Evidence Briefing 8: Older adults

Need to know

- In this evidence briefing, older adults have been defined as anyone aged 50 and over. At present, the proportion of older people with substance misuse continues to rise more rapidly than can be explained by the rise in the proportion of older people in the UK.
- While overall alcohol and drug consumption is falling, in older generations there is evidence that it is increasing, yet there is currently no alcohol strategy in Scotland that specifically considers the needs of older adults
- Older adults with problem alcohol use are the least likely to receive treatment, but the most likely to have positive outcomes
- Isolation and loneliness are more prevalent amongst older adults. The evidence supports "a strong social role" for drinking alcohol in older adults, thus interventions need to avoid "paradoxical harm", i.e. reduce the damage of drinking alcohol but retain the benefits of socialising.
- Age-related factors increase the risk of problem alcohol and drug use, including retirement, bereavement, dementia and chronic ill-health.

Key findings

- Older adults should be included as a distinct group within alcohol strategies, and their lived experience should be used to help design effective services
- Older adults' alcohol and drug use is commonly misdiagnosed or missed entirely. Training primary care staff to spot problem alcohol and drug use, specifically in over 50s, will improve access to treatment, particularly when an older age identification test and cognitive impairment test are used
- Venue choice is critical to making services accessible and acceptable for older adults, with a focus on access for those with limited mobility
- Intervention involving employers is important in being able to manage the transition to retirement
- Age-related alcohol guidelines need to be developed to combat a very low level of awareness of what these are amongst older adults[1]
- Reduced hepatic function and the issue of poly pharmacy in older adults mean that pharmacological interventions may be less appropriate for this group

Good practice

- Drink Wise Age Well resources and guidelines
- Mast-G (The Michigan Alcoholism Screening. Test – Geriatric) and MoCA assessment tests (Montreal Cognitive Assessment)
- Older adults' Cognitive Behavioural Theory manual (SAMHSA)
- Healthy working lives initiative

Potential Stakeholders

- Alcohol and drug services
- Geriatric services
- Community services
- Allied health professionals
- Employers
- Pain management services
- Policy teams

1 Introduction

This is a briefing on what works for older adults in alcohol and drug prevention. For the purposes of this briefing, older adults have been defined as anyone aged 50 and over. However, it is important to note that there is considerable diversity within this group, and there is thus a large crossover between this briefing and the adults briefing. This means that some older adult interventions will be suitable for those under the age of 50 (Briefing 7), and equally that some interventions highlighted in the adults briefing will be suitable for those aged 50 and over. Which interventions are most appropriate will depend on the issues that an individual is presenting with, and should be person-centred (Briefing 2).

2 Context

While overall alcohol and drug consumption is falling, in older generations there is evidence that it is increasing. A number of age-related factors drive greater risk of problem alcohol and drug use in older adults, including retirment, bereavement, dementia, social isolation and chronic ill-health and pain. Older adults are also at greater risk of alcohol and drug related harm due to physiological changes in processing these, and a slowing of their metabolic rate.

- In Scotland, harmful, hazardous drinking is increasing amongst those aged 65-74 but decreasing in other age groups[1]
- Problem use of prescription medicines, such as benzodiazepines or opioid analgesics is more prevalent in older age groups, particularly older women[2]
- The Scottish Drugs Forum reported in 2017 that older adults in Scotland with problem drug use were very likely to suffer from depression, anxiety, chronic pain and/or live alone[3]
- Within 70 years, one in three people in the UK will be aged 60 or over. This population is becoming more ethnically diverse as people from black and ethnic communities who came to Britain in the 1950s, 60s and 70s become older[4]**Error! Bookmark not defined.**
- Drug use, drug-related deaths and the number of older adults in treatment for problem drug use has increased in recent years in Scotland. “These upward trends are likely to continue as the remainder of the baby-boomers, who are currently aged between 49 and 68, make the transition into old age”[5]**Error! Bookmark not defined.**
- It has been argued that “acute alcohol withdrawal syndrome is more protracted and severe” in older adults[6]
- It is estimated that drug use in those aged 40 and over accelerates the ageing process by “at least 15 years”, including “premature degenerative disorders, circulatory problems…. injection site ulcers, strokes, respiratory problems, pneumonia, breathlessness, diabetes, hepatitis and liver cirrhosis”[7]
- “Generational differences, pride or a reluctance to discuss personal problems” can prevent older adults from accessing services[8]
- Older adults often have “extensive histories of alcohol [use], multiple and complex needs and failed treatment attempts” making intervention more difficult[9]
- There is a statistically significant relationship between retiring before 60 and problem alcohol use[10]

