Module VIII: Substance Use/Misuse/Abuse Among Older Adults

I. Purpose

The purpose of this module is to provide clinicians with information and techniques for working with older adults who are experiencing problems related to their substance use/misuse/abuse/dependence.

II. Learning Objectives

At the end of the training, the health care professional will have had an opportunity to:

- Know the definitions of low risk drinking, at-risk drinking, problem drinking, and alcohol dependence in older adults;
- Know the interaction effects of alcohol and specific medications;
- Know drinking guidelines for adults age 65 and over;
- Understand the prevalence of at-risk drinking, problem drinking, and alcohol dependence in older adults;
- Identify signs and symptoms of alcohol and/or medication misuse problems in older adults;
- Know how to use brief alcohol interventions with older adults;
- Be able to discuss barriers to interventions and treatment, and how to address some of these barriers.

III. Chronology (Approximately)

60 minutes

Strategy: Slide lecture focused on research related to prevalence, etiology, prevention, and treatment of problems related to substance use in older adults.

30 minutes

Strategy: Small group role play/discussion of case studies that highlight the special screening and intervention issues for this special population

20 minutes

Strategy: Large group wrap up discussion of cases and any other questions

IV. Facilitator Materials

- Power Point Slides (lecture and discussion)

V. Participant Materials

- Handouts
- References

Module VIII: Substance Use/Misuse/Abuse Among Older Adults

This handout is organized in the order of the Module VIII Slides. Following the number and title of each slide are notes that the presenter can use to educate the participants about each area of the material.

Slide 1: Module VIII: Substance Use/Misuse/Abuse Among Older Adults.
This is the title slide for Module VIII.

Slide 2: Learning Objectives
At the end of the training, health care professionals will be able to:

- Understand the prevalence of at-risk drinking, problem drinking, and alcohol dependence in older adults
- Know drinking guidelines for adults age 65 and over
- Know the interaction effects of alcohol with various medications
- Identify signs and symptoms of alcohol problems and medication misuse in older adults
- Know how to use brief alcohol interventions with older adults
- Be able to discuss barriers to interventions and treatment, and how to address some of these barriers

Slide 3: Prevalence and Problems Related to Use/Misuse/Abuse
The most common substances of misuse/abuse/dependence in older adulthood are (in order of prevalence): nicotine, alcohol, psychoactive prescription drugs, and illicit drugs. Research indicates a low level of illegal drug use among the current cohort of older adults.

Data drawn from the National Longitudinal Alcohol Epidemiologic Survey (NLAES) conducted by the National Institute of Alcohol Abuse and Alcoholism (NIAAA) showed changing trends (Korper & Council, 2002). NLAES was designed as a comprehensive survey of alcohol and other drug use, abuse, diagnosis, and treatment, and associated health conditions. A sample of 42,862 men and women aged 18 and older representative of the U.S. population were sampled in the contiguous United States and the District of Columbia, with greater than 90% response rate. Mean drinks/week are consistent with levels seen in other samples for similarly aged men and women, with the exception of the older ages, which were higher. Rates of alcohol abuse/dependence for both men and women are highest among young adults, dropping off substantially after age 64. For the Baby Boomer generation, these rates average about 8% for men and 3% for women. Rates for drug abuse/dependence are by far the highest among young adults, trailing off rapidly in older age cohorts. The rate of marijuana use for both men and women in the Baby Boomer cohort remains higher than for any other drug. Results from this large, population-based national dataset suggest that there have been and will likely continue to be substantial changes in the patterns of substance use and abuse over different age cohorts, particularly among those born after World War II, that will have a dramatic impact on the content, focus and delivery of specialized substance abuse prevention and interventions needed for adults in late life.

This, and other studies comparing cohorts indicates that, as the 'Baby Boom' cohort ages, the levels problems related to illegal drug use, as well as alcohol and prescription drugs, is expected to increase (Korper & Council, 2002), calling for newer, innovative strategies to approach these problems in older adulthood.

Slide 4: Graph of the Prevalence of drinking patterns in older adulthood (Fleming et al., 1999; Blow, CSAT, 1998)

Slide 5: Epidemiological Studies of at-risk, problem, and abusive drinking in adults age 60+ indicate the following:

- ~2-15% of older adults are at-risk drinkers, depending on definitions of at-risk or problem drinking (Fleming et al., 1999; Adams et al., 1995)
- Light/moderate drinkers maintain stable pattern (NIAAA, 1998a)
- Heavy drinkers tend to reduce or terminate drinking with age (Blow, CSAT, 1998)

Prevalence estimates of older problem drinking using community surveys have ranged from 1% to 15% (Gurland & Cross, 1982; Schukit & Pastor, 1978; Robins et al., 1984; Adams et al., 1996; Fleming et al., 1999). These rates vary widely depending on the definition of risk drinking or alcohol abuse/dependence, and the methodology used in obtaining samples. Overall, among clinical populations, estimates of alcohol abuse/dependence are substantially higher because problem drinkers of all ages are more likely to present in health care setting (Institute of Medicine, 1990).

Most research conducted on substance use and misuse in older adults has focused on alcohol misuse and abuse. The rates of illegal drug abuse in the current elderly cohort are very low (Blow, CSAT, 1998). Prescription drug misuse is a broad issue with multiple determinants, and causes and consequences. Most misuse can be treated without entry into specialized substance abuse treatment programs. The exception to this, psychoactive drug misuse and abuse, may need additional specialized treatment. Alcohol/medication interactions remain a significant concern for this age group (Blow, CSAT, 1998). However, it is important to note that problems related to alcohol use are the largest class of substance use problems seen in older adults today.

The majority of older adults who drink at risky levels have not been recognized as at-risk or problem drinkers by physical and mental health care personnel. Additionally, very few older patients with alcohol abuse or dependence seek help in specialized addiction treatment settings. Because older adults generally seek medical care on a more regular basis than younger adults, health care providers are crucial in identifying those older adults in their care who may need assistance with at-risk or problem drinking.

Slide 6: Graph of Lifetime Patterns of Use

The percent of older adults with no history of problems related to alcohol use that developed these problems after age 60 (often related to life stressors – e.g., change in health status, retirement, widowhood) is not well documented. Earlier literature indicated that approximately 1/3 of the older adults with problems related to their alcohol use had 'late-onset' problems. More recent studies have found the rates to be 10% or less. Careful

histories often reveal that individuals who are have at-risk or problem drinking in later life exhibit a number of patterns and degrees of problems related to their use in earlier life. The patterns of alcohol and medication/drug use misuse over the life span are complex and varied.

Slide 7: Aging, Drinking and Consequences
Older adults pose special concerns when developing alcohol consumption guidelines. Compared with younger people, older adults have an increased sensitivity to alcohol as well as over-the-counter and prescription medications. There is an age-related decrease in lean body mass versus total volume of fat, and the resultant decrease in total body volume increases the total distribution of alcohol and other mood-altering chemicals in the body. Liver enzymes that metabolize alcohol and certain other drugs are less efficient with age and central nervous system sensitivity increases with age. Of particular concern in this age group is the potential interaction of medication and alcohol. For some patients, any alcohol use, coupled with the use of specific over-the-counter or prescription medications, can be problematic. Because of the age-related changes in how alcohol is metabolized and the potential interactions between medications and alcohol, alcohol use recommendations for older adults are generally lower than those set for adults under age 65.

Slide 8: NIAAA Drinking Guidelines.
The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the CSAT Treatment Improvement Protocol (TIP) on older adults (Blow, CSAT, 1998; Dufour & Fuller, 1995; NIAAA, 1995) recommend that persons age 65 and older consume:

- no more than 1 standard drink*/day or 7 standard drinks/week
- no more than 2 standard drinks on any drinking day.
- the limit for women should be slightly less than 1 standard drink/day

The drinking limit recommendations for older adults have been shown to be consistent with data regarding the relationship between consumption and alcohol-related problems in this age group (Chermack et al., 1996). Recommendations are also consistent with the current evidence on the beneficial health effects of drinking (Poikolainen 1991; Doll et al., 1994; Klatsky et al., 1997).

Slide 9: Standard Drink Chart
In the U.S., a standard drink is the equivalent of the following: 12 ounce bottle of beer=4 ounce glass of wine=1½ ounces (a shot) of liquor (e.g., vodka, gin, whiskey)=4 ounces of liqueur.

Slide 10: Definitions
For the purposes of clarification, the following definitions are used in this module. The case studies used as examples are adapted from Barry & Blow, 1999.

Abstinence refers to drinking no alcohol in the previous year. Approximately 60-70% of older adults are abstinent. If an older patient is abstinent, it is useful to ascertain why alcohol is not used. Some individuals are abstinent because of a previous problem with alcohol.

Some are abstinent because of recent illness, while others have life-long patterns of low risk use or abstinence. Patients who have a history of alcohol problems may require preventive monitoring to determine if any new stresses could exacerbate an old pattern.

