Substance Misuse Factsheet Slides-Category IV Distinctive Groups: Older People

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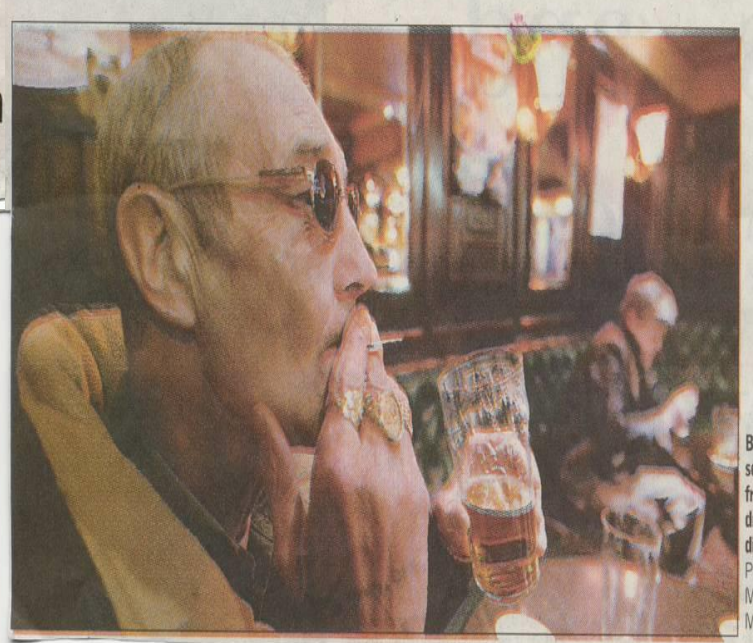
You'll be lucky to reach 60 here. But it's not the Third World, it's east Glasgow

Shettleston's diet of chips, fags and booze means that life expectancy is actually falling in one of the most deprived parts of the UK



Bolly Dunn has seen many of his friends die from drink-related diseases. Photograph by Murdo MacLeod.

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Learning Outcomes

- Recognition of core distinctive issues for older people with substance misuse
- Appreciation of key components of a detailed history relevant to older people
- Provide effective advice about the impact of substances on daily living
- Initiation of a care plan appropriate to older people
- Acknowledgement that older people do respond positively to effective treatment

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Introduction

Older people present with complex problems which may be atypical and subtle

Physical health problems can precipitate substance misuse in older people

Psychiatric comorbidities are common in older people with substance problems

Social issues e.g. bereavement, retirement, may be associated

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Prevalence

Older people, 60+, will constitute

42% of the UK

population by 2027

'Older' generally means **over the age of 60,** though it can refer to **clients over 40 years, or over 50 years**

Older' people are using

more legal & illegal drugs

including over the counter & prescription drugs

10% of people over 60 in 2020

still smoke

vs **30% in 1980**

60% NHS prescriptions

for over 60s, Alcohol consumption above adult 'safe limits'

