ALCOHOL MISUSE: ASSESSMENT, TREATMENT AND AFTERCARE

Consumption is increasing among older people, so healthcare professionals need to overcome their reticence to ask patients about drink habits, says Jay Murdoch.

Abstract
Alcohol misuse among older adults is increasing, with evidence of its adverse effects on health. However, healthcare professionals and patients may be uncomfortable about broaching the subject for a variety of reasons. This article provides an overview of assessment, treatment and aftercare options for older people who misuse alcohol. It highlights that all healthcare professionals are responsible for raising the issue of substance misuse if appropriate and referring to specialist services if required.

Keywords
Alcohol, alcohol misuse, alcohol-related harm, assessment, dependency, substance misuse

ALMOST HALF of all adults in the UK aged 65 and older consume alcohol (Borok et al 2013). The pattern of alcohol consumption varies across the adult lifespan with those aged 60 years or older being the most likely to drink on a daily basis, although not necessarily to harmful or dependent levels (Tait et al 2012), but the least likely to seek help. Alcohol-use disorders among older people have been described as a hidden problem because of the stigma attached to misuse (Dar 2006). Older patients often find it difficult to confess that they are concerned about their drinking because of this stigma. Clinicians often find it difficult broaching the subject with older people for fear of offending them. However, substance misuse among older adults is on the rise in the UK, with evidence of its adverse effects on health (Watts 2007, Powell 2011, Immonen et al 2011, Blow and Barry 2012, Snyder and Platt 2013).

It is difficult to find a precise definition of ‘older person’ and in the field of substance misuse a degree of flexibility in definition is required. The National Service Framework for Older People (Department of Health 2001) stated that people 'entering old age' could include those as young as 50. For the purposes of this article, older people are defined as those aged 65 and older (World Health Organization (WHO) 2013, DrugScope 2014).

Older people with alcohol use problems can be further categorised into ‘early-onset’ and ‘late-onset’ drinkers. In the UK, DrugScope (2014) highlighted that two thirds of older people with alcohol-use problems fall into the early-onset category, that is, those who have a long history of alcohol misuse that persists into older age. Late-onset drinking is where alcohol misuse does not become a problem until the person is older (Box 1).

Box 1 Possible reasons for late-onset drinking
- Isolation/loneliness.
- Retirement.
- Boredom.
- Loss of friends and family.
- Ill health.
- Decreased mobility.
- Stressful life events.
- Financial restrictions.
- Pain management/self-medication.
(Wadd et al 2011)
Ageing is generally associated with increased prevalence of chronic disease, disability and death, and therefore a public health goal is to maintain health, independence and function (Royal College of Psychiatrists (RCP) 2011, Snyder and Platt 2013). Anderson et al (2012) stated that increased alcohol use is associated with more than 60 medical disorders and conditions (Box 2). Alcohol-related conditions are estimated to be responsible for 10% of the total disease and injury burden in Europe (Anderson et al 2012). Not only does alcohol misuse affect health, it also has major social, interpersonal and legal consequences (Amato et al 2010).

Much less is known about the consequences of alcohol misuse in older people compared with younger adults (Anderson et al 2012). However, as the human body gets older it becomes more susceptible to the adverse effects of alcohol (Colella et al 2010, RCP 2011, Galluzzo et al 2012). Alcohol can exacerbate the effects of certain medications or alter the pharmacokinetics and pharmacodynamics of a drug. Older people are more likely to take regular medication and often multiple medications. Furthermore, as people age their metabolism alters, there is a fall in water-to-fat ratio and decreased hepatic blood flow and inefficiency of liver enzymes, which means the liver is more susceptible to the damaging effects of alcohol.

The brain’s responsiveness alters, leading to alcohol producing a more rapid depressant effect, which results in impaired co-ordination and memory (Immonen et al 2011, RCP 2011, Wadd et al 2013). Galluzzo et al (2012) indicate that the chronic conditions which cause the most problems for older people are usually the result of unhealthy lifestyle choices such as alcohol, smoking, diet and lack of exercise. Older people also face unique barriers to treatment and are more likely to remain ‘hidden’ from services (Wadd et al 2011).

**Box 2** | Examples of conditions exacerbated by or related to increased alcohol intake
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- Cardiovascular: myocardial infarction and hypertension.
- Neurological: stroke and Wernicke’s encephalopathy.
- Gastrointestinal: ulcers, gastritis and liver disease.
- Vascular: peripheral vascular disease and neuropathy.
- Mental health: depression and impulsive behaviour.
- Accidents: falls and head injuries.
- Cancers: oesophageal, liver and breast.