Low risk drinking is alcohol use that does not lead to problems. Older adults in this category drink within recommended drinking guidelines (NIAAA, 1995), are able to employ reasonable limits on alcohol consumption, and do not drink when driving a motor vehicle or boat, or when using contraindicated medications. NOTE: Low risk use of medications/drugs would include using medications following the physician's prescription. However, a careful check of the number and types of medications is important since medication interactions/reactions are not uncommon in older adults. These persons can benefit from preventive messages but may not need interventions (Barry et al., 2001).

Use that increases the chances that a person will develop problems and complications is ***at-risk use***. Persons over 65 who drink more than 7 drinks/week – one per day - are in the at-risk use category. Although they may not **currently** have a health, social, or emotional problem caused by alcohol, they may experience family and social problems and, if this drinking pattern continues over time, health problems could be exacerbated. Additionally, individuals who are using medications that interact with alcohol can be at-risk for problems with any alcohol use. Brief interventions are useful for older adults in this group as a prevention/early intervention measure.

Older adults engaging in ***problem use*** are consuming alcohol or medications/drugs at levels that have already resulted in adverse medical, psychological, or social consequences. Potential consequences can include injuries, medication interaction problems, and family problems, among others. It is important to reiterate that some older adults who drink even small amounts of alcohol can experience alcohol-related problems. Quantity and frequency of alcohol use may not be the first determinant of the usefulness of intervening. The presence of consequences also drives the need for intervening.

Alcohol or drug medication dependence refers to a medical disorder characterized by loss of control, preoccupation with alcohol or drugs, continued use despite adverse consequences, and physiological symptoms such as tolerance and withdrawal (American Psychiatric Association, 1994). Formal specialized treatment is generally used with persons who meet criteria for alcohol abuse or dependence and cannot discontinue drinking with a brief intervention protocol. Nonetheless, pre-treatment strategies are also appropriate for this highest problem severity population. Brief interventions have been recommended by the Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol (TIP) on Brief Interventions and Brief Therapies for use either as a pre-treatment strategy to assist individuals on waiting lists for formalized treatment programs, for some patients who meet abuse or dependence criteria with no physical dependence or withdrawal, or an adjunct to specialized treatment to assist with specific issues (e.g., completing homework for treatment groups, attendance at work, adherence to the treatment plan) (Barry, CSAT, 1999).

Slide 11: Issues Unique to Older Adults
Research has suggested that elderly individuals have unique drinking patterns and alcohol-related consequences, social issues, and treatment needs (Atkinson, 1995). Because of this, early identification and secondary prevention of alcohol problems in late life are likely to require elder-specific approaches. Older adults present challenges in applying brief intervention strategies for reducing alcohol consumption. Because drinking guidelines are lower for older adults and because of historical and cultural factors that lead to feelings of disgrace, older adult problem drinkers find it particularly difficult to identify their own risky drinking. In addition, chronic medical conditions may make it more difficult for clinicians to recognize the role of alcohol in decreased functioning and quality of life. These issues present barriers to conducting effective brief interventions for this vulnerable population. The issues listed in this slide are commonly faced by older adults. It is important to remember that these factors, individually or in combination, are not necessarily related to alcohol problem but, if other signs and symptoms are present, should be considered when screening for use/misuse.

Slide 12: Alcohol Dependence in Older Adulthood
Rates of alcoholism appear to decline with age. Drinking patterns that do not meet traditional abuse definitions can lead to higher BAC, chronic illness, poor nutrition and poly-pharmacy in older patients. Therefore, DSM-IV criteria are not always the best guide for diagnosing alcohol problems in older adults. Many older adults who are experiencing problems related to alcohol and/or medication misuse do not meet criteria for abuse/dependence using standardized criteria (Blow, CSAT, 1998).

Slide 13 – Alcohol Dependence in Older Adulthood (continued)
If past reliance on alcohol to resolve problems exists, then loss of spouse, occupational and role status, and poor social supports can make older adults more vulnerable to misuse. In this age cohort, there is less use of illicit drugs and more unintentional misuse of drugs due to memory loss or misunderstanding of dosing instructions. These factors need to be taken into consideration when determining treatment options.

Slide 14 – Alcohol Misuse Among Older Women
Older women may be at slightly greater risk for later onset alcohol problems than older men related to potential loneliness and depression from outliving a spouse and/or friends, and other losses associated with aging. Due to how women metabolize alcohol, women are physiologically at greater risk for problems related to lower levels of use at any age and particularly as they age. Brief intervention strategies have been found to be particularly useful in helping women to consider reducing or stopping drinking (Blow & Barry, 2002; Fleming et al., 1999).

Slide 15 – Potential Comorbidities with Alcohol Use
The medical and emotional consequences of heavy alcohol consumption have been well chronicled in most mental health texts. However, there is emerging evidence of the medical risks of moderate alcohol use among older adults. Moderate alcohol consumption has been demonstrated to increase the risk of strokes caused by bleeding, although it decreases the risk of strokes caused by blocked blood vessels (Hansagi et al., 1995). Moderate alcohol use has

also been demonstrated to impair driving-related skills even at low levels of consumption and it may lead to other injuries such as falls (Kivela et al., 1989). Of particular importance to the elderly is the potential interaction between alcohol and both prescribed and over-the-counter medications, especially psychoactive medications such as benzodiazepines, barbiturates and antidepressants. Alcohol is also known to interfere with the metabolism of medications such as digoxin and warfarin (Adams, 1995; Fraser, 1997; Hylek et al., 1998).

Although the impact of excessive alcohol use on Activities of Daily Living (ADL's) is not fully understood, several studies have demonstrated a relationship between alcohol use and functional abilities especially among older subjects. In a recent study by Ensrud and colleagues, a former history of alcohol use had an odds ratio of 2.2 in predicting impairment in ADL's among older women (Ensrud et al., 1994). Alcohol use was more strongly correlated with impairment than smoking, age, use of anxiolytics, stroke, or lower grip strength.

It is important to note that, in contrast to this finding, several authors have demonstrated that among older community dwelling persons moderate alcohol use is associated with fewer falls, greater mobility and improved physical functioning when compared to a comparison group of non-drinkers (Nelson et al., 1992; 1994; LaCroix et al., 1993; O'Loughlin et al., 1993). These studies did not include many heavy drinkers or subjects with alcohol use disorders. There also have been studies suggesting that alcohol consumption in older persons may exhibit a protective effect in moderate doses (Scherr et al., 1992). For a more complete discussion of both the protective and detrimental effects of alcohol use in aging, see the SAMHSA/CSAT Treatment Improvement Protocol (TIP) #26, Substance Abuse in Older Adults (Blow, CSAT, 1998).

Epidemiologic studies have clearly demonstrated that comorbidity between alcohol use and psychiatric symptoms is common in younger age groups. Less is known about comorbidity between alcohol use and psychiatric illness in late life. A few studies do indicate that dual diagnosis with alcoholism is an important concern among elderly individuals (Finlayson et al., 1988; Blow et al., 1992a; Blazer & Williams, 1980; Saunders et al., 1991; Oslin et al., 2000). Comorbid depressive symptoms are not only common in late life but are also an important factor in the course and prognosis of psychiatric disorders. Depressed persons who are alcohol dependent have been shown to have a more complicated clinical course of depression with an increased risk of suicide and more social dysfunction than non-depressed alcoholics (Cook et al., 1991; Conwell, 1991). Moreover, they were shown to seek more treatment. However, relapse rates for alcoholics did not appear to be influenced by the presence of depression. Alcohol use prior to late life has also been shown to influence treatment of late life depression. Cook and colleagues found that a prior history of alcohol abuse predicted a more severe and chronic course for depression (Cook et al., 1991).

The relationship between alcohol use and dementing illnesses such as Alzheimer's Disease is complex. Alcohol-related dementia may be difficult to differentiate from Alzheimer's Disease. Determining whether alcohol use, especially heavy use, influences Alzheimer's Disease requires autopsy studies that can establish neuropathologic diagnoses of Alzheimer's Disease. Although the rates of alcohol-related dementia in late life differ according to

diagnostic criteria used and the nature of the population studied, there is a consensus that alcohol contributes significantly to the acquired cognitive deficits of late life. Among subjects over the age of 55 evaluated in the ECA study, the prevalence of a lifetime history of alcohol abuse or dependence was 1.5 times greater among persons with mild and severe cognitive impairment than those with no cognitive impairment (George et al., 1991).

Sleep disorders and sleep disturbances represent another group of comorbid disorders associated with excessive alcohol use. Alcohol causes well-established changes in sleep patterns such as decreased sleep latency, decreased stage IV sleep, and precipitation or aggravation of sleep apnea (Wagman et al., 1997). There are also age-associated changes in sleep patterns including increased REM episodes, a decrease in REM length, a decrease in stage III and IV sleep, and increased awakenings. The age-associated changes in sleep can all be worsened by alcohol use and depression.

