BALLYFERMOT LOCAL DRUG & ALCOHOL TASK FORCE

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It's like we're the forgotten ...

An exploration of the issues affecting older people in Ballyfermot who are experiencing problematic drug and alcohol use

For Ballyfermot Local Drug and Alcohol Task Force

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Art work kindly supplied by participants in a range of projects in Ballyfermot LDATF area

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Executive Summary

This report consulted community and statutory addiction service providers and substance users in the 40+ age group in Ballyfermot. Specific sub groups of substance users surfaced in the research. Stigma and isolation were considered by both service users and providers to be chronic challenges to be overcome. Data was analysed and differences in how service providers capture and use data were evident at local level. Barriers were identified with weak joint working practices and insufficient information on services and referral practices signalled as challenges, amongst other themes.

Key issues emerged as needing attention:

- Strengthen joint working protocols and collaboration to improve outcomes for the cohort
- Provide training on bias, awareness raising/ education/ information on what service provision to ensure that both statutory and community based providers understood each other's services, approach, ethos, referral and services
- Provide a safe, social, stigma free space for 40+ group who experience problematic substance use

Recommendations for drug and alcohol specific services in how to support older drug users

1. BLADTF to consider how to progress the data recommendations in section 6.4
2. BLADTF to decide how to implement the methadone clinic recommendations in section 7.2.3
3. BLADTF to consider how to progress the recommendations for people on methadone maintenance treatment in section 6.2.5
4. BLADTF to consider how to progress the recommendations on joint working in section 7.9.5
5. BLDATF to consider how to implement the proposals to meet need from the Covid-19 service provider survey in section 5.4
6. BLDATF to lead on a reflection process on how service providers can redouble their efforts and work collaboratively to reduce stigma and isolation for this cohort

Recommendations for the wider support services for older people in how to identify and provide suitable support with regard to drug and alcohol use amongst the target population

1. Dublin City Council and community providers to examine how they can contribute to meeting this cohort's specific health and psychosocial care needs
2. BLDATF to consider engaging with other agencies in the Ballyfermot area with a view to examining the broader issue of relevant service provision for older residents
3. BLDATF to conduct further discussion and reflection with relevant stakeholders to examine the merits, risks and sensitivities of either a generic or specialised day centre service for this cohort. The decision making with regard to this issue needs to be teased out robustly. A measured, informed and balanced approach will be critical to the success of this venture
4. BLDATF to ascertain if the relevant commitments in the HSE 2021 Service Plan Social Inclusion section are planned to be implemented in Ballyfermot and if so how it can engage and collaborate with these
5. BLADTF to consider how to progress the specific recommendations from service providers and service users in section 8

Recommendations on how to outreach to older people in the community who might be experiencing problematic drug and alcohol use but are not accessing appropriate services

1. BLDATF to strengthen outreach to this cohort to improve their awareness of and engagement with the various addiction services available
2. BLADTF to consider how to progress the recommendations on stigma, bias understanding, training and information in section 7.8
3. BLDATF to devise and run a communication campaign aimed at raising awareness of the risks of drug taking as people age. Relevant delivery channels to be used to achieve the highest penetration to this group ie leafletting, social media may not be the primary channel given the age cohort in question

There are also recommendations on data, stigma, bias, understanding, training and information needs and joint working.

1 Context for the report

The Ballyfermot Local Drug and Alcohol Task Force (BLDATF) is at the forefront of an integrated response to the impact of problematic substance use on local communities, families and individuals in the area. It is one of 14 Local Drugs Task Forces set up in 1997 to facilitate a more effective response to the issue of problematic drug use in communities. The role of local Drug and alcohol Task Forces as set out in the Government's current national drugs strategy *Reducing Harm Supporting Recovery 2017 - 2025*[1] is to implement this strategy in the context of the needs of the regional/local area and to strengthen community based responses in partnership with the community, voluntary, statutory and political sectors.

This research was commissioned by BLDATF, on the suggestion of the Dublin City Council representative on the Task Force, to explore the issues affecting older people in the community who are experiencing problematic drug and alcohol use. Previous feedback at local level to the BLDATF had indicated that there was a high volume of older drug and alcohol users (40+ yrs) in the community, some of whom were engaged in services and others who were hidden in the community with known problematic drug and alcohol. Mindful of action 2.1.23 of the national drug strategy which is improve the response to the needs of older people with long term substance use, BLDATF agreed the aims of this research as:

- Help build a supportive environment for older drug and alcohol users in the Ballyfermot community in partnership with key stakeholders
- Research the needs of older drug and alcohol users in the community
- Make recommendations with regard to the development and strengthening of appropriate supports in partnership with other stakeholders

This report contributes to the Task Force's work to ensure that its funded services, projects and programmes are meeting the current and emerging needs of its catchment population and that the applied models of practice are contemporary and compliant with latest research findings for addressing problematic drug and alcohol use.

[1] Department of Health (2017) *Reducing Harm Supporting Recovery 2017 – 2025* Government of Ireland.

2 Methodology

This research used a mixed methods approach. Qualitative data was generated via one to one semi structured interviews and focus groups where pre-determined yet open ended questions were used to explore participant's views. This material was transcribed and analysed using an inductive approach. Themes and issues emerged which were translated into recommendations. Grey literature and research findings were used in the literature review section.

Data from external sources, the Health Research Board RB National Drug Treatment Reporting System (NDTRS) and the Central Methadone Maintenance Treatment List was analysed and used in the data section of the report.

A month into the field work, which began in February 2020, Covid-19 pandemic restrictions were imposed which resulted in a pause in the research. The work restarted in January 2021. To capture the impact of the pandemic and the Government restrictions on the services and service users in question a survey was added to the scope of the research. This survey was administered in February 2021 to 16 services providers, both community and statutory. There was a response rate of 63% with 10 responses returned. A short analysis of this survey is included in this report.

The report ends with a series of recommendations in section 9. These recommendations come directly from the voices of those spoken to for this report and cover a range of themes: what barriers block substance users accessing supports and services, how programmes could better meet their needs, how inter agency and joint working practices can be improved and finally what resources would improve physical and mental health for the 40+ age group using substances in the area.

3 Short profile of Ballyfermot

Ballyfermot, an area of significant disadvantage to the west of Dublin has a population of 22,091. It is made up of seven Electoral Divisions, which themselves are comprised of Small Areas (usually between 80 to 120 housing units). There are 73 Small Areas in Ballyfermot about 7,500 housing units. The area has low levels of educational attainment and high levels of unemployment.

The report from the HSE National Office of Suicide Prevention published in July 2020 provides useful insights into the level of disadvantage in Ballyfermot (see Table 1 below). The 2016 Pobal Deprivation Index measures the disadvantage score of small areas (of between 80 to 120 houses) from the most disadvantaged -40 to the least disadvantaged 40+. Using this methodology six out of the seven Electoral Divisions in Ballyfermot are classified as disadvantaged. This report provided a granular analysis of Ballyfermot which found that of the total of 73 Small Areas in Ballyfermot 7 were very disadvantaged (scores -20 and -30) and that 56 were disadvantaged (scores between -10 and -20). In total this study found that 86% of the Ballyfermot area was "significantly impacted by deprivation".[2]

That said, Ballyfermot is well serviced by public amenities with a number of local parks, good transport links to the city centre, a new Civic Centre, HSE Primary Health Care centre, family resource centres and library. The area has thriving community structures such as the Ballyfermot and Chapelizod Partnership and has a range of local projects and voluntary organisations. There is significant recovery capital available in the community which could be used as a launchpad to generate specific responses to improve outcomes for the cohort in question.

Recommendation:

BLDATF should:

- Review the amenities available local and consider how best to ensure that these are optimised in individual care planning for clients
- Adopt a proactive creative approach to ensure that all addiction services in the community are aware of and incorporate amenities in their client work, current Covid-19 restrictions allowing

Table 1. *Ballyfermot population & level of deprivation*

Name of Electoral Division	Population	Number of small areas within Electroal Division	HR Deprivation Index
Cherry Orchard A	3254	6	-13.97
Cherry Orchard B (Carna)	2836	9	-14.96
Cherry Orchard C	4545	12	-10.94
Kylemore	2657	10	-16.27
Drumfinn	3588	13	-13.90
Decies	2677	11	-15.18
Kilmainham A	2534	12	-9.08
Total	**22,091**	**73**	

Source: HSE Rapid Assessment into Suicide and Community Response Dublin South July 2020[3]

2 HSE NSOP (2020) Rapid Assessment and Community Response to suicide and suspected suicide in Dublin South. Government of Ireland.
3 Ibid

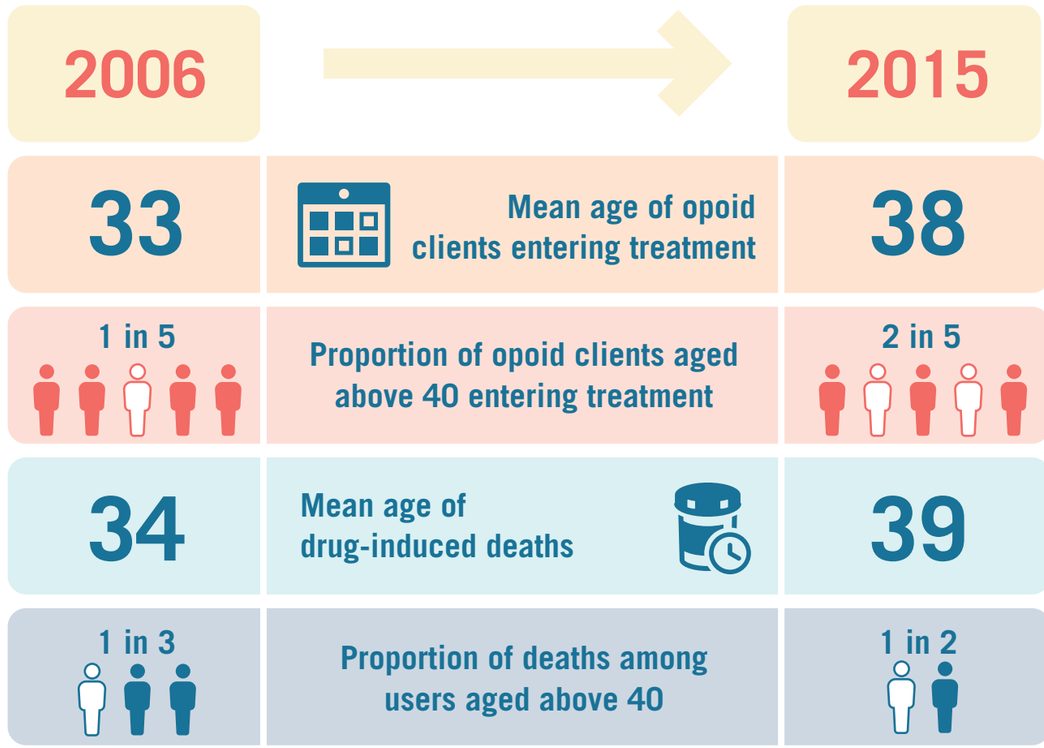
4 Short literature review

This brief literature review provides an overview of both national and some international research into the particular challenges faced by older drug users. There is consensus in the literature that older substance users are a silent hidden group whose needs are not always met, often for reasons of isolation and stigma. The literature is clear that policy and practice must develop to meet this group's current and emerging needs.