♂ **20%** in men

♀ **10%** in women over 65

Highest alcohol death rate is in ages

55-74

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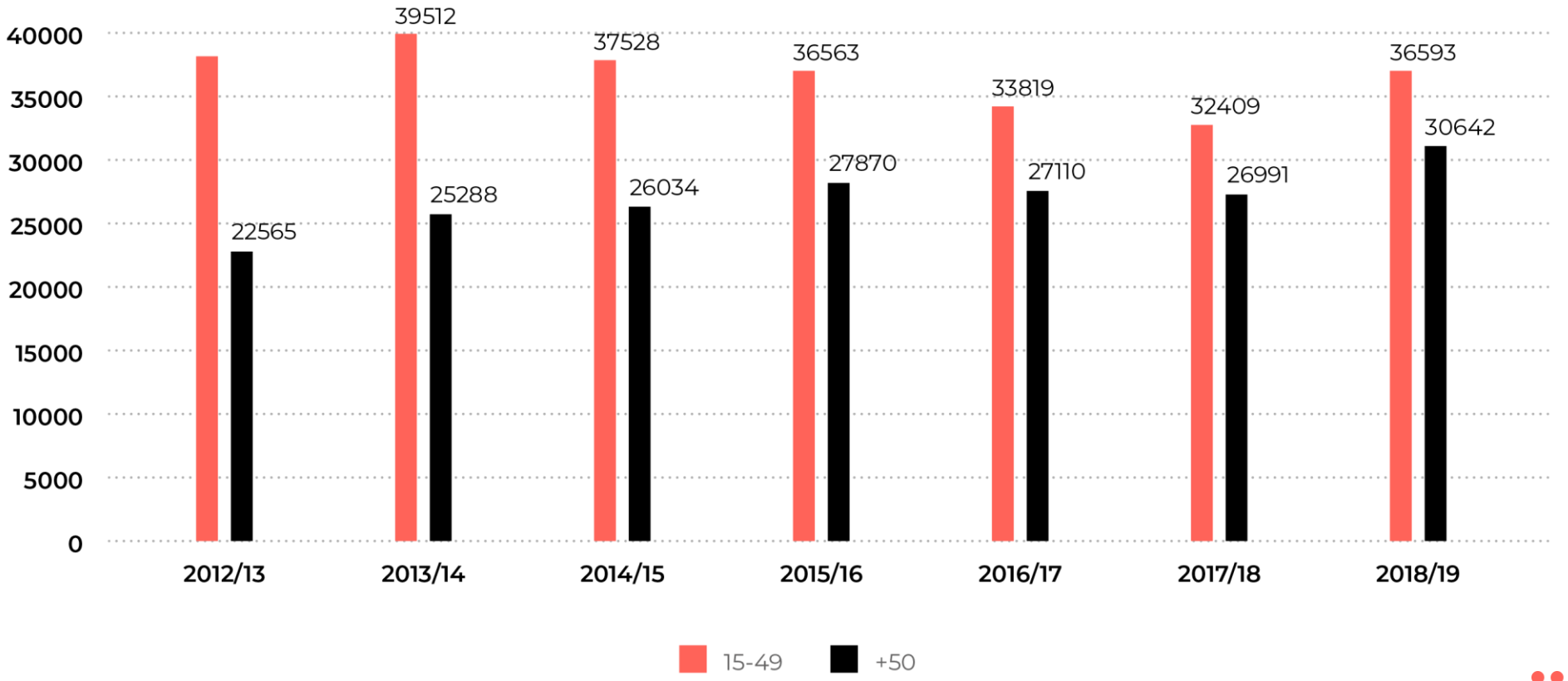
Alcohol-specific admissions in England for mental and behavioural disorders



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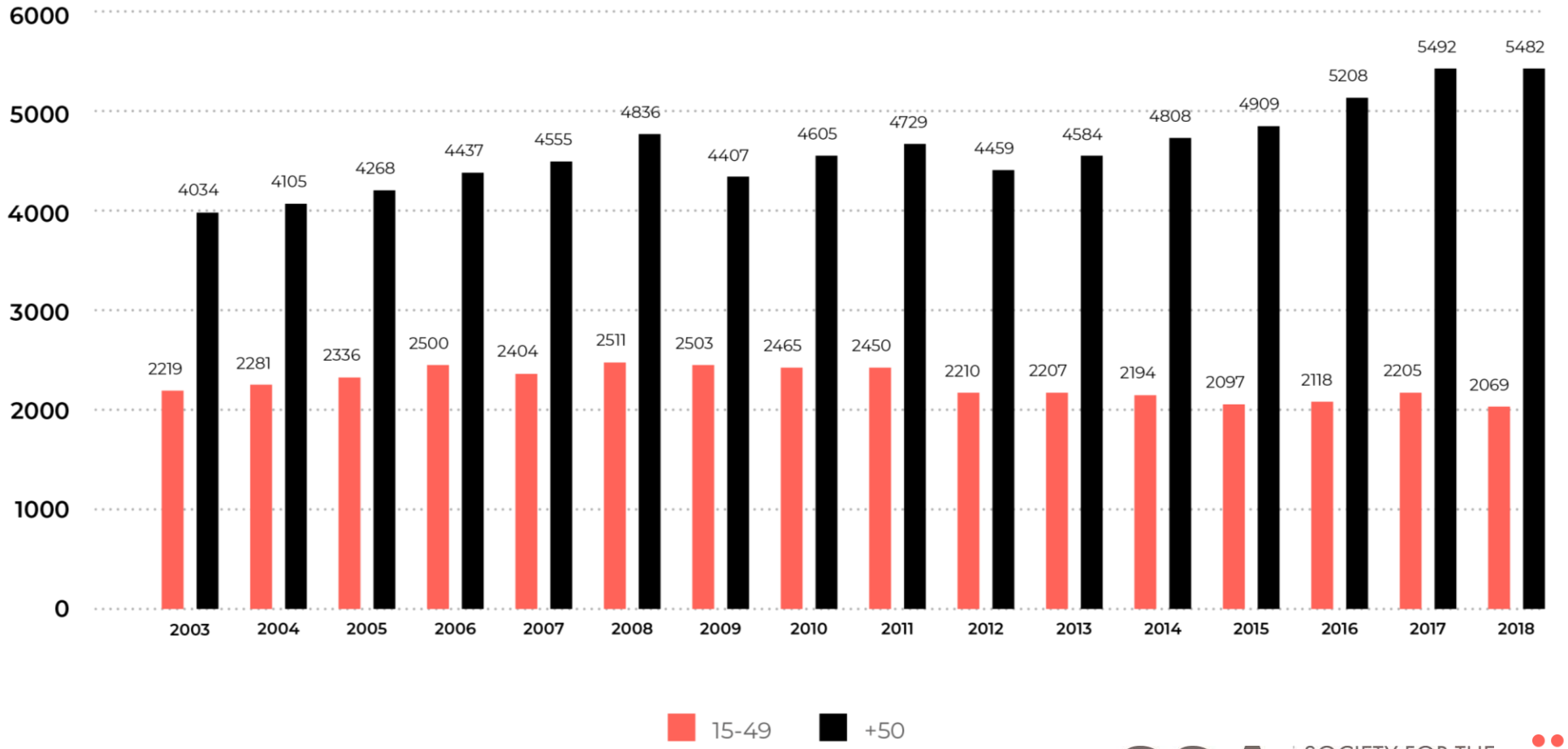
Alcohol Specific Deaths in the UK: 2003-2018



