Welcome to our program about the special needs of older adults.
As a reminder, this training is part of the Screening, Brief Intervention, and Referral to Treatment – Training Iowa Preceptors and Students program that is funded by the Substance Abuse and Mental Health Services Administration.
Today we are going to review some of the special challenges of substance use among older adults. We call this approach SBIRT Plus, to emphasize that there are some additional considerations when thinking about risk factors among older adults – as listed on the slide.
All of the main principles that are part of SBIRT are also part of SBIRT Plus. The focus is on risky substance use, not dependency or abuse.
So we are still using the same three-step process outlined in the earlier training:
- Two-step screening,
- Brief intervention, and
- Referral to specialty care when indicated.
Our focus on older adults is based on the fact that MOST SBIRT training targets adults, not older adults. That is likely because older adults – at least today’s older adults – are less likely to drink or use drugs. However, that is changing as the Baby Boomer generation ages.
And as Volkow and others have stated, there are lots of reasons for providers to take late life drinking and drug use seriously. A number of factors that cluster in late life change the proverbial “landscape” of substance use and misuse.

Reference:


One of the most important starting points is that the sheer number of older adults in the U.S. is going to demand our time and attention as health care providers. By 2040, there will be about 82 million older people, over twice the number there was in 2000. That means that about 22 percent of the population will be 65 years or older – or about 1 in 5.

Reference:
Administration on Aging, Administration for Community Living, U.S. Department of Health and Human Services.
This chart just gives a visual image of what the growth in numbers looks like. Note that the number of older adults will more than double from rates in 2000 by 2040, which is less than 25 years away. So this has everything to do with you and your practice!

Reference:
It’s also important to keep in mind that aging in Iowa is an issue! We have some of the highest rates of older adults in the country.
And as we think about older adults, we need to also consider the many changes that occur in late life – like health, loss, and changes that lead to people living alone, becoming isolated, and in turn being at risk for substance use – which we will review shortly.

Reference:
In terms of substance use, most older adults tend to drink versus using drugs for recreational purposes. And there are two main groups of drinkers – ones that have drank their entire life, and ones that started drinking more heavily in late life due to stress. In general, the latter group tends to respond best to the SBIRT approach.

Reference:
Currently, rates of illicit drug use among older adults are pretty low. About 1 percent of older adults report using illicit drugs (compared to nearly 20 percent of those age 18 to 25 years). However, rates are expected to increase as Baby Boomers age. And, as noted on the slide, misuse of prescription drugs is an important consideration.

Reference:
As we think about older adult substance use, some key risk factors should be kept in mind. Think about the population you are serving, and think about known risk factors for substance use.

Reference:
Four main types of age-related issues and concerns tend to combine and interact with “risky” substance use in older adults. Let’s briefly review each one.
Most healthcare providers are well aware of the universal changes – sometimes called “normal aging changes” – that occur in later life. While these are marginally important by themselves, they make a big difference when other problems overlap.
As noted on the slide, health-related problems generally increase with advancing age. In general, older adults have higher rates of chronic illness, lower overall health status, and increasing risk of disabilities.

In turn, many also experience limitations in their activities of living.

Reference:
That’s important because alcohol use – all by itself – can cause health problems. And the additive effect – for example, existing heart disease plus alcohol-related heart change – increases risks of more serious problems.
Another important consideration is that new onset psychiatric illness is a big concern for older adults – but is an even bigger issue when substance use is involved. Depression and substance use, particularly drinking, in late life is a common comorbid problem.

Reference:
The strong relationship between depression and drinking was underscored in the BRITE project, which used SBIRT methods but also screened for depression.

Reference:
Another big consideration for older adults is use of medication, including both the prescription medications they are given for their health problems and also over-the-counter drugs that can interact with alcohol.

Reference:

A few common examples are listed on the slide, but there are many, many others in the National Institutes of Health publication. In short, there’s a lot to think about:

- Direct damage,
- Risk of accidents, and
- Worsening of the health condition.

Reference:
The last group of late life risk is social stress and losses that tend to cluster in late life. Unanticipated and unwanted changes, in particular, can cause a lot of stress. In turn, the older person may seek “comfort” in drinking.

Reference:
It’s also important to think about how health-related changes and disabilities cause stress – and in the same way, may trigger drinking to “treat” the problem or sense of distress the older adult may feel.
Along with the loss of loved ones – particularly spouses and partners – and health-related change, we know that a lot of older adults will be living alone, and/or changing their residence to better manage – which can contribute to social isolation and risk of drinking.

Reference:
Basically, we need to think about universal changes, and how that might affect the outcomes associated with the person’s “usual” habits.

Reference:
We also need to think about the onset of chronic illness, all the medications that are used to treat chronic illness, and the stress that can bubble up from loss and change.
As before, drinking can make lots of late life problems even worse! And sadly, some older adults aren’t even aware that their level of drinking is contributing.

There is considerably more evidence that relates to the use of alcohol with respect to health, but there are increasing bodies of evidence that relate to illicit drugs – such as cocaine and heroin – and to abuses of various prescription medications.
Our goal, then, is to just use the very same SBIRT steps – but with a few modifications. The biggest issue is to not “skip” the older adult because we stereotype them as “not at risk.”
As a reminder, the flow of decision-making is the same.
Just remember to adjust the limit of “drinks in a day” to fewer than 4 for older adults.
We also want to think about using common symptoms of substance use as “triggers” to asking the “pre-screening” questions, the ones on the Annual Questionnaire, on any visit!

Reference:
The scoring of the 10-item Alcohol Use Disorders Identification Test – or AUDIT – and the 10-item Drug Abuse Screening Test – or DAST – is the same. One of the biggest differences in applying the brief intervention may be helping the older person identify causal and contributing factors that also need treatment – like clinical depression – and drawing on both personal and community supports.
As you think about the brief intervention, remember that most drug use in older adults is actually misuse of drugs that are being used for a medical purpose. It isn’t recreational; it’s misuse. While that isn’t part of the SBIRT focus, it’s an important part of clinical care and should be part of the conversation.

Another consideration is that the stigma of both psychiatric and substance use treatment may keep older people from seeking help. In turn, primary care providers may need to play a larger and more expanded role in substance-related counseling and assessment with those who refuse referrals.

In brief intervention, remember to use your best motivational interviewing skills.
Greater involvement by primary care providers in monitoring of risky substance use among older adults is a good practice overall. Taking time to ask, show interest, and advance movement toward changes to reduce risky substance use – just like any other “safety” issue – is important. Although information sheets are not a substitute for discussion, they can reinforce ideas and give the person and his or her family something more to think and talk about.
In summary, SBIRT Plus relies on healthcare providers believing that older adults should be screened, just like any other adult. Only by asking can we identify those who are at risk – so it really does rely on you.
Being aware of the special needs and characteristics of older adults will help guide the brief intervention, and if needed and accepted, referral to treatment.

Thank you for your attention.
Acknowledgements