SDF Scottish Drugs Forum

Older People with Drug Problems in Scotland:

A Mixed Methods Study Exploring Health and Social Support Needs

Report to the Scottish Government

“I don’t trust nobody… I keep myself to myself unless they ask anything but apart from that I feel isolated. Put it [this way], if I was deid, nobody would miss me, that’s how bad it is”

(Woman, 39 years old)

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Report to the Scottish Government

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Executive Summary

Background

The population of problem drug users in Scotland is aging. This research was commissioned by the Scottish Government to provide a better understanding of the issues facing Older People with a Drug Problem (OPDP) in Scotland so that policy and practice can be targeted appropriately. The aim of the study was to identify and explore the health care and social support needs of older drug users (>35 years) in a cross sectional sample across Scotland.

Methods

A mixed method study design was used in which semi structured, face to face interviews collected both qualitative and quantitative data from participants. Data collection was undertaken by four peer researchers in a range of non NHS services across Scotland (Greater Glasgow and Clyde, Lothian, Fife, Tayside and Grampian). A face to face questionnaire collected structured quantitative data. In depth, qualitative interviews provided insights into the views and experiences of OPDP. A quota sample was used to ensure participants were reasonably representative of the population of OPDP with a target recruitment of 100.

Quantitative findings

Data was collected from 123 OPDP, 93 male 30 female. Participants were 35-57 years old with a mean age of 41 years. Key findings were:

- Drug use became 'problematic' at a mean age of 25 years
- 79% were living alone
- 37% had been in treatment five or more times
- 75% had overdosed at some time in their lives
- 95% were on welfare benefits
- Three individuals worked
- 96% had convictions for any offences
- 84% had been in prison at some time in their lives
- 91% had been homeless at some time in their lives
- Five individuals had *never* been in treatment
- 75% were in opiate replacement treatment
- 95% suffered from depression
- 89% suffered from anxiety
- 53% suffered from chronic pain
- 80% used prescribed medicines other than opiate replacement treatment with antidepressants most frequently noted
- 32.5% used over the counter medicines
- 86% would use mental health support service in future
- 83% would use substitute prescribing in future

Qualitative findings

Full transcription and thematic analysis was undertaken on a purposive sample of 30 out of the 123 participant interviews. Key findings were:

- *Stigma*, *isolation and loneliness*, *the need to talk* and *being older and wiser* were recurring themes.
- OPDP could feel 'forgotten about' in treatment.
- Willingness of service providers to take time to talk with OPDP was valued.
- Lack of support services alongside ORT treatment limited engagement.
- Mental health problems were evident and contributed towards isolation and loneliness.
- Chronic pain may be undertreated as stigmatisation prevented people accessing treatment.
- OPDP felt there was more stigma towards them compared to younger drug users, as people were perceived to dismiss them as a 'lost cause'.

- Female OPDP could have more issues in their past that limited their engagement with services.
- Younger people with a drug problem were seen to have different priorities to OPDP.
- This age gap amongst service users could limit engagement of OPDP as they felt marginalised.
- There was an expressed desire to separate older and younger drug users in services.
- Many participants wanted specific services for OPDP, particularly peer support groups.
- OPDP believed their life experience could be used positively to support younger people.

Conclusion

This research highlighted, very starkly, the issues facing those aged thirty five and over with a drug problem. In particular it highlighted that issues facing this group (average age 41) that would be equivalent to people in the general population fifteen years older. The report suggests that the working group consider actions in the following areas:

Isolation and loneliness

79% were living alone with very little social interaction and this need to talk and be listened was significant to people's quality of life.

Care and support models which respond directly to issues of isolation and loneliness among OPDPs should be explored. Informal support, not necessarily linked to treatment, might be a first step to encourage engagement.

Mental Health

Depression was under diagnosed and under treated. The loneliness of living alone was compounded by and linked to depression, anxiety and other mental health conditions such as paranoia. There was also willingness to engage with services as the majority expressed an interest in using mental health support services in future. Potential under-diagnosis and under treatment of mental health conditions generally is a significant issue.

General Health

Through the quantitative part of the study it was evident that people experienced multiple morbidities with ODPDs general health having suffered through lengthy drug problems. Regular general health checks must be undertaken with OPDPs and models to ensure this is undertaken should be explored.

Pain Management

Access to appropriate treatment for common multi-morbidities such as pain control was hampered by perceived stigma among service providers.

There is a need to explore improving access to specialist pain management. Work relating to optimal pain management pathways for opiate dependant patients should be conducted.

Pain clinics may require specialist training on managing people with opioid dependence.

Retention

The majority had accessed drug treatment services but continued engagement was limited by the (perceived) lack of support services and feeling marginalised in services that were perceived to be focussed on younger people.

It was evident from the survey that many OPDPs had multiple drug treatment episodes. Ways to reduce the poor retention of OPDPs in services should be explored this could include the need to:

- increase the range of ORT medication provided including Heroin Assisted Treatment
- provide assertive follow-up of those who drop out of services
- match a worker to the OPDP (including consideration of worker age) in order to build a long-term therapeutic and supportive relationship
- undertake regular reviews of treatment including ORT.

Stigma

The stigma felt by people with a drug problem was compounded by age and was likely to make individuals more wary of seeking help and support. The issues around stigma are challenging and there would be value in considering:

- training around stigma and engagement for those working with people who use drugs
- service providers reviewing their services for evidence of systematic (and probably unintentional) stigmatisation of OPDP.

Gender

There are clear gender specific issues for OPDP that services she be aware of. These issues include, support around abuse, responsibilities of childcare and the trauma of having children removed. Services should also be responsive to problems of childcare that might prevent attendance.

Impact of Welfare Reform

OPDP currently rely heavily on welfare benefits as very few are in work. However some expressed willingness to work if support for employment was provided. How welfare benefits advice is provided to OPDPs should be explored including considering how such provision might be provided within addiction services.

Advocacy

It was clear that there were significant unmet needs within this population and that advocates may well be an option that is worth exploring to ensure needs are met.

Providing client advocates might help more vulnerable and isolated clients access appropriate treatment for both their drug problem, and co-morbidities.

Vulnerability

OPDPs have multiple vulnerabilities (drug use, overdose risk, poor physical and mental health, homelessness and isolation). These needs are currently not being met in a co-ordinated manner. Models such as ‘Making Every Adult Matter’ should be explored further (meam.org.uk).

In conclusion, this is a challenging and very vulnerable group due to their multiple health and social support needs who, although engaging with services, could be overlooked. However there are encouraging signs that many OPDP are keen to engage with services to improve their situation.

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Acknowledgements

Thanks go to the peer researchers: Louise Aitken, Pauline Farrow, Jean Hamilton and Lea Anne Smith who did an excellent job in conducting interviews which could be distressing at times. Thank you to all the services who worked with the research team to identify participants. Thank you to Eilidh Matheson for efficient data entry and Helen Robertson for accurate transcribing that retained the colloquialisms that allowed local accents to be represented. Finally, and most importantly, thank you to all participants who gave up their time to contribute, despite often difficult personal circumstances.

1 Background

In 2015 the Scottish Government Justice Analytical Services division commissioned an extensive international literature review of examples of service responses for older high risk drug users (Atkinson, 2016) to inform a Scottish Drugs Forum working group tasked with planning for Scotland's aging cohort of drug users. The review identified particular issues around isolation, shame and stigma that hamper treatment engagement. Mental and physical health issues can be prominent in older people with a drug problem (OPDP) and the complexity of needs may require a more focussed service response. The review highlighted that some OPDP may not be in touch with drug treatment services because these do not meet their needs or because they have become disillusioned with services as a result of past experiences. Isolation was also highlighted as a particular problem. Many of the academic papers identified in the review were themselves reviews and a lack of empirical information specifically on older drug users was noted.

Anecdotal evidence from those working in services has also identified difficulties for drug users receiving adequate pain control for both chronic pain and, in hospital, for acute pain. In addition, the working group on older drug users identified specific groups of interest where evidence was scarce, such as older female drug users and those based in rural settings. Furthermore, the brief required that recent changes to the Welfare System should be considered as these might impact on health and wellbeing. Thus there are a number of issues that policy makers are keen to explore to ensure that services (health and social) in the future are adequately equipped to manage this aging cohort of drug users. However, it is also important to have an understanding of the characteristics of this group in terms of demographics, drug use, health, and use of services as this provides the wider context. Thus the Scottish Government commissioned this research to gain a better understanding of OPDP. In particular, the aim of the research was to consider the experiences of OPDP who were not using services, the barriers this group face in accessing services, to improve our understanding of how we can better engage with this group. It became apparent from early planning discussions that only including those currently not using services would be unnecessarily restrictive. Many long term drug users cycle in and out of treatment so this approach would only capture people not in treatment at that point. This would also be extremely challenging. This work sought to provide evidence based information for the working group looking at the needs of OPDP which can be used to inform and improve policy and practice in this area.

2 Aims

2.1 Overall Aim

The aim of the study was to identify and explore the health care and social support needs of older drug users (>35 years) in a cross sectional sample across Scotland.

2.2 Research Questions

1. What are the demographic characteristics of OPDP?
2. What are the drug use characteristics of older drug users (OPDP)?
3. What health conditions do OPDP have?

4. What medicines (prescribed/over the counter/other supply) do OPDP take?
5. Which services have and do OPDP use?
6. How do OPDP engage with the current services available?
7. Are their health and social care needs being met by current services and if not, how should services be developed to meet their needs and what specific services do they think there should be for OPDP?
8. Are there any gender specific issues that affect service engagement?
9. Have recent changes in welfare affected them, and if so in what way?

3 Methods

3.1 Overview of Study Design

A mixed method study design was used in which semi structured, face to face interviews collected both qualitative and quantitative data from participants. This manuscript only present quantitative survey data. Ethical approval was granted by the North of Scotland Research Ethics Committee (reference: 16/NS/0036). Data collection was managed by SDF who recruited four peer researchers to undertake interviews. Comprehensive training was provided. Training covered confidentiality, data protection, communication skills, interview skills, skills for lone working and handling difficult conversations. Using peer researchers aimed to improve the validity and reliability of the data provided. Participants were made aware that researchers were former substance users with a view to encouraging study engagement. Given the nature of some of the questions asked regarding drug use, it was thought that peer researchers would gain a more open and honest response without the fear of prejudice or judgement. All four peer researchers were female.

3.2 Sampling and Recruitment

The network of Non NHS services was used as the sampling frame because the study aimed to include those not in treatment. A previous audit of services by SDF identified services (with high numbers of OPDP) willing to help recruit participants. From those who were willing to recruit participants, a purposive sample was identified to give geographical coverage and to cover a range of type of service (e.g. counselling, needle exchange). This method of sampling sought to include a range of factors that might influence individuals' views and experience. The areas covered included Greater Glasgow and Clyde, Lothian, Fife, Tayside and Grampian thereby covering North, East and West. Across this range city centre and services in outlying towns were included. Furthermore a range of services were included covering needle exchange, voluntary organisations' addiction services, and homelessness services.

Participant target recruitment was 100. To ensure appropriate numbers of particular sub-groups of interest were represented, a quota sample was used based on the age and gender profile of the Scottish drug using population. The sampling frame is shown in table 1. There was no upper age limit for recruitment. Inclusion criteria were i) over 35 years old, ii) male or female, iii) current heroin injectors and iv) those who have stopped daily heroin use in the last 12 months (but may still inject on occasion). Comparison of target and actual sample is considered in the discussion.

Table 1 Age and gender profile of the population and target sample (source: ISD, 2016)

	35-44	45-54	55-64	Totals
Males	15,000	6,000	1,000	22,000
Target recruitment	40	16	4	60
Females	5,500	2,500	1,300	9,000
Target recruitment	25	11	4	40

3.2.1 Qualitative interview sample

A purposive sample of 30 interviews were selected from the total of 123 for full transcription and qualitative analysis. The sample was selected to cover a range of factors that might influence a participant's views and experience. These were: gender, age, in treatment/not in treatment, rural/ city/small town and geographical area. Full qualitative analysis of all interviews was not methodologically appropriate as the emphasis was on the identification of themes rather than quantifying responses.

3.3 Data Collection Tools

The questionnaire was developed jointly by CM and the SDF team. The content was informed by the literature review by Atkinson (2016), the discussions of the working group and the knowledge of the team. The questionnaire was reviewed by SDF staff and tested by peer researchers on each other. Minor revisions were subsequently made. The quantitative component of the questionnaire was six pages in length and contained 27 questions covering: demographics, living circumstances, income, criminal justice history, drug using history including overdose, treatment history, general health, medication prescribed and possible future service use. This part of the interview took 15-20 minutes to administer. The qualitative component covered drug treatment experience, health status, age and gender issues including questions on whether there should be specific services for OPDP, welfare and employment and aspirations for the future. This qualitative part of the interview took approximately 45 minutes. The questionnaire and topic guide are attached as an appendix.

