

# ACMD

## Advisory Council on the Misuse of Drugs

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Rt. Hon. Sajid Javid MP  
Home Secretary  
2 Marsham Street  
London, SW1P 4DF

14 June 2019

Dear Home Secretary,

### **Re: ACMD report - Ageing cohort of drug users**

In recent years, statistics have been published to show a demonstrable shift in age profile of individuals accessing treatment for drug use in the UK. In response to this the Advisory Council on the Misuse of Drugs (ACMD) undertook this self-commissioned report to review the evidence of this trend and assess the implications of an ageing cohort on specialist drug treatment services.

In this report, the ACMD describes the changing age profile; provides an overview of the challenges faced by this ageing cohort in the UK; explains why current service regimen are not meeting the needs of this group and makes recommendations for practise and policy.

The ACMD concluded that this ageing cohort of drug users (those over the age of 35 years) now account for a significant proportion of patients in specialist community drug treatment services. Many substance misuse services in the UK do not adequately cater to the needs of this cohort and services will need to adapt to fit to this permitting trend.

### **Conclusions**

- Specialist community drug services are treating an ageing cohort of patients. Predominant among these are those with problematic opiate/opioid use.
- Research suggests that older drugs users, particularly opiate/opioid users, have multiple additional risk factors resulting from their deteriorating physical and mental health, difficulty in navigating complex health and social care systems and experience of stigma.

- There are indications which suggest that addressing the complex and varied needs of older opiate/opioid users will increasingly become a mainstream treatment activity.
- Specialist community drug services are insufficiently prepared to manage the complex needs of this ageing cohort, despite the increase in older drug users attending for treatment.
- Commissioners, providers and the specialist drug treatment workforce all need to ensure that staff are competent to meet these demands with the expected increase in complexity of treatment required by attendees.
- Future trends in treatment presentations of ageing cohorts are difficult to predict and careful monitoring of drug treatment populations and other metrics of drug misuse should be explored and utilised. The better recording of prevalence of substance misuse by ageing drug users will improve understanding of the ageing treatment cohort and support service planning and delivery.

## **Recommendations**

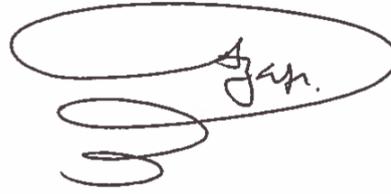
- Specialist community-based drug treatment services should develop training for staff to highlight the treatments and specific risks for older drug users, particularly opiate/opioid users.
- Given the changes to the specialist community drug treatment workforce over the last five years, an assessment should be conducted of the current range and availability of skills, treatment and support available to people presenting to treatment. A particular focus should be the availability and knowledge of staff to address the complex physical and mental health issues of older drug users.
- An evaluated pilot programme to determine whether the use of the service navigator model will assist older drug users to engage more successfully in complex health and social care systems, improve the quality of care and health outcomes and be cost effective.
- Close and ongoing analysis of treatment presentation data and wider metrics of drug misusing patterns, with particular attention given to refining and standardising age categories.

We welcome the opportunity to discuss and present this report to the Drug Strategy Board.

Yours sincerely,

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**Dr Owen Bowden-Jones**  
**Chair of ACMD**

A handwritten signature in black ink, appearing to read "Kostas Agath". The signature is highly stylized, featuring a large, horizontal oval shape at the top and several loops below it.

**Dr Kostas Agath**  
**Chair, ACMD Ageing cohort working group**

# ACMD

Advisory Council on the Misuse of Drugs

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# Ageing cohort of drug users

June 2019

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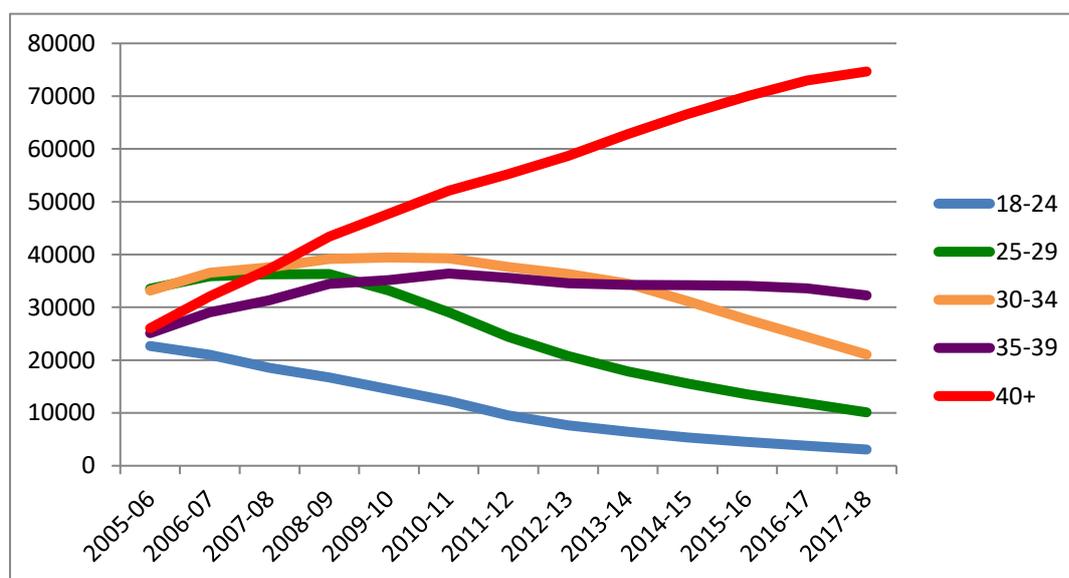
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## 1. Introduction

- 1.1. The past decade has seen a demonstrable shift in the age profile of individuals accessing treatment for drug use. An ageing cohort, who have survived lengthy histories of heavy drug use, now account for an increasing proportion of those in specialist community drug treatment in the UK and in Europe. Ageing added to the effects of long-term heavy drug use means that this cohort is now experiencing a range of issues, including deteriorating physical and mental health. Many substance misuse services in the UK do not cater adequately to the needs of this cohort, meaning that ageing drug users may feel disengaged and fall out of treatment or be perceived and/or actually judged as unsuitable.
- 1.2. Those ageing in community drug treatment services are most likely to be using opiates/opioids. Since the 1970s, problem opiate/opioid users (often injectors) in the UK have represented the largest group receiving specialised drug treatment. More recently, the number of opioid users entering treatment across the EU has declined, while the average age of those retained in treatment has increased. High-risk drug users aged over 40 may soon become the largest drug treatment population in Europe (EMCDDA, 2017). The impact of these demographic changes has only recently been recognised. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has suggested that addiction services and other healthcare services have been insufficiently aware of the specific needs of the ageing cohort of drug users and they continue to need to prepare for increases in demand from this age group (EMCDDA, 2008; 2010).
- 1.3. This report from the Advisory Council on the Misuse of Drugs (ACMD) aims to describe the changing age profile of people accessing drug treatment, provide an overview of the challenges faced by the ageing cohort in the UK, explain why current service regimens are not meeting the needs of this group and make recommendations for practice and policy.
- 1.4. This report will focus on those attending specialist drug treatment services for treatment of illicit drug use. The report will not consider:
  - drug users outside treatment services;
  - the misuse of prescription medication; or,
  - primary alcohol users.
- 1.5. For the purposes of this report:
  - the ageing cohort is considered to be those aged over 35 years.
  - the term 'substance misuse service' will be used to describe treatment services in general.

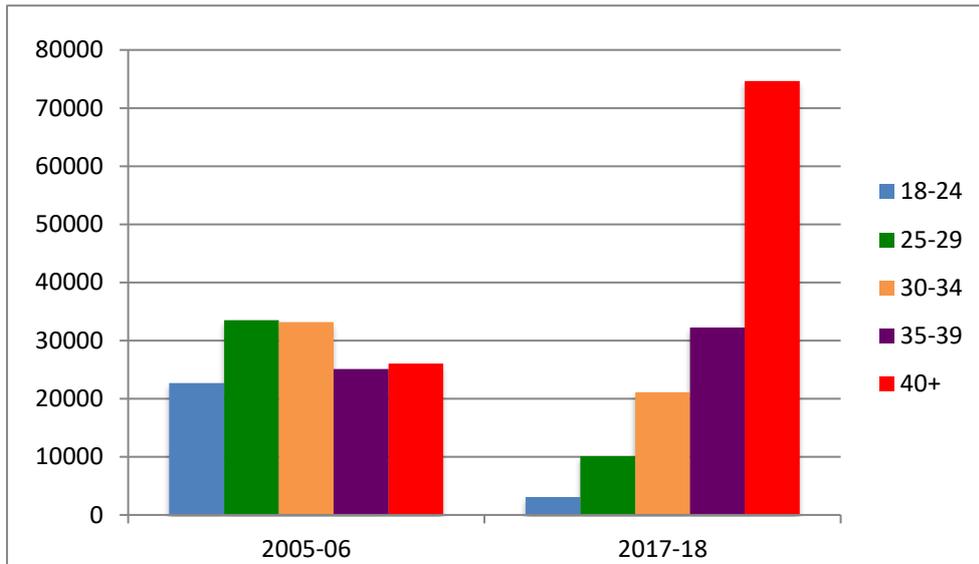
## 2. Treatment statistics indicating a changing profile

- 2.1. Specialist drug treatment data have charted a looming challenge with increases in the number of older drug users receiving treatment.<sup>i</sup> The ageing cohort we focus on is characterised by problematic opiate/opioid use. Available data show a substantial, consistent, year-on-year increase in the number of treated opiate users who are over the age of 40: this number almost tripled, from around 26,000 in 2005/06 to around 75,000 in 2017/18 (see Figure 1).
- 2.2. **Figure 1** shows that the number of individuals in treatment for primary opiate problems under the age of 30 has declined substantially over the past decade (from around 55,000 to around 13,000 (compiled by a working group from PHE, NDTMS data).



**Figure 1: Number of opiate users in treatment in England, by age group and year of treatment: 2005/06 to 2017/18 (PHE, NDTMS data)**

- 2.3. **Figure 2** shows the change in age distribution of treated opiate users from 2005/06 to 2017/18. By 2017/18, just 9% of treated opiate users were under the age of 30 years, 38% were in their 30s, and 53% were over the age of 40. Notably, 16% were over the age of 50 (PHE, NDTMS data).



**Figure 2: Comparison of the age distribution of treated opiate users in 2005/06 and 2017/18 (PHE, NDTMS data)**

- 2.4. These data suggest that an ageing, opiate-using cohort currently dominates demand for substance misuse services and this will continue into the future.
- 2.5. Other groups engaging in substance misuse treatment include non-opiate drug users, non-opiate and alcohol users and alcohol only users (see **Table 1**), Younger people account for a larger proportion of these groups than is the case for primary opiate users in treatment. It is not clear whether drug use within this group will persist with age to the same degree as has been observed for opiate users.

**Table 1: Age and substance use of all individuals in substance misuse treatment in England: 2017/18<sup>1</sup>**

Age	Opiate		Non-opiate only		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	n	%	n	%	n	%
18	116	0%	948	4%	721	3%	204	0%	1,989	1%
19	184	0%	829	3%	483	2%	176	0%	1,672	1%
20-24	2,772	2%	4,361	18%	3,122	11%	1,824	2%	12,079	5%
25-29	10,114	7%	5,001	21%	4,698	17%	4,516	6%	24,329	9%
30-34	21,067	15%	4,337	18%	5,106	18%	7,184	9%	37,694	14%
35-39	32,263	23%	3,234	14%	4,431	16%	9,369	12%	49,297	18%
40-44	28,968	21%	1,987	8%	3,288	12%	10,880	14%	45,123	17%
45-49	22,876	16%	1,388	6%	2,813	10%	12,624	17%	39,701	15%
50-54	13,612	10%	827	3%	1,770	6%	11,602	15%	27,811	10%
55-59	5,784	4%	408	2%	869	3%	8,463	11%	15,524	6%
60-64	2,350	2%	165	1%	295	1%	4,761	6%	7,571	3%
65-69	850	1%	113	0%	68	0%	2,579	3%	3,610	1%
70+	233	0%	132	1%	20	0%	1,605	2%	1,990	1%
<b>Total</b>	<b>141,189</b>	<b>100%</b>	<b>23,730</b>	<b>100%</b>	<b>27,684</b>	<b>100%</b>	<b>75,787</b>	<b>100%</b>	<b>268,390</b>	<b>100%</b>

Note: Percentages may equal 0% or not sum to 100% due to rounding

2.6. **In England:** Figure 3 shows a marked geographical variation in the age distribution of opiate users in treatment across England (see Figure 3). Although estimates of the prevalence of opiate misuse in England do indicate a declining population, the decline has, hitherto, been rather modest:

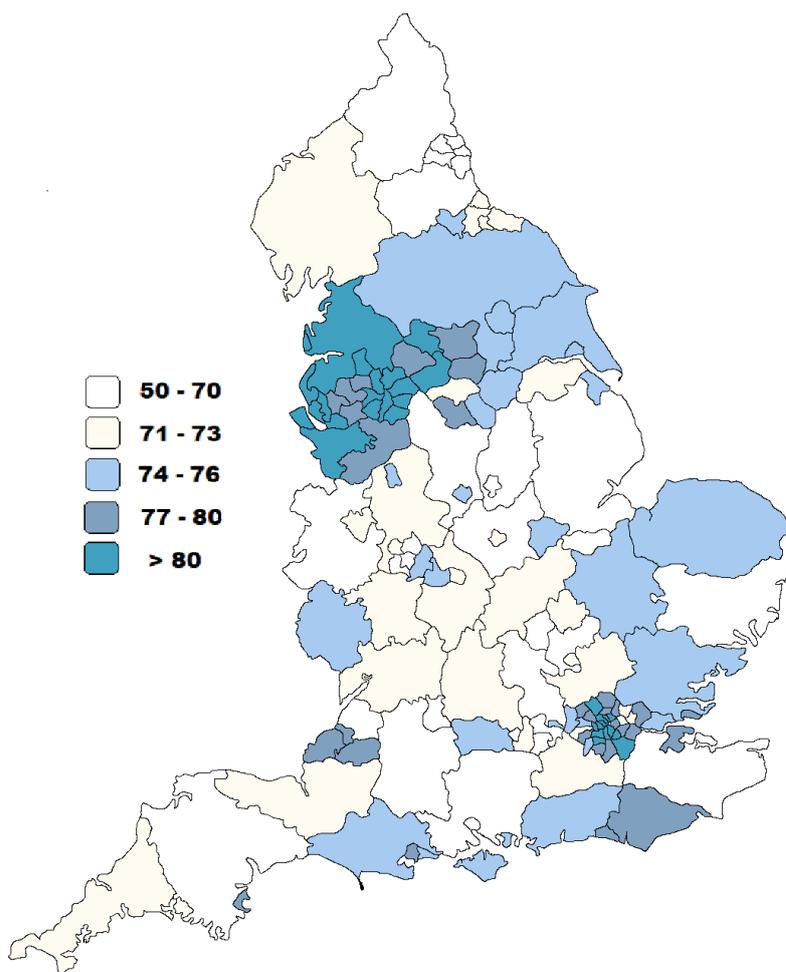
- from circa 281,000 individuals in 2004/5 (95% CI 280,000 to 293,000);
- to 261,000 in 2016/17 (95% CI 259,000 to 271,000).

