Geriatric Addiction

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"You don't stop laughing because you grow older.
You grow older because you
stop laughing." Maurice Chevalier

The Extent of the problem

- In Maine 18,000 people turn 65 each year
- Maine has the third highest incidence of depression among seniors in the U.S.
- Maine has the highest rate in the U.S. for Rx of long term, extended release opiates: 21.8/100 people in Maine vs 10.3 /100 nationally

Substance abuse in the elderly is one of the fastest growing health problems and it is a silent epidemic.
The problem remains:

- Under estimated
- Under identified
- Under diagnosed
- Under treated

- In 1990, 13 percent of Americans were over 65; by 2030, that bloc will represent 21 percent of the population
- A recent study found that 15 percent of men and 12 percent of women age 60 and over treated in primary care clinics regularly drank in excess of limits recommended by the National Institute on Alcohol Abuse and Alcoholism (i.e., no more than one drink per day
- 17% of those over 60 yrs misuse drugs (samsha)

THE PROBLEM

- Adults 65+ will increase from 43.1 million in 2016 to 72.1 million by 2030.
- Currently, about 25% have a Mental Health or Substance Use (MH/SU) problem.
- Among adults 60+, SU, particularly of alcohol and prescriptions drugs, is one of the fastest growing health problems facing the country.
- Abuse of heroin and other opioids occurs in those who abused opiates in younger years.
- Primary care and other essential providers are not trained in MH or SU

www.aoa.acl.gov/aging_statistics/index.aspx
Karel MJ, Gatz M, Smyer MA. Aging and mental health in the decade ahead: what psychologists need to know. Am Psychol. 2012 Apr;67(3):184-98.
Institutes of Medicine (2012).The mental health and substance use workforce for older adults. In whose hands.
www.iom.edu/reports/2012

AGING

The mind and body become more vulnerable.

- This means that people become more sensitive to things like stress, injuries, illnesses, and medication side-effects.

Multiple chronic illnesses

- Most chronic illnesses become more common as people age. As people get older, it's not uncommon to have 3 or more chronic health conditions. These can have overlapping symptoms and sometimes interact. Also, people often end up with a lot of pills and self-healthcare to manage.

Chronic impairments of the body or mind

- Eventually many people have some part of the body or mind that doesn't work as well as it used to. Although some problems can be treated or reversed, most older adults eventually develop chronic difficulties that require them and their families to change things somewhat

Geriatric syndromes

- These include problems such as falls, incontinence, pain, and declines in independence. They are common in aging adults and usually are related to a combination of the three factors listed above.

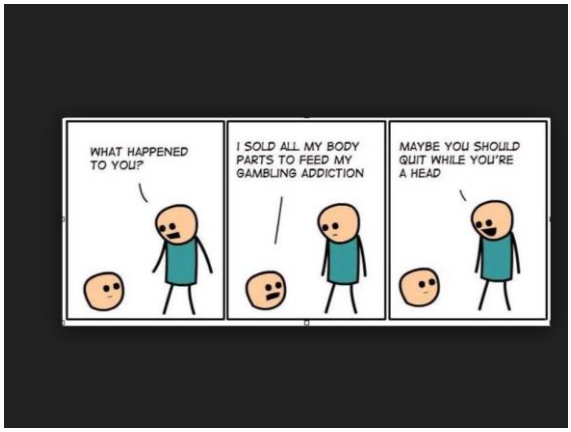
Barriers to diagnosis

Barriers to diagnosis

- Relative absence of clinical guidelines and well-validated screening tools
- Health care providers overlook substance abuse and misuse among older patients - misattributed to other physical or mental disorders
- Older adults and their families are more likely to hide their substance abuse and less likely to seek help.
- Older adults can present with multiple complex comorbidities

Barriers…continued

- Limited information about treatment options.
- Diagnostic and treatment strategies are neither age-specific nor sensitive.
- Often drug trials of new medications do no include older adults.
- Striking lack of research and outcome data on drug use and dependence in the elderly.
- Government funding historically goes to other substance abuse problems.



Common myths and misconceptions about addiction in older adults

- *It's his last pleasure. Let him drink*
- *The problem is temporary. She drinks to deal with her grief (loneliness, insomnia, etc).*
- *My mother's too old to change*
- *It's unlikely someone my grandfather's age will become addicted to alcohol or other drugs.*
- *You can't help someone until he wants help*

AGEISM – Collusion

In the United States there is widespread stereotypic revulsion and fear about growing old.

