# Executive Summary

Index

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>The scope and extent of the issues</td>
<td>3</td>
</tr>
<tr>
<td>Types of substances</td>
<td>9</td>
</tr>
<tr>
<td>The harm older people may be experiencing</td>
<td>10</td>
</tr>
<tr>
<td>Barriers to change and accessing services</td>
<td>12</td>
</tr>
<tr>
<td>What services, training, resources and solutions does the Island need?</td>
<td>13</td>
</tr>
<tr>
<td>Recommendations</td>
<td>15</td>
</tr>
<tr>
<td>Conclusion</td>
<td>16</td>
</tr>
</tbody>
</table>
Introduction

Motiv8 was awarded a grant from The Manx Lottery Trust (as a delegated partner of Big Lottery Fund) under their 2015 Community Awards Thematic Funding Programme for projects to address the needs of older people in the Isle of Man. Part of the grant was used to fund an awareness raising conference, which led to this scoping study into alcohol and substance misuse in older people living on the Island. There is growing evidence that we may be facing an epidemic of alcohol-related harm among older people.

At present, according to the census data of 2016, over 65’s make up 21% of our resident population. Since 1996, those aged 95 and over has increased by 188%! JSNA (2014) Isle of Man Government

This Scoping Study focused on 6 key areas:

1. The scope and extent of the issues
2. The types of substances that are causing harm, including legal, illegal, prescribed and over-the-counter medication
3. The harm older people may be experiencing
4. The barriers that stop older people from accessing services
5. What types of services professionals feel would benefit this group
6. What training and resources would enable professionals to work more effectively with this group

Data was collated using interviews, focus groups and a survey. The data was then subset to a systematic qualitative, thematic analysis from which a number of themes emerged.

The Scope and Extent of the Issues

The Isle of Man... a heavy drinking culture?

- Heavy drinking is a normalised activity in Manx culture
- The older generation are less likely to ask for help with substance problems because of a sense of pride and fear of exposure leaves older people at greater risk
- 8% of the adults on the Island meet the definition of binge drinkers, around 13,500 adults (1 in 5 of the adult population), are drinking at increasing and high-risk levels
- There are reports that older people were continuing to drink in pubs. There is also a correlation with smoking in this age group
- It is common practice to be prescribed certain prescription drugs which were potentially as addictive and physically damaging

Patterns of alcohol/drug use

- The IOM Social Attitudes Survey 2016 found that the group most likely to be at increased risk from alcohol were the 55 to 64-year-old males, at 43%
- Twice as much alcohol is now bought from shops than three decades ago (ONS, 2016)
• The Director of Public Health’s Annual Report 2017 reported that 4000 Manx residents are estimated to have used drugs (excluding prescription medication) in the last year
• Concern was expressed about the physical and mental wellbeing of older opiate users
• Cannabis use is “normal” in certain sections of Manx society
• Prescription drugs were reported to be widely used/prescribed
• Over the Counter (OTC) and internet New Psychoactive Substances (NPS) are emerging as a concern

Hospital Data

Many of the interviewees bemoaned the lack of research in all groups and fields of health, with one professional noting, “A & E data lacked statistical rigor.” Fortuitously, it appears that there is some data that is being routinely collected – this is ALL AGE GROUPS. A recent Freedom of Information Request in October 2017 asked the following:

1. Can you please advise how many people were admitted to Nobles Hospital for drug abuse in the last 3 years?

The table below shows admissions for intentional drug poisoning.

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Count</th>
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<tbody>
<tr>
<td>2014/15</td>
<td>186</td>
</tr>
<tr>
<td>2015/16</td>
<td>176</td>
</tr>
<tr>
<td>2016/17</td>
<td>134</td>
</tr>
<tr>
<td>2017/18*</td>
<td>86</td>
</tr>
</tbody>
</table>

*please note this is a part-year figure

2. What drugs were they, as (1) above?

The list of drugs is vast and complex, and possibly not what people would normally assume would be used as an intentional drug poisoning. For example, several categories include types of anti-epileptic drugs and drugs used in the treatment of cardio-vascular disorders – all of which could be prescribed. Illicit substances also feature, such as cannabis and cocaine. Caution should be used when interpreting this data as it does not include non-intentional overdoses and only codes for the ‘primary diagnosis’ which excludes other drugs and alcohol.

3. How many people were admitted to Nobles Hospital for alcohol abuse in the last 3 years?

The table below provides the number of patients (not private patients) admitted to Nobles Hospital with a diagnosis of any of the following: Acute Intoxication/Alcoholic Liver Disease/Alcoholic Polyneuropathy/Degeneration of Nervous System due to Alcohol/Alcoholic Gastritis.

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Count</th>
</tr>
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<tbody>
<tr>
<td>2014/15</td>
<td>1175</td>
</tr>
<tr>
<td>2015/16</td>
<td>1058</td>
</tr>
<tr>
<td>2016/17</td>
<td>1333</td>
</tr>
<tr>
<td>2017/18*</td>
<td>990</td>
</tr>
</tbody>
</table>

*please note this is a part-year figure
Again, these figures need to be interpreted cautiously as they do not include other alcohol-related admissions that are not part of ICD-10 coding, such as: alcohol-related accidents e.g. falls/broken bones, head injuries, assault. The World Health Organisation states that “the harmful use of alcohol is a casual factor in more than 200 disease and injury conditions.” And, “overall, 5.1% of the global burden of disease and injury is attributable to alcohol...” (WHO (2018) www.who.int/mediacentre/factsheets/fs349/en)

Service Access
- Older clients that drank heavily are reportedly difficult to engage
- Older people tend to drink at home and are less visible to health and social care services and police
- Lack of access to services, eligibility criteria, waiting lists and adherence to strict referral criteria acted as a barrier to the older generation accessing services

Impact of drug misuse in the elderly
- Premature ageing through the impact of substances
- Poor nutrition and frequent falls are a feature with older clients. There is evidence that this can lead to prolonged episodes in hospital
- The IOM Director of Public Health Annual Report 2017 noted that there were 343 emergency hospital admissions for falls for the over 65’s
- Korsakoff’s syndrome, alcoholic dementias and forms of ARBD, (Alcohol Related Brain Damage) are frequently cited as under-diagnosed and misdiagnosed as Alzheimer’s

Accommodation
- A cohort of older drinkers live in substandard single-room accommodation
- The psychological impact of living in substandard accommodation is a risk factor for poorer mental health and can lead to persistence of substance misuse
- Social inequality and substance misuse led to the alcohol harm paradox (lower socio-economic groups consume less alcohol than higher groups, but experience greater alcohol-related harm)
- The Island’s lack of homeless legislation and accommodation such as a wet house is recognised as a major barrier

Screening and Detection
- Late detection due to lack of visibility is a factor of older drinker’s care
- This is cited as a reason for a ‘significant level of unplanned detoxes’
- Missed opportunities for diagnoses

Solutions for Screening and Detection
- Brief opportunistic interventions (BI’s) tailored for elderly drinkers in primary health care settings; screening and BI’s could be included in non-obvious health care settings
- The introduction of screening tools, validated on elderly populations, in hospitals and other primary healthcare settings
- Clear advice on diagnostic criteria for detection of ARBD
“Over the next 20 years, the number of older persons in the IOM is projected to increase by 75%, compared to a 2% increase of those of working age and a 7% rise in the number of children. This represents a seismic shift in the population.”

“The 65+ population in the Isle of Man will increase by 11.2% and 20.3% by 2019 and 2024 respectively. This is higher than United Kingdom projections. The proportion of the population aged 85 years and over, projected to increase until at least 2026, is again higher in the Isle of Man than in the UK. Unfortunately, there is a gap in data preventing identification of life expectancy in the Isle of Man. It is also recognised that the fastest growing sector of the population is the 85 + age group.” (DHSC, Adult Social Care 2016)
Manx At Risk Groups

Some population groups as they age were felt to be more vulnerable, highlighting potential at risk groups, concerns and indicators of demand.

Identified Concerns

- A fear that older people’s services may not be seen as a priority (over children services)
- A shift in drugs of choice - more people who are on heroin replacement, people using cannabis and other addictions rather than smoking and alcohol
- Physiological changes associated with ageing means that older people can experience harm even at low levels of drug use
- Drugs prematurely age people, damaging health and wellbeing
- Cannabis ages users at an exponential rate
- Long-term effects of smoking cannabis on the cardiovascular system
- Injecting related vein damage that can lead to riskier injecting
- Drug use leading to brain changes across the lifespan
- Dependent cocaine users “exhibit an increased number of age-related white matter (brain) lesions”
- Addiction to medication, both prescription and over-the-counter was a hidden issue. The way in which future older generations procure drugs may also change (the Dark-Web)
Morbidity/Mortality

- Living longer doesn’t necessarily equate to living healthier and improvements in morbidity
- There is no local available data on ALL alcohol-related deaths
- The IOM’s Health Minister revealed in May 2017 that drug-related deaths are higher here than in England. Mrs Beecroft confirmed that 14 out of the 23 deaths between 2013 to 2015 were related to opioids. “The other main area of concern was the number of deaths relating to prescription drugs”
- Mortality rate for liver disease on the Isle of Man that is considered preventable (i.e. through alcohol, obesity or viral hepatitis) is similar to the England average 12.6 per 100,000 in the under 75’s

The Third Sector

- There are some indications that third sector opinion is that their operations have been, in part, undermined by the competitive tendering processes
- Lack of understanding that “lower level” interventions from the third sector stop the revolving door problems and potentially stop issues from escalating to crises point
Types of Substances

- Alcohol was the most misused drug by older people. Some services reported an increase in alcohol related referrals
- Misuse and multiple use of prescription medication
- Potential for unintentional prescription abuse and overdose
- The misuse of pain relief in some older clients and its interaction with psychotropic drugs

Illicit drugs

Cannabis

- Drug users from the sixties era are now elderly baby boomers for whom Cannabis use is ‘normal’. *Long-term cannabis toxicity* deficits in people with a long history of heavy use is enhanced in the elderly
- Long-term use over years produces memory and attention dysfunction, as well as amotivational syndrome
- Preference of illegal drugs over prescriptions in terms of managing a health condition

Heroin

- Those with long histories of drug dependency are more likely to be in poor health and to engage in dangerous injecting behaviour, and are at greater risk of dying from overdose
- Studies have shown some deterioration of the brain’s white matter due to heroin use

OTC – Over the Counter Medication

Hazardous for older people due to the complex interactions with ageing.

Prescribed drugs

Z-drugs, particularly Zopiclone, were noted to be one of the most used night sedatives.
There are numerous ways in which an individual can experience harm as a result of the use of substances:

- Vulnerability
- Interactions with other medications
- Falls & accidents
- Malnutrition
- Isolation
- Mental health
- Self-neglect
- Domestic abuse
- Financial issues
- Mortality attributed to substance misuse
- Alcohol related neurological conditions
- Chronic physical problems

**Mental Health**

The 2014 Isle of Man Government JSNA highlighted that 7% of referrals to mental health for anxiety were in the over 65’s. Furthermore, for depression this was 16% in the over 65 age group.

**Alcohol-related neurological conditions**

Public Health England – the number of 60 to 74-year-olds treated as inpatients for **alcohol dependence** and alcohol withdrawal has almost doubled over the past decade.
All of this points to a large cohort of older, heavy drinkers with neurological deficits remaining unidentified, undiagnosed and without evidence-based appropriate care.

**Impact on crime**

Typically less than half of all arrests are noted as being alcohol related. However, in 55-64 and 65+ ages groups the proportion is slightly higher than 50%.

*(IOM Constabulary)*

**Impact on Family**

As an organisation that help support family members, Motiv8 knows how emotionally, mentally, financially and physically challenging it can be to either live with or try and help support someone with a substance issue.

In relation to older people, some participants noted in particular that there were 2 main aspects:

1. Family members may, in the end, remove themselves from a person/situation and therefore the substance using person may end up even more isolated and vulnerable.

2. Conversely, some family members may end up ‘colluding’ with the person by purchasing alcohol for them – this was even happening in care homes where staff had asked family members not to.

Grandparents who were left with the responsibility of caring for grandchildren sometimes found themselves embroiled in substance issues, leaving them vulnerable and potentially exploited.
Stigma

- Living on a small Island led some to suggest that addiction is often hidden. As one drug and alcohol professional put it:

  "The stigma associated with dependency in an older person is an important feature to consider”

- Embarrassment about seeking professional help.
- Families embarrassed for services to become involved with their substance-using relative.
- Difficulties in navigating services and a fear of authority, with some older people not being good at asserting their needs.

"A fear of services and the outcome”

Professional ambivalence

Professional ‘burn out’ with chronic and revolving door clients. Also, a belief that older people should be ‘left to it’ and no point of trying to change them in their latter years.

Evidence based drug & alcohol policy

Political will and a lack of evidence-based alcohol policy was suggested by some as a local issue e.g. minimum pricing per unit.

Cost & accessibility

Low price of alcohol can lead to increased consumption for all age groups.

Lack of detection & signposting

Professionals were not being trained to pick up on the subtle signs of substance issues.

Austerity measures were affecting all manner of services.

‘Gate keeping services’, being “stripped back so far”, with a suggestion that access was limited to the most acute cases therefore (they were) “missing out on early intervention opportunities”
Service design

- Service design was also a barrier, with services being more geared towards younger people.
- Also, the traditional ways of engaging with older people such as day centres were felt to be outdated.

Transport

Transport links and physical access for appointments is an issue.

Current service provision

- Only a fraction are presenting for help.
- Services were not adequately equipped and that having dedicated provision for older people might help to attract clients.

“The demographic shift doesn’t seem to be planned for in services. Accommodation and care seem to be the biggest problems.”

What Services, Training, Resources and Solutions Does the Island Need?

Community support mechanisms

- Inventive methods
- Community premises with a multipurpose remit
- Needs-based service provision
- Holistic approach and assertive outreach
- Older Persons’ outreach provision within Tier 2 addiction services
- A home visiting service
- An Older Persons’ Champion
- Age-appropriate social activities and groups that are needs driven
- To work more effectively together and share resources
- Preferred places for older people to socialise
Recognitions of early signs

It was felt that people in their late 40’s and 50’s could be targeted more and that early preventative strategies were lacking.

Reducing stigma and increasing engagement

More public health messages around substance misuse that hopefully could reduce stigma and increase the likelihood of older people wanting to engage in services.

A basic education or understanding of substance misuse for all professionals who may come into contact with older substance misusers.

Workplace campaigns and the ageing workforce

There was a good example of OPMHS training about dementia awareness within the private sector. Similar models could be considered for substance misuse in later life.

