Incidence of excess alcohol consumption in the older person

Abstract
This article discusses some of the concerns regarding older people's excess alcohol consumption and draws specific attention to those considered to be very elderly. Concerns have been expressed that the worldwide increase in the ageing population indicates that the number of older people with alcohol problems is increasing. The article describes three types of older problem drinkers, the consequences of excessive alcohol consumption in the older age group and goes on to provide a brief indication of treatment. Three examples are provided from the author's own clinical practice.

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There is growing concern over an aspect of older people's health: the issue of excess alcohol consumption and the damage to their health. In the older age group even low levels of alcohol consumption are potentially a health risk (Clough et al 2004). There is also concern that people aged 80 years and older, the fastest growing part of the older population, may have additional risks. However, there is little specific information for people aged 80 and over and only one study described patterns in the over 75s.

It is usual for alcohol consumption to decline in later years. However, with greater disposable income, better overall health, more leisure time and holidays abroad, many older people are drinking more than the government's recommended levels. This causes several physical and mental problems for the older person but is often misdiagnosed because of the ageing process. The article discusses some of the issues, risks to health and provides a brief discussion on treatment.

Prevalence
It is widely accepted that alcohol consumption for most people declines with age (IAS 1999, Cybernurse 2006). The reasons for this are believed to be changes in life circumstances, health and attitude, and that the costs of alcohol consumption begin to outweigh any pleasurable benefit (Cybernurse 2006). In this age group 28 per cent of men and 55 per cent of women drink less than one drink per week or are non-drinkers (IAS 1999).

In the over 75 age group one study reported non-drinkers as 23 per cent, those under the recommended drinking limit as 73.6 per cent and those over the drinking limit as 3.4 per cent (Hajat et al 2004). But it is recognised that there is very little research evidence available on alcohol consumption in the very elderly (Hajat et al 2004). Most of the literature searched describes consumption in people over 65.

However, the General Household Survey (1994 and 2002) indicates that the present population of older people drink more heavily than previous generations (National Statistics 2006). This may be due to high social availability and acceptability of alcohol in their formative years and higher levels of disposable income in retirement.

The UK’s older population is rising (Shaw 2002). There appears to be a corresponding increase in the numbers of problem drinkers within that population. There is concern that the worldwide increase in the ageing
Example 1: The retired business man
Andy, 73, a successful business man, had been a regular heavy drinker all his life with chaotic binges lasting several weeks. He had built up three successful haulage businesses but had lost them all due to his drinking and gambling. He had been married four times and had bought three large houses. All the marriages failed because of his drinking and the houses were sold to pay debts. He had had several serious accidents where alcohol had played a major part: a drink driving accident where his car turned over into a ditch, suffering two broken legs, a broken arm, collar bone and several ribs; a fall from a ladder that resulted in a fractured skull, coma and a lengthy period of hospitalisation and rehabilitation; a boating accident in which he nearly drowned. He has been referred to the alcohol service many times, each time he remains abstinent and goes to AA for a few weeks but then relapses. He is now living in sheltered accommodation and continues to drink.

Types of problem drinkers:

Three types of problem drinkers have been identified in older people (IAS 1999, Cybernurse 2006).

Survivors
Older people who are early-onset problem drinkers and have continued their alcohol misuse into later life. Some authorities suspect that about 65 per cent of problem drinkers are in this group (Example 1).

Reactors
These people begin alcohol misuse in later life, often in response to a traumatic event such as the loss of a partner, leaving employment, loneliness and physical or mental pain (Graham et al 1992). Other reactions are to use alcohol as a ‘self-medication’ to reduce anxiety brought about through social change, reduced physical/mental capabilities, feelings of loss of worth and sleeplessness. Alcohol is used to ease emotional or physical pain and can become a means of justifying drinking (Example 2).

Binge drinkers
This group has an intermittent excessive drinking pattern which is not confined to the ‘young-club-going-culture’. Higher levels of disposable income in retirement are a factor, which enables older people to indulge in this type of drinking pattern (Example 3).

