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Alcohol Concern's Quarterly Information and Research Bulletin

Alcohol misuse among older people

Alcohol misuse among older people is an issue of increasing concern for care workers, health services and alcohol services. In western countries the proportion of older people within the population has continued to grow throughout the twentieth century. In 2000 there were over 10 million adults over the age of 65 living in the UK. Projections show that in 2001 people over 65 made up 16% of England's population and this is forecast to rise to 21% by 2026 (*1 Falaschetti 2000*) making them one of the fastest growing population groups in society. At the same time alcohol is the most commonly misused substance in the world associated with serious social, economic and health costs for the individual and society.

Although general population figures indicate that alcohol use and misuse decrease with age, research evidence suggests that the problem has been underestimated and that alcohol problems can impair significantly the health and quality of life of older people. A market research survey by the pharmaceutical company Pfizer on differing lifestyles among people over 55 in Europe found that the British are the most likely to be regular drinkers (20%) and this is the only country to have a statistically significant number (1%) drinking over 6 units of alcohol per day. (*2 Carvel 2002*)

In moderation, alcohol consumption can contribute to older people's quality of life. However, alcohol also puts their health and well-being at risk. There is a pressing need to assess the scale and nature of alcohol misuse among older people and find means to support this vulnerable group within the community.

Summary of drinking patterns

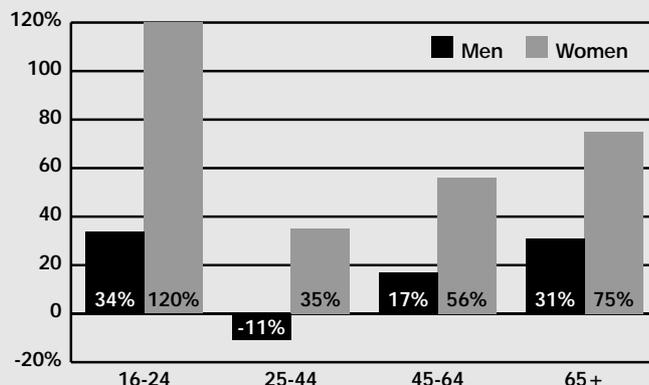
The following statistics provide an overall picture of drinking among older people aged 65 and over in Great Britain in 2000:

- **abstinence** – 33% of men and 57% of women aged 65 and over reported that they were abstinent in the previous week compared to 40% of the population as a whole.
- **frequency of drinking** – 28% of men and 14% of women reported drinking at least 5 days in the week and of these 74% of men and 78% of women drank the same each day.
- **consumption on the heaviest drinking day in the last week** – 50% of men and 38% of women drank up to the Department of Health's (DoH) guidelines for sensible drinking (4 units per day for men

and 3 units for women), with 16% of men and 4% of women drinking over the guidelines.

- **weekly drinking** – in 1988 13% of men drank over weekly guidelines of 21 units per week and this increased to 17% in 2000 (an increase of 31%). For women, drinking over weekly guidelines of 14 units per week increased from 4% in 1988 to 7% in 2000 (an increase of 75%).
- **numbers exceeding weekly guidelines** – in 2000, 644,000 men and 372,000 women were drinking over sensible limits (*3 ONS 2000*)

Figure 1 Percentage increase of different age group drinking over 14 units per week for women and over 21 units per week for men between 1988 and 2000



