

Alcohol, drugs and much more in later life

Álcool, drogas e muito mais entre idosos

Gary K Hulse

Department of Psychiatry and Behavioral Science, Faculty of Medicine and Dentistry, The University of Western Australia

Abstract Elderly adults are greater consumers of prescription and ‘over the counter’ medications than any other age group and polypharmacy, including the co-use of alcohol, is common in this group. Age related physiological changes which influence drug concentrations, metabolism, polypharmacy and interaction of other drugs with alcohol can negatively influence functional capacity, psychomotor ability, and cognition, including attention and memory, placing the older person at greater risk of accident, injury, isolation and ultimately institutionalisation. It is argued that DSM-IV criteria used to define “abuse” or “dependence” are of limited value to the majority of elderly ‘problem’ alcohol or drug users, with ICD-10 criteria that identify those who are experiencing ‘a risk’ of or where use “is actually” causing “early” harm, more appropriate. Impediments to psychiatrists and other medical practitioners identifying ‘problem’ alcohol and other drug use, and appropriate assessment and intervention procedures are briefly discussed. The potential for decreasing the incidence and severity of physical and psycho/social events following a reduction or cessation in problem alcohol or other drug use means that assessment and intervention should be one cornerstone of management practice for this often disenfranchised and vulnerable group.

Keywords Ethanol. Alcoholismo. Smoking. Hipnotics and sedatives. Drug dependence. Drug abuse. Aged. Therapeutics. Case management.

Resumo *Idosos são os maiores consumidores de prescrições e medicamentos vendidos sem receita médica, de forma que a polifarmácia, incluindo o uso concomitante de álcool, é comum nessa faixa etária. As mudanças fisiológicas que acompanham o processo de envelhecimento influenciam as concentrações de medicamentos e seu metabolismo, de forma que a polifarmácia e a interação de outras drogas com álcool podem influenciar negativamente a capacidade funcional, bem como a habilidade psicomotora e cognitiva (incluindo atenção e memória) dos idosos – o que aumenta o risco de acidentes, ferimentos, isolamento e, finalmente, institucionalização. Este artigo argumenta que a definição do DSM-IV de “abuso” e “dependência” tem valor limitado para a maioria dos idosos que consomem álcool ou drogas de modo “problemático”. Nesse sentido, a CID-10 é capaz de identificar de forma mais adequada indivíduos “em risco” ou com sinais “iniciais” de comprometimento. Discutem-se as dificuldades que os psiquiatras e outros clínicos podem enfrentar para identificar o consumo problemático de álcool e outras drogas entre idosos, bem como o uso de instrumentos de avaliação e intervenções terapêuticas. O potencial para reduzir a incidência e gravidade das complicações físicas e psicossociais associadas a uma redução ou abandono do uso de álcool e drogas entre idosos sugere que a avaliação e o tratamento desses pacientes devem ser uma das prioridades no manejo clínico desse grupo vulnerável, e frequentemente desprovido de direitos, da população.*

Descritores *Álcool etílico. Alcoolismo. Tabagismo. Hipnóticos e sedativos. Dependência de drogas. Abuso de drogas. Idoso. Terapêutica. Administração de caso.*

Introduction

The size of the problem

Addiction to drugs is commonly considered a problem of early adulthood. However, recent estimates suggest that alcohol and prescription drug misuse affect as many as 17% of older adults.^{1,2} Although total alcohol consumption is commonly lower in the elderly population, physiological changes increase the effects of alcohol. Harmful and hazardous alcohol use is more common in males than females, with many not aware of the hazardous nature of their drinking.³ Older women with alcohol problems are more likely to have had a problem drinking partner, have experienced death of a partner, experienced depression or been injured in a fall.⁴ Tobacco use is less frequent in later than early adulthood, but those who continue to smoke likely represent the 'hard-core' group whose dependence is harder to let go of. Tobacco use is a major factor for a number of leading causes of death amongst individuals 60 years and older eg heart disease, pulmonary disease⁵ and associated with an increased loss of mobility in both men and women.⁶ Smoking is more prevalent in older problem drinkers, with estimates of 60% to 70% of older male problem alcohol consumers smoking a pack per day.⁷ While the use of illicit drugs is generally considered to be low in the elderly, in alcohol dependent and psychiatric populations some illicit drug use, particularly cannabis, may continue.⁸ Elderly adults consume more prescription and OTC medication than any other age group,⁹ with benzodiazepines and other sedatives frequently prescribed to the elderly, especially to women.¹⁰ Although older adults in the US constitute less than 15% of the population, they receive approximately 30% of all prescriptions and are more likely to continue use of psychoactive drugs for longer periods than younger counterparts.¹¹

