

## Chapter 4—Treating Alcohol Misuse in Older Adults

### KEY MESSAGES

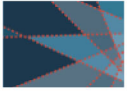
- Older adults are more likely than younger adults to feel the negative effects of alcohol and are at risk for alcohol–drug interactions. Therefore, widespread screening for alcohol use and misuse in all healthcare settings and emergency departments is recommended.
- Screening and assessment tools and treatment options for alcohol misuse among older adults should be senior friendly and meet their unique physical, emotional, and social needs.
- Education about low-risk levels of alcohol use and about alcohol–drug interactions can be a powerful brief intervention as well as a prevention tool in keeping seniors safe.
- You can help increase your older clients' chances of success by offering many different treatment choices based on their symptoms and needs; addressing all co-occurring health conditions; and using a stepped-care approach to the management of referrals and ongoing coordination of care.

Chapter 4 of this Treatment Improvement Protocol (TIP) will benefit healthcare, behavioral health service, and social service providers working with older adults. It addresses alcohol use and misuse among older adults. National survey data show that alcohol use, binge drinking, and alcohol use disorder (AUD) are increasing in this population at a concerning rate.<sup>567</sup> Addiction counselors and other healthcare providers should understand the unique needs of older adults when addressing alcohol-related issues. Although older adults generally have lower rates of alcohol misuse, including AUD, than younger adults, baby boomers (born between 1946 and 1964) are more likely to drink and have alcohol-related problems than earlier generations of older adults. Even low levels of drinking can lead to negative health effects in older adults because of age-related physical changes, negative interactions between alcohol and commonly used medications, and decreases in physical and cognitive functioning (thinking abilities).

### Organization of Chapter 4 of This TIP

This chapter of TIP 26 presents facts about alcohol misuse, including AUD, among older adults. It also addresses screening and assessment, co-occurring health conditions and mental disorders often related to alcohol misuse, and treatment and recovery management approaches for older adults.

The first section of Chapter 4 describes alcohol misuse among older adults. It includes definitions; numbers and figures; and the physical, mental, social, and economic effects of AUD. It also addresses co-occurring health conditions and mental disorders in older adults who drink.



The second section addresses screening and assessment of alcohol misuse in older adults. It covers screening tools for alcohol misuse, limitations of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) diagnostic criteria for AUD as applied to older adults, signs of late-onset AUD, and misuse of alcohol with prescription medications. **This section also addresses screening for and assessing commonly co-occurring health conditions and mental disorders among older adults who drink.**

The third section briefly describes the continuum of care for older adults, including brief interventions for alcohol misuse and inpatient detoxification or rehabilitation.

The fourth section discusses specific treatment approaches for older adults with AUD. These include brief interventions, cognitive-behavioral therapy (CBT), problem-solving therapy (PST), skill-building and relapse prevention therapy (RPT), 12-Step Facilitation (TSF) therapy, age-specific inpatient and outpatient rehabilitation, and pharmacotherapy.

The fifth section explores recovery management strategies for older adults. It covers strategies for including family members in treatment; addressing caregiver needs; and linking older adults to evidence-supported, community-based recovery support groups such as Alcoholics Anonymous (AA) and SMART (Self-Management and Recovery Training) Recovery.

The sixth section presents clinical scenarios to show how to match treatment approaches to a client's level of alcohol misuse, from those who are abstinent (not drinking at all) for health reasons to those with AUD requiring inpatient rehabilitation and ongoing recovery management.

The final section offers targeted resources to support your practice. For more resources related to addressing substance misuse among older adults, including misuse of alcohol, see the Chapter 4 Appendix and the additional resources in Chapter 9 of this TIP.

For definitions of key terms you will see throughout Chapter 4, refer to Exhibit 4.1.

## EXHIBIT 4.1. Key Terms

- **Addiction\***: The most severe form of substance use disorder (SUD), associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.
- **Age-sensitive**: Adaptations to existing treatment approaches that accommodate older adults' unique needs (e.g., a large-print handout on the signs of substance misuse).
- **Age-specific**: Treatment approaches and practices specifically developed for older adults (e.g., an older adult specialty group in a mixed-age SUD treatment program).
- **Alcohol misuse**: The use of alcohol in any harmful way, including heavy drinking, binge drinking, and AUD.
- **At-risk/high-risk drinking**: Drinking alcohol in excessive amounts. This definition encompasses both binge drinking and heavy drinking. Additionally, any alcohol consumption is considered risky when carried out by individuals with certain medical conditions that are worsened by alcohol, those taking medicine that can interact harmfully with alcohol, those driving a car or engaged in other activities that require alertness, or people recovering from AUD.<sup>568,569</sup> Note that for purposes of this TIP, at-risk drinking and high-risk drinking are synonymous and either term is acceptable to describe an older adult's drinking patterns.
- **AUD**: DSM-5 defines this disorder.<sup>570</sup> An AUD diagnosis is given to people who use alcohol and meet at least 2 of the 11 DSM-5 symptoms in a 12-month period. Key aspects of AUD include tolerance, withdrawal, loss of control, and continued use despite negative consequences. AUD covers a range of severity and replaces what the previous edition of DSM termed alcohol abuse and alcohol dependence.

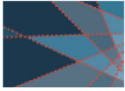
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- **Binge drinking:** A drinking pattern that leads to blood alcohol concentration levels of 0.08 grams per deciliter or greater. This usually takes place after four or more drinks for women and five or more drinks for men.<sup>571,572</sup> However, older adults are more sensitive to the effects of alcohol, and treatment providers may need to lower these numbers when screening for alcohol misuse.<sup>573</sup> Additionally, other factors such as weight, decrease in enzyme activity, and body composition (e.g., amount of muscle tissue present in the body) can also affect alcohol absorption rates.
- **Caregivers:** Informal caregivers provide unpaid care. They assist others with activities of daily living (ADLs), including health and medical tasks. Informal caregivers may be spouses, partners, family members, friends, neighbors, or others who have a significant personal relationship with the person who needs care. Formal caregivers are paid providers who offer care in one's home or in a facility.<sup>574</sup> Most older adults do not need caregivers and are as able to address their own needs as younger adults, whether or not substance misuse is a factor in their lives.
- **Drug–drug interaction:** The interaction of one substance (e.g., alcohol, medication, an illicit drug) with another substance. Drug–drug interactions may change the effectiveness of medications, introduce or alter the intensity of side effects, and increase a substance's toxicity or the concentration of that substance in a person's blood. Potentially serious interactions can also occur with certain foods, beverages, and dietary supplements.<sup>575</sup>
- **Harmful drinking:** Alcohol use that worsens or complicates current alcohol-related problems.<sup>576</sup>
- **Hazardous drinking:** Alcohol use that increases the risk of future harm.<sup>577</sup>
- **Heavy drinking:** Consuming five or more drinks for men and four or more drinks for women in one period on each of 5 or more days in the past 30 days.<sup>578</sup>
- **Moderate drinking:** According to the 2015–2020 *Dietary Guidelines for Americans*, moderate drinking is defined as up to two drinks per day for men and up to one drink per day for women.<sup>579,580</sup> However, the Centers for Disease Control and Prevention (CDC) notes that these numbers apply to any given day and are not meant as an average over several days.<sup>581</sup> Additionally, individuals who don't metabolize alcohol well may need to consume even lower quantities. Some people, particularly those with certain alcohol-related illnesses or engaging in tasks requiring concentration, should not consume alcohol at all. The *Dietary Guidelines* stipulate that those who don't drink should not begin drinking for any reason.<sup>582</sup>
- **Mutual-help groups:** Groups of people who work together on obtaining and maintaining recovery. Unlike peer support (e.g., the use of recovery coaches or peer recovery support specialists), mutual-help groups consist entirely of people who volunteer their time and typically have no official connection to treatment programs. Most are self-supporting. Although 12-Step groups such as AA and Narcotics Anonymous are the most widespread and well researched type of mutual-help groups, other groups may be available in some areas. They range from groups affiliated with a religion or church (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART Recovery, Women for Sobriety).
- **Peer support:** The use of peer recovery support specialists (e.g., someone in recovery who has lived experience in addiction plus skills learned in formal training) to provide nonclinical (i.e., not requiring training in diagnosis or treatment) recovery support services to individuals in recovery from addiction and to their families.
- **Recovery\*:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome them and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called being in recovery. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, prosocial feature.
- **Relapse\*:** A return to substance use after a significant period of abstinence.

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- **Remission:** A medical term meaning a disappearance of signs and symptoms of the disease or disorder. DSM-5 defines remission as present in people who previously met SUD criteria but no longer meet any SUD criteria (with the possible exception of craving).<sup>583</sup> Remission is an essential element of recovery.
- **Stepped care:** A science-based approach that matches an individual's treatment needs to different levels of care, from least intensive to most intensive.
- **Substance misuse\*:** The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).
- **Substance use disorder\*:** A medical illness caused by repeated misuse of a substance or substances. According to DSM-5,<sup>584</sup> SUDs are characterized by clinically significant impairments in health and social function, and by impaired control over substance use. They are diagnosed through assessing cognitive, behavioral, and psychological symptoms. SUDs range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Multiple factors influence whether and how rapidly a person will develop an SUD. These factors include the substance itself; the genetic vulnerability of the user; and the amount, frequency, and duration of the misuse. Note: A severe SUD is commonly called an addiction. A mild SUD is generally equivalent to what previous editions of DSM called substance abuse; a moderate or severe SUD is generally equivalent to what was formerly called substance dependence.

\* The definitions of all terms marked with an asterisk correspond closely to those given in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. This resource provides a great deal of useful information about substance misuse and its impact on U.S. public health. The report is available online (<https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>).

## Alcohol Misuse Among Older Adults

**More older adults are misusing alcohol than in earlier years.** An estimated 23.2 million adults ages 65 and older drank alcohol in the past month, 5.6 million engaged in past-month binge drinking, and 1.5 million engaged in past-month heavy drinking.<sup>585</sup>

**The signs and effects of alcohol misuse, including binge drinking and AUD, often differ between older and younger adults.** Understanding the differences will help you identify, assess, and treat older adults.

## Age-Specific Effects of Alcohol Use

**Older adults metabolize alcohol less efficiently than younger adults.** Older adults have less lean body mass and less total body water than younger adults. This smaller water volume is one reason why an older adult and a younger adult can drink similar amounts of alcohol, but the older adult's blood alcohol level will be higher and stay high longer. In addition, older adults' central nervous system (CNS) is more sensitive to alcohol's effects, leading to lower tolerance.<sup>586</sup> These differences can **lead to or worsen chronic illnesses common in older adults (e.g., high blood pressure).**<sup>587</sup>

**Drinking also increases health-related risks for older adults who take medications that may interact negatively with alcohol.** Older adults are more likely than younger adults to take multiple



medications, further increasing this risk. Moreover, up to 19 percent of older adults in the United States use alcohol and prescription medications in a way that could be considered misuse.<sup>588</sup>

## Alcohol Misuse

Older adults can meet the definition of alcohol misuse at lower levels of alcohol use than adults younger than 60. **Older adults who have been drinking for years may face more alcohol-related problems—and those problems may be more severe—even if their use has not increased over time.** A review of survey data indicates that 4 percent to 14 percent of older adults may misuse alcohol.<sup>589</sup>

**The rate of alcohol misuse among older adults increases when including health status and overall functioning,** rather than just amount of alcohol used and frequency of use. For instance, a study on alcohol-related health risk in older adults in the United States found that among older adults who drink, 53.3 percent had harmful or hazardous use.<sup>590</sup> This number was more than three times greater than the number of older adults consuming alcohol above federal guideline limits. The discrepancy in the consumption rate and the rate of harmful or hazardous use is explained by the health status of older adults.

### RESOURCE ALERT: A CONSUMER WEBSITE FOR CALCULATING ALCOHOL CONSUMPTION

***Rethinking Drinking: Alcohol & Your Health*** ([www.rethinkingdrinking.niaaa.nih.gov](http://www.rethinkingdrinking.niaaa.nih.gov)) is a National Institute on Alcohol Abuse and Alcoholism (NIAAA) interactive website that provides individuals with accurate information about what a standard drink is and how to calculate their level of alcohol use based on the types and amounts of alcoholic beverages they drink.

**Low-risk drinking guidelines at this website are for *all* adults; they are not reduced for older adults.** Discuss why older adults may need to adhere to lower numbers before referring your clients to this website.

**Alcohol misuse among older adults is likely responsible for a large portion of the damage some experience to their health and well-being.**<sup>591</sup> For the older adult population, drinking even small amounts of alcohol can have serious physical, mental, and social effects. For example, one or two drinks a day may lead to increased cognitive impairment (problems with thinking) for individuals who already have dementia, or sleep problems (e.g., sleep apnea).<sup>592</sup>

**The economic costs of alcohol misuse among older adults are significant.** Older adults who misuse alcohol are at greater risk for injury and falls. Certain events among older adults that can be related to alcohol use—such as injury deaths, falls treated in emergency departments, hospitalized falls, and fall-related traumatic brain injury deaths—have risen significantly in the past decade.<sup>593</sup>

Older adults who misuse alcohol are at risk for:<sup>594</sup>

- Liver disease.
- Sleep problems.
- Cancer.
- Diabetes.
- Congestive heart failure.
- Lowered general health functioning.

Older adults who drink beyond recommended guidelines have higher rates of tobacco use disorder and are at risk for:<sup>595,596,597</sup>

- Depression, anxiety, and mood disorders.
- Memory problems.
- Cognitive changes such as dementia.
- Sleep disorders.
- Agitation or violent behavior.
- Suicide.

