Alcohol Misuse Among the Elderly: An Opportunity for Prevention

Current census estimates predict that by the year 2020, 18% of the population will be 65 years or older. As most adults in this age group have health care needs, it is vital that clinicians are competent in identifying and intervening in the most common health issues among older adults. The article in this issue by Blazer and Wu (1) again reminds us that alcohol use, including binge drinking, is common among older adults and that despite popular culture, alcohol misuse does not disappear as one ages. As noted in the article, the findings are very consistent with other epidemiological literature. Blazer and Wu found that 13% of men and 8% of women reported at-risk drinking and that 14% of men and 3% of women reported binge drinking. This is not to suggest that many older drinkers have a diagnosis of alcohol dependence. However, identification and delivery of appropriate interventions focused on those with regular heavy use of alcohol and binge drinking provide an opportunity for clinicians to help improve overall health, promote independence, and reduce health care costs.

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One of the strengths of the Blazer and Wu study is its large, diverse sample, which seems well representative of the population seen in outpatient primary care and mental health clinics. Including subjects ages 50–64 was helpful for comparison, as it showed drinking was greater in the younger group than in the older individuals. The study variables used to assess alcohol use for patients with low-risk, at-risk, and binge drinking were clinically appropriate, as they were set to detect those who might be most at risk for harm related to their drinking. One of the findings of great importance was that alcohol misuse in this population was a marker for other problems, including illicit drug use, tobacco use, and misuse of prescription medications. The data demonstrate differences between at-risk and binge drinkers across various demographic groups. For instance, the variables associated with men and women who reported binge drinking suggest that those at risk from each sex tended to be from different backgrounds. These associations can help target at-risk populations, but our overall goal is to screen all of our geriatric patients.

Taken as a whole, the findings of the study by Blazer and Wu underscore the need for screening and assessment of older adults, not only to facilitate prevention of alcohol-related medical complications but also to open an avenue for identifying other health concerns. The United States Preventive Services Task Force and other organizations have consistently called for systematic alcohol screening of all adults in medical care settings. Primary care clinics and mental health care programs are two venues that are particularly important for such screening. Recent advances in the treatment of alcohol use disorders highlight the need for recognition and intervention, especially in patients such as the elderly, who are at risk for functional disability from multiple health problems. To be able to practice prevention and early intervention with older adults, clinicians need to screen for alcohol use (frequency and quantity), drinking consequences, and problems related to interactions of alcohol and medications. Screening can be done as part of routine mental and physical health care and should be updated annually, before the older adult begins taking any new medications, or in response to problems that may be related to alcohol or medication. Screening questions can be asked by

means of a verbal interview, a paper-and-pencil questionnaire, or a computerized questionnaire. All three methods have equivalent reliability and validity (2, 3). Any positive responses can prompt further questions about consequences and associated problems, such as depression, other drug use, or family problems. To successfully incorporate alcohol (and other drug) screening into clinical practice with older adults, the process should be simple and consistent with other screening procedures already in place (4). One of the most simply implemented screening tools is the AUDIT-C test (5), which has the advantage of identifying heavy drinking as well as more severe drinking patterns. The CAGE questionnaire (6) is perhaps the most widely known alcohol screening test, but it mostly identifies patients with probable alcohol dependence, rather than the broader public health problems of at-risk drinking and binge drinking (7).

What Should Providers Do With a Positive Screen?

All clinicians should be able to screen and discuss alcohol use with patients. As a follow-up to a positive screen, brief interventions of low intensity or brief therapies have been suggested as cost-effective and practical techniques that can be used as an initial approach to at-risk and problem drinkers in various clinical settings (8). These interventions are relatively easy to learn and can be delivered by a wide range of staff, including nurses, social workers, psychologists, and physicians. Studies of brief interventions for alcohol problems have employed various approaches to change drinking behaviors. Pharmacotherapy with "anti-craving" medications is also highly recommended as a first-line treatment in both primary care settings and mental health care settings. While there have been only a handful of clinical trials for older adults, there are also no compelling reasons to believe that medications such as naltrexone or acamprosate are not safe to use in this population (9).

Summary

Over the past several years there has been a growing awareness that addictive disorders among the elderly are a common public health problem. Epidemiological studies suggest that alcohol dependence is present in up to 4% of community-dwelling elderly, and some evidence suggests that the prevalence of alcohol abuse or dependence among older adults is on the rise (10). Moreover, as suggested by the Blazer and Wu article, problem or hazardous drinking is estimated to be even more common among the elderly than alcohol dependence (10, 11). However, there continues to be a gap between the number of older adults who need treatment for addictive disorders and the number who are provided treatment. Although there are many reasons for patients not to be engaged in treatment, recommending treatment partially relies on clinicians systematically screening for problems and using effective treatments. Toward this end, there needs to be better dissemination of information regarding currently available and efficacious treatments for at-risk drinking, alcohol dependence, and other addictive disorders, as well as continued development of more effective treatments. There is also a clear need to conduct research and clinical training beyond the problems of alcohol use.

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