Additional factors contributing to problem drug use in the elderly

Three additional factors contribute to the evolution of 'problem' drug use in the elderly. First, as the body ages, a number of physiological changes take place which significantly increase the effects of alcohol and other drugs. Lean body mass and total body water decrease, while fat increases. The increase in body fat prolongs half-life of fat-soluble drugs such as benzodiazepines while the decrease in lean body mass and smaller water volume decreases the distribution area available for water-soluble drugs such as alcohol. As a consequence, older adults will have higher plasma and tissue levels of both water and fat soluble drugs. In addition, reduction in gastric alcohol dehydrogenase, which metabolises alcohol prior to absorption, results in higher blood alcohol levels for the same amount consumed.^{12,13}

As a result of the physiological changes associated with ageing, older adults can easily move from a situation of none to significant clinical and social problems without changing their alcohol consumption.³ This decreased tolerance to alcohol means that general community guidelines for 'safe',

hazardous or harmful alcohol use that designate specific quantities of alcohol are inappropriate for older people.

Secondly, it is not uncommon for elderly patients to visit a number of different doctors that furnish them with several prescriptions. This may result from the appropriate consultation of specialists for different conditions or represent an unmonitored search for other opinions. Older persons have been noted to hoard and use other people's medications.¹⁴ Misuse of drugs can also be an unintentional result of errors caused by confusion and poor sight or memory. Where there is no system for monitoring drug use there is increased risk of polypharmacy. The physiological effects of ageing make the older person more vulnerable to the effects of multiple drug use and polypharmacy.

Thirdly, some of the life changes that take place in later adulthood may contribute to changed drug use patterns. Retirement and loss of previously relevant social roles may lead to overuse of alcohol and prescribed medication such as benzodiazepines, antipsychotic drugs and polypharmacy.¹⁵ Alcohol, tobacco and other sedatives are often used to block out loneliness, give self-confidence, cheer up, help with sleep and relaxation, or relieve pain.¹⁶ Older people with problems related to alcohol or prescription drugs use are more likely to live alone, have experienced the death of a spouse, have experienced depression, been injured in falls and to lack social support and satisfying leisure activities.^{4,17}

Clinical presentations: contrasts with younger adults

Alcohol and other drug use

Similarly to the majority of younger age groups older persons with 'problem' alcohol or other drug use rarely present seeking help for these problems. Alcohol, prescription and over the counter (OCT) drugs (eg benzodiazepines, antihistamines, codeine containing compounds) used in isolation or combined may compromise functional capacity and negatively affect physiological arousal, psychomotor ability, and cognitive functioning (including attention and memory).¹⁸ Presentations in the primary care setting are therefore often associated with the resulting accident, injury or compromise functional capacity. Presentations are also associated with social isolation and ultimately, institutionalisation.^{2,12,19}

Problem consumption of alcohol and sedative agents is also associated with increased psychiatric morbidity in later life. Between 10% and 30% of older persons with alcohol abuse or dependence have a primary mood disorder.²⁰ These patients have a greater social dysfunction and are at an increased risk of suicide compared to non-depressed 'problem' alcohol users.²¹ In the case of those with a previous history of psychosis, there may be cannabis use which may exacerbate the existing psychiatric morbidity.⁸ Psychiatric presentation should therefore flag the need for assessment of alcohol and other drug use.

Physical and mental state examination may reveal evidence of recent drug abuse or dependent use, since this is commonly associated with decline in global functioning, evidenced by poor general appearance, personal hygiene, overall health and

nutrition. Changes in these over time should be noted and used as possible markers for increased substance use. A range of sequelae identified during assessment and examination should prompt enquiry in relation to alcohol and drug use. These include sleep complaints and significant changes in sleep pattern, unusual fatigue, daytime drowsiness, apparent sedation, cognitive impairment, memory or concentration disturbances, disorientation or confusion, difficulty following older person's conversations, seizures, malnutrition and muscle wasting, liver function abnormalities, persistent irritability without obvious cause and altered mood, depression or anxiety, incontinence, urinary retention, difficulties urinating, poor hygiene and self neglect, unusual restlessness and agitation, complaints of blurred vision or dry mouth, unexplained nausea and vomiting or gastrointestinal distress, changes in eating habits, slurred speech, tremor, uncoordination, shuffling gait, frequent falls and unexplained bruising.¹⁴

Tobacco

Unlike other drugs, use of tobacco is rarely concealed by the patient. However after a lifetime of smoking, older persons may be reluctant to quit because, unlike younger age groups, they see the damage as already done. The family may also not support change, considering smoking to be one of the few pleasures left to the elderly person. However, contrary to common belief, smoking cessation in the older person leads to substantial improvements in health,^{5,22,23} including a likely decrease in the risk of reduced cognitive functioning and Alzheimer's Disease.²⁴