4.1 Summary of trends at EU level

The 2017 EMCDDA paper[4] states that older people with drug problems are more likely to have poorer health outcomes and that the numbers needing health and social care interventions will increase in coming years. Of note is the fact that between 2006 and 2016 there was a drop of 45% in the numbers of people starting opioid treatment. Other relevant facts are included in the below infographic:

Figure 1. *Ageing Cohort of High Risk Drug Users in Europe changes 2006 to 2015*[5]



4 European Monitoring Centre for Drugs and Drug Addiction (2017), Health and social responses to drug problems: a European guide, Publications Office of the European Union, Luxembourg.
5 Ibid pg 99.

The paper notes that while the cohort is not a homogenous one many of the group began their drug use with heroin 1980s and 1990s and are now at high risk of a variety of serious conditions and will need health and social care interventions in the future.

It goes on to describe other challenges faced by this group, such as reduced social interactions due to bereavements in their circle. It cites social isolation and exclusion resulting from stigma and suggests that the shame of drug use serves as a barrier to accessing services. The physical and mental health risks this cohort are at a higher risk of include:

- Accelerated ageing
- Higher rates of physical and mental health problems than their peers
- Earlier onset of degenerative disorders, circulatory and respiratory problems, pneumonia, breathlessness, diabetes, hepatitis and liver cirrhosis
- Higher risk of drug-related infections, overdose and suicide
- Blood-borne viral infections
- Serious dental problems
- Anxiety, dementia, loneliness, memory problems and confusion

4.2 Proposed policy responses for older substance users

A range of policy responses are proposed in this paper to tackle the emerging challenges:

- ✓ *Joined-up treatment approaches*
- ✓ *Interagency partnerships*
- ✓ *Established referral pathways between specialised and mainstream health and social services*
- ✓ *Training for staff in mainstream services essential to ensure successful implementation of these models of care*
- ✓ *Training for mainstream health and social care staff to ensure that these models of care are successful*
- ✓ *Drug treatment services for older people to provide multidisciplinary care to address their medical and psychological needs as well as their social isolation*
- ✓ *Awareness-raising and training of health and social care staff dealing with elderly people about how to respond to the needs of older people with drug problems to ensure appropriate care and avoid stigmatisation*
- ✓ *Improved access to, and uptake of, hepatitis C antiviral therapies.*
- ✓ *Specialised nursing homes for long-term residential care of ageing drug users.*
- ✓ *Appropriate physical health care, including dental health services*
- ✓ *Advocacy support to increase self-esteem, acceptance and positive feelings about the future, with peer-led approaches likely to be particularly appropriate*

THE PAPER CITES SOCIAL ISOLATION AND EXCLUSION RESULTING FROM STIGMA AND SUGGESTS THAT THE SHAME OF DRUG USE SERVES AS A BARRIER TO ACCESSING SERVICES.

A UK Drugscope report '*It's about time*' also offers useful recommendations and observations on both policy and practice to achieve good health and psychosocial outcomes for older drug and alcohol users.[6]

A key point made in this report is that not all older people who develop problems with substance use need specialist interventions. The report states that for some, especially those with alcohol issues accessing health and psychosocial support in the community can be sufficient. For this approach to be successful health and social care professionals working in community settings need to be adequately trained to pick up on problems and to know which service to refer such people on to.

[6] Drugscope (2014) It's about time tackling substance misuse in older people London.

[7] O'Shea, J., Goff, P. and Armstrong, R. (2017) SAOR: Screening and Brief Intervention for Problem Alcohol and Substance Use (2nd ed). Dublin: Health Service Executive. Retrieved from: https://www.hse.ie/eng/about/who/primarycare/socialinclusion/homelessness-and-addiction/alcohol-and-substance-use-saor/

The SAOR theoretical and operational framework for the delivery of screening and brief interventions for problematic substance use is used in Ballyfermot, as across other settings in the HSE. The framework provides a useful model to guide workers in utilising a person-centered approach throughout their engagement with service users. SAOR II supports workers from their first point of contact with a service user to enable them to deliver brief interventions and to facilitate those presenting with more complex needs with entry into treatment programmes.[7]

The benefit of 'non therapeutic' groups for this age cohort was stressed where the emphasis is social and activity based, and not rule bound and structured. This type of group was found to foster confidence and improved attendance.

Open ended access to supports was another positive factor identified in services where the older service users had entrenched behaviours and lifestyles and were unlikely to either sustain or aspire to abstinence. This report found that for those who do not have abstinence as their goal, but who want to maintain a level of social connection and supports, a social welcoming space where risk reduction was encouraged was found to be sufficient to meet their needs. This was noted to be in marked contrast to services which had mixed age groups attending which were more likely to have abstinence outcomes as a funding requirement.[8] It is important to note, in the context of Ballyfermot, that abstinence outcomes are not a funding requirement for HSE funded agencies.

Positive interventions such as one-to-one support, including keywork and counselling, social groups and activities were identified as factors which combat the loneliness and isolation felt by this cohort. Other relevant policy responses include:

- Ensure that service users' physical and psychological needs are known and carefully managed
- Develop strong case management and partnership working
- Prioritise good information flow and communication between the different stakeholders working with the service users
- Provide family oriented approaches - offering support to other family members
- Link with community services which have social activities
- Employ peer mentors - 'real peers' who have lived experience of problematic substance use
- Include home visits
- Develop awareness of the need to protect vulnerable adults – links with HSE Adult safeguarding REC
- Provide easy to read literature, assessment checklists etc
- Adopt a strengths based approach

The above interventions and approaches resonate very strongly with the findings of this report which emphasise the need for a specific, stigma free social space for this cohort where they can access a range of interventions.

In February 2021 the new EU Drugs Strategy 2021 - 2025 was launched. Strategic priority 6 - ensure access to and strengthen treatment and care services - identifies older people with a history of long-term drug use and dependence as a priority cohort. It states that "effective engagement with these groups also requires models of care that recognise the need for cross-service partnerships between healthcare, youth and social care providers, and patients/carers groups".[9]

4.3 National policy and literature on older drug and alcohol users

The current drugs strategy continues the partnership working approach between statutory services and community and voluntary service providers first established in the 2009 - 2015 strategy. The rapid expert review report of the 2009 – 2016 strategy noted the critical role contributed by community organisations in both the development and delivery of the strategy.[10] That review found 'blurred communication' and less clear roles and responsibilities between actors at local levels. A key finding confirmed the lack of clarity and effective joint working at local level.

Of note, within the context of the national drug strategy, is the National Drug Treatment Rehabilitation Committee which was set up to map out a rehabilitation policy and strategy for the integrated

[8] This report found that most of the services for older substance users which were based on a risk reduction as opposed to abstinence model of outcomes were funded independently and not by mainstream drug and alcohol funders.

[9] Council of Europe (2021). *EU Drugs Strategy* 2021-2025. Brussels. Retrieved from: https://data.consilium.europa.eu/doc/document/ST-14178-2020-INIT/en/pdf

[10] Griffiths, Paul and Strang, John and Singleton, Nicola (2016) *Rapid expert review of the National Drugs Strategy 2009-2016.* Dublin: Department of Health. Retrieved from: Ireland_Expert_Review_Final (drugsandalcohol.ie)=

drugs rehabilitation services and to oversee the implementation of the Report on the Working Group on Drugs Rehabilitation. This framework outlines the shared protocols and referral arrangements across community statutory and voluntary agencies. [11]

Irish research also reflects the European trend of an age increase in the older drug and alcohol users cohort. The 2018 study by Carew and Comiskey analysed almost 19,000 people who went into treatment in Ireland and found that they were older, using longer and going into treatment later, with implications for policy and services.[12]

In 2019 the Health Research Board carried out research into how to maximise the integration of mental health and addiction services to best meet the needs of service users and improve outcomes.[13] The methodology involved visits to integrated dual diagnosis settings where both service providers and service users were consulted. Over 150 international literature were reviewed.

A key finding from this research was that the service user needs to be at the centre when the integration of these services is being implemented and involved in the co-production of the services. Other recommendations include building competence, confidence and clear communication between providers and ensure payment and allocate resources to enable the integration.

The HSE 2021 National Service Plan states that improving health outcomes for socially excluded groups such as those with "increased vulnerabilities including complex general health, mental health and addiction problems" is one of its priorities. It references the national drug strategy and notes that the Covid-19 pandemic has caused major challenges for this cohort of the population.

There are specific relevant commitments stated on page 52 of the 2021 HSE Service Plan in the Social Inclusion chapter, namely: [14]

1. Expand services for women who use drugs and alcohol in a harmful way
2. In agreement with the Department of Health support the development of an area-based approach to community health and wellbeing improvement with a particular focus on areas of deprivation with the implementation of a new community-based integrated alcohol services across primary and acute settings
3. In line with a health-led approach to drug use, co-lead on the phased implementation of the Health Diversion Programme with the Department of Health including the targeted expansion of SAOR screening and brief intervention and the roll-out of a national drug awareness campaign

Recommendation:

- BLDATF should explore if the above commitments will be implemented in its catchment area and if so ensure that it engages collaboratively with these initiatives

4.4 Methadone Maintenance Treatment

While it is outside the scope of this literature review to examine in depth the situation of people in Methadone Maintenance Treatment (MMT), this group emerged as a particularly vulnerable one, experiencing much stigma and isolation, in the qualitative research for this report.

