



# Calling Time

Addressing ageism and age discrimination in alcohol policy, practice and research



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**Rather than dismiss age as an irrelevance, any more than one should dismiss a person's gender, ethnicity, religion or other personal characteristics, we should respect it.**

**There is not only a moral imperative for this to happen but also a pressing business need as more of us progress into later life.**

Royal College of Psychiatrists, 2009

”

# Foreword

**When we think about harmful drinking, the images conjured up are often of the homeless “alcoholic” on the street, late nights, hangovers, football fans, stag parties, missed work, or binge drinkers.**

In fact, many youngsters have heeded advice, favour the gym or sports field over the pub, and have been brought up never to drink and drive. Indeed, the only age group where drinking has increased is the 65-74 year old. So our consideration, and prevention of problem drinking has to turn to the retired, or those who'll approach it over the coming years.

At a personal level, this may mean replacing the bottle of booze as a Christmas present to our older friends and relatives.

More widely, it means focusing on what improves the physical and mental well-being of the old, the cause of loneliness or falling self-worth, and at identifying risk factors and early symptoms. And it means a more holistic approach to the needs of this age group. Attitudes to older adults – discrimination is not too strong a word – means that services are failing them, blind to their needs and rights.



Through consideration of case studies and research on older people and drinking, and some approaches to policy on prevention and services, Drink Wise, Age Well has drawn up guidance and recommendations for a swathe of organisations and professions, providing a vital tool in promoting health, happiness and a productive retirement for a growing generation.

*Dianne Hayter*

**Baroness Dianne Hayter**  
November 2017



# Acknowledgements

**This report includes research from the Substance Misuse and Ageing Research Team (SMART) at the University of Bedfordshire and the International Longevity Centre – UK (ILC-UK). The first chapter contains evidence collected by SMART on current ageism and age discrimination in alcohol policy, practice and research. The second chapter contains research from ILC-UK on age discrimination legislation and policy in the UK, with examples of positive practice.**

We would like to thank a number of colleagues for their contribution and assistance in the writing of this report.

Firstly, we would like to thank **Julie Breslin**, Head of Programme, Drink Wise, Age Well for her support and guidance throughout the process.

We are very grateful to **Maureen Dutton**, Public and Expert by Experience Researcher (PEER) at the University of Bedfordshire Substance Misuse and Ageing Research Team (SMART) for her focus group facilitation and all the Drink Wise, Age Well service users who participated in the group.

Huge thanks must be given to all our colleagues across the UK who responded to our on-line survey sharing their knowledge and expertise, in particular **Elsa Browne** from Substance Misuse Management in General Practice (SMMGP) for enthusiastically sharing the survey link.

Thanks also to **Andrew Horne**, **Nancy McLardie** and **Steve Moffatt** at Addaction, **Karl Demian** at Royal Voluntary Service, **Caroline Phipps** at DrugAid Cymru, **Thelma Abernethy** at Addiction NI, **Iolo Madoc-Jones** from Glyndwr University and **Lawrie Elliott** from Glasgow Caledonian University for reviewing an early draft of the report.

Finally we would like to thank our funders – the **Big Lottery Fund** who directly support our work at Drink Wise, Age Well and **Alcohol Research UK** who funded the Substance Misuse and Ageing Team at the University of Bedfordshire to carry out research on alcohol rehabs. This study provided key insight and evidence of how ageism can manifest in practice.

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# Executive Summary

**This report reveals evidence of age discrimination in alcohol policy, practice and research. The findings are based on a survey of professionals, interviews and focus groups with older adults with alcohol problems and a summative review of relevant policy and published literature.**

In Great Britain, the Equality Act 2010 made age discrimination illegal. Age discrimination can either be direct or indirect. Direct age discrimination occurs when a difference in practice or policy based on age cannot be justified. Here we identify various examples of direct age discrimination including arbitrary age limits which prevent older adults accessing alcohol rehabs, younger clients being prioritised over older adults in terms of alcohol treatment, older adults not being offered alcohol treatment because of their age and older adults being excluded without good reason from studies on alcohol. Indirect age discrimination occurs when people from different age groups, with different needs, are treated in the same way, with the result that the needs of people in certain age groups are not fully met.

Examples identified in this report include alcohol services unable or unwilling to carry out home visits for older adults unable to attend the service and alcohol service premises or rooms within the premises inaccessible to older adults with limited mobility.

This discrimination is likely to be due to pervasive misconceptions, attitudes and assumptions based on stereotypes, for example older adults are incapable of change or alcohol problems predominantly affect young people. Older adults may also be discriminated against because of socially ingrained ageism which means that younger people are valued more by society. Age discrimination is rarely a result of malign intentions or motives and people are often not even aware of the prejudices they have.

Whilst older adults may not know that they are being discriminated against on an individual level, older adults that we spoke to felt that in terms of alcohol younger people are prioritised and targeted more, there is more concern for younger people, professionals are not going to “bother so much” with older adults and that younger people are more likely to receive funding for residential treatment because “they think you’re a bit of a spent penny at a certain age”. Both people with alcohol problems and older adults are often assigned a devalued social identity with the result that older adults with alcohol problems may be particularly likely to experience social exclusion and are some of the most vulnerable members of our society.

Older adults have a right not to be discriminated against on the basis of age and ageism presents a major barrier to reducing alcohol-related harm in our population. In the UK, harmful drinking is decreasing across the whole population but increasing in older adults. This pattern is also evident in other countries. Combined with an ageing world population, the shift towards higher levels of drinking in older age groups has profound implications worldwide and the World Health Organisation has identified alcohol-related harm among older adults as an increasing concern.

Ageist policies can be identified easily and abolished in a relatively short period of time. The same cannot be said of more indirect and subtle forms of ageism, for example, unconscious age-based rationing of alcohol services such as alcohol rehab. Age discrimination and increasing alcohol use in older adults is a national priority that requires more than superficial attention and a piecemeal approach. This report contains a set of recommendations that, if implemented, will be a considerable step towards eradicating age discrimination in alcohol policy, practice and research.

