Alcohol misuse in older patients – a hidden problem

Alcohol use disorder can be missed in older people due to confounding comorbidity, failure to screen and lack of sensitivity in screening tools, writes **Juliet Bressan**

ALCOHOL use disorders in older people are often described as a hidden problem. There are many challenges in identification of patterns of at-risk drinking.[1] The epidemiological evidence is that while older populations drink less than younger populations, in developed countries, regular and frequent alcohol use is prevalent in older people, as is binge drinking.

Data in the US from National Surveys on Drug Use and Health 2005-2006, for example, found at-risk and binge-drinking patterns, with alcohol dependence symptoms reported by 11% of adults aged over 50, and 6.7% of adults aged over 65. Epidemiological data is available in Europe also, where 8.2% of Finns aged over 65 are reported to be binge drinkers.[2]

In Ireland, where alcohol consumption is approximately 30% higher than in other European countries (n = 14), alcohol consumption in the over 65s is lower than for that of other age groups and 23% of over 65s abstain from alcohol. However, 10% of over 65s consume alcohol on more than four days per week.[3]

Therefore, while older people may consume less alcohol in volume per capita, their pattern of drinking is risky. Binge drinking and frequency of consumption are a special problem in older people, due to the increased vulnerability of age.

Challenges to diagnosis – *identification*

Patterns of drinking may explain partly why diagnosis is a challenge in this age group. However, lack of appropriate screening tools and failure to implement screening tools in this age group has been identified as a major barrier to identification.

O'Connell et al[4] found that the vast majority of screening tools for self-report of alcohol use were developed in the US, many in veterans administration institutions. This limits the generalisability of results.

Self-reporting of alcohol consumption may fail to identify alcohol use disorder, especially if the relevant tool does not specifically quantify age-related aspects of consumption (eg. drinking as a social outlet, drinking due to retirement time-capacity, or accidents caused by alcohol).

The CAGE tool is commonly used in general practice, for example,[4] and while this tool identifies dependent drinkers, it does not necessarily identify risky social drinking which is very acceptable in countries like Ireland: such drinkers can only be identified with more appropriate tools such as the AUDIT5 or SMAST-G, which is the Short Michigan Alcoholism Screening Test – Geriatric Version.[6]

The Irish Longitudinal Study on Ageing, for example (TILDA), found that while 3.9% of men aged 65-74 gave a history of alcohol or substance abuse, when assessed using a formal ques-

CAGE questionnaire

- Have you ever felt the need to **C**ut down on your drinking?
- Have you ever **A**nnoyed anyone with your drinking?
- Have you ever felt **G**uilty about your drinking?
- Do you ever take an **E**ye-opener in the morning to relieve anxiety/shakes?

Two positive responses are considered a positive test and indicate further assessment is warranted

Reference: *Detecting alcoholism. The CAGE questionnaire. Ewing JA. JAMA 1984 Oct 12; 252(14): 1905-1907*

tionnaire, the prevalence was significantly higher at 4.8% in the same men.[3]

Therefore, being aware that alcohol is a possible problem in older people, applying a screening tool, and using the appropriate screening tool for that age group, can enhance identification in primary care.

Challenges to diagnosis – *comorbidity*

Alcohol use in older people can lead to a range of physical, psychological and social problems, including acute gastric bleed, stroke, ischaemic heart disease, Parkinson's and cancers. Presentation with acute symptoms of any one of these diseases will prevail upon a hospital admission and therefore the underlying alcohol use disorder may be missed.

Alcohol disorder typically presents in older people as falls, dementia, cardiac problems, hypertension, insomnia, confusion, depression or self-neglect.

Estimates have been made that up to 14% of emergency room admissions are due to alcohol use disorder in elderly people, 18% for medical inpatients and 23-44% for psychiatric inpatients.[4]

Challenges to diagnosis – *barriers to identification in practitioners*

There are several barriers to diagnosis from within the health professions.[1] Societal myths can lead relatives and family of older people to believe that regular alcohol consumption is tolerable or to be encouraged socially in older people. This can impact on attitude and awareness of health practitioners.

In addiction, similarity between the symptoms of alcohol disorder and other conditions such as dementia, depression or insomnia, as well as the unreliability of self-reporting and failure to use appropriate screening tools, all present barriers to identification for the concerned GP.

