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TREATING SUBSTANCE USE DISORDER IN OLDER ADULTS – MODULE 1

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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 1-75. Publication No. PEP-20-02-01-011, 2020

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TREATING SUBSTANCE USE DISORDER IN OLDER ADULTS – MODULE 1

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.

- **Substance misuse is not something that only occurs in younger people.**
- **Substance misuse among older individuals is very dangerous and can increase their risk of death and other physical harms.**
- Not only are **rates of illicit drug use among older adults growing, rates of co-occurring mental disorders are also high.**
- **Older adults with SUDs are more likely to misuse alcohol than any other substance.**
- **Most older adults take at least one medication, and many take more than one.**
- **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.**
- **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.**
- **Multiple treatment approaches for SUDs exist that are effective for older adults.**

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.

- **To give older clients the best opportunities to access and beneft from substance use treatment and services, you must acknowledge, respect, and respond to differences among populations of older individuals.**
- **Organizations should create a treatment/ service environment that gives older clients the best chances for successful recovery.**
- As a provider, **you should learn the signs and symptoms of SUDs in older adults and be prepared to respond appropriately when they appear.**
- **Person-centered care is the preferred approach for this population**
- **Investing time and money in developing an age-sensitive workforce throughout your organization is important.**
- **Older adults with substance misuse can beneft greatly from social support and community resources.**
- **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.**

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.

- **By learning the steps to accurate and effective screening and assessment, you increase the chances of older adults receiving timely and appropriate care.**

• To ensure proper and timely identifcation 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.**
- **When communicating screening results, you should praise clients for fndings that indicate abstinence, and follow up on fndings that indicate substance-related problems.**
- **You should follow up on screening that indicates a potential substance-related problem by conducting an assessment.**
- **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 suffcient (e.g., education, motivational interviewing). For older adults with moderate-to-severe SUDs, formal treatment may be necessary.**

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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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.**

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.
Assistant Secretary for Mental Health and Substance Use
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

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.

TIP Development Participants

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

KEY MESSAGES

- Estimated rates of substance misuse in older adults vary widely. Substance misuse by this population is underrecognized and undertreated.
- Substance misuse can be very dangerous for older adults. They are affected by substances differently than younger adults, and smaller amounts of substances can have more of an impact. Substance misuse by older adults can worsen any chronic medical conditions they may have. Older adults also often take more than one medication, which increases their odds of being exposed to harmful drug interactions.
- It is never too late to stop misusing substances, no matter one's age. Treatment for older adults is available. Providers need to learn about effective interventions for older adults so that they can offer treatment or referrals for treatment quickly and appropriately.

Chapter 1 of this Treatment Improvement Protocol (TIP) benefits all audiences (providers, supervisors, administrators, older adults, caregivers, and family members). It summarizes the extent of substance use and substance misuse, including substance use disorders (SUDs), among older adults. Chapter 1 will help you understand the current situation and trends to gain an overall, broad understanding of this critical issue. This TIP is for all audiences who provide care and support to older adults, including older adults themselves as well as individuals who are connected to an older adult, such as family members, friends, formal and informal caregivers, behavioral health service and healthcare providers, and aging services providers.

Organization of This TIP

Chapter 1 contains information of value to all audiences: it is an overview of substance misuse and addiction treatment among older adults. Chapter 1 also defines terms and summarizes issues to help clients and providers communicate more clearly with each other.

Exhibit 1.1 defines important terms this TIP uses.

EXHIBIT 1.1. 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-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 alcohol use disorder (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.[1,2] 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.
- **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.[3,4] 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.[5] 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, 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.[6] 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.[7]
- **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.[8]
- **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).
- **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.[9,10] 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.[11] 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.[12]

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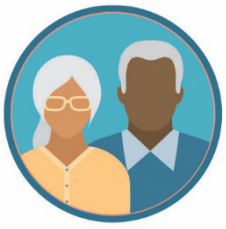
- **Psychoactive substances:** Substances that can alter mental processes (e.g., cognition or affect; in other words, the way one thinks or feels). Also called psychotropic drugs, such substances will not necessarily produce dependence, but they have the potential for misuse or abuse.[13]
- **Recovery*:** 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.
- **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).[14] Remission is an essential element of recovery.
- **Sensitivity:** The extent to which a substance affects someone physiologically. Aging causes people to develop increasing sensitivity to substances. As a person ages, a given dose of a substance will have a greater physiological impact than it did when the person was younger.
- **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,[15] 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).

Who Can Benefit From This TIP and How?

The demand for services to address substance misuse in older adults is increasing. All healthcare, behavioral health, and aging service/long-term care providers need training in working on substance misuse–related problems with older adults, their families and friends, and formal and informal caregivers.[16,17] Such providers include primary and specialty healthcare providers, case workers, social workers, psychologists, drug and alcohol counselors, peer recovery support specialists, clergy, providers of aging-related services, and direct care workers.

~23% of SUD treatment programs in the U.S. offer services tailored to **OLDER ADULTS.**[18]



Caregivers and families need resources to help navigate initial identification, screening, assessment, and treatment options for older people who misuse substances or have SUDs. Key societal changes have made this a critical time to address substance misuse in the aging population:

- Substance use and SUDs among older adults are rising:
  - **Illicit drug use is more common among current older adults than among previous generations of older adults.** Current 65-and-older individuals and aging baby boomers (those born between 1946 and 1964) are more likely than members of previous generations to use illicit drugs.
  - **SUDs among older adults are expected to continue increasing.** Rapidly growing numbers of older adults will need substance misuse prevention and counseling, and sometimes SUD treatment services, particularly to address nonmedical use of prescription medication.
- **Substance use and chronic health conditions have compound effects on older individuals.** Chronic health conditions in older adults can complicate the effects of their substance use, increasing their need for comprehensive, integrated services.[19] Likewise, substance use can complicate the management of chronic conditions.[20]
- **Older adults are increasingly willing to seek services.** Baby boomers tend to view addiction treatment as more acceptable than previous generations have.[21,22] As baby boomers continue to enter old age, the number of older people needing treatment will continue to increase—and so therefore will **the overall percentage willing to seek treatment.** However, feelings of shame and stigma linked to SUD treatment settings cause many older adults to seek addiction care from providers who do not specialize in addiction treatment, including primary care and emergency department providers.[23]
- **Older adults are affected by co-occurring mental disorders and SUDs.** In the 2019 National Survey on Drug Use and Health (NSDUH):[24]
  - 1.5 percent of Americans ages 50 and older (1.7 million) had any past-year mental illness and SUD; an estimated 0.5 percent (607,000) reported both a past-year serious mental illness (SMI) and a past-year SUD.
  - 37 percent with a past-year SUD also had any mental illness; 13 percent, an SMI.
  - 11 percent of older adults with any mental illness in the past year also had an SUD.
  - 18 percent of older adults with an SMI in the past year also had an SUD.
- **Few providers specialize in dealing with geriatric substance use.**

Much research has been done with older adult populations, but guidance has lagged on implementing research findings in ways that will improve services. **This TIP fills gaps in the field by focusing on ways to implement and improve the delivery of SUD treatment based on evidence and promising practices specifically for older adults.** Current gaps include:

- **A science-to-service gap in resources for providers.** Few service improvement resources focus on tailoring treatment services for older clients with SUDs who may also have co-occurring physical disabilities or mental disorders.
- **A gap in addiction treatment resources for clients, their families and friends, and caregivers.** Free, user-friendly publications that inform older clients and those close to them about substance use and addiction services are difficult to find.

When reading this TIP, remember that some misuse is accidental or inadvertent. For example, individuals who are unaware of a medication's potential to cause dependence or other harms may consume more than prescribed. Other individuals may have difficulty in monitoring when they have taken their medication and take more than the recommended dose. Some individuals may become substance dependent even though they take their medication as prescribed. The pathway to misuse helps guide the selection of interventions and, if necessary, treatment. Accidental misuse stills requires a response.

Overview and Scope of the Substance Misuse Problem

Older Adults Today

The Older Adult Population

The older adult population is becoming more diverse. In the coming decades, the percentage of non-Hispanic White older adults in the U.S. population is projected to drop, whereas the percentages of Hispanics and races other than White are expected to increase. Gender ratios are also changing. The gap between the number of women and men is beginning to narrow because of the increased life expectancy of men, especially among men ages 85 years and older.[25]

Healthcare and behavioral health service providers and caregivers must understand this diversity to provide culturally responsive services, including interventions and treatments for alcohol and other substance misuse.[26] Providers should also recognize differences between generations of older adults that may make some older adults more willing than others to discuss addiction and mental illness with their healthcare providers.

The number of older adults with SUDs is increasing. The U.S. population of older adults increasingly consists of baby boomers. Baby boomers came of age at a time when substance use tended to be more culturally acceptable, making them more open to and less judgmental about substance use than prior generations. (Not all subgroups of baby boomers experienced this openness and freedom from judgment about substance use, such as racially and ethnically diverse populations.) Because of baby boomers' exposure to drugs and alcohol at a younger age, their generation has higher rates of past or current SUDs compared with previous generations.[27,28]

These changes in older adult demographics will have major consequences for SUD prevention and treatment programs. Shifts in the older population will strain retirement systems, healthcare facilities, and other services. A rapidly increasing number of older adults will need comprehensive, integrated, age-specific SUD screening, assessment, and treatment services.[29]

Substance Misuse Among Older Adults

Substance misuse in older adults is dangerous and potentially deadly. They have increased vulnerability to alcohol and to adverse drug reactions (whether the drugs are prescription or illicit)[30] because of physiological and mental changes associated with aging. Such changes include slower metabolism and lower body fat. This increased vulnerability makes identifying SUDs in older adults especially critical.

SUDs do occur in older adults, although less often than in younger people. Of adults ages 65 and older in the 2012–2013 Wave of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC III):

- 2.3 percent had a 12-month AUD, and 13.4 percent had a lifetime AUD.[31]
- 0.8 percent had a past-year drug use disorder, and 2 percent had any lifetime drug use disorder.[32]

Substance misuse rates in older adults vary by gender, race/ethnicity, and education level:

- In NESARC III, past-year cannabis use was reported by about 4 percent of non-Hispanic Whites, 6 percent of non-Hispanic Blacks, 3 percent of Hispanics, 0.7 percent of Asians, and 11 percent of American Indians/Alaska Natives ages 50 and older.[33]
- In the 2004–2005 Wave of NESARC, past-year prevalence of any SUD in adults 55 and older was:[34]
  - 3.9 percent for non-Hispanic Whites, 3.6 percent for African Americans, 3.3 percent for Hispanics, 3.0 percent for American Indians/Alaska Natives, and 1.7 percent for Asian/Native Hawaiian/other Pacific Islanders.
  - 2.9 percent for individuals with less than a high school education, 3.1 percent for individuals with a high school education, and 4.5 percent for those with at least some college.

Older adults are often willing to seek help for substance misuse or SUDs, as they are tending to take more accepting views about addiction treatment.[35] Yet negative attitudes (sometimes termed "ageism") about older adults' ability to recover from addiction persist, despite evidence that treatment is effective in reducing or stopping substance misuse and improving older adults' health and quality of life.[36,37,38,39,40,41]

Substance misuse, including SUDs, among older adults often goes unrecognized and untreated. Societal norms, values, and biases play a large role in this phenomenon. Some people hold the ageist false belief that SUDs do not exist or need no treatment in this age group. Others—even some healthcare providers—mistake SUD symptoms for normal age-related changes. Some healthcare providers may focus more on older adults' reports of physical/medical complaints. Similarly, some older adults may deny or hide their substance use-related problems from their healthcare providers.[42]

Current cultural biases tend to minimize the scope of substance misuse among older adults, but **this public health concern is more urgent than ever.**

Prevalence and Characteristics of Substance Use Among Older Adults

Alcohol

Alcohol is the substance that older adults use and misuse most frequently. The 2019 NSDUH[43] found that, in individuals ages 65 and older, an estimated 5.6 million (10.7 percent) engaged in past-month binge alcohol use and an estimated 1.5 million (2.8 percent) engaged in past-month heavy alcohol use.

The survey also showed that 903,000 adults ages 60 to 64 and 1.04 million adults ages 65 and older met *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition (DSM-IV) criteria for alcohol dependence or abuse in the past year. These numbers were similar among slightly younger groups of older adults, with 939,000 adults ages 50 to 54 and 1.02 million adults ages 55 to 59 meeting DSM-IV criteria for alcohol dependence or abuse in the past year.

Exhibit 1.2 shows what constitutes a standard drink by type of alcohol.

EXHIBIT 1.2. What Is a Standard Drink?

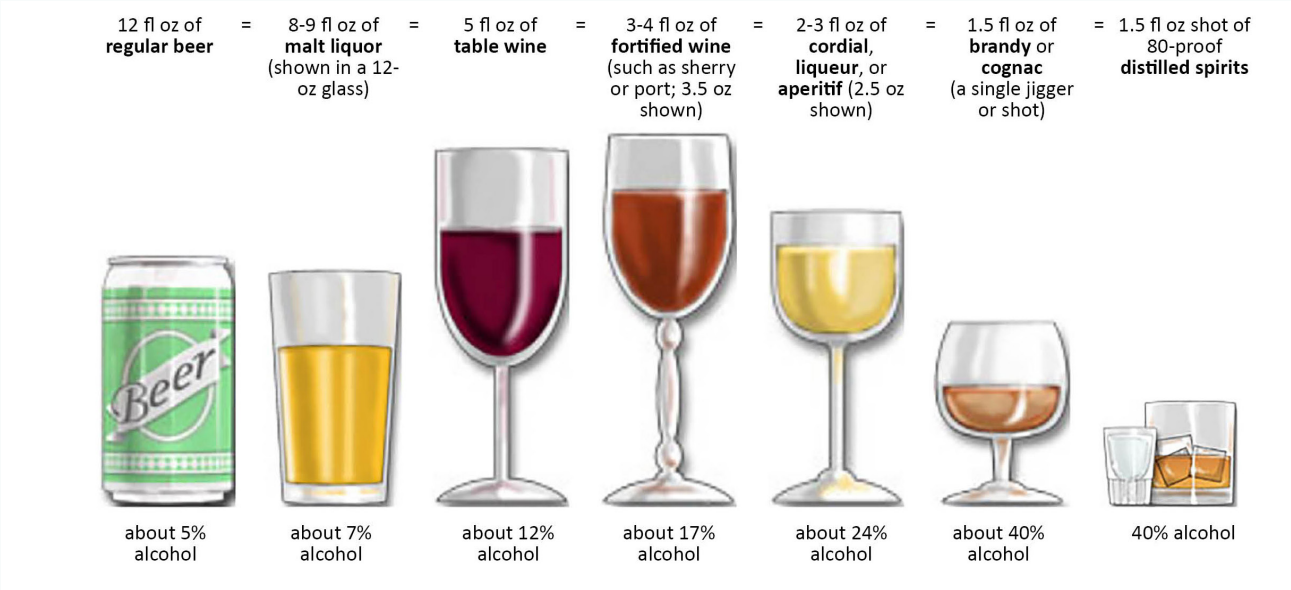


Image adapted from material in the public domain.[44]

In healthcare settings, up to 15 percent of older patients may meet criteria for at-risk drinking.[45,46,47] For example, one study[48] of 24,863 adults ages 65 and older in military and civilian healthcare clinics found that 9.2 percent of men and 2.1 percent of women regularly drank in excess of federal guidelines. The study found that 21.5 percent of patients drank moderately, 4.1 percent engaged in at-risk drinking, and 4.5 percent drank heavily or engaged in binge drinking. Among those who drank moderately, 10.2 percent had engaged in heavy episodic drinking one to three times in the past 3 months.

The *Dietary Guidelines* define moderate drinking as consuming up to one drink a day for women and up to two drinks a day for men. Exceeding these numbers can lead to high-risk drinking. Older adults who drink at all in the following situations are also engaging in high-risk drinking:[49]

- While taking certain prescription medications (such as opioids or sedatives)
- Despite having a medical condition that drinking could worsen (like diabetes or heart disease)
- When planning to drive a car or engage in other activities that require alertness
- While recovering from AUD

Older clients who engage in heavy drinking are at risk for worsening of existing health problems (e.g., diabetes, high blood pressure, mood disorders, cancer).[50,51,52] In addition, certain life stressors[53,54] are linked to increased risk of alcohol misuse in older adults and could cause existing health problems to worsen. Such life stressors include:

- Financial strain.
- Job loss/retirement.
- Housing changes.
- Bereavement.
- Being a victim of theft.

As adults age, they metabolize alcohol differently and become more sensitive to its effects even when they drink less.[55] This increases risk of confusion, falls, and injury, and worsens existing health issues.

Establishing clients' history of use can help providers recognize possible substance use concerns in the future. Taking a history is also an opportunity to **offer prevention messages and encouragement** to individuals maintaining abstinence or very low use.

Older adults are more likely to take medications that interact badly with alcohol. Exhibit 1.3 lists some of these "alcohol-interactive" (AI) medications. In a review of 20 studies on reported use of alcohol and AI medication, more than half of individuals who used AI medication reported drinking alcohol.[56] Another study found that 77.8 percent of older adults who drank alcohol also took AI medications.[57]

EXHIBIT 1.3. Potential AI Medications[58]

- Medications to control heart or circulatory problems like arrhythmia or high blood pressure
- Diuretics, sometimes called water pills
- Seizure medications
- Antianxiety medications
- Muscle relaxers
- Pain medications, including opioids (e.g., oxycodone, hydrocodone) and nonsteroidal anti-inflammatory medications (e.g., ibuprofen)
- Medications to control diabetes
- Antidepressants

Older adults who drink and regularly take AI medications may experience severe negative reactions (e.g., falls, gastrointestinal bleeding, low blood pressure, drowsiness, heart problems, liver damage).[59] Drinking can also make these medications less effective in treating health conditions. Healthcare and behavioral health service providers should discuss the risks of combining alcohol and AI prescription medications with older clients, especially those with a history of alcohol use.

Prescription Medications

Most older adults take at least one prescription medication. Many take more than one. According to national estimates released in 2019,[60] 87.5 percent of older adults in the United States have at least one prescribed medication, and 39.8 percent take five or more prescription medications at the same time. **From 2015 to 2016, the percentage of adults taking a prescription medication was greater for the 65 and older age group (87.5 percent) than for any other adult age group.**

High prescription medication use puts older adults at greater risk than the general population for harmful side effects and drug–drug interactions, especially when they use over-the-counter (OTC) medications in addition to their prescriptions.[61] Many prescription medications may interact badly with alcohol (Exhibit 1.3) and other substances, compounding this risk. Additionally, older individuals are more likely to experience negative side effects from prescription medications because of aging-related changes that alter how the body processes such substances.[62]

# of older adults who **VISITED** the **ER** because of the prescription opioid **TRAMADOL** increased **481%** from 2005 to 2011.[63]

In addition, **older adults may make medication errors (e.g., take too much, forget to take medications) because they have difficult or complex medication regimens.** According to the Agency for Healthcare Research and Quality,[64] 50 percent of emergency department visits for adverse drug events in Medicare recipients are caused by four medication types: medications for diabetes (e.g., insulin), oral blood thinners (e.g., warfarin), anti-blood-clotting medications (e.g., aspirin, clopidogrel), and opioid pain relievers. Many older adults take numerous medications, thus increasing their chances of making errors.

Adults 65 and older are particularly vulnerable to misusing prescription medications. Prescription medication misuse involves taking a medication other than as prescribed, whether accidently or on purpose.

In 2019, the most commonly misused medications were pain relievers, with an estimated 1.7 percent (900,000) of adults ages 65 and older misusing them in the past year.[65] In 2019, pain reliever misuse was the fourth most common type of substance misuse among adults ages 65 and older in the United States.[66] Some older adults do use prescription medications to "get high," but many develop SUDs from misusing prescription medications to address sleep problems, chronic pain, or anxiety.[67,68,69]

The medications of most concern are psychoactive medications such as opioids and central nervous system (CNS) depressants. Opioids are medications that relieve pain. CNS depressants include antianxiety medications, tranquilizers, sedatives, and hypnotics. These medications affect brain function, which can result in changes in consciousness, behavior, mood, pain, perception, and thinking.

Nonmedical use of prescription medications by older adults will likely increase in the future. Most misused medications (e.g., pain relievers, stimulants, tranquillizers, sedatives) are obtained by prescription.[70]

Opioids

Older adults are at risk for nonmedical use of opioids, given the high prevalence of chronic pain in this population.[71] Chronic pain is among the most common reasons for taking opioid medications, but for some individuals, prescription opioids do not relieve pain.[72]

Older adults are also at risk for alcohol–opioid interactions. When taken with opioids, alcohol increases the risk of negative outcomes in older adults, including death.[73, 74,75]

Rates of death and suicide caused by prescription opioid misuse are increasing.[76] In 2016, the Food and Drug Administration (FDA) issued a warning about serious risks, including death, from combining opioids with benzodiazepines or other CNS depressants, and required boxed warnings for prescription opioids and benzodiazepines. FDA's action was not meant to suggest that providers withhold buprenorphine or methadone, which treat opioid use disorder (OUD), from patients also prescribed benzodiazepines, although FDA recommends careful medication management of these patients.[77] Exhibit 1.4 lists common opioids.

EXHIBIT 1.4. Common Forms of Opioids

- Hydromorphone
- Oxycodone
- Codeine
- Methadone
- Fentanyl
- Meperidine
- Hydrocodone
- Morphine

Older adults may receive prescriptions for opioids to help manage their pain. For some, this creates a desire to get more pain medication than prescribed, because of tolerance. Having staff trained in the administration of naloxone is important in case clients experience an overdose of opioid medication. Providers should also learn about and offer older adults nonopioid pain medications (e.g., acetaminophen, antidepressants) and nonpharmacological pain management options (e.g., cognitive–behavioral therapy, relaxation training, exercise).