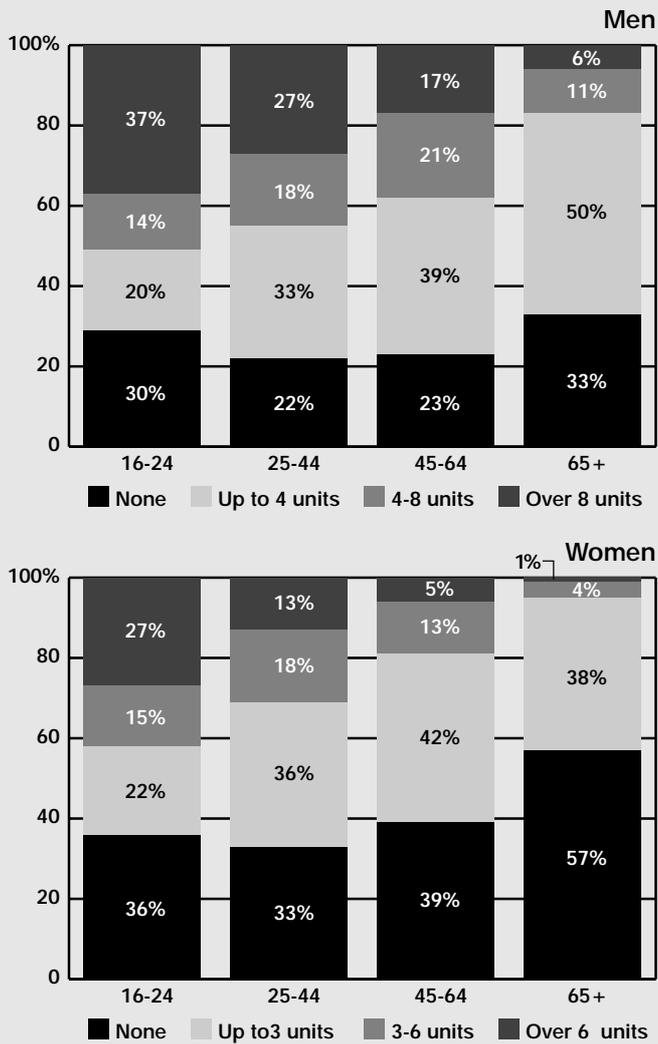
Scale and nature of the problem

Alcohol misuse among older people is often described as a 'hidden' or 'neglected' area of research in the UK. There are several problems that hinder the development of the evidence base to tackle the problem.

Estimating the true size of the problem in the UK is difficult:

- There is a lack of uniformity in the terms used to describe alcohol misuse and terms such 'hazardous' 'harmful' and 'dependent' are applied to different levels or conditions according to the agency using them.
- UK research from the early 1990s (*4 Naik and Jones, 1994*) suggests that older people have a marked tendency to under-report their drinking often missing out alcoholic drinks which they regard as medicinal to alleviate other health problems.

Figure 2 Maximum daily amount drunk during the last week by age and sex



Alcohol problems among older people can go undetected for longer:

- Older people tend not to have regular employment and often have reduced social contact so their behaviour is not so noticeable to other people.
- Alcohol misuse often goes undetected because it presents in a large number of non-specific ways such as accidents, depression, insomnia, confused states and self neglect – many of which are linked to the aging process.

Much of the research originates in the USA so not all of the findings can be generalised for the UK.

- Low levels of drinking among older people in general, compared with younger age groups, have tended to make them less of a research priority in the UK. However, the data in Figure 1 make it clear that the problem is on the increase and needs more serious consideration.

Problem drinking in old age: who drinks to excess and what are the trigger factors?

Studies in the UK indicate that the prevalence of problem drinking among older people varies between 2 and 15% depending on the population base used in a study or survey. In studies based on hospital or institutional populations the proportion of problem drinkers tends to be higher than in community based studies (5 Simpson 1993). Research literature tends to distinguish between 2 types of problem drinking in later life:

- **early-onset drinking** – ie the individual had an existing chronic problem
- **late-onset drinking** – ie the individual developed the problem late in life.

Generally it is the latter style of drinking that attracts the greater interest in studies of older people. US studies suggest that late-onset drinkers account for 40-46% of older problem drinkers (6 Black 1990).

Key factors associated with heavy drinking

In 1999 the Health Education Authority published findings of a statistical analysis of data from the 1992 and 1994 General Household Surveys and the 1993 and 1994 Health Surveys for England looking at health related behaviour in older people. The analysis identifies the heavier drinking groups among older people and examines some of the characteristics of these groups.

Key factors include:

Age

Older people are not a homogeneous group and there are different patterns of drinking across different age groups. The proportion of people drinking decreases significantly with age, with nearly 3 times more men and four times more women drinking over sensible limits in their late 50s compared with the oldest age group, aged 85 and above. Studies suggest that cohort differences exist between different age groups and successive generations have different patterns based on differing cultural norms of drinking linked closely to ideas of what is appropriate for men and women of varying ages (7 Dean 1989, 8 Goddard 1997). The increased social acceptability of drinking among younger age groups at present, suggests that the proportion of older people drinking at higher levels could increase in future.

Gender

Men were more than twice as likely to exceed sensible guidelines for weekly drinking. In terms of excessive drinking 2% of men aged 70 to 74 drank over 50 units per week compared to less than 1% of women over 70 drinking over 35 units per week. Older women were more likely to abstain than men in all age bands between the age of 55 and 85. Data in figure 1 indicate that women in the younger age groups show the greatest increase in drinking over sensible limits, so the existing pattern of drinking in older women could be expected to change.