**They look at people of my age, “no point”, they’re more likely to put the funding to someone who’s younger... I think they think you’re a bit of a ‘spent penny’ at a certain sort of age.**

“

**Bob,**  
Research Participant



# Introduction

**The United Kingdom is currently experiencing a generational shift in terms of alcohol use. Harmful use of alcohol is declining across the whole population but increasing among older adults.**

In England, those aged 65-74 are the only age group where daily alcohol consumption is increasing.<sup>(1, 2)</sup>

In Scotland, harmful, hazardous and binge drinking is increasing amongst those aged 65-74 but decreasing in other age groups.<sup>(3)</sup> In Wales, those aged 65 and over are the only age group where drinking above the daily guidelines is increasing.<sup>(4)</sup> In Northern Ireland, the most noticeable increases in alcohol consumption in recent years have been amongst those aged 60-75.<sup>(5)</sup> Of equal concern is the population that will soon make the transition into old age. Today, for the first time in recent history, drinkers aged 55-64 in England and Scotland drink more and are more likely to exceed the recommended weekly guidelines than any other age group.<sup>(1, 3)</sup> Alcohol consumption is also increasing in older adults in the United States<sup>(6)</sup> and other European countries.<sup>(7)</sup> The World Health Organisation has identified alcohol-related harm among older adults as an increasing concern.<sup>(8)</sup>

Combined with a rapidly ageing world population, the shift towards higher levels of drinking in older age groups has profound implications worldwide. The four nations of the United Kingdom have set ambitious strategic objectives in terms of alcohol such as a reduction in the number of adults drinking above recommended levels<sup>(2, 10)</sup> a reduction in the number of alcohol-related deaths,<sup>(2)</sup> a reduction in alcohol consumption,<sup>(10)</sup> a reduction in the level, breadth and depth of alcohol-related harm<sup>(11)</sup> and a reduction in harm to individuals, their families and wider communities.<sup>(12)</sup> The World Health Organisation has set a target of at least 10% relative reduction in the harmful use of alcohol by 2025.<sup>(13)</sup> However, without consideration of older adults, these objectives may simply be unachievable.



**One of the greatest challenges to reducing alcohol-related harm in older adults is ageism. In this report we use the following definitions:**

**AGEISM** “A term first used by Robert Butler in 1969, is an attitude of mind which may lead to age discrimination”. It describes existing assumptions, prejudices, and stereotypes about someone’s age.

**AGE DISCRIMINATION** Actions and outcomes related to ageism that can be observed, assessed and compared.

**DIRECT AGE DISCRIMINATION** When individuals are treated differently on the basis of age, despite having the same needs, and this difference of treatment cannot be justified.

**INDIRECT AGE DISCRIMINATION** Equal treatment of individuals of different ages with different needs so that those with particular needs are disadvantaged. Moreover, it can involve a neutral provision, practice, or measure that harms one group or person.

**If ageism leads to discrimination, there are several different forms this can take. These include:**

**INSTITUTIONAL** Written into policy. This can also be at the national, political, societal and institutional level.

**INDIVIDUAL** Resulting from ageist attitudes. At this level, age discrimination may be indirect and covert, but it can be overt as well.

**OVERT** Open, explicit and visible.

**COVERT** Hidden conventions, subconscious attitudes.

Source: Centre for Policy on Ageing, 2009<sup>(14)</sup>

### In Chapter 1

In Chapter 1 of this report, we present evidence of age discrimination in alcohol policy, practice and research.

### In Chapter 2

In Chapter 2, we describe the legislation and guidelines aimed at preventing age discrimination and examples of good practice in tackling age discrimination in health and social care.

Ageism and age discrimination have long been recognised as a significant issue in health and social care but the extent of ageism specifically in terms of alcohol has not yet been explored either in the UK or abroad. This report looks at evidence of ageism in alcohol policy, practice and research focusing on the UK and makes recommendations anchored in the evidence which are in many cases easy to implement with very little demand on limited resources. Any investment that is required is likely to be offset by a reduction of the substantial costs associated with alcohol problems. In doing so, the report has the potential to transform the way alcohol policy-makers, researchers and service-providers perceive and respond to ageism in older adults in the UK and stimulate debate and encourage research in other countries.

# Recommendations

## UK AND NATIONAL GOVERNMENTS SHOULD:

- 1 Develop alcohol strategies which incorporate age as a cross-cutting theme and explicitly recognise that older adults needs may differ from those of younger adults.
- 2 Consult with older adults with 'lived experience', their families and carers, via relevant advocacy groups.
- 3 Following the example of the Welsh Government, convene an advisory panel to develop substance misuse guidance focused specifically on older adults.
- 4 Ensure that the issue of alcohol use in our older population is a key agenda item on national cross and all party groups on alcohol-related issues.
- 5 Deliver on the Northern Ireland Executive commitment to introduce equality legislation for goods, facilities and services that protects people from age discrimination.
- 6 Inform alcohol services of their legal obligation to provide equitable care and take action if services are consistently discriminating against older adults.

## NATIONAL PUBLIC BODIES SHOULD:

- 1 Ensure national prevalence studies which collect data on alcohol include older adults and report key data by multiple categories e.g. young old (65-74 years) middle old (75-84 years) and old old (85 years and over).
- 2 Monitor and report on older adults' access to all elements of the alcohol treatment system when producing alcohol treatment statistics. Key data should be reported by multiple age categories as described above.

## COMMISSIONERS FOR SERVICES, REGULATORY BODIES & FUNDERS SHOULD:

- 1 Ensure that any alcohol services which they fund or commission comply with equality law and best practice.
- 2 Monitor access to alcohol services by age via contract reporting, and review the contracts of providers found to be discriminating based on age.
- 3 Embed checks against age discrimination within alcohol treatment service audits and inspections carried out by regulatory bodies such as the Care Inspectorate and Care Quality Commission.
- 4 Complete a local population needs analysis and where there is a high prevalence of alcohol problems in an older population, commission and fund specialist older peoples' substance misuse services.