(Liverpool John Moores University; UK Focal Point on Drugs, 2017).<sup>2</sup>

2.7. These prevalence estimates also indicate that an increasing proportion, and number, of opiate users are over the age of 35 years. **Table 1** shows the age distribution of all individuals in substance misuse treatment in 2017/18. The estimates currently are commissioned on the basis of reporting prevalence for the age groups 15-24, 25-34 and 35-64 years. Given the increasing concern regarding this ageing cohort of drug users, it may be advisable to review the age categories on which these estimates are produced. That is, to divide the category 35-64 into more specific age-ranges such as 35-44, 45-54, 55-64.

<sup>1</sup> Reproduced from Public Health England (2016) 'Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): 1<sup>st</sup> April 2015 - 31<sup>st</sup> March 2016'

<sup>2</sup> <https://phi.ljmu.ac.uk/wp-content/uploads/2019/03/Estimates-of-the-Prevalence-of-Opiate-Use-and-or-Crack-Cocaine-Use-2016-17-Sweep-13-report.pdf>



**Figure 3: Percentage of opiate users aged 35 and over in treatment, by local authority area. (NDTMS, 2017/18)<sup>ii</sup>**

2.8. **In Scotland:** In 2015/16 it was estimated that over half of people with a drug problem in Scotland were over the age of 35. Among those seeking help from specialist drug treatment services, the percentage of individuals aged 35 and over increased from 29% in 2006/07 to 51% in 2016/17 (ISD, 2019). A review of opioid substitution therapy (OST) in 2013, noted that the average age of those using substances had markedly increased. Given that ageing is associated with worsening health in general, the degree of both physiological and psychological difficulty, already high among those in OST, is likely to increase further (Independent expert review of opioid replacement therapies in Scotland, 2013).

2.9. **In Northern Ireland:** The Northern Ireland Substance Misuse Database (SMD) records information on new presentations to treatment services with problem drug and/or alcohol use. As such, it is not possible to compare the Northern Ireland data to the England data. For instance: (a) it is not possible to know the number of those over the age of 35 in the treatment system from the SMD data; (b) furthermore, the age breakdown by the number of new heroin users according to the SMD would not be comparable to the NDTMS, which reports heroin/opiate users in treatment. In 2016/17, the SMD recorded a total of 4,368 clients presented to services with problem drug misuse in Northern Ireland, of which approximately 10% reported heroin use

(Northern Ireland Substance Misuse Database, 2017). The majority of those reporting heroin use (approximately 80%) were aged under 40, which could suggest differences in the age profile of opiate users in Northern Ireland compared to the rest of the United Kingdom.

- 2.10. **In Wales:** In 2017, the Advisory Panel on Substance Misuse (APoSM) had found that the population in treatment for substance misuse problems was ageing and that substance misuse among older adults was a significant and growing problem (APoSM, 2017).
- 2.11. Across the UK, with the exception of Northern Ireland, treatment services are characterised by an ageing population of opiate users who have remained periodically in contact with agencies but have struggled to achieve sustained abstinence from opiate use. It is likely that this is a reflection of the clinical nature of opiate dependence, with periods of relapse and remission continuing over many years. The patterns for other drug use are less clear.

#### **Likely development of UK drug treatment population over time**

- 2.12. As this cohort ages, some will recover, achieve sustained abstinence and exit specialist treatment services. Some people will die as a direct or indirect consequence of their drug use or other age-related conditions. Over time, it might be expected that the older opiate-misusing treatment population will reduce in size, but those still in treatment will have increasingly complex physical, psychological and social needs.
- 2.13. This expectation is supported by PHE projections in 2017. These suggested that, whilst the number of opiate users in treatment was likely to decline, by 2018:
- around three-quarters of this group would be aged 40 years or more;
  - a third would be aged 50 years or more; and,
  - around three fifths of treated opiate users would have been using for 20 years or more.
- (Burkinshaw *et al.* 2017).
- Moreover, this PHE analysis of National Drug Treatment Monitoring System (NDTMS) data indicates that the likelihood of successfully completing treatment deteriorates with duration of use.
- 2.14. It seems likely that this older population will have poor prospects of achieving permanent abstinence, although some may do so and this may continue to be the ultimate aim of treatment. Their need for stabilising substance misuse treatment will persist, as will the need to address increasing and premature age-related ill health. Therefore, unless there are dramatic and unexpected changes in this population, addressing the complex and varied needs of older opioid/opiate users will become the mainstream of treatment activity rather than a treatment specialism.
- 2.15. In studies of older heroin users, high levels of physical, psychological and psychiatric comorbidities have been found (Rosen *et al.*, 2011). Psychological problems can be severe and partly relate to trauma, bereavement and grief (Templeton *et al.*, 2016). Problem drug use often

adds further trauma and life difficulties to pre-existing ones, which can escalate drug use further (Scottish Drugs Forum, 2013).

2.16. A study by the Scottish Drugs Forum reported the biggest problems faced by older drug users compared with younger people as:

- problems accumulated with age;
- stigma;
- feeling forgotten about; and,
- lack of services.

(Scottish Drugs Forum, 2017a; 2017b).

### 3. Physical and mental health of ageing drug users

3.1. Ageing opioid users suffer from accumulated physical impairments and have high levels of both physical and mental health problems (EMCDDA, 2010).

3.2. Older problem drug users show a unique combination of features which present a challenge to health and care services. The chronic effects of problem drug use exacerbate and complicate the effects of ageing (Beynon, 2009). The ageing process itself is often associated with a range of psychological and physical health problems (Dowling *et al.*, 2008). Drug intoxication and the residual effects of drug use may differ in older persons, affecting the cognitive, motor and physical functions of individuals. Individuals who have used drugs for many years are more likely to have poor general health related to physical functioning, role limitations due to physical health and bodily pain when compared with younger drug users and the general population (Lofwall *et al.*, 2005).

3.3. The cumulative effects of polydrug use, non-fatal overdose and infections over many years accelerate physical ageing among these users, with implications for treatment and social support services.

3.4. Injecting drug users may already be stigmatised as undeserving or demanding and this situation is compounded among older, entrenched drug users with histories of poor treatment engagement (Lloyd, 2012, Simmonds *et al.* 2009, Neale *et al.* 2008).

3.5. A UK study compared the characteristics of a group of patients aged over 50 years old entering a methadone maintenance programme for opioid dependence with those aged under 50 (Badrakalimuthu *et al.*, 2012). The study reported statistically higher rates of blood-borne viruses, physical and mental health morbidity in the 50 and over age group, compared with those aged under 50. Moreover, ageing drug users who had engaged in injecting behaviours over the course of their drug career may be at higher risk of having contracted and suffering the health consequences of Hepatitis C (HCV), which can take decades to manifest (Beynon 2009). The consequence of contracting HCV may only become apparent in later life with the onset of advanced liver disease. (Davis *et al.*, 2010).<sup>iii</sup> Older adult methadone patients are likely to have accompanying mental health disorders (Rosen *et al.*, 2011).

3.6. Emerging evidence highlights that the increase in fatal overdose risk faced by opioid users as they age may be specific to methadone (Gao *et al.*, 2016; Pierce *et al.*, 2018). That is, methadone may present particular risks to older users. In addition, the risk of a fatal overdose is observed to be greater among those who are in receipt of higher daily doses, so that older users who also receive the top quintile for daily-dose face dual risks.<sup>iv</sup> Whilst it is vital to note that opioid substitution therapy (OST), in general terms, is highly protective against a fatal overdose (Pierce *et al.*, 2016), there is a need to:

- develop our understanding of methadone's effects in older users; and,
- for clinicians to monitor with particular care amongst older users the known risks of high-dose methadone regarding QTc prolongation.

### **Mortality and morbidity**

3.7. Drug use, particularly opioid/opiate use is associated with increased mortality and morbidity. Mortality rates in this ageing cohort of drug users are elevated and mortality risk accelerates with increasing age (Pierce *et al.*, 2015). The ACMD reported on reducing opioid-related deaths in 2016.<sup>3</sup>

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<sup>3</sup> Drug-related deaths (DRDs) have increased over the past 20 years, with significant increases in the numbers registered in the last 3 years among older heroin users, many of whom may have been in poor health after long periods of using the drug. The number of poisonings related to heroin use is also increasing, notably among older heroin users (Burkinshaw *et al.*, 2017: 41). Those who are older and those with significant health problems, have a higher risk of premature mortality than the general population (*ibid*: 96). In 2013, the average age of those dying from a drug-related death was 41.6 years, with males tending to be about 5 years younger than females (40.5 years and 45.1 years, respectively). The median age at death increased from 32 in 1999 to 41 in 2012. The median age at death for women who suffered a drug misuse death was higher than for men (44 [in 2012] compared with 39 in 2012), with the median age for both sexes generally increasing over the period. More than half of the nearly 3000 DRDs in England and Wales in 2013, and over 80% of nearly 500 DRDs in Scotland in 2012, involved opioids, and were predominantly overdoses (PHE, 2015).

**Table 2: Cause-specific crude mortality rates (CMR) and standardised mortality ratios (SMR) for a cohort of 198,247 opioid users in England (Reproduced from Pierce et al (2015) Drug & Alcohol Dependence, 146, 17-23)**

Cause of Death and SMR linear trend by age group	Age-group								
	18 -34 years, (pys = 298,111)			35 - 44 years, (pys = 175, 464)			45 - 64 years, (pys = 68,317)		
	n <sup>i</sup>	CMR per 10k pys [95% CI]	SMR [95% CI]	n <sup>i</sup>	CMR per 10k pys [95% CI]	SMR [95% CI]	n <sup>i</sup>	CMR per 10k pys [95% CI]	SMR [95% CI]
<b>Infectious/parasitic diseases</b>	23	0.8 [0.5, 1.2]	<b>5.7</b> [3.8, 8.6]	56	3.2 [2.5, 4.1]	<b>11.0</b> [8.5, 14.3]	80	11.7 [9.4, 14.6]	<b>23.2</b> [18.6, 28.8]
<i>SMR trend p &lt; 0.001</i>									
<b>Cancers</b>	33	1.1 [0.8, 1.6]	<b>1.3</b> [0.9, 1.8]	72	4.1 [3.3, 5.2]	<b>1.5</b> [1.2, 1.9]	191	28.0 [24.3, 32.2]	<b>2.1</b> [1.8, 2.4]
<i>SMR trend p = 0.003</i>									
<b>Circulatory system</b>	71	2.4 [1.9, 3.0]	<b>3.6</b> [2.9, 4.6]	143	8.1 [6.9, 9.6]	<b>3.2</b> [2.7, 3.8]	204	29.9 [26.0, 34.3]	<b>2.9</b> [2.5, 3.3]
<i>SMR trend p = 0.24</i>									
<b>Respiratory system</b>	40	1.3 [1.0, 1.8]	<b>7.5</b> [5.5, 10.2]	88	5.0 [4.1, 6.2]	<b>10.2</b> [8.3, 12.6]	131	19.2 [16.2, 22.8]	<b>8.7</b> [7.3, 10.3]
<i>SMR trend p = 0.24</i>									
<b>Digestive system</b>	59	2.0 [1.5, 2.6]	<b>5.8</b> [4.5, 7.5]	164	9.3 [8.0, 10.9]	<b>6.0</b> [5.1, 6.9]	200	29.3 [25.5, 33.6]	<b>7.1</b> [6.2, 8.2]
<i>SMR trend p = 0.16</i>									
<b>Diseases of Liver:</b>	44	1.5 [1.1, 2.0]	<b>6.4</b> [4.7, 8.5]	136	7.8 [6.6, 9.2]	<b>6.3</b> [5.3, 7.4]	165	24.2 [20.7, 28.1]	<b>7.9</b> [6.8, 9.2]
<i>SMR trend p = 0.10</i>									
<b>Alcoholic liver disease</b>	35	1.1 [0.8, 1.6]	<b>6.8</b> [4.9, 9.4]	105	6.0 [4.9, 7.2]	<b>6.4</b> [5.3, 7.7]	109	16.0 [13.2, 19.3]	<b>7.1</b> [5.9, 8.5]
<i>SMR trend p = 0.75</i>									
<b>Fibrosis and cirrhosis of liver</b>	2	0.1 [0.0, 0.3]	<b>2.6</b> [0.7, 10.5]	18	1.0 [0.6, 1.6]	<b>6.3</b> [3.9, 9.9]	46	6.7 [5.0, 9.0]	<b>14.1</b> [10.6, 18.9]
<i>SMR trend p &lt; 0.001</i>									
<b>Homicides</b>	35	1.2 [0.8, 1.6]	<b>8.8</b> [6.3, 12.2]	28	1.6 [1.1, 2.3]	<b>15.3</b> [10.7, 22.3]	14	2.0 [1.2, 3.5]	<b>27.3</b> [16.1, 46.0]
<i>SMR trend p = 0.002</i>									
<b>Suicides</b>	93	3.1 [2.5, 3.8]	<b>2.7</b> [2.2, 3.3]	79	4.5 [3.6, 5.6]	<b>3.1</b> [2.5, 3.9]	27	4.0 [2.7, 5.8]	<b>3.2</b> [2.2, 4.6]
<i>SMR trend p = 0.55</i>									

<sup>i</sup> number of observed deaths

Notes:

SMR – standardised mortality ratio

Pys - person years

N – number of observed deaths

CMR – crude mortality rate

CI – confidence interval

3.8. There are indications of certain types of deaths not related to opioid use being disproportionately high among this group compared with younger opioid users or same age non-drug using individuals.<sup>4</sup>

3.9. Older drug users in contact with treatment services were significantly more likely than younger drug users to die from causes that were not defined as drug-related (as shown in **Table 2**, see also **Figures 4 and 5**), where ‘drug related’ referred to acute drug toxicity and mental and behaviour disorders only (Beynon et al., 2010). Kidney disease and diabetes may be more prevalent. Neurological and respiratory disorders, cancer and many other age-associated diseases may also be exacerbated by problem opioid use. Balance, coordination, vision and judgement may also be affected (Arona et al. 2015). Among the physical effects of long-term

<sup>4</sup> This applies to infectious diseases, cancers, liver cirrhosis and homicide – SMRs for these causes are statistically significantly higher with age. This does not apply to other causes (Pierce et al., 2015).

opioid use are the direct effects of intoxication, overdose and withdrawal, which can especially affect the liver, veins and lungs (*ibid*).

