



# ALCOHOL USE AND THE AGING POPULATION

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# YOUR PRESENTERS



## PHOEBE AXTMAN

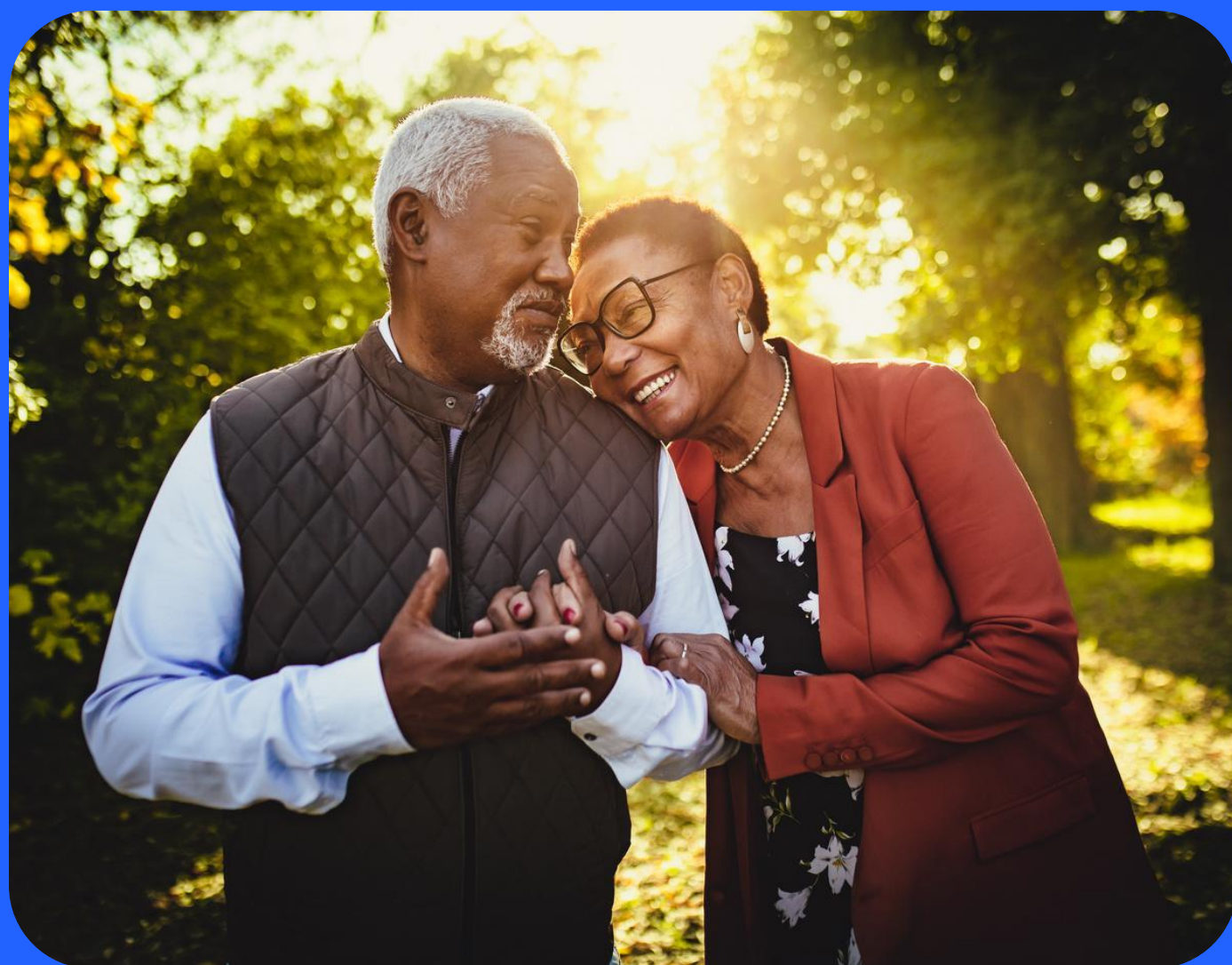
- Owner of Be One Counseling
- Masters Licensed Alcohol and Drug Counselor in NH
- Licensed Clinical Social Worker in NH, ME, and MA
- Boards: NHADACA, NHCPG
- Coordination and Cooperation Task Force for Governor's Commission on Addiction, Treatment and Recovery
- Passionate about harm reduction, gender affirming care, and bridging the gap between SUD & mental health



## EMILY CARRARA

- Substance Use Prevention & Recovery Programming Supervisor at Amoskeag Health
- Master's in Clinical Mental Health Counseling
- Boards: NHADACA (Secretary)
- Passionate about collaborating, connecting and compassionate care.

