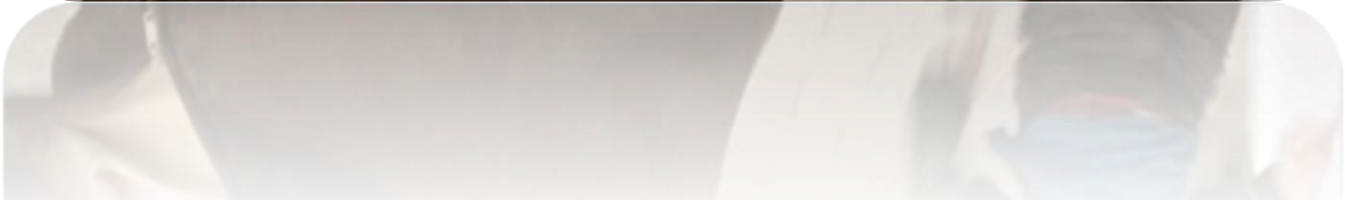


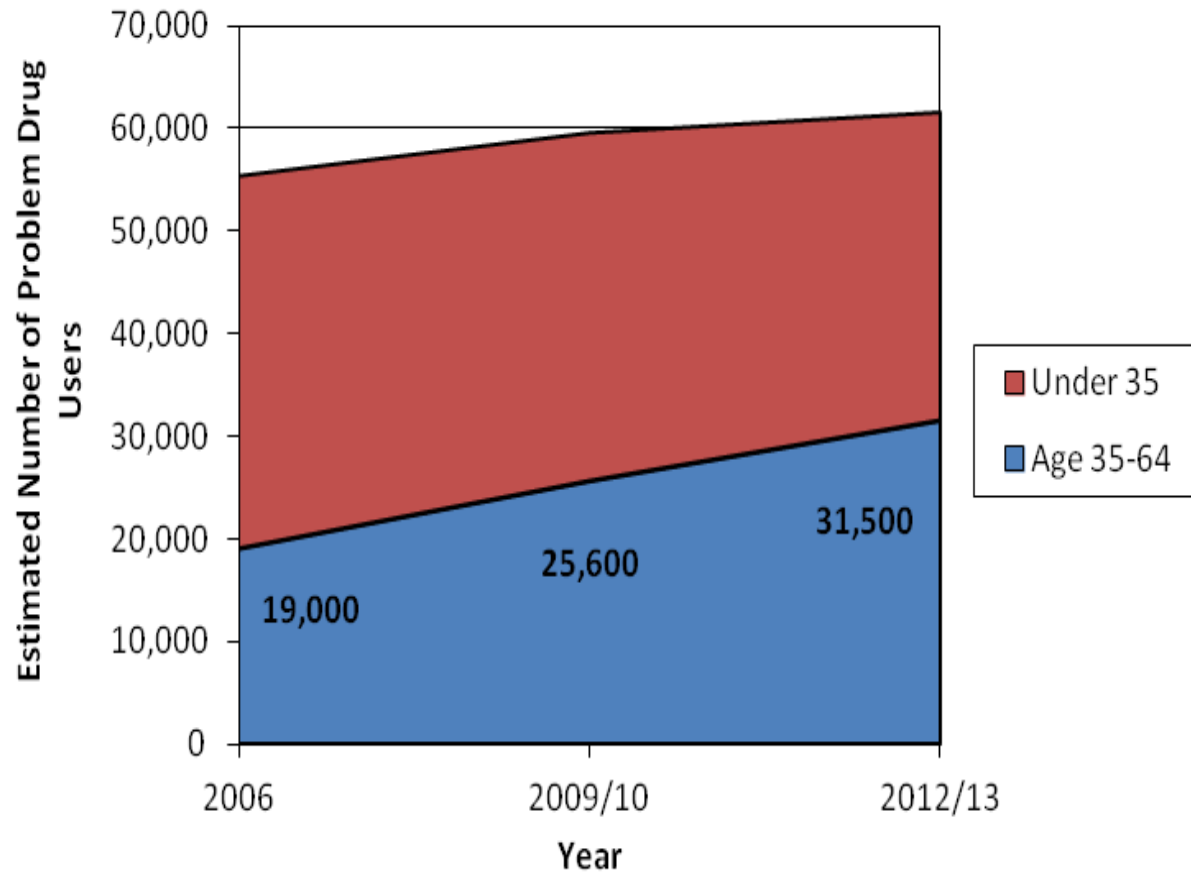
Working with older people with drug related problems

John Budd

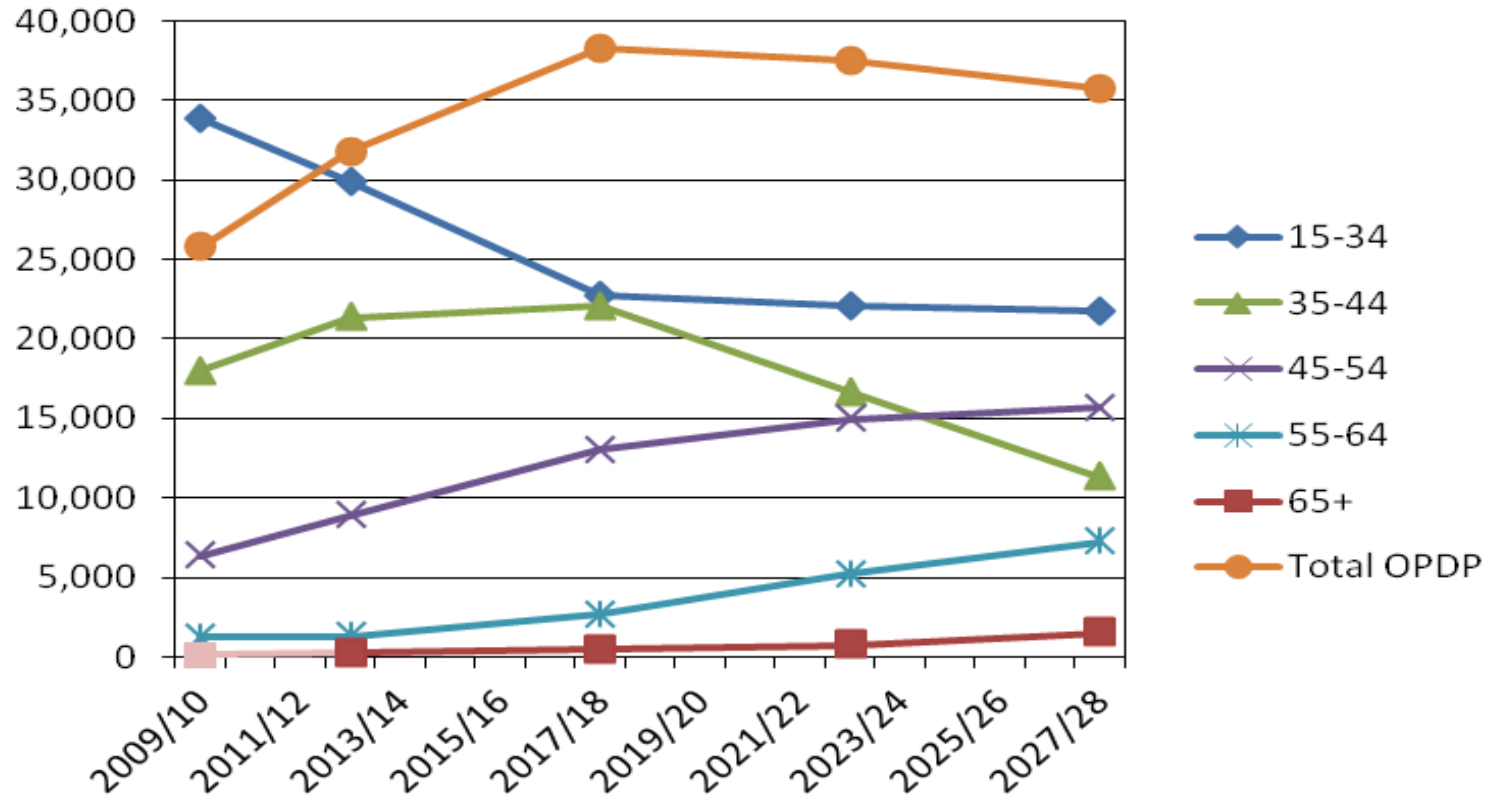
GP Edinburgh Access Practice



Estimated Prevalence of problem drug use in Scotland by Age Group



OPDP Population estimates and projections (both sexes; 2009/10 to 2027/28;)



Source: ISD (2016 & OPDP population projections with 20% non-relapse rate)

Mixed methods study of older people with a drug problem;

The following is a summary of the key findings.

Data was collected from 123 OPDP, 93 male 30 female.

Participants were 35-57 years old with a mean age of 41 years.

- Drug use became 'problematic' at a mean age of 25 years
- 91% had been homeless at some time in their lives
- 79% were living alone
- 95% were on welfare benefits (three individuals worked)
- 96% had convictions for any offences, 84% had been in prison
- 5 individuals had *never* been in treatment
- 37% had been in treatment five or more times, av. length less than 3 months
- 75% were in opiate replacement treatment
- 75% had overdosed at some time in their lives
- 95% suffered from depression, 89% suffered from anxiety
- 53% suffered from chronic pain
- 80% used prescribed medicines other than ORT, with antidepressants most frequently noted
- 32.5% used over the counter medicines

Qualitative findings

- Full transcription and thematic analysis was undertaken on a purposive sample of 30 out of the 123 participant interviews. Key findings were:
- *Stigma, isolation and loneliness, the need to talk and being older and wiser* were recurring themes.
- OPDP could feel 'forgotten about' in treatment.
- Willingness of service providers to take time to talk with OPDP was valued.
- Lack of support services alongside ORT treatment limited engagement.
- Mental health problems were evident and contributed towards isolation and loneliness.
- Chronic pain may be undertreated as stigmatisation prevented people accessing treatment.
- OPDP felt there was more stigma towards them compared to younger drug users, as people were perceived to dismiss them as a 'lost cause'.
- Female OPDP could have more issues in their past that limited their engagement with services.
- Younger people with a drug problem were seen to have different priorities to OPDP.
- This age gap amongst service users could limit engagement of OPDP as they felt marginalised.
- There was an expressed desire to separate older and younger drug users in services.
- Many participants wanted specific services for OPDP, particularly peer support groups.
- OPDP believed their life experience could be used positively to support younger people.

Conclusion

- This research highlighted, very starkly, the issues facing those aged thirty five and over with a drug problem.

Key issues emerging -

- *Mental health and isolation*
- *Stigma around drug use and age*
- *The need to talk*
- *Feeling 'forgotten about' in treatment*
- *Pain/health management*
- *Impact of welfare reform*
- *Punitive nature of some treatment*

Mental Health and isolation

*“ I’ve been so poor. So suicidal all the time, self-harming all the time, I cry constantly, I find it hard to go out on my own. I’d rather be locked in my house. But the ladies here [support service] are encouraging me to come down”
(female, 47 years)*

