A GROWING CONCERN: SUBSTANCE USE DISORDERS, MEDICATION MISUSE, AND OLDER ADULTS

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In the United States, adults age sixty-five years and older currently account for 15.2% of the nation's total population.[1] By 2029, this percentage is expected to increase to more than twenty percent.[2] While these percentages may seem trivial on their own, when translated into actual numbers, the result is that over 49 million persons are currently age sixty-five and older, and that number is growing dramatically.[3] With the benefits of modern medicine and an increased awareness of healthy lifestyle choices, older adults are living longer lives compared to their counterparts in the 1950s.[4] This increase in life expectancy, however, also requires recognition that many conditions and diseases still plague older adults,[5] particularly those typically associated with younger individuals, such as substance use disorders and medication misuse.[6] Accordingly, Part I will describe the background

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1 *QuickFacts: United States,* U.S. CENSUS BUREAU, http://www.census.gov/quickfacts/table/US/PST/045216 (last visited Sept. 16, 2017) (noting that the nation's total population as of 2016 was 323,127,513 persons).

2 Sandra L. Colby & Jennifer M. Ortman, *The Baby Boom Cohort in the United States: 2012 to 2060*, U.S. CENSUS BUREAU, 1 (May 2014), http://www.census.gov/prod/2014pubs/p25-1141.pdf.

3 American FactFinder, *Community Facts*, U.S. CENSUS BUREAU, https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml (last visited Aug. 29, 2017) (click "community facts" tab, select age group, select geographical area).

4 Nat'l Inst. on Aging, *Living Long & Well in the 21st Century: Strategic Directions for Research on Aging*, NAT'L INST. OF HEALTH, U.S DEP'T. OF HEALTH AND HUMAN SERVICES, 8 (Nov. 2007), https://permanent.access.gpo.gov/lps109005/Strategic_Plan108.pdf.

5 *Id.*

6 These conditions and diseases may be overlooked for several reasons, some of which relate to the way data is collected and disseminated, with some sources grouping statistics based on age 65 years and older and others using age 55 years and older. Another reason may be the way deaths of older adults are handled, with pressure from families to *not* conduct toxicology screens on their deceased loved ones. *See* Frederic C. Blow, *Tip 26, Substance Abuse Among Older Adults: Treatment Improvement Protocol (TIP) Series 26,* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S DEP'T. OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE

information and current law necessary to understand addiction, substance use disorders, and medication misuse, as such conditions impact older adults. Part II will then illustrate the problems associated with older adults' misuse of, abuse of, and dependency on medically indicated prescription pain relievers. Lastly, Part III will discuss solutions critical to recognizing and responding appropriately to these concerns in a rapidly aging population.

I. BACKGROUND INFORMATION AND THE LAW

The statistics mentioned in the Introduction reflect the impact of the Baby Boom—the generation born in the United States between 1946 and 1964, and estimated at 72.5 million persons.[7] The first of the Baby Boom generation reached age sixty-five in 2011, while the last of the generation will reach age sixty-five by the end of 2029.[8] The nation's population of those age sixty-five years and older will double to over 72 million by 2030 and to over 83 million by 2050.[9] By 2056, the number of persons age sixty-five years and older will overtake the population of those age seventeen years and younger.[10] This anticipated shift in demographics, together with the facts that at present, over ninety percent of all adults age sixty-five and older have at least one chronic disease,[11] and that in 2015, approximately 6,000 individuals in the United States age fifty-five years and older died due to opioid overdoses,[12] indicate a need for increased awareness and attention to all issues faced by those in later life.

AMONG OLDER ADULTS, (7th Rev. 2012). http://adaiclearinghouse.org/downloads/tip-26-substance-abuse-among-older-adults-67.pdf.

7 Colby & Ortman, *supra* note 2, at 2.

8 *Id.* at 1.

9 Jennifer M. Ortman, Victoria A. Velkoff & Howard Hogan, *An Aging Nation: The Older Population in the United States,* U.S. CENSUS BUREAU 16 (May 2014), https://www.census.gov/prod/2014pubs/p25-1140.pdf.

10 Colby & Ortman, *supra* note 2, at 1.

11 *Healthy Aging Facts*, NAT'L COUNCIL ON AGING, https://www.ncoa.org/news/resources-for-reporters/get-the-facts/healthy-aging-facts/ (last visited Aug. 29, 2017).

12 *Opioid Overdoes Deaths by Age Group*, THE HENRY J. KAISER FAMILY FOUND., http://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-age-group/ (last visited Aug. 29, 2017).

A. Psychoactive Substances – Definitions, Descriptions, and the Current Law

Human use of psychoactive substances, which are defined by the World Health Organization as "substances that, when taken, have the ability to change an individual's consciousness, mood or thinking processes,"[13] is not a new concept.[14] These substances are grouped into three categories based on their social and legal statuses: 1) medically indicated or medicinal; 2) illegal or illicit; and 3) legal or licit.[15] The inherent distinctions between these categories are based on both cultural and historical understandings "about what should be viewed as uniquely dangerous or alien."[16]

Medically indicated or medicinal substances are lawfully used in the United States to relieve pain by reducing the severity of pain signals reaching the brain.[17] These drugs are commonly grouped together and their grouping is referred to by many different names,[18] but for the purposes of this paper, they will be referred to

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[13] WORLD HEALTH ORG., NEUROSCIENCE OF PSYCHOACTIVE SUBSTANCE USE AND DEPENDENCE 1–2 (2004), http://www.who.int/substance_abuse/publications/en/Neuroscience.pdf [hereinafter WHO, PSYCHOACTIVE SUBSTANCE USE].

[14] *See* Marc-Antoine Crocq, *Historical and Cultural Aspects of Man's Relationship with Addictive Drugs*, NAT'L CTR. FOR BIOTECHNOLOGY INFO., 355–56 (2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3202501/pdf/DialoguesClinNeurosci-9-355.pdf (discussing man's relationship with addictive drugs beginning with ancestors who lived as hunter-gatherers and collected information on plants with psychoactive properties).

[15] *See* WHO, PSYCHOACTIVE SUBSTANCE USE, *supra* note 13, at 2 (describing three categories of psychoactive substances "according to their sociolegal status"). *See also* Crocq, *supra* note 14 (describing psychoactive substances as being used "in religious ceremonies," "for medicinal purposes," and "as staple commodities, by large segments of the population in a socially approved way.").

[16] WHO, PSYCHOACTIVE SUBSTANCE USE, *supra* note 13, at 4.

[17] *Misuse of Prescription Drugs*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/research-reports/misuse-prescription-drugs/which-classes-prescription-drugs-are-commonly-misused (last visited July 23, 2017).

