The Forgotten People: Drug Problems in Later Life

A Report for the Big Lottery Fund – July 2014

S.Wadd (sarah.wadd@beds.ac.uk) with contributions from S. Galvani, both Substance Misuse and Ageing Research Team (SMART), Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire.
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Executive Summary

In March 2014, the Big Lottery Fund (the FUND) commissioned the Substance Misuse and Ageing Research Team (SMART) at the University of Bedfordshire to carry out a short scoping study to provide:

- An overview of the scale, nature and consequences of drug misuse in older people across the UK.
- An understanding of the extent to which substance misuse strategies in the four UK countries address the issue.
- Guidance on what action is most needed and where investment from independent and statutory funders might be most useful.

The findings are based on analysis of existing data, a summative review of relevant policy and published literature and interviews with professionals.

The results show that there are more than 2,000 people aged 60 and over receiving treatment for a drug problem in the UK and more than 400 injecting drug users aged 60 and over in treatment in England alone. However, many more people in this age group are likely to be experiencing drug problems because only a minority will be in treatment. Illicit drugs most commonly used by those aged 60 and over in treatment are opiates only (65%), opiates and crack cocaine (18%) or crack only (2%). 1.1% and 0.2% of the population aged 60 and over in England and Scotland respectively report using drugs in the last year (data is not available for Northern Ireland and Wales). Illicit drugs most commonly used in this age group are cannabis, amyl nitrate (poppers) and magic mushrooms. Risk factors are poorly understood because research into illicit drug use has primarily focused on young people.

Addiction to medicines is likely to be prevalent in older age groups - estimates suggest that 30-40% of older long-term users of benzodiazepines (primarily used for the treatment of sleep disorders and anxiety) or opioid analgesics (painkillers), become dependent on them and these drugs are often used in old age. There is some evidence that the prevalence of addiction to medicines may be particularly high in Northern Ireland for reasons that remain unclear. Risk factors for addiction to medication are likely to include being female, socially isolated, poor health and chronic illness, taking a number of medicines and a previous history of substance misuse or psychiatric illness. Poor prescribing practice can also contribute to medication addiction and some doctors have different rules and strategies for prescribing addictive medicines and are more tolerant of long-term use in older people.

Whilst most indicators of drug use are decreasing in young people, they are increasing in older people. Evidence presented here suggests that drug use, drug-related deaths and the number of older people in treatment for drug problems has increased in recent years. This is likely to be largely due to the ageing of the ‘baby-boomer’ generation – those born during the period of increased birth-rates following World War II, who grew up in a period of relatively high levels of illicit drug and medication misuse. These upward trends are likely to continue as the remainder of the baby-boomers, who are currently aged between 49 and 68, make the transition into old age.

Both illicit drug use and addiction to medicines can have devastating consequences for older people including premature death, physical and mental health problems, self-neglect and
withdrawal from family and friends. The ageing process means that older people are more likely to experience the harmful effects of drugs and drug use can exacerbate or accelerate the onset of conditions which are associated with ageing such as falls and confusion. Some older people use drugs throughout their lives, often with periods of reduction, cessation and abstinence followed by cycles of relapse or escalation in consumption. Their relatively long history of drug use can mean that they are in poorer health and their drug use is entrenched. Others use drugs for the first time in later life for reasons that include stressful life events or a reduction in motivations for controlling drug use such as raising children or work responsibilities. Some older people inadvertently become addicted to medicines that they originally took as instructed by a doctor.

Older people with drug problems in the UK fail to get the same attention as young people and this neglect may be fuelled by systemic ageism identified in this study. This includes, exclusion of older people from national drug prevalence surveys and treatment data, upper age limits in some substance misuse treatment services, “age-blindness” in some national substance misuse strategies and a constellation of ageist attitudes and prejudicial assumptions that may prevent professionals identifying and taking action with regard to drug problems. Drug prevention programmes targeted at older people have the potential to create substantial cost savings as well as reducing unnecessary suffering and loss of life but most are targeted at young people. Older people respond well to treatment for drug problems - 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. Evidence suggests that treatment outcomes can be improved further if treatment is delivered by a substance misuse service specifically for older people but few of these services exist in the UK and most that do exist are only commissioned to deliver alcohol treatment.

Previous neglect of this issue means that independent and statutory funders have an opportunity to make a real difference. Six priorities for funders have been identified in this study:

- Increasing knowledge about what works in the identification, treatment and prevention of drug problems in older people and improving the collection and reporting of data.
- Increasing professionals’ competencies and skills in identifying and working with older people with drug problems.
- Developing and testing approaches to increasing older people’s ability to cope with stress and adversity (resilience) which can contribute to some people starting, returning to or escalating drug use in later life.
- Scaling-up and rolling out an intervention which has been shown to be effective in identifying and treating medication addiction.
- Broadening the remit of existing specialist alcohol services for older people to include treatment for drug problems and commissioning new integrated alcohol and drug treatment services for older people.
- Providing advocacy for older people with drug problems.

It is important that funding for interventions and services includes provision for evaluation and monitoring with an economic component to give policy-makers and commissioners the
clearly costed evidence. Innovative approaches, long-term investment and collective action with and between national and local government, health and social services, voluntary groups, local communities and other key stakeholders will be required. Programmes will be more effective if older people and the communities in which they live are part of the solution and they have genuine opportunities to influence programme development and delivery.

The time to act is now. Within 70 years, 1 in 3 people in the UK will be aged 60 and over. Given the current population projections, taking action on drug use and misuse in older people can be regarded as a sound investment that will have long term value for subsequent generations.
1. Introduction

This study is about older people with drug problems. Older people, like younger people, use a variety of drugs from cannabis to heroin. Some older people develop a drug problem for the first time in later life whilst others have a lifelong history of drug problems. Older people use drugs for a variety of reasons including enjoyment, to cope with difficult problems, situations or feelings or they may inadvertently become addicted to medicines that they took as instructed by a doctor. Drug misuse can lead to social, financial, psychological, physical and legal problems for older people. It can reduce their quality of life, cause significant distress to their families and carers and lead to increased health and social care costs.

In March 2014, the Big Lottery Fund (the FUND) commissioned the Substance Misuse and Ageing Research Team (SMART) at the University of Bedfordshire to carry out a short scoping study to provide:

- An overview of the scale, nature and consequences of drug misuse in older people across the UK.
- An understanding of the extent to which substance misuse strategies in the four UK countries address the issue.
- Guidance on what action is most needed and where investment from independent and statutory funders might be most useful.

This report combines statistical data, published research and the views of professionals. Quotes from professionals interviewed during this study are included in boxes throughout the report.

The study is about ‘older people’ but when does a person become ‘old?’ Chronological age is not a precise marker for changes that accompany ageing, there are dramatic variations in health status, levels of participation and independence amongst adults of the same age (World Health Organisation, 1999). The National Service Framework for Older People (Department of Health, 2001), rather than labelling people by chronological age, distinguishes older people who are:

- Entering old age: These are people who have completed their career in paid employment and/or child rearing. This is a socially constructed definition of old age, which, according to different interpretations, includes people as young as 50, or from the state pension age, which is currently between 61 and 68 depending on when someone was born and if they are male or female. These people are active and independent and many remain so into late old age.
- Transient phase: This group of older people are in transition between 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: These people are often vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both.

