12 Treatment and care for older drug users

12.1 Introduction

Verifiable data on the topic Treatment and care of older drug users are mainly available for opioid users in Germany. Therefore, this selected issue will mainly look at this group of users. Taking the last ten years as the period of reference, it shows that current surveys and statistics contain data on a larger portion of older opioid users than ten years ago and that the average age of these users has increased over this period of time. This is attributed, on the one hand, to substance-using people surviving longer these days and, on the other, to less young people using opioids.

The introduction of harm reduction strategies is regarded as one of the major causes for survival despite continuance of drug use. Since the mid-eighties, addiction treatment facilities have been offering survival aids that are not strictly abstinence-oriented and that reach a larger number of addicts. The expansion of substitution therapy has made a crucial contribution to the survival of many drug addicts. The professionalization of low-threshold offers has led to a reduction of the infection risk with hepatitis and HIV and of fatal overdosages and to a general increase in life expectancy.

Despite the progress made, the social and health situation of older drug users is very problematic. They are affected by exclusion from society and from the drug scene and display serious physical and psychological health problems.

Legal regulations referring to the specific needs of senior drug dependents do not exist as of yet. The complicated German social law with different institutions being responsible for treatment and care, require considerable efforts to be undertaken by social workers to for example set up ambulatorily-supervised living communities for older (ex) drug users. Drug aid experts and charity organizations recommend a close cooperation between drug aid and eldercare based on a legal framework regulating care and responsibilities.

Data analysis and data sources

By “older drug users“, this selected issue is supposed to refer to users of 40 years of age or older. With the study designs differing very much from each other, an evaluation based on this qualification is subject to great restrictions – some studies set the cut off point at “35 years and older” others “at 45 years”. Therefore, surveys and literature that do not correspond to the abovementioned age definition of the EMCDDA are also taken into account in the following presentation insofar as they describe relevant tendencies or phenomena.

To describe the profile of older drug users in treatment, a special evaluation of the German Statistical Report on Treatment Centres for Substance Use Disorders (DSHS) of the year 2008 was analyzed. Furthermore, the yearly published data of the DSHS were compared with each other to identify trends and data from the hospital statistics of the Federal Health Report evaluated. The data on drug-related deaths were taken from the Drugs Data File (Falldatei Rauschgift, FDR) kept by the Federal Criminal Police Office.

The project SDDCARE which is currently carried out in the four European countries Germany, Austria, Poland and Scotland was also tapped for information. The project runs until the middle of 2010 and is to provide basic knowledge about the life situation and the health conditions of senior drug dependents and their care needs. The age limit set by the project for “older drug users” is > 35 years of age. There are interim results available for the first six months of the year 2009. Within the framework of the project, an analysis of the national data situation on the topic of senior drug dependents (Vogt et al. 2009) and an overview work of the legal framework for the treatment of older drug users (Lenski & Wichelmann-Werth 2009) were carried out.

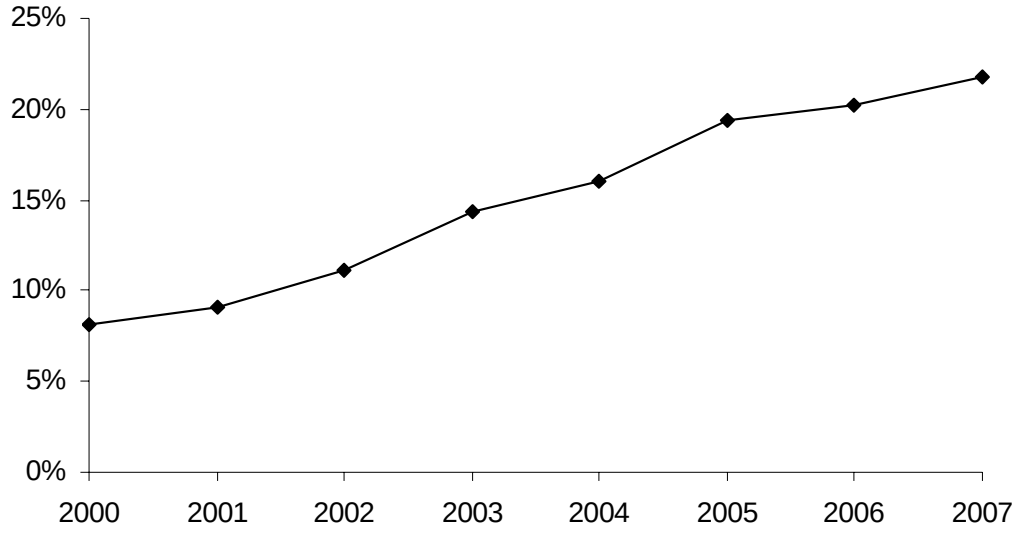
The German Centre for Addiction Issues (DHS) which forms part of the “National Focal Point of the Reitox Network” in the DBDD - the German Reference Centre for the EMCDDA, has asked drug aid specialists to give a brief statement or a personal report on the health and social situation of senior drug dependents. In these reports, the experts generally refer to patients in substitution treatment and psychosocial counselling therapy who are 40 years of age or older.