# INTRODUCTION TO THE TOPIC

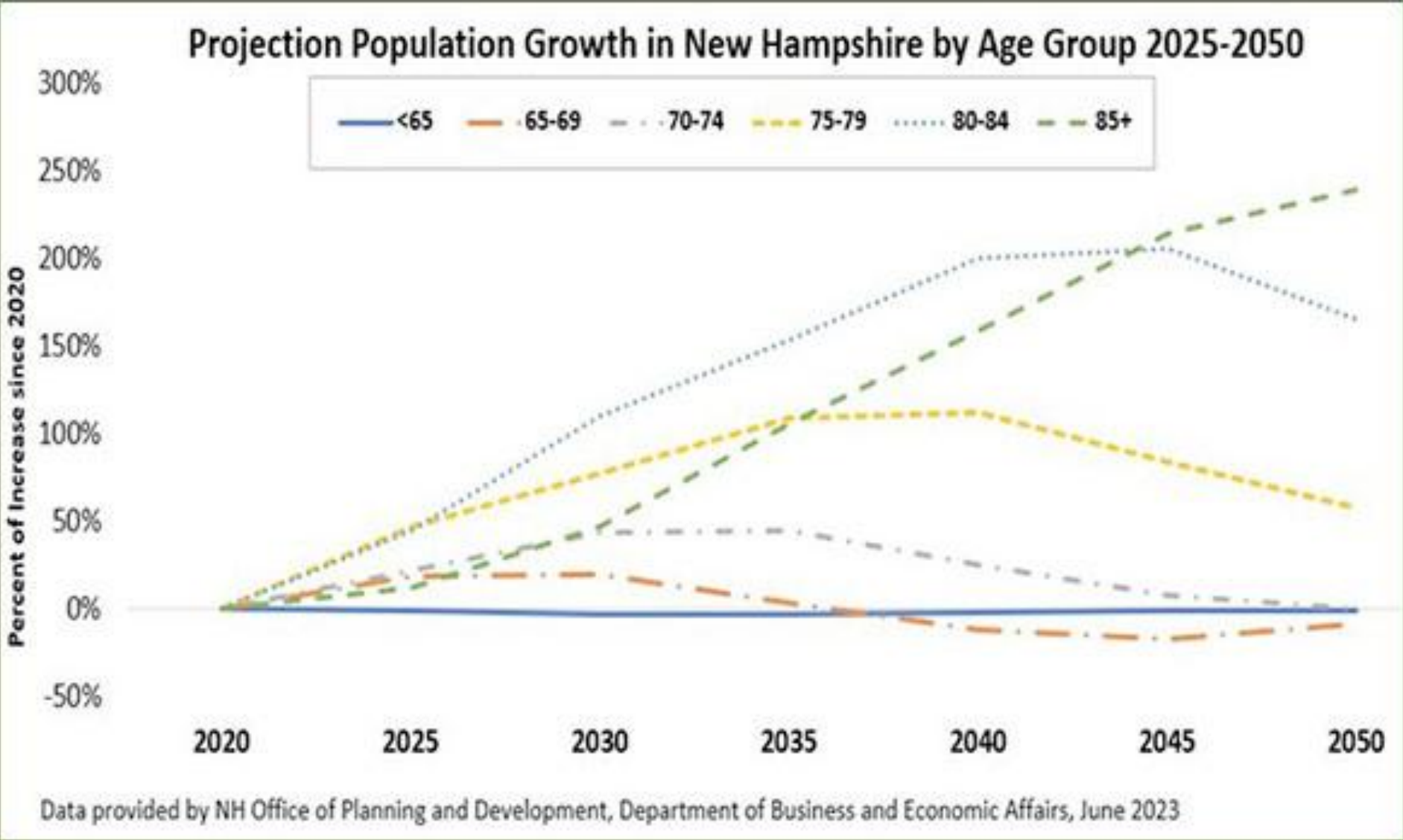
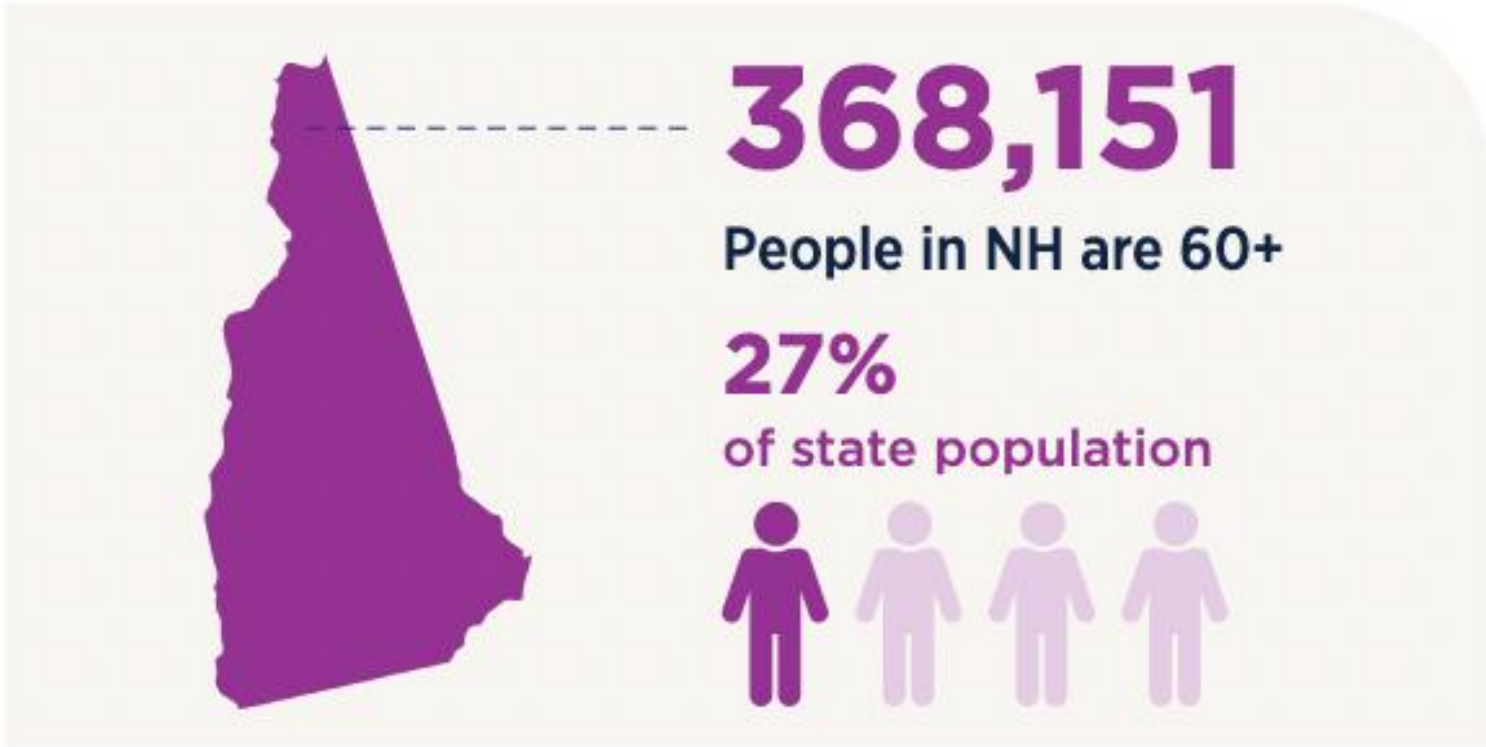


- We live in the nation's second-oldest state
- More than 1 in 4 residents (26.7%) are aged 60 or older
- 1/4 of NH older adults live alone
- Alcohol use is increasing among adults 65 and older, while the population expands at a rapid rate.
- With aging comes health concerns, sleep issues, cognitive decline, fall risk, injury and death from accidents.
- Alcohol use increases the vulnerability to these issues in the aging population and with long term use puts them at risk of cancer, liver disease, and cardiovascular disease.
- With the rapid expansion of this generation and their increase in alcohol use from previous generations, we must brace ourselves for strain on an already hemorrhaging health care system.

# 2025 NEW HAMPSHIRE HEALTHY AGING DATA REPORT

## New Hampshire's older population grew 66,000 people

Since our 2019 report



This line graph compares growth rates for age groups in NH from 2025 to 2050. The fastest growing age groups are the oldest age groups including those over 70, over 80 and 85+.