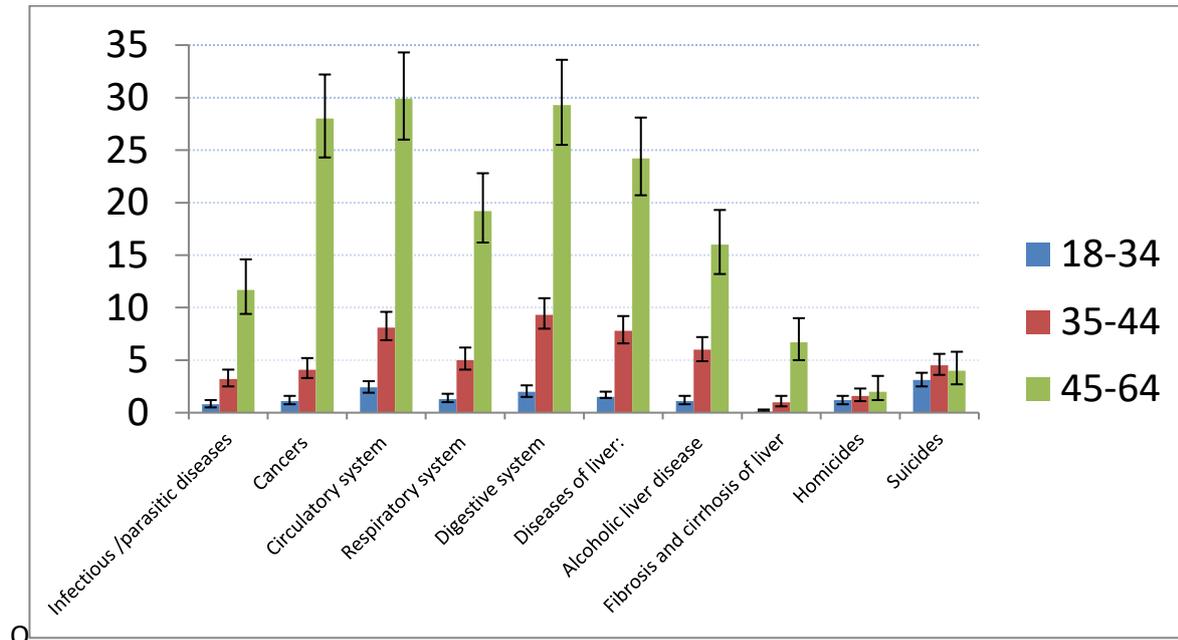


Figure 4: Crude mortality rate per 10,000 person-years, by cause and age (n= 198,247) (Findings from Pierce et al., (2015) *Drug & Alcohol Dependence*, 146, pp17-23)

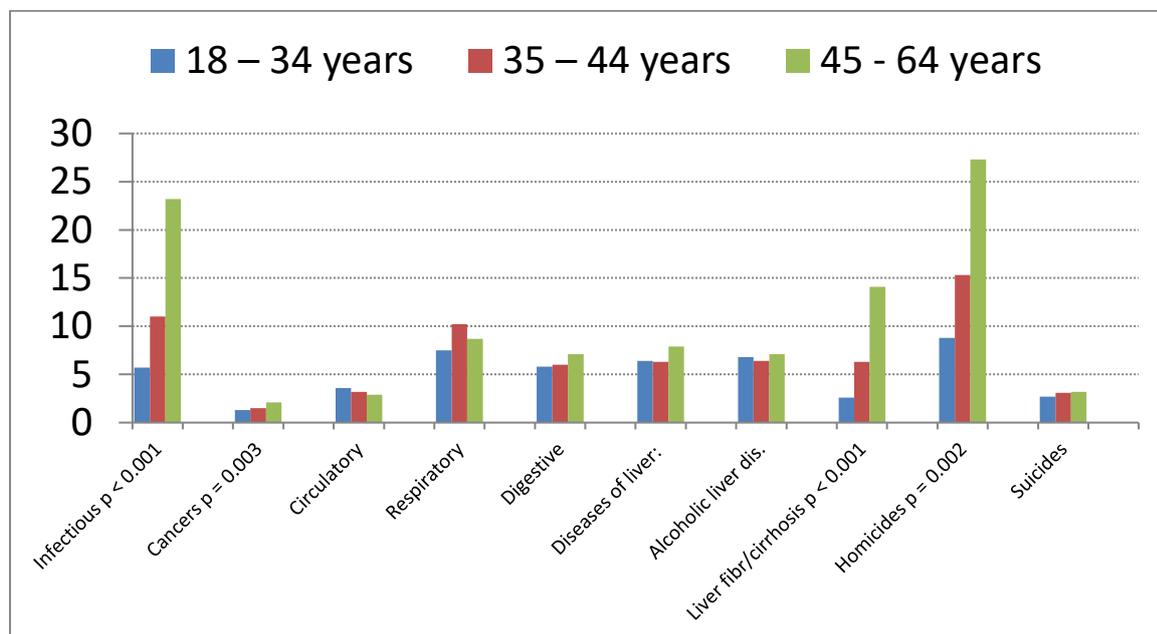


Figure 5: Standardised mortality ratio by cause and age (n= 198,247) (Findings from Pierce et al., (2015) *Drug & Alcohol Dependence*, 146, pp17-23)

### Existing policies

3.10. Policies limiting the time that people are able to spend in treatment can be counter-productive (PHE, 2013). While there is a need to maintain a realistic recovery ambition for ageing

heroin users with complex needs, it should be accepted that the proportion of these people who will successfully complete treatment is likely to continue to fall (*ibid*). The report concluded that:

- they are more difficult to treat;
- they have been with treatment services a long time;
- they find it difficult to move on;
- recovery is not an easy task;
- they have entrenched problems;
- they have failing health;
- treatment may be a source of stability for them, which gives structure to their lives;
- one quarter have been in treatment for five years or more, showing the benefits of methadone prescription; and,
- dependence is hard to overcome.

3.11. Each year, a proportion of the opiate treatment population makes the first steps towards recovery and abstinence, although the number completing treatment free of dependence has reduced since its peak (14,792 opiate users in 2011/12 compared with 9,309 in 2017/18 [PHE, NDTMS data]).

3.12. PHE has previously recommended that national drug strategies should make explicit reference to the specific needs of the ageing cohort of drug users. They also recommended that all local authority, clinical commissioning groups and NHS Trust strategies that address the needs of older people should consider explicitly the needs of older people with a drug problem (Burkinshaw *et al.*, 2017).

3.13. It follows logically from the above observations, that it would make sense for existing mainstream drug services to adapt their provision to cater for the ageing cohort of drug users. In addition, specific innovative services could be set up, ideally with built-in evaluation.

#### **Challenges for treatment services**

3.14. There is rising concern about the lack of attention to substance use among older people (Royal College of Psychiatrists, 2011, 2018). This wider issue remains important and provides part of the context within which the specific question of the ageing cohort of drugs users should be addressed (EMCDDA, 2008; Beynon, 2009; DrugScope/Recovery Partnership 2014).

3.15. Community-based specialist drug services have experienced significant disinvestment and also experienced a loss of skilled staff (Finch *et al.*, 2018; ACMD 2017). This is highly likely to impact on the capacity of the treatment system to undertake the type of complex interventions needed by an ageing cohort of opioid/opiate users. Concerns have been raised about the declining involvement of professionals in delivering community drug treatment services, especially addiction specialist doctors, psychologists, nurses, and social workers.<sup>v</sup> There is growing recognition among the workforce and stakeholders of increasingly complex needs in the service user population. The workforce that is needed should be 'competent in identifying and responding to a wide range of health and social care needs and be able to support people to access treatment for co-existing physical and mental health issues' (Public Health England/Royal

College of Nurses (RCN) 2017: 4). A series of briefings have been produced as a response to concerns raised by PHE stakeholders about reducing numbers of professional roles within alcohol and drug services, which reflect discussions and co-production with relevant stakeholders (BPS, 2012; Galvani, 2015). The PHE/RCN briefing noted that 'there is an ageing population of people accessing drug treatment services. Ageing and older service users tend to have more complex comorbidities and other health and social care related problems, and therefore nurses can potentially add value by offering the option of a 'one stop shop' for various physical, mental health and/or social care needs of older adults. This includes: providing advice on falls prevention; delivering interventions at an appropriate pace using modes of information that can overcome sensory and cognitive impairment; NHS health checks; testing for and providing advice on: chronic obstructive pulmonary disease (COPD); diabetes; ischaemic heart disease; hypertension; Parkinson's disease; dementia; and helping people to access end of life care' (PHE/RCN, 2017: 13-14).

- 3.16. It is therefore recognised that as this cohort ages further, it will require a set of costly and multi-disciplinary interventions beyond specialist drug treatment. Such measures do not appear to be in place at the levels required to meet the current and upcoming needs of this population (Pirone *et al.*, 2016). Less successful outcomes in treatment populations is a particular concern for healthcare services.<sup>5</sup>
- 3.17. It is likely that dual diagnosis/comorbidity patients in older age groups will present in increasing numbers to mental health professionals (Searby *et al.*, 2014; Bartels *et al.*, 2006; Kerfoot *et al.*, 2011).
- 3.18. A joined-up treatment and care approach with effective inter-agency partnerships and referral systems between specialised and mainstream health and social services is even more important for ageing drug users than for the general drug treatment population due to their complex needs (EMCDDA, 2010; Department of Health [no date]). The police, prisons and probation also need more training on the specific needs of older drug users and on how to link with other services (Hayes *et al.*, 2012).

### **Challenges for the user and the role of other services**

- 3.19. Caring for the ageing cohort of drug users requires highly skilled workers who can deal with the complexity of health and social care needs with which the ageing cohort of drug users is likely to present (Scottish Drugs Forum, 2017a, 2017b). As well as providing a full range of services and interventions focused on drug use, there is also a need for housing support and improving access to appropriate health services for this older age group (PHE, 2013).

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<sup>5</sup> 'There were significant increases in the proportion of individuals (aged 18 and over) leaving successfully for all substance groups between 2007–2008 and 2011–2012. Since then the rates have levelled off, with a decline in the proportion of opiate users completing treatment. This decline is likely to be in part because many of those who now remain in treatment for opiate use are older; and often have health and mental health problems and entrenched lifestyles and drug dependence' (Burkinshaw *et al.*, 2017: 34). Opiate users tend to be much older than those in treatment for other drug problems in prison-based drug treatment (*ibid*: 36).

- 3.20. The ageing cohort of drug users suffers from multiple disadvantages. These complicate their access to services, such as housing, dental care, hospital clinics, counselling and welfare benefits/social security. Although contact with primary and secondary healthcare services may provide an opportunity to screen ageing drug users, substance use disorders among older people may often be missed or misdiagnosed (Crome and Bloor, 2005). Owing to these complex needs, professionals working in this field have long recognised the value of multidisciplinary team work. As the 2017 PHE/RCN report noted, a varied skill mix is required in the workforce to respond adequately. Furthermore, as a PHE 2014 report noted, individuals with the most severe problems and complex needs will usually require close liaison with a range of other services. This liaison will, at times, require expert analysis and authoritative liaison by an addiction specialist.<sup>vi</sup>
- 3.21. Drug services thus need a workforce skilled in the complexity of need among older drug users, covering not just substance use, but common comorbidities. Non-drug services, that are generic and other specialist health and social care services, need skills to detect drug use in the older population and awareness that some of their service users may be long-term substance users.
- 3.22. Some service providers consider that the outcomes expected of mixed-age services are problematic for ageing people with long-term substance misuse problems, for whom abstinence may not be a realistic goal (evidence provided by stakeholders during the evidence gathering session, including from the Bristol Drugs Project). Participants in a consultation by DrugScope considered that for some long-term heroin users, care and treatment, and addressing long-term medical conditions, were the most appropriate outcomes (DrugScope/Recovery Partnership 2014).

## Solutions

- 3.23. Treatment outcomes may be improved further if treatment is delivered by a substance misuse service specifically for ageing people (as indicated by examples, such as programmes operated within services like those at the Bristol Drugs Project). However, few of these services exist in the UK and most that do exist are only commissioned to deliver alcohol treatment (Wadd and Galvani, 2014; Slaymaker and Owen, 2008).
- 3.24. Several best practise examples of services for the ageing cohort and innovatory services exist (see Appendices, Appendix 3 and Appendix 4). The active ingredients of these examples include the following.<sup>6</sup>
- *Person-focused interventions:*
    - intensive case management;
    - helping clients to build their confidence;
    - encouraging physical activity;
    - helping clients to develop and maintain a social network; and,
    - providing a stable independent home combined with personalised support.
  
  - *Service structures:*

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<sup>6</sup> These are all elements in a package of treatment and care to be devised appropriately for each individual case, taking into consideration the characteristics of that person's social environment and available resources.

- comprehensive support package;
  - specialist older persons substance misuse service;
  - outreach services, and;
  - wrap-around services.
- *Service processes:*
    - allowing service users to dip in and out;
    - meeting at the prison gate;
    - helping with navigating people from service to service; and,
    - outward facing services – engagement outreach and assertive outreach (Roy and Buchanan, 2016).

### **Best practise examples**

There are few services specifically directed for older drug users.

