Chapter I.

A hidden epidemic: the use of drugs among older persons

Introduction

1. People throughout the world are living longer; with a longer life come a number of opportunities and challenges. Among those challenges is the increasing vulnerability of older persons to drug use and drug dependence.

2. In 2016, INCB devoted chapter I of its annual report to the issue of women and drugs and, in 2019, to improving substance use prevention and treatment services for young people. Patterns of increasing drug use and drug dependence among older persons led the Board to devote the present thematic chapter to this development.

3. According to the United Nations, there were 703 million persons aged 65 or over in the world in 2019. That number is projected to double, to 1.5 billion, by 2050. Globally, the share of the population aged 65 years or over increased from 6 per cent in 1990 to 9 per cent in 2019. That proportion is projected to rise further and, by 2050, it is expected that 16 per cent of the global population, or one in six people, will be aged 65 or over.[1] In 2018, it was projected that, in 2020, the number of people over the age of 60 would be greater than the number of children under the age of 5, for the first time ever.[2]

4. The trend towards an ageing population originally started in high-income countries and occurred over a relatively long period of time. This trend is now also visible in low- and middle-income countries and is occurring over a considerably shorter period of time. For example, it took France 150 years to transition from 10 per cent to 20 per cent of its population being over the age of 60. Brazil, China and India are expected to make the same transition in 20 years. In Japan, 30 per cent of the population are aged over 60; by 2050, it is expected that Chile, China, Iran (Islamic Republic of) and the Russian Federation will have a proportion of older persons similar to that of Japan. Furthermore, by 2050, it is also expected that 80 per cent of all older persons will live in low- and middle-income countries.[3] Planning for the impact of these global changes and the possible problems and challenges of substance use among older persons is, however, needed now.

5. In line with the global trend in population ageing, evidence from the United States of America and many parts of Europe suggests that drug use and drug-related deaths among older persons and the number of older persons in treatment for drug use problems has also increased in recent years.[4] This increase, mostly in high-income countries, may be the result of the ageing of the "baby-boomer" generation (those born between 1946 and 1964, which was a period of increased birth rates, and who came of age during a period with relatively high levels of illicit drug use and medication misuse). This upward trend in the number of older persons who use drugs is likely to continue as the remainder of this generation make the transition into old age.[5]

[1] *World Population Ageing 2019: Highlights* (United Nations publication, 2020).

[2] WHO, Fact sheets, "Ageing and health", 5 February 2018.

[3] Ibid.

[4] *World Drug Report 2018,* booklet 4, *Drugs and Age: Drugs and Associated Issues Among Young People and Older People* (United Nations publication, 2018).

[5] Sarah Wadd and Sarah Galvani, "The forgotten people: drug problems in later life – a report for the Big Lottery Fund—July 2014", (Luton, University of Bedfordshire, 2014).

6. Limited epidemiological data exist on the extent of substance use among older persons. In general, comprehensive and long-term data on substance use are available mostly for high-income countries, with the age range normally considered being 15–65. Information on substance use among people above the age of 65 is limited even in countries in which regular drug use surveys are undertaken. Data collection on substance use has focused on the general population (15–65 years of age), young people, young adults and marginalized and at-risk groups; some groups such as women and, in particular, older persons have been neglected in such data collection. Scientifically, epidemiologically and culturally there has been a tendency to ignore older persons and this is evident from the gaps identified in the literature and in the prevailing attitudes to older persons within society. The problem of substance use among older persons has only recently been recognized as such and specific studies have only recently started to be conducted. One of the consequences of limited information and data is that, while the challenges of ageing well are recognized worldwide, the challenges of those who use drugs ageing well are not.

Defining older persons

7. Most industrialized countries consider a person aged over 65 as an older person. This definition is associated with the age at which a person is entitled to receive pension benefits, although the age for retirement is increasing towards 70 in several countries as life expectancy increases. However, the definition of older persons is not common across all cultures and societies. In many low- and middle-income countries and in non-Western cultures, the age of retirement is not institutionalized and pensions (where they exist) are not always sufficient, forcing older persons to continue working later in their life. Beyond the chronological milestone (65 years) and the economic status (retiree), other factors, such as cultural role in the community and health status may be more relevant in some societies for defining older persons.

Defining older persons who use drugs

8. Some studies across Europe have chosen 40 as the threshold for considering persons who use drugs as older.[6,7] In Wales, United Kingdom of Great Britain and Northern Ireland, people who use substances (alcohol and drugs) have been defined as older if they are aged 50 or more.[8] The Advisory Council on the Misuse of Drugs of the United Kingdom has found that, in recent years, statistics showed a demonstrable shift in the age profile of individuals accessing treatment for drug use in the United Kingdom and the ageing cohort is considered to be those aged over 35.[9] A literature review of alcohol use and alcohol use disorders among older persons in India was focused on those aged over 50.[10] For a review of health and social issues among older persons receiving opiate maintenance treatment in Norway, older persons were categorized as those aged 45 or over.[11]

9. The lack of consensus on what constitutes "older" in substance use statistics can have a huge impact on people who use drugs and on how practitioners and services work with their clients and patients.[12] It was estimated in one study that the ageing process among people with substance use problems is accelerated by at least 15 years; a range of physical health problems typical of older persons is evident among this prematurely ageing group.[13]

Global estimates of the scale and nature of the challenge

10. As mentioned above, substance use among older persons is underresearched because national epidemiological studies on drug use tend to limit the population surveyed to those aged under 65. However, some information is available, and it points to a general increase in drug use among older persons.

