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Older high-risk drug users

This submission focuses on the following questions with reference to older high-risk drug users

- What is the extent of their health harms resulting from drug use?
- What are the reasons for their continued, sustained use of drugs?
- How effective and evidence-based is treatment provision for this group?
- Is policy sufficiently geared towards treatment?
- What would a high-quality, evidence-based response look like?
- What responses internationally stand out as particularly innovative and / or relevant, and what evidence is there of impact in these cases?

Summary

- the average age of people in drug treatment is rising, with increasing proportions in their 40s, 50s and 60s
- many of these are part of an ageing cohort of people who have had a drug problem for an extended period of time
- mortality rates in this group are highly elevated and their mortality risk accelerates with increasing age
- as they age, the needs of high-risk, problem drug users become more complex
- the likelihood of successfully completing treatment deteriorates with duration of use
- by the age of 40 years, long-term drug users need a level of care corresponding to that required by non-substance using elderly people
- there is currently a mismatch between the design of services and the needs of this group, which require multi-disciplinary and multi-agency interventions as well as specialist drug treatment, and attention to chronic and complex needs to reduce the burden of health inequalities they experience.
1. Introduction

1.1 The 2017 Drug Strategy observed that the average age of people in treatment is rising, with increasing proportions in their 40s, 50s and 60s. It noted that the ACMD is currently looking at the evidence that exists around problems for ageing drug users (aged over 45 years). A Working Group has been established to map the numbers of older drug users in the UK and draw on UK and international evidence to establish the current and future needs of this cohort. The government has said that it will give full consideration to the findings and recommendations from the ACMD once received.  

1.2 The two authors are members of the ACMD working group and have contributed to its deliberations. The views expressed here are however their own and shared by Bristol Drugs Project.

1.3 This submission focuses on an ageing cohort of people with a drug problem who have had a drug problem for an extended period of time. They represent a group with complex needs and a long treatment history. They have lengthy histories of mainly Class A drug use and exhibit deteriorating physical and mental health.

2. What is the extent of their health harms resulting from drug use?

2.1 These older users typically have a history of poor health, long-term drug taking, chronic tobacco and alcohol use, and age-related deterioration of the immune system, which make them susceptible to chronic health problems, such as cardiovascular and lung conditions. Infection with one of the hepatitis viruses can place them at increased risk of cirrhosis and other liver problems.

2.2 The chronic effects of problem drug use exacerbate and complicate the effects of ageing. Many develop chronic and life-threatening conditions resulting in premature ageing. They also exhibit a range of psychological and physical health problems, including cardiovascular and lung conditions, chronic pain and renal problems.

2.3 Mortality rates in this group are highly elevated and accelerate with increasing age. As they age, their risk of experiencing a fatal overdose increases dramatically as does their rate of premature mortality due to other causes. Thus the needs of ageing, high risk, problem drug users are complex.

2.4 They thus exhibit a range of health harms including
• higher rates of blood-borne viruses including hepatitis C
• higher rates of physical and mental health morbidity
• psychological effects of long-term drug use like depression, self-harm and memory disturbance

2.5 The key aspects of the health harms they experience are:
• comorbidity
• chronic conditions
• overdose deaths
• early ageing
• excess mortality and morbidity. iv

3. What are the reasons for their continued, sustained use of drugs?

3.1 The stigma which surrounds the lives of this group compounds and amplifies the health harms they experience. Long term users of Class A drugs develop physical and psychological dependency on these substances. In addition, the 2017 Drug Strategy noted with regard to older drug users the challenges of ageing, including pain, loneliness, or depression. v

3.2 Many of those with a long and severe history of drug dependence are socially isolated, marginalised and unemployed, that is they lack ‘recovery capital’. For a variety of reasons, they also have histories of poor treatment engagement.

3.3 Many live in insecure accommodation, separated from their families and are often to be found among the homeless. They are marginalised, social excluded and stigmatised.

4. How effective and evidence-based is treatment provision for this group? This refers to both healthcare services and wider agencies, and the extent to which joined-up care pathways operate.

