

# Substance misuse in the older person: setting higher standards

Iana Crome

**ABSTRACT** – The number of older substance misusers requiring treatment is likely to double over the next couple of decades. However, there are many misconceptions and myths about this often hidden population. Older people misuse alcohol, nicotine, prescription medication and illicit drugs. All indications are that this is increasing. This may be as a cause and/or the result of physical or mental illness, and the consequent morbidity and mortality are costly to the patient, their families and society. Patients present to a very wide variety of social and medical care settings, so screening and assessment for substance use are of paramount importance. This provides the opportunity to determine to what extent the substance problem is related to the presentation, which may be subtle and atypical in older people. Since evidence is accumulating of the benefit of treatment for substance problems in the older population, this group should not be marginalised and neglected by practitioners, researchers, educators and policy makers.

**KEY WORDS:** Older person, substance misuse, treatment, policy

## Introduction

It is being increasingly acknowledged that substance problems in the population aged over 65 years old are important features in clinical presentations in a very wide range of medical settings.<sup>1–3</sup> (Note: in this paper, ‘substance’ will be used to describe licit substances, such as tobacco and alcohol, and illicit substances, including opiates and opioids such as heroin and methadone and stimulants such as cocaine, amphetamine and ecstasy. The term will also be used to describe use of prescription drugs or medications bought over the counter and used in a manner not in accordance with medical advice. The term ‘older’ will generally be used to denote individuals over the age of 65, but if the information is based on younger age groups, this will be stated.) These observations are due to several factors which include the growing numbers of older people in the population, the cohort of ‘baby boomers’ born after 1945 who are now in their sixties being the first group in which drug use during the teenage years was relatively widespread, and the greater likelihood that older people will be admitted to hospital, despite the higher cost of inpatient admissions as compared with accident and emergency admissions.<sup>4,5</sup> The number of older people needing treatment

for substance misuse is likely to double in the next two decades.<sup>1,2,6</sup> Tobacco, alcohol and illicit drugs constitute the second, third and eighth leading risk factors respectively for disease burden in Europe. The costs are considerable: conservative estimates, which do not include the wider societal costs, are that alcohol costs the UK £21 billion per annum and drugs £15 billion per annum.

The scale of the problem in the UK is immense. The stereotype of the young drug addict needs to be re-evaluated! For example, at least 10% of over 60s still smoke cigarettes and smoking remains the largest cause of premature death. Alcohol consumption over the recommended limits for adults occurs in 20% of men and 10% of women.<sup>7</sup> Alcohol use in the elderly has risen substantially in the past decade, with a parallel trend in mortality from alcohol-related conditions. Prescription drug misuse poses a new problem: approximately 45% of NHS prescriptions are to the over 65s, often in multiple medications, with some being inappropriate and with plenty of scope for interactions, adverse effects and misuse. The growth in new presentations to specialist drug services in older clients contrasts with a decline in younger age groups.<sup>8</sup> In the adult population it is estimated that substance misuse can reduce life expectancy by up to 17 years, and if combined with a serious mental illness (which is commonly the case), by a further 13 years.<sup>9,10</sup>

## Assessment

The imperative is to demythologise the issue. There are commonly held – usually uninformed – ideas regarding older people and the use of substances. Older people can and do misuse substances. Consequently older people are seriously at risk and affected by their consumption of licit and illicit substances.<sup>11</sup>

The older substance misuser may present to both medical and social care systems: thorough knowledge of the assessment process is necessary in all related settings. Older people may not arrive with an informant and may be confused about what medications and other substances they may have been taking, or have omitted to take.

Older people are at particular risk of the complications of substance use, misuse and dependence. This is due to decreased metabolism and resulting accumulation of substances including medications. Brain sensitivity to the effect of drugs may be increased. Thus, older people do not need to use substantial quantities of substances for adverse effects to occur. The original ‘geriatric giants’ – ie iatrogenesis, immobility, intellectual deterioration, incontinence and instability – can all be associated with substance misuse.

Ageing itself is associated with the development of comorbid mental and physical health problems. The interrelationships

---

Iana Crome, emeritus professor of addiction psychiatry, Keele University

between these illnesses and substance use can be very complicated but need to be understood to make rational diagnostic formulations and treatment plans. Illness resulting in symptoms such as pain, sleep disorder or anxiety may precipitate substance use, lead to a deterioration in substance problems, or be a complication of substance use. The presenting illness can be a combination of all these, which may emanate from the misuse of different substances. Without accurate and detailed information about the course of the illness and substance use, and knowledge of potential complications, treatment can be inappropriate.