# STRUCTURE

## OVERVIEW

- The current landscape
- The population
- High risk behaviors and long term impact

## INTERVENTIONS

- Assessment signs and symptoms
- Best practice and treatment options
- Addressing hesitations

## CALL TO ACTION

- So what do we do?

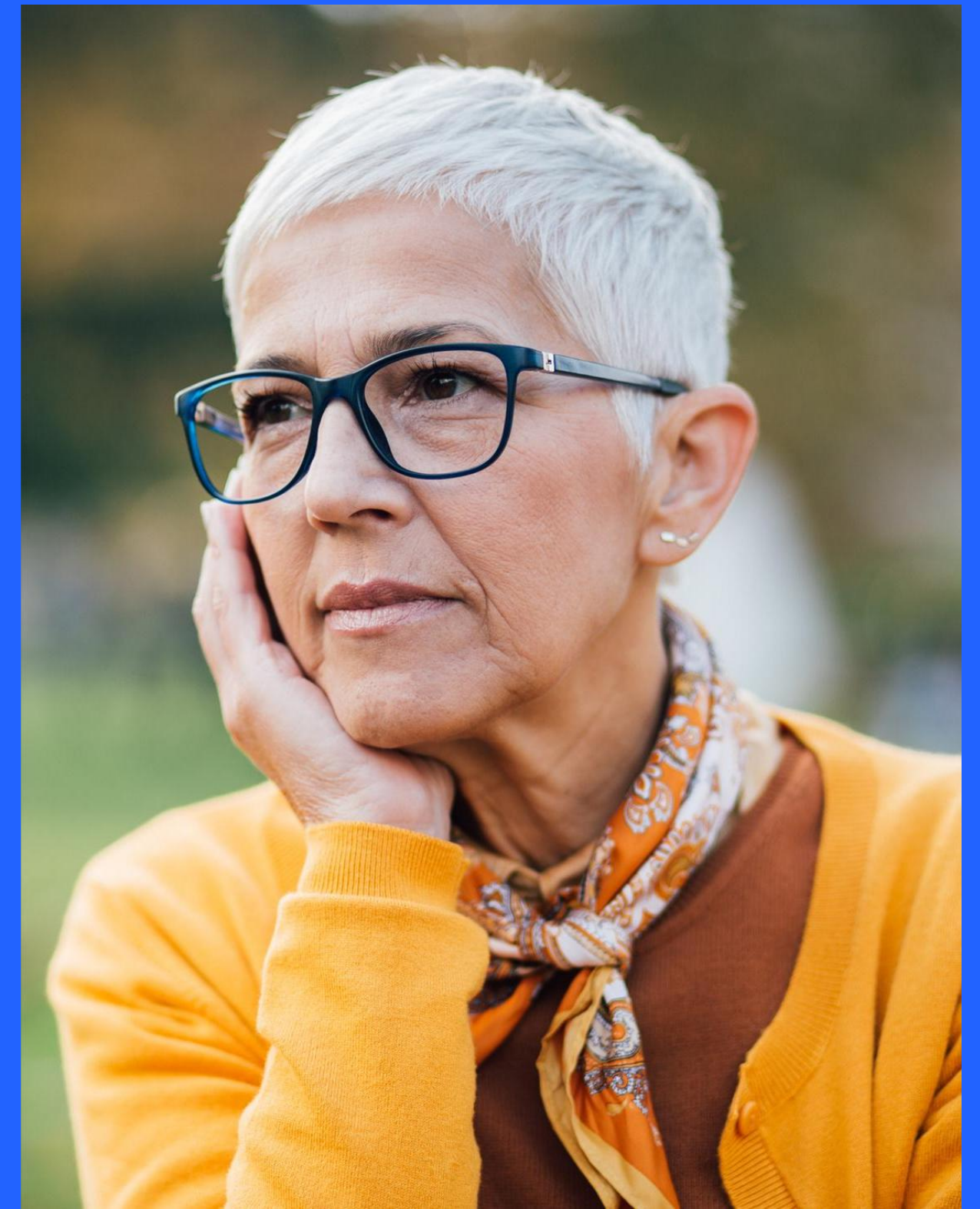
CASE STUDY



# FRAN

## CASE STUDY

Fran is a 68 year old Caucasian cisgender woman living in Concord, NH. Fran started drinking alcohol socially when she was 22 years old and participated in sporadic cannabis use in college. Fran is widowed, losing her husband of 31 years, 5 years ago to a heart attack. She has a daughter who is 37 years old living in Massachusetts, who is married with 2 children. Fran enjoys spending time with her grandchildren; however, her daughter does not visit often and Fran is unable to drive due to a recent injury. Fran gets a ride to the state liquor store once a week, however recently has been finding herself walking to the corner store mid-week because she has run out of wine.





# OVERVIEW

**PROBLEM  
DRINKING  
AND OLDER  
ADULTS**



# THE CURRENT LANDSCAPE

## (THE FACTS)

### ACCORDING TO THE 2024 NSDUH...

34.4 million people ages 65+ (57.5% in this age group) reported that they drank alcohol in the past year.

26.6 million people ages 65+ (44.5% of this age group) reported that they drank alcohol in the previous month.

6.8 million people ages 65+ (11.4% in this age group) reported binge drinking in the previous month.