Opioids can be appropriate in the short term and for specific uses, such as postsurgical discomfort or cancer-related pain. But for many older adults with chronic (e.g., greater than 3 to 6 months) noncancer pain, nonopioid options are appropriate, effective, and well tolerated.

Benzodiazepines

Benzodiazepines are frequently prescribed to older adults to treat anxiety and insomnia, despite having a high dependence potential. Benzodiazepines interact with alcohol, increasing the risk of negative outcomes. Recent research shows that, frequently, benzodiazepines are prescribed long term for older adults without a clear need for ongoing treatment.[78]

Benzodiazepines are linked with a number of risks in older adults, including falls,[79] problems with thinking,[80] motor vehicle accidents,[81] and overdose death.[82] Exhibit 1.5 lists common benzodiazepines.

EXHIBIT 1.5. Common Benzodiazepines

- Lorazepam
- Clonazepam
- Diazepam
- Alprazolam

Cannabis

Cannabis is illegal at the federal level, although an increasing number of states have legalized the recreational and medical use of cannabis. **In 2019, about 2.7 million adults ages 65 and older (5.1 percent) engaged in past-year cannabis use.[83]** The number of older adults using prescribed cannabis is unknown. From 2013 to 2014, 12-month prevalence of medical cannabis use among U.S. adults ages 50 and older was only 0.6 percent.[84]

Older adults using medical cannabis are at risk for misuse and diversion (including forced or coerced diversion by others).[85] Other adverse effects can include psychomotor slowing (e.g., gait instability leading to fall risk), cognitive problems (e.g., short-term memory impairment), and increased risk of heart attack, stroke, psychotic episodes, and suicide.[86] Studies have shown limited benefits of cannabis for medical purposes, with, for example, some evidence suggesting possible improvements in neuropathic pain and spasticity from multiple sclerosis in older adults;[87] also, certain components of cannabis have demonstrated some medical value when treating seizure disorders (Dravet's syndrome, Lennox-Gastaut syndrome), wasting illnesses, and lack of appetite.[88] Other medications can treat these conditions, but they do not always work for older adults and may have unpleasant side effects.

Little is known about interactions of cannabis with specific medications.[89] Cannabis affects the CNS. **The substance is associated with memory and thinking problems, difficulties with motor skills, depression, and anxiety, among other negative effects.[90,91,92,93]** Moreover, the increasing potency of cannabis in recent decades may make cannabis use riskier.[94]

Illicit Drugs

Older adults are much less likely to use illicit drugs than younger adults. However, the pattern of drug use in older adults is changing. According to national survey data, use of illicit drugs among adults ages 50 to 64 rose from 2.7 to 10.4 percent from 2002 to 2019.[95,96] Baby boomers are more likely than earlier generations to report use of heroin and psychoactive drugs like cocaine or methamphetamine.[97]

OTC Medications and Dietary Supplements

According to a 2016 analysis of national survey data,[98] about 38 percent of older adults take at least one OTC medication; more than 63 percent take a dietary supplement (e.g., herbal products, vitamins). Among those who take prescription medications, 71.7 percent also take OTC medication or dietary supplements.

OTC medications, including OTC pain medications like acetaminophen and ibuprofen, and dietary supplements can interact harmfully with prescription medications, illicit substances, and alcohol. Older adults may lack awareness of side effects and possible negative interactions, because information that comes with OTC medications often does not include warnings specifically for older adults.

Providers should routinely discuss OTC medication use with older clients and advise them of possibly harmful interactions with prescribed medications, alcohol, and other substances.[99]

Older adults (and their families and caregivers) should inform their healthcare providers of any OTC medications and dietary supplements, including herbal products, they take. Asking for guidance on safety is crucial when taking multiple OTC medications or using them in combination with alcohol or a prescribed medication.

Risk and Protective Factors for Substance Misuse in Aging

The unique physical, emotional, and cognitive challenges older adults face tend to mask SUD symptoms, making it harder for providers to identify and address SUDs.

The aging process often includes major life changes and transitions. Some older adults turn to drugs or alcohol to cope.[100] Older adults also face many aging-related physical and mental health issues that may increase their risk of substance misuse and make detection and treatment difficult.

The aging process can cause changes in and problems with thinking**. Symptoms of cognitive decline and symptoms of substance misuse may be similar.** This makes it harder for family members, caregivers, and healthcare and behavioral health service providers to recognize when older adults misuse substances.

Many older adults who misuse substances have a history of co-occurring mental disorders, which suggests that mental illness is a risk factor for this population. Older adults with co-occurring mental and substance use disorders are at risk for negative outcomes like greater need for behavioral health services and higher rates of homelessness and suicidal thoughts.[101,102,103]

Exhibit 1.6 lists risk factors for substance misuse in older adults.

EXHIBIT 1.6. Substance Misuse Risk Factors in Older Adults[104,105]

- Retirement (when not voluntary)
- Loss of spouse, partner, or family member
- Environment (e.g., relocation to assisted living)
- Physical health (e.g., pain, high blood pressure, sleep and mobility issues)
- Previous traumatic events
- Mental disorders (e.g., disorders related to depression and anxiety)
- Cognitive decline (e.g., Alzheimer's disease)
- Social changes (e.g., less active, socially disconnected from family and friends)
- Economic stressors (rising medication and healthcare costs, living on reduced income)
- Lifetime or family history of SUDs
- High availability of substances
- Social isolation

Protective factors help prevent or reduce substance misuse in older adults.[106,107,108] Exhibit 1.7 lists protective factors against substance misuse in older adults.

EXHIBIT 1.7. Substance Misuse Protective Factors in Older Adults

Protective factors are factors that can reduce substance misuse or make it less likely to occur. They include a person's strengths, skills, and abilities as well as environmental factors. Protective factors include:

- Resiliency.
- Marriage or committed relationship.
- Supportive family relationships.
- Retirement (when voluntary).
- Ability to live independently.
- Access to basic resources such as safe housing.
- Positive self-image.
- Well-managed medical care and proper use of medications.
- Sense of identity and purpose.
- Supportive networks and social bonds.

EXHIBIT 1.8. Barriers to Seeking Treatment

- **Negative attitudes.** Some families, caregivers, and service providers don't feel comfortable addressing substance misuse because of their negative views about SUDs. They may also be afraid of "making waves" or feel that asking about the issue would intrude on the older adult's life or independence.
- **Denial of the problem.** Family and friends often either ignore or accept older adults' substance misuse, especially if the problem is long standing.
- **Accepting attitudes.** Some adults live in settings where family and peers have accepting attitudes toward alcohol and drugs. Even caregivers and medical professionals may view substance use as okay for older adults (e.g., viewing substances as older adults' "one last pleasure").[109,110]
- **Lack of knowledge.** Family and friends may not realize that older adults undergo physiological changes that make the effects of alcohol or drugs more dangerous.
- **Misinformation about treatment.** Some people hold the false belief that older adults cannot be treated for SUDs. However, evidence shows that addiction treatment for older adults has positive outcomes, can reduce or stop substance use, and improves health and quality of life.[111,112,113,114,115,116]

See the Chapter 1 Appendix for a more detailed list of barriers to seeking treatment.

Barriers to Seeking Treatment

Exhibit 1.8 lists some of the barriers that prevent older adults from getting the SUD treatment they need. Understanding these barriers is a key step in reducing substance misuse in the older adult population. Such misuse limits one's ability to function and to achieve the best possible quality of life, regardless of age.

The following two sections will be of greater interest to healthcare providers. These sections give overviews of basic information on screening, diagnosis, and treatment as they apply to older clients from the provider's point of view.

Screening and Diagnosis

Screening, brief intervention, and referral to treatment (SBIRT) is the overall model for and approach to screening and intervening with individuals who misuse, or are at risk for misusing, substances. Older adults with SUDs may receive screening, diagnosis, and treatment for SUDs in many different settings and from a variety of professionals. Few older adults seek help in specialized addiction treatment settings.

All healthcare, behavioral health, and aging service providers must know the signs/symptoms of SUDs and substance misuse in older adults and have protocols for screening, treatment, or referral.[117,118]

See Chapters 3, 4, and 5 of this TIP for more information about screening, assessment, and SBIRT.

Screening

Universal screening is key in SBIRT. Providers should screen all older clients for substance use (type of substance, frequency, quantity), misuse (including of prescriptions), consequences, and drug–drug interactions.

UNIVERSAL SCREENING[119]

Healthcare and social service providers should give all older clients a brief prescreen. Most will screen negative, but prescreening helps identify substance misuse that may otherwise be overlooked.

Settings in which older adults may receive screening for substance-related problems include:

- Healthcare clinics.
- Hospitals.
- SUD treatment programs.
- Home health care.
- Nursing homes.
- Social service agencies.

- Senior centers.
- Assisted living facilities.
- Faith-based organizations.

The TIP consensus panel recommends yearly screening for all adults ages 60 and older and when major life changes occur (e.g., retirement, loss of partner/spouse, changes in health). For more accurate histories, ask questions about substance use in the recent past while asking about other health behaviors (e.g., exercise, smoking, diet). Asking straightforward questions in a nonjudgmental manner is the best approach. Providers should also ask about medical marijuana prescriptions or use.

Screening helps fully determine which substances (including alcohol) and medications a client takes and what, if any, interactions these substances, prescription medications, OTC medications, and dietary supplements may have with each other. Many providers fail to ask about OTC medications. However, some OTC medications (particularly anticholinergic agents, like diphenhydramine [Benadryl], doxylamine [Unisom], and acetaminophen/diphenhydramine [e.g., Tylenol PM]) can be problematic in combination with alcohol or prescription medications as well as illicit drugs.

Screening for older adults can be verbal (e.g., by interview), with paper-and-pencil forms, or with computerized forms. All three methods are reliable and valid.[120] Any positive responses should lead to further questions constituting full assessment (or referral for full assessment by a qualified provider).

Chapter 3 of this TIP offers further information about substance misuse screening measures and how to follow up with clients who screen positive as well as those who screen negative.

Diagnostic Issues in Working With Older Adults

Some DSM-5 SUD criteria may not apply to older adults with substance use problems, even though DSM-5 criteria generally determine SUD diagnoses. For example, in retired older individuals with fewer familial and work obligations, substance use may not cause failure to fulfill major obligations at work, school, or home. Even so, it may negatively affect health, daily activities, or functioning.[121]

Older adults have unique risk factors that increase their vulnerability to substance misuse, but signs and symptoms of SUDs often resemble those of other health issues, making detection difficult. Bodily changes (e.g., slower metabolism, reduced muscle mass, altered body fat percentages and organ functions) make older adults more sensitive to the effects of alcohol and drugs. Because of such changes, smaller amounts of substances may cause more harmful effects. These changes can occur gradually, which may make them harder to notice.

Older individuals who misuse substances may require treatment even if they do not meet DSM-5 criteria for an SUD. Quantity-frequency measures may be less effective than assessment of impact on overall well-being and quality of life in identifying substance misuse for this population. Healthcare and behavioral health service providers must determine these effects before focusing on interventions and treatments.

Treatment

Addiction treatment programs have begun to see an increase in admissions among older adults because of the population increase and the higher prevalence of lifetime substance use among baby boomers.[122,123] Although alcohol use remains the primary reason for admission, the years 2000 to 2012 saw a decrease in alcohol-related admissions and steep increases in admissions for prescription opioids as well as illicit drugs such as cocaine, crack, and heroin.[124]

Early- and Late-Onset Substance Misuse

SUD diagnosis and treatment planning depend, in part, on when substance use began in older adults. "Early onset" substance use is present in those with a history of at-risk or harmful substance use that began before age 50.[125] "Late-onset" substance use is present in those who began to misuse substances only later in life. Exhibit 1.9 shows early- versus late-onset aspects of alcohol misuse as an example.

EXHIBIT 1.9. Characteristics of Early-Onset Versus Late-Onset Alcohol Misuse[126]

- Early onset:
  - Risky or harmful drinking patterns prior to age 50
  - Long-term denial, which complicates treatment
  - Multiple medical comorbidities, limited social support, poor emotional skills, and cognitive impairment
  - More common, making up two-thirds of older adults[127]
- Late onset:
  - Began misusing alcohol later in life (possibly following alcohol problems at various periods earlier in life)
  - May have begun misusing alcohol because of age-related stressors (e.g., retirement, loss of income or partner)
  - Preceded by stable periods of abstinence or low-level drinking over a long period of time
  - May appear "too healthy" to raise concerns

People with late-onset misuse may seem "too healthy" to raise concern. Providers should ask older clients about lifetime substance use patterns. Problems can arise with stressors in older adulthood.[128,129]

Medication Interventions

AUD

Acamprosate, disulfiram, and naltrexone are approved to treat AUD. They can improve outcomes[130] but are not usually used for long-term treatment of older adults with AUD.

Acamprosate

Acamprosate is approved by FDA to treat AUD.[131] Clinical evidence suggests that acamprosate can help people with alcohol dependence maintain abstinence by reducing cravings and the pleasurable effects associated with alcohol.[132,133] It may also lessen symptoms of prolonged abstinence such as anxiety and insomnia.[134] To date, **research on acamprosate use in older adults is not readily available.** Because acamprosate is removed from the body through the kidneys and older adults are at elevated risk of diminished kidney function, this population should have baseline and frequent renal function tests as part of acamprosate treatment.[135]

Disulfiram

Disulfiram is approved by FDA to treat AUD.[136] Disulfiram triggers an acute physical reaction to alcohol, including flushing, fast heartbeat, nausea, chest pain, dizziness, and changes in blood pressure.[137,138] These reactions are supposed to motivate a person to avoid drinking alcohol.

Because the effects of taking this medication in combination with alcohol can be harmful to older people, it is generally not recommended for use in this population and, if used, is done so only with great caution.[139,140]

Also, for disulfiram to be useful, clients must stick to strict medication protocols.[141] Doing so may be hard for older adults who have cognitive impairment or live alone and have no one to support them in taking medication as prescribed. A meta-analysis suggests that when compliance with disulfiram is not monitored, its efficacy is no different from that of control conditions.[142] **Monitoring for adherence is essential for disulfiram to be effective.** People taking disulfiram may also need to be observed, as some may stop taking it on a day during which they want to drink.

Naltrexone

Naltrexone is approved by FDA to treat AUD.[143] It reduces craving for alcohol and decreases the rate of relapse to heavy drinking. Some research suggests that naltrexone is tolerable in adults ages 50 and older, but widespread data on its tolerability in older individuals are lacking.[144]

Naltrexone is an opioid blocker and cannot be used in clients who require prescription opioids for pain relief. Giving naltrexone to a client who takes opioid medication for pain may cause significant opioid withdrawal symptoms.

OUD

Medication treatment for OUD can reduce risk of relapse.[145,146] **Three medications can treat older adults with OUD: naltrexone, buprenorphine, and methadone. The opioid overdose medication naloxone is also safe and effective in older adults.** Learn more about medication for OUD in the Substance Abuse and Mental Health Services Administration's (SAMHSA) 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).

Naltrexone

Naltrexone can prevent relapse after medically supervised opioid withdrawal.[147] It is not a pain medication. It is a medication that reduces cravings for and effects of opioids and alcohol. Research on its use in older adults with OUD is not readily available, but some studies have shown it to be **safe and acceptable in older adults** with AUD.[148,149]

Buprenorphine

Buprenorphine can treat opioid withdrawal or provide long-term medication maintenance for OUD. It is so effective that the World Health Organization (WHO) lists it as "an essential medication."[150,151] **Compared with methadone, less is known about use of buprenorphine in older adults with OUD.** It may be preferable to methadone, because it is less likely to cause withdrawal symptoms, erectile dysfunction, and prolonged QT interval (see "Methadone" section). It may be safer than methadone for older adults with cardiovascular/respiratory disorders.[152] A study of short-term use of low-dose buprenorphine for older adults with depression found the medication to be safe and well tolerated.[153] However, more studies are needed to fully understand the benefits and side effects of buprenorphine in older adults with OUD.

Certain buprenorphine formulations are FDA approved to treat chronic pain. One such formulation is the buprenorphine transdermal system,[154] which appears safe for pain treatment among older adults.[155]

Methadone

Methadone is used to prevent opioid withdrawal symptoms and reduce cravings for people with OUD.[156] As with buprenorphine, it is considered so effective that WHO lists it as "an essential medication."[157,158] Methadone is available through federally certified and accredited opioid treatment programs. It can be effective on its own, but research shows that it is often **more effective in treating OUD when used with behavioral, social, and other medical services.**[159] Methadone can also be prescribed to treat chronic pain in older adults.[160,161]

Older adults taking methadone may experience certain side effects, some of which can be serious.[162] Methadone is associated with higher risk of prolonged QT interval, which can cause a potentially deadly cardiac arrhythmia.[163] This risk is even greater when methadone is taken at higher doses, with other QT-prolonging medication, or by someone with congestive heart failure. Many medications negatively interact with methadone.[164] This is an important consideration in older adults, who are likely to take multiple medications. As with other opioids, methadone can increase the risk of falls in older adults.[165]

Each older adult has an individual history and unique needs. Each older client's intervention or treatment path will also be unique. The path to improving outcomes is determined, in part, by the severity of the problem, the individual's willingness to get help with reducing or stopping substance misuse, the types of programs available, and the cost of care.

Summary

Evidence-based screening techniques, brief interventions or treatments, and specialized care options give older adults the best chances of improving their physical and emotional health. Identification and treatment of SUDs can be challenging, but is possible with the right knowledge and tools.

This TIP will guide SUD treatment providers, supervisors, and administrators; mental health service providers; state and community behavioral health service agencies; healthcare providers; caregivers; families; and older adults in understanding and accessing evidence-based screening, intervention, and treatment options to address substance misuse in a number of settings.

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Chapter 1 Appendix

Older Adults and Barriers to SUD Treatment and Mental Health Services

Older adults face barriers at many levels in accessing SUD treatment and mental health services. Barriers can be personal, interpersonal, structural, or a combination. Recognizing, understanding, and working to remove barriers will help all older clients receive the best possible care for substance misuse.

The following table shows the many types of barriers older adults potentially face in addressing substance misuse. The table includes citations of supporting research; access these references to learn more about each barrier and how it affects older adults.

Barriers Older Adults Face in Addressing Substance Misuse

BARRIER	DEFINITION, DESCRIPTION, OR EXAMPLE OF BARRIER	SAMPLES OF RESEARCH
Common myths and negative beliefs	Myths and negative beliefs include "Drug addiction is only a 'young person's problem'" or "Once an alcoholic, always an alcoholic." Providers or family members with these beliefs might not offer to help an older person who misuses substances. Similarly, an older person who fears stigma that comes from hearing other people express these negative beliefs might not ask for help.	Choi et al. (2014)[177] Blais et al. (2015)[178] Crome (2013)[179]
Co-occurring physical and mental health conditions	Symptoms of substance misuse can seem similar to symptoms of other conditions common in older adults, including depression, anxiety, posttraumatic stress disorder, chronic pain, and sleep problems. Providers, family members, and clients themselves can easily mistake the symptoms of substance misuse for one or more of these conditions. Little research clarifies barriers for older adults with co-occurring mental and substance use disorders. But in adults in general, these co-occurring disorders (CODs) are associated with several barriers to treatment access: stigma, negative beliefs about addiction and mental health services, lack of specialized services for people with CODs, and providers' failure to recognize both conditions in a client with CODs.	Royal College of Psychiatrists (2015)[180] Crome (2013)[181] Center for Behavioral Health Statistics and Quality (2020)[182] Priester et al. (2016)[183]

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Continued

BARRIER	DEFINITION, DESCRIPTION, OR EXAMPLE OF BARRIER	SAMPLES OF RESEARCH
Lack of awareness on the part of older clients	Older clients may not realize how much they are drinking or that their substance misuse is a problem. For instance, older people are affected by alcohol differently than when they were younger. This is because of changes in the body that are a normal part of aging, like losing lean mass. For example, a woman in her 70s might think she can safely drink the same amount of alcohol that she drank in her 30s. This is not necessarily so. Some older adults think the amount of alcohol they drink is not risky although it exceeds recommendations for low-risk drinking. Sometimes a client's lack of awareness can result from cognitive impairment, making it hard for the client to self-monitor alcohol intake.	Sacco & Kuerbis (2013)[184] Borok et al. (2013)[185] Kuerbis et al. (2014)[186]
Family members' lack of awareness of older adults' misuse	Adult children may not know how much their parent is drinking or that his or her substance misuse is harmful. Even when aware of an older adult's substance misuse, family members may not seek help as quickly as needed. They may have thoughts such as "Alcohol is my father's last pleasure in life. I'd hate to take that away from him."	Royal College of Psychiatrists (2015)[187] Briggs et al. (2011)[188]
Ageism	"Ageism" refers to negative beliefs or attitudes about older people that lead to stereotyping or discrimination. An example of ageism is failing to screen a client in her 80s for SUDs because "people her age don't benefit from treatment."	Royal College of Psychiatrists (2015)[189] Chrisler et al. (2016)[190]
Views of SUDs as a moral failure or weakness	An older client who believes that having an SUD is a sign of being "weak" or a "bad person" might feel too ashamed to ask for help.	Royal College of Psychiatrists (2015)[191]
Financial problems, insurance issues	Examples of this barrier include low income or no income, as well as having no insurance or insurance that does not cover SUD treatment and mental health services.	Choi et al. (2014)[192] Osborn et al. (2017)[193]
Limited mobility, transportation, or both	Examples of these barriers are having difficulty walking or not having access to mobility assistance devices (like a walker or wheelchair). This barrier also includes being unable to travel to appointments (e.g., not having a car, not having access to public transportation).	Choi et al. (2014)[194] Hadley Strout et al. (2016)[195]