The literature is clear that this sub group of ageing drug users experience a range of chronic and severe physical and mental health problems which impact severely on their daily lives. Many authors point to the fact that this group uses self isolation as a coping mechanism, with some of the cohort self medicating using alcohol, street drugs or illicit drugs.

The 2018 report "*Just Maintaining the Status Quo?*" by Dun Laoghaire Rathdown Drug and Alcohol Task Force provides sobering insights into the experiences of long-term participants in methadone maintenance treatment.[15] This report emphasises the "interconnectedness of the medical, psychological and social needs of individuals who are long-term clients of MMT and notes the corrosive impact of stigma on the cohort. Accessing and staying in MMT was shown to be difficult for both genders many of whom experienced depression and isolation. Of particular note were the issues faced by women, some of who only attend to access their prescription, and who did not engage with any other supports. Barriers identified for women included 'negative stereotyping, social stigma and lack of childcare'.

This report notes the location, at a national policy level, of addiction treatment within the Social Inclusion Division of the Department of Health as evidence of the fact that neither Mental Health nor Primary Care include this service within their structures. It cites the 2017 statistic that over 60% of people on MMT were attending specialist addiction clinics rather than local GP surgeries as proof of that marginalisation. It is noteworthy that in Ballyfermot that HSE Addiction Services are located within the Primary Care centre building.

4.5 Local findings

The Ballyfermot Alcohol Study 2016[16] stated that the alcohol consumption rate in Ballyfermot was 'significantly higher' than the population norm. This study showed that there was low awareness of what constitutes binge drinking, with low levels of people accessing alcohol related services and little public acknowledgement of the problem.

It stated that the dangerous drinking patterns were likely to cause problems in the future and that this had implications that need to be addressed for local service providers in the future, particular with regard to referral systems, multi agency work and funding.

The 2016 report *Supporting women to access treatment. An exploration of women's participation in health and substance misuse services in Ballyfermot* authored by the Ballyfermot Drug and Alcohol Task Force Co-ordinator examined the fact that while women were underrepresented within specialist drug and alcohol treatment services in the area that there had been a significant increase in alcohol use by women. This indicates that problematic alcohol use is a hidden phenomenon for women in the Ballyfermot area, with 27% of the female methadone patients presenting with problematic alcohol use. That report highlighted the strong evidence for the effectiveness of brief intervention within non-specialised settings for this cohort.[17]

11 https://www.hse.ie/eng/services/publications/socialinclusion/ndric/ndrframework.pdf
12 Carew, AM and C. Comiskey (2018) 'Rising incidence of ageing opioid users within the EU wide treatment demand indicator; the Irish opioid epidemic from 1996 to 2014. Drug and Alcohol Dependence 192:329-337.
13 Galvin, Brian (2019) HRB evidence review on dual diagnosis treatment service. Drugnet Ireland , Issue 69, Spring 2019 , pp. 3-5.. Retrieved from: Drugnet69_final.pdf (drugsandalcohol.ie)
14 HSE (2021) Service Plan 2021. Dublin.
15 Maycock, p, Butler S, Hoey, D. (2018) 'Just maintaining the status quo' The experiences of long term participants in Methadone Maintenance Treatment Rathdown Drug Alcohol Task Force. Dublin, Retrieved from: Just maintaining-Report-WEB-2.pdf (drugsandalcohol.ie)
16 Archways (2016) Ballyfermot-Community-Alcohol-Study. Dublin. Retrieved from: Ballyfermot-Community-Alcohol-Study-2.pdf (ballyfermotldatf.ie)
17 Geaney, C 2016. Supporting women to access treatment. An exploration of women's participation in health and substance misuse services in Ballyfermot. Ballyfermot Drug Alcohol Drug Alcohol Task Force. Dublin. Retrieved from: Supporting women to access treatment (2016) drugsandalcohol.ie

5 Impact of Covid-19 survey on older drug and alcohol users in Ballyfermot

The qualitative data collection for this report began in late February 2020 but by the third week in March this work was paused to comply with HSE Covid 19 restrictions to ensure the safety of both participants and researcher. When the work began again in early 2021, surveying how the Covid-19 pandemic had impacted both users and service providers was added to the scope of the research.

An online survey was sent to 16 recipients, a mix of statutory and specific drug and alcohol organisations in direct contact with the 40+ group using drugs and or alcohol. There were 10 replies, a response rate of 63%. Of those who replied six were HSE statutory services (Mental Health and Addiction services) and four were community based services working specifically with substance users. There was a blended approach used by all Task Force agencies, and the HSE Addiction Services continued to provide onsite MMT and healthcare services throughout the pandemic. This blended provision of services meant that all providers were having some contact with service users and some continue to provide carefully delivered face to face contact within current restrictions.

Low threshold and statutory services are the exception as they continue to provide specific services to their service users. It was clear that all services had made great efforts to meet user need and to modify how their services were delivered.

5.1 Impact on service users

When asked what the impact of the Covid pandemic and restrictions has been on the group aged 40+ using drug and or alcohol the responses were largely negative and wide ranging. Intermittent access to statutory services was noted as a challenge, including HSE, Homeless Unit, Detox progression & aftercare services. The impacts noted are in descending order of frequency

- Higher use of drugs and alcohol
- Increase in mental health problems
- Reduced coping skills
- Some reverting to previous addictive behaviours as a coping mechanism
- They have nowhere to go
- They are feeling more lonely and isolated
- Increase in domestic violence is an issue 2
- Relapse for some for some in long term recovery
- Higher stress and anxiety especially for those who prefer face to face meeting and who are now isolated
- Higher unemployment leading to less income for drugs and or alcohol or less money for essential bills (esb, gas, food)
- Food poverty is an issue
- increase in intimidation for drug debts both to themselves and/or a member of their family sometimes small amounts.
- Increase in use of crack cocaine for people who hadn't used before

5.2 Changes in cohort due to pandemic

When asked to share the changes observed for this group, replies covered various themes:

- Stigma has increased, they are more visible, there is increased drinking on the streets, with less footfall
- Some clients managing the restrictions really well while some are struggling
- Some are more likely to admit to alcohol abuse
- Relapse has increase for people in long term recovery, drug/alcohol use has increased for people who were already using harmfully
- Less engagement with our services
- Greater reliance on substances to manage stress and boredom
- Increased motivation in some cases
- Utilisation of self help guidelines with positive indications
- Increased multi substance use by some
- Mental health issues exacerbated as a result of pandemic 'isolation'

5.3 Needs of older drug and alcohol users

When asked what this group's needs were, participants replied:

- Age specific targeted interventions for this age group
- Specific day care service which supports their mental and physical wellbeing
- Social supports/interaction with others
- A welcoming social space to meet up in
- Virtual digital access does not suit everyone in this age group they have no face to face access, this is problematic
- Access to general health services
- They need to feel that they belong
- Reduce the stigma in the community
- Create a feeling of belonging for people

5.4 Proposals to meet need

When asked what their organisation, and other agencies/services can do to meet the unmet needs of older drug and or alcohol users in Ballyfermot affected by Covid 19 restrictions the priority recommendation was to ***improve joint working and collaboration*** with 7 out of the 10 participants suggesting this. They described it in different ways:

- More interagency working
- Improved co-ordination and collaboration of services for this cohort
- A central Ballyfermot based organisation that is more advocacy based
- COVID-19 has demonstrated the need for inter agency collaboration to ensure that all aspects of the person's life can be supported, from emotional and mental health support to accessing practical supports such as food etc
- More co-ordination/ joint working between all the services this group is needed
- More linkage between statutory and non statutory bodies
- Develop better links with local drug and alcohol services

More training and education was the second most suggested item, with 4 out of the 10 respondents proposing this:

- Provide training on the relationship between substance use and mental health
- Community education targeted at the over 40s and the community at large
- Education about the difference between major mental illness and problematic substance use issues.

> THERE IS ALSO A LARGE NUMBER OF PEOPLE ON VERY LONG TERM METHADONE TREATMENT AND PRESCRIBED BENZO WHO HAVE NEVER BEEN OFFERED A DETOX OR AN OPPORTUNITY TO REDUCE THEIR USE OF THESE MEDICATIONS.

- Explore with other services, including the HSE, providing a community detox service for both alcohol and drug users, to include those on prescribed methadone
- Provide digital supports, laptops etc
- Offer effective employment supports
- Provide drop-in services catering for the needs of the over 40 yrs age group
- Use larger spaces to facilitate group sessions when level 5 are lifted

5.5 Other insights from the survey

People offered various relevant observations on the cohort in question:

- Lack of daily structure/community employment schemes/work - this cohort needs to be supported, encouraged and incentivised to participate in employment schemes
- The lack of a co-ordinated effort between services for this age group is probably due to the funding requirements for different services
- Ballyfermot is a well funded area, peer led and centralised organisations need to be streamlined with statutory and non statutory input
- This area is large and more family orientated than others, this can lead to reliance on relations and friends and a sense of frustration. It can be somewhat insular in its approach
- There is also a large number of people on very long term methadone treatment and prescribed benzo who have never been offered a detox or an opportunity to reduce their use of these medications. They continue to carry the stigma and feelings of shame associated with their use even if it's prescribed
- People at that age can be entrenched in their behaviours and attitudes but so also can the services
- follow on training / supports, especially for those who have completed their training time / allowance on CE programmes.
- More concentration on training, self help towards further education, mental health service access, financial advice etc

Addressing the lack of social integration of the group was also identified as a recommendation by 4 out of the 10 respondents:

- Reduce stigma in the community
- Create a feeling of belonging for people
- Create a social space

Specific recommendations for action to meet this group's needs included:

- Target the over 40s age group with regard to a "reduce the use group"[18]

[18] Reduce the use is a successful poly-drug addiction programme, more details can be found here: https://www.saolproject.ie/resources-rtu2.php

6 Data on older drug and alcohol users in Ballyfermot

6.1 Prevalence - research participants perspective

Every stakeholder spoken to for this research was asked their view on the prevalence of drug and alcohol use in the 40+ age group in Ballyfermot. Of note was the absence of hard data from research participants on prevalence, however It was widely agreed that the use of alcohol and other substances is at a problematic level in the community for this age group.