Professional practitioners and carers may not realise that the link between the patient's somatic and psychological symptomatology is the misuse of substances. Overdose can be the result of inappropriate prescribing and/or inappropriate consumption. For example, somatic symptoms may be incorrectly attributed to physical illness, or cognitive and functional impairment may be attributed to 'ageing'. Subtle presentations, likely in older people, can be easily missed.

A vital aspect of assessment lies in the manner in which patients, families and carers are approached. A non-judgemental and non-confrontational approach is to be recommended. Low self-esteem, feelings of low mood, lack of self-respect, feeling unwell, and, very importantly, previously difficult experiences with caring agencies and others, including family members, can make patients reticent to disclose information which would enhance understanding and improve treatment options.

It is critical to undertake a systematic and meticulous history. The presenting problem or condition can frequently disguise the substance misuse, so practitioners should be alert to this possibility. Indeed, given the prevalence described above, it is highly likely the substance use will in some way be linked to the presenting complaints, and the clinician should ensure careful assessment is undertaken before dismissing the contribution of substance use as a factor.

This assessment should cover medical, psychological and, crucially, social components of the background and current situation. Exhaustive probing with regard to each substance – prescribed, over the counter, licit, illicit, which may have been obtained from several sources eg family, friends or the internet – to determine quantity, route, frequency and development of dependence symptoms (although older people do not necessarily have to have developed addiction or dependence for the impact on their health to be seriously affected by use). Assessing their general health, in particular cognitive state and changes in pattern of behaviour (eg pain, sleep, mood), and obtaining a history of previous treatment interventions and consequent impact are pivotal to the assessment procedure. A combination of mental illness and substance misuse greatly increases the likelihood of chronic physical illness. Self-harm and suicide are serious risks for the older substance misuser.<sup>12</sup> The patient's life circumstance and social function, including their support network, degree of social isolation, forensic history and financial situation, is as significant in piecing together a picture of the patient's needs as the strictly medical or biological facets.

Assessment needs to be continuous, and responses dynamic. Traditional rating scales lack sensitivity and validity in the elderly. While there are a clutch of instruments that may aid assessment, as yet there is no one single tool that is standardised for the older person. Those available for alcohol include the AUDIT, and AUDIT-C (a shorter 3-item version), which are not specific for older people, a short version of the CAGE (ie excluding the first item 'have you ever tried to cut down'), SMAST-G (short Michigan Alcohol Screening Tool), ARPS (Alcohol Related Problems Survey) and shARPS (Short ARPS) have been developed.<sup>13</sup> As not all these tools have been compared with each other, it is debatable which is superior for older alcohol misusers.<sup>14</sup> Combinations have been recommended, in association with a proper history. There is not an equivalent for illicit drug misuse, but Lam and Cheung<sup>15</sup> have used a tool developed for the assessment of inappropriate prescribing, for screening. Given the extent of the problem, this is necessary and highly valued. Furthermore, Blazer has reported on the DAPA-PC, the Drug and Alcohol Assessment for Primary Care, which a computerised screening system for primary care which seems the way forward in that it is itself administered, internet based, scores automatically and presents motivational messages to the patient on the basis of the results.<sup>16</sup> It may also be helpful to use other tools for depression (Beck or Hamilton rating scales), the mini-mental state for cognition, and the Fagerstrom test for nicotine dependence, in addition to the 'brown bag review' of all the substances the patient may be taking, whether wittingly or not.

There has until recently been a dearth of training for medical practitioners in this neglected area. However, a national curriculum to train undergraduate medical students has been implemented nationally, and the Royal Colleges are collaborating to improve postgraduate education.<sup>17,18</sup> Training is often regarded as an optional extra, but it is essential for confidence not only in assessment and diagnosis but in implementation of the most effective treatment.

