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Testimony to the Senate Special Committee on Aging
Understanding a Growing Crisis: Substance Use Disorder Among Older Adults
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I would like to thank Chairman Casey, Ranking Member Braun, and all the honorable members of this Committee for facilitating this hearing and for the opportunity to testify on this important topic. It is a deep honor to be asked to return to the Special Committee to focus on substance use disorders and older adults. In my initial testimony in 2018, I noted a growing need for opioid use disorder (OUDs) services for older Americans. This is true beyond OUDs. Older adult communities are experiencing challenges accessing treatment and recovery support services for all substance use disorders (SUDs). This is in a large part because stigma creates unique challenges for systemic change to support recovery for all persons with SUDs, but perhaps none as much as in respect to our older adults because of the additional challenge of Ageism.

The most significant challenge facing older adults with an SUD are the prevalent negative attitudes that exist about addiction and recovery so very prevalent in our society. As background, in February of this year, Elveyst and PRO-A, the organization I lead, released the largest survey on substance use and recovery related stigma in healthcare conducted in the US, titled, OPPORTUNITIES FOR CHANGE - An analysis of drug use and recovery stigma in the U.S. healthcare system. We found that only around one in three health care providers surveyed think that a person who uses drugs or alcohol problematically would be able to maintain recovery. We found similar rates beyond healthcare workers. If Americans do not think that recovery is the probable outcome when we support the recovery process, we will not make headway. When we factor in ageism and the false notion that older people are set in their ways, that they perhaps not worth the effort, we can begin to grasp the scope the magnitude of the challenge in creating services for older adults to help them heal.

When people seek help and find healthcare professionals who do not think people like me can recover, we far too often give up. Recovery is highly probable if people get what they need to heal, although that does not occur nearly as often as it should. This is particularly true for our older adult community members. We ignore them when they are suffering. We often do not even identify SUDs as related to their deaths because of the underlying stigma. So, when our older friend or neighbor has an alcohol use disorder and dies from a fall while intoxicated, it gets recorded as a fall. When they die from a substance use related medical cause, the underlying root cause of SUDs are rarely even documented.

Stigma prevents older patients from reporting they have a problem, the medical community in asking patients questions about substance use and it even prevents family members from seeking help for their loved one. As a result of these dynamics, perhaps the most significant fact here today is that we do not know the true prevalence of SUDs in this population.

The people, the problems, the solutions, and the value of these people remain largely invisible to our society.

I am grateful to this committee for creating a space to talk about this critically important issue. We cannot solve problems we do not acknowledge. As a person in recovery for 38 years, is a poignant lesson life lesson when considering this topic. Older adult SUDs are not the focus of medical training. They are not a focus of social work training; they are not a focus in adult care homes or any of our systems of care. We have a long way to go. We need to acknowledge that as well. Our older adult family members, friends and community members who have SUDs need us to do so far more often, and then to fix our systems to help them heal.

Ageing demographics – We have an aging population. Those twenty-year-old kids from 1968 are 75 years old this year. Their substance use dependency rates have remained higher than prior generations as they age. We are seeing similar trends in those of us who came after them, which suggests we should be preparing for an increased prevalence of need for substance use services for older adults moving forward. The median age in America in 1980 was 30. According to U.S. Census Bureau data, last year it set a record of 38.9. In that same year, in my home state of Pennsylvania, the median age was 40.9 years old, the oldest median age in the nation. Pennsylvania currently ranks fifth among 50 states when it comes to the size of its population aged 65 and older (2.2 million). The demographics reveal that our population of older adults will be increasing over the next 20 years. We will need to think more critically about what we do with respect to older adults. There are going to be even more of us in the coming years. We cannot afford to ignore their needs any longer.

