ALCOHOL RESEARCH UK

Accessibility and suitability of residential alcohol treatment for older adults

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AUTHOR DETAILS

Sarah Wadd is the Director of the Substance Misuse and Ageing Research Team (SMART) and Maureen Dutton is a researcher with SMART. SMART is the UK's only research group for substance misuse and ageing. It sits within the Tilda Goldberg Centre for Social Work and Social Care at the University of Bedfordshire. Established in March 2012, SMART is a collaborative working group consisting of researchers from a variety of disciplines including addictions, social gerontology, public health, social work and social care. Importantly, half our research team have lived experience of later life substance misuse. This has been made possible by our innovative research apprenticeship scheme for people who have lived experience of later life substance misuse but no prior research training.

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EXECUTIVE SUMMARY

A strong and consistent evidence base demonstrates the benefits of residential rehabs for alcohol and drug problems (Sheffield Hallam University, 2017). The National Treatment Agency (2012) has identified rehabs as a "vital" component to the treatment system to which "anyone who needs it should have easy access".

However, this study has found that three out of four residential rehab facilities in England are excluding older adults on the basis of arbitrary age limits. This is contrary to the government's Equality Act (2010) which places a duty on services not to discriminate on age grounds. It means that many older adults will find it difficult if not impossible to secure a place in a residential rehab. The majority of residential rehabs have limited or no disabled access, further limiting access to those with disabilities or limited mobility. Residential rehabs should remove arbitrary age limits. A person's access to rehab should be based on their individual condition, circumstances and ability to benefit, not assumptions based on their age. Rehabs should also do more to make premises accessible to those with disabilities or limited mobility.

Up to five generations could 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. They talk about a "generation gap" which can result in tensions and a sense of being ostracised. An inability to participate in some organised social activities such as mountain biking, caving, kayaking, football and hiking can compound the isolation. Some older adults feel unsafe in this environment and are bullied, intimidated and subjected to ageist language and attitudes.

However, not all older adults encounter these difficulties. Some of the residents we spoke to embrace the richness of the intergenerational environment and feel that living with younger residents enriches their experience of rehab and provides opportunities for intergenerational exchange of knowledge, experiences and perspectives. Some participants felt that a shared experience of addiction binds residents together, regardless of age.

Our findings suggest that some residential rehabs may be 'age-blind', that is, they treat all residents in a similar way with the result that the needs of older adults are not fully met. Older adults' needs identified in this study include social activities that people of all ages can enjoy, a variety of social spaces, permission to spend time alone in rooms or private spaces within the rehab, a more relaxed approach to house rules and domestic duties and single bedrooms with en suite bathroom facilities.

As well as ensuring that they are responsive to the needs of residents of all ages, we suggest that providers should view residential rehabs through a generational lens which means recognising that generational differences and similarities are a valid, important and enriching form of diversity which should be amplified and harnessed (Kaplan et al, 2016).

Whilst intergenerational rehabs can work well and result in a melding of views and experience, some older adults are likely to benefit from being grouped with residents of a similar age. This could be done by similar units within a single residence or through different facilities.

INTRODUCTION

Young people and young adults are mentioned 31 times in the Government's alcohol strategy (Home Office, 2012). There is no mention of older adults. This is despite the fact that:

- Men and women aged 55-64 in England and Scotland have the highest weekly alcohol consumption and are more likely to exceed the (revised) recommended weekly drink limits than younger age groups (Health and Social Care Information Centre, 2016; Scottish Government, 2016).
- In Wales, men and women aged 55-64 are more likely to exceed the daily guidelines (not revised) but are less likely to binge drink than younger age groups (Welsh Government, 2016).
- People aged 55-64 and 65-74 in Scotland are just as likely to have an AUDIT score which indicates alcohol dependence as those aged 25-34, 35-44 and 45-54 (Scottish Government, 2016).
- Older adults are more likely to die and be admitted to hospital for an alcohol-related condition than younger adults (Wadd and Papadopoulos, 2014).