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Prevalence (contd)

Older people can present in any health and social care setting with the effects of substance use but

older people fail to get same attention as younger people

Alcohol & prescription drugs

are the most commonly used substances in the older age group

Number of people aged 60+ receiving drug treatment

has increased rapidly

during the period 2006-2013

Older people may take more than prescribed due to

poor memory, concentration, and judgment, anxiety, malaise

Effects may be misattributed to

ageing, or stereotyping substance use

are a young person's activity

62% of older people

aged 60+ who receive treatment complete treatment free of dependency compared to **47% of 18-59 yr olds**

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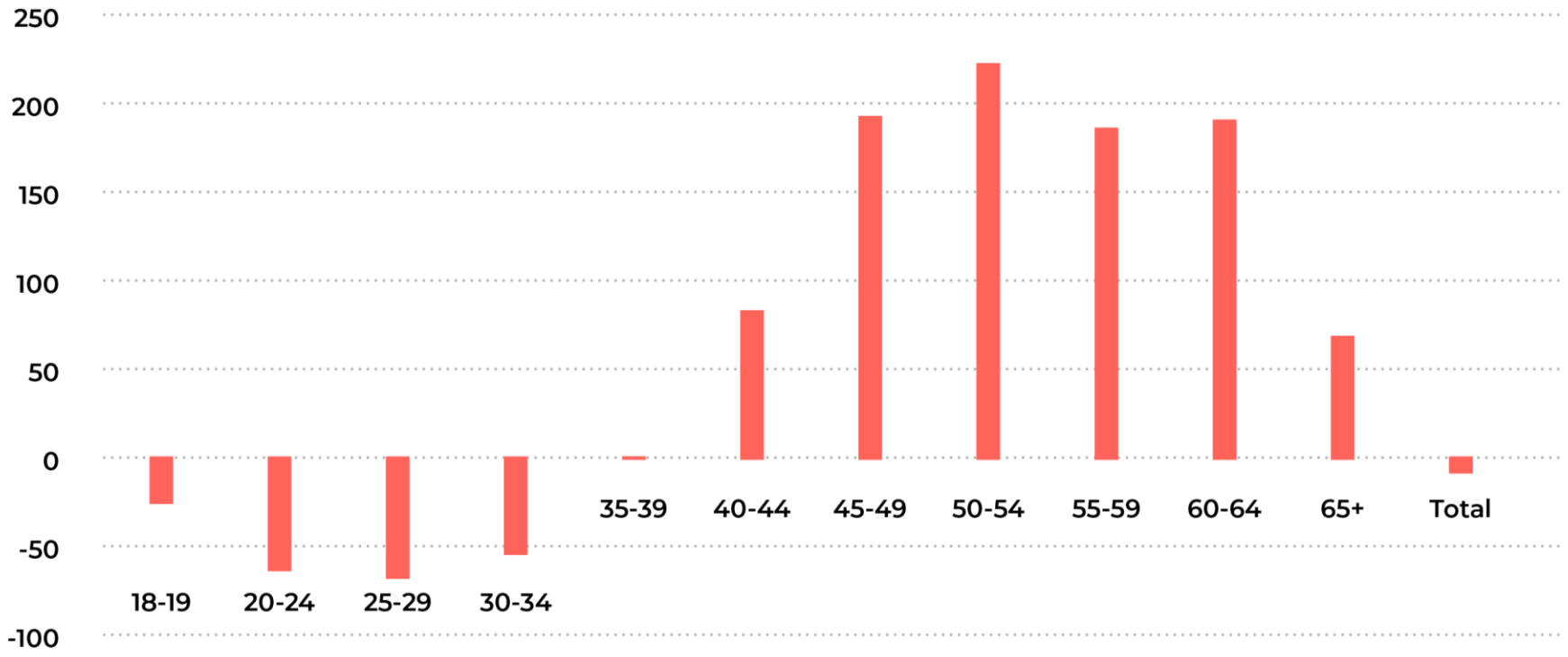
Percentage change in numbers accessing addiction treatment services in England 2005/06 to 2018/19



