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TREATING SUBSTANCE USE DISORDER IN OLDER ADULTS – MODULE 2

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This distance learning course package was developed for CEU Matrix John Tinsley, PhD. It is based on information found in SAMHSA TIP26 Manual pages 87-156. Publication No. PEP-20-02-01-011, 2020

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TREATING SUBSTANCE USE DISORDER IN OLDER ADULTS – MODULE 2

Chapter 4: Treating Alcohol Misuse in Older Adults

This chapter discusses key aspects of alcohol misuse and the screening, assessment, and treatment of/services for binge drinking and AUD.

In Chapter 4, you will learn about:

- **The ways in which older adults are at risk for harm from alcohol misuse,** including age-specifc health effects as well as negative co-occurring mental and social conditions.
  - **The need to screen all older adults for alcohol misuse and alcohol-related problems.**
  - **Measures developed and approved for use with older populations,** such as the Alcohol Use Disorders Identifcation Test and the Short Michigan Alcoholism Screening Test-Geriatric Version.
  - The ways in which **prescription medications can interact negatively with alcohol.**
  - **The steps to guiding older clients through the continuum of care** for substance misuse, including brief interventions, prevention strategies, outpatient care, inpatient rehabilitation, follow-up services, referrals, and recovery management.
  - **Adapting treatment and services for age-specifc needs of older adults,** including clinical approaches (e.g., nonconfrontational and supportive approaches), treatment and service structure (e.g., fexible scheduling, shorter sessions), and content needs (e.g., focus on increasing behavioral change, quality of life, and social connectedness).

Chapter 5: Treating Drug Use and Prescription Medication Misuse in Older Adults

This chapter discusses age-appropriate interventions and services for older adults with substance misuse (non-alcohol-related), including illicit drug use and nonmedical prescription medication use.

In Chapter 5, you will learn that:

- Prescription medication misuse can be unintentional, underscoring the importance of **educating your older clients about how to take medication correctly** (including avoiding harmful interactions).
- **Older adults are at risk for opioid addiction,** given the high prevalence of chronic pain in this population.
- Illicit substance use (e.g., opioids, cannabis, stimulants) does occur among older adults and can be treated using behavioral and pharmacological methods.
- **Routine screening and assessment will help you detect substance misuse early and accurately.**
- **Diagnostic criteria for SUDs may not fully apply to older clients.**
- **Older adults with SUDs can beneft from a wide range of age-sensitive and age-specifc treatment and services across the continuum of care,** including prevention strategies, early and brief interventions, formal inpatient and outpatient treatment,

- **Mutual-aid support programs and family involvement are important components of the continuum of care** for older adults with SUDs.

Treating Substance Use Disorder in Older Adults

UPDATED 2020

TREATMENT IMPROVEMENT PROTOCOL

TIP 26

SAMHSA
Substance Abuse and Mental Health Services Administration

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Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the U.S. Department of Health and Human Services agency that leads public health efforts to reduce the impact of substance abuse and mental illness on America's communities. An important component of SAMHSA's work is focused on dissemination of evidence-based practices and providing training and technical assistance to healthcare practitioners on implementation of these best practices.

The Treatment Improvement Protocol (TIP) series contributes to SAMHSA's mission by providing science-based, best-practice guidance to the behavioral health field. TIPs reflect careful consideration of all relevant clinical and health service research, demonstrated experience, and implementation requirements. Select nonfederal clinical researchers, service providers, program administrators, and patient advocates comprising each TIP's consensus panel discuss these factors, offering input on the TIP's specific topics in their areas of expertise to reach consensus on best practices. Field reviewers then assess draft content and the TIP is finalized.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of care and treatment of mental and substance use disorders. My sincere thanks to all who have contributed their time and expertise to the development of this TIP. It is my hope that clinicians will find it useful and informative to their work.

Elinore F. McCance-Katz, M.D., Ph.D.
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U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

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Executive Summary

Treatment Improvement Protocol (TIP) 26 provides a wide range of guidance in the latest evidence-based screening and assessment approaches, interventions, and services for substance misuse, including substance use disorders (SUDs), in older adults. It is intended for behavioral health service providers, healthcare professionals, and older adults, as well as those people who are significant in their lives.

Introduction

Older adults are a special group because they are particularly vulnerable to the negative effects of substances and therefore substance misuse. Further, providers, professionals, and family and caregivers tend to overlook substance misuse in older people, meaning they are less likely than younger adults to be correctly diagnosed and offered treatments, services, or referrals. This oversight makes SUDs particularly dangerous for this population in terms of possible effects on mortality and comorbid conditions (including physical, cognitive, and mental disorders). This TIP is designed to help providers and others better understand how to identify, manage, and prevent substance misuse in older adults. This publication describes the unique ways in which SUD signs and symptoms manifest in older adults; drug and alcohol use disorder (AUD) screening tools, assessments, and treatments specifically tailored for older clients' needs; the interaction between SUDs and dementia and other cognitive disorders; and strategies to help providers improve their older clients' social functioning and overall wellness—both of which are critical to successful recovery.

A consensus panel developed the TIP's content based on a review of the most up-to-date literature and on their extensive experience in the field of geriatric alcohol and drug addiction treatment. Other professionals also generously contributed their time and commitment to this publication.

This publication is an update of the original TIP. The content addresses many of the same key topics and messages, as well as new ones. Revisions reflect the most recent scientific knowledge, clinical advances, and guidance pertaining to preventing and treating substance misuse among older adults.

Overall Key Messages

Substance misuse in older adults is often overlooked and undertreated. In part, this is because of false beliefs among providers, professionals, and the general public that older adults do not develop or need treatment for drug and alcohol use disorders. Providers and professionals can benefit from an improved awareness about substance misuse in older clients, including how to approach screening, assessment, and treatment. Similarly, family members/caregivers can benefit from information and resources to help them recognize, prevent, and respond to substance misuse in their older loved ones.

Empirical evidence supports the use of SUD treatment for older adults—especially when tailored to their age-related needs. The notion that older adults are not interested in or do not respond well to treatment for substance misuse is simply untrue. In fact, when interventions are adapted to the physical, cognitive, and psychosocial needs of older clients, they are likely to be effective. It is critical that providers and professionals learn about available interventions and local resources so they can treat, serve, or otherwise refer older clients appropriately.

Like treatments and services, screening and assessment techniques can and should be adapted to older adults. Many instruments have been developed specifically to detect possible SUDs and common comorbid mental and physical conditions (e.g., depression, anxiety, pain) in this population. Age-appropriate screening tools and interventions are available for older adults struggling with alcohol use, illicit drug use, or nonmedical prescription medication use. Comprehensive assessments should explore other areas relevant to older adults and substance misuse, such as their trauma history and risk of current elder abuse, fall risk, cognitive decline, and ability to perform activities of daily living and other functions.

Nearly all of us will experience changes in our thinking as we age, but **substance misuse can potentially worsen normal age-related changes in cognition.** Further, older people already experiencing cognitive conditions, including dementia or mild cognitive impairment (MCI), may have difficulty using substances like alcohol and prescription medications safely and according to recommended guidelines.

Alcohol is the most widely used substance among older adults with substance misuse. It is vital that older adults and their family and caregivers receive information about moderate versus high-risk drinking, harmful effects of alcohol misuse, and available treatments for AUD.

Providers, professionals, and family and caregivers should be **especially watchful for signs and symptoms of nonmedical prescription drug use,** including that of opioids and benzodiazepines. Most older adults take at least one prescription medication, and many take more than one. This increases their risk for potentially dangerous drug–drug interactions and drug–alcohol interactions.

Older adults often experience reductions in their social network and social functioning as a part of normal aging, but among older individuals with substance misuse, this can be especially problematic. **Social support is a critical piece of achieving and sustaining long-term recovery from substance misuse for all people, including older adults.** Providers and professionals should be mindful of this and work closely with older clients to help them enhance the size and diversity of their social network, increase their social functioning, and engage in meaningful, recovery-oriented social activities (e.g., mutual-aid support programs, peer recovery support).

Recovery is just one part of wellness. To help older clients achieve true health and well-being, be sure to help them address any areas in which functioning may be lacking. This includes their physical functioning, mental health, emotional well-being, intellectual activities, spirituality, work or volunteer activities, and social life. **All of these aspects of wellness play a role in recovery** and in overall health.

Many older adults consume alcohol, but how does one know whether an older adult's alcohol use is a problem? Part of your role is to **provide a wide range of education and resources** to help older adults and their family or caregivers better understand the risk factors for, signs and symptoms of, and treatments and services available for alcohol misuse.

This TIP is divided into nine chapters designed to thoroughly cover all relevant aspects of the ways in which SUDs affect older adults and how providers, professionals, and family members and caregivers can offer treatment, services, support, and resources to help older adults prevent or overcome substance misuse.

Content Overview

The TIP is divided into chapters to make the material more accessible according to the reader's interests. Below is a summary of each TIP chapter's main messages and key content areas.

Chapter 1: Older Adults and Substance Misuse: Understanding the Issue

This chapter lays the foundation for understanding the scope and importance of substance misuse as a problem among older aged populations. It is for a variety of audiences (e.g., providers, professionals, administrators, informal and formal caregivers, family).

This chapter emphasizes the fact that **substance misuse is indeed a serious—and increasing—problem among older adults.** SUDs tend to be underrecognized by providers, professionals, and family and caregivers in part because of false beliefs that drug and alcohol addiction is only a "young person's disease" and that older clients are not interested and willing to engage in treatment or services. These myths contribute to low rates of diagnosis, treatment, and service provision among older persons and interfere with their chances for recovery. Most providers and professionals do not have specialized training in geriatric substance misuse, and most family members and caregivers do not know how to recognize and respond to these problems in older adults. This chapter helps fill these knowledge gaps by laying out the facts and statistics, many from large-scale surveys and empirical research, that underscore how problematic drug and alcohol addiction truly is for older adults.

In Chapter 1, you will learn that:

- Even though rates of drug and alcohol addiction are higher among adolescents and younger adults, SUDs can and do occur in older persons. **Substance misuse is not something that only occurs in younger people.** These ageist beliefs are a large reason why we see low rates of diagnosis and treatment/services in the older adult population.
- **Substance misuse among older individuals is very dangerous and can increase their risk of death and other physical harms.** Older persons are vulnerable to negative drug and alcohol interactions with prescription medications, adverse reactions from illicit drugs and prescription medications, and the harmful effects of alcohol.
- Not only are **rates of illicit drug use among older adults growing, rates of co-occurring mental disorders are also high.** As the number of older individuals in the U.S. population increases, the need for treatment providers and programs that understand and can respond to the needs of older adults with SUDs also will likely rise over time.
- **Older adults with SUDs are more likely to misuse alcohol than any other substance.** This is concerning because older individuals' bodies do not metabolize alcohol as efficiently as those of younger people, increasing their risk of cognitive and physical problems, like confusion and falls.
- **Most older adults take at least one medication, and many take more than one.** This makes substance use and misuse even more dangerous because of potentially deadly or otherwise harmful interactions between prescription medications and drugs and alcohol. Like their younger counterparts, some older adults do engage in nonmedical prescription medication use, including nonmedical use of opioids and benzodiazepines.
- **Providers and professionals may struggle to identify SUDs in older clients because symptoms can be hard to recognize and do not necessarily mirror diagnostic criteria.** For example, changes in thinking attributable to alcohol misuse may appear similar to normal age-related changes in cognition.
- **Although the idea that older adults are unwilling to seek treatment or services for substance misuse is false, certain barriers can make this population less likely to seek treatment.** These barriers include negative attitudes among providers, professionals, or family/caregivers; denial on the part of the older adult; lack of knowledge about substance misuse among family and caregivers; and lack of provider awareness about available and effective treatment and services.
- **Multiple treatment approaches for SUDs exist that are effective for older adults.** These include screening, brief intervention, and referral to treatment; brief structured treatment; patient education; relapse prevention techniques; formal SUD treatment programs; and pharmacotherapy (e.g., methadone, buprenorphine, naloxone).

Chapter 2: Principles of Care for Older Adults

This chapter describes guiding principles for evidence-based, effective, and safe treatments and services for older adults with substance misuse. This chapter will most benefit providers.

Older adults are a diverse and unique population, and **their SUD treatment and service needs typically differ somewhat from those of younger adults.** Providers should understand developmental differences but also generational differences (e.g., baby boomers versus earlier cohorts) among their older clients. Age-sensitive and age-specific interventions can help increase older adults' chances of achieving and sustaining long-term recovery. The treatment/service environment itself also should be adapted to this population, for example, through organization-wide training and encouragement of staff attitudes responsive to older clients' needs. Consider each older client's cultural background, gender, and age of onset of an SUD, all of which can influence treatment needs and recovery outcomes.

In Chapter 2, you will learn the following:

- **To give older clients the best opportunities to access and benefit from substance use treatment and services, you must acknowledge, respect, and respond to differences among populations of older individuals.** This includes differences in generation, age of and reason for substance misuse onset, gender, recovery needs and wishes, attitudes about substance use/misuse, available support network, and more. In short, providers must remember that no two older clients are alike.
- **Organizations should create a treatment/service environment that gives older clients the best chances for successful recovery.** This means considering how the physical environment, as well as staff skills, services, abilities, and policies, can be tailored to overcome any age-related barriers.
- Older adults are diverse in gender, race/ethnicity, and sexual orientation. Bias and discrimination can occur as easily as in any other age group. **Take time to learn how such diversity may influence your clients' late-life substance misuse, health disparities, and access to care.**
- Early identification, education, and intervention, even if brief and informal, are important because substance misuse in older adults is often unrecognized by older adults themselves, as well as by their family members, friends, and healthcare and social service providers. As a provider, **you should learn the signs and symptoms of SUDs in older adults and be prepared to respond appropriately when they appear.** This includes performing routine screening and assessment for substance misuse. For older adults uninterested in abstinence, provide health risk reduction services, such as education on the health benefits of reducing alcohol use.
- **Person-centered care is the preferred approach for this population** and emphasizes older clients' values, needs, and preferences from among a menu of care options.
- Age-sensitive approaches include those that are tailored to older clients' physical needs (e.g., difficulties with mobility, hearing, vision, or a combination of these), cognitive problems (e.g., memory and attention difficulties), learning needs (e.g., using a slower pace, repeating information), and age-related preferences (e.g., desiring age-specific rather than mixed-age group treatment).
- **Investing time and money in developing an age-sensitive workforce throughout your organization is important.** Staff recruitment, hiring, retention, supervision, and professional development strategies should include a focus on understanding evidence-based approaches that are effective and appropriate for older adults.
- **Older adults with substance misuse can benefit greatly from social support and community resources.** Keep on hand a listing of resources and referrals, and help older clients access and engage in these services.
- **Including caregivers throughout treatment and services (as appropriate) and providing them with education and resources (including access to case managers) can improve older clients' recovery chances.** Not only will this

help them better understand the nature of SUDs and the recovery process, it can help reduce caregiver burden and stress, which, if unaddressed, can affect their own health as well as that of the older adult with the SUD.

Chapter 3: Identifying, Screening for, and Assessing Substance Misuse in Older Adults

This chapter addresses how, when, and why to use screening and assessment for substance misuse in older clients. This chapter will most benefit behavioral health service providers, social service providers, and other healthcare professionals and paraprofessionals.

Identification, screening, and assessment are critical steps to linking older adults with substance misuse to needed treatment and services. Older adults' signs and symptoms of SUDs can be difficult to spot, however. **By learning the steps to accurate and effective screening and assessment, you increase the chances of older adults receiving timely and appropriate care.** This means taking a comprehensive approach that not only focuses on specific drug and alcohol use disorders but also on related conditions that influence (or are influenced by) substance misuse. These conditions include co-occurring mental disorders (e.g., depression, anxiety), certain physical problems (like chronic pain and sleep disorders), cognitive impairment, falls, trauma, and abuse (history and current experiences), and everyday functioning.

In Chapter 3, you will learn the following:

- Screening and assessment for SUDs in older persons can be challenging because the signs and symptoms are not necessarily the same as those in younger adults and do not always mirror diagnostic criteria. To ensure proper and timely identification of problems, **you should learn how to recognize and overcome these challenges.**
- As a provider, **you should regularly screen your older clients for substance misuse, at least annually.** Also consider screening if the client displays signs or symptoms that are concerning, if the client or family/caregiver reports substance-related difficulties, or if you otherwise suspect substance misuse may be present.
- Numerous screening instruments are available that have been developed for or tested and approved for use with older persons. These include instruments to help you screen for alcohol misuse, illicit drug use, and nonmedical prescription medication use. Older adult screeners are also available to help you explore related areas, such as depression, posttraumatic stress disorder (PTSD), anxiety, cognition, pain, and daily functioning.
- **When communicating screening results, you should praise clients for findings that indicate abstinence, and follow up on findings that indicate substance-related problems.** Be sure to also occasionally rescreen older clients even if their findings suggest no problems are present.
- **You should follow up on screening that indicates a potential substance-related problem by conducting an assessment.** Brief assessments can occur immediately after screening. More thorough, comprehensive assessments are lengthier and may require a separate appointment.
- Comprehensive assessment for SUDs is a multistep process that will help you determine whether substance misuse is truly present and differentiate SUDs from possible co-occurring disorders (CODs), physical conditions common in older populations, and signs of normal aging.
- You should fully explore older clients' psychological, medical, family, vocational or retirement-related, social, sexual, financial, legal, substance use, and substance-related treatment histories. Also ask about older clients' fall risk, abuse potential, skills and abilities, and functional status.
- **Not all clients who screen positive will need formal substance use treatment. For older clients with or at risk for mild or moderate substance misuse, a brief intervention may be sufficient (e.g., education, motivational interviewing). For older adults with moderate-to-severe SUDs, formal treatment may be necessary.**

Chapter 4: Treating Alcohol Misuse in Older Adults

This chapter discusses key aspects of alcohol misuse and the screening, assessment, and treatment of/services for binge drinking and AUD. It will most benefit healthcare, behavioral health, and social service providers working with older adults (physicians, nurse practitioners, physician assistants, nurses, social workers, psychologists, psychiatrists, mental health counselors, alcohol and drug counselors, and peer providers).

Alcohol is the most commonly used substance among older individuals with an SUD or substance-related problems. Although widespread screening is an effective method of detecting alcohol-related problems in this population, many providers and professionals fail to screen because of false beliefs (e.g., that older people do not experience AUD or would not be interested in treatment) and lack of knowledge about the importance of widespread screening.

For older clients in need of treatment, services, referrals, or some combination thereof, you should **use age-sensitive and age-specific approaches to care that respect and respond to the unique needs of older adults.** A wide range of interventions are available to draw from, including pharmacologic and nonpharmacologic options.

In Chapter 4, you will learn about:

- **The ways in which older adults are at risk for harm from alcohol misuse,** including age-specific health effects as well as negative co-occurring mental and social conditions.
- **The need to screen all older adults for alcohol misuse and alcohol-related problems.** Screening is especially important in primary care and emergency department settings, where older adults are often seen for co-occurring conditions like chronic pain and falls. Screening is necessary in certain situations, like following major life changes (e.g., retirement [especially if forced or unwanted], loss of a significant other), when starting a new medication, and as part of an annual physical exam.
- **Measures developed and approved for use with older populations,** such as the Alcohol Use Disorders Identification Test and the Short Michigan Alcoholism Screening Test-Geriatric Version.
- The ways to respond appropriately to older clients who screen positively for alcohol misuse or alcohol-related problems. As a provider, **remember that not all diagnostic criteria for AUD apply to older adults in the same way they apply to younger adults.** For instance, older adults may report reduced socialization, but this is common with aging and not necessarily a sign that drinking is interfering with social abilities.
- The ways in which **prescription medications can interact negatively with alcohol.** This is critical information for providers and professionals because most of your older clients will be taking at least one prescription medication. Older adults taking numerous prescriptions or taking certain medications (e.g., benzodiazepines, antidepressants, blood thinners) are especially at risk for potentially harmful alcohol–drug interactions.
- **The steps to guiding older clients through the continuum of care** for substance misuse, including brief interventions, prevention strategies, outpatient care, inpatient rehabilitation, follow-up services, referrals, and recovery management.
- **Adapting treatment and services for age-specific needs of older adults,** including clinical approaches (e.g., nonconfrontational and supportive approaches), treatment and service structure (e.g., flexible scheduling, shorter sessions), and content needs (e.g., focus on increasing behavioral change, quality of life, and social connectedness). You also should be aware of pharmacologic and nonpharmacologic interventions and their effectiveness and safety for use with older adults.

Chapter 5: Treating Drug Use and Prescription Medication Misuse in Older Adults

This chapter discusses age-appropriate interventions and services for older adults with substance misuse (non-alcohol-related), including illicit drug use and nonmedical prescription medication use. This chapter will most benefit

healthcare, behavioral health, and social service providers who work with older adults (e.g., physicians, nurse practitioners, physician assistants, nurses, social workers, psychologists, psychiatrists, mental health counselors, alcohol and drug counselors, peer recovery support specialists).

Older adults can and do develop SUDs involving illicit drugs and nonmedical use of prescription medication. Many older adults take multiple medications and may be unaware of potential harms arising from substance misuse (e.g., overdose; dangerous interactions with alcohol and with other medications; increased risk of physical, mental, and cognitive problems). Age-specific, evidence-based treatments and services are available for older clients with these conditions, including SUDs involving opioids, cannabis, stimulants, and benzodiazepines and other sedative-hypnotics.

There is no "wrong door" by which older adults access care for drug addiction, and as a provider, you should ensure education, formal and informal treatment, services, and referrals are available throughout the entire course of care, from prevention through continuing care and recovery management.

In Chapter 5, you will learn that:

- Prescription medication misuse can be unintentional, underscoring the importance of **educating your older clients about how to take medication correctly** (including avoiding harmful interactions).
- **Older adults are at risk for opioid addiction,** given the high prevalence of chronic pain in this population. Opioid overdose prevention strategies, detoxification, and medication can be used safely and effectively with this population.
- Illicit substance use (e.g., opioids, cannabis, stimulants) does occur among older adults and can be treated using behavioral and pharmacological methods.
- **Routine screening and assessment will help you detect substance misuse early and accurately.** Thoroughly explore not just the client's substance misuse (current and past) but also other health behaviors (e.g., exercise, diet), changes in physical and mental functioning, and major life events that may put the person at risk for substance misuse (e.g., retirement, moving, loss of a loved one).
- A full assessment should cover topics like co-occurring medical and mental conditions, sleep problems, occurrence of pain, fall risk, and daily functioning.
- **Diagnostic criteria for SUDs may not fully apply to older clients.** Older clients' substance-related signs and symptoms may differ from those in the diagnostic criteria and in younger adults.
- **Older adults with SUDs can benefit from a wide range of age-sensitive and age-specific treatment and services across the continuum of care,** including prevention strategies, early and brief interventions, formal inpatient and outpatient treatment, and recovery management techniques.
- **Mutual-aid support programs and family involvement are important components of the continuum of care** for older adults with SUDs. Social support and connectedness are often lacking in older adults and can help those with substance misuse achieve and sustain recovery, optimal functioning, and good quality of life.

Chapter 6: Substance Misuse and Cognitive Impairment

This chapter outlines the ways in which substance misuse can affect (and be affected by) declines in thinking, including the occurrence of dementia. This chapter will most benefit behavioral health, healthcare, and primary care service providers and prevention specialists who offer direct care to clients in behavioral health and healthcare settings and care for older adults who misuse substances.

Changes in thinking, like difficulties with memory, attention, and learning, are a normal part of aging for most of us. But for older adults with substance misuse, these changes in thinking can be more severe and may develop faster than in the absence of substance misuse. **Substance misuse can increase the risk of certain cognitive problems and can make managing those cognitive problems more difficult.** Furthermore, problems with thinking may make it harder for some older adults to remember how to take

prescription medication appropriately or keep track of their alcohol consumption to ensure it does not exceed recommended guidelines. In other words, **cognitive disorders can increase older adults' chances of experiencing substance-related problems.** The key to offering timely and effective treatment is to engage in routine screening and assessment to detect potential cognitive impairment, like dementia and MCI, as soon as possible.

There are **many age-appropriate interventions and services you can offer** (or offer referrals for) to help maintain or improve older clients' mood, functioning, and quality of life. **Involving caregivers is also important to make sure clients struggling with their thinking take prescription medication correctly, avoid or consume safe amounts of alcohol, avoid illicit drugs, and stay engaged in treatment and services.**

In Chapter 6, you will learn about:

- Facts that show **substance misuse can and does occur in older adults,** particularly alcohol misuse.
- The latest research on the **effects of substances and certain medications (e.g., benzodiazepines) on cognition** and brain functioning in general.
- **The link between substance misuse and the risk of developing cognitive disorders in the future,** such as dementia and MCI.
- **The many mental disorders/symptoms that co-occur with substance misuse and that negatively influence thinking,** such as depression and depressive symptoms, anxiety, and PTSD and trauma. If offering treatment or services for older clients' substance misuse, it is critical to screen and assess for these mental disorders/symptoms because, if present and untreated, cognitive problems may persist.
- **Screening instruments developed for and tested in populations of older individuals are available.** These tools will help you detect possible co-occurring mental disorders as well as cognitive impairment.
- The numerous **interventions for older clients with substance misuse and co-occurring behavioral health and cognitive disorders,** including education, drug and alcohol counseling, brief counseling, referral to mutual-aid support programs and peer-recovery programs, and other interventions that do not involve pharmacotherapy.
- Why **including caregivers is essential for successfully treating older adults with substance misuse and co-occurring dementia or MCI.** Additionally, your role is to help ensure caregivers have the support and resources they need to maintain their own health and well-being (including avoiding substance misuse themselves).

Chapter 7: Social Support and Other Wellness Strategies for Older Adults

This chapter outlines ways to help older clients with substance misuse leverage social supports and other wellness strategies to improve their chances of achieving and maintaining long-term recovery. This chapter will most benefit healthcare, behavioral health, and social service providers who work with older adults (physicians, nurse practitioners, physician assistants, nurses, social workers, psychologists, psychiatrists, mental health counselors, alcohol and drug counselors, and peer recovery support specialists).

Strong social networks are an essential part of older adults' health and well-being. You can help **increase older adults' chances of recovery by offering interventions, services, and resources that target social supports and other aspects of wellness,** like health literacy, illness management, and relapse prevention. Social isolation is unfortunately common among many older individuals and has been linked to risky behaviors, including substance misuse, as well as poor physical, cognitive, and mental health. But you can help older clients enhance their social functioning as a part of recovery treatment/services through interventions that expand your clients' social network, increase their feelings of connectedness, promote neighborhood/community supports, and engage their family members in recovery activities.

In addition to addressing socialization, **do not overlook other areas of health and well-being that may help enhance recovery efforts and**

improve quality of life. This includes the older adult's physical health, emotional well-being, spirituality, vocational or volunteer work, and more.

