2013) suggest that more attention should be paid to educating health care professionals. While training of geriatricians, nurses and pharmacologists about drug misuse in the elderly is important, our research suggests that incorporating knowledge aimed at licensed administrators about the potential for abuse in aging Baby Boomers is urgently needed.

Fourth, beyond educating skilled nursing providers, another potential direction for future efforts includes the development of screening instruments for elderly illicit substance abuse. The Florida Brief Intervention and Treatment for Elders (BRITE) project (Schonfeld et al., 2010), geared toward prescription drug and alcohol abuse among the elderly, offers some evidence that an effective substance-abuse screening tool could be developed to use with older adults.

Fifth, policies need to be developed for dealing with both use and abuse situations regarding illegal drugs and facility residents. Because the nursing staff is a key determinant of care practices within a facility, attention should be paid to the role of the Director of Nursing and his or her nursing team in implementing policy. Norton (1998) and Ford (2011) both noted that the challenges inherent in interpersonal relationships between health care provider and patient should be addressed when implementing policy change. And, lastly, one issue these new policies need to address is the use of medical marijuana in skilled care facilities.

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