

CATEGORY IV – DISTINCTIVE GROUPS: OLDER PEOPLE

1.0 Introduction

Approximately 19% of the UK population are over 65 years old and this will increase to 22.4% by 2032. It is anticipated that the number needing support for substance problems will double by 2020. Alcohol and prescription drugs are the most commonly misused substances in the older population, and are often associated with physical and mental health difficulties. Moreover we are seeing a number of older people who have a long history of drug misuse and who are now presenting to services with physical health problems in the context of ongoing misuse. Typically, older people may present with complex problems. Physical health problems and long term prescription of medication are potentially important factors in the development of substance misuse in older people. Psychiatric co-morbidities including intoxication, delirium, withdrawal symptoms, anxiety, depression, self-harm and attempted suicide, psychosis and cognitive changes are common in older people who use substances. Often patients present with indirect use of drugs and alcohol such as collapse, falls, burns, confusion or other substance related conditions. These issues may not be immediately evident, or may be atypical or subtle, without exploration of lifestyle issues through an assessment. Furthermore, problems may be related to social aspects of life such as bereavement, retirement, boredom and loneliness.

This fact sheet is concerned about older people who present to services. The definition of older may have different meanings in different specialities. For example in substance misuse services, this may refer to someone who is over 40, for other services this may mean people over 60, or for mental health services, this may mean over 75s. For the purpose of this fact sheet, we refer to people over 60, but note that, for some conditions such as Korsakoff's, and dementia, consideration needs to be given for early onset of conditions.

LEARNING OUTCOMES

Medical students will gain knowledge in:

- Recognising and understanding the core issues for older people in relation to substance misuse.
- Taking a detailed substance misuse history in older people and list key differential diagnoses.
- Initiating an appropriate care plan recognising that older people do well with substance misuse interventions.
- Providing effective advice to older people about the impact of drugs, alcohol and other medications on their daily living.

Vignettes

Case 1: Alcohol Vignette

BACKGROUND

Mrs Annette Smith is an elderly Caucasian lady in her mid-70s living on her own following bereavement four years ago. She functions well with minimal support in the community. Her daughter lives 20 miles away but only visits occasionally.

Recently, her neighbours had called the fire services after they noticed smoke billowing from her house. The fire was put out and Mrs Smith took residence with her daughter. Investigations by the fire service revealed that the source of the fire was a microwave (she had put some metal in the microwave).

CONTACT WITH MEDICAL SERVICES

A couple of days after Mrs Smith moved into her daughter's, she presented with seizures and was admitted to a medical ward. Alcohol withdrawal was considered the cause for the seizures.

On further enquiry, her daughter had noticed that a day after she moved into their house, she was tremulous, anxious and irritable. They attributed this to stress relating to fire incident. They were unaware of the extent of her alcohol intake which she had concealed from the family.

Whilst on the medical ward she admitted to the doctors that she had been drinking alcohol heavily starting in the morning and continuing with frequent drinks throughout the day. On further detailed history taking she was deemed dependent on alcohol as she was drinking in the morning to avoid the withdrawal symptoms. Her alcohol content was mainly gin drinking half a litre to one litre daily.

She reported that following her husband's death four years ago she had become depressed and started drinking. This had quickly escalated and she concealed her drinking problem from the family members. On the day of fire she had put a metal plate in the microwave by mistake under the influence of alcohol and then fell asleep on the sofa.

CONTACT WITH MENTAL HEALTH SERVICES

Following an alcohol detoxification in the acute hospital she was referred to the regional Drug and Alcohol team where she went through systematic assessment including a comprehensive history, motivational interview and examination. Consideration was given to Acamprosate but she was not keen when the side effects related to renal functioning were explained. She was assessed as having

SUBSTANCE MISUSE FACT SHEETS

CATEGORY IV – DISTINCTIVE GROUPS: OLDER PEOPLE

moderate depression and citalopram 10mgs OD was commenced.