12.2 Aging of problem drug users

12.2.1 Age trends in drug users

German Statistical Report on Treatment Centres for Substance Use Disorders (DSHS)

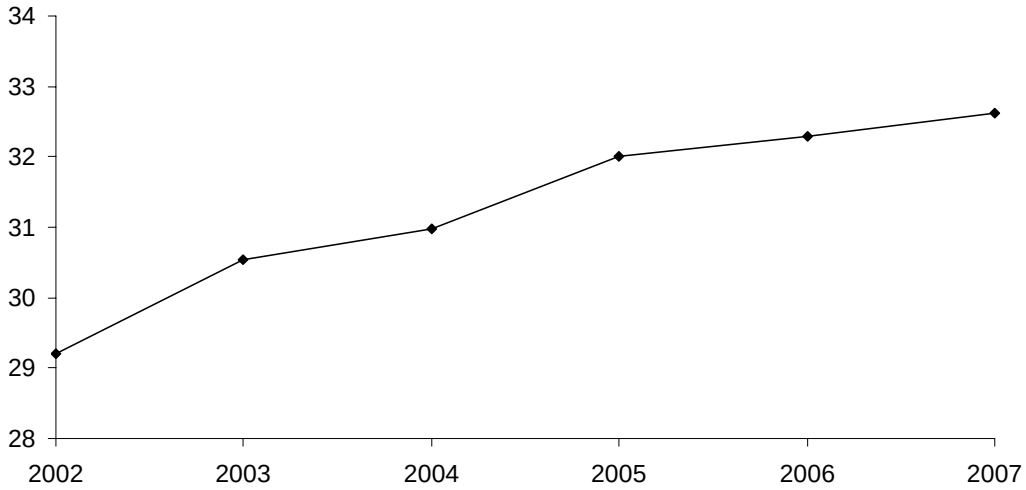
The data from the DSHS on the persons in outpatient treatment with the main diagnosis opioid dependence (broken down by below 40-year olds and above 40-year olds) show a clear age trend between the years 2000 and 2007. The portion of documented treatments/therapies of the above 40-year-olds continually increased from 8.2% in the year 2000 to 21.8% in the year 2007.



DSHS 2001-2007.

Figure 12.1 Share of persons above 40 years of age in all patients with an opioid main diagnosis in outpatient addiction treatment 2000-2007

Comparing the average age of persons with an opioid main diagnosis at the start of treatment in the period from 2002-2007, one finds the age trend increasing from 29.2 years to 32.6 years.



DSHS 2001-2007.

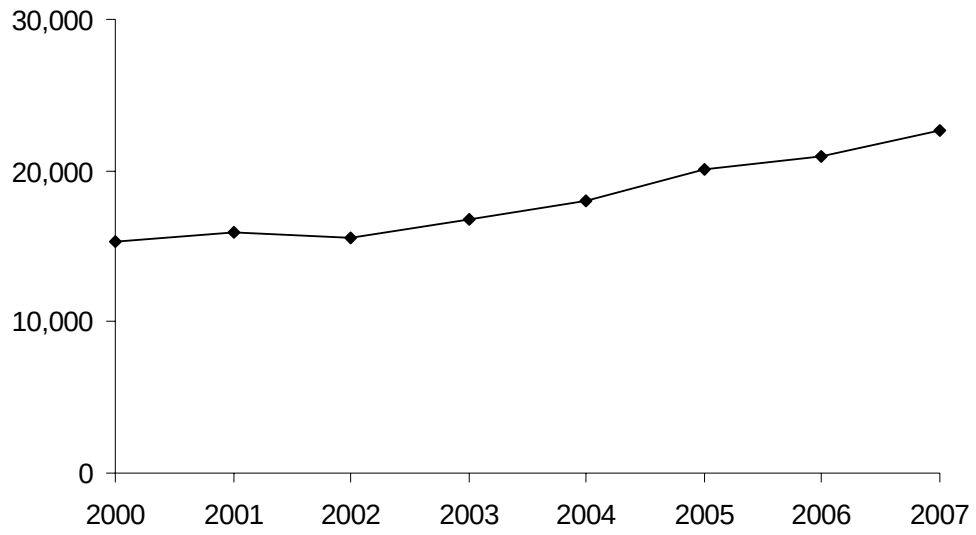
Figure 12.2 Average age of persons with an opioid main diagnosis in outpatient treatment 2002-2007

Hamburg Base Documentation

In the reporting year 2007, a special evaluation on the topic “Age and Addiction“ was carried out based on the data of the status report 2007 of the Hamburg Base Documentation on Outpatient Treatment Centres for Substance Use Disorders in the city of Hamburg. In the special evaluation, clients above 45 years of age were defined as older drug users. Here too, it showed that the average age of the opioid addicts clearly increased in the period between 1997 and 2007, namely from 32.0 years (1997) to 38.1 years (2007) (Verthein et al. 2008).

