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Institute of Psychiatry and Neurology

# Senior Drug Dependents and Care Structures:

## Scotland: Qualitative Report

**January 2010**

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**Scottish Drugs Forum**

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## Acknowledgements

The Scottish Drugs Forum thanks all the participants who agreed to be interviewed for this report and staff at services who kindly facilitated the process.

# 1. Introduction

This study was commissioned by the Executive Agency for Health and Consumers (EAHC) and the Scottish Government The study, explores the experiences and perceptions of a sample of older drug users, to better understand their perceived current and future health and social care needs and service requirements.

In all European Union countries we find a growing population of senior drug users (SDU). The group can be characterised as polydrug users with

- a preference for opiates (use of heroin and/or oral methadone),
- long drug careers (including criminal careers),
- high rates of co morbidity (mental ill health, chronic infectious diseases and other chronic illnesses), and
- socially marginalised (high rates of unemployment, lack of social networks)

The overall aim of the Senior Drug Dependents and Care Structures project is to enhance the knowledge base regarding SDU and to contribute to the mental health and well-being of this marginalised group of drug users. As part of a European collaboration, this report explores these issues in a Scottish context and will be complemented by four other national reports on older drug users in Germany, Austria and Poland (http://www.sddcare.eu.*)*.

## *1.1. Background*

The introduction of medical treatment and harm reduction interventions, as well as medical advances has increased the life expectancy of problem drug users. Consequently, there is an ageing population of drug users across Europe and the USA. It is estimated that in Europe the number of people aged 65 or over with a substance use problem or needing treatment for drug use will more than double between 2001 and 2020 whilst over the same time period in the US, the numbers needing treatment will more than double between 2000 and 2020 (Gfroerer et al, 2003**).**

Analysis of Scotland's data shows a large increase in new clients aged 35 and over entering treatment over a seven year period. The proportion of older drug users entering treatment in Scotland increased from 14% in 2000/01 to 29% in 2006/07 (Shaw, 2008). Prevalence data for the North West of England also shows a significant increase in the proportion of drug users aged 50 and over in contact with specialist treatment agencies and among those in contact with injecting equipment provision services between 1998 and 2004/05 (Beynon, 2007).

Older problem drug users have a unique combination of features which present a challenge to health and care services (Boeri, 2003). The chronic effects of problem drug use exacerbate and complicate the effects of ageing (Beynon, 2009). The ageing process itself is often associated with a range of psychological and physical health problems (Dowling et al, 2007). In addition to these problems, social problems may arise from bereavement, social isolation, lack of social support and financial difficulties (Gray, 2009). As well as the consequences of ageing, these are also risk factors for problem drug use. There is a danger for older drug users that these effects are multiplied in a vicious circle.

Although contact with primary and secondary healthcare services may provide an opportunity to screen older drug users, substance use disorders among older people may often be missed or misdiagnosed (Crome and Crome, 2005). Health professionals may lack adequate training in this field and the assessment of dependence and addiction in older people may be less than satisfactory. Furthermore older users may be reluctant to admit a problem for fear of the stigma it may bring (EMCDDA, 2008; Radcliffe and Stevens, 2008). However there is some evidence to suggest that older drug users may have equivalent or better outcomes when they enter treatment. A long-term follow-up study in the USA compared the treatment outcomes of younger, middle-aged and older adults in a managed care programme. It found that older adults stayed longer in treatment than younger adults. Furthermore older users were less likely to have peers who encouraged drug and/or alcohol use. Over half of older adults reported total abstinence in 30 days prior to interview compared to 40% of younger adults; and older women had higher 30 day abstinence rates than older men or younger women (Satre et al, 2004).

There is ample evidence of the complexity of needs amongst opiate users however there is less research that has been able to follow the same cohort through their drug 'careers'. The richness of the data available through such studies is exemplified by a study undertaken by a General Medical Practice in Edinburgh. In this study, a cohort of 814 injecting drug users presenting at a single practice between 1980 and 2004 were traced and followed up through a combination of personal interviews and linkage to data sources. Follow up was achieved for 678 cohort members. The team found early life adversity in most cases, with high levels of non-injecting drug use and criminality preceding their injecting careers a prevalent feature. Most reported poor physical and mental health, long-term unemployment and periods of imprisonment. The majority had been on opiate substitution therapy (OST) at some point and 83% remained in OST at time of interview. Although length of time in treatment varied with age, the older groups were often in treatment for longer than 10 years. The mortality rate was also high with 28% of the original cohort dying at a mean age of 35 years. Blood borne infections and

overdose were the main causes of premature mortality (Robertson, 2008).

An American study looked at the influence of ageing and social change among older drug users. It found that the older users (drug users aged over 50) were unable to transcend or assimilate fully into the cultural practices of contemporary drug culture and responded to their situation by embracing what the authors called 'poise' (a refusal or inability to resolve the ambivalence of marginality despite possible cost in loneliness, anxiety or increased personal tensions). The biological and social aspects of ageing can increase the sense of diminished self-worth among older people and particularly among older drug users, for who long-term drug use may have exacerbated the normal ageing process. The fear of victimisation by younger users caused the study participants to remove themselves increasingly from active participation in the drug scene to a self-imposed isolation along its peripheries as a protective strategy against harm. Thus the authors posit that older drug users become 'the marginal among the marginal of society' (Anderson and Levy, 2002). However, the authors further suggest that long-term drug users may prefer to 'age in place' by remaining in a 'familiar socio-economic environment where they know the rules and what to expect.' They argue that older users may be too old and too socially disenfranchised to leave behind the subculture in which they have matured and grown older (Levy and Anderson, 2005).

Mullen and Hammersley propose that long-term management of opiate users should address the positive factors that attract users into a heroin subculture, such as friendship, excitement and income; the factors that discourage use such as risks, problems and harms as experienced by the individual user; the 'pushes' away from conventional life, including stigma and boredom; and the 'pulls' towards conventional life such as employment, significant others, children and a sense of self-worth outside the drug using subculture. They found that successful cessation of heroin use occurred after many attempts and repeated treatments. Relapse occurred when there was inadequate mental preparation; returning to previous life circumstances, areas and social networks in which they had used; life difficulties, the monotony of life without heroin; and an inability to cope with 'normal emotions' previously blocked by heroin use (Mullen and Hammersley, 2006).

The challenge then for mainstream health and care services will be to screen for, or otherwise identify drug use-related problems among their older client group and to develop appropriate and adequate responses which do not stigmatise this group.

# 2. Methodology

## *2.1 Aims*

Qualitative semi-structured interviews were utilised to explore the subjective perspective of the target group and to better understand “problem drug users’ perceived needs for, and experience of, interventions”. The interviews focused on drug use, living arrangements and social networks, current health status and treatment, and thoughts about the future needs of older problem drug users. In addition a short structured questionnaire was utilised to supplement the qualitative interviews and provide quantitative data on the participants’ living conditions, time spent in prison, drug use and health. The questionnaires were developed in collaboration with the European research team to ensure standard questions across the four countries.

## *2.2 Sample and Recruitment*

Twenty-three interviews were conducted with current (n=7) and ex-opiate users (n=16) abstinent from illicit opiates for no more than one year. Participants were recruited from community support services (n=16) and residential units (n=7) in Edinburgh and Glasgow. The interviews took place in services and each interview lasted approximately 40 minutes. Informed consent for participation in the study was obtained prior to interview, as was agreement to recording. Participants were reimbursed for their time with a shopping voucher.

## *2.3 Data analysis*

The initial stage of the data analysis involved transcribing the interviews. Once the interviews were transcribed verbatim, the transcripts were imported into QSR NVivo 2.0 (a qualitative data analysis software package). The documents were then categorised into seven broad themes (or ‘parent’ nodes) based on the questions asked during interview.