Assessment and scales

Diagnostic considerations in the elderly

The DSM-IV definition of alcohol and drug 'abuse' or 'dependence' focuses on social and inter-personal consequences of drug abuse, such as current legal, social or inter-personal problems, and the failure in role obligations. Concurrent lifestyle changes in later life, such as reduced responsibilities and activities, and increased ill health may make it more difficult to apply these criteria. Additionally, while the diagnoses of abuse or dependence may apply to a select few elderly persons, it is of limited relevance to the vast majority of elderly patients who are 'at risk' or experiencing 'a risk' associated with the increased impact of alcohol, other drug use, or poly-pharmacy.

Patterns of substance use, where use is actually causing harm, is often referred to as harmful use. This is defined in World Health Organisation's (WHO) International Classification of Disease 10th Edition (ICD-10) as a pattern of substance use that causes physical or psychological harm for the individual. No specific level or pattern of substance use is inferred. ICD-10 is therefore more appropriate as a classification system for general assessment of the elderly because of its ability to detect new situations where a non-specific pattern of substance use confers a risk of or is actually causing 'early' harm. ICD-10, however, does not allow for the identification of 'at risk' persons.

At risk substance use is commonly referred to as hazardous substance use and it is clearly significant in the assessment and management of the elderly because it allows for the early stage diagnosis of developing substance use problems and initiation of early intervention before the development of major physical or psychosocial problems. Many authorities define hazardous or risky substance consumption (commonly alcohol) as a regular daily intake. As already noted, levels of intake applied to the general population cannot readily be extrapolated to the elderly, and potential consequences such as risk of diminished cognitive performance or injury due to falls are more appropriate.

Wide differential diagnosis

Psychological and physical symptoms associated with problem substance use in the elderly also typically mimic other conditions, with substance use symptoms mistaken for those of delirium, dementia or depression. Cognitive impairment associated with drug misuse can be such that drug related delirium or dementia may be wrongly labelled as Alzheimer's disease.²⁵ Problem alcohol consumption is also associated with worsening performance on dementia screening scales and may cause difficulty in making an accurate diagnosis.²⁶ Depression for several days or more following prolonged, or high binge drinking episodes may not indicate true depression.²⁷ The result is there being a wide differential diagnosis and commonly an assumption that the presenting condition is unrelated to substance misuse.²⁸ Increased vigilance to discern these presentations is necessary.

Timing of assessment

The elderly persons should be assessed for 'at risk', 'harmful' or 'more significant' alcohol and prescription drug use (eg abuse or dependence) as part of their regular physical examination or reassessed following the identification of physical or psychosocial indicators or following significant life change or transitions (eg menopause, approaching retirement or retirement, caretaker for an ill relative, death of a spouse, or movement to supportive accommodation).¹⁴

Screening tests

Liver function and blood mean corpuscular volume, uric acid, serum albumin and haemoglobin, gamma glutamyltransferase and aspartate amino transferase are commonly used in the clinical assessment for alcohol and drug use. There is, however, preliminary evidence suggesting that these alcohol related abnormalities are more frequent amongst younger than older alcohol users.²⁹ This may be, in part, because problems with alcohol can occur with relatively low levels of use.³⁰ These tests should therefore be used and interpreted with caution.

Context for and accuracy of assessment

An accurate history of drug consumption will depend much on the skill of the interviewer and the context in which the history is obtained. Assessment should take place in a

confidential setting and in a non-threatening, non-judgmental manner. Older adults may not perceive their substance use as problematic, particularly because their consumption pattern may be similar to younger age groups or that of their younger days. In addition, lack of awareness of the negative physical, social and psychological effects also contributes to under reporting.³ Non disclosure of drug use should therefore not be automatically interpreted as denial. On the other hand, patients who are aware of their 'problem' drug use often feel guilty, or embarrassed about their use. A sensitive approach to these varied presentations will result in a more accurate assessment.

The use of stigmatising labels such as 'alcoholic' or 'drug abuser' should be avoided. For those not suspected of abuse or dependence, it is important to introduce the topic of alcohol and drug use as an unremarkable behaviour, so that drug use is seen within the spectrum of common human activities that require detailed assessment. It is important that older adults understand that information on drug use is necessary to ensure a correct diagnosis, treatment, and to avoid potentially harmful drug interactions.

Most consultations between older adults and their psychiatrist lend themselves to collateral discussions about substance use patterns. For example, alcohol and prescription drugs can often affect how another medication is working, so 'let's review what you are currently using so we can maximise the effect of this drug I am prescribing'.