## DRINKING IN RETIREMENT COMMUNITIES

Participating in social activities with family and friends who drink reinforces alcohol use and misuse. This is particularly true in retirement communities, where drinking and socializing often go hand in hand.<sup>598</sup> A recent study of a large retirement community in Florida found that 15.4 percent of the respondents to a survey on drinking reported hazardous drinking levels. However, when asked about health-related concerns and quality of life, most responded that drinking was a part of their social lives, did not report many health concerns, and reported a high quality of life.<sup>599</sup>

This result suggests that some older adults whose social drinking exceeds recommended limits may improve their quality of life, which could balance out any potential health risks. However, subjective measures of health-related effects of heavy alcohol use are not always as trustworthy as objective measures, such as lab results for medical conditions. **When you assess the health risks of an older adult's drinking, keep in mind the cultural context of his or her drinking, the amount and frequency of drinking, and any objective measures of health effects in addition to self-report findings.**

## Binge Drinking

**Binge drinking is a drinking pattern that leads to blood alcohol concentration levels of 0.08 grams per deciliter or greater. On average, this occurs after five or more drinks for men and four or more drinks for women.<sup>600,601</sup> However, for older adults, who have increased sensitivity to alcohol, lower alcohol consumption levels may be considered binge drinking.**

According to the National Survey on Drug Use and Health (NSDUH), 10.7 percent of adults ages 65 and older binge drink (defined as five or more drinks for men and four or more drinks for women, per event).<sup>602</sup> This percentage would be even higher if the survey could factor in that binge drinking occurs at lower alcohol consumption levels for some older adults. **Binge drinking appears to**

**be more of an issue for older men than older women.<sup>603</sup> Yet binge drinking among older women is rapidly increasing.<sup>604</sup>**

Binge drinking creates additional health problems for older adults. Binge drinking is related to a number of health and safety issues, including accidents, an increased chance of physical injury (e.g., falls), and higher death rates.<sup>605,606</sup> Binge drinking is also related to a higher risk of AUD in both men and women as they age.<sup>607,608</sup>

## AUD

**Baby boomers drink more than earlier generations, which is likely to lead to a large increase in the number of older adults with AUD as this generation ages.<sup>609</sup> Furthermore, the number of adults ages 65 and older in the U.S. population is predicted to increase from about 56 million in 2020 to more than 85 million by 2050.<sup>610,611</sup>**

In the general population, only an estimated 1.52 percent of adults ages 60 and older report AUD in the past 12 months; 16.1 percent report AUD in their lifetime.<sup>612</sup> Conversely, up to 30 percent of older adults hospitalized in general medical units and up to 50 percent hospitalized in psychiatric units have AUD.<sup>613</sup> This is significant, because older adults with AUD who are hospitalized might not report their level of drinking to healthcare providers and could be at risk for alcohol withdrawal during their hospitalization. So too, these percentages may not capture the actual prevalence of AUD in this population, as DSM diagnostic criteria do not always accurately identify AUD in older adults.<sup>614</sup>

**According to the 2019 NSDUH, 10.7% of adults ages 65 and older BINGE DRINK.**



## Co-Occurring Health Conditions and Mental Disorders

Alcohol use can worsen the effects of many co-occurring mental health and health conditions (e.g., depressive disorders, high blood pressure, and diabetes). In addition, many physiological changes naturally take place during the aging process; clients need to understand that drinking can accelerate these health-related changes.

### Anxiety

Anxiety symptoms and anxiety disorders are common in adults ages 60 and older in community and treatment settings.<sup>615</sup> Older adults also have a high rate of co-occurring anxiety disorders and AUD.<sup>616</sup> Anxiety causes high personal distress, reduces life satisfaction, and increases the risk for disability among older adults. Anxiety also increases the risk of death among older adults from suicide and from heart disease.<sup>617</sup> **Older adults who drink to lessen their anxiety increase their health-related risks.**

### Depression

Depression is one of the most common co-occurring mental disorders among older adults with AUD. Approximately 4.5 percent of older adults (ages 50 and older) met past-year prevalence of major depression.<sup>618</sup> This estimate does not include those who meet either DSM-5 diagnostic criteria for other depressive disorders or have symptoms of depression that interfere with everyday functioning. The negative effects of depression in older adults include suicide risk, increased cognitive impairment, a higher risk of dementia, and poorer physical health.<sup>619</sup>

**Alcohol is a depressant drug (meaning it reduces activity of the CNS).** Drinking alcohol can worsen depression or increase the risk of late-life depression.<sup>620</sup> In approximately 30 percent of older adults with co-occurring AUD and depression, the depression is not directly linked to drinking but instead was present before the onset of AUD or developed separately from AUD.<sup>621</sup>

## RESOURCE ALERT: TREATING DEPRESSION IN OLDER ADULTS

See SAMHSA's Evidence-Based Practices KIT (Knowledge Informing Transformation) *The Treatment of Depression in Older Adults* (<https://store.samhsa.gov/product/Treatment-Depression-Older-Adults-Evidence-Based-Practices-EBP-Kit/SMA11-4631>) for more information and treatment strategies.

**Diagnosing depression in older adults with AUD is challenging.** Depression may be underdiagnosed because its symptoms are similar to those of dementia and common complaints of older adults, such as loss of interests, slowed thinking, lack of energy, or general aches and pains.<sup>622</sup> **Assess depression and other mood disorders at the start of AUD treatment, and reassess from time to time** to learn whether abstinence or a reduction in alcohol use reduces symptoms of depression.

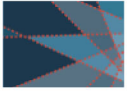
### Serious Mental Illness

People with serious mental illness (SMI), like schizophrenia, typically have higher levels of stress, tobacco use, and alcohol use than the general population. They are also more likely to have poor overall health, an inactive lifestyle, and an increased risk of death.<sup>623</sup> **About 19 percent of older adults with SMI have a co-occurring SUD, and AUD is one of the most common.**<sup>624</sup>

Co-occurring AUD and SMI among older adults has not been studied widely. However, alcohol use is a factor in people not taking their psychotropic medication as prescribed, and co-occurring AUD is related to longer length of psychiatric stay and an increase in co-occurring medical conditions.

See Chapter 6 of this TIP for details on the links between alcohol use and dementia among older adults.





### Pain

Chronic pain is a common condition in older adults that reduces their ability to move and perform ADLs. A study of U.S. older adults estimated that 52.9 percent, or as many as 18.7 million, have pain that makes their daily functioning difficult.<sup>625</sup>

**Older adults with chronic pain who drink to reduce their pain are at risk for late-onset AUD.<sup>626</sup> Drinking while taking pain medications also increases other health-related risks** (e.g., serious liver disease, overdose death). Common pain medications older adults may take include nonsteroidal anti-inflammatory drugs (NSAIDs) and opioids (e.g., hydrocodone, oxycodone).

### Screening and Assessment

**Many older adults who misuse alcohol do not need specialized addiction treatment services. Still, screening and brief educational and motivational interventions can help older adults reduce alcohol use and health-related harms** when delivered in healthcare and mental health service settings.<sup>627</sup>

**AUD is often underdiagnosed in older adults.** Some DSM-5 diagnostic criteria may not apply to them. For example, the criterion of failing to fulfill major duties at work will not apply to an older adult who is retired. Furthermore, **providers may mistake AUD symptoms for other conditions** that are commonly, yet often incorrectly, thought to be normal signs of aging, such as:<sup>628</sup>

- Sleep problems.
- Memory loss.
- Depression.
- Anxiety.
- Aches and pains.
- Poor diet.
- Loss of interest in sex.

Older adults in long-term care settings, such as assisted living and nursing homes, are often not diagnosed or treated for AUD.<sup>629</sup> The key to finding the right interventions for alcohol misuse, including AUD, is to **adapt screening, assessment, and diagnostic criteria to older clients, regardless of the settings in which they receive health or social services.**

### Widespread Screening

Widespread screening in healthcare and behavioral health service settings is an opportunity for brief intervention and, when needed, referral to addiction-specific treatment services.<sup>630</sup>

**Older adults are often not screened for alcohol misuse because providers hold incorrect beliefs about alcohol use in this population.** They may think that older adults don't drink much or, if they do drink, they should be allowed this "one last pleasure" of life.<sup>631</sup> Providers also may choose not to ask older adults about their drinking history and current alcohol use for fear that asking these questions will hurt their relationship with these clients. However, baby boomers tend to be more accepting than earlier generations of the idea of talking about and seeking help for mental disorders and SUDs.

**Challenge false beliefs by educating your fellow providers and supporting widespread alcohol screening as a normal, ongoing practice.** Doing so can help reduce any mixed feelings providers have about screening older adults. It can also increase the chances of identifying alcohol misuse early in older clients. (Chapter 3 of this TIP offers more information on screening and assessing for substance misuse in older adults.)

### WHEN TO SCREEN OLDER ADULTS FOR ALCOHOL MISUSE<sup>632</sup>

- As part of every annual physical exam
- As part of the initial assessment in behavioral health service settings
- As part of the initial intake or admission process to older adult-focused social service programs
- When the older adult starts a new medication
- When the older adult has major stressful life changes (e.g., death of a significant other, retirement, major illness or declining health, loss of social supports)
- When potential signs and symptoms of an alcohol-related problem are present, such as sleep difficulties, falls, injuries, depression, and problems with daily living skills
- When the older adult has multiple healthcare providers or uses more than one pharmacy
- When the older adult reports that a medication is not working as well over time
- When the older adult reports a past personal or family history of substance use or mental disorders

The consensus panel recommends widespread screening of older adults for alcohol misuse and alcohol-related problems in all healthcare settings and emergency departments, where older adults are frequently seen because of accidents and falls related to alcohol use. Also screen older adults for alcohol misuse at the initial intake or assessment when admitted to social services agencies and behavioral health service programs.

### Screening Tools

The Alcohol Use Disorders Identification Test (AUDIT) and the Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G) are two common, easy-to-use, brief instruments that can successfully screen older adults for alcohol misuse and signs of AUD.<sup>633</sup>

### AUDIT

The AUDIT is a 10-item screening instrument for heavy drinking from the World Health Organization. The AUDIT collects information about alcohol use, drinking behaviors, and alcohol-related problems over the past year.<sup>634</sup> It is a validated (tested and approved) measure of alcohol-related risk in people of different genders, ages, and cultures.<sup>635</sup> There are two versions—one given by clinicians and one that clients complete by themselves. (See the Chapter 4 Appendix for both.) A cutoff score of 8 generally indicates hazardous and harmful alcohol use. For older adults, however, a score of 5 means you should assess further.<sup>636</sup>

### SMAST-G

Researchers at the University of Michigan developed the MASt-G, a 24-item screening instrument specifically for use with older adults. The MASt-G can be used to identify alcohol misuse in older adults.

The SMAST-G is a shorter, 10-item, validated version of MASt-G.<sup>637</sup> The SMAST-G does not ask about amount and frequency of alcohol use; it focuses more on the older adult's relationship to alcohol and effects of drinking. The SMAST-G is about as reliable and accurate for older adults as the AUDIT. Two or more "yes" responses indicate possible alcohol misuse.<sup>638</sup> (See the Chapter 4 Appendix for the SMAST-G.)

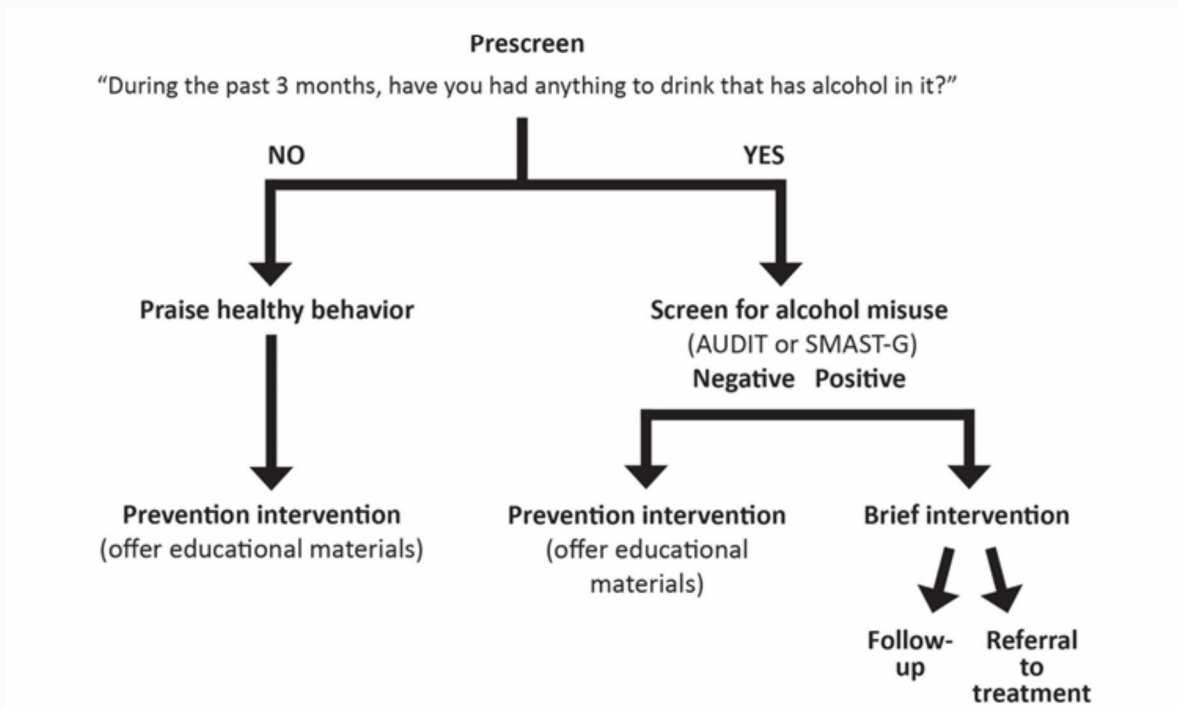
### Considerations When Using AUD Screening Instruments

Although screening instruments can help you quickly identify potential alcohol misuse in older adults and offer a chance to use prevention strategies (Exhibit 4.2), they can sometimes be overly sensitive and lead to false positives.<sup>639</sup> Some questions on alcohol screening instruments refer to physical complaints that are often age associated. Conversely, brief screening does not always capture symptoms that may indicate AUD. **Always follow up positive screens with more questions and indepth assessment (or referral to assessment) for AUD.**

## EXHIBIT 4.2. Preventing Alcohol Misuse Among Older Adults

You can support prevention efforts by helping older adults develop the knowledge, attitudes, and skills they need to make good choices about alcohol use before their drinking puts their physical and mental health at risk. The key to prevention is identifying early which older adults drink alcohol. You can often help older adults to reduce their drinking, or to seek help if their alcohol use begins to affect their health, simply by giving them information about standard drink sizes, guidelines for low-risk drinking, health risks of alcohol misuse, and health risks of mixing medication with alcohol.