Socioeconomic group

In both sexes higher levels of drinking were most prevalent among the higher social classes and the most affluent groups. There was a more pronounced decrease in high consumption among women as their socioeconomic position decreased. For men there was a slight upturn in consumption levels among the poorest income groups and unskilled social class, particularly in relation to excessive drinking (50+ units per week). Note that in 1997 the average weekly income of a retired person was around £225 a week as against £150 a week for people who had retired five or more years earlier. This real increase in income coincides with an increase in the proportion of people drinking above sensible limits between 1988 and 2000.

Living arrangements and partnerships

Older married men are least likely to drink heavily. Older widowed or divorced men are more likely to engage in health damaging behaviour such as smoking or excessive drinking. Men living alone are thought to experience greater psychological distress than married counterparts. In contrast older married women had the highest levels of consumption. It has been suggested that heavy drinking among older married women is linked to heavy drinking in their spouse. Non-married older women have lower levels of consumption than married women and generally show the best health behaviour (9 Cooper 1999).

Other factors not included in the HEA analysis but needing consideration include:

Social exclusion

A survey of older homeless people in London showed that around 30% of homeless people were aged 50 and above and of these a significant proportion would be likely to be drinking problematically (10 Kelling 1999).

Ethnic and religious origins

Surveys of drinking among ethnic minorities show that drinking patterns vary considerably across different ethnic groups and between men and women. In general Afro-Caribbean women report drinking less than their white counterparts as do Muslim and Hindu women. In contrast older men had more alcohol problems than younger men in the case of Asian Muslims, Sikhs and Hindus (11 Cochrane and Bal 1993).

What causes or triggers problem drinking

Although the population studies of the type described above can identify factors associated with heavy drinking, they cannot explain why some older people drink heavily and in particular why some older people develop alcohol problems later rather than earlier in their lives. A number of fairly self-evident causes or triggers have been identified including:

- Bereavement – death of partners, family members and friends
- Mental stress

- Physical ill health
- Loneliness and isolation
- Loss – including loss of occupation, function, skills, income or loss of important people in their lives.

Longitudinal studies looking at the changing lives and drinking behaviour of individuals are needed to find out how these triggers work but there is a serious dearth of this type of research. A recent study from the US (12 Brennan, et al 1999) highlighted the complex two-way relationship between different types of stress (eg financial, health-related or emotional) and drinking behaviour. Older men and women responded differently to various types of stress, for example, women were likely to develop drinking problems in response to financial stresses and men were more likely develop drinking problems as a result of stress in relationships with partners. The authors concluded, *“There may be a harmful feedback cycle whereby problematic drinking and life stressors exacerbate each other, but also a benign feedback cycle in which moderate alcohol consumption and life stressors reduce each other.”* Much more research of this type is needed in the UK. Understanding of individuals’ sensitivity to different forms of stress would be of real value when developing tailored interventions for older people.

Mortality

On the basis of a recent statistical analysis of data on alcohol consumption and mortality statistics health researchers have recommended that women can drink 2 units per day until the age of 74 and 3 units per day after 75 without risk to their health and men can drink 4 units a day until the age of 84 years and 5 units a day over the age of 85. (13 White et al 2002). This is a slight increase on the limits advised by the DoH. Although this age group may be statistically at less risk of alcohol-related deaths, substantial numbers of older people die as a direct result of alcohol consumption.

In 1999, of the 3628 people who died as a direct result of harmful drinking 690 deaths were among people aged 65 and over (19%). The peak for age range for deaths from alcohol misuse occurs in the previous age band, 45-60 years. Alcohol-related ill-health is more of a problem for older people (14 ONS 2000).

Health effects

Maintaining good health is a critical issue for older people. Average life expectancy is increasing but this has not necessarily been accompanied by improvements in morbidity across the whole population. People aged over 65 are some of the heaviest users of health services, with the NHS spending around 40% of its annual budget on this age group. Excessive or inappropriate drinking can further jeopardise an older person’s health (15 Falaschetti 2000).

Physiological changes that occur as part of the aging process mean that older people are more vul-

nerable to alcohol and experience problems at lower levels of consumption. Firstly, body water content declines and body fat increases with age. The lean body mass (muscle) decreases by 10% between the ages of 20 and 70 and this accounts for higher blood alcohol concentration (BAC) in older people after a standard dose. Secondly, certain areas of the brain undergo faster neuronal loss with aging and these changes result in loss of cognitive and motor skills (*16 Dunne and Schipperheijn, 1989*).