3.4 Data Collection Process

Those meeting the inclusion criteria were given a participant information leaflet by the service staff. This explained the purpose of the research and what would happen with the information including confidentiality. Peer researchers went through this information with each participant at the start of each interview. Participants were informed that the researcher would be present in the service on a given date to undertake interviews. In addition a poster was displayed which gave further information on the study. Those expressing an interest were informed when the researcher would be present and a drop in system was used as flexibility was important. This meant researchers were available to undertake interviews at short notice if clients presented and wanted to be interviewed that day. A few people were given fixed appointment times.

The interviews were administered face to face by trained peer researchers, of which there were four. Interviews were conducted on service premises in a private room to ensure privacy and protect confidentiality. Participants signed a consent form before the interview started. Before starting the qualitative part of the interview the researcher checked the participant was still willing to proceed with the recording. In line with the ethical approval given, participants were told they could withdraw at any time from the process until the full interview had been completed. If participants became distressed and visibly upset, such as being tearful, the interview would be stopped until they were able to either continue or say if they wanted to withdraw. Interviews generally lasted between 20 and 45 minutes. A few participants did get tearful and had a break mid-interview. Participants were provided with emotional support and signposting as appropriate. Peer researchers engaged with staff (on the request of interviewees) for additional support on at least one occasion.

Data was collected over a five week period between end of April and beginning of June 2016. Participants were given a £10 voucher for a supermarket as an honorarium for participation.

3.5 Data Management and Analysis

Quantitative data was entered into an SPSS database for storage and analysis. Data entry was checked in a 10% sample of questionnaires. Simple descriptive statistics were undertaken. Thirty qualitative interviews were transcribed by an experienced transcriber. No names were recorded on the transcript to protect anonymity and the participant code was used as an identifier. Transcript files were sent electronically to researcher Catriona Matheson for analysis. The aim of the qualitative analysis was to describe the range of experience and views of a purposive sample of older drug users. A thematic analysis approach was used in which themes emerging under each topic were identified and the range of experience under each theme presented using illustrative verbatim quotes. Thematic analysis was undertaken on full transcription of 30 interviews. Quantitative and qualitative content analysis was undertaken on one question from the qualitative interview i.e. Should there be specific services for OPDP and if so, what should these be? This was undertaken because this question was central to the research and the phrasing and consistency in which this question was asked by researchers lent itself to this more additional analysis.

Due to limited resources, only topics relevant to the research questions were covered in the qualitative analysis. Thus there is outstanding information e.g. on future aspirations of drug users that are not included in this report. However, the data can be considered a resource that can be drawn on in future.

4 Quantitative Findings

Key statistics

- Participants were 35-57 years old with a mean age of 41 years
- Drug use became 'problematic' at a mean age of 25 years
- 75.1% had overdosed at some time in their lives
- 95.1% were on welfare benefits
- Three individuals worked
- 95.9% had convictions for any offences
- 83.7% had been in prison at some time in their lives
- 91.1% had been homeless at some time in their lives
- Five individuals had *never* been in treatment
- 74.8% were in opiate replacement treatment
- 95.1% suffered from depression
- 88.6% suffered from anxiety
- 52.8% suffered from chronic pain
- 80.5% used other prescribed medicines and 32.5% used over the counter medicines
- 86.2% would use mental health support service in future
- 82.9% would use substitute prescribing in future

4.1 Participation

Over a five week data collection period 123 people participated in an interview. This included 93 males and 30 females. The median age was 41 years for both males and females with an age range of 35-55 years for men and 35-57 years for females. Two thirds were from a city centre location (63.4%, n=78) with 17.1% (n=21) from a 'large town', 16.8% (n=20) from 'small town' and 3.3% (n=4) from a 'rural' area. However both rural and small towns would be considered remote in terms of accessing services. The geographical spread is displayed in table 2.

Table 2 Geographical area of participants

Area	n	%
Glasgow	39	31.7
Edinburgh	15	12.2
Fife	20	16.3
Tayside	22	17.9
Grampian	27	22.0
Total	123	100.0

4.2 Demographic Profile of Participants

Almost all participants were UK nationals (98.1%, n=120), and most were single (85% (n=104). The majority had been homeless at some point (91.1% n=112). Many were currently living in their own apartment/house but a third lived in an emergency shelter/hostel. Details of living arrangements are displayed in table 3.

Table 3 Living arrangements of participants

Living Arrangements	**n**	**%**
Own apartment/house	54	43.9
Emergency shelter/hostel	42	34.1
Other	11	8.9
Supported accommodation	9	7.3
In apartment/house of other person	5	4.1
Assisted living	1	0.8
Residential home/rehab	1	0.8
Total	123	100
Who Do You Live With?		
Alone	97	78.9
With parents	1	0.8
Alone with child/children	6	4.9
With partner only	7	5.7
With partner and child/children	3	2.4
With friends	1	0.8
Other	8	6.5
Total	123	100

Educational level attained is displayed in table 4.

Table 4 Educational level

Education	**n**	**%**
Never went to school/ never completed primary school	5	4.1
Primary school only	9	7.3
Never completed secondary school	30	24.4
Secondary school	39	31.7
Higher level of education (college/university)	38	30.9
Other	2	1.6
Total	123	100

Only three people were in work with 66.7% (n=82) unemployed and 30.9% (n=38) disabled or unfit for work. The majority, 95.9% had been convicted of an offence (n=111) and 83.7% (n=103) had been in prison. The vast majority, 95.1% (n=117) were on some form of welfare benefit, mostly Employment and Support Allowance (ESA) with a few on Job Seekers Allowance (JSA) or Personal Independence Payment (PIP) for those unfit to work.

4.3 Drug Use History

Participants were asked when they started their drug use and when they felt it had become 'problematic'. The majority started using drugs in their teens with a median age of 15 years. The earliest use was at 9 years and the oldest was 51 years. The median age of injecting drug use was 25 years but this is skewed due to a small number of people who started injecting relatively late. The most frequently noted (mode) age to start injecting was 15 years. The mean age for drug use becoming 'problematic' was 25 years (mode 28 years, range 11-43 years, standard deviation 7.6). At interview, 45.5% (n=56) of participants were injecting. The frequency of injecting is displayed in figure 1.

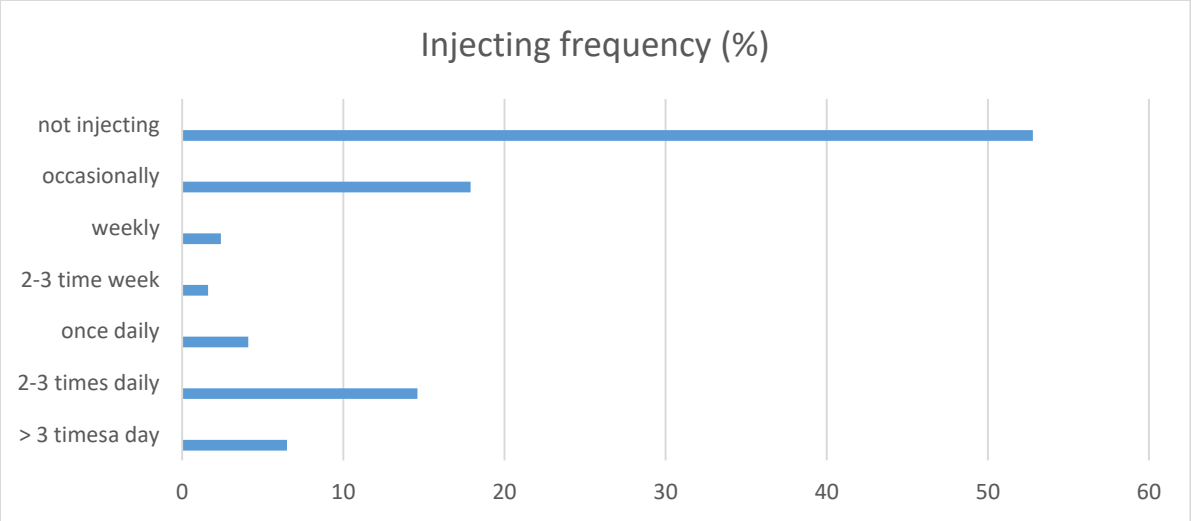

Figure 1 Injecting frequency (n=123)

4.4 Overdose Experience

Participants were asked if they had ever overdosed. 71.5% (n=88) said yes, 20.3% (n=25) said no and 8.1% (n=10) were unsure. There was no significant difference between males and females in experience of overdose (p=0.514, chi-squared). When asked when their last overdose was, over half (56.3%, n=49) stated over two years ago. However, 9.2% (n=8) reported having overdosed in the previous month, 17.2% (n=15) had overdosed between two and six months ago, 6.9% (n=6) between seven and twelve months ago and 10.3% (n=9) between one and two years ago. Participants were asked what happened at their last overdose. In a third of cases an ambulance had been called, but a quarter said 'nothing' i.e. no action was taken. See table 5 (more than one response was possible).

Table 5 Last overdose

What happened at last overdose?	n	%
Ambulance was called by someone	38	30.9
Peer administered naloxone	9	7.3
Treated in A&E	13	10.6
Nothing	31	25.2
Other- Coma	4	3.3
Other- Friend brought him out of it	3	2.4
Other- refused to go to hospital	1	0.8

4.5 Treatment and Service Use

Participants were asked how many times they had been in treatment. Five individuals had never been in treatment. Responses are displayed in table 6.

Table 6 Number of times in treatment

Times in Treatment	n	%
1	13	10.6
2	24	19.5
3	16	13.0
4	16	13.0
5	11	8.9
5-10	27	22.0
>10	9	7.3
Never	5	4.1
Total	121	98.4
Missing	2	1.6
Total	123	100.0

At the time of interview 74.8% (n=92) were in a drug substitution programme (opiate replacement treatment), 70.7% (n=87) were taking methadone and 3.3% (n=4) were taking buprenorphine. The length of time in treatment on the last occasion is shown in figure 2. The median was 12 weeks.

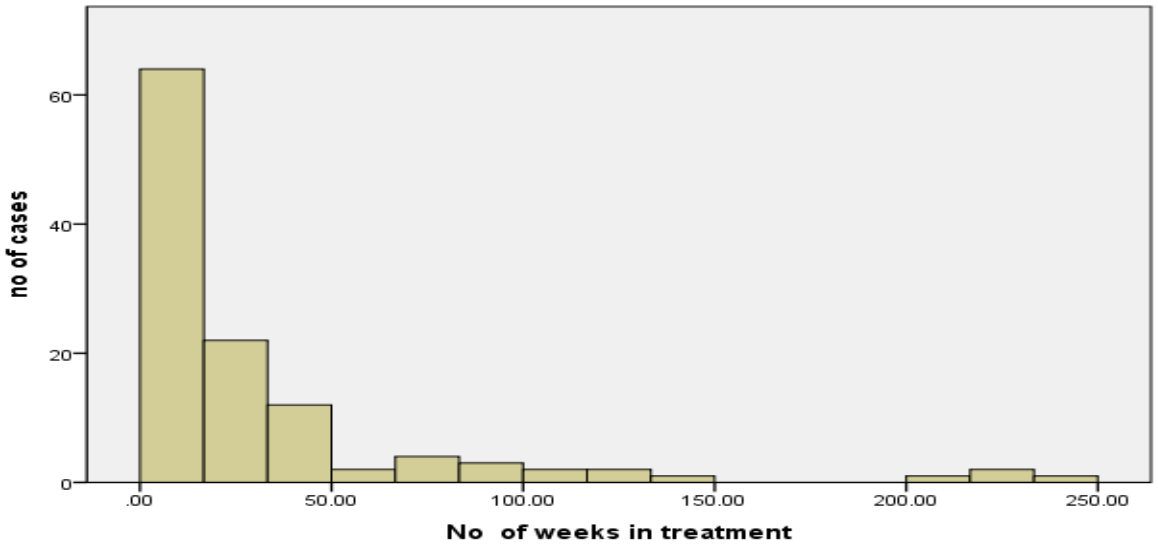

Figure 2 Length of time in last treatment episode in weeks

The past use of a range of services was explored and is displayed in figure 3. The vast majority had used a needle exchange service. Participants were also asked what services they might use in the future. Results are displayed in figure 4.

