

# Older People with Drug Problems in Scotland:

## Addressing the needs of an ageing population



The Expert Working Group on Older People  
with a Drug Problem





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**Final Report**

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- The 123 older people with a drug problem who gave their valuable insights.
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## List of Abbreviations

ADP:	Alcohol and Drug Partnership
BBV:	Blood Borne Virus
DRD:	Drug Related Death
DTTO:	Drug Treatment and Testing Order
DVT/PE:	Deep Vein Thrombosis
EMCDDA:	European Monitoring Centre for Drugs and Drug Addiction
HAT:	Heroin Assisted Treatment
HCV:	Hepatitis C Virus
IJB:	Integrated Joint Board
ISD:	Information Services Division
OPDP:	Older people with drug problems
ORT:	Opiate Replacement Treatment
PADS:	Partnership for Action on Drugs in Scotland
PDP:	People with a drug problem
SDF:	Scottish Drugs Forum

# Contents

<b>1</b>	<b>Overview</b>	<b>5</b>
<b>2</b>	<b>Policy Context of the Report</b>	<b>7</b>
<b>3</b>	<b>Working Group and Terms of Reference</b>	<b>7</b>
<b>4</b>	<b>Methodology</b>	<b>8</b>
4.1	Data linkage	8
4.2	Literature review	8
4.3	Empirical research with OPDP	8
4.4	Survey of service professionals	9
4.5	Stakeholder consultation day	9
<b>5</b>	<b>Summary of Key Findings and Recommendations</b>	<b>10</b>
5.1	Scale of the problem	10
5.2	Multiple health conditions	11
5.3	Mental health and isolation	13
5.4	Overdose deaths	14
5.5	The role of specialist addiction services	14
5.6	Gender issues	15
5.7	Stigma: staff training and development issues	16
5.8	Wider aspects of support: employment, finance, housing and care	16
5.9	Future planning	17
5.10	Resources	18
<b>6</b>	<b>Current Prevalence and Trends of Older People with Drug Problems</b>	<b>19</b>
<b>7</b>	<b>Present and Estimated Future Health and Social Care Needs of OPDP</b>	<b>24</b>
7.1	Population estimates	24
7.2	Hospital admissions	25
7.3	Future health and social care needs	32
<b>8</b>	<b>Commissioned Literature Review</b>	<b>34</b>
<b>9</b>	<b>Online Survey of Service Professionals in Scotland</b>	<b>36</b>
<b>10</b>	<b>Older People with Drug Problems in Scotland: A Mixed Methods Study Exploring Health and Social Support Needs</b>	<b>41</b>
<b>11</b>	<b>Key Issues</b>	<b>45</b>
11.1	Mental health	45
11.2	Physical health and multi-morbidity	46
11.2.1	Respiratory disease	48

11.2.2	Pain management.....	48
11.2.3	Hepatitis C, other blood borne viruses (BBVs) and liver damage .....	49
11.2.4	Diet and nutrition.....	50
11.2.5	Oral and dental health.....	50
11.3	Isolation, stigma and discrimination .....	50
11.4	Family .....	52
11.5	Sub-populations .....	52
11.5.1	Gender.....	52
11.5.2	Late onset drug users .....	53
11.6	Opioid Replacement Therapy (ORT).....	54
11.7	Pressure to withdraw from ORT .....	54
11.8	Financial issues .....	55
11.9	Housing and care homes .....	56
11.10	Criminality and criminal justice issues .....	58
11.11	Recovery, quality of life and relapse .....	58
11.12	Employment, education and volunteering .....	60
11.13	Developing practice.....	60
<b>12</b>	<b>Summary and Conclusions .....</b>	<b>62</b>
<b>13</b>	<b>Membership of Working Group.....</b>	<b>63</b>
	<b>References .....</b>	<b>64</b>
	<b>Appendix 1: List of Recommendations .....</b>	<b>70</b>
	<b>Appendix 2: Summary of literature on service responses for older drug users .....</b>	<b>73</b>
	<b>Appendix 3: ISD OPDP population modelling based on different levels of relapse ....</b>	<b>81</b>

## List of Figures

Figure 1: OPDP population estimates/projections (both sexes, 2009/10 - 2027/28)	10
Figure 2: Projected annual number of hospital bed days (PDPs, by age group 2012/13-2017/28)	12
Figure 3: Estimated Prevalence of problem drug use (Scotland; 2006 <sup>1</sup> -2012/13, by Age Group)	19
Figure 4: Drug related deaths in Scotland, 3 and 5 year moving averages, drug related deaths among individuals over 35 years	23
Figure 5: OPDP Population Estimates /Projections (both sexes; 2009/10 to 2027/28; 20% non-relapse)	24
Figure 6: Individuals admitted to hospital for COPD/asthma (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)	27
Figure 7: Individuals admitted to hospital for hepatitis C (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)	27
Figure 8: Individuals admitted to hospital for liver disease (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)	28
Figure 9: Individuals admitted to hospital for epilepsy (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)	28
Figure 10: Individuals admitted to hospital for Deep Vein Thrombosis/Pulmonary Embolism (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)	29
Figure 11: Individuals admitted to hospital for skin infection (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)	29
Figure 12: Individuals admitted to hospital for depression (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)	30
Figure 13: Individuals admitted to hospital for psychosis (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)	30
Figure 14: Individual admitted to hospital for lung cancer (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)	31
Figure 15: Individuals admitted to hospital for heart disease (2012/13 PDPs and rest of the population per 10,000 by sex and age group)	31
Figure 16: Projected annual number of hospital bed days (PDPs, by age group, 2012/13-2027/2028)	32
Figure 17: Projected annual number of hospital stays (PDPs, by age group; 2012/13-2027/28)	32
Figure 18: Projected annual number of emergency hospital stays (PDPs, by age group, 2012/13 -2027/28)	33
Figure 19: How important would you rate the following issues for older drug users that you currently see in your service? (n=74)	36
Figure 20: What areas do you see as increasingly important for this population in future years?	37
Figure 21: What key strengths would you identify with this group?	39
Figure 22: What treatment and support options are more likely to be successful with this 35+ age group, compared to younger drug users?	39
Figure 23: What type of living environment best suits this group as they get older?	40

## List of Tables

Table 1: Estimated Prevalence of OPDP in Scotland by Age Group (2012/13)	20
Table 2: OPDP Age/Sex Estimates by Council Area (2012/13)	20
Table 3: Individuals admitted to hospital for selected conditions (2012/13) OPDP and rest of population, rates per 10,000 by age group)	26
Table 4: What proportion of your clients are older people with a drug problem? (n=74)	36

## 1 Overview

The challenges of responding to needs of older people with a drug problem (OPDP), defined in this report as over the age of 35, are significant and will increase considerably over the coming years. Among people with drug problems, those aged over 35 will become the main client group in specialist services for the foreseeable future. They will also be a significant challenge to a wider range of services that will increasingly be required to offer help and support. Therefore, in terms of planning for the future, OPDPs complex and long-term care needs must be taken into consideration in the planning and development of all health, social care and related services.

A person with a drug problem (PDP) is defined as anyone who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his/her own use of drugs or other chemical substances. Many people with a drug problem did not anticipate or prepare for old age. Over half of those with drug problems in Scotland are now aged 35 years or over and face ageing much sooner than the general population in terms of both morbidity and life expectancy. Drug use and social deprivation have led to older drug users having health problems generally associated with people in the general population who are fifteen years older (Vogt, 2009). This report presents data on the size and nature of the OPDP population in Scotland and defines their care, support and recovery needs and how these could be met.

OPDP are often doubly disadvantaged in terms of their general health. They are generally drawn from the most deprived communities in Scotland where they grew up as children and adolescents and may have numerous consequent health inequalities. Furthermore, they may have spent most of their adult lives dependent on illicit drugs and have lived an associated lifestyle which can have a very negative impact on general health. It is evident that current strategic planning of health and social care service planning has not adequately taken account of this group, or the consequences of their ageing, in terms of service demand. At present services, commissioners and planners, as well as Scottish society more widely, are generally unprepared to meet the care and support needs of this older drug-using population.

It is hoped the findings and recommendations of the Working Group on OPDP will provide an opportunity to develop and implement an effective, strategic and operational response which will be progressed across Scotland. This ageing cohort is a large group which will increase in size over the coming years with increasing demand on wider health and social services. Effective planning for their health and social care needs is important not only to improve outcomes for individuals but also



because failing to plan and invest in their care will result in an increase in the cost of meeting their needs, in an unplanned reactive way. For example we estimate that in 2012/13 the cost of hospital bed stays was £51m for OPDP (ISD 2017) with projections that this figure will rise considerably if no preventative action is taken through improved and earlier interventions for this population.

Due to the identified health burden, this report focuses on people aged 35 years and over who have had a lengthy history of problem drug use (i.e. 15 years or more). Furthermore, the largest cohort of drug users in Scotland currently is in the 35-44 year age bracket. Including what might seem like a relatively young age group can help better define the future care needs of those in older age groups as this age range will reflect premature ageing. Whilst the focus was on long term opioid users it is recognised that there are many long-term problem alcohol users who will experience similar and distinct challenges. It was also recognised that there are other, albeit much smaller, sub-groups of OPDP using other illicit drugs. However this was beyond the resources and scope of this report. Although OPDP may have been engaging with services for some time including services specifically for older people, less is generally understood specifically about older opioid users in this context.

## 2 Policy Context of the Report

At the time of writing significant changes to the health and social care landscape in Scotland have been taking place. A new drugs advisory landscape in Scotland has been established. The Partnership for Action on Drugs in Scotland (PADS group) brings together leaders from the fields of addiction, mental health, inequality, social work and health and social care. It includes a sub-group on drug related harms.

Specialist drug and alcohol services across Scotland currently operate in a recovery orientated policy context identified in the Road to Recovery, (Scottish Government, 2008) and which is well established in service provision. Legislation to implement health and social care integration came into force on April 1, 2016 and aims to bring together NHS and local council care services under one partnership arrangement for each area. Working together, NHS and local council care services are now jointly responsible for the health and care needs of those individuals accessing their services, with the aim of ensuring that those who use services get the right care and support, whatever their needs, and at any point in their care journey. Local Alcohol and Drug Partnerships which are tasked with planning services for this population, are now situated under this integration structure.

The Welfare Reform process implemented by the UK Government has had a significant negative impact on OPDP (Poverty Alliance, GCVS and SDF 2015). Furthermore, the continuing move towards Universal Credit may also have consequences which are not yet fully understood.

## 3 Working Group and Terms of Reference

A working group was established in 2015 with a membership drawn from an extensive range of stakeholders from across Scotland. The terms of reference were:

*To explore the issues of people aged 35 years and older with a drug problem, focusing on those who have had a drug problem for an extended period of time i.e. 15 years or more.*

Within this framework the group worked towards the following aims, to:

1. *use existing data to describe the demographics of the population in terms of age, gender and location, and analyse this at different age bands: 35-44, 45-54 and over 54 years respectively*
2. *project future demographics for this population over a five, 10 and 15 year period*
3. *describe the present and likely future health and social care needs of this population*
4. *describe the nature and extent of present and future service demand of this population*
5. *identify effective service responses including existing good practice*
6. *make recommendations for policy beyond the drugs and alcohol field and across the changing health and social care landscape.*

## 4 Methodology

The working group met on five occasions including an evidence day held in June 2015. The working group took a multi-pronged approach to addressing the gaps in the evidence base on OPDP and meeting the group's terms of reference. There were five components to the gathering of evidence:

1. Data linkage of NHS data via the Information Services Division (ISD)
2. A comprehensive literature review
3. Empirical research with OPDP
4. A survey of service professionals
5. A consultation day for stakeholders

### 4.1 Data linkage

The data linkage analysis, commissioned by the Scottish Government, was carried out by the Information Services Division (ISD) of NHS National Service Scotland (NHS NSS). The aim of this work was twofold. The first step was to recalibrate existing models in order to provide national estimates of OPDP in Scotland in 2012/13. This component addressed the first aim – *to use existing data to describe the demographics of the population in terms of age, gender and location, and analyse this at different age bands: 35-44, 45-54 and over 54 years respectively*. These enhanced estimates provided contextual data for the second step i.e. the data linkage work. Analysis was undertaken of mortality and morbidity among a cohort of OPDP in the primary care, specialist drug treatment and hospital settings. Data were used to estimate future service provision requirements and survival for this cohort. This data linkage analysis addressed the second and third aims – *to project future demographics for this population over a five, 10, 15 year period and describe the present and likely future health and social care needs of this population*.

### 4.2 Literature review

The literature review was commissioned by the Scottish Government in February 2015, and carried out by the Scottish Centre for Crime and Justice Research (SCCJR) which looked at the international literature on service responses for older high-risk drug users (page 11). The purpose of this review was to address the fifth aim – *to identify effective service responses including existing good practice*. It also informed empirical research with OPDP in Scotland.

### 4.3 Empirical research with OPDP

The working group felt it was essential to hear the views of OPDP themselves and commissioned SDF and Catriona Matheson to undertake empirical research (from

March-October 2016), in order to address the gaps identified in the evidence base. In particular, the research aimed to address evidence gaps around:

- understanding the experiences of OPDP who are in and out of treatment and were either current injectors or had injected in the last six months
- the barriers to accessing services
- understanding the attitudes and experiences of older, female drug users
- issues specific to those in rural settings
- understanding the impact of welfare reform and sanctions on this group.

This addressed the third and fourth aims – to *describe the present and likely future health and social care needs of this population* and to *describe the nature and extent of present and future service demand of this population*.

#### **4.4 Survey of service professionals**

SDF repeated a survey of service professionals in Scotland that was previously conducted in 2010, to investigate which issues are key to service professionals regarding OPDP, and whether there has been any change in views and service provision over the past six years. This also addressed the third and fourth aims above. Examples of existing good practice across Scotland also came from the Working Group membership.

#### **4.5 Stakeholder consultation day**

Finally, a consultation event was held with stake holders in June 2016 to ensure that all aspects of the needs of OPDP were covered. Interim findings from the OPDP research were presented and a series of facilitated discussion groups were held. Notes were taken and helped inform the working groups thinking. Over 100 people attended the event.

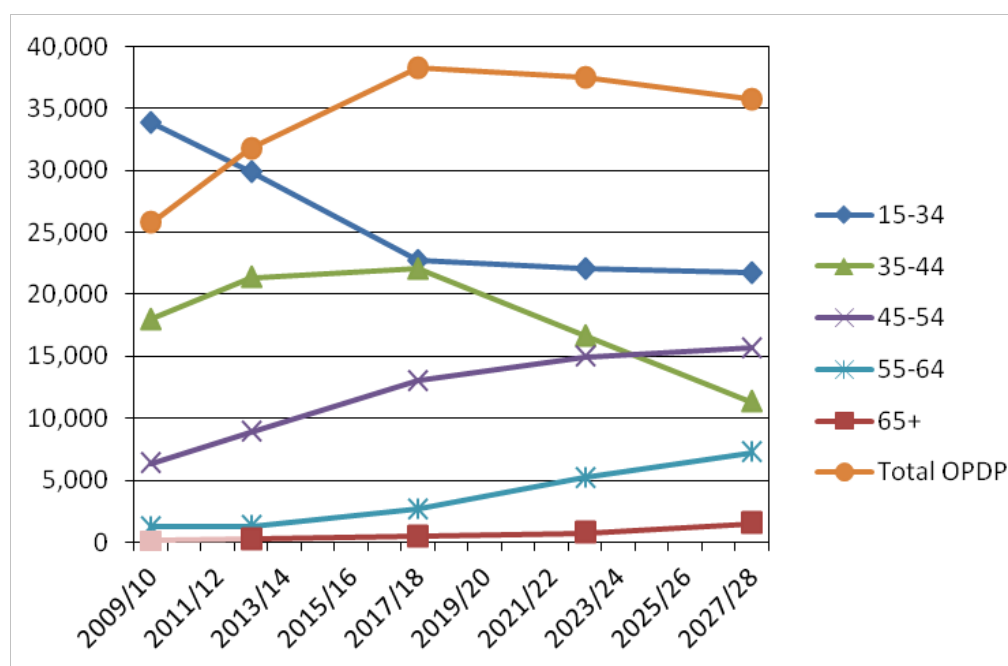
## 5 Summary of Key Findings and Recommendations

### 5.1 Scale of the problem

There is an ageing group of OPDP that will grow in size over the coming years. ISD estimate that in 2012/13 there were 31,500 people in Scotland with a drug problem who were aged 35 years and over (23,000 males and 8,500 females) within a total population of 61,500 PDP. This older population was not evenly spread across Scotland. The highest percentage of the 35-64 year old population with a drug problem was seen in Glasgow City council area (5.54%), while the lowest on mainland Scotland was seen in the Moray council area (0.49%).

ISD also undertook a modelling exercise as part of this work that provided projections of the size and demographic composition of the future OPDP population. Data is presented in figure 1 below.

**Figure 1: OPDP population estimates/projections (both sexes, 2009/10 - 2027/28)**



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

These projections show an increasing trend in the population of OPDP before numbers begin to stabilise, suggesting that this population will become established as the mainstream client group for Substance use services.

## **5.2 Multiple health conditions**

A high proportion of this group have multiple underlying health conditions and have a physiological health age which is comparable to those who are 15 years older in the general population (Vogt, 2009).

Since many OPDPs are primarily identified as PDP their underlying health conditions, particularly chronic conditions, are often not identified or treated effectively.

This population are more likely to have increased mortality and morbidity from a range of underlying health conditions due to late presentation and engagement with health services.

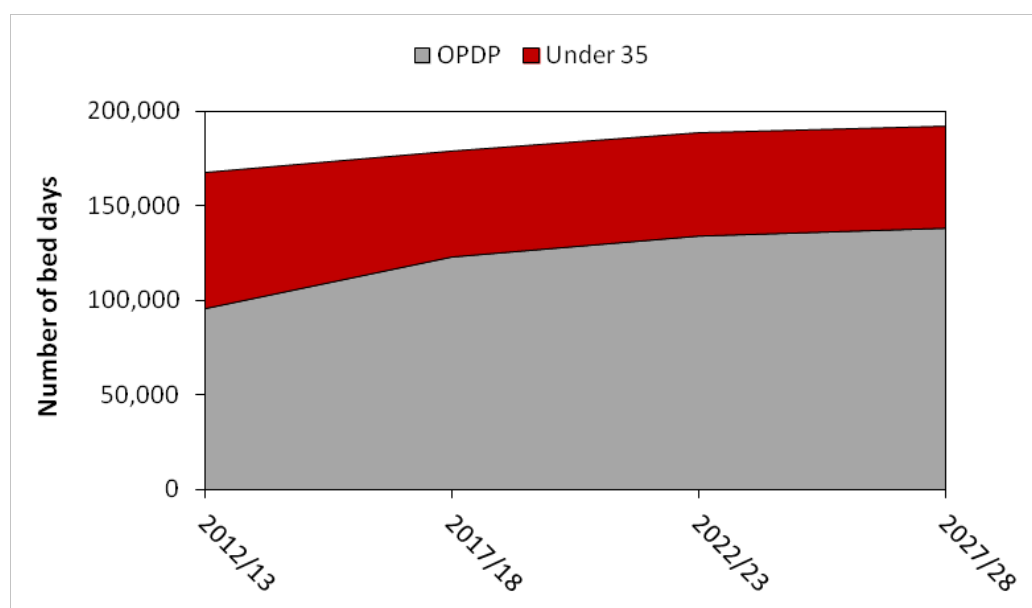
The modelling work undertaken by ISD identified significantly higher rates of hospital admissions for the following conditions than individuals of comparable age/sex among the rest of the Scottish population:

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

These findings were confirmed by the self-reported health conditions noted by OPDP in the research project.

