
IAS Factsheet

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The WHO Charter has been signed by all the Member States of the EU, including the UK.

The World Health Organization's European Charter on Alcohol states the following:

"All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care."

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The Size of the Problem

A recent government health survey found that 1 to 5 per cent of elderly people who drank more than occasionally were 'problem drinkers', reporting significant psychological and/or physical dependence on alcohol.

Other studies have found higher proportions of elderly problem drinkers, especially in men. One found 5 - 12 per cent of men in their 60's to have alcohol problems.

Another possible measure is the proportion of older people exceeding government recommended "sensible limits" for regular consumption, although there is a question as to whether the limits are appropriate for the elderly, as they are based on evidence relating to younger age groups. Older people may be more vulnerable to the effects of alcohol - see below.

The 1994 General Household Survey found that in those aged 65 and over, 17% of men and 7% of women exceeded the 'sensible limits' of regular consumption i.e. around 1 in 6 men and 1 in 14 women. These are relatively high proportions of those who drink regularly, given that in this age group, 28% of men and 55% of women consume less than one drink per week or are non-drinkers.

Changing Patterns of Consumption

Generally, alcohol consumption declines with age and the proportion of non-drinkers increases. The reasons for this decline in consumption are presumably connected to changes in life circumstances and attitudes and, in the later middle aged and older, growing ill health.

There is evidence that today's population of elderly people may be relatively heavier drinkers than previous generations. This could be the result of an effect whereby a generation which has had its formative years at a time of high social availability and acceptability of alcohol may be more likely to retain the habit of drinking. Higher levels of disposable income in retirement could also be a factor. Certainly, drinking surveys suggest that since 1984, in both men and women aged 45 to 65 and over the proportions of those exceeding the 'sensible limits' have been rising steadily.

In regard to the number of elderly problem drinkers, another factor is simply that due to longer life expectancy and the ageing of the population there are more elderly people. In 1991 there were 10.6 million people of pensionable age, a rise of 16 per cent since 1971. It is projected that there will be a further increase of 38 per cent, with 14.6 million people

of pensionable age by the year 2031 in the United Kingdom.

Health benefits of alcohol

While there appears to be a rising incidence of problem drinking in the elderly, there are also reports that low risk drinking may provide benefits to older populations. Indeed, arguably most of the supposed benefits of alcohol consumption are to be found in older people. So, for example, the claimed protective effect of alcohol in regard to cardiovascular disease applies to the late middle aged and elderly. For this reason, the recommended optimum level of alcohol consumption for health is higher for the elderly than the young. (See IAS factsheet Alcohol – what is problem drinking?)

As well as medical benefits, there are also reports that low to moderate alcohol consumption may be associated with better cognition, psychological wellbeing and improved quality of life in elderly populations. However, there are difficulties of interpretation in relation to such studies, such as whether alcohol is truly the cause of the benefits, or whether they actually derive from, for example, higher levels of social interaction with which alcohol may be associated.²

Elderly Drinkers

Three ‘types’ of elderly drinkers have been identified:

Early-Onset drinkers or ‘Survivors’ are those people who have a continuing problem with alcohol which developed in earlier life. It is thought that two thirds of elderly problem drinkers have had an early onset of alcohol misuse. However, because of the health risks connected to heavy drinking and dependence on alcohol, the chances of reaching old age are reduced - one estimate is that the life span of a problem drinker may be shortened by on average ten to fifteen years.

Late-Onset drinkers or ‘Reactors’ begin problematic drinking later in life, often in response to traumatic life events such as the death of a loved one, loneliness, pain, insomnia, retirement etc.

Intermittent or Binge drinkers use alcohol occasionally and sometimes drink to excess which may cause them problems. It is thought that both the late-onset drinkers and the intermittent or binge drinkers have a high chance of managing their alcohol problem if they have access to appropriate treatment such as counseling and general support.

Reasons For Drinking - How Older People May Use Alcohol

Disruption of lifestyle such as retirement and decreased social activity, are thought to be some of the main contributory factors among people who develop a problem with drinking later in life. Isolation and loneliness in old age can lead to increased drinking. Coming to terms with illness and pain which might accompany old age can mean that people use or start to use alcohol as an anaesthetic - this may also be seen as a way of justifying the drinking.

People may use alcohol to help them sleep, especially if they are experiencing some sort of physical or emotional distress. However, although alcohol in small quantities may aid sleep, in larger quantities it can itself cause disturbed sleep patterns and wakefulness during the night.

Consequences Of Drinking For The Older Person

Tolerance to alcohol is significantly lowered in the elderly so it is possible that the same amount of alcohol can have a more detrimental effect than it would on a younger person. Elderly people are less tolerant to alcohol because of physical changes including:

- A fall in ratio of body water to fat - less water for the alcohol to be diluted in
- Decreased hepatic blood flow - liver will receive more damage
- Inefficiency of liver enzymes - alcohol will not be broken down as efficiently
- Altered responsiveness of the brain - alcohol will have a faster effect on the brain

It is therefore possible that the same amount of alcohol may produce a higher Blood Alcohol Concentration (BAC) in the elderly than younger people. Elderly car drivers are three times more likely to be involved in a motoring accident after consuming even a small amount of alcohol, than they are at a zero level of alcohol.

