Excessive alcohol use and misuse of psychoactive prescription drugs represent major, but often neglected public health problems among older Americans, even among those who regularly receive health care from a physician.¹ These problems include heavy drinking, drinking and driving, medication interactions, depressive symptoms, insomnia, poor nutrition, congestive heart failure, impaired cognitive function, osteoporosis, and loss of balance leading to falls, the most common cause of fractures and accidental death in this age group.²

Evidence-based screening instruments exist that can detect harmful alcohol and other drug use in this vulnerable population. Brief interventions that can be delivered during a single primary care office visit have been tested in multiple randomized trials, including a multi-center one in the Medicare eligible age group. They demonstrate that screening and intervention significantly reduce health risks, and generate cost-savings of approximately $4 dollars for every dollar invested in providing them.³

Substance use problems in this population are not uncommon. Among 12,000 older adults living in a California retirement community, 31% of men and 22% of women reported consuming an excessive amount of alcohol⁴. Another study conducted in community clinics found that 15% of men and 12% of women age 60 and older that used any alcohol drank at levels above the limits recommended by the National Institute on Alcohol Abuse and Alcoholism (NIAAA).⁵ Analysis of the 2008 National Survey on Drug Use and Health (NSDUH) finds that 27.3% of men 65 years (2,001,279 men) and older and 10.4% of older women (694,505 women) report drinking 5 or more drinks on at least one occasion within the previous 30 days, levels that exceed NIAAA recommended limits⁶. One older adult in fifteen (6.6%) report heavy alcohol use on two or more occasions in the previous month.⁷ Although a small proportion of older men and women meet diagnostic criteria of alcohol use disorders (1.5% for men, 0.3% for women)⁸, the much larger number of older Americans who use alcohol at unhealthy amounts that can dangerously interact with other medications that they take.

Few older adults use street drugs (only 0.1% of elderly in the 2009 NSDUH met criteria of a drug use disorder)⁹. However, as many as one in four older adults take psychoactive medications (i.e., sedative-hypnotics, anxiolytics, and narcotic-analgesics) that have high abuse potential, are frequently prescribed for common geriatric conditions (e.g., insomnia, anxiety, and chronic pain), and that interact dangerously with alcohol and other prescription drugs⁹. Analysis of the 2008 NSDUH shows that 8.2% of older men and 6.5% of older women report misusing prescription psychoactive medications¹⁰. Older individuals are more likely to experience adverse side effects from these medications, and their use can lead to significant drug interactions¹¹.
Alcohol and psychoactive substance use are associated increased the risk of hospitalization, nursing home placement and death among older adults. A national study using Medicare hospital claims data found the rates of alcohol-related hospital admissions to be similar to admission rates for heart attacks. A recent study of Medicare beneficiaries found that presence of heavy alcohol use more than doubles older the risk of hip fractures. Nightly use of benzodiazepines is associated with a significantly increased risk of falls among older adults, and other psychoactive medications (sedative-hypnotics, tranquilizers, and prescription analgesics) appear to also increase risk of falls in the elderly.

Unfortunately, many physicians mistakenly believe that substance use problems are largely confined to the young. They are significantly less likely to recognize an alcohol problem in an older patient than in a younger one. As a result, these problems usually go undetected, resulting in harmful, expensive, and sometimes even catastrophic consequences.

This is demonstrated by the fact that few older adults who need substance use treatment actually receive it. In 2005, persons 65 years and older made up only 11,344 out of 1.8 million substance use treatment episodes recorded.

Physicians unaware of patients’ alcohol or drug use may inadvertently prescribe medications that dangerously interact. Patients who do not know about interactions between alcohol, illicit drugs and prescription and over-the-counter drugs that they take can seriously hurt themselves by mistake. In an examination of drug adverse events reported to FDA between 1997 and 2003, researchers at George Washington University found 3,088 reports identifying alcohol in combination with a prescription or over-the-counter drug involved with death, disability or serious injury. Nearly a third (976) resulted in death. Just three drugs – oxycodone, acetaminophen and diazepam (Valium) – accounted for 41% of the cases where alcohol was a suspect. Other drugs that dangerously interact with alcohol use include ketoconazole (Nizoral), an anti-fungal drug can cause vomiting, nausea and other effects from consumption of even a small amount of alcohol; methotrexate (Rheumatrex), a commonly prescribed drug for rheumatoid arthritis that may cause severe injury to the liver if a patient drinks; and warfarin (Coumadin), a widely used to prevent blood clots, but a small overdose can cause severe bleeding and too little is ineffective. A few drinks at one sitting increases warfarin concentrations and can lead to bleeding. A person with alcoholism who takes warfarin even when sober can break down the drug unusually quickly, leading to ineffective blood concentrations. Even though individuals over the age of 65 comprise less than 15% of the U.S. population, they account for nearly one-fourth of all adverse drug-related events that requiring an emergency department visit, and nearly half of those that result in costly hospital admission.

Many different types of drugs contribute to these events. A study of 549 current drinkers aged 65 and older reported that nearly half (46%) were taking 1 to 3 medications with substantial interaction potential, 32% were taking 4 to 6 medications, and 9% were taking 7 or more such medications. One in four who are active in their community use psychoactive medications to help them cope with mental health
problems, or painful chronic medical conditions, and 15% of drinkers living in
retirement communities use sedative or narcotic medications on a regular basis.\textsuperscript{xvi,xxv}
Thus, it is not surprising that psychoactive drugs are among the more common causes of adverse medication-related complications that require emergency medical care in elderly patients.\textsuperscript{xxiii, xxiv}

The cost to Medicare of the lack of routine screening and intervention for substance use is substantial. By applying alcohol attributable risk fractions from the CDC’s Alcohol Related Disease Impact tool to 2003 MarketScan Medicare data, Goplerud estimated the annual cost to Medicare for the illnesses and injuries caused or complicated by alcohol use\textsuperscript{xxv,xxvi}. Overall, the estimated paid claims for Medicare beneficiaries were $1,194,075 per 1,000 enrollees annually ($99.51 per beneficiary per month).

This cost was composed of $374,184 per 1,000 patients for outpatient services, $5,197 for emergency services, $735,671 for inpatient care, and $79,063 for time spent in a skilled nursing facility. One out of every six dollars spent by Medicare, more than $53 billion annually, goes to treating alcohol-related illnesses and injuries\textsuperscript{xxvii}.

SAMHSA has projected future alcohol and drug use disorders among elderly patients.\textsuperscript{xxviii} They estimate that rates in this population will rise by 44% by 2020. Thus, it is timely and critical to introduce routine screening and brief intervention for alcohol and harmful prescription drug use problems as a routine component of clinical care for this fastest growing segment of society.\textsuperscript{xxix,xxx}

\textsuperscript{v} Alcohol Researchers Prove Brief Intervention Successful In Older Problem Drinkers. NIH News. June 23, 1999.
\textsuperscript{vi} Analysis of NSDUH 2008 conducted November 29, 2009, Goplerud EN.
\textsuperscript{vii} Analysis of NSDUH 2009 conducted January 17, 2011, Goplerud EN
\textsuperscript{viii} Analysis of NSDUH 2008 conducted November 29, 2009, Goplerud EN.
\textsuperscript{ix} Analysis of NSDUH 2009 conducted January 17, 2011, Goplerud EN

Goplerud EN. Analysis of NSDUH 2009 conducted January 17, 2011, Goplerud EN


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http://www.statehealthfacts.org/comparemaptable.jsp?ind=628&cat=6

