Substance Abuse in Later Life

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SUMMARY

Substance abuse affects an appreciable portion of the elderly population. Elderly people have characteristics that could hinder identification, diagnosis, intervention, and treatment of substance abuse. If physicians use strategies specific to the elderly, management is often successful.

RÉSUMÉ

L'abus de produits toxiques affecte une portion appréciable de la population âgée. Les personnes âgées ont des caractéristiques qui compliquent l'identification, le diagnostic, l'intervention et le traitement de l'abus de ces produits. Le traitement s'avère souvent une réussite lorsque le médecin fait usage de stratégies spécifiques aux personnes âgées.

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THE FIRST MENTION OF ELDERLY substance abusers as a distinct subgroup with definable characteristics occurs in 1964.[1] In 1968, Simon et al[2] studied the geriatric psychiatric population in a San Francisco general hospital and concluded that substance abusers constituted a substantial portion of the elderly mentally ill. During the 1970s, interest in this subject increased, and prominent researchers, such as Schuckit, documented the abuse of alcohol and other drugs by the elderly.[3-5]

Neither statistical evidence[6] nor anecdotal reports from treatment agencies indicate that the elderly in Canada use street drugs. The drugs, other than alcohol, that elderly people abuse are bought over the counter (eg, acetylsalicylic acid, antihistamines, and laxatives) and prescribed by doctors and clinics (eg, sedative-hypnotics, anxiolytics, and narcotics). Some literature[7] suggests that elderly populations in other countries abuse drugs, such as heroin.

The literature of the 1960s and 1970s raises issues that continue to concern us today. Often, caregivers do not perceive the possibility of substance abuse among the elderly or they do not perceive a reason for recognizing it. They could be confused about the definition of substance abuse or lack knowledge about appropriate diagnostic tools for the elderly. Physicians and other caregivers are often more accustomed to working with younger individuals and might have difficulty applying their knowledge to the specific needs of elderly substance abusers.

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Incidence and prevalence

Meta-analysis of research on alcohol abuse among the elderly, based on 18 studies from 1962 to 1976,[8] demonstrated enormous variation in the amount of substance abuse among the elderly. These studies of patients in the general population, on acute care wards, in long-term care facilities, in psychiatric wards, and in substance abuse treatment programs in the United States, Europe, and South Africa suggest prevalences ranging from 6% to 53%.

A Canadian study carried out by the Senior Citizen's Bureau in 1983[9] revealed that 2% to 10% of the ambulatory elderly, 6% to 20% of those in acute care settings, and up to 40% of veterans in care abused drugs. A recent survey of long-term care patients at a veterans' facility in Alberta revealed a prevalence of at least 43%.[10]

Alcohol abuse might not be of long standing. Abrahms and Alexopoulos[11] described elderly people who did not develop problem drinking until after they became elderly, although most elderly alcohol abusers enter later life with a long history of problem drinking. Saunders,[12] from her experience with the Community Older Persons Alcohol Program (COPA) in Toronto, estimated that one third of the elderly people who abuse alcohol are late onset abusers.

Evidence indicates that elderly people abuse drugs other than alcohol. Holder and Stefanson[13] report that older adults are more likely than younger people to abuse nonprescription drugs. They attribute this to self-medication for the effects of chronic illness, such as pain. Physiologic changes in the elderly make drugs last longer in their systems and have greater effects.[14]

Considerable evidence suggests that the elderly abuse prescription drugs. Elderly people use benzodiazepines more than any other age group,[15] and North American studies[16] demonstrate that 17% to 23% of drugs prescribed for the elderly are benzodiazepines. Their use in long-term care facilities is common.[17] Jinks[18] found that 5% of the elderly ambulatory population he studied were prescription drug abusers. In his study, the four drugs most commonly abused were diazepam, codeine, meprobamate, and flurazepam.

A prospective study at Saint Boniface Hospital in Winnipeg[19] demonstrated that men and women had significantly different patterns of drug abuse. Elderly women were found to abuse prescription drugs to a greater extent than men. Women made up 73.3% of prescription drug abusers. Elderly men, on the other hand, abused alcohol to a greater extent, comprising 65.4% of the alcohol abuse group.

Characteristics

In Canada, the first documented study of substance abuse in later life was done by Dr Sarah Saunders of the Addiction Research Foundation of Ontario on patients in a nursing home in Toronto between 1973 and 1981.[20] As a result of her research, Saunders generated a profile[12] of older problem drinkers that described them as people subject to:

- multiple medical problems,
- malnutrition,
- increased incidence of accidents and injuries,
- isolation and loneliness,
- problems with the activities of daily living,
- having TV as an only interest,
- refusing to leave home,
- depression,
- gross neglect of self and home, and
- inappropriate behaviour.

Saunders has influenced almost every agency in the field in Canada, including the two agencies in Calgary: the Substance Abuse in Later Life (SAILL) team at the South Alberta Regional Geriatric Center and the CAAPS Project (Committee on Alcohol Abuse Prevention by Seniors) in the downtown core, run largely by Isobel Hardock.