The overall framework which is useful in the treatment pathway is the '5 As': ask for details of substance use; assess comprehensively, including motivation to stop or reduce use and complications related to use; advise on the most appropriate method to achieve goals with feedback, information and self-help material; assist with coping strategies by instilling hope and self-esteem; and arrange admission in the case of severe addiction with polysubstance use, social instability and comorbidity, if necessary.<sup>19</sup>

## Complications

There is a vast literature on the morbidity associated with the use of substances and it is well beyond the scope of this piece to focus on this in great detail. However, not only are some disorders – such as delirium, dementia, depression, anxiety and grief reactions – more common in older people, but these and other less common conditions, including bipolar disorder, post-traumatic stress disorder and schizophrenia, may present differently in this group. Moore *et al*<sup>20</sup> have described the numerous conditions with which older people with alcohol problems who

were attending primary care may present; these include hypertension (30%), depression (12%), gout (8%), diabetes (5%), ulcer disease (4%) and liver conditions (4%). Sleeping problems presented in nearly 40%, gastrointestinal symptoms in 24%, memory problems in 23%, feeling sad or blue in 17% and tripping and falling in 18%. There was also considerable medication use with the potential for interactions or abuse: 32% were on antihypertensives, 18% were on non-steroidal anti-inflammatory drugs, 13% on non-prescription drugs, 12% on antidepressants, 10% on sedatives and 17% on opioids. A study on ageing heroin users<sup>21</sup> demonstrated similar high levels of comorbidity: 50% were hypertensive, 33% had abnormal pulmonary function, and they commonly concurrently smoked cigarettes (84%), used alcohol (18%), or used cannabis (21%).

## Treatment

Another commonly held myth is that older people do not respond to treatment for their substance misuse. Fortunately there is a rapidly accumulating evidence base that this is not the case.<sup>22–29</sup> Addiction is conceptualised as a chronic disorder, and many older people will have experienced problems with addiction for most of their lives. Those that develop problems in later life are likely to have different aetiological features and probably a better prognosis. Older people often use substances because of boredom, bereavement, depression, loneliness, loss of income and other social difficulties.

The aim of treatment is to focus on self-management in partnership with professionals and agencies, preferably in the community, but where continuity of care with a responsive team can be flexible, coordinated and integrated. Following assessment of all substance use, it is helpful to decide whether the patient is dependent or not on each substance, because this will have a bearing on treatment decisions. In young people, pharmacological agents are rarely recommended if they are not dependent on a particular substance. A diagnosis of dependence (commonly referred to as 'addiction') depends on meeting three or more of the following criteria over the previous 12 months: tolerance, withdrawal, and relief of withdrawal, inability to control use, a compulsion to use, increased time spent obtaining substances, reduction of activities or obligations due to use, and continued use despite the development of physical and psychological consequences. It should be noted that these criteria were developed in the general adult population and therefore should be applied cautiously in older people, where the quantity and frequency of use may be as relevant as dependence criteria in establishing the impact on substance use on the presentation.

Since older people may not become dependent according to the criteria listed above, the decision about initiation of pharmacological treatment is one that needs to be taken by a specialist in addiction and a geriatrician. It is recommended that the commencement of pharmacological agents should be undertaken by a specialist in addiction.

Pharmacological agents can be given to manage withdrawal, eg benzodiazepines, methadone, lofexidine, nicotine replace-

ment or bupropion, or for the maintenance of abstinence, eg methadone, buprenorphine, nicotine replacement or bupropion. They are also used for the prevention of complications; for example, vitamin supplementation such as thiamine for Wernicke Korsakoff's syndrome. The agents used to manage relapse include naltrexone, which blocks pleasant effects, acamprosate, to reduce craving for alcohol, and disulfiram, which produces an unpleasant reaction with alcohol ingestion. These medications have not been investigated or licensed for the treatment of substance misuse in the over 65s, so caution is needed. Benzodiazepines may accumulate but dosage needs to be sufficient to cope with withdrawal. Acamprosate, disulfiram and naltrexone should be used with utmost caution, while methadone and buprenorphine should be supervised. Nicotine replacement and bupropion should not be considered if there are contraindications. Of course concurrent psychiatric conditions, such as depression, and physical conditions, such as diabetes, need to be treated with the appropriate pharmacological agent. Medication alone should not be the mainstay of treatment and should always be delivered in the context of the patient's psychosocial environment. There are a variety of psychosocial interventions which can be administered. A recent review of these has indicated that there is definite benefit in treating older people who suffer from substance problems.<sup>30</sup> Patients respond positively, have the capacity to change, and are likely to do as well as younger counterparts with regard to substance use, mental and physical health, and social function. It appears that they can be effectively treated by doctors, using both brief advice and motivational enhancement, in both elder-specific and adult programmes, although the more orientated the service is to the specific needs of older people the more likelihood there is of improvement. It is recognised that there is a need for research into longer term management and outcomes, but the main conclusion is that older age should not be a barrier to addressing substance problems.

