Advisory Panel on Substance Misuse

(APoSM)

A Report on:

Substance Misuse in an Ageing Population

February 2017

Contents

Executive Summary

In Wales, the trend towards an increasing proportion of older adults (defined as those aged 50-plus) in the population is more pronounced than elsewhere in the UK: the proportion of the older population in Wales is projected to rise to 41 per cent by 2020. Not only are there an increasing number of older adults forming a bigger proportion of the population, they are, as a group, more likely than earlier generations to develop substance misuse problems – meaning greater demands on health, social care and other services. In prisons, people aged 60-and-over are the fastest-growing age-group. Older prisoners often have substance misuse problems when they enter prison but their substance-misuse related needs may not be adequately met in the prison system. Although alcohol use declines with age, older adults in England and Wales are more likely than younger adults to exceed the recommended drink limits, and older adults consume alcohol at high risk levels; they use large amounts of prescription and over-the-counter medication (more than four-fifths of people in Wales aged 65-plus report regularly taking prescribed medicines for a year or more) and unintended dependency or misuse can be a problem; and, while illicit drug misuse is not widespread among older adults, it is an issue for some, and the population in treatment for substance misuse problems is ageing. In Wales, the only group where referrals to substance misuse treatment services are increasing is those aged 50-plus.[1] Mortality rates linked to drug and alcohol misuse are higher among older adults, and alcohol-related deaths in older populations are increasing in Wales, with fibrosis and cirrhosis of the liver and alcohol-related liver disease the two main causes of death. Chronic diseases are more frequent in older adults and there is increased pressure on resources for pain management; the use of multiple and long-term medication which can lead to dependence is therefore common in this group.

The Welsh Government has strategies and policies relevant to older adults: the *Strategy for Older People in Wales 2013-2023, The Substance Misuse Strategy for Wales 2008-2018* and, as part of its suite of Substance Misuse Treatment Frameworks, *Improving Access to Substance Misuse Treatment for Older People.* Nevertheless, most substance misuse services are not configured to best meet the needs of older adults and specialist older adults' services are scarce: the Welsh Centre for Action on Dependency and Addiction (WCADA) runs the only

[1] Of course, this could be at least partly due to professionals being more likely to ask older adults about substance misuse and refer them to treatment when it is identified.

specialist older persons' substance misuse service in Wales. Substance misusers (of all ages) face considerable difficulties in accessing housing.

All services for older adults need to be aware of the potential for substance misuse among their clients and know how to address it appropriately: age-appropriate drug prevention, support and treatment can improve older adults' health and quality of life.

Summary of Recommendations

(See the recommendations in full in Section 6.)

Older people with substance misuse problems do not receive as much attention as young substance misusers: yet preventing, detecting and addressing problem substance use in older adults is important. Generic services are increasingly having to deal with an ageing population and will need to give greater attention to this group. Services specifically for older adults need to be aware of, and address, substance misuse among their clients.

The Welsh Government and national and UK bodies should promote good practice, such as ensuring that documents on substance misuse address the needs of older adults and documents on healthy ageing consider substance misuse. It would help if surveys and statistical data provided breakdown by age categories; older adults should be included in relevant surveys.

Substance misuse services across Wales need further development to improve their reach to older adults. For example, service managers and Area Planning Boards should make premises accessible, safe and welcoming to older adults and have a flexible approach to providing treatment.

All relevant services should be taking account of the ageing population and the changing patterns of substance misuse, and should be adapting their services appropriately. Good practice should be widely shared.

Other services that support older adults need to be more aware of, and informed about, the potential for substance misuse by their clients, the impact this may have, and how they can alleviate it. They need to be more aware of referral pathways to substance misuse services.

The Prison Service should continue to address the needs of older prisoners with substance misuse problems. The needs of older ex-prisoners with substance misuse problems need continued attention from the Probation Service.

Sustaining tenancies is a priority in supporting the health and wellbeing of older tenants. Landlords managing tenancies for older people should proactively carry out health and well-being assessments and refer appropriately.

New approaches to service provision are needed and should be piloted and evaluated.

Further research, analysis and modelling of the potential future health burden of substance misuse should be undertaken to help services plan for the future.

Acknowledgements

Annex A lists the members of APoSM. The Panel thanks the organisations and individuals who submitted written evidence and who attended the evidence-gathering day (see Annex B). We thank the co-opted members of the Ageing Population Sub-committee: David Liddell, Karen Ozzati, David Tovey and Dr Sian Heke.

Special thanks to Dr Sarah Wadd, of the University of Bedfordshire, where she leads the Substance Misuse and Ageing Research Team (SMART), a collaborative working group of researchers, including peer researchers, from several disciplines. Thank you to Professor Ilana Crome of Keele University for reading a late draft of the Report and providing helpful comments. APoSM's work is supported by its Secretariat, whose names are listed in Annex A.

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1. Introduction

Substance misuse among many older adults is a hidden problem. Older adults may not talk about their substance misuse or may play down their intake; this may be due to a feeling of shame, fear of stigma, or embarrassment. In many cases, they may not even realise they are exceeding the recommended limits for alcohol use, or developing a dependence on their prescribed medication. Their problems may not be identified, as the effects of substance misuse are sometimes mistaken for physical or mental health problems associated with ageing, or, due to a false belief that 'older adults don't experience substance misuse problems', they may not be asked questions about alcohol and drugs. This may mean that the person does not get the help that they need.

This Report examines the evidence on substance misuse among older adults: it draws on the academic literature; on data collected by (among others) the Welsh Government and Public Health Wales; and the knowledge and experience of the APoSM Ageing Population Sub-Committee members, both those from the Panel and the co-opted members. APoSM called for evidence from a range of relevant organisations and held an evidence-gathering day (see Annex B). The Panel aimed to develop population projections to identify what the current trends might indicate for future demands of an ageing population on services. Some population data are included at Annex D; the Panel's work on this issue is ongoing and it is intended that a short report on this matter will be published in 2017.

This Report concludes that substance misuse among older adults is a significant and growing problem that, despite significant and appropriate actions, is not always being fully addressed. It makes recommendations that arise from this conclusion.

In this Report 'older adults' are defined as those aged 50 or older, in line with existing service frameworks published by Welsh Government[2] and Department of Health[3].

This Report does not consider, tobacco, although the use of this has major health implications, of course.

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[2] Welsh Government 2014 *Substance Misuse Treatment Framework (SMTF) Improving Access to Substance Misuse Treatment for Older People*. Available at: http://gov.wales/docs/dhss/publications/141113substanceen.pdf

[3] Department of Health 2001 *National Service Framework for Older People.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

The most common substance of misuse is alcohol and this Report considers this substance in separate sections. A previous report of the APoSM has recommended that minimum unit pricing of alcohol is introduced in Wales.[4] The Welsh Government has consulted on draft legislative proposals to introduce a mandatory minimum unit price for alcohol sold or supplied in Wales. The proposals contained within the draft Public Health (Minimum Price for Alcohol) (Wales) Bill would make it an offence for an alcohol retailer to supply, or authorise the supply of, a serving of alcohol for a selling price below the set minimum unit price for alcohol in Wales. If enacted, these proposals would decrease the affordability of alcohol and would be likely to reduce levels of consumption (among all ages) and decrease alcohol-related harm.[5]

A group of drugs that are often overlooked but which are increasingly subject to misuse are Prescription only Medicines (POMs) and over-the-counter (OTC) medicines. This Report therefore presents information about the effects of these substances. APoSM is currently considering the misuse of prescription only medicines and a report on this matter will be published in 2017.

The definitions of substance misuse are included in Annex C. Annex F has more information about alcohol.

[4] APoSM 2014 *Minimum Unit Pricing: A Review of its Potential in a Welsh Context* Advisory Panel on Substance Misuse http://gov.wales/topics/people-and-communities/communities/safety/substancemisuse/publications/unit/?lang=en

[5] Welsh Government Draft Public Health (Minimum Price for Alcohol) (Wales) Bill http://gov.wales/docs/dhss/consultation/150715consultation-draften.pdf

2. Substance misuse in an ageing population

'When considering how we respond to drug problems in the community or the needs of those in treatment, we have to accept that drug use in Europe is no longer a phenomenon restricted to the young. This fact brings with it the obligation to develop approaches and review interventions to ensure that they are also appropriate for older citizens.' Wolfgang Götz, Director, EMCDDA[6]

The UK population is increasing, as is the proportion of older adults in the population[7]: see Figure 2.1 (below). This trend is set to continue due to a range of factors, including increased longevity. Furthermore, in Wales the ageing population trend is more pronounced than elsewhere in the UK: the proportion of the older population in Wales is projected to rise to 41 per cent (1,301,000 people) by 2020, with a further increase to 1,398,000 people by 2035.[8] This trend has significant implications for many areas of life, such as the economy. For this Report, APoSM focused on: the nature and scale of substance misuse in the ageing population; the resulting physiological, psychological, social, and behavioural harms to individuals, families, and communities; this Report also looks at other issues, in particular, prisons and housing. It explores substance misuse treatment needs – and the service provision requirements to meet those needs – now and in the future.

For those who are already substance users in treatment it is relatively easy to estimate the numbers that will continue to require treatment as they age. But it is difficult to estimate how many older adults have a drug or alcohol problem and are *not* in contact with services. It is more difficult to predict the future demand from older adults who may develop substance misuse problems as they age; and those whose transition from one substance to another leads to problems.[9] What *is* known is that this will be a challenge: data for

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[6] European Monitoring Centre for Drugs and Drug Addiction.
[7] Office for National Statistics *National Population projections* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/z4zippedpopulationprojectionsdatafilesextravariantswales
[8] Welsh Government 2014 *Substance Misuse Treatment Framework (SMTF) Improving Access to Substance Misuse Treatment for Older People* Welsh Government http://gov.wales/topics/people-and-communities/communities/safety/substancemisuse/policy/treatmentframework/?lang=en
[9] Strictly speaking, past performance is not an indicator of the future. But if there was no change in the use of alcohol by younger people, the next generation of older adults would have similar problems. Fortunately, indicators of harmful alcohol use are decreasing in

both alcohol-related hospital admissions and new assessments in specialist substance misuse services show that the over-50s are the only age group showing year-on-year increases.[10] It is also likely that most of the increase in demand on treatment services from older adults in the future is likely to be related to alcohol rather than other drugs: more than 85 per cent of people aged over 50 referred to treatment for substance misuse in Wales during 2012-13 had alcohol as the primary substance of misuse.[11]

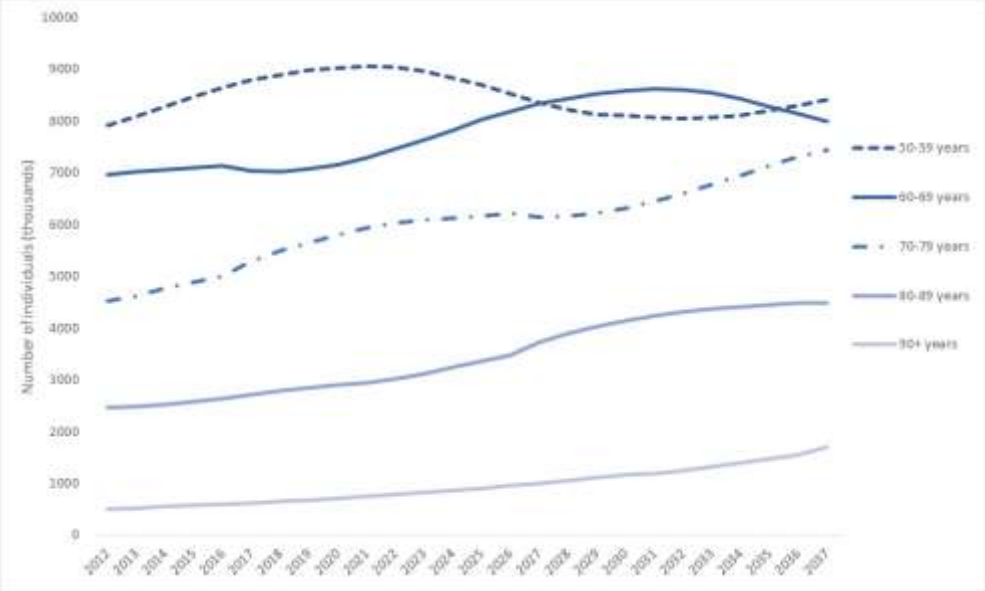

Figure 2.1: Projected population estimates for older people, aged 50 years or more by age group, United Kingdom, 2012-2037. [12] (Source: Office for National Statistics)

Not only are there an increasing number of older adults forming a bigger proportion of the population,[13] they are, as a group, more likely to develop substance misuse problems than earlier generations (including both alcohol and illegal/illicit drugs[14]). The EMCDDA[15] report, *Substance*

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younger people, for example, as a group, young people are these days more likely not to drink alcohol. And young adults are less likely to binge-drink.

[10] Public Health Wales 2015 'Reading between the lines: annual profile of substance misuse in Wales 2014-15' Available at: http://gov.wales/docs/dhss/publications/151029phw-report1en.pdf.

[11] Welsh Government 2015 *Treatment Data – Substance Misuse in Wales 2014-15* Available at: http://gov.wales/docs/dhss/publications/151029annual-reporten.pdf

[12] Office for National Statistics National Population projections Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/z4zippedpopulationprojectionsdatafilesextravariantswales

[13] (because of older adults' increasing longevity and a lower rate of population replacement).

[14] Tobacco smoking is also an important issue, but APoSM is not constituted to consider this.

misuse among older adults: a neglected problem reported an estimate that:

> '…the number of older people with substance use problems or those needing treatment for substance misuse will more than double between 2001 and 2020, and to date their needs have not been well met.'[16]

Substance misuse among older adults is an increasing public health concern. In 2011, the Royal College of Psychiatrists' Report, *Our Invisible Addicts*, set out the issues:

- 'The proportion of older people in the population is increasing rapidly, as is the number of older people with substance use problems
- Mortality rates linked to drug and alcohol use are higher in older people compared with younger people
- High rates of mental health problems in older people (including a high prevalence of cognitive disorders) result in frequent, complex psychiatric co-morbidity accompanying substance use disorders
- Older people may show complex patterns and combinations of substance use (e.g. alcohol plus inappropriate use of prescribed medications)
- Older people use large amounts of prescription and over-the-counter medicines and rates of misuse (both intentional and inadvertent) are high, particularly in older women
- Although alcohol use does decline with age, a significant number of older people consume alcohol at dangerous levels
- Although illicit drug use is uncommon in the over-65 age group at present, there have already been significant increases in the over-40 age group. As this cohort ages we should anticipate a significant increase in the number of older people using illicit drugs.'[17]

It may be helpful to distinguish between those with long-term problematic substance misuse and those whose problematic substance misuse has

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[15] European Monitoring Centre on Drugs and Drug Addiction.
[16] EMCDDA 2008 *Substance use among older adults: A neglected problem* – available at: http://www.emcdda.europa.eu/attachements.cfm/att_50566_EN_TDAD08001ENC_web.pdf
[17] Royal College of Psychiatrists 2011 *Our invisible addicts: First report of the Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists (pp6-7)* – available at: http://www.rcpsych.ac.uk/files/pdfversion/cr165.pdf

developed later in life: sometimes called 'early onset' and 'late onset'.[18] The 'early onset' group are likely to experience greater harm, because:

- early onset means a longer period of substance misuse, and so a person is more likely to experience the chronic effects of substance misuse, which could include conditions such as cirrhosis, certain cancers and mental health issues, as well as poorer general physical health
- those who have been substance misusers for a long time are more likely to have had contact with criminal justice services, and may have experienced negative consequences such as incarceration; this may have adversely affected their lives, for example, by making it harder to find work
- an important positive influence on a decision to enter drug treatment is the encouragement of family and 'concerned others'. Many ageing early onset substance misusers not in contact with treatment services have weak links to positive family influences[19],[20]
- those with early onset may have experience of unsuccessful contact with substance misuse services (as well as with other health and social care services) and, as a consequence, some may be harder to re-engage with services.[21]

There are other ways of categorising older substance misusers (one, the 'baby-boomer' phenomenon, is discussed in Annex E); but the individual pathways into and out of substance misuse are complex; therefore, services should address people's specific and individual needs.

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[18] Wadd *et al* define an 'early-onset drinker' as 'An individual who started drinking problematically before the age of 40', and a 'late-onset drinker' as 'An individual who started drinking problematically after the age of 40' (Wadd S Lapworth K Sullivan M Forrester D Galvani S 2011 *Working with Older Drinkers* University of Bedfordshire).

[19] Landau J Duncan Stanton M Brinkman-Sull D Ikle D McCormick D Garrett J Baciewicz G Shea R Browning A & Wamboldt F 2004 'Outcomes with the ARISE Approach to Engaging Reluctant Drug-and Alcohol-Dependent Individuals in Treatment' *The American Journal of Drug and Alcohol Abuse 30(4):711-48.*

[20] However, one study found that the concerns of family members and friends were the most common factor motivating older adults for inpatient treatment for alcohol problems. (Finlayson R Hurt R Davis L and Morse R 1988 'Alcoholism in elderly persons: A study of the psychiatric and psychosocial features of 216 inpatients' Mayo Clinic Proceedings 63:753-760, 1988).

[21] Smith J & Lyons M 2010 'Influencing factors and implications of unplanned drop out from substance misuse services in Wales' Public Health Wales Available at: http://www2.nphs.wales.nhs.uk:8080/BloodBorneVirusesDocs.nsf/3dc04669c9e1eaa880257062003b246b/bee22a0587b6a00d802576f0003ccd13/$FILE/Influences%20and%20implications%20%20of%20unplanned%20drop%20out.pdf

The relationships between substance misuse, cognitive function, and mental health problems (for example, anxiety and depression[22]) are also complex. This is particularly so among older adults as physiological changes associated with ageing probably put older adults at increased risk of the adverse effects of substance misuse, even at relatively modest levels of intake.[23] Physical health problems and the long-term use of prescribed medicines are often intertwined with substance misuse. Psychosocial factors, such as bereavement, retirement, boredom, loneliness, isolation and depression are all associated with alcohol misuse.[24]

Although ageing is a biological process, it is experienced differently by everyone.[25] Lifestyle factors (such as diet and exercise) contribute to the health disparities in ageing; men and women are affected by different social norms around ageing; wealthy older adults experience ageing differently to those who are poor, and life expectancy varies significantly between different social groups. Social inequality affects the health implications of substance misuse, but in ways that are difficult to disentangle.[26]

Older adults with substance misuse problems in the UK do not receive the same attention as younger substance misusers. Currently, many specialist drug services tend predominantly to deal with younger male opiate users and are not configured to meet the needs of older substance misusers, and alcohol services, while providing coverage of a wider age group, are sometimes not well-aligned with the needs of older adults.

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[22] Alcohol use can lead to depression, and depression may also be a risk factor for alcohol use. (Moore S 2016 personal communication).

[23] Wadd S & Papadopoulos C 2014 'Drinking behaviour and alcohol-related harm amongst older adults: analysis of existing UK datasets' *BMC Research Notes* 7:741 (http://www.biomedcentral.com/1756-0500/7/741)

[24] Wadd S et al. 2011. Working with Older Drinkers, Available at: http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0085

[25] The National Service Framework for Older People (Department of Health, 2001), distinguishes three groups of older people:

Entering old age: completed their career in paid employment and/or child rearing; mostly active and independent and many remain so into late old age.