Benefits of alcohol for older people

- Low levels of alcohol consumption (1 unit per day minimum) can provide protection against coronary heart disease (CHD). The DoH guidelines recommend an upper limit of 3-4 units per day for men and 2-3 units per day for post-menopausal women (*17 DoH 1995*)
- Reduced systolic blood pressure combined with moderate alcohol consumption can protect against cognitive deterioration in later life (*18 Cevilla, et al 2000*)
- In moderation alcohol consumption can contribute to older people's quality of life particularly if the drinking takes place as part of a social activity with other people.

Alcohol-related health problems for older people

- Excessive drinking puts older people at increased risk of CHD, hypertension and stroke (*19 DoH 1995*)
- Alcohol adds to the risk of falls and accidents and has been identified as one of the three main causes of falls which are a significant cause of mortality and ill-health in older people (*20 Wright and Whyley, 1994*)
- Problems with insomnia can be exacerbated through misuse (*21 Tabloski and Maranjian Church, 1999*)
- Alcohol can increase the likelihood of incontinence and gastrointestinal problems (*22 Tabloski and Maranjian Church, 1999*)
- Memory loss and depression (*23 Woodhouse 1987*)
- Alcohol can contribute to dementia – 10% of elderly people presenting with dementia have alcohol-related brain damage (*24 Hislop et al 1987*)
- Alcohol may provoke Parkinson's disease in older people and delirium tremens is associated with higher mortality rates in this age group (*25 Feuerlein et al 1986*)
- Heavy drinking is implicated in a whole set of problems relating to self-neglect including poor nutrition, poor hygiene, hypothermia (*26 Woodhouse 1987*)
- psychiatric problems such as depression, phobias and anxiety are associated with alcohol misuse in old age. In addition alcohol is impli-

cated in one in three elderly suicides (*27 Crome 1991*)

Prescribed drugs and alcohol

Of particular concern is the likelihood of older people mixing alcohol with prescribed drugs. Around 8 out of 10 people aged 65 and over regularly take prescribed medicine and polypharmacy is reasonably common with around a third of men and women in private households taking four or more prescribed medicines at one time (*28 Falaschetti 2000*). Alcohol is contraindicated for use with many of the drugs taken by older people. Alcohol can increase the sedative effect of drugs such as benzodiazepines (taken by 10-15% of older people) and increase the risk of falling (*29 Herring 1995*). Drugs taken for epilepsy, high blood pressure and coughs may cause drowsiness or dizziness when mixed with alcohol. Drugs for rheumatism, arthritis, pain and general infection can cause problems, while mixing alcohol with drugs prescribed for depression may cause psychological problems (*30 Wesson 1992*).

Sensible drinking for older people – a debatable issue

The DoH guidelines for sensible drinking are consistently stated to be 3-4 units per day for men and 2-3 units per day for women. Although the report of the Inter-departmental Working Group (*31 DoH, 1995*) expresses concern that the limits should be refined in relation to younger people, it does not mention the fact that older people are also more vulnerable to alcohol. NIAAA (The National Institute on Alcohol Abuse and Alcoholism) in the US recommends that people over 65 consume no more than 1 standard drink per day (a standard drink contains 12 gms of pure alcohol compared to 7.9 gms in a UK alcohol unit), 7 standard drinks per week and no more than 2 drinks at any one time. This is stricter than UK recommendations but is worth looking at considering how vulnerable older people are to alcohol-related health problems. It is also a much clearer message which would help people to make more informed choices about their drinking and assist carers in assessing whether an older person has a problem. The report '*Drinking: adults' behaviour and knowledge in 2000*' showed that older people are one of the least well informed groups when asked about alcohol units, with 62% of people over 65 reporting that they had heard of measuring alcohol consumption in units compared to 82-85% in younger groups (*32 Lader and Meltzer 2001*).

Identification of alcohol problems

One recent review of alcohol assessment in older people found that identification of problem drinkers is generally thought to be more difficult. Barriers to identification include:

- atypical symptoms presented by older people that mimic other geriatric illnesses
- the tendency of older people to be less accurate in self-reporting on their alcohol consumption

- family members, health professionals and care system personnel often ignoring or failing to identify problems or the carers most close to the drinker often colluding with them out of feelings of embarrassment or a feeling that 'this is all that's left' for the drinker

These problems are compounded by the attitudes of health professionals. Doctors are rarely likely to consider alcohol when assessing their patient and previously, older patients were less likely than others in the general population to have had an alcohol history taken by a doctor (33 Naik and Jones 1994). However, practices and attitudes are changing, for example the REDUCE project based at St Mary's Hospital, Paddington, now regularly screens older patients when they present at A&E (34 Age Concern 2002).

