agenda here that needs to be tackled. Improving the outcome for these depressed older people does not only have implications for well-being but also for physical recovery and utilisation of healthcare resources.

While the value or practicality of population screening is doubtful, perhaps, we should just concentrate on education programmes that enable ward teams to recognise the key features of depression in this population and to then have easy access to liaison psychiatry teams competent in assessing older people’s mental health. Reliance on quick tests, which in any case still need to be interpreted, rather than applying informed clinical knowledge and skill, and talking to patients, may be counterproductive and produce poor clinical practice. This condition is sufficiently common for it to be a routine part of training for all general hospital clinicians.

Key points

- The value and practicality of routine screening for depression in older hospital inpatients are doubtful.
- We should concentrate on education programmes that enable ward teams to recognise the key features of depression in this population and to then have easy access to liaison psychiatry teams competent in assessing older people’s mental health.
- Reliance on quick tests, rather than applying informed clinical knowledge and skill and talking to patients, may be counterproductive and produce poor clinical practice.
- Depression is sufficiently common for it to be a routine part of training for all general hospital clinicians.

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References


Substance misuse and older people: better information, better care

Background

The publication of a new guide for health professionals assessing and managing older people with substance misuse heralds a new era of clinical practice, fuelled by the increasing numbers of ‘baby boomers’ joining the over 65-year-old population. Substance Misuse in Older People: An Information Guide was published by the Royal College of Psychiatrists in April 2015 [1], as a follow-up to Our Invisible Addicts [2], the first report on this topic. It provides guidance stretching from assessment, through to the management of physical
and psychiatric emergencies; also including sections on increasingly relevant clinical presentations such as alcohol-related brain damage (ARBD). The Guide is derived from the evidence for treatment of older substance misusers where this exists, and the extensive evidence for adult substance misusers. It draws on clinical expertise in a range of disciplines and professional groups. The Faculties of Addiction and Old Age Psychiatry of the Royal College of Psychiatrists also reviewed the Guide. The intention of this editorial is to capture the essence of the Guide and its relevance to the medical care of older people. It is also set in the context of renewed interest in the widening area of addictions in older people [3, 4].

**Assessment**

The Guide emphasises the importance of a systematic and thorough assessment, which can be more challenging than in a younger age group. In the first instance, the assessment should be non-judgemental and non-ageist. Several important themes reverberate throughout the Guide, but start with the initial assessment, which is regarded as the initiation of treatment. Dignity, individuality, including patient experience and their values are highlighted, respectfulness and empathy stressed, as many older people may need more time for examination, due to sensory deficits or chronic disorders. Not made of the fact that presentations can be atypical and the absence of information may be more important than what is actually reported. Indeed, under-reporting may be the result of denial, stigma, lack of awareness, memory disorder, ageism, stereotyping and misattribution of signs of substance misuse to other disorders. A suggested framework for the outlined assessment is the core of a management plan, which, of course, will be subject to regular review. With collateral information, it will be possible to build up a clinical picture, including the need for safeguarding. Clinical staff should be competent to detect the acute and chronic effects of substances [5]. Other pointers to a high index of suspicion are social factors such as homelessness, bereavement, retirement, social isolation and immobility. There could be interactions with prescribed and over-the-counter medications given that older people may suffer from multiple co-morbidities. Most of the ‘geriatric giants’ may be precipitated by substance misuse. The most widely used age-specific screening tools, the Short Michigan Alcoholism Screening Test—Geriatric version and the Alcohol Use Disorders Test (AUDIT), particularly AUDIT-5 (a 5-item tool) and AUDIT-C (a 3-item tool), have been validated in older populations and are recommended [6, 7]. As validated screening tests specific to older substance misusers are confined to alcohol problems but not to other substances, the value of the comprehensive assessment is reiterated. Key relevant aspects of a mental state (e.g. delirium, mood, cognition, psychosis) and physical examination (vigilance on specific signs of substance misuse) are described, and the need for assessment of functional status is underlined. The culmination of the assessment should inform decisions about the lead service, which can coordinate care.

