

The illegal drug use behaviour and social circumstances of older adult class A drug users in Britain

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**The illegal drug use behaviour and social circumstances of
older adult class A drug users in England**

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This thesis is submitted in partial fulfillment of the requirements
of the award of Doctor of Philosophy

First submission for examination

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The research described in this thesis is the author's own work and has not been submitted in
the same form elsewhere.

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Abstract

Substance use problems are seen as the domain of younger age groups. However, recent trends in drug use and the demand for drug treatment show an increasing prevalence among older adults. Over the next twenty years it is anticipated that the number of older substance users will increase. It is therefore becoming more important to understand the compound challenges faced by older adults who use class A drugs.

The research questions for this study are: What are the illegal drug use behaviours and social circumstances of adult class A drug users over 50 in England? and How and why do they use class A drugs?

To answer these questions a constructivist grounded theory methodology was adopted. Semi-structured, face-to-face interviews were conducted with 30 (24 men and six women) participants, over 50 years old, living in England. All participants had used a class A drug in the last month.

The results showed a heterogeneity of social circumstances among the sample. For the majority of the participants their drug use was highly dynamic - frequently managed in line with their circumstances. These participants also adapted their drug use in line with their awareness of their changing physical vulnerability. For others however, their drug use was fixed and linear. All participants' drug use is described by the major category 'managing lifestyle'. Participants were using drugs to change the way they felt - described by the major category 'altering feelings'. The data also suggested an apparent interaction between how and why these participants were using drugs. A model of drug use in older adults was developed from the fourteen major categories - underpinned by the core category 'achieving balance'. It describes a process of ongoing balancing, influenced and informed by the participants' experiences of the past and expectations of the future.

Organisation of the thesis

This thesis has ten chapters. Chapter 1 is the introduction, which describes the preparations made for the study - addressing the background and identifying the existing knowledge gaps that provide its justification. It also details the research questions and the original contribution of the study. Chapter 2 goes on to review the literature on drug use among older adults and describes previous studies of the assessment and treatment of older adult substance users. Chapter 3 describes the theoretical background for the study by looking at research into the processes, patterns and reasons for substance use.

Chapter 4 details the method adopted. It starts with an introduction to, and a summary of, the methodological decisions made to undertake the study. This covers the decision to use qualitative methods and particularly grounded theory. It then goes on to address the practical issues connected to the study such as sampling. Finally, it describes how grounded theory processes were employed to organise and analyse the data.

Chapters 5 to 8 present the study's results. Chapter 5 presents information obtained about the participants, describing their social circumstances and drugs used. Chapter 6 then goes on to describe how these participants are using drugs, while Chapter 7 describes why they are using drugs. Chapter 8 then presents a theoretical model of drug use in older adults, describing how the categories identified in the data are connected.

Chapters 9 and 10 are the discussion and conclusion. Chapter 9 discusses the findings in relation to other research and theory in the area, before exploring the study findings. Finally, Chapter 10 presents the conclusion, which covers the implications arising from the study for policy and practice, particularly for service providers, older substance users, their families and carers.

Chapter 1. Introduction

Research background

People who use illegal drugs in their 50s constitute a ‘largely unrecognised but increasing’ group (Beynon, 2009, p. 8). Little research exists however exploring their characteristics and behaviour - particularly why they behave in a way which might be considered harmful as they become more physically vulnerable.

The prevalence of drug use among older adults¹

While older adults are known to be the highest consumers of over the counter medications and prescription drugs (Shulman, 2003; Substance Abuse and Mental Health Service Administration (SAMHSA), 2005), they are not commonly assumed to be users of illegal drugs (Beynon, 2009). The prevalence of drug use among different age groups in England and Wales has been estimated by a range of official statistics. Instruments such as the Home Office Addicts Index first collected data on substance users of different ages who were in contact with national drug-related services. The final count of people classified as problematic drug users was 43,000 in 1996. However it has been estimated that there are more than three times this number (Hartnoll and Lewis, 1985). These data have subsequently been collected in a variety of forms such as the Regional Drug Misuse Databases (RDTMS) and the National Drug Treatment Monitoring System (NDTMS). The National Drug Treatment Monitoring System (NDTMS) collects, collates and analyses information from and for those involved in the drug treatment sector. The NDTMS is a development of the Regional Drug Misuse Databases (RDMDs), which have been in place since the late 1980s².

¹ See page 14 for use of the term of older adults.

² <http://www.nta.nhs.uk/ndtms.aspx>. Accessed, May 2008.

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These sources are used for monitoring the use of national, regional and local services, and for forecasting future demand. However they only describe the numbers of people who come into contact with agencies and therefore only those with the most problematic behaviours. Using these data alone it is difficult to estimate the prevalence of drug use among older adults as they are less likely to report substance use problems (Nemes et al, 2004) and less likely to receive help for them (Moos et al, 1993).

More recently, the national prevalence of drug use among different age groups has generally been predicted by surveys with a criminal justice element, such as the Crime Survey for England and Wales (CSEW)³. This survey accesses a nationally representative population of adults and young people over the age of 15 in England and Wales. The first major prevalence survey of drug use in the United Kingdom (UK) was carried out by Leitner et al (1993). This was the forerunner of what would later become the drugs misuse module of the British Crime Survey (BCS) (e.g. Ramsay et al, 2001) before it then became the CSEW.

The CSEW is the most reliable source of data on drug use in the country. It is a general household survey of a representative sample of adults and young people across England and Wales. While the survey itself is specifically designed to provide data to measure the impact of national government policy on crime and anti-social behaviour, there are also a number of self-completed questions on drug use, which are designed to reveal the national prevalence of illegal drug use.

However, the CSEW has no accurate way of measuring the prevalence of drug use in the general population over 50 years old, given the size of the sample drawn from this age group, the disproportionate use of drugs among different age groups, and the small number of reported users the survey was able to locate. It has been argued that prevalence measures (such as the previous years, or even the previous months use) do not always provide a

³ Originally the British Crime Survey, beginning in 1982.

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reliable guide to the level of drug use within the general population (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2002).

Results from the most recent drug use module of the CSEW presenting data by age group (Home Office, 2013) highlights the fact that drug use was more prevalent amongst younger than older drug users. Figures showed that 16.4% of 16-19 year olds and 16.2% of 20-24 year olds admitted taking an illicit drug⁴ in the previous year, while only 3.5% of adults aged 45-54 and 2.3% of people aged 55-59 admitted taking any drug over this same period. This level of self-reported use by over 45s is lower than that for younger cohorts, but there are indications that this figure is growing. For both groups (45-54 and 55-59 year olds) these figures represent a progressive statistically significant increase against 1996. This is especially important when over this same period use for all age groups up to 30 years old shows a significant decrease in the use of any drug.

Also, since 1996 the proportion of adults aged 45-54 reporting they had used a class A⁵ drug in the previous year (as defined under the Misuse of Drugs Act 1971) had also more than trebled from 0.2% in 1996 to 0.7% in 2013. This also represents a statistically significant increase (Home Office, 2013).

What drugs do older adults use?

Cannabis has consistently been the most commonly used illegal drug among all demographic indicators (Egginton and Parker, 2002; Nutt and Nash, 2002; Parker et al, 2002; EMCDDA, 2013a; Home Office, 2013).

Qualitative research also supports this finding (e.g. Wibberley and Price, 2000). Table 1 below shows the proportion of people reporting illicit drug use in the last year, by age group.

⁴ For the purposes of the CSEW this includes cocaine, crack, ecstasy, LSD, magic mushrooms, heroin, methadone, amphetamines, tranquilisers (e.g. barbiturates and benzodiazepines), anabolic steroids and cannabis.

⁵ A full list of Class A, B and C drugs are listed in Appendix 1.

Age group	Cannabis (%)	Any class A drug (%)
16-19	14.3	3.5
20-24	13.0	5.7
25-29	9.4	5.4
30-34	6.4	3.1
35-44	4.4	1.9
45-54	2.6	0.7
55-59	1.7	0.2
All adults aged 16 – 59	6.4	2.6

Table 1. Proportion of people reporting use of illicit drug use in the last year, by age group (Home Office, 2013)

Table 1 shows that cannabis was the most frequently used drug, with 6.4% of all adults aged 16-59 admitted using the drug in the previous year (equivalent to around two million people in the general population). Its use was most common among 16-19 and 20-24 year olds with 14% and 13% respectively. While comparatively lower it was still also the most commonly used drug among older adults, with 2.6% of people aged 45-54 and 1.7% of adults aged 55-59, admitting to using the drug in the last year. In a sample of adults in London over 50, Fahmy et al (2012) also describe an increase in cannabis use among this smaller group.

The next most frequently used single drug by the general population was powder cocaine (1.9%). Again this was also the case for younger and older adults, with 2.1% of 15-19 year olds, 4.4% of 25-29 year olds and 3.7% of 20-24 year olds admitting using the drug in the last year. This is compared to 0.5% of adults aged 45-54 and 0.1% of 55-59 year olds.

Table 1 also shows that younger people are also more likely to use class A drugs compared to older adults. It show that 5.7% of 20-24 year olds admitted using a class A drug in the last year, followed by 5.4% of 25-29 year olds and 3.5% of 16-19 year olds. This is compared to 0.7% of older adults aged 45-54 and 0.2% of 55- 59 year olds.

Poly-drug use among older adults

Poly-drug use, or the use of more than one drug at the same time or simultaneously (Hoare, 2009) is also more prevalent among younger age groups. People aged between 16-24 and 25-34 are more likely to have used three or more illegal drugs in the previous year compared to people over 35 (Hoare, 2009). The differences in poly-drug use between these age groups suggests that this behaviour is likely to be associated with experimentation with drugs, and that drug users tend to reduce the range of drugs they take as they get older (e.g. Dark and Hall, 1995; Calafat et al, 1999).

However, there are still older drug users who admit to using more than one drug regularly. Further analysis of the most recent data available shows an important interaction between ageing and poly-drug use. Hoare (2009) states that two percent of adults aged 55-59 reported taking two or more illegal drugs in the previous year. While prevalence data suggests that one of these drugs is likely to be cannabis, the use of more than one drug suggests a commitment to drug use, especially considering that the percentage of 55-59 year olds taking just one drug was also two percent. These figures suggest that people who are still regular drug users at the age of 55 are just as likely to be poly-drug users.

This suggests a potentially interesting pattern. While people may use a range of drugs when they are younger it is possible that many just experiment with drugs once, twice or a few times - any drug use then tends to be limited mostly to cannabis after 35 (Hoare, 2009). However, from these data a small proportion of drug users seem to remain committed to using drugs throughout their lives. Although the chosen drug of many of them is cannabis, there is also likelihood that members of this group will be using more than one drug and one or more of these will be class A drug.

This pattern had been further described by the EMCDDA (2002). They identified what they believe to be three main types of poly-drug users -

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younger (i.e. 16-20) experimenters of any kind of drug, slightly older (i.e. 20-30) generally recreational users, and older clients (for which no age is given) described as mostly male opiate users who generally combine a range of opiates (e.g. heroin, methadone, benzodiazepines) and cannabis. This is consistent with the pattern described by Hoare (2009) whereby the most prevalent poly-drug users are more likely to be found at either end of the age spectrum. In younger adults poly-drug use seems to be indicative of experimentation while in older adults it seems more indicative of a management regime. What is not clear from these data is whether older poly-drug users are switching drugs, using drugs in combination or using one drug instead of another when supply is scarce.

Methodological weaknesses of drug use prevalence surveys

The argument has been put forward that any measure of current drug use is only a partial snapshot of a person's overall lifetime drug use and that longitudinal studies provide a more complete picture of drug use prevalence (e.g. Egginton and Parker, 2002; Parker et al, 2002). While it is difficult to argue with this position, longitudinal studies such as this are also fraught with methodological difficulties, including sampling, the complexity of recruitment and retention of participants and ethical issues (Taplin, 2005). In the absence of this kind of more detailed data, current statistics are an important indicator of prevalence. What is important to bear in mind is that current statistics reflect only a fraction of the actual incidence of drug use among the older users. General population surveys potentially underestimate the scale of drug use amongst this group by not questioning people in care homes or institutions (where a large proportion of older adults live) or those who are homeless or in prison. The most recent CSEW module on drug use presenting data by age group (Home Office, 2013) also didn't question anyone over 59. Obviously pertinent when trying to gain an understanding of drug use in older adults. There are also a number of methodological issues with general household surveys. While the CSEW is the most comprehensive tool for measuring general trends in issues such as victimisation and drug use, it has certain limitations.

The principle source of concern with any sort of survey response is the validity of the findings. This is particularly the case where the subject matter is illegal drug use. There is always a danger that respondents may not wish to disclose their drug use for fear of repercussions. Some people (and this might particularly apply to older people, who might hold different values about the social desirability of illegal drug use) might feel that there is a stigma attached to any sort of drug use. Consequently, the data from the CSEW might under-report the prevalence of drug use in general, and especially so in some groups.

Evidence from studies which have attempted to correlate self-reported drug use with biomarkers such as urinalysis, oral fluid and blood samples has suggested that drug users' accounts of their life and their drug use are generally accurate (e.g. Johnson et al, 2000; Neale and Robertson, 2003). However, these studies have only considered the accounts of comparatively young drug users. With older drug users, the issue of memory recall might be considered a potential limitation as long-term drug use can have a deleterious effect on memory (e.g. McGuire, 2000; Solowji et al, 2002; Lundqvist, 2005). Coupled with this, general health and age may also impair long-term cognitive ability and therefore limit one's ability to recall events accurately (e.g. Andrews-Hanna, et al, 2007).

While large-scale prevalence surveys are helpful in providing context to the understanding of drug use among older adults, it can be an unreliable method for gathering data to understand how drug use might affect their lives. Smaller, more focussed studies have been effective for examining drug use among particular vulnerable groups, such as young offenders (Hammersley et al, 2003) the homeless (Wincup et al, 2003) and care leavers (Ward et al, 2003).

The ageing population in United Kingdom, Europe and the United States

The populations in the United States (US) and Western Europe are getting progressively older as the post Second World War baby boomers age⁶. By 2050 it is estimated that more than a third of the population of Europe will be over 60 (Gossop, 2008). Projections from the Office for National Statistics (2009) suggest that in the UK the proportion of people over state pension age is projected to rise from 16% in 2008 to 23% in 2033. These figures have not been revised subsequently. The Office for National Statistics also project that less support will be available for older cohorts because of what they call support ratios. In 2008, there were 3.2 people of working age for every state pensioner. This ratio is projected to decrease to 2.8 by 2033, making the support requirement greater for those of working age. The most recent data for life expectancy in the UK showed that, on average, women are now expected to live to around 82 years and men 78. In 2031 it is projected to be around 86 years for women and 83 for men.

These factors are important firstly because they are expected to foretell an increase in the number of drug users using drugs in their 50s and older. In North America, the baby boom cohort has had higher rates of drug use than any other age group or cohort before or subsequently (Johnson and Gerstein, 1998). It is the first in history where the majority used illegal drugs when they were in their 20s and 30s. It has the youngest average age for the first use of marijuana and the highest level of lifetime use of any cohort in the US (Gfroerer et al, 2003). Rosen et al (2011) suggests that this ageing of the post war baby-boom generation ‘almost guarantees that the growing problem of ... addiction among older adults will continue to worsen’ (p. 280).

Future drug use projections among older adults

In the US, projections seek to measure the potential demand for drug use treatment over the next twenty years and beyond (Gfroerer et al, 2003;

⁶ The post Second World War ‘baby boom’ is defined as between 1946 and 1964.

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Colliver et al, 2006; Han et al, 2009)⁷. Colliver et al (2006), using modelling techniques which built on work by Gfroerer et al (2003), estimated that the number of past year marijuana users aged 50 or over would increase from around 719,000 to 3.3 million (an increase of 355%), by 2020. More recent projections, have also tried to estimate the number of adults in the US over 50 who will present with Substance Use Disorder (SUD) by 2020. Using logistic regression models, taking account of current levels of substance use (which they ascertained from National Survey on Drug Use, and Health data) Han et al (2009) hypothesize that the numbers of older adult drug users will more than double (a rise of 113%) from 1.6 million in the period 1999-2001 to 3.5 million in 2020. And the numbers of people presenting with SUD will double from an annual average of 2.8 million to 5.7 million. They conclude that the main drivers for this are a projected increase in the population in that age group, and a high level of lifetime use among this cohort.

While there are no equivalent data for the UK, the most recent data available for lifetime drug use by age group shows that 15% of persons aged 55–59 were lifetime drug users (i.e. they had used illicit drugs at some time) (Roe and Man, 2006). Among the cohort which will be aged 55–59 in 2020, 34% were lifetime drug users in 2005/06. Among the cohort which will be aged 55–59 in 2025, 46% were lifetime drug users in 2005/06. The assumptions underpinning this are that as drug use is a ‘chronic relapsing disease’ (e.g. Heyman, 2009, p. 81), cohorts with greater lifetime rates of drug use are likely to have greater rates of current use and therefore future use.

In a review of substance use problems among older adults Farkas (2004) provides information which she feels will help people who come into contact with older substance users. She reviews substance use and its treatment among older adults with the aim of identifying the associated problems and helping people deal with them. Farkas (2004) suggests that

⁷ No work of this nature has been carried out or is planned for the UK (National Treatment Agency, Freedom of Information request, 2009).

the baby boom cohort will continue to use what they perceive to be recreational drugs to self-medicate and manage chronic pain from arthritis and other conditions as old age sets in. Throughout the review Farkas (2004) generally concentrates on alcohol use among older adults, although she also argues that other drug use, and the way these drugs interact with alcohol, will cause additional problems for this cohort, creating a greater demand for support and eventually substance use treatment.

The increase in older adults seeking treatment for drug use

To some extent this predicted increase in the demand for drug treatment is already being witnessed in the UK. Along with the statistically significant increase in the prevalence of drug use among older adults there has been a progressive increase in the numbers and proportions of older adults entering drug treatment over the past 15 years. Data from the RDTMS for the period 1993-2001 and from the NDTMS⁸ for the years 2003-2006 have both shown an increase in the number of new agency referrals for older adults. Data from both databases indicate that the sharpest increase in new treatment episodes has been among 55-59 year old males. It should be borne in mind that the data are from a small base (22) for the six month period ending September 1993, but even so, the rise to 74 for the six months to March 2001 is statistically significant. This is also the case in the later NDTMS data, which indicate an even steeper rise between September 2003 and September 2006.

More recently, Beynon et al (2007) analysed the returns to a bespoke database they had developed in 1997 and the NDTMS for Cheshire and Merseyside between 1998 and 2005. After collating the databases and identifying individual cases using a unique identifier code, they arrived at over 26,000 cases of data from individuals aged 11-74. The aim of the study was to establish at what age people were presenting to drug treatment

⁸ In 2001 the monitoring system recording the referral of individuals to drug treatment centres changed from the RDTMS to the NDTMS. Consequently, the results from the two databases are not directly comparable.

services in the area and to identify any changes or trends. They found that the median age of drug users in contact with treatment services and syringe exchange programmes (SEPs) rose from 31 to 35 in the period covered by the study, and the median age of drug injectors in contact with SEPs increased by almost eight years over this time. Directly pertinent to this study, they found an increase in the number of adults over 50 accessing treatment, from 80 to 310 for males and from 46 to 117 for females.

Data for treatment admissions in Australia and US show a similar pattern (SAMHSA, 2005; Australian Institute of Health and Welfare, 2010). The annual US Treatment Episode Data Set (TEDS) is a data set collating information from public drug treatment facilities on admissions to treatment rather than individuals, so these data might potentially double-count people who report to treatment facilities more than once over the course of the year. The data set was most recently used to look at the issue of drug use in older adults in 2005. It showed that between 1995 and 2002 the number of admissions to drug treatment in public facilities among adults aged 55 and over rose by 32% from 50,200 to 66,500. In the same period, the number of admissions among all drug users as a whole increased by 12%. While between 1992 and 2008 the proportion of people aged 65 and over being admitted to treatment facilities for heroin addiction increased from 7% to 16% (SAMHSA, 2010a).

Implications for the management of drug use in older adults

If the observed trends in drug use and the demand for drug treatment continue to rise across age cohorts, there is a high probability that the UK will be faced with a growing, ageing population of drug users with higher levels of lifetime drug use, and that services will have to deal with rates of drug use which are higher than those seen in previous generations.

What is also clear is that the need to help this group, at the very least with the provision of information about potential problems relating to their drug use, will increase. Resources will have to be made available to meet this

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need. When fieldwork on this study began in 2008 only one service was identified in the UK that was working directly with the challenges presented by older adults, and was aware of the distinct challenges they present (Gossop, 2008). It is apparent that this will become progressively more important if, as projected, services find themselves encountering more and more adults with substance misuse problems.

About this PhD study

With an ageing population and growing demand for drug treatment, the health and social care systems in England and Wales are likely to come under increasing pressure in the future. There are therefore clear advantages to understanding the nature of drug use in this group. The research questions for this study are: What are the illegal drug use behaviours and social circumstances of adult class A drug users over 50 in England? and How and why do they use class A drugs?

This study concentrates on describing the current class A drug use and social circumstances of a sample of adults aged over 50 years old and whether and how their illegal drug use interacts with their ageing. However it also explores their current drug use within the context of their earlier drug taking behaviours, social circumstances and broader life histories. This will be incorporated in a theoretical model of drug use in older adults.

Definitions and terms

This study focuses directly on two main issues, ‘drug use’ and ‘older adults’. To avoid any ambiguity or misunderstanding throughout the thesis, the definitions and terms used in this study are presented below.

Drug use

The illegal drug use behaviours and social circumstances of older adult class A drug users

For the purposes of this study, ‘drug use’ is defined as any use of any psychoactive drug (Strategy Council on Drug Abuse, 1979, in Glantz, 1981).

Illegal drug use

For the purposes of this study an ‘illegal drug’ is defined as any drug which is illegally owned or obtained and has controls placed on it by the Misuse of Drugs Act (Home Office, 1971), the Methylamphetamine Review (Advisory Council on the Misuse of Drugs, 2005) and the Control of Mephedrone and other Cathinone Derivatives (Home Office, 2010). The initial 1971 Act and its subsequent updates are the main pieces of legislation covering drug use in the UK.

Class A drugs

Different kinds of illegal drugs are divided into three different categories or classes depending on their perceived seriousness. These classes (A, B and C) carry different levels of penalty for possession and dealing⁹. Possession of a Class A drug for example can bring a prison sentence of up to 7 years, a fine or both. This falls to 5 years for possession of a Class B drug such as cannabis and 2 years for a Class C drug such as gamma hydroxybutyrate (GHB).

For the purposes of this study, anyone using a class A drug in the previous month is considered eligible for inclusion. Class A drugs were chosen in an attempt to elicit the greatest diversity of people who might be using drugs, with potentially the greatest risk to their own personal health. This section has illustrated how the most frequently used drug by all age groups in the UK is cannabis. Had anyone who had used any drug in the last month been eligible for interview it is likely that the study would have been based on an over-representation of people who had used cannabis. If the aim is to

⁹ <https://www.gov.uk/penalties-drug-possession-dealing>. Accessed, Dec 2014.

The illegal drug use behaviours and social circumstances of older adult class A drug users understand how and why these participants are using drugs generally, those describing a range of different drugs will present the most diverse range of behaviours.

Illicit drug use

The term 'illicit drug use' is occasionally used in the study. It is only used to accurately cite studies which have used that particular term directly (e.g. CSEW).

Substance use

For the purposes of this study, the term 'substance use' includes all illegal drug use plus the use of any legal drug, including prescription drugs, over the counter drugs, alcohol or tobacco.

Drug abuse and drug misuse

Occasionally, the terms 'drug abuse' and 'drug misuse' are used. These are not intended to be used interchangeably, and both differ from the umbrella terms of drug use or substance use. Again they are used to cite studies or authors that use the terms in their own context. 'Drug abuse is defined as the non-therapeutic use of any psychoactive substance, in such a manner as to affect adversely some aspect of the user's life. The substance may be obtained from any number of sources, legal or illegal, and the use pattern may be occasional or habitual' (Strategy Council on Drug Abuse, 1979, in Glantz, 1981, p. 117). 'Drug misuse is the inappropriate use of drugs intended for therapeutic purposes. This includes inappropriate prescribing or use of drugs resulting from, (a) lack of knowledge on the part of the prescriber; (b) errors in judgment by the prescriber; (c) use by a patient of a prescription drug not under the supervision of a physician; and (d) self medication by a patient with a drug in a way that is inconsistent with the label information' (Strategy Council on Drug Abuse, 1979, in Glantz, 1981, pp. 117-8).

Older adults

There is no clear or standard definition of what constitutes an ‘older adult’, although there are certain definitions of what constitutes ‘old age’. In the UK the Friendly Societies Act (1875) defined old age as ‘any age after 50’ (Holdsworth, 2008), yet state pension schemes mostly set 60 or 65¹⁰ as the age at which people can start to receive their state pension (Roebuck, 1979). Some recent research has categorised ‘the old’, with the ‘young-old’ listed as anyone aged 60 to 79 and the ‘oldest-old’ or ‘frail elderly’ as anyone who is over 80 (Gwordz and Sousa-Poza, 2009; Smith et al, 2009). However, it is recognized that these categories are still broad enough to span more than one generation and may include people with a wide range of characteristics and cultural experiences (Gavazzi et al, 2002).

This study takes 50 years of age and older as the operational definition of an ‘older adult’ for three main reasons. Firstly, medical evidence suggests that by the age of 50 the majority of people who have used illegal drugs for long periods, exhibit problems associated with their use, exacerbated by ageing (e.g. Cushman and Dole, 1973; Pascarelli, 1974). Secondly, the few existing studies in this area tend to focus on this age range (e.g. Levy, 1998; Anderson and Levy, 2003; Gfroerer et al 2003; Schlaerth et al, 2004; Levy and Anderson, 2005; Beynon et al, 2009).

A recent literature review of the characteristics and consequences of heroin use among older adults covered both of these reasons. The authors took the ‘decision to define older adults as those individuals over the age of fifty was based on the high rates of mortality in this population, along with data indicating that many heroin users die in their fifties’ (Rosen et al, 2011, p. 280). Finally, the third reason is largely pragmatic. Fifty is the ‘youngest’

¹⁰ The State Pension age in the UK is 65 for men. For women born on or before 5 April 1950, State Pension age is 60. ‘The State Pension age for women born between 6 April 1950 and 5 November 1953 will increase gradually to 65 between now and 2018. From November 2018 the State Pension age will be 65 for both men and women’ (HMRC, nd).

age at which studies have classed participants as ‘old’ or ‘older’; adopting this as the cut-off age is likely to provide access to the largest possible sample of participants (Capel and Stewart, 1971; Pottieger and Inciardi, 1981; Korper and Raskin, 2002).

The study’s original contribution to knowledge

This study aims to make an original contribution to existing knowledge in two main ways, firstly, by the scale of work undertaken into the methods of, and perceived reasons for, drug use of a group of adults over 50 in England; secondly by considering how and why they are using drugs, and how this is impacting on their lives. As such, it is expected that the findings will offer fresh insights to an ‘under-investigated’ cohort (Satre et al, 2004, p. 1295).

Chapter summary

This chapter began by outlining the structure of the thesis. It presented evidence and data which suggest that while drug use and treatment among older adults is less prevalent compared to younger age groups it is a growing problem. There have been statistically significant increases in the proportions of adults over 45 reporting having used a class A drug in the last year and also presenting for drug treatment for example. The chapter also presented evidence that both of these issues are forecast to rise and coupled with a growing older population in the UK are likely to present significant health and social care challenges in the coming decades. The chapter then presented the implications of this. This is the rationale that provides the context for the research study - the need to understand the nature of drug use among adults over 50 and their experiences of taking drugs as they become older. The chapter then presented the research questions this study will now seek to answer. It finished by describing the definitions and terms used in the study, and by outlining the original contribution to knowledge it intends to make. The next chapter reviews the literature on drug use among older adults and their treatment.

Chapter 2. Literature review

Introduction

The aim of this chapter is to provide a focused review of the studies that have specifically aimed to examine drug use among older adults. As this study adopts a grounded theory approach it will begin by considering the role of the literature review in grounded theory more generally. This is followed by the methodology and search terms used to compile the review. The review itself will then describe those studies that elucidate characteristics of older drug users and their drug use behaviour. The chapter ends with a consideration of the treatment of drug use in older adults, and a summary of the conclusions from the review.

Methodological considerations and the status of the literature review in grounded theory studies

This PhD study uses a grounded theory methodology (Glaser and Strauss, 1967). One particular characteristic of this approach that its proponents believe set it apart from others is the position of the literature review. Glaser and Strauss (1967) originally felt that the review should be written last so that the findings would not be coloured by existing research. Strauss and Corbin (1998) began the break away from this position by suggesting that grounded theory researchers inevitably bring their own background and experiences to their research, often from their professional experience. This acknowledgement of researcher reflexivity has been taken further by Charmaz (2006) who advocates a more pragmatic approach to the place of the literature review in grounded theory. She suggests that researchers should familiarise themselves with existing research in the area, set it aside, and then use it later in the analytical process. This literature should then be used to complement the final theory and strengthen the argument and credibility of the researcher. She also suggests that this is important to develop initial research questions that do not replicate existing work.

Charmaz (2006) talks about letting the initial review 'lie fallow until after you have developed your categories and the analytic relationships between them' (p. 166). She goes on to say that at that point a researcher should 'then begin locating your work within the relevant literature. Since you began your study, you may have travelled to new substantive terrain ... The literature review can serve as an opportunity to set the stage for what you do in subsequent sections and chapters. Analyse the most significant works in relation to what you addressed in your now developing grounded theory' (p.166). This way Charmaz (2006) believes that the insights from the ongoing review can make a positive contribution to the quality and direction of the research and theory development. Lempert (2010) supports this position also arguing for an initial literature review supported by an iterative review based on the developing categories, which can then strengthen the analytic depth of the study.

This researcher adopted this position - recognising that he had previous knowledge of the evidence base in this area from prior experience of working in the field of substance use. The initial review would provide the structure for the development of the study while an iterative review would be carried out to provide insight and focus for development of theory as the study progressed. The methods for the initial literature review are described below with the method for the iterative review following this.

The literature review for this study

Initial literature review

In line with the Charmazian (2006) approach outlined above an early literature review was undertaken for this study with two aims. The first was to assess the research already undertaken with older drug users. This would identify the gaps in knowledge, and the most appropriate research questions. The second was to provide information about their drug use and social circumstances - the context for the study.

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The following databases were used for the initial and iterative literature searches: Applied Social Sciences Index and Abstracts (Assia); Criminal Justice Abstracts; CSA (Cambridge Scientific Abstracts) Illumina; Common Good research site; Google Scholar; GreyLit Network; Grey Literature at GWU; Index to Theses; Ingenta; Intute; Managing Access to Grey Literature Collections (MAGiC); Medline; Psyc Articles; PsychLit; RefWorks; SilverPlatter; and Swetswise.

The following search terms were used on these databases: old*; adult; old age; late onset; elderly; gerontology; middle age*; baby boomer; and drug use*; drug *use; drug research; illegal drug; substance *use; use of drugs; inappropriate use; psychotropic; dependen*; inject*; cocaine; heroin; crack; marijuana; *amphetamine; meth*; ecstasy.

Search terms were initially limited to publication dates in the ten years before the initial review which was undertaken in 2007 (therefore the search parameter for year, was 1997 to 2007). However after an initial search all date restrictions were lifted in an attempt to increase the number of studies for review. After double counting was eliminated 853 references were obtained. The titles and abstracts were reviewed to establish whether they met the following inclusion criteria: 1) studies where the focus of the findings was on a sample or identifiable sub-sample of drug using adults aged 50 or over; 2) studies describing the social circumstances and illegal drug use behaviours of older drug users; or drug treatment for older adults and 3) studies published in the English language. This resulted in 110 articles that met the study inclusion criteria that were obtained either electronically or through inter-library loan.

Studies meeting the inclusion criteria were scanned and the bibliographies and reference sections searched for further relevant studies. This process continued until no new, relevant studies were identified.

Further literature searches were conducted using these search terms on these databases every month between September 2007 and March 2014 in an

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attempt to find any sources of relevance published during the development of the study and during the initial review.

Iterative literature review

During the research process when the core category (*'taking a survivor approach'* and then *'achieving balance'*) and the major categories *'managing lifestyle'* and *'altering feelings'* began to develop, a further literature review was undertaken. The aim of this review was to use the literature as a tool to 'promote analytical conceptualization' (Strauss and Corbin, 1998, p. 53) and guide ongoing analysis, consistent with the process outlined by Charmaz (2006) above and developed by Lempert (2010), as it was clear that these were the processes which described how and why these participants were using drugs.

The following search terms were used on the same databases described for the initial review : Illegal drug use; illicit drug use; theories of drug use; class A drug use; drug *use; use of drugs; cocaine; heroin; crack; marijuana; *amphetamine; meth*; ecstasy and manag*; adapt*; chang*; alter*; ration*; chip*; career; path; behav* patterns; controlled; uncontrolled; self-medocat*; mood; feelings; health.

To make the search as contemporary as possible search terms were limited to publication dates in the twenty years prior to the review having been undertaken (1990-2010). After double counting was eliminated 668 references were obtained. The titles and abstracts were reviewed to establish whether they would be relevant to the themes of the developing core category and major categories, i.e. the management and control of drug use. This resulted in 191 articles that were obtained either electronically or through inter-library loan. The bibliographies and reference sections of these studies were also searched for further relevant studies. This process continued until no further studies, which would add depth to the developing core category and major categories (thereby adding to the understanding of how and why older adults might use drugs) were found. Further ongoing

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searches of this literature were also undertaken on an ongoing basis for this purpose.

The findings from the initial literature review are presented below. The findings from the iterative review are presented after this in Chapter 3: How and why people take drugs. This also includes the presentation of the theoretical framework for this study (West, 2006) which was identified during the iterative literature review in line with the grounded theory principles stated above.

Illegal drug use among older adults

The initial position with regards to drug use among older adults was established by Winick (1962) which posited that people stop taking drugs either because of their age or their length of lifetime use. Winick (1962) concluded that people who use drugs have fewer stresses as they approach middle age, which he considered to be from age 35 to 42, and are therefore less likely to rely on drugs as a form of self-medication. This led to the historic perception that older adults tended not use illegal drugs (Beynon, 2009).

A series of follow up studies by other researchers tested the maturation hypothesis (e.g. O'Donnell, 1964; Ball and Snarr, 1969; Stephens and Cottrell, 1972; Snow, 1973; Vaillant, 1973; Harrington and Cox, 1979; Maddux and Desmond, 1981; Anglin et al, 1986) and recently by Lankenau et al (2010) studying Ketamine users. All show varying amounts of support for the hypothesis. Although most studies found some people who use drugs did abstain from doing so after a long period, this phenomenon was clearly more prevalent among some than others. One of these studies' major weaknesses, however, is that they attempted to explain the complex nature of drug use by simply examining rates of abstinence after a certain follow-up period. Subsequent work began to posit that the arc of illegal drug use had a more complex and cyclical nature, continuing for many years, subject to abstinence and relapse, sensitive to social, political, economic, and environmental events (e.g. Riley and Waring, 1978).

One of the first studies specifically established to examine the lives and behaviours of older people who were still using drugs was undertaken by Pottieger and Inciardi (1981), who analysed data from 42 structured interviews with male street drug users in Miami. They found that their sample was 'typically white, few had been born in Miami and only one in three had finished High School' (p. 208), and all were males. According to the authors, the respondents stated that as their participants got older their drug use had become less intense and less frequent, and they also committed

fewer offences. The authors concluded that the 42 men in their sample had become increasingly dissatisfied with their lifestyles and the social support available to them and had tried to regain a foothold into more mainstream society. While the study was not established to test the maturational hypothesis, on the face of it, it seems to describe Winick's (1962) position well.

Using only cross-sectional data however did not allow Pottieger and Inciardi (1981) to explore the context or the nature of these individual's change, or any adaptive techniques that might have been prevalent among their sample. Their conclusions rest on the description of 'one inadequately detailed database' (p. 209), and does not allow the kind of exploration of the lives of older drug users they recommend. Not only this, the study is now over 30 year old. In this time drug use trends have changed and developed significantly. Policing, social care and drug treatment policy and practice have also changed and developed - all affecting the way that people buy, sell and consume drugs (e.g. Reuter and Stevens, 2007). Pottieger and Inciardi (1981) themselves suggest that any research in an adaptive and dynamic environment such as theirs is itself 'time-bound' (p 209). However the study laid an important foundation for developing an understanding of their participants' general drug use behaviour.

Cross-sectional studies are only likely to provide a partial picture of drug users' behaviour. To provide more detailed understanding qualitative studies are needed to get closer to the lived experience of people who use drugs. The benefit of qualitative study is that researchers can explore a topic in more depth to answer questions about 'how rather than how many' (Sagoe, 2012, p.3).

Rosenberg (1977) importantly challenged Winick's (1962) hypothesis suggesting that it was only based on drug users' experiences with the criminal justice system. Rosenberg (1997) states that people might continue their drug use differently by essentially dropping out of the drug scene and the potential criminal culture that comes with it rather than by discontinuing

using illegal drugs altogether. He suggests that drug users might manage through various techniques to continue using them with less intensity and less frequency, without coming to the attention of law-enforcement authorities, treatment agencies, or both (Rosenberg, 1997). Stephens (1991) notes that if this is the case, older drug users probably have to adjust their lifestyles. This might mean making changes such as changing their main drug of choice, rationing what few illegal drugs they acquire through whatever means, substituting legal prescription drugs as Valium for illegal ones, or drinking more alcohol (Abrams and Alexopoulos, 1988). Alskne (1981) described how detoxification programmes could enable people addicted to drugs to taper their drug use. This could then provide them with the necessary support to address any problems with their health.

Older drug users monitoring and managing their drug use behaviour

The 'first systematic study (examining the characteristics and motivations of older drug users) ever undertaken' was carried out by Courtwright et al (1989, p.62). They used biographical methods to develop oral histories of a group of methadone patients in New York City. The authors set out to interview what they considered 'elderly' (p. 48) drug users setting the lower age limit at 60 but giving no rationale or sample size. The majority of the participants reported that they had used most drugs over the course of their lives and most were poly-drug users - using opiates and marijuana regularly. Courtwright et al (1989) found that the group came from a wide variety of backgrounds, a range of classes, ethnicities, both genders and from different living circumstances and occupations. They suggest that their main finding is the longevity of their participants. The authors suggest that the reason for this was that the sample exhibited character traits that helped them to manage their use more ably, including using clean needles, and carefully monitoring their drug use and behaviour. They were very conscious of their health and were very careful about things such as dosages and frequency of use - seeing themselves as 'not greedy' (p. 53). Using a qualitative method the researchers enabled themselves to explore the issues facing older people who use drugs in more depth. However, as with Pottieger and Inciardi

(1981) this study was also undertaken in the 1980s when drug use and drug prevention and treatment policy and practice were very different from today - and the pertinence to this thesis could be seen as limited. It is important therefore to consider the findings alongside more recent work.

A more recent case study by O'Brien (2008) offers support to the position that older people who use drugs might monitor their drug use behaviour closely. It is also important in exploring how gender-specific behaviour might interact with drug use. O'Brien (2008) presents a case study detailing the treatment of a 50-year-old woman receiving methadone maintenance in the US. The paper gives a brief outline of the life of the patient, known only as 'Ms. W' who began using heroin in her teens. Ms. W had received a number of treatment episodes, but had relapsed repeatedly sometimes after periods of abstinence. What is perhaps most pertinent to this study about the case is that, according to O'Brien (2008), his patient represents some 'typical and some atypical aspects of opiate addiction' (p. 315). It is reported that Ms. W had Hepatitis C, which is not uncommon among injecting heroin users (e.g. Day et al, 2003). Other aspects of Ms. W's life are also identified as 'common among women addicted to heroin' (p. 315) such as a being a survivor of childhood sexual abuse, suffering incidents of domestic violence as an adult and a previous involvement in sex work. Ms. W also admitted that her drug use was often connected to her ability or inability, to cope with any challenges in her life, 'When something happens in your life that's traumatic, you're like, 'Oh, I want to use, I don't want to deal with this,' (p. 315). However, the paper reports some aspects that are described as more atypical of other adult drug users. Throughout her life, according to O'Brien (2008), Ms. W 'remained concerned about her health' (p. 315), being careful of the risk of diseases such as Human Immunodeficiency Virus (HIV) (she took care never to exchange needles), stopping smoking tobacco in her youth for fear of lung cancer, and avoiding all drugs while she was pregnant.

These studies go some way to exploring how people might use drugs over long periods by maintaining an ongoing awareness of their use and how it

interacts with their health. While the authors describe aspects of what has been called problematic drug use over long periods (e.g. see Cave et al, 2009) in some places, they also describe a process of management in an attempt to incorporate other factors into their lives alongside their drug use. Pottieger and Inciardi (1981) describe aspects of careers and home lives for example, while Ms. W describes being a mother and undertaking an adult education course. O'Brien's (2008) case study provides very clear and detailed evidence of behavioural changes and adaptive modifications Ms. W used.

The case of Ms. W was specifically chosen to highlight the nature of substitute prescribing. Particularly how alternatives to heroin had enabled her to function in mainstream society while she was using illegal drugs. While it is not possible to generalise from a single case study Ms. W's case provides further depth and an example of what Courtwright et al (1989) describe, particularly as an awareness of one's own health.

While Ms. W's story does present a good example of the nature of adaptive drug use, one reason to be mindful of O'Brien (2008) is that the paper ends with a question and answer session, where the author states his ideological position on drug use and the treatment of people who use drugs. In doing so he moves further away from the research evidence to presenting his opinions. The presentation of these opinions does not in itself weaken the research but does provides an insight into the author's disciplinary background, and intended audience. Substitute prescribing is one method of treating drug use - but is prevalent among those who subscribe to the medical model of drug use treatment (Smith, 2007). Ms. W had used her own adaptive drug use techniques and behaviours prior to entering any kind of drug use treatment and clearly prior to her treatment by Dr. O'Brien, but it is unclear how much her behaviour was affected by any subsequent treatment on substitute drugs.

Older drug users modifying their drug use behaviour as they age

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Levy (1998) set out specifically to describe and understand the behaviour of a group of drug users over 50, recruiting 53 injecting drug users (IDUs) aged between 50 and 86 in a 'large American city' (p. 781). The majority of the group were men (42), sharing stable accommodation (only six were living alone and four were homeless or living in temporary accommodation). Their main drug of choice was heroin, but all were poly-drug users, frequently reporting substituting drugs for whatever was available.

Levy (1998) reports that 52% of men and 27% of women used 'street hustles' (p. 783) to get money to buy drugs, but also about how this had waned as they aged. Nine of the 53 (seven women and two men) reported exchanging sex for drugs or money to buy drugs. Some of the group still maintained an active interest in the drug world (but peripherally such as bagging up and acting as lookouts in open markets). Levy (1998) suggests that they did this in order to remain close to a source of drugs and make procuring them easier. Most importantly, however she concludes that this group seemed much more risk averse than younger IDUs, exhibiting fewer risky drug use and sexual behaviours as they got older. The most common injection pattern among the group was now only once per day. All said that they injected in their own homes or in those of their friends.

The study is extremely valuable at highlighting some of the care-taking behaviours used by the group to enable them to use (and particularly inject) illegal drugs and still remain comparatively healthy. However Levy (1998) herself points out that it is difficult to generalise from the size and specificity of her sample. The large majority of the sample is described as 'African American' (76%), with 16% described as 'Latino' and only eight percent described as 'white'. This ongoing critique of the samples of studies described in this review highlights the consistent challenge when trying to consider identifiable patterns of behaviour among this group.

Later work by Kwiatkowski and Booth (2003) supports this. They carried out a secondary analysis on the National Institute on Drug Abuse (NIDA)

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investigation of drug use and HIV risk, conducted in the US between 1992 and 1999. Comparing the responses from 1,508 people over 50 to a random sub sample of 1,515 aged 50 or younger they found that: older drug users were more likely to have a lower level of educational achievement; were less likely to have a job and more likely to be registered with a disability; and less likely to be homeless than younger drug users. Kwiatkowski and Booth (2003) also found differences within the older group, suggested that as respondents became older their use became less frequent and their behaviour less risky - they were less likely to inject drugs and less likely to use dirty equipment when they did.

The authors acknowledge that while the sample was not drawn at random, and therefore potentially not appropriate for inferential statistical analysis, they believe that it is large enough to compensate for any deficiency in the quality of the sample. They further acknowledge that care should be taken not to generalise to all drug users.

Older drug users and switching drugs

Kwiatkowski and Booth's (2003) study is notable for identifying an important behavioural change among older adults who use drugs - the trend for late-onset use of crack-cocaine in some of their sample. No reason is given for this but there is a suggestion that switching from injecting use to smoking might be seen as less risky. Particularly as those who were using crack cocaine reported doing so less frequently, potentially suggesting further behaviour modification as they aged.

Johnson and Sterk (2003) carried out work into late-onset crack use in more detail, undertaking observation and depth interviews with 27 active older black users in Atlanta. They found the majority of participants were in stable accommodation (only a quarter of the men and a third of the women were homeless), the majority having been in prison and also in drug treatment. Johnson and Sterk (2003) describe five typologies of drug use behaviour among their sample - three for men and two for women, although

the categories seem to show overlap. The first of the male typologies were injecting drug users who had switched drugs so that they now only used crack. While the authors do not explore the reasons for switching, they also hypothesize that it could be for health reasons. The second also switched drugs, but having previously been heavy users of alcohol. These were men who had been introduced to crack by women, often in homeless shelters or refuges, or in return for allowing the woman to stay in their home. This is also connected to the final male typology - men with no previous drug use experience at all who started using drugs after striking up sexual relationships with women who were already crack users.

The two female typologies mirrored this pattern with women being introduced to crack by men described as having 'high sexual demands' (p. S231) - they differed only in their previous exposure to drug use - some prior, the remainder none at all. The authors state that common to both female typologies was the worry, expressed by the women, that they were 'violating social norms' (p. S231), either by being involved in drug use at all, or through their sexual behaviour.

This study illustrates well that drug use behaviour is not necessarily fixed or restricted simply by ageing. It also illustrates that the participants were not a single homogenous group, displaying a range of behavioural characteristics. Therein lies one of its potential weaknesses however, the representativeness of any typology - particularly one arrived at using convenience or self-selecting samples, and one with such subtle differences and overlap among the subgroups. It is not clear how the recruitment methods directly led to the finding of these groups or how many participants were in each group. Perhaps other people using crack cocaine might present different patterns.

Having said this Johnson and Sterk (2003) achieves its aim of furthering the understanding of the drug use behaviour of older adults. Two subsequent case studies have also described some of the characteristics of the typologies presented by Johnson and Sterk (2003), those having started using crack as a

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result of a sexual relationship, the first having had no previous exposure to illegal drug use, the second however being a long-term drug user.

The first of these was published by Nambudiri and Young (1991), who describe what they consider to be the first ever case of late-onset crack dependence in an older adult. In a medical case study they describe the social and drug use circumstances of someone who is identified only as ‘a 64-year-old Hispanic male ... who spiralled into drug use, debt and social isolation as a result of their use’ (p.253). Kouimtsidis and Padhi (2007) also present a case study of late-onset cocaine and crack dependence, this time in the UK in a male patient aged 72, whom they called ‘Mr. A’. Like Nambudiri and Young’s (1991) case study Mr. A came to the attention of community health services after having used illegal drugs and attempted suicide at 72.

While these are cases of drug use among older adults, the patterns of drug use are consistent with people of any age - repeating cycles of ‘abstinence and periods of relapse with associated suicidal risk’ (e.g. Nambudiri and Young, 1991, p. 667).

Both sets of authors suggest that the incidence of late-onset drug use, though still comparatively low, may be increasing. Conversely to Winick’s (1962) original hypothesis Nambudiri and Young (1991) finish by suggesting that drug use among older adults might be associated with stressful life changes brought on by ageing, such as ‘coping problems related to retirement, physical illness, losses, or low self-esteem’ (p. 255), and suggest that more cases are likely to become apparent with an increasingly elderly population.

Carstensen et al (2011) however have found that adults can become calmer and more stable as they get older and sometimes find their emotional health can improve. While many adults anticipate social loss and a decline in their support network, they often experience a greater sense of emotional peace as their perspective and priorities change over time. Carstensen et al (2011) assert that as people age, they concentrate on the issues that are most

important to them and bring the most meaning to their lives. However, her research does not address changes in life experienced by substance users, who may bring other compound factors into their old age such as mental health challenges. It is uncertain whether, or how, this emotional rebalancing is affected in participants with such challenges.

Older drug users and changes to identity

Levy (1998) concludes her paper by setting a research agenda that suggests that further examination is needed to understand ‘how age intersects with drug use’ (p. 791). She aimed to address this question in more detail in her work looking at the behaviour of older drugs users in the study she conducted with Tammy Anderson. Anderson and Levy (2003) undertook in-depth interviews with 40 lifelong, illegal drug users between the ages of 50 and 68 in Chicago. Their 40 respondents were mostly black (96%) male (63%) parents (90%) and single (80%). Over one third (37%) had not completed high school, while none were college graduates. Just under a quarter (24%) had tested positive for HIV. Participants admitted to taking a range of drugs but the main drugs used were heroin (86% had used in the previous month) and crack (43%).

In a separate paper from the same data, Levy and Anderson (2005) found that as their participants aged they moved from being actively engaged in criminal activity to a more marginal position in the drug market hierarchy. They concluded that as their participants had grown older, their feelings of marginalisation within the drug-using world had an impact on their overall identity. They reported the ‘gradual eroding of ties to the non drug using world and lessening interaction over time with family, friends and others who are non-users’ (p. 251) was an important factor in individuals continued involvement in drugs. As the drug use careers of Levy and Anderson’s (2003) sample had begun more than 25 years earlier, when they had other life options, the connections they had during their youth became increasingly distant as they moved further into the black economy. They also tended to become progressively more isolated over time through the

mortality and morbidity of their peers. Although such mortality and morbidity tend to affect all addicts (Darke et al, 2006), ageing can exacerbate the situation - their opportunities to make new acquaintances and forge new relationships became limited by stigma and the context of their lives. They tended to feel marginalised within the wider marginalised population of the drug world (Anderson and Levy, 2003).

In this further work which concentrated on the changing identity among their original sample, Levy and Anderson (2005) identified in them what Goffman (1963) called a 'spoiled identity' (p. 253). This means that long-term addicts, particularly those who began using drugs when they were young, have not had the time to develop their own personalities, have been unable to develop a sense of self-worth, and their illegal drug use and interactions within the drug world have shaped their life experiences and personalities. Levy and Anderson's (2005) sample displayed behaviours reminiscent of other older people, but within the drug world. They appeared to be committed to their drug careers, and 'like many older adults they prefer to age in place by remaining in a familiar socio-environment where they know the rules and what to expect' (p. 256). The authors note that their participants seemed committed to their drug use lifestyle, expressing a desire to stop using drugs. However this was frequently offset by the feelings of familiarity and comfort that drugs gave them. This was also a pattern identified by Pottieger and Inciardi (1981) who stated that their sample had become socialised into their own subculture as they had aged, principally as a mechanism for sharing social and cultural norms and as a result of their need for social support. Levy and Anderson (2005) also connect this pattern of socialisations back to work carried out with street drug users by Preble and Casey (1969), with drugs and drug use forming the core of their identity.

The transition among drug users involved in criminality to older age was found to be more difficult for women (Levy and Anderson, 2005), as many had been involved in sex work, which was becoming increasingly less likely to be an option, and for those who continued, it had become increasingly

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more physically demanding (see also Bourgois et al, 1997). It is therefore apparent that similar to older people in other forms of the labour market or any other life career, ageing had placed demands on their sample's physical abilities that they found difficult to maintain.

This describes well the concept of 'ageing in place' (Lanspery, 2002). The debate around 'ageing in place' is very new and has not begun to address the issues facing older adults and how ageing interacts with criminality (Wahidin et al, 2006). Anderson and Levy (2003) introduce the concept of identity change but place it in the context of a career approach - i.e. as part of a broader lifestyle. Wahidin et al, (2006) state that the issue of identity among older offenders is beginning to be recognised - particularly how older people in the criminal justice system can begin to shape their own identity. Also though what factors restrict older adults from reconstructing their identity away from a crime, after it has been shaped by time. Wahidin and Aday (2011) further argue that for older women involved in criminal activity this process of reshaping is even more complex as they are constrained by the sexist and ageist expectations, not only of their peers but what she believes to be the criminal justice system.

Older drug users and changes to physical health

Levy and Anderson (2005) highlight further important interactions in some situations between ageing and drug use that involved age-specific problems and challenges. Many problems connected to alcohol and drug use affect people of all ages, but problems such as abscesses at injection sites, stomach disorders, hepatitis, oedema, and inflamed or collapsed veins are more apparent and potentially more harmful in older people. Levy and Anderson (2005) also found that older drug users find these problems harder to manage because doing so competes with general problems more prevalent in older people such as arthritis, rheumatism, eyesight failure, and dementia.

Similar health problems were also identified in the only research so far undertaken among older drug users in the UK. Beynon et al (2009)

conducted a study into the 'self-reported health status and health service contact of ten illegal drug users aged 50 and over' (p.1). Nine men and one woman were recruited from drug treatment centres in Liverpool. All participants lived alone (six were single and four were divorced). 'Their accommodation varied; some lived in a hostel, others in their own home (council house, flat or housing association bed sit), one man lived in a care home and another lived in a caravan' (p. 3). The authors reported three patterns of use as their participants aged, these included, intermittent use characterised by peaks and troughs; long periods of abstinence followed by long periods of use and; continual use.

Beynon et al (2009) found a 'high level of physical morbidity; circulatory problems, respiratory problems, pneumonia, diabetes, and liver cirrhosis' (p. 3). Although many of these problems are visible in the adult population generally, and particularly in older adults (e.g. Sahyoun et al, 2001), the participants in the study seem to have felt that their problems had been exacerbated by their drug use.

Similar to Levy and Anderson (2005) and O'Brien (2008), Hepatitis C was also identified in Beynon et al's (2009) sample. However according to the authors, the drug users themselves did not see their infections as problematic or serious - they saw their health problems as the price they paid for their use. With long careers of drug use, some of the participants reported vein damage due to injection. In contrast to Levy (1998) who identified less risky behaviours in their participants as they aged, Beynon et al (2009) noted that rather than seeking help with their use, or adopting other, less-risky methods of administration, all of these users reported switching to more 'risky injection practices' (p. 4) such as injecting in the groin. Groin injection or femoral vein injecting has been linked with an increased risk of Deep Vein Thrombosis (DVT), leg ulcers and vascular insufficiency. Arterial injection is associated with arterial spasm and arterial thrombus formation (Maliphant and Scott, 2005).

Finally, Beynon et al (2009) discuss the experiences of the participants with general and with substance use-related healthcare services. Almost every participant reported having had negative interactions with a number of different healthcare services. All the respondents perceived this as the direct result of the negative attitudes of healthcare providers to illegal drug use, and particularly so to older users. This visible prejudice and associated stigma has also been recently identified by O'Conner and Rosen (2008) in a study examining the experiences of stigma in a group of older adults in a methadone maintenance programme. As with Beynon et al (2009) this included overt discrimination and the use and apparent normalisation of derogatory language.