Mrs Smith was also referred for bereavement counselling and a social care package was arranged to enhance her functioning. Her family and GP became more closely involved. She was offered cognitive behavioural therapy and invited to attend Alcoholic Anonymous meetings. She worked well with the cognitive behavioural therapist and developed good insight into her alcohol problems. Mrs Smith found it particularly beneficial attending Alcoholic Anonymous meetings. She engaged well with the services and eventually recovered from her alcohol problems and her depression improved.

RELAPSE

With the support of Recovery team from Drug and alcohol services she remained abstinent for 6 months. Since she was functioning well her care package was stopped. Around the same time her daughter moved to Dubai with her husband who was working in an oil refinery. She had a drink on her 72nd birthday but soon this escalated to drinking to her previous levels which was a bottle of gin daily. She was drinking first thing in the morning and dependent on alcohol neglecting her personal hygiene and not eating very well. She then disengaged with services.

ALCOHOL DEMENTIA

Mrs Smith reverted to her previous levels of drinking for the next few years. As her daughter was still living away, her neighbour who was her good friend became concerned regarding her memory as she was getting increasingly forgetful. In particular her short term memory was poor and her neighbour noticed that her personality was changing. She became socially less active and not engaging in any meaningful conversation.

Her neighbour was particularly concerned as on one occasion, she had left her door open and was found wandering in the streets without any proper clothing and acting in a strange manner. Her neighbours informed the police who found her very distractible, confused and hallucinating. She was detained under Section 136 of Mental Health Act (1983) by the police and taken to nearest 136 Suite at the local Psychiatric Hospital. After assessment by the psychiatrists she was admitted to the Acute hospital under the Mental Capacity Act where delirium tremens was suspected.

She received the treatment with intravenous thiamine, vitamin supplements and diazepam for alcohol withdrawal and transferred to a psychiatric unit for further assessment once the delirium tremens resolved. During her stay in the psychiatric unit which lasted 2 months, a comprehensive assessment involving detailed history, dementia screen, blood investigations, brain imaging, cognitive tests and physiotherapy and occupational therapy assessment was carried out and she was diagnosed with alcohol related dementia. She had scored 63 out of 100 on ACE-R (Addenbrookes Cognitive Examination) and neuroimaging showed generalised atrophic changes, enlarged ventricles and without any lobar predilection. She was diagnosed with an alcohol related dementia.

Since this was an alcohol related dementia she was not started on cognitive enhancers. Assessment also showed that her visuospatial skills were poor as she was bumping into objects and her ability to look after personal activities of daily living was

affected requiring assistance with most of the activities of daily living. She was becoming easily disorientated in the ward and at times she tried to leave though generally was compliant. The risks in terms of self-neglect and wandering were clearly identified and she was deemed not to have capacity to decide her treatment and management.

Therefore a best interest meeting was convened involving various members of the multi-disciplinary team i.e. psychiatrist, community psychiatric nurse and inpatient nursing staff, occupational therapist, physiotherapist, social worker and Independent mental capacity advisor. A DOLS (Deprivation of Liberty Safeguard) assessment was also completed. Her daughter was also able to join the meeting. Considering the significant risks it was felt that it was not safe to manage her in the community and the different assessments had indicated that she would require EMI (Elderly Mental Illness) nursing care. Therefore she was discharged to a care home with a clear follow up plan from the community mental health team.

Case study 2: Poly substance use vignette

BACKGROUND

Mr John Brown is a 63 year old gentleman who self-referred to the Drug and Alcohol services with poly substance misuse. He has an extensive previous history for addiction having started smoking heroin in his early 30's and developed heroin dependence. He had started using drugs with his girlfriend who was a poly substance misuser. They were each smoking 3-4 bags of heroin daily and then started to inject after 6 months due to tolerance. He then contracted Hepatitis C infection and received treatment successfully.

In terms of alcohol, he had started drinking socially over the weekends in his early 20's and by early 30's he was drinking heavily up to a bottle of vodka most nights. He was also smoking cannabis 2-3 times a week.