In England, the Bristol Drugs Project's '50 Plus Crowd' is open to anyone aged 50 and over with drug and/or alcohol problems. Most using the service are on long-term methadone prescriptions with the BDP shared care team and have not been engaging with treatment services beyond these appointments. A twice-weekly group and regular social activities (swimming, yoga, dance therapy, gardening and walking) aim to help clients to develop and maintain a social network and build their confidence. Service users can 'dip in and out', attend social activities, and the group can be a route back into more structured treatment and engagement.

WCADA has been providing a range of treatment interventions for those affected by substance misuse for over 30 years, originally from a single office in Swansea now with six agencies across Swansea, Neath Port Talbot and Bridgend. WCADA is one of the leading substance misuse treatment agencies in Wales, providing Minnesota 12-Step Abstinence treatment and Harm Reduction services, including needle exchange and outreach, targeted to individual need. Other services provided include information, advice and treatment for young people, older and disabled people, family members and carers.

A comprehensive support package is available to older adults. It includes:

- advice and awareness sessions;
- health promotion; structured individual support and access to clinical alcohol; and,
- drug treatment services, as appropriate, and wrap-around services, such as diversionary activities.

Focus is placed on reducing isolation and supporting older adults to enhance their support network.

In Wales, WCADA service users were asked 'What Works Well?' (APoSM, 2017).

The following were included among the suggestions that were relevant to illicit drug users:

- a friendly and welcoming atmosphere;
- a non-judgemental approach where users are not stigmatised or criticised;
- the central location of the service;
- the availability of telephone support;

- regular contact with staff who understand;
- support from family and friends; and,
- an activities programme.<sup>7</sup>

In Liverpool, a pilot programme was designed to improve the health of older high-risk drug users through exercise referral schemes. Resources were provided to encourage gym attendance (bus passes, sports clothing and membership fees). Improvements in self-esteem and confidence were noted (Beynon *et al.*, 2013). There is a role for further development and innovations in encouraging physical activity among older illicit drug users (Neale *et al.*, 2012).

- 3.25. Knowledge about substance use and misuse among ageing drug users needs to be embedded beyond the obvious hospital specialties of emergency medicine, geriatrics and internal medicine, to include allied health professionals and general practice, who are often the first port of call when illnesses occur.<sup>8</sup> There is a need for training of practitioners and integrating their services with the specialist drug services. Integrated and joined up support from a full range of generic and specialist interventions represents an opportunity to intervene earlier and more effectively.
- 3.26. Training for staff working in drug and alcohol treatment services needs to be improved and expanded, especially given the loss of training posts with the run-down of addiction psychiatry (submission to consultation from the Royal College of Psychiatrists, see Appendices).
- 3.27. Models of good practice with specialist nurse teams within hospital settings focusing on alcohol could be adapted for illicit drug users and evaluated (Ryder *et al.*, 2010).
- 3.28. There is a problem of misdiagnosis and inappropriate or no treatment among older drug users (Crome and Bloor, 2005, McGrath *et al.*, 2005). The accurate diagnosis of high-risk drug use by the ageing cohort and addressing the various associated health issues will depend upon increased awareness and training of professionals and practitioners to support older high-risk drug users.
- 3.29. One organisation representing treatment providers expressed the view that services need to fundamentally improve the referral systems between drug and alcohol treatment and mainstream health resources (submission from Collective Voice).
- 3.30. Underlying the lack of appropriate responses and training is a lack of research and evaluation. There is a paucity of UK-based research and evidence for treatment interventions (Royal College of Psychiatrists, 2018).

## Challenges for users

### Stigma

- 3.31. The ageing cohort is likely to experience considerable stigma when dealing with the general public and with services (Ayres *et al.*, 2012; Wu and Blazer, 2011; EMCDDA, 2008; Conner and Rosen, 2008; Radcliffe and Stevens, 2008) and may have low expectations of health services

<sup>7</sup> These suggestions are also relevant for younger service users

<sup>8</sup> Geriatrics usually treat patients who are over 65 years.

(Beynon, 2009). Negative attitudes on the part of staff in specialist and in mainstream services get in the way of effective service delivery and deter attendance (Neale *et al.*, 2008). Women drug users are doubly stigmatised (EMCDDA, 2000; Taylor, 1993; Ettore, 2007; Bows, 2015).

3.32. Ageing chronically sick drug users are among those least able to navigate the complex pathways that make up the contemporary NHS and welfare systems (Hayes, 2016). Barriers for injecting drug users in general may relate to the burden of appointments, difficulties in travelling to services, stigma, negative staff attitudes, personal ill-health, lack of material resources and anxieties (Neale *et al.* 2008).<sup>9</sup>

3.33. Care and support models that respond directly to issues of isolation and loneliness are appropriate. To respond to the issues of stigma and discrimination and to help in navigating services, advocates or service navigators are needed to ensure that substandard care is appropriately challenged and remedied. Transitions between various healthcare services are potential points for fragmented care and can be confusing and complicated for patients, formal and informal caregivers. These challenges are compounded for older adults with chronic disease, as they receive care from many providers in multiple care settings. System navigation has been suggested as an innovative strategy to address these challenges. The role of a navigator for the chronically ill older person is a relatively new one. There is some evidence that integrated and coordinated care guided by a navigator, using a variety of interventions such as care plans and treatment goals, is beneficial for chronically ill older adults transitioning across care settings. There is a need to further clarify and standardise the definition of navigation, as well as a need for additional research to assess the effectiveness and cost of different approaches to the health system (Manderson *et al.* 2012). There is scope for experimentation to apply this approach with regard to older drug users, especially the ageing cohort of opiate users. Service navigation has developed in cancer care and been employed to assist people with AIDS. Studies have observed a reduction in barriers, improvement in mediators, and improved health outcomes (Bradford, Coleman and Cunningham, 2007). Problems in accessing care by stigmatised groups such as Gay and Lesbian elders and their families have been noted (Brotman, Ryan and Cormier, 2003) and recommendations made include engaging in advocacy strategies, training, and outreach.

3.34. Providing advocacy for the ageing cohort of drug users could be done through:

- mainstream services for older people, such as Age UK;
- by specialist drug services; or,
- by mutual aid groups.

(Wadd and Galvani, 2014). Specifically, the issue of accessing welfare benefits advice should be addressed.

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<sup>9</sup> These mostly apply across all ages

## 4. Conclusions and recommendations

For the purposes of this report, the 'ageing cohort' and 'older drug users' are considered to be aged over 35.

### Conclusions

- **Conclusion 1:** Specialist community drug services are treating an ageing cohort of patients. Predominant among these are those with problematic opiate/opioid use.
- **Conclusion 2:** Research suggests that older drugs users, particularly opiate/opioid users, have multiple additional risk factors resulting from their deteriorating physical and mental health, difficulty in navigating complex health and social care systems and experience of stigma.
- **Conclusion 3:** There are indications which suggest that addressing the complex and varied needs of older opiate/opioid users will increasingly become a mainstream treatment activity.
- **Conclusion 4:** Specialist community drug services are insufficiently prepared to manage the complex needs of this ageing cohort, despite the increase in older drug users attending for treatment.
- **Conclusion 5:** Commissioners, providers and the specialist drug treatment workforce all need to ensure that staff are competent to meet these demands with the expected increase in complexity of treatment required by attendees. <sup>vii</sup>
- **Conclusion 6:** Future trends in treatment presentations of ageing cohorts are difficult to predict and careful monitoring of drug treatment populations and other metrics of drug misuse should be explored and utilised. The better recording of prevalence of substance misuse by ageing drug users will improve understanding of the ageing treatment cohort and support service planning and delivery.

### Recommendations

**Recommendation 1: Specialist community-based drug treatment services should develop training for staff to highlight the treatments and specific risks for older drug users, particularly opiate/opioid users.**

#### **Who is the recommendation directed to?**

*Public Health England (PHE), with a specific request that they incorporate training into the current opioid substitution therapy (OST) quality improvement programme.*

*Also applicable to: NHS England, Public Health Wales (PHW) and NHS Health Scotland and the Department of Health, Social Services and Public Safety (Northern Ireland), Royal colleges, commissioners and specialist community drug services.*

#### **What metric would indicate that the recommendation had been implemented?**

*The availability of a national learning package on the needs of older drug users along with evidence that this had been implemented by specialist community drug services. These*

*outcomes should be recorded and published, periodically reviewed and revised where appropriate.*

**Recommendation 2: Given the changes to the specialist community drug treatment workforce over the last five years, an assessment should be conducted of the current range and availability of skills, treatment and support available to people presenting to treatment. A particular focus should be the availability and knowledge of staff to address the complex physical and mental health issues of older drug users.**

***Who is the recommendation directed to?***

*PHE, NHS England, PHW and NHS Health Scotland, Department of Health, Social Services and Public Safety (Northern Ireland), Royal colleges to conduct a review of the specialist community drug treatment workforce to determine whether the necessary expertise is available to treat the emerging needs of older drug users.<sup>viii</sup>*

***What metric would indicate that the recommendation had been implemented?***

*A published review of the workforce as part of a broader strategy to ensure that the workforce is skilled to meet the demands of an evolving treatment population.*

**Recommendation 3: An evaluated pilot programme to determine whether the use of the service navigator model will assist older drug users to engage more successfully in complex health and social care systems, improve the quality of care and health outcomes and be cost effective.**

***Who is the recommendation directed to?*** *PHE, NHS England, PHW and NHS Health Scotland and the Department of Health, Social Services and Public Safety (Northern Ireland)*

***What metric would indicate that the recommendation has been implemented?*** *Published evaluation of service navigator model(s) to understand whether they are cost effective and improve the engagement of older drug users and improve the quality of care and health outcomes.*

**Recommendation 4: Close and ongoing analysis of treatment presentation data and wider metrics of drug misusing patterns, with particular attention given to refining and standardising age categories.**

***Who is the recommendation directed to?*** *For surveys and collection of data by government agencies in Wales, Scotland and Northern Ireland; and more broadly, by others, especially researchers.*

***What metric would indicate that the recommendation had been implemented?*** *The standardisation of recording and presentation of age categories in prevalence of substance misuse data across the UK.*

## References

ACMD (2016) *Reducing opioid-related deaths in the UK*. London: ACMD

ACMD (2017) *Commissioning Impact on Drug Treatment The extent to which commissioning structures, the financial environment and wider changes to health and social welfare impact on drug misuse treatment and recovery*. September London: ACMD

Advisory Panel on Substance Misuse (APoSM) (2017) *A Report on Substance Misuse in an Ageing Population* (Welsh Government)

A Arona, A O'Neill, P Crome and F C Martin (2015) 'Clinical medicine and substance misuse: research, assessments and treatment' in *Substance Use and Older People* edited by I Crome, L-T Wu, R Rao and P Crome, Wiley: 35-56

C Atkinson (2015) *Service responses for older high risk drug users – a literature review*. Scottish Centre for Crime and Justice Research

R M Ayres, L Eveson, J Ingram and M Telfer (2012). 'Treatment experience and needs of older drug users in Bristol, UK' *Journal of Substance Use*, 17(1): 19-31

V Raja Badrakalimuthu, A Tarbuck and A Wagle, (2012). 'Maintenance treatment programme for opioid dependence: characteristics of 50+ age group'. *Drugs and Alcohol Today*, 12(3): 157-163.

J Barclay (2016) *Changing systems, changing lives. A brief review of the Making Every Adult Matter (MEAM) Coalition* April

S j Bartels, F C Blow, A D Van Citters, & L M Brockmann, (2006). 'Dual diagnosis among older adults: Co-occurring substance abuse and psychiatric illness'. *Journal of Dual Diagnosis*, 2(3): 9–30;

C M Beynon (2009) 'Drug Use and ageing: older people do take drugs' *Age and Ageing* 38: 8-10

C Beynon, J McVeigh, A Hurst and A Marr (2010) 'Changing mortality of drug users in treatment in North West England' *Int J Drug Policy* 21: 429-431

C M Beynon, A Luxton, R Whitaker, N T Cable, L Frith, A H Taylor, L Zou, P Angell, S Robinson, D Holland, and S Holland, S (2013) 'Exercise referral for drug users aged 40 and over: results of a pilot study in the UK' *BMJ open*, 3(5), p.e002619.

H Bows (2015) *The Conversation* 15 June 2015

J P Bradford, S Coleman and W Cunningham (2007) 'HIV system navigation: an emerging model to improve HIV care access' *AIDS Patient Care and STDs* vol 21 No 5:111 Jun <https://doi.org/10.1089/apc.2007.9987>

British Psychological Society. (2012) *The contribution of clinical psychologists to recovery orientated drug and alcohol treatment systems*, London: BPS;

[www.nta.nhs.uk/uploads/contributionofclinicalpsychologiststorecoveryorientateddrugandalcoholment2012-022013.pdf](http://www.nta.nhs.uk/uploads/contributionofclinicalpsychologiststorecoveryorientateddrugandalcoholment2012-022013.pdf)

S. Brotman, B Ryan and R Cormier (2003) 'The health and social service needs of Gay and Lesbian elders and their families' *The Gerontologist* vol 43, 2: 192-202

P Burkinshaw, J Knight, P Anders, B Eastwood, V Musto, M White and J Marsden (2017) *An evidence review of the outcomes that can be expected of drug misuse treatment in England* PHE  
[https://www.gov.uk/government/uploads/system/uploads/attachments\\_data/file/58611/PHE](https://www.gov.uk/government/uploads/system/uploads/attachments_data/file/58611/PHE) (pdf)

K O Conner and D Rosen, (2008). "You're nothing but a junkie": Multiple experiences of stigma in an aging methadone maintenance population'. *Journal of Social Work Practice in the Addictions*, 8(2): 244-264.

I Crome and R Bloor (2005) 'Older substance misusers still deserve better diagnosis—an update (Part 2)'. *Reviews in Clinical Gerontology*, 15(3-4): 255-262.

I Crome, L-T Wu, R Rao and P Crome (2015) *Substance Use and Older People* Wiley

CSJ (Centre for Social Justice) (2017) *HOUSING FIRST - Housing-led solutions to rough sleeping and homelessness* London: CSJ

G L.Davis, M J.Alter. H El-Serag,T Poynard, L W Jennings (2010) 'Aging of Hepatitis C Virus (HCV)-Infected Persons in the United States: A Multiple Cohort Model of HCV Prevalence and Disease Progression' *Gastroenterology* Vol 13: 2; 513-521 e6

Department of Health (nd) *Comorbidities: a framework of principles for system wide action*

E Dolphin (2016) *Evaluation Report. Assertive Case Management Team Pilot*. Dublin: Health Service Executive.