The number of hospital bed days for OPDPs was calculated for 2012/13 and estimated for future years. Data is presented in figure 2.

**Figure 2: Projected annual number of hospital bed days (PDPs, by age group 2012/13-2017/28)**



Source: ISD OPDP cohort 2012/13 & population projections with 20% non-replace rate

There is a real need to ensure that the wider health care needs of this growing population are met (physical and psychological). Failing to plan for this group's care needs will result in increased burden on a wide range of services in the future. Within specialist drug and alcohol services, there needs to be a focus on ensuring services are geared to the needs of OPDP so that the best outcomes can be achieved, ensuring people are safe, stable, have a good quality of life and are engaged with relevant services, reducing the frequency of unplanned hospital admissions for this group.

The role of general practice in identifying, screening and treating this population is crucial. This role needs to be recognised and supported. The role of community pharmacists also need to be explored as a means to screen for and manage long term conditions such as COPD and Hepatitis C.

### **Recommendation 1**

**As part of national quality improvement work, partners, alongside Scottish Government, should test models to explore how best to identify and treat underlying health conditions of OPDPs in both specialist and primary care services.**

According to the Scottish Advocacy Alliance website, advocacy services for people with drug and/or alcohol problems are patchy at best. There is little evidence of actual uptake, with the recent Care Inspectorate work looking at Alcohol and Drug Partnerships implementation of the Quality Principles for Alcohol and Drug Services identifying that there were very few mentions of advocacy services in case files examined.

## **Recommendation 2**

**Scottish Government, with partners, should test models of independent advocacy services to ensure that sub-standard care, particularly in relation to underlying health conditions for this population, is appropriately challenged and remedied.**

Pain management emerged as a major theme both for chronic and acute conditions for OPDPs.

## **Recommendation 3**

**ADPs and Integrated Joint Boards (IJBs) for health and social care should develop training in this area and build partnership working between pain services, primary care and addiction services.**

### **5.3 Mental health and isolation**

Persistent and enduring mental health problems are common within this population. The survey of 123 OPDP revealed self-reported levels of anxiety at 89% and depression at 95%.

A significant proportion of OPDP are living alone, with limited family involvement resulting in isolation and loneliness. The survey of 123 OPDP revealed 79% living alone (average age 41). Loneliness and isolation are recognised as significant independent risk factors for adverse health outcomes.

The service provision that meets the needs of OPDP who have a dual diagnosis should be explored as these issues must be dealt with in tandem.

## **Recommendation 4**

**IJBs should ensure that mental health and addictions services work effectively together at operational and strategic levels in order to better identify and meet the needs of OPDP. This should include the development of assertive outreach models of care which seek to make contact with those who are not engaging with existing provision.**



## **Recommendation 5**

**ADP's and partners should consider at a local level how they can develop appropriate support to reduce isolation and loneliness amongst OPDP and develop meaningful productive activity programmes. This will include specialist addiction services as well as community services and recovery / volunteer groups.**

**Progress on issues relating to isolation should be a required element of ADP's annual reporting to Scottish Government.**

### **5.4 Overdose deaths**

A significant and increasing number of OPDP are dying from drug overdoses, which are largely preventable. The risk of overdose and of an overdose being fatal is increased as a result of underlying untreated physical multi-morbidity, chronic mental health problems and social isolation.

### **5.5 The role of specialist addiction services**

Specialist addiction services have a crucial role in the care and support of this population. The issue emerged of how services can be appropriately supported to review their practice towards OPDP in order to identify if changes can be made to service provision that would enhance engagement and the care for this population to aid retention. For example:

- Involving this client group in the design and development of services
- By ensuring that staff are 'age aware' and competent to work with older users and are working in a psychologically informed way
- By offering choice, if possible, to clients with regard to who they are supported by (workers, volunteers and peers)
- By working closely with primary care to assist in ensuring that underlying health needs are being met
- By developing satellite and assertive outreach services
- By ensuring good practice in terms of how ORT is delivered and an increased range of ORT options be explored to maximise retention with this population, including Heroin Assisted Treatment
- By encouraging the view that long-term engagement with treatment services is a positive protective factor

The majority of those surveyed had accessed services but length of stay in treatment was surprisingly short.

## **Recommendation 6**

**ADPs should ensure that services are able to:**

- **reach out to OPDP using a range of strategies including assertive outreach**
- **provide an accessible service that takes account of, and addresses, issues OPDP may face in accessing services**
- **provide a quality psychologically informed service that is able to retain people appropriately in the service; and**
- **progress on these issues should be a requirement of ADPs annual reporting to Scottish Government.**

The working group identified a variety of pockets of good practice within specialist services and the survey of professionals indicated sympathetic workforces who were aware of the issues facing OPDP.

## **Recommendation 7**

**Scottish Government and partners should explore the funding of large and small scale pilot projects (including small tests of change) to generate increased evidence and practice models for how to best work with this population in a way that can be replicated within mainstream provision.**

### **5.6 Gender issues**

There are clear gender specific issues for OPDP that services should 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. Women with self-medicating drug use histories due to trauma experience increased levels of physical discomfort, insomnia, irritability, anxiety, and depression with age and physiological age related changes put them at higher risk for relapse to drug use.

## **Recommendation 8**

**There is a need for ADPs and frontline services to ensure that gender issues for older women with a drug problem are addressed as part of their treatment and care, including underlying issues such as trauma and/or domestic violence. Addressing these issues should be a focus of treatment and the process of identification and addressing these issues should be undertaken as early as it is safe and appropriate to do so.**

## **5.7 Stigma: staff training and development issues**

The stigmatisation of OPDP was a potential barrier to receiving effective care. The importance of training was identified as a key aspect in improving practice and overall responses to OPDP. Initial groups in need of training included:

- Specialist drug services
- Home care staff
- Hostel staff and sheltered accommodation staff
- Those working in criminal justice settings including prisons
- General health staff in key areas likely to work with significant numbers of OPDP including secondary and primary care
- Community learning and development
- Third sector providers delivering community groups

Scottish Drugs Forum's Workforce Development Team has developed a training module on working with OPDP.

## **Recommendation 9**

**Scottish Drugs Forum, as the national training agency, should work with Scottish Government to explore how best to ensure training on working with OPDPs is made widely available to those who need it.**

## **5.8 Wider aspects of support: employment, finance, housing and care**

The issues of hope, aspiration and opportunity were explored and there appeared to be an identified need to widen opportunities for this group to move into volunteering, education and employment. It was apparent that many OPDP are seeking these opportunities.

Welfare reform has led to further cuts to the income of OPDP. This has impacted on other aspects of life including housing and nutrition. There is a need to explore how this vulnerable population can be assisted to overcome or ameliorate these challenges.

The challenges for OPDP may be further exacerbated in more rural and remote parts of Scotland, through the difficulty of accessing services.

The Housing First model, which has a strong evidence-base, looks promising for OPDP, with its emphasis on giving people a home, providing ongoing flexible support of the individual's choice and adopting a harm reduction approach.

Many local authorities provide Social Care in a different way to the over 65s (the usual age for defining someone as an 'Older Person'). The Scottish Government's

Free Personal and Nursing Care policy is directed at the over 65s. With a growing number of people living longer, the age range in Care homes for older people is typically over 75 years. The growing population of OPDP identified in this report are quite a different group despite having similar health needs. The working group found examples of:

- Services being denied to OPDP because of stigma associated with them having a known drug problem and being perceived as problematic.
- Existing Older People's Services are not well equipped to meet the social and health needs of older people with a drug problem. Resources in this area are already stretched with the challenges in providing for the complexities of an ageing population.
- Care Management being transferred to an Older Person's team at age 65, thereby losing the therapeutic relationship with their existing workers and the new worker being inexperienced in supporting their needs and aspirations.
- Problems for people using services as they cope with social security benefits and differing personal contributions in different settings – Care Homes typically require financial contribution of all but a personal allowance, whereas Supported living allows retention of benefits.

The demographic modelling predictions described elsewhere in this report suggest that we can expect a much larger group of people aged 65 years and over with an ongoing drug problem.

## **Recommendation 10**

**Partners should work alongside relevant Scottish Government departments and other stakeholders to explore options for meeting the accommodation needs of this group, with particular attention to the potential to develop Housing First models whereby accommodation and any necessary support is provided without condition as to the person's substance use.**

**This may be provided in a 'core and cluster approach' that would mean that housing and isolation needs could be addressed together.**

**Where care needs lead to people needing a care or nursing home setting, consideration must be given to how services to Older People adapt to accommodate this group. Local authorities, providers and Scottish Government should work together to consider this issue and how, working jointly, this can be anticipated and addressed. This includes understanding the scale of this need, where it will present and the staff and service developments required to address this.**

## **5.9 Future planning**

Retention, unplanned discharges, outreach etc. data on those not engaged with specialist services and wider support linked to recovery domains (housing, welfare

support/nutrition, mental and physical health) is not currently reported on with relation to this specific population and could be helpful in service planning and design.

## **Recommendation 11**

**ADPs and IJBs for health and social care should work alongside Scottish Government and partners to develop guidance which could offer assistance in commissioning processes, including tendering and Service Level Agreements, for services specifically related to OPDP.**

### **5.10 Resources**

Issues relating to funding of services and how to secure an appropriate level of funding for the care of this population were considered. This includes making the case for investment that would save the public purse in other areas (emergency services, hospital admissions for infections, HIV treatment etc).

Modelling work undertaken by ISD highlighted the number of hospital admissions by OPDP and likely future demand and costs.

Assuming that the hospital activity observed among the cohort was representative of the wider population of PDPs, it is estimated that the following hospital usage figures were associated with PDPs in 2012/13:

- 168,200 hospital bed days (estimated to cost £88.8 million, of which £50.8 million was attributable to OPDPs)
- 26,800 hospital stays; of which,
- 20,700 were emergency hospital stays

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

- 192,600 hospital bed days (estimated cost: £101.8 million (based on 2012/13 costs), of which £73.2 million would be attributable to OPDPs)
- 30,100 hospital stays; of which,
- 21,800 were emergency hospital stays

## **Recommendation 12**

**A strong case needs to be made to IJBs that investment in quality drug and alcohol treatment and care services for OPDPs, alongside accessible primary care services, will make a positive impact on the demand for other services. There would be a likely significant reduction in emergency and unplanned hospital admissions as well as impacting on drug related deaths.**

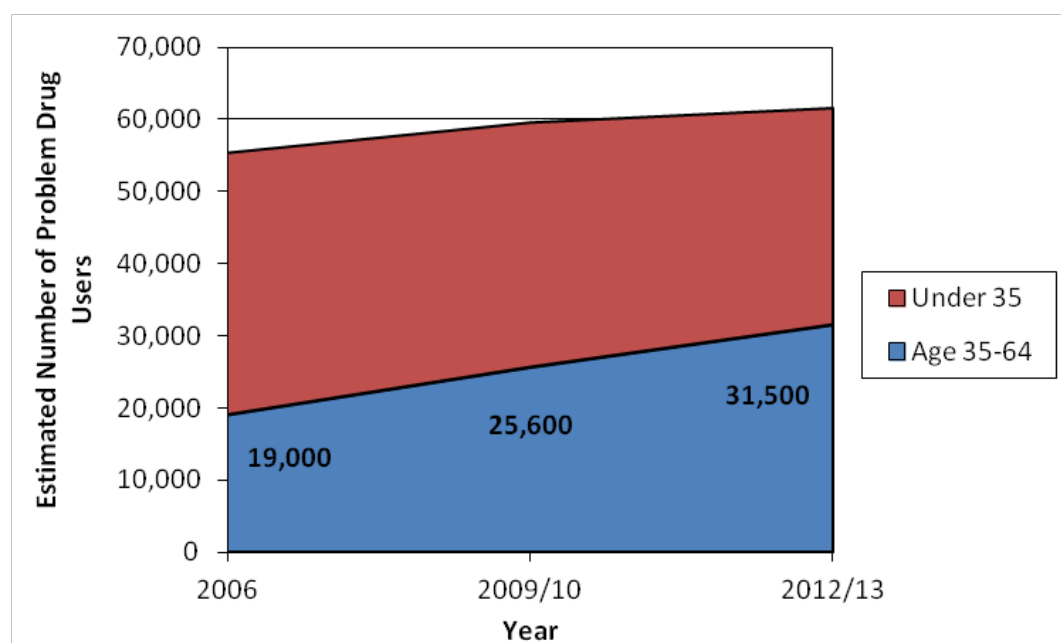
A list of recommendations is included in appendix 1.

## 6 Current Prevalence and Trends of Older People with Drug Problems

This section presents a range of data, from ISD, describing trends in relation to people with a drug problem aged over 35 years and their specific health needs.

ISD estimated that in 2012/13 there were 31,500 people in Scotland with a drug problem who were aged 35 years and over (23,000 males and 8,500 females) within a total population of 61,500 people with a drug problem, an increase from the 2006 estimate (19,000 of 55,300). See figure 3.

**Figure 3: Estimated prevalence of problem drug use (Scotland; 2006<sup>1</sup>-2012/13, by Age Group)**



1. Data for 2006 refer to the calendar year and are calculated on the basis of estimated prevalence compared to mid-year population estimates. Estimates for 2009/10 and 2012/13 refer to financial years and are based on bespoke analysis undertaken by ISD.

Data were further analysed by age and gender. The older age group of problem drug users (OPDP) (35-64 years) was split into three 10-year age groups, stratified by gender. These estimates are presented in Table 1. It was estimated that the number of male PDPs was higher than females in all age categories and that the 35-44 year age category accounted for two thirds or more of both males and females.

**Table 1: Estimated Prevalence of OPDP in Scotland by Age Group (2012/13)**

	<b>35-44</b>	<b>45-54</b>	<b>55-64</b>	<b>Total</b>
<b>Males</b>	15,681	6,361	997	23,039
<b>Females</b>	5,654	2,531	312	8,497
<b>Total</b>	21,335	8,892	1,309	31,536

Source: ISD, 2016

ISD also provided estimates for population size by local authority area which identified geographical differences in the number of OPDPs as a percentage of people in the 35-64 age group. This reflects historical differences in patterns of problematic drug use across Scotland.

**Table 2: OPDP Age/Sex Estimates by Council Area (2012/13)<sup>1</sup>**

Council Area	Male 35-44	Male 45-44	Male 55-64	Female 35-44	Female 45-54	Female 55-64	Total OPDP	OPDP prevalence (males 35- 64)
Aberdeen City	642	260	41	231	104	13	<b>1,290</b>	2.14
Aberdeenshire	197	80	13	71	32	4	<b>397</b>	0.50
Angus	162	66	10	58	26	3	<b>326</b>	0.98
Argyll & Bute	113	46	7	41	18	2	<b>227</b>	0.91
Clackmannanshire	113	46	7	41	18	2	<b>227</b>	1.48
Dumfries & Galloway	353	143	22	127	57	7	<b>709</b>	1.65
Dundee City	564	229	36	203	91	11	<b>1,134</b>	3.11
East Ayrshire	395	160	25	142	64	8	<b>794</b>	2.24
East Dunbartonshire	106	43	7	38	17	2	<b>213</b>	0.68
East Lothian	197	80	13	71	32	4	<b>397</b>	1.36
East Renfrewshire	219	89	14	79	35	4	<b>440</b>	1.69
Edinburgh City	1,692	686	108	610	273	34	<b>3,403</b>	2.62
Falkirk	451	183	29	163	73	9	<b>908</b>	1.96
Fife	705	286	45	254	114	14	<b>1,418</b>	1.37
Glasgow City	4,266	1,730	271	1,538	688	85	<b>8,579</b>	5.54
Highland	303	123	19	109	49	6	<b>610</b>	0.89
Inverclyde	437	177	28	158	71	9	<b>879</b>	3.82
Midlothian	204	83	13	74	33	4	<b>411</b>	1.70
Moray	63	26	4	23	10	1	<b>128</b>	0.49
North Ayrshire	501	203	32	180	81	10	<b>1,007</b>	2.62
North Lanarkshire	846	343	54	305	137	17	<b>1,702</b>	1.81
Orkney Islands <sup>2</sup>	*	*	*	*	*	*	*	n/a
Perth & Kinross	296	120	19	107	48	6	<b>596</b>	1.40
Renfrewshire	776	315	49	280	125	15	<b>1,560</b>	3.04
Scottish Borders	148	60	9	53	24	3	<b>298</b>	0.86
Shetland Islands	113	46	7	41	18	2	<b>227</b>	3.15
South Ayrshire	176	72	11	64	28	4	<b>355</b>	1.13
South Lanarkshire	846	343	54	305	137	17	<b>1,702</b>	1.86
Stirling	134	54	9	48	22	3	<b>269</b>	1.08
West Dunbartonshire	374	152	24	135	60	7	<b>752</b>	2.96
West Lothian	275	112	17	99	44	5	<b>553</b>	1.07
Western Isles	14	6	1	5	2	0	<b>28</b>	0.34
<b>Scotland</b>	<b>15,681</b>	<b>6,361</b>	<b>997</b>	<b>5,654</b>	<b>2,531</b>	<b>312</b>	<b>31,536</b>	<b>2.10</b>

**Source: ISD, 2014, 2016**

**Notes:**

1. Numbers of total OPDP within each area may not equal the sum of the age/sex categories due to numerical rounding. For the same reason, Scotland totals may not equal the sum of the council areas presented.
2. No Orkney Island estimate was provided in published ISD estimates (2014).



Information from the Scottish Drug Misuse Database (ISD, 2017) on individuals assessed for specialist drug treatment also illustrates this trend. The percentage of individuals assessed who were aged 35 years and over has increased from 14% in 2000/01 to 50% in 2015/16. The median age of individuals assessed for specialist drug treatment increased from 26 years in 2000/01 to 35 years in 2015/16. However these figures are likely to underestimate the proportion of OPDP as they only refer to new episodes of treatment and excludes those in long-term treatment.