Family collude or ignore substance misuse by older family members:

- "Grandmother's cocktails keep her happy"
- "Dad is old. What difference does it make?"

Older people internalize these stereotypes

- Avoid seeking mental health and substance abuse care
- Fear of being classified as "senile" or "crazy"

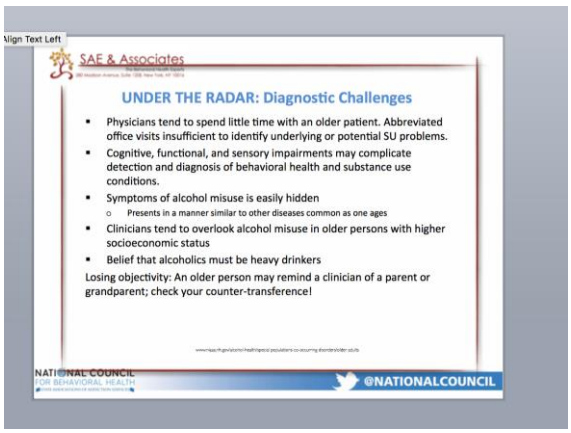
Providers may not acknowledge the need for SU treatment

- Common belief that quality of life will remain poor for older people even if successfully treated for SU
- Not worth the effort involved in treating or changing behavior: "They will die soon"

Pharmaceutical companies

- Drug trials routinely exclude subjects 60+
- Without this input there is no way clinicians can predict adverse reactions.

Kydd AS, Fleming A. Ageism and age discrimination in health-care: Fact or fiction? A narrative review of the literature. Maturitas. 2015 Aug;81(4):432-8.10.1016/j.maturitas.2015.05.002. Epub 2015 May 18.



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INVISIBLE IN PLAIN SIGHT – Older Substance Using Adults

- Isolation - No longer in the workforce, with smaller social networks to observe changes or problem behaviors and provide support and recognition of misuse.
- Less likely to drive a car – Those who do drive under the influence or intoxicated are more likely to be stopped and identified with a substance problem; they and family are made aware of the substance problem with its legal ramifications. Those who do not drive are less likely to be identified socially and legally in need of care.
- Losses that occur, e.g., the death of a spouse, may trigger or worsen depression and lead to severe, debilitating symptoms that may complicate, trigger or mask substance misuse.
  - A major depression may be interpreted as normal grief.

Older adults who "self-medicate" with alcohol or prescription drugs are more likely to characterize themselves as lonely and having lower life satisfaction

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ACT LIKE A LADY: Women and Substance Misuse

Social stigma regarding addictions is greater for older women than men:

- Frequently better at concealing alcohol or drug misuse.
- Tend to drink less often in public places. They often drink alone and unobserved during and after.
- Are more likely to have had a problem-drinking spouse, to have lost their spouses to death, to have experienced depression, and to have been injured in falls.
- Women are prescribed more, and consume more psychoactive drugs, particularly benzodiazepines, than older men and are more likely to be long-term users of these substances. Length of prescribed time heightens the potential for substance misuse.
- Physicians tend to under-assess signs/symptoms of MH/SU in older women.

If a woman attributes her alcohol problems to a breakdown in morals, she is not likely to seek substance abuse treatment.

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COMORBIDITY IN OLDER ADULTS

- Comorbidities that can complicate assessment and diagnosis of alcohol or substance misuse:
  - medical issues
  - cognitive impairment
  - mental health disorders
  - sensory deficits
  - lack of mobility
- Older persons with comorbidities may be discouraged from pursuing treatment for their substance abuse problems:
  - Discouraged from attending evening Alcoholics Anonymous (AA) meetings, if they cannot walk flights of stairs or drive after dark
  - Screened out of treatment programs because of poor cognitive tests or because health professionals do not think they will benefit.
  - Treatment programs may not have the facilities to accommodate their special functional needs.
  - Programs may not accept medicated older adults with mental health disorders.

