

# Applying Geriatric Principles to Hazardous Drinking in Older Adults



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## KEYWORDS

- Older adults • Polypharmacy • Frailty • Unsafe drinking • Hazardous drinking
- Alcohol use disorder • Annual medicare wellness • Alcohol intervention

## KEY POINTS

- The concept of hazardous drinking addresses the risks of alcohol consumption in older adults that may not fit the DSM-5 AUD criteria.
- The interplay of ethanol with physiological changes of aging, comorbidity and polypharmacy increases risk for falls, traffic accidents, drug interactions and victimization.
- Increased numbers of older adults and increased proportions of older adults who continue to drink warrants clinical vigilance.
- Routine office visits and the Medicare Annual Wellness Visit are opportunities to screen using short, validated tools such as the AUDIT-C and the SASQ.
- Always consider alcohol or benzodiazepine withdrawal in hospitalized older adults who become delirious.

## INTRODUCTION

For many older adults, alcohol is an adjunct to family celebrations and other social engagement that is important to their sense of well-being.<sup>1,2</sup> Recently a respected Washington political columnist wrote his reflections on reaching the age of 80 years and complained about his doctors lecturing him about his evening martini.<sup>3</sup> We need to understand in our patients and our society that having a drink is not inherently good or bad or unhealthy. There are guidelines for safe drinking and red flags that any clinician caring for older adults should recognize. This article will focus on recognizing and distinguishing potentially unhealthy alcohol intake in older adults from alcohol use disorder (AUD) and summarize approaches to counseling older adults for safe drinking and treatment of AUD.

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Clin Geriatr Med 38 (2022) 145–158

<https://doi.org/10.1016/j.cger.2021.08.001>

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## EPIDEMIOLOGY OF DRINKING AND POLYPHARMACY

Alcohol has been around for a long time. Over the past century, the age at first alcohol use has trended to younger ages, now averaging about 25 years.<sup>4-8</sup> Among those older than 65 years, drinking declines with age. Among those older than 85 years, fewer than 5% continue to drink. Surveys find risky drinking in the single digits among adults older than 75 years. Clinical samples in outpatient clinics<sup>9-11</sup> and emergency departments<sup>12,13</sup> have a selection bias for higher drinking, but even there, the proportion of older adults in the trauma bay is small.<sup>14-16</sup> Older adults are also using both recreational and prescription substances.<sup>4,17-19</sup> The general caution should be that all health surveys of older adults suffer from survivor bias.<sup>20,21</sup> Older adults who continue to drink say that they drink less not for health reasons but rather for lack of opportunity, lack of access, and direct concern about drug interactions.<sup>1,16,22,23</sup>

Polypharmacy is problematic for older adults with multiple comorbidities. Between 26% to 40% of Medicare age adults are at risk of adverse drug interactions simply because of numbers of prescription and over the counter (OTC) drugs they take.<sup>24-27</sup> Older adults are more likely to get new prescriptions for opiates<sup>25,26,28,29</sup> and benzodiazepines.<sup>30</sup> Other risky drugs more frequently prescribed to older adults include muscle relaxants, antidepressants, antihistamines, anticholinergics, antihypertensives, and hypoglycemic drugs.<sup>24</sup>

## THE PHARMACOLOGY, CHEMISTRY, AND PHYSIOLOGY OF ETHANOL

Ethanol is absorbed directly from the upper gastrointestinal (GI) tract, metabolized in the liver by alcohol dehydrogenase (ADH) and, to some extent, by the cytochrome P450 CYP-2E1 that also metabolizes fatty acids. The first 2 steps reduce ethanol back to acetaldehyde and ultimately to CO<sub>2</sub> and H<sub>2</sub>O. There are many genetically determined variants of both enzymes, so there is great individual variability in the rate of metabolism and subjective response to and excretion of ethanol.<sup>31</sup>