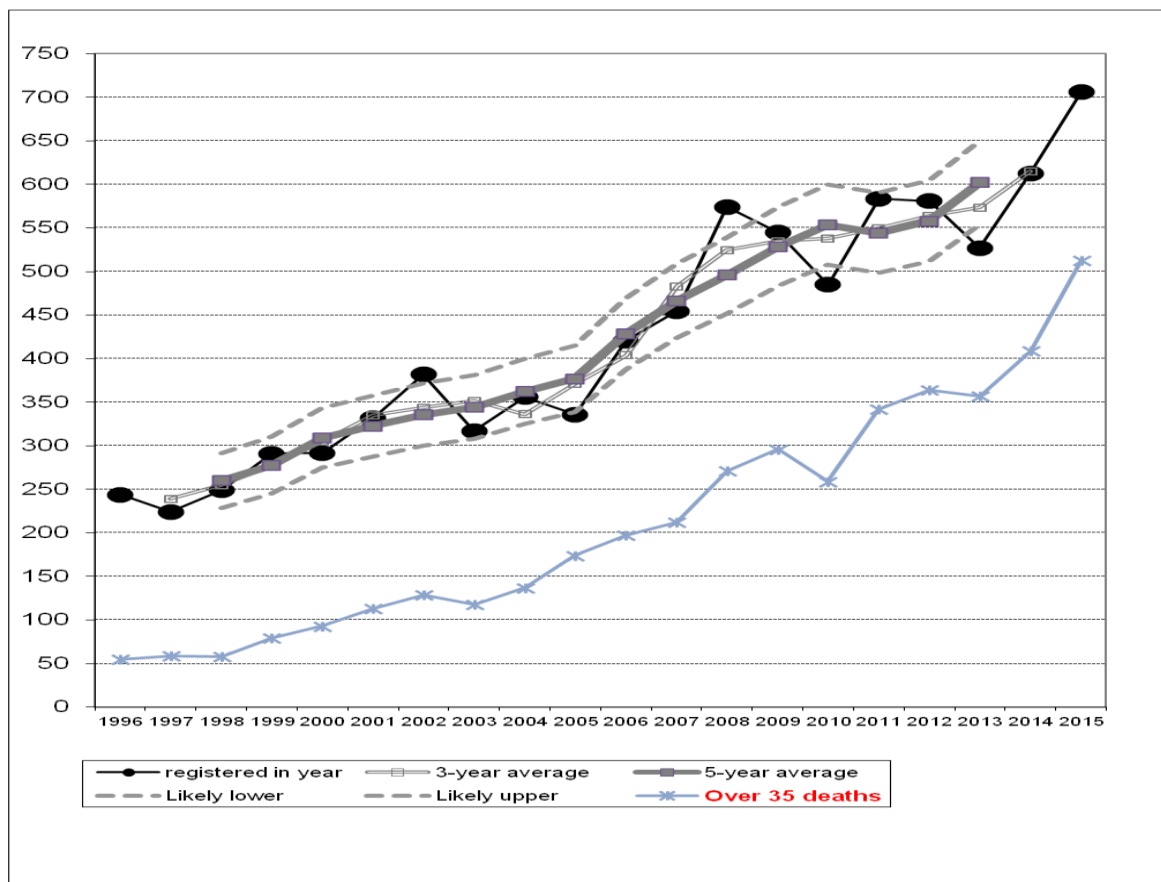
The most recent Needle Exchange Surveillance Initiative report (University of West of Scotland, 2017) also highlighted increasing numbers of OPDP, reporting that the mean age of respondents has increased by approximately one year in each of the last four surveys, from 33.4 years in 2008/09 to 38.2 in 2015/16.

Regarding bacterial infections among drug injectors, the evidence suggests that older injectors may be particularly vulnerable to bacterial infection (EMCDDA, 2015). This may be linked to the prevalence of injecting or risky injecting practices (particularly muscle injecting, caused by the inability to access veins) among this group. Similar patterns, showing a disproportionate prevalence among older problem drug users, were evident for a range of bacterial infections (anthrax, botulism, Group A Streptococcus and Staphylococcus Aureus).

Statistics on the botulism outbreak in Scotland in 2014/15 show that two-thirds (26, 67%) of identified cases occurred among males and that the median age of individuals affected was 42 years (range 24-56 years) (EMCDDA, 2015).

Mortality data also illustrate a clear trend of increasing drug-related fatalities among OPDP. Figure 4 below shows Drug-Related Deaths (DRDs) in Scotland from 1996 to 2015, highlighting overall numbers of DRDs, 3-year and 5-year moving averages and numbers of DRDs among OPDPs. While deaths among under 35s have remained consistent at about 200 per year, deaths among OPDP have increased from 55 in 1996 to 513 in 2015. Therefore, the observed increase in deaths among OPDPs largely accounts for the rise in DRDs since 1997.

**Figure 4: Drug related deaths in Scotland, 3 and 5 year moving averages, drug related deaths among individuals over 35 years**



Source: National Records of Scotland, 2016

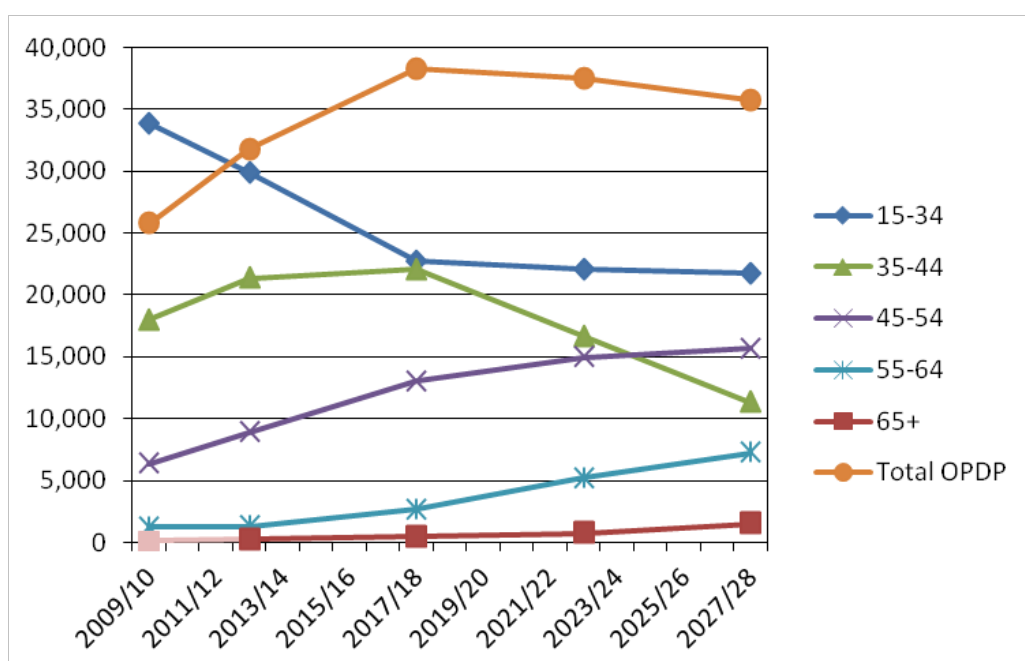
## 7 Present and Estimated Future Health and Social Care Needs of OPDP

### 7.1 Population estimates

ISD undertook data linkage work to estimate the future demographics of the population of OPDP in Scotland and to quantify the current and future health and social care needs of this population.

The following estimates based on the detailed 2012/13 OPDP estimates produced by ISD were produced by modelling the effect on the population of a range of factors including incidence of problem drug use, recovery rates and survival rates. For the recovery rates, data on successful treatment completion from the National Treatment Agency (successful exits from treatment were people who left drug free and did not re-present within six months) was combined with an estimate of a non-relapse rate of 20%. This was considered to be a conservative estimate of relapse rate and is used throughout the following analysis. See Appendix 2 for other estimates using different percentages of relapse rates (10%, 20% and 30%), which illustrate the potential range of OPDP population projections.

**Figure 5: OPDP Population Estimates /Projections (both sexes; 2009/10 to 2027/28; 20% non-relapse)**



These estimates highlight that the population of OPDP will continue to increase before starting to stabilise. As there are a range of variables in these estimates they can only be used as a guide. However these estimations do reinforce the likelihood

that OPDP will become established as the mainstream client group for Substance use services over the coming years.

## **7.2 Hospital admissions**

The OPDP cohort was linked to an individual level dataset of Scottish Morbidity Record data (containing Inpatient and Day Case records from acute general (SMR01) and psychiatric (SMR04 hospitals) for Scottish residents. This contained details of the cumulative length of stay (number of bed days), number of stays and number of stays resulting from an emergency admission across a five-year period from 1 April 2010 to 31 March 2015. For the same period, flags were also created indicating hospital admissions for the following conditions:

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

Comparisons of rates of conditions associated with hospital admissions are shown in Table 3 and Figures 6 to 15. While different age group and gender patterns were observed, for all conditions except lung cancer and ischaemic heart disease, rates among PDPs were higher than for the rest of the population.

**Table 3: Individuals admitted to hospital for selected conditions (2010/11 to 2014/15)  
OPDP and rest of population, rates per 10,000 by age group)\***

	Under 35		35 and over		All	
	PDP	Rest of population	PDP	Rest of population	PDP	Rest of population
COPD/asthma	471	133	1,006	462	799	365
Hepatitis C	350	1	590	4	497	3
Liver disease	98	5	329	43	240	32
Epilepsy	207	31	271	59	246	51
DVT/PE	500	5	425	34	454	25
Skin infection	911	58	832	145	862	119
Depression	455	54	589	92	537	81
Psychosis	115	13	138	13	129	13
Lung cancer	1	0	45	62	28	44
Ischaemic heart disease	20	5	296	583	189	412

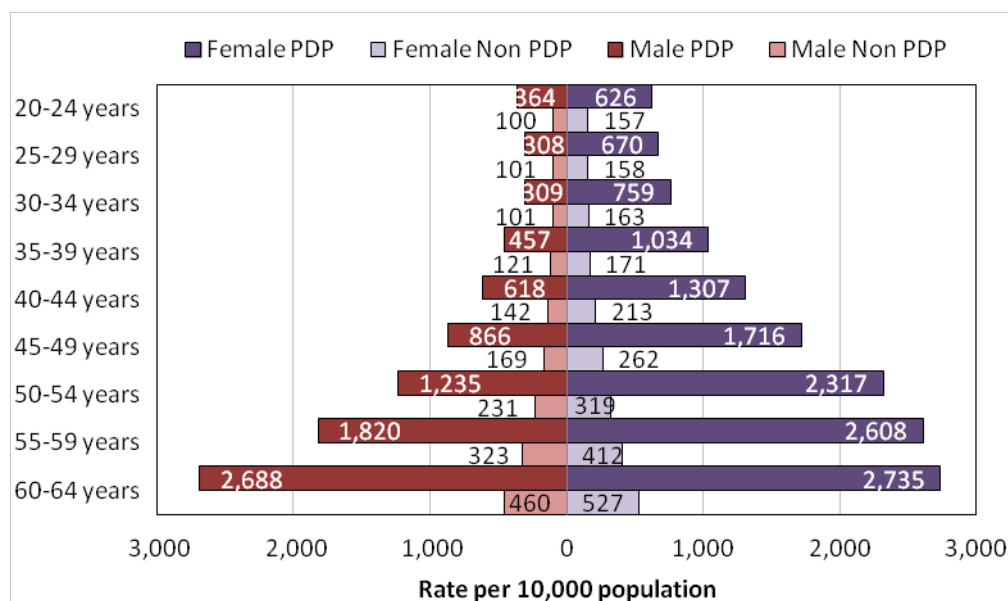
Notes:

COPD: Chronic Obstructive Pulmonary Disease

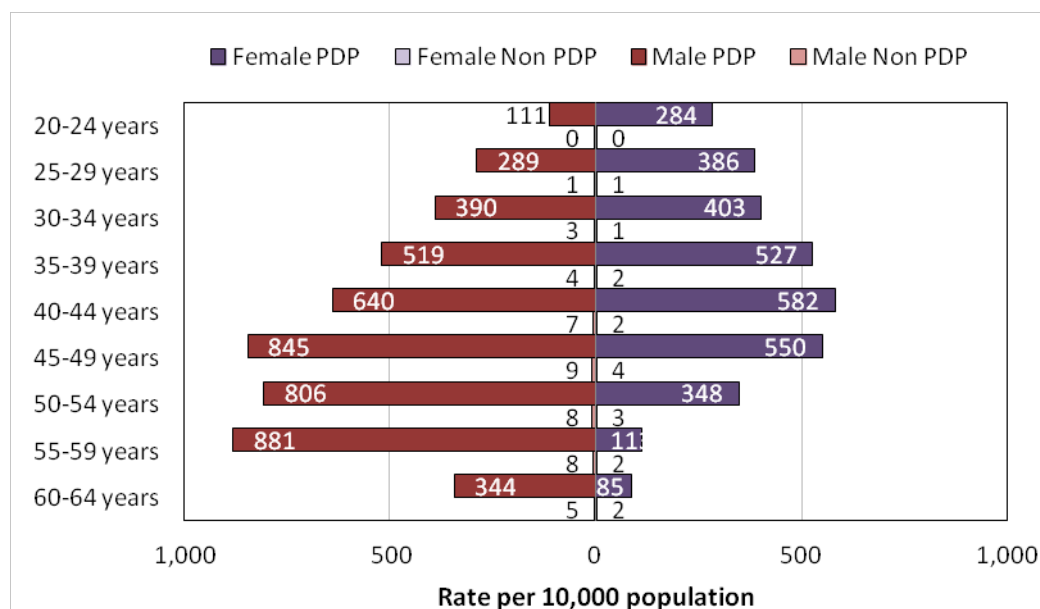
DVT: Deep Vein Thrombosis

PE: Pulmonary Embolism

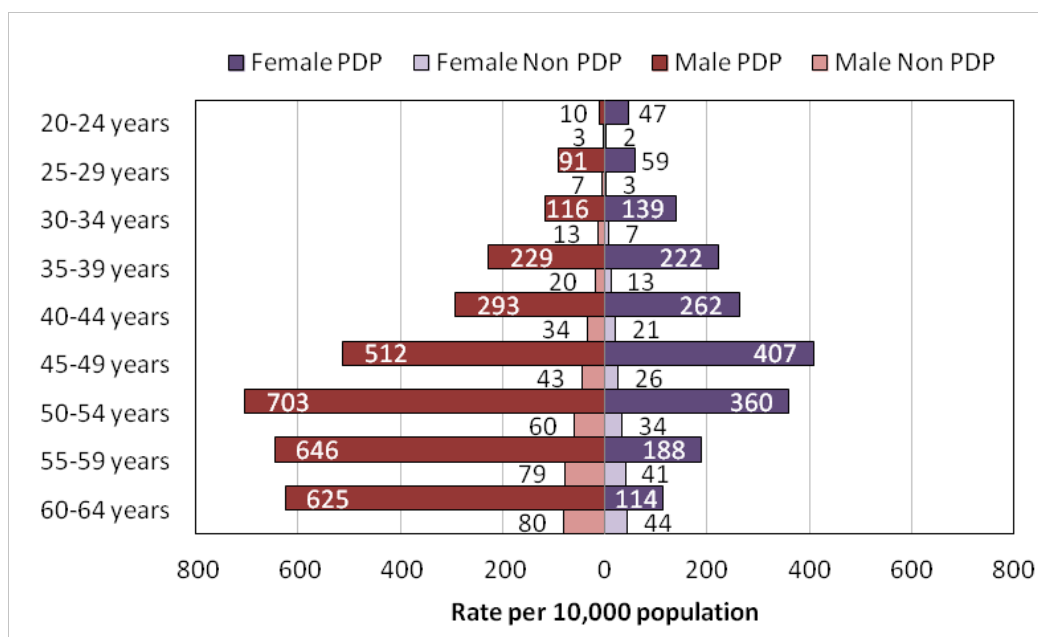
**Figure 6: Individuals admitted to hospital for COPD/asthma (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)**



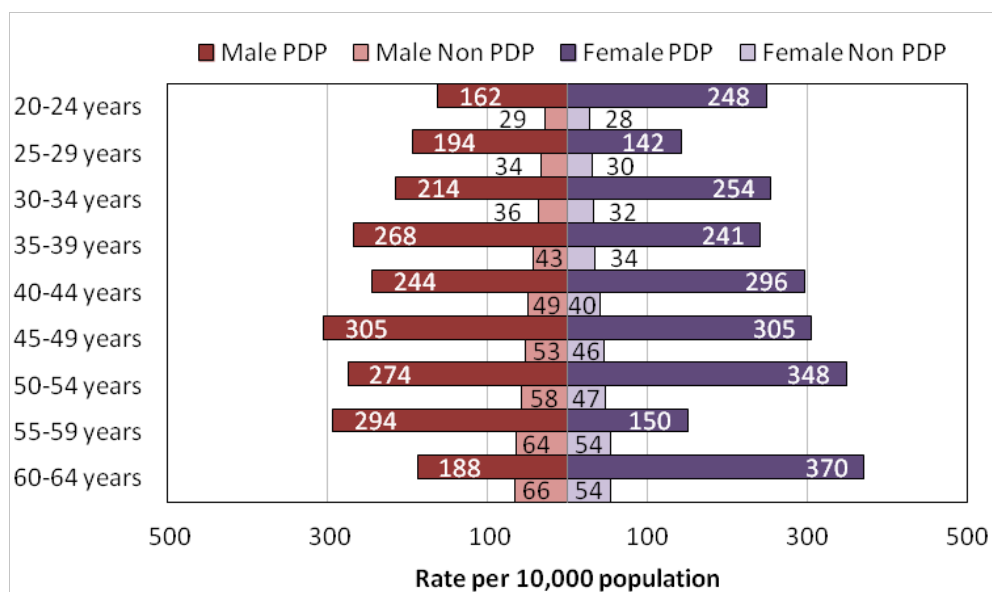
**Figure 7: Individuals admitted to hospital for hepatitis C (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)**



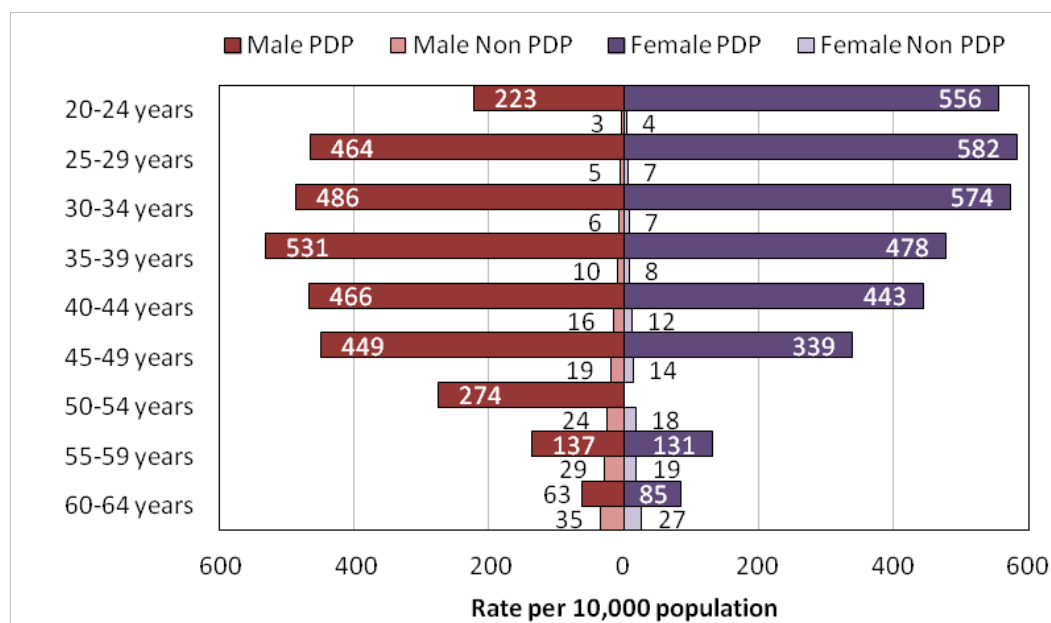
**Figure 8: Individuals admitted to hospital for liver disease (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)**