In 2015, we were commissioned by Drink Wise, Age Well[1] to carry out a questionnaire study of 16,700 people aged 50 and over from ten different areas across England, Scotland, Wales and Northern Ireland. This study suggested that 1.5% of over 50s who drink alcohol are likely to be alcohol dependent[2] (Wadd et al, paper in preparation). People who are alcohol dependent should be considered for referral to a substance misuse service. In England in 2015-16, 30,879 people aged 50 and over received treatment in a substance misuse service (Public Health England, 2016). Given that there are over 19.7 million people aged 50 years and over in England (Age UK, 2017), of whom 118,200 are likely to be alcohol dependent, only 1 in 4 of the people in this age group who need alcohol treatment are receiving it (Wadd et al, paper in preparation). If older adults do receive alcohol treatment, they are more likely to be treated successfully than younger adults (Public Health England, Response to Freedom of Information Request, 2012).

This study is about a specific type of alcohol treatment - residential treatment services. From this point onwards we will use the terms 'residential rehab' or 'rehab' to describe these services. In 2015/2016, 812 people aged 50 and over and 73 people aged 65 and over received residential rehab for an alcohol problem in England (Public Health England, Response to Freedom of Information Request, 2017).

[1] Drink Wise, Age Well is Big Lottery funded programme to reduce alcohol-related harm in over 50's – Drinkwiseagewell.org.uk

[2] Alcohol dependence was determined by an Alcohol Use Disorders Identification Test (AUDIT) score of 20+

Most residential rehabs accept people with both drug and alcohol problems. They are provided by both the voluntary and independent sector. The National Treatment Agency (2012) 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". There is a strong and consistent evidence base which demonstrates the benefits of residential treatment both from treatment outcome studies and randomised trials (Sheffield Hallam University, 2017).

Unusually, residential rehabs cater for multiple generations under one roof. Most other residential services such as care homes and inpatient mental health services are generally segregated by age. 'Generations' can be classified in different ways. One example of a classification is the Maturists (born pre-1945), Baby boomers (1945-1960), Generation X (1961-1980), Generation Y (1961-1980) and Generation Z (born after 1995) (Barclays, 2013). A rehab could quite possibly have residents ranging in age from 21 to 73 and thus residents from five generations.

Residential rehabs can be based on a variety of models such as 12-step, therapeutic community and faith-based. Some rehabs provide residential detox facilities in addition to the rehabilitation programme. The feature that these services have in common is that residents have to live on-site for 24 hours a day and are usually expected to be abstinent before they start the programme. Rehabs provide an intense programme of support and care aimed at people who have difficulty becoming alcohol or drug free in the community. They tend to cater for people with relatively complex needs and entrenched substance misuse histories (NICE, 2007; National Treatment Agency, 2012). Residents are usually expected to participate in regular groupwork sessions with other residents, a range of tasks around the house (domestic duties or gardening for example) and to participate in group social activities. People usually stay for 3-12 months. Treatment focuses on life skills and the skills required to sustain an alcohol or drug-free lifestyle.

Residential settings are considerably more expensive than non-residential alternatives although there is evidence that initial costs of residential treatment are to a large extent offset by reductions in subsequent health care and criminal justice costs (Sheffield Hallam University, 2016). Whilst some people pay for the entire cost of their treatment, most people receive at least a contribution from public funds. The amount that people have to pay themselves depends on their income including private or state pension, benefits and earnings from employment.

Admission to residential rehabs is dependent on an assessment of eligibility. Public Health England (2017) describes the process:

- An initial assessment of need will usually be made by a substance misuse service, criminal justice agency or general advice service which will refer the client for a community care assessment.
- A community care assessment is carried out to ensure that the person meets admission and eligibility criteria. Care managers in local authority social service departments usually perform this function but it may be delegated to a substance misuse service.
- If eligibility for residential care is supported and funded, the person is referred directly to a rehab.
- The rehab will then usually make its own assessment of the person's suitability for the programme.

Some local authorities use preferred provider lists and block contracts which give them stability and relatively easy access to discounted places (National Treatment Agency, 2009).

