Assessment & Management of Alcohol Use Disorder in Older Adults: *A Review of the Evidence*

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Session Objectives

- Appraise challenges in assessment & screening of older adults **(OAs)** with **alcohol use disorder (AUD)** in primary care setting
- Integrate emerging research evidence regarding AUD in OAs & targeted interventions that optimize successful treatment
- Delineate ways nurses can impact the identification & treatment of OAs with AUD including referral, teaching & advocacy, in community-based settings

Problem Drinking
Nothing New

- Droller (1964) 1st to note **"alcohol abuse"** in older adults (OAs)
- Substance abuse was fairly rare among OAs (65+yrs) in 60s, 70s
- ETOH use usually declines with age
  - Health problems
  - Medications
  - Access

(McEvoy et al., 2013; Satre, 2015)

The Numbers *Globally*

- 5.9% of deaths attributable to ETOH consumption
- **5th leading cause of preventable death**
- Population maturing - 800 million aged 60+
- Estimated to grow to **1.5 - 2 billion+ by 2050**

(UNFPA, 2012; WHO, 2016)

The Numbers
United States

- 15.1 million 18+ yrs est. with AUD
- 88,000 die from ETOH-causes annually
- **4th leading cause of preventable death**

- ***Estimated* 14.5% OAs** consume alcohol above recommended limits
  - Underestimated, self-report bias
- **Drinking problems is largest category of substance abuse in OAs**

(NIAAA, 2017)

Enter the Baby Boomers

- Those born 1946 – 1964
  - 65 yrs+ population ~ **13%** currently
  - By 2030, increase to **19%** or **1 in 5 OAs**

(NIAAA, 2017)

- *And*…this cohort is ***DIFFERENT***
  - Social lifestyle
  - More lenient attitude toward alcohol
  - Recent claims of its health-conferring benefits

(Alpert, 2014; Babatunde et al., 2014)

From Alcoholism, Alcohol Abuse to **Alcohol Use Disorder (AUD)**

- **DEFINED:** Problematic pattern of alcohol use leading to significant impairment or distress
- Manifested by at least **2 of the following:**
  - Alcohol taken in larger amounts over longer period than intended
  - Persistent desire/unsuccessful efforts to cut down or control use
  - Craving or a strong desire or urge to use alcohol
  - Great deal of time spent in efforts to obtain/use alcohol & recover from effects
  - Recurrent use resulting in failure to fulfill major role obligations at work, school or home
  - Continued use despite persistent problems

(APA/DSM-V, 2013)

What defines a “drink”?

12 fl. oz. of regular beer

5% alcohol

=

5 fl. oz. of table wine

12% alcohol

=

5 fl. oz. of distilled spirits (gin, rum, vodka, whiskey, tequila)

40% alcohol

Definition of LOW-Risk Drinking

- **MEN**
  - No more than 4 drinks/day or 14 drinks/wk
- **WOMEN**
  - No more than 4 drinks/day or 7 drinks/wk

(NIAAA, 2017)

Types of Drinkers by Onset

- **EARLY-ONSET**
  - Dependent **BEFORE age 60**, mostly male
  - Comprise 2/3 of OAs with AUD
  - More severe course, need more tx
- **LATER-ONSET**
  - Dependent **AFTER age 60**, more women
  - Start after stressful event, loss, depression
  - Risk factors - Family hx, pain, loneliness
  - Milder clinical picture

(Alpert, 2014; Trevisan, 2008)

Assessment Challenges: *Healthcare Provider Side*

- **Not assessed**
  - Long list of physical problems
  - Short office visits, lack of time/materials
- **Physical S/S misinterpreted** as med condition
- **Diagnosis missed**
  - Age bias, skepticism
  - Failure to fulfill roles (work) not applicable
  - Poor screening, lack of training/confidence

(Babatunde et al., 2014; Caputo, 2012)

Assessment Challenges: *Client Side*

- **Client in DENIAL**
- **FAMILY**
  - Denial, age bias
  - Failure to recognize problem, symptoms
  - Lack of knowledge about screening
  - Age-related sensitivity to ETOH with age means problems with low intake
    - ***LESS is MORE***

(Alpert, 2014; Babatunde et al., 2014)

MANY Multisystem Consequences

- Gastritis, bleeding, poor eating/nutrition
- Impaired memory, cognition
- Hypertension
- Sleep disorders, sleep apnea, aspiration
- Signs of immunodeficiency disorders, infections
- Edema in lower extremities, liver complications
- Peripheral neuropathy, increased risk of falls
- Medication interactions

(Alpert, 2014; Babatunde et al., 2014)

We now know…

- Multifaceted complex condition
- Genetic component
- Socio-environmental influences

- Growing body of research exploring problem in vulnerable, overlooked, stigmatized OA population

Examining the Evidence

- **SEARCH TERMS**
  - Alcohol use disorder
  - Alcoholism
  - Older adults
  - Elderly and substance abuse
    - *Substance abuse articles excluded unless significant/updated AUD component*
- **RESULTS**
  - 36+ articles in past decade
  - 4 of those integrative reviews

Assessment

Once misuse suspected….

- Several instruments available
- 2 widely used & validated in OA population
  - CAGE Questionnaire
  - Michigan Alcoholism Screening Test (MAST)

Nurses in all settings serving adults over age 60 should screen for excess alcohol use.

