Older Drug Users in Scotland: professionals' views

Biba Brand, Scottish Drugs Forum

ISFF

ScottishdrugsForum

Institute of Psychiatry and Neurology

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The seven organisations at which the ten professionals interviewed face-to-face workers were: NHS Lothian, Glasgow Addiction Service, Turning Point Scotland, Crossreach, Glasgow Simon Community, Cordia (Services) Limited Liability Partnership (LLP), Centre for Public Health at Liverpool John Moores University.

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1. Background and literature

This report focuses on the health and care needs of older drug users in Scotland as perceived by professionals in the addiction and related fields.

Older drug users are defined as being over 35 years. This was determined by the terms of the collaboration with the three other European partner countries in this study - Germany, Poland and Austria.

Research has been conducted by April Shaw of the Scottish Drugs Forum (SDF) on national and local data to ascertain the various areas of need for older drug users. Further research was conducted by Dave Liddell and the author Biba Brand of SDF on the legal and financial framework for older drug users in Scotland. Copies of these reports are available through the Scottish Drugs Forum. Further comparative reports have been completed on older drug users in the partner European agencies in the countries previously mentioned. These can also be obtained through the Scottish Drugs Forum (email enquiries@sdf.org.uk).

2. Type of study

In gaining the views of professionals two methods have been used – both quantitative and qualitative cross sectional analysis

Firstly, ten face-to-face interviews were conducted with workers, managers, clinicians and researchers from drugs, homelessness, criminal justice and generic care fields.

These interviewees were from residential and community-based specialist and generic services.

The questionnaire and consent for this work is available as Appendix 1.

Secondly, the quantitative method, the electronic social research medium Survey Monkey was utilised to request and gather views from the staff of the 240 drug services (statutory/voluntary and private) in Scotland. From this group 76 services responded, with 71 completing the questionnaire on older drug users and 5 stating that their age range was out with the scope of the study.

The content of the Survey Monkey online questionnaire is available as Appendix 2.

3. Methodology

Aims
The aim of the study was to explore the experiences of professionals working with older drug users and describe the services required to provide healthcare for this group now and in the future.

Professionals from various backgrounds were interviewed. The study covered across Scotland but focussed on Edinburgh and Glasgow. It was decided that contact should be made with professionals with significant experience in this area. Due to the difficulty in identifying and locating such individuals in Scotland where there is no specific service provision for the target group the electronic social research tool Survey Monkey was used to capture a greater breadth of views from professionals.

Sample and recruitment

i. Face-to-face interviews

Professionals to be interviewed face-to-face were selected from two areas (Glasgow and Edinburgh), where the most concentrated areas of high prevalence of drug use occurs and where problematic heroin use has the longest history in Scotland. Professionals working in a variety of addiction-related fields were identified.

Type of service

Addiction/criminal justice - community	1
Addiction/research	1
Addiction/general practice - community	1
Addiction/specialist prescribing – community	1
Addiction - residential	2
Addiction - community	1
Homelessness - community	2
General home support and care – community	1

Within this range of services there was a spectrum of entry criteria as regards drug use. Some were for a client group that is currently attempting to be drug free (2), others for those maintaining stability (5) and others for those who are still quite chaotic (3). This spectrum was sought in order to ascertain if there were any differences in characteristics, aspirations and health care needs of the client groups.

Roles of respondents

Research	1
Manager	6
Front line worker	1
Clinician	2

Employer sectors

Academic	1
Statutory	4
Voluntary	4
Private/LLP	1

ii Self-completion

Professionals from all treatment and care addiction services in Scotland were invited to respond to a self-completion electronic questionnaire using *Survey Monkey*. These services were identified using the Scottish Drugs Forum's online Directory of Scottish Drug Services which is funded by the Scottish Government. - www.scottishdrugservices.com

Type of drug (and alcohol) service

The majority of services involved in the study were statutory with a large minority of voluntary sector services. The vast majority were specialist addiction services, 70% of which were community based, with 11% either residential rehabs or in-patient hospital services. Although a small number of respondents had a policy, planning or commissioning role in their organisation (see roles below), no policy development organisations responded in this study.

The 71 services completing the questionnaire were from the following backgrounds:

Statutory	**54.9% (39)**
Specialist Community Based	70.4% (50)
Voluntary	**42.3% (30)**
Specialist Residential/In-patient	11.3% (8)
Private	**2.8% (2)**
Non-specialist Support Service (DTTO, A&R, maternity, ETE)	18.3% (13)

Roles of respondents

The majority of respondents were managers, a small number also had joint roles encompassing direct client work or policy, planning and commissioning. There were a large minority of respondents working directly with drug users.

Manager	47.9% (34)
Front line worker	47.9% (34)
Administrator	1.4% (1)
Policy/Planning or Commissioning (including 1Team response)	2.8% (2)

Location of respondents

Respondents were able to keep their survey returns anonymous. However, location was identifiable from those who chose to provide contact details. The following areas were represented: Edinburgh, Glasgow, Ayr, Kilmarnock, North and South Lanarkshire and Dundee. This range includes Scotland's main cities and urban conurbations as well as small town and semi-rural settings.

Qualitative interviewing

Face-to-face interviews (10) each lasting approximately 60-120 minutes in length were digitally recorded, transcribed and notes were taken for each interview. The data produced from this process was predominantly qualitative.

Data analyses methods

Face-to-face interviews were coded for analysis using Nvivo the qualitative research programme and manual coding. These were tabulated under themes for comparison.

Self-completion responses provided mainly quantitative data. This was analysed electronically using Survey Monkey and cross-tabulated for statistical comparison. Comments and responses provided by respondents were manually coded thematically.

4 Findings

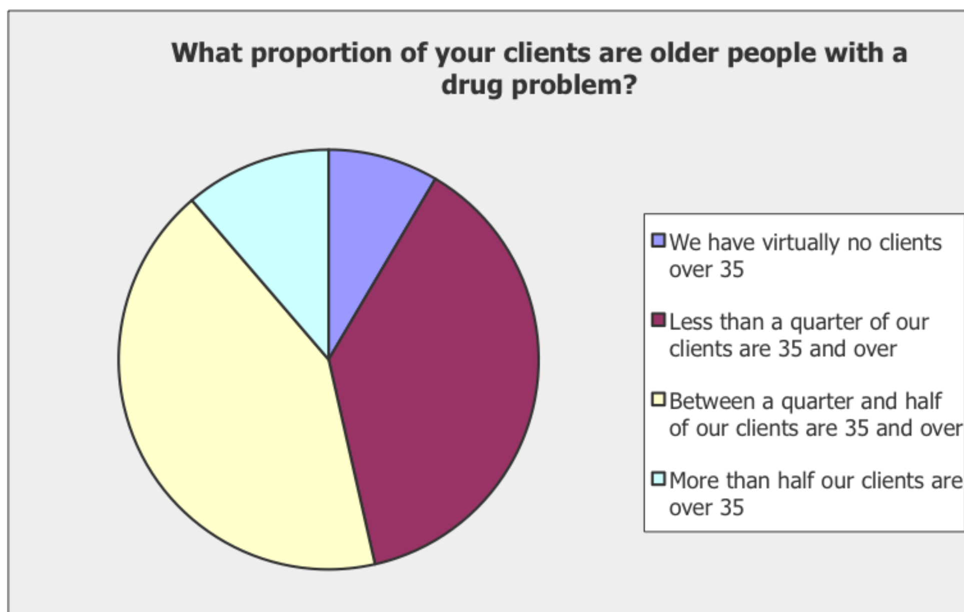
4.1 General experience with older problem drug users in own organisation

Prevalence of older drug users in addiction services

Many addiction services are reaching older drug users with their standard treatment and care provision. This is shown from the numeric data from face-to-face interviews and self-completion. Figure 4.1 shows that 54% (38) had between 25-50% of their client group aged over 35 years. 11% (8) had over half their clients aged greater than 35years, many of these stated specifically that 70-90% were in this older age group.

Several of the 10 respondents estimated that 30-50% of their service users were aged over 35 years. Addiction services with a more chaotic client group estimated that 25-45% of their caseload were over 45 years, but those with more stable service users had much lower numbers, 4-5%. (Some respondents did not record this older age group specifically as >45 years.)

Figure 4.1 from self completion data



In the recent Scottish drug users' prevalence report it is estimated that in 2007 there were 15,000 (28%) drug users in the 35-64 year age group, including 270 (0.5%) aged 55-64years. (Hay el al, 2009) These are problematic drug users using opiates, benzodiazepines etc.

Current targeted provision

Overall addiction services are not providing services which are targeted at older drug users specifically. Services tend not to differentiate between clients on the basis of age, unless to target younger drug users.

Much of the health and care available in services is for drug using adults of any age. However these services do cater for many of the needs of older drug users through interventions, such as home support and day care, needle exchange, wound care, access to HCV testing and treatment, etc.

However some of the larger services are struggling with large caseloads. Difficulties do occur when staff have high caseloads or services are understaffed and remits get squeezed and waiting times lengthen. These waiting periods may be for a second or third treatment (wound care, testing for HCV) not necessarily for first treatments such as substitute prescribing. These types of waiting periods are not the subject of the targets set to reduce waiting periods and improve service access. These waiting times are not so obvious to service planners and managers. In these circumstances the complex range of needs of older drug users is harder to identify, assess and meet.

Most services engage with service users on the basis of their needs, rather than their age. For example, if someone has a liver pain they will be encouraged to go for hepatitis testing and liver function testing. There is no routine testing for HCV amongst drug users even amongst older drug users despite the high rate of infection, higher likelihood that they are symptomatic and treatment should be regarded as a necessity. However a model for screening exists and is common practice for a range of other conditions amongst the elderly (over 60/65 years)

Some services undertake group work with their service users and do not differentiate between older and younger drug users. This can present difficulties. i.e. a group of service users may choose what activities for the group. Younger individuals tend to choose more physically active activities, whereas older individuals choose more leisurely activities. Each service user is encouraged to respect the others' choices, to be unselfish, less self-centred and to broaden their views as part of their development. However, older service users may be uncomfortable or feel unable to be involved in selected activities because they are physically demanding or are regarded as suitable for younger people. Where there are clear mobility issues concessions may be made but these are made on the basis of disability rather than on preference.