Alcohol

For alcohol it is important to establish quantity and frequency of consumption, as well as beverage type. From this information, an average daily and maximum alcohol use at any single setting can be calculated. The relationship of changes in alcohol use patterns to cognitive functioning and accidental injury (eg falls) should be identified.

With regard to alcohol, the three most useful questions are:

- I. how many drinks do you consume each day?
- II. how many drinks do you consume at any one session?
- III. do you drink within half an hour of waking up in the morning?

These questions assist quantifying the risk of 'problem' alcohol use and in determining whether the person is physically dependent. A 'yes' to question III indicates that physical dependence is highly likely. The recommended levels of alcohol use should be lower for the elderly than general community, with many health authorities defining 'unsafe' use for this group as regular daily intake of more than approximately 20 grams of alcohol per day for elderly males and 10 grams for females.^{14,30} Questions I & III are also useful for assessing tobacco consumption (replacing the word 'drink' with 'cigarettes'). Again the first question quantifies the risk of 'dependence' and the third, whether the person is physically dependent.

For alcohol, questions can also be posed about possible physical and psychosocial sequelae and dependence. Two screening tests are commonly used for the detection of alcohol abuse or dependence in the elderly. The Michigan Alcoholism

Screening Test – Geriatric version (MAST-G)³¹ was specifically developed for use with older adults and has a high level of sensitivity and specificity for detection of alcohol abuse or dependence amongst older adults. The CAGE,³² which uses four simple questions, has also been validated for use in later life. Importantly, the CAGE assesses lifetime use, so that it is important to ascertain that the elderly person currently drinks and to instruct that answers should relate to recent experience (eg the last 12 months).

The CAGE and the MAST-G are, however, unsuited to the identification of early stage (hazardous or harmful) alcohol use amongst the elderly. The Alcohol Use Disorder Identification Test (AUDIT)³³ may prove more useful in the identification of these early stage problem drinkers, although the MAST-G and CAGE have been shown to out perform the AUDIT for detecting alcohol abuse and dependence in elderly males.³⁴

Prescribed medication

Information on prescription drugs centres on the quantity (in number of tablets and milligrams or grams), the duration of use and if the medication has been taken in accordance with medical prescription. Co-use of medications with alcohol or within 3 hours following alcohol use should be identified. As with alcohol the relationship of changes in use patterns to cognitive functioning and accidental injury (eg falls) should be identified.

Collateral information

Any impairment to an individual's cognition will interfere with provision of information and of screening for alcohol and drugs, and collateral participation from family members or friends may be necessary. This type of secondary screening should also be delivered in a confidential setting using a non-confrontational approach which explains and legitimizes the reason for secondary enquiry. For example, 'I am endeavouring to establish the best management plan for your mother to prevent ongoing falls and injury, and am wondering whether use of other prescription drugs or alcohol are important factors'.

Consent should always be sought from the patient first unless the need to make a prompt diagnosis outweighs privacy concerns. Corroborative history can also be obtained from other treating professionals, such as general practitioners or from past medical records.

Principles of management and treatment

Why treat at all

Psychiatrists and other medical practitioners should not be pessimistic about achieving a significant and sustained change in drug use in the elderly patient. There is increasing evidence that the elderly patient is more likely to complete treatment³⁵ with long term outcomes at least equal, if not superior to those of younger people.³⁶

Management of polydrug use

Inappropriate polypharmacy including co-alcohol use,

especially where abuse or dependence is absent and the elderly person is not aware of their problem use, can, assuming cognitive competence, be dealt with by simply reviewing and rationalizing drug use and providing clear and explicit instructions. Educate about the effects of their drug use, emphasizing personal effects since this is a stronger stimulus to change behaviour than general information.

Given the vast extent of prescription, OTC and other drugs often housed and used by the elderly, it may be difficult for them to provide a comprehensive itinerary upon request. In such instances, the 'big bag' approach may be beneficial. Here the psychiatrist asks the elderly patient to empty all medications (prescription, OTC) into a bag and bring them to the next consultation. Drug use can then be reviewed and rationalised.

Issues of co-use of other licit drugs such as alcohol and tobacco can also be woven into the consultation. This 'show and tell' approach may also serve to reinforce appropriate drug use patterns and should take place on an annual basis or following the identification of significant indicators and life changes.

Hazardous and harmful drug use

Where hazardous or harmful alcohol and drug use is identified, the least intrusive treatment option should be explored first. The two most commonly used procedures are brief intervention and motivational counselling.¹⁴

Many patients do not see their drug use as a problem and so do not recognise any need to change. Accordingly, the psychiatrist needs to be skilled in helping patients recognise the true consequences of their drug use. Confrontation may produce defensive behaviour in the patient, including minimising the problem or denying its existence. An alternative to confrontation is known as motivational interviewing or motivational enhancement therapy.