11. In booklet 4 of the UNODC *World Drug Report 2018,* entitled *Drugs and Age: Drugs and Associated Issues Among Young People and Older People*, it was stressed that there was evidence in some countries that the use of drugs among older persons had been increasing over the previous decade at a faster rate than among younger age groups. While there is no universal evidence, there are some statistics available that show that these changes are being observed in high-, middle- and low-income nations.

[6] Catherine Comiskey and others, *Addiction Debates: Hot Topics from Policy to Practice* (London, SAGE Publications, 2020).

[7] Lauren Johnston and others, "Responding to the needs of ageing drug users" (EMCDDA, Lisbon, 2017).

[8] Wales, United Kingdom, Advisory Panel on Substance Misuse, *A Report on Substance Misuse in an Ageing Population* (February 2017).

[9] United Kingdom, Advisory Council on the Misuse of Drugs, *Ageing Cohort of Drug Users* (June 2019).

[10] Abhijit Nadkarni and others, "Alcohol use and alcohol-use disorders among older adults in India: a literature review", *Aging and Mental Health*, vol. 17, No. 8 (May 2013).

[11] Zhanna Gaulen and others, "Health and social issues among older patients in opioid maintenance treatment in Norway", *Nordic Studies on Alcohol and Drugs*, vol. 34, No. 1 (March 2017), pp. 80–90.

[12] Comiskey and others, *Addiction Debates*.

[13] I. Vogt, "Life situations and health of older drug addicts: a literature report", *Suchttherapie*, vol. 10, No. 1 (2009), pp. 17–24.

12. In Germany during the period 2006–2015, past-year use of any drug increased more among those aged 40 and over than among younger age groups. In Sweden, past-year prevalence rates of the illicit use of any drug among those aged 55–64 was 5.8 per cent in 2017. In terms of specific drugs, the use of cannabis has been on the rise among those aged 55–64 in some of the most populated countries in Western Europe. Annual prevalence data from France, Germany, Italy, Spain and the United Kingdom show that cannabis use among those in that age group has been increasing at a higher rate than any other age group.

13. In Australia during the period 2007–2016, prevalence rates of drug use among those in the 50–59 and 60 and older age groups increased by 60–70 per cent. In Chile, the past-year use of cannabis among those aged 45–64 showed a fourfold increase over the decade to 2016, and an almost thirtyfold increase between 1996 and 2016. Similar patterns were also revealed for cocaine use, for which the annual prevalence increased fourteenfold among those aged 35–44, while it declined for those in the 12–18 and 19–25 age groups during the same period.

14. In the United States, the number of people aged 50 or older who had used drugs in the past year rose from just under 1 million in 1996 to almost 11 million in 2016.[14] In 2018 and 2019, among persons aged 65 or older in the United States there was a past-year illicit drug use prevalence of between half and one third of that among the population as a whole for most drugs (see table 1).

15. If the rates for some selected drugs (those for which a comparison is possible) from 2012 are compared with those from 2019, the increase in the prevalence of use among those aged 65 or older is evident. Between 2012 and 2019, past-year use among persons older than 65 increased three times or more for most drugs; for the population as a whole, the increase was more limited.

16. For instance, past-year prevalence of cannabis use for those aged 65 or older increased from 1.2 per cent in 2012 to 5.1 per cent in 2019 – representing a rate of increase of 325 per cent. For the total population, the increase was relatively contained, from 12.1 per cent in 2012 to 17.5 per cent in 2019 – representing a rate of increase of under 50 per cent. A similar pattern can be seen for the illicit use of other drugs. The past-year non-medical use, or misuse, of pain relievers doubled (from 0.8 per cent in 2012 to 1.7 per cent in 2019) among people aged 65 or older, while among the total population there was a slight decrease (from 4.8 per cent in 2012 to 3.5 per cent in 2019) (see table 2).

[14] Comiskey and others, *Addiction Debates*.

Table 1 Past-year illicit drug use among those aged 65 or older and among the total population, United States of America, 2018–2019

Drug type	Past-year use (percentage) 2018		Past-year use (percentage) 2019	
	65 or older	Total population	65 or older	Total population
Any illicit drug	5.7	19.4	7.1	20.8
Any illicit drug other than cannabis	2.1	8.5	2.7	8.6
Cannabis	4.1	15.9	5.1	17.5
Opioids	0.4	1.1	0.5	1.1
Pain relievers (misuse)	1.3	3.6	1.7	3.5
Cocaine	0.1	2.0	0.2	2.0
Stimulants	2.4	6.6	2.5	6.6
Hallucinogens	0.1	2.0	0.2	2.2
Methamphetamine	0.1	0.7	0.1	0.7

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019.

Table 2 Past-year illicit drug use among those aged 65 or older and among the total population for selected drugs, United States of America, 2012–2019

Drug type	Past-year use (percentage) 2012		Past-year use (percentage) 2019	
	65 or older	Total population	65 or older	Total population
Any illicit drug	2.3	16.0	7.1	20.8
Cannabis	1.2	12.1	5.1	17.5
Pain relievers (non-medical use/misuse)	0.8	4.8	1.7	3.5
Cocaine	0.0	1.8	0.2	2.0
Hallucinogens	0.1	1.7	0.2	2.2

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012 and 2019.

17. New prevalence estimates on substance use in India[15] and Nigeria[16] show, within the 45–64 age group, a considerable prevalence of non-medical use of pharmaceutical opioids and cough syrup. In Nigeria, those aged 60–64 had the highest annual prevalence rates for the non-medical use of both cough syrups (3.7 per cent) and tranquillizers (1 per cent).

18. In the Islamic Republic of Iran, a study found that environmental factors were the most common reason for drug use among older persons. Such factors included easy access to drugs, a lack of sports and recreational facilities, and friends also using drugs.[17]

19. A study on the consequences of the long-term misuse of anxiolytics and hypnotics by older persons has highlighted the risk of drug dependence that results from the long-term use of benzodiazepines by older persons.[18] In Japan, for example, an evaluation of prescription patterns for hypnotic and anxiolytic agents showed that the proportion of prescriptions for those drugs is disproportionately high among older patients.[19] The study also showed that high doses of anxiolytics and hypnotics were commonly prescribed to patients, mostly older persons, suffering from sleep and/or anxiety disorders. It was also common for such patients to be prescribed more than one medicine containing hypnotic and anxiolytic agents.

20. In the United States, people aged 65 and over make up more than 10 per cent of the total population; however, they account for 30 per cent of medical prescriptions. There is a higher prevalence of past-year use of pain relievers, tranquillizers, benzodiazepines and sedatives among that older group than among the population as a whole (see table 3). Moreover, there have been reports of widespread overuse of psychoactive drugs in the treatment of older persons suffering from dementia who are living in nursing homes, assisted living facilities or in their own homes.

[15] Atul Ambekar and others, *Magnitude of Substance Use in India 2019* (New Delhi, Ministry of Social Justice and Empowerment, 2019).

[16] UNODC and Nigeria, "Drug use in Nigeria 2018: executive summary" (Vienna, 2019).

[17] Fatemeh Kazemi and others, "Predisposing factors for substance abuse among elderly people referring to Qazvin addiction treatment centers, Iran 2017", *Journal of Qazvin University of Medical Sciences*, vol. 22, No. 5 (2018).

[18] N. N. Ivanets and others, "The efficacy of psychopharmacotherapy of late onset depression: the optimization of treatment duration", *Zhurnal Nevrologii i Psikhiatrii imeni S.S. Korsakova* (Korsakov Journal of Neurology and Psychiatry), vol. 116, No. 4 (January 2016).

[19] Takaaki Hirooka, "Excessive prescribing of hypnotic and anxiolytic drugs in Japan", *Nihon Rinsho* (Japanese Journal of Clinical Medicine), vol. 73, No. 6 (June 2015), pp. 1049–1056.

Table 3 Past-year prescription drug use among those aged 65 or older and among the total population for selected drugs, United States of America, 2018–2019

	Past-year use (percentage) 2018		Past-year use (percentage) 2019	
Drug type	**65 or older**	**Total population**	**65 or older**	**Total population**
Pain relievers	35.0	31.6	35.0	30.0
Tranquillizers	21.4	16.9	20.1	16.0
Benzodiazepines	13.0	11.2	12.6	10.7
Sedatives	9.1	6.1	8.3	5.7

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019.

21. In the UNODC *World Drug Report 2018*, a threefold increase in deaths from drug use disorders was noted among those aged 50 or over in the western Pacific[20] and the Americas over the period 2000–2015. In the United States, although the rates of drug overdose deaths increased over the period 1999–2017 for all age groups, in 2017, rates were significantly higher for those aged 25–64 (31.4 per 100,000) than for those aged 65 and over (6.9 per 100,000). However, from 1999 to 2017, the greatest percentage change in drug overdose death rates occurred among adults aged 55–64, increasing from 4.2 per 100,000 deaths in 1999 to 28.0 per 100,000 deaths in 2017.[21]

Challenges experienced in prevention, treatment and recovery across the policy domains

22. The general lack of data on substance use among older persons[22] translates into a lack of attention to the issue in the development of policies and programmes. Given the limited number of dedicated programmes and the limited collection of scientific evidence, it is difficult to identify the interventions and policies that have resulted in positive outcomes in terms of prevention, treatment and rehabilitation in relation to the use of drugs among older persons.

23. In the outcome document of the thirtieth special session of the General Assembly, entitled "Our joint commitment to effectively addressing and countering the world drug problem",[23] age- and gender-appropriate services and policies are briefly mentioned, but no emphasis is placed on the specific needs of older persons.

