Women's Commission on Alcohol and Drug Issues of Oregon

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WINTER / SPRING **2019**

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To increase public awareness of women's alcohol and drug abuse issues and to promote services related to women throughout the state of Oregon. This means ALL women who are affected by their own alcohol or drug use or that of their family or friends.

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PO BOX 14495 · PORTLAND, OR 97293

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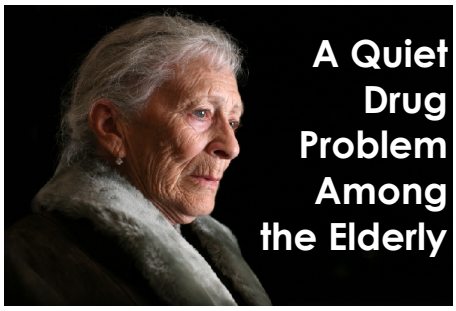
From an article by Paula Span, New York Times, Mach 16, 2018

Despite warnings from experts, older people are using more anti-anxiety and sleep medications, putting them at risk of serious side effects and even overdoses. Often called "benzos," the problem drugs include Valium (diazepam), Klonopin (clonazepam), Xanax (alprazolam) and Ativan (lorazepam).



A Quiet Drug Problem Among the Elderly

The cautions have had scant effect: Use of the drugs has risen among older people, even though they are particularly vulnerable to the drugs' ill effects. Many patients take them for years, though they're recommended only for short periods. The chemically related "z drugs—Ambien, Sonata, and Lunesta—present similar risks.

Now the opioid epidemic has generated fresh warnings, because pain relievers like Vicodin (hydrocodone with Tylenol) and OxyContin (oxycodone) are also frequently prescribed for older people. When patients take both, they're at risk for overdosing.

"Why are opioids dangerous? They stop you from breathing, and they have more power to do that when you're also taking a benzo," said Keith Humphreys, a Stanford University researcher and co-author of a disturbing editorial about overuse and misuse of benzodiazepines (published in the New England Journal of Medicine).

Numbers from the Centers for Disease Control and Prevention tell the story: In 1999, it tallied just 63 benzodiazepine-related deaths among those aged 65 and older. Almost 29 percent also involved an opioid. By 2015, benzo deaths in that age group had jumped to 431, with more than two-thirds involving an opioid. (Benzo-related deaths in all age groups totaled 8,791.) In 2016, the Food and Drug Administration issued a warning about co-prescribing benzodiazepines and opioids.

Even patients taking the drugs exactly as prescribed can unwittingly wind up in this situation, since both sleep problems and chronic pain occur more frequently at older ages. "A psychiatrist puts a woman on Xanax," Dr. Humphreys said. "Then she hurts her hip, so her primary care physician prescribes Vicodin."

But fatal overdoses — which are a comparatively tiny number given the size of the older population — represent just one of many longtime concerns about these medications.

(Continued on page 2)

"Set aside the opioid issue," said Michael Schoenbaum, an epidemiologist at the National Institutes for Health. "Way too many older Americans are getting benzos. And of those, many — more than half — are getting them for prolonged periods. That's just bad practice. They have serious consequences."

Probably the most serious: falls and fractures, already a common danger for older people, because benzos can cause dizziness. They're also associated with auto accidents, given that they cause drowsiness and fatigue.

Moreover, "they have a negative effect on memory and other cognitive function," says Dr. Donovan Maust, a psychiatrist at the Veterans Administration Ann Arbor Health Care System. Yet when Dr. Maust and his colleagues looked at a broad national sample of older adults, they found that the proportion of primary care and psychiatry visits that resulted in benzo prescriptions rose from 5.6 percent in 2003 to 2005 to 8.7 percent just seven years later, including 11.5 percent of visits by patients older than 85. Several studies show that women are more likely than men to be prescribed a benzo.

Persuading older people that benzos can hurt them — and that alternative treatments like cognitive behavioral therapy and improved sleep hygiene can be as effective for insomnia, though they take longer — has proved an uphill fight. Some people take benzos for years without increasing the dose, so describing them as "dependent" or "habituated" — let alone "addicted" — often causes angry reactions.

Nevertheless, even people who have taken benzos for extended periods without noticing any problem face potential harms at older ages, Dr. Humphreys noted.