Motivational interviewing

The goal of motivational interviewing is to encourage the patient to determine if the harms associated with their drug use outweigh the benefits and so assess if action is required. Instead of the psychiatrist confronting the patient, the patient is encouraged to discuss their drug use in an open manner.

There are a number of techniques that can make motivational interviewing more effective. These include:

- using summary statements from time to time: trying to pull together the views of the patient into a coherent statement;
- responding to resistance by reframing the patient's statement, e.g. "so you don't think there are any negative aspects to your alcohol use?";
- encouraging and supporting patients whenever they make statements about actively choosing or changing their behaviour.

The techniques of motivational interviewing can be extended to other behaviours including compliance with medication schedules, dietary changes, exercise, etc.

Goal

Those who have early problem drug use, but are not dependent, or have a dependence which is mild to moderate, and who have good and stable psychosocial support networks are more likely to be suitable for a goal of moderation of drug use. The most widely accepted method of achieving a moderation in drug use is by use of a brief intervention.

Brief intervention

Use of brief intervention has been shown to reduce the level of hazardous or harmful alcohol and tobacco use, and harm associated with this use.^{37,38,39} While the exact composition of a brief intervention may vary, a number of common elements can be identified. A typical brief intervention consists of a structured therapy of short duration (5-30 minutes) which is offered to help the individual to cease or reduce drug taking and commonly includes motivational interviewing, information, and counselling on problem solving strategies.

The components of brief intervention have been summarised using the acronym "FRAMES":

- feedback on the risk of drug use;
- responsibility for change lies with the patient;
- advice to change behaviour;
- menu of change options offered;
- empathetic style of interview;
- self-efficacy of the patient to change behaviour emphasised.⁴⁰

Withdrawal

Alcohol withdrawal is potentially life-threatening, particularly in the elderly who have a higher risk of developing complications such as dehydration, encephalopathy and peripheral neuropathies. Inpatient withdrawal management is clearly warranted for those elderly patient with significant levels of alcohol or prescription dependency or poly dependencies, or where there is significant comorbidity, either physical (eg emphysema, angina) or mental (eg suicidal, depression) or the elderly are brittle or frail. Only where physical dependency is mild, there are no significant comorbidities and there is a supportive framework to monitor withdrawal and supervise medications should withdrawal at home be considered.

Alcohol withdrawal syndrome is more protracted and severe in older than younger adults.^{41,42} Commonly, the initial dose of withdrawal drug should be one third to one half that used for younger adults. This level is maintained for 24-48 hours then tapered at a slower rate than for younger adults, with close observation for negative clinical response.²⁸

High dose benzodiazepine with long or intermediate half-lives should not be used in detoxification of alcohol or psychoactive prescription drugs, as they can accumulate in the body and result in toxicity with cognitive impairment, interfering with general functioning capacities, post-withdrawal and discharge. Oxazepam or lorazepam where metabolism does not involve hydroxylation by the liver are desirable for patients with moderate to severe liver disease.⁴²

Since organic mental syndromes related to alcohol use (eg. Wernicke's encephalopathy & chronic alcoholic dementia) are more common in the elderly, thiamine administration is recommended as a standard part of treatment.^{43,44}

Following withdrawal

Post-withdrawal the elderly patient should be closely monitored to ensure they do not exhibit signs of the abstinence syndrome, which may not occur until days or even weeks after the withdrawal process is complete. This is especially where physical dependence is associated with drugs of long half lifetimes such as diazepam or methadone.

Cognitive dysfunction may persist for several weeks after drug withdrawal and should therefore not be assessed until the end of this window period until reversible cognitive impairment is likely to have occurred.¹⁴

Alcohol and depressive symptoms

The relationship between alcohol consumption and depressive symptoms is complex and a diagnosis of depression should be made with care. For example, depression for several days or more following prolonged, or high binge drinking episodes may not indicate true depression²⁷ although where symptoms persist for several weeks treatment is indicated.⁴⁵ Similarly, alcohol can increase lithium toxicity and enhance central nervous system depression in persons taking tricyclic antidepressants.

Long term management considerations in the elderly

In considering longer term treatment for the elderly it is important to recognise age-related differences in leisure time, medical comorbidity, social supports and other psychosocial issues. Age-specific studies are few but indicate that cognitive behavioural and self-management approaches are effective. Improved treatment outcomes are associated with programs for the elderly that emphasise social relationships and social support and are slower paced. Wherever possible the extended family should be involved.^{36,46}

Important ingredients for any long-term management plan are:

- where a specific group treatment is available and accepted, it should be supportive and non-confrontational and enhance person's self-esteem;
- there should be a focus on coping with depression, loss of social (eg recent retirement) or personal (eg spouse) and on enhancing social networks and activities;
- there should be linkage with medical, social and support services.

