Executive Summary and Recommendations

Researchers are only beginning to realize the pervasiveness of substance abuse among people age 60 and older. Until relatively recently, alcohol and prescription drug misuse, which affects as many as 17 percent of older adults, was not discussed in either the substance abuse or the gerontological literature.

The reasons for this silence are varied: Health care providers tend to overlook substance abuse and misuse among older people, mistaking the symptoms for those of dementia, depression, or other problems common to older adults. In addition, older adults are more likely to hide their substance abuse and less likely to seek professional help. Many relatives of older individuals with substance use disorders, particularly their adult children, are ashamed of the problem and choose not to address it. The result is thousands of older adults who need treatment and do not receive it.

This TIP brings together the literature on substance abuse and gerontology to recommend best practices for identifying, screening, assessing, and treating alcohol and prescription drug abuse among people age 60 and older. The Consensus Panel, whose members include researchers, clinicians, treatment providers, and program directors, supplements this research base with its considerable experience treating and studying substance abuse among older adults. Because so much of older people's substance abuse is never identified, this TIP is aimed not only at substance abuse treatment providers but also at primary care clinicians, social workers, senior center staff, and anyone else who has regular contact with older adults.

The TIP aims to advance the understanding of the relationships between aging and substance abuse and to provide practical recommendations for incorporating that understanding into practice. **The TIP's recommendations appear below in *italic type*. Those based on research evidence are marked (1), whereas those based on Panel members' clinical experience are marked (2). Citations for the former can be found in the body of the text.**

Alcohol Abuse

Physiological changes, as well as changes in the kinds of responsibilities and activities pursued by older adults, make established criteria for classifying alcohol problems often inadequate for this population.

One widely used model for understanding alcohol problems is the medical diagnostic model as defined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV). The DSM-IV criteria for substance dependence (see Figure 2-2, p. 17) include some that do not apply

to many older adults and may lead to underidentification of drinking problems.

Diagnostic criteria for alcohol dependence are subsumed within the DSM-IV's general criteria for substance dependence. Dependence is defined as a "maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period" (American Psychiatric Association, 1994, p. 181).

The Panel recommends that clinicians consider that the DSM-IV criteria for substance abuse and dependence may not be adequate to diagnose older adults with alcohol problems. (2) See Figure 2-3 (p. 18) for an outline of special considerations.

Some experts use the model of at-risk, heavy, and problem drinking in place of the DSM-IV model of alcohol abuse and dependence because it allows for more flexibility in characterizing drinking patterns. In this classification scheme, an *at-risk drinker* is one whose patterns of alcohol use, although not yet causing problems, may bring about adverse consequences, either to the drinker or to others. As their names imply, the terms *heavy* and *problem* drinking signify more hazardous levels of consumption. Although the distinction between the terms *heavy* and *problem* is meaningful to alcohol treatment specialists interested in differentiating severity of problems among younger alcohol abusers, it is less relevant to older adults. *To differentiate older drinkers, the Panel recommends using the terms* at-risk *and* problem *drinkers only.* (2) In the two-stage conceptualization recommended by the Panel, the *problem drinker* category includes those who would otherwise fall into the *heavy* and *problem* classifications in the more traditional model as well as those who meet the DSM-IV criteria for abuse and dependence.

The Consensus Panel recommends that older men consume

- *No more than one drink per day* (1)
- *A maximum of two drinks on any drinking occasion (e.g., New Year's Eve, weddings).* (1)

The Panel recommends somewhat lower limits for women. (1)

Abuse of Prescription Drugs

People 65 and older consume more prescribed and over-the-counter medications than any other age group in the United States. Prescription drug misuse and abuse is prevalent among older adults not only because more drugs are prescribed to them but also because, as with alcohol, aging makes the body more vulnerable to drugs' effects.

Any use of drugs in combination with alcohol carries risk; abuse of these substances raises that risk, and multiple drug abuse raises it even further. For example, chronic alcoholics who use even therapeutic doses of acetaminophen may experience severe hepatoxicity. Alcohol can increase lithium toxicity and enhance central nervous system depression in persons taking tricyclic antidepressants. High doses of benzodiazepines used in conjunction with alcohol or barbiturates can be lethal. The many possible unfavorable reactions between prescription drugs and alcohol are summarized in Figure 3-6 (p. 44).