Home support and care services like Cordia LLP go into older peoples' homes to help them maintain their homes, and provide direct care to these individuals, such as washing, shopping, cleaning, cooking and visits to the toilet. They do not live onsite with individuals but visit them in their homes sometimes more than once a day if required, if approved and funded by Social Work or on discharge from acute hospital settings.

Again these services are not targeted on the basis of substance use but need. Staff consider the number of their clients who are older drug users is significantly higher than the 12 recorded, since many people will be recorded as having a disability or mental health condition – this being the reason for care

need – but there is no record of the cause for the disability/condition being for example drug use. This may be viewed as being beneficial, less stigmatising, since people are treated as 'normal', and in a less judgemental manner, but in terms of measuring need it allows for under representation. There is a danger that services and those commissioning or purchasing services do not understand changes within their client group and emerging issues. This will effect the development and future delivery of services to older drug users as inadequate provision may be made for a rise in the number of people with these needs due to their substance use.

District nurses also go into homes and provide nursing care in post operative situations, cleaning wounds, and helping housebound individuals. This healthcare is available throughout the UK. This is a generic service open to all, including drug users.

Interviewees expressed the opinion that their clients were treated judgementally by primary and acute generic health service, such as hospital Accident and Emergency departments. In these services many staff seemed to take the view that older drug users should have stopped using drugs long ago. Many members of staff are shocked to think someone of an older age could still be using drugs. This affects the quality of the treatment and care they offer. Even compared to drug users as a patient group, older drug users are particularly poorly treated. In this sense, older drug users are doubly stigmatised.

One service user was told by medical staff
"You should know better at this age"'

Planned developments in services for older drug users

Only one of the ten interviewees stated that they plan to provide a targeted service for this group. The planned service is for homeless individuals who state that they intend to continue drug use. This new service will be based on a model from New York, Housing First which provides a secure tenancy irrespective of social issues and drug use. This means drugs could be consumed in a resident's house without police prosecution, which can often lead to eviction. Support would be provided by the care organisation offsite. It still remains to be seen if age will be a selection criteria, but there is a perception that the service will be appropriate for and attract older drug users. This model of provision is regarded as an innovation in Scotland (see Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an International Review (Scottish Government 2008) and Effective Services for Substance Misuse & Homelessness in Scotland: The recommendations of the Advisory Group on Homelessness and Substance Misuse (Scottish Drugs Forum 2010)

One individual stated that an increase in the provision of generic health services would improve the delivery of services to older drug users, for example more GPs, district nurses, mental health services, etc. If these services had more staff, the greater needs of older drug users could be met and manageable caseloads would mean better interagency information sharing. Drug users would have the full range of their health needs met and not only those acute conditions associated with their drug use.

4.11 Time since taking in elderly problem drug users

All agencies have been supporting older drug users routinely within all age adult provision for many years, in some cases decades, but have limited experience of elderly drug users in their sixties. Amongst Cordia's mainstream client group, people in their sixties would be considered as being young, but they too recognise the particular needs of older drug users and would welcome more experience and training regarding substance use and dependency.

4.12 Intake criteria:

Amongst the services surveyed most accept referrals from social work, health and some will accept self-referrals. A few services have occasional referrals through the police, and one recruits through proactive work, assertive outreach, on the streets with homeless individuals.

Drug use with dependency is a key requirement from most of those interviewed. Generic care services will accept people as need presents, addiction or otherwise. Two or three services stated that they had an age limit of 65 years based on funding. However service commissioners tend to be flexible about this and appear to be able to find a route to accommodate each case and attempt to ensure continuity of care for those who reach 65 and eventually need to move on to an older people's service.

All the services that responded to the survey, only accept adults (variously defined as people over 16 or over 18).

The main criterion for accessing most addiction services is motivation to change, particularly for residential rehabilitation services. This is assessed by the services themselves but also by statutory sector Social Work services who refer clients and pay for their residential treatment. However some community services also said that clients should be motivated to change. For others such as GP services, motivation is not assessed as a criterion for entry and clients simply present for treatment without conditions placed on access to that treatment although treatment regime compliance is required to stay within the treatment programme. In other services, for example needle exchange services there are no criteria for accessing the service although the legal framework on which these services are based requires that they cannot be used wholly anonymously and without supervision.

4.2 Characteristics of elderly problem drug users

4.21 Contact with family members and friends

General Comments

Older drug users are a very isolated group in terms of children, wider families and non drug using friends. Some will express the feeling that they 'deserve' to be isolated and try to come to terms with their isolation, because they have hurt so many people. Others are struggling with their social isolation and want it to end. They do not feel they deserve to be treated this way by society.

As with other members of society, older drug users' social networks tend to reduce with age. However, in the case of older drug users, this can be experienced far earlier than in mainstream society. For some, many drug using peers, including siblings and other family members, may have died through overdose and, particularly in Edinburgh, through HIV/AIDS. In addition they may be bereaved of parents. This is exacerbated through isolation from family who may have separated themselves from drug users because of the pain and frustration of dealing with their drug use. Intensifying this, older drug users have become distant from families because of guilt and depression - this seems to be more prevalent amongst older drug users. If at all, they tend to see family on particular occasions or events for example if someone else dies – a family funeral. However many family events are avoided. This in turn can cause more guilt and resentment. This is self-perpetuating. Many elderly people experience a great deal of loss as friends and family die. A defining characteristic of the older drug user group is that they experience this much earlier than the average person in Scotland. They are doubly disadvantaged in this respect because their drug using peers die young but as many drug users come from communities that live in the most deprived areas of Scotland, where the life expectancy, even of their non-drug-using peers, is low; for example life expectancy in Calton in the East End of Glasgow is 54 yr for a man - even less for a drug user. [1]

Contact with extended family of the same generation, for example siblings and cousins, exists for many older drug users only when they have drug use in common. There can be intergenerational support based on a shared experience of substance use - one case was reported of a father supporting his son because both had a former addiction, the father was very supportive and both attended an Alcoholics Anonymous / Narcotics Anonymous meetings as part of a 12 step programme.

As regards children, most senior drug users had fragmented relationships with their children. Men often leave the family home, and their drug using lifestyle re-enforces the separation and poor relationships, where there are any relationships, develop. One service interviewed with a total of 750 male and female service users said half had no contact with their children whatsoever. In general men tend to display ambivalence about this and are content to continue drug use; where as women find separation from their children painful and this can affect their behaviour in a variety of ways. Some women feel intense guilt and shame about being a female drug user with children or at having lost children because of drug use. They want to change their identity as a drug using mother and re-identify themselves as a 'good' mother or daughter.

The stigma for women seems to be much greater and possibly puts more pressure on them to become drug free when they are more damaged and therefore will find it more difficult to achieve this.

[1] Bridging the GAP - WHO, 2008

'Women have very unrealistic expectations of going from A to Z. For men it's hard to encourage them to go from A to B.'

'They are continually trying to become drug free but have often suffered so many traumas – prostitution, exploitation, sexual abuse and domestic violence – it's a constant uphill struggle.'

Drug users, especially men, often feel that parenthood has been a 'missed opportunity' and that their parenting or absence has caused the loss of chances for positive experiences or relationships with their children. Two services interviewed mentioned that stable older drug users, now grandparents, concentrate their efforts on their grandchildren. In this role they do not feel judged, there is no negative history and in some ways they can help their own children by offering childcare and respite from parenting duties. Here they can be a better parent and have a *'fresh start'*. Grandchildren are also a motivation to become drug free or stable, since older drug users feel embarrassed to be still 'using' and do not want to be seen by grandchildren as still 'mad with it'. So this link is very motivating for them. Children can be very frank about their feelings towards drug using parents and express these feelings clearly. This can cause drug-using parents to distance themselves from their adult children but can also act as a motivator to some parents. It also allows drug-using parents to understand the conditions on which a better relationship might be built.

Older drug users tend to have friends who were themselves using drugs As such; they felt they could have limited trust in them. Experience of such relationships meant that they viewed these friends as not true friends that these friends could not be trusted, and that these relationships were very self-centred and, sometimes mutually, exploitative. These relationships were unstable. There was a lot of 'falling out' and 'in' and both parties were very needy with very little to give.

Attempts to address problematic drug use threatened these relationships. If there was an attempt to become drug free these friends were rarely viewed as a good influence and tended to sabotage these attempts. Drug use is part of the conditionality of these relationships. Many services, especially those aimed at achieving abstinence discouraged such friendships. Some actively worked against them by not allowing visits to residential services from such friends in attempts to safeguard clients from drug-using visitors and dealers. They view such social networks as wholly negative and irredeemable.

Perhaps surprisingly, pet animals were mentioned by some interviewees. Pets are very important to some very isolated individuals. They motivate some older drug users to leave their home and be more physically active, to go for a walk with someone else and to keep active. However some services stated that housing providers often had restrictions on keeping pets, in high rise flats for example. Given the strength of their relationship with a pet, some older drug users would refuse accommodation if it was conditional on them no longer living with their animal. This is a very common condition in accommodation provided for people who are homeless. In fact it is almost universal. Often older users would not care for themselves but be very attentive with their dog. One

respondent gave the example of a man…

'He just ate chips every single day but he bought his dog fresh food every day.'

4.22 Anniversaries of significant personal events and festivals.

There was recognition from interviewees that significant events, birthdays, religious and other festivals, anniversaries of deaths of friends and relatives, children's birthdays especially where an older drug-using parent no longer had contact with their child, were difficult times.

These could lead to changes in mood and behaviour including drug use that could impact on the older drug user and the relationship with others and with services. In the extreme there is a risk of overdose and death at these times. Stable or abstinent drug users can relapse and sometimes overdose. They may seem not to care whether they overdose or even whether they live or die. Older drug users who have been drug free or on low dose maintenance may have far lower tolerance than they have previously experienced and the risk of overdose high.

Some former drug users describe drugs as something they expect to use again in the future, that drugs are how they cope when something bad happens. Planning to take steps to avoid this reactive use of drugs is a challenge as, by definition it happens in a situation in which the older drug user is not in control and is under stress. The answer may lie in the dealing with issues out with drug use. One respondent quoted an older drug user and called for counselling services for this group…

"We need to look at why older drug users continue to use or go back to using. If they had been able to tap into services, like counselling for bereavement maybe, quickly, they may not have started using drugs. They even said things like… "When you are a drug user it's your first safety net. The moment anything happens – straight back on drugs. Whereas maybe if we could tap into services and deal with that aspect of life we might not sort of begin to use drugs again".'