Frequency and level of consumption are commonly used criteria for identifying alcohol misuse but these are less relevant in assessing older people given the way that older people metabolise alcohol and their increased sensitivity to it. The behavioural and health effects of alcohol use are more relevant but again many of the behavioural, biological and cognitive indicators for alcohol misuse differ in old people. Practitioners need to become more aware of the relevant indicators when making assessment for problem drinking. Alcohol misuse problems are classified according to the DSM-11-R system (American Psychiatric Association). However, many of the social and occupational dysfunction criteria are not applicable to older drinkers and it has been suggested that these criteria be refined for a diagnosis with older people (35 Timms 1997).

Similarly there needs to be a more focused use of screening tools appropriate to older people. Some of the existing tools are applicable to older people and are not sufficiently sensitive or specific to identify problems in women drinkers or discriminate between early and late-onset use. Screening tools that have been validated for use with older people include the geriatric version of the Michigan Alcohol Screening Test, (MAST-G), the Drinking Problem Index (DPI) and the shorter U-OPEN (Unplanned use, objections, preoccupation with use, response to emotional stress and neglect of responsibilities) (36 Derry 2000).

Interventions – treatment types and service approaches to help older drinkers

Trials have shown the efficacy of different treatment approaches for older drinkers including:

- Social approaches aimed at improving social support and removing behavioural antecedents to misuse
- family therapy interventions that recruit family members and friends to assist in behaviour change
- multi-component cognitive-behavioural approaches that include medical, cognitive and social components (36 Derry 2000)

Research suggests that the efficacy of individual treatments depends on the type of older problem drinker, with late-onset drinkers being more likely to adhere to treatment once a problem has been identified (37 McKee 2000).

Alcohol Concern's 2002 report mapping alcohol service provision in England showed people over 60 made up only 7% of service users (38 Alcohol Concern 2002). Some of these barriers to attendance are practical in that physical disabilities will prevent older people from attending. For some there is a stigma attached to problem drinking so services need to develop an outreach approach including the provision of well-placed information material/leaflets explaining about the type of help offered (39 Goodman and Ward 1995). Privacy is particularly important for older people so arrangement for home visits would be appropriate. One issue open for debate is the question of whether alcohol services put in place specialist services for older clients or develop their existing services and tailor them to the specific needs of older people. Training and awareness-raising among alcohol practitioners would be essential in assisting them in these developments.

Increasingly practitioners are recognising that for older people alcohol problems are closely inter-related with personal problems such as housing, social isolation, financial stresses, physical illness and cognitive impairment. So it is essential to address these related problems either before or during treatment for the substance misuse problem. The development of 'care in the community' means that there is a complex network of voluntary, statutory and private agencies that deliver care to older people that could be utilized to provide integrated service provision. However, a number of key components would need to be put in place first, including:

- Staff training to improve rates of identification both among medical personnel and non-specialist care staff (40 Derry 2000) and training packages to raise awareness of problems in this age group (41 Raby 1999)
- Good liaison structures/systems between services and referral to specialist medical care (42 Derry 2000)
- Production and careful distribution of health promotion leaflets for older people to improve knowledge and understanding of potential problems relating to alcohol

Various cross-agency partnerships are now working to develop these types of initiatives, for example as part of the Wandsworth Alcohol Misuse, Older People Project (43 Age Concern 2002).

One major change that must be made is to alter the mind-set in society that makes people believe that it is not possible for older problem drinkers to change their drinking behaviour or assume that because they do not actively seek treatment, they are not interested in taking up treatment (44 Age Concern 2002). Current projects set up to assist older drinkers have shown some very encourag-

ing results. The CASA Older Person's Service in North London found that of the 96 people using the service during the year:

- 20% stopped their use of alcohol
- 52% stabilised or reduced their drinking
- 72% demonstrated some improvement in self-care or psychological or social functioning (45 Taber 2001).

The respect that has developed among the alcohol workers for their clients in overcoming their alcohol problems is one immeasurable benefit of the project.

Conclusion

There are still some outstanding questions surrounding alcohol misuse among older people particularly on definitions of problem drinking and prevalence. However, there are clear signs of increased awareness of the problem and its implications for older people with voluntary organisations coming together with statutory health and social services to look at ways of tackling the issue. In addition the publication of the Older Persons' National Service Framework (NSF) means that alcohol is now being considered as a priority within the overall context of healthcare standards for older people.

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