POLICY INTERVENTIONS NEEDED TO TACKLE SUBSTANCE MISUSE IN AN AGEING POPULATION

Review by the Advisory Panel on Substance Misuse

Response from BMA Cymru Wales

24 February 2015

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the review of the policy interventions needed to tackle substance misuse in an ageing population that is being undertaken by the Advisory Panel on Substance Misuse (APoSM).

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

1. Would you be happy for us to contact you again to explore your views further?

Yes.

Name: Dr Rodney Berman. Job title and organisation: Senior Policy Executive. Telephone number: 029 2047 4646. Email: policywales@bma.org.uk
2. What do you consider to be the main issues currently facing older substance misusers in Wales?

In the experience of our members, they observe that alcohol tends to be a major contributory factor in the majority of cases of substance misuse. As such, they consider that services targeted at individuals with alcohol-related problems must be maintained as a priority.

We are aware, however, that there can be a wide variety of types of substance misuse, so it is difficult to generalise. Substance misuse can for instance range from use of alcohol itself through to anabolic steroid abuse, abuse of prescription medications and illicit drug use. It can also affect individuals across all social strata – such as from the senior professional undertaking recreational use of cocaine or heroin at the weekend, to the homeless man drinking strong cider under the flyover on a daily basis.

Amongst older abusers, one common occurrence our members observe is the abuse of prescription medicines – with many using hypnotics anxiolytics and analgesics on a long-term basis. Some will have started using these medications at a time when long-term dependence was not recognised and the safety of these (then new) medicines seen as favourable in comparison to previously-used barbiturates.

We consider that this group should be targeted by support teams, with a view to reducing and stopping such abuse of medication.

A history of long-term misuse is often a common factor amongst older substance misusers, including those taking illicit psychoactive drugs. Compared to younger substance misusers, they are less likely to have started their substance misuse recently and are therefore more likely to have a drug of choice and a predictable usage pattern.

Although not exclusively, they are also less likely to have recently spent time in prison or have younger children. These factors will reduce their ability to access services as they will be less likely, for instance, to have a court order referring them to a drug rehabilitation team and less contact with social services.

Older substance misusers are more likely to suffer from co-morbidities and be less aware of risks such as hepatitis C as a result of less exposure to information about it.

Some key issues that require consideration are:
- Accessing services – in part due to worries about criminalisation.
- Delays in service delivery – such as time spent waiting for a Community Drug and Alcohol Team (CDAT) assessment.
- The presence of co-morbidities – such as chronic obstructive pulmonary disease (COPD), hepatitis, ischaemic heart disease etc.
- Denial – misusers may not perceive their drug use as a problem.
- Unemployment – a drug habit may prevent a misuser from seeking regular employment.
- Difficulties in accessing housing and benefits.

As with all addiction services, we consider that timely access can often be key to successful intervention. For an individual who may have taken the decision to alter their habits and cease their dependence, we feel it is important that they are able to obtain an appointment with an appropriate specialist addiction service with minimal delay.

3. What should the national goals and priorities be in terms of improving and supporting the health and wellbeing of older substance misusers in Wales?

We consider that easy access to services in a timely manner is key, preferably via a single point of access.

We would note that as this age group often also suffers intercurrent chronic illness which can mean they are already under regular care from their GP. However, we would note that alcohol abuse and non-
prescription drug use can often be concealed from a treating doctor. GPs should perhaps therefore be as prepared to screen older patients for substance misuse as they are for younger patients.

In relation to opiate misuse, we consider that it may be beneficial to concentrate more on the maintenance prescribing of an alternative drug rather than on a short-term detox regimes. This is because older users are more likely to be long-term users, and therefore much more likely to relapse back into misuse after completing detox treatment.

4. How could older substance misusers be given more power to shape services?

As is the case in relation to all types of addiction, the patient must take the first step towards dealing with the problem. BMA Cymru Wales believes that what is most important in this regard is for the NHS in Wales to be able to ensure that services are readily available at this key point in time. Otherwise, there is a likelihood that the moment may pass and the patient may then lose their resolve to seek treatment.

5. Are there any policies, services or coalitions that you feel demonstrate best practice in this field?

We are interested in initiatives, policies, programmes or services that have been designed or adapted specifically or are particularly effective for this age group

We note that there are specialist services already in place for benzodiazepine use, but these are poorly funded and overstretched. This could give the impression that their primary aim is to reduce the drugs bill, rather than to benefit patients — even though both goals are important. We consider that the well-being of patients should be at the centre of all service planning.

One of our GP members recalls that, approximately ten years ago in the Bridgend area, what was seen as a revolution in drug misuse care was championed by a new consultant working in this particular field. This consultant established a rapid access CDAT team which was comprised of doctors and specialist nurses to fast track drug and alcohol referrals through the service. Crucially, the time to assessment from referral was within two weeks.

There was also a push to recruit interested local GPs to become involved in shared care (through prescribing and monitoring in stable patients with opiate abuse). A key benefit to local GPs was that, with the new rapid assessment service in place, they could then more easily deal with those patients who repeatedly sought alcohol or drug detox on a frequent basis, often to appease their own relatives.

Under the scheme GPs, could offer fast track access to the service. In return, they were expected to respond by providing a follow-up prescribing and monitoring service once the patient was seen assessed and initiated on treatment. They were in turn supported by specialist nurses, and a close liaison between primary and secondary care developed. Some interested GPs also undertook post-graduate qualifications in substance misuse.

For a number of years, this particular service was regarded as a breath of fresh air and led to closer links between services, rapid assessment and treatment of users, as well as the establishment of maintenance treatments. Regrettably, instead of further resources being made available for this service, funding was withdrawn after the consultant who had established it moved on. Although a number of benefits of the scheme remain in place, the key element of providing rapid access to assessment has since been lost.