In Chapter 7, you will learn that:

- Declines in social functioning are a normal part of aging for many individuals, but you can (and should) help older clients with substance misuse do something about this. **By helping older adults increase and enhance their social network and feelings of connectedness, you are at the same time also helping them improve their chances of overcoming substance misuse.**
- You should help older clients with substance misuse expand the size and diversity of their social network, engage neighborhood and community supports, and involve family members or caregivers in their recovery. **Be sure to offer recovery-specific social supports, like mutual-aid support programs and peer support programs,** among your services and referral options.
- Area Agencies on Aging are wonderful sources of information, support, and services to help your older clients engage in social support and other healthy activities. Online social networks, though often associated only with adolescents and young adults, also are a potential useful resource for older adults. Explore whether your older clients are interested in and need help accessing social media and related technologies; they can be an asset for older individuals who experience barriers to establishing or growing a social network of support.
- In addition to focusing on social functioning, **help older clients with substance misuse establish all-around wellness by addressing multiple areas of functioning, like their physical health, spirituality, emotional health, finances, work, and cognition.** All of these can play an important role in recovery.
- Wellness recovery activities keep your older clients engaged in all aspects of life, health, and well-being. **Brainstorm ideas together and link your clients to a wide range of wellness activities,** like exercising, joining a spiritual or religious fellowship, creating a safe and welcoming living environment, enrolling in adult education or senior college courses, and volunteering.
- Complementary therapies and activities, like animal-assisted therapy, may help your older clients improve certain aspects of their physical, social, and emotional health. But be sure to discuss with them both the benefits and potential limitations of these strategies.
- Older adults should **learn self-management techniques to independently monitor and improve their health.** This is important for addressing chronic illnesses, like heart disease and chronic pain, which often affect older individuals and, if unmanaged, can lead to significant impairments in functioning and quality of life. By learning to independently track and manage their symptoms, clients feel empowered and gain control of their health. This also applies to recovery; by continuing to engage in recovery activities, use relapse prevention techniques, and rely on social supports, **older clients can strengthen their resilience and maintain a sense of control over their recovery.**

Chapter 8: Drinking as an Older Adult: What Do I Need To Know?

This chapter focuses on older adults' alcohol consumption and key facts and information they (and family members/caregivers) should know about alcohol use and misuse. This chapter is for older adults who drink (including those with questions about how much they should drink), their caregivers, and their families.

Many older adults drink alcohol but do not develop alcohol misuse or other alcohol-related problems. Understandably, they may have questions about what defines a "safe" level of consumption; the signs, symptoms, and effects of alcohol misuse; and how, why, and when to seek professional treatment or services. **Family and caregivers should be similarly armed with this information** so they can offer support to an older significant other in need of care for alcohol misuse.

In Chapter 8, you will learn about:

- Guidelines that define **"moderate" and "at-risk/high-risk" amounts of alcohol for**

adults, including what counts as one drink. Keep in mind that what is high risk for older adults is often different than what is high risk for younger individuals, because older adults experience the negative effects of alcohol at lower amounts.

- The **causes of older adults' alcohol misuse,** such as certain stressful major life events (e.g., forced retirement, death of a significant other), increased isolation, physical disability, and boredom/lack of meaningful activities or hobbies.
- The **signs and symptoms of alcohol misuse in older adults,** including cognitive, physical, emotional, social, and behavioral conditions.
- Aspects of alcohol use that can lead to or worsen health conditions.
- How to make sense of media reports that suggest light or moderate drinking is healthy.
- Which medications can have harmful interactions with alcohol and what those interactions include.
- Tips and strategies for older adults who want to try to **manage their alcohol misuse on their own** and how to tell when it is time to seek help from a professional.
- The **steps that occur when a person accesses professional treatment or services,** such as screening, assessment, and follow-up visits. Also, you will learn about treatment options across the continuum of care, including formal and informal interventions, and **how to select the best-fitting treatment.**
- Ways to engage family and friends in support of recovery, as well as self-motivation strategies.
- **Vital information for family and caregivers,** like warning signs of alcohol misuse, helping an older adult access professional care, and the importance of self-care.

Chapter 9: Resources for Treating Substance Use Disorder in Older Adults

Chapter 9 provides a compendium of resources described in all other portions of the TIP, plus additional resources.

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Consensus Panel

Each Treatment Improvement Protocol (TIP) consensus panel is a group of primarily nonfederal addiction-focused clinical, research, administrative, and recovery support experts with deep knowledge of the TIP's topic. With the Substance Abuse and Mental Health Services Administration's (SAMHSA) Knowledge Application Program (KAP) team, they develop each TIP via a consensus-driven, collaborative process that blends evidence-based, best, and promising practices with the panel's expertise and combined wealth of experience.

Note: The information below indicates each participant's position and affiliation when the panel was convened and may not be current.

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Stakeholders represent a cross-section of key audiences with a deep interest in a TIP's subject matter. Stakeholders review and comment on the draft outline and supporting materials for the TIP to ensure that its focus is clear, its stated purpose meets an urgent need in the field, and it will not duplicate existing resources produced by the federal government or other entities.

Note: The information below indicates each participant's position and affiliation when the meeting was convened and may not be current.

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Disclaimer

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Chapter 4—Treating Alcohol Misuse in Older Adults

KEY MESSAGES

- Older adults are more likely than younger adults to feel the negative effects of alcohol and are at risk for alcohol–drug interactions. Therefore, widespread screening for alcohol use and misuse in all healthcare settings and emergency departments is recommended.
- Screening and assessment tools and treatment options for alcohol misuse among older adults should be senior friendly and meet their unique physical, emotional, and social needs.
- Education about low-risk levels of alcohol use and about alcohol–drug interactions can be a powerful brief intervention as well as a prevention tool in keeping seniors safe.
- You can help increase your older clients' chances of success by offering many different treatment choices based on their symptoms and needs; addressing all co-occurring health conditions; and using a stepped-care approach to the management of referrals and ongoing coordination of care.

Chapter 4 of this Treatment Improvement Protocol (TIP) will benefit healthcare, behavioral health service, and social service providers working with older adults. It addresses alcohol use and misuse among older adults. National survey data show that alcohol use, binge drinking, and alcohol use disorder (AUD) are increasing in this population at a concerning rate.[567] Addiction counselors and other healthcare providers should understand the unique needs of older adults when addressing alcohol-related issues. Although older adults generally have lower rates of alcohol misuse, including AUD, than younger adults, baby boomers (born between 1946 and 1964) are more likely to drink and have alcohol-related problems than earlier generations of older adults. Even low levels of drinking can lead to negative health effects in older adults because of age-related physical changes, negative interactions between alcohol and commonly used medications, and decreases in physical and cognitive functioning (thinking abilities).

Organization of Chapter 4 of This TIP

This chapter of TIP 26 presents facts about alcohol misuse, including AUD, among older adults. It also addresses screening and assessment, co-occurring health conditions and mental disorders often related to alcohol misuse, and treatment and recovery management approaches for older adults.

The first section of Chapter 4 describes alcohol misuse among older adults. It includes definitions; numbers and figures; and the physical, mental, social, and economic effects of AUD. **It also addresses co-occurring health conditions and mental disorders in older adults who drink.**

The second section addresses screening and assessment of alcohol misuse in older adults. It covers screening tools for alcohol misuse, limitations of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) diagnostic criteria for AUD as applied to older adults, signs of late-onset AUD, and misuse of alcohol with prescription medications. **This section also addresses screening for and assessing commonly co-occurring health conditions and mental disorders among older adults who drink.**

The third section briefly describes the continuum of care for older adults, including brief interventions for alcohol misuse and inpatient detoxification or rehabilitation.

The fourth section discusses specific treatment approaches for older adults with AUD. These include brief interventions, cognitive–behavioral therapy (CBT), problem-solving therapy (PST), skill-building and relapse prevention therapy (RPT), 12-Step Facilitation (TSF) therapy, age-specific inpatient and outpatient rehabilitation, and pharmacotherapy.

The fifth section explores recovery management strategies for older adults. It covers strategies for including family members in treatment; addressing caregiver needs; and linking older adults to evidence-supported, community-based recovery support groups such as Alcoholics Anonymous (AA) and SMART (Self-Management and Recovery Training) Recovery.

The sixth section presents clinical scenarios to show how to match treatment approaches to a client's level of alcohol misuse, from those who are abstinent (not drinking at all) for health reasons to those with AUD requiring inpatient rehabilitation and ongoing recovery management.

The final section offers targeted resources to support your practice. For more resources related to addressing substance misuse among older adults, including misuse of alcohol, see the Chapter 4 Appendix and the additional resources in Chapter 9 of this TIP.

For definitions of key terms you will see throughout Chapter 4, refer to Exhibit 4.1.

EXHIBIT 4.1. Key Terms

- **Addiction*:** The most severe form of substance use disorder (SUD), associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.
- **Age-sensitive:** Adaptations to existing treatment approaches that accommodate older adults' unique needs (e.g., a large-print handout on the signs of substance misuse).
- **Age-specific:** Treatment approaches and practices specifically developed for older adults (e.g., an older adult specialty group in a mixed-age SUD treatment program).
- **Alcohol misuse:** The use of alcohol in any harmful way, including heavy drinking, binge drinking, and AUD.
- **At-risk/high-risk drinking:** Drinking alcohol in excessive amounts. This definition encompasses both binge drinking and heavy drinking. Additionally, any alcohol consumption is considered risky when carried out by individuals with certain medical conditions that are worsened by alcohol, those taking medicine that can interact harmfully with alcohol, those driving a car or engaged in other activities that require alertness, or people recovering from AUD.[568,569] Note that for purposes of this TIP, at-risk drinking and high-risk drinking are synonymous and either term is acceptable to describe an older adult's drinking patterns.
- **AUD:** DSM-5 defines this disorder.[570] An AUD diagnosis is given to people who use alcohol and meet at least 2 of the 11 DSM-5 symptoms in a 12-month period. Key aspects of AUD include tolerance, withdrawal, loss of control, and continued use despite negative consequences. AUD covers a range of severity and replaces what the previous edition of DSM termed alcohol abuse and alcohol dependence.

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- **Binge drinking:** A drinking pattern that leads to blood alcohol concentration levels of 0.08 grams per deciliter or greater. This usually takes place after four or more drinks for women and five or more drinks for men.[571,572] However, older adults are more sensitive to the effects of alcohol, and treatment providers may need to lower these numbers when screening for alcohol misuse.[573] Additionally, other factors such as weight, decrease in enzyme activity, and body composition (e.g., amount of muscle tissue present in the body) can also affect alcohol absorption rates.
- **Caregivers:** Informal caregivers provide unpaid care. They assist others with activities of daily living (ADLs), including health and medical tasks. Informal caregivers may be spouses, partners, family members, friends, neighbors, or others who have a significant personal relationship with the person who needs care. Formal caregivers are paid providers who offer care in one's home or in a facility.[574] Most older adults do not need caregivers and are as able to address their own needs as younger adults, whether or not substance misuse is a factor in their lives.
- **Drug–drug interaction:** The interaction of one substance (e.g., alcohol, medication, an illicit drug) with another substance. Drug–drug interactions may change the effectiveness of medications, introduce or alter the intensity of side effects, and increase a substance's toxicity or the concentration of that substance in a person's blood. Potentially serious interactions can also occur with certain foods, beverages, and dietary supplements.[575]
- **Harmful drinking:** Alcohol use that worsens or complicates current alcohol-related problems.[576]
- **Hazardous drinking:** Alcohol use that increases the risk of future harm.[577]
- **Heavy drinking:** Consuming five or more drinks for men and four or more drinks for women in one period on each of 5 or more days in the past 30 days.[578]
- **Moderate drinking:** According to the 2015–2020 *Dietary Guidelines for Americans,* moderate drinking is defined as up to two drinks per day for men and up to one drink per day for women.[579,580] However, the Centers for Disease Control and Prevention (CDC) notes that these numbers apply to any given day and are not meant as an average over several days.[581] Additionally, individuals who don't metabolize alcohol well may need to consume even lower quantities. Some people, particularly those with certain alcohol-related illnesses or engaging in tasks requiring concentration, should not consume alcohol at all. The *Dietary Guidelines* stipulate that those who don't drink should not begin drinking for any reason.[582]
- **Mutual-help groups:** Groups of people who work together on obtaining and maintaining recovery. Unlike peer support (e.g., the use of recovery coaches or peer recovery support specialists), mutual-help groups consist entirely of people who volunteer their time and typically have no official connection to treatment programs. Most are self-supporting. Although 12-Step groups such as AA and Narcotics Anonymous are the most widespread and well researched type of mutual-help groups, other groups may be available in some areas. They range from groups affiliated with a religion or church (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART Recovery, Women for Sobriety).
- **Peer support:** The use of peer recovery support specialists (e.g., someone in recovery who has lived experience in addiction plus skills learned in formal training) to provide nonclinical (i.e., not requiring training in diagnosis or treatment) recovery support services to individuals in recovery from addiction and to their families.
- **Recovery*:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome them and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called being in recovery. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, prosocial feature.
- **Relapse*:** A return to substance use after a significant period of abstinence.

Continued on next page

Continued

- **Remission:** A medical term meaning a disappearance of signs and symptoms of the disease or disorder. DSM-5 defines remission as present in people who previously met SUD criteria but no longer meet any SUD criteria (with the possible exception of craving).[583] Remission is an essential element of recovery.
- **Stepped care:** A science-based approach that matches an individual's treatment needs to different levels of care, from least intensive to most intensive.
- **Substance misuse*:** The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).
- **Substance use disorder*:** A medical illness caused by repeated misuse of a substance or substances. According to DSM-5,[584] SUDs are characterized by clinically significant impairments in health and social function, and by impaired control over substance use. They are diagnosed through assessing cognitive, behavioral, and psychological symptoms. SUDs range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Multiple factors influence whether and how rapidly a person will develop an SUD. These factors include the substance itself; the genetic vulnerability of the user; and the amount, frequency, and duration of the misuse. Note: A severe SUD is commonly called an addiction. A mild SUD is generally equivalent to what previous editions of DSM called substance abuse; a moderate or severe SUD is generally equivalent to what was formerly called substance dependence.

* The definitions of all terms marked with an asterisk correspond closely to those given in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.* This resource provides a great deal of useful information about substance misuse and its impact on U.S. public health. The report is available online (https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf).

Alcohol Misuse Among Older Adults

More older adults are misusing alcohol than in earlier years. An estimated 23.2 million adults ages 65 and older drank alcohol in the past month, 5.6 million engaged in past-month binge drinking, and 1.5 million engaged in past-month heavy drinking.[585]

The signs and effects of alcohol misuse, including binge drinking and AUD, often differ between older and younger adults. Understanding the differences will help you identify, assess, and treat older adults.

Age-Specific Effects of Alcohol Use

Older adults metabolize alcohol less efficiently than younger adults. Older adults have less lean body mass and less total body water than younger adults. This smaller water volume is one reason why an older adult and a younger adult can drink similar amounts of alcohol, but the older adult's blood alcohol level will be higher and stay high longer. In addition, older adults' central nervous system (CNS) is more sensitive to alcohol's effects, leading to lower tolerance.[586] These differences can **lead to or worsen chronic illnesses common in older adults (e.g., high blood pressure).**[587]

Drinking also increases health-related risks for older adults who take medications that may interact negatively with alcohol. Older adults are more likely than younger adults to take multiple

medications, further increasing this risk. Moreover, up to 19 percent of older adults in the United States use alcohol and prescription medications in a way that could be considered misuse.[588]

Alcohol Misuse

Older adults can meet the definition of alcohol misuse at lower levels of alcohol use than adults younger than 60. **Older adults who have been drinking for years may face more alcohol-related problems—and those problems may be more severe—even if their use has not increased over time.** A review of survey data indicates that 4 percent to 14 percent of older adults may misuse alcohol.[589]

The rate of alcohol misuse among older adults increases when including health status and overall functioning, rather than just amount of alcohol used and frequency of use. For instance, a study on alcohol-related health risk in older adults in the United States found that among older adults who drink, 53.3 percent had harmful or hazardous use.[590] This number was more than three times greater than the number of older adults consuming alcohol above federal guideline limits. The discrepancy in the consumption rate and the rate of harmful or hazardous use is explained by the health status of older adults.

RESOURCE ALERT: A CONSUMER WEBSITE FOR CALCULATING ALCOHOL CONSUMPTION

Rethinking Drinking: Alcohol & Your Health (www.rethinkingdrinking.niaaa.nih.gov) is a National Institute on Alcohol Abuse and Alcoholism (NIAAA) interactive website that provides individuals with accurate information about what a standard drink is and how to calculate their level of alcohol use based on the types and amounts of alcoholic beverages they drink.

Low-risk drinking guidelines at this website are for *all* adults; they are not reduced for older adults. Discuss why older adults may need to adhere to lower numbers before referring your clients to this website.

Alcohol misuse among older adults is likely responsible for a large portion of the damage some experience to their health and well-being.[591] For the older adult population, drinking even small amounts of alcohol can have serious physical, mental, and social effects. For example, one or two drinks a day may lead to increased cognitive impairment (problems with thinking) for individuals who already have dementia, or sleep problems (e.g., sleep apnea).[592]

The economic costs of alcohol misuse among older adults are significant. Older adults who misuse alcohol are at greater risk for injury and falls. Certain events among older adults that can be related to alcohol use—such as injury deaths, falls treated in emergency departments, hospitalized falls, and fall-related traumatic brain injury deaths—have risen significantly in the past decade.[593]

Older adults who misuse alcohol are at risk for:[594]

- Liver disease.
- Sleep problems.
- Cancer.
- Diabetes.
- Congestive heart failure.
- Lowered general health functioning.

Older adults who drink beyond recommended guidelines have higher rates of tobacco use disorder and are at risk for:[595,596,597]

- Depression, anxiety, and mood disorders.
- Memory problems.
- Cognitive changes such as dementia.
- Sleep disorders.
- Agitation or violent behavior.
- Suicide.

DRINKING IN RETIREMENT COMMUNITIES

Participating in social activities with family and friends who drink reinforces alcohol use and misuse. This is particularly true in retirement communities, where drinking and socializing often go hand in hand.[598] A recent study of a large retirement community in Florida found that 15.4 percent of the respondents to a survey on drinking reported hazardous drinking levels. However, when asked about health-related concerns and quality of life, most responded that drinking was a part of their social lives, did not report many health concerns, and reported a high quality of life.[599]

This result suggests that some older adults whose social drinking exceeds recommended limits may improve their quality of life, which could balance out any potential health risks. However, subjective measures of health-related effects of heavy alcohol use are not always as trustworthy as objective measures, such as lab results for medical conditions. **When you assess the health risks of an older adult's drinking, keep in mind the cultural context of his or her drinking, the amount and frequency of drinking, and any objective measures of health effects in addition to self-report findings.**

Binge Drinking

Binge drinking is a drinking pattern that leads to blood alcohol concentration levels of 0.08 grams per deciliter or greater. On average, this occurs after five or more drinks for men and four or more drinks for women.[600,601] However, for older adults, who have increased sensitivity to alcohol, lower alcohol consumption levels may be considered binge drinking.

According to the National Survey on Drug Use and Health (NSDUH), 10.7 percent of adults ages 65 and older binge drink (defined as five or more drinks for men and four or more drinks for women, per event).[602] This percentage would be even higher if the survey could factor in that binge drinking occurs at lower alcohol consumption levels for some older adults. **Binge drinking appears to be more of an issue for older men than older women.[603]** Yet binge drinking among older women is rapidly increasing.[604]

Binge drinking creates additional health problems for older adults. Binge drinking is related to a number of health and safety issues, including accidents, an increased chance of physical injury (e.g., falls), and higher death rates.[605,606] Binge drinking is also related to a higher risk of AUD in both men and women as they age.[607,608]

AUD

Baby boomers drink more than earlier generations, which is likely to lead to a large increase in the number of older adults with AUD as this generation ages.[609] Furthermore, the number of adults ages 65 and older in the U.S. population is predicted to increase from about 56 million in 2020 to more than 85 million by 2050.[610,611]

In the general population, only an estimated 1.52 percent of adults ages 60 and older report AUD in the past 12 months; 16.1 percent report AUD in their lifetime.[612] Conversely, up to 30 percent of older adults hospitalized in general medical units and up to 50 percent hospitalized in psychiatric units have AUD.[613] This is significant, because older adults with AUD who are hospitalized might not report their level of drinking to healthcare providers and could be at risk for alcohol withdrawal during their hospitalization. So too, these percentages may not capture the actual prevalence of AUD in this population, as DSM diagnostic criteria do not always accurately identify AUD in older adults.[614]

According to the 2019 NSDUH, **10.7%** of adults ages **65** and older **BINGE DRINK.**

Co-Occurring Health Conditions and Mental Disorders

Alcohol use can worsen the effects of many co-occurring mental health and health conditions (e.g., depressive disorders, high blood pressure, and diabetes). In addition, many physiological changes naturally take place during the aging process; clients need to understand that drinking can accelerate these health-related changes.

Anxiety

Anxiety symptoms and anxiety disorders are common in adults ages 60 and older in community and treatment settings.[615] Older adults also have a high rate of co-occurring anxiety disorders and AUD.[616] Anxiety causes high personal distress, reduces life satisfaction, and increases the risk for disability among older adults. Anxiety also increases the risk of death among older adults from suicide and from heart disease.[617] **Older adults who drink to lessen their anxiety increase their health-related risks.**

Depression

Depression is one of the most common co-occurring mental disorders among older adults with AUD. Approximately 4.5 percent of older adults (ages 50 and older) met past-year prevalence of major depression.[618] This estimate does not include those who meet either DSM-5 diagnostic criteria for other depressive disorders or have symptoms of depression that interfere with everyday functioning. The negative effects of depression in older adults include suicide risk, increased cognitive impairment, a higher risk of dementia, and poorer physical health.[619]

Alcohol is a depressant drug (meaning it reduces activity of the CNS). Drinking alcohol can worsen depression or increase the risk of late-life depression.[620] In approximately 30 percent of older adults with co-occurring AUD and depression, the depression is not directly linked to drinking but instead was present before the onset of AUD or developed separately from AUD.[621]

RESOURCE ALERT: TREATING DEPRESSION IN OLDER ADULTS

See SAMHSA's Evidence-Based Practices KIT (Knowledge Informing Transformation) *The Treatment of Depression in Older Adults* (https://store.samhsa.gov/product/Treatment-Depression-Older-Adults-Evidence-Based-Practices-EBP-Kit/SMA11-4631) for more information and treatment strategies.

Diagnosing depression in older adults with AUD is challenging. Depression may be underdiagnosed because its symptoms are similar to those of dementia and common complaints of older adults, such as loss of interests, slowed thinking, lack of energy, or general aches and pains.[622] **Assess depression and other mood disorders at the start of AUD treatment, and reassess from time to time** to learn whether abstinence or a reduction in alcohol use reduces symptoms of depression.

Serious Mental Illness

People with serious mental illness (SMI), like schizophrenia, typically have higher levels of stress, tobacco use, and alcohol use than the general population. They are also more likely to have poor overall health, an inactive lifestyle, and an increased risk of death.[623] **About 19 percent of older adults with SMI have a co-occurring SUD, and AUD is one of the most common.[624]**

Co-occurring AUD and SMI among older adults has not been studied widely. However, alcohol use is a factor in people not taking their psychotropic medication as prescribed, and co-occurring AUD is related to longer length of psychiatric stay and an increase in co-occurring medical conditions.

See Chapter 6 of this TIP for details on the links between alcohol use and dementia among older adults.

Pain

Chronic pain is a common condition in older adults that reduces their ability to move and perform ADLs. A study of U.S. older adults estimated that 52.9 percent, or as many as 18.7 million, have pain that makes their daily functioning difficult.[625]

Older adults with chronic pain who drink to reduce their pain are at risk for late-onset AUD.[626] Drinking while taking pain medications also increases other health-related risks (e.g., serious liver disease, overdose death). Common pain medications older adults may take include nonsteroidal anti-inflammatory drugs (NSAIDs) and opioids (e.g., hydrocodone, oxycodone).

Screening and Assessment

Many older adults who misuse alcohol do not need specialized addiction treatment services. Still, screening and brief educational and motivational interventions can help older adults reduce alcohol use and health-related harms when delivered in healthcare and mental health service settings.[627]

AUD is often underdiagnosed in older adults. Some DSM-5 diagnostic criteria may not apply to them. For example, the criterion of failing to fulfill major duties at work will not apply to an older adult who is retired. Furthermore, **providers may mistake AUD symptoms for other conditions** that are commonly, yet often incorrectly, thought to be normal signs of aging, such as:[628]

- Sleep problems.
- Memory loss.
- Depression.
- Anxiety.
- Aches and pains.
- Poor diet.
- Loss of interest in sex.

Older adults in long-term care settings, such as assisted living and nursing homes, are often not diagnosed or treated for AUD.[629] The key to finding the right interventions for alcohol misuse, including AUD, is to **adapt screening, assessment, and diagnostic criteria to older clients, regardless of the settings in which they receive health or social services.**

Widespread Screening

Widespread screening in healthcare and behavioral health service settings is an opportunity for brief intervention and, when needed, referral to addiction-specific treatment services.[630]

Older adults are often not screened for alcohol misuse because providers hold incorrect beliefs about alcohol use in this population. They may think that older adults don't drink much or, if they do drink, they should be allowed this "one last pleasure" of life.[631] Providers also may choose not to ask older adults about their drinking history and current alcohol use for fear that asking these questions will hurt their relationship with these clients. However, baby boomers tend to be more accepting than earlier generations of the idea of talking about and seeking help for mental disorders and SUDs.

Challenge false beliefs by educating your fellow providers and supporting widespread alcohol screening as a normal, ongoing practice. Doing so can help reduce any mixed feelings providers have about screening older adults. It can also increase the chances of identifying alcohol misuse early in older clients. (Chapter 3 of this TIP offers more information on screening and assessing for substance misuse in older adults.)

WHEN TO SCREEN OLDER ADULTS FOR ALCOHOL MISUSE[632]

- As part of every annual physical exam
- As part of the initial assessment in behavioral health service settings
- As part of the initial intake or admission process to older adult–focused social service programs
- When the older adult starts a new medication
- When the older adult has major stressful life changes (e.g., death of a significant other, retirement, major illness or declining health, loss of social supports)
- When potential signs and symptoms of an alcohol-related problem are present, such as sleep difficulties, falls, injuries, depression, and problems with daily living skills
- When the older adult has multiple healthcare providers or uses more than one pharmacy
- When the older adult reports that a medication is not working as well over time
- When the older adult reports a past personal or family history of substance use or mental disorders

The consensus panel recommends widespread screening of older adults for alcohol misuse and alcohol-related problems in all healthcare settings and emergency departments, where older adults are frequently seen because of accidents and falls related to alcohol use. Also screen older adults for alcohol misuse at the initial intake or assessment when admitted to social services agencies and behavioral health service programs.