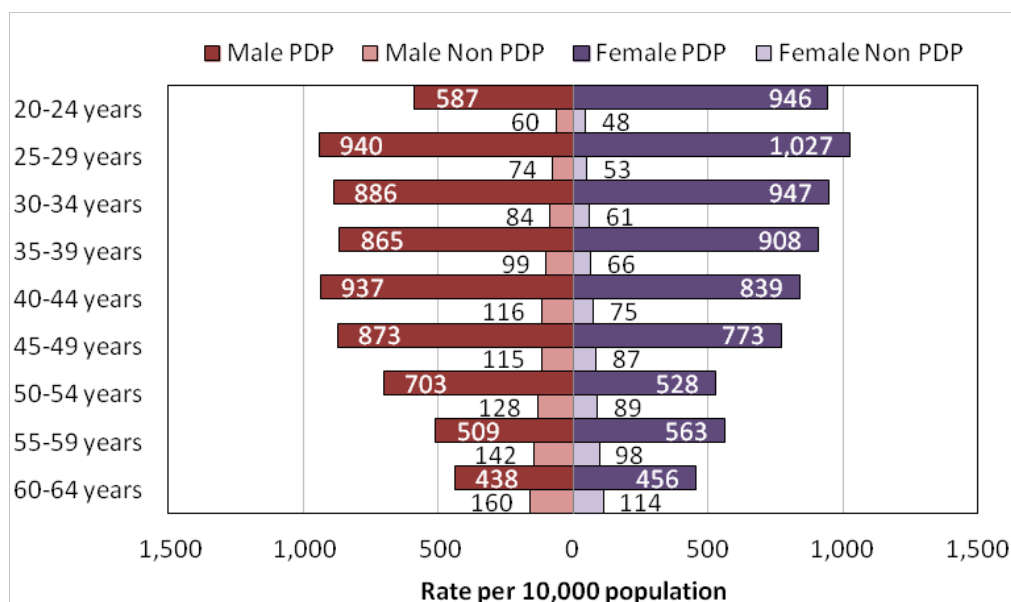
**Figure 9: Individuals admitted to hospital for epilepsy (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)**



**Figure 10: Individuals admitted to hospital for Deep Vein Thrombosis/Pulmonary Embolism (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)**

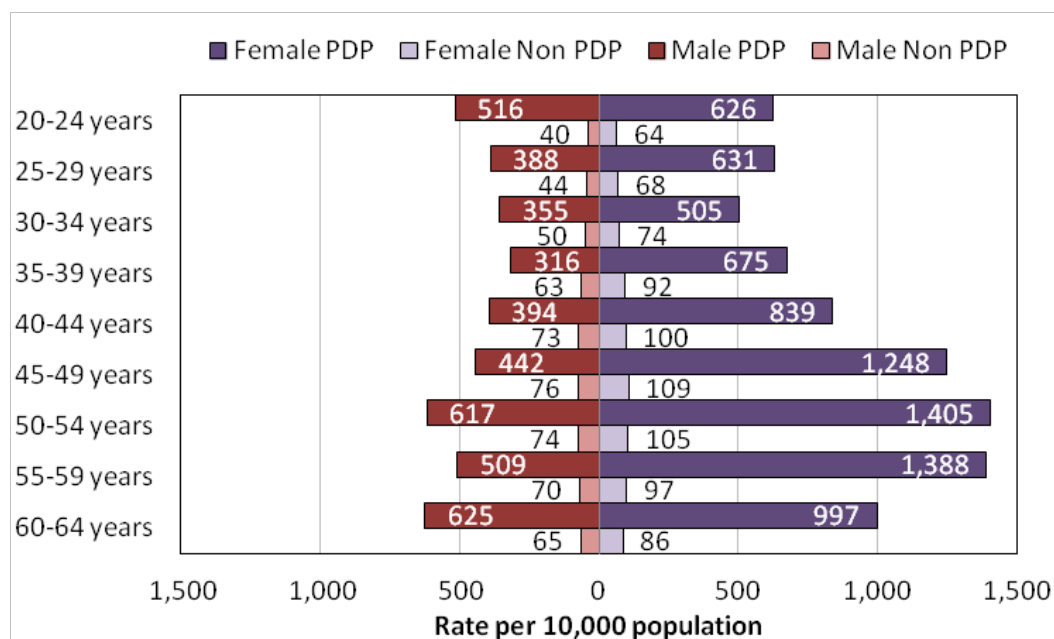


**Figure 11: Individuals admitted to hospital for skin infection (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)**

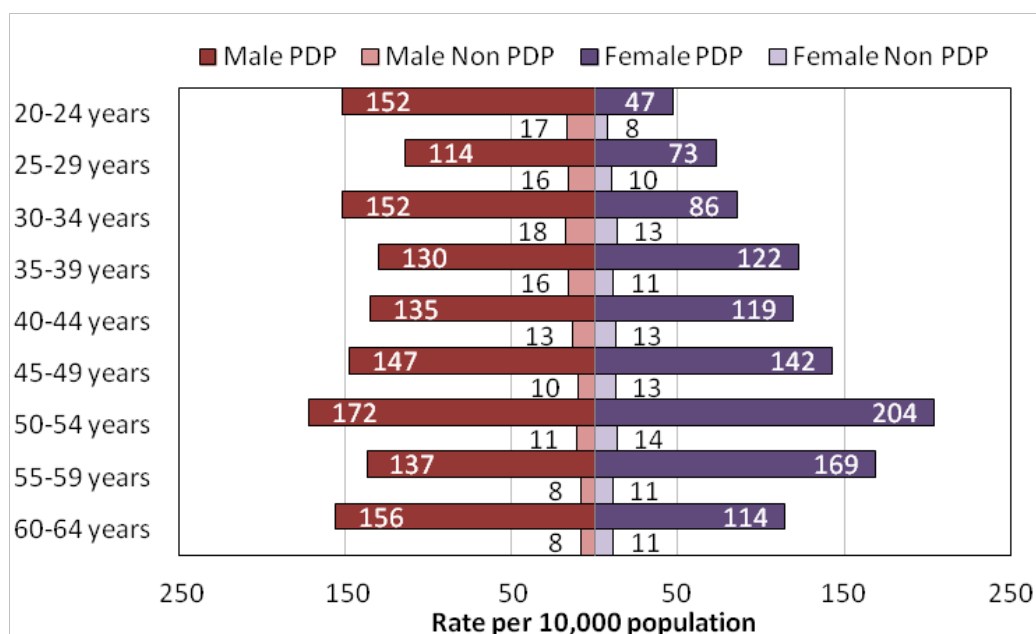




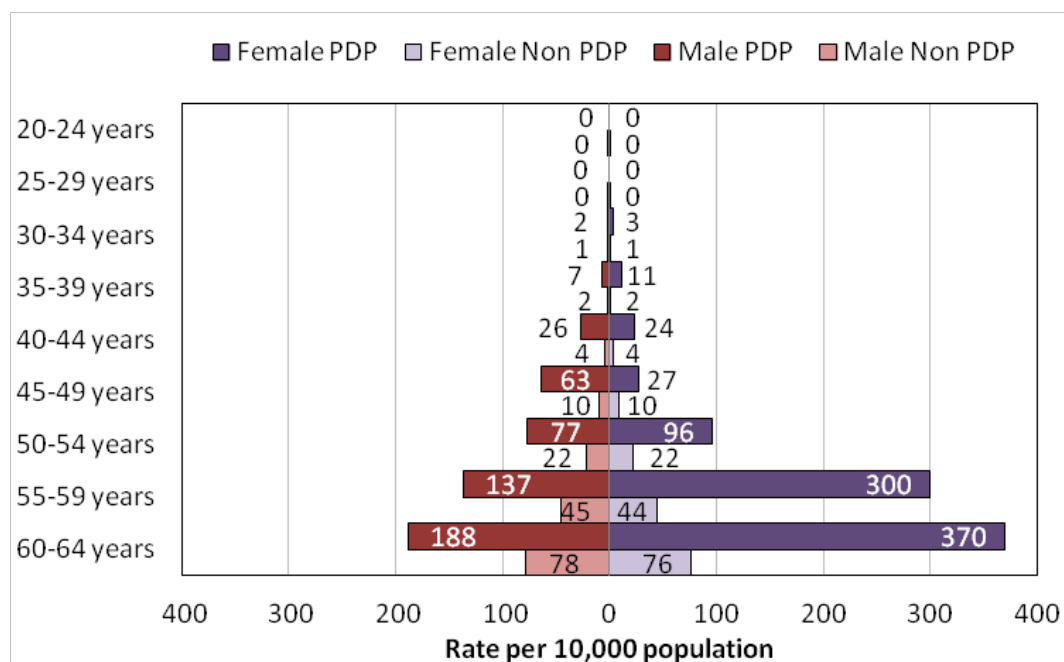
**Figure 12: Individuals admitted to hospital for depression (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)**



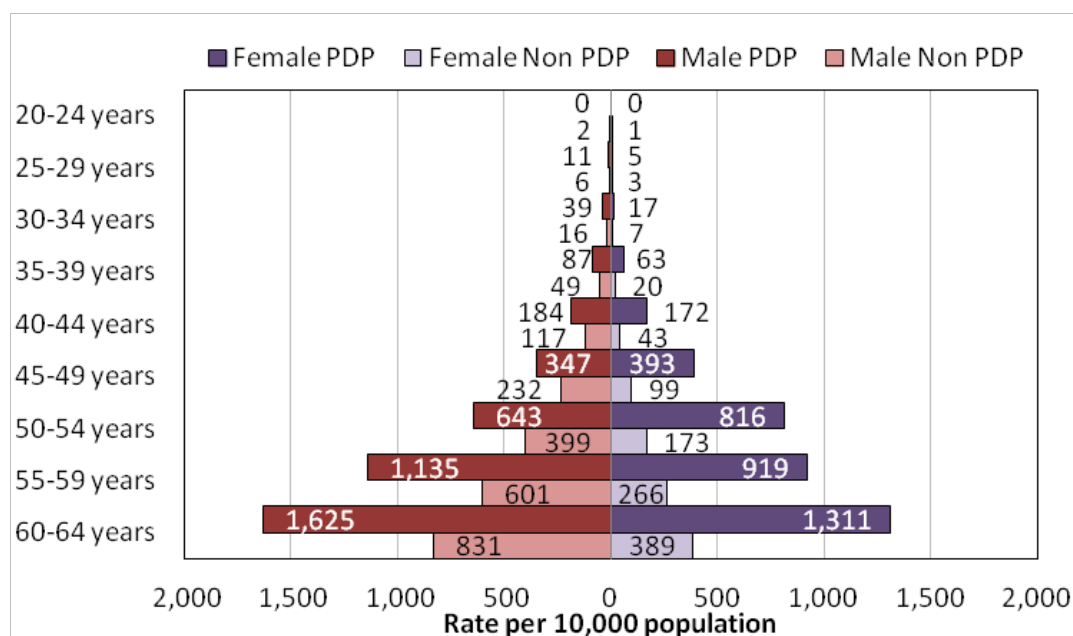
**Figure 13: Individuals admitted to hospital for psychosis (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)**



**Figure 14: Individual admitted to hospital for lung cancer (2012/13 PDPs and rest of population, rate per 10,000 population by sex and age group)**



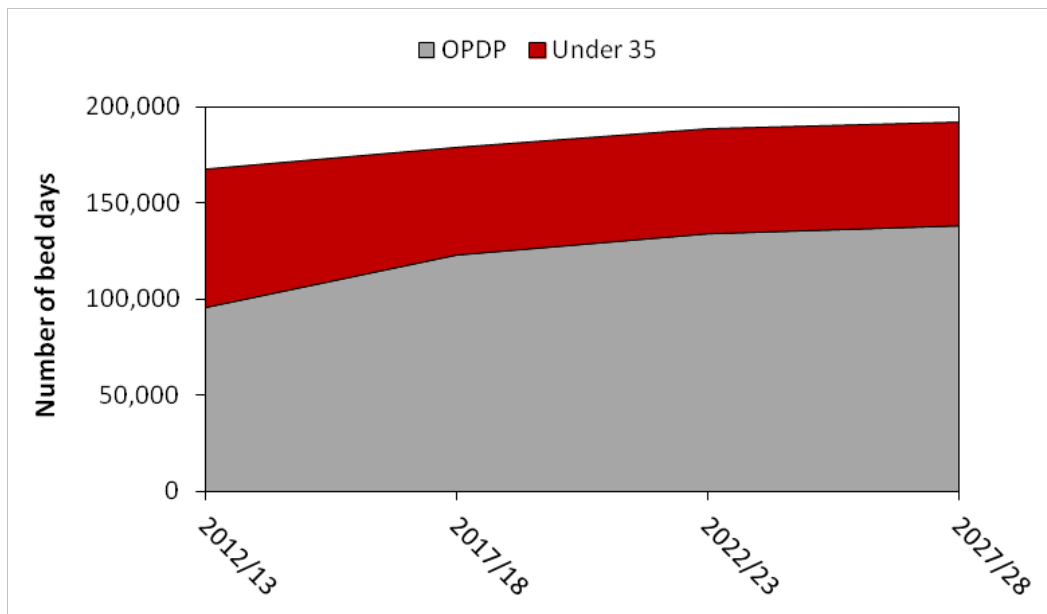
**Figure 15: Individuals admitted to hospital for heart disease (2012/13 PDPs and rest of the population per 10,000 by sex and age group)**



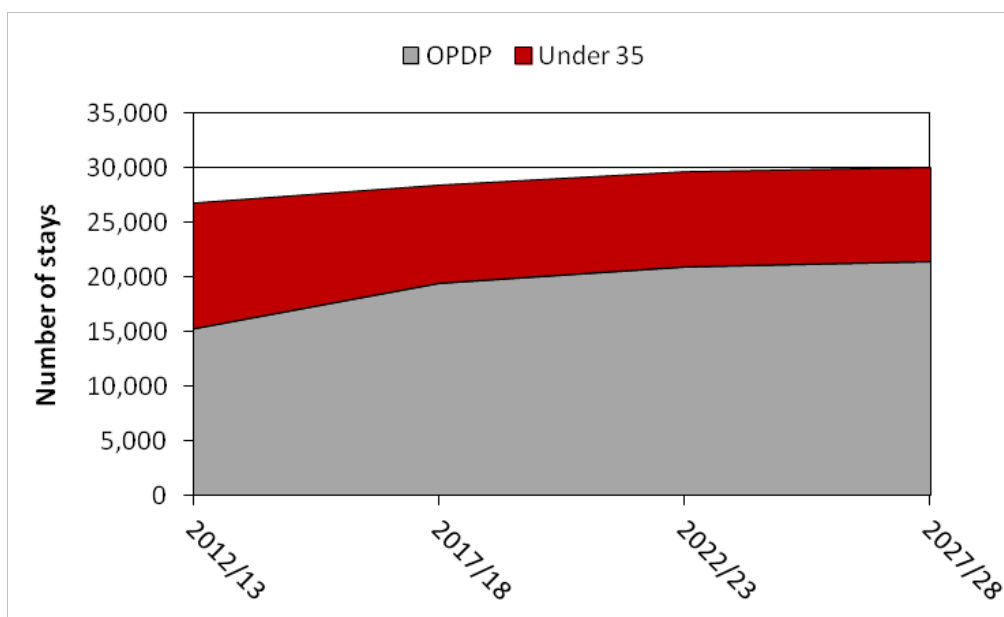
### 7.3 Future health and social care needs

Basing OPDP population projections on the 20% non-relapse parameter, it is possible to forecast the likely future health and social needs of PDPs and OPDPs in 5, 10 and 15 years. Figures 16 to 18 below show the projected increases in hospital bed days, stays and emergency stays. These show the likely future increases in hospital usage resulting from increases in the size of the OPDP population and the effect of ageing within that group.

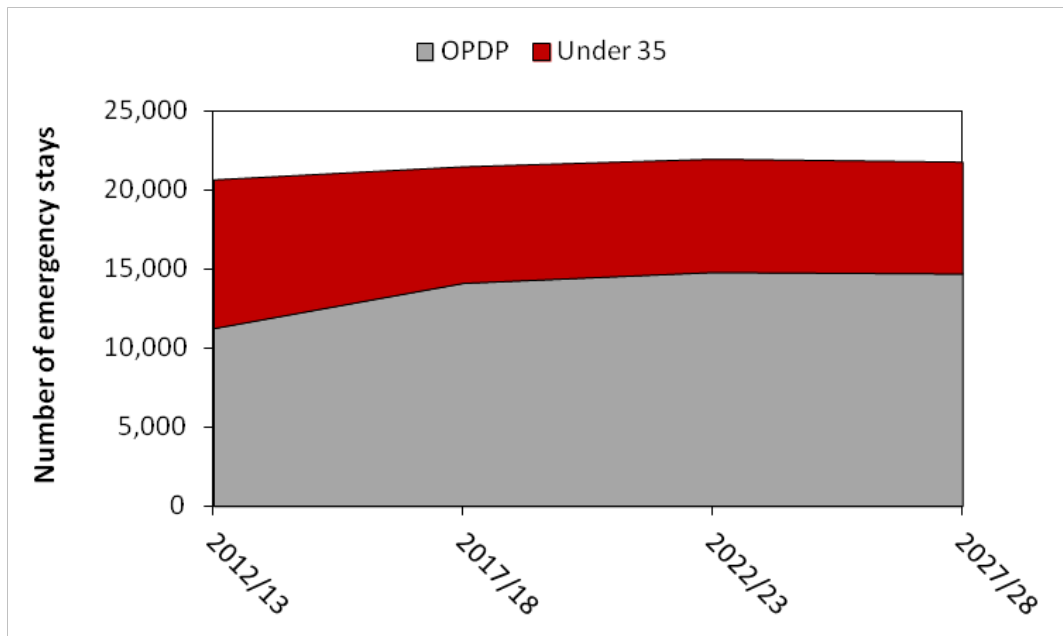
**Figure 16: Projected annual number of hospital bed days (PDPs, by age group, 2012/13-2027/28)**



**Figure 17: Projected annual number of hospital stays (PDPs, by age group; 2012/13-2027/28)**



**Figure 18: Projected annual number of emergency hospital stays (PDPs, by age group, 2012/13 -2027/28)**



## 8 Commissioned Literature Review

As part of the work to identify key issues a literature review was commissioned by the Scottish Government and undertaken by the Scottish Centre for Crime and Justice Research, University of Glasgow. This literature review informed the direction and scope of the working group and guided the commission research surveying older problem drug users. The study identified 56 papers for inclusion, 22 of these were literature reviews. Of the empirical papers six were from the UK. Qualitative methods were the most commonly used in empirical studies. The executive summary is presented below and the studies included are listed in appendix 2. The full report is published separately and can be found here- <http://www.sccjr.ac.uk/publications/service-responses-for-older-high-risk-drug-users-a-literature-review/>

### **Executive Summary**

#### **Introduction**

Background and aims of the research: this report identifies and reviews the academic literature on service responses for older high-risk drug users. It aims to identify the key literature on the older high-risk drug user, distil from this literature the main characteristics of OPDP and their needs, and provide an evaluative account of the responses to OPDP in a format that can inform evidence-based planning and policy for Scotland's older drug using population.

#### **Who is the older drug user?**

The characteristics and trajectories of older high-risk drug users demonstrates that older high-risk users are distinct from young counterparts, and that, even within this older population, there is difference and diversity in experiences of drug use and the ability to navigate towards and achieve recovery.

#### **Shame and Stigma**

Social isolation and exclusion, shame and stigma are that older high-risk drug users may experience more frequently or acutely than younger counterparts, raise particular challenges and barriers to accessing service responses.

#### **Need of age specific services**

There is a requirement to specifically design or adapt services – either existing or bespoke – in order to effectively engage with older high-risk drug users.