Federal Health Report (Gesundheitsberichterstattung des Bundes, GBE)

Diagnostic data of persons in inpatient hospital treatment can be gleaned from the Federal Health Report (see also the data sources presented in chapter 5). A comparison of the data between 2000 and 2007 also indicates an increasing age trend in the treated drug users (ICD-10 Codes F11-F16, F18-F19).



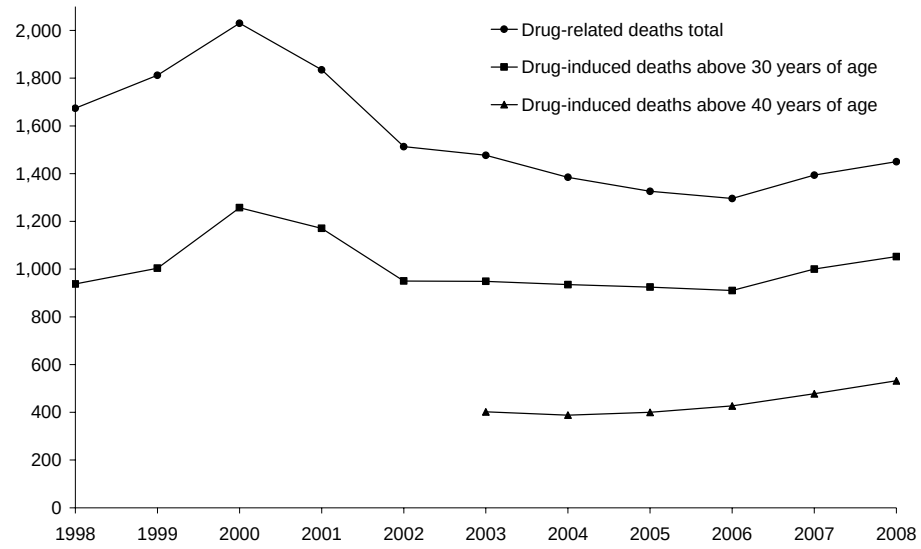
Krankenhausdiagnosestatistik 2000-2007.

Figure 12.3 Number of persons in inpatient treatment above 40 years of age (diagnoses: F11-F16, F18-F19; 2000-2007)

Figure 12.3 shows the changes in the absolute figures of persons above 40 years of age with substance use disorders (without alcohol) in inpatient hospital treatment in the period between 2000 and 2007. Except for 2002, a continual increase of patient figures was to be observed from 2000 to 2007 (2000: 15.263; 2007: 22.600). At the same time, the share of the above-40-year olds in all patients increased from 18% (2000) to 25% (2007).

Drug-induced deaths

Data on drug-induced deaths may be gleaned from the reports of the Federal Criminal Police Office. Age trends for the category “above 30 years“ have been recorded since 1998. For the category “above 40 years”, data have been available since 2003. [41]



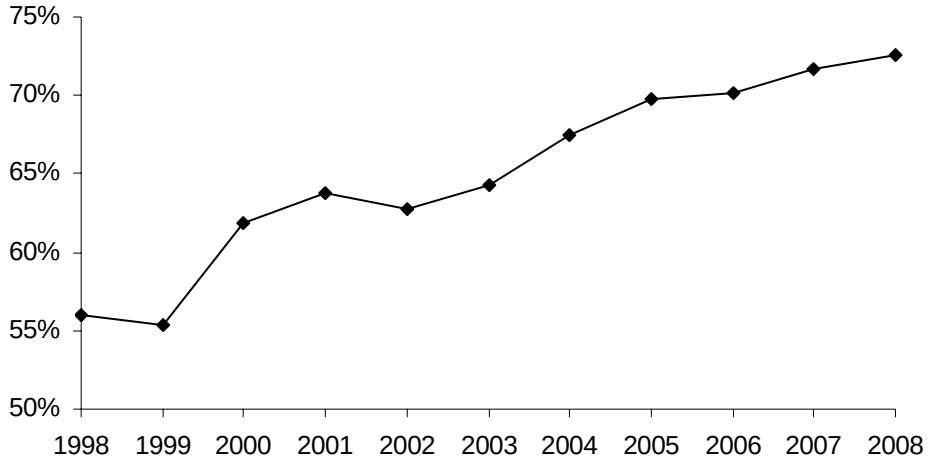
BKA 2008.

Figure 12.4: Drug-related deaths total, drug-induced deaths above 30 years of age, drug-induced deaths above 40 years of age

The BKA-figures show a clear decline in the overall number of drug-induced deaths between 2000 and 2002 (from 2,030 to 1,513). The number of the drug-induced deaths above 30 years of age also strongly declined between the years 2000 and 2002 (from 1,257 to 950). But then, the declining curve flattens out more strongly than the one of the total number of drug-related deaths. The share of drug-induced deaths above 30 years of age in the overall number of drug-induced deaths increased between 1998 and 2008 from 56% to 72.6% (figure 12.4).