Screening Tools

The Alcohol Use Disorders Identification Test (AUDIT) and the Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G) are two common, easy-to-use, brief instruments that can successfully screen older adults for alcohol misuse and signs of AUD.[633]

AUDIT

The AUDIT is a 10-item screening instrument for heavy drinking from the World Health Organization. The AUDIT collects information about alcohol use, drinking behaviors, and alcohol-related problems over the past year.[634] It is a validated (tested and approved) measure of alcohol-related risk in people of different genders, ages, and cultures.[635] There are two versions—one given by clinicians and one that clients complete by themselves. (See the Chapter 4 Appendix for both.) A cutoff score of 8 generally indicates hazardous and harmful alcohol use. For older adults, however, a score of 5 means you should assess further.[636]

SMAST-G

Researchers at the University of Michigan developed the MAST-G, a 24-item screening instrument specifically for use with older adults. The MAST-G can be used to identify alcohol misuse in older adults.

The SMAST-G is a shorter, 10-item, validated version of MAST-G.[637] The SMAST-G does not ask about amount and frequency of alcohol use; it focuses more on the older adult's relationship to alcohol and effects of drinking. The SMAST-G is about as reliable and accurate for older adults as the AUDIT. Two or more "yes" responses indicate possible alcohol misuse.[638] (See the Chapter 4 Appendix for the SMAST-G.)

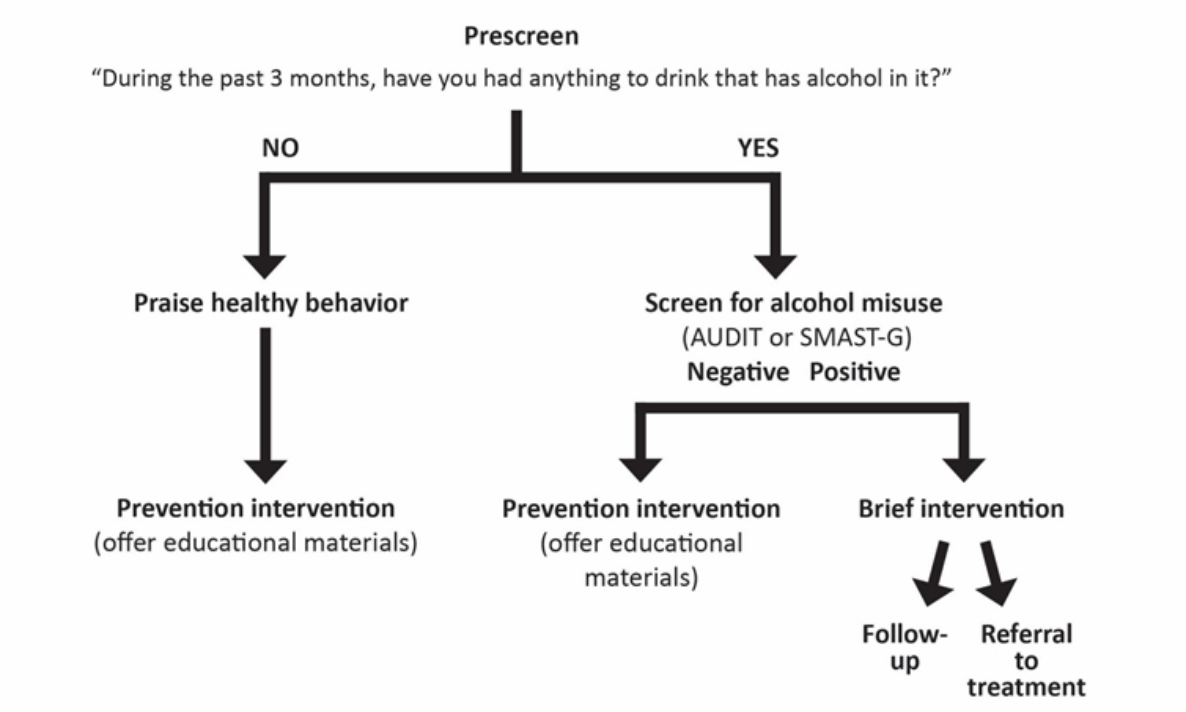
Considerations When Using AUD Screening Instruments

Although screening instruments can help you quickly identify potential alcohol misuse in older adults and offer a chance to use prevention strategies (Exhibit 4.2), they can sometimes be overly sensitive and lead to false positives.[639] Some questions on alcohol screening instruments refer to physical complaints that are often age associated. Conversely, brief screening does not always capture symptoms that may indicate AUD. **Always follow up positive screens with more questions and indepth assessment (or referral to assessment) for AUD.**

EXHIBIT 4.2. Preventing Alcohol Misuse Among Older Adults

You can support prevention efforts by helping older adults develop the knowledge, attitudes, and skills they need to make good choices about alcohol use before their drinking puts their physical and mental health at risk. The key to prevention is identifying early which older adults drink alcohol. You can often help older adults to reduce their drinking, or to seek help if their alcohol use begins to affect their health, simply by giving them information about standard drink sizes, guidelines for low-risk drinking, health risks of alcohol misuse, and health risks of mixing medication with alcohol.

Early identification and prevention begin with widespread prescreening in all healthcare and community-based senior service settings.[640] The following decision tree shows the early identification and prevention process.



Adapted from material in the public domain.[641]

Assessment and Diagnosis of AUD

It is essential that you, or another provider with sufficient qualifications, perform indepth assessments for AUD in your older adult clients. Older adults with AUD are often underdiagnosed because DSM-5 criteria do not always capture AUD in older adults. Also, some signs of AUD may be mistaken for symptoms of co-occurring medical or mental disorders or natural aging processes. **If you only use DSM-5 diagnostic criteria to diagnose AUD, you may miss many older adults with alcohol-related problems, which means they may not receive proper treatment.**[642]

A full assessment should address the client's:

- History of alcohol use.
- Age of onset of alcohol-related problems.
- Past and current amount and frequency of alcohol use (with attention to periods of binge drinking).
- Relationship between his or her drinking and daily functioning.
- Co-occurring medical conditions.
- Past attempts to limit or control alcohol intake.

- Co-occurring mental disorders, particularly depression and anxiety.
- Current medications.
- Use of alcohol to cope with sleep problems, depression, anxiety, stressful life events, or pain.

For information on how to give an indepth assessment for AUD, refer to Chapter 3 of this TIP.

Understanding DSM-5 Diagnostic Criteria Versus Alcohol-Related Risk Criteria

For an AUD diagnosis, your client must have at least 2 out of 11 symptoms listed in DSM-5. However, as noted before, some of these symptoms may not apply to older adults. Exhibit 4.3 summarizes the physical, cognitive, and social aspects of aging you should think about when using these criteria to assess and diagnose AUD in older adults.

EXHIBIT 4.3. DSM-5 Criteria for AUD and Considerations for Older Adults

DSM-5 CRITERIA FOR AUD[643]	CLINICAL CONSIDERATIONS[644,645,646,647,648]
Criterion A1	Older adults may need less alcohol to feel physical effects. Cognitive impairment can make it hard for older adults to keep track of their drinking.
Criterion A2	No special considerations for older adults.
Criterion A3	Effects of alcohol can result from drinking even small amounts, so relatively less time may be spent getting and drinking alcohol and recovering from using it.
Criterion A4	No special considerations for older adults.
Criterion A5	Older adults may have different role responsibilities because of life-stage changes, such as retirement. Role responsibilities more common in older adulthood include caregiving for a spouse or another family member, such as a grandchild.
Criterion A6	Older adults may not realize that social or interpersonal problems they are experiencing are connected to their alcohol use.
Criterion A7	Older adults may take part in fewer activities generally, making it more difficult to discover when drinking is causing them to withdraw from activities.
Criterion A8	Older adults may not understand that their alcohol use is hazardous, especially when they are drinking the same as or less than before. In addition, older adults may not realize the physical dangers of drinking in certain situations (e.g., before using a step stool).
Criterion A9	Older adults experiencing physical or psychological problems may not realize that drinking could be a factor.
Criterion A10	Changes in tolerance occur because of increased sensitivity to alcohol with age. Previously manageable quantities of alcohol may cause greater impairment.
Criterion A11	Withdrawal symptoms in older adults can last longer, be less obvious, or be mistaken for age-related illness.

DSM-5 diagnostic criteria related to physical and emotional effects (e.g., craving, desire to cut down) may be key signs of AUD in older adults.[649] When deciding whether an older individual's alcohol misuse meets DSM-5 criteria for AUD, remember older adults' lowered tolerance to alcohol and the unique aspects of withdrawal from alcohol and other sedative-hypnotic drugs, like benzodiazepines.

To diagnose AUD in older adults, use alcohol-related risk criteria in addition to DSM-5 diagnostic criteria. For example, alcohol-related risk criteria for older adults in the Comorbidity Alcohol Risk Evaluation Tool (CARET), based on the Alcohol-Related Problems Survey,[650] include:[651]

- Amount and frequency of alcohol use (e.g., drinking more than recommended guidelines).
- Brief periods of excessive drinking (e.g., binge drinking).
- Driving after drinking.
- Others being concerned about the older adult's drinking.
- Co-occurring medical and mental disorders.
- Symptoms caused or worsened by drinking (e.g., cognitive impairment).
- Medications that interact negatively with alcohol or that do not work properly if taken with alcohol.

The amount and frequency of drinking described as "at-risk" for older adults is paired with specific drinking behaviors, use of medications, and co-occurring conditions in the past 12 months. For more information about the items in the CARET and how to score them, please see Barnes et al., 2010.[652]

For example, if an older adult has chronic liver disease and drinks any alcohol or even binge drinks just once a week, he or she may not meet DSM-5 criteria for AUD. Still, his or her drinking is a risk for serious alcohol-related health consequences. **Using age-adjusted DSM-5 criteria and CARET health-related risk criteria will more accurately gauge severity of AUD** and the degree to which your client may exhibit behavioral or health-related effects of drinking that should be a focus of treatment.

In assessing and diagnosing AUD in older adults, the consensus panel recommends that you think through all aspects of health-related risk in addition to age-specific issues.

Late-Onset Alcohol Misuse and AUD

Most older adults meeting criteria or receiving treatment for AUD began drinking earlier in their lives. However, **some older adults begin to misuse alcohol later in life (called late-onset alcohol misuse or, if severe enough to meet criteria for AUD, late-onset AUD). Older adults who begin misusing alcohol late in life may not realize their increased risk for health-related harms related to drinking.** They may start misusing alcohol to cope with co-occurring medical or mental disorders, grief and isolation upon the loss of a loved one, or the stress of life changes, such as retirement.[653] Stress, role or identity loss, and approval of drinking by members of older adults' social groups are linked to an increased risk of late-onset AUD.[654]

Assessments should address risk factors related to late-life alcohol misuse among older adults (Exhibit 4.4). **Assessment is a chance for you to use education as a prevention and early intervention tool.**

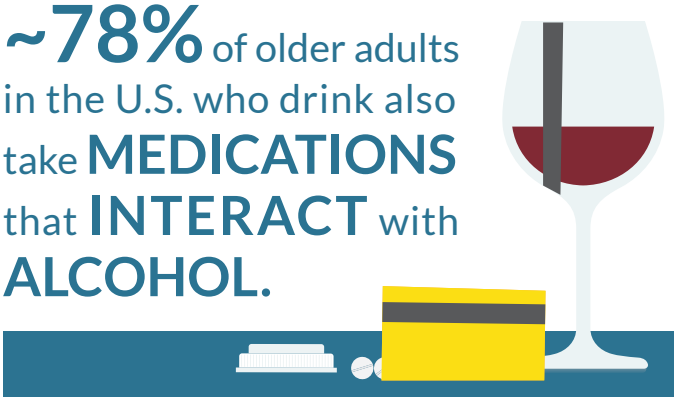


EXHIBIT 4.4. Risk Factors Related to Alcohol Misuse in Late Life[655]

Physical risk factors:

- Long-lasting pain
- Physical disabilities or problems getting around
- Changes in care or living situations
- Poor health status
- Chronic physical illness
- Multiple prescription drugs

Mental risk factors:

- Avoidance coping style (e.g., drinking to cope with stressful events)
- History of alcohol misuse
- Past or co-occurring SUDs (including tobacco use disorder)
- Past or co-occurring mental disorders

Social risk factors:

- Financial stress, including having a fixed income and having difficulty obtaining Medicare/Medicaid and other health benefits
- Bereavement
- Unexpected or forced retirement
- Social isolation

Assessing Alcohol–Drug Interactions

Alcohol–drug interactions are a major factor in the overall health risk for older adults who drink.[656] Changes in older adults' ability to absorb and metabolize alcohol and medications (i.e., higher sensitivity) can increase the risk of negative alcohol–drug interactions. Alcohol can also increase or reduce a medication's therapeutic effect and interfere with its effectiveness in treating medical illnesses commonly seen in older adults, like high blood pressure, depression, gout, and insomnia.[657]

Some older adults may also be at greater risk for negative alcohol–drug interactions because of the number and types of medications they take. Approximately 78 percent of older adults in the United States who drink also take medications that interact with alcohol.[658,659] Emergency department visits are increasing for dangerous alcohol–drug reactions in older adults.

Many classes of prescription medications can interact negatively with alcohol, including:[660]

- Antibiotics.
- Antidepressants.
- Antihistamines.
- Barbiturates.
- Benzodiazepines.
- Muscle relaxants.
- Nonopioid pain medications.
- Anti-inflammatory agents.
- Opioids.
- Anticoagulants.

Learn more about commonly used prescription and over-the-counter medications and how they interact with alcohol in NIAAA's publication *Harmful Interactions* (www.niaaa.nih.gov/publications/brochures-and-fact-sheets/harmful-interactions-mixing-alcohol-with-medicines).

RESOURCE ALERT: ALCOHOL AND DRUG INTERACTION CHECKERS

Learn more about interactions between alcohol and specific medications by using a drug interaction checker (e.g., the one available at www.drugs.com/drug_interactions.html). Check for interactions between ethanol (the type of alcohol in alcoholic beverages) and medications (prescription and over-the-counter) and dietary supplements (e.g., vitamins, herbal products).

With permission, you can also check with your client's pharmacist about alcohol–drug interactions for the specific medications your client takes.

Always learn which medications your client takes. Nonjudgmentally offer information about the ways alcohol can interfere with a medication's effectiveness and increase the risk of harmful effects.

The consensus panel recommends that you educate older adults about negative alcohol–drug interactions and work with your clients to help them reduce or abstain from alcohol use while taking these medications.

Continuum of Care

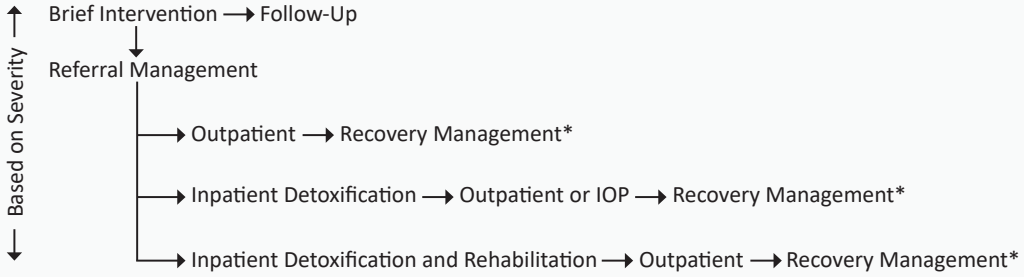
A continuum of care exists for older adults with alcohol misuse, including AUD. It ranges from least to most intensive: from brief interventions, to outpatient or intensive outpatient treatment (IOP) in programs that specialize in mental health services or SUD treatment, to inpatient detoxification and rehabilitation.

Continuing care should focus not only on achieving abstinence from or reducing alcohol use but also on improving quality of life. AUD treatment goals are like treatment goals for any other chronic condition. They include:[661]

- Respectfully helping older adults participate in treatment throughout the continuum.
- Helping them stay motivated to change risk behaviors to improve their health and quality of life throughout treatment and recovery.
- Using multiple treatments as needed, including pharmacotherapy and psychosocial interventions.
- Reducing the risk of relapse.

Apply a stepped-care approach that starts with the least intensive treatment option that meets the needs of the older adult, and then increase the level of intensity as needed. Exhibit 4.5 shows the possible treatment pathways along the continuum of care for older adults with alcohol misuse.

EXHIBIT 4.5. Continuum of Care Pathways for Older Adults



Note: Pharmacological interventions may be started at any time across the continuum of care to meet clients' needs.

*For more about recovery management, see the "Recovery Management" section of this chapter.

Treatment Approaches Suited to Older Adults

Despite common stereotypes, older adults are generally open to and accepting of alcohol treatment, especially when programs offer age-specific groups, age-sensitive treatment (i.e., treatments that meet their special needs), and providers trained in issues unique to older adults.[662,663] Older men and women who participate in alcohol treatment:[664]

- Are successful in reaching treatment goals of abstinence or risk reduction.
- Have nearly the same or better outcomes than younger adults.
- Are more likely to complete treatment than younger adults.
- Benefit greatly from age-specific treatment.

The consensus panel recommends that all treatment providers adopt the age-sensitive practices in Exhibit 4.6. (For more information on principles of care for older adults, see Chapter 2 of this TIP.)

EXHIBIT 4.6. Characteristics of Age-Sensitive Alcohol Treatment for Older Adults[665]

Regardless of the settings and modalities in which you offer treatment services to older adults, they are more likely to be open to and respond to treatment if interventions are:

- **Supportive and nonconfrontational** (e.g., forming a respectful partnership with your clients, which is the primary way to support behavior change).
- **Flexible** (e.g., supplying services at home or over the phone if clients cannot get to you).
- **Sensitive to gender differences** (e.g., addressing in AUD treatment the fact that women are more likely to be prescribed psychoactive medications than men).
- **Sensitive to cultural differences** (e.g., using print materials in your clients' primary language).
- **Sensitive to the client's level of physical and cognitive functioning** (e.g., using shorter sessions; meeting in a room close to the building entrance; giving information in multiple formats, like verbally and in writing).
- **Holistic and thorough** (e.g., addressing cognitive, physical, social, mental, financial, emotional, and spiritual factors that may inhibit treatment engagement or enhance recovery).
- **Focused on helping older adults develop and improve coping and social skills** (i.e., instead of focusing on internal mental processes, using treatment that focuses on behavioral change to reduce their alcohol-related risk and increase quality of life, such as developing problem-solving strategies to manage triggers for drinking and strengthening social connections with nondrinking friends or members of mutual-help groups).

Brief Interventions for Alcohol Misuse

Brief interventions can support AUD prevention and risk reduction (e.g., helping clients to reduce or abstain from drinking to decrease health-related risks). Brief intervention also can be a starting point for entry into more intensive AUD treatment. (See Chapter 3 of this TIP for more information.) Older adults are likely to participate in and accept this approach to addressing alcohol misuse.[666,667,668]

Brief interventions are a good fit for many different treatment settings, including primary care, emergency departments, older adult-focused social service settings, and outpatient behavioral health service programs. **They are cost effective, low intensity,[669,670] and efficient,** generally consisting of one to four sessions that last from 15 to 60 minutes.[671,672] Brief interventions may include:

- Referral as needed to medical specialists.
- Inpatient/outpatient addiction-specific treatment.
- Older adult–focused social services.
- Community-based mutual help and recovery support groups, such as AA.

RESOURCE ALERT: SCREENING AND BRIEF INTERVENTIONS FOR OLDER ADULTS

See SAMHSA's *A Guide to Preventing Older Adult Alcohol and Psychoactive Medication Misuse/Abuse: Screening and Brief Interventions* at www.ncoa.org/wp-content/uploads/SBIRT-Older-Adult-Manual-Final.pdf for more information about prevention strategies and brief interventions. You can use the guide's "Health Promotion Workbook" (included as an appendix) when conducting brief interventions for alcohol misuse.

Motivational Interviewing

Motivational interviewing (MI) strategies are a cornerstone of brief interventions for alcohol misuse. You can combine these strategies with longer therapeutic approaches to treat AUD in older adults.[673] MI can help people of many different ages and ethnic, racial, and cultural backgrounds participate in treatment. MI is flexible and focuses on empathetic, reflective listening and a respectful, client-centered approach.[674] MI strategies may be particularly useful with older adults who may not be aware of the health risks related to their alcohol use. Because MI is a nonjudgmental and nonconfrontational approach, it may also be useful with clients who have mixed feelings about changing their drinking.

MI can help older adults change risk behaviors, such as reducing or abstaining from alcohol use.[675,676,677] However, not many studies have looked at MI's usefulness in getting older adults to reduce or stop alcohol use. Some of the ways in which MI affects behavior change may be different for older adults than for younger adults.[678]

KEY ASPECTS OF MI

- Being willing to collaborate with the client
- Being accepting and nonjudgmental
- Offering compassionate and empathetic responses to client concerns
- Asking clients about their concerns and goals for treatment instead of forcing your own agenda for change on them[679]

The mnemonic "FRAMES" outlines the most common MI strategies used in brief interventions to address alcohol misuse:

- **F: Give specific and nonjudgmental, objective Feedback to your clients about their drinking,** including information about health risk and potential effects. This feedback is often based on results of alcohol misuse screening instruments.
- **R: Point out to your clients their personal Responsibility for change** and emphasize that it is up to them to decide what, if anything, to change about their drinking. Responsibility for change also means respecting your clients' independence and decisions about behavior change.
- **A: Give clear Advice and recommendations to your clients about changing their drinking.** In the spirit of a client-centered approach, ask permission to give advice, and then ask your clients about their understanding of the recommendations you offered.
- **M: Offer a Menu of options for changing drinking behaviors** if your clients choose to change. Options may include altering drinking behaviors, abstaining, or accepting referral to more intensive mental health services or addiction-specific treatment.
- **E: Use an Empathetic communication style** that is respectful, supportive, and focused on listening to your clients' views and concerns about their drinking.
- **S: Support Self-efficacy** by recognizing clients' knowledge about and ability to change behaviors in support of their health and well-being, including changing drinking behaviors.[680,681]

MI generally focuses on:[682]

- Helping clients deal with any mixed feelings they may have about changing their drinking.
- Asking clients about their own reasons for change.
- Having a respectful and joint conversation about behavior change based on clients' stated goals.

Exhibit 4.7 shows a brief intervention developed specifically for older adults that builds on the FRAMES model and uses MI strategies, such as discussing the client's reasons to reduce or quit drinking and summarizing the discussion at the session's end.

EXHIBIT 4.7. Brief Alcohol Intervention Parts for Older Adults[683]

After you find that an older adult is misusing alcohol, use a semistructured brief intervention, including the following steps:

1. Ask the client about future goals for health, activities, hobbies, relationships, and financial stability.
2. Adapt your feedback based on the client's responses to screening questions relating to drinking patterns and other health habits (which may also include smoking, nutrition, and tobacco use).
3. Discuss how the client's drinking compares with that of others in his or her age group; review definitions of standard drinks (one standard drink equals 12 ounces of beer or ale, one 1.5 ounce shot of distilled spirits, 5 ounces of wine, 3–4 ounces of sherry, or 2–3 ounces of liqueur[684]).
4. Discuss the "pros and cons" of drinking if appropriate. Doing so can help you understand the role of alcohol in the older adult's life, including its role in coping with loss and loneliness, without influencing the client to move toward any specific change.
5. Give information about the effects of heavier drinking in a nonjudgmental way. Some older adults may have problems in physical, mental, or social abilities despite drinking within recommended limits.
6. Discuss the client's reasons to cut down or quit drinking. Staying independent, having good physical health, and keeping mental abilities can be key motivators in this age group.
7. Offer information about drinking limits and ways to cut down or quit (e.g., participating in social activities that do not involve alcohol, taking up hobbies and interests from earlier in life, finding volunteer activities).
8. Create a drinking agreement. Agreed-upon drinking limits that are signed by the client and the provider are particularly helpful in changing drinking patterns.
9. Discuss ways to cope with risky situations when the client may feel tempted to drink beyond agreed-upon limits. Social isolation, boredom, and negative family interactions can be problems in this age group.
10. Summarize the session.

If clients are already motivated to change their drinking, exploring their mixed feelings can accidentally lead to "sustain talk" (i.e., talk about reasons for not changing) instead of "change talk" (i.e., talk about reasons for changing). Sustain talk can keep clients from making improvements. You should assess clients' readiness to change at the beginning of a brief intervention. **If clients appear ready to make changes, urge them to talk more about the positive reasons for changing their alcohol use instead of focusing on the "pros and cons" of changing.**[685,686,687,688]

Treatment of Co-Occurring Conditions and Disorders

Co-occurring medical conditions and mental disorders can contribute to or worsen AUD. They can also complicate treatment of AUD in older adults. These conditions should be addressed at the same time as AUD, either by the same provider or provider team or through active referral to and care coordination with other medical or behavioral health services.[689] Factors that will help you decide how to address co-occurring conditions include:[690]

- The severity and duration of AUD and any co-occurring conditions.
- Client preference.
- Availability of services in the community.
- The availability of care coordination among different providers.

You can address co-occurring health conditions and mental disorders in older adults by:

- **Helping clients who do not have a primary healthcare provider find one,** and referring them to healthcare for an indepth physical, including screening and assessment for:
  - High blood pressure.
  - Liver disease.
  - Osteoporosis.
  - Sleep disorders.
  - Cancer.
  - Diabetes.
  - Heart disease.
- **Screening for cognitive impairment** and, if needed, referring for an indepth geriatric assessment. (See Chapter 6 of this TIP for more information.)
- **Providing emotional support and behavioral interventions** instead of standard CBT for older adults with cognitive impairments.[691]
- **Assessing for other SUDs,** including tobacco use disorder and opioid use disorder.
- **Giving clients treatment and intervention options for tobacco use disorder, pain management, and sleeping difficulties** (e.g., CBT, relaxation training, exercise, physical therapy).[692] Options should be scientifically supported and nonpharmacological whenever possible.
- **Screening, assessing, and treating mental disorders** (including depression and anxiety) within the scope of your practice, or referring to mental health services.
- **Referring for pharmacotherapy for SUDs or mental disorders as needed** to a medical provider trained in older adult care.
- **Addressing mental disorders** in age-sensitive/age-specific co-occurring treatment programs.
- **Following up with other providers regularly and keeping track of clients' treatment progress together with the clients.** (See the "Referral Management and Care Coordination" section.)

The consensus panel recommends that you treat co-occurring medical conditions and mental disorders among older adults while you treat the AUD.

Referral Management and Care Coordination

The keys to positive outcomes in a stepped-care approach are effective management of referrals to the right level of treatment and ongoing coordination of care. You can adapt to many different settings the following strategies for referral management and care coordination for older adults:

- **Identify a provider** (e.g., nurse manager, case manager, social worker) in your organization who can help older adults with referral and follow-up after referral. This provider should be knowledgeable of older adults' needs and of age-sensitive/age-specific resources in the community.
- **Identify and develop linkages** to age-appropriate medical, mental health, addiction treatment, recovery support, and social service resources and programs in your community.[693] In areas where no age-specific treatment is available, work with programs to offer such services.