Co-morbidities are a serious, but common, concern when working with older adults. It is useful to keep potential comorbid factors in mind when conducting health screening with older adults to determine if the use/misuse of alcohol and other medications is an exacerbating factor in symptomotology.

Slides 16-18: Psychoactive Medications with Significant Alcohol Interactions
These slides list **psychoactive medications** with significant alcohol interactions. The chart includes angiolytic benzodiazepines and sedative/hypnotic benzodiazepines.

Older adults use a high number of prescription and over-the-counter medications, which increases their risk for inappropriate use of medications. In contrast to younger substance abusers who most often abuse illicit drugs, substance abuse problems among elderly individuals more typically occur from misuse of over-the-counter and prescription drugs. Overuse, underuse, or irregular use of either prescription or over-the-counter drugs are all forms of drug misuse. In its extreme form, misuse may become drug abuse (Patterson & Jeste, 1999; Ellor & Kurz, 1982). Studies report that older persons regularly consume on average between two and six prescription medications and between one to three over-the-counter medications (Larsen & Martin, 1999). Combined difficulties with alcohol and medication misuse may affect up to 19% of older Americans (Bucholz et al., 1995; D'Archangelo, 1993; NIAAA, 1998a, 1998b). Factors such as previous or coexisting drug, alcohol, or mental health problems, old age, and being of the female gender also increase vulnerability for misusing prescribed medications (Finlayson, 1995a, 1995b; Finlayson & Davis, 1994; Cooperstick & Parnell, 1982; Sheahan et al., 1989).

Slide 19: Identification, Screening and Assessment Recommendations for Older Adults
The SAMHSA/CSAT TIP #26 expert panel (Blow, CSAT, 1998) recommended that providers screen all patients age 60 and older for alcohol and prescription drug use/misuse/abuse as part of regular physical examination (yearly) and that the patient be screened or re-screened if certain physical symptoms (see Slide 20) are present or if the older person is undergoing major life changes or transitions. It is important to ask direct questions about concerns and is useful to preface questions with link to medical conditions or health

concerns. Recommendations include using a motivational, nonjudgmental approach that avoids using stigmatizing terms (e.g., alcoholic).

The goals of screening are: 1) to identify at-risk drinkers, problem drinkers, or persons with alcohol dependence; and/or 2) to determine the need for further assessment. The rationale for screening for alcohol problems is that there is a high enough incidence to justify the cost, alcohol can adversely affect morbidity and mortality, there are effective treatments available, and there are valid, cost-effective methods for screening.

Generally, providers can obtain more accurate histories by asking questions about the recent past; embedding the alcohol use questions in the context of other health behaviors (i.e. exercise, weight, smoking, alcohol use); and paying attention to nonverbal cues that suggest the patient is minimizing use (i.e. blushing, turning away, fidgeting, looking at the floor, change in breathing pattern). The "**brown bag approach**" is often recommended to determine medication use.

Brown bag approach:
Ask the patient to bring in all prescribed and over-the-counter medications, as well as any herbal remedies they are currently taking in a 'brown paper bag'. This will provide the opportunity to assess the numbers of medications, the number of prescribing providers working with the patient, and if discussions with other health care providers regarding any medication concerns would be helpful at this point.

Alcohol screening questions can be asked by verbal interview, by paper-and-pencil questionnaire, or by computerized questionnaire. All three methods are reliable and valid (Greist et al., 1987; Barry & Fleming, 1990). Any positive responses can lead to further questions about consequences. To successfully incorporate alcohol (and other drug) screening into clinical practice with older adults, it should be simple and consistent with other screening procedures already in place (SAMHSA, CSAT, 1998).

Slide 20: Signs and Symptoms of Potential Alcohol Problems in Older Adults
These signs and symptoms are not uncommonly observed when working with older adults and may not be related to alcohol/medication misuse, but may be related to other problems seen in later life. However, it is more typical for practitioners and family members to attribute these signs and symptoms to normal aging or other health conditions when they may be related to alcohol or medication misuse. They are included here for consideration as part of any differential diagnoses.

Slide 21: Screening Instruments and Assessment Tools (see Appendix II for examples)
The most common alcohol screening questions include: 1) alcohol consumption (quantity, frequency, binge drinking); and 2) alcohol consequences. Some of the instruments that have been used with older adults are in a 'stand alone' format focusing exclusively on alcohol use (ex: Alcohol Use Disorders Identification Test (AUDIT); Michigan Alcoholism Screening Test-Geriatric version (MAST-G) (Blow et al., 1992b); CAGE (acronym for a 4-item screener: Have you felt you should '**C**ut down? Have you felt **G**uilty about your drinking? Have you been **A**nnoyed by others concerns about your drinking? Have you needed a drink

when you first get up the morning [**E**ye-opener]?). The MAST-G is a validated elder-specific screening instrument that targets consequences. The Health Screening Survey (HSS) includes quantity/frequency, binge, CAGE, and perceptions of a past or present problem with alcohol (Fleming & Barry, 1991). This scale imbeds alcohol questions in a health context with three other health behaviors -- exercise, nutrition, and smoking.

Screening for alcohol use and problems is not always standardized and not all standardized instruments have good reliability and validity with older adults. This module contains examples of questionnaires that have validity and reliability when used with older adults -- the Short Michigan Alcoholism Screening Test - Geriatric Version (SMAST-G) (Blow et al., 1998) (below), and quantity/frequency questions imbedded in a Health Screening Survey (HSS) (Fleming & Barry, 1991). Both of these instruments have been widely used and tested with older adults. The CAGE, a widely used alcohol screening test, does not have high validity with older adults (Adams et al., 1996) and, if used, should be part of a larger questionnaire (e.g., the HSS) or interview that includes quantity/frequency questions, and questions about consequences.

Slide 22: Graph of the Spectrum of Interventions for Older Adults
There is a spectrum of prevention-intervention-treatment strategies for older adults that include: 1) prevention/education; 2) brief advice; 3) brief interventions; 4) pre-treatment interventions; and 5) formal specialized treatment. Each of these strategies has its place in working with older adults with problems related to alcohol/medication misuse/abuse/ dependence. More than one strategy may be applied to any one individual. For example, an individual who is currently abstinent (but has had problems related to alcohol at mid-life) may benefit from prevention/education to encourage continued abstinence. If this patient starts consuming alcohol again at some point in the future, brief interventions and even formal treatment may be needed. The process can repeat over time. It is important for providers to stay flexible in their approach. Knowledge and skills can allow a clinical response based on the needs of the patient at any point in time. A nonconfrontational, flexible approach provides the widest array of options when working with this vulnerable patient group.

Slide 23: Brief Intervention (BI) Definitions
The SAMHSA/CSAT Treatment Improvement Protocol # 34, Brief Interventions and Brief Treatments for Substance Abuse (Barry, CSAT, 1999) defined brief interventions as time limited (5 minute to 5 brief sessions) targeting a specific health behavior (e.g., at-risk drinking). The goals of a brief alcohol intervention are to: a) reduce alcohol consumption; or b) facilitate discontinuing use and/or entering specialized treatment. Interventions rely on the use of screening instruments to help to specify the level of use and consequences to determine intervention strategy.

Slide 24: Empirical Support for BI with Older Adults
Brief interventions have empirical support for efficacy and effectiveness in younger and older adults. Studies of brief interventions for alcohol problems have employed various approaches to change drinking behaviors. Strategies have ranged from relatively unstructured counseling and feedback to more formal structured therapy (Kristenson et al.,

1983; Chick et al., 1985; Persson & Magnusson, 1989; Fleming et al., 1997), and have relied heavily on concepts and techniques from the behavioral self-control training (BSCT) literature (Miller & Taylor, 1980; Miller & Hester, 1986; Miller & Munoz, 1976; Miller & Rollnick, 1991). A number of brief alcohol intervention studies have been conducted in primary care settings with younger adults (e.g., Kristenson et al., 1983; Chick et al., 1985; Persson & Magnusson, 1989; Fleming et al., 1997), with primarily positive results. Both brief interventions and brief therapies have been shown to be effective in a range of clinical settings (Barry, CSAT, 1999). Brief alcohol interventions have particular usefulness with older adults (Fleming et al., 1999; Blow, CSAT, 1998).

To date, there have been two brief alcohol intervention trials with older adults. Fleming and colleagues (1999) and Blow and colleagues (Blow & Barry, 2002; Blow et al., in preparation) have conducted randomized clinical brief intervention trials to reduce hazardous drinking with older adults using advice protocols in primary care settings. These studies have shown that older adults can be engaged in brief intervention protocols, the protocols are acceptable in this population, and there is a substantial reduction in drinking among the at-risk drinkers receiving the interventions compared to a control group.