G J Dowling, S R Weiss, and T P Condon, (2008). 'Drugs of abuse and the aging brain'. *Neuropsychopharmacology*, 33(2): 209-218.

DrugScope (2014) *It's about time. Tackling substance misuse in older people* A briefing by DrugScope on behalf of the Recovery Partnership, February

EMCDDA (2000) *Annual report on the State of the Drugs Problem in the EU*;

EMCDDA (2008) 'Substance Use among older adults: a neglected problem' *Drugs in Focus* Lisbon: EMCDDA

EMCDDA (2010) *Treatment and Care for Older Drug Users* Lisbon: European Monitoring Centre for Drugs and Drug Addiction

EMCDDA (2017) *Responding to the needs of ageing drug users*

E Ettorre (2007) *Revisioning Women and Drug Use* Palgrave Macmillan

V Fahmy, S Hatch, M Hotopf and R Stewart (2012) 'Prevalence of illicit drug use in people aged 50 years and over from two surveys' *Age and Ageing*, 241 (4): 553-556

D Finch, J Bibby and T Elwell-Sutton (2018) *Taking our health for granted: plugging the public health grant funding gap* The Health Foundation

S Galvani S. (2015) *Alcohol and other drug use: the roles and capabilities of social workers*. Manchester: Manchester Metropolitan University;  
[www.mmu.ac.uk/media/mmuacuk/content/documents/hpsc/research/Alcohol%20and%20Other%20drug%20use%20report.pdf](http://www.mmu.ac.uk/media/mmuacuk/content/documents/hpsc/research/Alcohol%20and%20Other%20drug%20use%20report.pdf)

L Gao, P Dimitropoulou, J R Robertson, S McTaggart, M Bennie and S M Bird (2016) 'Risk factors for methadone specific deaths in Scotland's methadone prescription clients between 2009 and 2013' *Drug and Alcohol Dependence* Oct, 1;167:214-23

L Gao J R Robertson, S M Bird 'Scotland's 2009-2015 methadone-prescription cohort: quintiles for daily-dose of prescribed methadone and associated risk of methadone-specific death': in review.

G Hay, A R dos Santos, Z Switherbank, (2017) *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use 2014/15: Sweep 11 Report*, Public Health Institute, Liverpool John Moores University September

P Hayes (2016) 'Our neglect of ageing heroin users has fuelled the rise of drug related deaths' *The Guardian* 9 September <https://www.theguardian.com/commentisfree/2016/sep/09/ageing-heroin-users-drug-deaths-four-steps-to-save-lives-nhs>

A J Hayes, A Burns, P Turnbull and J J Shaw (2012), 'The health and social needs of older male prisoners,' *International Journal of Geriatric Psychiatry* 27: 11; 1155–1162, November

Independent Expert Review of Opioid replacement therapies in Scotland (2013)  
<https://www2.gov.scot/resource/0043/00431023.pdf> -

ISD (2018) *National Naloxone Programme Scotland Monitoring Report 2017/18*, 27 November, Information Services Division Scotland

ISD (2018) *Scottish Drug Misuse Database Overview of Initial Assessments for Specialist Drug Treatment 2016/17*, 26 June 2018, Information Services Division Scotland

ISD (2019) *Prevalence of Problem Drug Use in Scotland 2015/16 Estimates*, 5 March 2019, Information Services Division Scotland.

K E Kerfoot, I L Petrakis, & R A Rosenheck, (2011). Dual diagnosis in an ageing population: Prevalence of psychiatric disorders, comorbid substance abuse, and mental health service utilisation in the Department of Veterans Affairs. *Journal of Dual Diagnosis*, 7(1): 4–13;

C. Lloyd, (2012), 'The stigmatization of problem drug users: a narrative literature review', *Drugs: Education, Prevention and Policy*, 2: 85-95

M R Lofwall, R K Brooner, G E Bigelow et al (2005) 'Characteristics of older opioid maintenance patients' *Journal of Substance Abuse Treatment* 28 (3): 265-272

B Manderson, J McMurray, E Piriano and P Stolee (2012) 'Navigation roles support chronically ill older adults through health care transitions: a systematic review of the literature' *Health and Social Care in the Community* Vol 20, 2: 113-127

A McGrath, P Crome, and I B Crome (2005). 'Substance misuse in the older population'. *Postgraduate Medical Journal*, 81(954): 228-231

NDTMS (2016a) *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1st April 2015 to 31st March 2016* (NDEC, DH, PHE)

J Neale, C Tompkins, and L Sheard (2008) 'Barriers to accessing generic health and social care services: a qualitative study of injecting drug users' *Health and Social Care in the Community* 16 (2): 147-154

J. Neale, S Nettleton and L Pickering (2012) 'Heroin users' views and experiences of physical activity, sport and exercise' *International Journal of Drug Policy*, 23,2: 120-127

M Pierce, S M Bird, M Hickman and T Millar (2015) 'National Record Linkage Study of Mortality for a large cohort of opioid users ascertained by drug treatment or criminal justice sources in England 2005-2009' *Drug and Alcohol Dependence* 146: 17-23

M Pierce, S M Bird, M Hickman, J Marsden, G Dunn, A Jones and T Millar (2016) 'Impact of treatment for opioid dependence on fatal drug related poisoning: a national cohort study in England' *Addiction* 11 (2): 298-308 doi:10.1111/add.13193

M Pierce, T Millar, J M Robertson and S M Bird (2018) 'Ageing opioid users' increased risk of methadone specific death in the UK' *International Journal of Drug Policy* Volume 55: 121-127

A Pirona, B Guarita, L Montanari, A Noor (2016)). *Ageing and addiction: challenges for treatment systems* EMCDDA

Public Health England (2013) *Drug treatment in England 2012-13*. PHE

Public Health England. (2014) *The role of addiction specialist doctors in recovery orientated treatment systems: a resource for commissioners, providers and clinicians*: London: PHE; <http://www.nta.nhs.uk/uploads/the-role-of-addiction-specialist-doctors.pdf>

PHE (2015) *Trends in drug misuse deaths in England, 1999 to 2014* PHE

PHE (2016) Substance misuse statistics from the NDTMS 2015/16 [http://www.nta.nhs.uk/uploads/adult-statistics-from-the-national-drug-treatment-monitoring-system-2015-2016\[0\].pdf](http://www.nta.nhs.uk/uploads/adult-statistics-from-the-national-drug-treatment-monitoring-system-2015-2016[0].pdf)

PHE/ Royal College of Nursing (2017) *The Role of Nurses in Alcohol and Drug Treatment Services: A resource for commissioners, providers and clinicians*

P Radcliffe and A Stevens, (2008) 'Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatised identities'. *Social Science & Medicine*, 67(7):1065-1073.

D Rosen, A Hunsaker, S M Albert, J R Cornelius, and C F Reynolds (2011) 'Characteristics and consequences of heroin use among older adults in the United States: a review of the literature, treatment implications, and recommendations for further research'. *Addictive Behaviors*, 36(4),:279-285

A Roy and J Buchanan (2016) 'The Paradoxes of Recovery Policy: Exploring the Impact of Austerity and Responsibilisation for the Citizenship Claims of People with Drug Problems' *Social Policy and Administration* May Vol 50 No 3:398-413

Royal College of Psychiatrists (2011) *Our Invisible Addicts: First report of the Older Persons Substance Misuse Working Group*, London RCPsyc.

Royal College of Psychiatrists (2018) *Our Invisible Addicts*. 2<sup>nd</sup> edition College Report CR211

S D Ryder, G P Aithal, M Holmes, M Burrows (2010) 'Effectiveness of a nurse led alcohol liaison service in a secondary care medical unit' *Clinical Medicine* Vol 0: No 5; 435-40

Scottish Drug Forum (2010) *Senior Drug Dependents and Care Structures: Scotland: guidelines for service response* SDF: Glasgow

SDF, R Hammersley and P Dalgarno (2013) *Trauma and recovery amongst people who have injected drugs within the past five years* SDF

Scottish Drugs Forum (2017a) *Older People with a Drug Problem in Scotland: addressing the needs of an ageing population. Expert Working Group on Older People with a Drug Problem.*

SDF (2017b) *Older People with Drug Problems in Scotland: a mixed methods study exploring health and social support needs.*

A Searby, P Maude and I McGrath (2014) 'Dual diagnosis in older adults: a review' *Issues in Mental Health Nursing*, 1-8

L Simmonds, R Coomber (2009) 'Injecting drug users: a stigmatised population' *International journal of drug policy*, 20:121-130.

V J Slaymaker, and P. Owen (2008) 'Alcohol and other drug dependence severity among older adults in treatment: Measuring characteristics and outcomes', *Alcoholism Treatment Quarterly*, 26(3): 259-273.

A Taylor (1993) *Women drug users* Oxford University Press;

L Templeton, C Valentine, J McKell, A Ford, R Velleman, T Walter, G Hay, L Bauld & J Hollywood (2016) 'Bereavement following a fatal overdose: The experiences of adults in England and Scotland', *Drugs: Education, Prevention and Policy*, DOI: 10.3109/09687637.2015.1127328

S Wadd and S Galvani (2014) *The Forgotten People: drug problems in later life* Big Lottery/ University of Bedfordshire

The Welsh Assembly (2008) *The Welsh Strategy, Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018*

C Winick, (1962). Maturing out of narcotic addiction. *Bulletin on narcotics*, 14(1): 1-7.

L T Wu and D G Blazer (2011) 'Illicit and nonmedical drug use among older adults: a review'. *Journal of aging and health*, 23(3): 481-504.

## Additional Bibliography

Adfam (2016) *Issues in Recovery: housing and recovery* April London:Adfam

T L Anderson and J A Levey (2003) 'Marginality among older injectors in today's illicit drug culture: assessing the impact of ageing' *Addiction* 98, 761-770

C M Beynon, J McVeigh and B Roe (2007) 'Problematic drug use, ageing and older people: trends in the age of drug users in north west England' *Ageing and Society* 27: 799-810

C van Boekel, E P M Brouwers, J van Weeghel, H F L Garretston (2013) 'Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review' *Drug and Alcohol Dependence* 131: 1-2; 23-35

M Boeri, T Whalen, B Tyndall and E Ballard (2011) 'Drug use trajectory patterns among older drug users' *Substance Abuse and Rehabilitation* 2: 89-102

G Bramley, S Fitzpatrick et al (2015) *Hard Edges. Mapping Severe and Multiple Disadvantage* Lankelly Chase

S L Carroll Chapman and L-T Wu (2015) 'Epidemiology and demography of illicit drug use and drug use disorders among adults aged 50 and older' in I B. Crome, L-T Wu, R Rao and P Crome (eds) *Substance use and Older People*, First Edition. John Wiley & Sons, Ltd: 91-100.

J D Colliver, W M Compton, J C Gfroerer, and T Condon, (2006). 'Projecting drug use among aging baby boomers in 2020'. *Annals of epidemiology*, 16(4): 257-265.

C M Comiskey (2015) 'The Australian Treatment Outcome Study—implications for treatment philosophies, policy, political processes and practice'. *Addiction*, 110(6): 994-995.

E Dyb (2016) 'Housing First or no housing? Housing and homelessness at the end of alcohol and drug treatment'. *International Journal of Drug Policy*, 36: 76-84.

P Flynn, M Anglin, M Brecht *et al.* (2013) 'Characterizing durations of heroin abstinence in the Californian Civil Addict Program; results from a 33 years observational cohort study' *J Epidemiol*, 177: 675-682.

B Han, J C Gfroerer, J D Colliver and M A Penne (2009) 'Substance use disorder among older adults in the United States in 2020' *Addiction* 194: 88-96

M Harris and T Rhodes, (2013). 'Hepatitis C treatment access and uptake for people who inject drugs: a review mapping the role of social factors'. *Harm Reduction Journal*, 10(1):7

T Hafford-Letchfield, B Thom, R Herring (2018) *Community Based Care for Older People with Alcohol-Related Harm: Findings from a consultation workshop with practitioners in social work and social care*. Drug and Alcohol Research Centre, Middlesex University, UK

Y Hser, D Huang, C Chou and M Anglin (2007) 'Trajectories of heroin addiction: growth mixture modelling results based on a 33 year follow up study' *Eval Rev* 31; 548-63

M Kirst, S Zerger, V Misir, S Hwang, V Stergiopoulos (2015) 'The impact of a Housing First randomized controlled trial on substance use problems among homeless individuals with mental illness' *Drug and Alcohol Dependence* 146; 24–29

P Mannelli, L-T Wu and K T Brady (2015) 'Pharmacological and integrated treatments in older adults with substance use disorders' in *Substance use and Older People*, First Edition. Edited by Ilana B. Crome, Li-Tzy Wu, Rahul (Tony) Rao and Peter Crome. John Wiley & Sons, Ltd.

R McNeil and M Guirguis Younger (2012) 'Illicit drug use as a challenge to the delivery of end of life care services to homeless persons: perceptions of health and social services professionals' *Palliative Medicine* 26: 350-359

N Metrebian, T Groshkova, J Hellier *et al.* (2014) 'Drug use, health and social outcomes of hard-to-treat heroin addicts receiving supervised injectable opiate treatment: secondary outcomes from the Randomized Injectable Opioid Treatment Trial (RIOTT)' *Addiction*, 110: 479–490

D Nambier, P A Agius, M Stooze, M Hickman and P Dietze (2015) 'Cessation of injecting drug use – the effects of health service utilisation, drug use and demographic factors'. *Drug and Alcohol Dependence* 154: 208-313

E F H Outlaw, J M Marquart, A Roy *et al.* (2012) 'Treatment outcomes for older adults who abuse substances' *Journal of Applied Gerontology* 31 (1) 78-100.

Scottish Executive Effective Interventions Unit (2004) *Advocacy for Drug Users: a Guide*

M Teesson, C Marel, S Darke *et al.* (2015) 'Long Term mortality, remission, criminality and psychiatric comorbidity of heroin dependence: 11 year findings from the Australian Treatment Outcome Study' *Addiction* 110: 986-993

E Termorshuizen, A Krol, M Prins *et al* (2005) 'Long term outcome of chronic drug use: The Amsterdam cohort study among drug users' *Amer J Epidemiol* 161: 271-9

L Ti, P Voon, S Dobrer, J Montaner, E Wood and T Kerr (2015) 'Denial of pain medication by health care providers predicts in-hospital illicit drug use among individuals who use illicit drugs' *Pain Research and Management*, 20(2): 84-88.