Ethanol is a naturally occurring chemical that is used as a drug. Pharmacokinetic studies have examined how ethanol interacts with drugs using a variety of designs. A systematic review concluded that due to factors of variable study design, small numbers and unmeasured subject genetic variability, prior ethanol exposures, and multidrug interactions, it is difficult to identify specific drug-ethanol interaction effects based on kinetics. The literature is more consistent about the pharmacodynamic, or subjective, effects of ethanol with other drugs. There were consistent additive effects on symptoms such as subjective intoxication, sedation, hypertension, psychomotor performance impairment, blood pressure, and heart rate when ethanol was given with a target drug.<sup>32</sup> With aging, the volume of distribution decreases, so equivalent servings of alcohol produce higher blood levels faster in older drinkers. Age- or disease-related decreased liver enzyme (ADH, CYP-450-2E1) activity and decreased renal clearance increase alcohol blood levels and delay its clearance in women and older drinkers. Interplay with genetic variability, sex, age-related changes in central nervous system (CNS) function, and additive effects of other drugs make for a complicated picture. **Table 1** shows, for example, the ten drugs most often prescribed to older adults in the United States (U.S.) with potential alcohol interactions.

Ethanol has both acute and chronic toxicity. The metabolite acetaldehyde independently causes subjectively unpleasant flushing and sweating in some drinkers. Alcohol can induce direct irritation and inflammation in the upper GI tract. It binds avidly to the inhibitory neurotransmitter gamma-butyric acid receptors in the CNS, but it also indirectly stimulates the mu and dopamine receptor reward systems. This poses a

<b>Drug</b>	<b>Indication</b>	<b>Metabolism</b>	<b>Potential Ethanol Interaction</b>
Simvastatin	Hyperlipidemia, atherosclerosis, diabetes (DM)	Liver CYP 450:2D6, 3A4 Inhibits cholesterol synthesis	Caution in alcohol use due to liver enzyme elevations
Lisinopril	Hypertension (HTN), congestive heart failure (CHF)	None, inhibits ACE conversion of angiotensin 1 to angiotensin 2.	Hypotension
Levothyroxine	Hypothyroidism	Metabolized in liver unknown pathway	None known
Amlodipine besylate	Hypertension (HTN)	Liver CYP450: 3A4	Hypotension
Omeprazole	Acid reflux	Liver CYP 450: 2C19, 3A4	None known
Azithromycin	Antibiotic, pneumonia, bronchitis	Liver	None known
Metformin	Type 2 diabetes	None	Inhibits hepatic gluconeogenesis, prolongs hypoglycemia, increases risk for lactic acidosis.
Amoxicillin	Antibiotic	Limited, excreted in urine	None direct
Hydrochlorothiazide	Diuretic, HTN, CHF	None	Hypotension
Hydrocodone	Pain	Liver extensive CYP450: 2D6, 3A4	Coingestion raises hydrocodone levels additive risk of respiratory depression, sedation, psychomotor impairment, hypotension. In combination with acetaminophen increased liver toxicity

particular risk for older drinkers who experience disturbances of attention and coordination at blood levels much lower than required to impair younger drinkers.<sup>16,33,34</sup>

Alcohol is a depressant, so after a first pleasant euphoria at high blood levels, it causes sedation, coma, and death. Ethanol antagonizes the excitatory transmitter glutamate from binding with N-Methyl-D-Aspartate (NMDA) receptors. Under the influence of continuous suppression by daily drinking, glutamate receptors multiply creating the substrate for withdrawal syndromes including catecholamine rebound tachycardia, hypertension, hallucinosis, seizures, and delirium.<sup>33</sup> Mortality from

delirium tremens, the most severe withdrawal syndrome, has declined with improved recognition and management, but it remains deadly for older adults.<sup>12</sup>

### ASSESSING DRINKING SAFETY FOR OLDER ADULTS

The terms “problem drinking”, “alcohol abuse”, and “alcohol dependence” have been replaced in the diagnostic and statistical manual (DSM)-5 with “substance use disorder” which includes 10 classes of ingestible or injectable substances.<sup>35</sup> The DSM-5 defines substance use disorders as continuing to use a substance after experiencing problems either caused by or associated with use. This is distinguished from substance-induced disorders such as hallucinations or withdrawal syndromes. Eleven criteria in 4 domains of adverse substance use apply to drinking as well and are linked to altered activation of the brain’s intrinsic reward system. **Boxes 1** and **2** show the 11 criteria and scoring system used to diagnose AUD. The DSM-5 also recognizes substance-induced psychiatric disorders including depression, anxiety, psychosis, obsessional-compulsive disorders, neurocognitive disorders, sleep disorders, sexual dysfunction, and delirium. These disorders are distinct from intoxications and withdrawal syndromes.