Substance use, dependence, & addiction mortality trends in older adults - Substance use related mortality is increasing in older adult populations. While younger people are more likely to use drugs, the rate of drug use in people over 40 is increasing faster than it is among younger age groups. The drug-related deaths for users over 50 increases 3% annually. 75% of deaths from SUDs are among users aged 50 years and older are caused by opioids. 6% of drug deaths among 50-plus users are from cocaine and amphetamines, and 13% are from other drugs. In 2020, alcohol-induced causes were recorded as the underlying cause of death for 11,616 adults aged 65 and over and age-adjusted death rates for alcohol-induced causes have been increasing since 2011 and rose by 18.2% from 2019 (17.0 deaths per 100,000 standard population) to 2020. We need to get ahead of this curve by providing prevention, treatment, and recovery community support for older adults.

COVID Pandemic isolation and older adults in the US - The COVID-19 Pandemic resulted in strain on older adult communities in ways that will be with us for decades. According to the CDC, COVID-19 was the underlying cause of death for 350,381 people in 2020. Although COVID-19 can affect people of any age, older adults were especially impacted. 81% of COVID-19 deaths in 2020 (282,836) occurred among those aged 65 and over. In this age group, COVID-19 was the third leading cause of death, after heart disease and cancer. It was highest in marginalized communities. Traumatic loss became all too common among older adults.

The isolation of older adults to protect them from the virus also had consequences, social isolation causes a variety of problems for older adults including depression, anxiety, cognitive dysfunction, heart disease, and mortality. As noted by the former surgeon general, Vivek Murthy, loneliness is a major concern for older adults. He states, “the most common pathology I saw was not heart disease or diabetes; it was loneliness.” Social isolation has been associated with increased cardiovascular disease risk, inflammatory processes, increased dementia risk, disability, cognitive decline, and reduced quality of life. In a large study of middle-aged and older US adults during the first wave of the COVID-19 pandemic, it was found that changes in alcohol consumption were associated with depression, anxiety, and loneliness.

Older adults with SUDs often have complex care needs requiring specialized care - When older adults seek help, they typically have comorbid conditions that can complicate the substance use treatment and recovery support process. Physically, this can include common medical consequences include liver damage; immune system impairment; cardiovascular, GI, and endocrinological problems. Depression and anxiety issues also occur at a higher incidence rate for older adults with SUDs than in other older adult populations.

The kinds of complex care that these patients need to stabilize in the very earliest stages of healing are in short supply. These kinds of programs typically provide structured residential care with more intensive medical and psychological care than the average younger substance use typically required. Drug use patterns

have become more complex across all age groups. We are seeing more debilitated patients in earlier stages of the life span. An example would be the rapid increase in the use of fentanyl in combination with xylazine. These cases often require similar intensive combinations of medical care in coordination with addiction services. While the combination of these drugs and the debilitating impact that they have on the body are not things we are commonly seeing in older adults, this trend is creating competition for a finite resource, residential beds designed for physically debilitated patients. We need this infrastructure now.

We have a handful of beds for these types of patients in PA and beyond that are available across all age categories. These trends will likely continue into the near future, and unless we build this infrastructure, competition for these beds means it is unlikely older adults will be able to access the care they require.

SUD Workforce strains impact the efficacy of services – On the eve of COVID-19, the Annapolis Coalition released a report commissioned by SAMHSA noting a severe national workforce shortage across our behavioral health system. They calculated that nationally we will need an additional 1,103,338 peer support workers and 1,436,228 behavioral health counselors, as part of the 4,486,865 behavioral health workers estimated to fill workforce gaps. Following the dramatic labor changes and increased demand for behavioral health services that started with the COVID Pandemic, this worker gap is increasing. These estimates now seem overly optimistic.

Our SUD workforce has been in a crisis state for decades. The pandemic and demographic shifts in the US labor force have created additional challenges. Programs lose staff at an increased rate, placing strain on those who remain. Positions stay open as there are fewer candidates, which means programs cannot serve as many people. This costs human lives and resources. When people are left untreated or unsupported, the burden shifts to healthcare, human service, and criminal justice systems. People can lose their lives.