I Vogt, R Simmedinger and N Kuplewatzky (2009) *SDDCARE Reanalysis of selected German national and local data* Institute für Suchtforschung an der Fachhochschule, Frankfurt am Main

M White, R Burton, S Darke, B Eastwood, J Knight, T Millar, V Musto and J Marsden (2015) 'Fatal opioid poisoning: a counterfactual model to estimate the preventative effect of treatment for opioid use disorder in England' *Addiction* 1. 10 (8): 1321-9

S Zerger (2012) 'Housing: a fundamental component of drug policy' *IJDP* 23 (2): 91-3

## Appendices

The ACMD would like to thank the many contributors to this investigation, both through evidence gathering and those who have provided recommendations on this subject previously (full details in the following appendices).

## Appendix 1: Terms of Reference

To explore the specific issues for older people (those aged over 35) with a drug problem focusing on those who have had a drug problem for an extended period of time. The Ageing cohort working group will work towards the following aims:

- Using existing data to describe the demographics of the population in terms of age, gender, location, morbidity and mortality and analysing this at different age bands; 35-44, 45-54, 55-64 and over 65.
- Projecting future demographics and needs for this population over a 10 and 20 year period.
- Describing the present and likely future health and social care needs of this population.
- Describing the nature and extent of present and future service demand of this population.
- Identifying effective service responses including existing best practice.

The working group will then make specific recommendations for practise and policy.

## Appendix 2: Working group membership

### **ACMD members**

Mr Dave Liddell (co-Chair until December 2017)

Dr Kostas Agath (co-Chair; Chair 2018-19)

Professor Tim Millar

### **Co-opted members**

Dr Caryl Beynon (Public Health England)

Dr Gordon Hay (Liverpool John Moores University)

Professor Susanne MacGregor (London School of Hygiene and Tropical Medicine)

Maggie Telfer (Bristol Drugs Project)

### **Secretariat**

Linsey Urquhart (Secretary to the Ageing Cohort working group until June 2018)

Zahi Sulaiman (Secretary to the ACMD)

Matthew Gavin (ACMD Secretariat)

Imogen McHarg (ACMD Secretariat)

## Appendix 3: Stakeholder consultation and methodology

The working group wrote to stakeholders requesting written/oral submissions, addressing the following questions:

Q1. What are the distinctive <u>challenges</u> older drug users (ODUs) face in terms of: a. Mental health b. Physical health c. Wider social issues
Q2. What are the distinctive substance misuse <u>needs</u> of ODU with respect to: a. Wider healthcare b. Non-healthcare support c. Criminal justice system
Q3. What are the distinctive <u>barriers</u> ODU face when accessing: a. Healthcare services b. Recovery services
Q4. Could you share any <u>practices</u> that: a. Appear to work well with ODU b. Have been less successful with ODU
Q5. Could you share any examples of <u>commissioning</u> addressing the needs of ODU?
Q6. Would the <u>future needs</u> of ODU be different to the current ones? (If so, how?)
Q7. Do you have <u>experience</u> of ODU groups? If so, which ones?

### Written Evidence was received from the following:

British Association of Social Workers (Professor Sarah Galvani, Dr Wulf Livingston and Mr Trevor McCarthy)

Bristol Drugs Project

Collective Voice

University of Bedfordshire (Dr Sarah Wadd)

Her Majesty's Chief Inspector of Prisons

Making Every Adult Matter

National Care Association

Release

Royal College of General Practitioners

Royal College of Nursing

Royal College of Psychiatrists

The Salvation Army

SMART Recovery

### Oral Evidence was received from the following at the Evidence Gathering Day:

Collective Voice – Paul Hayes

Making Every Adult Matter – Sam Thomas

### *Project methodology*

A small working group, consisting of ACMD members and co-opted members with relevant experience (Appendix 2), convened to identify the scope and methodology of the project. During the course of the project, the working group held six meetings to consider the evidence and come to its conclusions and recommendations.

### *Overview*

To deliver the terms of reference the working group analysed evidence collected from three complementary and sometimes overlapping routes:

- a literature review;
- a stakeholder consultation;
- an analysis of a time-series of treatment data for England.

### *Literature Review*

A wide range of literature was reviewed. This was a narrative rather than a systematic or comprehensive review, as the latter was beyond the resources available to the group. The working group did, however, search relevant databases of research literature (journal articles in particular) and access grey literature available on the Internet: this included documentary material (official reports) and publications by stakeholder groups. The group also searched international literature to provide some context for coming to their judgements but focused particularly on material from the UK. Overall there is a lack of research on this cohort in UK. However, the group's approach was to triangulate evidence from published scientific works with administrative data and evidence from stakeholders before coming to their judgements.

### *Stakeholder consultation*

The working group elicited stakeholder consultation through the submission of written evidence and/or participation in an evidence gathering meeting for the submission of oral evidence. To obtain the written evidence, in July 2016, a 'call for evidence' was issued to relevant stakeholders requesting comments on a set of questions listed at the beginning of this Appendix.

Responses were received from 13 groups.

To obtain the oral evidence, on 21 September 2016, an evidence gathering meeting was held attended by a number of stakeholder organisations.

### *Limitations*

The project had a number of limitations that are worth discussing.

The terms of reference set the working group a very ambitious main task: to model the future demographics, health and social care needs and service demand of older problem drug users. The lack of substantial previous work in the area had meant that a number of compromises had to be made for this project to reach its main output – this report.

In reviewing the extant evidence, the group drew on articles in peer-reviewed journals and peer-reviewed books and chapters. These numbered over 75. In addition, the group drew on data from government publications and data bases such as PHE. These numbered 22. Another source was expert syntheses and overviews, especially those of the ACMD: these numbered 11. The group also referred to findings reported in eight quality research reports from non-government bodies. A final source was commentary from informed stakeholders, numbering 17. This range of sources gave the group a thorough overview of the situation and key facts and issues.

The working group would like to make the following four points.

- Only a narrative rather than a comprehensive review was feasible given the limited membership and resources available to the group;
- The group had to work with existing data and the definition of the population of interest had to be broad rather than narrow to maximise the flexibility in using relevant *extant* data. So, whilst the terms of reference were set to investigate issues faced by ‘people over 35 years with a drug problem over an extended period of time’; The extant literature has mainly addressed the issues of the opiate using population, although noting that polysubstance use is common. With the single exception of *cocaine*, very little is known about other forms of illicit problem use in older age. The resulting report therefore had an opiate focus.
- Given the above, the group’s ability to generalise findings to non-opiate using populations with prolonged drug problems is limited. Crome *et al.* have provided the most comprehensive overview of Substance Use and Older People (Crome *et al.* 2015). This was the first book devoted to substance use disorders in older adults. The substances they considered include alcohol, illicit drugs and tobacco use. The book has a multinational focus. The ageing cohort of ‘problem drug users’ that this working group focused on is a subsection of the larger group of older substance users but they share some characteristics and needs that have implications for service configurations. Experience in clinical practice supports the view that this is a growing but neglected vulnerable group. The report *Our Invisible Addicts* encouraged greater attention to this age group (Royal College of Psychiatrists, 2011). All these studies have emphasised the centrality of **comorbidity** in older age groups.

The working group did, however, take seriously the views of experienced practitioners, service providers and their representatives as given through the consultation. These views were important in identifying key issues and priorities for attention.

## Appendix 4 Issues raised in the consultation

### *Bristol Drugs Project*

Research and experience at this project have identified key issues for drug users aged 55 years and/or older as:

- A lack of access to services; and,
- older users feeling out of place where the client group is predominantly younger.

This group of people experience social isolation and have a range of needs relating to income, housing and stigma. They should be treated with compassion and sympathy.

Long-term use can produce a feeling of hopelessness about any possibility of change and profound fear of both recovery (in a world where their recovery capital has shrunk) and continuing dependence into older age.

It is important to recognise complexity. Clients suffer from a range of other conditions, as well as drug use and these can lead to problems, including the possibility of medication interactions.

As drug use acts as a master status, other health issues can be overlooked or not recognised. Diversity within the group is often not recognised with other minority special needs being overlooked.

### *The British Association of Social Workers (BASW)*

The British Association of Social Workers (BASW) added that there were specific needs relating to bereavement and early onset dementia. Other problems highlighted were with regard to residential placements where a person may fall outside either the commissioners' and/or providers' age range.

There are a lack of services addressing co-existing mental health and substance use.

Changes due to ageing may lead to reductions in tolerance resulting in unintended, and fatal, overdose.

Other health issues include dental and respiratory problems.

One major problem lies with the lack of identification of substance problems by front-line health and social care practitioners and this is particularly so with this marginalised age group. Hospital staff need education and support. There is concern about clinical and social responses to people entering the hospice system with alcohol and drug problems.

There has been a systematic failure to give priority to addressing and working with alcohol and other drug use in mainstream social work. There is a need for clinical and practice guidance for substance use and palliative/end of life care services with regard to working with people presenting with both conditions. These are currently being developed by Professor Sarah Galvani of Manchester Metropolitan University). [Galvani, 2015].

There is a need for peer-led, rather than professional-led, recovery services, focused advocacy and partnership, and to ensure that existing guidance is followed.

### *Collective Voice*

The experience of members of Collective Voice is that the overwhelming majority of premature deaths of those in treatment arise from the consequences of physical ill health rather than overdose.<sup>10</sup> Offenders, the homeless and people with mental health problems often have no GP. In particular, it is regrettable that drug and alcohol treatment in prison has become disengaged from community provision; this presents real challenges to prisoners on release. Health and Well-being Boards are failing to deal with these issues.

### *University of Bedfordshire: submission from Dr Sarah Wadd*

This research team have noted numerous examples of ageism in relation to substance misuse. These include:

- Upper age cut-offs in substance use services which means that older adults cannot access them.
- Older adults being excluded from clinical trials and intervention studies.
- Drink and drug public awareness campaigns that are almost exclusively targeted at younger adults.
- Older adults being excluded from national prevalence studies, for example, people aged 60 and over are not asked about illicit drug use in the Crime Survey for England and Wales. Older adults (aged 75 and over) are not included in the national reporting of drug and alcohol treatment statistics (only recently addressed).
- Older adults being less likely to be referred for treatment.
- Ageist attitudes amongst professionals, for example, 'they are too old to change their behaviour' (this despite Dr Wadd's analysis of treatment data that shows that older adults are *more* likely to be treated successfully for a drug problem than younger adults).

The team suggests that there may be opportunities to nurture the types of peer support, community and voluntary activities that are one of the many strengths of the lesbian, gay bisexual and transgender (LGBT) communities.

There is a need to extend training to people providing:

- home care;
- sheltered accommodation and care homes;
- falls prevention services;
- carer support services;
- pain clinics;
- older adults' mental health services;
- older adults' social work teams; and,
- volunteer befriending services.

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<sup>10</sup> Recent research suggests that 75% of premature mortality among opioid users aged over 45 and under 65 years is due to causes other than overdose, compared with 36% among 18 to 25 year olds (Pierce *et al.*, 2015).

## *MEAM*

In addition to agreeing with the points made by others in the consultation, Making Every Adult Matter (MEAM) also noted issues around access to GPs and thus onward referrals. There is a lack of continuity of care.

## *Release*

Release's national helpline receives a worrying number of calls from older drug users, both in and outside of treatment settings. There is a lack of provision of quality psychological input alongside pharmacological interventions. Older drug users may experience death anxiety.

It is Release's experience that drug users needing large doses to relieve pain are often seen as engaging in 'drug seeking' behaviour. In addition, the prescribing of diazepam and other benzodiazepines among older patients is an important issue.

Older service users may resent workers half their age, particularly 'recovery champions', telling them "if I can do it, so can you". It seems distressingly common for long-term users to be told they have to cut down and come off, often on a first appointment in a new service.

Release recommends that people are not forced into abstinence and that they are allowed to move away from, for example, regular pharmacy visits when this places an undue stress on them. Services might also recognise the achievement of a range of treatment goals, such as those defined by the client, perhaps in relation to what the general population view as 'ordinary' goals - personal, housing, good general health, and community involvement, - encompassing public health goals and responses that go beyond the imperative of people becoming 'drug free'.

There is a need for innovative services, such as sessional workers who could help clients with housing, benefits, learning computer skills and other interventions.

## *Royal College of General Practitioners and Substance Misuse Management in General Practice*

The Royal College of General Practitioners and Substance Misuse Management in General Practice (RCPG/SMMGP) observe that it is possible that a significant number of drug-related deaths may not be accidental overdoses but have a degree of intent, something that should be explored and researched.

Commissioners must start to plan for the care of problem drug users who are unable to leave their home, who might need, for example, home help services and the delivery of substitute medication. This group has specific accommodation needs.

The new 'Orange Guidelines'<sup>11</sup> have specific information regarding pain management and older drug users and should be used as the basis of good practice. Increasing awareness of these guidelines should be undertaken to improve compliance.

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<sup>11</sup> <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>

There is also a need for provision to support a dignified death without discrimination.

#### *Royal College of Nursing*

The Royal College of Nursing (RCN) notes that all discussions on service needs have to take into account the context of reduced capacity in health services.

#### *The Royal College of Psychiatrists*

The Royal College of Psychiatrists (RCPsych) emphasises that older drug users often use alcohol, nicotine and over the counter medications as well as illicit drugs and prescribed medication. 'Substance use' must be looked at in the broadest sense. Furthermore, a more substantial evidence base with regard to older people is needed.

The second edition of their report '*Our Invisible Addicts*' (Royal College of Psychiatrists, 2018) concluded that comorbidity was the key feature and that the problem can be best addressed through an approach that is multi-professional, involving psychiatry, nursing, pharmacy, occupational therapy, psychology, social work and the voluntary sector (including peer support). This matches with this report's conclusions. They also concluded that there is a need for best practice to be implemented and extended to all relevant settings including the criminal justice system and end of life care.

The RCPsych also stated that there was a paucity of UK-based research and evidence for treatment interventions and services relating to the management of substance use disorders in older people.