A newer concept is “at-risk” or “unhealthy”<sup>36</sup> or “hazardous” alcohol use which is defined as consumption of any amount of alcohol that may result in adverse effects and does not fit criteria for a diagnosis of AUD. Based on epidemiologic studies, multiple public health authorities including the National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, Surgeon General, and US Preventive Services Task Force (USPSTF) (2018)<sup>37</sup> have agreed on safe levels of alcohol intake for

#### Box 1

##### DSM-5 criteria for alcohol use disorder

1. Uncontrolled use
  1. Drinking more or for longer than intended
  2. Repeated unsuccessful attempts to cut back or control drinking
2. Continued use despite consequences
  3. Social problems (job problems) caused or exacerbated by use
  4. Using alcohol in physically hazardous settings
  5. Medical or psychological problems caused or worsened by drinking
3. More time spent on alcohol
  6. A great deal of time spent using, obtaining or recovering from alcohol
  7. Have given up important things or cut back on previously important, enjoyable things because of drinking
  8. Failure to fulfill major obligations (work, family, relationships) due to drinking
4. Biological responses
  9. Craving, thinking about it a lot, missing the sensations
  10. Tolerance, takes more to get the same level of positive sensation
  11. Withdrawal symptoms, shakiness, seizures, nausea, vomiting, tachycardia, and hallucinations on stopping

#### Scoring:

- Mild AUD 2 to 4
- Moderate AUD 4-5
- Severe AUD  $\geq 6$

*Data from* DSM-5 Task Force C, Diagnostic and Statistical Manual of the American Psychiatric Association. Fifth ed. 2013. Arlington, VA.

**Box 2****Unhealthy drinking National Institute on Alcohol Abuse and Alcoholism guidelines for adults: drinks per week, per day**

Daily limits for men  $\leq 5$ , for older men greater than 4

Daily limits for women  $\leq 4$ , for older women  $\leq 3$

Weekly limits for men  $\leq 14$  Weekly limits for women  $\leq 7$

Alcohol equivalents: 1 drink = one 12-oz bottle or glass of beer, one 5-oz glass of wine, one 1.5-oz shot of liquor

the general adult population and issued a modified recommendation for older adults. **Boxes 1 and 2** additionally show the current guidelines for safe drinking in adults.

The risk in “at-risk” drinking includes the drinker and a spouse who is also at risk due to disability, frailty, and cognitive impairment. Alcohol is implicated in geriatric trauma including traffic, occupational, firearm, and household accidents. Older drinkers in motor vehicle accidents have lower blood alcohol concentration than younger drivers involved in traffic fatalities. Polypharmacy exacerbates the risk of hemodynamic, glycaemic, and cognitive events. The interaction of small amounts of cannabis and alcohol is of increasing concern as both are legal and widely available without prescription. The ability to compensate for alcohol is affected by how many small deficits an older adult has accumulated, a well-accepted principle in geriatric medicine.<sup>38</sup> The idea of aging itself as the accumulation of decreased organ reserve and decreased ability to restore homeostasis is especially pertinent for older people who drink.<sup>39</sup> The subclinical markers of frailty that can be detected by a thorough geriatric examination can identify “vulnerabilities” to the effects of ethanol on older adults.