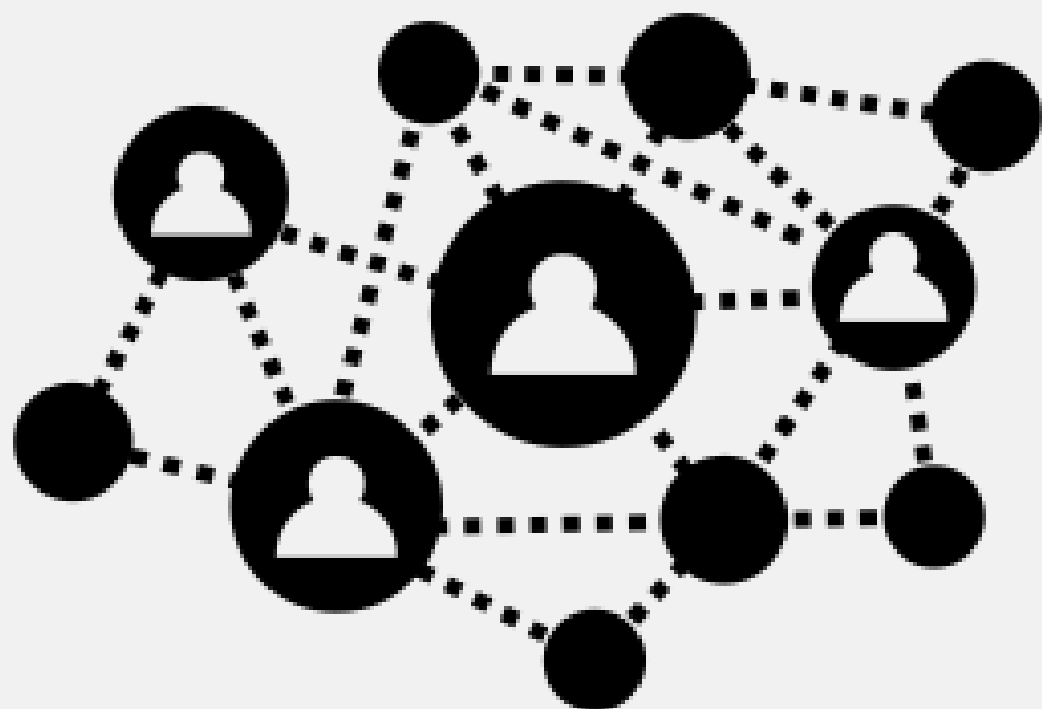
2.9 million people ages 65+ (4.8% in this age group) met the criteria for past-year alcohol use disorder.<sup>5</sup>



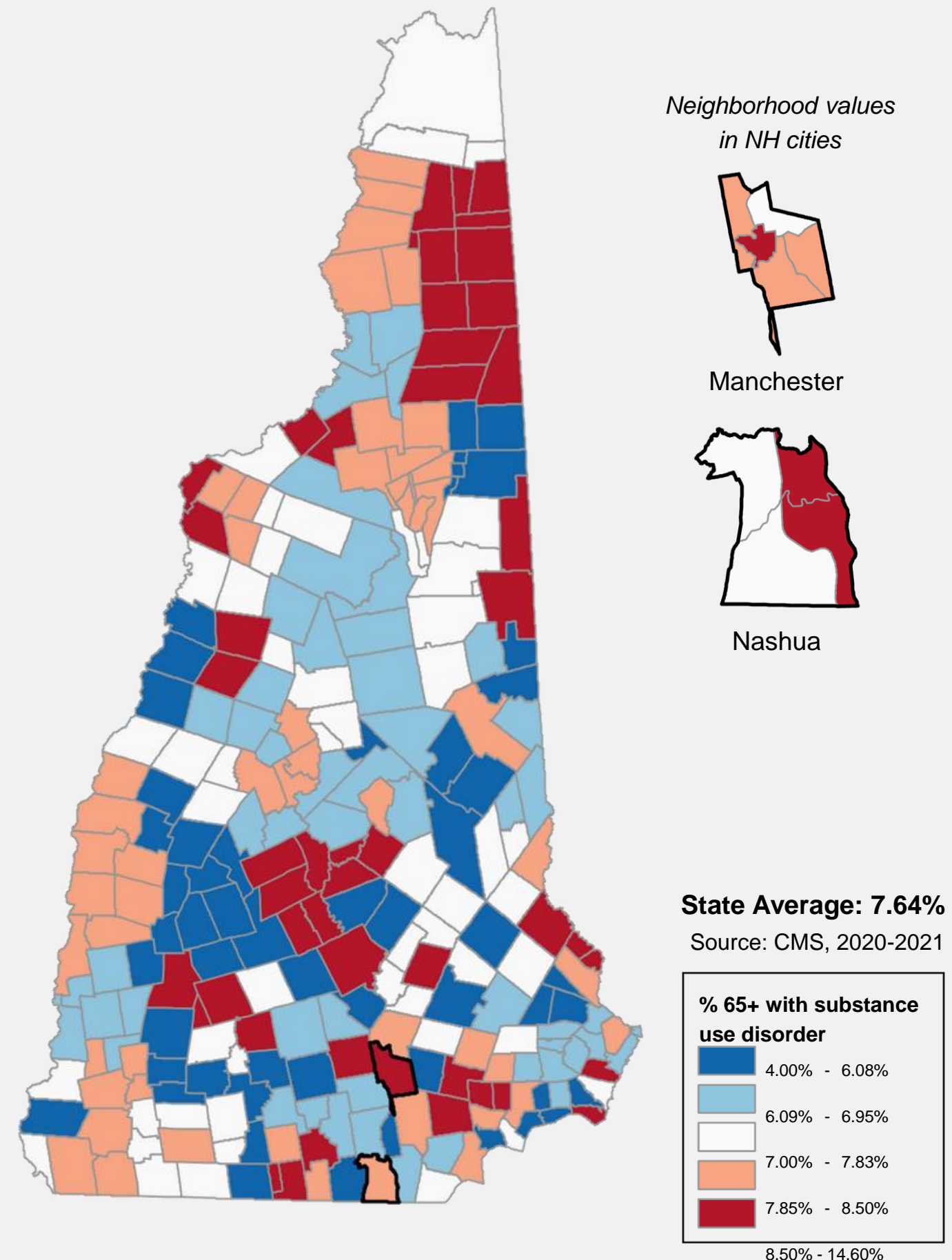
*These statistics are likely underreported, meaning the real prevalence is higher because many cases go unidentified or unreported.*

# WHAT DO YOU NOTICE ABOUT THIS MAP?

- Telehealth- recent technical details have changed.
- As you go North, access becomes more difficult.
- Community resources decrease in proximity as areas become more rural.
- How can we leverage and utilize diverse resources to provide comprehensive care to older adults struggling with alcohol use? Connecting is key!



Percentage of Medicare Beneficiaries Age 65+ Years with Substance Use Disorder



# THE BOTTOM LINE

Medicare enrollment in New Hampshire is notably higher than the national average, where nearly 17% of individuals are covered by Medicare. This disparity is largely due to New Hampshire's older population, which is projected to increase to 26.9% by 2050.

There are no Medicare approved inpatient detox in new hampshire.

There are no Medicare approved residential programs in NH.

Older adults seeking in patient treatment or detox for alcohol use disorder either have to pay out of pocket, purchase private insurance, go to the hospital or go out of state to receive treatment.



\*\*some treatment settings scholarship Medicare recipients, but these are available on a limited basis and are typically funding dependent.