In the substance misuse research literature, the age cut-off for an ‘older’ drug user can be as low as 35 years (e.g. Shaw, 2009). This may be partly due to the common age bias that drug problems occur in the young but not the old. Others have argued that the ageing
process among older people with chronic drug problems can be accelerated by at least 15 years (Beynon et al., 2009). The difficulty is that using low age cut-offs creates even more heterogeneity in what is already a diverse group and someone in their 30’s or 40’s is likely to have very different life circumstances and needs to someone in later life. Therefore, for the purposes of this report, we have included people aged 60 and over in the older age group. In some cases, where we use information provided by others, we have had to include people below 60 years of age.

There are nearly 14.5 million people in the UK aged 60 and over (Office for National Statistics, 2013a), more than the number of people aged under 18 (Office for National Statistics, 2011a). The number of people in this age group is expected to pass the 20 million mark by 2031 (Office for National Statistics 2011b) and within 70 years, 1 in 3 people in the UK will be aged 60 or over (Office for National Statistics, 2009). This population is becoming more ethnically diverse as people from black and ethnic communities who came to Britain in the 1950’s, 60’s and 70’s become older (Age UK, 2014).

Older people with drug problems in the UK fail to get the same attention as young people, yet preventing, detecting and addressing problem drug use in older people is just as important. There are a number of age-related factors that mean that older people as a group have specific needs and vulnerabilities that require special consideration and some of these are illustrated in Figure 1. It is vital that prevention, detection and treatment strategies are sensitive to the needs of older people and the diversity within the ageing population. Identification and delivery of age-appropriate drug prevention, treatment and support provides an opportunity to help improve overall health and quality of life for older people, enable them to maximise their potential and reduce the costs and wider impacts on society.

Having briefly outlined the context, this report will now move on to explore the extent, nature, trends and consequences of illicit drug use and medication addiction in older people. There will then be a consideration of what can be done in terms of prevention, identification, treatment, harm reduction and ensuring that older people with drug problems receive adequate social care. Next, substance misuse strategies from the four UK countries will be reviewed to see to what extent they acknowledge and address the age-related needs of older people. The report concludes with six key priorities for funders that have emerged from this study.
Figure 1 Age-related factors that mean that older people have unique vulnerabilities and require different intervention strategies in relation to their drug use

**Physical Changes**
- Older people have a reduced ability to metabolise and excrete drugs which can result in enhanced or prolonged drug effects.
- Drug use can exacerbate or accelerate the onset of conditions which are associated with ageing (e.g. cognitive impairment, falls).
- Older people are at increased risk of chronic conditions (e.g. insomnia and chronic pain) for which medications with addiction potential are prescribed.

**Psychological Factors**
- Older people may be more likely to conceal drug problems and less likely to ask for help because of high levels of shame and embarrassment and generational differences in terms of pride and disclosure of personal problems.
- Older people may have different motivations for pursuing healthier behaviours e.g. maintaining independence and mental capacity.

**Life Circumstances**
- Losses, life changes and transitions associated with ageing can result in isolation, loss of independence, loneliness and psychological distress and may contribute to some people starting, recommencing or escalating drug use in later life.
- Older people may have fewer or less active social roles (e.g. no longer employed, not raising children) therefore their drug problems may be more likely to escape notice.
- Drug and alcohol problems can make older people more vulnerable to elder abuse.

**Challenges for Intervention**
- Older people may have extensive histories of drug use, multiple and complex needs and failed treatment attempts.
- Older people 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 people or take action when problems are identified.
2. Extent and Nature of the Problem

Illicit drug use

Prevalence

The National Treatment Agency (now part of Public Health England) recognises that “information about the number of people who use illicit drugs is key to formulating effective policies for tackling drug-related harm” (National Treatment Agency, 2011a). The Crime Survey for England and Wales is the main source of data on the prevalence of illicit drug use in England. Although approximately 17,000 people aged 60 and over are interviewed for this survey each year, people aged 60 and over are not asked questions about drug use as an “economy measure, reflecting their very low prevalence rates for the use of prohibited drugs” (Home Office, 2013a). This presents a missed opportunity to collect valuable information on prevalence and trends in drug use in older people. There is some data on drug use among older people in England from the 2007 Psychiatric Morbidity Survey, however, it only provides information on 2,639 people aged 60 and over. We analysed this data and found that 1.1% of the 2,639 people aged 60 and over who were interviewed had used drugs1 in the last year. This was lower than the prevalence of drug use in any other age group (Figure 2).

Figure 2 Prevalence of past year drug use by age group, England 2007

Source: Psychiatric Morbidity Survey, 2007

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1 Excludes drugs prescribed by doctor.
Unlike the Crime Survey for England and Wales, the Scottish Crime and Justice Survey has no upper age cut-off and in 2010/11, of the 3,793 people aged 60 and over who gave information about drug use, 0.2% had used drugs in the last year\(^2\) (Scottish Government, 2012). Once again, interpretation of this finding is limited by the relatively small number of older people who were interviewed.

There is very little data on the prevalence of drug misuse in people aged 60 and over for Wales or Northern Ireland. This is because Wales relies on data from the Crime Survey for England and Wales with its upper age cut-off of 59 years and Northern Ireland uses the Northern Ireland Drug Prevalence Survey which has an upper age cut-off of 64 years.

Further analysis which was carried out on the 2007 English Psychiatric Morbidity Survey data as part of this study showed that, amongst those people aged 60 and over who had misused drugs in the last 12 months, drugs used were cannabis (43%), tranquillisers (40%), magic mushrooms (27%), amyl nitrate/poppers (7%) and anabolic steroids (7%)\(^3\). In the Scottish Crime and Justice Survey, of those people aged 60 and over who had misused drugs in the last 12 months, 75% had used cannabis and 25% had used amyl nitrate/poppers. Whilst much of this drug use may not be problematic, the physiological changes associated with ageing means that older people can experience harm even at low levels of drug use.

It is not possible to directly measure the number of people who use the most harmful illicit drugs, that is heroin, other opiates and crack cocaine, because their use is largely hidden. Analytical techniques have been developed to estimate the number of people who use these drugs, based on data such as the number of drug offences in an area and the number of people receiving treatment. Estimates using these techniques suggest that in England in 2010/11, there were 143,778 heroin, other opiates and crack cocaine users in the 35-64 year old age group (Hay et al., 2013). This is the oldest age group for which the estimates are available and comprises 52% of the total estimated population of heroin, other opiates and crack cocaine users.