- Service Experiences
- Social networks and help
- Drug consumption
- Health
- Future
- Marginalisation
- Life Circumstances

Within these broad thematic categories the texts were further coded into ‘child’ nodes[1]. This process allowed the research team to build a picture of the views and experiences of the study participants and facilitated the identification of common themes and perceptions among the participants. The qualitative data was entered into SPSS 17.0 and descriptive statistics were used to summarise the data.

[1] Tree nodes are organized into hierarchies, moving from a general category at the top (the parent node) to more specific categories (child nodes). See appendix ?

# 3. Findings

This section provides a descriptive analysis of the data collected from the interviews. The following sub-sections are divided into the seven main themes with further sub-categories.

## *3.1* Life Circumstances

### 3.1.1 Age

The sample comprised 23 participants aged 35 years and older. Seven females and 16 males were interviewed. The mean age of the sample was 42 years old (range 35 – 50). Nine participants were aged below 40: and 14 were aged 40 or over. Table 1 shows the sample breakdown by gender and age band.

**Table 1: Cross tabulation by gender and age band**

| | Age Bands | | | Total |
|---|---|---|---|---|
| | 35-39 | 40-44 | 45 and older | |
| MALE | 5 | 5 | 6 | 16 |
| FEMALE | 4 | 2 | 1 | 7 |
| **Total** | **9** | **7** | **7** | **23** |

### 3.1.2 Marital status and children

The marital status of the majority of participants was unmarried (n=17) although three were in a current relationship; four were divorced and two were married but separated.

Eight participants had children, including two with adult children. Of the six with younger children, only one respondent lived with their children (as a single parent); five participants stated their children were looked after by their grandparents or ex-partners. Six had regular contact with their children but two were estranged from their children with limited or no contact.

### 3.1.3 Educational Achievement

The majority of participants (n=12) had attained a higher level of education, by attending further education colleges or university. Five had completed secondary school; a further five had not. One respondent reported that he had been in 'List D schools' (no longer in existence) from the age of 11 to 17. Children residing in these schools were subject to compulsory measures of residential care as a result of vulnerability and/or offending behaviour.

### 3.1.4 Vocational training and employment

Almost half of the participants (n=11) had completed vocational/job training while three had started but not completed training. Nine had never started any type of training.

Although 11 participants had previous work experience, no respondent was in employment at time of interview. Sixteen participants described themselves as unemployed; seven described themselves as economically inactive due to disability. All participants were receiving government welfare benefits.

### 3.1.5 Criminal convictions and prison

Seventeen participants had previous criminal convictions. The majority (n=9) had 11 or more convictions. Eight males had 11 or more convictions, compared to one female.

**Table 2: Cross tabulation by sex, age band and number of convictions**

| SEX | | | NUMBER CONVICTIONS | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | | | 0 - 5 | 6 -10 | 11 - 15 | 16 - 20 | 20 OR MORE | |
| MALE | age bands | 35-39 | 0 | 1 | 1 | 0 | 1 | 3 |
| | | 40-44 | 2 | 1 | 0 | 0 | 1 | 4 |
| | | 45 and older | 0 | 0 | 2 | 1 | 2 | 5 |
| | Total | | 2 | 2 | 3 | 1 | 4 | 12 |
| FEMALE | age bands | 35-39 | 1 | | 1 | | | 2 |
| | | 40-44 | 2 | | 0 | | | 2 |
| | | 45 and older | 1 | | 0 | | | 1 |
| | Total | | 4 | | 1 | | | 5 |

Twelve participants have spent time in prison (11 males: 1 female). The average time spent in prison was 7 years (minimum 3 months: maximum 23 years).

### 3.1.6 Accommodation

The majority of participants were accommodated in their own tenancies (n=14); four were living in a residential rehabilitation unit; two lived in supported accommodation; two lived in their parents' house; and one in their partner's house.

Of the four participants in residential rehabilitation, three had been living in homeless hostels prior to entering the units; one had her own flat. All four were being provided with help to enter supported accommodation after completing their period in residential rehabilitation.

The majority of participants (n=19) lived alone; two males lived with their parents and two females lived with their children (n=1) and partner (n=1) respectively.

#### 3.1.6.1 Satisfaction with accommodation

Eleven participants were satisfied with their accommodation. Living in a relatively drug free area was the main factor contributing to high levels of satisfaction (n=6). Other factors included:

- Better area
- Chosen not to mix with other drug users
- Personal space
- Security of tenure

The participants felt they had some security over their accommodation, particularly when it was their own tenancy, the environment was 'safe' and it provided some stability in their lives:

> *"Love it, aye! It has given me that bit of stability back in my life which I need. Although I had been living in a temporary furnished flat for a couple of year before I got that one, it was still not my own tenancy. You didn't have the same; it didn't have nothing in writing saying this is yours… you didn't have the peace of mind basically, you know. So now this is mine's in writing. And if they want to put me out they have to start taking court action and stuff like that, so it is good and having the support there as well."*

The available professional support was important for the two participants living in supported accommodation. The support was available 24 hours per day with additional one-to-one support for one respondent and available 9am – 5 pm on weekdays for the other. It was important that help was available for problems as they arose, while having someone to simply talk to, if needed, was appreciated.

Dissatisfaction with accommodation was largely related to poor quality of housing and a poor physical environment; although for one respondent his desire to remove himself from the local drug scene was the underpinning reason for wanting to move away.

> *"Hate it, honestly. I don't want to be here, like. See when I was on the heroin there, I used to let people come in and have a smoke in ma house, or inject it if that's what they were doing, or whatever. Now that I don't allow them in to do it, they don't even come to see me, do you know what I mean, which suits me down to the ground anyway…"*

Six people mentioned their previous experiences of rough sleeping or living in homeless hostels. One former hostel resident noted how he found it difficult to get out of the routine of informing staff of his intentions.

> *"I am not in a routine yet see because I was 10 years in the hostels and on the streets. If you know the way the hostels worked, if you were not in for like some places it was 10 or 12 o'clock at night, you lost your room. So I am still in the habit of, like if I am going out, I go down to the office and say, 'That is me going out, I will be back at…' like whatever time. And they are like, 'You don't need to do that anymore.' And I am like 'But I have done that for the past 10 years' … you know what I mean? - it is like institutionalism basically."*

One female who had been resident in a hostel for a short period spoke about the difficulties of trying to stay drug free while living in a hostel environment:

> *"It was terrible in there so it was, you know; a lot of fighting and using. It was as if they* (the hostel management/staff) *had no control… I was in there 3 weeks. I was meant to be in longer, but just through the circumstances I couldn't have stayed there, because I began using and drinking. So it was pointless me being there when I was wanting to get clean. So that is when I went back to my care manager, and she is like that, 'No, you are not going back'. And she just ran me over to the Crisis Centre* (short-term residential crisis intervention unit), *which thank god they took me there and then."*

## *3.2 Social Networks and Marginalisation*

### 3.2.1 Social Networks

The participants were asked about their social networks – who they spent time with, what activities they engaged in and contact with their family.

Friends and family were the main social contacts. Friends were usually former drug users who were no longer using illegal drugs or people with no drug using history.

Fifteen participants spoke about reducing their contact with drug using peers. The main reason for staying away from other drug users (including opiate using siblings) and former associates was that the participants felt they were more vulnerable to relapse if in their company.

*"I can't afford to be hanging about with old associates. Nothing against them or that; it is just that I need to think about keeping myself safe."*

*"I hate to say this, but a lot of my pals are still on prescriptions and stabilised. They will still be my pals and that, but the friendship will probably be on a different level because I will need to think about my safety and my wellbeing and my future, you know. It is not that you are trying to be thingy, you know, it is just that you are looking out for yourself, but you need to change a lot and change your thinking."*

Five participants described themselves as 'reclusive'; four participants were currently refraining from heroin use (all were on a substitute prescription); therefore removing themselves from perceived risk situations was largely a safety mechanism to ensure they kept away from conditions that might encourage them to use drugs. However two current drug users spoke about how alcohol and drug use, and ageing had contributed to their 'drift away' from social contacts and friends.