\*\*\*these barriers exist due to specificities found in the language within Medicare coverage (“hospital like settings”)

# THE AGING POPULATION

## RISK FACTORS

Older age is associated with major life changes like retirement, boredom, loss of purpose, bereavement and medical issues. Additionally, increased isolation.

## PHYSICAL CHANGES

Decreased muscle mass, impaired liver and kidney function, medication comorbidities and alcohol use making preexisting conditions worse.



## VULNERABILITY

As people get older, the same amount of alcohol use can cause more damage (increased falls, cognitive issues, memory, interactions with other medications).





## DEMOGRAPHIC TRENDS

Stigma, under recognition, under reporting and under screening are all associated with this demographic.

*“Age is just a number, but sometimes that number can be a pain in the neck.” – Unknown*

# UNDERSTANDING DEMOGRAPHIC TRENDS AND TRAITS

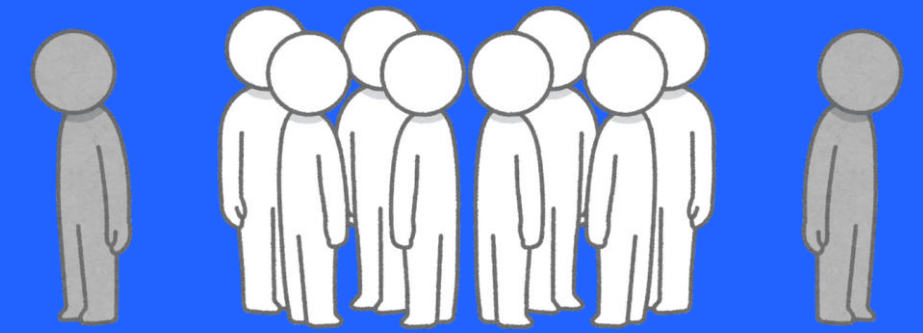


<b>1940s-1950s</b> Silence and Stigma	<ul style="list-style-type: none"><li>• Mental health was a taboo topic</li><li>• Institutionalization was common</li><li>• Limited understanding of mental health under espere prodvce</li></ul>	
<b>1960s</b> The Beginning of Change	<ul style="list-style-type: none"><li>• The Community Mental Health Act-Org pushed deinstitutionalization</li><li>• Counterculture movement encouraged open expression</li></ul>	
<b>1970s</b> Awareness and Reform	<ul style="list-style-type: none"><li>• Deinstitutionalization expanded without enough community resources</li><li>• Lead to homelessness and lackoissupport</li><li>• Terms like-peace of mind" and "self-</li></ul>	
<b>1980s</b> The Rise of Diagnosis and Medication	<ul style="list-style-type: none"><li>• DSM-III redefined how mental disorders were classified</li><li>• Antidepressants like Prozac revolutionized treatment and helped normalize</li></ul>	
<b>1990s</b> Talking About It	<ul style="list-style-type: none"><li>• Mental health entered the mainstream daytime talk shows, magazines, and workplaces begin to discuss it</li><li>• "chemical imbalance" theory popularized</li></ul>	
<b>2000s</b> The Digital and Diagnostic Boom	<ul style="list-style-type: none"><li>• Online mental health resources (forums early early therapy apps began</li><li>• Awareness campaigns grew, Mental Health Awareness Month gaining traction</li></ul>	
<b>2020s</b> Normalizing Mental Health	<ul style="list-style-type: none"><li>• Pandemic impact, COVID-19 made the gynce urgent and universal, age amenities</li><li>• Younger generations (Millennials, Gen Z) lead open discussions about therapy, medication</li></ul>	

# THE LONELINESS EPIDEMIC

“It is strange to be known so universally and yet to be so lonely.”

-Albert Einstein



## Risk Factors:

- Living in a rural area
- Poor functional status (ADL's/cognitive)
- Widowhood
- Lower income/lower education
- Urinary Incontinence
- Depression
- Living Alone
- Poorly understood by others

## Loneliness and Alcohol Use

- Studies show that older adults who report chronic loneliness or bereavement are 2–3x more likely to engage in risky drinking (defined as more than 7 drinks/week or 3 drinks/day for older adults).
- A 2020 study in *Aging & Mental Health* found that loneliness was one of the top psychosocial predictors of increased drinking frequency among adults 65+, particularly those living alone or widowed.
- The association is strongest among men living alone, recently retired adults, and those with mobility limitations restricting social contact.

# THE CURE FOR LONELINESS IS NOT FOUND IN A BOTTLE

Humans are social creatures, it's the connection with others that allows us to survive and thrive.

- Widowers over the age of 75 have the highest rate of alcoholism in the U.S.
- Nearly 50 percent of nursing home residents have alcohol related problems.
- Older adults are hospitalized as often for alcoholic related problems as for heart attacks.
- Alcohol use can temporarily numb feelings of loss, isolation and lost purpose or meaning in life.
- Drinking can fill the many idle hours.
- Alcohol or drugs replace the love, concern, and emotional nurturing that are a part of intimacy that is no longer available.

# ALCOHOL USE + AGING = PROCEED WITH EXTREME CAUTION

## DUIs

Due to the outlined risk factors, older adults are very susceptible to driving under the influence; they may not even realize it.

A study out of the University of Memphis discusses that out of a sample of 87,000 drivers involved in car crashes, almost  $\frac{1}{3}$  of them were older adults who were under the influence.

## Medications & Comorbidities

Many of the most prescribed medications for adults over the age of 65 years old can cause very serious consequences when mixed with alcohol, please see handout for more specific information.

## Falls, Cognition & Isolation

Older adults often experience low bone density and cognition issues due to balance and motor skill inhibition. Adding alcohol to these underlying conditions can increase risk for fall, serious injury, coma or death. Additionally, memory issues further increase the risk of over consumption.