*(Change 4 Life 2014a)*

**Box 3** | Healthcare practitioner and individual barriers to detection and diagnosis of alcohol misuse

<table>
<thead>
<tr>
<th>Practitioner barriers</th>
<th>Individual barriers</th>
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<tbody>
<tr>
<td>Ageist assumptions.</td>
<td>Attempts at self-diagnosis.</td>
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<tr>
<td>Failure to recognise symptoms.</td>
<td>Symptoms attributed to ageing process or other illnesses.</td>
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<tr>
<td>Lack of knowledge about screening.</td>
<td>Many do not self-refer or seek treatment.</td>
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<tr>
<td>Discomfort with topic.</td>
<td>Perceived stigma of the word ‘addiction’.</td>
</tr>
<tr>
<td>Lack of awareness of substance misuse in older people (‘if you don’t think about it, you won’t see it’).</td>
<td>Reluctance of patients to report because of shame, denial, desire to continue use, pessimism about recovery, ignorance and lack of self-awareness.</td>
</tr>
<tr>
<td>Misuse traditionally considered to be rare in older age.</td>
<td>Cognitive problems: substance-induced amnesia, underlying dementia.</td>
</tr>
<tr>
<td>Symptoms may mimic or be hidden by those of physical illnesses.</td>
<td>Unwillingness to disclose.</td>
</tr>
<tr>
<td>Unwillingness to ask.</td>
<td>Collusion of informant(s).</td>
</tr>
<tr>
<td>Absence of informants.</td>
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**Identification and assessment of alcohol misuse**

Confidence in identifying and responding to alcohol misuse in older people is vital for effective practice (Dance and Allnock 2013). Lack of awareness and knowledge is a major barrier to detection and diagnosis (Box 3) (RCP 2011). Practitioners can use screening tools to identify people who are drinking at ‘at-risk’ levels. Screening tests can be useful and provide the basis for further discussion (Bowman and Gerber 2006), although they should never be considered substitutes for thorough clinical assessments. Screening tools include the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al 1993), which is the gold standard for detecting alcohol-related harm or the Michigan Alcoholism Screening Test – Geriatric Version (MAST-G) (Blow et al 1992).
The screening tools use questions that are scored with the total score indicating level of risk. It is important that screening tools take into account the drinker’s age. For older people consider lowering the scores or units at which risk is suspected (Box 4).

Dance and Allnock’s (2013) research identified that healthcare professionals who worked with older adults tended to ask about alcohol use less often than other professionals. Alcohol use is a taboo subject and one that many people feel uncomfortable broaching especially with patients who are not seeking treatment for alcohol misuse. Clinicians must overcome this unwillingness. Their attitudes towards alcohol can affect the way it is discussed with patients leading to missed opportunities to offer support and help make lifestyle changes.

The traditional view that alcohol misuse is uncommon in older people means that clinicians fail to ask about misuse and overlook or discount evidence of such problems (RCP 2011). Dance and Allnock (2013) reported that some clinicians find discussing alcohol use with patients ‘intrusive’ and ‘impertinent’ and question whether they have a ‘right to ask’.

Hanson (2014) stated that communicating with older people can be difficult. Practitioners may lack confidence about what to ask. They may rationalise patients’ drinking, for example, ‘drinking is all they’ve got’, or deny that there is a problem (RCP 2011). However, risks associated with increased alcohol intake are clear and healthcare professionals have a responsibility to try to safeguard against them. It is every healthcare professional’s responsibility to broach the subject of alcohol use by including it routinely in assessments.

Alcohol misuse can affect every area of a patient’s life and a complex holistic assessment is required if alcohol misuse is expected. However, clinicians should ask about alcohol intake during any assessment to ensure appropriate treatment plans can be introduced (Table 1, page 22). Wadd et al (2011) stated that assessment should be comprehensive and assess competencies with activities of daily living, safety needs and coping responses. A comprehensive assessment will identify needs or other areas that require investigating such as safeguarding concerns, physical withdrawal symptoms and/or acute medical problems. The assessment needs to be phrased in a sensitive, non-judgemental manner so that it enables people to talk about problems and concerns. It should result in practitioners developing an appropriate treatment plan.

### Box 4 Daily alcohol units and lower-risk guidelines based on research in younger adults

Men: three to four units daily, that is, not much more than a pint of strong lager, beer or cider (alcohol by volume (ABV) 5.2%).

Women: two to three units daily, that is, no more than a standard 175ml glass of wine (ABV 13%).

At least one alcohol-free day every week.