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BARRIER	DEFINITION, DESCRIPTION, OR EXAMPLE OF BARRIER	SAMPLES OF RESEARCH
Living situations and social settings that "normalize" substance misuse	A home setting or social network that supports older adults' misuse of substances can hinder diagnosis and treatment. For instance, in some assisted living facilities, residents frequently use alcohol. This could make it harder for staff to identify an older client who misuses alcohol because drinking is seen as "normal." In some nursing homes, staff do not regularly ask about alcohol use at intake and may fail to recognize when residents are misusing alcohol. Many long-term care facilities have no policies on illicit drug use. This suggests that staff members may not be fully prepared to recognize and respond to residents' drug use. Older adults with spouses/friends who misuse alcohol or support drinking may be at more risk for alcohol misuse because they are surrounded by people who make their alcohol misuse seem "normal."	Castle et al. (2012)[196] Klein & Jess (2002)[197] White et al. (2015)[198] Moos et al. (2011)[199]
Lack of social support, including social isolation or low social connectedness	Older adults with few or weak social relationships (like being single, widowed, or divorced) may be less likely to visit healthcare providers compared with older adults with stronger social ties (like being married or living with someone else). Older adults who are socially connected and feel positive about their social network appear to have better access to healthcare services and better health and well-being than older people who are not socially well connected.	Bremer et al. (2017)[200] Graham et al. (2014)[201]
Limited numbers of providers with knowledge of and commitment to working with older adults	Too few healthcare providers and behavioral health service providers are trained to work with older adults who misuse substances. Without this training, providers are less likely to screen, assess, diagnose, and treat older clients who misuse substances.	Institute of Medicine (2012)[202] Bartels et al. (2014)[203]
No coordinated services; limited access to behavioral health or social services across care settings or geographic regions	Older adults who misuse substances, have other problems related to behavioral health, or both need coordinated, person-centered care. Coordinated care helps address all of clients' physical, mental, and social service needs. Many older clients who misuse substances do not receive coordinated care. Healthcare providers (including physicians, nurses, and physician assistants) and behavioral health service providers should be appropriately trained and working together closely when providing SUD treatment or mental health services.	Institute of Medicine (2012)[204] Gage & Melillo (2011)[205]

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BARRIER	DEFINITION, DESCRIPTION, OR EXAMPLE OF BARRIER	SAMPLES OF RESEARCH
Lack of case management or care management	Case managers (or "care managers") coordinate healthcare and behavioral health services across providers. When care is not coordinated, clients might not get access to the full range of treatments they need. The workforce needs to identify and include in coordinated services case managers or care managers who are specially trained in older adults' unique substance misuse and mental health issues. Providers who do not understand the particular ways that older adults experience substance misuse may be less likely to screen, assess, diagnose, and treat older clients for SUDs, as needed.	Institute of Medicine (2012)[206]
Ambivalence about changing a health behavior	Like young and middle-aged adults, older adults may feel ambivalent about changing a long-standing health behavior. This can be a barrier to entering treatment or following a provider's recommendations.	National Research Council (2006)[207]
Normal life changes	Older adults commonly experience life changes that increase their risk of misusing substances. Such changes include moving into assisted living or other long-term care facility, retiring from work, and losing a family member (such as a spouse or adult child). It might be easy to "normalize" or make light of an older person's substance misuse in one of these situations. ("He doesn't really have a drinking problem. He's just drinking because he lost his wife. Who can blame him?") But substance misuse in these situations is just as serious and potentially harmful as in any other situation.	Kuerbis et al. (2014)[208]
Loss, especially death of children, spouse, siblings, or close friends; also, loss of employment (e.g., forced retirement)	The death of a family member or friend can be extremely distressing. In some older adults, grief can increase the risk of substance misuse, especially alcohol misuse and tobacco use. Grieving older adults may misuse substances as a way of coping with their loss. If this is their main method of coping, it can be a barrier to entering treatment, as they likely will not want to quit. Some older people consider retirement a form of loss, especially when the retirement is unwanted. Many people define themselves by their work. For them, leaving their job represents a loss of their identity and can lead to negative self-esteem. People may misuse substances as a way of coping, which could be a barrier to entering treatment.	Stahl & Schulz (2014)[209] Kelly et al. (2018)[210]

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BARRIER	DEFINITION, DESCRIPTION, OR EXAMPLE OF BARRIER	SAMPLES OF RESEARCH
Lack of health literacy	"Health literacy" is a person's ability to access, understand, and communicate about health-related information. Older people with low health literacy may have trouble talking about substance misuse with their providers. They may also not understand, for example, what amount of alcohol is considered low risk versus harmful. In these instances, these individuals may not seek treatment.	Levy & Janke (2016)[211] Geboers et al. (2016)[212] Findley (2015)[213]
Cultural norms	Cultural norms can influence a person's help-seeking behavior. For example, an older person whose culture discourages talking about mental illness or substance misuse may not seek help. In some cultures, it is more acceptable to talk about physical symptoms, such as aches and pains or sleep problems, than it is to talk about symptoms of addiction or mental illness, like feeling depressed or wanting to hurt oneself. This can make it hard for a provider to know when a client from this kind of cultural background has a problem related to substance misuse or mental illness.	Royal College of Psychiatrists (2015)[214] Barrio et al. (2008)[215] Jimenez et al. (2013)[216]
Racial and cultural differences among older clients	Racial and cultural factors can affect how a person thinks and speaks about his or her behavioral health, seeks help for addiction or mental illness, and receives treatment. For instance, an older individual who does not speak English fluently may feel uncomfortable asking for help from a provider who speaks only English.	De Guzman et al. (2015)[217] Barrio et al. (2008)[218] Sorkin et al. (2016)[219]
Gender and sexual identity	Like race and culture, older adults' gender and sexual identity can affect whether they seek and receive help for substance misuse or mental illness. For example, older lesbian, gay, bisexual, transgender, and questioning adults may be slow to seek treatment out of fear that providers will refuse to care for them or because they are uncomfortable with physical exams. Older women are especially vulnerable to some barriers, like stigma, low income, or providers not recognizing their substance misuse.	Auldridge et al. (2012)[220] Koenig & Crisp (2008)[221] Chrisler et al. (2016)[222]

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Chapter 2—Principles of Care for Older Adults

KEY MESSAGES

- Incorporating age-sensitive and age-specific treatment practices into your program is important for engaging older clients and improving their retention in treatment.
- The older adult population is culturally, racially, and ethnically diverse. Recognize and address diversity and health disparity issues related to aging.
- Collaboration among service providers across settings is essential when working with older adults who misuse substances, particularly for those with co-occurring medical conditions and mental disorders.
- Hiring, training, and retaining staff who demonstrate high motivation and commitment to serving older adults are vital to successfully implementing substance use disorder (SUD) treatment programs and services for this population.

Chapter 2 of this Treatment Improvement Protocol (TIP) will most benefit healthcare, mental health, addiction treatment, and social service providers who work with older adults. It addresses principles of care for older clients who present across settings with substance misuse. By tailoring traditional treatment methods and adopting age-specific, age-sensitive, science-informed interventions, providers can better fulfill the needs of a growing population of older adults who misuse substances. Older adults receive services in many settings besides SUD treatment programs: mental health service programs, primary care practices, emergency departments, senior centers, adult day programs, faith-based organizations, and assisted living and residential care facilities. Across settings, early identification, universal screening, and education for substance misuse can facilitate brief intervention and referral to treatment.

Organization of Chapter 2 of This TIP

Chapter 2 addresses the general principles of care—across service settings—for older adults with a history of substance misuse. The following are essential principles of care:

- Understand the developmental issues of aging.
- Acknowledge and address the diversity among older adults.
- Recognize the difference between early- and late-onset SUDs among older adults.
- Emphasize client education, early identification, screening, and brief treatment.
- Engage in health risk reduction practices.
- Provide person-centered care.
- Build alliances with older clients; use age-sensitive strategies to engage/retain them in treatment.
- Help older clients use social networks and community-based services.
- Encourage family and caregiver involvement.
- Coordinate care and develop service linkages.
- Make programmatic changes to effectively serve older adults with SUDs.
- Invest in age-sensitive workforce development.

Chapter 2 concludes with a list of targeted resources to support the delivery of older adult–focused services to address substance misuse. A more detailed resource guide is available in Chapter 9 of this TIP.

Exhibit 2.1 provides definitions for key terms that appear in Chapter 2.

EXHIBIT 2.1. 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).
- **Alcohol misuse:** The use of alcohol in any harmful way, including heavy drinking, binge drinking, and alcohol use disorder (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. [223,224] 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.
- **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.[225,226] 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.[227] 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.[228] 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.[229]
- **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.
- **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.[230]
- **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.[231,232] 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.[233] 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.[234]

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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 Alcoholics Anonymous 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 [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.
- **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.
- **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).[235] 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,[236] 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).

General Principles of Care

Older adults tend to do as well as or better than younger adults in mixed-age SUD treatment.[237,238] Moreover, growing evidence links age-specific treatment to better treatment adherence and long-term outcomes for many older adults.[239] Even so, only about 23 percent of SUD treatment programs in the United States offer a program or group specifically tailored to older adults.[240]

Few SUD treatment approaches are designed specifically for older adults. Therefore, this TIP provides general principles of care that can inform a flexible approach for age-sensitive, age-specific treatment of substance misuse among older adults. The principles are a framework to guide your work with older adults across settings to address issues related to their misuse of substances.

Understand the Developmental Issues of Aging

Older adults are not a homogenous group. As with any group, older adults may hold a diverse range of opinions and attitudes toward alcohol and drug use. For example, within the older adult population, **people in various age ranges differ from one another in significant ways that may influence which approaches will most successfully address substance misuse.**

Earlier cohorts of older adults (e.g., adults born before or during World War II) are more likely to have moralistic attitudes about drinking and drug use—attitudes that, for some, were shaped by Prohibition and the Temperance Movement.[241] They may feel deeply ashamed about alcohol misuse or drug use. If they attribute their substance misuse to a moral failing, they may be less likely to seek SUD treatment.[242] These cohorts are likelier to **benefit from screening and brief intervention with a healthcare provider when questions about drinking and drug use are part of an overall approach to health assessments.**

Baby boomers (i.e., adults born between 1946 and 1964) grew up in a time when substance use was more culturally acceptable. They **may have more permissive attitudes toward drinking and drug use. They are also more likely to be willing to seek and agree to specialized addiction treatment.**[243]

Older adults have unique developmental challenges that younger adults may not have. These include possibly losing a spouse or partner, as well as experiencing:

- Increasing numbers of deaths of friends in the same age cohort.
- Role changes in families and work-related activities.
- Reduced opportunities for increasing or maintaining income levels.
- Normal age-related cognitive and physical decline leading to loss of functioning and reduced capacity to carry out ADLs.[244]

Providing age-sensitive, age-specific treatment approaches helps older adults feel more comfortable discussing personal issues and age-related changes than they would feel doing so in mixed-age treatment programs.[245] Whether or not you can offer age-specific treatment options, your program needs to **create an environment that responds to older adults' needs** (Exhibit 2.2).

EXHIBIT 2.2. How Administrators Can Create a Treatment Environment Responsive to Older Adults[246]

Older adults have specific developmental needs. To create an environment that is responsive to older adults' needs, the entire organization, not just providers, must be committed to this purpose. Some of the strategies administrators can use to create an age-sensitive treatment or service environment include:

- Make a commitment to understanding the developmental needs and cohort differences.
- Review and update your vision and mission statement to reflect your commitment to older adults.
- Conduct an organizational self-assessment of attitudes, knowledge, and skills needed to effectively respond to older adults in your program.
- Conduct an organizational self-assessment of the physical environment and other barriers to access that must be addressed to provide services to older adults.
- Address organization-wide competence in the developmental needs of older adults and cohort differences in your strategic planning process.
- Assign one staff member to oversee the development of age-specific practices and services.
- Develop an advisory board or task group with older adult members from the community.
- Engage clients, staff, and community members in planning/developing age-specific services and programs.
- Develop and review policies and procedures to ensure that all staff are responsive to older adults' needs.
- Create an older adult-friendly environment that enhances engagement and retention of clients.
- Develop outreach strategies to improve access to care.

The consensus panel recommends that you engage your clients in discussions about their attitudes toward substance misuse, create an age-sensitive treatment environment that is responsive to older adults, and offer age-specific treatment options when possible.

Acknowledge and Address Older Adults' Diversity

The older adult population is as culturally diverse as other age groups. Yet **older adults who are members of racial/ethnic and other minority groups are often at greater risk of poor health, disability, social isolation, and poverty** than are their younger counterparts. Older adults from diverse racial and ethnic backgrounds are also more likely to be underinsured and receive fewer routine screenings for health concerns.[247] Therefore, they face more barriers to accessing health care and experience greater health disparities.[248] These **disparities increase risk for developing SUDs and increase barriers to treatment.**

> Higher rates of deaths, disability, and chronic illness are more common among older adults who identify with diverse racial and ethnic groups.[249]

Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) older adults may experience poor health care and lack of access to services. Given discrimination and prejudice, they may have to hide, or feel the need to hide, their LGBTQ identity to receive care.[250]

Gender-related disparities can create or compound health disparities in older adults. Older women are at higher risk for co-occurring mental disorders and social isolation than older men.[251] They are also more likely to be prescribed medications (e.g., benzodiazepines) that negatively interact with alcohol and to be prescribed them for longer periods of time, increasing the risk of SUDs.[252]

OLDER WOMEN are at higher risk for **CO-OCCURRING** mental disorders and social isolation than older men.

Providers and program administrators must learn how older clients' race, ethnicity, sexual orientation, gender identity, and socioeconomic status influence overall health, substance misuse, and availability of healthcare and behavioral health services.[253] They should **also recognize that older adults can draw on their cultural heritage in ways that improve health and well-being.**[254]

> "As people age, they shape their world in ways that maximize their well-being … within the confines and definitions of their respective cultures."
>
> —H. H. Fung (2013), p. 375[255]

The consensus panel recommends that you maintain awareness of older adults' racial, ethnic, gender, and LGBTQ diversity when addressing late-life substance misuse, health disparities, and barriers to access to care. Provide culturally responsive screening, assessment, and treatment for clients across settings.

RESOURCE ALERT: IMPROVING CULTURAL COMPETENCE

The Substance Abuse and Mental Health Services Administration's (SAMHSA) TIP 59, *Improving Cultural Competence* (https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849), helps providers and administrators understand the role of culture in the delivery of mental health services and SUD treatment.

Recognize the Difference Between Early- and Late-Onset Substance Misuse

Diagnosis and treatment planning differ for older adults who have a history of substance misuse (early onset) and those who develop problems only later in life (late onset). For example, older adults who begin to drink because of late-life stressors (e.g., loss of a significant other) may not have the same chronic, co-occurring medical conditions or mental disorders that older adults who have been drinking since adolescence or early adulthood have. Late-onset substance misuse may respond well to brief interventions. Older adults who exhibit chronic misuse may need more intensive SUD treatment.[256]

The consensus panel recommends that, as part of regular screening and assessment, you determine whether clients have a history of substance misuse or are using in response to more recent stressors. Use this information to identify appropriate treatment options. Discuss these options with clients.

Emphasize Client Education, Early Identification, Screening, and Brief Treatment

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. To ensure that older adults receive education, screening, assessment, and treatment, all who have regular contact with them—whether in the home, at healthcare visits, at community-based senior services, or in long-term care facilities—must recognize the signs of substance misuse (including prescription drug misuse) in older adults.

Older adults are less likely to get referrals to specialized SUD treatment from healthcare providers than other sources (e.g., self-referral, referrals from legal incidents related to driving and substance misuse).[257] **Yet healthcare providers are well positioned to identify and screen for substance misuse** in older adults.

Older adults are more likely than younger adults to see their healthcare providers to discuss and receive treatment for numerous medical and health-related concerns. **Healthcare visits are opportunities to discuss substance use and related health risks and consequences.** Healthcare providers can also take these opportunities to talk with older clients about drug–drug interactions with alcohol, prescription medications, and other substances in the context of routine medical care.[258]

If you are a healthcare or social service provider who has contact with older adults in home-care situations, residential care facilities, community-based programs, or emergency departments, you should **be aware of the signs of substance misuse among this population. Within your scope of practice, you should engage in routine screening of older adults for substance misuse** in accordance with your program's policies and procedures.

A home healthcare nurse noticed empty beer bottles and the smell of alcohol on Joe's breath during one of her regularly scheduled home visits to monitor Joe's management of his diabetes. Joe also seemed unsteady on his feet. She recognized the signs of a potential problem and had a friendly conversation with him about his health in which she embedded screening questions about his drinking. Joe agreed to let her call his daughter to arrange for a ride for him to see his healthcare provider for an assessment.

A growing body of research demonstrates that different kinds of **brief interventions delivered in a variety of healthcare and social service settings can effectively reduce alcohol consumption and substance misuse** and lower health-related risk among older adults.[259,260,261,262,263] Brief interventions can also facilitate entry into more intensive treatment.[264]

The consensus panel recommends that providers across settings in which older adults may seek care:

- Promote early identification, education, outreach, and prevention in their programs/communities.
- Promote universal screening for alcohol misuse, drug use, and prescription medication misuse for older adults.
- Develop and expand brief interventions for older adults who misuse substances.

Engage in Health Risk Reduction Practices

Older adults who misuse substances may not want to set abstinence as their goal. Engaging in health risk reduction practices is an important and viable option for older adults and is consistent with age-sensitive treatment practices.[265] For example, medical providers can slowly taper older adults to the lowest possible doses of benzodiazepines without withdrawing them completely. Another health risk reduction approach specifically designed for older adults is the BRITE project, an adaptation of screening, brief intervention, and referral to treatment (SBIRT). It has demonstrated lowered alcohol severity and depression in older adults and improvements in medication misuse.[266] (See Chapter 3 of this TIP for more information on screening and assessment.)

Risk reduction strategies lower health-related risk for older adults and can boost functioning. Risk reduction can also be a first step toward abstinence. For example, once older adults who misuse alcohol begin to experience the health benefits of less drinking, they may be more willing to stop completely.

The consensus panel recommends engaging in health risk reduction practices to lessen the impact of substance misuse on the physical and mental health of older adults.

Provide Person-Centered Care

Based on a literature review and qualitative research, a consensus panel convened by the American Geriatrics Society determined that **a**

person-centered approach to care for older adults puts older adults' values and preferences at the center of the decision-making process regarding healthcare options and treatment goals.[267]

> "'Person-centered care' means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires."
>
> —American Geriatrics Society (2015), p. 16[268]

Consider client needs and preferences when deciding treatment intensity (e.g., inpatient or outpatient), method (i.e., group or individual treatment), and goal choice (i.e., abstinence or reduction in use).

Collaborating with clients to develop treatment goals enhances positive outcomes.[269] Offer clients a menu of treatment options that fit their needs and preferences. Options should include the least intensive treatment approaches that are medically appropriate as well as more intensive alternatives.

More treatment leads to better outcomes, regardless of the level of care (e.g., residential versus outpatient treatment) or whether treatment is greater in intensity or greater in length of overall treatment. The more attention older clients receive, the more likely they are to improve.[270]

Continually reassess older clients' needs, treatment goals, priorities, and intensity of care throughout treatment. Maintaining clients at the center of the conversation is essential to this process.

The consensus panel recommends that you engage older clients in a comprehensive, person-centered, trauma-informed approach to SUD treatment that emphasizes their values, needs, and preferences. Offer a menu of care options, including the least intensive treatment approach.

Build Alliances With Age-Sensitive Engagement and Retention Strategies

Building a strong treatment alliance with each client fosters engagement and retention in treatment. The treatment alliance is a collaborative process based on agreement on treatment goals and tasks and a bond between you and your client.[271] A large body of research shows the alliance as significant in all kinds of helping relationships across a variety of treatment methods, including SUD treatment.[272]

Retention in SUD treatment predicts good outcomes for older adults regardless of treatment approach.[273] Retention refers to a client's length of time in treatment and adherence to treatment.

To engage and retain older adults in treatment, the following practices are helpful:

- **Recognize the importance of establishing a collaborative relationship** as the primary mechanism for engaging clients in treatment and supporting behavior change.
- **Create a culture of respect,** which is nonconfrontational, focuses on building older clients' sense of value and worth, acknowledges the wisdom of their own lived experience, and expresses confidence in their ability to participate in treatment and accomplish their treatment and recovery goals. Respect the customary social conventions of older adults' age cohort (e.g., refrain from swearing or using slang) and ask clients how they would like to be addressed and introduced to others.
- **Use proven treatment approaches** that have demonstrated effectiveness or shown promise with older adults in addressing substance misuse across a variety of settings. Such approaches include brief advice and brief interventions, SBIRT, motivational interviewing, supportive therapy, problem-solving therapy, individual therapy, and cognitive–behavioral therapy.[274,275]

- Match treatment to older adults' needs and levels of functioning.
  - Outpatient programs should provide services during daytime hours and assist clients with transportation. Offer in-home or telehealth support services to homebound older adults.
  - Inpatient and residential treatment programs should create an environment that is easy for older adults to navigate. Facilities should be well lighted and accessible to individuals with disabilities, and should have other accommodations as needed for older clients.
  - Programs should modify design and delivery of services to accommodate vision, hearing, and mild cognitive problems that develop or increase in later life.
  - A slower program pace, repetition of information and instructions, and allowing time for clients to integrate and respond to information and questions can enhance their learning and participation in program activities.
- **Implement age-sensitive group treatment approaches to meet older adults' needs and preferences.** Older adults, regardless of gender, tend to be more private and concerned about how much personal information they will share in a mixed-age group setting. They may not relate to or feel comfortable sharing their problems with younger adults.[276]
- **Use age-sensitive adaptions if your program only has mixed-age groups:** Emphasize privacy/confidentiality, accommodate physical needs, establish group norms for respect, and ensure older adults' voices are heard by creating opportunities to share without pressure to disclose.
- **Work with older clients to explore pros and cons of age-specific and mixed-age groups, and honor their preferences** if possible in your program. Age-specific groups for older adults should focus on topics such as grief and loss, trauma, social isolation, social pressure to drink, life-stage and role transitions, and coping skills specific to older adults (e.g., strategies for coping with loneliness).
- **Match older adults to groups** based on availability, primary substance use concerns, age-related issues, and client preference. If possible, match older adults who have experienced trauma to gender-specific groups and those with chronic pain to groups that address pain and medication misuse.