## HOW TO RECOGNIZE UNSAFE DRINKING IN OLDER ADULTS

Unsafe drinking and AUD are different conditions in older adults. Cutoffs derived from a population survey found that greater than 1 drink per day, greater than 7 drinks per week, or  $\geq 3$  drinks on any occasion predicted alcohol-related problems in middle-aged drinkers. At 10-year follow-up, when they were 65 to 75 years old, most of the daily drinkers had cut down or stopped. But even at the same levels of drinking, older drinkers experienced fewer of the 11 alcohol-related problems detailed in the DSM-5 criteria than the younger drinkers.<sup>40</sup> Although fewer than 20% of those over 70 drink, the consequences are serious enough to warrant screening older adults who can answer for themselves. Several screening tools identify AUD. The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item questionnaire widely used in English and translations.<sup>41</sup> The AUDIT-C short form is used as a first-level screen. It is limited to the first 3 quantity/frequency items which were adopted in setting the safe levels referenced previously. The Single Alcohol Screening Questionnaire (SASQ) about having 5 or more drinks on one occasion in the past year has been shown to identify hazardous drinking in outpatient settings. The 4-item Cut-down, Annoyed, Guilty, Eye-opener (CAGE) and the 24-item Michigan Alcohol Screening Test (MAST-G)<sup>42</sup> also screen for AUD. The AUDIT-C is a less intimidating way to open the conversation at least for initial interviews in a primary care setting. The MAST-G recognizes that older adults are likely to be retired, so there are fewer employment-related consequences. They are more likely to be unpartnered, so there are fewer people be annoyed by their drinking.<sup>36,43</sup>

## CLINICAL APPROACHES TO ALCOHOL IN OLDER ADULTS IN OUTPATIENT CARE

Alcohol, tobacco, and off-prescription addictive or recreational drug use are subsumed under social history in many electronic medical records. This is unfortunate

because it encourages a superficial approach to important health-related behaviors, exposures, and social risk. The Annual Medicare Wellness (AMW) visit provides clinicians with an opportunity to screen for harmful alcohol use. Pathways for screening and intervention in primary care have described and evaluated.<sup>43</sup> Alcohol abstinence on a screening tool may be a marker of previous problems with alcohol. Nondrinkers should be asked how long they have been abstinent or if they just never drank. Adult-onset abstinence should prompt a query about reasons for stopping. Previous heavy drinking may have contributed to their current comorbidities involving heart, liver, pancreas, trauma, and neurologic function. Current or previous heavy alcohol use may identify comorbid psychiatric illnesses and family dysfunction. The Review of Symptoms offers another opportunity to identify alcohol effects especially urinary frequency and sleep complaints. Screening for depression is part of an AMW.<sup>29,43</sup> Higher than recommended alcohol intake even in the absence of a formal AUD diagnosis can be associated with other off-prescription substance use. Older adults should be asked about other drugs. The decision to prescribe narcotics or benzodiazepines should be carefully evaluated in patients with at-risk alcohol use.

The drug review at every geriatric clinic visit is one of the most important medical procedures to be offered. It reveals adherence or nonadherence, identifies other prescribers, and facilitates drug reconciliation and deprescribing based on the STOPP-START principle.<sup>44</sup> Medication review should always include OTC medications and nutraceuticals. Medication review and reconciliation provides a platform to discuss actual or potential drug-alcohol interactions and provides a clear rationale for counseling.<sup>28</sup>

Patients who trigger concern for hazardous drinking or AUD should be evaluated using more in-depth questionnaires such as the full AUDIT, CAGE, or others. Hazardous drinking may not need a formal outpatient or inpatient rehabilitation approach. If the clinician is comfortable with an office-based intervention, several authorities recommended proceeding to the Brief Negotiated Interview (BNI).<sup>45</sup> The BNI starts with the clinician stating their concern and requesting the patient's permission to discuss their drinking. The clinician inquires about the patient's perception of their drinking. If there is agreement about the concern, the patient can be engaged to identify a change they would be willing to make to enhance their health. The BNI has 7 steps:

1. Establish rapport with the patient.
2. Explore their views about pros and cons of changing their alcohol drinking.
3. Review the health risks of continued drinking.
4. Summarize and ask whether they think a change is needed.
5. Explore readiness, that is, what things they would need to do to change their drinking.
6. Identify a goal.
7. Explore their confidence that they can do it.

The BNI constitutes the first step of the Screening Brief Intervention Referral to Treatment (SBIRT) structured approach to alcohol intervention.<sup>46</sup>

### **CASE 1: A 70-YEAR-OLD MARRIED MAN**

The patient was seen virtually for his AMW visit. There have been no changes in his state of health. His review of systems (ROS) is negative.