In the same period, the average age of the drug-induced deaths increased from 31 to 36 years. Given the age structures of heroin addicts, it is to be expected that the absolute figure of older drug-related deaths is going to further increase in the future and to remain at a high level (Die Drogenbeauftragte der Bundesregierung 2009; Vogt 2009b).

[41] The data on the drug-induced deaths that are based on the evaluations of the General Mortality Registry of the Federal Statistical Office form part of the standard reporting within the framework of the REITOX Report. Age trends for drug-induced deaths are shown in figure 6.2 in this Report. As can be seen from this figure, drug-induced deaths tend to occur in older drug users.



BKA 2008.

Figure 12.5 Share of the drug-induced deaths above 30 years of age in the overall figure of drug-induced deaths

12.2.2 Factors related to the aging and increasing life expectancy of drug users

Since the middle of the eighties, the drug aid concept, which was mainly abstinence-oriented, has been complemented by a stronger focus on harm reduction approaches. Structure and organization of the drug aid system were transformed by the introduction of substitution treatment at a broad scale, the set-up of low-threshold help offers and the promotion of self-help initiatives (Ebert & Sturm 2006; 2009). Among the low-threshold measures it was in particular the introduction of syringe exchange programmes, consumption rooms and distribution of condoms which has brought about a continual decline in new HIV-infections over the last 15 years (Vogt 2009b).

Thanks to the stronger integration of the medical care system into drug aid work it has also become possible to have concomitant diseases (e.g. infectious diseases) treated by the substituting physicians (Verthein et al. 2008; Vogt 2009b). As a result, the health situation of opioid addicts has improved, morbidity and mortality have declined and life quality and life expectancy have increased. Survival despite addiction and continued substance use over years, in some part over decades, has become possible (Ebert & Sturm 2006; 2009; Verthein et al. 2008). Drug aid experts, too, see in the restructuring of the aid system – in particular in the expansion of substitution offers – a substantial contribution to the survival of drug users (Wagner, personal communication). The decline in the number of drug-related deaths between 2000 and 2006 by 36% is presumably to be explained by the introduction and the expansion of harm reduction measures (Lenski & Wichelmann-Werth 2009). Another contribution to the increase in the average age of drug users has been made by the decline in first-

time users of opioids. While in the year 2000, 33% of the clients with an opioid main diagnosis were below 25 years of age, the figure was only at 17.8% in 2007 (DSHS 2000, 2007)[42].

12.3 Drug use, health and social characteristics of current older drug users

12.3.1 Characteristics of older drug users

For the year 2008, a special evaluation of the DSHS data was carried out on the reference group “40 years of age and older“ (Pfeiffer-Gerschel et al. 2009a). The following descriptive evaluation comprises sociodemographic data like living and housing conditions, employment situation and other relevant characteristics. The focus of this description is on older opioid users. Older users of cocaine, cannabis and stimulants are referred to for comparison.

Age at the start of therapy and age at first use

At the start of therapy the majority of older drug users were between 40 and 50 years old. More than 80% form part of this age group for all presented substances. In the following age categories, the percentages decline substantially. Opioid and cocaine users who start treatment as late as at the age of above 60 years account for less than 1% of the persons under review. As for use of cannabis and stimulants, percentages range between 1.7% and 2.1% respectively (table 12.1).

Table 12.1 Main diagnosis and age at the start of treatment

Main diagnosis	Age at treatment start		
	40-49	50-59	60+
Opioides	83.3%	15.8%	0.9%
Cannabinoides	83.6%	14.7%	1.7%
Cocaine	87.3%	12.1%	0.5%
Stimulants	86.0%	11.9%	2.1%

Pfeiffer-Gerschel et al. 2009a.

Current older opioid addicts started using opioids at the age of 24.4 years on average. Little less than 75% of the population have used opioids for the first time before they were 30 years of age. Thus, at the age of 40, their drug career is already at least 10 years old.

Above-40-year old cannabis users have on average started earlier to use drugs. On average, the age at first use was here 18.4 years. Older cocaine users started using drugs at 27.6 years on average – almost a decade later. While only very few cannabis users started use at the age between 30 and 40 years, this is the case for every third cocaine user (table 12.2).

[42] Homepage of the German Statistical Report on Treatment Centres for Substance Use Disorders: www.suchthilfestatistik.de; the table volumes of inpatient and outpatient treatments, “admissions/discharges” and “all treatment” of the years 2002, 2003, 2004, 2005, 2006, 2007 as of 11.08.2009.