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Prevalence (contd)

The relationship may be missed due to

atypical and subtle presentation

Substances can interact with

physical and mental health conditions

which are part of ageing, and for which medications are prescribed

Older people

drink less but more frequently

than younger counterparts

The impact from a similar amount at a younger age may be

greater in old age

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Barriers to detection

Older people may	Practitioners
Feel stigmatised	Are not trained
Fear being judged	Are not confident
Feel no one cares about them, there is no one to care for them	Do not easily recognise atypical or subtle presentations
Feel they are a burden, and no one is there to help	Do not have a high index of suspicion

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Warning signals

- Sleep complaints
- Cognitive impairment, memory or concentration disturbance
- Depression and anxiety
- Pain
- Liver function abnormalities
- Incontinence
- Poor hygiene and self neglect
- Unusual restlessness/agitation or persistent tiredness
- Unexplained nausea and vomiting
- Changes in eating habits
- Alteration in and erratic behaviour
- Slurred speech, tremor, poor coordination
- Frequent falls and unexplained bruising
- Requests for more prescription drugs
- Evidence of illegal activities

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Detailed substance use history

- Demographics Age/Sex/ethnicity/living arrangements/ living environment
- Presenting problem may be masked
- Past and Family Psychiatric history
- Occupational and Psychosexual history
- Medical history (especially known complications from substance and effects on existing age-related impairment)
- Forensic history (especially public order and acquisitive offences)
- Discuss substances separately (Alcohol/nicotine/OTC/prescribed/Illicit)
- Treatment (dates, service, intervention, outcome)
- Consent and Capacity
- Social vulnerability Risk of falls, social/cultural isolation, financial abuse
- Social function Activities of daily living, statutory/voluntary/ private care
- Social support Informal carers and friends
- Social pressures Debt, substance using 'carers', open drug dealing
- Investigations (including cognitive testing and neuroimaging)

Age at first use, weekend, weekly, daily use	Age of dependence syndrome	Maximum use and when/how long	Pattern (Quantity/ Frequency) over day/week	Route	Cost/'funding'	Abstinence/ relapse, link stability/life events	Preferred substance(s)

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Assessment - Collateral

Collateral information

Relatives

GP consultations and medications

Hospital discharge summaries

Home carers

Day centres

Housing officers/ Wardens of Sheltered accommodation

Criminal justice agencies

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Treatment

Evidence exists which demonstrates that older people want to stop substance use and do well with treatment

Support with reducing/abstaining from substance use should be given

The treatment that is offered will depends on the nature and extent of the problems and availability and accessibility of services

May include home visits, supervision by medical and care staff or family, admission to hospital e.g. detoxification for acute presentation with alcohol withdrawal

Assess to what extent patient wishes to change pattern of substance use

Withdrawal of unnecessary prescribed medication gradually

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Pharmacological Treatment

Pharmacological treatment should be undertaken cautiously and be safe, effective and tolerated

Short acting benzodiazepines are first choice for alcohol withdrawal

Diagnosis of dependence is necessary

Some medications e.g. acamprosate, naltrexone and disulfiram should be administered with extreme caution

Medication for substitution therapy should be initiated after discussion with an addiction specialist and are usually prescribed at about half that for adults

Pharmacological treatment should always be implemented within the context of psychosocial interventions

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Multidisciplinary Team Working

- No single empirically supported approach which is superior
- Responsive to needs and supports adaptive strategies
- Education and advice
- Brief interventions
- Motivational interviewing
- Cognitive behavioural therapy
- Mutual self help

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Admission

Threshold for admission for older people is lower than adults

Criteria: Chaotic lifestyle, heavy substance use and dependence, emergency presentations, comorbid conditions, social circumstances

Exclude head injury (detected or suspected), infections, malnutrition, depression, Wernicke Korsakoff

Exclude other causes of thiamine deficiency eg AIDS, thyrotoxicosis, metastases, congestive heart failure, thyrotoxicosis

Assess the need to institute treatment immediately eg if Wernicke Korsakoff's is a possibility

Undertake investigations on serum and urine

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Conclusion

The number of older people with substance use problems is rising as is the proportion of older people in our population

Older people are entitled to the same treatment as young people

Older people can and do respond to effective treatment

Older people have distinctive differences which impact on the manner in which assessment and treatment are delivered

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References

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- It's about time. Tackling substance misuse in older people **http://www.drugwise.org.uk/wp-content/uploads/its-about-time-report.pdf**
- Calling time for change A charter to support all older adults in England to live free from the harm caused by alcohol **https://www.drinkwiseagewell.org.uk/media/publications/pdfs/calling-time-for-change-england.pdf**

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