The casual nature of substance use in Ballyfermot was also remarked on. Community based services offered many observations that problematic substance use is widespread and accepted in the Ballyfermot area:

Not unusual to see people walking the streets drinking it's very normalised

There's a huge generational acceptance of high levels of alcohol use including street drinking in the Ballyfermot area, so for people who misuse alcohol there is a high level of acceptance but this can make it difficult for people to go for help as they can be seen as "soft" by peers and family

We are seeing a rise in benzos prescribed drugs street tablets

We are now in a situation of third possibly fourth generation drug users here there isn't a family out there who hasn't been impacted in some shape or form

We were out an about for a half an hour and saw three people smoking weed, was in a pub recently and couldn't believe the numbers of people using drugs in the pub

Yeah there's lots of houses crack houses with about 20 people from 30 up to 55 yrs age range

You can see it here the coke fuelled aggression, fights outside pubs, you can feel it…

It's a big problem….in every second house…. we are now in a situation of third possibly fourth generation drug users here there isn't a family out there who hasn't been impacted in some shape or form

Coke it's getting cheaper and cheaper, lots of people are working to use

It tends to be more alcohol at that age, most referrals I get are linked to drug and or alcohol usually in the household

At my daughter's confirmation they were looking to buy coke, in my garden at a kids party….it's very blasé

Feedback from the statutory services was clear that prevalence was high in the different services:

At least 15% up to 20% of my case load in the foot clinic are misusing substances, I see lots of chronic disease, diabetes, this group has poor self care

About 80% of my case load is currently using substances including prescription drugs, people using singly or in combination

It's a huge group

One voluntary worker noted that he was the only person in his peer group not using any drugs.

6.2 Specific sub groups of drug and alcohol substance users

Useful insights into the different sub cohorts of people who are experiencing problematic substance use in the Ballyfermot area emerged in the research

with specific sub groups identified:

- Single people aged 40 to 60 living in succeeded tenancies group, drinking heavily, functioning
- Isolated, vulnerable men living in local authority senior housing complexes
- Older women at home not accessing services
- Adult siblings in a household who are difficult to access with very entrenched behaviours
- Crack houses with people in the 30+ age group using together
- Functioning substance users who do not identify themselves as having a drug/alcohol problem
- People on Methadone Maintenance Treatment

6.2.1.Single older men - a vulnerable group

There was a clear view expressed regarding single older people living in the five local authority senior housing complexes. Specific issues with this single vulnerable group include the low level of motivation to change their lifestyle and lack of interest in accessing supports and services. People in this group, usually single older men, are viewed as entrenched, vulnerable and isolated. One person noted:

You find with them they are very vulnerable they live alone, they drink heavily, they go to the pub at about 12 o clock and come home and go to bed, they don't eat properly

I see lots of men 50+ using alcohol and prescribed pain medication who don't want to change their ways, they get their cans and go home and drink them

A manager in a community based project noted that this group is one which has experienced deep stigma, often for decades, living very isolated lives. It is felt that a reason for this group's reluctance to assimilate is that they feel that their previous history is widely known in the area. Others working with this cohort also noted the high level of isolation in this cohort as they have little or no contact with their families and do not reach out to access any supports or services to help with their addiction. Statutory workers who engage with this group note the level of vulnerability, especially when their contact with key workers drops off after they settle in.

Some of them… they go back to their routines they start going back to town and the trouble starts. You might just have one person but it's what comes with it.. noise, anti social behaviour, hygiene problems, shouting

They come in with key workers but that falls off and they're on their own

Recommendation

The ongoing failure of the integration of this group into the communities they live in, points to a policy failure. The ongoing lack of engagement with either other residents or services where they live points to the entrenched nature of the marginalisation of this group.

- Dublin City Council and community providers to examine how best to meet this group's specialised health and social care needs

6.2.2 Older women substance users - a hidden group

Problematic substance use was not viewed as a male only problem. People noted that they saw older women, in their mid 50s, coming into services with mental health issues, depression, on prescription drugs:

They don't admit they take tablets and drink every night we know what we know but there's nothing we can do…for the men the drink is the biggy…we have the banter with them but that's as far as we can go

A community worker noted:

They are downbeaten… hopelessness… they don't think it's possible to change

I see a lot of Solpadeine addiction in women, it's respectable to take

Yes the amount of women using is much smaller, mostly prescription stuff….

A worker in a low threshold service observed:

Some are previous intravenous heroin users now using crack cocaine hiding it from adult children living in the household, this group is not mobile, do not access services

We have a lot of over 40 women who come in for crack cocaine pipe exchanges and also others who come on behalf of their friends and peers

The older women too having a joint in the evening when they go home

A community worker commented that this group of older women have no expectations that they can access supports:

They don't ask for support with alcohol and weed…they just get on with it, they function every day not doing much but they're not looking for help

The level of this group's acceptance of their life style was noted by another worker:

They have no desire to change they don't want to upskill and get work

All those women are conditioned to not asking for help accepting chaos

While it was acknowledged that this group had low expectations for themselves they were noted as having aspirations for their children to escape this pattern of addiction.

6.2.3. Cocaine and cannabis users - a group that thinks it 'doesn't have a problem'

There was a sense that the people over forty using cocaine or cannabis did not perceive themselves as problem users as they appeared to be functioning in their day to day lives. It was felt that this group did not see themselves as having an addiction, don't view their substance use as problematic and therefore do not access services. They see themselves as having stable homes, families and are getting on with their lives, despite their ongoing drug use. One community worker noted

There's a real difference...these people wouldn't go into Advance if they're doing coke they think that place is for heroin users…..

Another remarked

Coke users, they see themselves as recreational, they don't think they are problem users and they won't go to the services

The majority are not looking for services it's part of their life style they don't see it as a problem. They don't think they have a problem, they're still functioning they have their house, their routine

Most of the people I deal with are entrenched in addiction. Crack cocaine issue is hidden behind doors…but I see people in their 50s buying coke from people in cars outside pubs

The risks to health status for cocaine and crack cocaine users are higher given their age as substance users are more likely to experience poorer health and psychosocial outcomes as outlined in section 4 above.

Recommendation:

- BLDATF to devise and run a communication campaign aimed at raising awareness of the risks of drug taking as people age. Relevant delivery channels to be used to achieve the highest penetration to this group ie leafletting, social media may not be the primary channel given the age cohort in question

6.2.4. Prescription drug users - a group under the radar

A statutory worker commented on the volume of people prescribed pain medication who had become addicted to it, which when combined with their regular high intake of alcohol causes physical and mental health problems:

I think it's prescription stuff, you see the boxes of valium, solpadeine. They mix them too, taking the meds and drinking too

Solpadeine addiction is very high…it's respectable to take, you get an initial buzz there's caffeine in it

They don't admit they take tablets and drink every night

6.2.5 People on Methadone Maintenance Treatment (MMT)

This group was identified as being very vulnerable and visible. A statutory worker who works with this group expressed their frustration at the situation whereby GPs do not provide community based detox and refer patients to the MMT clinic, where they cannot be taken on unless they have an opiate addiction. This worker noted that there were calls to their service, in the single digits, every week from people who want help with their drug use such as cocaine, and other drugs, but cannot be seen in this service as their addiction is not an optiate one.

Stigma and marginalisation was the biggest issue for the older service users on MMT, see section 7.3 below. Their stories of poor treatment and ongoing GP access problems indicate that they do not feel that their needs are being met in a respectful dignified way.

Recommendations for people on MMT

- Community service providers to strengthen and refresh their working relationships with HSE clinic staff.
- Work with HSE clinic staff to agree and establish a robust referral protocol for people who contact the clinic looking for help with their polydrug use to ensure that they are referred to the appropriate community based and or statutory services.
- Ensure that the clinic has up to date accurate promotional material, leaflets, flyers and posters advertising what services exist and how they can help polydrug users for clinic staff to share with their clients.

6.3 Local data on older drug and alcohol users from national databases

A deep dive into the data collection and recording techniques used by service providers was not within the scope of this report. This report did not seek to measure how various providers collect and report data. However, data collection and analysis surfaced as an area where different approaches at individual service level is evident. Trends in drug use are normally reported accurately by outreach workers and service users before national or local statistics are published and this is the case in Ballyfermot. Data on service users presenting to more than one service multiple times during the same calendar year is an important part of the local picture, yet GDPR can inhibit information sharing in this regard.

The attitude towards data management (collection and analysis) varied from provider to provider. Statutory service providers noted the problem of accuracy in the data collected and analysed, while community based providers expressed concerns regarding the possibility for duplication, therefore leading to inaccuracies.

The two databases used in this secondary research are the HRB National Drug Treatment Reporting System (NDTRS) and the Health Service Executive Central Treatment List (CTL) which records Opioid Substitute Treatment (OST). It is hoped that the analysis and recommendations provided below will be useful in future strategic planning level for both the Task Force itself and the individual service providers.

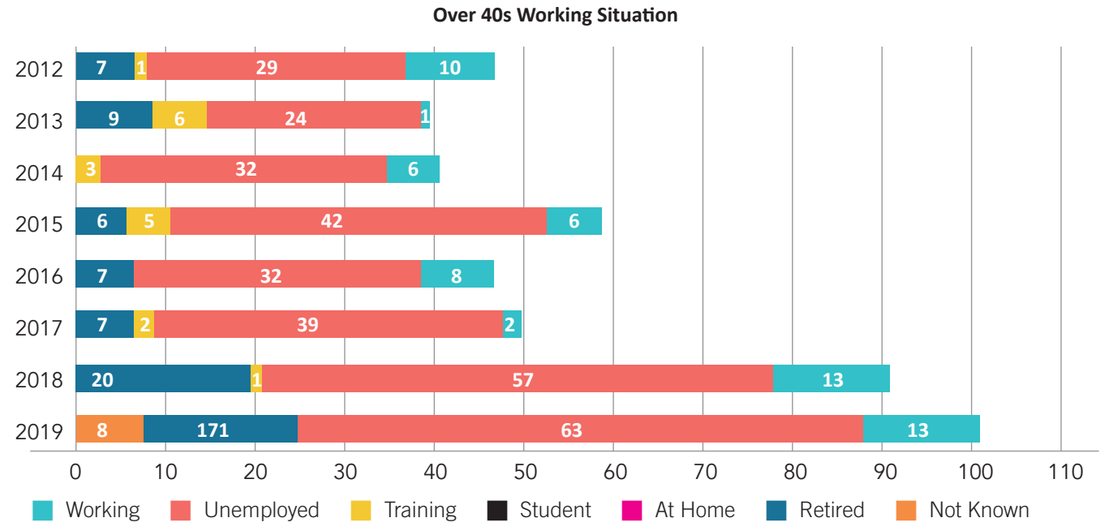
However, it is important to note that analysis of data from both these databases will not provide a completely accurate picture as not all service providers use the NDTRS in particular, so information from these two sources does not provide the full picture of activity, need and interventions.

