SUBSTANCE MISUSE IN OLDER PEOPLE

Louise Leonard
Nurse Practitioner
November 2018

louise.leonard@waikatodhb.health.nz

23 Aug, 2017 12:46pm 3 minutes to read

LIFESTYLE

Baby boomers hitting bottle and bong at alarming levels

23 Aug, 2017 12:42pm 2 minutes to read

Trending Topics

- The Liberation of Le Quesnoy
- Duke and Duchess of Sussex royal tour
- US mail bomb threats
- Airline swapsies

BABY BOOMERS AT HIGHEST RISK

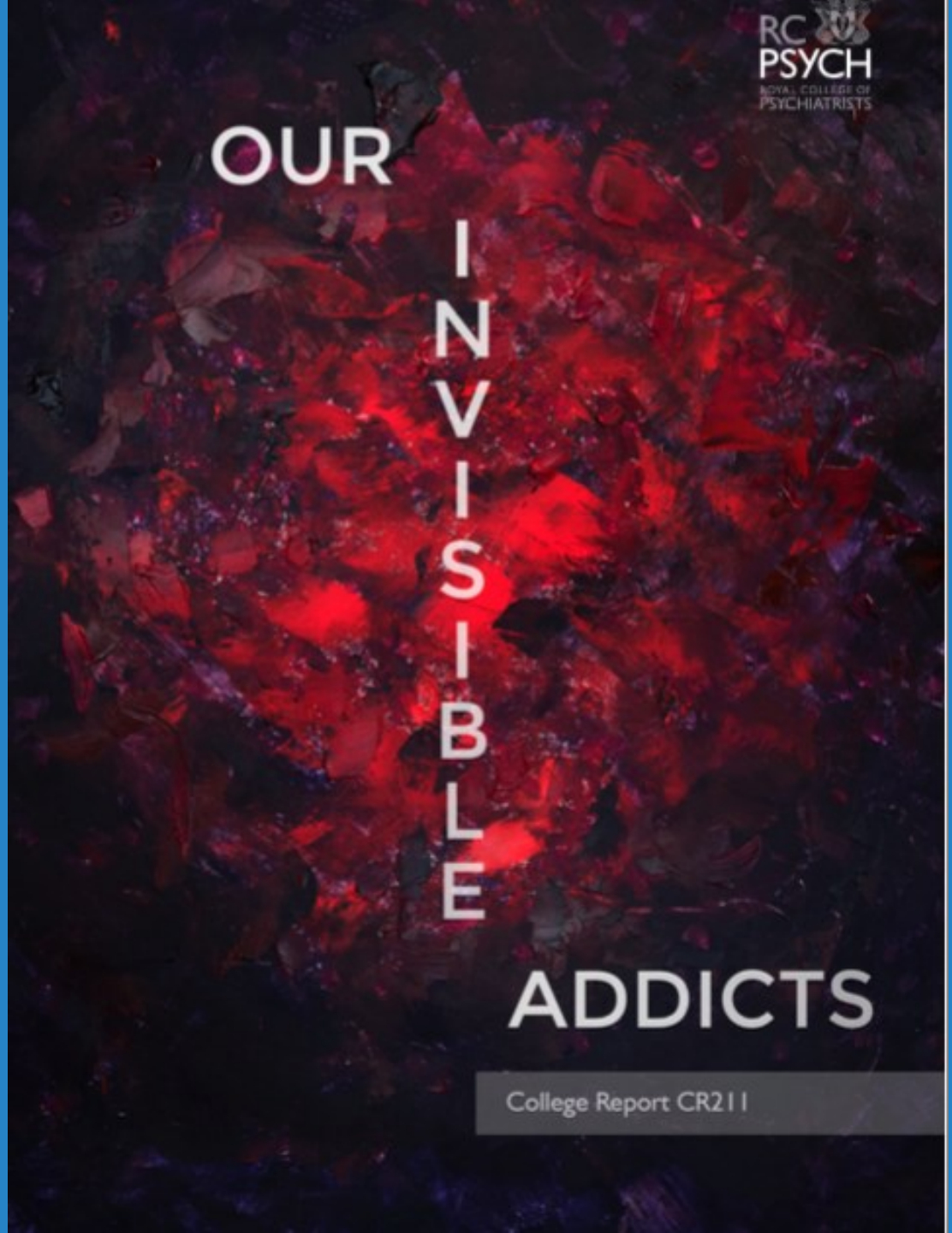
No. of people >50 with substance misuse is growing rapidly

In both UK and Australia risky drinking is declining except in >50

Strong upward trend for episodic heavy drinking

Not just alcohol – prescription drugs!