**Older People Receiving Drug Treatment**

To find out how many people aged 60 and over in the UK were receiving drug treatment, a review of existing data was carried out. Data for Scotland and Northern Ireland is published with age 40 and over as the oldest age category, therefore Freedom of Information requests were submitted to obtain this information for the 60 and over age group. In England, whilst data is published for the 60 and over age group, it excludes people aged 75 and over. Freedom of Information requests were submitted to Public Health England to obtain information on the number of people aged 60 and over receiving treatment including people aged 75 and over. Data for Wales was available for the 60 and over age group from the Profile of Substance Misuse in Wales 2012-13 (Welsh Government, 2013).

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\(^2\) Excludes drugs prescribed by doctor.

\(^3\) Percentages do not add up 100 because some people had used more than one drug.
The findings are shown in Table 1. In total, 2,223 people aged 60 and over received treatment for a drug problem in the United Kingdom during 2012/13. The number of older people in drug treatment is not a true representation of the number of older people who experience drug problems because only a minority of them will receive treatment in a substance misuse service.

**Table 1** The number of people aged 60 and over receiving treatment for a drug problem in a substance misuse treatment service in 2012/13

<table>
<thead>
<tr>
<th></th>
<th>Number of People Aged 60 and Over Receiving Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>2,130</td>
</tr>
<tr>
<td>Scotland</td>
<td>47</td>
</tr>
<tr>
<td>Wales</td>
<td>46</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>141</td>
</tr>
<tr>
<td><strong>United Kingdom</strong></td>
<td><strong>2,223</strong></td>
</tr>
</tbody>
</table>

More detailed information was also requested on people aged 60 and over who had received treatment in England in 2012/13 from Public Health England. This information showed that, amongst those aged 60 and over receiving treatment, 75% were male and 25% were female. Figure 3 shows that, the primary drug of use was mostly opiates only (65%), opiates and crack (18%) and benzodiazepines or other prescription drugs (6%). There were 402 current injecting drug users aged 60 and over in treatment. In total, 52% of the people aged 60 and over receiving treatment were either currently injecting or had previously injected drugs (Figure 4).

Importantly, the data provided by Public Health England showed that the majority of people aged 60 and over who received treatment were treated successfully⁴; 62% of those aged 60 and over completed treatment free of dependency versus 47% of 18-59 year olds. This may be partly because they are less likely to drop out of treatment than younger people; 12% of those aged 60 and over dropped out of treatment compared to 24% of 18-59 year olds.

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⁴ Free of dependency when treatment completed
**Figure 3** Primary drug of use for those aged 60 and over in treatment for a drug problem in England in 2012/13

**Figure 4** Injecting status of people aged 60 and over in treatment for a drug problem in 2012/13
Age of onset and patterns of drug use

Analysis of data from the 2007 Psychiatric Morbidity Survey carried out during this study showed that 23% of people aged 50 and over who had ever used cannabis, said that they first used the drug after the age of 40. Data from the Crime Survey for England and Wales showed that amongst adults aged 16-59 who had used powdered cocaine, 1% used the drug for the first time after the age of 40 and the oldest first time user was aged 57 (Home Office, 2012). A study in the United States found that 6% of past year illicit drug users aged 50-59 started using drugs after the age of 40 (Han et al., 2009). Drug use which first occurs after the age of 40 is known as late onset drug use. There are reports of late onset drug use in scientific journals (Beynon, et al., 2009; Boeri, Sterk, & Elifson, 2008; Kouimtsidis & Padhi, 2007; Nambudiri & Young, 1991; Roe, et al., 2010), for reasons that include stressful life events such as divorce or bereavement, close personal relationships with a drug user (Roe, et al., 2010) or a reduction in motivations for controlling drug use such as raising of children or work responsibilities (Boeri, Sterk, & Elifson, 2008). Kouimtsidis & Padhi (2007) describe a case of an English man who had no history of alcohol or other substance misuse until he was introduced to cocaine by a sex worker at the age of 68 years with the aim of enhancing his sexual performance. The use of cocaine escalated to daily use and at the age of 70 he started using crack and very rapidly became dependent. Studies also suggest that whilst most people start injecting drugs in their late teens and early twenties, people start injecting across a wide age range, including after the age of 40 (Arreola, 2014; Carneiro et al., 1999).

Roe et al. (2010) describe lifetime patterns of drug use in 11 people aged 49 and over in contact with drug treatment services. These patterns included periods of reduction, cessation and abstinence followed by cycles of relapse or escalating consumption. In Box 1 (page 13), this chronic relapsing pattern is illustrated by a case study of a 70 year old man who has been using heroin on and off for over 50 years.

Trends

Whilst fewer young people (aged 16-24) are using drugs (National Treatment Agency, 2012), evidence suggests that drug use in older age groups may be increasing. Fahmy et al. (2012) analysed data on past year cannabis use in people aged 50-74 using data from Psychiatric Morbidity Surveys in 1993, 2001 and 2007. The results, shown in Figure 5, suggest that there has been a significant increase in cannabis use in the 50-64 year old age group and modest increase in those aged 65-74 during this period.

“I have had people that have only started using heroin and crack in their 30’s and 40’s although it is less common as you get older, it is not unheard of.”

General Practitioner
Box 1 Case Study Illicit Drug Use

Danny (not his real name) is a 70 year old male has been in contact with an Older People’s Substance Misuse Service for the last 2 – 3 years and has fully engaged over the last 3 months.

Danny is primarily a heroin user although he has used crack periodically. He first used heroin at the age of 20 and his use became problematic at the age of 22. He has injected in the past but not for a long time. Danny’s drug use has destroyed his marriage and relationship with his children with whom he has no has contact. It has also had a detrimental effect on his career. He has trained and worked in many fields but his heroin use has always sabotaged any progress.

Danny first sought treatment for his drug use in 1963 when he felt it had become problematic and he was prescribed diamorphine hydrochloride. He later went onto being prescribed methadone and has spent his lifetime in and out of treatment with varying degrees of success. He stopped completely for about 6 years around the late sixties and early seventies and held a highly skilled and responsible job during this time but eventually relapsed. He has made several attempts to detox with varying degrees of success.

Currently he is on a very low dose of buprenorphine (0.8mg daily), has a shared care worker and is engaged in an older person’s service, attending the social group, various activities and having key work sessions to explore issues around detox anxieties. The aim is to come off buprenorphine when he feels the time is right with the support of the service. Danny said “this service is the best so far in that I am getting full support and I am surrounded by my peers who have already achieved the task of getting drug/methadone free and inform me that it is achievable for me”.

Figure 5 Trends in past-year cannabis use in people aged 50 and over in England

Source: Fahmy, Hatch, Hotopf and Stewart, 2012
Estimates of opiate and/or crack cocaine use also suggest that whilst there have been significant decreases in the prevalence of opiate and/or crack cocaine use within the 15-24 and 25-34 age groups, there has been an increase in the number of opiate and/or crack cocaine users in the 35-64 age group (Hay et al., 2013).