Multi-agency retirement training

A lot of contributors queried how many companies did retirement training and if they did, were alcohol and drugs covered within that?

Future Demands

- Anticipate the demand for specialist beds for Korsakoff’s/ARBD patients
- More recognition and support for private nursing homes who felt alone managing alcohol misusing residents
- Recognition of the large volume of mental health patients and the future implications of this

“A whole care approach in terms of addressing any other issues the client may have such as mental health, socialising, routines, hobbies and in general, life fulfilment.”
The following list of recommendations have been drawn out from the opinions expressed throughout this document. They have been raised with a view to them being used as discussion points amongst stakeholders or a working party group and not as a definitive or exhaustive list.

➢ The IOM could include drug ‘mapping’ of older drug users (the ACMD has established a working group to map the numbers of older drugs users in the UK and draw on UK and international evidence to establish the current and future needs of this cohort.)
➢ Charity regulator/Commission (UK model)
➢ Impact assessment on removing services for O.P. (eg. meals on wheels)
➢ Further supervision (of prescription medication) should be in place for older people who are known to have substance issues
➢ Perhaps GP surgeries could, with input from other agencies, formulate withdrawal/cutting downs plans with support to be put in place through practice nurses or similar before removal of drugs older people have been prescribed long term
➢ The RTLC consider introducing training for current and prospective taxi drivers on how to deal with moral dilemmas such as purchasing alcohol on behalf of the vulnerable and the elderly and dealing with older vulnerable adults/safeguarding.
➢ Campaign to remind older people taking medications to check with their doctor or pharmacist before getting behind the wheel (THINK! campaign UK – posters on the IOM govt site)
➢ Harm reduction work for change resistant older people (blue light project)
➢ More befriending style interventions which give rise to earlier detection/Training for befrienders
➢ Drug and alcohol and public health services increase professional and public understanding of the roles of services and increase assertive outreach approaches.
➢ Review of age-appropriateness of current services and pathways into support?
➢ Targeted public health campaigns for this population group e.g. Drink Wise, Age Well as an example of good practice
➢ Retirement planning programmes in the general population, preparing people for retirement and including substance education in this.
➢ Introduction of screening at A & E/Nobles
➢ Introduction of brief interventions at A & E/Nobles
➢ More intelligence gathering/systematic data collection needed, for example:
  ❖ Collection of alcohol and drug-related data at A & E department
  ❖ Review of alcohol/substance-related cases seen at OPMHS
  ❖ Review of alcohol/substance-related old person’s admissions and outpatient’s appointments at Nobles
  ❖ Review of alcohol/substance and mental health cases as admitted at Mannanan Court
  ❖ Review of drug and alcohol treatment services data to ensure relevance
Conclusion

Whilst there is a growing body of research and evidence from the UK and further afield about older people and substance issues, it has been extremely interesting to gain a local perspective from professionals who work on various levels with this group. From the third sector, to criminal justice, mental health, care homes, substance misuse to those at more policy level, we feel we have been able to understand far more about how people are feeling about this issue both at a current and future level.

Whilst there is an acknowledgement that this is a somewhat hidden issue at times, it has become clear that workers are encountering this group and have very real and relevant concerns about them. This is reflected in their views on both how these individuals present and how complex their care can be to how the Island could perhaps be ‘future proofing’ this group through the likes of:

Certainly, there are obvious funding implications for some of the ‘wish list’ of services or activities that professionals would like to see and areas that improvement might be made. However, we feel that if a working party could be formulated to start looking at the areas that have been highlighted as possible recommendations then this would be a very positive start for the Island as a whole. If we are to avoid the consequences of ignoring this potential ‘silver tsunami’ then any action taken now would help professionals and services work together to address this often complex need.
Main Report

Understanding Alcohol and Substance Misuse in Older People on the Isle of Man

Authors: Kay Mylchreest & Thea Ozenturk
Special Report by Professor Robin Davidson inc.
Index

Introduction ........................................................................................................................................... 21

The scope and extent of the issues ......................................................................................................... 23
The Isle of Man...a heavy drinking culture? ......................................................................................... 23
Patterns of drinking ............................................................................................................................. 24
Patterns of other drug use .................................................................................................................. 26
Hidden harm ......................................................................................................................................... 27
Lack of engagement and service dilemmas ......................................................................................... 27
Service isolation and lack of access to services ................................................................................ 28
Younger people made older through substance misuse & the health impacts of substance misuse.. 29
Accommodation ..................................................................................................................................... 31
Screening ............................................................................................................................................. 32
Population and demographic trends – Future demand ................................................................. 35
Hospital data ......................................................................................................................................... 41
Joint strategic needs assessment ....................................................................................................... 44
GENACIS ............................................................................................................................................... 44
Pathways to Addiction – Experiences of addiction and recovery in the Isle of Man...................... 44
Morbidity ................................................................................................................................................ 45
Mortality ................................................................................................................................................ 46
Early versus late onset of substance misuse .................................................................................... 48
The importance of the third sector in working with older people .................................................... 50

Types of substances .............................................................................................................................. 51
Illicit drugs ............................................................................................................................................ 51
OTC – Over the counter medication ................................................................................................... 52
Prescribed drugs .................................................................................................................................. 53

The harm older people may be experiencing ..................................................................................... 55
Vulnerability .......................................................................................................................................... 55
Malnutrition .......................................................................................................................................... 56
Isolation ................................................................................................................................................ 56
Falls and accidents ............................................................................................................................. 56
Treatment data (IOM) .......................................................................................................................... 56
Mortality attributed to substance misuse .......................................................................................... 57
Mental health.................................................................................................................................................. 57
Alcohol-related neurological conditions – A Special Report by Professor Robin Davidson............... 58
Domestic abuse................................................................................................................................................. 59
Self-neglect..................................................................................................................................................... 60
Financial issues.............................................................................................................................................. 61
Chronic physical problems............................................................................................................................ 62
Behavioural change when intoxicated.......................................................................................................... 62
Cognitive issues.............................................................................................................................................. 62
Impact on the family........................................................................................................................................ 63
Impact on crime............................................................................................................................................. 64
The Drug Arrest Referral Scheme/Alcohol Intervention Referral Scheme............................................. 65

**Barriers to change and accessing services**.......................................................................................... 66
Stigma............................................................................................................................................................. 66
Professional ambivalence.............................................................................................................................. 67
Evidenced based drug and alcohol policy.................................................................................................... 67
Cost and accessibility.................................................................................................................................... 68
Lack of detection and signposting................................................................................................................ 68
Service design................................................................................................................................................ 68
Why change? .................................................................................................................................................. 69
Capacity.......................................................................................................................................................... 69
Transport......................................................................................................................................................... 69
Accessing support......................................................................................................................................... 70
Current service provision............................................................................................................................ 71
Lack of awareness of what constitutes a dependency................................................................................. 71

**What services, training, resources and solutions does the Island need?**................................. 72
Community support mechanisms................................................................................................................ 72
Recognition of early signs............................................................................................................................. 72
Whole-care approach................................................................................................................................... 72
Reducing stigma and increasing engagement............................................................................................ 73
Workplace campaigns and the ageing workforce......................................................................................... 73
Multi-agency retirement training.................................................................................................................. 73
Improving responses for this age group...................................................................................................... 74
Types of services that would benefit this group of people......................................................................... 75

**Best practice example: Drink Wise, Age Well**................................................................................. 76
Introduction

Motiv8 were fortunate to be awarded a grant from Manx Lottery Trust (as delegated partner of Big Lottery Fund) under their 2015 Community Awards Thematic Funding Programme for projects to address the needs of older people in the Isle of Man. As part of the grant we successfully delivered an awareness raising conference which was attended by over 100 people. The second part of the grant was to conduct a scoping study into alcohol and substance misuse in older people living on the Island. There has been a growing body of evidence from the UK, and further afield, that we may be facing an epidemic of alcohol-related harm amongst older people. It is anticipated that alcohol dependence will increase as the ‘baby boomers’ age - since this cohort has a greater history of alcohol consumption than current cohorts of older adults. They were a generation that lived through a time of increasing availability, affordability and social acceptability and as a result have potentially hung on to a habit that could put their health, relationships and lifestyles at risk.

Likewise, Public Health England has suggested that generic services for older people will play an increasingly important role in the care of individuals with substance misuse problems. Factors which become more common in older age like financial difficulties, retirement and bereavement could all be risk factors for drug use “particularly because we are now living in a world where the use of drugs has been commonplace for several generations.” (Dr Caryl Benyon, 2010) (1)

We are aware that our elderly population is increasing – as the Lottery Trust themselves acknowledged, the 2014 Government Joint Strategic Needs Assessment indicates that over the next 20 years the number of older persons in the IOM is projected to increase by 75% which indicates a “seismic shift” in the population profile.

At present, according to the census data of 2016, over 65’s make up 21% of our resident population. Since 1996, those aged 95 and over has increased by 188%! (2)

The Scoping Study was designed to gain understanding from 6 key areas:

1. The scope and extent of the issues
2. The types of substances that are causing harm, including legal, illegal, prescribed and over-the-counter medication
3. The harm older people may be experiencing
4. The barriers that stop older people from accessing services
5. What types of services professionals’ feel would benefit this group
6. What training and resources would enable professionals to work more effectively with this group
The study gained information from various sources, including local quantitative data (where available). With the aim of understanding the current and future extent of the issues we conducted the following:

1. 1-1 interviews
2. Focus group discussions
3. An online survey

This involved professionals from fields of work on the Island that may interact with older people and/or substance misuse, including: drugs and alcohol, criminal justice, the care sector (both public, private, voluntary and ‘family’ carer), 3rd sector representatives, mental health and public health.

In order to get a full range of opinion with a stratification of views across the Island, many invitations were sent out for people to take part. Unfortunately, as is the way with some research, there were some areas or services that were unresponsive to our requests, so it may be that their views and opinions are not expressed here. We realise and appreciate that this line of work is often very busy and demanding and it is sometimes difficult to take ‘time out’ to do something such as this! However, we are hopeful that we have been able to do justice to the views of those that were able to take part.

The data collated was then subset to a systematic qualitative, thematic analysis from which a number of themes emerged.

*Drink Wise, Age Well (3)*
The Isle of Man... a heavy drinking culture?

It was overwhelmingly acknowledged and felt by many in the focus groups that heavy drinking was a normalised activity in Manx culture. It was seen as acceptable and tolerated in all age groups and older people were of no exception to this.

Many of the respondents reported knowing older individuals who had always drank to excess. This sometimes included individuals who had been involved in a heavy drinking trade which normalised heavy and daily drinking.

It was also suggested that the older generation were less likely to ask for help with substance problems because of a sense of pride and fear of exposure in a small community. It was felt that the older generation were reluctant to ask for help, liked their privacy, and it was a ‘very Manx thing’ to be fearful of people “knowing their business.”

It is possible that our tolerance to alcohol, in what many describe as a ‘wet culture’, coupled with high levels of stigma and embarrassment leaves older people at greater risk.

There was also a general consensus by those interviewed that the Manx were generally “too fond of drinking.” It was seen as a too regular pastime amongst all age groups. Previous research conducted on the Island added weight to this theory. As the GENACIS survey of 1000 Manx residents drinking and lifestyle habits revealed:

“Manx respondents reported having a greater number of positive experiences from drinking than their UK counterparts.”

(GENACIS, 2005) (4)

The IOM Director of Public Health Annual Report noted that 8% of the adults on the Island meet the definition of binge drinkers, but more worryingly:

“Around 13,500 adults (1 in 5 of the adult population), are drinking at increasing and high risk levels as defined by the Alcohol Use Disorders Identifications Test (AUDIT). 1 in 4 (25%) adults drink two to three times per week with 1 in 6 adults drinking four or more times per week.” (5)
There were reports that older people were continuing to drink in pubs and that their times of drinking varied in comparison to other population groups. An officer from the Central Alcohol Unit suggested:

“There was also a correlation with smoking in this age group. One contributor to a focus group noted there was a positive aspect to the traditional pub environment in that:

Furthermore, older peoples’ level of embarrassment and stigma associated with having an alcohol problem made it less easy to identify and address:

Conversely, it was seemingly seen as ‘okay’ to be prescribed certain drugs which were potentially as addictive and physically damaging, as an OPMHS worker noted:

Patterns of drinking

The IOM is sadly lacking in data on consumption of alcohol. Data from the GENACIS health and life style survey 2005 revealed high consumption patterns in older women purportedly drinking double that of their UK counterparts (Journal of Substance Use, 2007) (4). More recently, the IOM Social Attitudes Survey 2016 found that:

“Under the UK unit guidelines standard, the group most likely to be at increased risk from alcohol were the 55 to 64 year old males, at 43%.” (6)
UK research reports yielded more data suggesting that in 2014, “people aged 65 and over in Great Britain were more likely than any other age group to have drunk alcohol on 5 or more days in the previous week.” (Health Survey for England report, 2014) (7)

Furthermore, the Office of National Statistics noted that, “A major part of the increase in drinking from the 1960’s onwards has been driven by the rise in boozing at home – twice as much alcohol is now bought from shops than is purchased in bars, pubs and restaurants. This form of alcohol consumption is more common in the older age groups and explains why the most frequent drinkers are the middle-aged, particularly those among high income groups.” (Office of National Statistics, 2016) (8)

Making sense of the unit system and alcohol related harms in general was also a cause for concern. The ‘Drink Wise, Age Well’ study found that 75% were unable to identify alcohol units and lower risk guidelines. (Holley-Moore, G and Beach, B, 2016) (9)

Evidence from the focus groups suggested that problematic drinking continues for this generation even into much older age. A Manager of an older persons’ care home of many years suggested an increase in alcohol addiction, remarking:

“...it is getting worse. 20 years ago, it was very rare for people to have a drink in a care home, maybe an odd glass of sherry, but now it can be a glass of wine per night. Patterns of drinking are changing, it used to be seen as a treat, now there is an expectation to have a glass every night. People are different now, people are living longer, older people want to do more, want to be involved more and expect more. They have a sense of self-awareness of their entitlements.”
Older people didn’t see themselves or associate themselves with the ‘alcoholic’ image, possibly because they are more likely to be lower-level daily drinkers as opposed to binge drinkers. The GENACIS survey 2005 noted that:

On the Isle of Man there was a “Higher frequency (of drinking) in the older age groups” and that “the age group most likely to drink alone were those aged 75 and older.” It is worth noting that this was also the age group which was most likely to drink at home and was also the most balanced in terms of gender. In terms of week day drinking before 5pm, the 65-74 and 75+ groups also scored the highest. *(GENACIS, 2005) (4)*

**Patterns of other drug use**

Analysis from the study trends in ‘Past year Cannabis use in people aged over 50 in England’ showed significant increases in Cannabis in the 50 to 64 age group. Noting on historical influences on trends, Wadd notes “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 1960’s and 70’s todays 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...The use (and misuse) of prescription drugs with addiction potential, including barbiturates and tranquillisers, was widespread.” *(Wadd, S, 2014) (10)*

![Figure 5](image-url)  
*Figure 5 Trends in past year Cannabis use in people aged 50 and over in England*  
The 2017 Drug Strategy released in July by the UK Home Office also concedes to the decline in treatment outcomes for older opiate users, who “often have health and mental problems and entrenched drug dependence.” Sadly, this is also linked to the dramatic rise in drug misuse deaths since 2012 – “deaths involving heroin, which is involved in around half the deaths, more than doubled from 2012 to 2015.” There was also concern that further rises in drug deaths were predicted. *(Home Office, 2017)* *(11)*

The 2017 Drug Strategy states that the ACMD has established a Working Group to “map the numbers of older drug users in the UK and draw on UK and international evidence to establish the current and future needs of this cohort.” *(11)* Drug deaths on the IOM are reportedly higher than in the UK – see chapter on ‘harm.’

