

Alcohol and drug problems among older persons

Sir, we agree that the proportion of older persons in the UK who consume alcohol at a hazardous or harmful level is set to increase. Clearly the identification of such persons and the subsequent offer of an intervention to reduce harms and/or consumption should be a priority for clinicians. Although the Royal College of Physicians report (1) recommends that General Practitioners adopt the Geriatric version of the Short Michigan Alcohol Screening Test, our own experience of integrating alcohol screening into the new patient registration process (2) suggest that such changes to routine practice are difficult to implement. Recent guidance from the Department of Health (3) offers local commissioners an incentive based opportunity to encourage General Practitioners to increase their alcohol screening activity, with the AUDIT (both short and full versions) stated as the screening tool to be applied to all new patient registrations.

Many GP practices offer a "health check-up" to all their registered patients upon the occasion of their 65th birthday. We suggest that this could also be an ideal opportunity to assess the alcohol consumption of these patients, and that as practices may well be familiar with the AUDIT, that this is the screening tool employed.

The AUDIT is not specifically designed for use on a population of older drinkers. We know that both physiological changes and concurrent medication use by this population can interact with alcohol consumption (even at lower dosages than recommended by the Department of Health (4)), and as such the AUDIT may not reliably identify older hazardous and harmful drinkers. Specialist screening tools such as the ShARPS (5) have been specifically designed for use in an older population, however the addition of yet another questionnaire may not be well received by the busy practitioner.

We suggest that some modification to the cut-off points for the AUDIT may offer a useful method to improve the detection of alcohol misuse among older people. We recently conducted a pilot study to determine the optimal AUDIT score that had the best concordance in terms of sensitivity and specificity with the ShARPS. From a small sample of 32 patients aged over 65 years, who completed both instruments in the waiting area of a London clinic, we found that using a cut-off of 4+ on the AUDIT (rather than the 8+ recommended for the wider population) had a sensitivity of 0.80 and specificity of 0.93. Clearly these results are based on a small sample and need to be replicated as part of a larger study, however they do suggest that by lowering the cut-off for older patients the AUDIT can be used to effectively identify hazardous and harmful drinkers who would otherwise have not been detected.

(1) Royal College of Psychiatrists. Our invisible addicts. First report of the older persons' substance misuse working group of the Royal College of Psychiatrists College. 2011.
www.rcpsych.ac.uk/files/pdfversion/CR165.pdf.

(2) Kaner E. et al. (2009). Screening and brief interventions for hazardous and harmful alcohol use in primary care: a cluster randomised controlled trial protocol. BMC Public Health 2009, 9:287

(3) Primary Medical Services (Directed Enhanced Services) (England) (Amendment) Directions 2011. Department of Health, London, 2011

(4) Sensible drinking: Report of an inter-departmental working group. Department of Health, London, 1995.

(5) Fink A et al. The Alcohol-Related Problems Survey: Identifying hazardous and harmful drinking in older primary care patients. J Am Geriatr Soc 2002 Oct; 50:1717-22.

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