This study came about because a member of the research team had spent time volunteering in residential rehabs. This experience led her to question whether residential rehabs are well suited to older adults. Worryingly, she witnessed older residents being bullied by younger residents. A previous Alcohol Research UK funded study found older adults had been bullied and intimidated by younger residents in residential rehabs (Wadd et al., 2011). Another study found that rehab staff can be reluctant to accept referrals for older adults (Wadd et al., 2013).

We sought funding from Alcohol Research UK to find out:

1. To what extent do residential rehabs have upper age thresholds?
2. Are the needs of older adults different from those of younger adults in residential rehab?
3. What are older adults' experiences of these services?

We have only been able to identify one study about the experience of older adults in mixed-age residential rehabs and this was a quantitative study of men in the United States. Lemke and Moos (2002) examined older men's (55 and over) satisfaction with a residential rehab for veterans compared to satisfaction amongst younger (ages 21-39) and middle-aged men (ages 40-54). They concluded that older men perceived the rehab somewhat more positively than middle-aged and younger men.

It is possible that older adults respond differently to treatment in a residential rehab than younger adults. However, relatively few studies report outcomes based on age. The few that have suggest that outcomes for older adults are at least as good as for younger adults (Lemke & Moos, 2002; Lemke & Moos,

2003a; Lemke & Moos 2003b). None of these studies were carried out in the UK.

In the United States, there are a small number of residential rehabs specifically for older adults (age-specific programmes) (e.g. Caron[3] and Hazelden Betty Ford[4]). These programmes are adapted to meet the needs of older residents. For example, they are accessible to wheelchair users, those with limited mobility, hearing loss, visual and cognitive impairment, take into account co-existing health issues such as diabetes and cardiac problems when developing a treatment plan, have age-appropriate physical activities such as movement therapy (music, stretching) and meditation, and provide support for chronic pain and medication management. Group therapy focuses on age-specific issues such as bereavement and age-related loss and loneliness. A perceived benefit of age-specific programmes is the effects of social bonding with same-age peers (Atkinson, 1995). Evaluation studies have shown that older adults are more adherent to treatment and have better outcomes in age-specific rehabs compared to mixed-age rehabs (Kofoed, Tolson et al. 1987; Kashner, Rodell et al. 1992; Atkinson 1995; Blow, Walton et al. 2000; Slaymaker and Owen 2008).

[3] https://www.caron.org/our-programs/inpatient-treatment/seniors
[4] http://www.hazeldenbettyford.org/treatment/models/specialized-programs/older-adults

METHOD

Upper age thresholds in residential rehabs and disabled access

In July 2016, we carried out a search of 'Rehab Online' – http://www.rehab-online.org.uk/searchresults.aspx. This is Public Health England's online directory of residential rehab services. We used the "find a rehab" facility and added the "alcohol treatment" filter. We looked at each service and the age range of clients in the "who we treat" tab. The rehab staff are responsible for entering the age categories and other information in the database.

Whilst it was not one of our original objectives, we also used the "facilities/vacancies" tab to find out the level of wheelchair access which was categorised on the website as "none", "limited" or "full".

Interviews with older residents

Through our professional networks, we recruited five residential rehabs, four from England and one from Wales. We asked each participating service to invite a maximum of four residents who had attended the rehab since their 50th birthday to take part in the study. Assurances were given that neither the services nor the residents would be identifiable from the outputs of the study. Semi-structured interviews were carried out with 16 residents in the rehab premises between September 2016 and May 2017. A researcher with lived experience of a later life alcohol problem conducted the interviews. The interviews lasted 30-60 minutes and participants were given a £10 gift voucher to thank them for their time. All interviews were tape recorded (with permission) and transcribed verbatim before being coded.

The coding and categorising of data followed the approach of developing an analytic hierarchy, that is, of moving from data management (generation of themes) to descriptive accounts (assigning meaning) to explanatory accounts (developing more abstract concepts) (Ritchie et al, 2003; Spencer et al, 2003). This began with the identification of first-level codes which were then grouped into categories and then synthesised within thematic domains. One member of the research team took the main responsibility for coding but a researcher with lived experience of a later-life alcohol problem cross-checked, verified and refined the codes and themes.

Ethical approval

Ethical approval for the study was granted by the Institute of Applied Social Research Ethics Committee at the University of Bedfordshire and the University's Research Ethics Committee.