#### **Co-presence of physical and mental health issues**

Older high-risk drug users may have mental health issues in addition to their use of illicit substances. Additionally, the use of illicit substances may also have an adverse

impact on their physical health. Such issues must be considered when devising and delivering effective service responses, which must tackle the range of issues in a holistic manner.

### **The promise of exercise-focused interventions**

There is indication in the research of some positive effects of exercise on the health and well-being of high-risk drug users of all ages, including older people. However, the results of the literature review also indicated barriers to the effectiveness of service responses to older high-risk drug users.

### **Complexity of needs and qualities in older people with a drug problem**

OPDP have accumulated a range of health, social, economic challenges and patterns of behaviour and coping that constitute them as a highly complex group. The accurate diagnosis of older high-risk drug use, and the various health issues associated with this, will depend upon increased awareness and training of professionals and practitioners to support older high-risk drug users.

### **Evidence gaps and implications for policy and practice**

The following are needed in order to inform future policy responses to older high-risk drug users:

1. There are very few models of effective service responses – if any – that can be un-problematically transposed to the Scottish context in their existing form.
2. Whilst an awareness of the heterogeneity of older high-risk drug users has emerged, further work is required to fully understand the intersecting issues of gender, ethnicity, geography, social class, education and other social factors that may be important in understanding the needs of this population and their engagement with treatment and service responses.
3. The evidence on the awareness of the range of professionals and practitioners on the issue of older high-risk drug users and the challenges they face remains limited, and further work on this in the Scottish context would be welcome. Understanding the views and perspectives of professionals and practitioners who engage with such groups would be invaluable to devising effective and bespoke services to meet the needs of older high-risk drug users.

## 9 Online Survey of Service Professionals in Scotland

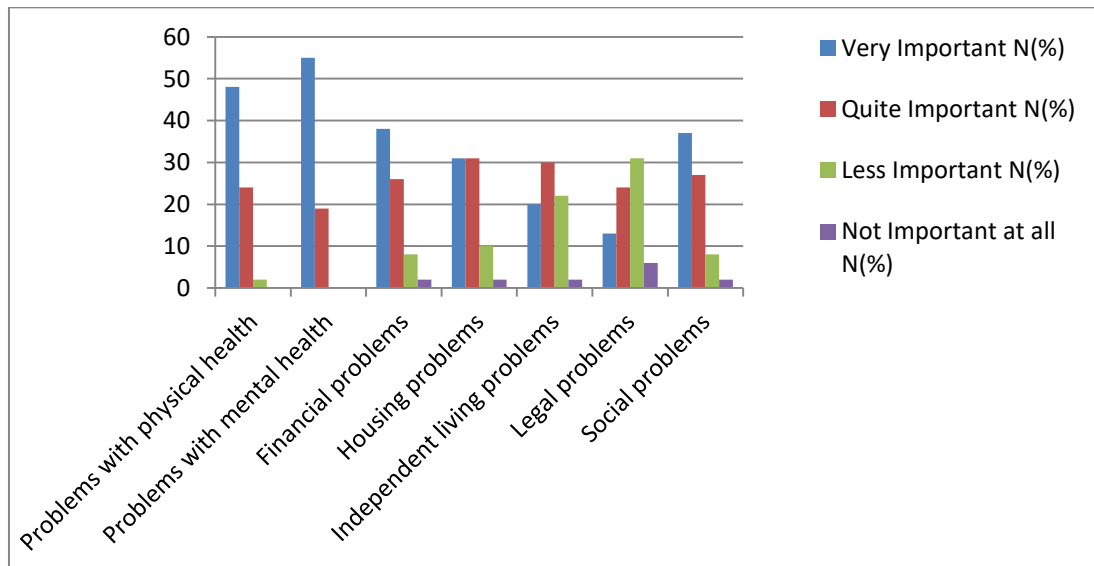
The SDF conducted an online survey of service professionals using a survey tool used previously (Brand, 2010). The survey was distributed to 222 services and responses were received from 74 professionals after two reminders (33% response rate). Responders were working in the statutory sector (51.4%), voluntary sector (44.6%) and private sector (4%). The majority (85.1%) were from Specialist Community Based Drug Service with 4% from Specialist Residential/In-Patient Drug Service and 10.8% from non-specialist support services.

**Table 4: What proportion of your clients are older people with a drug problem? (n=74)**

Answer Choices	No of responses n (%)
We have virtually no clients over 35	2 (2.7)
Less than a quarter of our clients are 35 and over	17 (23.0.)
Between a quarter and half of our clients are 35 and over	35 (47.3)
More than half our clients are over 35	20 (27.0)

Problems with mental and physical health were rated as the most important as displayed in figure 19. These were also seen as most important in the future (see figure 20).

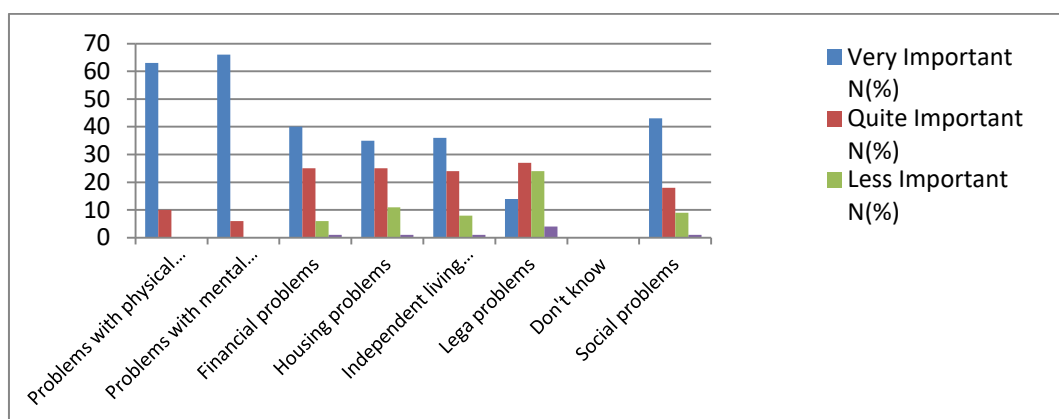
**Figure 19: How important would you rate the following issues for older drug users that you currently see in your service? (n=74)**



Sample of additional comments made under this question:

- *“I am aware of a number of service users in this bracket with respiratory problems, including COPD.”*
- *“Isolation, mental health especially anxiety depression and sleep problems.”*
- *“Overall, Older drug users that present to the service are more likely to talk about injecting injuries past and present as well as additional health issues that may be associated with prolonged drug use and age related [issues] such as aches and pains, nerve damage also common. More likely to talk about long prison sentences and wanting to change their lives. A few have presented to the service in temporary accommodation or have been homeless. They talk about the struggle to fund substance misuse on benefits and at times their struggle to prioritise their finances for food, electric etc. Some service users that are older talk about wanting to change while others are content with current usage. Older drug users also talk about their mental health and at times traumatic events which may contribute to their drug use.”*
- *“Appears to be some degree of cognitive deterioration.”*

**Figure 20: What areas do you see as increasingly important for this population in future years?**



Examples of additional comments made under this question:

- *“Inability to make rational choices/decisions”*
- *“With universal credit coming in, housing and financial issues will escalate significantly within our client group.”*
- *“Likely increasing drug related deaths in this group. Lack of medical staff in addiction services to assess and safely prescribe. higher level of skill needed to carry our medical assessments. Co-morbid alcohol and opiate dependence an increasing problem. Co-prescription of other sedating drugs and particularly gabapentanoids plus illicit use of these increases risk of overdose. Difficulty accessing relevant investigations such as ECGs, blood tests. Financial pressures to prescribe methadone rather than buprenorphine will exacerbate risks of drug related death or death due to arrhythmias.”*
- *“Patients can be very isolated and lonely. Most have stabilised in treatment or are in the process of finishing their drug treatment and have been away from illicit drugs for a long time. However, this leaves them isolated from peers, most are estranged from family members and very much on their own.”*

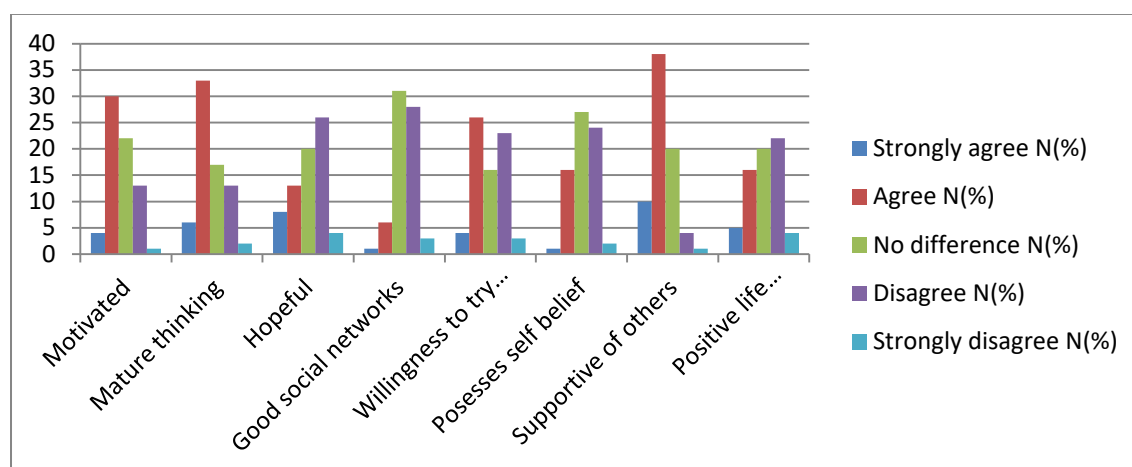


When asked “Do you currently provide any specialist or tailored services to this population within your own service? 40.5% responded ‘Yes’. Analysis of the comments given when asked to provide further details suggested some were providing a holistic approach within a general service. A sample of the responses is given below:

- *“1-1 mentoring/befriending weekly social groups”*
- *“Specialist physical health staff with ORT and Mental health staff with ORT”*
- *“We provide Drug Testing and Treatment Orders through the court, as well as tailored 'day programmes' for service users with addiction issues. Equine Assisted Therapy is another specialised service that we provide. Anger management is also provided. Oral Drug testing is also provided.”*
- *“Counselling, support advice and information.”*
- *“We provide individual and daycare support to recovering substance users. We support service users to develop individual recovery plans focusing initially on the higher priority areas identified in the drugs and alcohol outcome star. We support and monitor progress towards achieving stated goals linking with key partners as required.”*
- *“Long term psychosocial support, liaison with complimentary services, advocacy work, partnership work with mental and physical health service providers. Continued aftercare following closure for ease of access and re-referral.”*
- *“Long term approach required. Assistance with lifestyle needs, beyond the medical model. Require motivational work and encouragement to achieve as much as possible within their own limitations.”*
- *“Work in GP Shared Care and health check-ups undertaken regularly. We previously had an excellent third sector provider who had a local base with drop in, support workers, rehab worker and counsellors that was particularly important to our older patient group. However, under the genius of the commissioning process ... won the contract to provide 'services' here and we now have no local base, 'recovery workers' who do not see support or engagement with people as their role and provide no local facility for drop in.”*

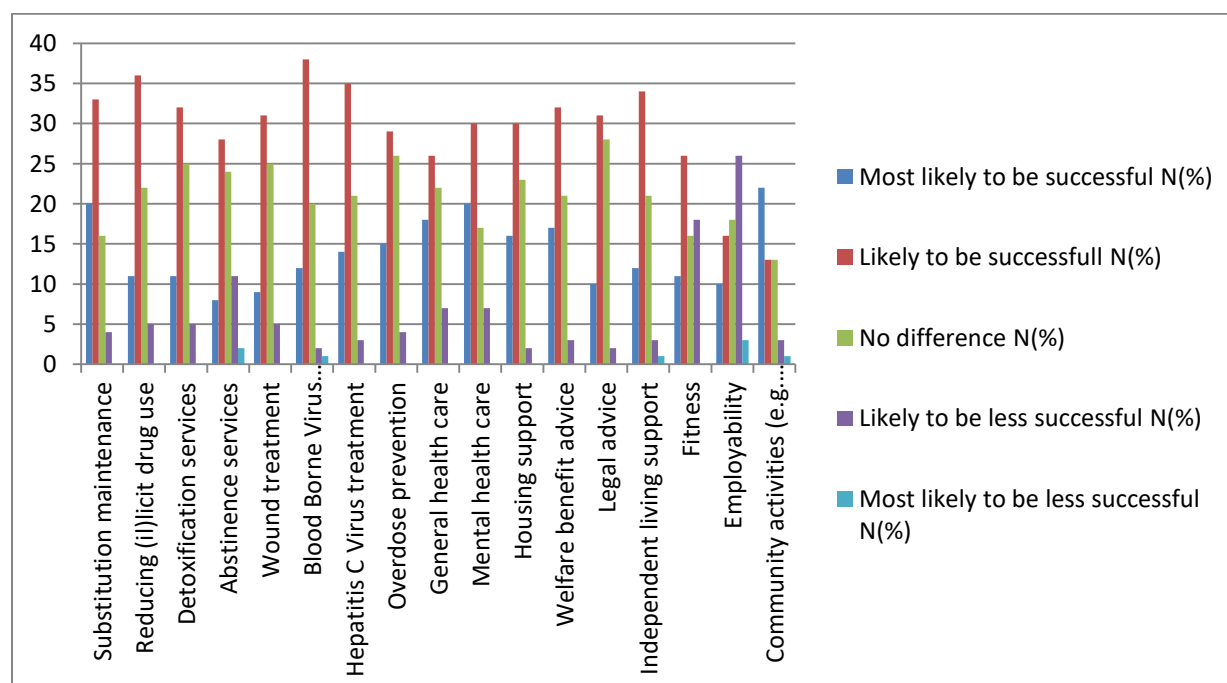
When asked what strengths were associated with this group, most agreed with 'being supportive of others'. See figure 21.

**Figure 21: What key strengths would you identify with this group?**



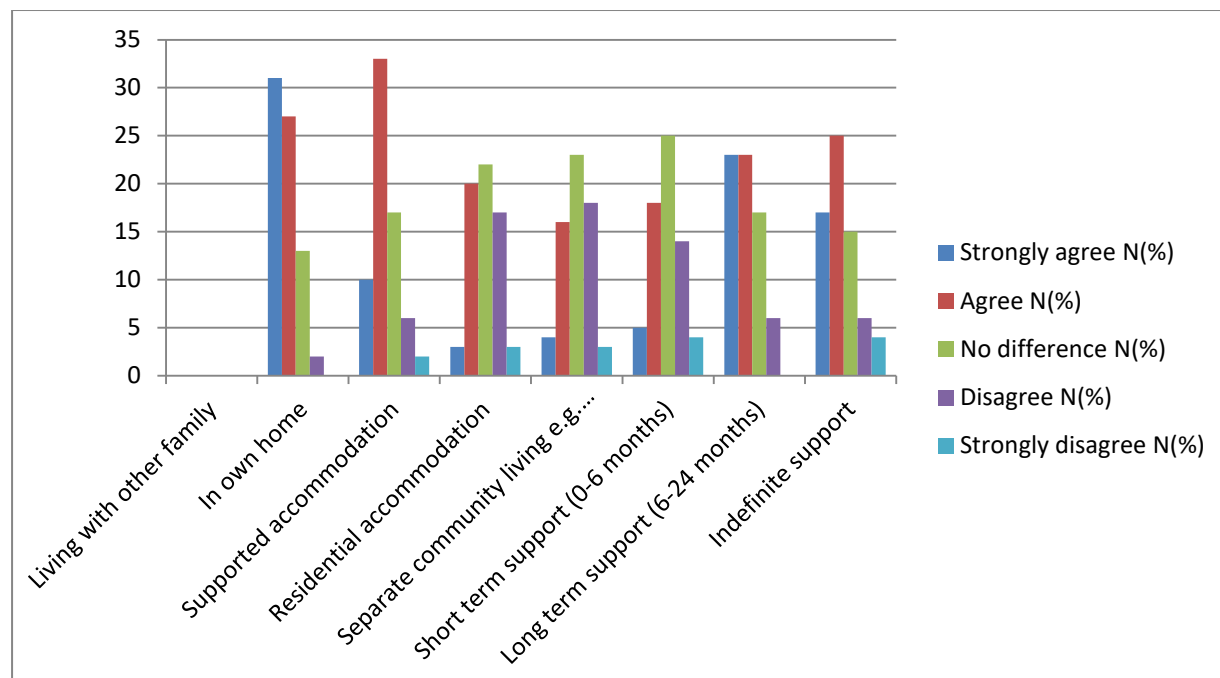
When asked what services might be successful, community activities, mental health support and substitution maintenance treatment were most frequently noted. (figure 22)

**Figure 22: What treatment and support options are more likely to be successful with this 35 + age group, compared to younger drug users?**



When asked about living environment in the future, 'own home' and 'supported accommodation' were the most highly agreed with options.

**Figure 23: What type of living environment best suits this group as they get older?**



## 10 Older People with Drug Problems in Scotland: A Mixed Methods Study Exploring Health and Social Support Needs

An interview based study of OPDP (>35 years) was undertaken in 2016, with the full research report being published alongside this working group report. The follow is a summary of the key findings.

### 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. The report made suggestions to the working group in the following areas:

### **Isolation and loneliness**

79% were living alone with very little social interaction and this need to talk and be listened to 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 OPDPs 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 had multiple drug treatment episodes. Ways to reduce the poor retention of OPDPs in services should be explored. This might 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
- ensuring service provider review their services for evidence of systematic (and probably unintentional) stigmatisation of OPDP.

## **Gender**

There are clear gender specific issues for OPDP that services should 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](http://meam.org.uk)).

In summary 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 were encouraging signs that many OPDP are keen to engage with services to improve their situation.

## 11 Key Issues

In this section key issues identified across the following working group's evidence gathering activities are considered:

- Evidence day
- Modelling work conducted by ISD
- Literature review
- Empirical research with OPDP
- Survey of service professionals
- Consultation seminar held in June 2016

Where possible knowledge of existing good practice and service developments are noted. Quotes from the OPDP research are used throughout this section to illustrate issues. (Matheson & SDF, 2016).

### 11.1 Mental health

Poor mental health is the most significant issue for OPDP and this may underlie many of the other issues presented in this section. There is strong link between mental health and problem drug use. For those with underlying mental health issues moving into later life there is potential for these to be exacerbated in a number of respects.

The survey of service professionals identified mental health as the most problematic issue for older drug users, as did the research with OPDP. The literature also acknowledged that OPDP are disproportionately more affected than the general population by mental ill health (Dowling et al., 2008). OPDP are at high risk of mental health issues for four reasons. Firstly, many drug users will have underlying mental health problems that pre-date their problem drug use. They may never have received appropriate treatment or mental health services may have failed to retain them in treatment. Mental health problems may be part of the cause for people becoming involved in drug use. Secondly, problem drug use and the associated lifestyle associated with involvement in buying and using street drugs and being marginalised within society can cause or exacerbate mental health problems. Thirdly, the effect of long term substance use may be the cause of mental health problems. Fourthly, old age in itself may bring problems with mental health such as isolation and depression, as it can for the general population.