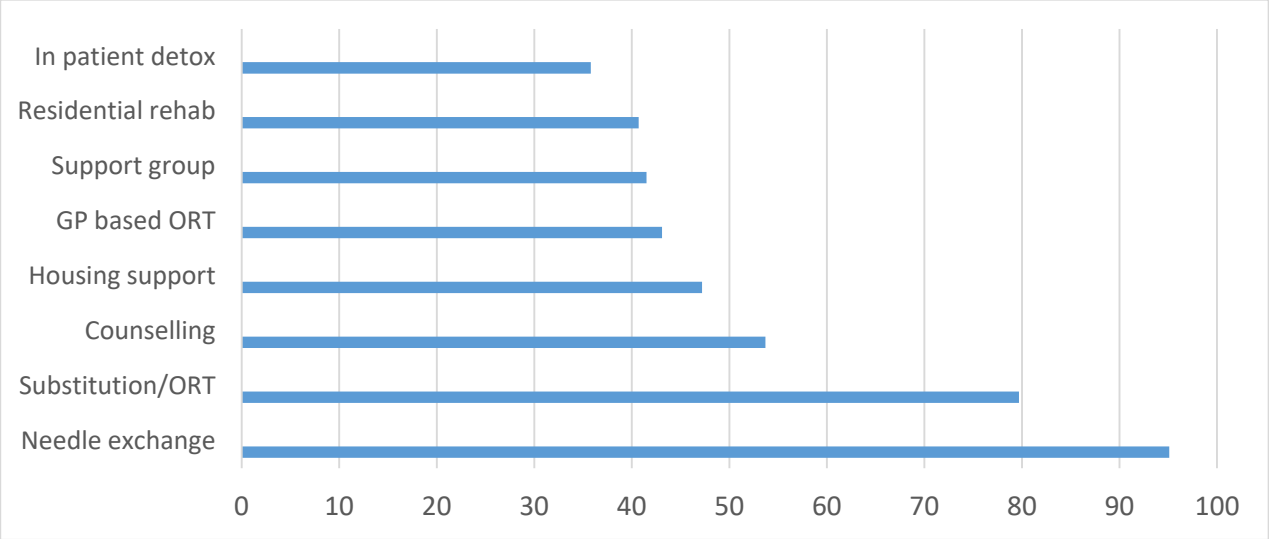

Figure 3 Services ever used in past (%)

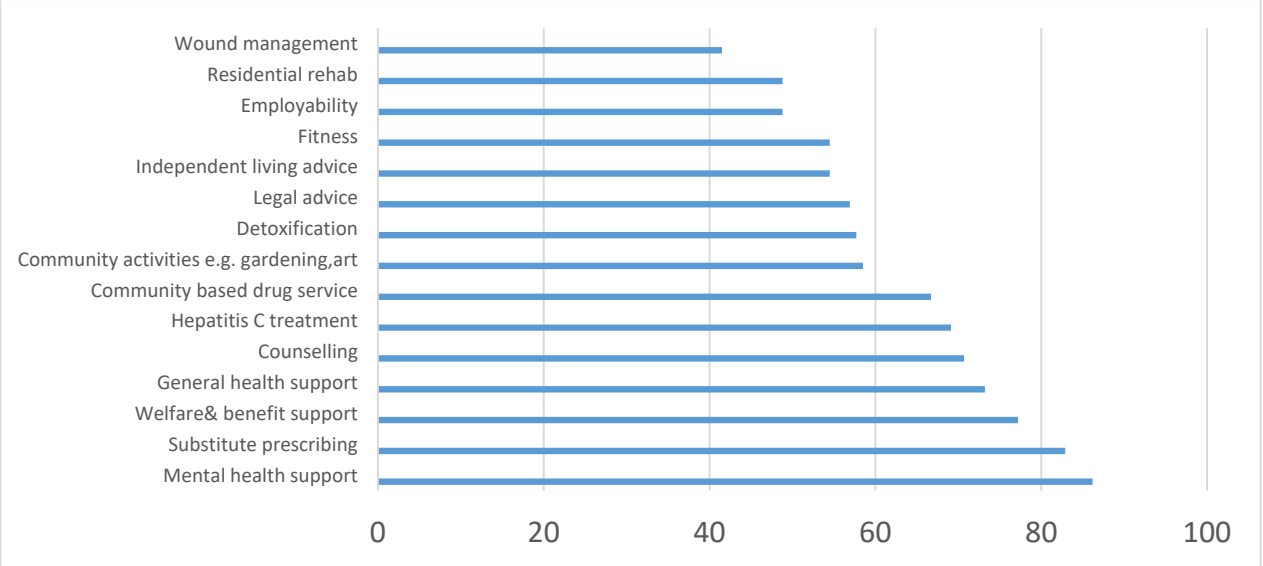

Figure 4 Services which might be used in the future (%)

When asked to rank their top three services, substitute prescribing/ORT was ranked first most frequently (22.8% n=28) followed by mental health support (16.3%, n=20) and hepatitis C treatment (11.4%, n=14).

4.6 Health

Participants were asked what health conditions they had from a list of common health conditions. The vast majority suffered from depression. Mental health conditions and chronic pain were experienced by many individuals. However, considerable numbers also experienced digestive problems, respiratory problems and arthritis. The full list is displayed in table 7.

Table 7 Health conditions

Do You Suffer from the Following Health Conditions?	n	%
Depression	117	95.1
Anxiety	109	88.6
Chronic pain	65	52.8
Other mental health	64	52.0
Heartburn/reflux	62	50.4
Constipation	47	38.2
Asthma	34	27.6
Arthritis	30	24.4
High blood pressure	26	21.1
Bronchitis	20	16.3
Diarrhoea	20	16.3
COPD (chronic obstructive pulmonary disease)	18	14.6
Heart disease	15	12.2
Other	11	8.9
Other respiratory disease	10	8.1
Other digestive problem	5	4.1
Obesity	1	0.8

Over two thirds (69% n=85) of the participants had used hepatitis C services in the past (Figure 3) and hepatitis c treatment was the third highest ranked service in regards intention to use in the future. This suggests a higher level of general hepatitis C prevalence than the overall drug using population.

80.5% (n=99) participants were taking other prescribed medication, and participants were asked what prescribed medication they took. Responses were grouped and counted and are displayed in table 8. Medication for mental health conditions featured highly as did medication for pain related conditions. There was no significant difference between levels of prescribed drug use between men and women (p=0.563 Chi squared). A third (32.5%, n=40) also used over the counter medicines.

Table 8 Prescribed medicines

Medication Prescribed	n	% of those prescribed medication (n=99)
Antidepressants	66	66.7
Antipsychotics	23	23.2
Anxiety/Insomnia medicines	24	24.2
Gabapentin/pregabalin	15	15.1
Analgesics/Anti-inflammatory	14	14.1
Gastrointestinal	14	14.1
Cardiovascular/hypertension	13	13.1
Respiratory	11	11.1
Dietary supplements	6	6.1
Epilepsy/Seizure	4	4.0
Other	8	8.1

The majority, 79.7% (n=98) had spent time in hospital as an inpatient at some point. The conditions mentioned were broken down into i) General medical: pneumonia, pleurisy, stomach pain, constipation. ii) Mental health conditions: attempted suicide, overdose. iii) Injecting related injuries: abscesses, cellulitis, blood clots and septicaemia and iv) fractures: ankles, heels, nose, ribs, legs.

4.7 Relative Importance of Different Issues

Participants were asked how important a range of issues were to them. Health problems generally featured highly with mental health problems most often noted as very important. See figure 5.

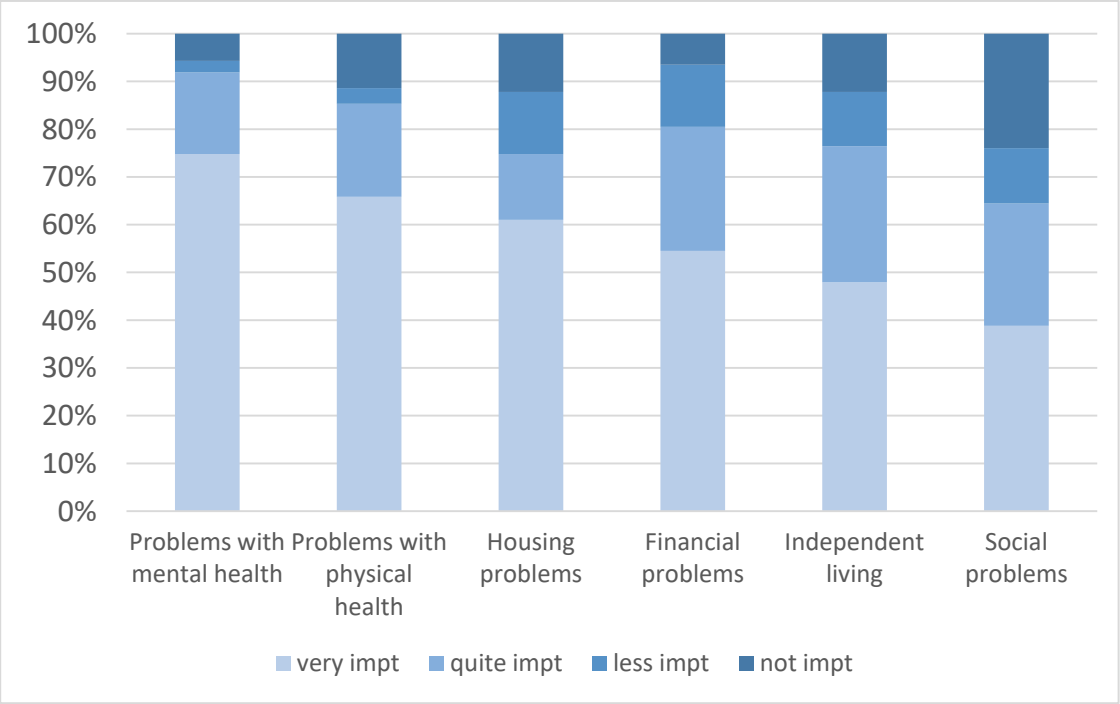

Figure 5 Relative importance of different issues

5 Qualitative Interview Findings

Key Findings

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

In depth thematic analysis was conducted on 30 qualitative interviews. As a range of factors were covered to select the 30 cases, there is no reason to believe the views will be different from the remaining participants. Some participants were keen and able to speak whilst others spoke quietly or did not answer questions in any depth. Consequently, such cases are less likely to be used for illustrative quotes. Verbatim quotes are used to illustrate themes below with explanatory notes in square brackets. The case number is shown in brackets. The distribution of participants across a range of variables is shown in table 9.

Table 9 Qualitative sample characteristics (n=30)

area	Greater Glasgow & Clyde 9	Edinburgh 7	Fife 5	Tayside 4	Grampian 5
gender	male 15	female 15			
location	city 17	Large town 7	Small town/village 4	Rural area/countryside 2	
treatment episodes	never 3	1-2 7	3-5 10	5-10 9	>10 1

5.1 Drug Treatment Services

To stimulate discussion participants were initially asked about their experiences of treatment. They were asked to describe good and bad experiences. Many participants had had several different episodes of treatment services given their age and length of drug use. These included both positive and negative experiences.

5.1.1 Positive experiences

Positive experiences revolved around two main themes. These were i) the benefits of being in opiate replacement treatment (often referred to as substitution treatment by participants) and ii) positive experiences of having a good relationship with staff.

Several participants noted that methadone had helped them stop injecting, reduced the need for crime to fund their drug use and given them a stable home life:

"It's good being on the methadone prescription because obviously it's, it's taking away a certain percentage of the need for illicit drugs. It doesna take it away entirely, but em, it certainly helps a good deal. As I say, the good side is, having been on the methadone it saves you, you're no quite so desperate for the drugs, .. … you've got a more settled home life." (male, 41 years, 319)

However another participant also raised a point about the appropriate length of treatment, feeling she personally had been on methadone treatment too long:

"Ah well, I have had good experiences, as in the methadone helped me get clean fae heroin, but, I was on it too long, 13 year, which I shouldn't have been on it that long." (female, 53 years, 106)

Positive and supportive relationships were noted from a number of participants. In the following example a positive support worker had been key to her moving on in treatment:

"she had been great, she was being fantastic. It was her that got me involved in courses and things like that as well eh. Em, I got on wi her, I got on wi her really good" (male, 35 years, 317)

A couple of participants noted positive experiences of staff during detoxification who they felt had given them the support needed. This was clearly valued:

"Because you're workin, in rehab, you've got your groups and that to go to, do you know what I mean. And if anybody's ever bothering you, there's a member of staff there, that will take you into another room and speak to you about things" (female, 40 years, 131).

Similarly another participant clearly valued the willingness of their support worker to simply talk and to speak to them in a way that put them at ease:

"He was a super person, yeh he actually spoke to you on a level, spoke awa' to you fine and then, nae treat you ken like a, …I don't know, some of them are very clinical but [name] *used to sit and talk to you like a person"* (female, 40 years, 511)

5.1.2 Negative experiences

Two strong themes emerged when participants discussed bad experiences of treatment. These were i) lack of support services and ii) punitive use of treatment.