In Australia – largest percentage increase in SU 2013-2016 , 60+ prescription drugs, 50+ - cannabis


RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS
OUR
INVISIBLE
ADDICTS
College Report CR211

OUR INVISIBLE ADDICTS 2018

On the rise!

Baby boomers at highest risk!

Misuse of illicit drus – cannabis, amphetamines, prescription pain killers and gabapentinoid drugs a growing concern

SU assoc. with reduced life expectancy & accelerated aging, compounded by socioeconomic deprivation

OUR INVISIBLE ADDICTS 2018

Higher death rates in older SU than general population

Death rates by poisoning from SU on older people > doubled over past decade

Low risk drinking levels ? too high for this group (1.5 units /day – Men 11SD/week; Women 7 SD /week)

OUR INVISIBLE ADDICTS 2018

Psychosocial factors – social isolation, financial probs, retirement, life events, pain & insomnia

Prevention of alcohol misuse vs. alcohol as a social lubricant

Those with mental health co-morbidity – anxiety, depression, personality disorders – have higher rates of SU

THE NEW ZEALAND SCENE

"YEAH RIGHT!"

CHRISTCHURCH STUDY

(Khan, et al 2002):

N =141, randomly selected 65 +, in community, plus patient's GPs

36.9% drank 4 or more / week

24.8% had lifetime alcohol dependence

9.9% - hazardous drinking in the last 12/12 ; 2X more likely to be hospitalised, less likely to have seen GP

OF THE 108 GP PATIENTS

26.9% had lifetime alcohol dependence

cf 3.7% identified by GP records

10.5% hazardous drinking in past 12 months but none detected by GP

i.e. We are missing it!

HIGHER PREVALENCE FOR MAORI

Mental disorders – 1.7X more likely than other ethnicities

SUD - 3X more likely to experience

Risk factors for dementia, CVD, depression, head trauma

Reduced life expectancy

GREY MATTERS: Preventing and responding to alcohol and other drug problems among older Australians

Information Sheet 3

NCETA
Australia's National Research Centre on AOD Workforce Development

The silver tsunami: The impact of Australia's ageing population

Roger Nicholas | Ann M Roche

As the population ages, generalist and specialist alcohol and other drug agencies will have an expanded role in preventing and responding to associated problems among older people.

Substance use among older people occurs along a spectrum as it does in the broader population. Some people don't use any substances or their use is not problematic. For others, use can be problematic and associated with intoxication, hazardous use or dependence (Figs 1 & 2). Use can fluctuate over time.

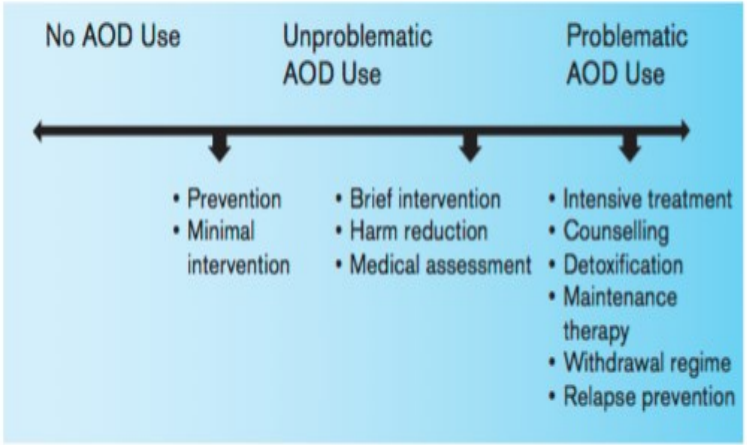


Figure 1: The spectrum of alcohol and drug (AOD)

OLDER SUBSTANCE USERS – VARIOUS GROUPS

Maintainers

- Have continued their previously unproblematic use into older age
- Age-related changes in metabolism may result in harms later in life

Survivors: Early onset users[2]

- Make up two thirds of older problem drinkers
- Have a history of substance use which persists into older age
- Often have co-morbidities

Reactors: Late onset users[2]

- Problem use begins in 50s or 60s
- Associated with stressful events e.g., bereavement, retirement, marital breakdown or social isolation

RISK FACTORS

Social factors
Bereavement, social isolation, lack of social support, financial difficulties
Psychological factors
Depression, loneliness, anxiety, memory problems, cognitive impairment, dementia, confusion
Physical factors
Lack of mobility, falls, reduced self-care, general ill health