Because of physiological and metabolic changes associated with ageing these limits are not appropriate for older people: 1.5 units a day is the upper limit for older people recommended by the Royal College of Psychiatrists (2011).

(Change 4 Life 2014b)

### Intervention and treatment

Treatment options can vary depending on the assessment as well as service provision and/or available services. During the assessment the practitioner should use the information obtained to promote conversation and offer health promotion and advice on lifestyle changes or rationales for the need to make changes (Box 5). Wadd et al (2011) suggested that older people are more adherent to alcohol treatment than younger adults and are as likely to benefit from it. Due to the heterogeneity of this group, treatment must be tailored to individual needs (Bowman and Gerber 2006, RCP 2011, Wadd et al 2011, DrugScope 2014). Treatment options also vary depending on where patients are on the alcohol-use disorders spectrum: increasing, higher risk or dependent.

**Increasing and higher-risk drinkers** Increasing and higher-risk drinkers are categorised as those who drink more than the recommended daily units and

### Box 5 Health promotion

A patient states she is drinking four vodka and lemonades a night. During your assessment you find out she has had a previous myocardial infarction and is taking lifelong cardiac medication including warfarin.

You should explain to the patient the possible risks associated with her current level of alcohol intake and further cardiac events. You should also discuss how alcohol can affect clotting, which will affect her international normalised ratio results.

Use any available information given to you to promote healthier living or to highlight the dangers of increased alcohol intake on health. Make every contact count.
are therefore at an increasing or higher risk of associated harm. Assessment will identify how much the person is drinking, which should lead to an intervention.

Where the drinker is not dependent, brief or extended interventions are appropriate. They can comprise either a short session of structured brief advice or a longer, more motivationally based session. Both sessions aim to reduce or sometimes stop alcohol consumption, and non-alcohol specialists can conduct them (Amato et al 2010). They aim to motivate people to change by exploring reasons for their behaviour and identifying positive reasons for making change. This can be done using the FRAMES acronym as a guide (Box 6).

Interventions may have to be repeated to ensure patients understand the risks associated with their drinking. Public health and health promotion are everyone’s responsibility no matter what their area of nursing or medicine.

**Dependent drinkers** The National Institute for Health and Care Excellence (NICE) (2011) stated that alcohol dependence is characterised by craving, Table 1 Components of holistic assessment

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Question</th>
<th>Rationale</th>
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<tr>
<td>Presenting complaint</td>
<td>Why have you attended today? Why have you been referred to me/this service?</td>
<td>To see if there is a link between the patient’s primary complaint and increased alcohol use.</td>
</tr>
<tr>
<td>Alcohol</td>
<td>How much? How often? How long have you had this pattern? Have you ever had alcohol withdrawal symptoms? Have you ever been involved with any alcohol services? Have you ever had detoxification previously?</td>
<td>To gather a robust alcohol history that will influence the treatment plan. It also allows the clinician to discuss the person’s alcohol use and offer appropriate advice and support.</td>
</tr>
<tr>
<td>Medical history</td>
<td>Do you have any medical problems? Physical and mental health?</td>
<td>To detect older people who are at risk of experiencing problems because of their alcohol use in conjunction with comorbidities.</td>
</tr>
<tr>
<td>Drug history</td>
<td>What medication is the patient on: over the counter, prescribed and herbal? Do you have any problems with your medication? Do you take any illegal drugs?</td>
<td>To educate the patient and identify any risks with current medication and level of alcohol consumption. There are lots of medications that interact with alcohol such as codeine-based analgesics or warfarin. Many older people are on multiple medications.</td>
</tr>
<tr>
<td>Physical examination</td>
<td>Look at your patient. Are they jaundiced, unkempt, thin, confused, and/or agitated? Do they have an unsteady gait, a swollen abdomen, changes in eating habits and tremors? This will vary depending on the clinician’s level of experience and competence.</td>
<td>To identify undiagnosed or treated problems and lead to further investigations, tests and referrals. It also enables identification of concerns about mobility for example and risk assessment.</td>
</tr>
</tbody>
</table>

(Box 6) FRAMES acronym

- **Feedback** – on the patient’s risk of having alcohol problems.
- **Responsibility** – change the patient’s responsibility.
- **Advice** – provision of clear advice when requested.
- **Menu** – what are the options for change?
- **Empathy** – an approach that is warm, reflective and understanding.
- **Self-efficacy** – optimism about the behaviour change.

(Bien et al 1993)
tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences. The International Statistical Classification of Diseases (ICD-10) (WHO 2010) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association (APA) 2000) define alcohol dependence as either absent or present (NICE 2011). However, in reality dependence exists on a continuum of severity: mild, moderate and severe and it can be measured by the clinical presentation of alcohol withdrawal syndrome (AWS) (Murdoch and Marsden 2014).

