

Health and social issues among older patients in opioid maintenance treatment in Norway

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Background

In 2015 the Ministry of Health and Care Services was revising the National Action Plan for drug treatment and rehabilitation in Norway. Connected to this, Alcohol and Drug Research Western Norway (KORFOR) examined the health and social issues for older patients with substance-use disorder (SUD) and the possible challenges for the healthcare services.

The report to the ministry (KORFOR, 2015) was divided into two general areas: the elderly and alcohol, and the elderly in opioid maintenance

treatment (OMT). The report sought to answer the following questions:

- Which social and health issues do these two groups struggle with?
- How are the support services for these groups organised and developed, both in the municipalities and the specialist health services? What consequences may an increased number of the elderly in these groups have for the need to increase capacity and to change services?

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- What skills do professionals (physicians, psychologists, nurses and social care workers) need to provide appropriate assistance related to social and/or health problems? What competencies are necessary at this work?

This article presents a summary of the arguments and aspects highlighted in KORFOR's report on the elderly with opioid addiction. For the last 20 years OMT has been a treatment option in Norway. Healthier lifestyles and improved living conditions have resulted in an increased longevity. Patients within this treatment are ageing, and the mean age is now 43 years (Waal, Bussesund, Clausen, Haaseth, & Lillevold, 2014). How long we live is linked to genetic patterns, but age also has a subjective dimension.

The term "older/elderly" is defined differently from one country to another. Across Europe the official retirement age usually starts at 60 years, while administrative and legislative frameworks consider the age of 65 years to be "elderly" (EMCDDA, 2010). Even though there is no standard definition for "older drug users", the cut-off point is lower than 60 years old (EMCDDA, 2010). There are different reasons for this. First, those dependent on drugs have had a long career of problematic drug use. Second, drug use accelerates conditions associated with ageing, and patients suffer from reduced mobility and age-related chronic diseases (Dürsteler-MacFarland, Herdener, & Vogel, 2014; EMCDDA, 2010). Third, they die approximately two decades before those without the drug dependence diagnosis (De Alba, Samet, & Saitz, 2004; Firoz & Carlson, 2004; Lofwall, Brooner, Bigelow, Kindbom, & Strain, 2005). In Europe, opioid users are five to ten times more likely to die earlier than non-using peers, mainly due to their risky lifestyle. The average age of drug-induced deaths in Europe is 38 years (EMCDDA, 2010).

Some studies in Europe have used 40 years of age as the cut-off point for older drug users (EMCDDA, 2010), while several American

studies have used 50 years or more (Lofwall et al., 2005; Rajaratnam, Sivesind, Todman, Roane, & Seewald, 2009). In this report, based on the above aspects, the cut-off point was set at 45 years.

Methods

Various methods of data collection and analysis were used in the report to provide a reliable picture of the situation for older patients in OMT. Methodological triangulation (which involves the use of multiple qualitative and quantitative methods to enhance the analysis and the interpretation of findings) and data triangulation (using different sources of information in order to increase the validity of the study) were applied (Patton, 1999). If a finding emerges within different methods, it can be considered more valid than if it had been achieved with just one method (Denzin, 1989; Patton, 1990). Results were retrieved from several data sources and were cross-checked against each other.

PsycINFO, EMBASE, MEDLINE, Web of Science and SveMed+ were searched for relevant articles. Combinations of keywords and terms were: elderly, aging/ageing, older, adult, person, client, patient, individual, addict, dependent, user, opioid, opiate, buprenorphine, methadone, substitution, replacement, assisted and maintenance. References from the retrieved articles were reviewed to include additional papers. The abstracts were reviewed to measure whether they met the following criteria: (1) participants aged 45 years and older; (2) active OMT patients; (3) patients with mental, somatic or social problems. All in all, 32 Nordic and English studies were selected.

Three statistical sources were used: Quality Assurance Project, Status Report and User Plan survey. Data from these surveys were re-analysed in order to distinguish patients over/under 45 and 60 years old.