Alcohol depresses the brain function to a greater extent in older people, impairing co-ordination and memory, which can lead to falls and general confusion. It can also heighten emotions leading to moodiness, irritability or even violence. Alcohol in excess affects digestion, making it more difficult to absorb vitamins and minerals. However, a recent study conducted at Indiana University, found no evidence to indicate an association between moderate long-term alcohol intake and lower cognitive scores in ageing individuals. There was a suggestion of a small protective effect on cognitive functioning of past moderate drinking.

Interaction With Other Drugs

Prescribed medication taken in conjunction with alcohol can cause adverse side effects and generally, older people are advised not to drink when they are taking other drugs. Problems caused by using alcohol and other drugs concurrently may include a diminished effect of the drugs in an individual who drinks regularly and the increased sensitivity to drugs conferred by malnutrition and severe liver damage, for example cirrhosis. Alcohol in moderate amounts can depress the rate of drug metabolism so that the action of some drugs is exaggerated, such as benzodiazepines. Drugs which act on the central nervous system, such as diazepam (Valium), depress the rate of alcohol breakdown so that the effect of alcohol may be increased. Alcohol taken in conjunction with antidepressants such as Tofranil or Prothiaden may actually worsen the depression.

Sleep

Although alcohol is a brain sedative and promotes sleep, it actually reduces the amount of quality rapid eye movement (REM) sleep which we need to be fully rested and increases slow wave sleep. Its sedative effect lessens as the night progresses, arousal from sleep and continued wakefulness being likely to occur when the blood alcohol concentration approaches zero.

Like other people, the elderly may have recourse to alcohol and prescribed drugs to help them cope with stress, anxiety and depression. However, recent research has suggested that for some people alcohol, even in relatively moderate quantities, actually makes things worse, prolonging rather than reducing the problem.

The Diagnosis of Alcohol Problems in the Elderly

Ageing tends to be associated with a growing burden of disease and prolonged heavy drinking is itself a cause of health problems such as liver disease, raised blood pressure, and some forms of cancer. Alcohol misuse may also lead to an increased likelihood of falls, incontinence, cognitive impairment, hypothermia and self-neglect. These sorts of problems may be regarded by health professionals and members of the family merely as signs of ageing. The Royal College of Physicians suggest that as many as 60 per cent of elderly people admitted to hospital because of confusion, repeated falls at home, recurrent chest infections and heart failure, may have unrecognised alcohol problems.

Alcohol misuse can also be obscured by non-specific health problems such as gastrointestinal problems and insomnia, or misdiagnosed as dementia or depression. Health professionals may recognise and diagnose the secondary medical problem, but fail to combat the possible primary cause.

General Practitioners are usually the first medical point of contact for elderly people, but some doctors may fail to diagnose alcohol misuse in a population where there are other urgent medical matters and some believe that it may be better for the individual to continue in their established pattern of drinking as altering it could be harmful. Elderly patients may show reluctance at disclosing their alcohol intake and relatives may wish to hide the evidence of the misuse of alcohol and deny the existence of the problem. Appropriate screening measures are necessary in order to identify alcohol or other substance misuse among the elderly - and these measures need to be on going. It has been suggested that a full history of alcohol use should be taken at regular intervals, including questions about amounts taken in tea and coffee which patients may disregard as being irrelevant.

Alcohol Services For The Elderly

Treatment and counselling of older people needs to be based on assessment and matching of each person's needs to the range of treatment and services available. Emphasis needs to be placed on non-drinking social activities such as day centres and clubs in the context of the person's life circumstance and social support network – it may be necessary to work on redefining a social or family support mechanism. Some

specialists argue that there is a need for specific treatment programmes designed for older people as there is more likelihood of a higher success rate than if older people are treated within a mixed aged client group.

Alcohol and Older People Seminar

Together with Age Concern, on 8 December 2008 the Institute of Alcohol Studies held a seminar to consider alcohol issues relating to older people. A list of participants and copies of the following presentations can be found at

<http://www.ias.org.uk/resources/events/elderly/london081208.html>

Institute of Alcohol Studies
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References

¹ Sources:

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² Moderate alcohol consumption in older adults is associated with better cognition and well-being than abstinence – Lang, I; Wallace, R B; Huppert, F A; Melzer, D: Age and Ageing, March 12 2007 and A Drink to Healthy Aging: The Association between older women’s use of alcohol and their health-related quality of life – Byles, J; Young, A; Furuya, H; Parkinson, L: Journal of the American Geriatrics Society, 54:1341-1347, 2006