

SUBSTANCE USE AND OLDER ADULTS

CHAPTER 4: DETECTION OF SUBSTANCE USE, ABUSE, AND DEPENDENCE AMONG OLDER ADULTS

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- ◆ Both health care and substance abuse professionals frequently underestimate or misunderstand problems related to substance use among older adults.
- ◆ There are a number of barriers that explain why professionals underestimate or misunderstand problems related to substance use among older adults

A number of factors contribute to the under-detection of substance use and substance-related problems among older adults. Beullens and Gertgeerts (2004) catalogue earlier studies that have linked a variety of factors to under-detection of alcohol use and abuse among older adults: the similarity of age-related health problems and substance abuse symptoms (Thibault & Maly, 1993); the relationship between decreased consumption and desired mood state (Thibault & Maly, 1993); stereotypic understanding of alcohol problems among professionals (Curtis, Geller, Stokes, Levine, & Moore, 1989); and use of unreliable self reports and age-insensitive screening instruments (Graham, 1986).

Similar factors affect assessment for substances other than alcohol (King, van Hasselt, Segal, & Hersen, 1994; Lynskey, Day, & Hall, 2003). Menninger (2002) details the barriers to identification of alcohol problems in older people including the following: 1) stereotypic thinking about alcohol and people who have alcohol-related problems; 2) pessimism about treatment and lack of knowledge about treatment; 3) feelings of stigma or shame that lead to underreporting or denial; 4) placing too much emphasis on alcohol-related consequences associated with work, legal problems, or family conflicts; 5) overlap of medical conditions and alcohol-related health problems; and 6) unintentional use of alcohol or other substances contained in over-the-counter medications.

Families may create barriers to screening and assessment by trying to protect or minimize an older adult's substance use and related problems. Stigma associated with alcohol and other drug use has been discussed as a barrier among older adult cohorts. A number of publications address barriers to screening and assessment among older

cohorts; however, these barriers and other issues of age-related stigmas and social taboos related to substance use and abuse have not been explored systematically.

- ◆ Detection of substance use, abuse, and dependence among older adults relies most often on self-report.
- ◆ Research on barriers to screening and assessment should examine differences in stigma among and between different cohorts of older adults and their families.

As in younger adults, detection and assessment of substance use, abuse, and dependence in older adults relies heavily on self-report. Because of this reliance on self-report, interviewers must be able to ask questions about alcohol and other drug use in a non-judgmental and supportive manner and know how to use screening tools that have demonstrated reliability and validity with older adults.

Frequency and Patterns of Use Questions

- ◆ Patterns and changes in patterns of alcohol use and expectancies of alcohol use can be helpful in detection and assessment efforts with older adults.
- ◆ Questions about frequency of use are as important as quantity in assessing older people.
- ◆ Questions about reasons for use and patterns of use (frequency of use and amount consumed) should be repeated annually as part of annual health screenings for all older adults (Blow, 2000).
- ◆ Satre and Knight (2001), in a study of patterns of alcohol use in a small convenience sample, found older people consumed less alcohol per occasion than younger people, but that older people reported more drinking occasions per month than younger people.

Satre and Knight (2001) concluded that “quantity and frequency appeared to compensate for one another in the total quantity of alcohol consumed” (p. 77). In a small convenience sample, the majority of those who drank alcohol said they drank for social reasons and enjoyment (Kahn, Wilkinson, & Keeling, 2006). A beginning assessment of alcohol use might well focus on social opportunities for drinking alcohol.

- ◆ Studies show a relationship between an older person’s beliefs about alcohol’s effects and his or her alcohol consumption (Satre & Knight, 2001).

In the Satre and Knight study (2001), older people showed lower levels of positive attitudes towards alcohol use than younger people. Both positive and negative beliefs about alcohol were related to alcohol use among older men. Among older women, negative attitudes were related to less alcohol use.

- ◆ Currently, research on the cohort effects of alcohol expectancies is limited.