The Quality Assurance Project led by the Department of Addiction Medicine,

Division of Research and Development at Haukeland University Hospital, presented data from 30 local patients for 2015. The registry contained information on drug use, physical and mental health, social situations and activities for a better handling of harmful use or drug dependence.

The national Status Report was based on information from all Norwegian OMT facilities in 2013. It consisted of data from over 2500 patients related to their sociodemographic factors, mental and physical health.

The regional records from User Plan survey 2014 provided information from employees in health, care and welfare services in the municipalities. The material contained the personnel's impressions of over 1500 patients.

The brainstorming e-Lab method was used to identify health and social problems and subsequent implications for health, care and welfare services in the municipalities. Three e-Lab groups were conducted in 2015. Two groups included researchers and professionals: general practitioners, psychiatrists, representatives from different addiction treatment centres and from the municipalities, and acknowledged researchers within the OMT field in Norway. The third e-Lab group involved patients over 45 years of age who contributed with their own experiences. Participants used PCs linked together and could see what others wrote on a big screen, but the sender was not identified. Then they ranked aspects in the order of importance as perceived by them.

Qualitative data collection with a snowball approach was carried out by means of questionnaires via email and telephone in 2015. Experienced professionals and researchers were contacted. This yielded 42 telephone interviews and 28 emails.

The findings presented below include: mental and physical health among patients in OMT, patients' social issues, healthcare services and the challenges they face in relation to this

group, and a summary of findings and recommendations. The objective was to focus on the results and avoid repetition instead of presenting the information about the different data sources separately.

Mental health

Results from literature and e-Labs indicated that mental health problems are common among the older OMT population (Dürsteler-MacFarland, Schmid, & Vogel, 2010; KORFOR, 2015; Roe, Beynon, Pickering, & Duffy, 2010; Rosen, Smith, & Reynolds, 2008). Individuals often suffer from memory loss, paranoia, changed mood or anger. Some studies illustrate that the incidence in comparison with younger OMT patients is somewhat similar (Firoz & Carlson, 2004), while others suggest higher rates of mental illness among the older group (Badrakalimuthu, Tarbuck, & Wagle, 2012). Regardless, most chronic mental illnesses do not diminish over time, but persist into older age.

Psychological disorders tend to vary depending on age and gender. On the one hand, severe functional impairment, anxiety and malfunctions in relation to mental health declined, as shown in Figure 1. Status Report showed that 26% of those registered in the 45–59 years age group had had severe anxiety during the previous four weeks. The number decreased to 15% for those aged 60 years and over. User Plan illustrated that 59% of patients in the first age group were considered to have some degree of impairment of mental health, and again it reduced with age to 48%.

On the other hand, depression and depressive symptoms occurred often in the older population (Beynon, Roe, Duffy, & Pickering, 2009; KORFOR, 2015; Lofwall et al., 2005; Roe et al., 2010; Rosen et al., 2008). According to Status Report, one in five patients was considered to have severe depression, and the literature has specified a significantly higher prevalence among women: 44% versus 27% (Rosen et al., 2008). Also, unlike men, women

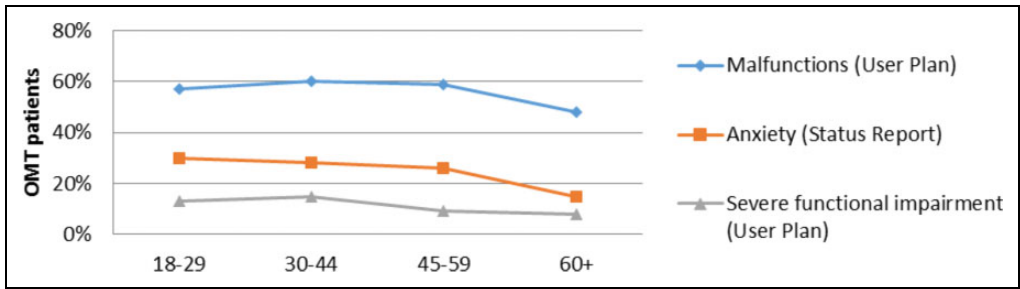


Figure 1. Mental health problems of opioid maintenance treatment patients.