Beynon et al (2009) do present some examples of their participants being cared for with 'compassion and sensitivity' (p. 7). While no indication is given to the proportion of positive versus negative perceptions, it does illustrate that not all of the participants' experiences were unfavourable. While Beynon et al's (2009) sample is small compared to the other studies cited in this review, it is important in that it is the first published qualitative study with older drug users undertaken in the UK. Clearly care should be taken to make generalisations from such a sample. However the patterns identified by the authors show a great deal of consistency with other research in this area. Also the authors state that their participants' experiences of specialist drug treatment services found many results consistent with those from work with younger drug users. This suggests a consistency which makes the findings valuable.

Differences in drug use by older adults from different ethnic groups

All of the studies mentioned above have touched on some potential differences between older drug users from different ethnic groups. Bourgois et al (2006) however used a multi-method approach with the specific aim of examining the patterns of drug use among African American and White males in San Francisco. This appears to be the only study that has

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specifically examined differences in the behaviours of older drug users from different ethnic groups.

The authors observed and interviewed 70 'street-based heroin injectors' (p. 1806) aged 45 and older over the course of six years. Bourgois et al (2006) describe what they call 'survival strategies' (p. 1806) apparent among their entire sample, making modifications to their drug use such as switching to sub-cutaneous (i.e. under the skin) injection. This was seemingly done as a health preservation mechanism to protect their already damaged veins, but had the converse effect by leading to an increase in skin abscesses. However they also report differences among the groups. The White participants considered themselves to be 'outcasts defeated by addiction' (p. 1805) compelled to continue using heroin to avoid experiencing negative withdrawal symptoms. The African Americans participants on the other hand were more likely to stress the pleasurable aspects of their drug use and their continued autonomy. Bourgois et al (2006) suggest that the African American users saw themselves as 'outlaws' (p. 1808) defining themselves positively by their drug use, as opposed to their White peers who reported feeling defeated by their addiction. All participants obtained most of their money through petty crime and offering services to non-users such as cleaning car windows.

This importantly, shows there is an interaction not only between ageing and drug use, but also between ageing, drug use and ethnicity. Bourgois et al (2006) recognize the difficulties associated with sampling from this population, acknowledging that their responses may be subject to bias by limiting their sample to 'one social network of older heroin injectors' (p. 1812). This was a larger sample of participants however when compared to the other studies found for this review and for qualitative studies more generally (Mason, 2010).

One of the weaknesses of this study however is that while it set out to describe drug use among older adults from different ethnic groups it only considered the drug use of African Americans and Whites. Analysis of data

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from a subsample of over 55 year olds from the National Household Survey on Drug Abuse (NHSDA) in the US (SAMHSA, 2001) found the highest levels of drug use among respondents self-classified as 'Hispanic'.

Differences in drug use by older men and women

Mixed findings have been reported when considering potential differences in the drug use behaviour of older men and women. The NHSDA in the US (SAMHSA, 2001) identified no significant differences in the drug use of males and females over 55 for any kind of illicit drug use. However data from the updated version of the survey - the NHSDA (SAMHSA, 2005) did report a significantly higher level of illicit drug use among males when compared to females. In contrast Rosen (2004) used organisational data to describe the characteristics of a group of 143 adult drug users over 50 reporting to a methadone clinic in the Midwestern US. No significant differences were reported between men and women but the study did find that men were significantly more likely than women to be receiving welfare and benefits. While Schlaerth et al (2004) investigated illegal drug use in a sample of client records of 107 adults over 50 who had presented themselves to a hospital Accident and Emergency department in Los Angeles. Cocaine was the most frequently used single drug (by 63% of the sample) followed by opiates (16%), marijuana, (14%) and barbiturates (7%). However their participants reported having used a range of drugs. Schlaerth et al (2004) note that men were more likely to use stimulants (e.g. cocaine and/or barbiturates) and women more likely to be opiate and/or benzodiazepine users.

Perhaps one of the most striking findings from this review has been the lack of research specifically aimed at examining difference between older males and females. Indeed Hamilton and Grella (2009) highlight this in their study of gender differences among older heroin users. They undertook eight focus groups with 19 men and 19 women over 50 in Los Angeles. They conclude that few differences existed among their sample's drug use behaviour, reporting 'overriding similarities related to the interactive effects of drug

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use and ageing and social relationships' (p. 9), stating any gender related differences to be modest, and those were mainly in the way that the focus group dynamics operated. However differences were observed in the way that participants reported the impact of their drug use. Women in the study tended to focus on how their use had affected their family (similar to Johnson and Sterk (2003) whose female participants seemed concerned about social norms) whereas men appeared to be more egocentric, focussing on their own health and wellbeing.

The assessment and treatment of older drug users

The previous chapter suggested that there are likely to be more older adults presenting for drug treatment over the next 20 years. It is therefore important to be able to identify those adults who need support when they encounter any statutory service, whether this is to intervene before their use becomes too entrenched or to help them manage their use. However the assessment and treatment of older drug users is also an area that appears to have received less attention compared to the treatment of younger age groups.

Hinkin et al (2001) evaluated the success of an assessment tool (a series of questions aimed at exploring the depth of an individual's drug use), used by medical practitioners for screening alcohol abuse, which had been modified to identify older adults with problem substance use. They found that the tool could accurately identify 'better than 9 abusers out of 10' (p.324), but that it could not accurately identify which the problem substance was, being more successful at identifying problem alcohol use. Nemes et al. (2004) also attempted to use an assessment tool to identify problematic older substance users. They explored the differences between the responses of adults aged 55 and over and those of younger adults (aged 18 to 54) to a computerised drug and alcohol abuse screening instrument. They found that of the 327 adults attending a medical facility in Washington D.C, older adults were less likely to see their use as a problem and more likely to see it as a 'moral

failing' (p. 640) rather than a health issue. Consequently, they were less likely to report their substance use problems and less likely to seek help for them. The authors conclude that the instrument is a useful way of screening substance use in older adults, although they admit that people who primarily used alcohol gave different responses from those who used illegal drugs.

A large part of the problem in identifying drug use in older adults is that the issues presented by them can be understated or interpreted by healthcare staff as what they believe to be general signs of ageing. Loss of physical mobility, loss of cognitive functioning and dementia - and the associated erosion of autonomy for example (Levy and Anderson, 2005) - or an observed increase in the likelihood of falls (Ziere et al, 2006) have been rationalised as the side effects of ageing. It takes specific probing and questioning to identify substance use problems through these apparent symptoms. The difficulty of diagnosis is highlighted by McInnes and Powell (1994), who found that healthcare staff could only identify three out of 88 problem users of benzodiazepines, 29 out of 76 smokers, and 33 out of 99 people with alcohol problems. McInnes and Powell (1994) concluded that the attitudes of staff to substance misuse, particularly in older adults, influenced their perception of how problematic an issue was. This is particularly important because Moos et al (1993) found that a significant number of patients over 65 who present with alcohol problems have corresponding drug use problems.

Treatment of older drug users

In a systematic review of literature relating to older adults being treated for addiction, Moy et al (2011) found only one study that fitted their inclusion criteria of older adults being treated for use of illegal drugs. This included all studies on the Maryland Scale. Firoz and Carlson (2004) examined the treatment outcomes of a group of 54 adults over 55 years old in a methadone maintenance programme, and compared them to a group of 705 younger adults. In a matched samples study, at the nine month follow up, the majority of older adults in their treatment group (61%) urine-tested

negative for illegal drugs, were employed, and showed no evidence of criminal activity. This was compared to just over half of the younger adults (35%). The study also showed that the level of chronic problems was greater among the older sample at the baseline stage, suggesting that treatment can be effective in older adults even with entrenched behaviours and social, medical and psychological challenges. The conclusions drawn in these studies of general substance use (traditionally alcohol and prescription drugs) among older adults are that older adults remain on treatment programmes for longer, drop out of programmes less frequently, and are more successful than younger adults at remaining abstinent for longer (e.g. Atkinson et al, 1993).

Satre et al (2004) undertook what they described as ‘the first long-term outcome study of older adults’ in drug treatment (p. 1287). The study aimed to compare the treatment outcomes of older adults aged 55-77 with those of a cohort aged 40-54 and a younger cohort aged 18-39. An initial finding from the study was that older adults remained in treatment programmes for longer. Satre et al (2004) then followed up the cohort five years later. They found that the older adult cohort were more likely to be abstinent after five years than either of the younger cohorts. The authors therefore suggest that older adults have potentially more favourable outcomes when following treatment compared to younger adults.

However there is evidence to suggest that they are less likely to be offered intervention. Moos et al (1993) undertook a study that aimed to examine the diagnoses and treatment received by late middle aged and older adult substance users. Because older users are more likely to have associated health problems and longer histories of substance use, they are also more likely to have specialist needs, particularly in relation to drug treatment. Moos et al (1993) divided a sample of 3,598 drug users from California hospitals into four age cohorts, 18-34; 35-54; 55-64; and 65+, and looked for differences in issues such as demographic characteristics, how they had been diagnosed, what drugs had been used, and what treatment they had received.

The authors found that the two older age groups (55-64 and 65+) were more likely to have a wider range of medical diagnoses. More than 80% had been diagnosed with at least one medical disorder (compared to 61% of the 35-54 year olds and 47% of the 18-34 year olds). They were more likely to have been diagnosed with ‘circulatory system disorders’, ‘nervous system disorders’, ‘respiratory disorders’ and ‘muscle and connective tissue disorders’ than those from the younger age groups (p. 483).

Whether this is an issue of misdiagnosis or actual illness is unclear but, either way, what is apparent is that older substance users potentially require a greater level of medical intervention. However, what actually happened was that older adults were less likely to get help for their substance use. Nearly twice as many of the 18-34 year olds (60%) compared to 33% of the 65+ age group and 50% of the 55-64 year old age group were found to have received a treatment intervention. This suggests that as patients got older they were more likely to need specialist healthcare but less likely to receive it. The authors state that medical healthcare professionals in the US do not allocate specialist services to older adults as perhaps they believe they will not benefit from them. Some authors suggest that implicit within this is the stigma with which older drug users are treated, not just in the US (O’Conner and Rosen, 2008) but in the UK also (Beynon et al, 2009).

Arndt et al (2005) also found evidence that healthcare providers might be failing older substance users. They compared the characteristics and admission routes, of a group of over 55 year olds, with those of adults aged 30-54 from the US TEDS. They found that older adults rarely gained admission to treatment services through healthcare professionals. Only 12% of older adults received a referral from healthcare providers compared to eight percent of the younger group. The authors suggest that this represents a ‘missed opportunity for healthcare professionals to make treatment referrals in the elderly substance-abusing population.’ (p. 391). They also noted the lack of specialist care and treatment for older adults with any form of substance use problem.

Conclusions from the literature review

This review has found that the existing evidence base of the social circumstances, drug use behaviour, and screening and treatment of older drug users is limited to a comparatively small number of studies examining different samples from highly diverse populations. However, some common patterns are observed. Some studies (e.g. Levy, 1998; Kwiatkowski and Booth, 2003; but most apparently by Anderson and Levy, 2003) have found that their participants did seem to become more watchful of their drug use as they got older. This meant tailoring or moderating their use because of their increased physical vulnerability (as hypothesized first by O'Donnell (1969) and then subsequently by Abrams and Alexopoulos (1988) and Stephens (1991)). Also even when participants in the studies reviewed seemed to be engaged in risky behaviours there was evidence that some still reported a measured or controlled approach to their drug use, and an awareness of their personal health (e.g. O'Brien, 2008).

It cannot be over-stated however that where similarities or differences exist this is just as likely to be as a result of the sampling strategies of the study authors, as observed patterns among older drug users more generally. For example in Pottieger and Inciardi's (1981) sample only one in three participants had finished High School compared to Levy and Anderson's (2005) research who found that just over one third had not. This could be a geographical effect with the latter study having been carried out in Chicago, a generally more affluent area than Miami; or a temporal effect with Levy and Anderson's (2005) study having taken place over 20 years later after general improvements in schooling; or Courtwright et al's (1989) study having taken place thirty years ago in New York City. While some of the drug users' motivations and the ways they manage their drug use are likely to have been universal, the cultural circumstances faced by one group of participants compared to another are likely to be different - particularly in a world of rapidly changing illegal drug use trends.

The variations among all of these studies are too great to infer any universal characteristics of older drug users. This is a logical conclusion given the nature of the studies themselves - all involve comparatively small opportunity samples. No qualitative study aims to be representative of the population, or even of a population of drug users. The authors themselves acknowledge this. All the authors concerned suggest that the nature of their snapshots means that further work is necessary in other geographic areas, with other samples, to provide a more complete picture. Particularly those at large in the general population, who are not, or have never been, in contact with drug treatment services. Ultimately what these studies appear to be describing in the main, are problematic drug use behaviours (which are likely to be a highly atypical extreme of one type of drug use) and participants responses to them. What is apparent from this review however is that there is still a limited understanding of how and why older adults use drugs in their 50s and over, particularly those in the general population.

Chapter summary

This chapter began by outlining the role of the literature review in grounded theory and outlined the method used for the review, including the inclusion criteria, search terms, databases and parameters. It reviewed the studies which have specifically aimed to examine drug use among older adults, drawing out the main themes from these studies, more particularly how they have, and continue to, monitor, manage, modify and adapt their drug use and behaviour. It then went on to present evidence which discussed the importance of identity in older drug users - and how changing physical health brought on by compound challenges of long term drug use and ageing, might affect their use. It finished by considering the assessment and treatment of drug use in older adults. It outlined the comparative successes which older adults can have with treatment interventions compared to younger groups, but also the challenges and hurdles they can face entering treatment and being treated. It finished with a summary of the difficulties one has in drawing conclusions from this ‘under-investigated’ (Satre et al, 2004, p. 1295) group, where the comparatively few studies which exist have

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almost exclusively taken place across highly diverse times and places. The overwhelming majority of these having been in the US.

Chapter 3. How and why people use drugs

Introduction

This chapter now considers how and why people use drugs. The first part describes research that elucidates how people of any age take drugs. To this end the concept of control is introduced as being of importance. More theoretical work is then presented on the concept of capital, which deepens the discussion of control, by introducing susceptibility to drug use. This also provides a potential link to the next section of the chapter, which discusses the potential reasons why people use drugs. The chapter concludes with a recent attempt by West (2006) to synthesize a range of theories to offer an attempt at a more comprehensive understanding of why people take drugs. This work is used as the theoretical framework for this study.

The process of drug use

Drug use careers

As the previous chapter showed, studies of older adults who use drugs began by suggesting that they matured out of their drug use (Winick, 1962), while subsequent research tended to adopt a life course perspective as the conceptual framework for understanding drug use (Hser et al, 2007), focussing on long-term (frequently chaotic or addicted) use. Most have concentrated on the transition from the earliest, experimental and casual, stages of use to more consistent and regular consumption over long periods, often leading to lifelong addiction (e.g. Biernacki, 1986; Faupel, 1991; Waldorf et al, 1991).

This has been characterised as a career approach to drug use, whereby people go through stages of development. Becker (1963) was among the first to apply this concept to illegal drug users by describing the process through which long-term cannabis users move from mainstream society into being outsiders, and how they cultivate this role. He found that cannabis-use

careers move through the three discreet stages of acquiring it, experimenting with it, and finally deciding to continue to use it. The previous chapter described how Levy and Anderson (2005) had applied this term to the addiction careers of their sample of drug users over 50. They found that long-term drug use was initially incorporated within a broader lifestyle that often included licit and illicit activities, but concluded that their sample eventually neglected these other aspects in favour of their drug use career. The study of drug use careers concentrates on the development of drug use through an individual's life, however as Ward et al (2010) point out 'the extent to which trajectories inform drug use progression remains largely unknown' (p. 755).

The non-linear nature of drug use

Hunt (1997) was among the first to identify the complexity of measuring illegal drug use over an individual's life, and the difficulty of applying a simplistic career metaphor. Subsequently the complex nature of drug use has been noted, suggesting that the career metaphor might not be completely appropriate (e.g. Heyman, 2009). Heyman (2009) describes illegal addiction as a 'chronic relapsing disease' (p. 81), the implicit assumption being that people who use drugs do so for long periods of time, frequently returning to their use after time away, and often against either their will or better judgement. This is suggestive of a cyclical, and potentially sometimes in/sometimes out pattern of use and non-use, rather than the classic definition of a career as a straightforward arc. Hathaway (2004) also described a 'cycle of moderate use, misuse and abstinence' (p. 403). While Galai et al, (2003) described drug use similarly but also from more of a medical perspective as a chronic disease, with long-term patterns involving a cycle of cessation and relapse - and what they described as multiple transitions from one phase to another.

More recently, attention has turned to examining drug use in its personal and environmental context. Duff (2007) has argued that while commentators accept the importance of social context in drug use, its role is not

completely understood however (Moore and Dietz (2005) in Duff (2007)). While Windle (2010) for example has taken a more ‘developmental, contextual approach’ (p. 124), and Henry and Thornberry (2010) have examined factors which effect ‘intra-individual change’ (p. 122) and the context of substance use among young people. These approaches focus on the interaction between large-scale or ‘macro’ factors that can influence individual drug use, alongside smaller or more ‘micro’, personal factors - where the changes in a person’s life such as psychological, physical and environmental changes, are seen as the strongest predictor of personal changes in substance use. At any one time these factors can affect how and why a person takes drugs, they may be different for each individual and affect different people in different ways (e.g. Chen and Kandel, 1998).

Accepting that life course factors play an important role in an individual’s drug use (and vice versa) means that there is a need to consider their current circumstances within the context of the rest of their life. This might be particularly important, as people grow older, where habits and behaviours change and develop, alongside their physical changes and those of their environment.

How people use drugs

The role of the drug, person and their social context in illegal drug use

Perhaps the earliest work to suggest that there might be an interaction between a range of internal and external variables in someone’s drug use was Zinberg (1984). Studying why some people became addicted to certain drugs at different times in different places, while others did not, Zinberg (1984) hypothesized that there were three important factors that dictated whether and how a person used drugs. These were: the ‘drug’, i.e. the type of drug and their effects; the ‘set’, i.e. each person’s individual psychological state, their previous experiences with and future expectations of the drug; and the ‘setting’ or the social and physical environment. Zinberg (1984) went on to argue that social controls, sanctions or restraint

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help an individual to maintain a level of control over any substance they are using. Zinberg (1984) was the first to challenge the notion that there were only two alternatives to drug use - cessation or unmoderated use leading to addiction. A more realistic understanding of controlled use, suggests Zinberg (1984), would see that however much of a substance people might use, they could always use more. This suggests even the most extreme drug use behaviour still has some level of control attached to it. This seems to offer a highly plausible explanation of how drug use progression and cessation operate, and illustrates how control is important to understand how people take drugs.

Controlling illegal drug use - individual and social control mechanisms

Whether some are able to use highly addictive drugs such as heroin in a controlled way, or whether they inevitably move into uncontrolled use remains unclear. Warburton et al (2005) reported mixed findings of controlled use from an online survey of heroin users. Of the 123 self-selected respondents 71% said that their use had caused them a problem at some point, and had taken up an increasing amount of their time. This is potentially an indication of escalating use. However it questions whether heroin users are the best judges of their own behaviour - what constitutes unproblematic to one person might be problematic to another, or to other people in their lives such as their friends, families, and employers.

There are however cases where those involved in drug use seem to have been able to design the licit and illicit parts of their lives to complement each other (Marshall and Levy, 1990). This might involve combining a long-term illegal drug career with running a business and being a spouse and parent for example. This was alluded to in the previous chapter. To enable people to do this, the process of more controlled use tends to involve a strong adherence to personal rules or regulations. Again, this relates back to Zinberg's (1984) description of the role of social controls.

Waldorf et al's (1991) study of heavy cocaine users reinforces this connection to social functioning and commitment. They found that the importance of social functioning and people's roles and life responsibilities outside of their drug use were the keys to managing or controlling regular cocaine use among their sample. They found that controlled users were more likely to have several different roles that gave their lives meaning away from cocaine. These roles helped to anchor their lives providing them with rules and routines away from drugs. McPhee (2013) also described how rules tend to include limitations such as using the drug no more than a certain number of times per week or only on weekends, rigorously limiting the amount used, never injecting, and using it only in the company of similarly casual users who are known and trusted friends. McPhee (2013) found that what he described as controlled users, actively avoided interacting with those whom they perceived to be addicted; they acquired their illegal drugs from certain trusted sources they perceived to be outside the drug world - working hard to maintain their distance from anything that might identify them as drug users.

This is a process reminiscent of 'othering' (e.g. Johnson et al, 2004) also known as 'moral distancing', which describes the tendency of people to distance themselves from others based on a belief they hold. Researchers have identified othering with drug users particularly. Rødner (2005) found that what she called 'socially integrated drug users' (p. 334) tended 'towards positive self-presentation' (p.334). Rødner (2005) found that her participants used the 'other' identity of the 'drug abuser' to 'provide a negative identity that reinforces the informants' desired self-presentation' (p. 333). By presenting themselves as 'other', distinct from what they felt were widely accepted identities of drug users, they distanced themselves from what they believed would be negative perceptions of themselves.

A frequently cited study of control and drug use was undertaken by Decorte (2001) who carried out a large-scale survey of long-term controlled cocaine users in Antwerp. Decorte (2001) continued the position initially described by Zinberg (1984) by stressing the importance of personal and social

attributes when it came to managing an individual's own use. He argued that pharmocentrism has captured the study of illegal drug use, and maintained that since all illegal drug users begin at the same level, the balance of whether their use tips towards controlled or uncontrolled use depends as much on their personal characteristics and social circumstances as the properties of the drugs themselves.

Those in Decorte's (2001) sample were most likely to consider periodic abstinence important for controlled cocaine use, followed by being able to refuse cocaine when offered it, using it in small doses and using it infrequently. A small proportion of Decorte's (2001) sample considered themselves uncontrolled users. The most frequently considered characteristics of uncontrolled use were bingeing, taking overly large doses, spending too much on drugs, lying about their cocaine use, and using it too frequently. Factors such as the amount of drugs that people used, and the frequency with which they used it were taken as markers for guiding individual drug use behaviour.

Decorte (2001) concluded that most experienced users recognise their rules and have knowledge about their drug use, and that this is most prevalent among people who use drugs in a controlled way. These mechanisms tend to be tacit and the people who implement them tend to do so unconsciously. Decorte (2001) argues that they act as 'boundary protection mechanisms' (p. 317) which helps them to maintain restrictions between themselves, their drug use, and the rest of their lives. Decorte (2001) finally concluded that many in the sample had shifted between controlled and uncontrolled use throughout their drug careers. Implicit from the participant's responses is that they seemed to have experienced periods of lack of control, but had learned from this experience and adapted their use as a result. Because of this Decorte (2001) concludes that it would be more accurate to think about controlled drug use as an ongoing process rather than something that is present or absent.

By emphasising that an individual's personal and social characteristics interact with their environment to modify their relationship with their drug use, Decorte (2001) seems to be describing drug use as a dynamic ongoing phenomenon, much as Zinberg (1984) had done. This suggestion that a combination of personal and social factors can influence an individual's substance use at any stage in their life is the foundation for the concept of recovery capital (Granfield and Cloud, 1999). This suggests a mechanism for how one individual with a slightly different background might be better able to control their substance use compared to another in an otherwise similar position. It stresses the importance of the personal and social resources an individual can draw on to manage their use.

Capital and recovery capital

Illegal drug use, while visible among people from all socio-economic backgrounds, is more prevalent among some groups compared to others (Home Office, 2013). However, the level with which it is experienced by people and the effect it has on them varies considerably (Cloud and Granfield, 2008). Granfield and Cloud (1999) introduced the construct of recovery capital in an attempt to explain why this might be. They posited that an individual's ability to manage their illegal drug use was connected to their environment, their personal characteristics and the resources available to them. They called these various resources, 'capital' and described four separate forms: (1) Social capital (drawing on the work of Bourdieu and Wacquant (1992) and earlier Bourdieu (1972) describing how far an individual is connected to others who can provide support); (2) Physical capital (e.g. financial resources); (3) Human capital (e.g. knowledge, qualifications, physical and mental health); and (4) Cultural capital (Cloud and Granfield (2008) describe this as the cultural rules developed by the individual through socialisation, including factors such as values, beliefs and perceptions). For Granfield and Cloud (1999), all of these factors contribute to the overall concept of recovery capital.

Granfield and Cloud (1999) assert that the degree to which an individual possesses each of these forms of capital can accurately predict their ability to manage their substance use, or recover from addiction. Those with more capital, they suggest, are better able to balance substance use with other aspects of their lives.

Cloud and Granfield (2008) have further extended their previous work to introduce the concept of negative recovery capital. This is where the presence of some factors can mitigate against the development of recovery capital, having a negative effect on an individual's ability to overcome or manage their use. They describe four factors that they believe may contribute to an individual's negative recovery capital: age, gender, mental health and physical health. In doing so their contribution is to outline the complexity of how an individual's personal characteristics, their experiences, circumstances, and place in their society can underpin their ability to manage and stop their substance use. They suggest that while certain groups and individuals might be susceptible to substance use their capacity to deal with the commensurate challenges it brings, differ markedly.

Recovery capital has also been identified as being important in helping to contribute to self-change and maintenance in a range of diverse populations where reduced capital might be expected, e.g. people with eating disorders (Vandereycken, 2012); gay and lesbian men and women with alcohol problems (Rowan et al, 2013); and prisoners re-entering the community (Lyons and Lurigio, 2010). All of this highlights that while individual differences in the management and control of substance use are important, structural factors also play a key role in helping to shape an individual's use. This suggests that people with access to more capital appear to have a greater ability to maintain control over their use. Their bond with substances appears weaker than those with less capital who might rely on substances for their personal and social needs (e.g. Åslund and Nilsson, 2013). Granfield and Cloud (1999) describe a process whereby an individual's level of control may be dictated by their level of personal and social coping

mechanisms. This could offer an important bridge between how and why people might use drugs, and in certain ways. Those with less capital available to them for example, might be more likely to depend on substances to cope with everyday stressors. This also then has implications for helping people who present with substance use problems – an individual's ability to control their use might be a function of the extent to which these needs can be met away from drugs. The next section will go on to describe aspects of why people use drugs.

Why people take drugs

United Nations Office on Drugs and Crime (UNODC) (1997) asserts that the reason people take drugs is ‘the most complex and heavily debated aspect’¹¹ in the field of substance use research.

Different disciplinary perspectives on why people take drugs

In his review of why people take drugs, Fields (2007) states that the earliest models of substance use in the US were medical, describing it as a disease with either genetic or biological origins. This emphasis initially dominated substance use research for a number of years. However, since the development and growth of the social sciences, and research into these disciplines, biological explanations have been supplemented principally by those from psychology and sociology. Some authors have subsequently sought to emphasize the role of economics in psychological theories but ultimately these theories still rely heavily on aspects of individual psychology such as choice and decision making (e.g. Becker and Murphy, 1988; Rasmussen et al, 1998). Authors who posit a psychological explanation to substance use see it as a behavioural problem or personality disorder with elements of individual adjustment, reaction and choice. While authors adopting a sociological perspective see substance use as socially or environmentally determined or exacerbated, with a heavy reliance on the cultural context (adapted from Pickens and Thompson (1984) and Abadinsky (2010)).

One of the earliest attempts at categorising or classifying drug use theories was undertaken by Lettieri et al (1980). In their extensive review for the US Department of Health and Human Services they presented 43 theories of drug use in over 350 pages, dividing them into four themed categories: ‘theories on one’s relationship to self’ (principally psychological approaches); ‘theories on one’s relationship to others’ and ‘theories on one’s

¹¹ http://www.un.org/ga/20special/wdr/e_exesum.htm. Accessed, Jan 2009.

relationship to society' (principally sociological and cultural explanations); and 'theories on one's relationship to nature' (principally biological or medical approaches). They assert that this reflects the division of the sciences from which the theoretical perspective is approached by each author. Subsequent reviews have found similar categorisations or classifications based on these disciplines. Other authors have further classified theories within individual disciplines (e.g. sociological approaches, Dull (1983); Sussman and Ames (2001)).

UNODC (1997) identified the most common drug-use models, which are principally those connected to the sociological, psychological, and medical fields - the social-environmental approach, which addresses the influence of social and cultural factors, the constitutional-personal approach, which addresses the influence of biological functioning and personality variables, and the interpersonal approach, which addresses the influence of family, peers and significant others. The report concludes that theories of motivations for drug use stem from the approaches taken in order to understand its aetiology. While more recently Fields (2007) outlined 10 different models that once again encompass the three principle disciplinary divisions: Medical or biological explanations (Disease model; Genetic model -adoption studies/twin studies); Psychological (Self-medication; Personality trait; Personality disorders; Mood and Affect disorders, Poor self-concept) and Sociological (Family model, Social learning, Socio-cultural).

What has been argued more recently is that no one approach or theory can explain the totality of every individual's drug use choices - a position presented perhaps most comprehensively by Goode (2012) in his recent thorough explication of 'Drug use in America'. Goode (2012) argues that most theories of drug use concentrate on very particular aspects of the phenomenon, adopting a single disciplinary perspective. It is probably more practical to conclude therefore that substance use arises out of a subtle set of reasons, motivations and choices that are affected by biological constitution, individual psychology, and social context or culture (Goode, 2012).

The practicality of a synthesised theory of drug use

As Goode (2012) concludes, a greater understanding of drug use would benefit from a more multi-disciplinary perspective. Any theory derived from this perspective would consider issues of initiation but also of continuation and cessation, particularly considering life experience and the affect of cultural and social factors. This would account for drug use across the entire life course and is directly pertinent to older people who use drugs.

A multi-disciplinary approach to understanding drug use

West (2006) asserts similarly that existing theories of addiction concentrate on specific areas but do not describe its development, progression, or the contexts in which it occurs. He developed what he calls ‘the first truly synthetic theory’ (p. 192) of addiction. His theory attempts to combine some parts of various existing theories, placing addiction within the larger framework of general human motivation, and then placing this in turn in the wider social context in which addiction operates.

West (2006) provides a comprehensive review of addiction theories, developing their history from learning (e.g. Bandura, 1977) and choice theories (e.g. Slovic et al, 2002) to more comprehensive theories of populations (e.g. Orford, (2001)). He covers a range of theories from different disciplines as crucial to the synthesis of his theory, dividing these into five categories, each of which forms an important theme: choice theories; impulse and self-control theories; theories of drug transitions; theories of habit and instrumental learning; and addiction in populations and comprehensive theories. While West (2006) still groups the theories, his categorisations are based on the outcome of the theory, rather than the processes that informs the theory, for example, there are both medical and psychological theories in the ‘theories of behaviour’ category. Theories of habit and instrumental learning also reflect elements of psychological and biological processes.

West's PRIME theory of motivation

While West's (2006) text begins with a review of existing theories of addiction his aim is not just to summarise what work has been undertaken in the area with a view to dismiss it. West (2006) presents each theory and then critiques it, identifying which parts he believes are useful, and thus assessing where the evidence gaps exist. As such the development of his own theory is seen as highly rational. His aim is to select the different parts of different theories which explain the totality of addiction and begin to bring them together into a major theory of addiction. This is why West (2006) calls his theory a synthesis of a theory - a 'pegboard' into which can be plugged theories at other levels' (p. 146).

West (2006) considers the principal construct with regard to addiction to be motivation, which operates on five different levels that interact with each other, but with the higher-level functions principally acting upon the lower-level. West (2006) calls this the Planning-Response-Impulse and inhibition-Motives-Evaluations (PRIME) theory of addiction. In stating that the concept behind PRIME is motivation it has applications beyond substance use and addictions - however considering the position of West's (2006) PRIME theory as a general theory is weakened by the fact that he does not provide any other applications of its use beyond this.

While PRIME is essentially built around motivation, the theory does span theoretical disciplines. West's (2006) initial starting position is that addiction begins with a corruption of choice (e.g. economic and rational choice theories), but moves through this to consider that the corruption of choice is affected by a complex interaction between an individual's neurochemical management (e.g. dopamine hypotheses) and their environment - through consideration of their learning (e.g. behaviourist and operant conditioning theories) and the role of personal and social networks and cultural dynamics (e.g. theories of socialisation and environmental susceptibility).

This highlights the breadth of coverage of the PRIME theory and for the first time offers a truly integrated multi-disciplinary theory which spans the three major disciplines which have previously sought to explain substance use at a general level - psychology (highlighting the importance of the self and identity); sociology (describing how individual identity is shaped by interaction with the environment; and biology (the influence of brain chemistry and its interaction within the unstable mind).

PRIME does not, however, seek to explain every aspect of addiction. West (2006) maintains that the strength of this approach is that it brings its concepts together on a broad, general level and integrates them with more detailed explanations of human behaviour informed by evidence and research. It concentrates heavily on human motivation, depending heavily on the elements of stimulus, efficacy, and control. It offers a logical structure for the inclusion of available and developing knowledge. Although it is a synthesised theory, one potential criticism might be that, similar to Orford (2001), its explanatory strength might be a weakness due to the difficulty of testing such integrated, whole theories.

In creating such a theory West (2006) has been accused of not addressing some of the finer points of addiction. While PRIME considers the role of environment and socialisation it does not address something as fundamental to the nature of drug use such as culture for example. EMCDDA (2013b) suggest that culture can play an instrumental role in influencing an individual's motivation to use drugs, both in terms of content and functioning and plays a key role in influencing individual and group behaviour. The absence of any mention of culture in PRIME is therefore particularly striking given that motivation and planning are central to an understanding of West's (2006) theory.

The discussion of the development of PRIME, while comprehensive is highly discursive. West (2006) presents evidence in places for the retention and rejections of part of each theory but does not consider them in detail. As

PRIME is pitched at such a general level it provides room for factors such as cultural and psychodynamic constructs, but West (2006) does not discuss their role himself. Taking the theories and plugging them into the pegboard at a very general allows for a number of potential inconsistencies within the theory but there is a potential criticism that it then becomes 'too inclusive for rigorous testing' (Redvers, 2007, p. 274).

As a practitioner Redvers (2007) states that the relevance of PRIME to the understanding and treatment of psychiatric disorders for example might be limited. While West (2006) presents a practical model of treatment for people with addiction the suggestions for intervention are pitched at a similarly high level - it is suggested for example that treatment sessions should be scheduled close together than currently available but there is no evidence to suggest whether this is effective or not. West's (2006) model for intervention also suggests a gradual regime for managing problematic drug use - changing an individual's identity as a problem drug user in order to change their behaviour - positing what is essentially a harm minimisation approach. However practical this might be, critics of this approach have suggested that it sends a message (particularly to young people) that taking drugs of any kind is acceptable behaviour (Leshner, 2008). Nevertheless more recent work has shown that changing an individual's beliefs about their addict role and thus their identity can successfully predict the success of their quit attempts (West and Fidler, 2011) - also correctly hypothesized by West (2006). However, West (2011) himself acknowledges that in terms of smoking cessation one area that the theory 'needs updating is the inclusion of direct imitation as a source of change' (para. 1).

PRIME is presented as a position statement on the current evidence base of addiction theories, with West (2013) having latterly said that the aim of further work is to test the theory and assess what needs further work or development. While his theory could therefore potentially be criticised for being more of a working hypothesis than a complete theory, it does represent possibly the most comprehensive attempt at a total theory of addiction available.

The suitability of West's (2006) PRIME theory as the study's theoretical framework

Prior to the study and during the initial and iterative literature reviews, a number of theories of drug use were assessed for suitability for the study's theoretical framework. As this chapter has highlighted this has included a number of theories which spanned a range of different disciplines. One of the themes of this chapter has been that researchers and authors developing theories of drug use have tended to do so while being guided by their disciplinary background, i.e. medical, psychological or sociological.

The first reason that PRIME was felt to be the most appropriate theoretical framework for this study was that it encompassed aspects of all of these disciplines. This was particularly important given that this researcher has a background in social policy and does not hold to a particular discipline. Given this position the intention to adopt a multi-disciplinary perspective to this study from the outset. This position was found to be characterised perfectly in West (2006).

The second reason for the suitability of PRIME as the appropriate theoretical framework for this study was that as the fieldwork progressed, West (2006) seemed to describe the nature of the developing core and major categories well. As chapter 2 indicated, the development of the iterative literature review took place alongside the development of the core category (*'taking a survivor approach'* and then *'achieving balance'*) and the major categories (*'managing lifestyle'* and *'altering feelings'*) during analysis, in line with grounded theory processes outlined by Charmaz (2006).

The developing analysis was revealing that an appropriate theoretical framework would need to offer explanatory power for issues such as: the role of motivation and control in drug use; the ongoing balance and management of external inputs along with how participants balance their drug use to prevent it from becoming problematic; how the participants

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managed (or not) what they called the drug user identity or in some cases the ‘junkie’ identity; and how individual environments might affect how these are shaped.

West’s (2006) coverage of these issues was found to be the most comprehensive of any theories assessed. It also offered two important differences which this researcher agrees with ideologically: firstly, that many drug use theories are only partial in their coverage and explanation of drug use and addiction (and that this partiality is frequently dictated by theorists’ disciplinary backgrounds); secondly, that it also offered a framework for helping people out of addiction pathways. It was found that as the study developed, practical support was expressed by some of the participants for different aspects of the framework.

Perhaps what was most striking about the synergy between PRIME and the developing findings was that as this study developed it became clearer as to how the different aspects of West’s (2006) theory offered explanatory power to the analysis. Chapter 8 offers a description of how the fundamental principles of PRIME are reflected in this research study.

Chapter summary

This chapter began by stating its intent to explore how and why people (particularly older adults) take drugs. Research to consider how people take drugs has historically concentrated on a traditional pathway of drug use – that an individual begins by taking drugs when they are young and then either stops or descends into problematic use. More recently a life-cycle and intra-individual approach has been taken in attempting to understand the process of drug use, whereby the reasons for an individual’s initiation and continuation into, or abstinence from drug use, are considered multi-factorial (e.g. Manning et al, 2001). The interaction of these might include macro and micro, positive and negative, protective and risk factors that are open to considerable variation over the course of their life.

The motivations for why an individual takes illegal drugs are perhaps the most widely researched topic in the field of substance use. They are also equally multi-factorial. The second half of this chapter started with the suggestion that authors have tended to be influenced by their disciplinary perspective, when exploring this. Historically the motivations posited for using illegal drugs have tended to be biological, psychological or social. The last part of this chapter described a more recent approach taken by West (2006) who has aimed to provide a multi-disciplinary theory which outlines one possible framework for the processes and motivations of substance use and misuse. In doing so it offers a strong framework for understanding drug use in older adults.

The next chapter will now present the methodological position and method for the study.

Chapter 4. Study methodology and method

Introduction

This chapter describes the methodology and the method for this PhD study. The first part of the chapter describes constructivist grounded theory as the methodology, providing some background to the development of the approach. The chapter then examines the practical application of grounded theory as the method and describes the processes through which the data for this study were obtained. It then considers some ethical issues concerning the sensitivities involved in interviewing the participants. It finishes with a description of the development of the core and major categories.

The development of symbolic interactionism

To completely understand the values and beliefs that underpin the methodological approach and the method for this PhD study it is important to describe the development of symbolic interactionism, as it was George Herbert Mead's (1934) work that first influenced Anselm Strauss and Barney Glaser to develop grounded theory (Stern et al, 1982). Their aim being to develop a methodology that drew on but at the same time challenged the dominant empirical ideology, suggesting its foundations were open to interpretation.

To understand society and social processes Mead (1934) believed that it was vital to immerse oneself in the surroundings of what one was aiming to study. The conclusion of that point of view was that there was no single reality, and meaning in any social setting was negotiated. This led Mead (1934) to develop his social construction theory that asserted that the human mind was developed as a result of the interaction between society and the individual, and this interaction was socially constructed.

Mead (1934) saw language as central to this, writing that communication was the key to intelligent and social behaviour. Blumer (1962) took Mead's

(1934) work one step further and asserted that individuals are 'a continual flow of self-indications, notions of things with which he deals and takes into account' (p.182). This is the interaction between the self and then society, which develops meaning, understood by symbols and formalised through agreement. Crotty (1998) states that 'only through dialog can one become aware of the perceptions, feelings and attitudes of others and interpret their meanings and intent' (1998, pp.75-76).

Symbolic interactionism and constructivism

The theory of knowledge that underlies symbolic interactionism is the epistemology of constructivism (Crotty, 1998). This is the assertion that human understanding through acquired knowledge is constructed through interaction in society and in the world. As with symbolic interactionism humans interact with the world around them and create a reality which they ascribe meaning to. Constructivist epistemology maintains that scientific knowledge is constructed and not discovered. King and Appleton (2002) state 'this mode of inquiry offers researchers an opportunity to examine in detail the labyrinth of human experience as people live and interact within their own social worlds.' (p. 642). The importance of constructed reality runs consistently through constructivism. Stringer (1996) states that this negotiated reality results in 'sense-making representations' (p. 41). For Schwandt (1994) it is constructions that help people to understand their reality and ascribe meaning to their environment.

Symbolic interactionism and the development of grounded theory

Glaser and Strauss (1967) were critical of Blumer's use of qualitative research and the application of symbolic interactionism. They were particularly critical of the use of data to verify theory. Their stance was that as meaning is derived from interaction data should be gathered as a 'legitimate exercise' (p.7) and theory objectively drawn from meaning. This led Glaser and Strauss (1967) initially to break away from the symbolic interactionist tradition and develop their own methodology which initially

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attempted to bridge the gap between traditional empirical methods and more constructivist qualitative research methods. To understand the development then of grounded theory it is important to understand the criticism of symbolic interactionism in the early 1970s by Gouldner (1971) for example, when the dominant approaches to sociology in the US were structural and quantitative. As a result of their development of grounded theory Glaser and Strauss (1967) attempted to posit not just a method of gathering and analysing data but a methodology for placing how that data is gathered.

The development of grounded theory

Grounded theory emerged in the late 1960s, developed by American sociologists Barney Glaser and Anselm Strauss. The approach was first used in the study 'Awareness of Dying' (Glaser and Strauss, 1965) and led to the publication of 'The Discovery of Ground Theory' (1967) which explained the grounded theory methodology. Glaser and Strauss had sought to develop an approach for using qualitative data to generate theory through the process of collecting and analysing data, without any preconceived ideas or hypotheses. In this sense it was in direct opposition to the use of experimentation and positivism (i.e. the belief that all things are knowable and quantifiable through neutral observations, which forms the basis of predictions) which prevailed in the social sciences at that time (see Blaikie, 2007 for example). Grounded theory aimed to use more structured rules and steps to develop what is termed 'formal theory' (a theory that crosses boundaries or disciplines) - something that previous qualitative approaches had not sought to do. In this sense it has been seen as an attempt to bridge the gap between more empirical quantitative research and more specific meaning orientated ethnographic study (Goulding, 2002).

Glaser and Strauss (1967) felt that too much emphasis had been placed on discovering overarching theories using the hypothetico-deductive method (the arrangement of propositions in a hierarchical way so that one logically follows another to create a theory or model). They felt that these theories were not truly representative or meaningful as they were not developed from

data. Glaser and Strauss (1967) suggest that their approach made the theories they developed more practical and meaningful in the real world. After their initial collaboration in the 1960s however, Glaser and Strauss began to interpret and develop the application of grounded theory in divergent ways.

Overview of the various adaptations and inconsistencies in the application of grounded theory

Throughout the 1970s and 1980s Glaser continued to assume an objective reality in his application of grounded theory (Glaser, 1978). His position is often referred to as being closer to traditional positivism (Echevarria-Doan and Tubbs 2005). Strauss on the other hand (e.g. Strauss and Corbin, 1998) saw his position as different on one fundamental issue - he now felt it was impossible for researchers to divorce themselves from the subject under investigation.

The beginnings of the grounded theory continuum

According to Charmaz (2000) this led to grounded theory becoming polarised along a 'continuum' (p. 510) - at one end of this continuum was the more traditional objectivist approach advocated by Glaser (1978), while at the other the beginnings of a newer, more constructivist approach, advocated by Strauss (Strauss and Corbin, 1998).

A more deductive approach to grounded theory ignores the social context of the data collection, how the data are gathered, any influence of the researcher and the interaction between them. A researcher adopting this approach would likely assert that all data represents facts about the world that are objective and knowable. In this tradition the facts already exists in the world, it is up to the researcher to find them – they discover the theory that already existed and their role is to act as a reporter (e.g. Glaser and Strauss, 1967; Glaser, 1978). In contrast to this the characteristics of a more

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inductive or constructivist interpretation of grounded theory reflects how the researcher interacts with the data (Charmaz, 2000).

During the 1990s and at the turn of the 21st century more authors had begun to accept Glaser and Strauss's original invitation in 1967 to interpret and use grounded theory flexibly (Seale, 1999; Charmaz 2000; and Bryant, 2002). It is Kathy Charmaz (2000) however who is credited with taking Strauss' constructivist ideas of grounded theory, developing and refining the approach.

Charmaz and the development of constructivist grounded theory

Charmaz first outlined her approach in Emerson's (1983) 'Contemporary field research', and then developed her position further in the chapter 'Constructivist and objectivist grounded theory', in Denzin and Lincoln's (2000) 'Handbook of Qualitative Research'. In it she asserts that it is possible to use the basic grounded theory guidelines and interpret them with new and revised assumptions. These assumptions began the development of the constructivist/interpretive grounded theory approach. Charmaz (2000; 2006) suggests that it is impossible for researchers to remove themselves from a situation and the mere act of their presence will affect it. As a result, objectivity will always be unobtainable. She believes that the grounded theory researcher should remain sensitive to different and alternative realities and viewpoints. The interpretation of any data and final theory will inevitably be arrived at through the experiences of the researcher and their interaction with the world. It is her assertion that grounded theorists do this from close to the experience as can be achieved realising and accepting that it is impossible to know or replicate the experiences of the participants.

Charmaz (2006) acknowledges that any theory developed because of a grounded theory study is only ever a researcher's interpretation of a participant's reality. She asserts that the theory depends on the researcher's view and can never be separated from it. Different theorists can essentially come up with different views of the same data. For the first time Charmaz

(2006) asserted that grounded theorists needed to consider the environment in which any study takes place, and the background of the researcher themselves. She moves the constructivist position yet further away from Strauss and Corbin's (1998) early constructivist developments by asserting that only someone with experience of the study situation can actually lend a deeper understanding to a study. Anything that is experienced and relayed by the participant and observed by the researcher is bound up in the values of the researcher. Charmaz (2006) asserts that researchers using a constructivist framework need to be aware of their own values and how this may influence the outcomes.

Cooney (2010) states that the growth in popularity of constructivist grounded theory reflects a wider movement towards a general constructivist thinking within the social sciences, asserting that this style of analysis is more 'compatible with contemporary thinking' (p. 21). Cooney (2010) suggests that in doing so constructivist grounded theory can offer an analysis of social context at the same time as a framework to understand the personal and individual.

The theoretical basis for adopting a constructivist grounded theory approach for the study

The theoretical approach adopted for this PhD study is that outlined by Charmaz (2000; 2006), which takes an interpretive/constructivist approach and is felt to be more pragmatic for real world research (Lomborg and Kirkevold 2003). It will seek to identify the perceived reasons for these participants' drug use, along with their experiences, and examine the conditions under which these experiences have taken place. It acknowledges the presence of the researcher and their interaction with the data. These issues are made apparent and reflexively examined throughout the course of the study. Rajendran (2001) for example highlights the importance of undertaking constant reflective processes in developing any qualitative study. The processes described in the grounded theory method are ideal for this. At its foundation constructivist/interpretative grounded theory is felt to

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be a suitable and appropriate methodological framework for this study because of the unique perspective it offers to frame the experiences of the research participants, while providing an understanding of the structural processes in which they exist.

The selection of grounded theory as the study method

The heading qualitative research covers a wide range of methodological approaches. Tesch (1990) identified 27 different kinds of qualitative research from diverse disciplines. She describes how these different kinds of research are frequently underpinned by an author's epistemological position, with each growing out of different philosophical backgrounds, and based on different assumptions (see also Reicher, 2000). This can mean that a researcher's choice for adopting a certain kind of method can often be ideological as well as pragmatic. The next section describes how a combination of these factors indeed led this researcher to select grounded theory as the appropriate method for this study.

This researcher's personal position and ideological reasons for choosing grounded theory

Possibly the most important reason for the selection of the style of grounded theory used in this study was this researcher's own personal beliefs about how the world is structured and how knowledge is gathered - particularly that an objective reality does not exist but is instead constructed through interaction and interpretation. It was felt that this is particularly the case in qualitative social research where knowledge is constructed through interaction and negotiation between researchers and participants. As such Charmaz's (2006) view that elements of knowledge generally, and grounded theories particularly, are inevitably constructed 'through our past and present involvements and interactions with people, perspectives, and research practices' (p. 10). Because of this belief this study does not assume an objective reality divorced from its surroundings and context; instead it

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seeks to develop a representation of an interactive process that aims to consider issues such as the time, culture and situation in which events occur.

This researcher feels that his world view fashioned the study in the following ways:

- Dictating the research area (drug use in older adults through personal interest) and the research framework (methodology and research strategy).
- Directing the study through semi-structured interviews (a desire to understand the world view of the participants).
- Influencing the way the findings were interpreted and presented (Guba and Lincoln 2005).

Lomborg and Kirkevold (2003) suggest that Charmaz's (2006) approach allows for the interpretation of the researcher and acknowledges their position in the study. This was felt to be particularly important when it came to studying an issue where this researcher had no past experience - that of an older drug user engaged in clandestine and criminal behaviour. This researcher has experience working in the field of substance use but not directly as a service user. As a result it is strongly felt that it is not possible to understand the position of the participants from an objective reality. Instead any understanding derived would always be an interpretation of the lived experience of the participants.

This researcher strongly agrees that it is the participants in the study that have the expertise about their own situation - it is therefore their own understanding of the situation that this researcher sought to elicit. Participants over 50 will have developed their world views based on a number of years life experience, and it is believed that an understanding of how these experiences shape their reality are central to understanding the answers to the research questions.

It was felt that the study outcomes in this thesis could only be achieved with participants acting as guides through their own realities. In allowing them to do so it also aims to address the criticism of constructivist approaches that they concentrate on micro-level aspects of human interaction and social life and do not provide accounts of structural processes. While this study concentrates on micro-level processes (the lives of older adult drug users) it also seeks to place their lives in context within their social world. It aims to report on their realities and explain how they are shaped by structural factors such as their personal and social circumstances, their available capital and the nature of their interaction with the social world.

Seeking to empower the participants as the study experts also reveals this researcher's political opinions in the desire to give a voice to older substance users, termed by Anderson and Levy (2003) as 'marginal among the marginal' (p. 762). Mills et al (2007) assert that grounded theory provides an excellent framework for marginalised groups as it is often useful to use in studies where little is known about the personal and social situations of groups under investigation - in essence giving voice where one previously had not existed (this is discussed further below).

Pragmatic reasons for choosing grounded theory as the study method

Constructivist grounded theory was also viewed as the pragmatic approach for the study, by providing a synergistic fit with the main aims of the research – to understand and capture the subjective worldviews of the participants. As such a subjectivist epistemology (participant and researcher create understanding through negotiation) was felt to offer a neat fit (Denzin and Lincoln, 2005). There are three main pragmatic reasons why constructivist grounded theory was adopted for this study.

1) Grounded theory provides a framework for studies where key concepts or variables may not be known

As touched on above, grounded theory offers a framework for a data driven methodology (Cooney, 2010) which is particularly useful for exploratory studies where the issues that might explain the phenomena are not immediately apparent. Grounded theory offers the researcher a systematic process to enter the data collection process from the data, which may not have been considered initially important. By building connections it is then possible to find explanatory power in the data and build theory.

Constructivist grounded theory particularly offers the greatest level of flexibility, allowing the researcher room for their negotiated, participant driven approach.

Chapter 2 highlighted the dearth of studies in the area of older drug use. The research found the literature review touched on some of the demographic characteristics of small samples of older adults who use drugs in the US, and provided only a general description of their drug use and behaviour. As a result this researcher decided that the questions for this PhD study would concentrate on these two key areas. Establishing background information of the participants, for example where they were living and who with, whether they were working etc. This would provide the important context for understanding the later, more detailed questions about the nature of their personal use, understanding their drug use behaviour in more detail.

2) Grounded theory provides a structure for building categories into concepts to develop theory or models out of this derived data

The second pragmatic reason as to why grounded theory (and particularly constructivist grounded theory) was chosen as the appropriate approach for this study is that it offers a series of steps for developing qualitative research (as stated previously this is also particularly useful when it comes to studies which might be exploratory).

While there are differences between the various styles of grounded theory, all proponents agree on what constitutes the main features of the grounded theory method. Glaser and Strauss (1967); Glaser (1978); and Strauss

(1987) state that the defining features of grounded theory are, the supplementary literature review (discussed in the previous chapter); coding from data; theoretical sampling; the constant comparative method, theoretical saturation; memo writing; and theory development. These characteristics were rigorously adhered to throughout this study and their practical applications are described throughout. However Cooney (2010) suggests that those who adopt a more constructivist approach to grounded theory are generally attracted by the clearer guidelines for data analysis (see also McCallin (2003) and Heath and Cowley (2004)) and the need for more flexibility. This was the case for this researcher who felt this approach suited the needs of the study most appropriately.

3) Grounded theory provides for building process and context into the study approach

Within grounded theory, process is defined as ‘the linking of sequences of action/interaction as they pertain to the management of, control over or response to, a phenomenon’ (Strauss and Corbin, 1990, p. 143). It was felt that grounded theory would offer a way of accounting for or explaining the development and change which inevitably occur over a person’s life. Process might involve analysis of the conditions and actions that move the drug user from one phase to another and the analysis of any adjustments made by drug users in response to changing conditions in their life circumstances. Again, this is particularly important for understanding the context of personal drug use. The fact that grounded theory would also allow for the production of a theory or model of drug use in older adults was felt to be propitious, as it would help to add abstract explanatory power to the findings. Again this researcher felt that the flexibility afforded by the constructivist grounded theory approach would provide the framework to achieve this most effectively.

Because of its concentration on process, grounded theory requires the researcher to examine the context of the issue under study - assessing the individual’s place in their surroundings, as expressed by Charmaz (2006)

above. For this study this meant looking at how the participants' drug use behaviours might be influenced by the people around them, their families and friends, their personal background, and their previous and current socio-economic status. This meant that the context of how the participants operate with other drug users, buyers and sellers was considered, along with how they interact with external forces such as enforcement (e.g. the police) and other agencies (e.g. health and social care).

In summary, and considering the methodology and epistemology, grounded theory was chosen as an appropriate method for this study from a constructivist/interactionist perspective - offering a synergistic fit between the ideological stance of this researcher and the pragmatic requirements of the study. The remainder of this chapter will now describe how the grounded theory method was applied to this PhD study.