Defining 'older adults'

In its broadest sense, older adults can be taken to represent anyone aged 50 and over. This means that 'older adults' represents a diverse group, in which "chronological age" does not precisely predict health or independence[11]. The National Service Framework for Older People categorises older adults into three distinct groups, with varying needs:

1. **Entering old age:** "These are people who have completed their career in paid employment and/or child rearing. This is a socially constructed definition of old age"[12]
2. **Transient phase:** "This group of older [adults] are in transition between healthy, active life and frailty" and "often occurs in the seventh or eighth decades but can occur at any stage of later life"[13]
3. **Frail older people: "**These people are often vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both"[14]

Interrelated risk factors

- The evidence supports "a strong social role" for older adults in drinking alcohol. As social participation has been shown to be important for cognitive health, attempts to reduce alcohol use in older adults need to avoid "paradoxical harm". However, there is also a link between problem alcohol and drug use and social isolation[15]
- Compared to over 50s still in work, those "looking for work" were more than three times as likely to have problem alcohol use, and for those "unable to work" this increased to more than five times as likely[16]

In some immigrant populations, alcohol use and type is related to recreation of their homeland cultures and national identities[17]

- Among men, the prevalence of drinking more than 14 units a week increases with age and is most common among men aged 65 to 74 years[18]
- The risk of problem alcohol use is thought to be particularly acute for LGBT people aged 55+, "especially those who come out or transition later in life"[19]

3 Detailed analysis of what works

Key to evidence briefing

High quality and multiple source evidence to support this approach	(1)
Some evidence or emerging evidence to support this approach	(2)
Limited evidence for this approach or potential development area for further investigation	(3)

Designing alcohol and drug services and related strategies	Identifying alcohol and drug use in older adults	Creating accessible and acceptable services	Specific interventions
Service user consultation (1)	Older Service User Engagement and Screening (1)	Informed Service Development (1)	Alcohol Brief Interventions (ABIs) (1)
			Producing age-related alcohol guidelines (1)
			Cognitive Behavioural Therapy and Supportive Therapy Models for alcohol and drug use harm (2)
			Workplace based interventions for alcohol and drug use (2)
			Age friendly and inclusive volunteering for alcohol and drug use prevention (2)
			Pharmacological therapy and detoxification treatments for alcohol and drug use harm (3)

Intervention Type	Description	Relevant Group Settings	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Service User Consultation	Older adults are often excluded from population level analysis, and from alcohol and drug services. There is a need to acknowledge older adults as a distinct group from 'adults', to explore their needs and what works for them, particularly acknowledging that alcohol plays a role in socialising for some older adults, and thus a need to be aware that services should not act to increase isolation and loneliness.[20]	**Designing alcohol and drug services and related strategies**	Few services have been designed using this approach, but many sources recommend that they should be	✓ Develop alcohol and drug strategies which incorporate age as a "cross-cutting theme" and "explicitly recognise that older adults' needs may differ from those of younger adults"[21] ✓ Consult with older adults with "lived experience", their families and carers and use this information to design services, co-produced by older adults[22] ✓ Complete a "local population needs analysis" and where there is a high prevalence of alcohol and drug related issues in an older population, "commission and fund specialist older adults' substance [use] services"[23] ✓ NHS and local authority adults' services should "review existing local care pathways" to ensure that access to alcohol and drug services for those aged over 50 years is improved[24] ✓ Services to reduce use need to ensure that older adults are still socially included and not isolated, as isolation and loneliness are strong drivers of alcohol and drug issues, while alcohol plays a role in socialising for some older adults[25]	