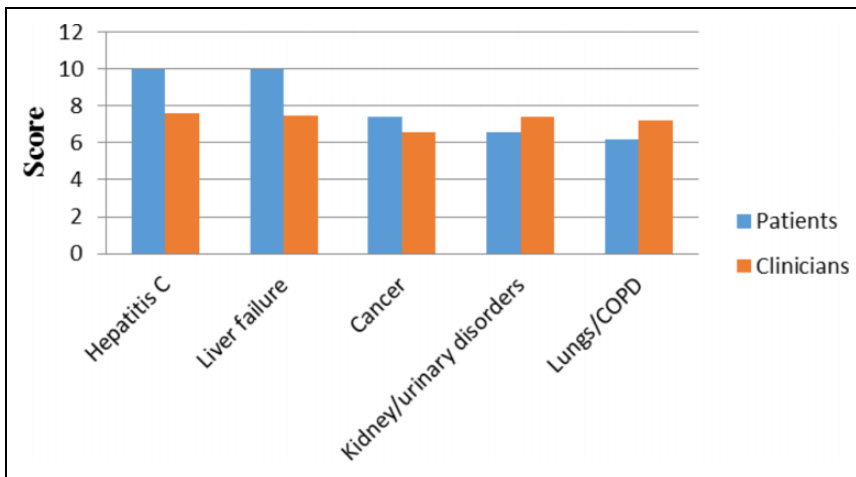


Figure 2. Somatic problems of opioid maintenance treatment patients over 45 years old (e-Lab).

experienced greater psychological distress through suicidal thoughts and attempts (Grella & Lovinger, 2012).

E-Lab ranked mental health as a major problem among the older OMT patients. The clinicians classified high suicidal risk and thoughts, while the patients highlighted social anxiety, trauma and post-traumatic stress disorder.

Physical health

The number of opioid maintenance treatment patients with somatic comorbidity increased with age (Badrakalimuthu et al., 2012; Haaland, Lie, Nesvåg, & Stevenson, 2015; Waal et al., 2014).

Figure 2 shows the main somatic problems demonstrated by e-Lab: hepatitis C, cancer and liver, kidney and lung diseases. Status Report

supported the finding that the percentage of patients infected with hepatitis C also went up (from 42% to 56%). Among the older group the reported worldwide incidence of liver cirrhosis was 14% (Rosen et al., 2008), hepatitis C varied between 24% and 82% (Fareed, Casarella, Amar, Vayalapalli, & Drexler, 2009; Lofwall et al., 2005; Rosen et al., 2008), and incidence of liver disease ranged between 11% and 18% (Firoz & Carlson, 2004; Novick et al., 1993).

E-Labs pointed out that prevalence of cancer disorders increased. The healthcare system had little knowledge about the needs of the OMT population, and it could be difficult to follow them up. Patients in OMT had the same needs for palliative treatment (pain relief, nursing/care and improved quality of life) as all other

cancer patients. Still, some of them did not get the help they needed and were stigmatised because of their lifestyle. Persons with substance-use disorders had limited resources of their own and depended on healthcare professionals to offer them help other than just medication and disease treatment.

E-Lab results showed kidney problems caused by various impure substances and/or after prolonged use of amphetamines that could lead to amyloidosis and development of renal failure. Somatic problems with lung diseases described among the older group were chronic lung disease 22% (Rosen et al., 2008) and respiratory problems 33% (Beynon et al., 2009). The prevalence of chronic obstructive pulmonary disease (COPD) varied between 9% and 16% (Fareed et al., 2009; Novick et al., 1993) and the incidence of asthma between 4% and 10% (Firoz & Carlson, 2004; Lofwall et al., 2005; Novick et al., 1993).

Other health problems mentioned by e-Lab included blood clots, “difficulties in taking blood samples”, endocrinological diseases, musculoskeletal disorders and abscesses/infections.