**Recommendation: Drug ‘mapping’ of older drug users on the IOM**

**Hidden Harm**

Organisations that participated in the focus groups felt that “denial of a problem” was commonplace. The Live at Home Scheme noted:

“There is a great deal of denial in older people who don’t believe they have a drinking problem. I think they get to a certain age and think no-one is going to tell me what to do, I’ve earned it.”

Also, speaking to their clients about their drinking and complying with the request to drink less at organised events proved tricky. Whilst these organisations did challenge clients about their drinking and in particular asking them to drink less it was difficult to see sustained changes:

“I’ve got two clients who when you talk to them about the problems they are causing are very compliant for a few weeks onwards, but then it goes back to the way it’s been.”

“We have an old guy who wanted to be dropped off at the garage to buy alcohol and when we refused he became verbally abusive.”

Drug and alcohol treatment services view denial as being a normal part of the stages of change - namely pre-contemplation - when an individual is perhaps not ready or frightened to contemplate changing and are fearful of life without their coping mechanism.

**Lack of engagement and service dilemmas**

It was felt by some that older clients that drank heavily were difficult to engage and often cause services a dilemma. Crossroads described clients not turning up because of their drinking and therefore a space not being utilised. There was an understanding that removing a drinking client’s space would lead to further isolation and drinking.

“When denying her a space we are feeding that problem. It was meeting her needs versus leaving a space empty. A service dilemma.”
The Live at Home scheme offers outings in local areas for older people to socialise and decrease isolation. However, this sometimes causes issues and dilemmas for staff when dealing with older drinkers. For example, LAH noted:

“A couple of people are drinking heavily before they are picked up and their behaviour is impacting on all the group, the staff and volunteers and they’ve had to withdraw their services.”

They have tried to support these individuals with other services.

The Live at Home scheme also had experience of clients wanting alcohol in excess of the norm at organised events. This was concerning as it was felt that this would leave individuals vulnerable and incapacitated on returning home. Workers felt a strong duty of care even though faced with disgruntled older clients, which was a challenge to their practice and raises safety concerns. They used one example of a frail lady who had one glass of wine at an event, which was fine, but then wanted another and became disgruntled when staff said no. Staff knew she would be on her own for a few hours before her daughter came home and they were worried she might fall.

In social settings such as this, older clients may also be coerced into purchasing alcohol when it isn’t appropriate as others may be unaware of any medication they may be taking.

Live at Home noted:

“It feels awkward to ask when they’re older not to drink and many won’t accept being told.”

Crossroads also noted the pressure on their staff at times, for example, when “carers were in dilemma when presented with a shopping list that primarily has alcohol above all other food stuffs on it.” Crossroads conducts individualised care and recognised that they had to make safety choices in these cases, as all staff were aware that these cases are often of frail, isolated individuals.

Statutory services also reported pressure on staff when working with challenging clients, suggesting even if just “one individual has an increased exacerbation of their condition this has a direct effect on the whole team.”

**Severe isolation and lack of access to services**

The flip side of non-engagement was the clients noted by participants to be marginalised who struggle to gain access to services. Graih described one individual in their late 60’s who had a history of substance misuse with mental decline. Graih was the one service at that time who had contact with him. He was transient, he had no family and no carers.
It was reported that the lack of access to services, eligibility criteria, waiting lists and adherence to strict referral criteria acted as a barrier to the older generation accessing services and this was a recurrent theme from many participants.

Younger people made older through substance misuse & the health impacts of substance misuse

Graih reported seeing clients presenting as much older in years. They described substance misuse making the people they see looking physically much older, taking its toll and generally ageing someone through the impact of substances. They remarked:

“A drug and alcohol professional also noted:

“Due to the lifestyles of our clients someone in their 50’s may present as someone in their 70’s due to health problems and physical decline.”

DAT reported also seeing clients in their 50’s with health challenges normally faced by much older people. Their older person’s worker felt her role should be targeting people from the age of 50 as it was felt that many dependent individuals perhaps did not survive and that the service would lose them. DAT also noted that in 2016 they had received a ‘cluster’ of referrals (8 people) for the over 75’s.

All participants noted that poor nutrition and frequent falls were a feature with older clients.
In the GENACIS Final Report of 2014, the author makes several points relating to falls, including the economic impact:

“It is worth noting that people who are older are perhaps more likely to use alcohol almost as a medication, for example a glass of whisky at night is often seen as preferable to a sleeping tablet. Alcohol is a diuretic, which means that the person will be even more likely to have to get up during the night to empty their bladder. The scenario is clear – if they are unsteady on their feet due to age related issues or alcohol and they fall and break a leg they will face an extended stay in hospital causing them and their families worry……the longer healing times will also place a financial burden on the health service as well as issues of blocking beds which cause so much concern in many hospitals.”

(GENACIS, 2014) (12)

The IOM Director of Public Health Annual Report 2017 noted that there were:

343 emergency hospital admissions for falls for the over 65’s.

It would not be unreasonable to suggest that a proportion of these may be falls caused by impairment due to alcohol or other drugs. (5)

Korsakoff’s syndrome was mentioned by several contributors as a challenge. Korsakoff’s syndrome is a form of ARBD, (Alcohol Related Brain Damage) in which the main cause is a clear lack of thiamine (Please see later chapter by Robin Davidson). It was reported that clients suffering from this condition in their 50’s were in residential care with much older residents due to this condition.

The Royal College of Physicians have stated that the “highest prevalence of ARBD is found in the 50-60 age group” and that ARBD…… “can affect memory, judgement and reasoning, problem solving skills and understanding.” (13)

Other impacts are discussed in detail later in the report.
Anonymised Example

This lady was referred to us after a prolonged period of hospitalisation following an alcohol-related collapse. She was transferred to a care home for respite before returning home. Memory issues and cognitive decline were part of the complicating factors for this lady in her 70’s. Indeed, the Motiv8 worker found it difficult to assess and work with this lady because of these issues. It also brought to light just how many people and services are involved in the care of just one person – e.g. social worker, neuro-psychology/OPMHS, reablement, care worker, Motiv8 – not to mention the lengthy hospital and care home stays and the input of her family, which was also fairly substantial.

Accommodation

Grai reported a cohort of older drinkers living in substandard rooms in old boarding houses who want to remain independent - possibly so that they could continue with lifestyle choices which involved the ongoing use of substances.

However, as Graih noted:

“Some live in boarding houses in atrocious conditions. One person was living in a converted coal cellar which was flooded out with sewage when the promenade was flooded a few years ago.”

There are obvious health implications with sub-standard housing:

“The older and frailer they get the more at risk they are of chest infections etc. because of poor accommodation.”

There was concern suggested around the suitability of this accommodation for older people.

“One younger Motiv8 client was noted to call his accommodation the “Heartbreak Hotel” due to the older isolated male residents who live at the premises.

“Older people will be more adversely effected by adverse accommodation than someone in their 30’s who can walk quite easily.”
The psychological impact of living in substandard accommodation was also noted to be a risk factor for poorer mental health and led to persistent substance misuse to cope with poor environmental conditions.

Social inequality and substance misuse is an issue within itself, as an Institute of Alcohol Studies report highlighted: “There is also evidence that those living in more deprived circumstances face greater barriers to accessing health and alcohol related services and interventions than those in less deprived circumstances. Barriers include factors such as costs, distance, transport and availability, and stigmatisation, with stigma a particular problem for those of low socio-economic status.” (IAS, ‘Alcohol, Health Inequalities and the Harm Paradox’, 2014) (14)

Although complex, and not yet entirely understood, research suggests that lower socio-economic groups consume less alcohol than higher groups, but experience greater alcohol-related harm, known as the ‘alcohol harm paradox.’

The Island’s lack of homeless legislation and accommodation such as a wet house (a unit which tolerates the use of alcohol) was recognised as a major barrier to helping those severely dependent and disenfranchised.

**Screening**

It was noted across all focus groups, one to one interviews and online survey contributors that screening and detection of substance misuse, particularly in Primary Care was lacking. As a public professional noted:

> “We are lacking in tier 1 and tier 2 provision outside Douglas and in the central area.”

As one contributor stated:

> “People don’t always get into the service for many years and it is just not something that has been flagged up. Until you get into the service and then when you’re digging round for information that’s when it really becomes an issue.”

A further comment from OPHMS highlighted the issues with late detection:

> “I would imagine if we are seeing them in the state they are in then it has been going on for quite a while, so in the community it is getting missed. So, they are either not going to their GP’s or not having involvement with district nurses or health visitors and it is only when they get to crises and by that stage there are usually quite severe problems including cognitive decline.”
With regard to screening in GP practices, information obtained from a Freedom of Information request (Feb 2017), pertaining to the percentage of people on the Island who are screened at Primary Care level and the percentage of people who need brief interventions or sign-posting to additional services, revealed the following: (15)

Newly registered patients who undertook a short standard case finding test (e.g. FAST OR AUDIT), was reported as;

<table>
<thead>
<tr>
<th>How many newly registered patients have had a short standard case finding test*</th>
<th>How many screened positively and undertook fuller assessment</th>
<th>How many were harmful/hazardous drinkers and have received brief intervention</th>
<th>How many of the patients have been referred for specialist advice for dependent drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>228</td>
<td>99</td>
<td>2</td>
</tr>
</tbody>
</table>

* Practices are required to screen newly-registered patients aged 16 and over using either one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaire: FAST or AUDIT-C. FAST has four questions and AUDIT-C has three questions, with each taking approximately one minute to complete. Patients with a positive score should be given the full screening test and offered brief advice for a score between 8 and 19, or be considered for referral to specialist services for a score of 20 or more.

Whilst this is some local information it only takes account of GP practices and new patients and excludes other health care settings where data could be collated.

The ‘Isle of Man in Numbers’ survey 2016 by the Cabinet Office showed that in 2015, 17,132 over 65’s patients were registered at GP practices. They represent almost 20% of the total patients registered on the Island. (16)

A lack of screening was perhaps cited as a reason for a ‘significant level of unplanned detoxes.’ As one contributor noted:

“They have a fall, end up in Nobles, and we get involved from there.”

There was also reports of many older people having to be detoxed when admitted for falls and similar accidents in an impromptu fashion.

As a Drug and Alcohol professional noted:

“I think that Nobles do a lot of these detoxes for every age group, it is the crises ones where they have been brought in an ambulance, perhaps collapsed, had a fall or a fit.”
Many contributors were passionately vocal about introducing screening in Nobles, as one Drug and Alcohol Professional said:

“Why wouldn’t resources be put into screening for drug and alcohol issues, when these conditions have such an impact on the hospitals resources?”

Furthermore, the lack of screening was reportedly resulting in missed opportunities in diagnoses. One Drug and Alcohol professional noted:

“My theory is they are being missed when they go into hospital over the years and they are not getting treatment and the recognition, and the Wernicke’s ends up as Korsakoff’s.”

The ‘Drink Wise, Age Well’ study found that “Four-fifths of over 50’s who are drinking at levels that exposed them to increased harm had never been asked by family, friends, or professionals about their alcohol use”. (Wadd, S et al, 2014) (10)

Moreover, the Alcohol Concern ‘Blue Light’ Project into change resistant drinkers found that brief advice in such settings worked. “1 in 8 recipients of IBA (identification and brief advice) (people scoring 8-19 on AUDIT) reduce their drinking to lower-risk levels after brief advice. Furthermore, the effects persist for periods up to two to four years after intervention and perhaps as long as nine to ten years. On average, following intervention, individuals reduced their drinking by 15%....it will reduce their alcohol-related hospital admissions by 20%.” (18)

Conversely, change resistant drinkers are unlikely to benefit from this approach. Nonetheless, this remains a good starting point as it allows workers to:

- Begin a conversation on the basis of a validated screening tool
- Make a few statements about the need to change and the potential benefits

“If no one talks about the drinking, opportunities to change will be missed and the pressure on the person to change will be minimised. Indeed, if workers say nothing it may be seen as a statement that nothing is wrong with the drinking.” (Blue Light Project, Alcohol Concern, 2014) (18)

The GENACIS study posed the question that “whether non-obvious health care settings should include alcohol screening, e.g. chiropody services, osteoporosis screening, as they may be able to detect perhaps a hidden issue with alcohol in the older population. Picking it up sooner.” (GENACIS, 2014) (12)

Some professionals cited a lack of education as a reason for people not being identified. A Drug and Alcohol professional noted:

“In terms of people being missed I think it’s education and training” and also “communication between services and agencies.”
It was felt that the introduction of a recognised screening tool in hospitals and other primary healthcare settings should be introduced with staff training on how to conduct the screening. Also, training on brief interventions and harm strategies.

Population and Demographic trends – Future demand

It has been widely reported that the IOM is about to see a huge increase in the older population which undoubtedly will create greater demand on all aspects of health care. The executive summary of the findings from the IOM Government Joint Strategic Needs Assessment 2014 noted that:

“Over the next 20 years, the number of older persons in the IOM is projected to increase by 75%, compared to a 2% increase of those of working age and a 7% rise in the number of children. This represents a seismic shift in the population.” (2)

Furthermore, a public consultation conducted by the IOM Adult Social Care Older Persons Service in 2016 reported that:

“The 65+ population in the Isle of Man will increase by 11.2% and 20.3% by 2019 and 2024 respectively. This is higher than the United Kingdom projects. The proportion of the population aged 85 years and over, projected to increase until at least 2026, is again higher in the Isle of Man than in the UK. Unfortunately, there is a gap in data preventing identification of life expectancy in the Isle of Man. It is also recognised that the fastest growing sector of the population is the 85+ age group.” (DHSC, Adult Social Care) (19)
The 2013 Council of Ministers Report on modernising government, ‘Smaller, Simpler, Stronger’ identified 3 significant pressures facing government;

- **The ageing population**
- **The rise of long-term conditions**
- **Increasing public and political expectation**

*(DHSC, Adult Social Care) (19)*

Some population groups as they age were felt to be more vulnerable. One health professional interviewed noted a pertinent issue relating to Island life, in that:

> “Families who came to work and settle are finding their children are leaving the Island which is leaving parents starting to age with a lack of family support and network.”