The consensus panel recommends incorporating into your program age-sensitive and age-specific treatment practices that engage clients and improve retention in treatment. (See Chapters 4 and 5 for additional information on treatment of older adults for AUD and other SUDs, respectively.)

Help Older Clients Use Social Networks and Community-Based Services

Older adults in long-term recovery from SUDs demonstrate better outcomes when they have social supports that promote abstinence.[277,278] Social networks for older adults in recovery include caregivers, family, friends, faith-based communities, peer recovery support services, and mutual-help groups.

Older adults' social networks frequently narrow because of retirement, loss of spouses or friends, or reduced ability to engage in activities outside the home. This can increase some older adults' isolation and contribute to substance misuse.[279]

Assess older adults' current social networks. Help them improve and use social supports to reduce isolation and support recovery from substance misuse.

CASE MANAGEMENT SERVICES

Case and care management (CCM) services are often the keys to better outcomes, particularly for older adults with SUDs or co-occurring medical conditions or mental disorders.[280] The CCM provider helps clients gain access to healthcare, addiction treatment, mental health, social, financial, education, employment, and other community-based services. CCM services can be provided by a nurse care manager, social worker, addiction treatment or mental health counselor, or a peer recovery support specialist. Programs serving older adults should either provide CCM or actively link clients to a CCM provider who can connect older adults and their families to community-based resources and services.

The consensus panel recommends that SUD treatment programs help older clients connect with social networks that promote recovery. Use a CCM approach to link clients actively to community services.

Encourage Family and Caregiver Involvement

Involving caregivers throughout treatment and ongoing recovery enhances retention and improves treatment outcomes for people with SUDs.[281] Include caregivers (e.g., family members or guardians) in the entire treatment and recovery process, with the permission of the older client. Caregivers and family members can be essential partners in helping older adults participate fully in treatment and recovery activities. For example, they can assist older adults who have mobility challenges and cognitive impairments that make it difficult to follow treatment and recovery plans without support.

Educate caregivers about how substance misuse can affect older adults' physical and mental health, as well as their relationships. Include them in counseling sessions that focus on recognizing relapse triggers, improving communication, and teaching constructive problem-solving skills. This knowledge will help them more effectively support the recovery of your older clients.

Family members are often both caregivers and case managers for older adults with SUDs. The stress of this responsibility and resulting neglect of their self-care can put them at risk for developing SUDs, worsening chronic medical conditions, or increasing vulnerability to stress-related illnesses.[282] Help caregivers reduce their stress levels and maintain their own mental, emotional, and physical health.[283] Encourage family members to take care of their own emotional, mental, and health needs and participate in community-based supports such as caregiver groups.

The consensus panel recommends that, with older clients' consent, providers across service settings involve caregivers in all aspects of older clients' treatment and recovery.

Coordinate Care and Develop Service Linkages

Develop linkages to appropriate services and maintain ongoing relationships with other providers to coordinate care across settings for older adults with SUDs. Doing so will increase successful referral outcomes.[284] Coordinated care involves establishing and strengthening referral streams and partnering with community-based resources serving older adults (e.g., local Area Agencies on Aging).

Referring older clients to other services is not a once-and-done event. It requires actively connecting clients to appropriate providers or services (e.g., a "warm handoff" in which you make a referral to another agency in person with the client present) and following up with clients to ensure that referral was successful.

Care coordination and management are especially important for older adults with co-occurring medical or mental disorders. For example, a client with an SUD in a healthcare setting who screens positive for anxiety or depression should receive a referral for further assessment and treatment to a mental health service clinician experienced in working with older adults who have co-occurring disorders. Consider availability, accessibility, and client preferences when making referrals to other providers or community-based services. In addition, stay informed of available services. Treatment options within a given agency may change frequently.

RESOURCE ALERT: DEVELOPING REFERRAL RESOURCES

SAMHSA's Toolkit *GET CONNECTED: Linking Older Adults With Resources on Medication, Alcohol, and Mental Health* (https://store.samhsa.gov/product/Get-Connected-Linking-Older-Adults-with-Resources-on-Medication-Alcohol-and-Mental-Health-2019-Edition/SMA03-3824) addresses developing and actively linking to referral resources for alcohol misuse prevention and treatment among older adults.

The consensus panel recommends that you establish ongoing relationships with providers across services and community-based programs to ensure active linkage of clients to older adult services, healthcare professionals who specialize in geriatrics, addiction treatment services, mental health services, and recovery resources.

Make Programmatic Changes To Effectively Serve Older Adults With SUDS

Before administrators and clinical supervisors can focus on workforce development, they must establish their organizations' vision and commitment to making programs more accessible to older clients and to creating new or adapting existing programs to accommodate older adults' unique needs. **Start with an organizational self-assessment and change plan** that includes:

- A rationale for providing age-sensitive and age-specific services.
- An assessment of the organization's strengths and needs for improving services for older adults.
- A review of priorities, goals, and tasks to help develop or augment existing services for older adults.
- A plan for adapting facilities and programs to accommodate the unique needs of older adults throughout the continuum of care. This includes establishing age-sensitive and age-specific policies and practices for outreach, universal screening for substance misuse, and enhancing access and flow of clients through the continuum of care from screening to brief intervention and referral or admission to SUD treatment and continuing care.
- A plan for identifying and developing linkages to community-based resources serving older adults.
- A plan for involving staff, older clients, and members of older adult programs and recovery-focused organizations in the planning and implementation of services.
- Guidelines for implementing organizational change that describe roles, responsibilities, timeframes, and specific activities for each step of the change process.[285]

In addition, administrators need to be aware of state-level variance in policies and practices, which can dictate the parameters and limitations of a program's features and implementation process.

The consensus panel recommends that you do an organizational self-assessment and have a plan in place before implementing any organization-wide changes to policies and practices.

Invest in Age-Sensitive Workforce Development

To implement older adult-specific SUD treatment programs and services successfully, program administrators must **hire and retain highly motivated staff who are committed to serving older adults.** To ensure staff are knowledgeable and have the skills to care for older adults with SUDs, **engage in ongoing workforce development practices:**[286,287]

- Develop staff recruitment, retention, and promotion strategies that engage clinical and program staff who are knowledgeable about older adult health, mental health, and substance misuse and are motivated to work with this population.
- Recruit older peer recovery support providers and create a work environment that recognizes lived experience as a valuable source of knowledge.
- Develop pathways for integrating older peer recovery support providers into service teams and provide them with ongoing supervision and professional development opportunities.
- Create training plans and curriculums that address ageism, health disparities, and cultural diversity among older adults; the culture of aging; physical and mental health needs of older adults; and treatment practices and evidence-based approaches that are effective with older adults.
- Provide ongoing clinical and administrative supervision that emphasizes the attitudes, knowledge, and skills required to care for older adults.
- Evaluate staff performance on the attitudes, knowledge, and skills required to care for older adults.

The consensus panel recommends that you implement workforce development strategies for building or improving age-sensitive and age-specific treatment for older adults with SUDs.

Summary

The principles of care this TIP describes will support efforts to develop and improve age-sensitive and age-specific services for older adults with SUDs. The key to implementing these principles is to work collaboratively with staff, older clients, other providers, and community stakeholders to foster awareness and commitment to providing quality services to older adults and their families.

Chapter 2 Resources

Provider Resources

American Psychological Association (APA)—*Guidelines for Psychological Practice With Older Adults* (www.apa.org/pubs/journals/features/older-adults.pdf): These guidelines provide information on evaluating psychologists' readiness for working with older adults; this information is also applicable to other behavioral health service providers.

APA—*Multicultural Competency in Geropsychology* (www.apa.org/pi/aging/programs/pipeline/multicultural-competency.pdf): This report describes behavioral health service providers' multicultural competencies for working with older adults.

Council on Social Work Education—Gero-Ed Center (www.cswe.org/Centers-Initiatives/CSWE-Gero-Ed-Center.aspx): The center's website provides resources, educational materials, and a curriculum to enhance social work competencies, which apply to all behavioral health service providers caring for older adults.

Institute of Medicine (IOM)—*The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* (www.nap.edu/download/13400; download for free as a guest): The IOM provides this report as an overview of the eldercare workforce and workforce development barriers and needs. (IOM is now the National Academy of Medicine.)

Office of Minority Health—National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (https://thinkculturalhealth.hhs.gov/clas): These standards describe principles of culturally appropriate services applicable to treating culturally diverse older adults in healthcare and behavioral health service settings.

Understanding Issues Facing LGBT Older Adults (www.lgbtmap.org/file/understanding-issues-facing-lgbt-older-adults.pdf): This report from the Movement Advancement Project and SAGE helps providers and others better understand the social isolation and health challenges that affect many LGBT older adults.

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

KEY MESSAGES

- Behavioral health service and healthcare providers in any setting should screen older clients for substance misuse. Many different healthcare providers can play a role in this. There is no "wrong door" through which older adults can arrive at the right diagnosis and care.
- The main reason for screening and assessment is to help you decide whether, where, and how to address substance misuse.
- Substance misuse affects older adults differently than it does middle-aged and younger adults. Providers across settings should be trained in giving age-appropriate care. They also need to have the skills to recognize substance misuse in older clients.

Chapter 3 of this Treatment Improvement Protocol (TIP) will most benefit providers. It discusses identifying, screening for, and assessing substance misuse in older clients. In the United States and elsewhere, more and more people ages 50 and older struggle with substance misuse, but many providers do not screen for, diagnose, or treat substance use disorders (SUDs) among this population.

OLDER ADULTS are less likely to be screened for **SUBSTANCE MISUSE** and more likely to be taking **MULTIPLE** medications.

Older adults are less likely than younger adults to receive screening and assessment for substance misuse.[288] This is potentially dangerous because, as people age, they are more likely to feel the negative effects of drugs and alcohol. Older adults are also more likely to take multiple medications, which means they may face dangerous and potentially fatal drug–drug interactions. Furthermore, identifying substance misuse in older adults is not simple. The signs and symptoms of substance misuse can be easily mistaken for normal aging or physical or mental disorders common in older populations.

Even so, substance misuse is detectable and treatable among older adults. Yet if left untreated or poorly treated, it can shorten their lives and keep them from living healthily and independently. For example, substance misuse increases the risk of falls, cognitive impairment, overdose, heart disease, high blood pressure, certain cancers, HIV, hepatitis, cirrhosis, and mental disorders.[289,290]

This chapter of TIP 26 will help behavioral health service providers, social service providers, and other healthcare providers who work with older adults better understand how, when, and why to use screening and assessment to address substance misuse in their older clients.

Who Can Benefit From Chapter 3 of This TIP and How?

Chapter 3 will support behavioral health service and healthcare providers who work with older adults in overcoming barriers to identifying, screening for, and assessing substance misuse in older clients by helping these providers:

- Recognize early warning signs of substance misuse in older adults.

- Understand the relationship between substance misuse and depression, anxiety, trauma, and problems with thinking (also called cognitive impairment).
- Become more aware of common myths about substance misuse in older adults.

Who in the geriatric workforce should be identifying, screening for, or assessing substance misuse in older adults? Nearly everyone! The Institute of Medicine report *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?*[291] notes that the full range of providers should help meet the needs of older adults who misuse substances. These providers include:

- Mental health service and SUD treatment providers, including psychiatrists, psychologists, social workers, psychiatric nurses, and addiction counselors.
- Primary care providers, general internists, family medicine practitioners, trained pharmacists, advanced practice registered nurses, and physician assistants.
- Geriatricians, geriatric nurses, geriatric psychiatrists, geropsychologists, and gerontological social workers.
- Direct care workers who provide in-home support services.
- Peer recovery support service providers.
- Informal and formal caregivers.
- Supports within the faith community.
- Social service providers.

Chapter 3 will be useful across settings in which these workers encounter older adults. No single service provider or setting is solely responsible for making sure older adults receive the substance use-related care they need. However, all providers and settings can fulfill an important role.

Organization of Chapter 3 of This TIP

Chapter 3 offers a wide range of information and strategies to help you screen, assess, and treat older clients for substance misuse.

The first section of Chapter 3 is about the challenges to screening and assessing older clients for substance misuse. It also discusses why you need to screen and assess these clients. You will be more likely to use screening and assessment once you understand why they are so important. In the end, this will help your clients increase their chances for recovery.

The second section discusses how to screen for substance misuse in older adults. Screening for substance misuse also includes screening for co-occurring mental and neurocognitive disorders that can affect (and are affected by) substance use, such as depression, anxiety, posttraumatic stress disorder (PTSD), and dementia. Knowing why, how, and whom to screen for substance misuse and co-occurring mental or neurocognitive disorders will help you provide more complete care. It also increases the chances of clients receiving the correct diagnosis and needed treatment.

The third section describes how to use brief assessments—an important follow-up to screening—for clients who screen at risk for substance misuse and co-occurring mental or neurocognitive disorders. Brief assessment helps make or rule out diagnoses and aids you and your clients in making appropriate shared treatment decisions.

The fourth section describes how to fully assess older adults who screen positive for moderate-to-severe substance misuse. A full assessment does more than just ask clients about substance use. It also asks about their overall health and well-being. This will give you a more complete picture of your clients' substance-related issues and will help you understand how substance misuse affects them.

The fifth section guides providers in treatment planning, treating, or referring for treatment. Knowing how and why to screen and assess is only half the picture. Understanding what steps to take in offering effective care or referral for care is a cornerstone of good clinical practice.

The final section identifies targeted resources to support your practice, from screening to referral. A more detailed resource guide is available in Chapter 9 of this TIP.

For definitions of key terms you will find in Chapter 3 of this TIP, see Exhibit 3.1.

EXHIBIT 3.1. 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-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 alcohol use disorder (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.[292,293] 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.
- **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.[294,295] 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.[296] 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.[297] 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.[298]
- **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.[299]
- **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).
- **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.[300,301] 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.[302] 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.[303]

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- **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.[304]
- **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.
- **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).[305] Remission is an essential element of recovery.
- **Screening:** A process for evaluating the possible presence of a specific problem. The outcome is normally a simple yes or no.
- **Screening, brief intervention, and referral to treatment (SBIRT):** An evidence-based, comprehensive, integrated public health approach to identify, reduce, and prevent misuse of and dependence on alcohol and illicit drugs.
- **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,[306] 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).

Challenges to Identification, Screening, and Assessment

Some health experts have called older adults who misuse substances an "invisible" population.[307,308] Although older adults have frequent medical visits, behavioral health or healthcare providers often do not recognize substance misuse in their older clients.

Older clients are less likely than younger clients to tell you that they are having a problem with substance use and are less likely to ask for treatment.[309] Some barriers older adults face are unique to their population. **Older adults' substance misuse can stay "hidden" when:**[310]

- **Providers believe that older clients do not have alcohol or drug problems later in life.** ("Drug use is a young person's problem." Or, "No one starts abusing alcohol in their 60s.")
- **Providers have negative thoughts and attitudes about aging.** This is also called ageism. ("Talking about drugs and alcohol with someone who is older is a waste of time." Or, "He's 83 years old and has been drinking his whole life. He's never going to change, so why bother?" Or, "Older people are less likely to change or benefit from treatment.")
- **Providers feel uncomfortable talking about substance use and misuse** with older adults. ("Given his age, I don't want to be disrepectful or tell him what to do.")
- **Family members feel uncomfortable asking an older relative to stop using substances—** especially alcohol. ("I'd rather not ask Mom to stop drinking. I'd be taking away her one last pleasure in life.")
- **Providers lack knowledge** about drug and alcohol screening and assessment tools. ("I don't know the first thing about how to look for addiction problems in older clients.")
- **Providers and family members misunderstand the difference between symptoms of substance misuse and similar symptoms** of physical and cognitive decline or mental illness common in older populations. Such problems include dementia, pain, anxiety, and depression. ("At her age, it's normal to forget people's names. Drinking has nothing to do with it," or, "Dad's not depressed; he just lost his 'pep' in getting older.")
- **Providers believe that they don't have enough time** to give screening and assessment measures. ("I barely have time to see all my clients. There's just no time for screening and assessment.")
- **Older adults experience substance-related functional impairment,** which providers may have a hard time detecting in older clients who no longer work, drive, or have significant obligations to others professionally or at home.
- **Older adults seek services in nontraditional addiction treatment settings.**
- **Providers spend too little time with clients** (and older adults in particular).

To remove these barriers, providers need education and skills training aimed at helping them better recognize possible substance misuse in their older clients.

To spot substance misuse in older clients as early as possible, tailor your approach to working with them:

- Be aware of your beliefs about/attitudes toward older clients that make you not screen for substance misuse.
- Choose a method for drug and alcohol screening that you can use with all older clients.
- Use an interview style that older clients will find comfortable (e.g., supportive).
- Train counselors on how to spot substance misuse early.

Screening for Substance Misuse in Older Adults

Substance misuse is common among clients seen in healthcare[311] and behavioral health service settings. Although most older adults do not misuse substances, some do. Consider these facts, which show that **substance misuse does occur in older people:**

- In 2019, estimates showed that 4.7 million adults ages 50 and older had a past-year SUD.[312]

- In 2019, an estimated 8.8 million adults ages 50 and older reported using an illicit drug in the past month.[313]
- In 2019, more than 56 million adults ages 50 and older were estimated to have engaged in past-month alcohol use.[314]
- The rate of prescription opioid misuse among older adults (ages 60 and older) is lower than among younger adults (ages 20 to 59), but from 2006 to 2013, older adults increasingly misused prescription opioids with suicidal intent and showed an increasing trend in death rate.[315]

Know the different types of prescription medications older clients may misuse. These include:

- Sedative-hypnotics: These medications are often used to help people relax or sleep. They include barbiturates (like amobarbital and secobarbital) as well as benzodiazepines (like lorazepam and alprazolam).
- Opioid analgesics: These medications are often prescribed to provide pain relief by attaching to opioid receptors in the brain. Examples include oxycodone and hydrocodone.

Why, When, and How To Screen

The TIP consensus panel recommends that addiction treatment, other behavioral health service, and healthcare providers screen for alcohol, tobacco, prescription drug, and illicit drug use in all older clients at least annually. The TIP consensus panel recommends performing universal screening during health visits.

Screening and assessment are very important steps in diagnosing substance misuse and making the right care decisions. **Screening can help you answer the following important questions:**

- **Does my client need an assessment?** Although the two terms are often confused for one another, "screening" is not the same as "assessment."
- **Screening** is the process of evaluating whether symptoms of substance misuse are present. Screening helps you decide whether further assessment is necessary.
- **Assessments** give detailed information for diagnosis, treatment decisions, and treatment planning.
- **Is my client's substance use potentially harmful?** Screening can help you learn whether a client's alcohol or drug use could be harmful because of an existing condition or use of prescription medications. In some cases, any substance use at all may be harmful. Many older clients have chronic medical illnesses and take more than one prescription medication. Combining drugs and alcohol with medications can be dangerous and even lead to death. Drug and alcohol use can also make certain illnesses worse and keep clients from feeling their best.
- **Does my client seem afraid to ask for help?** Screening is necessary because older clients are less likely than younger clients to ask directly for help.[316] However, older adults are diverse, and older adults from the baby boomer generation (birth dates 1946 through 1964) may be more willing to discuss SUD and mental illness with their healthcare providers than earlier generations. Screening is helpful when clients feel afraid or ashamed of revealing their problem spontaneously.

SUDs are chronic conditions. You can help older clients feel less shame and stigma by talking about substance misuse in the same way you would a mental disorder, like depression or anxiety. Use basic terms rather than confusing or judgmental language. Be sure to also ask about their overall health, functioning, and well-being. This shows clients that you are concerned and feel empathy for them rather than making them feel like their substance use is a consequence of weak willpower or a personal flaw.

- **My client doesn't seem to meet diagnostic criteria for an SUD. Could this person still be misusing substances?** Screening is initially more useful than relying solely on DSM-5 diagnostic criteria. Most older adults who misuse substances do not meet full DSM-5 criteria for a specific SUD but may be engaging in risky use of substances. This is because several key criteria are not typically present in older adults.

For example, older adults have lower tolerance for substances like alcohol than younger and middle-aged adults and may experience harmful effects at lower amounts of consumption than younger adults. Compared with younger and middle-aged adults, older adults are significantly less likely to endorse the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) alcohol abuse criterion for alcohol use in "physically hazardous" situations.[317]

- **Does my client need SUD treatment?** Screening can lead to earlier treatment, and thus, better health.[318]

The U.S. Preventive Services Task Force (USPSTF) recommends that healthcare providers screen for unhealthy alcohol use in adults age 18 years or older and provide people engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use (www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryDraft/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions).

Chapter 3 will help you decide which screening tools to use, how and when to administer them, and who should do so. Every practice should select screening tools and develop procedures for who will give the screenings and when to give them. You can select screening measures based on which substances you want to ask about (Exhibit 3.2). Be aware that not all of these measures have been validated—in other words, tested and approved for use—in older adults. Your practice should also identify steps to take when screening tests are positive (see the section "Communicating Screening Results").