*"I don't really hang about with anybody. To be honest with you, I keep myself; I am quite a private person. Beforehand I wasn't; I was quite out there in the drug world, but I've basically became introvert, as they say."*

*"The older I've got, the less I have tended to spend time with other users, you know. Like when I was younger, I had pals that we would use together, you know what I mean, and we would meet every morning and spend days together and go out shoplifting together. But the older I've got, I've tended to move away from that, because people have gone and done different things and lives have went in different paths, you know. You just become more self independent. You become more selfish, do you know what I mean. The older you get, the harder it gets to maintain a drug habit."*

Family relationships were mixed. While a number of participants had good relationships and support within their families, 10 participants spoke about being estranged from their family. The majority of breakdowns in family communications were due to the participants' problem drug use; one was due to a previous abusive relationship. However five of the participants reporting family breakdowns also reported familial problem drug and alcohol use. Three participants were actively trying to rebuild positive relations with family members. Rebuilding trust was an important factor in reconciling families for these three participants.

*"Takes a few years for things to change, but once it does sort of start to change then the trust starts to come back. It gets better and better."*

*"As soon as once I was clean, and I got my relationship built up with my sister really quickly, you know, I got trust back. Once I started* (at drug service), *in fact, and she knew I was going there… I think I got trust back with her really quickly, which was a good feeling. And it sort of built on that from there."*

Rebuilding relationships though can be difficult for some drug users, one woman spoke about her feelings of guilt when in contact with her mother.

Respondent: ***"****The only kind of contact I have got today is my mum and that is just by phone. I was through last Friday for a few hours, but I just felt I just didn't feel right being there."*

Interviewer: *"With your mum?"*

Respondent: *"Aye, because I just kept looking at her and seeing the pain, seeing what I have caused, you know. Through my addiction she has aged a lot, you know, and you can see the pain that is in her. I have got a lot of the guilt and shame and that, you know, so I tend not to go through because I hate experiencing that, because I come back feeling dead sad and feeling terrible within myself because of what I have done."*

Social activities among those in recovery included visiting family and friends, Narcotics Anonymous meetings, church and where possible activities with the participants' children. Five participants spoke about their 'spiritual' recovery with three being active church goers.

Further activities included voluntary work, college, attending community rehabilitation projects and working part-time.

For those participants still engaged in opiate use, their day-to-day activities centred on buying and taking drugs, and in one case engaging in criminal activities to finance their drug use.

### 3.2.2 Marginalisation

Marginalisation and isolation can be a problem as people get older, and for drug users who may already feel stigmatised and outside 'normal' society, such feelings can be exacerbated. The study team wanted to explore this notion of marginalisation among the sample of participants.

Five male participants stated that they did not feel isolated. All were abstinent, living in supported accommodation and engaged in daily activities. All stated they had felt isolated when they were using drugs but now they had stopped using, they felt less so. One respondent, speaking about his experience of being homeless, said:

> *"I feel important now, because out there I just didn't feel important, you know. I just thought basically I am living my life and nobody bothered with me. You know, I feel important in here, like I am doing chores and that in here like I never did outside, you know, like even working, going to college, things like that. I do feel important. I feel as if I can give something back to society, sort of thing, where out there I was just a statistic basically; a homeless one, another homeless person. Nobody is interested when you are homeless, you know."*

The seven current opiate users all expressed feelings of isolation. Coping strategies included using drugs (n=4), exercise (n=1) and sleeping (n=1). One female respondent who until recently was working, said she did not mind being on her own and described how being in employment gave her some structure and helped reduce her drug use:

> *"Yeah, I think it's better when I'm working. You don't seem to take as much drugs and stuff as well. Even got like a routine where you got to get up and got to work, and not like trying to run around to get drugs and stuff."*

Nine participants said their feelings of loneliness were a result of their own withdrawal from social activities and interactions. Some described their isolation as 'self inflicted'. Lack of motivation, confidence and low self-esteem were cited as possible reasons for periods of loneliness.

*"I find it hard asking for help, and I don't know if that is because I have been drinking and using drugs from I have been 12, and I have not got the ability. No, I haven't got the confidence or manner of self-esteem to just go out and then chap* (knock) *a door and then say, 'Listen, want to help me?' So I was a kind of loner."*

*"I think it was brought on by me because I put myself in the sort of isolation but because I knew I wasn't really good for people who wanted into my life you know people that cared about me."*

The interviews suggest then that there are a combination of forces that contribute to feelings of isolation and marginalisation: active withdrawal by the individual as well as feeling marginalised by others.

### 3.2.3 Emotional Security

The participants were asked 'How much do you feel cared about, liked or loved by the significant people in your life (such as family members, friends and so on?)'. Two participants said they did not feel loved or valued by their wider family although they did feel loved by their children. Most of the participants spoke about rebuilding relationships with family and friends following years of drug use. The majority (n=19) felt they were valued by their friends and family.

Professional support by drug/key workers was also mentioned as a source for feeling valued (n=4), although one person (quoted below) found the initial contact with support services somewhat demanding.

*"I know that there are a lot of people out there that are there to help me, and at one point in time there was so many people that it actually became pressurised that there was so many people out there that were trying to help me, that I felt like obligated to go to all of these meetings and things like this. And I just felt like, 'Christ, just gonnae leave me alone and let me get on with it!' I mean it was overkill. Now I am happy and contented I come and see* (worker) *once a week."*

*"I like to run before I can walk and* (worker) *seen this in me, and he took me basically under his wing kind of thing, and pushed me forward and that. It opened up another world to me."*

*"I was at* (Community rehab) *every day. I was interacting with them every day so they seen me you know from like 9 in the morning to 5 at night so I could relate more with the lassie that was my key worker at the rehab than I can do with my drug worker. I can seem to tell her things and open up…I built up a good relationship with her and a lot of trust."*

## *3. 3 Drug Consumption*

### 3.3.1 Experiences of Illicit drug use

Five males and two females were current heroin users at the time of interview (four were using heroin on top of their methadone prescriptions). Their ages ranged from 36 to 48 years.

Fourteen participants were on a substitute prescription at time of interview, with four participants topping up. Therefore 10 were on a substitute prescription only, and had been abstinent from illicit heroin use for periods of between three weeks and one year.

Six participants were completely drug free at time of interview (four were in residential rehabilitation and two were in community rehabs).

All participants had been or were polydrug users (alcohol, cocaine, crack cocaine, benzodiazepines, methadone, cannabis etc). Eight participants also mentioned previous problematic alcohol use.

All participants were asked about their drug use history. Across the full sample, the main drug of choice was heroin (n=22). The majority had injected (n=16) and used on a daily basis (n=18). The average weekly spend on heroin use was £162 (range £5 – 500).

The average age at which the participants first used heroin was 27 years (range 15 – 39). The average age at which they perceived that their use had become problematic was 28 years (range 15 – 43) and the average age at which participants started their first treatment episode was 33 years (range 18 – 48).

Table 3 shows that among this sample the older the respondent, the older the average age at which they first started using opiates. The older the age group the longer the period between first use and age at which participants first sought treatment: e.g. among the 35-39 year olds, the average length of time between first use and first treatment was 2 years compared to those aged 45 and older where the average length of time was 11 years.

**Table 3: Cross tabulation by age band and average age at first use of opiates, problem developed and start of first treatment episode**

| Age Bands | Average age first used opiates | Average age problem developed | Average age at first start treatment episode |
|---|---|---|---|
| 35 -39 (n=9) | 21 | 22 | 23 |
| 40-44 (n=7) | 24 | 29 | 35 |
| 45 and older (n=7) | 31 | 34 | 42 |

Participants stated there was a connection between the onset of opiate use and personal circumstances or significant events in their lives such as bereavement, stress/trauma, drug use within the family, prior alcohol/cocaine use and use whilst in prison.