[18] Substances with acceptable medical uses are grouped together and commonly referred to as "prescription pain relievers," "opioid analgesics," "controlled substances," "narcotics," "opiates," or "opioids." The difficulty with using these terms interchangeably is that "controlled substances," "narcotics," "opiates," and "opioids" are also used to refer to substances like heroin, which is chemically similar to prescription pain relievers, but has no acceptable medical use. Likewise, there is a difference between medically indicated use of pain relievers and analgesics, medication misuse of these substances, and non-medical use. Medically indicated use of pain relievers may lead to medication misuse, which in turn may lead to a substance use disorder, diagnosed as a combination of substance abuse and substance dependence. *See The Science of Drug Abuse and Addiction: The Basics*, NAT'L INST. ON DRUG ABUSE, http://www.drugabu

as medically indicated prescription[19] pain relievers,[20] and are defined in federal law as drugs that have acceptable medical uses in treatment.[21] Such acceptable medical uses, however, require "a prescription . . . issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."[22] These drugs are marketed under different names, such as Lortab®, Norco®, Vicodin®, and Percocet®, but typically contain the same combination of ingredients—acetaminophen and either hydrocodone or oxycodone.[23] One of the

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se.gov/publications/media-guide/science-drug-abuse-addiction-basics (last visited July 23, 2017) (describing how drug disorders are categorized by the American Psychiatric Association as of 2013). Non-medical use may also lead to a substance use disorder. *See* Nora Volkow, *America's Addiction to Opioids: Heroin and Prescription Drug Abuse*, NAT'L INST. ON DRUG ABUSE (May 14, 2014), http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2014/americas-addiction-to-opioids-heroin-prescription-drug-abuse (transcribing Volkow's testimony to the Senate Caucus on International Narcotics Control regarding the abuse of and addiction to substances, and describing both prescription pain killers and heroin as an opioids); *Opiates/Opioids*, NAT'L ALLIANCE OF ADVOCATES FOR BUPRENORPHINE TREATMENT, http://www.naabt.org/education/opiates_opioids.cfm (last visited July 23, 2017) (describing the term "opioid" as referring to *all* opioids and opiates, even though "opioids" once referred to synthetic drugs created to mimic opium's properties, while "opiates" referred to drugs actually derived from opium); 21 U.S.C. § 802(17)–(18) (2012) (defining and describing the terms "narcotic drug" and "opiate"); 21 U.S.C. § 812(c)(Schedule I)(a)–(b) (listing and describing drugs that have no acceptable medical uses in treatment in the United States).

[19] The most instructive definitions of the term "prescription" are "a written message from a doctor that officially tells someone to use a medicine, therapy, etc.," and "a written direction for a therapeutic or corrective agent; *specifically:* one for the preparation and use of a medicine." *Prescription,* MERRIAM-WEBSTER DICTIONARY, http://www.merriam-webster.com/dictionary/prescription (last visited July 23, 2017).

[20] *See* 21 U.S.C. § 812(c)(Schedule II)(a)–(b) (2012) (listing and describing the most commonly referred to names for substances with acceptable medical uses in treatment).

[21] *See* 21 U.S.C. § 812(b)(2)–(5) (2012) (listing the findings required for federal drug scheduling for Schedule II, III, IV, and V substances with acceptable medical uses in treatment).

[22] 21 C.F.R. § 1306.04(a) (2014). A "practitioner" is defined as "a physician, dentist . . . or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he practices . . . to distribute, dispense . . . a controlled substance in the course of professional practice." 21 U.S.C. § 802(21) (2012).

[23] *FDA Drug Safety Communication: Prescription Acetaminophen Products to be Limited to 325 mg Per Dosage Unit; Boxed Warning Will Highlight Potential for Severe Liver Failure*, U.S. FOOD & DRUG ADMIN. (Jan. 13, 2011), http://www.fda.gov/Drugs/DrugSafety/ucm239821.htm. Acetaminophen is found in many over-the-counter products, such as Tylenol®. *Acetaminophen Information*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm165107.htm (last updated Apr. 13, 2016).

newest drugs included in this category is marketed under the name Zohydro ER®, and contains hydrocodone only.[24]

Illegal or illicit substances are unlawfully used in the United States for both recreational and pain management purposes "to enjoy or benefit from the psychoactive properties of the substance."[25] Drugs in this category include, but are not limited to, marijuana, cocaine, and non-medical use of prescription pain relievers.[26] Heroin is also included in this category.[27] While cocaine and prescription pain relievers are defined in federal law as drugs that have acceptable medical uses in treatment, despite the possibility of dependence,[28] marijuana and heroin are defined in federal law as drugs that have no currently acceptable medical uses in treatment and are unsafe to use even under medical supervision.[29]

Legal or licit substances are lawfully used in the United States "by a significant proportion of the population on a regular basis."[30] These substances include alcohol, nicotine, and caffeine, which are not only considered "palatable for their mild psychotropic

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Although acetaminophen is not characterized by the federal government as having any potential for abuse, hydrocodone and oxycodone are characterized by the federal government as having "a high potential for abuse which may lead to severe psychological or physical dependence." *See* 21 U.S.C. § 812(b)(1)–(5) (2012) (listing those substances characterized by the federal government as having a potential for abuse); *Controlled Substance Schedules*, DRUG ENFORCEMENT ADMIN., http://www.deadiversion.usdoj.gov/schedules/ (last visited July 23, 2017) (explaining that Schedule II/IIN Controlled Substances have a high potential for abuse).

[24] *FDA Approves Zohydro ER and Responds to CLAAD Citizen Petition,* U.S. FOOD & DRUG ADMIN. (Oct. 25, 2013), http://www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm369273.htm.

[25] WHO, PSYCHOACTIVE SUBSTANCE USE, *supra* note 13, at 2.

[26] *See id.*

[27] *See DrugFacts: Heroin*, NAT'L INST. ON DRUG ABUSE, http://www.drugabuse.gov/publications/drugfacts/heroin (last revised July 2017) (describing heroin as "an opioid drug made from morphine, a natural substance taken from the seed pod of the various opium poppy plants grown in . . . Asia."). *See also* WHO, PSYCHOACTIVE SUBSTANCE USE, *supra* note 13, at 9 (discussing the availability of heroin under the subtitle "Illicit use of controlled substances").

[28] *See* 21 U.S.C. § 812(b)(2)(A)–(C) (2012) (listing the findings required for Schedule II drugs with acceptable medical uses in treatment or acceptable medical uses "with severe restrictions"). *See also* 21 U.S.C. § 812(c)(Schedule II)(a)(1)–(4) (2012) (listing opium and opiate derivatives, their chemical equivalents, opium poppy, and cocaine specifically).

[29] *See* 21 U.S.C. § 812(b)(1)(A)–(C) (2012) (listing the findings required for Schedule I drugs with no acceptable medical uses in treatment). *See also* 21 U.S.C. § 812(c)(Schedule I)(b)(10) & (c)(Schedule I)(c)(10) (2012) (listing heroin and marijuana, respectively).

[30] Crocq, *supra* note 14, at 356.

properties,"[31] but also "can be a source of nutrition, of heating or cooling the body, or of thirst-quenching."[32] Despite their widespread acceptance, the United States spends billions of dollars each year due to the negative impacts of alcohol and nicotine consumption on health care and workplace productivity.[33]

B. Addiction "Then" and "Now"

The term "addiction" "has been in widespread [medical] use only since the [twentieth] century," where it is most commonly understood to refer to a state of being characterized by a compulsion and need for a drug due to previous use.[34]

1. Addiction "Then" – The Pyramid

The history of addiction can be traced to Roman law and through the Middle Ages, when addiction referred to "the sentence pronounced against an insolvent debtor who was given over to a master to repay his debts with work."[35] In other words, the debtor relinquished control over his own self and became "enslaved because of unpaid debts."[36]

Although "[t]he definition of addiction has evolved over time,"[37] the three categories of substances described in Part I.A. maintain their social and legal structures, guiding the creation of "new addiction terminology," despite such terminology being used to describe the "same disease."[38] Addiction can most easily be

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[31] *Id.*

[32] WHO, PSYCHOACTIVE SUBSTANCE USE, *supra* note 13, at 2.

[33] *See Excessive Drinking Costs U.S. $223.5 Billion*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/features/alcoholconsumption/ (last updated Apr. 17, 2014) (stating that excessive alcohol consumption cost the United States $223.5 billion in 2006 . . . or about $746 per person); *Economic Trends in Tobacco,* CTRS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/tobacco/data_statistics/fact_sheets/economics/econ_facts/index.htm (last updated June 16, 2017) ("Smoking-related illness in the United States costs more than $300 billion each year, including: [n]early $170 billion for direct medical care for adults [and] [m]ore than $156 billion in lost productivity.").

