Mike Massey is a 58-year-old successful business executive, and he is also a product of the baby boomer generation. Like many men and women his age, he grew up in a time of rock music, long hair, and drug experimentation. It is no surprise that in his youth, Mr. Massey regularly got high on marijuana and cocaine. However, by his 30’s, he had stopped using drugs altogether, became successful in his career, and started a family. Fast forward to age 50, when Mr. Massey injured his knee and was prescribed opioids to manage the pain related to his injury. These prescriptions became a gateway to drug abuse after reminding him of the highs he experienced in his youth. After several episodes related to his drug abuse, including a near-death overdose and an ultimatum at work, he went into recovery and was able to stop abusing drugs in 2013.¹

Drug abuse is a problem that runs rampant in America today. As pharmacists, it is our responsibility to prevent, recognize, and minimize drug abuse, but are we aware of the growing problem of drug abuse in the elderly? The warning signs may be there for some of our patients, but because of our preconceived ideas of older people, we ignore those signs or excuse them. However, drug abuse does not discriminate based on age. As the baby boomer generation continues to age, we are expected to see a growing number of elderly patients who abuse drugs.
Drug abuse is defined by the American Society of Consultant Pharmacists’ STAMP OUT program as “intentionally taking medications that are not medically necessary, or for the experience or feeling a drug causes”. The baby boomer generation abused drugs in their youth at the highest rates of any other generation, and are also aging in an era of widespread prescription drug abuse. Experts say that these two factors together are the reasons that drug abuse rates among the elderly will continue to increase. Consider the story above; in a recent interview with the Wall Street Journal, Mr. Massey stated of baby boomers that “we know how to get high; we know the sensation. In a broad sense, once you’ve been there, it’s easier to get back into it.” Case studies published in Consultant Pharmacist tell similar stories of elderly patients in assisted living facilities who struggle with drug abuse that is not immediately recognized because of factors associated with age.

Between 1992 and 2003, while the US population increased 14%, prescriptions for controlled drugs increased by 154%. This increase comes in the context of campaigns by organizations such as the late American Pain Foundation and the American Academy of Pain Management, who launched the Let’s Talk Pain coalition to encourage patients and physicians to discuss pain, a topic that has historically been considered taboo because of drug abuse. The World Health Organization also recommends the use of opioids in their algorithms for pain treatment, even in the case of mild pain. In addition to increased opioid prescribing, doctors are working to treat mental illnesses more aggressively than ever before, which leads to an increase in the prescribing of benzodiazepines and stimulants. While the treatment of pain and mental illness are good and necessary parts of both physical and mental health, it is no
surprise that along with an increased prescribing of controlled substances comes an increase of their abuse. During the recent time frame of this sharp increase in controlled substance prescribing, the number of people abusing controlled prescriptions increased by 94%; shockingly, data shows this to be twice the increase in the number of people abusing marijuana, five times the number abusing cocaine, and 60 times the number abusing heroin. Controlled prescription drugs are now falling in line right behind marijuana, alcohol, and tobacco as the top most abused drugs in America. The most recent data from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2013 shows that, among adults aged 50-64, the rate of current illicit drug use, including prescription medications used non-medically, increased by 122%.

According to the Drug Abuse Warning Network (DAWN), which monitors drug-related admissions to emergency departments (EDs) in the US, over 1.2 million ED visits in 2011 were associated with nonmedical use of prescription medicines, over-the-counter drugs, and other types of pharmaceuticals; pain relievers were most commonly implicated, at a rate of 46%. Notably, 18.6% of these ED visits involved patients aged 55 years and older. We can compare this most current data with that of DAWN 2004 data, which reported under 500,000 ED visits related to nonmedical use of pharmaceuticals.

The 2011 DAWN Area Profiles of Drug-Related Mortality reported 7.8 drug-related deaths per 100,000 people in Virginia, and 11.8 deaths per 100,000 people in Tennessee. What are the consequences of this growing problem of drug abuse for North Carolina? According to the National Center on Addiction and Substance Abuse
(CASA) findings, 19.3% of our state’s budget is spent on risky substance abuse and addiction. Further, one cent from every dollar spent in this area pays for prevention and treatment, and 91 cents of every dollar pays for the consequences related to our state and country’s failure to prevent and treat addiction and abuse. Costs are only expected to rise in the future.

The disparity between spending on prevention and treatment and spending on consequences reflects a lack of quality programs available in our state to handle the growing problem of drug abuse. As pharmacists, we must make every effort to prevent drug abuse as we recognize it. We must also be a resource for patients who want to make a change and seek treatment. The American Society of Health-System Pharmacists (ASHP) published their Statement on the Pharmacist’s Role in Substance Abuse Prevention, Education, and Assistance in 2013. This statement lists many responsibilities we have as pharmacists because of our unique knowledge and skillset, and our position within the community. Related to prevention, we are called to develop or contribute to substance abuse prevention and assistance programs, participate in substance abuse education, discourage diversion by establishing controlled substance inventory systems, report controlled substances via the available reporting systems, and discourage prescribing practices that foster drug abuse behavior, to name a few.

We must also recognize the challenges we face when attempting to identify drug abuse in the elderly population; these challenges are partly due to stereotyping, but also due to the actual effects associated with age. Symptoms of drug abuse, including memory gaps and stumbling, are commonly experienced by elderly people, and may mimic dementia or Parkinson’s disease. Elderly people are also often
spending more time unsupervised, which allows drug abuse signs to go unnoticed for a longer period of time than would typically occur. Challenges are also involved when attempting to address drug abuse in elderly patients; abrupt withdrawal of a drug of abuse in an elderly patient may pose a greater danger due to the same physiologic changes that make this population more sensitive to adverse effects. As a generation, elderly people are also more secretive about medication habits and are less likely to admit to addiction for fear of shame or embarrassment. We must therefore be vigilant in our attempts to recognize and address the signs of drug abuse in elderly patients.

In contrast to drug abuse, we must also consider drug misuse in the elderly population. Drug misuse is defined as using medications other than as directed or indicated. This includes taking too much or too little of a drug, taking it more often than prescribed, or taking it when it was not prescribed. Examples of drug misuse include taking an old pain medication in an attempt to obtain relief from a condition unrelated to its original prescription, or taking a friend’s pain medication to obtain relief. Misuse can be seen with any drug, not just pain medication. Misuse can also be accidental, especially in the elderly population. Consider the many variables that affect the elderly patient, including vision and cognitive impairment. A patient may misuse a medication due to difficulty reading a label or identifying a pill, or due to difficulty understanding directions. Some patients may also simply believe that “more is better”, and may have a misconception that prescription and over-the-counter drugs are safe, even when taken without the supervision of a healthcare team. A case study published in Consultant Pharmacist in 2010 told of a 77-year-old man who was referred to a geriatric assessment clinic to evaluate worsening cognition. Upon review of his
history and home medications, it was determined that his mental status decline was due to gross misuse of 23 herbal and dietary supplements. The patient also had a long history of illicit drug use, which contributed to his drug misuse problem. Prior to the detailed evaluation and questioning from his physician and pharmacist, his worsening cognition was thought to be due to underlying Alzheimer’s dementia.\(^4\) Drug misuse is an area where pharmacists can have a great impact; patient education can go great lengths in preventing, identifying, and correcting drug misuse.

Drug abuse and misuse the elderly are becoming widespread within our state and nation. We are in a unique position to come alongside patients and provide support and education in every stage of life, and we can and must use our influence and knowledge to intervene in these growing problems.

References