Benzodiazepines

Benzodiazepine use for longer than 4 months is not recommended for geriatric patients. (2) Furthermore, among the different benzodiazepines, longer acting drugs such as flurazepam (Dalmane) have very long half-lives and are more likely to accumulate than the shorter acting ones. They are also more likely to produce residual sedation and such other adverse effects as decreased attention, memory, cognitive function, and motor coordination, and increased falls or motor vehicle crashes. By contrast, some shorter acting benzodiazepines

such as oxazepam (Serax) and lorazepam (Ativan) have very simple metabolic pathways and are not as likely to produce toxic or dependence-inducing effects with chronic dosing. *Because of these side effects, the Panel recommends caution in selecting the most appropriate benzodiazepines for elderly patients.* (2)

Sedative/Hypnotics

Aging changes sleep architecture, decreasing the amount of time spent in the deeper levels of sleep (stages three and four) and increasing the number and duration of awakenings during the night. However, these new sleep patterns do not appear to bother most medically healthy older adults who recognize and accept that their sleep will not be as sound or as regular as when they were young. Although benzodiazepines and other sedative/hypnotics can be useful for short-term amelioration of temporary sleep problems, no studies demonstrate their long-term effectiveness beyond 30 continuous nights, and tolerance and dependence develop rapidly. *The Panel recommends that symptomatic treatment of insomnia with medications be limited to 7 to 10 days with frequent monitoring and reevaluation if the prescribed drug will be used for more than 2 to 3 weeks. Intermittent dosing at the smallest possible dose is preferred, and no more than a 30-day supply of hypnotics should be prescribed.* (1)

The Panel further recommends that clinicians teach older patients to practice good sleep hygiene rather than prescribe drugs in response to insomnia. (1) The former includes regularizing bedtime, restricting daytime naps, using the bedroom only for sleep and sexual activity, avoiding alcohol and caffeine, reducing evening fluid intake and heavy meals, taking some medications in the morning, limiting exercise immediately before retiring, and substituting behavioral relaxation techniques.

Antihistamines

Older persons appear to be more susceptible to adverse anticholinergic effects from antihistamines and are at increased risk for orthostatic hypotension and central nervous system depression or confusion. In addition, antihistamines and alcohol potentiate one another, further exacerbating the above conditions as well as any problems with balance. Because tolerance also develops within days or weeks, *the Panel recommends that older persons who live alone do not take antihistamines.* (1)

Identification, Screening, and Assessment

The Consensus Panel recommends that every 60-year-old should be screened for alcohol and prescription drug abuse as part of his or her regular physical examination. (2) However, problems can develop after the screening has been conducted, and concurrent illnesses and other chronic conditions may mask abuse. Although no hard-and-fast rules govern the timing of screening, *the Panel recommends screening or rescreening if certain physical symptoms (detailed in Chapter 4) are present or if the older person is undergoing major life changes or transitions.* (2)

Although it is preferable to use standardized screening questionnaires, friendly visitors, Meals-On-Wheels volunteers, caretakers, and health care providers also can interject screening questions into their normal conversations with older, homebound adults. Although the line of questioning will depend on the person's relationship with the older person and the responses given, *the Panel recommends that anyone who is concerned about an older adult's drinking practices try asking direct questions.* (2) (Examples of these and of less direct questions appear in Chapter 4.)

The Panel recommends that health care providers preface questions about alcohol with a link to a medical condition when screening older people. (2) For example, "I'm wondering if alcohol may be the reason why your diabetes isn't responding as it should," or "Sometimes one prescription drug can affect how well another medication is working. Let's go over the drugs you're taking and see if we can figure this problem out." *Do not use stigmatizing terms like* alcoholic *or* drug abuser *during these encounters.* (2)

Although it is important to respect the older person's autonomy, in situations where a coherent response is unlikely, collateral participation from family members or friends may be necessary. In this case, *the screener should first ask for the older adult's permission to question others on his or her behalf.* (2)

Instruments

The Panel recommends use of the CAGE Questionnaire and the Michigan Alcohol Screening Test–Geriatric Version (MAST-G) to screen for alcohol use among older adults. (1)

The Alcohol Use Disorders Identification Test (AUDIT) is recommended for identifying alcohol problems among older members of ethnic minority groups. (2)

Assessment

Substance abuse

The Panel recommends a sequential approach that looks at various dimensions of an older adult's suspected problem in stages, so that unnecessary tests are not conducted. (1)

The Panelists recommend the use of two structured assessments with older adults: the substance abuse sections of the Structured Clinical Interview for DSM-III-R (SCID) and the Diagnostic Interview Schedule (DIS) for DSM-IV. (2)