[34] Crocq, *supra* note 14, at 359.

[35] *Id.*

[36] *Id.*

[37] *Id.*

[38] *See* Stuart Gitlow, *Commentary: DSM-5: New Addiction Terminology, Same Disease*, PARTNERSHIP FOR DRUG-FREE KIDS (June 7, 2013), https://drugfree.org/learn/drug-and-alcohol-news/commentary-dsm-5-new-addiction-terminology-same-disease/ (discussing the importance of recognizing that despite revisions to diagnostic manuals used by clinicians in the field, "addictive disease itself has

described as:

> A primary, chronic disease of brain reward, motivation, memory and related circuitry . . . [that] is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.[39]

While this description provides an introductory approach to understanding addiction, it is important to be aware of the historical differences between this term and the terms "abuse" and "dependence," both of which are seen as "markers" of addictive diseases[40] or "technical terminology for the concept of 'addiction.'"[41]

The differences between the three terms are debated among health professionals based on the terms' historical developments,[42] as well as their usefulness in describing an individual's condition or disease.[43] Abuse means "periodic bingeing," motivated by "pleasurable recreation," while dependence means "tolerance, withdrawal," and compulsion, motivated by "needing the substance on a regular basis just to get by."[44] The distinction between abuse and dependence was previously envisioned as a pyramid, "where mere use falls at the base of the pyramid, abuse falls partway up, and dependence lives at the peak."[45] The pyramid itself represented addiction.[46] Ultimately, this view meant that substance abuse was likely "the first step on a path that eventually leads to Substance Dependence."[47]

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not changed").

[39] *Definition of Addiction*, AM. SOC'Y OF ADDICTION MED., http://www.asam.org/for-the-public/definition-of-addiction (last visited July 23, 2017).

[40] Gitlow, *supra* note 38.

[41] WHO, PSYCHOACTIVE SUBSTANCE USE, *supra* note 13, at 12.

[42] Crocq, *supra* note 14, at 359.

[43] *See* Allen Frances, *DSM5 "Addiction" Swallows Substance Abuse*, PSYCHIATRIC TIMES (Mar. 30, 2010), http://www.psychiatrictimes.com/addiction/dsm5-addiction-swallows-substance-abuse.

[44] *Id.*

[45] Gitlow, *supra* note 38.

[46] *Id.*

[47] Frances, *supra* note 43.

2. Addiction "Now" – Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

The most recent method for evaluating addiction, abuse, and dependence is the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5), published in 2013.[48] The DSM "is the standard classification of mental disorders used by mental health professionals in the United States" and contains a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system.[49] Professionals in many disciplines used previous versions of the DSM as tools to identify psychiatric disorders and "for collecting and communicating public health statistics" about such disorders;[50] this assumption is proving true with respect to the latest edition.[51] As such, the DSM–5's newest addiction terminology combines substance abuse and substance dependence into one diagnosis—"substance use disorder"—addressed with respect to specific substances (*e.g.*, alcohol use disorder) and measured using a continuum approach (*e.g.*, mild, moderate, severe) based on symptoms.[52]

The justification for this change included concerns that "most people link dependence with 'addiction' when in fact dependence can be a normal body response."[53] The new approach, however, "continues to be based solely upon qualitative and subjective criteria while ignoring the abundance of quantitative data" such as "quantity or frequency of consumption"[54] (*e.g.*, five twelve-oz. beers every night before bed); therefore this approach fails to utilize exploration of the link between quantity and frequency of

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[48] *DSM History*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm (last visited Oct. 6, 2017).

[49] *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/practice/dsm (last visited July 23, 2017).

[50] Li-Tzy Wu et al., *Heterogeneity of Stimulant Dependence: A National Drug Abuse Treatment Clinical Trials Network Study*, 18 AM. J. ON ADDICTIONS 206, 206 (2009).

[51] *See About DSM-5*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/practice/dsm/about-dsm (last visited July 23, 2017) (discussing the DSM's use in various settings, both clinical and community and its necessity as a tool for collecting and disseminating information about different disorders).

[52] *Substance-Related and Addictive Disorders*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Substance-Use-Disorder.pdf (last visited Sept. 16, 2017).

[53] *Id.*

[54] Anna Lembke, *DSM-5 Gets It Right, But . . .*, THE FIX (Apr. 9, 2013), http://www.thefix.com/content/dsm-5-spectrum-disorder-risky-drinking8269.

use "to health outcomes."[55] While there are obvious difficulties in comparing the number of alcoholic beverages consumed with the number of heroin doses injected based on government regulation of one, including easily found knowledge of a standard drink,[56] such information may "spur researchers to further explore quantity and frequency for the other substances."[57]

3. Early-Onset Versus Late-Onset Abusers

In order to accurately recognize the potentially "adverse interactions . . . [on] an aging brain" of substance use disorders and medication misuse, it is important to categorize older adults with such conditions "as early-onset or late-onset abusers."[58] Although for most, substance use, particularly of alcohol, declines with increasing age, for others, substance abuse develops later in life.[59] Early-onset abusers are categorized as those persons whose first substance-related problems began before age sixty-five.[60] Their reasons for abusing are thought to mirror those of younger individuals[61] and "the incidence of psychiatric and physical problems tends to be higher than that in their late-onset counterparts."[62] In contrast, late-onset abusers may develop such behaviors "subsequent to stressful life situations that include

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[55] *Id.*

[56] *See What is a Standard Drink?*, NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM, http://pubs.niaaa.nih.gov/publications/Practitioner/PocketGuide/pocket_guide2.htm (last visited July 23, 2017) (describing a standard drink size with respect to grams of alcohol and comparing standard drink equivalents for drinks such as beer, malt liquor, table wine, and spirits).

[57] Lembke, *supra* note 54.

[58] Olivera Bogunovic, *Substance Abuse in Aging and Elderly Adults*, PSYCHIATRIC TIMES (July 27, 2012), http://www.psychiatrictimes.com/geriatric-psychiatry/substance-abuse-aging-and-elderly-adults/page/0/1.

[59] Blow, *supra* note 6, at 19. This document is part of a series of publications by the Center for Substance Abuse Treatment within the U.S. Substance Abuse and Mental Health Services Administration. *Id.* The documents within the series are referred to as "Treatment Improvement Protocols (TIP)." *Id.* This document, colloquially known as "TIP 26," is seen by treatment providers and other similarly-situated service coordinators, like Sara J. Luck at the Fulton County Drug Court, located in Johnstown, New York, as the most useful collection of information on the topic of substance abuse and older adults. *Id. See generally Fulton County Courts,* 4TH JUDICIAL DIST., http://www.nycourts.gov/courts/4jd/fulton/specialtyparts.shtml (last updated Feb. 8, 2017) (providing contact information for the Fulton County Drug Court).

[60] Bogunovic, *supra* note 58.

[61] Blow, *supra* note 6, at 20.