Figure 6 shows that the number of people aged 60 and over receiving drug treatment has increased rapidly during the period 2006-2013, with the greatest increase in men (an increase of 241% compared to 57% in women). This is in contrast to younger age groups where the number receiving drug treatment is decreasing (National Treatment Agency, 2012).

There has also been an increase in the number of drug-related deaths in older age groups. For example, the annual report of the National Forum on Drug-Related Deaths in Scotland (2013) concluded "the most significant demographic change in 2012 was the increasing prevalence of individuals of older age groups among drug-related deaths. The percentage of individuals aged 45 and over increased from 14% in 2011 to over a quarter (26%) in 2012." In England and Wales during the period 1993-2012, the number of deaths related to drug misuse for men aged 50-69 has increased by 255% (from 44 to 156) and for women by 94% (from 54 to 105) (Office for National Statistics, 2013b). In contrast, drug-related deaths in people aged 30 and under have decreased (National Treatment Agency, 2012).

“We have got a 60 year old that we are treating at the moment, for heroin use. He is still on buprenorphine to treat his heroin, he has had an MI, he has got angina, he has got alcohol dependence, he has got COPD, he has had a rectal prolapse, he has got oxygen at home, he has got left ventricular failure. So very, very high needs.”

General Practitioner
Figure 6 The number of people aged 60 and over receiving drug treatment in England, 2006-20013

Historical influences on trends

The increase in indicators of drug use in older people is likely to be largely due to the ageing of a generation who grew up in a period of high levels of drug use and relatively liberal attitudes towards drugs. In the 1960s and 70s, today’s 60 year olds were in their formative years. During this time there was an increase in the recreational use of illicit drugs, particularly cannabis but also LSD, amphetamines and magic mushrooms. Drugs were popularised by music and mass media. The public’s attitude towards drug use shifted towards a higher level of tolerance. The use (and misuse) of prescription drugs with addiction potential including barbiturates and tranquilisers was widespread. Many of today’s 60 year olds formed their attitudes about drugs during this era and experimented with drugs as they reached adolescence during the 70’s. Some will have carried that drug use into old age.

During the 1980’s, today’s 60 years olds were in their late 20’s and 30’s. At this time, parts of the UK, particularly Merseyside, Greater Manchester, London, the Scottish cities and towns down the western side of Britain, experienced epidemics of heroin use as relatively cheap, smokeable heroin became widely available (Parker et al., 1998). The epidemics continued into the 90’s. They predominantly involved young, marginalised men, living in inner-city areas with high levels of unemployment and deprivation. Some of today’s 60 year olds became addicted to heroin during these epidemics and due to the chronic, relapsing nature of heroin addiction, many of the survivors continue to be dependent on heroin or other opiates.
Today’s 60 year olds are part of the ‘baby-boomer’ generation – the generation born during the period of increased birth-rate following World War II (1946-1965). The baby-boomers are now aged between 49 and 68. The younger baby-boomers were also youths during the heroin epidemics therefore they are likely to further increase the number of older heroin users as they age. Given the increasing number of older people, even if the prevalence of drug use were to stay the same, the number of older people who use drugs is likely to increase. Similar trends have been observed elsewhere in Europe (EMCDDA, 2010) and the United States (Han et al., 2009) and have led to predictions of a surge in the number of older adults requiring treatment for drug problems (Colliver et al., 2006; Han et al., 2009).

**Consequences**

Older drug users have high levels of physical and mental health problems and blood-borne virus infection (Hser, et al., 2004; Roe, Beynon, Pickering, & Duffy, 2010), poor quality of life (Roe, Beynon, Pickering, & Duffy, 2010), high levels of loneliness, stress and fear of victimisation (Beynon, Roe, Duffy, & Pickering, 2009; Levy & Anderson, 2005). They often experience injecting-related vein damage that can lead to riskier injecting practices such as injecting into their feet or groin (Beynon et al., 2009).

In one of the few research studies that have carried out in-depth interviews with older drug users (aged 49-61) in the UK, Roe et al. (2010) found that of the 11 people interviewed, most lived alone, were single or divorced and had experienced multiple bereavements of family and fellow drug users. Another study which interviewed 20 older drug users (aged 55-66) in Bristol found that many were ashamed and embarrassed that they were still using drugs at their age and some felt that they not received adequate pain relief from healthcare providers because their use of heroin and methadone had increased their tolerance to opioid analgesics (Ayres et al, 2012). Concerns have previously been raised that people with long histories of opioid dependence or receiving long-term opioid substitution therapy experience avoidable pain because they have been prescribed inadequate doses of opioid analgesics (Gossop and Moos, 2008).

**Medication Addiction**

The National Treatment Agency (now part of Public Health England) has identified three distinct but overlapping populations who experience problems with medicines:

- Those who overuse medicines to cope with genuine or perceived physical or psychological symptoms.
- Those for whom the prescribed use of a medicine inadvertently led to dependence, sometimes called involuntary or iatrogenic addiction.
- Those who use medicines as a supplement or alternative to illicit drugs or as a commodity to sell.

(National Treatment Agency, 2011b)

People can develop problems with a variety of medicines including some cough and cold, anti-diarrhoea and anti-allergy medicines, stimulants (e.g. Ritalin) and epilepsy medicines. However, the two main classes of medicines most likely to lead to dependence are
benzodiazepines and z-drugs, primarily used for the treatment of sleep disorders and anxiety (benzodiazepines only), and opioid analgesics (painkillers).

Benzodiazepines induce feelings of calm, drowsiness and sleep. Dependence can occur even when they are taken as instructed. Withdrawal symptoms include muscle tension and spasm, muscle weakness, pins and needles, flu-like symptoms, anxiety, depression, insomnia, nightmares, impaired memory and concentration. Older people are more sensitive to the adverse effects of benzodiazepines such as memory problems, daytime sedation, impaired motor coordination, and increased risk of road traffic accidents and falls (Madhusoodanan & Bogunovic, 2004). The incidence of hip fractures may be increased by 50% or more, particularly when other medication such as antihypertensives and antidepressants are co-prescribed (Ray et al, 1987). Prolonged use of benzodiazepines has been associated with cognitive impairment which may continue even when the individual has stopped taking them (Barker et al., 2004). The Royal College of Psychiatrists recommends that benzodiazepines should only be used for periods up to four weeks and that they should generally not be prescribed to people over the age of 60 (Royal College of Psychiatrists, 2013). Z-drugs (also called non-benzodiazepines) have similar effects and dependence potential to benzodiazepines but they have different chemical structures.

Opioid analgesics can produce a sense of euphoria and well-being. They are most commonly prescribed for chronic back pain, long-term post-trauma pain, osteoarthritis, rheumatoid arthritis, osteoporosis and neuropathic (nerve) pain. Some low dose opioid analgesics are available without a prescription (over-the-counter medicines). Their use can lead to excessive sedation, slowed breathing, and impairment in vision, attention and coordination as well as falls among older people (Leipzig et al., 1999; Meuleners et al., 2011).