Early identification and prevention begin with widespread prescreening in all healthcare and community-based senior service settings.<sup>640</sup> The following decision tree shows the early identification and prevention process.



*Adapted from material in the public domain.<sup>641</sup>*

### Assessment and Diagnosis of AUD

**It is essential that you, or another provider with sufficient qualifications, perform indepth assessments for AUD in your older adult clients.** Older adults with AUD are often underdiagnosed because DSM-5 criteria do not always capture AUD in older adults. Also, some signs of AUD may be mistaken for symptoms of co-occurring medical or mental disorders or natural aging processes. **If you only use DSM-5 diagnostic criteria to diagnose AUD, you may miss many older adults with alcohol-related problems, which means they may not receive proper treatment.**<sup>642</sup>

A full assessment should address the client's:

- History of alcohol use.
- Age of onset of alcohol-related problems.
- Past and current amount and frequency of alcohol use (with attention to periods of binge drinking).
- Relationship between his or her drinking and daily functioning.
- Co-occurring medical conditions.
- Past attempts to limit or control alcohol intake.



- Co-occurring mental disorders, particularly depression and anxiety.
- Current medications.
- Use of alcohol to cope with sleep problems, depression, anxiety, stressful life events, or pain.

For information on how to give an in-depth assessment for AUD, refer to Chapter 3 of this TIP.

### **Understanding DSM-5 Diagnostic Criteria Versus Alcohol-Related Risk Criteria**

For an AUD diagnosis, your client must have at least 2 out of 11 symptoms listed in DSM-5. However, as noted before, some of these symptoms may not apply to older adults. Exhibit 4.3 summarizes the physical, cognitive, and social aspects of aging you should think about when using these criteria to assess and diagnose AUD in older adults.

## **EXHIBIT 4.3. DSM-5 Criteria for AUD and Considerations for Older Adults**

DSM-5 CRITERIA FOR AUD <sup>643</sup>	CLINICAL CONSIDERATIONS <sup>644,645,646,647,648</sup>
Criterion A1	Older adults may need less alcohol to feel physical effects. Cognitive impairment can make it hard for older adults to keep track of their drinking.
Criterion A2	No special considerations for older adults.
Criterion A3	Effects of alcohol can result from drinking even small amounts, so relatively less time may be spent getting and drinking alcohol and recovering from using it.
Criterion A4	No special considerations for older adults.
Criterion A5	Older adults may have different role responsibilities because of life-stage changes, such as retirement. Role responsibilities more common in older adulthood include caregiving for a spouse or another family member, such as a grandchild.
Criterion A6	Older adults may not realize that social or interpersonal problems they are experiencing are connected to their alcohol use.
Criterion A7	Older adults may take part in fewer activities generally, making it more difficult to discover when drinking is causing them to withdraw from activities.
Criterion A8	Older adults may not understand that their alcohol use is hazardous, especially when they are drinking the same as or less than before. In addition, older adults may not realize the physical dangers of drinking in certain situations (e.g., before using a step stool).
Criterion A9	Older adults experiencing physical or psychological problems may not realize that drinking could be a factor.
Criterion A10	Changes in tolerance occur because of increased sensitivity to alcohol with age. Previously manageable quantities of alcohol may cause greater impairment.
Criterion A11	Withdrawal symptoms in older adults can last longer, be less obvious, or be mistaken for age-related illness.

DSM-5 diagnostic criteria related to physical and emotional effects (e.g., craving, desire to cut down) may be key signs of AUD in older adults.<sup>649</sup> When deciding whether an older individual's alcohol misuse meets DSM-5 criteria for AUD, remember older adults' lowered tolerance to alcohol and the unique aspects of withdrawal from alcohol and other sedative-hypnotic drugs, like benzodiazepines.

**To diagnose AUD in older adults, use alcohol-related risk criteria in addition to DSM-5 diagnostic criteria.** For example, alcohol-related risk criteria for older adults in the Comorbidity Alcohol Risk Evaluation Tool (CARET), based on the Alcohol-Related Problems Survey,<sup>650</sup> include:<sup>651</sup>

- Amount and frequency of alcohol use (e.g., drinking more than recommended guidelines).
- Brief periods of excessive drinking (e.g., binge drinking).
- Driving after drinking.
- Others being concerned about the older adult's drinking.
- Co-occurring medical and mental disorders.
- Symptoms caused or worsened by drinking (e.g., cognitive impairment).
- Medications that interact negatively with alcohol or that do not work properly if taken with alcohol.

The amount and frequency of drinking described as "at-risk" for older adults is paired with specific drinking behaviors, use of medications, and co-occurring conditions in the past 12 months. For more information about the items in the CARET and how to score them, please see Barnes et al., 2010.<sup>652</sup>

For example, if an older adult has chronic liver disease and drinks any alcohol or even binge drinks just once a week, he or she may not meet DSM-5 criteria for AUD. Still, his or her drinking is a risk for serious alcohol-related health consequences. **Using age-adjusted DSM-5 criteria and CARET health-related risk criteria will more accurately**

**gauge severity of AUD** and the degree to which your client may exhibit behavioral or health-related effects of drinking that should be a focus of treatment.

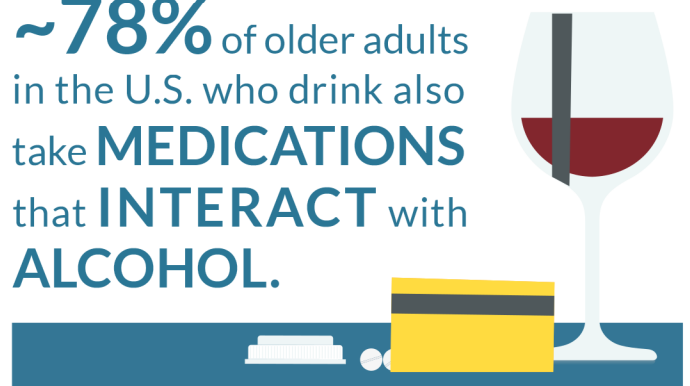
**In assessing and diagnosing AUD in older adults, the consensus panel recommends that you think through all aspects of health-related risk in addition to age-specific issues.**

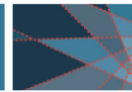
### *Late-Onset Alcohol Misuse and AUD*

Most older adults meeting criteria or receiving treatment for AUD began drinking earlier in their lives. However, **some older adults begin to misuse alcohol later in life (called late-onset alcohol misuse or, if severe enough to meet criteria for AUD, late-onset AUD).** Older adults who begin misusing alcohol late in life may not realize their increased risk for health-related harms related to drinking. They may start misusing alcohol to cope with co-occurring medical or mental disorders, grief and isolation upon the loss of a loved one, or the stress of life changes, such as retirement.<sup>653</sup> Stress, role or identity loss, and approval of drinking by members of older adults' social groups are linked to an increased risk of late-onset AUD.<sup>654</sup>

Assessments should address risk factors related to late-life alcohol misuse among older adults (Exhibit 4.4). **Assessment is a chance for you to use education as a prevention and early intervention tool.**

**~78%** of older adults in the U.S. who drink also take **MEDICATIONS** that **INTERACT** with **ALCOHOL.**





## EXHIBIT 4.4. Risk Factors Related to Alcohol Misuse in Late Life<sup>655</sup>

Physical risk factors:

- Long-lasting pain
- Physical disabilities or problems getting around
- Changes in care or living situations
- Poor health status
- Chronic physical illness
- Multiple prescription drugs

Mental risk factors:

- Avoidance coping style (e.g., drinking to cope with stressful events)
- History of alcohol misuse
- Past or co-occurring SUDs (including tobacco use disorder)
- Past or co-occurring mental disorders

Social risk factors:

- Financial stress, including having a fixed income and having difficulty obtaining Medicare/Medicaid and other health benefits
- Bereavement
- Unexpected or forced retirement
- Social isolation

### ***Assessing Alcohol–Drug Interactions***

**Alcohol–drug interactions are a major factor in the overall health risk for older adults who drink.**<sup>656</sup> Changes in older adults' ability to absorb and metabolize alcohol and medications (i.e., higher sensitivity) can increase the risk of negative alcohol–drug interactions. Alcohol can also increase or reduce a medication's therapeutic effect and interfere with its effectiveness in treating medical illnesses commonly seen in older adults, like high blood pressure, depression, gout, and insomnia.<sup>657</sup>

**Some older adults may also be at greater risk for negative alcohol–drug interactions because of the number and types of medications they take.**

Approximately 78 percent of older adults in the United States who drink also take medications that interact with alcohol.<sup>658,659</sup> Emergency department visits are increasing for dangerous alcohol–drug reactions in older adults.

**Many classes of prescription medications can interact negatively with alcohol, including:**<sup>660</sup>

- Antibiotics.
- Antidepressants.
- Antihistamines.
- Barbiturates.
- Benzodiazepines.
- Muscle relaxants.
- Nonopioid pain medications.
- Anti-inflammatory agents.
- Opioids.
- Anticoagulants.

Learn more about commonly used prescription and over-the-counter medications and how they interact with alcohol in NIAAA's publication *Harmful Interactions* ([www.niaaa.nih.gov/publications/brochures-and-fact-sheets/harmful-interactions-mixing-alcohol-with-medicines](http://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/harmful-interactions-mixing-alcohol-with-medicines)).



## RESOURCE ALERT: ALCOHOL AND DRUG INTERACTION CHECKERS

Learn more about interactions between alcohol and specific medications by using a drug interaction checker (e.g., the one available at [www.drugs.com/drug\\_interactions.html](http://www.drugs.com/drug_interactions.html)). Check for interactions between ethanol (the type of alcohol in alcoholic beverages) and medications (prescription and over-the-counter) and dietary supplements (e.g., vitamins, herbal products).

**With permission, you can also check with your client's pharmacist about alcohol–drug interactions for the specific medications your client takes.**

Always learn which medications your client takes. Nonjudgmentally offer information about the ways alcohol can interfere with a medication's effectiveness and increase the risk of harmful effects.

**The consensus panel recommends that you educate older adults about negative alcohol–drug interactions and work with your clients to help them reduce or abstain from alcohol use while taking these medications.**

## Continuum of Care

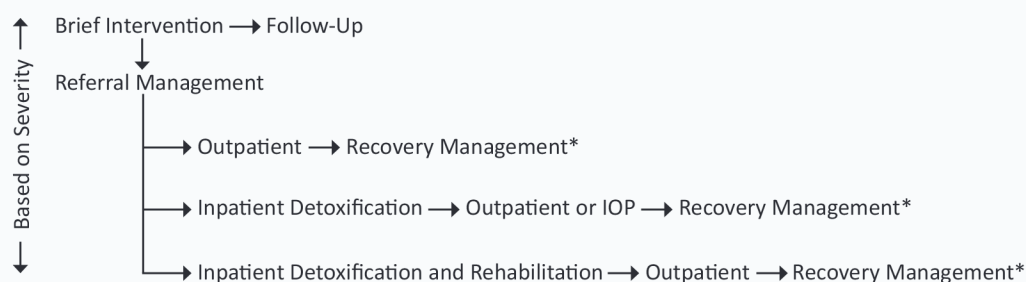
A continuum of care exists for older adults with alcohol misuse, including AUD. It ranges from least to most intensive: from brief interventions, to outpatient or intensive outpatient treatment (IOP) in programs that specialize in mental health services or SUD treatment, to inpatient detoxification and rehabilitation.

**Continuing care should focus not only on achieving abstinence from or reducing alcohol use but also on improving quality of life.** AUD treatment goals are like treatment goals for any other chronic condition. They include:<sup>661</sup>

- Respectfully helping older adults participate in treatment throughout the continuum.
- Helping them stay motivated to change risk behaviors to improve their health and quality of life throughout treatment and recovery.
- Using multiple treatments as needed, including pharmacotherapy and psychosocial interventions.
- Reducing the risk of relapse.

**Apply a stepped-care approach that starts with the least intensive treatment option that meets the needs of the older adult, and then increase the level of intensity as needed.** Exhibit 4.5 shows the possible treatment pathways along the continuum of care for older adults with alcohol misuse.

## EXHIBIT 4.5. Continuum of Care Pathways for Older Adults



Note: Pharmacological interventions may be started at any time across the continuum of care to meet clients' needs.

\*For more about recovery management, see the "Recovery Management" section of this chapter.

## Treatment Approaches Suited to Older Adults

Despite common stereotypes, older adults are generally open to and accepting of alcohol treatment, especially when programs offer age-specific groups, age-sensitive treatment (i.e., treatments that meet their special needs), and providers trained in issues unique to older adults.<sup>662,663</sup> Older men and women who participate in alcohol treatment:<sup>664</sup>

- Are successful in reaching treatment goals of abstinence or risk reduction.

- Have nearly the same or better outcomes than younger adults.
- Are more likely to complete treatment than younger adults.
- Benefit greatly from age-specific treatment.

The consensus panel recommends that all treatment providers adopt the age-sensitive practices in Exhibit 4.6. (For more information on principles of care for older adults, see Chapter 2 of this TIP.)

### EXHIBIT 4.6. Characteristics of Age-Sensitive Alcohol Treatment for Older Adults<sup>665</sup>

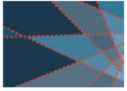
Regardless of the settings and modalities in which you offer treatment services to older adults, they are more likely to be open to and respond to treatment if interventions are:

- **Supportive and nonconfrontational** (e.g., forming a respectful partnership with your clients, which is the primary way to support behavior change).
- **Flexible** (e.g., supplying services at home or over the phone if clients cannot get to you).
- **Sensitive to gender differences** (e.g., addressing in AUD treatment the fact that women are more likely to be prescribed psychoactive medications than men).
- **Sensitive to cultural differences** (e.g., using print materials in your clients' primary language).
- **Sensitive to the client's level of physical and cognitive functioning** (e.g., using shorter sessions; meeting in a room close to the building entrance; giving information in multiple formats, like verbally and in writing).
- **Holistic and thorough** (e.g., addressing cognitive, physical, social, mental, financial, emotional, and spiritual factors that may inhibit treatment engagement or enhance recovery).
- **Focused on helping older adults develop and improve coping and social skills** (i.e., instead of focusing on internal mental processes, using treatment that focuses on behavioral change to reduce their alcohol-related risk and increase quality of life, such as developing problem-solving strategies to manage triggers for drinking and strengthening social connections with nondrinking friends or members of mutual-help groups).