## Policy conclusions

There has been extraordinary interest in the concept of a 'safe limit' for older people, since recommended adult limits may not apply.<sup>31</sup> While there is probably no such thing as a 'safe limit', the United States guidelines advise limits of one US (14 gm alcohol) drink a day, and not more than seven US drinks per week in healthy older people.<sup>32,33</sup> (A UK unit is equivalent to 8 gm of alcohol.) More than three US drinks per day is considered harmful. Older people should be given instructions not to drive, swim or use machinery after drinking and, when they drink, they should do so slowly, and after food. It may be that for those older people with comorbid conditions and/or who are on medication, alcohol may be inappropriate. This is a message that may not be palatable to many. The evidence base for these recommendations is under review by the Chief Medical Officer.

Every day there is an article in the press about just how poorly older people are treated.<sup>34</sup> Those with substance problems are likely to be exceptionally marginalised. Negative stereotypes

about old age as well as addiction, and the numerous medical and social issues that this group face, render them especially vulnerable, victimised, exposed and helpless. A much higher priority needs to be afforded to research with a focus on epidemiological trends in substance use, diagnostic criteria, testing and dosage of pharmaceutical treatments, inclusion of older people in the evaluation of psychological interventions, and the functional outcomes. Older people should be included in all relevant clinical trials so that it can be determined whether a specific intervention, programme or service model can be recommended over the long term. This has not been the case hitherto. As stated in the introduction, the nature and extent of these problems, and the need for treatment, is bound to increase over the next decade or two. In accordance with the logo of the Royal College of Physicians, there is no doubt that we need to 'set higher standards' for this sizable, too often mistreated, sometimes destitute, population.

