**Chapter 27**

**Proposals for Policy Development: Drugs.**

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**ABSTRACT**

Drug use among older people is a neglected topic. Not all older drug users are a social problem; they have varying needs and live in different situations within and between countries. Most policies focus on the young but numbers of older problem drug users are rising. There are high levels of unmet need and co-morbidity. Mainstream services will have to adapt to the changed profile of this population. A variety of proposals have been suggested by researchers and practitioners. There is a need to expand harm reduction services, provide services in the community and involve primary care physicians, encourage services to be more sensitive to the needs of this group, recruit and train staff appropriately, initiate innovations, link generic and specialist practitioners and coordinate health services with social care and housing provision. Key dilemmas are how to organise and finance services and whether these should be specialist or mainstream.

**Key words**

older drugtakers; policy; needs; services; treatment; care; finance; housing; health

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**Proposals for Policy Development: Drugs**

**Introduction**

Drug use among older people is a neglected topic. [1, 2]] Need remains hidden and policy documents are largely silent on the issue. [1, 3] Since the 1960s, debates have focused on the young.[4] Use of drugs is not even recorded for some age groups. [5]

Increasingly however, influential voices have mobilised evidence and called for more attention to the issue. [1, 2, 6, 7, 8, 9, 10] In Europe, ageing was first highlighted by the Amsterdam cohort study, which followed up 899 chronic drug users from 1985 to 2002. The findings challenged the idea that the majority of drug users would ‘mature out’ to a drug free state. [11] The issue was recognised earlier in the USA where guidelines were developed in 1998.[12] However, even there, much still remains to be done.[1, 13, 14] Policy responses have to adapt to the constantly changing shape of epidemics and changing profiles of drug users, which vary over time and across different countries.

 Policies centred on the assumption that drug use is entirely a young people’s issue are increasingly inappropriate. However, it would be wrong to replace them simply by a focus on ‘older drug users’. Like drug users in general, older drug users are a mixed bag – in different situations, with different health statuses and needs, each requiring a different response.[15] Not all drug users pose a social problem.[16]

Policy (as distinct from wider public discussion) primarily focuses on ‘problem drug users’ (users of ‘hard’ drugs like heroin or cocaine), and often on the socially excluded, poor or criminal. To adapt policies to both a changing reality and altered perceptions of the problem, a series of linked activities would need to be initiated:

* recognition of the need or problem, supported by collecting evidence
* articulation of a justification for the development of policy, citing values or pragmatism
* identification of policy options
* formal adoption of policy recommendations and acceptance of responsibility
* detailed policy design
* implementation and evaluation.

This chapter will review the development of policy through each phase of this process.

**Recognition of a need or problem and arguments made to justify the development of policy**

Arguments for a new policy response often refer to ‘need’, assuming that pointing out a growing problem and the existence of need are in themselves enough to justify the development of services. [1, 2] These claims rest on concepts of human rights, ethics and values, or social justice. Others refer more pragmatically to the consequences of failing to respond, citing evidence of effects and costs: for example, the misuse of expensive resources in hospital emergency departments or prisons if drug dependence is not dealt with in more appropriate locations [17]; or the cost-effectiveness of early interventions which can prevent more complex conditions, which would cost more to treat. Or they refer to social disorder, citing behaviours such as prostitution, homelessness or criminality among unsupported drug dependents and the ineffectiveness of criminal justice interventions. [18]

Growing awareness among front line staff, with evidence from epidemiological studies, has charted a looming public health problem, an estimated more than doubling in the numbers of older illicit drug users between 2001 and 2020.[1, 10, 13, 14, 19]. Drug treatment services will need to adapt.[2,,20] Mainstream clinical services specialising in the care of older people may also have to adapt and the general treatment infrastructure become sensitive to the problems of older illicit drug users. [1, 10] At present, there is a high level of unmet need with under-identification and under-treatment for substance abuse. In addition, there is higher prevalence of prescription use and misuse and age-related changes in metabolism can increase the potential for negative effects.[1, 2] There is a need to look for early warning signs and develop and test screening instruments specific to this population.[1, 18] Where these are utilised, the finding is often one of co-morbidity. [2] Older drug users suffer from accumulated physical handicaps or impairments and have higher levels of both physical and mental health problems.[7]

US studies have noted increased need for hospitalisation or nursing home placement and a lack of substance abuse treatment facilities with a programme or group designed specifically for seniors.[14, 21] Others have noted the value of community -based services.[1, 22] Han and colleagues concluded there is an urgent need to expand treatment services for older patients and to integrate primary care with substance abuse treatment programmes. [14] They emphasised the value of providing substance misuse services in primary care settings, offering screening, identification and brief interventions. There is potential to take this forward, as in the UK, by developing a group of primary care physicians with specialist expertise in substance dependence.