"There's a parallel with alcohol," he said. "Maybe you had a double Scotch before dinner without problems through your 50s. In your 60s, you get lightheaded" from the same amount, because older bodies metabolize drugs differently. (Alcohol, by the way, is another substance you don't want to combine with benzodiazepines.)

Persuading users that they should stop is only the first step, however. "Weaning someone off these things when they've become habituated is incredibly difficult," Dr. Schoenbaum said. It can also lead to some dangerous withdrawal symptoms and must be done carefully and in a planned fashion.

Significant declines in benzo use among older people in Canada and Australia and in the Veterans Administration health care system in the United States show that it can be done, with more cautious prescribing and programs to help users become ex-users. ❖

Substance Use Disorders in Older Adults: A Women's Issue in Oregon

Researchers are only beginning to realize the pervasiveness of substance abuse among people age 65 and older. Alcohol and prescription drug misuse has been estimated to affect as many as 17 percent of older adults. Yet, it is difficult to find information regarding prevalence and treatment of this age group in Oregon or nationally.

The reasons for this silence are varied. It may be that health care providers tend to overlook substance abuse and misuse among older people, mistaking the symptoms for those of dementia, depression, or other problems common to older adults. In addition, older adults are more likely to hide their substance abuse and less likely to seek professional help. Many relatives of older individuals with substance use disorders, particularly their adult children, are ashamed of the problem and choose not to address it. And policy makers have not yet turned their attention to this demographic. The result is thousands of older adults who need treatment, specialized treatment, and who do not receive it.

What we do know is that the population over 65 in Oregon has increased by 64% from 2000 to 2018, and by 33% in the last eight years. And we also know that the majority of those over 65 in Oregon are women. Based on the prevalence estimate of 17%, there are about 121,800 older adults in Oregon who have an alcohol or drug problem. About 67,000 of those are women. In 2017, only 138 women over 65 received substance use treatment in Oregon (as reported by the Oregon Health Authority)!

Letters to the Editor

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Our Other Prescription Drug Problem

Excerpt from an article by Anna Lembke, M.D., Jennifer Papac, M.D., and Keith Humphreys, Ph.D. New England Journal of Medicine, February 22, 2018

The epidemic of opioid addiction and overdose has appropriately garnered national attention and led to concerted efforts to reduce overprescribing of opioids, a major cause of today's drug crisis. By contrast, there has been little effort to address inappropriate prescribing of benzodiazepines — controlled substances such as alprazolam, clonazepam, diazepam, and lorazepam. The Food and Drug Administration (FDA) has approved benzodiazepines for a diverse set of clinical indications, including anxiety, insomnia, seizures, and acute alcohol withdrawal. These drugs are also prescribed off-label for many other conditions, such as restless legs syndrome and depression.

Between 1996 and 2013, the number of adults who filled a benzodiazepine prescription increased by 67%, from 8.1 million to 13.5 million, and the quantity of benzodiazepines they obtained more than tripled during that period, from 1.1-kg to 3.6-kg lorazepam-equivalents per 100,000 adults.1 According to data from the National Institute on Drug Abuse, overdose deaths involving benzodiazepines increased from 1135 in 1999 to 8791 in 2015. Despite this trend, the adverse effects of benzodiazepine overuse, misuse, and addiction continue to go largely unnoticed. Three quarters of deaths involving benzodiazepines also involve an opioid,1 which may explain why, in the context of a widely recognized opioid problem, the harms associated with benzodiazepines have been overlooked.

Benzodiazepines have proven utility when they are used intermittently and for less than 1 month at a time. But when they are used daily and for extended periods, the benefits of benzodiazepines diminish and the risks associated with their use increase. Many prescribers don't realize that benzodiazepines can be addictive and when taken daily can worsen anxiety, contribute to persistent insomnia, and cause death. Other risks associated with benzodiazepines include cognitive decline, accidental injuries and falls, and increased rates of hospital admission and emergency department visits. Fortunately, there are safer treatment alternatives for anxiety and insomnia, including selective serotonin-reuptake inhibitors and behavioral interventions. Just as with opioids, some patients benefit from long-term use of benzodiazepines. But even in low-risk patients, it is best to avoid daily dosing to mitigate the development of tolerance, dependence, and withdrawal.