Application of the method

University ethics approval

Before any work with human participants could be conducted, approval from a university ethics committee was required. Permission to carry out the study was sought from the Oxford Brookes University Research Ethics Committee (UREC) on 29th January 2008. A full research proposal was sent to the committee for scrutiny, outlining a description of the research, the processes to be undertaken and the research questions. A recruitment advertisement (Appendix 2) and Information for participants sheet, given to potential participants prior to interview (Appendix 3), were also presented to the committee. The study was given approval, subject to minor revisions, on the 8th February 2008. The ethics committee stipulated that the comfort of the participants should be paramount, and any interviews should not be undertaken in the participants' own homes. A letter was sent to the ethics committee by the researcher accepting these revisions.

The development of the interview schedule

After ethical clearance had been given the interview schedule was developed. This was undertaken in stages. A first draft interview schedule was developed based on the research questions and knowledge gaps identified through the literature review. The aim at this stage was to develop a number of prompts and probes that would then be tested on exploratory participants. The order of the questions was also considered at this stage. This researcher decided that the easier contextual questions would be asked at the beginning with the more personal questions being asked as the interview progressed. Seven key question areas were developed with a minimum of 37 questions, not including prompts (Appendix 4).

Exploratory fieldwork with the interview schedule

An exploratory interview was undertaken using the initial interview schedule shown in Appendix 4, with a service user who was a personal contact of this researcher. When the interview was completed a cognitive interview (Geiselman et al, 1984) was undertaken to test the participant's interpretation of the questions. A cognitive interview is a separate interview with a research participant after the main interview. The interviewer works through the study instrument with the participant asking them what they understood by each question and what they felt they were being asked. This process enables the interviewer during exploratory fieldwork to assess whether the appropriate wording is being used to elicit the data they require. This had two aims, to get an understanding of what the participant felt they were being asked; and to confirm the internal validity of the interview schedule (asking the participant what they understood by the questions being put to them, ensuring that the appropriate issues were being addressed). The cognitive interview also provided the opportunity to ask whether the participant felt any of the questions were intrusive or caused offence.

After the first exploratory interview this researcher felt that the interview took too long. In addition, the structure and timing meant that it was difficult to explore issues in detail. Firstly this researcher felt that it took too long to get through the contextual data (i.e. social demography) to the drug use questions which were of most importance. Also the structured approach often meant that the participant seemed to be breaking off from exploring some issues in detail as a result of feeling that they needed to explore all the questions. The responses felt somewhat clipped and brief.

Further refinement of the interview schedule was then undertaken as a result of the first exploratory interview. A more open-ended schedule was developed with topic areas listed as guides. This researcher felt that this would be more conducive to eliciting the rich data required by the grounded theory approach. The schedule was shortened, not only to allow more time to discuss the main questions but also to enable the gathering of data which would answer the more contextual questions about personal circumstances.

A second exploratory interview using this revised version of the interview schedule was undertaken with another personal contact of the researcher. A cognitive interview was also undertaken with this exploratory participant. This approach seemed to work much better. Although this exploratory interview took slightly longer than the first, it seemed to flow more naturally from subject to subject. The subsequent cognitive interview confirmed this. Following the results of the cognitive testing, this researcher decided that the more open-ended version of the interview schedule would be used in the study. The main topics were: current social circumstances, whether and how this has changed; current drug use (all factors that might describe 'how' the participants are using drugs, e.g. what drugs, frequency, amount); perceived reasons for current drug use; exploring any changes to the participant's use, recently and over longer periods (further exploring any reasons for this); periods of abstinence; and feelings about the future. The full interview guide is shown in Appendix 5.

The use of intensive interviews

Charmaz (2006) feels that the use of intensive interviews is the most conducive method for gathering rich data for a grounded theory study. She advocates giving the participant time and freedom to reflect upon their experiences in ways that seldom occur in everyday life. As Wragg (1978) points out, the semi-structured interview schedule tends to be the one most favoured by researchers adopting a more interactionist perspective. This allows participants to express themselves at some length, but offers enough shape to prevent what he calls 'aimless rambling' (p. 185).

Sampling and interviewing

In the grounded theory approach, the process of theoretical sampling is used to develop a study sample. Theoretical sampling was originally developed by Glaser and Strauss in 1967 as a way of identifying how research cases are chosen for grounded theory studies. An initial case is selected which it is felt will best provide data to answer the research question. Subsequent cases are then chosen after data from this case are analysed. When carrying out theoretical sampling, people, events or information are sought to illuminate and define the initial, and then subsequent, categories (Charmaz, 2006). The aim of theoretical sampling is not therefore to develop a representative spread of an occurrence, as in quantitative methods, but to look in detail at a given phenomenon and explain and describe the process behind it.

The sample then emerges as the study progresses and the data are analysed. As categories emerge from the data, the researcher continues to sample cases to explore the depth and structure of the developing categories as fully as possible. This strengthens the emerging findings by explaining how the different categories relate to each other. Morse (1989) asserts that the quality of any research is fundamentally affected by the selection of the sample. At the beginning of a grounded theory study all that is required is

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that the opening case is directly relevant to the study¹². Subsequent cases are selected to follow up ideas that develop in the data (Charmaz, 2006). Strauss and Corbin (1998) call the initial case the ‘departure point’ (p. 205). It is from this point that the selection of sampling points develops, according to the emerging data.

For this study a theoretical sampling strategy was developed in line with grounded theory principles, to obtain a broad and diverse initial sample that it was hoped would facilitate access to further potential participants. Letters and emails were sent to all independent, non-abstinence drug treatment and drop in centres, and needle exchange centres dealing with adults over 18, in London initially (where the researcher is based), and then across England, promoting the research as a piece of work aiming to understand the lives and circumstances of older drug users. The recruitment advertisement (Appendix 2) was sent via email requesting help identifying potential participants. All centres were identified through the DrugScope online directory (<http://drugscope.soutron.com/helpfinder.asp>) and through DrugScope’s ‘Get involved’ page (<http://www.drugscope.org.uk/resources/get-involved.htm>). Those agreeing to help were asked to place recruitment adverts in the centres. The staff of participating agencies were also asked if they would be willing to promote the research to their clients. The study was also promoted via word of mouth to health and outreach workers and to members of the London Drug User Forum, who circulated publicity materials at their meetings.

Advertisements were placed in the following newspapers and periodicals, Kensington and Chelsea Informer, Camden New Journal, Ham and High, Croydon Gazette, East London Adviser, The London Student, The Mature Times, (Appendix 6); and adverts and publicity were placed on the following websites, internet forums and internet message boards, Black Poppy, British National Formulary, CCNewz, DrugScope, East End Drug

¹² For the purposes of this study the only criteria that needed to be fulfilled to ensure inclusion were that the participant be an older adult (in this case over 50 years of age), who had taken a class A drug in the previous month.

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Forum, Independent Drugs Monitoring Unit, Methadone Alliance, Release, Substance Misuse Management in General Practice, Transform and Urban 75 (Appendix 7).

Apart from the two exploratory cases, at no stage was anyone approached initially by this researcher to talk about their drug use. The participants for the exploratory fieldwork were recruited via opportunity sampling through personal contact with active drug users. These participants were under 50 years old and so not eligible for the full study. They were recruited to test the flow of the study instruments and what potential participants might understand by the questions.

All publicity materials and advertisements gave contact details for potential participants to contact the researcher if they were interested in taking part in this study, and all clearly stated the study's inclusion criteria - that participants had to be currently over 50 years old and had used a class A drug in the last month.

Accessing the sample

Drug treatment services

Sixteen of the participants in the final sample were accessed through their engagement with drug treatment services. These participants were currently accessing a range of drug treatment services in order to help them with their drug use.

Ten were seeking help as a result of their heroin use. These participants were a mixture of referrals to drug treatment services by their GP and self-referrals. The drug treatment services were nearly all administrated by national and local charities and other third sector organisations, however three participants mentioned private treatment services they were accessing. All participants who were receiving help for their heroin use from drug treatment services were either undertaking methadone reduction or

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maintenance programmes which were aiming to stabilise their drug use in order to be able to deal with the other challenges in their lives. Some participants were also receiving naltrexone (which blocks the effects of opiates like heroin). Participants generally talked about having to take these prescriptions under supervised conditions at their treatment centre (which was one way they heard about the study).

Some participants were also involved in a mixture of one-to-one counselling sessions with drugs workers, psychologists or counsellors, and other support groups. Four participants for example talked about being involved in what they called 'self-help' groups, which involved regular contact with other drug users. Again these were administered by local drug treatment agencies which were another route the participants heard about the study. In some cases some participants attended these groups more than once a week. Two participants were currently trying to establish their own groups for local service users.

All participants who were receiving treatment for their substance use talked about having a key worker (in some cases this was a doctor, a nurse or a drugs worker) who managed their treatment. Some participants had heard about the study through their key worker.

Six participants were seeking help for stimulant use; four were engaged with treatment services in order to manage their amphetamine use, while the remaining two were seeking help with crack and poly-drug use of stimulants. A number of these participants talked about their frustration at what they felt was a lack of appropriate treatment for people who were using stimulants. Participants talked about a range of services they were engaged with and interventions they were experiencing, these included: counselling and therapy; prescriptions for muscle relaxants, anxiety and depression; and what they called 'alternative therapies' such as acupuncture. Again these participants heard about the study directly from the organisations administering their treatment.

In general these participants' contact with drug treatment services seemed to be related to their vulnerability. While none were engaged on an in-patient basis some described situations (such as homelessness coupled with chaotic injecting drug use and drug-related health care challenges) where they were being helped by a range of health care workers sometimes once a day or once every other day. All of these participants except for three either self classified as unemployed or economically inactive. Those in work and receiving a high level of intervention were either working in the drug treatment field or self-employed.

All of these participants were accessed directly through the various different drug treatment centres they were attending. In all cases the work had been publicised by local drug treatment charities, either through the advertisements circulated directly by this researcher or through word of mouth from other colleagues or their management structure. Some participants who were interviewed for the study mentioned that their drug worker felt their involvement could help their treatment - i.e. by talking openly about their drug use to a third party who had no engagement (and therefore no perceived agenda) with their treatment.

Throughout the course of the study this researcher continued to contact those drug treatment centres who expressed an interest in the work, in an attempt to boost the sample but also to build positive working relations. This contact was undertaken by email, telephone and face to face. This researcher made 18 visits to drug treatment centres across England to talk with agencies and staff about the work. On three occasions presentations were also given to treatment centre management boards. This researcher also kept in regular phone contact about the progress of the work and the emerging findings from the study with those centres and agencies who were actively involved in recruiting potential participants. These were said to be valued a great deal.

Social media

The remaining 14 participants were accessed through various different social media. This involved a combination of participants contacting this researcher as a result of either having seen adverts placed on internet bulletin boards, information sites or internet chat sites.

Over the course of the study 10 participants were recruited using internet bulletin boards or information sites. This involved logging onto sites and requesting access as a subscriber or user. Once access was given to the site the appropriate place was sought to leave a message advertising the research. This researcher then copied the internet message board advert (Appendix 7) into the appropriate place where it would be seen by most visitors. The researcher set up email alerts which alerted him as to whether anyone had replied to the advert within the site itself. In all cases the potential participants initiated contact directly via the email address on the advert. Fifteen responses were received in this way. Ten of these responses led to interviews while the remaining five did not fit the eligibility criteria (they were either younger than 50 or had not taken a class A drug in the last month).

The remaining four participants were recruited using internet chat rooms on the following websites: Urban 75 Chat; CCNewz; and Lifeline. These were found via internet search engine using the search terms 'illegal drugs' and 'chat room'. In order for this researcher to have access to the sites' chat rooms a profile was required.

Fernández et al (2004) found that gaining access to people who use internet chat rooms for online recruitment was challenging - with differing views among their participants about the need for chat room profiles. However Silvestre et al (2006) found that successful online recruitment involved being seen as trustworthy by potential participants. The comparative success of this researcher to use social media as a recruitment tool seem to reflect the increasing proliferation of the internet, the desire of the participants accessed in this way to keep their drug use private, and their desire to access

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information about drugs (as well as provide it - some participants accessed in this way used the internet in an attempt to offer information and guidance about drug use to other potential users).

This researcher established a chat room profile as a 40+ year old male based in London with no other identifying characteristics. As with the bulletin boards this researcher then copied the internet message board advert (Appendix 7) into the profile. In order to maintain the ethical profile of the study the permission of a chat room moderator was sought where it was required in one case (CCNewz). This was provided and one participant was accessed as a result of this interaction. During the entirety of the fieldwork this researcher never entered an internet chat room or engaged in conversation on any website or bulletin board. This researcher's social media accounts, advertisements, and online messages were deleted from all websites upon completion of the fieldwork. The aim of utilising social media was simply as another outlet to publicise the study and raise its profile in places where potential participants might see it.

It was felt that a supplement to the University ethics clearance was not needed for any social media outlets as the original ethics proposal included publicising the study through bulletin boards. Also, that this researcher would never contact anyone about their drug use - and that a telephone contact number and email address were provided on information leaflets to enable any potential participants to do this. The ethical standards of the study were maintained throughout as at no time was any potential participant approached about their use unsolicited via any medium, and no conversations were entered into online about the study. Potential participants contacted this researcher by email but in all cases an initial telephone conversation was sought prior to any further interaction - in the same manner as with those participants who initiated contact through adverts placed in drug treatment centres.

Contacting potential participants and getting ready for the interview

To access and manage the study sample it was intended that a Modified Chain Referral (MCR) technique, developed by Watters and Biernacki (1989), would be used, adhering as closely as possible to the authors' original text. In a similar way to other purposive sampling strategies initial contact with a participant in MCR serves as a link in the chain to other participants, but the follow up is intended to be more systematic. Using MCR requires the researcher to collect potential participants from which they then select the order in which to interview them depending on the developing needs of the study.

For this study it was intended that as many potential participants were recruited as possible and interviewed when their basic characteristics represented something important about a different issue under study. Then, as concepts from the analysis of those interviews were developed, further potential participants would be sought to elucidate those concepts and so on. During this process it was anticipated that certain concepts would become more or less important. The more important would then be explored through the appropriate participants who would shed light on them. For example in this study when it was found that factors such as having accessed drug treatment was important in an individual's drug use, participants who had been recruited who had accessed drug treatment were asked to be interviewed. It was anticipated that this process would continue until no new patterns or concepts would appear. It was intended that the MCR would be a useful tool to organise recruitment and better meet the needs of grounded theory's theoretical sampling approach - where it is crucial to look for cases to saturate categories that have been developed from the data (Watters and Biernacki, 1989).

As the previous section showed a number of methods were used to publicise the study. This led to potential participants getting in touch via telephone and email. Once this happened this researcher would set up an initial telephone conversation to discuss their eligibility and willingness to be interviewed. The study and the interview process were then described to the

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potential participant (including the fact that the interview would be recorded).

During the initial screening conversation the participant was asked for some brief personal details relevant to the study (e.g. age, gender, the last time they used a class A drug, what this drug was). Potential participants were asked if they minded this information being recorded on a spreadsheet and maintained as part of the MCR process. If the participants said that they were comfortable with this process, and their profile fitted the needs of the study at that time an interview date was arranged.

Each participant was given information about the study (see Appendix 3) by email before agreeing to undertake an interview. They were also made aware of the confidentiality of the data. All the participants were asked if they were comfortable with being involved in the process. Since potential participants retained the right to withdraw at any point, they were made aware that the issue of informed consent for the study would be ongoing. It was made clear that informed consent started at the interview where participants would be asked to sign a form acknowledging this or give their consent verbally on the audio recorder.

On all occasions the potential participant chose the time and date for the interview, along with a venue that was comfortable to them. This was intended to minimise feelings of discomfort for the participants. All interviews took place in public venues, e.g. cafes, restaurants, bars, shopping arcades and libraries. In three cases, participants did not arrive for their interview. Every attempt was made to re-contact these participants and re-arrange their interviews. None of these three participants were interviewed in the study.

If it was felt that the potential participant was not a suitable candidate for interview at that time (i.e. as a result of the needs of theoretical sampling process) they were asked if they would be comfortable remaining on a contact list for interview at a later date. This occurred on seven occasions -

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in each case the participant was re-interviewed at a time convenient to them. All were still interested in taking part in the study when recontacted. Regular contact was maintained with these participants by email and all were eventually re-interviewed. No participant had to wait more than a matter of weeks to be interviewed.

As the study progressed it was important to maintain control over the sample and manage the order of the interviews as appropriately as possible. As a result a number of inter-connected processes were happening concurrently:

- Interviews were being undertaken which meant that data gathering continued.
- Interviews were being transcribed to facilitate data analysis.
- Data analysis was being undertaken to answer the research questions.
- Further analysis was undertaken to steer the needs of future sampling.
- The next participants were being contacted to arrange interview dates.
- Further potential participants were being sought with the aim of boosting the sample.

As the study progressed control over the sample became more selective than during its early stages. Between interviews 6 and fifteen, analysis was revealing that the core process defining the participants' drug use was a method of management, moderated by issues such as their social circumstances (e.g. capital and support) and the importance of drugs in their lives. Working with drug treatment centres to recruit the sample meant that the majority of the earliest participants had experienced challenges with their use. As the study progressed it became more and more necessary to discuss the role of management with people who had not been involved in any kind of drug treatment over the course of their lives, i.e. people who had

managed their drug use alone or for whom it had never led to any challenges. To this end more effort was put into recruiting participants through social media.

As the analysis evolved further patterns began to be firmed up and these concepts provided the next step for future sampling. At this point control over the sample was not just selective but based on theoretical considerations (i.e. working out how the different parts of the developing model were connected). This continued until fewer and fewer new patterns were identified.

In what became the final stages of the fieldwork it was apparent that new participants were not shedding any further explanatory light onto the theoretical model or core category. At this point the decision was taken to begin to close the fieldwork (this is discussed further later in this chapter) and not seek any new participants. Instead those remaining to be interviewed were asked if they were still willing to take part in the study. Interviews at this stage were undertaken to augment the existing theory, along with the dimensions of the core and major categories

Audio recordings

In all cases, interviews were recorded either onto an audio tape recorder or a digital audio recorder. On balance this researcher felt that the value of using the recorder to record information that might otherwise be lost was felt to outweigh the perceived intrusiveness of the device. The primary advantage of using an audio recorder during the interviews was that it allows a researcher to take full part in the discussion at the time. During the course of the interview, the use of the audio recorder allowed the conversation to flow more naturally, while notes were taken to follow up on any issues that were raised by participants. Using the recorder also meant information could be easily retrieved later. A number of things were taken into consideration before this researcher decided to use an audio recorder for the interviews. The most obvious of these was that potential participants might feel

uncomfortable being interviewed with a microphone and audio recorder. Some participants raised concerns that their words might be heard by others at a later date. Where this concern was raised, reassurance was given that this would not be the case. It was explained to the potential participant that the interview would only go ahead if they were entirely comfortable with the whole situation. Once the decision to record the interviews had been made, and the interviews undertaken, transcribing them presented challenges of its own. These are considered later in this chapter.

Two participants did not want their interview to be tape recorded for personal reasons. This was respected and detailed notes were taken during the interview. Relevant points were noted and pursued with the participants. Detailed notes were written up after the interview. From these notes it was possible to integrate the themes discussed during the interviews into the final analysis.

During the interview

During the earliest interviews when the work was at its most open and exploratory, very little prompting or probing took place. In line with Charmaz's (2006) suggested approach, the joint aims were to let the participants talk about their stories as freely as possible, and explore what was important to them, at the same time ensuring that all the research topics were covered. It was anticipated that this would establish the boundaries for the research topics and ensure that no issues had been overlooked in developing the research schedule. With this in mind, the focus of the interviews was on listening, except when clarification was needed to understand what the participants were trying to communicate. All participants were encouraged to talk about the issues that were meaningful to them. Care was taken not to impose meaning onto participants' responses.

Care was also taken during the interviews to engage participants in the research process by using non-judgemental checking, i.e. not cutting the participant off directly, but instead intervening by checking their position

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back with them, asking questions such as, ‘let me check that I have understood this correctly ...’ or ‘are you saying that ...’. It was then possible to begin asking about other topics that were of direct relevance to the research.

To further build rapport Egan’s (1990) model of active listening techniques was used during the interviews. The model cites five qualities that should be adhered to during an interview, utilising an open posture; sitting squarely towards the participant; maintaining eye contact to a degree comfortable to the participant; leaning forward; and being relaxed.

After the interview

The process was not terminated directly after the interview was completed. Instead, once the audio recorder had been turned off this researcher spent as long as the participant wanted talking about the study, and answering questions such as what would be done with their data. This was essentially to reassure them once again of their confidentiality in the study. Often, participants took the opportunity to ask about the experiences of this researcher in the substance use field and about their views on particular topics.

It was strongly felt that the interview process was about more than gaining rich data. It was an implicit aim that the participant would come out of the interview situation feeling as though they had communicated their story, in their own words. It was encouraging to hear therefore that a number of participants stated independently that the experience had been important to them.

Interviewing the participants

This researcher found the interview process challenging, stressful, frustrating but ultimately extremely rewarding. There were a range of factors to be considered prior to and during the interview, as the method has

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addressed, but this researcher was adamant that the main one should be to ensure the participants stress was kept to a minimum (Warren, 2005). This was especially felt to be the case when considering the subject matter of the study. Having interviewed vulnerable older adult drug users before, this researcher was aware that these participants might be facing very complex lives with the compound challenges of ageing and substance use.

This researcher realised that the questions from the study might elicit highly emotionally charged memories. This was always considered throughout the interviews. This researcher wanted to elicit rich data and attempted to do that in the most professional way, however the comfort of the participants and ethical principles were considered uppermost throughout.

Another important factor to this researcher was that care was taken to ensure that participants did not consider the process a therapeutic situation. It mirrored one in a number of ways (e.g. confidentiality, establishment of rapport, participant led, value-free and neutral) but it was made clear to the participants that this researcher was not a qualified healthcare worker. This researcher had a role as an interviewer to elicit answers to questions, not to give opinions and not challenge as a therapist might (Ruusuvuori and Tiitula, 2005). However care was taken to show empathy where it was felt appropriate as complete neutrality might be taken as lack of interest and a barrier to establishing rapport (Pirkanen, 2009). Some participants however mentioned after the interviews that the process had been therapeutic to them. In some cases (i.e. those that had never been in contact with any kind of service) this was the first time that the participants had spoken of their experiences and felt very positive about it. These were more likely to be the participants who had kept their drug use very private. These participants frequently said that they had valued being able to talk about their use in a non-judgemental situation. One mentioned that he would consider undertaking private therapy sessions after his interview, to explore the issues that the interview had raised for him further.

As it transpired any concerns that this researcher held about the interview situation were allayed. All of the participants were extremely flexible and accepted it comfortably. While this researcher found the process very natural, enlightening and captivating. This researcher was extremely humbled by the participants and their willingness to express and share their memories, thoughts, feelings, experiences, hopes and in a number of cases fears for the future. Coupled with this, this researcher found it remarkable how easily these participants talked so freely and with apparent trust about an illegal activity. One man however did go to great lengths (wanting to see information on the University website about the study, and carrying out background checks by looking at this researcher's public research profile on the internet) to ensure his own personal safety. He consistently asked for reassurance that this researcher was not working for either the police or an insurance company.

This researcher found all of the interviews emotionally demanding. Most were done one per day, but there were occasions where two were undertaken on the same day. These latter occasions were extremely difficult and towards the end of those days this researcher felt mentally drained. On a few occasions a handful of participants were showing visible health problems, such as emphysema, and sometimes found talking for long periods physically challenging.

For this researcher it was challenging to see people with physical and emotional difficulties talk about problems they had faced in their lives because of their drug use. Only to then analyse the information while it was still fresh, before switching off the voice recorder and walking away – still processing the situation and the information while at the same time trying to put it out of mind.

There were some moments that gave cause for concern but in hindsight, these were no more than this researcher trying to understand and empathise with the lives of others while remaining emotionally neutral. It was also related to coming to terms with being in these participants' situations,

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realising the complexity of the situations they faced, which was far outside this researcher's lived experience.

After concluding the fieldwork this researcher was left with the feeling that it was of paramount importance to complete the work, whatever the personal outcome. This would ensure that none of these participants' stories had been wasted. What had started as a course of self-learning and development had ended up more of a personal cause, to represent the voices of an under-represented, unnoticed and frequently marginalised group.

Transcribing the interviews

Once the interviews had been completed they were transcribed verbatim. Transcribing interviews is very time consuming. It can also be very difficult to detect all of the nuances and details of the conversation. A transcriber was hired to transcribe nine of the interviews. Permission was sought from these participants prior to a transcriber to be commissioned. This was given in all nine cases. The decision whether to use the transcriber depended on the sensitivity of the data obtained in any particular interview; the more sensitive and personal the data obtained, the less appropriate it was felt to be to use an external transcriber. Gregory et al (1997) suggest that care needs to be taken when employing transcribers, particularly when the study deals with sensitive information. This was felt to be highly pertinent for this study, given the sensitive nature of the data obtained during the interviews.

Davidson (2009) states that Ochs (1979) was one of the first to address the complexity of issues involved in interview transcription in social research studies, but goes on to assert that little attention has been given to it subsequently. Davidson (2009) concludes that the upshot of this has been that a number of researchers 'naturalize what is an interpretive process' (p. 36). While Kvale (1996) had previously acknowledged this also - that interview transcripts are 'interpretative constructions' (p. 165). This resonates with the previously stated constructivist position adopted

throughout the study. The transcripts were therefore believed to be an interpretation of reality and not intended to be a representation of it.

This meant that there were clear implications for maintaining consistency and rigor if a transcriber were to be employed. There might be a danger that a transcriber could introduce a different style of interpretation into the transcript, and therefore the data and resulting analysis for example. If this were the case any benefits obtained by the time saved from employing a transcriber might be offset by disbenefits created as a result of inconsistent transcription. However this researcher decided that the potential disbenefits could be managed by a series of techniques.

Firstly to ensure trustworthiness the transcriber employed was a former colleague of the researcher who had worked with him in the criminal justice field. It was felt that this experience would aid in two ways - firstly they would be familiar with much of the terminology (particularly drug-related) used during the interviews, and also this familiarity would help in communication when dealing with the sensitive nature of the interview subject for example. Before any data were given to the transcriber an initial conversation took place about the sensitivity of the data. It was also felt important to give the transcriber an opportunity to ask any questions about the data or the process at this stage. The transcriber was also asked to sign a confidentiality agreement, agreeing to: keep all information related to the project confidential; return all information to the researcher; and destroy any information upon completion. After each transcription was complete a short debriefing conversation took place. This gave the transcriber a chance to talk about any feelings they might have experienced while listening to the recordings.

Secondly, guidelines were given to the transcriber to maintain consistency and rigor. The only instructions given to the transcriber was that they should type all text that was audible. Portions of the recording which were unclear should be indicated with a record of the time elapsed in the interview e.g. '[00:01:37]'. The transcriber was then asked to send the typed script back to

the researcher electronically. The only other instructions given to the transcriber was that all names in the transcripts should be replaced by the term '[NAME]' along with any other information pointing directly to an individual. Whenever this was done the term '[TEXT REMOVED]' should be indicated within the text.

The final technique used to make sure that this process was as rigorous and consistent as possible was that all transcripts would be checked thoroughly. When a transcript was received this researcher would read it through while listening to a playback of the audio recording and edit it to a consistent standard. This was completed for all transcripts, regardless of who had typed them - ultimately the final transcripts used for the data analysis were all the consistent work of this researcher. MacLean et al (2004) also suggest that these processes can help to avoid transcription errors or corrections.

These processes were regarded as sufficient to ensure rigor and consistency throughout. The intention was not to create a verbatim report documenting every nuance of the interview or revise the participants' grammar or syntax. It was simply to develop an accurate record of the interview which could be used to answer the research questions.

A template was developed for all final transcripts based on guidelines published by the UK Data Archive (Van den Eynden et al, 2011) and called Best Practice by them. They state that each transcript should:

- have a document cover sheet or header with brief interview or event details such as date, place, interviewer name, interviewee details.
- have a unique identifier that labels an interview either through a name or number.
- have a uniform layout throughout a research project or data collection.
- use speaker tags to indicate turn-taking or question/answer sequence in conversations.

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- carry line breaks between turn-takes.
- be page numbered.

(Adapted from Van den Eynden et al, 2011; p.15)

These criteria were adhered to. An example of an interview transcript is shown in Appendix 10 which highlights all of these criteria. The cover sheet and unique identifier have been removed to preserve participant anonymity, while turn taking is indicated with bold text for the researcher and unbolded text used for the research participants.

The use of grounded theory processes to organise and analyse the data

Coding is the process in qualitative research where labels are attached by the researcher to particular pieces of data. These pieces can be of different length (e.g. words, sentences or entire paragraphs), but the main aim is the same - to explain what is being stated in the data. A piece of data can have a number of codes attached to it as it may represent a number of different things.

What makes the grounded theory coding process unique is the ongoing nature of the process exemplified by the simultaneous data collection and iterative analysis (Birks and Mills, 2011). In grounded theory, codes arise specifically from the data, not developed in a preconceived way before the data are collected, and then fitted together in an iterative fashion.

Researchers collect the data in the first instance, read the text for important phrases that illustrate the research topics, and then label them. There has been some disagreement about the exact nature of the steps used in grounded theory studies (largely due to how far one adheres to the original form of grounded theory developed by Glaser and Strauss (1967) or the more constructivist version developed by researchers such as Charmaz (2000)) but essentially the process is the same. In all grounded theory studies there is an initial coding phase, where the researcher acquaints themselves with the data, followed by a more targeted form of coding. The

next step is to make sense of how the data fits together as a whole. The final stage is concerned with looking for data to deepen one's understanding of the phenomenon under investigation, and developing any theoretical model.

Notes and diaries

Notes were kept over the entire course of the study, from before registration as a PhD student, throughout the development and fieldwork process, and thesis writing. Firstly they contained details of discussions with supervisors. Secondly they contained notes of interviews with the participants themselves. They were often made directly after each interview and reflected on the processes that were at work with each participant, incorporating issues such as non-verbal communication, tone and inflection. These often formed the basis of Memos, which facilitated deeper analysis (see Appendix 8 for an example of a memo which helped to shape issues worthy of further investigation in the study). Thirdly they provided an on-going description of the improvements and changes to the study as it developed. At intervals, this information was written into the qualitative analysis software package NVivo, where it was relevant to analysis. Alternatively they remained as hard copy in PhD diaries. These latter diary entries included times and dates of events and also recorded factual information such as changes to the development of the study (see Appendix 9 for an example of a typical diary entry).

Initial coding

As with all qualitative coding processes the first stage of coding is about interpreting the data. Charmaz (2006) calls this stage 'initial coding' (pp. 47-57). In this process the researcher scans the data, developing codes that are initially apparent. Charmaz (2006) says that it is better to do this process quickly so that codes develop more intuitively. Data can easily be re-coded as the study develops, or if the researcher's first impressions were inappropriate (see Appendix 10 for an extract of a coded interview transcript).

Initial coding for this study was carried out on a printed transcript of the first interview. The transcript was read over a number of times to gain a careful understanding of what the participant was trying to communicate. Key words and then phrases were highlighted, and codes describing them were written in the margin. Three further interviews were undertaken with potential participants from the MCR database. Upon completion, these initial four interviews were open coded. Detailed coding was carried out on transcripts of the first four interviews. This netted a total of 725 open codes.

All of the codes were then entered onto an MS Excel spreadsheet with the aim of distilling them into groups of codes with mutually exclusive meanings. At the first stage of this distillation process, repeated codes were removed. As the four initial interviews were coded independently it was often the case that the same issue re-occurred but with subtle differences e.g. 'achieving balance' and 'achieve balance'. After this process was completed a total of 623 codes remained.

The next step was to merge codes that were used twice and were similar but not the same e.g. 'achieving complete balance' and 'achieving total balance'. At the end of this process 569 codes remained. Codes were then merged further by creating groups of codes with similar phrases e.g. 'Achieving complete balance' / 'achieving total balance' and 'acquiring balance'. After this process 349 codes remained.

As outlined in Charmaz (2006) these groupings of similar code phrases were then further grouped together to create more detailed codes, or what Tavokel et al (2006) call 'clusters' (p. 4) e.g. 'achieving balance' - which held codes such as, 'Bring about balance', 'Effect equilibrium', 'Getting to where I want to be' and 'All my ducks in a row'. This process continued with more codes and code groups being merged. At the end of this process 157 codes remained.

The next step was to merge codes that on the face of it might have been regarded as slightly different, but which, on closer inspection (and where possible by re-contacting the participants themselves to clarify their meaning) shared the same meaning from the point of view of the respondent, e.g. 'achieving balance', 'Getting peace of mind' and 'Becoming self sufficient'. The process of merging and distillation ended when codes and code groups became mutually exclusive. This left a total of 43 codes.

The first four transcripts, and this coding structure, were then entered onto the NVivo database. Typed interview transcripts were imported into NVivo as text files. Individual chunks of text which represent codes can then be selected (these are referred to as nodes in NVivo). Nodes can then be linked between documents in the second and third stages of grounded theory coding - axial and theoretical coding. This allows for links to be made between interview transcripts as codes are linked into categories and then concepts. At various stages of the study models were made which described the data at that particular stage. These structural developments within the data were recorded, allowing the development of the analysis to be traced. The final theoretical model is shown in Chapter 8. The memo feature allowed memos or notes to be linked to selected text and nodes, to describe the development of ideas attached to individual codes, categories and concepts.

The interviews were then re-coded with this new coding framework. The original transcripts with the hand-written codes were then compared to the NVivo versions to check whether the same logic had been used to code the data. Both versions showed a high level of correspondence. Further interviews were then undertaken, and the same coding process was utilised. The remaining interviews were coded, in turn, directly into NVivo using these 43 major codes as a framework for the focussed coding process. No new codes emerged at this time.

However during the sixth interview a new code emerged, which was labelled 'Changing health'. This researcher decided that this was sufficiently exclusive as not to be explained by any of the existing categories. The previous five interviews were then re-coded for any references to this category. This 44th category was used in the subsequent data analysis. This is an illustration of the constant comparative method – what grounded theory authors often refer to as comparing data with data and comparing codes with data. Once achieved, categories are continually compared with all new data as it is coded. These categories are then compared with other categories to achieve fewer, more dense, high level categories.

As the coding process continued it was apparent that the 44 codes overlapped in places, and so these codes were collapsed and merged still further. Finally, after further interviews, transcription, coding, analysis and code comparison, major codes were achieved. These are shown below.

1	Accepting the self	15	Feeling hard done by
2	Achieving balance	16	Feeling like an outsider
3	Altering feelings	17	Fooling people
4	Avoiding responsibility	18	Gained wisdom
5	Beating the system	19	Leaning on others
6	Being reflective	20	Managing lifestyle
7	Changing health	21	Placing regret
8	Confused identity	22	Putting into perspective
9	Constrained choices	23	Questioning the self
10	Counting blessings	24	Resolution to change
11	Craving stability	25	Resolution to use drugs
12	Denying the truth	26	Self deprecation
13	Establishing credentials	27	Self sacrifice
14	Facing up to loss	28	Wanting to be like others

Focused coding

The next stage of Charmaz's (2006) approach is 'focussed coding' (p. 57-60). As the interviews progressed, some codes became more or less dominant, and patterns between the codes began to emerge. After twelve interviews it was clear that the 28 major codes were sufficient to cover all emerging codes. No new codes had emerged since the sixth interview, and the interviews showed a high level of homogeneity in what the participants were expressing (see Bowen, 2008). The main concepts of the study were also becoming apparent. At this point selective sampling of the data took place (Tavokel et al, 2006). Tavokel et al (2006) suggest that it should be clear which data are the most important and which are less so - researchers may then choose to gather further data selectively to 'evolve ... and identify the properties of the main variables' (p. 4)

After fifteen interviews one code was raised to the main or core category. Initially called 'Taking a survivor approach' the category aimed to describe a process whereby participants tried to maintain an overall holistic approach over their drug use to stop it dominating all of their lives. The initial name for the core category was an 'in vivo' code - taken directly from a quotation by a participant - it was overwhelmingly stated throughout all interviews and fitted the definition of a core category posited by Strauss (1987). It was felt at this stage that the nature of the core category was concerned with controlling ones drug use. However as the study progressed it was clear that the nature of the core category was about more than control and that control was in itself an amorphous concept. This was only fully understood as the axial coding stage progressed (described below).

To be considered a core category Strauss (1987) suggests that a category should be,

'central to and related to as many other categories as possible; occurs frequently in the data; easily relates to other categories and the connections are frequent and can be clearly identified; has implications for the development of a more formal theory; moves forward in development; and allows the researcher to build maximum variation from the analysis of data

and to identify, for example, dimensions, properties, conditions, consequences, and strategies which relate the different sub patterns of the phenomenon references by the core category' (Strauss, 1987, p. 36).

However, once the fieldwork was complete and the analysis had begun, the core category was subsequently renamed 'achieving balance' to better reflect the entirety of the process these participants experienced in the whole of their lives and in interaction with their drug use. It described the ongoing process to which these participants continually referred back and also seemed the process West (2006) described as 'balancing input' (p. 168). Once the core category had emerged, the aim of the analysis was to identify its relationship to the remaining codes and categories and consider their properties and dimensions.

As Tavokel et al (2006) correctly highlight it was also becoming apparent at this stage which codes were the most important and which were less so. This can be when further codes are raised to the status of categories. LaRossa (2005) suggests that the process of raising codes to categories is vague, and definitions differ among grounded theory authors. However LaRossa (2005) suggests it involves an abstract process of realising those codes which offer the greatest explanatory power. In this study 14 codes were raised to the status of categories (including the core category). These categories were providing a potential framework for the beginnings of a model of drug use in older adults, described in Chapter 8. The 14 major categories are listed below.

1	Accepting the self	8	Changing health
2	Achieving balance	9	Leaning on others
3	Altering feelings	10	Managing lifestyle
4	Being reflective	11	Placing regret
5	Counting blessings	12	Putting into perspective
6	Facing up to loss	13	Resolution to change
7	Gained wisdom	14	Resolution to use drugs

It was also becoming apparent that two of these categories were answering the how and why research questions (described in detail in Chapters 6 and 7) ‘managing lifestyle’ and ‘altering feelings’ respectively.

Axial coding

The next phase of coding in Charmaz’s (2006) process is ‘axial coding’ (p. 60-3). Axial coding describes the properties of the categories that have now been developed - describing the axis of the data to develop a more abstract understanding of what it is saying.

As the study developed further (and theoretical sampling and interviewing were implemented) the research topics for the later interviews (from 15 onwards) became more focussed on the ‘properties’ and ‘dimensions’ (e.g. Charmaz, 2006) of the core category and those around it.

It became apparent that the participants’ methods for using drugs (described by the category ‘managing lifestyle’) and their perceived reasons for doing so (described by the category ‘altering feelings’) were inter-related, these in turn were subsumed by and created the core category which was renamed ‘achieving balance’ which better described the holistic nature of the participants drug use. This relationship is illustrated below in Figure 1.

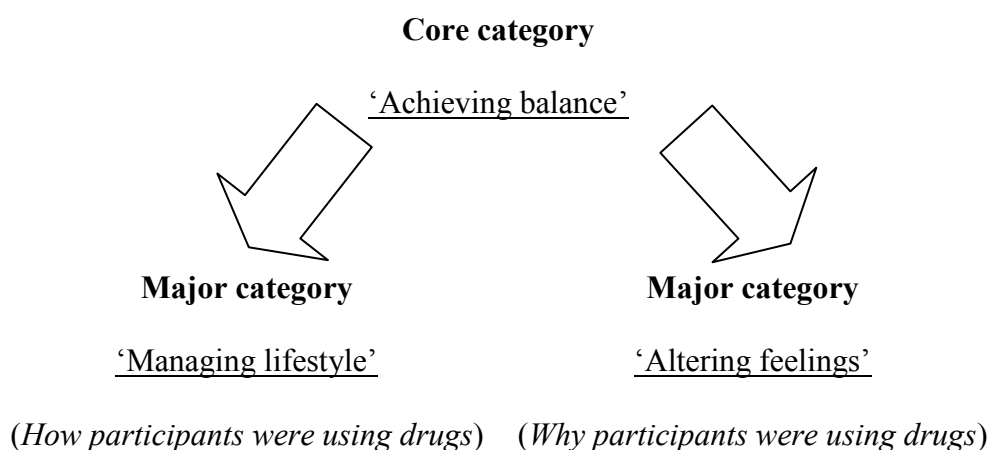


Figure 1. The relationship between the core category 'achieving balance' and the two major categories, 'managing lifestyle' and 'altering feelings'.

This researcher felt that the initial understanding of the core category - 'Taking a survivor approach' implied a simplistic one-size-fits-all relationship between the participants and their use. What was becoming more apparent was that each participant had their own sense of what they wanted from their lifestyle (and how their drug use fitted into that). For some this meant an intense, full-time relationship with drugs, while for others their most desirable state was a more arms-length, infrequent relationship. In each case it was for the participants to determine how they were managing this, rather than an arbitrary one enforced by this researcher. This is central to understanding the model for drug use in these participants.

It was also clear that the developing model was now one that was describing an ongoing temporal process of balance, which required constant management of lifestyle and feelings. Participants were also couching their current situation in their feelings about the past, and expectations of the future, further describing a process whereby they moderated and reflected on their drug use, their life, and their health. For this reason the codes 'gained wisdom' and 'changing health' were also felt to have a high level of explanatory power. As the axial coding process developed, the relationship between the core category and the remaining codes became deeper. Each of

the codes represented different facets of how the participants were managing their lifestyle. This is described in the final model of drug use which can be seen in Chapter 8.

This stage of the data analysis also helped to deepen the properties and dimensions of the categories in order to address the research questions. So the major category 'managing lifestyle' was explored in more detail in order to better answer how the participants were using drugs. The properties identified were: the frequency of their drug use, the amount they used, how much they spent on drugs, what drugs they used, how they took them (their method of administration), how they bought them (their method of purchase) and who they bought them from.

It was further established during this stage of the analysis that the dimension of each property was an indicator of how far the participant was 'managing lifestyle'. For example, the property 'route of administration' extended along an axis from 'smokes drugs or ingests orally' to 'injects into vulnerable injection sites' (i.e. described by the participants as least harmful to most harmful). Where the participant placed themselves on the dimension for that property indicated how far they were felt to be managing their lifestyle and what this meant to the participant themselves. Secondly the major category 'altering feelings' was explored in more detail to deepen the understanding of why the participants felt they were using drugs. The one property identified for this category was 'how their use made them feel'. This varied dimensionally between altering their feelings to cover up or mask existing negative feelings, or to experience feelings of euphoria. According to grounded theory, it should be possible to locate any new participant within these spectra and establish how much they were managing their lifestyle or altering their feelings. This was apparent as the final interviews progressed.

Theoretical coding

Once the core and major categories, along with the properties and dimensions, had been identified the final stage of Charmaz's (2006) coding process ('theoretical coding' (pp. 63-70)) can take place. This involves working out how all of the data fit together to provide a complete picture of the issue under examination. This in turn provides the theory or model. When this researcher had arrived at what was believed to be a final model, a draft was sent to two of the participants to assess whether it presented an accurate picture of their reality. Both participants gave very positive feedback.

Theoretical saturation, closing the fieldwork,

Saturation was felt to have been achieved when no further data were needed to populate the main categories. As this process could be considered subjective, further objective measures of saturation were also sought. Firstly a re-analysis of the codes and data categories, replicating Guest et al (2006). Secondly, following Bowen's (2008) example, all of the counts of the coding strips from all interviews were analysed to measure the frequency of mentions of the 28 major codes (and within this the 14 major categories). Both of these are attempts to measure the homo/heterogeneity of participants narratives. On both counts the data from this study could be classed as saturated by both of these definitions. Ultimately however quantitative measures should not be used to determine when saturation has been reached.

While a researcher can always explore the characteristics of properties and dimensions in more detail with more and more interviews, there comes a stage in any study where there is a diminishing scale of returns from the potential pool of data. Strauss and Corbin (1998) state that the process of data collection is potentially endless. It is up to the researcher to recognise this and weigh up what any new data might yield against the time it would take to collect it. All of the factors considered above led this researcher to conclude that this point had been reached with this PhD study.

The use of categorical data in this study

Some categorical data (e.g. information pertaining to social demography) were gathered during the course of the study. As outlined in this chapter, ongoing analysis of this data helped to guide the theoretical sampling process. As the study progressed it also provided another perspective on which factors were becoming more important and which variables were becoming more peripheral. It is very important to bear in mind that this study is designed to be qualitative and as such the sample is not intended to be statistically representative. As this is a grounded theory study however 'all is data' (Glaser, 2001, p. 145) and any data gathered during the course of the study can be used to answer, or provide context, to the research questions. It is important to bear in mind that when using quantitative data in a qualitative grounded theory study the concepts for any analysis have to arise from the data (in the same manner as any qualitative data) (Glaser and Strauss, 1967; Strauss and Corbin, 1998; Silverman, 2000). These data are used in the following chapter to help set the scene by describing who these participants are in more detail, while at the same time addressing the first of the research questions: What are the illegal drug use behaviours and social circumstances of adult class A drug users over 50 in England?

Chapter summary

This chapter has described the highly detailed and systematic approach to the methodology and method used for this PhD study - constructivist grounded theory. It began by outlining the foundation for the approach with a description of the development of grounded theory from the beginnings of symbolic interactionism and constructivism. It then described the diversity of approaches which grounded theory has become before assessing its suitability and appropriateness for use in this PhD study. This was due to the fit between the appropriateness of a qualitative method, its provision of a framework for studies where key concepts or variables may not be known, along with a structure for building categories into concepts to develop theory or models out of data, and finally this researcher's own world view.

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It then described the characteristics of the constructivist grounded theory approach outlined by Charmaz (2006) before describing how it was used and applied in this study. The chapter finished with an illustration of the continual process of data collection and analysis that was undertaken to achieve the core category, 'achieving balance', and the thirteen other major categories which were used in the construction of the model of drug use in older adults in Chapter 8. The next chapter presents the first set of findings - the drug use and social circumstances of the participants.

Chapter 5. What are the illegal drug use behaviours and social circumstances of adult class A drug users over 50 in England?

Introduction

This chapter describes the participant's social circumstances and substance use. It begins with information about factors such as their living arrangements, relationships and employment status, before introducing an overview of their current illegal substance use. The chapter then goes on to describe their criminal behaviour and contact with the criminal justice system, before concluding with a description of their current physical health status and their contact with generic and specialist healthcare treatment.

This chapter is intended to begin to address the initial research question of, what are the illegal drug use behaviours and social circumstances of adult class A drug users over 50 in England? by providing an all round picture or profile of the lives of these participants.

Thirty people were interviewed for this study, 24 men and six women. The youngest was 50 years old and the eldest 63, both males. At the time of the interviews, all participants were living in England. The majority were living in the Greater London area (16); seven were living in the south east of England; three in the east of England; two in the west midlands region and two in the Yorkshire and Humberside area.

Participants' social circumstances

The first part of this chapter presents the social circumstances of the participants, beginning with their living arrangements, followed by a profile of their relationships and a description of their employment status.

Living arrangements

Fifteen participants owned their own home. Six lived in private rented accommodation and five lived in properties they rented from the social

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sector (either maintained by a housing association, registered social landlord or the local authority). The remaining four participants said they were in various states of homelessness (one woman said she sometimes lived with her mother in her council rented flat, after living on the streets for a number of years, one man said he slept on the floor of a friend's flat while waiting rehousing, another man varied his time between sleeping on a friend's floor and sleeping on the streets, another man slept on the streets or in a vacant shed).

Relationships with significant others

At the time of the interview 15 participants described themselves as being in relationships - 13 were married and living together, while two described themselves as co-habiting. Of the remaining 15 not in a relationship, 10 classified themselves as single (two were gay males); four were divorced and the remaining participant was widowed as a result of her partner's illegal drug use. Six participants had current partners who also used drugs, while two different participants both labelled their partners as alcoholic.

Twenty out of the 30 participants had children (two mentioned having grandchildren). Of those participants who had children, two had three children, two had two and the remaining 15 had one. The youngest child of any of the participants was in their mid-teens at a technical college.

Children's illegal drug use

Participants were not asked whether their children had used, or were using drugs, however they frequently volunteered this information. Their experiences varied. Some talked about discussing drug use positively with their children, while others less so. One father for example described a positive experience while sharing a cannabis cigarette with his son. He and his wife had argued about drug use but both wanted to present a non-judgemental attitude to their children. However another father, shared a

more negative experience – his use had itself been problematic, and he described his son’s use in a similar way.

There is evidence to suggest that parental attitudes to drug use can influence the behaviour of their children. Horgan (2011) for example, found that ‘parental substance misuse raises the risk of drug and alcohol use during adolescence and is a risk factor for adult drug and alcohol misuse’ (p. 38). However it is too simplistic to say that one has a direct causative effect on the other. Another father talked about how his own drug use had led to arguments with his son, who was ‘now very anti-drugs’ (Male, 52 years). Rather than influence their decision to use drugs, this man’s son had actively been turned away from drug use by the experiences of his parents. However while it is too simplistic to say that parental behaviours leads to, or causes certain behaviour in their children, it is apparent that parental attitudes to drug use can play a role in a child’s decision to use drugs or not use drugs (Frischer et al, 2001).

Employment status and economic circumstances

Table 2 below shows the employment status of the participants and also compares it to all adults between 50 and 64 in England and Wales in 2009/10 which relates to the fieldwork period.

	Participants in this study	Males and Females in England and Wales aged 50-64
Full-time employment ¹³	40% (12 out of 30)	47%
Part-time employment	- (0 out of 30)	18%
Unemployed	30% (9 out of 30)	3%
‘Economically inactive’ ¹⁴	30% (9 out of 30)	32%

Table 2. Participant’s economic status compared to the general population of England and Wales, males and Females aged 50-64, 2009/10.

Table 2 shows that at the time of interview 18 participants were not in the labour market. Nine participants (or 30%) were ‘unemployed and looking for work’ while nine (or 30%) were ‘economically inactive’. All were currently in receipt of benefits. Over half of these were receiving disability allowance principally as a result of their drug use. Of those unemployed however six were currently volunteers either working with substance users or with the homeless.

The remaining 12 (40%) were all engaged in full time employment. Six were full time paid employees (two of these were drugs workers); four classified themselves as self-employed (one was a writer of independent means; one an artist; the third a session musician; and the last a business owner). The remaining two participants were currently working on short-term contracts through employment agencies.

What is most apparent is that participants in this study were less likely to be in full-time employment than the general population of adults this same age (40% compared to 47% for full-time employment, and 0 compared to 18%

¹³ Respondents to the Labour Force Survey are asked to self-classify their employment status.

¹⁴ People who are out of work, but who do not satisfy all of the International Labour Organisation criteria for unemployment, because they either are not seeking work or are unavailable to start work.

for part-time employment). They were also more likely to be unemployed and looking for work (30% compared to three percent). The level of those 'economically inactive' was similar, 30% in this study compared to 32% in the general population.

There are no data to compare the employment status of this sample with those of other class A drug users over 50. However it is possible to compare them to that of class A drug users more generally. In the 2012 CSEW, 75% of people between 16 and 59 who reported using a class A in the last year were employed; nine percent classified themselves as unemployed; with 15% economically inactive. This study has found a lower level of employment generally (40% compared to 75% in the CSEW), and a higher level of unemployment (30% compared to nine percent). The largest difference is the proportion of people classed as economically inactive (30% compared to 15% more generally). While these figures should be taken with caution as a result of the size of the sample in this study it is indicative of the fact that while differences exists between this group and class A drug users more generally, the distribution is similar. The most pronounced difference is among the level of economic inactivity in this group compared to people reporting using class A drugs across all ages. Any differences in employment activity between this group and people of any age who use drugs are just as likely to be as a result of their age as their drug use.

Employment rates for the participants in this study are also higher than those of any age entering drug treatment. The most recent data from the National Drug Treatment Monitoring System (Roxburgh et al, 2012) shows that 18% of people entering drug treatment were classified as being in work. This increased to 21% after six months in treatment. Three percent were enrolled in an educational course rising to four per cent at the six month review stage. Again, comparisons should be made carefully with the participants in this study; however it does illustrate the mixed demographic nature of the sample. Clearly there are some participants in this group who socio-demographically bear more of a resemblance to any adults over 50, regardless of whether they use drugs or not. While at the same time there are

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also those who socio-demographically have more in common with other drug users of any age, than they do with their peers over 50.

Illegal drug use

Class A drug use in the last month

To be included in the study participants had to have used a class A drug in the last month. The type of class A drug reported by the participants is shown below in Table 3.

Participants' class A drug use in the last month	Number of participants
Heroin	12
Amphetamine ¹⁵	7
Cocaine Powder	5
Crack	3
LSD	2
More than one class A drug	1
Total	30

Table 3. Participants' class A drug use in the last month.

The most common class A drug used in the last month was heroin. This was used by 12 participants. This was followed by amphetamine which seven participants reported using, and cocaine, eight participants (five reported using powder cocaine, while three reported using crack cocaine). Two participants reported using LSD in the last month while the remaining participant reported using more than one class A drug.

Current main drug of choice

¹⁵ Amphetamine is only classed as a class A drug when it is prepared for injection.

During the interviews, it emerged that not all participants considered class A drugs to be their preferred main drug of choice. Table 4 below shows the drugs they considered as being their current main drug of choice - a drug that, when it was available, and they had the money to buy it, they would choose to take above all others.

Participants current main drug of choice	Number of participants
Heroin and other opiates	9
Amphetamine	8
Cannabis	5
Cocaine Powder	3
Crack	2
Magic Mushrooms/Hallucinogens	2
Valium	1
Total	30

Table 4. Participants' current main drug of choice.

Table 4 shows that the most common main drug of choice was Heroin and other opiates. Participants reported using predominately heroin but reported other regular opiate use such as opium, morphine, buprenorphine, methadone etc. Nine participants stated they would choose to take these above all other drugs if they had the choice. The next most common current main drug of choice was amphetamine, favoured by eight participants. The next most common current main drug of choice was cannabis, mentioned by five participants. Five participants also gave cocaine as their main current drug of choice, three of these favoured powder cocaine and two, crack cocaine. Two participants gave magic mushrooms as their main current drug of choice but also used other hallucinogens such as LSD. These participants were a married couple who used drugs together or with other friends. The final participant gave her current main drug of choice as valium. She had

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also used methadone, for which she had a private prescription, and crack cocaine, but less frequently.

Participants' criminal behaviour

All participants in the study raised the issue of criminality. Engaging in an illegal activity meant that all these participants knew themselves to be committing a crime by using drugs but not all considered themselves to be such. All commented on what they believed to be contradictions in current drug policy, and all felt drug use should be legalised, or decriminalised to varying extents. Nearly two thirds of the participants (18 out of 30) had become directly involved in crime as a result of their involvement with drugs.

The types of crimes committed by these participants

Fifteen participants had been arrested for a range of different crimes, although they reported that they were almost always for selling drugs ('Possession with intent to supply' - eight participants) or trying to obtain money to buy drugs ('Soliciting', two participants; 'Robbery', two; 'Theft', one; 'Breaking and entering', one and 'Shoplifting', one). These crimes were only an indication of the sorts the participants were charged with over the course of their lives. Those that did engage in criminal behaviour said they had committed a number and a variety of offences, principally to gain money to buy drugs,

'When they did that CRB (Criminal Records Bureau) check, mine came back with sheets and sheets of it, which only worked out to one thing. When I worked it out statistically, I was still far better off getting caught once a year. I was pretty good at what I was doing.' (Male, 56 years)

This man not only illustrates the range of offences the participants had committed but, for some, the volume. When they were committing crime in order to obtain drugs they had built crime into their planning and coping

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processes. This also serves to support West's (2006) point about developing plans to obtain their goals.