Not all drug users need treatment. [16] Recreational drug users, such as long-term cannabis users, should however have their drug use recognised when their general health is being assessed. But disclosure may be hindered by the illegal status of some substance use. Primary care physicians and other specialists should be prepared to ask about use of substances, both legal and illegal, as a routine matter. All practitioners should be aware of the possible existence of psychotropic drug use among older people. [1]

Much of the evidence on drug dependence is drawn from treatment populations, which can distort understanding. Studies of other groups, such as those out of treatment, in prison, the homeless, those living in the community and employed, give a different profile and understanding of need, implying different policy responses.[23] Older women may have specific needs as would those who use prescription and over the counter (OTC) drugs.[24, 25] In surveys of populations currently not in treatment, a lack of education regarding hepatitis C has been found, including among middle and upper middle class respondents. In one US survey of sexual minorities, high rates of health insurance coverage were found but low use of substance abuse treatment, thought to be explained by age discrimination and fear of rejection. [26] These authors called for screening and services sensitive to the needs of lesbian, gay and bisexual older people. Other specific groups have been studied (e.g. long-term injecting, heroin using, ageing, Mexican American men) indicating needs specific to each.[27] It would however be impossible and even undesirable to provide separate services for each finely differentiated sub-group. What is needed is for all services to be sensitive to the wide range of life-styles and needs which may be found among older clients and patients and training to include cultural competence [1]. Local needs assessments are important when planning services and appropriate training and recruitment of staff.

Studies of socially excluded and marginalised groups, especially of the homeless, find high levels of need. Evidence from studies of homeless, uninsured or socially isolated groups has led to calls for an expansion of services, especially harm reduction programmes, focused on older adult drug users. Dietz concluded in 2009 from a detailed study in USA that ‘there is a need for more pointed efforts in addressing substance misuse among the homeless and marginally housed’. [23] Street level sex work may continue and jails and prisons are high risk environments for infectious diseases. Other studies have identified specific needs among older veterans [21] and new AIDS cases. [28] The needs of injection drug users (IDUs) require an urgent response as IDU remains one of the most frequently cited modes of HIV transmission worldwide, contributing to epidemics in Russia, India and other countries. Researchers have demonstrated the value of community based services for these groups, such as non-profit organisations operating in open drug markets. They have concluded that older drug users are vulnerable to contracting infectious diseases and more needs to be done to reach this ageing population. [28] Those working with older drug users, such as prison officials, social workers and public health workers, could help to reduce transmission of infectious diseases by incorporating harm reduction strategies into their policies.

**Policy options**

How a problem is defined shapes the proposed policy response and the way a problem is perceived is influenced by both values and evidence. The shape of the evidence reflects the way data are gathered, especially what sub-populations are observed. Research evidence is also supplemented by evidence gained from experience.

In looking at how the problem is defined, the first question is whether drug users are seen as a ‘problem’ or as ‘normal’ people? Related to this is the general question of whether opioid addiction is seen as a chronic relapsing condition,[7, 29, 30] requiring perhaps decades of maintenance treatment, together with relapse prevention and other psychosocial supports, or whether a more assertive and optimistic focus on recovery, abstinence and mutual aid could work wonders.[31] In the USA there have been successful innovations like GET SMART in Los Angeles which started in 1991 and provided weekly support groups to veterans aged 60 and older with problems including use of illicit drugs.[21] While arguments about the potential for recovery are well made and it is important not to write people off, especially simply because they are older, at the same time, it is sensible to be realistic about the likelihood of relapse and aware of the danger of overdose as a consequence. [32]

Secondly, what is ‘old’? The literature shows a variety of age categories from 37-55, to 40+, 45+, 50+, 65+ and 50-74. [1, 2, 7, 9, 14, 18, 19, 21, 22, 24] As a start, there is a clear need to develop common agreement about the ages policy would be interested in. It should be required to record the age of older users and distinguish specific ages more finely. The issue is the degree of fit between chronological, physical and mental age and the early ageing of drug users’ bodies. At the age of 40, drug users may need a level of care corresponding to that required by non-substance using elderly people.[33] The policy question then is how to respond to ‘older’ rather than ‘old’ drug users. Many people feel increasingly invisible and marginalised as they get old and social isolation is linked to a decline in wellbeing so older drug users are doubly disadvantaged.[34] Poly-drug use, including a mixture of drugs prescribed for different conditions, often has deleterious side effects, only increased by illicit drug use, along with tobacco and alcohol.[1]