No screeners have been statistically validated for assessing prescription or over-the-counter (OTC) medication misuse that would identify accidental misuse or noncompliance issues. Nevertheless, healthcare and behavioral health service providers should assess how older adults use such medications, with an eye toward potential adverse reactions and interactions. **The American Geriatrics Society's 2019 Beers Criteria® address medications that are potentially inappropriately prescribed for older adults.**[319] See the Chapter 6 text box on the 2019 Beers Criteria®.

EXHIBIT 3.2. Drug and Alcohol Screening Tools

Alcohol:

- Alcohol Use Disorders Identification Test (AUDIT)
- Alcohol Use Disorders Identification Test-C (AUDIT-C)
- Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G)
- Senior Alcohol Misuse Indicator (SAMI)

Cannabis:

- Cannabis Use Disorder Identification Test-Revised (CUDIT-R)

Multiple substances:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Brief Addiction Monitor
- CAGE Adapted to Include Drugs (CAGE-AID)
- National Institute on Drug Abuse (NIDA) Quick Screen V1.0

Screen older clients for substance misuse at intake. Screen regularly, before starting new medication, and when potentially substance-related problems arise, such as injury or accidents. Have clinical assistants administer screening instruments in an interview or as part of other health screenings. **Provide a paper or digital tablet version for clients to complete by themselves. USPSTF recommends electronic screening and brief intervention as an effective strategy** to prevent excessive alcohol use.[320] Some older adults may not be comfortable using computers or tablets. Others may have difficulty reading or writing. Be sensitive to each client's skills and abilities when selecting screening formats.

Review screening results and discuss them with clients. Help clients understand their risk levels and the consequences of substance misuse. Gauge motivation and readiness for change. Keeping an open, nonjudgmental attitude will help your clients feel more comfortable sharing more information with you.

Make sure you have the required training and credentials or licensure before performing screening, assessment, or diagnosis. If no providers in your program have appropriate licenses or credentials to screen, assess, or diagnose clients for mental disorders, refer clients to another program for those needs. Also make sure you review the training requirements on administration and scoring; formal training may be required prior to using some instruments. When formal training is unnecessary, learn how to give each screening measure and assessment; instructions and scoring may vary depending on population demographic features and other factors.

Federal guidelines for moderate drinking are as follows:[321,322,323]

Overall consumption that minimizes risk and can help avoid alcohol-related problems includes:

- No more than one standard drink a day for women and no more than two standard drinks a day for men.
- These numbers apply to any given day and are not meant as an average over multiple days.

However, guidelines do not recommend that individuals who do not drink alcohol start drinking for any reason.[324]

Older adults should not drink any alcohol if they:

- Are taking alcohol-interactive prescription medications, especially psychoactive prescription medications (e.g., opioid analgesics, benzodiazepines).
- Have medical conditions that can be made worse by alcohol (e.g., diabetes, heart disease).
- Are planning to drive a car or participate in other activities requiring alertness and skill.
- Are recovering from AUD.

Substance Misuse Screening Measures Appropriate for Use With Older Adults

This section discusses examples of substance misuse screening instruments useful for older adults. A full selection of screening resources appears in the Chapter 3 Appendix. Many tools described here were developed specifically for older adults. Some are self-report tools (i.e., clients complete the tools themselves); a behavioral health service provider must deliver others. Older clients may have limited vision or difficulty writing and may need help completing screens.

Alcohol Screening

USPSTF recommends screening adults for alcohol misuse,[325] including screening for risky drinking and AUD **with brief instruments like the AUDIT-C.** USPSTF also recommends brief counseling for clients who engage in risky drinking.[326,327]

A very brief "prescreen," especially for alcohol misuse, can be easily incorporated into healthcare clinic or social service agency screening protocols. A short prescreen is not burdensome as a universal screening tool. However, many clients will be ruled negative for problematic use. If results are positive, more comprehensive assessments can be administered to determine severity and make treatment recommendations.

For more information about alcohol screening, see the "Screening and Assessment" section in Chapter 4 of this TIP.

AUDIT

The AUDIT was developed to screen for heavy alcohol use. It can reveal alcohol misuse in people ages 65 and older.[328] The first three AUDIT questions measure alcohol intake and are known as the AUDIT-C. Use the AUDIT or the AUDIT-C to get more detailed information from clients who use alcohol. The AUDIT has demonstrated reliability in studies of AUD screening.[329] The AUDIT (self-report version) and the AUDIT-C are available in the Chapter 3 Appendix.

SAMI

The SAMI[330] is a five-item questionnaire for older adults who may engage in risky alcohol use. This questionnaire includes a checklist of symptoms and open-ended questions about alcohol use.[331] A score of 1 or higher suggests problem alcohol use. The SAMI is available in the Chapter 3 Appendix.

SMAST-G

The SMAST-G is the first brief alcohol misuse screener developed for older adults. If a client marks two or more items on the SMAST-G with a "yes" response, that suggests potential alcohol misuse.[332] The SMAST-G is available in the Chapter 3 Appendix.

Cannabis Screening

CUDIT-R

The CUDIT-R[333] measures cannabis misuse in the past 6 months. Developed from the AUDIT measure, it is a short version of the 20-item CUDIT screener. A score of 12 or higher means you should assess for cannabis use disorder. Yet this cutoff score has not been tested thoroughly. Do not assume that a score below 13 means the client does not misuse cannabis.[334] The CUDIT-R is available in the Chapter 3 Appendix.

Screening for Multiple Substances

ASSIST

ASSIST screens clients for all categories of substance misuse, including alcohol and tobacco (see "Resource Alert: The ASSIST Screener"). This World Health Organization (WHO) screener also measures substance-specific risk. Many providers do not use the ASSIST because it is long and somewhat hard to score. A computer version and a shorter version (ASSIST-Lite; see https://eassist.adelaide.edu.au/#/eassist-lite for a computer version) are available and easier to use.[335,336,337]

RESOURCE ALERT: THE ASSIST SCREENER

The full version of WHO's ASSIST screener, scoring system, and client feedback guidance can be downloaded in multiple languages (www.who.int/substance_abuse/activities/assist_test/en).

Brief Addiction Monitor

The Brief Addiction Monitor is a 17-item scale originally made for the Veterans Health Administration healthcare system.[338] **It can indicate the severity of a client's substance misuse and show how people in treatment or recovery are doing.[339]** The Brief Addiction Monitor asks about risk factors for substance misuse (e.g., craving, family or social problems) as well as factors that protect against substance misuse (e.g., social supports for recovery, religion or spirituality). This instrument is available at www.mentalhealth.va.gov/communityproviders/docs/bam_continuous_3-10-14.pdf.

CAGE-AID

The CAGE (Cut down, Annoyed, Guilty, Eye opener) Questionnaire is widely used to screen for risk of alcohol misuse. A similar version, **the CAGE-AID,[340] asks about substance misuse.** A "yes" response on any of the questions can mean substance misuse is present. However, the CAGE-AID does not ask about certain important aspects of substance use, including past substance use, frequency of use, and effects of using the substance. The CAGE-AID should be used with, but not in place of, longer and more detailed alcohol and drug screeners. It is available at www.hiv.uw.edu/page/substance-use/cage-aid.

NIDA Quick Screen V1.0

The NIDA Quick Screen V1.0 is a brief screener that asks about a client's past-year use of alcohol, tobacco, prescription drugs (nonmedical use), and illegal drugs. If a client answers "yes" to the question about using illegal drugs, follow up by giving a slightly longer screening tool called the NIDA-Modified ASSIST V2.0. Both tools are available on NIDA's website (www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf).

Screening for Co-Occurring Disorders and Conditions

Co-Occurring Mental Disorders

Many older people who misuse substances also have co-occurring mental disorders. Some of these disorders, like major depressive disorder (MDD), anxiety, and PTSD, have symptoms similar to those seen in substance misuse and in cognitive impairment. You might at times have difficulty telling these conditions apart from one another. Co-occurring mental disorders can make substance misuse worse or result from substance misuse. You might be surprised to learn that:

- In 2019, approximately 1.7 million U.S. adults ages 50 and older had an SUD and a mental disorder.[341]
- Approximately 36.8 percent of adults older than age 50 with SUDs also have mental disorders, and 10.7 percent of adults over 50 with mental disorders also have SUDs.[342]
- SUDs in older adults often occur alongside depression and other affective disorders, psychosis, and cognitive disorders (e.g., dementia).[343,344]
- Older people with serious mental illness (SMI; complex mental disorders like bipolar disorders and schizophrenia) are especially likely to misuse substances compared with older adults without SMI,[345] but more research is needed. For example, of more than 7,000 adults ages 50 and older receiving inpatient services for SMI, 26 percent also met criteria for an SUD.[346] The most common SUD was for cocaine (9.5 percent).

In 2019, approximately **1.7M** Americans 50 and older were living with an SUD & a **MENTAL DISORDER.**

- **For older adults with both an SUD and a mental disorder, alcohol misuse and depression are a common combination.**[347] Having these two co-occurring disorders (CODs) may lead to negative physical and behavioral health consequences. For example, in a study of adults ages 65 and older who were receiving inpatient treatment for depression, those with co-occurring alcohol misuse had higher rates of drug use, liver disease, and suicidality than older adults with depression who did not also misuse alcohol.[348]

Be sure to screen older clients who misuse substances for co-occurring mental and cognitive disorders as well. Exhibit 3.3 indicates which screening measure to use by specific disorder, plus it lists a screening instrument for elder abuse. Older adults may also be at risk for negative outcomes, including:

- Increased mortality.[349]
- Increased risk of unintentional injuries leading to emergency department service use.[350]
- Increased risk of self-harm.[351] Older adult men are at especially high risk for suicide. Older adults with CODs may also have an increased risk of suicide attempt, but this requires more research.[352]
- Self-medication through substance misuse.

EXHIBIT 3.3. Screening Tools for Co-Occurring Mental and Cognitive Disorders

Co-occurring conditions in general	• Comorbidity Alcohol Risk Evaluation Tool (CARET)
Depression	• Geriatric Depression Scale (GDS)–Short Form • Patient Health Questionnaire-9 (PHQ-9)
Anxiety	• Geriatric Anxiety Scale (GAS) • Penn State Worry Questionnaire (PSWQ)
PTSD, trauma symptoms, and elder abuse	• PTSD Checklist for DSM-5 • Primary Care PTSD Screen for DSM-5 • Elder Abuse Suspicion Index© (EASI©)
Cognitive impairment	• Mini-Cog©

CARET

You can screen for CODs using the CARET, which was developed from the short version of the Alcohol-Related Problems Survey.[353] Research supports using the CARET with older adults[354,355] to identify those at risk for alcohol misuse. The CARET asks about alcohol-related risk factors and risky behaviors—many of which you may see in older clients. Such risk factors and risky behaviors include using alcohol while also:

- Having physical conditions negatively affected by drinking (like high blood pressure and diabetes).
- Having a history of falls or accidents.
- Having memory problems.
- Having trouble sleeping.
- Feeling sad or "blue."
- Taking medications that can be harmful when mixed with alcohol. These include arthritis and pain medications, depression medications, blood thinners, antiseizure medications, and sleep medications.
- Driving a car or other vehicle.

For more information about the items in the CARET and how to score them, please see Barnes et al., 2010.[356]

Depression Screening

Make sure to screen for depression. Depression is both a risk factor for and an outcome of substance misuse in older individuals.[357] Approximately 4.7 percent of adults in the United States ages 50 and older have depression.[358] MDD is commonly found in older clients who misuse substances.[359,360]

GDS–Short Form

One of the most commonly used depression screeners for older adults is the short form of the GDS[361] (Exhibit 3.4). Clients with a GDS score of 6 or higher need further assessment and may need treatment for MDD.[362] Clients with a GDS score below 6 should be screened again in 1 month if symptoms of depression are still present.[363] If a client's depressive symptoms are no longer present in 1 month, give the depression screener again in 6 months.[364]

EXHIBIT 3.4. Geriatric Depression Scale (GDS)–Short Form

Client Version

Client's Name: Date:

Instructions: Circle the best answer for how you felt over the past week.

1.	Are you basically satisfied with your life?	Yes	No
2.	Have you dropped many of your activities and interests?	Yes	No
3.	Do you feel that your life is empty?	Yes	No
4.	Do you often get bored?	Yes	No
5.	Are you in good spirits most of the time?	Yes	No
6.	Are you afraid that something bad is going to happen to you?	Yes	No
7.	Do you feel happy most of the time?	Yes	No
8.	Do you often feel helpless?	Yes	No
9.	Do you prefer staying at home, rather than going out and doing new things?	Yes	No
10.	Do you feel you have more problems with memory than most people?	Yes	No
11.	Do you think it is wonderful to be alive now?	Yes	No
12.	Do you feel pretty worthless the way you are now?	Yes	No
13.	Do you feel full of energy?	Yes	No
14.	Do you feel that your situation is hopeless?	Yes	No
15.	Do you think that most people are better off than you are?	Yes	No

Scoring Version

Client's Name: Date:

Scoring: Count boldface responses for a total score. A score of 0–5 is normal. A score of 6 or above suggests depression.

Instructions: Circle the best answer for how you felt over the past week.

1.	Are you basically satisfied with your life?	Yes	**No**
2.	Have you dropped many of your activities and interests?	**Yes**	No
3.	Do you feel that your life is empty?	**Yes**	No
4.	Do you often get bored?	**Yes**	No
5.	Are you in good spirits most of the time?	Yes	**No**
6.	Are you afraid that something bad is going to happen to you?	**Yes**	No
7.	Do you feel happy most of the time?	Yes	**No**
8.	Do you often feel helpless?	**Yes**	No

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9.	Do you prefer staying at home, rather than going out and doing new things?	**Yes**	No
10.	Do you feel you have more problems with memory than most people?	**Yes**	No
11.	Do you think it is wonderful to be alive now?	Yes	**No**
12.	Do you feel pretty worthless the way you are now?	**Yes**	No
13.	Do you feel full of energy?	Yes	**No**
14.	Do you feel that your situation is hopeless?	**Yes**	No
15.	Do you think that most people are better off than you are?	**Yes**	No

The Client Version and Scoring Version of the GDS–Short Form were both adapted from material in the public domain.[365]

PHQ

The nine-item PHQ-9 is commonly used to screen for depression in adults of any age.[366] **It is tested and approved for use with older clients.**[367] The PHQ-9 is also useful for monitoring depression severity and treatment response in clients who already screened positive for or are diagnosed with depression. The PHQ-9 is available via https://cde.drugabuse.gov/instrument/f226b1a0-897c-de2a-e040-bb89ad4338b9.

A two-item version of the PHQ-9 is available (the PHQ-2) that includes only the first two questions from the PHQ-9. However, compared with the **PHQ-9, the PHQ-2 has a higher likelihood of giving older adults a false positive** (that is, incorrectly rating a person as depressed when they are not).[368] To get more reliable results, you should give the full PHQ-9. If you give the PHQ-2, be sure to give the full PHQ-9 to older adults who have a total score of 3 or higher.[369]

Scoring: The total score for the PHQ-9 is derived by first summing each column (e.g., each item chosen in column "More than half the days" = 2), then summing the column totals. Total scores range from 0 to 27 and indicate the following levels of depression severity:

0–4: None-minimal
5–9: Mild depression
10–14: Moderate depression
15–19: Moderately severe depression
20–27: Severe depression

In addition to the total score, review responses to Question #9 (suicidality) and the unnumbered question below it (the effect of symptoms on the client's daily functioning) when determining whether to initiate or refer for further assessment and treatment.[370,371,372]

Screening for Anxiety

About 10 to 11 percent of older adults have had an anxiety disorder in the past year.[373,374] About 15 percent have had an anxiety disorder in their lifetime.[375] Older women may be especially at risk for anxiety. The number of women ages 55 and older with any anxiety disorder in the past year has been estimated to be almost double that of older men (about 14 percent versus nearly 8 percent).[376]

Anxiety is underdiagnosed in the older adult population.[377] Providers may view older clients' worries and concerns as a normal part of aging.[378] Older adults' symptoms of anxiety can also be mistaken for physical conditions common in older age, as well as depression.[379]

Yet different types of anxiety disorders can and do occur in older people. Some of these include:

- **Generalized anxiety disorder (GAD), panic disorder, and social phobia.**[380] In the National Comorbidity Survey Replication, the 12-month prevalence of GAD in people ages 65 and older was 1.2 percent.[381] In the same study, 0.7 percent of adults ages 65 and older had past-year panic disorder, and 2.7 percent had past-year social phobia.
- **PTSD.** Estimates of past-year PTSD prevalence for those 65 or older range from 0.4 percent to 2.6 percent.[382,383]

Symptoms of anxiety that are present but do not meet full criteria for an anxiety disorder are more common than full anxiety disorders. **As many as half, or possibly slightly more, of older adults in the community and in treatment settings may have anxiety symptoms.**[384]

It is not unusual for older people with anxiety to misuse substances, especially alcohol and tobacco:

- In the National Epidemiologic Survey on Alcohol and Related Conditions, adults 65 and older with any anxiety disorder in their lifetime had a 1.5 times greater chance of having a lifetime AUD, when compared with adults 65 and older without anxiety disorders.[385] They also had a 1.6 times greater chance of having a lifetime tobacco use disorder.[386]
- Among older people assessed for treatment for alcohol misuse,[387] the most commonly reported reason for using alcohol among women (24 percent) was "to reduce tension or anxiety." This was also the second-most-common reason reported by men (20 percent).
- Adults ages 55 and older with GAD in the past year were 2.2 times more likely to have had an SUD in the past year.[388] Adults ages 50 to 64 who had an anxiety disorder in the past year were 1.7 times more likely to have smoked cigarettes in the past year.[389]

A review of anxiety assessment tools created for or approved for use with older people[390] found the PSWQ and the Geriatric Mental Status Examination are useful and strongly supported by scientific evidence. The Geriatric Mental Status Examination is a somewhat lengthy semistructured interview, not a brief screening tool. For that reason, it is not included here. **Another valid and reliable self-report anxiety scale designed specifically for older people is the GAS** (Exhibit 3.5).[391] The original GAS has 30 items. A short form of only 10 items was developed and, like the full measure, was found to be valid for use in older people.[392]

Higher scores on the GAS indicate higher anxiety. More research in larger clinical samples is needed to determine the optimal cutoff score, although in the 30-item scale, a cutoff of 16 may be clinically useful.[393]

EXHIBIT 3.5. Geriatric Anxiety Scale (GAS)

Below is a list of common symptoms of anxiety or stress. Please read each item in the list carefully. Indicate how often you have experienced each symptom during the **PAST WEEK, INCLUDING TODAY,** by checking under the corresponding answer.

	Not at all (0)	Sometimes (1)	Most of the time (2)	All of the time (3)
1. My heart raced or beat strongly.				
2. My breath was short.				
3. I had an upset stomach.				
4. I felt like things were not real or like I was outside of myself.				
5. I felt like I was losing control.				
6. I was afraid of being judged by others.				
7. I was afraid of being humiliated or embarrassed.				
8. I had difficulty falling asleep.				
9. I had difficulty staying asleep.				
10. I was irritable.				
11. I had outbursts of anger.				
12. I had difficulty concentrating.				
13. I was easily startled or upset.				
14. I was less interested in doing something I typically enjoy.				
15. I felt detached or isolated from others.				
16. I felt like I was in a daze.				
17. I had a hard time sitting still.				
18. I worried too much.				
19. I could not control my worry.				
20. I felt restless, keyed up, or on edge.				
21. I felt tired.				
22. My muscles were tense.				
23. I had back pain, neck pain, or muscle cramps.				
24. I felt like I had no control over my life.				

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	Not at all (0)	Sometimes (1)	Most of the time (2)	All of the time (3)
25. I felt like something terrible was going to happen to me.				
26. I was concerned about my finances.				
27. I was concerned about my health.				
28. I was concerned about my children.				
29. I was afraid of dying.				
30. I was afraid of becoming a burden to my family or children.				

GAS Scoring Instructions

Items 1 through 25 are scorable items. Each item ranges from 0 to 3. Each item loads on only one scale. Items 26 through 30 are used to help clinicians identify areas of concern for the respondent. They are not used to calculate the total score of the GAS or any subscale.

Total Score = sum of items 1 through 25.
Somatic subscale (9 items) = sum of items 1, 2, 3, 8, 9, 17, 21, 22, 23
Cognitive subscale (8 items) = sum of items 4, 5, 12, 16, 18, 19, 24, 25
Affective subscale (8 items) = sum of items 6, 7, 10, 11, 13, 14, 15, 20

The PSWQ[395] is a self-report instrument with 16 items, each rated on a 5-point scale. Items 1, 3, 8, 10, and 11 are reverse scored as follows:

- Very typical of me = 1 (circled 5 on the sheet)
- Circled 4 on the sheet = 2
- Circled 3 on the sheet = 3
- Circled 2 on the sheet = 4
- Not at all typical of me = 5 (circled 1 on the sheet)

The remaining items are scored regularly. The item scores are added to produce a total score ranging from 16 to 80, with higher scores reflecting more worry. **A score of 50 or higher by an older person could mean significant worries are present,** but research on cutoff scores in older people is too limited to know for certain.[396] Do not assume that an older client who scores below 50 does not have anxiety. The PSWQ is available in the Chapter 3 Appendix.

Screening for PTSD, Trauma Symptoms, and Abuse

People with PTSD are at high risk for substance misuse.[397] People with PTSD may use substances to help themselves cope and feel better. Even if a person does not meet criteria for PTSD, experiencing a traumatic event at any point in one's life raises the risk for substance misuse.[398,399] As with any other clients, explore whether older clients have a history of trauma.