Stigma

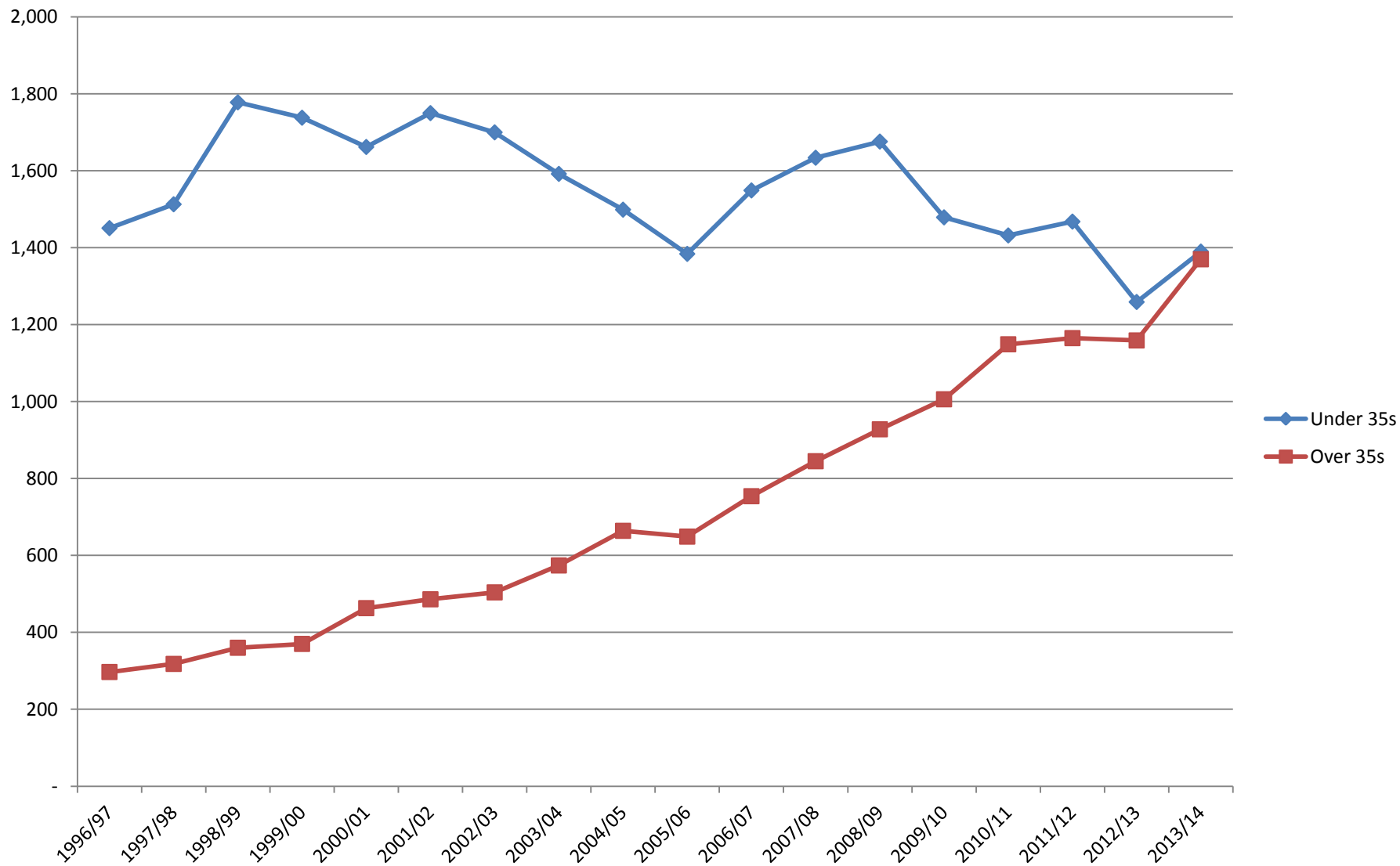
*“Aye, we’re older, so basically they don’t care about us, know what I mean, whereas younger ones, they are trying to get them to the stage of getting them come off it right, so cos we’re older, we’ve been on it longer, so, they’re like that, they’re lookin at us going “Waste of space”, they won’t come off it now”
(female, 40 years)*

Multiple health conditions

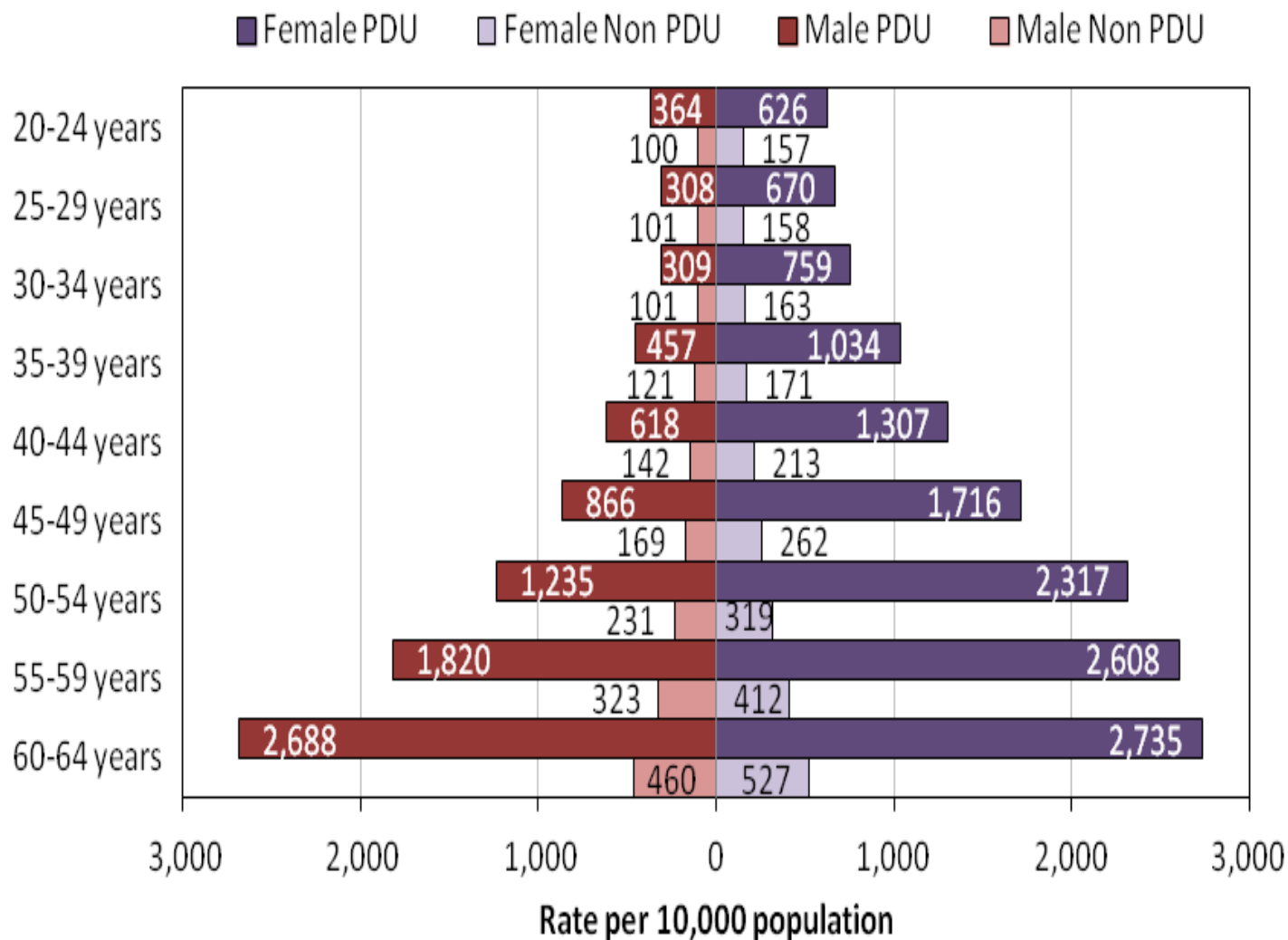
The modelling work undertaken by ISD identified significantly higher rates of hospital admissions for the following conditions than the general population of comparable age:

- Chronic Obstructive Pulmonary Disease (COPD)/asthma
- Hepatitis C
- Liver disease
- Epilepsy
- Deep vein thrombosis/pulmonary embolism
- Skin infections/cellulitis
- Depression
- Psychosis

General acute inpatient & day case new patients with a diagnosis of drug misuse in any position; number and rate of new patients. Source ISD

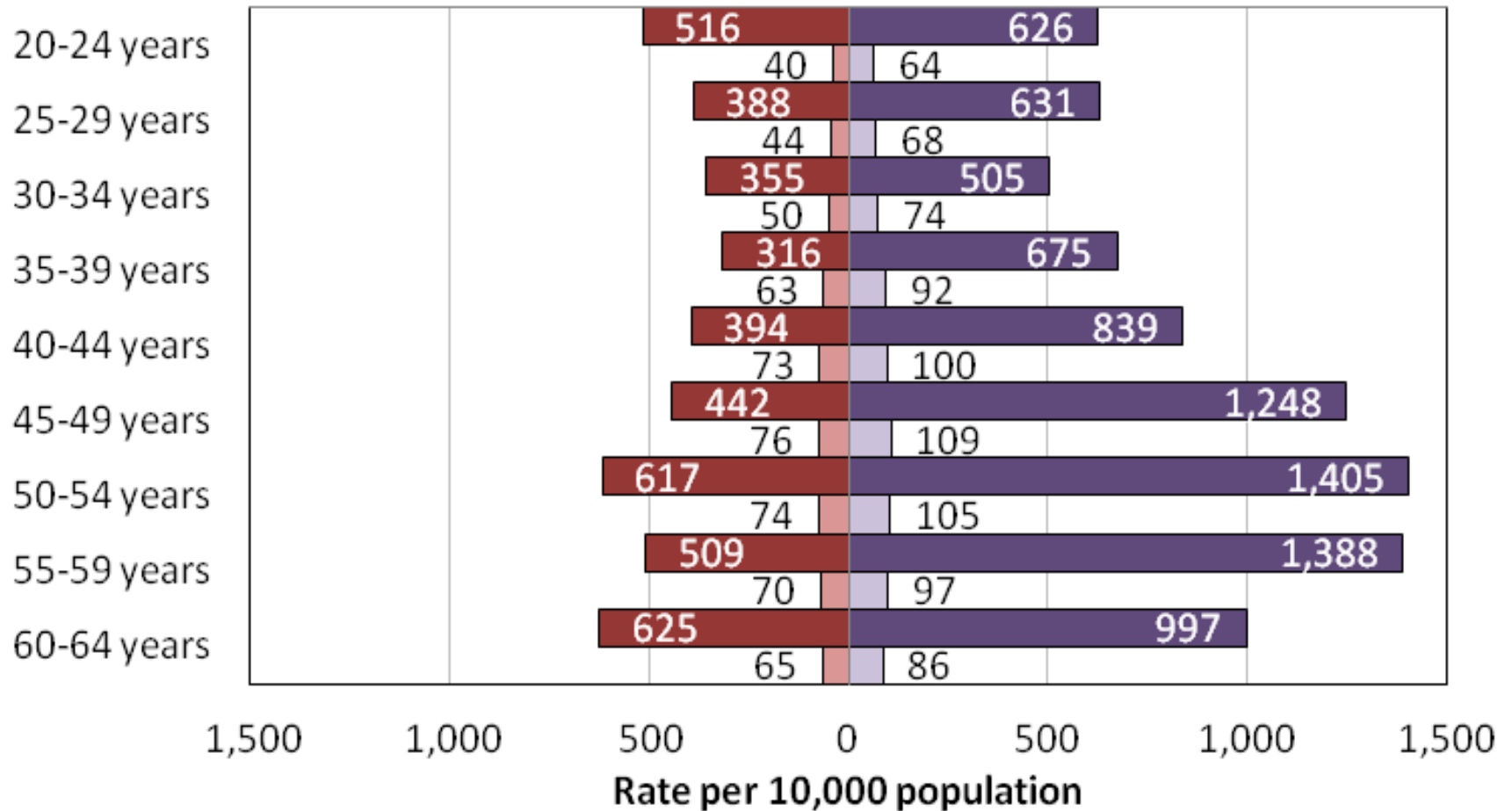


Individuals admitted to hospital for COPD/asthma (2012/13 PDUs and rest of population, rate per 10,000 population by sex and age group)