Indeed two males spoke about their previous 'problematic' alcohol use which they gave up when they started using heroin in their late thirties.

Drug use within the family occurred among 10 participants. Two participants spoke about their parents' illicit drug use while a further three spoke about excessive alcohol use within the family. Five participants had opiate using siblings. The risk of relapse was cause enough for two participants to stop contact with siblings who were still engaged in opiate use.

#### 3.3.1.1 Experiences of abstinence from illicit drug use

Just one male (aged 41) - an active opiate user of five years had had no periods of abstinence from heroin. Twenty-two participants had attempted at least one episode of abstinence from heroin use; the average number of abstinence periods was two (range 1 – 6). The average age at first period of abstinence was 34 years (range 19 – 49), with an average abstinence period of 15 months across the drug using careers of all participants (range 1 – 60 months).

Table 4 shows the older the participants the later their first period of abstinence, although there is little difference in the length of time they are abstinent from heroin. The higher age of first abstinence period may be reflected by the later onset of drug use as most started using heroin in their late twenties and thirties.

**Table 4: Cross tabulation by age bands and average age first period of abstinence and average period of abstinence**

| Age Bands | Average age first period of abstinence | Average period of abstinence (months) |
|---|---|---|
| 35 -39 (n=9) | 27 | 14 |
| 40-44 (n=6) | 35 | 18 |
| 45 and older (n=7) | 42 | 14 |

#### 3.3.1.2 Reasons for abstinence

There were a number of factors that encouraged participants to abstain from illicit drug use: prison, difficulties injecting, stability and responsibility (e.g. new housing, children), absence of enjoyment and ageing.

Two male users aged 49 and 50 cited getting older as a reason for stopping opiate use.

*"I mean the feelings weren't the same anymore. I was existing. I mean I knew something had to be done drastically, especially with my age gap. There was a lot of factors… I was getting to the age now, 'Well, what are you going to do? Stick to taking drugs or embarrassing yourself more by taking drugs or just call it a day, you know what I mean, and be a bit graceful about it?' But, eh, so I decided to do something about it."*

*"I don't want to go back down that path again. I mean I'm too old as well. I believe that once you are over the 50 mark it starts to show a little, once the years add on so to speak, you know what I mean."*

### 3.3.2 Experiences of Substitute Prescribing

Fourteen participants were currently in a substitute prescribing programme: 11 were prescribed methadone with an average prescribed dose of 80mls (range 11 – 150mls). Three participants were prescribed Suboxone, Subutex and Dihydrocodeine respectively.

Four participants were using opiates on top of their prescription; three were on prescribed methadone (range 90 – 100mls) and one was prescribed Dihydrocodeine only.

The 11 participants had been on a methadone prescription between 17 years and one year, however there were periods of non-prescribing, for instance during periods in prison or detoxification.

The participants reported that substitute prescribing helped them to maintain some stability and structure in their lives, as well as enabling heroin-free episodes. However the less positive views on methadone prescribing focused primarily on the quality of the service they received from their prescribing and support service. For example six participants were dissatisfied with the lack of time given to counselling, or that they had no regular worker. There was a consistent view that clients go in to pick up a prescription with little or no time to talk to their worker/prescriber. Furthermore one respondent said that he felt he had no control over the dosage of his methadone – his desire to reduce his methadone dose was curtailed by his prescriber, who felt the respondent was not 'ready'. However the most negative factor ascribed to substitute prescribing was the daily pick-up from the chemist, in particular the danger of meeting other drug users and putting oneself in a vulnerable position (i.e. a situation which may lead to illicit drug use).

Two participants felt that methadone was substituting one addiction for another, and two people spoke about their 'fear' of withdrawal from methadone which they considered worse than heroin withdrawal. This 'fear' was predicated on witnessing a sibling's withdrawal from methadone in one case and through hearsay from other drug users in the other.

### 3.3.3 Drug Use in Future

The participants were asked what they thought their drug use would 'realistically' be like in five to ten years time and what would have to change in their lives for them to be drug free.

All but three stated they would want to be drug free; two participants said they could not answer the question and one thought he would be using in later life:

> *"If it keeps going the way it's going, I would like to think, I would like to get off drugs but at the back of my head as you get older I know, and this is going to sound so stupid I am gonnae go back on drugs again….Because in my mind there's not much more that life has to offer now, unless I was to win the pools and go away and travel the world or something like that, I've done what I wanted to do, I've had a good life so as I get older I certainly don't want to die of senile dementia or anybody wiping my arse or anything like that."*

While the remaining participants were clear they wanted to be drug free, there was a sense of 'realism'. Ten participants were 'hopeful' they would be off drugs suggesting a lack of certainty in maintaining a drug free life; nine had previously abstained and relapsed.

Participants' perception of what changes in their lives that would initiate or support being drug free were:

- being in some form of education or employment
- reducing off methadone prescription
- avoiding drug using friends/acquaintances/areas
- having coping strategies and some form of structure in their lives.

## *3. 4 Physical and Mental Health*

### 3.4.1 Physical health

Nine participants described their physical health as 'good'; three of whom were still using opiates. Five males engaged in exercise regimes and this was said to contribute to an improvement in their physical health.

Ten participants said they had chronic health problems that continued to 'interfere with their life.' Table 5 shows the main problems were blood borne viruses – notably hepatitis C, dental problems and respiratory problems. Almost half of the sample (n=11) had been diagnosed with hepatitis C, although only two participants were sure of their hepatitis B status.

**Table 5: Which of the following medical problems have you ever had or have now?**

| Physical Health problems | Ever | Now |
|---|---|---|
| Dental problems | 11 | **9** |
| Hepatitis B | 1 | **1** |
| Hepatitis C | 3 | **8** |
| Sexually transmitted disease | 1 | **0** |
| HIV | 0 | **1** |
| Respiratory problems | 2 | **7** |
| Heart diseases | 0 | **3** |
| Pelvic inflammatory disease | 0 | **1** |
| Deep Vein Thrombosis | 0 | **1** |
| Crohn's Disease | 0 | **1** |
| Epilepsy | 0 | **1** |
| Genetic Hypermobility | 0 | **1** |
| Psoriasis | 0 | **1** |
| Urology complaint | 0 | **1** |

Hepatitis C was contracted through shared injecting practices. One male was awaiting results from a liver function test. A second male was hoping to start treatment for hepatitis C in the near future.

*"I want to get my hepatitis dealt with the now while I am not in a full time job. I think this is the best period to get it dealt with while I am doing my volunteer work and stuff, and hopefully get it cleared before I hopefully start full time work… So I think the now is the best time, and I think that is why I decided to get it dealt with and approach the Hospital about it… I think that is the best thing… because it is like chemotherapy, as I understand it you know, and I don't think that will be conducive to working a full-time job. So that is why I am trying to get that sorted just now."*

However six of those with a current HCV+ diagnosis were not receiving any treatment. There was a degree of reluctance to embark on any course of treatment. One respondent felt his hepatitis was an inevitable outcome of his injecting drug use; he was diagnosed in 1997 but reported not being offered any treatment and had no interest in determining his current HCV status.

Another respondent had backed out of a course of treatment in order to deal with his drug use and another was reluctant to go into treatment because of the reported side-

effects of Interferon.

*"I'm a manic depressive, and the major side affect from interferon is depression, do you know what I mean. My liver nurse told me that it might not affect me the way it affects other people, do you know what I mean. But I could be walking about like a zombie for a year, and I don't fancy that at all. I know what depression's like, and the major side affect from interferon is depression, so it's going to make mine more than double I would say, least 5 times worse, and I don't fancy that at all. I don't need to take it if I don't want to."*

Fourteen participants spoke about their weight and diet. Eleven participants reported an improved diet and increasing their body weight. Two were concerned that they were underweight and one complained of loss of appetite and poor diet following treatment for hepatitis.