## Brief Interventions for Alcohol Misuse

Brief interventions can support AUD prevention and risk reduction (e.g., helping clients to reduce or abstain from drinking to decrease health-related risks). Brief intervention also can be a starting point for entry into more intensive AUD treatment. (See Chapter 3 of this TIP for more information.) Older adults are likely to participate in and accept this approach to addressing alcohol misuse.<sup>666,667,668</sup>

Brief interventions are a good fit for many different treatment settings, including primary care, emergency departments, older adult-focused social service settings, and outpatient behavioral health service programs. They are cost effective, low intensity,<sup>669,670</sup> and efficient, generally consisting of one to four sessions that last from 15 to 60 minutes.<sup>671,672</sup> Brief interventions may include:



- Referral as needed to medical specialists.
- Inpatient/outpatient addiction-specific treatment.
- Older adult-focused social services.
- Community-based mutual help and recovery support groups, such as AA.

### RESOURCE ALERT: SCREENING AND BRIEF INTERVENTIONS FOR OLDER ADULTS

See SAMHSA's *A Guide to Preventing Older Adult Alcohol and Psychoactive Medication Misuse/ Abuse: Screening and Brief Interventions* at [www.ncoa.org/wp-content/uploads/SBIRT-Older-Adult-Manual-Final.pdf](http://www.ncoa.org/wp-content/uploads/SBIRT-Older-Adult-Manual-Final.pdf) for more information about prevention strategies and brief interventions. You can use the guide's "Health Promotion Workbook" (included as an appendix) when conducting brief interventions for alcohol misuse.

## Motivational Interviewing

**Motivational interviewing (MI) strategies are a cornerstone of brief interventions for alcohol misuse. You can combine these strategies with longer therapeutic approaches to treat AUD in older adults.**<sup>673</sup> MI can help people of many different ages and ethnic, racial, and cultural backgrounds participate in treatment. MI is flexible and focuses on empathetic, reflective listening and a respectful, client-centered approach.<sup>674</sup> MI strategies may be particularly useful with older adults who may not be aware of the health risks related to their alcohol use. Because MI is a nonjudgmental and nonconfrontational approach, it may also be useful with clients who have mixed feelings about changing their drinking.

**MI can help older adults change risk behaviors, such as reducing or abstaining from alcohol use.**<sup>675,676,677</sup> However, not many studies have looked at MI's usefulness in getting older adults to reduce or stop alcohol use. Some of the ways in which MI affects behavior change may be different for older adults than for younger adults.<sup>678</sup>

### KEY ASPECTS OF MI

- Being willing to collaborate with the client
- Being accepting and nonjudgmental
- Offering compassionate and empathetic responses to client concerns
- Asking clients about their concerns and goals for treatment instead of forcing your own agenda for change on them<sup>679</sup>

The mnemonic "FRAMES" outlines the most common MI strategies used in brief interventions to address alcohol misuse:

- **F: Give specific and nonjudgmental, objective Feedback to your clients about their drinking,** including information about health risk and potential effects. This feedback is often based on results of alcohol misuse screening instruments.
- **R: Point out to your clients their personal Responsibility for change** and emphasize that it is up to them to decide what, if anything, to change about their drinking. Responsibility for change also means respecting your clients' independence and decisions about behavior change.
- **A: Give clear Advice and recommendations to your clients about changing their drinking.** In the spirit of a client-centered approach, ask permission to give advice, and then ask your clients about their understanding of the recommendations you offered.
- **M: Offer a Menu of options for changing drinking behaviors** if your clients choose to change. Options may include altering drinking behaviors, abstaining, or accepting referral to more intensive mental health services or addiction-specific treatment.
- **E: Use an Empathetic communication style** that is respectful, supportive, and focused on listening to your clients' views and concerns about their drinking.
- **S: Support Self-efficacy** by recognizing clients' knowledge about and ability to change behaviors in support of their health and well-being, including changing drinking behaviors.<sup>680,681</sup>



MI generally focuses on:<sup>682</sup>

- Helping clients deal with any mixed feelings they may have about changing their drinking.
- Asking clients about their own reasons for change.
- Having a respectful and joint conversation about behavior change based on clients' stated goals.

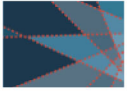
Exhibit 4.7 shows a brief intervention developed specifically for older adults that builds on the FRAMES model and uses MI strategies, such as discussing the client's reasons to reduce or quit drinking and summarizing the discussion at the session's end.

### EXHIBIT 4.7. Brief Alcohol Intervention Parts for Older Adults<sup>683</sup>

After you find that an older adult is misusing alcohol, use a semistructured brief intervention, including the following steps:

1. Ask the client about future goals for health, activities, hobbies, relationships, and financial stability.
2. Adapt your feedback based on the client's responses to screening questions relating to drinking patterns and other health habits (which may also include smoking, nutrition, and tobacco use).
3. Discuss how the client's drinking compares with that of others in his or her age group; review definitions of standard drinks (one standard drink equals 12 ounces of beer or ale, one 1.5 ounce shot of distilled spirits, 5 ounces of wine, 3–4 ounces of sherry, or 2–3 ounces of liqueur<sup>684</sup>).
4. Discuss the “pros and cons” of drinking if appropriate. Doing so can help you understand the role of alcohol in the older adult's life, including its role in coping with loss and loneliness, without influencing the client to move toward any specific change.
5. Give information about the effects of heavier drinking in a nonjudgmental way. Some older adults may have problems in physical, mental, or social abilities despite drinking within recommended limits.
6. Discuss the client's reasons to cut down or quit drinking. Staying independent, having good physical health, and keeping mental abilities can be key motivators in this age group.
7. Offer information about drinking limits and ways to cut down or quit (e.g., participating in social activities that do not involve alcohol, taking up hobbies and interests from earlier in life, finding volunteer activities).
8. Create a drinking agreement. Agreed-upon drinking limits that are signed by the client and the provider are particularly helpful in changing drinking patterns.
9. Discuss ways to cope with risky situations when the client may feel tempted to drink beyond agreed-upon limits. Social isolation, boredom, and negative family interactions can be problems in this age group.
10. Summarize the session.

If clients are already motivated to change their drinking, exploring their mixed feelings can accidentally lead to “sustain talk” (i.e., talk about reasons for not changing) instead of “change talk” (i.e., talk about reasons for changing). Sustain talk can keep clients from making improvements. You should assess clients' readiness to change at the beginning of a brief intervention. **If clients appear ready to make changes, urge them to talk more about the positive reasons for changing their alcohol use instead of focusing on the “pros and cons” of changing.**<sup>685,686,687,688</sup>



## Treatment of Co-Occurring Conditions and Disorders

Co-occurring medical conditions and mental disorders can contribute to or worsen AUD. They can also complicate treatment of AUD in older adults. These conditions should be addressed at the same time as AUD, either by the same provider or provider team or through active referral to and care coordination with other medical or behavioral health services.<sup>689</sup> Factors that will help you decide how to address co-occurring conditions include:<sup>690</sup>

- The severity and duration of AUD and any co-occurring conditions.
- Client preference.
- Availability of services in the community.
- The availability of care coordination among different providers.

You can address co-occurring health conditions and mental disorders in older adults by:

- **Helping clients who do not have a primary healthcare provider find one**, and referring them to healthcare for an indepth physical, including screening and assessment for:
  - High blood pressure.
  - Liver disease.
  - Osteoporosis.
  - Sleep disorders.
  - Cancer.
  - Diabetes.
  - Heart disease.
- **Screening for cognitive impairment** and, if needed, referring for an indepth geriatric assessment. (See Chapter 6 of this TIP for more information.)
- **Providing emotional support and behavioral interventions** instead of standard CBT for older adults with cognitive impairments.<sup>691</sup>
- **Assessing for other SUDs**, including tobacco use disorder and opioid use disorder.
- **Giving clients treatment and intervention options for tobacco use disorder, pain management, and sleeping difficulties** (e.g., CBT, relaxation training, exercise, physical

therapy).<sup>692</sup> Options should be scientifically supported and nonpharmacological whenever possible.

- **Screening, assessing, and treating mental disorders** (including depression and anxiety) within the scope of your practice, or referring to mental health services.
- **Referring for pharmacotherapy for SUDs or mental disorders as needed** to a medical provider trained in older adult care.
- **Addressing mental disorders** in age-sensitive/age-specific co-occurring treatment programs.
- **Following up with other providers regularly and keeping track of clients' treatment progress together with the clients.** (See the "Referral Management and Care Coordination" section.)

The consensus panel recommends that you treat co-occurring medical conditions and mental disorders among older adults while you treat the AUD.

## Referral Management and Care Coordination

The keys to positive outcomes in a stepped-care approach are effective management of referrals to the right level of treatment and ongoing coordination of care. You can adapt to many different settings the following strategies for referral management and care coordination for older adults:

- **Identify a provider** (e.g., nurse manager, case manager, social worker) in your organization who can help older adults with referral and follow-up after referral. This provider should be knowledgeable of older adults' needs and of age-sensitive/age-specific resources in the community.
- **Identify and develop linkages** to age-appropriate medical, mental health, addiction treatment, recovery support, and social service resources and programs in your community.<sup>693</sup> In areas where no age-specific treatment is available, work with programs to offer such services.

- **Gather information** about programs' eligibility criteria, treatment length, type of treatment, philosophy, and continuing-care options so you can match clients to the right program.<sup>694</sup>
- **Keep an updated referral list** of contacts and phone numbers of treatment resources. Keep on hand current information on services offered, cost, schedule, and accessibility.<sup>695</sup> Contact key individuals in that organization, and maintain an ongoing relationship with them.
- **Match the referral to treatment** with your clients' stated goals, treatment needs, problem severity and available resources.
- **Include family members and caregivers** in conversations about treatment planning, with clients' permission.
- **Address your clients' hopes for treatment** by:
  - Describing the type of program to which you are referring clients.
  - Asking and responding to any questions they may have.
  - Acknowledging their worries through reflective listening.
  - Clearing up incorrect beliefs with information about treatment and its usefulness.
  - Offering hope by describing other older adults' positive outcomes with AUD treatment.
- **Address clients' concerns** about confidentiality, and get all necessary paperwork signed so you can communicate with other providers while your clients are in treatment.
- **Offer a "warm handoff"** (i.e., introduce clients directly) to the care coordinator or behavioral health service provider in your integrated care organization.
- **Be prepared to take on the responsibility** of managing the referral and coordinating care if you are not part of an integrated care team.<sup>696</sup>
- **Follow up** with clients to make sure referral was successful or to make another referral if needed.<sup>697</sup>
- **Keep track of clients' progress** in treatment; work closely with other providers to offer ongoing care as needed.

## Higher Intensity Treatment Approaches for AUD

Several scientifically supported approaches to AUD treatment are a good fit for older adults in outpatient, intensive outpatient, or inpatient residential settings. Treatment approaches that work best for older adults with AUD who need more intensive treatment than a brief intervention include CBT, TSF, pharmacological interventions, and inpatient AUD treatment tailored to older adults.

### CBT for Older Adults

CBT is a well-established and scientifically supported approach for treating AUD as well as co-occurring conditions often present in older adults, such as depression, anxiety, pain, insomnia, physical disability, and other SUDs.<sup>698,699,700</sup> CBT includes both cognitive and behavioral interventions applied separately or together. CBT is effective for individual and group sessions. **Its flexibility and adaptability are pluses for treating the complex medical and mental health concerns of older adults.**<sup>701</sup> Although CBT can be adapted to healthcare, outpatient, inpatient, and residential settings in which SUD treatment is available, older adults may have better outcomes with CBT in outpatient settings.<sup>702</sup>

**CBT for AUD focuses on helping clients find and change thoughts, feelings, and behaviors that lead to alcohol misuse.** CBT assumes that thoughts and feelings that occur before drinking behaviors take place are set in motion by situations or cues (e.g., attending a wedding where alcohol is served, smelling a favorite alcoholic beverage). In CBT, the client learns to identify these thoughts, feelings, and cues and then applies skills and coping methods to manage them.<sup>703</sup>

**Strong evidence supports CBT's usefulness in helping a wide range of client populations and ages, including older adults, reduce alcohol misuse and support and continue abstinence.**<sup>704</sup>

For older adults with memory problems, CBT provides a structured and educational approach.<sup>705</sup> Treatment programs using CBT report improved



drinking outcomes for older veterans with significant co-occurring medical, mental health, and social problems and for women with late-life onset of heavy drinking.<sup>706</sup>

Given common age-related cognitive changes, CBT can be useful with older adults when you:<sup>707</sup>

- Make sure the older adult remembers the information and skills learned in counseling sessions.
- **Summarize and repeat information**, cognitive and behavioral change strategy steps, and the client's new awareness and insights several times throughout and at the end of each session.
- **Urge the older adult to take notes on key points** of the session, or you can take notes and give a copy to the client at the end of the session. Once permission is obtained from the client, you may want to arrange for a family member or significant person to attend and learn information and skills.
- **Offer handouts, forms, and reminder calls** to increase the chances that the older client will complete between-session assignments and tasks.

Skills-based approaches, relapse prevention, and PST are CBT adaptations that have been used successfully in the treatment of AUD among older adults.

### Skills-based approaches and relapse prevention

**Skills-based approaches may work well with older adults. Skills-based interventions focus on reducing health-related risks for alcohol use and continuing abstinence** if the client decides that abstinence is the goal. The most commonly used skills-based approaches in AUD treatment that can be adapted for use with older adults are social skills training and coping skills training.

**Social skills training helps older adults grow or improve social networks to decrease the effects of substance use, loneliness, and depression in their lives.** Social skills training helps clients keep existing or create new social networks that support reduced drinking or abstinence. A key element for clients with AUD is learning skills for turning down drinks when in social situations.

**Coping skills training helps older adults learn about and avoid or manage high-stress or high-risk situations they used to cope with by drinking.** Key elements of coping skills training adapted for older adults with AUD are learning the ABCs (antecedents, behaviors, and consequences) of alcohol use, breaking down this chain of events, then identifying and practicing other ways of coping in high-risk situations.<sup>708,709</sup> Exhibit 4.8 depicts an example of an AUD behavioral chain for a 72-year-old woman.