Despite the many parallels to the opioid epidemic, there has been little discussion in the media or among clinicians, policymakers, and educators about the problem of overprescribing and overuse of benzodiazepines and z-drugs, or about the harm attributable to these drugs and their illicit analogues. We believe national efforts to reduce overprescribing of opioids and to educate the medical and lay communities about their risks should be expanded to target benzodiazepines. Educators and policymakers could address the overprescribing and overuse of benzodiazepines in tandem with current efforts to curb the opioid epidemic. ❖

Reducing Inappropriate Benzodiazepine Prescriptions Among Older Adults Through Direct Patient Education

The American Board of Internal Medicine Foundation Choosing Wisely Campaign recommends against the use of benzodiazepine drugs for adults 65 years and older. A study was conducted to determine the effect of direct-to-consumer educational intervention compared to the usual care on benzodiazepine therapy discontinuation in older adults.

Delivery of an empowerment intervention to engage older adults in discussing the harms of benzodiazepine use with their physician and/or pharmacist yielded a benzodiazepine discontinuation rate of 27% compared with 5% in the control group 6 months after the intervention. An additional 11% of recipients achieved dose reductions. The effect of the intervention was robust across age, indication, dose, and duration of benzodiazepine use.

Supplying older adults with evidence-based information that allows them to question medication overtreatment appears safe and effective. Without a direct-to-patient educational component, educational efforts directed only to physicians may fail or have a smaller impact. In an era of multimorbidity, polypharmacy, and costly therapeutic competition, direct-to-consumer education is emerging as a promising strategy to stem potential overtreatment and reduce the risk of drug harms. The value of the patient as a catalyst for driving decisions to optimize health care utilization should not be underestimated.

— Study conducted by Cara Tannenbaum, Phillippe Martin, Robyn Tamblyn, Andrea Benedetti, and Sara Ahmed. Published in the Journal of the American Medical Association, June 2014.

Designing Substance Abuse Treatment for the Older Adult

The number of older adults, and thus the number of older adults with substance abuse problems, is greatly increasing in the United States. Substance abuse treatment providers will face new challenges in delivering services that address the particular needs of this growing demographic.

In 2000/2001, an estimated 1.7 million older adults were in need of substance abuse treatment. Projections suggest that this number will triple to 4.4 million by 2020. Unfortunately, opportunities are rare for older adults to get specialized help recommended for their age group, because few substance abuse treatment centers provide special services for older adults. Perhaps for this reason, the sheer numbers of SUD admissions for older adults is small. In 2005, of the 1.8 million total treatment admissions, only 11,300 (0.6%) older adults were admitted to treatment .

Suggested Treatment Approaches and Expert Panel Recommendations for Older Adults

It should come as no surprise that age-specific programs are linked to better treatment outcomes and adherence in older adults. This finding may be linked to the nature of social roles among older adults. For example, older adults rarely have the primary concerns of younger adults (e.g., family formation, employment, obtaining child care). Conversely, older adults have unique challenges that are rare among the young: widowhood, shrinkage of friendship networks, lack of means for increasing income, cognitive and physical decline leading to loss of functions such as sexuality. Thus, older adults may gain greater benefits in age-specific settings and feel more comfortable disclosing and discussing problems with same-age peers than participating in mixed-age groups in either outpatient or inpatient care.

An expert panel commissioned by SAMHSA identified the following specific SUD treatment approaches with older adults:

- Engaging in non-confrontational treatment
- Focusing on (re)building self-esteem
- Teaching skills to cope with depression, loneliness, loss
- Focusing on (re)building social networks
- Tailoring content & pace toward older adults
- Hiring staff interested/experienced working with older adults
- Providing linkages with medical services and community-based services

As the number of older adults with substance use disorders is expected to increase over the next decade, it will become increasingly more important for treatment centers to make available age-specific services by incorporating these approaches. ❖

Source:

Substance Abuse Treatment for Older Adults in Private Centers

Tanja C. Rothrauff, Ph.D., Amanda J. Abraham, Ph.D., Brian E. Bride, Ph.D., and Paul M. Roman, Ph.D.

Published on-line in the Journal of Substance Abuse, February 6, 2011

Great Source of Information on Health Care in Oregon

The Lund Report is the first, independent news website in Oregon dedicated to educating you about the inner workings of the healthcare industry. The Lund Report also hosts the Oregon Health Forum presentations which are packed with information.