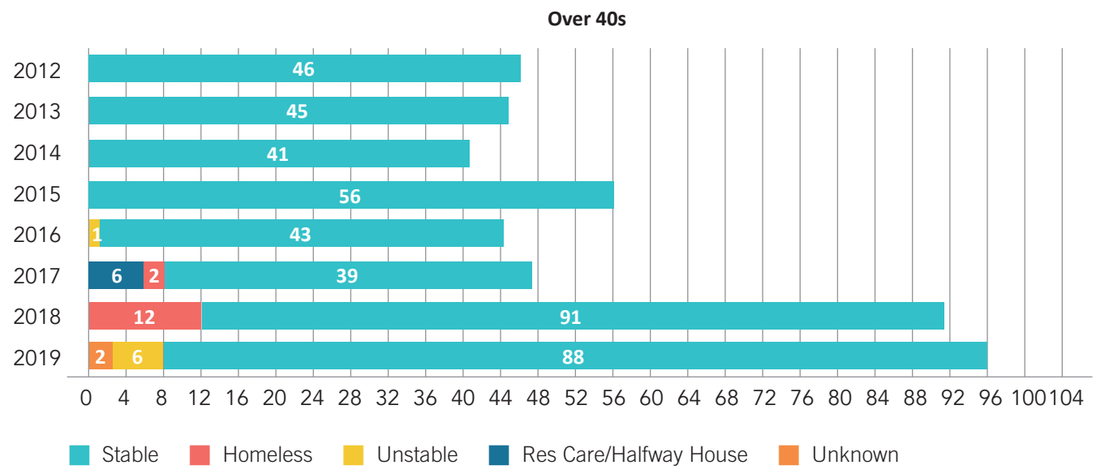
Therefore the statistics and figures below do not accurately reflect the level of engagement with services, rather the level of engagement with the reporting system itself. It is also the case that clients can be counted more than once in their interaction with different services.

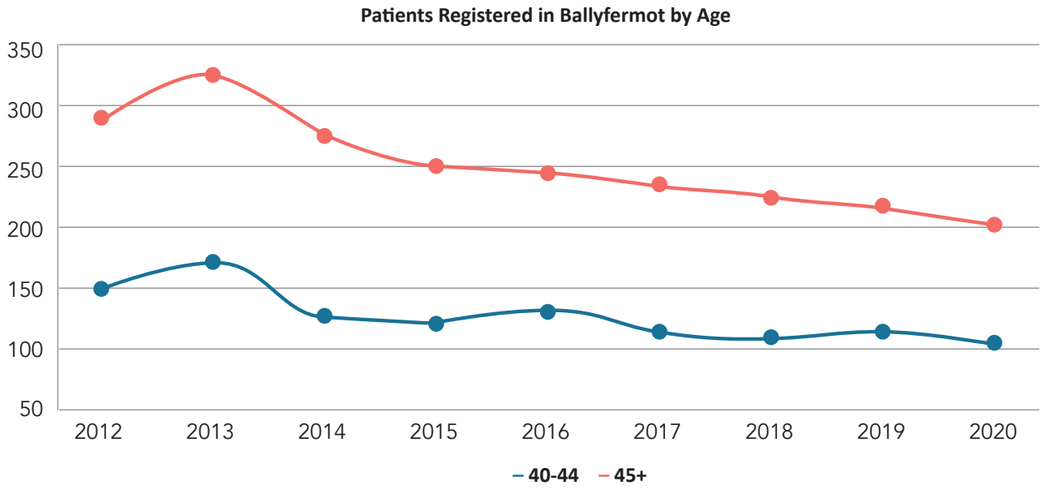
The NDTRS unit in the Health Research Board provided data for treated cases of problematic substance use for people living in the Ballyfermot area, excluding prisons, for the period 2012 to 2019. The following sections offer a short analysis of what that data shows, in full awareness that this is a partial view.

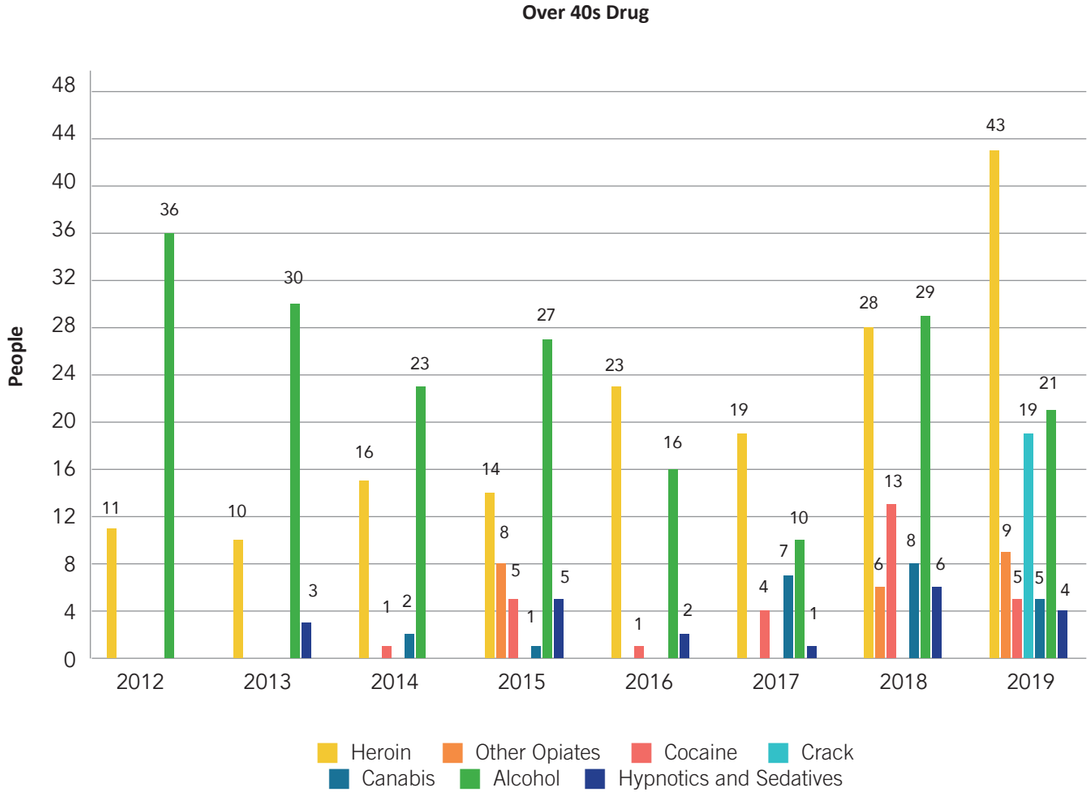
6.3.1.Employment status

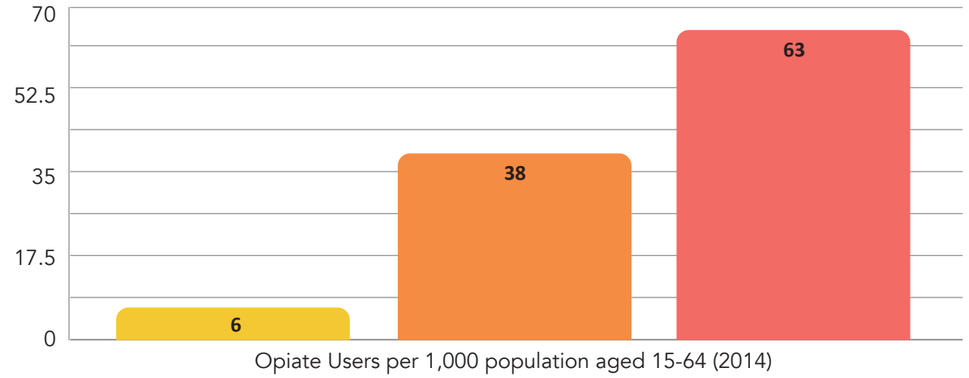
The below graph illustrates the known fact that Ballyfermot has a high level of unemployment, with those out of work making up the largest cohort, rising to 57 in 2018 and 63 in 2019.











Opiate Users per 1,000 population aged 15-64 (2014)

6.3.2 Living situation

Stable housing tenure is a striking feature with the majority of NDTRS clients living in local authority housing. There are very low numbers presenting as either homeless or unstable however these figures are likely to underrepresent the numbers couch surfing or living in overcrowded households.

6.3.3 Primary drug being treated

In 2012 alcohol was the primary drug people were being treated for, while the numbers in treatment for heroin treatment rose sharply from 11 in 2012 to a high of 43 in 2019. This steady rise in the numbers being treated for heroin could be accounted for by the wider access to community based service providers during this period.

Main treated drug for 40+ cohort

6.3.4 Numbers in Methadone Maintenance Treatment

Data from the Central Methadone Treatment list was analysed for the same time period, 2012 to 2020. The age profile of individuals recorded in the CTL data indicates clearly shows a gradual reduction in the number in the 40+ group who are prescribed methadone. In 2012 the total number receiving methadone treatment in the 40+ age group was 436, in 2020 this number had dropped to 304.

In 2019 there were 304 people on MMT making up 1.5% of the total population of Ballyfermot, 22,091. A report from the Ballymun Local Drugs and Alcohol Task Force published in late March 2021 puts Ballyfermot in the second highest position for the numbers of people on methadone maintenance treatment per 1,000 of the population.[19]

Source Ballymun a brighter future. Ballymun Drug Alcohol Task Force

While it is undeniable that Methadone Maintenance Treatment provides positive outcomes to individuals and society, the deep and enduring deep stigma felt by people in treatment came through very clearly in the interaction with this group. The deep sense of shame, discrimination and marginalisation felt by those on the programme in Ballyfermot was clearly evident, this theme is covered in more detail in sections 7.2 and 7.3.

6.4 Data recommendations

- BLDATF should consider exploring the variance in approach to data collection and management within the various community providers. This could include providing training on data management skills (processing and analysis) with a view to enhancing resource planning for the Task Force.
- BLDATF should consider examining how data is collected and used by service providers to improve its potential to provide accurate, quantitative and qualitative information on how services can be best aligned and configured to achieve optimal service user outcomes and effective use of funding and resources.
- BLDATF should consider conducting a thorough overview analysis from both national datasets (NDTRS and CTL) to inform future strategic planning.
- BLDATF to explore getting access to relevant HSE data at local level to strengthen joint working outcomes.