EARLY INVOLVEMENT WITH HEALTH SERVICES

This pattern of drug and alcohol misuse lasted for five years until he had a car accident and was admitted to hospital. He underwent alcohol and opioid detoxification and following investigation he was told that he had fatty liver and was advised to reduce his alcohol intake. After discharge from the hospital, he started a relationship with a friend and they became engaged. He gradually reduced his heroin use and alcohol on his own and eventually stopped. He opened a gym and became very busy with life after the marriage and the birth of their son. He remained abstinent of alcohol and recreational drugs for 25 years and stopped smoking cannabis. He continued to smoke cigarettes.

RELAPSE

Over the years he developed Chronic Obstructive Pulmonary Disease as he was smoking 20-30 cigarettes per day and developed hypertension. Due to the failing health he sold his business and retired. He was admitted to hospital with septicaemia when he was 60 and one of his kidneys had to be removed. Whilst in the hospital he was prescribed morphine for pain and this continued when he was discharged home. After the prescription was stopped a couple weeks later he found it difficult to cope and started using heroin again. He was smoking three bags of heroin but remained abstinent of alcohol. His wife came

SUBSTANCE MISUSE FACT SHEETS

CATEGORY IV – DISTINCTIVE GROUPS: OLDER PEOPLE

to know about it and advised him to seek help. He self-referred to the Drug and Alcohol services and started receiving treatment with methadone.

Mr Brown progressed well with intensive treatment and input from the Recovery team at the regional Drug and Alcohol services. He was having regular urine drug screening, practising cognitive behavioural therapy techniques to develop good insight into his drug habit and he was regularly attending Narcotic Anonymous meeting.

DEPRESSION

Unfortunately after a year his son was diagnosed with terminal cancer and he became depressed as he had significantly reduced his eating and drinking and he had lost considerable amount of weight. Mr Brown had lost interest in watching football, going for walks and meeting people and engaging in interesting conversation with wife. He was not sleeping very well waking up early in the morning and feeling tired during the day. He was talking about life not worth living. Despite this he had remained abstinent of street drugs and alcohol. His family and the care worker raised concerns regarding his deteriorating mental and physical health.

Mr Brown was taken to Drug and Alcohol services where he was seen by a psychiatrist and he agreed for an informal admission to a functional ward at the local Psychiatric Hospital for further assessment and treatment. Following admission he was seen by the admitting doctor who found him very depressed with suicidal ideations but no active plans. Mr Brown was prescribed his regular medication including methadone. He underwent physical examination and the routine blood investigations and ECG which were unremarkable. His urine drug screen was negative for all the drugs but positive for methadone. His breath alcohol was negative. He was placed under 15 minute intermittent observation level due to suicidal ideation and for effective monitoring of his mental health.

Mr Brown was commenced on an antidepressant, sertraline. An initial review meeting was convened to gather collateral information and the events leading to admission. His wife visited him regularly and there were further meetings involving members of the multidisciplinary team and family. He underwent physiotherapy and occupational therapy assessment which was fine. His antidepressant dose was gradually increased. After few weeks in the hospital, he started to improve in his mental health and he was eventually discharged from the hospital once there was good recovery in his depression. He was given an out-patient appointment for follow up with a psychiatrist and there was a clear post discharge follow up plan by the CPN and the care

2.0 Context

Older people are increasingly using legal and illegal substances including misuse of both prescribed medication and over the counter medication. Alcohol related deaths in the 55-74 age group more than doubled between 1991 and 2005, from 1,200 to 2,600. Older people use twice as many prescription drugs as young people. They are at risk of multiple physical and mental health co-morbidities associated with ageing. Treatment for older substance misuser is effective: Older people often do better than their younger counterparts.