## ALCOHOL SERVICE PROVIDERS, PRACTITIONERS & REFERRERS SHOULD:

- 1** Remove arbitrary age limits for alcohol services. Specialist alcohol services for young or old people who have specific age-related needs are acceptable because they are considered to be fair and reasonable.
- 2** Consider carrying out an age discrimination audit, such as that developed by the King's Fund<sup>(15)</sup> and ensure services have a current Equality Impact Assessment with clear actions for addressing ageism.
- 3** Ensure inclusion of people of all ages in the design, planning, delivery and evaluation of services, and make people aware of their right to complain where services are ageist and are not providing equitable access.
- 4** Ensure that all staff are skilled and trained to be flexible and responsive to the needs of service users of all ages and recognise how attitudes arising from stereotypes of older adults may affect their practice.
- 5** Make sure that a decision on whether or not to refer someone to rehab is made on ability to benefit. Age alone should not be a barrier to referral.
- 6** Request a written explanation for decisions not to accept a referral for an older adult. Where there is a suspicion that the older adult has been unfairly discriminated against on the basis of their age, the decision should be appealed.

## THE RESEARCH COMMUNITY SHOULD:

- 1** Ensure that older adults are included in clinical trials and research studies unless there is good justification for not doing so in which case the justification should be stated in all study outputs.
- 2** Ethics committees, reviewers of journal articles and grant proposals should ensure that papers/proposals are rejected if they exclude older adults without good reason.
- 3** Research funders should consider issuing themed calls for research into alcohol problems in older adults.

# CHAPTER ONE

## Evidence of age discrimination in alcohol policy, practice and research

by Sarah Wadd and Rebecca Jones,  
Substance Misuse and Ageing Research  
Team at the University of Bedfordshire.



## AGEISM IDENTIFIED BY PROFESSIONALS AND OLDER ADULTS RECEIVING HELP FOR AN ALCOHOL PROBLEM

We used social media and our professional networks to invite practitioners to take part in an anonymous online survey to find out whether ageism exists and how it might be demonstrated.

We received 152 responses from participants in England (60%), Scotland (24%), Northern Ireland (12%) and Wales (7%). Participants categorised their job role as substance misuse practitioner (52%), health practitioner (9%), social care practitioner (7%), housing officer (1%) and other (31%).

### Frontline professionals had observed:

Older adults being “written off” as too old to change.

A perception that it is not worth intervening with older adults due to potential life expectancy.

A perception that drinking is “part of the parcel of getting older”.

A belief that it is wrong to deprive older adults of their “only pleasure”.

An assumption that alcohol problems predominantly affect young people which means that alcohol problems in older adults are more likely to be overlooked.

### Practitioners gave numerous examples of older adults apparently being discriminated against in terms of their age. These included:

In contrast to younger adults, older adults not offered referral to alcohol treatment, only management of issues relating to alcohol use (e.g. rehydration, vitamin injections).

Older adults less likely to be asked about their alcohol use in health care services.

Younger adults prioritised over older adults in terms of alcohol treatment.

Arbitrary age limits in some substance misuse services.

Older adults guided into generic services as a result of their alcohol problem (e.g. care home rather than rehab or older adults social work teams instead of community alcohol service).

Many participants reported that substance misuse services were unable or unwilling to carry out home visits for those older adults who are unable to attend the service premises. They also described substance misuse services where the premises or rooms within the premises are inaccessible to those with mobility issues.

A significant number of participants felt that some older adults find substance misuse service waiting rooms intimidating, particularly if they are combined drug and alcohol services and that group work can be daunting for some older adults because of “younger more lively clients”. They gave examples of older adults deciding not to attend substance misuse services or dropping out of treatment for this reason.

While many participants gave accounts of substance misuse services which they felt did not meet the needs of older adults, some substance misuse practitioners said that they felt that the services they worked in did meet the needs of older adults. For example, one practitioner told us:

I have worked with many people in the upper age group. My oldest client was 87, I am not aware of any discrimination. Elderly people are treated in a way which best suits them, i.e. home visits etc. if needed.

Professional Survey Respondent

We also carried out a focus group with older adults who were receiving a service from Drink Wise, Age Well for an alcohol problem. Like the professionals who took part in the survey, members of the group felt that some people believe older adults are set in their ways and unable to change. One participant said:

What I believe is a lot of people believe the older generation are far too set in their ways and can't change whereas they possibly think they could make some change in the younger generation.

Focus Group Participant

Another member of the focus group felt workers from the alcohol service had “more time for the younger generation than the older generation”.

Whilst one participant believed that “younger people are prioritised more and targeted more” he added “I don't think we're treated any differently to the young people once we're in the machine”.

Some of the group felt that alcohol services are more likely to advertise in places where younger people tend to congregate rather than older adults because “there is more concern for the younger people and therefore the audience they're targeting is the younger people”.

## SERVICES WHICH ARE NOT ACCESSIBLE OR DO NOT MEET THE NEEDS OF OLDER ADULTS

A study which we carried out with funding from Alcohol Research UK has found that three out of four residential alcohol rehabilitation services in England exclude older adults on the basis of arbitrary age limits.<sup>(16)</sup> In addition, the majority of rehabs have limited or no disabled access, further restricting access to those with limited mobility.

Without access to rehab, older adults are deprived of this important element of the alcohol treatment system. The National Treatment Agency stated that “residential rehabilitation is a vital and potent component of the drug and alcohol treatment system... anyone who needs it should have easy access to rehab”.<sup>(17)</sup> The study suggests that these arbitrary age limits are due to an assumption that the care needs of an older adult will be higher and that their care needs can't be met in a rehab. However, age alone is no predictor of care needs. It is quite possible that the care needs of a 40-year-old will be higher than those of a 65-year-old, especially if someone is experiencing poor health through alcohol related harm.

Up to five generations can potentially reside in a rehab at one time. Some older adults find living alongside younger residents in residential rehabs challenging, particularly if they have to share a bedroom and social spaces.

**For example, one participant told us:**

I haven't shared living accommodation with anyone except my wife and family for 40 years. I've come into shared accommodation and I was in a shared bedroom with a 26-year-old. The 26 year-old, it was like living with a chinchilla. They were everywhere, bounding around. They didn't go to bed until two o'clock in the morning. I got up in the morning, I potted around, they were still in bed. Literally on a number of occasions I turned the mattress so they'd get out of bed.