Where worker/client relationships were strong, staff try to be aware and to provide support in the periods before, during and immediately after these events. An obstacle to this level of service is that service users may not articulate that they are feeling low, they may not disclose that a difficult event is approaching and they themselves may not be aware that this is the reason for feeling upset.

Some services providing support at home and residential services have an environment to celebrate birthdays and Christmas, and give gifts at these times. There is recognition here, particularly in residential, that the staff and residents form a pseudo-family environment for that period, with others in treatment and care and with workers may be the only acknowledgement of a birthday.

Other services seem less connected to the significant events in service users' lives. They did recognise that this was not good, but felt constrained by large caseloads and short appointments with service users. In this situation, any good practice seems dependent on the values of the worker rather than the remit of the service. Gifts and lunches also tend to be rewards for becoming drug free, etc. rather than routine at birthdays independent of good progress. Youth services were regarded as a possible model for improving practice.

Some services fail to recognise or recognise but do not see it as their role to address, older drug users' isolation.

Moving on to community-based generic services

In terms of moving people on, services who tried to link older drug users into community activities found limited success. These individuals often enjoyed the activity but felt very insecure with other people.

A similar feeling was expressed with community-based rehabilitation since these services focussed on keeping participants active and engaged in activities. They will usually work with younger people and older drug users felt alienated by the age gap between them and most other service users and they felt unable to fit in.

In response to these difficulties, a number of services were increasingly promoting 12 step programmes like Alcoholics Anonymous / Narcotics Anonymous which the viewed as having the potential to provide settings where some older drug users could feel socially comfortable, with respect to their drug using history, background and age. At times drug users will attend AA, rather than NA, possibly to avoid former drug using peers and perhaps because the older age range in AA is more comfortable. However, some older drug users do not want to attend any 12 step programme, citing the spiritual element or previous negative experience of these programmes as a barrier.

Two interviewees described aftercare/peer support groups where former drug users who previously used their service could continue the social support of being in services and maintaining abstinence.

These groups seem to develop a strong bond and meet over a long/indefinite period of time. Such 'graduate' peer support is sometimes able to be supported by staff resources.

4.23 Strengths and challenges of target group (in institution) by gender

Strengths

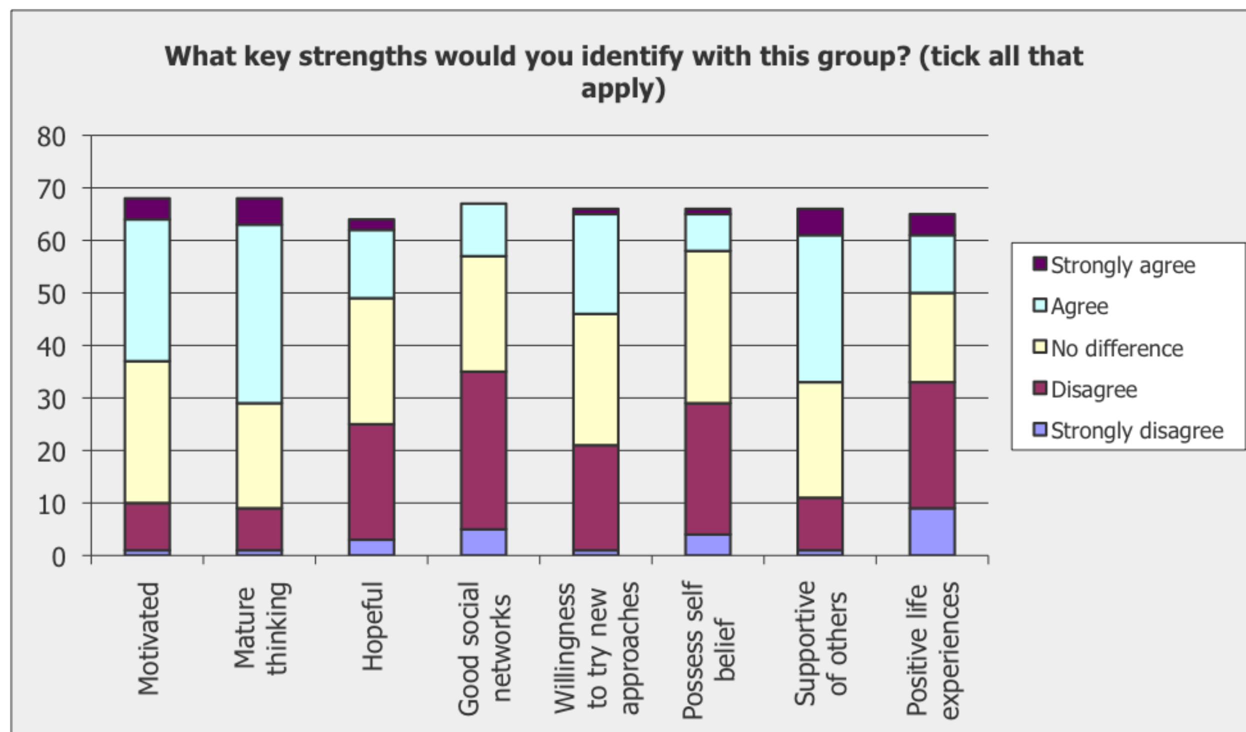
Respondents described older drug users in the following way:

- Mature
- Determined
- Grateful for opportunity to receive help
- Feeling lucky to be alive – so many of friends are not
- Realistic about the future and what works for them - through life experiences
- Cautious - Less risky drug use (but still low tolerance with age and chronic conditions)
- Responding well in group work
- Ready to deal with HCV issues and general ill health symptoms.
- More able to engage with Cognitive Behavioural Therapy, psychosocial interventions, secondary services and substitute prescribing, which may never have attempted before
- Grandchildren give them hope – a way for them to give back to family via child care
- Accepting of their chronic conditions, and their need for help to deal with these
- Resourceful – managed to survive
- Having potential as drug workers and peer educators/mentors

Figure 4.23a shows the views of 71 addiction services which support the views of interviewees. This shows that motivation, mature thinking, and supportiveness of others are key features. In addition these services like interviewees also highlight a high level of disagreement about good social networks, self belief and positive life experiences, i.e. that older drug users are indeed very isolated, have poor self-efficacy and have had significant negative life experiences.

Willingness to try new approaches and possessing hope gained more neutral responses from services with low levels of agreement.

Figure 4.23a Strengths of Older Drug Users



The following areas may appear negative but in this context are relative strengths bearing in mind how chaotic and risky older drug users' lives have been in the past.

Caring for others

As drug users age and become more stable or even drug free some are involved in caring for others. For example, in organising care for frail parents; in providing child care and maintaining contact with grandchildren; and in providing peer support or mentoring to younger drug users, in an attempt to keep them safe and 'look out' for them.

The willingness and ability of older drug users to offer support to others is a resource that has often been untapped by service planners and providers. In the field of health promotion and peer education, more education and training would be required to ensure accurate health improvement messages are shared with younger drug users. However, there are many potential areas for peer education - for example, about improving injecting practice and reducing risks including sharing injecting equipment and how to prevent and deal with an overdose. Amongst older drug users, there are a very mature and experienced group who want to 'give back' and to take on this role either through employment or through volunteering or through friendships and social networks.

Recovery peer networks are also developing in many parts of Scotland. Again these are for people for those seeking abstinence and allow an opportunity to care for others through peer support to promote their recovery.

Opportunities in employing this group in addictions care work are being harnessed in Scotland and specifically through projects like the Scottish Drug Forum's Addiction Worker Training Project where older drug and alcohol users have been employed and trained as addiction workers. Similarly through parallel projects in West Dunbartonshire and the Connect2 Project in Lanarkshire, all of which have had high levels of success in retaining this group as well as onward employment in the addiction field. It should be noted, however, that this work may be adversely affected by the economic recession in the future. This is true of all employability work - one respondent mentioned that service users were finding it difficult to even gain even low level employment in shops, for example.

Drug use – pattern of drug use and abstinence

Professionals reported that some drug users simply "get fed up" with using drugs - they reach what seems to them as an 'end point' and have given up drugs. This stage may be defined by psychological or social factors or by physical factors – simply not having accessible veins into which to inject. In Scotland, some of the recovery projects that have developed recently have taken this group as a locus for their work, identifying motivated individuals and supporting them to detoxify and maintain abstinence.

For others drug use continues but in a reduced amounts and more stable than in their youth. They may have experimented with a larger variety of drugs when younger, but seem to stick to a particular drug using pattern – using one or two drugs.

Mature thinking and self-awareness

Respondents regarded older drug users as more mature in their thinking. One example of this may be that older drug users seeking abstinence seem to prefer to stay in their communities, being older and having established links there; whereas younger drug users are more likely to request that they move away and start new lives in another area. It may be that some older drug users have concluded that physical removal from an area that has become problematic will not be a panacea for their problems. This same maturity in thinking may account for the respondents' view that this client group were characterised by their positive response in group work; being more able to engage with Cognitive Behavioural Therapy psychosocial interventions; being ready to deal with HCV issues and general ill health symptoms; willingness to engage with secondary services and substitute prescribing, which may never have attempted before.

Injecting Practices and Risk

Professionals often described the drug consumption and injecting practices of older drug users as being less risky than that of drug users generally or younger drug users in particular. Older drug users are more careful about who they use drugs with. They tend not to share injecting equipment. If they do share, it is with one person or in very small groups in established patterns and

relationships. One respondent stated that older drug users in their service avoid needle exchanges due to embarrassment about being an older drug user, so they attempt to clean injecting equipment themselves. The rigour with which this procedure is carried out is in doubt which is concerning but the fact that they try to clean the equipment shows a desire to keep safe.

Public injecting seems to be less common with older drug users. Participants reported that some older drug users allowed their homes to be used by younger drug using friends to inject rather than outdoors.

Whether older drug users have always taken lower risks and this is a factor in both their survival into middle age and also the ability to keep using drugs or whether their maturity has changed and modified their behaviour and attitudes is not known.

Relationships with younger drug users

While, as stated elsewhere older drug users tended to try and avoid younger drug users, professionals reported that where relationships existed, they were not necessarily negative. These could be reciprocal relationships where the younger drug user helped the older drug user - by buying groceries, for example or bringing drugs to a less mobile older drug user. There were reports of older drug user 'looking after' younger drug user and offering them support and advice and even of sharing (welfare) benefits.