[62] Bogunovic, *supra* note 58.

losses that commonly occur with aging (*e.g.*, death of a partner . . . isolation)."[63] These individuals usually experience fewer physical and mental health problems when compared to early-onset abusers, and may appear too healthy or "normal" to raise suspicions.[64]

II. THE PROBLEM

While trends indicate that substance abuse is a problem affecting both the Baby Boomer generation and younger generations, many difficulties exist in determining the breadth of the problem with respect to Baby Boomers, including the intentions and motivations for use, attitudes toward use versus sobriety, and the complications and risks associated with substance use disorders and medication misuse.[65]

A. Addiction "Now" – Medication Misuse

Although the DSM–5 provides guidance with respect to substance use disorders, not all individuals who use some of the substances described in Part I.A. categorically, if at all, meet the criteria for use disorders.[66] Nonetheless, medically indicated use of prescription pain relievers *and* non-medical use of such medications may lead to misuse. This misuse may, at some point, meet the diagnostic criteria of certain substance use disorders. Even before reaching these criteria, however, medication misuse poses many dangers.[67]

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[63] *Id.*

[64] *Id.*

[65] *See Combating Misuse and Abuse of Prescription Drugs: Q & A with Michael Klein, Ph.D.*, U.S. FOOD & DRUG ADMIN. (July 28, 2010), http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm220112.htm (discussing the motivations and intentions for use of prescription drugs, attitudes toward use versus sobriety, and the complications and risks associated with substance use disorders and medication misuse).

[66] *See Substance Use Disorders*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., http://www.samhsa.gov/disorders/substance-use (last updated Oct. 27, 2015) (describing some of the diagnostic criteria for "common substance use disorders such as those related to alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids."). *See also Alcohol Use Disorder: A Comparison between DSM–IV and DSM–5*, NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM (2016), http://pubs.niaaa.nih.gov/publications/dsmfactsheet/dsmfact.pdf (comparing the criteria for alcohol abuse or alcohol dependence under the DSM–IV and an alcohol use disorder under the DSM–5).

[67] *Combating Misuse and Abuse of Prescription Drugs: Q&A with Michael Klein, Ph.D.*, *supra* note 65.

Misuse of medically indicated prescription pain relievers happens:

> [w]hen a person takes a legal prescription medication for a purpose other than the reason it was prescribed, or when that person takes a drug not prescribed to him or her. . . . Misuse can include taking a drug in a manner or at a dose that was not recommended by a health care professional. This can happen when the person hopes to get a bigger or faster therapeutic response from medications such as sleeping or weight loss pills. It can also happen when the person wants to 'get high.'[68]

While the intentions and motivations of an individual misusing such drugs are important considerations in understanding why he or she was treating him or herself, it is even more important to note that while all drugs may produce adverse side effects, these risks "are managed by a health care professional" when the individual is taking the drug in a medically indicated way.[69] When an individual misuses that medically indicated prescription pain reliever, "there is no medical oversight of the risks."[70] A person may view such a drug as a "safe high" because it was ordered via prescription, but not understand that taking it outside of its medically indicated manner, particularly after the drug is no longer needed, is medication misuse and may lead to death due to "respiratory depression . . . for example."[71] Additionally, a person who has never been prescribed such medications may also view their use as a "safe high" and begin using such drugs in an entirely non-medical way based on the drugs' euphoric effects and easy accessibility "in the home,"[72] or because that person finds the drug helpful in managing persistent pain.

B. Addiction "Now" – How This Opioid Epidemic Began

According to the most recent Substance Abuse and Mental Health Services Administration's (SAMSHA) National Survey on Drug Use and Health, 267 million individuals age twelve and older were classified as having substance use disorder diagnoses in

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68 *Id.*
69 *See id.*
70 *Id.*
71 *Id.*
72 *Id.*

2015.[73] Among adults age fifty-five years and older—those persons falling squarely within the Baby Boom generation[74]—the rate of illicit drug use within the past year was approximately 9.5%.[75] The rate of misuse of prescription pain relievers within the past year was 2.5%,[76] meaning that approximately one-third of older adults' illicit drug use stems from the misuse of prescription pain relievers alone. When compared to younger individuals, the statistics regarding the misuse of prescription pain relievers among adults age fifty-five years and older are strikingly similar, with misuse of prescription pain relievers by youth ages twelve to seventeen years over 1.0% higher than misuse by older adults.[77] These statistical similarities will become gradually more important to monitor as the number of persons age fifty-five years and older overtakes the population of those age seventeen years and younger.[78] This anticipated shift in demographics, coupled with the facts that at present, over two-thirds of older adults have at least one chronic disease,[79] and between twenty and forty percent take five or more prescriptions daily,[80] means that "susceptibility to the deleterious effects" of illicit substances may increase complications and risks for this growing population.[81]

Equally as important as recognizing the impact of demographic shifts is understanding how this opioid epidemic began. In 1996, a semi-synthetic opioid pain reliever, OxyContin, entered the market.[82] Research indicates that the manufacturer of OxyContin

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[73] Center for Behavioral Health Statistics & Quality, *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 160418 tbl.5.1A (2016), https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf [hereinafter CBHSQ Survey]. The survey itself is based on the results of interviews with approximately 70,000 civilian, non-institutionalized persons age 12 and older. *About the Survey*, NAT'L SURVEY ON DRUG USE & HEALTH, https://nsduhweb.rti.org/respweb/project_description.html (last visited Aug. 13, 2017).

[74] *See* Sandra L. Colby & Jennifer M. Ortman, *The Baby Boom Cohort in the United States: 2012 to 2060*, U.S. CENSUS BUREAU, at 1 (2014), https://www.census.gov/prod/2014pubs/p25-1141.pdf.

[75] CBHSQ Survey, *supra* note 73, at 160405 tbl.1.15B.

[76] *Id.* at 160405 tbl.1.23B.

[77] *Compare id. with id.*

[78] Colby & Ortman, s*upra* note 74, at 10 fig.8.

[79] *See Healthy Aging*, NAT'L COUNCIL ON AGING (2016), https://www.ncoa.org/wp-content/uploads/Healthy-Aging-Fact-Sheet-final.pdf.

[80] U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH, UNITED STATES, 2016, 25 fig.15 (2017), https://www.cdc.gov/nchs/data/hus/hus16.pdf.

[81] Bogunovic, *supra* note 58.

[82] Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial*

aggressively promoted and marketed the drug, significantly understating the risk of addiction in its promotional literature by "train[ing] its sales representatives to carry the message that the risk of addiction was 'less than one percent.'"[83] Furthermore, the manufacturer did not study long-term use of this pain reliever for persistent, non-cancer pain.[84] Even though just over ten years later, the manufacturer of OxyContin was found liable for misleading regulators by understating the risk of addiction and abuse, there was little impact on prescribing rates, as the number of opioids prescribed per person continued to climb, and by 2015, the prescribing rate was three times higher than in 1999.[85]

Correspondingly, many states have seen a dramatic increase in the impact of illicit drug use and medication misuse during this same time frame.[86] In 1999, approximately 500 adults in the United States age fifty-five years and older died due to opioid overdoses.[87] By 2015, that figure was nearly 1,000% higher at approximately 6,000 deaths.[88] California, Ohio, Florida, New York, and Texas currently rank the highest for the number of opioid overdose deaths amongst older adults.[89]

C. Diagnostic Difficulties

As substance abuse by older adults continues to be studied, the number of Baby Boomers who need assistance in combatting substance use disorders and medication misuse climbs.[90] The difficulty in assisting such persons revolves around the challenge of identifying users, and once identified, engaging users in treatment.[91] For many persons in this generation, failure by

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Triumph, Public Health Tragedy, 99 AM. J. PUB. HEALTH 221, 221 (2009).

[83] *Id.* at 221, 223 (alteration in original).

[84] *Id.* at 223.

[85] *Id.* at 223; CDC Vitalsigns, *Opioid Prescribing*, CTRS. FOR DISEASE CONTROL & PREVENTION 1–2 (July 2017), https://www.cdc.gov/vitalsigns/pdf/2017-07-vitalsigns.pdf.

[86] *See* CDC Vitalsigns, *supra* note 85.