Prevalence

There is no national data on the prevalence of medication addiction in the UK which has led to calls for a new system to collect this information (All Party Parliamentary Group for Involuntary Tranquiliser Addiction, 2009).

In a UK-based study, 40% of older primary care patients (aged 60 and over) who had been on low dose opioid analgesics for a year were reported to have fulfilled the World Health Organisation’s Diagnostic Criteria for

“People will say “oh I’m fine with them doc, just keep prescribing them” and that is difficult because by continuing them, you are actually continuing the problem. But there is going to be a huge breakdown in relationship if you say to people I’m not going to prescribe them.”

General Practitioner

“They become isolated, they lose their focus, a lot of them report that they don’t keep up their jobs, the cleaning, bills and things.”

Specialist Medication Addiction Worker talking about clients with medication addiction
dependence (Edwards & Salib, 2002). However, as this finding was based on a relatively small number of people, the findings should be interpreted with caution. A French study of people aged 65 and over who were ‘chronic users’ of benzodiazepines or z-drugs found that 35.2% of the participants showed signs of dependence (Morgane Guillou Landreat et al, 2014). One study in the United States estimated that 11% of women aged 60 years and over misuse prescription medicines each year (National Center on Addiction and Substance Abuse, 1998) whilst another found that 1.4% of community-living adults aged 50 and over reported misusing prescription analgesics\(^5\) during the previous year (Blazer & Wu, 2009). There is some evidence that the misuse of legally prescribed drugs in those aged 15 to 64 is particularly prevalent in Northern Ireland (DHSSPNI, 2012). Whilst data on those aged 65 and over is not available, it is likely that older age people in Northern Ireland may also be at increased risk. Late onset of medication dependence may be common. A study of 50-59 year olds in the United States found that 20% had started using prescription drugs non-medically\(^6\) after the age of 40 (Han et al., 2009).

**Risk factors and consequences**

Very little is known about the risk factors and consequences of medication addiction in older people and the brief literature review carried out as part of this study did not identify any research which has carried out in-depth interviews with older people addicted to medicines. A case study of an older person who is addicted to medicines can be found in Box 2 (page 18). As well as the physiological effects of medication addiction in older people, other adverse include loss of motivation, memory problems, having difficulties with activities of daily living, self-neglect and withdrawal from family, friends and normal social activities (Substance Abuse and Mental Health Services Administration, 2013). Risk factors are likely to include being female, socially isolated, poor health and chronic illness, taking a number of medicines, previous history of substance misuse and a previous history of psychiatric illness (Simoni-Wastila & Yang, 2006).

**Prescribing Practice**

Barbiturates were widely prescribed for anxiety, depression and insomnia in the 1960s but they were replaced by safer but still highly addictive benzodiazepines during the late 1960’s and 1970’s. The use of benzodiazepines increased dramatically during the 1960’s and 1970’s but has decreased in the last two decades whilst prescriptions for z-drugs have increased (Reed et al., 2011). The prescribing of opioid analgesics has also increased significantly in the past two decades (National Treatment Agency, 2011b).

A North American study of primary care doctors’ perspectives on prescribing benzodiazepines for older people found that they often had different rules and strategies for

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\(^5\) Any self-reported use of prescription pain relievers that was not prescribed for the respondent or that the respondent took only for the experience or feeling they caused.

\(^6\) For the experience or feeling the drug causes
prescribing these medications in older versus younger people and were more tolerant of long-term use in older people. The doctors largely ignored the potential for adverse health effects in the absence of obvious signs of addiction and believed that attempts to discontinue them would fail and be met with resistance from patients (Cook et al., 2007).

<table>
<thead>
<tr>
<th>Box 2 Case Study Medication Addiction</th>
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| Ruth (not her real name), a retired nurse in her early 60’s initially self-referred to an older person’s substance misuse service regarding her daughter’s misuse of the sleeping tablet, Zolpidem (a z-drug). Ruth disclosed in the second session that she had also been misusing Zolpidem which has not been prescribed for her, but had managed to self-detox approximately 4 weeks before she started treatment.

Ruth had been taking around 2 tablets a day, often taking the first one around 5pm to help her “cope”, “manage” and to “drift away when feeling anxious”. It was not until her eldest son arrived unannounced to the house one evening that she realised things needed to change. Both Ruth and her daughter were under the influence of sleeping tablets and her daughter told her son they did not want to live any more. Her son, following some research sourced a substance misuse service and both mother and daughter made separate referrals.

The treatment focused on exploring issues relating to her drug use and her concerns about her daughter’s drug misuse. It included:

- Exploration of current and alternative coping strategies.
- Identification of feelings e.g. feelings of guilt
- Identification of her needs
- Discussions about ‘hope’
- Exploration of the ‘pros’ and ‘cons’ regarding her own drug use
- Relapse prevention e.g. urges and cravings / how to manage these
- Discussion around changing her routine, i.e. volunteering, education etc.
- Exploration of support networks

During the 7 week period of attendance at the service, Ruth reported improved levels of motivation and that she was more engaged in activities e.g. cleaning, washing, cooking, socialising with family and friends. She also reported a greater interest in her appearance (wearing make-up and going clothes shopping).
3. Tackling the Problem

Prevention

Drug prevention programmes mostly focus on young people. However, prevention programmes which target older people could create substantial cost savings as well as reducing unnecessary suffering and loss of life. Evidence presented in this report has shown that older people can start, return to or increase drug misuse in later life therefore it is never too late for prevention.

People don’t develop drug problems solely on the basis of personal characteristics. Factors that increase a person’s risk of drug problems (risk factors) and factors that can reduce the risk (protective factors) can be intrinsic (e.g. personal attributes and disposition), or extrinsic (e.g. availability of drugs). It is the interaction and accumulation of these factors over time that predisposes a person to drug use. In Figure 7 we suggest some potential risk and protective factors for drug use in older people. These factors can be further divided into modifiable and non-modifiable factors. Although non-modifiable risk factors such as gender, biology and genetics are of interest, the focus in terms of prevention is on modifiable factors. A key approach to drug prevention is to decrease risk factors and increase protective factors.

For example, poor prescribing practice is a risk factor for medication addiction. Prevention approaches targeting doctors could include ensuring that they prescribe within recommended guidelines, avoid using repeat prescriptions for benzodiazepines/z-drugs, consider alternatives to addictive medicines such as psychological therapies, and provide older patients with information on the risk of dependence and how it can be reduced.

In contrast, resilience, that is an individual’s capacity to cope with stress and adversity, is likely to reduce the risk of medication addiction because some older people misuse medicines to help them cope with stress. In other words resilience is a protective factor. There has been increasing interest in recent years on developing ways to promote resilience among older people.

“A lot of people that have been prescribed these drugs have not been given the basic information they didn’t know that they were addictive, they didn’t know that they shouldn’t be on them long term, they didn’t know that there were any side effects.”

Specialist Medication Addiction Worker

“Evidence suggests that only about a third of people with non-cancer pain benefit from opiates. So whilst they are worth trying it is very easy just to escalate and escalate and not ever consider that perhaps they are just not going to work and you just compound the issue for people.”