Alcohol: use of pharmacotherapy

Disulfiram is contraindicated in patients with cardiovascular disease and other serious illnesses, and generally not recommended because the elderly patient is more likely to show significant distress to the alcohol-disulfiram negative reaction. The opiate antagonist naltrexone, with a dosing regime of 50mg per day has been shown to be well tolerated by

older men with reduced alcohol relapse shown compared to placebo controls. Poor renal or hepatic function is a contraindication to naltrexone.⁴⁷

Tobacco

Intervention involves offering information, support and if appropriate pharmacotherapy. Advise the patient that cessation of smoking is associated with increased mobility and physical function. Like younger people, older smokers fear weight gain, loss of pleasure, failure and boredom in smoking cessation, so the identification of ways to control weight increase, alternative activities, and the provision of positive reinforcement are standard components of the management strategy. Discuss the management of insomnia associated with nicotine withdrawal since this is already a common concern in the elderly, stressing that symptoms are temporary.²²

Older smokers should be considered for nicotine replacement therapy and anti-craving pharmacotherapy as long as contraindications such as unstable angina, recent myocardial infarction or cerebrovascular events are not contraindications.^{23,39}

Sedative hypnotics and sleep

Where maturational changes in sleep patterns are seen by the patient as abnormal and a reflection of medical 'ill health', the use of hypnotics to ameliorate sleep is clearly inappropriate. Here it is essential to destroy the myth of the "8 hour sleep", explaining the normal decrease in sleep time which occurs over lifetime. Strategies include activities to encourage a delay in retiring time such as later evening meal times, or a snack later in the evening. Encourage exercise during the day (since this promotes deeper sleep), a regular wake-up time, and the use of bed for sleep only (not for worrying, reading, or watching television). Patients should be advised to avoid daytime naps, and immediately prior to bedtime reduced exercise, fluid intake, heavy meals and caffeine, alcohol, drugs that interfere with REM sleep.

Adequate pain management techniques are also important to reduce insomnia and early waking, which is often related to pain from osteoarthritis. In many instances use of a simple analgesic such as paracetamol before retiring or when awakened by pain, is all that is required to promote a good night's sleep.¹³

Where sleep problems are identified poor behavioural practices need to be addressed prior to consideration of benzodiazepine use. When hypnotics are used, short term (eg 5-7 days) use should be considered, with frequent monitoring. At recommended therapeutic doses, longer acting benzodiazepines such as temazepam and diazepam are more likely to accumulate and therefore likely to produce residual sedation, decreased attention, reduced cognitive functioning and motor co-ordination and increased falls and accidents/injuries. Short acting benzodiazepines such as oxazepam and lorazepam are more appropriate.^{28,42}

Benzodiazepines are often first prescribed as a short-term aid during a significant stressful life event such as bereavement.

However the high rate of continued use leads to the question of whether their use is better avoided. Again, in most cases of short-term relief of anxiety and insomnia it may be prudent to only prescribe enough medication for a few days. Many current users of benzodiazepines first started during a period of hospital admission or acute stress. Routine hospital use because of the noisy surroundings is not appropriate.

Conclusions

Researchers now recognise the high prevalence of drug use and poly-pharmacy which affects as many as 17% of older adults. However, despite this high prevalence of use the assessment and management of substance use is frequently absent from everyday psychiatric and general medical practice,³ with older adults less likely to receive, for example, a primary diagnosis of alcoholism, than their younger counterparts.^{48,49}

The reasons for this include the reluctance of many elderly patients to report alcohol and drug use due to embarrassment or lack of insight,⁵⁰ and a low index of suspicion or reluctance to diagnose on the part of the clinician.¹⁴

Given the expectation that doctors will be at the forefront of providing advice and help, it is however unacceptable for psychiatrists and others dealing with the elderly not to identify and manage elderly patients' alcohol and drug use. This means that alcohol and drug use should be considered in all elderly patients and a history of substance use appropriately blended into the overall medical history taking.

The potential for decreasing the incidence and severity of physical and psycho/social events following a reduction or cessation in problem alcohol or other drug use means that assessment and intervention should become one of the cornerstones of management in this often disenfranchised and vulnerable group.