Challenges

A range of chronic conditions, emotional traumas and social issues have been cited by respondents as affecting this client group. These are viewed as a reason for starting drug use, continuing drug use and for not stopping drug use. Recovery in this environment is very difficult. The economic conditions in our society create challenges for workers and drug users trying to encourage individuals and build on motivation, to foster the aspiration to more fulfilling and more satisfying lives.

Drug use – practice and attitudes to drug use and abstinence

Many older drug users tell professionals that they envisage that they will continue to use drugs and do not see an end to this. Men are more likely to have a settled and accepted view that they will continue using drugs indefinitely.

For some older drug users, polydrug use has narrowed to the use of a narrower range of illicit substances than they may have used when younger. However reports that they combine opiate use with heavy alcohol use was frequently mentioned.

Physical Health

Drug users have poorer general physical health as they get older. This pattern is not dissimilar to the general population but the process happens at an accelerated rate so that in terms of physical health, older drug users experience premature ageing. Respondents report many older drug users aged over 45

years whose physical appearance and health is more similar to that expected in someone aged over 60 years. The combination of ageing, drug use and associated lifestyle, including poor nutrition and lack of physical activity, as well as social conditions can have a drastic impact on health.
Physical processes such as healing become less efficient. Wounds and injection sites can become infected. Abscesses can develop that become several centimetres wide. Social conditions can add to the individual's ability to keep good hygiene, especially if they are in extreme social conditions – if they are homeless for example.

Dental problems are highly prevalent due to poor dental hygiene, poor nutrition and limited engagement with dental services and years of opportunistic infection due to the dry mouth caused by opiate use.

Chronic conditions were repeatedly mentioned by respondents. Some of these were common amongst the general population living in deprived communities – for example respiratory problems due to environmental factors and to tobacco smoking; heart disease due to poor nutrition and diet, lack of exercise and hereditary factors. Cancers related to lifestyles and environments were also reported.

As well as the onset of these conditions, drug users have conditions which are directly related to their drug use. Infection with hepatitis C and other blood-borne viruses are highly prevalent in this group due to sharing injecting equipment. Due to primary harm reduction focussed services in Scotland in the 1980s, HIV infection rates are not high.

Injecting drug use in the older drug users can represent a physical onslaught of 10-20 years duration. Circulatory problems due to poor injecting techniques are common – these vary in severity and can lead to joint stiffness, chronic infection or amputation of limbs.

Managing pain amongst drug users was frequently mentioned. This seemed to be handled well in exceptional cases where addiction staff advocated on behalf of service users. However there were frequent reports of problems and of limited awareness of addiction issues by other health specialists and of the difficulties that can be caused if drug users do not complete treatments due to lack of effective pain relief. Of particular concern is the management of pain in the treatment of cancer in older drug users.

'…when they go to the pain clinic it's going to be more complicated…it's going to be a far higher dose, but other than that they are like any normal patient and behave in the same way, (once you make allowance for their drug use/pain medication/etc)'

These chronic conditions, reducing body mass with age and changing drug use status can lead to reduced tolerance in older drug users, making them more susceptible to overdose. This is a complex issue with social issues also impacting but certainly drug related death prevalence shows this group is at high risk[2].

[2] GROS, 2009

Mental Health

The cumulative effect of multiple traumas is greater for older drug users. Many older drug users have experienced trauma in childhood and have, during their adult life, experienced further trauma. Some of this trauma will be a result of their drug use and the social networks that have developed around their drug use. Other trauma may be due to other factors or experiences. However, all trauma is viewed as a cause of or a reason to sustain drugs use.

Experiences may include childhood sexual and physical abuse, childhood bereavements of significant relatives and alcohol problems amongst parent(s). Even those who have avoided sexual and physical abuse may have experienced a more generalised neglect from parents and others. There is also a wider issue of poverty in childhood.

As adults, drug users commonly experience assaults, sexual assault, sexual exploitation, domestic violence, homelessness, loss of peers and associates through overdose and suicide, the death of parents, lost contact with their own children or the removal of contact by other family or by the Social Work Department, acting on behalf of the state, with their own children who are no longer in their care. Others have contact with their children limited by the state or by other family members.

All these negative experiences not only make them susceptible to fatal overdose and suicide but make them less resilient. They become unable to cope with each new negative event compounding their drug problem and their ill health. Mental health therefore can deteriorate developing into depression, anxiety, paranoia and more severe and enduring conditions such as psychosis.

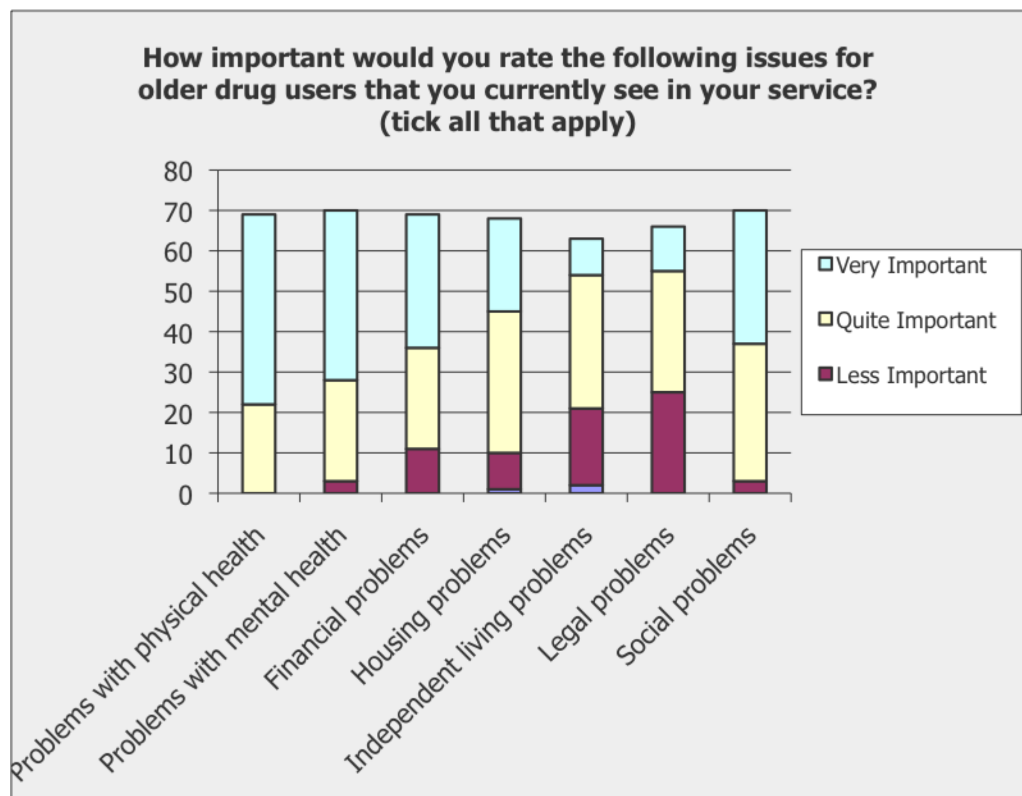
Some drug users have personality disorders and learning difficulties which may pre-date their drug use. These affect their ability to develop and sustain personal relationships and may explain their initial involvement and sustained involvement with drug use.

The stigma experienced by older drug users also compounds mental health problems and isolation. Staff in generic health services but also in addiction specialist services can display limited and at times judgemental attitudes. There are poor understandings of mental health as well as substance use issues. There is also the issue of a failure to diagnose and communicate diagnosis of mental health conditions to other services. This can increase withdrawal from services, cynicism, low self worth and paranoia in individuals.

Many respondents stated that older drug users in general, but particularly men, were reluctant to come forward for physical or mental health checks. Some were even reluctant to use addiction services even needle exchanges. This was due to fatalism, low expectations of what services might offer and, amongst some, the shame of being an older drug user. Women felt more acute shame but were more likely to come forward for help. There was a view that mothers in particular would accept help from services if it allowed them to access their children and to change their identity away from 'drug user'.

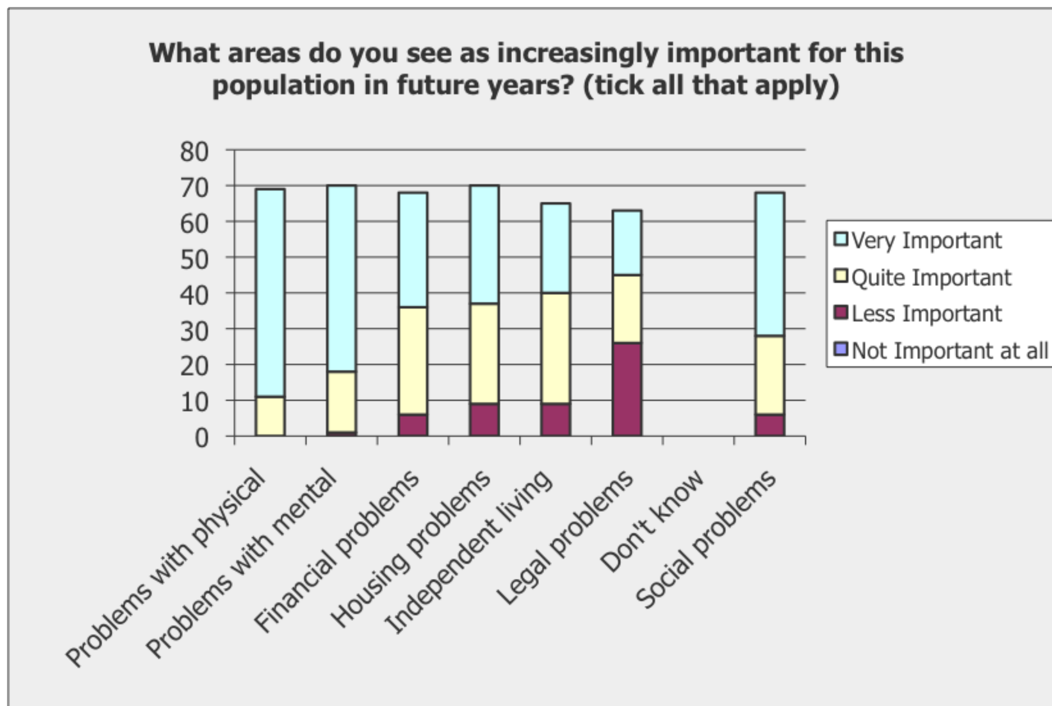
Figure 4.23b shows the range of health and social issues which the 71 addiction services involved in the study felt were important. This is supported in the interview findings. Physical health, mental health, financial issues, social and housing problems are seen as very important. Independent living and legal problems are generally not seen as important, and often seen as not important at all. The latter could be because of the less risky behaviour of older drug users cited by many of the 71 services and the 10 interviewees. Independent living may not be a strong feature of current services users, possibly because of the current low prevalence of people needing care at home.