General Practitioner
people (Perkins, 2014). This could include enhancing coping strategies, improving social networks and social capital and ensuring that older people have opportunities to participate in a range of activities that enhance wellbeing (Mguni et al., 2013). There is some evidence that resilience training may be able to boost resilience in otherwise healthy adults. For example, the READY Program (REsilience and Activity for every DaY, READY) is a group psychosocial resilience training program which aims to promote well-being by targeting five protective factors identified from empirical evidence: Positive emotions, cognitive flexibility, social support, life meaning, and active coping (Burton et al., 2010). Sessions involve psycho-education, discussions, experiential exercises, and home assignments. A small-scale pilot study of this intervention suggests that the training leads to improvements in positive emotions, stress, self-acceptance, valued living and autonomy. Similarly, hardiness training which aims to teach ‘hardy’ skills of coping, social support, relaxation, nutrition and physical activity has been shown to increase hardiness levels and social support whilst decreasing indices of strain (Maddi, 2002). Resilience interventions could be helpful in tertiary prevention (with older people who already have drug or alcohol problems so they will have a greater likelihood of recovery), in secondary prevention (with older people who are experiencing stress and adversity but have not yet developed a drug or alcohol problem), and in primary prevention (where the people involved have not yet encountered age-related transitions that could lead to drug or alcohol problems).

**Figure 7** Potential risk and protective factors for drug use in older people
Identification

It is important that drug problems are identified as early as possible because failure to do so means that people may not get access to interventions until the problems are more chronic and difficult to treat. Identification of drug problems in older people can be particularly challenging. Older people don’t always show outward signs of drug problems and those which do exist (such as confusion or falls) can be mistaken for the signs of ageing. Older people are often very ashamed of their drug use, therefore they may be more likely to conceal it and less likely to seek help. Because their social roles tend to be fewer and less visible, their drug problems are more likely to go unnoticed. The author’s previous research suggests that professionals can find it difficult to conceive that older people experience drug and alcohol problems and are embarrassed to ask them about their substance use (Wadd et al., 2011). Even when they do recognise that an older person has a drug or alcohol problem, they often wrongly assume that older people are too old to change their behaviour and don’t refer them for specialist help.

Many older people have a complex network of family, friends and service providers in a position to identify and intervene with drug problems. However people working in statutory and voluntary services that frequently encounter older people (e.g. falls prevention and home care services) rarely receive training in substance misuse. It may be difficult for family and friends to know how to get help for an older person who wants it. Interestingly, Birmingham has a helpline for members of the public who are concerned about an older person’s health, wellbeing or welfare and the local older person’s substance misuse service has received a number of referrals in this way (Wadd and Galvani, in press).

Treatment

Many older people with drug problems are likely to benefit from specialist treatment in substance misuse services and data presented here has shown that 62% of older people complete treatment free of dependency (compared to 47% of people aged 18-59). Substance misuse services in the UK are generally provided by the voluntary sector, typically with some funding from the statutory sector. Adult substance misuse services should, in theory, be open to people of all ages but we have heard many instances of services refusing to accept referrals for older people. A review by the Healthcare Commission (2009) found that older people were denied access to the full range of substance misuse services because:

“They are very much a hidden group, they rarely come and say, I have got a problem with my tablets.”

General Practitioner

“Even when they were theoretically available, they were either not offered in an age-appropriate way or were not available when staff attempted to refer to them. Many were geared towards younger people, usually males, and were felt not to be appropriate for older people, who could feel vulnerable in the atmosphere.”
There are a small number of substance misuse services specifically for older people in the UK (approximately six at the time of writing) but most are only commissioned to deliver alcohol treatment so older people with drug problems don't have access to them.

One of the advantages of older people’s substance misuse services is that they can be tailored to meet the needs of older people. This might include:

- Establishing a case-finding and referral system for isolated older people.
- Focusing on age-specific issues such as grief, loneliness, boredom, retirement and rebuilding client’s social support network.
- Providing diversionary activities and social activities.
- 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 drug or alcohol problem.
- Providing longer and more frequent sessions where there are complex needs or an extensive history of drug use.
- Addressing wider support needs.
- Supporting families and carers.
- Having greater linkage across health and social care systems.
- Engaging older people in planning and delivery of the service.
- An emphasis on building trust and confidence.

An example of an older person’s substance misuse service is the Bristol Drugs Project which provides a social place where older people (aged 50 and over) with drug and/or alcohol problems can meet and socialise. The majority of people who use the service are on long term methadone maintenance therapy. A group of between 17 and 26 older people meets twice a week and there are regular group activities such as yoga, swimming and walking. Practitioners send text messages to clients to keep them informed of upcoming events and activities. Drug workers are also available to provide one-to-one support.

There is some evidence that older people’s substance misuse services offer additional benefits to treatment in mixed-age services. People who attend them report feeling more comfortable in treatment settings with their peers (Wadd et al., 2011). Research in the United States suggests that they have better outcomes than mixed-age services and that older people attending them are less likely to drop out of treatment (Kofoed, Tolson et al. 1987; Kashner, Rodell et al. 1992; Atkinson 1995; Blow, Walton et al. 2000; Slaymaker and Owen 2008).

However, new approaches are required to treat older people who are addicted to prescribed medicines which don’t necessarily involve treatment in a substance misuse service. Lader (2012) describes how “middle-aged anxious housewives and elderly insomniacs dread being referred to the Addiction Unit” and the All Parliamentary Group for Involuntary Tranquiliser Addiction (2009) concluded that:

“Many people described the lack of support available when discovering they were dependent on medication they had been prescribed by their GP or that they had

7 http://www.bdp.org.uk/
bought from their pharmacy. Drug-treatment services are not necessarily geared to help individuals with a dependency on over-the-counter or prescription only drugs. So small charities, support groups and online forums are often their only source of advice and help.”

The Bridge Project\(^8\) is a substance misuse service in Bradford that has developed an innovative approach to identifying and working with people who are addicted to benzodiazepines. The service is open to all age groups but 40% of the clients are aged 65 and over. A specialist drugs worker from the substance misuse service contacts GP practices where benzodiazepine prescribing activity is higher than normal and asks them if they would be interested in using the service. If the practice agrees, the worker reviews the patient list to identify patients on long term benzodiazepine prescriptions who may be suitable for the service. These patients are sent a standard letter from their GP asking them to attend a review appointment with the specialist worker from the substance misuse service at the GP surgery. At this appointment they are asked if they will engage with the worker to reduce or cease their benzodiazepine use. If they agree, an in-depth assessment is carried out and a reduction plan is developed by the specialist worker in collaboration with their GP. The worker provides structured psychosocial interventions and ongoing support to the patient. There is no cost to the GP practice and it requires minimal input from the GP themselves. An evaluation of the service found that patients accessing the service had been prescribed benzodiazepines for over 12 years on average (Bray, 2012). Approximately 65% of patients achieve sustained abstinence.