[87] *Opioid Overdose Deaths by Age Group*, THE HENRY J. KAISER FAMILY FOUND., http://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-age-group/ (last visited Sept. 8, 2017) (select "1999" in the "Timeframe" section).

[88] *Compare id.*, *with id.* (select "2015" in the "Timeframe" section).

[89] *Id.* (select "2015" in the "Timeframe" section, then click top of the "+55" column).

[90] Louis A. Trevisan, *Elderly Alcohol Use Disorders: Epidemiology, Screening, and Assessment Issues*, PHYSICIANS PRAC. 1 (May 9, 2014), http://www.physicianspractice.com/printpdf/198782/page/0/1.

[91] Christina Reardon, *The Changing Face of Older Adult Substance Abuse*,

health care professionals to screen for substance abuse and attitudes toward use threaten "an explosion in the number of elderly substances abusers."[92] Additionally, as medically indicated prescription pain relievers continue to be prescribed for pain management at rates approximately twenty percent higher than just five years ago, overdose deaths, emergency room visits, and admissions to addiction treatment programs all grow proportionately.[93]

1. Practitioner Recognition and Coordination

While older adults may see health care practitioners more regularly than younger individuals, a practitioner's ability to recognize and diagnose substance-related conditions plays a central role in the quality of service provided to an older individual.[94] Importantly, the symptoms of substance abuse may "mimic those caused by other health problems related to aging."[95] As a result, older adults may be hospitalized or sent to specialists for treatment of the symptoms rather than treatment of the underlying substance-related condition or disease.[96]

Practitioner interaction with the older adult's other practitioners is also an important consideration in substance abuse recognition and the quality of service provided to an older adult.[97] Medication misuse may occur if an older adult becomes confused about what medications to take and misinforms one practitioner of another practitioner's prescriptions and recommendations.[98] In these instances, medication misuse becomes problematic in a different way—the concern is not that an older adult is actively seeking to misuse medications, but instead, is doing so inadvertently. This inadvertence may lead to dangerous

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SOC. WORK TODAY 8, 10 (Jan./Feb. 2012), http://www.socialworktoday.com/archive/012312p8.shtml.

92 *See* Susan Abrams, Note, *Inebriated Elders: The Problem of Substance Abuse among the Elderly*, 9 ELDER L. J. 229, 230, 232 (2001).

93 Peter Eisler, *Seniors and Prescription Drugs: As Misuse Rises, So Does the Toll*, USA TODAY (May 22, 2014, 4:30 AM), https://www.usatoday.com/story/news/nation/2014/05/20/seniors-addiction-prescription-drugs-painkillers/9277489/.

94 Abrams, *supra* note 92, at 237–38.

95 *Id.* at 238.

96 *See id.*

97 *See* Carol Colleran, *Older Adults and Addiction: Why We Should Care*, 6 MARQ. ELDER'S ADVISOR 125, 127 (2004).

98 *See id.*

interactions and reactions between drugs,[99] particularly since "the elderly . . . tend to use multiple medications;"[100] the first practitioner may have prescribed Drug "A" instead of Drug "B" because of adverse interactions between Drug B and Drug "C," but the second practitioner, not knowing about the patient's legitimate use of Drug C, prescribes Drug B, thereby causing an adverse reaction requiring hospitalization.

2. Treatment of Persistent Pain

Many of the same diagnostic difficulties in recognizing and diagnosing substance-related conditions and diseases likewise pose difficulties in effectively managing persistent pain,[101] defined as "pain that persists past normal healing time" and "recurs for more than 3 to 6 months."[102] Persistent pain may affect older adults in several ways, including emotional well-being, ability to enjoy everyday activities, sleep patterns, and attitudes about pain and treatment.[103] In the United States, more than fifty percent of older adults report having bothersome pain, but some practitioners struggle with determining how to assess the pain, particularly in distinguishing between what is causing the symptoms.[104] Practitioners also struggle with how to treat the pain; various options available range from over-the-counter medications, such as acetaminophen and non-steroidal anti-inflammatory drugs, to opioid prescription pain relievers.[105] As with recognizing

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[99] *See id.*

[100] AM. COLL. OF PREVENTATIVE MED., USE, ABUSE, MISUSE, AND DISPOSAL OF PRESCRIPTION PAIN MEDICATION TIME TOOL: A CLINICAL REFERENCE 7 (2011), http://c.ymcdn.com/sites/www.acpm.org/resource/resmgr/timetools-files/painmedsclinicalreference.pdf.

[101] *See id.* at 2. "Persistent pain" is also commonly referred to as "chronic pain." For the purposes of this paper, persistent pain will be used, as many health care professionals and others who study this field note that chronic pain is often perceived as pain that may be cured, even after a significant period, rather than persistent pain, for which there is no cure, and management may be the best option. *See, e.g.*, Joel Katz et al., *Chronic Pain, Psychopathology, and DSM-5 Somatic Symptom Disorder*, 60 CANADIAN J. PSYCHIATRY 160 (2015).

[102] Rolf-Detlef Treede et al., *A Classification of Chronic Plain for ICD-11*, 156 PAIN 1003, 1003 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4450869/pdf/jop-156-1003.pdf.

[103] *See id.* at 1004.

[104] *See* AM. COLL. OF PREVENTATIVE MED., *supra* note 100, at 19; Rolf-Detlef Treede et al., *supra* note 102, at 1004. One example that a physician may face is distinguishing weakness due to pain from weakness due to a decrease in motor functioning. Rolf-Detlef Treede et al., *supra* note 102, at 1004.

[105] *See, e.g.*, Hrachya Nersesyan & Konstantin V. Slavin, *Current Approach to*

substance-related conditions or diseases, collaboration between multiple practitioners is necessary to ensure persistent pain is managed effectively without inadvertently causing medication misuse.[106] Although opioids may provide sustained relief, there are still concerns regarding long-term use of such pain relievers for improving persistent pain and function as well as a lack of research evaluating abuse and addiction.[107]

3. Lenient Attitudes

In addition to the role practitioners' training plays, older adults' lenient attitudes toward substance use based on preconceived personal and societal notions of the risks associated with such use, impact resolutions to the problem. For Baby Boomers, "[who] grew up in an era when illicit drugs were widely available . . . their use [has] a certain allure."[108] For some, availability of drugs in the home and a perception that such drugs are "safe,"[109] combined with "grief and loss issues," may prompt use.[110] For other, early-onset users, "many of these boomers have been using consistently" since their youth,[111] but now may be in need of treatment because their bodies are no longer able to tolerate the effects of these substances "physically and mentally."[112] Furthermore, this generation is faced with "heightened anxiety about job security and retirement savings."[113]

4. Misuse, The "Perfect Storm," and Heroin

While some older adults instinctively minimize the risks associated with certain substances based on deep-seated attitudes, "[practitioners] are currently challenged to deal with the 'perfect

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Cancer Pain Management: Availability and Implications of Different Treatment Options, 3 THERAPEUTICS & CLINICAL RISK MGMT. 381, 381–82, 385, 388 (2007).

[106] *See* AM. COLL. OF PREVENTATIVE MED., *supra* note 100, at 11.

[107] *See* Roger Chou et al., *The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institute of Health Pathways to Prevention Workshop*, 162 ANNALS INTERNAL MED. 276, 276, 278 (2015), https://www.pcori.org/sites/default/files/PCORI-Stakeholder-Workshop-LongTerm-Opioid-Therapy-Systematic-Review-060915.pdf.

[108] Reardon, *supra* note 91, at 9 (alteration in original).

[109] *Combating Misuse and Abuse of Prescription Drugs: Q&A with Michael Klein, Ph.D.*, *supra* note 65.