Figure 4.23b Current Health Issues of older drug users



However in terms of future need these services expect that physical health, mental health and social problems will become increasingly important. (See Figure 4.23c)

Figure 4.23c Expected Important issues for older drug users



<u>Social Issues</u>

Social issues are a major feature of this group, with some difficulties around housing and finance. There are also personal characteristics which are affected by these social issues - their willingness to try new approaches, to possess hope and to believe that they can have success in their pursuits, treatments and positive life choices. (See Figure 4.23a and b)

Respondents involved in treatment provision reported that working with older drug users was informed by the drug users' experiences of treatment. Their experience meant that they had an understanding of what treatment was like, a realistic expectation of what treatment might involve and the effect it may have on them. However there was a danger that a more sceptical attitude may develop which could easily turn to cynicism. There was a danger that previous failure of a treatment may be associated with the treatment rather than a combination of environmental and social issues and the client. There was a risk that older drug users may not engage with a treatment which may not have worked in their youth but could work now in their more mature stage of life.

Finance was not mentioned so much by respondents, though this may be because there is a general acceptance of the poverty constraints for drug users in general. Respondents perhaps see this as 'beyond' the remit of services. Other evidence suggests a strong correlation between drug use and poverty.

Housing was mentioned more frequently. In general good secure housing is more an issue than street homelessness. As individuals become older, ensuring the right level of support to allow them to live alone at home or eventually in supported accommodation becomes a more prevalent issue. Living at home or in supported accommodation was regarded as the best solutions identified by the self completion respondents.

However acute homelessness is certainly a problem amongst a minority of older drug users. Homeless services had examples of wheelchair using older drug users sleeping rough under bridges and at the bottom of the stairwells of buildings. In these situations individual solutions were found, one through long term supported accommodation which would continue until retirement after which they would enter a retirement or nursing home, and the other through a temporary furnished flat where home support and care were being provided on a daily basis. However there is no effective system to prevent these situations arising or to provide an effective response when it does happen. Each case is dealt with as it is found.

Respondents stated that motivation seemed crucial with this group. Many older drug users have experienced many negative life experiences. Due to this they have become fatalistic, hopeless and have no self-belief. Within this negative state of mind many older drug users do not feel there is any point in approaching services or in getting treatment for any symptoms they may have. There is a strong feeling of low self-worth and of everything being pointless so not worth trying. Respondents reported that many older drug users take a long time to agree to being referred to a service, if at all, and then frequently do not attend appointments. In the end they are 'struck off' waiting lists because they fail to attend or engage properly.

Services and staff can become frustrated in working with older drug users. The services themselves are not designed to deal with people who do not engage readily. Services do not usually conduct home visits or engage in proactive outreach work and it is necessary for motivation to come from the drug user since otherwise there is no way to get in touch with an individual not in contact with services. Where outreach is possible staff are able to be more persistent, to keep believing in the client, trying to stay positive but realistic by keeping the pace slow and ensuring any larger goals or aims are broken down into very small and achievable tasks.

Mothers who still had their children had a fear of approaching services in case child protection services became involved and children were removed from their care by the state. This meant that such women were more isolated from services, with their children in the community, with no or limited support. This issue also limited honesty regarding children for those who did access services. Women, and men, would be vague or evasive about the existence of, or their contact they had with, children, including other people's children, the children of partners etc.

Although some women had the right to only restricted contact with their children, particularly with very young children or children who had been removed from them when they were very young, contact had been lost completely or there was very little contact due to guilt. Where children were older this guilt often continued with grandchildren. Older males who were grandfathers were less affected by guilt and two respondents talked about the increased role of older males with their grandchildren.

Assessments and Care Plan Review

It was difficult to assess the quality and currency of assessments. It appeared from one respondent that due to large caseloads and many long term drug users with very complex histories (10-20yr) that many assessments of older drug users may be obsolete and care plans not recently (in the last 12-24 months) fully updated. Child protection and substitute prescribing medication information is given very high priority and this information is likely to be up-to-date. However other issues such as significant life events, housing situation, welfare benefits information, mental health and general health information, is less likely to be updated. This can affect the quality of work with this client group. It can make any effective work and interagency information sharing ineffective and potentially dangerous for older drug users. All these issues need to be regularly reviewed and care plans devised and reviewed periodically and with individuals' involvement.

These are serious concerns as services are losing an accurate up-to-date picture of clients' situation and missing opportunities to make effective interventions to help and support clients.

Medication Supervision and Delivery

A number of the medical respondents and those providing support in the community talked about medication and how this was handled when people needed care at home. In general pharmacies can deliver medications to the home if care at home is required. However in this situation there seems to be difficulties around substitute prescribing, or possibly in particular methadone. Health staff, for example district nurses, are reluctant to take controlled drugs for a named individual to their home, possibly due to security issues. Often family members or friends are providing this service and delivering methadone to their family member's or friend's home. However, for older isolated drug users with mainly drug using peers as contacts this can be expected to become problematic. Additionally, in Scotland most methadone is prescribed on the condition that it is dispensed under daily supervised consumption at a drug service or pharmacy. In this case "take-home" would be required or a daily visit from a health practitioner which would be very costly. Where care in the home is already provided daily through companies such as Cordia additional capacity may be created through the development of a service similar to current daily pharmacy supervision.

Control of own care

Budgets were mentioned by several respondents. Personalised budgets would allow service users to decide what kind of care they got – for example, home support staff who would be able to sit and have casual conversation in their home or to take them to a café or to visit a relative, instead of very rigid routines of food shopping and cleaning the house at specific times. There are ways of giving mentally ill, disabled and older people this control through a UK initiative called Direct Payments (outlined in the Legal and Financial Framework for Scotland, Liddell and Brand, 2008). However respondents did not mention this scheme where the individual is assessed for certain types of care and given the budget to allocate themselves. Amongst staff working with drug users Direct Payments has a low profile, there is a waiting list to be able to access Direct Payments and doing so would not be under the criteria of addictions but of mental health, older person or disability impairment – conditions which are increasingly relevant to this group.

Interesting cultural anomalies exist in this service, which may explain why drug users have not been viewed as appropriate for a Direct Payments regime. - A service that does food shopping for infirm individuals and delivers it to their home will not purchase or deliver cigarettes or alcohol. Under Direct Payments a friend, distant relative or neighbour could provide regular shopping of these legal commodities along with food. One caveat would be that any increased budget and access for Direct Payments caused concern that other budgets would reduce relative to this budgetary change.

Generation gap in addiction services

Services who refer service users on to other services expressed concern about linking older drug users into community rehabilitation services. Their client groups were seen by older drug users as too young and that activities were too active or sports related. Groups for older drug users or set days when they could come in and determine any activities themselves were felt to be a good approach to avoid age specific services but to target and attract this more excluded client group.

4.3 Provision for older drug users with mobility issues

4.31 Provisions on site

Only two services had the provision of physical adaptations on site for infirm older drug users, e.g. lifts, wheel chair ramps. However there were no hoists, staff had not had lifting and handling training, though home support services did have this. Provisions on site were for all drug users independent of age and were generally not for people with mobility-related disabilities.

4.32 Co-operation/joint work with other services (including elderly care)

Two respondents spoke of linking with elderly care services, though one was a general care provider. The Protecting Vulnerable Adults Legislation had assisted this joint working and had opened staff up to new targeted budgets and services available to elderly people, though this was generally because drug users were vulnerable due to learning difficulties or alcohol issues.

All respondents said that joint work with elderly care services would be beneficial for both sides. Awareness-raising was perceived to be required to prevent potential discrimination and attitudinal issues affecting client groups. There was a strong view that all health care fields should benefit from joint working and training on addiction issues to help staff from these fields to appreciate that older drug users are just 'normal' people who happen to have a special need which needs to be taken into account like any other special need, rather than as drug users who are a problem, who will not engage or who are not worthy of receiving treatment.

Two respondents working with general health care staff that had had this type of training said that their staff do not find the client group more 'difficult' than other client groups.

'They just worry about their service users' increased risk of danger; they are more time consuming and complex, but are not outwith their ability to care for.'

One respondent suggested the introduction of certain supports available to the elderly for this client group, such as cheap transport and free gym membership to increase health, keep active and prevent social isolation. In Scotland there does exist 10 week prescription for sports available for therapeutic treatments of depression, circulatory and respiratory problems and such conditions. An extension of such prescriptions to make these available in the longer terms may be beneficial.

Two respondents suggested that the routine screening for health conditions amongst older people should be carried out with younger people who are older drug users.

4.33 Transfer services to caring homes etc. (and keeping in contact?)

Needing care at home

Most respondents knew of small numbers of examples of older drug users requiring care at home, with two examples of people going into care homes usually provided for the elderly, in their late 40s. However where it did occur very personalised solutions were required to provide appropriate care. For example staff advocacy to ensure good pain management in palliative care, relatives collecting methadone and supervising its dispensing in the home themselves, supported accommodation for alcohol users (and drugs) accommodating one person, etc.

The number of clients who needed care at home amongst the services represented by interviewed respondents was in the region of 25-50 in Glasgow, although home support services only reported having 12 addiction individuals on their caseload. It was felt that this discrepancy was due to the referral criteria listing issues associated presenting conditions that give the need for support e.g. 'amputation' rather than wider background descriptions such as 'drug user' or 'addiction'. One service had 25% of case load with HIV, who had in the main been infected in the 1980s. Another respondent spoke of 50-60 older drug users who required care at home in an area of Edinburgh. This care might be temporary - post hospital discharge for example.

As part of the research, residential and nursing homes were contacted in very deprived areas but in each case managers said they had never experienced anyone with drugs (including benzodiazepine) or alcohol dependency.

In terms of creating special residential care homes for this group, when the need grows, respondents were opposed to separate age based services. Even with care homes it was felt that their 'special need' (drug use) should be taken into account but not used to exclude or create new specialist units. The presenting condition should be the focus. Amputations, blindness, liver conditions (hepatitis C), abscesses, agoraphobia were just some of the conditions mentioned by respondents interviewed.