Also, it is widely established that ex service personnel are more at risk of developing a substance issue. As one contributor noted:

> “Ex-forces with alcohol and drug problems are ‘hidden’ on the IOM and are starting to present to services.”

It was felt that there would be an increasing demand on services with our growing population of ageing residents. The recent census has seen a reduction in the younger working population groups and growing retirement age groups. The impact this will have on future service provision is significant.

A very recent consultation by the IOM Health and Social Care Department noted that:

> “Based on projected demographic trends it can be inferred that the demand for Social Work input will increase by 11.2% by 2019.”

*(DHSC, 2016 – Appendix ii) (19)*
It is possible that demand is already increasing for older age groups. One consultant is concerned about the future overall volume of all patients for Older Persons’ Mental Health Services that would need support in what is already a stretched service.

Also, the Drug and Alcohol Team noted that the future needs of ageing drug users requiring continued treatment needed to be considered - particularly clients on harm reduction opiate maintenance programmes such as Methadone and Suboxone. They suggested:

“The other group which is not quite there yet are the Methadone maintenance groups who are coming into their fifties. We have the supplementary prescribing schemes, where we refer a lot of stable maintenance patients. Some of my patients who I referred up to 5 years ago, promised me they would be off, and five years later everything is the same.”

Whilst not palatable to some, maintenance programmes have been instrumental in keeping individuals alive. As previous research from the National Treatment Agency noted, “Although an early death is a reality for many addicts, methadone prescriptions and the success of harm reduction programmes now mean that huge numbers of people who began using drugs in the 1960s’ and 1970’s are living longer.” *(The Guardian, 2011)* (21)

This view was reiterated by Dr Wafer, Consultant for the Drug and Alcohol Team, who noted their current case load consisted of:

“Mainly alcohol use at present, but with time this will include older patients on opioid replacement treatment. Iatrogenic dependencies in older patients and poly-pharmacy also increasing but numbers still very small.”

Another Drug and Alcohol professional noted:

“The issue of long term prescribed medication and possible misuse is not acknowledged across services.”

According to the Royal College of Physicians, there are gender differences in terms of substance use: “Older men are at greater risk of developing alcohol and illicit substance use problems than older women. However, older women have a higher risk of developing problems related to the misuse of prescribed and over the counter medications.” *(Royal College of Physicians, 2011)* (13)

An older persons’ care home manager also voiced concerns and felt that there would be an increased demand on care homes to house burgeoning numbers of individuals with alcohol problems. People living longer with good medical care meant those with alcohol problems would more likely end up in local care homes. There was a feeling that providers would not be equipped to deal with this.
Martin Green of the English Community Care Home Association said “Managing people with addictions will be an enormous challenge. Care homes are not paid to look after addicts and do not have the requisite expertise to manage people with significant drugs or indeed alcohol problems. A local care home manager noted “If a client has had a drink they are asked to stay in their room and not be around other clients as we have clients who have alcohol issues from time to time.” (20)

Some also voiced the view that older people’s services may not be seen as a priority. A Drug and Alcohol professional felt that:

“The needs of older persons have to ‘compete’ with child safe-guarding and/or adult mental health agendas.”

A shift in drugs of choice in the future was also highlighted with one older person’s worker noting:

“I think we will see more people who are on heroin replacement, people using cannabis and other addictions rather than smoking and alcohol.”

A recent Freedom of Information request revealed that since 2013 to 2017 the IOM Department of Health has spent just over £300,000 on replacement drugs, such as methadone, for those addicted to substances like heroin. (21)

Looking to the UK, the NTA, now part of Public Health England, does not ask questions about drug use in the over 60’s. So, it is difficult to know true prevalence rates and there is a shortage of data on drug use. However, researchers for the ‘Forgotten People: drug problems in later life’, were able to collate data from the English Psychiatric Morbidity Survey which reports 1.1% of people aged 60 and over had used drugs in the last year. Further analysis was able to break down this data into types of drugs used by the over 60’s:

![Drug use in older people](image)

(please note percentages do not add up to 100 as some people use more than one drug)

(Source ‘The forgotten people: Drug Problems in later life’ Wadd et al 2014) (10)

The researchers highlighted further concern “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.” (Wadd et al, 2014) (10)
There were 2223 people aged 60 and over receiving treatment for a drug problem in 2012 to 2013.

According to Caryl Benyon, “European estimates suggest the number of people aged 65 and over with substance abuse problems or requiring treatment for substance abuse disorders will more than double between 2001 and 2020.” (Benyon, C 2009) (1)

![Figure 3 Primary drug of use for those aged 60 and over in treatment for a drug problem in England in 2012/13](Source 'The forgotten people: Drug Problems in later life' Wadd el al 2014) (10)

The substance treatment services on the Island, namely the Drug and Alcohol Team and Motiv8 Addiction Services, are able to furnish us with age-related data. For the Drug and Alcohol Team, out of a total of 243 new clients referred to the service for drug and/or alcohol treatment April 2016 to March 2017, 48 of those were aged 50+, representing 20% of the total. For Motiv8, a total of 443 clients were referred to the service for alcohol or drug treatment from January 2016 to December 2016 – 76 of these were aged 50+, representing 17% of the total. (It should be noted that this includes 11 people aged 50+ who were family members accessing support.)

What is clear is that substance misuse does not abate for some and will likely present as a significant issue for health planners in the years to come.

There is some research that suggest other drugs also prematurely age people. A study in 2016 into the ageing impact of Cannabis use suggested that, for those who used cannabis over a long time, not only does it age you, it increases ageing at an exponential rate over time which is alarming.…. “The level of cannabis exposure in the group studied was much higher than we have seen reported before in other studies for developed nations.” (17)

Professor Reece, lead researcher with this study, added it was concerning that this was the first study to look at the long-term effects of smoking cannabis on the cardiovascular system and there were comparatively few studies across the world looking at its long-term effects. “It is important to the health
of populations worldwide that such research be continued, with the study highlighting the large-scale costs to the health system from cannabis use.” (17)

Older drug users have high levels of physical and mental health problems and blood bourne virus infection, poor quality of life, high levels of loneliness, stress and fear of victimisation. They often experience injecting related vein damage that can lead to riskier injecting such as injecting into their feet or groin.” (Wadd, S, 2014) (10)

In her paper, “Drug use and ageing: older people do take drugs!”, author Caryl Benyon talks about how the brain changes across the lifespan and alterations occur in the neurotransmitters – what is not yet clear is how ‘these changes alter drug-brain interactions and what implications these changes have for older drug users is not yet clear.’ (1)

Information on dependent cocaine users shows that they “exhibit an increased number of age-related white matter (brain) lesions, which in turn are thought to be associated with cognitive abnormalities.” (Benyon, C 2009) (1)

Also, it was noted by a Drug and Alcohol professional that a:

“Lifetime of drug use lowers peoples pain thresholds, leaving them vulnerable to inadequate pain relief from health care providers.”

Anecdotally, many contributors suggested that addiction to medication, both prescription and over-the-counter was a hidden issue on the Isle of Man. This is a difficult area to get clarity on as on examination it was noted that there is no local or UK national data on the prevalence of medication dependency.

The manner in which future older generations procure drugs may also change and whilst many contributors felt it was not a current issue, there was an acknowledgement that accessing drugs via the internet in the future may be a common trend. The emergence of the dark web may well see a change in how people obtain drugs. There was a current example from an older person’s professional, who noted it was a rare case however:

“The guy was late 60’s, buying and selling, having people in the house, smoking Marijuana, whatever he could do he would dabble; alcohol, drugs anything. He was buying all sorts on the internet. You can buy all these legal highs and he was trying it. He was probably one of the first to try the new stuff over here.”
**Hospital data**

Many of the interviewees bemoaned the lack of research in all groups and fields of health, with one professional noting, “A & E data lacked statistical rigor.” Fortuitously, it appears that there is some data that is being routinely collected – this is **ALL AGE GROUPS**. A recent Freedom of Information Request in October 2017 asked the following (49):

1. **Can you please advise how many people were admitted to Nobles Hospital for drug abuse in the last 3 years?**

   The table below shows admissions for *intentional* drug poisoning.

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>186</td>
</tr>
<tr>
<td>2015/16</td>
<td>176</td>
</tr>
<tr>
<td>2016/17</td>
<td>134</td>
</tr>
<tr>
<td>2017/18*</td>
<td>86</td>
</tr>
</tbody>
</table>

   *please note this is a part-year figure

2. **What drugs were they, as (1) above?**

   The list of drugs is vast and complex, and possibly not what people would normally assume would be used as an intentional drug poisoning. For example, several categories include types of anti-epileptic drugs and drugs used in the treatment of cardio-vascular disorders – all of which could be prescribed. Illicit substances also feature, such as cannabis and cocaine. Caution should be used when interpreting this data as it does not include non-intentional overdoses and only codes for the ‘primary diagnosis’ which excludes other drugs and alcohol.

3. **How many people were admitted to Nobles Hospital for alcohol abuse in the last 3 years?**

   The table below provides the number of patients (not private patients) admitted to Nobles Hospital with a diagnosis of any of the following: *Acute Intoxication/Alcoholic Liver Disease/Alcoholic Polyneuropathy/Degeneration of Nervous System due to Alcohol/Alcoholic Gastritis.*

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>1175</td>
</tr>
<tr>
<td>2015/16</td>
<td>1058</td>
</tr>
<tr>
<td>2016/17</td>
<td>1333</td>
</tr>
<tr>
<td>2017/18*</td>
<td>990</td>
</tr>
</tbody>
</table>

   *please note this is a part-year figure

Again, these figures need to be interpreted cautiously as they do not include other alcohol-related admissions that are not part of ICD-10 coding, such as: alcohol-related accidents e.g. falls/broken bones, head injuries, assault. The World Health Organisation states that “the harmful use of alcohol is a casual factor in more than 200 disease and injury conditions.” And, “overall, 5.1% of the global burden of disease and injury is attributable to alcohol…” (50)

Historically, a major piece of work was conducted during 1 January to 30 June 2005 on the alcohol admissions to the Medical Assessment Unit (Ward 6) (25). From the hospital coding system, there were
a total of 220 admissions due to alcohol-related issues in those 6 months. A total of 145 of those patients were admitted to the MAU. The remaining 75 admissions were split between Children’s Ward, Orthopaedic Ward and Surgical Ward.

Out of all the admissions which categorised into age groups there were 33 in the 51 to 65 age group and 10 in the 66 to 80 age group.

Over 100 admissions came through A & E. Reasons for admission to the MAU included:

- Alcohol misuse
- Intoxication
- Intoxication/overdose
- Overdose
- Other
- Withdrawal seizure
- Notes missing

It is worth noting that referrals for all age groups appear to be ‘crises driven.’ Suggesting a hidden population of problem drinkers who don’t access other services or engage in a uniform manner.

As was noted:

“The total number of admissions to the MAU in the first 6 months of 2005 was 1973 and of those, 145 were admitted for alcohol misuse, which was 7% of all admissions as coded by the Doctor’s discharge letters. This indicates that there are more admissions due to alcohol misuse to the MAU in those 6 months, than in the whole of the previous years’ statistics (143 in 2004).”

The report also highlighted the need for screening and opportunistic moments (for Brief Interventions) as being required for our local hospital. The author, Jayne Paton, had her own recommendations, which included:

- Clear guidelines for Doctors to follow on prescribing of both vitamins and detoxification programmes.
- Use of a withdrawal scale
- Use of a screening tool to assess risk
- Education for Doctors and Nurses on addiction to enable clearer understanding of the complexity of each individual’s client’s needs
- Clear guidelines for nurses on referral to other services
- Improved communication between agencies
Three years on the audit was repeated with a total of 323 patients admitted to Nobles between January 2007 and December 2008 coded as alcohol-related. This was a total of 241 patients admitted to MAU, equating to 496 actual treatment episodes.

However, changes to the hospital data management system may have contributed to difficulties with coding. As the author reports:

“It is recognised within this audit and as with the previous that not all patients admitted with alcohol-related problems may have been identified, due to the variability of coding by different doctors and now the new Medway system also impacts on these figures.” (Paton, J, 2008) (26)

The author calculated that the cost to the hospital for admissions in 2007/08 totalled 2,344 bed days. With an estimation of a hospital bed costing £500 the author totalled this to be £1,172,000.00.

A recommendation was made that systems could be improved by employing a hospital alcohol specialist nurse to implement screening, brief interventions and training for hospital staff.

The UK literature search yielded extensive data on the impact of substance misuse. “A national survey of most of the UK’s emergency departments found that 70% of night time attendances and 40% of day time attendances were caused by alcohol.” (Drummond, D et al, 2005) (27)

The National Treatment Agency in a 2013 document showed how investment in screening and treatment saves money:

![Investing in alcohol interventions saves money](image)

(28)
Joint Strategic Needs Assessment

A Joint Strategic Needs Assessment was started by the Island’s multi-agency Drug and Alcohol Steering Group in October 2016. The work was jointly undertaken by the Centre for Public Innovation in the UK and the Public Health Directorate, Isle of Man. Financed by the seized assets fund, the work is hoped to help inform government and other stakeholders on the needs of the Island’s community. We are still awaiting the final report from this.

GENACIS

Conducted in 2005, the GENACIS survey ‘Gender Alcohol and Culture an International Study’ was a major research project in which a sample of 1000 Manx residents completed one to one interviews. Funded by the Isle of Man Medical Research Council and conducted in collaboration with Motiv8 and the University of the West of England, GENACIS Isle of Man was a landmark piece of research for the Island and provided the very first and only baseline data on adult alcohol consumption. This enabled comparison between the IOM and other countries both in relation to demographics, alcohol consumption, levels, patterns, related harm and general information on health policy.

Reporting in the ‘Journal of Substance Use’ in August 2007, the 65 year and older female group were reported to be drinking double that of their UK counterparts. (GENACIS, 2007) (4)

The Isle of Man compared unfavourably to the UK in the older age groups. In the proportion of all respondents drinking alcohol in the 65 to 74 age groups, 4.5% of the sample exceeded sensible levels compared to 2.8% in the UK sample. In the over 75’s group, in the IOM for women it was 10% of the sample compared to 1.2% in the UK. Indeed, women over 75 were drinking more than the 18 to 24 year olds (9.4%) - traditionally the heaviest drinking group.

