High-Risk Alcohol and Opioid Abuse Among Those 55 and Older
Participant Questions & Answers*

Special Populations

Q: Are there any differences in alcohol and opioid use in rural and urban older adults?

A: See the following resource:


Q: Are there any data on trends for women and/or rural communities?

A: Drinking is increasing among women in general. In contrast to findings for opioids and cannabis, alcohol use is not increasing among pregnant women. However, in general, the traditional “gender gap” in drinking rates between men and women has narrowed considerably in recent years, particularly among adults age 26 and older. According to the research, rural Americans are twice as likely to die from an opioid misuse as their urban counterparts and adults ages 45 and older account for nearly half of these deaths. The recorded webinar on Opioid Issues & Trends Among Older Adults in Rural America will be available at: https://www.jbsinternational.com/expertise/opioid‐epidemic/substance‐abuse‐among‐older‐adults‐webinars.

Q: Is there any differentiation in the data presented for the general population and the veteran population? Would inclusion of vets skew the results of the information?

A: Yes. Veterans have higher rates of substance abuse probably due to their higher prevalence of mental health and psychiatric disorders. If veterans are overrepresented in a community study, it could potentially skew the results.


*Participant questions that were personal in nature or that required the advice of a physician were not included.
Data Analysis and Methodology

Q: Are the U.S. drug overdose death rates per 100,000 population for 1999–2016 statistically significant (slide 31 in the PPT)?

A: Yes, the increases were significant.


Q: There was a decrease in alcohol use in one of Dr. Hasin’s slides. What time frame was that, and was there a significant event that correlated with that period?

A: Alcohol use and alcohol use disorder increased across all time frames. The decrease was in the rate of binge drinking between 1991–1992 and 2001–2002. There is no particular event that can explain this. However, the important thing is that overall the prevalence of binge drinking increased, and this increase was especially marked between 2001–2002 and 2012–2013.

National Epidemiologic Survey on Alcohol and Related Conditions-III (2012–2013)

Q: What was the method used for the survey? What question was asked to define nonmedical use?


Nonmedical use of prescription drugs is defined as taking a medication in a manner or dose other than prescribed; taking someone else’s prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high). It is important to note that nonmedical use (or misuse) of prescription drugs can be intentional or unintentional.


Q: Do any of the studies show results for older adults who are abusing alcohol and opioids together?

A: Here are some studies that show results for older adults who are abusing alcohol and opioids together:

Q: Is the increase in nonmedical drug use (slides 33 and 34) due to the aging of baby boomers?

A: The increase in nonmedical drug use is due to a combination of factors: aging baby boom population, increased availability of these drugs (i.e., via the Internet and increased prescribing), and the addictive potential of these drugs.

Risk Factors and Contributing Factors

Q: What are the reasons for increased alcohol and other drug consumption among this population, given that some of the risk factors, such as loss and grief and feeling distressed, are not new?

A: Current and lifetime illicit drug use are more common among the current 65+ population and aging baby boomers than in previous generations. This group came of age at a time when the use of drugs and alcohol became more permissive, which resulted in higher rates of drug/alcohol use when compared to previous generations. Because previous use of drugs/alcohol is a prominent risk factor for future use and the aging process brings with it major life changes and transitions (e.g. loss of mobility, loss of spouse/loved ones, loss of independence, new living situations, etc.), this generation has turned to drugs/alcohol more often. However, factors such as the increased prescribing of drugs and their high addictive potential further contribute to their misuse.

As people live longer and stay healthier longer, they may be carrying their habits with them from youth, including their drinking habits. Alternatively, since moderate drinking is thought by many to be associated with better health, some older persons may be drinking or continuing to drink for expected health benefits.

Q: Is there an evidence-based risk stratification for the S-MAST-G?

A: The Short Michigan Alcohol Screening Test—Geriatric Version (S-MAST-G) was developed as an alcohol screen for those age 60+, but there has been no research on risk stratification.

Q: Why are women more susceptible to prescription drug misuse and abuse?

A: Older women are prescribed more and consume more psychoactive medications than men, particularly benzodiazepines (BZDs), and are more likely to be long-term users of these substances. Greater use and misuse of prescription medications among older women may be connected to the loss of a spouse or partner, divorce, low income, mental health issues, or poor overall health. Reasons for drug-specific sex differences in dependence include men's preference for alcohol and the possibility that among users of psychotherapeutics, women use more heavily than men.

Q: Would early childhood trauma be a major risk factor, especially for those who have not found other solutions/resilience to live with the memories?

A: Yes. The evidence shows that early childhood trauma can lead to psychological problems such as depression, anxiety, and post-traumatic stress disorder (PTSD) which are key risk factors for substance abuse.


Clinical Questions

Q: How often should meds be reviewed by primary physicians if elders are taking more than five prescriptions at a time? I have come across elders over 60 taking up to 12–15 meds daily. How should these be reviewed?