Lack of Appropriate Support Services

A lack of support services was evident in all geographical areas. Mental health support and counselling were mentioned.

" I could do wi speaking to somebody about all these things and that, mental health issues and my drugs and all that but you dinna get anybody, you just, as soon as they see you, you're only in there for five minutes. My prescription is actually and they just hand it to you, fffffft, out the door. [laughs]" (male, 48 years, 219)

However, just taking the time to talk seemed to be an important aspect of treatment that was perceived to be lacking:

"I'm just, you're in ken, clean sample, then away back out the door and that eh. They dinna sit and talk, talk." (female, 50 years, 310)

However, one participant did admit that he had been advised to get additional support from other agencies:

"And then, it's almost like, you go in there to get help but it's just the treatment side o things, but, it, you're no getting the, counselling side o things eh. They do advise you to go to, other agencies like [name] *and they could refer you and all that… I've been roond them all,"* (male, 38 years, 320)

This participant went on to explain why he felt counselling alongside treatment, as a package, was important to treat the underlying issues behind their problem drug use:

"it's no, it's no fixing the underlying issue why you started using in the first place because when they're treating you, and you get stable and all that, you're maybe like cutting oot the crime and recreational things and, all thae kind o things. But you've still got all the issues that you've never dealt wi, that you would, probably started using drugs to start wi" (male 38 years, 320)

Punitive Treatment

The other strong emerging theme under poor experience of treatment was that treatment (usually methadone) could be used in a disciplinary manner:

"But then there's obviously, there's more, bad side to it [methadone] *than there is good side because they use it punitively. They give you methadone but you've to jump through a thousand hoops to stay on it and to get on it and obviously, like they gie you methadone and then tell you to stop taking drugs but, obviously it's no just quite as easy as that. So they gie you basically a methadone habit and then if you, if you don't stop taking drugs then they take the methadone away. Which, obviously just leaves you in a worse position than you were before you started*" (male, 41 years, 319).

Another participant perceived he had been punished through his methadone prescription for something his brother had allegedly done:

"Well, one bad experience, going in to get your methadone and them turning and saying "you're cut aff". And cut aff for nothing, what because my wee brother stole, that had nothing to do wi me. So, why am I getting the blame for it. And then that was me cut aff for seven days." (male, 39 years, 411)

The full details of this case are not known but it does highlight the potential practice of abruptly stopping an opiate replacement treatment which could leave people in a vulnerable situation. Another participant explained:

"..instead of making it worse, kicking you off your script and, and just basically turning your life upside doon, which is obviously what happens when you get kicked off your script" (male, 41 years, 319)

A number of other issues were mentioned by individuals such as feeling they had been put on methadone too easily, feeling they had been forced to go onto a methadone script, feeling stigmatised in the pharmacy, and services not being sufficiently responsive to their particular needs.

"They know that I can't go out a lot on my own so, because of all this carry on, I continue using and I continue missing appointments, though they know the situation with, the boys [two children at home] *and not going out, and the mental health. And I feel that's it's not fair* [voice faltering]. *You know, some day I can't make the appointments".* (female, 47 years, 402)

5.2 Health

5.2.1 Mental health

It was evident from quantitative findings that mental health conditions were extremely prevalent. Almost all qualitative interviews described having a mental health condition but not all had sought treatment. Several participants were upset and tearful during interviews which underlined their poor mental condition. Many participants believed their mental health problems were a result of their long term drug use:

" I've got endogenous depression which is a chemical imbalance or something. I think it's caused wi drug use cos I've used drugs all my years" (male, 41 years, 225)

Depression, paranoia and anxiety were frequently noted:

"I just [get] *anxious, panicky, paranoia, eh, scared, unhappy, sad*" (female, 39 years, 408)

Memory loss, psychosis, panic attacks and suicide attempts were also noted by several participants:

" I've got mental health problems where I'm, I'm so paranoid, I've got psychosis where I'll lash out at people….If I didn't have to leave my house to get my methadone I wouldn't leave the house. It's just I've no friends, nothing" (male, 41 years, 117)

As with this quote there were several participants who mentioned they were isolated:

" I've been so poor. So suicidal all the time, self-harming all the time, I cry constantly, I find it hard to go out on my own. I'd rather be locked in my house. But the ladies here [support service] *are encouraging me to come down"* (female, 47 years, 402)

Being isolated was, for some, their own choice. However it was clear for others that it was a feature of their mental health condition because they felt paranoid or anxious in company:

"Very anxious all the time em I get myself really low at times Where I won't come out of my flat… I'll sit up all night, cos I can't sleep and I just get, you know, and, [I] *have panic attacks sometimes, when I'm coming* [to the service]…" (female, 50 years, 321)

One participant described a lack of trust in other people generally:

"I don't trust nobody… I keep myself to myself unless they ask anything but apart from that I feel isolated. Put it [this way]*, if I was deid, nobody would miss me, that's how bad it is*" (female, 39 years, 408)

This self-isolation could result in deep loneliness. One participant, with probing from the interviewer, described how her loneliness and lack of support had led to despair and suicidal thoughts:

"Aye quite left oot, very left oot."
I: " and wi you no having a worker or anything like that"
R: "No, I've never had that"
I: No emotional support?"
R: "Ken you look at your wrists and that but I would never, eh life's too precious at the end of the day and that, ken the thoughts are there but doin it's a different story" (male, 48 years, 219)

Mental health support and treatment

When participants mentioned mental health conditions they would be asked if they had sought treatment or help for this. Several were being prescribed antidepressants and, as this participant described, they could be beneficial:

"she's [GP] *really good wi me, she got me my mirtazapine and that. …I was hardly getting any sleep at al and eh, I said to her, and eh, she put me on mirtazapine and they are a mild sedative and eh, depressant, antidepressant, and they help wi your sleep and ..they were brilliant*" (male, 38 years, 320)

However, there were also challenges in adhering to treatment which were probably being compounded by their mental health condition:

"I'm supposed to be on mirtazapine but I keep forgetting to go [to get the prescription]*. I have a really bad habit o forgetting. My memory just wanders"* (female, 40 years, 511)

Others have not sought support for their mental health problems. In some cases this was because they had not looked for help:

"no I've never been offered support and I've never looked for support" (male, 41 years, 319)

5.2.2 Physical Health

Physical health was also explored during in depth interviews. Many people described poor physical health and several had multiple health problems. Respiratory disease, gastric problems, weight loss and arthritis were all described. However, the most frequently mentioned conditions were pain related. Pain as a result of nerve damage from injecting was noted by several participants. A couple of people noted pain from tissue damage from taking legal highs:

"my hand gets sore with legal highs at times you know and I need to get that checked as well because I don't really know what damage is done there" (female, 57 years, 213)

"my legs get really sore. It's like em, it's severe nerve damage that done to them, it's like know, numb, like pins and needles" (female, 35 years, 126)

A few participants said they were prescribed gabapentin for such pain. Others mentioned attempting to self-medicate with street drugs such as diazepam or pregabalin:

I: "And do you get prescribed pain killers for your, your pain?"
R: "Em, because I'm on the methadone programme, I'm, no. It's because I'm on methadone."
I: "So the doctors won't prescribe you any?"
R: "No anymore, eh, I'm on Gabapentin, but, I, I take extra o them, they know that. I even buy Pregabalin, off the street" (female, 39 years, 408)

Others did not seek help because they felt they would either not get it, or were embarrassed to *ask:*

"they just say it's self inflicted. It's almost like it is my fault, so I've dealt with it. And it's sort of embarrassing, it is, going and having to explain what you've done to yourself" (male, 38 years, 320)

This quote also hints at feeling shame. There was also evidence of being stigmatised as a couple of participants perceived they had not received treatment because they were drug users:

"it gets worse when I go to bed at night an all, it's horrible. I just lie in bed and [swears] *greet at night it's that sore"*
I: "so do you no get any painkillers or anything for that?"
R: "because I've got, I use, and the hep, they won't give me any" (female, 41 years, 128)

Several participants just accepted pain as part of their everyday life:
"I just get on wi it" [laughs] (female, 35 years, 508)

5.3 Age Specific Issues

When asked about age specific issues and what were the biggest problems faced by older drug users compared to younger people, five recurring themes emerged and a number of others were noted by individuals. The main themes were:

1. Problems accumulate with age
2. Stigma
3. Feeling forgotten about
4. Lack of services
5. The benefit of experience

5.3.1 Problems accumulate with age

Some participants noted that they had more problems simply because they were older and had been through more. This related to more life problems but also more physical health problems, the implication being it was part of the aging process:

"*because they're getting older and that. Their system's no working that good*" (male, 41 years, 207)

5.3.2 Stigma

Experience of stigma was described by several participants although they did not necessarily use the term 'stigma'. This was mentioned in relation to society generally:

"even the younger person… if they're not a drug addict… they'll get treated better than we will. People look at us as scum, as… like an alien, like…. even if you were in a pub and you drunk out of a tumbler you would see the people throwing the tumbler in the bin as if… well, as if you've, you're carrying this kind o disease that we're gonnae infect the full pub and things like that" (male, 41 years, 117)

Indeed comments from a couple of participants suggested that there is also stigma associated with aging:

"all they do is, see as you're getting older, all they do is moan about, you're a candidate for a heart attack, that's all I get. A candidate for a heart attack". (male, 45 years, 417)

It was perhaps difficult to separate two potentially stigmatising factors of drug use and aging:

"*when I was on the methadone and trying to go on the straight and narrow and sort my life oot, I, I found it hard to get any sort o work, any sort of job you know, and I don't know if that's because of my age or no, em".* (male, 41 years, 225)

Stigma was also evident in health and drug treatment services. One participant noted feeling they were treated differently at the pharmacy:

"The older people… in the chemist, they'll get their prescriptions first, even though we've been sittin there twenty minutes. If somebody comes in, they'll get treated first, if they're not a drug addict. "(male, 41 years, 117)

Stigma or experiences of being treated differently, were also evident at drug treatment services, where participants felt they were regarded as failures of treatment:

"Aye, we're older, so basically they don't care about us, know what I mean, whereas younger ones, they are trying to get them to the stage of getting them come off it right, so cos we're older, we've been on it longer, so, they're like that, they're lookin at us going "Waste of space", they won't come off it now" (female, 40 years, 131)

This may be exacerbated by the age gap between staff and older drug users:

"I think you get looked on as, just, the same as the little youngsters, I mean I can only go by my experience at the DTTO?, I mean they're all little kids [the staff] *and, em, they just look at you the same, you know, as just a little kid when you, Christ I'm 50 years old but they just, it's like a box, they're all users"* (female, 50 years, 321)

This participant felt that both young and old drug users were stigmatised. However several others felt older drug users were treated differently compared to younger drug users in treatment. This links to the next theme of feeling forgotten about.

5.3.3 Feeling forgotten about

A few participants noted feeling that drug treatment providers had almost given up on them. They felt they were considered to be a lost cause:

"Well I think, maybe people kind of look at it like once you're past a certain age, it's kind o like, well, it's not worth really doing anything now, cos you're never gonnae change" (female, 57 years, 213)

There was a sense that the emphasis of treatment was on younger people:

"I think, oh, I think we're needing more help eh, I think cos the older you are, they [services?] *think you can deal wi it better sort o thing eh and the young ones that's just starting to use something and that, they are actually getting more help*" (female, 50 years, 310)

This extended to there being a perception that there were more groups available for younger people as this participant went on to say:

"because they're just starting to use drugs and that and they're trying to help them, know to come aff it. Because we're older, we have done it, ken we have dealt wi it and that eh, ken. And, ken, a few of them said, like, say "Is it all in [centre name]*?", "Well you can go to thae groups, you can go to that group, you could do this, you could do that". And they never asked me once ken*" (female, 50 years, 310).

Thus some participants felt excluded from some of the support groups that younger people were encouraged to attend although it was not clear if this was because the groups were aimed at young people or because OPDP were being overlooked.