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OLDER PERSONS FREQUENTLY SELF-MEDICATE

- Each year, adverse drug events (ADEs) - harm resulting from the misuse of medication - result in over 177,000 visits to emergency departments by older adults.
- Older adults often hide information from physician and self-medicate to avoid perceived social stigma and being judged.
- They swap drugs with friends/relations to save money.

The cost for treating preventable ADEs among Medicare enrollees has been estimated at $887 million annually.

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- 2 age cohorts very different..baby boomers vs those over 70

Pharmacodynamics in Older Adults

- Increased sensitivity due to age-related alterations in the CNS receptors
- Benzodiazepine receptors in the brain become more sensitive, causing increased sedation, unsteadiness, memory loss, and disinhibition
- Psychomotor studies among elderly patients using benzodiazepines indicate that they have a greater risk of sedation, particularly those with dementia, hypoalbumenia, or chronic renal failure.
- The simultaneous use of multiple medications increases the risk of adverse drug reactions

Early onset

- 70% of elderly alcoholics
- 14% of male population
- 1.5% of female population
- These patients have problems with alcohol most of their lives
- Likely to have a family history of alcoholism

Late Onset

- 30% of elderly alcoholics
- Onset is usually after 50
- Triggered by a major life stressor

Late Onset

- Most late onset addicts are effected by:
- Retirement
- Social Isolation
- Physical Health Problems
- Grief and Loss Issues (Losses for older people tend to be more irreversible, leading to a sense of hopelessness, fatalism)
- Housing Issues (Moving out of a home occupied for decades)
- Marital problems
- Mental health problems- particularly depression

Late Onset…

- Fewer medical and mental health problem
- Stronger societal connections
- Less likelihood of having been in a correctional facility
- Less likelihood of having been in alcohol or drug treatment
- A better prognosis for recovery- since they have not suffered the physical and psychological ravages of long term substance abuse

Polypharmacy

While older adults constitute 13% of the US populations, they are the largest users of prescription and over the counter medications in the US, accounting for approximately 30% of all prescriptions and 40% of all over the counter medications sold. The average older person is prescribed eight medications for three heath conditions.

Prevalence of Medication Use

- 90% of those 65 and older take at least one prescription medication: A third have five or more prescriptions (NCHS, 2010)
- > 50% use five or more medications total (including OTCs, vitamins, herbals); 20% use 10 or more (Qato, 2008; Slone Survey, 2011)
- 25% of elders have been Rx'd an opiate
- 30 percent of those over 65 take eight or more prescription drugs daily (Sheahan et al., 1989).

why more drugs

- arthritis
- insomnia
- depression
- anxiety
- more doctors

"Oh, I've always taken this drug."

Younger and healthier brains experience less dysfunction from these drugs. That's because a younger brain has more processing power and is more resilient. So drugs that aren't such problems earlier in life often have more impact later in life. Just because someone took a drug in their youth or middle years doesn't mean it's harmless to continue once they are older.

5 most commonly used meds that dampen brain function

- Benzodiazepines
- Non-benzo sedatives
- Anticholinergic meds
- Antipsychotic and mood stabilizers
- Opiates

Benzodiazepines

-Note that it can be dangerous to stop benzodiazepines suddenly. **These drugs should always be tapered, under medical supervision.**

-Elderly on benzos can look just like someone with dementia

Benzos can cause dementia, falls, muscle weakness

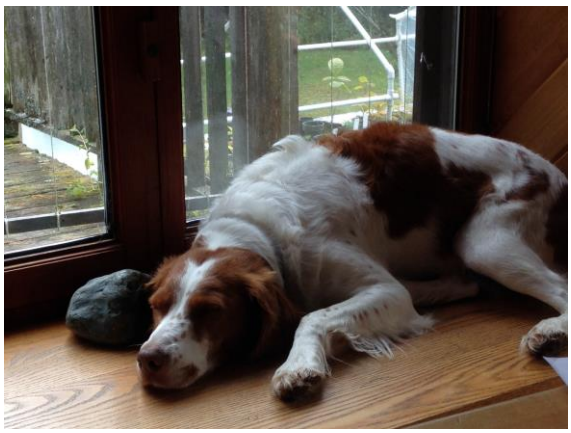
-Commonly prescribed benzodiazepines include lorazepam, diazepam, temazepam, alprazolam, clonazepam (brand names Ativan, Valium, Restoril, and Xanax, Klonopin respectively)