Darren





Diversions activities organised by the rehabs were often based on physical activities such as mountain biking, caving, kayaking, football and hiking. Some (but not all) older residents found it difficult to take part in these activities with the younger residents and this could create a sense of isolation.

I can't kick the ball in the garden [play football with other residents], that's me walking away and being a lonely person which I'm used to... I don't feel like I belong, I don't belong to being with them, playing or joking and laughing.

Dan

Sometimes it's quite awkward and you try and fit in because you don't want to be like isolated or ostracised or anything, trying to fit in... A load of the boys go hiking, they said "why don't you come with us?" and I said, "I don't think I could walk ten miles", they said "you could try" and I said yes, not to look like I'm keeping away from everything, I said "I'll try, if I can't, I'll have to turn back."

Anne

The study also found that older adults can feel unsafe in rehab and are bullied and intimidated. Younger residents sometimes called them names such as "old fella" and "grandad". Participants described instances where younger residents and staff expressed ageist attitudes. "A guy from Liverpool [resident] said "it ain't worth it, recovery at your age". (Derek) "What they [workers in rehab] do say is "you're looking too high, your goals are too high for your age group". (Bob)

Some of the residents exhibited self-directed ageism. They used ageist terms such as "old fart", "miserable old bat" and "fuddy duddy" to talk about themselves or the way that they thought younger residents viewed them. Others clearly, felt that they were lucky to get a place or be funded to attend rehab, 'despite their age':

They look at people my age, "no point", they're more likely to put the funding to someone who's younger." I think they think you're a bit of a 'spent penny' at a certain sort of age.

Bob

I don't know whether they're going to bother so much with people who are over 50 anyway I'm not sure, because we haven't got much work left in us you know.

Sarah

## AGEISM IN RESEARCH

We carried out a literature search of Medline/Pubmed and Applied Social Science Index and Abstracts for peer-reviewed journal articles published between 1st January 2000 and 1st September 2017 using the following search terms:

alcohol young



alcohol older people



alcohol adolescents



alcohol older adults



alcohol teenagers



alcohol elderly



alcohol children



The search identified almost twice as many peer-reviewed journal articles for young people as older people (205,503 versus 114,616).

We also wanted to assess the extent of exclusion of older adults (65+) from clinical trials regarding alcohol. We examined data from ongoing clinical trials on alcohol extracted from the World Health Organisation Clinical Trials Registry Platform. We found that adults over the age of 65 were excluded from 46% of the alcohol trials (paper in preparation). A literature search that we carried out also suggests that many alcohol studies inappropriately exclude older adults.

For example, trials of the feasibility of alcohol screening and treatment in dentist surgeries,<sup>(18)</sup> a web-based cognitive bias modification for people with alcohol problems<sup>(19)</sup> and efficacy of Acamprosate in the maintenance of abstinence in people who are alcohol-dependent<sup>(20)</sup> all excluded people over the age of 65.

## ALCOHOL STRATEGIES

**We reviewed the extent to which UK national alcohol strategies highlight and address the needs of older adults.<sup>(Box 1)</sup> We found that this varied significantly ranging from no mention of older adults at all in the Scottish strategy to significant consideration in the Welsh strategy.**

Effective strategy doesn't follow a 'one size fits all' approach, it uses targeted strategies for different segments of the populations, depending on people's needs and level of risk. An example of a strategy which gives consideration to the needs of older adults is the mental health strategy for England 'No Health Without Mental Health: Delivering better mental health outcomes for people of all ages'.<sup>(21)</sup>

The strategy describes mental health problems that are common in older adults, which groups of older adults are most at risk, which interventions are most effective for older adults and suitable outcomes for older adults.



## ALCOHOL STRATEGIES CONT...

Age is a continuous variable and there is no point at which populations become discretely separate.<sup>(22)</sup> However, age is a proxy marker at a population level of a set of characteristics and needs that are different from younger adults.

### Older adults require specific attention in alcohol strategies because:

In many parts of the UK, they drink more, are more likely to exceed the recommended alcohol limits and are more likely to be hospitalised or die from an alcohol-related condition than younger adults.<sup>(1, 3, 23)</sup>

Physiological changes occur with increasing age which mean that older adults can have a reduced ability to metabolise and excrete alcohol making them more vulnerable to the harmful effects.<sup>(24)</sup>

Alcohol can exacerbate or accelerate the onset of conditions which are associated with ageing (e.g. cognitive impairment, falls).

Older adults may be more likely to conceal alcohol misuse and less likely to ask for help because of high levels of shame and embarrassment and generational differences in terms of pride and disclosure of personal problems.

Older adults may have different motivational priorities e.g. maintaining independence and cognitive functioning.

Losses, life changes and transitions associated with ageing can result in isolation, loss of independence, loneliness and psychological distress and may contribute to some people starting, recommencing or escalating alcohol misuse in later life.

Older adults may have fewer or less active social roles (e.g. no longer employed, not raising children) therefore their alcohol misuse may be more likely to escape notice.

Older adults often have extensive histories of alcohol misuse, multiple and complex needs and failed treatment attempts.

Older adults may find it difficult to access alcohol services (e.g. due to decreased mobility).

(Box 1) – Review of the extent to which national alcohol strategies highlight and address the needs of older adults.

### **The UK Government’s Alcohol Strategy<sup>(2)</sup>**

Older adults are mentioned twice in the cross-government alcohol strategy while young people and young adults are mentioned 26 times. Statistics on drinking above the recommended guidelines are provided for young people and for adults aged 25-64 but not for those aged 65 and over. The strategy mentions that the Government requested that the review of alcohol guidelines consider whether separate drinking guidelines are “desirable” for people over 65. Specific guidelines for older adults weren’t implemented in the 2016 alcohol guidelines review.<sup>(25)</sup> The strategy also mentions that the Department of Health would include alcohol identification and brief advice within the NHS Health Check for adults aged 40-75 for the first time from April 2013. Older adults are not specifically identified as a high-risk group, though the strategy does identify some other “at risk” populations such as offenders and those with mental health problems.