Challenges to treatment – *barriers in policy*

National policies and prevention strategies may not be targeting elderly people in their drive to bring down alcohol consumption, if young people are the prime target. In Ireland, for example, the Department of Health framework for health and wellbeing has a key performance indicator of decreasing alcohol consumption. However, its target is to reduce alcohol consumption by people aged over 15.

The 2012 Steering Group Report on a National Substance Misuse Strategy advocated an integrated approach to tackle the problem of substance misuse among the Irish population, and does recommend research on certain groups in society, including older people, to better understand their attitudes and behaviours when it comes to alcohol. However, the focus of the report is younger age groups, and there are no specific actions aimed at the challenges associated with alcohol misuse in the over 65s.[3]

A HRB study in 2012 found that most people don't know what a standard drink is or if they did know, what level of alcohol it contains.

The Health Promotion Unit of the Health Services Executive[13] which is the organisation tasked with implementing policy, has a website (**www.yourdrinking.ie**), which aims to raise awareness of alcohol misuse in Ireland, has a dedicated section for 'Young people and alcohol' but not for older people.

The national charity Alcohol Action Ireland has a specific section entitled 'Older People and Alcohol' on its website that mentions that older people are more susceptible to the effects of alcohol, but does not recommend any specific strategy or targeting prevention for alcohol use in the elderly.[11]

Therefore, it is possible that the elderly are not being targeted for treatment in a meaningful way, even in countries where alcohol policy is a major national concern, despite increasing awareness of the risk of alcohol use in this group.

Challenges to treatment – '*not fitting-in*'

Substance use disorder (SUD) or addiction services are not conventionally linked with care of the elderly. Therefore, as older SUD patients may have multiple medical comorbidities, as well as psychiatric dual diagnoses, these patients do not 'fit in' well with either SUD treatment services or mainstream medicine.

Physical health challenges such as electrolyte balance, Wernicke's and Korsakoff's syndromes, and benzodiazepine withdrawal require extra caution in older patients.[4] Older people are under-represented in clinical trials, and polypharmacy adds risk to treatment models.[7]

Challenges to treatment – *within services*

Healthcare practitioners in mainstream medicine are not necessarily trained, skilled or resourced to identify and treat the psychosocial aspects of alcohol use disorder.[8] While elderly people with alcohol use disorder or problem drinking may fail to present to appropriate treatment services, substance use or alcohol treatment services also fail to provide treatment facilities appropriate to older people.

Treatment programmes that focus on addiction behaviour may be unprepared for physical aspects of ageing such as dementia, incontinence, disability access, lifting, assisted feeding, as well as social aspects of old age such as end-of-life care, widowhood, isolation, prescription medicines, and cognitive behavioural techniques may not apply in older patients.[9]

Challenges to treatment – *within the patient*

Elderly people who drink in an at-risk way may suffer accidents or other adverse outcomes due to excess drinking or pattern of binging, but do not identify themselves as alcoholic and therefore may not consider the need for help in addressing their drinking pattern.

Dar et al[1] have identified two models for alcohol disorder in older persons:

- Those who have been lifelong alcoholics with a family history who now present with an alcohol-related physical or psychiatric problem, or
- Those who only developed problem drinking later in life, who are better educated and for whom a stressful life event has lead to increased drinking.

Therefore, the latter group can be difficult to engage in treatment due to psychosocial comorbidity, lack of insight or ambivalence.

Appropriate models of care

Treatment services that focus on youth substance use, on peer-led treatment, or on inpatient abstinence-based rehab, may not be appropriate for elderly people who wish to remain socially active in their family or community or for whom there is a taboo on alcohol treatment.

Elderly people with alcohol use disorder may also require inpatient treatment for medical reasons of safety due to physical vulnerability and frailty or comorbidity.