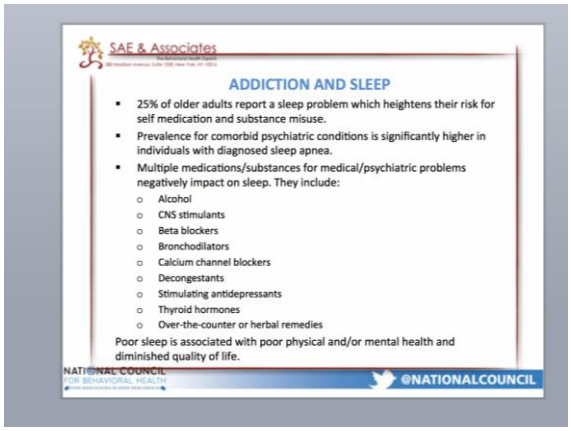
Benzodiazepines

- Benzodiazepines and opiates are the types of prescription drugs most likely to be abused by seniors
- Approximately 20% of the senior population use benzodiazepines
- Benzodiazepine abuse more common in females
- Even when taken as prescribed there is a danger that tolerance, dependence and toxicity may develop
- Longer acting benzodiazepines can increase risk of falls and hip fracture
- Slurred speech, ataxia and delirium may result

Alternatives to benzos to consider

- for insomnia: CBT
- for anxiety: passionflower, st. John's wort, SSRI's





"z-drugs"

-zolpidem, zaleplon, and eszopiclone (brand names Ambien, Sonata, and Lunesta, respectively)

-all have the same side effect profile as benzos: cognitive issues, falls, weakness

-in addition : Parasomnias

Anticholinergic Drugs

- Sedating antihistamines, such as diphenhydramine (brand name Benadryl).
- The "PM" versions of over-the-counter analgesics (e.g. Nyquil, Tylenol PM); the "PM" ingredient is usually a sedating antihistamine.
- Medications for overactive bladder, such as the bladder relaxants oxybutynin and tolterodine (brand names Ditropan and Detrol, respectively)

Anticholinergic cont.

- Medications for vertigo, motion sickness, or nausea, such as meclizine, scopolamine, or promethazine (brand names Antivert, Scopace, and Phenergan).
- Medications for itching, such as hydroxyzine and diphenhydramine (brand names Vistaril and Benadryl).
- Muscle relaxants, such as cyclobenzaprine (brand name Flexaril)

Anticholinergic cont

- Less commonly:
- Non sedating antihistamines: zyrtec, etc
- H2-blockers: Zantac, Pepcid

Antipsychotics and mood-stabilizers

- Commonly prescribed antipsychotics are mainly "second-generation" and include risperidone, quetiapine, olanzapine, and aripiprazole (Risperdal, Seroquel, Zyprexa, and Abilify, respectively).
- The first-generation antipsychotic haloperidol (Haldol) is still sometimes used.
- Valproate (brand name Depakote) is a commonly used mood-stabilizer.

Opiate pain medications

- Commonly prescribed opiates include hydrocodone, oxycodone, morphine, codeine, methadone, hydromorphone, and fentanyl
- Tramadol (brand name Ultram) is a weaker opiate. it interacts with a lot of medications and still affects brain function

Medication Abuse and Misuse

Abuse vs Misuse

- Abuse- deliberate and intentional
- Misuse-inadvertent, at times perpetuated by the health care system

Medication Misuse High Risk Behaviors?

- Takes more than one type of prescribed medication
- Difficulty remembering how many meds to take
- Prescriptions from two or more doctors
- Felt worse soon after taking meds
- Taking meds to help sleep
- Uses up meds too fast
- Takes meds for nervousness or anxiety
- Doctor/nurse expressed concern about use of meds
- Take pain relieving meds
- Take pills to deal with loneliness, sadness
- Saving old medications for future use
- Chooses between cost of meds and other necessities
- A family member reminds them to take pills
- Uses dispenser or other method to help remind
- Fails to take meds supposed to
- Borrow someone else's meds
- Feel groggy after taking certain medications

Medication Abuse and Misuse

Adults 65 and older consume more prescribed and over-the-counter medications than any other age group (13% of population but 25-30% of medications)- one of fastest growing health concerns.

Medication Abuse and Misuse (cont.)