Three further participants said they had been heavily involved in sex work, two women and one man. Again however this had become part of a process to obtain money in order to buy drugs. For both of the women their drug use had then become part of a coping mechanism to cope with the physical abuse they suffered as a result of their involvement in sex work. This became a vicious circle, illustrated well by this woman,

'I had to take it to keep on doing it and I had to keep doing jobs to get money so I could buy dope so I could use it to keep on doing jobs like. It were one big circle ... Heroin just numbs everything, you can do anything in the end, anything, if you're loaded up on heroin and booze you can do anything and no one cares.' (Female 52, years)

This is supported by existing literature in this area which talks about the high level of correspondence between sex work and heroin use (e.g. Maher and Curtis, 1992; Bourgois, et al 1997). Levy and Anderson (2005) however describe a process whereby the option of using sex work to gain money to buy drugs becomes harder for women as they get older. They report that their sample 'Found their social capital in sexual bartering had diminished with age' (p. 249) after which time they relied on other strategies to remain close to a drug supply, e.g. bagging drugs or other tasks, (see also Rosenbaum, 1981). This is illustrated well, if harshly, by one of the participants in this study, 'I mean when I started I was a good looking girl right, not like the old bag I am now, I mean people, I got paid quite a lot at times' (Female, 52 years). This woman was now seeking treatment for her drug use and was staying in a women's hostel having just left an abusive relationship. She was trying to make holistic changes to her life, completely leaving drug use and sex work. The opposite was true of another woman however. Rather than move out of sex work she has used her contacts and transferable skills to diversify from straight sex work, to working on a sex phone line and for a dominatrix,

‘I was working for this woman I’d met. I did enjoy it, but I just wasn’t earning enough ... One thing I would rather enjoy doing is setting up my own dungeon. I do enjoy the sex industry, actually’ (Female, 59 years)

This further supports the assertion that older people who use drugs, and are also involved in crime often move to the periphery of criminal activity as a result of their age and perceived vulnerability. Some participants spoke about how they now felt vulnerable to younger more aggressive criminals. The three participants still criminally active admitted to offences such as ‘Money Laundering’ and ‘Shoplifting’.

The most commonly committed single reported crime type in England and Wales is Theft (24%); followed by Violence against the person (20%); criminal damage (19%); Burglary (12%); and Vehicle offences (11%) (Smith et al, 2012). In the UK the age of offender is only available for crimes which have been detected and are not routinely monitored by police forces. In the US however the Uniform Crime Report (Federal Bureau of Investigations, 2012) shows that the most common crimes committed by adult offenders over 50 are: Driving under the influence; Drug abuse violations; Other assaults; Drunkenness, Larceny-theft; and Disorderly conduct. These crimes seem to be indicative of a decreasing level of violence or conflict among older criminals.

A number of studies have attempted to describe the relationship between drugs and crime over the last thirty years (e.g. Gandossy et al, 1980; Chaiken and Chaiken, 1990; Hough, 1996). While the association has generally found to be strong the exact nature of the relationship is complex, and is not constant for all individuals (Bennett et al, 2008). Bennett et al, (2008) found that the extent and strength of the connection between drug use and criminal behaviour varied by the type of drug use – the more expensive drugs a person used (such as heroin, crack, and cocaine use) the stronger the association between drug use and acquisitive crime. In England drug using arrestees have been found to be more likely to commit

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shoplifting and handling offences. However there is an important variation within this in that heroin and cocaine users were more likely to commit high risk, high return crimes of robbery and burglary (Bennett, 2000).

What is apparent is that this group of participants have committed, and are still committing crimes, which are more similar to those committed by drug users, than those committed by general offenders or older adults - their main aim and motivation for their involvement in crime has always been to acquire money to buy drugs. However there also seems to be a decreasing level of violence or conflict among the types of crimes they are committing.

Participants' contact with the criminal justice system

All of the 18 participants who had become directly involved in crime as a result of their drug use, reported having had some sort of contact with the criminal justice system. Fifteen of those went on to be charged with at least one crime. Of those 15 participants, 11 went on to be imprisoned. One participant who was charged and arrested for drug supply offences was later, tried, found 'not guilty' and released. Those participants who were imprisoned described themselves as repeat offenders and talked about being imprisoned on more than one occasion, such as this man,

'To be quite honest, prison holds no... because I've been to prison that many times, it holds no fear. The police hold no fear. Apart from the serious crimes that you'd seriously stop and think about, the rest of it holds no fear at all. Petty shoplifting, I've given that up. I've been arrested once since '04 and for me that's a big achievement because normally I'm in jail at least two or three times a year.' (Male, 55 years)

This man illustrates well the feelings about prison of those habitually involved in crime - they saw it as an occupational hazard and something that was part of their life and routine. This man then went on to talk about how prison also gave them a break - 'it gives you time off. You haven't got to go out stealing and the discharge grant is just enough to get you a day's gear'

(Male, 55 years). He was comfortable using prison as part of his life, rather than something to be avoided. This is supported by Friedman et al (2011) who found that arrest or incarceration did not reduce an individual's injecting drug use, and similarly McKeganey (2013) found that police activity had little impact on many drug users decisions to take or continue using drugs.

Participants' physical health

The most common health conditions presented by older adults with substance use problems have also been attributed to general conditions associated with ageing (McMahon, 1993), for example heart conditions, arthritis, hypertension and elevated blood pressure (Rosen et al, 2008). This raises an interesting conundrum about the interaction between illegal drug use and ageing, which was apparent among these participants. Whatever their patterns of drug use, now or in the past, some participants who were experiencing health problems were unsure whether they were created or exacerbated by their drug use, or as a result of ageing more generally. What was apparent was that this was a concern to them, and something which they were frequently reflective about.

Two participants talked about their bone related conditions, osteomyelitis and osteoporosis, while another talked about curvature of the spine. All regularly reflected on whether these conditions were connected to their drug use, or perhaps more pertinently, their lifestyle while using drugs heavier and more frequently. Similarly falls are also common among older adults but are also potentially indicative of an underlying condition, of which there may be several causes. While one of these factors is ageing (Rubenstein, 2006) another can be drug use or misuse, including use of over the counter medication and inappropriate prescribing (e.g. Sheahan et al, 1995; Modreker and von Renteln-Kruse, 2009). One man talked about the health problems he had in relation to a fall,

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‘I had a bad fall. I fractured my spine and my knees ... when I came out; it was about eight months before I could walk again properly. When I did start to walk, the knees just kept on... I don’t know if it had anything to do with drugs or what, but ... and I often do it, fall over, again and make it worse’
(Male, 55 years)

This man continued to use drugs up to and after his fall and also talked about increasingly frequent instances of slipped disks. He did not feel able to say whether this was connected to his use and did not want to mention this to his General Practitioner (GP) for fear of reprisals. This issue of reflection by participants over their use of drugs and how it is affecting their life now is a consistent theme in this study.

There were participants however who were sure that their physical health problems were directly attributable to their drug use. Nine of the 30 participants reported that they are currently in receipt of disability allowance benefits, as a result of physical problems caused by their drug use. It is prescient to consider the health problems these participants are experiencing.

Health problems associated with injecting drug use

Perhaps the most frequently mentioned health problems by these participants were blood-borne viruses, diseases and conditions they felt they had contracted as a result of their injecting behaviour. These included Hepatitis A, B, and C, HIV, Liver Cirrhosis, Septicaemia; Blood clots, Abscesses, and DVT. The most common of these was Hepatitis C (it was mentioned unprompted by seven participants). The number of participants in this study with any form of Hepatitis might be greater than this as participants were asked about the health issues that were important to them, and how they affected their drug use rather than incidents of specific illnesses. Further research into Hepatitis among this group would be needed to answer this question in more detail.

The issue of injecting behaviour, in relation to Hepatitis and HIV, was of continual reflection and concern to a number of participants. They frequently talked about the damage that injecting had done to their veins. In some cases this went hand in hand with them starting to re-evaluate their attitude to their drug use,

‘I’m still injecting but I’m running out of veins. I’ve got abscesses in my legs, see? And my veins have all collapsed in my arms here and here. I have just been starting my neck so I think I’ve still got some time to finish it off ... I know I can’t have lots of health problems because my immune system and you know, my sort of system overall has taken a real battering from all of the shit that I’ve done to it, being HIV now ... it puts things in perspective.’ (Female 52 years)

This woman didn’t know whether it had been her drug use or her involvement in sex work that had led to her becoming HIV positive, however it had become part of a set of problems for her – medical problems associated with her use, general medical problems as a result of her age, and the abuse she had taken over her life. This had led her to re-evaluate not just her drug use but her entire life.

For others though no such re-evaluation was taking place, instead the problems they were now experiencing as a result of their injecting behaviour was leading them to engage in even more risky behaviours, as also described by Beynon et al (2009)

‘The last four times I have injected heroin I’ve been injecting in my neck. You can get clots forming on the inside of the brain. A friend showed me how to do it in my neck. He started going in his groin, then he’d been going in his groin for two months, and he’s now got a blood clot and an abscess on the inside of his groin’ (Male, 50 years)

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This man is a long-term injector of a number of drugs. While he was aware of the health consequences of this behaviour he had still enlisted the help of a friend to find new injection sites. He considered his choices to be highly rational having weighed up the pros and cons he still wanted to continue using drugs.

Another man talked about his contraction of DVT which is a potential risk for any injecting drug user, but more so among older adults as a result of lowered blood pressure (e.g. Gupta and Lipsitz, 2007). This man talked about his problems resulting from injection behaviour. In a similar way to all participants who were experiencing health problems as a result of their drug use he was sanguine about the consequences. His account was value free and non judgemental being fully aware of the consequences of his actions.

Participants' health problems related to smoking drugs

Three participants also talked about health problems they were experiencing as a result of smoking or inhaling drugs. All participants felt their diagnoses were directly attributable to their long-term drug use. They also felt that they needed to be particularly watchful because of their age and perceived physical vulnerability. Two talked about diagnoses of Chronic Obstructive Pulmonary Disease, one man summed up his diagnosis and his resulting concerns well,

‘My chest is terrible because of smoking. It’s like a new term for emphysema. I’ve got really bad breathing. Through smoking anything and everything. Apart from that, I’ll have an occasional smoke of cannabis and crack and other stuff, but only very occasionally because I’ve got Chronic Obstructive Pulmonary Disease. I find if I smoke it really hurts my chest. I used to smoke daily, but I’ve stopped because it was just hurting my chest. I shouldn’t really be smoking these thing [holds up cigarette he is smoking], but I can’t stop them.’ (Male, 56 years)

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This man talked about how he had smoked a range of drugs over his life including opiates, powder and crack cocaine and cannabis regularly. He was convinced that his behaviour had contributed to his current health problems - particularly his problems with breathing and chest pains - but continued to smoke and inhale, a range of substances. This man also chain smoked and drank alcohol throughout the interview. A third man talked about being diagnosed with cancer which his doctor believed was bought by a combination of smoking and opiate use (through unexpelled urine),

‘I had a drug problem when I was a young man – opiates – and I’d go all day without a pee, and sometimes two days, and I was smoking.’ I can’t go five minutes without a pee now. That was an interesting one for me. Those many years of opiate dependency, there was constipation. I have no problem whatsoever with that now but I worry about how much damage I did through those years. I’m talking constipation. I’m very vigilant around bowel cancer and that kind of stuff.’ (Male, 55 years)

For this man his cancer diagnosis was one thing that had made him more attentive to his own personal health. He had been an injecting opiate user and in his own words had experienced a range of problems as a result. He went on to talk however about how he was now pre-occupied with his health and made sure he had regular checkups. He still used powder cocaine infrequently but after having made a professional career (in substance use services) had taken out private health insurance for himself and his wife.

Acute drug toxicity or overdose

Nearly all participants talked about the risk of overdose, either their fear, or their experiences of it, sometimes at length. There was a growing awareness of the potential for overdose among most participants as a result of their ageing - most were becoming increasingly conscious that their body could not recover from any extremes of use. Some used this increased awareness to guide them towards re-evaluating their current use,

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‘Just the now I had an overdose of AZT the AIDS drugs ...and that nearly killed me. I only just came round from that. ... I was lucky ... I’ve gotta watch doing stuff like that an all, now I’m getting on’ (Male, 51 years)

This man’s observations about his changing health were enough to start to making him adapt his behaviour. He felt he had managed his drug use (however uncontrolled it appeared to others) throughout his life but had recently presented himself to a substance use service feeling that he needed support as he got older.

What a number of these participants illustrate is that it isn’t just the problems they are experiencing as a result of long-term (and in some cases erratic) drug use which were causing them concern – it is the interaction with their perceived vulnerability brought on by ageing that was frequently the catalyst for some to be more watchful about their behaviour. While all participants mentioned some kind of physical health problem they were now experiencing, not all blamed their drug use or acknowledged its impact on their health. What was clear however was that participants who reported more severe health problems acknowledged and accepted that their drug use was a likely contributor - none was oblivious to the impact their use had on their health.

Finally one aspect of healthcare rarely mentioned in the literature on drug use is the impact of injecting drug use on teeth. This man talked about dental problems he was now having,

‘All my teeth are falling out now. The trouble is a lot of my teeth are hollow. A lot of that is to do with Vitamin C. The citric acid gets into your teeth and your teeth go hollow. I’ve just been to the dentist and I’ve got to have twenty something fillings, thirty something, nine abstractions, I’ve got an abscess here. I’ve got to have a block of four teeth here extracted, and the abscess removed because it has started to explode’ (Male, 50 years)

Other participants mentioned having dental problems, but also a lack of access to dental care. Some mentioned that they felt excluded from mainstream healthcare, but others talked about problems with their teeth as a result of poor nutrition and a lack of dental hygiene. Both of these issues are common among illegal drug users, often because dental care requires daily attention and a change in attitudes and behaviour. Charnock et al (2004) found that nearly 70% of drug users reported oral health problems compared to half of non-drug users, while 60% of a non-drug using group regularly attended dental health services compared to fewer than 30% of drug users. Sheridan et al (2001) found similarly that barriers to accessing dentists and dental health services might include social exclusion, low self-esteem, anxiety, unsympathetic and stigmatising behaviour by professionals, and simply being refused treatment by dentists. People who use drugs with poor dental hygiene can respond positively to treatment; this has a similarly positive effect on their recovery from drug use (e.g. Robinson et al, 2005). This was found to be the case with one man who talked about a friend who was a drug user with poor dental hygiene, being 'very self conscious' of his teeth, covering his mouth when he spoke. He went on to talk about when he found a dentist who would work with him he felt much more empowered to be able to manage his drug use.

Participants' experiences of healthcare services

Because of the focus that participants had on their own physical health one of the issues which concerned them most was their interaction with generic and specialist healthcare services. They described mixed experiences from different aspects of the healthcare system.

Participants' experiences of general healthcare services

Participants talked about consistently negative experiences of the National Health Service (NHS) when they presented any kind of problems which might seem to others a result of drug use. However they also reported neutral experiences at best even when they presented with more everyday

maladies. Participants felt that this was because their healthcare workers knew them to be drug users. Those who talked about this said that they would hide it from their GP wherever possible. This was harder when participants talked about needing substitute prescriptions such as methadone, which could only be prescribed as a result of drug use. More than one participant tried to hide their drug use from their GP by buying a private prescription for any medications relating to their use. Others however were not able to do this. This man summarises well the kind of reaction reported by general healthcare providers when they became aware of their drug use,

‘My GP doesn’t speak to me ... he just blanks you. And I’ve been laying here sick, when antibiotics would have done me, and I haven’t, and he’s put the phone down on [gives wife’s name] maybe you can get underway with that by saying you’re not the person, but she was just trying to make an appointment, and it had nothing to do with drugs, he just was rude and put the phone down, slam’. (Male, 56 years)

This man reported similar experiences on more than one occasion - feeling that his GP was unhelpful and judgemental. He also felt that he and his family were being ‘pushed to the back of the queue’ by similarly judgemental reception staff. On another occasion he talked about his teenage daughter being unable to make an appointment. Similarly this man felt his entire family had been removed from their ‘Doctor’s list’ once he felt their GP knew he used illegal drugs - he was a London Bus driver until recently but had an accident after working an extended shift.

‘I went to see the company doctor and for some reason I blurted it all out. Crazy really, crazy, but that was probably my state of mind at the time. So I said to the company doctor, blah, blah, blah, amphetamines this, amphetamines, blah, blah, blah. And the fallout of that was that I got taken off by my own doctor, not a word, nothing’ (Male, 51 years)

Other participants reported more overt discrimination. They frequently reported feeling as though they were constantly being judged or being held to a 'different standard' (Male, 55 years) by healthcare staff when it was known they were drug users. For others these judgements were more apparent and made to them directly based on their behaviour or appearance, 'I walked into another doctor's one day, and he took one look at me and said 'I don't treat drug addicts.' (Female, 59 years). Another reported similarly negative reaction from hospital staff when he confronted a nurse about their negative attitudes towards drug users and asked to speak to a supervisor, 'Do whatever you want. As far as I'm concerned, you're a dirty druggo.' (Male, 54 years). He went on to talk about drug user's experiences he was aware of, 'there are still quite a few people in this project that haven't got GPs. Their doctors have struck them off because they are users.'

This also supports the findings of O'Conner and Rosen (2008) who found that the older drug users in their study had experienced the normalisation of derogatory language among generic healthcare staff.

Participants who had experience of the general healthcare system felt that staff were suspicious of drug users who treated them in a negative way. This is highlighted most starkly by one woman who was treated with extreme suspicion by a GP (who knew her to be a problematic drug user for many years). She talked about a time recently where she had called her GP because she was suffering from extreme pain,

'That night my leg was hurting but ... the next morning I couldn't walk. [Gives husband's name] called the doctor out and they assumed I'd been fixing in my leg, which I never do. [Gives husband's name] ordered an ambulance which they then stood down and said 'No, she's just trying to get more drugs.' This went on for a week. I was laying there and I'd never had pain like that in my entire life. It was literally 'Ahh,' all the time, except when [gives husband's name] would whip out, come home with some heroin, and give me an injection. Maybe for an hour I'd be able to be quiet. I just couldn't take that for long. After a week, [gives husband's name] came

home and I was trying to hit myself with the bedside light to just try and knock myself out. Luckily, he'd been keeping a diary of events. He just went into panic mode and phoned an ambulance. Luckily, I got into hospital and they said I had septicaemia. I spent two months in hospital ... I ended up suing the doctor' (Female 52 years)

A number of participants reported similar experiences of suspicion which they felt from the medical profession. However none were as extreme as this which ended in a malpractice suit and compensation. This woman had been suffering from an extremely dangerous condition but her GP had failed to call for an ambulance believing this to be a ploy to obtain drugs. This seemed to be at the heart of a number of participants fears; they seemed to express an institutional mistrust by the general healthcare system. One man who was a long-term heroin user talked openly about the voluntary work he was doing with GPs - running training courses for a healthcare provider on working with drug using clients. He talked about how shocked he was at how little he felt GPs knew about drug use, suggesting that the 'average drug user knows more about medicine' (Male, 55 years). He believed that this led GPs to be immediately suspicious of anyone who reported using drugs.

Some participants presenting with health problems relating to substance use reported feeling marginalised, not only as a result of their drug use but also as a result of their age,

'A lot look at users are just dirty junkies, 'specially my age, you're left on the scrapheap, I've had people say to my face there's no point treating you, there's nothing we can do for you, your age.' (Male 52, years)

This was at the heart of a number of participants' concerns. They were finding themselves needing to have more contact with healthcare systems as a result of age and drug related conditions, and the interaction of both. They were however increasingly concerned that they were becoming doubly marginalised. One man whose drug use behaviour had never been

problematic talked about how he felt the healthcare service seemed to give him less and less time now he was older. He was concerned that his doctor saw him as a 'drain on resources at my age' (Male, 57 years). General healthcare systems are only seen as being able to deal with the responsive treatment of acute physical conditions, where the concept of successful treatment relies on physical recovery (Lamy, 1980). Lamy (1980) suggests that this is because these systems are only designed to deal with acute management of symptoms. For a more specialised treatment of their problems participants either referred themselves or were referred to substance use treatment services. The experiences they reported were much more positive by comparison.

Participants' experiences of specialist substance use services

Sixteen participants were currently seeking help from some kind of substance use service (e.g. medical healthcare and drug treatment) as a direct result of their drug use. These participants were positive about their experiences, particularly when compared to generic healthcare services. Participants talked about the main reason for this being the non-judgemental way in which they were treated by specialist services, but also the potential opportunities they were presented with beyond helping them physically and mentally,

'The services down there have been great ... If you want to, you can get involved in going down and doing stuff. There's places where there's computers. You can get into that. There was one time we started going down and there were massages and stuff ... I don't know what I'd have done if it hadn't been for them'. (Female, 55 years)

This woman talked about how she felt the treatment service had helped her as a person, rather than as a substance user. She felt that her substance use was now stable and was now embarking on a training programme which would help her to achieve a qualification in substance use counselling. This was not the only participant who wanted to use her substance use and a

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treatment service as a springboard for a potential career. These participants talked about how their substance use had given them something to focus on which was bigger than them; this is summed up succinctly by this man,

‘I have done a few courses here. Here they do things ... I also got a group now ... After I’ve been drug free for six months I’d like to volunteer and try to maybe help somewhere. I don’t know how it works ... but if I can come in as a volunteer and just help people... I’d like to become a useful member of society again ... I’ve hit rock bottom before and now I’m on my way up. That’s the best I can do. Once I am clean, if I can get one person off drugs then that will do. That’s one way of paying people back.’ (Male, 53 years)

This man was currently using ‘anything between two and six bags (of heroin) a day’ and had set himself a goal to be drug free. He talked about having been a drug dealer in the past and was now trying to bring his experience as a drug user to counselling. He talked about how setting this goal was helping him focus on his recovery. Other participants who reflected in a similar way talked about wanting to make amends for what they saw either as time they had ‘wasted’ in their life where they might have done something different, or for problems they had caused others. This is perhaps one of the reasons why specialist services were seen as positive - because the majority of participants had made self referrals. They had sought help for themselves and talked about their determination to overcome the barriers they were facing as a result of their substance use.

The idea that non-judgemental and holistic treatment of participants was behind the positive feelings they expressed is supported by the rare negative comments. This man attributed his poor experience he was having at specialist services to the high workload of their case worker,

‘... back in the day the key worker and the client had a relationship where the key worker would look at their social housing, their benefits, every aspect of their life to set them goals and targets around each of them

individual titles to move them on a little bit. But that don't tend to happen now'. (Male, 54 years)

This man wasn't the only one who talked about his history of specialist services and how he felt the treatment he was receiving now was inferior to that which he had received previously. He talked in a similar way about drug treatment provision as the earlier man, but also reflected on how he felt this was changing. He went on to talk about how this seemed to make a difference in how he was responding to his treatment this time. This might also be connected to participants' feelings about their treatment now they were older. Some talked about feelings of self-consciousness expressing sensitive and personal information to a counsellor who was often younger than they were. However there was more than one participant who expressed reservations about the qualifications of younger counsellors and key workers, suggesting this might be the reasons for their perceived differences in the treatment they were receiving now compared to when they were younger,

'I had this counsellor who was trying to help me out, bless her. I'm not taking the piss or anything yeah she's just a kid, might be my kid for all I know, and she's trying to help people and that so fair play to her, but I mean ... she's never been inside my head ... not with my years. She don't know how difficult it is after all these years.' (Male, 55 years)

This man's reaction seemed to reflect a negative, derogatory and ageist attitude towards his counsellor. It was perhaps reflective of a deeper frustration he felt at being in treatment again and trying to deal with problems which in his own words 'wouldn't go away'. There was also a recognition that any frustrations he felt were as a result of his own extensive experiences of drug treatment over his life. In the same way that one of the previous participants talked earlier about knowing more than GPs, this man talked about feeling 'at my age I know all there is to know'.

While there were other participants who talked about the age of their counsellor there were none who mentioned being self conscious around other drug users younger than themselves. This is particularly interesting when considering the literature presented earlier which highlighted the effectiveness of age specific services. Those who talked about the ages of the younger people they knew using drugs tended to talk about them in something of a protective way like this man,

‘I have a bloke around here sometimes, well he’s a kid really, twenty one ... pathetic really, skinny little rake, nothing left of him ... I try to help him out but he ain’t interested ... do I have him around here just so I know he’s safe and someone can watch him or call an ambulance if anything goes wrong? I don’t know. I want him to live long enough so he can come around and try to sort himself out.’ (Male 52 years)

Talking further there seemed to be recognition by this man - that he saw himself at a younger age and wanted to try to help him in some way. There was a feeling that by helping this younger user he would perhaps be helping himself. In a similar way other participants talked about wanting to ‘make amends’ to people they knew and loved, and this added to the sense of self worth they expressed.

What the participants were like

This chapter has illustrated the participants’ demography including variables such as their gender, their age range, their social and professional status and their health.

From the point of view of this researcher, these participants were a highly diverse group of people. Outside the fact that they had all used a class A drug in the last month there were few common social histories.

The professional participants in the study for example took markedly different routes to establishing their lifestyles, some progressed through

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Higher Education (one woman had been a manager of a family-run restaurant and then took a position as a flight attendant for security, expressing a risk averse nature) while others were more entrepreneurial (another man had started a successful carpentry business in his own caravan). While another man had started a successful building business after completing a further education course.

Some other participants were highly creative such as a writer, a painter, and a musician: the first from a middle class professional background whose life experience had led him around the world. A second from a similarly middle class background whose drug use had oscillated and had been through a number of periods of drug treatment. The third had been in successful music bands all his life, and had undertaken large tours.

Another group of participants were brought together by their desire now to work in drug treatment and helping other drug users. They displayed a similarly diverse range of backgrounds: a merchant seaman; a career criminal; a Parliamentary private secretary; a tennis coach and tree surgeon. These participants came from vastly different places, but periods of challenging drug use had led them to a common goal of substance use work.

Finally there were a distinct group of participants who were brought together by their (generally lifelong) involvement in criminality. In all cases this was somehow connected to their drug use.

What these vignettes are intended to illustrate is that these participants lives overlapped and intertwined, converging and diverging. This researcher was left with the feeling that drug use and drug use behaviour can be quite limiting in its parameters. It was apparent that for a group of people to have led vastly heterogeneous lifestyles these participants tended to exhibit consistent sets of behaviours and characteristics when it came to using drugs. By its nature as an illegal activity drug use had tended to place quite restrictive boundaries around the behaviours of these participants. The nature of their lives had varied considerably but their actions around this

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one activity often created highly homogenous groups of behaviours. It is these behaviours which the next two chapters will describe.

Chapter summary

This chapter has described the substance use and social circumstances of the 30 participants who took part in this study. It has offered an insight into their lifestyles. It described their diversity of living arrangements, their relationships, both with partners and children, their employment status and economic circumstances. It then went on to describe their current illegal drug use particularly their class A drug use and their drugs of choice, before presenting findings on their criminal behaviour and engagement with the criminal justice system. It finished with a description of the current health challenges they face and their predominately negative experiences of generic healthcare provision and predominately positive experiences of specialist drug treatment services. Overall the chapter described a heterogeneous group from a wide variety of backgrounds. However it also began to describe their similarities with regards their drug use preferences and behaviours. The chapter has also begun to illustrate how these participants drug use has interacted with their lives and particularly what impact this is having on them now (e.g. in terms of their physical health particularly). The next two chapters continue this theme by presenting further findings from the study on how and why these participants are using drugs.

Chapter 6. 'Managing lifestyle' - how older adults use drugs

Introduction

This chapter now turns to answering the first of the main research questions - how these participants are using drugs. The chapter begins with an overview of the core category 'achieving balance'. As described in Chapter 4 the core category subsumes the two major categories 'managing lifestyle' and 'altering feelings'. These two categories answer the how and why questions of this study respectively. This chapter concentrates on the 'how' - describing the seven key properties of the major category 'managing lifestyle': type of drugs used; frequency with which drugs are used; amount of drugs used; amount spent on drugs; how drugs are taken; how drugs are bought, and social support and peer networks.

The core category, 'achieving balance', and its relationship to how participants are using drugs

As Chapter 4 described, the core category was found to be 'achieving balance'. This describes how participants were constantly balancing a range of different factors, such as: the different aspects of their lives; their personal responsibilities; the management of their drug use; their feelings about their own use; and how far they were coping with these feelings. Central to understanding the core category therefore are the concepts of management and control, i.e. how these participants were maintaining their drug use within the context of the rest of their lives.

'Achieving balance' expresses the totality of the participants' behaviour. When participants were 'achieving balance' in their lives and over their drug use, they were managing their lifestyle in a way they wanted to and able to maintain perspective over their perceived reasons for using them. When participants were less able to do this, their drug use became heavier and more frequent. They became less able to manage their lifestyle and

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However it is too simplistic to say that all of these participants consistently exhibited one or other of these types of behaviour. While this was the case with some, they were a minority. The behaviour and drug use of the majority of participants sometimes oscillated between stable and erratic, along with lighter or more heavier use. It therefore makes more sense to see the participants as people who used drugs in a certain way at various times, rather than to say that they were a certain type of drug user.

Major category 1: 'Managing lifestyle' - how people are taking drugs

The major category 'managing lifestyle' formed the part of the core category which described how these participants are using drugs. This includes the nature of their drug use but not restricted to it. As the chapter goes on the importance of context will become apparent.

Seven components, or in grounded theory terms 'properties' of 'managing lifestyle' were identified by the participants as central to understanding how they were managing their lifestyle. The seven properties are classified in three groups - factors associated with drugs; factors associated with individual's behaviour; and social or structural factors. It is these individual properties to which this chapter now turns - they are illustrated below in Figure 2 and then described throughout.

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	Individual properties	Characteristic of lighter, more infrequent use		Characteristic of heavier, more frequent use
Factors associated with drugs	Type of drugs used	Predominately hallucinogens and non-class A drugs	↔	Either opiates and crack
	Frequency with which drugs are used	Intermittent ≤ monthly	↔	Regular ≥ daily
	Amount of drugs used	Rationed, careful use of weights and measures - weekends only	↔	Laissez-faire use on any day of the week, any amount
Factors associated with individual's behaviour	Amount spent on drugs	Spending within a carefully costed daily budget	↔	Spending beyond means, often engaging in illegal activity to fund their drug use
	How drugs are taken	Orally, inhaled or smoked	↔	Injected
	How drugs are bought	Bought from friends or single trusted source	↔	Bought from an open street drug market, or closed market using long-term connections
Social or structural factors	Social support and peer networks	Non-drug using peers	↔	Only drug using peers

Figure 2. The individual properties and dimensions of the major category 'managing lifestyle' - describing how participants were using drugs.

During the course of the interviews, the properties in Figure 2 were identified as instrumental to understanding how these participants were using drugs. These are similar types of behaviours identified by other authors such as McPhee (2013), Warburton et al (2005) and Decorte (2001). All of these studies found that people who use drugs often impose what they termed rules or guidelines on their use, described by Decorte (2001) as ‘boundary protection mechanisms’ (p. 172). Decorte (2001) found that the participants in his study who adhered to these rules most often, were those who were most able to maintain control over their drug use.

When the participants in this study were adhering to all or most of the properties in Figure 2 they too tended to be able to manage their drug use better. They tended to use drugs infrequently and with a lesser intensity than at any other time. Managing all aspects of their life alongside this. Conversely when they were not, they tended to lead more erratic lifestyles and lapse into degrees of heavier and more frequent drug use. This man talked about this process well,

‘I know when I’ve got all my ducks in a row I’m doing well. When I’ve got money to spend, when I know I can get what I want, and there’re plenty of it around, I don’t have to worry about it. It’s all fine then. I can do what needs doing. It’s when there ain’t that I start clucking’. (Male 55 years)

However there was no apparent correlation between the numbers of properties each of the participants were exhibiting and their ability to manage their lifestyle in a way they wanted to. Each of the properties was personal to the participants. The presence or absence of one or all of them did not affect their ability to manage their lifestyle. Some participants exhibited only one property for example at the expense of others but were still able to manage their lifestyle well. While others exhibited more than one and were not. The reason for this seemed to be that different properties carried different weights of importance for each participant. It was the quality of their connection to the properties rather than the quantity which

was important. As such, an individual's status with regards to each of the properties is not intended to be a means of defining their total ability to manage their lifestyle, and the thesis does not present findings in this manner.

Finally, Decorte (2001) describes the processes used by his participants as unconscious. This was not the case with the participants in this study. It was clear that the properties they expressed were often consciously implemented. This woman describes this well. She also describes it as an ongoing process.

'I would say it is very conscious. I definitely like to keep a handle on it all the time. Many a time I'll have money in my purse and could have bought two bags instead of one, but I'll be strict with myself. When I got a bag, I'd not just do it all in one go. I'd be really strict with myself. I'd always be thinking about it. How can you not?' (Female, 53 years)

Others described the properties as 'morals', and another as 'guidelines'. Not all participants named them or identified them so clearly, but even those who didn't seemed to be aware of them (e.g. by describing them in others). However while they seemed aware of the role the properties played in their drug use, their desire or ability to maintain them fluctuated.

Types of drugs used

A fundamental dimension of these participants drug use was the type of drugs they used (see also Warburton et al, 2005).

Participants' drug use initiation

All participants had started taking illegal drugs in their teens or early twenties, and all were long-term illegal drug users. This supports existing evidence that reports the majority of people who use drugs do so from an

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early age; and those that do often continue for long periods of time (e.g. Chen et al, 2005).

Their initiation and progression into drug use was highly diverse. While around a half of the participants (14 out of 30) started using illegal drugs by using cannabis, supporting progress and initiation theories such as gateway theory, e.g. Kandel et al (1992), for remainder there was a less discernible pattern of progression to class A drug use.

Nine participants described a pattern of initiation and progression which was more erratic - typified by one woman who used a number of drugs, i.e. amphetamines, benzodiazepines and other opiates, along with cannabis, before becoming a regular class A drug user. This woman now nominated valium as her main drug of choice. Two other participants had progressed to using stronger opiate drugs such as heroin and morphine after having been prescribed prescription painkillers. This progression of less harmful substances to more frequent use of stronger drugs has been identified as a frequent route into addiction (e.g. Siegel et al, 2003; Lankenau et al, 2012).

For the remainder of the sample (7 out of 30) their initiation to class A drug use was more direct. These participants all mentioned having used class A drugs as their first.

Participants' drug use development

The development of the participants' illegal drug use was no less diverse. All participants talked about having experimented with more than one drug. However, the majority (21 out of the 30 participants) said that they could point to one type of drug that they had used predominately over the course of their life. They seemed to label themselves as either 'stimulant' users (e.g. amphetamine or cocaine users), or opiate users (e.g. heroin, opium, morphine, buprenorphine, or methadone users). While they talked about a commitment to using that type of drug, they frequently switched within them - none of those who considered themselves either a stimulant or opiate

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user, had switched to the other however. In some cases, seemingly to reaffirm this, some participants talked about how they had tried a stimulant (while considering themselves an opiate user) and vice versa, and not liked the experience. This man's experience typifies this well,

'Heroin to me ... I've always been susceptible from keeping away from it. But I went over to his place one day and he had some in a joint. He's gone to me do you want some of this I did know what was in it because he told me ... I took two drags of it something like that, I went from the settee ... into his toilet, I opened my mouth, it didn't need no help it just gushed out like a stream of sick down the toilet ... When I finished and I was wiping my mouth, all me head had caved in ... and I sort of staggered back to his front room, sat down and he's gone to me 'you alright' and I went, no I ain't alright at all. I don't know how you call this turning on mate, I feel ill. Oh because it's your first time, obviously your body's rejecting it. I went 'thank fuck for that'! So downers, no, no way me, no way.' (Male, 51 years)

Harms associated with drugs and 'managing lifestyle'

It became apparent early in the fieldwork that there was a loose association between the types of drugs used by these participants and the way they were able to manage their lifestyle. Those participants who were best able to manage their lifestyle in a way they wanted to and achieve balance in their life were those who were more likely to use those drugs they saw as less harmful (i.e. class B and C drugs) more regularly. When they did use class A drugs they were more likely to use cocaine, or hallucinogens.

Some participants talked about consciously barring themselves from using certain kinds of class A drugs they perceived to be more harmful. Most expressed that they felt there were different levels of harm connected with different drugs. Some talked with knowledge about research into drug related harm. One man for example mentioned the (then) new research by Nutt (2009) into the harms caused by legal and illegal drugs. His narrative questioned the criminalisation of drug users suggesting that tobacco and

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alcohol caused more harm than certain drugs. Another man who had only ever used hallucinogens, knew enough about the class A classification to question it,

‘The whole classification of drugs is nonsense. Talking about substances and how dangerous they are and how much damage they do, you have very powerful substances like heroin in with LSD, which, as far as I know, has never killed anyone’. (Male, 63 years)

A number of the participants expressed a hierarchy of class A drugs seeing some as more harmful than others. Opiates were regarded as more harmful than cocaine (or crack) for example, which was regarded as more harmful than amphetamines (however any injecting behaviour was regarded by most as more harmful than any other method of administration). While the least harmful class A drugs were regarded as ecstasy, and finally hallucinogens as the previous man highlighted. All participants who expressed an opinion perceived heroin as the most harmful drug that anyone could take. This man exemplified this opinion connecting taking opiate use to harm,

‘I think people take different things for very different reasons. I mean I doubt if someone using something to get them up would move onto heroin unless they had major trauma and just wanted to do themselves harm, you know? They’re not very positive things, they’re very addictive and just do harm. That’s a huge difference. I always kept people who did that sort of thing at arm’s length; it just meant trouble to me. LSD is more of a life affirming thing I think and that’s always the way I looked at it’. (Male, 63 years)

These opinions are not necessarily confined to the participants in this study. Morgan et al (2010) found that drug users understand well the potential harms which different drugs can do. The 1,500 respondents to their survey of UK drug users, judged opiates and cocaine as most harmful, while ecstasy, cannabis and LSD were regarded as least harmful.

In a similar way to the participants in this study Morgan et al (2010) also found that those drugs their respondents regarded as least harmful were also perceived as having benefits. This is also supported by Carhart-Harris and Nutt (2010) who found that drug users also found beneficial effects in hallucinogenic drugs such as psilocybin (or 'Magic Mushrooms').

Importantly the opinions of Morgan et al's (2010) respondents correlated well with those of practitioners which did not reflect any classification under the Misuse of Drugs Act (1971). This suggests that they were based on their own personal judgements rather than reflecting generally held beliefs. More recent support for this comes from Singh and Luty (2013) who found that drug users expressed more fear of heroin and alcohol than non-drug users. The authors conclude that this may be a mechanism which helps to protect certain drug users from becoming addicted to more harmful drugs than they are already using. This seems to exemplify the positions of many participants in this study well.

Helzer et al (2006) support this view that not all drugs are equally harmful. They take their argument one step further however and call for a more sophisticated refinement the classification of SUDs on the Diagnostic and Statistical Manual of Mental Disorder (American Psychiatric Association, 2013). They suggest that a spectrum of SUDs would be more accurate, arguing that someone addicted to heroin for example shows different symptoms (and therefore requires different treatment) to someone diagnosed as being addicted to cocaine or cannabis.

Perhaps seemingly reflecting this a number of participants made a connection between the type of drugs that participants used and their reasons for using them. Many, like the previous man, connected an individual's drug choice to their perceptions of their ability to manage their use. Those participants who talked about being less able to manage their drug use tended to be using drugs such as opiates (predominately heroin). However, their initiation and pathway to heroin use differed. Some talked about a slow sequence of experimentation from class B and C drugs such as

benzodiazepine, cannabis, or opium use to heroin use, supporting progression theories such as gateway theory (e.g. Kandel et al, 1992) or stepping stone theory (e.g. Golub and Johnson, 2001). However, others talked about deliberately choosing to embark on the path towards what they saw as heavier use by opting for the most harmful drugs such as opiates.

‘For me ... I started on heroin straight up and took to it right away. No problems on that one at all. I went onto injecting pretty quick, it were easier I thought and back then I think I knew I wanted to be a junkie’. (Female, 52 years)

This woman specifically wanted to use heroin, in order to become what she described as a junkie. In her eyes only people who used heroin could be described in this way, and she talked about them (and therefore herself) in the most derogatory terms. She was not alone in associating heroin with the term junkie.

Nearly all participants who talked about heroin use (not necessarily their own) mentioned its painkilling or anaesthetic qualities. Every participant who used heroin, except one, went on to use it (at some point) frequently and heavily, and nearly all of these participants talked about mental health issues in relation to their drug use. This offers support for the Self-Medication Hypothesis first developed by Khantzian et al (1974) to describe how people use drugs to help them manage distressing mental states. This relationship is explored further in the next chapter.

It was also apparent among some of these participants that legal drugs such as tobacco and alcohol had a role to play in their drug use regimes.

Legal and illegal drug use and ‘managing lifestyle’

Twenty-seven out of the 30 participants said they drank alcohol every day, with two of these participants labelling themselves as alcoholics. Two of the participants who did not drink alcohol were a married couple. They were

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also the oldest of the 30 participants. All participants except three smoked some sort of tobacco cigarettes every day. Participants reported that they had been smoking tobacco as long, or longer than using illegal drugs

Legal substances seemed to play very different roles in the lives of these participants. Some mentioned that the availability of legal substances was helping them to manage their illegal drug use through substitution, such as this man.

‘it helps with the other if I drink, keeps me away from just having a dabble. I can live with that because keeps me out of trouble, keeps me away from things I need to stay away from, and away from people I don’t need to be around if you know what I mean? You know what as well though, if I go back to Dr [gives GP’s name] with liver trouble they’ll be’ fine we can deal with that’ but if I go back as a junkie with whatever again I’ll be out on my ear ... stupid ain’t it.’ (Male 58 years)

This man was a lifelong heroin user but was now taking a more instrumental approach to his substance use. He was using alcohol to help him manage his heroin use, and its associated harms better. However, this was not without tension. He also talked about the harm he felt his alcohol use was doing to him and his treatment by the health service.

Cross addiction from illegal drugs to alcohol is apparent among all age groups and a range of people who use drugs (Johnson and Alberici, 1998). However it may play an important role in drug use among older adults as a result of physical changes due to ageing. Some participants such as this man who drank alcohol frequently knew that its use was harming his body, however he felt that using it as a substitute substance kept him away from harms caused by illegal drugs such as crime and less manageable physical conditions. He also felt that any medical conditions he developed because of his alcohol use would be more likely to be treated by his GP. He felt this would not be the case if he presented with problems more likely to be associated with illegal drug use.

The majority of participants though did not see any benefits, or differences for that matter, in the harms associated with their legal drug use and their illegal use. In fact the opposite was more likely to be true - a number of other participants, whether they were using legal substances as substitutes or not, felt that drinking alcohol and smoking was now causing them more harm. This man particularly saw his problems now being more as a result of his legal substance use rather than illegal drug use,

‘If there’s anything I’d really like to cut out it would be cigarettes and or alcohol. I see cigarettes as being the most dangerous substance I’m taking at the moment, with alcohol as a very close second. I can see that... I haven’t totally crossed over but in a lot of ways I have transferred my substance use and it’ll probably do for me quicker than anything else I take.’ (Male, 57 years)

This tension between the perceptions of legal and illegal drugs was a common thread throughout many of the participants’ narratives. Even the married couple who did not smoke felt that alcohol and tobacco were more harmful than using hallucinogens, which were their main drugs of choice, and harder to stop using. This is not only evident in these participants. Singh and Luty (2013) found that drug users are more likely to regard alcohol as a ‘menace to society’ (p. 221) compared to non-drug users.

The participants in this study who had experienced problems because of their illegal drug use often expressed their frustration at finding it harder to manage their alcohol and tobacco use, than their illegal drug use. The reason given for this was frequently concerned with the availability of legal drugs, illustrated well by this woman.

‘I got addicted to cigarettes when we were in Holland. When we were in Bradford, we only used to have draw at the weekend. But when we were in Holland, because it was so much cheaper, and the availability, we used to

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smoke draw every day. That got me addicted to cigarettes, because of using the joints and I bloody can't kick it, now can I?' (Female, 55 years)

Like this woman, some participants felt that rather than helping her manage her illegal drug use, the free availability of legal drugs was somehow conspiring in her inability to manage her use better. All of this seems to add support to Zinberg's (1984) and Decorte's (2001) positions that that an individual's personal characteristics and social context are just as important in managing their substance use as the substances they use. Participants who were having, or had, problems managing their illegal drug use seemed to be just as likely to have similar problems managing their legal substance use. As one of the men quoted above suggested - they had seemingly transferred their use from one substance to another.

A more flexible pattern of drug use

Further support for Zinberg's (1984) and Decorte's (2001) positions comes from a subsample of the group. Nine participants talked about changing their main drug of choice over the course of their life or not having a main drug of choice, but choosing different drugs for different reasons, including stimulants and opiates, legal and illegal substances. This man describes this well,

'I've used every drug known to mankind; you know ... the package increases as time goes by. The package increases to heroin, methadone, alcohol. At one time it was methadone, now it's methadone, heroin, alcohol, cocaine, crack, benzos, like, one, two, three, four, five, six, you know, and it goes on ... whatever I wanted, for whatever I needed.' (Male, 52 years)

This man talked about having used many different drugs at many different times, sometimes simultaneously. However sometimes his use had been frequent and heavy while at others it had been less frequent and much lighter.

On the face of it, these participants seemed to show a different and more dynamic pattern than those presented earlier who were able to nominate a drug type of choice. However, they simply served to illustrate the same pattern in a different way. Like others similar to him the one pattern this man did identify is that the times he used drugs less frequently were those that coincided with positive factors in his life. When he was using drugs infrequently and in moderation, he was in his own words ‘a responsible parent’ in regular and full-time employment. This is in contrast to when he used illegal drugs more frequently and heavier and was, again in his own words, ‘fly-by-night and unreliable’.

Poly drug use and ‘managing lifestyle’

Those participants who used more than one drug or who tried a number of drugs (or different types of drugs) tended to talk about experiencing problems with their use. Those participants who were poly-drug users frequently talked about doing so because their drug of choice was not available; principally it seemed to offset any negative withdrawal symptoms.

‘sure I’ll take H but if it’s not available I’m not gonna to go without, I don’t want to be sweating do I? I’ve taken anything I can get my hands on, it’s easy to get someone else’s script to tide me over, or I’ll pills or weed or even get bladdered if I have to, if I’m in the mood for something I’m not going to go without.’ (Male, 58 years)

However rather than switch drugs indiscriminately this man said he was more likely to use other drugs that gave him similar effects to heroin. For him there was a clear relationship between the reasons he chose the drugs he did and the types of drugs he used. This pattern was consistent across most, if not all participants.

Other participants who had used drugs more heavily also talked about feeling they would not have had a problem with drugs if they had a steady

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supply of their drug of choice. This is similar to Levy and Anderson (2005) who suggest that one of the most important factors for using drugs into older age would be how people handle lean times when they were not able to acquire the drugs they wanted to.

There seemed to be a difference among the participants, that suggested those who used more than one drug (and especially more than one type of drugs) were doing so as a form of management by switching drugs when supply was scarce. The alternative pattern of poly-drug use amongst these participants was that they were switching drugs for instrumental reasons, i.e. using cannabis to offset any negative withdrawal symptoms from stimulants such as amphetamines or cocaine. Both of these patterns suggests support for EMCDDA (2002) which describes more entrenched drug use among older poly-drug users. In comparison, the participants who were best able to manage their lifestyle talked about how they were comfortable not taking any drugs if they were unable to acquire their drug of choice.

In sum, those participants who were managing their lifestyle least well described themselves as favouring the most harmful kinds of drugs. However the context in which they were using them seemed just as important to their ability to achieve balance in their lives, as the drugs themselves.

Frequency of use

Another fundamental dimension of these participant's drug use was the frequency with which they used them. Again this was also found to be the case by Warburton et al (2005).

Ten out of the 30 participants interviewed said they used an illegal drug every day, while 11 said they used illegal drugs at least once a week. Both of these groups were more likely to be heroin users or those participants that injected their drugs. The remaining nine participants said they used illegal drugs approximately every month.

Weekend/weekday drug use and employment

Participants varied in terms of the flexibility of their pattern of drug use, using drugs at different times of the month, the week and the day. Those who talked about managing their lifestyle in a way they wanted to said they used them in a more structured fashion, at certain times. A number of participants had clear guidelines about when they allowed themselves to use drugs. With this style of use, there were times when it was appropriate to use drugs and other times when it was not. Perhaps the most clearly defined time for these participants to use drugs were at the weekend, or more accurately Friday and Saturday nights, so that it would not affect their working week. This man elucidates this clearly, describing his own pattern of use as a regular schedule,

Q. So how frequently would you say you are using drugs at the moment?

A. 'in moderation maybe, a weekend thing maybe, tolerable maybe, I think it can be tolerable to be honest with you, but you have to know when you can do it. I know Friday night I go out with the boys, have a fucking good sherbert. Saturday we're going football, football, drink and a smoke. Sunday, maybe Sunday morning have a drink but Sunday night I've got to be in bed and relax, otherwise I ain't going to work Monday ...' (Male, 53 years)

The important point for this man was that he would specifically keep Sunday to recuperate from any excesses, or in case he felt any negative effects because of his weekend use. What was also apparent was that he talked about his use now being 'in moderation' and about it being 'tolerable' with reference to his age now as well. He had been using drugs more heavily at one point in his life and used this structure firstly to help him manage his use better, but also to enable him to continue to use drugs as he talked about becoming conscious of his own physical vulnerability.

For the participants in this study it was clear that they had internalised 'working-week/weekend-leisure' and expressed it consistently. The difference seemed to be how far they subscribed to it. This reflects what Calafat et al (1999) describe as a structured social pattern or a new cultural model. If this is a cultural model then it is one that was well understood by the participants in this study, thus extending Calafat et al (1999), whose work concentrated on young people and cultural change. For these participants this wisdom was acquired through experience and age. More recently, Measham and Moore (2009) have documented patterns of increased drug use at weekends among substance users, suggesting that this is not an isolated phenomenon.

For some their working week and their related lifestyle were not restricted to nine-to-five, five-days a week, however they still talked about building their drug use around this. Once again underscoring the importance of employment in managing an individual's drug use and lifestyle. They managed their lifestyle but again by only using drugs during their time away from work when they would have downtime to recuperate such as this woman, who had previously been a long-haul flight attendant,

'But the thing is I mean I wouldn't take it when I wasn't flying, and I wouldn't take it if I wasn't doing a long shift or an overnight shift, so I wouldn't say it was regular. My days off were my own and I tried to unwind, when I have a line or two, whatever the day of the week that was'
(Female, 51 years)

This woman talked about using cocaine recreationally but also talked about taking amphetamine tablets during the week to help her stay alert during flights. Both of these factors were clearly connected to her perceived ability to function at work most appropriately. She did not take what she saw as a more harmful drug when she was not working. She seemed to have rationalised using amphetamines as instrumental to her work, and cocaine during her breaks. She also talked about the potential risks of using cocaine, including how she had 'Googled everything that people mix with it'

(adulterants), illustrating her awareness of risk and harm. She went on to talk openly about the fear she experienced about having a negative reaction while at work.

‘I can’t trust and know something that I don’t have total control over with a job at stake. It was different when I was at college, if I had a bad reaction or anything I knew that I could miss a day of study and the recriminations wouldn’t be that harsh. But at the airline I can’t risk not showing up for work, or even worse having a bad reaction while I’m at work, so that knowledge is important. I think it’s important to say even now when I’m taking something I’m very, very careful’. (Female, 51 years)

This woman didn’t want to keep taking drugs if she might lose her job. For a majority of these participants employment was a crucial property in their drug use behaviour. Existing research in this area seems to be dominated by the effects of drug use on employment outcomes, whether people who use drugs are more or less likely to be employed (e.g. MacDonald and Pudney, 2000, 2001), or the barriers faced by people who have experienced problems with drugs in regaining employment (e.g. Sutton et al, 2004). However authors such as Granfield and Cloud (1999) have highlighted the importance of employment in maintaining social capital, while Warburton et al (2005) mention the importance of the work role in moderating drug use. What is implicit in this work, and among the narratives of these participants, is the perceived importance of employment in maintaining a foothold in non-drug using society or the regular economy.

When participants were integrating their drug use and other parts of their life, such as their work, they made a conscious effort to maintain that drug use had a very clearly defined place in their life. It was expressed by more than one participant that this made them ‘someone who uses drugs’ as opposed to a ‘drug user’. This is related to what Warburton et al (2005) termed a ‘junkie identity’ (and touched on earlier with one of the female participants) - an undesirable state or identity identified by some people who use drugs. For some participants this notion of being a junkie was driven by

a shame or stigma associated with drug use. Some talked about how they saw drug users as uncontrolled criminal heroin users (e.g. Radcliffe and Stevens, 2008). Defining themselves as apart from other people who used drugs was very important to some of the participants.

While some participants talked about curtailing their drug use to fit in with their work regime, others without a job talked about how they had to try very hard to keep avoiding their use becoming heavier. Some participants who were using drugs more heavily talked about having started using them at the weekend, but had, as their use had become heavier, relaxed this.

‘For a long time it was, ‘I’ll get paid on Friday so I’m going to buy it.’ It would be Friday, Saturday, Sunday, and then perhaps Monday, and I’d perhaps try and save a little bit for the middle of the week. So it would be Friday, Saturday, Sunday, Monday, and then perhaps Wednesday. There was only two days where I didn’t have it ... and then the problems started. It’s been like that ever since’. (Male, 53 years)

This man has been unable to maintain the weekend/weekday division, drifting incrementally towards problems with his use. He had tried to maintain ‘only using at the weekends’, but as time had gone on and he had been less able to manage his use, it had spread into the rest of the week. Even then, he still thought of Friday as the beginning of a usage cycle.

Other participants had previously let their drug use slip in this way but were now consciously trying to re-implement weekend-only use as a way of managing their use. One man without a job for example, talked about trying to adhere to the weekend-only guideline,

‘I hold myself together and keep on and know I’ll be doing it at the weekend. It’s what’s keeping me together now. I think I can keep it up for now so long as I can get into a routine, it’s important for me to get a routine, I think when I get a habit going, like a new habit maybe then if I can do it I

think I've got a chance at making some changes and not letting drugs run my life for the rest of my life' (Male, 56 years)

Similarly, re-establishing weekend-only use had also become important for another man who had used drugs more heavily in the past. This man was also trying to manage his use once again by designating weekdays drug free. Both of these men had become aware that weekday use had made them unable to manage their use. As a result, they were now trying to maintain their use only at the weekend. Contrary to Decorte's (2001) assertion that cocaine users implemented such guidelines only unconsciously, these participants were consciously seeking to limit their use to weekends, even though (like a number of the participants in this study), they were unemployed. Without the structure of a job, they sought distractions during the week to curb their use. They recognised weekend-only use, through past experience (when they were employed and managing their lifestyle better) as key to avoiding harmful outcomes. It was a pattern they were familiar with which worked for them. It was also expressed as an ongoing process which required frequent monitoring.