Transient phase: in transition between a healthy, active life and frailty. This transition often occurs in the seventh or eight decades but can occur at any stage of later life.

Frail older people: often vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both.

https://www.google.co.uk/search?q=National+Service+Framework+for+Older+People+(Department+of+Health&rlz=1C1GGGE_en-GBGB443GB443&oq=National+Service+Framework+for+Older+People+(Department+of+Health&aqs=chrome..69i57j0.334j0j0&sourceid=chrome&es_sm=93&ie=UTF-8 (accessed 30-11-15)

[26] Marmot M 2015 *The Health Gap: The challenge of an unequal world* London: Bloomsbury Publishing.

As with all other populations, identification and delivery of appropriate drug prevention, treatment and support should provide an opportunity to help improve overall health and quality of life for older adults. Wadd (2014) reports that older adults often respond better to treatment than younger people.[27] Bhatia *et al* reviewed research on treatment for older people with substance misuse problems and found that older people responded to certain interventions, including brief interventions, counselling, educational interventions and multicomponent interventions.[28] Crome *et al*'s book describes how to recognise and treat substance problems in older patients.[29]

Wadd's report[30] identifies four areas in which older adults' needs may be different to those of other groups, perhaps requiring different approaches to overcome barriers to accessing treatment and support for substance misuse issues.

1. Physical changes

- Older adults' ability to metabolise and excrete drugs is reduced; this can result in enhanced / prolonged drug effects.
- Drugs can exacerbate or accelerate the onset of conditions associated with ageing (e.g. cognitive impairment, falls).
- Older adults may have chronic conditions (e.g. pain) for which potentially addictive medications are prescribed.

2. Psychological factors

- Older adults may conceal drug problems and not ask for help.
- Older adults may have different motivations for pursuing healthier behaviours e.g. maintaining independence and mental capacity.

3. Life circumstances

- Losses, life changes and transitions can lead to isolation, loss of independence, loneliness and psychological distress.

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[27] '…62% of people aged 60 and over who receive treatment in a substance misuse service complete treatment free of dependency compared to 47% of 18-59 year olds. They are half as likely to drop out of treatment as younger people.' Wadd 2014 p3

[28] Bhatia U Nadkarni A Murthy, P Rao, R Crome I 2015 'Recent advances in treatment for older people with substance use problems: An updated systematic and narrative review' *Eur Geriatr Med* http://dx.doi.org/10.1016/j.eurger.2015.07.001

[29] Crome *et al* 2014 *Substance Use and Older People* Wiley

[30] Wadd S 2014 *The Forgotten People: Drug Problems in Later Life* Big Lottery Fund Available at: https://www.biglotteryfund.org.uk/research/older-people (accessed 30-11-15)

- Older adults may have fewer, or less-active, social roles (e.g. no longer employed, not raising children).
- Substance misuse can increase vulnerability to elder abuse.

4. Challenges for intervention

- Older adults may have extensive histories of drug use, multiple and complex needs and failed treatment attempts.
- Older adults may find it difficult to access services (e.g. due to decreased mobility or lack of transport).
- Ageist attitudes and prejudicial assumptions mean that professionals may not identify drug problems in older adults or may not take action when problems are identified.[31]

Data for both alcohol-related hospital admissions and new assessments in specialist substance misuse services show that those aged over 50 years are the only age-group with year-on-year increases. The year 2014-15 was the third consecutive one in which hospital admissions for alcohol-specific conditions increased in this age-group, with a 3.3 per cent increase on the previous year. Hospital admissions involving named illicit drugs rose amongst those aged 50 years and over compared with 2013-14. The only group with consistent year-on-year increases in new presentations and assessments in specialist substance misuse services since 2012-13 is the 60-plus age group. [32] This has significant implications for the development of services for the future.[33]

[31] adapted from Wadd 2014 page 7 (figure 1)
[32] Public Health Wales 2015 *Reading between the lines: annual profile of substance misuse in Wales 2014-15* Available at: http://gov.wales/docs/dhss/publications/151029phw-report1en.pdf.
[33] Wadd S Lapworth K Sullivan M Forester D Galvani S 2011 *Working with Older Drinkers* Tilda Goldberg Centre / University of Bedfordshire

3. The Impact of misuse

Substance misuse at any age can have a significant impact on the family, and on friends; they may need support to help them to cope. The person may become isolated, which, in turn, may escalate their substance misuse. Isolation may be especially likely among older misusers and among those living in rural areas.

3.1 People with multiple or complex needs

The majority of referrals to Older Adult Mental Health Services are of patients with cognitive impairment requiring assessment and treatment for dementia. A small proportion has an existing diagnosis of substance misuse which add to their problems; for example: 'Between 50-80% of individuals with chronic alcohol problems experience cognitive impairment, including memory problems, difficulties concentrating and difficulties explaining things to others.[34] Such patients often require input from many different professionals, such as community psychiatric nurses, pharmacists, social workers, and occupational therapists. They may require an in-patient detoxification.[35] In addition to their misuse problems they are often socially isolated, have financial difficulties, lack family support, have health co-morbidities, or have co-existing conditions ('dual diagnosis') often including depression and anxiety.

These patients may be unable to address their problems due to their cognitive impairment.[36] If they have been misusing for many years they may be unable or unwilling to stop, and they may be reluctant to acknowledge the links between their habit and their problems. They may not access support from specialist substance misuse services because they may find it difficult to attend appointments (due to, for example, poor mobility, lack of transport, the stigma of attending a 'drugs clinic'); and

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[34] 'Wadd *et al* 2013 *Alcohol Misuse and Cognitive Impairment in Older People* Alcohol Research UK p4 http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0110.pdf

[35] A current ongoing study on the extent to which residential rehabilitation and detox services are accessible and acceptable to older adults has found widespread use of upper age cut-offs: meaning that older adults can't access them. (Wadd S 2016 personal communication)

[36] Cognitive difficulties can impair the ability to verbalise feelings; short term memory impairment can make it difficult for individuals to recall their substance use; alcohol-related cognitive impairment can lead to poor motivation and impulse control.

very few services offer home visits. People who are cognitively impaired have poorer substance misuse treatment outcomes.[37]

While community support is essential if they are to maintain their independence, because of the behaviour problems of some (although not all) patients, it can be challenging to provide this. The following three case studies illustrate some of the issues.

Case Study 1

A 73-year-old female was initially referred 10 years ago with memory problems. She had been dependent on alcohol for many years. Following assessment, she was treated, and monitored for cognitive impairment and depression. She always refused to accept that she had an alcohol problem. Her family find her very difficult to live with; also, her husband is physically unwell.

When intoxicated, her behaviour becomes aggressive and unmanageable; during such episodes she had been arrested. She had symptoms of psychosis and attended A&E on many occasions, sometimes leading to psychiatric assessment and detention under the Mental Health Act.

She has not engaged with alcohol treatment services. She has had multiple and prolonged in-patient stays for assessment and treatment. She has not been able to stay abstinent except when in hospital. She now requires specialised care and support in a care home.

Case Study 2

A 70-year-old male was referred as he was misusing alcohol and over-the-counter pain relief medicine. An appointment was arranged for a home visit, but he fell and fractured his femur; hospitalised, he presented with low weight and suffered alcohol withdrawal symptoms, for which he received treatment.

In hospital for several weeks, he was visited by the substance misuse caseworker; prior to his discharge, a multi-disciplinary team meeting agreed a package of care. He engaged with the substance misuse service, receiving interventions, including diversionary activities and attendance at self-help groups; he stated that these played an important part in helping reduce his alcohol consumption. The caseworker helped his wife to get additional support from the family service.

[37] Wadd S Randall J Thake A Edwards K Galvani S McCabe L Coleman A 2013 *Alcohol Misuse and Cognitive Impairment in Older People* Alcohol Research UK http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0110.pdf

He has received support for several years and ceased his alcohol misuse. He has learned to identify triggers that may lead to relapse and has developed a range of appropriate coping strategies.

Case Study 3

A 71-year-old female was referred to substance misuse services, where it was identified that an inpatient alcohol detoxification was required, in addition to addressing misuse of over-the-counter analgesia. She successfully completed this intervention and a support package following discharge was provided. She was slowly 'getting her life back on track' and again began attending bingo: the only event where she socialised and met people.

She found an alternative pain reliever for her long-standing spinal and joint pains: she revealed that she was purchasing cannabis from a friend at the Bingo Hall. She said that a number of her friends were suffering from arthritic pain and that this was helping to manage the pain. Concerns were raised because she was prescribed medication for a long-standing mental health issue. When the legal consequences were explained, she said she was unaware that cannabis possession was illegal and that she was therefore committing a crime. She was dismayed to hear the potential consequences and agreed to see her GP, from whom she obtained a referral to the Pain Management Team to investigate other ways to manage her pain. She remains abstinent from alcohol and is not misusing over-the-counter analgesic medicines or cannabis.

3.2 Older drug misusers in the criminal justice system

The prison population is ageing and is having to respond to the challenges that this presents. Some of these older prisoners enter prison already having a substance misuse problem (others may develop a problem while they are incarcerated). Their substance misuse may lead to difficulties both during their prison sentence and on their release; their needs may not be fully catered for in the prison system which is overcrowded and which has been affected by government cuts.[38]

In December 2014, there were 4,679 people in prison with a home address in Wales, 2,653 of whom were serving their sentence in a prison in Wales.[39] In the HM Inspectorate of Prisons thematic review[40] of

[38] 'There are now fewer staff looking after more prisoners. The number of staff employed in the public prison estate has fallen by 29% in the last four years — 12,980 fewer staff.' Prison Reform Trust 2015 *Prison*: *the facts* (based on Table 2, Ministry of Justice 2014 *National Offender Management Service workforce statistics bulletin: December 2014*, London: Ministry of Justice). The 2016 edition of the Prison Reform Trust Paper is at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/summer%202016%20briefing.pdf

[39] The limited size of the prison estate in Wales means that the remaining 2,026 Welsh prisoners were held in prisons in England. http://www.publications.parliament.uk/pa/cm201415/cmselect/cmwelaf/113/11306.htm

substance misuse in Prisons in England and Wales 2015 drug use in the two months prior to imprisonment was reported by 52 per cent of all prisoners, of these, 19 per cent were aged 50 years or older. This compared with 64 per cent of those aged under 30 reporting recent drug use. One in seven prisoners aged 50-plus reported either illicit drugs or (diverted) medication in their current prison.

People aged 60 and over are the fastest-growing age-group in the prison estate. Between 2002 and 2015, the number of sentenced prisoners aged 60 and over rose by 164 per cent.[41] People aged 50 and over make up 14 per cent of the prison population: there are 11,720 people aged 50 and over in prison in England and Wales, and 3,984 are aged 60 and over.[42] The proportion of older adults has increased. The majority of men in prison aged 60 and over (56%) have committed a sexual offence. A higher proportion of male older prisoners belong to a minority ethnic group than in the general population.[43]

As well as the ageing of the population as a whole, there are other reasons for the increase in older prisoners, including: harsher sentencing practises; technological advances which have facilitated retrospective prosecutions (especially of sex offenders); and an ageing prison 'lifer' population within the prison system.

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[40] HM Inspectorate of Prisons 2015 'Changing patterns of substance misuse in adult prisons and service responses – A thematic review' (Available at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/12/Substance-misuse-web-2015.pdf)

[41] Table A1.5, Ministry of Justice 2014 Offender management statistics annual tables 2013, London: Ministry of Justice (quoted in Prison Reform Trust 2015 *Prison*: *the facts*) The 2016 edition of the Prison Reform Trust Paper is at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/summer%202016%20briefing.pdf

[42] Table 1.3, Ministry of Justice 2015 Offender management statistics quarterly bulletin October to December 2014, London: Ministry of Justice quoted in Prison Reform Trust 2015 *Prison*: *the facts*). The 2016 edition of the Prison Reform Trust Paper is at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/summer%202016%20briefing.pdf

[43] 'The majority of the over-50 … prison population are serving sentences between four years and "life". The 60-plus age group has become the fastest growing age-group in the prison population (Ministry of Justice, 2007), with the number of men more than tripling between 1996 (699) and 2008 (2,242) (Prison Reform Trust, 2009). This compares to a one-and-a-half times increase among the under-sixties prison population. The majority of men in prison aged 60 and over (56%) have committed a sexual offence. Out of all the 60–69 year old prisoners, 52% have been imprisoned for sex-related offences and among the over-seventies it is 73% (Prison Reform Trust, 2009). More than one in 10 male older prisoners who are 60 and over belong to a minority ethnic group, which is far higher than the proportion of the general population. At the end of August 2007, the oldest male prisoner was 92, while 454 were over 70 years of age (Prison Reform Trust, 2009).' Written evidence from Dr Wahidin (EV38) in *House of Commons Justice Committee: Older prisoners - Fifth Report of Session 2013–14 London:* The Stationery Office

However, there is no comprehensive policy addressing their specific needs,[44] nor do the Home Office have any plans to introduce a separate strategy specifically for older prisoners.[45] This has led to criticism that the rehabilitation and resettlement needs of older prisoners are not being addressed in prison or on release so they face further neglect and exclusion upon their release.[46] Because of the higher rates of drug misuse among prisoners, this population may include a relatively large number with drug-related health problems[47] but the lack of research on male offenders over the age of 50 makes it impossible to quantify[48] or to estimate the treatment needs of such prisoners.[49]

As *recoop*[50] puts it:

> 'The lack of targeted support can result in an older cohort experiencing deteriorating mental and physical health, social isolation and feelings of hopelessness about the future. These presenting factors increase the challenge for successful resettlement and community integration.'

Another compounding factor that *recoop* identifies is that people in this group may be less likely to have stable accommodation to return to: around a third (35%) of prisoners have nowhere to stay on release.

There is little published research that focuses specifically on the substance misuse and subsequent treatment needs of older prisoners; the Ageing Population Sub-Committee found only a USA exploratory study.[51]

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[44] HM Chief Inspector of Prisons 2004 *No problems – old and quiet: Older prisoners in England and Wales* London: Home Office https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/no-problems-old-and-quiet-older-prisoners-in-england-and-wales-a-thematic-review/

[45] Prison Reform Trust 2007 *Bromley briefings: Prison fact file* London: Prison Reform Trust

[46] Crawley, E. 2004 'Release and resettlement: The perspectives of older prisoners' *Criminal Justice Matters, 56, 32-33.* Collins, R., & Bird, R. 2007 'The penitentiary visit: A new role for geriatricians?' *Age and Ageing*, 36(1), 11-13

[47] Singleton, N., Farrell, M., & Meltzer, H. 1999 *Substance misuse among prisoners in England and Wales*. London: ONS.

[48] Borrill, J., Maden, A., Martin, A., Weaver, T., Stimson, G., Barnes, T., Burnett, R., Miller, S., & Briggs, D. 2003 'Differential substance misuse treatment needs of women, ethnic minorities and young offenders in prison: Prevalence of substance misuse and treatment needs' Home Office Online Report 33/03; Cope, N 2000 'Drug use in prison: The experience of young offenders' *Drugs: Education, Prevention and Policy*, 7(4), 355-366.

[49] When the Panel visited Cardiff Prison, there was only one prisoner over the age of 50 in contact with a treatment service.

[50] A charity, 'resettlement and care for older ex-offenders and prisoners', http://www.recoop.org.uk/pages/resources/index.php, (Accessed 24-01-16)

[51] by Arndt S Turvey L and Flaum M 2002 'Older offenders, substance abuse, and treatment' *The American Journal of Geriatric Psychiatry* 10.6: 733-739.

Focusing on offenders' substance abuse histories by age group, that research found that 71 per cent of older prisoners (in this study, aged 55-plus) had a substance misuse problem upon entering prison. The primary drug misused was alcohol, but the research found misuse of many illicit substances (including methamphetamine, marijuana, cocaine and crack cocaine).[52]

Studies of psychiatric morbidity among older prisoners, which often include substance abuse and dependence disorders defined by DSM-IV criteria, also provide relevant information. Singleton *et al*'s 1999 report of the psychiatric morbidity survey carried out in 1997 among prisoners confirmed that illicit drug misuse and hazardous drinking was a part of the pre-prison lives of some of the older prisoners[53]; heavy cigarette smokers also tended to be older. Some prisoners did not commence illicit drug misuse until they were over forty, and these had used cannabis, heroin, methadone, crack and cocaine. It was reported that a small percentage of prisoners aged over 45 were dependent on cannabis, opiates and stimulants in the year before entering prison, and one per cent of this group said they had injected drugs in the month prior to imprisonment.[54]

Another study interviewed a stratified sample of 19 per cent of the English and Welsh male prison population aged sixty and over.[55] Just under five per cent reported current substance misuse,[56] while 11 per cent had a lifetime history of alcohol misuse. There were some cases of comorbidity of substance misuse with personality disorder or psychiatric illness. [57]

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[52] Because of the differences between services in the USA and the UK, this study is unlikely to reflect the UK situation.
[53] over 45 years in this study
[54] Singleton et al *ibid.* The situation may be more positive now than when that report was published
[55] Stratified sample of 203 prisoners 59-plus from 15 prisons in England and Wales (male; female - 5:1)
[56] (the substance was not specified)
[57] Fazel S Hope T O'Donnell I and Jacoby R 2001 'Hidden Psychiatric morbidity in elderly prisoners' *British Journal of Psychiatry* 179 533-39

4. Substances of misuse by older adults

This Chapter considers three groups of substances that are most widely misused. While many people, when thinking about 'drugs' would think of illicit or 'illegal' (controlled) drugs, alcohol is the most problematic substance of misuse: in part, because it is used so widely (perhaps largely because of its legality), often in combination with other substances. Least is known about the misuse of prescription and over-the-counter medicines.

4.1 Alcohol

Alcohol consumption is very common throughout Welsh society. Alcohol has possible protective effects for certain health conditions, and many people feel that it has a range of social benefits. But while the positive effects of alcohol are widely expressed in the alcohol industry's advertising and marketing, as well as in the way that it is often represented in the media and in people's conversations, the negative effects are not so prominently represented. Most people view alcohol very differently to other drugs. Public Health Wales analysed Wales-specific data from the Crime Survey of England and Wales 2015-16 to show that while a third of respondents in Wales felt that the occasional use of cannabis was acceptable (and this was much higher than for other controlled drugs), more than two-fifths (84%) thought that getting drunk ('frequently' or 'occasionally') was acceptable.[58]

Current health advice is that any level of alcohol use is considered to be potentially damaging to health.[59] Furthermore, many drinkers drink to excess, with greater potentially damaging health consequences. Therefore, the costs – direct and indirect – of alcohol-related physical, psychological and social harms are significant. These costs are wide-ranging and include direct costs to the NHS in treating alcohol-related diseases, and the indirect costs, such as alcohol-related family breakdown.

Alcohol acts as a depressant on the human central nervous system (CNS). The CNS depressant effects of some classes of medicines such as anxiolytics, hypnotics, antidepressants, antipsychotics and opioid

[58] Smith J 2016 personal communication. (Data from ONS 2016)
[59] 'The risks of cancers associated with drinking alcohol were not fully understood in 1995. Taking these risks on board, we can no longer say that there is such a thing as a "safe" level of drinking. There is only a "low risk" level of drinking.' NHS Choices 'New alcohol advice issued' 08-01-16 http://www.nhs.uk/news/2016/01January/Pages/New-alcohol-advice-issued.aspx (accessed 31-10-16)

analgesics may be significantly enhanced if used with alcohol, and this may lead to increased risk of premature death.