- Adults 65 and older consume:
  - 25- 30% of all medications.
  - 70% of all over-the-counter medications.
- Average adult over 65 uses 11 different prescriptions over one year.
- One out of four prescription medications taken by older adults is psychoactive.

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Medication Abuse and Misuse (cont.)

- 50% of prescribed medications are not taken according to directions.
- Older adults experience two to three times as many adverse drug reactions as do younger adults.
- Over ½ of individuals who are hospitalized for adverse drug reactions are over age 65.
- Special concern - prescription medications and alcohol!

Medication Abuse and Misuse (cont.)

- Age-related changes affect how we process medications and alcohol:
  - Lean body mass decreases
  - Fat increases
  - Total body water decreases
  - Decrease in the stomach's ability to metabolize alcohol
  - Renal changes
  - Decreases in liver function
  - Neurotransmitter/brain-related changes

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Risk Factors for Medication Misuse

- Taking extra doses, missing doses, not following instructions, taking the wrong medications.
- Using medications that have expired.
- Not knowing about side effects.
- Sharing or borrowing medications.
- Mixing medications or drinking alcohol while taking medications.
- Going to multiple physicians to get more of the same drug.
- Going to multiple physicians who are unaware of complete medications regiment.

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Risk of Drug Misuse Among Older Persons Increases for Many Reasons:

- Inappropriate prescribing, especially for women.
- Failure to tell doctor about OTC, herbs, vitamins.
- Memory problems.
- Problems taking medications.
- Small print on packaging and labels.
- Health literacy issues, e.g., not understanding the physician's instructions.
- Missing or misunderstanding instructions – vision, hearing and/or language barriers.

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ETOH

Myths about Alcohol Use/Abuse

- Feeling sad or depressed is part of growing old. There's nothing you can do to help the older adult.
- Over-the counter medications and alcohol can be used together safely.
- Very few women become alcoholics.
- If an older adult says that drinking is his or her last remaining pleasure, it is generally best to allow the person to continue to drink.

Medicines and Alcohol Interactions

- Even social drinking can be a problem for someone taking medications regularly.
- Examples of dangerous drug-alcohol interactions:
  - Taking aspirin or arthritis medications and drinking alcohol can increase the risk of bleeding in the stomach.
  - Acetaminophen (such as Tylenol) may cause liver damage in people having three or more drinks a day.
  - Alcohol can worsen central nervous system depression in persons taking anti-depressants.

National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health – Senior Health, August 2010.

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Medicines and Alcohol Interactions Cont.

- Examples of dangerous drug-alcohol interactions cont.:
  - High does of sedatives mixed with alcohol can be lethal.
  - Drinking alcohol and taking medications for high blood pressure, diabetes, ulcers, gout, and heart failure can make those conditions worse.
  - Cold and allergy medicines that contain antihistamines often makes people sleepy. Drinking alcohol can make this drowsiness worse and impair coordination.
- Increased risk of gait disturbance and subsequent falls.

Alcohol and Substance Abuse

Alcohol and substance abuse is less likely to be recognized in the older adult:

- Lack of adequate history
- Alcohol-related problems may be mistaken for medical or psychiatric problems
- Older individuals live alone
- No job-related difficulties
- Usually no legal problems

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- For many adults, the phenomenon of aging, with its accompanying physical vulnerabilities and distinctive psychosocial demands, may be the key risk factor for alcohol problems. To differentiate older drinkers, the Consensus Panel (NIAAA) recommends using the terms *at-risk* and *problem* drinkers only.

Drinking Guidelines for Older Adults

The Consensus Panel[1] recommends the following usage guidelines for Older Adults:

Guidelines for Men

- No more than one drink per day (1)
- A maximum of two drinks on any drinking occasion (e.g., New Year's Eve, weddings).

Guidelines for Women

- Somewhat lower than for men

[1] TIP 26: Substance Abuse Among Older Adults, Frederick C. Blow Consensus Panel Chair, SAMHSA· 1998.

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One Drink is Equal to the Following:

One 12-ounce can or bottle of regular beer, ale, or wine cooler

One 8- or 9-ounce can or bottle of malt liquor

One 5-ounce glass of red or white wine

One 1.5-ounce shot glass of hard liquor (spirits). The label will say 80 proof or less. Spirits include whiskey, gin, vodka, rum, and other hard liquors.