Planned Continued Care

All respondents interviewed planned to continue providing care to older drug users, except one service who can only provide very short term care with referral onto other services.

Two respondents described 'sticking' with very chaotic low threshold service users until they were fully engaged and established within the second service to ensure they did not lose withdraw and spiral out of control again. This is regarded as innovative because referral to another service sometimes ends the referring service's involvement with a service. This is sometimes due to funding arrangements. Even where joint working, where two or more agencies are working with a client and may share some information on this, the services will not ensure that the client is engaging with the other service or 'stick with the' if they drop out from both services' provision.

Home support services were able to visit people at home all through the day and night if necessary (and funded) to assist with cleaning, washing, toilet visits, etc. This is to a maximum of about 4 visits per day. Once unable to live at home a nursing or residential home would be required.

4.4 Elderly problem drug users as specialist target group

4.41 What kind of health promotion messages are required?

Health improvement messages were felt to be potentially appropriate for this age group. Respecting their life experiences was viewed as crucial in communicating with the older drug using group. Ideas for potential messages were on sexual health, injecting practices, preventing late onset injecting and general public health.

Specific sexual health messages are needed for older people generally and for older drug users. Information about the emergence of new conditions, e.g. Chlamydia and new treatments needs to be delivered to people who have disengaged from mainstream health services or who have not prioritised their sexual health. In addition blood borne virus prevention messages, particularly around hepatitis C are still important to prevent re-infection with different strains of the hepatitis virus which may be more resistant.

Adding to this is the minority issue of late onset injecting experienced in handfuls (2-5 over a year) by particularly low threshold interview respondents. These injectors who began in their 40s seem to have been introduced through either prisons or homeless accommodation late in life where they meet new social networks and possibly also have heavy alcohol use so are more vulnerable to drug taking and injecting.

General public health (smoking, nutrition, dental health, heavy alcohol consumption) are also areas of focus particularly when drug use is less chaotic and either stable or abstinent. At these times people's lives tend to be more stable and the other health issues need attention to prevent other chronic conditions developing or developing further. These messages could be individually packaged for this client group.

4.42 What, if any, type of service is needed

Priority

The majority of respondents interviewed did not think this group should be a priority but that all drug users, in fact all of society, should be treated on the basis of assessed need. In this scenario it is likely that older drug users would receive priority treatment and care but not purely due to age.

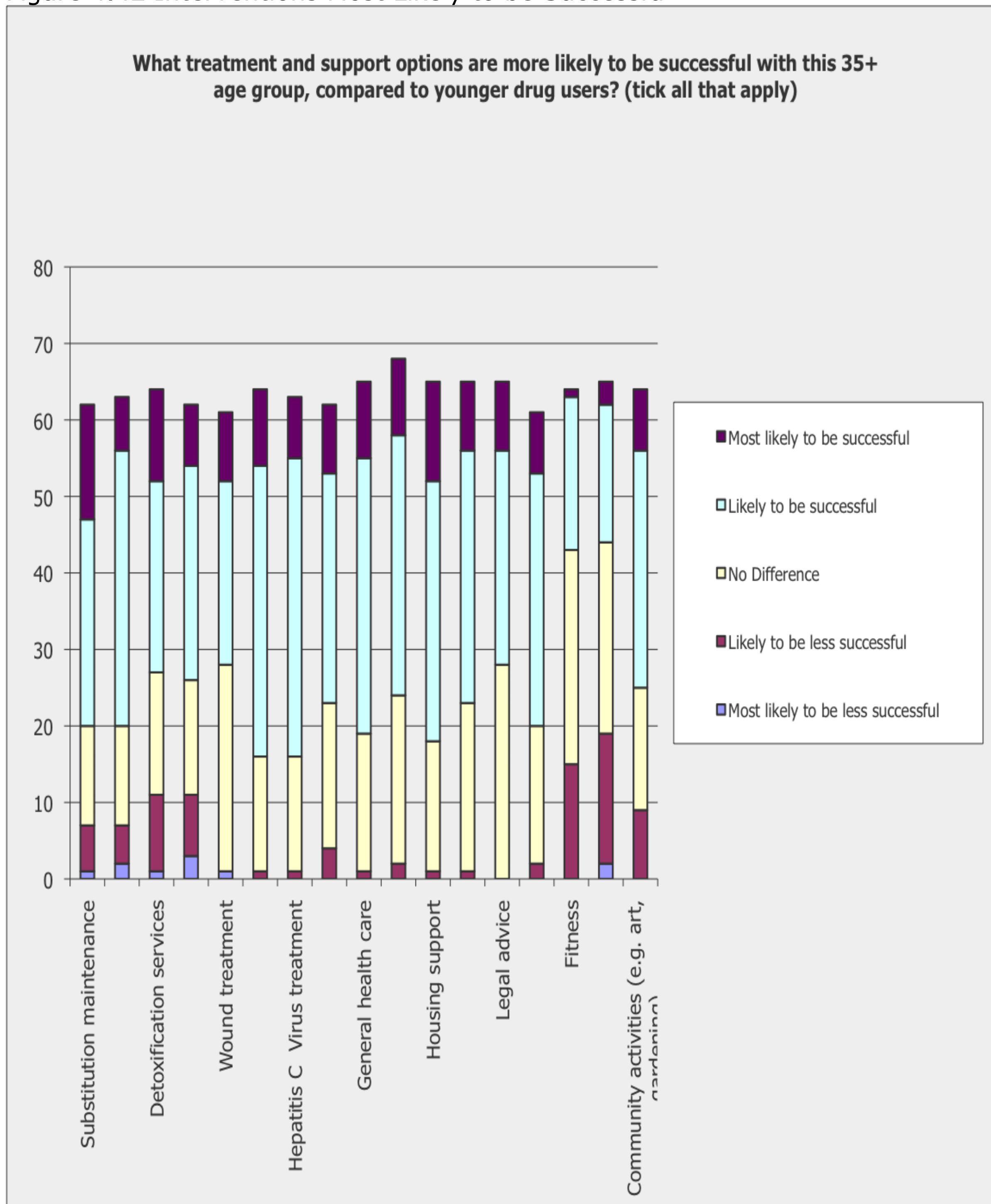
There was an acknowledgement that young people, children and pregnant women are regarded as priority, that it is considered that there is more hope here and that financial resources are targeted in this direction with a view that damage and harm can be prevented before it is too late. However no-one expressed the view that this was right. A minority (1) stated that they could only help those who were motivated and that there was a cut off age (35-40yr) after which it would be too late, so interventions were needed to target this age and build on any motivation immediately

'[over 40yr] They're the ones who won't get services because they're not motivated'

Specialist provision

Figure 4.42 shows the provisions which 71 services felt most likely to work with this client group. Most successful ones from chart and full questionnaire (see Appendix 7) include: substitute prescribing, reducing medication, BBV and HCV treatment, General and mental health care, housing support. Those least likely to be successful were fitness, employability and engaging in community activities such as gardening and art.

Figure 4.42 Interventions Most Likely to be Successful



The 71 services went on to suggest that older drug users would be suited to live in their own homes, possibly in supported accommodation (not based on old age), and to have support for 6-24 months. They felt that indefinite support, separate community living and to an extent residential care were less appropriate. This was supported the 10 interviewees; they were opposed to providing separate age based services though often favoured older people's groups within existing all age addiction services.

Interestingly 'fitness, employability and community activities, the last 3 mentioned on the table of Figure 4.42, indicate that services are not persuaded that older users will be successful in these areas. Those interviewed face-to-face shed some light on this. These respondents stated that age discrimination in an economic crisis where drug use is much stigmatised, makes employability opportunities very challenging. Older drug users may be interested in learning and training but employment opportunities are few and where drug use has continued over possibly 20 years, it is difficult for such older long term drug users to have enough self-efficacy to maintain potential jobs. Community activities are sought but the low-esteem makes it difficult for older drug users to feel they fit in with 'normal' society. Fitness is more modest for example walking, rather than more active, high energy fitness generally preferred by young drug users. The latter can be a barrier for older drug users trying to access community drug services, where this tends to occur. Physical exercise with the aim of health improvement remains an alien culture to many in Scotland's most deprived communities. While this is changing slowly older drug users are likely to remain within the group least likely to change in this respect. However, this should not be regarded as a universal view of the group.

The limited range of prescribing available in Scotland and the strict daily supervised prescribing regimes seems off-putting for many older drug users who are very chaotic. They may have tried this in the past and found it will hard for them to try again so are very reluctant to come forward to services, since they have a perception that this is the only treatment available.

Clients in services find it hard to see beyond this service and relapsing. Those outwith think drug use will never end and don't want the limited range of prescribing on offer

Staff training and implications

In working with this mature group, who have a lot of life experience and are also embarrassed about their situation, more experienced and possibly older staff would be beneficial in providing support.

Characteristics of staff working with older drug users need to be flexible, patient, proactive, non-judgemental, adaptable and flexible to changing circumstances, accepting and able to believe in this client group.

Staff need to be willing to go at the particularly slow pace of older drug users who are anxious about dealing with their drug use and entering the health care system. Very small and achievable goals need to be set at the start of engagement and reliable, steady staff.

Reviews are beneficial particularly where these have not been conducted for some time, and possibly at these times re-consideration of designated staff, to ensure care provisions are challenging as well as supportive. At the same time this needs to be balanced with person centred care, established positive relationships and the issue of isolation which older drug users experience. It is possible that with good supervision and training continued staff relationships would be beneficial and challenging.

The avoidance of creating specialist staff for client sub-groups e.g. older drug users, with specific caseloads enabled staff to all be trained to the same high level, avoided uneven caseloads with extreme imbalances.

4.43 Visions

From interviews, three respondents stated that specialist age specific drug services were required (heroin prescribing to stabilise and bring chaotic excluded drug users into services, and housing where people are allowed to use illicit drugs on the premises without losing their tenancies); and seven stated that in Scotland we should be extending and enhancing what is already provided. This included adapting existing services to attract older drug users (older drug user groups/days) and extending provision and training of community health and social care professionals to provide for this growing group of older problem drug users.

5.1 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, innovative treatment and psycho-social support approaches should be explored which might specifically benefit this population such as Housing First models (see Recommendation 4) and heroin prescribing for those who fail to engage with other services and age specific group work (See Recommendation 6).