SUD service programs find themselves in a perpetual state of orienting new staff with a dearth of seasoned staff who possess the critical institutional knowledge and skills that need to be transferred to these newer staff members. This tends to increase the turnover rate in a negative feedback loop. This results in additional challenges, particularly for programs serving older adults because these programs tend to be more demanding on staff and require more seasoned workers, many of whom themselves are among those also now retiring.

These strains are most pronounced in publicly funded programs which we need to serve older adults because they simply cannot afford to compete with private organizations for seasoned staff because of lower reimbursement rates across the public sector.

We need to shift our SUD service system to focus beyond acute stabilization – As my distinguished colleague Deborah Steinberg of the Legal Action Center will note, we do not cover all of the treatment services older adults require to sustain recovery from an SUD. Roughly 85% of people who sustain five years of recovery remain in recovery for life, but older adults don't get a full continuum of support, because we do not fund it.

Consider how we treat cancer with varied interventions, support, and regular checkups over the long term as practitioners work with their patients to achieve the goal of five-year remission. We should set the goal of getting more people to achieve five-year remission from SUDs and ensure that a continuum of care is available. While we do not do so for any age group, the age group we have the least resources available for is our older adult community. How we treat older adults is an important measure of our society's quality of life. We need to improve on this long-term recovery measure. We have a long way to go, but the effort to move our care system in this direction for older adults and every other age category is a vital one.

Needs Moving Forward

Service infrastructure for older adults – Ensure we have the care infrastructure in place to serve older adults in need of treatment and recovery support services across a continuum of healing. We should do so much in the same way we provide care for other chronic conditions. This would require sustained investment to create and support, yet would yield improved quality of life for our older adult community members while ensuring that they remain contributive members of our society. Everyone would benefit.

Invest in our SUD Workforce – Our field requires a new generation of workers who are retained in our field across a career span. Unlike other labor sectors, we have a pool of people in recovery who are eager to do this work, but far too often face significant barriers to get into and remain in the SUD workforce. We should invest in the recruitment and retention of staff to work with the diverse population of older adults across our nation.

Fund the full continuum of services to support long-term recovery for older adults – Ensure that the gaps in treatment funding that exist across Medicare and Medicaid and other funding streams are filled. This would help expand our focus for recovery support beyond acute care, just as we do for other chronic conditions.

Include older adults in the planning and of efforts to support their needs – In my home state of PA, Governor Shapiro signed an executive order earlier this year to develop a Master Plan for Older Adults. It is a 10-year strategic plan designed to transform the infrastructure and coordination of services for older Pennsylvanians. It recognizes that PA is diverse geographically, racially, and socioeconomically. It includes a focus on SUD treatment and recovery needs. This is a vital step to identifying not only the challenges our older adult community members face, but also their inherent strengths and talents that they offer our society.

Create an Older Adult Recovery Community Corp to better utilize the skills and talents of our older adult recovery community members – Service to others is an inherent value of the recovery community. There are millions of older adults in recovery who could support efforts to help others heal. Older adults in recovery face the same inherent challenges of increased isolation, loss of purpose and loss in social support that is often associated with the aging process. It is likely that leveraging older adults in recovery to support the hope, purpose and connection for other older adults would be beneficial to all involved, including these volunteers.

By the year 2060, it is projected that 98 million, or nearly one in four Americans will be age 65 or over. As our society ages, the most important thing we can do is to better harness the inherent strengths and accumulated life experiences of our older adult community members. They are our nation's most significant underutilized human resource. An Older Adult Recovery Community Corps focused on mentoring efforts to assist other older adults into sustained recovery is perhaps the most important thing we can invest in at this time. It would result in an increased sense of hope, purpose, and connection across the diverse communities of older adults that extend across our great nation. It would save lives and resources.

It was an honor to testify here today on this vitally important issue, thank you.

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