RESULTS

Upper age thresholds in residential rehabs and disabled access

Of the 118 services listed, excluding those specifically for young people (under the age of 18), three quarters (75%) stated that they had an upper age limit of anywhere between 50-90 years. By the time someone has reached the age of 66, more than half of the rehabs (55%) exclude them. The upper age thresholds are given in the table below:

Upper age threshold	**No of rehabs**	**% of total**	**Cumulative %**
50 years	2	2	2
60 years	2	2	4
64 years	1	1	5
65 years	59	50	55
70 years	4	3	58
75 years	12	10	68
80 years	7	6	74
85 years	1	1	75
90 years	1	1	75
No upper age threshold	29	25%	-
TOTAL	118	-	

We also searched 'rehab online' for residential rehabs which stated that they had limited or no disabled access. Of the 118 services listed, 75% said they had limited or no disabled access.

Interviews with older residents

Of the 16 participants that we interviewed, six were women and 10 were men. Fifteen of the participants were in the residential rehab for an alcohol problem and one for a drug problem. Participants ranged in age from 52-73 years with an average (mean) age of 59 years. We have not given participants specific ages in this report to protect their identities. All names have been changed and other identifying information has been removed.

The qualitative analysis resulted in four key themes.

The "generation gap"

Perceived differences in values, attitudes and behaviour between younger and older residents (one participant referred to this as "the generation gap") had an impact on older residents' experience of residential rehab. Participants compared the experience to "walking into a nursery school",

"living in a student house" and "being back at school". They gave accounts of:

- "Childish behaviour" – "stupid jokes and stupid comments and throwing cushions when there's no need".
- Different interests and use of leisure time – "they're sort of still into this mountain biking, boyish stuff and they're in a group and they lay around sleeping on the settees".
- Aggressive/offensive language, comments and sexual innuendos – "they were using a different language, it was more aggressive in tone"; "the language is pretty bad, almost every other word is effing this and effing that".
- Different attitudes to treatment – "I think when people are laughing and joking and things like that and I'm thinking, no that's just like a child, like play and things, you should be taking it really serious".
- Higher energy levels – "I tend to get tired quicker these days, their energy levels are bouncing around".

Some older residents felt unsafe in the rehab environment.

> *"I came down at 6 o'clock in the morning to put my rubbish out and people have gone, opened the back door, gone outside for a cigarette and then left it open so it's open for anyone to jump over the fence and walk in. People laugh about it but I think it's very dangerous to leave the door open and knowing what sort of place this is as well, to hear that a couple of blokes have stolen from drug dealers and they think they're going to come after them, I don't want to hear that sort of thing and then somebody else is an ex-arsonist and it's scary when you get older, you're quite scared, you're thinking what else is going to happen?"* **(Anne, late-fifties)**

Diversionary activities organised by the residential rehab were often based on physical activity such as mountain biking, caving, kayaking, football and hiking. Some older residents found it difficult to take part in physical 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, mid-fifties)**

> *"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, late-fifties)**

The fact that younger residents often had different interests presented challenges, but for some older residents, also an opportunity to try something new.

> *"Dreadfully difficult when I started, "come on, let's play Pictionary" on a Friday night, very difficult, "Let's have a disco", "let's have a karaoke night", let's go kayaking", very difficult because all those things are, for older people, a lot of older people, outside their comfort zone. ... I ended karaoke singing and kayaking and disco dancing and playing Pictionary and playing Bingo and joining in*." **(Derek, early-seventies)**

> *"It's hard to talk to them because you don't know what to say and then they think your being [pause] you do feel quite lonely at times because you can't relate, the films they watch. Luckily we've got two lounges because it's all boys' films, horror and gore that sort of stuff so luckily the other television room we've got is more older, well I suppose over 30 basically, so we watch a different sort of television but there's still that feeling of isolation, that you're the oldest one here…there'll be six blokes sitting there talking about, I don't know, going to the gym or weightlifting and stuff happened, so and so from that film and you'll be standing there with your tea thinking, oh God, now what do I do? Shall I go and sit with them? It's like they've got their own little group and they're talking about stuff I can't even relate to.*" **(Anne, late-fifties)**

Even those residents who were generally very happy living alongside younger residents enjoyed some respite when the younger residents weren't there.