References

1. D'Archangelo E. Substance abuse in later life. *Can Fam Physician* 1993;39:1986-93.
2. Bucholz K, Sheline Y, Helzer J. The epidemiology of alcohol use, problems, and dependence in elders. In: Beresford T, Gomberg E, editors. *Alcohol and Aging*. New York: Oxford University Press; 1995. p. 19-41.
3. McInnes E, Powell J. Drug and alcohol referrals: are elderly substance abuse diagnoses and referrals being missed? *BMJ* 1994;308:444-6.
4. Wilsnack S, Wilsnack R. Drinking and problem drinking in US women: patterns and recent trends. *Recent Dev Alcohol* 1995;12:29-60.
5. Cox J. Smoking cessation in the elderly patient. *Clin Chest Med* 1993;14(3):423-8.
6. LaCroix A, Guralnik J, Berkman L, Wallace R, Satterfield S. Maintaining mobility in late life: smoking, alcohol consumption, physical activity and body mass index. *Am J Epidemiol* 1993;137:858-69.
7. Finlayson R, Hurt R, Davis L, Morse R. Alcoholism in elderly persons: a study of the psychiatric and psychosocial features of 216 inpatients. *Mayo Clin Proc* 1988;63:761-8.
8. Rosenberg H. The elderly and the use of illicit drugs: sociological and epidemiological considerations. *Int J Addict* 1995;30(13/14):1925-51.
9. Gomberg E. Medication problems and drug abuse. In: Turner F, editor. *Mental Health and the elderly*. New York: Free Press; 1992. p. 355-74.
10. Gomberg E. Older women and alcohol use and abuse. In: Galanter M, editor. *Recent developments in alcoholism. Alcoholism and Women*. New York: Plenum Press; 1995. p. 61-79.
11. Woods J, Winger G. Current benzodiazepine issues. *Psychopharmacology* 1995;118:107-15.
12. Smith J. Medical manifestations of alcoholism in the elderly. *Int J Addict* 1995;30(13/14):1749-98.
13. Finlayson R. Comorbidity in elderly alcoholics. In: Beresford T, Gomberg E, editors. *Alcohol and Aging*. New York: Oxford University Press; 1995. p. 56-69.
14. Blow F. Substance abuse among older adults. Rockville, Maryland: US Department of Health and Human Services; 1998. Report No.: DHHS Publication no: (SMA) 98-3179.
15. Welte J, Mirand A. Alcohol use by the Elderly: patterns and correlates: a report on the Erie County Elder Drinking Survey. Buffalo, New York: Research Institute on Addictions; 1992.
16. Adlaf E, Smart R. Alcohol use, drug use and well-being in older adults in Toronto. *Int J Addict* 1995;20(13/14):1985-2016.
17. Hendricks J, Johnson T, Sheahan S, Coons S. Medication use among older persons in congregate living facilities. *J Geriatr Drug Ther* 1991;6(1):47-61.
18. Gambert S, Katsoyannis K. Alcohol-related medical disorders of older heavy drinkers. In: Beresford T, Gomberg E, editors. *Alcohol and Aging*. New York: Oxford University Press; 1995. p. 70-81.
19. Roy W, Griffin M. Prescribed medications and the risk of falling. *Top Geriatr Rehabil* 1990;5(20):12-20.
20. Koenig H, Blazer DGI. Depression. In: Birren J, editor. *Encyclopedia of Gerontology: Age, Aging and the Aged*. San Diego, California: Academic Press; 1996. p. 415-28.
21. Conwell Y. Suicide in elderly patients. In: Schneider L, Reynolds C, Lebowitz B, Friedhoff A, editors. *Diagnosis and treatment of depression in late life*. Washington (DC): American Psychiatric Press; 1991. p. 397-418.
22. Orleans C, Jepson C, Resch N, Rimer B. Quitting motives and barriers among older smokers. *Cancer* 1994;74:2055-61.
23. Orleans C, Resch N, Noll E, Keintz M, Rimer B, Brown T, et al. Use of transdermal nicotine in a state-level prescription plan for the elderly. *JAMA* 1994;271:601-7.
24. Almeida O, Hulse G, Lawrence D, Flicker L. Smoking as a risk factor for Alzheimer's disease: contrasting evidence from a systematic review of case-control and cohort studies. *Addiction* 2002;97:15-28.
25. Pomara N, Stanley B, Block R, Berchou R, Stanley M, Greenblatt D, et al. Increased sensitivity of the elderly to the central depressant effects of diazepam. *J Clin Psychiatry* 1985;46:185-7.
26. Hendrie H, Gao S, Hall K, Hui S, Unversgt F. The relationship between alcohol consumption, cognitive performance and daily functioning in an urban sample of older black Americans. *J Am Geriatr Soc*. 1996;44:1158-65.
27. Blazer D, Hughes D, George L. The epidemiology of depression in an elderly community population. *Gerontologist* 1987;27:281-7.
28. Finlayson R. Misuse of prescription drugs. *Int J Addict* 1995b;30(13/14):1871-901.