- **Gather information** about programs' eligibility criteria, treatment length, type of treatment, philosophy, and continuing-care options so you can match clients to the right program.[694]
- **Keep an updated referral list** of contacts and phone numbers of treatment resources. Keep on hand current information on services offered, cost, schedule, and accessibility.[695] Contact key individuals in that organization, and maintain an ongoing relationship with them.
- **Match the referral to treatment** with your clients' stated goals, treatment needs, problem severity and available resources.
- **Include family members and caregivers** in conversations about treatment planning, with clients' permission.
- **Address your clients' hopes for treatment** by:
  - Describing the type of program to which you are referring clients.
  - Asking and responding to any questions they may have.
  - Acknowledging their worries through reflective listening.
  - Clearing up incorrect beliefs with information about treatment and its usefulness.
  - Offering hope by describing other older adults' positive outcomes with AUD treatment.
- **Address clients' concerns** about confidentiality, and get all necessary paperwork signed so you can communicate with other providers while your clients are in treatment.
- **Offer a "warm handoff"** (i.e., introduce clients directly) to the care coordinator or behavioral health service provider in your integrated care organization.
- **Be prepared to take on the responsibility** of managing the referral and coordinating care if you are not part of an integrated care team.[696]
- **Follow up** with clients to make sure referral was successful or to make another referral if needed.[697]
- **Keep track of clients' progress** in treatment; work closely with other providers to offer ongoing care as needed.

Higher Intensity Treatment Approaches for AUD

Several scientifically supported approaches to AUD treatment are a good fit for older adults in outpatient, intensive outpatient, or inpatient residential settings. Treatment approaches that work best for older adults with AUD who need more intensive treatment than a brief intervention include CBT, TSF, pharmacological interventions, and inpatient AUD treatment tailored to older adults.

CBT for Older Adults

CBT is a well-established and scientifically supported approach for treating AUD as well as co-occurring conditions often present in older adults, such as depression, anxiety, pain, insomnia, physical disability, and other SUDs.[698,699,700] CBT includes both cognitive and behavioral interventions applied separately or together. CBT is effective for individual and group sessions. **Its flexibility and adaptability are pluses for treating the complex medical and mental health concerns of older adults.**[701] Although CBT can be adapted to healthcare, outpatient, inpatient, and residential settings in which SUD treatment is available, older adults may have better outcomes with CBT in outpatient settings.[702]

CBT for AUD focuses on helping clients find and change thoughts, feelings, and behaviors that lead to alcohol misuse. CBT assumes that thoughts and feelings that occur before drinking behaviors take place are set in motion by situations or cues (e.g., attending a wedding where alcohol is served, smelling a favorite alcoholic beverage). In CBT, the client learns to identify these thoughts, feelings, and cues and then applies skills and coping methods to manage them.[703]

Strong evidence supports CBT's usefulness in helping a wide range of client populations and ages, including older adults, reduce alcohol misuse and support and continue abstinence.[704] For older adults with memory problems, CBT provides a structured and educational approach.[705] Treatment programs using CBT report improved

drinking outcomes for older veterans with significant co-occurring medical, mental health, and social problems and for women with late-life onset of heavy drinking.[706]

Given common age-related cognitive changes, CBT can be useful with older adults when you:[707]

- Make sure the older adult remembers the information and skills learned in counseling sessions.
- **Summarize and repeat information,** cognitive and behavioral change strategy steps, and the client's new awareness and insights several times throughout and at the end of each session.
- **Urge the older adult to take notes on key points** of the session, or you can take notes and give a copy to the client at the end of the session. Once permission is obtained from the client, you may want to arrange for a family member or significant person to attend and learn information and skills.
- **Offer handouts, forms, and reminder calls** to increase the chances that the older client will complete between-session assignments and tasks.

Skills-based approaches, relapse prevention, and PST are CBT adaptations that have been used successfully in the treatment of AUD among older adults.

Skills-based approaches and relapse prevention

Skills-based approaches may work well with older adults. Skills-based interventions focus on reducing health-related risks for alcohol use and continuing abstinence if the client decides that abstinence is the goal. The most commonly used skills-based approaches in AUD treatment that can be adapted for use with older adults are social skills training and coping skills training.

Social skills training helps older adults grow or improve social networks to decrease the effects of substance use, loneliness, and depression in their lives. Social skills training helps clients keep existing or create new social networks that support reduced drinking or abstinence. A key element for clients with AUD is learning skills for turning down drinks when in social situations.

Coping skills training helps older adults learn about and avoid or manage high-stress or high-risk situations they used to cope with by drinking. Key elements of coping skills training adapted for older adults with AUD are learning the ABCs (antecedents, behaviors, and consequences) of alcohol use, breaking down this chain of events, then identifying and practicing other ways of coping in high-risk situations.[708,709] Exhibit 4.8 depicts an example of an AUD behavioral chain for a 72-year-old woman.

EXHIBIT 4.8. Drinking Behavioral Chain of Events

This chain of events is for a 72-year-old woman who recently lost her spouse. She is having trouble sleeping.

Adapted from material in the public domain.[710]

RPT combines social skills and coping skills training into a structured program that can be used in group or individual treatment. One 16-week group treatment approach designed for older adults includes the following structured sections that can be repeated as needed:[711]

- Identifying individual-specific behavioral chains for drinking
- Managing social pressures to drink
- Developing coping strategies for being home and alone
- Coping with negative thoughts and emotions related to drinking (e.g., anxiety, anger, depression, loneliness)
- Managing cues that lead to drinking (e.g., seeing a beer commercial on television)
- Coping with urges to drink
- Preventing a return to drinking after a period of abstinence (also known as a "slip") from becoming a full return to past levels of alcohol use and negative effects

PST

Older adults face many everyday stressors, including chronic medical illnesses and cognitive and physical limitations. PST is a simple approach that older adults can learn easily, including those who have mild cognitive impairment.[712] PST assumes that finding the best solution to everyday problems reduces stress. Reducing stress improves people's functioning and well-being. Teaching people problem-solving skills helps them identify and apply solutions to current and future problems of living.[713]

PST includes the following steps:

- **Identify the client's view of the problem** (i.e., a positive or negative view of the problem or of the possibility of identifying solutions).
- **Define the problem** in specific terms.
- Brainstorm possible solutions to the problem.
- Review the possible solutions.
- **Select the best** possible solution.
- **Use the chosen solution,** and track whether it is useful.
- **Adjust the solution,** if needed, and then use and review the new solution.[714]

PST is widely used in many settings, including healthcare settings, outpatient addiction treatment, and home care. It is useful across age groups, including older adults, and across many mental disorders.[715]

MINING THE WISDOM OF AGE AND LIVED EXPERIENCE

When you work with older adults, remember that they have a great deal of wisdom from their life experience. This experience is like gold; mine it to help them solve their current problems. After you help clients define a problem, ask, "How have you dealt with a similar challenge in the past?" or "What are some of the ways you solved similar problems in your life?" Talking with older adults about their skills and abilities empowers them and is a respectful and supportive way to help them recognize their own knowledge and wisdom.

TSF

Twelve-Step recovery support groups such as AA, as well as other mutual-help groups, can deliver positive outcomes for people with AUD. Such outcomes including a greater likelihood of stopping alcohol use, improved psychosocial functioning, and greater levels of self-efficacy.[716] Factors related to these improved outcomes include:

- Participating in 12-Step meetings held at the treatment facility.
- Attending 12-Step meetings while participating in outpatient or inpatient addiction treatment.
- Attending and actively participating in 12-Step meetings consistently, early in the recovery process, and frequently (e.g., three or more meetings per week).
- Participating in other 12-Step group activities (e.g., doing service at meetings, reading 12-Step literature, doing "step work," getting a sponsor, calling other AA members for support).[717]
- Creating nondrinking social networks.[718]
- Increasing spirituality and participating in spiritual practices like prayer and meditation.[719,720]

TSF therapy is a structured therapeutic approach that links people to, and helps them stick with, community-based 12-Step recovery support groups. TSF interventions range from 4 to 12 sessions of individual or group treatment in inpatient or outpatient settings. During sessions, the provider:

- Explores different 12-Step themes (e.g., powerlessness, personal responsibility, spirituality).
- Explores the client's attitudes about those themes and other aspects of 12-Step support groups.
- Identifies solutions to barriers hindering the client's active participation in 12-Step support groups.

Some evidence exists that TSF therapy is effective with older adults and, like CBT, gives support, structure, goal direction, and opportunities for older adults to develop positive coping skills and a social network that values abstinence and a recovery focus.[721]

RESOURCE ALERT: TSF THERAPY MANUAL

The *Twelve Step Facilitation Therapy Manual*—found at https://pubs.niaaa.nih.gov/publications/projectmatch/match01.pdf—was designed to standardize TSF therapy as a 12-session treatment approach for the original Project MATCH multisite clinical research trial. The manual, published by NIAAA, offers an overview of Project MATCH and the trial's standardized TSF modules. The TSF manual is the basis for other types and adaptations of TSF interventions. **Adapt the confrontational interventions described in this manual for older adults, who respond better to and are more accepting of nonconfrontational approaches.**

Pharmacological Interventions

Options for pharmacological interventions to treat AUD are more limited for older than younger adults.[722] Although these medications may work well and be safe for older adults, the risk of negative reactions is higher because older adults are more likely to have co-occurring medical problems, take multiple medications, and have a decreased ability to eliminate medications given age-related changes in liver and kidney functions.[723,724]

To avoid harmful drug–drug interactions, prescribers must review all medications an older adult uses before giving a new prescription to treat AUD and consider a lower dose of the AUD medication when appropriate.

Three medications are approved by the Food and Drug Administration to treat AUD, but clinicians should note for each of these the effectiveness and safety profile in older adults specifically. Furthermore, **none of these medications have been studied across numerous long-term, randomized, controlled trials of older populations.[725]** This limits understanding of their true benefits and drawbacks to older clients. Nonetheless, potential pharmacologic options and some of their considerations include:

- **Acamprosate,** which reduces symptoms of protracted withdrawal from alcohol, such as sleep and mood problems, by altering brain changes related to alcohol use.[726] It can also reduce craving and the pleasurable effects of alcohol.[727,728] Not enough research exists on the efficacy and safety of acamprosate in older adults. Because it is removed from the body through the kidneys, healthcare providers should first evaluate and then monitor renal function in older clients.[729,730]
- **Naltrexone,** which reduces craving and the pleasurable effects of alcohol.[731] It comes in an oral formulation that is taken daily or an injectable formulation that requires a monthly visit to a healthcare provider. A very small number of studies suggest that naltrexone may be tolerable in adults ages 50 and older, but widespread data on its tolerability in older aged

individuals are missing.[732] Prescribers should consider the following:

- Naltrexone is removed from the body through the liver and should be used cautiously in older adults with possible liver problems.[733]
- Naltrexone blocks the effects of opioids used to treat chronic pain, which is common in older adults.[734] A client who begins naltrexone treatment while still taking opioids can suffer acute opioid withdrawal serious enough to require hospitalization.[735,736] Ask older adults about their use of opioid pain medication before starting naltrexone treatment. (See SAMHSA's TIP 63, *Medications for Opioid Use Disorder* [https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006], for more information about naltrexone.)
- Naltrexone can trigger symptoms of major depression, including suicidal ideation.[737] Closely watch older adults with a history of depression who take naltrexone.[738]
- Although naltrexone's potential side effects are relatively benign (e.g., dizziness, nausea, reduced appetite, increased daytime sleepiness), they can be significant in older adults.[739] Clinicians should monitor older clients appropriately.

- **Disulfiram,** which triggers an acute physical reaction to alcohol, including flushing, fast heartbeat, nausea, chest pain, dizziness, and changes in blood pressure. It is prescribed to motivate people to abstain from alcohol. Because these effects can be harmful to older people, disulfiram is generally not recommended for use with older adults and, if used, is done so only with great caution.[740,741] Physicians and other providers must closely monitor older clients taking disulfiram for the occurrence of these effects. Additionally, family/caregivers may need to supervise older adults taking disulfiram to make sure they take it correctly and do not take it while continuing to use alcohol, which can lead to serious complications.[742]

RESOURCE ALERT: MEDICATIONS FOR AUD

For more information about medications for AUD, including dosing considerations for older adults, see SAMHSA's *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide* (https://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907).

Medical Management Counseling

Older adults with AUD who have no access to addiction-specific treatment and do not need medically supervised withdrawal can get treatment in general healthcare settings with pharmacological interventions and brief treatment. Medical management counseling for this approach includes:

- Providing feedback on lab tests that show potential drinking-related health issues. This feedback can help increase motivation to change drinking habits.
- **Recommending abstinence as the safest course** while supporting movement toward that goal.
- Frequently checking that the older adult is taking his or her medication as prescribed, then reducing the frequency of visits after an appropriate period of abstinence.
- **Actively linking the older adult to supports,** such as to AA or other mutual-help and recovery support groups (see the "Recovery Support Groups" section) that welcome older adults.
- Urging and supporting active participation in recovery activities.

Brief medical management counseling and following clients to make sure they take AUD medications as prescribed can help individuals with AUD stop drinking and remain alcohol free.[743]

The consensus panel recommends using medications to treat AUD in older adults when necessary. Key parts of pharmacotherapy for older adults include:

- Carefully reviewing potentially harmful drug–drug interactions.
- Using lower doses of medications.
- Following up with clients and making sure they take medications as prescribed.
- Linking clients to recovery supports.

Inpatient AUD Treatment for Older Adults

Inpatient treatment can be a good fit for older adults who:

- Meet criteria for AUD.
- Have co-occurring health and mental health concerns.
- Need medically supervised withdrawal.
- Chose abstinence as their primary treatment goal.

Inpatient treatment may be limited to medically supervised withdrawal followed by active referral and immediate start of outpatient or IOP specialty treatment or can include a longer residential stay for an indepth recovery-oriented rehabilitation program.[744] **All inpatient treatment programs should use age-sensitive practices for older adults** (Exhibit 4.6).

Medically supervised withdrawal

Alcohol withdrawal symptoms in older adults can differ in severity, may occur 7 days or longer after the last drink, and are more likely to happen in people who have had withdrawal symptoms in the past.[745] Detoxification, also known as medically supervised withdrawal, should **consider the unique aspects of alcohol withdrawal in older adults:**

- **Older adults are more likely to have delirium** (i.e., rapid onset of a confused mental state) during withdrawal, which may be mistaken for early signs of dementia.[746]
- Typical withdrawal symptoms may be less obvious yet last longer in older adults.[747] Typical withdrawal symptoms include:
  - Autonomic hyperactivity (e.g., increased pulse rate, blood pressure, and temperature).
  - Restlessness.
  - Sleep problems.
  - Anxiety.
  - Nausea.
  - Tremor (shaking/shivering).
- **Withdrawal may worsen other medical issues** (e.g., heart disease, diabetes) and mental disorders (e.g., depression, anxiety) in older adults.[748]
- **Older adults are at greater risk than younger adults for alcohol withdrawal-related medical and neurological problems.** This is because older adults have higher rates of co-occurring physical and mental disorders and cognitive impairments and an increased sensitivity to medications used to treat withdrawal symptoms (e.g., benzodiazepines).[749] Watch older adults closely for signs of delirium or seizures during withdrawal.

Older adults may be at greater risk for harmful drug events during medically supervised withdrawal if they are taking medications to treat other medical conditions. Conduct an indepth assessment and continue to follow clients to learn:

- Which medications are being taken for other medical conditions.
- The client's risk of falls while being treated with common medications for managing withdrawal symptoms (e.g., benzodiazepines).
- Which co-occurring medical conditions are present (e.g., heart disease, breathing problems, diabetes, cognitive impairment). See Chapter 6 for more information about assessing cognitive impairment in older adults.

RESOURCE ALERT: TIP 45, *DETOXIFICATION AND SUBSTANCE ABUSE TREATMENT*

SAMHSA's TIP 45 offers guidance for medically supervised alcohol withdrawal and additional information about older adults (https://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA15-4131).

To reduce the risk of complicated withdrawal, older adults should complete medically supervised withdrawal in a medically supervised inpatient facility.[750] The revised Clinical Institute Withdrawal Assessment of Alcohol Scale–Revised (CIWA-Ar) is an objective measure of alcohol withdrawal and shows the use and dosage of medications (e.g., short-acting benzodiazepines) to ease withdrawal symptoms. See "Resource Alert: Clinical Institute Withdrawal Assessment of Alcohol Scale–Revised (CIWA-Ar)." However, the CIWA-Ar may not be as accurate for older adults with co-occurring medical conditions that hide or increase withdrawal symptoms.[751] Treatment during withdrawal should be based on your knowledge of the unique physiology of older adults, clinical judgment, and close tracking of clients.

RESOURCE ALERT: CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE–REVISED (CIWA Ar)

The CIWA-Ar is available for download at https://umem.org/files/uploads/1104212257_CIWA-Ar.pdf.

Age-specific treatment

Age-specific treatment for older adults helps support clients in seeking, entering, and staying in treatment. It also improves their treatment experience.[752] Whereas some older adults benefit from mixed-age treatment, other older adults are more likely to benefit from age-specific treatment, such as those with more chronic co-occurring health conditions and problems with functioning, and those ages 75 and older.[753] Research shows positive outcomes; for instance, **60 percent to 85 percent of older adults who participated in age-specific inpatient treatment programs were still abstinent 12 months after leaving treatment.**[754] These programs offered:[755]

- Individual and group therapy and community activities.
- Adaptations for older adults (e.g., slower pace; adaptations for vision, hearing and cognitive needs).
- Special topic groups for older adults that focused on grief, loss, isolation, physical health issues, recreation, and life changes.
- A nonconfrontational therapeutic approach highlighting the therapeutic alliance while using CBT, MI, and a 12-Step philosophy.

PARTS OF A SUCCESSFUL INPATIENT REHABILITATION PROGRAM FOR OLDER ADULTS

Positive outcomes have been achieved by inpatient SUD rehabilitation programs for older adults that use:

- Nonconfrontational group therapy for grief, denial, anger, shame, age-related loss, and loneliness.
- CBT and dialectical behavioral therapy (DBT) focusing on:
  - Teaching clients how to manage distress, how to control emotions, and how to improve relationship skills.
  - Allowing people to rebuild social-support networks.
  - Using self-awareness to deal with grief, loneliness, and depression.
- Medical and mental health services, including 24-hour access to nursing care.
- Personal care aides, if needed.
- Health and wellness activities, including:
  - Massage.
  - Acupuncture.
  - Hydrotherapy.
  - Movement therapy.
  - Meditation.
  - Mindfulness practice.
- Family involvement in treatment.
- Active links to medical, social, and case management services.

Recovery Management

Per SAMHSA, recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[756] Recovery management is an organizing philosophy for addiction treatment and recovery support services to help individuals and family members achieve and continue long-term addiction recovery. **Not everyone who misuses alcohol needs ongoing recovery management support, but some older adults may benefit from ongoing tracking and recovery support,** including those with:[757]

- Co-occurring medical conditions or mental disorders.
- Social isolation.
- Little support from family and friends.

Recovery support for older adults who misuse alcohol can begin after a brief intervention in a healthcare setting or while the older adult is in mental disorder or AUD treatment (Exhibit 4.5). However, ongoing recovery management is most like the continuing care approach to addiction treatment and to the philosophy of ongoing illness management in the treatment of chronic medical illnesses like diabetes. In the addiction treatment research, some of the continuing care interventions that work well for older adults and show positive effects include:[758]

- Home visits.
- Telephone counseling.
- Recovery checkups.
- Linkages to community resources, such as recovery support groups.

In addition, using case management services and helping supportive family members participate in the older adult's treatment can support ongoing recovery.

Case and Care Management Services

Case and care management (CCM) services focus on helping older adults reduce the health-related risks of alcohol misuse and enter addiction-specific treatment when necessary. CCM models can be particularly helpful to older adults who are isolated, because the CCM provider can offer services:

- In the client's home.
- By phone.
- Through videoconferencing.
- At the healthcare provider's office.
- In community-based social service settings.
- In residential or long-term care facilities.

For older adults, whose social networks tend to get smaller with age, CCM strategies should focus on connecting them to age-related resources in the community that support recovery. The CCM provider helps clients access medical, mental health, social, financial, education, work-related, and other community-based services. Nurse care managers, social workers, addiction treatment or mental health counselors, or peer recovery supporters can offer CCM. CCM services often lead to positive outcomes for older adults with AUD or co-occurring medical conditions or mental disorders.[759]

CCM models may be particularly good at supporting and keeping older adults in treatment and offering a complete approach to addressing the needs of older adults with complex medical and mental health issues. CCM services are part of a comprehensive approach. They focus on overall health improvement, which is a common goal among older adults, rather than just addressing AUD (which may feel uncomfortable or shameful to older adults).[760] Program reviews of CCM approaches support case management as a key part of a long-term recovery management approach for older adults with AUD.[761]

Caregiver Involvement

Involving caregivers throughout treatment and ongoing recovery can help improve an individual's chances of staying in AUD treatment. It can also improve AUD treatment outcomes.[762] However, the client must give permission for you to involve others in their treatment. Issues of confidentiality and protection of dignity are highly important. You should know whom the older adult trusts or prefers for support. Caregivers may include a spouse or partner, adult children,

siblings, or extended family members, friends, or neighbors. Caregivers may be family members or individuals significant to the older adult who might be involved in the older adult's health decisions.

Caregivers:

- Often make the first contact with treatment services and should be involved in the initial assessment of the older adult (with the older adult's permission).
- Often supply strong motivation for the older adult to enter treatment.
- Can also offer important details about the older adult's drinking history and health-related risks related to current alcohol use.
- Should also be involved throughout treatment, including during development of a posttreatment recovery plan for the older adult and ongoing recovery support.

Ways to involve a caregiver in AUD treatment include helping the caregiver:

- Develop contingency contracts for specific AUD behaviors (e.g., taking AUD treatment medication, attending mutual help and recovery support groups, effects of returning to drinking).[763]
- Improve daily interactions and reinforce positive communication.
- Find caregiver education groups where caregivers learn and share with others.
- Develop and engage in shared recreational activities as alternatives to drinking.
- Reinforce positive change (e.g., praising steps to reduce or stop alcohol use).
- Develop constructive problem-solving skills (e.g., how to identify relapse triggers and respond with coping skills or strategies to prevent relapse, how to reengage with the recovery plan).
- Respond more effectively to the older adult's drinking (e.g., make sure the older adult is safe, then follow through with the consequences agreed to in the contingency contract instead of arguing or judging; encourage reengagement with the recovery plan and return to treatment if needed).

RESOURCE ALERT: HOW TO TALK TO AN OLDER PERSON WHO HAS A PROBLEM WITH ALCOHOL OR MEDICATIONS

This easy-to-read online article for family members and concerned others offers information about how to identify signs that the older adult may be misusing alcohol, how to talk with the older adult in a nonconfrontational way, and how to get help (www.hazeldenbettyford.org/articles/how-to-talk-to-an-older-person-who-has-a-problem-with-alcohol-or-medications).

A legal guardian (who may or may not be a family member) should participate in the treatment and recovery process for an older adult with cognitive impairment who cannot manage his or her own affairs. When a guardian has the healthcare power of attorney, the guardian should sign releases to speak with all providers involved in the older adult's treatment.

Addressing Caregiver Needs

Family members and others significant to older adults with AUD often take on the role of caregivers and case managers, particularly when co-occurring chronic medical conditions (e.g., diabetes) or mental/neurocognitive disorders (e.g., depression, dementia) are involved. Caregivers often get left out of treatment decisions and recovery planning, despite their commitment to and important role in the care and ongoing health management of these older adults.[764]

Because of the stress of this responsibility and lack of support, caregivers can develop health-risk behaviors, such as sleep disorders, poor diet, smoking, alcohol use, and substance misuse. Caregivers may ignore their own care, which may worsen their own chronic medical conditions or increase their risk of stress-related illnesses.[765] **You can help address caregivers' needs by:**[766]

- Identifying primary caregivers by reviewing clients' medical records.[767] Make sure all necessary paperwork is signed to allow family members and other providers to speak with one another.

- Involving them in the treatment and recovery planning process.
- Asking them about their own use of alcohol and other substances and history of mental disorders.
- Screening, assessing, and referring them to treatment for SUDs or mental disorders as needed.
- Supporting their use of healthy self-care activities, such as:
  - Getting enough sleep.
  - Eating a healthy diet.
  - Quitting smoking.
  - Exercising moderately.
  - Getting an annual physical with their primary care provider.
  - Reducing or avoiding alcohol use.
- Reminding them to ask for help from other family, friends, community members, or social service agency representatives who may be able to offer respite care.
- Exploring available caregiver supports in the community, such as the local Area Agency on Aging. (See "Resource Alert: Community-Based Supports for Caregivers.")
- Urging them to participate in mutual-help groups (e.g., Al-Anon, caregiver support groups).
- Reminding them to take breaks from the caregiver role.
- Pointing out that they are still the relative, spouse, or partner of the older adult, and that relationship has meaning and can still give them satisfaction.

RESOURCE ALERT: COMMUNITY BASED SUPPORTS FOR CAREGIVERS

For more information on **Al-Anon family groups** and finding local/online meetings, go to https://al-anon.org.

For more information about local and online **caregiver support groups** for family members of older adults with dementia, go to www.alz.org/events/event_search?etid=2&cid=0.

Recovery Support Groups

Older adults who have social supports that reinforce abstinence from alcohol have better outcomes in long-term AUD recovery than older adults without those social supports.[768] Two key factors for older adults in continuing recovery over time are having people in their lives who support their recovery and not having people in their social networks who encourage or enable alcohol use.[769]

> A key factor in long-term recovery for older adults is **not** having people in their social networks who encourage alcohol use.

Community-based recovery support groups highlight the importance of developing social relationships that support recovery rather than drinking.[770] Although a growing range and number of recovery support groups are available to adults who have AUD, **AA and SMART Recovery are widely available and may be the most useful supports for older adults.**

AA

AA is the most well known and widely available recovery support group for older adults with AUD. It offers a community-based, long-term recovery management approach to treating AUD. AA meetings and activities following treatment can be cost-effective sources of ongoing social support.[771] Key elements of AA especially well suited to older adults include:[772,773]

- Decreasing social ties that support drinking.
- Increasing social ties that support abstinence.
- Providing social support, goal direction, and structure.
- Offering opportunities to participate in substance-free social activities.
- Helping participants improve their self-efficacy and coping skills.