The first, Project GOAL: Guiding Older Adult Lifestyles (Fleming et al., 1999) was a randomized, controlled clinical trial conducted in Wisconsin with 24 community-based primary care practices (43 practitioners) located in ten counties. Of the 6,073 patients screened for problem drinking, 105 males and 53 females met inclusion criteria (N=158) and were randomized into a control (n=71) or intervention group (n=87). One hundred forty-six subjects participated in the 12-month follow-up procedures. The intervention consisted of two, 10-15 minute, physician-delivered counseling visits that included advice, education, and contracting using a scripted workbook. No significant differences were found between groups at baseline on alcohol use, age, SES, smoking status, rates of depression or anxiety, frequency of conduct disorders, lifetime drug use, or health care utilization. A baseline, both groups consumed an average of 15-16 drinks/week. At 12-month follow-up, the intervention group drank significantly less than the control group ($p<.001$).

The second, larger elder-specific study, the Health Profile Project, was completed in primary care settings located in Southeast Michigan (Blow et al., in preparation). The elder-specific intervention contained both brief advice discussion by either a psychologist or social worker, as used in the WHO studies, and motivational interviewing techniques (Miller & Rollnick, 1991), including feedback. A total of 452 subjects were randomized in this trial, with over 26% African American. Follow-up rates of 92% were obtained at the 12-month follow-up. The Blow et al. study found preliminary results similar to the Fleming et al. (1999) in terms of 7-day alcohol use and binge drinking at 12-month follow-up. These randomized controlled clinical trials extend the positive results of trials with younger at-risk drinkers to even more vulnerable populations of older adults.

Slide 25: Key Components of Alcohol Brief Interventions

The essential components of alcohol brief interventions include: 1) screening; 2) feedback on the screening results; 3) a motivational approach to facilitate change; 4) the use of strategies for change; 5) a negotiated behavioral agreement ('contract'); and 6) follow-up.

Slides 26 and 27: Steps in a Brief Alcohol Intervention for Older Adults

Brief alcohol interventions can be conducted using guidelines and steps (Barry et al., 2001) adapted from work by Cutler, Wallace and Haines (Wallace et al., 1988); and Fleming and colleagues (Fleming et al., 1997). The brief alcohol intervention is designed for use in busy clinical settings. Auxiliary issues included in the brief alcohol intervention for older adults vary based on individual patient issues and the time available for the intervention. Brief alcohol screening and intervention techniques can be particularly useful with older adults who are at-risk and problem drinkers.

Brief Alcohol Intervention Components with Older Adults

Following identification of at-risk or problem drinkers through screening techniques a semi-structured brief intervention can be conducted. The content of the intervention needs to be elder-specific and includes the following steps:

1. *Identification of future goals for health, activities, hobbies, relationships, and financial stability.*
2. *Customized feedback on screening questions relating to drinking patterns and other health habits* (may also include smoking, nutrition, tobacco use, etc.).
3. *Discussion of types of older drinkers in the population, where the patient's drinking patterns fits into the population norms for their age group, and definitions of standard drinks* (one standard drink=12 oz. Beer or ale; 1.5 oz. shot of distilled spirits; 4-5 oz. wine; 4 oz. sherry; 4 oz. liqueur).
4. *Pros and cons of drinking.* This is particularly important because the practitioner needs to understand the role of alcohol in the context of the older patient's life including coping with loss and loneliness.
5. *Consequences of heavier drinking.* Some older patients may experience problems in physical, psychological, or social functioning even though they are drinking below cut-off levels.
6. *Reasons to cut down or quit drinking.* Maintaining independence, physical health, and mental capacity can be key motivators in this age group.
7. *Sensible drinking limits and strategies for cutting down or quitting.* Strategies that are useful in this age group include developing social opportunities that do not involve alcohol, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.
8. *Drinking agreement.* Agreed upon drinking limits that are signed by the patient and the practitioner are particularly effective in changing drinking patterns.
9. *Coping with risky situations.* Social isolation, boredom, and negative family interactions can present special problems in this age group.
10. *Summary of the session.*

Brief intervention protocols often use a workbook containing the steps listed above (1-10). Workbooks provide opportunities for the patient and practitioner to discuss sections on drinking cues, reasons for drinking, reasons to cut down or quit, a drinking agreement in the form of a prescription, and drinking diary cards for self-monitoring. Providers can be easily trained to administer the intervention protocol through role-playing and general skills

training techniques in educational programs. As discussed earlier, this approach is non-confrontational and generally follows motivational interviewing principles as described by Miller and Rollnick (1991).

Slide 28: Barriers to Seeking Alcohol Treatment for Older Adults
For older adults who are in need of formal specialized alcohol abuse/dependence treatment, there are a number of barriers to seeking assistance from their providers and other professionals to help them with these problems. They include:

- ⊠ Resistance to asking for help
- ⊠ Disdain of labels and feelings of stigma (e.g., alcoholic, old)
- ⊠ Lack of transportation
- ⊠ No significant others to assist in motivation to seek help
- ⊠ Providers less likely to refer older adults
- ⊠ Gaps in substance abuse, aging, and mental health services

Working with staff and family members (if appropriate) to help patients deal with these barriers will improve the potential for positive outcomes from any specialized treatment programs.

Older patients are often reluctant to enter a hospital or residential treatment center because they are concerned about leaving their homes unprotected or about making arrangements for their stay. Some older patients may be reluctant to turn to "outsiders" for help. Inpatient treatment is preferred when the patient is suffering the effects of poor nutrition, poor overall health status, a history of DT's or seizures, or cognitive problems. Inpatient treatment is also needed when there are no obvious community support systems for the patient (i.e., family, caretakers, services for aging). In the U.S. there are a very few alcohol and drug treatment programs that have specialized services for older adults (Blow, CSAT, 1998).

Although alcohol abuse/dependence is a significant and growing health problem in the United States (Council on Scientific Affairs, AMA, 1996), there have been few systematic studies of formal alcoholism treatment outcome among older adults (Atkinson, 1995). The study of treatment outcomes for older adults who meet criteria for alcohol abuse/dependence has become a critical issue because of their unique needs for targeted treatment intervention. Because traditional alcoholism treatment programs generally provide services to few older adults, sample size issues have been a barrier to studying treatment outcomes for older adults in formalized treatment. The development of elder-specific alcoholism treatment programs in recent years has provided sufficiently large numbers of older adults with alcohol abuse/dependence to begin to facilitate studies of this special population (Atkinson, 1995). A remaining limitation with this population is the lack of longitudinal studies of treatment outcomes. More work needs to be done in this area to determine if elder-specific treatment is effective and if older clients in an elder-specific program show better outcomes than older clients in a mixed age program.

Slide 29-31: Age-Specific Treatment Elements
All treatment approaches for older patients need a strong social support component. Group

socialization experiences can help the patient overcome some of the isolation often accompanying alcohol problems in this age group. Social intervention appears to benefit both early and late onset disorders. In some communities, Alcoholics Anonymous has special meetings appropriate to older adults. Older patients tend to be more faithful than younger patients in attending support group meetings and in completing specialized treatment programs. They, however, tend to be uncomfortable with the high noise level, rough language, and cigarette smoke in larger groups. Hearing and visual impairment affect the types of specialized and self-help groups that provide the most comfort.

There are a number of elements listed in slides 29-31 that improve the potential for specialized substance abuse treatment programs to show positive results with older adults.

Slide 32: Summary

- Screening for alcohol use/misuse/abuse in the context of health issues is effective
- Brief alcohol interventions are effective
- Brief interventions are one of a spectrum of approaches for use with older adults
- The approach used depended on the individual client background, needs, and resources available
- Older adults can benefit from a nonjudgmental, motivational, supportive approach to screening, prevention/intervention, referral, and treatment
- Treatment is available and works!

Slide 33: Case Studies and Role Play (see Appendix IV for Case Studies)

Participants should break up into pairs and receive the following case studies. Each participant should have a turn acting the patient while the other role plays the practitioner. Participants should practice discussing alcohol use with the patient, evaluating the risk level of drinking behaviors, and developing a brief intervention agreement with the patient if appropriate.

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Appendices

I. Core Competencies for Health Providers in the Care of Older Adults with Problems Related to Substance Use/Misuse/Abuse
II. Screening Instruments: Examples for Older Adults
III. Resources
IV. Case Studies and Role Play

APPENDIX I

Recommendations: Core Competencies for Health Providers in the Care of Older Adults with Problems Related to Substance Use/Misuse/Abuse

These competencies are presented as a specific guide to the core knowledge, attitudes and skills that are essential to meeting the needs of older adults who have problems related to their use/misuse/abuse of alcohol/medications/drugs.

Recommendations

The following recommendations are divided into four critical areas: 1) recognition and assessment; 2) initial management and referral; 3) specialized management; and 4) acute treatment and rehabilitation. Recommendations in these areas can assist in the development of educational and certification programs that would enhance prevention and treatment efforts with older adults seeking health care who are at-risk for or currently have substance use problems. These recommendations are focused on core competencies that individual clinicians and providers should possess.