Somebody else who was trying to manage her lifestyle again after a period of heavy use had also developed a conscious strategy to mitigate any risk of using drugs during her working week. This woman still felt that she needed to use drugs in order to manage her reintegration into working life, but knew this involved risks. So to manage her lifestyle best she was testing the drugs she would be using in the morning, the night before,

'I have the morning one ready at night. Sometimes you can have a dirty hit and I have to try a bit that night because I think if I go down with a dirty hit in the morning I'll be late for work'. (Female, 53 years).

This woman had been aware of problems associated with using drugs during the week and was now trying to implement a strategy to offset that.

What these examples also show is that experience has become important in helping them to manage their drug use better. It is also a good example of how the participant's drug use cannot be looked at in isolation from the rest of their lives. Some participants had learned important lessons as a result of their lifetime use which they were now implementing.

For all of these participants this understanding that using drugs at certain times which did not interfere with other aspects of their lives, was the safest way of protecting themselves against a use pattern they did not want. These participants talked about this as part of a conscious process of reflection. They were describing an ongoing progression of self-monitoring akin to an internal monologue. Even those participants who had infringed on this principle recognised they had done so, and were able to describe it. While other research has shown that these properties exist (e.g. Warburton et al, 2005) it is only research into drug use in older adults (e.g. Levy and Anderson, 2005), with their life course of experience, which has described this type of reflection.

Amount of drugs used

Just as these participants used reflection and experience in the process of managing their frequency of use, a number talked similarly about the amount of drugs they used. They often talked about a process of rationing their quantity of use, which reflected the temporal rationing the participants expressed previously. One woman used the term 'ration' unprompted and went on to describe how she took a certain amount during the day, in the morning, the afternoon and the evening. She used this to manage her use better. She had also maintained a moderate use pattern by buying what she could afford and using it over an extended period. Another man talked similarly about managing his use in this way,

'My attitude is to buy a lump, sit on it, and gradually spread my way through it. I've still got about thirty or forty grams of the last one I bought,

which I would have bought in Easter. If I can afford it, I grab a chunk of it, put it aside. (Male, 52 years)

This man said that he bought a ‘lump’ of opium when he could afford it and used his limited means to control his use. Some other participants who used drugs every day described managing their use in a similar manner - by portioning it out over a period. A man and a woman from a married couple were interviewed independently (both were aware the other was taking part in the study) and mentioned this. They described how the wife would divide their purchase into seven piles, and they would share one each day. Her husband described the same interaction exactly, and both went on to describe how this tactic helped them to manage their use. It was a conscious strategy they had negotiated between themselves - both agreed that the wife was more trustworthy partner and her management skills had enabled them to do this effectively. Both seemed to be describing a scenario whereby she was more responsible for their pastoral care, almost adopting a more traditionally gendered division of labour.

Like other participants in this study, this couple knew how much they were using and when, although they didn’t restrict use to a particular time of the week or time of day. Not only did they see this as effective for monitoring their day-to-day use, they also felt this would be important for their long-term use now they were getting older.

Similar to the participants in this study Greenspan et al (2011) found that ‘club-drug’ users (p. 56) utilised guidelines to manage their drug use, key to these guidelines were their participants ability to ration their drugs. The authors assert that this was a conscious and ongoing process. Frank et al (2013) also found that their sample of cannabis users took a systematic approach to their use in order to avoid it conflicting with their daily lives. Particularly the authors talk about ‘balancing a controlled use’ (p. 44) within the rest of their day to day activities.

All participants talked about the weights and measures of different drugs they liked to use, in a knowledgeable way. Coupled with this they were aware of their tolerances to each, and again, like his couple, showed an awareness that this was changing as a result of their age.

Participants who had used drugs more heavily than those quoted above had described less monitoring, or an active flouting of their desire to monitor the amount they used. In a similar way to those participants who were using drugs indiscriminately during the week. These participants used terms like 'bang at it', 'shovel it in' or 'necking pills' to describe use without attention to amount. This man talked about what happened when he stopped monitoring the amount he used each time,

'I know I'm doing more now than I ever did; I don't have a bottomless pit of money; I know my money don't go far anymore, but I don't care, I don't know why, you can ask me that over and over but I don't know. It's not a conscious thing. I know when I get a pocketful again it'll all be gone. I say 'right, I've got a bit of heroin coming and so I might as well get a bit more crack.' You try and say 'I am not going to buy a load. I'm not going to spend five hundred pounds or whatever, but you do, when it has run out after about an hour I just want more.' (Male, 58 years)

This man had managed his drug use more carefully in the past but now felt less able to. He had some awareness of his level of use on reflection but only up to a point. When he said 'you can ask me that over and over' he signalled defensiveness. It wasn't clear whether he really didn't know why he couldn't manage his use or whether he just chose not to confront it.

Those participants who felt unable to manage their lifestyle as they wanted to, typically recognised this but felt it was a barrier they could not currently breach and thereby externalise. Some externalised this as lack of regard for themselves and their health, frequently talking about themselves in disparaging terms. There were others who talked about these barriers in more structural terms. These personal and structural factors will be described next.

Amount spent

Eighteen out of 30 participants said that they spent approximately £50 a week on their illegal drug use, with the remainder saying they spent more than this. Seven out of the 10 participants who said they used illegal drugs every day reported spending less than £50 a week. This was financed in a range of ways including crime, benefits and employment. Those who spent more on drugs were either using more expensive drugs, and were generally involved in crime to finance their drug use. This was similarly found by Bennett et al (2008).

As mentioned above, some participants were using financial constraints to manage their drug use. Some participants budgeted by the day; others talked about their drug use in terms of a household budget. The amount of money spent on drugs was also talked about as an external indicator of one's level of use. Some participants used their disposable income as a way of managing their lifestyle. Just as they set other expenses, they would set aside a finite amount of money for their use. Warburton et al (2005) identified that an individual's ability to pay for their own drugs through legal means as an important dimension of control. One woman for example talked about her general skill at budgeting. Similarly, another man talked about how he and his wife, who were both currently using drugs, budgeted in a similar way. They had learned to curb their use when they did not have much money to spend on drugs,

'I'm not doing much at the moment ... we're really short of money, like everyone is, we have our bit of money put aside for the gear between us but we're having to make it last longer these days. We do about a gram a week now between us. (Male, 56 years)

Both of these participants were currently managing their drug use as they wanted to and were buying drugs within their disposable income. This man's reference to the current national financial situation suggested another

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layer of macroeconomic influences were important in helping some to regulate their use. These participants saw external pressures beyond their own earning ability, as important in regulating their drug use as any other factors.

Participants who did not allow money to dominate their use talked about looking for new ways to make money to buy drugs, typically through crime. Those participants whose drug use had become heavier and more frequent talked about living beyond their financial means, spending as much as they could on drugs, consuming them until they were all gone and then attempting to acquire more money to buy more drugs as quickly as possible. Some participants had only begun to face the scale of their use when confronted with clear external financial markers such as this man who talked about having spent all of the money he had made from a house sale on drugs,

‘Then in the end it got so I had to sell my house, which I lost out big time on because I had to sell it quick. You’d have thought after having to sell my house through drugs, that would have been it, like, you know, that’s it, I’ve finished with them. But, no, once I got that money then, it ended up I’d got forty-six thousand pounds left so I just went big time, even worse than I was before.... Now, I’ve lost everything I’ve got.’ (Male, 50 years)

Two participants spoke ruefully and consciously of their level of use and expense. Both had turned to illegal means to support their use. For these participants illegal money-making activities coincided with heavy use. As one man put it,

‘To keep habits going, you either do two or three things.... You either sell them, you either go out and commit major crime, you go shoplifting, or you rip people off by doing burglaries and things like that’. (Male, 58 years)

This man was committing crime to manage his lifestyle, expressing what he felt were his limited options. He made a distinction between what he called

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drug users with a 'habit', meaning someone who he felt was compelled to use drugs through addiction, and others.

Some authors have suggested that there is little evidence available on the study of drug use and illegal earnings (Uggen and Thompson, 2003; Debeck et al, 2007) . Debeck et al (2007) found that the majority of injecting drug users enrolled in the Vancouver Injection Drug Users Study, had committed crime in the past month to fund their drug use. However, perhaps more importantly, those using heroin and cocaine were significantly more likely to commit crimes than those using other drugs. They conclude by stating that a significant number of their participants said that they would give up their illegal income if they did not need money to pay for their drug use. Uggen and Thompson (2003) also found that drug users increased their illegal earnings along with the intensity of their heroin and cocaine use (compared to other drugs). As with Debeck et al (2007) they also found that as people began to manage their drug use better the desire to earn money illegally decreased quickly.

The participants in this study frequently connected heavier use - and the resulting increase in money spent on drugs - to crime. Those participants who used all of their disposable income and savings to buy drugs felt they were left with only two options - to stop using drugs or find money by any means to purchase them. Those who chose the first option were often more likely to be those participants who had other aspects to their lives, where drug use was not central to their identity. Those who took the second route were more likely to be those for whom drug use had become disproportionately important, and fundamental to their sense of identity.

How drugs are taken

Participants used a mixture of administration methods to take their drugs - they smoked or inhaled them, took drugs orally or injected them. Generally, the way participants took their drugs was not only connected to the type of drug they were using but their overall drug use style. Those people who

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used heroin or other opiates tended to inject them, while those people who used cannabis and cocaine, tended to smoke or inhale them. All participants understood that the method of administration was connected to the intensity of the feelings they experienced (or would experience) from their use. This man highlights well the different effects that the different methods of taking amphetamines has on him,

‘If I took it orally it’s more physical, the instant gratification part on the works where you’ve got that head rush initially, where you come out of that head rush I’d be quite content to sit on that settee and do absolutely nothing because it feels as if it’s all in my head and it’s not physical at all. Whereas if I do it in a ‘depth charge’ wrapped up in a Rizla I want to get up and go on a mad cleaning thing you know where you could eat your fucking dinner off the top the door you know what I mean because it’s all wiped down disinfected, if I’m injecting though [gives sharp intake of breath] that’s a different ball game you know? I just go on and on, I don’t stop for days’
(Male, 54 years)

All participants who injected drugs talked about the difference in the intensity of their feelings when they injected as opposed to taking them in any other way. They were also aware however that injecting drugs incurred a range of associated risks and harms, particularly as they got older, and that once having done so they had found it hard to take drugs in another way.

Injecting drug use is frequently associated with harm and other chaotic behaviours, such as using non-sterilized needles thus putting the user at risk of infection from blood borne viruses, increased likelihood of criminality, risky sexual behaviour, homelessness and poor health (e.g. Detels et al, 2004; Jones et al, 2005; March et al, 2005; Le Marchand, 2013). Conversely Darke et al (2004) found that non-injecting drug users were more likely to be better educated and employed. While less likely to be involved in crime or be enrolled in drug treatment programmes. They also described less frequent patterns of drug use. This is supported by follow up work by Darke

et al (2009). These patterns seem to characterise the participants in this study well.

This issue of method of administration was found to be fundamental to how and why the participants in this study are using drugs. Those participants who were managing their lifestyle in a way they wanted to tended to take their drugs orally or smoke them. This distinction particularly applied to people who had used heroin and crack cocaine, which can be prepared for injection. The only participant who talked about heroin and other opiates as his main drug of choice and had always managed his lifestyle well, said he had never any injected drugs.

‘I think that’s another thing that’s stopped me from sinking really low. I’ve never injected, never. I think once you do start on the injecting thing then it does grip you more’. (Male, 53 years)

This man regarded the method of administration as an important property in managing his lifestyle as he wanted to. This was also the case for other participants who had talked about using heroin and other opiates infrequently, and those who were trying to manage their drug use better after periods of heavier use. Nearly all of those participants who smoked or took drugs orally mentioned the fact that they had not injected them and talked about those who had injected them as indicative of having a problem. Nearly all participants identified injecting unprompted as what they felt to be a problematic behaviour, including people who injected. Some participants moved away from injecting in an attempt to manage their use better. This woman made this connection explicit as she described her plans,

‘I’d like to get onto smoking, that’s the next step. When I’m clear of needles that’ll be a day. Then it won’t be long before I’m off altogether’. (Female, 52 years)

When asked about what she based this on she felt that using syringes carried a range of risks, such as HIV/AIDS, hepatitis and abscesses at injection

sites, along with the increased risk of overdose. She talked about being aware of the health risks associated with injecting drugs and saw a move away from that as a move away from higher risk and therefore better health. For her the issue of injection was one of risk. Particularly now she perceived herself as more physically vulnerable because of her age. Existing evidence supports these participants belief that relates use cessation with moving away from injection - this is not only the case for complete cessation of drug use but also short-term injecting cessation (e.g. Bravo et al, 2007). Further to this Bridge (2010) argues that while injecting drug use is frequently associated with drug use harms, little attention is paid to helping drug users move to less harmful methods of administration in order to manage their use better.

How drugs are bought

The way participants bought their drugs tended to reflect a combination of their perception of personal risk and their connection to the drugs world. Participants purchased their drugs from a range of sources depending on which particular drugs they wanted, how much and how often. For many participants the most important issue when it came to buying drugs was trust. This man for example talked about how important it was to have a trusted source to buy from,

‘I would never have taken something from someone who hadn’t taken it themselves, like a recommendation from a friend. I couldn’t afford to. I took them because I felt as though I had to and in doing that I took them from a trusted source. If the people I knew hadn’t had anything for me I would have gone without and probably drunk very strong coffee for a night or two’
(Male, 52 years)

Generally when participants were managing their lifestyle in a way they wanted to they were reluctant to associate with the people they saw as drug users and dealers. This meant only buying their drugs from people they knew and trusted. These participants identified the act of buying drugs from

open markets (i.e. where there are few barriers to access, and anyone who looks like a plausible buyer will be able to purchase drugs, e.g. Edmunds et al, (1996)) or from people they didn't know or trust, as very high risk and indicative of problem use. This man for example highlights both of these concerns,

'Likewise, approaching a likely looking teenager on a corner, it's not going to happen. I've never tried it, but I wouldn't be particularly comfortable.'
(Male, 52 years)'

He went on to talk about how he was not only concerned with the potential of being arrested, showing himself as someone buying drugs in public, but this quote also highlighted his consciousness of his age. A number of participants talked about how they felt more vulnerable about their use now, regardless of how and why they were using drugs - feeling that drug use was something associated with younger people.

All participants talked about trust among their peers, people they used with and bought from, but it was most apparent for those participants who were managing their lifestyle in a way they wanted to. Those who relied exclusively on trusted sources were more likely than others to be employed, many in a professional career, more likely to be married, have children, and have friends and acquaintances who did not use drugs. Many expressed how much they had to lose if their drug use was ever exposed. The fear of arrest and sanctions was very high among these participants. This issue of stigma was one of the factors that helped these participants seemingly manage their lifestyle in a way they wanted to - they expressed going without drugs if they couldn't buy from a trusted source. For one woman in this study her fear about being found out or uncovered manifested itself initially in concerns about the unregulated nature of the drug trade,

'I wonder what's gone into it and what it's doing to my body. Cocaine especially, who knows what's in that. I mean I had a look on the internet one time, I can't remember, there were things on there saying it gets cut

with, mixed up with, worming powder and insecticide and other stuff too. I don't know how true those things are, they might just be scare stories, but they scare me. I'm really worried about that ... I don't know where I'd end up if I took something bad' (Female, 51 years)

This woman talked about the adulterants she feared were in drugs, but on further probing her fear was connected to either becoming sick as a result of adulterants, and coming to the attention of healthcare services as a result, or the police. To minimise this risk she only bought from sources she could trust, such as long-standing friends. This also has reference to Myers et al (2009) who found that people tend to avoid seeking any kind of help with their drug use for fear of losing their job or status if they were identified as a drug user. In a similar way other participants also feared retribution by purchasing drugs from unknown sources. For this woman this manifested itself as a fear of becoming a victim of a crime if she bought drugs from open-air markets. She also tied this concern to being a woman,

'I suppose with acid always trusting someone to make sure it's okay, knowing where you got it from, knowing who was sort of getting it ... being careful, it's just about being careful, and trust, trust is very important, I think especially for a woman, I don't give my trust away too easy'. (Female, 58 years)

Participants who were using drugs less frequently and more moderately than their peers in this study, seemed to have an increased sense of risk and a sense of their own safety. This reflected their attitude to drug use more generally. They understood that there was a level of risk to any drug use and took care to monitor and minimise this risk to what they saw as an acceptable level. Decorte's (2001) study of cocaine users also revealed that users preferred sources they could trust to avoid being 'ripped off' (p. 164). He goes on to conclude that for participants to express feeling safe while buying their drugs it was better to make a purchase from 'a regular dealer with whom a relationship based on trust can be developed' (Decorte, 2001, p. 164).

All participants had their own perception of risk, and measured and tolerated it differently. For some, a certain amount of risk was acceptable, while for others any risk was completely unacceptable. Participants who were using drugs more moderately than others in this study tended to tolerate less risk, being careful to hide all facets and outward indicators of their drug use from non-drug using friends or partners such as this gay man,

‘I’ve had three long-term relationships – I’ve actually lived with somebody – and they were never drug users. It was never really an issue with the first two but the last one it was. He was very anti-drugs. I told him when we first met that I was on drugs. It’s like them or me, in other words, so I told him that I’ve packed them in ... he doesn’t have a clue, not a clue’. (Male, 50 years)

This is supported by work from previous authors. Frank et al (2013) also described how ‘socially well integrated’ (p. 44) cannabis users kept their drug use separate from the rest of their lives in this way. While participants from studies by Oselin (2010) and Tempier et al (2011) both (independently of each other) identified the level of risk associated with their use. They talked about having too much to lose by not managing their use, and thereby exposing themselves as drug users.

Participants who were using drugs more heavily and more frequently than others in this study saw risk differently. Some of these participants seem to have stopped monitoring risk altogether and were less careful about their own health and behaviour. As their drug use had become heavier and more frequent they described a process whereby their attitude to risk had all but diminished. To them their greatest risk was not being able to buy drugs and feel the onset of physical and psychological withdrawal and all of the associated feeling that came with that. This man describes this declining tolerance for risk well - he funded his drug use with progressively more risky criminal activity,

‘It was for the greed of it all, just for the drugs to try and get the money. I wanted to get cash to get the nicest things, fucking everything. I wanted to be living good, the quicker I’d get the money the better. I got caught one time early on and that was that, once you’re on the record you know you’re done then, they know you and that’s that. People ... they’ll never touch you again because they don’t want to be seen with you or even around you, so your name’s dirt then, nobody wants to touch you. But it all went downhill from there ... now though I only do the really shitty jobs, the really risky ones that no one else wants’. (Male, 58 years)

This man had become involved in organised drug dealing to earn money to support his drug use. Like other participants who used heavily, he felt that breaking the law was an acceptable risk to take. His criminal record only increased his risk tolerance. Those participants-using drugs more heavily exhibited this tolerance and took even greater risks as they increased their use.

This phenomena has also been identified by Schulz (2014) who found that people engaged in crime are more likely to lower their perception of risk after arrest and incarceration. Pogarsky and Piquero (2003) suggest that the reason for this could be that people who are caught believe they would be less likely to be caught a second time. However McCarthy and Hagan (2005) found this lowered perception of risk was particularly apparent among individuals who used drugs . They suggest that a more practical explanation is therefore more likely to be associated with impaired decision making processes.

Those participants in this study who exhibited this reduced risk also bought drugs from acquaintances, but they were more likely to have additional contacts to buy drugs from, and more likely to go to other sources or buy other drugs if their supply dried up, as opposed to going without. They tended to know more people from whom they could buy drugs. These participants talked about the unreliability of professional dealers and

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suppliers that added to their frustration at having to buy drugs regularly. In short, their level of investment in their drug use was greater.

Trust and safety were still important to these participants, though they expressed far less fear of structural factors such as the criminal justice system. Many tended to have less money to spend, and therefore had to purchase smaller amounts of drugs more often. As a result, they placed themselves at risk more frequently. They sought to minimise risk by using a range of tactics to avoid arrest and detection. Some described tactics that were well honed out of experience. Taheri (2012) suggests that exposure plays an important role in this relationship. She argues that drug users more familiar with operating in this environment are more likely to exhibit a lower level of personal risk.

Regardless of their ability to manage their lifestyle in a way they wanted to all participants talked about developing a heightened sense of their own personal vulnerability, due to their age. They regarded it as a potential reason to think about either stopping or curtailing their use, or at least changing their behaviour. This man for example talked about using open air markets at one time but felt he was now too old for that,

‘I don’t want to be scoring on the streets anymore at my age so I’ve hooked up with some other blokes who help me out and get my stuff for me’. (Male, 55 years)

This issue about age and the use of open-air markets has been raised by other authors. One of the central themes of the work by Levy and Anderson (2005) has been to understand how older drugs users seem to move to the margins of the drug use world as they become older, in a similar way to the previous man, as a result of his own perceived vulnerability. In a similar concession to age, another man only used drugs at home in the presence of his wife,

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‘I use at home now. I don’t use anywhere else. That’s been quite a long time. Now I’m older I don’t feel comfortable using at other people’s houses. I don’t feel comfortable until I get home. If I’ve got the stuff and my partner is not in, I don’t use until she gets home’. (Male, 52 years)

This man used drugs at home through fear of his own physical vulnerability, fearing a negative reaction to drugs, such as overdose, as a result of his age. However he also feared negative responses from other drug users, such as being robbed or assaulted. Other participants expressed similar strategies, changing the way they bought their drugs, from whom and from where. This suggests that all participants saw age as an important factor of building capital (as stated by Cloud and Granfield (2008)). They felt more vulnerable and less able to cope with challenges that carrying out an illegal activity might bring. This connects strongly to the next and final property, the participant’s social support and peer network.

Social support and peer networks

So far the properties identified by the participants as central to how they were using drugs focussed on their own personal perceptions and motivations. However, there were also structural factors which they talked about as being central to their own ability to manage their lifestyle in a way they wanted to. The most apparent of these being social support. The stronger the quality of the social support the participants mentioned, the more likely they were to be able to manage their drug use in a way they wanted to. Factors such as a stable marriage or strong intimate relationship appeared to be more important than a wide social circle. This suggests that it was the quality of attachment rather than the quantity that was important. All participants with strong social relationships who talked positively about their partners and friendship networks were managing their lifestyle in a way they wanted to. Conversely, those participants who talked about tensions in their relationships also talked about similar tensions they were experiencing with their drug use.

Participants who were managing their lifestyle well, talked about knowing few other people who used drugs. The people they did know who used drugs tended to be partners, family, or close friends. These participants talked about not socialising with other people who used drugs outside their friendship circle. They spoke about a strong social support system of people who did not use drugs as important,

‘The majority of my long-term friends, like [gives friend’s name] and people, they’ve never done drugs. I think that says it all - long-term friends. Drug friends aren’t long-term friends, if you get what I mean.... The drug free friends who I’ve had all my life, they’ve been the ones who have been in touch. They’ve been the ones who have come and picked me up and taken me over to their place, and I’d have dinner over there and enjoyed myself. They’re my true friends, and of course my family’. (Male, 50 years)

Maintaining distance from a drug user identity

Participants like this man who made a strong and clear division between their drug use and their non-drug-using lives benefited from a strong social support system. Moore (1992) argues that maintaining a part in mainstream society independent from drug use helps people to maintain their identity as a non-drug user. This stake in society provides an important sense of organization that helps to manage their use.

Participants in this study who talked about managing their lifestyle in a way they wanted to did so in a number of ways, however the main theme of their narratives was that they were able to maintain a separation of their use from other aspects of their lives - it was their desire and ability to place firm restrictions (what Decorte (2001) called a boundary) on and around their use. To identify it and demarcate it as something they did rather than someone they were. Warburton et al (2005) also identify what they call the desire of their respondents to maintain an ‘unobtrusiveness of use in other, aspects of their lives ... and on, and the informal control mechanisms they

employed, to regulate their ... use' (p. 45). To this man for example, this distinction was geographic,

'I'm very careful about what I do and when I do it. I don't do nothing this side of the river. I have friends the other side of the river that I go to occasionally'. (Male, 55 years)

This man would use drugs away from his home and work environment but apparently still only with people he called friends and knew and trusted. The issue of trust and the generally negative perception of other people who used drugs outside their friendship networks seemed to help these participants manage their lifestyle in a way they wanted to. As one participant mentioned earlier, they tended to keep people they saw as problem drug users at arm's length. Participants talked about not trusting other drug users, in fact a number of them expressed a stigmatized view of users, as this man did,

'I'm living on the edge of the estate, which I quite like because I've got my freedom. I can just be away from everybody if I want within five, ten minutes. It's nice and quiet. It didn't used to be. It used to be quite rough, but they've cleaned it all up. The police did a massive drug clearout and got rid of the bad element of that area ... the neighbours I've got round there are okay. They're elderly. They're my age or a few years older, which I appreciate because you haven't got the young idiots round every night causing trouble'. (Male, 56 years)

Other participants often described other people who used drugs as a 'bad element' or a 'bad lot'. Like the man above, they identified more with their non-drug-using neighbours, whom they also seemed to identify with in terms of age. Their comments showed a lack of trust in what they saw as other people who used drugs differently to them. One man said he would even bar the users he knew from his home. His lack of trust provided him with an indicator of his involvement in the drug-using world. It appears that,

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in not letting other people who used drugs into his home this man was putting up a physical barrier between himself and problem use.

These processes describe well the concept of othering (e.g. Johnson et al, 2004), introduced in Chapter 3. For this man and others like him there was a palpable sense of wanting to maintain a distance (actual and symbolic) from other drug users. In doing so he distanced himself from what he interpreted would be other people's negative perceptions of him. This helped him to maintain a foothold in mainstream society.

Maintaining standards

The desire of the participants who were managing their lifestyle in a way they wanted to by maintaining a set of outward facing standards, has been implicit throughout this chapter. They had an image of what they felt other people considered drug users to be (some participants actively described this as having an unkempt appearance, malnourished, and being homeless for example) and worked hard to maintain standards to distance themselves from this. Thus helping them to preserve their 'non-drug user' identity.

Participants who did this described an internal set of standards they applied to monitor things like the people they knew, the people they spent their time with, and who they bought their drugs from. They used these standards to distinguish themselves from other users, whom they stigmatised. Again this process was conscious and ongoing.

Some participants who emphasised the distinction between themselves and more frequent heavier drug users, had used heavily at some point and were now trying to implement rules to distance themselves from any such behaviour again. Some of these standards revolved around what they described as normative behaviour such as having a home or maintaining a regular healthy diet. This man who used drugs heavily was technically homeless. By staying with family or friends however he felt he was able to

distinguish himself from what he considered to be negative perceptions of homeless people,

‘I can’t say I’ve ever had to deal with being homeless or anything like that, not like some of the poor fuckers you see, fucking nuts and all that living in cardboard with those big fucking dirty beards and like all piss in the plastic bottles ...’ (Male, 55 years)

This man didn’t specifically connect all homelessness to drug use, but it was one of his own personal indicators to be aware of. Many participants used other people as external indicators to set the standard for their own behaviour. Those who were managing their lifestyle in a way they wanted to aligned themselves with people who did not use drugs, and thereby distanced themselves from what they considered to be more problematic drug use and behaviour.

Another important aspect of normative behaviour for some, particularly mentioned by two of the women in the study was making sure they ate regularly. For example this woman said,

‘One thing I’ve always thought is very important is food. Even when we were both injecting...it might not have been until two or three in the morning, but I would always cook us a two-course meal from scratch. We would always force it down. It’s like a car. If you don’t put in the fuel, it’s going to go bust. A lot of those people would just spend every penny they had on drugs. If they got any food in the meantime that was a bonus’.

(Female, 53 years)

This woman did not just talk about eating regularly she also talked about making sure that she carried out this role for her and her drug using partner. She had assumed the pastoral care role for both of them. Drumm et al (2005) also found that ‘strategies to improve nutrition’ (p. 607) were an important element of self-care among some drug users. This issue of

gendered care however was a theme that was also touched on by another woman who had been in a relationship with a drug-using partner.

‘Them up the road, whatever money they get all goes on drugs, and then they’ll worry about food and bills afterwards, whereas I did it the other way round. I’d always get my food and pay bills, and then whatever were left would go to drugs.’ (Female, 55 years)

Close proximity to people who used drugs more frequently than this woman seemed to be helping her to manage her use in a way she wanted to. She talked about using them as an example as to how not to behave or become. She went on to talk about other behaviours they exhibited which she did not like such as child neglect. It became apparent that caring for her own children was an important aspect of her identity and important to her in maintaining a foothold in mainstream society.

‘It’s always difficult I think with women, being the primary caregiver, a lot is expected, it’s difficult to take anything if you’re going to be taking care of children or go to work or something as well, which is always something I’ve tried to do as a working mother.’ (Female, 55 years)

This mother who was generally using drugs moderately and infrequently, but sometimes binged heavily during what she identified as stressful times, talked about not wanting to leave her children ‘without a mother’. Similar behaviour among some women has been described by Hatch (2007) who describes how stress in the lives of a sample of women contributed to their drug use. Both women in relationships with other drug users used this role as a connection to the non-drug using world to help them regulate their own drug use and manage their lifestyle in a way they wanted to. This is again described by Hatch (2007) who states that attachments to social roles in women can alleviate the impact of stress, thus negate the need to take drugs. This was also something noted by O’Brien (2008).

Safety, risk and care seemed to be consistent narrative among these women. They seemed to be expressing similar attitudes to those described by Johnson and Sterk (2003) who stated that the female crack users in their study were concerned that they were ‘violating social norms’ (p. S231) as a result of their use. However this was not the case for all of the women in the study, only those who talked about being in stable relationships with drug using partners, or were interested in maintaining a foothold in mainstream society.

While some of the fathers interviewed for the study talked about their children, they did so in a different way to the women. Their narrative tended to be more concerned with whether and how they were able to provide for their children, along the lines of traditional gender roles, which might be a result of their age. Further research might usefully examine gender roles in co-dependent drug using partnerships and intimate relationships.

Inability to maintain standards

As this chapter has highlighted throughout having a structure to individual’s lives, along with social and economic responsibilities was important to these participants to enable them to maintain a level of management over their use (also found to be important to Warburton et al (2005)). Warburton et al (2005) described the significance of having a stable relationship with partners and peers, along with strong ‘support structures’ (p. 44).

When participants in this study did describe being unable to manage their drug use as they wanted to, it was frequently in conjunction with challenges in other parts of their lives, such as breakdowns in relationships, unemployment or other circumstances, rather than simply drug use itself. This crystallises well the position outlined by Zinberg (1984) (and extended by Grund (1993)), whereby the three aspects of drug use they describe (drug, set and setting) are important in moderating individual patterns of drug use. While conversely Shewan et al (2000) suggest that a recognition of the importance of these three factors are instrumental in individuals being

able to manage their drug use. They go on to assert that social support networks are crucial to this.

This resonates well with the participants in this study. Those participants whose use oscillated between lighter and heavier also described their lifestyle as difficult to manage. When they experienced challenges in their life they talked about tending to use drugs more heavily and more frequently, and vice versa, such as this man.

‘I know when I have a problem again I start to fall back onto the drugs, I can’t help it, it’s just how I cope. I don’t have anyone, I just got made redundant, I know I shouldn’t, but it helps, you know, just for a bit. I know it’s not doing me any good in the long term but it helps.’ (Male, 53 years)

Indeed Agnew (2006) argues in a recent consideration of General Strain Theory and crime, that people with less social support, fewer social coping mechanisms along with deviant peers and values, are more likely to respond to stress with ‘crime as a coping strategy’ (p. 111) . While Zhou and He (2002) found that people who use illegal drugs had less of what they regarded as subjective social support, and the amount of social support a person believed they had correlated well with the perceived difficulty of their drug use. This actions of the previous man seems to support this.

The participants in this study who were currently using drugs more heavily tended to know other people who also used in this way; these were partners, family or friends, as well as acquaintances. It became apparent that these participants knew fewer people who did not use drugs and more people who did. In contrast to those participants above, the main difference between these participants and those using in a more moderate and infrequent way was that their primary relationships seemed to be inside their drug-using world, thus reinforcing more of a drug user identity. This man talks well of other drug users he knows for example,

‘They’re all nice people, on gear, and a lot of them you find are really talented. You’ve got a lot of talented people are fucked up on drugs and I know ... it’s part of that sensitivity which causes them to ... and I know that and we’re sort of ... I feel that ... people who I consider real addicts, not weekend users, but real hardcore addicts who have been using a long, long time, it seems to have been inevitable in their lives that they’d end up in this route.’ (Male, 54 years)

This man seemed to be expressing an opposite, mirror image to those earlier who attempted to keep a distance from other drug users. While those participants were ‘othering’ what they considered to be more problematic drug users, this man seemed to be ‘othering’ what he called ‘weekend users’, seemingly wanting to distance himself from lighter or more moderate users. He was expressing that he would rather align himself with people he saw as his peers. Maintaining these friendship networks with people whom he identified as similar to him seemed to be just as important as anyone - even if they were with other drug users.

Trying to reclaim standards

Friendship networks also played a key role in the lives of participants who were trying to manage their lifestyle after having been unable to. Some participants who were using drugs more heavily expressed that they had to avoid heavy users if they were going to change their behaviour. Whether this was due to a lack of trust in others who they felt might exert peer pressure to continue using heavily, or a lack of trust in his own resolve to continue to remain abstinent (or a combination of both) was not clear. Baldry et al (2012) point out that locating recovering drug users away from areas with prevalent drug markets (and areas they are familiar with) can offer the chance for habitual drug users to achieve distance from their former drug using peers. Doing so enables them to look further ahead to their own longer-term well-being by considering issues such as substance use treatment, employment, and relationships that can provide the individual

with much needed capital. This man described this process of moving away well,

‘It was a fresh start in my mind, but I did bump into the old crowd that I used to knock around with. They’re still at it, but I’ve made a decision not to get back involved in it so I purposely avoid seeing those people until I get myself stable, and then I can associate with them again.’ (Male, 56 years)

Developmental factors have been found to be associated with the onset and maintenance of substance use, by affecting the acquisition of social capital (e.g. Sampson and Laub, 1997). Perhaps one of the strongest of these developmental factors has been found to be associating with drug using peers. This can have detrimental effects not just on long-term development but over one’s life. Associating with drug using peers can affect the fundamental acquisition of life skills, including job attachment and social capital. It also prevents bonds being formed with non-drug using adult peers, and increases the likelihood of reinforcing socially detrimental values and close relationships. This underlines the importance of structural factors in the development of early substance use problems. Left unchecked these can be carried through the life course into older adulthood as identified by these participants’ narratives (Simons et al, 2002). Friedman (2002) also argues that developmental problems can frequently be traced to pressure within the individual’s socio-demographic environment.

Those participants in this study who were trying to manage their drug use better talked about avoiding people they had previously associated with (such as the previous man for example). They frequented different areas, shopped in different places, and as previously quoted, talked about moving towns completely. For some this was to associate a new area with a new start away from drugs, but overwhelmingly this seemed to be connected to the desire to remove the temptation of drugs from their lives completely. This man also describes this process well when trying to manage his lifestyle better once again,

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‘I have a friend up in Pembrokeshire, up in the mountains. He said to me ‘If you want you can come up and stay with me for a couple of weeks just to get used to not... walk around in some fresh air.’ I am probably going to do that.’ (Male, 53 years)

The implication seemed to be that by distancing himself from his old habits and routines he would distance himself from any unwanted behaviours. What this man’s quote also illustrates however, is the importance of having non-drug using friends when trying to achieve balance once again.

Anderson and Ripullo (1996) describe treatment regimens in which drug users in treatment are encouraged to build non-drug using identities around normalisation of new patterns of behaviour. This was found to be effective for some but what Anderson and Ripullo (1996) also found was that in distancing themselves from other former users their participants started to pass judgment on them. Suggesting that in shaping a new identity, ‘othering’ or ‘moral distancing’ are consistently identifiable patterns. The participants in this study showed similar kinds of thinking, and expressed similar attitudes as they withdrew from their previous drug using peers and identity. More recently Palamar et al (2013) have taken this further by arguing that psychologically distancing oneself from other drug users can be an important step towards managing one’s own drug use. They found that increased levels of stigmatization among problem drug users, towards other users, successfully predicted an individual’s chance of decreasing their own use. Work by Skrzypiec and Owens (2013) suggests that this is because an individual’s moral identity is important in predicting their intended drug use.

Loneliness and isolation as a result of diminishing peer networks

The age of the participants in this study meant that distancing themselves from peers might involve losing social connections of very long standing. The longer participants had used heavily, the more likely it was that the only people they knew were people who used equally heavily. Keeping a

distance from people who they had previously seen as supportive was therefore difficult. This man spoke about the important gap in his friendship network as a result of this,

‘A lot of full on addicts I known have been quite good friends together, some though the only reason they’re interested in other people is for what they can get out of them or what they can get off of them ... I don’t know though, not seeing people though it can just feel very lonely. There’s a lot of camaraderie in drugs, a lot, you know, you’re all in it together and that. Sometimes it can be like a family.’ (Male, 50 years)

This man was weighing the pros and cons of socialising with people from his drug using life as he sought to manage his lifestyle better. He had relied on drug-using friends in the past for social and financial support, but now knew if he stayed in contact with them he would be tempted to use heavily once again. However, this could lead to loneliness that he talked about as being stressful, which in turn could facilitate a desire to use drugs again. These circumstances had seemingly created a catch-22 situation, which he felt unable to resolve.

Loneliness caused some participants a great deal of distress. Being alone also seemed to lead to a level of impaired judgement. Some participants talked about being on their own and not seeing anyone for days, only speaking to other people who used, or sold drugs to them. In doing so they sometimes talked about becoming ‘swallowed up by my own thoughts’ (Male, 58 years), and tended to exaggerate and globalise their responses for example. It is not possible to know whether an underlying psychological condition caused their distress, but loneliness clearly triggered feelings of helplessness and depressive symptoms. What was apparent from this study was that these participants felt as though they faced more challenges, particularly when it came to social support and isolation as a result of their age. Social support and isolation are pressing issues in gerontology (e.g. Nicholson, 2012), as they are in substance use. Older drug and alcohol users suffering loneliness relating to a lack of ability to adapt with age and

unhappiness with family and social relationships has previously been described by Szwabo (1993) for example. When these two factors are compounded this is likely to present a unique and challenging set of circumstances, described well by this man.

‘I get lonely. Being like this for so long, you know, using and being alone, not having a wife or nothing, it’s just me. That used to be okay when I was younger, running around all jack the lad, there were plenty of people to see always, you always knew someone and knew you could go out. Now all them they’ve died or sick or moved on or you don’t see ‘em anymore. I don’t know anyone anymore. Lost track of any family, old friends. It’s just me and the people I see, the drugs. Who can I see? Where can I go? I’m hardly gonna go to the Rotary Club am I? It gets me down and I rely on the drugs’ (Male, 58 years)

This man’s feelings seemed typical of those suffering from a disconnectedness because of their drug use and ageing. He describes symptoms of depression and isolation, but also talked about the lack of desire to engage with what might be considered mainstream society.

This was also the case when talking about the participants’ engagement with GPs and other healthcare workers. As the previous chapter highlighted many participants were also reticent about discussing health issues related to their drug use, with their GPs. They feared being doubly stigmatised, firstly as older adults and secondly as drug users. This led some participants withdrawing yet further. This is reminiscent of Anderson and Levy (2003) who described their participants as feeling marginalised among the marginal. In a similar piece of work with the same sample (Levy and Anderson, 2005) they also talk about Goffman’s concept of the ‘spoiled identity’ (Goffman, 1963, p. 253) to describe the detachment their participants felt from mainstream society as they get older - particularly those who had never lived or worked among people who didn’t use drugs. This was also apparent among a number of participants in this study, as has already been highlighted.

In a similar way to the previous man a number of participants in this study reported having seen peers die as a result of their drug use, an experience more common in older samples than in younger users. This man for example had seen a number of deaths,

‘I used to say fifty was the dying age. When I was in Bethnal Green, so many of my friends disappeared when they got to fifty or around my age, sort of forty-seven or forty-eight. It was unbelievable. There were dozens of them.’ (Male, 53 years)

As with this man, participants who relied on drug use for their support networks saw them diminish with age, this included those who knew people who had passed away through poor health and drug related problems such as overdose. With isolation from their peers, parents and families these participants had further exacerbated their social capital and ability to cope as a result of depressive symptoms and guilt. This had become a vicious circle for some whose isolation was reinforced for these reasons, resulting in further isolation. To underscore this, one man talked about rebuilding his social capital by renewing ties with his family, from whom he had become isolated because of his drug use.

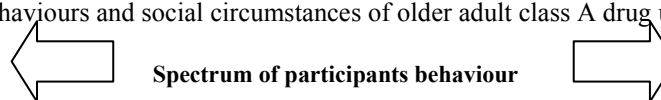
The spectrum of participants’ drug use, behaviour and social circumstances

The data presented above highlights a relationship between the participants’ personal characteristics, the drugs they were using and their social circumstances. This supports the assertions of Decorte (2001) and Zinberg (1984) who stressed the importance of the role of the individual’s use in their own environment. Both of these authors argue that personal characteristics and social circumstances are more likely to affect the frequency and intensity of their drug use than the properties of the different drugs themselves. It also points to a relationship between the importance of

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capital and an individual's own drug use. The nature of these interactions among these participants is described on the spectrum below in Figure 3.

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	Intermittent (monthly) and rationed (weekends only) careful use of weights and measures of predominately hallucinogens and non-class A drugs, spending within a carefully costed day to day budget.	Likely to use a greater range of substances on an infrequent and irregular basis. Current drug use is felt to be stable but have experienced periods of more frequent and heavier use.	Regular (daily) and laissez-faire use on any day of the week, any amount of either opiates and crack, spending beyond their means often engaging in illegal activity to fund their drug use.
Drug use	Drugs are taken orally, inhaled or smoked and bought from friends or single trusted source, and associate with non-drug using peers.	Likely to use Cannabis alongside less frequent use of class A drugs, which is more likely to be stimulants (where opiates are used they are smoked, where previously injected).	Drugs are injected and bought from either an open street market or through closed drug using connections, and associate only with drug using peers.
	Drug use is integrated into the rest of their lives and is peripheral to their identity.		Drug use is central to the rest of their lives and shapes their identity.
Drug treatment	Never sought help for any aspect relating to drug use.	Currently receiving treatment for drug use and/or have been in contact with drug services. Used or are using drug treatment as a route into 'mainstream' society.	Currently receiving treatment for drug use and/or have been in contact with drug services regularly over lifetime.
Health	More likely to be in good health, some report age related conditions e.g. arthritis.	Some age related conditions and problems as a result of their past history of drug use.	More likely to be suffering a range of health issues, often as a result of drug use.
Crime	Have never been involved in any other crime outside of purchasing illegal drugs.	Have been involved in crime and been in contact with criminal justice system agencies in the past.	Committing crime to fund drug use. Have served prison sentences, often because of drug-related crime.
Relationships	More likely to be married, or have a non drug using partner, with children.	More likely to be single or have a partner with similar substance use history. A range of friends, including some non-drug using friends.	More likely to be single or divorced. Where in relationships, it is with a partner who also uses substances, often problematically.
Living arrangements	More likely to be a private homeowner	More likely to be living in privately rented or owned accommodation.	More likely to be living in public accommodation or social housing.
Employment	More likely to be in professional occupations, often own or run own businesses.	Employed part-time or on contract. Some economically inactive. More likely to be either working or volunteering in substance use field.	More likely to be unemployed or economically inactive.

Figure 3. Spectrum of participants' drug use behaviour and the interaction with their social circumstances.

The left hand side of the spectrum shows behaviours which were characteristic of a lighter pattern of drug use. At this point people using drugs in this way tended to maintain professional occupations, functional relationships and households. They were less likely to come into contact with the criminal justice system and maintain a level of good health.

The right hand side of the spectrum illustrates a heavier and more frequent pattern of drug use, and the associated behaviours which seemed to go with it. When the participants were using drugs in this way they were less able to maintain consistent lifestyles away from drugs, hold down jobs and relationships. They tended to be in frequent contact with the criminal justice system, and drug treatment services. When participants were managing their lifestyles in this way they became characteristic of those described by Beynon et al (2009) and Levy and Anderson (2005). They frequently descended into highly risky potentially self-injurious levels of substance use.

However - while it might have been possible to place some of the participants from this study towards the extreme ends of the spectrum in all of the issues described, these participants would have been in a minority. For a large proportion of the participants in this study, their drug use had played a much more inconsistent and variable part in their lives. Sometimes they were abstinent for periods of time, or with drugs playing a minor or peripheral role. At other times their drug use was central to their life, and their behaviour was highly erratic, undertaking apparently destructive behaviours. In doing so they frequently oscillated across various parts of the spectrum.

For these participants the spectrum illustrates the complex nature of their drug use, and how these different factors can interact but also complement each other. Care should be taken not to consider the actions listed here as characteristic of groups of people but instead indicative of modes of associated behaviours.

It is for this reason that participants names or details are not presented in their quotations of throughout the text. This thesis does not aim to categorise participants but instead examines all of their behaviours, exploring where they are similar and where they are different. Taking the decision to have given participants pseudonyms for example would have distracted from developing the conceptualisation. By providing pseudonyms or identifiers within the text readers would be able to piece together individual narratives of the different participants. It was believed that in some cases where the participants' behaviour sometimes moved between extremes of behaviour this could appear misrepresentative of their journeys, particularly when taken out of context.

The aim of the study however is ultimately to present an abstracted model of their drug use, with the goal of the analysis being to make connections between the participants' behaviour and not differentiate between them. To achieve this it was decided that the best method would be to completely anonymise the data from the participants (only retaining the most basic of identifiers - gender and age) so that cases and not people, behaviours and not personalities were related to each other. In this sense this is seen as similar to the aim of Satchell et al (2006) who sought not to present the voices of their participants as individual entities but examples of their behaviour.

This researcher was conscious of his position when it came to analysing the study findings and writing about them. The aim was not to selectively retell these participants' stories but instead analyse their narratives and report on them at an abstracted level by presenting their 'stories as data' (Mphahlele, 2009; p. 36). Cutliffe (2000) also argues that this style of presentation acknowledges the interaction between the researcher's ideology, and the data they collect. As such this style of presentation is consistent with his position throughout the development and execution of the study. It acknowledges that the researcher has been intrinsically part of the social construction of the data,

but aims to report on it rather than interpret it, or more importantly misrepresent it. This is a comparable process to that used by Butson and Thomson (2011) whose participants act as ‘data gatherers’ which the researchers then report on.

Finally Charmaz (2006) acknowledges that the written format required for university qualifications can sometimes be at odds with the ideal conceptualisation of a grounded theory study. In developing the written structure for this thesis a number of published PhD theses were scrutinised which had adopted a constructivist grounded theory methodology. In doing so the structure of the presentation of the data was mirrored. The same pattern of presenting participant quotations without either pseudonyms or unique identifiers - beyond basic information (such as the gender and age of the participant) is utilised by the authors, however in these cases no rationale is given (Alberts, 2008; Sherwood, 2008; Greenberg, 2005; and Barnard, 1992).

Chapter summary

This chapter has described how the older adults in this study are currently using class A drugs. It described seven key properties which participants used to help them manage their lifestyle. The monitoring of these properties was described as conscious and ongoing.

Throughout the chapter the presence or absence of these properties seemed to predict how the participants were using drugs. When participants were utilising these properties they seemed more able to manage their lifestyle in a way they wanted to. Conversely, when participants were unable or unwilling to utilise the properties they were less able to do so. As a result, their use was greater, the drugs they used were more harmful, and they used them in more harmful ways. As these participants aged they had tended to describe themselves as being lonely and isolated.

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All of these participant's drug use and lifestyles interacted strongly, showing associations between their drug use patterns, their personal identity and their personal circumstances. The next chapter turns to the participants' perceived reasons for using drugs.

Chapter 7. 'Altering feelings' - why older adults take drugs

Introduction

The previous chapter described how the major category 'managing lifestyle' answered the main research question, how older adults are using drugs. This chapter now answers the second of the main research questions - why these participants are using drugs. It describes the second major category 'altering feelings' in order to do this. The chapter begins by describing the key property of the major category, feelings, and more particularly its dimensions. These represented the two reasons participants gave for their use - either to enhance positive feelings or alleviate negative feelings. The chapter then goes on to describe the relationship between the reasons these participants gave for their drug use and how they were taking drugs - how their desire for attempting to alter their feelings appears to be connected to the intensity of their use.

Major category 2: 'Altering feelings' - Participants perceived reasons for their drug use

The major category 'altering feelings' formed the second component of the core category. It was this category that described why these participants felt they were currently using drugs. Only one property was identified by the participants which they believed exemplified the nature of the category, it was however central to understanding why they were using drugs. The property ranged dimensionally from trying to create or bring about positive feelings, to trying to stifle negative feelings. This is illustrated below in Figure 4.

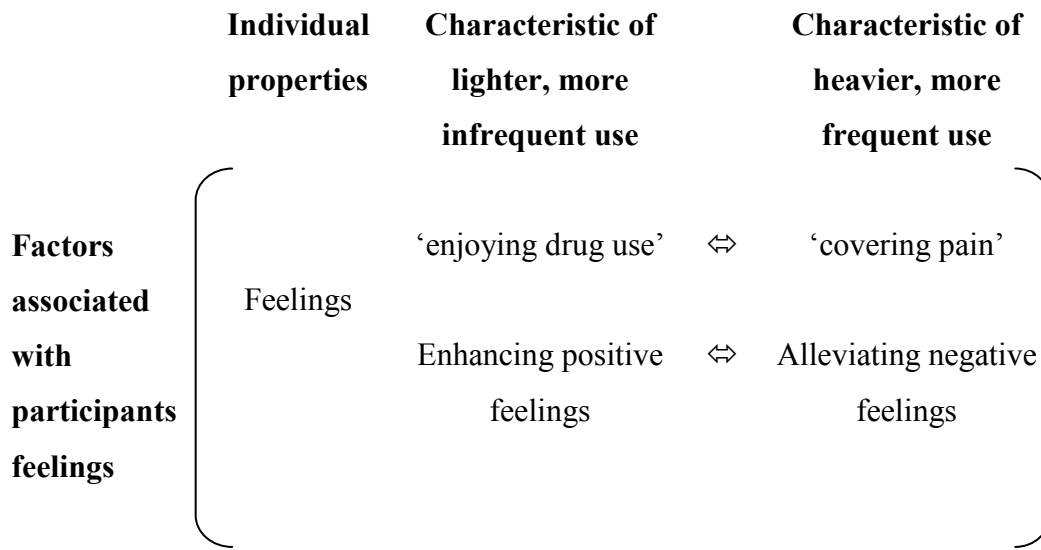


Figure 4. The individual property describing why participants were using drugs.

This chapter focuses on participants’ use at this point in their lives. However what became apparent was that their perceived reasons for their use had changed little over their lives (apart from a subtle exception to this, which might be considered a result of their ageing, which will be described later). When considering their use now participants talked unprompted about their drug use history, and how they affected each other. This man describes this position well,

‘I’d say that it’s never changed. Why I started then and now. It’s always just something I’ve done and been there. I don’t know how to explain it, it’s not like you change or anything. It’s always the same. That sounds a bit boring doesn’t it? I haven’t changed much have I? I’ve probably got the same haircut I had in 1980’ (Male, 53 years)

This interview was one of the first that took place. This meant that the importance of context was highlighted at an early stage. Many participants referred back to their initiation and their reasons for their initial use to provide the rationale, and in some cases self-expressed justification, for their current

use. This was most apparent in the first of the two reasons these participants gave for their drug use.

Taking drugs to alleviate negative feelings - ‘covering pain’

The most common reason given by these participants for taking drugs was to try to alleviate negative feelings. This became coded as ‘covering pain’. This pain included psychological pain (e.g. anxiety, depression, abuse and trauma) and physical pain. Almost all participants who talked about using drugs to alleviate psychological pain talked about having been troubled by symptoms for years before initiating drug use.

Participants such as this man had experienced childhood abuse, ‘I’ve been diagnosed with post traumatic stress disorder and I’m having a lot of comeback from my youth and so on, because I was abused every day.’ (Male, 53 years). Others, like this man had experienced a sudden traumatic loss, ‘I lost my mother and father, both on my birthday’ (Male, 53 years). Participants drew a straight line from childhood trauma to current use. One man responded to the question ‘Why are you using drugs now?’ with a story from decades earlier,

‘I was sat with my father watching Question of Sport. No, sorry, I was watching Southampton football match. Southampton scored and my dad jumped up and went ‘Argh...’ and keeled over.’ (Male, 53 years)

This man went on to talk at length about the death of his father and how this had affected him. He had been blamed for the death by the rest of his family and also talked about how he had been questioned by the police in relation to the death. He identified this, along with the abuse he had suffered at school, as the reason he had started using drugs, but also for the reasons that he still used them. This and other childhood traumas haunted him even in adulthood, the constant painful feelings he described generated by his father’s death and the

conflict with his family, perpetuated his need to continue using drugs. He talked about this giving him a perceived ability to cope with other aspects of his life,

‘I mean I can still... I still dream about it. Some of the dreams and some of the nightmares do come back, it’s over now, but I still see everything. Heroin, as I said before, puts you in a box. Nothing can touch you when you’re on heroin. You’re safe.’ (Male, 53 years)

This man had been in contact with drug treatment services a number of times and had recalled the story to drugs workers. He felt strongly that people he knew who used drugs for this perceived reason gave traumatic experiences as justification for their use. Participants who took drugs for ‘covering pain’ often expressed the belief that others did the same thing, such as this man,

‘I took drugs initially to blot out, as all alcoholics and drug users do. They do it because there’s something in their past or even present that they’re trying to mask. In my case it was my childhood, I just can’t deal with it, I can’t deal with remembering it every day, it’s them feelings that haunt me now not the thing anymore.’ (Male, 54 years)

For both of these men it wasn’t necessarily the events around the trauma or those subsequently which they talked about causing their drug use, but the feelings that the memories of the events elicited. They still felt unable to deal with the pain of the memories and nightmares they suffered. If the reason they had started using drugs was to self-medicate against a trauma then it would make sense that these reasons would be consistent across their lives. For people who are still currently taking drugs for covering pain necessarily implies that the pain hasn’t gone away. Taking drugs hasn’t solved their problem, it has only masked it.

Early years trauma has been associated with substance use. Debeck et al (2013) found that having a history of early physical abuse predicted progression to frequent injecting drug use, while Seedat (2012) argues that any kind of psychological trauma, not necessarily early years, can have long-term and debilitating physical and mental health outcomes, identifying women as particularly at risk of having experienced childhood sexual abuse and subsequently being at high risk of substance use. Seedat (2012) goes on to say that this is even more likely to be the case for individuals experiencing poverty and diminished social support. Similar patterns were found among these participants.