The agenda for upcoming Forums and the report itself can be found at:

https://www.thelundreport.org/

Alcohol-Related Liver Deaths Have Increased Sharply

Excerpt from an article by Kate Furby
July 18, 2018, Washington Post

Deaths from liver disease have increased sharply in recent years in the United States, according to a study published in the British Medical Journal.

Cirrhosis-related deaths increased by 65 percent from 1999 to 2016, and deaths from liver cancer doubled, the study said. The rise in death rates was driven predominantly by alcohol-induced disease.

Over the past decade, people ages 25 to 34 had the highest increase in cirrhosis deaths — an average of 10.5 percent per year — of the demographic groups examined, researchers reported.

The study suggests that a new generation of Americans is being afflicted "by alcohol misuse and its

complications," said lead author Elliot Tapper, a liver specialist at the University of Michigan.

Tapper said people are at risk of life-threatening cirrhosis if they drink several drinks a night or have multiple nights of binge drinking — more than four or five drinks per sitting — per week. Women tend to be less tolerant of alcohol and their livers more sensitive to damage.

The liver cleans blood as it exits the gut. The more toxins, sugars and fats consumed, the harder it has to work. If the liver gets overloaded, its plumbing can get blocked up, causing scarring that can reduce liver function.

If people with alcohol-related disease stop drinking, "there's an excellent chance your liver will repair itself," Tapper said. "Many other organs have the ability to regenerate to some degree, but none have the same capacity as the liver," he added. He said that he routinely sees patients going "from the sickest of the sick to living well, working and enjoying their life."

The new study found that men were twice as likely to die from cirrhosis and nearly four times as likely to die from liver cancer as women. The study also found whites, Native Americans and Hispanic Americans are experiencing increased death rates for cirrhosis, along with people living in Kentucky, Arkansas and New Mexico. The one positive report from the study is the declining rate of deaths in Asian Americans from both cirrhosis and liver cancer.

The BMJ report was consistent with data issued earlier in the week by the Centers for Disease Control and Prevention. In a new report, the agency's National Center for Health Statistics said that age-adjusted death rates for liver cancer increased steadily from 2000 through 2016 for both men and women. The agency said that liver cancer had moved to the sixth-leading cause of cancer deaths in 2016, up from the ninth-leading cause in 2000. ❖

2 Million Teens Vape Marijuana

Almost 1 in 11 American students have used marijuana in electronic cigarettes. The number is worrying because cannabis use among youth can adversely affect learning and memory and may impair later academic achievement and education.
— Reported by Carla Johnson for the Associated Press.

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2019 Oregon Legislative Session

WCADIO supports the following bills to be considered during the 2019 legislative session:

- Changes definition of DUII from .08 BAC to .05 BAC

  Senate Bill 7: A person commits the offense of driving under the influence of intoxicants if person drives vehicle and has .05 percent or more by weight of alcohol in person's blood.

- Improves the criminal justice system response to domestic violence

  Senate Bill 606: Sets up a commission to improve the criminal justice system response to domestic violence

- Improves the rules regarding contracts for services under the Oregon Health Plan

  House Bill 2447: Requires OHA to provide a forum for all vertically integrated, nonprofit health care systems in Oregon to collaborate on a vision for health care delivery in Oregon's future.

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What Addiction Treatment Services Does Medicare Cover?

Medicare covers alcoholism and substance use disorder treatment in both inpatient and outpatient settings if:

- Provider states that the services are medically necessary
- Services are received from a Medicare-approved provider or facility
- And, provider sets up a plan of care

Covered services include but are not limited to:

- Patient education regarding diagnosis and treatment
- Psychotherapy
- Post-hospitalization follow-up
- Prescription drugs administered during a hospital stay or injected at a doctor's office
  - Methadone may be covered in inpatient hospital settings, but it is not covered in

outpatient clinics where it is supplied orally

- Outpatient prescription drugs covered by Part D
  - Part D plans must cover medically necessary drugs to treat substance use disorder
    - ✦ Note: Part D plans cannot cover methadone or similarly administered medications to treat substance use disorder, but they can cover methadone for other conditions, such as pain.
- Structured Assessment and Brief Intervention (SBIRT) services provided in a doctor's office or outpatient hospital. SBIRT is covered by Medicare when individual shows signs of substance use disorder or dependency. SBIRT treatment involves:
  - Screening: Assessment to determine the severity of substance use and identify the appropriate level of treatment.
  - Brief intervention: Engagement to provide advice, increase awareness, and motivate individual to make behavioral changes.
  - Referral to treatment: If individual is identified as having additional treatment needs, provides them with more treatment and access to specialty care.