[19] Montague, A (2021) Ballymun a brighter future. Ballymun Drug Alcohol Task Force Dublin. Retrieved from: Ballymun – A Brighter Future by Andrew Montague (drugsandalcohol.ie)

7 Barriers to access for older drug and alcohol users - research findings

The qualitative data generated in this research offered a rich source of insights, observations and information on the various barriers impacting on older drug and alcohol users in the Ballyfermot area. The material offered by everyone spoken to for this research was analysed and clear themes emerged. Recommendations are offered where appropriate. The majority of these recommendations came directly from those spoken to. In some cases the recommendations were developed to fit into relevant policy and practice contexts.

A range of barriers were identified which blocked older people experiencing problematic substance use from accessing services. These ranged from entrenched behaviours resulting from lifelong experience of serious disadvantage to a variety of structural issues which made it more difficult for this group to access services easily and receive effective care in the setting best suited to their needs.

7.1 Distrust of statutory services

At the level of individual service users the long standing distrust and poor relationships with health land social care professionals was identified as a reason why people of this age group with a history of addiction can be reluctant to engage.

People in both statutory and community organisations identified that there was a perception and misunderstanding on the level and extent of power that statutory health services have over individuals. A comment by an experienced mental health professional expressed this fear:

> *People are fearful of engaging with services, they think they'll be taken away in a straightjacket*

This reluctance to engage resulted often in poor or inconsistent attendance at appointments which resulted in less than optimal results for the client. The issue of confidentiality was another area of concern which was noted as a barrier to people engaging:

> *Where does the info go?*

7.2 Physical location of the Methadone Treatment Clinic

The highly visible location of the methadone treatment clinic surfaced as a barrier to accessing services for both service users and providers. The clinic's setting, on the ground floor just to the left of the HSE Primary Care Centre reception and foyer means that all, or most, of the visitors to the building pass close by its entrance. One health and social care professional queried this location noting that there had been resistance from other HSE units to placing it elsewhere in the building which resulted in this very visible position.

Service users spoken to for this research were unanimous in their unhappiness at the clinic's location. One respondent reflected:

> *You might as well be getting your methadone outside your gaff as getting it in the clinic, there's no privacy…you walk in there everyone sees you*

Another remarked:

> *It's right in the front…everyone sees you*

> *It's like a walk of shame you get wanded to check you've no metal on you, I'm lucky I only go in once a week*

The impact of being seen using the clinic incurred negative results for some service users. One person described how he had to leave an activity that had brought him positivity and purpose. He had been helping out training a local boys' football team, but felt that he had no choice but to leave this activity as parents had seen him going into the clinic and had asked the coach about this. He said:

> *It's not fair a child coming to get trained and he's asking me why he sees me up in the clinic… so I said we'll just call it quits, it wasn't fair on him (coach) having to lie for me…I really miss it*

A firm opinion was expressed that this group had as much need for respect, dignity and privacy as other service users which was not felt possible with the current queuing system.

A service user commented:

> *My GP is up there in the centre (Primary Care centre) but the only thing I feel when I go through them doors, are people thinking I'm going to the clinic, there should be privacy, there should be another entrance, my doctor is near the clinic so I'm going in that direction…. for them going to the clinic they should have a separate entrance*

> *They plonked it right at the front door, it's ridiculous…they need privacy this is fixable! I'm not putting them down…but it's not working*

7.2.3 Methadone treatment clinic centre recommendations

- Use individual appointments spaced 10 minutes apart which would reduce the numbers of service users congregating at the same time. This would lead to a decrease in tension and the potential for disruptive behaviours.
- Consider moving the clinic to a less visible location.
- Community providers to support for those who use the MMT service to express their negative views about the location of the clinic, in particular to facilitate them to use the HSE Your Service Your Say system to lodge their complaints
- Increase detox availability for long term MMT clients

7.3 Stigma

Stigma was a theme which surfaced strongly within a specific cohort of drug users, namely those on methadone maintenance treatment. The views echoed the findings of the previously cited report by the Dun Laoghaire & Rathdown Drug and Alcohol Task Force "*Just Maintaining the Status Quo"? The experiences of Long-Term participants in methadone maintenance treatment.*[20] That report describes the deep stigma associated with methadone use and how it impacts on people's lives, perpetuating shame and isolation.

Older service users on methadone reduction programmes who contributed to this research were unanimous in their opinion that they were viewed negatively by others in the community:

> *If you're on the methadone in Ballyfermot you are lower class*

> *It's just like we're labelled sure they're only dirt …you can't have a proper life*

> *I'm on methadone nearly 30 years I've been in hospital a few times too…the minute you mention methadone it's a stigma that's never going to go away*

> *I used to love going to work on the building sites but I had to keep going to the clinic…me boss found out I was on the methadone I was labelled*

Low threshold service providers in the community observed the hierarchy of stigma evident in Ballyfermot regarding the use of different drugs:

> *There's a tradition here about heroin…you're a junkie if you use heroin but you're not if you take coke*

> *There is a real stigma around here about heroin and methadone users, people think you are a scumbag if you take or used to take heroin, you can see it here*

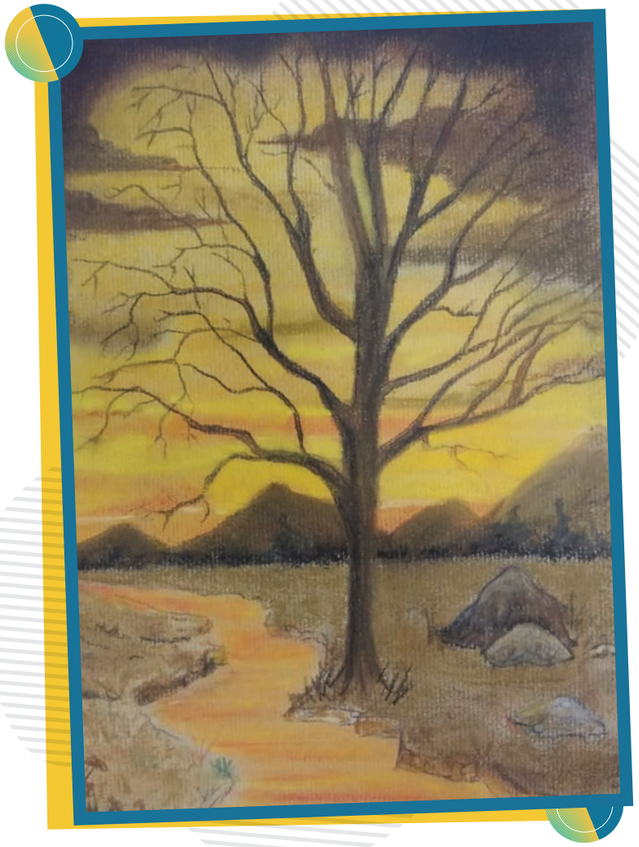
> *I see a huge stigma between crack and cocaine …cocaine is for older 40s and 50s they're the type of people who would not knock on our door*

> *Yeah they don't want to connect with services (cocaine users) ….in my experience*

A statutory worker also noted:

> *There's a hierarchy of stigma with heroin and methadone clients at the bottom*

[20] Maycock, p, Butler S, Hoey, D. (2018) 'Just maintaining the status quo' The experiences of long term participants in Methadone Maintenance Treatment Rathdown Drug Alcohol Task Force. Dublin, Retrieved from: Just maintaining-Report-WEB-2.pdf (drugsandalcohol.ie)



Another HSE staff member explained that it was sometimes difficult for her clients (recovering in rehab) to register for a medical card with local GPs. In one recent case direct liaison with the Primary Care Reimbursement Service was required after three GP refusals.

Service users recounted different stories of the poor treatment they had received at the hands of GPs and pharmacists with regard to their methadone prescribing, others shared positive stories of empathetic and kind health and social care professionals.

7.4 Bias – practitioners' perspective

The issue of how older people with drug and alcohol problems were viewed by statutory workers surfaced as a problematic issue for this cohort. One statutory worker stated that research had shown that people with addiction issues or mental health issues generally received poorer quality public health services than service users who present with physical symptoms:

> *The health services they don't they listen to them (older drug and alcohol users) they don't take them seriously*

Unconscious bias was identified as an important factor which impacts how health and social care professionals interact with their clients as it affects a person's ability to be non-judgemental. Another statutory worker commented that staff's attitude towards service users is rooted in their own value system. An example was given to illustrate this:

> *A colleague brought her concern to me of a client's problem drinking, (the client in question had consumed two pints of beer), due to that colleague's religious belief, this was not appropriate alcohol use*

It was also suggested that health and social care professionals' personal substance use (if they use substances) could affect their approach to the service users they work with and can result in inconsistency and variation in the quality of care this cohort receives:

> *Also you have people who might smoke pot themselves and they are relatively permissive with regard to their clients' use*

> *someone actually stopped me and queried if it was true that I was saying that people could be psychotic without being on drugs and I said ….yeah….actually*

It was stated that systematic denial of services to this cohort stemming from the unconscious bias of health and social care professionals has been witnessed. There was a view expressed by some statutory providers that older drug and alcohol users are viewed as passive and not very motivated. This lack of agency was noted by others who provide statutory services, with a sense of frustration expressed:

> *There is only so far we can go…we can't force ourselves on them*

7.5 Poor understanding of mental health

The lack of basic understanding of the language and facts regarding mental health, mental well-being and mental ill health was identified as a barrier to effective advocacy on behalf of clients. An analogy was given that in general people with a broken finger are not compared with those who have cancer, likewise people who have mental well-being are not the same as those who have a have a mental illness or poor mental health.

A lack of compassion was noted as an issue which had surfaced, uncommonly, where a reluctance had been observed within different services sharing common waiting areas:

> *When we moved into this building people said they didn't want to share a waiting room with our patients*

The varying levels of factual information on addiction and mental health was also identified as a contributor to bias. A health and social care professional commented:

> *People don't have mania by choice….you have more chance of being physically assaulted in dementia care services*

> *People don't want to hear facts that don't fit with their world view*

7.6 Differences in training and approach

The difference in approaches to working with clients and the varying levels of knowledge and training in both community and statutory providers was also identified as a potential barrier to effective working with clients. The differences in approach and training was noted by both statutory and community based staff. The range of approaches, ethos and working practices was identified as wide with the potential for confusion a possibility:

> *It's a whole medley of different groups, different approaches, different services with different rules, offering different things, different philosophies, it's not homogenous*

The diversity in community based services was commented on as an asset:

> *The richness of community development worker experience, lots HSE workers are middle class white females we are a very homogenous group, very few men.. but actually addiction workers are a much more diverse group…this is positive!!*

7.7 Lack of information on available services

A constant theme from both community based and statutory providers was the lack of accurate information and knowledge on what services were available to older drug and alcohol users.