Research on AA has found that older adults who attend more group meetings and have a sponsor have better 1-year alcohol-related and mental stress outcomes and less alcohol use at

5-year follow-up than those who do not.[774] The structured social support of AA may help older adults whose social networks have become smaller by improving their interpersonal and social coping skills.[775,776]

Some research has found that older adults are less likely to attend AA meetings than younger adults. Results are mixed on older adults' level of involvement in AA meetings compared with that of younger AA members.[777,778] **Sometimes older adults feel shut out** by the culture, language, and experiences of younger adults in AA meetings. However, other evidence indicates that older adults' membership in AA is increasing. The AA Membership Survey showed increases from 2007 to 2014 in members ages 61 to 70 (from 12.3 percent to 18 percent) and in members ages 71 and older (from 5.3 percent to 7 percent).[779]

Starting and staying in AA may be challenging for older adults with AUD, but not participating may put older adults at increased risk for return to alcohol use and negative long-term outcomes.[780] **When older adults do participate in AA, they benefit by:**[781,782]

- Having better drinking-related outcomes.
- Feeling less stress.
- Participating in more spiritual practices.
- Increasing social interactions and support.
- Having improved recovery.

BARRIERS TO AA ATTENDANCE FOR OLDER ADULTS[783]

- Lacking transportation
- Facing physical limitations
- Feeling uncomfortable going to meetings at night
- Having smaller social networks because of aging
- Having less interest than younger adults in increasing their social networks
- Relying on a spouse for recovery support

SMART Recovery

SMART Recovery is a network of local and online abstinence-focused recovery support groups that is based on principles of CBT and MI. Unlike AA meetings, SMART Recovery meetings are run by trained volunteers. The SMART program[784] is based on helping people:

- Build and keep motivation.
- Cope with urges.
- Manage thoughts, feelings, and behaviors.
- Live a balanced life.

The principles and structured format of SMART Recovery follow CBT and MI approaches to treating older adults. Research suggests that it is as effective as other community-based mutual-help approaches in supporting abstinence and in reducing the severity of the effects of alcohol misuse, particularly for people with less severe AUD.[785] SMART Recovery may also be an important option for those who feel uncomfortable with the spiritual underpinnings of AA and the 12-Step approach. Although the mutual-help group is less available in some areas of the country, online or telephone meetings are becoming more popular in all recovery support groups.

The program does not support use of labels such as "alcoholic," which may benefit older adults who feel shame and fear discrimination or judgment because of having AUD. SMART Recovery, like AA, offers chances for older adults to improve their recovery and quality of life by serving as volunteers.

RESOURCE ALERT: SMART RECOVERY WEBSITE

The SMART Recovery website (www.smartrecovery.org) gives information about SMART Recovery principles and training opportunities, including how to become a facilitator for meetings. It also has a searchable database of local and online meetings.

You can help older adults become involved in mutual-help groups by:

- Actively linking clients to available mutual-help groups, and supporting them in trying different groups so that they can find the one that best fits their needs.
- Asking clients about their understanding of and any past participation in mutual-help groups.
- Discussing the benefits of being involved in mutual-help groups as a part of recovery.
- Exploring ways to overcome barriers to joining and participating in mutual-help groups.
- Contacting local, regional, or state AA groups or other mutual-help groups or recovery community organizations (RCOs; see text box) to ask about community outreach efforts for older adults.
- Helping older clients find an age-friendly home group with older adult participants or a Seniors in Sobriety meeting (see "Resource Alert: Seniors in Sobriety").
- Linking older adults to mutual-help group volunteers/peer recovery support specialists who can introduce them to the group, attend some meetings with them, and introduce them to other older members.
- Teaching them about sponsorship and how clients can find an AA sponsor or mutual-help group mentor who can guide them in the recovery process.

RESOURCE ALERT: SENIORS IN SOBRIETY

Since 1990, AA has actively reached out to older adults with AUD. Efforts include urging local meetings to be senior friendly and starting Seniors in Sobriety (SIS) meetings. The SIS website (www.seniorsinsobriety.com/) has information on SIS's history, focus, and annual conference and other meetings.

WHAT IS AN RCO?

"A recovery community organization (RCO) is an independent, nonprofit organization led and governed by representatives of local communities of recovery. These organizations organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and supply peer-based recovery support services (P-BRSS)."[786]

Search for an RCO near you (https://facesandvoicesofrecovery.org/arco/arco-members-on-the-map/).

The consensus panel recommends that you actively link older clients to age-sensitive case management and ongoing recovery supports for older adults. Family, caregivers, and community-based mutual-help groups are key elements of recovery support for older adults.

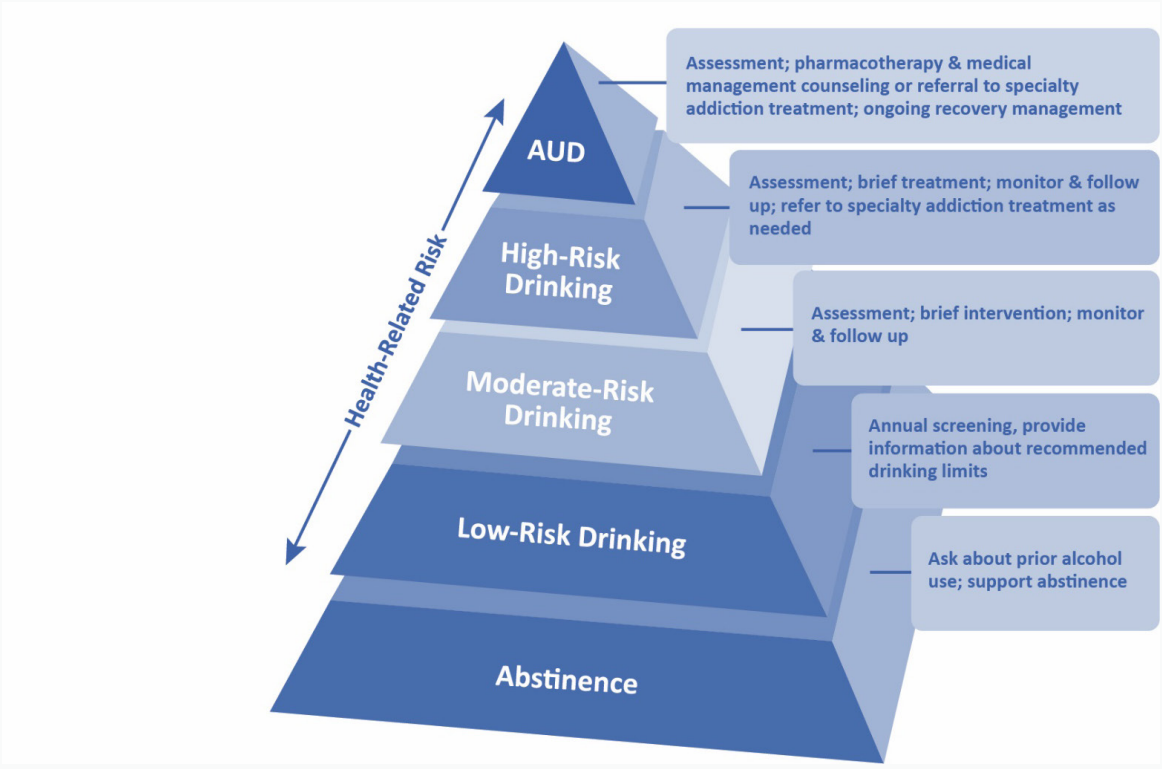
Clinical Scenarios

The level of intensity of clinical interventions for older adults should match the severity of alcohol misuse. Interventions range from healthcare providers asking clients about their alcohol use during an annual screening to inpatient treatment for older adults who have AUD. Exhibit 4.9 shows how to match levels of health-related risk associated with alcohol misuse with different clinical interventions.

The higher up the pyramid, the higher the level of risk and the more intense the intervention. In this graphic, the level of health-related drinking risk is defined as follows:

- **Abstinence:** Does not currently use alcohol.
- **Low-Risk Drinking:** Drinks within recommended limits.
- **Moderate-Risk Drinking:** Drinks above recommended limits.
- **High-Risk Drinking:** Binge drinks or drinks above recommended limits and has a co-occurring health condition or mental disorder.
- **AUD:** Meets DSM-5 diagnostic criteria for AUD.

EXHIBIT 4.9. Alcohol Health-Related Risk and Treatment Response Pyramid[787,788,789]



The following clinical case scenarios are examples of different levels of alcohol misuse. They show how to use prevention strategies and clinical interventions that match risk levels in Exhibit 4.9.

Clinical Scenario: Abstinence

During the initial screening for alcohol misuse, ask about earlier alcohol use even if the older adult reports that he or she does not drink at all. The older adult may have always abstained from alcohol, identify as being in recovery, or have stopped drinking for health-related reasons, which is common as people age. The following clinical scenario shows the importance of asking about earlier alcohol use when deciding which treatment to offer.

- **Abstinence:** An older adult reports no alcohol use in the past 3 years.
- **Treatment Setting:** Outpatient healthcare clinic
- **Provider:** Nurse practitioner (NP)
- **Prevention/Treatment Strategies:** Ask about earlier alcohol use; support abstinence using a brief problem-solving intervention.

George is 76 years old and has been divorced for 5 years. He recently moved to a retirement community near his oldest daughter. He goes to see a new primary care provider for an initial medical exam. As part of the health history questionnaire, which includes the AUDIT, George says that he does not currently drink, but he was injured earlier because of his drinking. His primary care provider reviews George's questionnaire and

sees that George does not meet the AUDIT criteria for alcohol misuse but flags the item about alcohol-related injury.

During the clinical interview, the provider asks about an item on the AUDIT in a curious, nonjudgmental way. The NP says, "I noticed on the health questionnaire that you may have been injured after drinking. Can you tell me more about that?" George says that he used to drink from time to time, but 3 years ago he twisted his ankle badly after having a couple of drinks and had to use a walker for several weeks. He tells the NP that he decided not to drink at all because he didn't want to risk any more injuries. The NP praises his commitment to his health and urges him to continue to avoid drinking.

George feels comfortable opening up to the NP and says that since he moved to the retirement community, he has participated in a lot of social activities with alcohol. He likes socializing but feels uncomfortable when people offer him drinks all the time. He says, "I know they are just being friendly, but sometimes they just don't give up." George states that he does not want to drink but does want to keep going to the social activities. The NP uses brief problem-solving by asking George, "How have you dealt with a challenge like this in the past?" The NP then invites George to brainstorm some solutions to the current problem, including ideas from his earlier struggles. George decides that he can say "no" firmly and tell people that alcohol doesn't agree with him when they continue to urge him to drink. George states that he feels good about that solution and will try it out at the next social event. The NP writes a treatment note about George's chosen solution in the electronic medical record and gives him a copy, telling him that if this plan doesn't work to schedule a follow-up visit soon.

Clinical Scenario: Low-Risk Drinking

For many older adults, the relationship with their primary care provider is often one of their strongest and most stable. The annual physical is a chance to screen for alcohol misuse and any changes in alcohol use related to life events, such as a death in the immediate family. The following scenario addresses the importance of conducting an annual screen for alcohol misuse with older adults and shows how to actively link clients to a referral for grief counseling and care coordination.

- **Low-Risk Drinking:** An older adult drinks within recommended guidelines and has no co-occurring physical or mental illness that limits daily functioning.
- **Treatment Setting:** Integrated outpatient medical and behavioral health clinic
- **Providers:** Primary care provider (PCP); licensed clinical social worker
- **Prevention/Treatment Strategies:** Screen for alcohol misuse, depression, and stressors that may put the older adult at risk for increased alcohol use; supply information on drinking guidelines for older adults; offer a menu of options for addressing grief; coordinate follow-up care.

Lily is 80 years old. Her husband of 60 years died 6 months ago. Lily goes to her doctor for her annual physical. Her PCP tells Lily that she is sorry to hear about her husband's death. They talk for a few minutes about how she is doing and what kinds of recreational activities and social support she has in her life right now. Lily tells her PCP that she belongs to the local church and is still active

REMINDER ABOUT DRINKING IN RETIREMENT COMMUNITIES

Hazardous drinking may be more common among older adults in age-separated residential settings (e.g., continuing care and planned retirement communities) than community-dwelling older adults. A recent survey reported that 15.4 percent of people who took the survey and live in a large retirement community had hazardous drinking compared with around 10 percent in the general older adult population.[790] Although older adults in these settings may drink to cope with problems, they usually drink because they want to socialize, and they believe that their peers affect their drinking.[791] Avoiding alcohol in these settings can be a challenge for older adults.

in volunteer activities there. Her son and her granddaughter live nearby and visit on a regular basis. She goes to an arts and crafts class on Wednesday afternoons at the local senior center.

The PCP then tells Lily that she wants to ask her a few more questions about her health, including alcohol use, if that is okay with her. Lily feels comfortable talking with her PCP and agrees. The PCP mixes in questions from both the AUDIT and the SMAST-G with her general health questions. Lily says that she drinks one 5-ounce glass of white wine two to three times a week (an AUDIT score of three) and sometimes has another drink when she feels lonely (an SMAST-G score of one), but she has not used more alcohol since her husband died. She says, "If I drink too much, I feel lightheaded, and I worry that I'll fall and break something."

The PCP offers information on drinking guidelines and praises Lily for staying within those guidelines. The PCP then tells her that sometimes when older people lose a spouse, they may start drinking a bit more when they feel sad or lonely or they may simply lose track of how much they are drinking. The PCP tells Lily to call her if that happens. Lily says she will, then states, "You know, I have been feeling a bit blue in the past few weeks, and I haven't been sleeping well. I really miss him."

The PCP follows up on Lily's statement by saying, "It seems like you are keeping busy and have a lot of good support in your life. At the same time, I am wondering if it would be helpful to have someone other than your family to talk to about how you have been feeling recently. I can suggest a few options if you are interested." Lily says that she doesn't like to burden her family and that talking to someone might be good. The PCP offers two suggestions: "There is a grief support group at the same senior center where you take your arts and crafts class. Or, I can introduce you to a counselor right here at the clinic who knows a lot about helping folks with loss." Lily says she wouldn't feel comfortable talking in a group. The PCP describes the counselor with whom she would like Lily to talk. Lily agrees to meet her after the appointment with the PCP. The PCP also conducts an initial depression screening.

The PCP arranges a follow-up phone call for Lily from the nurse care manager who will coordinate care with the PCP and the counselor. The PCP then walks Lily over to the licensed clinical social worker at the clinic and does a "warm handoff." The licensed clinical social worker talks briefly with Lily, gives her a large-print handout that explains the grieving process, and schedules a follow-up visit that includes a depression assessment. (See the Chapter 4 Appendix for a large-print handout on grief for older adults.)

Clinical Scenario: Moderate-Risk Drinking

All too often, spouses of people who misuse alcohol drink as a shared social activity with their spouse. For older spouses, this can easily turn into their own health risk behavior, particularly if, to reduce the stress of being a caregiver, they take medication that negatively interacts with alcohol. The following scenario focuses on the importance of assessing family members' alcohol and medication use while at the same time addressing their needs as caregivers.

- **Moderate-Risk Drinking:** An older adult drinks above recommended limits while also taking a sedating medication.
- **Treatment Setting:** Outpatient behavioral health program
- **Provider:** Behavioral health service provider (provider)
- **Prevention/Treatment Strategies:** Supply information about drinking guidelines; screen for anxiety; give information about risks for alcohol and medication use; explore strategies for family members to address the spouse's drinking and to address caregiver needs.

Rose is 69 years old. She is married to Ed, who is 78 years old. Ed drinks heavily daily, has a history of bipolar disorder, and recently was diagnosed with early-stage dementia. Ed sees the same PCP as Rose and also sees a psychiatrist for medication management for bipolar disorder. Rose is growing more worried about Ed's drinking and is unsure of how to take care of him as his dementia worsens.

Rose calls an outpatient behavioral treatment program after a friend of hers tells Rose that she is worried about Rose's health. The friend also recommends a counselor she had seen there.

At the initial appointment, the provider assesses Rose's substance use. Rose reports that she drinks one to three standard glasses of wine about three to four times a week when she and Ed go out to dinner or to social events. She also tells the counselor that she takes a benzodiazepine prescribed by her PCP about one to two times a week when she can't sleep. Rose states, "When Ed drinks at night, he becomes aggressive and sometimes gets very confused. I worry about him so much that I can't get to sleep."

The counselor acknowledges Rose's distress about Ed's drinking, then asks her if it would be okay to talk with her briefly about her drinking and use of benzodiazepines. Rose agrees. The counselor offers this personalized feedback to Rose: "Based on what you have told me about your own drinking, it looks like you are drinking over the recommended guidelines on the days you have more than one drink a day. Also, you may not be aware that the sleep medication you are taking can increase the depressant effect of alcohol in your body and could put you at risk for oversedation, memory loss, and even overdose if you forget how much you had to drink or mistakenly take too many pills." The counselor asks Rose what she makes of this information. Rose says, "I had no idea that drinking and taking sleep medication might be so dangerous. It also makes me think that I might not be helping Ed with controlling his drinking if I drink with him."

After exploring possible strategies to address her own health risks, Rose decides that she will stop drinking completely while she is taking the sleep medication and tell Ed why she can't drink with him when they go out. The counselor supports Rose's decision and suggests that one way she can help Ed is to find positive recreational activities that they can share without drinking. Rose becomes excited and says she can think of several things they can do together that they both enjoy without drinking, like going to lectures at the local senior adult education program.

The counselor then asks Rose to tell her more about her difficulties with worry and sleep, and conducts an anxiety screening. They also explore self-care strategies for managing worry and getting to sleep. Rose decides she can tell Ed that she is going to sleep in another room if he is up late and has been drinking. The counselor then teaches Rose a relaxation exercise she can do before bed, and Rose practices it in the session. Rose agrees to talk with her doctor about less risky medication for sleep.

RESOURCE ALERT: OLDER ADULTS AND SLEEP

The National Institute on Aging has a webpage with information and useful tips for helping older adults get a good night's sleep (www.nia.nih.gov/health/good-nights-sleep).

The counselor shifts the conversation to what further support Rose may need to address Ed's drinking while taking care of herself. Rose identifies her PCP and Ed's psychiatrist as potential supports. She states that Ed has given permission for her to talk with both. The counselor suggests she ask both to discuss Ed's drinking with him, state firmly that Ed should not drink at all, and then put their recommendations in writing. Both Ed and Rose can then refer to the recommendations instead of getting into an argument about his drinking. Rose likes this idea and feels confident that she can express her concerns to both of Ed's providers and ask for their help in addressing Ed's alcohol misuse.

The counselor explores other self-care and recovery strategies with Rose, including Al-Anon and a dementia caregiver support group. Rose is not sure that she wants to try Al-Anon but then agrees to talk with a peer recovery support specialist the counselor knows at the local recovery community center who is Rose's age and helps family members. The counselor sets up a series of sessions with Rose. She will continue to track Rose's drinking, benzodiazepine use, and strategies for self-care.

Clinical Scenario: High-Risk Drinking

Older adults may not know that their drinking is negatively affecting their physical and mental health. The following scenario focuses on the importance of screening for alcohol misuse in settings where older adults are being treated for mental disorders and shows how a brief intervention focused on alcohol use can improve physical and mental health.

- **High-Risk Drinking:** An older adult drinks above recommended limits, including binge drinks, and has a co-occurring mental disorder (depression) and health condition (high blood pressure).
- **Treatment Setting:** Hospital-based mental health clinic
- **Provider:** Geriatric psychiatrist
- **Prevention/Treatment Strategies:** Supply feedback on AUDIT score; give information about the risks of taking medications for depression and high blood pressure while drinking; offer nonjudgmental advice about abstaining from alcohol use; continue to watch alcohol and medication use.

Carl is 68 years old. His PCP refers him to a geriatric psychiatrist for medication management of his major depression. Carl currently takes one tricyclic antidepressant—which, when taken with alcohol, increases his risk for oversedation and low blood pressure—and a blood pressure medication, which can lower his blood pressure even more. The psychiatrist gives Carl the clinical interview version of the AUDIT as part of the initial psychiatric evaluation. Carl's score on the AUDIT is a 9 and includes positive responses to daily drinking and binge drinking about once a month.

The psychiatrist offers Carl nonjudgmental feedback about his AUDIT score and says that Carl's drinking may be worsening both his depression and his high blood pressure. At first, Carl makes light of his drinking by saying, "I really don't drink that much. And besides, I have been drinking the same amount for years, and it's never been a problem before." The psychiatrist acknowledges Carl's mixed feelings, then asks if he would be interested in more information. After Carl agrees, the psychiatrist describes the health risks of drinking while taking antidepressants and blood pressure medication, stating in a nonjudgmental, factual tone that alcohol can keep his medications from working correctly. He also states that the type of antidepressant Carl is taking can lead to low blood pressure when he drinks, especially when taken with his blood pressure medication, and can cause harmful effects like increased depression, dizziness, and fatigue. Carl responds, "Now that you mention it, I have noticed feeling very tired in the afternoon. I really don't like feeling that way. It's like the depression is getting worse."

The psychiatrist supports Carl's ability to make his own decisions, then gives him clear advice: "Although it is up to you in the end, I think that in your situation you are better off not drinking at all while you are being treated for depression and high blood pressure. What do you think you would like to do about the drinking?" Carl agrees to stop drinking to see whether abstinence improves his health. The psychiatrist supports Carl's decision; summarizes their conversation; writes out a brief alcohol use agreement that supports Carl's decision to remain abstinent but also tracks his alcohol use if he does drink; and schedules a follow-up visit in a month. (See the Chapter 4 Appendix for an alcohol use agreement and drinking tracking cards.)

At the next visit, Carl says that his depression has gotten better and that he no longer feels tired or gets dizzy. Carl says that he wants to continue not drinking because he feels so much better. The psychiatrist supports Carl's efforts to avoid drinking and, after discussion with Carl, prescribes a different antidepressant medication for him. In future medication management visits, the psychiatrist tracks Carl's depression, his response to the new medication, his blood pressure, and his success in avoiding alcohol.

Clinical Scenario: AUD

Older adults with a long history of heavy drinking, multiple past periods of treatment, or co-occurring mental disorders often need medically supervised withdrawal and age-sensitive, age-specific treatment to address multiple co-occurring

conditions at the same time. This scenario focuses on age-specific treatment, RPT, and recovery support for an older adult with AUD and co-occurring disorders.

- **AUD:** An older adult has a long history of heavy drinking and meets criteria for AUD.
- **Treatment Setting:** Inpatient detox and rehabilitation program
- **Provider:** Licensed alcohol and drug counselor on a multidisciplinary treatment team
- **Treatment Strategies:** Offer CBT, RPT adapted for older adults, trauma-informed counseling strategies to address emotional dysregulation, and recovery management strategies.

Barb is 72 years old and enters an inpatient treatment program after her three adult children intervene. She has a long history of heavy drinking and brief periods of treatment followed by a return to drinking. Barb has been married four times and was recently divorced from her fourth husband. She has been diagnosed with anxiety, depression, posttraumatic stress disorder, and binge eating disorder, for which she had gastric bypass surgery. This is her fourth treatment for AUD. Her pattern of returning to drinking tends to happen when she is having difficult relationships, intense emotions, and traumatic stress reactions. Barb is carefully watched throughout detoxification at the facility; she is then transferred to the rehabilitation program, which includes an age-specific track for older adults.

Barb's primary counselor offers relapse prevention approaches, which are focused on identifying and managing relapse triggers. Barb's CBT counseling focuses on strategies to address the communication issues between Barb and her daughter and to help her identify and replace negative automatic thoughts about drinking triggered by relationship problems. For example, when Barb's daughter criticizes her, Barb feels ashamed. Barb replaces the negative thought, "I drink because I can't stand to feel ashamed" with a more positive thought, "I can stand to feel shame for a while, until the urge to drink goes away."

Barb's group counseling at the older adult program includes focused topic groups for older adults, relapse prevention coping skills groups, and a DBT group. The DBT group teaches her mindfulness skills for distress tolerance, emotional regulation, and effective interpersonal interactions. With permission, Barb's counselor keeps contact with her family. They attend family group sessions, too.

During an individual session, Barb and her counselor discuss her improvement in treatment. The counselor opens the conversation: "I know this is your fourth time in treatment. How would you say this time has been different for you?" Barb says, "I really like the group discussions on topics that are important to me at this stage in my life. Staying here for such a long time has helped a lot, too. I needed the extra time to let all this information about recovery and all the skills I have learned really sink in."

Near the end of her time at the treatment facility, Barb's counselor actively links her to a continuing care group and individual outpatient counseling at an addiction treatment program in her community, as well as women's and senior-friendly AA meetings. Staying in treatment longer allows Barb to improve her emotional regulation, work on relapse prevention, and improve her interpersonal skills in a safe, supportive place. It also helps her get connected to community-based support before she ends treatment.

RESOURCE ALERT: DBT

DBT, a variation of CBT, was developed for adult women with chronic suicidal behavior who meet the diagnostic criteria for borderline personality disorder.[792,793] More recently, adaptations of DBT skills training have been shown to help adults with borderline personality disorder and SUDs, adults with binge eating disorder, older adults with depression, and family caregivers of older adults with dementia.[794,795] DBT uses mindfulness practices and helps people manage overwhelming emotions. This skill-building approach shows promise in treating older adults with emotional dysregulation and poor interpersonal skills.

For more information about DBT, the latest research, and training opportunities, go to the website of the Behavioral Research and Therapy Clinics at the University of Washington (http://depts.washington.edu/uwbrtc/).

Summary

As older adults' levels of alcohol use and related risk of negative health effects increase, more complex and intense interventions are needed. MI and adaptations of CBT (including PST and RPT) are useful in brief interventions and long-term treatment. Whichever strategy you use, take a nonconfrontational, age-sensitive approach when working with older adults with alcohol misuse, including AUD. Ongoing recovery management strategies increase the chance that improvements will continue over time and not only help older adults reduce negative alcohol-related health and mental health outcomes, but also help improve their quality of life.

Chapter 4 Resources

Provider Resources

A Clinician's Guide to CBT With Older People (www.uea.ac.uk/documents/246046/11919343/CBT_BOOKLET_FINAL_FEB2016%287%29.pdf/280459ae-a1b8-4c31-a1b3-173c524330c9): This workbook explores age-sensitive strategies for adapting CBT for older adults.

BNI-ART Institute—Tools for the Brief Negotiated Interview (BNI) (www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-brief-intervention/): This webpage includes an algorithm, or script, that guides providers through an intervention for substance misuse with carefully phrased key questions and responses.

Motivational Interviewing Network of Trainers (https://motivationalinterviewing.org): This website includes references, articles, videos, and links to training opportunities in the theory and practice of MI.

National Council on Aging—Resources (www.ncoa.org/audience/professional-resources/?post_type=ncoaresource): This webpage contains a searchable database of articles, webinars, and manuals.

Consumer Resources

AA—*A.A. for the Older Alcoholic—Never Too Late* (large print) (www.aa.org/assets/en_US/p-22_AAfortheOlderAA.pdf): This brochure describes the stories of men and women who became involved with AA as older adults and includes comments from AA speakers at meetings.

National Association of Area Agencies on Aging (n4a) (www.n4a.org): This national association provides searchable services, resources, and advocacy for older adults and professionals who work with them.

National Council on Aging—Resources (www.ncoa.org/audience/older-adults-caregivers-resources/?post_type=ncoaresource): This webpage contains a searchable database of articles and webinars.