Inpatient care

Part A should cover care if when a person is hospitalized and needs substance use disorder treatment. The plan's cost-sharing rules for an inpatient hospital stay should apply.

Note: If care is provided at an inpatient psychiatric hospital, keep in mind that Medicare only covers a total of 190 lifetime days.

Outpatient care

Part B should cover outpatient substance use disorder care received from a clinic or hospital outpatient department.

Original Medicare covers mental health services, including treatment for alcoholism and substance use disorder, at 80% of the Medicare-approved amount. As long as services are received from a participating provider, the patient will pay a 20% coinsurance after meeting the Part B deductible. If the patient is enrolled in a Medicare Advantage Plan, contact the plan for cost and coverage information for substance use disorder treatment. The plan's deductibles and copayments/coinsurance may apply.

Note: Some medications used to treat substance use disorder do not meet certain requirements for coverage under Medicare Part D. These medications are generally not covered by Part D or Part B. Medicare can pay for these medications during a Part A-covered inpatient stay.

Source: Medicare Rights Center

New Warning to Pregnant Women, Nursing Mothers: Stay Off Pot

Rita Giordano, The Philadelphia Enquirer (August 27, 2018)

A new report from the American Academy of Pediatrics (AAP) is cautioning pregnant women and nursing mothers to avoid marijuana due to possible adverse developmental affects in children.

The report, published in 2018 in the journal Pediatrics, is also a call for more research into the effects of marijuana on fetal and child growth and development, and a warning about the reservations that have already been raised.

"I think we have enough emerging and consistent evidence that there is reason to be concerned about a fetus' exposure to prenatal marijuana," as well as infants' exposure to "cannabis products from the mother," said Sheryl A. Ryan, lead author of the report and a professor of pediatrics at Pennsylvania State University.

"The fact that marijuana is legal in many states may give the impression the drug is harmless during pregnancy, especially with stories swirling on social media about using it for nausea with morning sickness," said Ryan, who is chair of the AAP's committee on substance use and prevention. "But, in fact, there is still a big question. We do not have good safety data on prenatal exposure to marijuana."

The appeal for caution also extends to nursing mothers who might consider using marijuana. Another article published Monday in Pediatrics reports that THC, an intoxicating component of marijuana, not only crosses the placenta and enters the brain of a developing fetus, but also has been found to be present in breast milk up to six days after a mother's last cannabis use.

That article also states that marijuana is the most commonly used illicit drug among breastfeeding women. According to the AAP, research statistics indicate that marijuana use among pregnant women has risen from 2.3 percent in 2002 to over 3.8 percent in 2014. Data from other studies suggest much higher percentages in some locations.

Both reports come when more states have made marijuana legal for recreational or medical use. Pennsylvania and New Jersey are among the states that allow marijuana to be used for certain medical purposes.

In addition, marijuana has become more potent, with average THC concentrations quadrupling since the 1980s.

Marijuana's federal status as a highly restricted, illegal substance has limited the amount and scope of research conducted on the drug, including its potential benefits and adverse effects. The AAP report notes that the existing research into marijuana and fetal and child development has its critics. Nevertheless, the studies that have been conducted suggest links between prenatal exposure and possible neurodevelopmental effects. Those include harm to children's executive function skills, such as attention, concentration, problem-solving, and impulse control.

Some research has suggested a higher risk of substance abuse disorder and mental illness among adolescents and adults who had prenatal exposure to marijuana.

"Many of these effects may not show up right away, but they can impact how well a child can maneuver in the world," Penn State's Ryan said. "Children's and teens' cognitive ability to manage their time and schoolwork might be harmed down the line from marijuana use during their mother's pregnancy."

Ryan said the hope is that more research will soon be conducted to confirm, clarify, or even put to rest some of these concerns. Pennsylvania, for example, has agreements with several universities to study the various therapeutic uses of marijuana.

But in the meantime, Ryan suggested that expectant and nursing mothers should side with caution and avoid substances that could have the potential to harm their unborn and newborn children. ❖

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