Table 12.2 Age at first use

Main diagnosis	Age at first use								
	-14	15 - 17	18 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40+	Median
Opioides	5.0%	17.0%	14.2%	23.6%	14.8%	10.5%	7.5%	7.5%	24.4
Cannabinoides	22.1%	40.2%	12.3%	11.9%	5.5%	3.2%	3.9%	0.9%	18.4
Cocaine	3.6%	9.8%	8.6%	19.3%	13.1%	20.2%	15.7%	9.8%	27.6
Stimulants	8.7%	24.4%	14.2%	12.6%	11.0%	10.2%	9.4%	9.4%	24.1

Pfeiffer-Gerschel et al. 2009a.

Employment and life situation, housing conditions

Older opioid users in particular are affected by unemployment (table 12.3). On the day of the start of the treatment, more than three quarters are out of work. But among the users of other drugs more than every second is also out of work when he is older.

Table 12.3 Employment situation on the day of the start of treatment

Main diagnosis	Employment situation on treatment start			
	Employed	Self-employed	Unemployed	Other
Opioides	13.6%	1.1%	77.1%	8.3%
Cannabinoides	26.3%	5.3%	58.7%	9.7%
Cocaine	24.8%	9.5%	60.5%	5.2%
Stimulants	21.7%	4.5%	62.1%	11.6%

Pfeiffer-Gerschel et al. 2009a.

A bit more than half of the opioid users over 40 years of age live alone. The same holds true for the cannabis users. More than 50% of the users of cocaine and stimulants do not live alone.

Users of all drug categories who do not live alone, live most commonly together with a partner, often with one or several children. More than a quarter of the older users of all drug categories live in other social constellations (e.g. friends) (table 12.4).

Tabelle 12.4 Life situation

Main diagnosis	Life situation					
	Living alone	Living not alone	Living together with…			
			partner	child/ren	parent/s	other person/s
Opioids	52.5%	47.5%	53.0%	28.7%	9.5%	26.3%
Cannabinoids	50.5%	49.5%	51.5%	37.9%	8.5%	24.3%
Cocaine	45.4%	54.6%	56.9%	30.5%	7.4%	29.8%
Stimulants	41.0%	59.0%	48.3%	38.1%	11.9%	30.5%

Pfeiffer-Gerschel et al. 2009a.

The large majority of opioid users live under stable housing conditions (table 12.5). This applies also to the users of other substances. However, opioid users live more often under “non-stable housing counditions“ (without apartment or in emergency shelters) than the consumers of other drugs.

About every fourth user of cocaine and stimulants is accomodated in a penal institution.

Table 12.5 Housing conditions on the day of the start of treatment

Main diagnosis	Housing conditions on the day of treatment start				
	Stable housing conditions	Non-stable housing conditions	Spec. hospital / inpatient drug-rehab	Youth penal inst. / hospital treatment order / detention	Other
Opioids	81.0%	5.7%	2.3%	8.6%	2.4%
Cannabinoids	84.9%	2.0%	1.5%	10.5%	1.0%
Cocaine	70.8%	1.7%	3.2%	23.7%	0.6%
Stimulants	70.9%	0.5%	2.4%	25.2%	1.0%

Pfeiffer-Gerschel et al. 2009a.

Referral to treatment

Older drug users often start treatment on their own account (respectively 40% of the people affected) (table 12.6). In comparison with the other client groups, opioid users are more seldom referred to treatment or care by their own families. About a third of the opioid users – and with this significantly more than for other substances – are referred to the respective treatment centres by doctors/psychotherapists. Strikingly, judicial authorities act more often as the referring institution in the case of users of cannabis, cocaine and stimulants than in the case of opioid users.

Table 12.6 Referral to care

Referral partners	Main diagnosis			
	Opioids	Cannainoids	Cocaine	Stimulants
None / self-referral	39.0%	40.5%	41.1%	41.4%
Family	2.7%	5.1%	7.0%	7.0%
Doctors, psychotherapists, hospitals, outpatient medical centres	31.0%	8.6%	6.4%	8.4%
Drug councelling centres, treatment facilities for substance-use disorders, rehab centres	13.8%	15.5%	18.3%	17.7%
Judical authoritites	6.4%	12.9%	16.1%	18.6%
Other	6.9%	17.2%	11.1%	5.6%

Pfeiffer-Gerschel et al. 2009a.

Social situation

Long-term drug use often leads to a consolidation of behaviours that are typical for the scene. Exposed to the permanent stress of procuring drugs and living a life in illegality often results in the loss of social contacts beyond the scene. The drug scenes that have formed in the larger cities are in this way a strongly isolated group. It appears that older drug users are more strongly affected by exclusion and stigmatization than their younger counterparts since they display less variable use and behavioural patterns and are less flexible in adapting to different situations (Vogt 2009a; 2009b). All contact with family members and relatives is also often broken off. Older drug users possibly also break ties with their own children (Ebert & Sturm 2006; 2009).