Social issues

Even though some OMT medications, such as methadone or buprenorphine, caused such side effects as insomnia, sore joints or sweating, “participants described components of the good life – housing, hygiene, freedom, transportation, family, relationships – as motivators for staying in recovery that outweighed the difficulties” (Redden, Tracy, & Shafer, 2013, p. 956). Repaired or improved relations with family and others could be the outcome of treatment (Guo, Winslow, Manning, & Thane, 2010; Hamilton & Grella, 2009; Redden et al., 2013). Many older OMT persons had the desire to be of benefit to others (Rosen, Goodkind, & Smith, 2011). They looked for opportunities to give something back and take responsibility for their children or grandchildren (Rosen et al., 2011). According to User Plan, as many as 42% of older adults reported a good social

functioning, and 40% of participants in the Quality Assurance Project were satisfied with their leisure pursuits. Nonetheless, the majority had little social support, few friends and often little or no contact with their family members (Dürsteler-MacFarland et al., 2010; Ege, 2012).

For many patients with SUD, social isolation was a part of the ageing process (Hamilton & Grella, 2009). Difficulties in relationships with family, unresolved conflicts and disappointments, and many years of absence had made it problematic to reconnect (Ayres, Eveson, Ingram, & Telfer, 2012; Hamilton & Grella, 2009; Nyhagen, 2014; Pedersen, 2006; Smith & Rosen, 2009). Some struggled with guilt about not contributing or being the role models they thought they should have been (Nyhagen, 2014; Smith & Rosen, 2009). Others in e-Lab reported grief over lost time with their children. Despite the nostalgia for the drug culture and lifestyle, they were also filled with shame and remorse for their choices and the consequences (Redden et al., 2013). Shame was tied to what they had exposed their families to, and what they had done in relation to substance abuse and criminal activities. Some of them had a feeling of shame that was connected to being an OMT patient (Smith & Rosen, 2009). They considered it a personal failure, partly because they still used drugs at this age (Ayres et al., 2012).

Poor social networks were reported by 70% of individuals in treatment aged 45 years and over in the User Plan. Patients in e-Lab highlighted social isolation as the second biggest problem after financial issues. Older men scored significantly lower on social functioning (Grella & Lovinger, 2012). According to different sources (KORFOR, 2015; Smith & Rosen, 2009), there could be several reasons for and barriers in a limited and isolated social life:

- Lack of social skills to build up a new social platform and make contact with “straight people”.
- Staying away from friends and family who still used drugs and could be the source of potential problems.

- Low tolerance to noise, chaos and “rush” for drugs, therefore shielding themselves from the drug environment.
- Reluctance to trust others.

The loss of spouse and friends in overdose, divorce, illness or other ways was common. Over 83% of elder participants in the Quality Assurance Project said that such losses had a negative effect on their lives and they were afraid to live through similar losses again. The older group had an unmet need in terms of a meaningful network (Nyhagen, 2014).

Many individuals felt that they were not part of society, and different quotes from e-Lab could be interpreted as an expression of experience with stigma, including “no use to change, ambient impression cannot be changed”, “the doctor doesn’t understand me, doesn’t listen to me, doesn’t see me” and “difficulty getting treatment in healthcare because you are labelled as an addict”. Four stigmas were simultaneously experienced by 66% of respondents. The most common combination was being an addict, older, receiving psychotropic medication and having depression (Conner & Rosen, 2008).

The following quotation illustrates stigma experienced by many:

I asked him [GP] about a personal problem, he said he hadn’t got time . . . I think it would have been different if I wasn’t a drug user, he [GP] thinks I’m after more medication. I most certainly got treated differently from other people because I am an addict, I feel I should be allowed the same pain relief as anyone else and not be refused opiate based pain relief if I need it and it works. (Ayres et al., 2012, p. 26)

The older group in OMT felt that the system was designed for the young (Nyhagen, 2014; Rosenberg, 1995): “When I come here and sit in the drop-in I feel embarrassed, younger people make me feel like I shouldn’t be here” (Ayres et al., 2012, p. 27). The experiences in treatment related to control, e.g., picking up the

dose and supervised intake, also felt stigmatising (Ayres et al., 2012; Pedersen, 2006).