There is a need for longitudinal analysis of attitudes regarding alcohol and how attitudinal changes are related to decisions about alcohol use. Future research should focus on the ages at which changes in attitudes toward alcohol use occur and under what circumstances.

Kahn, Wilkinson, and Keeling (2006) found that older people reduce their use of alcohol due to health concerns or encouragement from family and friends. There is a continuing debate on the nature of the relationship among alcohol use, traumatic loss, and depression among older adults (Colleran, 2002; D'Agostino, 2003; Shafer, 2004), indicating a need to develop systematic empirical investigations of these relationships in assessing alcohol and other drug use among older adults.

Early and Late Onset among Older Persons

- ◆ Early- and late-onset groupings have been used to characterize need and prognosis of older people with alcohol-related problems (Rosin & Glatt, 1971; Liberto, Oslin, & Ruskin, 1992).

Early onset drinkers have been described as people whose problematic alcohol use begins early and continues through life. Increased rates of psychiatric comorbidity have been associated with early onset groups (Schonfeld & Dupree, 1991; Atkinson, 1990). However, there is disagreement about what age should be used as the cut-off, and studies use different definitions of what should be considered "early" (U. S. Department of Health and Human Services, 1998). Late-onset drinkers have been described as those who develop alcohol-related problems later in life, but age cut-offs for this group have also varied.

- ◆ Stresses and losses of later life have been posited as triggers for late-onset alcoholism, but research has not generally supported these relationships (Gomberg, 2003).

Wetterling, John, Veltrup, and Driessen (2003) examined the data from 286 admissions to an alcohol detoxification program and compared early onset alcoholism (age ≤ 25) with late onset alcoholism (age ≥ 45) and reported that late-onset individuals were more likely to have a familial history of alcoholism, had fewer detoxifications, suffered less psychiatric co-morbidity, and had a higher abstinence rate at 12 months post-treatment. In a recent literature review, Wood (2006) presented a theoretical discussion of older drinkers' decisions to drink that is relevant to the discussion of onset classifications. Onset remains an important question in the study and treatment of alcohol and other drug abuse among older adults and is an area in need of continued research.

Alcohol Screening and Assessment among Older Adults

- ◆ Most screening and assessment tools are tied to DSM criteria, which are less appropriate for older than younger populations.
- ◆ Few alcohol abuse screening tools have been developed specifically for use with older people. Research on sensitivity and specificity of standardized screening tools in older populations is growing, but the information is not definitive.
- ◆ Effective screening depends on assessment setting, client characteristics, prevalence of alcohol use in the population, and cultural context.
- ◆ Screening and assessment should focus on both current and lifetime use of alcohol and other drugs.
- ◆ Some screening tools developed for use with younger populations do not adequately identify problems related to alcohol use among older adults.

Screening and assessment tools in AODA have focused on younger people and often miss problems in older populations. Practitioners must understand the need to tailor interviewing approaches and styles to facilitate a trusting and supportive relationship with the older person and his or her family, as appropriate. Questions should be stated clearly and with a non-judgmental attitude regardless of which approaches or tools are used.

- ◆ The most commonly used alcohol abuse screening tools for adults include the CAGE (Mayfield, McLeod, & Hall, 1974); MAST (Selzer, 1971); AUDIT (Saunders, 1993); AUDIT-C (U.S. Department of Health and Human Services, 2001) and ARPS and short ARPS (shARPS) (Fink, 2002); however, none of these tools were developed specifically for older adults.
- ◆ Screening tools specifically developed or adapted for use with older adults provide higher levels of sensitivity to and specificity of alcohol-related problems, though there are few such tools. The MAST-G, developed specifically for use with older adults (Blow et al., 1992), has been shown to be a high quality screening tool for use with older people in both clinical and community settings.
- ◆ Future research should focus on appropriate cut-off scores for screening tools to balance specificity and sensitivity.
- ◆ Future research is needed on screening tools that can accurately detect alcohol-related problems with cognitively impaired older persons and those with psychiatric illnesses.