Hardock studied 19 elderly men in Calgary (personal communications from Hardock I. *A lifestyle survey of alcoholic men.* Calgary, 1989). Her findings illustrate these patients' disengagement from caregivers, neglect of basic instrumental needs, and perceived lack of motivation for change. About two thirds of the group reported that they were alienated from their families. They seemed to be similarly disengaged from professional caregivers because, although they were impaired in a variety of ways, they received remarkably few home services of any kind: 63% had never received any home services; 15% had home services discontinued due to problem behaviour associated with alcohol abuse; and 22% discontinued the services themselves-often because of imposed restrictions on their lifestyle incompatible with alcohol abuse (they had to be at home, on time, sober).

The population studied by Hardock frequently did not go out of their homes to obtain needed services either (21% of this sample required some type of medical care, but did not receive it). Of the 14 patients who did take prescription medications, eight were judged to be compliant, four did not take their medications (three of these four were noncompliant because they stated that it might affect alcohol use), one patient took a friend's medication, and one patient could not say

Table 1. **Reasons advanced by nursing staff for not treating alcoholic patients**

- Lack of knowledge of appropriate interview techniques or of available treatment
- Confusion over treatment models or language (and therefore diagnosis)
- Personal issues, including fear of losing patients from treatment after confrontation
- Viewing alcohol as a beneficial means of escape from an unpleasant reality

with any certainty whether he complied with medications or not.

The issue of noncompliance raises the problem of cognitive impairment, which affects memory and therefore complicates assessment[21] both for diagnosis and treatment. Simple matters, such as assimilating advice, remembering appointments, and complying with medications, all depend on the degree of cognitive impairment. While neuropsychologic deficits might improve if patients moderated or stopped their drinking, ample evidence shows that impairment often persists even when drinking stops.[22] Blazer et al[23] report an incidence of cognitive deficit of 57% in "current elderly alcoholics." Finlayson et al[24] studied 216 elderly inpatients being treated for alcohol abuse and reported a 46% incidence of organic brain syndromes.

Table 2. **The CAGE test**

C	Have you ever felt the need to *cut* down on your drinking?
A	Has anyone ever *angered* you by criticizing your drinking?
G	Have you ever felt *guilty* over consequences of drinking?
E	Have you ever had an *eyeopener* (morning drink)?

Hardock also demonstrated what the Canada Health Survey[25] indicated: that elderly people's network of drinking companions shrinks as they age. In 68% of her sample, drinking was done at home, usually alone. When alcohol was consumed outside the home, 47% of the time it was consumed in the Royal Canadian Legion, 26% of the time in other similar private clubs, and only the remaining 27% of the time in public lounges and private residences.

Diagnosis

Diagnosing substance abuse in later life is often difficult. Problems arise from issues involving health care professionals, family and other caregivers, and patients themselves.

A study reported by Gaillard and Perrin in 1969[26] revealed that 57% of physicians surveyed believed that it was impossible, difficult, or very difficult to change the pattern of drinking of elderly residents under their care. There is reason to believe that time has not affected this prejudice. A study published in 1989[27] found that hospital house staff identified only 30% of patients older than 60 who met the criteria for alcoholism (compared with 60% of younger alcoholics). Elderly women were diagnosed less frequently than elderly men. When the diagnosis was made, treatment was less likely to be recommended for the elderly.[28] Even in those cases where treatment was recommended, it was less likely to be initiated for an elderly person (*Table 1*).

Nevertheless, recent literature on geriatric assessment by health care personnel now recognizes that substance use and abuse are appropriate subjects for assessment and counseling.[29]

Families also have been found to have difficulty recognizing substance abuse and sometimes ignore the seriousness of alcohol abuse among their older members.[4] Merril et al[30] discussed various reasons that families avoid dealing with the problem. They might not appreciate the risk of mortality or other serious consequences and therefore might not see any reason to part the elderly patient from his or her "last pleasure." Families of late onset substance abuse patients often ascribe falls, cognitive impairment, and incontinence to aging or disease processes, preferring a parent with Alzheimer's disease to an alcoholic.

If the substance abuse is of long standing, family members could be alienated with a long history of anger and frustration. They might seek to institutionalize the elderly patient in an attempt to control the substance abuse.[31]

Denial on the part of elderly patients also interferes with diagnosis. Giordano and Beckham[32] relate that the elderly have a greater tendency to deny substance abuse than younger age groups do. Saunders et al[33] reported that elderly patients deny, minimize, or even defend their abuse. Hardock found in her study that 58% of her subjects denied any substance abuse problem; the other

42% expressed no hope of improvement. In the study of Blazer et al,[23] 52% of the elderly alcoholics reported that they "wanted to quit, but couldn't."

Graham[21] also notes greater denial among the elderly and lists additional problems in establishing a diagnosis. The consequences of alcohol abuse can be quite different for the elderly from those for younger people; the elderly probably do not have jobs, driver's licences, or marriages to lose. The consequences likely to occur can be easily mistaken for common problems of aging, such as memory loss, incontinence, falls, and loss of friends.