The toxic by-products of alcohol metabolism are eliminated from the body mainly through the action of the liver. Liver damage is therefore the most common problem of excessive alcohol consumption; females seem to be more sensitive to liver damage than males. There are a number of other health consequences of alcohol misuse, such as impairments of cognitive function, stomach ulcers, pancreatitis and alcohol-related cancers. Alcohol misuse can lead to dependence.

Those in a lower socio-economic position in society are more likely to experience alcohol-related conditions. Some groups of those aged over 65 years who were born outside of the UK are at greater risk of alcohol-related conditions.[60]

More information on the effects and risks of alcohol is at Annex F.

Levels of drinking are defined in standard alcohol consumption units. People may 'binge' or drink too much on one occasion, or drink 'harmfully' or 'hazardously'; these ways of drinking can be described as 'misuse'.

In recent years, alcohol has become more affordable: it is cheaper in real terms; demand for alcohol (as with most other goods and services) is sensitive to its price: thus, when it is cheaper, people tend to drink more, so the prevalence of alcohol misuse – and therefore alcohol-related physical and social harms – has also increased over this period. However, as Figure 4.1 shows, alcohol-related deaths per head of population have fallen slightly since 2008.

[60] 'Compared with older drinkers, older unsafe drinkers contained a higher proportion of males, white and Irish ethnic groups and a lower proportion of Caribbean, African and Asian groups.' Rao R et al 2014 'Alcohol use, socioeconomic deprivation and ethnicity in older people' *BMJ Open* 2015;5:e007525. doi:10.1136/bmjopen-2014-007525 http://bmjopen.bmj.com/content/5/8/e007525.full

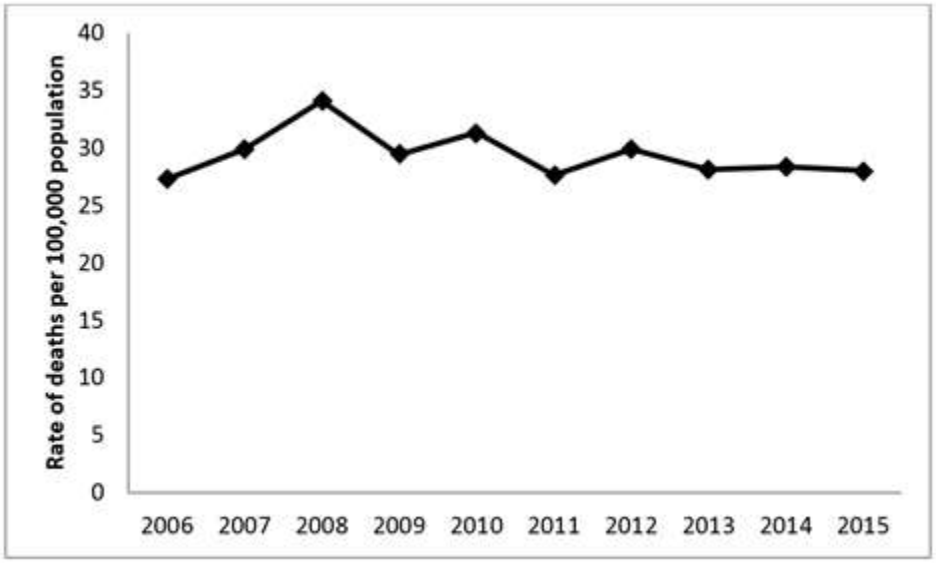

Figure 4.1 Alcohol-related deaths 2006 - 2015 in Wales among those age 50+ , rate per 1000 of population. (Source: ONS, 2016)

4.1.1 Alcohol misuse in Wales

Data from the 2015 Welsh Health Survey[61] recorded reported alcohol use in respondents (N = 13,656) aged 16 years-and-over, of whom 4,191 were aged 65 or over. Respondents were asked about their alcohol use on the day of the previous week on which they drank the most alcohol.[62] Responses were classified[63] as shown in Table 4.1

Description	*Reported alcohol consumption*
None	Did not drink in past seven days
Within guidelines	Drank something Men drinking no more than 4 units* Women drinking no more than 3 units*
Above guidelines	Men drinking more than 4 units* Women drinking more than 3 units*
Binge	Men drinking more than 8 units* Women drinking more than 6 units*

[61] Welsh Government 2016 *Welsh Health Survey 2015* Available at: http://gov.wales/statistics-and-research/welsh-health-survey/?lang=en

[62] They were asked about how many drinks they consume (the researchers create alcohol use categories from these data). But it is possible that, as older adults are more likely to drink at home, their levels of consumption are thus more likely to be underreported – because they don't use the standard measures/glass sizes that are used in pubs/restaurants. (Wadd S 2016 personal communication)

[63] Note that the Welsh Health Survey 2015 was carried out prior to the issuing of new guidelines on alcohol consumption by the UK's Chief Medical Officers in 2016

Very heavy drinking	Men drinking more than 12 units* Women drinking more than 9 units*
**on heaviest drinking day in previous week*	

Table 4.1 Classification of reported alcohol consumption, Welsh Health Survey 2015

Data in Figure 4.2 suggest that the proportion of lower-risk drinkers (drinking within guidelines or being abstinent) increases amongst those aged 65+ years compared with younger age groups. Data for assessments carried out by substance misuse services in Wales in which alcohol was reported as the main problematic substance show a steady decline in such assessments amongst older age groups.[64,65]

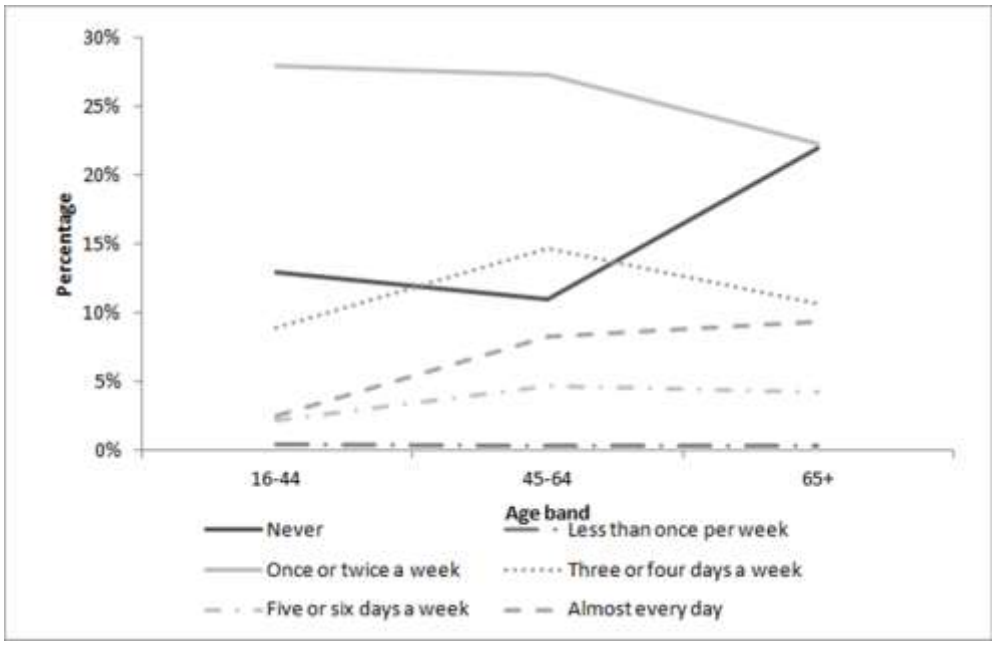

Figure 4.2 Frequency of alcohol consumption by age group. (Source: Welsh Health Survey, 2015)

[64] Of course, this is a relative decline: although the number of people with problematic drinking declines proportionately across the age groups, the actual number of older adults being referred with problems is increasing.

[65] In addition, this decline could be due to services not meeting the needs of this group or not being suitable. There may also be greater stigma experienced by older substance misusers: 55 per cent of adults over 65 believe that people with an alcohol problem have themselves to blame *Drink Wise Age Well – Alcohol Use and the over 50s in the UK* (http://drinkwiseagewell.org.uk/resources/report/)

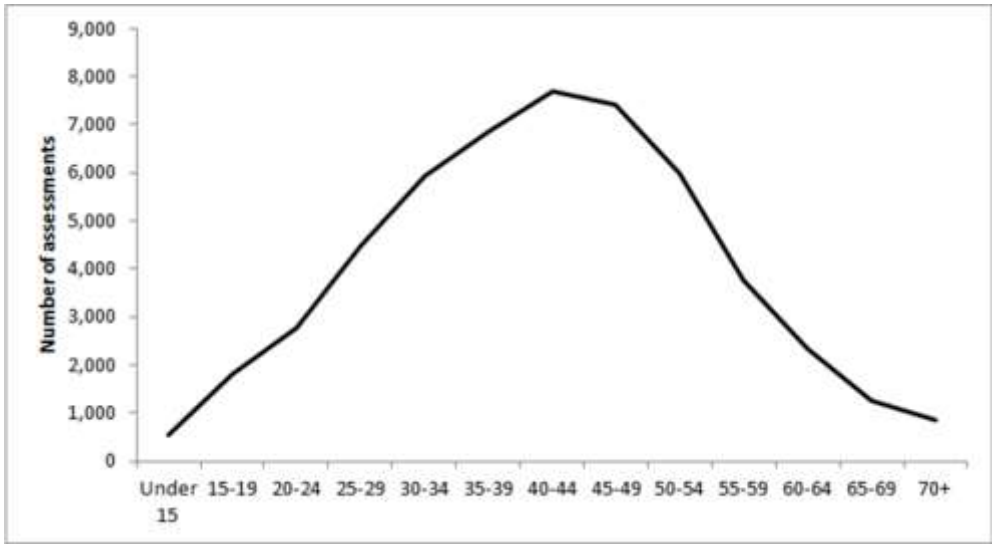

Figure 4.3 Number of assessments by substance misuse treatment services for alcohol by age group (2011-12 to 2015-16, Wales). Source: Welsh National Database for Substance Misuse (held by the NHS Wales Informatics Service)

Analyses using data from English Longitudinal Study of Aging[66] suggest that single older men drink more than other men, and that women who are newly widowed show a marked reduction in consumption.

Participants in a meeting of the National Partnership Forum for Older People in Wales suggested that many older adults use alcohol to help them sleep, or because of bereavement or loneliness instead of medication or other methods, and some take the view that 'at their age they haven't got much longer so want to enjoy themselves'.[67]

People with alcohol problems may abuse others or be themselves abused; a feasibility study found that:

> 'Practitioners [those working with older adults] were most challenged by cases where alcohol misuse had led to self-neglect or where the perpetrator was an alcohol misusing family member.[68]

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[66] (surveys in 1998, 1999, 2001, 2008, 2009, 2010 and 2011) Holdsworth C Mendonça M Frisher M Shelton N Pikhart H & de Oliveira C 2014 *Alcohol Consumption, Life Course Transitions and Health in Later Life* Keele University www.drugs.ie/resourcesfiles/ResearchDocs/Europe/Research/2014/alcoholconsumption_laterlifepaper_keele-ucl-2014.pdf (Accessed 31 January 2016)

[67] Gaylard 2015 personal communication email 19-11-15

[68] Sullivan,P et al 2014 *Use as Abuse: A Feasibility Study of Alcohol-related Elder Abuse* Report to Alcohol Research UK p2 http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0111.pdf

4.1.2 Hospital admissions

In 2015-16, there were 5,387 individual patient admissions to general hospitals in Wales among those aged 50 years or more in which an alcohol-specific diagnosis was recorded at any place in the admission record.[69,70] Two-thirds (68.4 per cent) of those admitted were men. Of these admissions, 2,189 (40.6 per cent of all aged 50-and-over admitted) were of people aged 65-years-and-over, giving an age specific rate of 3.5 per 1,000 population aged 65+.

Males represented 69.8 per cent of this group. More than a fifth (21.7 per %) of all those admitted in 2015-16 were aged 65 or over. This proportion has risen from 15.7 per cent in 2011-12, when 1,621 individuals aged 65 or over were admitted: a rise of 35 per cent over the five-year period. This compares with a fall of 2.7 per cent in the number admitted across the whole population over this period.

4.1.3 Alcohol-related deaths

The definition used for alcohol-related death includes only those deaths that are most closely associated with alcohol consumption; it does not include deaths from disease partially attributable to alcohol, such as cancers of the oesophagus and mouth.[71] The number of alcohol-related deaths in Wales[72] was combined with census data to provide a rate per 100,000; these rates are shown, for females and for males respectively, in Figures 4.4 and 4.5.

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[69] Public Health Wales and Welsh Government 2015 *Piecing the puzzle: the annual profile for substance misuse 2015-16* Available at: http://www.wales.nhs.uk/sitesplus/documents/888/Piecing%20the%20Puzzle%20FINAL%202016%2C%20v2%2C%2025%20Oct%202016.pdf

[70] These figures do not include conditions partially attributable to alcohol, such as breast cancer. They therefore underestimate the full impact of alcohol harm – and this is particularly the case for older adults where the partially-attributable conditions are more prevalent (see Wadd S & Papadopoulos C 2014 'Drinking behaviour and alcohol-related harm amongst older adults: analysis of existing UK datasets' *BMC Research Notes* 7:741 (http://www.biomedcentral.com/1756-0500/7/741)).

[71] The International Classification of Disease (ICD) codes used to calculate rates of alcohol-related death are: from 1991 to 2000 ICD-9: 291, 303, 305, 425.5, 571, 571.1, 571.2, 571.3, 571.4, 571.5, 571.8, 571 & E860; from 2001 onwards ICD-10: F10, G31.2, G62.1, I42.6, K29.2, K70, K73, K74 (Excluding K74.3-K74.5 - Biliary cirrhosis), K86.0, X45, X65, Y15.

[72] Office for National Statistics 2014 *Alcohol-related deaths in the United Kingdom 2013* Available at: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Alcohol-related+Deaths

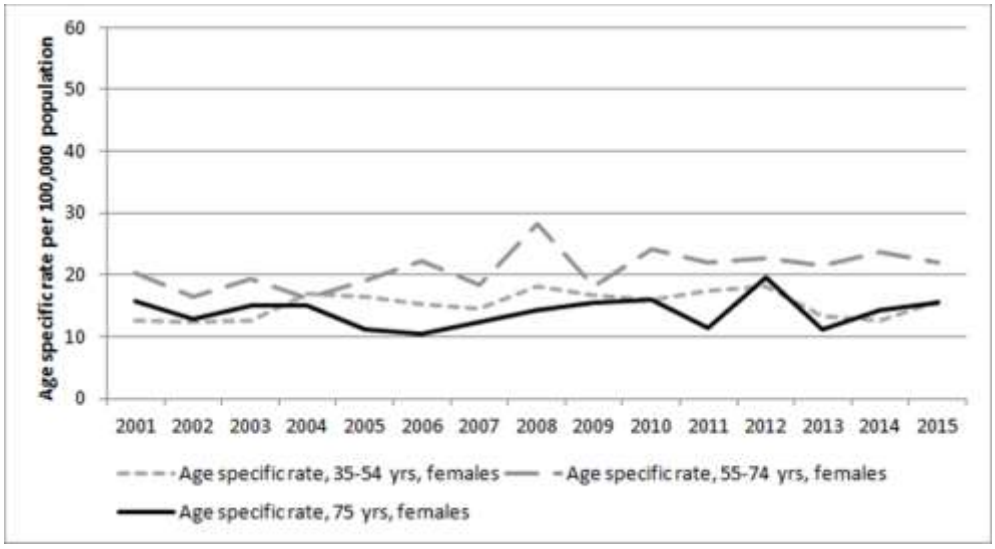

Figure 4.4 Age-specific alcohol-related death rates by age group, Wales, deaths registered 2001-2015: Females (Source: Welsh National Database for Substance Misuse (held by the NHS Wales Informatics Service)

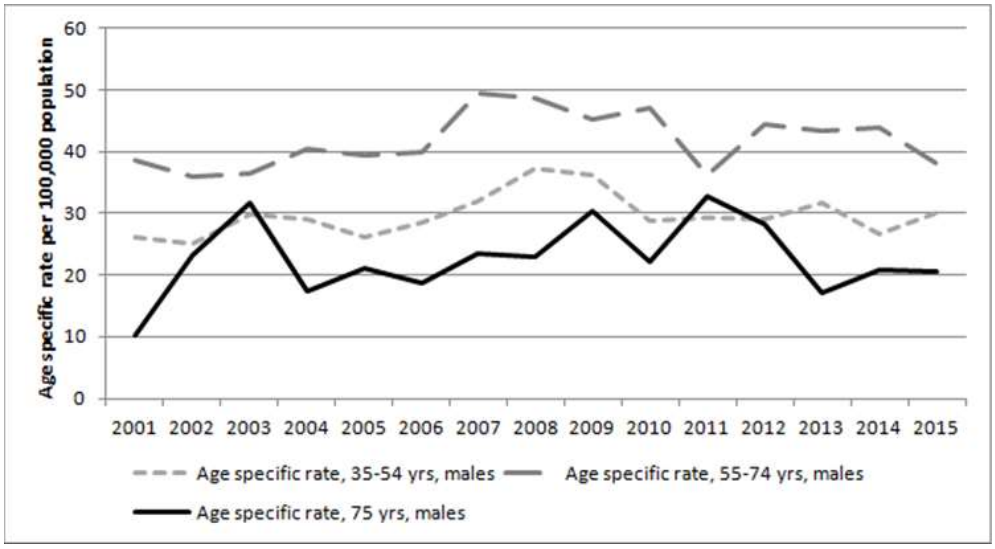

Figure 4.5 Age-specific alcohol-related death rates by sex and age group, Wales, deaths registered 1994-2013: Males (note: 2001 data is missing) (Source: Welsh National Database for Substance Misuse (held by the NHS Wales Informatics Service)

Figure 4.6 shows that alcohol-related death rates vary by age, with the more common causes of death being related to the liver. For all age groups, alcohol-related liver disease and fibrosis and cirrhosis of the liver accounted for 86.6 per cent of all alcohol-related deaths in Wales in

2015;[73] amongst those aged 65 years and over the proportion was almost identical (86.7 per cent).[74] Fibrosis and cirrhosis are chronic conditions and are typically the result of many years of alcohol misuse.[75] However, it appears to be consumption in the recent past that determines present risk. For example, for those aged 50 to 64 years old, it was their self-reported alcohol consumption between the ages of 40 and 59 years that predicted alcohol-related cirrhosis, not consumption during the earlier stage of life, between 20 and 39 years; this was true for both men and women.[76]

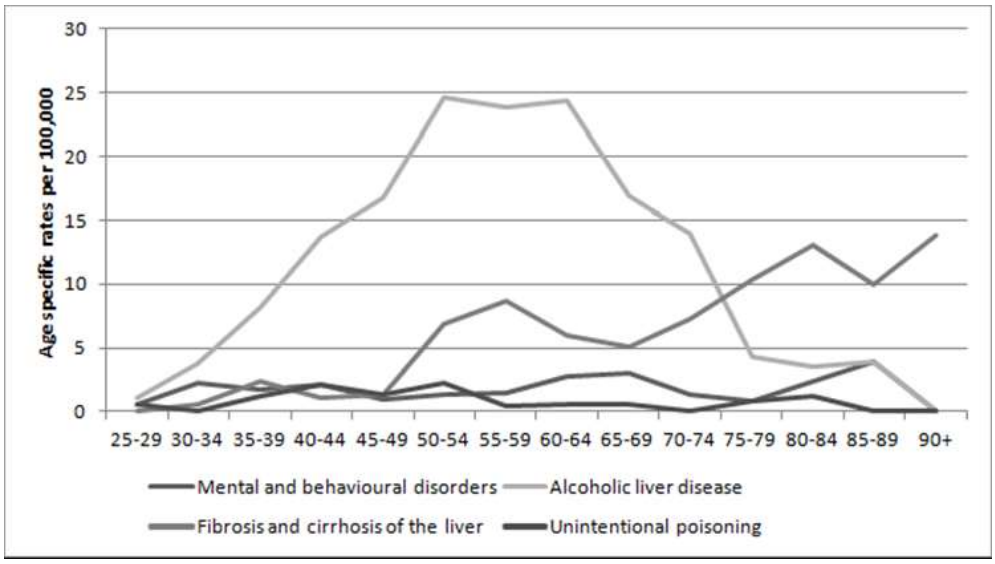

Figure 4.6 Top four alcohol-related causes of death by age group, age standardised rates, Wales, registered in 2015 (Source: Office for National Statistics)

[73] The National Statistics definition of alcohol-related deaths includes underlying causes of death regarded as those being most directly due to alcohol consumption
[74] (K29.2 - Alcoholic gastritis, K70 - Alcoholic liver disease, K73 - Chronic hepatitis, K74 - Fibrosis and cirrhosis of liver but excluding K74.3-K74.5 - billiary cirrhosis).
[75] Becker U Deis A Sorensen T Gronbaek M Borch-Johnsen K Muller C Schnohr P & Jensen G. 2003 'Prediction of risk of liver disease by alcohol intake, sex, and age: A prospective population study' *Hepatology*, 23(5), 1025-1029.
[76] Askgaard G Grønbæk M Kjær M Tjønneland A & Tolstrup J 2015 'Alcohol drinking pattern and risk of alcoholic liver cirrhosis: A prospective cohort study' *Journal of Hepatology*, 62(5), 1061-1067.