**Harm reduction**

Harm reduction (also known as harm minimisation) refers to approaches that aim to reduce the harms associated with drug misuse in people who are unable or unwilling to stop taking them. Examples include the provision of sterile needles/syringes and other injecting equipment, methadone maintenance therapy and blood borne virus testing/vaccination. Harm reduction services in the UK are delivered by the voluntary sector (e.g. substance misuse services), the private sector (e.g. pharmacies) and the statutory sector (e.g. the NHS). Harm reduction may be particularly important for older people with a lifelong history of illicit drug misuse for whom abstinence may be an unrealistic goal. However, older people can find it difficult to access these services because of poor health or disability caused by the cumulative effects of decades of drug use. A qualitative study of older drug users in Bristol (Ayres et al, 2012) found that daily supervised consumption of methadone and attending needle exchanges can be humiliating for older people because of their high levels of shame about their drug use. This suggests that some older people may benefit from outreach needle/syringe exchange and supervised methadone consumption in their own homes.

**Social care**

Roe. et al (2010) describe instances of drug users acting as unofficial carers for older people with drug problems. This could leave the older person vulnerable to abuse and exploitation. Older people with drug problems who are no longer able to look after themselves require

home and residential care services that allow them to live out their final years in comfort and dignity. But many will have complex needs, display challenging behaviour and have cognitive problems as a result of their substance use. Older people who use illicit drugs may present ethical dilemmas for home carers if they witness illegal activity or find drug using paraphernalia. Elsewhere in Europe, a number of care and nursing homes have been piloted specifically for older drug users but there are concerns that they might increase stigmatisation and social exclusion and have a detrimental effect on maintaining abstinence for those who wish to do so (reviewed in EMCDDA, 2010). There is unlikely to be sufficient demand for care homes specifically for older drug users in the UK but there are a small number of homes for older people with alcohol problems (e.g. Equinox Care Aspinden Wood⁹) and they may also be suitable for older people with drug problems. Providers of social support and social care services should be encouraged to develop new ways of providing care to older people which takes account of ongoing drug use.

⁹ http://www.equinoxcare.org.uk/services/equinox-aspinden-wood/
4. National Substance Misuse Strategies

The four UK countries have set out plans for tackling drug problems and how they expect them to be applied. Scotland and England have separate strategies for drugs and alcohol whilst Wales and Northern Ireland have integrated drug and alcohol strategies. In this section, we review the extent to which these strategies highlight and address the needs of older people.

Scotland

The Scottish Government’s national drug strategy “The Road to Recovery” was published in 2008. As the name suggests, the concept of recovery is central to this strategy which it defines as “a process through which a person is enabled to move on from their problem drug use towards a drug-free life and become an active and contributing member of society”. Recovery is something that most older people with drug problems would aspire to but it is also important to recognise that some people, particularly those with a lifelong history of drug use, may not be able to achieve it.

The Road to Recovery recognises the need for specialist substance misuse services for black and minority ethnic communities and other excluded groups (such as people with disabilities and lesbian, gay, bisexual, transgender and transsexual people) and the importance of ensuring that mainstream services are acceptable and accessible to them. However, it does not acknowledge that older people also have unique needs which require special consideration. Medication dependence is not addressed in this strategy.

The strategy states that “1 in 50 of our population aged between 15 and 54 are experiencing or causing medical, social, psychological, physical or legal problems because of their use of opiates, such as heroin and benzodiazepines.” This data comes from estimates of problem drug use which exclude people aged 55 and over and this could reinforce the view that drug problems only affect young people.

Wales

In contrast to the Scottish strategy, ‘Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018’ recognises the importance of addressing “the particular needs of older people”. It emphasises how important it is that professionals who come into contact with older people who misuse substances identify the problem rather than “assume for example, falls or confusion are due to other causes”. Working Together to Reduce Harm also emphasises the need to ensure that “every opportunity for secondary and tertiary prevention action is taken to improve outcomes for older people”. However, the data used to illustrate
the extent of drug misuse comes from the British Crime Survey which does not ask people aged 60 and over about drug use.

Working Together to Reduce Harm includes a number of policies which, whilst not specifically targeted at older people, are relevant to their needs. These include:

- Expanding outreach and harm reduction services.
- Doing more to engage priority and hard to reach groups.
- Identifying and minimising barriers to accessing treatment (including ensuring that all services can be accessed by those with physical disabilities).
- User focused services that meet the needs of a range of specific groups.
- Engaging substance misusers in the planning and design of services.
- Improving the understanding of health and social care professionals.
- Providing diversionary activities (e.g. volunteering, day services and leisure pursuits).

The strategy also highlights the importance of addiction to medication and recognises that poor prescribing practices can lead to dependence. To tackle medication addiction, it advocates:

- Encouraging more responsible prescribing.
- Monitoring the purchase of sensitive products such as cold remedies.
- Reducing inappropriately prescribed medicines such as benzodiazepines in primary care.
- Ensuring that suitable services are available for those dependent on medication.

**Northern Ireland**

The Northern Ireland “New Strategic Direction for Alcohol and Drugs: Phase 2, 2011-2016” identifies “older people drinking hazardingly, dangerously or dependent on alcohol and/or addicted to/misusing drugs” as a key priority. It also recognises the importance of medication dependence “often, but not solely, by older people” and reports that a group has been established to develop a range of key outcomes in relation to raising awareness of this issue, preventing further misuse, providing appropriate advice, professional training and treatment and support. The Strategy makes a commitment to the following policies which are relevant to the needs of older people:

- A greater emphasis on informal and outreach approaches, especially in respect of hard to reach groups.
- Harm reduction.
- Need to develop greater linkages across agencies and the health and social care system.
- Improved training for frontline practitioners.

However, data on drug prevalence comes from the Drug Prevalence Study for Northern Ireland which excludes people aged 65 and above.
England

The English strategy “Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug-Free Life” was published in 2010. It has a strong recovery focus. The strategy states that “according to the latest British Crime Survey, 8.6% of adults in 2009/10 had used an illicit drug in the last year”. However, as noted earlier, the British Crime Survey does not ask people aged 60 and over about their drug use so they are not included in this statistic. The strategy acknowledges the ageing of the heroin using population. It states that “services need to be responsive to the needs of specific groups” and “local services must take account of the diverse needs of their community when commissioning services”. Whilst it highlights the needs of black and minority ethnic groups and lesbian, gay, bisexual and transgender communities, it makes no mention of older people. It does, however, address addiction to medicines and makes a commitment to “promoting social action and encouraging and enabling people to become more active in society” which is particularly relevant to older people who tend to have fewer social networks and less social support. The annual review of England’s drug strategy (Home Office, 2013b) does not mention older people and they are not identified as a priority for the year ahead.
5. Priorities for Funders

Building the evidence base

Most of our knowledge of what works in the prevention and treatment of drug use comes from research on younger people. Data on the prevalence of drug use in older age groups is also lacking, particularly for Wales and Northern Ireland. Prevalence data is required in each of the four UK countries to inform service delivery, policy and practice, enable the monitoring of changes and impact of interventions, enable comparisons between the countries and inform country-specific decision making about priorities for action and resource allocation.