Recognition and Assessment

1. **All clinicians should be knowledgeable in assessing the quantity and frequency of alcohol and other drug use among older adult patients. This includes knowledge about standard drinks.**

   Rationale

   Approximately 8-15% of older adults (Adams et al., 1996) are at-risk drinkers or drink at relatively low levels that compromise cognitive or medical conditions. Additionally, some older adults also use prescription and over-the-counter medications that may have a negative impact on their physical and mental health functioning. Clinicians who work with older adults need to systematically address alcohol and medication/drug use as part of routine clinical care. Very few clinicians are trained in alcohol and drug screening techniques that are most effective with older adults.

   Actions Required

   1) increase preclinical and clinical training regarding the available alcohol screening instruments, methods to determine other medication and drug use (including OTC medications and herbal agents), techniques for conducting screening, and techniques to incorporate structured screening for alcohol, medications, and illicit drugs into standard clinical practice
   2) increase substance use screening questions in evaluation and test materials for preclinical and clinical training

Responsible Agents
American Medical Association; American Society of Addiction Medicine; American Psychiatric Association; American Psychological Association; Medical Schools, other allied health professional schools (Department of Psychology, Social Work, Nursing, Pharmacy) curriculum committees

Expected Outcomes
1) increased training and knowledge about alcohol and medication/drug screening techniques to determine frequency and quantity of use
2) increased screening of older adults for problems related to substance use in clinical settings

2. **All clinicians should be knowledgeable about the recommended upper limits of moderate drinking for all age groups.**

Rationale
The NIAAA (1995) guidelines for alcohol consumption are not generally part of preclinical curriculum or clinical training (internship, residency, practicums, CMEs, CEs). There has been even less training focused on issues of alcohol consumption and drinking guidelines for older adults. In order to determine if older adults are at-risk for problems related to alcohol use and if they use medications or drugs that may interact with alcohol, up-to-date guidelines and research evidence should be included in training.

Action Required
1) develop preclinical and clinical training content regarding alcohol use guidelines for all age groups, with specific reference to national consensus guidelines for alcohol use, misuse of prescription and nonprescription drugs, and alcohol/medication interactions common to people in later life

Responsible Agents
American Medical Association; American Society of Addiction Medicine; American Psychiatric Association; American Psychological Association; Medical Schools, other allied health professional schools (Department of Psychology, Social Work, Nursing, Pharmacy) curriculum committees

Expected Outcomes
1) increased training and knowledge about alcohol, medication, and drug guidelines
2) increased use of guidelines in screening older adults for problems substance use in clinical settings

3. **All clinicians working with older adults should have comprehensive knowledge of the physical, emotional and social problems associated with alcohol use and abuse, misuse of medications, and alcohol/medication interactions among older patients.**

Rationale

Because older adults may present with complex signs and symptoms of physical, cognitive, mental health, or social problems, it is important to determine if any of these are related to or exacerbated by alcohol or misuse of medications or drugs. These are differential diagnoses that are important in determining treatment plans but are often missed because clinicians may have limited training and experience around issues of substance use in older adulthood.

Action Required

1) incorporate preclinical and clinical training regarding the physical, emotional and social problems associated with substance use and abuse (including alcohol, prescription and nonprescription medications, and illicit drugs) among aging patients
2) funds for any additional training should be under the control of the professional programs incorporating the training (Medical Schools, Residencies, other allied health professional school programs)
3) programs should include case studies, clinical practice opportunities, and didactic materials on best practices to ensure that clinicians are comfortable making differential diagnoses regarding the role of substance use in presenting physical and mental health problems.

Responsible Agents

American Medical Association; American Society of Addiction Medicine; American Psychiatric Association; American Psychological Association; Medical Schools, other allied health professional schools (Department of Psychology, Social Work, Nursing, Pharmacy) curriculum committees

Expected Outcomes

1) increased training and knowledge about physical, emotional, and social problems associated with substance use in this age group
2) increased recognition and detection of substance use problems in older adults presenting with physical and mental health problems.

Initial management and referral

4. **All clinicians should be comfortable providing structured and targeted brief advice/interventions to assist older adults in cutting down or eliminating alcohol use. Advice and brief interventions can be delivered as part of early detection programs in clinical settings.**

Rationale

Approximately 15% of older adults may be at-risk drinkers or drink at lower levels that can still compromise cognitive or medical conditions. Brief alcohol interventions have been proven to be effective with older adults. They require short, concentrated training that includes motivational interviewing and structured materials to assist in the interventions. Materials are available nationally through the National Institute of Alcoholism and Alcohol Abuse and through the Center for Substance Abuse Treatment in

the Treatment Improvement Protocol Series (#26, #34). Training can be made available to professionals who work with older adults through preclinical and clinical education programs, continuing education credits, and other workshop opportunities. These are needed because, in a changing health care delivery system, brief, effective methods to deal with alcohol problems will be both clinically and cost effective. There are few preclinical and clinical programs that currently include techniques of brief alcohol interventions.

Action Required

1) develop preclinical and clinical brief alcohol intervention training materials for clinicians who work in a variety of mental and physical health care settings with older adults

Responsible Agents

American Medical Association; American Society of Addiction Medicine; American Psychiatric Association; American Psychological Association; Medical Schools, other allied health professional schools (Department of Psychology, Social Work, Nursing, Pharmacy) curriculum committees

Expected Outcomes

1) increased training and knowledge about brief alcohol advice and intervention techniques targeting older adults
2) increased use of brief advice methods by providers who work with older adults
3) better prevention/early intervention programs should lead to longer term health care cost savings

Specialized Management

5. All clinicians providing detoxification treatments to older adults should be knowledgeable about common medical and psychiatric conditions that complicate or are complicated by alcohol withdrawal. All clinics or health care systems that provide detoxification services should make available adequate provisions for servicing older adults who have acute and chronic medical conditions.

Rationale

Because older adults metabolize alcohol and medications differently than younger individuals, and because of increased vulnerabilities to the negative consequences of acute withdrawal, providers need comprehensive knowledge of guidelines for managing alcohol detoxification in older adults. The dangers of alcohol detoxification for elderly individuals are further exacerbated by previous withdrawal episodes. The combination of complex, chronic medical conditions and the use of multiple medications by older adults who are at risk for withdrawal requires protocols on alcohol withdrawal in the array of clinical settings commonly providing detoxification services. A number of medical centers have developed withdrawal regimens, including the appropriate use of benzodiazepines, for use with younger adults. There are recently published empirical

studies that have resulted in practice guidelines for managing alcohol detoxification and withdrawal for older adults that should be incorporated into detoxification services.

Specific core competencies (see Appendix I) for working with withdrawal in older adults include the management of chronic medical conditions common in late life, management of patients with mild to moderate dementia, and knowledge regarding the increased potential for adverse medication effects or the potential for drug interactions when using benzodiazepines with other psychoactive medications.

Action Required

1) disseminate preclinical and clinical training materials to providers on best practices for identifying older individuals who are at risk for alcohol withdrawal
2) disseminate training materials on clinical management algorithms for the inpatient or outpatient medical detoxification of older heavy drinkers, including assessment of withdrawal severity, recommendations on prescribing short-acting benzodiazepines, and monitoring progress through the withdrawal phase
3) establish detoxification guidelines and medical management guidelines for use with older adults in settings providing detoxification services.

Responsible Agents

American Medical Association; American Society of Addiction Medicine; American Psychiatric Association; Medical Schools, other allied health professional schools (Nursing, Pharmacy) curriculum committees, medical centers, regulatory agencies (State Substance Abuse Service Agencies)

Expected Outcomes

1) increased training and knowledge on alcohol withdrawal in older adults
2) increased appropriate use of medications for the management of withdrawal
3) improved outcomes for older heavy drinkers experiencing withdrawal symptoms
4) increased use of best practice guidelines for alcohol withdrawal and improved medical management of older adults in settings that provide detoxification services

Acute treatment and rehabilitation

6. **Specialty care providers (geriatricians, addiction specialist, geriatric mental health providers) should develop skills in the initial management and treatment of older adult patients with at-risk use, problem use, or substance abuse/dependence.**

Rationale

The training of addiction specialists has focused primarily on issues related to younger adults. Geriatricians and geriatric mental health providers generally have received little training on substance abuse issues. Providers in both specialties need cross training to meet the growing needs of older adults with substance use problems. Because of the range of older patients in need of substance abuse services, providers who have training in geriatric care or addiction specialties need to develop skills in the initial management of older adults with substance use problems. Knowledge and skills include motivational

approaches, least intensive treatment options, initiation of withdrawal protocols (see above), treatment engagement techniques, and treatment objectives and approaches.

