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December 12, 2023

The Honorable Bob Casey
Chair
Special Committee on Aging
United States Senate
Washington, D.C., 20510

The Honorable Mike Braun
Ranking Member
Special Committee on Aging
United States Senate
Washington, D.C., 20510

Dear Chairman Casey, Ranking Member Braun and members of the Committee:

Thank you for your decision to hold a hearing on December 14, 2023, titled "Understanding a Growing Crisis: Substance Use Trends Among Older Adults." My name is Chelsea Boyd, and I am a Research Fellow in Integrated Harm Reduction at the R Street Institute. Harm reduction is a practical approach that helps people decrease the potential negative consequences associated with a range of activities, including substance use. At the R Street Institute, we work to advance harm reduction as a pillar of public health policy.

Regardless of age, people use substances for a variety of reasons—from managing pain to coping with stress to seeking relaxation.[i] However, that use comes with risks, both directly resulting from the nature of the substances and, for illicit drugs, due to the opaque market and unstable quality of the supply.. In recent years, substance use, substance use disorder and substance-involved deaths have been on the rise among Americans 65 years and older.[ii] However, not all people who use substances have a substance use disorder. For example, although roughly 16.5 percent of adults 50 years and older use illicit drugs, only about 5.3 percent of this group have a substance use disorder, which is defined as continuing a pattern of use despite it causing "significant problems or distress."[iii] As such, harm reduction represents an essential tool to improve the health and extend the lives of older adults across the United States.

Opioid Use, the Overdose Crisis and Older Americans

More than 100,000 Americans died of a drug overdose last year, largely the result of an illicit drug supply that is increasingly unpredictable and adulterated with potent synthetic opioids such as fentanyl.[iv] Older adults are not immune to this crisis; in fact, they may be especially vulnerable.

Compared to their younger counterparts, Americans 65 and older are more likely to be prescribed prescription opioids, and more likely to take these medications for extended periods.[v] While these medications can be important tools in helping individuals manage the chronic aches and pains of later life, they also come with risks. In recent years, a growing proportion of older adults have sought treatment for opioid use disorder.[vi]

While it is tempting to address the increase in opioid-related suffering by restricting prescribing or reducing supply, history tells us this approach can actually create harms of its own. When policy pushes prescribers to drastically and rapidly cut doses of opioid medications without managing withdrawals or providing effective analgesic alternatives, many people—regardless of age—turn to the much more dangerous illicit market.[vii]

In fact, this phenomenon has likely contributed to the recent rise in overdose deaths in older adults. In 2020, more than 5,000 adults aged 65 and older died of a drug overdose.[viii] Although this accounts for a small proportion of the deaths among people 65 years of age and older, the rate has been increasing. And as with the country's broader overdose crisis, synthetic opioids such as illicitly manufactured fentanyl account for much of the most recent increase. From 2017 to 2020, the death rates involving prescription opioids such as oxycodone or hydrocodone stayed relatively constant, whereas those involving fentanyl and related substances rose by 53 percent.[ix]

Thus, rather than focusing on supply-side interventions, we encourage you to look to harm reduction. One of the most effective tools for preventing overdose death is naloxone, often referred to by the brand name "Narcan." Naloxone comes in different formulations and can be administered through a nasal spray or an injection into the muscle or vein. Studies find that policies and programs that ensure access among people who use opioids can reduce overdose death by up to 21 percent.[x] Recently, the Food and Drug Administration (FDA) approved the easy-to-use intranasal formulation for sale over the counter.[xi] This has the potential to increase access to the lifesaving drug by reducing pharmacy-related barriers such as stigma and privacy concerns. However, a potential limitation of intranasal naloxone's shift to over the counter status for older adults is that Medicare does not cover over the counter medications.[xii] For older adults, this may make purchasing naloxone over the counter unaffordable, since the price for a two-pack of the drug is around $45.[xiii] Although Medicare will pay for naloxone if it is prescribed, needing to get a prescription minimizes the potential impact of naloxone being available over the counter. For this reason, policies that provide alternative means of distributing free or low-cost naloxone, such as co-prescribing naloxone with opioids, using vending machines to distribute naloxone and implementing first responder leave behind programs are still vital to harm reduction efforts.