Furthermore:

- future research requires standardisation of age range, diagnostic tools and assessment instruments, treatment options and style of delivery in order to enhance comparability. The inclusion of older adults in all treatment intervention studies in substance misuse should be the norm.
- due to a dearth of research, there is scarce specific evidence to inform policy decisions in older people who misuse substances. There is a lack of research on policies that specifically target the older person's substance misuse and associated harms.

#### *The Salvation Army*

The Salvation Army's service user group (largely within the Homelessness Services) comes from a diverse age range, the majority of whom are under the age of 50. However, they are seeing an increase in those above this age entering Lifehouses (homeless hostels) and indeed treatment services. An individual with a substance issue is often perceived to be a nuisance and thus turned down for housing. Short time-bound treatment programmes can often be unsuitable for this client group as issues are:

- often entrenched;
- complicated with physical ailments; and,

Support networks need to be established so that recovery is not just short-term.

## *SMART Recovery*

Smart Recovery regrets that the constant round of commissioning services leads to a lot of short-term planning and thinking in service delivery. There is huge pressure to deliver 'results' which could make it very difficult for organisations to respond to the needs of groups, such as older people with addictions, who are the least likely to engage in service user forums or representation to get their voices heard.

## Appendix 5: Extracts from recommendations of other expert bodies

### **The DrugScope/Recovery Partnership 2014**

This collaboration recommended, among other things, the following in their briefing report *It's about time: Tackling substance misuse in older people* (Drugscope/Recovery Partnership, 2014).

- *For policy and decision-makers*

Substance misuse issues of various kinds affect a significant number of older people. This needs to be recognised and addressed in the development and implementation of national policies and outcomes frameworks, including those focused on generic health and social care provision for older people.

Drug problems among older people also need to be considered by decision makers at a local level and addressed in local health and wellbeing and older people's strategies.

At a local level, there is a diverse membership of Health and Wellbeing Boards – including Directors of Public Health, Clinical Commissioning Groups and Directors of Adult Social Services. This provides an important opportunity for the development of support and treatment pathways for older people with substance misuse problems as well as integrated services that recognise the range of needs they may have (for example, those who also have mental health problems, including people with dementia and Alzheimer's).

Older people with substance misuse problems are not a homogenous group. A range of interventions are therefore needed, such as age-appropriate, non-time limited treatment and support for those who are drug dependent.

A range of outcomes will be appropriate for older people with drug problems, including recovery outcomes for some of those with more serious problems, and a wide range of other outcomes focused on improved health and increased levels of wellbeing.

Options for sustainable funding need to be considered particularly as research indicates increased prevalence and need.

- *For substance misuse services*

A range of measures can be implemented to help to ensure the accessibility and relevance of services for older people, including specific groups or times for older people, satellite services operating out of community provision aimed specifically at older people, for example, local support groups – and home visits.

Social activities and events, as well as regular support groups should be developed. Service user consultation and involvement is crucial in the development of this provision. Substance misuse services also have an important role to play in supporting older people into meaningful engagement, such as volunteering, within their local community.

The use of peer support, from 'real peers', can cut across the stigma that some older people with drug problems experience, helping them to feel more comfortable in a service and providing examples of positive change. Peer mentors can provide support in a range of ways, including emotional and practical support on a one-to-one basis and by facilitating groups and social activities. Providing support as a peer mentor can also help older people who have had substance misuse problems in the past to sustain the changes they have made in their lives. Consideration and provision of appropriate levels and kinds of support for peer mentors is important.

There is a need for appropriate training for substance misuse practitioners on the particular needs of and issues faced by older people with drug and/or alcohol problems.

- *For older people's services*

Older people with substance misuse problems may come into contact with a number of health and social care professionals, including those working in primary care settings, older people's mental health services, residential services, and social care providers. There is a clear need for awareness raising and training of these professionals so that they are able to identify and assess substance misuse issues.

### **EMCDDA 2008; 2010**

These two reports from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) identified the following issues for older people.

- Substance use programmes for older adults should be able to provide basic-level medical services.
- Where severe or complex health problems are identified, referral should be to specialist medical services.
- Detoxification may be best conducted in a medical setting to avoid potential interactions between medications and other substances, or because of comorbid illnesses.
- Different dose regimens may be required because of age-related metabolic changes.
- As many therapeutic issues are poorly understood regarding ageing drug users, improved assessment of substance use disorders among older adults may require age-specific measures of use and dependence.
- 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.
- Although the identification of substance use disorders may be difficult, primary care and other healthcare services are well placed to screen for substance use problems.
- Integrating geriatrics in drug treatment staff training and raising awareness about drug addiction among mainstream health providers for the elderly could be important starting points.
- 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 and alternatives to current treatment.
- The prevalence of illicit drug use by older adults is increasing. 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.
- Improved assessment of substance use disorders among older adults may require age-specific measures of use and dependence.
- As a consequence of the multiple problems experienced by older drug users, a joined-up treatment and care approach with effective interagency partnerships and referrals systems between specialised and mainstream health and social services is becoming more important than ever.

**Public Health England (Burkinshaw *et al.*, 2017)**

The proportion of older heroin users, aged 40 and over, in treatment with poor health has been increasing in recent years and is likely to continue to rise. An ageing cohort of heroin users (many of whom started to use heroin in the 1980s and 1990s) is now experiencing cumulative physical and mental health conditions. Older heroin users are also more susceptible to overdose. It is important to help these people access to appropriate general healthcare services. All indications suggest that it is challenging to help people with complex needs and a long treatment history to achieve recovery.

PHE recommend that policy and practice should incorporate the following.

- Maintain a realistic recovery ambition for the ageing cohort of heroin users with complex needs, accepting that the proportion of people who successfully complete treatment is likely to continue to fall.
- Provide longer-term employment and housing support, including in-work support, to help people to gain and maintain employment and appropriate housing.
- Develop strategies to address the recent increases in drug-related deaths, including integrating healthcare with drug treatment for people who use drugs and improving local processes for reviewing incidents.
- Ensure that there are arrangements to meet the physical and mental health needs of people who use drugs, particularly for older people in treatment.
- Outcome expectations need to be cognisant of the fact that the proportion of older heroin users in treatment with poor health has been increasing in recent years and is likely to continue to rise. It may be challenging to help people with complex needs and a long treatment history to achieve recovery, but it is vital to help them to access appropriate healthcare services as a vital step in the process.

### **Scottish Centre for Crime and Justice Research (Atkinson, 2015)**

- *Need for age-specific services.* There is a requirement to specifically design or adapt services – either existing or bespoke – in order to effectively engage with older high-risk drug users.
- *Co-presence of physical and mental health issues.* Older high-risk drug users may have mental health issues in addition to their use of illicit substances. Additionally, the use of illicit substances may also have an adverse impact on their physical health. Such issues must be considered when devising and delivering effective service responses, which must tackle the range of issues in a holistic manner.
- *Exercise-focused interventions.* There is indication in the research of some positive effects of exercise on the health and well-being of high-risk drug users of all ages, including older people. However, the results of the literature review also indicate barriers to the effectiveness of service responses to older high-risk drug users.

### **Scottish Drug Forum 2010**

The guidance provided in Senior Drug Dependents and Care Structures Scotland: Guidelines for Service Responses was derived from the Senior Drug Dependents and Care Structures in Europe project work.

- *Need for future planning*

The proportion of older drug users among problem drug users in Scotland continues to grow and will require careful planning to meet future needs as the population ages further. Specialist services need not be set up to meet the specific needs of older drug users as their needs can be met by adapting existing non-age specific services. However, the development of innovative treatment and psycho-social support approaches that might specifically benefit this population such as Housing First models [cf CSJ 2017] and heroin prescribing for those who fail to engage with other services and age specific group work should be explored.

- *Social networks and isolation and mental health*

Services and commissioners must take account of issues of isolation when planning and delivering services to older drug users. The breakdown of social networks and isolation is a major feature of older problem drug users as a group and these impact significantly on users' well-being and their ability to be motivated to change their behaviour. There is a significant level of mental health problems within the drug using population. These appear to be particularly acute for older problem drug users often linked to or exacerbated by isolation and loneliness. It is thought by services that a significant number of the drug related deaths may not be accidental overdoses but have a degree of intent.

- *Therapeutic relationships*

Services for older drug users should place greater emphasis on forming meaningful therapeutic relationships as these are particularly important for this age group.

Given the high levels of isolation and loneliness among this population, it is evident that relationships between workers and users are of even greater significance than those with younger users. For many individuals, such relationships may be the most significant relationships in their lives.

A significant proportion of older drug users are isolated and lonely. However, services felt there was an opportunity to provide a role within families, for example caring for grandchildren.

Services should explore with older drug users if there are opportunities to re-engage with their families which could provide useful and supportive child care and reduce isolation.

- *Accommodation needs*

The Housing First model being developed in Glasgow should be explored for other parts of Scotland beyond Glasgow.

The specific accommodation needs of older problem drug users require attention:

- for those who are attempting to break away from their former drug using networks; or,
- are likely to continue using drugs and require accommodation with a tenure that is not threatened by their continued drug use.

- *Relapse and alternative coping mechanisms*

Services should recognise the importance of relapse prevention and encourage 'new coping mechanisms'. Older drug users, due to the length of their drug problem, have nearly all had periods of abstinence and stability followed by relapse or more chaotic use. It is not safe for services to assume that persons at the early stage of recovery are not at risk of relapse. Services report that older drug users have learned coping mechanisms for dealing with crisis and these tend to be drug use. The importance of providing new coping mechanisms was highlighted. These included:

- support/peer groups;
- alternative therapies;
- talking therapies; and,
- and other meaningful activity.

- *Individualised services*

Services should be providing individualised services to all, with older users having a significant input to their treatment plan, including substances prescribed and supervision arrangements. Issues relating to drug users and substitute prescribing include issues of choice of substitute drug, dosage level, means of administration and supervision arrangements. Gender emerges as a particularly important issue with older drug users. Workers felt strongly that women were inclined to rush through services while men on the other hand tended to move more slowly than necessary. Services need to acknowledge these gender issues which appear to be particularly apparent with older users. This could involve ensuring that women are encouraged to look at taking small steps with realistic goals, while men should be encouraged to focus more on long-term goals.

- *Innovative treatment approaches*

There is a need for services and planners to explore innovative approaches that might prove particularly attractive and relevant for older drug users as many have failed to engage with existing services. Innovative approaches might include assertive outreach for those dropping out of services. There is an evidence base for prescribing of injectables including heroin for those who have found it difficult to move away from injecting, particularly older users.

- *Physical Health*

There is a need for services working with older drug users to ensure, as far as practicable, that an individual's general health care needs are met effectively. Services report significant evidence of major health impairment among older drug users which will get significantly worse over the coming years. In particular, blood borne viruses, respiratory and dental health problems. A range of physical health problems are becoming more apparent among older drug users. As part of this, pain management emerges as a particular issue that does not appear to be being dealt with effectively. There is a need to improve pain management for older drug users. The 'Orange Guidelines' provide information for health staff regarding pain management and should be used as the basis of good practice. Awareness of these guidelines should be raised to improve compliance. There will be an increasing proportion of older problem drug users who will require care at home as a result of impairment of physical health. Services and particularly community services, must start to plan for the care of problem drug users who are unable to leave their home – in particular home help services and the delivery of any substitute medication.

- *Late onset injecting drug use*

Services should not assume that older drug users all have a lengthy drug problem, greater than 15 to 20 years. Although most will, there is a significant proportion that have developed a drug problem later in life. The drug problem may be less entrenched as a result and could necessitate different responses. The study has identified that the late development of injecting drug use is a surprisingly common phenomenon with vulnerable adults developing drug problems later in life (over 40 years old).

- *Staff training and awareness*

Training emerges as a significant issue if effective responses are to be delivered to the growing needs of older problem drug users over the coming years. Services should develop and support staff so that their services can be more responsive to and understanding of the specific needs of older drug users. Clearly all drug service staff should have the ability and skills to work with older drug users. However, in addition, there may be members of staff who have a particular understanding, awareness and empathy with older drug users. Means should be found to share this understanding and awareness.

**Scottish Drugs Forum (2017) *Older People with Drug Problems in Scotland: Addressing the needs of an ageing population***

Among people with drug problems, those aged over 35 will become the main client group in specialist services for the foreseeable future. They will also be a significant challenge to a wider range of services that will increasingly be required to offer help and support. Therefore, in terms of planning for the future, Older people with drug problems' (ODPD) complex and long-term care needs must be taken into consideration in the planning and development of all health, social care and related services.

OPDPs are often doubly disadvantaged in terms of their general health. They are generally drawn from the most deprived communities in Scotland where they grew up as children and adolescents and may have numerous consequent health inequalities. Furthermore, they may have spent most of their adult lives dependent on illicit drugs and have lived an associated lifestyle that can have a very negative impact on general health. It is evident that current strategic planning of health and social care services has not adequately taken account of this group, or the consequences of their ageing, in

terms of service demand. At present, services, commissioners and planners, as well as Scottish society more widely, are generally unprepared to meet the care and support needs of this older drug-using population.

Within specialist drug and alcohol services, there needs to be a focus on ensuring services that are geared to the needs of OPDPs so that the best outcomes can be achieved, ensuring people are safe, stable, have a good quality of life and are engaged with relevant services, reducing the frequency of unplanned hospital admissions for this group. The role of GPs in identifying, screening and treating this population is crucial. This role needs to be recognised and supported. The role of community pharmacists also needs to be explored as a means to screen for and manage long term conditions such as chronic obstructive pulmonary disease (COPD) and Hepatitis C.

Pain management emerged as a major theme both for chronic and acute conditions for OPDPs.

The majority of those surveyed had accessed services but length of stay in treatment was surprisingly short.

The Scottish Drugs Forum's Workforce Development Team has developed a training module on working with OPDP.

#### **Wadd and Galvani 2014**

The submission from Dr Wadd and Professor Galvani included the following suggestions:

- Increase knowledge about what works in the identification, treatment and prevention of drug problems in older people and improve the collection and reporting of data;
- Increase professionals' competencies and skills in identifying and working with older people with drug problems;
- Develop and test approaches to increasing older people's ability to cope with stress and adversity (resilience) which can contribute to some people starting, returning to or escalating drug use in later life;
- Scale-up and roll out an intervention that has been shown to be effective in identifying and treating medication addiction; and,
- Broaden the remit of existing specialist alcohol services for older people to include treatment for drug problems and commission new integrated alcohol and drug treatment services for older people.