Mental health problems may prevent engagement with services (both general health services and specialist services), but also exacerbate relapse. A study of attempted cessation of men approaching mid-life (over 28 years) found relapse occurred because of inadequate mental health preparation. They also had difficulty coping with normal emotions previously blocked by heroin use (Mullen & Hammersley,



2006). Thus mental health problems may have an impact on treatment engagement and retention. The research project identified mental health as a major problem linked to isolation:

*“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)

The issue of advocacy was raised at the stakeholder event as a means of helping those with mental health problems access appropriate services as well as enabling people to express their feelings about treatment they are currently receiving.

## **11.2 Physical health and multi-morbidity**

Poor physical health was the second biggest issue identified by OPDP in the research project and by service professionals in the survey. Furthermore the data from ISD provides strong evidence of the impact of poor physical health on hospital admissions now and in the future.

These findings are consistent with the literature. OPDP are likely to 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; Colliver, 2006). The ageing process itself is often associated with a range of psychological and physical health problems (Dowling et al, 2008). Drug intoxication and the residual effects of drug use may differ in older persons, affecting the cognitive, motor and physical functions of individuals (Colliver, 2006). The process by which drugs are absorbed, distributed, metabolised and eliminated from the body change with the onset of ageing (Dowling, 2008). Individuals who have used drugs for many years are more likely to have poor general health related to physical functioning; role limitations due to physical health; and bodily pain compared to younger drug users and the general population (Lowfall et al, 2004). A 33 year follow-up study of long term drug users (average age 58 years) found that, compared to the general population, these OPDP had high rates of morbidity, most notably abnormal lung and liver functions and infectious diseases (Hser, 2004).

It is estimated that the ageing process among OPDP is accelerated by at least 15 years. At the age of 40 years, drug users may need a level of care corresponding to that required by an elderly person in the general population (Vogt, 2009). This is consistent with a recent Scottish study which found that the most deprived decile of the population developed multiple long term conditions 10 to 15 years earlier than those from the most affluent decile (Barnett et al., 2012).

A further study identified the fact that deprived individuals with multiple conditions, including mental health problems, have a 51 fold increased risk of a potentially preventable unplanned hospital admission (Payne et al., 2013).

Cardio-pulmonary ailments are commonly found among OPDP and are among the most serious conditions. These are linked to a long history of tobacco and drug smoking and along with long-term injecting drug use. Vein damage from injecting results in injecting becoming more difficult leading to riskier practices such as groin injecting (Beynon et al., 2009; Woodburn and Murie, 1996) and leads to an increase the risk of deep vein thrombosis (Beynon et al., 2009).

The ISD analysis clearly shows very high and rising rates of unplanned admissions to hospital. The utility of these points of contact with statutory health services need to be maximised to improve health outcomes for the individual and prevent rising health costs. This should be seen as a preventive measure in line with the Christie report recommendations for public services (Christie, 2011).

Examples of likely effective interventions include identifying OPDP as a priority group for developing 'Key Information Summaries', a simple and effective way to facilitate communication between primary and secondary care.

The development of drug liaison work in secondary care could ensure that an individual's drug problem, along with any mental health issues, might be identified and addressed during their acute hospital stay. The working group received evidence of substance use liaison nurses in hospitals so there are examples of good practice that can be built on.

A further particularly promising intervention, in the acute hospital setting, is 'primary care in-reach'. This model has been developed by the Pathway charity in London, to holistically address the needs of homeless patients when admitted to hospital. It is a partnership model between GPs, hospital nurses, housing, third sector support services and experts by experience, as care navigators (Hewitt et al 2013). At risk patients are identified in hospital and a holistic health assessment is carried out that includes mental health, addictions, money and housing issues. The patient is then supported in the hospital setting by the care navigators and actively linked in to appropriate community services when discharged. The results have shown a reduction in readmission rates, as well as improving health outcomes for those with multiple and complex needs (Dorney-Smith et al., 2014).

Consideration should also be given to how the general health needs of OPDP might be addressed through the new GP contract. For patients with severe and enduring mental health problems there has been an enhanced service to ensure their physical health needs are addressed. This could be replicated for OPDP, given the overwhelming evidence of their very poor health outcomes.

#### 11.2.1 Respiratory disease

In the general population respiratory ill health increases with age. This is the same with PDPs although such problems are likely to occur at a younger age. This was starkly displayed in the ISD data on hospital admissions for COPD/asthma which identified a 5.5 times higher level of hospital admissions in the over 60 year age group and a 6.2 times higher admission rate in the 50-60 year age group compared to the general population. This in line with analysis of primary care data in Scotland which found significantly higher levels of both asthma and chronic obstructive pulmonary disease in people with a diagnosis of opiate dependence when compared to a matched sample of the population (Palmer et al., 2012). Respiratory conditions may be further exacerbated by particular forms of drug use e.g. smoking heroin and using cannabis with tobacco. The respiratory complications of smoking, which range from a shortness of breath to obstructive lung disease, are more common not only among cigarette smokers, but also among smokers of crack cocaine, heroin, cannabis, and other smokeable drugs (Hser et al., 2004). The causes of poor respiratory health are not fully understood but it is likely that lack of appropriate treatment is a feature.

There is a need to actively screen OPDP for chronic respiratory disease. This could be carried out in general practice, specialist drug services and community pharmacies through the use of spirometry. Initiation and monitoring of treatment for COPD, along with smoking cessation support should be available in all these settings. This is particularly relevant given the potential role of respiratory impairment in overdose risk.

#### 11.2.2 Pain management

Pain management was increasingly reported as an issue that needs to be addressed at the evidence day. This was also evident in the OPDP research and the service professional's survey where issues such as nerve damage were raised as a source of pain. This is clearly more acute for OPDP who are more likely to experience significant pain. Gossop & Moos (2008) highlighted the issue of pain management in ageing individuals with long histories of opioid dependence. The likelihood of under-medicating people with opioid analgesics is greater when treating clients with a known drug problem or receiving ORT. Such under-dosing relates in particular to

fears of overdosing, notions of drug seeking behaviour by the patient and prescription drug diversion (Alford et al, 2006), and may result in unnecessary pain for the client. This was evident in the OPDP research:

*“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)*

The literature review highlighted the need for educating prescribing professionals on pain management whilst being mindful of drug dependence. There are already examples of good practice in Scotland regarding joined up pain management and substance misuse services. In Edinburgh there is a joint clinic co-led by an anaesthetist and an Addiction psychiatrist (personal communication, Rebecca Lawrence, Addiction Psychiatrist). As well as perhaps considering extending such specialist services in other areas there needs to be education across generalist health care staff to ensure both chronic pain and acute pain are appropriately managed in PDPs. This was one area where advocacy might be considered.

### 11.2.3 Hepatitis C, other blood borne viruses (BBVs) and liver damage

Levels of Hepatitis C Virus (HCV) and other BBVs are closely associated with length of drug injecting. Consequently, age is a predictor for the likelihood of an individual being HCV positive and disease progression accelerates with age. ISD data identified considerably higher rates of hospital admission from Hepatitis C in OPDP compared to the general population. For those in regular contact with services HCV should have been diagnosed and appropriate treatment and care put in place, but there is a considerable level of undiagnosed and untreated HCV which is leading to significant liver cirrhosis within OPDP.

In addition to HCV liver damage there is also significant cirrhosis as a result of heavy alcohol consumption alongside drug use or in periods of abstinence from drugs. Alcohol use also accelerates HCV related liver disease. Liver damage will affect drug metabolism and may be linked to increased risk of overdose.

Encouragingly, from the professional’s survey there appeared to be optimism about hepatitis C and BBV treatment in this group. Results of the research with OPDP found that a high proportion noted hepatitis C services as services they would use in the future. Indeed it was raised that hepatitis C service providers may be a route into addressing some of the wider issues affecting OPDP. Co-locating drug and BBV services is an effective means to facilitate this, as demonstrated by the homeless GP practice in Edinburgh.

With recent developments in anti-viral treatment, hepatitis C is now a potentially easily treatable condition. We recommend that OPDP are identified as a priority group for hepatitis C screening, diagnosis and treatment.

#### 11.2.4 Diet and nutrition

Closely linked to welfare reform and financial issues was the issue of diet. Poor nutrition has long been recognised by those working with people with a drug problem. Recent research has also highlighted the poor nutritional status of PDPs (Sayura, 2016). It would seem particularly important to focus on this for the older population with increased morbidities. Alongside other issues of general health it would appear that diet and nutrition are largely neglected by services. Weight loss may be a contributory factor in some overdose deaths for example if a person's dose of methadone remained the same despite a considerable reduction in weight.

#### 11.2.5 Oral and dental health

Dental problems are highly prevalent among OPDP due to poor dental hygiene, poor nutrition/malnutrition and limited engagement with dental services as well as years of opportunistic infection due to the dry mouth caused by opiate use. (Brand 2010).

### 11.3 Isolation, stigma and discrimination

The issues of social isolation and exclusion were strong themes emerging from the literature review and from the research project. This was also noted in additional comments made by service professionals in the survey. A notable finding of the OPDP research was the very high proportion who lived alone (79%), much higher than in the general population. As ageing occurs, people are prone to experience the loss of key relationships and social networks. Many are grieving the loss of friends and partners. For people with a drug problem this will occur at a younger age than the general population. Incidences such as family breakdown, loss of job roles, mortality and morbidity among friends and significant others makes OPDP increasingly isolated and vulnerable (Beynon et al, 2009). However, the research with OPDP also found there were people who deliberately withdrew from wider society, leading to isolation:

*"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).*

Isolation and loneliness are now recognised as significant risk factors for mortality, including cardiovascular disease and depression. This is recognised as an increasing public health problem and OPDP are particularly affected (Steptoe et al.,

2013). This was also evident in the literature. Fear of victimisation by younger users may encourage OPDP to remove themselves from active participation in the drug scene to a self-imposed isolation along its peripheries as a protective strategy against harm, thus OPDP users may become 'the marginal among the marginal of society' (Anderson and Levy, 2003). Levy & Anderson (2005) suggest long-term PDPs may prefer to 'age in place' and remain in a 'familiar socio-economic environment where they know the rules and what to expect.' Therefore some may be too old and too socially disenfranchised to leave behind the subculture in which they have matured and grown older (Levy & Anderson, 2005). Responses in the survey of service professionals highlighted that this can be a particular challenge in small rural communities.

OPDP are likely to be more marginalised, have higher levels of unemployment, lower education, they are more often homeless, and they are more likely to have been in prison (EMCDDA, 2010). OPDP also have health issues (as has been demonstrated). These factors combined with the stigma which still exists around drug dependency creates a strong sense of isolation from their community. The research with OPDP found there was a strong perception of stigma and discrimination across services and society:

*"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)

A study by the EMCDDA (2010) identified that the observed absence of older users attending services beyond health centre-based opiate substitution therapy was due to feelings of shame and embarrassment. This prevented people from seeking help with their drug use, from being honest about drug-related harm that needed treatment, and led to isolation from family and friends, secretive drug use and interfered with positive social networks. Stigma associated with drug addiction was experienced by more than three quarters of respondents. However, the experience of multiple stigmas was common, most often combined with the stigma of ageing (33%), the stigma of depression and of taking psychotropic medications (25%).

The EMCDDA study also reported fears of judgmental attitude from professionals from OPDP (EMCDDA, 2010). This was also evident in the OPDP research. However the survey of services professionals in the sector revealed a very sympathetic and concerned workforce in relation to OPDP. This contradiction needs addressed.

Discrimination in various forms has been well documented as an important issue in the lives of those with serious drug problems particularly in regard to the services from which they are seeking help. What is less well documented is whether there are differences in the level of discrimination attached to those people with a drug problem who are older. However, what is clear is that this discrimination impacts disproportionately severely on the older person with a drug problem because of their increased health needs. This was described as ‘double jeopardy’ by Kelsall et al. (2011), i.e. the compounding issues of increasing health problems experienced by many OPDP alongside a health care system that is disinclined to treat them. Again this was evident in the OPDP research:

*“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)*

## **11.4 Family**

Many of those with a long history of a drug problem, as has been described, are socially isolated and marginalised. Part of this marginalisation is also likely to be from their extended family. While the wider family potentially have a key role in supporting an individual, this relationship may be challenging, particularly after such an extended period of problem drug use. However greater stability in older life particularly with regard to drug use may allow for the opportunity to rebuild broken family ties. Of note is that in the service professional survey, when asked what type of living environment best suits this group as they get older, none ticked the option of living with other family (figure 23).

A significant proportion of OPDP will also have children, mostly in adulthood. These relationships can be challenging but older age may be an opportunity to rebuild these. The review of the literature did not identify any previous studies around the role of the family in OPDP specifically. It might be possible to draw on the literature on family therapy (Saatcioglu et al., 2006). Given the lack of specific, recorded evidence on the role of the family in potentially supporting and engaging OPDP, this could be an area for innovative practice developments.

## **11.5 Sub-populations**

### **11.5.1 Gender**

There are significant gender differences amongst OPDP identified in the literature and in the OPDP research. Women for example are more likely to live with a problem drug user (Rosen, 2004), experience intimate partner violence (Engstrom, 2008; Bourgois et al, 2004) and engage in high risk sexual behaviours (El-Bassel et al., 2005).

In addition methadone treatment for female users may also be complicated by issues related to the menopause (Tuchmann 2007). Furthermore women with self-medicating drug use histories experience increased levels of physical discomfort, insomnia, irritability, anxiety, and depression during their menopausal transition and may be at high risk for relapse to drug use (Tuchmann, 2007). These issues suggest a need to explore gender differences among older methadone clients in particular and OPDP in general.

Brand (2010) found evidence among professionals that women were overly ambitious in terms of their expectations of service engagement and viewed relationships and having and keeping or gaining access to their children as a sole measure of success despite this sometimes being unlikely or impossible. Also professionals recounted a tendency for women to give up hope for themselves at the point where they realised that having and keeping a child or gaining access to their own children was impossible. The trajectory of their drug problems therefore was different from men for whom actual or envisaged fatherhood or the biological possibility of becoming a father had far less influence on their drug problem.

#### 11.5.2 Late onset drug users

While the majority of OPDP will have had a drug problem for an extended period of time, the literature review identified that there was a significant minority of OPDP who developed a drug problem later in life. The OPDP research also identified a small proportion of the sample whose drug use became problematic later, the oldest age being at 43 years.

Boeri et al (2008) reported that early onset users had a protective factor of years of experience in terms of controlling their drug use which differed from late onset users who need to learn to negotiate between their drug use and drug using environment, and mainstream society. Moreover the changing roles that occur across the life span e.g. parents, grandparents, work and retirement are integrated into the lives of early onset users. In contrast late onset users either lose these roles as their drug use escalates or are at more liberty to use drugs due to their decreased role in mainstream society. Nevertheless, whatever the drug of choice might be, late onset drug users may have different dependence characteristics and may therefore require different treatment approaches than early onset users (Boeri et al., 2008; Gossop & Moos, 2008).



## **11.6 Opioid Replacement Therapy (ORT)**

The delivery of ORT programmes across Scotland is challenging, with significant issues regarding effective delivery including access, retention and follow-up. The issues around OPDP are twofold:

Firstly, how best to respond to the needs of OPDP who have been on ORT for a lengthy period of potentially 10-15 years or more. This relatively stable group may have become somewhat invisible within services as they are not particularly demanding and may have low aspirations for themselves and with regard to the services they receive. This was very evident in the OPDP research.

Secondly, and even more challenging, is how to respond to the most unstable group who are extremely vulnerable as they are at greater risk of overdose death, have a history of frequently moving in and out of services and have relatively short periods on ORT.

There is a substantial body of evidence that retention in treatment is protective with regard to risk of overdose (Simoens et al., 2004). Given the substantial rise in overdose deaths it is crucial that services explore ways to engage more effectively with this second group. For the group who are on long term on ORT we need to continually review the level and range of support they are receiving and identify if additional support is required in relation to underlying health issues or social support. The OPDP research suggested assertive outreach should be used for those at risk of isolation. Furthermore matching workers, for example in terms of age to OPDP may help build the therapeutic relationship that could help keep people in treatment. Increasing the range of ORT options might also keep people in treatment e.g. heroin assisted treatment.

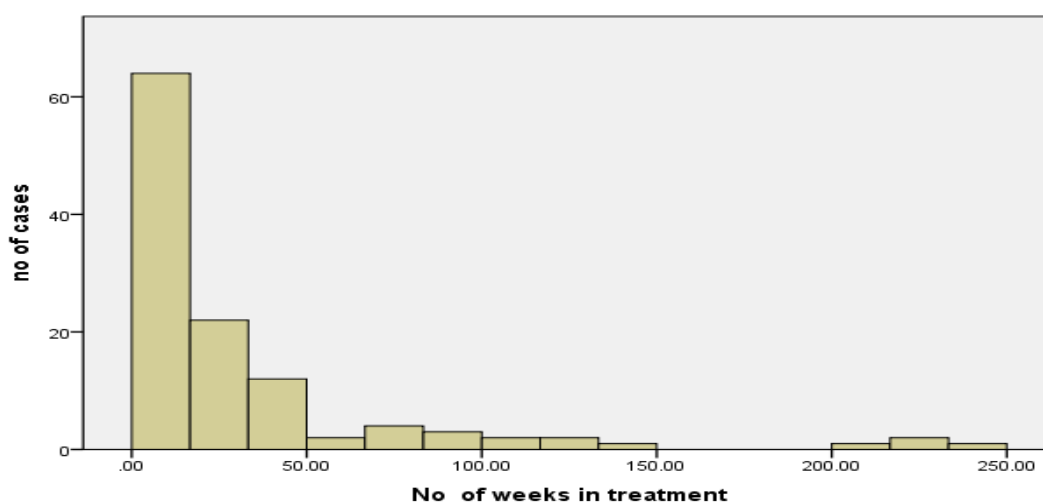
For the more vulnerable group who have failed to engage we took evidence from Switzerland where the average age of those in treatment was 41-42 years old. They had achieved a capture rate of 80% of those with a drug problem in treatment through swift access and a range of ORT options including slow release morphine and diamorphine i.e. heroin assisted treatment- (Dr Thilo Beck, presentation, Evidence day, June 2015).

## **11.7 Pressure to withdraw from ORT**

Over recent years there has been a range of pressures on people to come off ORT. This has in part been due to the increasing stigma around methadone and the public discourse that it is a 'bad drug' (Matheson et al., 2014). It may also be the result of inappropriate implementation of the recovery strategy at service level. This has the potential to be particularly harmful for those with underlying mental health problems. This can result in those who are stable on ORT becoming less so following

withdrawal. Indeed the survey of providers rated abstinence services lowest when asked what treatment and services are likely to be successful in this group. The following graph from the research with OPDP highlights the short time people are spending in treatment as a continuous period. The median time in treatment was just 12 weeks. This is of particular concern given the evidence that shorter treatment courses are associated with greater risk of mortality. Where the course of opioid replacement therapy is less than 12 weeks the risk may outweigh the benefit (Cornish et al., 2010).

Length of time in last treatment episode in weeks (Source OPDP research)



*“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 gi 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).*

It was considered that this might be another area in which advocacy might be required to help people in treatment express their views about their treatment plan.

## 11.8 Financial issues

The OPDP research identified that 95% were on welfare benefits. Significant hardship is evident through the impact of welfare reform and the imposition of sanctions was noted by service professionals in additional comments given as part of the survey. The research with OPDP identified individuals who had had benefits withdrawn leaving them reliant on family and food banks for basic supplies.