When it came to high risk drinking, women again fared poorly in the 65 to 74 age group with 2.3 % compared to 0% in the UK, and 3.3% and again 0% for the over 75’s. (Journal of Substance Use, Plant et al 2007) (4)

Pathways to Addiction – Experiences of Addiction and Recovery in the Isle of Man

This ground-breaking research was conducted by the National Centre for Social Research in London. The work was commissioned by Motiv8 from a grant awarded by the Manx Lottery Trust. This survey was the first of its kind on the Isle of Man to look at biographical life stories of more than 50 local individuals who were either in recovery or attempting to gain recovery from substance use.
It offered a unique insight into the difficulties and challenges individuals endure locally when trying to overcome an addictive behaviour. The sample broke down age groups as follows in the older demographic:

![Age Groups](image)

- 40-59 (24) 47%
- Over 60’s (5) 9.8%

The report highlighted several barriers to change including the challenges of small community living:

“A number of sufferers had to endure public humiliation when the IOM press ran stories about them, after they were prosecuted for an alcohol or drug related offence. The stories often included lurid details of their personal lives, which caused great distress and sometimes despair to them and their families.”  
(Pathways to Addiction, Pg.33) (29)

A recommendation from this research was to persuade the IOM media to be more sensitive when they report such stories.

The culture of drinking here was also mentioned as a stumbling block to change or an explanation as to why a problem may develop:

“Drinking-including heavy drinking, was seen to be widely tolerated or even encouraged in the IOM.”  
(Pathways to Addiction, Pg.54.) (29)

Some interviewees also spoke about issues surrounding prescription drugs:

“In relation to prescription drugs, one participant said that it was important for GP’s to have systems for monitoring so that people could not reorder large quantities of addictive substances without a review.”  
(Pathways to Addiction, Pg.55.) (29)

**Morbidity**

Maintaining good health is a critical issue for older people. Average life expectancy is increasing and medical advances are keeping people alive longer. However, living longer doesn’t necessarily equate to living healthier and improvements in morbidity. A UK report on working with older drinkers suggested that there was a marked increase in hospital admissions in all age groups but the increase was the greatest for older people: for men aged 65 and over admissions rose by 136% and for women in this age group 132%.  
(Wadd et al, 2011) (30). Furthermore, “during the last decade there has been an 87% increase in alcohol-related death rates in men aged 55-74 and for women this figure is 53%.”  
(DrugScope, 2014) (31)
Mortality

There is no local available data on ALL alcohol related deaths. A Freedom of Information request in March 2017 requested ‘mortality rates of alcohol-related liver disease for adults aged under 75 and the most recent statistics over a 12-month period.’ (32) This information was not released due to a future publication by the Department of Health and Social Care. However, it is likely that the Isle of Man is comparable to North West regions which rate as the second highest for alcohol related deaths. The latest data from the UK Office of National Statistics showed that alcohol-related death rates are highest amongst the 55 to 64 year and 65 to 69 year old males. A breakdown of UK alcohol-related deaths by age group shows that in 2015 the highest alcohol-related death rate was amongst those aged 60 to 64 years for males (44.9 per 100,000 males). Whereas for females the highest death rate was amongst those aged 55 to 59 years with a rate of 23.1 per 100,000 females; this is shown in Figure 2.

As they suggest “Alcohol-related death rates decreased among those younger than 65 years since peaking in the late 2000s. For males, age-specific rates of alcohol-related death for those aged under 65 years of age have decreased since they peaked in 2008. Whilst for males aged 65 and over, alcohol-related death rates have either remained at a similar level or have increased from 2008 to 2015. For females, since 2008 there has only been a statistically significant decrease in alcohol-related death rates for those aged 50 to 54. For all other age-groups, similar rates have been observed in the period between 2008 and 2015.” (ONS, 2017)
The IOM’s Health Minister revealed in May 2017 that drug-related deaths are higher here than in England. Mrs Beecroft confirmed that 14 out of the 23 deaths between 2013 to 2015 were related to opioids:

“Concerns over the numbers of deaths from opioid overdose.....which has been observed in the British Isles...led to the introduction of a home naloxone programme through the Drug and Alcohol Team.” The Health Minister also said “the other main area of concern was the number of deaths relating to prescription drugs, which was being looked into.” (Manx Radio/Hansard) (34)

Figure 5: Age-specific mortality rates for deaths related to drug misuse, deaths registered in 1993 to 2015

England and Wales

Source: Office for National Statistics
Early versus late onset of substance misuse

Substance misuse can be a long-standing problem that has existed over several years and can only come to the fore following a crisis in health and well-being. However, there are also categories of users who develop a problem in later life due to multiple factors including bereavement and isolation.

The Isle of Man Social Attitudes 2016 survey found that “in terms of mental health, whilst there were no significant differences between age groups and those most likely to be depressed, there were differences between those suffering a low mood. With 44% of the over 65’s answers scoring and showing they were likely to be of a ‘low mood.’ ... Also of note, “in terms of marital status the widowed group were more likely to be suffering a low mood.” (6)

Experiencing a loss of someone close such as a spouse in later life could trigger late onset dependency. A local CRUSE counsellor suggested that:

“Some clients did have an awareness of the potential of addiction in grief and chose to be careful around substances.”

However, for some it was the beginning of late onset misuse.

The GENACIS survey noted:

“By the 75 and older age group, over 40% of the respondents described themselves as widowed.”

“The age group most likely to report drinking alone were those aged 75 and older, they were also the age group most likely to drink at home and the most balanced in terms of gender.” (GENACIS, 2014) (12)

A carer who participated in the research interview noted late onset of a problem:

“My family member didn’t drink until he was 70, a year after his wife died. He is 87 now and has drank heavily for 17 years. He is defensive and won’t consider change, even though he has been offered help”
This carer felt that the support from medical services was lacking and the hospital didn’t take his drinking seriously in spite of suffering a serious gastric bleed following a heavy drinking episode.

Some older people could be more susceptible to developing a problem if they used alcohol later in life to manage health problems inappropriately. One participant noted that:

“Having a whisky at night to help them sleep or with the pain. A lot of them have arthritis and a drink helps them to cope with the pain and helps them to sleep.”

Being susceptible to an alcohol problem in later life and transitioning to retirement years can be a critical time. The first State of the Nation report from ‘Drink Wise, Age Well’ found that in the over 50’s population there was often a complex relationship between alcohol, employment and retirement. The data from their large-scale survey found that, for those surveyed whose alcohol use had increased, 40% cited retirement and 20% cited loss of purpose as the reason (House of Lords enquiry on alcohol risks and over 50’s work and retirement) (3). Carers were also noted to be susceptible to relying on alcohol for respite in later life.

In regard to earlier onset, a care home manager noted:

“I’ve been in the care of the elderly for 24 years and in the last five years I have seen a big difference in the amount of older people who are alcohol dependent. Also, in a change of age in presentation with more younger and in their 60’s, definitely an issue that is on the increase.”

**Anonymised Example – Late Onset**

This man was referred to us after a spell in hospital revealed drinking and severe depression. Although only in his mid-60’s, this man required home visits due to his poor health and physical decline. Although this man had always been a social drinker, his alcohol use increased substantially after his wife suffered a serious illness. Overnight he became a carer. He became isolated and despondent and drank to cope. Although he struggled to manage looking after her at home, when she was placed in a care home for a week or two’s respite he felt even more lonely and would drink heavily. His family stopped visiting and he became more isolated. It was noted that although carers went in to see him, he could be difficult and hard to manage at times.
The importance of the third sector in working with older people

Many from the third sector felt that their operations had been particularly undermined by the competitive tendering processes and commissioning of services. Third sector professionals noted:

“The third sector doesn’t work as well anymore, like the sharing of resources, because we’ve almost pitched organisations against each other with the procurement process.”

Some felt that organisations had become more “protective of their own empire” which prevented opportunities to work together as “the system has made them more guarded about the work they do.”

There was a strong sense that the third sector was highly trained, innovative, creative and more equipped to adapt and work the extra mile but services were being squeezed by the tendering process. Some had opted not to tender for work they had previously conducted due to the limited or reduced funds available. There was a sense of this reducing the capacity to work with older people, alongside the goodwill and vocational stance of the third sector. Operationally it was also felt that:

“Lower level interventions from the third sector stop the revolving door problems and potentially stop issues from escalating to crises point.”

Some interviewees felt that a charity regulator was perhaps needed to appreciate and indeed monitor the sector, oversee safeguarding and monitor fair processes in commissioning and the role of government. The UK charity commission regulates the administration and affairs of UK registered charities. This includes financing, fundraising, managing a charity, public service rules and regulations, staffing, trustees, governance, research etc. It also offers guidance and information through its Charity Governance Code.

There was a feeling that little had been done to rebalance the workforce and that government were continuing and even taking on more responsibility “by bringing things in house” due to unrealistic procurement processes. There was a suggestion that some senior Government officers had a naivety about the actual and true cost of most third sector work and providing services. An example of this was the recent retendering process for older persons’ day services. The previous contractor, ‘Age Concern IOM’, declined to bid for the contract stating “they can’t run it within the budget allocated by the DHSC.” (36)

In November 2017, the DHSC also confirmed that it was ending its support for the Meals on Wheels service – it previously paid £150,000 to Age Concern IOM who operated the scheme. This led to Age Concern IOM voicing their worries that this is not just about providing meals for older people, but it is also an important welfare check on the vulnerable and provides some social contact for people who may be otherwise quite isolated. Motiv8 are also concerned that for older drinkers, their nutrition and physical health may already be compromised, removing a nutritionally balanced meal could impact greatly upon certain more at-risk people.
The Royal Voluntary Service in the UK has gone as far as to say that they prefer to call this service ‘Meals with Care’ as this ‘is a more accurate description’. Their drivers “are instructed to ensure that the older person is safe, well and secure. In case of any doubt, the driver will contact next of kin where applicable. Our home delivered meals service provides friendly social contact for those who may be confined to the house, and a regular check that they are safe and well.” (37)

**Recommendation: Charity Regulator**

**Recommendation: Impact assessment on removing services from older people**

### Types of Substances

Alcohol was by far the most prolific and talked about substance misused by older people. Some services reported an increase in alcohol related referrals with OPMHS estimating that approximately 10% of their referrals are for alcohol.

Prescription medication was also cited as an issue. Many respondents talked about knowing widespread and multiple prescription use with individuals, but often without them knowing or understanding why they had been prescribed them. One OPMHS professional noted that:

> “Everyone that we know is taking a raft of medication, often they don’t know what it’s for and why they are taking it.”

**Recommendation: Further medical supervision should be in place for older people who are known to have substance issues**

Third Sector professionals also talked about the potential for unintentional prescription abuse and overdose and that there may be a lot of hidden dependencies on prescription medication that we are just not aware of.

The impact of UTI infections in older people can also affect the brain and cognitions. Given that some already have memory issues due to substance misuse and cognitive decline, this has the potential to make them much more vulnerable.

Age IOM noted they had come across the misuse of pain relief in some older clients and also mentioned other addictive behaviours such as problem gambling.

### Illicit drugs

Information from the IOM Director of Public Health Annual Report 2017 showed that:

> “4000 people on the island are estimated to have used ‘any drug’ (excluding drugs prescribed for medical use) in the last year, with cannabis being the most widely used.” (5)
Cannabis

Drug and alcohol professionals said drug users from the sixties era are now in the older age bracket and that Cannabis use is ‘normal’ on this Island.

In terms of cannabis use, Prof Robin Davidson has noted that as well as the acute effects, there are long-term cannabis toxicity deficits in people with a long history of heavy use. While the once popular, distinct phenotype cannabis amotivational syndrome is probably unnecessary, and the evidence is less strong than for intoxication, there is nonetheless compelling evidence that long-term use produces memory and attention dysfunction and in particular chronic motivational impairment.

Some 3rd sector organisations had experiences of older individuals who had a preference of illegal drugs over prescriptions in terms of managing a health condition. For example, they described a person with a chronic long-term health condition who was using cannabis. This was not without its drawbacks as sometimes engagement with a service could be hit and miss.

Heroin

As a Drug and Alcohol professional put it:

“Heroin users (are) in their 50’s, they are managing their heroin use and surviving their drug misuse and will be in their 60’s in the next ten years.”

However, as Public Health England points out “People with long histories of drug dependency are more likely to be in poor health and to engage in dangerous injecting behaviour, and are at greater risk of dying from overdose.” (28)

Researchers are also investigating the long-term effects of opioid addiction on the brain. Studies have shown some deterioration of the brain’s white matter due to heroin use, which may affect decision-making abilities, the ability to regulate behaviour, and responses to stressful situations. (National Institute on Drug Abuse) (36)

OTC – Over the Counter Medication

Drug and Alcohol professionals noted:

“A lot of elderly people are addicted to OTC or their prescribed medication and they are not taking it appropriately.”

There was also reports of “anecdotal evidence from pharmacies that a small minority of over 65’s may swap pills and medication and even sell them.”
A care home operator mentioned the potential misuse of paracetamol with older people having a “cure all” view of the drug which is probably an example of the medical model influencing the older generations views.

Normal aging changes the speed and ways in which the body metabolizes drugs and older people tend to have more diseases and to take more than one drug at a time. For these reasons, older people may be more likely than younger ones to experience side effects or drug interactions. More and more prescription drug labels specify whether different doses are needed for older people, but such information is rarely included on OTC drug labels.

Many OTC drugs are potentially hazardous for older people. The risk increases when drugs are taken regularly at the maximum dose. Many people neglect to mention their use of OTC drugs to their doctor or pharmacist. Drugs taken intermittently, such as drugs for colds, constipation, or an occasional headache, are mentioned even less often. *(Merck Manual)* (39)

There was also concern for those with life threatening conditions and the terminally ill. It was felt that the controlled medications prescribed to these individuals were not checked regularly enough. There was concern that these drugs could be accessed by others.

**Prescribed drugs**

Z-drugs, particularly Zopiclone, were noted to be one of the most used night sedatives. It was also voiced by drug and alcohol professionals that there was a change in strategy from GP’s to get their patients off certain medications, because it would now be considered excessive and bad practice, and that this could have a knock-on effect for tier 2 and 3 treatment services.

There is an understanding that “some people, especially older people, are at greater risk of having a fall and injury because of the drowsiness.” *(Knott,L, 2017)* (40)

For example, one professional noted that the removal of certain medications (Z-drugs) on prescription by one practice had led to a cluster of referrals from older people who were naturally frightened and concerned about withdrawals, what would happen to them and a worry about not sleeping.