4.1 There have been substantial, consistent, year-on-year increases in the number of treated opiate users who are over the age of forty years: this number almost tripled, from around 26,000 in 2005-6 to around 70,000 in 2015-16. By 2015-16, just 12% of treated opiate users were under the age of 30 years, 41% were in their thirties, and 47% were over the age of 40. Notably, 13% were over the age of 50 years. Public Health England (PHE) projections suggest that, whilst the number of opiate users in treatment is likely to decline, by 2020: around three-quarters of this group will be aged 40 years or more; a third 50 years
or more; and around three-fifths of treated opiate users will have been using for 20 years or more. vi

4.2 PHE’s analysis of National Drug Treatment Monitoring System (NDTMS) data indicates that the likelihood of successfully completing treatment deteriorates with duration of use.

4.3 By the age of 40 years, long-term drug users need a level of care corresponding to that required by non-substance using elderly people. As well as the usual health screening and monitoring that a non-drug user might be offered, they also have special health needs due to the complications of long-term drug (and alcohol) use and treatment. In addition, there are often social problems arising from bereavement, social isolation, lack of social support and financial difficulties.

4.4 There is currently a mismatch between the design of services and the needs of this group, which require multi-disciplinary interventions as well as specialist drug treatment.

4.5 Substance use disorders among older people may be missed or misdiagnosed. There is a lack of adequate knowledge and training among health and social care professionals.

4.6 In specialist drug treatment services today, this older, opiate-using group currently dominates treatment provision. Thus the everyday work of drug treatment services revolves to a large extent around their needs: targets for treatment regimes need to adapt to this. Achieving an immediate sustained recovery if defined as abstinence is not a realistic goal for them or for services.

4.7 Services need to focus on reducing the health and social risks of this group’s drug use and treating their comorbid conditions while maintaining the ultimate ambition of abstinence. The focus of attention should be on relieving chronic conditions.

4.8 Thus in responding to ageing drug users, the key facts that services have to recognise are:

• comorbidity
• chronic conditions
• overdose deaths
• early ageing
• excess mortality and morbidity
• histories of poor treatment engagement.
5. Is policy sufficiently geared towards treatment for this group? This includes the extent to which health is prioritised.

5.1 The overall need is for medical, nursing and social services to provide more varied support, including around employment, housing, health and wellbeing, smoking, physical activity, families and mental health.

5.2 There is a need for social care responses to these clients’ poor nutrition, poverty, poor housing, poor quality of life and social isolation. A wide range of social services are needed working together with primary care, acute and specialist health care and specialist drug services. Developing appropriate services also requires training, more research and more patient/client involvement.

5.3 As a consequence of the multiple problems experienced by older drug users, a joined-up treatment and care approach with effective interagency partnerships and referral systems between specialised and mainstream health and social services is becoming more important than ever. vii

6. What would a high-quality, evidence-based response look like?

6.1 All indications suggest that it is challenging to help people with complex needs and a long treatment history to achieve recovery’. viii

6.2 To meet these challenges, it would be necessary to:

- recognize the complexity of needs of older drug users
- prioritise physical health
- recognise mental illness
- give a key role to primary care
- recognise the distinctive role of substance misuse services in treatment and harm reduction
- improve social care
- increase attention to joined up working and partnership approaches
- develop advocacy services
- change regimes and cultures in services.

6.3 Local needs assessments and national strategies, including the NHS Long Term Plan, should include specific attention to older people with a drug problem. In particular, local commissioners should address this issue in their planning.
7. What responses to drugs internationally stand out as particularly innovative and/or relevant, and what evidence is there of impact in these cases?

7.1 Throughout Europe, specialised treatment and care programmes for older drug users are rare. European Monitoring Centre for Drug Dependence and Addiction (EMCDDA) have commented that addiction treatment and other healthcare services are insufficiently aware of the needs of older drug users and need to anticipate and prepare for predicted increases in demand from this age group. They recommend that substance use programmes for older adults should be able to provide basic-level medical services and where severe or complex health problems are identified, referral should be to specialist medical services. Different dose regimens may be required because of age-related metabolic changes. Appropriate and effective treatment should be tailored to the specific needs of older drug users, even if little is currently known about this patient group. This may require modifying existing forms of treatment or developing new ones. In particular, treatment should be more attentive to comorbid health conditions faced by older adults.

7.2 EMCDDA also recommend that older citizens should have access to effective healthcare services where they will be catered for with dignity and sensitivity. This may require developing a wider range of and alternatives to current treatment.