# OPPORTUNITIES TO SUPPORT

MAST

AUDIT-C

CAGE Screener

UCLA Loneliness Screener

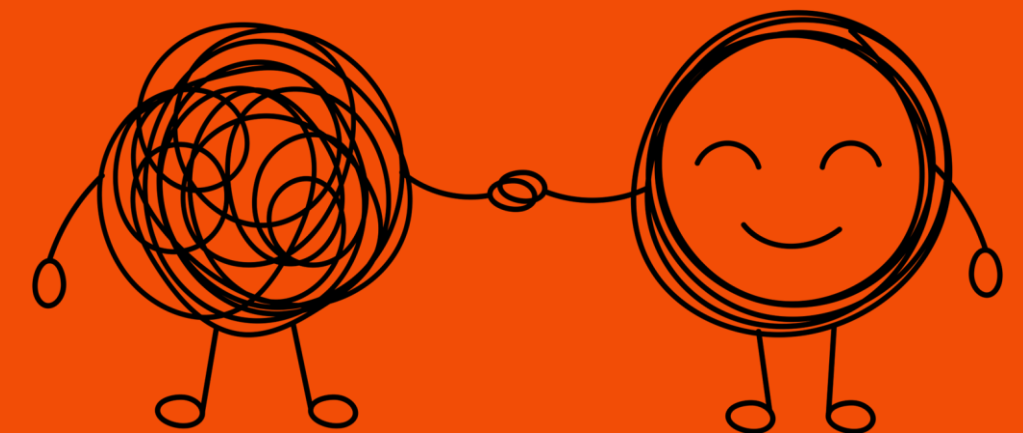
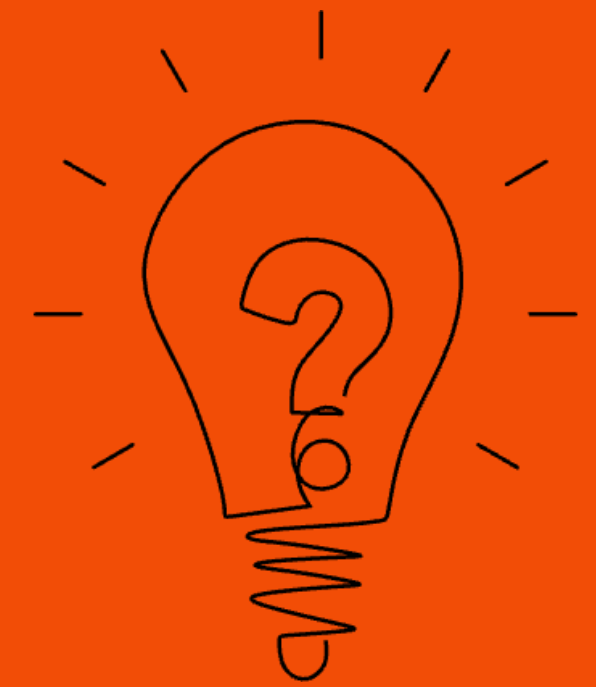
These can be done in any setting!

**What happens when you have concerns**

**but they're screeners are appropriate?**

*If the opposite of addiction is connection, then*

*how can we form a connection?*



# BUILD TRUST BY BEING CURIOUS

*Knowing what we know about this population, how do I approach the conversation?*

- Speak to them like a fellow adult and utilize humor if appropriate.
- Make them comfortable, ask if they need anything!
- Avoid hurrying them along, remember, **we want to connect, not reject!**
- Speak plainly and intentionally.
- Appear invested, avoid talking to patients with your back turned or while typing.
- Write down key takeaways and resources so that they have them.
- Remain open and aware that older adults may have rigid beliefs, and that's okay, hold space for that.



# FRAN

Fran comes into your office for the first time. You have minimal information about her before the encounter (only what was provided at the beginning of the presentation). During your first encounter, she shares about her drinking stating, “My daughter thinks that I need to be here. She says that I am drinking too much, but I don’t see the problem. I am an adult and it fills my time. I need the wine to sleep, and anyway she drinks wine too. I feel a little guilty, but I think she needs to lighten up.” In your conversation Fran identifies that she is spending less time with her friends and family, isolating more often. She appears to be addressing most of her ADLs, however there is a smell of incontinence and she shares that her appetite has decreased greatly. She passes out around 12pm and wakes up around 3am unable to fall back asleep. She has never participated in any recovery support groups and no past legal issues. Her injury from a fall keeps her from driving, however she is growing frustrated that the healing is taking too long and has intrusive thoughts about driving in the moments when she has run out of wine. She has expressed to you that she is drinking about one and a half bottles of wine daily. She recently had a fall late at night, requiring her to call EMS. In her last doctor’s appointment, she was diagnosed with high blood pressure and put on medication treatment. She is currently taking Ativan in the evening for the anxiety she has been experiencing since her husband passing. How would you approach this conversation with Fran? What concerns do you have?

# INTERVENTION AND APPLICATION



# ANOSOGNOSIA

## DISEASE WITHOUT KNOWLEDGE OF DISEASE

1914 Joseph Babinski established the term to describe patients lack of awareness of their paralysis following stroke. Doctor Amador's research and mental health application.

Clinical phenomenon caused by neurological changes, which impacts the brain's ability to process information about itself.

A lack of awareness and understanding of a health issue versus denial

Application to mental health

- A patient that is unable to acknowledge that auditory hallucinations are not real
- Inability to recognize significant emotion dysregulation as abnormal

Stage of change and anosognosia can complicate the treatment



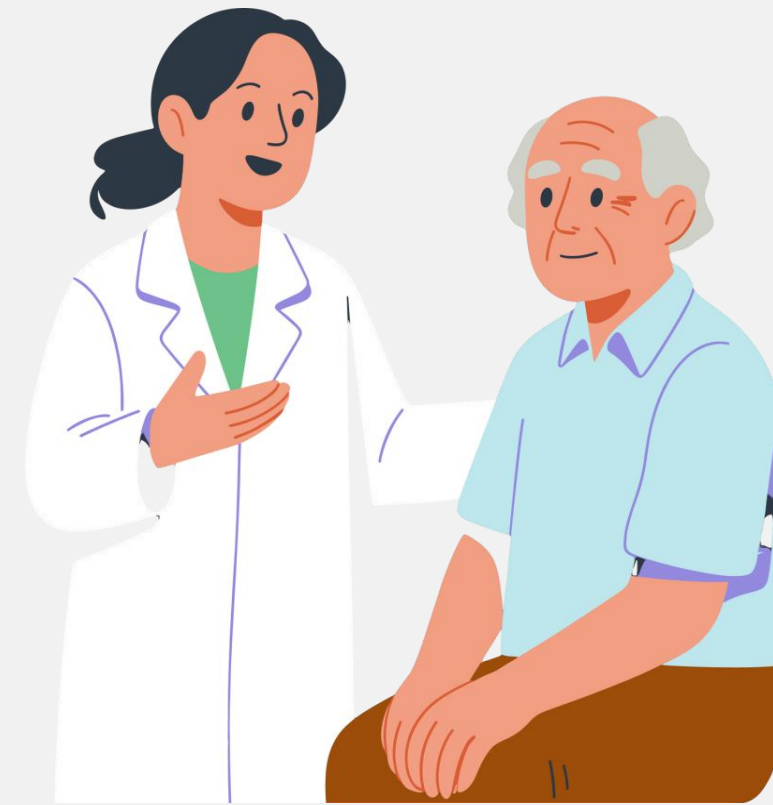
# INTERVENTIONS



Risk Reduction



Assessment and  
Education



Treatment &  
Medical  
Intervention



Resourcing

# HARM REDUCTION

Harm Reduction: “A philosophical and political movement focused on shifting power and resources to people most vulnerable to structural violence.”

harm reduction: “The approach and fundamental beliefs in how to provide the services.”