## EXHIBIT 4.8. Drinking Behavioral Chain of Events

This chain of events is for a 72-year-old woman who recently lost her spouse. She is having trouble sleeping.



Adapted from material in the public domain.<sup>710</sup>

**RPT combines social skills and coping skills training into a structured program** that can be used in group or individual treatment. One 16-week group treatment approach designed for older adults includes the following structured sections that can be repeated as needed:<sup>711</sup>

- Identifying individual-specific behavioral chains for drinking
- Managing social pressures to drink
- Developing coping strategies for being home and alone
- Coping with negative thoughts and emotions related to drinking (e.g., anxiety, anger, depression, loneliness)
- Managing cues that lead to drinking (e.g., seeing a beer commercial on television)
- Coping with urges to drink
- Preventing a return to drinking after a period of abstinence (also known as a “slip”) from becoming a full return to past levels of alcohol use and negative effects

### PST

Older adults face many everyday stressors, including chronic medical illnesses and cognitive and physical limitations. PST is a simple approach that older adults can learn easily, including those who have mild cognitive impairment.<sup>712</sup> PST assumes that finding the best solution to everyday problems reduces stress. Reducing stress improves people’s functioning and well-being. Teaching people problem-solving skills helps them identify and apply solutions to current and future problems of living.<sup>713</sup>

PST includes the following steps:

- **Identify the client’s view of the problem** (i.e., a positive or negative view of the problem or of the possibility of identifying solutions).
- **Define the problem** in specific terms.
- Brainstorm possible solutions to the problem.
- Review the possible solutions.
- **Select the best possible solution.**
- **Use the chosen solution**, and track whether it is useful.
- **Adjust the solution**, if needed, and then use and review the new solution.<sup>714</sup>

PST is widely used in many settings, including healthcare settings, outpatient addiction treatment, and home care. It is useful across age groups, including older adults, and across many mental disorders.<sup>715</sup>

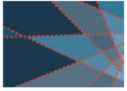
### MINING THE WISDOM OF AGE AND LIVED EXPERIENCE

When you work with older adults, remember that they have a great deal of wisdom from their life experience. This experience is like gold; mine it to help them solve their current problems. After you help clients define a problem, ask, “How have you dealt with a similar challenge in the past?” or “What are some of the ways you solved similar problems in your life?” Talking with older adults about their skills and abilities empowers them and is a respectful and supportive way to help them recognize their own knowledge and wisdom.

### TSF

**Twelve-Step recovery support groups such as AA, as well as other mutual-help groups, can deliver positive outcomes for people with AUD.** Such outcomes including a greater likelihood of stopping alcohol use, improved psychosocial functioning, and greater levels of self-efficacy.<sup>716</sup> Factors related to these improved outcomes include:

- Participating in 12-Step meetings held at the treatment facility.
- Attending 12-Step meetings while participating in outpatient or inpatient addiction treatment.
- Attending and actively participating in 12-Step meetings consistently, early in the recovery process, and frequently (e.g., three or more meetings per week).
- Participating in other 12-Step group activities (e.g., doing service at meetings, reading 12-Step literature, doing “step work,” getting a sponsor, calling other AA members for support).<sup>717</sup>
- Creating nondrinking social networks.<sup>718</sup>
- Increasing spirituality and participating in spiritual practices like prayer and meditation.<sup>719,720</sup>



TSF therapy is a structured therapeutic approach that links people to, and helps them stick with, **community-based 12-Step recovery support groups**. TSF interventions range from 4 to 12 sessions of individual or group treatment in inpatient or outpatient settings. During sessions, the provider:

- Explores different 12-Step themes (e.g., powerlessness, personal responsibility, spirituality).
- Explores the client's attitudes about those themes and other aspects of 12-Step support groups.
- Identifies solutions to barriers hindering the client's active participation in 12-Step support groups.

Some evidence exists that TSF therapy is effective with older adults and, like CBT, gives support, structure, goal direction, and opportunities for older adults to develop positive coping skills and a social network that values abstinence and a recovery focus.<sup>721</sup>

## RESOURCE ALERT: TSF THERAPY MANUAL

The *Twelve Step Facilitation Therapy Manual*—found at <https://pubs.niaaa.nih.gov/publications/projectmatch/match01.pdf>—was designed to standardize TSF therapy as a 12-session treatment approach for the original Project MATCH multisite clinical research trial. The manual, published by NIAAA, offers an overview of Project MATCH and the trial's standardized TSF modules. The TSF manual is the basis for other types and adaptations of TSF interventions. **Adapt the confrontational interventions described in this manual for older adults, who respond better to and are more accepting of nonconfrontational approaches.**

## Pharmacological Interventions

Options for pharmacological interventions to treat AUD are more limited for older than younger adults.<sup>722</sup> **Although these medications may work well and be safe for older adults, the risk of negative reactions is higher** because older adults are more likely to have co-occurring medical problems, take multiple medications, and have a decreased ability to eliminate medications given age-related changes in liver and kidney functions.<sup>723,724</sup>

**To avoid harmful drug–drug interactions, prescribers must review all medications an older adult uses before giving a new prescription** to treat AUD and consider a lower dose of the AUD medication when appropriate.

**Three medications are approved by the Food and Drug Administration to treat AUD,** but clinicians should note for each of these the effectiveness and safety profile in older adults specifically. Furthermore, **none of these medications have been studied across numerous long-term, randomized, controlled trials of older populations.**<sup>725</sup> This limits understanding of their true benefits and drawbacks to older clients. Nonetheless, potential pharmacologic options and some of their considerations include:

- **Acamprosate**, which reduces symptoms of protracted withdrawal from alcohol, such as sleep and mood problems, by altering brain changes related to alcohol use.<sup>726</sup> It can also reduce craving and the pleasurable effects of alcohol.<sup>727,728</sup> Not enough research exists on the efficacy and safety of acamprosate in older adults. Because it is removed from the body through the kidneys, healthcare providers should first evaluate and then monitor renal function in older clients.<sup>729,730</sup>
- **Naltrexone**, which reduces craving and the pleasurable effects of alcohol.<sup>731</sup> It comes in an oral formulation that is taken daily or an injectable formulation that requires a monthly visit to a healthcare provider. A very small number of studies suggest that naltrexone may be tolerable in adults ages 50 and older, but widespread data on its tolerability in older aged



individuals are missing.<sup>732</sup> Prescribers should consider the following:

- Naltrexone is removed from the body through the liver and should be used cautiously in older adults with possible liver problems.<sup>733</sup>
- Naltrexone blocks the effects of opioids used to treat chronic pain, which is common in older adults.<sup>734</sup> A client who begins naltrexone treatment while still taking opioids can suffer acute opioid withdrawal serious enough to require hospitalization.<sup>735,736</sup> Ask older adults about their use of opioid pain medication before starting naltrexone treatment. (See SAMHSA's TIP 63, *Medications for Opioid Use Disorder* [<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Documen/PEP20-02-01-006>], for more information about naltrexone.)
- Naltrexone can trigger symptoms of major depression, including suicidal ideation.<sup>737</sup> Closely watch older adults with a history of depression who take naltrexone.<sup>738</sup>
- Although naltrexone's potential side effects are relatively benign (e.g., dizziness, nausea, reduced appetite, increased daytime sleepiness), they can be significant in older adults.<sup>739</sup> Clinicians should monitor older clients appropriately.

- **Disulfiram**, which triggers an acute physical reaction to alcohol, including flushing, fast heartbeat, nausea, chest pain, dizziness, and changes in blood pressure. It is prescribed to motivate people to abstain from alcohol. Because these effects can be harmful to older people, disulfiram is generally not recommended for use with older adults and, if used, is done so only with great caution.<sup>740,741</sup> Physicians and other providers must closely monitor older clients taking disulfiram for the occurrence of these effects. Additionally, family/caregivers may need to supervise older adults taking disulfiram to make sure they take it correctly and do not take it while continuing to use alcohol, which can lead to serious complications.<sup>742</sup>

## RESOURCE ALERT: MEDICATIONS FOR AUD

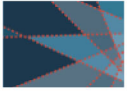
For more information about medications for AUD, including dosing considerations for older adults, see SAMHSA's *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide* (<https://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907>).

## Medical Management Counseling

**Older adults with AUD who have no access to addiction-specific treatment and do not need medically supervised withdrawal can get treatment in general healthcare settings with pharmacological interventions and brief treatment. Medical management counseling for this approach includes:**

- Providing feedback on lab tests that show potential drinking-related health issues. This feedback can help increase motivation to change drinking habits.
- **Recommending abstinence as the safest course** while supporting movement toward that goal.
- Frequently checking that the older adult is taking his or her medication as prescribed, then reducing the frequency of visits after an appropriate period of abstinence.
- **Actively linking the older adult to supports**, such as to AA or other mutual-help and recovery support groups (see the "Recovery Support Groups" section) that welcome older adults.
- Urging and supporting active participation in recovery activities.

Brief medical management counseling and following clients to make sure they take AUD medications as prescribed can help individuals with AUD stop drinking and remain alcohol free.<sup>743</sup>



The consensus panel recommends using medications to treat AUD in older adults when necessary. Key parts of pharmacotherapy for older adults include:

- Carefully reviewing potentially harmful drug–drug interactions.
- Using lower doses of medications.
- Following up with clients and making sure they take medications as prescribed.
- Linking clients to recovery supports.

### ***Inpatient AUD Treatment for Older Adults***

Inpatient treatment can be a good fit for older adults who:

- Meet criteria for AUD.
- Have co-occurring health and mental health concerns.
- Need medically supervised withdrawal.
- Chose abstinence as their primary treatment goal.

Inpatient treatment may be limited to medically supervised withdrawal followed by active referral and immediate start of outpatient or IOP specialty treatment or can include a longer residential stay for an in-depth recovery-oriented rehabilitation program.<sup>744</sup> **All inpatient treatment programs should use age-sensitive practices for older adults** (Exhibit 4.6).

### ***Medically supervised withdrawal***

Alcohol withdrawal symptoms in older adults can differ in severity, may occur 7 days or longer after the last drink, and are more likely to happen in people who have had withdrawal symptoms in the past.<sup>745</sup> Detoxification, also known as medically supervised withdrawal, should **consider the unique aspects of alcohol withdrawal in older adults**:

- **Older adults are more likely to have delirium** (i.e., rapid onset of a confused mental state) during withdrawal, which may be mistaken for early signs of dementia.<sup>746</sup>
- Typical withdrawal symptoms may be less obvious yet last longer in older adults.<sup>747</sup> Typical withdrawal symptoms include:
  - Autonomic hyperactivity (e.g., increased pulse rate, blood pressure, and temperature).

- Restlessness.
- Sleep problems.
- Anxiety.
- Nausea.
- Tremor (shaking/shivering).

- **Withdrawal may worsen other medical issues** (e.g., heart disease, diabetes) and mental disorders (e.g., depression, anxiety) in older adults.<sup>748</sup>
- **Older adults are at greater risk than younger adults for alcohol withdrawal-related medical and neurological problems.** This is because older adults have higher rates of co-occurring physical and mental disorders and cognitive impairments and an increased sensitivity to medications used to treat withdrawal symptoms (e.g., benzodiazepines).<sup>749</sup> Watch older adults closely for signs of delirium or seizures during withdrawal.

**Older adults may be at greater risk for harmful drug events during medically supervised withdrawal if they are taking medications to treat other medical conditions.** Conduct an in-depth assessment and continue to follow clients to learn:

- Which medications are being taken for other medical conditions.
- The client's risk of falls while being treated with common medications for managing withdrawal symptoms (e.g., benzodiazepines).
- Which co-occurring medical conditions are present (e.g., heart disease, breathing problems, diabetes, cognitive impairment). See Chapter 6 for more information about assessing cognitive impairment in older adults.

### **RESOURCE ALERT: TIP 45, DETOXIFICATION AND SUBSTANCE ABUSE TREATMENT**

SAMHSA's TIP 45 offers guidance for medically supervised alcohol withdrawal and additional information about older adults (<https://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA15-4131>).

To reduce the risk of complicated withdrawal, older adults should complete medically supervised withdrawal in a medically supervised inpatient facility.<sup>750</sup> The revised Clinical Institute Withdrawal Assessment of Alcohol Scale–Revised (CIWA-Ar) is an objective measure of alcohol withdrawal and shows the use and dosage of medications (e.g., short-acting benzodiazepines) to ease withdrawal symptoms. See “Resource Alert: Clinical Institute Withdrawal Assessment of Alcohol Scale–Revised (CIWA-Ar).” However, the CIWA-Ar may not be as accurate for older adults with co-occurring medical conditions that hide or increase withdrawal symptoms.<sup>751</sup> Treatment during withdrawal should be based on your knowledge of the unique physiology of older adults, clinical judgment, and close tracking of clients.

### RESOURCE ALERT: CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE–REVISED (CIWA Ar)

The CIWA-Ar is available for download at [https://umem.org/files/uploads/1104212257\\_CIWA-Ar.pdf](https://umem.org/files/uploads/1104212257_CIWA-Ar.pdf).

### Age-specific treatment

**Age-specific treatment for older adults helps support clients in seeking, entering, and staying in treatment. It also improves their treatment experience.**<sup>752</sup> Whereas some older adults benefit from mixed-age treatment, other older adults are more likely to benefit from age-specific treatment, such as those with more chronic co-occurring health conditions and problems with functioning, and those ages 75 and older.<sup>753</sup> Research shows positive outcomes; for instance, **60 percent to 85 percent of older adults who participated in age-specific inpatient treatment programs were still abstinent 12 months after leaving treatment.**<sup>754</sup> These programs offered:<sup>755</sup>

- Individual and group therapy and community activities.

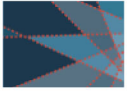
- Adaptations for older adults (e.g., slower pace; adaptations for vision, hearing and cognitive needs).
- Special topic groups for older adults that focused on grief, loss, isolation, physical health issues, recreation, and life changes.
- A nonconfrontational therapeutic approach highlighting the therapeutic alliance while using CBT, MI, and a 12-Step philosophy.