Elderly people often appear isolated; their substance abuse can be hidden because no one is readily available to observe them. Experience with the SAILL program in Calgary reveals, however, that patients are not constantly isolated over time. Information can be obtained from residence managers, estranged family or friends, disengaged health care workers, and hospital medical records. Such information helps to overcome obstacles to diagnosis, such as denial.

After surmounting the difficulties of gathering pertinent information in this context, physicians must then use appropriate definitions and diagnostic tools to clarify the diagnosis. The American Society of Addiction Medicine (ASAM)[34] defines substance abuse as a biopsychosocial disease characterized by loss of control, with escalating use and resulting consequences and preoccupation with obtaining and using the substance. For the elderly this definition has the advantage of being equally applicable to alcohol abuse, prescribed drug abuse, and multiple drug use.

One of the most commonly used diagnostic tools for applying this definition is the Michigan Alcohol Screening Test (MAST).[35] The MAST is not specific to the elderly in that it has questions aimed at younger individuals concerning such matters as jobs. In Canada, interest has focused on briefer tools, such as the Trauma Scale,[36] and especially the CAGE test (*Table 2*).[37] The Elders Health Project in Winnipeg used both the MAST and CAGE tests to screen for substance abuse among elderly patients in the outpatient department of St Boniface Hospital.[19] They found that all patients who tested positive on the MAST test also had positive results on the CAGE test. Another recent study[38] of the CAGE test, done in the United States, concluded that it could reliably detect elderly individuals with alcohol problems.

Treatment

The first issue in effective treatment is appropriate intervention, tailored to the specific elderly person and his or her environment. The Elders Health Project in Winnipeg has defined three levels of intervention for elderly patients with substance abuse problems.[39]

The first is a nonconfrontational expression of concern. This could include a suggestion that the patient seek help. This intervention is usually done by a family member with the support and guidance of a physician. However, the physician might be the only person sufficiently engaged with the patient to offer this intervention.

The second level of intervention confronts the patient in a compassionate manner with the consequences of substance abuse. The patient is advised of options for dealing with the problem and encouraged to choose one. Then he or she is helped to carry out the chosen treatment. This intervention can be undertaken by family or professional caregivers, including physicians.

In the third and most confrontational level of intervention, a group of family members and other people significant to the patient are coached and rehearsed by someone with training in this type of confrontation. The group then meets with the elderly patient, confronts him or her with evidence of substance abuse, requests compliance with a specified treatment regimen, and cites consequences if the patient refuses.

It has been my experience with the SAILL program that a level 3 confrontation can be successful if the patient perceives a need for something that the confrontors are in a position to provide. Often the elderly are no longer affected by the "levers" that are used to negotiate with younger people (spouses, jobs, driver's licences). Finding the appropriate lever for an elderly person takes a good knowledge

Table 3. **Approaches for elderly substance abusers**[42]

- DO ask about alcohol, over-the-counter drugs, and other substance use as you would other important issues when taking the history.
- DO request specific information about frequency and amounts of substances consumed.
- DO develop a nonjudgmental, friendly but persistent approach.
- DO NOT stigmatize or use labels.

Data from Devenyi and Saunders.[42]

of the person and his or her situation (eg, an elderly person with a drinking problem might be faced with a choice of abstaining or having visits with grandchildren stopped).

If intervention is successful, decisions about a particular course of treatment must be made.

Traditional inpatient treatment programs are widely available in Canada but are often unsuitable for the elderly.[12] Traditional programs require that a patient acknowledge a problem with the use of alcohol, have the desire to change his or her lifestyle, and be totally abstinent. Traditional treatment program content could be inappropriate because it focuses on younger people's motivational factors, feelings, and problems. Programs often do not consider chronic disabilities, such as hearing loss, a slowed pace, or difficulties with activities of daily living.

Substance abuse counselors frequently feel frustration, anger, and impatience when they deal with the elderly.[30] Elderly patients often move and think slowly, but counselors feel pressed to engage, assess, and treat them at the same rate as younger patients.

However, when traditional treatment programs are tailored to the elderly, superior treatment compliance[40] and success in outcome[24] ensue. Elderly-specific treatment programs do exist in Canada; in Alberta, there is O'Meara Lodge. Generally, patients with any significant medical, cognitive, or functional problems cannot be admitted to such a facility. Even a patient who requires a cane might be disqualified from such a program.

An alternative to traditional treatment was advanced by Zimberg.[41] He noted the marked tendency toward isolation in the elderly population, by which he meant a lack of family, social, and general contact. Treatments aimed at this perceived isolation have been termed "social model" treatments and have greatly influenced the development of programs for the elderly.

In Canada, Saunders and colleagues have used a social model to provide effective treatment for patients without removing them from their homes.[33] First, problems that interfere with improvement are identified by means of a global assessment of medical, functional, and psychosocial issues (*Table 3*[42]). Then a treatment plan is devised to remove the identified impediments to progress and develop healthy alternatives to substance use. The plan attempts to ensure appropriate medical care, compliance with medications, and proper nutrition; reduce isolation; and develop or improve leisure management skills.

As the treatment plan proceeds, the patient is encouraged to identify a link between substance use and its consequences. Such treatment plans have been shown to reduce substance use and associated problem behaviour.[43] ■

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