> *No I can't say I know who does what in the community services*

> *HSE doesn't have enough support for these clients so it makes sense for us to refer them to these but we don't really know what services they have*

The lack of understanding of the various roles and structures in the statutory health services was mentioned where some statutory staff felt that the level of knowledge in community providers varied. It was noted that not all community workers realised that GPs are independent practitioners and not HSE employees. This misapprehension was thought to

[21] https://www.ihrec.ie/our-work/public-sector-equality-and-human-rights-duty-faq/

result in frustration at times and could be avoided:

> *Please don't blame me if there is a problem with a GP*

A variety of recommendations to counteract the above barriers were proposed:

7.8 Stigma, bias, understanding, training and information recommendations

- ✓ *Training for all stakeholders (both statutory and community) on the various professions, their roles, referral protocols alongside information on addiction and mental health was suggested as a way to counteract myths and improve inter and intra agency working*
- ✓ *Training on biases, prejudice and discrimination, to include training on Section 42 of the Irish Human Rights and Equality Commission Act 2014 which places a duty on the HSE to eliminate discrimination, promote equality and protect the human rights of staff and services users*[21]
- ✓ *Training to clarify knowledge on problematic substance use and mental health facts so that both health care professionals and community service providers can deliver accurate information in a non-judgemental way*
- ✓ *Improve and standardise the levels of knowledge and understanding that exist between the HSE Addiction Services and Community Mental Health Services*
- ✓ *Training for community based projects and services on the HSE's structures, services and strategies to include allied agencies and stakeholders such as GPs*
- ✓ *Training for relevant HSE services who work with older drug and alcohol users on the projects and services operating in the community to include ethos, criteria, referral systems and opening hours*
- ✓ *Training on myth busting for both statutory and community based projects and services*
- ✓ *Training on the range of roles within HSE Addiction services*

7.9 Lack of joint working

There was agreement across both statutory and community based providers that there was a lack of joined up working in Ballyfermot drug and alcohol services. Voices from both statutory and community services offered the view that there were too many different voices working in the sector and that this caused confusion and inefficiencies. One manager stated emphatically:

> *There's no joined up working in Ballyfermot*

> *There's too many people involved not enough consistency*

Insights from community providers included:

> *We don't work efficiently together…the reasons are we're too busy after the economic downturn*

> *There's lots of competition for funding so we looked after our own situation, that's the reality of it*

Numbers became a big deal…..I have to hold onto my clients even though they might be better off in another service….staff linked to client numbers this is a numbers game

> *There's no clear working arrangements the shared care plans…that didn't take off*

No shared protocols lots of paper work generated on shared care plans they didn't fill it in

> *There's too many cooks*

> *It's not streamlined enough*

Some services explained that there were too busy to dedicate time to joint working. Staff described themselves as being too busy to spend time away from their work briefing other services and sharing information. Other services spoke positively of the bimonthly Treatment and Rehabilitation meetings which they found very useful, which is an example of joint working in practice. Statutory staff stated that they were not very clear on what services were being provided by community providers in the area.

7.9.1 Key working

This area was viewed as one where improvements would improve outcomes for clients. One statutory worker noted:

> *We need a lead person to manage the various interactions by agencies… they have to go here, there, everywhere, there are too many asks too many agencies…they're not speaking to each other*

A statutory worker commented that it was frustrating not to know the identity of a client's key worker based in a community provider. He suggested that it would be useful to have this information so that in the case of hospitalisation they could be notified:

> *In terms of trying to create a singular interface and joint care planning and joint work it doesn't work. If we could have their key worker available to be able to be with them in that space (hospital) that would be very welcome… we need a singular message I need to know their key worker*

Community providers also saw the benefit in allocating one key worker to clients to foster consistency with statutory services. This key worker could touch base with different projects:

> *If we refer to them (another service) and they have a key worker there..well if they have one there they don't have one here..it makes sense avoids duplication and potential for problems*

7.9.2 Duplication

Other statutory workers commented that the range and volume of services working with clients can lead to ineffective working with some clients accessing different projects, (which work with clients at different phases in their addiction journey) at the same time. This led to duplication of resources and clients cycling through projects without a clear progression pathway. One community based manager reflected that the current duplication and lack of information sharing made it difficult for vulnerable clients to navigate the services and structures in place. He questioned how someone struggling with addiction could have a clear sense of what pathway their journey would take given that people seemed to cycling between back and forth between services.

7.9.3 Need for timely follow up and progression

One service spoke of their frustration when some of their clients tell them that they engage with the

[22] Ballyfermot Local Drug and Alcohol Task Force CLG Annual Report 2017-2018 (drugsandalcohol.ie)

SOME COMMUNITY PROVIDERS EXPRESSED THE VIEW THAT IT WOULD BE BENEFICIAL FOR SERVICE USERS TO KNOW WHICH ORGANISATION WILL MEET THEIR NEEDS AT WHAT STAGE OF THEIR PROGRESSION EITHER TO RECOVERY OR STABILITY.

other community based services at the same time. This duplication of effort could be avoided if a clear protocol was set up which all services could use to avoid duplication and improve information sharing (GDPR allowing and with full client permission). The lack of a continuum of care also caused frustrations for providers who want their clients to move on:

If a person is at a contemplation stage we ring them back but sometimes there is no follow up for these clients we lose the opportunity for them to progress in their journey

So I ring them and they say there is no move on programme right now there might be one in six weeks… there is no integrated planned working we want a seamless move on we don't want to be doing the back office stuff we're wasting time…..

An example was offered (pre Covid 19 restrictions) of a young man who overdosed in the community who needed naxolone. This person needed to be referred onto other services to support him, but the service he presented at closes at 1 pm:

But there was nothing local to plug him into so he's lost now, he could overdose tonight. We had to close our door at 1pm but there was nothing local to plug him into so he's lost now we don't know where he is

This service is adamant that improving joint working would provide a higher quality more seamless level of care for clients who could choose from a clearly set out set of pathways. There was also frustration expressed at the amount of administrative work needed to move clients into an integrated continuum of care:

We want to be out there doing the work not doing the admin integration work to try to move them on seamlessly

Some community providers expressed the view that it would be beneficial for service users to know which organisation will meet their needs at what stage of their progression either to recovery or stability. The lack of a clear commonly agreed roadmap was regretted. It was felt that this map would give a clear sense of direction for both client and providers which showed the progression pathway that clients can access.

7.9.4 Need for a cohesive referral system

This topic generated much interest in those spoken to for the research. One area which caused some confusion between statutory and community services was the issue of inappropriate referrals to GPs from key workers. It was suggested that explaining that GPs are not HSE staff and have an autonomous status as independent practitioners would improve the potential for joint work between statutory and community workers and decrease the frustration and confusion on this point.

The 2017 - 2018 Annual Report of the BLDATF deals with the issue of joint working arrangements, including shared care planning tools, common assessment form.[22] These were reviewed by the BLADTF Treatment and Rehabilitation Group in 2019 in a process facilitated by the BLDATF Officer and included a Continuum of Care Document and Service Provision Table.

In spite of the above work by the BLADTF to support joint working the common assessment forms for use between community providers was mentioned by just three community providers spoken to for this research. The sense communicated was that these forms were not always used. It was also noted that there no joint protocols for referrals or common referral forms for use between primary care and community services. One community based worker stated:

The referral thing is a weakness I wouldn't have a clue who to go to if I walked into the Primary Care centre

Differences in understanding of what constitutes shared care-planning surfaced in the discussions with community service providers. The national drug strategy states that the lead role is taken by whichever agency has the most face time with the client, which is usually the keyworker in the addiction service. It would be useful to discuss this point and to discover whether people think of interagency work as being between local addiction services or if includes other relevant non addiction services such as Túsla, local authority housing services, GPs and statutory health and social care services. Without an explicitly agreed common approach the confusion and ineffective work practices identified in this report will continue and client outcomes will not be optimised.

The lack of a Memorandum of Understanding between the statutory services such as the clinic providing methadone prescribing and community services was noted:

We worked with people hiding their drug use from the clinic but there is no MOU no joined up working with these services we want to change this, we want a pathway to move people on

7.9.5 Joint working recommendations

Statutory and community based providers should work to improve inter agency working practice and consider the following:

- ✓ *Hold a refresher session for all relevant services, in particular the T & R Group, on the documents and processes regarding joint working and the currently available documents*
- ✓ *Adopt an outcomes oriented approach for clients which supports clients to reach their potential which does not necessarily mean abstinence is the goal*
- ✓ *BLDATF to facilitate a discussion with local addiction service providers to surface views on shared care-planning, joint working and use of locally agreed common assessment tools with the aim of agreeing a common understanding, approach and work practices. The key worker forum may be a useful channel for this work although buy in from all stakeholders in local addiction services will be critical to the success of this initiative.*
- ✓ *BLDATF to facilitate a discussion with local statutory services- HSE mental health, addiction, primary care and older persons services - also Túsla, DCC and other relevant agencies to communicate its agreed shared understanding, approach and protocols. The aim of this process would be to ensure that all statutory services understand and collaborate with the common approach and protocols, as appropriate.*
- ✓ *BLDATF to facilitate a joint process whereby community and statutory providers discuss and agree a common approach to how services work with the older drug and alcohol users cohort can have a common approach to working with this cohort, in particular in relation to the outcomes for this group*
- ✓ *Agree a shared clear roadmap for clients to understand and know how to access it and to understand where they are on the continuum. This roadmap needs to be simplified and streamlined with a clearer progression pathway*
- ✓ *Initiate interagency working arrangements where different projects staff work alongside clients based in other services to build relationships, facilitate easier transition and reduce uncertainty or unease as they clients progress onwards.*
- ✓ *Hold joint regular meetings to share information*
- ✓ *Strengthen the information sharing protocols and structures which support this practice*
- ✓ *Establish clear interagency protocols regarding case management, progression, information sharing and assessment, using the wide range of comprehensive assessment forms available for interagency work*
- ✓ *Conduct a mapping of all services and create a clear roadmap for clients*
- ✓ *BLDATF to establish or strengthen primary care service provision based in community based services such as nurse led health promotion, wound dressings, preventative work such as cancer prevention in high risk groups, using the community based locations for opportunistic screenings*
- ✓ *Establish a common referral system between statutory and community based services so that client outcomes can be agreed, captured and measured*
- ✓ *Consider establishing a Memo of Understandings between community based drug and alcohol service providers*

8 What do service users want ?

Both service users and providers were asked what was missing in the current mix of available services for the 40+ drug and alcohol users. Their responses were all gathered pre Covid-19 in February/March 2020.