About 52 percent of people 50 and older have had at least one adverse childhood experience,[400] such as sexual abuse, physical abuse, neglect, or extremely stressful family events including:

- Seeing the abuse of a family member.
- Living in the home with someone who misuses substances or has a mental disorder.
- Experiencing the death of a parent or abandonment by one's parents.

- Having a household member in the criminal justice system.

PTSD in older adults is not very common. Past-year PTSD occurs in only about 0.4 percent to 2.6 percent of people ages 65 and older.[401,402] Many people with trauma do not meet criteria for PTSD but do meet criteria for depression.[403] **Thus, depression screening is important in older clients who misuse substances.**

Trauma in older clients can include being a current victim of elder abuse. According to CDC, 1 in 10 adults (ages 60 or older) who live at home is a victim of elder abuse each year.[404] Elder abuse can manifest as emotional (or mental) abuse, financial abuse (or exploitation), physical abuse, sexual abuse, and neglect.[405] Of women over age 65, 20 to 30 percent have been victims of intimate partner violence.[406] Older adults who experience abuse are more likely to:[407]

- Have depression or anxiety.
- Have thoughts of suicide.
- Attempt suicide.
- Need emergency department care.
- Be hospitalized.
- Die prematurely.

Some research shows that older adults from minority ethnic or racial groups may be more likely to experience abuse.[408] The most recent nationally representative study of elder abuse found that lack of social support is a primary risk factor for experiencing elder abuse and for having negative outcomes following such abuse.[409] Cognitive disorders are a major risk factor for experiencing abuse. Older adults with dementia are almost five times more likely to be victims of abuse as older people without dementia.[410]

Ask all older clients with ongoing or past substance misuse about their history of trauma, including trauma in childhood and current trauma. Be sure to ask about any current abuse, including intimate partner abuse. Use brief screening measures to further explore these areas. Screening for trauma and abuse in older clients is important, as older adults with PTSD may have different or milder symptoms than younger clients. PTSD can thus be harder to recognize in older people.[411]

Trauma is a sensitive topic for many clients. You need to know not just what to ask but how to ask it. Otherwise, clients might "shut down" or feel uncomfortable sharing private details with you. Some tips to help you assess trauma fully but in a gentle, sensitive manner include the following:[412]

- **Remind the client you are there as a support.** Explain what will take place during and after the screening and assessment so that the individual knows what to expect.
- **Use screening and assessment tools that have been well researched and approved for use with older adults.**
- **Remember that trauma can come in many forms.** Use a checklist or question list to make sure you cover all possible traumas and not just ones that are commonly thought of (like physical and sexual abuse). You can find more information about Adverse Childhood Experiences (ACEs) on the CDC's website (www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html).
- **Tell clients that they can answer whichever questions they wish, however they wish.** If they choose to only partly answer a question, that's okay. If they choose not to answer a question at all, that's also fine.
- **Remind them that they are safe.** Sometimes talking about a trauma can feel scary, as if the traumatic event is happening again. You don't want clients to feel that talking about their trauma is dangerous. This could lead them to avoid talking about it altogether, and that is not helpful.
- **Do not ask clients to "relive" their trauma by describing it in detail.** Let your clients answer questions about their trauma in the ways that are most comfortable to them. There's no "right or wrong way" for them to talk about their experiences.
- **Ask how the client's trauma symptoms affect functioning.** This includes ability to complete daily activities, engage in self-care, and maintain intimate relationships and a healthy social life.
- Screen clients with histories of trauma for CODs and suicide risk.
- Some people naturally feel more comfortable sharing information in writing than verbally.

Have paper-and-pencil or computerized self-report trauma measures on hand for clients who would rather not take part in a clinical interview.

- **Share resources and information with clients** as needed to keep them safe and feeling supported.
- **End positively.** After assessment, ensure that the client feels safe and ready to leave the session.

PTSD Checklist for DSM-5

The PTSD Checklist for DSM-5 (PCL-5; Exhibit 3.6) is an updated version of the widely used and researched PTSD Checklist (PCL), which was based on DSM-IV criteria. Not much research has yet been conducted on the use of the PCL-5 with older adults. The PCL-5 has been used to screen for PTSD in some studies of older veterans,[413,414,415] but these studies were not designed to look at the validity of the PCL-5 in aging populations. More research is needed in this area.

The optimal PCL-5 cutoff score in older adults is unclear. One study of Vietnam veterans (thus, mostly older men) found a PCL-5 score of 37 made the best cutoff for PTSD screening.[416] The Department of Veterans Affairs (VA) instructions on the PCL-5 (www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp) note a cutoff score of 33 as "reasonable" to use until further research is published on the best cutoff scores in different groups of people (such as veterans versus civilians).[417] The VA warns that cutoff scores from the original PCL and those for the PCL-5 are neither equal nor interchangeable given that the PCL-5 contains changes in rating scales and number of items. **You should not use PCL cutoff scores when interpreting scores from the PCL-5.**

EXHIBIT 3.6. PTSD Checklist for DSM-5 (PCL-5)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem **in the past month**.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4

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In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4

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In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Reprinted from material in the public domain.[418] A digital, fillable form is available online (www.ptsd.va.gov/professional/assessment/documents/PCL5_Standard_form.PDF).

Primary Care PTSD Screen for DSM-5

The Primary Care PTSD Screen for DSM-5[419] (PC-PTSD-5) is a five-item questionnaire that identifies clients likely to have PTSD. It was approved for use in a sample of older veterans (mostly male; mean age 63 years).[420] All questions are yes/no. A score of 3 or more "yes" responses is considered positive.[421] More information on using this tool is available online (www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf). The PC-PTSD-5 is available in the Chapter 3 Appendix.

Elder Abuse Suspicion Index©

The Elder Abuse Suspicion Index©[422] is a six-item yes/no questionnaire. You should ask the client Questions 1 through 5. You can answer Question 6 yourself. Questions apply to the last 12 months. A "yes" response on one or more questions (other than on Question 1) is considered a positive screen. This measure appears in the Chapter 3 Appendix.

Screening for Co-Occurring Cognitive Disorders

You should also screen older clients who misuse substances for cognitive impairment, which includes dementia and mild cognitive impairment (MCI). **Dementia** is a brain disorder affecting mental ability and personality that gets worse over time. Several types of dementia exist, such as Alzheimer's (the most common form) and Parkinson's dementia. People with dementia have difficulties in at least one area of thinking, such as memory, learning, language, or attention. These difficulties make it hard for people to live their everyday lives without help from others (e.g., needing help getting dressed, bathing, feeding themselves, or managing their money). Current research suggests almost 9 percent of Americans ages 65 and older have dementia.[423] That includes over 3 percent of people ages 65 to 74, roughly 10.5 percent of people ages 75 to 84, and almost 30 percent of people ages 85 and older.[424]

MCI is a milder form of cognitive impairment that often represents early brain changes that may precede and lead to dementia. In MCI, deficits in thinking from a previous level of performance are present but are not severe enough for a person to need help from others in their everyday life. A person with MCI is at increased risk of developing Alzheimer's or another type of dementia. About 10 percent to 20 percent of adults in the United States ages 65 and older have MCI, with the likelihood increasing with age.[425,426,427] (Chapter 6 of this TIP provides more information about cognitive disorders and older adults who misuse substances.)

Substance misuse, especially heavy alcohol use, can negatively affect thinking. Keep in mind that:

- Heavy alcohol use can harm the brain, heart, liver, and other organs.[428,429]
- Alcohol's negative effects on the brain can lead to memory problems, difficulty learning new information, and difficulty thinking quickly.[430,431,432]
- Heavy alcohol use can also cause brain cells and tissues to shrink or no longer work properly.[433]
- In some people, even moderate alcohol use can harm the brain.[434]
- Heavy drinking may do more harm to older adults' cognitive abilities than those of younger adults.[435]

Less research has been done on how substances other than alcohol can affect one's chances of having a cognitive disorder like dementia or MCI. However, **the long-term use of benzodiazepines,[436,437,438] cannabis,[439,440,441] cocaine,[442] and tobacco does seem to carry a somewhat greater risk of cognitive problems.[443]**

Mini-Cog©

The Mini-Cog© is a brief screening tool that was created to detect dementia in older adults. It takes about 3 minutes to complete and involves a verbal memory task and a clock drawing task. The Alzheimer's Association endorses using the Mini-Cog© in primary care settings to screen for cognitive impairment, and the National Institute on Aging lists it as an instrument to consider using for this purpose.[444,445] Several reviews have found the Mini-Cog© to have acceptable-to-good test characteristics (e.g., sensitivity, specificity, negative predictive value), although research suggests that it is better at detecting dementia than MCI.[446,447,448]

The Mini-Cog© and its administration and scoring instructions are freely available to individual clinicians at https://mini-cog.com/mini-cog-instrument/standardized-mini-cog-instrument. Two brief screening tools for cognitive impairment that have been more widely administered—the Montreal Cognitive Assessment (which was created to screen for MCI) and the Mini-Mental State Examination—now have costs associated with their use.[449,450]

Communicating Screening Results

Knowing what to do after screening is as important as knowing why and how to screen in the first place. Whether negative or positive, you should **inform all clients of their screening results.** Read further to learn the specific steps to take next, which will differ based on the client's screening results.

Negative Results

No formal intervention is needed for people who screen negative. Instead:

- **Acknowledge clients who are substance free.** ("I see that it's important to you not to smoke.")
- **Offer positive comments about the benefits of drug- and alcohol-free living.** ("You know, people who don't smoke generally live longer, healthier lives than people who do.")
- **Reinforce attitudes, behaviors, and strategies that promote health.** Think about asking whether their lack of substance use is new or lifelong, or whether it is because they are in recovery. ("Not drinking is a healthy decision. What made you decide not to drink?")

For older adults who screen negative or at low risk for substance misuse, be sure to:

- Use positive language to urge them to continue using substances appropriately.
- Give brief education, such as reminding them of low-risk alcohol intake levels for older adults.
- Continue monitoring them for future signs and symptoms of possible at-risk substance use.

Even if a screener is negative, the TIP consensus panel recommends that you occasionally rescreen clients. Why is that necessary? Because substance use can change over an individual's lifetime. Substance use patterns can also change with life events, cognitive functioning, and mental health status.

No clear scientific data indicate exactly how often you should rescreen clients. The TIP consensus panel recommends that you use your clinical judgment to determine how often to rescreen. You might consider screening more often (at least once a year) if the client has repeatedly requested prescription drugs or has certain conditions, such as:

- Physical conditions that are often alcohol or drug related (e.g., high blood pressure, insomnia).
- Diabetes or ulcers unresponsive to treatment.
- Staph infection on face, arms, or legs.
- Repeated fractures, lacerations, or burns.
- Depression.
- Unexplained weight loss.
- Frequent falls.
- Repeated trauma suggesting domestic violence.
- Sexually transmitted diseases.

When doing an SUD screen, if the depression screener is negative but the client has some symptoms of depression, you will want to give another depression screen in 1 month. Symptoms to look for include low mood, difficulty making decisions, loss of interest in pleasurable activities, and feelings of hopelessness. You should continue to monitor the client's symptoms over time. You may want to give another depression screen earlier if the client reports worsening symptoms or if the client seems to be feeling worse. **If the depression screen is negative and the client has few or no symptoms of depression, you can continue screening on a yearly basis.** If the client reports new symptoms or you suspect the person may be feeling depressed at any time, you should give a depression screener again.

When doing an SUD screen, if trauma or elder abuse screeners are negative, continue with routine clinical care. Rescreen any time you suspect that trauma or abuse has occurred. For instance, if a client reports disagreements with her husband and has visible bruises, screen for possible abuse.

You can also give a substance-related, depression, or trauma screener again if the client experiences major changes that could lead to substance misuse, depression, anxiety, or PTSD. Such changes include the death of someone significant to the client, a transition to an assisted living residence or nursing home, or retirement.

Positive Results

For clients who screen positive for potential substance misuse, three possible approaches exist. These are based on the severity of the problem and possible risk of having substance misuse. (None of the three approaches listed below is appropriate for an intoxicated client, who may need an immediate and specific response [e.g., referral to detoxification].) The three approaches are:

- **Immediately give a brief assessment** during the same visit in which you gave the screening measure. (See the section "Conducting Brief Assessments and Interventions" below.)
- **Give a full assessment** if the screening results are unclear. You may need to schedule another visit for this longer assessment.
- **Refer the client to another provider for assessment.** Refer high-risk clients to a program where specialized SUD treatment services are available, if possible.

If a cognitive screener is positive, you should refer the client for further testing by a behavioral health service provider with special training in diagnosing clients with dementia and MCI. Making such diagnoses requires additional, indepth cognitive testing. Do not give a diagnosis of dementia or MCI based solely on a positive cognitive screen.

If a depression, anxiety, PTSD, or trauma screener is positive, give a full assessment using DSM-5 diagnostic criteria to determine whether a disorder is present (or refer the client for further evaluation if you do not have the training and credentials to make a mental disorder diagnosis).

This may mean giving a full diagnostic interview, perhaps at another appointment. Even if full diagnostic criteria are not met, the client may still benefit from treatment if symptoms are upsetting or interfere with daily living.

If an elder abuse screener is positive, follow your state's laws on reporting suspected abuse. Unless you work in private practice, you first need to contact your immediate supervisor to ensure that you are following program procedures and abiding by state laws. You may need to consult with social services or Adult Protective Services on next steps. The Department of Justice provides a list of online resources to help you learn your state's laws about reporting abuse and involving Adult Protective Services (www.justice.gov/elderjustice/elder-justice-statutes-0). The National Center on Elder Abuse links to state-specific reporting numbers and other agencies (https://ncea.acl.gov/Resources/State.aspx). Make sure you are familiar with these laws and resources before giving abuse screeners so that you can act right away if a screener is positive.

Present the results of positive screens to clients in a gentle manner. For example, you might say, "After reviewing your answers on the screening questionnaire, there are some things I'd like to follow up on with you," or, "Your answers are similar to the answers of people who may be having a problem with alcohol."

Conducting Brief Assessments and Interventions

Positive screens for substance misuse require follow-up, but next steps may not be immediately clear. Decisions about follow-up care depend on how much time and effort you can expend, how much training and experience you have in drug and alcohol counseling, and your program's treatment abilities. Also essential are the client's agreement, engagement level, and preferences.

Starting Off on the Right Foot

A successful assessment starts by creating a welcoming environment. This is key to helping older clients "open up" and feel safe talking about substance misuse. You can do this by keeping a gentle, respectful, and empathetic attitude. Many clients who misuse substances feel uncomfortable talking about their substance use in medical settings. A friendly, nonjudgmental atmosphere can put clients at ease and help them share information they may find embarrassing, like feeling depressed or being abused.[451] Using motivational interviewing approaches, such as asking open-ended questions, is more helpful than asking basic yes/no questions.[452] (See the Substance Abuse and Mental Health Services Administration's [SAMHSA] update of TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* [https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003]).

> **What is motivational interviewing (MI)?** Per SAMHSA, it is a clinical approach to helping clients make positive changes in their behavior. MI involves techniques like showing concern and empathy, avoiding arguing, and supporting a client's self-efficacy (a person's belief that he or she can successfully make a change).

Keep in mind that almost all clients will have mixed feelings about their substance use. They will find some aspects of it pleasant and beneficial but other aspects difficult, painful, or harmful. You can help clients discover their own reasons for wanting to change by talking about these mixed feelings and pointing out problem areas.

SAMHSA's TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse,* offers more guidance on how to make assessment and interviews successful.[453]

Looking for a simple way to help clients "open up"? Avoid asking yes/no questions. Open-ended questions are more thought-provoking and help clients share their own experiences in a more meaningful way. Start by asking broad questions about a client's health in general, such as:

- "How would you rate your health overall?"
- "Compared with other people your age, how would you say you are doing?"
- "What health problems do you have?"

Next, move into more specific questions about the client's substance misuse. Try asking questions like:

- "What concerns do you have about your alcohol use?"
- "In what ways might your life be different were you not using tobacco?"
- "How has using opioids affected your relationships?"

Questions that can be answered with a simple "yes" or "no" can seem harsh or judgmental. Older clients might already feel ashamed and uncomfortable talking about their substance use. Closed-ended questions could make those feelings even worse and cause clients to "shut down." On the other hand, open-ended questions can help clients become aware of and express their own experiences and motivations related to substance use.

Brief Assessments

If a client's screening results show mild substance misuse, conduct a brief assessment to get more information. Assessment questions should cover:

- The severity of substance use (including what, how often, and how much the client uses).
- The types of problems connected with the client's use.
- The frequency of problems that occur with the client's use.
- Other special physical and mental factors (e.g., whether a mental or physical disorder is present that could be making the person's substance-related symptoms worse).

If the client's responses suggest an SUD diagnosis per DSM-5 criteria, you should conduct or provide a referral for an indepth assessment. However, you can give a brief outpatient therapeutic intervention if:

- Only mild or mild-to-moderate substance misuse is present.
- The client appears to be at risk for harm because of current substance use.
- Co-occurring illnesses or conditions may be made worse by continuing to drink or use drugs.
- The client declines referral for further assessment or treatment.

Brief Interventions: SBIRT

SBIRT is an approach to providing brief interventions after screening, referrals for further assessment, or treatment. SBIRT approaches are focused on getting clients into treatment early. They include:

- **Screening** for possible substance misuse and level of risk.
- **Offering a brief outpatient intervention** to help clients understand the need to change their substance misuse and help them increase their desire to change.
- **Referrals** to SUD treatment programs or mental health services for clients who need more indepth assessment or intervention.

Behavioral health service and healthcare providers can easily **incorporate brief interventions into standard practices.** Brief interventions:

- Give you the chance to:
  - Explain screening results to clients.
  - Provide information about low-risk substance use.
  - Give advice about changing substance misuse habits.
  - Assess clients' desire for change.
  - Work with clients to set goals and strategies for change.
  - Figure out how best to make sure clients are sticking with their treatment plan.

- Are usually only 10 to 15 minutes long and include a limited number of sessions.
- May require at least one follow-up visit. However, even more follow-up sessions may be needed depending on the setting, the severity of the substance misuse, and clients' responses.
- Are usually inexpensive and quick to conduct.

Most older adults at risk for substance misuse do not need formal specialized SUD treatment. However, many clients can benefit from education to prevent problems before they occur. They can also benefit from SBIRT techniques. For instance, SBIRT that involves basic education as an intervention has been shown to help reduce older adults' risky alcohol use.[454,455] Educate clients on risky alcohol use as a prevention measure and an intervention. Boston University School of Public Health provides helpful information and resources (e.g., demonstration videos) on screening and brief intervention techniques successfully used in primary care and emergency department settings (www.bu.edu/bniart/sbirt-in-health-care/sbirt-brief-negotiated-interview-bni/).

Why do your clients want to change their substance misuse? Knowing the answer to this question is more useful than just knowing whether clients are ready to change. Helping clients explore their reasons for wanting to change their substance use can help them feel more positive and confident about making this change. It also helps better support them during assessment and treatment. It is okay if the reasons for change are initially attributable to outside forces rather than the clients' own desires. Clients pressured into treatment—such as through parole and probation or drug courts—are as or sometimes more likely to succeed in treatment as clients who enter on their own.[456]

SBIRT services must meet the special age-related needs of older adults to give them the greatest chance for success (Exhibit 3.7). You can make your SBIRT services age sensitive by:

- **Using supportive language** in your discussions so that older clients do not feel shame or fear.
- **Using clear, basic terms** with older clients rather than confusing terms or medical language.
- **Sharing information that is specific to older clients,** such as guidelines about low-risk levels of substance use for older adults or physical effects of substance misuse.
- **Including strategies and materials that are culturally sensitive** to clients and to the unique issues that older adults face. For example, your older adult clients may be:
  - Worrying about not being able to live independently, without help from others.
  - Coping with grief (over loss of a partner, spouse, child, or another significant person).
  - Adapting to major life changes, like retiring or moving into an assisted living residence.
- **Thinking about the role of chronic physical conditions in older clients' misuse of substances** (e.g., use of substances to manage chronic pain). Such conditions can also affect symptoms of substance misuse and treatment response.
- **Using tailored screening and assessment measures** that were made specifically for older adults or are approved for use with them.
- **Giving interventions that meet older clients' needs.** For instance, if possible, in-home treatment is helpful if clients cannot travel to your program.
- **Keeping referral information on hand** about local providers who specialize in addiction treatment and are skilled at working with older adults who misuse substances.

EXHIBIT 3.7. Successfully Applying SBIRT Principles to Older Adults

The Florida Brief Intervention and Treatment for Elders (BRITE) pilot project[457] was funded by the Center for Substance Abuse Treatment and modeled on SBIRT. In this program, older adults who screened as needing a brief SUD intervention received:

- **Education** to help reduce substance misuse, develop healthier habits, and improve quality of life.
- **MI** to increase their desire to change substance misuse-related behaviors.
- **Age-appropriate information** designed to address high-risk situations, coping with urges to use substances, and preventing return to substance misuse.

Results from the program were positive.[458] Specific outcomes included the following:[459]

- Clients who completed the program had lower SMAST-G scores.
- At the end of the study, nearly 30 percent of clients in the BRITE program had fewer flags in their medical chart for prescription medication misuse.
- People in the BRITE program had large decreases in depression (measured by the GDS) and suicide risk scores.
- The number of older adults getting treatment in the program was three times greater than the number who were getting SUD services before BRITE began.

RESOURCE ALERT: DESIGNING AND IMPLEMENTING SBIRT PROGRAMS FOR OLDER ADULTS

SAMHSA's *A Guide to Preventing Older Adult Alcohol and Psychoactive Medication Misuse/Abuse: Screening and Brief Interventions* is a manual to assist addiction treatment providers and administrators in designing, implementing, and delivering screening and brief intervention programs to prevent substance misuse in older adults. It is available online (www.ncoa.org/wp-content/uploads/SBIRT-Older-Adult-Manual-Final.pdf). SAMHSA has other resources to help you integrate SBIRT into your program (www.samhsa.gov/sbirt/resources).