29. Hurt R, Finlayson R, Morse R, Davis L. Alcoholism in elderly persons: Medical aspects and prognosis of 216 patients. *Mayo Clin Proc* 1988;63:753-60.
30. Barry K, Blow F. Screening and assessment of alcohol problems in older adults. In: Lichtenberg P, editor. *Handbook of Assessment in Clinical Gerontology*: John Wiley & Sons Inc; 1999. p. 243-69.
30. National Health and Medical Research Council. *Alcohol: Australian guidelines for consumption*; 2001.
31. Blow F, Brower K, Schulenberg J, Demo-Dananberg L, Young J, Beresford T. The Michigan alcoholism screening test. Geriatric version (MAST-G): A new elderly-specific screening instrument. *Alcohol. Clin Exp Res* 1992;16:372.
32. Ewing J. Detecting alcoholism: the CAGE questionnaire. *JAMA* 1984;252:1905-7.
33. Babor T, de la Fuente J, Saunders J, Grant M. AUDIT: The alcohol use disorders identification test: guidelines for its use in primary health care. Geneva: World Health Organisation; 1992.
34. Morton J, Jones T, Manganaro M. Performance of alcoholism screening questionnaires in elderly veterans. *Am J Med* 1996;101:153-9.
35. Cartensen L, Rychtarik R, Prue D. Behavioral treatment of the geriatric alcohol abuser. A long-term follow-up study. *Addict Behav* 1985;10:307-11.
36. Schonfeld I, Dupree I. Treatment approaches for older problem drinkers. *Int J Addict* 1995;30:1819-42.
37. Fleming M, Barry K, Manwell L, Johnson K, London R. Brief physician advice for problem alcohol drinkers: A randomized controlled trial in community-based primary care practices. *JAMA* 1997;277:1039-45.
38. Ockene J, Kristeller J, Goldberg R, Ockene I, Merriam P, Barrett S, et al. Smoking cessation and severity of disease: the coronary artery smoking intervention study. *Health Psychol* 1992;11:119-26.
39. Simon J, Solkowitz S, Carmody T, Browner W. Smoking cessation after surgery: a randomized trial. *Arch Intern Med* 1997;157:1371-6.
40. Miller W, Sanchez V. Motivating young adults for treatment and lifestyle change. In: Howard G, Nathan P, editors. *Alcohol use and misuse by young adults*. South Bend: University of Notre Dame Press; 1994.
41. Liskow B, Rinck C, Campbell J, DeSouza C. Alcohol withdrawal in the elderly. *J Stud Alcohol* 1989;50:414-21.
42. Brower K, Mudd S, Blow F, Young J, Hill E. Severity and treatment of alcohol withdrawal in elderly versus younger patients. *Alcohol Clin Exp Res* 1994;18:196-201.
43. Grant I. Alcohol and the brain: neuropsychological correlates. *J Consult Clin Psychol* 1987;55:310-24.
44. Smith D, Atkinson R. Alcoholism and dementia. In: Gurnack A, editor. *Older adults' misuse of alcohol, medicine and other drugs. Research and practice issues*. New York: Springer; 1997. p. 132-58.
45. Brown S, Inaba R, Gillin J, Shuckit M, Stewart M, Irwin M. Alcoholism and affective disorders: clinical course of depressive symptoms. *Am J Psychiatry* 1995;152:45-52.
46. Liberto J, Oslin D. Early versus late onset of alcoholism in the elderly. *Int J Addict* 1995;30:1799-818.
47. Oslin D, Liberto J, O'Brien J, Krois S, Norbeck J. Naltrexone as an adjunctive treatment for older patients with alcohol dependence. *Am J Geriatr Psychiatry* 1997;5:324-32.
48. Booth B, Blow F, Cook C, Bunn J, Fortney J. Age and ethnicity among hospitalized alcoholics: a nationwide study. *Alcohol: Clin Exp Res* 1992;16:1029-34.
49. Stinson F, Dufour M, Bertolucci D. Alcohol-related morbidity in the aging population. *Alcohol Health Res World* 1989;13:80-7.
50. Raschko R. "Gatekeepers" do the casefinding in spokane. *Aging* 1990;361:38-40.

Correspondence: Gary Hulse

Department of Psychiatry & Behavioral Science, Queen Elizabeth Medical Centre, Nedlands, Western Australia 6009
Fax: (+61) (9) 9346-3828 – E-mail: ghulse@cyllene.uwa.edu.au