24. Older persons misusing drugs have different characteristics. In some studies, they are considered as falling into one of three groups: *(a)* maintainers (unchanged lifetime patterns); *(b)* survivors (long-term problem users); and *(c)* reactors (later uptake or increased patterns). In other studies, two distinct categories are identified: *(a)* early-onset use; and *(b)* late-onset use. "Early-onset" refers to drug use by those who have a long history of substance use and who continue to use as they age, while "late-onset" refers to the use by individuals who develop a new habit as older persons.[24,25,26] The development of late-onset use may be associated with the prescription of pain relief medications: such medications have the potential for misuse if prescribed inappropriately. Managing chronic illness among older persons is complex and adequate pain management is also an issue: many older persons report that they do not receive

[20] Australia, Cambodia, China, Japan, Malaysia, Mongolia, New Zealand, the Philippines, the Republic of Korea and Viet Nam, as well as the Pacific island countries.

[21] Holly Hedegaard, Arialdi M. Miniño and Margaret Warner, "Drug overdose deaths in the United States, 1999–2017", NCHS Data Brief, No. 329 (Hyattsville, Maryland, United States, National Center for Health Statistics, November 2018).

[22] For the purposes of the present chapter, "older persons" are considered as those aged over 65.

[23] General Assembly resolution S-30/1, annex.

[24] Colin Atkinson, "Service responses for older high-risk drug users: a literature review", SCCJR Research Report No. 06/2016 (Glasgow, Scottish Centre for Crime and Justice Research, 2016).

[25] Anne Marie Carew and Catherine Comiskey, "Treatment for opioid use and outcomes in older adults: a systematic literature review", *Drug and Alcohol Dependence*, vol. 182 (2018), pp. 48–57.

[26] Brenda Roe and others, "Experiences of drug use and ageing: health, quality of life, relationship and service implications", *Journal of Advanced Nursing*, vol. 66, No. 9 (September 2010), pp. 1968–1979.

adequate pain relief from their health-care providers because their use of other substances has increased their tolerance to opioid analgesics.[27] In addition, as global populations age, the proportion of older patients undergoing surgery and receiving additional medications is increasing. The use of pain relief medications is an essential part of health care; further challenges include a lack of health insurance among older persons, which may force them to procure their medications or pain relief from illicit sources. The widespread prescription of benzodiazepines among older persons and the risk of their overuse has been identified previously by the Board, when it called upon all Governments to remain vigilant to the consequences of misuse and overuse of benzodiazepines and urged the close monitoring of the consumption levels of those substances.[28]

25. The classifications of early-onset and late-onset use are important to keep in mind in the development of interventions and programmes.[29] However, regardless of classification, the ageing process can trigger psychological, social or health problems that enhance the probability of, and susceptibility to, substance use, which, in turn, aggravates pre-existing problems.

26. Service providers and health-care professionals need to consider the possibility of co-existing or pre-existing mental health disorders, such as cognitive impairment and depression, as well as complex physical presentations, such as the presence of pain, insomnia or the non-medical use of prescription and over-the-counter drugs, among older persons who use drugs.[30] For example, a review of substance use disorders in India in 2015 highlighted the overlap of substance use and medical comorbidities.[31] In a study examining adverse drug events, it was highlighted that clinicians also need to be aware of herbal or dietary supplements used by patients, who may not volunteer that information but may be prone to drug interactions. This is more pertinent for older persons, as drug sensitivity can increase with age.[32]

27. Polypharmacy, that is, the use of five or more medicines per day, be they prescription, over-the-counter or illicit drugs, is a growing problem among older persons around the world. The negative medical, nursing, social and economic consequences of inappropriate medication use and polypharmacy have been highlighted in a study reviewing the extent of them globally.[33] In that study, it was found that attempts in different countries to improve the clinical and economic outcomes of inappropriate medication use and polypharmacy included a variety of clinical, pharmacological, computer-assisted and educational programmes. The conclusion reached in the study was that new approaches to research, education and clinical practice guidelines were required that were completely different from the "single disease model" and based on palliative, geriatric and ethical principles. Such new approaches might provide fresh tools for treating and reducing inappropriate medication use and polypharmacy and may also be relevant when considering polydrug use.

28. A series of studies and reviews provide some evidence of the challenges experienced by older persons who use drugs in relation to health and community and social activities.

29. With regard to health, the main issues in relation to older persons who use drugs are:

(a) A higher risk of death from disease, overdose and suicide;[34,35,36]

(b) A younger median age at death;[37]

(c) Premature development of degenerative disorders, cardiovascular conditions, liver disease, physical pain, curtailed physical functioning, respiratory problems and diabetes;

(d) A higher risk of HIV and hepatitis C infection;[38,39]

(e) The exacerbation of other age-associated diseases

[27] Johnston and others, "Responding to the needs of ageing drug users".

[28] E/INCB/2015/1, para. 769.

[29] Rahul Rao and Ann Roche, "Substance misuse in older people: baby boomers are the population at highest risk", *British Medical Journal*, vol. 358 (2017).