> *"Sunday afternoons are great because during the summer and autumn all the young people used to go out on a walk and go and play football in the park, then the house would just calm right down and you'd find people, average age old, were sitting reading the Sunday paper, that kind of thing. All of a sudden, bang, they would come back, the papers would be everywhere. It's like living with a bunch of puppies to be honest, but that's what happens I suppose if you take people who are young, fit, rehabilitating and you put them into an enclosed space.*" **(Darren, mid-sixties)**

Enacted and felt stigma

The term 'stigma' represents the attitudes, beliefs, behaviours and structures that act at different levels of society and manifest in prejudicial attitudes and discriminatory practices. 'Enacted stigma' is defined by acts of discrimination, prejudicial attitudes and ostracism whereas 'felt' stigma is defined as feeling stigmatised or fear of being stigmatised (Jacoby, 1994; Block, 2009). Stigma against old age is commonplace and the term used to describe this type of stigma is 'ageism'. Although the term 'ageism' was initially coined to describe

negative attitudes held about older adults (Butler, 1969), it is equally a measure of negative attitudes older generations hold toward younger generations.

Participants in this study experienced enacted stigma. For example, younger residents sometimes called them names such as "old fella" and "granddad". 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, early- seventies)**

> *"What they [workers in rehab] do say is "you're looking too high, your goals are too high for your age group".* **(Bob, early-fifties)**

Some older residents had experienced intimidation and threats of violence from younger residents but it was not clear whether they were targeted because of their age.

> *"There were three guys threatened to kill me...I said "I tell you what, I'll get a knife, I'm not sharpening it for you, and you can cut my throat"...I called their bluff and they didn't do it. They used to shove notes under my door and all this, put my glasses in a doggie bag somewhere...They shoved them [the glasses] somewhere, they hid them and I had to try and find them."* **(Scott, early-seventies)**

> *"He [another resident] used to jump in my chair so that I couldn't sit there like. But I would just go and sit somewhere else... he used to try and take the piss out of me a lot, I used to ignore it, ignore him".* **(Jim, late-fifties)**

It was clear that some of the residents experienced 'felt stigma'. 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. Older residents themselves had stereotypical ideas about older adults; "I think older people can be a bit grandiose", "older people are a bit miserable", "[older people are] stuck in their ways", "if you just had a whole bunch of older people, the place would smell of wee and cabbage". Some used ageist terms to refer to younger residents such as "childish", "juvenile" and "babyish" and described younger adults as "intimidating", "selfish", "lazy" and "[requiring to be] almost looked after".

A number of participants expressed surprise that they had been offered a place in the residential rehab, 'despite their age'.

> *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, early-fifties)**

"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, late-fifties)**

Relationships are crucial when it comes to community-oriented residential services. Some participants felt that their age resulted in social rejection whilst others were not aware of divisions and did not feel excluded.

"I found it hard to be accepted by the younger people but similarly, the younger people didn't want to be accepted by me....Even though I was open to being approached, they didn't want to approach me because of the fact that they thought I was old and I wouldn't understand their problems. That is what they have said rather than my impression of what they would say." **(Darren, mid-sixties)**

"You never get that feeling of the older ones are sitting here and the younger ones are sitting there because you all blend together and it was the same in detox, because you're all there for the same reason so it doesn't matter how old you are, you've all got a connection and so there's no them and us." **(Mark, mid-fifties)**

A number of participants were keen to point out that they felt supported by younger residents.

"Don't get me wrong, they're young at the end of the day, but they're polite, it's just their age. Say if you were struggling with something, they'd take it straight off you, "I'll carry it upstairs for you", they're really good like that." **(Julie, early-fifties)**

Autonomy, privacy and space

One of the features of residential rehab that participants struggled with was lack of autonomy. This can be difficult for people of any age, but some of the participants felt this was particularly challenging for older residents.

