Assessment & Management of Alcohol Use Disorder in Older Adults

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Objectives

- Appraise challenges in assessment & screening of older adults (OAs) with alcohol use disorder (AUD)
- Integrate research evidence regarding assessment strategies & targeted interventions that optimize successful treatment in OAs with AUD
- Identify ways nurses can impact the identification & treatment of OAs with AUD, including education, advocacy and referral

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 typically declines with age due to
  - Health problems, comorbidities
  - Medications
  - Access

The Numbers

- In US, 15.1 million 18+ yrs est. with AUD
- 88,000 die from ETOH-causes annually
- 4th leading cause of preventable death
- In older adults (65 + yrs)...
  - Alcohol is largest category of substance abuse
  - Estimated 14.5% of older adults consume alcohol above recommended limits
  - Underestimated
  - Self-report bias

Enter the Baby Boomers

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

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

No Laughing Matter...

Older adults with alcohol problems are a vulnerable population who require age-specific screening and interventions focused on issues associated with alcohol misuse later in life ...and soon to be a most pressing health concern. (Babatunde et al., 2014)

Issues such as ???

- Driving
- Walking/falls
- Comorbidities
- Medication management
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:
  - ETOH 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)

We also know that...

In addition to gender differences in metabolism that persist into older adulthood...

- **OLDER ADULTS in general**
  - Have less body mass
  - ↓ function of kidneys/liver for excretion
  - Age-related sensitivity to ETOH effects
    - LESS is MORE
  - ↓ tolerance

(NIAAA, 2017)

What defines a “drink”?

- 12 fl. oz. of regular beer
- 5 fl. oz. of table wine
- 1.5 fl. oz. of distilled spirits (gin, rum, vodka, whiskey, tequila)

= 5% alcohol

= 12% alcohol

= 40% alcohol

(NIAAA, 2017)

Risky vs. Low-Risk Drinking

Definition of LOW-Risk Drinking

- **MEN** ~ No more than 4 drinks/day or 14 drinks/wk
- **WOMEN** ~ No more than 3 drinks/day or 7 drinks/wk
- **OLDER ADULTS**
  - No more than 1 drink/day
  - 3 drinks on one occasion
  - 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)

Types of Drinkers by Onset (cont.)

- **INTERMITTENT**
  - Dependent **BEFORE age 60**
  - 3-5 years abstinence
  - Adverse event in later life → relapse

(NIAAA, 2017)

- Astute clinicians inquire about past/lifelong patterns, not just here & now
MANY Multisystem Consequences

- Gastritis, bleeding, poor eating/nutrition
- Impaired memory, cognitive problems
- Hypertension, anemia
- Sleep disorders, sleep apnea, aspiration
- Signs of immunodeficiency disorders, infections
- Liver damage (edema, ↓ blood clotting)
- Peripheral neuropathy, increased risk of falls
- Medication interactions

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

Addiction Defined

- A primary chronic disease of brain reward, motivation and memory circuitry
- Dysfunction in circuits leads to characteristic biological, psychological, social, and spiritual manifestations
- Results in pathologically pursuing reward +/or relief by substance abuse, other behaviors

(American Society of Addiction Medicine, 2014)

Etiology

- Previously viewed strictly from medical model point of view
- OR simply stigmatized as personality flaw/weakness

Now we know...

- Multifaceted complex condition
- Components
  - Genetic (familial predisposition)
  - Psychological perspective
  - Socio-environmental influences
- In right combo…turns on the “brain switch”

(Apert, 2014)

Assessment Challenges: Client Side

- Client in DENIAL
- FAMILY
  - Denial, embarassment
  - Age bias, “let them do what they want”
  - Failure to recognize problem, symptoms
  - Lack of knowledge about sensitivity to effects with lower intake
  - Lack of knowledge about screening
  - Burned out, disconnected

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

Assessment Challenges: Healthcare Provider Side

- Not assessed
  - Long list of physical problems
  - Short office visits, focus on physical concerns
  - Lack of time/materials
- Physical S/S misinterpreted as med condition
  - Aches & pains (ETOH – self-medication)
  - Insomnia, sleeping problems
  - Memory problems (normal aging or Alzheimer’s)

(Babatunde et al., 2014; Caputo, 2012)
Assessment Challenges: Healthcare Provider Side (cont.)