*"…before I had the treatment for hepatitis C I had a healthy appetite. Now I have got problems with my diet; I struggle to keep a healthy diet now, loss of appetite."*

Eleven participants had been offered advice on diet and nutrition; six of whom were diagnosed with hepatitis C. All stated they had benefited from the advice and found it useful, particularly information on supplements and vitamins and advice on budgeting. Among the 12 not offered advice, eight said they would benefit from advice and information on their diet.

### 3.4.2 Mental health

The most common mental health problem was depression, with all participants reporting depression either 'ever' or 'now'. Nervous disability (such as anxiety and panic attacks) was reported by the majority of participants with almost half reporting it currently.

**Table 6: Which, if any, of the following mental health problems have you ever had or have now?**

| | ever | **now** |
|---|---|---|
| Depression | 11 | **12** |
| Nervous Disability | 8 | **11** |
| Suicidal Ideation | 10 | **3** |
| Schizophrenia | 2 | **0** |
| Bipolar disorder | 0 | **1** |

One respondent spoke about using alcohol as a coping strategy for his depression. One respondent was accessing a local community based organisation set up to help people with mental health issues. This respondent was also challenging previous professional opinion:

> *"My biggest problem is my mental health you know but that is just par for the course and I think as well see because I have seen that many professional people like psychologists and psychiatrists over the years and they have always said 'we believe you might always suffer from mental health issues' and I think when I hear that from a professional person I tend to become susceptible and believe it. But see now that I have been going to this place* (Community mental health project) *they challenge me on everything and they are like 'no we don't believe that, we believe that you can change' so I am starting to believe that myself."*

Further challenges to conventional pharmacological treatments for depression and anxiety were expressed by another five participants through their unwillingness to be prescribed anti-depressants. Four of the participants wanted to try other therapies, such as counselling rather than accepting anti-depressants and one person did not want get into the 'cycle' of drug use (they were currently abstinent from all drugs).

Suicidal ideation had been experienced by 13 participants at some time (either currently or in the past). Over half the participants (n=13) had overdosed in the past; as recently as four months and up to ten years ago. This is a concern given the high number of drug deaths in Scotland

Nine people, abstinent from illicit drug use, described having 'good' mental health. Reasons for improvements included abstaining from illicit drug use, coming off anti-depressants or methadone, and engaging in exercise.

### *3.5 Service Experiences*

The participants were in contact with a range of medical and community support services. Table 7 shows the range of opinions and experiences that the participants expressed regarding access to support and medical services.

**Table 7: Participants' experiences of accessing medical and support services**

| **Positive experiences** |
|---|
| Substitute prescribing:<br>• Stability/structure<br>• Opens doors to other services/supports |
| Chemist - weekly pick up |
| Trusting relationship with worker/GP |
| Time for counselling/discussion |
| Urine testing – provides discipline/encouragement |
| Given Treatment options/choice |
| |
| **Negative experiences** |
| General Practitioner (GPs):<br>• Lack of control (prescribing)<br>Stigma (medical profession) |
| Chemist – daily pick up – stigma |
| Lack resources |
| Lack of information on available supports |
| Lack of sustained contact with the same worker |
| Lack time for counselling/discussion with GPs or workers |
| More help provided if in crisis |

The experiences and views that were discussed focused mainly on operational issues such as substitute prescribing, relationships with workers and GPs, and resource and information provision.

Eleven participants were prescribed methadone. Methadone prescribing was seen as beneficial in terms of providing an opportunity for stability and structure. Furthermore engaging with prescribing services had opened up access to other support services such as community rehabilitation services. Nevertheless a few participants said they were apprehensive about reducing or coming off their prescriptions in case they relapsed whilst some participants considered their prescribed treatment as prolonging their 'addiction.'

*“Even though you are not topping up and that you know there is something in my head that still says ‘I am an addict’, do you know what I mean? I am still addicted to methadone you know and I just never got that contentedness you know that you get when you are totally abstinent and clean.”*

Other less positive aspects of prescribing were a perceived lack of control over certain aspects of their treatment such as controlling dosage levels or choice of substitute drug. Nevertheless four participants who did have some choice over their treatment reported good relationships with their workers and prescribing GP.

Five participants considered urine testing (in the context of a maintenance prescription regime) helpful in encouraging and sustaining abstinence. In all five cases testing was a motivating factor to stay clean. Although all admitted to providing positive urine tests at points in their treatment, once they had established a number of negative or ‘clean’ tests workers provided encouragement and in a few cases rewarded this positive behaviour with weekly take-home prescriptions and assistance in accessing residential rehabilitation.

*“You had to do the toilet in front of the nurses, and once you started giving them a few clean urines, I started to feel better for it, you know, because they were encouraging me and that, you know. So I ended up giving clean urines all the time, and then they started going on about the drink, ‘You can’t drink, you can’t go for Methadone when you are intoxicated.’ So I stopped the drinking as well, and that is when everything started falling into place and it just all sort of came together for me.”*

A minority of participants felt there was an element of stigmatisation by some of the medical professionals. Primarily some participants felt that GPs were quick to judge them on the behaviour of ‘other’ addicts rather than treating them as individuals. A few participants were reluctant to disclose other health problems to their prescribers in case this was perceived as a ploy to get further prescriptions.

*“I suppose I am afraid to go to the doctors and all that and tell the doctor how I am feeling. I don’t sleep too well, you know, with worry and all that and I don’t want to tell the doctor in case he thinks I am looking for drugs just because of my history, do you know what I mean.”*

Further perceptions of stigmatising were apparent from those who were on a daily prescription picked up from the chemists. This perception was exacerbated by lack of privacy within participants’ local pharmacies, and as such, the participants felt they were being judged negatively by other customers.

*"That was a big thing for me going to the chemist. I used to hate it because I thought they were looking down at you at times. You know, maybe standing in a queue and everybody is all looking at you getting your methadone you know. It's horrible."*

Continuity of care and support were a common theme among the participants. Participants spoke about having numerous workers; for example, a few participants did not have one regular worker but might have seen several workers over a relatively short period and as such were not able to build any meaningful relationship. Conversely, participants who were able to build a client/worker relationship based on 'trust' and 'honesty' were satisfied with the support they received. Likewise, having regular contact and 'time' to discuss problems or issues with a worker was regarded positively:

*"It was good to have someone to talk to…you can sit and talk to a counsellor or even a drug worker. And they came to the house as well which was a good thing because I was starting to get that I didn't want to go out unless I had something you know."*

Other issues related to difficulties in accessing information on support services and treatment options and funding for residential rehabilitation. Four participants thought that their request for residential treatment was deferred or refused because they were not seen as being in greatest need, despite their own assessment of need.

*"I have been at college and you sort of have to justify why you need the funding you know and it is like I have had to fight for it and I am now getting it. But sometimes the more chaotic you are the easier it is to get help."*

In their own assessment, at the time of interview, participants said they had unmet need for alcohol and opiate detoxification, residential rehabilitation, psychiatric services, counselling and general support services.

## *3.6 Future*

In relation to the future, the participants were asked for their thoughts on services for older drug users including residential care for the elderly, and their aspirations for the future.

### 3.6.1 Services for older drug users

None of the participants were aware of support services specifically designed for older drug users, although they were aware of programmes for younger users.

The participants were asked 'what services do you think are needed for older drug users?' A range of support services was suggested by the participants.