[30] Ibid.

[31] Siddharth Sarkar, Arpit Parmar and Biswadip Chatterjee, "Substance use disorders in the elderly: a review", *Journal of Geriatric Mental Health*, vol. 2, No. 2 (December 2015), pp. 74–82.

[32] Paula A. Rochon, "Drug prescribing for older adults", UpToDate, 8 June 2020. Available at www.uptodate.com.

[33] Doron Garfinkel, Birkan Ilhan and Gulistan Bahat, "Routine deprescribing of chronic medications to combat polypharmacy", *Therapeutic Advances in Drug Safety*, vol. 6, No. 6 (December 2015), pp. 212–233.

[34] Johnston and others, "Responding to the needs of ageing drug users".

[35] Atkinson, "Service responses for older high-risk drug users".

[36] Sarah Larney and others, "Defining populations and injecting parameters among people who inject drugs: implications for the assessment of hepatitis C treatment programs", *International Journal of Drug Policy*, vol. 26, No. 10 (October 2015), pp. 950–957.

[37] Stephanie Yarnell and others, "Substance use disorders in later life: a review and synthesis of the literature of an emerging public health concern", *American Journal of Geriatric Psychiatry*, vol. 28, No. 2 (February 2020), pp. 226–236.

[38] Johnston and others, "Responding to the needs of ageing drug users".

[39] Atkinson, "Service responses for older high-risk drug users".

(this is particularly associated with problem opioid use);[40]

(f) A higher risk of falls, fractures, injuries and road accidents as a result of impaired driving;[41,42]

(g) Increased difficulty in conducting activities of daily living such as personal tasks concerning self-care, increased physical pain, an increase in the incidence of depression and difficulties with day-to-day life;[43]

(h) A higher risk of over-sedation, overdose, confusion and collapse;[44]

(i) A higher incidence of chronic mental health challenges.[45,46]

30. In relation to community and social activities, the main issues faced by older persons who use drugs are:

(a) The stigma associated with substance use problems may lead to a sense of shame that prevents them from seeking care, thus preventing families and health-care providers from identifying their need for care;[47]

(b) A higher incidence of financial problems, unemployment and homelessness;

(c) Limited contact with family and the community, which leads to social isolation, loneliness and exclusion;[48,49]

(d) A higher likelihood of receiving treatment as a result of contact with the criminal justice system than through self-referral or general health-care providers;

(e) Fear of being faced with a judgmental attitude from drug treatment service professionals.

31. A review of the epidemiological data and the evidence presented above points to three areas that need to be addressed in relation to drug use among older persons: *(a)* research and data collection; *(b)* combating stigma; and *(c)* the need for integrated, holistic and age-appropriate care.

Research and data collection

32. When discussing the challenges of drug use among older persons, the lack of data is one of the main problems that countries face. Because of the lack of monitoring and information, drug use among older persons is often not diagnosed; this is why it has been referred to as a hidden epidemic. Improving the measuring and monitoring of the health and well-being of older persons is a necessity in general, but an imperative in relation to those who use drugs. While recognizing that there is always a need for improvements in monitoring, it is also true that existing monitoring systems are not being adequately used. For example, data on treatment demand from existing monitoring systems could be used to improve information on older persons who use drugs.

33. **It is recommended that the age range of the population surveyed in epidemiological studies be expanded.** There is also a need for innovation and the harnessing of big data when addressing new global challenges in substance use. **It is therefore also recommended that policymakers and service providers look at using innovative assistive health technologies or drawing on existing technologies or innovative ways for coordinating the treatment of, supporting and monitoring the outcomes for older persons who use drugs.**

34. For example, remote communications systems can be used to provide access to telemedicine and can facilitate consultations with and monitoring by online health-care providers providing substance use services to older persons in rural communities. A further example of the use of remote communications systems for this purpose might be the adaptation of existing telephone or mobile telephone technologies currently used in the care and monitoring of older persons in their own homes or in the homes of family members. The development of remote communications technologies is essential to support those who are caring for an older family member.

35. The need for improvements in the assessment and monitoring of prescription drug use has also been

[40] *Ageing Cohort of Drug Users*.

[41] Marie-Claire van Hout and others, *A Scoping Review of Codeine Use, Misuse and Dependence* (Brussels, 2014).

[42] Ana Diniz and others, "Elderly substance abuse: an integrative review", *Psicologia: Teoria e Prática*, vol. 19, No. (2017), pp. 42–59.

[43] Van Hout and others, *A Scoping Review of Codeine Use, Misuse and Dependence*.

[44] Diniz and others, "Elderly substance abuse".

[45] Johnston and others, "Responding to the needs of ageing drug users".

[46] Atkinson, "Service responses for older high-risk drug users".

[47] Carol S. D'Agostino and others, "Community interventions for older adults with comorbid substance abuse: the Geriatric Addictions Program (GAP)", *Journal of Dual Diagnosis*, vol. 2, No. 3 (2006), pp. 31–45.

[48] Atkinson, "Service responses for older high-risk drug users".

[49] April Shaw and Austin Smith, "Senior drug dependents and care structures: Scotland – qualitative report" (Glasgow, Scottish Drugs Forum, 2010).

highlighted.[50] The development and use of a prescription-monitoring system has the potential to reduce, in general, but among older persons in particular, multiple prescriptions, prescription-shopping behaviour and emergency-department visits. In addition, it is important to improve diagnostic and assessment tools relevant for use in an older population who use drugs.[51,52]

36. A clear priority is the development of monitoring systems to measure the nature and extent of drug use, including the misuse of prescription and over-the-counter medications, among older persons. **The Board therefore recommends that Governments establish or extend and improve existing prescription-monitoring systems. Where monitoring systems already exist for illicit drug use, it is recommended that the common artificial upper age limit of 65 years be removed, and that the monitoring be extended to prescription and over-the-counter medications.**

37. Harnessing the power of and adding value to existing resources, including data sets, assessments and monitoring, and opportunities from novel, smart and emerging innovations and technologies are also recommended. **In terms of adding value to existing data, it is recommended that analysis and research are undertaken in relation to relevant existing national health record systems for older persons in order to provide preliminary estimates of the scale of the hidden prevalence of undiagnosed drug use, including the misuse of prescription medications, and related comorbidities among older persons.** This process should be repeated on a regular basis. Appropriate record systems might include hospital emergency department systems, out- or inpatient record systems, medication or pharmacy systems, general practitioner systems, health insurance systems and road traffic accident record systems. Where multiple data systems exist, it may be possible to use more advanced data analysis methods such as capture-recapture techniques to provide estimates of the hidden prevalence at the sub-national level.

Combating stigma

38. The global nature and challenges of substance use have been addressed at the highest international policy level. The thirtieth special session of the General Assembly, in 2016, was devoted to addressing and countering the world drug problem. In the outcome document of that session, Member States recognized drug dependence as a complex, multifactorial health disorder characterized by a chronic and relapsing nature with social causes and consequences that could be prevented and treated through, inter alia, effective scientific evidence-based drug treatment, care and rehabilitation programmes. That recognition of substance use as a global health challenge is significant in relation to addressing stigma.

39. Older persons who use drugs are more likely to suffer from stigma, social exclusion and isolation from family and friends. Such increased stigma was identified in a study of older persons in Austria, Germany, Poland and Scotland, United Kingdom.[53] In that study, it was found that the impact of stigma on older persons who use drugs can be profound and can be a significant barrier to treatment and recovery. Advocacy and practical responses to address stigma include challenging media language and stereotypes, encouraging public figures to speak out about their personal experiences, providing improved training for non-specialist staff and facilitating greater contact between people who use drugs and people who do not.[54]

40. The Canadian Coalition for Seniors' Mental Health has developed guidelines for the treatment of cannabis, opiate and benzodiazepine use within older populations.[55] A common finding was the recognition that social stigma and cognitive impairment among individuals may play a role in the underidentification of substance use among older persons. Taking into account the quality of the evidence, cost and feasibility, a set of recommendations was developed, a key one of which was ensuring that screening was non-judgmental and non-stigmatizing. In a review of substance use among older persons, the lack of recognition of the problem and the role of cognitive impairment and stigma in underdiagnoses were also identified.[56] The issue of stigma in relation to drug use in general was also recognized by the Commission on Narcotic Drugs in its resolution 61/11, entitled "Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for drug users".

[50] Rachel D. Maree and others, "A systematic review of opioid and benzodiazepine misuse in older adults", *American Journal of Geriatric Psychiatry*, vol. 24, No. 11 (November 2016), pp. 949–963.

[51] Ilana Crome, "Substance misuse in the older person: setting higher standards", *Clinical Medicine*, vol. 13, No. 6 (December 2013), pp. s46–s49.

[52] Diniz and others, "Elderly substance abuse".

[53] Shaw and Smith, "Senior drug dependents and care structures".

[54] Charlie Lloyd, "The stigmatization of problem drug users: a narrative literature review", *Drugs: Education, Prevention, and Policy*, vol. 20, No. 2 (2013), pp. 85–95.

[55] Canadian Coalition for Seniors' Mental Health, "Guidelines on opiate use disorder among older adults" (Toronto, 2019); and Canadian Coalition for Seniors' Mental Health, "Canadian guidelines on cannabis use disorder among older adults" (Toronto, 2019).

[56] Alexis Kuerbis and others, "Substance abuse among older adults", *Clinics in Geriatric Medicine*, vol. 30, No. 3 (June 2014), pp. 629–654.

41. **It is recommended that existing evidence-based prevention strategies are used to prevent the stigmatization of older persons who use drugs. It is also recommended that older persons are involved in the development of messaging to combat stigma at the community level and in professional development training for those delivering both universal and targeted prevention services. It is further recommended that anti-stigma training programmes are monitored and evaluated on an ongoing basis to ensure that they remain up to date and fit for purpose.**

42. In particular, it is recommended that older persons who use drugs are consulted and supported in the creation of messages to combat stigma that are to be used at the community level and in the creation of training for use as part of the continuing professional development of staff working in relevant services.

Need for integrated, holistic and age-appropriate care

43. Beyond the problem of stigma as a barrier to the recognition of the problem of drug use, **it is recommended that Governments develop effective service responses for older persons who use drugs**. These should include the co-treatment of multiple issues, such as those relating to physical health, mental health and drug dependence. Ongoing personal support should also be offered. A seamless continuum of care is needed to ensure that older persons who are struggling with a substance use disorder are adequately supported, from screening through to recovery. *The Global Strategy and Action Plan on Ageing and Health*[57] also addresses integrated care. Within the plans for integrated care it is highlighted that long-term care services need to be oriented around the functional ability and well-being of older persons. It is specified in the strategy that this can be achieved through care that is integrated across many professions and settings, as well as condition- and care-specific services. Dementia and palliative care services are given as examples, but the recommendations are relevant for drug dependence and mental health services. The International Association for Hospice and Palliative Care has also reiterated the need for training and access to internationally controlled essential medicines with regard to the treatment of severe pain, mental health conditions, substance use disorders and palliative, end-of-life care. It has highlighted the need to address ageism, the right to pain relief as part of palliative care, the importance of global access to essential medicines, and the lack of training among health professionals in those areas.

44. A study[58] comparing the effects of substance use and mental health services when integrated into primary care with the effects of such services when using enhanced referral to outside providers found that, although no differences in clinical outcome between the two models of care were noted, access to and participation in mental health and substance use services were found to be significantly better in the integrated care model. These findings could potentially be used to address benzodiazepine and opioid misuse among older adults in primary care settings.

45. The Royal College of Psychiatrists of the United Kingdom, in its information guide on substance use in older persons, recognizes that it is usual for people to be assessed and treated within a range of services, both in parallel and sequentially. To ensure appropriate referral and to improve the quality of care and of outcomes, it is important to work within a model of coordinated care where there is a lead service with a defined coordinator.[59]

46. The Geriatric Addiction Program was developed in the United States to meet the needs of older adults experiencing a range of problems related to drug dependence and general health. While the majority of clients were referred to the programme for alcohol problems, approximately 15 per cent had comorbid drug problems. The programme was a community-based intervention programme and focused on providing substance use intervention, assessment and linkage services for older adults from their own homes. The evidence from the programme demonstrated positive outcomes but, in spite of that, the programme has not been widely replicated.[60]

47. In general, research has shown that older persons who need assistance not only prefer to be cared for in their own homes rather than within formal institutions or nursing homes, but also prefer to be cared for by informal caregivers or family members instead of professionals and formal carers. Indeed, in many cultures and societies,

[57] WHO (Geneva, 2017).

[58] Maree and others, "A systematic review of opioid and benzodiazepine misuse in older adults".

[59] Rahul Rao and Amit Arora, *Substance Misuse in Older People: An Information Guide*, Faculty Report No. OA/AP/01 (London, Royal College of Psychiatrists, 2015).

[60] D'Agostino and others, "Community interventions for older adults with comorbid substance abuse".

it is the norm for older persons to live with and be cared for by their adult children or younger siblings.[61]

48. Domiciliary outreach, according to the UNODC and WHO *International Standards for the Treatment of Drug Use Disorders*, is work undertaken in the homes of target populations.[62] This is important in areas where people who use drugs are isolated from their communities because of stigma and discrimination. Domiciliary outreach involves regular visits to the homes of people who use drugs or of their family carers. Drug treatment programmes that include domiciliary outreach and integrated care and are specifically targeted at older persons living in their own homes or in the homes of family members who are caring for them have the potential to create substantial cost savings and to reduce unnecessary suffering and the burden of care on family members and relatives.

49. Peripatetic outreach is work undertaken in settings where people are either already accessing some services or where target populations are highly likely to be encountered (for example shelters for homeless older persons, or housing projects). Instead of focusing on individuals, peripatetic outreach focuses on organizations and settings where target populations can be found. Peripatetic outreach places emphasis on broadening the range of people who receive health education messages, and on training more workers and staff to provide education and outreach to their clients.

50. The need for a wider holistic view of treatment and recovery for substance use reflects the changing concepts of recovery in mental health services and also reflects the principles of the Convention on the Rights of Persons with Disabilities, which adopts a broad categorization of persons with disabilities. Pursuant to article 4 of that Convention, States parties are to undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. Moreover, the International Covenant on Economic, Social and Cultural Rights recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Regardless of the age of a person or the balance of economic costs and benefits to society, it is a basic and equal human right for both older and younger people to receive appropriate treatment for substance use dependence. As the needs of older persons who use drugs have been demonstrated, in studies across the globe, to be both unique and complex, it is imperative that a flexible and adaptable model for a coordinated continuum of integrated care be developed. It is important that policies and practices are used to work towards developing a comprehensive integrated care system for older persons who use drugs.