Some authors have tried to identify the relationship between abuse and trauma and substance use. Dube et al (2001) for example found strong associations between early life trauma and lifetime drug and alcohol use. However they also noted the use of substances in helping to prevent risk of suicide. They argue that their participants frequently used drugs and alcohol to stave off suicidal thoughts. This enabled them to function as they would like. Similar to the participants described above. Peters et al (2012) also stated that women experiencing repeat domestic violence frequently use drugs and alcohol in an attempt to help them cope with negative psychological effects of abuse. Further support for this position comes from Peltan and Cellucci (2011) who identified that women incarcerated for substance use problems showed very high levels of childhood abuse. They also found however that the level of abuse did not correlate with treatment episodes. They suggest that those women might be using drugs and alcohol to help them deal with their trauma symptoms, i.e. self-medication as a form of treatment.

It was apparent among these participants who used drugs for covering pain that they were doing so to avoid what they considered to be abnormal feelings associated with traumatic memories, and the inability to process those

memories. It was the ongoing struggle they expressed with the resulting feelings, that they now attributed as the reasons for their use.

To illustrate this further one woman used drugs to escape the negative consequences of psychological abuse she had suffered as she was growing up.

'I thought 'this is what has been missing in my life. I can cope with life using this'. It brings me up to the normal levels of other people ... It just lifted me up to a level that other people are working at. I just felt like once I'd had that drug inside me, I just felt sort of normal, you know? Just to keep up with everything. It just made me feel sort of I'm right now. There's always like something missing ... It's partly that. I was quiet and shy, so it gave me confidence. It just bucked me up and made me feel that I could do what I wanted to do instead of just sitting and thinking about it.' (Female, 53 years)

Feeling that she lacked the confidence other people have, she had turned to drugs. Although she perceived herself as taking drugs to enhance positive feelings, she acknowledged that she was using drugs to alleviate negative feelings about her lack of confidence which she attributed to childhood abuse. She had initiated a cycle of drug use for covering pain that she was now finding hard to break. Another woman who was using drugs for covering pain was doing something similar. Her pain however was more recent and ongoing. She had watched her husband kill himself, and had been held up at gun point in her job as a cashier. She was also caring for mother who suffered from dementia. In her life as a care giver and lone source of family income she had used valium first and then cannabis, and then heroin, to escape what she felt to be the debilitating effects of depression.

'I just have to take it in the morning to be normal. I don't get a high or anything out of it. Otherwise, I'd just be laid in bed with no energy and feeling crap ... I

can cope with life using this. It brings me up to the normal levels of other people.’ (Female, 55 years)

She talked about walking what she called ‘dangerous ground’ because she knew that taking drugs for covering her pain was not sustainable. While her pain and circumstances differed she was similar in some ways to the previous female participant. Both understood the difficulties of using drugs in this way, and for these reasons. They believed that they would continue to use drugs unless they one day came to terms with their trauma, knowing that drug use could only alleviate their symptoms. This pattern has also been identified by Cornford et al (2012) who found that illegal drug use was frequently a method used to cope with depression, particularly among women.

These participants also seem to describe well the Self-Medication Hypothesis (SMH), which sets out to describe how people with underlying psychiatric conditions use substances to alleviate symptoms associated with them. Some expressed this openly; if the pain they were feeling was taken away they would have no reason to take drugs. What also underscores the importance of the SMH to these participants is that their use was purposeful, i.e. they would select the drugs which best helped them to manage their symptoms. In this study participants who used drugs for covering pain were far more likely to use heroin or other opiates, than other participants.

Some participants who were using drugs for covering pain talked about wanting to harm themselves through their use. For these participants, emotional pain had become so intense they did not care for their own well-being. This man exemplified this,

‘I’m just realising now after all these years, the things I do to myself and what I do to hurt myself ... drugs, you name it I’ve done it. Talk about hurting myself

... I've done it all and it was all, you know, to hurt myself and give me pain and make me feel it.' (Male, 57 years)

This man had recently entered psychotherapy for the first time, along with drug treatment services. His interview also reflected the influence of therapy, as he (and others) often used psychotherapeutic terms throughout.

Covering pain and ageing

One of the problems associated with using drugs for covering pain however was the subsequent difficulties and negative drug experiences these participants had suffered as a result of their age and long-term use. This is one of the main factors which sets this study apart from those which describe motivations for drug use among younger drug users - ageing seemed to have a multiplier effect on some of these participants' pain. They had seen friends and peers die, been arrested by the police, or experienced physical pain from being around drugs and drug users for a number of years. For some this had created a cycle of bad experiences and an intensity of their use. They had initially taken drugs for covering pain, they were unable to manage their lifestyle in a way they wanted to and their drug use had become problematic. In doing so they had associated with more people with drug related problems and as a result expressed needing to perpetuate their drug use for covering this latter pain. As this man explained,

'People dying, overdosing, car crashing, jumping through windows, jumping through closed windows to escape the police, and just, you know, people losing their testicles, and people losing their legs, and people losing this, that, and the other. It just goes on and on, and it never stops, day after day, after day, after day. I am sure I've had a couple of nervous breakdowns. I must have had. Who wouldn't need to take something to deal with all that?' (Male, 53 years)

This man, like the participants described above, had started using drugs to deal with the pain of his challenging upbringing. His drug use had increased as he grew older, and as his lifestyle gave him more pain he felt he needed to cover. Like other participants in a similar position he ascribed his current level of use to having developed poor coping skills when he was younger, and having retained these coping strategies as he had aged. These participants also talked about having little or no social support, previously and currently. They had no outlet for expressing these feelings in a productive way. Other participants said that, having used drugs to cover pain, they had never learned to deal with crises, this in turn led them to take drugs whenever they were faced with even the least challenging situation. This man had drunk alcohol to prepare for his interview for example,

‘I’m also an alcoholic, but I went for a detox off the alcohol but I’m still drinking like it’s... this morning, if I hadn’t... Before the detox, if I hadn’t had a drink to come here and see you I’d have been rattling. I wouldn’t have been able to come and sit here talking to you ... it’d been too much for me, see what I mean?’ (Male, 53 years)

For participants who used drugs to cover pain ageing tended to bring new sources of pain. This could be in the form of social loss - such as the loss of relationships and friends and the withering of social ties; psychological or mental loss - such as the loss of self identity through retirement or the inability to work; and physical loss - such as becoming less active, the inability to do things they had previously. For those unable to manage their lifestyle in a way they wanted to, these different types of loss also compounded each other. For example, physical illness affected some participants’ ability to remain active, which limited their social interactions, which affected their desire to interact as time went on, including with healthcare services. Farkas (2004) and Szwabo (1995) found similar mechanisms at work in their respondents’ lives.

One woman who was trying to cut down on her drug use talked about having to 'taper' it to avoid a 'shock' to her body. For her, her ageing body could not take becoming immediately abstinent having used drugs for the majority of her life. Probing didn't reveal whether she feared the perceived strength it would take to change, or feared the unknown of the rest of her life without using drugs, but she expressed feeling that the length of time she had been using drugs had increased her difficulty in stopping. The thought of stopping completely now when she had used drugs as relief or a coping mechanism was difficult for her to countenance. This was also the case for many of these participants who felt they did not have anything to replace the role of drugs in their lives. This man talked about this interaction in detail,

'Anyway you get to an age doing drugs, longer than some people have been alive, they take on a different sort of meaning, you know, it means something different, it's all sorts of things, it's baggage, you get all sorts of baggage going through life and drugs is all tied into it. It's not like I do this and I do that and then leave it alone ... It's like drugs, I've got memories and it's all part of that, some of it good and some of it not so good. You get a lot of memories and a lot of baggage when you get to my age and things ain't so straightforward, you know, things ain't so black and white. '(Male, 58 years)

Drug users might raise this concern at any age, but older drug users have nearly all been using them for longer. For these participants this length of time played an important role. It had changed their relationship with drugs - the longer their use went on, they felt it harder to stop or moderate it.

Levy and Anderson (2005) identified similar aspirations to stop using drugs in an older population of users. They described a process whereby their participants became what they called 'seasoned and sometimes temporarily successful veterans of drug treatment' (p. 253). Their respondents did not expect to remain abstinent for very long, based on prior experience. They cited

as reasons 'few interpersonal links to the conventional world, little chance of future employment ... and bodies that have become accustomed to lifetime drug-use'. They felt their 'informants' futures seemed 'pre-programmed' (p. 254). The participants in this study showed similar characteristics - diminished ties to a social world which did not revolve around drugs, long-term unemployment and signs of physical and particularly psychological vulnerability brought on by the compound challenges of ageing and drug use. The participants in this study, also like Levy and Anderson's (2005), talked about their regret at not being able to manage their use or their lifestyles better. For some their age made them long to stop using, even as it presented particular challenges,

'Yeah, I think, over the last few years this is the first time I've looked around myself and thought, 'Fuck, what a fucking waste of money and what a fucking waste of a life'. I don't want to do this anymore, I just fucking don't. It's become like what they say, like having something on your back all the time. I look up 30 years later and think, 'Fucking hell, how did I get here?' (Male, 58 years)

This man talked about the regret he had after he had spent a lot of his life being unable to manage his lifestyle in a way he wanted to. Some participants talked about the feeling that their drug use had taken a larger part of their life than they had originally anticipated. All of the participants who had used drugs more heavily, or who had not been able to moderate their use at some point in their life, talked about this regret - regretting they had started and now regretting even more not being able to stop. Similarly, this man's comments were typical,

'Everything I've done for the last twenty-five years has been a total waste of money and I'm lucky I haven't killed myself. With me getting on a bit, my health is not good now. It wouldn't take a lot to kill me now'. (Male, 55 years)

This man had begun to reflect on his drug use after going into drug treatment. He expressed a great deal of regret for the time and money that had gone to his drug use. He also believed that ageing had made him more self-conscious about drug use and his physical vulnerability. For other participants who experienced similar levels of reflection or self-consciousness this manifested itself in different ways. Some turned their negativity about drug use on themselves; others who turned it outwards, such as this man, became defensive,

‘The last thing somebody needs when they’re in a situation like that the last thing I needed was, ‘you taking drugs?’, ‘What do you care?’ Nobody really bloody cares. People don’t care about people these days. Yeah, I’m using, but I’d like some support you and help the best way not just say, ‘You’ve got to stop taking drugs’ ... it’s all I got, all the time, not cause they care but because they just wanna give me a hard time, another stick to beat me with’. (Male, 55 years)

On further probing, this man talked about projecting back the negative thoughts and feelings that he felt were being levelled at him by his family, non-drug-using peers and drug service workers. He never mentioned getting any pleasure from drug use; he only talked about wanting to stop but feeling that he did not have the support he wanted to be able to. This seems to reflect the concept of negative recovery capital (Cloud and Granfield, 2008), while he talked about his family and peers it was not a positive influence on his life and he expressed quite toxic relationships with them. For this man having negative social support was causing him difficulty in trying to manage his drug use better. Social support, along with the respect and recognition of others were important to this man. He felt throughout that this would have been what he needed to stop using drugs. His helplessness became manifest in anger. This man imagined a future in which his drug use was one of the few things he had left. Drug use had become more of a defining part of his identity, as this comment reflects,

The illegal drug use behaviours and social circumstances of older adult class A drug users

‘It’s only other people telling me, ‘It’s bad, it’s this, it’s that.’ I ain’t doing no one else no harm and I’m still here so what’s all the big deal about? Why shouldn’t I do a bit of gear when I fancy it? It’s up to me, right? It’s all I got and all I know’. (Male, 58 years)

He had spent most of his life outside the mainstream economy and had no active social ties. This is also reminiscent of Ning (2008) who argues that drug users sometimes challenge attempts to control their use, by reasserting their personal identity - in this man’s case that of a drug user. Participants with these conditions were more likely to label themselves as ‘drug users’ or ‘junkies’. Drugs and drug use had become an important part of their identity. In this respect this study’s findings also mirror Levy and Anderson’s (2005). Individuals with this sort of identity frequently described feelings of helplessness and a lack of self worth,

‘I seem to be stuck in the same kind of rut myself, you know? I think, well, what’s the point, at the end of the day you’re going to get somewhere and then bang, that thought’s going to come down, or that door’s going to close and it’s going to be over for you and you’re going to be too old to go into somebody else, or really train, or try and do something else. What is the point of anything? I might as well just get stoned’. (Male, 55 years)

Participants without legal jobs often felt that ageism, as much as drug use, barred their way back to mainstream society, and as such felt doubly discriminated against. Some participants who felt they had limited options to get back into mainstream society, clung to drug use as a source of self-definition. This man explained his feelings that mainstream society had rejected him, and that he had retreated further into drug use as a result,

‘... there isn’t anything fucking better in my life. Nothing for me anyway. I get treated like shit by everyone now. No one cares if I get straight, no one wants to

bother with me, or bother helping me right but sometimes you want someone to say, 'Alright mate, how you going today?' I can't even get a dentist now if I want to because no one wants to have anything to do with junkies. The police stop me every other day and they look at me like shit and turn me over every day, 'What you doing with that?', 'Where'd you get that from?', 'What you doing that for?' and then they fuck off. I ain't got nothing on me, they just want to fucking hassle me. It all adds up, you know? I don't really care about the future'. (Male, 58 years)

This man was not dissimilar to others who talked about using drugs for covering pain. Some of these participants clearly felt marginalised not just because of their use, they also expressed feelings of uselessness and that their lives were over. For some of these participants their ageing seemed to make their motivation for using drugs become firmer and more entrenched. In doing this they often contrasted their use now to when they were younger, feeling as though they had once had more hope for a future, which had since disappeared.

Feeling powerless to stop using drugs

Those participants who were using drugs more frequently and more heavily tended to show less care for their own welfare, and relied on drugs to be able to function socially. They also frequently talked about continuing to use them now because they felt they were not able to stop. They felt their drug use had taken control of them rather than vice versa. Participants like this man talked about feelings of powerlessness and a perceived feeling of addiction,

'Right now I'd have to say if you were taking all that on like then I suppose I'm using it because I can't stop, because I'm an addict, I suppose that's what you could call me. But it's an easy way out right? I'd stop if I could.' (Male, 57 years)

All the participants who classified themselves as addicts described wanting to stop using drugs. Physically and psychologically dependent on drugs, they felt they could not stop while they were still dealing with psychological pain. A number spoke of their fear of the negative feelings they would once again experience if they stopped taking drugs, and the withdrawal pain they would suffer. This man felt withdrawal pain had intensified with age,

‘... especially when I’m smoking crack, because the withdrawals come so quickly with that. You feel rough and that ... just the fear of feeling bad, I don’t mean just the physical pain and that of withdrawal because that ain’t so bad with crack but it’s all those old demons again that’ll start coming out of the woodwork again, I just can’t cope ... I mean, it’s too much, asking me too much to give up and make it all better straight away. I don’t know if my body could take the shock I’ve been doing it for that long.’ (Male, 58 years)

This sub-set of these participants had come to see addiction as typically involving long periods of helplessness, which they had experienced before. They talked in conflicting terms about wanting to stop or at least wanting to be able to manage their use better but not knowing how. Some participants, however, responded well to help they had received. Almost unanimously these participants had found new ways of dealing with the pain they had used drugs to cover. This then began to negate their need for relying on drugs.

Recovering from pain

Some participants talked about gaining coping skills with age that allowed them to lessen their drug use. One man said, ‘I should have sought counselling or something but it’s far too late for that now because I’ve come to terms with it all.’ (Male, 51 years). These participants talked about their behaviours becoming less self-destructive as a result. Some participants talked about how they felt they were beginning to understand alternative ways of dealing with the

pain. This man talked about the importance, for himself and his partner, of confronting the pain first and the drug use second,

‘Very slowly we’ve managed to realise we could both live without having to dull our emotions all the time, what we’ve done is, instead of trying to hide the hurt and pain we’ve got, it’s just a different way of coping with it’. (Male, 57 years)

This man and his partner had begun modifying their levels of use and ‘achieving balance’ by managing their lifestyle better. More frequently though a number of participants in this study emphasised the importance of dealing with their psychological problems they had previously used drugs to medicate against by seeking help. This woman who had been a sex worker talked about the value of decreasing her pain after getting away from an abusive relationship,

‘My counsellor says if you see it like it’s all like bags or that on this trolley you’re pulling along, you take one piece off at a time everything else gets easier to deal with. Like I deal with the all the time heroin and that gets less, and then I can deal with the other stuff, the abuse and that, bit by bit. I can deal with one thing at a time, everything together, it’s too hard and I can’t do it all at once, I just can’t, so yeah, one at a time that’s good for me’. (Female, 52 years)

She had internalised her counsellor’s analogy comparing her psychological problems to an airport baggage trolley. She described her drug use as one piece of baggage on this ideational ‘trolley’ that she carried around with her. She talked about the analogy helping it to see that she could address one of her problems at a time. For her and a number of similar participants, developing new coping techniques to assuage the psychological discomfort that had previously led them to self-medicate with drugs had become key to managing her lifestyle better. External markers might have led some of them to desire

recovery, but a lasting recovery for those who used drugs to cover pain seemed to depend on intervention by mental healthcare professionals. Psychological intervention had helped them to reflect on the reasons for their drug use, the motivations behind it, and strategies for confronting it. It had also provided for some, a non-judgemental space to reflect and much needed positive support. Existing evidence for the efficacy of treatment approaches that use psychological therapies (e.g. group therapy and individual counselling) for older adults, even for users with entrenched social, medical and, psychological symptoms support this finding (Firoz and Carlson, 2004; Satre et al, 2004). These participants talked about how developing new coping mechanisms could give them the foundation for a lasting recovery, and more control over their drug use.

This seems to have a strong connection to the concept of recovery capital. There was an apparent association between those participants who started using drugs for covering pain and expressing feelings of powerless and marginalisation as a result of their use as they had aged. What seemed to have happened was that these participants had what might be described as low levels of (often negative) capital, and had started using substances to cope with the associated psychological discomfort. Drugs had originally been used to replace other aspects of capital they had lacked as they grew older (also hypothesized by West (2006)). Now they were older still and further alienated from other sources of capital they lacked the social resources to maintain a control over their use that, as one of the men above described, had taken an increasingly fundamental role in their life. They were now unable to replace this fundamental role with anything else. Those participants who had been able to manage their drug use, had done so by either drawing on other aspects of their lives for sources of recovery capital (e.g. rebuilding positive ties with family), or building new ones (e.g. seeking therapy or treatment).

Covering physical pain

Respondents who were using drugs (principally opiates) to cover physical pain showed similarities with those covering psychological pain, primarily in their lack of ability to manage their lifestyle in a way they wanted to better. However there were some qualitative differences between the two sub-groups. Some, like this man had started to use drugs after an injury, 'I got into the heroin. I had painkillers from my doctor for my back. I had a slipped disc and trapped nerve in my spine, dislocated my shoulder, sprained my ankles...' (Male, 54 years). Others who were already taking drugs found they helped relieve their symptoms,

'One doctor said, 'You've got rheumatism, so you'll have it the rest of your life.' About this time when we started using regular, it flared up again, and I'd been going to the doctor and crying in pain. It was probably because the kids were little. One was a baby and one was in a pushchair, so it was hard work. He said, 'I've given you the strongest tablets I can give you,' but it still wasn't touching it, yet when my husband gave me heroin I got some relief, so that was another part of using it ... pain relief was another reason for using it'. (Female, 55 years)

Some participants like this woman who were experiencing physical pain talked about the potential for their drug use to increase in intensity as part of a possible pain management regime in the future. Similarly one man thought he might increase his drug use with age as pain management became more pressing,

'I can see it becoming an option yes. I know how to use it and it's all you would get if they gave you something on prescription. I think I know more than the average GP about my body, how it responds to drugs and the best way to treat it, at the end of the day, heroin, morphine, it's all the same thing, I'll do whatever I have to cope with it'. (Male, 52 years)

This man felt that using class A drugs and other illegal drugs for pain management was a distinct option for him. He was managing his drug use now but could see how he might increase his use as he aged if he felt more pain. His knowledge of drugs generally, his access to class A drugs, and his ability to use drugs in a utilitarian way led him to believe he could still continue to maintain this balance. He seemed to be saying that using illegal drugs were no different to legal ones in this respect. While this might be factually accurate it did not take account of any added risk this would involve as he became older.

An important interpretation of these participants position is offered by embodiment sociology. Contemporary sociologists have been prominent in raising the issue of the body in social life, Foucault (1979) for example raised the issue in his analysis of power in institutions, while Bourdieu (1995) later in his discussion of body habitus. More recently in the UK, Shilling (1993) has developed these positions further, stressing the importance of the body and its role in understanding social change - how a person experiences their own body, how they understand it, and how this in turn affects and impacts on their place in society. Gorringe (2007) argues particularly that human bodies are not only experienced by the individual but by society as a whole - the prevailing social awareness shapes bodies by valuing some over others, and thus individuals in their place in the socio-economic hierarchy. Gorringe (2007) asserts that embodied sociology illustrates 'that the body, embodied practices and the physicality of agency are at the, very core of a critical account of social life.' (p. 19). He goes on to argue that this needs to be seen in particularly relation to power. The body, they argue, is at the centre of the understanding of social power, that 'corporeality' is central to shaping and defining social life. Newton (2003) suggests that biological bodies have 'conversations' (p.6) which are independent of people as individuals, but are reflective and reflect their place in society. The body, he contends, is not only experienced by the individual but by the wider culture in which they exist. It both influences and is influenced by externalities. This was certainly apparent in this discourse of these participants

who were very aware of their bodies, both in the effect of drug use and in an ageing context.

There is an important interaction within the narratives of these participants between the ways they experience their own bodies and how they relate this to their social life. Many of these participants talked about the changes in their bodies as a result of ageing. Particularly how they related to their bodies, and how they experienced their bodies in relation to their worlds around them. A number of their narratives were concerned with how well they understood their bodies better than anyone else (such as the two previous participants), particularly how it responded to drug use.

More importantly they had developed a heightened understanding of how it was changing in relation to their drug use as they were ageing - they were listening to their bodies and adapting their drug use as a result. With the ageing nature of their bodies it was clear that some of these participants were very conscious of the way others were relating to them. This supports assertions of the changing nature of hierarchy brought about socially valued bodies. Not only have these individuals become conscious of their ageing bodies but in some cases they are also conscious of their bodies having experienced drug use. Two participants were using illegal drugs to supplement pain killing drugs given to them by their GPs. Both were doing so because they felt their doctors were disregarding their feelings and not understanding the problems with their bodies.

As lifelong users of drugs both of these participants felt they knew their bodies better than anyone, and talked about discrimination as a result of their age. Putting aside any complications with drug interactions these participants illustrate one central point of this thesis. Their experience with class A drugs has meant that they see self-medication as a pain management option for problems associated with ageing. It is only their exposure already to illegal drugs that made them consider this. As Chapter 1 showed the UK will be

The illegal drug use behaviours and social circumstances of older adult class A drug users experiencing an increase in the proportion of older adults in the next 20 to 50 years. This cohort will be the most experienced users of illegal drugs this country has seen. As such there is no reason to believe that there will be more people who see this style of self treatment as a feasible option.

Taking drugs to enhance positive feelings - enjoying drug use

The remaining participants talked about how they used drugs because of the positive feelings it gave them. These participants interpreted 'enjoying drug use' in a range of ways. This man, for example, said he used them because he enjoyed doing so as a social act,

'I definitely have a reason for taking it though and that is just because I want to be involved in something and enjoy something with people, a shared experience ... for me it is about being sociable now and just doing something for the sheer enjoyment of it. I've never had much of that'. (Male, 55 years)

Another spoke of deferred gratification,

'I suppose if one has had a ... day at work, I do quite look forward to getting home and pouring myself a gin and tonic if I haven't had one at the workshop, and rolling a single skin joint.' (Male, 52 years)

This man like several participants who favoured hallucinogens, spoke of being able to access feelings in a way they couldn't at any other time, or in any other way,

'... For me it's not about the feelings; they're not about the sensation and the emotional sort of lift or high. It's always been to, helping me achieve or be connected to the universe.' (Male, 63 years)

Finally, three men separately, spoke of drugs as enhancing their sexual pleasure,

‘To be totally honest, I think the reason ... it was a sexual thing as well. We both weren’t getting our sexual needs met. That might sound really whacky. We do now, every now and again. We’re fifty five and fifty six so I don’t expect to be jumping off wardrobes these days ... I’m certainly not ready for that to be over. That’s tied into it as well.’ (Male, 55 years)

Again, there was a strong interaction between these participants perceived reasons for using drugs and the way that they managed their lifestyle. Those participants who talked about using drugs for enjoyment tended to use stimulants (such as powder cocaine, hallucinogens or oral amphetamine) or cannabis rather than opiates; none ever injected drugs; and they were far less likely than other respondents to have been in contact with drug treatment services or the criminal justice system. They had begun taking drugs to explore the positive feelings and had been able to maintain that throughout their lives. Some participants expressed a desire to actively seek out drugs for pleasure-seeking purposes, while for others it happened to them incidentally. Whatever the initial expressed motivation, the outcome was the same; they saw drug use as a positive experience that they continued to integrate into their lives.

Wakeman (2013) argues that the development of embodiment sociology also offers an important perspective in helping to understand pleasure as an individual’s perceived reason for taking drugs. An individual’s concentration on their own body and the sensations it is expressing are central to understanding the role of drug use in embodiment sociology - individual’s with a heightened understanding of their own self (what MacLean (2008) calls ‘corporeal pleasure’) expressing their drug use in, what might be considered a somewhat simplistic manner - as expressed sensation. However Wakeman (2013) argues that this sensationalising might also be understood as a deeper

satisfaction expressing an integrated mind/body physical duality. This understanding of the role of pleasure seems to have received little explication in the substance use literature (Moore, 2008).

The participants in this study who expressed that they used drugs for pleasure talked about their use in an initially straightforward way, but this initial description also covered a deeper, more meaningful relationship for some. A number of participants felt that age allowed them to enjoy their use more, and perhaps more often. They felt they had earned their drug use through hard work generally and through managing their lifestyle specifically. Some said they would like to take drugs more frequently, but compromised to maintain their foothold in mainstream society. Colliver et al (2006) raise the matter of whether ‘large numbers of baby boomers who previously used drugs and stopped in earlier adulthood will resume in retirement, when they are relieved of their responsibilities of work’ (p. 263). While it is not possible to generalise from the findings of this study, some of the participants seemed likely to follow this pattern. This woman owned her own home, was now economically independent, and talked about ‘enjoying life more’ as her life changed, and was now considering retirement,

‘I think I might be shaking off that austerity a bit after all these years. I still like being what I am and who I am but I do like kicking off my heels a bit now and again and let my hair down. I still think that I am growing up and finding myself out for myself.’ (Female, 51 years)

This woman was still incorporating drug use into her wider life. Even as she increased her drug use, especially on weekends, she considered drugs a small part of her life.

Enjoying drug use, and ageing

Participants who talked about using drugs for pleasure sometimes noted that drugs gave them less pleasure now than they had previously. For these participants though, rather than increase their use or look for other drugs to give them the same pleasure they talked openly about stopping their drug use altogether. This man suggested, unprompted, that he might be maturing out of indiscriminate drug use,

‘I think you mature ... One’s tastes are refined, somewhat, and I think it’s a very close and urgent judge. Where I’m lucky is... I don’t consider myself to be wealthy. Broadly speaking, by general terms, I’m definitely comfortable. That means that one doesn’t have to buy the cheapest thing. If I could not get heroin, it would not interest me taking barbiturates.’ (Male, 52 years)

Others, like their counterparts in this study who took drugs to cover pain, felt that ageing had changed the way drugs affected their body, but unlike people who were using drugs more heavily, they took less because of the change. This man said, ‘I’m inclined to think hallucinogenics are too wearing on the brain for my age. I rarely see taking them again.’ (Male, 52 years). Another talked about a similar feeling,

‘I suppose it’s like when you go out and have a few drinks. You get up the next morning, go to work, and you might be a bit... but you can still cope ... I’m fifty-one, see, so when I was forty-one it was starting to take effect where... Do you find that sometimes when you go out on a Friday and Saturday night the next day is slightly more difficult than it was when you were eighteen or nineteen? ... That’s what I mean.’ (Male, 51 years)

Studies have found varying amounts of support for Winick’s (1962) original maturational hypothesis. Although most found that some drug users abstain over time (most convincingly for example, O’Donnell, 1964; and Maddux and Desmond, 1981), this phenomenon was clearly more prevalent among some

than others. A number of participants in this study showed signs of maturing, not necessarily out of their drug use, but in their drug use. Their drug use had matured with them.

The use of a number of other participants who used drugs for pleasure, seemed to be maturing in a slightly different way. These were participants who made references to their experiences of drug use within ‘counter-cultures’ (e.g. Roszak, 1969). Two participants referred to their experiences on ‘the hippy trail’ (Male, 53 years, and Male, 52 years) while one of the couples both talked about how they had spent time on the West Coast of America (Male, 63 years, Female, 58 years). These participants talked about the positive experiences that their drug use had given them. They spoke of learning and discovery, through experiences including drug use and how their drug use had made an impact on their journey through their lives. They also related their use to belonging to a group of like-minded individuals, an alternative group. This man exhibited a strong sense of belonging through drug use,

‘I started my journey taking LSD and I’ve moved on as my life changed and my need to explore and understand other experiences has changed ... With LSD I started, we started taking what we called tabs, which were, back then, watercolour paper soaked in solution. This is, what, was supposed to be the preparation. The people I lived with made sure you knew how to make your own blotter ... And you’d prepare it from there. My friends and I would only ever prepare it with people who we felt had the right energy. I wasn’t aware of this at the start but you become more and more enlightened as you work along the right path.’ (Male, 63 years)

This man and his wife were older than any other participants in this study. They referred to the summer of 1967, the ‘Summer of Love’ in North America, as part of the beginning of their drug use, which was tied into social change and development. The study’s youngest participant has a similar history; another

had begun taking ecstasy in the UK and Ibiza during ‘the second Summer of Love’ in 1988-89. Ecstasy experienced sudden popularity around this time in the UK, connected with a culture of electronic dance music and ‘the rave scene’ (Kennedy et al, 2010). More than 20 years apart the same desire to belong to an alternative sub culture had seemed to stimulate both patterns of use.

These participants’ initial drug use experiences were connected to pleasure seeking and self discovery. As they aged, drug use became a connection to their past through these subcultures. While participants using drugs to cover pain also tried to relive their past, or had remained stuck in the past (in a similar way to how Levy and Anderson (2005) describe Goffman’s (1963) ‘spoiled identity’, p. 253), they did so because of a painful present. Participants who sought to connect to an alternative culture had new concerns in the present, such as marriages, legal work, and children and grandchildren. The context of their use was completely different. This woman talks about her updated use,

‘The last time I took LSD ... was a single tab last summer ... we were out for a weekend with some friends and weren’t due back all weekend, we were communing and it seemed like a natural thing to do. It wasn’t very strong and didn’t last like a few hours but it was a nice feeling to experience again.’

(Female 58 years)

This woman talked about her drug use connecting her to those times, but not in a nostalgic way. Drug use seems to have affirmed her identity of who she was, how she has lived her life, and how she became the person she is now. She felt pride in a greater understanding of herself that she attributed to her drug use.

Participants who used drugs to connect to a counter-culture talked frequently about how their initial drug use developed from their first use. They had been shown how to use their drugs safely, then become more adept and showed others how. At the same time, this group talked about not being drawn into a

drug using world. On the face of it their identification with drug using culture directly contrasted with their assertion of being part of a more mainstream culture as they grew older. However while they identified with a counter-culture it was more in terms of, as they aged they brought the norms of those groups into the rest of their lives, rather than letting their lives be subsumed by the norms of a single culture. This seems to express the process of 'micro-diffusion' described by Parker (2001). However this study extends that process by considering the ongoing nature of learning in these participants by describing a process of teaching and mentoring subsequently.

These participants seemed to enjoy talking about rules and guidelines they followed in their drug use, including guidelines about where to buy drugs, how to use them, which drugs to take, and the correct or appropriate administration methods. These participants had learned how to manage their lifestyle in a way they wanted to from a younger age than participants who used drugs for pleasure, but not to identify with an alternative culture. Their descriptions suggested that these participants learned valuable lessons early on from friends who used drugs, also providing them with an important source of capital. Their interviews reflected an interaction between micro social factors of interpersonal relationships and more macro social factors of group norms and societal learning. These participants used group norms to understand what drug use meant and how it should be most appropriately adopted while interpersonal relationships supplied them with people like themselves who took a similar approach to drug use. And also had a similar outlook on life. Some talked about others' negative experiences when they violated guidelines - buying drugs from people they did not know or trust, using too much and too often, using drugs opiates, or injecting. This man had relationships with other users who shared his approach and with users who suffered from the mistake of violating guidelines,

‘I was always with enlightened people who helped me understand I had to let go of myself and what I understood was the world around me. If you do, it removes the fear and anxiety and you just see the experience as, just an experience. I’ve only ever seen it (a bad experience) once because someone I only knew through other people who wasn’t enlightened; he took too much of something he shouldn’t have and couldn’t deal with what was happening.’
(Male, 63 years)

While these participants talked about still getting pleasure from their drug use, the language they used in describing their past use seemed different from the language they used in talking about their current use. Drugs that were once exciting and enlightening now brought contentment and social fulfillment. These participants had learned how to achieve balance while continuing to use. Their use tended to have a social context, such as using with like-minded friends, or using at parties. This seems to reflect well the process of gaining a greater sense of emotional peace described by Carstensen et al (2001).

Most hadn’t matured out of their use; they had, rather, matured out of the pure sensualist aspect of their use. They enjoyed taking drugs as much as ever, although they used fewer drugs and less frequently than they had formerly. A sense of fulfillment replaced the more pleasure seeking hedonistic aspects of their use. Their maturation had occurred independently of their drug use, and they were now looking back at their use through their matured outlook.

At the same time though this sub-group of participants talked about drug use helping them to discover more about themselves and learn more about the universe. They described symmetry between their personal physical and psychological growth. While their drug use had grown and adapted with them, this goal of learning and self discovery continued. One man talked openly about the different ‘physical plains’ he saw through his drug use and the different level of understanding he had gained, built on through spiritual experiences

such as meditation. He talked about the power of drugs having helped him to experience the world in a different way now. He took pride in developing his own personal value system. He said he didn't believe that just because he was getting older his life was coming to an end. He talked about life being a process whereby he continued to learn.

However, this sub-group of participants did talk about ageing and the physical effects of drug use. Like the majority of participants who were interviewed for this study, all were highly self aware and constantly talked about monitoring the changes they were experiencing. It is what they did with this awareness which differentiated these participants from their peers in this study. They wanted to be able to continue to use drugs if they desired, for as long as possible, but made frequent reference to the challenges of doing so. These participants used drugs from a place of balance - stability rather than instability, with a stronger sense of themselves in the world. They also importantly showed a very well defined sense of place with many and various elements of capital, social and economic. All of them treated drugs with a measure of respect. They were openly scornful of drugs which they saw as damaging, particularly nicotine and alcohol. Only one of this group smoked cigarettes, and another drank alcohol, which she described as 'social drinking'. As this man put it, to disparage nicotine, 'I may be wrong but I've never heard of anyone suffer cancer from taking too much Acid' (Male, 63 years)

This sub-group of participants seemed to view their current drug use, and particularly their hallucinogenic use, as a familiar part of something which had been with them over the course of their lives. These feelings helped them to preserve a link to the past, and by doing so a link to a common part of their own identities. For some of these participants it was clear that they used drugs not only to maintain these links but to reinforce them. They distinguished their own drug use as something deep and fundamental, in keeping with the meaning

drugs had accumulated. In this respect these participants showed a distinct difference to those who showed signs of ageing in place.

When participants who were using drugs to gain pleasurable feelings felt they were starting to incur problems relating to drug use, either modified their use or started experimenting with other drugs. They seemed more able to choose to stop using them or to continue, as they had done over their lives. This was more likely to be as a result of their own personal psychological qualities and coping mechanisms coupled with their structural resources and access to opportunities (e.g. Zinberg, 1984; Decorte, 2001).

The connection between how and why participants are using drugs

This interaction between a conscious ability to exercise choice through cognitive control accompanied by a feeling of what participants wanted from their drug use might be seen as central to understanding the relationship between how and why these participants were using drugs.

This pattern of use and the interaction between the drug and the user is central to answering one of the research questions in this thesis - a preference for one specific type of drug, and how they used them, seemed to be connected to the reasons why people used drugs. This has been highlighted throughout this and the previous chapter. Participants had very particular reasons why they took the drugs they used. In that respect their use was very utilitarian - they had an aim or specific plan for taking drugs they did.

Participants' reasons for altering their feelings interacted strongly with their ability to manage their lifestyle in a way they wanted to and thus 'achieving balance' in their lives. Participants who talked about using drugs to enhance positive feelings generally wanted to manage their use very closely, while living other aspects of their lives. This allowed them to safeguard all of their

roles independently. As they saw it, if they were not able to do this, drugs might then interfere with their pleasure, either directly by making them sick, or indirectly by putting them in jeopardy of arrest or violence.

When participants were using drugs for pleasure they generally saw them as peripheral to other aspects of their lives. Their definition of managing their lifestyle seemed to be very rigid, and they saw any deviation from their normative levels of the amount of drugs they used as managing less well. While an objective view might interpret this increased use as no threat to their job or relationships, they rigidly avoided it. This created a virtuous cycle that helped them to monitor their level of use, and is reflected in the theoretical model in the following section.

Those participants who used drugs to avoid pain, for which drugs were more central, seemed to define their ability to manage their lifestyle in a way they wanted to more flexibly. So long as they were able to function (with the aim of ultimately buying and using drugs), they frequently seemed to consider themselves as ‘achieving balance’. In Zinberg’s (1984) terms they were still managing to some extent because they could have always used drugs more aggressively. But they were managing on their own terms, by their own definition. This is also a pattern which has been identified by Drumm et al (2005) who describe a level of ‘self-care strategies among chronic and injecting drug users’ (p. 607).

Chapter summary

This chapter has explored the participants expressed reasons for using drugs - to avoid negative feelings, or experience positive ones. These patterns of use are prevalent in existing research - taking drugs to self medicate (e.g. Khantzian, 1985) and for pleasure (e.g. Wakeman, 2013). The majority of those interviewed talked openly about using drugs to cover pain; fewer used drugs for

pleasure. Those who used them to cover pain mentioned psychological or physical pain with a variety of origins. Most had always used drugs to cover the same type of pain. A subset of this group expressed feeling compelled or constrained to use drugs, which none of the participants who used for pleasure did. These participants saw themselves as addicted and were frequently trying to moderate their use, but felt unable to stop. Those participants who were using drugs principally for pleasure expressed some different reasons for doing this, but ultimately their goal was the same - to enhance a complimentary experience. The chapter concluded by considering the interaction between the participants perceived reasons for using drugs and how they were using them. This is the central relationship expressed in the core category of the theoretical model which is described in the next chapter.

Chapter 8. A theoretical model of drug use in older adults

Introduction

This final chapter of the results aims to connect the data into a theoretical model of process described by the participants. Chapter 4 described how the model has been developed - by growing the codes to major categories, as the frequency with which they were mentioned during the interviews, increased. The core category of 'achieving balance' was established, and after axial and theoretical coding outlined by Charmaz (2006) a model of the process of drug use in this group of older adults was developed around this. This is shown below in Figure 5. It illustrates the model, how the major categories within it fit together, and most importantly describes under what circumstances it operates. It does not seek to explain drug use in all older adults, but instead describes the experiences of this group of participants.

Grounded theory does not exclusively aim to develop grand theory. Instead, it enables studies to hypothesize relationships between different categories and codes to develop a more general abstract understanding of how a process operates. Strauss and Corbin (1998) provides the most appropriate definition of a theory for this study as 'a set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena' (Strauss and Corbin, 1998, p. 15).

This section will follow an outline suggested by Charmaz (2006) who states that, 'carefully crafted grounded theory categories work well as signposts ... use your major categories for headings of sections' (pp. 161-2). Each of the major categories are presented in turn (with the exception of 'managing lifestyle' and 'altering feelings' which were described in the previous two chapters)

considering what they contribute to the model, along with how they relate to each other.

The chapter will conclude by highlighting how the work of West (2006) provides a rationale for how the processes described in the model might operate. As Charmaz (2006) suggests, by comparing theoretical models derived from grounded theory studies with existing work in the area, authors can illustrate how their theories ‘extend dominant ideas’ within their field (p. 165).

The temporal theory illustrating the interaction between ageing and drug use

The previous sections have described how the participants saw their drug use within the context of their current social circumstances and within the rest of their lives. Their drug use was part of a process which had progressed for a number of years and was ongoing. Their previous experiences affected their current situation and this in turn frequently dictated their future actions. The theoretical model below attempts to describe this process. The chapter begins by describing how the participants feel now, followed by how they experienced the past, and then what they expect from their future. All of which influenced their drug use.

However this presentation should not imply a simple linear relationship. The core category (in the centre of Figure 5 below) has a dynamic and interactive connection with the other major categories. It provides the frame for the theory, and all other categories emanate from this and inter-relate in their own way - all influence the model and the underlying process on an ongoing basis.

The illegal drug use behaviours and social circumstances of older adult class A drug users

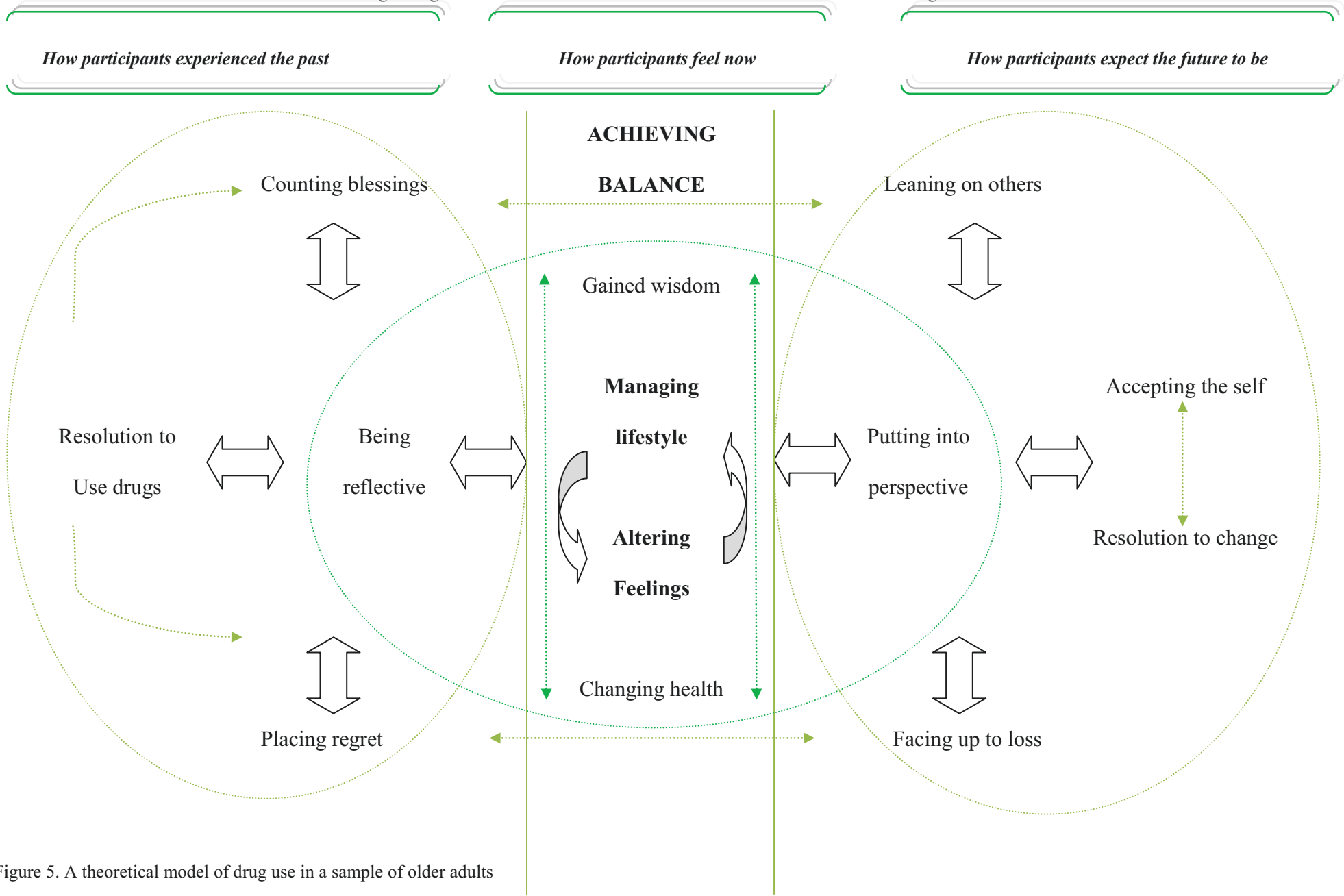


Figure 5. A theoretical model of drug use in a sample of older adults

How participants feel now about their drug use

Figure 5 provides a diagrammatic representation of a theoretical model of drug use in this group of older adults. In the model, the participants' current situation is characterised by the central oval. It encompasses the core category and provides the process, which is responsible for how the participants feel about themselves, and about their drug use now. This is in turn moderated by experiences of their past (the oval to the left) and their expectations of the future (the oval to the right).

Achieving balance

As Chapter 4 described, the core category of this study is 'achieving balance'. This was originally named 'a survivor approach'. This was subsequently renamed to better reflect the nature of the process these participants described in their relationship to their drug use, and the rest of their lives. West (2006) uses the term 'balancing input' (p. 168) to refer to the process by which people weigh up information from internal and external stimuli to consider future action, either consciously or unconsciously. This seemed to explain well the central process which these participants described.

The previous two chapters highlighted the major categories within the core category - concerned with how and why these participants are using drugs. 'Achieving balance' is more than a category in this case - it is the fulcrum of the entire study. It aims to describe the process under investigation. In this process participants highlighted constant balancing, using words such as watching, managing, monitoring, and controlling. The connection to the past was through 'being reflective' (suggested by the two way arrow to the left of the present or central oval) whereby participants described the role played by experience. This moderated how they considered the future - illustrated by the major category 'putting into perspective' (suggested by the two way arrow to the right of the present or central oval). The major categories

‘gained wisdom’ and ‘changing health’ contributed an overseer role in this process.

The interview process invited participants to reflect, but every question seemed to invite reflection. Even during the earliest interviews where the participants were allowed to give the process a good deal of direction, they talked about how their drug use had made a lasting impact on themselves and their identity. Some also started to talk about how their drug use was moderated. This is perhaps described best by this man who talks about detaching himself from any hedonistic feelings around his use which helped him to manage his use,

‘When I look back I used to get so attached to these thoughts and believe that they were real ... I learned to see the thoughts, and feelings, and emotions of what they are, and through the practice of meditation you can actually distance yourself, and if you get a craving, for example, for a drug or anything you can actually see that for what it is rather than go with it. It gives you that space to actually pause. It’s like taking a cognitive pause. It helps me do what I need to do.’ (Male, 54 years)

This quote illustrates the central aspect of the core category in a snapshot. What this man called the cognitive pause is at the very centre of the process - it then emanates outwards. It is the beginning of the mental balancing act that then affects, and is affected by the participant’s behaviour. This act of balancing was conscious. It had arisen through a process of acquiring wisdom through experience, and moderating responses based on current physical and cognitive health.

But while the central process of the core category is about personal balance its effects emanated outwards into the rest of their lives. The first part of Chapter 6, on how these participants were using drugs, considered the kinds of factors (in the shape of properties, such as the kinds of drugs they used and the frequency with which they used them) which they were balancing daily. It described the kinds of decisions they were making and then the

reasons they believed they were making them. While it was possible to separate these participants' current drug use from the rest of their lives to present descriptively, it became apparent that this would prevent a deeper analytical understanding (as one of the participants in the previous chapter suggested).

For these participants this is also where the personal connected to the social. Their drug use was a personal activity driven by personal choices and behaviours, but it was an ongoing act that had made a social impact on their lives. Even for those for whom drug use was a peripheral activity it still defined certain aspects of their identity (as the previous chapter also highlighted).

This man attempts to describe the place of drug use in his life. The difficulty he had in separating it from other aspects of his life and particularly his life now. His drug use had been a supplementary activity adding colour to the rest of his life. His first reaction was to consider the feelings that it gave but as he went on broadened this out to the impact this had made on the rest of his life.

'I think that's what's hard to say goodbye to, it's that link to the past. Those feelings. If you speak to most people who take drugs, that's the bit they'll talk about. There are things in life, such as being with a woman or a man who you feel is your soul mate. You can reach that plateau where things can really affect you but there is something that can take you that stage further - that euphoric feeling that you don't get from any relationship ... that's what drugs gives you. And you get to my age and you've tried a few things and nothing is the same. I don't know how I'll be if I have to give that up, sort of like retirement I suppose.' (Male, 58 years)

This man's consideration of feelings embraced a much wider perspective. The feelings he received from drug use were not just bodily feelings connected to altering moods, but brought with it memories of the past connected to his identity now.

Ongoing information processing contributed to the development of wisdom, which the participants used to factor in when further processing was required. ‘Gained wisdom’ allowed them to reflect on their own behaviour, and take appropriate action.

Gained wisdom

A major category connected to, but subsumed by, the core category was ‘gained wisdom’. The role of ‘gained wisdom’ in moderating the participants responses to everyday matters, and more particularly their drug use (as illustrated by the man above), was central to the model. All of the participants talked about having ‘gained wisdom’ through lived experience and through questioning their own actions. Their outcomes were highly variable but all talked about having learned through their experiences with their drug use. The previous chapters described this in detail, the kinds of experiences they had and the ways in which it had moderated their behaviour. Participants expressed tangible outcomes as a result of learning through the wisdom they had gained - considering, for example, how realistic future desires, aims, and goals were. It played a central part in the way that these participants understood, related to, and interacted with their world.

Changing health

This thesis has considered the importance of the participants ‘changing health’ throughout. They expressed a great deal of concern about their health throughout all of the interviews, making it a central concept in the theory. Their ‘changing health’ was another pillar they were using to reflect on their behaviour, and this was more apparent to these participants as they constantly reflected on how drug use had interacted with their health. Nearly all participants raised the issue of their current personal health

independently¹⁶, before being asked about it. They described a strong interaction between their current personal situations, their drug use, and their physical and mental health.

As the previous chapters described, the participants who had used drugs more heavily at times in their lives felt that their use had been in some way detrimental to their body; while those participants who used drugs less heavily by comparison, manifested fewer drug related physical changes. Although they were still conscious of how their bodies had changed because of ageing. Most acknowledged that they could no longer use drugs in the way they once had. However, most felt they could continue their use by ‘achieving balance’.

As the previous chapters also highlighted participants also talked about their changing psychological health and cognitive abilities. For a number this manifested itself in a consistent negative decline in the shape of apparent symptoms of depression, anxiety, loss, and isolation. These participants tended to be those who were or had been using drugs more heavily. Other participants who had used drugs similarly but were subsequently now using more moderately, reported positive psychological changes. One talked about ‘valuable life lessons’ he had learned through his experiences.

Some participants reported having undergone life changing attitudes after suffering physical health changes they felt to be a direct result of their drug use, such as this woman who had suffered long-term physical and sexual abuse as a sex worker,

‘I’m sick I know that much, and it’s drugs have made me this way. I’m never going to work again I know that, but I can read and I can go to groups and I can talk to people and help someone else maybe. I’m looking at the world now with a bit different eyes now I can see different things and it looks better, not looking down for my next fix, my sort of life is more than

¹⁶Fourteen participants mentioned their current physical health in the opening sentence of the interview.

that now. I do other things. I live in the best city in the world and there's a lot of free stuff to do here. Plus I go to the library every day and try to learn something I didn't know about, I read the papers too and go to groups and just talk to people and try not hate them. That's a big step for me, not hating everyone or everything anymore, I want to stop being angry at everything, letting go of that anger, I've been angry my whole life and I don't want it anymore. I'm too old and too tired.' (Female, 52 years)

Some participants felt that ageing, long-term drug use, and the collected wisdom they had gained as a result of it, merited respect. These participants felt they had 'gained wisdom' through physical decline. In terms of the model, changes in their health were placed in the context of their past health ('being reflective') and future expectations of their health ('putting into perspective').

However participants considering their 'changing health' did not always mean rueing declining health. They saw the changes in their health as part of the ageing process which to them was a positive thing, recognising the wisdom that ageing brought with it. Some participants, as reported in the previous chapter, regarded their drug use itself as parallel to their life's journey. They believed that it had been responsible in a number of ways for helping them to learn more about their life.

How participants experienced the past

A large majority of the participants talked about how they reflected on their lives. Some said the interview questions mirrored questions they often asked themselves. Participants' reflections considered and reconsidered their drug use and their lives with and without it. This is indicative of the balancing process these participants underwent. While participants' drug use did not determine the person they were or had become, there was a strong indication that their experiences of drug use had helped to shape them as a person. This was true for both those participants who were 'achieving balance' or not.

Placing regret

For these participants reflection frequently seemed to accompany regret, often brought on by considering ageing. These regrets tended to differ however between the participants. Participants' perceptions of balance between their drug use and the rest of their lives seemed to affect how positively or negatively they now felt about themselves. Those participants who felt they did not have the right balance in their lives and were using drugs more heavily were more likely to have invested a significant amount of their life in drug use as a lifestyle. They spent a large part of their lives using drugs and seeking to acquire them. These participants expressed regret, not just about this experience, but also about things such as not having a family, stable housing, a job or a career. One participant in particular had begun a promising, well received career as a singer and songwriter but his drug use had curtailed this. He now talked about being an infrequent session musician. He regretted that he might have enjoyed a much higher profile in the entertainment industry had his drug use not taken up more of a role in his life than he wanted to. A number of other participants talked about extremes of behaviour they had experienced such as death, serious illness, and harm in a matter of fact way, and acknowledged that this was not normative. This man sums this up well,

'It affects who you are, how can it not? You go through your life from one bad experience to the next thinking at the time it's a lot of fun, but it's not it's shit and drugs are shit. We all con ourselves thinking we're really enjoying it and it's great but it isn't. I defy anyone to go through what I've been through and come out the other side thinking their life was great, you don't sleep through a nightmare and wake up feeling alright do you?' (Male, 54 years)

These participants talked about the negative impact of their drug use. Positive reflection by these participants was often connected with issues such as successfully using their problem solving skills, being resourceful, and outwitting the police by committing crime and evading capture.

When participants were 'achieving balance', they spent more time, money, and effort on all parts of their lives. Their careers, their families, and interests completely separate from drugs shaped their lives. Drug use had played a part in shaping their identity, but other parts of their lives had made more impact. This woman describes this for her,

'But I hope you've got, from me it's not about the feelings, they're not about the sensation and the emotional sort of lift or high. It's always been to, helping me achieve or be connected to the universe. I think I get this better now through meditation and practice better now than anything I ever used before, and I think that's about wisdom. As I get older I think I'm more attuned to my environment and my body and I feel certainty. I've gotten more of myself, I think I've gotten more comfortable in myself and less with my sort of outward appearance and being myself. I feel more connected with what's going on around me. This is what I'm living for, and that's what gets me moving in the morning, desire, wanting to be with something and be a part of something bigger' (Female, 58 years)

This woman went on to talk about being 'blessed' to have her family - emphasizing how much it meant to her and , particularly how much 'richer' she felt for having been able to be connected to her social network. Even though she was 'achieving balance' however, she went on to express some regret for the things that she would miss in her life as it passed. She talked about her life being 'gone in the blink of an eye'.