Whilst those over 65 drink less alcohol than their younger counterparts, they consume more frequently. More older people are admitted to hospital with alcohol-related conditions than younger age groups and from 2002 to 2010, the number of alcohol related admissions in those aged over 65 in England, doubled to reach 500,000. The trend in admissions for mental health and behavioural problems related to alcohol shows a 150% increase from 2002-2013. Similarly, alcohol related deaths in the UK, have risen by 58% between 1991 to 2011 from 528 to 834, in those over 75 years.

A lifespan of alcohol use can also manifest itself in Wernicke-Korsakoff Syndrome (WKS), which is a spectrum of disease resulting from thiamine deficiency, usually related to alcohol misuse. Wernicke's encephalopathy was originally described by German neurologist Karl Wernicke in 1881 as a classic triad of symptoms (mental confusion, ataxia and ophthalmoplegia). Korsakoff's psychosis is the late manifestation of the condition, where Wernicke's encephalopathy has not been adequately treated. There is much greater risk in those who drink alcohol continuously rather than binge drinking. It affects 1 in 1,000 of the population worldwide, the peak onset is seen in males aged 40-59 years and in females aged 30-49 years. Approximately 2% of alcohol abusers develop the syndrome.

3.0 Common presentations

3.1 Special features

Presenting problems may be assumed to be the effects of old age so that the detection of drug or alcohol use may be missed. Drinking patterns change as people get older and alcohol can have an effect on drug interactions with other medications, and mental and physical co-morbidities. Older people are more likely to have co-occurring physical and mental health conditions for which they are receiving prescriptions.

Older people may present in any setting with a health or social care issue, and there may be a drug or alcohol issue which is not immediately evident, that may affect their health or social well-being. The presenting problem could be the side effects of a prescribed or over the counter medication. Older people may unknowingly take more than that prescribed due to memory changes, reduced concentration, poor judgment, lack of ability to look after themselves, anxiety and generally feeling unwell. Tremors, unexplained bruising, and increased frequency of trips, slips, falls and accidents are common presenting features. Furthermore, older people may put themselves at risk or in a vulnerable position in their efforts to obtain alcohol and medication such as going out in the dark, giving money to a stranger to buy alcohol or medication (legal and illegal) for them.

3.2 Distinctive features

- Older people may metabolise substances more slowly so that they accumulate more in the blood.
- Older people's brains may be more sensitive to the effects of substances.
- Older people are at greater risk of adverse effects even at low doses of substances so even though substance use declines with age, the impact may be great.

SUBSTANCE MISUSE FACT SHEETS

CATEGORY IV – DISTINCTIVE GROUPS: OLDER PEOPLE

- Older people are more likely to have medical and mental health problems which may predispose them to the use of substances.
- Older people may not recognise that their symptoms could be related to substance.

3.3 Barriers to detection

Many older patients

- Fear being judged
- Feel that no one cares about them, and that they don't want to be a burden
- Feel there is no one to care for them, no family and no friends who can help
- Think it's only a drink, it can't do any harm
- Deny drug or alcohol use or minimise the issues
- Who have memory loss may find it difficult to give an accurate history of substance use.
- May consider that it wasn't relevant to mention substance use as it was usual behaviour and this has been the same pattern of use for many years, maybe even decades and so patients does not perceive it as a problem and therefore wouldn't mention it.
- Feel some level of loneliness and depression and that they gain comfort from substance use.
- Experience stigma.

4.0 Assessment:

Virtually every system in the body can be damaged by alcohol; accidents and injury are particularly frequent. It is therefore important to ensure that any assessment includes consideration of all systems of the body and not just focused on the overt presenting issues and that the use of drugs and or alcohol is considered as a possible factor in all cases. It is only ethical to give older people the same detailed assessment as younger people so as not to be ageist, to stereotype and to perpetuate myths about substance use in older people. Therefore, a comprehensive assessment of their current and past use of substances is required in every case. Lack of knowledge or lack of confidence of the practitioner making an assessment may be due to an assumption that older people do not misuse substances.

Practitioners need to have a high index of suspicion in relation to the impact of substance use on older people as it is frequently overlooked. This is essential in order to determine the appropriate treatment approach. Sometimes older people

themselves, their carers' and even the clinicians who are caring for them, have not had the opportunity to gain a full picture of the range of substances that the person may be using, and the effect this has on their overall health and clinical presentation. For instance, any erratic or alteration in behaviour, requests for more prescription drugs, financial problems, and illegal activities should alert health and social care professionals.

Older people do not need to use high quantities of substances for these to have a detrimental impact on their health and well-being. Furthermore a detailed probe about this is essential since they often use over the counter medication and therefore iatrogenesis is a major contributor to substance related problems in older people. Older people may suffer from substance problems directly related to prescribing for medical conditions. They may also be troubled by the side effects of the pharmacological treatment of substance misuse. Treating older people with medication is frequently a subtly balanced judgement taking account of their individual co-morbidities, pharmacological treatments for these, interactions of prescribed medications with each other and with substances of misuse, e.g., alcohol. Practitioners should give sufficient medication, e.g., pain relief, but be vigilant to toxic effects.

Assessment should include a detailed history from the patient where appropriate. If the patient can give consent then information from family, carers and friends can be invaluable. Confidentiality must be respected in older people as in any other age group e.g. young people, adults. A physical examination and investigations including a urine screen should complement this.

It is also useful when taking a history to obtain information where possible from friends and neighbours or carers involved who may provide further information to build up a picture of needs.

Review all medications to establish whether they are all still necessary as some older people may be on medication for years without a review and may not require them or may need a different medication or arrange for pharmacy and GP to review medications. It is important to explain to people the effect alcohol can have on their medication and to involve family members in assessment, treatment and care planning. Asking others involved such as neighbours, friends and carers, whether they have noticed any changes, or have any concerns that will help build up a picture and it is useful to cross check information given to obtain an accurate picture especially where memory deficits appear to be an issue. Patients should not be sent home without a safe plan of care in the community.

SUBSTANCE MISUSE FACT SHEETS

CATEGORY IV – DISTINCTIVE GROUPS: OLDER PEOPLE

Examples of questions	Reason for asking
What do you like to drink?	The patient should be probed specifically about types of drinks e.g. white wine, red wine, beer, whiskey etc. and the actual amounts
How many days a week do you have a drink?	To establish regularity of drinking
Are there any days when you don't have a drink?	To assess whether there is a dependency and whether the individual is able to control drinking
How much do you drink each day that you drink?	To be able to assess the number of units the individual is drinking
Show me how big a glass you might use?	People do find it difficult to know how much they drink, and so might use terms such as small glass, so if they show you (compared to another drinking vessel) it gives the assessor an indication of size, as they may be drinking more than they describe
What time do you usually have your first drink of the day?	This gives an indication of severity of drinking
How do you usually get your drink?	Whether it is regular, part of routine shopping, or someone buys it for them
Have you ever needed to ask someone passing by to go and buy you something?	Assessing severity of problem and vulnerability
How much do you think you spend on your drinking?	Get a sense of whether drinking has an impact on other needs, such as buying food and other provisions
How does drinking affect you (sleep, walking, movements, concentration, etc.) What would happen and how would you feel, if you didn't have a drink or drank less?	Obtain the person's own view of any effects and whether this is a problem or stops them doing their usual activities during the day
What medication do you take that isn't prescribed?	To establish whether the person is taking over the counter medication
Do you know what these medications are for, and how do they help you?	To establish why they take them Also helps you assess whether there are contraindications with prescribed medications that may lead to problems assessed
Does anyone else give you any medications that they have or don't need?	Whether getting additional supplies and where from, again to assess any vulnerability
How does the medication affect you (sleep, walking, movements, concentration, etc.)? What would happen/ and how would you feel, if you didn't take any of these medications?	Obtain the person's own view of any effects and whether this is a problem or stops them doing their usual activities during the day

5.0 Treatments

With older people the type of treatment response will need to be considered in light of the type of drug or alcohol use, the effect on their health and social circumstances and appropriateness. This may include supervised treatment by health and social care staff or family, or home visits. It may also include utilising the opportunity of an admission to hospital to provide the necessary treatment such as detoxification from a substance of dependence under medical supervision.

