HHS Public Access

Author manuscript

Int J Drug Policy. Author manuscript; available in PMC 2019 August 01.

Published in final edited form as:

Int J Drug Policy. 2018 August ; 58: 135–136. doi:10.1016/j.drugpo.2018.06.005.

Aging, multimorbidity, and substance use disorders: The growing case for integrating the principles of geriatric care and harm reduction

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Given the unprecedented aging of many populations throughout the world, coupled with high rates of unhealthy substance use among baby boomers, we are at the cusp of an epidemic of older adults with a substance use disorder (SUD) (Han & Moore, 2018). Indeed, in many areas of the world, including Australia, Western Europe, and North America, an increasing number of older adults find themselves in substance use treatment, particularly for opioid use disorder (Carew & Comiskey, 2018). SUD management in this population is uniquely complicated because aging is associated with chronic medical conditions, an increase in prescription medications, and declines in function. Further complicating SUD management among the aging is the fact that substance use itself can have harmful effects on chronic diseases and its treatment. Accordingly, caring for older adults with SUDs presents both medically and socially complex challenges, and will increasingly pressure healthcare systems to provide coordinated care to be effective. However, little research into the health of older adults with multi-morbidity (generally defined as 2 chronic medical conditions) and SUD has been done. The lack of awareness on the interplay of aging, chronic medical disease, and substance use among providers limits the effectiveness of care for this growing population. Although addiction medicine historically has not focused on older adults, effectively tackling the health needs of older adults with SUDs demands a geriatric-based approach informed by the principles of harm reduction and grounded in the addiction treatment model.

The fundamental approach of geriatric medicine is providing optimal care for older adults with multimorbidity in a setting of competing risks. A major emphasis in geriatric medicine is not to focus solely on disease-specific outcomes, but to integrate patient-centered, goal-oriented outcomes, such as maximizing functional status, maintaining independence,

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Conflict of interest
None.

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symptom management, and de-escalating care when necessary (Reuben & Tinetti, 2012). Geriatric care also identifies and manages geriatric conditions, which tend to appear in old age, are common among vulnerable populations, have multiple causes, and often followed by declines in functional health. Common geriatric conditions include falls, cognitive impairment, urinary incontinence, and frailty. The recognition of geriatric conditions is critical because they are independently associated with functional decline and mortality. Addressing geriatric conditions improves the care of older adults, particularly for vulnerable populations, by decreasing mortality risks, nursing home admissions, and acute care utilization (Counsell et al., 2007). Recognizing geriatric conditions may be particularly relevant for adults with SUDs since problems associated with prolonged substance use, such as substance use-related comorbidities and health behaviors, are thought to accelerate frailty and may lead to the early onset of geriatric conditions (Han & Moore, 2018).

SUDs are best considered as chronic diseases that are life-long, relapsing conditions that require lifestyle changes and are often complicated by poor compliance. Adults with SUD often receive both uncoordinated addiction treatment and fragmented primary medical care to manage their chronic medical problems. To address these issues, a handful of models that integrate chronic medical care with addiction treatment have been developed. A major randomized trial utilized the chronic care management approach by creating multidisciplinary teams in a primary care clinic for patients with alcohol or other drug dependence (The AHEAD study), but it did not improve abstinence or treatment utilization (Saitz et al., 2013). However, another model that utilized an integrated primary care intervention in an addiction program using medical providers with specialty addiction training found improvement in abstinence only among a subgroup of patients with certain medical conditions and a nonsignificant trend for higher costs for the intervention group (Weisner, Mertens, Parthasarathy, Moore, & Lu, 2001). In addition, a systematic review focusing on the integration of medical care and substance use treatment note the low quality of current evidence and emphasize the lack of clarity on who may benefit from such interventions (Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2013). Relevantly, most of these studies focused on substance use outcomes rather than health-related outcomes. This is where the need to integrate the principles of geriatric care and harm reduction into addiction medicine are needed. Both geriatric medicine and harm reduction approaches frame care in the context of risks, patient-relevant benefits, and prognosis without an absolute focus on “cures or fixes”, which can help providers understand what outcomes are meaningful for patients.

Geriatric-based principles should be incorporated into the field of addiction medicine as an approach to integrated chronic medical care and substance use treatment for an aging population. However, despite expertise in chronic disease management, geriatric medicine has not focused on SUDs among older adults (Rosen, Engel, & Hunsaker, 2013). Unfortunately, some providers continue to use stigmatizing language around drug use, which may be particularly relevant for older adults in the United States who have lived through the punitive language of the “war on drugs.” While both the fields of geriatric medicine and addiction medicine have much to learn from each other, many of the principles of harm reduction interventions and the geriatric approach to chronic disease management overlap. Most of the harm reduction principles – humanism, pragmatism, individualism, autonomy,

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and incrementalism (Hawk et al., 2017) align with the guiding principles of approaching older patients with multimorbidity (American Geriatrics Society, 2012). Moreover, both fields emphasize shared decision-making. While the clinical settings and contexts for harm reduction and geriatric-based care traditionally differ, they share an overarching focus on patient-centered care that frames clinical decisions in practical and incremental ways. Given the complexity of how substance use can affect chronic medical diseases, the principles of harm reduction are vital to inform patient-provider relationships for adults with medical multi-morbidity and SUD to focus on the goals of improving health, maintaining function and independence, and improving quality of life. An example of such an intervention in this framework could be implemented in opioid treatment programs given the increasing age of their treatment population in many countries (Carew & Comiskey, 2018) and the frequent and long-term contact between patients and providers. An integrated geriatric-based model of care could be implemented through multidisciplinary teams in opioid treatment programs that incorporates opioid substitution treatment with the focus on chronic medical disease management, the identification and treatment of geriatric conditions, assessment of functional and cognitive status, and the anticipation and management of transitions of care and advance care planning.

We are witnessing now the magnitude of the intersection of aging and substance use. For healthcare systems to adequately care for the complexity of aging, chronic medical conditions, and substance use among its aging populations, a framework that draws from both geriatric-based principles and from harm reduction is required. Such a framework for caring for patients with multimorbidity must recognize the unique psychosocial issues and stigmas related to both aging and substance use. These issues need greater awareness both in addiction and geriatric medicine. Unfortunately, older adults are often not screened for SUDs in primary care, and even when identified many geriatric medicine providers are not aware of treatment options (Han & Moore, 2018). Geriatric medicine training should include screening, prevention, and treatments for SUDs for older adults, while an approach that integrates geriatric care into addiction medicine is also critical. Fortunately, there is a wealth of literature on the separate effects of geriatric-based interventions and harm reduction interventions from which real-world models of care that deliver coordinated and nonjudgmental care focused on patient-centered outcomes for adults with multimorbidity and SUD may be drawn. Moving forward, geriatric medicine and addiction medicine must work concurrently to address the growing population of older adults with SUDs.

Acknowledgments

Funding Statement: Research reported in this publication was supported by the National Institute On Drug Abuse of the National Institutes of Health under Award Number K23DA043651. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

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