The National Council on Aging also offers an instruction manual and workbook for effective screening and brief intervention strategies for risky alcohol use in older adults (www.ncoa.org/wp-content/uploads/BI_OlderAdults_ImplementationManual.pdf).

Conducting Full Assessments for Substance Misuse

Conduct a full assessment for any client whose screening suggests moderate-to-severe substance misuse. Full assessments gather not just substance-related information, but information about overall functioning and health (Exhibit 3.8). This information will help you differentiate among substance misuse, CODs, physical conditions common in older populations, and symptoms of normal aging. Common physical conditions and symptoms of normal aging that can be confused for substance misuse include low energy, memory changes, sleep problems, and decreased appetite.

EXHIBIT 3.8. Key Objectives of a Full Assessment for Substance Misuse

Key objectives of giving a full assessment for substance misuse can include:

- Getting older clients' substance use history (including prescription and OTC medications).
- Checking clients for CODs that can affect substance misuse, such as depression, anxiety, and PTSD.
- Checking clients for other trauma or abuse.
- Learning older clients' physical conditions and physical and medication history. This is especially important for physical conditions that can lead to or result from substance misuse, like sleep problems and pain.
- Asking about social supports available to older clients who misuse substances.
- Referring clients with cognitive problems for a full cognitive assessment by a neuropsychologist or neuropsychiatrist to see whether dementia, MCI, or delirium is present.
- Understanding clients' unique substance misuse. This means asking them about:
  - When and with whom they misuse substances.
  - Why they misuse substances.
  - How misusing substances fits into their life.
  - How they feel and what they believe about their misuse of substances.

Full assessments often involve several members of the care team, depending on the setting and available resources of your program. Which care team members contribute to the full assessment depends on the qualifications and level of expertise needed to address the client's problems. For instance, the assessment may start with a certified drug and alcohol counselor or other licensed provider taking a complete psychosocial history. Other licensed providers may need to complete a psychological evaluation (e.g., if the intake interview is given by someone not licensed to diagnose mental disorders) and look for withdrawal indicators or educate the client on the need for medical withdrawal. A medical staff member may take a medical history and perform a physical exam. Nurses or occupational therapists, rather than behavioral health service providers, usually give assessments of ADLs and fall risk. If your program does not have any medical staff members, you should refer clients elsewhere for this part of the assessment. A physician, nurse, or pharmacist may be consulted to determine risk for medication misuse, whether accidental or intentional.

Determining risk for medication misuse involves reviewing the client's:

- Current prescriptions and OTC medications.
- Management of these medications.
- Ability to obtain prescriptions (referring to cost as well as accessibility).
- Potential adverse reactions to medications.

Full assessments help the treatment team:

- **Make the right diagnosis** (whether it be an SUD, a mental disorder, or a cognitive disorder).
- **Learn the severity** of the substance misuse.
- **Guide treatment planning,** including giving clients the right level of care in the right setting.
- Decide whether medical conditions are present that need to be addressed during treatment.
- Decide whether other conditions are present that need to be addressed during treatment.

The Assessment Process

A complete assessment has several parts. These include:

- Full mental health, medical, family, vocational, social, sexual, financial, legal, substance use, and SUD treatment histories.
- A health history and physical exam for common co-occurring physical conditions that affect mental health as well as physical conditions that suggest the client has substance misuse (e.g., sleep problems, chronic pain). This part of the assessment also sometimes includes biological screening measures, like urine screens (for benzodiazepines and opiates), breath alcohol testing (i.e., breathalyzer), and laboratory tests. Medical professionals should also check

the Prescription Drug Monitoring Program for additional information about clients' prescribed medications.

- Further assessment for CODs. Sometimes referral to an outside provider (e.g., licensed psychologist, clinical social worker) is needed, depending on the expertise of the staff members in your program.
- Assessment of skills used in everyday living, like dressing, bathing, shopping, and managing money.
- Assessment of the client's fall risk. (For example, see the CDC's fall prevention program, "Stopping Elderly Accidents, Deaths, and Injuries," at www.cdc.gov/steadi/.)
- Assessment of the client's basic needs (e.g., housing, nutrition), support network, and strengths/resources.

The most important parts of your full assessment are gathering information about the client's substance use, mental health, physical health, and SUD treatment histories, as well as a listing of prescribed and OTC medications. It may take multiple visits to complete the assessment. Clients will feel safe sharing detailed information as their trust in you builds.

The following sections describe some of the most common parts of a full assessment, targeting only those parts that are most appropriate for older clients who misuse substances. The sections do not cover questions about a client's recreational, military, occupational, or avocational/retirement history.

The section on health history and the physical exam discusses disordered sleep and pain because these are common physical conditions seen in older people who misuse substances. But other health and physical assessments may be needed beyond what is listed in that section.

Make sure you have the required training and qualifications before assessing for or diagnosing SUDs. If no providers in your program have the necessary licenses and qualifications to assess for and diagnose mental disorders, make referrals as necessary to providers who can do so.

Health History and Physical Exam

Taking a complete physical history of clients is very important. Asking about clients' physical history can help you learn about:

- **The medical effects of their substance use** (e.g., soft tissue infection, hepatitis B or C, HIV infection) that may need treatment.
- **Consequences of substance misuse** that might get clients to change (e.g., elevated blood pressure, worsening acid reflux symptoms, increased risk of falls).
- **Physical health issues** (e.g., severe liver disease) that affect whether medications can be given for certain SUDs, such as opioid use disorder.
- Possible drug–drug interactions.

Sleep problems

Sleep quality is closely linked to substance misuse in adults in general. For instance:

- Alcohol misuse and withdrawal can lead to many types of sleep problems. These include:[460,461]
  - Increased awakening during the night.
  - Insomnia.
  - Excessive daytime sleepiness.
  - Less total sleep time.
  - Worsening of sleep apnea and other breathing-related sleep conditions.
- Adults ages 50 and older who binge drink are at an increased risk of insomnia compared with adults in this age group who do not binge drink.[462]
- Compared with people who have never smoked cigarettes, people who smoke report having worse sleep quality, taking longer to fall asleep, sleeping less than 6 hours, and having disturbed sleep.[463]
- Cocaine use is linked to taking longer to fall asleep and having decreased total sleep time.[464]
- Chronic opioid use is associated with an increased risk of central sleep apnea and other breathing-related sleep problems.[465]

RESOURCE ALERT: SAMHSA GUIDANCE ON TREATING SLEEP DISORDERS IN CLIENTS WITH SUDS

SAMHSA's *Treating Sleep Problems of People in Recovery From Substance Use Disorders* offers tips on how to manage clients who have SUDs and sleep problems.[466] It is available online (https://store.samhsa.gov/product/Treating-Sleep-Problems-of-People-in-Recovery-From-Substance-Use-Disorders/sma14-4859).

Sleep is an important part of clients' physical history. Sleeping less and waking earlier are normal parts of aging. But it is abnormal for older clients to be very tired in the day or not sleep through the night. These problems can increase risk of negative events like falls and even death.[467,468,469]

If symptoms of poor sleep are present, also ask about the client's:[470]

- Sleep history.
- Leg movements during sleep.
- Grief or recent loss.
- Level of physical activity during the day.
- Caffeine intake.
- Alcohol consumption.
- Need to use the bathroom during the night.

Several medication and nonmedication treatments can improve sleep problems. Depending on symptom severity, the medical provider conducting this part of the assessment may consult with a sleep medicine specialist for an indepth assessment or with a psychologist for behavioral management of symptoms. A full assessment of sleep should include an assessment for sleep apnea, which may involve an in-home or in-clinic overnight sleep study. Sleep problems that result from a physical condition or medication can usually be treated by addressing the medical illness and by switching medication or adjusting the dose.

Chronic pain

Chronic pain can be hard to manage in any client. But in clients who misuse or are at risk of misusing substances, managing chronic pain becomes even more difficult. This is because substance use can often affect chronic pain in positive ways, even though the substance itself is harmful. For example, many older clients start taking pain medication to reduce physical discomfort. However, they may continue taking the medication to also manage emotional pain or to reduce withdrawal symptoms that occur when they try to stop taking it. Clients may misuse both prescribed and nonprescribed substances, such as alcohol, for such reasons.

People with chronic pain may be at risk for substance misuse. This is not surprising given that substances like opioids, alcohol, and cannabis can help reduce physical pain. The following are findings from several studies of older adults:

- In Wave 3 of the National Epidemiologic Survey on Alcohol and Related Conditions, adults ages 50 and older who engaged in nonmedical cannabis use were significantly more likely also to report past-year injuries, greater pain interference, and nonmedical pain reliever use compared with those not using cannabis.[471] The study authors suggest that, in some older adults, nonmedical substance use and misuse may reflect their efforts to reduce pain without help from doctors.
- Having numerous painful medical conditions, or more severe pain, was associated with a 15-percent to 20-percent increased chance of having physical, mental, or social problems related to drinking.[472] Older adults with pain severe enough to interfere with ADLs were especially likely to have alcohol-related problems.[473]
- Using alcohol to self-medicate pain is associated with greater pain intensity, greater pain interference with everyday activities, and higher levels of depression and anxiety compared with not using alcohol to self-medicate pain.[474]

Older clients are likely to underreport their pain.[475] Using a two-step approach will help you thoroughly assess for chronic pain in older clients:

- **First, ask your clients directly about their pain.**
  - Self-report is the most reliable method of assessing pain in older people.[476] Even most clients with mild-to-moderate cognitive impairment can accurately tell you about their pain.[477]
  - Open-ended questions ("Tell me about your aches and sores," or "Tell me about any discomfort you are having") may be more useful than yes/no questions ("Are you feeling any pain?").[478]
  - You should try using words other than "pain," because some older adults will not report feeling pain.[479] Instead, you can use words like "discomfort," "aches," "hurt," and "sore."
- **Second, use a pain rating scale to learn the intensity of your client's pain.**
  - The revised Iowa Pain Thermometer (IPT-R; see the Chapter 3 Appendix) and the revised Faces Pain Scale (see the Chapter 3 Appendix) are approved for use in older adults, including those from diverse racial and ethnic populations.[480] The IPT-R can also be used with older adults with cognitive impairment.[481]
  - Verbal descriptor scales (VDS; Exhibit 3.9) can be used with older adults with and without cognitive impairment.[482] These scales come in two main types.[483] One type asks clients to rate their pain only using words, such as "none," "mild," "moderate," or "extreme." The second type asks clients to rate their pain using a number scale. The number scale usually ranges from 0 to 5 or 0 to 6.

All three of these tools (the IPT-R, the revised Faces Pain Scale, and VDS instruments) are easy to use and easy for older clients to understand. Although pain scales can be useful, do not rely on them alone. Assessment and treatment planning should consider not just how a client rates on a pain scale but also his or her level of functioning in the presence of pain.

EXHIBIT 3.9. Verbal Descriptor Scales (VDS)[484,485]

(Word-based scale) Please describe your pain from "no pain" to "slight," "mild," "moderate," "severe," "extreme," or "pain as bad as it could be."

(Number-based scale) Please describe your pain using these numbers: 0 for no pain, 1 for slight pain, 2 for mild pain, 3 for moderate pain, 4 for severe pain, 5 for extreme pain, and 6 for the most intense pain imaginable.

Older clients with chronic pain can be treated effectively. However, giving older clients prescription opioid medications to treat chronic pain raises concerns. That's because:

- **Little evidence exists that opioids offer long-term relief of chronic noncancer pain in older adults.**[486] Nonopioid medications, like acetaminophen and topical nonsteroidal anti-inflammatory drugs (NSAIDs), can be effective for certain conditions and are alternatives to opioid medications.[487]
- **Compared with younger adults, older adults have a higher risk of harmful drug–drug interactions** because they often take one or more prescribed medications for chronic illnesses. The combination of opioid medications and alcohol is also very dangerous in older people. (See the CDC's factsheet on screening for alcohol use before prescribing opioids at www.cdc.gov/drugoverdose/pdf/prescribing/AlcoholToolFactSheet-508.pdf.)
- **Long-term opioid use can increase the risk for certain negative physical conditions.** These conditions include breathing problems and hormone changes for older adults.[488]
- **This age group is also at risk for opioid misuse and addiction.**[489] In 2018, more than 9,200 opioid overdose deaths occurred among people ages 55 and older.[490] From 2017 to 2018, opioid overdose deaths among people ages 65 and older increased by 14.3 percent, and deaths from prescription opioid overdose among this same age group increased by 7.4 percent.[491]

- **Some nonmedication treatments may be beneficial and carry less risk** of harm to older adults than opioid medications, although more research is needed on these management approaches.[492,493]

Healthcare providers and prescribers must **carefully weigh the possible benefits of opioid treatment with its risks.** For instance, healthcare prescribers should:[494]

- Try using nonmedication treatments in place of or along with opioid treatment.
- Use a "start low and go slow" approach to dosing.
- Check for possible drug–drug interactions with clients' other medications.
- Discuss with clients the benefits and possible harms of taking opioids.
- Screen and assess clients for factors that increase the odds of misuse and addiction.
- Carefully monitor clients for harmful reactions.
- Educate clients about opioid-related safety issues. These include drug–drug interactions, fall risk, driving risks, and safe storage of opioid medications.
- Periodically review the ongoing need for the opioid medication, and consider whether the dose can be reduced, tapered, or discontinued.

Nonmedication and medication treatments are available to help older adults reduce their pain and improve their everyday activities and quality of life while keeping their risk of opioid misuse and addiction low. Nonopioid medication treatments for pain recommended by CDC in its 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain*[495] include:

- Acetaminophen.
- NSAIDs.
- Antidepressants.
- Anticonvulsants.
- Epidural injections.

In some instances, opioid medication may be appropriate and can be used safely if used within CDC guidelines for safe practices.[496] However, proven nonmedication approaches to pain management exist, such as acupuncture, cognitive–behavioral therapy, physical therapy, massage, biofeedback, and chronic pain self-management programs.

Of note, if medication is used, acetaminophen or oral NSAIDs in older adults can increase their risk of hepatic, cardiovascular, or gastrointestinal toxicity, especially when used long term, in excess, or in combination with certain other medications.[497,498]

Psychosocial History

Substance use history

Substance use histories can help you learn the severity of a client's substance misuse, make SUD treatment plans, discover whether potential drug interactions are present, and understand the negative consequences of the substance misuse. Asking about the client's history of substance use will help you learn about the individual's severity of use and effects of that use on life. This may include asking about:

- Choice of substances used.
- Age at first use.
- The person who first introduced the client to the substance.
- Routes of taking the substance (e.g., injection, smoking).
- History of tolerance, withdrawal, mixing drugs, and overdose.
- Reasons for starting and continuing to use the substance, which may change over time.

Be sure to also ask about current patterns of use, which will help you make treatment decisions. Such questions could include:

- "How much do you drink when you do use alcohol?"
- "How often do you smoke or use tobacco?"
- "When was the last time you had a drink?"
- "Have you ever wondered whether your substance use is affecting your life or health in any way? Have you ever had a DUI?"
- "Does drinking alcohol help you feel better? (If yes) In what ways does it help you feel better? How do you feel after you have stopped drinking?"

- "Which prescription and over-the-counter medications do you take? Do any of them interact with alcohol in a way that could harm you?"

SUD treatment history

Clients' history of seeking SUD treatment or stopping use on their own can help guide treatment planning. Also ask clients about what led to their return to substance use after having stopped for a period. Successful and unsuccessful quit attempts can help you make treatment planning decisions. Taking an SUD treatment history could include asking clients about:

- Specific settings in which they were treated (e.g., inpatient versus outpatient, criminal justice versus non-criminal justice).
- Their history of using support groups and community support and in what ways such supports were (or were not) helpful.
- Previous SUD treatments that were and were not successful. In addition, ask about periods following treatment where clients were successful (e.g., what worked for them).
- Previous attempts at stopping use, why they attempted to stop, and how many times they have tried to stop.
- Circumstances that led to the clients' starting treatment. (Was it voluntary? Why start treatment now, today?)
- Relapse prevention and recovery strategies that worked in the past.
- How treatment ended. (Did they complete treatment or leave treatment early? If the latter, why?)

History of mental illness and mental health services

Co-occurring mental illness is very common among people who misuse substances.[499,500] The 2019 National Survey on Drug Use and Health estimates that 49.2 percent of adults with an SUD in the past year also had a mental illness,[501] whereas only about 16.8 percent of adults without an SUD in the past year also had a mental illness.[502] The survey also estimates that 10.7 percent of adults ages 50 and older with any mental illness also have an SUD.[503] Meanwhile, an estimated 36.8 percent of adults ages 50 and older with an SUD have a co-occurring mental disorder.[504]

Depression, anxiety, and PTSD are especially likely to co-occur with substance misuse.[505,506,507,508] Keep the following points in mind when you assess for these conditions:[509]

- Older clients may be more likely to talk about physical symptoms than emotional ones.
- You should ask about any medications the client is taking. Some medications can cause side effects that are similar to symptoms of depression (like trouble sleeping or feeling low energy).
- Depending on the client's cognitive abilities, you may need to speak with a family member or a family caregiver to get information about the client's mental health and history. Be sure to get permission from the client before doing this.
- Older women in particular can be easily mistaken as having depression or other mental disorders (like anxiety) instead of PTSD.[510]
- Remember the importance of helping clients feel safe physically and emotionally.
  - Trauma and abuse can occur at any point in a person's life. Suicide also can occur in older people. Before assessing for depression and PTSD, make sure you have a safety plan in place. This will help you respond appropriately to any client's reports of abuse and self-harm.
  - Keeping your clients safe isn't just the right thing to do—it's the law. Make sure you know your state's laws about responding to reports of abuse and self-harm.

The co-occurrence of a mental disorder and SUD can make treatment difficult and is associated with negative events. In older adults, such events include increased mortality, an increased chance of experiencing harmful medication–substance interactions, the co-occurrence of complex medical conditions (like dementia), and an increased risk of suicide.[511] Be sure to ask clients about psychosocial symptoms they have during periods of substance misuse and abstinence.

Social history

Learning about a client's social environment and relationships can guide you in treatment planning. That is because social factors can affect whether a client stays in treatment or leaves treatment early, as well as treatment outcomes. Valuable information about the social environment includes the client's:

- Transportation.
- Caregiver needs.
- Caregiving responsibilities (e.g., whether the client cares for a child or other dependent).
- Cohabitating status (i.e., living alone versus with someone).
- Regular access to safe, secure, and stable housing.
- Criminal justice involvement.
- Employment status and quality of work setting.
- Relationships with family, friends, or close others who themselves use substances. (Get the client's consent before speaking to any of these people directly.)
- Sexual orientation, identity, and history, including risk factors for HIV and sexually transmitted infections.
- Level of safety at home, especially in terms of potential for violence. Note that substance use greatly increases the risk of intimate partner violence. Screen all women who seek SUD treatment for intimate partner abuse, regardless of their age.[512] Substance use increases the risk of abuse toward older adults,[513] and experiencing elder abuse can contribute to substance misuse among older adults. If you suspect an older adult is misusing substances, screen for elder abuse.

Family history

Family can play a major role in whether a person is at risk for substance misuse. Always ask clients about the substance use histories of their parents, siblings, and partners. Family-related factors that can increase the risk of having substance misuse include:[514,515]

- Genetic factors.
- The home environment in which a person was raised—specifically, whether the client was exposed to substance use in the household during childhood.
- Having a first-degree relative (i.e., a parent, child, sister, or brother) who misuses substances. For instance, a person has five times the risk of developing alcohol dependence if he or she has any first-degree relative with alcohol dependence.[516] The client's misuse may have a basis in genetic factors, modeling of behavior of others, or both.
- Having negative or low-quality parent–child relationships in adolescence that were unsupportive and featured a lot of arguing or fighting.[517]

Activities of Everyday Living

As people age, many sooner or later have problems completing everyday tasks on their own, like bathing, cooking, shopping, and driving. **Substance misuse can make everyday living even more difficult, including ADLs and instrumental activities of daily living (IADLs).** ADLs are basic everyday tasks like dressing, using the toilet, using the phone, and feeding oneself. IADLs are more complex tasks that need more skills to complete. They include balancing a checkbook, shopping, cooking, and driving. **As part of assessing substance misuse, measure clients' ability to complete ADLs and IADLs without help. This will paint a full picture of the effects of substance misuse.**

Katz Index of Independence in Activities of Daily Living

The Katz Index of Independence in Activities of Daily Living (Katz ADL; see the Chapter 3 Appendix)[518] is one of the most commonly used measures of ADLs. It assesses performance in six areas: bathing, dressing, toileting, transferring, continence, and feeding.

Barthel Index

Like the Katz ADL, the Barthel Index is a brief, widely used screener for ADLs.[519,520] It measures a person's ability to perform the following: feeding, bathing, grooming, dressing, toileting, controlling bladder and bowels, transfers, mobility, and using the stairs. Unlike the Katz ADL, the Barthel Index collects information from three sources—clients, their caregivers, and direct observation—to see whether older adults can complete activities without help.

Functional Activities Questionnaire

The Functional Activities Questionnaire is a measure of IADLs.[521,522] It is completed by a person (usually an adult family member) who knows the client well, has seen the client's behavior, and can assess the client's ability to complete IADLs and how much assistance the client needs to complete them, if any.