### PARTS OF A SUCCESSFUL INPATIENT REHABILITATION PROGRAM FOR OLDER ADULTS

Positive outcomes have been achieved by inpatient SUD rehabilitation programs for older adults that use:

- Nonconfrontational group therapy for grief, denial, anger, shame, age-related loss, and loneliness.
- CBT and dialectical behavioral therapy (DBT) focusing on:
  - Teaching clients how to manage distress, how to control emotions, and how to improve relationship skills.
  - Allowing people to rebuild social-support networks.
  - Using self-awareness to deal with grief, loneliness, and depression.
- Medical and mental health services, including 24-hour access to nursing care.
- Personal care aides, if needed.
- Health and wellness activities, including:
  - Massage.
  - Acupuncture.
  - Hydrotherapy.
  - Movement therapy.
  - Meditation.
  - Mindfulness practice.
- Family involvement in treatment.
- Active links to medical, social, and case management services.





## Recovery Management

Per SAMHSA, recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”<sup>756</sup> Recovery management is an organizing philosophy for addiction treatment and recovery support services to help individuals and family members achieve and continue long-term addiction recovery. **Not everyone who misuses alcohol needs ongoing recovery management support, but some older adults may benefit from ongoing tracking and recovery support**, including those with:<sup>757</sup>

- Co-occurring medical conditions or mental disorders.
- Social isolation.
- Little support from family and friends.

**Recovery support for older adults who misuse alcohol can begin after a brief intervention in a healthcare setting or while the older adult is in mental disorder or AUD treatment** (Exhibit 4.5). However, ongoing recovery management is most like the continuing care approach to addiction treatment and to the philosophy of ongoing illness management in the treatment of chronic medical illnesses like diabetes. In the addiction treatment research, some of the continuing care interventions that work well for older adults and show positive effects include:<sup>758</sup>

- Home visits.
- Telephone counseling.
- Recovery checkups.
- Linkages to community resources, such as recovery support groups.

In addition, using case management services and helping supportive family members participate in the older adult’s treatment can support ongoing recovery.

## Case and Care Management Services

**Case and care management (CCM) services focus on helping older adults reduce the health-related risks of alcohol misuse and enter addiction-specific treatment when necessary.** CCM models can be particularly helpful to older adults who

are isolated, because the CCM provider can offer services:

- In the client’s home.
- By phone.
- Through videoconferencing.
- At the healthcare provider’s office.
- In community-based social service settings.
- In residential or long-term care facilities.

**For older adults, whose social networks tend to get smaller with age, CCM strategies should focus on connecting them to age-related resources in the community that support recovery.** The CCM provider helps clients access medical, mental health, social, financial, education, work-related, and other community-based services. Nurse care managers, social workers, addiction treatment or mental health counselors, or peer recovery supporters can offer CCM. CCM services often lead to positive outcomes for older adults with AUD or co-occurring medical conditions or mental disorders.<sup>759</sup>

**CCM models may be particularly good at supporting and keeping older adults in treatment and offering a complete approach to addressing the needs of older adults with complex medical and mental health issues.** CCM services are part of a comprehensive approach. They focus on overall health improvement, which is a common goal among older adults, rather than just addressing AUD (which may feel uncomfortable or shameful to older adults).<sup>760</sup> Program reviews of CCM approaches support case management as a key part of a long-term recovery management approach for older adults with AUD.<sup>761</sup>

## Caregiver Involvement

**Involving caregivers throughout treatment and ongoing recovery can help improve an individual’s chances of staying in AUD treatment. It can also improve AUD treatment outcomes.**<sup>762</sup> However, the client must give permission for you to involve others in their treatment. Issues of confidentiality and protection of dignity are highly important. You should know whom the older adult trusts or prefers for support. Caregivers may include a spouse or partner, adult children,

siblings, or extended family members, friends, or neighbors. Caregivers may be family members or individuals significant to the older adult who might be involved in the older adult's health decisions.

Caregivers:

- Often make the first contact with treatment services and should be involved in the initial assessment of the older adult (with the older adult's permission).
- Often supply strong motivation for the older adult to enter treatment.
- Can also offer important details about the older adult's drinking history and health-related risks related to current alcohol use.
- Should also be involved throughout treatment, including during development of a posttreatment recovery plan for the older adult and ongoing recovery support.

Ways to involve a caregiver in AUD treatment include helping the caregiver:

- Develop contingency contracts for specific AUD behaviors (e.g., taking AUD treatment medication, attending mutual help and recovery support groups, effects of returning to drinking).<sup>763</sup>
- Improve daily interactions and reinforce positive communication.
- Find caregiver education groups where caregivers learn and share with others.
- Develop and engage in shared recreational activities as alternatives to drinking.
- Reinforce positive change (e.g., praising steps to reduce or stop alcohol use).
- Develop constructive problem-solving skills (e.g., how to identify relapse triggers and respond with coping skills or strategies to prevent relapse, how to reengage with the recovery plan).
- Respond more effectively to the older adult's drinking (e.g., make sure the older adult is safe, then follow through with the consequences agreed to in the contingency contract instead of arguing or judging; encourage reengagement with the recovery plan and return to treatment if needed).

## RESOURCE ALERT: HOW TO TALK TO AN OLDER PERSON WHO HAS A PROBLEM WITH ALCOHOL OR MEDICATIONS

This easy-to-read online article for family members and concerned others offers information about how to identify signs that the older adult may be misusing alcohol, how to talk with the older adult in a nonconfrontational way, and how to get help ([www.hazeldenbettyford.org/articles/how-to-talk-to-an-older-person-who-has-a-problem-with-alcohol-or-medications](http://www.hazeldenbettyford.org/articles/how-to-talk-to-an-older-person-who-has-a-problem-with-alcohol-or-medications)).

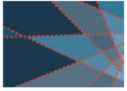
**A legal guardian (who may or may not be a family member) should participate in the treatment and recovery process for an older adult with cognitive impairment who cannot manage his or her own affairs.** When a guardian has the healthcare power of attorney, the guardian should sign releases to speak with all providers involved in the older adult's treatment.

## Addressing Caregiver Needs

**Family members and others significant to older adults with AUD often take on the role of caregivers and case managers,** particularly when co-occurring chronic medical conditions (e.g., diabetes) or mental/neurocognitive disorders (e.g., depression, dementia) are involved. Caregivers often get left out of treatment decisions and recovery planning, despite their commitment to and important role in the care and ongoing health management of these older adults.<sup>764</sup>

**Because of the stress of this responsibility and lack of support, caregivers can develop health-risk behaviors, such as sleep disorders, poor diet, smoking, alcohol use, and substance misuse.** Caregivers may ignore their own care, which may worsen their own chronic medical conditions or increase their risk of stress-related illnesses.<sup>765</sup> **You can help address caregivers' needs by:**<sup>766</sup>

- Identifying primary caregivers by reviewing clients' medical records.<sup>767</sup> Make sure all necessary paperwork is signed to allow family members and other providers to speak with one another.



- Involving them in the treatment and recovery planning process.
- Asking them about their own use of alcohol and other substances and history of mental disorders.
- Screening, assessing, and referring them to treatment for SUDs or mental disorders as needed.
- Supporting their use of healthy self-care activities, such as:
  - Getting enough sleep.
  - Eating a healthy diet.
  - Quitting smoking.
  - Exercising moderately.
  - Getting an annual physical with their primary care provider.
  - Reducing or avoiding alcohol use.
- Reminding them to ask for help from other family, friends, community members, or social service agency representatives who may be able to offer respite care.
- Exploring available caregiver supports in the community, such as the local Area Agency on Aging. (See “Resource Alert: Community-Based Supports for Caregivers.”)
- Urging them to participate in mutual-help groups (e.g., Al-Anon, caregiver support groups).
- Reminding them to take breaks from the caregiver role.
- Pointing out that they are still the relative, spouse, or partner of the older adult, and that relationship has meaning and can still give them satisfaction.

### RESOURCE ALERT: COMMUNITY BASED SUPPORTS FOR CAREGIVERS

For more information on **Al-Anon family groups** and finding local/online meetings, go to <https://al-anon.org>.

For more information about local and online **caregiver support groups** for family members of older adults with dementia, go to [www.alz.org/events/event\\_search?etid=2&cid=0](http://www.alz.org/events/event_search?etid=2&cid=0).

### Recovery Support Groups

**Older adults who have social supports that reinforce abstinence from alcohol have better outcomes in long-term AUD recovery than older adults without those social supports.**<sup>768</sup> Two key factors for older adults in continuing recovery over time are having people in their lives who support their recovery and not having people in their social networks who encourage or enable alcohol use.<sup>769</sup>

A key factor in long-term recovery for older adults is **not** having people in their social networks who encourage alcohol use.

Community-based recovery support groups highlight the importance of developing social relationships that support recovery rather than drinking.<sup>770</sup> Although a growing range and number of recovery support groups are available to adults who have AUD, **AA and SMART Recovery are widely available and may be the most useful supports for older adults.**

### AA

**AA is the most well known and widely available recovery support group for older adults with AUD. It offers a community-based, long-term recovery management approach to treating AUD. AA meetings and activities following treatment can be cost-effective sources of ongoing social support.**<sup>771</sup> Key elements of AA especially well suited to older adults include:<sup>772,773</sup>

- Decreasing social ties that support drinking.
- Increasing social ties that support abstinence.
- Providing social support, goal direction, and structure.
- Offering opportunities to participate in substance-free social activities.
- Helping participants improve their self-efficacy and coping skills.

**Research on AA has found that older adults who attend more group meetings and have a sponsor have better 1-year alcohol-related and mental stress outcomes and less alcohol use at**



**5-year follow-up than those who do not.**<sup>774</sup> The structured social support of AA may help older adults whose social networks have become smaller by improving their interpersonal and social coping skills.<sup>775,776</sup>

**Some research has found that older adults are less likely to attend AA meetings than younger adults. Results are mixed on older adults' level of involvement in AA meetings compared with that of younger AA members.**<sup>777,778</sup> **Sometimes older adults feel shut out** by the culture, language, and experiences of younger adults in AA meetings. However, other evidence indicates that older adults' membership in AA is increasing. The AA Membership Survey showed increases from 2007 to 2014 in members ages 61 to 70 (from 12.3 percent to 18 percent) and in members ages 71 and older (from 5.3 percent to 7 percent).<sup>779</sup>

Starting and staying in AA may be challenging for older adults with AUD, but not participating may put older adults at increased risk for return to alcohol use and negative long-term outcomes.<sup>780</sup>

**When older adults do participate in AA, they benefit by:**<sup>781,782</sup>

- Having better drinking-related outcomes.
- Feeling less stress.
- Participating in more spiritual practices.
- Increasing social interactions and support.
- Having improved recovery.

#### **BARRIERS TO AA ATTENDANCE FOR OLDER ADULTS**<sup>783</sup>

- Lacking transportation
- Facing physical limitations
- Feeling uncomfortable going to meetings at night
- Having smaller social networks because of aging
- Having less interest than younger adults in increasing their social networks
- Relying on a spouse for recovery support

#### **SMART Recovery**

SMART Recovery is a network of local and online abstinence-focused recovery support groups that is based on principles of CBT and MI. Unlike AA meetings, SMART Recovery meetings are run by trained volunteers. The SMART program<sup>784</sup> is based on helping people:

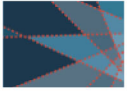
- Build and keep motivation.
- Cope with urges.
- Manage thoughts, feelings, and behaviors.
- Live a balanced life.

**The principles and structured format of SMART Recovery follow CBT and MI approaches to treating older adults. Research suggests that it is as effective as other community-based mutual-help approaches in supporting abstinence and in reducing the severity of the effects of alcohol misuse,** particularly for people with less severe AUD.<sup>785</sup> SMART Recovery may also be an important option for those who feel uncomfortable with the spiritual underpinnings of AA and the 12-Step approach. Although the mutual-help group is less available in some areas of the country, online or telephone meetings are becoming more popular in all recovery support groups.

The program does not support use of labels such as “alcoholic,” which may benefit older adults who feel shame and fear discrimination or judgment because of having AUD. SMART Recovery, like AA, offers chances for older adults to improve their recovery and quality of life by serving as volunteers.

#### **RESOURCE ALERT: SMART RECOVERY WEBSITE**

The SMART Recovery website ([www.smartrecovery.org](http://www.smartrecovery.org)) gives information about SMART Recovery principles and training opportunities, including how to become a facilitator for meetings. It also has a searchable database of local and online meetings.



**You can help older adults become involved in mutual-help groups by:**

- Actively linking clients to available mutual-help groups, and supporting them in trying different groups so that they can find the one that best fits their needs.
- Asking clients about their understanding of and any past participation in mutual-help groups.
- Discussing the benefits of being involved in mutual-help groups as a part of recovery.
- Exploring ways to overcome barriers to joining and participating in mutual-help groups.
- Contacting local, regional, or state AA groups or other mutual-help groups or recovery community organizations (RCOs; see text box) to ask about community outreach efforts for older adults.
- Helping older clients find an age-friendly home group with older adult participants or a Seniors in Sobriety meeting (see “Resource Alert: Seniors in Sobriety”).
- Linking older adults to mutual-help group volunteers/peer recovery support specialists who can introduce them to the group, attend some meetings with them, and introduce them to other older members.
- Teaching them about sponsorship and how clients can find an AA sponsor or mutual-help group mentor who can guide them in the recovery process.

### RESOURCE ALERT: SENIORS IN SOBRIETY

Since 1990, AA has actively reached out to older adults with AUD. Efforts include urging local meetings to be senior friendly and starting Seniors in Sobriety (SIS) meetings. The SIS website ([www.seniorsinsobriety.com/](http://www.seniorsinsobriety.com/)) has information on SIS's history, focus, and annual conference and other meetings.

### WHAT IS AN RCO?

“A recovery community organization (RCO) is an independent, nonprofit organization led and governed by representatives of local communities of recovery. These organizations organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and supply peer-based recovery support services (P-BRSS).”<sup>786</sup>

Search for an RCO near you (<https://facesandvoicesofrecovery.org/arco/arco-members-on-the-map/>).