National Institute on Aging—Alcohol Use or Abuse (www.nia.nih.gov/health/topics/alcohol-use-or-abuse): This webpage contains links to older adult-specific information on alcohol misuse.

NIAAA Alcohol Treatment Navigator (https://alcoholtreatment.niaaa.nih.gov): In addition to helping visitors find the best alcohol misuse treatment options, this treatment navigator details a step-by-step process for understanding AUD.

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Chapter 4 Appendix

Alcohol Use Disorders Identification Test (AUDIT): Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks." Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?
   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total of specific items here

Scoring: The cutoff score indicating hazardous and harmful alcohol use for the AUDIT is generally 8; however, for older adults a score of 5 indicates a need for clarifying questions and further assessment.[796]

Adapted from Barbor et al. (2001).[797]

Alcohol Use Disorders Identification Test (AUDIT): Self-Report Version

CLIENT: Alcohol use can affect your health and interfere with some medications and treatments, so it's important that we ask some questions about your alcohol use. Your answers will remain confidential; please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Adapted from Barbor et al. (2001).[798]

Provider Note: The self-report version should be given to older clients to fill out. Ask them to return it to you, and then discuss the results with them. A cutoff score of 5 means you need to assess further.[799]

Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G)

	Yes (1)	No (0)
1. When talking with others, do you ever underestimate how much you drink?		
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?		
3. Does having a few drinks help decrease your shakiness or tremors?		
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?		
5. Do you usually take a drink to relax or calm your nerves?		
6. Do you drink to take your mind off your problems?		
7. Have you ever increased your drinking after experiencing a loss in your life?		
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?		
9. Have you ever made rules to manage your drinking?		
10. When you feel lonely, does having a drink help?		

TOTAL SMAST-G-SCORE (0-10) _____

SCORING: 2 OR MORE "YES" RESPONSES IS INDICATIVE OF AN ALCOHOL PROBLEM.

Ask the extra question below but do not calculate it in the final score.

Extra question: Do you drink alcohol and take mood or mind-altering drugs, including prescription tranquilizers, prescription sleeping pills, prescription pain pills, or any illicit drugs?

© The Regents of the University of Michigan, 1991. Source: University of Michigan Alcohol Research Center.[800] Adapted with permission.

Large-Print Grief Handout

What Is Grief?

Grief is a natural response to loss. It's the emotional suffering you feel when something or someone you love is taken away. Whatever your loss, it's personal to you.

Coping With Grief

Although loss is a part of life that cannot be avoided, there are ways to help cope with the pain, come to terms with your grief, and eventually, find a way to move on with your life. This doesn't mean you will forget your loved one, but you can find a way to hold that individual in your heart and your memories while continuing to live your life. This includes:

- Acknowledging your pain.
- Accepting that grief can bring up many different and unexpected feelings.
- Understanding that your grieving process will be unique to you.
- Seeking out face-to-face support from people who care about you.
- Supporting yourself emotionally by taking care of yourself physically.
- Learning the difference between grief and depression.

The Grieving Process

Grieving is highly individual; there's no right or wrong way to grieve. The grieving process takes time. Healing happens gradually; it can't be forced or hurried—and **there is no "normal" timetable for grieving.** Some people start to feel better in weeks or months. For others, the grieving process is measured in years. Whatever grief is like for you, it's important to be patient with yourself and allow the process to naturally unfold.

Reprinted with permission.[801]

Alcohol Use Agreement and Drinking Diary Cards

The purpose of this step is to decide on a drinking limit for yourself for a particular period of time. Negotiate with your healthcare provider so you can both agree on a reasonable goal. A reasonable goal for some people is abstinence—not drinking any alcohol.

As you develop this agreement, answer the following questions:

- How many standard drinks?
- How frequently?
- For what period of time?

Agreement

Date _____

_____

_____

_____

Client signature _____

Clinician signature _____

Drinking Diary Card

One way to keep track of how much you drink is the use of drinking diary cards. One card is used for each week. Every day record the number of drinks you had. At the end of the week add up the total number of drinks you had during the week.

Card A

Keep Track of What You Drink Over The Next 7 Days

Starting Date _____				
	Beer	Wine	Liquor	Number
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
		WEEK'S TOTAL:		

Card B

Keep Track of What You Drink Over The Next 7 Days

Starting Date _____				
	Beer	Wine	Liquor	Number
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
			WEEK'S TOTAL:	

Adapted from material in the public domain.[802]

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Chapter 5—Treating Drug Use and Prescription Medication Misuse in Older Adults

KEY MESSAGES

- Illicit drug use and prescription medication misuse do occur in older adults, but they are treatable.
- Regular screening and assessment can help you learn whether an older client is struggling with drug use or prescription medication misuse.
- Education and brief interventions are often enough to help older adults prevent, reduce, or stop drug use and prescription medication misuse. Most older clients who use illicit drugs or misuse prescription medication do not need care from programs or providers that specialize in substance use disorder (SUD) treatment.
- Age-specific and age-sensitive treatments are useful in reducing drug use and prescription medication misuse and related health risks. These treatments are designed to meet the special physical, cognitive, and social needs of older individuals. For many older adults, these adaptations can make all the difference in helping them start, stay in, and benefit from treatment.

Chapter 5 of this Treatment Improvement Protocol (TIP) will benefit healthcare, behavioral health service, and social service providers who work with older adults (e.g., physicians, nurse practitioners [NPs], physician assistants, nurses, social workers, psychologists, psychiatrists, mental health counselors, drug and alcohol counselors, peer recovery support specialists). It addresses drug use, prescription medication misuse, and SUDs other than alcohol use disorder among older adults.

Prescription medications are some of the most commonly misused substances in this population,[803] and rates of substance misuse in general are increasing. These increases result, in part, from the size of the aging baby boomer generation (those born from 1946 to 1964) and the fact that baby boomers are living longer and have higher rates of lifetime substance misuse, including SUDs, than past generations.

Many older adults who misuse substances do not need specialized SUD treatment. Prevention strategies and brief interventions are often enough. Even so, research shows that older adults do benefit from addiction treatment.[804,805,806] In fact, older adults in addiction treatment programs are more likely than younger adults to complete treatment, and older adults have nearly as good or better outcomes.[807,808] Thus, as the older population in the United States grows, the need for a full range of treatment approaches that meet the unique requirements of older adults will continue to increase.

Organization of Chapter 5 of This TIP

This chapter of TIP 26 addresses rates of drug use and prescription medication misuse, including drug use disorders, among older adults as well as treatment and recovery management approaches that meet older adults' specific needs.

The first section of Chapter 5 describes illicit drug use and prescription medication misuse, including drug use disorders, among older adults. Definitions and facts are discussed as well as the physical, mental, social, and economic effects of drug use disorders.

The second section describes how to identify, screen, and assess for drug use disorders in older adults. The parts of screening, brief intervention, and referral to treatment (SBIRT) are discussed, along with specific tips for screening older adults.

The third section describes the continuum of care for older adults with drug use disorders, which ranges from brief interventions for prescription medication misuse to inpatient detoxification and rehabilitation for older adults with drug use disorders.

The fourth section discusses specific treatment approaches for older adults with drug use disorders. These approaches include acute care, overdose treatment, medically supervised withdrawal, medication maintenance therapy, psychosocial approaches, age-specific treatment options, referral management, and care coordination.

The fifth section provides an overview of recovery management strategies for older adults with drug use disorders. It covers topics such as family member involvement in treatment and linking older adults to evidence-supported, community-based recovery support groups such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA).

The sixth section provides clinical scenarios. This section uses clinical case material to show how to apply approaches and strategies discussed in Chapter 5 to older clients.

The seventh section identifies targeted resources to support your practice. A more detailed resource guide is in Chapter 9 of this TIP.

For definitions of key terms you will see throughout Chapter 5, refer to Exhibit 5.1.

EXHIBIT 5.1. Key Terms

- **Addiction*:** The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.
- **Age-sensitive:** Adaptations to existing treatment approaches that accommodate older adults' unique needs (e.g., a large-print handout on the signs of substance misuse).
- **Age-specific:** Treatment approaches and practices specifically developed for older adults (e.g., an older adult specialty group in a mixed-age SUD treatment program).
- **Caregivers:** Informal caregivers provide unpaid care. They assist others with activities of daily living (ADLs), including health and medical tasks. Informal caregivers may be spouses, partners, family members, friends, neighbors, or others who have a significant personal relationship with the person who needs care. Formal caregivers are paid providers who offer care in one's home or in a facility.[809] Most older adults do not need caregivers and are as able to address their own needs as younger adults, whether or not substance misuse is a factor in their lives.
- **Diversion:** A medical and legal term describing the illegal sharing of a legally prescribed, controlled medication (e.g., an opioid) with another individual.
- **Drug–drug interaction:** The interaction of one substance (e.g., alcohol, medication, an illicit drug) with another substance. Drug–drug interactions may change the effectiveness of medications, introduce or alter the intensity of side effects, and increase a substance's toxicity or the concentration of that substance in a person's blood. Potentially serious interactions can also occur with certain foods, beverages, and dietary supplements.[810]
- **Drug use:** The full range of severity of illicit drug use, from a single instance of use to meeting criteria for a drug use disorder.
- **Illicit substances:** Illicit substances include cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription medications that are taken other than as prescribed (e.g., pain relievers, tranquilizers, stimulants, sedatives).

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- **Mutual-help groups:** Groups of people who work together on obtaining and maintaining recovery. Unlike peer support (e.g., the use of recovery coaches or peer recovery support specialists), mutual-help groups consist entirely of people who volunteer their time and typically have no official connection to treatment programs. Most are self-supporting. Although 12-Step groups such as AA and NA are the most widespread and well researched type of mutual-help groups, other groups may be available in some areas. They range from groups affiliated with a religion or church (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART [Self-Management and Recovery Training] Recovery, Women for Sobriety).
- **Peer support:** The use of peer recovery support specialists (e.g., someone in recovery who has lived experience in addiction plus skills learned in formal training) to provide nonclinical (i.e., not requiring training in diagnosis or treatment) recovery support services to individuals in recovery from addiction and to their families.
- **Prescription medication misuse:** The full range of severity of problematic use of prescription medication (meaning using a medication to feel good, using more than prescribed or in a way not prescribed, or using medication prescribed to someone else), from mild misuse to meeting criteria for an SUD.
- **Psychoactive substances:** Substances that can alter mental processes (e.g., cognition or affect; in other words, the way one thinks or feels). Also called psychotropic drugs, such substances will not necessarily produce dependence, but they have the potential for misuse or abuse.[811]
- **Recovery*:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome them and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called being in recovery. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature.
- **Relapse*:** A return to substance use after a significant period of abstinence.
- **Remission:** A medical term meaning a disappearance of signs and symptoms of the disease or disorder. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) defines remission as present in people who previously met SUD criteria but no longer meet any SUD criteria (with the possible exception of craving).[812] Remission is an essential element of recovery.
- **Substance misuse*:** The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).
- **Substance use disorder*:** A medical illness caused by repeated misuse of a substance or substances. According to DSM-5,[813] SUDs are characterized by clinically significant impairments in health and social function, and by impaired control over substance use. They are diagnosed through assessing cognitive, behavioral, and psychological symptoms. SUDs range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Multiple factors influence whether and how rapidly a person will develop an SUD. These factors include the substance itself; the genetic vulnerability of the user; and the amount, frequency, and duration of the misuse. Note: A severe SUD is commonly called an addiction. A mild SUD is generally equivalent to what previous editions of DSM called substance abuse; a moderate or severe SUD is generally equivalent to what was formerly called substance dependence.

* The definitions of all terms marked with an asterisk correspond closely to those given in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. This resource provides a great deal of useful information about substance misuse and its impact on U.S. public health. The report is available online (https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf).

Drug Use and Prescription Medication Misuse Among Older Adults

Drug use and prescription medication misuse are growing problems among older adults. In the next decade, approximately 20 percent of the U.S. population will be over age 65.[814] As the large baby boomer population ages up, drug use and prescription medication misuse will likely increase. This group has higher rates of illicit drug use than past generations,[815,816] and their misuse of pain medication and other prescription medication is significant.

Taking opioids for pain is one pathway to drug use or prescription medication misuse for older adults. They may start taking opioids for pain and become physically dependent.

Other than alcohol and tobacco, the most commonly misused substances among older adults are psychoactive prescription medications, such as opioids and benzodiazepines (i.e., medications for sleep, pain, and anxiety). Research shows that older adults also use cannabis, cocaine, and heroin. For example, past-year cannabis use by older adults increased from 2006 to 2013 by 57.8 percent for adults ages 50 to 64 and by 250 percent for adults ages 65 and older.[817]

Drug use and prescription medication misuse can lead to many negative health outcomes for older adults, such as:

- Increased risk of injury and falls.
- Problems with thinking (also called cognitive impairment).
- Harmful drug–drug interactions.

Prescribed medication is not always misused on purpose. Older adults:

- Can accidentally take more of a prescribed medication than they meant to.
- Can accidentally mix up medications.
- May not know the potential risk of harmful effects of using certain substances (e.g., over-the-counter [OTC] medications, dietary supplements) while taking medication, even when taking it as prescribed.

- Overdose, which can be fatal.
- Suicide.
- Liver and heart disease.
- Sleep problems.

Drug use and prescription medication misuse have negative economic effects. They cost the United States billions of dollars each year, including $193 billion for illicit substances in 2007[818] (the last year in which those numbers were reported) and $78.5 billion for prescription opioids in 2013[819] (the last year in which those numbers were reported). Drug use and prescription medication misuse also lead to greater healthcare costs. Older adults already use more healthcare resources than younger adults. As older adults with drug use disorders age, they are at an increased risk of co-occurring medical conditions, which means they will use more healthcare services.[820,821,822]

Drug use and prescription medication misuse among older adults negatively affect relationships, families, and friends. Many family members, friends, and caregivers recognize but minimize drug use or prescription medication misuse among older adults. Well-meaning family and friends may assume that drug use and prescription medication misuse in older adults cannot be treated, especially if the behavior has been going on for a while. They may feel that the time for treatment has passed or that previous attempts at treatment make trying again pointless.[823,824] Often, friends and family view the use of certain substances by older adults as one of their "last pleasures" or distractions in life.[825]

Ageist, incorrect beliefs about drug use and prescription medication misuse among older adults can prevent older adults from getting treatment. Treatment access for older adults is key, as research increasingly shows that SUD treatment for older adults can reduce or stop drug use and prescription medication misuse and improve health/quality of life.[826,827,828,829,830]

Prescription Medication Misuse

Prescription medication misuse includes:

- Taking larger doses of a medication than prescribed.
- Changing the dose without guidance from the prescriber.

- Taking a medication for reasons other than its intended purpose.
- Taking someone else's medications.

Older adults are prescribed and use more medication than any other age group. From 2015 to 2016:[831]

- An estimated 87.5 percent of adults ages 65 and older took at least one prescription medication in the past 30 days, versus 67.4 percent of adults ages 45 to 64 and 35.3 percent of those ages 18 to 44.
- Adults ages 65 and older were the largest group of people taking five or more prescription medications in the past 30 days (39.8 percent) compared with adults ages 45 to 64 (19.1 percent) and adults ages 18 to 44 (3.9 percent).

Age-related changes to metabolism and body fat affect the medication dosage that older adults need and increase the risk of older adults feeling negative effects of medication. For example, older adults are very likely to feel memory-related and psychomotor effects of benzodiazepines and opioids. Also, older adults have a higher rate of co-occurring conditions than do younger adults, which means they take more medication and are more likely to experience harmful drug–drug, alcohol–drug, and drug–co-occurring condition interactions.[832,833]

Providers face challenges when prescribing for older adults in general and need to exercise extra caution. One challenge is that a medication may not have a recommended dosage for older adults, in which case providers should prescribe the minimum dosage needed to achieve a positive outcome. Prescribers also need to think about what formulation of a medication will work best for an older patient and what dosing schedule will be easiest to follow. Yet another common challenge is that older patients may be taking unnecessary medication given their specific clinical conditions. Such medication should be discontinued, consulting with the patient and using tapering as appropriate.[834,835] Also, some medications are potentially inappropriate for older adults: see the Chapter 6 text box on the American Geriatrics Society Beers Criteria®.

Younger people tend to misuse psychoactive prescription medication for mood effects (i.e., wanting to feel very happy or euphoric), but **older adults tend to develop drug use disorders because they are using drugs or misusing prescription medication to treat their chronic pain, anxiety, depression, and sleep issues.**[836,837,838]

Opioids

The United States is facing an opioid use and overdose crisis. (See SAMHSA's TIP 63, *Medications for Opioid Use Disorder*, for more information; https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006). The years 2006 to 2013 saw an increase in calls to U.S. poison control centers about older adults' misuse of prescription opioids, including misuse of prescription opioids for self-harm.[839]

Chronic pain is one of the most common reasons for taking medication. Older adults have the highest rate of chronic pain of any age group,[840] leading to more clinic visits and increased prescribing of opioid medication. Older adults with opioid use disorder (OUD) and chronic pain may have a hard time accepting that they have OUD.

Benzodiazepines

Benzodiazepines (e.g., lorazepam, alprazolam, clonazepam) are mainly used to treat sleep and anxiety disorders. Benzodiazepines are thought to be safer than barbiturates and nonbarbiturate sedative-hypnotics.[841] **However, the physical dependence potential for benzodiazepines is very high. Long-term use or misuse of benzodiazepines in older adults has many risks.** Results from more than 68 clinical trials show that benzodiazepines, no matter how long they are used (either short-, intermediate-, or long-acting) can lead to cognitive impairment. The greater the dose, the greater the impairment.[842]

Many older adults experience adverse drug reactions because they are managing numerous prescribed medications (sometimes from multiple prescribing physicians). Adverse drug reactions are not necessarily the result of intentional or accidental misuse; rather, they result from complying with a dangerous regimen of drugs.

Multiple Medications

The aging process causes changes to the body that increase the chances of older adults feeling negative effects of medication. For example, older adults have decreased ability to metabolize drugs. **Older adults often take more than one medication.**[843] **Negative effects are more likely to occur when older adults take many OTC or prescription medications.**[844] Taking more than one medication that affects the central nervous system (CNS) increases the risk of:[845]

- Problems with daily functioning.
- Cognitive impairment.
- Falls.
- Death.

Coprescribing of opioid and benzodiazepine medications is a concern. The risk of death increases with the dose of benzodiazepine prescribed.[846] In 2016, the Food and Drug Administration (FDA) issued a Drug Safety Communication warning about serious risks, including respiratory depression and death, from combining opioids with benzodiazepines or other CNS depressants (e.g., **alcohol**), and requiring boxed warnings for prescription opioids and benzodiazepines. FDA also cautioned that healthcare professionals "should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect." FDA further advised healthcare professionals to screen these patients for SUDs, plus listed other precautions.[847] Note that even greater caution should be used with older patients because of their higher risk of experiencing negative effects from medication.

FDA in 2017 advised against withholding buprenorphine or methadone treatment for OUD from patients taking benzodiazepines or other CNS depressants, but recommended careful medication management of these patients. Although combining these OUD medications with CNS depressants increases the risk of serious side effects, FDA noted that this risk can be outweighed by the risk and harm of untreated OUD.[848] For strategies on caring for these patients, see the FDA Drug Safety Communication at www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications and the section "Concurrent Substance Use Disorders (SUDs) Involving Benzodiazepines or Alcohol" in SAMHSA's TIP 63 (https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006). Again, keep in mind the need for using extra caution with older patients.

Illicit Substances

Illicit substances include cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription medications that are taken other than as prescribed (e.g., pain relievers, tranquilizers, stimulants, sedatives). Because federal law bans the recreational and medical use of cannabis, this publication considers it an illicit substance (although in some states, medical use of cannabis is legal and in others, both recreational and medical use are legal).

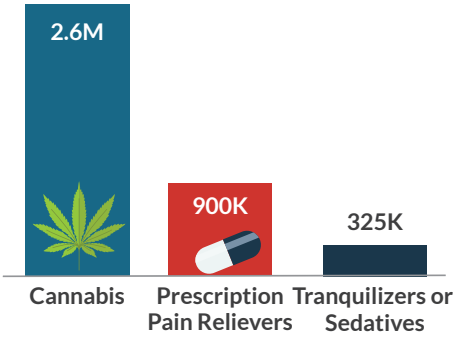
In 2019, 3.7 million adults ages 65 and older had used illicit substances in the past year.[849] Of these drugs, older adults most commonly used:[850]

- Cannabis: 2.6 million adults.
- Prescription pain relievers: 900,000 adults.
- Tranquilizers or sedatives: 325,000 adults.

From 2000 to 2012, SUD treatment admissions for illicit substance use increased for adults ages 55 or older.[851]

Rates of cannabis use among older adults are likely to continue rising. This is a major concern as baby boomers, who tend to be more accepting of cannabis use than previous generations, enter

3.7 MILLION ADULTS ages 65 and older used **ILLICIT SUBSTANCES** in 2019.



the later stages of life. From 2000 to 2019, the percentage of adults ages 50 to 64 who had ever used cannabis increased from approximately 24 percent to around 54 percent.[852,853]

The effects of using cannabis while also taking specific prescription medications are not known. However, **cannabis use is related to an increased risk of injury and short-term memory problems.** Cannabis affects central and peripheral nervous system processes in ways such as:[854,855,856,857]

- Increasing symptoms of anxiety and depression.
- Increasing problems with cognition and learning.
- Worsening motor coordination (i.e., the ability to use and control muscle movements).

Moreover, the increasing potency of cannabis in recent decades may make cannabis use riskier.[858]

Screening and Assessment

If you think a client might be using drugs or misusing prescription medication, screening measures will help you identify and address this behavior.[859] Screening older adults for drug use and prescription medication misuse and providing education about health risks related to interactions between prescribed medication, alcohol, and illicit substances are prevention strategies you can use in many different settings.

Screen and assess older adults for substance use and co-occurring medical and mental disorders (e.g., cognitive impairment) that can mask SUDs or appear similar to SUDs.

CO-OCCURRING CONDITIONS AMONG OLDER ADULTS

Older adults with SUDs have high rates of mental disorders and co-occurring health conditions. In 2019, an estimated 36.8 percent of adults older than age 50 with SUDs also had mental disorders.[860] Co-occurring mental disorders and SUDs among older adults are probably underdiagnosed, so the rates of co-occurring disorders (CODs) may actually be higher.[861]

Compared with older adults who have only an SUD or a mental disorder, those with both are at risk for:[862,863]

- Higher rates of inpatient and outpatient behavioral healthcare service use.
- Thoughts of suicide and of death in general.
- Certain physical conditions related to substance misuse (e.g., heart disease, organ damage, some cancers).

Given high rates of CODs in older adults with SUDs, you should use holistic, detailed approaches to screening, assessment, and treatment.

Screening Strategies

To successfully make routine screening for drug use disorders a part of your clinical practice with older adults, **use simple, consistent approaches that can be added to screening practices you already have in place.** Screening questions can be asked verbally, on paper, or electronically. Make sure print is large enough for older adults to read easily. Ask about drug use:[864]

- In a straightforward and nonjudgmental manner.
- While asking about other health behaviors (e.g., exercise, weight, smoking, alcohol use).
- While keeping the focus on helping clients improve their overall health, functioning, independence, and quality of life.

Screen adults ages 60 and older:

- Yearly, as part of the annual checkup in both healthcare and behavioral health service settings.
- When changes in physical or mental health status occur (e.g., falls, memory issues).

- During major life events or changes (e.g., retirement, moving, loss of a significant person).

The consensus panel recommends screening all adults ages 60 and older yearly and when life changes occur (e.g., retirement, loss of a partner or spouse, changes in health).

Several measures can help you screen for substance misuse, but few are validated (tested and approved for use) with older adults.[865] (See Chapter 3 of this TIP for an indepth discussion of substance use screening tools that can be used with older adults.)

One option is to use screening questions developed for the general adult population. For example, open your conversation with older clients by asking, "Have you taken a prescription medication differently than prescribed by your healthcare provider?" You can also use a single-question screener for drug use, such as, "How many times in the past year have you used an illegal drug or taken a prescription medication for nonmedical reasons?"[866] If the client says "yes" to the first question or answers the second question with one or more, begin more indepth screening.

Indepth screening includes asking clients about:

- Use of prescription and OTC medications.
- Use of other substances (e.g., alcohol, cannabis, tobacco).
- Amount/frequency of past-month substance use.
- Effects of using substances.
- Concerns about their substance use as well as concerns of family members or friends.

RESOURCE ALERT: NATIONAL INSTITUTE ON DRUG ABUSE-MODIFIED ALCOHOL, SMOKING, AND SUBSTANCE INVOLVEMENT SCREENING TEST

This screening tool (www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf) offers a helpful way to organize your questions about types of substances used, lifetime and recent amount and frequency of substances used, and substance use concerns.

SCREENING FOR USE OF MULTIPLE MEDICATIONS: A BROWN BAG MEDICINE REVIEW

Older adults often take a number of prescribed medications as well as OTC medications and dietary supplements. As part of an annual physical, or given signs that the older client is misusing medications (e.g., benzodiazepines, opioids), urge the client (or a family member, with consent) to bring in all prescribed and OTC medications and dietary supplements in a bag so that you and the client can review them together. This is known as a "brown bag medicine review." This is a chance to discuss the health risks of taking multiple medications, of drug–drug interactions, and of misuse.[867,868] **Brown bag medicine reviews can improve client reporting of medication use and improve provider–client discussions about medication use.**[869]

When using verbal, electronic, or printed screeners:

- Be empathetic and nonconfrontational.
- Make the screening questions easy to understand.
- Speak clearly and repeat instructions or questions as needed, especially if the client has cognitive impairment or problems with vision or hearing. Make sure the client can hear and understand you.
- Use large type for printed questions and screen reader–friendly adaptations for computer screening.
- Ask questions about the client's illicit substance use or prescription medication misuse as a part of assessing overall health status.
- Assess and reassess if the client is having problems using a computer, tablet, or writing on a printed form. If needed, offer a verbal interview in which you read the screening questions.

Assessment and Diagnosis of Drug Use Disorders

Screening is the first step in performing an indepth assessment of substance misuse. Some signs of drug use disorders in older adults may be mistaken for symptoms of co-occurring

LINKING SCREENING QUESTIONS ABOUT SUBSTANCE USE TO HEALTH STATUS

You can help older adults understand the reason for your asking substance use questions by giving them information about age-related changes in metabolism and how specific medications, such as sedatives and antianxiety medications, can negatively interact with alcohol. You can also help older adults understand the relationship between substance use and health outcomes by discussing their substance use and other health problems, such as falls, high blood pressure, and depression.

medical or mental disorders. Using DSM-5 diagnostic criteria alone may underdiagnose older adults who have drug use-related and prescription medication misuse-related health and functioning problems. This can keep clients from getting needed treatment.