7.3 In Dublin a multi-agency team focused on addressing the needs of a cohort of people with complex and multiple needs in the City Centre. The team provided intensive case management support to people identified as members of the target cohort. The team focused on conducting assertive case management in the city centre area by identifying, approaching, engaging with, and assisting those individuals with complex and multiple needs. The needs of the target group span four key areas: addiction and public injecting; homelessness and rough sleeping; anti-social behaviour, begging and criminal behaviour; and mental health.

7.4 The project is a partnership between Health Service Executive (HSE), Garda and Dublin City Council (DCC) and Dublin Region Homeless Executive (DRHE). They also link to Housing First.

7.5 Clients were supported to access services previously unavailable to them with better coordination of two specialisations - addiction and housing - to meet the needs of clients. There were significant improvements in the relationship between many clients and the Garda, leading to increased communication, trust and compliance with the law, fewer warrants and court appearances; reduction in drug-dealing, begging and anti-social behaviour.

7.6 With deteriorating health, limited social support and reduced mobility, many older problem drug users are faced with pressing accommodation and nursing needs. Due to the
difficulty in accommodating older problem drug users in mainstream nursing or retirement homes, a few countries (e.g. Denmark, Germany, the Netherlands) have developed specialised nursing homes and accommodation services for this group.

7.7 Two of the first such care facilities for older drug users were developed as pilot projects in the late 1990s in the Netherlands and Germany. The Dutch facility is part of an existing retirement home and aims to cater for older drug users who are no longer able to look after themselves. Older drug users live in 24-hour supervised accommodation, where the aims include helping them to learn and maintain living skills, manage their income, monitor medicine use, engage in activities and follow a daily routine. The main goal is to help drug users live out their final years in comfort and dignity. An important point is that while residents are encouraged to reduce their drug use, consumption is not prohibited.

7.8 The services provided within the German project comprise long-term residential care for older drug users and ambulatory forms of assisted living. Housed in living communities, older drug users can make use of outpatient drug treatment services and elder care. In Germany, several such projects have now been implemented as pilot projects, though do not form part of the regular care offer.

7.9 In 2004, the city of Copenhagen conducted a study of the needs for care and nursing facilities among persons over the age of 39 in substitution treatment and tried to assess their future care needs. The results suggested that about half of the users would start to need care and nursing services within five years. It was predicted that 76% of them would experience somatic problems, 31% mental disorders and between 30% and 40% social problems (social isolation, loneliness). The majority of older drug users lived in their own dwelling and were assessed to be capable of staying there with social support and care (home care, home nursing). A smaller share would need supported housing services that include supervision, social support, practical aid and care. Finally, due to their frailty, it would be necessary to place a significant number of older drug users in nursing homes.

7.10 As a result, a series of ‘alternative nursing homes’ were established throughout Denmark. The target clientele of these homes are ‘persons who, due to considerable and permanent physical and mental impairment of functions, need extensive help in ordinary, daily functions or care, nursing or treatment and who cannot get these needs covered in any other manner’ (Section 108 of the Consolidation Act on Social Services). Alternative nursing homes provide the same services as traditional nursing homes but must in addition be able to accommodate persons with an often more active and challenging behaviour than the mainstream nursing home patient. Also, besides satisfying the need for care, the aim of these homes is to create a social framework for users and prevent social isolation.

7.11 Elsewhere in Europe, a number of care and nursing homes have been piloted specifically for older drug users but there are concerns that they might increase stigmatisation and social exclusion and have a detrimental effect on maintaining abstinence for those who wish to do so.
7.12 In Germany it is becoming clear that the most vulnerable older drug users, those most in need of support, have health and social comorbidities that are likely to be incompatible with full participation in the labour market.

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1 HMG (2017) *Drug Strategy* p14
2 C M Beynon (2009) ‘Drug Use and ageing: older people do take drugs’ *Age and Ageing* 38, 8-10
7 EMCDDA (2010) *Treatment and Care for Older Drug Users* European Monitoring Centre for Drugs and Drug Addiction
8 Burkinshaw et al (2017) p.9
10 CSJ (Centre for Social Justice) (2017) *HOUSING FIRST - Housing-led solutions to rough sleeping and homelessness* CSJ
12 EMCDDA 2010.