In Wales in 2015[77] there were 463 alcohol-related deaths: a European Age Standardised rate of 19.3 per 100,000 males and 11.3 per 100,000 for females.[78] The highest number of alcohol-related deaths was recorded in the 50 to 54-years age group, with 78 deaths – 16.8 per cent of all alcohol-related deaths (Figure 4.7).

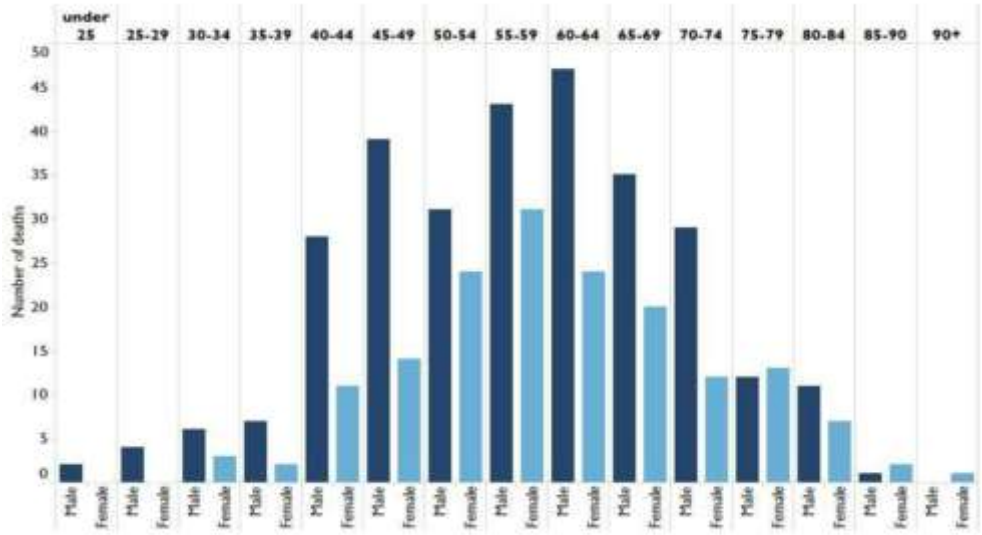

Figure 4.7: Alcohol-related deaths registered in Wales, 2014, by age band and gender (Source: Office for National Statistics, 2015)

Overall, there was a rise in the proportion of women who died of alcohol-related causes who were under 50 years from 18.3% in 2014 to 27.1 per cent in 2016. Male alcohol-related deaths of those men under 50 made up 24.8 per cent of all deaths amongst men registered in 2015, compared with 29.2 per cent registered in 2014.

As seen in previous years, the most frequently-recorded underlying condition in those who died of alcohol-related causes in 2014 in Wales (both those aged 50 and over and all ages) was alcohol-related liver disease. This was the underlying cause of death in 137 male cases (63.7 per cent) and 73 female cases (56.6 per cent) for those aged 50 or over. The next most frequently-recorded cause of alcohol-related death was cirrhosis or fibrosis of the liver.

[77] Public Health Wales and Welsh Government 2015 *Piecing the puzzle: the annual profile for substance misuse 2015-16* Available at: http://www.wales.nhs.uk/sitesplus/documents/888/Piecing%20the%20Puzzle%20FINAL%202016%2C%20v2%2C%2025%20Oct%202016.pdf

[78] Rates calculated using ONS methodology

4.1.4 Drink driving

In Wales, in 2013,[79] there were 3,264 convictions for driving after consuming alcohol or drugs, a fall of 32.8 per cent since 2009. Table 4.2 shows the data by age group: 543 convictions were of people aged 50 or older: 16.6 per cent of all convictions. For those over 60 years, the figure was 187 (5.7 per cent). But these figures are hard to interpret as they are, to some degree, affected by the hours that drivers spend on the road – and this is age-related.[80] Between 2009 and 2013, for all age-groups, convictions fell by almost a third (from 4,854 to 3,264); among older adults, they fell at a slower rate, with a decline of 15.3 per cent in convictions for those aged 50 and older and 19 per cent amongst the 60-plus age group.

Year: 2013		
age group (years)	*Number of convictions*	*%*
<17	4	0.12
17-20	266	8.15
21-29	1084	33.21
30-39	771	23.62
40-49	596	18.26
50-59	356	10.91
60 and over	187	5.73
total	**3264**	**[100%]**

Table 4.2 Findings of guilt at all courts for offences of driving after consuming alcohol or taking drugs by age group, Wales 2013 Source: criminal justice statistics, Ministry of Justice

4.1.5 Implications

Alcohol-related deaths in older populations are increasing in Wales for both men and women, with fibrosis and cirrhosis of the liver and alcohol-related liver disease the two dominant causes of death directly attributable to alcohol in older populations.

[79] Not the latest figures; the most recent figures do not contain this breakdown as the MoJ have changed how they report the data

[80] Craiger Solomons 2016 personal communication

Increasing age is associated with reduced health status – but current alcohol misuse is *not* associated with this decrease. This is probably because alcohol use declines in older age: binge drinking, and drinking above guidelines, decreases from the age of 60 onwards and those aged 60 years-and-over are less likely to be referred into substance misuse treatment.[81] Alcohol consumption across the lifecourse contributes to emerging alcohol harm in later life: excessive consumption in middle years of life is therefore a contributory factor to the alcohol-related deaths of those aged 65 years and over.

4.2 Prescription and over-the-counter medicines

Medicines prevent, treat or manage many illnesses and conditions, and are the most common intervention in healthcare. Older adults are frequent users of prescription-only medicines (POMs) and over-the-counter (OTC) medicines. Chronic diseases are more frequent in older adults and the use of multiple medicines, often over a long time, is common in this group.[82] More than four-fifths (87%) of people in Wales aged 65-plus report regularly taking prescribed medicines for a year or more.[83] Among those aged over 75, the percentage is even higher. Using several medicines concurrently (known as 'polypharmacy'[84]) is common; and is often problematic for elderly patients.[85, 86]

For the purposes of this Report, the misuse of POMs and OTC medicines is defined as: 'The use of a medicine not consistent with legal or medical guidelines'. This includes both dependent and non-dependent use and therefore does not correspond to the definition of dependence in the International Classification of Diseases 10th revision (ICD-10).[87]

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[81] Although there might be unmet need for treatment – the lower rate of referrals might be due to other reasons

[82] WeMeRec Bulletin 2011 *Prescribing for older people* Welsh Medicines Resource Centre. Cardiff. https://www.wemerec.org/Documents/Bulletins/Prescribing4OlderBulletin-online.pdf (accessed 07 June 2015)

[83] Dixon J Roberts C 2015 *Welsh Health Survey 2014: Health service use results.* Welsh Government Available at: http://gov.wales/docs/statistics/2015/150916-welsh-health-survey-2014-health-service-use-en.pdf (accessed 09 November 2015).

[84] Usually considered as concurrently using at least four or five medicines

[85] Hajjar E *et al* 2007 'Polypharmacy in elderly patients' *Am J Geriatr Pharmacother* 5: 345-351.

[86] Payne R Avery A 2011 'Polypharmacy: one of the greatest prescribing challenges in general practice' *Br J Gen Pract* 61: 83-84.

[87] United Nations Office on Drugs and Crime. *The non-medical use of prescription drugs: policy direction issues* Vienna; United Nations; 2011. Available at: https://www.unodc.org/documents/drug-prevention-and-treatment/nonmedical-use-prescription-drugs.pdf (accessed 25 August 2015). The term, 'nonmedical use of prescription drugs' is used in some countries, particularly in the USA. Such usage can be defined as the taking of prescription drugs, whether obtained by prescription or otherwise,

4.2.1 Problems with POMs and OTC medicines

The ready availability of OTC medicines, and the different methods of obtaining POMs and OTC medicines other than through legitimate channels, makes the use of multiple analgesics a particular problem.[88] People can develop problems with a variety of OTC medicines,[89] and with POMs such as opioid analgesics, hypnotics and anxiolytics, stimulants, and certain anti-epileptic medicines used for relief of neuropathic pain. However, the most common types of POMs that older adults misuse are the most likely to lead to dependence; these are benzodiazepines and Z-drugs (non-benzodiazepines used for the treatment of insomnia), and opioid analgesics.[90] Problematic use of medicines may be intentional or unintentional and may vary in its severity.[91] Dependence may result from the misuse of some of these medicines.[92]

There is concern about the misuse of POMs and OTC medicines at a European and international level. The European Drugs Strategy 2013-2020 designates responding to the challenge of the misuse of prescribed and OTC opioid medicines as one of the new priorities for drug demand reduction.[93]

The National Treatment Agency for Substance Misuse (NTA), in its England only study, *Addiction to medicine*, identified three groups of

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other than in the manner or for the reasons or time period prescribed, or by a person for whom the drug was not prescribed.

[88] Royal College of Psychiatrists 2011 *Our invisible addicts* Royal College of Psychiatrists Available at: http://www.rcpsych.ac.uk/files/pdfversion/CR165.pdf (accessed 07 June 2015)

[89] Such as analgesics, some cough and cold remedies, anti-diarrhoeals and anti-allergy medicines.

[90] Royal College of Psychiatrists 2015 *Substance misuse in older people: an information guide*. Royal College of Psychiatrists Available at: https://www.rcpsych.ac.uk/pdf/Substance%20misuse%20in%20Older%20People_an%20information%20guide.pdf (accessed 07 June 2015)

[91] European Monitoring Centre for Drugs and Drug Addiction 2008 *Substance misuse among older adults: a neglected problem* Lisbon: EMCDDA Available at: http://www.emcdda.europa.eu/attachements.cfm/att_50566_EN_TDAD08001ENC_web.pdf (accessed 07 June 2015)

[92] Dependence on drugs or alcohol is defined as a syndrome of symptoms by the International Classification of Diseases 10th revision (ICD-10), an international manual for the classification of mental disorders. Diagnosis of dependence can be made if three or more symptoms have been experienced at some time in the year preceding assessment. A person may use a substance for many years without becoming dependent (if use does not result in harm and they are in control of their drug use). 'Addiction' is not a diagnostic term in the ICD-10, but continues to be a term widely employed by professionals and the general public.

[93] Council of the European Union 2012 *EU Drugs Strategy 2013-2020* Official Journal of the European Union Available at: http://register.consilium.europa.eu/doc/srv?l=EN&f=ST%2017547%202012%20INIT (accessed 07 June 2015)

people who present for treatment for problematic use of prescribed or over-the-counter medicines:

1. *Therapeutic dose dependence*: people who have developed dependence on therapeutic doses of a POM or OTC medicine.
2. *High dose dependence:* people who may have started being prescribed a therapeutic dose but escalate their dose, often via illicit sources, but who do not have concurrent illegal drug problems.
3. *Recreational high dose misuse and dependence*: people who have POMs or OTC medicines problems and concurrent illegal drug or alcohol problems. [94]

4.2.2 Prevalence and patterns of misuse of POMs and OTC medicines

It is not possible to measure directly the number of people who misuse POMs or OTC medicines; it is largely a hidden problem. Data are lacking on the misuse of these substances and there are gaps in the monitoring of their legitimate use for medical purposes as prescribed or supplied by healthcare professionals.[95]

There are no UK-wide or national data for Wales on the prevalence of dependence on POMs and/or OTC medicines. However, a new system to collect this information has been advocated.[96]

The *Addiction to medicine* study found that 12.5 per cent (9,899) of all people newly presenting for drug treatment during 2009-10 reported their use of POMs and/or OTC medicines as being a problem. The majority of these people also had problems in relation to illegal drug use, while just 2.1 per cent (1,684) of all people newly presenting for drug treatment reported problems with POMs and/or OTC medicines without concurrent illegal drug use.[97]

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[94] National Treatment Agency for Substance Misuse 2011 *Addiction to medicine* London. Available at: http://www.nta.nhs.uk/uploads/addictiontomedicinesmay2011a.pdf (accessed 07 June 2015). (The NTA is now a part of Public Health England)

[95] United Nations Office on Drugs and Crime. *The non-medical use of prescription drugs Policy direction issues*. Vienna: UNODC; 2011. Available at: https://www.unodc.org/documents/drug-prevention-and-treatment/nonmedical-use-prescription-drugs.pdf (accessed 26 August 2015).

[96] All-Party Parliamentary Group for Involuntary Tranquilliser Addiction, House of Commons 2009 'Alternative report on an inquiry carried out by the All-Party Parliamentary Drug Misuse Group' [Online] Available at: http://www.benzo.org.uk/appg3d.htm (accessed 17 January 2016)

[97] Although, since the majority of older adults who are addicted to medicines are unlikely ever to receive treatment in a substance misuse service, this tells us little about the population prevalence.

The study also found that 16 per cent (32,510) of all people in treatment (not just those newly presenting during 2009-10), reported problems with POMs and/or OTC medicines. Of all people in treatment, two per cent (3,745) reported this in the absence of problems with illegal drugs. Those that presented with additional illegal drugs problems tended to be very similar to the general drug treatment population in terms of age and gender, while those reporting no illegal drug use were different; they were almost twice as likely to be female, and almost twice as likely to be over 40 years old.

The main classes of medicines misused which were identified in this study were benzodiazepines, prescribed opioid analgesics, Z-drugs, and other POMs and OTC medicines. Benzodiazepines were the main class of POMs misused among those who had concurrent problems with illegal drugs plus POMs and/or OTC medicines. The authors of the *Addiction to Medicine* study concluded that this was likely to have reflected some non-directed use (in a manner not indicated by a prescriber[98]) of these medicines within this cohort, as had been reported elsewhere.[99]

Other studies on prevalence of POMs and/or OTC medicines misuse in older adults include:

- A UK study indicated that 40 per cent of older primary care patients (aged 60 years and over) who had been taking low-dose opioid analgesics for a year were reported to have fulfilled the World Health Organisation's Diagnostic Criteria for dependence.[100] (This finding was based on a relatively small number of people and therefore should be interpreted with caution.)
- A literature review suggested that the prevalence of medicines misuse was four times higher among older women than among older men. It concluded that factors associated with drug misuse in older adults include female gender, social isolation, history of a substance use or

[98] *Directed use* of POMs/OTC medicines refers to use in the way they have been prescribed by a healthcare professional, or when OTC medicines are purchased and used in accordance with the label and leaflet. Examples of *non-directed use* of POMs/OTC medicines include: use of medicines by a person for whom they have not be prescribed; taking doses above prescribed levels; taking doses other than in the way, or for the reasons or time period prescribed; use of purchased OTC medicines not in accordance with the label and leaflet.

[99] Perera K M, Tulley M, & Jenner F A. 1987 'The use of benzodiazepines among drug addicts' *Br J Addict*., 82 (5), 511-5

[100] Edwards I, & Salib E. 2002 'Analgesics in the elderly' *Aging & Mental Health*, 6(1), 88-91

mental health disorder, and medical exposure to prescription medicines with misuse potential.[101]

- A French study of people aged 65 years and over who were 'chronic users' of benzodiazepines or Z-drugs found that more than a third (35.2%) showed signs of dependence.[102]
- Of studies in the USA:
  - One study estimated that 11 per cent of women aged 60 years-and-over misused prescription medicines.[103]
  - Another study found that 1.4 per cent of adults aged 50-and-over reported misusing prescription analgesics during the previous year.[104]
  - A study of 50- to 59–year-olds found that 20 per cent had started using prescription drugs non-medically after the age of 40, suggesting that the late onset of problematic use of medicines may be common.[105]

4.2.3 Treatment for problematic misuse of POMs and OTC medicines

The substance misuse strategy for Wales[106] makes explicit the intention to tackle the full range of substances which are misused. However, the management of dependence on POMs and/or OTC medicines has not been given the same attention as treatment for illicit drug misuse. This is because the problematic misuse of POMs and/or OTC medicines is not the main focus of current commissioned drug treatment services in Wales. Nonetheless, evidence from the literature, from the evidence given to APoSM's expert evidence-gathering day, and from APoSM's community visits suggest that misuse and dependence on these medicines are a problem for illicit drug misusers as well as for those who do not also use illicit drugs. Both groups can be treated: the *Addiction to medicine* Study[107] provided evidence, based on English national performance data, that

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[101] Simoni-Wastila L & Yang H 2006 'Psychoactive Drug Abuse in Older Adults' *American Journal of Geriatric Pharmacotherapy*, 4(4), 380-394

[102] Gérardin M Victorri-Vigneau Guerlais M Guillou-Landreat M Grall-Bronnec M & Jolliet P 2014 'Benzodiazepines consumption: does dependence vary with age?' *Substance Use & Misuse*, 49(11), 1417-1425

[103] National Center on Addiction and Substance Abuse 1998 *Under the rug: substance abuse and the mature woman* New York: Columbia University

[104] Blazer D & Wu L 2009 'Non-prescription use of pain relievers by middle-aged and elderly community-living adults: National Survey on Drug Use and Health' *Journal of the American Geriatrics Society*, 57(7), 1252-1257.

[105] Han B Gfroerer J Colliver J *et al* 2009 'Substance use disorder among older adults in the United States 2020' *Addiction* 104, 88–96.

[106] Welsh Government 2008 *Working together to reduce harm: the substance misuse strategy for Wales 2008-2018* Welsh Government, Cardiff. Available at: http://www.substancemisuseworkforcewales.org/resources/publications/workingtogether/?lang=en (accessed 07 July 2015)

[107] NTA 2011 *ibid (*Available at: http://www.nta.nhs.uk/uploads/addictiontomedicinesmay2011a.pdf)

people who accessed local drug treatment services and who had problems in relation to POMs and/or OTC medicines but without reported problems with illicit drugs could achieve relatively good outcomes.