**The consensus panel recommends that you actively link older clients to age-sensitive case management and ongoing recovery supports for older adults. Family, caregivers, and community-based mutual-help groups are key elements of recovery support for older adults.**

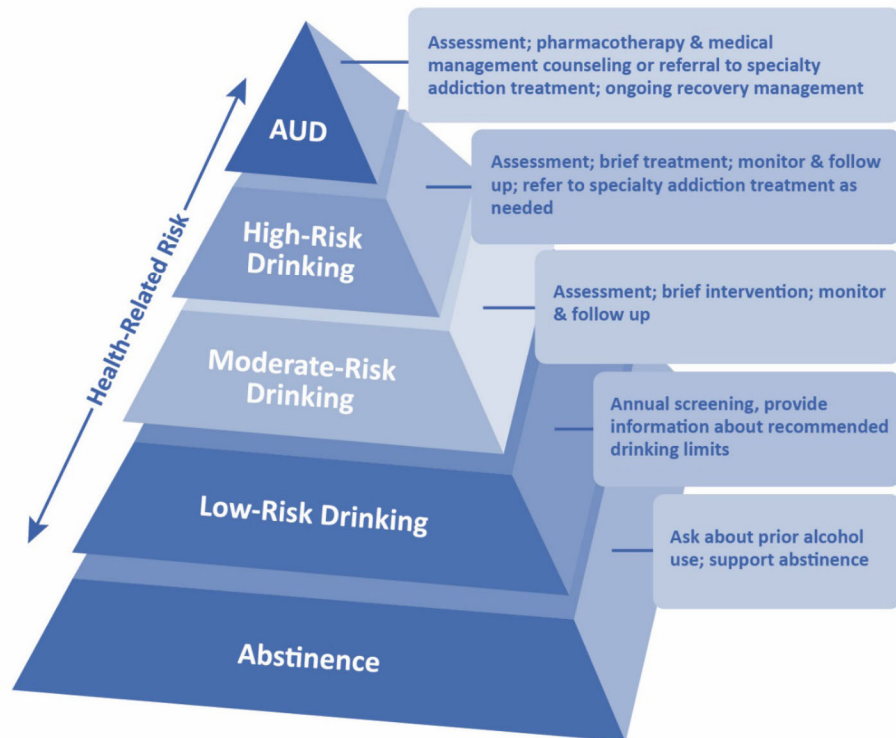
### Clinical Scenarios

**The level of intensity of clinical interventions for older adults should match the severity of alcohol misuse.** Interventions range from healthcare providers asking clients about their alcohol use during an annual screening to inpatient treatment for older adults who have AUD. Exhibit 4.9 shows how to match levels of health-related risk associated with alcohol misuse with different clinical interventions.

The higher up the pyramid, the higher the level of risk and the more intense the intervention. In this graphic, the level of health-related drinking risk is defined as follows:

- **Abstinence:** Does not currently use alcohol.
- **Low-Risk Drinking:** Drinks within recommended limits.
- **Moderate-Risk Drinking:** Drinks above recommended limits.
- **High-Risk Drinking:** Binge drinks or drinks above recommended limits and has a co-occurring health condition or mental disorder.
- **AUD:** Meets DSM-5 diagnostic criteria for AUD.

## EXHIBIT 4.9. Alcohol Health-Related Risk and Treatment Response Pyramid<sup>787,788,789</sup>



The following clinical case scenarios are examples of different levels of alcohol misuse. They show how to use prevention strategies and clinical interventions that match risk levels in Exhibit 4.9.

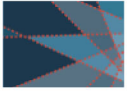
### Clinical Scenario: Abstinence

During the initial screening for alcohol misuse, ask about earlier alcohol use even if the older adult reports that he or she does not drink at all. The older adult may have always abstained from alcohol, identify as being in recovery, or have stopped drinking for health-related reasons, which is common as people age. The following clinical scenario shows the importance of asking about earlier alcohol use when deciding which treatment to offer.

- **Abstinence:** An older adult reports no alcohol use in the past 3 years.
- **Treatment Setting:** Outpatient healthcare clinic
- **Provider:** Nurse practitioner (NP)
- **Prevention/Treatment Strategies:** Ask about earlier alcohol use; support abstinence using a brief problem-solving intervention.

George is 76 years old and has been divorced for 5 years. He recently moved to a retirement community near his oldest daughter. He goes to see a new primary care provider for an initial medical exam. As part of the health history questionnaire, which includes the AUDIT, George says that he does not currently drink, but he was injured earlier because of his drinking. His primary care provider reviews George's questionnaire and





sees that George does not meet the AUDIT criteria for alcohol misuse but flags the item about alcohol-related injury.

During the clinical interview, the provider asks about an item on the AUDIT in a curious, nonjudgmental way. The NP says, “I noticed on the health questionnaire that you may have been injured after drinking. Can you tell me more about that?” George says that he used to drink from time to time, but 3 years ago he twisted his ankle badly after having a couple of drinks and had to use a walker for several weeks. He tells the NP that he decided not to drink at all because he didn’t want to risk any more injuries. The NP praises his commitment to his health and urges him to continue to avoid drinking.

George feels comfortable opening up to the NP and says that since he moved to the retirement community, he has participated in a lot of social activities with alcohol. He likes socializing but feels uncomfortable when people offer him drinks all the time. He says, “I know they are just being friendly, but sometimes they just don’t give up.” George states that he does not want to drink but does want to keep going to the social activities. The NP uses brief problem-solving by asking George, “How have you dealt with a challenge like this in the past?” The NP then invites George to brainstorm some solutions to the current problem, including ideas from his earlier struggles. George decides that he can say “no” firmly and tell people that alcohol doesn’t agree with him when they continue to urge him to drink. George states that he feels good about that solution and will try it out at the next social event. The NP writes a treatment note about George’s chosen solution in the electronic medical record and gives him a copy, telling him that if this plan doesn’t work to schedule a follow-up visit soon.

### Clinical Scenario: Low-Risk Drinking

For many older adults, the relationship with their primary care provider is often one of their strongest and most stable. The annual physical is a chance to screen for alcohol misuse and any changes in alcohol use related to life events, such as a death in the immediate family. The following

### REMINDER ABOUT DRINKING IN RETIREMENT COMMUNITIES

Hazardous drinking may be more common among older adults in age-separated residential settings (e.g., continuing care and planned retirement communities) than community-dwelling older adults. A recent survey reported that 15.4 percent of people who took the survey and live in a large retirement community had hazardous drinking compared with around 10 percent in the general older adult population.<sup>790</sup> Although older adults in these settings may drink to cope with problems, they usually drink because they want to socialize, and they believe that their peers affect their drinking.<sup>791</sup> Avoiding alcohol in these settings can be a challenge for older adults.

scenario addresses the importance of conducting an annual screen for alcohol misuse with older adults and shows how to actively link clients to a referral for grief counseling and care coordination.

- **Low-Risk Drinking:** An older adult drinks within recommended guidelines and has no co-occurring physical or mental illness that limits daily functioning.
- **Treatment Setting:** Integrated outpatient medical and behavioral health clinic
- **Providers:** Primary care provider (PCP); licensed clinical social worker
- **Prevention/Treatment Strategies:** Screen for alcohol misuse, depression, and stressors that may put the older adult at risk for increased alcohol use; supply information on drinking guidelines for older adults; offer a menu of options for addressing grief; coordinate follow-up care.

Lily is 80 years old. Her husband of 60 years died 6 months ago. Lily goes to her doctor for her annual physical. Her PCP tells Lily that she is sorry to hear about her husband’s death. They talk for a few minutes about how she is doing and what kinds of recreational activities and social support she has in her life right now. Lily tells her PCP that she belongs to the local church and is still active

in volunteer activities there. Her son and her granddaughter live nearby and visit on a regular basis. She goes to an arts and crafts class on Wednesday afternoons at the local senior center.

The PCP then tells Lily that she wants to ask her a few more questions about her health, including alcohol use, if that is okay with her. Lily feels comfortable talking with her PCP and agrees. The PCP mixes in questions from both the AUDIT and the SMAST-G with her general health questions. Lily says that she drinks one 5-ounce glass of white wine two to three times a week (an AUDIT score of three) and sometimes has another drink when she feels lonely (an SMAST-G score of one), but she has not used more alcohol since her husband died. She says, “If I drink too much, I feel lightheaded, and I worry that I’ll fall and break something.”

The PCP offers information on drinking guidelines and praises Lily for staying within those guidelines. The PCP then tells her that sometimes when older people lose a spouse, they may start drinking a bit more when they feel sad or lonely or they may simply lose track of how much they are drinking. The PCP tells Lily to call her if that happens. Lily says she will, then states, “You know, I have been feeling a bit blue in the past few weeks, and I haven’t been sleeping well. I really miss him.”

The PCP follows up on Lily’s statement by saying, “It seems like you are keeping busy and have a lot of good support in your life. At the same time, I am wondering if it would be helpful to have someone other than your family to talk to about how you have been feeling recently. I can suggest a few options if you are interested.” Lily says that she doesn’t like to burden her family and that talking to someone might be good. The PCP offers two suggestions: “There is a grief support group at the same senior center where you take your arts and crafts class. Or, I can introduce you to a counselor right here at the clinic who knows a lot about helping folks with loss.” Lily says she wouldn’t feel comfortable talking in a group. The PCP describes the counselor with whom she would like Lily to talk. Lily agrees to meet her after the appointment with the PCP. The PCP also conducts an initial depression screening.

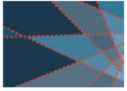
The PCP arranges a follow-up phone call for Lily from the nurse care manager who will coordinate care with the PCP and the counselor. The PCP then walks Lily over to the licensed clinical social worker at the clinic and does a “warm handoff.” The licensed clinical social worker talks briefly with Lily, gives her a large-print handout that explains the grieving process, and schedules a follow-up visit that includes a depression assessment. (See the Chapter 4 Appendix for a large-print handout on grief for older adults.)

### Clinical Scenario: Moderate-Risk Drinking

All too often, spouses of people who misuse alcohol drink as a shared social activity with their spouse. For older spouses, this can easily turn into their own health risk behavior, particularly if, to reduce the stress of being a caregiver, they take medication that negatively interacts with alcohol. The following scenario focuses on the importance of assessing family members’ alcohol and medication use while at the same time addressing their needs as caregivers.

- **Moderate-Risk Drinking:** An older adult drinks above recommended limits while also taking a sedating medication.
- **Treatment Setting:** Outpatient behavioral health program
- **Provider:** Behavioral health service provider (provider)
- **Prevention/Treatment Strategies:** Supply information about drinking guidelines; screen for anxiety; give information about risks for alcohol and medication use; explore strategies for family members to address the spouse’s drinking and to address caregiver needs.

Rose is 69 years old. She is married to Ed, who is 78 years old. Ed drinks heavily daily, has a history of bipolar disorder, and recently was diagnosed with early-stage dementia. Ed sees the same PCP as Rose and also sees a psychiatrist for medication management for bipolar disorder. Rose is growing more worried about Ed’s drinking and is unsure of how to take care of him as his dementia worsens.



Rose calls an outpatient behavioral treatment program after a friend of hers tells Rose that she is worried about Rose's health. The friend also recommends a counselor she had seen there.

At the initial appointment, the provider assesses Rose's substance use. Rose reports that she drinks one to three standard glasses of wine about three to four times a week when she and Ed go out to dinner or to social events. She also tells the counselor that she takes a benzodiazepine prescribed by her PCP about one to two times a week when she can't sleep. Rose states, "When Ed drinks at night, he becomes aggressive and sometimes gets very confused. I worry about him so much that I can't get to sleep."

The counselor acknowledges Rose's distress about Ed's drinking, then asks her if it would be okay to talk with her briefly about her drinking and use of benzodiazepines. Rose agrees. The counselor offers this personalized feedback to Rose: "Based on what you have told me about your own drinking, it looks like you are drinking over the recommended guidelines on the days you have more than one drink a day. Also, you may not be aware that the sleep medication you are taking can increase the depressant effect of alcohol in your body and could put you at risk for oversedation, memory loss, and even overdose if you forget how much you had to drink or mistakenly take too many pills." The counselor asks Rose what she makes of this information. Rose says, "I had no idea that drinking and taking sleep medication might be so dangerous. It also makes me think that I might not be helping Ed with controlling his drinking if I drink with him."

After exploring possible strategies to address her own health risks, Rose decides that she will stop drinking completely while she is taking the sleep medication and tell Ed why she can't drink with him when they go out. The counselor supports Rose's decision and suggests that one way she can help Ed is to find positive recreational activities that they can share without drinking. Rose becomes excited and says she can think of several things they can do together that they both enjoy without drinking, like going to lectures at the local senior adult education program.

The counselor then asks Rose to tell her more about her difficulties with worry and sleep, and conducts an anxiety screening. They also explore self-care strategies for managing worry and getting to sleep. Rose decides she can tell Ed that she is going to sleep in another room if he is up late and has been drinking. The counselor then teaches Rose a relaxation exercise she can do before bed, and Rose practices it in the session. Rose agrees to talk with her doctor about less risky medication for sleep.

### RESOURCE ALERT: OLDER ADULTS AND SLEEP

The National Institute on Aging has a webpage with information and useful tips for helping older adults get a good night's sleep ([www.nia.nih.gov/health/good-nights-sleep](http://www.nia.nih.gov/health/good-nights-sleep)).

The counselor shifts the conversation to what further support Rose may need to address Ed's drinking while taking care of herself. Rose identifies her PCP and Ed's psychiatrist as potential supports. She states that Ed has given permission for her to talk with both. The counselor suggests she ask both to discuss Ed's drinking with him, state firmly that Ed should not drink at all, and then put their recommendations in writing. Both Ed and Rose can then refer to the recommendations instead of getting into an argument about his drinking. Rose likes this idea and feels confident that she can express her concerns to both of Ed's providers and ask for their help in addressing Ed's alcohol misuse.

The counselor explores other self-care and recovery strategies with Rose, including Al-Anon and a dementia caregiver support group. Rose is not sure that she wants to try Al-Anon but then agrees to talk with a peer recovery support specialist the counselor knows at the local recovery community center who is Rose's age and helps family members. The counselor sets up a series of sessions with Rose. She will continue to track Rose's drinking, benzodiazepine use, and strategies for self-care.