The DSM criteria for alcohol or drug abuse and alcohol or drug dependence provide the base for most of the questions in the available tools. Since older adults are less likely to suffer the consequences addressed in these tools, such as legal or work-related problems from their use, screening tools based strictly on DSM criteria have diminished utility for identifying alcohol-related problems (Beullens & Aertgeerts, 2004; O'Connell et al., 2004). The MAST-G (Blow et al., 1992) was specifically designed to capture alcohol-related consequences among older people (Conigliaro, Kraemer, & McNeil, 2000).

Systematic reviews have compared commonly used self-report screening tools (O'Connell et al., 2004; Beullens & Aertgeerts, 2004). The MAST-G, used with a score of five or more as a cut-off, was found to be a sensitive screening instrument for use with older adults in a clinical setting, but specificity results indicate false positives are possible with this tool.

The CAGE, used with a cut-off score of two, was found to have low sensitivity (13%), but very high specificity (98%) in clinical settings; it is seen as a useful first-screening tool, especially in settings where clients have a high prevalence of alcohol-related problems. The CAGE was less useful in community settings, and its sensitivity was low in psychiatric populations.

In a study of 166 drinkers aged 60 and older who were patients at outpatient primary care clinics, Moore and colleagues compared the results from ARPS and the shARPS (Moore, Beck, Babor, Hays, & Reuben, 2002). Both were sensitive for identifying older drinkers, especially those classified as harmful or hazardous drinkers.

Co-Occurring Conditions Screening and Assessment among Older Adults

- ◆ Alcohol use and depression can present a difficult diagnostic problem among older people. Alcohol use among depressed older adults does not always meet criteria of abuse or dependence, but it can nevertheless be problematic (Blow, Serras, & Barry, 2007). Alcohol can exacerbate depression, and depression can exacerbate alcohol use—making the assessment process complex.

Alcohol and other drug abuse problems among older adults are often associated with depression and cognitive status and other issues of dual diagnoses (Bartels, Blow, Van Citters, & Brockmann, 2006). Depression and smoking tobacco have been linked in a sample of older HMO members (Green, Polen, & Brody, 2003). Risk for suicide should be a part of a thorough depression assessment with older adults. A frequently used scale to screen for depression is the Hamilton Rating Scale for Depression (Hamilton, 1960), which consists of 21 items, each rated in terms of severity. The reliability in samples of older adults is .73 (Riskind, Beck, Brown, & Steer, 1987).

- ◆ Cognitive problems should be ruled out or identified during the screening and assessment process with older adults.

The Mini Mental State Exam (MSSE) is a 30-item scale with brief measures of attention and concentration, orientation, language, and executive control (Folstein, Folstein, & McHugh, 1975). Scores must be adjusted to reflect differences in education levels.

In a study of substance abuse treatment initiation, older male veterans (aged 55+) with better cognitive status were more likely to initiate substance abuse treatment (Satre, Knight, Dickson-Fuhrmann, & Jarvik, 2004). Data from the Second Longitudinal Study of Aging indicated that an average of one drink or less each day was protective for women to maintain cognitive functioning, but not for men (McGuire, Ajani, & Ford, 2007). However, caution was suggested in using this finding as a guide because of other risks of alcohol consumption.

Tobacco Screening and Assessment among Older Adults

- ◆ Research findings are clear that smoking cessation can improve health outcomes for older adults across a range of conditions and demographic groups (Fiore, Bailey, & Cohen, 2000).
- ◆ Smoking cessation can be especially challenging for older adults because most are chronic smokers who experience a variety of barriers to change (Appel & Aldrich, 2003).

Fisher and colleagues (2008) found that older cohorts of smokers were more likely than younger cohorts to deny smoking. Some have argued that older adults can benefit the most from smoking cessation efforts because they have been smoking the longest, have high levels of nicotine dependence, lifelong psychological dependence on tobacco, and are more vulnerable to smoking-related health problems (American Lung Association, 2007).