Fall Risk Assessment

Older people are at an increased risk of falling, and substance misuse can increase this risk. Falling is the number one cause of injury among people ages 65 and older.[523] Each year, more than 800,000 adults are hospitalized for a fall.[524] Between 30 and 40 percent of adults in the community (that is, not in a hospital) ages 65 and older fall at least once each year. In 2014 alone, older Americans had approximately 29 million falls, which resulted in roughly 7 million injuries.[525] Falls are not only potentially dangerous, they can be expensive as well. The direct cost of care for nonfatal fall-related injuries in older adults in the United States is estimated to be more than $31 billion a year.[526]

Physical and mental conditions (including substance misuse) that can increase an older person's fall risk include:[527,528,529,530,531,532]

- Dementia.
- Delirium.
- Cognitive problems in general.
- Depression.
- Poor sleep.
- Use of multiple medications, especially antidepressants.
- Benzodiazepine use.
- Excessive alcohol use.

How do you know which client does and does not need a fall assessment? The American Geriatrics Society and the British Geriatrics Society[533] suggest you **ask yourself three simple questions:**

- Has the client had two or more falls in the past year?
- Has the client had a recent fall?
- Does the client have trouble with walking or balance?

If you answered "yes" to any of these questions, you may want to assess the client for fall risk.

Timed Up & Go Test

The CDC's Timed Up & Go is one of the easiest ways to assess a client's fall risk. This test measures a person's ability to stand from a sitting position, walk a short distance (10 feet), turn around, and walk back to where the individual was sitting. Instructions for how to give the Timed Up & Go are available online (www.cdc.gov/steadi/pdf/TUG_Test-print.pdf).

Determining Diagnosis and Severity of an SUD

Because diagnosing SUDs in older adults differs from diagnosing SUDs in younger adults, try:

- Using DSM-5 criteria to make an SUD diagnosis.[534] Using an SUD assessment instrument based on DSM-5 criteria will improve diagnostic accuracy. However, not all DSM-5 diagnostic criteria apply to older adults. Always use clinical judgment when making an SUD diagnosis.
- Using diagnostic decision trees made specifically for SUD in older clients.
- Making a treatment plan only after getting a positive substance misuse screen, completing a full assessment, and making a diagnosis of SUD.

- Knowing how to keep older adults interested and willing participants in the screening and assessment process (e.g., knowing what to say to older clients and how to say it).

If diagnostic criteria are met, also find out the severity of the diagnosis. You can do this by counting the number of DSM-5 SUD criteria met by the client's symptoms.[535]

- A mild SUD is present when 2 or 3 of the 11 SUD diagnostic criteria are met.
- A moderate SUD is present when 4 or 5 criteria are met.
- A severe SUD is present when 6 or more criteria are met.

Keep in mind that DSM-5 criteria should be interpreted in an age-appropriate manner. (See Chapter 4 for examples of how DSM-5 criteria for AUD might not be age appropriate.) For instance, tolerance is a DSM-5 criterion for an SUD diagnosis. But older people are more likely to achieve tolerance faster and on smaller amounts of the substance than younger adults. Therefore, tolerance in an older individual does not necessarily mean that they are dependent on the substance. Also remember that symptoms of SUDs are often the same as symptoms of other physical diseases and mental disorders. You must rule out these other mental and physical disorders before making an SUD diagnosis.

Remember that **not every addiction treatment provider is qualified to make a mental disorder diagnosis.** If you do not have the training and licensure to make diagnoses, send the client to another provider in your program who can. If no one in your program has the required qualifications, refer the client to another program that does. Integrated programs can be particularly effective at meeting older adults' full range of biopsychosocial needs and may be a suitable referral option. When possible, help facilitate these referrals by offering a "warm handoff" of clients to the referred provider, which helps ensure that clients are able to successfully access mental health services.

Treatment Planning, Referrals, and Treatments

Treatment Planning

Treatment planning includes preparing to provide treatment or refer to the most appropriate treatment provider. You should start with treatment planning, and then either give the treatment or refer to an outside provider if your program cannot provide the services or level of care the client needs. Although rare, age-specific treatment settings and programs may provide the most effective care for older clients.

The foundation of treatment planning is individualized assessment. This should be done systematically with a tool such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS 20).[536] LOCUS allows the user to characterize the following dimensions based on client strengths, challenges, resources, and risks and produce a specific rating:

- Risk of Harm
- Functional Status
- Medical, Addictive and Psychiatric Co-Morbidity
- Recovery Environment both in terms of level of stress and level of support
- Treatment and Recovery History
- Engagement and Recovery Status

For older adults, be sure to think also about age-related factors when making decisions about where to place the client for treatment. For example, if a client uses a wheelchair, you will want to select a treatment setting that the individual can access. Clients who are Deaf or Hard of Hearing may need individual therapy, small-group therapy tailored to their hearing needs, or both. LOCUS 20 describes six broadly defined levels of care and provides a decision tree and grid to help you map the multidimensional assessment of the client to the level of care most likely to meet their needs. The six levels of care are:

- Recovery Maintenance/Health Management.
- Low Intensity Community Based Services.
- High Intensity Community Based Services.
- Medically Monitored Non-Residential Services.
- Medically Monitored Residential Services.
- Medically Managed Residential Services.

The LOCUS 20 tool can be downloaded for free from www.communitypsychiatry.org/resources/locus.

Using Shared Decision Making

Shared decision making helps people who are receiving treatment for or in recovery from an SUD feel more involved in their own care. Decision making should involve the client in determining preferences for treatment. Statements like those below can help clients participate in the shared decision-making process:

- "I want to work with you to find the best treatment setting possible for you and your needs."
- "Let's see what your spouse and brother think about these treatment options." (Be sure to get the client's consent before speaking with family.)
- "Let's review your smoking cessation options so that you know everything that is available to you."
- "Many people do not understand what 'intensive outpatient addiction treatment' means. Let's talk about that so I can clear up any misunderstandings and answer any questions you might have."
- "You said you would like to hear more about inpatient detoxification. Let me review with you the admission requirements so we can figure out whether this type of setting is best for you."
- "I know we talked about many treatment options today. Why don't you tell me what you think would be the best fit, and then I can share with you my thoughts about the best option. I'll bet we can find something we both agree on."

When cognitive impairment is present, you may need to adapt these statements to elicit an older adult's feedback. Nonetheless, best practices suggest that service providers, healthcare professionals, and guardians maximize each individual's input in the healthcare decision-making process.[537,538]

Research supports involving clients with SUDs in treatment decision-making processes.[539] In some cases, matching clients' substance-related treatment preferences has led to improved outcomes.[540] However, shared decision making in the context of SUDs can be challenging. Clients who have SUDs may have mixed feelings about whether they can, or even want to, stop using substances. This is where MI can be a useful tool.

MI

Motivational interviewing is a client-centered approach to treatment planning that can be used with shared decision making. Combined, these methods can help clients feel confident in their treatment decisions and ability to change their substance misuse.[541]

MI has been reported to be effective for people with many different health conditions, including SUDs.[542] **It has been used successfully with older adults** to help improve physical health and health-related behaviors (e.g., weight loss, exercise) as well as substance misuse (including alcohol misuse and tobacco use).[543] MI can help clients:[544]

- Address any mixed feelings they have about entering treatment.
- Explore their thoughts about changing their behaviors, such as cutting down on alcohol use or monitoring their prescription medication intake.
- Develop personal and meaningful reasons for wanting to change their behaviors.
- Create an action plan for how they will change their behaviors.

Referrals

If your program cannot offer treatment for SUDs, refer your clients to counseling and tailored psychosocial supports that have the capacity to meet older adults' unique needs. You should refer to the level of care that is the least intense yet will address all the client's needs. The following paragraphs describe several options.

A safe withdrawal is the first order of business. If detoxification is needed, that will be the first referral indicated, whether inpatient or outpatient. **Develop a plan for seamless transitions between services and warm patient handoffs.**

Refer for SUD treatment and mental health services as needed. You may need to refer the client to an outside provider for SUD treatment if your setting cannot offer the level of care or types of services the client's symptoms warrant. For example, a client may need inpatient drug and alcohol rehabilitation, but your program only offers outpatient care.

Referral to mental health services is appropriate if the severity or type of mental illness is beyond what you can treat. Clients with depression, PTSD, or other mental disorders may be more likely to succeed in addiction treatment if those conditions are managed.

When considering referral for treatment, first consider the client's thinking abilities. Problems with thinking could affect a client's ability to participate in treatment. The client might need a treatment provider who has experience working with older clients with cognitive problems. Individual treatment rather than group treatment might also be a better choice.

Even if you refer to formal SUD treatment elsewhere, you can still support the client. Follow up with him or her by periodically asking about current substance use and progress in treatment. Use these questions as an opportunity to identify clients at risk for relapse while offering positive reinforcement in a warm and nonjudgmental manner. Addiction treatment providers can also provide ongoing support and encouragement to older clients who enter the formal treatment system by:

- Learning about treatment resources in the community that offer appropriate services. (See "Resource Alert: Making the Most of Your Referral Resources.")
- Keeping in touch with the client's specific treatment program. This can help you make sure the program is offering appropriate care. It will also help you understand the approach and services the program offers so you can appropriately refer future clients there.
- Asking the treatment program to share with you, from time to time, reports about the treatment plan and how the client is doing in treatment. (Get the client's written permission before doing so.)
- Stressing the importance of continuing with treatment when discussing progress with the client.

Make referrals to medical services that provide respectful, consistent physical health care. This can help clients recover from substance misuse. As with any client, you should make appropriate referrals for medical care that is beyond what your practice setting offers.

Make referrals to mutual-help groups for clients who wish to join such groups in addition to receiving addiction treatment or mental health services. These programs can offer clients social support and encouragement to help them avoid substance misuse. (See "Mutual-Help Programs" below.)

Make referrals to additional services that meet clients' needs. In addition to SUD treatment, mental health, and medical services, older adults who have SUDs may need additional support in certain areas. They may benefit from help in areas like:

- Case management.
- Food access.
- Housing.
- Transportation.
- Legal assistance.
- In-home services and supports to facilitate completing ADLs and IADLs.
- Insurance-related needs (e.g., assistance enrolling in Medicare, Medicaid, or both).

RESOURCE ALERT: MAKING THE MOST OF YOUR REFERRAL RESOURCES

Having a collection of substance-related treatment referral resources on hand will help you give clients more options and better access to care. Ask yourself the following questions to help make the most of the available referral resources.

What specialized SUD treatment programs are in my community?

Most communities have a public or private agency that keeps a directory of SUD treatment programs. This directory can give useful information about program facilities (e.g., type, location, hours, accessibility to public transportation), services, eligibility criteria, cost, and staff experience, including languages spoken. Each state also has a single state-level alcohol and drug agency that oversees the licensing and program review for all SUD treatment programs in that state. This agency often offers a statewide directory of all SUD treatment programs licensed in the state.

- You can find SUD treatment facilities by using https://findtreatment.gov/.
- SAMHSA offers a Behavioral Health Treatment Services Locator (https://findtreatment.samhsa.gov/) and a National Directory of Drug and Alcohol Abuse Treatment Facilities (https://www.samhsa.gov/data/sites/default/files/reports/rpt23267/National_Directory_SA_facilities.pdf).

Who are my local resources and points of contact? Reach out to local resources and introduce yourself. Learn what services they offer. This will help you get clients into the system of care more quickly.

What mutual-help groups are in my community? What do they offer older clients specifically? Keep on hand names of mutual-help groups that can meet older clients' age-related needs. For instance, Seniors In Sobriety (SIS) (www.seniorsinsobriety.com) is a part of Alcoholics Anonymous (AA). SIS maintains an online list of SIS and senior-friendly AA meetings in several states (http://www.seniorsinsobriety.com/wp-content/uploads/2019/03/SISMeetings-Mar2019.pdf).

Treatments

Older adults can and do benefit from SUD treatment, although less is known about what works for older adults than for other age groups.[545] **Older adults who get SUD treatment may show the same levels of abstinence as younger adults.[546] In some cases, older adults have had even more success than younger adults.[547,548]** More treatment (e.g., more outpatient sessions, longer inpatient stays) can improve older adults' treatment outcomes.

Mental Health Services

A range of mental health interventions exist for older adults who misuse substances. Effective psychosocial treatments and levels of care that have worked for older clients include:[549,550,551,552]

- Motivational enhancement.
- Cognitive–behavioral therapy.
- Individual and group therapy.
- Supportive therapy.
- Pharmacological treatments.
- Couples and family therapy.
- Brief advice or targeted education.
- Telephone-based brief interventions.
- Relationship enhancement therapy.
- Case management.
- Outpatient treatment.
- Inpatient treatment.

Many of these treatments can also address MDD, PTSD, and other CODs in older clients who misuse substances. To get the best results, recommend mental health services that meet older adults' special needs. Age-related needs often relate to the unique stressors and life events, like retirement, death of a significant individual, or moving into a nursing home, that older adults are likely to experience.

Mutual-Help Programs

Well-known mutual-help programs include the 12-Step programs AA and Narcotics Anonymous. Many other peer-recovery support groups are available as well, like:

- Women for Sobriety.
- SMART (Self-Management and Recovery Training) Recovery.
- LifeRing Secular Recovery.
- Secular Organizations for Sobriety/Save Our Selves.
- Celebrate Recovery.
- Double Trouble in Recovery (for people with CODs).
- Dual Recovery Anonymous (for people with CODs).

Mutual-help programs offer older adults a network of peers with whom they can relate. These groups help older adults share common experiences in substance misuse and recovery. Mutual-help programs also help keep clients socially active and reduce loneliness. These groups and their availability vary greatly in various parts of the county. Some will not be available in many localities, but online and telephone meetings may be available.

Finding local mutual-help programs that are only for older adults can be difficult. Instead, try to find local groups that are open to adjusting their sessions toward older clients and their needs (e.g., using a slower pace, being willing to discuss life-stage changes and loss). You should also look for local groups that already have older-age attendees.[553]

RESOURCE ALERT: AA AND OLDER ADULTS

AA offers a large-print handout for older adults interested in attending an AA meeting. This handout is titled *A.A. for the Older Alcoholic—Never Too Late*. Consider sharing this with older clients who misuse alcohol and express an interest in learning more about 12-Step programs.

(Available at www.aa.org/assets/en_US/p-22_AAfortheOlderAA.pdf)

Summary

A well-thought-out approach to comprehensive screening and assessment will help you identify older adults with or at risk for substance misuse and related conditions. This is an important step in making sure clients get the right diagnosis and timely treatment (or treatment referral). The many screening tools approved for use with older adults can help you detect substance misuse. In addition, numerous measures can help you identify conditions common in older people with substance misuse. These conditions include problems with thinking, depression, anxiety, PTSD, elder abuse, sleep problems, chronic pain, struggles with ADLs, and risk of falling. Indepth assessments allow you to better understand the full range of factors in clients' substance misuse. Screening and assessment results contribute to client-centered care by helping you offer treatment options that meet clients' individual symptoms, risk factors, treatment needs, and treatment preferences.

Remember that a wide range of providers in many different settings can be involved in helping to identify, screen, and assess older clients for substance misuse. There's no "wrong door" through which older adults can receive a diagnosis and the treatment they need.

Appendix A: Treating Substance Use Disorder in Older Adults – Module 1

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. What percentage of older adults in the United States have at least one prescribed medication?
   A. 87.5 percent
   B. 50 percent
   C. 39.8 percent
   D. 75 percent

2. What is defined as moderate drinking for women according to the Dietary Guidelines?
   A. Four drinks a day
   B. Up to two drinks a day
   C. Up to one drink a day
   D. Five drinks a day

3. What is the expected trend for substance use disorders (SUDs) among older adults?
   A. They are expected to decrease
   B. They are expected to remain the same
   C. They are expected to continue increasing
   D. They are expected to disappear

4. What is the definition of heavy drinking for men?
   A. Four or more drinks on each of 5 or more days
   B. Five or more drinks on each of 5 or more days
   C. Two drinks a day
   D. One drink a day

5. What is a common risk factor for alcohol misuse in older adults?
   A. Being physically active
   B. Having a medical condition that drinking could worsen
   C. Having a high income
   D. Living alone

6. What are some protective factors against substance misuse in older adults?
   A. Lifetime history of SUDs
   B. Social isolation
   C. High availability of substances
   D. Resiliency

7. Which medication can prevent relapse after medically supervised opioid withdrawal?
A. Buprenorphine
B. Methadone
C. Naltrexone
D. Naloxone

8. What is a common reason for older adults to take opioid medications?
A. Economic stressors
B. Social isolation
C. Chronic pain
D. Social changes

9. What percentage of older adults take at least one OTC medication according to a 2016 analysis?
A. 38%
B. 50%
C. 25%
D. 10%

10. What is a barrier to seeking treatment for substance misuse in older adults?
A. Access to basic resources
B. High availability of substances
C. Positive self-image
D. Negative attitudes

11. What is defined as moderate drinking for men according to the 2015–2020 Dietary Guidelines for Americans?
A. Up to one drink per day
B. Up to two drinks per day
C. Five or more drinks per day
D. Four or more drinks per day

12. What is the term for the interaction of one substance with another that may change the effectiveness of medications?
A. Substance misuse
B. Drug use
C. Drug-drug interaction
D. Heavy drinking

13. What is the drinking pattern that leads to blood alcohol concentration levels of 0.08 grams per deciliter or greater?
A. Moderate drinking
B. Binge drinking
C. Heavy drinking
D. At-risk drinking

14. What is the medical term for the disappearance of signs and symptoms of a disease or disorder?
A. Substance use disorder
B. Substance misuse
C. Remission
D. Drug use

15. Which group is more likely to have moralistic attitudes about drinking and drug use?
A. Baby boomers
B. Older men
C. LGBTQ older adults
D. Older adults born before or during World War II

16. What should be considered when deciding treatment intensity for older adults?
A. Client needs and preferences
B. Only medical history
C. Age of the client
D. Location of treatment

17. What enhances positive outcomes in treatment for older adults?
A. Focusing solely on medication
B. Using only group treatment
C. Collaborating with clients to develop treatment goals
D. Ignoring client preferences

18. What is a key factor for better outcomes in older adults in long-term recovery from SUDs?
A. Isolation from peers
B. Social supports that promote abstinence
C. Limited social interactions
D. Avoiding treatment altogether

19. What is recommended for older adults who misuse substances and do not want to set abstinence as their goal?
A. Only providing medicaton
B. Forcing them into abstinence
C. Ignoring their preferences
D. Engaging in health risk reduction practices

20. What should treatment programs do to help older clients connect with recovery resources?
A. Use a case management approach
B. Focus only on individual therapy
C. Limit client involvement

D. Avoid community services

21. What is substance misuse?
A. The use of substances only in large quantities
B. The use of any substance in a manner that can cause harm
C. The use of substances that are legal
D. The use of substances only by young adults

22. What does SUD stand for?
A. Substance Uncontrolled Disorder
B. Substance Underuse Disorder
C. Substance Use Disorder
D. Substance Utilization Disorder

23. What is the recommended maximum alcohol consumption for women according to federal guidelines?
A. Three standard drinks a day
B. Two standard drinks a day
C. One standard drink a day
D. No alcohol consumption allowed

24. What does the SAMI330 questionnaire assess?
A. Risky alcohol use in older adults
B. General health of older adults
C. Mental health disorders in older adults
D. Physical fitness of older adults

25. What is the purpose of screening for substance misuse in older adults?
A. To identify only illegal drug use
B. To discourage all alcohol use
C. To promote social drinking
D. To increase chances for recovery

26. What is the purpose of the PHQ-9?
A. To screen for depression
B. To assess anxiety
C. To evaluate cognitive impairment
D. To measure elder abuse

27. Which screening tool is specifically mentioned for assessing anxiety in older adults?
A. Geriatric Depression Scale
B. Geriatric Anxiety Scale
C. Patient Health Questionnaire-9
D. Mini-Cog

28. What is a risk factor for experiencing elder abuse according to the document?
A. Social isolation
B. Physical health issues
C. Cognitive disorders
D. Financial problems

29. What percentage of people aged 50 and older have had at least one adverse childhood experience?
A. 32%
B. 52%
C. 72%
D. 42%

30. What is the Geriatric Depression Scale (GDS)–Short Form used for?
A. To assess cognitive function
B. To measure anxiety levels
C. To evaluate substance use
D. To screen for depression

31. What is one of the three approaches to addressing substance misuse based on severity?
A. Immediately give a brief assessment during the same visit
B. Provide a full assessment if screening results are clear
C. Refer the client to a detoxification program
D. Ignore the screening results

32. What should be done if a cognitive screener is positive?
A. Conduct a brief assessment
B. Refer the client for further testing by a behavioral health service provider
C. Schedule another visit for a full assessment
D. Provide immediate treatment

33. What was one of the outcomes for clients who completed the BRITE program?
A. Higher rates of hospitalization
B. Increased substance use
C. Lower SMAST-G scores
D. No change in substance use

34. What is MCI a milder form of?
A. Cognitive impairment
B. Substance use disorder
C. Depression
D. Anxiety

35. How often does the TIP consensus panel recommend rescreening clients?
A. Every two years

B. Every month
C. At least once a year
D. Only when requested by the client

36. What should be in place before assessing for depression and PTSD?
A. A treatment plan
B. A safety plan
C. A medication list
D. A referral list

37. What is a potential risk of prescribing opioid medications to older adults?
A. Increased pain relief
B. Improved sleep quality
C. Lower risk of falls
D. Higher risk of drug interactions

38. What is one of the tools mentioned for assessing pain in older adults?
A. Pain Assessment Tool (PAT)
B. Verbal Descriptor Scales (VDS)
C. Chronic Pain Scale (CPS)
D. Pain Intensity Scale (PIS)

39. What should you do if a client has had two or more falls in the past year?
A. Conduct a fall assessment
B. Ignore the falls
C. Increase medication dosage
D. Refer to a dietitian

40. What is the purpose of shared decision making in treatment?
A. To speed up the treatment process
B. To involve the client in their care
C. To reduce treatment costs
D. To make decisions for the client

Name: _____

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