As well as expanding and adapting to the needs of older service users, through improved training of staff, ensuring the age of staff better match the age of service users, and paying attention to medication management,[1, 2] it has been argued that clinical services should engage in outreach and active engagement ,[1, 35] use peer educators [4] and make better links to other services, specialised and mainstream, including geriatric services.[1, 36] A comprehensive approach, multi-agency and multi disciplinary, is favoured – encouraging that much desired but often elusive ‘joined up’ system. [1, 7]

**[BOX 27.1 NEAR HERE]**

Advocates for reform point to the need to rethink drugs-related support and rehabilitation services. EMCDDA has commented that ‘alternative social reintegration policies and options may have to be developed’ for older problem drug users.[7] The relevance of job training programmes has been questioned for people who are unlikely to be classified as employable. [37] Debates about reintegration into society and employment presuppose that drug users are of working age and are healthy enough to work. In England and in Scotland, for example, greater emphasis than ever is being placed on facilitating the reintegration of drug users into society through employment and to incentivise engagement with drug treatment services for those claiming financial benefits paid to those not in work.[9] In the context of increased healthy life-expectancy, many countries propose to raise the retirement age. For those who are unhealthy, this implies an even longer period of time in long-term unemployment and consequent poverty and ‘welfare dependency’. The intermediary years between becoming an adult, when one is expected to be self-supporting, and reaching an age when eligibility for pension, income support and other services is reached are the crucial ones for policy to deal with.

The early ageing of very unhealthy and disadvantaged groups is the key factor. For whatever cause (lifestyle choice, effect of some earlier trauma or response to environmental constraints) such people constitute a significant group in many post-industrial societies and they cannot match up to the demands of the contemporary work environment. They are the long-term unemployed, variously categorised as chronically sick and disabled or incapacitated or ‘workshy’. They form a distinctive group among the users of health and social services, where such exist, or form an outsider underclass, living in the margins of society geographically and socially, where they do not. Their situation varies across different societies, depending on the general health, social services and social security policy framework and generosity of benefits in each country. Whether they are classed as ‘mad, bad or sad’, their health and income status reflects the income level of the society and the way it chooses to allocate resources. Ideally, if full rehabilitation is not possible, policy would provide sheltered housing and employment. However provision of facilities for drug users, unlike for example people with learning disabilities, lacks public support, especially in an era of fiscal austerity. Even ‘deserving’ groups, like the physically disabled, are unsupported in some welfare regimes. There is a need to devise imaginative ways to encourage less employable groups to make a social contribution thus reducing moral condemnation. The dilemma is how to provide needed services without too great a public subsidy. One radical proposal which might meet the needs of older problem drug users as well as other disadvantaged groups would involve a basic citizen’s income provided to all adults on condition of ‘participation’ possibly through volunteering with an NGO.

 In the US eligibility for many social benefits is based on concepts of normal ageing. The drug user exhibiting early onset physical and mental ageing can become part of a homeless population, excluded from support, whose only recourse to assistance is through use of emergency rooms. A similar situation is found in Poland. [38] In Warsaw, homeless drug addicts have only limited access to therapy including antiretroviral treatment. In richer societies like Germany, the Netherlands or Sweden, with well- established welfare systems, the situation of the ageing drug dependent is better. [33, 39, 40]

This links most poignantly to debates about palliative and end-of- life care. Illicit drug use poses a challenge to these services.[41] For the most disadvantaged, homeless, illicit drug users, policy decisions surround questions of access and service delivery, the role of harm reduction and pain management. Drug users are likely to be excluded from mainstream end-of- life care services, such as community hospices and hospitals, because of differences in lifestyles, behavioural problems or complaints from other residents. Balancing the wishes and needs of different client groups is a challenge to managers of services. From a study in Canada, McNeil and Guirguis-Younger suggest alternatives might include low-barrier, shelter-located palliative care based on a harm reduction model. [41] A few countries like Denmark, Germany and the Netherlands have developed specialised nursing homes and accommodation services for older problem drug users with multiple health and social needs but these are few and far between.[7]

There is a need for research on the application of harm reduction models to end -of -life care settings, including the question of the suitability of supervised drug injection. The European Commission Public Health Executive Agency has partially funded a project SDDCARE (Senior Drug Dependents and Care Structure Project) which made recommendations at the EU level for services and responses.[42] This project compiled information on provision in Germany, Scotland, the Netherlands and Poland. [43] It recommended experimenting at national levels with both separate services for older drug users and integrated settings (perhaps involving young and old drug users, old drug users and old non-drug users).