His medications are amlodipine, losartan, hydrochlorothiazide, tamsulosin, atorvastatin, and aspirin. His rapid geriatric assessment (RGA) indicates no concerns regarding nutrition, gait and balance, depression, or cognition.<sup>47</sup>

### **Social History**

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He enjoys going on cruises with his wife and is looking forward to “when all this (Covid) is over.” He does not smoke or use other substances. On AUDIT-C, he reports he has always had a couple drinks before dinner, occasionally more if out with friends. He denies ever having more than 5 drinks on any occasion in the past year. When he has been drinking, he states his wife is the “designated driver.” But with Covid, that has not happened lately. In follow-up, SASQ was rephrased as “ever.” He says he has had episodes of greater than recommended drinking before Covid.

### **Assessment**

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He does not trigger either AUD or hazardous intake for age. But it is borderline and possibly situational.

### **Intervention**

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We engaged in a brief motivational interview about drinking safely “when things open up again.” He agrees to revisit the subject at his next annual examination. He is advised to increase his exercise.

This case illustrates a man whose drinking is within recommended levels, but there is a small concern regarding his past intake and the effects of increased opportunities for socializing. If AUD or hazardous drinking is identified during his follow-up visit, the previous SBIRT can be recalled and reviewed. This patient does not appear to need referral to a specialized treatment program.<sup>48</sup>

## **TREATMENT MODALITIES**

The success of multimodal interventions depends in part on how the patient identifies goals of abstinence, low risk drinking or no goal.<sup>49</sup> Multimodal programs have shown equivalent efficacy in older adults.<sup>49</sup> Abstinence is not necessarily the goal of all treatment programs, but patients who set the goal of abstinence tend to do better. Interventions with patients suffering from AUD should be multimodal. The evidence for outpatient cognitive behavioral therapy (CBT) alone is not convincing.<sup>50</sup> Examples of psychosocial interventions include CBT, motivational interviewing to promote change, and mutual help groups including but not limited to Alcoholics Anonymous. Participating in more than one treatment modality appears to promote patients' adherence to their goals. The COMBINE trial compared medical management with naltrexone or acamprosate or both or neither with Combination Behavioral Intervention (CBI) with medical management or alone, a six-arm trial. Only the naltrexone combined with CBI achieved significant resolution of heavy drinking. A caveat is that median age of the 1383 subjects was 44 years.<sup>51</sup> There are few studies of AUD treatment either focusing on or including enough older drinkers to make an aging-specific recommendation. But a meta-analysis is encouraging.<sup>49</sup>

Medication-assisted treatment for all substance use disorders has been increasing. This includes AUD. There are 5 available drugs shown in **Table 2**: naltrexone, acamprosate, disulfiram, topiramate, and gabapentin. There are few head-to-head trials, but all have shown efficacy in decreasing heavy drinking. Evidence for baclofen is uncertain.<sup>52</sup> When caring for an older adult with AUD, the choice of the drug depends on potential interactions with other drugs they are taking, renal and liver function, ability to manage their own medications, and cost. Disulfiram is contraindicated in older adults because of the severity of adverse reactions if they do drink or accidentally use mouth wash or cough syrup with alcohol. Naltrexone is effective and relatively free of adverse

**Table 2**  
Pharmacotherapy options for treating AUB in older adults

Indication	FDA Approved	FDA Approved	FDA Approved	Off Label	Off Label
Drug	Disulfiram	Acamprosate	Naltrexone	Topiramate	Gabapentin
Mechanism of action	Inhibits enzyme acetaldehyde dehydrogenase	Unknown, affects interaction between gamma-butyric acid (GABA) and glutamate	Opiate antagonist	GABA agonist, glutamate antagonist, inhibits carbonic anhydrase, antiepileptic activity.	Modulates glutamate release, antiepileptic activity
Safety concerns	Alcohol ingestion triggers flushing, tachycardia, nausea, vomiting. May be severe. May be triggered by other drugs, for example, metronidazole	Should not be used in depression, suicidality, renal CrCl<30	Should not be used if taking opioids for pain or in substance abuse management without consultation.	Should not be used if actively drinking, taking metformin, glaucoma depression or suicidality.	Should not be used if taking opioids, caution with liver, renal impairment Can be sedating.
Comorbidity/polypharmacy concerns	Heart disease	Renal failure, depression screening, other antiepileptic, neuropathy medications	None specific after opiate screening, medication review	Diabetes, history psychiatric illness, glaucoma, verify psychiatric, diabetic, and glaucoma medications	Commonly used in treatment of neuropathy, verify current medications
Community pharmacy cost (GoodRx)	\$40/mo	\$80/mo	PO \$30/mo IM \$1200/mo including adm	\$20	\$10/mo