### **Changing Scotland’s Relationship with Alcohol: A Framework for Action<sup>(10)</sup>**

Older adults are not mentioned in the alcohol strategy for Scotland. The emphasis is on upstream interventions such as pricing, affordability and accessibility which target the whole population. However, the strategy does give special attention to young people and families where parents have problems with alcohol.

### **New Strategic Direction for Alcohol and Drugs: A Framework for Reducing Alcohol and Drug Related Harm in Northern Ireland<sup>(11)</sup>**

The alcohol strategy for Northern Ireland identifies older adults who are drinking hazardously, or who are dependent on alcohol, as potentially vulnerable in respect of alcohol misuse and alcohol-related harm. A key objective of this strategy is to provide education and training for professionals, carers and families to enable them to help older adults with substance use problems.

### **Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018<sup>(12)</sup>**

The strategy for Wales does more to highlight and address the needs of older adults than other alcohol strategies. It acknowledges the importance of addressing “the particular needs of older people”. It emphasises how important it is that professionals who come into contact with older adults who misuse substances identify the problem rather than assume for example, falls or confusion are due to other causes. The strategy also emphasises the need to ensure that “every opportunity for secondary and tertiary prevention action is taken to improve outcomes for older people”.

The Welsh Government’s Advisory Panel on Substance Misuse has recently published a report on best practice and strategic responsibilities in terms of older adults in the document ‘Substance Misuse in an Ageing Population’.<sup>(26)</sup> In 2014, the Welsh Government published ‘Improving Access to Substance Misuse Treatment for Older People’ as part of its suite of Substance Misuse Treatment Frameworks.<sup>(27)</sup>

## HEALTHY AGEING STRATEGIES

We also examined whether alcohol is considered in healthy ageing strategies. Neither the cross-government policy on older adults<sup>(28)</sup> nor the older adults strategy for Northern Ireland<sup>(29)</sup> mention alcohol.

However, the strategy for ageing in Scotland identifies risky use of alcohol by baby-boomers as a priority area for action.<sup>(30)</sup> The strategy for older people in Wales<sup>(31)</sup> identifies older adults as an “at risk” group and explains how alcohol affects people as they age. One of the Welsh strategy’s key objectives is raising awareness of substance misuse in later life. It also includes plans for how this objective will be achieved (by monitoring 50+ referrals to substance misuse services and raising awareness through Alcohol Concern Cymru campaigns).

**Excluding people aged 75 and over gives the false impression that people in this age group do not experience problems with drinking.**

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## POLICY

**We examined whether policies exhibited ageism and found that in some cases they did. Northern Ireland's Adult Drinking Patterns Survey is a survey which has been conducted at regular intervals since 1999 to inform policy on alcohol in Northern Ireland.**

However, the survey only includes people between the ages of 18 and 75 meaning that there is no data on alcohol consumption for people over the age of 75 for Northern Ireland. The department that is responsible for this study has agreed to include people over the age of 75 in future surveys. Similarly, until recently, the National Treatment Agency for Substance Misuse (now part of Public Health England) only reported data on alcohol treatment for people up to the age of 75.

Excluding people aged 75 and over gives the false impression that people in this age group do not experience problems with drinking. However, in Wales, 23% of male and 10% of female drinkers over the age of 75 report drinking above the guidelines<sup>(32)</sup> and in Scotland, 22% of male and 7% of female drinkers aged 75 and over report drinking above the guidelines.<sup>(3)</sup> Since Public Health England started reporting alcohol treatment data for people over the age of 75, it has become clear that almost 500 people in this age group receive alcohol treatment in a substance misuse service in England alone each year.<sup>(33)</sup>



# CHAPTER TWO

## Age discrimination legislation and policy – examples of positive practice

by George Holley-Moore and Amna Riaz,  
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## HUMAN RIGHTS ACT

There is a variety of legislation within the UK which can be used to prevent and challenge age discrimination.

The 1998 Human Rights Act (based on the European Convention on Human Rights) is a UK-wide law that enshrines certain fundamental rights. Whilst the act doesn't specifically mention age discrimination, case law shows that the act has been used to legally challenge age discrimination.

### The Articles of the Act most relevant to discrimination in health and social care are:

<b>ARTICLE 2</b> <b>Right to life</b>	Serious cases of abuse and malpractice in health and social care, can be in breach of the right to life.
<b>ARTICLE 3</b> <b>Right to freedom from inhumane and degrading treatment</b>	If an older adult is in an institutional setting such as a care home, and is subjected to neglect, this can breach Article 3.
<b>ARTICLE 5</b> <b>Right to liberty</b>	This can be relevant to people with dementia, e.g. if they are informally kept locked inside without going through the process of determining mental capacity.
<b>ARTICLE 8</b> <b>Right to respect for private and family life</b>	This can relate to care arrangements that deprive an older adult of a private life and reinforces the right for an older adult to make choices around their care and treatment.

Source: Age UK, The Human Rights Act and Older People: An evidence paper.