Being in OMT could provide a better economy (Redden et al., 2013). Status Report demonstrated that the main source of income for as many as 68% of the patients was a disability pension, while 17% had a work assessment allowance and 5% had social benefits. User Plan data showed that 60% in the age group 45 years and over had a good financial situation. However, there was self-reported poverty among the older group (Conner & Rosen, 2008; KORFOR, 2015). Of the participants in Quality Assurance Project, 56% were not satisfied with their financial situation. Some individuals were financially dependent on their children (Guo et al., 2010). Few had jobs and many lived on the minimum of disability benefits (Dürsteler-MacFarland, Vogel, Wiesbeck, & Petitjean, 2011; Haaland et al., 2015; KORFOR, 2015; Waal et al., 2014). Findings from e-Labs showed that financial difficulties were the main social problem, especially related to debts. Many had old debts (including those in the drug environment), followed by new debt-collection claims that kept growing. Causes of unemployment among older patients, highlighted in e-Lab, were lack of work experience, large gaps in CV, little or no education and little help from the public services in finding a job. Economic deprivation caused people in treatment difficulties in planning activities and taking care of their children. Some patients had little contentment in everyday life. While most of them often had a great desire to fill their spare time with vocational activities such as day centres, training or welfare, they actually took part in few or none. Over half of the participants in the Quality Assurance Project stated that they did not have a satisfying daily occupation.

The majority of older persons with SUD had a place to live (Haaland et al., 2015; Rajaratnam et al., 2009; Waal et al., 2014). However, 60% of participants in the Quality Assurance Project were not happy with this place. Patients in e-Lab described it as “living in plastic bags”. Many lived in the same area with people who

used drugs but were not in treatment. This often led to disorder and trouble. The OMT group faced pressure from others to sell or give away their medicine. For many it caused anxiety and stress. The patient group in e-Lab highlighted two important factors of future planning and improving quality of life: a safe place to stay and buying their own house. Furthermore, older patients who could no longer function sufficiently had a need for extra professional help (Firoz & Carlson, 2004; KORFOR, 2015). Therefore, other suitable accommodations mentioned by an expert group in e-Lab were nursing homes and social housing for the elderly with SUD.

Healthcare services

The following section is based on information provided by experienced professionals and scientists. These experts believe that the growing health problems among OMT patients are best resolved through an adequate support system consisting of GPs, special healthcare services, home care and municipal housing services. The help of GPs would be crucial in regard to increased somatic morbidity as a result of age, which is why it would be important to establish close cooperation between physicians and other support services.

Over the next ten years the need for nursing home placement will increase. Specialist healthcare and the municipalities together should examine solutions to provide for patients in nursing homes. Most of the patients would be able to live in regular nursing homes. OMT medicine would have to be treated like any other medication. Patients with the lowest ability to take care of themselves should be offered municipal day-based monitoring, e.g., staffed shared accommodation and/or nursing homes. Elderly people who live in their own accommodation and need home visits on a regular basis would require skilled home nurses whom they could trust.

The demand for somatic healthcare increases with age. However, the proportion of patients

who have individual plans – a systematic cooperation between the user and support services in order to place responsibilities for the different tasks at the right support services and to improve quality of life and make use of the person's resources, based on the principle of user involvement – decreases. There is no reason to believe that the need for an individual plan would become less important with age.

Services in general appeared to be low skilled regarding ageing in OMT and age-related mental health problems. To improve the skills and the treatment spectrum the specialists made the following suggestions:

- Increase awareness of the fact that problems related to cognitive impairment, dementia and self-care ability can occur several years earlier than in the general population.
- Develop methods related to maintenance of the patient's existing skills and compensating for lost skills.
- Include examination of dementia in a standard assessment for older patients.
- Investigate minor mental problems (anxiety, depression) in outpatient clinics.
- Ensure access to trauma treatment.