[110] Reardon, *supra* note 91, at 9.

[111] *Id.* (alteration in original).

[112] *Id.*

[113] *Id.*

storm'—a confluence of pain control versus the risk of misuse and abuse of prescription medications."[114] On one hand, "the consequences of not treating pain are significant"[115] and can force patients to live with persistent pain, which can lead to an overall decreased quality of life. On the other hand, practitioners' ability to reach into their "tool box" and relieve pain with a "prescription pad" can result in patients building up a tolerance, suffering more pain, and finally, asking for more medication.[116] When asking for more medication is no longer an option, whether because the practitioner recognizes signs of misuse or abuse or the medication is no longer medically necessary, heroin may become the next drug of choice because it can give users "the same high at a cheaper price [since] [b]oth are opiates."[117]

D. Vulnerability to Abuse

As life expectancies increase and the population of older adults continues to grow, "so does the hidden problem of elder abuse, exploitation, and neglect."[118] Factors found to increase the risk of such abuse include alcohol use, as there is a strong link "between alcohol and interpersonal violence in general."[119] Caregivers or individuals may rely on older adults for the financial means to fund their substance use.[120] Such persons may also encourage older adults to "drink in order to make them more compliant or exploit them financially."[121] Conversely, "abused elders may use alcohol as a means of coping with abuse or neglect"[122] and as such, further increase their vulnerability to abuse by others or self-neglect, whereby they are unable to care for their own daily needs.[123]

The consequences of such abuse may include physical injury,

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114 AM. COLL. OF PREVENTATIVE MED., *supra* note 100, at 2.

115 *Id.*

116 Eisler, *supra* note 93.

117 Michael Martinez et al., *Denver Mom Survives Darkness of Prescription Drug Abuse Epidemic*, CNN, http://www.cnn.com/2014/07/23/us/prescription-drug-heroin-abuse-epidemic/ (last updated Aug. 27, 2014).

118 AM. PSYCHOLOGICAL ASS'N, ELDER ABUSE & NEGLECT: IN SEARCH OF SOLUTIONS 1 (2012), https://www.apa.org/pi/aging/elder-abuse.pdf.

119 WORLD HEALTH ORG., ELDER ABUSE AND ALCOHOL 3 (2006), http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_elder.pdf?ua=1.

120 *Id.*

121 *Id.*

122 *Id.*

123 *See id.* at 5.

social withdrawal, and malnourishment.[124] Additionally, financial exploitation may result in the complete depletion of an older adult's resources, particularly since "older people often have lower incomes and less opportunity to replace money."[125]

III. SOLUTIONS AND RESPONSES

Increased awareness and attention by family members and friends of older adults, caregivers, and elder care professionals is perhaps the easiest way to identify substance use disorders or medication misuse, particularly "due to the isolation of many seniors from . . . common social interaction . . . [such as] employment and education."[126] Responding to such issues must take into account each individual's attitudes as well as the impact on the "already-strained healthcare, mental health, and social services systems."[127] Coordination of services between, and education of, elder care professionals "must be considered a key component of any policy designed to increase prevention and detection of substance abuse among the elderly."[128]

A. Framing the Response – Social and Legal Responses

In order to effectively respond to the problems associated with substance-related conditions and diseases in older adults, family members and friends of older adults, caregivers, elder care professionals, and the government itself each play unique roles in bringing substance use disorders and medication misuse out into the open.

1. Changing Perceptions

As mentioned in Part I.B., the term addiction was first used to refer to a person who relinquished control over himself based on his enslavement to another.[129] Although the definition of addiction has since evolved, "many people [do not] understand why or how other people become addicted to drugs."[130] Some assume that

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124 *Id.*
125 WORLD HEALTH ORG., *supra* note 119, at 6.
126 Abrams, *supra* note 92 (alteration in original).
127 Reardon, *supra* note 91.
128 Abrams, *supra* note 92, at 249.
129 Crocq, *supra* note 14, at 359.
130 *Understanding Drug Use and Addiction*, NAT'L INST. ON DRUG ABUSE (Aug. 2016),

substance abusers "lack moral principles or willpower and that they could stop [using drugs] simply by choosing to [change their behavior]."[131] This belief results in substance use disorders often being "treated as a moral and criminal issue, rather than a health concern."[132] These stereotypes about addiction are also "perpetuated by the media" and "unintentionally reinforced by addiction professionals."[133]

The difficulty with stereotyping is that it can impede "efforts to build social acceptance of people with substance use disorders."[134] The result is that people with substance use disorders become alienated socially and may fail to seek help in overcoming their illnesses, leading to a cycle of adverse outcomes, "including poor mental and physical health, non-completion of substance use treatment, delayed recovery and reintegration processes, and increased involvement in risky behavior (*e.g.*, needle sharing)."[135] To further complicate issues, health-care practitioners, holding negative beliefs about people with substance use disorders, may fail to provide adequate care.[136] The result of this actual or perceived failure to provide care is that persons "with substance use disorders may choose to conceal their substance use problems to avoid stigma" and not receive the care appropriate for their condition, instead receiving inefficient or medically worthless

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https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/df_understanding_drug_use_final_08_2016.pdf [hereinafter DRUGFACTS].

131 *Id.* Ironically, these beliefs do not coincide with the historical meaning of addiction because these beliefs insinuate that a person relinquishes control of his own self voluntarily, while in reality, such relinquishment was historically done through the forcefulness of a court order. *See* Crocq, *supra* note 14, at 359 (discussing the historical roots of the term "addiction" as referring to the sentence for a debtor who relinquished control over his own self and became "enslaved because of unpaid debts.").

132 James D. Livingston et al., *The Effectiveness of Interventions for Reducing Stigma Related to Substance Use Disorders: A Systematic Review*, 107 ADDICTION 39, 40 (2012).

133 *See Addiction Expert: Treatment Providers Can Perpetuate Media Stereotypes of Patients*, NAT'L COUNCIL ON ALCOHOLISM & DRUG DEPENDENCE, INC. (Feb. 6, 2013), https://www.ncadd.org/blogs/in-the-news/addiction-expert-treatment-providers-can-perpetuate-media-stereotypes-of-patients (discussing the media's portrayal of addiction as something positive and appealing, rather than as a serious disease and discussing addiction professionals' unintentional reinforcement of the media's negative and superficial portrayal of addiction by using slang terms "like 'dirty' or 'clean' to refer to a urine drug test, instead of the more medical 'positive' or 'negative.'").

134 Livingston et al., *supra* note 132, at 40.

135 *Id.*

136 *Id.*

care[137] (*e.g.*, a sixty-five-year-old woman presenting with hypertension conceals her daily consumption of five twelve-oz. beers to avoid stigma and her practitioner prescribes an antihypertensive, with the alcohol consumption leading to decreased effectiveness of the medication).[138]

Due to such stereotyping, research on "managing health-related stigma" has been a focus for many governments and professional organizations.[139] The purpose of this research is to develop ways to overcome the stereotyping in an effort to find appropriate methods of intervention "[to] facilitate interaction between the public and people who live with stigmatized health conditions."[140] Changing perceptions is an important step in reducing the negative consequences that substance abuse, including medication misuse, has for individuals and society, particularly as "estimates of the total overall costs of substance abuse in the United States, including productivity and health-and crime-related costs, exceed $600 billion annually."[141] Many assumptions regarding substance abusers, while accurate to a "small degree . . . are not generally applicable to all members of a particular social group,"[142] and therefore should not be used as a basis to contend that all those with disorders of this type have "*personal* control over their illness[es]."[143] This contention fails to consider the reality that "drug addiction is a complex disease, and quitting takes more than good intentions or a strong will."[144] With regard to the DSM–5, the importance of changing perceptions is reflected in the manual's newest technical terminology, combining substance abuse and

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137 *Id.* at 40–41.