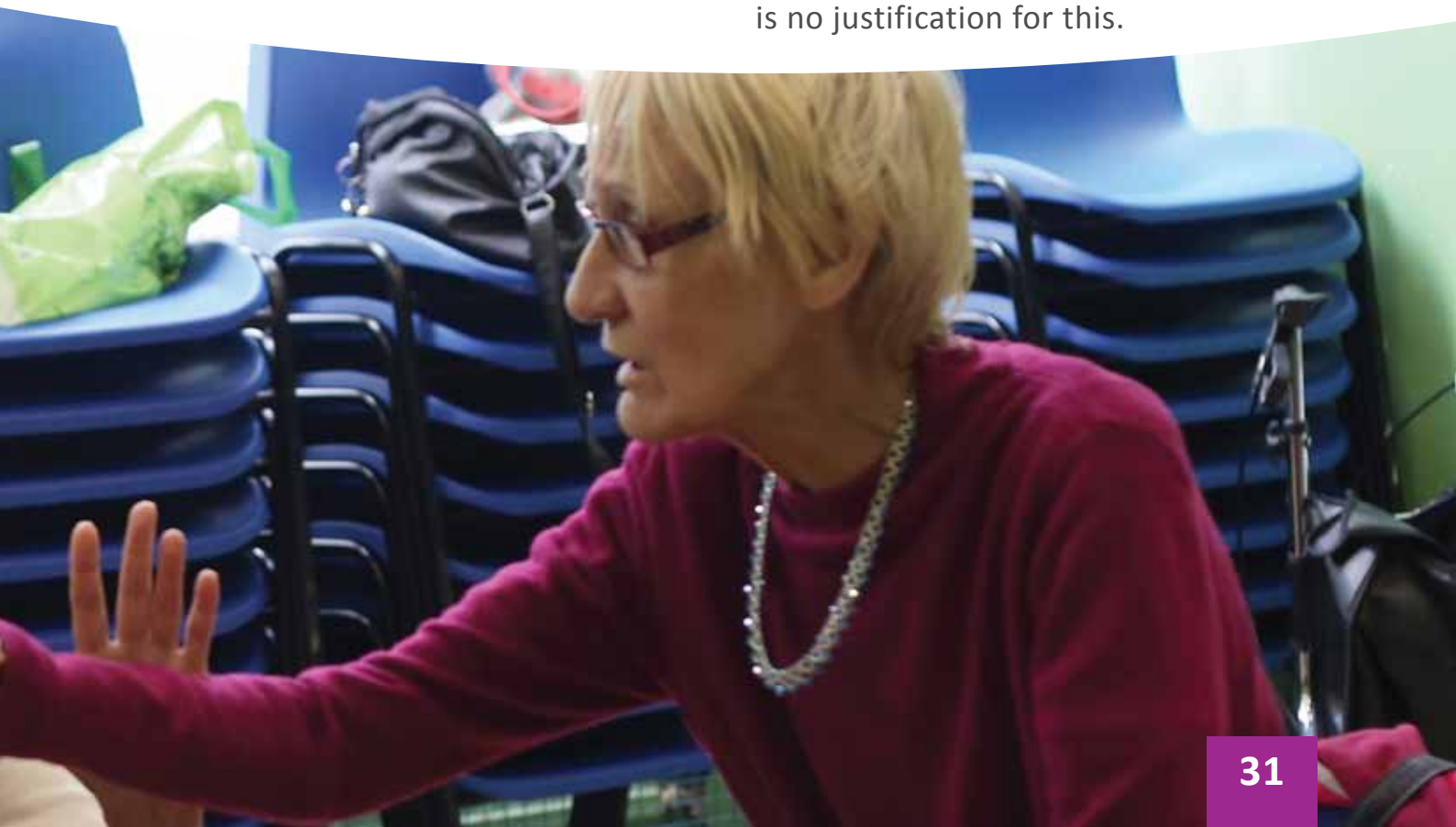
## EQUALITY ACT

**The 2010 Equality Act which is relevant to Britain but not Northern Ireland, underpins much of the positive action that has taken place in health and social care to end both direct and indirect age discrimination. This Act was the first to specify that an individual cannot be discriminated against or treated unfairly due to their age. It is designed to protect against direct and indirect discrimination, harassment and victimisation.**

The Act applies to health and social care including alcohol services which are mostly delivered by the voluntary sector in the UK. It specifies that services must provide equal services regardless of age or disability. It is therefore against the law for services to “provide inferior services, or refuse to provide services purely because of a person’s age, unless there is a good or sufficient reason.

Current practice states that age-specific services are acceptable, and often benefit the patient, if the correct tests are applied when deciding on whether to make services available to certain age groups.

The Equality Act 2010 permits that ‘services’ can be age specific but it must be “objectively justified”. All actors within the health and care sector need to be able to justify an approach that differs by age using a two-step test and appropriate evidence which explores if (1) There is a legitimate aim and (2) A proportionate approach. Services that fail to meet the care needs of individuals based on age, and that cannot evidence objective justification for this, are in breach of the Equality Act. We believe in the case where there are arbitrary age cuts off in alcohol rehabs and treatment there is no justification for this.



## GUIDANCE

Throughout the UK, country and institutional level guidance has also been developed which is relevant to age discrimination.

### ENGLAND

The **NHS England Constitution** states that the NHS is “available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status”.<sup>(34)</sup>

The England-specific NICE document ‘Addressing Equality issues in Developing Clinical Guidelines’ also contains clear guidance on how they formulate treatment pathways and best practice, taking into account age without being discriminatory.<sup>(35)</sup> NICE “do not refer to age in guidance recommendations unless there is evidence that age is a good indicator of either risk or benefit from treatment. If age is referred to, the reasons for the reference must be explained”.

### SCOTLAND

**The Patients’ Rights (Scotland) Act** creates statutory rights for those using the NHS in Scotland. Whilst it doesn’t address age equality specifically, a principle of the Act is that treatment should focus on patients’ needs, and that healthcare should always follow clinical guidelines and standards.<sup>(36)</sup> Therefore treatment approaches which focus on age alone and not individual needs are prohibited by this Act.

### WALES

#### **Strategy for Older People in Wales:**

The Welsh government has been proactive in tackling age discrimination across all areas of life and service provision, including health and social care. A key aim of the strategy is to counteract age discrimination.<sup>(31)</sup>

The government has also released a toolkit, clearly explaining what age discrimination looks like and how to raise concerns.<sup>(37)</sup> It covers ageism in the media, at work, health and care services, and consumer services, and points out relevant organisations to contact to challenge ageist practices.

### NORTHERN IRELAND

Northern Ireland is not covered by the Equalities Act, and older adults there lack much of the legal protection given in other countries of the UK. The Employment Equality (Age) Regulations (Northern Ireland) 2006 covers age discrimination in employment but does not extend to goods and services, therefore does not cover health and social care or alcohol services.<sup>(38)</sup> There is no relevant protection for older adults outside of the Human Rights Act in Northern Ireland. There was a commitment from the Northern Ireland Executive to introduce legislation by 2015 however this has not yet happened.<sup>(39)</sup> There was also a consultation on extending age discrimination laws to goods and services in 2015, but the response has not yet been published by the Executive.



## GOOD PRACTICE

The following section provides examples of good practice in relation to health and social care in a wider context, some of which could be adopted into alcohol treatment and care.