"There's lots of rules and regulations and they're all meant to be there for my care but I find it quite difficult because I feel like I'm a grown-up person who's been in charge of my life for a long time and I find it quite difficult not to go to the shops and not do this and not do that....I'm nearly 60 and I can't go the shops." **(Sarah, late-fifties)**

Another issue that participants struggled with was sharing bedrooms with younger residents.

"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 pottered around, they were still in bed. Literally on a number of occasions I turned the mattress so they'd get out of bed." **(Darren, mid-sixties)**

However, some older residents had successfully shared a room with a younger resident.

"Somebody new came in [to share bedroom] and he's younger than me and we got on really well, every now and again you want to go to bed early because you want time on your own but yes, you'd like a single room with your own bathroom and everything like that but as I said, you've got to think about where you are." **(Mark, mid-fifties)**

It was important to the residents that they had a place to "retreat" or "take solitude" – one participant said he needed a "bolt-hole".

"It would be nice to have a quiet space it would be nice to have the option, even, of not even single occupancy but having the option of spending time with people of my own age occasionally. It's nice, it's lovely being with younger people, I like being with younger people, as I said I was a [profession that involves working with children]. It's nice to get their ideas, but sometimes it just a little bit wearing. I feel like the old fuddy duddy that I'm sure they believe I am." **(Darren, mid-sixties)**

In some residential rehabs, spending time on your own was described as "isolating" and actively discouraged by staff. This was frustrating to those who sought time and space alone.

Mixed-age versus age-specific rehabs

Given some of the tensions between older and younger residents identified in this study, we wanted to find out whether participants would prefer to be in a residential rehab specifically for older adults.

Some residents felt that they would have preferred an age-specific service.

"I'd feel a lot more comfortable [with people of own age] and you'd have something more in common, you can talk to each other about different things." **(Anne, late-fifties)**

However, some residents felt differently. They embraced the intergenerational social environment in the rehab.

"Some of us, we come in here, we can't remember the last time we've laughed and the youngsters, they're brilliant and the kindness and

empathy they have, genuine kids. I wouldn't want to be in a treatment centre full of people my age, no way, no way, I'd probably come out feeling 90!" **(Karen, mid-fifties)**

"If you said, look, there's a rehab centre and it's for people over 50, I'd have run a bloody mile. Why the hell would you create an environment like that? It's stigmatising, you know? You are over 50, therefore you are special and different and therefore we're going to make you special and different. That's not a good environment for recovery, you're just like everybody else." **(Derek, early- seventies)**

For some, being in a rehab with younger adults provided them with an opportunity to pass on their wisdom and experience to younger residents, a role that was described as "being the elder statesman" and a "father role". There was also a recognition that older residents had something to learn from younger residents.

"I think you need the younger people and the older people to be there because you need the breadth of experience that each of them can bring to the general melting pot. You need the mixture of social backgrounds, you need the mixture of addiction types...The mixture of ages is very important. I can see that some people would love to have only people over 50 and I'm sure it would make them feel safe but I think they would lose a lot. Young people have an awful lot to tell us, if we just listen to the right bits....I think it would be a poorer programme without the mixture of ages to be honest." **(Darren, mid-sixties)**

Some of the participants felt that having a shared experience of addiction was a great leveller that bound them together regardless of age and generational differences.

"The thing with being in addiction is because you're all the same, it doesn't matter what you're addicted to, it creates a bond anyway, regardless of age or circumstances." **(Clare, late-sixties)**

Some participants felt that rehabs could do more to meet the needs of all ages.

"I think they're trying their best to accommodate as I said, multiple types of addiction, all age groups and if it's pointed out to them that an older person requires something specifically, over and above something what they believe to be the general client needs, they respond to it generally....I find that [name of service] try and strike a happy medium and the happy medium they strike is not really what either side are looking for. I think that the service provider should be aware of the different requirements of the age groups and try and facilitate those better and be more prepared for them rather than just saying, anyone

from the age of 21 to 70 is a client. Thinking that they will have the same requirements and will require the same services, they don't obviously because of their age. There are age-specific requirements, as you get older, you need different stuff." **(Darren, mid-sixties)**

DISCUSSION

This study has found that older adults are excluded from three quarters (75%) of residential rehabs on the basis of their age. Whilst it was beyond the scope of this study to find out why residential rehabs are imposing these age limits, conversations with service managers suggest this is due to an assumption that the care needs of an older adult will be higher and that their care needs cannot be met in a rehab. However, age alone cannot determine care needs. It is quite possible that the care needs of a 40-year-old will be higher than those of a 66-year-old.

We were also told by one person who sat on a funding panel that there have been instances where younger adults have been prioritised over older adults in terms of funding for a place in a rehab because of a perception that younger adults will give a better return on investment due to predicted lifespan. We have no way of knowing if this practice is widespread.

Age discrimination can either be direct or indirect. Direct age discrimination occurs when people of comparable needs are treated differently or denied access to services purely on the basis of their age. By imposing age limits, residential rehabs are directly discriminating against older adults. Unjustifiable age discrimination is contrary to the government's Equality Act (2010) which places a duty on services not to discriminate on age grounds. This practice has no place in the substance misuse treatment system. A person's access to rehab should be based on their individual condition and circumstances, not assumptions based on their age. In 2009, a Healthcare Commission report found that people over 65 are often denied access to the full range of mental health services available to younger adults including alcohol and drug services and identified tackling age discrimination as a key priority for action (Healthcare Commission, 2009).

Older residents who do become residents in residential rehab are likely to be a select population. They have overcome the barriers to access described above and are likely to be relatively amenable to living alongside younger residents in a community-oriented environment because they chose to enter the rehab knowing that they would be part of an intergenerational community. Even so, our interviews with older residents show that some found that living 'cheek-by-jowl' with younger residents and sharing domestic duties, social spaces, bedroom and bathroom facilities, can create tensions. Some older residents experience social exclusion, bullying and intimidation, felt unsafe and unable to participate in physical social activities with younger residents leading to further social exclusion. Older and younger residents held negative age stereotypes about one another and complained about members of other (and their own) generations.

While intergenerational conflict did occur, there were also examples of intergenerational cohesion. Some older residents not only enjoyed the company of younger residents, they felt that their experience of rehab was enriched by it. They experienced kindness and compassion from younger adults. Being in an intergenerational rehab provided an opportunity to pass on their wisdom to younger residents and to take part in activities that they wouldn't have participated in under normal circumstances. A number of participants felt that age was not important because members of the community were bound by their shared experience of addiction.

Services may indirectly discriminate against older adults even when, in theory, there is no obstruction to their access. Indirect age discrimination occurs when people from different age groups, with different needs, are treated in a similar way with the result that the needs of older adults are not fully met. This is sometimes described as being 'age-blind'.

Our findings suggest that some residential rehabs may not be sufficiently responsive to the needs of older adults. It would be overly simplistic to suggest that all older adults have the same needs based on a particular age categorisation. Generational groups are not homogenous units with predictable needs, preferences and behaviours. However, this study has identified some factors which, if implemented, would make them more responsive to the needs of older adults. These needs include providing social activities that people of all ages can enjoy, a variety of social spaces, permission to spend time alone in their rooms or private spaces within the rehab when residents seek solitude, a more relaxed approach to house rules and domestic duties and single bedrooms with en suite bathroom facilities.

We suggest that residential rehabs strive to become 'age-advantaged'. Age-advantaged means promoting policies and practices that increase cooperation, interaction and exchange between people of different generations, enabling all ages to share their talents and resources and support each other (Metlife Foundation, 2016). This intergenerational approach recognises that generational differences and similarities are a valid, important and enriching form of diversity that should be amplified and harnessed (Kaplan et al., 2016). Examples of intergenerational strategies can be found in the recommendation section of this report.

Whilst intergenerational rehabs can work well for some people and result in a melding of views and experience, some older adults are likely to benefit from being grouped with residents of a similar age. This could be done by similar units within a single residence or through different facilities.

Finally, this study has also found that the majority (75%) of residential rehab facilities report limited or no wheelchair access, indicating that physical accessibility issues may be a further barrier for older (and younger) adults who are disabled or have limited mobility. The reported levels of accessibility for

people with disabilities are likely to underestimate actual accessibility. Voss et al. (2002) found that substance misuse treatment providers in the United States frequently overestimate the accessibility of their facilities.