A full assessment should include questions about a client's:

- History of substance use (including alcohol and tobacco use).
- Age at which substance misuse issues began.
- Amount and frequency of substance use.
- Current prescription medications, OTC medications, and dietary supplements.
- Co-occurring medical conditions.
- Relationship between substance use and daily functioning.
- Co-occurring mental disorders, particularly depression and anxiety.
- Use of substances to cope with sleep problems, depression, anxiety, stress, or pain.
- Management of daily medication regimens.

Note any signs that clients may be under the influence of substances. Although clients who appear to be so may give incomplete answers, current influence of substances is by itself a clear sign that further assessment and intervention are needed.

DSM-5 Diagnostic Criteria

A formal SUD diagnosis is based on your client meeting 2 out of 11 DSM-5 diagnostic criteria. However, **some of the physical and social factors described in DSM-5 may not apply to older adults** because of age-related changes in tolerance to substances, cognitive functioning, role responsibilities, or social isolation.[870] **Exhibit 5.2 summarizes the physical, mental, and social aspects of aging you should consider when using these criteria to diagnose SUD in older adults.**

EXHIBIT 5.2. DSM-5 Criteria for SUD and Considerations for Older Adults

DSM-5 CRITERIA FOR SUD[871]	CLINICAL CONSIDERATIONS[872,873,874]
Criterion 1	Older adults may need less of a substance to feel its physical effects. In addition to age-related or co-occurring medical-related decline in cognitive functioning, use of many substances can increase cognitive impairment and the ability to keep track of the amount and frequency of substance use.
Criterion 2	This is the same as in the general adult population. There are no special considerations for older adults.

Continued on next page

Continued

DSM-5 CRITERIA FOR SUD	CLINICAL CONSIDERATIONS
Criterion 3	Effects from substance use can occur from using relatively small amounts compared with the general adult population.
Criterion 4	Although older adults may have cravings, they may not recognize substance cravings in the same way as the general adult population (e.g., cognitive decline may increase confusion about physiological cues related to craving).
Criterion 5	Role responsibilities may be different for older adults because of life-stage changes, like retirement. Role responsibilities more common among older adults include caregiving for a spouse with a chronic illness and parenting a custodial grandchild.
Criterion 6	Older adults may not realize their substance use is related to social or interpersonal problems.
Criterion 7	Older adults may participate in fewer activities than younger adults, making it difficult to know whether a reduction in activities is related to substance use. However, social isolation is related to substance use and should be noted and addressed.
Criterion 8	Older adults may not understand that their use is harmful, especially when using substances in smaller amounts. Older adults may not identify certain situations (e.g., using a step stool or taking medications together) as physically dangerous.
Criterion 9	Older adults may not realize their substance use is related to physical (e.g., gastrointestinal distress) or mental problems (e.g., anxiety).
Criterion 10	Because of increased sensitivity to substances with age, older adults may have lowered rather than increased tolerance depending on the substance used.
Criterion 11	Withdrawal symptoms among older adults can be less obvious and more drawn out. Older adults may not develop physical dependence if they started using the substance in late life; if prescribed and correctly using medications like benzodiazepines, they may develop physical dependence.

Biopsychosocial Assessment and Placement

The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS 20) is an assessment and placement tool that supports adoption of a systematic approach to these important steps in meeting the needs of older adults. The tool can be downloaded for free from www.communitypsychiatry.org/resources/locus.

Continuum of Care

The SUD treatment continuum of care has many points of intervention where older adults can receive services (Exhibit 5.3). Treatment for drug use disorders can be delivered in many different settings using behavioral and pharmacological methods.

EXHIBIT 5.3. SUD Treatment Continuum of Care

PREVENTION	EARLY INTERVENTION	TREATMENT	RECOVERY MANAGEMENT
Address individual and environmental risk factors for substance use through science-informed prevention strategies aimed at individuals, families, and communities.	Identify and screen for substance misuse; provide psychoeducation and brief interventions to reduce health risk; refer to treatment as needed.	Provide medication as needed, psychosocial interventions, and supportive services to achieve recovery and maximize functioning. Levels of Care: Outpatient Intensive outpatient/ partial hospitalization Residential/inpatient Medically managed intensive inpatient services	Offer comprehensive discharge planning, referral management, continuing care, and linkage to community-based services (e.g., mutual-help groups; medical care; social, legal, educational, and financial services) that support ongoing recovery and improve wellness and quality of life.

Adapted from material in the public domain.[875]

More than 14,500 specialized treatment facilities in the United States provide SUD services, such as:[876]

- Counseling.
- Rehabilitation.
- Behavioral therapy.
- Case management.
- Medication therapy.
- Psychoeducation.
- Peer recovery support services.

Early intervention for an older adult's drug use or prescription medication misuse can take place in a healthcare office, a hospital, an emergency department (ED), an outpatient behavioral health clinic, or an older adult-focused social service agency. Primary care providers (PCPs) are often the entry point for brief interventions and referral to drug use disorder-specific treatment.

Different levels of care include:

- Outpatient individual, group, and family counseling.
- Intensive outpatient care (i.e., daily or weekly individual and group counseling for many weeks/months).
- Residential care (i.e., 24-hour supervision and clinical monitoring).
- Medically managed inpatient care (i.e., treatment services in a medical or mental hospital setting).

When you work with clients to develop a treatment and recovery plan based on their preferences, as well as on the accessibility and appropriateness of the chosen treatment, clients are more likely to follow your recommendations. Unless clients present with active suicidal ideation, withdrawal risks, or an acute health concern (e.g., overdose, significant impairment, delirium, falls), let them choose their preferred treatment method. Offer options and discuss the benefits of each as they apply to each client.

Recovery management, including discharge planning and continuing care, is an important part of the continuum of care. Older adults leaving intensive addiction treatment should:[877]

- Have routine medical care for co-occurring, chronic medical conditions.
- Be linked with older adult-focused, community-based services.
- Be introduced and referred to recovery groups to support their ongoing recovery but also to reduce isolation and loneliness, which are common among older adults. (See Chapter 7 of this TIP for more information about social isolation.)

Treatment Approaches Suited to Older Adults

Many safe and effective interventions exist for older adults who use drugs, misuse prescription medication, or have drug use disorders. You should approach decisions about treatment by considering:

- The drug being used or the prescription medication being misused.
- The level of care needed (e.g., brief intervention, detoxification, maintenance).
- Overdose prevention and treatments.
- Psychosocial approaches adapted to older adults.

This section describes general approaches that work with older adults who misuse prescription medications and use illicit substances. It also describes treatment strategies for specific kinds of substances.

ENDING, CHANGING, OR CONTINUING TREATMENT[878]

Clients' progress in treatment, as gauged by clearly defined, agreed-upon goals, should determine their length of time in treatment. The main criterion for discharge is that clients have met treatment goals. If clients are making progress and that progress is likely to continue, treatment should continue. If clients cannot meet treatment goals or they develop new treatment-related challenges, they should receive recommendations for different types of services or treatments.

SBIRT

Many older adults who use illicit drugs or misuse prescription medication do not need specialized addiction treatment. Education is often enough to help older adults change their behaviors. Older adults often respond well to nonjudgmental, brief education about:

- Medications they are taking.
- Potential drug–drug interactions.
- Negative effects of using medications in ways other than as prescribed.

SBIRT is an indepth approach to screening and brief intervention with older adults who may exhibit at-risk drug use, misuse of prescription medications, or use of illicit substances.[879]

- **Screening** helps you quickly assess the severity of drug use or prescription medication misuse and identifies the right type and intensity of treatment.
- The **brief intervention** focuses on helping older adults increase awareness of their drug use or prescription medication misuse and motivation for changing health risk behaviors.
- **Referral to treatment** secures access to assessment and treatment by providers who specialize in addiction, when needed.[880] Providers can implement SBIRT in many settings, including behavioral health service programs and healthcare clinics.

Chapter 3 offers indepth discussion of SBIRT, research on its usefulness, and adaptations for older adults.

Treatment for OUD

Opioid Overdose Treatment

Because of physiological changes, older adults show higher blood concentrations of opioid metabolites. This results in greater substance potency, toxicity, and longer duration of action than in younger adults.[881,882] These factors may **increase older adults' risk of opioid overdose, which should be treated as a life-threatening emergency.**

Follow recommended guidelines for naloxone administration, and **offer overdose prevention education and emergency naloxone kits to clients, caregivers, and families in case of overdose.**[883,884]

Medically Supervised Opioid Withdrawal

Older adults are likely to have intense opioid withdrawal symptoms, especially related to chronic pain.

ACUTE CARE: MEDICAL STABILIZATION AND SUPERVISED MEDICAL WITHDRAWAL

Individuals must be medically and mentally stabilized if they:[885]

- Are acutely intoxicated.
- Are having an overdose.
- Are in withdrawal.
- Return to substance use.

Acute inpatient treatment may also be needed for individuals who:

- Are frail.
- Have multiple addictions.
- Have suicidal ideation.

Medically supervised withdrawal in a monitored or managed setting is recommended for older adults who have been taking high doses of a substance (e.g., opioids) or using for a long time. Inpatient treatment will ensure that individuals are medically monitored for a safe withdrawal process. This is especially important for older adults with co-occurring mental and medical conditions. Monitoring reduces risk of severe negative effects, including death, as older adults have more clinical risks related to withdrawal and medical stabilization.

Medication To Treat OUD

Three FDA-approved medications[886] can treat OUD in older adults:

- **Buprenorphine. Buprenorphine carries less risk for overdose than methadone.**[887,888] Buprenorphine's risk of respiratory depression or sedation is low,[889] and the medication doesn't produce the euphoria caused by heroin or synthetic opioids. Buprenorphine:
  - Is a good option for patients with repeated return to opioid use.
  - Is usually more convenient and cost-effective than methadone, because it can be provided in office-based settings by qualified physicians, NPs, physician assistants, and, until October 1, 2023, qualified clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives.
  - Is available as an implant, in sublingual and transmucosal formulations, and as an injection. This makes it a **good option for older adults with mobility or transportation issues, as it reduces the need for frequent visits to the provider.**[890]

- **Methadone. Methadone can prevent opioid withdrawal symptoms and reduce drug cravings.** Methadone is available in almost every state from specially licensed opioid treatment programs. Methadone is a beneficial intervention.[891]
- **Naltrexone. Naltrexone is best for clients who want to stop all opioid use.** Research on naltrexone for OUD treatment in older adults is not readily available. It is less useful for individuals needing long-term medication maintenance therapy for SUDs or for those with chronic pain. Naltrexone must not be prescribed to individuals who are currently using opioid medications.

Nonopioid Treatments for Chronic Pain

Older adults may develop OUD because of chronic pain. Given the complexities of managing the care of older clients with chronic pain, a comprehensive treatment approach is recommended.[892] Chronic pain in older adults is best managed by a multidisciplinary team that includes (when possible) a:[893]

- Geriatrician.
- Rheumatologist.
- Physical medicine and rehabilitation physician.
- Psychiatrist or psychologist.
- Physical therapist.
- Occupational therapist.
- Pharmacist.

Nonpharmacological treatments can successfully treat chronic pain in older adults. These include:[894]

- Meditation.
- Relaxation.
- Cognitive–behavioral therapy (CBT).
- Exercise therapy.
- Physical therapy/occupational rehabilitation.

Exhibit 5.4 shows the general approach to managing chronic pain in older adults.

RESOURCE ALERT: VETERANS AFFAIRS CLINICAL DECISION TOOLS FOR OPIOID USE AND CHRONIC PAIN

The Department of Veterans Affairs/Department of Defense *Clinical Practice Guideline for Opioid Therapy for Chronic Pain* (www.healthquality.va.gov/guidelines/Pain/cot) describes the critical decision points in the management of opioid therapy for chronic pain. It provides clear and comprehensive evidence-based recommendations using current information and practices for practitioners throughout the Department of Defense and Department of Veterans Affairs healthcare systems. It includes special dosing considerations for older adults.

The *Opioid Safety Initiative Toolkit* (www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_OSI.asp), created by the Veterans Health Administration National Pain Management Program, can aid in clinical decisions about starting, continuing, or tapering opioid therapy and other challenges related to safe opioid prescribing. Clinical teams caring for older adult veterans with chronic pain may find this useful.

EXHIBIT 5.4. Chronic Pain Assessment and Treatment Approaches for Older Adults[895,896]

Assessment. An indepth assessment should review the client's:

- Cognitive and functional status.
- Social support.
- Co-occurring medical and psychiatric conditions and SUDs.
- History of pharmacological and nonpharmacological treatments.
- Current medication and alcohol use.
- ADLs. (See Chapter 3 for more information about assessing these.)
- Goals and hopes for treatment.

Treatment. An indepth approach should include:

- Building a treatment alliance with the older adult by asking about his or her preferences and goals.
- Providing consistent and prompt follow-up to a client's requests and phone calls.
- Providing backup coverage with providers who understand the unique treatment needs of older adults.
- Providing/actively linking the client to physical or occupational therapy and other community-based resources.
- Offering pharmacological (when needed) and other treatments (e.g., CBT, physical therapy, mindfulness).
- Using praise and positive reinforcement when the client meets treatment tasks and goals.
- When necessary, adapting treatment approaches to meet the needs of the older adult.
- Including family and caregivers in treatment planning and recovery/rehabilitation activities (with the older adult's permission).

If you are treating older adults with opioids for chronic pain, do not stop treatment suddenly. This can cause serious withdrawal effects. In addition, the return of pain may lead older adults to misuse or use other prescribed medications, alcohol, OTC medications, and illicit drugs. **The consensus panel recommends that you slowly titrate older adults off of opioids, while at the same time offering them other pharmacological and nonpharmacological treatment options.**

Treatment of Drug Use Disorders Other Than OUD

Benzodiazepines

Given the potential risks and harmful effects, medical providers are cautioned against prescribing benzodiazepines to older adults. If a benzodiazepine is needed, prescribe the lowest dose for the shortest amount of time. Harmful effects of benzodiazepines can include:[897]

- Residual sedation.
- Decreased attention.
- Decreased memory and cognitive function.
- Changes in motor coordination.
- Increased risk of falls.
- Drug dependence and withdrawal.
- Increased risk of car accidents.

Although life-threatening benzodiazepine overdoses are rare, the risk is higher in older adults because of age-related declines in medication metabolism. In the event of a benzodiazepine overdose, low doses of a benzodiazepine antagonist are safe for older adults.[898]

Medically supervised withdrawal from benzodiazepines for older adults should include:[899]

- Counseling.
- A stepped withdrawal schedule.
- Client education about benzodiazepine use and withdrawal.

Benzodiazepine withdrawal symptoms can be similar to alcohol withdrawal symptoms. Withdrawal symptoms can include anxiety, sleep disturbances, and life-threatening complications such as seizures. A gradual, tapered approach to medically supervised withdrawal is best.

Because older adults can have withdrawal symptoms even after taking the medication for relatively short periods of time, tapering should be gradual. It should last for a minimum of 4 weeks, although most clients need longer.[900] One study using a 22-week tapering protocol and education about the tapering process found that 27 percent of clients stopped taking benzodiazepines within 6 months, compared with 5 percent in the control group.[901] A review of 28 studies of older adults tapering off benzodiazepines reported positive outcomes and no serious harmful effects with tapering only (32 percent), tapering and CBT (32 percent), and tapering plus other medication (36 percent).[902]

Other Sedative-Hypnotics

Medical providers often prescribe sedative-hypnotic medication to older adults for insomnia. Sedative-hypnotics should not be first-line treatment for insomnia. Some older adults can benefit from benzodiazepines and other sedative-hypnotics as short-term solutions to sleep issues. However, **long-term use of these medications increases the risk of physical dependence. Be very cautious prescribing them to older adults** because of the increased risk of:[903]

- Memory impairment.
- Falls.
- Fractures.
- Car accidents.

The consensus panel discourages treatment of insomnia with sedative-hypnotics for more than 7 to 10 days. Patients need frequent monitoring and reassessment if treatment continues past 2 to 3 weeks. Intermittent dosing at the lowest possible dose is best. Prescribe no more than a 30-day supply.

SLEEP HYGIENE TO REDUCE INSOMNIA IN OLDER ADULTS

The aging process can cause changes in sleep that lead to increased awakenings during the night. Older clients who practice good sleep hygiene and receive CBT can retrain their bodies and brains for better, more restful sleep. Sleep-related best practices that combine principles of sleep hygiene with CBT include the following:[904,905,906,907]

- Avoid alcohol and caffeine, especially before bed.
- Take medications in the morning if possible, especially if they are stimulating or cause alertness.
- Don't take daytime naps.
- Follow a regular bedtime.
- Use the bedroom only for sleep and sexual activity; remove TVs, electronics, and items unrelated to sleep.
- Limit exercise to earlier in the day.
- Avoid heavy meals before bedtime.
- Learn relaxation techniques and use them before bed and during night wakening.
- If awake for 10 to 15 minutes, get out of bed and do something quiet and relaxing (e.g., read a book in some place other than bed). Go back to bed only when sleepy. This helps the brain link the bedroom to sleep only.
- Keep a sleep diary to track habits and changes in sleep over time.

Cannabis

The widening legalization, availability, and social acceptance of cannabis has led to more frequent recreational and medicinal use of this drug by older adults. Sometimes, this results in cannabis use disorder (CUD). According to DSM-5, CUD includes symptoms such as:[908]

- Taking cannabis in larger amounts or over a longer period than was planned by the person.
- Having an ongoing desire to cut down or control use or past unsuccessful efforts to do so.

- Failing to fulfill major role responsibilities at work, school, or home because of cannabis use.
- Experiencing tolerance or withdrawal.

Withdrawal symptoms can lead to a return to use and include:[909]

- Irritability.
- Depression.
- Anxiety.
- Sleep problems.
- Dysphoria (sad mood).

Evidence-based treatments for CUD are lacking for the general population and for older adults. More studies and interventions designed for older adults are needed.

The National Institute on Drug Abuse recommends three behavioral approaches to treat CUD:[910] motivational interviewing (MI), CBT, and contingency management.

Stimulants

Stimulant intoxication (e.g., from cocaine or amphetamines) is linked to mental symptoms (e.g., anxiety, agitation, psychosis) as well as autonomic hyperactivity (i.e., high blood pressure, rapid heart rate). Benzodiazepines or neuroleptics may be prescribed for withdrawal-related symptoms, such as agitation and sleep issues (e.g., insomnia, extreme sleepiness).[911] Other withdrawal symptoms can include:

- Depression.
- Irritability.
- Anxiety.
- Psychosis.

At this time, there are no FDA-approved, evidence-based pharmacological treatment options for individuals with cocaine use disorder[912] **and no approved treatments specific to older adults with stimulant use disorders.** However, some pharmacotherapies have shown success in adult populations, including disulfiram, bupropion, and naltrexone.[913] **CBT remains the gold-standard treatment for stimulant cravings and return to stimulant use.**[914]

Psychosocial Treatment Approaches

Psychosocial interventions are generally effective in reducing and even stopping drug use and prescription medication misuse. Some interventions, such as CBT, MI, and relapse prevention therapy, are effective for many types of drug use.[915] Medication treatments for drug use may be more effective in combination with psychosocial treatment, compared with either medication or psychosocial interventions alone.[916,917]

It is unclear which psychosocial treatments are most effective for older adults with drug use disorders. Some psychosocial approaches, like problem-solving therapy and CBT, have effectively treated older adults for other behavioral health issues (e.g., depression, tobacco addiction) that often co-occur with drug use disorders.[918,919,920] A systematic review found that older adults do as well as or better than younger adults across SUD treatment approaches.[921]

You can adapt standard psychosocial counseling methods for use with older adults by:

- Repeating information.
- Using a slower pace.
- Offering shorter sessions.
- Giving information in different ways (e.g., verbally, in large print) to match clients' level of physical and cognitive functioning.
- Using age-sensitive approaches with structured (not open-ended) questions. Such approaches are:
  - Supportive.
  - Nonconfrontational.
  - Responsive to gender/cultural differences.
  - Flexible (e.g., provide in-home or phone service for clients without transportation).
  - Focused on helping older adults learn/improve coping and social skills. (Chapter 4 of this TIP discusses CBT, MI, relapse prevention therapy, and problem-solving therapy treatment approaches for older adults in more detail.)

Age-Specific Treatment

Age-specific treatment approaches and practices help older adults seek, participate in, and complete treatment. Such approaches also improve older adults' treatment experience (Exhibit 5.5). Whereas some older adults benefit from mixed-age addiction treatment, those ages 75 and older or with more chronic co-occurring health conditions and functional limitations benefit from age-specific treatment.[922] Regardless of the treatment approach, older adults prefer age-specific, age-sensitive approaches that are nonconfrontational, person centered, and flexible.

Age-specific programming[923,924] improves treatment completion and improves older adults' 12-month rates of abstinence. It also results in higher rates of attendance at group meetings compared with mixed-age treatment. Age-specific programs that have been studied have featured:[925]

- An emphasis on individual and group counseling and community activities.
- Adaptations such as slower pace and accommodations for vision, hearing, and cognitive impairment.
- Special topic groups for older adults focusing on:
  - Grief.
  - Loss.
  - Isolation.
  - Physical health issues.
  - Recreation.
  - Life changes.
  - Purpose.
  - Support.
- An emphasis on the therapeutic alliance while using CBT and MI, and a 12-Step philosophy.

Exhibit 5.5 highlights important characteristics of age-specific treatment for older adults recommended by the consensus panel.

Referral Management and Care Coordination

Limited time and resources may keep you from treating older adults with drug use disorders. However, as part of care coordination, you should develop linkages with treatment providers who

EXHIBIT 5.5. Age-Specific SUD Treatment for Older Adults

Accessibility

- Use a larger font on print and electronic client screening, assessment, and educational materials.
- Offer adaptations for individuals with cognitive, vision, or hearing impairments.
- Offer transportation, in-home services, and telephone checkups.
- Offer a sliding scale for self-paying clients.
- Use adaptations for individuals with physical disabilities and problems getting around.
- When needed, supply linkages to:
  - Food, clothing, and shelter.
  - Specialized medical services.
  - Older adult-focused social services.
  - Employment services.
  - Financial and housing assistance.

Program Specific

- Use a nonconfrontational manner emphasizing the therapeutic alliance while using therapeutic approaches that have been shown to work with older adults (e.g., CBT, MI, problem-solving therapy).
- Focus on building self-esteem and coping skills.
- Use a slower pace and adaptations for vision, hearing, and mild cognitive problems.
- Offer individual, group, and family counseling.
- Offer special topic groups for older adults.
- Give individual counseling and one-on-one attention.
- Ensure that staff are trained in the unique concerns and treatment needs of older adults.
- Use gender-specific content.
- Offer counseling with providers who specialize in geriatrics.
- Offer age-specific linkages to services within the community.
- Offer peer recovery support services geared to older adults.

can do so and with other resources within the community.[926] (See "Resource Alert: Developing Referral Resources" in Chapter 2 of this TIP.) **Referring older clients to the right level of treatment and offering ongoing coordination of care are the keys to getting positive outcomes for older adults in addiction treatment.**

Effective referral starts with matching your referral to the client's stated goals and available resources. You must also address the client's outlook and hopes for the referral.

Once you make a referral, follow up with both the client and the other provider to make sure that the client is continuing in treatment. Work together with the other provider to offer ongoing care as needed. (See Chapter 4 of this TIP for more strategies for referral management and care coordination.)

Recovery Management

Recovery management is an organizing philosophy for addiction treatment and recovery support services. Recovery management can help individuals and family members participate in treatment and achieve long-term recovery.[927] Not everyone who uses illicit substances or misuses prescription medication needs ongoing recovery management support. However, **some older adults may need ongoing monitoring and recovery support,** especially if they have co-occurring medical conditions or mental disorders, experience social isolation, or receive little support from family and friends.[928]

Continuing care interventions that suit older adults and positively affect addiction treatment include:

- Home visits.
- Telephone counseling.
- Recovery checkups.
- Active linkage to community resources, such as recovery support groups.

Offering case management services and including supportive family members in the older adult's treatment can also support ongoing recovery. (See also the "Family Involvement" section.)

Case and Care Management Services

Case and care management (CCM) services can help older adults reduce health-related risks of drug use or prescription medication misuse. The CCM approach to addiction treatment is broad. It addresses clients' overall health and connects them to recovery resources within the community, such as NA and AA. CCM services focus on getting clients into addiction treatment programs when needed and linking them to other services, like:

- Housing support.
- Employment services.
- Financial services.
- Specialty medical treatment.

CCM services are commonly available in community-based agencies, healthcare offices, and residential or long-term care facilities.[929] Addiction treatment programs and comprehensive behavioral health programs also may have care coordination and resource linkage services, which are increasingly offered by peer recovery support specialists.

CCM models can help older adults enter and stay in treatment, possibly because this approach seeks to reduce feelings of shame older adults often feel about entering treatment, and it provides support to the individual. CCM does this by focusing on older adults' overall health rather than just their drug use.[930,931] CCM strategies should help older adults gain access to age-related resources in the community that support recovery.[932,933]

Family Involvement

Involving family throughout treatment and ongoing recovery can help improve older clients' chances of staying in addiction treatment. It can also improve treatment outcomes. Family members:

- Often make first contact with treatment services.
- Can motivate the older adult to participate in treatment.

- Can help the older adult overcome barriers to access.
- Can help the older adult with the difficulties of the medical and specialized addiction treatment systems.
- Can provide important details about the client's history of and current substance use.

With the client's permission, involve family members and caregivers who support the older adult's recovery efforts:

- In the initial evaluation of the older adult.
- Throughout treatment.
- During ongoing recovery support.
- In posttreatment recovery plan development.

Although family members and caregivers can be key in providing support, they may also feel shame related to their family member's drug use disorder. You can help them feel more open to being involved by stressing that addiction is a chronic illness, like heart disease, and reminding them of the confidential nature of treatment. Without meaning to, sometimes family members exacerbate the older adult's drug use or prescription medication misuse by helping him or her get access to illicit substances or supporting the misuse of prescribed medication. Family members may benefit from psychoeducation, delivered in a nonjudgmental way, about the health risks of drug use and prescription medication misuse. (See Chapter 4 of this TIP for more information about family involvement in treatment and caregiver support resources.)

Mutual-Help Groups

Twelve-Step recovery support groups offer community-based support for individuals who have drug use disorders, including people who are in continuing care following brief interventions or specialized addiction treatment.[934] A growing body of research suggests that mutual-help group participation improves long-term recovery, psychosocial outcomes, and self-efficacy.[935,936] However, no systematic studies address outcomes for older adults. Even so, **mutual-help group participation may improve recovery and help older adults reduce social isolation, shame, and the effects of discrimination associated with drug use disorders.**[937]

The key to linking older adults to mutual-help groups is finding available resources in your community and matching clients to specific groups that may be a better fit for older adults. For example, when an older client cannot easily access an NA meeting, the client may benefit from attending AA meetings instead.[938] Older clients may feel more comfortable going to AA than NA, where participants are typically younger and use multiple substances.[939]

Key elements of 12-Step groups that are especially well suited to older adults include:[940]

- General social support, goal direction, and structure.
- Participation in substance-free social activities.
- Activities to improve participants' self-efficacy and coping skills.