138 *See Know Your Risk for High Blood Pressure*, AM. HEART ASS'N, http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/UnderstandYourRiskforHighBloodPressure/Understand-Your-Risk-for-High-Blood-Pressure_UCM_002052_Article.jsp# (last updated Apr. 18, 2017) (describing risk factors for developing high blood pressure, also called hypertension, based on drinking too much alcohol). *See also* Marwa Noureldin et al., *Drug-Alcohol Interactions: A Review of Three Therapeutic Classes*, U.S. PHARMACIST (Nov. 17, 2010), https://www.uspharmacist.com/article/drug-alcohol-interactions-a-review-of-three-therapeutic-classes (describing the impact of alcohol consumption on medications taken for hypertension, including decreased effectiveness and "prolonged intoxication").

139 Livingston et al., *supra* note 132, at 39.

140 *Id.* at 47.

141 JOSEPH J. BRADLEY, ADDICTION: FROM SUFFERING TO SOLUTION 205 (2015).

142 Livingston et al., *supra* note 132, at 40.

143 *Id.* (emphasis added).

144 DRUGFACTS, *supra* note 130, at 1.

substance dependence into a single substance use disorder.[145] The purpose of this effort is reflective of the DSM's goal to "improve clinicians' ability to understand and diagnose a wide range of conditions."[146] In doing so, the hope is to provide more accurate diagnoses and more useful treatment options by "eliminating the confusing and invalid dichotomy between abuse and dependence,"[147] and instead getting to the point: "addictive illness is still addictive illness,"[148] but individuals *can* regain control and recover with appropriate treatment.

2. Family Members and Friends

For many older adults, "family and friends are . . . an underutilized resource" as a support system for effective treatment.[149] These persons can provide different types of support to an older adult ranging from companionship throughout the process to knowing pertinent medical history that the older adult may be unaware of, such as "[g]enetic or hereditary factors [that] may predispose an individual to substance abuse."[150] Family members and friends may also be able to provide necessary information regarding the duration and severity of a substance use disorder or medication misuse to practitioners or others involved in the treatment process, despite the awkwardness involved in confronting or informing on someone.[151] Practitioners may be able to "facilitate the dialogue by counseling patients who may have elderly parents or loved ones" to be aware of the signs of substance abuse.[152] Alternately, these discussions can "provid[e] an opportunity to freely discuss substance[-related conditions] that may afflict the . . . patient," himself or herself.[153] Ultimately, family members and friends serve an important role in giving people "the chance to develop the vocabulary necessary to bring the issue out into the open,"[154] as a result changing perceptions and defeating stereotypes about addicted patients.

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145 *See DSM History*, AM. PSYCHIATRIC ASS'N, *supra* note 48.
146 *Alcohol Use Disorder: A Comparison between DSM–IV and DSM–5*, *supra* note 66.
147 Lembke, *supra* note 54.
148 Gitlow, *supra* note 38.
149 Abrams, *supra* note 92, at 253.
150 *Id.* at 254.
151 *See id.*
152 *Id.*
153 *Id.* at 255.
154 *Id.*

3. Professional Awareness

Unlike family members and friends, elder care professionals, such as health care practitioners, have a unique opportunity to recognize and respond to substance use disorders and medication misuse. Educating medical students about the DSM–5 and "exposing them to people with substance use disorders [is] likely to decrease their stigmatizing attitudes and increase comfort levels towards working with this population."[155] Additionally, increasing education about substance abuse will likely decrease practitioners' failures in diagnosing older adults' symptoms – failures that "may have life-threatening consequences."[156]

Other elder care professionals, such as lawyers, are also in unique positions to recognize patterns of alcohol consumption and medication misuse,[157] both of which may lead to a substance use disorder. As such, lawyers should be careful not to assume that a client "who appears to suffer from dementia is beyond hope of recovery. Some may not actually have dementia, but another curable condition."[158] As with family members and friends of older adults, lawyers may not feel comfortable attempting to address issues of substance abuse with a client by "prying into a client's personal life outside the office."[159] Nonetheless, certain signs of cognitive impairment, such as "significant memory loss, impaired abstract thinking, difficulty communicating, extreme emotional reactions and outbursts, and disorientation as to time"[160] should "never be accepted without investigation."[161] Lawyers may be one of the few points of contact for an older adult, since the "client is likely to be retired and not engage in as many activities" and "the substance use may not interfere with social or occupational functioning;" therefore, the client's behavioral changes may go unobserved and their condition or disease may fall under the radar.[162]

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155 Livingston et al., *supra* note 132, at 47.

156 Abrams, *supra* note 92, at 250.

157 *See* H. Amos Goodall, Jr., *My Client is Confused; Is it Dementia? Can it be Abated?*, 4 NAELA J. 255, 256 (2008).

158 *Id.*

159 *Id.* at 262.

160 *Id.*

161 *Id.* at 263.

162 *Id.*

4. The Government – Regulatory Reform and Drug Take Back Days

Federal and state governments also play strong roles in recognizing and responding appropriately to concerns regarding substance use disorders and medication misuse. In 2014, the Federal Government rescheduled hydrocodone from a Schedule III to a Schedule II drug pursuant to the Controlled Substances Act.[163] Ultimately, this rule changed the prescribing and dispensing regulations for hydrocodone combination products[164] to make access to such products more restricted.[165] Specifically, prescriptions for these combination products issued on or after October 6, 2014, cannot authorize any refills, whereas, prior to this scheduling change, such prescriptions could authorize refills.[166] The goal of the legislation is to balance the "risk of abuse and misuse with the need to maintain access to the important medications that provide needed relief to people in pain."[167]

The Federal Government even more recently approved regulations related to prescription drug returns in an attempt to expand options available to ultimate users[168] in the disposal of prescription pain relievers.[169] These regulations permit retail pharmacies to voluntarily administer mail-back programs and maintain collection receptacles.[170] Additionally, the regulations provide a standard for destroying the collected drugs that allows

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[163] Schedules of Controlled Substances: Rescheduling of Hydrocodone Combination Products from Schedule III to Schedule II, 79 Fed. Reg. 49661 (Aug. 22, 2014) (to be codified at 21 C.F.R. pt. 1308).

[164] *See* discussion *supra* Part I.A. (defining combination products as drugs containing acetaminophen and hydrocodone).

[165] *See* 21 C.F.R. § 1308.12 (2017) (rescheduling hydrocodone combination products).

[166] Schedules of Controlled Substances: Rescheduling of Hydrocodone Combination Products from Schedule III to Schedule II, 79 Fed. Reg. 49661 (Aug. 22, 2014) (to be codified at 21 C.F.R. pt. 1308).

[167] Douglas C. Throckmorton, *Re-scheduling Prescription Hydrocodone Combination Drug Products: An Important Step toward Controlling Misuse and Abuse*, U.S. FOOD & DRUG ADMIN. (Oct. 6, 2014), http://blogs.fda.gov/fdavoice/index.php/2014/10/re-scheduling-prescription-hydrocodone-combination-drug-products-an-important-step-toward-controlling-misuse-and-abuse/.

[168] 21 U.S.C. § 802(27) (2012) (defines "Ultimate users" as those persons, more appropriately referred to as patients, for whom prescriptions are written and drugs are dispensed).

[169] 21 C.F.R. §§ 1317.30, 1317.35 (2017) (related to prescription drug take backs, including expanding options available to ultimate users in the disposal of controlled substances).