**Recommendation:** If GP practices need to formulate withdrawal/reduction plans, it would be good practice for support to be put in place, through practice nurses or similar, before the removal of drugs, particularly when older people have been prescribed that medication over a long period of time.

There was a feeling that GP’s were under pressure which may explain continued prescribing, but that a lack of reviews could lead to stockpiling of medications for patients. However, there was anecdotal evidence that GP’s were under pressure as they had a lack of alternatives to direct patients to due to long waiting lists for mental health support, when required.
An older person’s professional noted:

“We come across it, you can open peoples’ cabinets and they will have stocks and stocks of very high (strength) medications, loads of diazepam, sleeping tablets and things.”

The IOM prison also had its share of older people with substance issues. It was noted that they had 5 over 60s’ detainees; 2 had historical intra-venous drug use issues, 1 had an alcohol problem and 2 were individuals on substitute opiate prescriptions. On reception to the prison, it was noted that new arrivals had painkiller issues and heavy prescribing of drugs such as Tramadol. Older detainees tended to steer away from NPS (Novel Psychoactive Substances, formerly known as legal highs) seemingly preferring to stick to ‘tried and tested’ drugs.

OPHMS noted that the elderly with mental health issues were more likely to be prescribed benzodiazepines. As an OPMHS worker noted:

“We have a lot of people who are dependent on lorazepam and diazepam. Also, in terms of pain relief, we’re getting some of the more addictive pain relief certainly – codeine and tramadol, this is a big one.”

In terms of dependency it was noted that tolerance had increased in some as larger amounts were taken “to get the same beneficial effects or pain relief.”

There was also a correlation with heavy smoking with those who were using these types of meds or had drinking issues. There was concern that those that were taking these drugs were potentially forming dependencies and displaying tolerance symptoms as a result of using drugs for an effect.

For some individuals, difficulties in cognition meant remembering levels of consumption was a challenge which inevitably poses a risk to them. Often family members had to be relied upon to give a more accurate alcohol history to professionals. Survey respondents also were asked the main presenting substance issue and whilst alcohol was the most cited, one contributor said that “prescription and OTC issues maybe a significant unknown”

Valium prescriptions were also noted to be an issue by several contributors.

There can be adverse effects for older people using benzodiazepines though. Dr Ashton of the Institute of Neuroscience quoting on benzo.org.uk states that: “Older people are more sensitive than younger people to the central nervous system depressant effects of benzodiazepines. Benzodiazepines can cause confusion, night wandering, amnesia, ataxia (loss of balance), hangover effects and "pseudodementia" (sometimes wrongly attributed to Alzheimer’s disease) in the elderly and should be avoided wherever possible. Increased sensitivity to benzodiazepines in older people is partly because they metabolise drugs less efficiently than younger people, so that drug effects last longer and drug accumulation readily occurs with regular use. However, even at the same blood concentration, the depressant effects of benzodiazepines are greater in the elderly, possibly because they have fewer brain cells and less reserve brain capacity than younger people.” (Ashton, H, 2002) (41)
There are numerous ways in which an individual can experience harm as a result of the use of substances.

**Vulnerability**

It was noted by several contributors that misuse of substances left older clients more vulnerable due to impaired judgement, poor choice of friends and not being so discerning about choice of people around them. It was widely reported that many were open to exploitation. Friction with other family members due to behaviour from substance misuse could lead to elder abandonment and further isolation.

The IOM Director of Public Health Annual Report 2017 noted that 21.5% of families were affected by alcohol use and 7.5% of families were affected by drug use. (5)

Conversely, it was also noted that some family members were enabling substance problems (particularly alcohol), by purchasing on the older person’s behalf.

One drug and alcohol professional noted:

> “There are older people who are having their medication taken by their children or grandchildren, they are very vulnerable. These drugs can include prescribed strong opiate pain relief medication.”

**Anonymised Example — Significant Other/Vulnerable Adult**

75 year old grandfather of an adult grandson who had an opiate dependency. The son was often verbally intimidating and the grandfather disclosed an assault to Motiv8 which he didn’t wish to pursue. The police had been involved in previous incidences of intimidation to gain funds for his drug habit. However, there was a reluctance on the part of the grandfather to press charges for fear of criminalising his grandchild. The vulnerable adult Social Work team would not accept a referral on the grounds that he was not a recipient of any other Social Care services. Discussions about the grandfather’s presentation bearing similarities to being a victim of domestic violence were not listened or heeded to.

OPMHS also shared examples of exploitation by neighbours and there were reports of taxi drivers who were more than willing to purchase alcohol and deliver it to the home - with one drug and alcohol professional encountering a taxi driver in a bed-bound client’s bedroom, highlighting just how vulnerable and at risk both parties can be.
Recommendation: To safeguard the vulnerable, the Road Traffic Licensing Committee could consider introducing training for current and prospective taxi drivers on how to deal with moral dilemmas, such as purchasing alcohol on behalf of the vulnerable and the elderly.

All drug and alcohol professionals have cited frequently having to call upon the police to conduct welfare checks on individuals - particularly those who live alone, were unresponsive to any type of contact and at high risk of harm.

**Malnutrition**

There were several reports of older clients choosing alcohol over food and other well-being items. Some clients would appear undernourished and underweight. This has potential to lead to very significant other health problems including vitamin deficiency, peripheral neuropathy damage and much more.

**Isolation**

There was general consensus that older substance users were generally very isolated and many had lost or had minimal contact with family members.

The GENACIS survey noted that:

> “By the 75 and older age group, over 40% of the respondents described themselves as widowed.” *(GENACIS, 2014) (12)*

**Falls and accidents**

Many cited falls and accidents as being highly indicated in older clients. Quite often, the only way a substance issue was detected was after a hospital admission for a fall or similar. This ‘crisis point’ might be the first time that a substance issue has been highlighted or addressed with an individual. The GENACIS study revisited in 2014 noted that:

> “One thing is clear, if an older person does fall, the increased risk of broken bones, due to Osteoporosis and the longer healing times will also place a financial burden on the health service as well as issues of blocking beds which cause so much concern in many hospitals.” *(GENACIS, 2014) (12)*

One questionnaire respondent noted multiple problems from “Soft tissue injuries, due to falls, *(through to)* all round reduced medical outcomes and continence issues.”

**Treatment data (IOM)**

In response to a Freedom of Information Act question, the DHSC were able to provide data on the number of patients who successfully completed alcohol treatment over a 12-month period. *(40)*
Relating purely to the Drug and Alcohol Team this showed that between 1 Jan 2016 to 31 Dec 2016, 11 patients were discharged as either ‘completed alcohol treatment’, ‘situation improved or resolved’ and did not re-present within a six month period.

Motiv8 analysed their discharge figures for the over 50 age group and found that, for the period April 2016 to March 2017, 16 patients were discharged as ‘treatment complete’, and 12 were discharged as ‘situation improved/resolved’ – only 3 clients re-presented within a six-month period.

There is research that shows that older people, particularly who are suffering from late-onset substance issues, can often fair very well and will engage in treatment. *(Wadd, S, 2014)* *(10)*

**Mortality attributed to substance misuse**

Early death due to substance misuse is a cause for concern. A report written for Alcohol Concern stated that “While alcohol-related deaths have risen among all ages the 55 to 74-year-old category showed the highest death rates and the steepest rise since 1990.” *(Future proof – can we afford the cost of drinking too much? Alcohol Concern, Professor Martin Plant 2009)* *(43)*

Information from the IOM Director of Public Health Annual Report 2017 revealed that:

“There were 20 deaths from drug misuse on the island between 2013 and 2015, significantly higher than the England average. Over half of these involved opioids and almost one third mentioned alcohol. The majority of drug deaths (80%) occurred in males.” *(5)*

This report also stated that our mortality rate for liver disease that is considered preventable (i.e. through alcohol, obesity or viral hepatitis) is similar to the England average at 12.6 per 100,000 in the under 75’s. *(5)*

**Mental health**

The 2014 Isle of Man Government JSNA highlighted that 7% of referrals to mental health for anxiety were in the over 65’s. Furthermore, for depression this was 16% in the over 65 age group. *(2)*

As these issues are often correlated with substance misuse, it is likely that some of these individuals may be using drugs and alcohol to cope. *(2)*

“The number of people aged 60 to 74 admitted to hospitals in England with Mental and Behavioural disorders associated with alcohol use has risen by 150% over the past 10 years. The number of people aged 60 plus admitted to hospital in England with Wernicke’s Korsakoff’s syndrome has risen by 140% over the last 10 years. Admissions outweigh those for alcohol related liver disease.” *(Trends in alcohol related admissions for older people with mental health problems 2002 to 2012).* *(44)*

There were some reports of the challenges in promoting change in those who had become reliant upon prescription medication:
The Royal College of Psychiatrists, on the release of their own guidelines to improve healthcare for older people at risk of the effects of substance misuse, disclosed that in 2012, the 80-84 age group had the UK’S highest suicide rate and that “the baby boomers born between 1946 and 1964 have the highest suicide rates at any age than other generations.” (45)

**Alcohol-related neurological conditions:**

**Special Report by Professor Robin Davidson**

The Public Health England figures of May 2016 indicate the rate of alcohol-related admissions are falling in the under 40s but rising in the over 65s. We also know that the number of 60 to 74-year-olds treated as inpatients for alcohol dependence and alcohol withdrawal has almost doubled over the past decade. Both of these increases far outstrip the growth in the elderly population and indicate that there is a disproportionate increase of alcohol related problems among the elderly.

There is a range of medical problems common among the elderly which are compounded by alcohol, for example gastritis, cirrhosis, cancer, hypertension and depression. Furthermore, the average person over 65 takes 2 to 7 prescription medications daily. Alcohol and medication interactions are especially common among the elderly. 17% of the UK population is over 65 but uses 35% of prescription medication.

It is however not only the physical and medical conditions and drug interactions which impact disproportionately on elderly drinkers but also there are a number of specific neurological conditions which have, until recently, been under reported in this demographic.

Dr T Rao, the distinguished old age psychiatrist, has written that alcohol-related memory problems have until recently been hugely under-reported and often been mistaken for Alzheimer’s. He says that typically Alzheimer’s or depression would have been diagnosed in elderly patients. Now disclosure of their continuing history of heavy drinking would make a diagnosis of alcohol-related brain damage much more likely. The average age of these patients has also reduced. Ten years ago it was people in their mid-70s; It is now those in their mid-60s.

There are a number of alcohol induced neurological conditions normally presenting in the elderly and which until recently have often been missed. The most common are alcohol cognitive impairment and Wernicke-Korsakoff’s psychosis. The latter is characterized by life changing short term memory loss, grossly impaired new learning ability, retrograde amnesia, confabulation and dislocation of events in time.
It is distinct from alcohol induced dementia but both are an increasing source of alcohol morbidity among our over 60s. It is possible that these types of alcohol induced neurological conditions are missed in the elderly because there is a tendency among staff to more routinely diagnose cognitive deficits as Alzheimer’s or multi-infarct dementia. I think this is probably the default position when there is a clear cognitive deterioration in an old person. Furthermore, because old people tend to drink at home and it is not public and there are no obvious adverse effects or dysfunctional behaviour arising from their drinking (that it is less apparent than equivalent drinking in the younger population). Furthermore, an elderly persons drinking may not be routinely enquired about in an examination.

Clearly, research of this nature and a greater understanding among Health and Social Care staff of the possibility of alcohol use among the elderly would increase detection rates. It is particularly important as the baby boomer generation becomes the elderly demographic as there is a tendency towards alcohol and drugs during young and middle age which will be translated into old age.

The most robust prevalence evidence relates to fairly old post-mortem studies, which found that between 0.5 and 1.5% of the general adult population have changes in their brain as a consequence of alcohol misuse. Many are not diagnosed during life and fall into what the Royal College of Psychiatrists Report on Alcohol Related Brain Damage (2014) calls “default circumstances” (such as elderly mentally infirm (EMI) nursing homes) or receive no services at all. In these circumstances, the elderly individual is likely to relapse into alcohol misuse, be readmitted into acute care for withdrawal and stabilisation of their physical condition and is subsequently discharged; and the cycle is repeated.

It is estimated that 35% of those with long standing alcohol dependence will exhibit post-mortem evidence of Wernicke–Korsakoff syndrome or cerebellar atrophy.

These are UK figures but it is unlikely that it is any different on the Isle of Man. If anything, it may be a greater hidden problem given our higher per capita alcohol consumption than some parts of the UK and our older population.

If we extrapolate these percentages to the over-18 adult population of the Island from the 2016 census data, then somewhere between 345 (0.5%) and 1381 (2%) of adults could have changes to their brain as a consequence of alcohol misuse.

All of this points to a large cohort of older, heavy drinkers with neurological deficits remaining unidentified, undiagnosed and without evidence-based appropriate care.

**Domestic abuse**

There were some reports of historical as well as current domestic abuse. Some contributors wondered whether the older generation would understand that what they were experiencing or had experienced
was, in fact, domestic abuse. Therefore, they may not feel able to disclose such abuse and would be less likely to remove themselves from that situation.

**Anonymised Example – Family Member/Domestic Violence**

Lady in her early 60’s. Her husband, to outsiders, was a charming man, however this hid the true fact that when alone at home she was subjected to domestic abuse. This took the form of some physical violence and a lot of emotional abuse, including controlling behaviours and constant undermining of her self-esteem. Her husband drank heavily. This lady felt utterly humiliated and because it was a second marriage ‘later in life’ felt that she could not leave and thought friends and family around her would judge her and think her stupid for making such a mistake.

“In the IOM GENACIS study of those reporting incidents of violence, women were slightly more likely than men to report that their current partner had been the perpetrator. It is noticeable that in those aged 55 and older all those reporting such incidents were still living with the abusive partner. This may be another incidence where it could be worthwhile to look at bit more closely at older people attending A & E presenting with falls or walking into doors.” *(GENACIS, 2014)* (12)

The GENACIS study noted that in the age group 65-74 “around 7% of respondents reported being injured or injuring another due to their drinking.” *(GENACIS, 2014)* (12)

**Self-neglect**

Some individuals were noted to pay less attention to their personal care, with examples of poor hygiene and infrequent changes of clothing. Bed wetting and continence issues were also frequently cited as issues which affected personal care. This could also extend to the home environment with many examples of home visits by professionals witnessing very poor living conditions. OPHMS noted:

“We have come across quite a few where, of course, the alcohol takes over and they lose interest in the house.”