Nine participants thought there should be age specific programmes designed to support older drug users. The participants spoke about the different attitudes and behaviours of younger clients which could be a disincentive to older users accessing the same services. Older drug users often eschewed the company of younger drug users, who they saw as tending still to have a fascination with the sub-culture of drug use, often glamorizing or exaggerating the realities; older drug users tended to be more firmly focused on leaving that experience behind. Moreover the younger clients were more likely to group together leaving the older participants somewhat isolated from the group as a whole. In addition it was thought that older users often have less social supports than younger users, and as such their needs were different.

A few participants also spoke about the embarrassment they experienced in approaching services as older drug users. One respondent also felt older drug workers would be beneficial, as they have more experience than the younger workers.

*"Younger folk have maybe got like more support from parents and family members. But you know by the time you have got older, maybe through the years because of all the stuff that has gone on, maybe they have lost contact with family members. And so they are on their own pretty much a lot of them, do you know, and they don't have that. I think they need more services, for you know, that work with them individually."*

*"I thought that once you hit like 40 that is it, you don't get a chance at treatment. That is what I thought, but it is not true. There is help out there, you know, but if people don't know where to go or how to get help because I didn't know. It was people that showed me there is help there you know."*

*"Older drug workers, because I am fed up of going in and talking to 23-year old boys, you know what I mean. And I know they kind of mean well, but some of them are young, you know, and it is quite difficult. I am not going to sit and lie, it is alright talking to someone kind of ages with myself or just a wee bit younger. But when you are talking to someone just kind of straight out of college or they are on a placement and they are dead enthusiastic about the job, but they are trying to tell you how to boil eggs and you are trying to be nice about it."*

The types of support services that were perceived as meeting the needs of older drug users were community rehabilitation centres that focused on counselling, confidence building, improving self-esteem and programmes designed to develop existing and/or vocational skills. Residential rehabilitation and detoxification centres for older drug users were also mentioned.

Two participants thought that long-term drug users who were likely to continue using opiates should be prescribed heroin. Both noted the damage that may be caused by contaminants in street heroin and prescribed heroin would eliminate the problems (such as injecting site wounds) that occur through street bought heroin. Furthermore they thought that prescribed heroin could assist in improving health, finances and reducing criminal behaviours.

*"I think prescribing them legal heroin is the best; it takes out all the shit. I mean, see the biggest problem, abscesses and all the sores that go along with it aren't caused by the heroin, it's all the shit that is cut through it. And say if someone is like 50 years old and they have been using from they were 14 or 15, and they have got to 50 year old, it is like they are maybe never going to get clean… Their life will get better to a degree, in the sense that they have got a wee bit more money, you know, so they can eat healthier. They do not have to buy heroin, so it is cutting away the crime factor, you know what I mean. And I think that would probably be the best answer."*

*"The older ones again, I would say it would have to be, give them clean heroin. And if they are going to stay on it, and an older person probably knows what they want in life, then what else can you do? He's probably happy that way, and he's not going to go rock climbing and canoeing and blah, blah, blah. He just wants to be comfortably numb, for the want of a better word, and he is no dumb. People are on heroin for some reason."*

Two participants thought no age specific programmes were required:

*"I think the services pretty much cater for most ages you know. I can't see why you would need something specific for older drug users."*

*"What they need is mostly out there for them. Everything has been put in place I think that needs to be, like needle exchanges, people on their prescriptions."*

The majority (n= 16) of participants held negative views in relation to elderly residential homes for older drug users. Most could not 'imagine' living in a residential care home with people who have no experience of illicit drug use. A small number of people found the idea of living in a residential home 'scary' (n=2) or worried that they would become a burden for their family (n=2) and have to live in a residential home. Two participants said they would consider euthanasia rather than live in an elderly care home. A few (n=4) people had experience of elderly care homes, through previous work or visiting relatives; the experiences were not positive endorsements for this type of care.

Three males though were quite positive about the possibility of living in an elderly care home. Two were living in supported accommodation and all had spent time in prison (average time in prison 7 years).

The participants were asked what they thought might be the practical difficulties of having a mixed elderly care home for illicit drug users and non-drug users. Twelve participants envisaged a number of problems with this scenario, including confidentiality issues, staff competencies and continuing heroin use.

However the most frequent difficulty cited was the possible stigmatising of elderly drug users. Nine participants spoke about the cultural and social gaps between non-drug users and illicit drug users. Participants spoke about non-users having led '*productive'* lives compare to illicit drug users, and that this could be a source of friction. Three people suggested separate accommodation for elderly illicit drug users would be necessary to avoid any stigmatisation of residents.

*"I think people's attitudes and belief systems that they have had all their lives are not going to change just because the circumstance that they are in has changed. Some people are going to stigmatise others and some people stigmatise themselves. See I could see people, with those kinds of problems - potentially myself - being marginalised from a lot of homes because they don't want 'the kind of elderly that are hard to place' kind of thing… and the not-in-my-backyard crowd of 'we don't want these geriatric junkies bugging our kids'."*

Five participants thought there would be no difficulties in mixed residential homes due to the effects of ageing and the likelihood that most residents would be on some form of medication anyway. However two participants noted that extra care may be required for drug users who may have health problems such as hepatitis or other diseases and conditions that may have arisen as a consequence of their drug use.

*"I think society has got an obligation no matter what you have done in your life to change the way you feel, it doesn't mean to say you don't deserve to be cared for or looked after."*

### 3.6.2 Aspirations

The participants' aspirations in the short term (5 – 10 years) were similar to their long-term goals. The table below shows that in terms of practical goals, the majority hoped to be in employment; five participants wanted to use their own experiences to go into some type of addiction work while four wanted to work in the care sector though not necessarily in the drugs field. Having a stable home environment, entering some form of education or training and becoming drug free were further desired goals. Reconciliation with family members was also an important goal for a significant minority – particularly for four females and two males who were currently estranged from their children.

**Table 8: Respondents' aspirations for the future**

| Aspirations | N |
|---|---|
| Job | 16 |
| Drug free | 9 |
| House | 7 |
| Familial reconciliation | 7 |
| Normality | 6 |
| Education | 5 |
| Partner/relationship | 5 |
| Member of society | 2 |
| Creative work | 2 |
| Travel | 2 |

In addition to stating their practical aspirations a small number of people also spoke about their social aspirations such as their hopes of building a relationship with someone and gaining a partner to share their life with. Participants also spoke their hopes to be 'contented' and 'happy', and living a 'normal' life.

*"I would just like to get a job and all that and just be like a normal person, but certain months of the year take a break, take a holiday and that. Just like to be living like the same mundane existence that eight tenths of the population are living."*

*"I want just a life that I can be normal and just have the nice things you know like a house, a job, a bit of money and my family."*

*"I would like to try working somewhere you know now that I have been you know straight. Because I have never really experienced anything and the last 25 year I've just been abusive to myself so maybe I suppose do something, work, see how the other side live."*

# 4. Main Findings

The findings from this qualitative study raise a number of important issues concerning the current and future needs of older problem drug users. While it is acknowledged that this study does not represent all problem drug users, for example those that are not in contact with services, the findings do add to the growing evidence base regarding older drug users in the UK and indicate a need for policy and service development to address the issues raised by this study.

The sample of respondents was predominately single; living alone and in their own tenancies. Only six were completely abstinent from all illicit and prescribed drugs; fourteen were on a substitute prescription; and seven were current heroin users (four were topping up their methadone prescriptions). Most had some form of qualification, either through education or vocational training. Nevertheless all were unemployed at time of interview and the relatively high rate of criminal convictions is likely to make mainstream employment difficult to achieve for this group.

## *4.1 Accommodation*

Older drug users understand that satisfactory housing is important in stabilising older drug users' lives and sustaining or achieving abstinence from illicit drugs. The appropriateness and quality of housing is important but importantly so, too, is location. Respondents thought it important not to be housed in areas where previous drug use has happened or where there are high levels of drug use. Accessing appropriate accommodation has a potential impact on both positive and negative social networks.