The interviewed specialists argued for municipal responsibility for solving problems associated with social challenges. Both guided and self-help groups could be effective approaches against loneliness. These groups should be organised as low-threshold services. In larger towns volunteer organisations already provide good access to these services. Similarly, public authorities seemed to offer satisfactory forms of activities to patients, but availability and accessibility varied. One great challenge was the lack of expertise in healthcare services in addressing loneliness among OMT patients. A preliminary obstacle was the missing awareness of this problem. Many did not know that loneliness problems occurred earlier in this group than in the general population. Subjects such as grief, loneliness, reconciliation

and forgiveness (both to themselves and others) are possibly very important for the elder group. Issues related to faith and doubt may also emerge. Volunteer organisations could offer help regarding grief and loss of meaning of life. Self-help groups, spiritual care and support persons were other examples of assistance with existential support. The public support system should have a total overview of existing services in order to offer appropriate guidance. The interviewed specialists considered health and care services to have too little expertise to handle such issues.

Municipalities were also responsible for providing assistance in housing matters. The OMT group was heterogeneous, which meant that suitable accommodation was defined by the individual. The variety of housing possibilities was broad and ranged from patients' own flats without supervision to staffed shared flats and nursing homes. On occasion different forms of communities and nursing homes would have to be established in close cooperation with specialist health services. The services should continually monitor the needs of the individual so that they could adapt the housing if necessary. The specialists maintained that suitable housing with adequate follow-up was essential in order to provide assistance to nearly every other problem area discussed in the report. However, there was a lack of such housing for OMT patients in high-demand areas in particular. Primarily organisational and resource barriers were perceived as the main challenges for this category of problems.

Summary and recommendations

The number of older adults in opioid maintenance treatment is increasing. In 2014, 22% of these patients were over 50 years old. This percentage will have nearly doubled by 2020. There are many challenges both for the ageing patients themselves and the welfare system in Norway.

The report showed that somatic and mental illnesses affected the entire OMT population. However, the prevalence of depression was somewhat higher in the older age group.

Somatic health problems increased with age. Liver, lung and kidney disorders were the main health challenges. Poor cognitive functioning, including dementia, was more prevalent among the older population. Social isolation and loss of life meaning were a growing problem for many patients as they were getting older. Even though a relatively small percentage of the elderly faced serious problems with housing or regular income, the majority were not satisfied with the quality of living conditions and had debts that caused financial problems.

The general consensus was that ordinary services would be the best answer to psychiatric and somatic challenges and those of social welfare. Conventional nursing homes would be an adequate measure for the majority of patients. Exceptions would have to be made for those who were poorer than the rest of the OMT population. Services would have to be flexible and broad enough to avoid drop-out. Healthcare structures should also be arranged to allow ageing individuals to receive help when needed. This could be done through low-threshold programmes such as field care and street hospitals.

The OMT group requires services where staff have good interaction skills and the ability to recognise the individual's needs. Health and care facilities should address organisational challenges and should enhance professional competences. They need to ensure that the majority of patients obtain age-related assistance within the ordinary services. However, it would be crucial that they identify the most unstable clients and offer them customised care solutions. All in all, general practitioners, municipalities and specialist healthcare should provide age-adequate services for the patient's lifetime.

Alcohol and Drug Research Western Norway gave the following recommendations:

- First, healthcare services are obliged to provide appropriate treatment to people with mental health problems and substance-use disorder.
- Second, all involved parties in treatment, primary and secondary care services and

municipalities need to strengthen the competence and capacity to identify and screen increasing somatic and cognitive health problems of the elderly in OMT.

Third, municipalities and health authorities have to establish closer collaboration to provide necessary healthcare for OMT patients.

Fourth, non-government organisations should engage in providing appropriate activities to include older OMT patients in social communities.

Last, models of low-threshold nursing and care services in combination with customised multi-residential solutions with their own staffing should be developed for older OMT patients with poor health and social issues.

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