Intervention Type	Description	Relevant Group Settings	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Older Service User Engagement and Screening	It can be difficult to identify alcohol and drug issues or harm in older adults, particularly as there is currently a lack of awareness and knowledge regarding use in this group, and a reluctance to raise the issue. Screening tools routinely used with adults (such as AUDIT) are less precise for older adults. The reason being, older adults are more sensitive to the effects of alcohol. This needs to be taken into account.	**Identifying alcohol and drug use in older adults**	Many sources recommend a specific approach to identifying alcohol and drug use in older adults	✓ Supportive, non-judgemental and non-ageist approaches[26] ✓ Discussions of alcohol and drug use should occur in the context of an overall assessment with the goal of health promotion[27] ✓ Alcohol and drug use issues should be considered in those presenting with self-neglect[28] ✓ Train staff in primary care settings including GPs, dentists, A&E staff[29], general medicine, gastroenterology and old age psychiatry[30] on how to identify older adults with alcohol and drug issues ✓ Use an older age identification test such as MAST-G, or adapt adult screening tests such as AUDIT C ✓ Test comprehensively to ensure that alcohol and drug issues are not mistaken for dementia, depression, Wernicke's Encephalopathy, delirium etc. (e.g. by using MoCA) ✓ Allow enough time for examination – many older adults need more time for examination due to sensory deficits or chronic disorders[31] × More assertive styles of assessment and intervention[35] × Approaching the assessment with the goal of identifying a person with alcohol and drug issues[36]	The Michigan Alcohol Screening Test for older adults can be useful, however, this test can be time consuming The Montreal Cognitive Assessment[32] (MoCA) has been recommended by the Scottish Government to test for cognitive impairment[33] Drink Wise Age Well offer training for professionals on identifying alcohol use in over 50s[34]

Intervention Type	Description	Relevant Group Settings	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Informed Service Development	Older adults often have specific accessibility needs which need to be taken into account. They have also been shown to experience high levels of stigma and shame in relation to their alcohol and drug issues, thus the "acceptability" of services is an important consideration.	**Creating accessible and acceptable alcohol and drug services**	Many sources recommend this approach	✓ Ensure "acceptable" venue choices, including at-home support, particularly for older adults with co-existing mental health and alcohol and drug issues[37]. Provide disabled access in treatment centres for those with limited mobility[38] ✓ Where problem use of prescribed painkillers is an issue, involve GPs and specialist pain services[39] ✓ Increase knowledge of specialist services for older adults amongst this population ✓ Evidence suggests that treatment outcomes can be improved further if delivered by a service specifically for older adults[40] ✓ Training for health and other professionals on age-specific needs, and likely co-morbidities, as well as changing attitudes towards older adults ✓ Innovative interventions and treatments for older adults which are well monitored and evaluated[41]	North Southwark Community Team for Older People[42]
				× Services that are explicitly labelled as alcohol and drug services	

Intervention Type	Description	Relevant Group Settings	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Alcohol Brief Interventions (ABIs)	Brief interventions are short, evidence based, structured conversations between a patient/client and a trained professional. They can last as little as 5-15 minutes, but duration should depend on situation, including time available, level of drinking involved and what the client wants. The conversation should primarily concern motivating and supporting the individual to think about and/or plan a change in their drinking behaviour (and potentially environment) in order to reduce their consumption and/or their risk of harm.	**Specific Interventions**	Effective in adults, some evidence of effectiveness specifically in older adults[43] **See Adults briefing for more detail**	✓ Cognisant of age ✓ Use motivational approaches[44] ✓ Ensure that primary care staff consider brief interventions for older adults, as well as referral to age-appropriate services[45] ✓ Train staff to use Alcohol Brief Interventions specifically adjusted for use with older adults ✓ Use age appropriate and/or adjusted screening tools (see identifying alcohol and drug use section of this briefing)	

Intervention Type	Description	Relevant Group Settings	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Cognitive Behavioural Therapy (CBT) **and Supportive Therapy Models** (STM) for alcohol and drug use harm	Supportive Therapy Models represent treatment with age-specific modifications. They focus on developing "a culture of support and successful coping" for older adults with problematic substance use and take a "global approach to treatment planning". [46] Cognitive Behavioural Therapy focuses on "identifying and altering sequences of thinking, feeling, and behaving that lead to problem drinking or drug use"[47]. **(See Adults briefing)**	**Specific Interventions**	Effective in some cases[48], with better response than in younger adults[49] Most effective for those with late-onset alcohol and drug use disorders[50] Evidence on age-adjusted treatments is limited	✓ Highly structured, instructional approaches are particularly helpful to older adults because of the tendency to present with memory difficulties[51] ✓ Using motivational approaches may be beneficial[52] × Insufficient evidence for inhibiting factors	The Substance Abuse and Mental Health Services Association have published a CBT treatment manual specific to older adults[53]