**Emergency presentations**

Older people can present to the Accident and Emergency Department with non-specific signs, which may not be recognised as being related to substance misuse. Common acute presentations such as falls and delirium can be drug-related. Age-related physiological changes as well as polypharmacy, poor physical and mental health may make older people more susceptible to the complications of substance misuse. Patients may present with acute intoxication, which may evolve into a withdrawal state, which is often missed or confused with Wernicke’s Encephalopathy. It is vital that practitioners are aware of the need to differentiate and treat both these conditions within a medical setting to prevent brain damage from withdrawal and to limit the development of Korsakoff’s Syndrome.

Recognition of the dangerous impact of acute withdrawal syndromes is described in some detail, since these are often the result of misuse of alcohol and sedatives/hypnotics, which are the most commonly used substances in the older population. Delirium resulting from intoxication or withdrawal and the co-morbid medical conditions are underlined, due to high mortality rates if untreated. Overdose from opiates and benzodiazepines is discussed. Attention is drawn to the systemic effects of substance use on the gastrointestinal and cardiorespiratory systems.

Psychiatric symptoms may be those related to mood disorder, psychotic illness or cognitive dysfunction. Self-harm and suicide are serious risks. These symptoms may not be typical or it may be difficult to assess in older people due to their restricted lifestyle or may be masked by physical illness or alcohol intoxication. Depression and alcohol use are commonly linked. Psychosis may be the result of delirium, alcohol-related brain injury, depressant (alcohol and sedative/hypnotic) withdrawal, mood disorder, schizophrenia, the use of hallucinogens and stimulants or a combination.

**Alcohol-related brain damage**

The presence of a distinct picture encompassing a specific clinical presentation of brain injury from alcohol misuse is not a forme fruste. Instead, it is now recognised that multiple pathological processes present with an array of cognitive deficits and neuropsychiatric syndromes, ranging from Wernicke’s Encephalopathy/Korsakoff’s Syndrome to more widespread alcohol-related dementia [8]. In this respect, it is now considered that the term alcohol-related brain damage is a more valid description, while still able to differentiate isolated memory deficits from more global cognitive impairment. There is the potential for recovery and living in the community for the 50% of patients who respond to proper treatment and appropriate rehabilitation.
Implications for practice, policy and service development

Research that has been undertaken in older substance misusers points to considerable grounds for optimism in that older people want to change, can change and can be effectively treated with outcomes as favourable—if not better—than younger people. A non-judgemental, non-confrontational and supportive style of treatment is fundamental to build self-esteem and foster engagement. Brief interventions comprising following screening have been well researched and evaluated in adults and are found to be effective. This includes feedback based on the AUDIT score and biological tests, and an information leaflet. This can be the starting point for behaviour change, which can be encouraged by every generalist. Motivational interviewing or motivational enhancement (which include active listening, summarising and reflection) can further influence positive change. If more intensive treatment is required, cognitive behavioural therapy may be beneficial [3].

For far too long, the provision of needs-led services for older people with substance misuse (in particular, alcohol misuse) has operated within parallel or sequential services, where patients have often received multiple assessments and treatments for the same problems. Thus, an older person with alcoholic liver disease may be treated by hepatology, addiction services, geriatric medicine, old age psychiatry, both within the NHS and the voluntary sector. The Information Guide sets out a framework that should allow policymakers and commissioners to have a clearer vision about how services for older people with substance misuse could be better designed and co-ordinated. Although there are isolated pockets of good practice [9, 10], we are still far off the mark. The Information Guide should therefore go some way in shaping the future for improving health and social outcomes for older people with substance misuse.

Key points

• The rates of substance misuse in the older population are increasing.
• Identification is undermined by stigma, ageism, denial, stereotyping, non-specific symptoms and complex diagnoses.
• Detection, screening and a comprehensive assessment should be routine in clinical practice.
• Older people respond positively to evidence-based approaches.
• Multidisciplinary teams, working with families and carers, offer greatest likelihood of optimal outcomes.

Conflicts of interest

None declared.

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