These strategies can help you link older clients to community-based recovery support groups:

- Become familiar with age-friendly mutual-help groups available in your community.
- Contact local support group offices and ask which meetings are accessible to people with disabilities and have active members who are older adults.
- Ask groups to provide contact information for older adult members who can act as temporary sponsors or provide transportation.
- Link clients to peer recovery support specialists in your own organization or in the community.
- Urge older clients to attend several different meetings before they decide whether mutual help is something they want to pursue, because each meeting has its own tone and feeling.

RESOURCE ALERT: SMART RECOVERY

SMART stands for Self-Management and Recovery Training. SMART Recovery is a network of local and online abstinence-focused addiction recovery support groups based on evidence-supported principles of CBT and MI approaches, which are appropriate for treating older adults. Unlike AA, NA, and Cocaine Anonymous, SMART Recovery meetings are run by trained volunteers and do not include a spiritual component. The SMART Recovery website (www.smartrecovery.org) offers information about SMART Recovery principles and training opportunities, including how to become a facilitator for meetings. It includes a searchable database of local and online meetings. You can also learn more about SMART Recovery in Chapter 4 of this TIP.

Clinical Scenarios

The clinical cases that follow give examples of substance misuse by older adults and ways to apply clinical interventions in these situations. Interventions and treatments can range from PCPs asking the older adult about personal use of substances (e.g., benzodiazepines, cannabis, cocaine, alcohol use with medication misuse or illicit substance use) to inpatient addiction treatment. The level of intensity of interventions and treatments for older adults depends on:

- The substance used.
- The level of use.
- Effects on and risks to client.

Clinical Scenario: Benzodiazepine Misuse and Polypharmacy

For many older adults, the relationship with their PCP is often one of their strongest and most stable. Visits to their PCP provide an opportunity to screen for substance use and misuse, including substance use related to late-life changes (e.g., retirement, moving, grieving a death). **This scenario demonstrates thorough screening of a new client and strategies for problem-solving and referral.**

- **Sedative, Hypnotic, or Anxiolytic Use Disorder:** An older adult woman becomes physically dependent on benzodiazepines after long-term use and increases her health risk by taking benzodiazepines with other sedative-hypnotic medications.
- **Treatment Setting:** Outpatient healthcare clinic
- **Providers:** PCP; clinical social worker (CSW)
- **Treatment Strategies:** Screen for alcohol misuse; discuss history of sedative use; provide information on risks of taking substances together; explore tapering off benzodiazepines; refer to CSW who uses CBT strategies for anxiety; follow up with the client.

Joan is a 70-year-old widow who has two grown children who live far away from her. She started to have significant anxiety in her 50s, when the company she worked for closed and her job ended. She was never able to look for or find a job again. At that time, she was prescribed a benzodiazepine by her PCP and she has taken it for many years. In the past year, her husband died, and she moved from her house to an apartment because she could not afford to stay in the house. She became more anxious and started taking extra doses of the benzodiazepine. Her sister also has a benzodiazepine prescription and has given Joan extra pills when she runs out, which happens more often lately. Joan has arthritis pain, making sleep difficult. To help with this, her doctor prescribed sleeping pills on a short-term basis. Joan stopped drinking alcohol when her husband stopped drinking 10 years before his death.

Her long-term PCP retired recently—another significant loss for Joan. She started seeing a new PCP at the same group practice after the nurse care manager reached out by phone to set up an initial consultation. Her new provider is screening all new clients for a variety of health behaviors. The PCP asks Joan about her alcohol use and notes that she has been taking benzodiazepines for more than a decade. Joan states, "I have been taking Xanax for years for my 'nerves.' It made it easier for me to go to social events and church after Jake died." Joan also says that the pills make it a little easier to sleep but that she has recently had to take more sleeping pills to get any sleep at all. Joan likes her new doctor, so she is willing to talk

about her benzodiazepine dosage. She discusses how she gets some extra pills from her sister because she runs out before the prescriptions are ready to be filled and starts to feel "bad."

At this meeting, the new PCP discusses Joan's anxiety and, in a nonjudgmental way, gives information about the risks of taking benzodiazepines for a long time, taking more than prescribed, and adding sleeping pills to the mix. She says, "You know, many people who take this medication for a long time, even as prescribed, start to need a higher dose just to keep the anxiety at bay or then add a sleeping pill because the tranquilizer isn't working anymore. There are some options we can talk about that could help you feel better without all of this medication. Can we discuss some options and figure out together what might work best for you?" Joan says that she would like not to have to take so many pills, and she worries that if her sister isn't around, she won't be able to get more tranquilizers from her.

The PCP and Joan discuss several options, including a long-term taper from the benzodiazepines, and work together to find the best option for Joan. The PCP explains the tapering process and explains how Joan can manage anxiety and sleep problems as she tapers off the medication. Initially, Joan is a bit nervous about tapering off the medication but agrees to this option after the PCP reassures her that she will work closely with her to make sure the taper is adjusted correctly for her situation.

The PCP then asks Joan whether she would be willing to talk to the clinic's social worker about connecting with age-friendly activities in the community and learning to manage her anxiety without medication. Joan says "yes." The PCP walks Joan over to the social worker's office and introduces Joan to her. They set up an appointment for an initial visit.

The social worker is trained in CBT strategies to manage anxiety and introduces them to Joan at her initial visit. In their next session, the social worker discusses with Joan how the CBT is affecting her ability to manage anxiety. The social worker continues to see Joan weekly. Each week, Joan gets a structured, between-session assignment and a quick telephone reminder about practicing the exercise.

CBT FOR ANXIETY AMONG OLDER ADULTS

A review of psychosocial treatments for anxiety among older adults found that CBT had the strongest research support.[941] The authors reported that CBT could be even more useful for older adults when adapted to their needs. Some of these adaptations include:[942]

- Simpler CBT interventions.
- Between-session reminder phone calls.
- A weekly review of concepts discussed.
- At-home assignments.

The social worker also helps Joan connect with social activities she enjoys. With support, Joan feels she can improve how she feels physically and emotionally. Her PCP is in contact with Joan's social worker and sees Joan on a regular basis to assess how well the taper is going and whether it needs adjustment.

Clinical Scenario: Use of Opioids and Alcohol for Pain Management

When older adults taking pain medication use alcohol, they can experience additional negative health effects. Older adults who live in retirement communities and long-term residential care facilities often find themselves in social situations where drinking is supported.[943] Visits to the PCP provide a chance to screen for alcohol misuse as well as offer new options for pain management. **This scenario demonstrates screening thoroughly before prescribing additional pain medication, educating clients on the dangers of using alcohol with medication, and providing nonpharmacological pain management strategies.**

- **OUD and Alcohol Misuse:** An older adult living in a retirement community who drinks to socialize becomes physically dependent on opioids after surgery.
- **Treatment Setting:** Outpatient healthcare clinic
- **Providers:** PCP; NP

- **Treatment Strategies:** Screen for prescription drug and alcohol use; discuss current health status of the client; provide information on risks of using alcohol while taking opioids; perform initial brief interventions; suggest physical therapy and a tapering program; conduct multiple follow-up brief interventions and calls with the client.

Louise is a 75-year-old retired middle school teacher who is married. She and her husband, a retired high school principal, just celebrated their 50th wedding anniversary. They have a son, a daughter, and three grandchildren. For the past 5 years, they have lived in a retirement community. They have made friends in the community and take part in activities, including golf, exercise classes, card games, and book clubs. Many of these events include alcohol. In addition, the community sponsors regular happy hour gatherings at the clubhouse that Louise and her husband also attend.

One month ago, Louise had knee replacement surgery. She began taking opioids for pain in the hospital and was sent home with a prescription so that she could continue to use the medication during rehabilitation. She was still having pain during the day, with greater pain at night. To add to the effects of the opioids and make them "go further," she drank wine at the usual get-togethers with friends and had additional drinks in the evening before bed. A neighbor, Pat, had prescription opioids from a past surgery. She offered them to Louise to help "tide her over" until she saw her doctor. Louise waited to make an appointment until she was almost out of her neighbor's opioid medication.

Louise makes an appointment with her PCP to see whether she can get more pain medication. She tells her PCP that the pain is not going away, and that she is almost out of medication. The PCP talks with Louise about her pain and screens for amount and frequency of alcohol use and medication use. He discovers that she is drinking while taking the opioids and has been using more opioids than recommended. He then gives her nonjudgmental feedback about the results of the screens. He says, "Based on your answers to my questions about your alcohol use and use of pain medication, it looks like you are at risk for some serious health problems if you continue drinking alcohol and taking medication in this way. We know that when people your age drink and take the kind of pain medication you are on, they can have problems with their breathing, ability to move around, or memory. Are any of those happening to you?" Louise starts to become concerned and responds, "You know, I have been getting more confused about things lately and feeling like I sometimes have a hard time breathing easily. But I am worried about the pain and how I will manage without pain medicine or extra alcohol."

The PCP acknowledges her concerns by stating that maintaining her health and level of activity is important. The PCP asks whether she would be willing to work with him and an NP to come up with a plan to manage her pain while lowering the health risks she faces by drinking and using pain medication at the same time. Louise says, "Well, what's most important to me is to get my knee in good shape again."

The PCP supports Louise's goal and calls in the NP, who is trained in giving substance-related brief interventions and has worked with other clients to help them cut back on alcohol and reduce or stop their use of opioids. The NP schedules Louise for two face-to-face meetings and two follow-up phone calls between visits. She and Louise develop a treatment plan that includes Louise going to physical therapy and a rehabilitative exercise class in her community to help her knee heal and improve her range of motion so she can get back to golfing with her group. Louise also agrees to keep track of her alcohol use and to follow an opioid taper plan over the next month to get off the pain medication.

Clinical Scenario: Screening, Assessment, and Referral to Addiction Treatment

Older adults with a history of substance misuse have increased risk of return to substance use when they have additional stressors (e.g., injury, divorce, family conflict). Heavy substance use also leads to many health problems; these are often the primary reason a client seeks treatment or winds up in the ED. A study found that SBIRT in an ED setting was a factor in reducing substance use at follow-up, suggesting that an ED visit for another medical

problem may be a "turning point" for many individuals with substance misuse concerns.[944] **This scenario shows the importance of the ED as a setting for screening, assessment, and referral; it also demonstrates strategies providers can use to take advantage of "teachable moments" with clients.**

- **Cannabis and Alcohol Misuse:** An older adult with a long history of alcohol and cannabis misuse has co-occurring medical conditions.
- **Treatment Setting:** ED of a community hospital
- **Provider:** ED attending physician
- **Treatment Strategies:** Get the client medically stable; order a blood test screen for alcohol; order a urine screen for cannabis; discuss the current state of the client; provide information on the risks of using alcohol with cannabis; conduct a brief intervention; recommend short-stay, inpatient detoxification and treatment followed by outpatient care.

Walter is 69 years old and divorced. He lives with his girlfriend. He has an adult son and a granddaughter. Walter likes to hunt and fish with his male friends but has little other social contact. Walter had some problems with alcohol when he was younger, including being arrested for driving under the influence. He cut back on drinking but started smoking cannabis daily. After he got married, he stopped using cannabis and drank only occasionally for several years. He started drinking heavily and smoking cannabis again after an on-the-job back injury in his early 50s. He divorced 10 years ago and retired the next year. He met Sally, his long-term girlfriend, 5 years ago. Walter drinks heavily and uses cannabis daily. In the past year, there have been many times when he did not remember what he did when he was intoxicated. His girlfriend used to enjoy smoking cannabis and drinking with him, but as he increased his use, she is no longer comfortable living with him and has threatened to move out if he keeps using.

Walter has been having some health problems, including high blood pressure, diabetes, and chronic back pain. He sometimes forgets to take his medications. He was stopped by the police for unsafe driving recently but was not arrested.

In addition, he had a falling out with his son and daughter-in-law. They do not want him spending time with his granddaughter because he is often drunk and high.

A week later, he starts drinking and smoking cannabis when he wakes in the morning and continues to use all day, passing out in the late afternoon. When he awakens a few hours later, he has chest pain, nausea, and sweating. Worried of a heart attack, his girlfriend takes him to the ED. The attending physician sees him immediately, takes a medical history, and orders lab tests to rule out a heart attack. However, a blood draw shows his blood alcohol level is 0.18. A urine screen is positive for cannabis. The ED physician then performs a more indepth screen and assessment of Walter's substance use history and, with Walter's permission, invites Sally to discuss the effects of Walter's drinking and cannabis use.

Once Walter is less intoxicated, the ED physician talks with him about his medical status. In a nonjudgmental and nonconfrontational tone, he says, "Walter, the good news is that you did not have a heart attack. Based on your other lab tests, your age, and other medical conditions and what you and Sally have told me about your drinking and cannabis use, I want you to think about a short stay at an inpatient treatment program so you can get a handle on your substance use." At first, Walter is not sure, but then Sally supports him. He then says, "I feel so sick, and thinking I was having a heart attack really scared me. I guess it's the best thing for me to do." The ED physician introduces Walter and Sally to the nurse care manager and assures them that she can answer any questions they have about the treatment process and will help transfer his care to the inpatient program.

Clinical Scenario: Polysubstance Misuse With Co-Occurring Medical Conditions

More and more older adults with a history of illicit drug use, particularly heroin and cocaine, are being admitted to inpatient addiction treatment programs.[945,946] Cocaine use in older adults is related to multiple medical problems, including higher rates of high blood pressure, breathing issues, heart attack, stroke, and cognitive

impairment.[947] Older adults with a long history of polysubstance misuse (misuse of multiple substances at the same time) and co-occurring medical conditions are at risk for return to substance use and lack of follow-up for medical conditions after inpatient treatment. **This scenario demonstrates referral management and ongoing recovery support strategies for an older adult with a history of polysubstance misuse and co-occurring medical conditions.**

- **Polysubstance Misuse:** An older adult has a history of misuse of heroin and cocaine.
- **Treatment Setting**: Inpatient detoxification and rehabilitation program
- **Provider:** Licensed alcohol and drug counselor (LADC) on a multidisciplinary treatment team
- **Treatment Strategies:** Offer referral and recovery management strategies before discharge.

Hal is 74 years old and never married. He started using heroin as a soldier in the Vietnam War. After discharge from the service, he started using cocaine to stay awake during his night shift at the post office. His drug use stayed about the same for many years but increased after he retired. He lives alone, and his social life includes playing poker with friends on Thursdays. During a recent game, Hal had numbness in his arm and slurred speech. One of his buddies brings him to the ED. Hal is having a mild stroke. After he is medically stabilized, Hal enters an extended-care inpatient SUD treatment program. After 8 weeks of treatment, Hal meets with his primary counselor to discuss his continuing care plan.

ADAPTING RESIDENTIAL CARE FOR OLDER ADULTS

Because many older adults have problems getting around, upon admission to residential and inpatient programs, older adults can benefit from being paired with a "senior buddy" to help them learn the facility and move from one treatment activity to another.[948]

The counselor opens the conversation by saying, "Hal, you've done really well in treatment. You've participated fully in therapy and educational groups here and have a solid plan to keep yourself from relapsing and to help you cope with any triggers to use once you go home." Hal responds, "Thanks. It's good to hear that you think I've been doing well. Frankly, I was kind of anxious when I was first admitted to the program. It really helped that you paired me up with Bill to show me the ropes."

The counselor says, "Let's talk about your goals for ongoing recovery." Hal says he doesn't want to go back to using but worries that he has no recovery support back home. He says, "My poker buddies all drink and smoke pot. Even though that wasn't my thing, I think that will be a trigger to use again. I liked the NA meetings a lot, but I live in a really small town, and there aren't any NA meetings nearby."

Hal's counselor had already contacted the AA central service office closest to Hal and gotten the names and contact information of an older AA volunteer who would be willing to help Hal get to meetings and act as a temporary sponsor. The counselor says, "I already talked to Jerry. It turns out he is a Vietnam vet, too." Hal says that talking to someone who has "been there" would be a big help to him.

Hal and his counselor talk about other recovery management options, like linking with a counselor and a continuing care group at an outpatient SUD treatment program nearby and getting Hal an appointment with a PCP who can provide medical care. The counselor tells Hal of a recovery checkup program with a peer recovery support specialist who will call him regularly to see how he is doing and whether he needs linkage to other community resources. The counselor will provide a "warm handoff" by introducing Hal to the specialist before discharge. Hal says, "That sounds great. It will be nice to have that connection to the rehab." Hal and his counselor write down his continuing care plan and all contact information. His counselor says, "Your homework is to call the AA contact and schedule a meeting after your discharge on

Thursday. Mine is to make referrals to the PCP and outpatient addiction counseling program." Hal is satisfied with the recovery plan and motivated to follow through and continue his recovery program.

Summary

Widespread screening, brief intervention, and referral and recovery management are essential to the successful treatment of drug use and prescription medication misuse, including drug use disorders, in older adults. Whatever specific treatment method or strategy you use when working with older adults who have drug use disorders, make sure it is nonconfrontational and age sensitive. Ongoing recovery management strategies increase the chance that improvements will continue over time and not only help older adults reduce negative drug-related health and behavioral outcomes, but also improve the quality of their lives.

Chapter 5 Resources

Provider Resources

National Council on Aging—Resources (www.ncoa.org/audience/professional-resources/?post_type=ncoaresource): This resource provides a searchable database of articles, webinars, and manuals.

Consumer Resources

FindTreatment.gov (https://findtreatment.gov): People seeking treatment for SUDs can use this federal locator maintained by SAMHSA to find treatment facilities based on location, availability of treatment for co-occurring mental disorders, availability of telemedicine care, payment option, age, languages spoken, and access to medication for OUD. The site also links to information on understanding addiction, understanding mental illness, and paying for treatment.

SAMHSA—Behavioral Health Treatment Services Locator (https://findtreatment.samhsa.gov/): SAMHSA offers people seeking treatment for addiction or mental illness a confidential, anonymous information source about treatment facilities in the United States and U.S. Territories.

SAMHSA's National Helpline (www.samhsa.gov/find-help/national-helpline): The National Helpline is a free, confidential, 24/7, 365-days-a-year treatment referral and information service (in English and Spanish) for people facing mental disorders and SUDs. The toll-free phone number is 1-800-662-HELP (4357) or 800-487-4889 (TTY).

Faces & Voices of Recovery—Guide to Mutual Aid Resources (https://facesandvoicesofrecovery.org/resources/mutual-aid-resources): Visitors can find a listing of mutual-help group contact information.

Appendix A: Treating Substance Use Disorder in Older Adults – Module 2

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions.

> Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:
>
> http://www.ceumatrix.com/studentcenter
>
> Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.
>
> To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater you will have access to the Certificate of Completion. This is the final step in the process, and you may save and/or print your Certificate of Completion.
>
> If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

If you have any difficulty with this process, or need assistance, please e-mail us at ceumatrix@ceumatrix.com and ask for help.

Answer the following questions by selecting the most appropriate response.

Quiz

1. According to the 2015–2020 Dietary Guidelines for Americans, what is defined as moderate drinking for men?
   A. Up to one drink per day
   B. Up to two drinks per day
   C. Five or more drinks in one sitting
   D. Four or more drinks in one sitting

2. What is the relationship between binge drinking and health problems in older adults?
   A. Binge drinking has no impact on health problems
   B. Binge drinking improves overall health
   C. Binge drinking is related to higher death rates
   D. Binge drinking is only a concern for younger adults

3. What is the definition of heavy drinking for men according to the document?
   A. Five or more drinks on one occasion
   B. Two or more drinks on any day
   C. Four or more drinks on one occasion
   D. Three or more drinks on any day

4. What percentage of older adults in the United States are estimated to misuse alcohol?
   A. 1 percent to 3 percent
   B. 25 percent to 30 percent
   C. 15 percent to 20 percent
   D. 4 percent to 14 percent

5. What is a significant risk factor for older adults who misuse alcohol according to the document?
   A. Increased physical activity
   B. Lowered general health functioning
   C. Improved cognitive abilities
   D. Higher social engagement

6. What is a significant reason older adults with Alcohol Use Disorder (AUD) are often underdiagnosed?
   A. DSM-5 criteria do not apply to older adults
   B. Older adults do not seek help
   C. Alcohol misuse is not common in older adults
   D. Older adults are less likely to report their drinking habits

7. What is one of the treatment goals for older adults with AUD?
A. To completely eliminate alcohol use
B. To improve quality of life
C. To increase social drinking
D. To reduce medication use

8. Which of the following is a risk factor for late-onset alcohol misuse in older adults?
A. Increased physical activity
B. Improved mental health
C. Higher income
D. Social isolation

9. What should assessments for older adults with AUD include regarding their alcohol use?
A. Only current alcohol consumption
B. Family history of alcohol use
C. History of alcohol use and its impact on daily functioning
D. Personal preferences for alcohol

10. What is a common screening tool used to identify alcohol misuse in older adults?
A. Geriatric Alcohol Use Questionnaire
B. Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G)
C. Alcohol Misuse Risk Assessment Tool
D. Older Adult Alcohol Screening Test

11. What is a key strategy to help older adults cope with risky situations related to alcohol use?
A. Promoting boredom
B. Encouraging social isolation
C. Discussing ways to cope with risky situations
D. Ignoring negative family interactions

12. What is the primary focus of Motivational Interviewing (MI) when treating older adults with alcohol misuse?
A. Empathetic, reflective listening
B. Confrontational techniques
C. Strict adherence to treatment plans
D. Minimizing client input

13. Which treatment approach is specifically mentioned as being effective for older adults with Alcohol Use Disorder (AUD)?
A. Behavioral Activation
B. Psychoanalysis
C. Group therapy without age considerations
D. Cognitive Behavioral Therapy (CBT)

14. What should treatment providers do to ensure successful referrals for older adults?
A. Only refer clients to specialists
B. Avoid contacting clients after referral
C. Follow up with clients to ensure referral success
D. Limit communication to initial assessments

15. What is a common misconception about older adults and alcohol treatment?
A. They are generally open to and accepting of alcohol treatment
B. They are resistant to treatment
C. They prefer treatment in non-age-specific groups
D. They have worse outcomes than younger adults

16. What is a significant risk factor for older adults during medically supervised withdrawal from alcohol?
A. Lower sensitivity to medications
B. Higher rates of co-occurring disorders
C. Increased social support
D. Decreased risk of falls

17 Which of the following is a recommended approach for involving caregivers in AUD treatment for older adults?
A. Developing punitive measures for non-compliance
B. Creating contingency contracts for specific AUD behaviors
C. Encouraging isolation from social networks
D. Limiting communication with healthcare providers

18. What is the purpose of the Clinical Institute Withdrawal Assessment of Alcohol Scale–Revised (CIWA-Ar)?
A. To assess cognitive impairment
B. To evaluate renal function
C. To measure alcohol withdrawal symptoms
D. To determine medication dosages for older adults

19. What is a potential side effect of naltrexone that requires close monitoring in older adults?
A. Dizziness
B. Increased appetite
C. Enhanced cognitive function
D. Improved social interactions

20. Which of the following interventions is considered effective for ongoing recovery management in older adults?
A. Avoiding community resources
B. Increased alcohol consumption
C. Isolation from family
D. Home visits

21. What is a common risk behavior for older spouses of people who misuse alcohol?
A. Drinking less than their spouse
B. Drinking as a shared social activity
C. Avoiding alcohol completely
D. Encouraging their spouse to drink

22. What is one of the main reasons older adults may feel shut out from AA meetings?
A. They prefer online meetings
B. They do not want to recover
C. They are too busy to attend
D. They find the language and culture unfamiliar

23. What is the primary focus of SMART Recovery meetings?
A. To provide a social environment
B. To offer medical treatment
C. To encourage drinking in moderation
D. To promote abstinence through CBT and MI

24. What should a primary care provider do during the initial screening for alcohol misuse?
A. Only ask about current alcohol use
B. Ask about earlier alcohol use as well
C. Focus solely on mental health
D. Refer the patient to a specialist immediately

25. What is a potential benefit of the structured social support of AA for older adults?
A. It increases their alcohol consumption
B. It isolates them from younger members
C. It discourages them from attending meetings
D. It helps improve interpersonal and social coping skills

26. What is the term for the use of any substance in a manner that can cause harm to users or those around them?
A. Substance use disorder
B. Substance misuse
C. Drug use
D. Illicit substances

27. Which of the following is a common reason for older adults to take medication?
A. Chronic pain
B. Social anxiety
C. Weight loss
D. Sleep enhancement

28. What percentage of adults aged 65 and older reported using illicit substances in the past year in 2019?
A. 3.7 million
B. 2.6 million
C. 900,000
D. 325,000

29. What is a significant risk associated with long-term use of benzodiazepines in older adults?
A. Increased cognitive function
B. Reduced anxiety levels
C. Improved sleep quality
D. High physical dependence potential

30. What is the primary focus of the second section of Chapter 5 in the TIP document?
A. Exploring the history of substance misuse
B. Discussing economic impacts of drug use
C. Identifying and assessing drug use disorders
D. Providing a summary of treatment options

31. What is a key factor that determines the length of time an older adult should remain in treatment for Substance Use Disorder (SUD)?
A. The client's age
B. The type of substance used
C. The client's progress in treatment
D. The client's family support

32. Which of the following is a psychosocial approach adapted for older adults with substance use issues?
A. Intensive outpatient care
B. Education about medications
C. Residential care
D. Medically managed inpatient care

33. What is one of the negative effects of using benzodiazepines in older adults?
A. Increased energy
B. Improved cognitive function
C. Increased risk of falls
D. Enhanced motor coordination

34. What should be included in the treatment planning for older adults with substance use issues?
A. Only medication management
B. No follow-up care
C. Strictly individual therapy
D. Family and caregiver involvement

35. What is a common misconception older adults may have regarding their substance use?
A. It is a sign of weakness
B. It is not harmful
C. It is always related to social problems
D. It is only a phase

36. What adaptations can make Cognitive Behavioral Therapy (CBT) more effective for older adults?
A. Incorporating technology in sessions
B. Simpler CBT interventions
C. Using group therapy exclusively
D. Focusing only on medication management

37. What is a key benefit of involving family members in the treatment of older adults with substance use disorders?
A. They can provide financial support
B. They can help with medication management
C. They can offer emotional support and encouragement
D. They can replace professional treatment

38. What is a recommended practice for older adults to improve sleep hygiene?
A. Drinking alcohol before bed
B. Taking naps during the day
C. Avoiding caffeine before bed
D. Using sedative-hypnotics regularly

39. What is a common risk associated with older adults using opioids and alcohol together?
A. Increased energy levels
B. Improved cognitive function
C. Serious health problems
D. Enhanced pain relief

40. What type of treatment approach do older adults prefer for substance use disorders?

A. Aggressive confrontation
B. Age-specific and person-centered
C. Standardized treatment for all ages
D. Strictly medication-based

Name: _____

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