6. Have you encountered any problems/barriers in accessing appropriate accommodation settings for anyone with substance misuse issues? Accommodation settings would include both temporary (such as Hostels, Refuges, Residential Care Homes, Foster Placements, Rehabilitation Placements etc) and permanent settings (such as Housing Associations, Local Authority Housing, Private Rented Sector etc).

We observe that many alcoholics and illicit drug users have accommodation difficulties as they often spend their income on their addiction to the neglect of everything else. As such they are often homeless,
or embark on ‘sofa surfing’, even in older age. Access to housing for such people, as well as to nutritional support, should therefore be regarded as a priority – possibly in lieu of monetary hand-outs.

Those with an addiction to prescription medication tend to have more stability in their lives as they are not having to pay out to feed their addictions. This may also be the case for those who are stable on medication (e.g. methadone or subutex for opiate abuse) for whom access to support to help them return to work should be regarded as a priority. For those on such treatment, considerable social support may also be required to prevent them simply exchanging one addiction for another.

We would note that those who are in regular work, and are in receipt of medication via a maintenance script, are much less likely to relapse or drop out of a treatment programme.

7. What assets (including people, time and space) are available to engage with older people with, or at risk of developing, substance misuse issues?

On a day to day basis, the vast majority will have access to General Medical Services. Services may also be provided through third sector organisations as well as within secondary care.

As we have previously indicated, the key concerns we have is that the access to specific support services to assist alcohol and substance misusers in managing their addictions tends not to be available in a sufficiently timely manner and services are over-stretched.

It also needs to be considered that the knock-on effects of addictions (e.g. falls, liver damage and accidents both in the home and on the roads) act as a financial burden on many secondary care services. As such, greater investment in services to tackle addiction could lead to cost savings elsewhere within health service provision.

8. What are the barriers, nationally and locally to identifying and working effectively with older people with, or at risk of developing substance misuse issues?

In the light of current knowledge, GPs are much more careful than may have been the case in the past in the way they prescribe potentially addictive medications. As a result, it would be expected that the incidence of abuse of prescription medicines should diminish with time.

It is the experience of our members that older patients may be less likely to view a drug or alcohol habit as a problem, and therefore be less likely to engage with support services for substance misuse unless a specific crisis develops.

Other barriers may include:
- Concerns about admitting to criminal activity.
- Concerns about the possibility of triggering social services involvement.
- Concerns about taking substitute medication (including daily pickups of substitute medication whilst holding down employment).
- Fear of stigmatisation.

9. How are older substance misusers identified / referred into your service? Is this process formal or informal?

From a primary care perspective, misusers may present themselves in different ways, including
- A direct request for help.
- The occurrence of a crisis resulting from their addiction – often with the involvement of friends or relatives.
- Identification during opportunistic screening when asked about their drug or alcohol habits
- GP IT systems may highlight identifiable patterns from the collection of prescribed medications, including requests for extra supplies.
Our GP members recognise that more might be done to appropriately scrutinise older people who exhibit symptoms that might be indicative of an addiction in the same way they might do so in relation to younger patients in such circumstances.

We would again reiterate that many services for dealing with addiction are over-stretched.

10. What are the barriers to older substance misusers accessing your service specifically?

As we have previously indicated, once a patient acknowledges that they have an addiction problem, there can then be too long a delay in them being able to access an appropriate service following a referral by a GP. As such, a key opportunity can therefore be missed.

We also note that there can be a plethora of different services on offer through both the NHS and voluntary organisations. This may cause confusion, both for an individual seeking to self-refer themselves for treatment and for a clinician seeking to refer someone on. To deal with this, thought could perhaps be given to offering a single referral/access point for such services.

11. What assessment tools (generic and/or specific to substance misusers) do you use to assess your service users? Are these tools effective in assessing the needs and preferences of older substance misuse?

GPs will consider various factors including their own judgement, knowledge of an individual’s case history, results of blood and urine tests and prescription history.

12. Do you refer older substance misusers to other services? If so, which services? Is this process formal or informal? (please attach any relevant referral forms)

As we have previously noted, self-referral can be confusing for an individual but primary care referrals are generally through recognised pathways. Practices may have close working relationships with local addiction services provided by their local CDATs or local voluntary organisations.

Again, though, we would highlight our key concerns that waits for treatment following such referrals can be prolonged. As such, primary care services are often left to cope as best they can until specialist services are available.

13. Are there any challenges specific to working with older substance misusers in your service?

As we have previously indicated, older misusers may have more stability in their lives than younger misusers and this can make contact easier. However, in the experience of our members, the same general challenges apply across the full range of substance misusers – with relapse being the most common of these.

14. How could your service evolve to better meet the needs of older substance misusers?

We would reiterate the need for increased resources and our suggestion of developing a single point of access for such services.

In relation to primary care services themselves, it needs to be recognised that dealing with substance misusers is only one aspect of what practices need to address. So whilst there is clearly a need for greater resources for primary care which is currently under increasing strain, in terms of improving service for substance misusers there is also a clear need for additional resources targeted towards specialist services dealing with addiction. We believe that more resources should be provided to CDATs to enable a rapid access service to be provided, and GPs should be encouraged to become more involved in substance misuse treatment in their own localities.
15. Do you believe you have sufficient information/evidence to commission services that meet the needs of older substance misusers?

It is not clear to us that the specific problems and needs of older substance misusers have been specifically quantified.

Additional comments

In summary, the key points that we believe should be addressed are as follows:

- Services should be rationalised to operate through a single access/referral point.
- Access to specialist addiction services needs to be sufficiently timely in order to be more effective.
- Additional resources need to be directed at these services in order that such rapid access can be achieved.