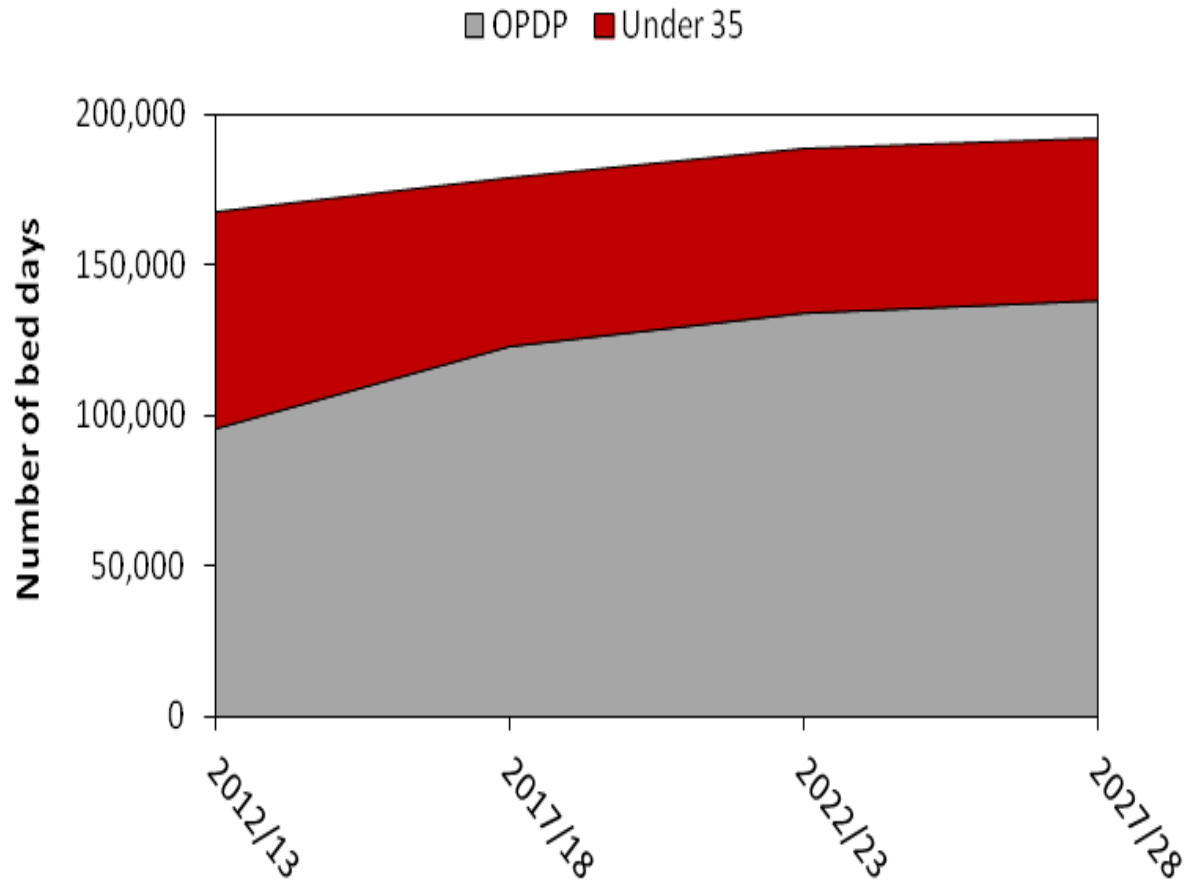


Individuals admitted to hospital for depression (2012/13 PDUs and rest of population, rate per 10,000 population by sex and age group)

■ Female PDU
 ■ Female Non PDU
 ■ Male PDU
 ■ Male Non PDU



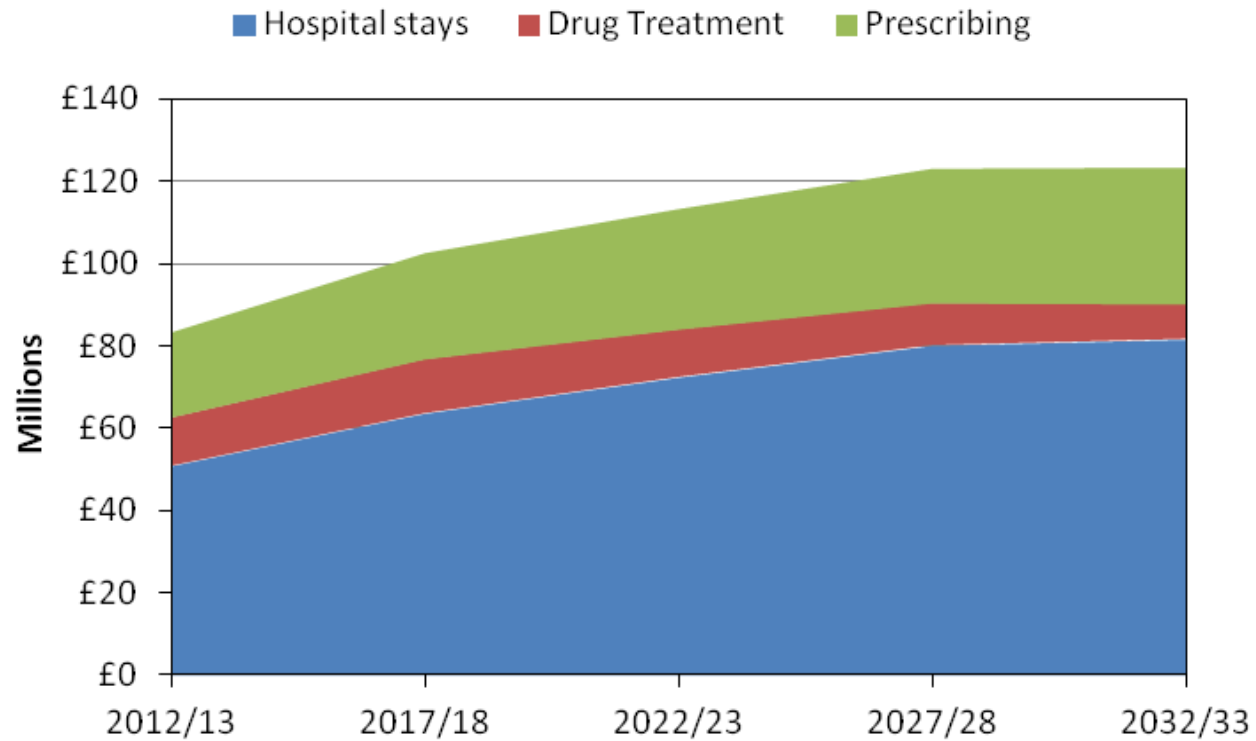
Projected annual number of hospital bed days (PDUs, by age group; 2012/13-2027/28)