- ◆ Screening for tobacco use should involve clear questions about tobacco use and a non-judgmental attitude. The five As (Ask, Advise, Assess, Assist, and Arrange for follow-up) provide a framework for assessment and intervention for older adults who use tobacco (Rigotti, 2002; Andrews, Heath, & Graham-Garcia, 2004).
- ◆ The role of social taboo should be considered in the development of screening and assessment techniques, since denial of smoking has been found to increase with age in one national study (Fisher, Taylor, Shelton, & Debanne, 2008); 25% of smokers, as determined by biomarker testing, in the 75+ age group denied use. Research on tobacco screening and assessment has

not focused on older adults and there is a need to understand differences and similarities among various age cohorts.

- ◆ Frail elderly participants in a community health service who continued to smoke cigarettes sought health services at an earlier age than non-smokers did, drank alcohol regularly, and obtained cigarettes without assistance (Haas, Eng, Dowling, Schmitt, & Hall, 2005).
- ◆ The Fagerstrom test is a six-item screening tool for detecting severity of nicotine dependence. Though not developed for specific use with older adults, it is a commonly used clinical and research tool (Heatherton, Kozlowski, Frecker, & Fagerstrom, 1991; Andrews, Heath, & Graham-Garcia, 2004).

Scoring for the Fagerstrom test is standardized: 0 to 4, low; 5, medium; 6 or 7, high; and 8 to 10, very high nicotine dependence. A score of 7 or more may indicate more severe withdrawal symptoms. This scoring system has not been validated with older adults.

- ◆ Policy research has indicted a relationship between state tobacco control program expenditures and reductions in smoking among adults, but information specific to older adults was not included (Farrelly, Pechacek, Thomas, & Nelson, 2008).

There is clearly a need for additional research in the area of age appropriate tools for screening and detection of tobacco use among older adults.

Medication Misuse Screening and Assessment among Older Adults

- ◆ Medication misuse is a broad topic that involves several types of medication problems (U.S. Department of Health and Human Services, 2006).
- ◆ Poly-pharmacy is another broadly based term used to describe medication use that is not clinically warranted (Zarowitz, 2006).
- ◆ Medications, both prescription and over-the-counter, can interact with each other and with alcohol and/or street drugs, causing difficulties in diagnosis and assessment (Meadows, 2006).

Older adults may take the wrong medications because of prescribing errors on the part of the physician. Older adults may also incorrectly use medications because they have cognitive deficits, they do not understand the instructions for proper use, or they do not have the resources to obtain adequate supplies of a medication. Medication misuse may arise because older adults attempt to self-treat pain and/or other conditions. Misuse of prescription medications, especially opiate drugs, can lead to substance abuse and substance dependence in all age groups. Substance abuse

treatment professionals are typically most interested in the use and abuse of prescription drugs with addiction potential.

Gerontological social workers or hospital or health care social workers are often responsible for assessing medication misuse among older adults. However, the increase in the numbers of older adults seeking treatment for substance abuse problems provides a rationale for teaching substance abuse professionals how to screen for medication misuse as part a routine assessment for substance-related problems.

- ◆ Assessment for medication misuse begins with “The Brown Bag Review” (Colt & Shapiro, 1989).

The Brown Bag Review method requires the older adult to bring all of his or her medications in their original containers and to discuss their use with the health care provider. This method of assessment requires that the provider understand different types of medications, their utility in older adult populations, and possible interactions and side effects. Included in the “The Brown Bag Review” should be all prescription medications, over-the-counter medications, herbs, vitamins, dietary supplements, and topical treatments such as ointments and creams (Meadows, 2006).

Situations that may increase the risk of medication misuse (Bergman-Evans, Adams, & Titler, 2006) include 1) self management/treatment of physical and mental health problems, 2) absence of coordinated health care, 3) an older adult’s impaired cognitive status, and 4) an older adult’s complicated medication regimen.

- ◆ Chronic pain is often a reason for misuse of prescription medications or drug-seeking behaviors (Trafton, Oliva, Horst, Minkel, & Humphreys, 2004).