Once the use, misuse, harms and addictive use of the range of substances have been established, the patient should be offered support in reducing or stopping substance use. This may include

pharmacological treatments and psychosocial interventions. Unnecessary prescribed medications may need to be withdrawn, sometimes gradually. If the patient has presented in an acute state, e.g., alcohol withdrawal, this phase may require emergency inpatient treatment, rather than community detoxification. However, following the resolution of the acute presentation, certain interventions may be offered in the inpatient or outpatient or primary care setting e.g., brief interventions (see information below and link to fact sheet assessment and tools), behavioural treatments, and support with social problems. However, referral to substance misuse services e.g. smoking cessation, alcohol and drug statutory NHS

or voluntary services may be appropriate. There are no designated services for older people with addiction problems in the UK, but a multidisciplinary team approach is the preferred option. Thus old age psychiatry/addiction and general medical or geriatric services and teams should work together. The evidence indicates that older people do well in treatment and often do better than their younger counterparts. Older people should be given special advice on the effects of medications and other substances on driving. Lastly, but most importantly, older people should not be denied treatments that are effective in adults.

As demonstrated in the vignettes, the first intervention that might be considered is a detailed assessment. Be mindful that the patient may find solace and comfort in drinking and will not want the only thing that helps them to cope be taken away. When assessing the patient and considering treatment options, consider that s/he may not wish to change his drinking habits. Patients may require some “talking therapies” where s/he can talk about how the drinking helps him and in what way it helps him, so that he can explore other strategies to cope without drink. This intervention starts at the point of assessment. The patient and their family may need advice to understand how the alcohol affects the patient and family and how it will impact on physical health.

Detoxification most probably will need to be undertaken in a hospital setting potentially because of a patient’s chaotic life style, heavy drinking pattern, comorbidity or if they are living alone. Other causes such as infection, undetected head injury, underlying medical condition, depression and malnutrition should be excluded. It is also important to differentiate delirium tremens from Wernicke Korsakoff’s Syndrome. Consider the differential diagnosis such as other chronic conditions that may cause a thiamine deficiency including AIDS, thyrotoxicosis, cancers that have spread, long-term dialysis and congestive heart failure. For those where there are clinical indications of Wernicke Korsakoff’s Syndrome, a range of investigations should be considered. Diagnosis is based mainly on the history and physical examination, and if the condition is suspected, treatment should not be delayed whilst waiting for test results. If the history is significant for chronic (long-term) alcohol abuse, serum or urine alcohol levels may be elevated.

When taking a history it is useful to consider whether substance use has any effect on the condition presented or assessed. It is also an opportunity to provide some education and guidance to older people about the effect of alcohol or other medications and drugs on their body and health. For example, someone complaining of not being able to sleep but takes an OTC preparation to aid sleep and also drinks lots of caffeine and takes analgesia for arthritic pain. It is a good opportunity to discuss about reduction of caffeine intake in the evening and discuss management of pain.

6.0 Referral, networks and services

Older people may access many different care pathways as compared with younger people. These include liaison psychiatry, old age psychiatry services, GPs and acute hospitals. They may be referred from emergency services, from their place of employment, from care homes, from carers and relatives as they may still be in their own homes. ‘Dual diagnosis’ (comorbid substance misuse and psychiatric illness), rather than substance misuse alone, is the most common presentation within old age psychiatry. Older people may also be known to the local authority, and may be supported in the community by church groups, voluntary services and volunteers. They may access a range of voluntary services such as Age Concern, Red Cross, Alzheimer’s Society, League of Friends and other local voluntary services.

Local drug and alcohol services may have volunteers and peer supporters who work specifically with older people and support them. When thinking about older patients contact the local services and ask if they have services working with older people.

7.0 References and useful resources

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