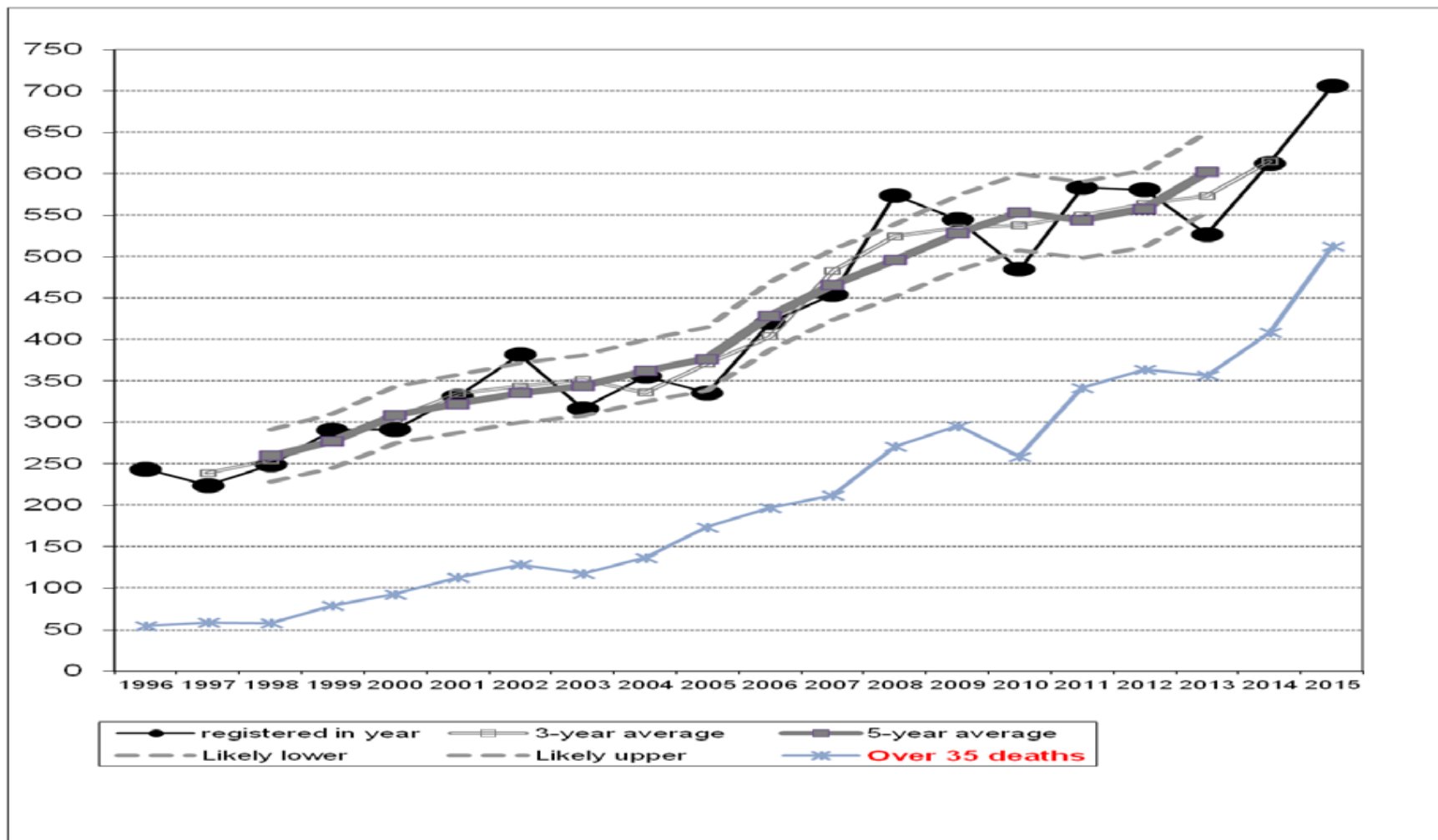
Assuming that these patterns of hospital usage apply to future years, the projected changes in the PDP population (principally the increase in OPDPs and ageing among that group) are expected to result in increases across all three measures. On this basis, the following hospital usage figures associated with PDPs are projected in 2027/28:

- 192,600 hospital bed days (estimated cost: £101.8 million (based on 2012/13))
- 30,100 hospital stays; of which,
- 21,800 were emergency hospital stays

Projected Annual Costs (Scotland 2012/13-2032/33; OPDUs, by cost type)

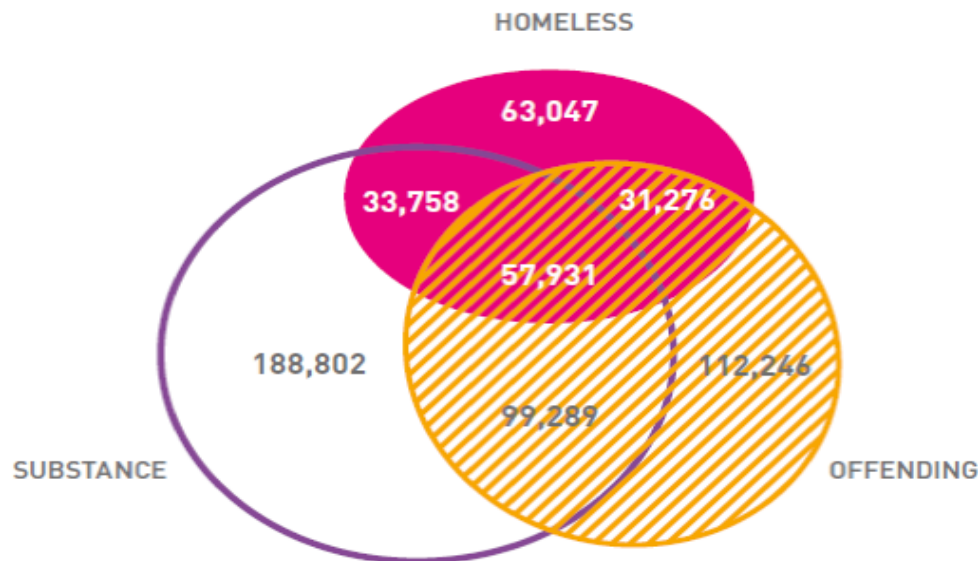


Drug Related Deaths in Scotland, 3 and 5 year moving averages, Drug Related Deaths among individuals over 35 years



Who are the severely marginalised in our society?

- On the extreme margins of social disadvantage are adults involved in the homelessness, substance misuse and criminal justice systems, with poverty and mer



Severe and multiple disadvantage

- Why is this disadvantaged group different?
- ‘Distinguishable from the other forms of social disadvantage because of the **degree of stigma and dislocation from societal norms** that these intersecting experiences represent... as they push people to the edge of the mainstream’

Hard Edges: Mapping severe and multiple disadvantage. Lankelly Chase Foundation. 2015. <http://lankellychase.org.uk/multiple-disadvantage/publications/hard-edges/>

What works in inclusion health?