5.3.4 Lack of services

As a consequence of the issues raised above there was a feeling that there was a lack of services for older people:

"There's nothing out there for us, there's nae help at all, no to my knowledge. I've never been asked off anybody for, "Do you need any help, do you need somebody to talk to, do you need this, do you needs this". (male, 40 years, 219)

However one participant did acknowledge that older people might not realise there was help available so might not seek it out:

"*Like a lot o people, you know, maybe a bit older than me, like people right in their 60s and that, don't know that there's help and stuff, you know because there wasn't back when they were, so they don't go and ask for it the same, as a younger person would.*" (female, 57 years, 213)

5.3.5 The benefits of experience

Many participants noted the main difference between older and younger drug users was their increased experience. This was presented as a positive. Older drug users were seen to take less risks and to be more cautious about using needles. They considered themselves to be older and wiser. Some felt this made them less vulnerable than younger users:

"Well, in my case I, there's no issue because of age, experience comes with age, so you're not as vulnerable, as a young user, like a young user is. You're more mature in your mind". (female, 52 years, 222)

Several noted that this experience around drug use could be put to good use to try to teach younger drug users about risky behaviour:

"Basically they've just got a lot more problems than younger ones have, do you know what I mean, we've been through all that. And I think like, people that is, like groups and that, I think they should try and open the group, try and let ones like us, older ones, that are using, no using but, are on methadone to thae groups to try and teach the younger ones no to do it, give their life stories." (female, 40 years, 131)

One participant had a very personal and rather alarming angle on young people learning from the experience of others:

"My son, he's just started using eh, I hated it for him when I found out he was on it, but I find me, I'm having to do it for him, cos, he ended up wi abscesses a' over him and that's just cos he's getting will-nilly, folk to hit him up" (male, 40 years, 525)

5.3.6 Minor themes

Other issues relating to being older that were mentioned by individual participants included experiencing worse withdrawals, getting less enjoyment out of drug use, feeling more guilt

about their drug use and the lack of opportunities they have had in life as a result. This included employment but opportunities to engage with or have a family:

"well, oh, I was quite young when I started and, I thought to myself, "Well I won't be taking this for long and I'll get fed up of it". Em, but found very quickly that, it took hold of me and now that I'm 35 I'm thinking "Oh my God, I'm nearly hitting 40, I'm still using gear, I haven't got a job, a lot of mental illness, I haven't got any kids, I'm not married. My Mum and Dad wanted more for me than that and I feel, they make me feel guilty about that you know." (female, 35 years, 503)

5.4 Gender Specific Issues

When participants were asked if there was a difference in the problems faced by drug users depending on whether they are men or women, several responded that they were unsure or did not think there was any difference. The main reason for this response seemed to be that they were using the same substances and in the same way. However a number of respondents, both male and female, gave more depth to their responses which are explored below.

Several (both men and women) noted that women are more prone to abuse:

"I feel girls… can have it a wee bit harder as well as, men do abuse girls, and that's wrong know and I'm staunchly against that, I, I hate people that abuse girls, or treats them bad, because I've seen it over the years, quite, I've seen it so much, girls wi black eyes, girls wi, men putting girls out tae work on the streets and take the money off them" (male, 41 years, 117)

It was also recognised that women might need specific services if they have been abused:

"Ken what I mean, they've maybe been abused or something, when they were younger or something, and that's maybe why they're taking drugs. Could you imagine them going into a place that's mixed and there's guys, how are they gonna be able to start to talk aboot their stuff, when there's guys sitting there. It would be awfae difficult for them". (male, 38 years, 320)

Or they might need specific services because they have children:

"Obviously women get, tend to get better help because they usually have children to look after and stuff like that so, they get a bit of preferential treatment but then that's understandable." (male, 41 years, 319)

Women were seen by some to have more emotional challenges. It was recognised that older men and women might have different motivation for their drug use:

"I think, well a lot of women, it's mare emotional, they do it [use drugs] *through more, their past and, what's happened in their life. Women are, I don't know, men do it, och I don't know it's weird. I think women do it to block out what's happened in their life, like, abusive relationships, losing their weans, whatever, but men do it more* [use drugs] *because they want to do it I think*" (female, 41 years, 128)

Some female participants noted that women tended to have more responsibilities, particularly if they had children at home:

"some of them [men] *help to bring the weans up, some don't, some don't care, do you know what I mean, so that's a bigger issue for us* [women]*. If you've got that, trying to look after weans, em, also, trying to address their drug problem, going into a chemist every day, do you know what I mean, all that."* (female, 40 years, 131)

As this participant indicated this could be difficult to manage when in treatment and having to attend a pharmacy daily.

Prostitution was raised by a few participants during this discussion of differences between men and women. It was recognised by both men and women as an option for making money and some female participants had personal experience of prostitution:

"Well a lot of women end up in prostitution and stuff, you know what I mean, that's a common one, you know, just to get money for drugs. It's an easy way, to get money, no, it's not easy, but it seems, you know, if that gives you a few hundred quid or something at the time, you're em, and it's a bad way" (female, 57 years, 213)

However as this female participant noted, prostitution was not an easy option for women and brought complicated emotional issues, particularly having children taken away which could cause mental health problems, as she went on to explain when recalling a friend who resorted to prostitution:

"she had a breakdown because her kids got taken into care and stuff [as a result of prostitution] *and ended up a lot worse you know*. (female, 57 years, 213)

Prostitution was a complex issue and no drug users were doing this happily of their own accord. Some were forced into prostitution by partners or, as this participant explained, by her own mother:

"I, I, I just, I, all I can say on that is, I, I dinna think we get treated properly and we dinna get treated fairly….Especially if you've been in the sex industry, ken what I mean. You're just basically, you're a lost cause, because you're no only a junkie, but you're a low-life prostitute"
I: How does that make you feel?
R: "Angry because, I didna, I didna get into prostitution for drugs. I got put into prostitution on my 16th birthday, by my mother, wi the guilt trip that, if I didn't work, if I didn't sell, I wasn't even sexually active. But if I didna work, if I didna go and sleep wi these guys and what not wi these guys, then my wee brother and sister were sufferin. They were the ones that were gonna do without food, roof over their head, clothing, fae the age of 12 I brought up my wee sister and brother" (Female, 42 years, 217)

Finally, one participant noted that she felt women might be more likely to change priorities as they age with less emphasis and interest on drugs. This reflected their wider interest in family and the effects of their drug use on family:

"Well, a man might be able to brush it off and say, "Oh I don't care about having kids, or getting married and, I just want to", not so much "be a bum all my life" but "I'm comfortable where I am", sort of thing, that attitude…. Whereas a woman, I don't know, your mindset changes, know what I mean. I've found that my mindset's changed a lot over the years, recently because I'm getting that bit older and I'm like, heroin's not as important to me as some other things…"

I: "So what other things are important to you?"

"Well, like my dog and, being healthy and, looking after my Mum and Dad because my Mum and Dad have looked after me, through thick and thin, so I think it's about time I repaid them

the debt. Cos I don't want to be, I don't want to be cruel but, it can be selfish in a way, if you carry on using into your old age." (female, 35 years, 503)

In summary, where differences were perceived to exist between men and women it was related to their higher risk of abuse, prostitution and the impact of having children taken into care in their past drug using lives. Although this is not exclusive to older women they were more likely to have experienced some or all of these simply because they had been drug users for longer.

5.5 Specific Services for OPDP

5.5.1 Awareness of existing specific services

Participants were asked if they were aware of any specific service for older drug users. None of the 30 participants were aware of such services although a couple of people were unsure.

5.5.2 Should there be age specific services?

Content analysis of all 123 interviews was undertaken on this specific question because it was asked of all participants and generally gave a yes/no response with further qualitative justification. Two thirds of all participants thought there should be specific services for OPDP and a fifth of participants did not think there should be specific services for OPDP. The explanations given for the latter view (from all that gave an explanation) were that they were all drug users and so needed the same type of services.

Table 10 Should there be specific services for OPDP?

Do you think there should be specific services for older people with a drug problem?	n	%
Yes	77	62.6
No	26	21.1
Missing	10	8.1
Unclear or Not recorded	10	8.1

Those who thought there should be specific services were asked what these services should be. Grouped responses are displayed in table 11. Comments made largely fell within four broad themes which will be expanded on below.

1. Desire to separate older from younger people in services
2. Support groups
3. Employment support programmes
4. Holistic health services

Table 11 Suggested services for OPDP (n=77)

Services suggested by participants for OPDP	n
Separate old and young in services (different mindset)	13
Peer support group	12
General support/to feel supported	8
Practical support e.g. running a house and managing money	6
Social clubs/something to keep OPDP busy	6
Emotional support	4
Residential detoxification and rehab for OPDP	3
Mental health/counselling	3
Holistic health service	3
Health check	3
Employment support i.e. to find employment	3
Employability training including confidence building and literacy and numeracy training	3
Drop in	3
Community projects	2
Volunteering leading to a qualification	1
Support services	1
Support for injectors	1
Support for families	1
Smart recovery for OPDP only	1
Housing support	1
Don't know	5
Missing/no response	4

Note some participants gave more than one suggestion

5.5.3 Separation of older and younger people in services

Thirteen individuals, of the 77 who wanted separate services, stated that they would like to be separated from younger drug users in services. Thereby it was apparent that many actually wanted the same services but felt they would benefit from being grouped by age. One participant summed up all the issues as the following:

"there is different frame of minds, so there's different ways of tackling that and the older drug user has got, health problems, money problems, criminal problems, homeless problems, relationship problems, ken, you can keep going, a drug addict, an older one there's a lot of problems [small laugh] *aye, aye."* (male, 35 years, 313)

Those who raised this issue generally cited reasons that having to mix with younger people did not feel appropriate:

"Well probably much the same thing as they do with younger people. Just the meeting groups and stuff like that, where it's people the same age. You know not em, not people that are all 20 years younger than you, or more you know. Eh, there's a lot of people wi the first time round, just out of their teens kind of thing. Then me sitting wi a lass of 21, not reading from the same page, you know" (female, 57 years, 213)

As another participant noted, this was because younger and older people with drug problems had different perspectives:

I: "Why do you think having the same age groups would be good?"

R: *"Because you, you're alike more to each other. You've got ken, probably grandchildren, you've got, ken, same sort of issues. Instead of all being like in their 20s, they've all got the same thing, they're thinking different. When you're younger you do think different" (*female, 50 years, 310)

It was also suggested by a couple of participants that OPDP are more likely to take treatment more seriously:

"they should have, a residential for people over a certain age, like… if you, if you're older you're mature know, and, I was in the [centre name] *the other day and I was sitting and there were a young girl and she kept shoutin for a cup of tea, … and I was sittin sayin to myself,* [blows through lips] *was I like that?, …. they shouldnae have to really mix wi these people, we should mix wi people wir own age, … who has been usin drugs for so many years, instead of havin to sit wi young uns, that, I feel they carry on and they just, they disrupt your, your rehabilitation so they do, with a lot of their carry on and things like that, OK, everybody likes a laugh but, it's not a laugh when you're dicing wi death every day, know, if things are serious." (male, 41 years, 117)*

This participant implied younger people might even be disruptive to their treatment. The suggestion being it was a deterrent to treatment (which was a rehabilitation facility in this instance).

5.5.4 Support groups

The next most frequently mentioned service was to have peer support groups of OPDP (n=12) so that people could be grouped with like-minded people. For some this was seen as a source of emotional support, indeed four people specified needing emotional support. For others, it was a means of social support that would help reduce isolation and boredom:

"Well somewhere you can go, sit, talk to other people, other users, see how everything's getting on" (male, 48 years, 219)

"Help with housing, help with social life, help with meeting people, things like that….You need to be active in the community." (female, 50 years, 222)

Eight people just felt they need to feel more supported generally but were not really able to articulate in what way. Six people suggested a group that could provide practical support such as household management skills including managing money:

"Practical support, like, keeping a, keeping a clean house is good for your, your mental health…. Yeh, and, sort of like, balancing out your money, so you pay the important things first and then what's left is yours to play with." (female, 35 years, 503)

One participant had some past experience of this type of programme and clearly found it enjoyable.

"they done "Life Shapers", I went to that it was afa good."
I: "What was that?"
R: Em it was em, it was really meant to be for once you'd finished treatment but a lot o folk was still in treatment really. Em, and it was the first group, for, for 12 weeks we went down to the, it was the [hotel name]*, em I think it was fae about nine o'clock, half nine til about four o'clock….You got your breakfast and dinner. Em, they done computing once a week, baking*

once a week, you did relapse prevention work, em, we was surfing, we was fishing, stuff like that, we done a lot o stuff, so it was, it was really good, it was really good." (female, 35 years, 508)

5.5.5 Employment support/programmes

Six participants noted the need for courses and support to find employment:

"There definitely should be mare courses oot there, for people" (male, 35 years, 313)

This included skills to make them more employable (e.g. literacy and numeracy) as well as support to find employment. However one participant noted that the stigma of being seen as a drug user was a barrier to employment:

"well things for older people to get back into work because there's a lot o fear round about, they're gonnae know that I was a user, they're gonnae know that I've got, dealt in drugs or whatever, so I think there should be mare stuff like that.
I: So do you think that would be problematic for you?
Definitely, I'm hoping, through going to see and doing a bit o volunteering, it will help me, but I have got a lot of fear round about it. Cos, there's always stigma round about a junkie." (female, 35 years, 126)

This participant considered that volunteering would be a good way to try to overcome the challenges of getting back into work, however, this was clearly a daunting prospect with her noting feeling fearful. Another participant suggested that it would be beneficial if a programme of volunteering could lead to a qualification.

