Alcohol Use Disorder among Older Adults

Overview

Alcohol Use Disorder (AUD) among older adults is on the rise and is poised to overwhelm our national resources (Institute of Medicine, 2012). Individuals 65 and older are projected to increase from 40.3 million in 2010 to 72.1 million by 2030, a 56% increase, and will double to 88.5 million by 2050 (U.S. Census Bureau, 2010). Moreover, those 85 and older are projected to triple from 5.4 million to 19 million by 2050 (Kalapatapu & Sullivan, 2010).

Concomitant with this dramatic population growth is the expected rise in AUD and need for substance use treatment among older adults. This increase in alcohol abuse is directly associated with the retiring "baby boomer" generation (Gfroerer, 2003; Institute of Medicine, 2012). The "baby boomer" generation maintains the highest prevalence of substance use compared to other cohorts (Wang & Andrade, 2013). One in five older adults currently have a mental health or substance abuse condition and healthcare institutions are unable to meet the needs of this population (Institute of Medicine, 2012). Older adults with substance abuse disorders (4.4 million) are projected to double by 2020 and those in need of treatment will escalate to almost 6 million (Sahker, Schultz, & Arndt, 2015). More than 50% of older adults drink alcohol regularly (Merrick, Horgan, Hodgkins et al., 2008).

The Committee on the Mental Health Workforce for Geriatric Populations assessed the current and future needs of older adults and found significant deficits in geriatric training among healthcare providers and insufficient community resources. Further, the Committee also found a significant lack of specialists engaged in the detection, diagnosis, treatment, care, and management of geriatric conditions (Institute of Medicine, 2012). The lack of a prepared workforce is projected to continue and burdens on the local, state, and national resources will increase exponentially.

The health consequences of long-term AUD for older adults are significant and include both physical and socioeconomic consequences (Substance Abuse and Mental Health Services Administration, 2009). Potential physical consequences include cirrhosis of the liver, cancer, immune system disorders, cardiomyopathy, cerebral atrophy, and cognitive deficits (National Institute on Aging, 2013). Alcohol use also exacerbates preexisting conditions such as osteoporosis, diabetes, high blood pressure, and ulcers (National Institute on Aging, 2013). Older adults seeking hospitalization for alcohol-related conditions do so at rates similar to those admitted for myocardial infarction (Merrick et al., 2008).

Prevalence

Blazer and Wu conducted a secondary analysis of the National Survey on Drug Use and Health in order to assess prevalence, distribution, and correlates of at-risk alcohol use in the United States among older adults (2009). Researchers found that at risk alcohol misuse and binge drinking are more frequent among individuals 50 to 64 years of age compared to those 65 and older. Furthermore, among those 65 and older, 13% of men and 8% of women were at-risk drinkers and...
14% of men and 3% of women were binge drinkers. The study also found that binge drinking among males was associated with higher income, being separated, divorced, or widowed, and being employed. Binge drinking among women was associated with non-medical use of prescription drugs. The use of tobacco and illicit drugs was also associated with binge drinking for both men and women (Blazer & Wu, 2009).

In the Netherlands, Geels and colleagues (2013) found that age, sex, and initiation of cigarette and cannabis use were significant predictors of AUD. For men, frequency of alcohol misuse was highest for older adults aged 65 and over (30.6-32.7% of men and 20.2-22.0% of women). For women, the highest prevalence of excessive drinking (14 and more glasses per week) was reported for those between 55 to 60 years of age. For both men and women 65 years and older, significant factors for abuse included early initiation of regular alcohol use and early age at first intoxication (Geels et al., 2013).

**Assessment**

Health care providers should follow clinical guidelines defined by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (2005) and the National Institute on Aging (2013). These organizations suggest that more than seven drinks per week or more than three drinks on any single day is considered “risky drinking” for individuals over 65; women's alcohol intake should be less than men (National Institute on Aging, 2013; National Institute on Alcohol Abuse and Alcoholism, 2005).

Alcohol use is considered contraindicated for older adults who have health conditions requiring complex medication regimes; thus, abstinence is recommended (Merrick et al., 2008).

The most straightforward method for assessing at-risk drinking or alcohol use disorders is to ask the patient how much they drink and how often the daily maximum number of drinks has been exceeded. This straightforward screening method has been found to be as sensitive and as specific as other alcohol screening methods (Smith, Schmidt, Allensworth-Davies, & Saitz, 2009; Willenbring, Massey, & Gardner, 2009). This method provides an educational opportunity to discuss appropriate alcohol limits (Willenbring et al., 2009).

The 10 item Alcohol Use Disorders Identification Test (AUDIT) is also a useful method for assessing alcohol consumption behaviors and for educating patients (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). You can access this instrument at [http://www.integration.samhsa.gov/AUDIT_screener_for_alcohol.pdf](http://www.integration.samhsa.gov/AUDIT_screener_for_alcohol.pdf).

Alcohol Assessment Questions for the Healthcare Practitioner from the Clinical Guidelines of Alcohol Use Disorders (Society of Hospital Medicine, 2004)

What to ask first.

"Tell me about your use of alcohol, including any beer, wine, or liquor/spirits."
Follow up those who have had any alcohol in the last year, by asking

"On average, how many days per week do you drink alcohol?"

"On a typical day when you drink, how many drinks do you have?"

(I drink = 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of liquor/spirits)

What is the maximum number of drinks you had on any given occasion during the last month?

Then, ask CAGE questions:

"Have you ever felt that you should Cut down on your drinking?"

"Have people ever Annoyed you by criticizing your drinking?"

"Have you ever felt Guilty about your drinking?"

"Have you ever had a drink (Eye opener) first thing in the morning to steady your nerves or get rid of a hangover?"

**Alcohol Use Disorder**

Alcohol abuse and dependence are now considered Alcohol Use Disorder—a subcategory under Substance Related and Addictive Disorders in the DSM 5 (APA, 2013). AUD is defined as a clinically significant impairment or distress due to maladaptive patterns of substance use that often results increased tolerance, increased time spent on substance use activities, withdrawals, craving, increased amounts of the substance, unsuccessful efforts to control use, continued usage despite adverse consequences, and a decrease in social, occupational, or recreational activities.

**Intervention**

NIAAA suggests that a combination of medication with a disease management approach has been effective as alcohol intervention (Smith et al., 2009). If an alcohol problem is suspected the health care provider should clearly communicate consequences of continued alcohol use and recommendations for treatment, and explain the comorbidity of alcohol use with other medical conditions (Willenbring et al., 2009).

The following interventions have been shown to be effective for treating AUD in older adults:

- Motivational interviewing
- Substance use counseling
- Cognitive behavioral therapy
- Pharmacotherapy
- A combination of pharmacotherapy and psychotherapy
- Alcohol rehabilitation treatment
References