5.2 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

Social networks and isolation

The breakdown of social networks and isolation is a major feature of older problem drug users and these impact significantly on users well being and their ability be motivated to change their behavior.

Mental health

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 or exacerbated by isolation and loneliness. It is thought by services that a significant number of the drug related deaths may in not be accidental overdoses but have a degree of intent.

5.3 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.

Relationships

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 with younger users. For many individuals such relationships may be the most significant relationships in their lives.

Exploring opportunities to rebuild family ties

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.

5.4 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 specific attention, for those who are:

- attempting to break away from their former drug using networks
- likely to continue using drugs and require accommodation which reflects this.

5.5 Relapse and alternative coping mechanisms

Services should recognise the importance of relapse prevention when working with older drugs 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 mechanism was highlighted such as support/peer groups, alternative therapies and talking therapies.

5.6 Individualised services

Services should be providing individualised services to all, with older users having a significant input to their treatment plan including substance prescribed and supervision arrangements.

Individualised services

Issues relating drug users and substitute prescribing include issues of choice of substitute drug, dosage level and supervision arrangements.

These have emerged as particularly important issues for older drug users who are likely to have had significant experience of different approaches over their years of receiving services. Improved user input is potentially easier for services to achieve with older drug users who are likely to have significant insight into their own problems.

It was consistently highlighted that the maturity of older drug users was potentially an asset which could perhaps be harnessed. It was felt that older long-term users were in most cases risk averse who took considerable care about keeping themselves safe – e.g. with regard to overdose or blood borne viruses.

It was also reported that they could act, and often did, as positive role models with younger less experienced users encouraging safer practices.

Gender-sensitive services

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 too slowly.

Services need to acknowledge these gender issues which appear to be particularly apparent with older users. This could involve ensuring the women are encouraged to look at taking small steps with realistic goals, while men should be encouraged to focus more on long-term goals.

5.7 Innovative treatment approaches

There is a need for services and planners to explore innovative approaches which might prove particularly attractive and relevant for older drug users as many have failed to engage with existing services.

Some examples of innovative approaches might include:-

- Assertive outreach for those dropping out of services
- Prescribing of injectables such as heroin for those who have found it difficult to move away from injecting

5.8 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.

Physical health

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.

Pain Management

As highlighted a range of physical health problem are becoming more apparent among older drug users. As part of this pain management emerges as a particular issue which does not appear to being dealt with effectively.

There is a need to improve pain management for older drug users.
The 'Orange Guidelines' should provide information for health staff regarding pain management and should be used as the basis of good practice. Awareness of these guidelines should be undertaken to improve compliance.

Home Care & Support

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 those 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 if any substitute medication.

Diet and nutrition

This is reported as a significant issue among older drug users who in many cases give very little attention to diet and the nutritional value of what they eat.

5.9 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 maybe 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's).

5.10 Staff Training and Awareness

Training emerges as a significant issue if we are to respond effectively over the coming years to the growing needs of older problem drug users.

Services should develop and support staff so that their services can be more responsive to and understanding of the specific needs of drug users.

Developing work force expertise

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 old drug users.

6. Appendix 1 - Face-to-face questionnaires and consent form for Professionals' Views

Final version of qualitative expert interview: "Core Questions". Results of wp7 working group, January 30th 2009

Introduction:

Thank you for taking the time to participate in the interview. My name is *Biba Brand* and I work for the *Scottish Drugs Forum. SDF* is a partner in an international project taking place in Germany, Austria, Poland and Scotland looking at the support, treatment and care needs of problem drug users aged 35 years and older. At the moment there is little information about older problem drug users and their life circumstances, their social assistance needs, and their ideas about how they would like to spend their time in the future. As a consequence we would like to increase our knowledge of older problem drug users and you can help us by sharing your experiences, thoughts and ideas on their support, treatment and care needs both now and in the future.

I would like to record this interview with your permission. I have an information sheet and consent form which I would like you to read before we start, and if you agree to take part in the study I will ask you to sign it. I can assure you that your statements and answers will be dealt with the greatest care and your data will be made anonymous and protected in line with the data protection act.

Ensure participant receives and reads the information sheet and consent form. Give the participant the opportunity to ask any questions and if agrees to interview ask them to sign the consent form (One copy for participant, one copy for interviewer).

If there are no questions, I would like to start the interview.

First of all can we be clear that we are defining an older drug user as those aged 35 and particularly 45 years and older.

Name of the Service ____

Name ____

Professional title and responsibilities: ____________________________________

1. ***We would like now to ask you about your service and older problem drug users (for survey monkey, for details see records wp7):***

   1 Which proportion of drug users aged over 35 years do you have in your service at present?
   2 Do you have any drug users aged 45 years or older? If yes, how many, at what proportion?

2. Do you have services or support systems that target older problem drug users directly?

if Yes **(go to yes-question)**

if No **(go to no-question)**

2a. If yes, what is the current or planned service provision for this target group of problem drug users over the age of 45?

1 When did you start providing these services or when do you plan to start providing such services?
2 Do you have intake criteria?
3 Who are (or will be) the main referrers to your service?

3. If no services or support systems that target older drug users directly please ask:

3 Have you thought about providing services for older problem drug users?
4 Do you have any plans to develop provision?
5 Please describe these plans

4. Do you think there are or could be particular issues that require special attention when working with this target group?

Prompt:

1. What do you think might be the strengths of this target group?
2. What do you think might be the particular challenges or difficulties?

5. Do you think there are any gender differences of older problem drug users?

6. Are there gender differences at treatment support and care needs?

6. Drug users who inject have a relatively high risk of contracting HIV and especially Hepatitis C. What do you see as the specific risks to older problem drug users?

Prompt: Do you think there should be special preventive messages about safer drug use and safer sex for older problem drug users?

7. In your service, are there problem drug users aged 45 years and older that are ill and not able to take care of themselves?

If Yes If yes, how many?______________ **(go to the next question)**

If No **(go to question: Do you think networking with generic....)**

8. Do you aim to continue to support those clients or are you looking for alternative or additional support for them?

Prompts:

1. What kind of support are you looking for?
2. If you keep them in your service, how does your service care for them?
3. Are there any specialist workers for older problem drug users?
4. Do you have a network of other medical or social support services that come in to your service and could attend to older clients?

9. Do you think networking with generic elderly care services could benefit drug service providers?

Prompt: What do you think would be the benefits and challenges of networking between generic elderly and drug services?

10. Some older problem drug users have few social contacts. Can you tell me about your clients and their social contacts (e.g. are most of them still in contact/touch with…)

11. Their family e.g. parents and siblings
12. Their own children
13. Drug using friends
14. Non-drug using friends
15. In your experience do men have more social contacts than women or are there no differences between the sexes?

11. How do you deal with older clients who do not have any relatives or friends, and are alone all or most of the time? Do you offer them any specific help and if so, what might this be?

Prompt: Do you celebrate special occasions (e.g. birthdays/Christmas) with your clients? If so, who arranges it, how does it work? Please give me an example.

12. Do you see older problem drug users as a specialist target group that do or will need specialist services currently and in the future?
13. What specialist services might be required (e.g. specialist home support, supported accommodation, day care centres)
14. What do you think would be the main implications for providing specialist drug services for older problem drug users (e.g. specialist training)?
13. Will you give any priority to older problem drug users compared to younger clients?

This is the final question

14. Imagine setting up a service for older (i.v.) problem drug users, with sufficient funding and the freedom to do what you want. Please describe what service you believe would be ideal for older problem drug users and what kind of service would you create?

Thank you!

Final extended version of qualitative expert interview: "Core Questions". Results of wp7 working group, January 30th 2009
(Original questionnaire adjusted for use with social researcher expert)

Introduction:

Thank you for taking the time to participate in the interview. My name is *Biba Brand* and I work for the *Scottish Drugs Forum. SDF* is a partner in an international project taking place in Germany, Austria, Poland and Scotland looking at the support, treatment and care needs of problem drug users aged 35 years and older. At the moment there is little information about older problem drug users and their life circumstances, their social assistance needs, and their ideas about how they would like to spend their time in the future. As a consequence we would like to increase our knowledge of older problem drug users and you can help us by sharing your experiences, thoughts and ideas on their support, treatment and care needs both now and in the future.

I would like to record this interview with your permission. I have an information sheet and consent form which I would like you to read before we start, and if you agree to take part in the study I will ask you to sign it. I can assure you that your statements and answers will be dealt with the greatest care and your data will be made anonymous and protected in line with the data protection act.

Ensure participant receives and reads the information sheet and consent form. Give the participant the opportunity to ask any questions and if agrees to interview ask them to sign the consent form (One copy for participant, one copy for interviewer).

If there are no questions, I would like to start the interview.

First of all can we be clear that we are defining an older drug user as those aged 35 and particularly 45 years and older.

Name of the
organisation____

Name ______________________

Professional title and responsibilities (area of research): ______________

1. ***We would like now to ask you about your work on older problem drug users (for survey monkey, for details see records wp7):***

   1. In your study of 10 (9:1 older drug users) how many still used opiates?
   2. (Which proportion of drug users aged over 35 years do you have in your service at present?)
   3. (Do you have any drug users aged 45 years or older? If yes, how many, at what proportion?)
   4. What proportion of drug users aged over 50 years is there in the Merseyside/Cheshire area?
   5. How does that compare with illicit drug crime figures for older drug users?
   6. What is the overall total problematic drug use prevalence in this area?
   7. In NEX what proportion of older drug users use these services, compared to all ages of service user?
   8. What future predictions do you have for the population of older drug users?

2. Are there services or support systems that target older problem drug users directly?

if Yes (go to yes-question)
if No (go to no-question)

2a. If yes, what is the current or planned service provision for this target group of problem drug users (over the age of 50)?

1. When did these services start or when are they planned to start?
2. Is there intake criteria?
3. Who are (or will be) the main referrers to these services?

3 **If no** services or support systems that target older drug users directly please ask:

   4 Have you thought about the provision of specialist services for older problem drug users?

   5 Please describe what if anything you would recommend for this group.

4 Do you think there are or could be particular issues that require special attention when working with this target group?

Prompt:

   1 What do you think might be the strengths of this target group?
   2 What do you think might be the particular challenges or difficulties? (Maturity, risky behavior, vein care, stress, mental health)

5 Do you think there are any gender differences of older problem drug users?
   6 Are there gender differences at treatment support and care needs? (Prompt: child care responsibilities/contact, social networks)

6 Drug users who inject have a relatively high risk of contracting HIV and especially Hepatitis C. What do you see as the specific risks to older problem drug users?