drug interactions in older adults. However, as many older adults have been prescribed narcotic analgesics, this should be done only after narcotics have been withdrawn. If pain cannot be managed without narcotics, one of the other drugs could be considered.<sup>49,52</sup>

Referral to outpatient multimodal therapy may tax an older person's transportation system, especially if driving is a concern. An additional consideration in caring for an older adult with AUD are comorbid medical conditions, visual and hearing impairment, mobility, cognitive status, comorbid psychiatric diagnoses, and cognitive impairment. The family of older drinkers may include adult children who need to be mobilized in support of the older drinker or counseled for their own trauma as survivors of family dysfunction related to the drinker.

## CASE 2: AN 83-YEAR-OLD WIDOWED MAN

The patient came alone to a *routine follow up in the clinic*. He has no new complaints. On *ROS*, he continues to complain about difficulty falling asleep. He is bothered by urinary frequency. He denies short of breath, chest pain, weight loss, or falls. He recently experienced sudden loss of vision in one eye.

*His medications* reflect his significant cardiac history: lisinopril, carvedilol, simvastatin, clopidogrel, aspirin, levothyroxine, tamsulosin, mirabegron, diazepam 5 mg at night for sleep, apixaban, metformin, glargine, and omeprazole. His office HbA1c was 10.9 indicating poor adherence to diabetes management.

*His social history* is remarkable for having a highly successful business career. His wife passed away several years ago, and he misses her very much. He used to play golf, but his vision and low back pain do not permit it anymore. He never smoked. AUDIT-C revealed he has "a couple of drinks" in the evening to help him sleep. He goes to his private club once a week but stated he never has more than 2 drinks with his friends. When asked how far away his club is from his home, he states it is "a couple of miles" so he drives. He generally goes in the evening to avoid rush hour.

On *physical examination*, he is alert and able to state date, place and situation. RGA revealed mild dementia (SLUMS 25/30). His gait is broad-based but steady. He does not use a cane. He screened negative for depression and nutritional risk. He has movement-only vision in his left eye and wears a hearing aid on the right.

### Assessment

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Assessments involved polypharmacy including several drugs with potential ethanol interaction, anticoagulants, metformin, insulin, antihypertensives, and a nonanticholinergic medication for urinary incontinence. His use of a long-acting benzodiazepine is worrisome. He denies any heavy drinking. He denies falls.

### Intervention

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When counseled to cut down or stop drinking, he is not agreeable to further discussion about his drinking, but he does agree to stop driving because of his poor vision. He gives the clinician permission to call his son to report concerns.

At a *second appointment*, the father and son were asked to come together. His son reports significantly heavier drinking than the patient admits and multiple falls. A diagnosis of AUD is made. Although the depression screening responses are negative, his son reports that his father has been quite alone since his wife died and he talks about missing her often. The patient was not agreeable to a psychiatry referral. The patient did agree to prescription of an antidepressant, mirtazapine, and tapering the benzodiazepine. However, his medication adherence was not certain. His son agreed to visit

daily to give him his medications until he could arrange with a home care agency to provide a companion and medication supervision. The father and son agreed to discuss a senior living community nearer to the son where he will have more socialization. The patient and his son agreed to return in a month to review their progress and reconsider a referral to outpatient psychiatry to treat depression.

Another consideration in older adults as well as any older substance users is the network of support they have. For older adults, as seen in case #2, the patient has a son who is willing to support his AUD treatment. Owing to vision and hearing loss, it is doubtful the patient could manage multimodal outpatient therapy. With better supervision, risk for falls, diabetic control, and transportation can be addressed. Caregivers vary in their ability to recognize the problem and their own resources to intervene. The prevalence of psychiatric comorbidity in actively drinking older adults can lead to additional safety concerns besides falls, motor vehicle accidents, and suicide.