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Icohol

My Doctor said "Only 1 glass of alcohol a day". I can live with that.

Risk Factors for Alcohol Problems – Late Onset

- Death of a spouse, friends and other family members
- Separation from children and loss of home as a result of relocation
- Loss of job – and related income, social status and sometimes, self-esteem – as a result of retirement
- Loss of mobility – trouble using public transportation, inability to drive, etc.
- Impaired vision and hearing, insomnia and memory problems
- Family history of addiction
- History of depression, anxiety
- Declining health because of chronic illness
- Loss of social support and interesting activities

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Adverse effects of EToH in Elderly

- Falls
- Delirium tremens
- Orthostasis (diuretic effect)
- Cerebellar damage (wide based gait)
- Osteoporosis
- Wernicke Encephalopathy (confusion, ataxia, nystagmus, related to thiamine)
- Korsakoff Syndrome (confabulation)

Age related changes affecting how alcohol is handled

- Decrease in body water, increase in body fat
- Increased sensitivity and decreased tolerance to alcohol
- Decrease in the metabolism of alcohol in the gastrointestinal tract.

- Although the criteria listed in the latest DSM is used to diagnosis substance dependence and substance abuse in the elderly, the stated criteria for dependence and abuse many not necessarily apply to older adults for several reasons. Older adults need less alcohol to become inebriated. Therefore older adults who consume smaller amounts of alcohol consumption than listed may go undetected as having a substance abuse problem.

- Another DSM diagnosis problem is that older adults are more likely to be retired and not engage in as many activities and thus may not meet the DSM criteria that substance use interferes with social or occupational functioning. Think for a moment about many elderly who are socially isolated, do not drive, work, volunteer, etc. They may have even a problem with alcohol for example, but may not meet the criteria for diagnosis: (1) failure to fulfill a major role obligation at work, school or home; (2) using substances in situations in which it is physically hazardous; and (3) legal problems.

Problem with DSM-V definition

- The drinking practices of many older adults who do not meet the diagnostic criteria for abuse or dependence place them at risk of complicating an existing medical or psychiatric disorder. Consuming one or two drinks per day, for example, may lead to increased cognitive impairment in patients who already have Alzheimer's disease, may lead to worsening of sleep problems in patients with sleep apnea, or may interact with medications rendering them less effective or causing adverse side effects.

Cues for the elderly

- Physical symptoms and health cues. Chronic alcohol use for example results in considerable damage to many body organs systems, particularly the brain, gastrointestinal tract, liver and heart. But even vague symptoms such as upset stomach, incontinence, drowsiness, sedation, and weight loss should be explored.
- Behavioral and social changes including doctor shopping, financial problems, and increased social isolation.

Cues for the elderly, continued

- Cognitive changes especially abrupt onset of confusion, memory loss, anxiety, auditory hallucinations, or delusions. Alcohol can also affect complex cognitive skills, fine and gross motor skills, visual accommodation, and reflexes. Therefore new difficulties with activities of daily living, decision making, and diminished hygiene maybe signs of substance abuse.

Cues for the elderly, continued

- Depression. Depression can either precede or accompany substance abuse. Depression may be specifically related to the abrupt drop in blood alcohol levels that follows and episode of heavy drinking as well as to the general central nervous system depressant effects of alcohol, or to an underlying depressive syndrome.

Cues for the elderly, continued

- Insomnia. The effect of alcohol and other drugs, along with the reduced deep sleep that accompany normal aging, results in very little sleep for the older adult with substance abuse problems.
- Frequent falls or other types of accidents.

Michigan Alcoholism Screening Test-Geriatric (MAST-G)

- Michigan Alcoholism Screening Test-Geriatric (MAST-G). The MAST-G is a version of the Michigan alcohol screening test and includes questions with geriatric specific consequences. Tests on the instrument indicate that it is very sensitive (93.9%) and specific (78.1%) in identifying alcoholism among the elderly.