This sometimes led to a cost implication for social care as homes became health risks, sometimes to the point of being uninhabitable, and requiring the employment of cleaning services.
Even in a care setting, a care home manager noted that:

“Alcohol dependent clients would not wash and would refuse to change their clothes” with “residents not having any interest in their personal hygiene as a result of being intoxicated. Residents who are fully independent sitting urinating themselves and refusing to get washed.”

Anonymised Example – Early Onset/Physical Complications

Lady in her mid-50’s who self-referred on the advice of her GP – and with some persistence from her daughter! She appeared frail, underweight and lacking in some personal care – also presented as far older than her years. She was quite isolated and at times appeared to have some cognitive issues. She rarely presented at the service in person and subsequent contact was by telephone. We became very concerned for her health when she talked of a persistent infections. With the help of her daughter she got a rapid GP appointment, at this appointment her GP immediately referred her to Nobles as she was jaundiced. There ensued a lengthy hospital stay at which point OP Social Worker became involved. After a brief period of respite and a deterioration in her health she was again hospitalised. The decision was then made for this lady to be placed in long-term residential care at a relatively young age.

Financial issues

The economic downturn led some respondents to comment that more people they saw now drank in the home environment as opposed to the pub. With cheaper supermarket deals and the secretiveness of home drinking, this could lead to increased consumption. Taking this into account with other risk factors is concerning. A health professional noted that we have more risk factors on the IOM if you take into account: “Overlaying substance use with (the) economic downturn, and different Island demographics and the baby boomer generation.”

The Chief Constable noted in his opening address for the Triennial session that:

“There is always a danger that financial pressures (in the trade) will lead to the bottom with evermore aggressive price reductions, accompanied by new ways of marketing will lead to a diminution of standards.” (46)

A drug and alcohol professional noted:

“At one end of the spectrum the Island has attracted many older people here to retire and with that cohort of individuals, where money is no object, the lifestyle often involves heavier drinking.”
As one ex care worker noted:

“I looked after wealthy people that had retired, aristocracy, they still lived like they were in the colonies, when they had their Gin and Tonics with nibbles, wine with dinner and night caps. I would put many people to bed at night very unsteady on their feet.”

For others who were on limited means alcohol is very affordable and accessible. However, with an alcohol problem, alcohol could be prioritised over essential items including food, utility bills, and so on. The Island has a higher cost of living and it could be fair to say that some older substance users are falling into this bracket of fuel and food poverty. Graih the homeless charity, supported many older clients with supplementary food.

**Chronic physical problems**

The physical health issues facing older people are vast and complex. Respondents were keen to discuss Hepatitis C, liver function, diabetes, strokes and pancreatitis amongst others. A drug and alcohol professional noted that:

“There was no treatment for Hepatitis C on the Island. Folk will be living longer term having developed it in their 20’s and 30’s. It takes 20 years to develop secondary problems including cancer and liver failure.”

A medical officer also noted that Hepatitis C sufferers “Could have liver problems, dementia, cognitive impairment because of the toxins, depression and psychosis.”

**Behavioural change when intoxicated**

A care home manager noted that:

“Alcohol misuse could cause some individuals to become verbally aggressive towards staff and this was a challenging management issue.”

Aside from cognitive damage, which is discussed in a separate chapter, it was noted that dealing with and managing intoxicated individuals was a challenge all-round for many respondents.

**Cognitive issues**

A Consultant at OPMHS also spoke about a condition called Mild Cognitive Impairment (MCI), this is a condition in which someone has minor problems with cognition – worse than would normally be expected for someone of their age – but not with severe enough symptoms that interfere significantly with daily life and thus not defined as dementia.
They stated that MCI can have an alcohol-related component to it and this will be asked upon all assessments. On a positive note, he has found that individuals diagnosed with MCI are often very receptive to making lifestyle changes that would reduce any further decline in cognition – and alcohol can be addressed as such.

* Also see chapter by Professor Robin Davidson *

**Impact on the family**

Often, family members have to deal with older people in the first instance and the strain can be difficult with extra carer responsibilities and demands. These family members themselves can often end up with physical and mental health problems because of the stress of living with or caring for a relative in this situation. This was made worse if the problem user was not receptive or willing to change. Some respondents felt that services did not intervene or support enough. However, some service providers thought families acted as barriers to change due to their own issues of embarrassment, shame and stigma. OPHMS noted that:

“*A lot of the time the drinker has affected the family to the point where they don’t want anything more to do with them and they have been left on their own, so they have become socially isolated and that has maybe caused them to drink more.*”

*It is estimated that 1 in 4 of the GENACIS respondents were concerned about the drinking of a close family member. (GENACIS, 2007) (4)*

Whilst this includes all age demographics, we can be sure that older clients and their families are included in this age group. On the other hand, there were issues surrounding enabling substance misuse, as a care home manager noted:

“*Some families, friends and colleagues bringing in alcohol in spite of being told not to.*”

63
Impact on crime

Data requested from the IOM Constabulary revealed some very useful findings on alcohol and drug arrests in older people. (47)

55 to 64 and 65 and over groups particularly relating to arrests for alcohol and drug related offending.

Time period reviewed: 2014-2016 (three years). There are no obvious trends over the last three years (the numbers of arrests each year are roughly equal). (47)

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<th>Alcohol Arrests</th>
<th>&lt;55</th>
<th>55-64</th>
<th>65+</th>
<th>Total</th>
<th>% of arrests</th>
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<td>785</td>
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<tr>
<td>All Arrests</td>
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<td>187</td>
<td>77</td>
<td>4080</td>
<td>93.5% 4.6% 1.9%</td>
</tr>
<tr>
<td>% Alcohol involved for age group</td>
<td>48%</td>
<td>57%</td>
<td>56%</td>
<td>48%</td>
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</table>

Typically less than half of all arrests are noted as being alcohol related. However, in 55-64 and 65+ ages groups the proportion is slightly higher than 50%.

It can be stated that of the alcohol-related arrests, the proportion of arrests for the particular arrest reason of being Drunk and Incapable is around three times higher in 55-64 age range than in other age ranges (20 arrests of 106: 11% for 55-64, 150 of 3816: 3% for <55)

<table>
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<tr>
<th>Drug Arrests</th>
<th>&lt;55</th>
<th>55-64</th>
<th>65+</th>
<th>Total</th>
<th>% of arrests</th>
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<td>76</td>
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<tr>
<td>All Arrests</td>
<td>3816</td>
<td>187</td>
<td>77</td>
<td>4080</td>
<td>93.5% 4.6% 1.9%</td>
</tr>
<tr>
<td>% Drug reason arrests for age group</td>
<td>19%</td>
<td>5%</td>
<td>1%</td>
<td>18%</td>
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</tr>
</tbody>
</table>

Typically almost one in five of all arrests are noted as being drug related. In 55-64 and 65+ ages groups the proportion is much lower. (IOM Constabulary)

One third sector professional went so far as to say that drug use was kept under the surface in the IOM because “we want everybody to believe that we live in this lovely little safe haven, no crime, no drugs and we have all bought into that.”
The figures for older people are particularly worrying and they replicate the findings of the Strategic Needs Assessment which found dangerous levels of alcohol abuse, particularly amongst middle aged and elderly men. The societal and health dangers are considerable and much needs to be done if this is not to become a very real problem.

Drug arrests for over 55’s were much lower. However, there was anecdotal evidence of drug driving being an issue in this age group. This related to unintentional driving whilst unfit due to prescription medication etc.

The Drug Arrest Referral Scheme/Alcohol Intervention Referral Scheme

The Drug Arrest Referral Scheme, a joint initiative between Motiv8 and the IOM Constabulary, showed 4 arrests for Cannabis and 1 for Mephedrone for the over 50’s. This was out of a total of 236 referrals since October 2014.

Another scheme run by Motiv8 and the police is the Alcohol Intervention Referral Scheme. Initially, the scheme was set up deal with 18 to 24 year olds as they presented in the greatest number. However, the scheme has now opened to all age groups so over 50’s are included.

The referral scheme deals with alcohol-related first time offences only and those of a ‘lower level’ nature, such as Drunk and Disorderly and Drunk and Incapable – it does not include offences such as domestic violence or drink driving. From 2014 to August 2017, 6 over 50’s and 2 over 60’s attended and completed the AIRS course.

Data on offending from further afield has highlighted “an increase of 41% across 2000 to 2009 in convictions in people aged 65 and over for drink and drug driving. Compared to a decrease over the same period for people below this age range.” (DrugScope, 2014) (31)

New drug drive legislation came into effect in March 2015. This set limits at very low levels for 8 drugs commonly associated with illegal use, such as cannabis and cocaine, but also included 8 prescription drugs. The THINK! campaign aimed to remind drivers of their responsibility to take medication correctly.

There was concern about drug driving and the lack of awareness in this and other age groups about the impact that this has on an individuals’ ability to drive safely. As some research has highlighted that “Benzodiazepine use impacts on cognition, mobility and driving skills and they increase the risk of falls.” (National Institute of Health, 2014) (48)

Recommendation: Campaign to remind older people taking medicines to check with their doctor or pharmacist before getting behind the wheel (THINK! campaign UK – posters on the IOM govt site)
Barriers to Change and Accessing Services

Stigma

Living on a small Island led some to suggest that addiction is often hidden. As one drug and alcohol professional put it:

“The stigma associated with dependency in an older person is an important feature to consider.”

One online survey respondent noted:

“I feel the barriers concerned with older people (are) coming from a culture of personal pride, and embarrassment about seeking professional help.”

It was also reported that for some:

“There was a lack of understanding about what may be involved, a fear of services and the outcome.” For example, “losing independence and being put into a care home.”

There was sometimes a feeling that support could be denied by the wider family as much as the individual, with examples given by the ‘Live at Home’ schemes. It was felt that families might be too embarrassed for services to become involved with their substance-using relative.

Some noted that with age came “limited hope, coupled with habit and cultural norms and a fear of change.” There were reports about how older people found it difficult to navigate services and a fear of authority, with some older people not being good at asserting their needs.

There was some criticism of the ‘gate keeping services’, particularly mental health, being “stripped back so far”, with a suggestion that access was limited to the most acute cases therefore (they were) “missing out on early intervention opportunities” and a “feeling that the eligibility criteria for accessing services becomes stricter when services are under threat.”

Another third sector professional went on to say that:

“There is a dominant narrative that certain clients are too messy and services don’t have time and resources etc. People become very aware if they think they are being a burden to services or to people. Services just want them discharged.”
It was also thought by criminal justice professionals that the media is not helpful towards sufferers of alcohol and drug problems and irresponsible reporting could lead to a lack of engagement by some. This was highlighted in our Pathways to Addiction research as a potential barrier to someone accessing help.

**Professional ambivalence**

For some who had previous involvement with the Criminal Justice System, or multiple emergency service involvement having an historical record for offending or call outs from emergency services, could lead to further withdrawal and isolation. Some of these individuals could be seen as being resistant to change and therefore less likely to engage, with some experiencing an intolerance towards them by professionals: A Motiv8 staff member noted that “There is a sense of some professionals being ‘burnt out’ with blue light clients.”

“There was a common belief amongst those interviewed that some professionals imposed their own values and held the view that “there was no point of changing in older age.” With attitudes such as they’re old/let them crack on/they’ve earned it. This attitude meant that some older people could suffer prolonged problems of a physical and psychological nature.

Some professionals noted it was difficult to raise the subject of substance misuse and this also acted as a barrier. “From my point of view, I would hate to go into someone’s house and teach Granny to suck eggs.”

**Recommendation: Harm reduction work for change resistant older people (blue light project – see Pg.77)**

**Evidence based drug and alcohol policy**

Political will and a lack of evidence based alcohol policy was suggested by some as a local issue. One drug and alcohol professional noted:

“It’s a cultural thing. It’s also a political thing, they could actually help by minimum pricing per unit. It would reduce harm in a moment, there are lots of population studies to support this idea.”

It is important to note that ‘cultural shifts’ in attitudes towards drugs and drug laws are becoming evident. The Positive Action Group hosted a talk by Professor Knutt, ‘The truth about drugs’, with a scientific discussion on the relative harm caused by legal and illegal drugs. More recently Chief Constable Gary Roberts has called for a ‘scientifically-based debate on drugs and drugs law ‘ (IOM Examiner, 18th July 2017) (49) and Dr Alex Allinson, MHK for Ramsey, has called for the legalisation of cannabis for medical purposes. Meanwhile, the Positive Action Group invited representatives from TRANSFORM – exponents of drug legalisation - to the Island with a presentation on ‘Safer Drug Control’ in April 2017.
However, the recent release of the July 2017 Drug Strategy by the UK Home Office makes it very clear that “we have no intention of decriminalising drugs. Drugs are illegal because scientific and medical analysis has shown they are harmful to human health. Drug misuse is also associated with much wider societal harms including family breakdown, poverty, crime and anti-social behaviour. We are aware of decriminalisation approaches being taken overseas, but it is overly simplistic to say that decriminalisation works. Historical patterns of drug use, cultural attitudes, and the policy and operational responses to drug misuse in a country will all affect levels of use and harm.” (11)

Whilst the debate continues, it is fair to say that our current policies are being questioned by those that work within this field.

Cost and Accessibility

Alcohol was cited as more affordable nowadays and over-the-counter preparations such as codeine were also lower in price. It was noted that older people who had developed substance issues were more likely to be purchasing in off-licences and supermarkets where it was more affordable, as opposed to licenced premises.

Lack of detection and signposting

A lack of public health campaigns and multi-agency working was also cited as leading to a lack of understanding about what constitutes a substance misuse problem in the general population, leading to people being missed.

It was also noted that some professionals were trained to pick up on the subtle signs of substance issues. However, not all were trained, so signs and indicators could be missed. It was not noted to be a problem until crises point and then emergency services involvement was often needed. Furthermore, not detecting problems could lead to a lack of signposting people correctly to services.

Also, austerity measures were affecting all manner of services, with one third sector contributor noting that opportunities to detect problems in the earlier stages are less likely now and gave the example of “wardens in sheltered accommodation not doing visits anymore.”

**Recommendation: More befriending style interventions which give rise to earlier detection**

Service design

It was felt that service design was also a barrier, with services being more geared towards younger people. An older persons’ worker noted:

“there has been very little in the past for us to refer to for older people.”

The DAT waiting room was felt to be not very conducive to engaging older people. It was seen as being a potentially ‘off putting’, busy place and more the domain of younger clients attending for medication appointments.
It was noted that drug services could be challenging environments at times, which would certainly not be the ideal environment for older and indeed vulnerable clients. As one professional commented:

“Imagine an 85-year-old coming in when there are the drug clinics and all the nonsense that can be going on.”