- Diagnosis missed
  - Age bias, skepticism
  - Failure to fulfill roles (work) N/A if retired
  - Often isolate themselves, live alone
  - Poor screening
  - Lack of training, confidence

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

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
  - Cut down on your drinking?
  - Annoyed by people criticizing your drinking?
  - Guilty about drinking?
  - Eye-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)

Michigan Alcoholism Screening Tool (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)

Instruments

Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993)

- 10 questions
  - Likert-type scale ranging from 1-4
  - Questions
    - Quantity
    - Frequency of alcohol use, binge-drinking
    - Dependency, ETOH-related problems
    - Greater sensitivity in populations with low prevalence for AUD
  - Less sensitive in OAs

(Aippet, 2014)

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/supervised "detox" usually needed with OAs, comorbidities

2nd phase... **Rehabilitation**
- In addition to pharmacologic approaches
  - Psychological
  - Socio-behavioral

**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
  - Example: Alcoholics Anonymous (AA)

**Alcoholics Anonymous (AA)**
- Most well-known approach
- Uses 12-Step Model
  - Envision life without alcohol
  - ID high-risk situations for relapse
  - Sponsor for support
- In OAs ~ evidence says...
  - Targeted “home group” by AGE/ETOH use only associated with better outcomes

**Cognitive Behavioral Therapy (CBT)**
- DEFINED: Structured talk therapy with goal of developing coping strategies for lifelong recovery ~ behavioral & cognitive approach
  - 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)

**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, focused

**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
**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)*

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**Tx WITHOUT Giving Up Alcohol?**

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

(aka Harm Reduction or Controlled Drinking)

- Traditional (AA) model ~ complete abstinence/zero tolerance
- **RRD ~ Reduce** ETOH intake
  - Cochrane review (2006) ~ no convincing evidence that 12-step approach ↓ intake, achieving/maintaining abstinence

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

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**Reduced-Risk Drinking (RRD)**

- Remains controversial
  - Yet…RRD can work for **subset**
    - Fewer ETOH-related consequences
    - Better mental health
    - Addresses treatment gap
- **Contraindications**
  - Repeated RRD failures, severe withdrawal
  - Meds - Dangerous combined with ETOH*
  - Significant comorbidities*
- Not typically recommended for OAs

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

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**Nurse can play KEY Role in AUD**

**Assessment & Referral**

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

**Advocacy**

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**Nurses Role**

**Assessment & Referral**

- Interventions effective, must SCREEN 1st
- Start conversation, use appropriate instruments
  - CAGE & MAST-G together – **more accurate**
- ID triggers
  - Depression, pain, anxiety, PTSD
- Determine readiness for tx, assess barriers
- Appropriate referrals
  - Consider situational/cultural factors
- Resist placing in rigid categories, rather view on spectrum

**Education & Advocacy**

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Conclusion

- Recognize OAs with AUD underserved, stigmatized group
- Change attitudes, non-judgmental approach
- Systematic screening of 60 yrs+
  - Targeted instruments in expanded settings
- Age-specific interventions, support groups 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? NO
- 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 environment for…

Encouraging insight, Dismantling denial & Envisioning recovery

(DiBartolo & Jarosinski, 2017)

Resources

- MAST-G Assessment Instrument
  - Hartford Institute for Geriatric Nursing
    - Consult Geri TRY THIS series
    - https://consultgeri.org/try-this/general-assessment/issue-17
  - Formerly AGE PAGES
  - Health information, A-Z Health Topics
    - Alcohol use & abuse

References

References