OLDER DRUG INJECTORS

Older PWID also increasing, in the developed world

Many began injecting in 80-90's and have continued

Considerable levels of co-morbidity

Barriers to accessing treatment – stigma and discrimination; service models that don't fit; economic disadvantage and competing priorities

OLDER PWID/OST

In Australia – nearly 50,000 on OST, 22% >50 years

cf

In NZ – approx. 5000 on OST, >50 years - % unknown

In Waikato – 300 on OST, approx. 30% >50

Because of stigma – fewer PWID seek PHC

High rates of smoking – CVD, other chronic conditions - HCV

CHAIR OF RCP UK - 2011 LAUNCH

"Because of the pre-conception that A&D use are problems of the young, there is a generation of older people for whom these problems have gone undetected……Our challenge is to improve detection of these invisible addicts and offer treatments which we know can transform people's lives."

OLDER PEOPLE WITH SUBSTANCE MISUSE

Many want to abstain and have the capacity to change

Benefit from treatment … can have better outcomes than younger people

Respond well to brief advice and motivational enhancement therapy

Should not be excluded from treatment because of their age: treatment should be available, attainable and accessible

STIGMA AND DISCRIMINATION

Ageism (societal and internal)

Family feels ashamed

Unspoken assumptions:

“Not worth treating!”

“A waste of time and resources”

“Shouldn’t we be focusing on youth”

“Why deprive them of what little pleasure they have left”

UNMET NEED / LOSS

Employment

Mobility

Health

Peers

Partners

Hope

Identity

Independence

TREATMENT FOR OLDER PEOPLE

Pharmacological + psychosocial interventions

Critical to treat co-existing physical and mental health problems

Age specific programmes deliver the best results BUT …

Generally – the more treatment delivered the better the outcome

KEY COMPONENTS OF TREATMENT

Supportive,

Non-judgemental,

Non-confrontational,

Flexible,

Sensitive to gender and culture differences,

Focused on functioning , coping and social skills,

Holistic

WHAT DO WE NEED?

Development of a clinical workforce with the appropriate knowledge, skills and attitudes to provide identification, assessment, treatment and assist in recovery and referral for substance misuse in an older population.

A multidisciplinary approach – psychiatry, nursing, pharmacy, OT, psychology, social work and voluntary sector (peer support).

CASE STUDY - MURPHY

65 year old NZ European man, looks older than his chronological age

Lives alone; council flat

Referred after multiple presentations to ED

Acute alcohol withdrawal

Severe alcohol dependence – relapsed to drinking 8 months ago - 3 L wine /day – 4-5 days /week, until the money runs out

CASE STUDY – MURPHY - background

Macrocytic anaemia – ETOH related ; nutritional

Atrial flutter

Cardiomyopathy 2ndary to AF and ETOH

HTN

T2DM

Bipolar affective disorder

Polio as a child

Chronic pain – fall 20 yrs ago – multiple fractures

Historical sexual abuse

Current smoker / COPD

CASE STUDY – MEDS.

Omeprazole

Dabigatrin

Sotalol

Frusemide

Cilazapril

Venlafaxine 225 mg od

Quetiapine 100 mg od

Lithium 250 mg nocte

Metformin 850 mg bd

Thiamine

Folic Acid

Multivit

Disulfiram 200 mg po od

Paracetamol

PROBLEM LIST

Alcohol intoxication / falls

Alcohol withdrawal /risk of seizure

Poor mobility

SOB

Poor nutritional status

Self neglect

Estranged from family

Social isolation / loneliness

TREATMENT- COMMUNITY BASED VS. RESIDENTIAL

Engagement – CADS keyworker (RN) home visits

Safety - Manage risk - falls/withdrawal

Priority inpatient admission for 7 days

Stabilize – bloods/meds/dietary intake

Add Disulfiram – supervised dosing

Back to GP for referral to cardiology /COPD clinic

Referral to CADS Living with Complexity group

Re-engage with family

RESIDENTIAL?

Limited options

Long waiting times – weeks to months

Mostly based on 12 step approaches – AA.

Limited expertise – mostly NO MDT

Not age specific

Varied duration – 12 weeks vs. 20 weeks vs. 1 year

BUT - Give up flat – but finite duration, so where to?

- Possibly go to a different geographical area

OUTCOME

Early days – 6 weeks sober

Well engaged

Compliant with medications

Attending pharmacy 3 times a week for supervised dosing

Family visiting /reconnected with son

Seeing GP, referrals in place for OP f/u

Motivated to remain alcohol free

Mobility poor, pain persists, fatigue – but some improvement!