When participants were using drugs in this way they still expressed regrets but their regrets were more likely to be connected with issues concerned with the rest of their lives and things they missed as they aged, and they saw their lives changing - such as not having had the job or career they wanted, not feeling more secure in themselves as they got older, being unmarried or not having children.

Counting blessings

In the same way that reflection was often accompanied by regret, it was also frequently accompanied by contentment. This manifested itself in different ways among the participants however. Participants who talked about being unable to achieve balance expressed gratitude for families and good friends, and for what health they did have, sometimes for just being alive still. However these expressions often referenced death and ill health - they expressed surprise for their good fortune in relation to what they had seen and experienced. For some there were feelings of relief at the challenges they had overcome.

Participants who were 'achieving balance' also expressed a similar contentment. However this was more likely to be more fixed and stable, based around things they had built over their lives, for example their families, homes, and careers - frequently these were external indicators of their perceived success and good health.

The interviews did not, however, suggest that the participant's drug use determined their comfort with their life. There was no simple association between this and their drug use. There were people who had used drugs less heavily than others who reflected more negatively on their lives - while others who had used more so now appeared to be more comfortable in themselves. A possible reason for this comes back to the foundation of this model - how a person's experiences and expectations for the future shapes their relationship to their present situation. Participants' feelings about their experiences seemed to be relative to their own personal situation and highly contextual (i.e. factors other than drugs also had an effect on this relationship).

How participants expect the future to be

Putting into perspective

Participants' responses to questions about their expectations for the future reflected that they had considered this frequently. Some had what sounded like well rehearsed narratives about their futures, while others described plans and proposed directions.

Those participants who felt they could not achieve balance at present had few positive expectations for the future. They frequently talked in a fatalistic way about how much 'time they had left' and what they felt the likely outcome for them was.

'I'll be 56 soon and [gives wife's name] she's 53 year old who also uses heroin, we've lived together for 30 years and have been co-dependent for most of those, the future terrifies me. I don't think about the future. People like me there ain't no future, no one wants to know us, [gives wife's name] HIV positive. We don't think about the future. We think about not getting sick, getting ourselves through another day, getting ourselves to our appointments, getting through to tomorrow, having enough for tomorrow and where money's coming from, just surviving and getting by, like most people, we could be anyone but we use drugs'. (Male, 58 years)

These participants tended to focus on what they saw as their 'changing health' and potential negative outcomes related to it, such as those described previously. Participants with HIV or AIDS or other serious illness did not consider their future at all. They focused on managing their conditions one day at a time.

Those participants who were 'achieving balance' tended to talk about retirement, travelling, or basically having more free time. Some saw this negatively, others positively. This seemed to depend on their general outlook, irrespective of their drug use. The oldest couple for example who had experienced their drug use initially in 1960's US, talked about having gained perspective and a sense of emotional peace.

All participants, regardless of whether they were ‘achieving balance’, had seemingly put their future into perspective based on their expectations, however negative or positive that future appeared to them.

Facing up to loss

‘Facing up to loss’ they had suffered helped participants to gain perspective on their lives. As the previous chapters highlighted, nearly all participants had suffered loss at some point, many as a result of using or having used drugs. Some talked about the losses they had suffered in the past and the effects this had on them now, and some used drugs to avoid facing this loss.

Participants who were using or had used drugs more heavily at some point talked about the disorientation, and sometimes guilt, losing people to an overdose or drug-related illness had caused. One woman said she was ‘the last one left’ among her peer group of friends. Some talked about the losses they had suffered as they had moved away from drug using friends, and how they missed the connection with others. However they described the changes they had made as necessary in order to be able to achieve balance.

Those who were using drugs less heavily than their peers, tended to talk about less tangible and more abstract losses. They talked about declining cognitive and physical abilities. Some talked about being unsure whether this was because of using drugs or ageing. The losses they perceived due to physical decline ranged from going to all night parties to gardening. This woman talked about this kind of loss shaping her current feelings about herself and her life,

‘I know as I get older I won’t be able to do the things I did, like for now ... I can’t work long haul anymore because my knees start to hurt if I’m on my feet for all that time. Do I miss it? Maybe, yes I did enjoy my life as I was, nobody wants to get old do they? Being older means being vulnerable, not being able to cope, who would want that? Especially being single, being a woman, having to rely on myself ... but then again having a schedule, a

routine has been really good for me ... I've got a lot to be thankful for it would be really selfish of me to dwell on the negatives. I don't think too much about the future. I am happy where I am for now. I like my life at the moment'. (Female, 51 years)

A two-way dotted line in Figure 5 traces a relationship to 'placing regret'. This is intended to express an interaction between these two categories. Those participants who were able to face up to the losses they experienced seemed less likely to experience regrets, or better able to come to terms with them. Further work might usefully consider this.

Leaning on others

Chapter 6 described the importance of the participant's social relationships and the impact this had in their lives. It also alluded to the influence of positive and negative relationships and how these acted as moderators of the participants' drug use.

When participants talked about not being able to achieve balance they were generally less able or less willing to draw on relationships for support. But even negative or fragile relationships afforded some possibility to lean on others. Some participants were leaning on partners and friends who also used drugs. Some relied on their partners to help them. Partners who had been diagnosed with depression or Post-Traumatic Stress Disorder provided support in limited ways. At least six participants had partners managing physical and psychological problems directly related to their own current substance use, including HIV-AIDS and alcoholism. Participants spoke about 'feeling needed' in these relationships, giving them a sense of purpose. These participants talked about how important it was to have a partner who understood the complication of a life that included drug use.

A number of the participants were dependent on older parents and other relatives for things such as housing and food. However, the situations they described were also caring relationships. Some participants talked about

how the older relatives they lived with were house or wheelchair bound, reliant on someone other than themselves for things such as help with healthcare appointments, preparing meals and their general well-being. These participants talked about how these relationships of co-dependence (two mentioned the term unprompted) gave them a sense of well-being and purpose. More than one participant said drug use had made them hedonistic and selfish and that caring for a relative changed their lives for the better. This man talked about having moderated his drug use to care for his mother,

‘I like taking my drugs right now but I can’t do it that often or I’ll go nuts I know that, you know what I mean. I can’t let that happen, I’m hanging on sometimes but you know like most of the time I’m okay, I’m keeping busy and keeping myself together. I don’t think I’ll slip back again, I don’t because I know like I’m needed. When I was at it all the time I mean I’d just go missing for days on end just sit in a room doing it over, five six days at a time and then just bang crash and nothing. I can’t do that no more, you know if I did that Mum wouldn’t last, sometimes she’s so bad she needs someone to change her oxygen ... she couldn’t get out and I can’t let it happen so I’ve got to keep it together. It’s alright, I’m okay and handling it. In my really bad times I get I think the worst thing and this is being really selfish I know that, and I’d never tell anyone this, if something happened to her and I got everything you know, right now it’d take everything I had, I don’t know what would stop me just blowing it all on crack. I could see that happening I could which is another reason I have to make changes. I hope Mum keeps it together and being around her for a while’ll help me keep myself together. It’s funny ain’t it, all my life I’ve been a waster and now my Mums in a wheelchair and on oxygen and I still need her as much as she needs me. I’ll do my best for her. Make sure I see her right and try to undo some of the damage I know I’ve done her.’ (Male, 55 years)

This man described a situation whereby caring for someone else helped him care more for himself. This was not uncommon among other participants. It also gave him a sense of security having a ‘roof over his head’ and giving him a routine outside of drug use. Some participants talked about ‘making

amends' (a code which was later subsumed by the category '*Leaning on others*') for the impact their drug use had on their relatives. Some described how they felt they were trying to make up for what they had done over their lives by caring for someone now. A number of other participants also talked about 'making amends' to society. As Chapter 5 indicated, six participants were now working as volunteers with other substance users. All mentioned that they would like to 'give something back' or 'make amends' for the perceived harm they had done as a result of their drug use.

Participants who were 'achieving balance' tended to speak similarly about relationships. For them however they tended to be able to draw important support from positive and fulfilling relationships with parents, spouses, and children. Those who were able to lean on others tended to feel more able to count their blessings. Their perspective differed from those who were unable to. Those who viewed their futures less positively, their expectations tended to be framed with loss and regret. This relationship is expressed in Figure 5 by the two-way dotted line between 'facing up to loss' and 'placing regret'. Again, further work might usefully examine this relationship in more detail.

Accepting the self

All participants accepted responsibility for the role their drug use played in their lives. Some exhibited a negative acceptance and some more positive. Participants' perceived balance seemed to interact with their level of acceptance of themselves and their situation.

Most participants who talked about feeling unable to achieve balance were more likely to accept themselves with resignation. These participants put their lives and their drug use into perspective and tended to accept themselves as they were. This did not mean they were comfortable with their situation but instead were resigned to dealing with the situation as it was, even if that resolution meant not dealing with it. They talked about having a realistic idea of who they were, what their personal situation was

and what the future held for them. They talked about this in lucid and practical terms. There were no participants whose understanding of their future (from the point of view of this researcher) seemed unrealistic from what they were describing.

Those participants who talked about trying to achieve balance but felt they were failing, sometimes seemed unnecessarily pessimistic however. Some in this situation talked about how they tried and failed to stop using drugs, if they were trying now they tended to view their chances of success to be poor, and their future, to them, looked bleak and they reported it as such. This man sums that position up well,

‘I don’t know how long I’ve been without since I was about 24 now...All this time, one thing or another. I’ve stopped and started again, stopped and started again. I don’t know what it’s like to be clean as an adult, that’s really fucking scary isn’t it? I’m what? 52 now? I’ve been stoned longer than I’ve been clean, fucking hell, what are my chances after all this time? ... You might as well just sweep me up with the rest of the rubbish.’ (Male, 52 years)

This position seemed to be characterised by a frustration but at the same time there was still a sense of ‘accepting the self’. For these participants’ acceptance of themselves carried no hope of a changed future. Like the participants in Levy and Anderson’s (2005) study, some older adults were more comfortable ageing in place rather than trying to break their cycle of dependence.

Those participants who were ‘achieving balance’ generally expressed more contentment with themselves. They talked about having successfully negotiated the challenges their lives had brought and in the context of this study, did this continually in relation to their drug use. Some participants among this sub group talked about frustrations in their lives - not having achieved the things they had wanted to for example - but these were not connected to their drug use. They were however interested in changing these

issues. But in contrast to the more fatalistic participants in this study felt more able to implement these changes if they applied themselves.

Resolution to change

Participants talked frequently about changes they wanted to make in their lives. For some this was a continual process of change and development. While others wanted to make larger changes. They had reached this formulation by putting their lives into perspective and expressing a 'resolution to change'.

Some of these participants who wanted to make changes as a result of their drug use said they felt unable to do so, as the previous man described. However there were others who described practical, achievable, and clearly formulated plans, to make the necessary changes. They talked about how things would be difficult but they described ways in which they knew they could overcome any barriers. It is impossible to make generalisations from such a small sample. However, there were two striking differences in the narratives of these two sub-sets of participants.

Firstly, those participants who were more positive described times in the past when they had been successful at 'achieving balance' and were able to describe what change might look like. Secondly, these participants also tended to have wider social networks. They talked about friends who might be able to help them and perhaps most importantly, friends and relatives who were not, or had never used drugs. In terms of the theory they tended to have people who they could fall back on, or lean on others. This crystallises well the concept of recovery capital. Those people with a greater set of structures to fall back on are more likely to show positive outcomes connected with substance use (e.g. Lyons and Lurigio, 2010; Vandereycken, 2012; and Rowan et al, 2013). While individual factors were crucial to the outcomes of many of the participants in this study, structural factors clearly played an important role.

Theory statement

It is hypothesized that the older adults who participated in this study use an ongoing process of monitoring to manage their behaviour, their drug use, and the reasons for taking drugs. This contributes to them being able to achieve balance in their lives. When this process is absent it is hypothesized that the participants are unable to achieve balance in this way.

This is an ongoing process but has been, and continues to be, shaped by the individual's past experiences. This in turn has shaped their identity and helps to moderate their future behaviour. All of this occurs within the context of each individual's environment, and the passing of time.

It is further hypothesized that this process involves a physical, psychological and social awareness. Some participants had reflected on their self-identity, considered who they were and who they might become, how they felt about their place in the world, and most important how drug use has influenced this. In contrast, other participants were less likely to have done this.

Theoretical basis for the model

Theoretical reading and subject based review was undertaken alongside the fieldwork and analysis for this study, to derive a theoretical basis for the findings and subsequent model. This section describes how West (2006) provides an appropriate theoretical basis under which the core category (along with a number of the major categories) and central process might operate.

'Achieving balance' and the unstable mind

This study hypothesizes that the core category of 'achieving balance' is central to these participants' ongoing attempts to manage their drug use within the rest of their lives.

West (2006) concept of how individuals face their daily lives as a ball rolling across a landscape featuring valleys and hills that diverge and converge at various points, representing challenges. The changing environment and the individual's reaction to it dictate the path of the ball. West (2006) borrows the term 'epigenetic landscape' (p. 170) from Waddington (1977) to describe this. West (2006) describes the human mind as 'inherently unstable' (p. 167) and requiring constant balancing stimuli and information and changing course to negotiate where an individual wants to be. This is described as analogous to a 'fly-by-wire' (p. 167) aircraft - designed to be unstable to make it as manoeuvrable as possible. An individual's effectiveness at this balancing process is dictated by their ability to balance new inputs, and to change and adapt as necessary.

In this study some of these participants described how they did this very effectively by being continually watchful of their drug use, evaluating it and monitoring it regularly. In doing so they had placed drug use within the rest of their lives. They reflected on whom they were, accepting themselves and putting their behaviours into perspective - they were 'achieving balance' through 'gained wisdom'. Any resolution to change was made on an ongoing basis. This was not only reactive - when participants were 'achieving balance' well they were also anticipating change and making plans to adapt to their new environments. The findings in the previous chapter described how some participants were identifying signs of 'changing health', and were making changes in their lives and their drug use to adapt to this for example.

West (2006) describes how individual's evaluations of their worlds drive their motivations and their subsequent behaviour. He is suggesting that we seek out the 'thing that enhances our well-being' (p. 153) and attempt to avoid things and situations that threaten it. So when these participants foresaw potential difficulties that threatened future balance, they evaluated the evidence available to them, formulated a plan and pursued that course across their own personal 'landscape'.

However when participants described a process where they were unable to do this, or had stopped doing it, they had become less effective at negotiating this hypothetical landscape. They describe an outcome posited by West (2006) where they had let themselves be pushed down into a valley, unable to manage their drug use. They described a situation where they were now unwilling or unable to move out of.

Chapter 3 described how a pattern of behaviour develops through a 'presence of influences that take it in a particular direction or equally importantly the absence of balancing input from other influences' (West, 2006, p. 168). Participants in this study who were not 'achieving balance' had stopped balancing the stimuli and information that came from the environmental factors of their daily lives. Their inputs were restricted to the sensations that came with the world of drug use. They were now wholly enveloped by the reward seeking behaviour of their need and desire to use drugs. Again this is also hypothesized by West (2006) who describes an individual's behaviour at this point as solely moderated by 'mindless' (p. 173) influences of reflex and habit. On this basis West (2006) seems to provide a valuable description of the core category and central process which these participants described.

Like West (2006) the theoretical model developed for this study represents behaviour as a constant and ongoing process of negotiation (what West (2006) describes as 'flow' (p. 131)). As such it attempts to distance itself from other work involving cognition in drug use (such as rational choice theory) which proposes behaviour as a series of stop/start selection of choices. The flow model described by West (2006) seems to better describe the behaviour of the participants in this study.

The model developed for this study also emphasizes the context in which this personal process exists - the importance of an individual's environment, and how their identity is shaped through experience. West (2006) focuses on the importance of 'moment-to-moment influences' but further develops his theory by describing that the 'plasticity of the system' is shaped by

‘habituation/sensitisation, explicit memory, and associative learning’ (p. 167). This seems to represent well the experiences of the participants.

Past, present, and future - ‘mindful’ and ‘mindless’ processes

Understanding this model of drug use in older adults in the context of West’s (2006) PRIME theory depends on understanding the ‘causal links between emotional states, evaluations and motives’ and the ‘ways in which our motivational system is affected by past experience’ (West, 2006, p. 156). West (2006) argues that when it comes to substance use there is no form of ‘now’; instead an individual undergoes a continual relationship of conscious and unconscious processing. Their past feelings and experiences of the phenomena as well as their expectations of future substance use affect and influence this. The concept of balancing inputs across the epigenetic landscape revealed this need to process the present continually. West (2006) further postulates that the strategies used to negotiate the past frequently become the strategies that an individual uses to negotiate the present, and that an individual’s expectations for the future moderate this. The previous chapters have described this process well among the participants in this study.

This interaction between the past, present, and future is central to the theoretical model described in Figure 5. The ongoing monitoring process described by the core category ‘achieving balance’ is set within the centre of the model, moderated by these participant’s pasts (to the left) and futures (to the right).

West’s (2006) PRIME Theory hypothesizes how an individual develops a set of motivational responses, formed by experience, which then become the foundation for their decision making. This foundation can be moderated by further experience if the individual reflects on this. Should they not it could lead to making inappropriate (in West’s (2006) terms, largely reflex or habitual) decisions. These motivational responses add to an individual’s sense of identity which then contributes to their future decision making, as

the individual strives for internal stability. For West (2006) 'beliefs drive actions by way of feelings' (p. 152).

As the findings in the previous chapters described all of the participants in this study talked unprompted about how they believed their past experiences had in some way (particularly their perceived reasons for their current drug use) shaped their current behaviour. Those participants who described having developed higher, or in West's (2006) terms more 'mindful' (p. 173) processes to guide their behaviour, talked more about 'achieving balance' in their lives. In contrast, the behaviour of those participants who talked about being less able to achieve balance, seemed to be guided by reflex, habit or in West's (2006) terms, largely 'mindless' (p. 173) processes of reflex and habit.

In West's (2006) terms it could be hypothesized that as individuals were able to develop more mindful processes they were more able to achieve greater balance. This indeed was the case with these participants. As the findings described, when participants who had been able to develop more appropriate behavioural responses, through therapy and intervention for example, they described being more able to manage their drug use as they wanted to. This also seems to underscore what West (2006) advocates for treating people with entrenched addictive behaviours - altering an individual's processing techniques to reframe their identity (this process was indeed described by some of the participants in the previous chapters). This then provides a foundation for behaviour change. In the terms of this study those participants who had been able to make positive changes in their drug use had considered their identity, 'accepting the self' providing a 'resolution to change'.

This also describes well the situation of those participants who were less able to do this and might be seen as ageing in place. Those participants who described themselves as unwilling or unable to change had seemingly accepted their identity as fixed. West (2006) suggests that this is a divergence from other (again particularly choice) theories, which he

believes suggest that these processes are fixed and stable among all individuals. He asserts however that they only exist, or are created, under the right circumstances. He hypothesizes that individuals exposed to rich and stimulating environments are better able to develop more mindful processes, while those from less stimulating environments are afforded less of an opportunity to do so. West (2006) proposes the importance of an individual's environment shaping their experience, their identity and therefore their behaviour.

The context for 'achieving balance' - environmental resilience and susceptibility

Thus far, West (2006) describes an intricate choice theory of drug use. Theories of drug use which describe addiction, or challenging drug use, as a result of inappropriate decision making processes, already exist (e.g. Skog, 2000; Ryan, 2002; Slovic et al, 2002), as do those which focus on issues such as self-medication and identity change (e.g. Prohaska and Velichir, 1997; Gelkopf et al, 2002; Kearney and O'Sullivan, 2003). However while West's (2006) theory has elements of decision making, choice and identity it progresses these by describing their development through a social or environmental foundation. He sees the process of individual balancing and ongoing monitoring within a landscape - this represents the individual's environment they face on a day-to-day basis. While each individual is seen as responsible for their own choices, these choices are influenced by their interaction with their environment. This interaction can shape a susceptible individual whose motivational system has been formed to accommodate certain behaviours. West (2006) sees environments that do not provide the appropriate level of care and support, particularly the lack of available opportunities for individual fulfilment, as more challenging to navigate and promoting addiction.

This seems to provide a fitting description for the participants in this study, and once again a synergy for describing the processes of this model. This model, and the previous chapters have described a strong interaction

between the participants structural and environmental conditions and their personal reactions to them. Those participants who described more stimulating backgrounds tended to be more adept at 'achieving balance', using drug use as a supplement in their lives. While the opposite was true from those participants from more challenging environments (e.g. those participants who described backgrounds of abuse). Those from less stimulating and supportive environments were less adept at 'achieving balance', using drugs principally to cover pain. The (frequently abusive) environmental conditions these participants described created an inner discomfort that seemed to provide a strong pull towards challenging substance use. In West's (2006) terms their drug use had provided an escape, or an important source of capital, where none existed. This in turn seemed to reduce these participants' sense of self-worth, and thus reducing any 'desire for self-protection' (West 2006, p. 177). In some cases this had continued as they aged.

Potential weaknesses of the theoretical model

The theoretical model presented here does have a number of caveats. Encapsulated within it are a number of complex psychological phenomena, such as concepts of the self, self-image, and self-monitoring. This model does not intend to be a psychological elucidation of complex inner motives. It adheres purely to overtly stated information that these participants present as important to themselves. It does make analytical assumptions, but these are based only on the data presented by the participants. Care has been taken throughout not to attempt to describe or infer psychological processes or phenomena. As such the model is intended as an inductive description of these participants in their own words.

All of the participants started using drugs when they were comparatively young and as such had been using drugs in a variety of ways over a long period. The model used to explain their behaviour inevitably reflects this, and as such may or may not apply to drug use among older adults who might be described as 'late-onset users'. However, this theory places drug

use within an age related context, and explains the lives of the participants in this study. To some extent, the age of onset was not felt to be important when developing the model because it is intended to reflect the lives of these participants and their drug use in a contextual manner. While it is under-pinned by life experience it does not attempt to describe a life course theory. Further research could usefully enquire as to how this interaction might take place among people starting to use drugs later in life, particularly what significance drug use has in their lives. Longitudinal research might also usefully examine how individuals continue to monitor and balance inputs and whether changes in some factors (e.g. housing, employment, relationships) carry a greater weight and require greater energy to continue to monitor and steer their way through their environmental landscape than others.

Conclusion

Charmaz (2006) describes how theories derived from grounded theory processes can differ radically; she suggests that two researchers can look at the same data and draw different conclusions - working in a framework of constructivist grounded theory, both outcomes are completely justified and each of equal importance. The theoretical model presented here has aimed to elucidate a hypothesized process of the drug use among this group of older adults. The model has been inductively derived from the interview data and therefore can be said to be theoretically grounded (Glaser and Strauss, 1967, Strauss and Corbin, 1990, Charmaz, 2006). It is also underpinned by the PRIME Theory by West (2006) which describes how this process might work. The model presented here is the first that this researcher is aware of to qualitatively describe this process in relation to an existing cohort.

Chapter summary

This chapter has outlined a theoretical model of drug use in older adults, which has been developed through the data analysis. It drew together the

findings from the main research questions - how and why these participants are using drugs and placed them within a contextual framework. It described how these participants' histories and their current personal circumstances all affect their current drug use. It shows how all of the major categories fit together to shape these participants current reality - describing what each of the major categories means and how they are connected. The completed model illustrates an ongoing act of monitoring moderated by each participant's understanding of their past and their expectations of the future. The chapter finished by describing connections between the model developed for this study and West's (2006) PRIME Theory - particularly how the process around the core category of 'achieving balance' is described well by West (2006) in his concept of balancing inputs and the unstable mind. Also the importance of these participants' identities, personal histories and backgrounds is drawn out in the model. These are also described in West's (2006) theory which hypothesizes the importance of how the identity is developed and shaped, and environmental susceptibility, in understanding an individual's drug use. The chapter finishes with a description of the strengths and weaknesses of the theoretical model. The next chapter presents a discussion of the findings presented in the previous chapters.

Chapter 9. Discussion

This penultimate chapter discusses the study findings. It begins by reiterating the main findings before going on to describe how they relate to previous research in this area - particularly how they are similar to and/or different from, these works. The chapter finishes with a discussion of the methodological approach and potential weaknesses and limitations of the study.

Discussion of the study findings

There was a high level of heterogeneity among the lifestyles, life experiences and personal circumstances of the participants in this study. However there was a commonality among a number of their drug use behaviours. Within these behaviours some highly distinctive, observable patterns made some of the participants' drug use narratives very similar.

The main finding from the analysis was the process discovered behind these participants drug use - the level of ongoing monitoring required by the participants to maintain and manage their drug use in a way they wanted to. This was a dynamic, non-linear process which varied over the participants lives, frequently dependent on a multi-factorial interaction between their personal characteristics and social circumstances (including their levels of capital). They used a mixture of internal and external guidelines to measure or monitor their use that they reflected on to achieve as much of a balance as they were able. This virtuous loop of management through reflection and modification, informed the model in Chapter 8. Some did this in a way they were comfortable with while others were either unable or unmotivated to do so, even though they seemed to be aware of its need.

Consequently, the second key finding from this study is concerned with the concept of control, or what has been largely referred to throughout this thesis in the participant's own terms as management. It was only as the study progressed that its importance became apparent. However it was

found to be an unstable and subjective concept - what was considered being in control for one participant was different to another. As such, it is suggested that control is relative and contextual, connected to the participants' pasts, presents and futures, how they compared themselves to others, other parts of their lives and the resources they felt were available to them.

The third key finding from the study is the connection between how and why these participants were using drugs. The results from Chapter 7 outlined two major reasons participants gave for their use, they were either using drugs to enjoy the positive feelings they brought (pleasure seeking); or attempting to alleviate negative feelings (self-medicating). Those participants who were using drugs to enjoy their positive feelings tended to be able to manage their drug use in a way they wanted to better than those who were not - thus 'achieving balance' in their lives. Those participants who were using drugs to self medicate against what they saw as negative feelings seemed less able to manage their lives as they wanted to and were generally less able to achieve a balance they were comfortable with. Although some expressed comfort with their apparent lack of management. This connects back once again to the subjective nature of control, and what control might mean in the context of substance use.

The final major finding concerns the participants' perceptions of their ageing experience, and how this interacted with their drug use. The results showed a wide heterogeneity of characteristics among the sample, which reflected the nature of their life experiences. However two extreme patterns were discernible. For some participants, drug use had pervaded and shaped their lives and their identity. This now interacted strongly with their personal health. They had become unwilling or unable to manage their use more effectively. These participants showed behaviour and had socio-demographic profiles, which mirrored those of long-term drug users. For others their drug use had been a peripheral activity which (while affecting their identity in some ways) they attached no more importance to than any other aspect of their lives. These participants were aware of the need to

manage their drug use as they got older, in line with their awareness of their changing physical vulnerability. These participants had socio-demographic profiles which were more likely to mirror those of their non-drug using peers. This latter finding suggests that an individual's ability to manage their drug use over the course of their lives can play an important role in their development and maintenance of personal coping resources, capital and social circumstances.

Relationship to other work

The social and drug use circumstances of older adults

There are contrasting differences between the social circumstances of the participants in this study and those in previous studies. Bourgois et al (2006) for example found that a large proportion of their participants were currently homeless (60% African American and 71% White), while almost opposite to this Arndt et al (2005) wrote that 14% of their sample reported being homeless with 75% living 'independently'. Rosen (2004) does not cover the issue of homelessness but does report that around a quarter of their sample were living in 'unstable' (p. 546) conditions. By comparison most of the participants in this study were living in comparatively stable housing conditions. The majority owned their own home and another larger proportion of the remainder were private rental tenants. Only four out of 30 described themselves as homeless.

The ranges of employed and unemployed participants in previous studies have showed a degree of similarity. Rosen (2004) reports that around a quarter of their sample of 143 were employed, while over a half of their sample required public assistance (the US equivalent to being in receipt of benefits). Similarly approximately a quarter of Bourgois et al's (2006) sample (24% African American and 22% White) had received an income from a job in the last six months. Also similar to Rosen (2004) the largest proportion of income from their participants came from social services (45% African American and 42% White). Arndt et al (2005) also reported

around 22% of their sample being in employment, with 62% being unemployed (71% of these reported being 'retired'). Kwiatkowski and Booth (2003) report that around 16% of their participants were employed and looking for work (in either part time or full time capacity) while less than one per cent were retired. Similarly, the proportion of those employed in Firoz and Carlson's (2004) study of older methadone maintenance patients was 14%. However differences were observed between the employment profiles of the participants in these studies and those in this study. This study found a higher proportion of employed participants (40% or 12 out of 30), and lower proportions of those either unemployed or economically inactive (both nine out of 30, or 30%).

There were also a higher number of participants in this study who described themselves as being in relationships. Half (15) were married with the minority reporting either being single, widowed, or divorced. By comparison Arndt et al (2005) reported that 28% of their participants were married, and 45% either divorced or widowed. In Firoz and Carlson's (2004) study of people using methadone maintenance, only 15% of 705 people they studied were married.

Finally, other studies with older adult drug users have found comparatively high proportions of participants who are involved in crime. Seventy eight percent of Pottieger and Inciardi's (1981) study had been arrested and the large majority of these were for theft related offences. Bourgois et al (2006) collected data on 70 individuals over a ten-year period and found similarly that a large proportion of their study sample had been incarcerated (72% African American and 56% white). While Kwiatkowski and Booth (2003) found that 77% had been arrested over their life. A slightly smaller proportion of the participants in this study (around two thirds or, 18 out of 30) had been directly involved in crime as a result of their involvement with drugs. All of these participants had contact with the criminal justice system.

The participants in this study showed some similarities but also some striking differences to those from previous studies - with those from this

study tending towards being more socially healthy. A possible reason for these apparently arbitrary similarities and differences could be the nature of the different sources for the samples. The large majority of participants from those studies cited above were generally contacted through drug treatment services, and other health care interventions. However, Brown and Chaing (1983) for example found that people in drug treatment programmes are not representative of drug users as a whole. Indeed they concluded that a number of research studies in the past had been guilty of making recommendations and basing policy on a 'biased portrait of substance abuse among the elderly' (p. 3). The participants from this study were drawn from a range of sources, with a number of them having never been in contact with any services in connection with their drug use. Those participants from this study who had been in contact with drug treatment services however did show similarities to those from previous studies (i.e. were more likely to be unemployed, less likely to be in a relationship and more likely to have been in contact with the criminal justice system). However this should only be regarded as indicative due to the size of this subsample.

The nature of these participants' drug use

Currently the literature presented dealing specifically with this cohort paints a mixed picture of their drug use. Pottieger and Inciardi (1981) reported that the majority of their 42-person sample were more frequently marijuana users, being nearly twice as likely to use marijuana as another other drug. The most commonly reported drugs used after marijuana were barbiturates. Only a small minority reported using heroin or cocaine, the majority being more likely to drink alcohol. While Schaelerth et al (2004) found that the majority of their participants were cocaine users, with only a minority using marijuana and opiates (and other barbiturates). While Arndt et al (2005) reported the large majority of their sample of participants over 55 admitted for drug treatment in 2001, were using one substance on admittance (77%), however their primary substance use was also overwhelmingly alcohol. The only other UK study with this cohort, describe their sample as having used a 'variety of drugs including alcohol' (Beynon et al, 2009, p. 4).

This draws attention to one of the main findings from this study - the diverse nature of drug use among older adults. The most frequently used drug by participants in this study during the last month was 'heroin and other opiates' (followed by amphetamines) however some also used more than one drug. The literature presented in Chapter 2 highlighted that drug users tend to reduce the range of drugs they take as they get older (e.g. Dark and Hall, 1995; Calafat et al, 1999). While Hoare (2009) shows that there were three age groups where the use of more than one drug was at its most prevalent - the youngest and the very oldest. This suggests a pattern of use which sees younger people experimenting with a range of drugs, or looking for something which gives them the experience they are seeking and then settling to one drug of choice.

Different participants in this study showed similarities with the different patterns described above. Some participants were using drugs in a highly disorganised way, taking whatever they were able to acquire whenever they could. However the majority could be described as using drugs within an instrumental or purposeful range. They may use more than one drug but they also tended to use only one type of drug, i.e. favouring either stimulants or depressant. They had perhaps a main drug of choice, but around that there was a core of drugs they were comfortable and experienced at using - having used them in the past they were aware of their effects and potential side effects. If they were going to deviate from their regular pattern of use they therefore knew what to expect. West (2006) alludes to this also when he talks about having a 'range of uncertainty' (p. 172), whereby an individual's behaviour in two similar situations at different times might diverge (and often look different on the surface) but it is within a given range for the individual. They have a potential set of responses within a range, executing the most appropriate one for the situation they find themselves in at that time.

A number of participants in this study talked about switching and substituting drugs within this range but at the same time only substituted

one opiate for another or one stimulant for another - importantly they had settled on a main drug of choice for the effects it brought and only switched drugs knowing that it would bring a similar effect. Only a small proportion of participants would substitute one kind of drug for another and often then to balance the effects of one against another, e.g. using cannabis retrospectively to balance the effects of using amphetamine. Again suggesting an instrumental nature to their substitution.

Levy (1998) discusses the nature of switching or substituting drugs among older adults particularly when their main drug of choice was not available. Suggesting that for more chaotic drug users switching between drug types is more prevalent and using alcohol as a way of helping them to manage potentially negative physiological effects of lack of management. Johnson and Sterk (2003) similarly report some people switching from heroin to crack and vice versa in their study of late-onset crack cocaine users. Again however, this behaviour is perhaps more likely when studying problematic use among a more chaotic sample. It was more likely to be the case in this study that those participants who were less able to manage their drug use in a way they wanted to, were also those who talked about using a greater range of drugs. They also talked about using alcohol to manage their substance use when their main drug of choice was not available. Those participants who were more able to manage their drug use only talked about drinking alcohol socially rather than as part of a drug use management regime.

The main similarity between other studies and this one appears to be the instrumental nature of switching drug types among some participants. When participants did switch their drug of choice, there appeared to be a reason for it and that reason was generally informed by purpose. In this respect using a variety of drugs seemed to be more normative as they were getting older. While their use pattern was largely established, their use tended to be more dynamic than a simple drug of choice model. Using more than one drug was purposeful, and helped the participant manage their drug use experience but sometimes for different reasons.

However this had not always been the case. This instrumental nature of these participants drug use appeared to have been arrived at through experience, reflection and wisdom. These participants had used their experience of their drug use to inform the range of drugs they were now using. This was not just informed by their experiences of drug use but their life experiences, having lived through different circumstances and among different people, and subject to different challenges at different times. This supports work by Windle (2010), and Henry and Thornberry (2010) which highlights how an individual's use is frequently subject to a range of psychological, physical and environmental factors. These participants were engaged in a range of behaviours over their lives, which ran parallel to a range of drug use behaviour, each of their own experiences varying dramatically at times. This work also supports that of Heyman (2009) who posits that drug use is not only complex, but is also a cyclical phenomenon with in/out patterns of use, rather than a more linear, career type model suggested for example by Levy and Anderson (2005).

It is this which prevented the creation of groups and classifications (e.g. Boeri, 2004; Notley, 2005; Wilkinson et al, 2006) of the participants in this study. Sorting these participants into different groups of drug users based on observable characteristics may have been possible to some extent but would also have been arbitrary, with their classification being based only on how they were behaving around the time of the research interview.

It would be possible to take some of the participants from this study and categorise them in the same way that other studies have. There are participants from this study whose behaviours very closely matched for example those depicted by Beynon et al (2009). They describe the drug use of their 10 participants over 50 simply as 'divided into three camps, with some interviewees ceasing drug use for many years at a time, some using drugs intermittently with short periods of abstinence, while others followed a course of near continual consumption' (p. 3). Some of the participants could be placed into these groups. However what is apparent is that they are

too rigid as they suggest three straightforward groupings with consistent linear narratives. Some of the participants in this study did not use drugs for many years at a time, then used heavily for a short period, then stopped again for a short while, and then used drugs moderately followed by heavily etc. In this case it would not be clear which ‘camp’ this drug use behaviour pattern fitted into based on Beynon et al’s (2009) grouping. Instead for the participants in this study it was more sensible to consider the totality of all the use patterns (hence the spectrum of use, Figure 3 in Chapter 6, and the theoretical model, Figure 5 in Chapter 8) and acknowledge that any participants could be at any point, at any period of time.

The behaviours and characteristics described by these participants suggests that another interview at another time (considering another period) could have presented a different picture. In addition, this would have been different to a picture to that taken a year ago, five years ago or longer. Ultimately, it was felt that this would have been an unreliable representation of these participants’ lives. Instead, the best way of representing these participants, their perceptions of their lives and their drug use was felt to be the more general, abstract, theoretical model of behaviours and processes, presented in the previous chapter.

As previously stated there were extremes of fixed behaviour among some participants but this hid the deeper meaning of their drug use, and its dynamism over their lives. This study asserts that these participants’ drug use has often been a variable concept subject to internal and external pressures. As one man put it he felt he was ‘achieving balance’ now, but was ‘only ever a day away from being an addict again’.

The subjective nature of control

Central to the theoretical model in the previous chapter, the process and the core category in this study revolves around the concept of control or what has been referred to as management throughout this thesis, and the purposeful desire to use drugs. This in turn is monitored and managed by a

cycle of reflection and action. When participants from this study were using drugs in a way they wanted to they did so by talking about consciously monitoring their use. This study found the use of principles or structure to be important in helping the participants to manage this. A number of these are present in the existing literature. McPhee (2013) for example saw his sample placing limitations on the amount of drugs they use, how frequently they used them, how they administered them, the days of the week they used, the company they kept and the relationships they maintained. Similarly Decorte (2001) who describes what he calls 'boundary control mechanisms' which cocaine users employ to prevent them from presumably crossing a theoretical boundary to uncontrolled use. These are individual rules such as periodic abstinence, monitoring the amount of drugs used, frequency of use, amount spent on drugs, as helping them to maintain a level of control they were comfortable with. These were also the factors that helped them to define uncontrolled use.

Shewan and Dalgarno (2005) found similarly that to maintain illegal drug careers, individuals reported using drugs intermittently and often not for long periods. The days of the week phenomena has previously been illustrated by Calafat et al (1999) who describe a pattern whereby illegal drug use is most likely to occur at the weekend or around the end of the working week, as this gives individuals time to recuperate afterwards. They are then able to return to work for the rest of the week in order to indulge once again next weekend.

Calafat et al (1999) describe this pattern as well established among young people, suggesting that they have been socialised into organising their time in this way. In this way the working week is seen as structured and uniform while the weekend is seen specifically for leisure activities. Parker and Williams (2003) also describe a pattern of abstaining from substance use during the week among young English adults, to enable them to go out at the weekends to binge drink, or consume illegal drugs. They consider the phenomena well established in English culture.

This study extends this research by examining similar patterns among older adults. This pattern of working-week/leisure-weekend use was described by many participants as important in managing their use. This suggests that they had learned and internalised the strategy identified by Calafat et al (1999) and Parker and Williams (2003) when they were younger, and were still trying to implement it. However the results also described this pattern among participants who were not working but were eager to maintain this work-leisure division as a way of managing their use. This suggests a deeper, culturally internalised phenomenon.

Social functioning was clearly an important variable in managing these individual's drug use. Waldorf et al (1991) also found controlled cocaine use was moderated by social roles. People who were using cocaine used these social roles as a check against the kinds of behaviours (e.g. sobriety) that were expected of them. The participants in this study used the concept of 'othering' (Johnson et al, 2004) to help them to maintain their social roles, particularly by keeping those who they perceived to be unable to manage their drug use at arm's length.

While this shows an element of rationality and conscious reflection it did not always stand that if participants were not following their own principles closely this would lead to unmoderated drug use. This was only the case in a certain context. As such, the findings from this research follow the psychosocial model of drug use posited by Zinberg (1984), whereby an individual's relationship to their drug use changed depending on the drug they were taking, their own personal psychology ('set') and the context they were taking it in ('setting'). An individual's drug use in this study is described along a continuum that relate to these factors (Figure 2). For Zinberg (1984) control over an individual's drug use is not only moderated through an interaction between the internal and the external but this is not fixed, it is dynamic, fluid and contextual. This was also found to be important to understanding the nature of management and balance among the participants in this study - there was an interaction between a range of factors that provided the outcome of how well the participants were

managing their lifestyle and ‘achieving balance’ in their lives. This study also extends the work of Grund (1993) who considered the role of drug availability as key to determining an individual’s ability to manage their use. This study found that the role of drug availability was not as instrumental as in Grund (1993). Indeed it was only considered alongside other factors which were expressed as more important (such as social roles) in an individual’s management regime.

Further to this the results of this study illustrated that each participant’s concept of how they were managing their drug use was individual to them. Also it not only varied between participants but within participants over a given period - with their concept of management sometimes shifting. This is one of the reasons the expression ‘managing their drug use as they wanted to’ is used throughout this thesis. What one person might describe as out of control might be manageable by another and vice versa. Certainly for some of these participants there was an element of what might be considered controlled chaotic behaviour - they knew exactly what controlled drug use looked like to others and what it meant, but did not aspire to outwardly maintain it. Instead they were comfortable that their level of use was manageable. Ning (2008) concludes that it is those administering drug treatment regimes who set the nature of control among people who use drugs. She questions the dichotomy of being either in control or out of control, and asserts that ‘individual experiences of addiction occur within a wide range rather than in binary opposites’ (p. 230). This sums up the nature of control among the participants in this study well.

Sharek (2013) has recently argued that the subjective or objective nature of how people understand control, and whether estimates of control are accurate, have not moved on significantly since Langer’s (1975) ‘illusion of control’. Sharek (2013) argues that the nature of control is still not wholly understood and in research terms may be an artefact of experimental design.

Rather than a model of objective control of drug use this study better reflects the work of Decorte (2001) who introduces the concept of users’

perceptions of control. This suggests that each person's perceptions of control is the result of their own understanding of their use regardless of how accurate these might be (or factually correct as Decorte (2001) considers it). Decorte (2001) describes how personal rules and observed patterns of behaviour among others interact in the formulation of each individual's perceptions of control. This study has found similarly but extends this by considering the role of monitoring and reflection. It has also extended Decorte (2001) by illustrating how some participants' perceptions embrace ageing. As such it shows how these participants' concepts of their own desired level of management is affected by the passing of time, and wisdom gained as a result.

The Self-Medication Hypothesis (SMH) and Pleasure Seeking dichotomy

The Self-Medication Hypothesis (Khantzian, 1985) as outlined in Chapter 3 of the literature review is still described as influential (Lembke, 2012). Chapter 3 also outlined a range of studies and reviews that have produced conflicting support and refutation. However all authors (even those who feel they have produced evidence to contest it) acknowledge its influence on substance use research as significant (Lembke, 2012).

Lembke (2012) however has criticised the SMH for no longer being useful for understanding people's reasons for substance use, describing what she calls a lack of robust evidence for the hypothesis. What does seem to be apparent however is that there is a stronger level of support for the SMH as reported psychiatric disorders become less serious and arguably more treatable without psychiatric intervention (e.g. depression and anxiety, (Mason, et al 2009; Hooshmand, et al 2012), controlling aggression (Arendts et al, 2007), and sexual harassment (Graduss, et al 2008)) while less so, for more serious conditions, such as schizophrenia (Martins and Gorelick, 2011). This is perhaps underscored by one review which found that when self medication was used 'strictly to cope with symptoms of mental disorders' (Henwood and Padgett, 2007, p. 160) 11 out of 72 studies were found in support of the hypothesis. However, when self-medication

was expanded to where people used substances 'to cope with painful feelings in general' (Henwood and Padgett, 2007, p. 160) this figure rose to more than half of the studies.

Results from this study found a level of support for the SMH - with a larger proportion of participants reporting using substances to help them alleviate negative and painful feelings. It was very clear to these participants that they were reliant on substances to help them achieve a general level of functioning. For some this self-medication allowed them to manage their lifestyle in a way that meant they were 'achieving balance' (i.e. self-medicating in order to function personally and socially). For others however such a balance was not possible, and not even desirable - cycling very quickly into problematic use. For these participants their use seemed as much about self harm as self medication, caring less about functioning and more about obliterating painful feelings. This also connects to West (2006) who talks about those who care little for their self being more likely to engage in harmful substance use behaviour.

Also in support of the SMH the participants in this study clearly stated their use was purposeful, choosing drugs, and a particular type of drug for a reason. Some described in detail the type of symptoms it helped them to address, and the type of characteristics they wanted to acquire (i.e. confidence or comfort).

Finally, Khantzian (1985) also asserted that treating any underlying psychological problem or symptoms would have a positive effect on treating any problems associated with substance use. For some participants in this study this was also true. The results in Chapter 7 described a process whereby some participants reported being more able to cope with their substance use once they had faced the feelings they were trying to self medicate against.

Dichotomously opposed to these participants' rationales for taking drugs was the desire for some to use drugs for pleasure seeking. A pleasure-

seeking model of drug use is well understood. In their study of drug use across Europe Calafat et al (1999) recommend that it would be sensible to differentiate between people who use drugs socially for entertainment or pleasure and those who use drugs as a form of self-abuse. This dichotomy is also described by Hirschman's (1992) General Theory of Compulsive Consumption. Her model is an attempt to synthesize research on substance use categorising people on their motivations to consume as either 'distressed' or 'sociopathic'. (p. 157). The former strive to alleviate a negative emotional state while the latter are driven by sensual gratification.

This thesis does not use the same value laden terms as Hirschman (1992) but finds general agreement for this dichotomy among these participants. Firstly what Hirschman (1992) calls 'distressed' users show similar characteristics to those in this study who were taking drugs for 'covering pain'. She continues,

'roots of addictive consumption often lie in personal feelings of inadequacy and inauthenticity (sic) ... addicted consumers appear to have in common an emotional vacancy that they are compelled to fill with something.'
(Hirshmann, 1992, p. 178).

There is a level of correspondence with some of the participants in this study who it might be hypothesized were using drugs as a form of capital (i.e. as Hirschman's (1992) description of 'inadequacy') and were more likely to fit the description of addicted. Some participants described themselves as 'addicts' and therefore felt unable to do anything other than acquire and use drugs.

However this researcher rejects the term 'sociopathic' for those people who Hirschman (1992) considers as using drugs for pleasure. These participants were the most likely to have highly balanced lives of which drug use was only a part. What was important about these participants was their understanding of drug use as a process. They knew and understood that illegal drugs were highly addictive. As a result they stayed away from the

factors that they felt would lead them to addiction. The most important one of these appeared to be their drug of choice. These participants seem to have selected what they believed to be the least harmful drugs to take (e.g. powder cocaine, and hallucinogens) and the least risky way to take them (orally or inhaling). It was this continued wisdom that enabled them to manage their lifestyle in a way they wanted to and achieve the balance they wanted. Blanchard-Fields et al (1995) talks about how as people age they gain a tool kit of social and emotional skills that enables them to make better life decisions. The model in the previous chapter outlined how drug use was balanced for these participants. It describes the reflective process which 'achieving balance' necessarily requires. This toolkit description seems to fit these participants well.

The interaction between age and drug use

One of the overarching aims of this study was to consider whether there was an interaction among a group of drug users over 50, between their drug use and their age. Were these participants different in any way to younger people who use drugs, and if so how? Were there any difference to the way in which they were using drugs, and again, if so how? Essentially were these participants any different to younger people who used drugs simply because of the nature of the temporal changes to their bodies and their lives.

There is no doubt that the human body and mind both undergo changes as it gets older. These changes have considerable effect on an individual's physical and cognitive abilities, and a large number of these influence their desire and ability to consume and metabolise drugs. Because of changes to water, and fat density in the human body drugs absorb at lower rates while normative liver functioning (instrumental in the expulsion of drugs from the body) decreases and slows. This means that drugs are broken down, metabolised, and removed from the body at a lower rate - they stay in the body and remain at more concentrated levels for longer. In addition, people who have been using drugs for long periods are more likely to have experienced a range of medical conditions as a cumulative effect of their

drug use. This in turn is likely to have an effect on the way they are able to use drugs now and the effects those drugs have on their bodies (e.g. Alcoweb, 2002; Benschoff and Harrawood, 2003).

In the only other previous research study with this cohort in the UK, Beynon et al (2009) found what they considered poor levels of physical and mental health in their sample. They went on to say that their study adds support to the argument that drug use ‘exacerbates the onset of medical conditions which are more prevalent in older age’ (p. 8). They describe a range of conditions associated with people of any age who use drugs, including circulatory and respiratory problems, hepatitis and cirrhosis of the liver. They particularly describe the prevalence of hepatitis as common. This is consistent with other studies in this area. Levy and Anderson (2005) for example also report the prevalence of hepatitis in their sample, along with further complications indicative of long-term injecting behaviour (e.g. inflamed or collapsed veins and abscesses at injection sites).

The results of this study showed that some of the participants reported a similar range of physiological problems, principally as a result of long-term, sometimes increasingly risky, drug use. Some of the problems expressed by these participants are likely to be present in anyone using drugs, in such a way, for long periods, regardless of their age. However the difference seems to be the prevalence of these problems. All participants who talked about experiencing problems with their drug use expressed corresponding health concerns. Those for whom drug use had become a problem were progressively more likely to encounter a corresponding (potentially life-limiting) health problem, which was now being exacerbated by age (found also by Anderson and Levy (2003)). So for these participants their problems were not simply as a result of the length of time they had been using illegal drugs, but the decreasing ability of their bodies to deal with this. Regardless of these participants perceptions of the changes in their bodies, the interaction between the physical and metabolic changes highlighted above, and their continued insistence on not moderating their drug use, had affected

their health. This was previously hypothesized Caracci and Miller (1991) and found to be the case for some of these participants.

These participants also reported suffering challenges in trying to recover from these problems. The changes in their bodies brought about by age, had made them less resilient. However they also showed a strong belief that they were being discriminated against, or misunderstood, by healthcare professionals when seeking help. This was also the case for Beynon et al (2009) who also reported a less than optimal level of care among their sample. Discrimination of substance users by healthcare staff has been reported among any age group (e.g. Lloyd, 2010). It has also been reported by older people who are not substance users (e.g. Lievesley, 2009). The unique set of challenges that these participants presented therefore made them feel as though they were being doubly discriminated against. These studies suggest there may be a foundation for this belief.

While physiological changes are observable it is much harder to identify cognitive and psychological changes in older adults generally, and older people who use drugs more specifically. Ziere et al (2006) noted an increased likelihood of falls in older substance users, observing however that this is often missed as a potential indicator of substance use mistaken for a symptom of ageing. This was no different for two participants in this study - both having fallen under the influence of substances and having had symptoms misdiagnosed as signs of ageing.

Perhaps the most common psychological changes reported in studies of older substance users are those to do with loss and isolation. Individuals take on a number of roles over their lifetime that they add to, leave behind and modify. As the results showed this is no different to people who use drugs for long periods. However Levy and Anderson (2005) reported that the gradual withering away of social networks led to greater problems among older adults who used drugs leading to progressive social isolation and loss, and a regret of those losses. This in turn contributed to an inability to form new relationships as more time was spent in what might be

considered inside the drug world. While loss and isolation are common among younger groups they are once again more likely to be exacerbated as a result of ageing, and particularly among drug using older adults, due to the increased likelihood of peer illness and morbidity.

Levy (1998) and Kwiatkowski and Booth (2003) both reported that their participants who were engaged in risky, or criminal behaviour related to their drug use, had tended to modify this behaviour as they had aged. Similarly, in this study the results showed that those participants who had once engaged in highly risky criminal activity were now more circumspect. Those participants in this study still engaged in criminality were now more likely to be involved at the margins, as they carried out tasks such as bagging up drugs (described similarly Levy and Anderson (2005) and Courtwright et al (1989)), letting others use their bank accounts, and helping to set up illegal accounts for money laundering. They had also become pushed to the margins of the marginalised as Anderson and Levy (2003) report.

There were a number of other participants in this study however for whom ageing and drug use did not show any apparent interaction. Those participants who took, and had taken, a more balanced approach to their lives reported feeling in comparatively good health now. These participants reported having never visited a GP or a specialist treatment service to discuss their drug use. The most important difference between these, and other participants who reported challenges with their health, was their ability to adapt their drug use behaviour. This was the case now as much as ever. For this subset of participants there was an increasing awareness that their bodies were ageing and because of this drugs would have a differential effect now compared to when they were younger.

There are studies that have highlighted the phenomena of long-term unproblematic or social drug use (e.g. Warburton et al, 2005, Marshall and Levy, 1990). However, these studies were not with older adults and by that token the length to which these studies consider 'long-term' use is

questionable. This thesis has uncovered few studies that report participants having used class A (i.e. the most harmful) drugs into their 50s without apparent detriment to their health or other roles in their lives. The only exception to this was Courtwright et al (1989) who highlight how participants in their study had been able to maintain long-term (and in some case injecting) drug use due to the care and diligence they took with constantly monitoring and managing their use.

This thesis began with the rationale that as the body changes with age so does an individual's ability to use and metabolise drugs. The questions were then posed as to whether and what changes would be made to their behaviour, and more specifically their drug use because of this. It found that many of the factors which affect these participants (such as ill-health as a result of their drug use, loss and social isolation, and discrimination by healthcare staff) affect drug users of any age. However, the most discernible difference between these participants and those younger is the level and prevalence of these effects.

Consideration of methodological approach and potential weaknesses

Reflections on the method

One of the strengths of this study has been the robust and systematic approach taken to the recruitment, fieldwork and analysis. The rationale for adopting the methodological approach for the study was described in Chapter 4.

Grounded theory and process

The iterative structure for analysing the data gave this researcher license to recode against new interview data and explore new concepts and new lines of questioning as they progressed. Practically this meant that participants were given license to explore their personal experiences. Each in turn talked

about issues that had affected them over their lives, but they continually kept this in the context of their current experiences. Initially it was felt that participants were somehow trying to justify their reasons for using drugs or for engaging in other illegal behaviours. However, as the interviews progressed whenever participants did this their narratives were more about exploring reasons for their use within themselves, and then externalising them. The participant centred, constructivist approach allowed them space to talk about their own perceptions of their drug use and of its significance in their lives.

It was this approach that led to the discovery of one of the main findings of the study. Allowing participants to talk about their drug use alongside other factors that were occurring in their lives enabled them to make connections about different times when their drug use had fluctuated in intensity. On the face of it there were apparent contradictions in their narratives about what style of drug use they might be describing. Their descriptions were made more complex by the often cyclical nature of their use. This included periods of highs and lows, which taken in snapshot may not have made sense, but put in context and examined within the rest of their lives highlighted the dynamic nature of their use.

Many participants frequently found it difficult to describe how at one point their drug use had been peripheral in their life but central during other times. Some talked later outside of the interview process about how they felt this had helped them to understand some of their current habits and behaviours better.

A biographical or life history approach might have elicited some of the same data in a similar way. However, the focus of this study was on participants lives now, what was it like to use drugs and be over 50. Their lives and drug use histories were felt to be crucial to the study but only insofar as they affected the present. Alternatively, a phenomenological approach might have helped to understand these participants' lived experience but equally may have missed the importance of the ageing

process and its context. Grounded theory provided a similar but very subtly different approach that enabled this researcher to draw exactly the style of data needed for the study, while the participants were able to maintain control over the process throughout.