That study also indicated that members of this group were different from the usual clients of drug treatment services, and, once they were in treatment, they engaged better with services than the usual treatment population.[108] This suggested that local drug treatment services were able to meet their individual needs, even though they were likely to present more complex difficulties. However, it must be remembered that most people addicted to medicines – and particularly older adults addicted to medicines – do not attend substance misuse services: and many do not want to.[109]

The authors of the study suggested that the length of time that most POMs and/or OTC clients were engaged with drug treatment (ten months, plus) supports the idea that treatment was being provided in an appropriate timeframe; this length of time for treatment follows guidance on reduction and withdrawal from benzodiazepines[110] recommended by the British National Formulary.[111]

APoSM has convened a sub-committee to look at the misuse of POMs (and, as far as possible, OTC medicines); it will report in 2017.

4.2.4 Pain management

Chronic pain is one of the most common conditions encountered by healthcare professionals, and is particularly seen among older adults aged 65 years old and over.[112] As the population continues to age the prevalence of those with chronic pain in later life is expected to increase; this will increase the public health impact of pain,[113] and there will be greater pressure on resources for pain management.

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[108] (based on English national performance indicators)
[109] Wadd S 2014 *The Forgotten People: Drug Problems in Later Life* A Report for the Big Lottery Fund https://www.biglotteryfund.org.uk/-/media/Files/Research%20Documents/Older%20People/the_forgotten_people.pdf
[110] (these drugs have often been prescribed inappropriately for older adults (Wadd S 2014 *The Forgotten People: Drug Problems in Later* Life A Report for the Big Lottery Fund https://www.biglotteryfund.org.uk/-/media/Files/Research%20Documents/Older%20People/the_forgotten_people.pdf))
[111] British Medical Association, Royal Pharmaceutical Society. *British National Formulary. No 72*. 2016
[112] Carrington Reid M, Eccleston C Pillemer K 2015 'Management of chronic pain in older adults' *BMJ*; 2015:350
[113] Institute of Medicine Committee on Advancing Pain Research, Care, and Education 2011 *Relieving pain in America: a blueprint for transforming prevention, care, education, and research*. National Academies Press [USA]

The British Geriatrics Society reports evidence that pain in older adults is not recognised or managed as well as it is in younger adults.[114] While recognising that there are several methodological challenges to measuring pain prevalence, the Society reviewed studies on the prevalence of chronic pain (which had persisted for at least three months) among older adults. The prevalence of chronic pain among older adults living in the community ranged from 25 to 76 per cent, while for older adults living in residential care the prevalence estimates were even higher, in the range 83 to 93 per cent.

Assessing and managing older adults' pain is often challenging. There are many barriers to the effective identification and management of chronic pain in older adults.[115] Often, these barriers relate to communication difficulties. It may be difficult for some people (such as nursing home residents[116]) to articulate their pain, particularly those with severe sensory or cognitive impairment.[117] Treatment may be complex; for example, older adults may be at increased risk of an adverse reaction to prescribed medicines – especially in combination with other substances. Prescribing can be complicated because of the higher likelihood of older patients being in receipt of other medicines for the treatment of co-morbid conditions, which increases the chances of harmful interactions and adverse reactions. Concurrent use of other substances, licit or illicit, can also contribute to deleterious interactions.

There are two further challenges for prescribers: providing certain classes of medicines for pain relief to those with substance misuse problems (or a history of such problems); and concerns about the use of such medicines leading to dependency. Pain management has tended to be seen as a clinical issue to be resolved by professional judgement about the best course of action for the patient; but patients are increasingly being involved in decisions about their pain management. Professionals' concerns to avoid patients becoming dependent on their medicines, as well as the regulatory framework and clinical guidance, should influence prescribing decisions. Appropriate screening tools can help to reduce the

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[114] British Geriatrics Society 2013 'Guidance on the management of pain in older people' *Age and Ageing* 2013; 42: i1–i57. Available at: http://ageing.oxfordjournals.org/content/42/suppl_1/i1.full.pdf+html (accessed 11 January 2016)

[115] Allcock N McGarry C 2002 Management of pain in older people within the nursing home: a preliminary study. *Health Soc Care Comm* 10: 464–71.

[116] Kassalainen S Crook J 2004 'An exploration of seniors' ability to report pain' *Clin Nurs Res*; 13: 199–215.

[117] Blomquist K Hallberg L 1999 'Pain in older adults living in sheltered accommodation-agreement between assessments by older adults and staff' *J Clin Nurs*; 8: 159–69

risk of prescribing to those assessed as having a greater propensity for misuse or addiction.[118]

Substance misusers in treatment may need to use medicines for pain management; but there is under-prescription to this group – understandably, since there has been a rise in opioid-related deaths connected to prescription medication.[119] Access to medicines for pain management is protected in international human rights law[120] and should not be denied to any patient. However, especially for patients with substance misuse problems (or a history of such problems), a challenge – especially when prescribing opioid analgesics – is balancing this legal right against the possibility of misuse.

A considerable challenge for clinicians is those patients with chronic pain who use opioid analgesics along with benzodiazepines and/or alcohol – they are at higher risk for fatal and nonfatal overdose.

APoSM will include more detail and discussion of the issue of pain management in its forthcoming report on the misuse of prescription–only medicines.[121]

4.3 Illicit drugs

There are limited data on illicit drug use among older adults in the UK; in the *Crime Survey for England and Wales* questions about drug use are not asked of respondents aged 60 and over. The decision to exclude this population 'was largely an economy measure, reflecting their very low prevalence rates for the use of illicit drugs'.[122] It is true that there is a lower

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[118] A potentially challenging issue is raised by the proposed use of screening procedures in Wales. The intent of the 1961 UN Single Convention on Narcotic Drugs was to reduce the misuse of narcotic drugs. The original focus was on stopping the 'abuse' of narcotics while at ensuring adequate provision of these drugs for relief of pain. Over-restriction means some people may suffer from inadequate pain relief, or may turn to illegal substances; while under-restriction might make misuse of medicinal drugs more likely. Some North American evidence suggests that, following increased restrictions, a small percentage of those misusing pharmaceutical analgesics switched to illicit heroin misuse – where the potential for harm is likely to be greater. In other words, the balance is hard to get right.

[119] EMCDDA 2010 *Treatment and care of older drug users* *http://www.emcdda.europa.eu/publications/selected-issues/older-drug-users*

[120] United Nations 1972 *Single convention on narcotic drugs, 1961, as amended by the 1972 Protocol amending the single convention on narcotic drugs* Geneva: UN. Available at: http://www.incb.org/documents/Narcotic-Drugs/1961-Convention/convention_1961_en.pdf

[121] This will include a discussion of how pain management is much more than prescribing medication – and it is often those interventions that are missing.

[122] Home Office 2014 *User guide to drug misuse: findings from the Crime Survey for England and Wales*. London: Home Office https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335842/drug-misuse-user-guide.pdf (accessed 20 April 2015)

prevalence of drug use in this group than in any other age group in the survey: an analysis of the 2007 *Psychiatric Morbidity Survey* for England found that 1.1 per cent of the 2,639 respondents aged 60 and over had used illicit drugs (excluding prescribed medicines) in the last year.[123] (The study found that the main illicit drug(s) reported by people aged 60 and over as having been used in the last 12 months were cannabis (43%), tranquilisers (40%), magic mushrooms (27%), amyl nitrate/poppers (7%) and anabolic steroids (7%).[124])

A recent study of illicit drug use by people aged 50-years-and-older in England concluded that the misuse of some illicit drugs, particularly cannabis, had increased in mid- and late-life. The authors commented: 'Although illicit drug use is currently likely to be relatively rare in older age groups, a significant increase can be expected as generations for whom this has been more common and accepted become older'.[125]

The *Scottish Crime and Justice Survey* does not have an upper age cut-off for questions on drug misuse. The 2012-13 Survey reported that illicit drug misuse decreased for both men and women as they aged. Analysis of the data showed that, while 18.9 per cent of 45 to 59-year-olds had 'ever' used any drugs, only 2.5 per cent had used in the last year and 1.7 per cent in the last month. This compared with 4.3 per cent 'ever' drug use, and 0.3 per cent for both use in the last year and last month in those age 60+ years.[126]

The *Drug use in Ireland and Northern Ireland Drug Prevalence Survey* has an upper-age cut-off of 64 years for questions on drug misuse. The 2010-11 survey showed that illicit drug misuse during the last year decreased for those aged 35 to 64 years (11.8%) compared with younger adults aged 15 to 34 years (36.9%).[127] The main illicit drug used in the last 12 months by people aged 35 to 65 years was cannabis (18.1%).

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[123] Wadd S & Galvani S 2014 *The forgotten people: drug problems in later life, a report for the Big Lottery Fund* http://www.biglotteryfund.org.uk/research/older-people (accessed 20 April 2015)

[124] The total percentage totals more than 100% due to poly-drug use i.e. respondents reporting use of more than one of the named drugs concurrently

[125] Fahmy V Hatch S Hotopf M & Stewart R 2012 'Prevalences of illicit drug use in people aged 50 years and over from two surveys' *Age and Ageing*, 41(4), 553-6 http://ageing.oxfordjournals.org/content/early/2012/03/16/ageing.afs020.full.pdf+html (accessed 20 April 2015)

[126] Scottish Government 2014 *Scottish Crime and Justice Survey 2012/13: drug use*. Edinburgh. http://www.gov.scot/Resource/0045/00455131.pdf (accessed 20 April 2015)

[127] National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIR) 2012 *Drug use in Ireland and Northern Ireland: Drug Prevalence Survey 2010/11* Belfast & Dublin. http://health.gov.ie/wp-content/uploads/2014/03/drug_use_ireland_new1.pdf

Household surveys such as the *Crime Survey for England and Wales* may underestimate those whose drug misuse is the most problematic and whose lives are often the most chaotic. However, analytical techniques have been developed to indirectly estimate prevalence in these groups.[128] Analyses using these techniques provide comparisons (for England), finding that, between the years 2010-11 and 2011-12, there were decreases in prevalence estimates for the 15-to-24 and the 25-to-34 age groups. There was, however, an *increase* in the number of opiate and/or crack cocaine users estimated to be in the 35 to 64 age group (see Table 4.3). This, the oldest age group for which the estimates are available, represented just over half (52%) of the total estimated population using these drugs during 2011-12. The increase in the older age group is mainly due to a cohort of drug users ageing and moving from the 25 to 34 age group to the 35 to 64 age group, rather than people in that age group beginning to use drugs.

Year	*Estimated number*	*Percentage*
2010-11	143,778	48%
2011-12	152,125	52%

Table 4.3 Estimated prevalence of opioid and/or crack cocaine users 35-64 years old, England, by year[129]

4.3.1 Age of onset and patterns of drug use

While there is some evidence that people in their mid-30's 'mature out of' drug misuse,[130] patterns of drug misuse have changed and older adults across Europe are, nowadays, more likely than previous generations to misuse drugs. Older drug misusers can be categorised as 'early onset' or 'late onset'.[131, 132, 133, 134] Early onset drug misusers typically have a long

[128] Hay G Rael dos Santos A & Worsley J 2014 *Estimates of the prevalence of opiate use and/or crack cocaine use, 2011/12: Sweep 8 report* Liverpool John Moores http://www.cph.org.uk/wp-content/uploads/2014/08/Estimates-of-the-prevalence-of-opiate-use-and-crack-cocaone-use.pdf (accessed 20 April 2015)

[129] Health and Social Care Information Centre 2014 *Statistics on Drug Misuse England 2014* Available at: http://www.hscic.gov.uk/catalogue/PUB15943/drug-misu-eng-2014-rep.pdf

[130] Winick C 1962 'Maturing out of narcotic addiction' *Bulletin on Narcotics* 14, p. 1-7. http://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1962-01-01_1_page002.html (accessed 20 April 2015)

[131] Roe B Beynon C Pickering L & Duffy P 2010 'Experiences of drug use and ageing: health, quality of life, relationship and service implications' *Journal of Advanced Nursing,* 66(9), 1968-1979. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2984546/ (accessed 20 April 2015)

[132] Gossop M & Moos R. 2008 'Substance misuse among older adults: a neglected but treatable problem' *Addiction*, 103: 347–348

history of drug misuse beginning in adolescence or early adulthood and persisting. Late onset drug users typically begin to misuse drugs later in life, often triggered by stressful life events (including retirement, marital breakdown, social isolation or bereavement), or through personal relationships with other drug misusers. See Annex E for a discussion of the issues around the concept of early and late onset.

There are a number of studies which report cases of late onset drug misuse.[135, 136, 137] Some findings show that, although most drug injectors start injecting in their late teens or early twenties, there are some who commence injecting later than this, even after the age of 40.[138, 139] Drug misuse can often fluctuate across people's lifetimes, with changes in drugs of choice and changes in frequency of use, periods of reduction and abstinence, as well as periods of treatment involving maintenance or substitution therapy.

4.3.2 Older adults receiving drug treatment in Wales[140]

The *Annual profile of substance misuse in Wales 2015-16* reported that the number of assessments within specialist substance misuse treatment services fell across all age categories (younger people aged under 25, working aged people aged 25-49 and older people aged 50+), but that the fall was smallest amongst older people.[141] Assessments of older adults for

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http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2007.02096.x/full (accessed 20 April 2015)

[133] Boeri, M Sterk C & Elifson K 2008 'Reconceptualising Early and Late Onset: A Life Course Analysis of Older Heroin Users' *Gerontologist*, 48(5), 637-645 http://gerontologist.oxfordjournals.org/content/48/5/637.full (accessed 20 April 2015).

[134] Johnson W & Sterk C 2003 'Late-Onset Crack Users: An Emergent HIV Risk Group.' *J AIDS.* 33:229-232

[135] Beynon C Roe B Duffy P & Pickering L 2009 'Self-reported health status, and health service contact, of illicit drug users aged 50 and over: a qualitative interview study in Merseyside, United Kingdom' *BMC Geriatrics*, 9, 45-45 http://www.biomedcentral.com/1471-2318/9/45 accessed 20 April 2015)

[136] Kouimtsidis C & Padhi A 2007 'A case of late-onset dependence on cocaine and crack'. *Addiction,* 102(4), 666-667. http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2007.01757.x/full accessed 20 April 2015)

[137] Nambudiri D & Young R 1991 'A case of late-onset crack dependence and subsequent psychosis in the elderly' *Journal of Substance Abuse Treatment*, 8(4), 253-255

[138] Arreola S Bluthenthal R Wenger L Chu, D Thing J & Kral A 2014 'Characteristics of people who initiate injection drug use later in life' *Drug & Alcohol Dependence*, 138, 244-250

[139] Carneiro M, Fuller C Doherty M & Vlahov D 1999 'HIV prevalence and risk behaviors among new initiates into injection drug use over the age of 40 years old' *Drug & Alcohol Dependence*, 54(1), 83-86

[140] This paragraph refers to older adults being assessed by treatment services (i.e. new referrals) which is slightly different to 'older adults receiving drug treatment' which would include people already in treatment

[141] Public Health Wales and Welsh Government 2015 *Piecing the puzzle: the annual profile for substance misuse 2015-16* Available at:

any substance misuse (drugs and/or alcohol) accounted for 18.8 per cent (N = 3,515) of all assessments in 2015-16. Within this age group there has been an increase of 27.4 per cent over the five-year period, 2011-12 to 2015-16, (from 2,760 assessments in 2011-12 to 3,515 in 2015-16). In 2015-16, alcohol was recorded as the primary problematic drug in 83.6 per cent of assessments, with the remaining 16.4 per cent recorded as due to problematic illicit drug misuse. Heroin was the most commonly reported illicit drug misused by over-50s referred to treatment services, with 219 assessments (6.2 per cent of total assessments) in 2015-16, a decrease of 1.8 per cent on the previous year (see Figure 4.8).[142]

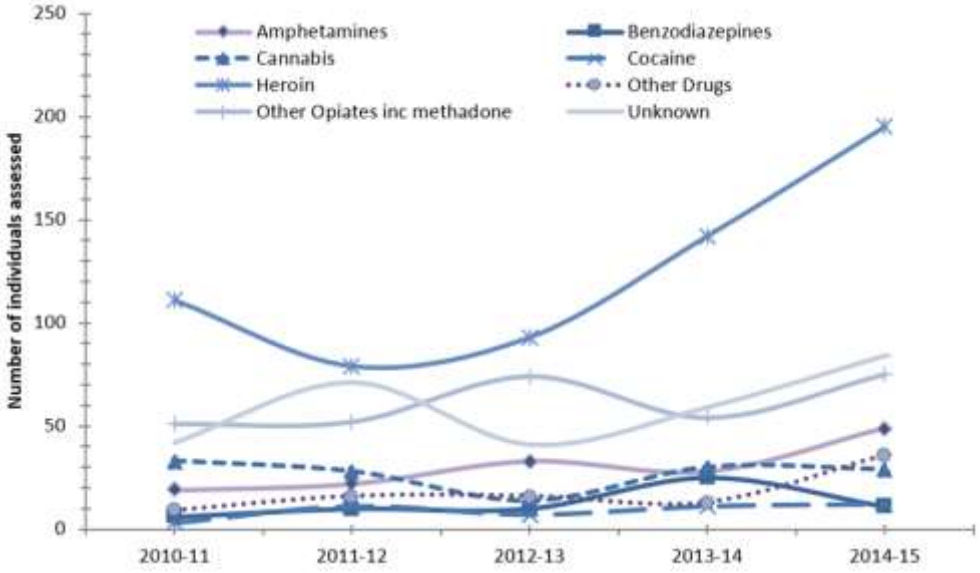

Figure 4.8: Referrals to drug treatment, named substances with >25 recorded referrals, older adults aged 50+ [143]

Data from the Harm Reduction Database Wales [144] Needle and Syringe Programme (NSP) module show that 995 people aged 50-plus years who inject drugs were regular service users[145] at NSPs in 2015-16. The

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http://www.wales.nhs.uk/sitesplus/documents/888/Piecing%20the%20Puzzle%20FINAL%202016%2C%20v2%2C%2025%20Oct%202016.pdf

[142] Welsh Government 2015 *Treatment Data - Substance Misuse in Wales 2014-15* Available at: http://gov.wales/docs/dhss/publications/160104substanceannualen.pdf

[143] Welsh Government 2015 *Treatment Data - Substance Misuse in Wales 2014-15* Available at: http://gov.wales/docs/dhss/report/141029submisuseprofilewalesen.pdf

[144] In 2010 Public Health Wales, supported by Welsh Government, introduced the Harm Reduction Database (HRD) in all statutory and voluntary sector Needle and Syringe Programmes (previously referred to as Needle Exchanges) across Wales. The HRD works as an anonymous web-based mechanism for recording demographic, substance use and blood borne virus associated details relating to clients accessing needle exchange. Further information is available at: Public Health Wales | Substance Misuse: Harm Reduction Database Wales (HRD)

[145] 'Regular service users' are those recorded as accessing services more than once in a given year and/or accessing in multiple years

majority (90 per cent) were males (N = 2,196). Regarding the reported primary drug injected, variations existed across age bands: amongst the 50 to 54-year age-group, the drug most frequently reported was an opioid, at 57.9 per cent (N = 400), followed by steroid and image enhancing drug (SIEDs) injectors, who accounted for a further 24.3 per cent; the remainder reported primary stimulant injecting. This overall trend decreases sharply onwards from the 55 to 59 age-group, as shown in Figure 4.9.