## *4.2 Social networks and isolation*

Older drug users understand the importance of social networks and are even willing to break familial ties to maintain their drug-using or drug-free state. A change from a period of drug use to a period of non drug use (or vice versa) involves a change in social and often family networks. In either transition this can be a long term process and can involve painful loss of previous social networks, and promote isolation. The majority of respondents were in the process, or already had, reduced contact with their former drug using associate and this was in large part, a self-imposed safety mechanism against further relapse.

For those with long drug careers these transitions can be more difficult, particularly where familial ties have broken down or relationships have become strained. Rebuilding 'trust' with parents, siblings and children was paramount to reconciliation suggesting perhaps a need for family mediation.

Isolation while using illicit drugs was common and was largely self-imposed and exacerbated by lack of motivation, confidence and low self-esteem; although the stigmatisation of drug users by wider society was also a contributing factor.

## *4.3 Relationships*

The motivation for older people's continuing drug use may be quite different from that of younger users who use as part of a 'scene' which may offer excitement and an alternative lifestyle. Older problem drug users who have 'been there, done that' may continue using drugs as a way of coping with increasing isolation, particularly as relationships break down and perceived or actual feelings of marginality/isolation increase. Consequently, relationships between client and workers are, in general, more likely to be more significant than with younger drug users. The study findings suggest relationships between workers and clients can be crucial in rebuilding confidence and self esteem. For some clients these may be the most significant relationships in their lives. Services should be designed bearing in mind the importance of these relationships, the boundaries involved, and with a view to developing supportive but not dependent relationships between staff and clients.

## *4.4 Employability*

Employment while still using drugs can be a way of reducing or controlling drug use and improving social networks. Employability, training and job seeking should not necessarily be seen as an activity that services offer only to people who are drug free or stabilised on methadone. The idea of therapeutic work should be considered by treatment agencies. However it is acknowledged that this process is complicated by previous criminal convictions and the reluctance of some employers to engage with, and offer employment to drug users within the formal economy.

## *4.5 Illicit drug use*

In relation to this sample's drug using histories, the demarcation between abstinence and drug using should perhaps be viewed as a snapshot of current state rather than anything more permanent or as a fixed status. It would be remiss to think of older drug users as a group of hard core drug users who will never be abstinent but as shown, abstinence is periodic and dependant on a number of factors.

The motivations for starting a period of abstinence, both from all drugs (including substitute medication) and illicit drugs are external and internal. Abstinence can be based on new external opportunities like housing, employment or relationships. Some will give up drugs when the effect of the drug or the lifestyle that surrounds it is no longer enjoyable. Ageing itself is a factor in the perception of what is enjoyable therefore some may 'mature out' of drug use (Prins, 2008). It is likely then that

motivation for addressing drug use may be increased in an ageing population by opening up discussions on what enjoyment can be derived from drug use (Hammersley).

Previous experience of cycles of drug use and abstinence was used as a predictor of future behaviour among the study's respondents. The majority of respondents hoped to be drug free in future although many had previous periods of abstinence followed by relapse and as such were aware of the possibility of continued opiate use in the future. In this sense, older drug users have a realistic picture of what dependent opiate use is like. They also have a clear insight into what factors would support and prolong periods of abstinence. We should not think of older drug users, therefore, as a hard core of drug users who lack the insight to understand their own drug using histories and behaviours.

## *4.6 Substitute prescribing*

Substitute prescribing although considered by some to prolong their dependence was also viewed as beneficial in terms of providing stability and structure; and crucial in accessing other support services. Nevertheless, a perceived lack of control over choice of substitute drugs or dosage was viewed negatively. It is worth considering that older, long-term drug users will often have experience of reducing from drugs (as seen by the multiple periods of abstinence) therefore it raises the question as to whether prescribers should take into account these prior experiences and self-knowledge of drug users prescribing histories. While not suggesting older drug users should have carte blanche to control their prescribing regime it is worth considering the previous successes and failures of each individual patient. Furthermore where respondents were given some choice over their treatment, better relationships with drug workers and GPs were reported, thus helping maintain motivation to remain free from opiate use.

## *4.7 Physical health*

As noted, continued drug use and the effects of ageing have a negative effect on physical and mental health and this was apparent among this sample of older users. Similar to Beynon et al's recent study, the participants reported high levels of physical morbidity which continued to 'interfere' with their lives (Beynon et al, 2009). While self reported physical health status is a poor indicator of actual health; blood borne viruses, respiratory and dental health problems were common among this group. Importantly, uptake of Hepatitis C treatment was poor. Three-quarters of participants with a hepatitis C diagnosis were not in treatment, although this was an outcome of the perceived negative effects of treatment on individuals' mental health, and as such respondents were making a conscious decision to forgo treatment.

While approximately one in 240 of Scotland's population had been diagnosed hepatitis C antibody-positive by March 2009, it is estimated that the number of undiagnosed hepatitis C antibody-positive cases in Scotland still exceeds the number of diagnosed cases and that this figure could be as high as 50,000 (1% of the population) (HPA, 2008). It has been estimated that approximately 20% of chronically infected individuals had ever been in specialist care and only 5% had received a course of antiviral therapy (HPA, 2008). The Royal College of Physician's of Edinburgh's Consensus Conference on Hepatitis C recommended *"a high priority for case finding should be given to former injecting drug users, especially those over 40, who are likely to have a stage of disease which would benefit from treatment' (2004).*

## *4.8 Mental health*

Mental health issues were very common among this group. The ambiguity of drug deaths being a result of accidental overdose or suicide through overdose is a concern in Scotland where the rates of drug deaths and suicide are very high relative to other countries in Europe. The rate of suicidal ideation in this sample was noteworthy and merits further investigation. However an interesting finding was the reluctance to accept pharmacological interventions for mental health problems, such as depression and anxiety. Respondents were interested in pursuing other therapies such as counselling, and viewed antidepressants as prolonging their drug use. Given that anti-depressants (such as benzodiazepines) are commonly used as drugs of abuse, it is not surprising that people who wish to maintain abstinence from illicit drug use are reluctant to be prescribed these drugs. There was a clear desire for other therapeutic interventions such as counselling to help deal with mental health problems. Indeed, improved mental health was attributed to abstinence from illicit drugs, anti-depressants and methadone; and for some, engaging in exercise.

## *4.9 Diet and nutrition*

Health improvement activity through physical exercise was an indicator of more generally improved health although poor diet remained an issue for some. Suboptimal diet and nutrition may be reflective of poverty or a lack of education or experience in self-care. Nevertheless where dietary and nutritional advice had been offered the information was beneficial; where it had not been provided, there was a demand for such information.

## *4.10 Stigma*

A common theme in many studies is the perceived or actual stigmatising of drug users across all ages, and this sample was no different. Relationships between GPs and patients are important but there was reluctance for respondents to disclose health problems to their doctor in case they were seen as a ploy to obtain further drugs. Delays in reporting poor health may exacerbate physical and mental health problems in older drug users. Therefore improved screening for general health among older drug users should be considered a routine procedure.

## *4.11 Continuity of care*

Notably, continuity of care and support was perceived as contributing to better outcomes. As already mentioned, older users may have considerably reduced social networks and the client/worker relationship may be, for some, an important motivational factor in reducing harmful drug use or maintaining abstinence.

## *4.12 Future services*

In relation to current and future services for older drug users a substantial minority thought there should be age-specific programmes for older users. Some felt that the generation gap between clients in services was a possible disincentive to older users accessing support. Although a number of treatments and supports were cited (e.g. community and residential rehabilitation), these are already available, so this was less about developing new types of service but rather about ensuring older users feel comfortable accessing these supports without feeling embarrassed or stigmatised because they are older. Because many older users are marginalised, the respondents thought that support should focus on improving self-esteem and confidence building, and developing existing skills, such as those gained through previous employment or training.