Action Required

1) incorporate clinical postgraduate training materials for specialty providers on best practices for the initial management of substance use problems in older adults, including motivational enhancement approaches, detoxification, and treatment engagement
2) incorporate clinical training on stabilizing and resolving medical and psychiatric comorbidities

Responsible Agents

American Medical Association; American Society of Addiction Medicine; American Psychiatric Association, American Geriatrics Society, regulatory agencies (State Substance Abuse Service Agencies)

Expected Outcomes

1) increased training and knowledge in geriatric and addiction on the initial management of substance use problems in older adults
2) improved outcomes for older adults with substance use problems in specialty settings
3) increased use of best practice guidelines for the initial management of substance use problems in older adults in specialty settings

7. **Specialty care providers (addiction specialists and geriatric mental health providers) should develop skills in the psychosocial and pharmacological interventions demonstrated to be efficacious in the treatment of older adults with substance use problems.**

Rationale

There is empirical evidence that pychosocial and pharmacological interventions have efficacy for a range of substance use problems in older adults. Specialty geriatric providers often receive little training in pharmacological substance use interventions. Addiction specialists may not receive training in early psychosocial intervention techniques. Both groups need training in these issues in order to work effectively with the growing number of older adults with substance use problems.

Action Required

1) incorporate clinical postgraduate training materials for specialty providers on best practices for psychosocial interventions including brief intervention techniques, cognitive behavioral approaches, group- and individual-based approaches, medical/psychiatric and pharmacological approaches, and aftercare
2) training in treatment objectives that are optimally effective for older substance abusers
3) training in consensus best practices for treatment of substance abuse problems in older adults

Responsible Agents
American Medical Association; American Society of Addiction Medicine; American Psychiatric Association, American Geriatrics Society, regulatory agencies (State Substance Abuse Service Agencies)

Expected Outcomes
1) increased training and knowledge for geriatric and addiction providers in pharmacological and psychosocial approaches to substance use problems in older adults
2) improved outcomes for older adults with substance use problems in specialty settings
3) increased use of best practice guidelines for substance use problems in older adults treated in specialty settings

The above recommendations stem from research that demonstrates the efficacy of treatment and the reduction in morbidity and mortality associated with reductions in alcohol and drug use among older adults. The focus of the above recommendations are educational in nature and implementation of these recommendations should follow the educational structure currently in place for the wide variety of providers affected by these recommendations. The traditional methods of education include the formal training received in graduate and post-graduate work, the voluntary and/or required need for continuing education and voluntary and informal educational formats such as readings, tutorials, seminars, etc. A parallel process of certification and accreditation exists in some of the fields of medical education that can be used to gauge the effectiveness of the recommendations and education programs.

While the above recommendations are clear and relatively straightforward, incorporating these recommendations into existing educational programs can be difficult. The difficulties lie in the diversity of providers that are affected as well as the diversity of medical specialties affected. From a policy perspective, there have been no centralized voice or authority to maintain and implement a core set of recommendations focused on late life substance use. Despite the lack of a coordinated effort, there are organizations both federal and guild that have recognized the need for and have implemented similar recommendations in their respective guidelines or regulatory requirements. Some of these organizations include the American Medical Association, the American Board of Psychiatry and Neurology, the America Psychiatry Association, the Center for Substance Abuse Prevention, the American Academy of Addiction Psychiatry, the Department of Veterans Affairs, and the American Society of Addiction Medicine. However, while there are similarities in the documents produced, many of these statements are outdated and there are some conflicting recommendations between the guidelines. For instance, the focus of many of the documents from subspecialty organizations is on persons who meet criteria for alcohol dependence with a strong endorsement of specialty provider care. This potentially ignores issues of prevention and hazardous or problematic drinking as well as the role of primary care providers and non-addiction health providers.

Separate and distinct from the clinician-level recommendations that are outlined above, is the need for policy level leadership to serve as a resource for developing educational programs for substance use that span all age groups and all levels of providers. All too often, clinical

issues such as late life substance use problems serve more to highlight administrative and policy differences and the lack of cooperation that can divide the fields of geriatrics, mental health and addictions rather than fostering a coordinated effort at addressing the problem. From an administrative policy perspective, we would advocate greater cooperation between these organizations and agencies and the possible development of a leadership resource panel that can be called upon by various organizations, training programs and federal and local agencies to assist in the development and implementation of recommendations. A recent example of an effort to bring together a resource panel was the support for the development of the Treatment Improvement Protocol focused on late life substance abuse (Blow, CSAT, 1998: TIP #26).

An exciting aspect to implementing training recommendations is the ever-expanding range of tools available to train and education potential patients, providers and administrators. In addition to traditional methods of published articles, book chapters, and lectures, there is the opportunity to use interactive video or telemedicine approaches, Internet applications, video and voice teleconferencing, and computer-based applications as educational tools. Few of these tools have been used specifically for education about late life substance use but that is likely to change in the near future.

Appendix II

Screening Instruments: Examples for Older Adults

Short Michigan Alcoholism Screening Test -Geriatric Version (S-MAST-G)

	YES (1)	NO (0)
1. When talking with others, do you ever underestimate how much you actually drink?	_____	_____
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?	_____	_____
3. Does having a few drinks help decrease your shakiness or tremors?	_____	_____
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?	_____	_____
5. Do you usually take a drink to relax or calm your nerves?	_____	_____
6. Do you drink to take your mind off your problems?	_____	_____
7. Have you ever increased your drinking after experiencing a loss in your life?	_____	_____
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?	_____	_____
9. Have you ever made rules to manage your drinking?	_____	_____
10. When you feel lonely, does having a drink help?	_____	_____

TOTAL S-MAST-G SCORE (0-10) _____

Scoring: 2 or more "yes" responses indicative of alcohol problem.

For further information, contact Frederic C. Blow, Ph.D., at the University of Michigan Alcohol Research Center, 400 E. Eisenhower Parkway, Suite A., Ann Arbor, MI 48104, 734-998-7952.

Quantity/Frequency Questions

1. **In the last three months,** have you been drinking alcoholic drinks at all (e.g., beer, wine, wine cooler, sherry, gin, vodka or other hard liquor)?

Yes No

If YES,

In the last three months, on average how many days a week have you been drinking alcohol?

None 1 2 3 4 5 6 7

On a day when you have had alcohol to drink, how many drinks have you had?

1 2 3 4 5 6 7 8 9 10 11

12 13 14 or more

2. **In the last three months,** how many times have you had 3 or more drinks on an occasion?

None 1 2 3 4 5 6 7 8 9 10 or more

Criteria:

Positive Score: based on quantity/frequency and binge drinking

Quantity x frequency =

Men and women : 8 or more drinks/week **or** 2 or more occasions of binge drinking in last month

Appendix III

Recommended Reference Materials

Barry, K.L. (Consensus Panel Chair) (1999). *Brief Interventions and Brief Therapies for Substance Abuse* (Treatment Improvement Protocol (TIP) Series No. 34). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U. S. Department of Health and Human Services.

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Blow, F.C., & Barry, K.L. (2002). Use and misuse of alcohol among older women. *Alcohol Res Health*. 26(4):308-15.

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Blow, F.C., Walton, M.A., Chermack, S.T., Barry, K.L., Coyne, J.C., Gomberg, E.S.L., & Mudd, S.A. (2000). The relationship between alcohol problems and health functioning of older adults in primary care settings. *J Am Geriatric Soc*. 48: 769-74.

Gurnack, A. (Ed.) (1997). *Older Adults' Misuse of Alcohol, Medicines, and Other Drugs: Research and Practice Issues*. New York: Springer Publishing Company.

National Institute on Alcohol Abuse and Alcoholism. (1995). *The Physicians' Guide to Helping Patients With Alcohol Problems*. NIH Pub. No. 95-3769. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Oslin, D.W. (2004). Late-life alcoholism: issues relevant to the geriatric psychiatrist. *Am J Geriatr Psychiatry*. 12(6):571-83.

APPENDIX IV

Case Studies and Role Play

Participants should break up into pairs and receive the following case studies. Each participant should have a turn acting the patient while the other role plays the practitioner. Participants should practice discussing alcohol use with the patient, evaluating the risk level of drinking behaviors, and developing a brief intervention agreement with the patient if appropriate.

Risk levels:
Abstinence: no alcohol in previous year
Low-risk use: alcohol use within guidelines and not associated with problems (Case 3).
At-risk and problem use: alcohol use that has resulted in adverse medical, psychological or social consequences; or substantially increases the likelihood of such problems (Cases 1 & 4).
Dependence: medical disorder characterized by loss of control, preoccupation with alcohol, continued use despite problems, physiological symptoms such as tolerance and withdrawal (Case 2).