Risk reduction: “tools and services to reduce potential harm.”

Understanding that substance use is:

Complex

Multi-faceted

A continuum of behaviors

Acknowledgement of some ways of using substances are safer than others

Improving quality of life for the individual and increasing connection to resources

Non-judgmental and non-coercive care and resourcing



# RISK REDUCTION

- Community Connections
- Routine health care visits
- Transportation
- Moderation tools
- Meets criteria for versus  
Person centered  
considerations

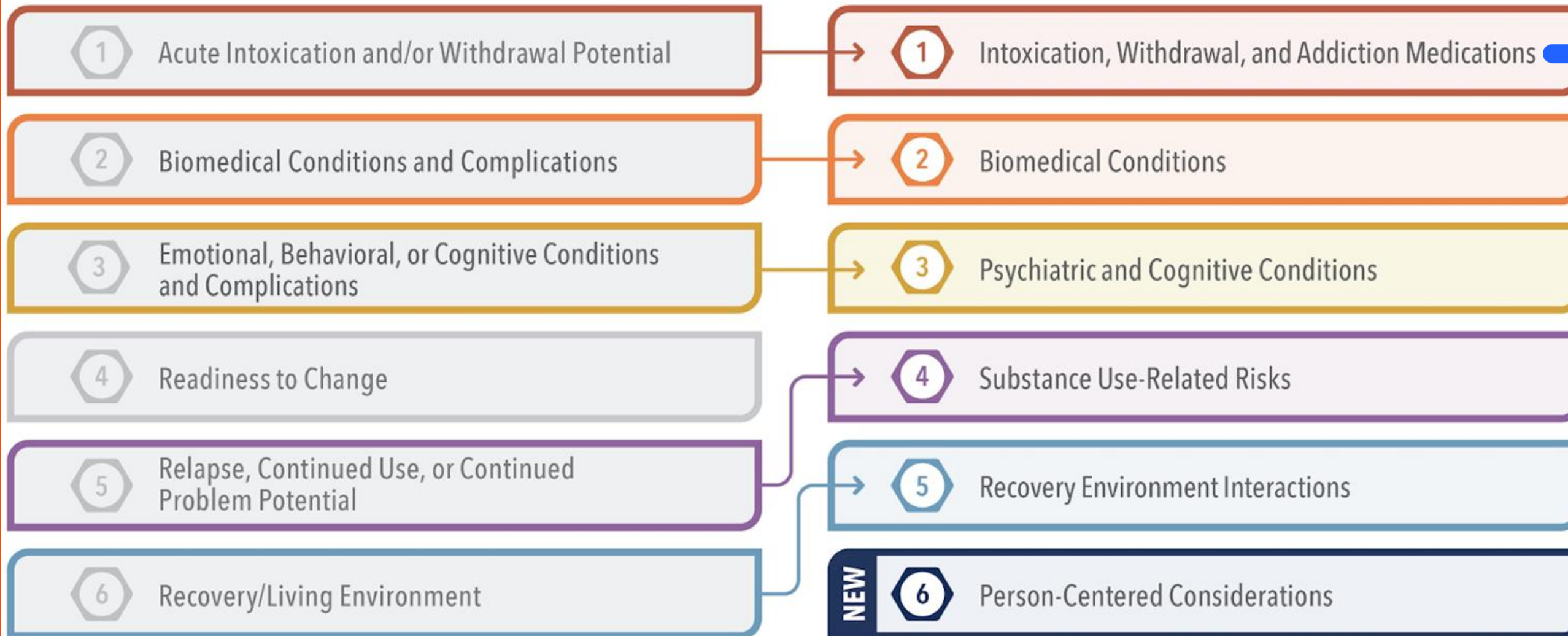
# ASSESSMENT AND EDUCATION

## ASAM Criteria

### Changes to *The ASAM Criteria* Dimensions in the Fourth Edition

#### Third Edition

#### Fourth Edition



PHQ-9, GAD-7, CIWA-AR

The Fourth Edition reorders the dimensions from the Third Edition. Readiness to change is now considered within each dimension, and the Third Edition Dimensions 5 and 6 were shifted to Dimensions 4 and 5, respectively, in the Fourth Edition. The new Dimension 6: Person-Centered Considerations considers barriers to care (including social determinants of health), patient preferences, and need for motivational enhancement.

# CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED (CIWA-AR)

- Nausea and Vomiting
- Tactile Disturbances
- Tremor
- Auditory Disturbances
- Paroxysmal Sweats
- Visual Disturbances
- Anxiety
- Headache- Fullness in head
- Agitation
- Orientation and clouding of sensorium – Ruling out age-related memory issues or neurological issues

The CIWA-Ar is not copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

**\*\*HANDOUT PROVIDED\*\***

# COMMUNICATING TREATMENT OPTIONS

## The ASAM Criteria Continuum of Care for Adult Addiction Treatment

<b>Level 4: Inpatient</b>				4 Medically Managed Inpatient
<b>Level 3: Residential</b>		3.1 Clinically Managed Low-Intensity Residential	3.5 Clinically Managed High-Intensity Residential	3.7 Medically Managed Residential
<b>Level 2: IOP/HIOP</b>		2.1 Intensive Outpatient (IOP)	2.5 High-Intensity Outpatient (HIOP)	2.7 Medically Managed Intensive Outpatient
<b>Level 1: Outpatient</b>	1.0 Long-Term Remission Monitoring		1.5 Outpatient Therapy	1.7 Medically Managed Outpatient
<b>Recovery Residence</b>	RR Recovery Residence*			



Your place to access care for substance use services.