"*More recovery based things em, confidence things and, for people that are volunteering, I think the volunteering should be recognised and there should be a qualification for it, to encourage people to get back into work, because a lot of older ones maybe have dyslexia, or never been to school. No confidence. Em, I think that would really, really help them."* (female, 43 years, 111)

5.5.6 Holistic health services:

"Em, yeh, I think there should be specific, mare, they're, asked a lot em, you, cut short your methadone em, come down and we'll get you eh, we'll get you into treatment, we'll get you working with a coun….., we'll get you seen, a lot more frequently. Get your health issues sorted out, that your teeth, your, your pain, your, because older drug users it's not just the drugs it's, you're, you're getting old, so you're getting what old people get. Ailments that some older people get." (female, 38 years, 421)

One noting the wide health problems and the consequent need for more health checks:

"I think mainly older drug users, our bodies are all physically messed up wi arthritis and blood clots and whatever, we should have, right, we should have mare checks on our bodies a couple o times a year to get checked out. A full MOT and all." (female, 53 years, 106)

5.5.7 Other issues raised

One participant made the point that long term drug users might need less recovery orientated services and services that were more accepting of ongoing drug use.

"Em, I don't know, I think they [service providers] *should just try and chill out a bit. …, when you get to 40-year-old and you've been taking heroin for 20 years, eh, as I say, it's pretty obvious that, if you've no been able to conquer it up to now then, you're obviously struggling and so, rather than just kicking people out o the service because, fae their point of view they're no trying hard enough, they should, they should have, they should have a certain part o the service that just allows for people to still get the help, the support, the, the, the substitute medication, but allowing for the fact that they, they're still gonna take illicit drugs because they, they, they cannae help it. I know obviously that's no great from a harm reduction point of view because obviously there's, as you're older there's a higher risk, but…"* (male, 41 years, 319)

Finally, one participant suggested using the skills and experience of OPDP in a positive way i.e. as service providers themselves:

"The, em… I think for, like, see the older people who've got... a wee bit better on and they're, getting over their addictions and, if they've stuck to a programme, they're doing good, to go roond like high schools and, detox, … I've done that afore when I was wi [name] *an went to* [area name] *the academy or something it was, it was like a, well to do school. Em, and we got up and done a talk on why we done what we done and, and it was to try and teach the younger ones no to do, no to go the route that we took, the cowardly route really"* (female, 41 years, 128)

There was also evidence that this happened in other settings such as using older drug users/ex drug users as counsellors in drug services:

"I will help them as much as I can, because there is not enough help out there. So, it's the elders [OPDP] *have actually took over fae all these drug workers and all these drug places, these Council places, the elders, the, the elder drug users are now tutoring the younger drug users and see if it wasna for the older drug users, the younger drug users would be more* [swears] *up than they already are. They don't have the right facilities and treatment ken what I mean. They can cure, anybody can get rid o a drug habit, but it's the mental scars and issues that are left*." (female, 42 years, 217)

Although many were keen for some form of targeted services for OPDP, there was an awareness of the challenges of providing a range of services for age (and gender). One participant was mindful that there might be limited resources for age specific services:

"It's like there's no enough facility.. for it to be all separated men and women eh, older and younger. It's almost like it's all, ken in one place. It's I don't know if it's to do wi funding or if it's bad enough getting the funding for just that [one service]*, never mind if it was all divided up. But I mean, maybe it would be mare, eh, service users, using the facilities if it was divided up like that, because o thae issues, like, women no being able to speak about stuff if guys are there. Or guys no being, cannae be bothered wi youngsters that think they ken everything aboot nothing, ken, and so things like that, so. But I mean, last year I was trying to access like, the NA and all that and they say "No, no, it's self-paced", somebody starts it ken, in the area, ken it's self-managed eh…and they're like, and they're like that, it's eh,* [city] *you have tae go to, and you're like "All the way to* [city]*, you're joking".* (male, 38 years, 328)

In this case the participant was also particularly challenged by the availability of services/ support due to the location where they lived.

5.6 Changes to the Welfare System

Many participants did not seem to be adversely affected by changes to the welfare system. However, a few people had experienced sanctions due to missed appointments that left them temporarily without any income:

"Aye I was cut aff for eight and a half weeks and then, I got put on that PIP and then.. now they're saying they are cutting that and they are cutting the ESA. So, basically the ESA that's £60 a week doon, £60 a fortnight doon, know what I mean. That a lot of money when it comes to it."
I:" How did you manage when your benefits were cut?"
R: "Through my mum. If she hadna been there I would have been[swears]*. Put it this way, I would be back in the jail."* (male, 39 years, 411)

As this participant indicated missing benefit payments meant they relied on other people. One participant had the added problem of looking after children:

"twice I've been sanctioned [for not attending appointments] …*just* [for] *a fortnight, that was going back when I had the kids, so it was hard"* (female, 47 years, 402)

Discussions of welfare led on to discussion of employment opportunities and willingness to work:

".. so a the changes and that… as I say it's a joke now, the welfare, it's almost like a game, they think folks kidding them on that they can't get a job and that, and they just want to sit in the hoose and like get money for nothing. And it's no like that ken…. There's only like 200 business in the area, and so many people….but they expect you to like get jobs when…they're nae there ken, plus Its harder for me wi having convictions" (male, 41 years, 320)

There seemed to be willingness to work but there was the added challenge of being a drug user with convictions to overcome.

Homelessness, particularly if sleeping rough, meant an individual might not have access to any welfare benefits. The following participant was not receiving any benefits and relied on soup kitchens via charities:

"*there's a church, its called* [name] *I go there…..and there's a van that comes round"* (male, 41 years, 207)

5.7 Cross Cutting Themes

A number of recurrent themes emerged across the topics discussed during interviews. These have been touched on in previous sections but are drawn out more explicitly here. These were:

1. Stigmatisation
2. Isolation and loneliness
3. The need to talk
4. Being older and wiser

5.7.1 Stigmatisation

Stigmatisation was noted by several participants. Stigmatisation was felt in pharmacies when participants felt they were kept waiting longer than necessary for prescriptions because other customers were served first. Stigmatisation was felt to be present in some treatment services and this was worsened by age as they felt they were considered a 'lost cause'. Stigmatisation was also referred to in relation to treatment in general practice and hospital treatment. One participant described their reluctance to seeking help for their health problems:

"I ask to get referred to places but I feel because I'm a drug addict that I don't get taken seriously. I know this has been said a few time but… I feel like a second class citizen" (male, 41 years, 117)

Furthermore, there was evidence of stigma amongst drug users themselves. Some OPDP felt that younger drug users were disrespectful towards them and looked down on them:

"you get the comments like, God, I hope I'm no still doing it when I'm that old ken."(female, 44 years, 306)

Several OPDP felt younger drug users were careless and risk takers who did not take treatment seriously:

"And, I do believe that they should be… a different section for the older people, older people I say like people over thirty-five, eh, that are more mature, and I'll not mess the counsellors about and try and rip them off for any drug they can get" (male, 41 years, 117)

One participant admitted to judging younger people based on his perception of their relative inexperience:

"for me, like…. it's like judging too, you know what I mean…. I can, like, "He's, he's no used as long as me", and, "he's no used as much as me" and all that kind o conflict, eh but I used to think you should have like groups, for the older people, you should be, where they go, like where older people can feel more comfortable." (male, 36 years, 143)

5.7.2 Isolation and loneliness

The theme of isolation and loneliness emerged strongly under discussions of mental health:

"I start getting panicky and a'thing, I hate being wi too much people. I prefer my ane company" (female, 40 years, 511)

However, these themes were also evident when discussing support services. Some participants clearly needed the company of others, ideally those in similar situations.

"Well somewhere you can go, sit, talk to other people, other users, see how everyone's getting on." (male, 48 years, 219)

Limited social contact with other people became routine in some on long term treatment:

"A cycle of use you know and that keeps the cycle, you need to break that cycle, do you know what I mean, so around about, just keeping going round the same way, up in the morning, going to the chemist, going for your messages, ….. go to the chemist get my methadone, come back home, tidy my house and all that and that's me in til the next day" (female, 40 years, 131)

This participant's description of her routine implied an element of boredom. Within this theme there were a few accounts like this one in which the daily trip to the pharmacy for their prescribed treatment was the one regular event that got them out of their house:

"If I didn't have support today, I would be at the chemist, I'd go home and that would be me in all day" (female, 39 years, 408)

In this case the support group attended helped to break the routine of pharmacy visit then home.

5.7.3 Talking was valued

Probably because of the isolation and loneliness felt by many, the need to talk and the value of straightforward, friendly conversation, was evident in several areas. The expressed desire for support groups was evidence of this. However, this was also evident from the value placed on supportive staff which was often framed around them being willing to give time to talking to participants and to talk in a manner that made them feel 'normal'.

"so the nurses here are really nice, the ones up in A&E and the ones up in [hospital]*, they really talk awa and a'thing*" (female, 40 years, 511)

As well as feeling they were being talked to as 'normal' people, there was also the need to feel they were being listened to:

" and my GP now, he listens to me… he is amazing, it doesna matter, I can tell him anything, everything and he's there for me regardless…..He, we sit and talk it oot and there's not many GPs will actually sit and do that when you get a five minute slot, that's it" (female, 42 years, 217)

5.7.4 Older and wiser

Finally, the benefits of age were noted across interview topics. For example this woman was talking about prostitution:

"I mean I did the prostitution thing. I did all that when I was younger so I can tell people it is not a good thing to do, and why… all the dangers you know, that kind of thing, and not getting yourself homeless and letting other people railroad your life and, you know, take over." (female, 57 years, 213)

Another participant was reflective about his past and admitted negative behaviour in the past:

"I've dealt wi the worst o the worst and I've been the worst … stealing and my mum's purse and dad's wallet. I've done it wrong, I want to get better." (male, 45 years, 417)

Again it was suggested that this could be used for the benefit of younger people:

"we [OPDP] *can even try to help the young ones, and I don't know, I mean we could gi them a wee bit of advice an all, if we had like meetings or whatever, the older ones that have been there and done that."* (female, 41 years, 128)

6 Discussion

6.1 Strengths and Limitations of the Research

This research sought to include a sample of people over 35 years with a drug problem by using a quota sample to ensure sufficient age groups and proportions of males and females were included. It is the first mixed method study in this group covering a large and diverse geographical area that has been identified in the literature. This sampling approach for the quantitative findings means that results should be reasonably generalisable for the Scottish population of OPDP. Willingness to participate was high and target recruitment was exceeded. Recruitment in Lothian was lower than in other areas and recruitment of females proved more difficult than males, despite considerable efforts to target females, particularly as recruitment went on. As a result males at the younger end of the age spectrum were slightly over-represented.

The study deliberately used non NHS facilities as the sampling frame to ensure those not currently using treatment services were included. This was partly successful in that a quarter were not currently on ORT and five of those individuals had never been in treatment. However three quarters were on ORT as well as using the service through which they were recruited. This might simply be an indication of how widespread ORT delivery is in OPDP. There may also have been under-representation of 'rural' OPDP despite targeted rural areas, particularly in Fife and Grampian. Only four individuals identified themselves as from a rural area but a further 20 were from a 'small town' which would also have challenges of access to services which was the reason behind targeting rural areas. Therefore these views have probably been sufficiently covered.

The lower age inclusion of 35 years could be questioned as not being sufficiently 'old'. However, as outlined elsewhere (Vogt, 2009), the physiological age of 35 years of OPDP is approximately 15 years older than those who have never suffered from problem drug use. There was certainly evidence of poorer health in our sample. However, of note is that participants who were still in their 30s to early forties also seemed to speak from an older perspective in that they referred to younger drug users as a group apart. This was very evident from qualitative interview data.

A limitation is the possible under-reporting of drug use as participants may have felt some distrust towards the research. There was limited evidence of this in that 53% were not injecting but 83% thought they might use ORT in the future.

A strength of this research is that it collected data that can be used as a resource for further selective analysis as required to inform policy and practice for example interview data from particular sub-groups (e.g. women, recent overdose cases, the homeless etc).

6.2 Demographic Characteristics of OPDP

A high proportion of the sample lived alone (78.9%) which compares to 37% of drug users initially attending treatment services (ISD, 2016/2) and 16% of the general population (NRS, 2013). This quantitative data chimes with the isolation and loneliness expressed in interviews. A considerable proportion of participants lived in some form of hostel or temporary accommodation with less than half having their own house/apartment. Also

notable, is the fact that a very high percentage of participants (91%) had been homeless at some point and only three people were in paid employment. High levels of unemployment are recognised in the literature across all age groups of drug users. Previous estimates of levels of unemployment in Scotland for people with a drug problem averaged at 85% (Shaw et al., 2007). Thus OPDP appear to have an even higher level of unemployment than the whole problem drug using population.