## References

- Crome I, Rao T, Tarbuck A, Dar K *et al.* *Our invisible addicts*. London: PCPsych, 2011. Available from: [www.rcpsych.ac.uk/publications/collegereports/cr/cr165.aspx](http://www.rcpsych.ac.uk/publications/collegereports/cr/cr165.aspx) [accessed 10 October 2013].
- European Monitoring Centre for Drugs and Drug Addiction. *Substance use among older adults: a neglected problem (Drugs in Focus 18)*. Lisbon: EMCDDA, 2008. Available from: [www.emcdda.europa.eu/attachements.cfm/att\\_50566\\_EN\\_TDAD08001ENC\\_web.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_50566_EN_TDAD08001ENC_web.pdf) [accessed 10 October 2013].
- Crome I, Sidhu H, Crome P. No longer only a young man's disease: illicit drugs in older people. *J Nutr, Health and Aging* 2009;13:141–43.
- National Information Centre. *Statistics on alcohol: England 2010*. London: Health and Social Care Information Centre, 2010. Available from: [www.hscic.gov.uk/pubs/alcohol10](http://www.hscic.gov.uk/pubs/alcohol10) [accessed 10 October 2013].
- National Information Centre. *Statistics on alcohol: England 2011*. London: Health and Social Care Information Centre, 2011. Available from: [www.hscic.gov.uk/pubs/alcohol11](http://www.hscic.gov.uk/pubs/alcohol11) [accessed 10 October 2013].
- Han B, Gfroerer JC, Colliver JD, Penne MA. Substance use disorder among older adults in the United States in 2020. *Addiction* 2009;104:88–96.
- Seymour R, Booth L. *Statistics on smoking – Commons Library standard note*. London: House of Commons, 2010. Available from: [www.parliament.uk/briefing-papers/SN03312](http://www.parliament.uk/briefing-papers/SN03312) [accessed 10 October 2013].
- National Treatment Agency for Substance Misuse. *Drug treatment in 2009–10*. National Treatment Agency, 2010. Available from: [www.nta.nhs.uk/uploads/nta\\_annualreport\\_0910.pdf](http://www.nta.nhs.uk/uploads/nta_annualreport_0910.pdf) [accessed 10 October 2013].
- Chang CK, Hayes RD, Broadbent M *et al.* All-cause mortality among people with serious mental illness (SMI), substance use disorders, and depressive disorders in southeast London: a cohort study. *BMC Psychiatry* 2010;10:77.
- Chang CK, Hayes RD, Perera G *et al.* Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. *PLoS One* 2011;6:e19590.
- Crome IB, Bloor R. Older substance misusers still deserve better services – an update (Part 2). *Rev Clin Gerontol* 2005;15:255–62.
- Blazer DG. Depression in late life: review and commentary. *Focus* 2009;7:118–36.
- Blow FC. The Michigan Alcoholism Screening Test – Geriatric version (MAST-G): a new elderly specific screening instrument. *Alcohol Clin Exp Res* 1992;199:372.
- Berks J, McCormick R. Screening for alcohol misuse in elderly primary care patients: a systematic literature review. *Int Psychogeriatr* 2008;20:1090–103.
- Lam MP, Cheung BM. The use of the STOPP/START criteria as ascreening tool for assessing the appropriateness of medications in the elderly population. *Expert Rev Clin Pharmacol* 2012;5:187–97.
- Zeiler CA, Nemes S, Holtz KD, Landis RD, *et al.* Responses to a drug and alcohol problem assessment for primary care by ethnicity. *Am J Drug Alcohol Abuse* 2002;28:513–24.
- Royal College of Psychiatrists. *Alcohol and other drugs: core medical competencies*. London: RCPsych, 2012.
- International Centre for Drug Policy. *Substance misuse in the undergraduate medical curriculum*. London: ICDP, 2007.
- Raw M, McNeill A, West R. Smoking cessation guidelines for health professionals: a guide to effective smoking cessation interventions for the health care system. *Thorax* 1998;53(Suppl 5):S1–19.
- Moore AA, Blow FC, Hoffing M *et al.* Primary care-based intervention to reduce at-risk drinking in older adults: a randomized controlled trial. *Addiction* 2011;106:111–20.
- Hser YI, Hoffman V, Grella CE, Anglin MD. A 33-year follow-up of narcotics addicts. *Arch Gen Psychiatry* 2001;58:503–8.
- US Department of Health and Human Services. *Substance Abuse among Older Adults: treatment improvement protocol (TIP) series 26*. Washington, DC: US Department of Health and Human Services, 1998.
- Lingford-Hughes AR, Welch S, Peters L, Nutt DJ. BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. *J Psychopharmacol* 2012;26:899–952.
- Department of Health. *Drug misuse and dependence: guidelines on clinical management*. London: Department of Health, 2007.
- National Collaborating Centre for Chronic Conditions. *Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications (NICE Clinical Guideline 100)*. London: NICE, 2010.
- National Collaborating Centre for Mental Health. *Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (National Clinical Practice Guideline 115)*. London: NICE, 2011. [guidance.nice.org.uk/CG115](http://guidance.nice.org.uk/CG115) [Accessed 10 October 2013].
- National Collaborating Centre for Mental Health. *Drug misuse: psycho-social interventions (NICE Clinical Practice Guideline 51)*. London: NICE, 2007.
- National Collaborating Centre for Mental Health. *Drug misuse: opioid detoxification (NICE Clinical Practice Guideline 52)*. London: NICE, 2007.
- Crome IB, Bloor R. Older substance misusers still deserve better interventions – an update (Part 3). *Rev Clin Gerontol* 2006;16:45–57.
- Moy I, Crome P, Crome I, Fisher M. Systematic and narrative review of treatment for older people with substance problems. *Eur Geriatr Med* 2011;2:212–36.
- Crome I, Li TK, Rao R, Wu LT. Alcohol limits in older people. *Addiction* 2012;107:1541–3.
- Naegle MA. Screening for alcohol use and misuse in older adults: using the Short Michigan Alcoholism Screening Test – Geriatric Version. *Am J Nurs* 2008;108:50–9.
- National Institute on Alcohol Abuse and Alcoholism. *Helping patients who drink too much: a clinician's guide*. Updated 2005 edition. NIH, 2005.
- Crome IB, Bloor R. Older substance misusers still deserve better services – an update (Part 1). *Rev Clin Gerontol* 2005;15:125–33.

**Address for correspondence: Prof I Crome, Medical Hub, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, St George's Hospital, Corporation Street, Stafford ST16 3SR.**  
**Email: [ilana.crome@btinternet.com](mailto:ilana.crome@btinternet.com)**