Intervention Type	Description	Relevant Group Settings	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Producing age related alcohol guidelines	Statistics on drinking above the low risk guidelines are provided for young adults and for adults aged 25-64 but not for those aged 65 and over[54]. As nearly three out of four older adults in the UK appear not to be able to correctly identify the low risk guidance, there is a need for age-related guidelines.	**Specific interventions**	Little research into the effectiveness of producing age-related alcohol guidelines, however strong evidence for a gap in understanding and in the existence of targeted campaigns	✓ Produce guidelines specific to older adults which are based on scientific evidence ✓ Advise that adults over the age of 65 should drink no more than 1.5 units per day (equivalent to approximately half a pint of strong lager or a small glass of wine)[55] ✓ Define harmful /hazardous drinking in older adults as more than 4.5 units in a single session for men, and more than 3 units for women[56] ✓ Provide a clear description of units and health messages ✓ Older adults often regulate their own drinking and strategies that emphasise the life experience of older adults to drink wisely may prove effective[57] × Use of language which could be considered "preaching" [60] × Targeting those who "got themselves drunk or lost self-control"[61]	Drink Wise Age Well has produced resources on recommended guidelines[58] Alcohol and Later Life Magazine, NHSGGC, 2014[59]

Intervention Type	Description	Relevant Group Settings	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Age friendly and inclusive volunteering for alcohol and drug use prevention	Age friendly and inclusive volunteering, as defined by the Centre for Ageing Better, represent volunteering opportunities that acknowledge and reduce the emotional, practical and structural barriers that older adults face in contributing to their communities[62]. Volunteering in later life has been shown to have a range of mental and physical health benefits, as well as increasing social connections and sense of purpose. As mental health issues and isolation, as well as the transition to retirement, have been linked with greater risk of alcohol and drug issues in older adults, it is likely that activities such as volunteering could help minimise risk.	**Specific interventions**	There is evidence supporting the effectiveness of volunteering in improving physical and mental health in older adults Limited/no evidence of successful alcohol and drug specific diversionary activities for older adults	✓ Flexibility in times and locations, with opportunities to review commitments[63] ✓ Practical help with access, expenses and training[64] ✓ Opportunities to socialise with other volunteers[65] ✓ "Meaningful" work, with opportunities for feedback and use of pre-existing skills[66] × Separate older adult volunteering programmes (as they can exacerbate ageism)[68]	The Centre for Ageing Better has produced recommendations on how to make volunteering age friendly and inclusive, including a number of case studies[67]

Intervention Type	Description	Relevant Group Settings	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Pharmaco-logical therapy and detoxification treatments for alcohol and drug use harm	Older adults presenting with opioid use (prescribed or illicit) may require substitute prescribing, but caution is required because of reduced hepatic function associated with age and the issue of poly pharmacy.	**Specific interventions**	Limited effectiveness in older adults	✓ Hepatic function needs to be monitored when treating with naltrexone[69] ✓ Referral to specialists with experience of prescribing for older adults may be necessary[70] ✓ Relapse prevention prescribing may also be appropriate in older adults[71] ✓ Pharmacological interventions need to be based on NICE guidelines[72] × Over-prescription of addictive medicines[74], (although pain should be considered) × There is evidence that Disulfiram places extra strain on the cardiovascular system within older adults[75] × Naltrexone should not be prescribed to older adults with chronic pain as it blocks the effect of opiate-based pain medications[76] × Out-patient detoxification may not be appropriate for older adults who are frail, who live alone with limited support, or who have multiple medical problems[77]	Drink Wise Age Well have produced an alcohol and medication factsheet[73]

Intervention Type	Description	Relevant Group Settings	Effectiveness	Factors that help (✓) or hinder (×) effectiveness	Good Practice
Workplace based intervention	Older adults may be reluctant to come forward about issues related to alcohol and drug use. This can be a combination of "generational differences", and fear of repercussions, such as being replaced by a younger, and cheaper workforce[78].	**Specific interventions**	Limited evidence on effectiveness, as few interventions exist, however there is evidence to suggest that it could be an important future approach	✓ Employers could offer a formal pre-retirement conversation including discussion on the health risks and challenges posed by retirement, such as issues related to alcohol and drug use, as well as a focus on health and wellbeing, routine and maintaining a sense of purpose[79] ✓ Environments that help overcome reluctance to seek help. This could be in the form of employee counselling services which provide alcohol and drug interventions, posters in communal areas or peer educators within the workplace[80] ✓ Clear alcohol[81] and drug policies[82] ✓ Employer age awareness training × Stigmatising or punitive approaches	Healthy working lives initiative[83]

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