[170] 21 C.F.R. §§ 1317.70, 1317.75 (2017).

for flexibility based on the resources and technology available at that location.[171] Before the enactment of these regulations, former regulations and practices prevented ultimate users from returning unused controlled substances to retail pharmacies because of the "closed system" of distribution meant to prevent drugs from being diverted outside of the strict manufacturer-to-distributor-to pharmacy and pharmacy-to-patient chain.[172] While ultimate users, and others possessing such pain relievers, may still bring the drugs to organized collection events, the new regulations provide more options for getting prescription drugs out of homes, where they are otherwise easily accessible.[173]

On the state level, programs such as New York's Internet System for Tracking Over-Prescribing (I-STOP) require practitioners to consult a central registry containing information about their patients' prescription histories when writing prescriptions for pain relievers in order to "allow practitioners to better evaluate their patients' treatment with controlled substances and determine whether there may be abuse or non-medical use."[174] Although *required* by law to consult I-STOP, the effectiveness of such measures is dependent upon practitioners' actually checking the registry *before* writing a prescription. Also, practitioners in emergency departments at general hospitals who write prescriptions for five-day supplies of controlled substances are not required to consult I-STOP,[175] meaning that practitioners should carefully consider patients' presenting medical issues to determine whether they are engaging in drug-seeking behaviors. In addition to New York, nearly all states have established or enacted legislation establishing similar prescription monitoring programs.[176]

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171 21 C.F.R. §§ 1317.90, 1317.95 (2017).

172 Disposal of Controlled Substances, 79 Fed. Reg. 53,520, 53,526 (Sept. 9, 2014) (to be codified at 21 C.F.R. pts. 1300, 1301, 1304, 1305, 1307, 1317).

173 *Id.* at 53,520.

174 *I-STOP/PMP-Internet System for Tracking Over-Prescribing-Prescription Monitoring Program*, N.Y. ST. DEP'T OF HEALTH, https://www.health.ny.gov/professionals/narcotic/prescription_monitoring/ (last updated Mar. 2017).

175 N.Y. ST. DEP'T OF HEALTH, FREQUENTLY ASKED QUESTIONS FOR THE NYS PMP 3 (2007), https://www.health.ny.gov/professionals/narcotic/prescription_monitoring/docs/pmp_registry_faq.pdf.

176 *See generally* NAT'L ALL. FOR MODEL STATE DRUG LAWS, STATE PRESCRIPTION MONITORING PROGRAM STATUTES AND REGULATIONS LIST (2016), http://www.namsdl.org/library/55EF159E-BEE2-D6D5-11D72729DF059351/ (providing a complete list of all states' prescription monitoring statutes).

5. Civil Commitment

Increased awareness and attention by family members and friends of older adults, caregivers, and elder care professionals to substance-related conditions and diseases also requires an understanding of treatment options, particularly those that implicate autonomy and due process rights, such as involuntary civil commitment.[177] Alcohol and illicit substance use can have devastating effects on both individual and public health and safety.[178] For older adults, "recognizing such drug use often is not easy"[179] especially since "many of the signs of substance abuse, such as anxiety, memory loss, disorientation, headaches, and incontinence, mirror symptoms of physical and mental health conditions that affect elders."[180] Even when family members or other persons in close contact suspect that an older adult has a substance-related condition or disease, "convincing users that they have a problem and need treatment can be an uphill battle."[181] For some older adults, their use stems from a sense of entitlement to relax after raising families or working for many years.[182] Regardless of an older adult's reason for use, the result may be that another person, such as a family member, recognizes and initiates treatment through civil commitment.[183]

Civil commitment is a legal procedure "for coercing the person into treatment without requiring entry into the criminal justice system."[184] Over half the states have statutes authorizing civil commitment based on substance abuse, with some never applying or rarely applying the statutes.[185] In California and New York, for example, there are no statutes permitting involuntary long-term

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177 *See, e.g.*, Rebecca L. Abensur, *What's So Civil About Civil Commitment?: Balancing the State's Interest in Treating Substance Dependence with the Protection of Individual Liberty Interests*, 37 HOFSTRA L. REV. 1099, 1110–11, 1119, 1125 (2009).

178 TRUST FOR AMERICA'S HEALTH, PRESCRIPTION DRUG ABUSE: STRATEGIES TO STOP THE EPIDEMIC 3 (2013), http://healthyamericans.org/reports/drugabuse2013/TFAH2013RxDrugAbuseRpt12_no_embargo.pdf.

179 Reardon, *supra* note 91.

180 *Id.*

181 *Id.*

182 *Id.*

183 Abensur, *supra* note 177, at 1102.

184 *Id.* at 1115–16.

185 Paul P. Christopher et al., *Nature and Utilization of Civil Commitment for Substance Abuse in the United States*, 43 J. AM. ACAD. PSYCHIATRY L. 313, 316 fig.1 (2015).

commitment or treatment for substance use.[186] In contrast, Ohio, Florida, and Texas permit involuntary long-term commitment and treatment based on alcohol and drug abuse,[187] and apply their statutes regularly.[188]

CONCLUSION

Although the benefits of modern medicine and an increased awareness of healthy lifestyle choices are leading to longer life expectancies for older adults, family members and friends of those persons, caregivers, and elder care professionals must remain vigilant in their attention to all issues faced by those in later life, particularly substance use disorders and medication misuse. Responding to such problems requires an examination of the current trends associated with addiction, including significant increases in illicit drug use and alcohol consumption by those in the Baby Boom generation. As the population of older adults increases, practitioner identification of users, engagement in treatment, and governmental response[189] will determine whether

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[186] *See* CAL. WELF. & INST. CODE § 5170 (Lexis 2017) (indicating that a person who is impaired by alcohol and is a danger to that persons or others may be held involuntarily for evaluation and treatment for up to 72 hours). A criminal defendant who "as a result of chronic alcoholism or the use of narcotics or restricted dangerous drug" is a danger to that person or others may be ordered to undergo an evaluation, but cannot be involuntarily held solely on this basis. CAL. WELF. & INST. CODE § 5225 (Lexis 2017); N.Y. MENTAL HYG. LAW § 22.09(c), (e) (Lexis 2017) (describing the circumstances under which an individual may be held "with his or her objection" as being limited to situations in which "there is a likelihood . . . [of] harm to the [intoxicated] person or to others," and that the holding period cannot last longer than either the time it takes the individual to no longer pose a harm or 48 hours, whichever is shorter. The statute applies only to *emergency services* for persons intoxicated, impaired, or incapacitated by alcohol and/or substances, *not* to involuntary commitment or treatment).

[187] *See* FLA. STAT. ANN. §§ 397.675–.6978 (West 2017) (describing involuntary admission procedures, including a requirement that the person is likely to suffer harm due to self-neglect or that there is a substantial likelihood that the person will cause harm to that person or others); OHIO REV. CODE ANN. § 5119.92 (West 2017) (describing the criteria for involuntary treatment, including a requirement of imminent or near future harm to that person or others); TEX. HEALTH & SAFETY CODE ANN. § 462.062 (West 2017) (describing the criteria for involuntary treatment, including that the person is likely to cause harm to that person or others).

[188] Christopher et al., *supra* note 185, at 315.

[189] *See, e.g.*, Brian Naylor & Tamara Keith, *Trump Says He Intends to Declare Opioid Crisis National Emergency*, NPR (Aug. 10, 2017), http://www.npr.org/2017/08/10/542669730/trump-says-he-intends-to-declare-opioid-crisis-national-emergency (reporting that the federal administration will be classifying the opioid epidemic as a national emergency).

or not the number of elderly substance abusers grows concurrently.