Rules and rituals are subject to frequent changes in drug scenes; sometimes they are intentionally altered by younger users to dissociate themselves from others. At increasing age, drug users find it increasingly difficult to procure drugs and they are more likely to become the victim of acts of violence or robberies within the scene. This leads to a displacement by younger scene members and and to a retreat of older drug users. This, in turn, results in a double exclusion: exclusion from society and from the drug scene. At increasing age, it shows that social exclusion and loneliness increase in opioid users. This also applies to couples living together. Existing partnerships are often marked by commun addiction-related problems. This is decreasing the chance of overcoming addiction and substance use problems (Verthein et al. 2008). Lacking possiblities of participation in the working world and recreational activities exacerbate the problem of isolation (Wessel, personal communication). Lack of prospects and isolation often impact the psychological condition of the people affected and aggravate for example depressive disorders (Vogt 2009a; 2009b) (Claas, personal communication).

Physical health

Especially older drug users with year-long substance use often suffer - in addition to their addiction – from concomitant acute and chronic diseases.

Infectious diseases like hepatitis and HIV are the main problem here. Despite the 15-year decline in the overall number of new HIV-infections, it is to be noted that the risk of a new infection slightly increases again with increasing age; this applies also to older drug users. At 10%, the infection risk of drug users of above 50 years of age is higher than average according to a survey carried out by Goordroad (2003; quoted from Vogt 2009b). The DSHS-data for the populations of the above-40-year olds identify 3.6% of the older opioid users as HIV-positive and 57.0% as negative. When interpreting these data it is however to be taken into account that the HIV status in 39.9% of the people attended to is unknown (Pfeiffer-Gerschel et al. 2009a).

Hepatitis C is the most common health problem of older drug users. In 42.2% of the older opioid users, hepatitis C is chronic, in 3.7% the disease is acute. However, here as well, the infection status is unknown in almost every third client (29.9%) (Pfeiffer-Gerschel et al. 2009a).

Year-long co-consumption of other licit and illicit drugs often leads to damage of the organs or exacerbates existing ailments. Liver and lung diseases are widely spread health issues among senior drug dependents (Ebert & Sturm 2006; Vogt 2009b).

Drug aid experts moreover report about circulatory disturbances, hypertension and renal insufficiences that are typcially prevalent in older patients undergoing substitution treatment (Meyer-Thompson, personal communication). Various types of cancer (Wessel, personal communication), damages of the blood vessels caused by year-long intravenous use, abscesses, thromboses and embolism are also reported. In the worst case, the harm done makes the amputation of limbs inevitable (Hoffmann, personal communication). It is furthermore reported that about half of the patients suffer from chronic pancreatitis (Müller, personal communication). Dental diseases are a widely spread problem among drug users. Insufficient dental hygiene and malnutrition often lead to dental diseases that remain untreated over years and decades. As a result, complete loss of all teeth between the ages of 25 and 35 is not uncommon (Vogt 2009b).

Year-long drug users aged above 40 years display an early and accelerated aging process. Aging processes in the human organism are accelerated by drug-use. Age-related diseases like diabetes mellitus type 2, osteoporosis and senile dementia occur earlier in drug users. This is attributable to various factors which go hand in hand with drug use and lifestyle: (temporary) homelessness, experiences of violence, prostitution, lacking hygiene, lacking possibilities of regeneration, malnutrition as well as sequelae and concomitant diseases. As a result, at the age of 40, drug users have a need of care that corresponds to the one of non-substance using elderly people (Lenski & Wichelmann-Werth 2009; Vogt 2009b). Drug aid experts also point to the early senescence of year-long drug users. Most of the clients are 15 years and more ahead in their aging process, both physically and mentally (Hoffmann, per-

sonal communication). It was also observed in some clients that the aging process sets in very suddenly and progresses at an accelerated speed (Wagner, personal communication).

It is important to recognize the sequelae of addiction as such at older age[43] and not to attribute them to the aging process. Symptoms are frequent falls, malnutrition, declining physical performance, cerebral dysfunction, lack of drive and interest, mood swings, social reclusion and decreasing physical hygiene to dilapidation (Diakonie 2008).

Mental health

In many cases, drug addicts suffer from multiple dependence on various psychoactive substances. Dependence on opioids is often paired with other dependencies on licit and illicit drugs. Politoxicomania is widely spread among older drug users (Vogt 2009b).

Among long-term opioid users, psychiatric comorbidity is a common problem. Affective disorders in particular like schizophrenic disorders are widely spread. Various authors are of the opinion that depressions, anxiety disorders and psychoses occur more frequently with increasing age and duration of addiction (Ebert & Sturm 2006; Vogt 2009b). On the other hand, the authors of the BADO report conclude that the mental state deteriorates at older age and report about psychological disorders that are in their extent comparable to the ones affecting already younger drug users. From this it may be concluded that the abovementioned psychological disorders seem to develop already in the early years of a drug use career and then seem to persist (Verthein et al. 2008).

Age-related changes of the metabolism

So far, surveys conducted on substance abuse at old age, have mainly been preoccupied with alcohol and prescription medications than with the abuse of illicit drugs. Some surveys investigated in particular the aspect of abuse of psychotropic substances taken at a constant dosage in relation with age-induced metabolic changes.