#### **The Welsh strategy (2008) 'Working together to reduce harm: the substance misuse strategy for Wales 2008-2018'**

The Welsh strategy 'Working together to reduce harm: the substance misuse strategy for Wales' recognises the importance of addressing the particular needs of older people. It recommends the following.

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

- Providing diversionary activities (for example, volunteering, day services and leisure pursuits).

## Appendix 6: Summary of some relevant studies and innovations

### **Addaction projects**

Addaction report on innovations to address the health needs of increasingly vulnerable service users. In Liverpool, it piloted a scheme that tested opiate users for respiratory problems, identifying hundreds of people who were unaware they had emphysema and referring them for treatment. In the South West, another pilot with the Hepatitis C Trust was successful in testing, treating and supporting people with Hepatitis C. Addaction also consider that the wider availability of naloxone has played a key role in saving lives of people who have overdosed.

### **Dublin assertive case management project**

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 (Dolphin, 2010). The team provides intensive case management support to people identified as members of the target cohort. The Anna Liffey Drug Project (ALDP) employs a team leader and a project worker using Health Service Executive (HSE) funding and provides management and volunteer support from existing resources. The two paid ALDP staff are the only members of the team who carry cases. They receive regular supervision from the ALDP head of services. The Garda have two members, one from each side of the city, allocated to working with the team. They give up roughly a quarter of their time each to the project, amounting to half a full-time input. Dublin City Council (DCC) provide the team with rent-free office and meeting space and resources. The Higher Level Group (HLG) is made up of senior management from: the HSE; the DCC; the Garda; and Dublin Region Homeless Executive (DRHE). The HLG meets every four-six weeks with the ALDP director in attendance to give an update on the project. An interagency case management team meeting takes place every week with the ALDP team leader and project worker, the Garda members and a Housing First representative. This meeting updates information and reviews all cases and identifies actions to progress cases. The team also has regular informal and/or structured communication with a range of other statutory agencies and community/voluntary charity/non-governmental organisations (NGOs) providing services in the homeless and addiction sectors. The team focuses 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.

A cornerstone of the assertive case management team (ACMT) model is the consent protocol that clients are encouraged to sign up to before being taken on as full cases. This allows for exchange of information between different agencies, including the Garda, to progress case management. The following soft and hard outcomes were particularly highlighted during interviews:

- emotional support to clients;
- giving hope to clients, positive thinking and problem-solving through care plans;

- doing hand-holding for example, helping with paperwork, accompaniment, advocating in relation to other services, which solves practical problems for the client and therefore reinforces trust and engagement;
- more rounded and informed assessment of client needs through interagency case management, leading to more comprehensive treatment plans;
- clients supported to access services previously unavailable to them or excluded from;
- better coordination of two specialisations - addiction and housing - to meet needs of clients;
- more clients keeping medical and legal appointments;
- clinics using the ACMT to follow-up on clients who drop out of medical treatment;
- significant improvement in the relationship between many clients and the Garda, leading to increased communication, trust and compliance with the law, warrants and court appearances; and,
- a reduction in drug-dealing, begging and anti-social behaviour.

Improvements might be through the following.

- the establishment of a crisis stabilisation/detox service for low threshold clients;
- the establishment of protocols and practice for fast tracking those engaged in ACMT into housing and treatment options; and,
- implementation of government policy on injecting rooms.

(Dolphin, 2016).

### **MEAM approach**

Between 2010 and 2013, Making Every Adult Matter (MEAM) supported a series of pilots to explore the better coordination of existing local services for people with multiple needs in three areas across England. These pilots were based in Cambridgeshire, Somerset and Derby, and focused on four core elements taken from previous multiple needs programmes:

- coordination;
- flexibility;
- consistency; and,
- measurement.

There are seven core elements:

- establish a partnership of the right people and understand local need;
- establish a consistent referral process;
- create a single point of contact to coordinate support for clients;
- create flexible responses from partner organisations;
- identify and fill any gaps in service delivery;
- measure the impact on clients and the public sector economy; and,
- embed change within the system so that improvements are permanent.

The focus is on the better use of existing local resources. By 2016, 8 of the 11 areas had developed strong partnerships, found local funding, and were delivering coordinated interventions to adults with multiple needs in their local area. In Derby, the multiple needs service has continued in a slightly different format, integrated into the city's substance misuse service. The principles of MEAM have

also helped to shape a programme of work on hospital discharge across the city. In Sunderland, a coordinator is based with the local substance misuse service, working directly with clients and influencing flexible service responses from local agencies. Norwich has established a partnership led by the Housing Department in the council, with representation from mental health, substance misuse and probation. The project is being coordinated by a local homelessness organisation. In Oxford, each client was assigned a 'MEAM status' allowing the client to access a small personalisation fund and additional hours of support from their existing key worker.

Evaluation of the pilots (Barclay, 2016) concluded that the following strengths and issues were identified:

- They liked the MEAM Approach, with its focus on those with most complex needs and improving coordination without being too prescriptive.
- The support from MEAM's Local Networks Team was well received and valued. Staff skills and experience in multiple needs, networking, communications, influencing policy and commissioners were cited as particularly helpful. Team members' independence from the local area and local organisational politics was seen as a positive.
- Local areas benefited from being part of a bigger network and the link to MEAM's national policy influencing.
- MEAM's monitoring tool and workshops/support with monitoring and evaluation was perceived as useful. Links to MEAM's national policy influencing helped coordinators/partnerships make the case locally and keep multiple needs/MEAM on local agendas.
- One area told the working group that their MEAM work has identified some gaps where housing needs are not being met. This had led to them securing funding for three pilots relating to housing for people with multiple needs.
- MEAM had to adapt to ensure addiction issues did not get lost from its work in the wake of DrugScope's closure.
- MEAM could highlight issues of concern around large reductions in funding drugs/alcohol support in parallel with an increase in mental health budgets, and increase awareness of the "false dichotomy" between mental health and addiction diagnoses.

### **Nursing homes**

Elsewhere in Europe, a number of care and nursing homes have been piloted specifically for older drug users, however, 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 (EMCDDA, 2010).

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 (for example, Denmark, Germany, the Netherlands) have developed specialised nursing homes and accommodation services for this group.

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.

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. It is up to the project leader to decide on a case-by-case basis whether the services should be primarily geared to the need to treat dependence or to aspects of nursing care. In Germany, several such projects have now been implemented as pilot projects, though do not form part of the regular care offer.

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.

As a result, a series of 'alternative nursing homes' have been 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.

### **Senior drug dependents and care structures (SDDcare) project (SDF 2010)**

The Senior Drug Dependents and Care Structures (SDDcare) project ran in four countries (Poland, Germany, Scotland and Austria) from 2008 to 2010 and was partly funded by the EU. It had the aim of:

- creating a knowledge base on older drug dependents,
- gathering data on the numbers involved,
- their life circumstances and health situation, and,
- their treatment and care needs.

During this period, national experts compiled national and local epidemiological data from the participating countries, and information on the national legal and financial framework conditions

relevant to older dependent drug users. In addition, professionals, national experts and older drug users were interviewed in order to assess the treatment and care needs of this group of users. Examples of best practices in nursing homes and residential care in these countries were compiled. Finally, national experts from the participating countries drew up a set of national and European recommendations on the treatment and care of older drug users relevant to policymakers, researchers and professionals.

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.

Linking drug users' welfare support to their compliance with treatment has been shown in some studies to have potentially negative consequences. Drug users forfeiting their benefits were found to be, in the short term, more likely to turn to crime to fund their drug use. Older drug users may be particularly vulnerable to such sanctions, as their drug dependence is possibly more entrenched than that of young drug users. Alternative social reintegration policies and options may have to be developed for older entrenched drug users.

## Appendix 7 – List of abbreviations used in this report

ACMD	Advisory Council on the Misuse of Drugs
ACMT	Assertive Case Management Team
AIDS	Acquired immune deficiency syndrome
ALDP	Ana Liffey Drug Project
APoSM	Advisory Panel on Substance Misuse
BASW	British Association of Social Workers
BDP	Bristol Drugs Project
BPS	British Psychological Society
CMR	Crude mortality rates
COPD	Chronic obstructive pulmonary disease
CSJ	Centre for Social Justice
DCC	Dublin City Council
DRDs	Drug related deaths
DRHE	Dublin Region Homeless Executive
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
Garda	An Garda Síochána
GP	General practitioner
HCV	Hepatitis C virus
HSE	Health Service Executive
ISD	Information Services Division
LGBT	Lesbian, Gay, Bisexual & Transgender
MEAM	Making Every Adult Matter
NDTMS	National Drug Treatment Monitoring System
NGOs	Non-governmental organisations
NHS	National Health Service
ODUs	Older drug users
OPDP	Older people with drug problems
OST	Opioid substitution therapy
PHE	Public Health England
PHW	Public Health Wales
RCN	Royal College of Nursing
RCGP	Royal College of General Practitioners
RCPsych	Royal College of Psychiatrists
SDDcare	Senior drug dependents and care structures
SDF	Scottish Drugs Forum
SMD	Substance misuse database
SMMGP	Substance Misuse Management in General Practice
SMR	Standardised mortality ratio
WCADA	Welsh Centre for Action on Dependency and Addiction

## Appendix 8– ACMD membership

<b>Dr Kostas Agath</b>	Consultant Psychiatrist (addictions), CGL Southwark
<b>Dr Owen Bowden-Jones</b>	Chair of ACMD, Consultant psychiatrist, Central North West London NHS Foundation Trust
<b>Dr Anne Campbell</b>	Lecturer in social work and Co-Director of the drug and alcohol research network at Queens University Belfast
<b>Mr Mohammed Fessal</b>	Chief Pharmacist, CGL
<b>Dr Emily Finch</b>	Clinical Director of the Addictions Clinical Academic Group and a consultant psychiatrist for South London and Maudsley NHS Trust.
<b>Mr Lawrence Gibbons</b>	Head of Drug Threat – NCA Intelligence Directorate – Commodities
<b>Dr Hillary Hamnett</b>	Senior Lecturer in Forensic Science, University of Lincoln
<b>Professor Graeme Henderson</b>	Professor of Pharmacology at the University of Bristol
<b>Dr Carole Hunter</b>	Lead pharmacist at the alcohol and drug recovery services at NHS Greater Glasgow and Clyde
<b>Professor Roger Knaggs</b>	Associate professor in clinical pharmacy practice at the University of Nottingham
<b>Professor Tim Millar</b>	Professor of Substance Use and Addiction Research Strategy Lead at the University of Manchester
<b>Mr Rob Phipps</b>	Former Head of Health Development Policy Branch, Department of Health, Social Services and Public Safety, Northern Ireland
<b>Mr Harry Shapiro</b>	Director - DrugWise
<b>Professor Alex Stevens</b>	Professor of Criminal Justice, University of Kent
<b>Dr Richard Stevenson</b>	Emergency Medicine Consultant, Glasgow Royal Infirmary
<b>Dr Paul Stokes</b>	Senior Clinical Lecturer in mood disorders, King’s College, London
<b>Dr Ann Sullivan</b>	Consultant physician in HIV and Sexual health.
<b>Professor Matthew Sutton</b>	Chair in Health Economics at the University of Manchester and Professorial Research
<b>Professor David Taylor</b>	Professor of Psychopharmacology, King’s College, London
<b>Professor Simon Thomas</b>	Consultant physician and clinical pharmacologist, Newcastle hospitals NHS Foundation Trust

**Dr Derek Tracy**

Consultant Psychiatrist and Clinical Director, Oxleas NHS Foundation Trust

**Miss Rosalie Weetman**

Senior Commissioning Manager of Substance Misuse

## ENDNOTES

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<sup>i</sup> In 1962, Winick, based on data from the Federal Bureau of Narcotics indicating a sharp decline in opiate misuse after the age of 36 years, hypothesised that a substantial majority of opiate addicts ‘mature out’ of their addiction as a result of the normal ageing process (Winick 1962). Subsequent findings, however, have not supported a cause-and-effect relationship between chronological age and the cessation of addiction. Instead, it is now evident that addiction initiated in youth often persists into advanced age.

<sup>ii</sup> For Figure 3 - NDTMS data on opiate users aged 35 and over in treatment, by local authority area can be found at: <https://www.ndtms.net/>

<sup>iii</sup> Cf Davis *et al.* (2010) who observe that ‘Fibrosis progression was inversely related to age at infection, so cirrhosis and its complications were most common after the age of 60 years regardless of when infection occurred’

<sup>iv</sup> Speculatively; this could possibly be due to age-related effects on QTc prolongation &/or renal /liver impairment and/or other aspects of methadone pharmacology that are not yet fully understood. Increased prevalence of underlying heart disease is also a factor increasing risk from QT prolonging medications.

<sup>v</sup> ‘Current data on the number of nurses employed in alcohol and drug treatment services is not available. However, stakeholders engaged in the development of this briefing reported that fewer nurses are employed in alcohol and drug worker roles than ten years ago’. (PHE/ RCN 2017: 5).

<sup>vi</sup> Expert liaison work relating to delivering care for alcohol and drug users is likely to include: liaising with relevant professionals to support delivery of recovery outcomes (including social care, criminal justice, housing, medical, psychiatric, employment, children and families professionals); working at the interface between alcohol and drug services and mainstream mental health; working at the interface between alcohol and drug services and the acute physical health sector, for example, treatment of blood-borne viruses and acute liver disease, cancer care, diabetes, managing the health complications of ageing and palliative care ; providing liaison alcohol and drug services in acute medical and psychiatric settings (PHE 2014).

<sup>vii</sup> Professionals working within services, whether frontline workers, clinical leads or service managers are responsible for their own professional conduct and competence, and for the quality of care that they provide (PHE, 2014: 6). Local authority-based directors of public health have new

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responsibilities to ensure that any clinical services they commission using the public health grant (including alcohol and drug services) have appropriate clinical governance arrangements in place that are equivalent to NHS standards (*ibid*).

<sup>viii</sup> See also ACMD 2017 *Commissioning impact on drug treatment*, which includes the recommendation that ‘The Government’s new Drug Strategy Implementation Board should ask PHE and the Care Quality Commission to lead or commission a national review of the drug misuse treatment workforce. This should establish the optimal balance of qualified staff (including nurses, doctors and psychologists) and unqualified staff and volunteers required for effective drug misuse treatment services. This review should also benchmark the situation in England against other comparable EU countries.’