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Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Editorial

Addressing Problems With Alcohol and Other Substances Among Older Adults During the COVID-19 Pandemic

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The COVID-19 pandemic poses great challenges for older adults and their families, support systems, caregivers, and medical and mental health care providers. Increased mortality among older adults following infection with SARS-CoV-2, the novel coronavirus, is now well established. Older people already are vulnerable to the detrimental effects of isolation and face disproportionate adverse consequences from social distancing and shelter-in-place guidelines, which may trigger or worsen anxiety, depression, substance use, and other psychiatric disorders. As long as social distancing guidelines remain in place, older adults in recovery from substance use disorders may find themselves cut off from support if they are unable to effectively use online treatment and self-help resources. Here we outline several key areas of clinical concern for mental health providers who work with older patients as well as issues for consideration in future COVID-19 research.

UNHEALTHY ALCOHOL USE

Alcohol is the substance most commonly used across the age span, and can lead to severe medical, functional, and psychiatric problems for older adults, as well as sleep disruption, falls, and other injuries and accidents. Unhealthy alcohol consumption is associated with a number of chronic medical conditions common in older adults.[1] Of particular concern, suicide risk is elevated among older adults with both depression and alcohol use disorders[2]. In 2015–2017, 10.6% of adults over 65 reported unhealthy drinking (5+ drinks in a day for men/4+ drinks in a day for

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women) in the prior 30 days, an increase over previous years.[3] Current National Institute of Health guidelines recommend that adults age 65 and over consume no more than 7 drinks per week and no more than 3 drinks in 1 day. However, for older adults with common medical conditions or psychiatric disorders there may be no level of safe alcohol use.

Because alcohol-related immune system impairment increases susceptibility to pneumonia and other infectious disease, minimizing alcohol consumption may be critical for older adults during the pandemic. Providers working with older patients, either in-person or using remote technologies, should ask about current quantity and frequency of alcohol use and about any recent increases in drinking that may be connected to social isolation or financial stressors, anxiety, depression, or suicidal ideation. Pharmacologic treatments for alcohol use disorders (e.g., naltrexone) and brief behavioral interventions such as motivational interviewing for patients with lower-severity alcohol problems[4] can be effectively integrated into care, even with increased use of telemedicine.

TOBACCO AND CANNABIS USE

Although tobacco use in the United States has decreased over time, about 8% of adults aged 65 and over smoked cigarettes in 2018.[5] In contrast, the proportion of adults 65 years and older who reported prior-year cannabis use increased from 2.4% in 2015 to 4.2% in 2018, with a greater increase among those who reported receiving mental health treatment or who also used alcohol.[6] There is strong evidence that smoking tobacco puts people at risk for more severe COVID-19-related symptoms; data from China indicate a case fatality rate of 6.3% for individuals with chronic respiratory disease, compared with 2.3% overall.[7] Vaping nicotine is thought to be less harmful than combustible tobacco yet there are also growing concerns that vaping nicotine may damage lungs in ways that make users especially vulnerable to COVID-19-related symptoms.[8]

In the context of the pandemic, providers should advise older adults to eliminate smoked tobacco and nicotine vaping, and encourage patients to use nicotine replacement (e.g., patches, gum) or anticraving medications such as bupropion. Among older adults, smoking cessation reduces cardiovascular and other health problems,[9] likely improving COVID-19 survival chances. For people using cannabis, edible forms of cannabis should replace smoking or vaping. Finally, providers should remain alert to adverse effects of cannabis on older adults including falls, anxiety and dependence.

PRESCRIPTION OPIOIDS AND BENZODIAZEPINES

Older adults have higher rates of chronic pain than younger adults and are more likely to be prescribed opioids (about 4% of adults age 65 and over were prescribed opioids in 2018),[10] leading to potential for dependence over time. As with younger adults, older people who misuse opioids are likely to have comorbid psychiatric and other substance use disorders. The COVID-19 pandemic poses substantial challenges to effective pain management and to addiction treatment for older adults. For those who use medications as prescribed, interruption of regular medical visits is a barrier to careful monitoring. Among individuals with an opioid use disorder who are engaged in treatment, care disruption may lead to decreased access to methadone, buprenorphine, naloxone treatment for overdose, as well as critical social services.[11] Lack of treatment access, in combination with social isolation, increases vulnerability to relapse and overdose for older adults during the pandemic.

Older adults are also at higher risk of experiencing negative effects of benzodiazepines, commonly prescribed for anxiety and insomnia.[12] Between 2010 and 2016, among older adults in the Veterans Administration, the prevalence of benzodiazepine use has ranged from approximately 9%–11% and incidence of new prescriptions has held steady at approximately 2%.[13] As of this writing, there are no published data regarding changes in benzodiazepine prescription rates associated with COVID-19; however, previous research has demonstrated increased use associated with disaster situations.[14] The American Geriatrics Society Beers Criteria strongly recommends avoiding benzodiazepine use, except in specific circumstances (e.g., alcohol withdrawal), because of the potential for cognitive impairment, falls, fractures, motor-vehicle accidents, other serious injuries, and delirium.[12] These hazards may be magnified by concurrent alcohol consumption, illicit substance and opioid use, and opioid-replacement therapy with methadone or buprenorphine.

The existing data regarding benzodiazepine use associated with disasters suggests that use of this class of medication tends to decrease to baseline levels following resolution of the disaster.[14] However, it is possible that some older adults will initiate or increase use of benzodiazepines during the COVID-19 pandemic and may continue these medications in the months following its resolution. Fortunately, there is evidence that gradual discontinuation of benzodiazepines is feasible, safe, and can be completed in primary care as well as mental health treatment contexts.[15]

SUMMARY

Older adults are more vulnerable than younger adults to the effects of substance use, including the exacerbation of chronic medical and mental health conditions. These concerns are compounded in the context of the COVID-19 pandemic. The already elevated risk of suicide in older adults has the potential to be increased by social isolation, anxiety, and depression related to COVID-19, and by alcohol and other substance use. Racial/ethnic disparities in income and insurance coverage can exacerbate these problems. It is important for future research to examine how major categories of substance use impact COVID-19 outcomes among older adults, how social isolation and mental health conditions may increase substance use among older adults, and how intervention strategies (including those offered through telemedicine) can help to mitigate substance use problems. Providers should be alert to potential increases in substance use among vulnerable patients. Risks to older adults can be addressed by helping to expand access to interventions, and by incorporating the assistance of partners, family, and caregivers in helping older patients use healthier coping techniques to manage stress as the pandemic continues.

AUTHOR CONTRIBUTIONS

Derek D. Satre, Matthew E. Hirschtritt, Michael J. Silverberg and Stacy A. Sterling have each contributed to the editorial equally.

DISCLOSURE

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