Therefore, treatment models may need to be community based and low-threshold, at the level of primary care,[5] but with the option of quality inpatient admission electively as well as in an emergency, to a unit with a focus on medical management, rather than the behavioural therapy model which is the

Case study 1: Rosanna

Roseanna is a 78-year-old academic, still actively working part-time. She presents with a request for her driving licence to be renewed, and a routine BP check finds a blood pressure of 178/130. Roseanna has been prescribed antihypertensives in the past but is reluctant to take them because she dislikes the side-effects. She herself is convinced that the hypertension is white-coat hypertension. Physical examination reveals that she has a mild intention tremor and some cogwheel rigidity. A suspicion of early Parkinson's is therefore relevant, and Roseanna is referred to a neurologist, with an appointment to return to the surgery next week for blood pressure monitoring.

Roseanna returns the following week. Her BP is now 150/110 and Roseanna is adamant that this proves the diagnosis of white-coat hypertension. She is also very alarmed at the suspicion of early Parkinson's and therefore much of the consultation is taken up with convincing her that this referral is relevant.

A decision is made to consider ambulant BP monitoring. Roseanna does not return to the surgery for this intervention, despite a reminder in the post and by phone. She informs the surgery staff that she is too busy and will manage her blood pressure herself.

Six months later, a letter is received at the surgery from the neurologist confirming the diagnosis of early Parkinson's disease and also remarking on a suspicion of cognitive impairment. A recommendation for a list of blood tests is made, which include liver function tests.

Roseanna returns to the surgery to receive a prescription for the levodopa the neurologist has prescribed, and undertakes the recommended blood tests. A serum bilirubin of 22 alerts the GP.

Roseanna reveals that she drinks wine daily, at least half a bottle and often a full bottle over a weekend evening with her husband. An AUDIT screening test is performed and Roseanna is diagnosed as high-risk drinking.

Case study 2: Richie

Richie is aged 62 and lives alone following a divorce. He is a retired taxi driver and smokes 15 cigarettes per day. He presents for his annual flu vaccine and seems grumpy and impatient in the waiting room. Richie is noticeably obese when he rolls up his sleeve for vaccination, and the nurse cannot get access to the deltoid. He also complains about painful feet and, on examination, he has extensive varicose eczema on both ankles with very swollen feet.

The nurse suggests that Richie could have a look at his BMI and begins to give nutritional advice and to enquire about family history of diabetes. Richie becomes worried and following the vaccination, agrees to return for a fasting blood glucose, triglycerides and cholesterol.

His BMI is 35 and he is shocked to have gained so much weight in the past year. A nutritional enquiry reveals that he drinks at least eight pints of beer each day.

The nurse performs the CAGE test and finds that Richie is not dependent on alcohol as his CAGE is negative. However, she is concerned about the number of units of alcohol Richie is drinking and the effect of the calorie intake from this.

An alcohol AUDIT reveals that Richie is actually at high risk with a score of 16, but that he has scored zero for questions about injury, loss of control, and concern among others because he lives alone and never drinks in the morning. He never feels out of control because he drinks socially in the pub with a group of other men who do likewise, and he has never felt guilty about his drinking as he regards eight pints per day as quite ordinary in his social circle.

current model of inpatient detoxification for alcohol care.

The Florida BRITE study was a state-wide, targeted, older persons substance use and misuse screening and treatment programme, involving screening and brief intervention for more than 25,000 people in 2006-2007, and those who had brief intervention showed significant improvements in alcohol disorder on discharge. The Florida BRITE study concluded that the elderly are under-served by alcohol and SUD treatment services. However, when targeted in a treatment programme that is tailored to the needs of the elderly, the treatment outcomes are as good as for younger drinkers.[10]

Possible solutions

The numbers of elderly people are increasing throughout the world. Alcohol use disorders are common and under-reported in this population. Alcohol use disorder can be unrecognised in the elderly, due to confounding comorbidity, failure to screen or lack of sensitivity in screening tools, lack of training or healthcare provision or cultural presupposition; therefore the increased vulnerability of the elderly to morbidity associated with alcohol use can be exacerbated.

National policies aimed at alcohol consumption reduction tend to focus on the risks to young people, rather than old,[12,13,14] and due to medical comorbidity, older people can fail to 'fit in' to conventional treatment models for SUD or psychiatry of older age.[7]

However, older people are as likely if not more likely than young people to benefit from screening, brief intervention and treatment for alcohol use disorder; therefore increasing training and awareness among health professionals and advocacy for senior health should be a priority to address the risks of alcohol consumption in this vulnerable population.[1]

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