When taking prescription medications, it needs to be taken into account that, as a result of physiological changes, resorption and distribution of the substance in the metabolic system can lead to a relative increase in dosage despite compliance with a constant prescription dosis. When taking medical drugs, patients are often not aware of the risks of abuse or dependence because the medical preparations have been prescribed by a doctor. However, the changing metabolism requires from doctors to permanently monitor the indicators of the prescription and, if necessary, to adapt the dosage. If this is not taken into account, this can lead to addiction without anyone noticing (Förster & Thomas 2009). Pharmacokinetic changes at old age are also investigated in connection with alcohol abuse. Here too, an increasing sensitivity paired with a declining tolerance is to be observed with increasing age. The same drinking quantity has a stronger physical impact at old age (Schäufele 2009).

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[43] The source mainly refers to dependence on alcohol and prescription medications but also to drug addicts in general.

Age-induced physical changes also affect users of other psychotropic substances. It would be nevertheless necessary to carry out special examinations for example for the use of opioids. The question as to whether a relative increase in dosage as observed in connection with alcohol and medical drugs also occurs in connection with the consumption of opioids is indeed relavant for the substitution treatment of older drug users.

12.4 Treatment, management and care of older drug users

12.4.1 Policies

The German Basic Law (article 20 alinea 1 GG) stipulates that socially deprived and needy persons have a right to social welfare assistance. Senior drug dependents are entitled to all services under the social law that address the treatment of addiction on the one hand but also the need of care on the other.

The various requirements of older drug users show clearly that there is need for concepts specifically tailored to this group of persons. They need to take into account both the treatment of addiction but also the need of care that differentiates this group from other drug users. Special legal regulations addressing the needs of senior drug dependents do not exist as of yet.

The parts of the social law relevant for the care, treatment and housing etc. of senior drug dependents are especially the social insurance scheme (SGB IV) that comprises the statutory health insurance scheme (SGB V), the pension insurance scheme (SGB VI) and the nursing insurance scheme (SGB XI). Of relevance are moreover the stipulations of the unemployment insurance scheme (SGB III), the rehabilitation and participation of disabled people (SGB IX), basic social care for job-seekers (SGB II) and in particular public assistance (SGB XII) (Lenski & Wichelmann-Werth 2009).

Senior drug dependents are, depending on their needs (e.g. nursing care or health rehabilitation), entitled to different services to be rendered by the health, pension and nursing care insurance schemes. Each individual has different constellations that require a case-by-case evaluation. Standard regulations specifically dedicted to senior drug dependents do however not exist.

The costs of treatment of addiction in the sense of a disease devolve upon the statury health insurance scheme. Anyone entitled to the basic social assistance for job-seekers is mandatorily health insured (according to SGB II). But this is problematic especially for drug users since the assistance is only granted to clients fit for work. However, this is often not the case with senior drug dependents. In the case of lacking insurance protection, the social insurance scheme (sickness benefits or respectively integration aids for disabled people in respect of SGB XII) provides the lowest social safety net (Lenski & Wichelmann-Werth 2009).

The service spectrum of addiction treatment under the German social law comprises outpatient and inpatient medical care including rehabilitation and substitution treatment with accompanying psychosocial care. It is to be supposed that measures aiming at restoring the working capacity in older drugs users tend to be rare, rather the question arises here if there

is a need for nursing care. Nursing care services are provided by outpatient care services or by in- or day-patient facilitites. Older (and also prematurely aged) drug users are entitled to make use of these social services, but especially residential eldercare facilities are not suited to meet the specific needs of these clients (Lenski & Wichelmann-Werth 2009).

12.4.2 Health and social responses

Harm reduction strategies

Harm reduction strategies start with information about possible risks of infection and measures to prevent infection. As part of the strategies, low-threshold access to help facilities is provided and pharmacologically-assisted treatment expanded. Harm reduction strategies comprise furthermore syringe exchange programs, emergency shelters, drug consumption rooms, safer use campaigns, distribution of condoms and also vaccination campaigns for hepatitis A and B and substitution treatments (Die Drogenbeauftragte der Bundesregierung 2009; Vogt 2009a).

Homes for senior citizens

In view of the special needs of senior drug dependents, the pros and cons of the concept of homes specialized for older drug users on the one hand and the accomodation of older drug users in ordinary homes for senior citizens on the other are currently discussed. At present, such homes only exist within the framework of demonstration projects. However, both forms of accomodation are regarded only as a compromise solution that cannot meet all the requirements of this group of persons.