Functioning

To identify functional impairments, *the Panel recommends measuring the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs)* with the instruments in Appendix B. (1) *Another useful instrument is the SF-36,* a 36-item self-report questionnaire that measures health-related quality of life, including both ADLs and IADLs. (1)

Cognitive dysfunction

Patients who have been medically detoxified should not be screened for cognitive dysfunction until several weeks after detoxification is completed, because a patient not fully recovered from detoxification may exhibit some reversible cognitive impairment. (2)

The Panel recommends use of the Orientation/Memory/Concentration Test (1), which is simple and can be completed in the office. *The Folstein Mini-Mental Status Exam (MMSE) is an acceptable alternative* (1), although it can be insensitive to subtle cognitive impairments among older problem drinkers who have recently attained sobriety (past 30–60 days). The MMSE is weak on visual–spatial testing, which is likely to show some abnormality in many recent heavy drinkers. *The draw-a-clock task is a good additional task to complement the MMSE.* (1) *The Neurobehavioral Cognitive Status Examination, which includes screening tests of abstract thinking and visual memory (not measured on the MMSE), is also recommended for assessing mental status in this population.* (1)

The Confusion Assessment Method (CAM) is widely used as a brief, sensitive, and reliable screening measure for detecting delirium. (1) The Panel recommends that a positive delirium screen be followed by careful clinical diagnostics based on DSM-IV criteria and that any associated cognitive impairment be followed clinically using the MMSE. (1)

Medical status

The Panel recommends that initial medical assessment of older persons should routinely include screening for visual and auditory problems, and any problems discovered should be corrected as quickly as

possible. (2) To assess the medication use of older adults, *the Panel recommends the "brown bag approach." The practitioner can ask older adults to bring every medication they take in a brown paper bag, including over-the-counter and prescription medications, vitamins, and herbs.* (1)

Sleep disorders

The Panel recommends that sleep history be recorded in a systematic way in order to both document the changes in sleep problems over time and to heighten the awareness of sleep hygiene. (2)

Depression

The Geriatric Depression Scale (GDS) and the Center for Epidemiological Studies Depression Scale (CES-D), reproduced in Appendix B, have been validated in older age groups although not specifically in older adults with addiction problems. *The Panel recommends the CES-D for use in general outpatient settings as a screen for depression among older patients.* (1)

Treatment

The Consensus Panel recommends that the least intensive treatment options be explored first with older substance abusers. (1) These initial approaches, which can function either as pretreatment strategy or treatment itself, are brief intervention, intervention, and motivational counseling. They may be sufficient to address the problem; if not, they can help move a patient toward specialized treatment.

The Consensus Panel recommends that every reasonable effort be made to ensure that older substance abusers, including problem drinkers, enter treatment. *Brief intervention is the recommended first step, supplemented or followed by intervention and motivational interviewing.* (1) Because many older problem drinkers are ashamed about their drinking, intervention strategies need to be nonconfrontational and supportive.

Conducting Brief Interventions

A brief intervention is one or more counseling sessions, which may include motivation for change strategies, patient education, assessment and direct feedback, contracting and goal setting, behavioral modification techniques, and the use of written materials such as self-help manuals. *An older adult-specific brief intervention should include the following steps* (2):

1. Customized feedback on screening questions relating to drinking patterns and other health habits such as smoking and nutrition.
2. Discussion of types of drinkers in the United States and where the patient's drinking patterns fit into the population norms for his or her age group.
3. Reasons for 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.
4. Consequences of heavier drinking. Some older patients may experience problems in physical, psychological, or social functioning even though they are drinking below cutoff levels.
5. Reasons to cut down or quit drinking. Maintaining independence, physical health, financial security, and mental capacity can be key motivators in this age group.
6. 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.
7. Drinking agreement in the form of a prescription. Agreed-upon drinking limits that are signed by the patient and the practitioner are particularly effective in changing drinking patterns.

8. Coping with risky situations. Social isolation, boredom, and negative family interactions can present special problems in this age group.
9. Summary of the session.

If the older problem drinker does not respond to the brief intervention, two other approaches—intervention and motivational interviewing—should be considered.

Intervention

In an *intervention*, several significant people in a substance-abusing patient's life confront the patient with their firsthand experiences of his or her drinking or drug use. The formalized intervention process includes a progressive interaction by the counselor with the family or friends for at least 2 days before meeting with the patient.