You Are Not Alone.  
Call 211



- Doorway Locations\***
- 1 Berlin
  - 2 Littleton
  - 3 Lebanon
  - 4 Laconia
  - 5 Concord
  - 6 Dover
  - 7 Keene
  - 8 Manchester
  - 9 Nashua

\*some Doorways offer multiple locations

# COMMUNICATING TREATMENT OPTIONS

Ambivalence and enhance motivation to change

## LEAP

- Listen, Empathize, Agree, Partner
- Using LEAP to support people in accepting their substance use
- Therapy approach by Doctor Amador--what if it were to be applied to PWUD?



## MOTIVATIONAL INTERVIEWING

- Evidence-based approach to behavior change
- Assessing stages of change: Precontemplation, Contemplation, Preparation, Action, Maintenance, sometimes recurrence
- “MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.” (Miller & Rollnick, 2013, p. 29)

## PERSON CENTERED TREATMENT

- WHOSE GOAL IS IT?
- Improving quality life- Start there!

# TREATMENT COMPLEXITIES

# AND RESOURCING

## TREATMENT COMPLEXITIES

Medical conditions

Mental health

Neurological issues

Insurance and programing

## RESOURCING

Internal:

Strength based

Prevention

External:

The Doorway

RCOs

MAT

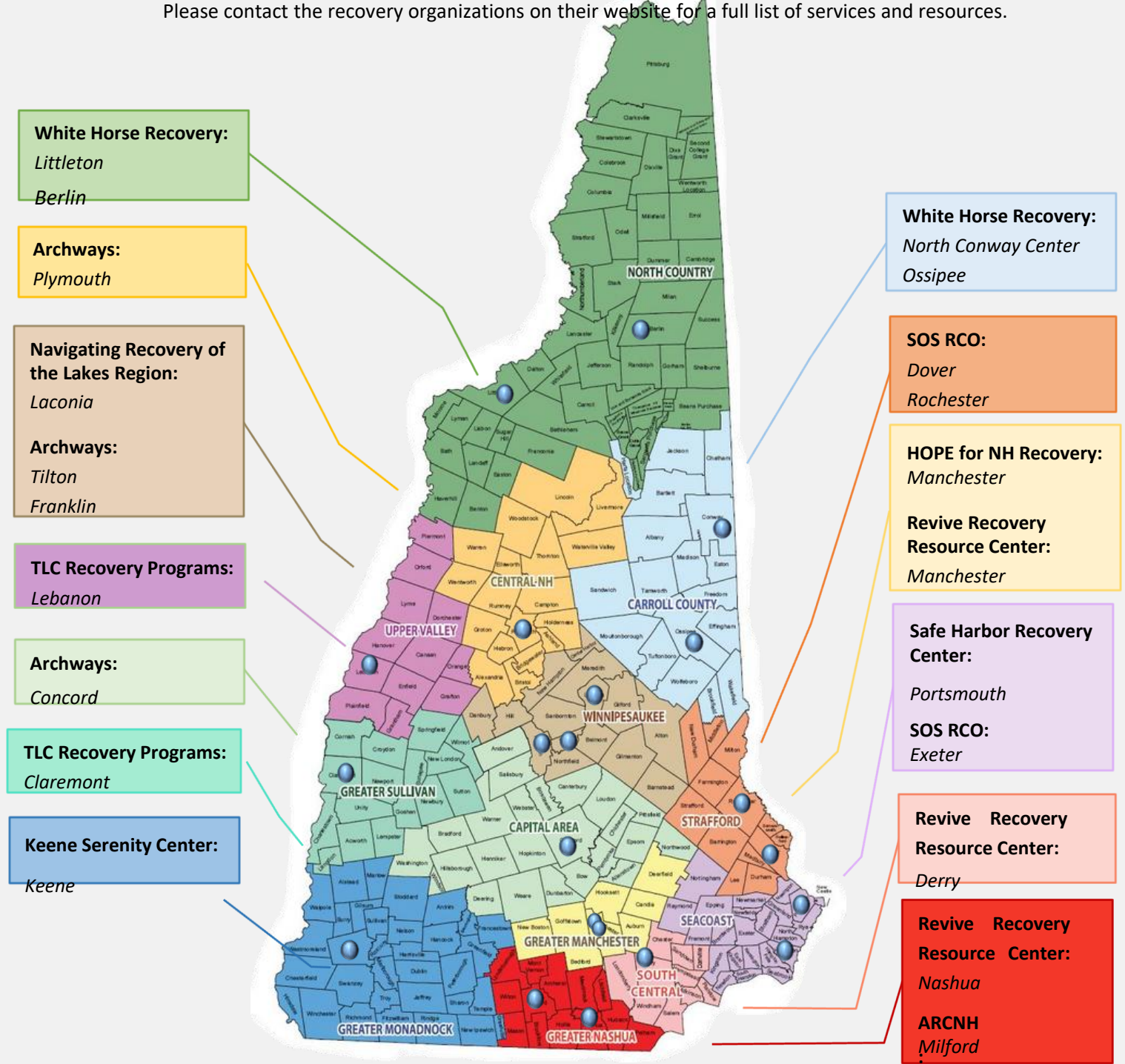
Recovery Support

### Recovery is possible.

Recovery Community Organizations (RCOs) are **peer-led** and **peer-run** agencies that provide services to support people in their recovery from substance misuse. All recovery centers throughout the state of New Hampshire are **low barrier** and **no cost** for services; the only requirement is a **desire to focus on your recovery**.

RCOs support **multiple pathways to recovery** and offer peer recovery coaching, telephone support, mutual aid groups, and family support programs. Most centers include services in harm reduction, system navigation, and advocacy.

Please contact the recovery organizations on their website for a full list of services and resources.



# FRAN

Fran is ambivalent about treatment and remains in the contemplative stage of change. You have completed screenings with her, which she scored high on. Her CIWA was at an 18, indicating the need for detox. She expresses no interest in inpatient treatment because she states “my cat can’t be left alone” and “I don’t want to lose my volunteer position at the church.” She has close friends and the support of her daughter. She is on Medicare for health insurance. She is very focused on not wanting to fall again, however has not made the connection between fall-risk and drinking. Using the information you have, what treatment approach would you recommend and how would you communicate it while addressing ambivalence?





**CALL TO ACTION**

# SO WHAT DO WE DO?

## Advocacy

- New futures

Increase screening and assessment

Prevention

Law of the few: the structure of our social network and how messages are spread.

Using your network and resources

Activity: Turn to the person/people next to you and discuss how you can pull resources together to support a client like Fran?



# GET IN TOUCH

Emily's contact information:

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603.782.6259

Phoebe's contact information:

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[beonecounseling.com](http://beonecounseling.com)



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