- **Address poverty** - The most effective upstream prevention policy is likely to be reduction of material poverty and deprivation, especially among families with children who are at high risk of maltreatment.
- **Housing** - People who have experienced exclusion have identified appropriate housing as the most important intervention, and systematic reviews have established the effectiveness of this intervention for improving health and social outcomes.
- **Physical and mental illness, and addiction** - services need to tackle this so-called tri-morbidity
- **Removal of barriers to access** - uptake of services can be accelerated by involving people who have experience of social exclusion.
- **Opioid replacement therapy is highly effective**
- Luchenski et al, Lancet 2017 ([http://dx.doi.org/10.1016/S0140-6736\(17\)31959-1](http://dx.doi.org/10.1016/S0140-6736(17)31959-1))

Opioid Substitute treatment (OST)

Findings of systematic reviews;

Increased engagement and retention of problematic drug users in health services.

Reductions in HIV and other infections.

Reduction in criminal offending.

Observational studies show reductions in deaths;

Introduction of OST in Barcelona associated with an increase of *21 years in the life expectancy of heroin users (Brugal et al 2005)*.

Threefold increase in OST in Sweden, 2000-2006, associated with a *reduction in opiate deaths of 20-30% (Romelsjö et al 2010)*

OST works for older people (Lofwall et al., 2005. Fareed et al., 2009).

Multimorbidity and Polypharmacy

- Multimorbidity at an early age
- Commonest co-morbidity is mental health problems
- High rates of COPD – need for stop smoking Rx, screening + spirometry
- Multiple meds/drugs effecting respiratory function
- Liver problems – alcohol + Hep C
- Chronic Pain
- Concerns over drug seeking – honest discussions
- Poverty and feelings of powerlessness – income maximisation
- Social isolation and need for meaningful activity
- HARM REDUCTION IS OUR GUIDING PRINCIPLE

General Health

New models of care to respond to unmet need:

1. General health care staff in specialist services
2. Specialist addiction workers within primary care
3. Pharmacists offering health assessments and chronic disease management
4. Hospital in-reach
5. Hepatitis C treatment as routine part of drug treatment
6. Pain management

EAP Population

- March 2017:
 - 740 registered patients total
 - 342 (46%) had been tested for HCV
 - Of these 181 (53%) were HCV antibody positive
 - 65 % prevalence amongst those with a history of drug use
 - 70% chronic infection

EAP Hep C treatment

- 2014 - 9 treated (Peg + riba) 8 SVR, 1 relapse
- 2015 – 5 treated (4 Peg + riba, 1 DAA), 3 SVR, 1 stopped Rx, 1 lost to follow up
- 2016 – 6 treated (3 Peg + riba, 3 DAA), 5 SVR, 1 non-responder
- 2017 – Feb'18 - 33 treated (all DAA), 15 SVR, 16 awaiting 12 week test, 2 PCR +ve (1 ?re-infection, 1 poor concordance)
- Total – 53 completed treatment (Feb'18)
- Currently 8 patients ready to start treatment and 6 more starting assessment

CHRONIC PAIN

Most pain is self-limiting and does not need treatment.

When pain becomes chronic, psychological factors become predominant in determining intensity of pain.

Opioids are effective drugs for the management of acute pain and for pain at the end of life but have little role in managing long-term pain.

Long-term harms reported for opioid therapy should also be discussed with the patient including opioid induced hyperalgesia (with worsening of pain).

Safe management of pain is underpinned by detailed assessment of the pain, of any dependence issues, and of any co-morbid mental health problems.

As acute pain is likely to be short lived, there should be a clear plan for reducing the added medications as the acute pain subsides.

Chronic pain is difficult to treat, with no intervention helping more than 20-30% of patients – need for realistic expectations.

Support for patients with chronic pain aims to promote self-management and to improve function: physical, emotional and social.

Clinically meaningful pain relief with gabapentinoids is achieved in fewer than 20%

Mental Health

Need for psychologically informed drug services –
ie from the patient's perspective

- Outward looking services, offering assertive outreach + support people to engage with services
- Gender sensitive services
- Retention in treatment as a +ve outcome
- Range of high quality treatment options , including HAT
- Partnership working with mental health services
- Role of independent advocacy services

Stigmatising behaviours and the links to Adverse Childhood Experiences.....

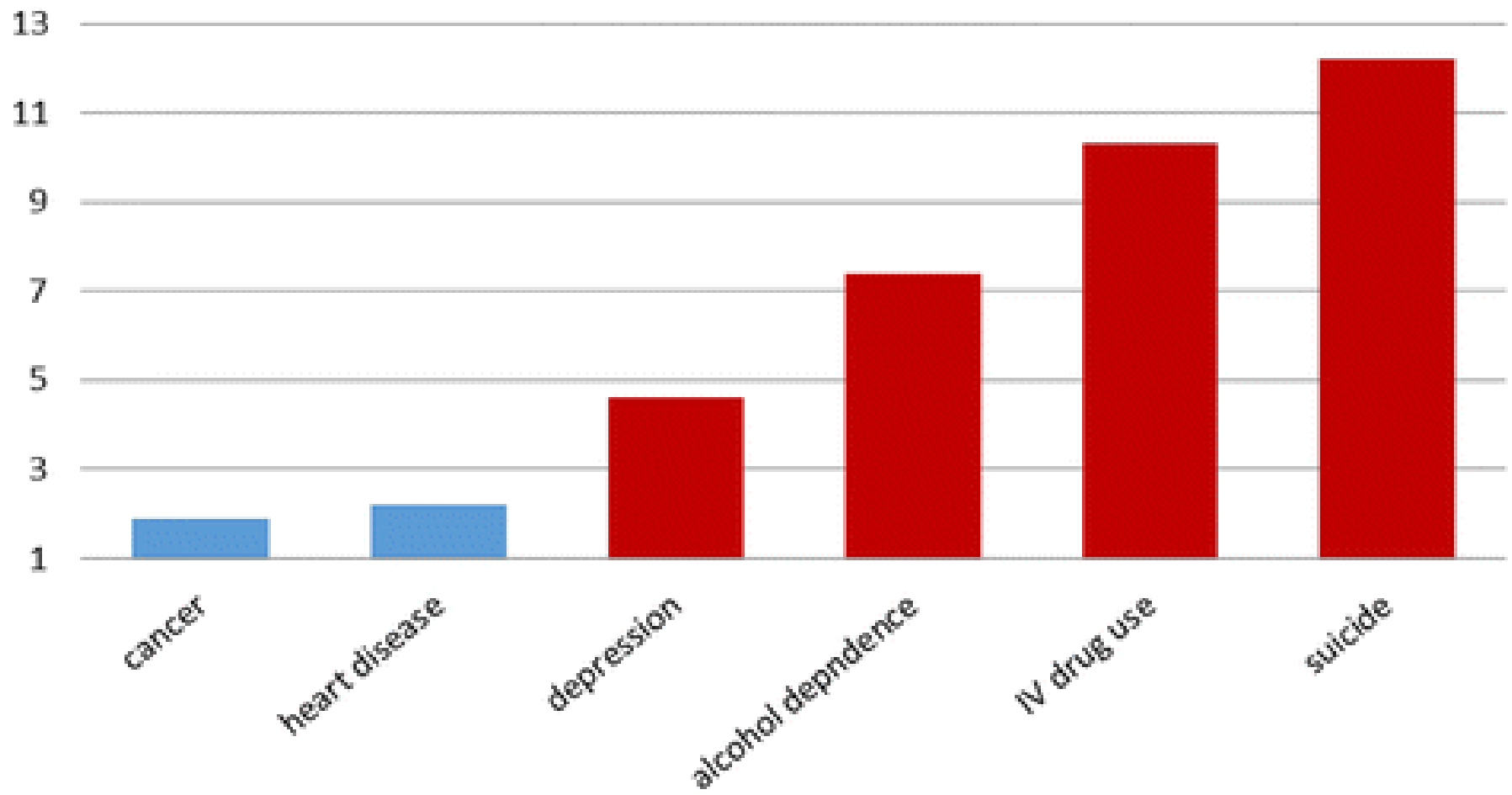
Moving from what's wrong with you,
to what's happened to you?