Other harm reduction strategies can help decrease risk from medical and non-medical use of opioids. Implementing policies that allow pharmacists to sell syringes without a prescription can reduce risk for wounds and infectious disease transmission.[xiv] Expanding access to medications for opioid use disorder by continuing to reevaluate and reduce excessive government restrictions helps

people improve their quality of life and reduce the risk of overdose.[xv] Even encouraging people who take medication to use a pill organizer to prevent accidental overconsumption, and educating healthcare providers and patients about the need to review medications for potential drug-drug interactions are helpful harm reduction strategies.

Beyond Opioids: Older Adults Deserve an Integrated Approach to Harm Reduction

While the risks of opioid use receive the most attention in the media, it is important to recognize that many older adults face risks associated with using the legal, non-prescription substances, tobacco and alcohol.

Tobacco

Unlike among younger populations, combustible cigarette smoking rates have remained largely consistent between 2011 and 2022 among people 65 year of age or older.[xvi] For people between the ages of 40 and 64, combustible cigarette smoking has declined relatively slowly, as well.[xvii] This is particularly concerning since about 300,000 of the roughly 480,000 smoking related deaths each year occur among people aged 65 or older.[xviii] Despite this, there are still benefits to quitting smoking at an older age. According to the National Institute on Drug Abuse, a person who quits smoking after the age of 65 might add two or three years to their life expectancy.[xix]

A harm reduction approach to smoking can include using FDA approved pharmaceutical cessation aids, decreasing the number of combustible cigarettes consumed, or switching to a non-combustible tobacco product (e.g. e-cigarettes, oral nicotine pouches, heat-not-burn devices), depending on the individual's goals. One study found older adults who decreased the number of combustible cigarettes smoked had a lower risk of death from any cause compared to older adults who increased or maintained the number of combustible cigarettes smoked.[xx] This study suggests that while people improve their health and decrease their risk of death the most by quitting smoking, there are benefits to reducing combustible cigarette consumption if a person chooses not to quit completely. Although not risk-free, e-cigarettes are less harmful than combustible cigarettes, and a Cochrane Review of the scientific evidence found that e-cigarettes increase quit rates compared to nicotine replacement therapy, switching to an e-cigarette can be considered another harm reduction approach to tobacco use for older adults.[xxi]

Policies that ensure older adults have access to a range of options to reduce the harm from combustible cigarette use are especially important for older adults. This includes access to behavioral support as well as pharmaceutical and consumer nicotine products that present fewer risks than combustible tobacco use.

Alcohol

Alcohol is the most commonly used drug among older adults.[xxii] As shown earlier, most older adults who consume alcohol do not have alcohol use disorder; however, that does not mean that this consumption is without risk.

Although alcohol use by itself can be harmful, it can be particularly risky when mixed with medications that interact with alcohol. Studies suggest that 18-39 percent of older adults consume alcohol and take medications that could interact with alcohol.[xxiii] Combined use of medications and alcohol can increase the risk of falls among older adults, which are a leading cause of injury and injury-related mortality.[xxiv] In this case, communication with healthcare providers and education about the risks associated with using alcohol with prescription medications are important harm reduction strategies.

For older adults who do have an alcohol use disorder, there are medications that can help manage alcohol use. Naltrexone is one medication that can help people decrease their alcohol consumption or abstain completely (though it should be noted that naltrexone cannot be used by patients who use opioids concurrently).[xxv]

What Could Substance Use Harm Reduction Look Like for Older Adults?
As described above, harm reduction is an approach that can benefit people of all ages, regardless of the substance(s) used and whether they use recreationally, medically or are suffering from a substance use disorder.

The approach focuses on meeting people where they are, without judgment, and empowering them to improve the quality of their lives.[xxvi] All the while, harm reduction does not minimize or ignore the potential harms associated with risky behaviors.[xxvii]

The examples provided in this letter represent only a fraction of the harm reduction strategies available to individuals, communities and policy makers. Since the spectrum of reasons for substance use is broad, no single harm reduction intervention will work for every person who uses substances. This is why it is important to consider a wide variety of policies to address substance use among older adults.

Thank you again for holding this important hearing and for your consideration of my views. Should you have any questions or if I can be of assistance to the Committee, please do not hesitate to contact me.

Sincerely,

Chelsea Boyd

Research Fellow
R Street Institute

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