(SAMHSA, 2017)

Instruments

CAGE *(Ewing, 1984)*

- 4 Yes/No questions
  - **C**ut down on your drinking?
  - **A**nnoyed by people criticizing your drinking?
  - **G**uilty about drinking?
  - **E**ye-opener needed to steady nerves?
- Two “Yes” responses means + screening
- Preferred for use in OAs
- May not capture recent cases of heavy drinking

(American Geriatrics Society, 2010)

Instruments

MAST-G *(Selzer, 1971)*

- Oldest, considered most accurate
  - Original MAST ~ 25 items
- Shortened geriatric version (SMAST-G)
- 10 Yes/No questions
  - Underestimate amt? Drink when lonely?
  - Skip meals? Problems with memory?
- 2 or more “Yes” means “possible problem”
- Sensitivity – 93.9%

(Hartford Institute for Geriatric Nursing, 2017)

If Formal Screening NOT Done

- Can ask client a simple open-ended question:

  What happens if you go for a few days without drinking?

- Invites insight
- Begins conversation
- Opportunity to initiate referral & treatment
- Nonjudgmental approach is KEY

(Fingerhood, 2000)

Interventions

- 1st step…**Detoxification** (withdrawal)
- S/S delayed in OAs
- Confusion (vs. tremors) predominant sign
- Inpatient “detox” usually needed with comorbidities *(Taheri et al., 2014)*

- 2nd phase…**Rehabilitation**
  - *In addition to pharmacologic approaches*
    - Psychological
    - Socio-behavioral *(Caputo et al., 2012)*

Interventions
Mutual-Help Groups (MHGs)

- **DEFINED:** Peer-run "support group" to share common experiences, discuss problems, develop support, ID strategies to avoid relapse
  - Can be central to tx plan or adjunctive
  - Alcoholics Anonymous (AA) most well-known
    - **12-Step Model** ~ Envision life without alcohol, ID high-risk situations for relapse
- Evidence ~ **Targeted "home group"** by AGE/ETOH use only associated with better outcomes

(Kelly & Yeterian, 2011; Schuckit, 2009)

Interventions:
Cognitive Behavioral Therapy (CBT)

(Beck, 1964; Lazarus & Folkman, 1984)

- **DEFINED:** Behavioral & cognitive approach; structured talk therapy with goal of developing coping strategies for lifelong recovery
- Well-suited for cognitively-intact OAs
- Involves shaping/modifying behavior through positive & negative reinforcement by identifying
  - Core beliefs central to use of alcohol (schemas)
  - Automatic thoughts (triggers to relapse)
  - Cognitive distortions (self-destructive behaviors)

(Babatunde et al., 2014; McDevitt-Murphy, 2011)

Interventions

Motivational Interviewing (MI)

- **DEFINED:** Client-centered, directive method for enhancing intrinsic motivation to change by exploring, resolving ambivalence
- Assists in
  - Recognizing problem
  - Eliciting reasons for drinking
  - Developing action plans
- Interventions are longer, directive, focused

(Miller & Rolnick, 1991)

Interventions
Alcohol Brief Intervention (ABI)

- Conducted in primary care or community-based settings…Less stigma than formal programs
- *Ranges from*
  - 1-5 group or individual counseling sessions
  - Multicomponent group sessions with CBT, MHGs, MI, family therapy
- Includes education on effects, feedback on patterns/reasons for drinking, support networks, drinking agreement
- Useful in reducing consumption

(Bakhshi & While, 2014)

ABI *(cont.)*
FRAMES Model

Feedback about risk

Responsibility for change placed on person

Advice for changing behavior given

Menu of options offered

Empathic style used by intervener

Self-efficacy promoted

- Use of workbook helpful
- Can train providers to administer protocol

(Blow & Barry, 2012)

Tx *WITHOUT* Giving Up Alcohol?

Abstinence vs. **Reduced-Risk Drinking (RRD)**

(AKA Harm Reduction or Controlled Drinking)

- Traditional (AA) model ~ **zero tolerance**
- ***Reduce*** ETOH intake vs. complete abstinence
- Cochrane review (2006) found no convincing evidence for 12-step approach/full abstinence in reducing intake, achieving/maintaining abstinence

(van Amsterdam & van den Brink, 2013; Witkiewitz et al., 2017)

Reduced-Risk Drinking

- **Controversial** *yet…*growing body of research indicates RRD works for **subset**
  - Fewer ETOH-related consequences
  - Better mental health
  - Addresses treatment gap
- **Contraindications**
  - Meds - Dangerous combined with ETOH
  - Repeated RRD failures, severe withdrawal
  - Significant comorbidities
- **More research needed**

(van Amsterdam & van den Brink, 2013; Witkiewitz et al., 2017)

Nurses Role

Assessment & Referral

- Initiate screening, start conversation
  - CAGE & MAST-G together – *more accurate*
  - ID depression, pain, anxiety/PTSD as triggers
- Determine readiness, assess barriers
- Appropriate referrals
  - Consider situational/cultural factors
  - Resist placing in rigid categories, rather view on spectrum
- **Interventions work, must screen 1st**

Nurses Role

Education & Advocacy

- Education on amounts, effects of alcohol
- Assure confidentiality
- Coordinate multidisciplinary approach
- Consider client resources/insurance, program availability, transportation, family support
- Keep client motivation high

Conclusion

- Recognize OAs with AUD **underserved, stigmatized** group
- Change attitudes, non-judgmental approach
- Systematic screening of those 60 yrs+ is 1st step
  - Targeted instruments in expanded settings
- **Age-specific** interventions superior to "mainstreaming"
- **Patient preference** is paramount

Future Research

- Which interventions work best for OAs?
  - Targeted MHGs (age-appropriate)
  - Combo approaches, individualized
  - System-level strategies
  - Examine accessibility & cost-effectiveness
  - Online approaches (forums, chat rooms)
  - RRD viable option?
- Longitudinal cohort studies of those moving from middle age to later life *(Babatunde et al., 2014)*

In Summary

Need to change attitudes, recognize problem & provide support for…

Encouraging insight,
Dismantling denial &
Envisioning recovery

(DiBartolo & Jarosinski, 2017)

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