### Clinical Scenario: High-Risk Drinking

Older adults may not know that their drinking is negatively affecting their physical and mental health. The following scenario focuses on the importance of screening for alcohol misuse in settings where older adults are being treated for mental disorders and shows how a brief intervention focused on alcohol use can improve physical and mental health.

- **High-Risk Drinking:** An older adult drinks above recommended limits, including binge drinks, and has a co-occurring mental disorder (depression) and health condition (high blood pressure).
- **Treatment Setting:** Hospital-based mental health clinic
- **Provider:** Geriatric psychiatrist
- **Prevention/Treatment Strategies:** Supply feedback on AUDIT score; give information about the risks of taking medications for depression and high blood pressure while drinking; offer nonjudgmental advice about abstaining from alcohol use; continue to watch alcohol and medication use.

Carl is 68 years old. His PCP refers him to a geriatric psychiatrist for medication management of his major depression. Carl currently takes one tricyclic antidepressant—which, when taken with alcohol, increases his risk for oversedation and low blood pressure—and a blood pressure medication, which can lower his blood pressure even more. The psychiatrist gives Carl the clinical interview version of the AUDIT as part of the initial psychiatric evaluation. Carl's score on the AUDIT is a 9 and includes positive responses to daily drinking and binge drinking about once a month.

The psychiatrist offers Carl nonjudgmental feedback about his AUDIT score and says that Carl's drinking may be worsening both his depression and his high blood pressure. At first, Carl makes light of his drinking by saying, "I really don't drink that much. And besides, I have been drinking the same amount for years, and it's never been a problem before." The psychiatrist acknowledges Carl's mixed feelings, then asks if he would be interested in more information. After Carl

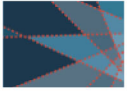
agrees, the psychiatrist describes the health risks of drinking while taking antidepressants and blood pressure medication, stating in a nonjudgmental, factual tone that alcohol can keep his medications from working correctly. He also states that the type of antidepressant Carl is taking can lead to low blood pressure when he drinks, especially when taken with his blood pressure medication, and can cause harmful effects like increased depression, dizziness, and fatigue. Carl responds, "Now that you mention it, I have noticed feeling very tired in the afternoon. I really don't like feeling that way. It's like the depression is getting worse."

The psychiatrist supports Carl's ability to make his own decisions, then gives him clear advice: "Although it is up to you in the end, I think that in your situation you are better off not drinking at all while you are being treated for depression and high blood pressure. What do you think you would like to do about the drinking?" Carl agrees to stop drinking to see whether abstinence improves his health. The psychiatrist supports Carl's decision; summarizes their conversation; writes out a brief alcohol use agreement that supports Carl's decision to remain abstinent but also tracks his alcohol use if he does drink; and schedules a follow-up visit in a month. (See the Chapter 4 Appendix for an alcohol use agreement and drinking tracking cards.)

At the next visit, Carl says that his depression has gotten better and that he no longer feels tired or gets dizzy. Carl says that he wants to continue not drinking because he feels so much better. The psychiatrist supports Carl's efforts to avoid drinking and, after discussion with Carl, prescribes a different antidepressant medication for him. In future medication management visits, the psychiatrist tracks Carl's depression, his response to the new medication, his blood pressure, and his success in avoiding alcohol.

### Clinical Scenario: AUD

Older adults with a long history of heavy drinking, multiple past periods of treatment, or co-occurring mental disorders often need medically supervised withdrawal and age-sensitive, age-specific treatment to address multiple co-occurring



conditions at the same time. This scenario focuses on age-specific treatment, RPT, and recovery support for an older adult with AUD and co-occurring disorders.

- **AUD:** An older adult has a long history of heavy drinking and meets criteria for AUD.
- **Treatment Setting:** Inpatient detox and rehabilitation program
- **Provider:** Licensed alcohol and drug counselor on a multidisciplinary treatment team
- **Treatment Strategies:** Offer CBT, RPT adapted for older adults, trauma-informed counseling strategies to address emotional dysregulation, and recovery management strategies.

Barb is 72 years old and enters an inpatient treatment program after her three adult children intervene. She has a long history of heavy drinking and brief periods of treatment followed by a return to drinking. Barb has been married four times and was recently divorced from her fourth husband. She has been diagnosed with anxiety, depression, posttraumatic stress disorder, and binge eating disorder, for which she had gastric bypass surgery. This is her fourth treatment for AUD. Her pattern of returning to drinking tends to happen when she is having difficult relationships, intense emotions, and traumatic stress reactions. Barb is carefully watched throughout detoxification at the facility; she is then transferred to the rehabilitation program, which includes an age-specific track for older adults.

Barb's primary counselor offers relapse prevention approaches, which are focused on identifying and managing relapse triggers. Barb's CBT counseling focuses on strategies to address the communication issues between Barb and her daughter and to help her identify and replace negative automatic thoughts about drinking triggered by relationship problems. For example, when Barb's daughter criticizes her, Barb feels ashamed. Barb replaces the negative thought, "I drink because I can't stand to feel ashamed" with a more positive thought, "I can stand to feel shame for a while, until the urge to drink goes away."

Barb's group counseling at the older adult program includes focused topic groups for older adults, relapse prevention coping skills groups, and a DBT group. The DBT group teaches her mindfulness

skills for distress tolerance, emotional regulation, and effective interpersonal interactions. With permission, Barb's counselor keeps contact with her family. They attend family group sessions, too.

During an individual session, Barb and her counselor discuss her improvement in treatment. The counselor opens the conversation: "I know this is your fourth time in treatment. How would you say this time has been different for you?" Barb says, "I really like the group discussions on topics that are important to me at this stage in my life. Staying here for such a long time has helped a lot, too. I needed the extra time to let all this information about recovery and all the skills I have learned really sink in."

Near the end of her time at the treatment facility, Barb's counselor actively links her to a continuing care group and individual outpatient counseling at an addiction treatment program in her community, as well as women's and senior-friendly AA meetings. Staying in treatment longer allows Barb to improve her emotional regulation, work on relapse prevention, and improve her interpersonal skills in a safe, supportive place. It also helps her get connected to community-based support before she ends treatment.

### RESOURCE ALERT: DBT

DBT, a variation of CBT, was developed for adult women with chronic suicidal behavior who meet the diagnostic criteria for borderline personality disorder.<sup>792,793</sup> More recently, adaptations of DBT skills training have been shown to help adults with borderline personality disorder and SUDs, adults with binge eating disorder, older adults with depression, and family caregivers of older adults with dementia.<sup>794,795</sup> DBT uses mindfulness practices and helps people manage overwhelming emotions. This skill-building approach shows promise in treating older adults with emotional dysregulation and poor interpersonal skills.

For more information about DBT, the latest research, and training opportunities, go to the website of the Behavioral Research and Therapy Clinics at the University of Washington (<http://depts.washington.edu/uwbtrtc/>).

## Summary

As older adults' levels of alcohol use and related risk of negative health effects increase, more complex and intense interventions are needed. MI and adaptations of CBT (including PST and RPT) are useful in brief interventions and long-term treatment. Whichever strategy you use, take a nonconfrontational, age-sensitive approach when working with older adults with alcohol misuse, including AUD. Ongoing recovery management strategies increase the chance that improvements will continue over time and not only help older adults reduce negative alcohol-related health and mental health outcomes, but also help improve their quality of life.

## Chapter 4 Resources

### Provider Resources

**A Clinician's Guide to CBT With Older People** ([www.uea.ac.uk/documents/246046/11919343/CBT\\_BOOKLET\\_FINAL\\_FEB2016%287%29.pdf/280459ae-a1b8-4c31-a1b3-173c524330c9](http://www.uea.ac.uk/documents/246046/11919343/CBT_BOOKLET_FINAL_FEB2016%287%29.pdf/280459ae-a1b8-4c31-a1b3-173c524330c9)): This workbook explores age-sensitive strategies for adapting CBT for older adults.

**BNI-ART Institute—Tools for the Brief Negotiated Interview (BNI)** ([www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-brief-intervention/](http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-brief-intervention/)): This webpage includes an algorithm, or script, that guides providers through an intervention for substance misuse with carefully phrased key questions and responses.

**Motivational Interviewing Network of Trainers** (<https://motivationalinterviewing.org>): This website includes references, articles, videos, and links to training opportunities in the theory and practice of MI.

**National Council on Aging—Resources** ([www.ncoa.org/audience/professional-resources/?post\\_type=ncoaresource](http://www.ncoa.org/audience/professional-resources/?post_type=ncoaresource)): This webpage contains a searchable database of articles, webinars, and manuals.

### Consumer Resources

**AA—A.A. for the Older Alcoholic—Never Too Late (large print)** ([www.aa.org/assets/en\\_US/p-22\\_AAfortheOlderAA.pdf](http://www.aa.org/assets/en_US/p-22_AAfortheOlderAA.pdf)): This brochure describes the stories of men and women who became involved with AA as older adults and includes comments from AA speakers at meetings.

**National Association of Area Agencies on Aging (n4a)** ([www.n4a.org](http://www.n4a.org)): This national association provides searchable services, resources, and advocacy for older adults and professionals who work with them.

**National Council on Aging—Resources** ([www.ncoa.org/audience/older-adults-caregivers-resources/?post\\_type=ncoaresource](http://www.ncoa.org/audience/older-adults-caregivers-resources/?post_type=ncoaresource)): This webpage contains a searchable database of articles and webinars.

**National Institute on Aging—Alcohol Use or Abuse** ([www.nia.nih.gov/health/topics/alcohol-use-or-abuse](http://www.nia.nih.gov/health/topics/alcohol-use-or-abuse)): This webpage contains links to older adult-specific information on alcohol misuse.

**NIAAA Alcohol Treatment Navigator** (<https://alcoholtreatment.niaaa.nih.gov>): In addition to helping visitors find the best alcohol misuse treatment options, this treatment navigator details a step-by-step process for understanding AUD.



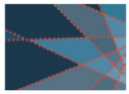
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## Chapter 4 Appendix

### Alcohol Use Disorders Identification Test (AUDIT): Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying “Now I am going to ask you some questions about your use of alcoholic beverages during this past year.” Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc. Code answers in terms of “standard drinks.” Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol? (0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily <i>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</i>	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
Record total of specific items here	
<p>Scoring: The cutoff score indicating hazardous and harmful alcohol use for the AUDIT is generally 8; however, for older adults a score of 5 indicates a need for clarifying questions and further assessment.<sup>796</sup></p> <p><i>Adapted from Barbor et al. (2001).<sup>797</sup></i></p>	



## Alcohol Use Disorders Identification Test (AUDIT): Self-Report Version

CLIENT: Alcohol use can affect your health and interfere with some medications and treatments, so it's important that we ask some questions about your alcohol use. Your answers will remain confidential; please be honest.

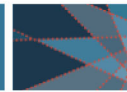
Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					<b>Total</b>	

*Adapted from Barbor et al. (2001).<sup>798</sup>*

**Provider Note:** The self-report version should be given to older clients to fill out. Ask them to return it to you, and then discuss the results with them. A cutoff score of 5 means you need to assess further.<sup>799</sup>





## Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G)

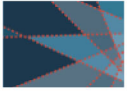
	Yes (1)	No (0)
1. When talking with others, do you ever underestimate how much you drink?		
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?		
3. Does having a few drinks help decrease your shakiness or tremors?		
4. Does alcohol sometimes 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 SMAST-G-SCORE (0-10) \_\_\_\_\_**

**SCORING: 2 OR MORE “YES” RESPONSES IS INDICATIVE OF AN ALCOHOL PROBLEM.**

Ask the extra question below but do not calculate it in the final score.  
 Extra question: Do you drink alcohol and take mood or mind-altering drugs, including prescription tranquilizers, prescription sleeping pills, prescription pain pills, or any illicit drugs?

© The Regents of the University of Michigan, 1991. Source: University of Michigan Alcohol Research Center.<sup>800</sup> Adapted with permission.



## Large-Print Grief Handout

### What Is Grief?

Grief is a natural response to loss. It's the emotional suffering you feel when something or someone you love is taken away. Whatever your loss, it's personal to you.

### Coping With Grief

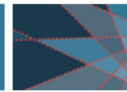
Although loss is a part of life that cannot be avoided, there are ways to help cope with the pain, come to terms with your grief, and eventually, find a way to move on with your life. This doesn't mean you will forget your loved one, but you can find a way to hold that individual in your heart and your memories while continuing to live your life. This includes:

- Acknowledging your pain.
- Accepting that grief can bring up many different and unexpected feelings.
- Understanding that your grieving process will be unique to you.
- Seeking out face-to-face support from people who care about you.
- Supporting yourself emotionally by taking care of yourself physically.
- Learning the difference between grief and depression.

### The Grieving Process

Grieving is highly individual; there's no right or wrong way to grieve. The grieving process takes time. Healing happens gradually; it can't be forced or hurried—and **there is no "normal" timetable for grieving**. Some people start to feel better in weeks or months. For others, the grieving process is measured in years. Whatever grief is like for you, it's important to be patient with yourself and allow the process to naturally unfold.

*Reprinted with permission.<sup>801</sup>*



## Alcohol Use Agreement and Drinking Diary Cards

The purpose of this step is to decide on a drinking limit for yourself for a particular period of time. Negotiate with your healthcare provider so you can both agree on a reasonable goal. A reasonable goal for some people is abstinence—not drinking any alcohol.

As you develop this agreement, answer the following questions:

- How many standard drinks?
- How frequently?
- For what period of time?

### Agreement

Date \_\_\_\_\_

---



---



---

Client signature \_\_\_\_\_

Clinician signature \_\_\_\_\_

### Drinking Diary Card

One way to keep track of how much you drink is the use of drinking diary cards. One card is used for each week. Every day record the number of drinks you had. At the end of the week add up the total number of drinks you had during the week.

#### Card A

Keep Track of What You Drink Over The Next 7 Days

Starting Date _____				
	Beer	Wine	Liquor	Number
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
WEEK'S TOTAL:				

#### Card B

Keep Track of What You Drink Over The Next 7 Days

Starting Date _____				
	Beer	Wine	Liquor	Number
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
WEEK'S TOTAL:				

*Adapted from material in the public domain.<sup>802</sup>*