The need for routine enquiry?

Association of childhood adversity with some adult physical health problems (shown in *blue*) and mental health and addiction problems (shown in *red*). The graph is adapted from Felitti [12], & shows odds ratios adjusted for age, gender, race, and educational attainment for adults exposed to four or more Adverse Childhood Experiences (ACE)

ACE and health outcomes

(adjusted odds ratio, 4+ ACE)



PIE

An environment -

- In which the **nature and quality of relationships between participants or members** would be recognised and highly valued
- Where the participants share some **measure of responsibility for the environment as a whole, and** where all participants – staff, volunteers and service users alike – are **equally valued and supported in their particular contribution**
- Where **engagement and purposeful** activity is encouraged
- Where there are opportunities for **creativity and initiative, whether** spontaneous or shared and planned
- Where decision-making is **transparent**, and both formal and informal leadership roles are acknowledged
- Where power or authority is **clearly accountable and open to discussion**
- Where **behaviour, even when potentially** disruptive, is seen as **meaningful, as a** communication to be understood.

Source: Haigh et al., 2012

Equality Act 2010

- Public Sector Equality Duty to have 'due regard to'...the need to advance equality of opportunity. (section 149)
- The Act also sets out that:
- meeting different needs includes (among other things) taking steps to take account of disabled people's disabilities
- fostering good relations means tackling prejudice and promoting understanding between people from different groups
- meeting the general equality duty may involve treating some people more favourably than others.

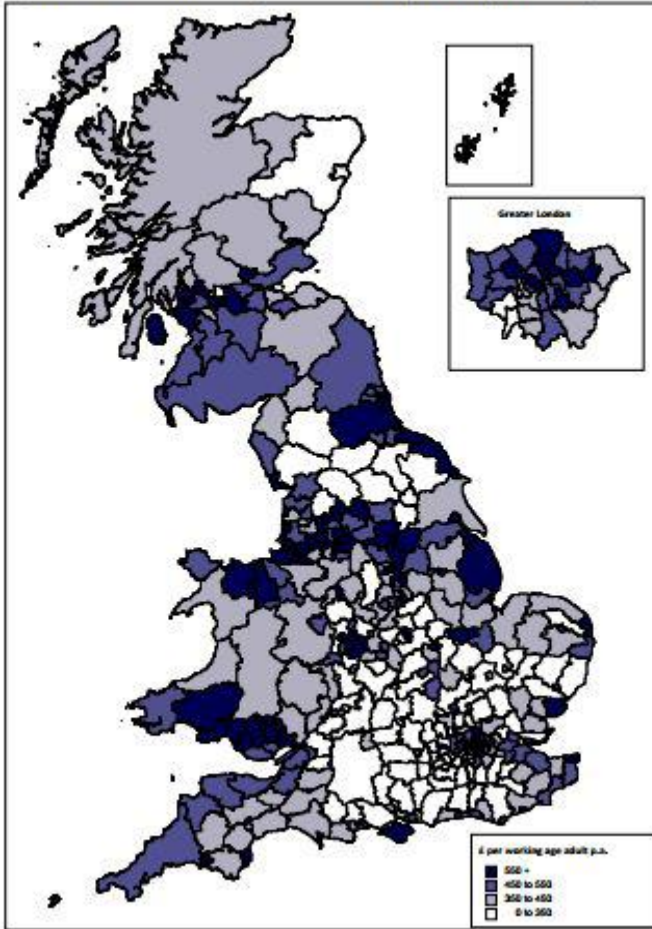
Social Health

- Housing first model – long term unconditional supported accommodation. Core + cluster housing
- Impact of sanctions and welfare change significant - welfare advice workers within services
- Employability options limited for older drug users - need to develop wider opportunities for productive activities

Redistribution away from people in poverty

Source: Beatty & Fothergill (2013) *Hitting the Poorest Places Hardest*

Figure 1: Overall financial loss arising from welfare reform by 2014/15²⁷, by local authority



Welfare cut per working age adult p.a.:

Blackpool - £910

Westminster - £820

Knowsley - £800

Liverpool - £700

S. Oxfordshire – £260

Cambridge - £250

City of London - £180

‘As a general rule, the more deprived the local authority, the greater the financial hit. ‘

Conclusions

- Older drug users now the main group
- Multiple long term conditions
- Chronic disease management
- Hepatitis C treatment
- Accessible, comprehensive and PIE services needed
- General Practice and community services ideally placed – with support
- OST treatment works – needs to be optimised
- HARM REDUCTION IS OUR GUIDING PRINCIPLE

Aspiration

“I would just like to get a job and all that and just be like a normal person, but certain months of the year take a break, take a holiday and ... (I'd) just like to be living like the same mundane existence that eight tenths of the population are living.”