Also, the traditional ways of engaging with older people such as day centres were felt to be “old hat” and not what this generation want anymore. Examples such as the ‘Men in Sheds project’ were frequently quoted as being more appealing.

It was felt though that there is still a distinct lack of community-type interventions that older people may want to engage with.

Recommendation: Drug and alcohol and public health services to increase professional and public understanding of the roles of services and increase assertive outreach approaches

**Why Change?**

Life debilitating circumstances were often felt to be a barrier to change. Experiences such as bereavement, ill health, loss of hope for future opportunity, depression and low mood were commonly cited by many of those interviewed as leading to a lack of motivation to change – with professionals subsequently struggling to work with these client groups.

**Capacity**

There was some reporting that older people with significant dependency problems were often too intoxicated and incapable of being assessed for support of any nature. Therefore, meeting their needs with an adequate assessment was often impossible, as many required clients to be sober or relatively sober in order to assess need or mental state.

**Transport**

Transport links and physical access for appointments was highlighted by many as an issue. An older person’s worker noted:

“If everyone had to come to a clinic like you have to in Nobles then 50% of our clients wouldn’t come.”
An older person’s worker also noted:

“Sometimes it can be physically hard getting to a place when people are living on their own, are isolated and don’t have transport.”

### Accessing support

The way services advertise and operate referral systems could be seen as a barrier for older people who were suffering from a variety of issues. A Live at Home professional noted:

“Hearing, sight and cognitive problems mean that people are sometimes not confident to talk about their issues.”

Also, third sector professionals noted that:

“Some older people are not savvy enough about how systems work and how you get referred” and also that it was, “knowing who to contact in the first place.”

This aspect was also highlighted in the Pathways to Addiction research:

“Although addiction services such as Motiv8 and DAT did advertise, several participants said for a long time they had not heard of them or had known next to nothing about them. Some participants might have benefitted from earlier support, especially for alcohol addiction which often continued for decades before they sought help. There were some participants who were prompted by professionals such as GP’s and probation officers to get help and who benefitted from it. The police and courts might consider referring people arrested for or convicted for alcohol and drug related offences to support services, possibly as an alternative to prosecution in minor cases.” (This does now take place in the form of DARS and AIRS schemes) *(Pathways to Addiction, Pg. 56)* (29)

**Recommendation:** Do services change how they advertise or signpost older people into services? Are services acting as a barrier and should we be more creative about how we attract people to engage in support?
**Current service provision**

One drug and alcohol professional commented via the questionnaire that:

“There is a hidden population of older female drinkers on the Isle of Man. We see only a small fraction of people and are at present geared to young adult patients. We have one worker who devotes a bit of her time to older persons work. A proper needs assessment is required.”

Many people who contributed to the online survey felt that services were not adequately equipped and that having dedicated provision for older people might help to attract clients in and give a strong message that older substance abuse DOES happen.

One contributor noted that:

“The demographic shift doesn’t seem to be planned for in services. Accommodation and care seem to be the biggest problems.”

Another commented that they were concerned that:

“In terms of specific services and working together to create a support network, I’m not aware of any strategies or networks that are specifically preparing for an older generation.”

There was a fear that in the future, services across-the-board are tending towards online access and this may not be appropriate for older people.

**Lack of awareness of what constitutes a dependency**

There was strong feeling amongst contributors that a lack of understanding about dependency on any substance existed not only with sufferers but also professionals. This in turn acted as a barrier to even considering using the services currently available. Also, when clients did make it to services confusion could remain:

“I think that’s the problem we have for those who have been referred for prescribed medication. Firstly, it’s not explained why it’s an issue and secondly, they think their medication is going to be removed and thirdly, they don’t realise they are dependent.”

(Questionnaire respondent)
Community support mechanisms

One contributor with vast experience of the third sector suggested that “far more could be done if services shared resources”. For example, he suggested that there were mini buses lying unused that could be utilised across third sector organisations.

“I would like to see a network of mini buses, being used throughout the community to help people get out of the house and become more active.”

There was a feeling from many contributors that more inventive methods could be employed to attract older people into contact with services.

Another suggestion was “community premises” which could be used in an integrated fashion and have a multipurpose remit where all sections of the community could utilise the facility.

It was discussed that there were many organisations in our community for the elderly, for example, Manx Retirement Association and the University of the Third Age, and these could possibly work together more closely to improve services for the older generation across a range of health outcomes.

Recognitions of early signs

It was felt that people in their late 40’s and 50’s could be targeted more and that early preventative strategies were lacking. The connection between alcohol, substance misuse and general health (e.g. hypertension, strokes, diabetes, heart disease and many more health problems attributed to poor health lifestyle choices) was felt to be underreported, and not the subject of local health campaigns. The ‘GENACIS revisited’ report of 2014 noted that there was a role for primary health care clinics and other settings where older people are more likely to come into contact with professionals:

“The obvious ones are A & E, well man and well woman clinics, but what about other ones, such as Chiropody services, and Osteoporosis screening for people who are older and maybe more isolated.” (GENACIS, 2014) (12)

Whole-care approach

It was felt that substance misuse was only the ‘tip of the iceberg’ and should not be seen in isolation. Older people often had a range of challenges facing them in their own personal lives from mental health to well-being, and services needed to respond to the holistic needs of the person.
A Motiv8 professional commented that:

“I think as a service we help older people regarding their drug or alcohol use but we need to work jointly with other services to facilitate a whole-care approach in terms of addressing any other issues the client may have, such as; mental health, socialising, routines, hobbies and general life-fulfilment.”

Reducing stigma and increasing engagement

It was felt generally that more could be done with public health messages around substance misuse that hopefully could reduce stigma and increase the likelihood of older people wanting to engage in services, if the need arose. A well targeted campaign, with the support of the media, that made it okay to ask for help, recognise a problem developing and awareness about what constitutes dependency could go some way to improve engagement.

Recommendation: Targeted public health campaigns for this population group

Workplace campaigns and the ageing workforce

It was noted that lots of companies and retail giants, due to full employment and people needing to work longer to collect a state pension, were employing older individuals. There were examples from older persons’ professionals giving talks to retail operators about signs and indicators of dementia. It was suggested that this model could be used to improve workplace education of substance misuse in later life. OPMHS gave a good example of approaching a large supermarket as they were aware that they employ a lot of older people, and they went in and raised awareness about dementia. It was noted that Marks and Spencer’s and Tesco had been very supportive of these types of campaigns.

Multi-agency retirement training

One contributor close to retirement had recently completed the Government retirement programme and had noted that lots of subjects were covered, apart from alcohol and drugs.

The importance of campaigns was resonated by another contributor who noted:

“you do 37.5 hours a week and then you suddenly retire, how do you fill that day? Alcohol then can help them to fill that day.”

It was not generally known or acknowledged if other companies did retirement training and that perhaps public health could play a role with a targeted campaign on transitioning to retirement.
It was felt that there was not enough emphasis on preparation for the challenges of getting older.

Recommendation: Retirement planning programmes in the general population, preparing people for retirement and including substance education in this

Improving responses for this age group

The following extensive list was considered as a way forward in improving responses for this age group:

- One drug and alcohol professional noted:

  “All health professionals, regardless of what tier of care they are in, but particularly primary health care, should have a basic education or understanding of substance misuse.”

- There was concern noted by third sector professionals that in the future there will be more demand with older people who misuse substances:

- One 3rd sector professional spoke about a service in another jurisdiction that connected older people through one central service or source which provided information. They felt that what was needed was to work more effectively together and there was a sense that resources were not always shared.

- Some care professionals felt more places for older people to socialise was important, as loneliness was a key factor for many individuals.

  “There will be more demand on the statutory services as they will have more complex needs after decades of drug taking and alcohol use.”

- There was also concern from care homes that not enough was being done to anticipate the future demand for specialist beds for Korsakoff’s/ARBD patients.

- For managers working in the private nursing homes, some felt they were quite alone with the issue of managing alcohol misusing residents and had limited support from their upper management.

- OPMHS was seemingly already under pressure with an extremely high volume of referrals, a caseload of 700+ individuals in 2017.

  In May 2014, it was reported by the DHSC that they had a caseload of 647 and one of the key challenges for the department was in relation to supporting people with a dementia diagnosis. This report also suggested that in the next 9 years there will be a 29% increase in the prevalence of dementia in the IOM population.

- A Consultant at OPMHS expressed some concern about the overall volume of ALL patients in the future and acknowledged that the current system for looking after some individuals with Korsakoff’s
was extremely costly. This type of care is very specialist and sometimes only an off-Island placement is suitable. They also felt that there was a place for either a care setting or a care system within the community for ALL Acquired Brain Injury cases, especially as was noted before it is not always appropriate for these cases to be in an ‘older persons’ care home.

Types of services that would benefit this group of people

Many participants had suggestions on what would improve service provision. One very succinctly talked about needing to;

“work jointly with other services in order to facilitate a whole care approach in terms of addressing any other issues the client may have such as mental health, socialising, routines, hobbies and in general, life fulfilment.”

Other suggestions included:

- Older Persons’ outreach provision within Tier 2 addiction services
- Home visiting service
- Age-appropriate social activities and groups that are needs driven
- An Older Persons’ Champion, who could for example:

  “Introduce screening into Primary Health care, specialist health campaigns and more training in prescribing. It’s not just about the older people who are dependant but the middle group who may have harmful or hazardous use. Nothing is happening though at the moment and it is a failing.”
Best Practice Example – Drink Wise, Age Well

The Drink Wise, Age Well project is a UK-wide lottery funded project that aims to influence and inform policy and practice in preventing alcohol-related harm amongst people aged 50 and over. The project has used extensive research to inform how best to engage with this group of people and has included:

➢ Community level public awareness campaigns
➢ Diversionary activities and social activities
➢ Volunteer befriending
➢ Pre-retirement training
➢ Resilience training
➢ Peer education programmes

They also look at providing training for non-specialists on how to identify and respond to later life alcohol problems, brief advice, fire safety checks and adverts in local media. In terms of treatment and prevention, the project aims to:

➢ Dispel the myth that older adults are too old for treatment
➢ Providing age sensitive treatment
➢ Screening for cognitive impairment
➢ Engaging older adults in planning and delivery of treatment services
➢ Home safety checks
➢ Providing interventions for family where older adult won’t engage

The Drink Wise, Age Well website offers a wealth of research, help and information to both individuals and professionals: www.drinkwiseagewell.org.uk

(Taken from Sarah Wadd’s conference presentation, Isle of Man, 2016) (50)
Best Practice Example – Blue Light Project

The Blue Light project is Alcohol Concern’s national initiative to develop alternative approaches and care pathways for treatment resistant drinkers who place a burden on public services. It is supported by Public Health England and 23 local authorities across the country.

The perception exists that if a problem drinker does not want to change, nothing can be done. This is untrue and has not been true since the early 1980s.

This group of drinkers places a huge burden on public services and is a key contributor to a range of issues from emergency hospital admissions and readmissions to crime and disorder.

In an average area high risk treatment resistant drinkers number at least 450 and will cost public services a minimum £12.5 million per annum

The project challenges the traditional approach and radically changes the working agenda by showing that there are positive strategies that can be used with this client group.

The project has delivered improved ways of working, risk assessment tools, advice on crucial nutritional approaches which can reduce alcohol related harm and ways to help non-clinicians identify potential serious health problems and deliver enhanced personalised education.

This has been drawn on a national and international evidence base and has been peer reviewed both by workers at a local level and clinicians within NHS England and Public Health England.

Research shows that these clients are not as unmotivated clients as they seem. At least 40% of higher risk and dependent drinking clients will try and change each year. The blue light project provides the tools for building on this.

(Taken from Alcohol Concern’s website, originally published on 5 August 2016) (18)
Recommendations

➢ The IOM could include drug ‘mapping’ of older drug users (the ACMD has established a working group to map the numbers of older drugs users in the UK and draw on UK and international evidence to establish the current and future needs of this cohort.)
➢ Charity regulator/Commission (UK model)
➢ Impact assessment on removing services for O.P. (eg. meals on wheels)
➢ Further supervision (of prescription medication) should be in place for older people who are known to have substance issues
➢ Perhaps GP surgeries could, with input from other agencies, formulate withdrawal/cutting downs plans with support to be put in place through practice nurses or similar before removal of drugs older people have been prescribed long term
➢ The RTLC consider introducing training for current and prospective taxi drivers on how to deal with moral dilemmas such as purchasing alcohol on behalf of the vulnerable and the elderly and dealing with older vulnerable adults/safeguarding.
➢ Campaign to remind older people taking medications to check with their doctor or pharmacist before getting behind the wheel (THINK! campaign UK – posters on the IOM govt site)
➢ Harm reduction work for change resistant older people (blue light project)
➢ More befriending style interventions which give rise to earlier detection/Training for befrienders
➢ Drug and alcohol and public health services increase professional and public understanding of the roles of services and increase assertive outreach approaches.
➢ Review of age-appropriateness of current services and pathways into support?
➢ Targeted public health campaigns for this population group e.g. Drink Wise, Age Well as an example of good practice
➢ Retirement planning programmes in the general population, preparing people for retirement and including substance education in this.
➢ Introduction of screening at A & E/Nobles
➢ Introduction of brief interventions at A & E/Nobles
➢ More intelligence gathering/systematic data collection needed, for example:
  ▶ Collection of alcohol and drug-related data at A & E department
  ▶ Review of alcohol/substance-related cases seen at OPMHS
  ▶ Review of alcohol/substance-related old person’s admissions and outpatient’s appointments at Nobles
  ▶ Review of alcohol/substance and mental health cases as admitted at Mannanan Court
  ▶ Review of drug and alcohol treatment services data to ensure relevance
Conclusion

Whilst there is a growing body of research and evidence from the UK and further afield about older people and substance issues, it has been extremely interesting to gain a local perspective from professionals who work on various levels with this group. From the third sector, to criminal justice, mental health, care homes, substance misuse to those at more policy level, we feel we have been able to understand far more about how people are feeling about this issue both at a current and future level.

Whilst there is an acknowledgement that this is a somewhat hidden issue at times, it has become clear that workers are encountering this group and have very real and relevant concerns about them. This is reflected in their views on both how these individuals present and how complex their care can be to how the Island could perhaps be ‘future proofing’ this group through the likes of:

Certainly, there are obvious funding implications for some of the ‘wish list’ of services or activities that professionals would like to see and areas that improvement might be made. However, we feel that if a working party could be formulated to start looking at the areas that have been highlighted as possible recommendations then this would be a very positive start for the Island as a whole. If we are to avoid the consequences of ignoring this potential ‘silver tsunami’ then any action taken now would help professionals and services work together to address this often complex need.
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