Vulnerability and risk
People’s tolerance to alcohol tends to decrease with age (WHO 1999, AGDHA 2001). Compared with younger people there is an increased probability of intoxication in older people because there is an increased blood alcohol concentration following consumption of equivalent amounts of alcohol (O’Connell et al 2003, WHO 1999). There is an increased risk of falls (Clough et al 2004, AGDHA 2001), heart failure (WHO 1999), hypertension and stroke (Acquire 2002), higher levels of medical and mental disorders (O’Connell et al 2003). However, Hajat et al (2004) found that there was little association between alcohol consumption and depression in the over 75s. Also of concern is the interaction of prescribed medication and alcohol (Acquire 2002).

Reasons for problem drinking:
There are a number of reasons for problem drinking that have been identified in older people but these are by no means exclusive to the older age group. However, as people grow older, these reasons may have more significant impact.

Bereavement
The death of a partner is always significant but in older people may cause higher levels of mental distress, which in turn is relieved by drinking (O’Hagan et al 1993, Acquire 2002). However, in one study of the over 75s there was little association observed in this phenomenon (Hajat et al 2004).

Health problems
Both the seriousness of the condition itself along with the impact of other concurrent health problems is a cause of excessive alcohol consumption (O’Connell et al 2003). This may be to help reduce pain or to assist sleep (O’Hagan et al 1993). Isolation and loneliness (Acquire 2002) following the loss of relatives and friends, or reduced mobility leading to increased social isolation where alcohol is used to numb these feelings and provide comfort.

Consequences:
There is less tolerance to alcohol in older people due to physical changes which include:

Altered brain responsiveness (IAS 1999): Alcohol use in older people depresses brain function greater than in young people. This in turn impairs co-ordination, leading to falls and other accidents and changes in personality, which includes abusiveness and violence. Memory is further impaired and the person often appears befuddled and confused which leads to less social acceptance and self-neglect. It is possible...
that with the ageing process the same amount of alcohol will produce a higher blood concentration which in turn produces increased levels of intoxication and harm. There is evidence that indicates older drivers are three times more likely to be involved in road traffic accidents following drinking small amounts of alcohol.

**A lessening in the ratio of body water to fat (IAS 1999):**
This results in higher concentrations of alcohol in the body for there is less water for the alcohol to be diluted in. Excess alcohol effects the older person’s digestion and makes it more difficult to absorb minerals and vitamins vital to good health. Appetite is affected and this patient group is then more easily put off preparing food for themselves resulting in a downward spiral in their health.

**Less hepatic blood flow and decreasing efficiency of liver enzymes (IAS 1999):**
This results in greater liver damage because the concentration of alcohol in the blood remains in the liver longer due to reduced blood flow through the hepatic circulation. Liver enzymes become increasingly inefficient in the older adult and alcohol consequently takes longer to break down. This results in blood alcohol concentration (BAC) being higher in older people and takes longer to reduce than the generally accepted rate of one unit per hour. Consequently, the effects of alcohol last longer and are often greater at small quantities.

**Disturbed sleep patterns (IAS 1999):**
One problem of using alcohol to induce sleep is that in larger quantities it can cause sleep disturbances. Tolerance to alcohol in older people is reduced so the same amount of alcohol can have a more detrimental effect than in a younger person. Older people also suffer with stress, depression and anxiety. Medication to deal with this in combination with alcohol enhances the effect and people become drowsy throughout the day. Again, this results in the decline in the person’s general health and self-neglect.

**Issues in recognising alcohol problems**
There is general agreement that the secondary medical problems of alcohol use in the older people are recognised. As professionals, we often miss and fail to combat the primary cause of alcohol misuse. There are difficulties in recognising excessive alcohol use due to the ageing process itself (McKee 2000). Mild confusion, forgetfulness, hoarding, poor diet and neglect of personal appearance may all be attributed to the ageing process but they are also symptomatic of alcohol misuse.

Nurses may have an attitude of not depriving the older person of some comforting ‘medication’ in their later years. This can be viewed as therapeutic nihilism when faced with such challenges (O’Connell et al 2003). Insufficient use of the valid assessments instruments for older people (O’Connell et al 2003) and a lack of recognition of good indicators (McKee 2000).

**Example 2: A woman with depression**
Mary, 65, lives with her husband.
They have had marital problems for many years but will not separate or divorce. Consequently, Mary has been treated for depression for the past ten to 15 years. Their children have all grown up and rarely visit. She began a pattern to drink prior to going to bed which meant the alcohol helped her sleep. Mary also found that she would be asleep before her husband came to bed which, in her words, meant she would not: ‘have to conform to his demands’.

