EURAD is a European drug policy network for prevention, treatment, recovery and reintegration. We advocate for evidence-based drug policies on the European and Global level. EURAD was established in the Netherlands in 1989 and is currently registered in Belgium.

Submission for the INCB board meeting discussion on "drug use among older people"

In many European countries, the number of elderly drug users is increasing. This is reflected in increasing number of older drug users in treatment, but also the increasing age of drug related deaths.

In many ways this is a welcome development. On the one hand, it indicates that a large number of drug users have received help and treatment that has increased their chances of survival, and on the other hand, increasing average age in drug related deaths suggests that recruitment of new cohorts of drug users has slowed down.

The challenge of drug policy is in many ways two-fold – to take care of the people who are suffering from substance abuse disorder and to prevent new generations of users from developing similar problems. Treatment, health services and harm reduction measures are important for helping the first group. Broader health and social policies, restrictive drug policies and more narrow substance prevention efforts are important for the latter.

Drug users who came of age in the heyday of the European heroin epidemic in the 1980s and 90s are now in their late 50s or even 60s. This means that they soon will enter the elderly population.

Many of them will have a long career of substance use problems behind them. Many have complex needs, with a combination of substance related problems, mental health problems and physical health problems.

Drug use is often associated with premature ageing, mental health problems and somatic health problems. The risk of drug induced deaths is high, but somatic diseases, including cancers, cardiovascular disease, liver disease and pulmonary disease, account for a large share of mortality in this group.

Some drug users will have more extensive needs for services than other people of the same age. These complex needs can present challenges for health personnel in care homes who may not have been trained to treat this patient group. There will be a need for staff training in homes and care facilities for the elderly, and in some cases perhaps even specialized facilities with expertise in this field.

Many countries are also reporting increasing alcohol consumption among the elderly. We also see increases in use of prescription medicines, such as benzodiazepines and opioids. The combination of

alcohol and prescription medicine may increase the risk of harms from falls and accidents, cause drug interactions and increase the risk of substance use problems. Hazardous alcohol and prescription drug use can affect quality of life, their ability to take care of themselves in their own home and reduce their chances of taking an active part in the lives of their partners, children and grandchildren.

Doctors and health personnel need to be aware of these risks, to address substance use and prescription medicine use with their patients and provide brief interventions and referral to specialized treatment if necessary.

Furthermore, there is clear evidence from the literature that core dimensions related to quality of life, such as low socioeconomic status, comorbid psychiatric conditions, and lack of family and social supports are among the most important predictors of relapse. Older drug users are also more likely to suffer from the negative social consequences of decades of drug use. Studies report that older drug users are often socially excluded and isolated from their family, friends and social networks outside the drug users' networks. They are more marginalised, stigmatized, have higher levels of unemployment, lower education, they are more often homeless, and they are more likely to have been in prison. Older drug users tend to have smaller social networks composed mainly of other older drug users, and they are less likely than younger drug users to make new friends, and are more prone to the loss of close friends and the associated feelings of depression, isolation and loneliness.

All of the above may undermine already fragile recovery especially as the available information suggests that specialised treatment and care programmes for older drug users are rare. Hence, fostering opportunities for improved functioning in key areas of recovery and social reintegration (psychosocial, education, employment, physical and mental health, housing, leisure activities) may have to be prioritised and may significantly enhance the likelihood of sustained long term recovery and improved quality of life.

There is a need to adapt existing services to an ageing drug using population and develop interagency partnerships and referrals systems between specialised and recovery services on one hand and health and social services on the other, which may have a positive impact on the effectiveness of and/or access to these services in a long run. There is also a need for a stronger researcher that will investigate the needs of older drug users, for their treatment, recovery and social reintegration and determining what constitutes adequate responses for this target group.