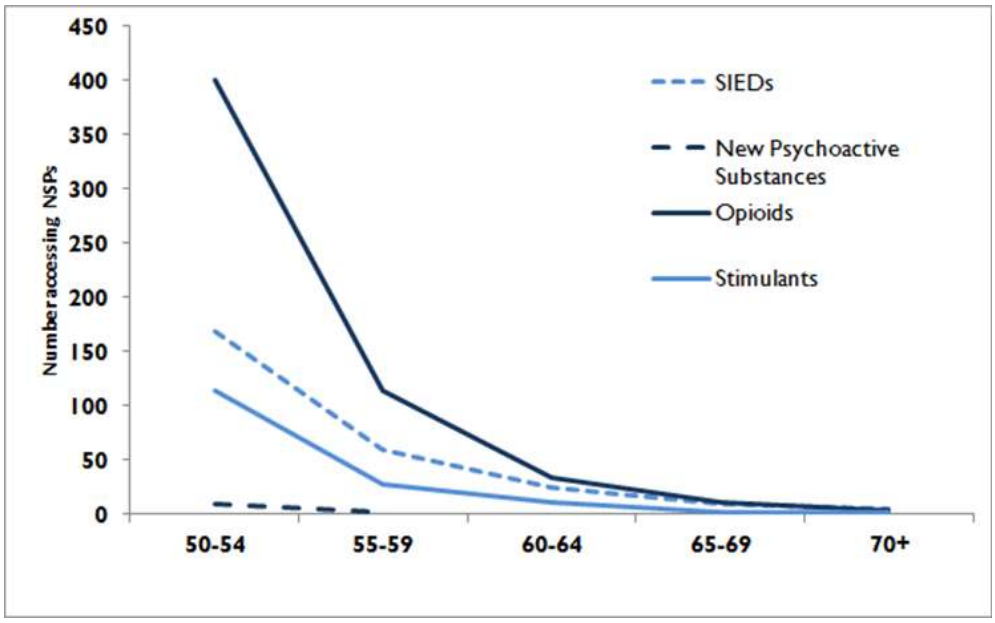

Figure 4.9: Regular service users (accessing >1 time in year and/or in multiple years) accessing needle and syringe programmes in Wales, older adults resident in Wales aged 50 years and older, 2015-16 (Source: Harm Reduction Database Wales 2015)

4.3.3 Hospital admissions for poisoning by named illicit drugs

In contrast with the relative stability in the numbers of alcohol-specific admissions,[146] there has been considerable year-on-year variation in the number of admissions of those aged 50-plus for poisoning by named illicit drugs[147] In 2015-16, there were 892 admissions; an increase of 6.2 per

[146] Public Health Wales and Welsh Government 2015 *Piecing the puzzle: the annual profile for substance misuse 2015-16* Available at: http://www.wales.nhs.uk/sitesplus/documents/888/Piecing%20the%20Puzzle%20FINAL%202016%2C%20v2%2C%2025%20Oct%202016.pdf

[147] The basis for the definition of 'illicit drug' in this context is substances controlled by the Misuse of Drugs Act 1971. However, substances may be covered by the MDA or not dependent on how they are acquired and in what quantity (e.g. many opioids can be legally possessed if prescribed but are otherwise illicit). It is not possible to definitively distinguish between hospital admissions involving substances which have been prescribed, legally acquired and illegally acquired. The methodology for calculating

cent from the previous year and up by 46.5 per cent in the five-year period, 2011-12 to 2015-16.

The number of admissions involving illicit drugs by year and five-year age band is shown in Figure 4.10, indicating differences between patterns of admissions for those aged 50-years-and-over in the last five-year period to 2014-15. Over this period, admissions for 50 to 54-year-olds increased from 210 to 322, an increase of 53.3 per cent. As seen in Figure 4.10, the number of admissions decrease for each age band; this rise continues for the very small number of admission amongst those aged over 80, a pattern stable over time.

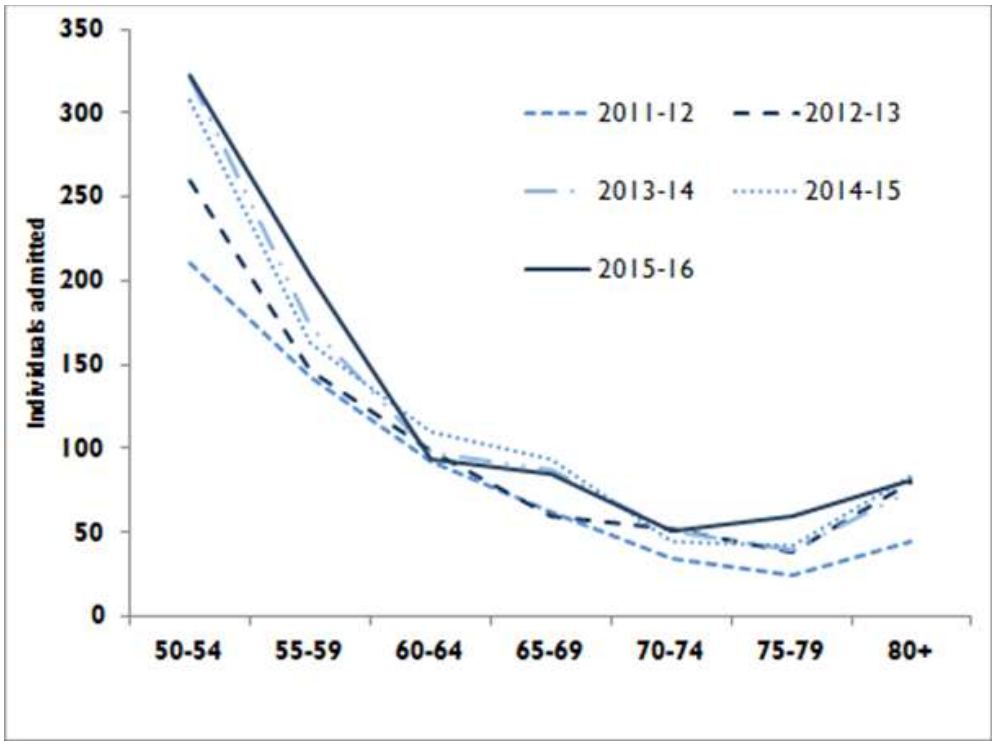

Figure 4.10: Hospital admissions related to illicit drugs, by age band, Wales, 2011-12 to 2015-16 (Source: Patient Episode Database for Wales)

hospital admission figures in relation to illicit drugs follows that developed by NHS Digital: see http://content.digital.nhs.uk/catalogue/PUB21159 for further details

5. Strategies, Policies and Actions in Wales

This chapter briefly outlines the relevant Welsh Government strategies and policies relevant to older people.

5.1 The Strategy for Older People in Wales

The Strategy for Older People in Wales: *Living Longer, Ageing Well* was first launched in 2003 to address the issues and aspirations of people aged 50 and over living in Wales.[148]

The first two phases of the Strategy (2003-13) sought to raise awareness of the needs of older people and identify the structures that needed to be put in place to enable the voices of older people in Wales to be heard. Throughout these initial phases of the strategy an Older People Commissioner was appointed, a Deputy Minister was assigned specific responsibility for older people, and a Ministerial Advisory Group was established. A number of specific programmes were also set up to support older people during these phases, including free swimming, free bus passes and free prescriptions. At a local level, each local authority has an elected member champion for older people, a co-ordinator who is a paid officer and "50+" forums.

The third phase of the Strategy spans the 10 years from 2013 to 2023; it aims to provide older people in Wales with the resources they need to deal with the challenges and opportunities which they face. The Strategy also seeks to ensure greater social participation by older people, that they have increased access to information, are not discriminated against, and have opportunities to engage in life-long learning and activities.

The strategy is supported by a Delivery Plan which sets out in more detail the actions the Welsh Government is taking (or planning to take) to ensure the well-being of all older people in Wales.[149] Actions include addressing the needs of older people with substance misuse problems, raising awareness and understanding of issues associated with substance misuse in older age and improving lifestyles (e.g. diet, exercise, smoking and alcohol) among older people.

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[148] Strategy for Older People in Wales (2013-2023) *Living Longer, Ageing Well* http://gov.wales/topics/health/publications/socialcare/strategies/older/%3bjsessionid=0778A16CF6BBE115429D330D3EA709E7?lang=en&dm_i=I34,1WEIX,63WD92,6TABT,1

[149] Strategy for Older People in Wales (2013-2023) *Living Longer, Ageing Well: Delivery Plan* http://gov.wales/topics/health/publications/socialcare/strategies/older/%3bjsessionid=0778A16CF6BBE115429D330D3EA709E7?lang=en&dm_i=I34,1WEIX,63WD92,6TABT,1

5.2 The Substance Misuse Strategy for Wales

Working Together to Reduce Harm is the Welsh Government's 10-year Strategy for tackling the harms associated with the misuse of alcohol, drugs and other such substances in Wales.[150] The Strategy describes how the actions are underpinned by four key aims:

- reducing harm
- improving the availability and quality of education, prevention and treatment services
- making better use of resources
- embedding the core Welsh Government values of sustainability, equality and diversity, support for the Welsh language and developing user-focused services and a rights basis for children and young people.

The Strategy recognises the importance of addressing the needs of older people and identifying and supporting older people at risk. It emphasises that professionals who come into contact with older people who misuse substances should identify the problem rather than 'assume, for example, falls or confusion are due to other causes'; and that 'every opportunity for secondary and tertiary prevention action is taken to improve outcomes for older people'.

Like the Older People Strategy for Wales, the Substance Misuse Strategy is supported by a Delivery Plan which sets out actions to address older people's substance misuse, together with actions to address issues affecting older people – including alcohol, POMs and OTCs.[151]

In 2014, the Welsh Government published 'Improving Access to Substance Misuse Treatment for Older People' as part of its suite of Substance Misuse Treatment Frameworks.[152] The main focus of the Framework is on access to treatment and the actions that should be taken by partners; including: local health boards, substance misuse and mental health service providers, local authority adult services, and those working in primary care at local level. It is intended to inform the development of local care pathways and to advise practitioners and those responsible for planning and managing services as well as service users themselves.

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[150] Substance Misuse Strategy for Wales 'Working Together to Reduce Harm'. http://gov.wales/dsjlg/publications/commmunitysafety/strategy/strategyen.pdf?lang=en

[151] The Substance Misuse delivery Plan 2016-18 http://gov.wales/topics/people-and-communities/communities/safety/substancemisuse/publications/dplan/?lang=en

[152] Substance Misuse Treatment Framework (SMTF) Improving Access to Substance Misuse Treatment for Older People http://gov.wales/docs/dhss/publications/141113substanceen.pdf

Substance Misuse Area Planning Boards (APBs) have been tasked with implementing the framework at a local level.

Progress in implementing the Framework's recommendations has been varied across APBs and is still continuing. Raising awareness with professionals working with older people and improving co-ordination and joint working between local older people and substance misuse treatment services continues to be monitored through the Welsh Government's APB 'performance dashboard'.

5.3 Support for older people in Wales

This section describes strategies, legislation, polices and initiatives that support older people in Wales.

The Well-being of Future Generations (Wales) Act 2015[153] came into force in April 2016. The Act aims to improve the social, economic, environmental and cultural well-being of Wales. Each public body listed in the Act must work to improve the economic, social, environmental and cultural well-being of Wales. Those public bodies listed in the Act will have to give more attention to the longer-term, and work more effectively, and in a more joined-up way, anticipating issues in order to prevent problems.

To do this, they must set and publish well-being objectives. These objectives will show how each public body will work to achieve the vision for Wales set out in the well-being goals. Public bodies must then take action to meet the objectives they have set. They will also need to ensure that their decisions take account of the future potential impact on people living in Wales.

The Substance Misuse Delivery Plan 2016-2018 makes clear the contribution that the substance misuse agenda can make in achieving the Act's goals: 'high-level' substance misuse outcomes are mapped against the relevant goals.

The Welsh Government's 10-year mental health strategy 'Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales'[154] aims to improve mental health and wellbeing, and the care and treatment of people using mental health services, as well as their carers and their families. Similar to the Older People Strategy for Wales and the Substance Misuse Strategy, it is supported by a delivery plan which sets out the priority actions required to implement the strategy. The delivery

[153] http://www.senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=010103
[154] http://gov.wales/topics/health/nhswales/mental-health-services/policy/strategy/?lang=en

plan for 2016-2019[155] includes actions to improving the quality of life for older people, particularly through addressing loneliness and isolation; and, by the end of 2016, producing a dementia strategic plan, including a focus on prevention.

In the Welsh Government's Programme for Government 'Taking Wales Forward 2016-2021'[156] it was confirmed that there would be further action to make Wales a dementia friendly country through developing and implementing a national dementia plan. This plan entitled '*Together for a Dementia Friendly Wales'* 2017 – 2022[157] is, at the time of writing, out for consultation and will close in April 2016 with the final document due to be published in the summer.

One of the themes in the draft strategy is in relation to 'risk reduction and health promotion' and reiterates guidance on dementia risk reduction published by the Welsh Government in 2015-2016. This states that people (of any age) can reduce their risk of dementia by living a healthier lifestyle; it sets out six recommended steps; step 5 is 'only drink alcohol within the recommended guidelines, if at all'.[158]

'Add to Your Life', is the health and well-being check for people aged 50 or over in Wales; this was rolled out nationally in April 2014.[159] This confidential self-assessment (which can be undertaken on-line or, with support, over the telephone by NHS Direct Wales) provides an overall picture of an individual's health, and supports people in improving their health and well-being in small steps; it also helps to improve their access to appropriate prevention services. The assessment includes a section on alcohol, which provides users with feedback on their alcohol consumption and, where necessary, tips and support in reducing it.

The Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem[160] is designed to inform and influence integrated and collaborative practice in mental health and substance misuse services for adults, children and young people. Responsibility for ensuring its implementation lies with managers, commissioners, planners and clinical leaders in health, social services,

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[155] http://gov.wales/topics/health/nhswales/plans/mental-health/?lang=en
[156] http://gov.wales/about/programme-for-government/?lang=en
[157] https://consultations.gov.wales/consultations/draft-national-dementia-strategy?lang=en
[158] http://gov.wales/newsroom/health-and-social-services/2017/dementia-risk/?lang=en
[159] Since 'Add to Your Life' was rolled out nationally nearly 24,000 people have accessed the site with over 12,000 completed health and well-being assessments undertaken.
[160] http://gov.wales/topics/people-and-communities/communities/safety/substancemisuse/publications/substance-misuse/?lang=en

education and third sector services. The Framework refers *to Integrated Assessment, Planning and Review Arrangements for Older People* Guidance[161] which requires health boards and local government in Wales to work with local communities and third sector partners, to ensure they have integrated well-being, assessment, care and support planning and review arrangements specifically to support older people.

5.4 Current provision and practice in Wales

5.4.1 WCADA

Specialist older adults' services in the UK are scarce.[162] In Wales, many projects, as part of their work, offer support to older drug users, but the Welsh Centre for Action on Dependency and Addiction (WCADA) has the only specialist older persons' substance misuse service in Wales. Delivered across Neath Port Talbot, the Service focuses mainly on outreach (at least initially), when the older person is unable to access the service at the agency. WCADA's Older Persons Service has been operational since 2001; its Domino Project offers a range of diversionary and educational activities that compliment other WCADA services. [163]

The Service helps those aged 50-plus to reduce the harm caused by their substance misuse. It includes case management in the home environment or at the agency base, assessing support needs, care planning, and liaison work with primary care, social services, residential and nursing homes and mental health services. A comprehensive support package is available to older adults; including advice and awareness sessions, health promotion, structured individual support and access to clinical alcohol and drug treatment services as appropriate and wrap-around services, such as diversionary activities.

Focus is placed on reducing isolation and supporting older adults to enhance their support network. This may include attendance at self-help groups and engagement with local community projects that facilitate activities and short courses. Three hundred and eighty-two people over

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[161] http://www.cciss.org.uk/sitesplus/documents/1131/Integrated%20Assessment%20for%20Older%20People.pdf

[162] Wadd S Lapworth K Sullivan M Forester D and Galvani S 2011 *Working with Older Drinkers* Tilda Goldberg Centre for Social Work and Social Care University of Bedfordshire. http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0085

[163] The DOMINO Project is a Big Lottery-funded therapeutic recreation service delivered by WCADA across the Western Bay area. It provides activities such as structured walks, gardening, IT and essential skills, cookery and nutrition, music classes and other activities for those affected by substance misuse. The service aims to engage people prior, during, and following treatment interventions in the productive use of their time; learning new skills in a supportive environment that encourages peer support and builds confidence and self-esteem.

the age of 50 accessed WCADA substance misuse services during 2014-2015 across the ABMU Health Board region, representing a quarter (25%) of total referrals to the Agency during the year; 89 of these people over 50 years received support from the specialist older person's part-time service. Sixty per cent of these over-50s presented for help with alcohol issues, 20 per cent for heroin and 20 per cent for family interventions.

WCADA service users were asked 'What Works Well?'; the following points summarise the aspects they felt were important:

- a friendly and welcoming atmosphere
- a non-judgmental approach and not stigmatised or criticised
- the central location of service
- the availability of telephone support
- regular contact with staff who understand
- the 12-Step Programme and AA meetings
- support from family and friends
- provision of Cognitive Behavioural Therapy (CBT) or social learning therapy
- an activities programme.

Case Study 4

'If I had not had the Domino Project I would not be in recovery now. Apart from giving me confidence to mix with like-minded people, I was able to share how I felt and get positive and helpful feedback. I also learnt new skills; it helped to re-kindle previous interests e.g. gardening. When I joined Domino I knew nothing at all about computers, I enrolled in the Domino Computer class in Swansea and I now have a responsible job which incorporates using computers. Cooking was not something I liked doing at home on a personal level but the Domino cookery courses @ Bryn College Swansea were really enjoyable and I completed the certificates. The allotments were amazing, no matter what the weather was like I would turn up in Swansea. I learnt so much, including a lot of handy tips I could use in my own garden.'

Utilising networks of older adults through service user forums and mentoring relationships to educate and support each other might make a major difference in reducing the numbers presenting to primary and secondary care services in the future.

Challenging ageist attitudes and myths that surround substance misuse and campaigning to raise awareness about the safe levels of alcohol consumption for older adults and the particular dangers to this group of combining substances would help to improve understanding among professionals working with older people. Such actions would contribute to

the prevention of problematic substance use and might lead to significant improvements in health and quality of life.

5.4.2 Pharmaceutical interventions

The choice of pharmacological intervention should depend mainly on the type and severity of the presenting problem(s), and the type and level of a patient's functional impairment. But pharmacological interventions for the treatment of substance misuse in older adults have a limited evidence base: often, interventions have been tested in younger populations – with older adults excluded from the clinical trials.[164] Furthermore, many of the medicines used for the treatment of substance misuse are sometimes not used in everyday clinical practice in either older adult mental health services, or substance misuse treatment services for older patients. Yet older adults can and do benefit from treatment:[165] being old should not be a barrier to receiving effective treatment.