Two innovations highlighted by the Scottish Drugs Forum are the Housing First Model (based on a model from New York providing secure tenancy irrespective of social issues and drug use) and heroin prescribing. They note that complex, older, chronic drug users require accommodation with a tenure which is not threatened by their continued drug use. But workers have noted that the use of generic services can be limited by deviant behaviour and/ or stigma and they conclude there is a need for individual, person-centred decisions to find the most suitable provision. However, implementing this is hampered by a general lack of choice.[44, 45]

For any of these policy proposals to be taken forward, government must accept responsibility and institutionalise principles in funding and action.[1, 2] Before government feels a need to know and act, there has to be pressure from stakeholders, along with awareness by policy-makers at national and local levels that the efficient functioning of services requires adapting to the new demands.

**Policy design and implementation**

There remains a need for more research on the service needs of these groups and acceptance of the fact that the task of caring for them is complex [1]. In general in many countries, policies need to pay more attention to chronic conditions, clarify statutory responsibilities and revise funding arrangements [1, 46]. The specific way in which policy on older drug users would be designed at any national or local level would have to reflect their general framework of health, social and criminal justice policies as well as link to their wider drug strategy.[7] The process would involve developing strategies and action plans, policy and practice briefings and guidelines, training, policy instruments and networks of concerned agencies and individuals to build support. There is a need for more training opportunities, guidance, mentorship, and financial incentives to develop both generic and specialist workforces appropriately [1]. Forums for stakeholders with a series of workshops could discuss developments and encourage learning from experience. There would be advantage in establishing a high-level national steering group as well as at local levels to maintain priority attention to the issue.[1] Evaluation and monitoring of initiatives, together with dialogue, feedback and redesign in the light of experience, would help to improve the policy response.

**Conclusion**

Underlying proposals for policy development is the question of whose responsibility is it to deal with the problem of older illicit drug users and to pay for services for them? The EU recognises a need to balance human rights with wider community interests. [7] With a stigmatised and often excluded group, whose choices are exacerbated by the illegal nature of their drug use, public attitudes will be hostile and there will be resistance to paying for services for groups who are thought to have brought their misfortune on themselves. Older people in general are more likely to need long- term care and experience financial pressures related to paying for care. [34, 47] A key question is whether to provide targeted or mainstream services. Adequate mainstream services are a prerequisite: selective services specific to minority needs and interests can only be provided adequately as extensions to an adequate level of provision for mainstream service users, currently often lacking. This applies especially to personal and nursing care for those in their own homes, in retirement communities and in care homes. And there is a general need to value more highly and better train those who provide care for older people and encourage inter-professional collaboration.[1]

What emerges is the value of policy development being led by health professionals and agencies, mainly because of their expertise, experience and adherence to ethical practices. In addition, the more decisions are taken on a pragmatic and technical basis and do not become fodder for media and political exploitation, the more likely it is that sensitive and effective policies will emerge.

In many countries, the situation is one of endemic rather than epidemic drug use. [48] In the end however the problem will only be fully addressed through prevention and promotion of healthy living.[49] These goals must be rediscovered as a priority, since for ageing post -industrial societies the health care burden of a range of unhealthy life styles – not only illicit drug use - is becoming increasingly unsustainable.

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**BOX 27:1 Examples of policy recommendations and guidelines**

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| **UK Royal College of Psychiatrists Report [1]**  | **Scottish Drugs Forum [35]**  |
| * close liaison between professionals
* clinical guidelines with care pathways addressing the various needs of older substance misusers
* specific local policies
* access on the basis of need
* elimination of age barriers
* easy transfer between services
* joint working and decisions regarding the lead service
* protocols
* training of health professionals
* improved attitudes – address stigma, therapeutic nihilism and social exclusion
* service models with a particular focus on long-term outcome
 | * assertive outreach for those dropping out of services
* meeting general health care needs effectively
* community services which plan for the care of problem drug users who are unable to leave their home
* good therapeutic relationships
* age- specific services and better match of ages of staff and service users
* good inter-agency work
* practice which is non-judgemental
* harm reduction information
* services which act as advocates
* service user involvement
* home support
* recovery
* training
* supported accommodation
* screening
* pain management.
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