Research priorities include determining:

**Illicit Drug Use**

- The extent to which older people use illicit drugs.
- Whether late onset illicit drug use in older people is increasing.
- Why some older people first start using illicit drugs in later life and what can be done to prevent it.
- How ageing affects illicit drug use.
- The treatment, harm reduction and support needs of older people with illicit drug problems.

**Medication Addiction**

- The prevalence of medication addiction in older people and who is most at risk.
- Why some older people become addicted to medicines whilst others who take the same medicines don’t become addicted.
- How medication addiction manifests itself in older people.
- The consequences of medication addiction for an older person.
- What works in preventing, identifying and treating medication addiction in older people.
- What are the challenges in preventing, identifying and treating medication addiction in older people and how can they be overcome.

Developing the workforce

Investment in the workforce will be vital if improvements are to be made in detection, prevention, treatment and support of older people affected by drug problems. Table 2 shows some of the training and development needs of different groups of workers. These could be met in various ways including interprofessional training and secondment opportunities between substance misuse and other statutory and voluntary sector services, enhanced undergraduate education, workshops for qualified workers and volunteers, best practice guidance and protocols and processes for joined-up working.

Initial funding will be required to develop best practice guidance and to develop training packages which can then be mainstreamed. Some relevant training already exists. For
example, the not-for-profit organisation Substance Misuse Management in General Practice\(^{10}\) can provide a workshop on medication addiction delivered by primary health care professionals for primary health care professionals. Older people’s substance misuse services also have an important role to play in training and awareness raising amongst professionals but extra resources will be required for them to develop and deliver this function.

**Table 2  Training and development needs of different groups of workers**

<table>
<thead>
<tr>
<th>Target</th>
<th>Training/development need</th>
<th>Sector</th>
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<tbody>
<tr>
<td>Frontline health and social care workers and volunteers who regularly encounter older people, e.g. people working in home care, sheltered accommodation and care homes, falls prevention services, carer support services, pain clinics, older adults’ mental health services, older adults’ social work teams and volunteer befriending services</td>
<td>How to identify and intervene with drug (and alcohol) problems in older people.</td>
<td>Voluntary, statutory and private</td>
</tr>
<tr>
<td>Prescribers</td>
<td>Safe prescribing of benzodiazepines, z-drugs and opioid analgesics to older people.</td>
<td>Statutory</td>
</tr>
<tr>
<td>Staff working in mixed-age substance misuse services</td>
<td>How to deliver substance misuse treatment which meets the needs of older people.</td>
<td>Mostly voluntary</td>
</tr>
<tr>
<td>Staff working in older peoples’ alcohol services</td>
<td>How to provide treatment for drug problems.</td>
<td>Mostly voluntary</td>
</tr>
</tbody>
</table>

**Testing resilience approaches**

There have been very few interventions developed to increase resilience (an individual’s capacity to cope with stress and adversity) in older people. Yet evidence presented here suggests that increasing resilience could reduce drug use in older people because stress and adversity can contribute to some people starting, recommencing or escalating drug use in later life (see pages 20-21). Stress and adversity are also associated with other mental health issues (Moyle et al., 2010) and alcohol misuse (Wadd et al., 2011) therefore resilience interventions have the potential to have a broad impact on the mental health of older people. Funders should consider releasing calls for proposals from voluntary sector organisations and academic institutions to develop and evaluate resilience approaches for older people. These could be scaled up if they are shown to be effective.

\(^{10}\) http://www.smmgp.org.uk/
Rolling out medication addiction services

An innovative intervention has been developed which has been shown to be effective in identifying and treating people who are addicted to benzodiazepines in general practice (see the Bridge Project Benzodiazepine Service, page 24). This novel intervention addresses an important gap in current service provision because most people who are addicted to medicines do not receive specialist help. Funders should consider commissioning substance misuse services across the UK to develop and pilot similar interventions. If these studies are robustly evaluated, this could build the evidence base further and increase the likelihood that this intervention would be mainstreamed.

Broadening the remit of older people’s alcohol services to include drug use

There is good evidence that older people’s substance misuse services have better outcomes and are more acceptable to older people than mixed age services. However, most of the services that do exist are currently only commissioned to deliver alcohol treatment and there are large areas of the UK that are not within reach of one of these services. Furthermore, there is not enough evidence to judge the relative cost-effectiveness of providing drug treatment in specialist older people’s services compared to mixed-age services but providing evidence for cost savings would make it more likely that these services would gain statutory funding. There is a clear opportunity for funders to commission and fund new older people’s substance misuse services and provide additional resources so that existing services can broaden their remit to include drug use. There is also a need for a randomised control trial and economic evaluation to compare treatment as normal (standard treatment in a mixed-age service) with age-specific treatment in an older people’s substance misuse service.

Advocacy

Older people face double discrimination from the combination of ageism and the stigma of drug use. Advocacy is about safeguarding individuals who are in situations where they are vulnerable and speaking up for, and with, people who are not being heard, helping them to express their views and make their own decisions and contributions (Scottish Executive, 2001). Activities might include a range of support such as:

- Providing advocacy help to older people for issues such as benefits, finance and debt, physical and mental health, training and employability and substitute prescribing.
- Helping older people to sort out and understand the large amounts of information they receive which can be confusing.
- Helping older people who find reading and writing difficult to complete forms and read a range of information sources.
- Helping older people who may not represent themselves very effectively to make themselves heard by telling them what to expect from a meeting, and how to conduct themselves when speaking to other people.
• Helping older people to be realistic about what to expect from services and what is expected from them when they use services.
• Helping older people to deal with the negative attitudes towards them from a range of professionals.

(Adapted from Scottish Executive Effective Interventions Unit, 2004)

Older people’s substance misuse services are ideally placed to provide advocacy for their clients, however, they will require additional investment to carry out this role. In areas where there are no older peoples substance misuse services, funders could consider providing funding for peer workers to provide advocacy within mixed-age substance misuse services. Peer support workers are increasingly being employed by mental health services. Evidence suggest that they can benefit the people being supported by increasing self-esteem, confidence and a sense of empowerment, give a greater feeling of being accepted and understood, lead to greater hopefulness about their potential and lead to more positive feelings about the future (Repper, 2013). There are also a range of benefits for the peer workers themselves including feeling empowered (Salzer & Shear, 2002), having greater confidence and self-esteem (Ratzlaff et al., 2006) and a more positive sense of identity, feeling less stigmatisation, having more skills, more money and feeling more valued (Bracke et al., 2008). Funding will be required to deliver training for peer advocates around advocacy issues including the aim of advocating on behalf of clients, specific issues around advocacy (e.g. the relationship between their views and the views of those they support), the benefits, boundaries, risks and limits of advocacy and the role of the advocate (Scottish Executive Effective Interventions Unit, 2004).
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