8.1 Multi purpose day centre

The priority unmet need identified as lacking for the 40+ cohort substance users was the lack of a specific day centre. Both service users and providers identified this as an amenity which would be beneficial to the cohort in question.

This space was described differently by the various people spoken to, but its functionality was clear - people wanted a place where this group could go to interact socially, access services and be signposted to other interventions. There was a strong emphasis on this space as an enabler of social connectivity, where people could engage in different activities and relax in and also be signposted to other relevant services. This space was seen as an important hub in which people could access health and social care services in, including preventative health care and screening services.

I'd like a place I could do something constructive with my hands anything it'd be great to be doing stuff that helps other people…I'm doing the planting with X I love it I'd love wood work stuff or metal work

It'd be nice to have a place to drop into during the day, pool table stuff like that a bit of art an art class

You don't want to be too dramatic but there's nothing for middle aged men here in Ballyfermot, like a café or something, or of an evening

I'd like to sit down and talk to people and see where they're at a game of cards, just chatting

There's no central place where it all happens

We should have a multi purpose centre but service providers may be resistant and reluctant to do this….they like their autonomy, getting their own funding don't know if they'd want to they'd have to pitch or come together to provide services

All of the service providers in the one place one day care centre for older people so they can access the services they need

In Ballyfermot there is no day care for the older users it is one of the black spots

There should be state of the art older persons where they become visible, the hidden groups might start to use it and also a robust referral system that everyone uses, communal assessment too

When asked to describe what sort of atmosphere this place should have the following factors were mentioned:

Making you feel comfortable keeping in touch

Meeting with others in the same situation gives you confidence keeps you going over the weekends knowing that there are others you can reach out to and talk to when you're feeling low

Not looking down their noses at you very important

How welcome you are made feel, how understanding they are

It's a very real feeling of being respected

People talking to you and listening to you that's very good

8.2 Daily structure

Many services users referred to how empty their days were, that they suffered from a lack of motivation as there was not much to get involved in:

Something to do during the day to get you up in the morning a structure to the day knowing what's ahead that there are things to do

At night it's hard there's nothing to do , it's boring I do watch real long films at night the longer the better to keep meself occupied

I'd like anything that keeps me busy, I love being busy keep you off the drugs

I'm doing X programme, I'd be lost without it, it's for 20 weeks only for a half a day but you've got the other half of the day all to yourself…..

I'd love to go on trips out for the day y'know like in a bus with other people it'd be gas

8.3 Stabilising space

Some methadone users wanted a space where they could try and get stable and reduce the double dosing, where they were taking both their methadone dose and additional drugs:

A place where you can take your methadone and get off the heroin there and just get on the methadone

I need a space to go into and take my 50 ml from the GP and the extra I'm taking and go in and reduce and stabilise meself

A place, not a detox, where you could take your 40 mls and that's enough

Not a real detox but a building to stabilise you.. to get you back on the level a stabiliser place to give you a break

We need a space where you can have an open conversation about what people are using

These service users knew that if they disclosed to their GP or to the methadone clinic that they were using other drugs that they would be put on a daily methadone dose and they did not want that. The lack of community detox and residential stabilisation services were also noted. It was felt that these added to the barriers for people who wanted to detox, while at the same time acknowledging that it would not be feasible to detox someone who is also other drugs as well as their methadone prescription. The long waiting list for residential detox was another barrier for this group.

8.4 Holistic treatment for both addiction and mental health issues

Some service users expressed a wish for a service where both addiction and mental health needs were met and treated at the same time:

Say you think you've had a breakdown and you're on methadone and you present yourself up there or your doctor refers you they ask you what medication you're on and you say methadone they won't treat you they can't do anything…

They're not able to treat you….you need to be able to be treated in one place and not be falling between the gaps….the place where mental health and addiction are together

It's all separate, you go up there and into the mental health team and you're on methadone and you can't go in there

8.5 Peer mentors

The need for peer mentors involved with the services they engage in was noted:

They understand, it gives you confidence that they know what it's like

I'd love to talk to the younger fellas coming up and tell them my story so they wouldn't get started on the weed and the crack

COMMUNITY SERVICE PROVIDERS IDENTIFIED THE NEED FOR A BUS TO PROVIDE LIFTS BACK TO THE CITY CENTRE FOR THOSE WHO ARE UNABLE TO MANAGE THEMSELVES (LOST BUS PASS, HAVE SOILED THEMSELVES, ARE INEBRIATED).

8.6 After hours services

A need to expand services opening hours (pre Covid-19) was identified. It was noted that some services operate 9 to 5 pm which leaves a gap for those who would engage with services if there were open later in the evenings (for crack pipe exchanges for example).

8.7 Bus

Community service providers identified the need for a bus to provide lifts back to the city centre for those who are unable to manage themselves (lost bus pass, have soiled themselves, are inebriated). This service was identified as important for the vulnerable group who have hostel accommodation in the centre but who are from the area and spend time in Ballyfermot.

It was suggested that this bus could be shared between organisations on a shared calendar. The preferred approach would be for this group to be housed in their own area.

8.8 Other deficits identified by service providers

Service providers identified other missing services:

- Lack of walk-in wound care clinic. There was a clinic in Cherry Orchard but this was by appointment only (pre Covid-19 restrictions). The appointment system was not seen as user friendly for users
- Lack of house visits for people who have mobility issues whose only way of connecting with services is via text
- Lack of family support model to work with adult siblings and parents in entrenched addiction living in the same household

8.9 Summary of recommendations service users want

The below is a summary of recommendations from both service users and providers:

1. Provide a multi purpose day centre
2. Provide a stabilising space for detox from double dosing
3. Improved access to HSE addiction and mental health services at the same time
4. Peer mentors in community based service providers
5. Improved access to after hour services
6. Bus shared by community providers

9 Conclusion

This report consulted community and statutory addiction service providers and substance users in the 40+ cohort in Ballyfermot. A short literature review indicated the need for specific interventions which meet this group's health and social care needs. Specific sub groups of substance users surfaced in the research. Stigma and isolation were considered by both service users and providers to be chronic challenges to be overcome. Data was analysed and differences in how service providers capture and use data were evident at local level. Barriers were identified with weak joint working practices and insufficient information on services and referral practices signalled as challenges, amongst other themes. The report ends with recommendations from both service users and providers which have the potential to improve outcomes for this cohort.

The following issues emerged as needing attention:

- Strengthen joint working protocols and collaboration to improve outcomes for the cohort
- Provide training on bias, awareness raising/ education/ information on what service provision to ensure that both statutory and community based providers understood each other's services, approach, ethos, referral and services

While there was strong consensus on the need for a safe, social, stigma free space for this cohort it was unclear whether or not this social space should be for substance users specifically or for the wider cohort of people 40+ living in Ballyfermot. This issue needs further reflection as there are positives and negatives in both approaches. There is the potential for further stigmatisation and marginalisation of this vulnerable cohort if a specific substance user only centre is considered and promoted solely as a space for substance users. This could lead to deeper and isolation, while a more generic space could be problematic if it was not introduced in an inclusive way as a benefit and asset for the entire community.

9.1 Summary of recommendations for older people using drugs and alcohol in Ballyfermot

The below recommendations include the next steps and key actions for BLDATF are set out under the specific headings set out in the tender document for this research.

9.1.2 Recommendations for drug and alcohol specific services in how to support older drug users

1. BLADTF to consider how to progress the data recommendations in section 6.4
2. BLADTF to decide how to implement the methadone clinic recommendations in section 7.2.3
3. BLADTF to consider how to progress the recommendations for people on methadone maintenance treatment in section 6.2.5
4. BLADTF to consider how to progress the recommendations on joint working in section 7.9.5
5. BLDATF to consider how to implement the proposals to meet need from the Covid-19 service provider survey in section 5.4
6. BLDATF to lead on a reflection process on how service providers can redouble their efforts and work collaboratively to reduce stigma and isolation for this cohort

9.1.3 Recommendations for the wider support services for older people in how to identify and provide suitable support with regard to drug and alcohol use amongst the target population

6. Dublin City Council and community providers to examine how they can contribute to meeting this cohort's specific health and psychosocial care needs
7. BLDATF to consider engaging with other agencies in the Ballyfermot area with a view to examining the broader issue of relevant service provision for older residents
8. BLDATF to conduct further discussion and reflection with relevant stakeholders to examine the merits, risks and sensitivities of either a generic or specialised day centre service for this cohort. The decision making with regard to this issue needs to be teased out robustly. A measured, informed and balanced approach will be critical to the success of this venture
9. BLDATF to ascertain if the relevant commitments in the HSE 2021 Service Plan Social Inclusion section are planned to be implemented in Ballyfermot and if so how it can engage and collaborate with these
10. BLADTF to consider how to progress the specific recommendations from service providers and service users in section 8

9.1.4 Recommendations on how to outreach to older people in the community who might be experiencing problematic drug and alcohol use but are not accessing appropriate services

4. BLDATF to strengthen outreach to this cohort to improve their awareness of and engagement with the various addiction services available
5. BLADTF to consider how to progress the recommendations on stigma, bias understanding, training and information in section 7.8
6. BLDATF to devise and run a communication campaign aimed at raising awareness of the risks of drug taking as people age. Relevant delivery channels to be used to achieve the highest penetration to this group ie leafletting, social media may not be the primary channel given the age cohort in question

APPENDIX 1

List of stakeholders consulted

Advance	HSE Community Mental Health
Ballyfermot Chapelizod Partnership	HSE Older Peoples Services
Ballyfermot Family Resource Centre	HSE Primary Care
Ballyfermot Social Intervention Initiative	JobPlan
Dublin City Council Housing Services	Matt Talbot
Fusion	Meals on Wheels
HSE Addiction Services	Star
HSE Community Healthcare Network	The Bungalow

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