Issue to consider:

- Care and support models that directly address isolation and loneliness should be considered.

6.3 Drug Use Characteristics of OPDP

6.3.1 Current drug use

Drug use patterns were variable, with two ends of the spectrum evident from quantitative data. Many were no longer injecting regularly whilst others were still injecting several times a day. However, there is a possibility some did not want to admit to injecting behaviour. Although there were some references to novel psychoactive substances during in depth interviews, the majority of drug use was opiate related. Three quarters of participants were on ORT, mostly methadone.

6.3.2 Overdose experience and risk

Three quarters of participants had 'ever' experienced an overdose (75.1%) and 33.3% of the whole sample had overdosed in the previous 12 months. If this figure is extrapolated up to whole of the drug injecting population over 35, which is estimated to be 14,000, (ISD, 2016) then there would be an annual overdose experience of over 4500 individual people who may have multiple health needs. This is an enormous figure and might go some way to explaining why the overdose deaths in Scotland continue to rise despite the considerable efforts being made to address the problem e.g. the Naloxone programme (naloxone.org.uk). Clearly not all overdoses result in death and many people regained consciousness despite no action being taken. However, as people age there are physiological changes in the body e.g. reduced liver and kidney functioning, and possible weight loss which could affect the body's capacity to metabolise drugs as efficiently. Furthermore, there was evidence of respiratory disease being common from this research and elsewhere (Palmer et al, 2012) and opioids are respiratory depressants. Co-existing respiratory morbidity could make people more susceptible to respiratory depression and further investigation of this hypothesis should be considered.

This study found that in a third of cases, no action was taken when a potential overdose occurred. Another issue is that 78.9% lived alone so if they overdosed and were not in company there would be no-one to administer Naloxone. All OPDP are at high risk of overdose. However, OPDP who live alone are a very high risk group and there should be targeted efforts to reach this group.

Issues to consider:

- For OPDP who live alone, there should be targeted harm reduction efforts to reduce the risk of overdose.

- Data linkage analysis could be undertaken to explore the possible link between respiratory disease and overdose. This could be a way of identifying those at increased risk.

6.4 Health Conditions of OPDP

6.4.1 Mental health

The most striking finding from this research was the extremely high prevalence of mental health conditions, principally depression but also very high levels of anxiety. Previous research had highlighted that older drug users might be more prone to mental health problems (Dowling et al, 2008). However, this research has highlighted the scale of the problem in a sample of Scottish OPDP. Prevalence in this study was self-reported but prescribing information partly validated findings in that antidepressants were the most frequently prescribed drugs. Whilst 117 said they had depression, 66 were reported being prescribed an antidepressant. The reason for there being an apparent discrepancy of 43 people was evident from interviews in which some people said they had not sought treatment. In some cases this was because of challenges in getting themselves to make an appointment and in other cases because they felt stigmatised and alienated from GP services. Clinical features of depression are a lack of energy, motivation and low self-esteem. When these clinical features are coupled with having a drug dependence and feeling stigmatised it could become a major hurdle to access appropriate treatment. There may also be unwillingness to seek treatment/ support for mental health issues due to continued drug use. Thus depression in OPDP seems to be underdiagnosed and undertreated. Drug treatment services should be skilled to diagnose dual diagnosis and manage mental health conditions. Therefore it seems reasonable to conclude that under-treatment might be because there is either insufficient reviews of OPDP or the reviews are inadequate in some way. There are of course a range of non-pharmacological treatments which could also be considered. Some of these such as emotional support groups would tie in with the type of services OPDP in this study felt were required.

6.4.2 Physical health

Physical health problems were also common with particularly high levels of chronic pain. There is less documentation of this in the published literature although there is an increasing awareness in the treatment and service community. Qualitative data provided some insight into the reasons behind painful conditions. Several people referred to previous injecting injuries causing nerve damage or arthritis which may potentially be related to injecting drug use. Many people were being prescribed medicines used for nerve related pain such as gabapentin. However, others self-medicated or went untreated. Pain control, when pain is the result of physical trauma to tissue, is difficult to treat (Stannard, 2014) and may require methods other than just medication. Pain clinics use a range of psychosocial methods such as mindfulness which could be of benefit to OPDP. Specialist pain clinics exist already in many areas but may not be familiar with managing those with a drug dependency. Access to such specialist treatment may be required for OPDP with chronic pain. However, this has a number of potential barriers that would need to be addressed e.g. stigma from staff, and the specialist knowledge of abnormal prescribing for those with opioid tolerance.

A number of other physical health issues were also common such as respiratory problems (asthma and COPD) and gastrointestinal symptoms. Other research in Scotland found both asthma and COPD were significantly higher in the drug using population (Palmer et al, 2012). Gastrointestinal symptoms are also commonly associated with opioids because this

group of drugs reduce gut motility (Fingleton & Matheson, 2013). These are conditions which are commonly treated in primary care by both GPs and pharmacists (for gastrointestinal symptoms). Ways of improving engagement of primary care to manage these wider health problems need to be explored. Co-existing physical and mental health problems were clearly evident (91% and 85% noted issues of mental and physical health as very/quite important). General practice would normally be where such co-morbidities are managed. However, there was a lack of willingness to seek treatment from general practitioners from some participants. This raises the possibility for more novel approaches such as using drug treatment clinics to also manage physical health problems, perhaps through employing general practitioners or generalist nurse practitioners.

This is also the general direction in which hepatitis C treatment is heading. Consequently there may be many potential benefits in widening the range of potential health issues current BBV practitioners are able to address.

Issues to consider:

- Potential under-diagnosis and under treatment of mental health conditions should be considered by services.
- Improving access to specialist pain management should be explored (and work relating to optimal pain pathway for opiate dependant patients should be carried out).
- Pain clinics may require specialist training on managing people with opioid dependence.
- Engaging primary care in the management co-morbidity of OPDP is essential.
- Drug treatment services should provide general medical care for those who cannot / will not attend their GP.

6.5 Medicines Used

The medicines used reflected the self-reported health conditions with high levels of antidepressants, anxiolytics, analgesics and gastrointestinal medicines used. This data validated the self-reported data on health conditions. Interviews also highlighted that some individuals self-medicated, for example for pain. Most OPDP would be eligible for the Minor Ailment Service (MAS) in Scotland in which pharmacists can supply a limited range of medicines for a range of minor ailments including some pain related conditions, gastrointestinal conditions, coughs, cold etc (MAS). Further promotion of this service to OPDP, who use pharmacies regularly for their ORT prescription, could improve management of these symptoms through safe and appropriate medicine use.

Issues to consider:

- The minor ailments scheme in pharmacies for OPDP to manage co-morbidity symptoms could be promoted in services.

6.6 Services OPDP have Contact With

Many participants had used a wide range of services from needle exchange to treatment to detoxification and rehabilitation. Not surprisingly the most frequently used service by OPDP was needle exchange services, followed by ORT. There was a range of experience of ORT with some valuing the stability that it gave them as they no longer had to inject street drugs, whilst others felt the underlying issues were not addressed and there was insufficient psychosocial support. When people had had access to more holistic services such as life

skills these were positively received. It is well recognised in the wide evidence base on ORT that treatment outcomes are improved if psychosocial support is provided alongside pharmacological treatment (Simeons et al, 2005).

Other services that OPDP come into contact with are likely to be homelessness services (91% had been homeless), the police/court (96% had convictions), the prison service (84% had been in prison at some point) as well as possibly the ambulance service and accident and emergency. Thus there is a case for multidisciplinary support. There is a responsibility for all to be working with and demonstrating support and positive attitudes in engaging with OPDP to provide adult protection. Rather than considering this group as drug users they should be seen as vulnerable adults at risk of multiple health problems and drug overdose.

Issues to consider:

- To facilitate multidisciplinary support this group should be considered as vulnerable adults under either the Care Act (2014) or the Adult Support and Protection Act (2007).

6.7 Engagement with Current Services

Analysis of the number of times participants had been in treatment found a full range. Almost a third had been in treatment over five times. Only five people have never been in treatment indicating treatment services are a key point of contact. However, the median length of time in treatment on the last occasion was just 12 weeks. This implies many people are leaving treatment prematurely, before they have really achieved any stability. This required further investigation to determine whether people are leaving by choice or have had treatment withdrawn. There was evidence from in depth interviews, that some people had experienced punitive treatment. There was also a suggestion that there needs to be acceptance by treatment providers that OPDP may not be able to stop using drugs. Indeed trying to 'force' them to stop using drugs may be counter-productive and might partly explain the limited time of treatment engagement. This is underlined by the fact that ORT was the most frequently noted service for possible future use.

It is also important not to leave people on ORT long term without review. Again in-depth interviews identified that some OPDP felt they had almost been given up on by treatment providers. Regular review is required to overcome these issues. During review ORT patients need to be made aware of, and actively encouraged, to use any support groups that might exist. Furthermore, services should ensure social support groups are provided and people are actively encourage to use these. Services may need to review how they actively encourage treatment retention. There may also need to be consideration of other models of ORT such as Heroin Assisted Treatment. Trials of injectable heroin have improved retention for treatment resistant injecting drug users who tended to be older (Strang et al. 2010).

Stigma was an underlying theme and was noted across services from specialist treatment to general services such as pharmacy and general practice. Stigma has been noted in previous research, as the review highlighted (Atkinson, 2016), and previous reviews have covered this in depth (Singleton, 2011). OPDP have the added stigma of aging and the physical health deterioration that goes alongside that, and mental health issues. Stigma is a complex issue and drug users themselves stigmatise other drug users (Matheson, 1998). In this group there was even an element of OPDP stigmatising younger drug users whilst also feeling they were being stigmatised by younger drug users. There is undoubtedly work to be done to address the stigma across services which will be considered further in the next section.

Issues to consider:

- Regular review of OPDP in treatment is essential. This should be by staff with appropriate training to enable thorough and holistic support and review. The emphasis of reviews may also need to change with more prominence given to detecting mental (and physical health) problems rather than solely drug dependence.
- Mandatory training around stigma and engagement for those working with people who use drugs is essential.
- Services should consider methods of improving retention in treatment including other models of ORT such as heroin assisted treatment.

6.8 Developing Services to Meet the Needs of OPDP

Overcoming stigma should be a priority area for services. Addressing stigma in primary care services requires engagement with general practice and pharmacy. Pharmacy already has a range of training available on managing drug users which is generally well utilised (Robertson et al, 2015). In addition there is a specialist pharmacists group who could be engaged to consider ongoing perceived stigma in the pharmacy as well as promoting the use of the MAS for OPDP. All treatment services should review their management of OPDP to identify if there might be systematic (unintentional) stigmatisation of OPDP. They should consider if there are less opportunities for OPDP to change their care plan or engage in additional support services. Consideration of possible stigmatisation should be built into staff appraisal to address this at an individual level. There may also be a role for advocacy when OPDP need to access other health services e.g. pain management.

Addressing isolation and loneliness is another priority area. More support groups, particularly for mental health support are required. Talking and being listened to was clearly valued so more opportunities for this would be beneficial. Support services could also include more informal groups that allow people to get together with like-minded people. In more remote areas this could be challenging so use of social media could also be considered e.g. via phones. Informal home visits may be necessary for some people who struggle to leave their house as was evident here. There might be a role for using OPDP to volunteer to lead such groups given the expressed willingness by some to work and to help others.

Age specific services were discussed because this had previously been raised as an area for development in previous research (EMCCDA, 2010) and was highlighted in the literature review of service responses to older high risk drug users (Atkinson, 2016). Participants in this research felt they would benefit from a more tailored approach with more support for mental and physical health problems. Potentially even grouping people by age in appointment schedules or for support groups within existing services such that OPDP and younger people are more likely to be with people with a more similar outlook. Furthermore, it would be appropriate to consider the age of staff as the age gap with younger staff may also affect service engagement.

Issues to consider:

- The Specialist Pharmacists in Substance Misuse (SPiSMs) group could be asked to review issues of potential stigmatisation from pharmacy staff and the promotion of the MAS for OPDP.
- Services should review their services for evidence of systematic (and possibly unintentional) stigmatisation of OPDP.
- Providing client advocates would help more vulnerable and isolated clients access appropriate treatment for both their drug problem, and co-morbidities.
- Services should consider grouping clients by age and/or providing tailored services targeting OPDP.
- Services should consider the age of staff that might provide care for OPDP.

- Both formal (e.g. mental health) and informal/social support groups should be provided and a range of formats used including face to face meetings and social media groups.
- Services should consider using OPDP to lead support groups, rather than just participate.