51. Implicit in the definition of integrated care is the notion that care should be centred on the needs of individuals, their families and communities. There is a need for cross-cutting clear leadership, expert guidance and direction that transcends the priorities of a single policy domain and places the older person at the centre of the solution. **In terms of participation, be it in health or wider social and security policy, it is recommended that older persons who use or have used drugs be included as part of the integrated care policy development process.**

52. **In terms of ensuring access to a continuum of care for older persons who use drugs, it is recommended that existing outreach services for people who use drugs be expanded or developed to include domiciliary and peripatetic services and that those outreach services be used as a gateway or entry point to a continuum of integrated care for the most marginalized of older persons who use drugs.**

53. Historically, older adults are less likely, in comparison with other age groups, to be screened for substance use and there are several factors that inhibit screening and subsequent identification of drug use. These factors include possible clinician discomfort in assessing for drug dependence, the similarities of the symptoms of substance use with other illnesses common in later life and the common perception among older adults that symptoms resulting from the use of drugs are part of normal ageing rather than resulting from the substance use itself. Furthermore, in some cultural and social settings, drug use may be seen as being one last pleasure or indulgence afforded to older persons.

54. **The screening and assessment of older adults for drug use are recommended, and improvements to such screening and assessment are also recommended. It is further recommended that existing screening and assessment instruments and evidence-based programmes currently in use for older persons who use drugs be culturally adapted for older persons from varying societies and backgrounds.**

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[61] Catherine M. Comiskey and others, "The BREATHE Project, a mobile application, video-monitoring system in family homes as an aid to the caring role: needs, acceptability and concerns of informal carers", *Digital Health*, vol. 4 (2018), pp. 1–8.

[62] UNODC and WHO, *International Standards for the Treatment of Drug Use Disorders: Revised Edition Incorporating Results of Field-Testing* (Geneva and Vienna, 2020).

55. In line with best practice and the WHO priorities for ageing it is recommended that a system of integrated care be established for older persons who use drugs. In services that support older persons, other than drug use treatment ones, there needs to be an awareness of and information about the potential for substance use by clients, the impact this may have, and how it can be alleviated. Moreover, there needs to be more awareness of referral pathways to services for the treatment of substance use disorders. Work towards an integrated care system will ensure that older persons who use drugs receive seamless care when and where they need it, be it from their primary care provider performing a medication review to their potential treatment for existing or future drug use- or age-related comorbidities. At the individual level, this may involve the development of guidance documents and care pathways for primary care providers and general practitioners, as well as guidance documents and shared care protocols for systems of care. Such protocols would outline the roles and responsibilities of staff within organizations and provide a means of inter-agency partnership and referrals between specialized and recovery services on the one hand and health- and social-care services on the other.

56. It is recommended that countries involve older persons who use drugs in the development of services. Listening to and acting on the views of service users are vital parts of the planning and delivery of health-care services for all citizens.

57. Given the commitment by Member States in the outcome document of the thirtieth special session of the General Assembly to age- and gender-appropriate services, **it is recommended that any policies developed for older persons who use drugs be underpinned by the principles of independence, participation, care, self-fulfilment and dignity, as set out in the United Nations Principles for Older Persons,[63] and should be developed using *Active Ageing: A Policy Framework*[64] and the *Global Strategy and Action Plan on Ageing and Health.***

Moving forward

58. In 2020, an unprecedented and unexpected pandemic raged across the globe, ignoring borders and other boundaries. The COVID-19 pandemic is having an impact on the global population in drastic ways, with older persons facing the most severe threats and challenges at this time. Although people of all age groups are at risk of contracting COVID-19, older persons face a significant risk of developing severe illnesses owing to physiological changes that come with ageing and potential underlying health conditions. A group that is particularly vulnerable is older persons who use drugs and, as the pandemic continues, countries should ensure that older persons who use drugs are provided with focused and appropriate health and social support to enable them to survive the pandemic while preventing drug use and its associated consequences.

59. The needs of older persons who use drugs range from individual needs to family, community and system and service needs. Health needs can be complex for all older persons and even more so for those who use drugs, particularly if those drugs have originally been prescribed by health professionals or if the substance use is a chronic relapsing condition, ranging from the inappropriate use of alcohol to the misuse of opiate pain medications and others. Other needs may be related to the fear of elder abuse; isolation from family and loss of friends; fear of stigmatization; fear of entering into contact with the judicial system; and fear of poverty and homelessness.

60. However, guiding principles, policies and good practices exist to address these very issues. Countries, communities and policymakers need to move away from a deficits-based model when addressing the needs of older persons who use drugs and need to embrace models based on citizen engagement, integrated holistic care and the co-creation of ongoing professional and community development to address stigma at the individual, family and service levels.

61. Older persons across the globe who use drugs are faced with health, security and participation challenges never before experienced on a global scale. **The Board would like to urge Member States to take action on the combined challenge of substance use and ageing in a comprehensive manner and to make use of the available scientific evidence and the recommendations in the present report (see chap. IV) to address the deficits of the past and move towards a more positive future for one of the most marginalized groups of society: older persons who use drugs.**

[63] General Assembly resolution 46/91.

[64] WHO (Geneva, 2002).