Please answer Yes or No to the following questions:	Yes	No
1. When talking with others, do you ever underestimate how much you drink?		
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?		
3. Does having a few drinks help decrease your shakiness or tremors?		
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?		
5. Do you usually take a drink to calm your nerves?		
6. Do you drink to take your mind off your problems?		
7. Have you ever increased your drinking after experiencing a loss in your life?		
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?		
9. Have you ever made rules to manage your drinking?		
10. When you feel lonely, does having a drink help?		
SCORING: Score 1 point for each 'yes' answer and total the responses **2+ points = are indicative of an alcohol problem and a BI should be conducted. The extra question below should not be calculated in the final score but should be asked.**		
Extra Q: Do you drink alcohol and take mood or mind altering drugs, including prescription tranquilizers, prescription sleeping pills, prescription pain pills, or any illicit drugs?"		

ETOH effect on the brain

- Alcohol use may have direct neurotoxic effects leading to a characteristic syndrome called *alcohol-related dementia* (ARD) or may be associated with the development of other dementing illnesses such as Alzheimer's disease or Wernicke-Korsakoff syndrome, an illness characterized by anterograde memory deficits, gait ataxia, and nystagmus.

- Certain medical conditions, for example, hypertension and diabetes mellitus, can be made worse by regular drinking of relatively small amounts of alcohol. In addition, the tendency "to take the edge off" with alcohol during times of stress, and its subsequent impact on cognition and problem-solving skills, may provoke inadequate or destructive responses, even in those older adults whose overall consumption over 6 months is lower than that for some younger, problem- free, social drinkers. Furthermore, older drinkers who do not meet the substance abuse criteria for "recurrent use" behavior or consequences may, nonetheless, pose potential risk to themselves or others.

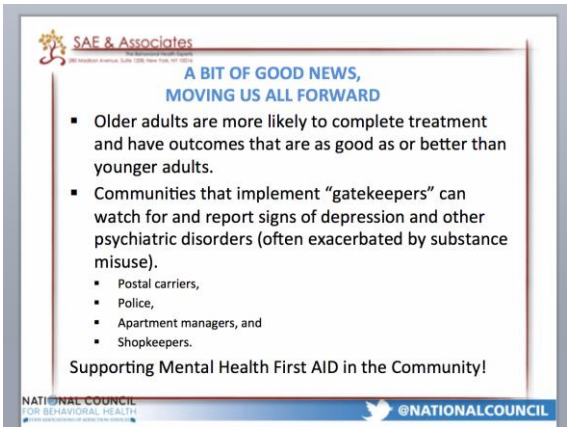
What is “normal” aging

- What’s his name?
- What’s that called?
- Where did I park?
- Where did I put those?
- Did I tell you this already? Yes.
- Did I ask this already? Yes.
- Did you tell me this already? Yes.

Treatment

Treatment

- Treat older people in age-specific settings where feasible
- Create a culture of respect for older clients
- Take a broad, holistic approach to treatment that emphasizes age-specific psychological, social, and health problems
- Keep the treatment program flexible
- Adapt treatment as needed in response to clients' gender.



Motivation

Treatment recommendations

- Age-specific, group treatment - supportive, non-confrontational
- Attend to negative emotions: depression, loneliness, overcoming losses
- Teach skills to rebuild social support network
- Employ staff experienced in working with elders
- Slower pace & age-appropriate content
- Create a "culture of respect" for older clients
- Broad, holistic approach to treatment recognizing age-specific psychological, social & health aspects

Specialized Treatment for Older Adults

- Need extended detoxification and medical stabilization
- Need slower transitions between levels of care
- May have cognitive issues to consider
- Hearing, speech and vision impairments
- Need for longer rest, relaxation and recreation periods
- Nutrition issues
- Chronic pain may be a problem
- Grief and loss issues
- Social support/ loneliness issues

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Specialized Treatment for Older Adults (cont.)

- Current older adults are more complaint with treatment and have treatment outcomes (medical) as good or better than younger patients (Oslin, 1997, Atkinson, 1995) – particularly late onset drinkers.
- Baby Boomers – treatment programs will need to adapt.
- At this time there are few "rehabilitation units" specializing in older adult and addictions in the country and it is a challenge to find ambulatory care options specifically for older adults.

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Specialized Treatment for Older Adults (cont.)

- Medicare will help pay for treatment of alcoholism and drug abuse in both inpatient and outpatient settings if:
  - You receive services from a Medicare-participating provider or facility;
  - A doctor states that the services are medically necessary; and
  - A doctor sets up your plan of treatment.

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THANK YOU

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