A: The Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol (TIP) #26 Expert Panel on Substance Abuse Among Older Adults recommended screening all adults age 60+ on a yearly basis and when there are changes that warrant additional screening (e.g., major life event: retirement, loss of partner/spouse, changes in health, etc.). Additionally, a “brown bag approach,” where the clinician asks the patient to bring in all medications, over-the-counter (OTC) preparations, and herbs in a bag to the next clinical visit, is one potential means of getting reliable information about all medication use. Many states allow physicians or pharmacists to query a state database of controlled substance prescriptions without a patient’s consent. This can reveal multiple prescribers for controlled substances, such as opioid analgesics or sedative-hypnotics. Today one must also ask about any medical marijuana recommendations, prescriptions, or use. Used together, these strategies allow the provider to determine what the patient is taking and what, if any, interaction effect these medications, OTCs, and herbs may have with each other and with alcohol. OTC
preparation use often remains unevaluated in clinical settings and the use of some OTC preparations (particularly anticholinergic agents) can be problematic in combination with alcohol or prescriptions.


Q: Why are opioids associated with lower levels of pain improvement?

A: Opioids are highly effective for acute pain, but their therapeutic role in chronic pain is less certain. Dependence (both physical and psychological) can happen after just a few weeks. Their role in chronic pain is mainly to ease the suffering, rather than treat the pain.


Q: Why is there reduced efficacy for cognitive behavioral therapies (CBT) for BZD users?

A: BZDs are commonly used for insomnia, though there is no evidence suggesting that BZDs are superior to CBT.1,2 While there may be initial benefit from combining a BZD with CBT during acute treatment,3 long-term outcomes are best with CBT alone.3,4 While non-BZD medications (e.g., fluoxetine and duloxetine) and psychotherapy have greater evidence of benefit and fewer harms in treating anxiety disorders, concurrent use of BZDs reduces the effectiveness of exposure-based therapies. One possible explanation is that the use of individual doses of medication to cope has a potential to interfere with the application of behavioral skills.5,6 In addition, anxiolytic treatments have been found to interfere with the enhanced tolerance to aversive stimuli observed in animals after repeated exposure; hence, BZD treatment may interfere with some of the beneficial biological effects of exposure treatment, referred to as “biological toughening-up.”7 As with exposure-based psychotherapy of other anxiety disorders, the combination of BZD plus psychotherapy leads to worse outcomes for patients with PTSD.8


Q: **Is it possible that changing medication abruptly and starting another BZD can cause problems?**

A: Abrupt discontinuation of BZDs can induce seizures, and excessively rapid tapers can cause rebound anxiety (i.e., anxiety levels higher than those preceding the initiation of treatment). If the BZD medication change is accompanied by a change in dosage, yes, this could cause problems. If the dosage is switched abruptly to a lower dose, it could cause withdrawal symptoms, especially in high-dose and/or long-term BZD users. BZDs in general are not recommended in older adults, because they are significantly associated with falls, fractures, and cognitive impairment, and the higher the dose the higher the risk. BZDs are generally highly effective when first given, but they should generally be given only for strict indications and for a limited time (2–4 weeks) due to their high dependence/addiction potential. For withdrawal treatment, the dose should be reduced gradually.


Q: **Has there been solid research on older adults with pets and anxiety, suicide, and drug abuse?**

A: The benefits of animal-assisted therapy (AAT) for humans with mental disorders have been well documented using cats and dogs.

One randomized clinical trial of AAT with farm animals for psychiatric patients (schizophrenia, affective disorders, anxiety, and personality disorders) showed significant increases in self-efficacy and coping ability compared to the control group.¹
Researchers found positive outcomes with the addition of a therapy dog in an adult residential substance abuse population, indicating that addiction professionals could increase treatment success by adding AAT to their treatments.2

One study among the incarcerated populations showed that inmates involved in the dog-assisted therapy sessions significantly improved their social skills, reducing craving, anxiety and depression symptoms compared to the control group.3


Q: Are there OTC meds that are just as effective as the prescribed meds?

A: It depends on the pain level. For mild to moderate pain, acetaminophen is the first-line treatment in older adults. Acetaminophen is considered a safe and effective drug when used correctly. However, OTC meds are typically not effective in severe or chronic pain. See article below for more detail.


Q: Dr. Blow, you mentioned that med-related delirium or dementia is sometimes being wrongly labeled as Alzheimer’s disease. Are there specific medications that are associated with this problem? Is consumption of alcohol related to this issue? Can you refer me to more information on this topic?

A: Several medications can lead to memory impairment. Decline in cognition results from the drugs blocking muscarinic receptors; the resulting worsening of working memory, speed of processing, and praxis predict overall performance and cognitive status as well as its impairment. Acute alcohol withdrawal can elicit delirium, complete with vivid hallucinations and delusions.

One study of 107 medications revealed moderate-to-severe anticholinergic activity with many frequently used medications (e.g., oxybutinin, tolterodine, diphenhydramine, amitriptyline, thioridazine, among others), warranting caution with their use in dementia. These drug-induced anticholinergic effects can cause cognitive deficits that resemble dementia and have the potential to worsen memory in those with mild cognitive impairment.


**Data-Related Questions**

**Q:** Are the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) data available at the state and community (county) level?

A: No.

**Q:** Is there more recent research on opioid misuse/abuse or other psychoactive meds in older women?

A: Yes. Here are some resources:


**Q:** Are there studies on co-occurring use of alcohol and opioids?

A: Here are some studies:


