Drug and alcohol referrals: are elderly substance abuse diagnoses and referrals being missed?

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Abstract

Objective—To examine the diagnosis of problem substance use in hospital inpatients aged 65 years and over and their referral to drug and alcohol services by medical staff.

Design—Questionnaire to registrars or house officers caring for patients 65 years of age and over with problem substance use.

Setting—3 hospitals in New South Wales, Australia.

Subjects—Medical staff caring for 263 inpatients.

Results—Medical staff did not recognise substance misuse in older hospital patients and did not seem to be aware of current recommendations of the National Health and Medical Research Council recommendations for safe use of alcohol and benzodiazepines. Three out of 88 problem users of benzodiazepines, 29 out of 76 smokers, and 33 out of 99 problem drinkers were identified by medical staff. Of those identified with problems, 2 benzodiazepine users, 6 smokers, and 19 drinkers were considered for referral to drug and alcohol services.

Conclusions—Greater awareness of recommendations for dealing with problem use of benzodiazepines and alcohol needs to be promoted among medical staff, along with an increased emphasis in medical education on substance use as a potentially important problem for older people. Drug and alcohol services also need to promote a broader role, particularly in regard to early intervention in a hospital setting for older patients.

Introduction

Problems can arise from several types of drug use among older people. These include polypharmacy, long term use of psychotropic drugs, smoking tobacco, hazardous use of alcohol, and the consumption of alcohol and other drugs in unsafe combinations.¹⁻⁶

Health professionals often fail to identify drug problems in old people. Reasons for this may be that drug use can be obscured by non-specific health problems (such as insomnia or gastrointestinal complaints) or misdiagnosed (for example, as depression or dementia)⁷⁻⁹ or that substance misuse by older people is likely to involve small but relatively frequent doses.¹⁰ A lack of awareness of substance use as a potentially important problem for older people, reluctance to ask potentially embarrassing questions of older people, failure accurately to record drug histories, and disinclination to take any action with regard to older people's drug use may also impede identification of this problem.¹¹

Method

The present study was part of a large survey of use of tobacco, alcohol, and drugs by inpatients aged 65 years and over in three hospitals in New South Wales. Part one of the aim of the study was to assess identification rates by medical staff of problem substance use among elderly inpatients and to assess whether those identified as problem users were considered for referral to the hospital drug and alcohol service.

The main study, conducted in 1991, used a cross sectional design, randomly sampling hospital inpatients aged 65 and over in three hospitals from daily admission lists.¹² About 4450 people aged 65 and over are admitted to the selected hospitals each quarter. A sample of 640 was considered adequate to conduct a test of proportion on this population.¹³

The patients were interviewed face to face at the bedside by trained interviewers after admission to hospital. Patients were asked about the frequency, quantity, and duration of use of benzodiazepines, tobacco, and alcohol; a standardised questionnaire, which had previously been piloted was used. The questionnaire also included questions about use of over the counter drugs, daily diet, and living conditions. Interviewers introduced themselves as being from the drug and alcohol unit and informed each subject that the hospital was conducting a study of substance use in older people.

For current smokers or people taking benzodiazepines or alcohol, or both, in excess of recommendations for safe use, the treating medical officer (either a registrar or house officer) was interviewed after the patient had been admitted to the ward and a history of substance use had been obtained by the medical officer; a short, standardised questionnaire was used.

Guidelines from the Australian National Health and Medical Research Council were used by the interviewers as criteria for harmful or hazardous use of alcohol and benzodiazepines.^{14,15} Hazardous alcohol use was defined as an intake of 40–60 g/day for men and 20–40 g/day for women; harmful use as >60 g/day for men and >40 g/day for women. Hazardous use of benzodiazepines was defined as use for periods of more than 2–4 weeks and harmful use was defined as use in excess of the recommended length of time coupled with drug seeking behaviour, withdrawal symptoms, or overdose as defined by DSM III-R.¹⁶ Any use of tobacco was classified as harmful as there is no recognised safe level of tobacco consumption.¹⁷

The staff questionnaire had been piloted among a random sample of staff and was designed to elicit medical staff's opinions on problem use among subjects under their care. Specifically, it asked whether or not the subject was considered to have problem use of drugs, alcohol, or cigarettes and, if so, whether this warranted referral to the hospital's drug and alcohol service.

Each hospital had access to the services of a drug and alcohol unit. In Sydney, the drug and alcohol service was located within the hospital and consisted of medical officers, clinical psychologists and clinical nurse specialists, and consultants. In the other areas the drug and alcohol services were located away from the hospital site. In one region the service consisted of counsellors with nursing or clinical psychology backgrounds and inpatients could be referred to the service. In the other region, at the time data collection took place, a drug and alcohol counselling service for hospital patients conducted by a clinical nurse consultant was being established; patients could be referred to the service after hospitalisation for drug and alcohol counselling. Doctors with drug and alcohol training,

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attached to the regional services, were not available.

As doctors typically had a substantial patient load, to refresh their memories they could consult medical case notes containing histories of substance use taken by medical staff at admission. Medical staff's rates of identification were then compared with those of the researchers, and whether the patient was considered for referral to the drug and alcohol services was noted. Replies were anonymous, and follow up of patients to see if referral to drug and alcohol services occurred was not possible. The statistical package for the social sciences (SPSS-PC version 4) was used for analysis.

Results

A total of 57 (9%) patients selected into the main study either refused to participate or were considered by ward staff too ill, incapacitated, or confused to participate. Nine of these (14%) had recorded histories of recent problem use of alcohol or tobacco.

Out of 640 subjects, researchers classified 263 problem users, excluding psychiatric patients and intermittent users of benzodiazepines. The medical staff for each of these patients were interviewed either by telephone or face to face with the same standardised questionnaire. Only one doctor refused to participate.

PROBLEM USE OF BENZODIAZEPINES

Eighty eight subjects were hazardous or harmful users of benzodiazepines and had taken these drugs for periods ranging from six months to 20 years. Table I shows that only three out of the seven harmful users and no hazardous users were identified by ward doctors. Referral to drug and alcohol services was thought to be warranted in two cases; the other was "managed at ward level."

PROBLEM USE OF TOBACCO

Of the 76 patients identified by researchers as engaging in harmful tobacco use, 29 (38%) were similarly identified by ward doctors (table I). A median of 17 cigarettes (range 1-50) was consumed by these subjects.

Table II shows that the group of smokers most likely to be diagnosed with harmful tobacco use is men aged 65-74, although the small numbers in some cells suggests that caution should be exercised in drawing conclusions. Those most likely to have their smoking disregarded would be older women. In every group,

TABLE I—Diagnosis of problem substance use in older men and women. Values are numbers (percentages of those identified by researchers)

	Alcohol	Benzodiazepines	Tobacco	Total
Harmful use:				
Identified by researchers	51	7	76	134
Identified by medical staff	29 (57)	3 (43)	29 (38)	62 (46)
Hazardous use:				
Identified by researchers	48	81		129
Identified by medical staff	4 (8)	0		4 (3)
Total:				
Identified by researchers	99	88	76	263
Identified by medical staff	33 (33)	3 (3)	29 (38)	66 (25)
Intervention	19 (19)	2 (2)	6 (8)	27 (10)

TABLE II—Diagnosis and intervention in harmful and hazardous use of tobacco and alcohol in older men and women. Values are numbers (percentages of those identified by researchers)

	Men		Women	
	65-74	≥75	65-74	≥75
Tobacco use:				
Identified by researchers	35	12	20	9
Identified by medical staff	16 (46)	4 (33)	8 (40)	1 (11)
Intervention	4 (11)	2 (17)	0	0
Alcohol use:				
Identified by researchers	60	19	14	6
Identified by medical staff	20 (33)	6 (32)	5 (36)	2 (33)
Intervention	15 (25)	2 (11)	1 (7)	1 (16)

Clinical implications

- More than 41% of hospital inpatients aged 65 years and over were found to use tobacco, benzodiazepines, and alcohol in excess of recommended safe limits
- Medical staff diagnosed 25% of problem users and considered only 10% of problem users for referral to drug and alcohol services
- These findings confirm the claim often made that older people who use drugs in hazardous or harmful ways tend to elude clinical attention
- Greater awareness of recommendations for safe use of tobacco, benzodiazepines, and alcohol and the role of hospital drug and alcohol teams needs to be promoted in a hospital environment

fewer than half of the problem smokers were identified as such. Intervention was considered appropriate for six men but no women.

PROBLEM USE OF ALCOHOL

The researchers identified 99 patients as problem users of alcohol. Four (8%) of those identified by the researchers as hazardous alcohol users and 29 (57%) cases of harmful alcohol use were identified by medical staff (table I). Table II shows doctors' diagnoses by sex and age. About a third of the cases in each group identified by the researchers were diagnosed by doctors.

Nineteen problem drinkers, including one hazardous drinker, were considered in need of referral to drug and alcohol services. Men aged 65-74 were more likely to be considered for referral.

There was also a regional effect in the diagnosis of problem alcohol use, with medical staff at the city hospital being more likely to diagnose problem use, (25 (39%) v 5 (25%) and 3 (20%) in the other hospitals) but the total numbers were too small to draw any firm conclusions.

Discussion

In this study a high percentage of elderly substance users were missed and intervention was unlikely. Overall, hospital medical staff diagnosed 25% of problem users and considered referring only 10% to drug and alcohol services (table I). There was no evidence of a change in problem identification of problem users during the study period—the rates of diagnosis and potential referrals remained low.

Several factors may hinder identification of substance misuse in older people. Firstly, medical staff may perceive their role to be one of diagnosing and treating only conditions related to admission, with long term use of benzodiazepines, alcohol, and tobacco being seen as a matter for general practitioners. Secondly, attitudes of hospital staff may have militated against intervention.¹¹ Some staff indicated a belief that to advise older people to give up established habits is inappropriate. Thirdly, history taking regarding drug use may be truncated or less accurate in older people with a multiplicity of health problems and perceptual impairment.¹¹ Fourthly, doctors' diagnoses may be influenced by the availability of specialist advice and treatment. This may account for the higher identification rates of problem alcohol use in the city hospital, where the drug and alcohol service is part of the medical establishment.

Drug and alcohol services need to educate hospital staff about current recommendations regarding safe use of substances. A hospital based drug and alcohol counsellor assigned to work specifically with older

hospital inpatients may also promote identification and referral of substance misusers. Regular medical audits of histories of substance use as a method of quality control may also improve rates of identification and referrals.

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Low blood pressure and depression in older men: a population based study

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Abstract

Objective—To determine if an association exists between low blood pressure and depressive symptoms in older men living in the community.

Design—Cross sectional, population based study.

Setting—Town of Rancho Bernardo, California, United States.

Subjects—846 men aged 60-89 years. Comparisons between hypotensive, normotensive, and hypertensive groups were limited to 594 men not taking drugs for hypertension.

Main outcome measures—Mean scores on Beck depression inventory and prevalence of scores ≥ 13 .

Results—Men with diastolic blood pressure < 75 mm Hg had significantly higher depression scores (mean scores 6.35 v 4.96 ; $P < 0.001$) and more categorical depression (7.6% v 1.8% with scores ≥ 13 ; $P < 0.01$) than men with diastolic blood pressure levels between 75 and 85 mm Hg. Men with diastolic blood pressure levels > 85 mm Hg had higher depression scores than men with intermediate blood pressure levels (mean scores 5.85 v 4.96 ; $P < 0.05$). Men with diastolic hypotension scored significantly higher on both affective and somatic item subscales of the Beck depression inventory and on individual measures of fatigue, pessimism, sadness, loss of appetite, weight loss, and preoccupation with health. Low diastolic blood pressure was a significant predictor of both mean depression score and prevalence of categorical depression, independent of age and change in weight since the baseline visit. The presence of several chronic diseases was associated with depressed mood and higher blood pressure but not with low blood pressure.

Conclusion—The association of relatively low diastolic blood pressure with higher depressive symptom scores and rates of categorical depression was independent of age or weight loss. Since fatigue is a prominent symptom of depression, any association of low blood pressure with fatigue could reflect depressive disorders or clinically important depression.

Introduction

The dangers of high blood pressure are well recognised, but the clinical importance of low blood pres-

sure is controversial. Several recent large studies reported an increased prevalence of fatigue, crying, or psychological dysfunction associated with low blood pressure.¹⁻³ Although a hypotensive syndrome manifested by subjective symptoms has been accepted in Europe, it has been dismissed in the United Kingdom and United States.^{4,5}

Depressive symptoms have been described in hypertensive subjects and have been variously ascribed to antihypertensive drugs or the effect of labelling of patients.^{6,7} To our knowledge no one has previously used a standard depression inventory to study the relation of depressive symptoms to low blood pressure in a population. We report here a cross sectional study of low blood pressure, depression, fatigue, and other somatic complaints in 594 older men living in the community.

Methods

In 1972-4, 82% (5052) of 6155 eligible adult residents of Rancho Bernardo, California, a geographically defined community, participated in a baseline evaluation which included a measurement of weight with subjects wearing light clothing and no shoes. The population is stable, white, and relatively homogeneous for social class and education. In 1984-7, all 1070 surviving non-institutionalised men aged 60 and older were invited to a clinic visit; 79% participated, and these 846 men form the basis of this report.

Participants completed a standardised medical questionnaire, which included questions about cigarette smoking, alcohol use, and exercise. Each subject was asked whether he had ever been diagnosed as having or had been treated for any of 17 common conditions (heart disease; high blood pressure; lung, liver, kidney, gallbladder, or prostate disease; cancer; arthritis; gall stones; thyroid disorders; stomach or duodenal ulcers; diverticulitis; emphysema; chronic constipation; stroke; or hip fracture). Current use of drugs was recorded by a trained interviewer and validated by drugs and prescriptions brought to the clinic for that purpose. Weight was measured according to the same protocol used at baseline. Blood pressure was measured twice by technicians certified for the hypertension and detection follow up programme protocol,⁸ using a standard sphygmomanometer in seated resting

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