Brief Alcohol Intervention Components with Older Adults

Following identification of at-risk or problem drinkers through screening techniques a semi-structured brief intervention can be conducted. The content of the intervention needs to be elder-specific and includes the following steps:

1. *Identification of future goals for health, activities, hobbies, relationships, and financial stability.*
2. *Customized feedback on screening questions relating to drinking patterns and other health habits* (may also include smoking, nutrition, tobacco use, etc.).
3. *Discussion of types of older drinkers in the population, where the patient's drinking patterns fits into the population norms for their age group, and definitions of standard drinks* (one standard drink=12 oz. Beer or ale; 1.5 oz. shot of distilled spirits; 4-5 oz. wine; 4 oz. sherry; 4 oz. liqueur).
4. *Pros and cons of drinking.* This is particularly important because the practitioner needs to understand the role of alcohol in the context of the older patient's life including coping with loss and loneliness.
5. *Consequences of heavier drinking.* Some older patients may experience problems in physical, psychological, or social functioning even though they are drinking below cut-off levels.
6. *Reasons to cut down or quit drinking.* Maintaining independence, physical health, and mental capacity can be key motivators in this age group.
7. *Sensible drinking limits and strategies for cutting down or quitting.* Strategies that are useful in this age group include developing social opportunities that do not involve alcohol, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.

8. *Drinking agreement.* Agreed upon drinking limits that are signed by the patient and the practitioner are particularly effective in changing drinking patterns.
9. *Coping with risky situations.* Social isolation, boredom, and negative family interactions can present special problems in this age group.
10. *Summary of the session.*

Case 1 Patient: Catherine Jones is a 70-year-old widow living alone in a small apartment in a large city. She has developed few interests and outside activities since her husband died four years ago. In a routine visit to her primary care clinic, the nurse practitioner asked some questions about her general health and Mrs. Jones reported that she was tired all the time and, because she did not sleep well, she was using over-the-counter sleeping pills. When asked, she said that she generally drinks one glass of wine a day before dinner just as she and her husband did when they were younger. She had been taking prescription medicine for stomach pain for 6 months but the pain has not improved. The effect of alcohol is exacerbated by age, by the use of some medications for stomach pain like Zantac, and by over-the-counter sleeping pills.

Case 1 Clinician: Her nurse practitioner discussed with her the potential problems of mixing some medications with alcohol, provided information about the senior center in her neighborhood and the name of a contact person at the center, and suggested she try the center for some activities and that she stop the use of alcohol since it could be starting to cause problems that would get worse with time. *"I am concerned about your use of alcohol with the medications for your stomach and the sleeping pills. The stomach medicine you take and the sleeping pills can increase the effect of the alcohol. I'm also concerned that you may not have a lot of options to see other people and that can be pretty lonely. I'm giving you the number for the senior center in your neighborhood and the name of the person to call at the center. In the next month, I'd like you to stop the use of alcohol and the sleeping pills to see how you feel, and I'd like you to try out the senior center. I'll see you in one month so we can determine together how things are going."* Mrs. Jones felt that she would be able to follow these recommendations. The provider made an appointment with her in one month to check on progress.

Conduct brief intervention.

Case 2 Patient: Joe Thompson is a 68-year -old retired electrician. He has had chronic abdominal pain and unresolved hypertension for the past ten years. He has a history of alcohol problems and had one admission to alcohol treatment fifteen years ago. Four years ago, after experiencing withdrawal symptoms during a hospital admission for a work-related injury, he again entered an alcohol treatment program. After two years of abstinence, Mr. Jackson began drinking again. He now drinks approximately 5 beers a day plus some additional liquor once a week.

Case 2 Clinician: His physician and social worker in the primary care clinic are aware that this is a chronic relapsing disorder and continue to work with Mr. Jackson to help him

stabilize his medical conditions and find longer term help for his primary alcohol dependence. *"Mr. Jackson, your high blood pressure and your stomach pains have not improved. The amount you are drinking can certainly interfere with them getting better and can make other physical and family problems worse. I know you've tried hard to deal with your alcohol problems and you kept those problems in check for a long time, but now they are getting in the way of your health and well being again. I know it takes a lot to stay sober and that relapses can occur when stresses increase. I'm concerned about your health and would like you to talk to someone from the alcohol program. Would you be willing to talk with them if we call and make the appointment together?"*

Conduct brief intervention.

Case 3: Marie Howell is a 67-year-old retired teacher who drinks one glass of wine when out to dinner with friends once or twice a week. She has a relatively large social network, walks in the mall with a friend 3 times/week for exercise, and is active in volunteer work in a literacy program. She has no family history of alcoholism and does not take contraindicated medications. She receives routine health care from a primary care physician, and attends a senior center where she has contact with other health care personnel including a social worker and a nurse.

Case 3 Clinician: Ms. Howell would benefit from prevention messages regarding her alcohol use in the context of her overall health and well-being. *"I know that one of your goals is to prevent health problems. Your exercise program looks good. You continue to be active with friends and in the community. You have no family history of alcohol problems, are taking no medication to interfere with alcohol, and don't exceed a glass of wine once or twice a week. These are all good things that you have been doing to stay as healthy as you can".*

Case 4: Jack Hendrick is a 64-year-old executive with a large marketing firm. He is a hard driving person who works long hours and has few hobbies and interests outside of work. Although the company has a policy that employees retire at 65, he has not planned what he will do. He is slightly overweight, does not exercise except for occasionally playing golf, and drinks 2 drinks/day during the week and 3-4 drinks/day on the weekends. He has had no diagnosed health problems related to alcohol use but his wife worries about his drinking and would like him to spend more time in activities with her that do not involve alcohol. He has gone to a psychologist at his wife's urging.

Case 4 Clinician: The message from his psychologist would include a statement regarding his use of alcohol and concern about potential problems. *"You indicated that, on average, you drink alcohol every day and drink 2 drinks at a time during the week and drink more than that on the weekends. You and I have talked about your stresses at work, your wife's concerns about your use of alcohol and your own worries about retirement. National guidelines recommend that men your age drink no more than (7 drinks/week: no more than 1/day). I am concerned that your pattern of alcohol use fits into the at-risk drinking category".*
Conduct brief intervention.

Module VIII: Substance Use/Misuse/Abuse Among Older Adults

Project MAINSTREAM

Draft – 10/05

1

Learning Objectives

Health Care Professionals will:

- Understand the prevalence of at-risk drinking, problem drinking, and alcohol dependence in older adults
- Know drinking guidelines for adults age 65 and over
- Know the interaction effects of alcohol with various medications
- Identify signs and symptoms of alcohol problems and medication misuse in older adults
- Know how to use brief alcohol interventions with older adults
- Be able to discuss barriers to interventions and treatment, and how to address some of these barriers

2

Substance Abuse Among Older Adults

The most common substance use problems/disorders in older adulthood are:

1 Nicotine (~18-22%)

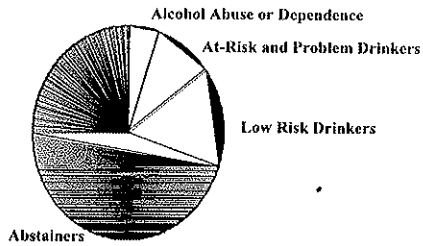
#2 Alcohol (~2-18%)

#3 Psychoactive Prescription Drugs (~2-4%)

#4 Other Illegal Drugs (marijuana, cocaine, narcotics) (<1%)

3

Spectrum of Drinking Among Older Adults



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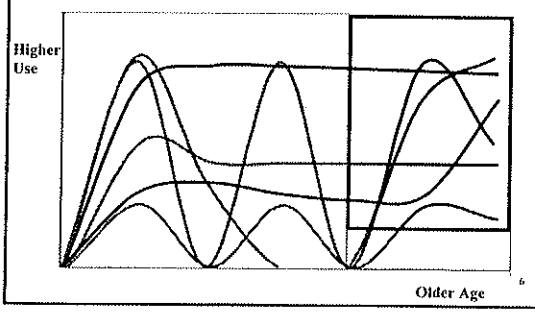
Prevalence and Patterns of Drinking in Older Adults

- Epidemiological Studies
  - 2-15% depending on definitions of at-risk or problem drinking
  - Light/moderate drinkers maintain stable pattern
  - Heavy drinkers tend to reduce or terminate
  - %? of older adults have late onset of risky/heavy consumption

Lifetime Patterns of Drinking and Other Drug Use



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Aging, Drinking and Consequences

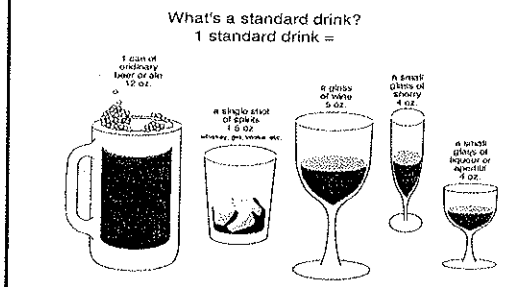
- Age-related changes make older adults more vulnerable to adverse alcohol effects
  - Higher BAC from a given dose
  - More impairment at a given BAC
- Implications for older adult drinkers:
  - Moderate levels of consumption can be more risky
  - More consequences from maintaining consumption
  - Increased consumption may quickly result in consequences