Most pharmacological interventions require a cautious approach, as medical conditions such as reduced hepatic function associated with increasing age and polypharmacy in older adults may require dosage reduction and careful monitoring. The prescribing of opioid substitute therapy may be indicated for older adults presenting with opioid dependence (prescribed or illicit). Relapse prevention prescribing for alcohol dependency may be appropriate for older adults following detoxification. Referral to specialists with experience of prescribing for this population group may be necessary.[166]

5.5 Examples of good practice

Examples of good practice from Northern Ireland, Bristol and London, as well as the four-country 'Drink Wise, Age Well' programme, are now given to illustrate how effective services can operate.[167]

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[164] Sarah Wadd's team is currently conducting a study provisionally entitled: 'exclusion of older adults from clinical trials about alcohol misuse' (Wadd S 2016 personal communication)

[165] In England, older adults are just as likely to be treated successfully for alcohol and drug problems as younger adults: 63 per cent of people aged 65-and-over were treated successfully compared to 48 per cent of those aged 18-64 (Public Health England, Response to Freedom of Information Request, 2012). Similarly, for drug use, 62 per cent of people aged 60-and-over completed treatment free of dependency compared to 47 per cent of people aged 18-59 (Wadd S 2014 *The Forgotten People: Drug Problems in Later Life* Big Lottery Fund).

[166] See Crome I *et al* 2014 *Substance Use and Older People* Wiley

[167] Some of these examples are drawn from DrugScope 2014 *It's about time. Tackling substance misuse in older people A briefing by DrugScope on behalf of the Recovery Partnership* DrugScope. Available at : http://www.scie-socialcareonline.org.uk/its-about-time-tackling-substance-misuse-in-older-people/r/a11G0000003DZEcIAO (Accessed 24-01-16)

Addiction NI – Older Focus Service

Since 1997, this service has been providing specialist treatment programmes for older adults with substance misuse problems across four of the five Health Care Trusts in Northern Ireland. It provides a range of treatment options (almost half the service users choose to receive the service in their own home), and also trains staff in other sectors. An open referral system operates: about half are self-referrals. The majority of referrals relate to alcohol.

Bristol Drugs Project's '50 Plus Crowd'

Open to anyone aged 50 and over with drug and/or alcohol problems, this service, funded by the NHS, aims to improve health and wellbeing among older adults. Most using the service are on long-term methadone scripts with the BDP shared care team, and have not been engaging with treatment services beyond these appointments.

A twice-weekly group and regular social activities (swimming, yoga, dance therapy, gardening and walking) aim to help clients develop and maintain a social network and build their confidence. Although service users can 'dip in and out', attending social activities and the group can be a route back into more structured treatment and engagement.

Drug and Alcohol Service for London – Silver Lining Project

The Drug and Alcohol Service for London (DASL) Silver Lining project, works,[168] on a long-term basis, with those aged 55 and over who are concerned about their drinking. The complexity of the issues experienced by older adults with alcohol problems means that long-term engagement is a key aspect of the service. Most who come to the project want to change their drinking habits but are not seeking abstinence.

The Project recruits and trains peer mentors. Both one-to-one and group support is offered to clients. A weekly group, facilitated by the peer mentors, has therapeutic aims and has creative and social activities aimed to address loneliness. Peer mentors also give individual support including counselling and practical issues. They are seen as important to help to overcome perceived barriers to access and to encourage and maintain engagement.

[168] Unfortunately, since this report was drafted, funding for this project has ceased

Drink Wise Age Well

'Drink Wise Age Well', a five-year multi-level Programme to reduce alcohol-related harm in older adults (50+) is being implemented and evaluated across the UK. The programme is being delivered in five 'demonstration areas' in England, Wales, Scotland and Northern Ireland. The Programme is evidence-based and designed specifically for older adults. It is supported by the Big Lottery Fund.[169]

Activities include delivering community-level public awareness campaigns, providing a telephone information line, a peer education project, a group resilience intervention, a programme of diversionary activities, alcohol training for professionals working in older adults' services and a range of age-appropriate interventions for those with existing alcohol problems. The Programme is also engaged with national and local policy-makers to increase the profile of the issue and ensure that the needs of older adults are considered and highlighted in relevant strategies. Early findings suggest that the Programme is reducing at-risk drinking, decreasing symptoms of depression and anxiety, increasing resilience, raising awareness of the issue, increasing professional capacity and improving positioning of the issue on the policy agenda.

5.6 Accommodation support

Lack of appropriate housing, problems acquiring money for rental deposits, historical rent arrears, and (often) a history of eviction and poor tenancy compliance all contribute to substance misusers (of all ages) facing considerable difficulties in accessing housing. It is difficult to find out where people with substance misuse issues are accommodated, and this is especially so for older adults who may not be known to those agencies which offer support and assistance. Placements are often temporary or short-term and of poor quality, and lack of support in daily living skills (in particular financial management and household maintenance) often means that people struggle to maintain their tenancies.

Ex-prisoners, and other offenders, who are substance misusers can have especial difficulties in accessing housing. Approved premises and bail hostels are available for those in the criminal justice system; none are specifically for older offenders.[170]

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[169] http://drinkwiseagewell.org.uk/ (accessed 18-10-16)

[170] Approved Premises are managed by National Probation Service and provide a short-term structured regime of interventions for offenders subject to license or community supervision. The main function is to protect the public through providing enhanced monitoring and supervision of offenders whilst also supporting their rehabilitation. The

Rehabilitation placements are of limited availability and the application process can be slow.[171]

Some people living in housing association accommodation or in hostels find the conditions difficult, especially where there are adjacent tenants with chaotic substance misuse. Similarly, some people accommodated in 'dry houses' experience difficulties when other tenants use alcohol and other drugs.

Substance misusers who have long-term alcohol misuse problems (especially street drinkers) have not been able to access accommodation or temporary hostels, as all the schemes operated a substance misuse-free policy until recently. However there are plans for a 'wet house' in Newport.

Appropriate accommodation for patients with advanced alcohol-related brain damage (ARBD[172]) is difficult to arrange due to the lack of sufficient special placements in Wales which some ARBD patients may require, and the limited understanding of the condition by care staff.[173] Such patients may continue to drink, their condition may worsen, and they may then require more intense and expensive interventions.

There is likely to be an increase in demand for these types of accommodation.[174] 'Housing first' approaches – offering immediate access to independent housing and supporting services without any requirement for them to first engage with treatment – can be effective for homeless people with mental health and/or substance misuse problems.

5.6.1 Provision in Wales

As elsewhere in the UK, there are four main forms of permanent housing available in Wales (in brackets, the 2013-14 percentages for Wales).[175]

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majority referrals for approved premises are for high risk offenders subject to statutory supervision, following a period of custody. Bail accommodation is for people who would normally be living in the community on bail or Home Detention Curfew (HDC) but do not otherwise have a suitable address or they need some extra support during the period of their bail or HDC licence.

[171] as evidenced in two responses to the Panel's call for evidence (received February 2015)

[172] sometimes described as Korsokoff's Syndrome or Wernicke's Syndrome

[173] Reported in Questionnaire Submission received in February 2015 from Dr Julia Lewis, Consultant Addiction Psychiatrist and Clinical Director, Aneurin Bevan University Health Board

[174] Royal College of Psychiatrists 2015 *Substance misuse in older people: an information guide,* Older Persons' Substance Misuse Working Group; and: *Alcohol and older people in Wales* 2011 Alcohol Concern Cymru Briefing

[175] This amounts to just over 1.4m units of accommodation with just under 980,000 units classified as owner occupation.

- Local Authority Social Housing (6.3%)
- Housing Association (9.7%)
- Owner Occupation (70%)
- Private Rented Sector (14%)

Of the 22 local authorities in Wales, 11 have housing stock of their own; the other 11 have transferred to housing associations. Each local authority area has both public and private provision of residential and nursing home accommodation; most cater for several different client groups: some will offer specialist services for people with substance misuse. Within the local authority and housing association sector there are a number of supported housing schemes (permanent or temporary), some of which support people with substance misuse issues with accommodation.[176]

Specialist accommodation ('sheltered accommodation') for people aged over 50 is available in all areas of Wales but to varying degrees: from as few as 13 schemes in Merthyr Tydfil to 156 in Powys. These are mainly rented from local authorities and housing associations; they are also available to buy or to lease from private owners. There are over 1,200 of these schemes across Wales; most schemes are made up of individual flats or bungalows with support from staff who sometimes live on site, or offer 'floating support'.

The Supporting People Programme Grant (SPPG) provided by the Welsh Government to all local authorities in Wales is used to provide housing-related support to vulnerable adults. Supported Housing Accommodation is provided by every local authority; most have dedicated provision for substance misusers, with (in most cases) attached support.[177] The Regional Collaborative Committees (RCCs) across Wales provide forums

[176] There are different access and eligibility criteria for each individual project across all types of accommodation. Social housing schemes have a number of differing allocation policies, even for organisations operating in the same locality. Costs vary across all sectors with the largest weekly cost being for residential and nursing care.

[177] Examples include: **Cwm Taf – Merthyr and RCT** – Gwalia Care & Support offer homeless service users with substance misuse issues aged 18 and over; **Western Bay – Swansea, Bridgend, and Neath Port Talbot**: The Wallich manages the Swansea Shoreline Project, a 24-hour supported project for former street drinkers; **Gwent – Newport, Torfaen, Monmouth, Caerphilly and Blaenau Gwent**: Kaleidoscope provides the KForce house which is a supported move-on house for people in recovery in the city of Newport;. **Mid and West – Carmarthenshire, Pembrokeshire, Ceredigion, Powys**: CAIS provide a supported housing project in Haverfordwest for up to 4 people referred through Pembrokeshire Substance Misuse services, who have completed a course of treatment in relation to substance misuse; **North Wales – Gwynedd, Wrexham, Denbigh, Flint, Anglesey and Conwy**: CAIS provide a supported housing project of 6 units in Wrexham for homeless prison leavers aged 18 and over and who have significant drug misuse issues**; Cardiff and The Vale – Cardiff, Vale of Glamorgan**: United Welsh Housing Association provides a project consisting of 20 single units in a 3 storey dry hostel in Cardiff.

where health practitioners can work with landlords, local authority 'supporting people teams' and the third-sector housing-related support providers to ensure that there is an appropriate range of services to address the needs of older adults with co-occurring housing and substance misuse issues.

For example, the Western Bay Regional Commissioning Plan has 'complex needs' as a priority work area for 2015-16. In the Western Bay region, the SPPG funding in 2014-15 was as follows:

- people with alcohol issues: £356k (all Swansea); 26 units[178]
- people with other substance misuse issues: £608k (Bridgend-£47k, Neath Port Talbot -£172k, Swansea -£390k); 41 units
- older people services: £2.4m; 3,656 units.

Supported Housing Accommodation is provided by every local authority; most have dedicated provision for substance misusers, with (in most cases) attached support. Examples include:

- SANDS Cymru offers a comprehensive menu of services, including a harm reduction service, working with drug and alcohol misusers of all ages; mainly those not yet ready to (or wanting to) abstain. The focus of the work is on reducing individual harm. The agency employs four housing workers who support people to maintain tenancies, become independent and be less socially isolated.

- Gorwellion, a newly-refurbished scheme with self-contained flats plus communal facilities available for group work and client interaction provided through The Wallich. The Wallich provide the Vesta project in Bridgend which has five fully-furnished self-contained flats.

- Swansea Shoreline Project, a 24-hour supported project for former street drinkers. It has a shared house for four people with single rooms and communal lounge, dining area, shared kitchen and bathrooms, garden and 24-hour staffing. It also has four self-contained one-bedroom flats and a bed-sit flat with emergency on-call to sleep-over staff.

- The Cross Borders Women's Project has 16 units: seven in a 'core house' and nine dispersed units (three in each of the LA areas of Swansea, Bridgend and NPT).

[178] 'units' refers to either direct accommodation or 'floating support'

- Haven Trust Supporting People provides a 24-hour supported housing project for nine people who are homeless and who wish to become abstinent.

- In Swansea, the Tenancy Support Unit provides a central referral and assessment service for accommodation-related support across all tenures, including support to help overcome drug and alcohol abuse.

Residential and Nursing Homes

There are approximately 2,000 residential and nursing homes in Wales: just over 800 residential schemes and just over 1100 nursing home schemes operated in local authorities and the private sector.

Residential care homes offer help with personal care, along with services such as laundry and meals. Some homes offer short-term or respite stays but normally they provide long-term or permanent care. A proportion of them will offer specialist care such as catering for people with alcohol dependency.

Many older adults with 'refractory alcohol problems' (alcohol problems that are resistant to change) require long-term residential care because they are unable to look after themselves. Some have lost their accommodation because of their alcohol use and become homeless. Others live in an unsafe way at home alone. They have a right to be cared for in a home which provides them with a place of safety, comfort and dignity. However, most care homes for older adults in the UK are neither accessible nor feasible for these individuals.

The Panel was told of two voluntary sector care homes that provide permanent, non-abstinence based supportive residential care to people with refractory alcohol problems. Their harm-reduction approach is a radical and controversial departure from the conventional approach which requires heavy drinkers to stop or greatly reduce their drinking before they can access long-term residential care.[179]

5.7 Good Services

The evidence reported here demonstrates that services to meet the needs of older substance misusers are needed; but such services can be

[179] Wadd S 2016 personal communication. Wadd's proposed study will: '… describe the models that these homes have developed and examine the perceived effectiveness of this approach. … The study will identify suitable objectives for this type of care and explore how reduction of harms might be measured. It will, therefore, provide a strong evidence base for other organisations who are considering commissioning or delivering this type of care'

provided in a variety of ways. Dedicated services for older adults with substance misuse issues may be helpful – especially for those who are difficult to reach, such as 'hidden' alcohol misusers, or long-term opiate users not in contact with services. Mainstream drug services may need to consider how they could adapt their service provision to better address the needs of their older service users, or to attract older substance misusers into treatment, and retain them. Non-substance misuse services working with older adults need to be aware of the possibility of substance misuse among their clients and know how to address their needs, what other services to call on, and what the referral pathways are. The Welsh Government's policies and guidance (for a summary, see sections 5.1 and 5.2 of this Report) are useful in helping services to identify and plan their approaches.

Because some older substance misusers may be quite entrenched in their behaviour, and be reluctant or unable to quit, harm reduction is important for this group.[180]

It is a truism that 'prevention is better than cure', which might imply intervention at an earlier age; however, the outcomes of prevention interventions are often quite long-term and therefore difficult to measure – partly for this reason, the effectiveness of many prevention approaches are uncertain. However, many population-level prevention actions are known to be effective: for example, a previous APoSM report has recommended minimum unit pricing of alcohol, which would impact on the heaviest drinkers and would generate health gains disproportionately for those in lower socio-economic groups.

Certain risk factors are associated with substance misuse, some of which may particularly affect older adults; these include: retirement; bereavement; social isolation and loneliness; poor health; and cognitive impairment. It is also important to attempt to increase the factors that may protect people from substance misuse problems, such as helping people to increase their resilience, for example, through improving their capacity to deal effectively with life's challenges and with stress.[181]

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[180] Ward M and Holmes M 2014 *Working with change resistant drinkers* (Alcohol Concern) is a helpful guide. Pdf at: http://www.therecoverygroupuk.org/pdfs/alcohol-concern-s-blue-light-project.pdf

[181] Recovery Partnership (2014) 'It's about time' *Tackling substance misuse in older adults*. A briefing by DrugScope on behalf of the Recovery Partnership – available at: https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0ahUKEwiX5_TKlsPKAhVHvA8KHaXRDFMQFggqMAI&url=https%3A%2F%2Fdrugscopelegacysite.files.wordpress.com%2F2015%2F06%2Fits-about-time-report.pdf&usg=AFQjCNEZ6nK3FZi3VHdeeNviTHLrKS3wsw&sig2=Cs_GqcLipdwuC6nXz_bXJg (Accessed 24-01-16)

This implies that reducing substance misuse problems is not just about a focus on substances, but is about health and well-being and healthy lifestyles. Services for older adults that address health broadly and lead to general health improvements are likely to be effective in reducing substance misuse problems. And patterns of healthier living established before the age of 50 may persist into older age, supporting the health of older adults and reducing substance misuse issues in this population.

6. Recommendations

Older people with substance misuse problems do not receive as much attention as young substance misusers: yet preventing, detecting and addressing problem substance use in older adults is important. Age-appropriate drug prevention, support and treatment can improve old people's health and quality of life. But many substance misuse services serve a predominantly young and male clientele who are mainly opiate users and thus are not configured to best meet the needs of older substance misusers. In addition alcohol services, while providing coverage of a wider age group, are sometimes not well-aligned with the needs of older adults.[182]

Generic services are increasingly having to deal with an ageing population and will need to give greater attention to this group. They will need to give particular thought to – and take action to address - potential substance misuse among their clients.

Further, services specifically for older adults need to be aware of the potential for substance misuse among their clients and know how to address it appropriately.

Recommendation 1

The Welsh Government has already developed a number of initiatives. National and UK bodies have a role in taking the lead and promoting good practice; they could further consider:

- that documents on substance misuse fully discuss the needs of older adults and that all documents on healthy ageing consider substance misuse
- reporting data for older adults in substance misuse statistics in more-differentiated age categories (such as: 55-64, 65-74, 75-84, 85+), rather than just one 60+ age category
- collecting more-differentiated prevalence data by removing the upper-age cut-off for questions about illicit drug use in the Crime Survey for England and Wales
- delivering alcohol and drink-driving campaigns which are specifically targeted at older adults, and in campaigns for a wide age-group include images of older adults

[182] Substance misuse services specifically for older adults may be better than mixed-age services for this group. Clients may feel more comfortable in treatment settings with their peers, and older adults attending them may be less likely to drop out of treatment, and have better outcomes than when in mixed-age services.

- developing a guide for practitioners on how to carry out substance misuse screening and brief interventions with older adults (include a list of screening tools that have been designed and/or validated for use with older adults).

Recommendation 2

Substance misuse services across Wales need further development to improve their reach to older adults. Service managers and APBs should:

- make premises accessible, safe and welcoming to older adults
- have older adults represented on service user groups
- in areas where substance misuse among older people is especially prevalent, consider developing a specialist service for older adults, or facilitating a peer support group specifically for them
- improve links with services that regularly encounter older adults and develop clear guidelines and procedures for working with them
- have a flexible approach to providing treatment that is effective with older clients, ideally offering: a choice of venue, including home visits (for ease of access and to offer some form of anonymity for those who fear the stigma of having a substance misuse problem); longer and more frequent sessions where there are complex needs or an extensive history of substance misuse; appointments at specific times or dates (perhaps coinciding with transport times or carer availability).

Recommendation 3

All relevant services should be taking account of the ageing population and the changing patterns of substance misuse, and should be adapting their services appropriately. This must be informed by relevant research and evaluation. Good practice should be widely shared through, for example, multi-disciplinary dissemination events.

All services should ensure that, where evidenced health harms relevant to different age groups are identified, they are effectively communicated to the appropriate client groups.

Recommendation 4

Other services that support older adults need to be more aware of and informed about the potential for substance misuse by their clients, the impact this may have, and how they can alleviate it. They need to be more aware of referral pathways to substance misuse services.

Some things that service managers might do include:

- ensure that practitioners receive training or guidance on how to identify and intervene with substance misuse in older adults and to recognise how their own attitudes towards older people (and substance misuse) may affect their practice
- develop a local care pathway which outlines the roles and responsibilities of their staff in tackling substance misuse with older adults
- use appropriate substance misuse screening and brief intervention tools that have been designed and/or validated for use with older adults.

