Welcome to our program about the special needs of older adults.

Screening, Brief Intervention, and Referral to Treatment
for the Special Needs of Older Adults

Sponsored by the University of Iowa
With funding from the Substance Abuse & Mental Health Services Administration (SAMHSA)
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.
What is SBIRT?

An evidence-based practice that targets “risky” substance use

- **Screening**: Two-step screening for quickly assessing use of alcohol, illicit drugs, and prescription drug use, misuse, and abuse
- **Brief Intervention (BI)**: Brief motivational and awareness-raising intervention given to risky or problematic substance users
- **Referral to Treatment**: Referrals to specialty care for patients with substance use disorders

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.

Why is SBIRT PLUS (+) Important?

- SBIRT training tends to focus ONLY on adults, not **unique needs of older adults**
- Alcohol use in late life is largely IGNORED, even though health consequences are HIGH
- “Risky” use of alcohol (and misuse of medication, along with illicit drug use in Boomers) is a GROWING concern
- Making changes NOW can help ease suffering AND prepare for the future!!
And as Volkow summarized here, 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.


Note: Dr. Volkow is the NIDA Director.
One of the most important starting points is that the sheer NUMBER of older adults in the US 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.
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!
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.
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.

Demographic Facts: Substance Use

- **Current trends**
  - Older adults tend to prefer alcohol over illicit drugs
  - Misuse of prescription drugs is more common than “recreational” use

- **Two main groups of “drinkers”** in later life
  - Drank throughout their lives; now at higher risk for having health-related issues
  - Started drinking later in life as a “reaction” to stress, loss, health problem; tend to be easier to treat
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.
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.

Demographic Facts: Substance Use

Risk factors for illicit drug abuse among older adults³

✓ “Young” older adults, unmarried male
✓ Low income
✓ Previous illicit drug use
✓ Current methadone maintenance
✓ Licit (prescribed) drug use
✓ Alcohol use
✓ Comorbid mental illness, especially depression and/or anxiety
✓ Involvement in crime
✓ Social isolation/poor social support
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.

**SBIRT PLUS (+): Understand Risks**

- “Risky Use” in older people combines with other age-related health problems!
  - **Universal age-related changes** (e.g., metabolism, sensory) increase risks
  - **Medical problems** that cluster in late life can complicate issues
  - **Medications** used to treat health-related problems interact with alcohol/drugs
  - **Loss/stress** can precipitate/contribute to use
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.

**Risks: Universal Aging Changes**

- Changes that occur in everyone/everywhere (aka, “normal” aging changes, not disease)
- Over time, affects cells in every major organ
  - Shift in muscle-to-fat ratio (sarcopenia)
  - Metabolic slowing
  - Sensory decline/changes: Visual (presbyopia), hearing (presbycusis)
  - Cardiovascular: SA node cell loss (slower heart rate), cardiomyopathy, atherosclerosis
  - Many others!!
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.¹

Risks: Chronic Illness in Late Life

- Disease-related problems have more impact than universal changes!
  - **Musculoskeletal** → Osteoporosis, falls, fractures, arthritis, degenerative joint disease
  - **Cardiovascular** → Hypertension, arteriosclerosis, coronary heart disease, arrhythmias, heart failure
  - **Nervous system** → Dementia, delirium, depression, Parkinson’s, many others
Chronic Illness in Late Life

Drinking ALONE has health consequences →

- **Cardiac**: Cardiomyopathy, arrhythmias, atrial fibrillation, ventricular tachycardia, strokes, hypertension
- **Liver**: Steatosis, alcoholic hepatitis, cirrhosis
- **Pancreas**: Pancreatitis
- **Cancer**: Mouth, esophagus, pharynx, larynx, liver, breast, colon/rectal
- **Immune system**: Suppress innate (WBCs, Natural Killer cells cytokines) and adaptive (T- and B-lymphocytes, antibodies) responses

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, is a huge concern.

**Chronic Illness in Late Life**

- New onset *psychiatric problems* are associated with substance use risks\(^4\)
  - Cognitive disorders → 10%
  - Anxiety disorders → 15%
  - Depression* → 21% to 66%

*Depression & drinking is the most common comorbid problem in late life!*
Depression & SU: BRITEx

Brief Interventions & Treatment for Elders

- Project modeled after SBIRT
- Problems leading to referrals for BI →
  - Alcohol use (9.7%)
  - Illicit drug use (1.14%)
  - Depression (64.3%); significant correlation between the alcohol and depression

The strong relationship between depression and drinking was underscored in the BRITEx project that used SBIRT methods, but also screened for depression.
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.
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.
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.
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.

Loss & Social Stress

- **Health-related changes**
  - Hip fracture → social changes
    - Unable to drive to shop, care for home, participate in leisure activities
    - Increased isolation, unwanted dependency
    - Risk of drinking/drug misuse to treat distress
- **Disabilities** → Pain, depression, fear related to loss of abilities, impending death
- **Sleep disturbances** → Typical/universal sleep pattern changes “treated” with alcohol
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.
Implications

• **Universal changes** increase older adult’s sensitivity to drinking\(^4\)
• “Usual” habits – meaning drinking hasn’t changed from midlife – can result in
  - Higher blood alcohol levels, AND
  - Associated adverse effects
    - Confusion
    - Slurred speech
    - Impaired coordination/fall risks

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

• Sheer number of **chronic illnesses** in late life AND **medications** used to treat them puts older adults at risk!
  - Additive effects of chronic illness & alcohol-related changes
  - Disease/drug & alcohol interactions
• Social and health-related **distress** “treated” with alcohol
  - Fear of disability, death, role changes, uncertainty
  - Depression, anxiety
  - Isolation, boredom

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, excessive 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.
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.”

**SBIRT PLUS (+): Meaning in Practice**

- SBIRT process is basically the same
- Minor adaptations tailored to older adults
  - Use lower drinking “threshold” for screening
  - Screen “as needed” based on observed changes in the older adult
  - Consider late life problems when applying BI
    - Problems/Issues at “baseline”
    - Root causes of substance use/related distress
    - Involvement of community services
    - Follow-ups by PCP or community service
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!

Symptoms: Beyond “annual”!

- Sleep complaints; unusual fatigue, malaise, daytime drowsiness; apparent sedation
- Cognitive impairment, memory or concentration difficulties, disorientation, confusion
- Seizures, malnutrition, muscle wasting
- Liver function abnormalities
- Persistent irritability (without obvious cause), restlessness, agitation
- Altered mood, depression, anxiety
- Unexplained complaints of chronic pain
- Incontinence, urinary retention, difficulty urinating
- Poor hygiene and self-neglect
- Complaints of blurred vision
- Changes in eating habits
- Unexplained nausea, vomiting
- Slurred speech
- Tremor, motor coordination problems, shuffling gait
- Frequent falls, unexplained bruising
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 a focus of 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.
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 . . .

• Screening is the **first step of the SBIRT process** and determines the severity and risk level of the patient’s substance use
• The result of a screen allows the provider to determine if a **brief intervention or referral to treatment** is a necessary next step for the patient
• **Provider BELIEFS** about the need to screen or intervene are **CRITICAL!!!**

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.
In Summary . . .

- Age-related health and psychosocial risks are often influential in late life substance use
- Comorbid depression is common, and should be assessed
- Referral for assistance with managing age-related stressors is likely to be a critical component of reducing substance use/drinking
  - Need to know aging services/point person
  - Not just substance use referrals

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.