## GOOD PRACTICE EXAMPLE 1

### Mental Health: East London NHS Foundation

The Care and Quality Commission (CQC) wrote a comparative report that reviewed best provision in combatting ageism within mental health.

Six trusts were visited between February and March 2008, and they represented approximately 10% of all mental health trusts in England.<sup>(40)</sup>

One of these trusts was the East London NHS Foundation, which specialises in older adults' mental health and was ranked outstanding by the CQC in 2016.<sup>(41)</sup>

The CQC report found that the East London NHS Foundation “appeared to have a service that was led by the needs of service users, with non-ageist policies embedded throughout the organisation and no restrictions to services on the basis of age”.

Likewise, there was a comprehensive and holistic management and delivery of service. Having a service that specialises in older patients, and takes a holistic approach to care provision, ensures that their needs are met, and they receive equal access to quality care.<sup>(42)</sup>

The report also found that the trust increased its inpatient workforce in order to raise the numbers of matrons' who are ambassadors for the older adult service.

Having a targeted mental health service for older adults ensures that the multifaceted nature of their needs are met by health care professionals.

## GOOD PRACTICE EXAMPLE 2

### Cancer treatment: MacMillan pilot sites

In January 2011, Macmillan selected five cancer networks throughout England to participate in a pilot scheme that looked at ageism within cancer treatment.<sup>(43)</sup> Merseyside and Cheshire Cancer Network, Thames Valley Cancer Network (TVCN), North East London Cancer Network (NELCN), South East London Cancer Network (SELCN) and Sussex Cancer Network (SCN) took part. The pilot involved introducing the Comprehensive Geriatric Assessment (CGA) which was new to this setting.

MacMillan saw that there was a strong case to transform cancer care for older adults. This was due to an increasing older population, a slower rate of improvement in outcomes for older cancer patients than younger cancer patients, and to meet the new duties from the Equality Act.

To reduce the chances of age discrimination, the treatment framework was changed to include an “objective assessment of an individual’s circumstances”. By focusing on the individual and not chronological age, it was hoped that medical staff would not make assumptions based on age. It was also hoped that the CGA would help identify any barrier to treatment for the older patients. Whilst the CGA was relatively novel in cancer treatment, it was commonly used by gerontologists across the NHS.

In one example, a Geriatric Oncology Liaison Development was piloted in the South East London Cancer Network by Guys and St Thomas’ NHS Foundation Trust. The pilot included 177 patients who were over the age of 70 and where the CGA was applied. Introducing the CGA allowed various needs of patients to be recognised and it allowed clinicians to prioritise, based on these needs. The feedback from oncologists was positive, and there were a number of patient cases where it was reported that patients tolerated treatment better as a result.

Overall, all the pilot sites revealed the unmet needs of older patients, which the new assessment addressed. It took affirmative action to reduce the instances of age discrimination by making sure treatment plans were based on objective needs rather than age, as well as making sure that services were designed to accommodate older patients with particular needs.

### GOOD PRACTICE EXAMPLE 3

#### Welsh Government's work on the rights of older people

The Welsh Government leads the way in developing policies that enhance the rights of older people and prevent overt discrimination in health and care services.

The National Service Framework for Older People in Wales presents national standards to ensure that health, wellbeing and independence is maintained, and ensure that older people's care is to a high quality and has parity with the services used by other age groups.<sup>(44)</sup>

The strategy aims to eliminate age discrimination and has requested that leaders within local authorities recruit older people's champions. Likewise, within the NHS ageism against older people should be eliminated within mental healthcare since they are the largest number of people who use mental health services.

The Government uses the King Fund's age discrimination audit in order to guide the evaluation of current policy and practice. This involves reviewing existing age limits within service provision, taking measures to have staff that reflect demographic change, changing attitudes around ageing and including older people in project design within healthcare.

In addition to the framework, the Welsh Government also has an Older People's Commissioner who acts as a champion of older people and the services they receive.<sup>(45)</sup> The commissioner works with health boards in Wales to improve services, and leads seminars that offer guidance on how assumptions around age could lead to age discrimination.

A review of these strategies in 2016 found that there were lasting results in raising the profile and rights of older people.<sup>(46)</sup> Although the review did state that the process of achieving age equality within healthcare was an ongoing process, the focus going forward was on implementation.



# Conclusions

**Older adults are given low priority in alcohol strategies for Scotland, England and Northern Ireland, suggesting that older adults are not a priority focus of policy makers' action on alcohol in these countries. This may be because the strategies are based on outdated stereotypes (e.g. alcohol is a problem of younger adults) or socially ingrained ageism (e.g. younger people are valued more by society). Wales is performing better than the other countries in this respect and has developed targeted strategy for older adults.**

One of the most striking examples of ageism presented in this report is that three out of four residential alcohol rehabilitation services in England exclude older adults on the basis of arbitrary age limits. These age limits are stated openly on a database of rehabs maintained by Public Health England. This appears to be due to a belief that the care needs of an older adult will be higher than for younger adults and that their care needs cannot be met in a rehab. However, chronological age is a poor marker for care needs. The impact of these age limits is likely to be that older adults have to make do without this valuable element of the alcohol treatment system or that responsibility is passed on to non-specialist services such as care homes.

Overt age discrimination of this type has become rare since the government's Equality Act (2010) placed a duty on services not to discriminate on age grounds.

Whilst arbitrary age limits can be identified easily and hopefully abolished in a relatively short period of time, the same cannot be said in relation to more indirect and insidious forms of ageism such as unconsciously making decisions based on age rather than ability to benefit from treatment. An example given in this report is that, in contrast to younger adults, older adults may only receive management of health issues relating to alcohol rather than referral for alcohol treatment. This type of age discrimination has also been identified in terms of alcohol in the United States.<sup>(47)</sup>

Similarly, in the area of mental health, 50% of younger people with depression are referred to mental health services, while only 6% of older adults are.<sup>(48)</sup> It has been suggested that practitioners may have a tendency to prescribe medication for depression to older adults rather than offer psychological interventions.<sup>(49)</sup> This type of age discrimination may be a response to pervasive misconceptions, attitudes and assumptions based on stereotypes for example, that older adults are too old to change their behaviour. In fact, there is substantial evidence that older adults are more likely to be treated successfully for an alcohol problem than younger adults.<sup>(50, 51)</sup> Practitioners may also believe that it is too late to intervene with older adults with alcohol problems because the harm has already been done. However, much alcohol-related harm can be prevented or reversed if harmful drinking is addressed no matter what age the individual is or how long they have been drinking.