6.9 Gender Specific Issues and Service Engagement

In depth interviews provided insight into particular issues that faced by women. Female OPDP were considered to have greater emotional challenges to overcome. They are more likely to feel guilt and regret if they have had their children taken into care. They are also more likely to have been subject to abuse and to have worked in prostitution, often forcibly. These gender issues are well recognised in the literature (EMCDDA, 2009). In depth interviews indicated that over time female drug users may have accumulated more negative experiences that affect their engagement with services. All services need to be aware of the possibility that female OPDP could have significant issues with trust that will need to be overcome to allow them to engage meaningfully with services.

Issues to consider:

- Services should be made aware of gender specific issues for OPDP and offer support around abuse, responsibilities of childcare and the trauma of having children removed.
- Services should be responsive to problems of childcare that might prevent attendance.

6.10 Effect of Changes in Welfare

Changes to the welfare system did not appear to have a big impact across the sample of participants in this study. However where sanctions were imposed and people had their benefits withdrawn this could force people into extremely challenging situations where they had to rely on other people. The lack of work opportunities, for those who felt able to work, was challenging. Again there may be issues of stigma from staff in benefits and employment agencies that should be addressed through training.

It is possible that more people might be eligible for Personal Independence Payment (PIP) than are currently receiving it given the high levels of multi-morbidity which appear to be underdiagnosed at present. Issue to consider:

- Services should be aware of the range of benefits available and ensure those who are unfit or unable to work e.g. through mental health problems, are considered for appropriate benefits. Services should actively facilitate access to appropriate advice or referral routes.

7 Conclusion

This research highlighted, very starkly, the issues facing those aged thirty five and over with a drug problem. In particular it highlighted that issues facing this group (average age 41) that would be equivalent to people in the general population fifteen years older. The report suggests that the working group consider actions in the following areas:

Isolation and loneliness

79% were living alone with very little social interaction and this need to talk and be listened was significant to people's quality of life.

Care and support models which respond directly to issues of isolation and loneliness among OPDPs should be explored. Informal support, not necessarily linked to treatment, might be a first step to encourage engagement.

Mental Health

Depression was under diagnosed and under treated. The loneliness of living alone was compounded by and linked to depression, anxiety and other mental health conditions such as paranoia. There was also willingness to engage with services as the majority expressed an interest in using mental health support services in future. Potential under-diagnosis and under treatment of mental health conditions generally is a significant issue.

General Health

Through the quantitative part of the study it was evident that people experienced multiple morbidities with ODPDs general health having suffered through lengthy drug problems. Regular general health checks must be undertaken with OPDPs and models to ensure this is undertaken should be explored.

Pain Management

Access to appropriate treatment for common multi-morbidities such as pain control was hampered by perceived stigma among service providers.

There is a need to explore improving access to specialist pain management. Work relating to optimal pain management pathways for opiate dependant patients should be conducted.

Pain clinics may require specialist training on managing people with opioid dependence.

Retention

The majority had accessed drug treatment services but continued engagement was limited by the (perceived) lack of support services and feeling marginalised in services that were perceived to be focussed on younger people.

It was evident from the survey that many OPDPs had multiple drug treatment episodes. Ways to reduce the poor retention of OPDPs in services should be explored this could include the need to:

- increase the range of ORT medication provided including Heroin Assisted Treatment
- provide assertive follow-up of those who drop out of services

- match a worker to the OPDP (including consideration of worker age) in order to build a long-term therapeutic and supportive relationship
- undertake regular reviews of treatment including ORT.

Stigma

The stigma felt by people with a drug problem was compounded by age and was likely to make individuals more wary of seeking help and support. The issues around stigma are challenging and there would be value in considering:

- training around stigma and engagement for those working with people who use drugs
- service providers reviewing their services for evidence of systematic (and probably unintentional) stigmatisation of OPDP.

Gender

There are clear gender specific issues for OPDP that services she be aware of. These issues include, support around abuse, responsibilities of childcare and the trauma of having children removed. Services should also be responsive to problems of childcare that might prevent attendance.

Impact of Welfare Reform

OPDP currently rely heavily on welfare benefits as very few are in work. However some expressed willingness to work if support for employment was provided. How welfare benefits advice is provided to OPDPs should be explored including considering how such provision might be provided within addiction services.

Advocacy

It was clear that there were significant unmet needs within this population and that advocates may well be an option that is worth exploring to ensure needs are met.

Providing client advocates might help more vulnerable and isolated clients access appropriate treatment for both their drug problem, and co-morbidities.

Vulnerability

OPDPs have multiple vulnerabilities (drug use, overdose risk, poor physical and mental health, homelessness and isolation). These needs are currently not being met in a co-ordinated manner. Models such as 'Making Every Adult Matter' should be explored further (meam.org.uk).

In conclusion, this is a challenging and very vulnerable group due to their multiple health and social support needs who, although engaging with services, could be overlooked. However there are encouraging signs that many OPDP are keen to engage with services to improve their situation.

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OLDER PEOPLE WITH DRUG PROBLEMS (OPDP) QUESTIONNAIRE REF NO:

PART ONE: STRUCTURED DATA

This part of the interview will take approximately 15 minutes. Ask questions exactly as written and read out response options to interviewees.

1a. What age are you now ? (in years): …… **1b. Gender**: ○male ○female ○other: ……

2. What is your Nationality ?

○UK national ○National with migrant background

○EU national ○National of another country

3. What is your Marital Status?

○Single ○Married

○Married but separated ○Divorced

○Widowed

4. What is your accommodation type?

○Own apartment/house ○In apartment/house of other person(s)

○Assisted living ○Residential home / rehab

○Emergency shelter/hostel ○Supported accommodation

○Other:……..……..

5. Who do you live with? Please mark only **one** answer.

○Alone ○With parents

○Alone with child/children ○With partner only

○With partner and child/children ○With friends

○Other: ……..

5a. Do you have any children that have previously been taken into care?

○Yes ○No

5b Do you have or have you ever had children that live/lived with someone else?

○Yes ○No

5c. If Yes, where does/did your child or children live?

○In foster care ○Living with adopted family

○Living with their mother or father ○Living with other relatives

○Other: …….

6. What is your highest level of education?
(Please tick the **highest** level completed only).

○Never went to school/never completed primary school ○Primary level of education

○Never completed secondary ○Secondary level of education

○Higher level of education (e.g. college/university)

○Other graduation: …….

7. Have you ever had any vocational/job training (e.g. apprenticeship)?

○Vocational training completed ○Quit vocational training

○Never started a vocational training

8. What is your employment status at the moment?

○Regular employment ○Full time ○Part time

○Unemployed ○Disabled/unfit for work

○Housewife/husband ○Pension

○Other……

9. What is your main source of income? Please mark only **one** answer

○Employment

○Unemployment pay ○Welfare benefits

○Pension ○Other: ……..……

10. Have you ever been convicted for any offences in your life? ○Yes ○No

10a. If Yes, how many convictions? ○0-5 ○6-10 ○11-15 ○16 -20 ○20 or more

10b. Have you ever been in prison in your life? ○Yes ○No

10c. If Yes: year of last time in prison: …….(e.g. 2010)

10d. If Yes, what is your total time spent in prison (lifetime)? ….. years and …….months

11. Have you ever been homeless? ○Yes ○No

11a. If Yes, on how many occasions? ……..

and

11b. What was the longest period of homelessness (in months):…….

and

11c. How long ago was your most recent period of homelessness? (tick box)

○3 months ○3-6 months ○6-12 months ○over 12 months

12. At what age did you start using drugs?.....(in years)

13. At what age did you start injecting drugs?.....(in years)

14. Do you consider your drug use as problematic? ○Yes ○No

If **Yes**, at what age did it become problematic?:

15. Are you still injecting drugs? ○Yes ○No

If **Yes**, how often?

○More than 3 times a day ○2-3 times a day

○Once daily ○2-3 times a week

○Weekly ○Occasionally

16. Have you ever overdosed? ○Yes ○No ○Unsure

If **Yes**, how many times?..... **and**

When was the last overdose? (tick box)

○In past month ○In past 6 months ○In past year

○1-2 years ago ○Over 2 years ago

17. What happened at you last overdose? (please tick all that apply from list below):

○Ambulance was called by someone ○Peer administer naloxone

○Treated in A&E ○Nothing

○Other:……..

18. How many times have you been in drug treatment? (tick box)

○1 ○2 ○3 ○4 ○5 ○5-10 ○ >10

19. For how long were you in treatment the last time? :……weeks/months/years

20. What type of services have you used in the past? (tick all that apply)

○Needle exchange service

○Specialist substitution/opiate replacement drug treatment

○GP based substitution/opiate replacement drug treatment

○In-patient detoxification ○Residential rehabilitation

○Counselling ○Support for employment

○Housing support ○Support group

○Other: …….

21. Are you in a drug substitution programme at present? ○Yes ○No

If **Yes,** please tick below and add dates and doses

Substance	**Prescribed since**	**Daily dose**
○Methadone	……	……..
○Buprenorphine	……	……..
○Heroin	……	……..
○Other: ……		……..

22. Do you suffer from any of the following conditions: (tick all that apply)

○Asthma ○Bronchitis ○COPD (chronic obstructive pulmonary disease)

○Other respiratory disease

○Arthritis ○High blood pressure ○ heart disease

○Obesity ○Chronic pain ○Depression ○Anxiety ○Other mental health

○Constipation ○Diarrhoea ○Heartburn/reflux ○Other digestive problem

○Other: (please list)……..

23. At present do you take any other medicines for any health problems that are prescribed by a doctor? ○Yes ○No

If **Yes**, please list: ……...

24. Do you take any other medicines for health problems other than for drug problem? ○No ○Yes

If **Yes**, is it for a physical or mental health problem? ○Physical ○Mental

If **Yes**, where do you get these?

○Chemist/pharmacy ○Friend ○Relative ○Street purchase

○Other:……

25. Have you spent any time in hospital as an inpatient? ○Yes ○No

If **Yes,** What for?, please list:……

26. How important are the following for you?
(please tick one box on each line)

	Very important	Quite important	Less important	Not important
Problems with physical health	○	○	○	○
Problems with mental health	○	○	○	○
Financial problems	○	○	○	○
Housing problems	○	○	○	○
Independent living	○	○	○	○
Legal problems	○	○	○	○
Social problems	○	○	○	○

27. Which of the following treatment and support services might you use in the future? (**tick all those that apply** and **then rate** the **top three**)

○ Substitute prescribing ○ Detoxification ○ Counselling

○ Residential Rehabilitation (e.g. therapeutic community)

○ Wound management ○ Hepatitis C treatment

○ General health support ○ Mental health support

○ Welfare and benefit support ○ Legal advice ○ Independent living advice

○ Fitness ○ Employability ○ Housing support

○ Community based drug service ○ Community activities e.g. gardening, art

27a. Rate Top three: First: …….

Second: …….

Third: …….

28. Finally, how would you describe the location of where you live?

○ A rural area/ in the countryside ○ A city

○ A small town or village ○ A large town

PART TWO: SEMI-STRUCTURED INTERVIEW –Switch on the digital recorder and re-check the participant is happy for the discussion to be recorded.

1 Drug Treatment Services

Tell me about your experience of drug treatment services -think about all your times in treatment – not just the last time?

Prompts
Tell me about a good experience and a bad experience?

What about substitute drugs like methadone are there areas of service that could be improved?
What about choices beyond methadone? buprenorphine, heroin, slow release morphine – would you consider these?

2 Health status other than your drug problem

Can you please describe your health situation?

Prompt
Can you describe any physical health problems?
Can you describe any mental health problems?
Do you attend any medical services for these conditions? e.g. GP or hospital clinic?
Do you get any other support for these health conditions?

Do you have any problems with painful conditions or pain generally?
If Yes how do you manage this pain?
Have you needed pain control in hospital? If so was it managed well?
Have you had any good or bad experiences in getting adequate control of pain?
If Yes – please tell me more about this.

Prompt
How satisfied are you with doctors, nurses and other health care personnel?
Do you get enough emotional support?

3 Age Specific Issues

What do you think are the biggest issues for older drug users compared to younger drug users?

Do you personally know programmes provided by drug services that are specially designed for older drug users?

4 Gender Specific Issues

Thinking about older people with a drug problem are the problems people face different for men and women?

5 Welfare and Employment

There have been changes to the welfare system – have these affected you and if so how?

Prompt:
Have you had any issues with sanctions, that is, having some benefits stopped?

If not working - ask:
Do you hope to do some training or get a job? If yes, please tell me more.
If you'd like to volunteer what areas would you like to volunteer in?
Thinking about work in the future what areas would you like to work in?

6 Future

Tell me about your life now and what you would like it to be like in 10 years time?

Prompts
What support would you need to get in the future?

Should there be specific services for older drug users?

What services do you think are needed for older drug users?

Thinking further forward, say 20 or 30 years time – where do you see yourself?

Prompts
Where do you see yourself living?
Is there something that you have wanted to do but never did it?

END Thank participant for their time and give voucher

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