7

Alcohol Consumption Recommendations for Older Adults

- NIAAA and CSAT recommend that adults age 65 and older follow these drinking guidelines:
  - No more than 1 drink per day
  - Never more than 2 drinks on any drinking day (binge drinking)
- Consistent with patterns shown to have potential health benefits
- Limits for older women should be somewhat lower than those for older men

NIAAA, 1995; DuFour and Fuller, 1995



Definitions

- ***Abstinence:*** no alcohol in previous year
- ***Low-risk use:*** alcohol use within guidelines and not associated with problems
- ***At-risk and problem use:*** alcohol use that has resulted in adverse medical, psychological or social consequences; or substantially increases the likelihood of such problems
- ***Dependence:*** medical disorder characterized by loss of control, preoccupation with alcohol, continued use despite problems, physiological symptoms such as tolerance and withdrawal

Issues Unique to Older Adults

- Loss (people, vocation, status)
- Social Isolation and loneliness
- Major financial problems
- Changes in housing
- Family concerns
- Burden of time management
- Complex medical problems
- Multiple medications
- Sensory deficits
- Reduced mobility
- Cognitive impairment or loss
- Impaired self-care

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Alcohol Dependence in Older Adults

- ↓ Rates of alcoholism appear to decline with age
- Drinking patterns that do not meet traditional abuse definitions can lead to higher BAC, chronic illness, poor nutrition and poly-pharmacy in older patients
- ? Extent of problem difficult to determine due to differences in definitions and lack of age-specific measures

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Alcohol Dependence in Older Adults
(continued)

- If past reliance on alcohol to resolve problems exists, then loss of spouse, occupational and role status, and poor social supports can make older adults more vulnerable to misuse
- ↓ Less use of illicit drugs
- ↑ More unintentional misuse of drugs due to memory loss or misunderstanding of dosing instructions

Alcohol Misuse among Older Women

- Older women may be at greater risk for alcohol problems due to potential loneliness and depression from outliving spouse, other losses
- Physiologically at greater risk as they age
- Alcohol use recommendations lower than those set for older men and younger women
- Screening and brief intervention useful

(Blow and Barry, 2002; Fleming, et al, 1999)

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Potential Comorbidities with Alcohol Use

- Interference with metabolizing medications
- Increased side effects from medication
- Sleep disorders
- Psychiatric conditions (e.g. depression, anxiety)
- Increased risk of suicide
- Dementia

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Psychoactive Meds with Significant Alcohol Interactions

- Anxiolytic Benzodiazepines
  - Alprazolam
  - Chlordiazepoxide
  - Diazepam
  - Lorazepam
  - Oxazepam
  - Clonazepam
  - Buspirone
  - Meprobamate
- Sedative/Hypnotic Benzodiazepines
  - Flurazepam
  - Prazepam
  - Quazepam
  - Temazepam
  - Triazolam

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Psychoactive Meds with Significant Alcohol Interactions
(continued)

- Other Sedatives
  - Zolpidem
  - Choral hydrate
  - Hydroxyzine
  - Diphenhydramine
  - Doxylamine
  - Glutethimide
- Opiate/Opioid Analgesics
  - Methylmorphine
  - Codeine
  - Hydrocodone
  - Meperidine
  - Oxycodone
  - Propoxyphene
  - Pentazocine
  - Morphine

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Psychoactive Meds with Significant Alcohol Interactions
(continued)

- Anticonvulsants
  - Phenytoin
  - Phenobarbital
  - Primidone
  - Carbamazepine
- Other Psychotropics
  - Phenothiazines
    - Chlorpromazine
    - Trifluoperazine
    - Lithium
- Other Drugs
  - Antidepressants, tricyclic
    - Amitriptyline
    - Nortriptyline
    - Imipramine
    - Desipramine
- Barbiturates
  - Phenobarbital

Identification, Screening and Assessment Recommendations for Older Adults

Every person age 60 and older should be screened for alcohol and prescription drug use/abuse as part of regular physical examination- 'Brown Bag Approach'

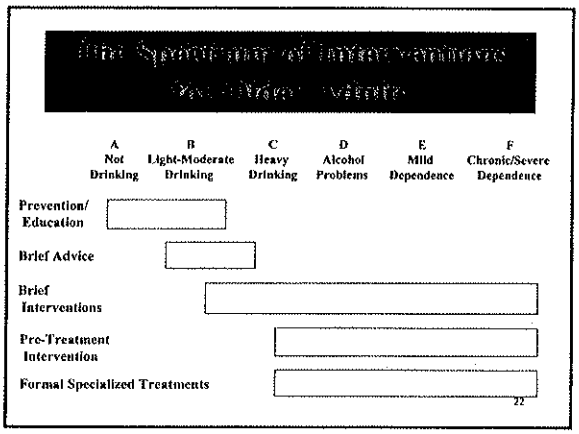
- Screen or re-screen if certain physical symptoms are present or if the older person is undergoing major life changes or transitions
- Ask direct questions about concerns
  - Preface questions with link to medical conditions or health concerns
  - Do not use stigmatizing terms (e.g. alcoholic)

Potential Signs and Symptoms of Alcohol Problems in Older Adults

- Anxiety
- Blackouts, dizziness
- Depression
- Disorientation
- Mood swings
- Falls, bruises, burns
- Family problems
- Financial problems
- Headaches
- Incontinence
- Increased tolerance to alcohol
- Legal difficulties
- Memory loss
- New problems in decision making
- Poor hygiene
- Seizures, idiopathic
- Sleep problems
- Social isolation
- Unusual response to medications

Screening Instruments and Assessment Tools

- Alcohol Consumption
  - Quantity, Frequency, Binge Drinking
- Alcohol Consequences
  - AUDIT, MAST, SMAST, CAGE
  - Elder-Specific: MAST-Geriatric Version, SMAST-G
- Health Screening Survey
  - includes other health behaviors
    - nutrition, exercise, smoking, depression



Brief Intervention Definitions

- ***Definition:*** Time-limited (5 minutes to 5 brief sessions) and targets a specific health behavior
- ***Goals:*** a) reduce alcohol consumption
  b) facilitate treatment entry
- Relies on use of screening techniques
- Empirical support of effectiveness for younger and older drinkers

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Empirical Support for Brief Interventions with Older Adults

- Project GOAL (Guiding Older Adult Lifestyles) focused on physician advice for older adult at-risk drinkers: Physician advice led to reduced consumption at 12 months (University of Wisconsin; N=156; 35-40% change)
- Health Profile Project: Preliminary findings indicate that an elder-specific motivational enhancement session conducted in-home reduced at-risk drinking at 12 months (University of Michigan; N=454)

Key Components of Alcohol Brief Interventions

- Screening
- Feedback
- Motivation to change
- Strategies for change
- Negotiated behavioral contract
- Follow-up

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Brief Alcohol Intervention Components

- Following identification of at-risk or problem drinking through screening techniques, a semi-structured brief intervention can be conducted.

Step 1. *Identification of future goals*

Step 2. *Customized feedback on screening questions relating to drinking patterns and other health habits*

Step 3. *Discussion of where the patient's drinking patterns fits into the population norms for their age group, and definitions of standard drinks*

Brief Alcohol Intervention Components (continued)

Step 4. *Pros and cons of drinking.*

Step 5. *Consequences of heavier drinking.*

Step 6. *Reasons to cut down or quit drinking.*

Step 7. *Sensible drinking limits and strategies for cutting down or quitting.*

Step 8. *Drinking agreement.*

Step 9. *Coping with risky situations.*

Step 10. *Summary of the session.*

Barriers to Seeking Alcoholism Treatment for Older Adults

- Resistance to asking for help
- Disdain of labels (alcoholic, old)
- Lack of transportation
- No significant others to assist in motivation to seek help
- Providers less likely to refer older adults
- Gaps in substance abuse, aging, and mental health services

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Age-Specific Treatment Elements

- Attention paid to age-related issues (e.g. illness, depression, loss)
- Consistent linkage with medical services
- Staff with geriatric training
- Avoid condescension and respect patient's views on spirituality, swearing, etc.
- Longer treatment duration, slower pace

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Age-Specific Treatment Elements (continued)

- Less confrontation and probing for "private" information
- Accommodate sensory and cognitive declines in educational components
- Groups are especially helpful in reducing shame and improving social network
- Preparation for AA is important due to high level of confrontation
- Less use of self-help jargon

Age-Specific Treatment Elements (continued)

- Less clinical distance/warmer relationships using appropriate self-disclosure
- Attention to calming fears regarding confidentiality
- Assistance from social services/family in medication monitoring
- More family involvement
- Home visitation

Summary

- Screening for alcohol use/misuse/abuse in the context of health issues is effective
- Brief alcohol interventions are effective
- Brief interventions are one of a spectrum of approaches for use with older adults
- The approach used depended on the individual client background, needs, and resources available
- Older adults can benefit from a nonjudgmental, motivational, supportive approach to screening, prevention/intervention, referral, and treatment
- Treatment is available

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Case Studies and Role Plays

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