Another way of addressing the research aims and building a picture of drug use in older adults might have been to follow them over a period of time - undertaking a number of follow-up snapshot interviews which could have tracked how external influences impacted on their drug use and whether and how they were able to adapt to that. In West's (2006) terms, this would have enabled closer tracking of the participant's journeys across the epigenetic landscape. Ideally, this would be across long periods, but it would have been equally revealing to study how these participants responded to balancing their drug use over a shorter range of between 1-5 years for example. Judging by the narratives of some of these participants even these shorter time-frames would have revealed major changes in their lives.

However while this might be ideal in one way, in another this would have taken the research into a different area, that of drug use pathways. The main research questions for this study were concerned with participants drug use now and whether and how it interacted with the participant being over 50 - when it is suggested (e.g. Cushman and Dole, 1973; Pascarelli, 1974) that people who use drugs are likely to show the first signs of physical vulnerability.

A person centred approach

Using an open ended, more flexible research instrument in conjunction with Egan's (1990) active listening techniques, an environment was established which allowed the participants to explore the areas that were important to them. This not only provided answers to the questions but also gave important context and background - crucial to the approach used in this study. Consequently, at times, participants were left to talk about subjects that may not have been directly relevant to the research topics. This

technique worked well, but had to be managed very carefully. At times it became apparent to this researcher that the participant had realised they were straying. Some participants apologised for 'going on' or 'going off on one'. This was disappointing because it seemed to take the participant out of the moment and remind them they were in an interview situation. When this occurred, rapport had to be re-established to re-attain the level of intimacy necessary to discuss some of the highly personal issues that were pertinent to the study. Sometimes it seemed that after this had happened, the participant became self-conscious and then concentrated on simply answering questions rather than talking about their life and experiences.

Another supplementary benefit of the study was the desire to give these (sometimes vulnerable) participants a voice. This allowed them freedom and space to explore their own version of events in their own words. This enabled this researcher to gather very minor details, which otherwise might not have come about in another way. Some later talked about how empowering they felt this to be. One woman said that she had felt 'enlightened' by the whole process.

This researcher believes strongly that these participants were completely honest, open and candid to the best of their own memories. At some points, these memories were so clear to the participants as to become apparently painful. At these points participants were given time to move the interview in any way they wished. On only one occasion did the researcher have to stop the tape recorder to allow the participant time to collect their own thoughts and decide whether they wanted to go on. This showed another unexpected benefit of using a digital recording device. Stopping the recorder enabled the participant to understand that they were no longer in an interview situation and could rest for a short while not feeling the need to provide an answer. When they wanted to continue they asked to hear back their own words to remember where they were up to. At this point, once the interview started again rapport was quickly and easily established.

Finally, after each of the interviews this researcher tried to undertake a short debrief with the participants, where the interview was discussed along with their feelings about the process. None of the participants said they regretted taking part, with the large majority saying they enjoyed the interview. Some said that it brought up painful and difficult memories but they talked about how they were faced with those daily. Importantly some mentioned it had helped them to resolve some things about their drug use that they would implement in the future. This was felt to be validation, in this researcher's eyes, of the constructivist position of acknowledging themselves as part of the research process. These participants had been affected by the research process and had talked about making changes in their lives because of it.

All of these processes flowed logically from the constructivist grounded theory stance taken by this researcher. Charmaz (2006) acknowledges that researchers bring a wide and diverse set of experiences to their work, and believes that they need to be aware of this, particularly how they might influence the study. According to Charmaz (2006) 'the constructivist grounded theorist takes a reflexive stance on modes of knowing and representing studied life' (pg. 509).

Throughout the study this researcher was conscious of his position within the research - from the selection and development of the methodological approach to the process of conducting the study, and presenting it as a piece of written work - a part of the data rather than separate from it (e.g. Cutcliffe, 2000). The decision to adopt this approach was developed through a logical series of steps acknowledged in Chapter 4 explaining the rationale behind the selection of the methodological approach. This researcher felt that this was the appropriate position to adopt given the nature of the study and his own personal ideology. This was felt to be less of a selection made from a set of equally suitable options, but more of a logical conclusion reached through a decision-making process. This researcher felt that if other options were available they were less fitting and less robustly defensible.

Upon completion of the study this researcher believes that this process and the position adopted throughout was the correct one. However upon reflection there may have been times where this approach might have hindered the study. For example it was stated openly to the potential participants from the start that they would be the experts in the area and the researcher was asking questions to gain knowledge. As such this researcher would develop areas for discussion and ask questions for clarification. The explicit aim was to empower the participants to lead the interview.

However this researcher was aware early in the research process of some participants' feelings about their low self-esteem. What was initially apparent was that some participants lacked confidence in talking about themselves and did not think that their narratives were important or worthy of consideration. Indeed some participants talked in these terms before the interviews. This admission was very important and was invaluable in order to manage the interviews as a result. It was reasoned that if the participants were told they were the experts but they did not see value in their words some might miss out important pieces of information. Also this researcher felt that there might be times when participants might not see value in the study believing for example that their narratives were 'not up to much' (as one participant put it) and the information being sought was available elsewhere or in another way. Upon reflection this might be seen as potentially detrimental to the study. On reflection it may have been easier to interview some participants by not stating this position and providing a set direction and parameters for the study

However the fundamental position adopted throughout the research was not simply about collecting data but was a process of empowering participants to develop their narratives (thus eliciting data in this way). Examples have been given already where it was felt that the research approach adopted allowed the participants to provide sometimes extremely personal accounts which moved the study forward very quickly indeed. This researcher believes that it was the ideological position openly stated and clarified to the participants which was ultimately responsible for enabling the study to

develop its analytical depth. It is acknowledged that this researcher was intrinsically part of the social world being constructed along with the participants, but was necessarily apart from it in letting them define it.

This ideological and methodological approach was integral to this study and was ultimately central to developing the work and the position presented in this thesis. Olesen (2005) considers that a researcher's position can be used to add depth to their work, believing that their experiences are a set of resources to be drawn upon to enrich any study. This researcher agrees with this position and believes it is inextricably woven throughout this thesis.

Personal histories of drug use, grounded theory and theory development

This study relied on eliciting individual personal narratives of drug use that meant, as described above, exploring often small, highly personalised pieces of information. Part of the tension of grounded theory is how to then turn that which is important to a very small number of people into theory. This would mean extending these personal narratives analytically and extrapolating them to a more general level. This could be considered a weakness of the grounded theory approach, in that on the one hand proponents would like to consider their approach able to develop theory, while on the other having to state that their work is relevant only to a comparatively small number of participants. However an appropriate response to this understandable criticism might be that it depends on what one considers to be theory and what part of the theory development process the researcher aims to present their theory at. For this study, theory was used in a more inductive, constructivist manner, to present a cohesive framework for a set of ideas. The developed theoretical model is very much at the beginning of the process, providing an empirical basis for theory that can then be tested further. This is especially relevant given the often-cited scarcity of empirical and theoretical evidence with this cohort. This researcher feels that this theoretical model can now be used to test understanding of the process of drug use in older adults.

Potential weaknesses of the method

Difficulties accessing the sample

The aim of the sampling process was to gather a large number of participants from a range of sources that could then be collated onto a central database and drawn from, as the needs of the study presented themselves. This was the rationale behind the MCR technique described in Chapter 4. As the study progressed, it became clear that this cohort was going to be particularly hard to reach for a number of reasons. Traditional purposive methods of recruiting participants for studies with drug users (e.g. snowball sampling and recruitment through drug use service) presented certain methodological problems.

As contact was made with potential participants, few said they knew of other drug users over fifty. Only three participants were able to identify others who fitted the study's inclusion criteria. When contacted subsequently, these three participants were not able to provide any further potential participants themselves. During the interview process the reasons for this became apparent. Many spoke about people they knew who had stopped, or were trying to stop using drugs, had moved out of the area, were in prison, or most frequently, had passed away. As this study has highlighted, contact with these participants' own peer group was limited.

Another frequently used method of contacting potential participants for studies into drug use is via drug treatment services. While it was shown in Chapter 1 that the number of older drug users presenting to these services is growing, the numbers are still small in absolute terms. Thus, it became apparent that contacting such services to publicise the study was only marginally more effective than the snowball method. It was often the case that treatment providers who had been contacted for the study reported that they did not have any clients with whom they could get in touch.

In hindsight however these apparent drawbacks became strengths of the study as more creative recruitment techniques were needed to complete the sample. Internet message boards, fora, online magazines and publications became important methods of recruitment. The unintended benefit of recruiting from these sources was that it elicited participants who were not in contact with drug treatment services - thereby ensuring a more diverse sample.

A self-selecting sample

Modified Chain Referral technique aside, the final sample was self-selecting. While the study sample was always intended to be purposive and not random, this does raise some points worthy of note. Bourgois et al (2006) found some differences in the responses of black and white males in their study of drug users in San Francisco for example. While Szwabo (1993) recommends considering gender differences in drug use when studying older woman compared to men. It is self-evident that people from different ethnic backgrounds and different genders will have very different life experiences because of those factors. However, for this study it is questionable as to how much those experiences affected the results and the final model. The issues of race and gender were discussed during some of the interviews with the mixed race male and the women. All who mentioned this noted how these factors had affected their lives and perhaps their social circumstances - but not with how or why they took drugs. While the results did raise some interesting points about gender roles, it was felt that at no point did the responses of men and women diverge enough to suggest that the under-representation of women had a detrimental effect on the study findings, and the development of the model.

Limitation of the work

Along with some of the potential methodological challenges faced during the study a potential weakness, alluded to earlier, is in the danger of oversimplifying complex psychological phenomena. West (2006) himself talks

about this by describing his own theory of substance use. He says that anyone seeking to describe processes such as these are in danger of making them seem no more than common-sense assertions.

It has been continually stated that the aim of this study has been to represent the participants in their own words, as they want to be understood. Not to diagnose them or their reported challenges. This has ensured that the resulting theory is firmly grounded in the data, rather than a projection of this researcher's background knowledge or experience. As West (2006) states, the study, the results, the model, are as 'complex as they need to be' (p. 3) to describe the processes at work in this sample at this time.

Chapter summary

This chapter began by reiterating the three main findings from the study. Firstly that drug use among these participants is a dynamic process. The second major finding examined the concept of control, principally arguing that control among these participants is relative, contextual and highly subjective. The third main finding from the study is the connection between how and why these participants were using drugs. Here there seemed to be an interaction between the personal nature of their drug use and the social context within which it existed, drawing on aspects of the Self-Medication Hypothesis (Khantzian, 1985). The chapter described the similarities and differences of the main findings in relation to other published research in the area in more detail, particularly those studies described in the literature review. It then finished the section with a discussion of the results on the interaction between ageing and drug use, finding similarities and differences between these participants and those from other studies. The main reason given for this is the diversity of these participants and the wide variation within a small group of very small scale studies drawn from highly diverse times and locations. The chapter then presented a consideration of the constructivist grounded theory approach used for the study and highlighted some potential weaknesses of the study and the method. Finally it reflected on some of the methodological challenges, principally sampling, which has

The illicit drug use behaviours and social circumstances of older adult regular Class A drug users
been identified throughout this thesis as a consistent challenge in this area,
implicit in the nature of the subject and the cohort.

Chapter 10. Conclusion

Introduction

The final chapter of this thesis presents the conclusions from the research. It begins with a summary of the study, then describes the main findings and their theoretical implications, before outlining the original contribution to knowledge. The chapter then finishes with a consideration of the implications for practice and suggestions for further research.

Study aims and method

This study sought to describe the drug use and social circumstances of a group of older drug users in England, their methods for using drugs, and their perceived reasons for their current drug use. The study also sought to develop a theoretical model of drug use in adults aged over 50, and policy and practice implications resulting from this work.

A constructivist grounded theory approach was chosen as the most appropriate method for the qualitative study. Thirty participants aged over 50 years old, and having used a class A drug in the last month were interviewed across England, using a semi-structured interview schedule.

Study findings

The 30 participants came from a range of backgrounds and social circumstances, showing a diversity of engagement in mainstream society. They used a range of drugs in a variety of ways, some using small amounts, infrequently, with others using different drugs, more often and in progressively more risky ways. Participants used drugs for two main reasons, either to enhance positive feelings or to self-medicate against negative feelings. Finally, a theoretical model was developed which centred around the core category 'achieving balance'. It described a temporal model,

whereby participants used monitoring (to a greater or lesser degree) to manage their drug use.

Theoretical implications of the findings

This study showed a relationship between the nature of participant's drug use and their social circumstances. It is noted that challenging environments and poor social capital experienced by the participants were often associated with ongoing challenging drug use, while positive social capital helped to moderate this. In doing so it provides support for the theories of environmental susceptibility (West, 2006) and the impact of capital on drug use (Granfield and Cloud, 1999). Particularly so with these participants whose social relationships had a clear impact on the management of their use.

With the lack of maturation and adaptability shown by some of the participants, support for the emerging concept of ageing in place (Lanspery (2002) and further noted by Levy and Anderson (2005)) was also identified. While it might be possible to extrapolate some support for the concept of maturing out (Winick, 1962) none was directly observed. It further showed support for the self-medication hypothesis (Khantzian, 1985). There is also evidence to support Hirschman's (1992) self-medicating/pleasure-seeking dichotomy, but this study's findings extend it by presenting a more holistic understanding of those who used drugs for pleasure.

The nature of long-term drug use, and drug use into old age, needs revisiting. This study has noted that the role played by drug use in the lives of these participants was extremely diverse, varying within and between participants, over long periods of time. The pattern presented here is more consistent with a non-linear pattern of drug use (initially hypothesized by Stanton et al (1978)) and more recently identified by Windle (2010) and Henry and Thornberry (2010), stressing the importance of non-linearity and context. This is opposed to a simple linear narrative hypothesized by gateway theory (e.g. Kandel et al, 1992) and described by Levy and

Anderson (2005) and Hser et al (2007) for example. A simple career model of use is appropriate for some but not all people who use drugs. Long-term or career drug use might encompass a range of use patterns from consistent and chaotic use, to infrequent social use or abstinence.

It is noted from this study that the nature of drug use management was similarly dynamic and subjective. Strong support was found for both a subjective, user-centred, concept of personal drug use management (e.g. Decorte, 2001) and the highly contextual nature of that use (e.g. Zinberg, 1984). To maintain this level of subjectivity support was found for the concept of 'othering' (Johnson et al, 2004). There is enough evidence presented to question an objective understanding of control in drug use, also criticised by Decorte (2001), and more recently Ning (2008).

Underpinning the subjective nature of management, this thesis found strong support for West's (2006) PRIME Theory, concerned with ongoing balance, reflection and modification. It recognises the role of cognition and decision making (e.g. Slovic et al, 2002) but extends this to the need to consider the context in which these decisions take place, and the resources individuals have, to make them. It also questions the stop/start nature of existing choice theories.

Originality of the findings

This thesis offers an original contribution to knowledge in the field of substance use in two ways. It is the largest and most comprehensive study undertaken into the methods and perceived reasons of drug use of a group of older adults aged over 50 years in the UK. This study has expanded on the only work previously undertaken in this country (Beynon et al, 2009), to consider the interaction between drug use, ageing, and a range of other variables such as social status and personal circumstances. Having established this the study went on to consider how and why the participants were using drugs at this point in their life. Neither of which has been done

with this cohort in this country and only briefly touched on in the US (e.g. Levy and Anderson, 2005). Finally it has drawn together the findings to present a model of how a process of drug use in older adults might function, presenting a new application of the work of West (2006) to describe this. This model extends existing research on how and why people use drugs by examining drug use in older adults specifically, in the context of their current social circumstances. This study's original contribution to knowledge is the culmination of a number of different, previously studied concepts, which have been brought together to draw a picture of an 'under-investigated' cohort (Satre et al, 2004, p. 1295).

Implications for policy - the delivery of regional drug treatment

In 2013 the UK government made some changes to the way that drug treatment was funded and delivered. Before 1 April 2013, drug and alcohol treatment in England was delivered through the National Treatment Agency (NTA) a Special Health Authority created in 2001 to manage the interests of the UK government departments with responsibilities which included drug use (particularly The Department of Health and the Home Office). However as part of the NHS White Paper (Department of Health, 2010) it was proposed that the NTA would become part of Public Health England (PHE) an executive agency of the Department of Health, from 1 April 2013. Reform which is also consistent with some international strategies such as those of The United States of America (Youngers, 2013) and The African Union (2007) who are aiming to develop policy and practice to respond to substance use as a public health issue.

Public Health England is divided into four regions, London, the North of England, the South of England, and the Midlands and East of England. Each region is led by a regional co-ordinator whose role it is to: manage discussions with partners and stakeholders; give professional support to the public health system (for example by providing clinical and medical

supervision); and seeing that PHE centres attend to each region's local priorities and need.

Along with data collected through the NDTMS, information and intelligence to meet regional and local need are generally gathered by networks of front line service providers and locality and engagement fora and groups, these also take input from local service users. It is anticipated that these networks provide an important source of peer learning and the sharing of knowledge and good practice. To further develop this local knowledge base, local authorities in each region are expected to do an annual needs assessment. To ensure that each area is funded according to local need the UK government allocates funding for substance use treatment services based on regional deprivation indices, numbers of people in treatment and in recent times for successful completions from treatment. Money for the delivery of substance use services now comes through PHE regionally to local authorities who have inherited the delivery of public health.

These developments have brought in a new era of planning and delivery of drug treatment services, instituted by a government committed to the localism agenda. Where once drug treatment was administrated centrally by the NTA through ring-fenced budgets, funding is now the responsibility of local authorities which PHE state in 'Our priorities for 2013-14' it 'will not performance manage' (Public Health England, 2013, p. 7).

Local authorities now have more control over the funding allocated for substance use treatment in their area. On the face of it these developments could be positive for the treatment of older drug users. It is the responsibility of the individual areas to identify their substance use treatment needs and to fund them appropriately - and in doing so the role of substance use can be brought into a wider discussion on its role within public health (Drugscope, 2013). However there is also a danger that services for older adults could be effectively marginalised. Along with the control to allocate funding to areas of need, local authorities have also been

given the power to disinvest in drug treatment altogether. Local authorities are only required to report spending annually on the categories of adult drug use, adult alcohol use, and young people's drug and alcohol treatment. The treatment for older drug users is to be subsumed under 'adult drug use'. There is danger that if there is no requirement to report spending on older adults then it is less likely to be seen as a priority.

Also while the allocation of funding regionally may benefit some areas there is a danger that it could harm others. In 2010 The National Audit Office found large regional variations in local capacity to deliver drug treatment effectively, with some regional drug leads reporting difficulty identifying good practice. It is too early to tell whether this challenge will be mirrored within the current drug treatment delivery regime. However the UK Drugs Policy Commission have echoed this concern (Beck, 2012) and called for 'regional collaborative learning events' (p. 8) to assist with local knowledge gathering and information sharing to offset this challenge.

As this thesis has noted the population of the UK is growing older. There will be a larger proportion of older adults in the population in the next twenty years than ever before. This will bring challenges in the area of social care provision (House of Lords, 2013) but more specifically in the area of substance use, as this group have also historically been the highest consumers of illegal drugs (e.g. Zablocki et al, 1988).

Implications for practice

An important implication from this research is that for a proportion of this group there will be no discernible impacts from their drug use. A small subgroup of the participants identified in this study had used class A drugs over the course of their life with no apparent detriment to their own personal health, well-being or liberty. They had monitored their use and adjusted it within their lifestyles accordingly. The results showed that they had changed and adapted their drug use whenever they felt they had needed to. Some had

talked about how their drug use had matured and they had matured in their outlook to their use, but they were never complacent about their use. It is likely that if these people continue to use drugs over the remainder of their lives they will also continue to use the same strategies of management and balance that have enabled them to function without the need for any kind of intervention - and without coming to the attention of drug treatment services or the criminal justice system.

Members of this sub-group frequently talked about how well-informed they felt and how much they relied on information sources such as the internet (indeed it is through such methods that the majority of them were recruited) to help them to manage their use better. One practical tool which could be implemented to help people similar to this, or those who felt that their use might be starting to interfere with other aspects of their lives, could be a web-based tool, developed on the rules identified in this study to help people monitor their use. This would seem to fit well this sub-group's desire for more information to help them achieve balance in their lives and also their desire to preserve their anonymity by keeping their use separate and private from the rest of their lives.

On the face of it there are no apparent implications for policy and practice for a group of people who use drugs and do not come into contact with services. However this study has found a series of properties which, when actively implemented allowed people to manage their lifestyles and achieve balance in their lives. Using these rules, which have also been identified in part by other studies (e.g. Warburton et al, 2005) could be a helpful method of allowing people to start to control their drug use better. What this study also found was that when some of the participants who had been using drugs more frequently and more heavily, had started to implement these rules - they started to manage their lifestyle better and in their own words saw improvements. What this study particularly has shown is that however entrenched these behaviours had been among some of the participants they had still been able to overcome some of the challenges of their use even though it had been compounded by the length of time they had been using

drugs and their chronological age. Publicising these rules more widely among older adults to help deal with their drug use and in turn tackle issues of loneliness and isolation could enable some older drug users to manage their use better and make immediate improvements to their lives. These are essentially the goals of harm reduction - stabilising a person's drug use before implementing further change. This also is identified by West (2006) as the method best placed to treat people with entrenched drug use problems. His stated strategy is to initially set about changing the individual's identity and their own beliefs of their use and then the behaviours associated with drug use will follow.

Considering these participants' drug use holistically as this study has, as part of an unfolding life process (rather than as a simple response to physiological stimulus) enables us to work out how to better support those facing problems with their use. Nowhere is this more appropriate than for those participants whose drug use was at its most challenging. What this study found was that it was not simply these participants' drug use which created problems in their lives, but the commensurate challenges of their drug use and their age - represented by diminished social support and perceived limited options (see also Levy and Anderson, 2005). These participants expressed becoming more and more isolated, principally as a result of their progressive drift from mainstream society over many years, as a result of their increased involvement in their drug use.

This study has shown that the implications for some of these participants of their physical and psychological well-being will not just be dependent on treating their drug use but will need to involve some kind of age-specific treatment after-care to help them deal with their isolation (which as this study has shown) can be a catalyst in itself for increased use, or relapse after cessation.

These participants will continue to need ongoing help and intervention as they become increasingly physically and socially vulnerable.

How this help is provided will need to be considered very carefully. Whether for example help needs to be provided by generic services or age specific services. Gossop and Moos (2008) suggest that existing services might not be attractive to older substance users, who might struggle to be able to integrate them into their existing treatment regimes. Barnea and Teichman (1994) highlight that few substance use workers actually advocate age-integrated services, believing them inappropriate for older adults. However, Koch and Rubin (1997) argue that treatment providers can be guilty of trying to provide a generic service aimed at helping as many people as possible. In doing so however they can neglect smaller populations such as older adults and other minority groups.

At the time of the fieldwork for this study only one substance use treatment service was identified in the UK working with older adults specifically (Gossop, 2008). In addition, no services were identified which were looking to establish groups or age-specific interventions with older substance users. Crome and Crome (2005) found this similarly, as did EMCDDA (2010).

This should not be viewed as a barrier to intervention for this group however. Age specific interventions need not mean age specific services. A number of the participants in this study reported responding positively to any help that was provided as long as they felt it was tailored to them individually. Age specific interventions could usefully include activities such as information provision concerned with how ageing affects the body and how this in turn has implications for issues such as the appropriate use of substitute medications, frequency of use, safe administration, dosages etc. What was also apparent among this group was that there were many years of experience at working through, and in some cases delivering, treatment services. This knowledge and reflection would seem to be vital in delivering a bespoke, individually tailored personal care plan. It could also usefully be utilised in a peer support system.

Participants expressed mixed opinions about whether they would rather use generic or age-specific services. Regardless of the service there was a

consensus as to how they felt older substance users should be treated. For these participants there was a strong sense of feeling marginalised and ignored. The words ‘dignity’ and ‘respect’ were mentioned frequently. It is striking then that Gossop and Moos (2008) state that older substance users respond well to being treated with ‘dignity and sensitivity’ (p. 348), while dignity was also mentioned by Colleran (2004).

Gossop and Moos (2008) suggest that in the absence of age-specific services healthcare providers would benefit from training designed to work with older adults. Particularly to manage any negative attitudes of staff. Gerontology and substance use need to be integrated into medical training programmes along with social work training, at degree and then subsequently postgraduate level to achieve this. A lack of understanding of the specific issues faced by older drug users was highlighted by a number of participants in this study. These results suggest that healthcare practitioners need to be more aware of drug use among older adults, how to identify it and respond to it. Along with this there needs to be an awareness of the risk factors for substance use issues that can trigger and prolong problems as people get older. These include problems with health brought on by ageing, including a lack of mobility and psychological factors such as loss, grief and particularly isolation.

Some of the participants talked about how little help they were offered from generic services, particularly front line care staff such as GPs. Front line intervention is critical for older adult substance users, particularly when they can benefit from ‘low intensity interventions’ (Gossop and Moos, 2008, p 348). At the very least front line care staff (such as GPs and social workers) need to be aware of what local arrangements exist for referring older adults with often complex substance use needs, in their area.

Another first line of contact are social workers who are in an ideal position to identify older adults at risk of substance use. Further training on identifying risk factors (e.g. isolation and loss) similar to the kind mentioned by one of the participants in this study could be beneficial. This could be the

first line of intervention supported subsequently by a range of healthcare staff such as nutritionists, pharmacists, dentists and GPs particularly. This might also usefully include physiotherapists to raise awareness and the benefits of healthier living and exercise. This could counteract some of the physical effects of ageing, improve health and raise self esteem.

A peripatetic inter-disciplinary team might be the most effective way of working with older substance users. This might also include working with family members (e.g. Kouimtsidis and Padhi, 2007) and building rapport slowly to provide a full picture of each client's needs (Colleran, 2004). Crome and Crome (2005) also advocate this multi-disciplinary team approach but go further stating that 'an important issue is choosing the right person for the job, i.e. someone who likes older people and is trained in their management' (p. 346). McGrath et al (2007) also suggest that the best approach for working with older substance users is to put the individual in touch with multi-disciplinary treatment services, believing that access to psychiatrists and geriatricians are essential to care in this age group. They assert that many NHS trusts have access to these integrated care management teams. However, few of the participants in this study described anything like this model of care or treatment.

Another implication raised by this study is that of appropriate housing. Some of the participants in this study talked about problems they had experienced being rehoused due to their age. At present it might still be appropriate to house some older substance users in generic homelessness and rehousing services, but as they become older still there will be a need to consider specialist care such as nursing or retirement homes. Staff from generic care homes are unlikely to have the training, and support, to work with clients who also use drugs and have problems associated with them (Ebert and Sturm, 2006). Some countries have developed specialised accommodation services for older drug users, e.g. Denmark, Germany, Netherlands (EMCDDA, 2010). These are not simply care homes or rest homes but offer residential treatment and assessment of future care needs. However, these may be impractical on the scale needed to meet the future

demands for the treatment of older drug users. A more practical solution would likely be the integration of these services into mainstream social care.

None of the UK or EU health strategies are aimed at tackling substance use among older adults. In the UK, older adults are intended to be captured under vulnerable groups at risk of alcohol or drug problems (EMCDDA, 2010). However in the US this issue is considered specifically by the United States Drug Abuse Warning Network (SAMHSA, 2010b). It is no surprise therefore that all of the research in this area (except for Beynon et al, 2009) is located in the US. With little focus in national strategies, targets or programmes there is less likely to be research among this group. This has been highlighted recently as NICE (2014) have called for Local Authorities to prioritise support for young drug users. This cohort is being under researched and as a result left uncared for (Crome and Crome, 2005). Without research there is a lack of understanding of the issues and a potential denial of appropriate treatment (Crome and Bloor, 2005).

Suggestions for further research

This thesis has highlighted the assertion by a number of authors (most recently Beynon et al, 2009) that this cohort is under researched. The evidence base on this group still appears to be in its very early stages of development. As such, recommendations for further research should encompass all areas of study with this group, from understanding initiation, to progression, to career, screening and intervention.

This study and the only other like it in this country (Beynon et al, 2009) have set about trying to describe the nature of the challenges within this group. However there is a need for more large-scale work to understand the size and scope of the challenge. The pooling and monitoring of administrative data (e.g. their social and demographic circumstances and the drug use behaviours) as an early warning system is quickly needed. This will help to assess national trends and highlight any need for intervention. At the very least it will assist policy makers and practitioners in observing

what is needed and where. There are disproportionate pockets of older adults, deprivation and drug use across the UK. There is no reason to expect older drug users to be normally distributed.

As this thesis has also highlighted, drug use and ageing bring compound challenges. There would appear to be an urgent need to identify what best practice looks like both in the screening and identification of illegal drug use problems among older adults, their treatment and support. This will be increasingly more pressing when older people in their 70s, 80s and 90s report to healthcare providers with drug use problems. There will, for example need to be an understanding of how drug use is managed in hospitals, hospices, care homes and other caring environments, and during end of life care. Similar research will also be needed within the criminal justice system to assess the most appropriate method of treatment and intervention with older adults who commit drug related crime.

Research with older adults who use drugs also needs to be ongoing, as it is in younger groups. There needs to be an understanding of any cohort effects that might be apparent which will affect results and therefore intervention. This study has considered drug use among a very specific group of adults who started using drugs during a specific time in a specific place (i.e. during the 1960s and 1970s and in one case the 1980s in the US and England) and then continued to do so shaped by these experiences. Different drugs such as Ecstasy and Methamphetamine for example have subsequently become available and continue to become more prevalent. There is currently no research that examines what effect the availability and use of these drugs will have over long periods and with older adults. It is only once a consistent and reliable evidence base for this group has been established that further work can be undertaken.

Chapter summary

This chapter has provided the conclusion to this thesis. It began with a brief summary of the work undertaken including the rationale and context,

followed by the study's original contribution to knowledge. This study has been the most wide-ranging of older adult drug users undertaken in the UK. The chapter then presented the implications for practice and suggestions for further research, principally by suggesting an extension and widening of the current evidence base. It also highlighted the need for training for professionals involved in the healthcare of older adults who may be experiencing unique and age-specific challenges associated with drug use. This also includes issues of identification for front line staff and knowledge of where and whom to refer clients to. There is also an important need to recognise how illegal drug use may interact with end of life issues in this group.

Appendix 1. Classifications of illegal drugs by class

‘The different kinds of illegal drugs are divided into three different categories, or classes. These classes (A, B and C) carry different levels of penalty for possession and dealing. The Misuse of Drugs Act 1971 (and subsequent updates) is the main piece of legislation covering drugs and their categorisation in the UK.’

Class	Drug
Class A	Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms, amphetamines (if prepared for injection).
Class B	Amphetamines, Cannabis, Methylphenidate (Ritalin), Pholcodine.
Class C	Tranquilisers, some painkillers, Gamma hydroxybutyrate (GHB), Ketamine.

All of the drugs on the list above - whether class A, B or C - are designated as controlled substances under the Misuse of Drugs Act 1971, and using them is illegal.

Class A drugs are considered to be the most likely to cause harm.’ (Home Office n.d.)

Appendix 2. Recruitment advertisement

<p style="text-align: center;">ARE YOU OVER 50 YEARS OF AGE?</p> <p style="text-align: center;">WOULD YOU BE WILLING TO TALK ABOUT YOURSELF AND YOUR DRUG USE?</p> <p style="text-align: center;">DO YOU HAVE A COUPLE OF HOURS TO SPARE?</p>
--

I am a PhD student at the School of Health and Social Care at Oxford Brookes University, researching older adults and their drug use

What is this study about?

I want to learn more about how and why people use illicit drugs (such as Heroin or Cocaine) as they get older.

Why am I asking you to take part?

Because you have firsthand experience of using illicit drugs.

What does it involve?

I will ask you to take part in an interview with me. This will take no more than an hour or two, but you are welcome to talk for longer if you want, or to end the interview at any time. You are also free to skip any questions you don't want to answer. With your permission I'd like to tape record the interviews so that when I come to write the report, it will be as accurate as possible.

What are the questions about?

The questions are about drug use and people's general life circumstances, about why they started taking drugs and why they continue. The questions are not hard.

Will anyone know your answers?

If you take part your answers will be **COMPLETELY CONFIDENTIAL**, with no one, knowing what you have said.

How can you get involved?

If you're interested, just give me a call, drop me a note, get a message to me, whatever is easiest for you. You can contact me on my email address or through the drop in centre.

THANK YOU

Appendix 3. Information for participants

INFORMATION FOR PARTICIPANTS

What is this study about?

This study is about people aged over 50 who take illicit drugs. It aims to understand the experiences and needs of older adult drug users and I hope that findings will be of use to drug treatment services

What would you have to do as an interviewee?

If you are interested, I would like to interview you about your drug use and your circumstances. Interviews of this kind usually take anything up to 2 hours using a tape recorder to record your comments, but you are welcome to take longer if you so wish or cut the interview short at any time. You are free to skip any questions if you don't want to tell me the answer.

Why have you been invited to take part?

My study is about the lives of drug users who are over 50 years old, so I am interested in talking to anyone around your age about their experiences. If you know of anyone else of a similar age who is taking drugs, and is not visiting the centre, I would be very interested in talking to them also.

Do you have to take part?

No. Taking part is voluntary. The success of the study depends on finding enough people to talk to. The more people who take part, the more useful the results will be. However, even if you say yes to begin with, you are free to stop and withdraw at any time.

Is the study confidential?

Yes. Your answers will be treated in strict confidence in accordance with the Data Protection Act. You will not be named at all, so no one will be able to find out what you have said in the interview. This includes the staff at any centre you may be attending, and any other case workers you might have from health or social services, or the courts, or anyone else at my University. The results of the study will not identify you or anyone else who takes part.

However confidentiality can only be protected within the limitations of the law. You should be aware that it is possible for data to be subject to subpoena or freedom of information claim.

What happens after the interview?

Once the interview is finished I will write up our conversation and store it on 'read only' password protected computer files.

Backup copies will be kept on a password protected external data drive (any printouts will be safely in a locked filing cabinet) and the tape recording of our conversation will then be deleted.

I will incorporate your comments, along with those of other participants, into a report that I would like to show to you to be sure that what I have written is a fair representation.

I may be interested in asking you some follow up questions, but as with the first interview this follow up is entirely voluntary. If you do decide to agree to the first interview you are not committing yourself to anything else. I will only contact you a second time through details that you provide me with.

The data will be kept securely in electronic form until after the completion of the research project. During this time however it will still be stored in the same secure way – this is simply a legal requirement.

In accordance with university rules the data will be kept for five years and then destroyed.

What if you have any other questions?

I hope this leaflet has answered your questions and shown the importance of the study. If you have any other questions, you can ask me, or contact me at the address below.

NAME: Mark Mason

TELEPHONE: XXXXX XXXXXX

EMAIL: markbmason@brookes.ac.uk

This project has received ethical clearance from the Oxford Brookes University Research Ethics Committee.

If at any time you have any concerns about the conduct of the research project please contact the Chair of the University Research Ethics Committee at Oxford Brookes: Ethics@brookes.ac.uk.

1st February 2008

Appendix 4. Structured interview schedule

DRAFT INTERVIEW SCHEDULE

The abuse of drugs in older adults and the implications for clinical management and service development

Aim

The aim of the research is to improve the understanding of drug use among older adults

Specific aims

- To describe the social and drug use circumstances of older illicit drug users;
- To understand how and why illicit drug users continue to use substances as they age;
- To develop a theory of drug use among older adults; and
- To provide information of potential use to drug services and policy makers.

Research question/s

What are the drug-taking behaviours and social circumstances of older illicit drug users, and how and why do they continue to use substances as they age?

Social circumstances

I would like to just start by asking you some simple questions about your current life circumstance to get more of an idea about who you are

SC1. Age last birthday?

SC2. Accommodation arrangements?

(PROMPT: E.G. somewhere you own or rent, squat, hostel, sleep rough, medical)

SC3. Working situation?

(PROMPT: E.G. employed, training or education, unemployed, unable to work, retired, carer)

SC4. Current spouse or partner?

(PROMPT: E.G. married, living with someone, single, divorced, separated, widowed) **whether they know if their current partner is a drug user?**

SC5. Children?

(PROMPT: E.G. what ages)

Opening issues

I'd now like to move on to asking some general questions about what drug use and the issues about it, that are important to you

Please feel free to talk about anything that you wish

After this I would like us to go into a bit more detail on some specific topics

O11. Why you they using drugs now?

Can I start by asking you how long you think you have been using drugs

Can I ask you to talk about why you use drugs

Drug use

I'd now like to talk more specifically about your drug and alcohol use

For each question I'd like us to explore what things are like at the moment and after that whether this has always been the case

Finally I'd like us to consider why you think any changes might have happened

DU1. Drug use

(PROMPT: E.G. which drugs, how often)

DU2. Routes of administration

(PROMPT: E.G. injecting, inhaling)

DU3. How much do you spend on drugs

DU4. Acquiring drugs

(PROMPT: E.G. from sellers, friends/partner, prescribed)

DU5. Any external factors affecting the way they use

(PROMPT: E.G. Quality, Violence, Droughts, Community attitudes to drug use, changes in policing and experience of GPs, relationships; accommodation; health; children; employment; any other)

DU6. Periods of abstinence

(PROMPT: Because of drug treatment, abstinence, self-administered treatment)

DU7. Do you think your use is a problem for you

(PROMPT: E.G. how you feel if they don't use)

(Explore what criteria they're using to measure that?)

DU8. What would make you stop using drugs altogether?

(PROMPT: E.G. Do you want to stop using? Do you want to change/reduce?)

Risk Behaviour

I'd now like to ask whether you've taken part in things that might be considered risky or dangerous in some way.

RB1. Indulgence in risky behaviours:

- Given or lent needles or syringes to anyone else
- Injected using needles or syringes that have already been used by someone else
- Taken two (or more) drugs together
- Overdosed on any drug you've taken

If **yes**, were they one offs or regular occurrences? When did they occur? What happened? Have any of these issues led you to rethinking how you use drugs?

If **no**, why not?

Offending / anti social behaviour

I'm interested in whether you've any experience of crime either as a victim or an offender

OASB1. Victim of a crime (specifically as a result of drug use)?

(PROMPT: E.G. robbed, assaulted, 'ripped off')

OASB2. Committed a crime (specifically as a result of drug use)?

(PROMPT: E.G. Committed any crimes under the influence of drugs? committed any crimes to buy or get hold of drugs?)

OASB3. History of arrest

If **yes**, how old were you? Has this affected the way you use drugs?

OASB4. History of imprisonment

If **yes**, was this related to your drug use? How?

Drug treatment

I'd like to move on now to talk about your experiences of drug treatment and any services that you might have come into contact with

DT1. Previous help, or treatment, for your drug use

If **no**, why not?

(PROMPT: Perhaps you don't see your drug use as a problem? Would you like to be able to receive treatment but have not been able to for some reason? What services would you like to receive? Concerns about accessing services?)

If **yes**, (ask them about the **sorts** of service/s they've accessed)

(PROMPT: How helpful were the service/s contacted? Since seeking assistance has your use changed? What were the experiences? What did you learn? What about other services/ agency contact – e.g. prison, social services? What services would you have liked to have received?)

Health issues

I'd like to ask you some questions about your health before we move onto the last few questions

As with the questions on drug use, I'd like us to explore what things are like at the moment for you, and after that whether this has always been the case

Finally I'd like us to consider why you think any changes might have happened

HI1. Feelings about your general health now

HI2. Whether your health is a concern to you

(PROMPT: limits their activities?)

HI3. Do you see your drug use as *affecting* your health (i.e. mental and physical)? Or perhaps *helping* your health?

The future

Just before we finish I would like to ask if you have any thoughts about the future and where you see yourself

TF1. Any thoughts on where you might be in a year's time ...

Five years time

TFR2. Thoughts on future drug use

If **yes**, in the same way?

If **no**, how do you think it might be different?

TF3. Do you think about how it might affect you at all?

TF4. Hopes, fears or ambitions for the future?

END

I would like to round up now by asking if there is anything that you would like to talk about before we close

End1. Any issues you might want to talk about in relation to why you're using drugs at this point in your life

THANK THEM FOR THEIR HELP

DEBRIEF

Appendix 5. Semi-structured interview schedule

SOCIAL CIRCUMSTANCES

- I would like to start by asking you a little about yourself as a person. Could I ask you to describe yourself and your life at the moment please? (*E.g. Family; work; living; health*)

DRUG USE

- I'd now like to move onto talking about your drug and alcohol use. Can I ask you to start by describing your drug use for me at the moment please? (*e.g. What drugs; How often; Spend; Administration; Acquisition; Problematic/Risky; When/ how long / how started; Smoking*)
- Can you tell me now about the ways you think your drug use might have changed: recently? Over the years? (*E.g. What drugs; How often; Spend; Administration; Acquisition; Problematic/Risky; When/ how long / how started; Smoking*)
- Can you tell me why you think this might be? (*The interaction between individual, social and societal*)
- Can you tell me about any times in your life when you weren't taking drugs at all? (*as above*)
- Bringing us back up to date now I'm really interested in understanding why it is you are taking drugs at the moment. Could you talk a little about that for me please?
Do you think you could stop taking drugs?
What do you think would happen if you stopped taking drugs?

THE FUTURE

- Just before we wrap up I would like to finish by asking you about your thoughts for the future. Could I ask you to talk about where you see yourself in 1 year; 3 years; 5 years time?

Do you think there is there a point in your life where you might stop taking drugs?

Can you think of anything that would make you want to stop taking drugs?

AND FINALLY ...

- Is there anything else you think I should know, or you would like to tell me about, to understand you and your drug use better?

- Finally is there anything that you would like to ask me?

Appendix 6. Newspaper advertisement

“Have you taken any drug in the last month? Are you over 50 years old? Older drug users wanted for interview for PhD research project. Expenses paid.”

Appendix 7. Website advert

The use of drugs in older adults and the implications for clinical management and service development: Help with a part-time PhD study

Research in the area of drug use and ageing has tended to concentrate on people who *stop* using drugs as they get older (essentially ‘maturing out’ of drug use). I am currently undertaking a PhD study however, which is exploring the lifestyles of current older drug users – essentially how and why they are using drugs at this point in their life.

To do this I am looking to interview anyone over the age of 50 who has used an illicit drug in the last year. If this is you, and you feel that you would be able to help me, I would be very interested in hearing from you.

Interviews would be at a place where you felt comfortable and should last no longer than 2 hours at the very most (the longest interview I’ve done so far has been around 90 minutes). Ideally, I would like to record the interview to make sure that everything you tell me is detailed accurately. You would be allowed to stop the interview whenever you wished, or skip over any questions you didn’t want to answer. The interview would be about you as a person, your current circumstances and your drug use.

If you are interesting in helping you can get in touch with me through my college email address, which is markbmason@brookes.ac.uk. I am based in London but am happy to travel across the UK.

I would be more than happy to provide any further information about the study, or talk to you about any issues or concerns you might have.

Thank you very much indeed.

Appendix 8. Example of a memo

From the previous interviews it seems that identity is becoming an important issue with these participants, not just how they see themselves, (although this important obviously) but about how they think about this in its entirety, what factors make it up, what are important and what are not (are these the same for all?), how they measure it and see it. On the face of it there seem to be some potential contradictions in their stories, but as I look again this is more about how they seem to be changing and re-evaluating things. Both in their lives and about their drug use. I have this thought how the participants were seeing their drug use, how important it had been and how important it was now to them. Did this affect the way they took their drugs? How do they shift their identity, what information do they use, how fixed is this and how dynamic?

I was thinking that this change comes when new information presents itself, (don't we all do this though? Perhaps, but perhaps more so if we are engaged in an illicit activity, having not done this I don't know. This needs exploring) runs counter to what the person originally thought of as their identity. They are provided with some new information that tells them something different about themselves. They originally thought one thing and now they have access to other information which now makes them think something different.

For their drug use this would mean that they re-evaluated what it meant and means over time. Not just over long periods but maybe yesterday, today and tomorrow maybe?

Interview 5, East Midlands, 50 year old, white male.

Initial thoughts were that this was the most apparent issue at work during this interview. A showed signs that he looks at identity

regularly or has done so in the past around his drug use. For him taking drugs was not simply a matter of 'getting high' it seemed to be more about changing his personality to the sort of person that he wanted to be and show to the world. He had an instrumental or facilitatory view of drugs, it helped him to achieve something he wanted. He is not the first participant to show this type of behaviour (this can relate back to P).

Andrew talked towards the end about how he looked at himself a lot and how he looked to others. He seemed very self-conscious he said. Not only this he talked about being judgemental (again not the first to express this - relates back to J) - he said that when he was younger and had been using drugs he felt that other people 'could tell' and he tried hard to hide this. He said he was 'always' thinking how he looked to others and how he judged himself. This perhaps seems to be indicative of 'othering' which will be useful to explore in further interviews, might other participants do this? Or be like this? Might this be something they use somehow to contrast their identity as a drug user and/or just someone who uses drugs? I will recheck the other interviews so far for this.

Another factor which has re-arisen (relates back to G again) is that A talked if he hadn't taken drugs then he would be a different person and he felt that his personality would be different. I asked him if this was something he looked at a) over his life, and b) on an ongoing basis (i.e. backwards and forwards). He said it was and that he was doing it all the time - this was interesting to me, again was this something that all did or had done? Again I will recheck the other interviews so far for this?

Towards the end he was keen to point out that he had been changing his drug use but at the same time e said that if he was in a situation where people were taking drugs he 'knew he would' CHECK QUOTE. This seemed to express a sort of ongoing monitoring

(conscious) but at the same time an urge (unconscious) about his drug use. Again, something to check and recheck. He did not seem like someone who was not in control of his use. I think this might be more about A being a 'social animal' in his own words.

While he said he was positive that drugs 'held no control' over him he cited the fact that that if he came into a situation where he was faced with them he would probably use them. Perhaps this reflects that he also like to use drugs socially and seemed like a very gregarious person. He said he liked being part of a crowd.

When probed he did say that drug use played a diminishing part in his life. Previously he said during the course of the interview that drugs had been important in his life. But when probed this was more about the lifestyle he had led and how important they had been and other factors in his life had been in the past.

He expressed a desire to change himself as he got older - largely as a result of what seemed like self criticism. This seemed as important to anything – the way that he presented himself to the world and the way that the world saw him. He expressed negative views of drug users (othering again?) and how older people 'should behave' ('set an example' - possible code?).

He said that having moved his home town he was dealing with a loss of something to his identity. This was not just about the drugs however, it was about almost mourning a hedonist lifestyle he was no longer able to maintain because of his age.

Issues to consider from this interview

- Identity and shifts/changes in identity

- Monitoring ones identity. Does being involved in an illicit activity mean that people do this more? Is this about risk?
- The importance of drug use in relation to other aspects in people's lives (how does this affect their use in turn),
- Othering and the participants views of other drug users,
- The participants perceptions of 'getting older' (anything about physical vulnerability? in here)

I need to continually keep in mind though that this is not a psychological study and I am not a psychologist, nor do I intend to be - these issues are only important insofar as they relate to and affect the participants drug use, what micro factors influence macro factors and vice versa.

Appendix 9. Example of a diary entry

Saturday 11th August 2007

This morning I've removed the word "continue" in the research question– "why do drug users continue to use drugs as they age". I am really interested in drug users who are using drugs at all – even if they've only been using drugs for a short while. Otherwise it sort of implies that I'm only implicitly interested in drug users who've been using for a long time. The more I think about it the more I'm looking at why drugs users are using drugs irrespective of the length of time that they've been using."

Appendix 10. Extract from a coded interview transcript

Can I start by asking you a little about yourself and your life at the moment please? Where you're living, working that kind of thing.

I've been a heroin addict solidly for two and a half years but on and off for about twenty five years. I first started using heroin to come down after using ecstasy. I used to find that to go to work on Monday I had a bit of smack on Sunday. I used to get up in the morning and go to work, but it was always a cycle of Monday, Tuesday, Wednesday was catching up on sleep, Thursday go out, and then Thursday to Sunday I just used to stay out all the time, so I'd just go through a cycle of sleeping during the week and then staying awake for four days.

Could we talk about your drug use at the moment?

I've been trying to get myself clean. I inject heroin. Basically, I went out and [00:01:37] and I decided a long time ago when I run out of veins to stop. Now I've run out of veins I'm stopping. That's a little promise I made to myself a long time ago. I didn't actually stop dead. The last four times I have injected heroin I've been injecting in my neck. You can get clots forming on the inside of the brain. A friend showed me how to do it in my neck. He started going in his groin, then he'd been going in his groin for two months, and he's now got a blood clot and an abscess on the inside of his groin. He's in [TEXT REMOVED] hospital now and it was pretty horrible. My partner of two and a half years doesn't do anything. She's an alcoholic but she doesn't take any drugs whatsoever – no crack, no heroin, no nothing. She has been my sort of state of the real world. Without her I don't know what I'd be doing. I'd probably be dead by now.

Where are you living at the moment?

I live with my partner. I used to... I originally... I'm ex public school. I had a private education. My brother works for [TEXT REMOVED], my little sister, she's a [TEXT REMOVED], my oldest sister works for [TEXT REMOVED] at [TEXT REMOVED], and my little brother is a [TEXT REMOVED], and I'm a junkie. Nice combination. Basically, they don't really have a lot to do with me.

Are you involved with your family at all?

I still keep in touch. My mum is seventy-odd and she's got God in her life now. Every time I speak to her she tells me she's going to pray for me. I think when you die you're worm food. I've got a couple of friends who go on the Access course at Woking churches and so forth. That helps them. Nobody knows until you snuff it.

Are you working at the moment?

My last job was I was working for [TEXT REMOVED]. That was about two years ago. But I became a heroin addict when I was working for them, and then I was speaking to my little sister and she informed me how much I was breaking the law by driving with heroin in my system and what would happen to me if I get caught. Her words were 'if you get caught driving with that shit in your system you'll get seven years, no hesitation.' I packed up my job. I lost my flat about two months later for non payment of rent. I ended up homeless, moved into [TEXT REMOVED] Road in [TEXT REMOVED], stayed there for four months, five months, got myself my own room. When I was living in there I had a load of homeless people staying with me. I got fed up with that, they kicked me out of there, and I moved in with my partner and I've been there ever since. I've been quite lucky really. I've been homeless. I was homeless this time around only two and a half months. I just didn't like it, It was too bloody cold.

Can we go back to your drug use at the moment please?

I use a bit a day – anything between two and six bags a day. A ten pound bag is about point two of a gram of what's supposed to be heroin but, as I said before, the rubbish you get round here, none of it is ... you get valium, diazepam, some pills, anything to make up the amount. The problem is I inject it, so basically whatever it is goes straight into my system, especially around my groin and all that. At the moment I've got about four abscesses on my groin. Now, as I'm giving up, my immune system is going down the toilet. I'm whacking all of it into trying to get [00:07:26] because that tends to clean your blood out. When you're giving up heroin, one of the first things to happen is your stomach and intestine relines itself, so I'm trying to make sure I eat lots of fibre so that passes... I haven't actually eaten for a couple of days but I haven't had no biscuits. I know if I eat one of them biscuits it's going to kill me.

Can we talk about what your drug use has been like over the course of your life and whether it's changed at all?

I remember quite clearly my first... my first spliff I ever had was [00:08:30]. I had some when I was about seventeen/eighteen. I just left school, climbed up a pine tree, there were two other kids at the top. They were sitting there and having a spliff up there because you didn't get caught. I had a few puffs, started feeling a bit funny. I got about halfway down, bounced the rest of the way down. You'd have thought that would put me off, but I did it for a couple of months and started on cannabis, so hash, a bit of scag every now and again if I could get it. I liked the camaraderie you get with it when you're a drug user. It's you against the establishment. You feel a sense of belonging because you're doing something that other people are doing that's illegal, and then they have a common tie. Because I went to boarding school down in [TEXT REMOVED], when I left school I

didn't know anyone, and it was a handy way of getting to know people. It was a good way of mixing with people. Then I did some university, some travelling, came back and started doing parties. I was at a party and I was sat there with a sound system going, and then the DJ came up and started playing and I recognised him – a bloke called [TEXT REMOVED] that I'd known for a few years. I got chatting. Within a few weeks I was going to parties, helping to set up parties, working on the door, and so forth. It was good money. Sometimes I'd earn on a weekend – I'd do from Thursday to Sunday – and on Sunday I'd get my cut of the door, which would be about five hundred/six hundred pounds. People don't realise these parties net anything up to thirty/forty thousand pounds. They thought it was just bits on the door, but they also controlled the drug scene. If any other dealers come on the property they either pay you protection for dealing at your party or they get their teeth kicked in and drugs nicked off them. I did that for about ten years. I was living in a squat at [TEXT REMOVED] – good times. I got shot twice, so there were bad times as well.

Can you tell me about the good times and bad times

Good times it was just because you were... everyone wanted to do the parties. They would be very nice parties and so forth. I used to go to the rigs. I used to go with [TEXT REMOVED], a mate of mine, and I used to go and check a building out, open it up, put the power supply on, get the toilets working, so forth. Then we had some people turned up and started sorting things out for running a party. Friday night we'd have a party, but you'd have to make sure that at least three or four hundred people were there in case the coppers turned up. In the old days it was squatter's rights. [00:12:07] on the door and the police had to spend three months kicking you out. As long as there was enough people there you could say 'Come on, kick us all out then,' and it was always too much for them and so nine times out of ten they'd walk away and let us get on with it. The

buildings used to last three parties, sometimes four parties. It was never more than four parties. By that time they were destroyed. Then you'd have to go out and find a new building. We even used [TEXT REMOVED] when it was being refurbished. That was fun. My mate locked himself in one of the cells and we didn't have a key to get him out. We had to nick a jackhammer and cut the door up to get him out. It was him and his bird, and he was in there for two days – no water, no nothing. It was funny. We had one in [TEXT REMOVED] when that was being refurbished, in the [TEXT REMOVED]. The police raided that one and closed it down, so we moved the party to a back up location, which was up in [TEXT REMOVED], which was an old venue we had. What everyone did was they left the party, stole a car and drove to [TEXT REMOVED]. It was in the papers the next day that there was four and a half thousand car thefts in [TEXT REMOVED] that night. They split up the party and had to deal with the aftermath, and the aftermath is three/four thousand people walking round at two in the morning, wanting to get to [TEXT REMOVED]. There wasn't night buses at that time so they nicked cars. Yes, they weren't too chuffed about that one.

You said bad times too.

I opened the door once and had a drive by. Someone shot at me with a shotgun. I ended up with a couple of pellets in my leg. You always do something on the door for back up, and I pushed the door down and the door took most of the shotgun blast. One of the head honchos who was one of the main party people, it hit the door and the door hit him and knocked him to the floor, and I saved his life. Before I was only getting... on the door money I was only getting one percent/two percent, after that I was getting ten percent, which made my wages jump from about hundred and fifty/two hundred pounds a week to about nine hundred pounds a week. The problem with that was you get nine hundred pounds on a Sunday and you go out and

buy a load of crack, a sixteenth of heroin, but it was money all the time, beer all the time, spliff all the time.

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