Evidence in this report also suggests that the alcohol treatment system is often poorly aligned with the needs of older adults which they should increasingly serve.

Whilst there appears to be great variation between services and practitioners, some older adults may be unable to access alcohol services, find the environment intimidating or simply find that the services are unsuitable for their needs.

A review by the Healthcare Commission found that older adults were denied access to the full range of substance misuse services because “even when they were theoretically available, they were either not offered in an age-appropriate way or were not available when staff attempted to refer to them... Many were geared towards younger people, usually males, and were felt not to be appropriate for older people, who could feel vulnerable in the atmosphere”.<sup>(40)</sup>

Bespoke older adults’ substance misuse services are the ideal model of care for some older adults, particularly if their alcohol use is caused by an age-related issue (e.g. grief, loneliness, boredom, retirement), they have age-related barriers to accessing or engaging with alcohol services (e.g. frailty, poor mobility, cognitive impairment, sensory limitations, comorbidity) or they are likely to feel intimidated in a mixed-age service. In terms of mental health services, a recent review by the Mental Health Taskforce Strategy advocated for older adults to be offered bespoke and age appropriate services.<sup>(52)</sup>

Investing in specialist substance misuse services for older adults is likely to save money in terms of the wider costs associated with alcohol problems because older adults are more likely to be treated successfully in these services than mixed age services.<sup>(53-56)</sup> However, in cases where mixed-age services would best meet the need of an individual or if the individual would prefer to be treated in a mixed age service, they should have access to them.

It is disappointing that older adults are excluded from almost half (46%) of clinical trials for alcohol research. The poor representation of older adults in clinical trials leaves practitioners in a dilemma. If they deliver treatments untested in older adults they do so in the absence of solid evidence of efficacy and toxicity in that age group. Alternatively, if they do not offer treatment they may be denying an older adult the worthwhile benefits of a treatment. There is considerable under-representation of older adults in all types of clinical trials.<sup>(57)</sup> The most common reasons clinicians give to justify upper age limits in clinical trials are high rates of polypharmacy, high rates of comorbidity, because adverse events are more common and because of cognitive disability.<sup>(58)</sup>

Since the late 1980s there have been concerted efforts by medical research agencies in the UK, Europe and the US to include more older adults in clinical trials with a number of organisations coming to a consensus that “there is no good basis for the exclusion of patients on the basis of advanced age alone”.<sup>(59)</sup>

Older adults themselves may not know if they are being discriminated against, or whether such discrimination is based on age. For example, if they find an alcohol service unsatisfactory or intimidating they may have no way of knowing whether their experiences might have been different if they were younger. It is even more difficult for an individual to know whether decisions about referral for treatment are being made on an age-related basis. If referral to a community alcohol service or rehab is not made because of some arbitrary age criterion or younger adults are being prioritised, an individual older adult would probably have no way of knowing that this was so.

However, in this report we have presented quotes from older adults with alcohol problems who believe that in terms of alcohol, younger people are prioritised and targeted more, there is more concern for younger people, professionals are not going to “bother so much” with older adults and that younger people are more likely to receive funding for residential treatment.

Older adults with alcohol problems may face ‘double jeopardy’ of ageing with an alcohol problem. Stereotypical societal viewpoints of old age, that of people who are sickly, dependent, frail and unproductive,<sup>(60)</sup> overlap with stereotypical views of people with alcohol problems, that is, incompetent to achieve life goals such as a good job or living independently, weak willed, self-pitying, being emotionally unstable, untrustworthy and to blame for their problem.<sup>(61-63)</sup> Both people with alcohol problems and older adults are regularly assigned a devalued social identity, with the result that older adults with alcohol problems may be particularly likely to experience social exclusion.

To conclude, we have presented examples of direct and indirect age discrimination in alcohol policy, practice and research but there are likely to be many other examples that we have not identified. Ageism is rarely a result of malign intentions or motives and practitioners are often not even aware of the prejudices they have. Nevertheless, ageism can be a major barrier to developing good strategy and also seriously impact the quality of care and support that older adults receive for alcohol problems. In the worst-case scenario, age discrimination may result in preventable deaths. Alleviating it will require action across multiple sectors so that action can be coordinated and balanced and will need to encompass the great diversity of older populations. Our recommendations are intended to be a starting point. The overarching message is optimistic: with the right policies and services in place, there is no reason why older adults should be left behind in terms of progress towards reducing alcohol-related harm.

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# About Drink Wise, Age Well

Drink Wise, Age Well was established in 2014 to help people aged fifty and over make healthier choices about alcohol as they age.

Supported by the National Lottery through the Big Lottery Fund, the programme is overseen by a strategic partnership which includes: **Royal Voluntary Service, Addiction NI, Drug and Alcohol Charity Wales**, the **University of Bedfordshire** and led by **Addaction**.

The community based programme is delivered across five “demonstration” areas: **Glasgow, Sheffield, Devon** county, Cwm Taf University Health Board area in **Wales** and the Western Health and Social Care Trust area in **Northern Ireland**.

## The programme aims to:

Raise awareness of alcohol related harm in the over 50s, reduce stigma and tackle discrimination

Deliver one-to-one support to people with alcohol problems and their families

Build resilience to alcohol related harm among individuals and communities

Train employers and work colleagues to help them recognise and respond to people over 50 at risk of problem drinking

Train health and addiction professionals to spot the signs of alcohol misuse and offer early interventions

For more information go to [drinkwiseagewell.org.uk](http://drinkwiseagewell.org.uk)

## STRATEGIC PARTNERS





LOTTERY FUNDED



For more information on  
Drink Wise, Age Well visit  
[drinkwiseagewell.org.uk](http://drinkwiseagewell.org.uk)