Increased hardship and sanctions in overall terms can exacerbate many other issues people are struggling with and may compound feelings of despair and worthlessness. There are a range of specific issues that older people with drug problems often struggle with including the harshness of incapacity benefits, difficulties of online benefit application, challenges of moving to a four week payment period and a sanction regime that appears to impact particularly severely on this population (Poverty Alliance, GCVS and SDF, 2015).

The EMCDDA also highlighted some of the challenges:

*“It could be argued that the current European debate on how to motivate problem drug users to access treatment, improve their employability and provide welfare support contingent upon abstinence or entering rehabilitation programmes appears to be largely framed around the needs and situation of younger users. Older problem drug users who have a long history of treatment programmes, and for whom achieving long-lasting abstinence may not be a realistic objective, may be particularly vulnerable and poorly served by some drug policies and social welfare models. Similarly, social reintegration through participating in the labour market presupposes that the individuals are sufficiently healthy to obtain and remain in mainstream employment. Such premises may be true for younger problem drug users, but alternative social reintegration policies and options may have to be developed for older ones.”*

(Treatment and care for older drug users, EMCDDA, 2010).

## **11.9 Housing and care homes**

Housing is a major issue for many people with a drug problem including finding accommodation or sustaining a tenancy. The research with OPDP found 91% had been homeless at some point. Many OPDP are in relatively stable living conditions but a substantial proportion have a long history of unstable accommodation with periods of rooflessness (Rome, 2010). More recently ‘multiple exclusion homelessness’ has been described in which homelessness is part of a raft of individual problems such as drug dependence, poor mental health and criminal justice issues. Homelessness is often a late presentation of challenging life circumstances which opens opportunities for early intervention (Hetherington & Hamlet, 2015). The main challenge is often the vicious cycle of an inability to find accommodation because of their drug use and an inability to deal with their drug problem without accommodation. There is a model recently introduced in parts of Scotland called ‘Housing First’ which provides tenancies with support without any requirement that a person’s substance use is stable. This model seems to work well with an older population who are seeking stability (Bretherton & Pleace, 2015).

To date there has not been a demand from significant numbers of OPDP requiring nursing home and residential care. However it is anticipated that this will change over the coming years. OPDP with deteriorating health, limited social support and reduced mobility will increasingly have pressing accommodation and nursing needs which are more commonly associated with a much older age group.

The EMCDDA report highlighted development elsewhere in Europe, developments and approaches that Scotland may well have to follow.

*“Due to the difficulty to accommodate older problem drug users in mainstream nursing or retirement homes, a few countries (e.g. Denmark, Germany, Netherlands) have developed specialised nursing homes and accommodation services for this group. Two of the first such care facilities for older drug users were developed as pilot projects in the late 1990s in the Netherlands and Germany. The Dutch facility is part of an existing retirement home and aims to cater for older drug users who are no longer able to look after themselves. Older drug users live in 24-hour supervised accommodation, where the aims include helping them to learn and maintain living skills, manage their income, monitor medicine use, engage in activities and follow a daily routine. The main goal is to help drug users live out their final years in comfort and dignity. An important point is that while residents are encouraged to reduce their drug use, consumption is not prohibited.*

*The services provided within the German project comprise long-term residential care for older drug users and ambulatory forms of assisted living. Housed in living communities, older drug users can make use of outpatient drug treatment services and elder care. It is up to the project leader to decide on a case-by-case basis whether the services should be primarily geared to the need of the treatment of dependence or to aspects of nursing care. In Germany, several such projects have now been implemented as pilot projects, though do not form part of the regular care offer.*

*In 2004, the city of Copenhagen conducted a study of the needs for care and nursing facilities among persons over the age of 39 in substitution treatment and tried to assess their future care needs. The results suggested that about half of the users would start to need care and nursing services within five years. It was predicted that 76% of them would experience somatic problems, 31% mental disorders and between 30% and 40% social problems (social isolation, loneliness). The majority of older drug users lived in their own dwelling and were assessed to be capable of staying there with social support and care (home care, home nursing). A smaller share would need supported housing services that include supervision, social support, practical aid and care. Finally, due to their frailty, it would be necessary to place a significant number of older drug users in nursing homes.”*

(Treatment and care for older drug users, EMCDDA, 2010)

The Scottish Government commissioned research in 2008 which recommended to Government that a Housing First model would be a significant part of a Scottish response to the challenge of housing people who have on-going drug problems (Pleace, 2008).

### **11.10 Criminality and criminal justice issues**

There continues to be significant numbers of OPDP who come into contact with the criminal justice system. This can be in a range of settings:

- police custody
- prison
- prison through-care workers
- diversion from prosecution programmes
- court disposal – a community payback order with a condition of drug treatment or a Drug Treatment and Testing Order (DTTOs)
- as victims of gender based violence.

With regard to DTTOs, of the 548 orders in 2014/15, 260 were for individuals aged 31-40. The percentage of those receiving a DTTO who were over 40 years has increased from 4% in 2004/05 to 17% in 2014/15. The Prisons Inspectorate in Scotland has reported on the challenge for the prison service of an ageing profile of the prison population (HMS Inspector of Prison, 2014). A significant proportion of these individuals will have a history of drug dependence.

### **11.11 Recovery, quality of life and relapse**

The importance of a broad view of recovery is crucial for this population which encompasses a range of factors that lead to improved quality of life. It is clear from the evidence base that key measures of quality of life, such as poverty and low income, co-morbid psychiatric conditions, and lack of family and social supports are among the most important predictors of relapse (Hser, 2007; McLellan et al., 2000; Termorshuizen et al., 2005; Weisner et al., 2003). This ageing group of long term PDP have all of these problems as well as significant physical health problems and challenges of isolation and stigma.

The EMCDDA highlighted clearly what is self-evident to those working in this area that:

*“Fostering opportunities for improved functioning and satisfaction in key areas (psychosocial, education, employment, physical and mental health, housing, leisure activities) may have to be prioritised and may significantly enhance the likelihood of sustained remission and improved quality of life”*

(Treatment and care for older drug users, *EMCDDA*, 2010)

This is in line with the survey of service professionals which showed that many did not consider abstinence services to be as likely to be successful.

Drug use fluctuates across the lifetime of use, with changes in drugs of choice and changes in frequency of use, periods of reduction and abstinence, maintenance and substitution (Roe et al., 2010; Boeri et al., 2006). According to Boeri et al (2006) attachment to and involvement in conventional social roles helps some users maintain control of their drug use. On the other hand drug users who lack self-control are able to “learn” self-control through involvement in another social role which may be unconventional or illegitimate. Thus a form of role legitimacy may be beneficial in building recovery capital. Recovery capital has been defined as relating to the following aspects (Daddow & Broome, 2010):

- safe and secure accommodation
- physical and mental wellbeing
- purposeful activity
- Peer support
- Supportive friends and family
- Supportive and non stigmatising attitudes in the broader community
- Community resources (for instance activities and transport links)
- Recovery communities

Roe et al (2010) also found that OPDP reported using more responsibly and attempting to maintain personal safety due to the experiences they had gathered over their drug using careers, e.g. illness, fatal and non-fatal overdoses, hospitalisation and unsafe personal situations. There was some suggestion from the survey of service professionals that a more mature approach can exist in this group. Service professionals also noted a willingness to be supportive of others (see figure 21). However it was also raised that cognitive function can deteriorate which may be detrimental to a more considered thought process about risky behaviours.

For some OPDP, fear of detoxification and withdrawal may be an important barrier from attempts to discontinue drug use (Ayres et al., 2012; Boeri et al., 2008). Ayres identified several categories of fear that may prevent progress. These were: fear that detoxification might not be successful and therefore might result in a return to dependence on illegal street drugs; fear that detoxification would be much harder with older age - this was based on experience of ‘failed’ detoxes when younger and the assumption that the process becomes progressively harder; and fear that if a detoxification regime was started there might be pressure to continue or proceed at too fast a pace (Ayres, 2012).

The OPDP research highlighted the need for mental health support and the value placed on service providers who took time to talk to people. Consequently, for a population with limited recovery capital (poor health, isolation, living alone), a range of factors are important to address in aiding recovery and reducing the risk of relapse. These areas include support in the following domains:

- psychosocial
- education
- employment/volunteering as a form of role legitimacy
- physical and mental health/social networks
- housing
- leisure activities

### **11.12 Employment, education and volunteering**

Many OPDP will be far from the labour market due to underlying health issues making it difficult for them to attend work regularly, or as a result of their current drug use. However, many OPDP may have aspirations to volunteer and work. This is challenging for many reasons and particularly because many OPDP will have limited educational qualifications and will have had either lengthy periods of unemployment or indeed may have never worked.

What is crucially important is having opportunities which allow people to have hope and an aspiration for a better future. These opportunities should include targeted and bespoke volunteering opportunities both within the sector and outwith it.

The limited work history and educational attainment alongside, in a significant proportion of individuals, lengthy criminal records, create significant barriers to employment. There is evidence that supported employment models can have positive outcomes with older people with a history of problem drug use (In Work Project, 2014). Indeed a positive finding from the OPDP research was that there was expressed willingness to use their life experience in a positive way and engage with volunteering or supporting other drug users.

### **11.13 Developing practice**

The literature review was supportive of the tailoring of specific services for older high-risk drug users. Evidence from Switzerland was cited (Gerlich et al, 2010), which found that when comparing heroin-assisted treatment (HAT) and abstinence-oriented residential treatment (AORT), HAT service responses may be more appropriate for older high-risk drug users, especially if there had been involvement in crime. Ayres et al, (2012) claimed the need to ensure that service provision is age-appropriate and that staff are trained to understand the needs and anxieties of older

users. Specifically, they discussed the ways in which residential and community detoxification programmes may need to adapt to meet the needs of older people. Ayres et al (2012) suggested detoxification regimes may need to be much slower with better medical support to accommodate age-related metabolic changes. The OPDP research identified a strong desire to separate older and younger drug users due to a perception that they had different priorities.

The survey of professionals indicated that some services are already trying to meet the needs of OPDP. A holistic approach was evident in some services and others provided services such as advocacy, counselling and physical health checks, all of which are beneficial to this population.



## 12 Summary and Conclusions

A high proportion of OPDPs have multiple health conditions and are exhibiting many of the conditions associated with the elderly e.g. cognitive decline, respiratory disease and chronic pain. A significant and increasing number of this population are dying from drug overdoses. Mental health problems are common and are compounded by isolation and stigma which hinders appropriate service access and wider community integration. Since many OPDP are primarily identified as drug users, their underlying health conditions are often not identified or treated effectively. A significant proportion of OPDP are living alone, with limited family involvement, resulting in isolation and loneliness. Welfare reform has led to further cuts to the income of OPDP which could impact on other aspects of life including housing and nutrition.

These issues amount to a lack of 'recovery capital' which suggests that 'Recovery' for this group should be considered in the broader context of accessing appropriate medical help for multi-morbidities, reducing isolation, improved nutrition and access to stable, long term housing. Advocacy may be required to enable this to happen. Encouragingly a significant proportion of OPDP would like to engage in meaningful activity, such as volunteering as they are generally considered supportive of others.

There are examples of good practice across Scotland including combined pain and addiction clinics, general medical staff based within specialist services to address general medical problems and a holistic approach to treatment within specialist services. Such good practice should be shared and extended.

Given the wealth of evidence over the shocking health outcomes for this group of citizens, it is clear that they face some of the most extreme health inequalities seen in Scottish society today. We believe that to address this situation services will need to work in a more integrated and proactive way. Furthermore, patients will need to be supported to enable them to access and make use of health services. This may require more funding initially but should result in a reduction of hospital admissions and indeed in the overall health finance burden in the medium to long term.

## 13 Membership of Working Group

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## Appendix 1: List of Recommendations

### **Recommendation 1**

As part of national quality improvement work, partners, alongside Scottish Government, should test models to explore how best to identify and treat underlying health conditions of OPDPs in both specialist and primary care services.

### **Recommendation 2**

Scottish Government, with partners, should test models of independent advocacy services to ensure that sub-standard care, particularly in relation to underlying health conditions for this population, is appropriately challenged and remedied.

### **Recommendation 3**

ADPs and Integrated Joint Boards (IJBs) for health and social care should develop training in this area and build partnership working between pain services, primary care and addiction services.

### **Recommendation 4**

IJBs should ensure that mental health and addictions services work effectively together at operational and strategic levels in order to better identify and meet the needs of OPDP. This should include the development of assertive outreach models of care which seek to make contact with those who are not engaging with existing provision.

### **Recommendation 5**

ADP's and partners should consider at a local level how they can develop appropriate support to reduce isolation and loneliness amongst OPDP and develop meaningful productive activity programmes. This will include specialist addiction services as well as community services and recovery / volunteer groups.

Progress on issues relating to isolation should be a required element of ADP's annual reporting to Scottish Government.

## **Recommendation 6**

ADPs should ensure that services are able to:

- reach out to OPDP using a range of strategies including assertive outreach
- provide an accessible service that takes account of, and addresses, issues OPDP may face in accessing services
- provide a quality psychologically informed service that is able to retain people appropriately in the service; and
- progress on these issues should be a requirement of ADPs annual reporting to Scottish Government.

## **Recommendation 7**

Scottish Government and partners should explore the funding of large and small scale pilot projects (including small tests of change) to generate increased evidence and practice models for how to best work with this population in a way that can be replicated within mainstream provision.

## **Recommendation 8**

There is a need for ADPs and frontline services to ensure that gender issues for older women with a drug problem are addressed as part of their treatment and care, including underlying issues such as trauma and/or domestic violence. Addressing these issues should be a focus of treatment and the process of identification and addressing these issues should be undertaken as early as it is safe and appropriate to do so.

## **Recommendation 9**

Scottish Drugs Forum, as the national training agency, should work with Scottish Government to explore how best to ensure training on working with OPDPs is made widely available to those who need it.

### **Recommendation 10**

Partners should work alongside relevant Scottish Government departments and other stakeholders to explore options for meeting the accommodation needs of this group, with particular attention to the potential to develop Housing First models whereby accommodation and any necessary support is provided without condition as to the person's substance use.

This may be provided in a 'core and cluster approach' that would mean that housing and isolation needs could be addressed together.

Where care needs lead to people needing a care or nursing home setting, consideration must be given to how services to Older People adapt to accommodate this group. Local authorities, providers and Scottish Government should work together to consider this issue and how, working jointly, this can be anticipated and addressed. This includes understanding the scale of this need, where it will present and the staff and service developments required to address this.

### **Recommendation 11**

ADPs and IJBs for health and social care should work alongside Scottish Government and partners to develop guidance which could offer assistance in commissioning processes, including tendering and Service Level Agreements, for services specifically related to OPDP.

### **Recommendation 12**

A strong case needs to be made to IJBs that investment in quality drug and alcohol treatment and care services for OPDPs, alongside accessible primary care services, will make a positive impact on the demand for other services. There would be a likely significant reduction in emergency and unplanned hospital admissions as well as impacting on drug related deaths.

## Appendix 2: Summary of literature on service responses for older drug users

Title	Year	Author(s)	Methodology	Geography	Age range	Drug type(s)	Response type(s)
1. An update on drug dependence in the elderly	1979	Pascarelli, EF.	Secondary analysis (literature review)	United States	Not specified	Various, including multiple drug use	Techniques to improve diagnosis and treatment in hospital and medical settings
2. The elderly abuser: a challenge for the future	1979	Peppers, LG. Stover, RG.	Primary research (user survey)	United States	Not specified	Alcohol and drugs	Holistic treatment
3. Drug and alcohol abuse among the elderly: is being alone the key?	1983	Brown, BB. Chiang, CP.	Primary research (interviews)	United States	55+	Alcohol and drugs	Implications for health and social service programs of the impact of social isolation, relationships and gender
4. Substance abuse among older adults. Treatment Improvement Protocol (TIP)	1998	Center for Substance Abuse Treatment	Secondary analysis (literature review)	United States	60+	Alcohol and prescription drugs	Identification, screening, and assessment
5. Cognitive-behavioural treatment of older veterans with substance abuse problems	2000	Schonfeld, L. Dupree, LW. Dickson-Roy, CM. Ehrmann, E. McDermott, CH. Rosansky, JS. Taylor, S. Jarvik, LF.	Primary research (user survey)	United States	60+	Various, including multiple drug use	Cognitive-behavioral (CB) and self-management approaches
6. Substance misuse in older adults: an emerging policy priority.	2001	Phillips, P. Katz, A.	Secondary analysis (literature review)	United Kingdom	Discussed, not specified	Alcohol, tobacco, drugs	Targeted research to prioritise treatment services
7. Maturing in (or into) drug use: a life course analysis of ageing drug users	2003	Boeri, MW. Serk, C. Elifson, K.	Primary research (interviews)	United States	35+	Methamphetamine or heroin	Treatment and public health interventions
8. Five year alcohol and drug treatment outcomes of older adults versus middle-aged and younger adult chemical dependency patients in a managed care program.	2004	Satre, DD. Mertens, JR. Areán, PA. Weisner, C.	Primary research (interview and case study)	United States	55-77	Alcohol and drugs	Long term treatment and adequate support following treatment

<b>Title</b>	<b>Year</b>	<b>Author(s)</b>	<b>Methodology</b>	<b>Geography</b>	<b>Age range</b>	<b>Drug type(s)</b>	<b>Response type(s)</b>
9. The DASIS report. older adults in substance abuse treatment: 2001	2004	Drug and Alcohol Services Information System	Primary research (patient data analysis)	United States	55+	Alcohol and drugs	Self-referral processes; criminal justice referrals
10. Characteristics of older opioid maintenance patients	2005	Lofwall, MR. Brooner, RK. Bigelow, GE. Kindbom, K. Strain, EC.	Primary research (interviews)	United States	50-66	Opioid use	Developing and evaluating health service strategies aimed at facilitating the delivery of appropriate evaluation and health care
11. Older substance misusers still deserve better treatment interventions – an update (Part 1)	2005	Crome, I. Bloor, R.	Secondary analysis (literature review)	United Kingdom	65+	Alcohol and drugs	Designated service for older people, including discussion of residential service (inpatient and residential units), and two kinds of community service (methadone reduction and methadone maintenance)
12. Older substance misusers still deserve better treatment interventions - An update (Part 2)	2005	Crome, I. Bloor, R.	Secondary analysis (literature review)	Various	65+	Alcohol and drugs	Accurate medical diagnosis
13. Substance misuse in the older population	2005	McGrath, A. Crome, P. Crome, IB.	Secondary analysis (literature review)	United Kingdom	Various	Various	Training and awareness of health practitioners
14. The DASIS report: older adults in substance abuse treatment: update, May 5, 2005	2005	Drug and Alcohol Services Information System	Primary research (patient data analysis)	United States	55+	Alcohol and drugs	Substance abuse treatment admissions in health care settings
15. Attempted cessation of heroin use among men approaching mid-life	2006	Mullen, K. Hammersley, R.	Primary research (interviews)	United Kingdom	28+	Heroin	Motivational interviewing, Relapse Prevention Therapy
16. Baby boomers drug users: career phases, social control, and social learning theory	2006	Boeri, MW. Sterk, CE. Elifson, KW.	Primary research (interviews)	United States	35-54	Methamphetamine or heroin	Evaluation of drug users for treatment, public health interventions, and policymaking.