Misuse of prescription drugs with addiction potential includes sharing medications, using high doses for a longer time than prescribed, and recreational rather than medical use. The two major classes of prescription drugs abused by older adults are benzodiazepine sedative-hypnotics and opioid analgesics (Simoni-Wastila & Yang, 2006). Younger people with a history of alcohol or drug abuse problems are known to be at risk when exposed to controlled substances (Isaacson, Hopper, Alford, & Parran, 2005), but this risk has not been well studied among older adults (Menninger, 2002).

The risk factors for medication mis-management are the same regardless of age. These factors include being female, social isolation, poor health status, chronic physical illness, previous and/or current substance use disorder, and previous/current psychiatric illness (Simoni-Wastila & Yang, 2006).

- ◆ Research on medication effects and misuse specific to older adults is needed.

Research on medication effects—both prescription and over-the-counter—must include adequate samples of older adults from various settings and cultural groups. Commonly used research measures of inappropriate drug use are of limited use with older adults. Future research on psychoactive drug use should incorporate clinical

assessment, target symptom measures, measures of functional status, and consensus-based criteria for appropriate drug and dosage (Talerico, 2002).

Illicit Drug Screening and Assessment among Older Adults

- ◆ Research on illicit drug screening and assessment specific to older adults is limited.

The empirical literature on illicit drug use among older adults is limited, and no tools have been developed to assess illicit drug use specifically among older adults. Questions about previous drug use and drug-related problems are useful because of the high correlation of current use with lifetime patterns of use (Rivers et al., 2004; Simoni-Wastila & Yang, 2006).

Over the next decade, clinicians and researchers should collaborate to develop screening and assessment tools for illicit drug use and drug-related problems among older adult cohorts with special emphasis on marijuana and non-medical use of prescription drugs.

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Curriculum Resources

The following resources include recommended key curriculum resources, course readings, and Web resources.

Suggested Readings:



- Beullens, J., & Aertgeerts, B. (2004). Screening for alcohol abuse and dependence in older people using DSM criteria: A review. *Aging & Mental Health, 8*(1), 76-82.
- O'Connell, H., Chin, A., Hamilton, F., Cunningham, C. Walsh, J., Coakley, D., et al. (2004). A systematic review of the utility of self-report alcohol screening instruments in the elderly. *International Journal of Geriatric Psychiatry, 19*, 1074-1086.

These articles point out the differences in DSM criteria and the realities of alcohol use among older adults and review studies of commonly used alcohol screening tools including AUDIT, MAST-G, and CAGE. O'Connell and colleagues provide copies of four screening tools as appendices.

- Blow, F., Brower, K., Schulenberg, J., Demo-Dananberg, L., Young, J., & Beresford, T. (1992). The Michigan Alcoholism Screening Test—Geriatric Version (MAST-G): A new elderly-specific screening instrument. *Alcoholism: Clinical and Experimental Research, 16*, 372.

Blow and colleagues describe the development and the use of MAST-G, the most widely recommended screening tool for older adults.

- Simoni-Wastila, L., & Yang, H. (2006). Psychoactive drug abuse in older adults. *The American Journal of Geriatric Pharmacotherapy, 4*(4), 380-231.
- Simoni and Yang provide an excellent review of misuse and abuse of legal and illegal drugs among older adults.

Teaching modules:



Older Adults and Alcohol Problems Older Adults and Alcohol

Problems (Module 10C of a larger curriculum entitled “Social Work Education for the Prevention and Treatment of Alcohol Use Disorders”) This curriculum is well-grounded in research, geared for MSW courses, and provides user friendly overheads, notes, and handouts. There are two case studies, with discussion questions, in the larger curriculum that are well-suited for teaching assessment of alcohol and medication misuse problems. Availability: Free from the National Institute of Alcohol Abuse and Alcoholism (NIAAA). Download from Web site at <http://pubs.niaaa.nih.gov/publications/Social/main.html>



Adult Medication: Improving Medication Adherence in Older Adults.

This curriculum, co-developed by the American Society on Aging (ASA) and the American Society of Consultant Pharmacists, provides an outstanding review of screening tools related to medication adherence in older adults, as well as considerations for culturally competent intervention. Download from: www.AdultMeducation.com.