Finally it was clear that the respondents were motivated to achieve what some termed a 'normal' life. There were no aspirations for unobtainable or unrealistic goals; respondents desired the same aspirations as the majority of the population – to lead a drug free and productive life, gain employment, rebuild and maintain stable relationships and access stable housing in environments where they felt safe and could progress without fear of relapse.

### *4.13 Conclusion*

This study has provided further evidence for the development of policies relating to the ageing drug using population and to highlight some of the issues concerning this particular cohort of problem drug users. While some of the issues raised are apparent across all age groups, the findings do provide some insight in to the current and future needs of the older drug user. Further research that compares the life course histories of older drug users and the worker-client relationship would be beneficial and may help further to identify best practice in relation to this group.

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# Appendix 1: Interview Guide

**Qualitative Interview Schedule**

**1. <u>Starter</u>**

- Could you please describe your present accommodation? e.g. where do you live, what's the area like?

***Prompts*:**

- How satisfied are you with your present accommodation?
- *(Ask If living with others)* What about the other people you live with – do they use drugs, how do they feel about your drug use?

**2. <u>Social networks and help</u>**

- We would like to know more about the social contacts you have? With whom do you normally spent your time with and How do you normally spend your time?

- What about your parents, brothers & sisters and relatives? Are you in contact with them? Please describe the contact? Is it good contact or not?

***Prompts*:**

- How would you describe the contact to your family?
- What do you do when you are together with your family?
- How would you describe your satisfaction with your family?

- Do you have friends and buddies you spend a lot of time with? What do you do when you meet with them?

***Prompts*:**

- Are your friends the same age as you are?
- Do they use drugs as well?
- Do you meet with them frequently?
- What do you do when you are together with your friends?
- How would you describe your satisfaction with your friends?

- How much do you feel cared about, liked or loved by the significant people in your life (such as family members, friends, and so on)?

- Are there times when you feel isolated?

***Prompts*:**

- How do you deal with loneliness?
- Do you feel you need more emotional support?

### 3. Current drug consumption

***NB: If the respondent is on a substitute prescribing programme ask the following***

- Do you currently attend a substitution programme or do you receive your substitute from a medical practitioner?

***Prompts***

  - Are you satisfied your substitution treatment? E.g. what is good and what is not so good?

- Could you please tell me your consumption patterns?

- Do you share or do you use clean needles every time?

- What do you think your drug use will be like in 5 to 10 years?

***Prompts***

- Realistically, what would you like your drug use to be like in 10 years time?
- What would have to change in your life for you to be drug free in 10 years time?

### 4 Health

- Can you please describe your health situation?

***Prompt***

- How do you cope with your physical health problems?
- How do you deal with your mental health problems?

- What kind of Drug Services do you use?

- Do you use other medical services?

***Prompt***

  - And how satisfied are you with doctors, nurses and other health care personnel?
  - Do you get enough emotional support?

### 5. Future

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

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

- If you think forward to the future, how would you like to live in 5 to 10 years?

- Thinking further forward, say 20 or 30 years time - Can you imagine living in a residential home for the elderly with people who have no experiences with illicit drugs?

***Prompt***:

- o What do you think might be the practical difficulties of having an elderly residential home where drug users and non-drug users live together?

- ➢ If you think forward to the future, is there anything you would like to do, some kind of wish or dream? Something that you ever wanted to do but never did it? Tell me about your dreams for the future.

**Thank you!**

**Part 2. Quantitative Survey**

**Year of birth** |_1_|_9_|__|__|

**Sex** ❍ male
❍ female

**3. Nationality**

❍ UK national
❍ National with migrant background
❍ EU national
❍ National of another country

**4. What's your marital status?**

❍ Single
❍ Married
❍ Married but separated
❍ Divorced
❍ Widowed

**5. What's your accommodation type?**

❍ Own apartment/house
❍ In apartment/house of other person(s)
❍ Assisted living
❍ Residential home / rehab
❍ Emergency shelter/hostel
❍ other: ………………………..

**6. What's your living status (with whom)?** Please mark only **one** answer.

- ❍ Alone
- ❍ With parents
- ❍ Alone with child/children
- ❍ With partner (alone)
- ❍ With partner and child(ren)
- ❍ With friends
- ❍ other: ………………………..

**6. What's you highest level of education?**
Please mark the **highest** level completed.

- ❍ 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's your employment status?**

- ❍ Regular employment
  - ❍ Full time ❍ Part time
- ❍ Unemployed
- ❍ Economically inactive (pension, housewives-/men),
- ❍ Economically inactive (Disabled/unfit for work)
- ❍ Other………………………………………

**9. What's your principal source of income?** Please mark only **one** answer

- ❍ Earned income – legal
- ❍ Earned income – illegal
- ❍ Unemployment pay
- ❍ Welfare benefits
- ❍ Pension
- ❍ Other: ………………………..

**11a. Have you ever been convicted for any offences (lifetime)?**

❍ No
❍ Yes: If yes, how often? ❍ 0-5,
❍ 6-10
❍ 11-15
❍ 16 -20
❍ 20 or more

**11b. Have you ever been in prison (lifetime)?**

❍ No
❍ Yes: year of last time: ___

**11c. If yes, what's your total time spent in prison (lifetime)?**

_____ Years and ______ months

**13. Are you in a substitution programme?**

❍ No ❍ Yes

| Substance | Prescribed since | Daily dose |
|---|---|---|
| ❍ Methadone | | |
| ❍ Buprenorphine | | |
| ❍ Polamidone | | |
| ❍ Codein | | |
| ❍ Heroin | | |

**14a. Are you currently using any illicit drugs?**

- No
- Yes If yes, Main drug of Choice ____________________

**14b. Use of illicit and non-prescribed drugs**

| Substance | Current Consumption | | | Route of administration 1=sniff 2=smoke 3=inject 4=oral | Weekly costs approx. | Age at first use | Age Problem developed | Age at start of first treatment episode |
|---|---|---|---|---|---|---|---|---|
| | daily | weekly | seldom | | | | | |
| Cannabis | ❍ | ❍ | ❍ | | | | | |
| Heroin | ❍ | ❍ | ❍ | | | | | |
| Methadone | ❍ | ❍ | ❍ | | | | | |
| Other (specify) | | | | | | | | |

**14c. Have you had any period of abstinence from illicit drugs**

- o No
- o Yes

| Abstinence Episodes | At what age | How long abstinent |
|---|---|---|
| | | |
| Episode 1 | | |
| Episode 2 | | |
| Episode 3 | | |
| Further episodes: | | |

**15. Do you have any chronic medical problems which continue to interfere with your life?**

❍ no
❍ yes

**16. Which of the following medical problems have you ever had or have now?**

| | **ever** | **now** |
|---|---|---|
| Dental problems | | |
| Hepatitis B | | |
| Hepatitis C | | |
| Venereal diseases | | |
| HIV | | |
| Tuberculosis | | |
| Other lung problems | | |
| Pelvic inflammatory disease | | |
| Heart diseases | | |
| Kidney diseases | | |
| Diabetes | | |
| Cancer | | |
| Others (specify) | | |

**17a. Which, if any, of the following mental health problems have you ever had or have now?**

| | **ever** | **now** |
|---|---|---|
| Depression | | |
| Bipolar disorder | | |
| Schizophrenia | | |
| Nervous Disability | | |
| Suicidal Ideation | | |
| Others (specify) | | |

**18a. Have you ever overdose on opiates?**

❍No
❍Yes

**18b. When did you last overdose?_________________________**

**19a. Have you been asked about your diet while attending drug/alcohol services?**

❍No
❍Yes

**19b. Have you been offered advice or information about diet and nutrition?**

❍No **If no, would you benefit from information and advice? -__________________**

❍Yes **If yes, who offered you the information/advice? _-___________________**

**Was the information/advice useful? _________________________**