Recommendation 5

The Prison Service should continue to address the needs of older prisoners with substance misuse problems, in the context of an increasingly aged prison population. It should ensure that, across all age-groups, it provides opioid substitution treatment and pharmaceutical treatment for withdrawal in prisons; ensures that opioid substitution continues on release; provides naloxone; gives first aid training for overdose; and provide psychosocial interventions for substance misuse whilst in prison. In order to monitor this, a prison health surveillance service should be developed. The needs of older ex-prisoners with substance misuse problems need continued attention from the Probation Service.

Recommendation 6

Landlords managing tenancies for older people should proactively carry out health and well-being assessments and include/consider substance misuse (especially alcohol) as part of the assessment. Appropriate referral to specialist agencies should be undertaken to avoid any potential homelessness and allow tenancies to be sustained.

Recommendation 7

New approaches to service provision are needed and should be piloted and evaluated. These might include:

- non-abstinence-based accommodation (such as ‘homes for life’) for older adults unable or unwilling to stop drinking
- new approaches to identifying and intervening with older adults addicted to medicines that do not require them to attend a substance misuse service

- resilience interventions that help people to cope with age-related transitions, stresses and life circumstances.

Recommendation 8

Further research, analysis and modelling of the potential future health burden of substance misuse should be undertaken by a range of researchers, within and outside Welsh Government to help services (including specialist substance misuse services, as well as primary and secondary health care) plan for the future. For example, it is important, in addition to addressing the needs of the older substance misuser, to explore more thoroughly in modelling the implications of the evidence that excessive drinking in the period of one's 40s does irreversible damage to health which only becomes apparent in one's 60s (or even older). This would mean a greater focus on prevention and harm reduction in these earlier years.

Annex A APoSM Members

Name	*Title*
Richard Ives	Education Consultant. Interim Chair of APoSM
Rosemary Allgeier	Principal Pharmacist in Public Health, Public Health Wales
Ifor Glyn	Regional Director, Drugaid Cymru
Kyrie James	Member of the International Association of Women Judges (resigned September 2016)
Professor Simon Moore	Violence & Society Research Group, School of Dentistry, College of Biomedical and Life Sciences, Cardiff University
Professor Philip Routledge, OBE	Head of Department of Pharmacology, Therapeutics and Toxicology, Institute of Molecular and Experimental Medicine, School of Medicine, Cardiff University
Josie Smith	Head of Substance Misuse, Health Protection, Public Health Wales
Dr David Doughty	Director, Hallidex Ltd
Dr Andrew Wilson	Senior Lecturer in Criminology, School of Social Sciences, Nottingham Trent University
Dr Julia Lewis	Consultant Addiction Psychiatrist / Clinical Director Adult and Specialist Mental Health Services, Gwent Specialist Substance Misuse Service
Professor Ceri J. Phillips	Head of College / Professor of Health Economics, Swansea University
Mark Polin	Chief Constable, North Wales Police

Secretariat

Tracey Breheny, Deputy Director for Substance Misuse Policy, Corporate & Ministerial Business

Chris Gittins, Head of Substance Misuse Policy and Finance

Julia Huish, Substance Misuse Policy Advisor

Daryl Kent, Substance Misuse Policy and Finance Team Support

Annex B Evidence-gathering

APoSM held an expert evidence-gathering day on 24 March 2015. The following people / organisations attended and provided evidence to the Ageing Population Sub-committee:

Name	*Organisation*
Bruce Diggins	Research Manager, The Wallich Centre
Susan Price	Medicines Management Pharmacist, Powys Teaching Health Board
Conrad Eydmann	Head of Partnership Strategy and Commissioning, Cardiff and Vale University Health Board
David Richards	CEO, Brynawel House Rehabilitation Centre
Dr Raman Sakhuja	Royal College of Psychiatrists
Karen Ozzati	Chief Executive, Welsh Centre for Action on Dependency and Addiction (WCADA)
Karen Black	Community Team Manager, Bristol Drugs Project

In addition, the following people and organisations submitted documents, information or written representations, or otherwise contributed to this Report:

Name	*Organisation*
Dr Julia Lewis	Gwent Specialist Substance Misuse Service
Andrew Misell	Alcohol Concern Cymru
Tracey James	Bellevue Group Practice, Newport
Dr Owen Powell	ABMU Health Board
Clive Wolfendale	CAIS
Steve Simmonds	Community Pharmacy Wales

Rhian Lewis	National Specialist Advisory Group (NSAG), Pain Sub Group
Wynford Ellis Owen	Living Room, Cardiff
Nicola Jones	Caritas Surgery
Katy Playle	DIP Regional Manager, North Wales
Kathryn Nur	Chronic Pain CNS, Hywel Dda University Health Board
Sue Jones	Cefn Coed Hospital
Sue Squire	Aneurin Bevan University Health Board
Cohen Lewis	NOMS Wales
David Richards	Brynawel House
Susan Price	Powys Teaching Local Health Board
Teresa Owen	Hywel Dda University Health Board, Public Health Team
Manel Tippett	Royal College of Psychiatrists
Conrad Eydmann	Cardiff & Vale Area Planning Board
Ryan Wood	G4S at HMP Parc and Community Interventions for Offenders
Bruce Diggins	The Wallich Centre
Jean Harrington	TEDS
Jo Simpson	Recovery Cymru
Clare Lloyd	CRI Cymru
Elen Jones	Royal Pharmaceutical Society
Sian Prior	Rhondda Integrated Substance Misuse Service (RISMS)
Jill Timmins	Betsi Cadwaladr University Health Board
Dr Rodney Berman	BMA Wales
Dr Phil Kloer	Hywel Dda University Health Board

Karen Miles	Hywel Dda University Health Board
Nic Davies	NOMS Wales
Emma Davies	Integrated Pharmacy and Medicines Management, Abertawe Bro Morgannwg University Health Board
Lisa Meredith	Gwent Area Planning Board
Dr Saloni Jain	Ash Grove Medical Centre
Lyn Webber	Gwent Police and Crime Commissioner
Paula Smith	Rehabilitation Nurse Practitioner, Abertawe Bro Morgannwg University Health Board
llana Crome	Keele University
Anne Craven	Welsh Centre for Action on Dependency and Addiction (WCADA)
Debra Fielding	Bradford NHS

Sarah Wadd provided helpful comments on a late draft of this Report; we are grateful for her timely help at that stage of the drafting process.

A community visit was convened at the WCADA Older Persons Service in March, 2015. The following is a brief account of some of the evidence obtained from this visit.

Six service users were asked if their substance misuse was historical or a more recent issue for them. All participants reported that while they had always enjoyed a drink, in most cases their drinking had escalated due to a trigger event in their lives; including:

- marriage breakdown
- bereavement
- retirement
- experience of domestic violence
- job loss
- a health condition.

Other reasons they gave for the escalation of their drinking included:

- to forget
- to mask problems

- to socialise/stay in touch with friends/work colleagues
- to alleviate feelings of depression
- to combat boredom/loneliness
- isolation.

Group members also said that their alcohol misuse resulted from inconsistent and ineffective treatment with analgesics for pain relief.

Annex C Definitions of misuse

It is important, in particular in order to estimate the potential requirement for treatment services, to differentiate drug and alcohol *use* from *misuse*. 'Substance misuse' is defined in this Report in relation to the consumption of alcohol, prescription-only or over-the-counter medicines, and illicit drug use in the following terms:

- *misuse of alcohol*: drinking above recommended guidelines [183] represented as a spectrum from 'harmful', through 'hazardous' to 'dependent' drinking
- *problematic or high-risk drug use*: recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems); or is placing the person at a significant risk of suffering such harms[184]
- *Misuse of prescription-only / over-the-counter medication*: The use of a medicine not consistent with legal or medical guidelines. This includes both dependent and non-dependent use.

Tobacco use is not considered in this Report as it is not in the brief of the Panel, but, clearly, smoking tobacco has major implications for the health of older adults, especially when it is in combination with other substance misuse.

[183] NHS http://www.nhs.uk/conditions/alcohol-misuse/Pages/Introduction.aspx
[184] European Monitoring Centre for Drugs and Drug Addiction 2013 PDU (Problem drug use) revision summary. Available at: http://www.emcdda.europa.eu/activities/hrdu

Annex D Population trends in Wales

These data are based on mid-year population estimates for Wales.[185] The cohort of people aged 65 and over includes those aged 75 and over; which, in turn, includes those aged 85 and over. In Wales, between 1991 and 2011:

- the overall population increased by seven per cent
- there was a 15 per cent increase in the number of people aged 65 and over
- there was a 26 per cent increase in the number of people aged 75 and over
- there was a 67 per cent increase in the number of people aged 85 and over
- there was a 28 per cent increase in the number of men aged 65 and over
- there was a 52 per cent increase in the number of men aged 75 and over
- the number of men aged 85 and over more than doubled from 11,000 to 24,000
- there was a six per cent increase in the number of women aged 65 and over
- there was a 13 per cent increase in the number of women aged 75 and over
- there was a 49 per cent increase in the number of women aged 85 and over
- the percentage of people aged 85 and over increased from 1.6 per cent to 2.5 per cent.

In 1991, there were more than three times as many women aged 85 and over as men: by 2011 it was twice as many.

In 2011, the percentage of people aged 65 and over was highest in Conwy (24.6%). It was also high in Powys (22.9%), the Isle of Anglesey (22.5%), and Pembrokeshire (22.0%).

In 2011, the percentage of people aged 65 and over was lowest in Cardiff (13.2%). It was also low in Newport (16.4%), Merthyr Tydfil (16.7%), and Caerphilly (16.7%).

In 2011, the percentage of people aged 75 and over was highest in Conwy (12.4%). It was also high in Powys (10.6%), the Isle of Anglesey (10.2%), and Pembrokeshire (10.1%).

In 2011, the percentage of people aged 75 and over was lowest in Cardiff (6.6%). It was also low (between 7 and 8%) in Flintshire, Wrexham, Rhondda Cynon Taff, Merthyr Tydfil, Caerphilly, Blaenau Gwent, and Newport.

In 2011, the percentage of people aged 85 and over was highest in Conwy (3.8%) and lowest in Caerphilly (1.9%), Cardiff (2.0%), and Merthyr Tydfil (2.0%).

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[185] ONS figures. Caution is needed in interpreting these, especially as ONS figures were updated in 2013 to bring them in line with the 2011 census. See: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

Annex E Who are 'the ageing'?

Clarifying and defining the issue of substance misuse in an ageing population, scoping its extent, and pinning down its effects are not straightforward issues. Terminology is also tricky: terms such as 'age strata', 'cohort', 'life cycle' and 'life-course' are often used in the discussions about ageing, but this Report eschews such not-particularly-helpful terms.[186]

Some of the generalisations and assumptions about the impact of substance misuse are open to challenge. There are problematic stereotypes both about substance misuse and about ageing: the association of the term, 'substance misuse' with notions of 'addiction', alcoholism, and other pejorative terms invoke negative images of a 'kind of person' that experiences problems – this can deflect attention from other, less visible, problems. Stereotyping and stigmatisation of people who use drugs can be a way to ignore their problems and may create barriers to treatment. Stereotypes of older adults - associated with notions of decrepitude and decline, failing physical and mental capacity and lack of connectedness to the changing world can lead to patronising treatment and sub-optimal health care that does not take account of the capacities of older adults.[187]

Part of the current older cohort is sometimes culturally defined as the 'baby boomer' generation. 'Baby boomers'[188], often defined as those born between 1946 and 1964, are a large and influential cohort which is sometimes stereotyped as a 'drug-wise' or 'drug aware' generation with an increased propensity to misuse drugs throughout their lives. However, the 'baby boom' period was a long one during which there were substantial social and cultural changes. This has led some commentators to distinguish between 'early' and 'late' 'boomers': the experiences shaping the life course trajectories of the 'early boomers', some of whom were

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[186] Vincent, J.A. 2003 *Inequality And Old Age*. London: Routledge.

[187] Drug misusers, too, are stereotyped and conflated into groupings that do not represent the reality of their drug behaviour. This is of practical significance; for example, the different trajectories of heroin misusers have significant implications for health care now and in the future – while some may have a high level of health needs (because, for example, of drug-related hepatitis or HIV), others may not. These examples are a reminder that drug misuse may not be the only factor contributing to drug misusers' health problems; and it is not always easy to separate the effects of drug misuse from aspects of the individual (genes, diet, social conditions, lifestyle, etc.) that will affect their health.

[188] Leach, R, Biggs,S Phillipson,C & Money A 2007 'Boomers and beyond: Intergenerational consumption and the mature imagination' in *Cultures of Consumption Research Programme*. ESRC End of Award Report, RES-154-25-0003, Swindon: ESRC

exposed to the so-called 'permissiveness' of the 1960s 'counter-culture' and the expansion of higher education, are different from the 'late boomers', who were confronted with high levels of unemployment and the heroin 'epidemic' of the 1980s and 1990s in the UK.[189]

Children of the older 'baby boomer' generation are now themselves becoming old. They have grown up in a society where there has been greater social acceptability of illicit drug use and they have perhaps experienced more liberal parental attitudes to drugs; furthermore, drugs have become more available. Patterns of alcohol consumption have changed; new types of drugs have emerged; there has, for example, been an increase in the use of steroids and image-enhancing and performance-enhancing drugs. As they age, members of this generation will present new challenges for substance misuse services.

In considering the ageing population, this Report uses the terms 'early onset' and 'late onset' misusers. While it does seem important to distinguish long-term drug misusers from those who become drug misusers later in life some members of the Panel were concerned that the dividing lines between these groups were not clear and the distinction was not especially helpful in understanding the needs of this group since people have complex pathways into and out of drug misuse over their lives.

For assessing health care needs, a useful distinction is between high-risk misusers (who often have experienced negative life events such as a disrupted early childhood and poor school performance), and those who are misusing drugs in less dangerous ways. The former group will require more health care than the latter.

[189] Home Office 2014 'The heroin epidemic of the 1980s and 1990s and its effect on crime trends - then and now' Available at: The heroin epidemic of the 1980s and 1990s and its effect on crime trends - then and now - Publications - GOV.UK

Annex F Alcohol

This Annex expands on the information in Chapter 4, providing some more-detailed background information on alcohol.

A considerable amount of alcohol consumption is higher risk and potentially damaging to health. This is as true for Wales as elsewhere. There are significant and wide-ranging costs to Welsh society of alcohol-related harms – physical, psychological and social. These include direct costs to the NHS in treating alcohol-related diseases, and the indirect costs, such as alcohol-related family breakdown. Some groups may be more affected than others: '…older people from some black and minority ethnic backgrounds have higher levels of alcohol misuse than the general older population, with Irish and south Asian (Sikh) male migrants to the UK being at particular risk' [190] Those in a lower socio-economic position in society are more likely to experience alcohol-related diseases.[191]

Alcohol consumption can lead to loss of inhibition and change in mood, and in the short term, may increase self-confidence and even euphoria. At higher consumption levels, there may be some degree of loss of motor coordination, including slurring of speech, unsteadiness and delayed reaction time. At very high doses, unconsciousness and death can occur.

Definitions

'Intoxication' is defined as a state of psychological and/or psychomotor impairment due to the presence of alcohol in the body. Consumption levels are defined as follows:

- *Episodic heavy drinking, or binge drinking*, denotes a drinking occasion where 60g or more of alcohol is consumed in a single session
- *Hazardous alcohol consumption* is a level of consumption that is likely to result in harm. The World Health Organisation (WHO) estimates the threshold of hazardous alcohol consumption is 20g-40g of alcohol a day for women (140g to 280g a week) and 40g-60g a day for men (280g to 420g a week)

[190] Rao R Schofield P & Ashworth M 2015 'Alcohol use, socio-economic deprivation and ethnicity in older people' *BMJ Open*, 5, e007525 p1 http://bmjopen.bmj.com/content/5/8/e007525.full

[191] Jones L Bates J McCoy E and Bellis M 2015 'Relationship between alcohol-attributable disease and socioeconomic status, and the role of alcohol consumption in this relationship: a systematic review and meta-analysis' *BMC Public Health* 15, 400 https://www.ncbi.nlm.nih.gov/pubmed/25928558

- *Harmful drinking* is a level of consumption that causes damage to health. The WHO estimates that the threshold of harmful drinking is more than 40g alcohol a day for women (+280g a week) and more than 60g a day for men (+420g a week).

The International Classification of Mental and Behavioural Disorders criteria for alcohol dependence are:

- a strong desire or compulsion to take the substance
- difficulties in controlling substance-taking behaviour
- physiological withdrawal state upon cessation of substance use;
- evidence of tolerance to a substance
- neglect of alternative interests due to time spent using the substance
- persisting with substance use despite evidence of harmful consequences.

Effects

About 90 per cent of the alcohol that people consume is metabolised in liver cells to acetaldehyde: a build-up of which contributes to the unpleasant physiological effects of excessive consumption – a 'hangover'.

Fat accumulates in the liver to produce 'fatty liver' and this may be followed by inflammation (hepatitis) and then by cell death and fibrosis, leading to cirrhosis (scarring of the liver tissue) due to prolonged heavy drinking. Most patients with fatty liver disease show no symptoms.

Cirrhosis may be accompanied by 'portal hypertension' (high pressure in the portal vein which brings blood from the gut to the liver), leading to complications such as dilation of the blood vessels in the oesophageal tract (these are varices and are prone to bleeding, which can sometimes be catastrophic). Liver damage may be associated with malnutrition, as alcohol may replace food as a source of calories in the diet of those who consume excessive amounts.

Long-term excessive drinking may be associated with permanent central nervous system effects such as convulsions and dementia. It may compromise the uptake of thiamine and result in thiamine (vitamin B1) deficiency leading to Wernicke's Encephalopathy and Korsakoff Psychosis (these are examples of alcohol-related brain damage: ARBD). Damage to the peripheral nervous system (neurotoxicity) may result in peripheral nerve damage (neuropathy). Alcohol stimulates gastric acid secretion, and excessive consumption, particularly in high concentration (e.g. in spirits) may result in gastritis (which may also cause bleeding). Damage to the

pancreas may present as pancreatitis, and chronic pancreatitis is associated with increased risk of insulin-dependent (type 1) diabetes mellitus. Muscle damage caused by alcohol may result in acute as well as chronic myopathy (muscle disease or wasting). Severe acute muscle damage may result in acute rhabdomyolysis where, as a result of the breakdown of muscle fibres, their contents are released into the blood-stream. This condition can result in excessive concentrations of myoglobin (an iron and oxygen binding protein) being excreted in the urine and this may result in acute kidney failure. Excessive alcohol consumption can be associated with an increased prevalence of hypertension (high blood pressure), arrhythmias (irregularities of the heart rhythm such as atrial fibrillation), inflammation of heart muscle (myocarditis) or permanent damage to heart muscle (cardiomyopathy) with increased risk of heart failure, as well as with certain cancers.

Government Advice

In the UK, a standard unit of alcohol is defined as 8g (or 10ml) of pure alcohol. The UK Chief Medical Officers recommend that both men and women should not drink more than 14 units of alcohol per week (i.e. 112g), and should spread their drinking over three days or more if they drink as much as 14 units a week. There is no safe level of alcohol to drink during pregnancy. Pregnant women, and women trying to conceive, are advised not to drink alcohol at all to keep risks to their baby to a minimum.