Prompt: Do you think there should be special preventive messages about safer drug use and safer sex for older problem drug users? (Prompt: Late onset of drug use/injecting – frequency.)

7 Through your research are there older problem drug users that are ill and not able to take care of themselves?

if Yes If yes, how many?________________ **(go to the next question)**
if No **(go to question: Do you think networking with generic….)**

8 Do you think existing services used by this group aim to continue to support those clients or are alternatives, additional support or training required?

Prompts:
   1 What kind of support?
   2 If kept existing services, how are they cared for?
   3 Are there any specialist workers for older problem drug users?

4 Is there a network of other medical or social support services that come in to service and could attend to older clients?
5 Generic health care services, A&E Depts.

9 Do you think networking with generic elderly care services could benefit drug service providers?

Prompt: What do you think would be the benefits and challenges of networking between generic elderly and drug services?

10 Some older problem drug users have few social contacts. Can you tell me about the clients you've interviewed and their social contacts (e.g. are most of them still in contact/touch with…)
11 Their family e.g. parents and siblings
12 Their own children
13 Drug using friends
14 Non-drug using friends
15 In your experience do men have more social contacts than women or are there no differences between the sexes?
16 Life expectancy, deaths of friends/family.
11 How are isolated older clients supported who do not have any relatives or friends, and are alone all or most of the time? Are they offered any specific help by services and if so, what might this be?

Prompt: Celebrate of special occasions (e.g. birthdays/Christmas)? How are these organized, if at all? Please give me an example.

12 Do you see older problem drug users as a specialist target group that do or will need specialist services currently and in the future?
13 What specialist services might be required (e.g. specialist home support, supported accommodation, day care centres)
14 What do you think would be the main implications for providing specialist drug services for older problem drug users (e.g. specialist training)?

13 Would you give any priority in terms of care and support for older problem drug users compared to younger clients?

This is the final question

14 Imagine setting up a service for older (i.v.) problem drug users, with sufficient funding and the freedom to do what you want. Please describe what service you believe would be ideal for older problem drug users and what kind of service would you create?

Thank you!

Scottish Drugs Forum

Research Participant Information Sheet

Older Drug Users and Care Structures

We would like to invite you to take part in a European research study that aims to identify the present and future care and treatment needs of drug users aged 35 years and older, and create guidelines for drug treatment services working with older drug users. Before you decide to take part you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully.

Purpose of the study

In all European Union countries at present there is a growing population of older drug users (35 years and older). Most drug users over 35 years are polydrug users with a preference for opiates. To date, action plans at the European and national level have largely focussed on preventing young people from experimenting with dangerous drugs and on treating them effectively. However, it is now necessary to gather knowledge on older drug users and their care and treatment needs. This collaborative project across four countries - Scotland, Germany, Poland and Austria concentrates on older drug users as a special risk group.

Who will take part in the study?

We will interview a minimum of 10 experts working in the field of addiction and/or with older people in care services in Scotland and the UK. Interviews will be confidence and will explore staff's experiences in working with older drug users and similar client groups, trying to elicit what treatment services may be needed for this group in the future.

We will also interview a minimum of 20 opiate users aged 35 years and older in Glasgow and Edinburgh who can volunteer some time to talk to us in confidence about their experiences of treatment services and their views on what they may need to help them in the future.

If you agree to take part

Your participation in this study is completely voluntary and you are free to refuse to take part or withdraw from the study at any time. You are also free to choose not to answer any particular questions. Your treatment and support will not be affected in any way whether you agree or refuse to take part in the study.

Should you agree to take part in the study we would like to ask you questions on the following topics:

1 qualifications
2 drug use among current client group now, and in the future
3 current health care service provision for older drug users
4 health care needs
5 living arrangements and social networks (e.g. friends and family)

6 your views on potential care and support for older drug users
7 your views on housing specifically for older drug users

The interview
The expert interviews will be carried out by the Scottish Drug Forum's West of Scotland Regional Manager, Biba Brand, and will last approximately one hour. You will be required to undertake one interview only and this will take place at a site that will guarantee both your safety and privacy (e.g. room in local agency).

With your written permission we will record the interview to ensure accurate note taking but you are free to refuse permission for recording. If you agree to being interviewed the recording itself will be deleted once interviews have been transcribed.

What happens to your information?
The information you provide for this study is completely confidential. No personal details that could identify you will be recorded and used in the final report. All personal information such as name and area will be anonymised to ensure you cannot be identified. The data collected during the study will be kept in a locked cabinet in a secure alarmed office for a period of five years after which point it will be destroyed.

What happens to the results of the study?
The results of the research study will be published by the Executive Agency for Health and Consumers and will be available in the public domain in 2009. Should you wish to receive a copy of the final report please let the researcher know and a copy will be forwarded to you. You will not be identified in the final report.

Complaints
If you have any concerns about any aspect of this study or are unhappy with the way the interview was conducted and wish to make a complaint, please contact Biba Brand or Dave Liddell (SDF Director) on 0141 221 1175.

Further information
Should you require further information about this study please ask the researcher at interview or if you would like more information before the interview please do not hesitate to contact Biba Brand, Scottish Drugs Forum: biba@sdf.org.uk or 0141 221 1175.

Scottish Drugs Forum

Senior Drug Dependents and Care Structures

EXPERT CONSENT FORM

Name of researcher:

1. I have read, understood and received a copy of the information sheet dated 22 05 09 and been able to discuss the research study and ask questions about it.

Yes **No**

2. I understand that I can withdraw from the study at any time, without having to give a reason.

Yes **No**

3. I agree to the interview being recorded **Yes** **No**

4. I understand that any information about me will be kept confidential. **Yes** **No**

5. I understand that any information I provide will be used for reporting purposes but that any such information will remain anonymous and will not identify me.

Yes **No**

6. I agree to take part in the above study **Yes** **No**

Participant's Signature ____

Date _____________________________

Researcher's Signature____

Date _____________________________

Thank you for agreeing to take part in this study

7. Appendix 2 - Self-completion questionnaire for Professionals Views

1. Services for older drug users

As part of a wider European research project, SDF is seeking views from people who deliver, plan or commission services for older people with drug problems (those over 35 years).

All responses will be kept confidential and we thank you for your help with this short questionnaire.

1. What proportion of your clients are older people with a drug problem?

We have virtually no clients over 35
Less than a quarter of our clients are 35 and over
Between a quarter and half of our clients are 35 and over
More than half our clients are over 35

If 'More than half' please state what percentage...

2. How important would you rate the following issues for older drug users that you currently see in your service? (Tick all that apply)

Very Important
Quite Important
Less Important
Not Important at all

3.Problems with physical health

How important would you rate the following issues for older drug users that you currently see in your service? (Tick all that apply)

Very Important Quite Important Less Important Not Important at all
For:

Problems with physical health
Problems with mental health
Financial problems
Housing problems
Independent living problems
Legal problems
Social problems

Please add more details here of specific problems

3. What areas do you see as increasingly important for this population in future years? (Tick all that apply)

Very Important Quite Important Less Important Not Important at all

For:

Problems with physical health
Problems with mental health
Financial problems
Housing problems
Independent living problems
Legal problems
Social problems

Please add more details here of specific problems

4. Do you currently provide any specialist or tailored services to this population within your own service, if yes please specify? **Yes No**

If 'Yes' please specify

5. Do you currently provide any specialist or tailored services to this population by arrangement with other services, if yes please specify? **Yes No**

If 'Yes' please specify

6. What key strengths would you identify with this group? (Tick all that apply)

Strongly agree Agree No difference Disagree Strongly disagree

Motivated
Mature thinking
Hopeful
Good social networks
Willingness to try new approaches
Possess self belief
Supportive of others
Positive life experiences
Other (please specify)

7. What treatment and support options are more likely to be successful with this 35+ age group, compared to younger drug users? (Tick all that apply)

Most likely to be successful Likely to be successful No Difference
Likely to be less successful Most likely to be less successful

Substitution maintenance
Reducing (il)licit drugs use
Detoxification services
Abstinence services
Wound treatment
Blood Borne Virus treatment
Hepatitis C Virus treatment
Overdose prevention
General health care
Mental health care

Housing support
Welfare benefits advice
Legal advice
Independent living support
Fitness
Employability
Community activities (e.g. art, gardening)
Other (please specify)

8. What type of living environment best suits this group as they get older? (Tick all that apply)

Strongly agree Agree No difference Disagree Strongly disagree

In own home
Supported accommodation
Residential accommodation
Separate community living, e.g communes
Short term support (0-6 months)
Long term support (6-24 months)
Indefinite support
Comments

9. The initial findings of this research show that injecting sometimes begins in people over 35 years. How frequently have you seen service users (over the last year) who started to inject drugs aged 35+ years?

Never seen Rarely Occasionally Frequently

What number out of total clients in the last year e.g. 10 out of 50 clients?

10. Are there any services you would like to develop for this client group if you had adequate resources and no other constraints? **Yes** **No**
If 'Yes' please specify

11. Is your organisation mainly a:

Specialist Community Based Drug Service
Specialist Residential/In-Patient Drug Service
Non-Specialist Support Service
Policy development
Other (please specify)

12. Is your role mainly:

Working directly with clients
Manager
Administrator
Policy/Planning/Commissioning
Other (please specify)

13. Which sector do you currently work within?
Voluntary Statutory Private

14. Would you be prepared to share further views on the needs of older drug users? **Yes** **No**

15. If yes, please leave your name and contact details below or contact Biba on 0141 221 1175 or email biba@sdf.org.uk.

Name:
Email Address:
Phone Number:

8. Glossary

AA	Alcoholics Anonymous: 12 step recovery peer network regarding alcohol which has a spiritual dimension.
A&R	Arrest and Referral: non-compulsory criminal justice initiative.
BBV	Blood Borne Virus
CBT	Cognitive Behavioural Therapy – increasing awareness of self.
DTTO	Drug Treatment and Testing Order: criminal Justice initiative.
ETE	Employment, training and education
GP	General Practitioner: community based doctor for general health
HCV	Hepatitis C Virus
LLP	Limited Liability Partnership: former city council department and similar to a limited company, able to make profit but with limited debt liability.
NA	Narcotics Anonymous: 12 step recovery peer network regarding drugs which has a spiritual dimension.