In the disussion it is stated as an argument against the set-up of special homes for senior drug dependents that a reduction of the (re-) integration chances of the residents and a possibly increasing stigmatization and exclusion by the home environment is to be expected. As an argument for setting up special homes it is put forward that this concept would offer the possiblity to have both care (psychosocial care and substitution treatment) and medical treatment for the residents provided by specifically trained staff. Speaking against accomodating older drug users in ordinary homes for senior citizens would be the fact that eldercare staff is not trained and prepared for the counselling and psychosocial care of this special group (Ebert & Sturm 2006; 2009). The older drug addicts themselves tend to disapprove of being accomodated in ordinary homes for senior citizens because they have every day routines and firmly established behavioural patterns which they find hard to change and difficult to reconcile with the operational processes of ordinary homes for senior citizens. They rather fear to be confronted with prejudices and stigmatization (Vogt 2009b).

Ambulatorily-assisted living

Within the framework of drug aid, ambulatorily-assisted living programs serve to stabilize the life situation of drug users after inpatient treatment. This type of outreach work makes it possible to profit from a high degree of indepence in a private environment in combination with assistance tailored to the individual needs. For senior drug dependents, this type of

program allows to combine the advantages of eldercare and drug aid (Ebert & Sturm 2006; 2009).

In practice, ambulatorily-assisted living groups can be formed for example for long-term substitution patients to overcome isolation of older drug users (Hoffmann, personal communication).

Substitution

In the medical treatment of opioid addicts, substitution treatment is the most important and most common treatment option. The average age of the substituted patients is – according to a study conducted on the care practice of substitution treatment for opioid addicts – at about 35 years (Vogt 2009b; Wittchen et al. 2004).

Psychosocial care forms part of the pharmacologically-assisted treatment of opioid addicts. It is to be assumed that senior drug dependents have, due to their special situation (i.e. double exclusion) an increased need for psychosocial care offering them possibilities of reintegration into society.

Social reintegration of older drug users

Concepts for the reintegration of drug users that are specifically dedicated to older persons do not exist as of yet. So far, reintegration mainly aims at restoring the working capacity (to enable reintegration into the labour market). The development of concepts that look at reintegration also from the perspective of nursing care needs and forms of accomodation is missing. At present, such concepts are only sporadically developed within the framework of projects and demonstrations projects.

When discussing possible types of accomodation for persons in need of care, the preferences of the drug users themselves ought to be, last but not least, be taken account of. In a non-representative survey Furhmann intreviewed drug users aged above 40 about their ideas and wishes with regard to the future. Reintegration into society, social reintegration, restoration of the working capacity and return to a regular every day life were the wishes expressed by the interviewees (cited from Vogt 2009b). Treatment and care of older drug uses can integrate such requests formulated by people affected in the conception of help offers in so far as they contribute to a successful reintegration. The request of setting up special forms of accommodation dedicated to older (ex) drug users corresponds for example to the opinion of drug aid experts who underline the necessity of the creation of specialized facilities.

Quality assurance and best practice

Cross linking eldercare and drug aid

The number and the portion of elderly people among drug users are presumably going to increase further in the future. These people are going to need, to an increasing extent, not only drug aid services and medical treatment of their addiction but also eldercare services.

An important role will also be played by the question as to find appropriate accommodation in in eldercare or health care facilities. Cooperation networks between eldercare and drug aid are desirable since eldercare staff are generally not trained for catering for the special needs of drug addicts and, vice versa, drug aid personnel are not trained for catering for the needs of elderly people and those in need of nursing care (Kämper 2009; Vogt 2009b).

The need for specific offers that take account of the social and health situation of the target group is clearly noticeable in the practical work with the elderly drug users. However, there is no legal framework as of yet to guarantee care for this target group and to combine offers in a structured way to reach the group of the elderly with addiction problems and provide them with specific help services. Special attention is to be attached to the networking of existing services, case management and the expansion of ambulatory care services (Diakonie 2008). Drug aid experts also report about being increasingly confronted with older patients and people in need of nursing care calling for the expansion of cooperation structures of the nursing care services and drug aid (Hoffmann, personal communication).

Housing of older drug users: demonstration project LÜSA

There are sporadic facilities that have oriented their help services to the special situation of senior drug dependents or that have expanded their original help offer for this target group. These are however run as demonstration projects and do not form part of the regular care offers.

The first project of this type was launched in 1997 under the name “Long-term transitional support offer“ (*Langzeit Übergangs- und Stützungs-Angebot, LÜSA*). Within the framework of this project, the concept of a “permanent residential facility for aging and severely ill chronic drug addicts” has been implemented since 2002. The services provided within the project comprise long-term residential care for older addicted people but also ambulatory forms of assisted living. Housed in living communities, older drug addicts can make use of outpatient drug aid services and eldercare. 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 addiction or to aspects of nursing care (LÜSA 2007). The homepage of the facility can be viewed at: www.luesa.de in the Internet.

Specialized facilities

Facilities providing special offers for senior drug dependents can by researched under the search category *facilities* on the homepage of the DHS. More than 230 facilities (counselling, outpatient and inpatient treatment facilities) in Germany state to cater to the needs of older drug users (http://www.dhs.de/web/einrichtungssuche/index.php).