<b>Title</b>	<b>Year</b>	<b>Author(s)</b>	<b>Methodology</b>	<b>Geography</b>	<b>Age range</b>	<b>Drug type(s)</b>	<b>Response type(s)</b>
17. Community interventions for older adults with comorbid substance abuse the geriatric addictions program (GAP)	2006	D'Agostino, CS. Barry, KL. Blow, FC. Podgorski, C.	Primary research (interviews)	United States	Unspecified (older adults)	Various	Geriatric Addictions Program indicate the need for training, service delivery changes, and research initiatives
18. Older substance misusers still deserve better treatment interventions - An update (Part 3)	2006	Crome, I. Bloor, R.	Secondary analysis (literature review)	United Kingdom	55+	Alcohol and drugs (various)	Psychological approaches, behavioural and psychodynamic therapies, information-based methods, counselling, pharmacotherapy
19. Retention and illicit drug use among methadone patients in Israel: A gender comparison	2007	Schiff, M. Levit, S. Moreno, RC.	Primary research (patient data analysis)	Israel	Various (18+)	Heroin, methadone	Methadone maintenance treatment (MMT)
20. "You're nothing but a junkie": multiple experiences of stigma in an ageing methadone maintenance population	2008	Conner, KO. Rosen, D.	Primary research (interviews)	United States	50+	Opioids/heroin	Recognition of multiple stigmas by clinicians
21. Reconceptualizing early and late onset: a life course analysis of older heroin users	2008	Boeri, MW. Sterk, CE. Elifson, KW.	Primary research (interviews)	United States	35+	Heroin	Treatment options, not incarceration
22. The prevalence of mental and physical health disorders among older methadone patients	2008	Rosen, D. Smith, ML. Reynolds, CF.	Primary research (interviews)	United States	50+	Heroin	Training of clinicians, health and mental health practitioners
23. Comparison of heroin-assisted treatment and abstinence oriented residential treatment in Switzerland based on patient characteristics	2009	Gerlich, MG. Schaaf, S. Gross, CS. Uchtenhagen, A.	Primary research (patient data analysis)	Switzerland	Various	Heroin	Heroin-assisted treatment and abstinence oriented residential treatment
24. Drug use and ageing: older people do take drugs!	2009	Beynon, CM.	Secondary analysis (literature review)	United Kingdom	50+	Illicit drugs	Further research is needed on the epidemiological and treatment aspects of drug use in older people
25. Life situations and health of older drug addicts: a literature report	2009	Vogt I.	Secondary analysis (literature review)	Germany	45+	Illicit drugs	Substitution treatment

<b>Title</b>	<b>Year</b>	<b>Author(s)</b>	<b>Methodology</b>	<b>Geography</b>	<b>Age range</b>	<b>Drug type(s)</b>	<b>Response type(s)</b>
26. Drug misuse in older people: old problems and new challenges	2010	Badrakalimuthu, V.R. Rumball, D. Wagle, A.	Secondary analysis (literature review)	United Kingdom	60+	Benzodiazepines and hypnotics, opioids and cocaine, other drugs, inappropriate and over-the-counter medication, poly-substance misuse	Awareness of this problem must be increased through education of the public and professionals. Social and health services should work collaboratively with the substance user through refined care pathways and produce pragmatic treatment plans
27. Older drug users in Scotland: professionals' views	2010	Brand, B.	Primary research (Interviews, self-completion survey)	United Kingdom	35+	Illicit drugs, opiates, benzodiazepines etc	Careful planning; take account of issues of isolation when planning and delivering services to older drug users; greater emphasis on forming meaningful therapeutic relationships; addressing specific accommodation needs of older problem drug users; recognise the importance of relapse prevention; encourage 'new coping mechanisms'; provision of individualised services; explore innovative approaches' meet general health care needs
28. Screening and brief intervention for substance misuse among older adults: the Florida BRITE project.	2010	Schonfeld, L. King-Kallimanis, BL. Duchene, DM. Etheridge, RL. Herrera, JR. Barry, KL. Lynn, N.	Primary research (patient data analysis)	United States	60+	Alcohol, illicit drugs, Prescription and over-the-counter medications	Screening and brief intervention

<b>Title</b>	<b>Year</b>	<b>Author(s)</b>	<b>Methodology</b>	<b>Geography</b>	<b>Age range</b>	<b>Drug type(s)</b>	<b>Response type(s)</b>
29. Treatment and care for older drug users	2010	EMCDDA	Secondary analysis (literature review)	Europe	Older drug users	Illicit drugs	Address the needs of ageing drug users within the framework of drug, health and social policies. Adapt existing services to an ageing drug using population
30. Older adults in methadone maintenance treatment: a literature review	2011	Doukas, N.	Secondary analysis (literature review)	North America	50+	Heroin, methadone	Methadone maintenance treatment
31. 30-year trajectories of heroin and other drug use among men and women sampled from methadone treatment in California	2011	Grella, CE. Lovingir, K.	Primary research (interviews and longitudinal data)	United States	35+	Heroin, methadone	Early intervention to address childhood conduct problems. Methadone treatment/opiate-substitution therapy for individuals who are at high risk of relapse and overdose. Treatment interventions
32. Addiction and ageing-awareness, assessment and action	2011	Crome, IB. Crome, P. Rao, R.	Secondary analysis (literature review and commentary)	United Kingdom	Older people, 50+	Legal substances and illegal drugs	Brief interventions
33. Characteristics and consequences of heroin use among older adults in the United States: A review of the literature, treatment implications, and recommendations for further research	2011	Rosen, D. Hunsaker, A. Albert, SM. Cornelius, JR. Reynolds, CF.	Secondary analysis (literature review)	United States	50+	Heroin	The development of appropriate interventions and treatment for older adult heroin users will be contingent on empirical research that adequately describes mental and physical health problem
34. Illicit and nonmedical drug use among older adults: a review	2011	Wu, LT. Blazer, DG.	Secondary analysis (literature review)	United States	50+	Illicit and non-medical drugs	Early identification and treatment. Further research is needed to include more diverse racial/ethnic groups, evaluate long-term outcomes, and examine effectiveness of treatments for older adults with drug use problems
35. Substance abuse treatment for older adults in private centres	2011	Rothrauff, TC. Abraham, AJ. Bride, BE. Roman, PM.	Primary research (interviews)	United States	65+	Alcohol, prescription drugs and illicit drugs	Preparation of treatment centres
36. Substance misuse and older people - our invisible addicts	2011	Crome, I. Rao, R.	Secondary analysis (literature review)	United Kingdom	55+	Various illicit drugs	Increased awareness amongst medical and health care professionals



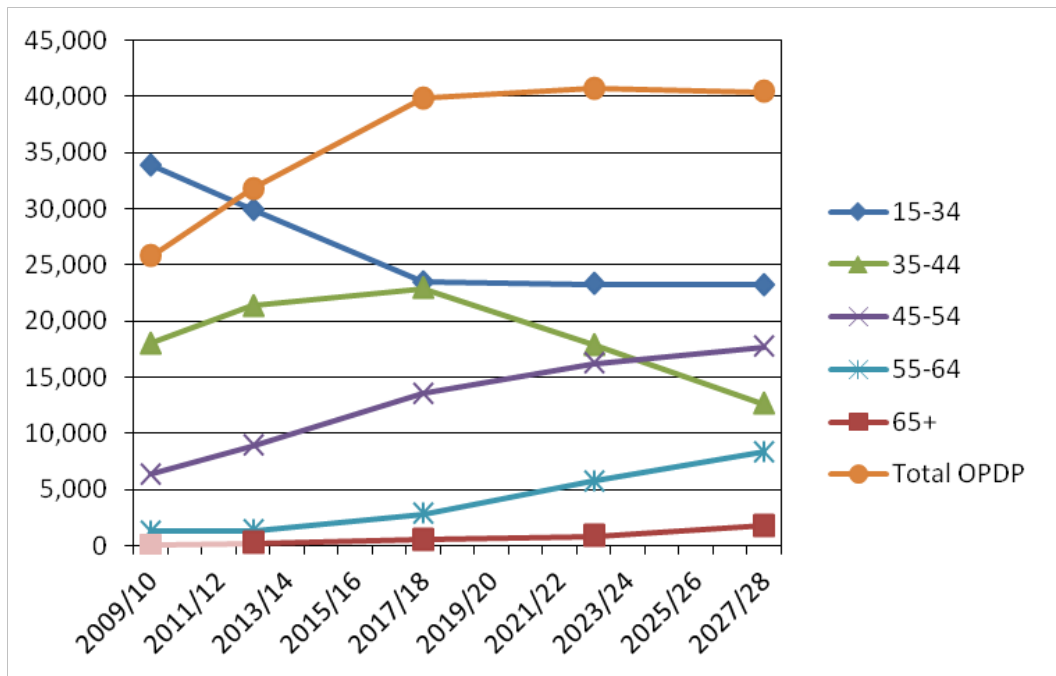
<b>Title</b>	<b>Year</b>	<b>Author(s)</b>	<b>Methodology</b>	<b>Geography</b>	<b>Age range</b>	<b>Drug type(s)</b>	<b>Response type(s)</b>
37. Systematic and narrative review of treatment for older people with substance problems	2011	Moy, I. Crome, P. Crome, I. Fisher, M.	Secondary analysis (systematic and narrative review)	United States (majority of studies)	50+	Alcohol, prescription drugs, methadone, smoking	Increased awareness, both among the medical profession and the general population, of the prevalence and importance of substance abuse and dependence in older people is a priority, so that there is better recognition, diagnosis and appropriate referral. Consideration should be given to the establishment of designated service provision of treatment programs that include older people, either separately or as part of a non-age-specific group
38. The older heroin user: the 40s and beyond	2011	Darke, S.	Secondary analysis (literature review)	Various	40+	Heroin	Maturing out hypothesis lacks contemporary relevance, and health based approaches are now required
39. A contextual comparison of risk behaviors among older adult drug users and harm reduction in suburban versus inner-city social environments	2012	Boeri, MW. Tyndall, BD.	Primary research (ethnographic fieldwork, interviews)	United States	45+	Heroin, cocaine, and/or methamphetamine	Need for the expansion of harm reduction services focused on older adult drug users who are homeless, uninsured, or socially isolated
40. Psychosocial factors in older heroin dependent patients in treatment	2012	Sidhu, H. Crome, P. Crome, IB.	Primary research (patient data analysis)	United Kingdom	45+	Heroin	Lack of specific guidance on treatment, training or policy for this group in the UK
41. Treatment experience and needs of older drug users in Bristol, UK	2012	Ayres, RM. Eveson, L. Ingram, J. Telfer, M.	Primary research (interviews/evaluation)	United Kingdom	55+	Oral substitution therapy and/or illegally bought drugs, such as heroin, crack/cocaine or benzodiazepines	Residential and community detoxification programmes may need to adapt to meet the needs of older people. Detoxification regimes may need to be much slower and better supported medically to accommodate age-related metabolic changes

<b>Title</b>	<b>Year</b>	<b>Author(s)</b>	<b>Methodology</b>	<b>Geography</b>	<b>Age range</b>	<b>Drug type(s)</b>	<b>Response type(s)</b>
42. Maintenance treatment programme for opioid dependence: characteristics of 50+ age group	2012	Badrakalimuthu, VR. Tarbuck, A. Wagle, A.	Primary research (survey)	United Kingdom	50+	Opioids, benzodiazepines, cocaine, amphetamines	Substitution treatment programme for opioid dependence
43. Gender differences in physical and mental health outcomes among an ageing cohort of individuals with a history of heroin dependence	2012	Grella, CE. Loving, K.	Primary research (interviews and statistical analysis)	United States	30+	Heroin	Tailored interventions
44. Epidemiology of alcohol and drug use in the elderly	2013	Wang, YP. Andrade, LH.	Secondary analysis (literature review)	North America Europe	60+	Alcohol and drugs	Medical screening
45. A review of existing treatments for substance abuse among the elderly and recommendations for future directions	2013	Kuerbis, A. Sacco, P.	Secondary analysis (literature review)	United States	Older adults not further specified	Alcohol and illicit drugs	Age-specific treatment
46. 'Every 'never' I ever said came true': transitions from opioid pills to heroin injecting	2013	Mars, SG. Bourgois, P. Karandinos, G. Montero, F. Ciccarone, D.	Primary research (interviews, longer-term participant-observation, ethnographic studies)	United States	Various, including 30+	Opioids/heroin	Public health measures, surveillance, harm reduction, Substance use treatment services
47. Exercise referral for drug users aged 40 and over: results of a pilot study in the UK	2013	Beynon, CM. Luxton, A. Whitaker, R. Cable, TN. Frith, L. Taylor, AH. Zou, L. Angell, P. Robinson, S. Holland, D. Holland, S. Gabbay, M.	Primary research (evaluation)	United Kingdom	40+	Illicit drugs	Exercise referral
48. Experiences of drug use and ageing: health, quality of life, relationship and service implications	2013	Roe, B. Beynon, C. Pickering, L. Duffy, P.	Primary research (interviews)	United Kingdom	49-61	Illicit drugs	Tailored support services

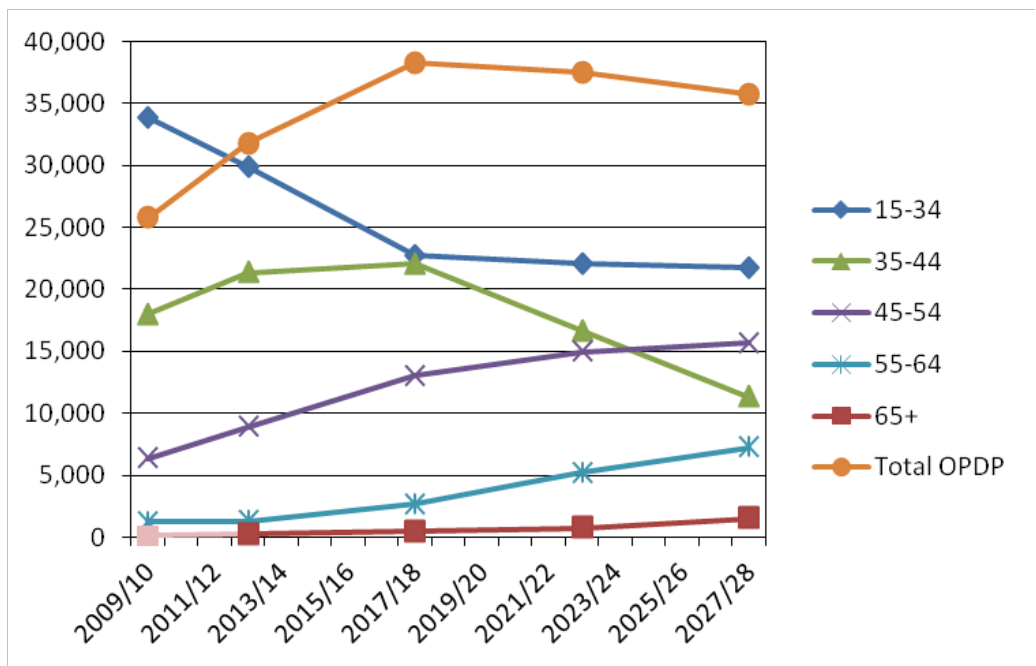
49. Substance misuse in the older person: Setting higher standards	2013	Crome, I.	Secondary analysis (literature review)	United Kingdom	65+	Alcohol, nicotine, prescription medication and illicit drugs	Treatment (clinical, pharmacological)
50. Under treatment of pain: a prescription for opioid misuse among the elderly?	2013	Levi-Minzi, MA. Surratt, HL. Kurtz, SP. Buttram, ME.	Primary research (interviews)	United States	60+	Prescription and illicit drugs	Education of clinicians
51. Residential treatment for drug use in Europe	2014	EMCDDA	Secondary analysis (statistics, expert opinion)	Europe	Older drug users	Illicit drugs	Residential treatment
52. The forgotten people: drug problems in later life	2014	Wadd, S.	Primary research (interviews) and secondary analysis (pre-existing data)	United Kingdom	Older drug users	Illicit drugs	Drug treatment, prevention, identification, harm reduction, social care, strategy
53. Screening, brief intervention, and referral to treatment (SBIRT) for substance abuse in older populations	2015	Liu, NH. Satterfield, JM.	Primary research (case study) and secondary research (literature review)	United States	50+	Alcohol, illicit drugs, and prescription drug misuse	Screening, brief intervention, and referral to treatment
54. Screening, brief intervention, and referral to treatment for older adults with substance misuse	2015	Schonfeld L. Hazlett, RW. Hedgecock, DK. Duchene, DM. Burns, LV. Gum, AM.	Primary research (client screenings)	United States	50+	Alcohol, illicit drugs, and prescription drug misuse	Screening, brief intervention, and referral to treatment
55. A scoping review of treatments for older adults with substance use problems	2016	Mowbray, O. Quinn, A.	Secondary research (literature review)	United States, Denmark	Discussed, not specified	Various	Treatments, primary care settings, health clinics, multiple treatments

### Appendix 3: ISD OPDP population modelling based on different levels of relapse

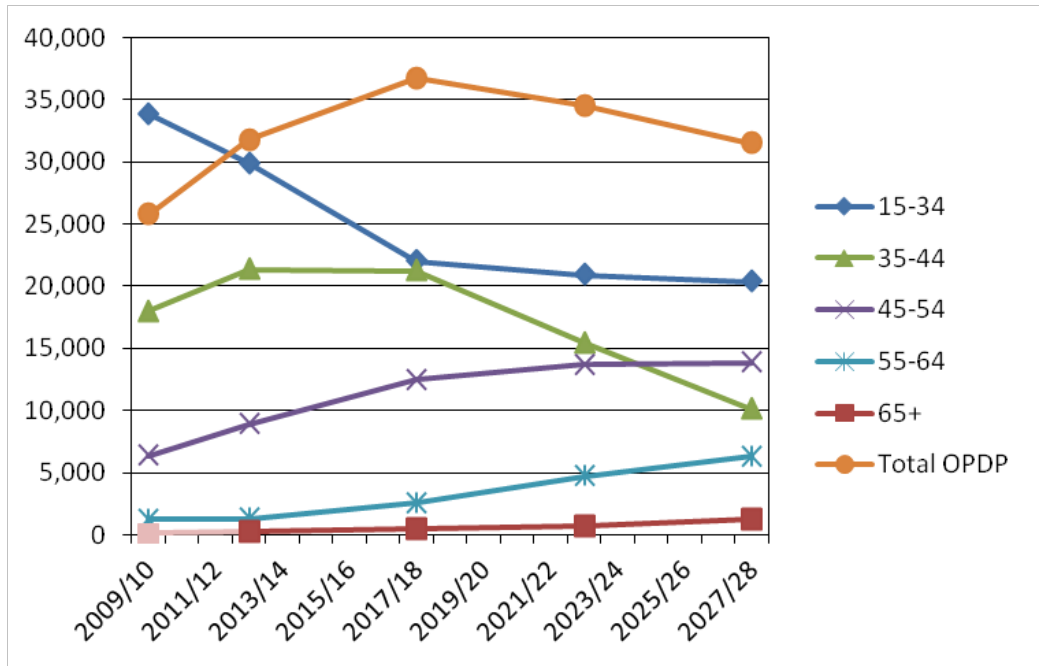
**Figure3a: OPDP Population estimates and projections (both sexes; 2009/10 to 2027/28; 10% non-replase)**



**Figure3b: OPDP Population estimates and projections (both sexes; 2009/10 to 2027/28; 20% non-replase)**



**Figure3c: OPDP Population estimates and projections (both sexes; 2009/10 to 2027/28; 30% non-replace)**





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