### **CASE 3: A DIVORCED 69-YEAR-OLD WOMAN**

The patient had previously lived with her daughter in another city. When that daughter died, her other daughter brought the patient to live with her. She was *seen in the clinic several weeks later to establish care and to obtain a referral to psychiatry*. The daughter knew very little about the medical history, but she had been treated for schizophrenia much of her life. The daughter did not know what medications she took and had none with her at the visit. On *social history*, the daughter reported smoking tobacco and cannabis and was very concerned about her drinking. The clinician asked how the patient got the drugs and alcohol. The daughter reported that the patient walked to the corner store while she was at work and bought a six-pack of beer mostly every day and some marijuana if one of the men was selling. She typically drank “a six-pack” a day.

On *physical examination*, the patient was not cooperative. She was agitated and difficult to redirect. She stated clearly that she did not want to be there. She did not have severe cognitive impairment. She could rapidly say the months of the year backward; she was oriented to person, place, day, date, time, and situation. She appeared to be at least her stated age. She got up several times to leave, using a wheeled walker to go out in the hall. She was reluctant to try to walk without it.

#### **Assessment**

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The first concern is to establish psychiatric care and provide supervision. Her drinking is hazardous because it exceeds safe amounts. Her fall risk is increased by gait instability and cannabis use. She is a target for street crime when she goes out alone using a walker to buy beer and pot. The daughter is unable to provide supervision because she needs to work. During Covid, senior day cares were closed, but it is likely that day care would depend on better management of her psychiatric symptoms.

#### **Intervention**

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The daughter refused direct hospital admission for psychiatric stabilization. The most urgent issue besides psychiatric stabilization is the lack of supervision. The daughter was informed that her mother was unable to care for herself in her present condition. She is in danger when she goes out alone with cash to buy pot and alcohol on the corner. This could be reported as neglect to the state department on aging. A social work organization was consulted to initiate home services. The daughter was assisted by social work to complete the Family Medical Leave Act forms to be excused from work by her employer while attending the patient's urgent medical needs. She agreed to have a caregiver while she was at work and to leave no cash, cards, or alcohol in the

home. Psychiatry referral was placed to establish psychiatric care as soon as possible. If the patient was in fact drinking a six-pack of beer a day, withdrawal seemed possible. The daughter was instructed to recognize those signs and call emergency medical services. Shortly thereafter, the patient was admitted through the emergency department at another hospital. From there, she was discharged to a long-term care facility.

## SUMMARY AND CONCLUSIONS

Geriatricians and other primary care clinicians should follow the USPSTF guidelines for safe drinking for older adults. If screening with a short form such as the AUDIT-C suggests a potential for risky drinking, it is recommended to start a conversation with the patient. If RGA indicates frailty, depression, malnutrition, increased fall risk, or cognitive impairment, a caregiver or family member should be engaged, with permission, in the discussion of hazardous drinking. Polypharmacy should prompt a review using the STOPP-START principles. The RGA may uncover additional obstacles to multimodal interventions. Multimodal interventions for frail older drinkers should also include geriatric interventions including mobilization of caregivers, support for caregivers, home health services, medication supervision, and falls prevention. The SBIRT cycle has been successful with cognitively intact older adults although there are few dedicated studies. Multimodal interventions are generally more effective than individual counseling. Pharmacotherapy should not be overlooked for selected older drinkers. However, adding another drug to polypharmacy requires a cautious approach. Clinicians who are not confident or experienced in managing AUD (or polysubstance abuse of any form) should promptly refer to specialty care.

## CLINICS CARE POINTS

- Older adults should be asked if they consume alcohol and if yes, use one of the short validated screening tools to assess potential risk. eg, excessive quantity, driving, falls.
- Review the medication list for potentially hazardous pharmacologic interactions and advise or deprescribe accordingly.
- Brief interventions including motivational interviewing may be effective for reducing hazardous drinking.
- If drinking patterns suggest an alcohol use disorder referral to treatment is advisable.

## DISCLOSURE

The author has nothing to disclose.

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