The Panel recommends the following modifications to interventions for older patients. No more than one or two relatives or close associates should be involved along with the health care provider; having too many people present may be emotionally overwhelming or confusing for the older person. *Inclusion of grandchildren is discouraged,* because many older alcoholics resent their problems being aired in the presence of much younger relatives. (2)

Motivational Counseling

Motivational counseling acknowledges differences in readiness and offers an approach for "meeting people where they are" that has proven effective with older adults. (1) An understanding and supportive counselor listens respectfully and accepts the older adult's perspective on the situation as a starting point, helps him or her to identify the negative consequences of drinking and prescription drug abuse, helps him or her shift perceptions about the impact of drinking or drug-taking habits, empowers him or her to generate insights about and solutions for his or her problem, and expresses belief in and support for his or her capacity for change. Motivational counseling is an intensive process that enlists patients in their own recovery by avoiding labels, avoiding confrontation (which usually results in greater defensiveness), accepting ambivalence about the need to change as normal, inviting clients to consider alternative ways of solving problems, and placing the responsibility for change on the client.

Detoxification

Some older patients should be withdrawn from alcohol or from prescription drugs in a hospital setting. Medical safety and removal from continuing access to alcohol or the abused drugs are primary considerations in this decision.

Indicators that inpatient hospital supervision is needed for withdrawal from a prescription drug include the following (2):

- A high potential for developing dangerous abstinence symptoms such as a seizure or delirium because the dosage of a benzodiazepine or barbiturate has been particularly high or prolonged and has been discontinued abruptly or because the patient has experienced these serious symptoms at any time previously
- Suicidal ideation or threats
- The presence of other major psychopathology
- Unstable or uncontrolled comorbid medical conditions requiring 24-hour care or parenterally administered medications (e.g., renal disease, diabetes)
- Mixed addictions, including alcohol
- A lack of social supports in the living situation or living alone with continued access to the abused drug(s).

In general, *the Panel recommends that the initial dose of a drug for suppression and management of withdrawal symptoms should be one-third to one-half the usual adult dose, sustained for 24 to 48 hours to*

observe reactions, and then gradually tapered with close attention to clinical responses. (1)

Treatment Settings

The Panel recommends that patients who are brittle, frail, acutely suicidal, or medically unstable or who need constant one-on-one monitoring receive 24-hour primary medical/psychiatric/nursing inpatient care in medically managed and monitored intensive treatment settings. (2)

As part of outpatient treatment, *the Panel recommends drawing the physician into the treatment planning process and enrolling him or her as a player in the recovery network.* (2)

The Panel also recommends serving older people who are dependent on psychoactive prescription drugs in flexible, community-oriented programs with case management services rather than in traditional, stand-alone substance abuse treatment facilities with standardized components. (2)

Treatment Approaches

The Panel recommends incorporating the following six features into treatment of the older alcohol abuser (1):

- Age-specific group treatment that is supportive and nonconfrontational and aims to build or rebuild the patient's self-esteem
- A focus on coping with depression, loneliness, and loss (e.g., death of a spouse, retirement)
- A focus on rebuilding the client's social support network
- A pace and content of treatment appropriate for the older person
- Staff members who are interested and experienced in working with older adults
- Linkages with medical services, services for the aging, and institutional settings for referral into and out of treatment, as well as case management.

Building from these six features, *the Consensus Panel recommends that treatment programs adhere to the following principles* (2):

- Treat older people in age-specific settings where feasible
- Create a culture of respect for older clients
- Take a broad, holistic approach to treatment that emphasizes age-specific psychological, social, and health problems
- Keep the treatment program flexible
- Adapt treatment as needed in response to clients' gender.

To help ensure optimal benefits for older adults, *the Consensus Panel recommends that treatment plans weave age-related factors into the contextual framework of the American Society of Addiction Medicine (ASAM) criteria.* (2)

The Consensus Panel recommends the following general approaches for effective treatment of older adult substance abusers (2):

- Cognitive–behavioral approaches
- Group-based approaches
- Individual counseling
- Medical/psychiatric approaches
- Marital and family involvement/family therapy
- Case management/community-linked services and outreach.