AWS is a cluster of symptoms that may develop in alcohol-dependent people after cessation of, or reduction in, heavy and prolonged alcohol use (APA 2000, WHO 2010). Amato et al (2010) explained that symptom onset typically occurs up to 48 hours after the last consumption of alcohol. There is substantial individual variation in the clinical manifestations of AWS, ranging from mild tremor and irritability to significant autonomic hyperactivity, for example, sweating or a pulse rate greater than 100 beats per minute (APA 2000, Amato et al 2010, Murdoch and Marsden 2014) (Box 7).

AWS symptoms in older people can be missed or misinterpreted as those of another illness, which emphasises the need for appropriate assessment. It is important to treat AWS to decrease the severity of symptoms and prevent more severe alcohol withdrawal-induced phenomena such as seizures, delirium tremens and Wernicke’s encephalopathy, which can be fatal (NICE 2011, Murdoch and Marsden 2014).

Benzodiazepines relieve the symptoms of alcohol withdrawal (Saitz et al 2004). When administered appropriately, benzodiazepines not only prohibit the development of AWS but also normalise brain function (Amato et al 2010). Patients require sufficient medication to prevent symptoms without causing over-sedation. Caution should be taken with use of benzodiazepines in older people and in patients with liver disease. Older people will be more susceptible to the effects of benzodiazepines such as increased confusion, sedation, respiratory depression and ataxia leading to increased falls risk.

In some areas a predisposed prescription is used, which means patients are administered medication at a set time with as-required medication being used if necessary.

NICE (2010) advocated a ‘symptom-triggered’ approach to detoxification. This means patients receive medication depending on their symptoms and are assessed frequently as their symptoms dictate. If older people do require detoxification hospitalisation is usually recommended. Post-detoxification other medications such as acamprosate or disulfiram can be considered to help prevent relapse in conjunction with counselling and appropriate aftercare.

### Aftercare and relapse prevention

The current health system will require a shift in focus to respond to the demands of older substance misusers (Snyder and Platt 2013). The availability of one-to-one support, including allocation of a key worker who can facilitate patients’ route to their end goal whether it is abstinence or reduction, and counselling can be particularly important for older people because of the stigma they may feel.

DrugScope (2014) highlighted the importance of social groups and activities to address loneliness and isolation. Age-appropriate services are also important but there is a lack of them. Mixed-age drug and alcohol services may not feel comfortable or welcoming environments for older people; some may find users ‘hectic’, ‘chaotic’ and even intimidating, for example (DrugScope 2014).

Practical barriers exist for older patients seeking help from services, for instance, transport or mobility difficulties. Furthermore, help that is available may not be well advertised and older people may not use the internet to search for appropriate services. Staff must be aware of these challenges and try to alleviate them where possible, for example, through home visits and provision of appropriate verbal and written information about services.

The person who undertakes the assessment has a responsibility to use the information gathered. Staff working with this patient group should have a good knowledge of local services to whom they can refer people for support or specialist advice (Box 8, page 24). Working with patients to help them decide what they want, expect and need can lead to positive changes and risk reduction. Appropriate referrals to services such as those listed in Box 8 can

### Box 7 Symptoms of alcohol withdrawal syndrome

- Tremor.
- Sweating.
- Agitation/irritability.
- Headache.
- Visual/tactile/auditory hallucinations.
- Nausea/vomiting.
- Anxiety.
- Problems with orientation/confusion.

(Drinkaware 2014)
help because older people are supported for longer periods of time and changes can be made that may address the causes of their drinking. Some older people have complex needs and their care requires effective case management and good collaboration and communication with colleagues (Wadd et al 2011) and wider multidisciplinary teams.

Conclusion
This article has provided an overview of the assessment, treatment and aftercare of older people who misuse alcohol. Managing older people with alcohol problems at any level is complex. All healthcare professionals should be aware of alcohol misuse as a potential concern for patients, be competent to address these issues and know how to escalate concerns. Further work is needed about the nature of alcohol misuse in older people and the effect of specific treatment strategies as well as easier access to age-appropriate and individualised treatment options.

Box 8  Examples of community services
- Community alcohol teams.
- Age UK.
- Activity groups such as art, gardening and walking.
- Libraries are useful sources of information.
- Bereavement counselling.
- Therapeutic groups.

Find out more
Alcohol Concern www.alcoholconcern.org.uk/concerned-about-alcohol/alcohol-services

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