LIMITATIONS

It is important to recognise the limitations of the study. We obtained information from 'Rehab Online' on upper age limits and wheelchair access. This information is entered by rehab staff and we can't guarantee that this information is accurate. We only interviewed sixteen individuals from five residential rehabs. No generalisations can be made to services and individuals that did not participate. As interviewees were selected by the rehab staff, it is possible that they selected those residents who they thought would give the most positive views of the rehab environment.

RECOMMENDATIONS

The following recommendations have been developed with a view to stimulating discussion within the sector to develop solutions to the issues identified in this report.

We suggest that **residential rehabs** should:

- Remove arbitrary age limits. A person's access to rehab should be based on their individual condition, circumstances and ability to benefit not assumptions based on their age.
- Ensure that people with mobility problems and disabilities are not automatically excluded. Decisions should be based on assessment and every effort should be made to make reasonable adjustments.
- Ensure that unsuccessful applicants and their referrers are written to with a full explanation of the decision. There should be a process for appeal.
- Develop an equality and diversity strategy and carry out an equality impact assessment.
- For each policy/decision within the rehab, consider:
  a) how will the proposed policy decision affect each generation?
  b) how will the proposed policy/decision be perceived by each generation?
  c) does the policy/decision ignore or exacerbate existing generational differences or tensions?
  d) based on the above responses, what revisions are needed in the policy/decision in order for it to be more age-inclusive? (Generations United and the MetLife Mature Market Institute, 2009).
- Ensure that intergenerational awareness, skills and strategies are components of competency. Staff should be trained to be flexible and responsive to the needs of residents of all ages.
- Ensure that house rules for residents include avoiding discriminatory language, behaviour and ostracising those with protected characteristics (including age) identified in the Equality Act 2010.
- Encourage reciprocity, cooperation, altruism and beneficence with respect to sharing knowledge, skills and resources between generations. Facilitate constructive cross-generational dialogue about age differences and stereotypes to help people of all ages shed false beliefs about other generations (Kaplan et al. 2016).
- Encourage residents to invest time discovering what they share with residents from other generations e.g. needs, goals, interests, points of view.
- Attempt to change older residents' mindsets about themselves by overcoming negative age stereotypes.
- On admission, assess individual's compatibility with existing residents and any risks due to challenging behaviour. Where risks are identified, put plans in place to support the individual to prevent and reduce risk.
- Consider intergenerational mentoring.

- Provide single rooms with en suite bathrooms wherever possible.
- Provide a variety of public spaces/lounges.
- Provide residents with opportunities to have privacy and solitude.
- Ensure that residents are not excluded by social activities that they are physically unable to participate in. Provide social activities that people of any age can enjoy.
- Consider imposing more flexible house rules and fewer, less physical housekeeping duties.
- Ensure inclusion of people of all ages in the design, planning, delivery and evaluation of the service.
- Consider developing units within existing rehabs or separate facilities specifically for older adults who are likely to benefit from or prefer an age-specific service.

We suggest that **referrers/funders** should:

- 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.
- Ensure that young adults are not prioritised over adults for funding purely on the basis of age.
- Consider only including residential rehabs on preferred provider lists if they have demonstrated a commitment to meeting the needs of people of all ages (including those with mobility problems and disabilities).
- Challenge ageist stereotypes, prejudice and discrimination. Request a written explanation for decisions not to accept an older adult. Where there is a suspicion that the older adult has been unfairly discriminated against on the basis of their age or a factor that may particularly affect older adults, the decision should be appealed.

We suggest that **Public Health England** should remind all residential rehabs of their obligation not to discriminate on the grounds of age and ensure that rehabs are not able to enter arbitrary upper age limits on 'Rehab Online' or any other directories unless the service is specifically for young people.

We suggest that the **Care Quality Commission** should ensure that residential rehabs that they inspect are safe and responsive to the needs of all age groups and that rehabs are not able to register as caring only for 18-65 year olds.

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