The Panel recommends that cognitive–behavioral treatment focus on teaching skills necessary for rebuilding the social support network; self-management approaches for overcoming depression, grief, or loneliness; and general problem solving. (1)

Within treatment groups, *the Panel recommends that older clients should get more than one opportunity to integrate and act on new information.* (2) For example, information on bereavement can be presented in an educational session, then reinforced in therapy. To help participants integrate and understand material, *it may be helpful to expose them to all units of information twice.* (2)

Older people in educational groups can receive, integrate, and recall information better if they are given a clear statement of the goal and purpose of the session and an outline of the

content to be covered. The leader can post this outline and refer to it throughout the session. The outline may also be distributed for use in personal note-taking and as an aid in review and recall. *Courses and individual sessions should be conceived as building blocks that are added to the base of the older person's life experience and needs. Each session should begin with a review of previously presented materials.* (2)

Groups should accommodate clients' sensory decline and deficits by maximizing the use of as many of the clients' senses as possible. *The Panel recommends use of simultaneous visual and audible presentation of material, enlarged print, voice enhancers, and blackboards or flip charts.* (2) It is important to recognize clients' physical limitations. *Group sessions should last no longer than about 55 minutes. The area should be well lighted without glare; and interruptions, noise, and superfluous material should be kept to a minimum.* (2)

The Panel recommends that counselors providing individual psychotherapy treat older clients in a nonthreatening, supportive manner and assure the client that they will honor the confidentiality of the sessions. (2)

Medications used to modify drinking behavior in older adults must take into account age- and disease-related increases in vulnerability to toxic drug side effects, as well as possible adverse interactions with other prescribed medications. *Disulfiram (Antabuse) is not generally recommended by the Panel for use in older patients because of the hazards of the alcohol–disulfiram interaction, as well as the toxicity of disulfiram itself.* (1) Of the other pharmacotherapies for alcohol abuse, naltrexone (ReVia) is well tolerated by older adults and may reduce drinking relapses. (1)

Depression for several days or longer immediately after a prolonged drinking episode does not necessarily indicate a true comorbid disorder or the need for antidepressant treatment in most cases, but *when depressive symptoms persist several weeks following cessation of drinking, specific antidepressant treatment is indicated.* (1)

The advantages of quitting smoking are clear, even in older adults. *The Panel recommends that efforts to reduce substance abuse among older adults also include help in tobacco smoking cessation.*

Staffing Considerations

The Consensus Panel recommends that the following principles guide staffing choices in substance abuse treatment programs (2)*:*

- Whenever possible, employ staff who have completed training in gerontology
- Employ staff who like working with older adults
- Provide training in empirically demonstrated principles effective with older adults to all staff who will interact with these clients.

Panel members believe that any program that treats even a few older adults should have at least one staff person who is trained in the specialization of gerontology within his or her discipline. This training should consist of at least a graduate certificate program (6- to 12-month) in the subfield of aging commonly called social gerontology. Staff with professional degrees should have a specialization in gerontology, geriatrics, or psychogeriatrics.

Outcomes and Cost Issues In Alcohol Treatment

Outcome assessment is invaluable from both a management and a referral perspective. The providers of treatment, the clinicians and agencies referring patients, and patients themselves need to have information regarding the likely outcomes of treatment. Because treatment options range from brief interventions to structured outpatient and inpatient treatment programs, *the Panel recommends evaluation of outcomes at varying points in the treatment process.*

(1) Baseline data should be obtained at the beginning of the intervention or treatment; first followup evaluations should be conducted 2 weeks to 1 month after the patient leaves the inpatient setting. The literature on patients receiving substance abuse treatment indicates that 60 to 80 percent of people who relapse do so within 3 to 4 months. Therefore, *outpatient outcomes should be assessed no sooner than 3 months and possibly as long as 12 months after treatment.* (1)

The Panel recommends that outcome measurement include not only abstinence or reduced consumption but also patterns of alcohol use, alcohol-related problems, physical and emotional health functioning, and quality of life and well-being. (1) One of the most widely used measures of physical and emotional health is the Medical Outcomes Study 36-Item Short Form Health Survey (SF-36). (1) Another measure of psychological distress useful for alcohol outcomes assessment with older adults is the Symptom Checklist-90-Revised (SCL-90-R) and its abbreviated version, the Brief Symptom Inventory (BSI). (1) *For measuring quality of life, an important measure for older adults with alcohol problems, the Panel recommends the Quality of Life Interview (QLI).* (1)

Future Research

The Panel believes that future research needs to be focused in some specific areas to advance the field and to address future problems that will arise in the coming years. *Those areas are alcohol and other drug consumption, treatment, biomedical consequences, behavioral and psychological effects, and special issues.* (1)

This TIP lays a foundation that research in the above areas must build upon if providers are to meet the treatment challenges on the horizon. In particular, providers must prepare for changes in demographics and in treatment delivery. As the country's over-60 population explodes and the health care system shifts to managed care, providers must adjust accordingly. The treatment protocols outlined in this book provide a roadmap for treating this unique and growing population into the next century.