Mary came to the alcohol specialist nurse’s attention following a routine referral from her GP. On routine monitoring of her depression, the GP had noticed some deterioration in Mary’s mental ability and physical presentation and asked about alcohol consumption. Mary said: ‘I drink two glasses of sherry at night.’
The GP was not satisfied and a referral was made.
The specialist nurse asked about Mary’s alcohol consumption and was given the same reply as the GP. He then asked to see the glass Mary used to drink the sherry, and was shown a half litre glass. Mary was drinking more than five litres of sherry per week; in the region of 105 units. The recommended level for women is 14 units per week.

**Example 3: A retired schoolteacher**
John, 84, lives alone in a rural village.
After his national service as a junior infantry officer, John returned to public school to teach English and other languages. He spent all his working life at this school and retired as head of department nearly 20 years ago. He had married but his wife had died soon after his retirement, there were no children.
In his university days, there was the occasional drunken night but cash was short and the events were few. During his time at the school, alcohol consumption became a regular occurrence at meals and later, as finances improved, an habitual event at the end of the day.
Following his wife’s death, John had a high level of disposable income and increased his alcohol consumption. John often spent nights with them playing cards and drinking with friends to the early hours. He came to the attention of the alcohol service following a referral by his GP after several home visits where he appeared confused, neglecting himself and smelling strongly of alcohol. On assessment, it was found that John was drinking three bottles of whiskey a week. This is approximately 96 units.
Visual indicators: Signs of poor hygiene and neglect of appearance, the person’s home uncleaned and cluttered with out of date food items and discarded packaging. The house is cold with a chair obviously used for sleeping. The person has bruising at furniture height, there are broken facial blood vessels, slurred speech, tremors and the person describes fatigue (McKee 2000). In some cases, there is a history of physical abuse by spouse, children or carer.

Assessment
Practitioners must be aware that routine screening questionnaires and diagnostic classifications may not apply to the older person (O’Connell et al 2003). An assessment must include in combination

- Activities of Daily Living (McMoran et al 2006)
- Geriatric home assessment and an alcohol use assessment
- The Michigan Alcoholism Screening Test adapted for use with older people is a valid and reliable assessment tool consisting of 24 yes or no questions (Hemet Valley Recovery Center 2006). The assessments should be done over several home visits at different times of the day (McKee 2000).

Treatment and care
Research has shown that older people can benefit from treatment as much as younger people (O’Connell et al 2003). Any treatment should be matched to the assessed needs of the older person (Department of Health 2001). Some authorities argue that specialist alcohol services for older people are needed. But there are few, if any, of these services available in the UK and therefore the older problem drinker is treated within the established treatment services.

Brief interventions have been shown to be effective (WHO 1999) and drink reduction and control are often the options tried in the first instance. However, if the person is unable to reduce their intake then detoxification may be the only option. Home detoxification can prove quite safe for the older patient provided that the risks are assessed and consideration is made for changes brought about by the ageing process. Otherwise, in cases of serious medical or psychiatric conditions (WHO 1999), inpatient treatment is recommended for older people (O’Connell et al 2003). This will allow services to provide supervision that is more intensive, a longer assessment of needs and care planning. Emphasis should be placed on social activities, day centres, clubs and increasing the person’s social support network (Acquire 2002).

Conclusion
There is concern that, due to the worldwide increase in the numbers of older people, there is a corresponding increase in alcohol problems within this group. The article has argued that alcohol misuse in the older person is often not recognised for various reasons. Some due to the ageing process itself, others of poor assessment and therapeutic nihilism. This in turn can lead to greater disability, higher risk and poorer prognosis. Older people with alcohol problems have been shown to gain from similar interventions to those offered to younger people. Therefore, in many senses there is no need for separate services and current opinion would suggest this approach is ageist. What appears to be needed is good assessment from the use of appropriate techniques following recommended procedure. Then there can be a positive outcome for interventions resulting in improved health. A positive aspect for the very elderly is that excessive drinking and associated problems are rare in people aged 75 years and over. Moderate social drinking in this group is associated with financial security, good health, more social contact and less cognitive impairment.

References


Hajat S et al (2004) Patterns and determinants of alcohol consumption in people aged 75 years and older: results from the MRC trial of assessment and management of older people in the community. Age and Aging 33, 2, 170-7


